

2007 China Tobacco Control Report

- Create a Smoke-Free Environment, Enjoy a Healthy Life -

**Office of the Leading Small Group for Implementation of
the Framework Convention on Tobacco Control
Ministry of Health
PRC**

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Preface

The Chinese government pays a great deal of attention to tobacco control and participates actively in the international tobacco control movement. From 2000 to 2003, a State Council-approved intergovernmental negotiation entity consisting of twelve ministries (commissions and administrations), including the National Development and Reform Commission, the Ministry of Health, and the Ministry of Foreign Affairs, actively supported and participated in the negotiation and development of the *Framework Convention on Tobacco Control* (the Convention). On May 21, 2003, the 56th World Health Assembly Session unanimously passed the Convention. China signed the Convention on November 10, 2003. On August 28, 2005, the 17th Session of the Standing Committee of the 10th National People's Congress formally ratified the Convention, making China the 89th ratifying country. On October 13, 2005, the Chinese government held a launching ceremony for implementing the Convention. The Convention became effective in China on January 9, 2006. In order to actively and effectively implement the Convention, in January 2007, based on the former Chinese intergovernmental negotiation entity, the State Council approved the establishment of the China Convention Inter-Ministerial Coordination Mechanism, consisting of eight ministries (commissions and administrations), including the National Development and Reform Commission and the Ministry of Health, tasked with the coordination of Convention implementation in China. These steps and measures underline the importance China gives to tobacco control and highlight China's serious commitment to strengthening international cooperation under the framework of the Convention, in response to the challenges in public health and protecting the citizens' health. The Convention poses new opportunities and challenges to China's tobacco control.

Article Eight of the Convention, *Protection from Exposure to Tobacco Smoke*, states:

1. Parties recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease, and disability.
2. Each Party shall adopt and implement the Convention 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.

It is estimated that each year, more than 100,000 people die from passive

smoking in China. Each fallen life testifies against passive smoking. However, a significant proportion of the public is not clear about the health hazards caused by passive smoking. In indoor workplaces, public transport, and indoor public places, exposure to passive smoking remains high. There is a significant gap in China from what the Convention mandates.

The theme of the 2007 World No Tobacco Day is “Smoke-Free Environments”. In order to publicize the hazards of passive smoking, and to take concrete steps to implement the Convention in China, the Office for Tobacco Control and Convention Implementation at the Ministry of Health organized experts to compile and publish the *2007 China Tobacco Control Report: Create a Smoke-Free Environment, Enjoy a Healthy Life*.

The Report, in response to the fact that the Chinese people lack a deep understanding of the hazards caused by passive smoking, lists the scientific evidence on health hazards caused by passive smoking, elaborates on the seriousness of the Chinese people’s exposure to passive smoking hazards, analyses key impacts of passive smoking, studies the public attitude towards prohibiting smoking in public places, and current legislation. In addition to this, it proposes related challenges and recommendations. It is hoped that the Report will facilitate governments at various levels to promulgate laws or related regulations and to effectively implement such laws or regulations to prevent the public from exposure to passive smoking hazards in indoor workplaces, public transport, and indoor public places.

I. Hazards to Health Caused by Passive Smoking

Passive smoking refers to nonsmokers inhaling the smoke exhaled by smokers and the emission from tobacco smoldering. It is also called involuntary smoking or secondhand tobacco smoking.

1. Smoke inhaled through passive smoking contains many toxins and carcinogens

When a cigarette is lit and smoldering at an extremely high temperature (900 °C), it produces a tobacco smoke that contains more than 4000 chemical substances, many of which are toxic and harmful, and over forty of which are carcinogenic. Table 1 lists the main carcinogens and toxins in tobacco smoke.

Table 1: Toxins and carcinogens in tobacco smoke

Toxins

Carbon monoxide, nitrous oxide, formaldehyde, ethanol, methane, toluene, hydrogen cyanide, lead, aluminum, zinc, magnesium

Carcinogens

Benzopyrene, vinyl chloride, nitrosamine, polycyclic aromatic hydrocarbon, nitrosotoluene, cadmium, nickel, polonium

A report by the U.S. Surgeon General in 2006^[1] clearly noted that:

- ◆ Secondhand smoke contains hundreds of known toxic or carcinogenic substances, including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, hydrocyanic acid, etc.
- ◆ Secondhand smoke has been classified as a known human carcinogen of category one by the U.S. Environmental Protection Agency and the International Agency for Research on Cancer. The U.S. National Institute for Occupational Safety and Health has concluded that secondhand smoke is an occupational carcinogen.

2. There is no such thing as a “safe level” of exposure to secondhand smoke

The density of tobacco smoke in indoor air is determined by the amount of smoke emission (number of smokers, quantity of smoking, and frequency of smoking), area of the indoor space, and extent of ventilation. Many people believe that as long as there are few smokers and the room is large enough,

the hazards of secondhand smoke can be minimized, or even non-existent; in other words, there are “safe levels” of exposure. The following scientific evidence shows that there are no safe levels of exposure to secondhand smoke.

When a cigarette is burned, the tobacco smoke it produces contains 180ng (1ng = 10^{-6} g) of benzopyrene. In a room with airspace of 30m^3 , this means there is a benzopyrene density of $6\text{ng}/\text{m}^3$, which is six times the permissible health standard ($1\text{ng}/\text{m}^3$). In order to dilute the density to a permissible level, the air in the 30m^3 room needs to be replaced five to six times every hour. However, at present, the central air conditioning and ordinary air conditioners in hotels and homes are not able to filter and eradicate ultra fine particulates such as benzopyrene. Once the tobacco smoke exists in the room, it is very difficult to get rid of it.

Researchers point to the fact that in a poorly ventilated room, exposure to tobacco smoke for an hour on average increases the Carboxyhaemoglobin (HbCO) in the blood of the passive smoker from 1.6% to 2.6%, which is literally equal to smoking a middle level tar cigarette.

Ordinary air cleaning systems can get rid of large particles, but not the smaller particles or the various gaseous components in secondhand smoke. The American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), the U.S. authoritative entity on ventilation issues, has concluded that ventilation cannot be used to control the health hazards from exposure to secondhand tobacco smoke. Therefore, such means of separating smokers from nonsmokers and installing air cleaning or ventilation equipment cannot resolve the hazards of secondhand smoke to nonsmokers. If a smoking area is set up in a building, the heating, ventilation, and air conditioning system will transmit the secondhand smoke to every corner of the structure.

Since secondhand smoke contains many compounds that can rapidly irritate and damage the intima of the respiratory tract, even a short exposure causes the following consequences:

- ◆ Damage to the upper respiratory tract of a healthy person, more frequent asthma attacks for asthma patients and worsening conditions
- ◆ Increase of blood thickness, damages to tunica intima of the vascular system, insufficient blood supply to the coronary artery, and increase of the hazards of a heart attack

Therefore, whether applying ventilation or filtering concurrently, exposure to indoor secondhand smoke cannot be lowered to acceptable levels. Only

completely smoke-free environments can effectively protect the health of nonsmokers.

3. Passive smoking causes serious hazards to people's health, especially in women and children

The impact of passive smoking on health was first described in the U.S. *Report of the Surgeon General: 1971*.^[2] In 1981, Japanese scientist Hirayama T. published *Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan*,^{[3][4]} which was a milestone in the research on the health hazards of passive smoking.

Hirayama T. observed the deaths of 91,540 non-smoking married women from twenty-nine districts in Japan. He discovered:

- ◆ The standard mortality rate of women dying from lung cancer married to nonsmoking men was 8.7/100,000
- ◆ The standard mortality rate of women dying from lung cancer married to men who smoked 1 to 19 cigarettes a day was 14/100,000, the relative risk being 1.61
- ◆ The standard mortality rate of women dying from lung cancer married to men who smoked 20 or more cigarettes was 18/100,000, the relative risk being 2.08

Thereafter, dozens of researchers further proved the hazards of passive smoking to health.

1) Hazards of passive smoking to adult health

The U.S. *Report of the Surgeon General: 1986*,^[5] and authoritative reports issued by the U.S. National Institute of Health in 1986 and 1999,^{[6][7]} the U.S. Environmental Protection Agency in 1992,^[8] and by the California State Environmental Protection Agency in 1997^[9] all point to the fact that passive smoking increases the risk of lung cancer, cardiovascular diseases, chronic obstructive pulmonary diseases (COPD), asthma in addition to damaging lung functions.

The U.S. *Report of the Surgeon General: 2006*^[1] further states that

- ◆ Compared to the tobacco smoke inhaled by the smoker, secondhand smoke contains an even higher density of carcinogens and toxic chemicals
- ◆ Even a short exposure to secondhand smoke causes adverse effects to the cardiovascular system immediately, thus increasing the risk of a heart

attack

- ◆ Non-smokers exposed to secondhand smoke at home or the workplace face a 25% to 30% higher risk of heart disease and a 20% to 30% higher risk of lung disease

Based on such evidence, the reports by the U.S. Surgeon General^[1] conclude that exposure to secondhand smoke causes immediate adverse effects to the cardiovascular system, which can lead to coronary ischemic heart disease and lung cancer.

Chinese researchers surveyed 60,377 women aged between forty and seventy from 1997 to 2000.^[10] The survey indicates that the risk of stroke in women exposed to passive smoking at home increases with the number of cigarettes their husbands smoke per day (Table 2).

Table 2: Relation between number of cigarettes husbands smoke and the risk of stroke in wives

Number of cigarettes smoked by husbands (number/day)	Risk of stroke in the wives (%)
1-9	28
10-19	32
>20	62

Another study by Chinese researchers^[11] used a statistical method to estimate the number of Chinese people dying from lung cancer and coronary heart disease due to passive smoking. The results show that 11,000 died from lung cancer and 31,300 died from coronary heart disease in 2002 due to passive smoking. They estimate that the number of people dying from passive smoking exceeded 100,000 in all. Compared to developed countries, the rate of female smokers in China is not high. However, since the male smoking rate remains high, more than half of all Chinese women are exposed to secondhand tobacco smoke every day and are the main victims of passive smoking.

2) Hazards of passive smoking to children's health

Passive smoking affects children's health in each stage of their growth and development. Pregnant women's active or passive smoking affects the fetus, and passive smoking after birth causes diseases, such as Sudden Infant Death Syndrome (SIDS), acute and chronic respiratory diseases, and acute and chronic middle ear diseases. It also causes the onset or worsening of asthma and negatively affects the development of lung functions.

Many studies abroad have proven that the risk of SIDS in infants with smoking

mothers is two to three times that of those with non-smoking mothers. If there are more than two smokers at home, the risk is five times higher. Therefore, we should not neglect the importance of a non-smoking environment at home as we stress banning smoking in public places.

In the late 1980s, Chinese researchers surveyed the in-patient rate in Shanghai of children with respiratory diseases and its relation to smoking parents.^[12] They found that children whose parents smoke have a 1.5 to 2 times higher in-patient rate due to respiratory diseases, and a 2.6 to 4.8 times higher rate of below average weight at birth.

In 1992, a U.S. Environmental Protection Agency report stated, "Exposure of children to ETS from parental smoking is causally associated with increased prevalence of respiratory symptoms of irritation."^[8]

In 1997, the California State Environmental Protection Agency pointed out that "...there is sufficient evidence that postnatal ETS exposure of a child is an independent risk factor for SIDS."^[9]

In 1998, the U.K. Scientific Committee on Tobacco and Health noted, "Sudden Infant Death Syndrome, the main cause of post-neonatal death in the first year of life, is associated with exposure to environmental tobacco smoke. The association is judged to be one of cause and effect."^[13]

In 2006, the *Report of the Surgeon General*^[11] summarized the scientific evidence over the past forty years, and concluded:

- ◆ Infants are especially susceptible to the harm of toxins in secondhand smoke throughout their development
- ◆ Infants exposed to secondhand smoke are more prone to deaths from SIDS
- ◆ Infants exposed to secondhand smoke have lower lung functions and face larger health risks
- ◆ Secondhand smoke causes bronchitis and pneumonia in infants, and increases the likelihood of middle ear disease
- ◆ Exposure to secondhand smoke increases the frequency of asthmatic attacks and worsens the symptoms of asthma

II. A Minimum of 500 Million in China are Exposed to the Hazards of Passive Smoking

1. A great many people are exposed to secondhand smoke

According to the estimate of the World Health Organization, about 700 million children in the world are exposed to air contaminated by secondhand smoke in the world, and this is especially prevalent in the home environment. When China participated in the “Global Youth Tobacco Survey,” 43.9% and 55.8% of youths in China were exposed to secondhand smoke hazards at home and in public places respectively.^[14]

China has 350 million smokers, the highest of any country in the world. Based on research and estimates, as many as 540 million people are exposed to the hazards of secondhand smoke in China at present, of which 180 million are children below the age of fifteen. Data from the National Smoking Behavior Epidemiology Surveys in 1984, 1996, and 2002 show that, despite a decreasing trend in the number of smokers, the situation with passive smoking has not improved in any way.^{[15][16]}

Secondhand smoke exposure rates are 49.7% and 54.0%, respectively, in urban and rural areas, with the rural areas higher than the urban areas. There are twenty provinces with more than 50% of the population exposed to secondhand smoke. The rate is over 60% in northern provinces such as Qinghai, Gansu, Shanxi, Shaanxi, Jilin, and Inner Mongolia.^[16]

Rate of secondhand smoke exposure



2. Venues with secondhand smoke are widespread

Homes, public places, and workplaces are all spaces exposed to secondhand smoke. Based on a survey in 2002, among people exposed to passive smoking, 82% were exposed at home, 67% in public places, and 35% at workplaces.

Among passive smokers, the rate of being exposed to secondhand smoke at different places varies according to age, gender, and occupation. Ninety percent of female passive smokers are exposed to secondhand smoke at home. Male passive smokers aged between twenty and fifty-nine are most exposed to secondhand smoke at public places and workplaces. Compared to the survey results in 1996, the rate of exposure at public places increased.^{[15][16]}

3. A great many factors affect passive smoking

1) There are high rates of male smoking and the behavior goes unchecked

Over the past twenty years, there has been a trend of falling rates of Chinese male smokers, but the rate is still very high. According to the National Smoking Behavior Epidemiology survey in 2002, 57% of males smoke, and their smoking behavior is basically unrestricted.^[16] This is the main reason for non-smokers being exposed to secondhand smoke in many places.

2) Effective laws or regulations on prohibiting smoking in public places and workplaces are absent

China does not have a national law or regulation to prohibit smoking in public places. By the end of October 2006, over half of the cities in China had not formulated local regulations to ban smoking in public places.^[17] As such, there is no way to effectively restrict smoking and protect the right of non-smokers to avoid the adverse effects of secondhand smoke.

3) The enlightened social etiquette of not smoking and not giving cigarettes as gifts has yet to take shape

In many parts of China, the social etiquette of entertaining guests with cigarettes and giving tobacco products as gifts is prevalent; offering cigarettes is viewed as polite and necessary for socializing. Some smokers believe the phrase, "smoking is my right and others can't intervene." Some non-smokers also share this belief, so they don't have the rationale to stand up against smoking in public places.

4) The public still lacks awareness of the hazards of passive smoking

The aforementioned survey shows that in recent years, the public is more aware of the health hazards caused by passive smoking, as evidenced by the increase of awareness from 24% in 1996 to 35% in 2002. Furthermore, 45% of the survey subjects believed smoking in pregnant women causes serious harm to the fetus. But there are still many misguided beliefs. For example, many people wrongly believe that “as long as ventilation equipment is used, indoor smoking doesn’t affect others.”^[16]

5) Other social factors

In some parts of China, especially rural areas, the concept that “men are superior to women” still has significant influence. As such, women usually are not able to stop smoking in the household or at social events. This has contributed to worsening the hazards of passive smoking.

III. Law Enactment is a Key Measure to Ban Smoking in Public Places

The successful experience of some countries indicates that law enactment is a key measure to achieve indoor smoke-free environments. In many countries, the public places where smoking is banned have expanded from public transport, cinemas, exhibition halls, shopping centers, banks, schools and hospitals, to workplaces, including government office buildings and business office buildings, and further to catering and entertainment places for the public, such as restaurants, bars, night clubs, and massage saloons. The process of banning smoking at public places reflects respect and protection for the nonsmoker segment of society, and is a positive step for societal development.

1. Successful international experience in tobacco control through law enactment

Before the Convention was signed and became effective, many countries enacted laws and gathered useful experience in banning smoking in public places. In 1970, Singapore enacted a law to prohibit smoking in public transport, cinemas, and other designated places. In 1988, the Canadian Federal Parliament passed the Non-Smokers Health Protection Act, stipulating a smoking ban in public places and areas, including on airline flights. Canada was the first to introduce a smoking ban on international business class flights. In 1995, Poland passed the Law on the Protection of Public Health Against the Effects of Tobacco Use, banning smoking in public places, medical and healthcare facilities, as well as cultural, educational, and sports facilities. In 1996, Brazil passed a law banning smoking in public places and tightening control over tobacco advertising, which lists government offices, bars, restaurants, hospitals, schools, and buses as non-smoking places. In 2002, New York City passed the Clean Indoor Air Act.^[18]

In May 2003, the 56th World Health Assembly passed the Convention. As the Convention is implemented, efforts to control tobacco through legal means will gather more momentum. In March 2004, Ireland became the first country in the world to create smoke-free workplaces through law enactment. The smoke-free environments included public places, all offices, restaurants, bars and hotels. In less than three months, a smoke-free law in Norway also went into effect. Following these two examples, twelve other countries including New Zealand, Italy, Spain, Guinea, Mauritius, and Uruguay, created smoke-free workplaces and public places.

Currently, through law enactment at provincial or state levels, 80% of Canadians and 50% of Americans already enjoy smoke-free workplaces and public places including bars and restaurants. Australia and England will also achieve completely smoke-free indoor public places by the end of the year.^[19]

The assessment reports in Ireland, New Zealand, Norway, and other countries and regions showed that enacting a comprehensive smoke-free law can improve health conditions and reduce tobacco consumption, with no negative economic impact to the service industry. Furthermore, the bans were well-received by smokers and non-smokers alike.

Law enactment to ban smoking in workplaces is an effective measure to reduce tobacco use. A research on the effectiveness of law enactment in Ireland found that the complete ban of smoking through enactment produced marked results: compared with October 2003, before the enactment, the smoking rate dropped from 62% to 14% in workplaces, from 85% to 3% at restaurants, and from 98% to 5% at bars and night clubs. Public support for the comprehensive ban also increased greatly: 46% of smokers say the enactment can help them to quit; 80% of successful quitters believe the law helped them to quit, and 88% believe the law can help them from restarting to smoke.^[20]

When a law banning smoking in public places goes into effect, secondhand smoke density drops, and diseases related to passive smoking also decline. Norway began to implement smoking bans at workplaces June 1, 2004, and illnesses related to smoking among workers decreased five months later.^[21] Researchers surveyed and tested the density of tobacco smoke in the air of 128 bars in fifteen countries for two years between 2004 and 2006, and found that, on average, the density of fine particulates (secondhand smoke components) in bars that completely ban smoking is 93% less than in bars that permit smoking.^[22]

2. Law enactment for banning smoking in public places in China

1) National laws and regulations

Today China does not have a law or regulation specifically banning smoking in public places. Related stipulations appear in some provisions or detailed rules of relevant laws and regulations. For example, the Ministry of Health's 1991 Detailed Implementation Rules for the Public Place Hygiene Management Regulation, which had been enacted by the State Council in 1987, stipulates that smoking is banned in thirteen types of public places: cinemas and theaters, video theaters, music halls, ballrooms, music tea rooms, recreational halls, sports arenas, libraries, museums, fine art galleries, shops, bookstores, and

waiting rooms for public transport.

In 1991, the 20th plenary session of the Standing Committee of the 7th National People's Congress passed the Tobacco Monopoly Law of the People's Republic of China. The General Principles of this law stipulate that "the State and society shall strengthen the publicity and education of the health hazards of smoking, and prohibit or restrict smoking in public transport and public places."

In 1991, the 21st plenary session of the Standing Committee of the 7th National People's Congress passed the Law on the Protection of Minors of the People's Republic of China. Its 27th article stipulates that no one should smoke in the classrooms, sleeping and activity rooms of primary and middle schools, kindergartens, and childcare centers, as well as other rooms where minors convene.

In 1997, the National Patriotic Public Health Campaign Committee, Ministry of Health, Ministry of Railroads, Ministry of Communications, Ministry of Construction, and Civil Aviation Administration enacted the Regulations on Prohibiting Smoking in Public Transport and Waiting Rooms, setting out further requirements on banning smoking in public transport and waiting rooms.

2) Local regulations

Local law enactment to ban smoking in public places first began in 1993. By the end of October 2006, 154 towns, cities, and districts across China had enacted regulations to ban smoking in public places. During those thirteen years, local regulations to ban smoking in public places appeared and developed, playing some role in controlling smoking in public places of the areas in question. However, there remain deficiencies, as follow:

A. At present, only 45.7% of cities and larger administrative regions have tobacco control regulations in China, while the remainder lack any regulations concerning tobacco control.

B. There are a limited number of places where smoking is banned. Most local regulations set bans at medical entities, cinemas and theaters, music halls, video halls, childcare centers and kindergartens, schools, conference rooms, libraries, exhibition halls, public transport, as well as postal, telecommunications, and banking offices. Only Guangzhou and Shenzhen set bans on smoking at air-conditioned restaurants. In all the local regulations, workplaces such as offices are not included.

C. The restrictions are vague and difficult to implement, while the law

enforcement body is unclear on the regulations. For example, some articles stipulate that those who violate will be given “administrative penalties” or will be “penalized according to related regulations”, but there is no law enforcement body nor any detailed penalty described.

3) Industry regulations

As early as 1983, the Civil Aviation Administration of China enacted a ban on smoking on domestic flights. Starting in 2003, it enacted a complete smoking ban on all domestic and international flights, which was the first ban on smoking across an entire industry. On March 1, 1987, Beijing Railway Station was declared to have a non-smoking waiting area. Most express trains to Beijing have become smoke-free, a prelude to a smoking ban for the railway industry. With the increasing speed and modernization of trains, in April 2007 express trains began enforcing comprehensive smoking bans, following the sixth increase of train speed.

In 2005, the Chinese Center for Disease Control and Prevention (China CDC) surveyed the tobacco control situation in fourteen provincial CDCs, and found that only four had partial or complete bans on smoking, representing 28%.^[23] CDCs should be the model for tobacco control, but less than one third of the organizations have regulations to some extent. It is safe to conclude that if this is the case with CDCs, and it is even more challenging to control tobacco in other industries.

4) Learning from the law enactment for tobacco control in the Hong Kong Special Administrative Region

On January 1, 2007, China’s Hong Kong Special Administrative Region began to implement a complete ban on smoking in public places and workplaces. There is a clear law enforcement entity – the Hong Kong Tobacco Control Office, with a staff of 100. The efforts on enforcement and publicity are strong, and the maximum fine for smoking in public places is HK\$5,000.

IV. Law Enactment to Ban Smoking in Public Places has Become Public Consensus

1. Attitude of the public towards enacting laws to ban smoking

A survey conducted in 2002 discovered that 61.6% of the people surveyed actively supported regulations to ban smoking in places such as schools, hospitals, government agencies, and public transportation.^[16] 2006 marked the 10th anniversary of the *Regulation on Prohibiting Smoking in Public Places in Beijing*, and a survey that year revealed that 71.3% of citizens actively supported the Regulation.^[24]

In 2006, China CDC conducted a survey in Beijing, Shanghai, Guangzhou, Changsha, Zhengzhou, Yinchuan and Shenyang, and found that, smokers or non-smokers, 90% of the people supported banning smoking on public transport, schools and hospitals. Over 80% supported a smoking ban in conference rooms and in workplaces. About 50% of smokers supported banning smoking in restaurants and bars. Table 3 details the attitudes of smokers and non-smokers towards banning smoking at different places.

Table 3: Percentage of citizens in seven Chinese cities supporting smoking bans in public places and workplaces (%)

	Smokers			Non-smokers		
	Complete ban	Partial ban	Total	Complete ban	Partial ban	Total
Public transport	94.3	2.9	97.2	93.8	2.5	96.3
Schools	93.5	5.2	98.7	95.1	3.9	99.0
Conference rooms	76.4	10.0	86.4	84.7	9.4	94.1
Hospitals	75.5	23.1	98.6	78.1	21.3	99.4
Workplaces	46.4	40.8	87.2	57.0	38.0	95.0
Restaurants and bars	23.5	20.3	43.8	41.5	29.1	70.6

Public attitudes are the foundation for law enactment and enforcement. Although the rate of support for smoking bans in some public places such as restaurants and bars is not high in China, international experience shows that, as enactment and enforcement are effectively put in place, the public, and especially smokers, will gradually change their attitude.

One year after a complete ban on smoking in workplaces was implemented in Ireland, support by smokers for smoking bans increased from 43% to 67% for workplaces, 45% to 77% for restaurants, and 13% to 46% for bars. Ninety-eight percent of people believe that workplaces are now healthier, including 94% of smokers, and 96% of people believe the ban was necessary and successful, including 89% of smokers.^[25]

Data from California showed the same results. Before and after smoking bans went into effect, customers' support for smoking bans at bars increased from 45.7% to 75.8%, and bar employees' support increased from 86.2% to 94.7%. Diners' support for smoke-free restaurants increased from 92.2% to 98.5%, and restaurant workers' support increased from 96.5% to 99.2%.^[26]

2. Service industry attitudes toward enacting smoking bans

On January 30, 2007, the Beijing Health Administration, Beijing Patriotic Public Health Campaign Committee, and China CDC Tobacco Control Office launched the Initiative to Conduct Tobacco Control in the Beijing Food Service Industry covering close to 40,000 restaurants. A survey of the operators in the industry was concurrently conducted and found that 86.4% of restaurant operators support tobacco control, but 52.2% are concerned that a smoking ban could affect revenues.

International experience shows that a complete ban on smoking in restaurants does not affect restaurant revenues. During the first quarter of 1992, the revenue of the food service industry in California was US\$1.8 billion; after the smoking ban was introduced during the first quarter of 1996, the revenue was US\$2 billion. In 1998 after a smoking ban was implemented at bars, the first quarter revenue was US\$2.1 billion, and in 2004 it reached US\$3 billion.

V. Challenges and Responses

1. Action by the government

In order to effectively implement the Convention with concrete measures, the Ministry of Health established and set up an office for the Leadership Team for Implementing the Convention. As entrusted by the State Council, the Ministry of Health is revising the Public Place Hygiene Management Regulation, which will strengthen provisions on banning smoking in public places.

In order to create a supportive environment for tobacco control across China, improve local competence to implement the Convention, and facilitate the effective implementation of local tobacco control activities, a designated budget for tobacco control was created in the 2006 and 2007 central government subsidies to local projects, and the competence of a tobacco control network in China is being strengthened. Priority is being given to the surveillance and intervention of tobacco control in public places such as government agencies, hospitals, schools, shopping centers, and public transport waiting rooms.

2. Implementation of smoking bans in public places

In a little over a decade, China has continuously developed smoking bans for public places.

In 1992, China began creating smoke-free Schools, and by 2004, 12,094 schools have been named smoke-free.

Under the leadership of the Ministry of Health, the China Association for Tobacco Control and China Association for Hospital Management organized the formulation of smoke-free Hospital Standards. Since 1999, many smoke-free Hospitals have reached the standards in Beijing, Shanghai, Guangzhou, Fuzhou, Dalian, and Shenzhen. In Beijing alone, forty-four hospitals meet the Standards.

3. A Smoke-free Olympics

Smoke-free Olympics originated in 1988 at the Canadian Winter Olympics, and in 1992, the Barcelona Olympic Games completely banned smoking. Each Olympic Games thereafter has been smoke-free. The host countries implemented a complete ban at public places, such as Olympic venues during

events, and prohibited smoking and all tobacco related advertising.

China is the first country to host the Olympic Games since the Convention went into effect. According to the instruction of Premier Wen Jiabao, a Smoke-free Olympics should be a part of the Green Olympics campaign. In the Notice on the 20th World No Tobacco Day issued by the Ministry of Health and the China Patriotic Public Health Campaign Committee, the Ministry and Committee called on the host cities of the Olympic Games to formulate action plans on a Smoke-free Olympics as soon as possible and to implement them using concrete measures. The Smoke-free Olympics action will further impel the creation of smoke-free and clean work and public environments.

On February 8, 2007, the Beijing Chamber of Commerce, Beijing Food Service Trade Association, Beijing Cuisine Association, and Beijing Western Food Association jointly issued the Initiative to Advocate the Creation or Addition of Smoke-free Dining Areas in Food Service Enterprises. On April 25, the Beijing Municipal Government convened a launch meeting for implementing tobacco control in the Beijing food service industry. The Beijing Health Administration, Beijing Chamber of Commerce, Beijing Tourism Administration and other agencies jointly issued a notice requiring the food service industry to implement tobacco control. Contracted hotels for the Olympics, Olympic premises, and restaurants in the Olympic Village must completely ban smoking before June 2008. Furthermore, food service outlets of medium and large sizes should advocate a complete ban of smoking; if, however, they cannot become 100% smoke-free, 75% of the area of the premises should be smoke-free.

The Framework Convention on Tobacco Control has become effective in China. However, with 300 million smokers and 540 million passive smokers, there is a long way to go to prevent passive smoking and achieve a smoke-free China.

We hope that every smoker, if addicted to smoking and as yet unable to quit, will not smoke in front of their child, spouse, colleagues, or friends, and that others will have the courage and sense of responsibility to tell the smoker to please go outdoors to smoke.

Let us work together to create a smoke-free environment, and enjoy a healthy life.

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