

Chapter 10

Evaluation

The Working Group evaluated the strength of the evidence for drawing the conclusions shown in the accompanying table, defined as follows:

Sufficient evidence:

An association has been observed in studies in which chance, bias, and confounding can be ruled out with reasonable confidence. The association is highly likely to be causal.

Strong evidence:

There is consistent evidence of an association, but evidence of causality is limited by the fact that chance, bias, or confounding have not been ruled out with reasonable confidence. However, explanations other than causality are unlikely.

Limited evidence:

There is some evidence of association, but alternative explanations are possible.

Evidence of no effect:

Methodologically sound studies consistently demonstrate the lack of an association.

Inadequate/no evidence:

There are no available methodologically sound studies showing an association.

In considering the evidence on the health consequences of secondhand smoke (SHS) (see Chapter 2):

- The Working Group agrees with other bodies: SHS causes harm to health, including lung cancer and cardiovascular disease in adults, respiratory disease in adults and children, and Sudden Infant Death Syndrome (SIDS) in infants.
- The Working Group agrees with the conclusion of the US Surgeon General: there is no established risk-free level of SHS exposure.

Evaluation of the weight of evidence

		Sufficient Evidence	Strong Evidence	Limited Evidence	Evidence of No Effect	Inadequate/No Evidence
1	Smoke-free policies do not cause a decline in the business activity of the restaurant and bar industry (see Chapter 4).	X				
2	Implementation of smoke-free policies leads to a substantial decline in exposure to SHS (see Chapter 6).	X				
3	Implementation of smoke-free legislation reduces social inequalities in SHS exposure at work (see Chapter 6).		X			
4	Implementation of smoke-free legislation causes a decline in heart disease morbidity (see Chapter 6).		X			
5	Implementation of smoke-free legislation decreases respiratory symptoms in workers (see Chapter 6).	X				
6	Smoke-free workplaces reduce cigarette consumption among continuing smokers (see Chapter 7).	X				
7	Smoke-free workplaces lead to increased successful cessation among smokers (see Chapter 7).		X			
8	Smoke-free policies reduce tobacco use among youth (see Chapter 7).		X			
9	Smoke-free home policies reduce exposure of children to SHS (see Chapter 8).	X				
10	Smoke-free home policies reduce adult smoking (see Chapter 8).	X				
11	Smoke-free home policies reduce youth smoking (see Chapter 8).		X			

Based on the quality and volume of the evidence reviewed, the Working Group concluded that there is *sufficient evidence* to support each of the following statements:

1. There are an increasing number of governments enacting and implementing smoke-free policies that conform to the Guidelines for Article 8 of the WHO FCTC (see Chapter 3).

2. There is usually majority support for smoke-free workplaces and public places (see Chapter 5).

3. Public support among both smokers and non-smokers for smoke-free policies increases following implementation of legislation (see Chapter 5).

4. When implemented, as described in the WHO FCTC guidelines, compliance with smoke-free policies is moderate to high (see Chapter 5).

5. There is a greater decline in smoking when smoke-free policies are part of a comprehensive tobacco control program (see Chapter 7).

6. Smoking in cars generates high levels of SHS (see Chapter 6).

7. Lung cancer incidence in nonsmokers can be expected to decline over several decades after the enactment of smoke-free legislation. Data are not yet available, however, documenting such declines, as most smoke-free legislation has only recently been implemented (Chapter 6).