Policies to reduce exposure to environmental tobacco smoke

Report on a WHO Working Group Meeting
Lisbon, Portugal, 29–30 May 2000

EUROPEAN HEALTH21 TARGET 10

A HEALTHY AND SAFE PHYSICAL ENVIRONMENT

By the year 2015, people in the Region should live in a safer physical environment, with exposure to contaminants hazardous to health at levels not exceeding internationally agreed standards

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 12

REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

Environmental tobacco smoke (ETS) poses a significant risk to health. It is carcinogenic to humans and is a risk factor for cardiovascular and respiratory diseases. Exposure to ETS is widespread, affecting people in houses, workplaces and public buildings. ETS is also a part of a broader problem of tobacco use. The Working Group was convened to discuss approaches to reducing the risks to health created by ETS and to support Member States in defining their policies on ETS. The Group concluded that public health policy and actions should aim at eliminating exposure to ETS by creating smoke-free environments for everyone. This should be achieved through a combined programme of legislation and education. Laws and regulations are essential to provide protection against involuntary smoking; voluntary arrangements are not sufficient. The meeting report includes specific recommendations on legislation, litigation, education and public information necessary to achieve smoke-free environments.

Keywords

TOBACCO SMOKE POLLUTION
AIR POLLUTION, INDOOR
ENVIRONMENTAL EXPOSURE
SMOKING
LEGISLATION
HEALTH POLICY
EUROPE

This document was text processed in Health Documentation Services
WHO Regional Office for Europe, Copenhagen

CONTENTS

Background

The risks to health related to exposure to environmental tobacco smoke (ETS) are well established. The revised WHO *Air quality guidelines for Europe* concludes: "ETS has been found to be carcinogenic in humans and to produce a substantial amount of morbidity and mortality from other serious health effects .... Acute and chronic respiratory health effects on children have been demonstrated in homes with smokers ... and even in homes with occasional smoking … There is no evidence for a safe exposure level." The WHO International Consultation on Environmental Tobacco Smoke and Child Health (Geneva, 11–14 January 1999) called for "swift action to highlight the need for strong public policies to protect children from exposure to tobacco smoke".

Environmental tobacco smoke is a major indoor air quality problem, affecting people in houses, workplaces and public buildings. It is also a part of the broader problem of tobacco use. The paramount importance of tobacco as a factor affecting health has been recognized by the World Health Assembly (WHA), which in resolutions adopted in 1999 and 2000 sets forth the process for WHO Member States to negotiate the Framework Convention on Tobacco Control and to present it for adoption by the WHA in 2003. The scope of the Framework Convention is subject to intensive negotiations between Member States, and environmental tobacco smoke is one of the items on the agenda.

The current project aims to strengthen the capacities of the Member States in defining their policies on ETS and to discuss the basis for possible international approaches to reduce the risks to health created by environmental tobacco smoke. A Working Group has been convened and held a meeting in Lisbon, Portugal, from 29 to 30 May 2000 to review Member States' current approaches to protecting populations from ETS exposure. Based on the exchange of experience, the meeting defined conditions for successful policies and recommended the most effective strategy for future action.

The meeting was attended by 35 participants from 26 countries, as well as staff from the WHO Regional Office for Europe (WHO/EURO) and WHO headquarters (see Annex 1). The national representatives were selected from a longer list of experts recommended to WHO by the governmental and nongovernmental bodies involved in setting policies on tobacco in Europe, as well as from experts in the fields of assessment and management of indoor air quality. Professor José Calheiros chaired the meeting, and Ms Jennifer Jinot and Mr Bill Coyne acted as co-rapporteurs. The WHO European Centre for Environment and Health, Bilthoven Division, organized the meeting, in collaboration with the WHO/EURO Tobacco or Health unit. The Portuguese-American Development Foundation hosted the meeting and contributed to the travel costs of participants coming from the United States, which is gratefully acknowledged.

The experts attending the meeting were invited to prepare short summary reports on the policies and activities aimed at reducing exposure to ETS in their countries. Reports were received from 26 European countries and distributed to participants in advance of the meeting. The reports are copied in Annex 2 (some in a version revised after the meeting). The initial session allowed for a synthesis of the reports as well as for an overview of recent evidence on determinants of population exposure to ETS. After the introductory presentations, the group split into three working groups to discuss the most effective elements of policy to reduce exposure to ETS as

well as determinants of their effectiveness. After an exchange of information about the main directions and progress in their discussions at a plenary session, the working groups continued with proposing recommended future actions. The final formulation of the conclusions and recommendations was conducted at a plenary session, with each point accepted by consensus of the entire group. This report, prepared by the co-rapporteurs and secretariat, has been reviewed and approved by the Working Group members.

Summary of discussion

The starting point of the discussion was the conclusions of the previous WHO assessments confirming the existence of risks to health related to the exposure to any level of ETS. These conclusions give a strong scientific basis for policies to eliminate exposure. However, there is still a need to improve the dissemination of the scientific evidence on the health effects of ETS exposure.

The reports describing current policies to deal with exposure to ETS indicated that approaches vary widely across countries. Some level of smoking restriction is most common in schools, day care centres, public transport and places of public entertainment (theatres, etc.). However, there are still several countries with no such restrictions, and in those with regulations, the restrictions are not comprehensive and compliance is often poor. In 6 out of 22 reporting countries, smoking is not restricted in hospitals. Workplace regulation is non-existent or unclear in 8 countries (out of 26 reporting), and in a further 8 it covers only state or other public enterprises but not private workplaces. Over half the reporting countries have no restrictions on smoking in restaurants, cafeterias and other catering facilities. In all countries, there are problems with the effectiveness of the existing regulations in preventing exposure to ETS.

The report on public health policy related to involuntary smoking in the United States emphasized that action against ETS is probably the best way to reduce *active* smoking. It has been observed that the four most significant predictors of progress towards people stopping smoking are a smoke-free workplace, a smoke-free home, an understanding that second-hand smoke is dangerous (especially for children), and cessation assistance based on counselling and other non-medical methods. In this respect, restricting smoking in the workplace is a powerful tool for reducing active smoking. According to the American experience, some time after the introduction of smoking restrictions, smokers stop because of the inconvenience and the decreasing social acceptance of smoking. It was also reported that the latest evidence suggests that children of parents who only smoke outside are less likely to start smoking themselves. Another important tool in reducing ETS exposure is community-level action to educate and mobilize nonsmokers to demand the realization of their right to clean air. An important determinant of effective action is to make the message clear that it is the smoke, not the smoker, that is the enemy. Also, proper appraisal of the economic consequences of smoking bans is necessary. For example, contrary to the claims made by the tobacco industry, there has been no decrease in restaurant revenues related to the introduction of smoking bans in restaurants.

At the level of the European Union (EU), a legal basis for action on passive smoking issues could exist under the EU Treaty Articles 136–138 dealing with the protection of workers. Furthermore, there are several resolutions of the Council of Ministers on the topic of passive smoking, although these are non-binding and their recommendations appear to be fairly weak. Several EU programmes could potentially provide funding for passive smoking activities, although only a few such activities have been supported to date. For example, the Europe against

Cancer programme supported the development of a review of the health effects of passive smoking, published by the French Comité national contre le tabagisme in 1999, and the Community Public Health Programme has recently approved a Swedish project on indoor air pollution, including passive smoking. There is also the Community Fund for Research and Information on Tobacco, although no project proposals on passive smoking have yet been submitted through this mechanism. Finally, there is the Fifth Framework Programme for Community Research.

The discussion revealed general agreement that enforceable legislation is required and that voluntary policies are not adequate to deal effectively with ETS exposures. To stimulate and implement this legislation, local action for educating and mobilizing people to demand smoke-free environments might be necessary in many countries. It was suggested that it would be helpful to have a European nongovernmental organization (NGO) dedicated to this issue (similar to Americans for Nonsmokers' Rights). Such a group should also function as a clearing-house for information, so that everyone can benefit from the experience of others and can point to successful examples. There was also interest in the idea of a resource centre which would have a range of important functions, including the coordination of standardized reporting efforts, acting as a repository for the resulting data, serving as a clearing-house for information on existing legislation and contacts, and providing support to counter misinformation from the tobacco industry.

Participants also discussed the usefulness and limitations of exposure monitoring to support action to reduce exposure. They accepted that no personal exposure measurements are necessary to confirm that the occupants of an indoor space are exposed to ETS when tobacco is smoked in their vicinity. Existing evidence showed that ventilation is not an effective solution to the problem of tobacco smoke pollution. Biomarker measurements may, however, be useful to highlight exposures in certain subgroups, such as children and restaurant workers, and to raise local awareness and propel action. Care must be taken that the measurements are not misconstrued so as to suggest that there are safe levels of exposure.

Further discussions concentrated on several specific points related to the most effective future action, for example:

- regulatory action should focus on workplaces in general: limiting action to specific environments such as schools or hospitals decreases its impact; if all workplaces are made smoke-free, hospitals and schools will be included;
- approaches aiming at reduction of exposure to ETS in the home should focus on children's health; this is a priority issue, as confirmed by the Third Ministerial Conference on Environment and Health in London (June 1999), as well as emotionally salient, and can be instrumental for the success of programmes to eliminate the exposure of other members of the household;
- the development and implementation of new communication strategies to educate and mobilize the public should be an important element of future action.

Conclusions and recommendations

General

1. Public health policy and action should aim at the elimination of ETS pollution by creating smoke-free environments for everyone.
2. This goal should be achieved through a combined programme of legislation and education. Legislation is necessary to create smoke-free workplaces and public places, including restaurants, educational institutions, day care centres and hospitals. Educational and promotional campaigns should be implemented to facilitate compliance with this legislation and also to encourage smoke-free homes.
3. An integrated multisectoral response should be developed involving, among others, the health, environment and education ministries as well as appropriate NGOs.

Legislation

4. Laws and regulations are essential to provide protection against involuntary smoking. Voluntary arrangements are not sufficient. For such legal instruments to be effective, they should have viable means of enforcement, be supported through educational and promotional programmes, and be equipped with appropriate sanctions for non-compliance.
5. Since there is no evidence for a safe exposure level, legislation limited to ventilation design and standards cannot achieve smoke-free workplaces and public places.
6. The enforcement instruments should be created and administered by the health, occupational health and safety, and environment agencies.
7. Action at both national and sub-national levels to develop and enforce legislation or regulations is important and mutually reinforcing. The model of local or grass-roots legislation (e.g. city by-laws) has proved very effective and should be encouraged in countries where this is possible. In countries where action cannot be taken locally, the focus should be on national legislation.
8. The tobacco industry should be required to disclose the names of people and organizations to which it provides both direct and indirect funding and support.

Litigation

9. Legal action should be taken using existing laws to protect nonsmokers and to require smoke-free environments. This action should be encouraged to use existing laws and legal systems to protect the rights of nonsmokers most effectively.
10. The American litigation has proved very effective in bringing the truth to the public, and has acted as a catalyst for political action. The British and Irish parliamentary enquiries and the USA Congressional hearings have also contributed to this. Such enquiries are most effective when parliaments have the legal authority to compel witnesses to testify and documents to be produced. Countries are encouraged to take appropriate action to hold the tobacco industry accountable for damage caused by second-hand smoke.

Education and the promotion of smoke-free environments

11. Governments should educate their populations regarding the right to smoke-free air, existing laws and the dangers of involuntary smoking, including the fact that there is no safe level of exposure.

12. Educational efforts on the particular dangers of second-hand smoke to children should be used as a critical part of educational campaigns designed to achieve smoke-free homes. These educational programmes should address parents, children, child health professionals and family doctors.

13. Employers, health professionals, teachers, occupational health and safety professionals, union leaders, policy-makers, the media, the hospitality industry and other opinion-formers should be informed of the benefits of and need for smoke-free environments.

14. Legislators, policy-makers and the public (including employers and members of the hospitality industry) should be educated about disinformation campaigns by the tobacco industry.

15. No educational institution should accept any "educational" programme prepared, distributed or financed by the tobacco industry.

Information/networking

16. WHO/EURO should provide a clearing-house to support legislation and other action to create and support smoke-free environments. This support should include a comprehensive database of existing legislation, individuals and organizations working to create smoke-free environments, current data on the health effects of involuntary smoking, and information on the tobacco industry's activities to prevent the creation of smoke-free environments.

17. WHO/EURO should disseminate the *Air quality guidelines* chapter on environmental tobacco smoke as a separate document. It should also encourage occupational agencies to promote smoke-free workplaces and advise Member States' environmental health agencies to promote smoke-free environments.

18. There is a need for a well supported, structured European network to share experience related to ETS on a continuing basis and to develop and operate standardized analytical tools.

19. WHO's activities need to recognize and address the distinct needs of different regions, which have different cultures and perspectives.

20. There is a need for uniform reporting of the indicators on both active and passive smoking across the WHO European Region to assess progress towards meeting the stated goals. Readily accessible data, which quantify the exposure of the population (both adults and children) and the efficacy of specific interventions, should be a part of this information. WHO should include these data in its information system.

Annex 1

PARTICIPANTS

Temporary Advisers

Ms Rose-Mary Alvarez
Comité National contre le Tabagisme, Legal and Prevention Area, 31 avenue du Général Bizot, 75012 Paris, France

Professor José Manuel Calheiros *(Chairperson)*
Instituto de Ciências Biomédicas Abel Salazar, Largo Prof. Abel Salazar 2, 4099-003 Oporto, Portugal

Ms Julia Carol
Americans for Nonsmokers' Rights, 2530 San Pablo Avenue, Suite J, Berkeley, CA 94702, USA

Professor Nicolas Choulis
Greek Antismoking Society, Pharmaceutical Technology, University of Athens, P.O. Box 511 73, 14510 Kifissia, Greece

Ms Susanne Conze
Federal Ministry for Health, Am Propsthof 78a, 53121 Bonn, Germany

Mr Bill Coyne *(Co-Rapporteur)*
Department of Health, Health Promotion Division, Room 436, Wellington House, 133–155 Waterloo Road, London SE1 8UG, United Kingdom

Mrs Christine Gafner
Passive Smoking OFSP, Progef, Neufeldstrasse 134, CH-3012 Berne, Switzerland

Dr Stanton A. Glantz
Division of Cardiology, University of California at San Francisco, Box 0130 MSG 1317, San Francisco, CA 94143, USA

Ms Jennifer Jinot *(Co-Rapporteur)*
NCEA – 8623-D, U.S. Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460, USA

Professor Asbjørn Kjønstad
University of Oslo, Karl Johans Str. 47, 0162-Oslo, Norway

Dr Verica Kralj
Health Promotion Programme Development Unit, Croatian National Institute of Public Health, Rockefellerova 7, HR-10000 Zagreb, Croatia

Dr Erik Loosen
Brussels Huisartsen, Stalingradlaan 15, 1000 Brussels, Belgium

Dr David M. Mannino
Air Pollution and Respiratory Health Branch, National Center for Environmental Health, Centers for Disease Control and Prevention, 1600 Clifton Road, MS E-17, Atlanta, GA 30333, USA

Professor Dr Manfred Neuberger
Department of Preventive Medicine, Institute of Environmental Health, University of Vienna, Kinderspitalgasse 15, A 1095 Vienna, Austria

Dr Thorsteinn Njalsson
Tobacco Control Task Force of Iceland, Drangagata 1, IS-220 Hafnarfjordur, Iceland

Ms Elisa Ong
Institute for Health Policy Studies, University of California at San Francisco, Box 0936, LHts 265, San Francisco, CA 94143, USA

Dr Bo Pettersson
Division of Environmental & Public Health, National Board of Health & Welfare, SE-10630 Stockholm, Sweden

Mr Thomas Power
Office of Tobacco Control, Department of Health and Children, Hawkins House, Hawkins Street, Dublin 2, Ireland

Ms Viktorija Rehar
National Coordinator Tobacco Control, SUHPE, Hmeljarska 3, 3310 Zalec, Slovenia

Dr Kari Reijula
Finnish Institute of Occupational Health, Arinatie 3A, FIN-00370 Helsinki, Finland

James Repace
Repace Associates, Inc., Second-hand Smoke Consultants, 101 Felicia Lane, Bowie, MD 20720, USA

Dr José Manuel Rocha Nogueira
Centro Regional de Saude Publica do Norte, Rua Latino Coelho, 260, 4049-032 Oporto, Portugal

Dr Peter Rudnai
National Institute of Environmental Health, Fodor Jozsef National Centre for Public Health, Gyali ut 2-6, H-1097 Budapest, Hungary

Ms Ulla Skovgaard Danielsen
The Danish Council on Smoking and Health, Ravnsborggade 2, 2200 Copenhagen N, Denmark

Dr Katarina Slotova
State Health Institute, Cesta K Nemocnici 1, 975 56 Banska Bystrica, Slovak Republic

Dr Tomas Stanikas
Kaunas University of Medicine, Mickeviciaus Str. 9, 3000 Kaunas, Lithuania

Dr Javier Toledo
Tobacco Control Programme, Servicio Aragonés de Salud, Departamento de Sanidad, Consumo y Bienestar Social, Av. Cesareo Alierta 9-11, E-50071 Zaragoza, Spain

Professor Jean Trédaniel
Unité de cancérologie thoracique, Hôpital Saint-Louis, 1 avenue Claude Vellefaux, 75010 Paris, France

Dr Theo van Iwaarden
Coordinator, Alcohol and Tobacco Policy, Directorate for Public Health, Ministry of Health, Welfare and Sport, P.O. Box 20350, 2500 EJ The Hague, Netherlands

Mr Peter van Soelen
Dutch Foundation on Smoking or Health, Stivoro, P.O. Box 84370, 2508 AJ The Hague, Netherlands

Dr Signe Velina
Department of Public Health, Ministry of Welfare, 28 Skolas street, LV-1331 Riga, Latvia

Professor Tudorache Voicu
Pneumology Clinic, University of Timisoara, Str. 1 Decembrie – 90 Sc.B. Et VI, Ap 24, 1900 Timisoara, Romania

Professor Dr Friedrich Wiebel
Institute of Toxicology, GSF Research Centre for Environment and Health, P.O. Box 1129, D-85758 Neuherberg, Germany

Dr Giovanni Zapponi
Laboratorio de Igiene Ambientale, Istituto Superiore di Sanità, Viale Regina Elena, 299, 00161 Rome, Italy

Professor Dr Witold Zatoński
Department of Epidemiology, Cancer Centre and Institute of Oncology, 5 Roentgena Str., 02-781 Warsaw, Poland

Observers

Ms Catherine Allen
Office of International Activities (R2660), US Environmental Protection Agency, 1200 Pennsylvania Ave, NW, Washington, DC 20460, USA

Ms Mallika Anand *(Assistant to WHO Secretariat)*
c/o Madhu M. Anand, P.O. Box 8801, Warren, OH 44484, USA

World Health Organization

Regional Office for Europe

Ms Elisabeth Asirifi
Tobacco or Health unit

WHO European Centre for Environment and Health, Bilthoven Division

Dr Michal Krzyzanowski
Air Quality project

WHO European Centre for Environment and Health, Rome Division

Dr Giorgio Tamburlini
Children, Health and the Environment

Headquarters

Ms Barbara Zolty
Tobacco Free Initiative

WHO Secretariat

Ms Debbie Romaniuk
Ms Karen Tonnisen

Annex 2

POLICIES TO REDUCE EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE IN EUROPE

This annex presents the papers prepared for the Working Group as background to the discussions at the meeting. They were made available to the Working Group members in advance of the meeting but were not discussed or peer-reviewed in detail at the meeting. Contributions from several countries were updated after the meeting. The papers present the point of view of the authors, and are not official statements made on behalf of their institutions, governments or WHO.

Overview of country reports

The tables below were constructed using the information from the background papers. Since the request for the background paper did not specify the structure of the reports, some authors might have omitted certain information, even though the relevant legislation exists in the country.

Table 1. Number of countries with restrictions on tobacco smoking in public places
(28 European countries reporting)

	Bans/ restrictions	Partial restrictions	Unclear regulations	No restrictions	No information
Workplaces	10	8[a]	8	–	2
Schools	19	2	–	–	7
Day care centres	6	1	–	–	21
Hospitals	17	4	6	–	1
Urban transport	19	–	–	2	7
Long-distance transport	14	–	–	–	14
Restaurants, etc.	11	3	–	12	2
Places of entertainment, etc.	23	–	–	3	2

[a] Smoking regulations in public (not private) workplaces only.

Table 2 presents an overview of indicators calculated on the basis of the information in the background papers. It serves to make a rough comparison between the countries of the existence of legislation related to restrictions on ETS exposure. For some countries, the information available in the background papers was not clear enough to assign a score; in these cases "–" is entered in the table.

Table 2. Summary indicators calculated on the basis of reports from 28 European countries

Country	Sum	Mean
Austria	–	–
Belarus	7	1.4
Bulgaria	8	1.1
Croatia	11	1.4
Czech Republic	–	–
Denmark	5	0.8
Estonia	7	0.9
Finland	5	1.3
France	–	–
Germany	8	1.1
Greece	11	1.6
Hungary	8	1.1
Iceland	–	–
Ireland	–	–
Italy	2	1.0
Latvia	10	1.1
Lithuania	9	1.0
Netherlands	–	–
Norway	11	1.6
Poland	5	0.8
Portugal	10	1.0
Romania	2	1.0
Slovak Republic	4	1.0
Slovenia	12	1.7
Spain	9	1.1
Sweden	–	–
Switzerland	8	1.1
United Kingdom	3	0.8

Summary indicator on policies to reduce exposure to environmental tobacco smoke

The indicator is constructed through assignment of scores for restrictions on smoking in the following settings and for restrictions on cigarette advertising:

1. schools
2. day care centres
3. government offices and other public buildings
4. public traffic vehicles: urban transport
5. public traffic vehicles: long distance (trains)
6. hospitals
7. workplaces
8. cinemas, theatres, museums, etc.
9. restaurants, bars, etc.
10. cigarette advertising

Score: "0" = no measures
"1" = restricted (partial regulations or implementation)
"2" = prohibited

Indicators: a) sum of the scores (range: 0–20)
b) mean (sum/number providing information) – range 0–2

Policies to reduce exposure to ETS in Austria

Professor Manfred Neuberger, Professor of Environmental Health, Institute of Environmental Health, University of Vienna, Austria

The Austrian Tobacco Law (431/1995) prohibits smoking in rooms dedicated to teaching and education, conferences or school sports. In multifunctional rooms and halls smoking is prohibited during the uses mentioned above (and before/during the necessary air exchange time). In offices open to the public, schools or similar institutions open for children and juveniles, universities and other educational institutions and institutions for public presentation, exhibition or performance, smoking is only allowed in separate rooms set aside for smoking, as long as smoke cannot escape from these rooms and if the general prohibition of smoking in these institutions cannot be circumvented.

The original intention of the Tobacco Law was to prohibit smoking in all school areas, but after protests from teachers, a separate regulation for schools (221/1996) restricted the prohibition to areas within school buildings which are open to the public, and allowed individual regulations (smoking-rooms for teachers) within the limits of the Employee Protection Law. The unfortunate result of this "deregulation" is students smoking in schoolyards and teachers smoking in their rooms, sometimes within sight of their pupils.

In hospitals, only individual regulations under the Hospital Law (801/1993) are in force and the initiative for a smoke-free hospital is left to the hospital director. The Tobacco Act introduced by the former Minister of Health was intended to ban smoking from all publicly accessible buildings such as hospitals, banks, railway stations and public transport stops and also from designated zones in restaurants. However, an agreement is still awaited between the Ministry of Economic Affairs and the interest group of innkeepers to regulate nonsmoking areas in restaurants.

The Ministry of Economic Affairs recently took over the responsibility for work inspection from the Ministry of Social Affairs and Health and, as the Ministry of Economy and Work, is now also in charge of protecting workers from ETS. The Employee Protection Law (450/1994) only requires employers to concern themselves with protection from ETS at the workplace "in as far as possible in the kind of enterprise", but clearly states that smoking is forbidden (in work-rooms shared by smokers and nonsmokers) if nonsmokers cannot be protected adequately by increased ventilation. In toilets and cloak-rooms smoking is prohibited and in other common rooms adequate technical and organizational measures are required for the protection of nonsmokers from ETS. Tobacco smoke, however, is not classified as a workplace carcinogen since it is argued that it is not produced from work.

The number of smoke-free enterprises is still small in Austria and dependent on the image of the company and the smoking behaviour of the head of the enterprise. Labour unions oppose stricter regulations because they fear that smoking could become the privilege of the chief in his/her own office, while the workers are not allowed to smoke even in large and well ventilated production areas. Only nonsmoking pregnant women have to be protected from ETS by either room separation or appropriate orders of the employer to her work mates (Mothers' Protection Law, 434/1995).

Nonsmoking areas in public transport facilities (including bus, rail, ship and air transport) are provided according to the Tobacco Act and have been enlarged in recent years, but controls

should be improved. Austrian, Lauda and Tyrolean Air Lines offer smoke-free flights only. (Nicotine replacement is recommended to smoking passengers on long-distance flights.)

Most important is the reduction of ETS exposure for the health of unborn or young children. Dr Außerwinkler (former Minister of Health) tried to link the amount of financial support for all mothers not only to participation in screening examinations during pregnancy, at birth and during the first three years of the child's life, but also to nonsmoking during pregnancy. So far, however, no cotinine tests are included in the health screening programme and financial support for mothers has been reduced in general for budgetary reasons.

NGOs such as the Doctors Initiative against Diseases from Smoking are engaged in communicating the health risks from passive smoking, in particular the life-threatening effects of ETS on young children, as well as the impairment of growth in lung function in elementary schoolchildren which was proved in a large epidemiological study in Austria. As a result of better information, an increasing number of parents have been observed smoking out of open windows or on their balconies and not in living rooms or bedrooms shared with children.

Many people, however, still tend to judge ETS and other air pollution according to different scales. Despite a high acceptance of environmental health protection needs in Austria, our research results showing that ETS affects the respiratory system in a similar way to industrial air pollution have not yet been acknowledged. We have experienced that health risk comparisons between outdoor air pollution and ETS have to be made with care. If we want to enlist the support of environmentalists fighting for clean air we have to avoid downgrading environmental risks by comparison with smoking. Comparisons with the risks of ETS should always stress that tobacco smoke is the worst killer and that combined effects between active smoking and environmental and occupational pollution[1] are also expected to occur between ETS and other indoor and outdoor pollution.

Unions, and especially teachers, have to be convinced that health protection is more important than the protection of materials or property in connection with which a worker is not allowed to smoke (e.g. in the production of computer chips). Journalists must also be convinced, and the financing of media by tobacco advertising must be stopped. The EU advertising ban must now be implemented in the Austrian Tobacco Act. If the implementation of this most important directive is successful we also expect improvements in the reduction of ETS exposure.

At present, the rates of smoking among Austrian adolescents and females (including future mothers) are still increasing. However, tobacco tax will be increased this year by 3 S (€ 0.22) per pack. The Secretary of State for Health, Dr Waneck, has restarted the discussion on dedication of tobacco tax revenues to national smoking prevention activities, and has also demanded a further increase of tobacco tax by 2 S per pack in 2001 to be dedicated to the prevention of and therapy for tobacco addiction. The Austrian Doctors against Diseases from Smoking support this intention and hope that part of this levy on the tobacco tax will be spent on improving the image of nonsmoking among children and adolescents, while the tobacco advertising ban will prevent the tobacco industry from further improving the image of smoking. New and indirect forms of tobacco advertising have to be stopped immediately during this critical phase of attempting to reverse the trend with the help of NGOs. The Austrian Cancer League has already started a number of projects for schoolchildren such as the smoke-free class competition (Be Smart, Don't Start) supported by

[1] See, for example, *Health effects of interactions between tobacco use and exposure to other agents*. Geneva, World Health Organization, 1999 (Environmental Health Criteria 211).

the EU. The Austrian physicians' network will also attempt to improve smoking cessation programmes, which help to prevent diseases from smoking and at the same time reduce sources of ETS. All educational programmes should attempt to make smokers respect the right of nonsmokers to breathe clean air. WHO's recommendations and conventions, and even more the directives of the EU such as on tobacco advertising, will be essential for the success of our efforts to create smoke-free environments by law, economic instruments and education in Austria.

Tobacco control in Belarus

Dr Irina Tioukhlova, Chief Doctor, Republican Centre of Health, Minsk, Belarus

Smoking is an acute problem in Belarus. About 45–47% of the adult population smokes. The government has passed a number of laws to control tobacco consumption. The laws "About prevention of disability and rehabilitation of invalids" and "About advertising" ban cigarette advertising in mass media. The presidential decree "About additional measures on state regulation of production and circulation of alcohol, non-food spirit containing products, ethyl alcohol from non-food raw materials and tobacco products" fixes the licensing, producing, storing and selling of tobacco products and excise duties and quotas. In accordance with this presidential decree, a special committee has been created under the State Tax Committee to control the production and circulation of alcohol and tobacco.

To create a favourable atmosphere for nonsmokers, the following normative acts have been drawn up and introduced which forbid:

- smoking at work places, except in specially assigned places
- smoking in local trains and its limitation to special places on long-distance trains
- smoking on 13 BELAVIA airlines
- smoking in cinemas except in places allocated for this purpose
- the sale of cigarettes to under age individuals.

The *Temporary guide for toxico-hygienic research of tobacco products* determines the demands on marking cigarettes (compulsory distinct and legible marking on each packet, ordinary or souvenir box of cigarettes containing a warning about the danger of smoking), and the maximum amount of nicotine, tars and pesticides allowed in tobacco products.

Measures to reduce tobacco consumption by the population are included in state programmes on the "Health of the nation", "Cardiology", "National programme for prevention of caries and dental illnesses among the population of Belarus", "Children of Belarus".

Several international projects working in Belarus consider smoking to be one of the risk factors for various non-infectious diseases, including the "New approaches to the prevention of dependence" project (WHO/Netherlands/Belarus), the WHO countrywide integrated noncommunicable disease intervention (CINDI) programme and its demonstration projects on health of industrial enterprise employees, stomatology, cardiology, prevention of non-infectious diseases in the city, and developing a healthy lifestyle in the Brest region.

Belarus has participated in the international lottery campaign "Quit and Win" three times. In 1998, 2824 people took part. Belarus was one of the 15 most active participating countries, and the second most active among the Commonwealth of Independent States.

Belarus has also participated in international nonsmoking days. Activities have included press conferences, races, telephone consultations, answering questions on the air, etc. The population is informed about the danger of smoking through special health activities, open information days, individual consultations, video lecturers, special brochures, educating youth leaders, organizing antismoking campaigns in mass media and different competitions.

Smoking prevention problems are included in the compulsory primary school curriculum. There are also different educational programmes, optional courses for junior and senior high school, further education establishments and universities.

The emphasis in information and education activities is on the harmful effect of smoking on the health of nonsmokers who have to deal with smokers every day.

In order to analyse the current situation and to plan further activities in this field sociological research is being carried out.

Bulgarian national policy related to ETS

Dr George Kotarov, Chief Expert, National Counterpart "Tobacco Free Europe", National Centre for Public Health, Sofia, Bulgaria

National legislation

Bulgaria has not yet adopted a national tobacco control act. The targets for tobacco control as determined by the WHO Third Action Plan for a Tobacco-free Europe and EU legislation are to be found in different legal acts. A public health act is in preparation at the moment in which it is proposed to include a chapter on the protection of public health through tobacco prevention and control.

Restrictions on smoking indoors

*Government workplaces***.** Smoking in workplaces is restricted according to People's Health Act (Art. 58/1 and /2, 1973, with amendment SG N12/1997), and Ordinance 2/1974 of the Ministry of Health (Art. 10, 11 and 12). Smoking is banned in workplaces where nonsmokers are employed.

*Private workplaces***.** No legal provisions are implemented yet.

Health care facilities. People's Health Act, Art. No. 58/3/; Ordinance No. 2, Art.3/2/.

Schools: People's Health Act, Art. No. 58/3/ and Ordinance No. 2, Art. 3/1/
According to the People's Health Act, health and educational premises should be smoke-free. However, the most recent version of the Act only restricts the tobacco retail trade on and in the close vicinity (no closer than 200 m) of these premises. Ministry of Health Ordinance No. 2, Art. 3/1 and 2/ imposes a direct ban on smoking on both these premises.

Public transport: People's Health Act, Art. 58/2/ and Order No 54 of the Transport Ministry, Art. 4, 5, 14, 15, 16, 17 of 1980.
Smoking is banned on domestic flights and on international flights lasting up to two hours. On longer distance flights, one third of the front seats are nonsmoking (permanently marked as

such). On the railways, there are designated coaches for nonsmokers. Other public transport is smoke-free.

Other public places: People's Health Act, Art. 58/2/ and Ordinance 2, Art. 3/1/, para 3–6/ and 7/. Smoking is permissible under conditions and procedures determined by a regulation of the Minister of Health (Article 58/2/). The objective is to protect the health of nonsmoking employees. The relevant text states: "Smoking shall be prohibited in workplaces where some of the employees are nonsmokers except by written agreement of nonsmokers; without exception where expectants or nursing mothers are employed, even if they agree". This relates to government workplaces only. We consider that although the cited acts are enforced, the lack of appropriate and updated fines and penalties strongly reduce their effectiveness.

Cigarette advertising

Radio and Television Act, Art. 75/2/, 76/3 and 4/, 77/1 and 2/, 80/2/, 90/2/; People's Health Act, Art. 55/2/, amended SG No. 12, 1997/; Tobacco and Tobacco Products Act, Art.35, amended SG 110/1996.

The Tobacco and Tobacco Products Act (Art. 35), prohibits direct advertising of cigarettes in all public places except those where tobacco products are produced and traded. The People's Health Act bans advertisements on the radio and television and in the vicinity of child education establishments, and advertisements targeted at minors. The recent Radio and Television Act imposes a total ban on direct advertising and sharply reduces the size and duration of advertisements in prime broadcasting time. The Act includes legal texts regarding advertisements affecting children's behaviour and health, hidden advertisements and those using subliminal perception. The last amendment of the Act states in Art. 80/2/: "Any advertisement of cigarette products and smoking shall be prohibited".

National programmes addressing exposure to ETS

National environmental health action plan, June 1998

The general objective of the national environmental health action plan is to improve social and physical living conditions in settlements, particularly for the disadvantaged, in order to prevent disease and accidents and enhance the quality of life. Among its more specific objectives, the plan also aims to produce information on the type and level of indoor air pollutants, especially in urban areas. The following priority actions are relevant to reduce ETS exposure:

- creating, updating and harmonizing the regulatory framework with the regulatory requirements of the EU;
- reducing diseases caused by indoor environmental factors (allergens, carcinogens, air pollutants, physical factors);
- producing well educated staff with the aim of implementing the national policy for environmental health, decision-making, selection of priorities, initiating and enforcing control measures;
- establishing health-related risk assessment as a management tool in the public health, environment and other sectors at national, regional and local levels through professional training and education, public information and health education, research and technological development;

- creating the prerequisites for public participation in the development and implementation of policy regarding indoor air quality and health;
- ensuring that there are possibilities for fulfilling the right to quality indoor air.

Health education and promotion

One of the main objectives of the draft action plan for tobacco control is protection of the rights of nonsmokers to an environment unpolluted by ETS. The main activities are directed towards preparing and disseminating health education materials, organizing training courses for health professionals and the media, preparing national and local campaigns for the World No-Tobacco and International Nonsmoking Days, carrying out surveys, etc. These activities are mostly prepared in cooperation with the Hygiene and Epidemiological Inspectorates, Health Promotion and Disease Prevention Departments, the Combat Cancer Foundation, the Bulgarian Red Cross, etc. In 1998 the National Coordinating Committee for Tobacco Control was set up, comprising the activities of more than 25 organizations and institutions. In 1999, the Bulgarian WAT Association was initiated. In February 2000 the Working Group for the preparation and endorsement of the Framework Convention for Tobacco control was set up by Order of the Minister of Health. However, there is no NGO defending nonsmokers' rights.

Surveys

The following surveys were carried out in the last decade regarding exposure to ETS in childhood and adolescence.

- Medical University, Clinic of Paediatrics survey (1987–1989), covering children aged 1 to 6 years from 38 settlements all over the country. The results showed that the average percentage of passive smoking children was 67%, varying from 32% in Veliko Tirnovo to 92% in Varna. In 50% of the families both parents smoked, in 37% only the fathers did, and in 13% only the mothers did.
- Sofia Municipal Hygiene and Epidemiological Inspectorates survey (1994–1995) examined smoking prevalence in 10 Sofia secondary schools. It showed that only 38.8% of the children included lived in smoke-free families.

The following projects have been designed but not carried out due to lack of funds:

- a survey of health risks in pre-school children exposed to environmental tobacco smoke; a joint project of the National Centre of Hygiene, Medical Ecology and Nutrition, the National Centre of Public Health and the Department of Hygiene, Ecology and Occupational Health of Sofia Medical University;
- a survey on smoking prevalence among doctors in Bulgaria, to be carried out by the National Centre of Public Health under the guidance of the British and Bulgarian Medical Associations.

Bibliography

MANOLOVA, A. ET AL. Environmental tobacco smoke and children's health. Strategies for tobacco prevention in Bulgaria. *Journal of Balkan ecology*, **1**(4) (1998).

National environmental health action plan. Sofia, Council of Ministers, 1998.

People's Health Act 1973, recent amendment SG N 90, 1999.

Tobacco and Tobacco Products Act 1993, recent amendment SG N 153, 1998.

Radio and Television Act 1998, recent amendment SG N 81, 1999.

Ordinance N 2 1974, Ministry of Health, Official Bulletin N 2, 1974.
Sanitary requirements on smoking in transport vehicles (in Bulgarian). Sofia, Ministry of Transport, 1980.

JORDANOV, J.S. ET AL. Cotinine concentrations in urine during early childhood with smoking parents at home. *In: Indoor and ambient air quality*. London, Printext Ltd., 1988.

JORDANOV, J.S. & MITEVA, P.I. Recherches sur la cotinine urinaire chez les fumeurs passifs. Nourrissons et enfants en bas age. *Archives de l'Union Medicale Balkanique*, **26**: 1–4 (1988).

JORDANOV, J.S. Cotinine concentrations in amniotic fluid and urine of smoking, passive smoking and non-smoking pregnant women at term and in the urine of their neonates on first day of life. *European journal of pediatrics*, **149**: 734–737 (1990).

JORDANOV, J.S. ET AL. Passives Rauchen und Positive Intracutane Allergenteste bei Kindern mit Respiratorischen Erkrankungen. *Pediatr. Grenzgab*., **30**(5): 389–395 (1991).

JORDANOV, J.S. ET AL. Passivrauchen und Arteriellen Blutdruck in Kindesalter. *Sonderbruck aus Sozialpaediatrie in Praxis und Klinik*, **14**(2): 124–128 (1992).

JORDANOV, J.S. Problematik des Passivrauchens bei Kleinkindern an Beispiel von Nord-Bulgarien. *Sonderbruck aus Sozialpaediatrie in Praxis und Klinik*, **13**(2): 109–116 (1991).

Croatian policy of reducing exposure to ETS

Dr Verica Kralj, Head, Health Promotion Programme, Croatian National Institute of Public Health, Zagreb, Croatia

The legal control of tobacco use, the protection of nonsmokers and environmental protection in Croatia have been regulated by the Tobacco Product Use Restrictions Act passed in November 1999, and partly also by the Health Care Act and the Tobacco Act.

The Tobacco Product Use Restrictions Act was designed to protect public health. It laid down measures aimed at limiting the use of tobacco products and reducing the levels of noxious cigarette ingredients, and introduced mandatory labelling on cigarette packs, smoking prevention measures and surveillance of the Act's implementation.

Measures to reduce and restrict the use of tobacco products include:

- a ban on sales of tobacco products to individuals aged under 18 years;
- an obligation for all points of sale to display this ban concerning minors;
- a ban on the sale of tobacco products through automatic vending machines and of cigarettes per piece;
- a ban on the advertising of tobacco products in the mass media, public places, buildings, transportation facilities and vehicles, books, journals, calendars, articles of clothing, stickers, posters and leaflets;
- a ban on all forms of direct and indirect advertising, including the display of logotypes on objects which, themselves, are not tobacco products;
- a ban on smoking in live public appearances on television, and on photographs or drawings of individuals smoking to advertise tobacco in the press.

Measures specifically related to reducing ETS in rooms are:

- a ban on smoking in all health and educational institutions;
- a ban on smoking in catering facilities, pastry shops and unlicensed restaurants;
- a ban on smoking in other public areas except for those parts designed for smokers and expressly marked as such, i.e. closed public spaces intended for the stay of a group of people in buildings undertaking activities relating to social welfare, trade, sport and recreation, catering, art and culture, and transport (waiting rooms), including conference rooms, etc., all halls for human gatherings, stadiums, public means of transport, lifts and cable cars;
- a limit on spaces set aside for smokers to no more than 30% of a public area's total space;
- the presence of ventilation devices, ash trays and fire extinguishers in smoking rooms;
- the signing of nonsmoking and smoking areas in catering facilities;
- the placing of signs visibly so that they can be read from a distance of 10 m.

Measures related to the noxa in cigarettes and mandatory labelling of tobacco products include:

- a ban on the production and marketing of cigarettes containing more than 15 mg tar per cigarette; in 2001 this allowance will be lowered to 12 mg tar per cigarette;
- the labelling of each tobacco product packaging to show the name of the product, its nicotine and tar levels, the manufacturer's name and address, the importer's name and address (for imported products), and the number of pieces assembled in one pack;
- the health warning "Smoking may be hazardous to your health" to be carried on each pack, together with one of the following: "Smoking may cause cancer", "Smoking during pregnancy may also harm the child's development", "Smoking may cause myocardial infarction and stroke", "Smoking can shorten life".

Antismoking measures oblige educational institutions to promote the knowledge of health hazards posed by the use of tobacco products within all regular educational activities in all children's and young people's age groups.

In fulfilment of society's duty to protect the population from the deleterious effects of smoking, the Croatian Health Minister has set up a Governmental Antismoking Commission charged with:

- monitoring the occurrence of smoking and proposing measures to restrain the influence of tobacco products on the population's health;
- putting forward smoking cessation programmes;
- proposing and organizing the issue of occasional publications for the promotion of nonsmoking as a healthy way of life and ceasing smoking;
- collaborating with international bodies which monitor the problems of smoking reduction;
- drafting reports on the prevalence of the smoking habit and the results of permanent preventive campaigns.

The implementation of this Act is supervised by sanitary, health, market, educational and tourism inspectors.

Under the Health Care Act, citizens seeking medical assistance are required to observe the house orders of the health institutions which have smoking bans in all their rooms.

The relationships between the growth, purchase, processing and marketing of tobacco and in the manufacture of tobacco products are regulated nationally by the Tobacco Act.

Czech policies to reduce exposure to ETS

Dr Ruzena Kubinova, Director of Environmental Health Monitoring, National Institute of Public Health, Prague, Czech Republic

In the Czech Republic, almost 30% of the adult population are smokers and about 22 000 people die from the sequelae of smoking. The number of adult smokers has shown a downward trend for several years, while the prevalence of smoking in children has been increasing (Table). Studies also confirm that many nonsmokers, including children, are daily and involuntarily exposed to ETS and are consequently at higher risk of developing diseases caused by tobacco smoke. In a study by the National Institute of Public Health, HELEN 98, which monitored population health status in relation to the environment, over than 50% of the nonsmoking respondents aged between 45 and 54 years (58.2% of men and 44.5% of women) had indicated that they were exposed to ETS for about 2.4 hours daily on average (men for 2.5 hours and women for 2.2 hours).

Schoolchildren aged 11–16 smoking 1 or more cigarettes per week, Czech Republic, 1994–1998 (%)

	11–12 years		13–14 years		15–16 years	
	1994	1998	1994	1998	1994	1998
Boys	2.3	1.9	7.3	10.1	15.9	22.4
Girls	1.5	1.0	4.2	6.9	11.9	17.6
Total	1.9	1.4	5.8	8.6	13.9	19.9

Source: Based on the *WHO Health Behaviour in School-Aged Children Study. Methods in: Health and health behaviour among young people*. Copenhagen, WHO Regional Office for Europe, 2000 (Health policy for children and adolescents Series No. 1).

Czech legislation comprises some provisions to protect nonsmokers but the issue is not treated in a comprehensive way and compliance with the articles is not sufficiently enforced.

The law on protection against alcoholism and other drug addictions as well as tobacco products dates back to 1989 and is outdated in many ways. It is therefore being amended, and is currently being commented on by different departments.

A comprehensive law on protection against the harmful effects of tobacco products which took into consideration the latest EU legislation and WHO recommendations, was prepared several years ago by the National Institute of Public Health Advisory Group for the Prevention of Smoking. The Ministry of Health submitted this to the Government in 1999, but unfortunately it was not submitted to Parliament for approval and only its core has been integrated into the amended law against alcoholism and other drug addictions mentioned above. The specialists in tobacco control do not consider such an approach as appropriate and expressed this opinion when the law was submitted for comments.

According to Act No. 37/1989, smoking is forbidden:

- in railway carriages with the exception of those reserved for smokers, in other means of public transport and in close rooms relating to this transport and reserved for passengers;
- at work if this means direct danger to life, health or property;
- at meetings, conferences and negotiations held in closed rooms;
- at work in rooms where nonsmokers are also exposed to effects of tobacco smoke;
- at health care facilities, schools, closed facilities intended for performance and sports activities, with the exception of the rooms reserved for smoking;
- in catering facilities with the exception of those reserved for smokers; where there is no independent dining room reserved for smokers, smoking is forbidden when breakfast, lunch and dinner are being served.

The Code of Labour also deals with protection of nonsmokers against ETS. Chapter 5 on safety and health protection at work, Art. 133 (3), directly indicates that the employer shall create safe working conditions with no danger to health and shall protect the health of employees from tobacco smoke at their workplaces. For this reason, he/she shall forbid smoking at workplaces where nonsmokers are also present.

Czech legislation also establishes the sanctions applicable in case of non-compliance with these provisions and the authorities responsible for control in this regard. Nevertheless, the rules are often broken and compliance with them is not sufficiently controlled and enforced.

The protection of nonsmokers against the harmful effects of tobacco smoke is one of the priorities of the prevention and health promotion programmes, which are based on WHO documents concerning HEALTH21, the Tobacco-Free Initiative, Tobacco-Free Europe and national environmental health action plans, and form the basis for the National Health Programme, the long-term strategy of the Ministry of Health in this field.

At present, the Czech Republic as a WHO Member State has been involved in preparation of the Framework Convention on Tobacco Control. Since Czech legislation needs to be harmonized with EU legislation prior to entry of the Czech Republic into the EU, the EU directives and the common standpoint of the EU member states concerning the Convention prepared will be the main guidelines for the activities of the intersectoral working group coordinated by the Ministry of Health that establishes the country's priorities for negotiations relating to different parts of the Convention and associated protocols.

Danish policies relating to passive smoking

Ulla Skovgaard Danielsen, Senior Executive Consultant, Legal Adviser, Danish Council on Smoking and Health, Copenhagen, Denmark

Present legislation on passive smoking

In 1995 Parliament adopted the Smoke-free Environments Act. The purpose of the act is to limit the nuisance from passive smoking in public premises, means of transport, etc. The act contains a number of specific provisions regarding the state sector where, in general, smoking is not allowed. Smoking in a workplace in the state sector is only allowed in rooms where several people work if

everybody who works in the room agrees. Otherwise smoking is only allowed in specially designated smoking rooms.

In the county and municipal sectors the Act makes it obligatory for county and municipal councils to lay down provisions on smoke-free environments in their institutions, means of transport, etc., and in county and municipal premises with public access. County and municipal councils are free to decide the extent of smoke-free environments.

In the case of workplaces in the private sector, there are no general provisions regarding access to smoking apart from a provision laying down that there should be appropriate measures to protect against passive smoking during lunch-time.

Government programme on public health and health promotion 1999–2008

In the spring of 1999 the Government adopted a comprehensive programme for the improvement of public health. The background to this initiative was the deplorable fact that over a number of years public health in Denmark had not developed in a satisfactory way. Since 1970 average life expectancy in Denmark had not followed the development seen in neighbouring countries. The reason for this is the population's lifestyles, and one of the big problems is the high proportion of smokers. Danish women smoke more than women anywhere else in the world.

One of the key issues addressed by the health promotion programme is smoking. It is a main aim of the programme that the number of smokers should be reduced significantly, partly through smoking cessation and partly through reducing the recruitment of new smokers. At the same time Denmark should be smoke-free for nonsmokers, including children.

All institutions for children and young people under 19 years should be smoke-free, as should hospitals. The Government sought, moreover, to promote the establishment of smoke-free environments in all workplaces.

The extent of passive smoking

The background for measures in these areas was a survey carried out by the Danish Council on Smoking and Health in cooperation with the Danish Cancer Society and the Heart Foundation. A survey showed that in 24% of Danish day-care centres children daily or sometimes occupied indoor areas where smoking is allowed and that in 55% of the day-care centres children watched the staff smoking.

A survey showed that in 41% of schools smoking was totally prohibited for pupils. In 88% of the schools there was a total prohibition against children smoking indoors. At the same time a survey showed that a large majority of the population was in favour of prohibiting indoor smoking in day-care centres and smoking among pupils in schools.

In 1999 a survey showed that all Danish hospitals have introduced restraints on smoking by staff, patients and visitors. This was not the case two years earlier. No hospital is smoke-free for staff, patients and visitors, but a significantly increased number of hospitals offer assistance to staff and patients who want to stop smoking.

In 1998 a survey of Danish workplaces showed that 40% of all employees are exposed to passive smoking. Some 70% of all large companies – both public and private – had rules limiting smoking.

New initiatives regarding passive smoking

As a result of the Government's health promotion programme it is expected that before long the Minister for Health will introduce a Bill prohibiting children and young people from smoking in all child care centres, primary schools and recreation centres for children and young people. Adults in these institutions will only be allowed to smoke in separate rooms to which there is no access for children and young people.

It has turned out that it was not possible for the Government to gain support for prohibiting smoking by hospital staff and by patients and visitors. Thus there will be no proposal regarding hospitals in the near future. But smoking policies have been sharpened in recent years in many hospitals, and a network of health-promoting hospitals has been formed of which one aim is the "smoke-free hospital". In a very limited number of hospitals the management has decided to prohibit smoking by the staff. Most hospitals allow smoking by the staff in designated smoking rooms. About 40% of hospitals intend to prohibit smoking by visitors at some point in the future. Only a small number of hospitals intend to prohibit patients from smoking, but smoking will be limited to designated smoking rooms.

The Ministry of Health in cooperation with the Ministry of Labour also intend to investigate the possibility of securing smoke-free environments in private workplaces. The unions will also be involved in these efforts.

There are at present no legal restraints on smoking in hotels, restaurants, theatres, cultural and sports events, etc. In the coming years the Ministry of Health will follow developments carefully and support any voluntary agreements.

Exposure to ETS in Estonia and relevant policies

Aro Tiiu, General Director, Health Protection Inspectorate, Tallinn, Estonia

The consumption of tobacco products in Estonia is high. Estonia is characterized by rather aggressive advertising of alcohol and tobacco products and a high level of smuggling these (especially counterfeit) products.

According to an international health behaviour study in 1998, 42% of men and 20% of women smoked daily and an additional 6% smoked occasionally. The general attitude towards smoking is tolerant, tobacco products are comparatively cheap (a pack of cigarettes costs on average a little bit less than US $1) and they are readily available. People may smoke in most places as there is no legislation to control smoking in public places. The population's awareness of the health-damaging effects of smoking and nicotine dependence is superficial and mainly relates to awareness of the hazards to health of forced smoking. According to the 1998 study, 37% of men and 14% of women were exposed to tobacco smoke outside their homes for at least one hour daily. Only 30% of men and 50% of women were in an environment not contaminated by tobacco smoke outside their homes. The proportion of people exposed to tobacco smoke inside their homes was 44%. According to data from the Estonian Institute of Cardiology published in 1996, every second family where there are growing children contains an adult smoker.

The first attempt to regulate smoking in public places was made by the Ministry of Social Affairs in 1996. A draft regulation prohibiting smoking in rooms to which the public have access and limiting smoking in leisure-time rooms, hotels and places of accommodation. The regulation could not be enacted because of the absence of a tobacco law to give it a legal basis. Had there been the political will, the regulation could have been enacted, because many governmental regulations were then in force without legislative bases. Besides, in 1995 Parliament had adopted the Public Health Law, whose §4 p.1 stated that "no person shall endanger the health of other persons by his or her direct action or by harming the physical or social environment", which could be a basis for the aforesaid regulation.

In 1997 the Ministry of Justice gave permission for initiation of a tobacco control law. The Ministry of Social Affairs prepared a draft in cooperation with specialists from other ministries. This was approved by the government in 1999 and has now received its second reading in Parliament. It is expected to become law later this year.

The primary purpose of the draft tobacco control law is to ensure the health protection of the population. The draft has a separate chapter dealing with limitations on smoking in public places and requirements for special smoking rooms. Smoking is prohibited on the premises of all health and educational establishments, in offices, cultural establishments and buildings, in public transport vehicles, in passenger lounges, sport buildings, and in trade, production and service enterprises (except in public catering establishments and enterprises providing accommodation, where separate rooms or areas for guests should be reserved and marked for smokers and nonsmokers). In the named places smoking may be permitted only in rooms which are designated and marked for this purpose and correspond to certain technical requirements, if the owner of the rooms, proprietor or employer considers it to be necessary and possible. All the measures help to reduce ETS and the morbidity risk to nonsmokers. The draft takes account of corresponding legal acts of the EU which are related to smoking in public places.

As well as legislation, policies to formulate public opinion and increase nonsmokers' awareness of the health-damaging influence of smoking play a significant part in increasing smoke-free environments. National and local activity in this field started in 1996 in the Centre for Health Promotion and Education with annual project work in the framework of the Tobacco and Health 1995–1999 programme. During these years much attention has been paid to ETS; media campaigns and press conferences have been organized and some small printed items have been produced, including the leaflet *50 questions and answers to a nonsmoker*, posters and thematic pocket calendars. ETS problems have been discussed in the press and at training seminars for public health workers.

The subject of smoking is an obligatory part of the national primary and general secondary education curricula. In the chapter on avoidance of smoking of the 1998 health education textbook, ETS has been handled as a separate subject. Seminars have been organized to target groups of health educators and county/municipal health promoters, at which the hazards of ETS have been explained. There has been close cooperation in recent years with the national cardiac project, especially with its traditional annual cardiac weeks campaigns, where reduction of prevalence of smoking and prevention of ETS have both been definite priorities.

Although parliament has not yet accepted the tobacco control law, there is a clear trend towards a reduction in ETS. In the last five years, the proportion of nonsmokers having no contact at all with ETS outside their homes has increased by 8% of men and 15% of women, and the

proportion exposed to tobacco smoke outside their homes for at least one hour a day has decreased about 20%. Smoking in the home has fallen during the same period by 6%.

A working group has been set up, consisting of specialists drawn from various ministries, to handle (i) the implementation of the policy to increase smoke-free environments and (ii) participation in the process of preparing the WHO tobacco framework convention and its protocols. It will also disseminate information about the convention and support it. We are convinced of the necessity of handling ETS separately in the WHO tobacco framework convention as one of the additional protocols.

Although there are enormous problems in introducing radical measures to curb the consumption of tobacco products, we are determined to continue our efforts in this field.

Tobacco legislation in Finland

Kari Reijula & Antero Heloma, Finnish Institute of Occupational Health, Helsinki, Finland

Tobacco Act in Finland since 1976

Finland has had comprehensive tobacco control legislation since 1976, when the Tobacco Control Act was accepted by parliament. The Act included restrictions on smoking in public places, an advertising ban on tobacco products, an age limit to tobacco purchases, and an earmarked appropriation for anti-tobacco health education [Leppo & Vertio, 1986]. However, no regulations on smoking at work were included in the legislation. In the climate of opinion in the 1970s it would not have been possible to restrict workplace smoking by legislative measures; if such measures had been taken, it would have been extremely difficult to enforce the legislation at the workplace.

Between 1960 and 1974, tobacco consumption per capita increased slightly in Finland [Tobacco Statistics, 1994]. However, substantial increases in the price of tobacco products as well as massive antismoking campaigns preceded the introduction of the Tobacco Act in parliament in 1976, and in 1975–1976 the demand for cigarettes fell permanently by 7% [Pekurinen & Valtonen, 1987]. In 1960 more than half of Finnish men smoked daily, while in 1995 only 29% of men were regular smokers. On the other hand, the prevalence of smoking among women increased from 1960 until the latter half of the 1980s [Leppo & Vertio, 1986, Rahkonen et al., 1992, Helakorpi et al., 1995]. Since 1987, smoking among women has remained stable, and in 1995, 20% of Finnish women smoked daily [Tobacco Statistics, 1994, Helakorpi et al., 1995].

Since the enforcement of the Tobacco Act, several important international studies on the hazards of involuntary smoking have been published [Surgeon General, U.S. Department of Health and Human Services, 1986, International Agency for Research on Cancer, 1986, National Research Council, 1986]. At the same time, the public interest in the topic also increased in Finland, and in 1988 the Ministry of Labour announced in a circular that smoking at work should be treated as a matter of workplace safety. However, the Ministry did not propose changes in the existing tobacco control legislation.

On the other hand, the new indirect marketing methods used by the tobacco industry to circumvent the advertising ban increased the activities of the anti-tobacco lobby which criticized the government about the poor implementation of the Tobacco Control Act [Rimpelä, 1992].

Reform of the Tobacco Act in 1995

Finally, in 1992 the Ministry of Social Affairs and Health began preparations for a reform of the Tobacco Control Act. The two most important improvements in the new legislation should have been the better protection of individuals against the hazards of involuntary smoking, especially at work, and stricter control of the ever growing indirect tobacco advertising. In the new proposal, the most important reform was the restriction of smoking in all workplaces to designated smoking areas, provided that the smoke would not spread to other locations in the workplace. Finally, in 1995 the Tobacco Control Act was enforced. However, the Act still excluded restaurants.

Even before the Tobacco Control Act was launched in March 1995, smoking in Finnish workplaces had diminished because many workplaces had restricted smoking by voluntary agreements. In 1984, two thirds of all employees were exposed to environmental tobacco smoke at work, while in 1992 the number had fallen to 39% [Färdig et al. 1994].

According to our studies [Heloma et al., 2000]) in medium- and large-scale workplaces among more than 1400 employees, the exposure of nonsmoking workers to ETS at work fell considerably after the implementation of the Tobacco Act reform in 1995. For example, the proportion of those exposed to ETS for more than four hours daily fell from 32% to 8%. The prevalence of daily smoking declined from 30% to 25% and the average consumption of cigarettes among smokers diminished. Median nicotine concentration in the workplace also fell significantly.

Reform of the Tobacco Act in 1999

After the revision of Tobacco Act was launched in 1995, the Ministry of Social Affairs and Health began preparing for another reform of the Act. Restaurants had not been included in the previous reform, and so an objective of the second reform was to protect patrons and workers in restaurants against ETS. A significant proportion of restaurant seats were to be reserved for nonsmoking patrons: from March 2000, at least 30% and from July 2001 at least 50% of the area reserved for patrons in restaurants must be smoke-free (restaurants smaller than 50 m^2 are exempt). Smoke must not be able to spread from smoking to smoke-free areas. Smoking is not allowed at bars and gaming tables (e.g. roulette) to prevent any exposure of restaurant workers to ETS. The most important improvement in the reform, however, was a paragraph added by parliament in the final stage of the legislative process to the effect that environmental tobacco smoke will now be regarded as a human carcinogen. Moreover, pregnant restaurant workers must be transferred to smoke-free areas in order to avoid them being exposed to ETS. If this is not possible, the worker is allowed to stay on leave with compensation until the end of her pregnancy.

In conclusion, the Tobacco Act from 1976 and the two reforms in 1994 and 1999 have had a significant impact on exposure to ETS among Finnish workers. In medium- and large-scale workplaces, exposure to ETS has decreased considerably due to the legislation. Unfortunately, investigations show that there are severe problems with implementing the Tobacco Act in small-scale workplaces. In every third small-scale workplace in Finland, employees report that they are still exposed to ETS.

References

NATIONAL RESEARCH COUNCIL. *Environmental tobacco smoke. Measuring exposures and assessing health effects.* Washington DC, National Academy Press, 1986.

FÄRDIG, P. ET AL. *Tobacco smoke as a harmful agent in workplaces.* Helsinki, Ministry of Social Affairs and Health, 1994 (in Finnish).

HELAKORPI, S. ET AL. *Health behaviour among Finnish adult population, spring 1995*. Helsinki, National Public Health Institute, 1995.

HELOMA, A. ET AL. The attitudes of occupational health personnel to smoking at work. *American journal of industrial medicine*, **34**: 73–78 (1998).

HELOMA, A. ET AL. *Short-term impact of national smoke-free workplace legislation on active and passive smoking among employees* (in publication).

HELOMA, A. ET AL. Smoking and exposure to tobacco smoke at medium-sized and large-scale workplaces. *American journal of industrial medicine*, **37**: 214–220 (2000).

LEPPO, K. & VERTIO, H. Smoking control in Finland: A case study in policy formulation and implementation. *Health promotion*, **1**: 5–16 (1986).

PEKURINEN, M. & VALTONEN, H. Price, policy and consumption of tobacco: the Finnish experience. *Social science and medicine*, **25**: 875–881 (1987).

RAHKONEN, O. ET AL. The development of smoking in Finland from 1978 to 1990. *British journal of addiction*, **87**: 103–110 (1992).

RIMPELÄ, A.H. Critical analysis of the Finnish Tobacco Act: implementation and legitimacy, 1977–89. *Tobacco control*, **1**: 285–293 (1992).

SURGEON GENERAL. *The health consequences of involuntary smoking*. Washington DC, U.S. Department of Health and Human Services, 1986.

Tobacco smoking. Lyons, International Agency for Research on Cancer, 1986 (IARC monographs on the evaluation of the carcinogenic risks on chemicals to humans).

Tobacco statistics 1994. Helsinki, Statistics Finland, 1995.

Policies to reduce ETS in France

Professor Jean Trédaniel, Oncologist, Hospital Saint-Louis, Paris, France
Pascal Mélihan-Cheinin, French Cancer League, Paris, France

The EU's position concerning second-hand smoke

Despite the fact that there is no EU legislation restricting smoking in public, the EU has encouraged member states to ban smoking in public places. On 18 July 1989, the Council stated that smoking should be restricted in public places and transport facilities (Resolution 89/C 189/01).

EU member states' legislation and regulations

In this connection, EU member states can be categorized as those with legislation restricting smoking in public, and those without any legislation or regulation banning smoking.

Since 1 November 1992, smoking has been banned in every closed and covered place where there are usually at least two people (*interdiction de fumer dans les lieux à usage collectif*). Prohibition of smoking in public transportation became effective sooner, on 1 January 1992.

French public opinion about the smoke ban

Foreign visitors believe that in France tobacco use is still widely accepted and the law is virtually ignored. In fact, French public opinion strongly supports the smoke ban and the "Evin law". Data from the French Health Education Committee (CFES) indicate that 69% of nonsmokers favour fines for people who smoke in places where it is prohibited. More surprisingly, 53% of smokers were in favour of such fines. They probably want to be protected against themselves. Other CFES data indicate that most of the relapses are due the influence of the environment. Today, most smokers seem willing to stop but would like to be helped, and smoke bans are particularly efficient in this respect.

Court cases, control and enforcement of legislation protecting nonsmokers' rights

The commitment of the State towards the enforcement of the tobacco acts has unfortunately been very limited. Since the law was passed and the decree came into force, there has been an under-emphasis by the government and public health institutions on getting information to the public to build support and consensus about the law. Media campaigns have almost only emphasized cessation. The government has not supported any campaign on passive smoking since the "Veil law" of 1976.

In 1997, due to the activism of the prominent oncologist Professor Maurice Tubiana, the French Académie de Médecine published, with the help of the French Cancer League, a report on second-hand smoke. This received good press coverage, and a copy (in French) of the report is available on www.tabac-info.net. But it remains a private initiative.

Thanks to the right granted to the tobacco control NGOs to file plaints for damages, there has been a notable amount of litigation since 1978 regarding three issues:

- illegal tobacco advertisements, numerous condemnations of which led to a dramatic fall in traditional tobacco advertising expenses in 1993;
- health warnings on packaging: the Supreme Court has ruled that the health warnings printed by the French tobacco monopoly Seita and Philip Morris were illegible and invisible, and the words "according to law No. 91-32" must be added to the warnings;
- the rights of nonsmokers.

Two other recent cases should also be quoted.

- On 8 December 1999, the court in Montargis ruled that Seita should compensate the family of a 47-year-old man who had died from lung cancer. The appeal against this first tobacco victim's lawsuit will soon be held in Orleans. Other similar cases are pending.
- Two state health insurers decided to file lawsuits against tobacco companies to recover the costs of treatment for diseases related to cigarette smoking. One of these was the Caisse Primaire d'Assurance Maladie in Saint-Nazaire, the city for which Claude Evin was Member of Parliament. The result will soon be known.

As regards second-hand smoke, cases can be categorized in four groups:

- cases against the tobacco industry's campaigns on passive smoking
- cases supporting employees suffering from ETS exposure at work
- cases seeking to ban smoking from transport, food or leisure facilities
- plaints filed by the families of people exposed to lethal amounts of ETS.

Two organizations have already filed suits in this field. The first is Nonsmokers' Rights (Droits des Non-Fumeurs, DNF), a volunteer NGO founded in the early 1970s by people unwilling to accept being smoked out, which has local branches outside Paris. The second is the National Committee Against Tobacco Use (Comité National Contre le Tabagisme, CNCT), a charity founded in 1968 by physicians and supported by the government which is currently mainly dedicated to the enforcement of the tobacco control legislation.

Examples of cases under the four headings above are given below.

1. The Ozeir case

The sister of a 44-year-old nonsmoking female died from lung cancer after having been smoked out at work despite the Evin law banning smoking. The Ozeir family filed a suit for damages against her former employer, supported by the DNF and CNCT. The court rejected the family's demand but stated that passive smoking is harmful to human health. This defeat was in fact a victory at a period where the misinformation efforts of the tobacco industry were particularly massive. The employer used the testimony of a member of the so-called "European working group on ETS and lung cancer", which is wholly supported by three cigarette manufacturers, and the family used the expertise of Jean Trédaniel.

2. The SNCF case

Due to the efforts of a grandmother living in a suburb of Lyons, who was active in the DNF and one of the leaders of the CNCT, on 27 January 1999 the appeal court of Lyons ordered the national railway company (SNCF) to pay damages to the two antismoking groups, ruling that there were not enough injunctions at a Lyons railway station to travellers to put out their cigarettes. The court ordered the SNCF to pay almost US $1600 to each. The court also said the presence of ashtrays in the train station, without nonsmoking signs posted nearby, led smokers to believe they had the right to light up.

3. The Philip Morris Europe disinformation campaign case

In 1995 and 1996, Philip Morris launched two Europe-wide American-style press campaigns. In France, the CNCT estimated that Philip Morris spent FF 10 million each year to buy advertising space in newspapers. In spring 1996, Philip Morris Europe (a subsidiary of the US corporation based in Switzerland) launched an advertising campaign in European newspapers and magazines. The advertisement compared the risk of lung cancer from exposure to second-hand smoke with a variety of other risks from everyday activities.

The CNCT contacted the authors of two American studies cited by Philip Morris Europe S.A. who reacted publicly in summer 1996. One of them stated: "It is obscene to use our findings to justify passive smoking".

Sued by the CNCT, the two campaigns were fined. The lawyer for the CNCT, a chain smoker who was one of my patients, pleaded against Philip Morris Europe in June 1997 and died from lung cancer on 1 August. On 1 September 1997 Philip Morris Europe was ordered by a Paris court to pay FF 100 000 to each of the two tobacco control organizations which had registered formal complaints about the advertisements (the European Union of Nonsmokers – UEN, a network of nonsmokers' rights movements founded in 1987 by the chairman of DNF, and the CNCT).

4. Cases concerning the enforcement of the regulation at work

These can be divided into the real successes and the procedural cases.

Employers do not have to set aside a room for smokers in workplaces. In this case, they are only obliged to explain the reason for the refusal (no space, too expensive, etc.) which means that the company or the office is smoke-free. The reality is too often the opposite: employers decide to do nothing and allow nonsmokers to be smoked out. In these cases, individuals can use industrial relations legislation.

If a nonsmoker who has asked for the regulation to be enforced in his company is punished by his employer, he can sue him before a court called *le conseil de prud'hommes* (composed half of union representatives, half of companies' officials). An appeal before a civil court is possible. Two examples can be quoted:

- a woman working for a local section of the national insurance system, whose director punished her for wanting to work apart from smokers, won her case before the *prud'hommes*, who stated the Evin law should be respected;
- a woman working for an insurance company who had to face a chief reluctant to let her breathe freely was finally rude to him and was fired; with the advice of the DNF she won her case and gained damages.

In the latter case, the employee could ask the Labour Department for an enquiry at her office. This investigation proved that her company did not comply with the law and was a great help for her. Employees can call the local section of this Department (*inspection du travail*).

Recently the CNCT has been successful in procedural cases. Indeed, this NGO has been granted the right to defend a nonsmoker before a court without revealing his identity. It should, indeed, be underlined that many people are reluctant to file a plaint because they fear for their jobs.

The physicians in charge of health at work (*médecins du travail*) are supposed to help employees regarding the enforcement of the law. The problem is that in many cases, they are also employees of the company and so fear for the security of their jobs. I have been told that one such physician, who wanted the decree to be enforced in his company, was fired after having been a victim of psychological harassment.

Evaluation

The Evin law included a provision for its enforcement and effectiveness to be monitored. In its report published in October 1999, the Evaluation Commission stated that the denormalization of passive smoking had certainly been the most important improvement from the law. It had brought about a change in public opinion.

Measuring enforcement precisely is particularly difficult. Some information is available, for example:

- in public transportation, enforcement has been good: the largest private airline prohibited smoking on all its flights, even those lasting more than 20 hours, in 1996, and the SNCF reports that most smokers ask for nonsmoking seats on trains;

- in care facilities and hospitals there is still a need for improvement, but there is a major campaign with a smoke-free hospital network which gives advice on how to comply with the decree;
- in restaurants and cafés, the situation is probably the worst: only about a third of restaurants enforce the regulation, which is probably why so many foreigners feel that our country is smoked out;
- application of the regulation at workplaces depends on the will of the employers; if they do not, they can be prosecuted and condemned, but without the help of dedicated non-profit organizations such as DNF and the CNCT, nonsmokers suffering from passive smoking at work do not have much help from the unions and from the Labour Department – unions appear to be particularly reluctant, although a distinction should be drawn between the leadership and the ordinary members;
- although the oldest restriction on smoking in public (decree of 12 September 1977) applies to schools, the Education Department has not yet enacted the regulation enforcing the decree, probably because the teachers' unions are not in favour of the Evin law; there are some totally smoke-free high schools, but also places where the regulation is violated.

The lack of enforcement is certainly due to the absence of a directive from the government to the state bodies in charge of applying the law. For instance, the Department of Health should ask all its local representatives to conduct surveys to monitor the enforcement of the decree in cafés and restaurants.

Conclusion

A law by itself is insufficient, and is effective only when it is supported by public opinion. In this respect, we recommend that:

- the general public should be made aware of the hazards attached to passive smoking, and disinformation from the tobacco industry should be put under scrutiny – some health professionals could be influenced by these false messages;
- action targeting both unions and governmental bodies in charge of industrial relations should be launched to explain (if necessary) the impact on health of passive smoking and what is at stake, and encourage them to protect nonsmokers at work;
- the costs of smoking at work, the problems due to the absence of a ban, etc. should be explained to employers.

In any case, it is necessary to show that this is a real public health issue and non-regulation or non-enforcement leads to more difficulties than a policy which would address the tobacco addiction of many smokers (by, for example, providing them with special cessation programmes).

Sources

EuroLego project, supported by the EU Europe against Cancer programme.
(Thanks to Dr Annie J. Sasco's team, which is currently in charge of the EuroLego project. For more information, please contact Dr Annie J. Sasco, e-mail: sasco@iarc.fr.)
International Agency for Research on Cancer
Professor Maurice Tubiana
Comité National Contre le Tabagisme
GLOBALink.

Protection of nonsmokers in Germany

Professor Friedrich J. Wiebel, Deputy Director, Institute of Toxicology, GSF National Research Centre, Neuherberg, Germany

The situation in Germany is difficult to assess in that the responsibilities for regulation are divided between various administrative bodies – the federal government, state (Länder) governments, local authorities and other intermediary local bodies.

At federal level, various administrative orders regulate smoking on premises belonging to the federal administration and on public transport. Even in these areas, the federal government has not adopted any uniform provisions concerning the protection of nonsmokers working in federal administrative offices.

A recommendation from the Ministry of the Interior published in 1975 sets down guidelines which have since been almost completely adopted by the various federal administrations. These guidelines foresee a separation of smoking and nonsmoking areas. Where this is not possible, smoking may only be allowed with the consent of nonsmokers present. The only areas and times where a total ban on smoking must be declared are canteens at meal times in cases where it is not possible to provide a separate smoking area.

In addition more stringent measures have been adopted by certain ministries and regional or local authorities.

At state level, the protection of nonsmokers in the public administration rests on the resolution of the state ministers of health which was adopted in November 1988. This resolution is based on the decision of the administrative tribunal which recognized the right of the nonsmoker to a smoke-free workplace. The resolution has the character of a (strong) recommendation and is not legally binding.

The resolution bans smoking in all shared offices, meeting rooms, canteens and communal areas. Smoking is to be prohibited in shared offices even if nonsmokers occupying them agree to it.

The resolution has been implemented in many public administration buildings. However, the exact extent of implementation is not known. The same applies to health care establishments.

Young people under the age of 16 are prohibited, under federal law, from smoking in public. This has helped to reinforce measures on smoking in schools and places open to young people.

Workplaces

There is no specific legislation on smoking in workplaces except for two provisions:

- smoking is banned in areas where there is a risk of fire or explosion and where food is handled;
- employers have to take “suitable measures for protecting nonsmokers against discomfort caused by tobacco smoke in work place rest rooms’ (§32 Arbeitsstättenverordnung ≅ Workplace Regulations and Approved Code of Practice of the United Kingdom).

However, general regulations on health and safety in the workplace indirectly provide protection against ETS. Thus §5 of the Arbeitsstättenverordnung establishes the employer's duty to ensure that there is a sufficient quantity of fresh (healthy) air in enclosed workplaces. Air is considered to be fresh when the quality of indoor air equals that of outdoor air.

On this basis, the right of employees to a smoke-free workplace has been repeatedly upheld in German courts.

In order to strengthen the position of nonsmoking employees, an amendment has recently been proposed by a group of members of parliament and is now under discussion. This amendment stipulates that "employers have to take suitable measures for protecting nonsmoking employees in workplaces against distress and health hazards". Parliament is expected to vote on this amendment within a year.

The new attempt to improve the protection of nonsmoking employees is aided by a recent opinion of the German Commission for the Investigation of Health Hazards of Chemical Compounds in the Work Area (MAK-Kommission). According to this opinion, tobacco smoke in the ambient air of the workplace has to be considered a human carcinogen.

Public transport

Smoking is banned on urban buses, trams, underground trains and "S-trains" (rapid local trains). The ban extends to underground stations in most cities.

All national flights are smoke-free. An increasing number of airports have been declared smoke-free. In these airports, ample smoking areas are provided which are frequently poorly separated from nonsmoking areas.

Enforcement of nonsmoking regulations in underground stations and airports is patchy. The smoking bans in buses, trams and trains, however, are well respected by users.

Areas or carriages must be set aside for nonsmokers in stations and trains. The number of places set aside for smokers is decided independently by the company. At present, smokers' compartments on trains of the (formerly) national railway company represents 35% on long-distance trains, 25% on express trains and 20% on commuter trains. The real requirement for smokers' compartments is appreciably lower than these percentages. This is indicated by the fact that – as a rule – smokers' compartments are half empty when the nonsmokers compartments are already crowded. Likewise, the number of reservations for smokers' seats is far lower than that for nonsmokers' seats.

Hotels, bars and restaurants

There are no state-wide or local laws restricting smoking in restaurants, hotels, bars, etc. A moderate number of restaurants provide nonsmoking areas. Only a very few places where meals or drinks are served are entirely smoke-free.

Conclusion

The majority of the German population is strongly in favour of comprehensive laws for the protection of nonsmokers. For example, in the INFRATEST survey of 1993, 92% of nonsmokers and 77% of smokers asked for a ban on smoking or a separation of smoking and nonsmoking areas in the workplace. Similarly, a survey by the Federal Ministry of Health in 1996 showed that about 80% of nonsmokers and 51% of smokers approve of smoking bans in public places.

However, the German government has been – and is – very reluctant to take any legislative measures for protecting nonsmokers against passive smoking. It is of the opinion that the current regulations suffice and that education and information have higher priorities than laws protecting nonsmokers (Report of the Commission to the Council COM [96] 573, 1996).

Policies to reduce exposure to ETS in Greece

Professor N.H. Choulis, General Secretary, Greek Antismoking Society, University of Athens, Greece

Basis for policies

The policies closest to dealing with ETS are based on:

- Public Health Regulation No. 389966 of 10 November 1952 (public transport)
- Public Health Regulation No. A2G 1989 of 12 April 1979 (hospitals and private clinics)
- Public Health Regulation No. A2G 3051 1980 (public places)
- Public Health Regulation No. 450 of 21 March 1990 (domestic flights),

and outline the following:

- smoking is banned in hospital establishments and private clinics;
- separate smoking areas should be provided for staff and visitors in establishments of over 200 m², equipped with an efficient air ventilation system;
- smoking is banned in all enclosed public places belonging to state agencies (including educational establishments) and public or private corporate organizations (the office dealing with poor people, telecommunications office, electricity board, etc.), including public waiting rooms, conference and meeting rooms, lifts, etc.

Public transport

Smoking is banned on public transport vehicles and on all domestic flights. Smoking areas may be provided in long-stay waiting rooms (at airports or railway stations).

Sanctions

No specific sanctions operate for non-respect of these regulations. Offenders may be taken to court where an appropriate punishment would be decided.

Workplaces

Regulations on smoking in the workplace do not exist except in areas where there is an increased risk to health due to the handling of harmful substances.

ETS-related policy in Hungary

Dr Peter Rudnai, Deputy Director, Jozsef Fodor National Centre for Public Health, Budapest, Hungary

The per capita consumption of cigarettes in Hungary is the third highest in the world. According to the various surveys conducted in Hungary during the past ten years, smoking prevalence is around 50% (higher in men and lower among women). As a consequence, lung cancer mortality in both sexes is among the highest in the world and is still increasing. The mortality rates of other diseases at least partly related to smoking (e.g. oral cancer and cardiovascular diseases) are also extremely high, especially among middle-aged men.

As a result of all these unfavourable phenomena and trends, several programmes have been initiated to help people stop smoking (e.g. Quit and win). Special attention has been paid to the education of young people with the aim of discouraging them from starting to smoke.

The widely distributed smoking habits of the population pose a significant threat to the air quality of various indoor spaces and to the health of nonsmoking people as well, especially children. This led parliament to pass an act on the protection of nonsmokers in April 1999 (Act 42nd of 1999 on the Protection of Nonsmokers and some regulations on the consumption and trade of tobacco products. Egészségügyi Közlöny 7/1999, pp. 1091-1094).

This Act prohibits smoking in all indoor spaces of public institutions open to the public, with the exception of places especially designated for smoking. The same general rules refer to workplaces, public transport vehicles and all indoor events.

No smoking areas can be designated in premises open to the public in primary health care facilities, outpatient departments and pharmacies or in rooms used by pupils of educational institutions or in indoor areas used for sports.

In restaurants and similar establishments, either a separate room must be designated for smoking or, if this is not feasible, proper ventilation must be provided (by 1 January 2001) which guarantees good air quality for both the smoking and the nonsmoking areas of the common indoor space. The person running a restaurant can decide to declare all premises smoke-free, which must be properly indicated at the entrance and in every room.

Local transport vehicles must be kept smoke-free. In trains serving distances over 100 kms smoking areas must be designated. Shorter distance trains may be declared smoke-free provided that this is properly indicated.

The adequacy of the separation or designation of smoking areas must be controlled by the local officials of the National Public Health and Medical Officers Service and the Fire Service. The appropriateness of marking of the designated smoking areas must be regularly controlled by the Consumer Protection Agency.

If these regulations are not complied with, the penalty is between Ft 50 000 and 100 000 (€ 200–400).

The conditions of the designation of smoking areas in workplaces and the consequences of lack of compliance are governed by special regulations and the employer’s decisions.

People under 18 years of age are prohibited from smoking, even in designated areas of public institutions or in public transport vehicles or during indoor events. People aged under 18 years who smoke, or people who smoke in areas where smoking is not allowed, are liable to a fine of up to Ft 30 000 (€ 120).

The same Act contains provisions regarding the trade in tobacco products. Cigarette packages must contain a warning relating to the seriously damaging effect of smoking on health on one of the main sides and another health protection text on the other one. They also have to display the exact quantity of soot and nicotine content of a unit volume of the main stream tobacco smoke.

Tobacco products cannot be sold in establishments of public education, social and health care and child welfare. They are permitted to be sold either in special tobacco shops or in well separated parts of other shops, but not to persons younger than 18 years of age. This is regularly controlled by the Consumer Protection Agency.

The above-mentioned Act came into force in November 1999, so it is too soon to assess its impact on the indoor air quality of public buildings or on the smoking behaviour of the population. Anyway, people seem to accept the general rule that smoking is allowed only in designated areas.

All these regulations are valid only for public places and do not necessarily apply to private premises. However, the results of both international and national epidemiological studies have shown that children of smoking parents are at special risk as far as the health consequences of passive smoking are concerned. The legal measures discussed above are not appropriate to solve this problem, although indirectly, by forming smokers' attitudes and helping them to realize the risk which ETS poses to other people's health, in the long run they may have a favourable impact on society's attitude towards smoking.

Environmental tobacco smoke: a report from Iceland

Dr Thorsteinn Njalsson, Chairman, Tobacco Control Task Force of Iceland, Reykjavik, Iceland

The Icelandic Tobacco Control legislation (1986 revised 1996) states that one of its main goals is to protect people from ETS, through:

- legislation
- regulation
- promotion of the agenda.

Legislation

The tobacco control legislation from 1986, revised in 1996, states in Chapter III that in all places, institutions, companies, factories and shops where the public is admitted, smoking is banned. This is not applicable in restaurants and discos, but restaurants have to provide smokeless areas of the same standard as the smoking areas. The legislation specifically bans smoking in:

- all schools and kindergartens
- all buildings for children's activities (social, sport and leisure)
- all public gatherings for children and young adults
- all places where health services are provided
- all public buildings and institutions before 31 December 2000
- all public transport.

Regulation of smoking in workplaces

A regulation based on the tobacco control laws came into force in June 1999 banning all smoking in workplaces, including in meetings and cafeterias. There are exceptions, but these are very strict; for example, an employer can permit a smoker to smoke in his or her office if no one else smokes there and the public has no access to that office.

Promotion of the agenda

Laws and regulations can be passed, but the public needs to accept and implement them. Under the tobacco control law, the Tobacco Control Task Force received adequate funding in 1996 of 0.7% of the total annual sale of tobacco. It was decided that to gain public acceptance, the Task Force's promotion activities should be run by a well accepted, energetic and preferably well known individual. Such an individual was found and enrolled to run the programme. As a result:

- public awareness of ETS and smoking in general has been raised;
- the law and regulations have been made more acceptable;
- people, institutions, offices and workplaces have volunteered to go further than the law requires.

As a result we have now (some according to law and others going further):

- all schools and school properties are now smokeless;
- working places are rapidly becoming smokeless;
- public offices are smokeless a year ahead of schedule;
- sport facilities and arenas are smokeless;
- model agencies and their fashion models are smokeless and promote only nonsmoking individuals;
- all beauty contests are smoke-free and participants are not enrolled unless they are nonsmoking;
- all airport terminals now have limited smoking areas;
- hotels offer smoke-free rooms;
- it is considered positive for big and small companies to support the Task Force and participate in its publicity;
- well known artists, musicians, politicians and public figures are participating in the Task Force's publicity without charge.

All the above contributes to a general agreement that ETS is not acceptable.

Currently the smoking rate of the group aged 18–5 years in Iceland is 22–23%, down from 31% in 1996.

What next?

The principal goal is to prevent the current smoking rate from rising, and indeed to reduce it further. Some suggestions for revision of the tobacco control laws have been made to the Minister of Health. In relation to ETS the main suggestions are:

- confirmation that an individual has a right to a smoke-free environment;
- restaurants must only allow smoking in designated smoking rooms separate from other facilities, and food or beverages may not be served in those rooms;
- hotels must make at least half their rooms smoke-free;
- separate and adequate air conditioning must be installed in places where smoking is permitted;
- confirmation that an employer is obliged to provide an employee with a smoke-free workplace;
- fines for offenders are implemented;
- 2% of the value of total sales of tobacco must be used for education and publicity, while waiting for international regulations to make a difference to the situation in Iceland.

Environmental tobacco smoke: Irish government policy

Tom Power, Chief Executive Officer, Office of Tobacco Control, Department of Health and Children, Dublin, Ireland

Passive smoking

The inhalation of ETS, sometimes referred to as passive smoking, is a serious risk to health.

Lung cancer and heart disease

Exposure to ETS is in itself a cause of lung cancer; in those with long-term exposure, the increased risk is reported to be in the order of 20–30%.

Exposure to ETS is a cause of ischaemic heart disease and in this respect alone represents a substantial public health hazard.

Smoking and infants

Smoking in the presence of infants and children is a cause of respiratory illness and asthmatic attacks in children. Middle ear disease in children is also linked to ETS.

Maternal smoking

Smoking in pregnancy causes adverse outcomes, notably

- miscarriage
- low birthweight
- perinatal death.

A recent study offers evidence that foetuses of women who smoke metabolize cancer-causing agents contained in tobacco.

Irish responses

Smoking is prohibited or severely restricted in schools, health care facilities, cinemas and theatres, taxis, hairdressers, certain clubs, government offices, offices of certain other businesses and restaurants. There is a voluntary code for workplaces.

Proposed new policy: "Towards a Tobacco-Free Society"

The Irish government is seeking to promote a tobacco-free society. In this context it has brought forward new proposals for, *inter alia*, protecting people against ETS, including a ban on smoking in enclosed working places in health care facilities, educational establishments, places of certain commercial transaction, certain places of entertainment, public vehicles, etc.

The policy will take account of technical specifications on emissions (the new EU Directive).

Bibliography

Towards a tobacco free society. Dublin, Ministry of Health and Children, 2000.

Policies to reduce exposure to ETS in Italy

Dr Giovanni Alfredo Zapponi, Laboratory of Environmental Hygiene, Istituto Superiore di Sanità, Rome, Italy

In Italy the problem of reducing exposure to ETS is seen in the context of the problem of reducing tobacco smoking, so that the two aspects are here considered jointly.

The National Plan for Health 1998–2000 (Piano Sanitario Nazionale), issued by the Minister of Health, has as its first objective specifically to promote behaviour and lifestyles for health, which is considered as the reduction and elimination of tobacco smoking and of active and passive exposure to it. The importance of this is also considered in the second objective, to oppose main pathologies, which includes tobacco smoke as one of the main risk factors for cardiovascular diseases and cancer.

The practical objectives are to reduce the prevalence of smoking to no more than 20% for men and 10% for women in the group aged over 14 years, to zero in pregnant women, in teenagers, and to reduce the average number of cigarettes smoked.

Although these rates appear high, it should be remembered that the prevalence of tobacco smokers has been high and is still significant – in some areas and among certain population groups it may be 50–60% and higher, with significant variations. Typically, higher levels of smoking are encountered in the poorer social classes, as happens in most countries.

Data collected since 1949 by the Doxa Institute, which deals with opinion polls and surveys, show that from 1949 to the end of the 1980s smoking in males fell significantly (from 71% to 38%) while in females it rose considerably (from about 10% to about 28%), according to the same trend observed in other European countries.

An opinion poll by the same agency in 1992 indicated that 75% of young people aged 15–24 years are nonsmokers, 19% are regular smokers and 6% occasional smokers, and that males smoke more than females (31% and 19%, respectively).

In the findings of a study which started in 1980 (published in 1991), the Italian National Institute of Statistics estimated that in 1987 smokers represented 28.6% of the population aged over 14 years (40.8% males, 17.4% females), ex-smokers represented 8.9% of the same population, and the average number of cigarettes smoked per person per day was about 15 (17 for males, 11 for females). The highest rate of smoking was in the group aged 30–39 years (about 52% for males and about 28% for females); after 40 years, the rate appeared to decrease. About 44% of male smokers and about 29% of female smokers had started to smoke before 18 years of age. The maximum number of cigarettes smoked per person has increased: at the end of 1940, 1.1% of males smoked more than 31 cigarettes per day, rising to 3–4% at the end of 1980. This trend runs parallel with a trend towards a decrease in the prevalence of smokers in the same population.

Education level appeared to be positively correlated with tobacco consumption in females (about 10% for primary school education level, and about 28% for high school or university levels) but not in males. The highest percentages of smokers were found in males among workers and in females among managers and professionals. These findings have been interpreted to show a correlation between the emancipation of females and their adoption of a male habit.

The latest conclusions are that there is a marked decrease in the percentage of male smokers, together with a stabilization of the percentage of female smokers. However, the authors of these studies underline that, in particular in the case of data obtained through questionnaires and interviews, the results obtained may somewhat underestimate the real phenomenon because of some restraints and the difficulty people find in admitting their smoking habits.

It is also clear from this information that smoking considerably increases with age, and that smokers have little or no knowledge or perception of the risks. Smoking by parents, relatives and friends is particularly important in stimulating young people to start smoking, and this influence may strongly counteract antismoking. Prevention campaigns should start within the family. People tend to start smoking young, and prevention activities have to start early and be programmed to take the above aspects into account. Different target groups may be identified that need specific approaches in prevention campaigns, for example, young people or even children (to stop them starting to smoke), the group aged 16–20 years (when the rate of smoking increases), the group aged 30–40 years (when smoking prevalence is higher), and specific professional or education categories where smoking is high (for instance, specific categories of female and male smokers). Regional differences also need to be considered.

National, regional and district programmes for schools include the prevention and reduction of smoking and of ETS exposure during the time that children are developing, stimulated by the above considerations. Campaigns against smoking and for the reduction of ETS exposure have been promoted in the mass media. However, preliminary data show that these messages seem to have a limited impact, in particular on younger people. It is planned to continue and increase all these activities in future years.

National laws forbid tobacco smoking in most indoor environments, in particular in public areas. These prohibitions are not always respected. For example, in restaurants, fast-food restaurants, cafés and other such places, even though there are signs prohibiting smoking, smoking is often

allowed in areas other than areas reserved for smokers (which might also not exist). One of the problems is that a strict ban on smoking leads to the loss of a large number of customers, so that managers attempt a form of compromise. An improvement in the national and regional regulations in this field might be the solution. Moreover, the need for some improvement in national legislation has become clear since a judgement in the Constitutional Court in 1996 confirmed that, based on the general principle of health protection, a smoking ban was legitimate and appropriate in working areas where people were present, even if this was not specifically mentioned by law. This could be achieved through both specific measures (covering e.g. smoke-free areas and conditions which have not yet been considered by existing regulations) and general principles (the significance of ETS as a risk factor in every condition).

An analysis of the impact of ETS has been carried out by the Italian National Committee for Indoor Air Quality. Recently, three Italian centres (Turin, the Veneto and Rome) have participated in a multicentre European study, coordinated by the International Agency for Research on Cancer. This study has confirmed a cancer risk increase for the spouse of a smoker (odds ratio: 1.16, 95% confidence interval: 0.93–1.44) and for ETS exposure at workplace (odds ratio: 1.17, 95% confidence interval: 0.94–1.45). The impact of ETS must also be considered in connection with exposure to radon in volcanic areas and the possible synergy between these two factors. The Committee's conclusion is that ETS is a main risk factor which requires maximum attention. This study and the publication of these data are part of ETS prevention.

Brief preliminary comments could include the following.

- Tobacco smoking is an old habit in Italy and not easy to eradicate.
- The situation has considerably improved in recent years.
- There is still some difficulty in persuading smokers to stop, especially in certain social categories or age groups.
- This difficulty is largely correlated with an incorrect risk perception (e.g. tobacco smoking and ETS are often considered minor risks compared to other risk categories), with "transgression attitudes", with difficulties in getting the message across to specific population groups, and other similar reasons.
- In the meantime, many population groups strongly support anti-ETS policies and actively promoting prevention. This is important in the practical implementation of policies.
- The support by WHO and by a European campaign may have a major positive effect.
- WHO's conclusions and recommendations should be presented to the population in a way that also considers risk perception. Suitable risk communication is essential.
- An essential step is to improve present legislation in this field. Reference to the international context, and in particular to WHO, is extremely important.

Policy on ETS in Latvia

Dr Signe Velina, Deputy Director, Department of Public Health, Ministry of Welfare, Riga, Latvia

In December 1996 the law "On restriction of manufacturing, sale, advertising and smoking of tobacco products" was adopted by parliament and came into force in January 1997. This was the first law on those issues since Latvia became an independent state in 1991.

The purpose of the law was to protect human health and the right to a pure environment unpolluted with tobacco smoke, and to lay down the procedure regarding state control of the manufacture, import, sale and advertising of tobacco products and smoking in public places by observing the rights and interests of population.

The restriction of smoking was defined as measures set by the state or based on the initiative of the population with the aim of restricting the use of tobacco and tobacco products.

Further, the law states that nonsmoking employees are entitled to refuse to work in places where other employees smoke. Such refusals shall not be considered violations of work discipline or the regulations of the civil service. Employers have the duty to provide nonsmoking employees with a workplace unpolluted by tobacco smoke.

Smoking is also forbidden in training and educational establishments, with the exception of places set aside for smoking.

Smoking by patients being treated in health care establishments is restricted by this law and by the internal regulations of the health care establishment.

Smoking is forbidden:

- in workplaces and places intended for common use, with the exception of places specially allocated for smoking;
- in cinemas, theatres, concert halls, museums, video and sports halls, with the exception of places specially allocated for smoking;
- in the public areas of banks, post offices and other establishments, with the exception of places specially allocated for smoking;
- in all types of public transport, apart from long-distance trains, ships and aeroplanes, where there should be separate carriages, saloons or cabins for smokers;
- in discos and dance halls, with the exception of places specially allocated for smoking.

Smoking is only permitted in cafés, restaurants and other places of public catering in places specially allocated for smoking. This also applies to establishments, enterprises and other public places.

No smoking areas must be indicated by a “No smoking” notice in the state language in white letters against a red background, and smoking areas with a similar “For smoking” notice in white letters against a green background, or with a symbol used in international smoking control practice.

State institutions supervise and monitor compliance with this law and enforcement of the regulations in accordance with the procedure stated by the law. The law also establishes the State Commission for Smoking Restriction, which coordinates the work of these institutions in enforcing the law.

The Commission realized that it was difficult to enforce the law on these issues because there was no clear statement of the controlling institutions, the penalty for smoking in nonsmoking places was only 5 lats (about US $9–10), and the existing wording could be interpreted to allow smoking on the entire premises of a café or restaurant. The law was therefore amended in

October 1999. A new definition was made for a place specially designated for smoking: a separate or separated room or part of a room, equipped with air ventilation and a special sign with the appropriate symbol or informative text. In addition, in all places where smoking is restricted and where there is only one common room which is intended for all visitors or workers, it is permitted to designate only part of the room for smoking.

It is hoped that this will stop the law being disregarded and make it easier for the controlling institutions to enforce the law. The main goal for this year remains to inform people about their rights and to enforce the law.

Environmental tobacco smoke control policy in Lithuania

Dr Thomas Stanikas, Lecturer, Kaunas University of Medicine, Lithuania

Background

About 50% of men and 15% of women are regular smokers. The prevalence of smoking is increasing in both males and females, especially in young women. There was a five-fold increase in smoking in women aged 25–29 years during the last four years. Of the 3.7 million population, about 7000 die prematurely from tobacco-related diseases. The health consequences of passive smoking have never been assessed. A recent study showed that only 35.7% of the adult population were never exposed to ETS at work, and 16.8% were exposed to ETS for more than five hours daily. Although the rights of nonsmokers are formally protected by law, smoking at work and other public places is too often considered as normal behaviour.

Tobacco legislation

During the decade following restoration of independence, over 60 legal acts dealing with tobacco have been issued by the parliament and government. The law on tobacco control adopted in 1995 and amended in 1999 covers all main aspects of tobacco control, including protection of the rights of nonsmokers. Article 14 of the law prohibits smoking in:

- all educational, development and health care institutions, and also halls where sports and other events take place;
- enclosed areas in workplaces, except for specially designated smoking areas;
- common living areas and other common areas where nonsmokers may be forced to breathe are polluted with smoke;
- all types of public transport, apart from long-distance trains (which must have specially designated cars for nonsmokers and smokers) and aeroplanes;
- public places for uniformed officials of the Republic of Lithuania, with the exception of specially designated smoking areas.

According to the law:

- Smoking shall be permitted in enterprises, institutions and organizations solely in specially-prepared areas (locations), the requirements for the setting up and use whereof shall be established by the Government of the Republic of Lithuania.
- Hotels, restaurants and cafés must have areas designated for nonsmokers.

- Local governments shall have the right to prohibit smoking in public places (parks, squares, etc.).
- Employers and managers must ensure that warning signs concerning smoking restrictions in designated areas are displayed in visible places.

Following the above article, the government issued resolution No. 1307 of 13 November 1996 "On the preparing of special areas (locations) for smoking in enterprises, institutions and organizations" The resolution lays down detailed regulations for establishing, equipping and the use of such areas. Institutions' administrations are responsible for implementing the resolution.

In Article 18 of the Law on tobacco Control, the State Tobacco and Alcohol Control Agency, local governments and police are mentioned among the institutions made responsible for implementation of the law.

Article 185 of the Code of Administrative Transgressions of the Law provides the possibility to fine those who smoke in smoke-free areas a maximum of 50 litas (US $12.5).

The Law on Environment Protection does not deal with any form of tobacco use and ETS is not officially recognized as a pollutant or harmful agent.

Tobacco control programmes

The National Tobacco Control Programme approved by the government in July 1998 aims to reduce the harmful effects of smoking, including passive smoking, with the creation of a smoke-free environment as one of the key tasks. The Programme is planned to run for 13 years from the end of 1998, but due to the difficult economic situation it has not yet been financed by the government. The National Smoking Prevention Programme for Schools also deals with passive smoking as a key issue; this was launched in 1992 but later suspended for the same reason. Thus little is currently being done to control passive smoking at the national level; some short-term local programmes dealing with ETS are also poorly financed and contribute little to the solution of the problem.

Protection of nonsmokers' rights

Although the rights of nonsmokers are formally protected by the law on tobacco control, implementation of the law is too slow and inadequate. The population is not adequately informed about the risk to health related to smoking in general and to ETS in particular, and protection of the rights of nonsmokers has never been high on the agenda.

The role of NGOs

The only nongovernmental organization concerned about the rights of nonsmokers is the Lithuanian Association of Nonsmokers, founded in Kaunas in 1993. This organization has contributed much to creating the legal basis for tobacco control and preparing the National Tobacco Control Programme, but its activities are not popular and it gets practically no support either from medical organizations or from the community in general.

Smoke-free zones

Just after the city of Kaunas joined the International Healthy Cities Project in 1990, an initiative by local tobacco control activists led to the Mayor proclaiming the main shopping street and two neighbouring squares as smoke-free zones. A few years later the City Council instructed police to fine smokers violating the ban. The number of transgressors fined in this way fell from 958 in 1994 to 216 in 1996. This may show the changing behaviour of smokers and may be contributing to the lack of acceptance of smoking in general. Although there was much controversy about the smoke-free zones and violation of the rights of smokers, the study showed that the majority of respondents supported the smoke-free zones.

Conclusions

Despite the relative success in creating comprehensive legal bases for tobacco control, implementation of the legal acts has not been sufficient and formulation of the state tobacco policy is still in its initial stage. More attention should be paid to ETS and protection of the rights of nonsmokers. In recent years the tobacco industry seems to have more influence on the government and mass media. There is an urgent need for more effective public control and increased activity by NGOs interested in public health issues.

Policies to reduce exposure to ETS in the Netherlands

Peter Van Soelen, Dutch Foundation on Smoking and Health, Stivoro, The Hague, Netherlands

Passive smoking is more and the more the subject of public attention. The number of nonsmokers has greatly increased. In the Netherlands there are 11 million nonsmokers as opposed to 4 million smokers.

ETS threatens wellbeing. Passive smoking is disagreeable to those who don’t smoke and a source of discomfort which ranges from persistent stench to irritation of the eyes, nose and throat. The smell of tobacco smoke penetrates clothes and hair. Tobacco smoke reduces taste and can cause headaches, nausea and dizziness.

ETS also threatens health. At the request of the former State Secretary of Welfare, Public Health and Culture, the Minister for Housing, Regional Development and the Environment and the Minister for Social Services and Employment, the National Health Council published its advice concerning passive smoking called *Passive smoking, an analysis of harm done through environmental tobacco smoke*. The main conclusions are:

- There are about 3800 different substances in the tobacco smoke that a nonsmoker inhales. These include irritating substances and substances that influence the function of the nervous system, the respiratory tract, the defence system, the blood and blood vessels of the nonsmoker as well as cause cancer. In the case of pregnant women the danger is extended to the unborn child.
- Smoking causes an important rise in concentrations of inner air pollution. Mutagenic and carcinogenic substances were found in the body fluids of nonsmokers exposed to ETS.
- In the Council’s view, it is probable that long exposure to tobacco smoke increases the chance of getting lung cancer for nonsmokers.

- Asthma patients and people with respiratory troubles are extra-sensitive to even short exposure to tobacco smoke; much more so than other people.
- In the Council's view, short exposure to tobacco smoke is harmful to health. The recurring nasty smell, irritation to eyes, nose, mouth and throat, and deterioration in the condition of asthma patients and others with respiratory troubles all cause problems in the proper functioning of society.

The tobacco law

The tobacco law passed in 1998 enables the government to control tobacco. Protecting young people and nonsmokers is a second important objective. An outcome of the law is a further regulation ("Algemene Maatregel van Bestuur") banning smoking in public buildings. The ban on smoking deals basically with the right of the nonsmoker to be protected from harm as stipulated in Art. 11 of the Constitution.

The ban on smoking came into effect on 1 January 1990 in more than 50 00 buildings subsidized or controlled by the government in the following main categories: governmental, health care, sociocultural and social services, health care, sports and state-subsidized education.

Enforcement of smoking ban is obligatory in all public and common spaces, excluding workplaces. Failure to respect the law is not penalized. A deliberate appeal has been made to the rationality and social control of citizens. A special phone number has been established to enable citizens to report irregularities in the application of the tobacco law.

The law does not apply to private business buildings. Refraining from interfering in private initiatives is in accordance with government policy.

Suggestions for changing the law include the possibility for employees to claim smoke-free workplaces and the possibility for penalizing the responsible party for breaking the law.

Workplace

Because the law does not apply to private corporations there are constant complaints about undesirable exposure to tobacco smoke.

A survey made in 1997 by the Dutch Foundation on Smoking and Health shows that 67% of employees report that others smoke in their presence, of whom 43% have serious complaints. The discomfort is worst in shared offices and canteens. Some 44% of employees who are bothered by smoke try to do something about it. Generally this implies that they try to reason with smoking colleagues rather than take matters higher up.

Working conditions are laid down in the Work Conditions Law**.** The Government recognizes that every employee has the right to work in an environment where health is not impaired.

Art. 3F of the same law takes into consideration the physical condition of employees who are not totally fit. These people have a right to extra protection. People to whom tobacco smoke is harmful are those with respiratory problems or those allergic to ETS. This group includes pregnant women as well as people with heart problems. Tobacco smoke slows down the recovery of patients recuperating from an infection of the respiratory tract.

The law does not oblige employers to provide employees with the facility to smoke. Since 1994 employers have been obliged to maintain inventories and evaluate all health risks.

In April 2000 a judge ruled that smoking endangers health. Nonsmokers experience health problems or discomfort as a result of environmental tobacco smoke in particular if they suffer from respiratory diseases. An employee therefore had the right to claim a smoke-free working area, meaning that a whole building should be smoke-free.

Public recreational places

There are no laws concerning decreasing exposure to ETS. There is no or little agreement in political or social fields regarding appropriate legislation in

Conclusion and recommendation

Legislation concerning ETS can only be significant if it is backed by good programmes focused on specific groups. Just making people aware of the law is not enough. The Netherlands has long-running intervention programmes for the specific groups of babies and young children as well as the whole education system.

Norwegian policies to reduce exposure to ETS

Professor Asbjørn Kjønstad, Professor of law, University of Oslo, Norway

Introduction

At the end of the 1960s the authorities prepared a comprehensive plan aimed at influencing smoking habits. This was to be done through the following three measures:

- a systematic information programme on the harmful effects of smoking
- therapeutic measures – helping people to stop smoking
- restrictions on the sale of tobacco products.

Norway is a welfare state northernmost in Europe with a population of just over 4 million. It is a long and narrow country with more than 20 000 km of coastline. There have been experienced four “waves” of legal measures in connection with tobacco-related diseases.

First, the Tobacco Act which was passed in 1973 and came into force in 1975. The purpose of this Act is “to limit the health damage involved in the use of tobacco products”. The Tobacco Act gives a clear signal of the authorities’ deep concern with the health damage caused by smoking. This Act introduced a total ban on all advertising for tobacco-related products, an order that tobacco products should be labelled with a warning concerning the health hazards of cigarette smoking, and a ban on the sale of tobacco products to persons under the age of 16 years (18 years from 1996). The purpose was to stop the tobacco industry’s positive influence on smoking.

Second was the so-called “Smoking Act” of 1988. This was a welfare act which had as its primary intent the protection of nonsmokers from becoming passive smokers. While Norway was a pioneer and received international attention in connection with the advertising ban, our actions concerning a smoke-free environment were not at the forefront internationally.

Third was a ban in 1989 on all new tobacco- and nicotine-containing products. It is now prohibited to produce, import, sell or hand over to others new types of tobacco- and nicotine-containing products. The same applies to tobacco- and nicotine-containing products intended for use in ways other than those normally practised in Norway.

Fourth, tort law cases are now being pursued. These stem from the USA, which has played a leading role with regard to product liability and consumer protection.

Legal protection against passive smoking

Introduction

The Tobacco Act of 1973 was aimed at smokers and potential smokers. Nonsmokers had no legal protection. In May 1988, the Tobacco Act was amended to include a new section, the so-called “Smoking Act”.

The contents of the “Smoking Act”

The first sentence of the “Smoking Act” reads: “In premises and means of transport to which the public have access the air shall be smoke-free. The same applies in meeting rooms, work premises and institutions where two or more persons are gathered.”

This provision is not formulated as a ban on smoking but as a right to breathe smoke-free air. When the Norwegian Council on Smoking and Health proposed the Bill, it was important to present it as an Act which gave people a right and not one which imposed a prohibition. There has been a tendency in Norway to oppose the introduction of prohibitive legislation.

The principle of smoke-free air is to apply to premises “to which the public have access”. Such premises include all indoor rooms in houses, buildings and halls, for example:

- post offices, social security offices and other offices providing public services;
- shops, travel agencies, banks and other premises for private services;
- lobbies, lifts, staircases, toilets, and similar rooms which people use for short periods;
- churches, cinemas, theatres, opera houses, teaching premises, waiting rooms and similar places frequented by the public for longer periods;
- taxicabs, buses, trams, trains, ships, aircraft and other public conveyances engaged in domestic trade.

The “Smoking Act” does not guarantee smoke-free environments in private houses. This may appear inconsistent, since studies have shown that the people most exposed to the harmful effects of passive smoking are spouses, children and other family members. In spite of this, it has not been wished to interfere in people’s private lives. But when a smoke-free indoor environment has become the norm in the rest of society, this is also usually followed in homes.

The “Smoking Act” applies to conference rooms and other work premises. A person sitting alone in his or her office may still smoke, but when two or more people work in the same room, smoking is not permitted.

Some exceptions have been made to the fundamental principle of smoke-free indoor air

The most important exception in the "Smoking Act" was that smoking was permitted in restaurants and hotels. This exception was introduced after strong pressure from these establishments. The bill proposed that one third of the seats and the rooms should be reserved for nonsmokers. The hotel and restaurant industry maintained that if this provision was adopted, it would lose customers and money and would have to lay off staff. The authorities yielded to this pressure and concentrated their efforts on getting the rest of the bill passed.

However, a provision was adopted which required the gradual introduction of smoke-free environments, particularly in connection with new buildings, and the reconstruction of existing buildings. In the course of five years, at least one third of the tables, seats and rooms should be reserved for nonsmokers. This was later extended to one half of the seats and tables. Furthermore, reception areas, corridors and other public areas shall be smoke-free.

Smokers have no right to have special areas reserved for them. However, if a company or building has several rooms of the same kind, smoking may be permitted in one of these rooms. This applies, for example, to a company where there are two canteens or one canteen which can be split into two by a dividing wall. In such cases the best and largest room has to be reserved for nonsmokers.

Dividing a room into two by using a wall is very different from dividing a room into a smoking zone and a nonsmoking zone. As a rule, unless there is excellent ventilation, smoke will pass into the zone where smoking is not permitted. A strict condition is imposed for permitting a room to be divided into smoking and smoke-free zones. It must be impossible for the smoke to pass into the smoke-free zone.

The debate on the "Smoking Act"

There was a massive attack in the Norwegian media on the provision providing the right to breathe smoke-free air. A trinity consisting of the tobacco industry, some well known people and many journalists fought a battle for the right to smoke anywhere and at any time.

The tobacco industry and retailers had their business interests to take care of. As much smoking as possible in as many places as possible gives the highest number of sales and ensures that smoking will continue. The tobacco industry is fighting to retain its market in industrialized countries and has intensified its marketing efforts to spread the habit of smoking in developing countries.

A small group of well known people – in particular some barristers – took the limelight in the media which should have focused on the thousands of sufferers with allergies and asthma, children and others affected by smoke. This group argued for the freedom of the individual, but the "freedom" to harm others cannot be permitted.

Journalists supported the group of pro-smokers. Newspaper offices and broadcasting houses are renowned for heavy smoking. Journalists cynically used the power of the written word and the airwaves to promote their own interests.

Obviously there were some journalists who wanted to talk to those of us who had formulated the new "Smoking Act". In the course of a few months, I was interviewed some 20 times about the Act. But – with two exceptions – these interviews were never printed. They were censored by the

smokers at the editorial desks. This has never happened to me before. Unfortunately I am not the only one to have experienced this with regard to the "Smoking Act". Very few newspapers gave a balanced picture of the new Act, in spite of the fact that it was supported by 80–90% of the population – even among smokers.

Enforcement of the "Smoking Act"

One of the arguments used against the Act was that it would be difficult or even impossible to enforce. This argument holds no water. The Labour Inspection reported that, compared with certain other legislation, the "Smoking Act" was easy to enforce. It is clear and leaves little room for personal interpretation.

It is the owner, or the person who has the premises at his or her disposal, who bears prime responsibility for ensuring that the smoking rules are observed. In places where any doubt may arise, clear notices must be posted to show where it is not permitted to smoke.

People who violate the provisions shall first be warned. If a warning does not help, the owner has the right to expel the person concerned from the premises. The Act also allows for penalties to be imposed, but as yet none have been.

In special cases dispensation may be granted, but very few applications have been received. The Labour Inspection in Oslo received about ten applications for dispensation in the course of the first year. In these cases the Inspection requested more information on ventilation, the consequences of a total ban on smoking, the possibilities and cost of building special rooms for smokers, whether any employees had allergies, etc. The Labour Inspection received no response to these questions, and therefore did not consider dispensation.

A survey has shown that, by and large, the Act concerning smoke-free indoor air has been positively received, is respected at places of work, and has led to increased wellbeing. Since it was enforced the situation has become more difficult for some smokers, but the majority of the population are better off. People who react negatively to tobacco smoke can now go to the theatre and airports and, in many other respects, take part in social and cultural life in the same way as others.

Passive smoking and tort liability

A tobacco case came before an Appeal Court in January 1999. A 41-year-old woman contracted lung cancer after smoking for 20 years and working in a heavily smoke-filled discotheque for 15 years. She sued her employer's insurance company – the workers' compensation insurance. Two medical experts appointed by the court evaluated the extent to which the passive smoking in the discotheque and her own active smoking could be seen as contributing to her lung cancer. They concluded that the contribution of passive smoking constituted a minimum of 40%, while her own active smoking constituted a maximum of 60%. The court could not disregard the passive smoking as insignificant. There was hereby a causal connection between the hazardous effects of the work environment and her health injuries.

However, the compensation was reduced by 25% because of the woman's own contribution. An appeal has been lodged against this part of the judgement, and it will be interesting to see what the verdict of the Supreme Court will be.

In the United States, the tobacco industry could be sued under both these two circumstances. Suits on the basis of passive smoking are regularly filed there against the tobacco industry. This is not out of the question in Norway either. And in any case, there is the possibility that this woman can take action against the tobacco industry for that portion of damages not covered by the workers compensation insurance.

A decision from an Appeal Court in an individual case is of course of little significance as a legal source. But in principle it is very important that a Norwegian court of justice has found in favour of a person who has been injured by tobacco smoke. This seems like a nail in the coffin of the tobacco industry.

Environmental tobacco smoke in Poland

Professor Witold Zatonski, Maria Sklodowska-Curie Cancer Centre and Institute of Oncology, Warsaw, Poland

ETS is a very sensitive health and social problem in Poland, a country with a long tradition of smoking and a widespread custom of smoking in the presence of others. WHO estimates that the consequences of smoking constitute the principal reason for the very high rates of premature death in Poland – nearly every second male premature death, and 60% of all cancers, are due to active smoking. In order to mitigate these consequences, a comprehensive tobacco control law was passed by parliament at the end of 1995. The first goal of this law is protection of the right of nonsmokers to live in a smoke-free environment.

Article 5 of this law reads:

1. Smoking is forbidden in the following places, with the exception of areas expressly set aside for smokers:
    1) health care establishments;
    2) schools and other educational facilities;
    3) closed spaces on the premises of institutions of employment and other public service buildings.
2. In special cases, the attending physician may exempt a patient staying at a health care facility from the ban on smoking tobacco products.
3. The Minister for National Defence, the Minister for Internal Affairs and the Minister of Justice shall issue ordinances stating the rules for permitting tobacco use on the premises of buildings in their charge.
4. The Council of a commune may adopt a resolution declaring places other than those listed in paragraph 1 as smoke-free public places within the territory of the commune.

During the preparation of this legislation, there was a lively discussion as to what can be done in the area of passive smoking. Experts and politicians agreed that progress must be by slow steps. So far, it has been very difficult to introduce a complete ban on smoking in some places, particularly cafeterias and restaurants. However, smoking was not traditionally accepted in some places, such as the majority of public places and the transport network. The most important regulation was to limit smoking in workplaces to specially designated areas. Unexpectedly, this regulation was quickly accepted by a large proportion of employers, especially in the private sector.

Based on scientific studies, it seems that health threats arising from passive smoking are greatest, from a public health point of view, for unborn and small children. In 1999 this problem was

addressed in a report which described the magnitude of the problem and showed that, in some environments, passive smoking is the greatest risk factor for infant mortality. In Poland, around 4 million children are involuntarily exposed to tobacco smoke. Overall, approximately 20–30% of women smoke during their pregnancies, but in some groups (in the large cities, among less educated women), 60–70% of women of reproductive age smoke. As a result, every year around 120 000-140 000 children are born less developed, worse prepared for life, and with a birthweight averaging 200–400 g less than expected. Some 60–75% of small children are exposed to ETS in their family homes. This is a cause of many frequently observed diseases, for example sudden infant death syndrome, diseases of the respiratory system, asthma, and middle ear infections.

For this reason, protection of children will be an essential part of the comprehensive programme for tobacco control. Good collaboration is needed between the medical profession and, especially, the young adult section of the population, in order to defend children from second-hand smoking. There is a need for regulation and education, as well as for changing the social climate so that children are protected from being exposed to cigarette smoke.

Portuguese policies on ETS

Dr Jose M. Rocha Nogueira, Centro de Saude de Oliveira do Douro, Oporto, Portugal

In Portugal, the first main regulations regarding ETS were published in 1959, with a ban on smoking inside closed premises for public events, followed by the prevention of smoking in public urban transports (1968), and in long-distance railway connections and boat transport (1978). The ban on any form of publicity related to tobacco in sports premises dates from 1977. It was not until 1982, however, that a comprehensive general law was published. This included the lead aspects of smoking prevention, and was followed by several other official documents regulating ETS control.

In general, apart from areas expressly assigned to smokers, smoking is not allowed as follows.

Institutions

- all health care units (including waiting rooms, ambulances, first aid units and pharmacies);
- nurseries and other premises frequented by minors;
- schools (including class rooms, study rooms, reading rooms, libraries, gymnasiums and canteens);
- closed sports-grounds;
- closed show rooms and premises for recreational activities in general;
- all state and private services with public access, in lifts, museums and libraries.

In these institutions, smoking can be permitted in areas expressly reserved to smokers, as long as those do not include areas which may be regularly used by unhealthy people, children aged under 16 years, pregnant or breastfeeding women and sportsmen.

The law also allows the following to ban smoking:

- restaurants, bars, pubs, coffee-houses or any similar premises, in areas assigned by the manager to nonsmokers, as long as these are properly signed;

- workplaces, whenever possible, through the existence of available alternative spaces for smokers.

Transport

- passenger public transport vehicles in urban areas, and suburban, long-distance, rented or tourist-carrying vehicles with a travel time of less than one hour;
- underground railway stations, accesses and facilities;
- taxi-cabs.

On long-distance trips in high quality buses, express buses, tourist-carrying and rented buses with a journey time longer than one hour, smoking is allowed in the three back rows (this can be increased up to one third of the seats if the vehicle is equipped with an effective ventilation device).

Publicity

All forms of tobacco publicity are forbidden. Any Portuguese publicity channel or foreign publicity channel with a Portuguese representative must comply with this law.

State organizations

In 1983 the Council for Smoking Prevention (Conselho de Prevenção do Tabagismo) was set up as a consultative board of the government directly under the Ministry of Health. The members of this Council are appointed by the government and include representatives of the following sectors: health (2), education (1), agriculture (1), finance (1) and environment and natural resources (2). Its tasks are:

- to formulate the principles of a smoking prevention policy, according to international recommendations;
- to propose programmes regarding the prevention of negative effects of ETS in the population, through investigation, education and regulation activities;
- to serve as a consultative organism for the government in smoking prevention;
- to advise on all regulations, programmes and budgets related to smoking prevention activities;
- to promote and support studies and other activities related to smoking prevention policies (including the identification of the substances that tobacco should not contain or release during its use);
- to cooperate with central administration departments, to make sure that regulations related to smoking prevention and control are implemented;
- to increase international cooperation in smoking prevention, promoting the exchange of knowledge and techniques with similar organizations from other countries;
- to produce annual reports on the situation in Portugal and its own activities, and to promote public knowledge.

Despite the existing regulations, very little has been done to bring about a real change in behaviour. The enforcement needed to accomplish all the laws and regulations is absent, and ETS is not regarded as a relevant health problem by some of the health authorities. About 1% of

tobacco taxes are assigned to health promotion activities and to treatment of patients suffering from smoking-related cancers, a rather small budget compared to the amount of the taxes.

According to official data (1996), 18.1% of the population (30.2% of men) are regular smokers. In 1999, the prevalence in adolescents (aged 12–19 years) was lower (14.9%). Curiously, some of the main agents in providing health information to the public about tobacco and advice to those who want to stop smoking are themselves heavy smokers. A study published in 1994 revealed that 35% of general practitioners were regular smokers and 10% of these admitted smoking when they are with a patient. Nevertheless, there have been some achievements, such as:

- a (very few) health care units and schools have become totally smoke-free;
- falling prevalence of smoking in young people;
- a study in 1998 that showed that young people aged 13–22 ranked smoking and smoking in public as third in a list of behaviour problems related to health, and considered not smoking as the fourth main healthy form of behaviour;
- the inclusion by the Northern Regional Centre of Public in its plan of activities of ETS as a priority problem causing indoor air pollution

The spread of tobacco smoking in Romania

Professor Tudorache Voicu, Pneumology Clinic, University of Timisoara, Romania

In recent years the extension of tobacco smoking, which has been compared to tuberculosis or AIDS for its aggressive character, has been directed more and more towards the developing countries. The international tobacco producers have invested enormously in these countries; they have focused on central and eastern Europe, considered to be new and prosperous potential markets. The prognosis for deaths caused by tobacco smoking in the former communist countries shows an increasing rate of more than 22% until the year 2020.

Since 1989 the Romanian market has been invaded by large quantities of foreign cigarettes brought in legally or by smuggling, and now also produced under licence. Every year about 42 000 tons of cigarettes are sold. Annual cigarette consumption is estimated to be 2339 cigarettes per person over 15 years of age, 40% without filter.

The arable soil surface cultivated with tobacco and thus the implicit national production of tobacco fell shortly after 1989 but has slowly increased since 1995 (14.611 ha or 13 034 tons in 1998).

National tobacco production, reorganized under the national company Romanian Tobacco, permitted the implementation of modern technology in old factories. Nevertheless, the variations in taxes have not always favoured national production in comparison with the foreign producers who own or have opened new factories in Romania.

The last official investigation estimating the tobacco prevalence in Romania among the population over 15 years of age showed values of 42.7 among men and 15.2 among women (1994, National Health Centre for Statistics and Medical Information). Mortality due to lung cancer was 35.3 per thousand population, representing a severe and serious impact of tobacco endemic.

Large official studies about the spread of tobacco smoking among different social categories, levels and professions suggest an increase in tobacco smoking among teenagers, university students (about 40% of the students attending high school smoke) and women.

Medical personnel, who should be the leaders in the fight against smoking, are deeply involved in smoking: over than 50% of the physicians are smokers or ex-smokers.

The most promising activities for blocking the extension of smoking among young people will be those organized by the school and the family, through the personal example of older people. These antismoking activities have been structured by the Romanian Union against Smoking coordinated by the National Health Medical Preventive Department.

In recent years, some prohibitive regulations against tobacco have been launched such as a ban on the sale of cigarettes to people under the age of 18 (OUG No. 55/1999) and on smoking in cinemas or during the intervals, and the obligation to display the notice "Tobacco smoking seriously damages health" below tobacco advertisements (CCE No. 622/1989). There has also been an initiative to print on national cigarette packs messages containing information about the risk and references to nicotine or tar concentrations. Romanian Tobacco has already taken some measures under these regulations.

Some NGOs such as the Leagues against Smoking (in Cluj-Napoca), the Romanian Movement for the Defence of Nonsmokers' Rights, Pure Air (in Bucharest), and Health Messengers (in Bucharest) have proved to be active factors in limiting the expansion of tobacco in schools or other social environments.

Some anti-tobacco consulting rooms or clinics have been set up (in Bucharest, Targu-Mures, Iasi, Craiova, Constanta, etc.), but nicotine substitutive treatment which would help smokers to stop smoking is too expensive: US $3–4/day (as against an average salary of only US $75 a month).

A law against smoking is still waiting to be passed by parliament. This is supposed to be able to solve at least some of the numerous problems related to smoking (anti-tobacco advertisements and labels applied on the packs, smuggling, second-hand tobacco smoking, etc.).

National policy related to ETS in Slovakia

Dr Katarina Slotova, Head, National Reference Centre for IAQ, State Health Institute, Banska Bystrica, Slovak Republic

ETS is one of the most important known indoor environmental pollutants, which are known to cause, or suspected of causing numerous health effects. In order to eliminate exposure of nonsmokers to ETS, the government has enacted are different policies on ETS.

Slovakia has had tobacco control legislation since 1966, when the public notice concerning the creation and protection of healthy living conditions banned smoking in restaurants and cafeterias at lunchtimes. The Ministry of Health later adopted decrees prohibiting smoking in health centres (except in designated areas) and on marking certain tobacco products by control mark.

The law on tobacco control presently in force covers all main aspects of tobacco control including protection of the rights of nonsmokers.

The main regulations regarding ETS are those concerning:

- the protection of healthy living conditions
- the labelling of tobacco products
- the maximum tar and nicotine content in cigarettes
- a prohibition of the sale of tobacco in certain locations.

All these regulations define the tasks and roles of the state administration involved.

The purpose of the Act 67/1997 Coll. On the Protection of nonsmokers is to secure such conditions which discourage addiction to tobacco, and to prevent negative impacts on health from smoking and other forms of tobacco use. The law includes a description of the terms and the prohibition of advertising of tobacco products.

Tobacco products must be labelled as under:

- each package of a tobacco product must have a visible warning label;
- the contents of the warning label are “WARNING FROM THE MINISTRY OF HEALTH – SMOKING SERIOUSLY ENDANGERS YOUR HEALTH”;
- this warning is amended every 12 months with an additional warning about other negative health effects;
- the proposals are subject to approval from the Ministry of Health;
- the appropriate labelling is required from 1 January 1999.

Limits on the contents of noxious substances have been set as follows:

- the tar content must be a maximum of 15 mg/cigarette from 1 December 1998 and 12 mg/cigarette from 1 January 2001;
- the nicotine content must be a maximum of 1.2 mg/cigarette from 1 January 1998.

The sale of tobacco is prohibited as follows:

- in specialized food markets
- in shops for children and young people
- in health care facilities
- in schools
- in vending machines
- in packs of cigarettes with fewer than 10 pieces
- to young people under the age of 18 years.

The areas where smoking is prohibited are:

- in passenger public transport vehicles (except restricted areas in trains), outside and inside waiting places;
- in workplaces except in restricted areas and offices occupied by only one person;
- at meetings, workshops and negotiations in indoor public places;
- in health care establishments (except in restricted areas);
- at schools and other educational facilities;

- in closed sports-grounds;
- in closed premises for recreational activities in general;
- in premises to which the public have access (shops, banks, churches, cinemas, theatres, lifts, lobbies, teaching premises, etc.);
- in restaurants except in restricted areas: 50% of the places in restaurant must be reserved for nonsmoking people;
- in premises for confectionery and fast food.

The law allows local and regional authorities to impose other smoking restrictions.

Several national authorities are responsible for the enforcement of this law (State Inspection of Commerce, the State Food and Agricultural Inspection, State Health Institutes, etc.).

Specific details of the constraints on the substances in tobacco products, their limits, labelling, etc. are published in the Decree of the Ministry of Agriculture and the Ministry of Health of the Slovak Republic (issued 19.10.1998) – No.2015/98-100 dealing with tobacco products as a part of the Food Code (No 390/1998). Chapter 29:

- lists the definitions of tobacco terminology;
- defines the use of tobacco and other products;
- defines the approval procedures for the use of tobacco;
- describes the core part of the Decree devoted to the content of the substances and their limits; The coding is in accordance with the regulatory codes of the EU;
- lists the labelling and selling conditions and requirements;
- clearly defines the tasks and roles of the state administrations involved.

The legislation regarding the tobacco products in Slovak Republic is fully harmonized with the EU, except for the approximation of the law relating to the advertising and sponsorship of tobacco products.

Health education regarding smoking

Public health authorities have done a lot of work in the field of the education. Several programmes have been initiated to help people to stop smoking and special attention has been paid to the education of young people to try to prevent them from starting to smoke. The following projects have been implemented:

- “We want to breathe clean air”: education for children in kindergartens; aim: to bring nonsmokers’ rights to public attention.
- “Smoking and me”. Peer programme for elementary school pupils; aim: to educate children to realize risk situations and inform them about the consequences of smoking and using other drugs.
- Smoking and pregnancy. Discussions with pregnant women in the gynaecology and obstetrics department in Bratislava.
- International activities – World No-Smoking and Tobacco-Free Days.

The main problems regarding ETS

The policy and regulations are mostly valid for public places and do not apply to private buildings. However, results from epidemiological studies have shown that children exposed to ETS in their homes are at special risk. This is a cause of many frequently observed diseases. Legal measures are not appropriate to solving this problem.

Although there are authorities responsible for controlling ETS, the rules are often broken and compliance with them is not sufficiently controlled and enforced. The population is not adequately informed about the risk to health related to smoking in general and to ETS in particular.

Therefore we recommended that:

- in order to get the public to accept and implement laws and regulations, a health-related risk assessment should be established or known results from epidemiological studies used as a management tool in different sectors of government policies at national, regional and local level;
- people should be informed about their rights to breathe smoke-free air and to enforce the law;
- good intervention programmes should be established focused on specific groups, because only making people aware of the law is not enough;
- protection of children should be an essential part of the comprehensive programme for tobacco control;
- there should be good collaboration between the medical profession and the Department of Health to ask all local representatives to conduct surveys to monitor the enforcement of the act for protection of nonsmokers;
- WHO's conclusions and recommendations should be presented to the population in an appropriate way and suitable risk communication is essential.

Participation in international activities

- World Health Days organized by WHO
  31 May – World Tobacco-Free Day
  Third Thursday in November – Nonsmoking Day
- "Quit and Win" contest
- Project: Harmonizing for a Tobacco Free Europe:

  Location: WHO Regional Office for Europe, Copenhagen, WHO Regional Office for the Eastern Mediterranean, Alexandria, seven countries of the European Region (Bulgaria, Estonia, Lithuania, Czech Republic, Romania, Slovak Republic, Slovenia, Turkey), and one country of the Eastern Mediterranean Region (Republic of Cyprus).

  Implementing partner: World Health Organization (headquarters and regional offices) and the Commission of the European Union

  Proposed start date: 1 June 2000

Objective 1: To provide technical assistance to eight candidate accession countries in order to help them adopt measures for the harmonization and approximation of national laws, regulations or administrative provisions to those of EU directives and regulations pertaining to tobacco control.

Objective2: To provide technical assistance, practical guidance and critical review of the effectiveness of national tobacco control programmes in eight candidate accession countries in order to align initiatives with those of the EU in the area of tobacco control.

Objective3: To foster and build a strong strategic alliance between the institutions of the European Union and the World Health Organization to achieve a coordinated and concerted response to the tobacco epidemic in Europe.

Indicators of success:

- country legislation
- tobacco tax
- knowledge enhancement.

The project is prepared for negotiation and approval of the Ministry of Health.

Policies to reduce exposure to ETS in Slovenia

Dr Viktorija Rehar, National Coordinator, National Tobacco Control, Calec, Slovenia

Background

Essential population and country data show how ETS policy should be developed and oriented.

According to the 1991 census, the total population was 1 965 986 (952 611 males and 1 013 375 women). Some 20.5% were aged 0–14 years, 68.5% were aged 15–64 years and 11.0% were aged 65 years and over. Live births were 9.1‰, the infant mortality rate was 5.2‰, and deaths were 9.5%. The population density is 97.1 per km^2. The agricultural population makes up 7.6% of the total population. Some 49.4% are economically active, 23.1% have their own incomes, and 27.5% are dependent. Purchasing power parity was US $12 600 in 1995. The unemployment rate was 14.4% in 1997.

The country is composed of 192 municipalities and 1249 local communities, and other smaller local communities with 640 195 households in urban and rural settlements.

The general development and promotion of the quality of life of the citizens are important indicators of health status in the population. There have been various situations and problems in connection with the tobacco epidemic and its consequences at level of the individual and society.

Analysis of the consumption of tobacco products over 25 years shows a constant decrease in the number of daily smokers among the adult population aged 18 years and over. In 1974/1975, 39.7% were daily smokers. In 1999 this fell to 24.5%. This is partly a result of previous smoking preventive work, which was laid down by several laws connected with working legislation.

Vision

We believe in a smoke-free generation and smoke-free environment in this century. Therefore, three main courses of action need to be developed.

1. *Building conditions for a smoke-free environment.* First we need positive legislation, which supports healthy lifestyles and a healthy environment and the national economy, socially acceptable development and standards of living and working conditions.
2. *Nonsmoking education of the young generations,* to overcome second-hand smoking. This should start in the family and continue through sustainable lifelong interactive education, by means such as the systematic display of information through all kind of channels and mass media (kindergartens, primary and secondary schools, universities, leisure time at the local and national level) by professionals and lay interest groups. *Smoke-free environment education* provides awareness and positive behaviour of the whole environment and of exposure to carcinogenic substances with a multiplicative effect on health.
3. The concept of *networking* and helping smokers to stop smoking in professional institutions and through supporting mechanisms, which are basic conditions for the effective promotion of positive role models.

Philosophy

Nonsmoking is the basis for creating smoke-free generations and a smoke-free environment. In general, people are not aware of what a positive philosophy means in connection with health and the environment: they understand it as thinking and acting like nonsmokers. We propose that children should start thinking and acting as nonsmokers in the family at a very early age, so much knowledge should be used and many more possibilities built up step-by-step to allow them to grow up as nonsmokers in a smoke-free environment. This is a long-term target, which everyone could realize through their own responsible decisions.

Taxes and prices need to be supported by the multisector-oriented general and economic progress and policy. Finances should come from these resources to cover the cost of promoting the smoke-free environment and smoke-free generations. This should be a part of the legislatively regulated documents, rules and laws regarding health promotion and tobacco policy.

Target groups

The biggest groups of smokers are in young people and women. They are in the greatest danger and need special programmes and a methodological approach. The percentage of these smokers is constantly growing and more and more young pupils are being targeted, even in primary schools.

Environment tobacco policy

Our target is the achievement of a smoke-free environment. Four main fields are important in this:

- strategic planning
- legislation
- activities and projects
- a practical approach.

The essential document is the law on restricted use of tobacco products. Some parts can also be found in the occupational health and safety law. Both have been adopted by parliament. The consensus between the state and the actors is the constitutive part of policy development.

Many programmes, projects and activities are running in different settings – education, health, economic and other institutions and where NGOs have their own original projects. These have contributed to overall changes in the approach towards, and strategies, methods, contents and research in the smoke-free environment. The learning process is open for acquiring knowledge, awareness and behaviour patterns as the components of successful networking and collaboration at individual, local and national level.

Strategic planning

The strategic approach and the implementation and development of mechanisms for the appropriate quality of life and care in the macro and micro environment are part of the national policy drawn up according to the national plans (general national development plan, national health care plan, national environment plan). The details are contained in general and special legislation, documents, rules and recommendations.

The health care and other sectors follow the general guidelines in the national health care plan and who and other documents on health and environmental promotion. Since independence the social system has changed from public to private. This is reflected in the way each public sector has changed and adapted its organization, structure and approach to the quality of care and the environment. It has also caused unexpected obstacles and problems.

The priority in solving problems in environment questions is connected with general, economic and public health policy in the national environment plan. The comprehensive tobacco policy, which takes account of the needs and participation of the whole population, is a multisectoral matter.

The strategic plan and basic infrastructure of networks and partners sets conditions for realizing the global and partial targets in ensuring the lifelong quality of people’s health and their environment.

Specific solutions are part of this strategy and are worked out in adequate programmes, projects or activities in professional and other institutions.

Tobacco legislation

In 1996, parliament adopted the Law on Restricted Use of Tobacco Products (ZOUTI, Official Gazette of the Republic of Slovenia, No. 57/1996, 1996-01-3318**).** The protection of nonsmokers, children, young people and the smoke-free environment is the main target of this law.

The law provides nonsmokers with the right to live in a smoke-free environment in public places, institutions and public transport, kindergartens, schools, health care institutions, restaurants, shops and workplaces regarding involuntary exposure to tobacco smoke and abuse by its substances.

This law clearly lays down general provisions, a total ban on tobacco products, direct and indirect advertising, promotion and sponsorship, labelling, age limits for buying tobacco products, tar and nicotine contents, tobacco control and penalties.

The main problem now is how to carry out the tobacco law in practice. This is the responsibility of the health (sanitary) inspector in each community.

Activities and projects

In the education, health and NGO sectors, educational curricula include programmes and projects actively involving care for health and the environment, according to Agenda 21. Under the national health care policy, smoking prevention has been given priority since 1992. For this purpose the Health Minister has sent a special circular to each health institution inviting professionals, lay people, patients and institutions as a whole to participate actively in nonsmoking activities. The main task groups are professionals and staff in health, education and the public sectors, and the whole population. The efforts of people participating in these activities have been directed towards and concentrated under the appropriate tobacco prevention law.

Practical approach

Systematic work has been started by lobbying the key people and target groups, such as professionals, doctors, mayors, politicians and parliamentarians. The great help and support of NGOs has contributed to achieving legislation.

The active participation of the mass media in showing the need to protect the young and people of all ages from tobacco smoke have led to a more transparent and positive policy. Policies are made more reasonable to the general public, for example the policy for healthy people in a healthy environment.

To change the quality of life and the environment, the interest of people and partners in this process should be stimulated and they should be provided with basic and post-basic continuing education and adequate information. The quality of the smoke-free environment is a matter for civil society, professionals and policies.

Summary of national policy regarding ETS in Spain

Dr Javier Toledo Pallares, Tobacco Control Programme, Servicio Aragones de Salud, Zaragoza, Spain

Introduction

In Spain the use of tobacco in public places is a matter subject to regulation as a public health measure. In this sense not only the central government but also the governments of the 17 autonomous communities and the 2 autonomous cities can legislate on this issue and each has done it differently.

At the national level, the main regulations are Royal Decrees No. 192 of 1988, No. 510 of 1992, No. 1185 of 1994 and No. 1293 of 1999.

The constitution (1978) lays down “the right of citizens to health protection”, and the General Law of Health (1986) declares tobacco to be a “noxious substance for people’s health”. The decrees introduce the general principle that, in case of conflict, nonsmokers’ right to health must take precedence over smokers’ rights. The regional governments can go further than the national regulations. It is the responsibility of the departments of health of the autonomous communities to sanction the non-fulfilment of the law.

Policies regarding specific public places

The workplace

The main sources of regulation and recommendations are:

- Royal Decree 192/1988
- Law on Prevention of Risk at Work (Ley 31/1995 de prevención de riesgos laborales)
- Royal Decree 486/1997
- Royal Decree 665/1997
- COM (1999)-407 FINAL.

Most smoking restrictions in workplaces are related to avoiding risks of fire or explosion or extra risks for workers or where food is handled. There is a total smoking ban in the workplace where there is increased risk to health due to handling of harmful substances, and in areas where pregnant women are working.

With regard to enclosed working places, Spain would be content to implement a European Community measure classifying environmental tobacco smoke as a workplace carcinogen, as stated in the *Commission report to the European Parliament, the Council, the Economic and Social Committee, and the Committee for the Regions on the progress achieved in relation to public health protection from the harmful effects of tobacco consumption*" (COM (99) 407 FINAL, Brussels, 08-09–1999).

The Law on Prevention of Risk at Work promotes the development of health protection policies for workers and forces companies to establish effective measures. The legislative consequence of this law has been several other decrees that deal with working hazards derived from ETS:

- Royal Decree 486/97, establishing minimum health and safety requirements for the workplace states:

  in Annex III.1: "Exposition to the environmental conditions in the workplace must not imply a risk for the security or health of workers";

  in Annex III.3.d: "Renewal of clean air in enclosed workplaces contaminated by tobacco smoke should be at least of 50 m^2 per person and per hour";

  in Annex V: "measures must be adopted for restrooms to ensure the protection of nonsmokers from the nuisances arising from tobacco smoke". This Decree applies to all workplaces excluding means of transport used outside the workplace, workplaces located within means of transport, construction sites, the extraction industries, fishing vessels, and land forming part of an agricultural or forestry undertaking.

- Annex 1:13 of Royal Decree 1216/97, establishing minimum health and safety requirements for work on board fishing vessels, states that "wherever possible, measures should be adopted in the crew's quarters to protect nonsmokers from the nuisances arising from tobacco smoke". Similar provisions are set out in Royal Decrees 150/96 and 1627/97 laying down minimum health and safety requirements for the extraction and construction industries.

- Royal Decree 665/1997, on the protection of workers against risks related to the exposure to carcinogens during work time, recognizes in some way that tobacco is a carcinogen since Article 11.1.a states that "employers should facilitate [the provision] to their employees [of] information and training on the potential risks for health, including those additional risks derived from tobacco use".

Public offices

Smoking is only banned in those areas where the public is attended to. There is no regulation applying to the rest of the areas.

Educational centres

In general, smoking is forbidden in all educational centres. The directors of these centres may allow smoking in some areas but never in those areas which teachers and pupils must share.

Health care centres, hospitals and social care centres

In health care centres, the managers can provide areas for smoking but those areas intended for personnel of the centre must be differentiated from those for clients.

Smoking is not allowed in social care centres designed for people aged under 16 years.

Public transport: buildings and means

This is a summary of restrictions that apply nationally. With regard to international transport, international rules and recommendations apply.

- Buses: smoking is banned in all vehicles or means of transport both on urban and interurban routes (including funiculars and cable cars).
- Taxis are regulated by municipal authorities. When there is no regulation, the general rule is that the right of the nonsmoker will prevail over the smokers.
- Trains and boats: smoking is allowed on open decks and in separated multiple occupancy carriages, lounges or cabins up to 36% of the total seats (estimated smoking prevalence in Spain).
- Aeroplanes: Royal Decree No. 510 of 14 May 1992, among other issues, banned smoking banned in “commercial aircraft on domestic flights of less than 90 minutes”. More recently Royal Decree 1293 of 1999 extended this ban to “all commercial flights in which both origin and destination are within Spanish territory”.
- Other: smoking is not allowed in vehicles used for transporting sick people, schoolchildren and where children aged under 16 years are allowed to travel.

Cultural settings

Smoking is not allowed in reading rooms or exhibition halls.

Shops

Smoking is not allowed in commercial sites where a certain number of people can concentrate. This measure mainly applies to department stores.

Entertainment

It is forbidden to smoke in theatres, cinemas and indoor sports centres. Only two autonomous communities have legislated that restaurants should have smoking and nonsmoking areas but without defining how these areas should be designated, making it practically impossible to

implement this measure. In some places, agreements between the regional government and the restaurateurs associations have been achieved.

Some autonomous communities have become closely involved in measures taken in this area by introducing their own legislation extending or complementing national legislation. For example, in Madrid there has been a voluntary agreement with restaurateurs to create separated areas for smokers, while in two other autonomous communities this has been regulated by Decree.

Other

Smoking is banned in lifts. Smoking is also banned in those places used for food processing, handling and sale except in those mainly dedicated to the consumption of food.

Responsibility for the observance of regulations

The managers of the centres are responsible for implementing those restrictions that apply to the building. They are also obliged to put up clear signs where smoking is not allowed.

Areas reserved for smokers

In general, in most places where smoking is banned, the managers should clearly signpost areas reserved for smokers. When this is not possible, the general rule is to ban smoking throughout the building.

References

Real Decreto 192/1988, de 4 de marzo, sobre limitaciones en la venta y uso del tabaco para protección de la salud de la población (Boletín Oficial del Estado 9 de marzo de 1988)

Orden de 8 de junio de 1988, por la que se desarrolla parcialmente el Real Decreto 192/1988, de 4 de marzo, sobre limitaciones en la venta y uso del tabaco para protección de la salud de la población. (Boletín Oficial del Estado 11 de junio de 1988).

Real Decreto 510/1992, de 14 de mayo, por el que se regula el etiquetado de los productos del tabaco y se establecen determinadas limitaciones en aeronaves comerciales (Boletín Oficial del Estado 3 junio 1992).

Real Decreto 1185/1994, de 3 de junio, sobre etiquetado de productos del tabaco distintos de los cigarrillos y por el que se prohibe determinados tabacos de uso oral y se actualiza el régimen sancionador en materia de tabaco. (Boletín Oficial del Estado 14 julio 1994).

Real Decreto 1293/1999, de 23 de julio, por el que se modifica el Real Decreto 192/1988, de 4 de marzo, sobre limitaciones en la venta y uso del tabaco para protección de la salud de la población. (Boletín Oficial del Estado de 7 de agosto de 1999).

Report from the Commission to the Council, the European Parliament, the Economic and Social Committee, and the Committee for the Regions on the response to the Resolution of the Council and the Ministers for Health of the Member States meeting within the Council on banning smoking in places open to the public. COMMA(96) 573 final Brussels, 14.11.1996.

Commission report to the European Parliament, the Council, the Economic and Social Committee, and the Committee for the Regions on the progress achieved in relation to public health protection from the harmful effects of tobacco consumption. (COM (99) 407 Final, Brussels, 08-09–1999).

Policies to reduce exposure to ETS in Sweden

Dr Bo Pettersson, Principal Administrative Officer, Division of Environmental Health, National Board of Health and Welfare, Stockholm, Sweden

Smoking is prohibited

1. in premises intended for child care, school activities or other activities for children and young people and in school playgrounds as well as in the equivalent areas at preschools and after-school recreation centres;
2. in premises intended for health and medical care;
3. in premises intended for joint use in residential accommodation and at establishments offering special services or care;
4. on means of transport in domestic public transport or in premises intended for use by those travelling by such means of transport;
5. in other premises than those referred to in 1–4 when a public meeting or event is arranged and in premises intended to be used by those taking part in such a meeting or event; and
6. in other premises than those referred to in 1–5 if the general public have access to the premises.

The prohibitions in 5 and 6 above do not apply to premises in restaurants and other refreshment facilities.

In hotels and other establishment where temporary accommodation is offered on a commercial basis, smoking is prohibited in a certain number of the rooms or the equivalent. As regards sleeping compartments and other space made available for temporary accommodation on means of transport in domestic public transport, prohibition 4 above applies instead.

Restaurants or other refreshment facilities which have more than 50 seats must, unless smoking is prohibited under prohibitions 1–4, have seating in one or more areas where smoking is prohibited.

The provisions in 3 above do not apply to housing and other premises for accommodation, which is not temporary.

Smoking is, notwithstanding the provisions of prohibitions 2–6, permitted in parts of the premises or other spaces referred to there, if these parts have been specially set aside for smoking. The same applies to premises referred to in prohibition 1, which are available only to members of staff. Deviations from prohibitions 2 and 4 may be made if there are special reasons for so doing due to the nature of the space available, its mode of usage or other circumstances. This also applies, mutatis mutandis, to such outdoor areas as are referred to in prohibition 1.

Any person in his or her capacity as owner or who otherwise disposes over premises, another space or an outdoor area mentioned above is responsible for the observance of the provisions.

If any person, despite being requested not to, smokes where smoking is not permitted, this person may be required to leave.

In cases other than those mentioned above, the employer is responsible for ensuring that the employee is not exposed against his or her will to tobacco smoke at the workplace or in similar premises where the employee is active.

The Labour Inspectorate exercises immediate supervision as regard premises and other spaces for employees.

Immediate supervision is exercised by the committee which carries out the responsibilities of the municipality in the field of environmental health care as regards the areas and premises mentioned in prohibitions 1–6.

In order to fulfil its responsibilities under this Act, a supervisory authority is entitled to gain access to areas, premises, and other spaces which are affected by the Act or by regulations made pursuant to the Act. The Enforcement Service is to render the requisite assistance for supervision.

A supervisory authority may, in its work of supervision, notify the orders or prohibitions required for observance of the Act or a regulation made pursuant to the Act. The supervisory authority may impose a conditional fine in a decision on an order or prohibition. This fine may not be commuted.

Protection against passive smoking in Switzerland

Christine Gafner, Project Manager, Passive Smoking OFSP, PROGEF, Berne, Switzerland

Background

The Passive Smoking Exposure in Adults and Chronic Respiratory Symptoms (SAPALDIA)[2] and Respiratory Health and Long Term Exposure to Air Pollution in Swiss School Children (SCARPOL)[3] studies conducted in the early 1990s provided evidence for the first time in Switzerland that passive smoking can damage health.

Statutory measures

Workplace

Since 1993, employers have been required to make sure that nonsmokers are not exposed to the harmful effects of other people smoking “within the limits of the possibilities of the business”. The interpretation of this article is stipulated in the guidelines, which state that smokers and nonsmokers must seek an agreed solution and that a ban on smoking must be the rule in the absence of a compromise.

[2] SAPALDIA Team. Passive smoking exposure in adults and chronic repsiratory symptoms. *American journal of respiratory and critical care medicine,* **150**: 122–128 (1994).
[3] Respiratory health and long-term exposure to air pollution in Swiss schools. *American journal of respiratory and critical care medicine,* **155**: 1042–1049 (1997).

Schools

The school system is organized at cantonal level. In many cantons, the rules for establishments are a matter for the local authorities or schools. Six of the 26 cantons impose a ban on smoking in schools, which is in practice confined to pupils.

Clinics and hospitals

No statutory measures apply. In practice more than 80% of hospitals do have rules, but these seldom involve a total ban on smoking.

Catering establishments

The law on trade in catering establishments is enacted at cantonal level. Six cantons have included an appropriate article in their law to the effect that "... no-smoking tables shall be offered as far as this is possible for the business concerned". The most progressive arrangement applies in Ticino canton: in places where food is consumed, at least one third of the floor space must be reserved for nonsmokers.

Public buildings open to customers

In the early 1980s, the post office already imposed a ban on smoking at its counters. Counter areas in railway stations, airports and banks are largely no-smoking zones with smoking islands.

Transport

Under pressure of Pro Aere, a nonsmokers' association, the public railways have constantly increased the number of no-smoking compartments in railway trains. No-smoking compartments currently represent around 60–70% of the total. For some years a total ban on smoking applied to local train traffic (urban railways), but this has been partially rescinded. Urban transport operations have imposed a ban on smoking for decades. The Swiss airlines have banned smoking on short-haul flights for many years and the ban now also applies to long-haul traffic with controlled experiments in the use of nicotine preparations.

Action by the Swiss Federal Office of Public Health to promote protection against passive smoking

Protection against passive smoking is one of the main topics of the first package of measures on tobacco adopted by the federal authorities for 1996–1999. Protection against passive smoking is one of the three main topics of the strategies of the Federal Office for Public Health (FOPH) for tobacco prevention in 2001–2005. In general, however, smoking is very well tolerated in Swiss society.

Workplace

The previously little known provision of labour law is the subject of wide communication at present to make sure that nonsmokers know their rights and are able to defend them if appropriate. Internal rules defined by employees themselves and enjoying general acceptance are sought for businesses.

Private businesses

In 1998, the FOPH conducted a qualitative survey of businesses with tobacco prevention experience. The intention was to determine the needs for subsequent solution-led intervention. An extensive campaign to achieve smoking bans in business premises has been put in hand. It is supported by FOPH, the State Secretariat for Economic Affairs, Directorate of Labour Working Conditions, Labour and Health, and the Association for Smoking Prevention, an NGO. Its purpose is to create an awareness of the rights of nonsmoking employees. A specially drafted manual gives instructions on the attainment of rules acceptable to all parties for a ban on smoking in business premises.

Public administrations and establishments

A survey of the heads of personnel in the cantonal administrations on the situation prevailing in 1999 showed that 2 out of 26 cantons have statutory rules. Four cantons regulate smoking problems through a decision of the cantonal or municipal council. Six have defined directives, while six have imposed restrictions on smoking throughout the administration. Public administrations and establishments receive aid and assistance with the creation of no-smoking premises in the same campaign as private businesses.

Federal administration

The directives on smoking are regularly verified for their topicality and adapted (1989, 1997). Adaptations take effect on the World Tobacco-Free Day and are accompanied by publicity measures. In 1997, stands were set up to provide information in 11 canteens in the federal administration and roses were handed out, together with a very short informative text. These activities were designed to motivate personnel to stop smoking.

Hospitals and clinics

A survey of existing rules on smoking is in progress in conjunction with a project on no-smoking rules in health centres. This shows that most hospitals and clinics have introduced rules on smoking, but that these are no longer satisfactory and should be adapted. Efforts are under way to design guidelines for no-smoking in health centres which also define the conditions for award of a quality mark. Close cooperation with the European network of healthy hospitals has been established.

Schools

In 1997, the Association for Smoking Prevention surveyed schools in six representative cantons to ascertain existing rules on smoking. Most of them do apply rules, but very few consider these to be up to date. A guideline on no-smoking in schools has been available since 1998 and the evaluation shows that very good use is being made of it.

Catering establishments

A survey by Gastrosuisse, the biggest association of catering establishments, showed that 86% of restaurants and cafés do not have no-smoking areas. In 1998, the FOPH commissioned a survey of the need for a national register of catering establishments with satisfactory no-smoking zones. This survey showed that the main demand was for regional registers of this kind, which already exist in four regions.

Working independently from the FOPH, Gastrosuisse launched a campaign under the slogan of "Tolerance and enjoyment of life" with the support of the tobacco industry. This was not particularly well followed and was therefore the subject of internal criticism.

Migrant population

In 1998/1999, the FOPH conducted a campaign directed at the migrant population for protection of unborn babies and infants. Information sheets for pregnant women and parents of infants and an illustrated brochure were distributed in Albanian, Italian, Serbo-Croat, Portuguese, Spanish and Turkish via mediators from the health care sector. The individual population groups received conceptual and financial support with the implementation of their own projects. These projects are currently in progress.

Pro Aere has prepared appropriate material for the domestic population.

Cooperation and networking

The FOPH leads campaigns for protection against passive smoking. At administrative level, it cooperates with the Swiss Environment and Health Action Plan and with other federal offices and departments.[4] The Federal Commission for Tobacco Control advises the Department of the Interior on matters of tobacco prevention. All the important NGOs are represented in this body.[5]

The Association for Smoking Prevention is the overarching professional organization of the NGOs in the area of tobacco prevention. Alongside national organizations, its members also include the regional tobacco prevention offices. Joint projects are the rule.

In future, the Swiss Federal Office of Public Health will place orders for performance and the Association for Smoking Prevention will be responsible for coordination, organization and control of individual projects. One of the aims for 2001–2005 is that nonsmokers must always have the opportunity to breathe smoke-free air.

Environmental tobacco smoke: the position in England

William P. Coyne, Senior Policy Manager, Department of Health, London, United Kingdom

Introduction

ETS is an important issue in England and there is widespread pressure for action. This pressure is based partly on health grounds, particularly in relation to the exposure of children and vulnerable groups such as asthma sufferers, but also on grounds of welfare and comfort. A large proportion of the population resent the smell of tobacco smoke on hair and clothing and demand the right to live and work in a smoke-free environment.

[4] Swiss Federal Office of Sports, Swiss Federal Statistical Office, Health Section, Swiss Council for Accident Prevention, Swiss Federal Office for Spatial Planning, Swiss Agency for the Environment, Forests and Landscape, Swiss Federal Office of Housing, State Secretariat for Economic Affairs, Directorate of Labour Working Conditions.

[5] Association for Smoking Prevention, Swiss Medical Association, Department of Social and Preventive Medicine, University of Berne, Swiss Lung Association, Swiss Society for a Smoke-free Air and against Tobacco Addiction (Pro Aere), Swiss Institute for the Prevention of Alcohol and drug Problems, Swiss Society for Public Health, Swiss Cancer League, Stiftung 19 – Swiss Foundation for Health Promotion.

Science

A number of scientific studies have examined the health effects of ETS. Current policy in England is based on the findings of the Scientific Committee on Tobacco and Health (SCOTH) whose report was published in March 1998.

Having carried out a full review of the available evidence, SCOTH concluded that long-term exposure of nonsmokers to ETS caused an increased risk of lung cancer which, in those living with smokers, is in the region of 20–30%.

The Committee also reported that:

- exposure to ETS is a cause of ischaemic heart disease and represents a substantial public health hazard;
- smoking in the presence of infants and children is a cause of serious respiratory illness and asthma attacks;
- sudden infant death syndrome (the main cause of post-neonatal death in the first year of life) is associated with exposure to ETS;
- middle ear disease in children is linked with parental smoking and this association is likely to be causal.

Public attitudes

A 1997 survey carried out on behalf of the Department of Health found that there was considerable support for restrictions on smoking in various areas: 84% at work, 85% in restaurants, 51% in pubs and 85% in other public places. There was little difference in the responses of men and women to this survey.

Although the survey showed a substantial majority in favour of restrictions, a much smaller number said that they would take the provision of a nonsmoking area into account when selecting a place to go for a meal or drink (42% for a meal, 19% for a drink).

Government action

In December 1998 a White Paper was published setting out the government's strategy on tobacco control. This deals with all aspect of the tobacco problem; ETS, as an important issue, receives due attention.

The purpose of the overall strategy is to reduce smoking prevalence. If successful, this will have an obvious effect on passive smoking. Similarly, restrictions on smoking in workplaces and public places will encourage smoking cessation. Active and passive smoking policies are therefore closely linked.

Smoking in the home is not a matter in which the government can exercise much if any control but the public education campaign which forms an important section of the new strategy will seek to persuade smokers, particularly parents, of the problems they can cause for those around them.

Public places

Smoking policies in public places are regarded as a matter for the managers of these places and we expect them to react to the pressure from customers and users. In general, public places such as banks, post offices and cinemas have an excellent record in the provision of smoke-free areas but the position in hospitality establishments such as pubs and restaurants is much less favourable.

The government has reached agreement with representatives of the licensed hospitality trade – pubs, restaurants and hotels – on the need for continuing improvement in the provision of nonsmoking facilities over the coming years. The industry has developed a Public Places Charter which will ensure that consumers are better able to choose whether to eat, drink or socialize in smoky atmospheres. A national industry-led scheme has been introduced to give badges to restaurants, pubs and bars with an agreed symbol denoting the type of smoking policy operating inside. New targets for increases in smoke-free provision in public places will be introduced.

Many local authorities and health promotion agencies have produced and published information on nonsmoking facilities in their area. This is not yet a universal practice but, as the Public Places Charter is more widely taken up, we expect the trend to continue and expand.

Virtually all public places are workplaces and it is the duty of employers to protect the health and welfare of nonsmoking staff. The Health and Safety Commission has consulted on a possible Approved Code of Practice on smoking in the workplace. The Code, if introduced, would clarify what employers need to do in this area to comply with existing health and safety legislation. The Commission will be considering the results of the consultation in the summer.

European Union perspectives on passive smoking issues

Presentation by Dr Erik Loosen, General Practitioner, Brussels, Belgium

“Mr Chairman, distinguished guests, Ladies and Gentlemen,

It is a real pleasure to present to you a bird’s eye view of the European Union policy on passive smoking. I will begin by saying a few words about the legal competence of the Community, and then go on to review some of the policy issues.

The European Union differs from national governments in that it can only act in those areas defined in the Treaty establishing it. This is the famous question of finding a solid legal basis before an act can be adopted by the European Parliament and Council, after a proposal is made by the European Commission, which holds the sole right to propose legislation.

We can see how important this legal basis question is in the current legal challenge before the European Court in Luxembourg to the European Union Advertising Ban Directive of 1998.

Therefore, before it acts in any particular matter, the European Union must first define its legal power or competence.

Public health matters are generally dealt with under Article 152 of the Treaty, which provides for policy incentive and support measures at Community level, but which excludes legal harmonization except in four defined areas, such as blood safety or veterinary measures for

human health protection. Other legal bases which could exist under the Treaty are as yet untried, but present possibilities. In particular, Articles 136–138 dealing with the protection of workers could be considered to have promise as regards our subject today, that of passive smoking. This could cover, for example, the protection of workers from the health effects of passive smoking, in the workplace.

Having looked at the legal background to the European Union's activities, I would now like to analyse some of the policy initiatives to date.

I suppose the principal incentive measure with an influence on the passive smoking issue is the "Europe against Cancer" programme. The heads of state and government set up this initiative as a direct result of intervention at their meeting in Milan in 1985. Three successive Europe against Cancer programmes followed, the latest of which is due to conclude in December of this year, but which it is planned to extend for a further two years. These cancer programmes have always stressed the importance of smoking prevention, since smoking is estimated to be at the root of about one third of all cancer deaths. Besides prevention activities directed at reducing active smoking particularly by young people, the cancer programme has also included a series of incentive measures intended to alert people to the dangers of passive smoking. It must be said, however, that over the years the support given by the cancer programme has concentrated almost exclusively on active smoking prevention, and passive smoking has taken the back seat, so to say.

In the latest 1996–2000 cancer programme, all funds are channelled through two networks, the European Network for Smoking Prevention in Brussels and the European Network on Young People and Tobacco in Helsinki. These two networks receive, organize and coordinate the management of smoking prevention projects for the cancer programme. A budget of on average € 2.5 million has been made available for this purpose. Within each network, four or five projects are selected annually.

As a general rule, applicants for financial support placed little stress on the passive smoking issue. An exception is the decision to organize shortly a European-level conference on passive smoking in the workplace. This event will be organized in the context of the European Network for Smoking Prevention and will help to provide input to the European Commission in drawing up its policy initiatives.

Another interesting project supported by the cancer programme was carried out by the French Comité national contre le tabagisme in 1996–1997. It consists of a detailed scientific review of the health effects of passive smoking, carried out with partners from several European countries. Unfortunately, this study has not received the attention from policy-makers that it certainly deserves.

In the Community public health context, another programme dealing with pollution-related diseases has already financed projects on indoor air pollution, including the principal source of such pollution, namely passive smoking. This Community programme is only a three-year one, from 1999–2001, and it has a small total budget of € 1.3 million annually. However, the interest shown in passive smoking provides a useful sign that the issue is no longer seen as a purely health issue but increasingly as an environment issue too. Under this programme, for example, a project headed by the Swedish National Institute of Public Health has already been approved, dealing with the issue indoor pollution, including passive smoking.

Both the cancer and pollution-related diseases programmes will be integrated into the new EU Public Health framework programme, recently proposed by the Commission. This is supposed to allow a more horizontal approach to health issues than is presently the case with the eight vertical or disease-related programmes.

Another third source of EU funding for tobacco-related projects is the so-called Community Fund for Research and Information on Tobacco, created by means of a levy on support given to tobacco growers under the Common Agricultural Policy. The Fund has a disposable income of about € 20 million annually, of which half is earmarked for information projects on the dangers of tobacco consumption for health. To date, no project has been submitted dealing with passive smoking, although it could be argued that such an information project would be eligible under the Fund. I understand that the Commission intends to publish the next call for tender under this Fund shortly.

Finally, the Fifth Framework Programme for Community Research should be mentioned. A part of this programme, dealing with human health research, could also help to support projects on passive smoking. Although the Fifth Framework Programme has very substantial resources of € 14.96 thousand million, no project has yet been submitted for consideration on the subject of passive smoking. The chapter on "Quality of life and management of living resources" has a budget envelope of € 2.4 thousand million; research resources exist in the Joint Research Centre in Ispra, Italy, which has had previous experience in smoking-related fields. There is therefore also considerable potential for action on environmental tobacco smoke through the Fifth Framework Programme on research.

My conclusion is that several European programmes provide for financial support for the matter of passive smoking both in terms of prevention, information and research. However, with a few notable exceptions, no major initiatives have been supported due to a lack of relevant applications. This may in fact reflect the real distribution of risk. The risks to health from active smoking far outweigh those associated with passive smoking. The numbers concerned are also not comparable. As a result, those active in the tobacco control field in Europe have clearly chosen to put resources in the area of greatest risk, preventing young people from taking up this deadly and addictive habit, and informing the public of the dangers to health of smoking.

Now, let me turn to the legislative approach of the European Union. As I pointed out in my introduction, the problem of the legal basis has in practice resulted in most of the initiatives being taken in the prevention field under Article 152 of the Treaty, such as the cancer or pollution-related diseases programmes I have earlier described, rather than as binding legislation such as Regulations or Directives.

However, if we look back to 1989, a Council of Ministers Resolution was adopted on passive smoking, which was of a more concrete legal nature than the prevention programmes. This Resolution has absolutely no binding nature but forms part of those instruments of Community law, which together with Recommendations, are called "soft law". The legal weight of this Resolution is therefore rather "light" or "low tar" compared to the "full flavour" of a Regulation or Directive, which have binding legal effects in the member states.

Nevertheless, the Resolution does provide a useful basis for the future, particularly perhaps as it was adopted unanimously. Its content concerns smoking in certain public places, and it recommends that Member States introduce measures to ban smoking in these areas in order to

prevent [adverse] health consequences. It specifically states that where the rights of smokers and nonsmokers are in conflict, the right to health of the nonsmokers has priority. This seems to be a significant statement for the future development of public health policy.

Since 1989, the European Commission has provided two reports on how the Resolution is being applied by the member states. In the latest report, issued in 1996, the Commission concluded that 14 of the 15 member states had put in place a legal mechanism for banning smoking in public places as [they had been] called upon to do by the 1989 Council Resolution. However, the Commission also remarked in that report that the issue of enforcement of these regulations was unclear. As everyone can confirm from daily experience, the implementation of smoking bans in public places varies considerably. This enforcement aspect will therefore need to be looked at much more closely.

In October 1996, the Commission's Advisory Committee for Cancer Prevention met in Helsinki (Finland) and adopted a series of recommendations on tobacco control. One of their recommendations dealt with passive smoking, as follows:

> To protect the rights of nonsmokers and prevent involuntary exposure to environmental tobacco smoke, the Cancer Experts Committee recommends that smoking be banned in public places and in the workplace. Separate smoking sections may be introduced in the workplace, and in places such as restaurants and bars. Smoking should be prohibited on air flights within the European Union.

On the basis of these recommendations, the Commission published in December 1996 its first ever policy Communication on smoking prevention in which it called for "the encouragement of measures to provide for greater protection for workers who are exposed to above-normal levels of environmental tobacco smoke." The Commission also called for national incentives to install improved ventilation facilities, especially in entertainment premises.

The Commission sent questionnaires to the member states in 1997 on protection from passive smoking in the workplace, possible classification of environmental tobacco smoke as a carcinogen and on any new legislation or voluntary agreements on smoking in public places. The results of this enquiry were then set out in a Commission report from September 1999. It may be noted that the picture is somewhat incomplete, since Belgium, Germany, Ireland, Italy and the Netherlands did not reply. The picture regarding the eleven candidate countries is also unclear, although reports from WHO may provide useful information.

The Commission will now need to look at these elements regarding member states' policies, complete the information from the member states and consider its next move. Clearly, the priority has been placed on processing the new proposal for a tobacco directive, currently working its way through the European Parliament and Council. A first reading in these institutions is due in June of this year.

The outcome of the European Court case challenging the EU tobacco advertising directive is expected in October this year, with a report by the Advocate-General on 16 June. The decision in this case will also play a role in deciding the speed and content of further proposals in the area of tobacco control at European level.

Another factor to be considered by the Commission will be the opening of negotiations for a WHO Framework Convention on Tobacco Control, due to begin formally later this year in Geneva. One of the protocols planned for the Convention concerns passive smoking. The process of negotiation of this protocol, if it progresses as planned, will oblige EU member states to

coordinate their positions on passive smoking much more closely than ever before. In this sense, the process of developing and negotiating the WHO Framework Convention on Tobacco Control may push forward the passive smoking issue in Europe to an unprecedented degree.

In conclusion, although some action has been taken on passive smoking at EU level, it would be fair to say that much more attention has been placed on the prevention of active smoking and on the regulation of tobacco products. Several possible funding sources have not been exploited for passive smoking aspects. Finally, although Treaty possibilities exist, the EU has not yet moved to propose legislation on protecting workers from the health effects of environmental tobacco smoke in their place of work. The development of a WHO Framework Convention and a possible protocol on passive smoking is a welcome initiative as it will certainly lead to an in-depth policy discussion at EU level. In this context, the decisions of the 15 EU member states will also influence the much wider populations of the 11 candidate countries.

Thank you again for your attention.”