



AN INITIATIVE
OF THE WHO
EUROPEAN
PARTNERSHIP
PROJECT
TO REDUCE
TOBACCO
DEPENDENCE



WHY SMOKING IN THE WORKPLACE MATTERS: AN EMPLOYER'S GUIDE

Why Smoking in the Workplace Matters: An Employer's Guide

by John Griffiths and Kate Grieves

This publication is a product of
the WHO European Partnership Project
to Reduce Tobacco Dependence.



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Promoting good health within the workplace

The importance of promoting and maintaining a healthy workforce is increasingly being recognised. Many organisations are already active in health promotion, particularly tobacco control. Existing systems include health-related policies, occupational health and health & safety departments, and a corporate culture and ethos that places importance on employee health and well-being. Workplace health promotion programmes should be a core element of the organisation's corporate ethos. This requires support at senior management level, with responsibility for implementation shared among several individuals or departments.

WHO Partnership Project to Reduce Tobacco Dependence

The WHO European Partnership Project to Reduce Tobacco Dependence was set up in 1999, for an initial three-year period, with the objective of reducing tobacco-related death and disease. The Partnership Project comprises private, non-commercial and public sector partners, including the pharmaceutical sector at the European level and in four target countries, France, Germany, Poland and the United Kingdom. In 2001, the Czech Republic joined the project.

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WHO Regional Office for Europe

The World Health Organization is a specialised agency of the United Nations with primary responsibility for international health matters and public health. The WHO Regional Office for Europe, in Copenhagen, is one of six regional offices worldwide. Each Regional Office has its own programme geared to the particular health problems of the countries it serves. The WHO European Region embraces 870 million people, from Greenland in the north-west and the Mediterranean in the south to the Pacific coast of the Russian Federation in the east. Since 1990, the number of member states has been 51.

World Health Organization

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European Healthy Workplaces Project

One of the initiatives developed by the Partnership Project was the European Healthy Workplaces Project. The aim was to facilitate the development of sustainable workplace tobacco control activities in organisations (both public and private) across Europe, by applying the principles of workplace health promotion in the context of workplace tobacco control. The guidance outlined in this booklet was developed from the experiences of 16 participating pilot organisations representing a wide range of organisations.

The Project Team was led by John Griffiths and Kate Grieves. Ongoing support at a national level was provided in France by Sylvianne Ratte (Réseau Hôpital sans Tabac), in Germany by Margot Wehmhoener (BKK Bundersverband) and in Poland by Patrycja Wojtaszczyk and Jacek Pyzalski (Nofer Institute of Occupational Medicine).

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France The municipality of Villeneuve d'Ascq,
Centre Hospitalier Universitaire d'Amiens,
Coca Cola Entreprise France,
USINOR

Germany The municipality of the City Dortmund,
Krankenhaus Links der Weser, Bremen,
Siemens AG, Mulheim am der Ruhr,
Volkswagen, Wolfsburg

Poland The municipality of Starostwo Powiatowe w Cieszynie,
The Santa Spirit Hospital in Rawa Mazowiecka,
Powszechny Bank Kredytowy SA,
Zaklad Energetyczny Torun SA

United Kingdom The municipality of Bridgend County Borough Council,
Birmingham Children's Hospital NHS Trust,
BAE Systems,
UNISON

Practical guidance for developing and implementing workplace tobacco control programmes can be found in the companion handbook "Tobacco in the Workplace: Meeting the Challenges. A Handbook for Employers"

Many factors make stopping smoking difficult, including media portrayal and cultural and societal acceptance of tobacco use.

Restricting smoking in the workplace protects employees against involuntary exposure to tobacco smoke and helps smokers reduce their daily intake of tar, and also reinforces the fact that smoking is socially unacceptable

1. The importance of the workplace

One half of all regular smokers die from tobacco use

Most adults spend at least one-third of their time at work, making their place of employment a key setting for action. By failing to address the challenge presented by tobacco, your organization sends out the message that smoking is not an issue for concern. This fails to acknowledge the risks associated with tobacco use – both for smokers and those around them.

2. Why employers should act

Smoking is the greatest single cause of preventable ill health and the leading cause of premature death in Europe. Smoking causes many debilitating and fatal illnesses, including cancer, heart disease, bronchitis, and emphysema. In the WHO European Region more than one-third of adults smoke every day – a total of 200 million smokers – and tobacco products kill more than 1.2 million people each year.

Why worry about tobacco?

The burden of disease

One half of long-term regular smokers are killed by cigarettes.

The harm it causes others

Breathing other people's tobacco smoke is unpleasant and increases the risk of lung cancer and other diseases.

Costs

Tobacco costs the world US\$200 billion a year. For most European countries, the tobacco industry is a huge drain on the economy.

What does this mean?

Tobacco causes 1.2 million deaths annually, 14% of all deaths, in the European Region.

This means around 23,000 deaths each week.

In the western part of the WHO European Region, 10% of men aged 35 will die from a tobacco-related illness by age 69.

In the eastern part of the WHO European Region, 20% of men aged 35 will die from a tobacco-related illness by age 69.

By 2020, tobacco will be the most important single cause of ill health and death worldwide.

By 2020, 2 million deaths, 20% of all deaths, will be caused by tobacco each year in the WHO European Region.

Tobacco smoke is a major health threat in the workplace. Most adults spend five days per week for most of their working life (around 40 years) at work. The presence of tobacco smoke in the working environment therefore has significant consequences for employees.

Adopting a workplace smoking policy deals with the issue of smoking in a professional and effective way is good business practice. The main purpose is to ensure that:

- all staff, customers, clients and contractors clearly understand their rights and obligations
- the workplace complies with relevant legislation
- the negative impact of tobacco on the business is minimised.

Employers should bear in mind changing attitudes in society. One important reason for a smoking policy is to implement what staff, customers, suppliers, shareholders and other stakeholders regard as good practice. Public opinion - even among smokers - strongly favours workplace smoking restrictions.

3. Smoking costs business

Tobacco use affects every organization, whether public, private, small, medium or large. The effects of tobacco include:

- Lost production and lower productivity
- Higher sickness and absence rates
- Increased early retirement due to ill health

Annual Cost of Employing Smokers (1995 Canadian dollars per smoking employee)

These all cost money. One Canadian study conducted by Health Canada reported the following annual costs to employers resulting from smoking:		
Increased absenteeism	\$ 328	Absenteeism and lost productivity Tobacco-related diseases probably account for 25-35% of the days lost to your organization in absenteeism. Ignoring this problem costs your organization money.
Decreased productivity	\$ 3,107	
Increased life insurance	\$ 107	
Provision of smoking areas	\$ 121	
Total annual cost	\$ 3,664	
\$ = \$CAD 1.40		

Smoking also reduces work time as employees leave their workstations to smoke. For example:

- A company has 10,000 employees
- Approximately 3,000 smoke
- Each smokes on average 6 cigarettes per day at work
- An average cigarette break lasts at least 5 minutes
- Each smoker wastes 30 minutes every working day
- An employee on € 8.64 per hour therefore costs the company € 1,037 per annum
- The 3,000 smokers cost the company a total of € 3.1 million per annum

About half of the deaths caused by tobacco occur in middle age (35-64 years), before retirement. Smoking-related absence often increases with age. In today's competitive environment, organisations cannot afford to lose valuable, expensively trained employees. Smoking generally causes long periods of declining health which is another drain on resources, in terms of capital cost through insurance cover and loss of productivity.

One study of 10,000 police officers in Hong Kong found that non-smoking men exposed to passive smoking for more than one year were twice as likely to take time off than colleagues working in a smoke-free environment. They were also 30% more likely to have needed treatment for respiratory symptoms in the preceding 14 days. The results held true even after passive smoking at home was taken into account.

*Smoking causes
35% of all deaths
among middle-
aged men in
developed
countries*

Similarly, a recent study of 300 staff in the United States reported that smokers had more than two extra days off sick each year compared to non-smokers. Smokers were absent from work for >6 days per year, compared to 4.5 days for ex-smokers and 4 days for non-smokers. Smokers were also considerably less productive than non-smoking counterparts because of poorer health and regular smoking breaks.

Many European countries face the challenge of an ageing population, with direct consequences for the labour market. Tobacco-related disease is the major cause of premature mortality and morbidity and results in the loss of experienced workers. Organisations that tackle tobacco in the workplace will be rewarded in the long term as experienced employees continue to work into later life.

Friction between colleagues

Smoking also creates tension as non-smokers frequently have to cover for colleagues who smoke. Cigarette breaks tend to be viewed as ‘time off’ during the working day, and non-smoking staff often resent colleagues who regularly absent themselves to smoke, particularly during periods of pressure. And as smokers often take more time off in general due to ill health, non-smokers can become disgruntled about ‘carrying’ such colleagues. Line managers do not always recognise this resentment, particularly if they smoke.

Other aspects

Smoking also results in extra burdens for employers, such as additional cleaning and redecoration costs, special ventilation requirements and provision of facilities to accommodate smokers. Insurance premiums may be higher because of claims for fire damage, and tobacco smoke may damage plants and machinery.

Tobacco also has an impact on the wider community. The community provides your organization with its workforce and, in many cases, its customer base. Because of the toll on the local population, both financially and in terms of health, tobacco has a knock-on effect on organisations.

4. Smoking affects everyone

The effect of environmental tobacco smoke is not trivial. It is a serious environmental hazard, that is easily avoided.

It is not only smokers who are at risk from tobacco-related disease. Although it is often mistakenly believed that passive smoking, or environmental tobacco smoke (ETS), is simply an irritation in reality it is far more hazardous. ETS can exacerbate asthma and cause heart disease, lung cancer and stroke in exposed adults, and is estimated to cause several hundred deaths from lung cancer each year in the UK alone.

The composition of tobacco smoke makes passive smoking so hazardous. Tobacco smoke contains over 4,000 compounds, many of which are poisonous and cause cancer, including: tar, which contains many extremely harmful substances; carbon monoxide, a colourless, poisonous gas; nitrogen oxides, which can damage the tissue of the lung; hydrogen cyanide, a toxin; around 30 metals including nickel, arsenic, cadmium, chromium and lead, and radioactive cancer-causing compounds.

Sidestream smoke (smoke that drifts from the lit end of the cigarette) contains higher levels of nicotine, ammonia, benzene, carbon monoxide and several

cancer causing agents than mainstream smoke (smoke drawn through the cigarette by the smoker) and exhaled mainstream smoke. The particles of sidestream smoke are also smaller than those of mainstream smoke, meaning that they can be inhaled more deeply into the lungs where they are more likely to cause disease. Environmental tobacco smoke is the combination of sidestream smoke and the fraction of exhaled smoke not retained by the smoker.

Passive smoking at work is surprisingly common. For example, a 1999 poll estimated that in the UK more than 3 million non-smokers were either continuously or frequently exposed to tobacco smoke at work. Even in France, which has adopted laws governing smoking in public places, 40% of employees are still exposed to ETS at work.

One study of German metal workers found that for many non-smokers exposure to ETS at the workplace exceeded exposure to ETS from any other source. Another recent study showed that 30 minutes of passive smoking can have a substantial impact on the coronary arteries of non-smokers.

In addition to the physical effects, non-smoking employees can also suffer psychological damage from ETS. Passive smoking has a negative impact on working relationships and morale, and undermines productivity. Tension and resentment towards smokers by their non-smoking colleagues can become a problem.

There is no safe level of exposure to ETS. Ventilation cannot ensure smoke-free workplaces and is not a policy option.

It is common regulatory practice to reduce workplace risks to below 1 in 10,000. A passive smoker inhales up to 1% of smoke inhaled by an active smoker. If the corresponding risk to health was 1% of that of active smoking, it would still be very high compared to other workplace hazards simply because the risks associated with active smoking are so great (a regular smoker has a one in two chance of dying prematurely because of smoking). Failure to recognise and address the risks associated with ETS could lead to legal action against employers.

Passive smoking causes heart disease, lung cancer, stroke and nasal cancer. It also exacerbates asthma, cystic fibrosis and decreased lung function.

Exposure to ETS in workplaces is comparable with, and often greater than, exposure in the home of non-smokers married to smokers

5. Litigation

The right of the individual not to be exposed to ETS in public places, including the workplace, is increasingly being recognised. This is embodied both in European Union law and also, increasingly, in national laws. Protection from ETS

can either take the form of a total smoking ban, or separate designated areas for smokers and non-smokers.

Considerable evidence indicates beyond doubt that exposure to environmental tobacco smoke is harmful. Failure to recognise and address the risk associated with environmental tobacco smoke could result in legal action.

Restriction of smoking in the workplace is a relatively recent development. The number of countries with specific national legislation dealing exclusively with workplaces remains limited, but the general thrust is towards the right to breathe clean air. The relative lack of regulation and frequent infringement of existing regulation leaves employers vulnerable to expensive litigation. The rights of non-smokers strongly prevail over those of smokers.

Civil litigation may increase, with employees whose health has been harmed by breathing in ETS suing their employers. Companies that address the issue of passive smoking reduce the risk of such legal action.

6. European Health and Safety Law

Many countries in Europe have already addressed the issue of tobacco in the workplace, often through health and safety legislation. In addition, several European Union Directives relating to health and safety in the workplace have come into force, by means of regulations since 1 January 1993. These place emphasis on management, especially senior management, having responsibility for health and safety. These duties are not optional.

Employers must undertake and provide a written risk assessment for all employees. Health risks caused by tobacco should be part of that assessment, especially for high-risk groups such as pregnant women and vulnerable groups such as asthmatics. The key factor in considering risk is not whether the employer knew about the risks of passive smoke, but whether s/he ought to have known.

Employers must minimise identified risks by taking ‘preventive measures’. Although, in theory, this could include effective ventilation, or air conditioning, the law expects employers to remove the source of risks rather than to attempt to lessen their impact.

Employees must be actively consulted and involved in health and safety matters. Their views on health and safety concerns must be sought as an intrinsic part of the legal structure.

Finally, health surveillance must be effectively developed in all organisations. Implicit in European law is a requirement that an employee’s health should dictate their work environment. For example, an employee with asthma or other respiratory or heart condition known to the employer should not be required to work in an environment which may exacerbate their illness.

Since 1 January 1996 workplaces have been required to provide ‘rest facilities’ for non-smokers (Regulation 25, Workplace Health, Safety & Welfare Regulations 1992) (EC/xx93). Rest facilities include canteens, lounges, reception areas, etc. Many workplaces do not have sufficient accommodation to provide dual facilities, so logic, as well as law, points to a smoke-free policy in these areas.

7. Government action

Across Europe there is increasing movement to protect people’s health by restricting smoking areas. The purpose is two-fold: to encourage smokers to cut down or stop smoking, and to minimise the impact of smoking on the health of non-smokers. This movement is increasingly endorsed and underpinned by public opinion which, in many countries, is ahead of political action and there is growing pressure for protection against ETS. In France, for example, even 61% of smokers favour better enforcement of legislation that protects non-smokers from ETS.

Governments worldwide recognise the consequences that widespread tobacco consumption will have upon their populations. The WHO seeks global solutions for a problem that cuts across national boundaries, cultures, societies and socio-economic strata. In response to the massive public health impact of tobacco, the WHO developed the first comprehensive response to deal with this ‘epidemic’.

In May 1999, the World Health Assembly (WHA), the governing body of WHO, began multilateral negotiations to set out rules and regulations to govern to-

bacco and tobacco products during the 21st century. The 191-member WHA unanimously backed a resolution calling for a Framework Convention on Tobacco Control (FCTC). This is a new legal instrument capable of addressing issues as diverse as tobacco advertising and promotion, agricultural diversification, smuggling, tax and subsidies. A record 50 nations pledged financial and political support for the Convention.

The FCTC has many benefits. The most significant is that with the Convention as a pathfinder and coordination vehicle, national public health policies, tailored around national needs, can be advanced without the risk of being undone by transnational phenomena (e.g. smuggling). While the FCTC obligates states to cooperate in key areas, it also forges important links between countries and other potential partners.

8. Many smokers want to stop

Introducing a workplace non-smoking policy can reduce employee smoking by 12-39%. In addition, among those who continue to smoke consumption falls by 3-4 cigarettes/day

As awareness of the risks of smoking increases, so does the desire to stop. Many smokers are unhappy about their smoking, so employers should not be concerned about raising the issue of quitting among staff. Surveys repeatedly report that smokers consider smoking restrictions as an aid to reduce or quit smoking rather than a discriminatory measure.

In the UK, an estimated 30% of employees smoke, and 70% of those say they want to stop. Approximately 10% of smokers are currently trying to stop, and 31% would like to stop soon. In Germany, where smoking prevalence is higher, over one-third of smokers say they would like to quit.

Most smokers find it very hard to quit without support and are more likely to succeed if they get help. Introducing a smoking policy at work can help smokers who want to stop.

Even the tobacco industry is concerned about smoke-free workplaces: Phillip Morris documents estimate that workplace bans can lead to a 20% quit rate among smokers.

9. Rights and responsibilities

Smoking at work is often considered something that employees should sort out for themselves, or a personal decision that should not be regulated by workplace rules. Smoking is often regarded as a personal habit, with attempts to restrict smoking in the workplace considered an infringement of personal liberty. However, non-smokers have a right to smoke-free air and the risks of ETS raise the important ethical issue of employees compromising their health while earning a living.

Employers do not ask employees to vote on fitting guards to dangerous machinery or handling toxic substances. It is incumbent upon employers to provide a safe working environment, and ensuring non-smokers are free from the risks of ETS may be part of compliance with current health and safety legislation.

Clearly smokers actively choose to continue smoking – perceiving the benefits (such as pleasure and avoidance of withdrawal) to override the costs of their behaviour. However, many smokers are not fully aware of the high risk of disease and premature death. Smoking usually starts in adolescence or early adulthood and, even when informed, young people are often not fully aware of the reality and have difficulty envisaging any repercussions from smoking.

Moreover, smoking is not a matter of free choice – nicotine is a highly addictive drug. It has similar effects on the brain to those of illicit drugs such as heroin or cocaine. Employers cannot wish away the problem of smoking in the workplace as it involves physical dependence and withdrawal. Responsible employers should offer support or make special provision for smokers trying to quit.

In addition to the health risks ETS, smoking also imposes other costs on non-smokers. Annual healthcare costs for smokers exceed that of non-smokers, so if healthcare is paid for to some extent by public taxation then non-smokers are bearing part of smokers' costs. In countries where employers finance staff healthcare, employers are shouldering the cost of smokers.

10. Cost-effective strategies

Although more needs to be done to develop successful organisational responses to tobacco, much is already known about what does or does not work. Much can be done with little or no capital investment. The accompanying handbook,

'Tobacco in the Workplace: Meeting the Challenge. A Handbook for Employers', provides step-by-step guidance on how to adopt a strong but cost-effective response to the problems of smoking.

Smoking policies are not about whether or not people smoke, but when and where they smoke

The principle requirements to implement successful programmes are visible senior management support, and a comparatively small amount of time made available to a key operational member of staff responsible for implementation.

Many organisations have addressed the tobacco issue and achieved a substantial improvement in employee health and reduced rates of sickness. They may also have gained in other ways, such as raising morale and improving the internal and external image of the organization.

11. Benefits of workplace tobacco control

The introduction of even a simple workplace tobacco policy can result in significant improvements in employee health and the working environment, including:

- reduction in daily cigarette consumption
- reduction in smoking prevalence
- more employees attempting to quit than without such regulations
- reduction in short-term effects of passive smoking
- improvement in working relationships and/or morale
- demonstrable health benefits; in the first year after stopping smoking, the risk of heart attack decreases by up to 50%
- direct contribution to employee workability and health through proactive introduction of policy

Addressing smoking can be one part of a broader approach to protect and improve employee health and well-being. One study of 1,400 European organisations by the European Foundation for the Study of Living and Working Conditions identified the benefits of such workplace-based activities:

Benefits for the employee	Benefits for the employer
Better health	Lower absenteeism
Improved working environment	Increased productivity
Improved working relationships	Improvements in relationships with employees
Reduced levels of stress	Development of a “caring” organization ethos
Improved morale	Improved staff morale
Increased levels of job satisfaction	Development of a positive corporate image
Greater personal awareness	Better recruitment and lower staff turnover

Tobacco control has a central role to play in the development and maintenance of a general workplace health promotion programme. Tobacco can be addressed as a single issue, but the lack of a cohesive approach towards the promotion of health and well-being at the organisational level could make the development of a comprehensive, sustainable tobacco control policy more difficult. A comprehensive workplace health promotion programme in which tobacco control plays a prominent role is therefore recommended.

12. Benefits of quitting

Stopping smoking has substantial and immediate health benefits for smokers of all ages. Ex-smokers live longer and have better health than continuing smokers, no matter what age they stop smoking.

The excess risk of death from smoking begins to decrease shortly after stopping and continues to decrease for at least 10–15 years. Smokers who quit before the age of 50 halve their risk of dying within the next 15 years compared to those who continue to smoke.

Quitting tobacco at any age results in both immediate and long-term health benefits

Time since quitting	Beneficial health changes
20 minutes	Blood pressure and pulse rate return to normal.
8 hours	Nicotine and carbon monoxide levels in blood reduce by half, oxygen levels return to normal.
24 hours	Carbon monoxide eliminated from the body. Lungs start to clear out mucus and other smoking debris.
48 hours	No nicotine left in the body. Sense of taste and smell are greatly improved.
72 hours	Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase.
2 - 12 weeks	Circulation improves.
3 - 9 months	Cough, wheezing and breathing problems improve as lung function increases by up to 10%.
1 year	Risk of heart attack falls to about half that of a smoker.
10 years	Risk of lung cancer falls to half that of a smoker.
15 years	Risk of heart attack falls to the same as someone who has never smoked.

1-2 years after quitting, the excess risk of death from heart disease caused by smoking is halved, and within 5 years of stopping the excess risk of oral and throat cancer is also halved. After 10 years, ex-smokers' risk of lung cancer is 30%–50% that of continuing smokers, although the risk remains higher than that for never-smokers for many years. And within 15 years, the risk of cardiovascular death is nearly that of never-smokers. The excess risk of other cancers, chronic lung disease, and stroke and other vascular diseases also decreases after quitting.

Tobacco use is not safe at any level. Maximising health and minimising risk involves complete abstinence from tobacco products and freedom from exposure to ETS. Effective treatment for tobacco dependence can significantly improve public health within a few years.

13. What can you do?

A few simple steps can markedly improve working conditions, employee health and well-being and therefore increase productivity and reduce absenteeism. You will also protect yourself against litigation and demonstrate compliance with good practice.

*Every
tobacco
death is
preventable*

Detailed, practical guidance for implementing coherent tobacco workplace policy can be found in the accompanying booklet, 'Tobacco in the Workplace: Meeting the Challenge. A Handbook for Employers'. Previous experience indicates that critical factors for success are:

- Visible support for tobacco control initiatives from senior management
- Appointment of an in-house 'champion' for tobacco control activities (such as a member of the Occupational Health or Human Resources team)
- Development of a written policy, clearly communicated to all staff, indicating precisely where and when staff may smoke. This should be reviewed every 18-24 months
- Provision of cessation support for staff trying to quit

Action on Smoking and Health, The National Asthma Campaign, The Trades Union Congress & The World Health Organization. Smoking in the Workplace, UK Edition. London 1999. Also available at: <http://www.ash.org.uk>
Bertera RL. The effects of behavioural risks on absenteeism and health care costs in the workplace. *Journal of Occupational Medicine* 1991, 33: 1119-1124.

Borland R, Cappiello M, Owen N. Leaving work to smoke. *Addiction* 1997; 92: 1261-1268.

Borland R, Chapman S, Owen N, Hill D. Effects of workplace smoking bans on cigarette consumption. *American Journal of Public Health* 1990; 80: 178-180.

Brenner H, Fleischle B. Smoking regulations at the workplace and smoking behaviour: A study from Southern Germany. *Preventive Medicine* 1994; 23: 230-234.

Chapman S, Borland R, Scollo M, et al. The impact of smoke free workplaces on declining cigarette consumption in Australia and the USA. *American Journal of Public Health* 1999; 89: 1018-1023.

Eriksen MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. *American Journal of Health Promotion* 1998; 13: [KG, please add page nos]

Farrelly MC, Evans WN, Sfeckas AE. The impact of workplace smoking bans: results from a national survey. *Tobacco Control* 1999; 8: 272-277.

Health Canada. Smoking and the bottom line: the costs of smoking in the workplace. 1997. Available at:
<http://www.hc-sc.gc.ca/hppb/cessation/air/bottomline/report.html>

Parrot S, Godfrey C, Raw M. Costs of employee smoking in the workplace in Scotland. *Tobacco Control* 2000; 9: 187-192.

Parry O, Platt S, Thomson C. Out of sight, out of mind: workplace smoking bans and the relocation of smoking at work. *Health Promotion International* 2000; 15: 125-133.

Willemsen MC, Meijer A, Jannink M. Applying a contingency model of strategic decision making to the implementation of smoking bans: a case study. *Health Education Research* 1999; 14: 519-531.

One of the initiatives developed by the WHO European Partnership Project to Reduce Tobacco Dependence was the European Healthy Workplaces Project. The aim was to facilitate the development of sustainable workplace tobacco control activities in organizations (both public and private) across Europe, by applying the principles of workplace health promotion in the context of workplace tobacco control. The case for introducing a smokefree workplace policy outlined in this booklet, "Why Smoking in the Workplace Matters: An Employer's Guide" is based on the existing evidence base and draws on the experience of 16 organizations. The organizations include:

France The municipality of Villeneuve d'Ascq,
Centre Hospitalier Universitaire d'Amiens,
Coca Cola Entreprise France,
USINOR

Germany The municipality of the City Dortmund,
Krankenhaus Links der Weser, Bremen,
Siemens AG, Mulheim am der Ruhr,
Volkswagen, Wolfsburg

Poland The municipality of Starostwo Powiatowe w Cieszynie,
The Santa Spirit Hospital in Rawa Mazowiecka,
Powszechny Bank Kredytowy SA,
Zaklad Energetyczny Torun SA

United Kingdom The municipality of Bridgend County Borough Council,
Birmingham Children's Hospital NHS Trust,
BAE Systems,
UNISON

Practical guidance for developing and implementing workplace tobacco control programmes can be found in the companion handbook "Tobacco in the Workplace: Meeting the Challenges. A Handbook for Employers"

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