

Editorial

Passive smoking: a reluctance to simplicity

It is estimated that passive smoking resulted in more than 600,000 premature deaths worldwide in 2004, with 40% of these death occurred in women, 28% in children, and the rest in men non-smokers [1]. Children and housewives were exposed to passive smoke mainly in the home environment. In addition to premature death, passive smoking damaged the non-smoker's health in area such as pneumonia, asthma, other respiratory illnesses, middle ear infections, cardiovascular diseases, increase risks of stroke, lung and other cancer, low birth weight, preterm delivery, and intrauterine growth retardation among others [1, 2].

As demonstrated by the cohort study in this volume, living with non-smoking partners were ineffective in inducing smoking cessation among male smokers in Japan [3] when no other support was offered. Thus, concerted efforts towards recommended public health and clinical strategies in controlling passive smoking exposures must be revisited [4].

Public health measures should be enacted. Those may include legal bans or restrictions on smoking, excise cigarette taxation for health promotion, education, marketing campaign directed at the public and at specific target group such as adolescents, limitation of promotional efforts of national and transnational companies, strengthening of healthy social norms, and promoting a non-smoking environment in schools, universities, temples, and churches. Policy instruments must be widely implemented to deal with disparities in secondhand smoke exposure [5]. The instruments could include targeting groups, allocation of resources to priority areas, provision of rules, regulation, and legal measures, and provision of appropriate services as recommended by The Task Force on Community Preventive Services [6]. Smoking bans in public places and transportation have proven effective [7]. All these will require policy makers to take actions. Leadership and political commitment in enforcement of the WHO's Framework Convention on Tobacco Control are of paramount importance particularly in

low and middle income countries. Examples of some successful initiatives such as those of VicHealth, Thailand, and others can be made readily available [8, 9]. One of the clinical measures has been the assertiveness of healthcare providers in encouraging smoking cessation with smokers during pregnancy, birth of a child, early childhood, and acute illness of a child when the illness is related to smoking such as asthma or infection [10]. Distant support to help smokers quit and maintain abstinence through telephone and internet counseling has been tried. Special smoking cessation clinics providing direct counseling, referral, and pharmacotherapy have been instrumental in reducing the number of smokers.

Complex problems usually require concerted efforts among actors. It is important that we refuse to adopt simplistic solutions for challenges confronting complex problems, which are required to control passive smoking. However, we should strive to make these processes as simple as possible. We should be encouraged to recognize the range of solutions that might be included to achieve success. We should be mindful of the diversity of other organizations and must be ready to seek support to maximize the experiences in understanding the complex nature of smoking cessation. This process will enable us to continually refine decision making to reap the greatest benefits from effective tobacco control, which is key to rapid progress in reduction of non-communicable diseases [9, 11].

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