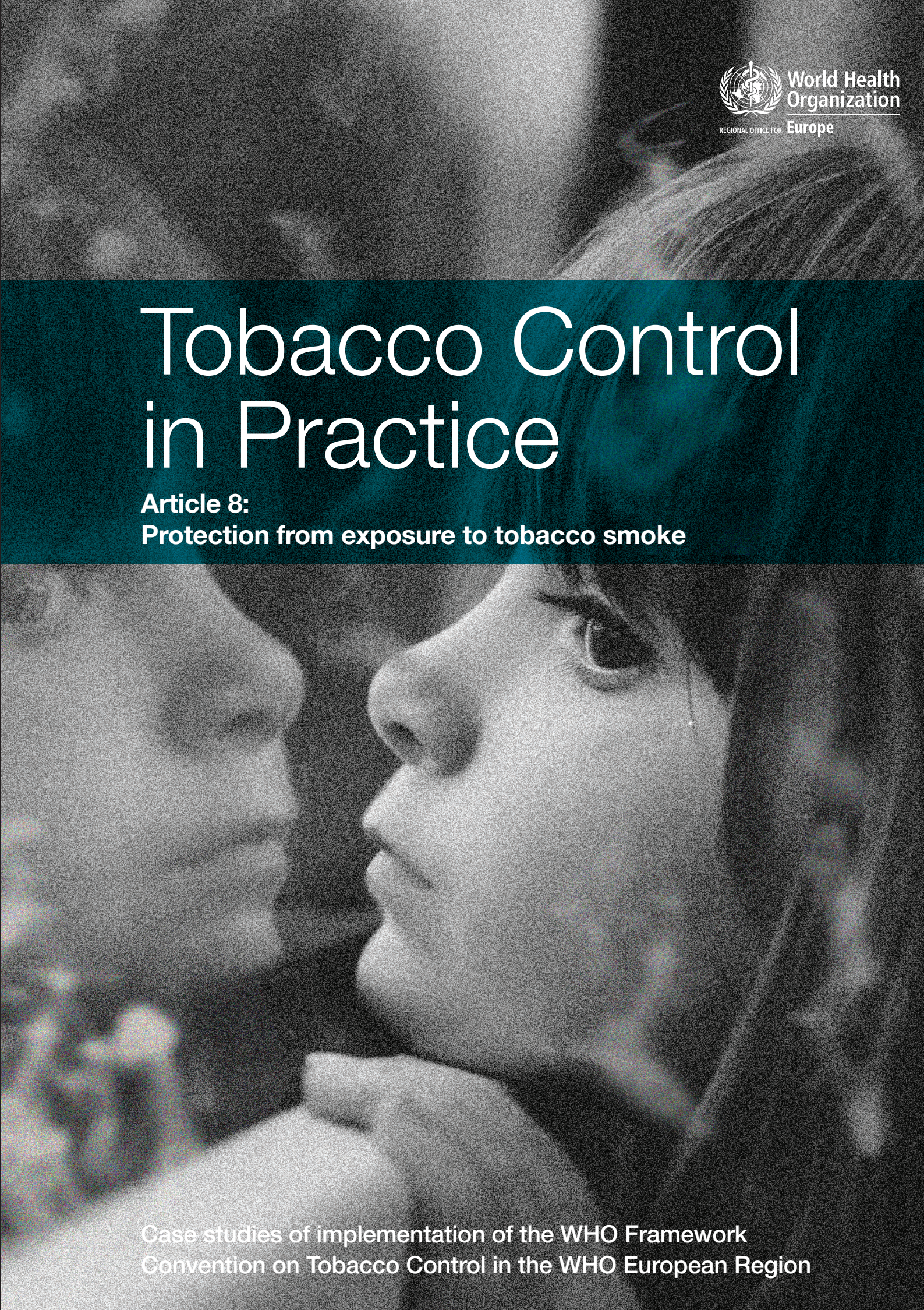

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Tobacco Control in Practice

Article 8: Protection from exposure to tobacco smoke

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Article 8: Protection from exposure to tobacco smoke

By Andrew Hayes

The WHO Framework Convention on Tobacco Control (WHO FCTC) is rooted in a concern for human rights and social equity: in particular the right to life – a right that everyone shares equally.

Article 8 acknowledges the health harm caused by exposure to tobacco smoke, recognizes that smoke-free environments protect the health of smokers and nonsmokers alike and requires the Parties to the WHO FCTC to protect their citizens from the health risks of tobacco smoke.

Three basic principles are involved.

- Everyone should be protected: there can be no justification for protecting some people but not others, such as by allowing smoking areas in restaurants.
- Partial measures – such as ventilation schemes – are ineffective.
- Legal protection is essential: voluntary measures do not work.

Legislation has to be comprehensive, well publicized, easily understood, properly monitored and – if necessary – enforced. In reality, though, smoke-free laws become self-policing. When introduced, they always command majority public support – among smokers and nonsmokers alike.

Article 8 guidelines? Yes

Timetable for implementation? As soon as possible: the Article 8 guidelines recommend within five years.

Implementation progress within the WHO European Region
Most countries have introduced some restrictions on smoking in public places, but relatively few (only eight) have achieved comprehensive, national smoke-free legislation. There are significant differences in enforcement and compliance – which may result from uncertainty concerning "who does what" in the event of violations. More than 385 million people in the Region remain unprotected from exposure to tobacco smoke.

Turkey

Population	75.5 million
Date WHO FCTC ratified	31 December 2004
Grand National Assembly adoption	25 November 2004, Law No. 5261
Official Gazette	30 November 2004, No. 25656
Prevalence of smoking (adults, age-standardized, 2008 Global Adult Tobacco Survey)	Men 47.8% Women 15.2% Total 31.2%
Selling price (per pack, 20 cigarettes)	Most sold US$ 2.59 Cheapest US$ 2.49 Highest (pack of Marlboro, Parliament): US$ 5.00

The story of Turkey

As the momentum is growing in the WHO European Region and more and more countries are protecting their populations from the harm of tobacco smoke, it becomes paramount to document successes, as well as challenges, that will inform and assist the efforts of other countries. This is a story about Turkey, a tobacco-growing country, which beat the odds and became the third country in the Region to go 100% smoke-free in public places.

By Nazmi Bilir and Hilal Özcebe

Case study questions

What were the favourable conditions within Turkey that enabled success?

Why was a two-phase approach taken for implementation?

Who were the important actors that made this a success?

How can the example of Turkey be applied and transferred to other countries?

Country context

Tobacco use is one of the most important and preventable causes of death globally. Every year it kills more than 5 million people, which translates to more than 100 000 in Turkey.

Beating the odds

Turkey is a tobacco-producing country, providing 1.7% of the world's tobacco production, a decrease from 4% before the 1990s. Until the 1980s, the state controlled tobacco farming, production of tobacco and its resulting products, and pricing and selling of tobacco product. The state-owned tobacco monopoly (TEKEL) has a long history dating to the Ottoman era, and since then multinational tobacco companies entered into Turkey with the privatization of the market during the 1980s.

After the entrance of multinational tobacco companies opened the door to rigorous tobacco advertising and tobacco consumption therefore increased rapidly *(1)*. One of the initial studies in 1988 indicated that 44% of adults smoke: 62% of men and 25% of women *(2)*. Since there were no restrictions on tobacco use, people could smoke everywhere in all public places, and exposure to second-hand tobacco smoke was very high.

In a 1995 study, smokers surveyed indicated that 90% smoke at home and 50–85% smoke in the presence of their children *(3)*. In the Global Youth Tobacco Survey in 2003, a similar number of 13- to 15-year-olds were exposed to second-hand smoke at home (82%) as in public places (86%) *(4)*. The Global Adult Tobacco Survey in 2008 revealed that 16 million adults currently smoke in Turkey and 22 million people (30% of the population) are exposed to second-hand smoke at home: 20 million of these are non-smokers *(5)*.

From challenge to success

The first attempt at a smoke-free law was unsuccessful in 1991, since the President vetoed it. However, tobacco control and protecting people from second-hand smoke exposure have been on the political agenda in Turkey since 1996, when the first tobacco control law (No. 4207) came into force. The law banned smoking in most indoor places, including health, education and sports facilities and in public transport (excluding commercial taxis). The law also banned "all kinds of" advertisement and promotion of tobacco products and prohibited selling tobacco products to children younger than 18 years of age. This law also mandated health warnings on cigarette packages and required television channels to devote at least 90 minutes of air time each month to report on the hazards of tobacco use.

After the WHO Framework Convention on Tobacco Control (WHO FCTC) was ratified in 2004, a specific department responsible for tobacco control activities was established in the Ministry of Health. In late 2004, the Ministry of Health initiated the preparation of the National Tobacco Control Programme, with the participation of more than 100 government institutions and nongovernmental organizations. At that time, amending the tobacco control law was on the parliamentary agenda and the nongovernmental organization community made great efforts to achieve a comprehensive tobacco control law in 2008, which required all indoor places to be smoke-free.

After the law was amended in 2008, Turkey has made substantial progress in the last three years in tobacco control and has become one of the tobacco control leaders in the WHO European Region as well as globally. With the comprehensive smoke-free policy, Turkey has become the third country in the Region to achieve such a high level of protection of its citizens

from tobacco smoke. The most remarkable progress has been made in five areas:

- monitoring tobacco use and prevention policies;
- comprehensive smoke-free public places, covering all closed areas;
- offering help to quit tobacco use;
- anti-tobacco mass-media campaigns; and
- increasing the taxes on tobacco products.

Timeline highlights

- 1991 First attempt to pass smoke-free law vetoed
- 1996 President approves the first tobacco control law
- 2004 The WHO FCTC ratified
- 2006 National Tobacco Control Programme and Action Plan developed
- 2008 Law on 100% smoke-free public places passed
- May 2008 First smoke-free phase
- July 2009 Second smoke-free phase

By another amendment of Law 4207 in 2012, Turkey prohibits sale of non-tobacco waterpipes and similar products to minors under 18 years old, bans totally tobacco advertising, promotion and sponsorship, including promotional discounts, brand-sharing and brand-stretching of tobacco products, and increases the combined pictorial and text warnings and messages on tobacco products at least 65% of two main display areas.

The excellence of the Turkey example lies in the whole-of-government approach to tobacco control, led by the Prime Minister. Driven largely by leadership from the Minister of Health and policy initiatives, a sophisticated system of intersectoral cooperation has been established in coordination with the Parliamentary Health Commission to fight the tobacco epidemic.

These achievements resulted in the Prime Minister, Mr Recep Tayyip Erdogan, receiving in 2010 the WHO Director-General's Special Recognition Award for Contribution to Global Tobacco Control and, in 2008, the Minister of Health, Professor Recep Akdag, receiving an award for his contributions to activities against tobacco. On 19 January 2012, the Minister of Health's Special Award 2012 was presented to the WHO Country Office in Turkey in recognition of its exemplary support to the tobacco control activities of the Ministry of Health.

Getting it on the agenda

Steps to 1996

After the President vetoed the first attempt at a smoke-free law in 1991, some interested physicians spearheaded a symposium on tobacco and health. During the first scientific meeting in 1992, representatives from political parties, the mass media and physicians discussed the hazards of tobacco use and the need to struggle through an organized system to advance tobacco control. Following several small group meetings, 11 organizations established the National Coalition on Tobacco and Health (SSUK: Sigara ve Saglık Ulusal Komitesi) in May 1995.

The major aim of the Coalition was to motivate the Parliament to place the vetoed law on the agenda and adopt it. To achieve this, several meetings took place with the Head of the Parliament, assistant director-generals of the political parties in the Parliament, individual members of the Parliament and the President.

Then the vetoed law was redrafted and submitted to the Parliament. Members of the National Coalition on Tobacco and Health participated in the discussions at the commissions in the Parliament, and on 7 November 1996 the law was adopted and published in the official gazette on 26 November 1996.

The 1996 restrictions on smoking in public places introduced the concept of smoke-free environments, which prepared the public, mass media and politicians to advance to 100% smoke-free legislation a little over a decade later.

Steps to 2006

The 1996 law introduced, for the first time, the concept of smoke-free environments in the public eye and in the Turkish mass media. At the same time, physicians researched the frequency of exposure to second-hand smoke in Turkey and revealed high levels, which resulted in serious health problems, particularly among children *(7–10)*. During the implementation of the 1996 law, the community understood and adopted smoke-free environments, one of the main effects of the law.

Highlights of the 1996 law

- The law banned smoking in:
- health facilities
- education facilities
- culture and sports facilities
- public transport (excluding commercial taxis)
- public offices with five or more people.

In 1997 and 1999, the Coalition organized a scientific congress on tobacco and health. With the participation of national and international experts, representatives from political parties, media and civil society discussed the international smoke-free developments that were evolving and the possibility of these developments being implemented in Turkey. The third congress was organized in 2006, and annual congresses were organized in 2010–2011 and 2012.

After the state monopoly on tobacco was privatized and its influence on tobacco control restricted, the Tobacco and Alcohol Market Regulatory Authority (TAPDK) was established in 2002 to regulate the tobacco market *(11)*. After Turkey ratified the WHO FCTC in 2004, a National Tobacco Control Programme and Action Plan was prepared by the Ministry of Health with the participation of more than 100 experts from government and nongovernmental organizations, which was published as a Prime Ministerial Circular in 2006.

Steps to 2008

Law No. 4207 of 1996 banned smoking in some public places, including health and educational facilities and on public transport but not in restaurants, bars and cafés and other kinds of hospitality venue. Smoking in these places is not only an important public health issue but also a workplace hazard for workers in the hospitality sector. After the Law had been implemented for about 10 years, amendments were needed to some of its provisions. A new proposal was prepared as part of the implementation of the WHO FCTC and submitted to parliament in 2006. Turkish nongovernmental organizations worked with the government, particularly with the Ministry of Health and global nongovernmental organizations, during the preparation of this implementation bill, facilitated mainly by WHO. Following long discussions in the relevant parliamentary commissions, it was accepted in January 2008 as Bill No. 5727 Amending the Law on Prevention of Hazards of Tobacco Control Products. It broadens the range of places where smoking is not allowed (including school premises, all hospitality workplaces and commercial taxis), bans the sale of tobacco products within schools and on their premises, bans all kinds of sponsorship in addition to the ban on advertising and promotion contained in the previous Law, clearly defines the rules in cases of violation and places the duty on the directors of the establishments to uphold the law. By this Law, Turkey became one of the first completely smoke-free countries in the world.

Implementation of Law No. 5727 was planned in two phases: the first phase, covering official premises, started 4 months later in May 2008, and the second phase, covering hospitality workplaces, started 18 months later in July 2009. The reason for the 18-month delay in implementing the second phase was to give the hospitality industry time to adapt to the new rules.

After the enactment of Law No. 5727, resistance and difficulty were anticipated from representatives of the areas of the hospitality industry, which would was to be included in July 2009. But instead of adapting their venues, the representatives of organizations and societies of coffee/- and tea-houses, restaurants and cafés tried to reverse the Law to permit the separation of smoking and non-smoking sections within the establishments.

Nongovernmental organizations organized a series of meetings with groups such as the Society of Coffeehouse Owners, the Society of Restaurant Owners and the Society of Tourist Hotels and Restaurant Owners to discuss the rationale for the smoke-free legislation and its scientific basis. Experts in tobacco control and ventilation systems engineers gave presentations to explain the working of separate smoking and non-smoking areas in their premises, and why the installation of ventilation systems was not enough to clean the indoor air completely.

The major concern of the hospitality industry representatives was the risk of economic loss due to a possible fall decline in the number of customers. Explanations were given about other countries' experiences, including the economic benefits to hospitality workplaces without economic loss. The Ministry of Health also organized meetings with representatives of the hospitality sector to explain the rationale of the smoke-free legislation and made clear that the Law would not be changed. The Prime Minister also gave a speech to the media in support of the Law.

Hospitality sector representatives were presented with evidence-based declarations by nongovernmental organizations, and the group reached a consensus before the second phase of the implementation of the

Law. However, although the representatives seemed to be convinced of the benefits of and need for completely smoke-free environments, after the meetings they continued to resist the implementation of the Law. Finally, they requested the Constitutional Court to cancel the articles regarding completely smoke-free workplaces. Following submission of a report detailing the scientific evidence by members of nongovernmental organizations and government officials, the Court rejected this request.

In addition to these meetings and discussions, several projects and small-scale surveys were carried out by the Ministry of Health and nongovernmental organizations to strengthen and consolidate implementation of the smoke-free provisions. A great effort was made to raise public awareness through such activities as public conferences, small group discussions, meetings with the press and news bulletins, talks on radio and television, articles for the media, etc.

A meeting with government, civil society and WHO was the most important milestone event on the way to achieving complete smoke-free environments.

Highlights of the 2008 law

Expansion of smoke-free places to:

- commercial taxis
- hospitality sector (restaurants and bars)

Clearly defined implementation of fines for violation and police can enforce it with penalties

Two-phase approach

- May 2008 – All public places excluding the hospitality sector
- July 2009 – Hospitality sector included

Why a two-phase approach?

Since the 1996 law already covered most indoor areas, the public accepted well the idea of smoke-free. Four months was therefore deemed to be enough time for the first phase, which implemented the law in most places. The hospitality sector was anticipated to be a challenging area. A large part of the culture involved smoking at coffee and tea houses, bars and restaurants. For this reason, a longer period (18 months) was planned for adoption.

In addition, implementation was planned during the summer, when most of the restaurants serve food and drink in outdoor areas such as gardens or terraces, where smoking is allowed. This gradual transition was key for the hospitality sector and the public to accept the law.

The battle was not over

The 2008 law required the hospitality sector to be smoke-free by July 2009, allowing 18 months to adapt these workplaces to the new reality. During this time, hospitality industry representatives posed major resistance, making many attempts to weaken the law to permit smoking and non-smoking sections.

The Ministry of Health, WHO and nongovernmental organizations organized a series of meetings with hospitality industry representatives. These meetings discussed the rationale for smoke-free regulation and its scientific basis. Experts on tobacco control and engineers specializing in ventilation systems made presentations to explain that ventilation systems are insufficient to clean indoor air completely and that separating indoor spaces do not provide 100% protection.

The major concern of the hospitality industry was economic loss because of fewer customers. Examples of experiences in other countries showing the economic benefits for hospitality workplaces were highlighted. Although the representatives of hospitality industries seemed to be convinced about the benefits of smoke-free environments, they continued to resist the implementation of the law.

Finally, the hospitality sector took the law to the Constitutional Court, requesting the cancellation of the provisions regarding 100% smoke-free workplaces. Civil society visited the Court and submitted a report on scientific evidence to its members. Concurrently, government and nongovernmental organizations worked at increasing public interest and awareness on the issue through public conferences, small group discussions, press meetings and bulletins

and working with the mass media via print, radio and television.

The Coalition was given a Smoke Free Partnership award to recognize all these activities.

Not surprisingly, another challenging group that presented obstacles was the tobacco industry. Their main aim was to block the discussions and delay the smoke-free legislation. After the Law was adopted, they tried to postpone the implementation date and took the law to Court several times.

The tobacco industry presented obstacles to delay the implementation of smoke-free legislation and to permit smoking indoors.

Favourable conditions

Political stability

Political stability in the country as a whole and commitment of the relevant ministers was instrumental to the success of the legislation process. Under the leadership of the Prime Minister, the Minister of Health and the Head of the Health Commission of the Parliament, great efforts were put forward in order to achieve the law *(12)*.

Civil society

Civil society, mainly the Coalition, participated in most of the discussions at various levels in Parliament, provided scientific evidence and lobbied extensively. Nongovernmental organizations worked very closely with the Ministry of Health and played a very supportive role, both before and after implementation. After the Law was enacted, nongovernmental organizations organized meetings with hospitality industry representatives and explained the benefits of smoke-free policies to increase compliance. Civil society monitored the mass media daily and reacted to negative coverage about smoke-free legislation.

Media

The mass media had been one of the most effective instruments to disseminate the knowledge to the public and build a supportive environment. The law requiring TV corporations to air at least 90 minutes of information on the harm of tobacco use and the benefits of quitting during prime time each month resulted in favourable public opinion. The Ministry of Health worked closely with the media and developed TV spots featuring the Prime Minister, Minister of Health, well-known artists and physicians showing support for the smoke-free law.

Evaluation

It is key that certain outcome measures not be monitored prematurely to avoid the risk of incorrectly portraying low levels of impact and endangering political support for the policy. During the early implementation period, the main variables monitored are:

- knowledge, attitudes and support for smoke-free policies among the general population and possibly specific groups (such as bar workers);
- enforcement of and compliance with smoke-free policies;
- reduction in employee's exposure to second-hand tobacco smoke in workplaces and public places;
- reduction in the content of second-hand tobacco smoke in the air in workplaces (particularly in restaurants) and public places; and
- reduction in the exposure to second-hand tobacco smoke in private homes.

Beyond the introduction of the smoke-free policy, the above-mentioned variables remain of interest, but additional health and economic effects become of particular importance:

- reducing mortality and morbidity from exposure to second-hand tobacco smoke;
- changing smoking prevalence and smoking-related behaviour;
- economic effects directly related to health;
- economic effects, such as changes in government revenue from tobacco taxes, tourism and businesses.

Public support

Many studies had been conducted to examine public reaction to the 2008 tobacco control law. An opinion poll was conducted 22 months after the second phase of the implementation of the law in 2009, demonstrating that 92% of those polled supported the law.

Public support is high among daily smokers at 77%. A study conducted at two time intervals (one month after the second phase of implementation and one

year after the first study) showed a positive trend towards greater acceptance of the law. In the first phase, 96% of non-smokers and 74% of smokers were positive towards the smoke-free environment. In the second phase, one year later, the percentage among smokers rose to 88%. Further, 79% said they either go out more often now to restaurants, bars and teahouses or have not changed their habits.

Enforcement and compliance
Strong public support leads to high compliance and cooperative enforcement of comprehensive smoke-free policies. In public opinion polls, 87% of those surveyed believe that the law is enforced and effective in indoor public places and workplaces and 86% in hospitality venues. A Ministry of Health report on the compliance assessment shows that within a little more than one year after the law entered into force, about 3% of the audits resulted in penalties.

The 2008 law established the Provincial Tobacco Control Board, which became responsible for implementing the law. It is chaired by the assistant governor of the province and consists of members from the police department, provincial health directorate, municipal officials, provincial department of national education and universities.

The police officer in the inspection team has the right to fine people who violate the smoking ban. However, since the members of the municipal council are elected, they often hesitated to fine establishments. Therefore, this item in the law has changed, and the authority for and duty of giving fines to establishments was assigned to the governors and district governors. After this change in the law, the inspections became more effective.

Protecting employees
Comprehensive smoke-free policies protect employees by reducing exposure to second-hand tobacco smoke in workplaces and public places. A study that investigated carbon monoxide levels among both smokers and non-smokers before and after the smoke-free policy was implemented showed a 36% reduction among smokers and a 50% reduction among non-smokers.

A group of studies showed that, even after the first phase of enforcement, the concentration of particulate matter in the public buildings declined by 97%. The Society of Public Health Specialists did several studies to assess indoor air quality in terms of measuring particulate in the ambient air. Although the levels were still above the permissible limit, improvement in the air quality was well documented. Complaints from workers (such as stuffy nose, watering eyes and dyspnoea) in restaurants declined substantially after implementation.

Effects on private places
Comprehensive smoke-free policies can cause a shift in beliefs and personal choice regarding rules about smoking in private places and reduce exposure to second-hand tobacco smoke in private homes or cars. In a study in 1995, about 90% of the smokers in various occupational groups indicated that they smoke at home. The 2008 Global Adult Tobacco Survey, which took place after the first phase of the smoke-free policies was implemented, found that smoking was allowed in 60% of homes. The next cycle of the Survey will better determine the effects of the comprehensive smoking ban in changing perceptions and tolerability to smoking in private homes.

Comprehensive smoke-free policies can cause a shift in beliefs and personal choice regarding rules about smoking in private places and reduce exposure to second-hand tobacco smoke in private homes or cars.

Reduced tobacco use
Comprehensive smoke-free policies can reduce smoking prevalence and smoking-related behaviour. After the second phase of the smoke-free policy was implemented, tobacco sales decreased to the lowest in 15 years, from 107.6 billion cigarettes to 93.5 billion between 2009 and 2010. However, the tax increase in January 2010 also probably affected demand.

Small-scale prevalence studies on employees indicated that 4% reported to have quit after the smoke-free law was implemented, and 61% reported to be smoking less. Before the law, the mean number of cigarettes smoked per day was 23, whereas the mean value was significantly lower at 16 three months after the law was implemented. In addition, the percentage of employees who smoked who expressed their willingness to quit smoking increased from 57% to 67% during the same time period (Table 1).

Reduced mortality and morbidity

Comprehensive smoke-free policies can reduce mortality and morbidity from exposure to second-hand tobacco smoke. Smoke-free legislation has been shown to improve health in non-smokers and reduce cigarette consumption among smokers. The scientific literature indicates that just a few months

after the law was implemented, hospitalization for myocardial infarction declined between 20% and 40% *(14–16)*. In Turkey, the numbers of patients admitted to the emergency departments of 10 big hospitals in Istanbul during January–May 2009 and January–May 2010 were monitored. The numbers of patients with diseases related to smoking and second-hand smoke exposure were investigated, noting a substantial decrease of 24% between 2009 and 2010; 34% for myocardial infarction, 16% for acute nasopharyngitis; 33% for pneumonia; 19% for acute bronchitis; 59% for allergic rhinitis; 61% for acute respiratory diseases; and 21% for chronic lung diseases.

Table 1. Changes in smoking behaviour of the customers and of the owners and employees of hospitality workplaces in Turkey, 2010

	Customers (n = 122)	Owners and employees (n = 122)
Not affected, smoking as before	45%	34%
Affected, less smoking	27%	50%
Affected, more smoking	6%	1%
Do not know	22%	15%

Source: Özcebe et al. *(13)*.

The health effects are enormous and are evident within a few months

Economic gains

Comprehensive smoke-free policies produce economic gains in the health system. Morbidity declines within just months after the smoke-free law was implemented, which translates into considerable savings for the health system. In Turkey, an estimated US$ 10–12 billion or more is spent on diagnosing and treating patients with smoking-related diseases.

Tourism gains

Another common argument against comprehensive smoke-free legislation is that it will drive away tourism. According to the World Tourism Organization *(17–19)*, 4 of the top 5 and 6 of the top 10 tourism destinations have strong or comprehensive smoke-free laws. Similarly, Turkey continues to have slightly increasing numbers of international tourists.

Business gains

Lastly, the central issue of debate is often whether or not the policy will have economic effects on businesses. A review of the literature *(20)* indicates that smoke-free policies affect businesses in numerous positive ways, from improving the health and productivity of their employees to reducing their insurance, cleaning, maintenance and potential litigation costs. Objective measures could include employment statistics and taxable sales information. Great caution should be used in self-reported measures for business owners, since studies may be biased and business owners surveyed often claimed losses. Objective reviews of employment and taxable sales data have shown no economic downturn.

In Turkey, data show that the smoke-free law did not have any negative economic effects on the hospitality sector – on the contrary. Based on the records of the Central Bank of Turkey, while the general gross national product in the country declined by 3.3% between 2008 and 2009, the income of hospitality workplaces actually increased by 5.2% during the same time period. Further, the number of hospitality workplaces increased by 2.7% between the beginning and the end of 2009. The increase was 3.5% in food sector workplaces and 3.0% in workplaces serving alcoholic drinks. In addition, the amount of VAT collected and transferred by the hospitality industry increased by more than 20% between January and October 2009. These data are consistent with public polls demonstrating that 79% of people surveyed said they either go out more often now to restaurants, bars and teahouses or have not changed their habits.

Conclusion

Importance

The WHO FCTC is a strong instrument that can reduce inequities both within and among countries through its comprehensive mix of tobacco control interventions at the population level. One of the key benefits of implementing comprehensive smoke-free policies is that, by its very nature, it protects all people from tobacco smoke. However, even smoke-free policies need to be examined carefully, particularly ensuring strong enforcement not only in the capital and other urban areas but also in the often-neglected rural regions of the country.

This case study is intended to draw on the best available evidence from Turkey. Turkey has complemented its smoke-free initiative with other WHO FCTC measures, such as tax increases, pictorial warnings on cigarette packages, educating people on the harms of tobacco use through the mass media

and offering cessation services. As the momentum is growing in the Region and more and more countries are protecting their populations from the harm of tobacco smoke, it becomes paramount to document successes, as well as challenges, that can inform and assist the efforts of other countries.

Unfinished business

Turkey experienced great achievements in tobacco control, particularly in its legislation for smoke-free environments. The first legislation came into force in 1996, which banned smoking in most of enclosed places. After more than 10 years, the law was amended in 2008 to cover hospitality workplaces and commercial taxis to guarantee smoke-free environments. Having a tobacco control law with a comprehensive ban is very crucial on the way to achieving a complete smoke-free country. Nevertheless, implementing the items in the law is another important point. The work has not finished yet.

Although considerable improvements are seen in indoor air quality after the law came into force, the concentrations of particulate matter in most of the places were still too high. Implementation should therefore be strongly enforced to reduce the concentrations below the permissible limits.

Checklist for success

- ✓ Organize civil society under one umbrella to manage capacity and efforts
- ✓ Learn about relevant international activities and international developments
- ✓ Learn about relevant national legislation
- ✓ Research the implementation and impact in other countries
- ✓ Meet representatives of stakeholders, listen to them and address concerns
- ✓ Use the mass media to distribute knowledge
- ✓ Respond to any incorrect information immediately
- ✓ Follow tobacco industry activities closely
- ✓ Strongly enforce the implementation of the law

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