

SMOKE-FREE HOMES: VISION OR NECESSITY AND FUTURE REALITY?

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Abstract: *The programs „Smoke-Free Homes“ support the restriction or full prohibition of smoking in homes where children are living. The rules offers the different levels of controls: smoking may be fully prohibited within the whole home („gold grade“), or allowed in only single well ventilated room („silver grade“); the lowest level is the simple agreement to do not smoke in the presence of children or other non-smokers („bronze grade“). There may be even another variants of these strategies. The scientific common opinion emphasizes the full protection of children in the smoke-free homes as main task; of course, the step-by-step approach is possible. Not only foreign, but also the Czech school-based anti-smoking educational programs include partially these problems: the initiation of parental co-operation and training children’s skills in anti-smoking defense strategies.*

Key words: *programs „Smoke-Free Homes, full protection of children, school-based anti-smoking educational programs, anti-smoking defense strategies*

Passive or involuntary smoking consists of the inhalation of air contaminated with smoke from the smouldering end of a cigarette (known as sidestream smoke) and the residue of the smoke exhaled by an active smoker (mainstream smoke). The US Surgeon General published evidence of the fact that exposure to air polluted in this way can cause medical problems in non-smokers as long ago as 1986. Toxicologists from the Environmental Protection Agency later classified cigarette smoke as a proven human carcinogen (class A – EPA 1992) and scientists are continually uncovering new knowledge on the dangers of passive smoking. The public has still not, however, perceived this information as a call for the active protection of the most sensitive people – children.

A Czech study assessing the success of the educational intervention programme “Non-smoking is a Norm” designed for pupils in years 1 to 5 of primary school found that around 75 % of children aged between six and eleven are exposed to the influence of smokers among their closest family members: almost 30 % of children have parents who smoke, more than 20 % have grandparents who smoke, while almost another 10 % have both parents and grandparents who smoke. If smoking behaviour among other relatives that children also see frequently (aunts, uncles, older siblings) is added to these figures, then around just a quarter of children are unaffected by this high-risk behaviour

on the part of adults (Hrubá 2008 a). Similar figures are given by another Czech study in the Teplice-Prachatice programme (Dostál 2008) and in a study from Scotland, where more than 80 % of children aged between 8 and 15 are exposed to a smoky environment, most frequently in their own homes (Bromley 2005). Studies from the USA show that the number of children exposed to cigarette smoke in the home environment is around five times higher than the number of adults exposed, and has amounted to around 35 % for the last 20 years (King 2009). Even in families in which the adult members of the family do not smoke, as many as a quarter of children are exposed to smoking on a daily basis when visitors to the home are allowed to smoke (Schuster 2002). Cars in which children travel with their parents are another site of medically-significant exposure. According to a recent study from Ireland, for example, almost 15 % of schoolchildren are frequently exposed in this way (Kabir, 2009). These are merely selected examples taken from the extensive specialist literature.

Passive or involuntary smoking represents a greater risk to children than it does to adults for a number of reasons. Damage to the health caused by the action of the toxicants in cigarette smoke, to which children are the most sensitive, is a direct consequence. Various diseases occur more frequently among people exposed to cigarette smoke, in particular diseases of the respiratory system, resulting complications (particularly inflammation of the middle ear), exacerbated asthma, and the necessity of more frequent hospitalisation (US DHHS 2006). Many studies also indicate the more frequent occurrence of leukaemias (Siegel 1993, Korte 2000). According to numerous scientific studies, the concentrations of the chemical substances in a smoky environment reach such levels that they represent significant toxic exposure for which there is no safe threshold (US DHHS 2006, Matt 2004). The seriousness and urgency of this problem is further augmented by the fact that children do not generally have the ability to avoid time spent in a smoky environment effectively or to move away from the vicinity of smokers (Thomson 2006).

The higher illness rate among such children is often accompanied by poorer school attendance and poorer school performance, for which reason life for children growing up in a family of smokers represents a set of causes of various negative conditions in later life (Muller 2007). The international study Health Behaviour in School-aged Children (HBSC), in which 32 countries in Europe, North America and Israel are participating, is gathering data that makes it possible to assess the relationships between smoking, social position, satisfaction with school work, and school performance. A sectional study encompassing Scandinavian countries and the UK has confirmed unambiguously that below-average school performance was significantly associated with a higher prevalence of smokers (Schnohr 2009).

A second significant risk is the fact that smoking among parents and other people with whom children have a close relationship can inspire them to imitate this behaviour, which has been proven both by numerous foreign studies and by our own study (Eurekac 2005, Hrubá 2008 b). Mothers that smoke increase the risk of smoking among their children more significantly than fathers that smoke (Kandel 1995, Rosendahl 2003, Rainio 2008, Hrubá 1996). When parents give up smoking, however, the frequency of smoking among their children also falls (Chasin 2002, Bricker 2005, Rainio 2008). A prospective investigation has shown that if parents give up smoking soon, when their children start attending school at the latest, the protective effect of their children's continuing life in a

non-smoking environment lasts until early adulthood – the number smoking at the age of 20 will be almost halved when compared to their contemporaries whose parents did not give up (Bricker 2009).

The social aspect, and specifically poverty and a low level of education, is repeatedly confirmed when risk factors influencing smoking in families with children are sought. Further important factors are the presence of a larger number of adults in the family, the children's parents and grandparents living together in the same home and, in particular, an adult person other than one of the child's parents having the dominant position in the home. Children in families in which one of the partners is not a biological parent are also more frequently exposed (King 2009).

The significance of the influence played by a family of smokers as a model of behaviour is sometimes called into question in reference to social developments in developed countries, where puberty begins at a younger age and the use of information technology and the number of activities in which children are engaged outside the family is on the increase. The reduction in the process of socialisation between schoolchildren and adult members of the family (Niemi 2002) and the reduction to the amount of time for mutual contact between parents and adolescent children (Zuzanek 2000) are also associated with this. These circumstances lead to logical expectations that children's greater degree of independence of their parents will also be reflected in the area of smoking. Such expectations have not, however, been confirmed by a study from Finland, which discovered that smoking among parents represents a permanent influence on the level of smoking among children that neither social and cultural changes nor earlier adolescence are able to modify (Rainio 2008).

The use of various pieces of technology (time spent watching television or videos, playing computer games, using mobile telephone networks) has been associated with worsened school performance in a number of studies (Durkin 2002, Gentile 2004). Experts and politicians are engaged in wide-ranging discussions relating to computer games and programmes with violent content, as a number of pieces of research have indicated a correlation between such activity and a higher level of aggressiveness among the young (Gentile 2004). The use of the Internet among adolescents has also been linked to an increased occurrence of various psychological problems such as loneliness, anxiety and depression (Kraut 1998). On the other hand, there is no doubt that modern information technology has many positive aspects, such as reinforcing visual capabilities and memory (Green 2007) and closer contact with friends (Valkenburg 2007).

A recent American study (Ohannessian 2009) investigated the use of modern technology in relation to smoking and alcohol consumption among the young, and discovered a number of interesting associations that should be considered when drawing up comprehensive prevention programmes:

- a correlation was found in boys between the length of time spent watching television daily and starting smoking at an earlier age;
- a significant association was found between smoking among children and children spending more than an hour a day sending and receiving e-mails or drinking a large amount of alcohol and coming from homes in which there was an occurrence of alcoholism among their parents;
- in contrast, no relationship was found between the consumption of legal drugs

and playing computer games, using telephones or searching the Internet.

Various models have been drawn up to explain the influence of parents on smoking among children, such as the theory of social learning (imitating observed behaviour), the theory of problematic behaviour (based on the interaction of the individual with the surrounding social environment), and the theory of social dependence (according to which children's relationship with their parents in early childhood influences their behaviour during adolescence and adulthood) (Scragg 2008). The attitudes held by parents towards smoking, the rules on smoking in place in the home environment and social models are all important factors influencing children and smoking behaviour (Jackson 2002, Kodl 2004, Wakefield 2000). Parents that smoke are generally more tolerant of children's experiments with smoking and, later, with regular smoking by their children, and provide them with tobacco products or the economic means to purchase them (Scragg 2003, Hrubá 2007). The children of smokers begin smoking at an earlier age (Hrubá 2008 b) and more frequently become regular and addicted smokers, which leads to their health being put at risk in later life as a consequence.

In these circumstances we currently have, in essence, three alternatives (Jarvis, 2008):

1. to do nothing to protect children, as has been the case so far
2. to take measures to prevent the exposure of children to passive smoking
3. to force parents to give up smoking

The first of these alternatives must be rejected as highly unethical, and the conditions associated with the remaining two alternatives examined.

In spite of the amount of specialist literature convincingly documenting the medical risks of passive smoking, and in spite of various educational campaigns, it is repeatedly shown that adults' knowledge of this issue is limited or confused (Philips 2007). Studies analysing the causes of a persisting unwillingness or inability to assure children a non-smoking domestic environment have been undertaken in Liverpool and Australia, and have found a number of social, physical, psychological and economic factors that parents perceive as an obstacle to the active protection of their children against exposure to a smoky environment. The following specific reasons have been given: the difficulties associated with continual child supervision, inadequate possibilities for smoking outside the home, the parents' wish to smoke in the pleasant and private environment provided by the home, a lack of understanding of smokers (addicts in particular), and fears about their negative reactions to efforts to restrict smoking in the home (Hill 2003, Robinson 2009). Mothers generally make efforts to protect children against exposure in infancy, but few continued such efforts when the children were older (Robinson 2007). Similar experiences have been recorded in the Czech Republic (Kukla 2008).

The places in which children are subjected to greatest exposure to passive smoking are clearly in the home and in the car; in these places children are offered considerably less protection than in public places. Plans for measures reducing this exposure come up against ethical questions relating to the use of forced measures leading to changes in behaviour in these private places.

From the viewpoint of social norms and laws, parents have the right to bring up their children without state interference, with the exception of situations in which their action or lack of action may expose their children to serious danger. There are already

a number of legal measures for protecting children: the protection of children against physical violence and sexual abuse, the legal requirements to wear helmets and use safety belts, etc. It is clear in this context that parents that smoke in the presence of their children are not acting in their best interests and represent a proven health risk to their children. Legislative measures would, therefore, be a logical step (Daschille 2005).

The fundamental approach to the issue of state interference in the privacy of its citizens encompasses the questions of **autonomy, discrimination, benefit and entitlement** (McCarty 2003). **Autonomy** is understood as free action (according to a set of personal rules formed on the basis of knowledge) that is not limited either by the interference of others or by personal limitations. Within a community of other people, however, boundless autonomy inevitably places limitations on others, for which reason it must be regulated in many areas of behaviour. From the viewpoint of exposing children to passive smoking, the autonomy of behaviour of adult smokers is in direct contradiction of their obligation to protect their children against harm (Beauchamp 1994).

Another point of view is offered by an analysis of the full meaning of autonomy, with particular emphasis on the reasoned choice of action based on good information. Is a smoker actually a fully competent person, when his or her behaviour is influenced by addiction to a psychoactive drug? Is he or she not rather a person who needs help from society in the form of information, education, appropriate restrictions and, most importantly, treatment? If the majority of smokers began to use the drug on a regular basis in childhood and developed an addiction to it at this age, then the whole momentous process began at a time when these smokers were unable to consider all the consequences of their behaviour, and they were certainly not acting autonomously. It is, therefore, necessary to take advantage of all possible ways of providing the necessary information and effective treatment. The treatment of smoking must not, of course, be forced upon people, but offered. If smokers accept this offer, then their autonomy is truly strengthened and their previous behaviour will cease to be a health risk to themselves and their surroundings. They will also feel the benefit socially and economically.

The general term “**benefit**” is sometimes confronted with **paternalism**, the central problem of which is “who decides what is good and proper?”. People are generally willing to accept the views of the experts, and the least problems in this regard are traditionally seen in medicine. Nevertheless, even here the relationship between the doctor and the patient has been altering from the previously highly paternalistic stance towards something approaching an equal partnership. The fundamental condition to this change is that the patient be fully informed (of his or her illness and the possibilities for treatment) and his or her will either to make an independent decision or to leave the course of further action up to the doctor (Buchanan 2008). In relation to the behaviour of smokers, the emphasis is placed on the rights of the smoker to the comprehensive provision of information not merely in general terms, but also on the level of the individual personification of risk.

The legitimacy of state-imposed restrictions on the rights of smokers to smoke anywhere is based on scientific documentation of the medical damage caused to non-smokers exposed to cigarette smoke, and relates first and foremost to children. If an adult smoker is not fully autonomous because he or she either does not have enough information and/or is acting under the influence of addiction, then the application of

restrictive measures to benefit the non-smokers he or she is putting at risk is fully justified. For many smokers, directives restricting smoking in the presence of non-smokers result in an increased interest in supplementary health education and in stopping smoking. Education and treatment are the path leading towards the attainment of true autonomy.

Effective defence has been created to **protect non-smokers**, with legislative measures prohibiting smoking in public; in the USA bans on smoking in the workplace and public places were first laid down in the state of Minnesota (1975). At the present time, certain forms of restriction are applied all over the world. The most comprehensive approach to the protection of non-smokers to date is contained in Article 8 of the Framework Convention on Tobacco Control, FCTC – WHO 2003; the Czech Republic is one of the few countries whose politicians have yet to ratify this document. Research to date shows that once people understand the purpose of protecting non-smokers against exposure to tobacco/cigarette smoke, they support the legislative measures adopted, and this includes smokers who did not at first agree with the regulation of their behaviour as smokers. Restrictions on smoking in the workplace, in schools and medical facilities, on public transport, in restaurants and bars and other public places gradually has the desired influence, i.e. a negative attitude to smoking taken by the majority of society (Hyland 2009).

In practice, however, these restrictions tend to protect adults, while **millions of children remain unprotected** against exposure to the toxicants produced by their smoking parents, relatives and visitors in their private homes and cars. Although many smokers, influenced by bans on smoking in public, are willing to assure a non-smoking environment in the home if they share it with non-smokers (Borland 2006), this approach is uncoordinated and attempts to intervene in this area have so far been sporadic.

There is a system of Family Courts in the USA, one of the areas they consider being the issue of domestic exposure to passive smoking, particularly among children with chronic respiratory diseases. In individual casuistries for which expert witnesses have defined the contribution made by exposure to passive smoking to the damage caused to children's health, a requirement for a complete ban on smoking in their presence has been enforced (Daschille 2005).

Smoking in cars has been assessed in a number of countries from the viewpoint of the safety risk presented by a driver holding or handling a cigarette and thereby having impeded control over the vehicle, in a manner analogous to the use of a mobile telephone. The majority of the legal restrictions relate to drivers of public transport vehicles, though such bans also relate to the drivers of private cars in a number of countries. Legislative prohibitions of smoking in vehicles in the presence of small children have been applied in three US states (Arkansas, Louisiana and California) for a number of years, and are being considered by the legislators in a number of others (Jarvie 2008).

Programmes for “**Smoke-free Homes**” have been created in the UK to support the restriction or complete prohibition of smoking in homes with children. These projects are similar, and their rules allow for the differentiation of various levels of restriction, from the complete prohibition of smoking anywhere in the home (“gold

promise”), allowing smoking in one well-ventilated room (“silver promise”), to an agreement not to smoke in the presence of children or other non-smokers (“bronze promise”) (Ritchie 2009). There are also other variants on these strategies regulating smoking in homes and cars, smoking at an open window, and smoking in corridors and WCs, though these are considered ineffective by the experts (Matt 2004).

The experts assessing these projects agree that the principal aim must be the comprehensive protection of children, which can only be assured by an agreement on the complete prohibition of smoking in the homes in which they live. In view of the aforementioned problems, however, a step-by-step approach may also be supported, beginning with not smoking in the presence of children and non-smokers, to limiting smoking to selected areas where children and non-smokers do not go, up to the final goal of a complete ban on smoking in the home (Ritchie, 2009). A study analysing social determinants influencing the risk of the early initiation of experiments with smoking found that important factors included not only smoking among family members and exposure to a smoky environment, but also children’s perception of the attitudes held by their parents to smoking and whether or not they felt able to discuss their personal problems with their parents (DiNapoli 2009).

In the programme for young schoolchildren “Non-smoking is a Norm” almost two-fifths of children (year four pupils) stated that someone smoked in their home. Less than a third of their parents admitted to this, however (tab. 1). The majority of parents – 86 % – agree with the bans on smoking in public places defined in the legislation of the Czech Republic and, somewhat surprisingly, there were no differences between respondents who smoke and respondents who do not smoke in this regard; around just 6 % do not agree with these bans, while more than another 5 % consider the scope of the banned places excessive. The majority of respondents are, however, sceptical about whether legal means protecting non-smokers in public places will influence the behaviour of smokers that puts those closest to them in danger in their own homes.

Tab. 1: Figures given by children and parents on smoking in the home (in percent)

DOES ANYONE SMOKE AT HOME?:	CHILDREN	PARENTS
Never	59.2	69.0
Sometimes	16.7	9.6
Yes	24.1	21.4

The problem as to **how to address the community of smoking parents** and those who do not smoke themselves, but do not actively protect their children against other smokers, remains to be resolved. Attention is focused in this regard primarily on doctors and other medical staff, who have a unique opportunity to draw parents’ attention to the risks associated with exposure to passive smoking, not merely when treating children for their illnesses, but also during the numerous preventative examinations. A number of monitored studies have already been published, and indicate a certain degree of success. Action taken by nurses directly in the homes of families with children has resulted in reduced exposure of children to cigarette smoke, though no decline in the number of smoking parents was recorded (Greenberg 1994). Ano-

ther study based on the same principle of home intervention had an extremely small effect (Tanski 2003) and a similar lack of success has been recorded by the work of Hovell (2000) and Muller (2007). An overview of 18 programmes provided by the Cochrane database did not provide conclusions that would indicate the unequivocal recommendation of any of them (Roseby 2003). In spite of certain confusion and the associated unwillingness of paediatricians to try to shape the smoking behaviour of parents, the recommendations from the experts are unambiguous, and take in approaches protecting children against exposure, advice on giving up smoking and help in the treatment of addiction to smoking (Tyc 2008).

Another possibility is provided by school-based anti-smoking educational programmes that prepare children in the use of various methods for ensuring a certain level of protection against toxic exposure in families. A unique set of anti-smoking educational programmes designed for children of various age groups has been created in the Czech Republic: in nursery schools children learn about the health risks of smoking from stories, colouring books and acted scenes, after which they try to avoid being in the vicinity of smokers spontaneously. Follow-up programmes for young and old schoolchildren continue both to provide further knowledge about the health risks and to expand the children's knowledge about the economic and ecological damage caused by smoking. They also initiate parental co-operation in various kinds of "homework" and teach children strategic approaches in negotiating with adults on conditions respecting the right of children to the assurance of home safety, including protection against exposure to passive smoking. These school programmes also include training of the skills necessary to recognise high-risk situations and ways of refusing offers of drugs and other kinds of high-risk behaviour. A programme with a three-level form of intervention has been created for schoolchildren who already smoke actively or who are already addicted (Hrubá 2001).

The anti-smoking influence schools have lies mainly in the fact that they assure a non-smoking environment and thereby reduce the exposure of children and adolescents to passive smoking. They also provide health education, not merely theoretical, but also the training of practical skills. They may, however, also modify the impact of inappropriate social models provided by the family and positively shape non-smoking behaviour among the young. Good relations at school and successful study results had a significant preventative influence in a group of pupils aged 13 to 15 in the HBSC study (Roberts 2007), its Scandinavian part (Schnohr 2009), among adolescent girls (DiNapoli 2009), and among secondary school pupils from Slovakia (Salonna 2008). Not merely teachers, but politicians as well, should accept that the comprehensive formation of a supportive and creative environment in schools is a significant priority and should support its implementation with all available means. They can, in this way, contribute towards improving the health of the population and reducing inequalities in health.

Conclusion

1. The protection of children against exposure to the toxicants in cigarette smoke is an important priority in primary prevention. There is an ethical problem to this clear aim in the conflict of views held by two groups of the population: on

one hand there are the liberal views on the privacy of the home, including the rights of smokers to freely behave in a way that puts others at risk; on the other there are documents from the WHO (2001) and UNICEF (1989) defending the rights of children to, among other things, protection against the effects of tobacco.

2. Health professionals, and paediatric specialists in particular, must take greater advantage of the unique possibilities open to them, inform patients of the health risks of passive smoking, and motivate them to take the kind of measures that would restrict or entirely preclude the exposure of children to cigarette smoke.
3. School education can endeavour in an effective manner to increase children's practical skills in avoiding involuntary exposure to cigarette smoke.
4. Attention must be paid to shaping the desired attitudes in society and creating effective strategic approaches to protecting children against passive smoking in the home. These should avoid stigmatising parents who smoke, particularly among lower social groups, while also supporting children's rights to grow and develop in a healthy environment.

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NEKUŘÁCKÉ DOMOVY: UTOPIE NEBO NUTNOST A BUDOUCÍ REALITA?

Abstrakt: Programy pro „Smoke-free homes“ podporují omezení či úplný zákaz kouření v bytech s dětmi. Pravidla umožňují odstupňování omezení od úplného zákazu kouření v celém bytě („zlatý stupeň“) přes povolení kouření v jediné dobře větrané místnosti („stříbrný stupeň“) až po dohodu nekouřit ani v přítomnosti dětí ani v přítomnosti ostatních nekuřáků („bronzový stupeň“). K těmto strategiím existují ještě různé varianty. Odborníci se shodují, že hlavním cílem musí být komplexní ochrana dětí, kterou lze zajistit jedine dohodou o úplném zákazu kouření v jejich domovech; lze podporovat etapovitý přístup. Školní výchovné protikuřácké programy nejen v zahraničí, ale i v České republice zahrnují i tuto problematiku: iniciují spolupráci rodičů na různých „domácích úkolech“ a učí děti strategickým postupům při jednávání s dospělými o podmínkách respektujících právo dětí na zajištění domácího bezpečí, včetně ochrany před expozicí pasivnímu kouření.

Klíčová slova: nekuřácké domu, komplexní ochrana dětí, školní výchovné protikuřácké programy, expozice pasivnímu kouření