Smoking policies in the workplace in the western Cape

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Summary
A postal survey of workplace smoking restrictions among the member organisations of the Cape Chamber of Industries was carried out in 1989. The response rate was 57.1%. Of the 572 respondent organisations, 66.1% had some smoking restrictions. Large workplaces were more likely to restrict smoking than small workplaces: 42.0% of those with fewer than 10 employees had restrictions, increasing to 90.9% of those with more than 500 employees. Organisations producing manufactured goods (other than engineering) were more likely to have restrictions than non-manufacturing concerns. Smoking was commonly restricted on the factory floor (61.3%) and in warehouses (55.8%), but only 7.4% prohibited smoking in shared offices. The reasons for smoking restrictions stated most frequently were the fire hazard (85.3%) and legislation (66.0%). Only 29.1% stated that health care concerns were an important reason for restrictions, while a further 16.3% stated that health was a minor reason for restrictions. Of the respondents, 48.4% expressed a need for guidance in improving their smoking policies. These results indicate that there is considerable potential for intervention to decrease both active and passive smoking in local workplace settings.

Smoking is generally considered to be one of the greatest preventable causes of ill health and premature death. In addition to the overwhelming evidence of the causal association between active smoking and disease, evidence of the health risks associated with passive smoking has accumulated over the past decade. In South Africa, smoking is a major cause of death in developed sectors of the population. Local studies in working populations have documented a very high prevalence of smoking, especially among blue-collar workers. With the increased smoking rates and tobacco consumption associated with demographic transition, smoking-related morbidity and mortality will increase.

In several overseas countries there has been a shift in attitudes about the social acceptability of smoking in public and also increasing recognition of the adverse effects and health risks associated with passive smoking. This trend has been particularly evident in North America, Europe, and Australia, and has led to increasing smoking restrictions in public places over the past 15 years. The workplace is one of the main sources of involuntary exposure to environmental tobacco smoke (ETS), and is the main source of exposure for adults who do not live with smokers. In addition to the need to protect non-smoking employees from ETS, the workplace provides a setting for smoking intervention both to prevent employees from starting to smoke, and to assist employees who smoke with reducing or giving up. This may be achieved by health education, smoking cessation programmes, and by providing a work environment where non-smoking is treated as the norm.

Over the past decade there has been a trend towards the introduction of comprehensive workplace smoking policies in several developed countries including the USA, Canada, the UK and Australia. In addition to restricting smoking in the workplace, these policies have included health education, the provision of smoking cessation programmes and, in some cases, incentives for employees to give up smoking. Many workplace smoking policies have come about as a result of private initiative rather than government regulations, sometimes in response to pressure from non-smoking employees, although legislation limiting smoking in the workplace has also made a contribution. In South Africa there have been few initiatives to promote workplace smoking policies, and local research in this area is lacking. Despite the evidence that smoking has a major impact on the health of the South African population, the Government has failed to take action to limit smoking, and social norms regarding the acceptability of smoking in public has lagged many years behind the UK, the USA, Canada and Australia.

The researchers were informed that several Cape Town businesses were exploring ways of promoting workplace smoking policies. This survey was therefore conducted as the starting point of an initiative to promote written workplace smoking policies in the Cape Town region. The study aimed to describe current practices with regard to smoking in the workplace, and to identify workplaces interested in receiving smoking policy guidelines. A further aim was to use the results to introduce the idea of workplace smoking policies to a South African audience in order to stimulate interest and action.

Subjects and methods
The 1 002 organisations that were members of the Cape Chamber of Industries (CCI) at the time of the study were surveyed. This study population was chosen because there was an accessible address list (a representative from the CCI had shown a willingness to co-operate with such a study), and because most workplaces were in the Cape Town region and could thus be the focus of a local initiative to promote workplace smoking policies.

Membership of the CCI is voluntary. Nearly all member organisations are situated in the Cape Town area and are characterised as having predominantly English-speaking management. Most member organisations belong to the industrial sector, with engineering firms and clothing manufacturers being the largest categories represented.

A short, structured English-language questionnaire was used. Questionnaires were first posted in April 1989, accompanying the Cape Chamber of Industries' Weekly Bulletin, which carried an editorial motivating the study and requesting a response, irrespective of the organisation's smoking policy. Since the bulletin was mailed to organisations rather than to individuals, it was requested that a senior person familiar with the organisation's policies complete the questionnaire. All
non-respondent organisations (856) were sent a second copy of the questionnaire in September 1989, with a covering letter similar to the editorial that had appeared in the bulletin accompanying the first mailing. An addressed freepost envelope for the return of the questionnaire was included with the second mailing.

Participants were assured that their responses would be confidential. Those organisations that did not wish to participate were requested to return the questionnaire with only the organisation's name indicated. Since smoking policies within an organisation may vary at different worksites, recipients of the questionnaires were asked to give information only for the site where they worked. Respondents whose workplaces had a written smoking policy were requested to include a copy of the policy document with the completed questionnaire.

Results

Profile of respondents

There were 146 returns after the first mailing and a further 440 returns following the second mailing. Fourteen questionnaires were returned unanswered, giving an overall response rate of 57.1%. The best-represented sectors were engineering and electrical (25.2%), clothing (14.2%), chemical and pharmaceutical (11.2%) and food and beverages (9.6%). Workplaces ranged in size from 2 to over 500 employees.

Smoking restrictions

Smoking was restricted in 66.1% of the respondents' workplaces, and 57.5% of respondents stated that their workplace had a smoking policy. As respondents differed in their interpretation of what constituted a smoking policy, results were analysed by the presence or absence of any smoking restrictions rather than the presence or absence of a smoking policy.

The likelihood of having smoking restrictions increased as the number of employees increased (Table I), and also varied by sector (Table II). Most workplaces in the clothing, textile, food, chemical, paper and packaging, and furniture sectors restricted smoking in their production areas.

The proportion of organisations restricting smoking in selected areas in the workplace is shown in Fig. 1. The areas where smoking was most likely to be restricted were the factory floor (61.3% had some restrictions) and warehouses (55.8%), but smoking in shared offices was prohibited in only 7.4% of workplaces.

<table>
<thead>
<tr>
<th>Sector</th>
<th>No. of respondents</th>
<th>Percentage with any smoking restrictions</th>
<th>Percentage interested in smoking policy guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing</td>
<td>81</td>
<td>93.8</td>
<td>45.7</td>
</tr>
<tr>
<td>Textiles</td>
<td>31</td>
<td>93.6</td>
<td>35.5</td>
</tr>
<tr>
<td>Food</td>
<td>55</td>
<td>89.1</td>
<td>60.0</td>
</tr>
<tr>
<td>Paper, packaging and printing</td>
<td>34</td>
<td>85.3</td>
<td>50.0</td>
</tr>
<tr>
<td>Chemical</td>
<td>64</td>
<td>84.4</td>
<td>53.1</td>
</tr>
<tr>
<td>Furniture</td>
<td>45</td>
<td>82.2</td>
<td>60.0</td>
</tr>
<tr>
<td>Building</td>
<td>38</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Engineering</td>
<td>144</td>
<td>38.2</td>
<td>41.0</td>
</tr>
<tr>
<td>Commercial and transport</td>
<td>49</td>
<td>24.5</td>
<td>49.0</td>
</tr>
<tr>
<td>Overall</td>
<td>572*</td>
<td>66.1</td>
<td>48.4</td>
</tr>
</tbody>
</table>

* Including 31 organisations from other small sectors not shown above.

TABLE I. PRESENCE OF SMOKING RESTRICTIONS AND INTEREST IN SMOKING POLICY GUIDELINES IN RESPONDING ORGANISATIONS BY NUMBER OF EMPLOYEES

The proportion of organisations restricting smoking in selected areas within the workplace (excluding organisations which did not have such an area from the denominators) is shown in Fig. 1. The areas where smoking was most likely to be restricted were the factory floor (61.3% had some restrictions) and warehouses (55.8%), but smoking in shared offices was prohibited in only 7.4% of workplaces.

No workplaces in the survey had comprehensive smoking policies. Components of smoking policies reported included: prohibiting smoking throughout the workplace (6); preferentially employing non-smokers (2); the provision of smoking cessation programmes for employees (3); and displaying health education posters depicting the adverse effects of smoking (3). Only 1 organisation provided a notice outlining smoking restrictions, while a further 3 organisations stated that they had written smoking restrictions, but did not provide the researchers with the requested documentation.

Reasons for existing smoking restrictions are shown in Fig. 2. The most frequently reported reasons for smoking restrictions were a fire hazard (85.3%) and legislation (66.0%). Only 29.1% of respondents indicated that the health of their
employees was an important reason for existing restrictions, while a further 16.3% stated that health was a minor reason. Conflicting opinions were expressed as to whether smoking restrictions improved or reduced productivity.

The absence of formal restrictions in shared offices in 92.6% of organisations in this survey is cause for concern, since this implies that many non-smoking employees are at present being involuntarily exposed to ETS in the workplace. In the UK and America there is increasing acceptance of the principle that: 'The preferences of both smokers and non-smokers will be respected, but when these conflict, the preferences of the non-smoker will prevail,' or, as the US Surgeon-General stated in his report on the health consequences of involuntary smoking: "It is evident from the data . . . that the choice to smoke cannot interfere with the non-smoker's right to breathe air free of tobacco smoke."

Certain occupational exposures are known to increase the risk of disease in those employees who smoke. The information obtained in the survey was not sufficiently detailed to determine whether workers were occupationally exposed to substances that would augment the risks of smoking, but this is an area which needs attention. Of concern is that 61.8% of workplaces in the engineering sector did not have any smoking restrictions. Many of these workers are likely to be at risk of lung disease due to the combined effects of exposure to cigarette smoke and occupational exposure to dust and welding fumes.

Many respondents reported that a high proportion of their blue-collar workers smoked and were resistant to restrictions. This is not surprising, since existing restrictions were usually imposed by management. Autocratic approaches to smoking restrictions have been shown not to work, as they do not have employee support, and are thus difficult to enforce. Most workplaces did not have written restrictions, although a few organisations indicated that they had 'no smoking' signs in areas where smoking was not permitted. Unwritten restrictions are difficult to enforce. Smoking policy implementation appears to be most successful when the following provisions are met: (i) the policy is formulated with broad input from employees; (ii) employees are given advance notice and policy is implemented in stages; (iii) policy is written and communicated well to employees; and (iv) smoking cessation programmes are provided. This approach is endorsed by several organisations with an interest in smoking and health.

This survey did not assess employee attitudes towards smoking in the workplace, or their knowledge of the health effects of both active and passive smoking. Research in this area is needed locally. Although a person's beliefs about the health consequences of smoking are not a major determinant of smoking behaviour, attitudes towards smoking affect the acceptability of smoking restrictions and compliance with smoking policies. Potentially, educating workers about the harmful effects of both active and passive smoking could help to decrease the resistance of smokers towards restrictions.

Trade union attitudes towards smoking in the workplace also need to be considered. Overseas experience has been varied: union opposition has been a barrier to the adoption of smoking policies in several instances, while other unions, including the Trades Union Congress in Britain, have actively campaigned for workplace smoking policies.

In this study nearly all the workplaces with smoking restrictions allowed smoking except in no-smoking areas, rather than a more restrictive approach of prohibiting smoking, except in designated smoking areas. The distinction between these two approaches is of importance, as the former conveys the attitude that smoking is the norm, while the latter implies that non-smoking is the norm, and gives greater protection to non-smoking employees. A shift in attitudes towards recognising the rights of non-smokers and establishing non-smoking as the norm is desirable. This shift has occurred in some overseas countries.

An important, although not unexpected, finding was that company size was associated with smoking restrictions and
interest in smoking policy guidelines. The size of the company needs to be taken into account when planning smoking policies, since small workplaces are not able to provide separate smoking and non-smoking areas. Only large workplaces are able to call on the resources of a nurse. It is encouraging that a high proportion of the organisations that indicated interest in smoking policy guidelines had a nurse on their staff, since nurses could contribute by carrying out health education and smoking cessation programmes.

Response rate to the second mailing was considerably better than the poor response to the first mailing (50.0% compared to approximately 14.4%). This difference was probably due to: (i) the first questionnaire being overlooked as it was posted with a bulletin, while the second questionnaire was mailed independently; and (ii) respondents to the first mailing had to provide an envelope and postage, while an addressed freepost return envelope was included with the second mailing. Response rate might have been further improved if questionnaires had been addressed to an individual within each organisation. Factors such as these, which can have a significant impact on response rate, need to be considered in the study design when doing postal surveys.

As the survey was conducted in a select study population, and the response rate was suboptimal, it is not known whether these results can be generalised to other local workplace settings. However, most of the results were as anticipated, based on published research from other countries. This study should be seen as an initial contribution to a neglected field, and the researchers hope that it will stimulate further similar research locally in other workplace settings.

The study documented a substantial need for comprehensive smoking policies in the study population. The interest shown by respondents in their requests for further information indicates that there is considerable potential for health education and for local workplaces to establish smoking policies of their own initiative. The South African Council on Smoking and Health has taken up this challenge, and has recently started a consultancy service for workplaces in the Cape Town region interested in introducing workplace smoking policies (Dr G. Baddeley — personal communication).

We would like to thank the Cape Chamber of Industries for their co-operation, and G. Joubert for statistical support.

REFERENCES

35. Brown ER, McCarrhy WJ, Marcus A. Health effects of involuntary smoking on published research from other countries. This study should be seen as an initial contribution to a neglected field, and the researchers hope that it will stimulate further similar research locally in other workplace settings.

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