Workplace Smoking

Working Paper: A Review of National and Local Practical and Regulatory Measures

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Preface

Workplace smoking can be a serious safety and health hazard and a cause of conflict. Promotion and implementation of a smoke-free work environment therefore fall under the ILO's mandate to create healthy and safe workplaces. This working paper, based to a large extent on an informal survey carried out by ILO SafeWork in 2003, sets out to provide an overview of attitudes, legislation and practices related to smoke-free workplaces in different parts of the world. It could serve as a background paper for further ILO tripartite discussions leading up to a new international instrument.

Because of the rapidly changing nature of the debate and legal frameworks related to workplace smoking, the overview will need to be reviewed and periodically updated. Such exercises may require pooling more examples of enterprise and trade union policies and programmes and undertaking a thorough analysis of existing legislation, policies and best practices.

The working paper has been written within the general framework of preventing psychosocial problems at work. Its purpose is to create a knowledge base for further activities in the area of promoting and implementing smoke-free workplaces and also the SOLVE interactive educational programme on psychosocial issues.

We hope that the document will promote discussion among policy makers, campaigners, trade unionists, employers and others interested in the promotion of smoke-free workplaces and provide inspiration to widen the research base. Additional contributions and comments are welcome and should be sent to Dr. David Gold at gold@ilo.org.

We extend our cordial thanks to all the participating governments and organizations for their collaboration and support. A list of all institutions that responded to the survey can be found in Annex 2.

We should also like to acknowledge the assistance of all those who cooperated in one way or another, namely: Ms. Lene Olsen of the ILO Bureau for Workers Activities; Mr. Emmanuel Guindon of the World Health Organization (WHO), Tobacco Free Initiative; Mr. Lucien Royer of the International Confederation of Free Trade Unions (ICFTU); and Mr. Rory O'Neill of *Hazards Magazine*.

The survey was conducted in 2003 and this document written in 2003-2004 by the author, assisted by Mr. Laurent Burlet, University of Grenoble.

Introduction

Why create smoke-free workplaces?[1] A study of regulations and campaigns pertaining to smoking at work in different countries reveals two points of departure. In the first, the objective is to achieve an overall decline in smoking prevalence, workplaces being one of many targeted environments. The second specifically targets the workplace and second-hand tobacco smoke[2] as an occupational safety and health hazard. Within the same government, achieving each objective is usually the responsibility of two different ministries: the ministry responsible for health on the one hand and the ministry of responsible for labour on the other.

Workplace smoking bans further the overall aim of health authorities, which is to reduce smoking. Studies show that smoke-free workplaces have a clear effect on people's smoking behaviour. Workers who are required to go to designated smoking areas at certain times of the day because they are no longer allowed to smoke at their work station, tend to quit smoking more often and smoke fewer cigarettes than those who work in workplaces with no regulations (Fichtenberg 2002; Farrelly 1999).

This working paper looks at the various problems related to smoking and exposure to second-hand smoke at work, including the poverty aspect and safety risks; whether legislation is the solution to those problems; and, finally, which steps could be taken apart from legislation to promote and implement smoke-free workplaces.

The paper has been divided into four chapters:

Chapter 1 presents different arguments in defence of regulating smoking at work. The first argument is the occupational health and safety risks of both active and passive smoking. Another underlines the additional costs incurred not only to employers and workers but to civil society in its entirety. These costs include: smoking-related illnesses and premature death; higher levels of sick absences from work; higher health insurance premiums; increased maintenance costs of premises and equipment; higher insurance premiums because of the risk of fires or explosions; and lower productivity due to a badly implemented or absence of a clear smoking policy causing conflicts and malaise. Chapter 1 also addresses ways to measure the effects of passive smoking.

Chapter 2 reviews the extent and types of legislation in force in 2003. Different types of legal instruments at international, regional and national level are presented as well as an international overview of workplace legislation. A discussion is also developed about how different types of legislation are shaped and, finally, the implementation and effectiveness of workplace smoking legislation.

In **Chapter 3,** the importance of committed governments, employers and workers' organizations is explained and illustrated by good practices from different countries and regions in the world.

[1] In this document, the definition of smoke-free workplaces means working environments with regulated smoking, i.e. where smoking can only be done in enclosed separate smoking areas so that no workers are involuntarily exposed to tobacco smoke during their working time.

[2] Throughout this document, exposure to ¨second hand tobacco smoke¨ will be used to mean the inhalation of tobacco smoke emanating from a tobacco product being smoked by another person. Other expressions meaning the same are: ¨environmental tobacco smoke¨ (ETS) and ¨passive smoking".

Chapter 4 examines other important elements that should be considered in the promotion and implementation of smoke-free working environments. This chapter also provides examples of good practices from different countries which illustrate the arguments developed.

The following methodology was used:

1. **Desk review.** Existing literature and databases provided sources for data collection with regard to the following: the overview of tobacco legislation and programmes; occupational exposure levels of second-hand tobacco smoke; and different activities related to workplace smoking, such as awareness raising and cessation aid.

2. **ILO SafeWork Survey: "Smoking at Work"**. Approximately 250 questionnaires (a copy is provided in Annex 1) were sent to the members of the International Association of Labour Inspectorates (IALI)[3], to the national and collaboration centres of the International Occupational Safety and Health Centre (CIS)[4], and to a number of trade unions contacted through the ILO Bureau for Workers Activities as well as the International Confederation of Free Trade Unions (ICFTU). Contact was also made with the ILO Bureau for Employers' Activities and the International Organization of Employers. The questionnaire was designed to access information on existing legislation in the country; attitudes to workplace smoking; and existing workplace assistance programmes. The 72 respondents, mainly composed of governments, occupational health institutes, and trade unions, are listed in Annex 2. A summary of the responses received is provided in Annex 3.

3. **Interviews** with government officials and occupational health specialists.

This is a first attempt to capture main trends in tobacco control at work and a reflection of the situation in 2003. Interesting changes, in some cases dramatic, are now taking place, both in terms of legislation and in terms of increased debate and new actors appearing on the scene, such as trade unions.

An important instrument in this changing scenario is the Framework Convention on Tobacco Control which was adopted on 21 May 2003 by the World Health Assembly. Years of international negotiation rounds preceding the Convention stirred much interest and attention to smoking around the world. Cross-sectoral working groups were set up by various governments to discuss the draft framework agreement and national tobacco policies. Policy changes as well as national action plans evolved as a result of this work. When the Convention enters into force, it is likely that this process of change will continue, as countries will be required to make further policy changes in order to ratify it.

A further stimulus to policy changes is the current debate around a new trend of more radical legislation. These new all-encompassing smoking laws involve bans or restrictions on smoking in all workplaces including bars and restaurants, areas which were formerly considered out of bounds in terms of regulation for a long time. Bans or restrictions on smoking in all workplaces first came into existence in a few states of the United States. Other states and countries are discussing whether to follow suit. For example, in 2004 legislation banning smoking in all workplaces will come into force in Norway and Ireland.

[3] The International Association of Labour Inspectors (IALI) is a worldwide association of over 90 members from more than 70 different countries, established to provide mutual support to labour inspection bodies mainly through conferences and other events and through networking.

[4] The International Occupational Safety and Health Information Centre (CIS) collects and disseminates information on the prevention of occupational accidents and diseases. It collaborates with 130 national institutions around the world.

The information presented only represents a snapshot of the situation in the world. It was a challenge to arrive at an overview of workplace programmes and campaigns because those activities are to a large extent carried out on local or enterprise levels rather than national level. Another limiting factor was the apparent low priority given to smoking-related questions in some occupational safety and health administrations. This could perhaps be explained by smoking traditionally being considered a ¨lifestyle¨ or ¨well-being¨ issue rather than a serious occupational health risk.

Chapter 1. The problem

It has been long acknowledged in most countries that smoking is a health hazard. Less widespread, but nevertheless gaining momentum, is the awareness that second-hand tobacco smoke is bad for health. One consequence of this rise in awareness is an increasingly vocal lobby demanding smoke-free environments. This health-conscious lobby demands smoke-free public places, workplaces, and since recently, smoke-free restaurants, cafes and bars, giving rise to an intense political issue in several countries at the turn of the century. In addition to various health arguments, there is also an economic dimension to the issue of smoking policies in the workplace. Besides the damaging effect the habit has on health, smoking can also contribute to financial problems for low-income users, in developed as well as developing countries. Another economic argument is that non-smoking working environments make sense for employers because of savings in such areas as maintenance costs, insurance costs, and improved working performance. Since the debate on health and economic arguments has been covered to a great extent in media and literature, Chapter 1 will only briefly present the main arguments and concentrate on an aspect that has been covered to a lesser extent: how to measure the extent and impact of exposure to second-hand tobacco smoke.

1.1. Smoking: an occupational hazard and a liability

In addition to harming the smoker's health, it is a long-known fact that passive smoking causes irritation to non-smokers, especially those who are subject to allergies or asthma. However, it has only relatively recently been made public the actual extent to which second-hand tobacco smoke is dangerous to non-smokers, regardless of their physical condition.

In 1986, the International Agency for Research on Cancer (IARC) [5] published a *Monograph on Tobacco Smoking*, in which it was established that cigarette smoking causes various types of cancer to humans. In 2002 IARC went one step further by also taking into account the risks of passive smoking. The IARC *Monograph Tobacco Smoking and Tobacco Smoke* (Vol. 83) states that tobacco smoking and tobacco smoke are carcinogenic to humans.

Prior to the IARC monograph the Surgeon General of the United States published the 1964 report *Reducing the Health Consequences of Smoking.* This was the first official statement in the United States that smoking can cause lung cancer as well as other diseases. Since then, the Surgeon General has released over 30 reports about the negative health effects of smoking and passive smoking,[6] and the message has become common knowledge in many corners of the world.

Another agency acknowledging that passive smoking could cause illness or even death is the United States Environmental Protection Agency (EPA). The EPA in 1992 classified second-hand tobacco smoke as a "Class A"[7] or human carcinogen, for which there is no protection.

[5] The International Agency for Research on Cancer (IARC) is an arm of the World Health Organization. IARC's mission is to coordinate and conduct research on the causes of human cancer, the mechanisms of carcinogenesis, and to develop scientific strategies for cancer control. The Agency is involved in both epidemiological and laboratory research and disseminates scientific information through publications, meetings, courses, and fellowships.

[6] All of Surgeon General's reports can be found at the Center for Disease Control's home page: http://www.cdc.gov/tobacco/sgrpage.htm

[7] The United States Environmental Protection Agency considers Class A carcinogens as pollutants with adequate human data indicating the chemical which causes cancer in people.

The negative health effects of smoking or inhaling second-hand tobacco smoke can multiply if a person is simultaneously exposed to other hazardous substances in the environment. How smoking or exposure to second-hand tobacco smoke impacts on a person's health may thus depend on the person's job. For example, smokers exposed to arsenic, asbestos or radon, run a higher risk of contracting lung cancer. A non-smoking worker exposed to asbestos runs a five-times higher risk of dying from lung cancer than a worker not exposed to asbestos. The same risk among smokers, which is 11 times higher than non-smokers not exposed to asbestos, multiplies 50-80 fold when combined with asbestos (Woitowitz, 2003:38). There is also a negative synergistic effect between smoking and alcohol consumption, which could increase risks of cancer of the oral cavity, pharynx, larynx and oesophagus. These occupational risks have been documented by the International Agency for Research on Cancer (IARC) and the International Programme on Chemical Safety (IPCS)[8] (IARC, 2002; IPCS, 1999).

Smoking is also an occupational safety hazard. The likelihood of fires and explosions in buildings where smoking is allowed is considerably higher than in buildings with a non-smoking policy (Parrott, 2000; Levine, 1997). WHO estimates that 300,000 persons were killed in the year 2000 due to fires caused by smoking (Mackay, 2002). Smoking can also cause accidents because of the distractive effect of lighting the cigarette or cigarette smoke causing decreased visibility. At the psychosocial level, smoking can cause conflicts between smokers and non-smokers at work, especially where no clear policy exists or where the existing policy is badly implemented.

An additional imperative to promote smoke-free workplaces is to lower the costs for the employer and society in terms of productivity, maintenance costs and insurance premiums. The costs are also considerable for smokers, especially since the recent trends around the world show that persons within lower income brackets smoke more than those within higher income brackets (Mackay, 2002). Studies also show that employers and governments that are successful in reducing workplace smoking benefit from increased productivity, lower rates of absenteeism, lower costs related to cleaning of premises and maintenance of machinery, and lower health care and insurance costs (Mackay, 2002; Levine, 1997; McGee, 2000).

The economic burden of smoking is thus stronger on those who need their income most. In poor countries, the portion of scarce income spent on tobacco products could be spent to acquire essential commodities such as food, clothes or school fees. The Organization for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC) referred to this link between smoking and poverty in a document entitled *Poverty and Health* (OECD, WHO, 2003: 34-36). The box below illustrates the link.

[8] The International Programme on Chemical Safety (IPCS) is a UN programme with two main roles: to establish the scientific health and environmental risk assessment basis for safe use of chemicals and to strengthen national capabilities for chemical safety. Within the programme, three UN organizations cooperate: ILO, WHO and UNEP.

Box 1.1. Smoker's costs

A survey of rickshaw pullers in Dhaka, Bangladesh, showed that the respondents spent 1 % to 40 % of their income on smoking, with an average of 12 % (Efroymson, 2000). A WHO publication illustrated the problem with an even more extreme case. Smokers in Minhang, China, spend as much as 60 % of their annual income on cigarettes (Mackay, 2002:43).

The different financial significance for smokers around the world can also be illustrated by the amount of working time needed to be able to purchase one pack of cigarettes. According to the WHO, a worker in Copenhagen, Denmark, had to work 23 minutes to afford an international brand of cigarettes, while a worker in Nairobi, Kenya, needed 158 minutes (ibid.).

1.2. Measuring second-hand tobacco smoke

It is useful to know the number of workers exposed to second-hand tobacco smoke at work or the quantity of smoke they are exposed to.

- The ability to prove that the air in a workplace is polluted by cigarette smoke can be used as an argument by workers who want a change of policy.
- Measurement of the air quality can be a useful tool for the work of labour inspectors and others responsible for the enforcement of non-smoking policies and legislation.

When trying to measure the impact of second-hand tobacco smoke, two aspects should be taken into consideration: firstly, the extent of occupational diseases and deaths caused by exposure to second-hand tobacco smoke; secondly, the amount of smoke in the air and the length of time workers are exposed to tobacco smoke. However, these measurements are not without difficulties.

To measure the extent of diseases and deaths caused by second-hand tobacco smoke, we are confronted with the following problems:

- Tobacco smoke is not composed of a single substance but is actually a compound of hundreds of chemicals, complicating the exercise of singling out the cigarette smoke in the air. Some of these chemicals are more hazardous depending on the environment, as they sometimes have a synergistic effect when reacting with other substances.
- There is a time lag between exposure and illness. Cancer, lung and heart diseases often appear after decades of smoking, which means that workers may experience illnesses related to passive smoking after retirement.
- It is difficult to isolate the effects of exposure at work from the effects of second-hand tobacco smoke exposure outside the workplace in places such as homes, restaurants or sports events.

Despite these hurdles, there have been attempts to measure the percentage of occupational deaths caused by different exposures in the working environment. One study in Finland, for example, estimated the attributable fraction of occupational mortality due to second-hand tobacco smoke to 15.6 % for men and 10.9 % for women in the category pneumococcal disease (Nurminen, 2001:161-213). However, because of the previously mentioned limitations, such data are considered rough estimates.

The extent of exposure to second-hand tobacco smoke in time and volume is also not an exact science. Measuring the air quality in worksites requires scientific equipment. Considering the limited capacity of labour inspectorates in many countries, this exercise would be difficult to carry out in more than a limited number of workplaces. There are, however, movements to develop inexpensive and easy-to-use equipment that could be used by non-scientists. Surveys measuring workers' perceptions of their air quality is perhaps the easiest method, but one fraught with the problem of subjectivity. People tend to notice cigarette smoke by its smell or when it affects vision or irritates eyes and respiration. The problem is that cigarettes contain carcinogenic substances that are odourless and colourless and can only be detected through scientific measuring.

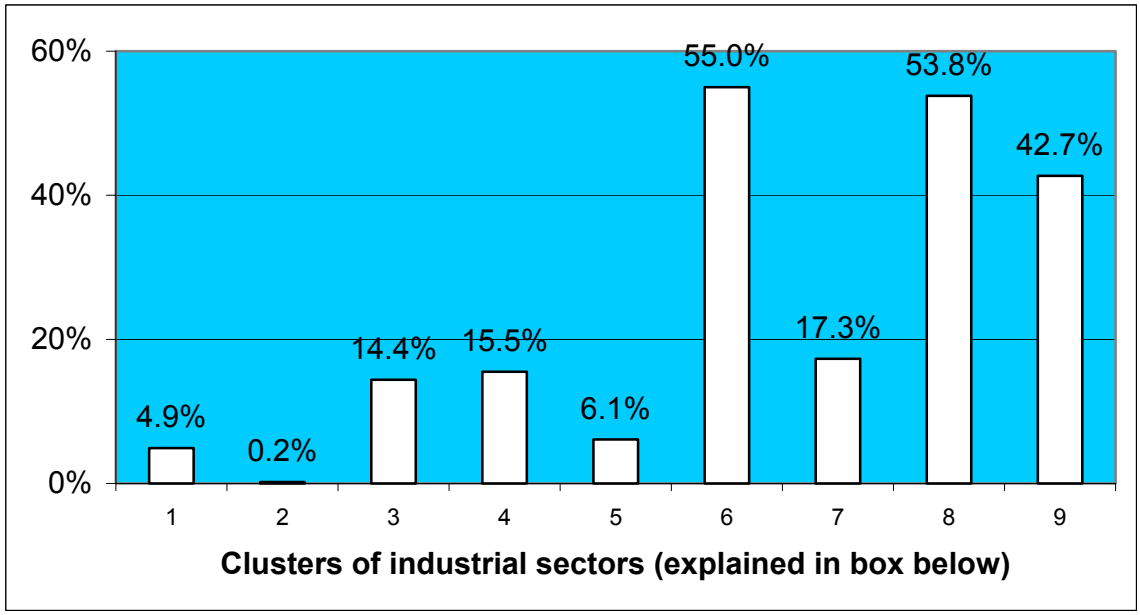
An interesting attempt to make an international comparison of occupational exposure to tobacco smoke is the CAREX report (CARcinogen EXposure), published in 1998 by the International Information System on Occupational Exposure to Carcinogens (CAREX/FIOH 1998). The results from CAREX clearly show that second-hand tobacco smoke is a serious occupational hazard. On the list of the most common cancer-causing occupational exposures, second-hand tobacco smoke ranked number two after solar radiation. A total of 7.5 million workers in 15 European countries[9]were exposed to second-hand tobacco smoke for at least 75% of their working time. The research team arrived at the conclusion that 23 % of those employed were exposed to one or several of the 139 carcinogens defined by the International Agency for Research on Cancer.

For our purposes, it is most interesting to compare the exposure-rates to second-hand tobacco smoke between different occupational sectors. CAREX categorized the data into 55 industrial sectors[10]. Among the different carcinogenic agents found in the air of these sectors, second-hand tobacco-smoke was present in almost all of them. In Finland for instance, exposure to second-hand tobacco smoke was found in 38 of the 55 industrial sectors.

The chart below shows the number of workers exposed to tobacco smoke in relation to other types of carcinogenic exposures. The 55 industrial sectors have been clustered into nine occupational groups (according to ISIC, Rev.2) for easier overview. Although the chart does not indicate exactly how many workers are exposed to second-hand tobacco smoke in each sector, it does illustrate which sectors are more problematic. The very low figure for mining and quarrying is not surprising considering the safety precautions involved in such working environments. The chart also shows that workplaces that are enclosed and separated from other people, such as manufacturing plants or electricity plants, seem to face a relatively low exposure to tobacco smoke. The problematic sectors, as illustrated below, seem to be workplaces where the employees are in contact with the public; either in the form of customers, clients or patients. More than half of all employees in wholesale and retail trade, restaurants and hotels, financing, insurance, real estate and business services were exposed to second-hand tobacco smoke. Community, social and personal services also showed a high exposure rate.

[9] The original CAREX report, which covered the 15 EU member countries, was complemented in 2001 with data from four countries about to join the EU (Kauppinen, 2001:343-345).
[10] The categorisation of the 55 industrial sectors was done according to the International Standard International Classification of all Economic Activities, Second Revision (ISIC Rev 2); the classification used by the Organisation for Economic Cooperation and Development (OECD).

Chart 1.1. CAREX 1998. Occupational exposure to second-hand tobacco smoke according to industrial sectors (numbers indicate clusters of industrial sectors as explained in the box below)



Industrial sectors in each of the CAREX Clusters:

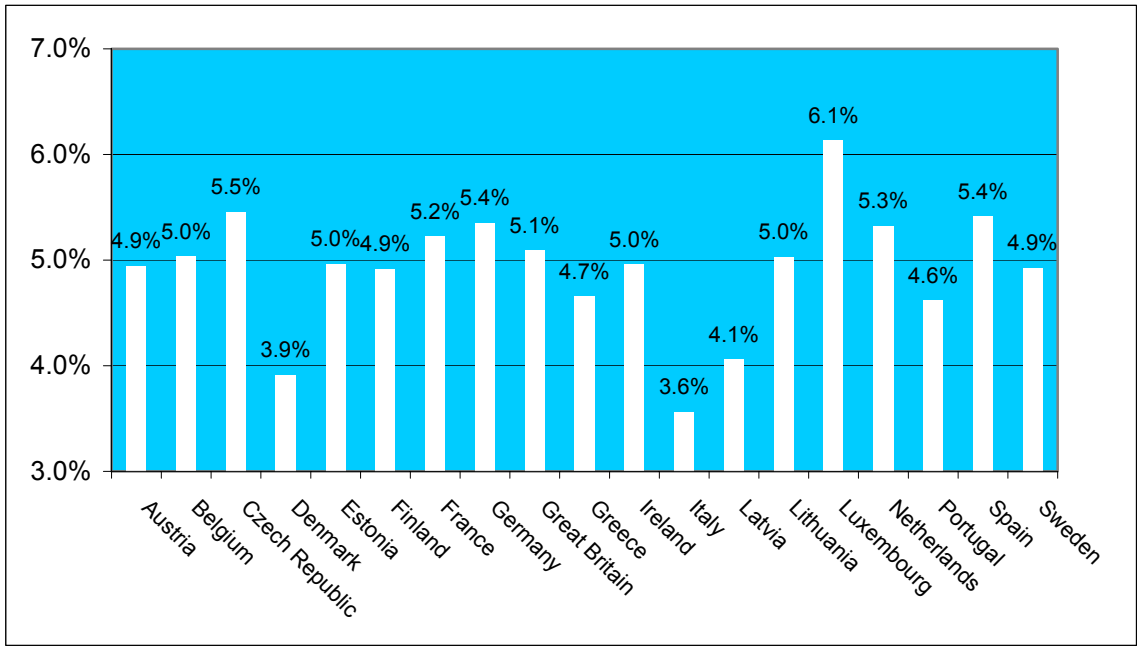
1. Agriculture, Hunting, Forestry and Fishing
2. Mining and Quarrying
3. Manufacturing
4. Electricity, Gas and Water
5. Construction
6. Wholesale and Retail Trade and Restaurants and Hotels
7. Transport, Storage and Communication
8. Financing, Insurance, Real Estate and Business Services
9. Community, Social and Personal Services

Source: CAREX/Finnish Institute of Occupational Health, 1998.

Another way of using the CAREX report is to compare the exposure rates of workers in each country. Chart 1.2 below shows the percentages of workers exposed to second-hand tobacco smoke 75 % of their working time or more.[11]

[11] The result shows a surprising similarity in the average rate of workers with most countries close to 5 %. Compared with the smoking rate for men and women in the same countries during the same period, some countries with lower smoking rates (and stricter legislation regulating smoking at work) scored quite high in terms of occupational exposure to second-hand tobacco smoke. The explanation lies in the methods used by the CAREX-team to measure exposures, which lead to rather crude estimates of the real value. Because of a lack of reliable data in most of the countries, American and Finnish exposure data for 55 different industrial sectors were used as proxy. In the case of second-hand tobacco smoke, only Finnish data were available and was thus used as the basis for calculations in all the countries. Individual differences indicate variable sizes of occupational sectors in each country.

Chart 1.2. CAREX Occupational exposure to second-hand tobacco smoke per country in the European Union 1990-1993



Sources: CAREX/Finnish Institute of Occupational Health 1998 (Kauppinen, 2001:343-345)

The CAREX report of 1998 was widely publicized. In 2001 the methodology was for the first time applied outside of Europe: the TICAREX[12] report (Partanen 2003). The TICAREX report, which covered the workforce of Costa Rica, used the same methodology as CAREX albeit slightly improved. To achieve a more accurate picture of Costa Rican exposures, the US-Finnish default values were adapted to Costa Rican circumstances and exposures were assessed separately for men and women.

Similarly to CAREX, TICAREX of Costa Rica showed that occupational exposure to second-hand tobacco smoke was a major problem. Ranking third on the list of carcinogenic exposures at work, after solar radiation and diesel engine exhaust, 5.4 % (71,700 workers in total; 47,100 men and 23,600 women) out of the total workforce of 1.3 million were exposed to second-hand tobacco smoke. The highest levels of exposure were measured in bars and restaurants. Other sectors where Costa Rican workers were exposed to second-hand tobacco smoke were: manufacture of transport equipment, instruments and photographic equipment, water transport, services allied to transport, education, and personal and household services.

1.3. Chapter 1. Summary

Smoking in the workplace affects the health and income of the smoker. Scientific evidence has shown that exposure to second-hand tobacco smoke is a potential source of the same illnesses as smokers are liable to contract, such as cancer, heart and lung diseases. All air pollution caused by smoking is an occupational health problem. This problem is more acute where the workers are exposed to other dangerous substances, such as asbestos; or if the worker is particularly sensitive because of, for example, asthma or pregnancy.

[12] TICA is the familiar word for someone Tico/Tica or something that comes from Costa Rica.

In addition to being a health problem, smoking is a safety hazard. Explosions and fires could often be avoided if smoking were prohibited. Lack of concentration during smoking and the potential source of conflict between smokers and non-smokers also argue in favour of considering the adoption of appropriate measures to deal with the phenomenon seriously.
There are also economic aspects to be considered when promoting smoke-free workplaces. Smoking is a particular burden for low-income smokers because of the additional cost and the health effects of smoking. Employers and the society as a whole can also gain from cleaner air in terms of increased productivity, lower maintenance costs, and lower health costs, among other benefits.

An important factor in the process of regulating smoking at work is the measurement of tobacco smoke in the air. If the results from air measurement find high levels of pollutants, this can be used as an argument for proponents of regulations, or as a tool by the ones who evaluate and control smoking regulations. The most commonly used method is to survey the perceptions of workers, which does not always produce an accurate result. More reliable measuring methods are often time consuming and costly.

The most extensive measurement of workplace air quality was the European CAREX report of 1998, which used proxy values to compare exposure to second hand tobacco smoke and other carcinogenic substances at the workplace. It was a first attempt to arrive at a more systematic international measurement of workplace exposures to carcinogens.

The next chapter will examine legislation regulating smoking at work. The first sections will concentrate on the different types of legislation and to what extent they are applied in different regions of the world. The subsequent sections will look at the way smoking legislation typically evolves in a country and whether laws are the best way of promoting smoke-free workplaces.

Chapter 2. Legislative aspects

As pointed out in Chapter 1, exposure to second-hand tobacco smoke is more common in certain occupations than others. It is particularly difficult to regulate smoking in areas that are at the same time public places and workplaces; where workers are in contact with the public, such as hospitals, banks, bars, restaurants or sports arenas. This variation in circumstances explain why most countries have different types of laws covering different types of workplaces rather than a single law protecting all workers from second-hand tobacco smoke.

In this chapter, regulation of smoking at work at the international, regional and national levels will be discussed. The chapter will also review the extent to which countries have laws for different types of workplaces. The order in which different types of smoking legislation has been developed in many countries will be discussed. The chapter will also provide an example of good practice in implementing smoking legislation. The final issue in this chapter addresses whether legislation is a necessary component in the promotion of smoke-free workplaces.

2.1. Legislation in the world

The realization that passive smoking can be a contributing factor to illness and death is increasingly a decisive factor in the way nations deal with smoking policies. Stronger legislation and awareness campaigns are taking shape in all corners of the world albeit to a greater extent in some regions. An additional boost to all these developments was the effect of years of negotiations and the adoption by the World Health Assembly of the Framework Convention on Tobacco Control (2003).

Initiatives at the international level

The most important international instrument to support tobacco-related legislation so far is the Framework Convention on Tobacco Control, adopted on 21 May 2003. The Convention will come into force 90 days after 40 countries have ratified, accepted, approved or acceded to it. It is open for signature until 29 June 2004. As of the publication of this report, 98 nations had signed the Convention and the following nine countries had become parties through ratification or approval: Fiji, India, Malta, Mongolia, New Zealand, Norway, Palau, Seychelles and Sri Lanka. Several other countries were preparing for ratification, and the European Health Commissioner David Byrne affirmed that the European Commission had the support from the European Parliament to promote the Convention in Europe.

Article 8 of the Convention, *Protection from Exposure to Tobacco Smoke,* addresses the question of smoke-free workplaces:

> *(...)2. Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.(...)*

Initiatives at the regional level

At the regional level no regulation has been developed related to occupational exposure to tobacco smoke. However, in Europe there are some movements in that direction.

The 1989 European Council Directive concerning the minimum safety and health requirements for the workplace (89/654/EEC) and the 1996 European Council Resolution on the reduction of smoking in the European Community (89/391/EEC), both suggested greater protection from exposure to second-hand tobacco smoking. In December 2002 a European Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control was adopted (2003/54/EC). All European member States were recommended to:

> *(...)4. Implement legislation and/or other effective measures in accordance with national practices and conditions at the appropriate governmental or non-governmental level that provide protection from exposure to environmental tobacco smoke in indoor workplaces, enclosed public places, and public transport. Priority consideration should be given to, inter alia, educational establishments, health care facilities and places providing services to children.(...)*

In 2003, the EU Health Commissioner, David Byrne, announced that collaboration with the Employment Commissioner was underway to develop a policy which would ban smoking in the workplace, as part of the latter's mandate to ensure safe working conditions (Financial Times, 18 Sep. 2003). However, a recommendation from the Employment Commissioner regarding a European schedule of occupational diseases is contradictory to including smoking in the occupational safety and health domain. The suggested list contains a list of chemical agents causing occupational diseases as well as a list of occupational diseases. Cigarette smoke or occupational diseases caused by second-hand tobacco smoke do not figure on the list (European Commission Recommendation 19 Sep. 2003).

Workplace smoking has also been on the agenda of a meeting of the Health Ministers of MERCOSUR, the trade agreement between the southern countries of South America, the Southern Cone (Freitas, 2003)

Initiatives at the national level

When comparing national legislation coverage, one notes that countries in northern Europe, North America, Australia and New Zealand have the longest experience in developing smoke-free environment legislation. However, such comparisons do not do justice to the fact that some of the more advanced smoke-free workplace laws today have been adopted below the national level, such as by the State of California in the United States or the Province of British Columbia in Canada, and will not appear in the statistics over national laws below. Many other countries also have strong local jurisdictions, such as the city of New Delhi and the State of Goa in India and several provinces in Spain.

In regions where the coverage of national smoking legislation is less extensive than in Europe and North America, many countries have found interesting solutions to the problem of workplace smoking, some of which derived from the responses to ILO SafeWork's Survey: "Smoking at Work". Another interesting consequence of the survey was a significant change in attitude towards smoking and second-hand smoke in the last ten years, especially among young people. Due to information campaigns and public discussion, public awareness has increased, providing a broader base to support anti-smoking initiatives.

However, despite increasing awareness, much ignorance still persists with regard to the damaging effects of smoking on health. The perception of smoking as a ”lifestyle” or “wellness” issue is still deeply ingrained. In developing nations, especially in Asia and Africa, health budgets are often undersized and competition is keen between tobacco-related diseases and other very serious health issues, such as malaria or HIV/AIDS.

In Africa, many countries are affected by poverty, the lack of resources, and the shrinking power of governments to act effectively to ensure safer and healthier workplaces. However, attitudes are changing vis-à-vis smoking and there are examples of nations that have introduced legislation and/ or awareness campaigns related to smoke-free environments, such as South Africa, Tanzania, Mauritius, Uganda and Gabon. The anti-smoking policy of the Government of South Africa, which includes increased cigarette taxes and the prohibition of smoking in public places and offices, has led to a drop in smoking rates from 30 % to 25 % (Sunday Times, Johannesburg, 21 Sep. 2003).

Resistance on the part of foreign-owned tobacco companies is a factor that places a brake on anti-smoking initiatives in some African countries, but the attitude of resistance is also shared by certain trade unions and governments. Tobacco production, in some cases, is a major foreign currency earner and creates much needed employment opportunities (ILO Sectoral Activities Programme, 2003). An example of the political sensitivity involved in regulating smoking in a tobacco growing country is Tanzania, where a law banning smoking in public places came into force in 2003 and calls were made for designated smoking areas. The law and the proposals were strongly condemned by the tobacco growers in the country (Kibanga, 2003). In Uganda as well, a ban on smoking in all workplaces including restaurants encountered strong resistance from the tobacco industry when it was first discussed in 2003. The law was subsequently passed in 2004 (Mugarura, Monitor 13 Sep. 2003). In Zimbabwe, a structured programme has not been set in place because tobacco production is viewed as a sector of significant economic benefit to the country (National Social Security Authority of Zimbabwe, ILO SafeWork Survey, 2003)

Countries in Latin America are also experiencing a change of attitude towards smoking. Workers are becoming less tolerant to being exposed to second-hand tobacco smoke. Brazil, Chile and Costa Rica are at the forefront with workplace legislation and government programmes for smoke-free workplaces, involving workers and employers.

The picture of Asia is very diverse. The largest country in the world, both in terms of consumption and production of tobacco products, is China. However, the response to the ILO survey indicates that although the Chinese still smoke one-third of the world’s cigarettes, attitudes have changed, especially among the young. Smoking at work is no longer as accepted as it used to be and many are aware of the health risks involved. In south Asia, initiatives to introduce legislation exist but the map is complex owing to the vast size of the population, poverty, and serious illnesses competing for the attention of government health campaigns. Some countries in east and south-east Asia show examples of very comprehensive anti-smoking legislation and campaigns, such as Thailand, Hong Kong (China) and Singapore. In anticipation of ratifying the Framework Convention on Tobacco Control, ambitious initiatives to change legislation have also been noted in the Philippines and the Republic of Korea.

In Europe, improvements for the protection of workers against tobacco smoke have been made in all countries. Legislation banning smoking and comprehensive campaigns and programmes were first developed in northern Europe, but this trend now also includes countries in southern Europe, such as Italy and Spain. During the 1990s, the eastern parts of Europe made the most significant changes to policies and legislation. According to the WHO Regional Office for Europe, in 2001, nearly four-fifths of the European countries had banned

or restricted smoking in public buildings and public transport. A range of restrictions existed on smoking in workplaces. (WHO Europe, 2002:28)

2.2. Workplace legislation

The responses to the ILO SafeWork Survey showed recognition of the harmful effects of second-hand smoke, especially to the more vulnerable sections of the population. As a measure of protection, legislation was often introduced to ban smoking in some or all of the following areas: health care facilities, educational institutions and child care facilities. Several countries also chose to regulate smoking in areas where many people work or transit, notably in government buildings, public sector worksites and public transport. A more difficult area to regulate seems to be private sector workplaces. However, it is not uncommon in geographical areas where awareness is relatively high that larger private enterprises introduce voluntary smoking bans before such legislation is in place. Areas where the regulation of smoking has proven more difficult are the smaller sized enterprises, the informal sector and the hospitality industry including such areas as bars, cafés, restaurants, discotheques and casinos.

The following section provides an overview of existing legislation related to smoke-free working environments, by regions. The material used for the overview is deriving from the most comprehensive collection of tobacco legislation: *Tobacco Control Country Profiles*, developed by the American Cancer Society with support from the US Center for Disease Control and Prevention (CDC) and the World Health Organization in 2000. With permission this report uses the latest updates from the various regions intended for a new edition of *Tobacco Control Profiles* which was released in August 2003 during the 12th World Conference on Tobacco or Health in Helsinki.

Laws have been divided into four different categories of workplace smoking legislation, corresponding to a common division of such laws. The four categories are as follows: public places, public sector employment, private sector employment, and the hospitality sector. Further explanations are provided in each of the sections below.

Not all occupations lent themselves to inclusion in one of the four categories, such as. One such example are hospital workers. Hospitals are public places but may have public sector as well as private sector employees working on the premises. They would thus fit into three different categories of legislation. The charts showing national legislation also omit laws on the city/municipality/provincial level. Thus, legislation at the state or federal level, such as in Canada, United States or Australia, does not appear in the statistics used for this comparison.

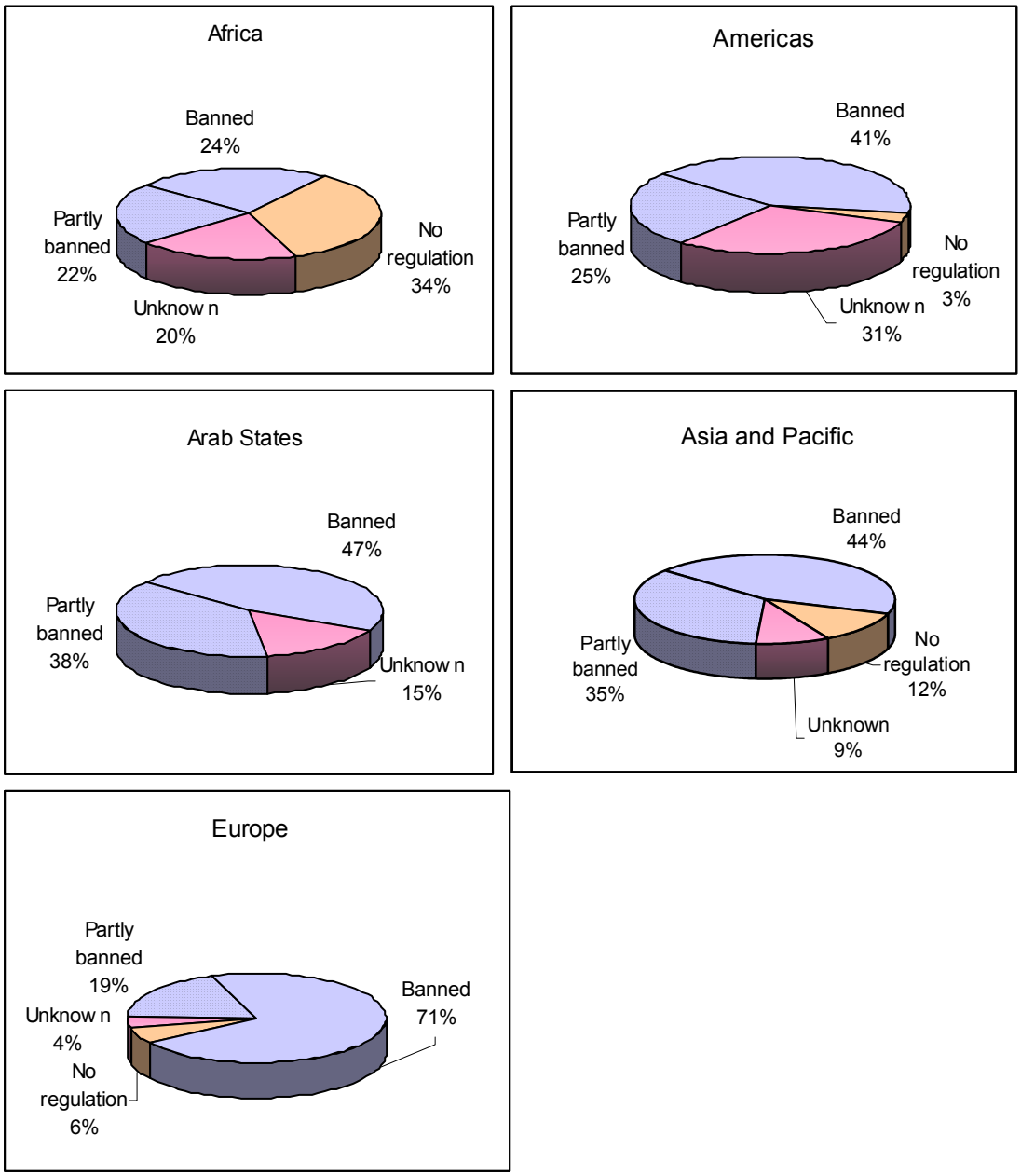
Public places[13]

Charts 2.1. below illustrate different types of legislation in the Americas, Africa, Arab States, Asia and Europe. The percentages show how many countries in each of these regions have one of the following types of legislation: banned, partly banned, no regulation or unknown. The two categories of the pie chart illustrating countries where smoking is banned or partly banned are coloured blue – except when printed in black and white.

¨Banned¨ signifies legislation that totally bans smoking or allows it only in designated smoking areas. ¨Partly banned¨ signifies legislation that bans or restricts smoking in two of the three main categories: educational facilities, health care facilities and public transport.[14]

[13] Public places legislation includes the following types of legislation: educational facilities, health care facilities and public transport.

Charts 2.1. National legislation regulating smoking in public places per region



Source: American Cancer Society: *Tobacco Control Country Profiles* (2003)

The charts above illustrate a rather positive picture: the coverage of non-smoking legislation in public places is widespread in most parts of the world. Although the objective of such legislation may not be to protect workers in particular, it does in practice cover the workers whose workplace is in public places.

By adding the number of countries where smoking is banned and partly banned in public places, the total number amounts to 90 % of the countries in the European region, 85 % of the

[14] The definition used in this document for ¨ smoking ban¨ is a total ban of smoking in all areas of work. Because the elimination of workplace exposure of cigarette smoke is the essential matter in terms of occupational health and safety, smoking in designated smoking areas that are totally secluded from the working environment are also considered as part of the area covered by a ¨smoking ban¨. However, in the section covering the more complicated hospitality sector below, a finer distinction has been made between bans and total bans.

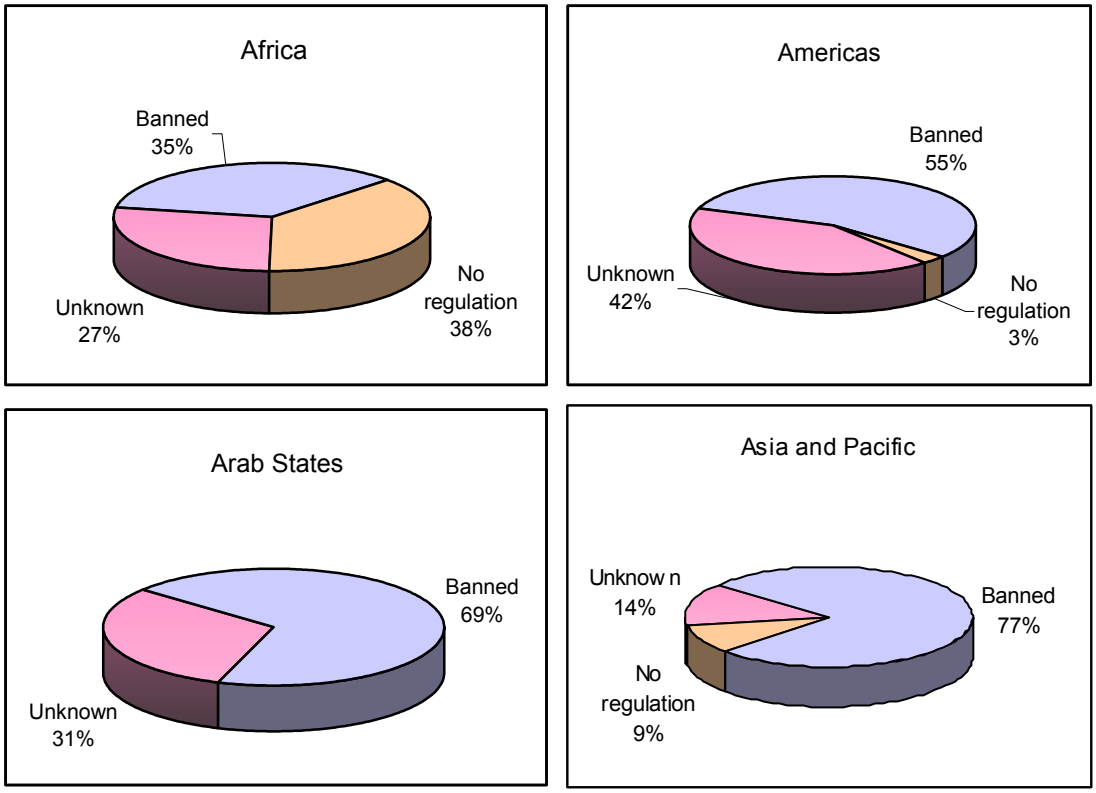
countries in the Arab states and 79 % of the countries in Asia and the Pacific. The slightly lower figures of 66 % in the Americas and 46 % in Africa could be related to a lesser degree of available data in those regions. Also to be noted is also that no legislation in the Arab States permits smoking in public places.

Public sector employment[15]

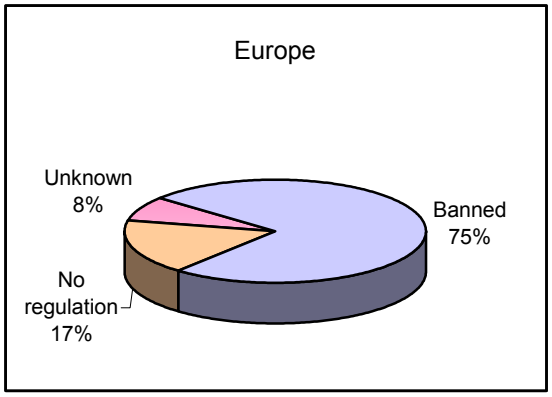
In this section the pie charts indicate the number of countries in each region that have one of the following three types of legislation: banned (total ban or with permission to smoke in designated smoking areas), no regulation, and unknown.

Legislation covering the health, transport and education sectors have not been included in this category since they were included in the previous category ¨public places¨.

Charts 2.2. National legislation regulating smoking in public sector workplaces per region



[15] This section covers legislation in government buildings (including worksites). Smoking bans on domestic and international flights have been excluded from the numbers as these data are often incongruent with other legislation in the country and seem to be affected to a great extent by international flight regulations.



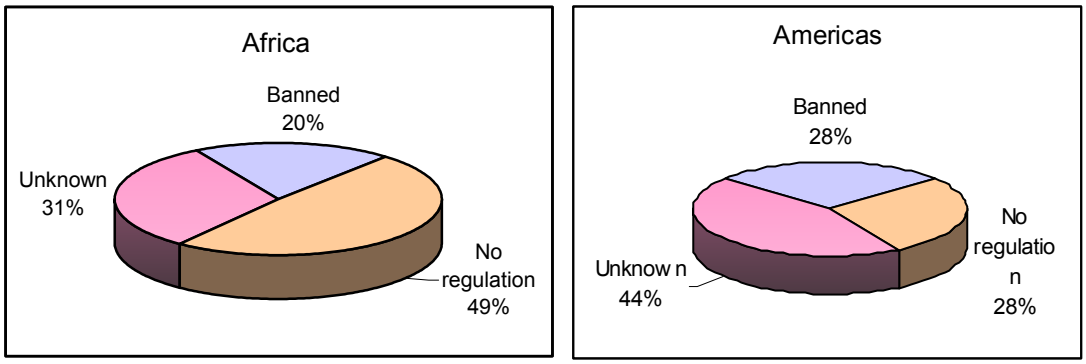
Source: American Cancer Society: *Tobacco Control Country Profiles* (2003)

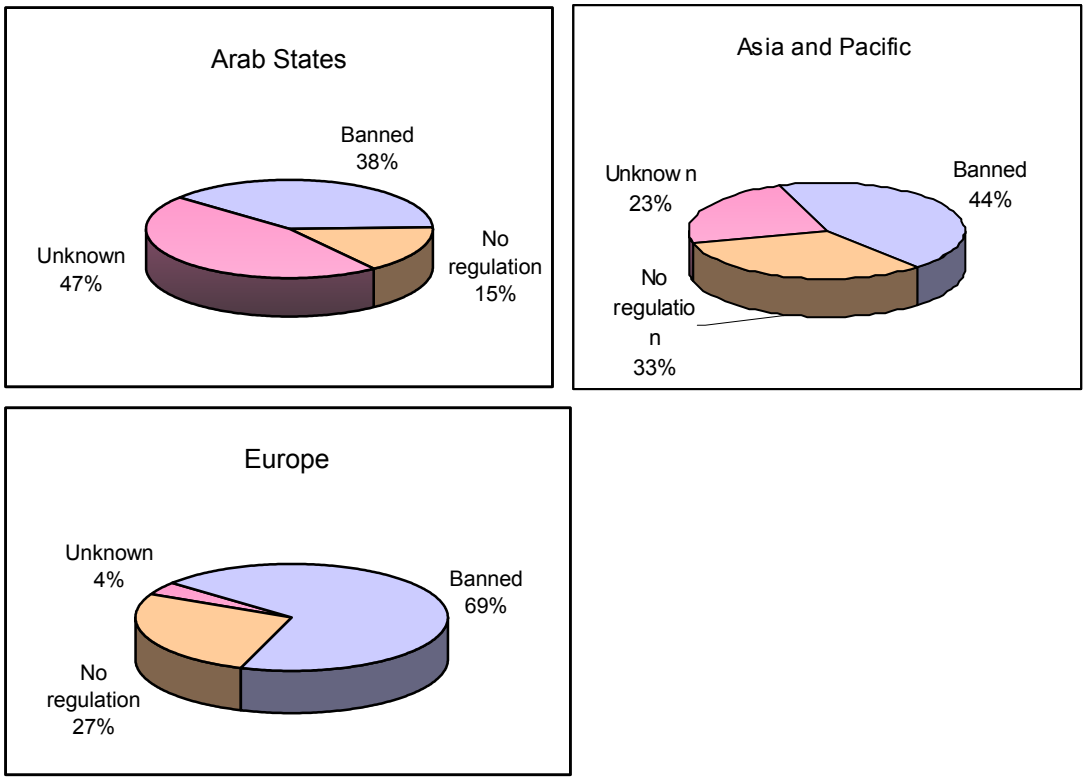
As can be seen in the charts above, the number of countries with legislation regulating smoking in public sector workplaces is also rather high, although less information is available than in the previous categories. This lack of knowledge is illustrated in the pie charts showing legislation in Africa, the Americas and Arab States, where approximately one-third of the countries have been listed in the "unknown" category.
If we look at the number of countries with smoking bans in public sector workplaces, the coverage in the regions are: 75 % in Europe (15 % less than in public places); 69 % in the Arab States (16 % less than in public places), 77 % in Asia Pacific (2 % less than in public places); 35 % in Africa (11 % less than in public places), and 55 % in the Americas (11 % less than in public places).

Private sector employment

Private sector legislation has also been divided into three categories: banned (indicating total ban or with permission to smoke in designated smoking areas), no regulation, and unknown.

Charts 2:3. National legislation regulating smoking in private sector workplaces per region





Source: American Cancer Society: *Tobacco Control Country Profiles* (2003)

Private sector workplaces are a more problematic area to regulate than areas governed centrally, such as public places and public sector employment. This particularly applies to smaller size enterprises. However, it is also true that larger enterprises sometimes introduce smoking policies although no law binds them to do so, a fact that is not reflected in our statistics on workplace legislation.

From the pie charts above it is clear that only Europe can boast a majority of countries banning smoking in private workplaces: 69 % as compared to 75 % in public sector workplaces. In the other regions, rates are approximately half of the rates for public sector employment. The "unknown" factor is also larger in this category: a third of the countries in Africa and Arab States and almost half of the Americas.

Hospitality industry

Legislation to ban smoking in bars, restaurants, casinos and discotheques is a strongly debated issue in Europe, North America, Australia and New Zealand. During the late 1990s and early years of the 2000s, this has been the category of workplace legislation where much and rapid change is taking place. The State of California in the United States was first to completely ban smoking in all workplaces including restaurants and bars. Other states followed suit, while some regions of Canada, Australia, and countries in Europe experimented with models that were not quite bans, but would improve the protection of workers in this sector. In some cases it became forbidden to smoke close to the bar counter, in others the smoking section would be closed off from the rest of the serving area so as to prohibit cigarette smoke from reaching personnel and non-smoking guests. In South Africa, where smoking has been regulated by law since 1993, the Government is considering increasing the fine for the owners of restaurants, bars, pubs and night clubs if they allow smoking in a non-smoking area. The suggested fine for a first offence is 20,000 rand (approximately 2,800 USD) and 100,000 rand (approximately 14,300 USD) if the offence happens is repeated (Tobaksfakta, 19 Oct. 2003).

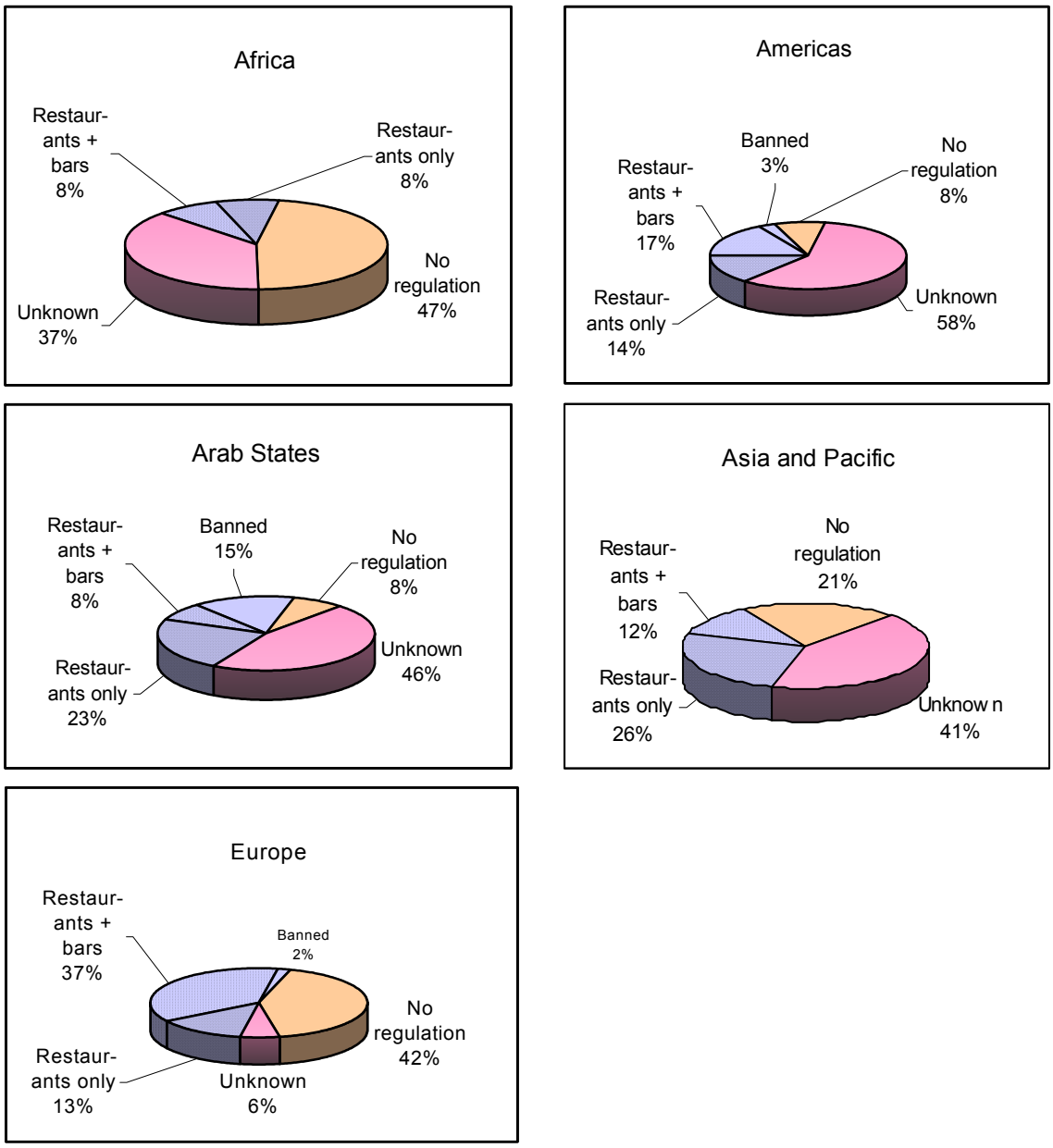
The foremost reason for the controversy is that these areas are considered recreational areas and not workplaces. Workers who can see the logic behind a non-smoking policy in the office or the factory might have a different opinion about the area where he or she goes to relax after work. Restaurant and bar owners have sometimes been fearful about the possible negative consequences of a smoking ban in their establishments in terms of sales. Workers' organizations representing workers in the hospitality industry have also been reticent to support smoking bans out of fear of lay-offs caused by decreasing sales. However, recent activities and campaigns seem to indicate a new trend in which trade unions are joining forces with health-minded anti-smoking non-governmental organizations (NGOs), demanding stronger legislation that would protect their members against exposure to second-hand tobacco smoke. This trend seems to be the effect of increased knowledge about the full impact of exposure to second-hand tobacco smoke in combination with studies from countries with smoking bans showing no loss in sales because of the new legislation (Financial Times, 10-11 May 2003).

The lobbies for the introduction of smoking bans in restaurants, bars, hotels and discotheques can now invoke the findings of various studies that support their viewpoints against the sceptics. A study in Los Angeles of customer compliance with California's smoke-free workplace law found that between 1998 and 2002 compliance rose from 46 % to 76 % in freestanding bars and from 92 % to 99 % in bars/restaurants. The study also looked at workers' compliance with the law, which rose from 86 % to 95 % in bars and from 97 % to 99 % in bars/restaurants. There are other studies that counter the argument of productivity loss being a necessary effect of smoking bans. Six months after the introduction of the smoke-free law in New York, a significant upturn in hotel bookings was noted and an increase of almost 10,000 jobs in the hospitality sector (Action on Smoking and Health news release, 23 Sep. 2003)

Because of the resistance to this type of legislation, it has often been introduced in various stages. In many cases the first step is a government decision to make restaurants and/or other establishments in the hospitality industry smoke-free by a particular date. Information campaigns consequently take place during a period when the concerned persons can prepare for the changes. The second step is often to ban smoking in a specified number of seats or tables, or a specified percentage of the area. It is also common to forbid smoking in the area close to the bar counter in order to protect the personnel working there. In some cases the smoking area must be totally enclosed so as to prevent smoke from spreading to the areas where the employees work or to the area where non-smokers sit. The third step, which until now has been taken only by a handful of nations, is to introduce a complete ban on smoking in the whole establishment (National Institute of Public Health, 2003).

The step-wise introduction of laws regulating smoking in the hospitality sector, resulting in a plethora of laws with slight modifications, is why the pie charts below are more detailed than in the previous categories. The definitions of the different types of legislation in the charts are as follows: ¨banned" (total ban the whole area of restaurants and bars), "restricted in restaurants and bars" (smoking is only allowed in one section of bars and restaurants), and "restricted in restaurants" (smoking is only allowed in one section of restaurants).

Charts 2.4. National legislation regulating smoking in the hospitality industry per region



Source: American Cancer Society: *Tobacco Control Country Profiles* (2003)

As shown in the charts above, not many countries have yet introduced total bans on smoking in restaurants and bars. The only region with a larger coverage of bans is the Arab Region. However, initiatives taking place at the sub-national level in the United States, Canada and Australia, are not reflected in our statistics on national legislation.

Another factor to keep in mind is that many countries are currently in the stage of preparing, developing or debating the introduction of such legislation. It is therefore reasonable to assume that current developments will change the figures above within the near future. To illustrate this changing trend, the Philippines recently adopted a law prohibiting smoking in all public places, including restaurants and bars, and Sri Lanka is developing a draft law based on the contents of the Framework Convention on Tobacco Control. Norway, Ireland and New Zealand passed laws prohibiting smoking in restaurants and bars which will come into force in 2004. In the United States, Florida became the sixth state to prohibit smoking in bars and restaurants as part of a law prohibiting smoking in all workplaces in July 2003. The trend in

the United States started in California, where a smoking ban in restaurants was introduced in 1995 and a ban in bars followed in 1998. The states of Maine, Delaware, Connecticut and New York have followed California's example.

2.3. The evolution of legislation

As already pointed out, countries and regions are at different stages of regulating smoking but the problems they encounter are often similar. There is a recurring pattern of introducing legislation in a similar order, which was pointed out in a report commissioned by the Swedish Government (Enarsson, 2003). According to this report, a common first step is to introduce smoking legislation governing public places. A common second step is to introduce legislation in public sector worksites, notably in the health and education sectors. Many private sector employers tend to go with the trend and introduce voluntary smoking bans before the introduction of private sector legislation, but usually such laws come into place as a third step in the evolution towards totally smoke-free workplaces. The last and most difficult step to take is often to regulate the hospitality sector. As already mentioned, this has been a hard battle in several countries as restaurant, bar and night club owners, as well as trade unions, respond with resistance.

To illustrate this pattern, the various movements and law-making processes related to smoking at work in Brazil and Sweden are compared in the following table:

Table 2.1. The historic evolution of workplace legislation regulating smoking in Brazil and Sweden

Decade	Brazil	Sweden
1960s		The government sets up a group of experts with a mandate to work on the connection between smoking and ill health. Public information campaigns are launched to prevent smoking among young people.
1970s	**1979** Medical societies in Brazil demand tobacco law	Public information campaigns are extended to include adults.
1980s	**1986** Act No.7488 creates National Day Against Smoking **1988** Inter-ministerial Ruling No.3257 recommends measures to restrict smoking in workplaces, to create designated smoking areas, and to award certificates of honour to companies with outstanding tobacco control campaigns. **1989** National network of governmental organizations and NGOs created, linked to Ministry of Health.	Different interest groups demand more information and improved laws for smoke-free environments. **1983** The government releases a document on how to reduce smoking in public places.
1990s	**1992** Tobacco Control and other Cancer Risk Factors Prevention Programme in the Workplace (Ministry of Health) **1996** Act No. 9294 prohibits smoking in collective areas except in designated areas and prohibits smoking in aircraft	**1990** The tobacco expert group of the Ministry of Social Affairs (founded in the 1960s) demands a tobacco law, smoke-free environments and more information dissemination. **1993** The tobacco law is created

	and mass transit vehicles. **1997** The national network is further decentralized to municipality level (26 States, 1,721 municipalities). **1997** National Traffic Code No. 9503 prohibits smoking while driving. **1999** Tobacco-Free Workplaces Programme (Ministry of Health). A survey lead to book called *Implementing the Tobacco Control and Other Risk Factors Prevention Programme in the Workplace* used for training of human resources in some 3,000 municipalities, reaching over 1,000 enterprises. **1999** Decree No. 3136 creates a national commission to prepare Brazil for the international negotiations on the Framework Convention on Tobacco Control (including Ministry of Labour and Employment).	**1994** The tobacco law is strengthened: smoking is only permitted in designated smoking areas in child care establishments, schools, health care facilities, public transport, public places, and restaurants with 50 seats or more. The employer is responsible for ensuring that workers are not exposed to second-hand smoke against their will.
2000s	**2000** tobacco control programmes reach 1,584 schools, 26,694 teachers, 590,607 students, 1,708 workplaces.	**2003** The tobacco law is strengthened: all restaurants must provide smoke-free area(s). A WHO report shows Sweden is the first country within WHO targets for smoking reduction with 16 % for men and 19 % for women. **2004** Parliament has set this year as a goal for totally smoke-free restaurants, at least in areas where employees work. If this does not happen voluntarily, lawmaking may be considered.

Sources: Costa e Silva, 2000; WHO/Brazilian Government, 2000; ILO SafeWork Survey, 2003; Swedish Government documents, 2003: Tobaksfakta documents, 2003; WHO, 2003.

Both countries described in Table 2.1 are considered to be successful in their strategies to create awareness and smoke-free environments. As for reducing smoking prevalence, Sweden has been more successful, but this will be further discussed in Chapter 3.

It is interesting to note that the political and action-oriented course of the two countries have been relatively similar. In the 1960s and 1970s, public support grew in favour of action on the part of the governments with respect to the health problem of smoking, and the first awareness campaigns started in Sweden. In the 1980s, when knowledge about the risks of passive smoking became more generally accepted, public support grew stronger and governments became more active. Both governments issued recommendations regarding reduced smoking and Brazil started the build-up of a national tobacco network. The 1990s were a decade of legislation and action programmes. In Brazil the first federal tobacco law was issued in 1996, and in Sweden, the first version of the tobacco law was introduced in 1993. Parallel to the legislation came two major federal/local workplace programmes in Brazil and similar activities in Sweden, albeit at the enterprise level. The 2000s have so far been the decade of the Framework Convention on Tobacco Control. Many governments are reviewing their legislative framework in order to prepare for ratification. In the case of Sweden, where smoking in public places and workplaces is no longer a major problem, the

current debate is dominated by the issue of protecting workers in the hospitality industry from exposure to second-hand tobacco smoke.

2.4. Successful implementation of smoke-free legislation

Finland has been chosen to illustrate successful implementation of smoking legislation. A report published in 2003 revealed that employee exposure to second-hand tobacco smoke for at least one hour per day had decreased from 51 % in 1994 to 17 % in 1995 and 12 % in 1998. The report also showed that the respondents' tobacco consumption diminished one year after the enforcement of the tobacco legislation, from 30 % to 25 %. Both smokers' and non-smokers' attitudes shifted gradually towards favouring a total ban on smoking at work. The nicotine concentration in the work areas also significantly decreased (Heloma et al, 2003).

The reasons behind Finland's success are various, including a relatively early start of a multi-pronged strategy and the emphasis on smoke-free workplaces. Finland was one of the first countries to introduce legislation regulating smoking at work and is the only country in Europe to list cigarette smoke on the list of occupational cancer-causing substances.

The awareness of the negative health aspects of smoking was already a concern in Finland in the 1950s. In 1961, the Parliament urged the government to adopt strong measures for the reduction of smoking. Since then, an effective tobacco policy has followed, primarily built on four approaches: health promotion, legislation, research and a price policy with high cigarette taxes. The successful combination of the four approaches has led to some of the lowest smoking rates for men in Europe: From 76 % in the 1950's to 27 % in 2002 (Reijula 2000; Simonen, forthcoming).

The legislation underpinning Finland's promotion of smoke-free workplaces matured through the following stages:

Box 2.1. Finnish legislation ensuring smoke-free environments

1977 Tobacco Act: Smoking bans in schools and child-care facilities, government agencies and institutions, indoor public events, public transportation.

1995 Revised Tobacco Act: Smoking ban in all workplaces except in designated smoking areas. Exception: restaurants and hotel rooms.

2000 Revised Tobacco Act: Second hand tobacco smoke classified as an occupational carcinogen; At least 50 % of seats in restaurants must be smoke-free by July 2001. Smoke must not spread from smoking to non-smoking areas and smoking is not allowed at bars and gaming tables. Pregnant restaurant workers must be transferred to smoke-free areas.

When the workplace tobacco law was introduced in 1995, offices had to a great extent already introduced voluntary smoking restrictions, particularly since the beginning of the 1990s. In fact, if in 1984 two-thirds of the total number of employees had been exposed to second-hand tobacco smoke, that number fell to 39 % by 1994. However, the introduction of the 1995

Revised Tobacco Act still made a big difference. The proportion of workers in medium and large-scale workplaces exposed to second-hand tobacco smoke for more than four hours daily, fell from 32 % to 8 %. Another effect of the revised legislation was a declining number of smokers, as well as a fall in the average number of cigarettes smoked (Heloma, 2001; Reijula, 2000).

The fact that the 2000 Revised Tobacco Act included tobacco smoke in the list of dangerous occupational substances is a result of the seriousness with which the Finnish Government considers the health hazards of exposure to second-hand tobacco smoke. This development dates back to 1988 when the Ministry of Labour first took up smoking on the agenda of workplace health and safety. When second-hand tobacco smoke was added to the list of workplace carcinogens in 2000 as a measure to protect workers via the Occupational Safety and Health Act, it was an innovative way of legitimizing the seriousness of the problem. It also shifted the issue from being considered merely a wellness or lifestyle issue to a serious workplace health and safety hazard that should be prevented by the authorities responsible for workers' health and safety.

Another important factor for the implementation of legislation is enforcement. In the case of Finland the division of responsibilities is clearly defined (see box 2.2.).

Box 2.2. Organisms responsible for the supervision of smoke-free legislation in Finland

Local authorities: Schools, child-care facilities, indoor government agencies and comparable bodies, and public transport

Occupational safety and health authorities: Ensure that employees are protected from second-hand tobacco smoke including in public places, bars and gambling tables.The legal base of their work is the Act on the Supervision of Occupational Safety and Health and the Appeal Procedure in Matters concerning Occupational Safety and Health.

Police: Public events

Instead, it is considered ¨normal¨ to go outdoors to smoke a cigarette. A good illustration of this attitude is the European survey described in Chapter 4 showing that non-smoking signs are less frequent in Finnish restaurants, probably because people are aware of the restrictions and do not need any reminder.

However, the Finnish scenario is not completely devoid of problems. One of them is small-scale enterprises where sometimes, contrary to the law, employers and employees decide to allow smoking. In the year 2000 one-third of all employees still reported exposure to second hand tobacco smoke. Some taxi drivers still smoked in their cars when waiting for clients. Restaurants also continue to resist anti-smoking measures. In spite of a transition period to ensure smoke-free areas by 1 July 2003, only coffee shops, cafes, lunch and dinner restaurants are really smoke-free. Nightclubs, dancing restaurants and pubs are still areas where smoking is tolerated (ibid.).

The successful combination of awareness campaigns, legislation, enforcement and price policies have led to smoke-free workplaces and a considerable drop in tobacco consumption in Finland. The main factors behind Finland's success in creating smoke-free workplaces are:

1. The awareness level is high thanks to a long tradition of promotion efforts (including awareness campaigns, price policies and legislation).
2. Legislation was introduced step-wise and always with broad public support.
3. The government has showed commitment towards the creation of smoke-free environments.
4. The government has treated smoking as an item on their occupational health and safety agenda (tobacco smoke was added to the list of workplace carcinogens, facilitating the enforcement of the occupational safety and health law by labour inspectors).
5. The clear division of responsibilities related to supervising the smoke-free legislation enhances the enforcement of the laws.

2.5. Is legislation necessary?

In this section we shall consider the question whether legislation is a necessary ingredient in a strategy to promote smoke-free workplaces. To illustrate the debate surrounding this question we shall look at the experiences of two western European countries of approximately the same size: France and Great Britain. Although these countries are similar in many respects, they have gone different ways in tackling the problem of smoke-free workplaces.

Great Britain

Second-hand tobacco smoke is considered a serious health risk by large sections of the population in Great Britain. Lobbying and media attention have played important roles in changing the attitudes and smoking habits of the people. Another reason for the change of attitudes is the price policy that has pushed up cigarette taxes. However, in line with the British legal tradition, preferring to solve a problem through a minimum of legal instruments, no new legislation was created to regulate smoking at work. When a proposal to an Approved Code of Practice was developed in 1999, the idea was that this instrument would facilitate the use of already existing legislation and guide employers in their work to protect workers' health.

In the 1990s, in line with similar trends involving stepped-up campaigns in other European countries, the British Government adopted various measures to promote smoke-free environments. Below follow some important developments since 1997:

1997

- A survey carried out on behalf of the Department of Health demonstrates considerable support for restrictions on smoking: 84 % for restrictions at work, 85 % in restaurants, 51 % in pubs and 85% in other public places.

1998

- The Scientific Committee on Tobacco and Health (SCOTH) publishes a report concluding that long-term exposure to second-hand tobacco smoke damages health.
- The government publishes *Smoking Kills – A White Paper on Tobacco*, setting out the government's strategy on tobacco control. The main point of the strategy is to reduce smoking, also in workplaces.
- The Department of Health initiates collaboration with the licensed hospitality trade (pubs, restaurants and hotels) to increase non-smoking areas.

1999

- The Health and Safety Executive develops an Approved Code of Practice: a legally binding instrument providing practical guidelines on how to use existing occupational

health legislation and guidelines on how employers can reduce or eliminate workers' exposure to second-hand tobacco smoke. In many workplaces the implication would be a total smoking ban. In others, such as in restaurants and bars, it would mean a partial ban. In all cases, the Code of Practice would have been legally binding on all employers, contrary to the previous voluntary approach. Pubs and bars would be given two years to comply with the new rules.

2000

- The Approved Code of Practice is endorsed by the Health and Safety Commission.
- The Department of Health and the licensed hospitality trade introduce a Public Places Charter according to which consumers should be better informed about the smoking policies of restaurants, pubs and bars.

2001

- 155 members of Parliament sign a motion in support of the Approved Code of Practice
- National Statistics publishes a report showing that 71 % of smokers want to give up smoking, 86 % would like workplace smoking restrictions, 88 % restrictions in restaurants, 86 % in public places.
- Britain's General Union (GMB), representing 700,000 members (of which 35,000 are in food and drink retail), calls for increased protection for bar and restaurant workers at their congress.

2002

- The Smoking in Public Places Investigative Committee recommends that the Government re-examine the Approved Code of Practice (London Assembly 2002: 27).
- GMB makes the following statement about the Public Places Charter: "A voluntary code is not enough for workers in the hospitality industry, we need tougher action in the form of a legally enforceable code of practice¨ (BBC News Online, 12 March 2002).

2003

- The Approved Code of Practice is still pending for government approval, four years after its creation. The lobby for smoke-free workplaces includes politicians, trade unions, employers, safety and health agencies and NGOs. At the top of their agenda is government approval of the Approved Code of Practice.
- A study released by the British NGO Action on Smoking and Health (ASH) (Repace, 2003) concludes that around 900 office workers, 165 bar workers and 145 manufacturing workers die each year as a direct result of second-hand tobacco smoke at work.
- During a conference organised by Action on Smoking and Health, the Trade Union Congress (TUC) and the Chartered Institute of Environmental Health (CIEH) call for the implementation of the Approved Code of Practice. The President of CIEH (the institute representing health inspectors responsible for enforcing such codes in service sector workplaces), says that, "Environmental Health Officers want to help protect workers vulnerable to passive smoking, but they need the government to provide them with the right tools to do the job¨ (BBC News Online, 23 April 2003).

Therefore, there is mounting public pressure to introduce legislation to protect workers from exposure to second-hand tobacco smoke in Great Britain, but emphasis remains on voluntary initiatives and there is a reluctance from employers and within the government to pass and implement a binding Approved Code of Practice.

France

The road taken by France to achieve smoke-free workplaces is quite different from the road taken by Great Britain. Rather than avoiding legislation, the first French smoking law was introduced already in 1977.

1977

- The Veil law (*loi Veil*) comes into force. Smoking is banned in public places and schools. The law grants NGOs the right to file complaints if the law is violated. Cases supporting employees suffering from second-hand tobacco smoke are taken to a court called *le conseil de prud'hommes*, composed of union and company representatives in equal proportions.

1992

- The Evin law (*loi Evin*) comes into force, banning smoking in all enclosed and covered places where at least two persons work. Individual workspaces, such as offices where only one person works, are not regulated. The law stipulates that the rights of non-smokers should be respected in open workplaces and encourages employers to provide a designated smoking area. In practice this means that reception areas, common eating areas and meeting rooms must become totally smoke-free, but further measures to protect workers from second-hand tobacco smoke are mainly up to the particular employer to decide.
- The publication *Le tabac sur le lieu de travail* is published by the Ministry of Labour to help employers comply with the law.

1995

- A survey evaluating the effect of the Evin law shows that 57 % of the respondents have not taken any action since the change of law. A third of the respondents claim to have introduced changes before the law. Most action is taken among the larger enterprises (with 50 or more employees). Reasons given for ignoring the law are lack of interest among employees or employers, or agreements between smokers and non-smokers. Some of the lack of interest seems to be due to low awareness levels about the risks of passive smoking (Grizeau, 1997:185-206).

1999

- An evaluation commission presents a report on the effects of the Evin law. The most important improvement is a change in public attitudes indicating less tolerance of exposure to second-hand tobacco smoke, or the denormalizing of smoking.

2001

- A study of the French occupational health system shows that smoking is banned in 68 % of workplaces and that the prevalence of workers exposed to second-hand tobacco smoke is 14.6 %. The same study shows that 29 % of smokers have changed their behaviour because of the Evin law, and 12 % of smokers say that they smoke less because of the law (Alcouffe, 2003: 239).

2003

- President Chirac launches a National Cancer Plan, in which tobacco plays a central role. Among the elements of the plan are: a campaign for schools without tobacco, expansion of health insurance to cover nicotine replacement therapy, training of doctors in tobacco questions, and improved enforcement of the Evin law.

Although laws were enacted at an early stage, they did not achieve what the government had intended during the first decades. This failure to implement the laws seems to have been

caused by a general lack of awareness, both of the existing legislation and of the negative health consequences caused by second-hand tobacco smoke. Another weakness was the lack of public support for the law, one of the key success factors in Finland, as described in the previous section. It could be argued that these weaknesses are related to the lack of systematic campaigns specifically targeting workplaces. The only exception, until President Chirac's call for increased awareness in 2003, was the employers' guide published by the Ministry of Labour in 1992.

Another difference between the developments in Finland and France was that the Evin law had no clear link to the portfolio of enforcement of occupational health and safety laws. The Evin law comes under the public health code (*Code de santé publique*) and not the labour code (*Code du travail*), complicating the involvement of labour inspectors in controlling the implementation of the law (Dubois, 2002). To a certain degree, the right to take disputes to the *Conseil de prud´hommes*, granted in the Veil Law, filled this gap of enforcement. NGOs have taken many complaints related to workplace smoking through this court, thus creating publicity around the existing rights to protection from exposure to second-hand tobacco smoke.

The Evin Law is also less restrictive and prescriptive than the Finnish law, and thus easier to ignore. If there is agreement in a room shared by several employees to smoke, for example, this can be done in France. Another example is the right of French employers to refuse the creation of a designated smoking area (Trédaniel, 2000: 26-30).

With the National Cancer Plan in 2003, however, the French Government stated a very clear new commitment to reverse the previous trend. A significant increase of awareness levels through nation-wide campaigns and increased education, as well as improved enforcement of existing legislation are important components of this national action plan.

To sum up

Both the governments of France and Great Britain consider workplace smoking a serious health hazard. However, they chose different roads to reach results. Whereas Great Britain has tried to promote smoke-free workplaces without legislation, France began by creating a law. In Great Britain, support is mounting for the introduction of a law. In France, the most recent drive of the government is to increase awareness and enforcement of existing laws. These two examples seem to support the conclusion that the introduction of legislation alone will not solve the problem, but that it is one of several factors which together could contribute to real change.

A study of trends in smoke-free workplace policy coverage in the United States (1993-1999) further illustrates this point. This exercise was built upon a Tobacco Use Supplement added to the Census Bureau's Current Population Survey. Results from the survey showed that nearly 70 % of the workforce in the United States worked under a smoke-free policy in 1999. However, differences as large as 30 % existed among the various States, depending on the type of legislation in force. The conclusion of the study was that the implementation of comprehensive regulation is crucial to achieve real progress if the protection of workers from second-hand tobacco smoke is to be achieved (Shopland, 2001).

2.6. The role of labour inspectors

The fundamental function of labour inspectorates in respect of indoor workplaces is to avoid any risks to workers' health and safety. They consequently have an important role to fill in

relation to legislation banning or regulating workplace smoking. Factors that have an impact on labour inspectors' work related to workplace smoking are:

1. The duties and responsibilities of the different actors involved in terms, inter alia, of:
   - ✓ Employers/employees/public
   - ✓ Government/legislators
   - ✓ Information/publicity/training
   - ✓ Research.

2. The role of the labour inspectorate in raising awareness and securing compliance in terms, inter alia, of:
   - ✓ Actual and anticipated role
   - ✓ Clarity of legislative provisions
   - ✓ Enforcement problems and solutions
   - ✓ Information provision and advice
   - ✓ Clarifications of tolerability of exposure (SLIC, 2004).

Another issue is ventilation, an item tabled for discussion by the Senior Labour Inspection Committee (SLIC) during a thematic day on 20 May 2004 in Dublin entitled "Environmental Tobacco Smoke (ETS) at the workplace" together with all EU Member and Accession States. The SLIC Committee is a forum for discussion between the European Commission and the representatives of the national authorities who are, among other things, responsible for monitoring the enforcement of secondary Community law and who are consequently in direct contact with the social partners. It is also a forum for the national authorities to compare experiences of the structure, methods and instruments of labour inspection.

The stance taken by SLIC on ventilation is the following: "If smoking is not banned, then risks need to be evaluated and preventive and protective measures implemented but it is also important to note that no tolerable level of ETS exposure has been suggested or recommended¨. SLIC recognized that some countries may not be able to introduce a smoking ban through legislation or workplace policy, especially in areas such as the hospitality and prison sectors, at least not in the short term. In such cases measures would have to be taken including:

- ✓ Segregating and sealing smoking areas
- ✓ Using ventilation to improve air quality in those areas where smoking is permitted
- ✓ Selective banning of smoking in certain work areas
- ✓ Non-smoking areas, which vary according to the time of the day
- ✓ Limiting employees' exposure to environmental tobacco smoke by monitoring and restricting the time they spend in smoking areas (SLIC, 2004).

However, most of these solutions will depend on some type of ventilation which, as pointed out in Chapter 1, will never completely protect non-smokers from the risks. Some solutions even entail that smokers are placed at greater risk.

2.7. Chapter 2. Summary

Legislation protecting workers against exposure to second-hand tobacco smoke exists to an increasing extent at the national or sub-national level. At the international level, the Framework Convention on Tobacco Control includes important passages that place obligations on States Parties to develop more smoke-free work environments. Years of negotiating the Framework Convention on Tobacco Control increased awareness and inspired many nations to start or intensify their work to ensure more sustainable efforts in this

direction. Regional initiatives exist, but no binding agreement has yet been created regarding work-free workplaces.

National laws regulating smoking exist in various forms. The most common laws ban or restrict smoking in public places. The intention of these laws is primarily to protect the general public, but since these places are also the workplace of many, they also serve to protect workers from being exposed at their workplace. Quite common also are the laws which regulate smoking in public sector workplaces. The more difficult areas to regulate are private sector workplaces and the hospitality industry. In private enterprises, it is not uncommon that the larger companies set a trend of smoking policies even before a law is in place, but it remains difficult to implement laws banning smoking in smaller enterprises. The most controversial area is the hospitality industry, where some states in the United States took the lead in the 1990s and where Australia, Canada and Europe are following suit in the 21st century amid a lively public and political debate.

Many countries have followed a similar step-by-step development of legislation, evolving from smoking bans in public places, to eventually include public sector workplaces, private sector workplaces and, in time, the hospitality industry. However, for this gradual evolution to be successful, it is important to support the implementation of laws with awareness campaigns and various incentives for people to stop or reduce their smoking, such as stop smoking initiatives and cigarette taxes. It is also important that the legislative framework clearly states who is responsible for the enforcement of the law. The importance of collaboration within governments and treating exposure to second-hand tobacco smoke as an occupational safety and health issue cannot be understated.

Regarding the relevance of legislation in the promotion of smoke-free workplaces, a legislative framework is important in many respects. First, a law is one of many measures that "normalizes" non-smoking at work as it places obligations on workers to change their smoking behaviour. This forced change of behaviour can eventually change attitudes towards smoking so that it becomes ¨normal" to go elsewhere when smoking. Secondly, a law institutionalizes the rule of non-smoking and facilitates enforcement. Thirdly, a law may be the only efficient means of achieving change in sectors such as the hospitality industry and smaller enterprises, which are more difficult to persuade through non-legislative measures.

Finally, the role of labour inspectors was discussed. As pointed out earlier, the only way of avoiding the risks of exposure from second-hand tobacco smoke is a total smoking ban. However, in places where a ban is not yet feasible, the labour inspectors should consider other preventive and protective measures. Labour inspectors also have an important role to fulfil in raising awareness and securing compliance with rules and regulations related to workplace smoking.

Chapter 3. Good practices: Carried out by governments, workers and employers

Chapters 1 and 2 of this paper reported that to achieve the right preconditions for successful smoking regulations, different factor need to keep in mind. Laws in themselves are not sufficient for the creation of smoke-free workplaces. The commitment of governments, employers and workers is crucial. Before real change occurs, attitudes must change and, as a consequence, behaviours. It must also be clear who is responsible for the implementation and enforcement of laws and regulations.

Again, it is interesting to ask the question: Why do we want to create smoke-free workplaces? A study of regulations and campaigns related to smoking at work in different countries, suggests two points of departure. In the first, the objective is to achieve an overall decline in smoking prevalence, workplaces being one of many targeted environments. The second objective specifically targets the workplace and second-hand tobacco smoke as an occupational safety and health hazard. Within the same government, achieving each objective is usually the responsibility of two different ministries: the ministry responsible for health on the one hand and the ministry responsible for labour on the other.

The overall aim of health authorities to reduce smoking prevalence is furthered by workplace smoking bans. Studies have shown that smoke-free workplaces have a clear effect on people's smoking behaviour. Workers who are forced to go to designated smoking areas at certain times of the day because they are no longer allowed to smoke at their place of work, tend to quit smoking more often and smoke fewer cigarettes than those who work in workplaces without regulations (Fichtenberg, 2002; Farrelly, 1999).

The promotion of smoke-free workplaces contributes to a safer and healthier working environment by limiting the exposure to second-hand tobacco smoke. Studies in the State of California, United States, where smoking legislation covering all workers was introduced in the 1990s, show an increase in smoke-free workplaces from 35 % in 1990 to 93.4 % in 1999. The resulting drop in exposure to second-hand tobacco smoke among non-smoking indoor workers was considerable as it decreased from 29 % in 1990 to 15.6 % in 1999 (Gilpin, 2002). Another study of exposure to second-hand tobacco smoke among non-smoking workers in New Zealand showed that workers in smoke-free establishments had a significantly lower level of cotinine[16] and less respiratory problems and irritation than workers in establishments where smoking was allowed (Bates, 2002).

Depending on which objective is selected to promote smoke-free workplaces, there may also be different criteria for success. If the objective is to reduce smoking rates, smoke-free workplaces will be one of many components, including education of children and youth, banning advertisement of tobacco products, adding warning texts to cigarette packs and raising cigarette prices (World Bank, 2000). From an occupational safety and health perspective, reducing smoking rates is interesting from a general health perspective. However, the main focus is to reduce the exposure to second-hand tobacco smoke and to avoid discrimination between smokers and non-smokers, which creates unacceptable working conditions.

[16] Cotinine is a chemical that is made by the body from nicotine, which is found in cigarette smoke. Since cotinine can only be made from nicotine, and since nicotine enters the body with cigarette smoke, cotinine measurements can show how much cigarette smoke enters your body.

In Chapters 3 and 4, practices from different countries related to the promotion of smoke-free workplaces will be examined. Chapter 3 specifically looks at the important involvement and commitment of the social partners: governments, employers and workers.

3.1. Committed governments

As demonstrated in Chapter 2, firm support from the government is essential if regulatory frameworks and campaigns are to be effective. There is increasingly strong commitment on the part of governments to this serious issue, as demonstrated during the intense negotiations which took place before the adoption of the Framework Convention on Tobacco Control in 2003 by the States Parties of the World Health Assembly. Interdepartmental committees sprang up in many countries to discuss dimensions of the Convention and to coordinate national activities related to smoking. Some nations even took it upon themselves to organize discussions between interested parties in between the half-yearly official negotiating rounds in order to find answers to some of the more difficult questions.

The responses to the ILO SafeWork Survey "Smoking at Work" show that many governments are concerned about the principle of clean air for workers. A tobacco control office has been created in many countries, usually under the ministry responsible for health. Tobacco laws have been created or improved, awareness campaigns are being carried out, and different types of incentives are offered to employers to introduce smoking policies.

Thailand has a long history of regulating smoking with legislation dating all the way back to the 1970s. One key behind their success is the formation of a broad coalition between the government and other actors. Another key is the tendency to treat smoking as a workplace safety and health issue.

Box 3.1. Thailand. A multi-sectoral response

In 1989, Thailand's National Committee for Control of Tobacco Use was initiated, chaired by the Minister of Public Health, recognizing the need for a multi-sectoral response to the problem of smoking. Other members include the National Legislative Assembly's Committee on Health and the Environment, the Ministries of Health, Finance and Education, the media and experts from non-governmental organizations. The involvement of the Ministry of Finance is important because of its control over production and sales of tobacco products (Chitanondh, 2000).

The 1992 Non-smokers´ Health Protection Act outlawed smoking in public places and workplaces. In November 2002, this law was expanded to include 19 additional smoke-free environments, including restaurants.

Complementing the work of the National Committee for Control of Tobacco Use, the Thai Health Promotion Fund, established in 2001, carries out promotion of smoke-free workplaces. There are also programmes established for departments under the Ministry of Public Health, e.g. the Departments of Medical Services and Health. One of these programmes is specifically concerned with smoking at work and workers' health promotion. It is implemented throughout the country at national, regional, local and enterprise level. The programme is linked to "WHO Healthy Cities" and "Healthy Workplace Guidelines"(Bureau of Occupational and Environmental Diseases, ILO SafeWork Survey, 2003).

In Europe, progress has been achieved in creating smoke-free environments in most countries thanks to decades of diligent health promotion. Although countries in eastern Europe still struggle with some of the highest smoking rates in Europe, this is also the region where the most significant changes are taking place (ILO SafeWork Survey, 2003; WHO Europe, 2001).

In terms of legislation, a compilation made by WHO Europe in 2001 shows that most countries with a complete ban were from the eastern parts of Europe. The total list included: Bulgaria, Croatia, Czech Republic, Estonia, Finland, Hungary, Iceland, Israel, Lithuania, Poland, Russian Federation, Slovakia, Sweden, the former Yugoslav Republic of Macedonia and Turkmenistan. Other important factors in an efficient government effort are national action plans and inter-sectoral coordinating bodies. In 2001, half of the European countries had both an action plan and a coordinating body, and at the top of the list were countries from Eastern Europe. However, the work was often hampered by lack of adequate funding (WHO Europe, 2002;36).

Responses to the ILO SafeWork Survey showed both perspectives: progress and commitment on one side and an attitude of resistance on the other.

Box 3.2. Eastern Europe: Commitment and complications

In Bulgaria, despite the smoking legislation in place, smoking prevalence ranks among the highest in the world. A partial explanation of this development could be the liberalization of policies in all domains of life during the period of transition, resulting in more tolerance of smoking at work. It is also difficult to enforce the laws effectively because of the lack of appropriate fines and penalties (National Center of Hygiene, Medical Ecology and Nutrition, ILO SafeWork Survey, 2003).

Belarus is also facing rising smoking rates, especially among young people and women. In order to counter this problem, a law passed in 2002 prohibits smoking in public places and government buildings except in designated smoking areas. A five-year health promotion plan has been set up for 2002-2006, including awareness campaigns, training courses and research related to smoking and other health problems. The government will collaborate with enterprises, organizations, and educational and social institutions in carrying out the health promotion plan (National Information Centre on Safety and Occupational Hygiene, ILO SafeWork Survey, 2003).

Latvia adopted a tobacco law in 1997 and established a State Committee on Limitation of Smoking. This coordinating institution is a broad tripartite coalition and includes representatives from healthcare organizations, the employers' confederation, trade unions, the tobacco industry, the Ministries of Welfare, Finance, Economy and the Ministry of Education and Science. A non-profit organization called the Health Promotion Centre functions as a secretariat of the committee. The objective of the committee is to ensure people's right to clean air unpolluted with tobacco smoke. It coordinates activities related to the limitation and prevention of smoking, smoking cessation, as well as questions related to tobacco production. Concrete activities include the campaign ¨Week without Tobacco Fumes¨ and the ¨Non-smokers Health Day¨ campaign (State Labour Inspectorate, ILO SafeWork Survey, 2003).

A 1992 study in Estonia showed that 54 % of men and 30 % of women worked in a smoky environment at least one hour per day. In 2002, the equivalent figures were 25 % for men and 10 % for women. The Health Insurance Fund carries out a campaign called ¨Free From Tobacco,¨ covering the whole population in Estonia (National Labour Inspectorate, ILO SafeWork Survey, 2003).

Croatian workers have been protected from tobacco smoke since 1997 when a provision for that purpose was incorporated into the Work Safety Act. Inspectors can now fine any worker found smoking outside a designated smoking area. They can take employers to court for not implementing measures for protection of non-smokers. The court has the right to punish a flouting employer with a substantial fine. Since the introduction of this provision, smoking at work has substantially decreased (Republic of Croatia State Inspectorate, ILO SafeWork Survey, 2003).

Another region with high smoking rates and increasingly committed governments is the Middle East. The box below gives samples of activities going on in three countries in this area.

Box 3.3. The Middle East: Iran, Saudi Arabia and Syria

Iran's effective smoke-free programme is said to be the reason behind a decrease in the nation's smoking prevalence from 14.6 % in 1991 to 11.7 % in 1999. This decrease is due to the successful enforcement of a new policy and the subsequent change in social values. At the core of the programme is the law passed in 1997 "Ban on smoking and supply of cigarettes and other tobacco products at public places". This law bans smoking in "roofed public places", including all workplaces. In addition, the government has established counselling clinics for people who want to quit smoking and carried out awareness-raising activities (Ministry of Health and Medical Education, 2002).

A Syrian decree in 1997 banned smoking in public places, including workplaces. Syria has also produced a national code of practice preventing people from smoking at work as well as a national programme on tobacco control managed by the Ministry of Health (ILO SafeWork Survey, 2003).

The increased smoking prevalence in Saudi Arabia has led the government to react. A Royal Decree now bans smoking in public places, government departments and schools. Anti-smoking campaigns and quit-smoking clinics, including mobile clinics, are other elements of the stepped-up struggle against smoking. WHO acknowledged the Saudi Arabian efforts in 2001 when King Fahd received a special award (UICC GLOBALink, 1 March 2002).

Costa Rica is one of the most determined governments in Latin America with regard to the goal of reducing smoking. As a result, Costa Rica has managed to halve the smoking prevalence of the population from the 1970s until now.

Box 3.4. Costa Rica: Oficina para el control del tabaco

The most important pillars of the Costa Rican strategy for smoke-free environments are:

1. The tobacco law (1995) banning smoking in practically all workplaces except bars and restaurants;
2. A tobacco control office *Oficina para el control del Tabaco* (established 1999) under the drug and alcohol institute IAFA (Ministry of Health). The role of the office is to give advice and disseminate information. Among the activities carried out by the tobacco control office are:
    - *Trazando el camino:* an educative programme for schools
    - Awareness campaigns during the annual event World No Smoking Day (31 May)
    - *Deje y Gane:* a quit and win competition to help smokers quit
    - Dissemination of scientific facts around the risks of smoking
    - *Guíe a sus pacientes a un futuro libre de tabaco:* a course for health personnel about the problem of smoking
    - Project for the promotion of smoke-free places (started in 2001)
    - A joint exercise between WHO and the Ministry of Health, IAFA, and the Costa Rican social insurance company, *Caja de seguro social.* This project is further described in Chapter 4 (WHO, forthcoming).

Similar to other large nations such as Canada and Australia, the power to regulate smoking at work in the United States lies at the state or municipal level. The strength of these laws are not at the same level in all states, but as mentioned in Chapter 2 of this paper, some texts of the United States state legislation are the most progressive in the world. A study carried out by the Center for Disease Control and Prevention illustrates that states which spend more on programmes to reduce smoking (Arizona, California, Massachusetts and Oregon) have experienced a drop in cigarette sales between 1990 and 2000 that is twice (43 %) that in the whole country (20 %) (CDC press release, 18 Sep. 2003).

Box 3.5. USA: Florida referendum

A Florida referendum in 2002 illustrates the importance the public attaches to a smoke-free environment in this State. For the first time, voters had the opportunity to choose whether or not they wanted a constitutional amendment to ban smoking in the workplace. An overwhelming 70.8 % voted for the amendment that prohibits tobacco smoking in enclosed indoor workplaces, including restaurants. In doing so, Florida joined California, Maine, Utah and Vermont as well as cities such as New York and Boston which have passed similar laws (*Safety and Health*, Jan 2003:10).

The New Zealand Government has been in the forefront of tobacco control for a long time with a comprehensive set of programmes and legislation. A lively debate is still on and progress in the country is steady.

Box 3.6. New Zealand: Hospitality sector next

One of the goals of New Zealand's comprehensive tobacco control programme, launched in 1985, was to create smoke-free workplaces. The 1990 Smoke-free Environments Act, which had won strong public support, cemented this drive for smoke-free workplaces. The law, which was subsequently amended twice, compelled employers to have a written smoking policy that would be reviewed every year. The 1990 law with amendments, regulates smoking in offices, public places, schools and parts of restaurants and bars. In 1996, the Ministry of Health established a regional smoke-free enforcement service.

Although smoking prevalence has decreased dramatically since 1990, all workers are still not protected from the exposure of second-hand tobacco smoke: some blue-collar workers and workers in the hospitality sector still fall outside the scope of smoking legislation. In December 2003 parliament approved an amendment bill that would strengthen the 1990 law to cover all indoor workplaces including restaurants and bars (WHO, forthcoming).

3.2. Committed workers' organizations

There has not been unity around the question of smoking in the world of trade unions, and to a certain extent that disunity still exists in 2003. The hesitant attitude towards tobacco control

has its roots on the one hand in fear that jobs will be lost in the hospitality industry if smoking regulation causes the industry to lose clients. On the other hand, unions representing workers in the tobacco growing and manufacturing industry fear loss of jobs as smoking rates decline.

However, a growing number of organizations representing workers in the hospitality industry has been convinced that protection of their members' health, i.e. from exposure to second-hand tobacco smoke, is a worthy cause.

One example of forceful trade unions supporting workers in the hospitality industry can be found in Australia.

Box 3.7. Australia: SmokeFree '03

The responsibility for smoking regulation in Australia rests primarily with state and territory governments. However, a National Tobacco Strategy was endorsed in 1994. One of the key elements of the strategy was the ban on smoking in enclosed public places or workplaces.

Although all states and territories have introduced legislation to reduce passive smoking in workplaces, none has so far introduced complete smoking bans in the hospitality industry, i.e. bars, restaurants, clubs, hotels and gambling venues (Risely, 2003). The trade unions have been lobbying very vocally for stronger legislation or smoke-free policies in particular venues. The Liquor, Hospitality and Miscellaneous Workers Union (LHMU), for instance, created a joint campaign with doctors and lawyers in 2001, setting up a web site with a passive smoking register enabling workers to document any smoking-related respiratory illness. This data could then be used as the basis for legal action to defend workers suffering from exposure to second-hand tobacco smoke at work (Robinson, 2001).

In 2003, LHMU went one step further, joining forces with a broad coalition constituted by the Musicians' Union of Australia; Media, Entertainment and Arts Alliance; Australian Council of Trade Unions; Action on Smoking and Health Australia; The Cancer Council Australia; National Heart Foundation of Australia; Australian Council on Smoking and Health; and Non-Smokers' Movement of Australia. This alliance calls itself SmokeFree '03 and maintains a web site with information related to smoke-free policies. Apart from information about smoke-free workplaces and excerpts from Australian laws, information about legal complaints, the Disability Discrimination Act and the Human Rights and Equal Opportunity Commission can be found on the following web site: www.ashaust.org.au/SF'03/partners.htm.

Another country where previously hesitant trade unions are now clearly for the protection of workers against exposure to second-hand tobacco smoke is the United States.

Box 3.8. United States. Organized Labor and Tobacco Control Network

The Organized Labor Tobacco Control Network was established in 2002. It is a joint effort of the Center for Community-Based Research at the Harvard-affiliated Dana-Farber Cancer Institute and the Department of Work Environment at the University of Massachusetts at Lowell.

Drawing on the fact that workers in blue-collar and service jobs tend to be more exposed to second-hand tobacco smoke and less successful in quitting smoking than white-collar workers, this network serves as a catalyst for collaboration between individuals and organizations in the labour and tobacco control movements.

The Network suggests that unions and the tobacco control movement, together, could:

- Provide union members and their families with information and referrals for preventing and stopping tobacco use;
- Join together in coalitions in support of tobacco control policies, such as smoke-free worksites and coverage for smoking cessation services;
- Advocate labour management health service providers to extend coverage of smoking cessation services and
- Divest union pension funds of tobacco company investments.

The Network offers the following services:

- Consultation on how to create links between the labour movement and tobacco control movements
- Information, presentations, and other resources about how to work with trade unions and the tobacco control movements
- Networking, research, and educational opportunities through network-sponsored activities (Dana-Farber Cancer Institute, Inc., 2002).

In Singapore, the government has legislated against smoking in all air-conditioned office premises and factory work areas under the purview of the Ministry of Environment. The government also gives financial support to organizations that demonstrate commitment in encouraging a healthier workforce. Organizations may, for instance, apply for resources to develop and implement a customized in-house cessation programme.

Box 3.9. Singapore: National Trade Union Congress

Within the framework of a National Smoking Control Programme, the Health Promotion Board works closely with the National Trade Union Congress (NTUC) and various workplace health facilitators to implement education and cessation programmes at workplaces.

Examples of specific activities carried out by NTUC:

- Helps the Health Promotion Board disseminate free consultation and education to workplaces wishing to carry out anti-smoking educational or cessation programmes.
- A Quit Smoking Support Group website with frequently asked questions on smoking; the benefits and methods of quitting smoking; normal reactions after quitting; how to deal with the urge to smoke; and personal testimonies from union leaders on how they have successfully quit smoking.
- Motivational talks and cessation counselling workshops coordinated jointly with the Health Promotion Board to help union leaders and members quit smoking (Singapore National Trades Union Congress, ILO SafeWork Survey, 2003).

In Europe an interesting project started in 2003, aiming at protecting workers from passive smoke.

Box 3.10. Europe: SmokeatWork, Protecting Workers from Passive Smoking

This pan-European project is funded by the European Commission and coordinated by the Trade Union Congress (TUC) in the United Kingdom, with participation from representatives from seven European countries: Belgium, Denmark, Ireland, Portugal, Sweden, Romania and the United Kingdom. The focus of the 12-month project is workers in the hospitality industry-pubs, nightclubs and restaurants.

The main aim of the project is to collect, develop and disseminate information that will help workers negotiate smoking policies at work. The overall objective is to assist union representatives to protect workers exposed to second-hand tobacco smoke.

The specific outcomes of the projects are:

1. A set of training materials aimed at workers' representatives covering the health effects of passive smoking, the legal situation in each European country, guidance on how to negotiate smoking policies, and best practice examples

2. A website (www.smokeatwork.org) with related information and training material

3. A European network of trade union representatives from different industrial sectors who will continue to share information after the project is over.

Australia, the United States and Canada have seen some high profile legal cases in which non-smokers with tobacco-related diseases were awarded compensation from employers after having convinced the jury that their illness was due to exposure to second-hand tobacco smoke at their workplace. The first of the two Canadian examples below relates one of these cases. The second example illustrates Canadian trade union commitment.

Box 3.11. Canada: Call for a ban

A non-smoking waitress in Ontario was compensated by the Workers' Compensation Board for terminal lung cancer, which was linked to workplace passive smoking. She then featured in an advertising campaign by Canada's federal government in 2002, warning of the dangers posed by second-hand smoke at work (Health Canada, 2002).

The Canadian Auto Workers Union (CAW) has informed the public, as well as its members, about the dangers of second-hand smoke. CAW represents 260,000 members, of whom 18,000 work in the hospitality industry. In a message to the members entitled Second Hand Smoke Butt it Out, CAW gives a clear message as part of their "prevent cancer" campaign. The President of CAW, Buzz Hargrove, states; ¨I have been repeatedly on record calling for smoke-free workplaces, except for enclosed, separately ventilated smoking areas. Insist that your employer implements this sensible policy¨(Canadian Auto Workers Union, 2003).

In Spain, trade unions are also active in the promotion of smoke-free workplaces. In many of the regions of Spain, trade unions inform their members of local laws regulating drug use; some of these laws also contain provisions related to workplace smoking. Examples of such regions are: Andalucía, Aragón, Canarias, Cantabria, Castilla León, Castilla La Mancha, Cataluña, Euskadi, Extremadura, Galicia, La Rioja, Madrid, Murcia, Navarra and Valencia. A national tobacco prevention plan, under development in 2003, aims to solidify the regional work and require each region to create its own prevention plans.

Box 3.12. Spain: Confederación Sindical de Comisiones Obreras

Action in the Spanish workers' confederation (C.C.O.O.) started after it noticed an increased number of problems related to smoking at work, in particular conflicts between smokers and non-smokers who share working space.

In 2003, C.C.O.O. collaborated with the government in carrying out workplace tobacco campaigns in various regions. Pamphlets and posters were used to reach their members, informing them about their legal rights and giving suggestions as to how a smoke-free working environment should be created. C.C.O.O. found it a big challenge to promote the establishment of designated smoking areas in smaller enterprises (C.C.O.O., ILO SafeWork Survey, 2003).

3.3. Committed employers

Support from employers is essential for successful implementation of workplace legislation as well as enterprise level policies. True commitment can only be built on understanding and awareness, and in this area, governments and employers' organizations have important roles to play. Governments should inform employers of their duties to protect workers from second-hand tobacco smoke.

There are many good examples of employers who are dealing with smoking at their premises. Below are two examples from India.

Box 3.13. India: Awareness-raising and rewards

After a goldsmith company in Mumbai invited an NGO to present the health risks of active and passive smoking, a radical change of policy took place, including making the canteen smoke-free. As a result of the campaign, consumption of the locally consumed tobacco products, *bidi* and *gutka*, declined and the number of smokers in the company halved. Inspired by the good results, 42 companies across the country signed up for similar campaigns with the same NGO.

A large enterprise in southern India encouraged its 1,200 person workforce to stop smoking and drinking alcohol by rewarding them with an additional monthly allowance on top of their salaries. The allowance was paid to the wives of the employees, and was stopped if an employee was found to have returned to the habit. After eight years of the programme in place, the company said that it was still very satisfied with the results.

Sweden's long tradition of social dialogue has also left a mark on the way smoking policies are developed. Below is an example of social dialogue showing how Ericsson, one of the largest employers in Sweden, introduced smoke-free policies in all its workplaces.

Box 3.14. Sweden: Ericsson

The Swedish communication equipment producer Ericsson is one of the country's largest employers, with a long record of successful efforts to create smoke-free working environments.

In order to successfully integrate the smoking policy into the organization, Ericsson went through the following measures:

1. Created a steering committee for the planning, monitoring and evaluation of the policy composed of the human resources department, the managing director, union leaders, press and smokers
2. Adopted a public, written policy that was approved by the management board
3. Distributed advance information to all involved actors, such as unions and management
4. The managing director wrote a personally signed letter to all employees and managers

Specific activities related to the policy included:

1. A baseline survey measuring attitudes to smoking
2. A competition campaign
3. "Stop smoking groups" receive help from the occupational health department
4. Articles on smoking published in the company newspapers
5. A guideline with information about the policy and passive smoking developed for managers
6. Designated smoking areas (ENSP, 2001: 113).

In Germany, workplace smoking legislation existed but was not very explicit until a decision in the Bundestag in 2001 led to a strengthening of the law. In October 2002 the amended law made it the employers' duty to protect non-smoking employees from second-hand tobacco smoke in most workplaces. The federal organization for employers played an active role in Initiativkreis für rauchfreie Arbeitsplätze (IKRA), a coalition for the promotion of smoke-free workplaces.

Box 3.15. Germany: Koalition gegen das Rauchen "Aktionsbündnis Nichtrauchen"

With the goal of improving the ability of enterprises to create smoke-free workplaces, the broad coalition Initiativkreis für rauchfreie Arbeitsplätze (IKRA) was established in 2002. The membership of IKRA includes the Confederation of German Employers (BDA), the trade union umbrella organization (DGB), the Association of German Occupational Physicians (VDBW), other workers' organizations including the trade union IG Metall, the occupational accident insurer (BUK), the health insurer (BKK), WHO's partnership project on tobacco, and the Federal Institute for Occupational Safety and Health (BauA).

Inspired by the revised legislation and an increasing number of enterprise smoking policies, IKRA organized a competition in 2002/2003. Divided into different groups depending on the size, enterprises were encouraged to send in good examples of successful measures leading to the protection of non-smokers (Hauptverband der Gewerblichen Berufsgenossenschaften, ILO SafeWork Survey, 2003).

At the international level, the programme *No Smoke Inc*. uses the concept of corporate social responsibility to convince multinational enterprises to promote smoke-free workplaces.

Box 3.16. International: No Smoke Inc.

No Smoke Inc. is one of the programmes of the Business Council for the United Nations. The focus of No Smoke Inc. is on large, global corporations with the aim of reducing smoking-related disease and death around the world.

The corporate guidelines issued by No Smoke Inc. include access to cessation help for smokers and rewards for smokers to quit; demonstrated commitment from management and the direct endorsement from the managing director of the smoking policy and programme; and the importance of a worldwide smoke-free policy covering all the employees of the enterprise (No Smoke Inc., 2003).

3.4. Chapter 3: Summary

In Chapter 3, examples of committed governments, employers, employers' organizations and workers organizations illustrated the difference they can make in promoting smoke-free workplaces.

Strong government support is essential because of the positive signal it gives to workers and employers to take the matter seriously. As illustrated by various examples, government action is most effective when there is an interdepartmental response. Considered a health matter by many governments, smoking tends to be a question for the ministry responsible for health. In the promotion of smoke-free workplaces, the involvement of the ministry responsible for labour is also desirable, as well as other departments, for example education, social affairs, and finance. National campaigns for smoke-free workplaces also benefit from a more structured and far-sighted non-smoking effort, which can be observed in countries that have national action plans and/or inter-departmental tobacco control offices.

Workers' organizations have a responsibility to protect their members from exposure to second-hand tobacco smoke. Assistance can be lent to workers in the form of information about existing laws and possible access to legal assistance. Workers' organisations can also be instrumental in awareness raising activities, which would lead to better understanding of new regulation as well as less tension between smokers and non-smokers and avoid discrimination related to smoking.

Employers have a great responsibility to create and implement policies that will protect their workers from exposure to second-hand tobacco smoke. Employers should make the transition from smoking to non-smoking working environments as painless as possible for everyone involved. One way of doing this is to involve workers in the development process of the policy. Another way is to offer support to workers who want to stop smoking.

In the following chapter, we will look at other elements that are important when promoting smoke-free workplaces.

Chapter 4. Good practices: Elements for achieving smoke-free workplaces

Chapter 2 explored the coverage and nature of workplace legislation regulating smoking at work. Chapter 3 stressed the importance of tripartism; and the necessary involvement of governments, employers and workers in order for the promotion of smoke-free workplaces to be successful. In this chapter, we shall consider other relevant factors for the achievement of smoke-free workplaces.

There are six key elements in achieving smoke-free workplaces. 1. Creating alliances that will further the cause. 2. Treating smoking as an occupational safety and health issue. 3. Information and communication. 4. Providing of guidelines. 5. Providing workplace assistance programmes. 6. Developing a policy on smoking.

4.1. Innovative partnerships

The example of partnership in California might not look innovative at first glance, but the fact that the hospitality industry joined forces with the trade unions has not been evident in most other places. This fact is also interesting in a nationwide context since in the United States California is the State with the highest population and is called the country's "political trend setter". Trends that start in California often spread to the rest of the country.

Box 4.1. USA: California Coalition

Since the introduction of California's *Smokefree Workplace Law* in 1995, smoking has been banned in all workplaces including restaurants. In 1998 this law was expanded to include bars and night clubs. Behind these laws existed a strong lobby made up of the
California Labour Federation (AFL-CIO), the California Hotel and Motel Association, the California Restaurant Coalition, the California Medical Association, the American Heart Association and the American Lung Association. The support from the hospitality industry may be related to fear of litigation. There has been an increase in claims for compensation based on health damage caused by exposure to second hand tobacco smoke (National Institute for Public Health, 2003:1: 37-38).

In countries where government institutions are less active in this area, alternatives can be explored. Bangladesh is an example where non-governmental organizations play an active role.

Box 4.2. Bangladesh: Workplace awareness programmes

Activities for smoke-free environments in Bangladesh are primarily carried out by non governmental organizations such as the Bangladesh Occupational, Health, Safety and Environment (OSHE) Forum and Adhunik (translated "we do not smoke"). They carry out awareness raising activities for workers such as OSHE Forum's campaign around the World No Tobacco Day in industries located in Dhaka and Chittagong.

An interesting factor in the evaluation of this work has been the usefulness of involving women in the campaigns since they tend to influence the behaviour of other family members i.e. husbands, brothers, fathers and other relatives. (ILO SafeWork Survey, 2003; Nazma Akter, 3 June 2003)

Adapting interventions to the particular socio-cultural situation of a region or country is very important. Bhutan is an example of a country where religion plays an important role. Considered a sin in their religion, Bhutan has made a commitment to the WHO to become the first country to be completely tobacco free. Smoking is already prohibited in 18 of its 20 districts, and it hopes to outlaw the habit by the end of 2003 (Globalink/Reuters, 25 Sep. 2003).

Religion is also one of the main pillars in Cambodian society and has become a factor to count on in the promotion of smoke-free environments. In the box below, a project for smoke-free Wats[17], is presented.

Box 4.3. Cambodia: Smoke-Free Buddhist Monks Programme

In Cambodia, where smoking prevalence for men is among the world's highest, the Adventist Development and Relief Agency (ADRA) has carried out a programme called "Tobacco or Health", including awareness and cessation programmes, together with the Ministry of Health and the Ministry of Education. A precept of Buddhism is "the abstaining from any state of indolence arising from the use of toxicants or harmful substances". However, owing to lack of awareness about the harmfulness of smoking, tobacco use has been common among monks. When Buddhist monks, who are considered important role models in Cambodia, showed interest in the programme, a locally adapted cessation programme ¨Khmer Quit Now¨, was developed. Since 1999, the cessation programme has been expanded to include the establishment of smoke-free Wats and the promotion of "smoke-free lives". Behind the effort are ADRA, Ministry of Cults and Religion, Ministry of Health, and leading monks.

The project was still in progress in 2003 and no formal evaluation had taken place. However, eight large Wats had been publicly declared smoke-free and a large number of monks had quit smoking. Anecdotal evidence indicates that smokers in the communities surrounding the Wats were quitting under the influence of monks and fewer people were offering tobacco to monks in ceremonies. A regional conference held in 2002 to discuss Buddhism and tobacco control included high-level monks from Cambodia, Thailand and Sri Lanka (WHO, forthcoming).

[17] "Wat" is the local term for a Buddhist monastery or pagoda, and also means the place where a community of Buddhist monks live and study as well as a place of worship for the local Buddhist community.

Another example of campaigning adapted to the particular socio-cultural structure is Singapore, where several ethnic groups co-habit, including the main groups: Chinese, Indians and Malays. For sensitization campaigns to be successful, it has been considered necessary to respect the different ethnic groups, such as a Ramadan[18] Quit Smoking Programme.

Box 4.4. Singapore: National Smoking Control Programme

A National Smoking Control Coordinating Committee was set up in Singapore in 1986. Chaired by the Ministry of Health, this committee formulates policies, coordinates activities and monitors the smoking control programme. In order to reach the main target groups, one of which is workers, a wide coalition of ministries, trade unions and private sector employers sit at the head of the committee.

In 1996, a civic committee was formed comprising business representatives, the community (youth organizations and self-help groups), media and health professionals. Some of the self-help groups represent the main ethnic minorities, including the Chinese Development Assistance Council; the Singapore Indian Development Association; and Mendaki (a Muslim educational welfare organization).

The Ramadan Quit Smoking Programme is an example of special programmes for ethnic minorities. It was conceptualized in 1995 and aims to encourage the Malays, who are Muslims, to quit smoking during the month of Ramadan. The rationale is that if smokers can stop smoking for one day, they could consider reducing the number of cigarettes or stop smoking. The campaign also encourages non-smokers to help their loved ones to consider giving up the habit (Chan, 1999:39-43).

4.2. Treating smoking as an occupational safety and health issue

It has already been suggested that smoking needs to be dealt with as a workplace issue, and not merely as a life-style or well-being issue. An important element of this re-orientation is to involve occupational health services. This can be done through cooperation with local primary care teams, providers of counselling and cessation advice, and pharmacists. Routine medical check-ups can be used to discuss and promote the benefits of smoking cessation.

Official classifications of tobacco smoke as a workplace hazard is also important. The example of Finland in Chapter 2 illustrates this argument. Another example is the United States classification of tobacco smoke as an occupational carcinogen by the Environmental Protection Agency (EPA) in 1992. EPA's recommendation of a total ban on smoking as the only secure method against passive smoking provided key support to the lobby for complete smoking bans in the United States (National Institute of Public Health, 2003).

[18] Ramadan is a holy month for Muslims. It is a time when Muslims cleanse their minds and bodies by fasting and praying. During the day they fast by avoiding food, drink and smoking.

Box 4.5. United States. Acknowledgement from important health institutions

1986: The Surgeon General draws the following conclusions:

- Involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers.
- Simple separation of smokers and non-smokers within the same airspace may reduce but does not eliminate exposure of non-smokers to second-hand tobacco smoke.

1991: The National Institute for Occupational Safety and Health establishes that:

- Second-hand tobacco smoke is a potential occupational carcinogen.
- Second-hand tobacco smoke poses an increased risk of lung cancer and possibly heart disease to occupationally exposed workers.
- Exposure to second-hand tobacco smoke should be reduced to the lowest feasible level.
- Employers should minimize occupational exposure to second-hand tobacco smoke by using all available preventive measures.

1993: The U.S. Environmental Protection Agency releases a report on the respiratory health effects associated with passive smoking with the conclusion that passive smoking causes lung cancer. Second-hand tobacco smoke is classified as a "Class A" carcinogen, i.e. a substance from which exposure workers are protected by law, together with substances such as asbestos, arsenic and radon.

In Australia, the national occupational safety and health authorities have also acknowledged the problem of smoking at work.

Box 4.6. Australia: National Occupational Health and Safety Commission

1994: The National Occupational Health and Safety Commission (NOHSC) endorses a Guidance Note on Passive Smoking in the Workplace, drawn up to assist employers to carry out their duties. The note was the result of a joint project set up by the government, trade union and employer representatives (NOHSC, 2002).

2002: The NOHSC calls for a voluntary ban on environmental tobacco smoke in all Australian workplaces as soon as possible. It says that the move was justified because World Health Organization guidelines and medical and government reports in Australia had confirmed that passive smoking could increase cancer, heart disease and asthma risks (ibid.).

2003: NOHSC releases a revised guidance note that replaces the one from 1994. It is stricter and holds employers responsible for eliminating all smoking from workplaces.

In the Canadian province of British Columbia, workplace smoking was included among other occupational safety and health issues in the amended health and safety regulations in 2002.

Box 4.7. Canada: British Columbia

All three levels of government in Canada (federal, provincial/territorial, and municipal) have authority to regulate smoking in public places and workplaces. Most provinces have such legislation and the most restrictive ones are found in British Columbia. Rather than creating separate workplace smoking legislation, the provincial Workers' Compensation Board declared that exposure to second-hand smoke in the workplace should be controlled under the amended Occupational Safety and Health Regulation as of 1 May 2002 (Workers' Compensation Board, 2002).

4.3. Information and communication

Knowledge is necessary for policies to be known and understood; for new policies to be respected and enforced; and, eventually, for attitudes and behaviour to change.

The results of a survey of non-smokers' protection in restaurants and bars in five European countries (Finland, Belgium, France, Germany and Spain) carried out in 2003 illustrated the importance of a good communication strategy for successful implementation of legislation. The survey focussed on owners, clients and workers in restaurants and bars. An interesting outcome was that the country with the highest awareness level, Finland, had fewest non-smoking signs in the non-smoking sections of restaurants and bars. This seems to indicate that effects of decades of campaigning (see Chapter 2) have led to a process of "denormalising" smoking in indoor areas. Finnish interviewees were more aware of the existence of a law than the French and Belgian interviewees (98 % versus 76 % and 73 %, respectively). The awareness of the contents of the law was also higher in Finland. When measuring the awareness levels of the health impact of passive smoking, Finland and Belgium scored higher than the other three countries, women scored higher than men, and interviewees coming from establishments with protection measures scored higher than those without (European Parliament, 2003).

In many cases, information campaigns for smoke-free workplaces are part of broader anti-smoking campaigns or public health drives. In the following example, a project in Costa Rica is described, which incorporates many of the necessary elements for increased awareness about smoke-free workplaces.

Box 4.8. Costa Rica: Espacios libres de humo de tabaco (smoke-free spaces)

The national social insurance security provider, the Ministry of Health, WHO and the Drugs and Alcohol Institute (IAFA), established this project promoting smoke-free places in 2001.

The goals of the project are as follows:

1. Raise awareness about the importance of smoke-free air
2. Disseminate information about where it is prohibited to smoke, according to the tobacco law
3. Create a national network of smoke-free environments
4. Stimulate smoking cessation.

First targeting public institutions and private enterprises, the objective of the project is to create educational materials; promote awareness-raising activities for workers and managers; create a system of official accreditation of smoke-free environments; and promote the creation of workplace cessation facilities.

The various activities of the project have resulted in increased interest and awareness around the issue as well as changing policies in several workplaces. During the first year, 37 enterprises participated in the project. Some enterprises, such as the largest supermarket chain *Supermercados Unidos* with 6,210 employees, decided to introduce a total ban on smoking. Others workplaces, such as the University of Costa Rica, decided to create designated smoking areas within the buildings (WHO, forthcoming).

As in the case of France, described in Chapter 2, Chile experienced enforcement problems with the 1995 tobacco law. The law had no general clause banning workplace smoking but prohibited smoking in most public places and in workplaces where smoking constitutes a safety risk. In order to improve the situation, the government launched the following programme.

Box 4.9. Chile: Programa Ambientes Libres del Humo de Tabaco (PAHLT)

The Ministry of Health created the Programme for Environments Free from Tobacco Smoke (PAHLT) in 2001. The objective of the programme is to change attitudes so that smoking would become considered a socially unacceptable behaviour and a private rather than a public habit. The strategies of PAHLT are below:

1. Dissemination of information about the problem and the programme
2. Education for different population groups, including workers
3. Promotion of social participation in the development of smoke-free environments
4. Studies of attitudes, processes, etc.
5. Accreditation and certification of smoke-free environments by the Ministry of Health to institutions that have introduced a policy-change (suggested timeframe: five months) following a suggested 7-step plan.

    1st step: Set up working group, develop action plan, inform
    2nd step: Assessment through a survey
    3rd step: Education and communication
    4th step: Adapt the physical space of the workplace to the new policy
    5th step: Official announcement
    6th step: Communication to the society surrounding the workplace
    7th step: Maintain the goals of the new policy.

6. Recommendations for the participating institutions on how to change their policies.

The results after a year of PAHLT's existence were the accreditation of over 500 establishments as smoke-free environments and enhanced public support for regulation of smoking at work. A survey of 20,848 workers in the health sector in 2002 showed that 89.5 % supported restrictions on smoking at their workplaces (Bello, 2002).

Awareness-raising about health risks or legislation can take different forms according to the cultural and social context. In countries with a well established tripartite structure and a large share of the working population in the formal sector, employers and trade unions can, and do, fill this role. Many Muslim countries, as indicated in the charts in Chapter 2, have smoke-free workplace legislation. In addition to legislation, religion is a medium used in awareness raising initiatives.

Box 4.10. Religion and smoking: Egypt and Oman

Despite a smoking control programme and a law banning smoking in hospitals, schools, cinemas and public transport, Egypt is experiencing an increasing number of smokers. In an attempt to change people's attitudes towards smoking, WHO launched a media campaign mentioning a *fatwa* (religious ruling) by a respected Islamic authority declaring smoking sinful (UICC GLOBALink, 8 August 2002).

In Oman, before the 1970s, an offender of the public smoking ban risked jail. However, as the country experienced rapid modernization from the 1980s onwards, smoking became increasingly common. Most Omanis, nonetheless, consider smoking to be an evil. In Oman too, scholars issued a *fatwa* forbidding smoking and considering it a waste of financial resources (WHO, unpublished).

A well prepared information campaign is also important when a policy change is introduced, whether it is an enterprise, a country or a province. The Canadian province British Columbia prepared the launch of its revised law in fine detail.

Box 4.11. British Columbia (Canada): Communications Plan

The thrust of the revised law in 2002 was to give workers in the hospitality industry greater protection against exposure to second-hand tobacco smoke. Hospitality workers now had a choice whether or not to work in designated smoking areas of the establishments.

A revision of the health and safety law of the provincial government was announced in January 2002. The new law was meant to come into force in May 2002. This gave the authorities (the Workers' Compensation Board) four months to carry out a compliance implementation strategy. At the heart of this strategy was communication, especially because the change of law was controversial and employers needed persuasion.

The communications plan intended:

- To use the implementation period to inform employers and workers about the new regulation: what it is, why it is needed, and how they can comply.
- To foster support and compliance in British Columbia workplaces for the new standard.
- To demonstrate leadership in health and safety, and in the protection of workers from known workplace hazards.
- To enhance the positive reputation of the Workers' Compensation Board and its Prevention Division (Workers' Compensation Board, 2002).

4.4. Guidelines

Many governments and organizations active in the area of workplace health have produced guidelines to facilitate the promotion of smoke-free workplaces. These guidelines come in different forms and sizes, for example as guidance notes, handbooks, information leaflets or codes of practice.

An example of a set of comprehensive guidelines is the 1999 document *Smoking in the Workplace*, which was published by the Trade Union Congress London (TUC) together with National Asthma Campaign, Action on Smoking or Health (ASH) and WHO Europe (Box 4.12). The report provides guidance and information for employers and employees on health, legal and practical aspects of how to make a workplace smoke-free.

Box 4.12. Great Britain: Trade union/NGO/WHO initiative

The guidelines suggest the following three-pronged approach:

1. Recognize the impact of smoking in the workplace
2. Understand the legal obligations and risks
3. Develop a smoking policy in consultation with staff.

The guidelines suggest including the following elements in a successful policy:

- Acceptance of the right of employees not to be exposed to tobacco smoke;
- Consultation with employees and trade unions;
- A timetable to initiate changes;
- Concrete support for attempts to quit smoking;
- Clear decisions on whether there will be a well-ventilated smoking room and/or how long it will be retained;
- Clear policies on smoking breaks (ASH, 1999: 2-3).

Another comprehensive guide is: *Making Your Workplace Smokefree. A Decision Maker's Guide,* released by the United States Department of Health and Human Services, Centers for Disease Control and Prevention together with the Wellness Councils of America and the American Cancer Society.

Box 4.13. United States: Making your workplace smoke-free

Suggested steps to an effective workplace tobacco policy (p. 34):

1. Assess the current situation
2. Decide on a new environmental tobacco smoke (ETS) policy and develop a plan to implement it
3. Communicate with employees and management
4. Announce and manage the policy

Suggested items to include in the smoking policy (p. 37):

- Purpose of the policy (harmful effects of ETS on health)
- The link between the ETS policy and cessation aid with recognizable corporate values (e.g. performance or employees as an asset)
- Clear statement of where smoking is prohibited
- Clear statement of where smoking is permitted (if anywhere)
- Clear statement on enforcement and consequences of non-compliance
- Clear statement of support to be provided for employees who smoke (e.g. cessation assistance)
- Name and telephone number of person who can answer questions about the policy

Another format was used in Sweden when an easy-to-use, low cost ¨toolbox¨ for employers was produced in 1999. This idea was picked up by Norway in 2003 when the Directorate of Social and Health released a similar but expanded employers' box. The Swedish toolbox (Box 4.14) is marketed by the participating organizations and considered a success because of the

large demand and the media attention it has attracted. Behind the initiative is a broad coalition of the largest employers' associations and trade unions; 22 county councils; the Swedish Work Environment Authority; the Swedish National Institute of Public Health; the Heart and Lung Foundation; and the Centre for Tobacco Prevention, Stockholm.

Box 4.14. Sweden: Smoke-free at work ¨toolbox¨

An evaluation of the project showed that the employers particularly appreciated the quit-line and the self-help book. By 2001, more than 1,500 kits had been sold to employers and occupational health centres. The facts that smoking is costly for enterprises and that employers should assist workers who wish to quit attracted much media attention

Contents of the ¨toolbox¨ for employers:

- Welcome-letter with recommendations for a non-smoking policy
- *Win-Win.* A motivating leaflet providing estimates of the costs induced by smoking for the company.
- *The Costs.* A leaflet explaining the cost implications of workplace smoking and how the employer could make his or her own calculations.
- *Smoking Cessation Programme.* An accessible and low-cost model for workers who want to quit. Ideal for small companies lacking occupational health care service. The prospective quitter receives a self-help programme (*Quit to be Free*), free treatment and advice via telephone help lines, and one month's supply of nicotine replacement therapy (NRT).
- Advice to the employer about how to use the cessation programme.
- Facts about NRT
- Access to a nation-wide network of counsellors
- Order sheet for *Quit to be Free*, the self-help-booklet (Holm Ivarsson 2001).

In order to determine common elements in different existing guidelines, 18 guidelines (listed in the table below) were analysed. Several of the guidelines were received through the informal ILO tobacco survey in 2003; others were found through the desk review. The chosen variables for the analysis were issues that we saw frequently in the guidelines. This analysis showed that the essential elements of the 18 guidelines analysed in this exercise are also included in the draft ILO Guidelines on Tobacco Smoke in the Workplace.

Full titles and origins of the documents can be found in Annex 4. The status of these guidelines vary from very comprehensive and detailed information, as in the case of Australia's guidance note, to more informal and less detailed information leaflets, as in the case of a booklet from the Spanish trade union C.C.O.O. Some have a more political than practical intention, for example ENSP´s call for action to all European governments and the British proposal for an Approved Code of Practice. However, common to all of them is that they give guidance to actors involved in the promotion of smoke-free workplaces.

Table 4.1. Analysis of guidelines to smoke-free workplaces

	Variables	**Australia NOHSC**	**Canada (BC). WorkSafe**	**Germany Min. of Health**	**Germany Bund Verlag**	**Hong Kong/World Bank**	**Europe WHO**	**Europe ENSP**	**Europe EU/TUC**	**Japan Ministry of Healtl Labour and Welfare**	**Netherlands STIVORO**	**Norway Dir. Of Health**	**Philippines Government**	**Spain C.C.O.O.**	**Sweden Tobacco Centre**	**UK HSC**	**UK ASH/TUC/WHO**	**US Government, CDC**	**World Bank**
1	Target Group(s)																		
	Workers	X			X				X					X		X	X		
	Employers	X	X		X		X				X	X	X		X	X	X	X	
	OSH professionals	X														X			
	Government							X					X						
	Not specified			X		X													X
2.	Background Information																		
	Occupational safety and health effects	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X
	Cost effects		X	X		X	X	X			X				X	X	X	X	X
	Conflicts		X	X	X	X	X	X		X	X	X		X	X		X	X	X
	Legal information	X	X	X	X		X		X	X	X	X	X	X	X	X	X	X	
3.	Elements in Guidance to Workplace Policy																		
	Management commitment						X		X	X	X	X			X			X	
	Assessment	X	X	X		X	X		X	X	X	X	X		X	X		X	X
	Consultation/Working Group	X		X		X	X		X	X	X	X			X	X		X	X
	Information/ Awareness Raising	X	X	X		X	X	X**	X	X	X	X	X	X	X			X	X
	Formulation	X				X	X		X		X	X			X			X	X
	Non-discrimination	X	X				X	X**				X		X			X	X	
	*Logistical action**	X	X	X		X	X			X	X	X	X	X	X	X	X	X	
	Disciplinary actions	X	X		X		X					X	X		X	X	X		X
	Monitoring/evaluation	X	X			X	X		X	X	X	X	X		X	X	X	X	X
	Integrated in overall health plan								X										
4.	References to workers' assistance																		
	Cessation aid	X		X		X	X	X**	X		X	X	X	X		X	X	X	X
	Legal Aid				X			X**	X								X		
5	Examples																		
	Model Policy	X			X	X	X		X			X						X	

	Model Questionnaire			X		X	X					X			X				
	Good Practice				X		X		X		X	X					X	X	
6.	Location of Smoking Areas																		
	Complete indoor ban	X						X**				X							X
	In designated smoking Areas		X				X		X		X		X	X	X	X	X	X	X
	In workspace if consent/ in separated work areas.			X	X					X									
	Not specified					X													

*) Eliminate tobacco vending machines, create safe and healthy indoor and outdoor designated smoking areas, eliminate ashtrays, post no-smoking signs.
**) This is a call to the European Governments to implement laws that oblige employers to provide smoke-free workplaces.

The analysis of the guidelines revealed that the documents have a similar pattern although the target groups are slightly different. Six out of the eighteen guidelines target only employers and two target only workers. The others target various groups or have not defined their audience.

As for background information, almost all provide comprehensive scientific and legal information regarding the effects of workplace smoking. More than half also found it valuable to stress the cost implications of workplace smoking and the potential conflicts that can arise because of smoking at work.

The third category in the table, elements in guidance to workplace policy, is the main theme of a majority of the guidelines. Some guidelines even provide examples of a worker questionnaire, a model policy, and examples of best practices (as indicated in category 5 of the table). Elements such as social dialogue, assessment and monitoring are in practically all guidelines. Other elements, such as management commitment and non-discrimination, are in only half of the guidelines, perhaps because those are less clear-cut issues.

The issue of discrimination, for example, is dealt with quite differently by different guidelines, although many suggest that the general approach should be to concentrate on banning the *smoke* and not the *smokers*. Examples of guidelines stressing the importance of preventing discrimination against or stigmatization of workers on the basis of their tobacco habit are: the Spanish trade union C.C.O.O., the European trade union project and the Australian Guidance Note. A passage from the Australian document reads:
"No program to eliminate ETS from the workplace should involve discrimination against or stigmatization of workers based on their dependency on tobacco. Nor should stigmatization of workers involved in the implementation of a smoke-free workplace be tolerated. The promotion of "Quit" smoking programs has an important place in workplace smoking policies. These programs should be offered and delivered in a supportive way and in accordance with best practice in the management of addiction and dependency." (NOHSC 2003, p. 4)

Other guidelines, such as the ones from Action on Smoking or Health (ASH) and WHO Europe, are supportive of non-smokers' rights but not as open to the argument of "smokers' rights". They argue that the right to health is more important, i.e. to work in an environment free from second-hand tobacco smoke, than the individual rights of smokers to pursue their habit at the workplace.

Disciplinary action is also dealt with quite differently by the various guidelines. The Swedish "Toolbox", for instance, takes a soft approach suggesting that breaking the smoking rules should be corrected through one-to-one dialogue. Other examples, including the ones from

Australia, the Philippines and the Netherlands are stricter and refer to legislation that stipulate fines or imprisonment for breaking the non-smoking rule in workplaces.

The fourth category refers to workers' assistance. A majority of the guidelines suggest the provision of aid to workers who want to quit smoking. Several guidelines provide legal information and aid to workers who want to take legal measures against their employers. Many of these provide examples of court cases featuring workers against employers, explanations of legal texts and contact details of available legal aid. Guidelines targeting employers on the other hand tend to suggest how disputes can be avoided or solved more easily: through a participative process, a clear policy and a mechanism for conflict solving.

The last category, the location of smoking areas, was difficult to determine because of the various nuances in the position of the guidelines. The categorization of the variable is therefore not precise but an approximation. The different opinions regarding a safe location of smoking areas is partly explained by recent research showing that it is expensive and difficult to achieve the necessary air ventilation in an indoor designated smoking area without the tobacco smoke drifting into other sections of the building. The 2003 Guidance Note from Australia and the employers' guide from Norway have taken note of these theories, and take a position against indoor designated smoking areas. For this same reason, the Australian guidance note does not endorse the Australian Standard *The Use of Ventilation and Air-conditioning in Buildings, Part 2: Ventilation Design for Indoor Air Contaminant Control,* but suggests the creation of safe outdoor designated smoking areas. A number of other guidelines suggest that total smoking ban is the ideal solution but in workplaces where this is not feasible, designated smoking areas will have to be created. The World Bank represents this view, recommending that designated smoking areas are considered a transitional arrangement before a total ban can be introduced. Other guidelines are more flexible, allowing smoking if all workers agree, if the creation of designated smoking areas is too difficult, or if ventilation systems are installed. The centre of attention of guidelines with a more flexible attitude is often on mutual respect and a reduction of conflicts between smokers and non-smokers.

Some of the differences in contents and tone of language in the guidelines are due to the rapid change in governments' position vis-à-vis workplace smoking during the past five to ten years, which have rendered parts of some guidelines obsolete. Examples of this process are the two German guidelines from 1995, eight years before the introduction of the current German legislation, which holds employers responsible for the provision of smoke-free work areas. The emphasis of these guidelines is on peaceful solutions to conflicts related to smoking and the use of existing related legislation rather than guidelines to employers regarding their rights and duties, as would probably be the case in an updated version of the guidelines.

Another example is in the British proposal to an Approved Code of Practice from 1999, which would perhaps have been couched in bolder language if written today. Page 32 of the guide reads: "Currently it may not be reasonably practicable to ban completely customers or clients smoking where (…) the public visit out of choice – for example, restaurants, cafés, public houses, bars, clubs, hotels, casinos and betting shops…" Five years later neighbouring country Ireland as well as Norway are taking the step that seemed impossible in 1999; they are introducing total smoking bans in all workplaces including pubs and restaurants.

4.5. Workplace assistance programmes

For a smoke-free workplace policy to be successful, it is important that information and support is given to everyone, smokers as well as non-smokers. We have already mentioned the importance of information and education to create awareness and public support. Moral and medical support are also vital components in order to prevent discrimination, on the one hand, and to help smokers get used to the new policy on the other hand. Table 4.1 (pp. 54-55) showed that 13 out of 17 analysed guidelines featured cessation aid.

Treatment of tobacco dependence can include one or several of the following methods: behavioural and pharmacological interventions such as advice and counselling; intensive support; and administration of pharmaceuticals that contribute to reducing or overcoming tobacco dependence. The choice of cessation aid that is offered to the employees will depend on the size, location, finances, culture and particular wishes of the enterprise or organization. A US survey of employers showed that 28 % of employers provided some tobacco cessation treatment, 16 % offered counselling, 24 % offered prescription pharmacotherapy, 8 % offered over-the-counter pharmacotherapy and 15 % supplied their workers with self-help materials(WHO Best Practice, forthcoming).

Offering quit-smoking programmes to the workers can give a positive boost to the policy change. Not only does such assistance have a positive psychological effect as it demonstrates the seriousness and the commitment of policy makers, it also makes it easier for smokers to cope with the change.

That is not to say that tobacco treatment is always easy. Programmes may need to overcome a number of factors, some of which are particularly serious in low and middle income countries (WHO, 2003) as follows:

- The lack of a supportive environment to help smokers quit;
- Lack of integration of tobacco dependence treatment into health care systems;
- Lack of knowledge and training of health care providers;
- High price of nicotine replacement therapy (NRT)[19] products and cessation services, and no insurance coverage;
- Regulation of NRT products.

The support of workers' organizations can be important for a supportive environment, for instance in providing support to workers who want to quit or to prevent discrimination or conflicts between smokers and non-smokers.

In Norway, the government has taken the lead to promote smoke-free workplaces. It offers a national programme of smoking cessation and prevention (including a free of charge telephone quit-line), 120 cessation experts carry out nationwide smoking cessation courses, and distribution of information material about smoking and cessation.

In Poland, a country with high smoking rates, the government has taken many initiatives to counter the problem. Smoking is prohibited by law in the premises of enterprises except in designated smoking areas. There is also a nation-wide tobacco control project called Workplaces Free of Tobacco Smoke. Many Polish employers grant motivating bonuses on top of the regular salary to workers who try to quit smoking. Employers often arrange for and

[19] There are currently six approved formulations of NRT (gum, patch, inhalers, nasal sprays, sublingual tablets and lozenges). The use of NRT increases the long-term rates of smoking cessation and relieves the symptoms of nicotine withdrawal. NRT doubles the smoker´s chances of quitting (WHO, 2003:10).

cover the costs of therapeutic sessions for smokers who want to quit (National labour Inspectorate Poland, ILO SafeWork Survey, 2003).

In other countries, a private network or specialized private service providers sometimes provides workplace cessation assistance. In Barbados, for example, workplace assistance programmes are carried out in many government and private enterprises. Perhaps the best known group running these programmes locally is a private organization called Network Services Centre Inc. that works with employers covering 53,000 employees out of a total workforce of 145,000 (Labour Department Barbados, ILO SafeWork Survey, 2003).

Active involvement from the occupational health service and local health care providers are also important, as in the following example from Italy:

Box 4.15. Italy: Discouraging smoking at work

Smoking at work has been a common phenomenon in Italy. New regulations have increased economic sanctions for violators of the non-smoking laws, but increased awareness is also leading to more workers disapproving of their smoking colleagues. The Ministry of Health is behind many campaigns including workplaces, but the private sector is also carrying out initiatives, and campaigns are carried out for workers' protection against second-hand tobacco smoke.

Besides economic sanctions, employers are discouraging workers from smoking by removing ash trays from corridors, placing warning notices, and appointing a ¨non-smoking marshal¨ on every floor of the office building. The occupational safety and health organization is collaborating with several regions in Italy to dissuade workers from smoking. Activities range from the development of information material to encouraging workers to attend public quit-smoking centers (Instituto Superiore per la Prevenzione e la Sicurezza del Lavoro, ILO SafeWork Survey, 2003).

4.6. The process of developing smoking policies

In Chapter 3 and 4, a number of factors which contribute to making workplaces smoke-free were discussed. The support of governments and of employers and workers, as well as their commitment are important. Information and education have a positive effect on public awareness and support. Employers appreciate clear guidelines on how to carry out a policy change. Examples of such guidelines have been provided.

It is important that the development process of a workplace smoking policy be transparent and that the trade union and all the relevant sections of the enterprise or organization be involved. Workers should be informed about the process and have a say in how the policy is formulated. Open discussion during this process will improve compliance and reduce the risk of frictions between smokers and non-smokers when the policy is in place.

An important factor in many models or guidelines is the integration of the smoking policy with other workplace policies and not offering it in isolation. An ILO programme called *SOLVE: Addressing Psychosocial Problems at Work,* stresses this point. It is a training programme active in 25 countries in both the developed and developing world aiming at enabling employers and workers to develop workplace policies including different psychosocial issues, e.g. stress, violence, smoking, drugs, alcohol and HIV/AIDS (ILO

SOLVE, 2001). More information about SOLVE can be found on www.ilo.org/safework/solve.

Another important element of policy creation is the integrated and cyclical aspect that will result in an ever-evolving, ever-improving workplace policy. On this theme, the ILO has developed an instrument called *ILO Guidelines on Occupational Safety and Health Management Systems* (ILO/OSH 2001). More information about ILO/OSH 2001 can be found at: www.ilo.org/safework

The experience of the promotion of non-smoking working environments within the National Health Service in Great Britain illustrates the idea of a participative, cyclical development process that leads to a comprehensive workplace policy based on strong support from workers and management.

Box 4.16. Great Britain: National Health Service (NHS)

The public health supplier NHS employs almost one million employees, making it the largest employer in Great Britain and in Europe. NHS has a history of more than twenty years of trying to curb smoking on the premises and, since 1993, it was meant to be virtually smoke-free. Much has been accomplished but challenges remain as was summarized in the report *Been There, Done That: Revisiting Tobacco Control Policies in the NHS* (1999).

The report paints a picture of successes and failures as well as lessons learned during the twenty last years. It also suggests that tobacco control in the health sector should be treated as a continuous process, or a "policy learning loop" as the process is called in the report. NHS stresses the importance of trades unions' involvement in the process. The policy learning loop should be structured along the following lines:

1. Reviewing current non-smoking arrangements
2. Planning the next steps
3. Preparation for change
4. Implementation of change
5. Auditing performance
6. Back to step one (NHS, 1999: 24 pp)

Another example of the cyclical model is found in the Netherlands, where increasing efforts are made to curb a longstanding tradition of workplace smoking. A national survey in 2000 showed that two-thirds of the workers smoked at their workplaces and that only 39 % of the companies surveyed had policies protecting workers from second-hand tobacco smoke. Pressure from, among others, the Labour Foundation (a bipartite cooperation institution of employers and workers), which in 1993 advised the government to protect non-smokers at company level from second-hand tobacco smoke, has led to a political response. A new law will take effect on 1 January 2004, obliging all employers to protect workers from tobacco smoke. A large national campaign will also take place to motivate employers to develop sound company policies on smoking.

Box 4.17. Netherlands: the seven-step plan

The Dutch government gave the non-governmental organization STIVORO the task to ensure a smooth implementation of the 2004 smoke-free workplace legislation. Alongside media campaigns and open debates, STIVORO sent out information packages to a large number of employers containing facts about workplace smoking and the rights and duties of employers once the law is in force. This package also contained a suggested road to a smoke-free workplace: the so-called seven-step plan.

De Stappenplan: Seven steps to an effective policy on smoking.

1. Create a support base. Draw attention to the subject.
2. Develop a structure. A workgroup is formed, consisting of representatives of management, works council, health service and the division of communication.
3. Make an inventory of the problem: analyse how many workers smoke, how employees see possible solutions, etc.
4. Develop a plan of action.
5. Start introducing the policy.
6. Evaluate the policy.
7. Maintain focus. The development of a smoking policy is a circular process: by going through points 4,5, and 6 again, the policy can be adjusted to changing circumstances (STIVORO, 2002; ENSP, 2001: 122-123; Arbeidsinspectie [labour inspection] ILO SafeWork Survey, 2003).

4.7. Chapter 4: Summary

In Chapter 3, we discussed the important roles of the main actors in smoke-free workplace promotion: the governments, the employers and the workers. In this chapter, we have explored other important elements that could be beneficial to this process.

The first element discussed in this chapter is innovative partnerships. It is important to build coalitions between different actors in a country, but there is no blueprint as to what the coalition should look like. In countries where religion plays a central role in society, such as in Bhutan and Cambodia, to cite only these two examples, it makes sense to involve monks in smoke-free campaigns. It is not uncommon, especially in the hospitality industry, that anti-smoking NGOs team up with trade unions to demand better protection for workers against the exposure to second-hand tobacco smoke. A more remarkable coalition was the lobby behind the Californian smoke-free workplace law, which included the unions and representatives from the employers.

The second element is the importance of dealing with workplace smoking as an occupational health and safety issue. We illustrated this point with countries where the national safety and health institutions contribute to smoke-free workplace campaigns; where the governments declare passive smoking an occupational health risk; where smoking regulation becomes part of occupational safety and health legislation; and where the ministry responsible for health and the ministry responsible for labour (or the labour inspectorate) are actively involved in the promotion and enforcement of smoke-free workplace legislation.

The third element is information and education. It is important to raise the awareness about the health risks of smoking and exposure to second-hand tobacco smoke in a systematic manner, preferably through a national all-encompassing programme. But it is also important to inform employers and workers about their rights and duties under the existing law. Employers and trade unions have a responsibility to inform and educate. How the information is disseminated depends on the socio-cultural setting.

The fourth element is the availability of clear guidelines to facilitate the creation of smoke-free workplaces. International and national organizations, governments and enterprises have produced a range of different guidelines, handbooks and leaflets for the purpose of guiding actors involved in the promotion of smoke-free workplaces. This report looks at seventeen different guidelines generated to address second-hand tobacco smoke at work. Similar patterns have been identified which can form the basis of future work.

The fifth element is access of workers to workplace assistance programmes giving moral and medical support. Such programmes give a positive signal from the management to the workers and to the surrounding community that they care about workers' health and safety. They can have a positive effect on the transition to a smoke-free workplace, making it as painless and friction-free as possible.

The sixth element is the process of developing smoking policies. We suggested that a workplace policy is developed in a democratic way, involving all the relevant departments of an enterprise or organization and as many workers as possible. It is also suggested that the policy is seen in a holistic way, taking into consideration the other workplace policies in place and other occupational health issues that need to be addressed. An example of a programme which does that well is ILO's SOLVE programme. To keep the policy updated and relevant, it should also go through regular cycles of evaluation and adjustments.

Summary and conclusion

When initiating the ILO SafeWork Survey: Smoking at Work, we had hoped to be able to compile data from a broad selection of countries into a table, providing systematic information regarding existing activities such as awareness campaigns, peer support groups, quit smoking programmes and subsidized nicotine replacement therapies. This goal was soon abandoned when we realized how difficult it was to obtain systematic information about specific workplace initiatives. The health sector has dominated prevention of tobacco use for a long time. The primary actors have been the WHO; Ministries of Health; and NGOs working with health questions, in particular organizations against cancer and various coalitions of health professionals. In the labour sector, the most obvious responsibility should lie within the occupational health sphere. However, smoking has traditionally been considered as a lifestyle issue that should be incorporated into health promotion campaigns, rather than treated as a serious occupational hazard. This attitude has changed to some extent in countries where regulating smoking has a longer history, for example Finland. Other countries will probably follow suit as nations continue to sign and ratify the Framework Convention on Tobacco Control, and as the regions (the European Union may be the first) follow the same trend towards stronger legislation.

An interesting outcome of our research is that the attitude towards smoking is changing and that a "de-normalisation" of smoking at work is taking place all over the world. It was also encouraging to note that many employers, especially in larger enterprises, consider a smoke-free working environment as a serious issue. We gave examples of salary incentives given to workers that quit smoking and "non-smoking marshals" controlling the enforcement of the ban. Trade unions, especially in the hospitality industry, show increasing interest in the protection of their members against passive smoke. Governments are also increasingly institutionalizing strategies to reduce smoking, through legislation, national programmes, inter-departmental coordination bodies, and massive campaigns. It is reasonable to believe that the development of the Framework Convention on Tobacco Control is contributing to the increased support for smoke-free environments and an increasing coverage in most countries of laws providing workers with smoke-free workplaces.

However, there is still a long way to go for many workers before they can enjoy completely clean air where they work, especially in the hospitality industry. Even in countries where smoke-free workplaces have become the norm due to legislation and campaigning, many workers in restaurants and bars are still exposed to second-hand tobacco smoke every day. Fortunately, certain states in the United States have initiated a new trend and introduced smoke-free workplace laws that include all workers, including the hospitality industry. Some European countries as well as parts of Canada, New Zealand and Australia are on the verge of following suit, but there is a hot debate raging between those who fear loss in income and employment and those who want to protect the health of clients and workers in bars, restaurants, hotels, etc.

Despite the strong arguments for smoke-free environments, smoking is seldom a priority issue for governments. This is particularly true in developing countries, where health budgets are too small and the competition stiff between many serious illnesses such as malaria and HIV/AIDS, and where the budget for labour issues has employment creation as a priority. In tobacco producing countries, especially in Africa, regulation of smoking risks becomes a conflict of interest where tobacco is an important foreign exchange earner and a source of employment.

Looking at workplace smoking legislation, there is no doubt that the Framework Convention on Tobacco Control has played a vital role in raising the profile of the problem. International

interest has been demonstrated through the high number of signatures which the Convention has obtained as well as through the large number of new legislation that are springing up. On the regional level, however, no concrete steps have been taken to create binding directives. Perhaps that will change in Europe, as the European Health Commissioner announced collaboration with the Employment Commissioner to propose a European smoking ban in public places.

In this paper, we identified a number of conditions that are important for the promotion of smoke-free workplaces. First of all, we discussed the importance of committed governments, employers and workers. Examples of such commitment are: governments who openly support smoke-free working environments within the framework of a broad-based national smoking programme; employers who inform their workers of the health and safety hazards and involve them in a policy-making process that will lead to a fair and supportive no-smoking policy; and trade unions that carry out awareness raising activities, and who give moral and legal support to their members.

In the last chapter, six important elements in achieving smoke-free workplaces were listed. It was found important to have innovative partnerships; treat smoking as an occupational safety and health issue; stress information and communication; have access to concrete guidelines; offer workplace assistance programmes; and use a comprehensive and dynamic process when developing a policy on smoking.

It is a major challenge to take all these elements into account when promoting smoke-free workplaces. But we should not forget that we are dealing with one of the most serious occupational safety and health hazards of our time. It will take time before awareness levels are where they should be, and before the main actors deal with the issue in a responsible way. Nevertheless, we hope that this document will enhance the knowledge of smoke-free workplaces and that it will stimulate discussion of and further action in promoting smoke-free workplaces.

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ANNEXES

Annex 1: ILO SafeWork Survey: Smoking at Work Questionnaire

This Questionnaire was sent out in an English, French or Spanish version to all members of the International Association of Labour Inspectorates; to the collaboration centres of the International Occupational Safety and Health Centre and to a number of trade unions connected to the ILO and the International Confederation of Free Trade Unions.

1	**Is smoking at work a problem in your country?**
	Yes ☐ **No** ☐
	If the answer is yes, in which way is it a problem?
	--- --- ---
2	**Has the frequency of problems related to smoking at work changed during the last 5-10 years in your country?**
	Yes ☐ **No** ☐
	If yes, please indicate how the situation has changed.
	--- --- ---
3	**Have attitudes changed with relation to smoking at work during the last 5-10 years in your country?**
	Yes ☐ **No** ☐

	If yes, please indicate how attitudes have changed
	--- --- ---
4	**Does national legislation regulating smoking in public places exist in your country?**
	Yes ☐ **No** ☐
	If yes, please provide us with copies or reference details.
	--- --- ---
5	**Does legislation, guidelines, codes of practice or other instruments concerning smoking at work exist in your country?**
	Yes ☐ **No** ☐
	If yes, please provide us with copies or reference details and mention whether these are at the national, regional, local or enterprise level.
	--- --- ---
6	**In your country, are there campaigns or programmes to discourage or prevent workers from smoking?**

	Yes ☐ **No** ☐
	If yes, please provide us with copies or reference details and mention whether these are at the national, regional, local or enterprise level.
	--- --- ---
7	**In your country, are workplace assistance programmes offered to workers who may wish to stop smoking?**
	Yes ☐ **No** ☐
	If yes, please provide us with copies or reference details and mention whether these are at the national, regional, local or enterprise level.
	--- --- ---
	Please give us your contact details:
	Name _____ **Organization** _____ **Address** _____ **E-mail** _____ **Telephone/ Fax** _____

Annex 2: ILO SafeWork Survey: Smoking at Work: List of responding institutions

Country	Institutions
Albania	BSPSH (NGO)
	Ministry of Labor and Social Affairs
Australia	National Occupational Health and Safety Commission
Bangladesh	Bangladesh Sanjukta Sramik Federation (trade union)
Barbados	Labour Department
Belarus	National Information Centre on Safety and Occupational Hygiene
	Ministry of Labour and Social Protection
Belgium	Service Public Fédéral Emploi, Travail et Concertation
Brazil	Ministerio do Trabalho e Emprego, Fundacentro
Bulgaria	National Center of Hygiene, Medical Ecology and Nutrition
	Confederation of Independent Trade Unions in Bulgaria
Chile	Labor Inspectorate (Dirección del Trabajo)
	Ministerio de Salud
China	National Center of Safety Science and Technology
	National Safety Training Center of Coal Mines (NSTC)
Colombia	Consejo Colombiano de Seguridad
Croatia	Department of Labor Inspection
Cyprus	Department of Labour Inspection
Denmark	Arbeids Tilsynet
	Danish Confederation of Trade Unions (Restaurant Workers Union)
Estonia	National Labour Inspectorate
France	Institut National de Recherche et de Sécurité INRS, Paris
	Institut National de Recherche et de Sécurité INRS, Vandoeuvre
	International Agency for Research on Cancer
Gabon	Ministère du Travail et de L'Emploi (Inspecteur Général de l'Hygiène et la Médecine du Travail)
Germany	Hauptverband der Gewerblichen Berufsgenossenschaften
	Deutscher Gewerkschaftsbund
Ghana	Department of Factories Inspectorate
Hong Kong	Occupational Health Services (Labour Department)
Hungary	Public Foundation for Research on Occupational Safety
	"Fodor Jozsef" National Center for Public Health
International	International Metalworkers' Federation
Israel	IIOSH-Israel Institute for Occupational Safety and Health-Information Center
	Dr. Curt Semesal
Italy	Istituto Superiore per la Prevenzione e la Sicurezza del Lavoro
Japan	Japan Industrial Safety and Health Association

Jordan	Occupational Safety and Health Institute
Latvia	State Labor Inspectorate, Ministry of Welfare
Lithuania	Lietuvos Respublikos Valstybiné Darbo Inspekcija
Madagascar	Union des Syndicats Autonomes de Madagascar (U.S.A.M.)
Malaysia	Department of Occupational Safety and Health
Mauritius	Ministry of Labour and Industrial Relations
Mexico	Mision Permanente de México
Morocco	Faculté des Sciences de l'Education
Namibia	Ministry of Labour
Netherlands	Arbeidsinspectie – Ministry of Social Affairs and Employment
New Zealand	Occupational Safety and Health Services
Norway	Directorate of Labor Inspection
Philippines	Occupational Safety and Health Center (OSHC)
	Trade Union Congress of the Philippines (TUCP)
Poland	National Labor Inspectorate Section for International Co-operation
	Central Institute for Labour Protection-National Research Institute (CIOP-PIP)
Russia	All Russian Centre for Occupational Safety and Health
Singapore	Singapore National Trades Union Congress
	Health Promotion Board, Government of Singapore
Slovenia	Government of Slovenia
Spain	Confederación Sindical de Comisiones Obreras
	Ministerio de Sanidad y Consumo
	Ministerio de Trabajo y Asuntos Sociales
Sri Lanka	Division of Occupational Hygiene
	Industrial Safety Division (Department of Labour)
	Employers Federation of Ceylon
Sweden	Swedish Work Environment Authority
	Arbetslivinstitutet (National Institute for Working Life)
Switzerland	Office Fédéral de la Santé Publique
	OCIRT Canton Geneva)
	Suva (Insurance Provider)
Syria	Institute of Social Insurance
Thailand	Bureau of Occupational and Environmental Diseases
Uganda	Occupational Safety and Health Department
Vietnam	Ministry of Labour, Invalids and Social Affairs
Zimbabwe	National Social Security Authority

Annex 3. ILO SafeWork Survey: Summary of responses

A. The geographical distribution of the 67 responses was as follows:

Region	Africa	Americas	Arab States	Asia & Pacific	Europe
Number of responses	8	6	2	16	35

B. Responses related to legislation have been summarized in Chapter 2.

C. Questions related to the changing nature of the problems related to smoking gave the following results (the countries indicating a worsening situation were Gabon, Chile and Slovenia).

Have problems related to workplace smoking changed? Responses	Situation has improved	Situation has worsened	No change	Unknown
Total	41	4	13	9
Africa	3	1	1	3
Americas	3	2	0	1
Arab States	2	0	0	0
Asia & Pacific	12	0	2	2
Europe	21	1	10	3

D. The question related to changing attitudes towards smoking at work (i.e. if there is more or less concern about second-hand smoke at work and whether there is a desire to create smoke-free workplaces), gave the following results (the countries indicating worsening attitudes towards smoking were Philippines, Chile, Albania and Belgium).

Have attitudes related to workplace smoking changed? Responses	Attitudes have improved	Attitudes have worsened	No change	Unknown
Total	50	4	5	8
Africa	4	0	1	3
Americas	4	1	0	1
Arab States	2	0	0	0
Asia & Pacific	13	1	0	2
Europe	27	2	4	2

E. On the questions whether workplace prevention programmes (awareness raising carried out by for example the employer or trade union) or workplace assistance programmes (quit-smoking activities), the various regions responded as follows:

Region	**Africa**		**Americas**		**Arab States**		**Asia & Pacific**		**Europe**	
Do you have workplace prevention programmes in your country? Total yes: 51 No: 16										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Responses	4	4	5	1	0	2	12	4	30	5
Do you have workplace assistance programmes in your country? Total yes: 32 No: 33 Unknown: 2										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Responses	2	6	1	5	0	2	10	6	19	14

Annex 4. List of analysed guidelines under section 4.4. (p.58-63)

	Country/Region	Publisher	Reference No./year	Title
1	Australia	National Occupational Health and Safety Commission	NOHSC:3019 (2003)	Guidance Note on Elimination of Environmental Tobacco Smoke in the Workplace
2	Canada (British Columbia)	WorkSafe. Workers' Compensation Board	2002	Environmental Tobacco Smoke. Managers' Resources
3	Germany	Bundesministerium für Gesundheit (Ministry of Health), Bundeszentrale für gesundheitliche Aufklärung	1995	Rauchfrei. Über das Rauchen und über Nichtraucherschutz (Smoke Free. About Smoking and Protection of Non-smokers)
4	Germany	Bund Verlag. Author: Joachim Heilmann	1995	Rauchen am Arbeitsplatz. Handlungshilfe für Betriebsräte (Smoking at the Workplace. Guidelines for workers' committees)
5	Hong Kong/World	World Bank Web Site: www.worldbank.org/hnp Author: Judith Mackay		A Guide to Creating a Non-smoking Workplace
6	Europe	WHO Europe	2002	Set of two handbooks: 1. Tobacco in the Workplace: Meeting the Challenges. A Handbook for Employers. 2. Why Smoking in the Workplace Matters: An Employers Guide
7	Europe	European Network for Smoking Prevention	2003	Smoke Free Workplaces. Optimising Organisational and Employee Performance. Policy Recommendations
8	Europe	Funding: the European Union. Organizer: Trades Union Congress (UK).	2003	SmokeatWork. Protecting Workers From Passive Smoking. www.smokeatwork.org
9	Japan	Ministry of Labour	February 1996, revised May 2003	Guidelines for Measures on Smoking at Work
10	Netherlands	STIVORO for the Dutch Government	2003	Roken en de werkplek (Smoking and the workplace)
11	Norway	Directorate of Health and Social Affairs	2003	Bedriftspakke for röykfrihet (Enterprise box for smoke-free a workplace)
12	Philippines	Civil Service Commission	Memorandum Circular No. 07 s. 1999	Policy on working conditions at the workplace relative to smoking prohibition
13	Spain	C.C.O.O (Spanish Trade Union Federation)	Information leaflet	Salud en tu lugar de trabajo (Health in your workplace)

		Castilla-La Mancha/ Junta de Comunidades Castilla - La Mancha (Regional government of Castilla-La Mancha)		
14	Sweden	Centrum för Tobaksprevention (Centre for Tobacco Prevention)	Toolbox 1999	Rökfri på jobbet (Smoke Free at Work.)
15	United Kingdom	Health and Safety Commission	Consultative Document 1999	Proposal for an Approved Code of Practice on passive smoking at work
16	United Kingdom	Action on Smoking and Health, National Asthma Campaign, Trades Union Congress, WHO Europe Partnership Project	1999	Smoking in the Workplace UK Edition
17	United States	U.S. Department of Health and Human Services. Centers for Disease Control and Prevention		Making Your Workplace Smokefree. A Decision Maker's Guide.
18	World	World Bank	2002, revised version 2003	Smoke-free workplaces at a glance: www1.worldbank.org/tobacco/

This working paper could be used as a background document for a future ILO tripartite discussion

SafeWork, the ILO's InFocus Programme on Safety and Health at Work and the Environment, has four major goals:

- To develop preventive policies and programmes that protect workers in hazardous occupations and sectors;
- To extend effective protection to vulnerable groups of workers falling outside the scope of traditional protective measures;
- To better equip governments and employers' and workers' organizations to address problems of workers' well-being, occupational health care and the quality of working life; and
- To document he social and economic impact of improving workers' protection and promote its recognition on the part of policy- and decision-makers.