POLICIES TO REDUCE THE EXPOSURE OF CHILDREN TO SECOND-HAND TOBACCO SMOKE

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Composite index of capacity to implement policies to reduce exposure to second-hand tobacco smoke (SHS) and promote smoke-free areas for children

This summary is based on data on the capacity to implement policies to reduce the exposure of children to SHS (also known as exposure to second-hand tobacco smoke or passive smoking) and promote smoke-free areas for children. It contains an assessment of the situation in the WHO European Region.

KEY MESSAGE

😐 Most countries in the European Region implement policies to restrict smoking in public areas and on public transport, the direct advertisement of tobacco products and the sale of tobacco products to minors, the aim being to reduce exposure of children to tobacco smoke in public areas and discourage active smoking. However, some countries still have no legal restrictions on smoking, even in health care or educational facilities. The exposure of children to tobacco smoke, both before and after birth, has been linked to various effects on health, including sudden infant death syndrome (SIDS), respiratory problems, cancer and impaired mental and social development.

RATIONALE

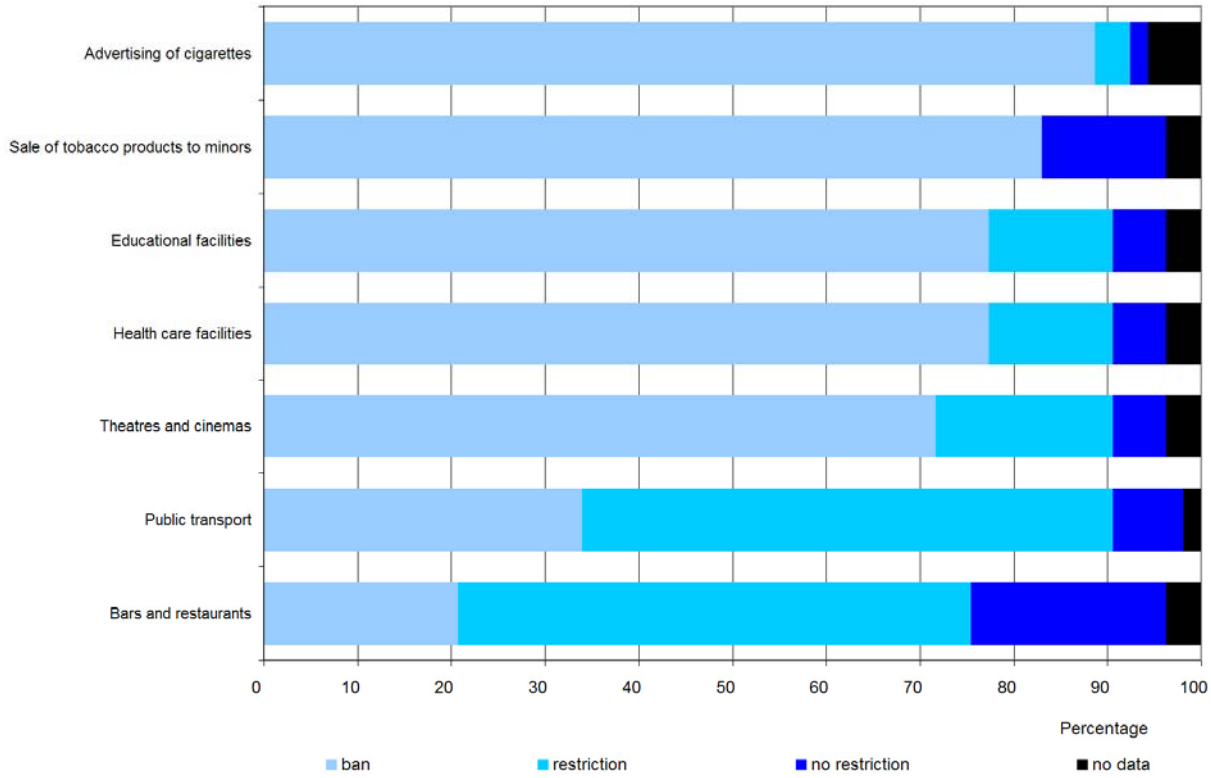
This indicator illustrates the existence and stage of implementation and enforcement of national legal instruments to ensure smoke-free areas, smoke-free public transport, restricted advertising of tobacco products and bans on the sale of tobacco to minors.

PRESENTATION OF DATA

Fig. 1 indicates the percentage of the 53 countries in the Region that either do or do not have a relevant policy contributing to the summary indicator (i.e. bans or restrictions on smoking, advertising of tobacco products and sale of tobacco to minors).

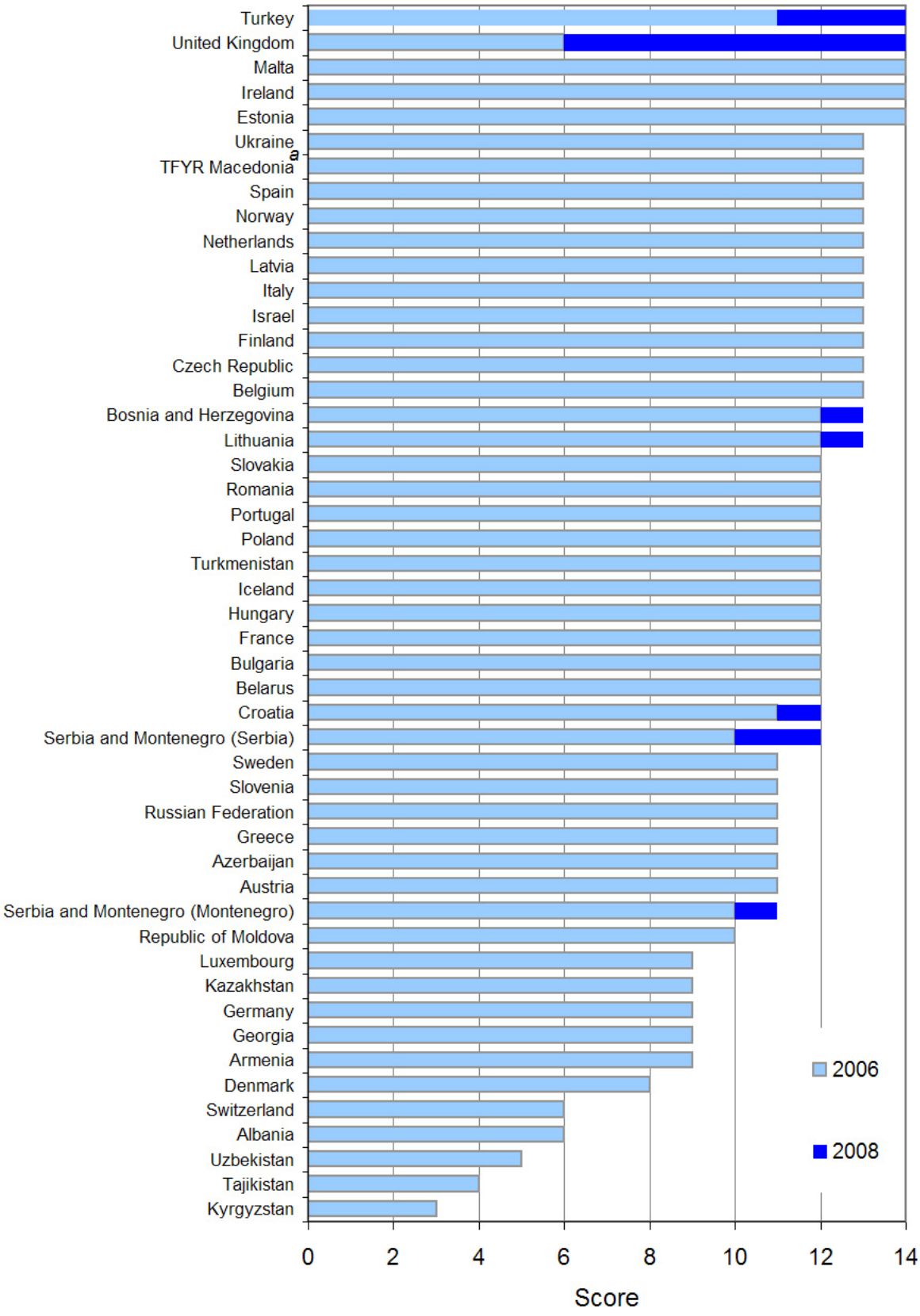
Fig. 2 represents the score of the indicator by country. A higher score reflects a more extensive scope and comprehensive policy. The composite index was calculated on the basis of data retrieved from the WHO tobacco control database as of November 2008 (1).

Fig. 1. Proportion of countries in the WHO European Region implementing policies to reduce exposure of children to SHS



Source: WHO tobacco control database *(1)*, November 2008.

Fig. 2. Degree of implementation of policies to reduce exposure of children to SHS in the WHO European Region



[a] TFYR Macedonia = The former Yugoslav Republic of Macedonia.

Notes. No data available for Andorra, Cyprus, Monaco and San Marino. Turkey has a legal ban on smoking in bars and restaurants effective from July 2009.

Source: WHO tobacco control database *(1)*, November 2008.

HEALTH AND ENVIRONMENT CONTEXT

Exposure to SHS is defined as the involuntary or passive breathing of air contaminated with tobacco smoke by someone who is not smoking. It is well established that such exposure increases the risk of lung cancer. Epidemiological evidence and mechanistic studies show that SHS increases the risk of morbidity and mortality from cardiovascular disease in non-smokers (2).

Smoking by mothers, exposure to SHS during pregnancy and exposure of children to SHS all cause an increased risk of SIDS, low birth weight, reduced lung function, asthma, lower respiratory tract infections and middle ear infection in children. Prenatal and postnatal exposure may also be associated with reductions in mental and social development. Several studies suggest that exposure to SHS may be causally associated with childhood cancer (3). A review of exposure to SHS in European countries can be found in ENHIS fact sheet No. 3.4 (4).

The European Respiratory Society estimates that SHS causes more than 80 000 death each year in the 25 countries of the European Union (EU) plus Switzerland (5). These estimates include deaths from heart disease, stroke, lung cancer and some respiratory diseases. However, they omit deaths in adults due to other conditions related to exposure to SHS (such as pneumonia) and do not reveal the burden of the serious acute and chronic morbidities caused by passive smoking.

Evidence shows that smoke-free policies in public places can positively influence both smoking cessation and household smoking restrictions, effectively reducing children's exposure to SHS (6). A study of schoolchildren in Scotland found a 39% reduction in salivary cotinine concentration in non-smoking children between January 2006, before the implementation of smoke-free legislation in March 2006, and January 2007 (7).

There are important health benefits to be gained from reducing exposure to SHS. Most studies have shown rapid improvements in respiratory symptoms (e.g. wheeze and cough) and sensory symptoms (e.g. upper airway and eye irritation) and have benefited workers in the hospitality industry (8). A recent study analysing acute coronary events in Italy before and after the implementation of the smoking ban in January 2005 found a statistically significant reduction in acute coronary events in 35–64-year-olds (11.2%, 95% CI 6.9–15.3) and in 65–74-year-olds (7.9%, 95% CI 3.4–12.2) (9).

POLICY RELEVANCE AND CONTEXT

The WHO Framework Convention on Tobacco Control (FCTC), the first legal instrument designed to reduce tobacco-related deaths and diseases around the world, came into force in February 2005 (10). The FCTC has been ratified by most of the reporting countries, and those that have not yet ratified it are taking the final steps towards doing so. The FCTC requires countries to: enforce restrictions on tobacco advertising, sponsorship and promotion; set parameters for new packaging and labelling of tobacco products that provide reliable information about the health effects, hazards and emission of tobacco smoke; establish clean indoor air controls; and strengthen legislation to eliminate all forms of illegal trade in cigarettes and other tobacco products. Policy recommendations on protection from exposure to SHS have been developed by WHO (11) to assist the FCTC implementation process and provide guidance to the growing number of jurisdictions in becoming smoke-free.

The European Strategy for Tobacco Control (12) reflects increased political commitment to, and public health expectations from, tobacco control in the European Region. It was adopted by the WHO Regional Committee for Europe in September 2002 and provides an evidence-based framework and guidance for effective national action and international cooperation. The strategy specifies guidelines for action in the Region to be carried out through national policies, legislation and action plans. It also makes recommendations on monitoring, evaluating and reporting on tobacco use and tobacco control policies. Finally, it specifies mechanisms, tools and a time frame for international cooperation.

In 2004, the Fourth Ministerial Conference on Environment and Health adopted the Children's Environment and Health Action Plan for Europe (CEHAPE), which includes four regional priority goals to reduce the burden of environment-related diseases in children (13). One of the goals (RPG III) aims at preventing and reducing respiratory diseases due to outdoor and indoor air pollution, thereby contributing to a reduction in the frequency of asthma attacks and ensuring that children can live in an environment with clean air. SHS is the dominant form of indoor air pollution where tobacco is smoked, even in areas that are properly ventilated.

The EU plays an active role in global tobacco control policies, and it ratified the FCTC in July 2006. The Community's tobacco control activities include legislative measures such as Council Recommendation 2003/54/EC on the prevention of smoking and initiatives to improve tobacco control (14), Tobacco Products Directive 2001/37/EC "on the approximation of the laws, regulations and administrative pro-

visions of the Member States concerning the manufacture, presentation and sale of tobacco products" (15), Tobacco Advertising Directive 2003/33/EC on "the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products" (16), tobacco control projects under the Public Health Programme and information campaigns such as "Feel free to say no" (2002–2004) and "HELP – For a life without tobacco" (17). The comprehensive antismoking strategy supports Europe-wide smoking prevention and cessation activities, including health education measures, improved consumer information and assistance, and restrictions on the advertising and marketing of tobacco. The EU is also integrating tobacco control into a range of other Community policies in areas such as taxation and agriculture. In January 2007, the Commission presented the Green Paper Towards a Europe free from tobacco smoke: policy options at EU level and opened a new strategy aiming "to launch a broad consultation process and an open public debate, on the best way forward to tackle passive smoking in the EU" (18).

EU Member States have been implementing stronger smoking control measures since European Council Recommendation 2003/54/EC was issued (14) and most of them have enforced laws in response to EU Directives 2003/33/EC (15) and 2001/37/EC (16).

It should be stressed that policy implementation enables indirect measurement of the exposure of children to SHS. A study conducted in Ireland, on the effect of the ban on smoking in public spaces on smoking behaviour at home, shows that policies directed at reducing exposure to SHS in public places potentially influence self-regulatory practice within the private sphere (19).

Health promotion initiatives employing the media and educational campaigns to convey the message about the harm caused by SHS are an essential tool in reducing children's exposure to SHS. A study measuring the association between perception of the harmful effects of tobacco smoke and smoking in the home and in vehicles found those with a strong perception of harm to be twice as likely to ban smoking in vehicles and the home (20).

ASSESSMENT

The most common instruments used to reduce exposure to SHS are laws dealing with aspects of smoking. Legislation to prevent the exposure of non-smokers, and children in particular, to SHS in public places are in place in most countries in the Region. In all countries, policies are based on the principle that non-smokers should be protected from SHS in all public indoor environments. Policies tend not to focus exclusively on children, although they are generally considered a priority group. Many countries focus on child-specific environments such as nurseries, kindergartens, schools and play areas.

Most countries have introduced a wide range of comprehensive policies to reduce and eliminate tobacco smoke and, since 2006, some of them have reinforced and strengthened their regulations. Nevertheless, there is significant room for improvement in implementing 100% smoke-free environments as the only effective way to protect people from harmful exposure to SHS in the Region.

Nearly 80% of the European Member States have banned smoking in educational and health care facilities. Most national legislation prohibits smoking in theatres and cinemas. Smoking in restaurants and bars continues to be regulated less strictly: 20% of countries have now imposed a ban compared to 15% in 2006, 55% have some restrictions, and a quarter have no restrictions (21%) or no data available (4%). Stronger policies should be implemented to protect the health of staff and customers in bars and restaurants, where the customers often include children and adolescents. The vast majority of countries have either bans or restrictions on smoking in public transport. The advertising of cigarettes and the sale of tobacco products to minors have been banned in more than 80% of the countries in the Region.

This demonstrates strengthening regional cooperation and political commitment to achieving the goals established by the FCTC, although for many countries there remains room for improvement.

It is important to recognize that private spaces such as residences and vehicles remain unregulated, yet they constitute major if not the predominant areas where children are exposed to SHS. Smoke-free policies in the home are much more effective (21) and smoke-free homes are known to be associated with reduced tobacco use and successful cessation (22). A better understanding is needed of the influence of smoking bans on smoking practices in private spaces and, moreover, of the psychosocial factors that determine behavioural change.

Studies have highlighted the existence of a gradient of socioeconomic status in the use of smoking bans in the home (23) as well as smoking cessation following the implementation of bans in public

places (20). A cohort study in Finland assessed the impact of the 1976 Tobacco Control Act on the prevalence of daily smoking across socioeconomic groups (20). A widening gap in daily smoking males existed between socioeconomic groups by birth cohorts: of those born in 1926–1930, 75% of "blue collar" workers had been daily smokers compared to 60% of "upper white collar" workers; in the 1971–1975 birth cohort, the respective figures were 62% and 25% (20). The impact of such a variable must be taken into account in order to redress the socioeconomic disparities in death and morbidity rates that result (24). Further, there is considerable evidence of disparities in the effectiveness of media campaigns to influence public perceptions, with campaigns being "often less effective among socioeconomically disadvantaged populations" (25).

DATA UNDERLYING THE INDICATOR

Data source
WHO tobacco control database (1).

Description of data
The tobacco control database (1) covers 41 indicators on tobacco use and control policies in 48 Member States in the Region. The data are drawn mainly from the regional survey of country-specific data (provided by the WHO national counterparts for the Action Plan for a Tobacco-free Europe), first undertaken in 2001, and other internationally recognized sources. The database covers five main areas: smoking prevalence, legislation, economics, cessation and general policy. It is constantly updated. An important advance on the 2001 exercise is that information from countries about their national legislation on tobacco control has been directly checked and cross-checked with information received from other sources.

Country data on three additional sub-indicators were collected for the purpose of this fact sheet: smoke-free public areas, smoke-free public transport and direct advertising of tobacco products. The data were collected in a meta-data sheet and assessed according to the scoring system.

Method of calculating the indicator
For each component, the following scoring is accepted:

0 = no restriction or prohibition
1 = partial restriction, prohibition or voluntary agreement
2 = complete ban or prohibition.

The index is computed as a sum of the score of seven components, SUM (Ci), where Ci is the score for component i. Maximum value of the indicator (a score of 14) means that all aspects are fully regulated, providing maximum legal protection for children against exposure to SHS in public spaces.

The full list of components (Ci) is as follows:

1. smoking prohibited in health care facilities;
2. smoking prohibited in educational facilities;
3. smoking prohibited in bars and restaurants;
4. smoking prohibited in theatres and cinemas;
5. smoking prohibited in public transport vehicles (combined component of seven means of transport: buses, taxis, trains, domestic and international air transport, and domestic and international water transport);
6. advertising of tobacco products prohibited in the national mass media; and
7. sale of tobacco to minors prohibited (sale of tobacco to persons aged under 16 years not allowed, with or without the imposition of penalties such as fines for such sales).

Geographical coverage
All 53 countries in the WHO European Region.

Period of coverage
The analysis is based on the latest available information. The database was accessed in November 2008.

Frequency of update
The database is reviewed and updated regularly in close collaboration with the national counterparts for the European Strategy for Tobacco Control.

Data quality

The tobacco control database does not cover regulations about smoke-free areas of particular relevance for children, such as sports arenas, gymnasiums and other exercise facilities.

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