# Ireland's workplaces, going smoke free

*The result of sustained, evidence based, policymaking in support of better health*

On 29 March 2004 Ireland became the first European country to implement legislation creating smoke-free enclosed workplaces, including bars and restaurants.[1] Norway (June 2004) and Sweden (2005) are on schedule to introduce similar legislation. Though there are some minor exemptions in the Irish legislation, this move is ground breaking and is of immense public health importance. The legislation shines as a beacon for other jurisdictions that might want to follow Ireland's lead.

There were many twists and turns in the development of the Irish legislation. Over the past 15 years in particular, activity in all areas of tobacco control helped create the platform on which this legislation on secondhand smoke developed. Politicians, public servants, trade unions, and non-governmental organisations all played their part.

In the 1990s the government introduced legislation that prohibited smoking in a small number of public places, but it had no general application to the workplace.[2] In the mid-1990s, despite the growing evidence of the harmful effects of secondhand smoke, a purely voluntary code of practice on smoking in the workplace was agreed between the government, employers, and trade unions.[3] It offered little in the way of protection for those exposed to secondhand smoke and nothing for those working in the hospitality sector.

The non-governmental tobacco control community, along with others, including some public servants, pressed for further action. Politicians, public servants, and trade unions were extensively lobbied on a range of tobacco control actions including the need to protect workers from secondhand smoke. International research on the health effects of secondhand smoke and developments in the United States were kept to the fore in the media.[4] The overriding strategy was to get tobacco control issues firmly on the agenda of policymakers in all sectors. On the issue of secondhand smoke, the strategy was simple: this was a health and safety issue and needed to be tackled accordingly.

The overall strategy had a fair degree of success. A key health strategy document highlighted the importance of tobacco control.[5] In addition senior health officals published a blueprint document for creating a tobacco-free society, which was adopted by government.[6] The political system also responded. The influential all party Oireachtas (Parliament) Joint Committee on Health and Children examined the issue of smoking and health. It sought input from a wide range of groups, including the tobacco industry. The tobacco industry insisted that there was insufficent evidence to link secondhand smoke to any illness in non-smokers. The committee rejected this argument, however, and unanimously recommended a new national antismoking strategy, to include restrictions on smoking in workplaces, including bars.[7 8] A subsequent refusal by tobacco industry representatives to come before another meeting of the committee undermined their ability to lobby politicians once the legislation was published.

Subsequently an Office of Tobacco Control (www.otc.ie) was established by the government to build capacity for tobacco control measures. It drew on international expertise on how to deal with the issue of secondhand smoke and brought experts to Ireland so that politicians, policymakers, the media, and trade unions representing hospitality workers might understand how best to proceed. Of particlur importance was the input of James Repace, a renowned US health physicist, who estimated that up to 150 Irish barworkers could be dying annually as a result of their exposure to secondhand smoke.[9]

A new tobacco bill was published in 2001, which gave the minister for health and children the power to create smoke-free workplaces. It was supported by the opposition parties and was signed into law in 2002. Further discussions continued on how widely restrictions on smoking in the workplace should extend. To help that debate, the Office of Tobacco Control and the Health and Safety Authority commissioned independent scientists to review the entire evidence on secondhand smoke. Their report concluded that secondhand smoke was harmful, that employees needed to be protected from it in the workplace, and that legislative measures were needed.[10] So definitive were their findings that at the launch of this report in January 2003 the minister for health and children, Mr Micheál Martin TD, announced that he would make the necessary orders to ensure that all enclosed workplaces, including bars, would be smoke-free on 1 January 2004.

Not surprisingly, some difficulties were then encountered. After extensive lobbying by the hospitality sector to seek to have bars and restaurants exempted, some ministers buckled under pressure. However, with the support of the Taoiseach (prime minister) and the majority of the government, along with the opposition parties, the minister for health and children held firm. The minister also received strong support from the healthcare sector, trade unions, and the public throughout the debate.[11 12] Further concerns arose when the proposed implementation date was twice changed because of the need to bring in some exemptions and to notify these changes to the European Union. Though there was concern that the whole thing might unravel because of the exemptions and the delays, the end result is that we now have legislation in place that is robust and more likely to resist any legal challenges. The legal challenges that were being threatened by the hospitality sector have fallen away, and a detailed implementation programme is being rolled out nationally (www.otc.ie, www.smokefreeatwork.ie).

The development of this legislation and its subsequent implementation underscores the value of prolonged public health advocacy in helping good, evidence based policymaking. It also shows that politicians are prepared, if adequately supported, to tackle vested interests in the pursuit of better public health.

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1 *Public Health (Tobacco) Acts 2002 and 2004.* Dublin: Stationery Office, 2004.
2 *Tobacco (Health Promotion and Protection) Regulations 1995.* Dublin: Stationery Office, 1995.
3 Department of Health. *Working together for cleaner air. Developing smoke free policies in the workplace.* Dublin: Health Promotion Unit, 1994 .
4 California Environmental Protection Agency. *Health effects of exposure to environmental tobacco smoke.* Sacramento: California Environmental Protection Agency, 1997.
5 Department of Health and Children. *Quality and fairness. A health system for you.* Dublin: Stationery Office, 2001. www.doh.ie/hstrat/index.html (accessed 1 Apr 2004).
6 Department of Health and Children. *Towards a tobacco free society: report of the tobacco free policy review group.* Dublin: Stationery Office, 2000. www.doh.ie/publications/tobacco.html (accessed 1 Apr 2004).
7 Joint Committee on Health and Children. *A national anti-smoking strategy. A report on smoking and health.* Dublin: Houses of the Oireachtas, 1999.
8 Joint Committee on Health and Children. *Second interim report of the sub-committee on health and smoking.* Dublin: Houses of the Oireachtas, 2001.
9 Repace J. Right to life overrides right to smoke. *Irish Times* 2002;Feb 11.
10 Allwright S, McLoughlin JP, Murphy D, Pratt I, Ryan MP, Smith A. *Report on the health effects of environmental tobacco smoke (ETS) in the workplace.* Dublin: Office of Tobacco Control/Health and Safety Authority, 2002. http://69.20.28.11/article.asp?article=34 (accessed 1 Apr 2004).
11 National and united force representing at least 1.1 million people living in Ireland fully endorse smoking ban and welcome date. www.smokefreeatwork.ie/news/detail.asp?id=10 (accessed 18 Feb 2004).
12 Smokers say publicans should obey the smoking ban. www.otc.ie/article.asp?article=145 (accessed 4 Nov 2003).


# Partner reduction and the prevention of HIV/AIDS

*The most effective strategies come from within communities*

*Education and debate* p 891

In an era of increasingly complex HIV/AIDS analyses and responses, Shelton et al reaffirm the simple truth that without multiple sexual partnerships, an HIV epidemic would not occur and that by extension partner reduction is the most obvious, yet paradoxically neglected, approach to the prevention of HIV (p 891).[1] They note that in the ABC model for preventing AIDS/HIV (abstinence, or deferred sexual inception—A, be faithful, or partner reduction—B, and condom use—C), sexual deferral and condom use have persuasive advocates but partner reduction does not.

Their analysis of the vital part played by partner reduction in reducing HIV infection in Western gay communities, Uganda, and Thailand is timely. We face a crisis in HIV prevention. The successes in Uganda and Thailand occurred 15 years ago, and in the intervening period no national declines of similar clarity or scope have occurred. Similarly, in HIV prevention research, the heady days of the Mwanza sexually transmitted infections trial were succeeded by the disappointing findings (albeit explicable) in the more ambitious Rakai sexually transmitted infections trial, the Masaka triplet IEC (information, education, and communication) and sexually transmitted infections trial, and most distressingly, the recent Mwanza adolescent trial.[2–5] Shelton et al's analysis may help to infuse new life into HIV/AIDS prevention. Their argument that partner reduction is the potential centrepiece of a unified ABC approach is good common sense—and good epidemiology.

Whether the ABC approach addresses the needs of women is debatable, with commentators arguing that many women are unable to negotiate relationships based on abstinence, faithfulness, or condom use.[6] The enduring contribution of gender inequalities, including economic inequality and gender violence, to women's vulnerability to HIV is incontrovertible. Yet it is intriguing that some of the steepest declines in HIV infection levels in Uganda seem to have occurred among women, particularly young women, putatively the most powerless members of society. Shelton et al present evidence that where HIV prevalence has declined among pregnant women (Uganda, Thailand, Zambia, Ethiopia, Cambodia, and the Dominican Republic) the primary reported behaviour change has been partner reduction and monogamy by men, especially older men. Uganda's experience shows that achieving sexual deferral and partner reduction among men, particularly older men, may create safer environments for women, particularly young women. Community norms that proscribe older men having sexual relationships with younger women may be especially protective. A successful ABC approach that reduces HIV infection among women, particularly young women, is a vital element of a broader gender response. Uganda's ABC approach was reinforced by practical measures to increase women's participation in higher education and political life and to protect women from gender violence and sexual coercion.

Analysis of factors contributing to behaviour change in Uganda and elsewhere is even more challenging than the reaffirmation of partner reduction. Contexts as disparate as California, Uganda, and Thailand share unnerving similarities.[7–10] Above all, HIV prevention responses were rapid, endogenous, inexpensive, and simple.[8 9] They were based on the premise that communities, however disparate, have within themselves the resources and capital to reverse this epidemic. They preceded large scale exogenous assistance and occurred largely without the involvement of specialist agencies. They were locally led, by gay leaders and activists in California and by political, religious, and community leaders in Uganda. They promoted changes in community norms, thus creating enabling and protective environments long before the concept gained currency. They stressed simple messages and actions and in doing so achieved declines in HIV infection that preceded the growth in HIV services, including distribution of condoms and voluntary counselling and testing. They relied on interpersonal communication channels and networks, rather than mass media.[8 9 11]

Remarkably they combined high fear approaches with openness and the capacity to rise above discrimination and to integrate prevention and care effectively.[8 9] In doing so they created a context in which people perceived high personal risk of HIV infection and a personal proximity to the epidemic (measured, for example, by the extent to which we know people who have died of AIDS) that many communities with equally high HIV infection levels have not yet attained.

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