The first conclusive evidence on the danger of passive smoking came from Takeshi Hirayama’s study in 1981 on lung cancer in non-smoking Japanese women married to men who smoked. Although the tobacco industry immediately launched a multi-million dollar campaign to discredit the evidence, dozens of further studies have confirmed the link. Research then broadened into other areas and new scientific evidence continues to accumulate. As a passive smoker, the non-smoker breathes “sidestream” smoke from the burning tip of the cigarette and “mainstream” smoke that has been inhaled and then exhaled by the smoker.

The risk of lung cancer in non-smokers exposed to passive smoking is increased by between 20 and 30 percent, and the excess risk of heart disease is 23 percent. In addition, children exposed to passive smoking at home are at particular risk from adults’ smoking. Adverse health effects include pneumonia and bronchitis, coughing and wheezing, worsening of asthma, middle ear disease, and possibly neuro-behavioural impairment and cardiovascular disease in adulthood.

A pregnant woman’s exposure to other people’s smoking can harm her fetus. The effects are compounded when the child is exposed to passive smoking after birth.

Numbers affected by passive smoking in the USA
annual 1990s

- Lung cancer: 3,000
- Lymphatic heart disease: 35,000 to 62,000

Infants and children

- Low birthweight: 8,700 to 16,600
- Cot death (SIDS): 1,900 to 2,700
- Bronchitis or pneumonia in infants: 150,000 to 300,000

Respiratory effects in children

- Middle ear infection: 700,000 to 1,800,000
- Asthma induction (new cases): 8,000 to 26,000
- Asthma exacerbation (after birth): 400,000 to 1,000,000

Role model
Greater likelihood of becoming a smoker as a teenager