MMWR™
Morbidity and Mortality Weekly Report
Weekly July 8, 2005 / Vol. 54 / No. 26

State Smoking Restrictions for Private-Sector Worksites, Restaurants, and Bars — United States, 1998 and 2004

Secondhand smoke is a known carcinogen (*1*). Exposure to secondhand smoke causes approximately 35,000 heart disease deaths and 3,000 lung cancer deaths among nonsmokers in the United States every year (*2*). Implementing policies that establish smoke-free environments is the most effective approach to reducing secondhand smoke exposure among nonsmokers (*1*). Smoking restrictions and smoke-free policies can take the form of laws or regulations implemented at the state or local level or of voluntary policies implemented by private employers and businesses. Smoking restrictions limit smoking to certain areas within a venue; smoke-free policies ban smoking within the entire venue. One of the national health objectives for 2010 is to establish laws in all 50 states and the District of Columbia (DC) that prohibit or restrict smoking in public places and worksites. A related objective calls for all worksites to voluntarily implement policies that prohibit or restrict smoking. To assess progress toward meeting the first objective, CDC reviewed the status of state laws restricting smoking as of December 31, 2004, updating a 1999 study that reported on such laws as of December 31, 1998 (*3*). This report summarizes the changes in state smoking restrictions for private-sector worksites, restaurants, and bars that occurred during 1999–2004.The findings indicate an increase in the number and restrictiveness of state laws regulating smoking in private-sector worksites, restaurants, and bars from 1999 through 2004. At the end of 2004, however, 16 states still had no restrictions on smoking in any of the three settings considered. Although secondhand smoke exposure among U.S. nonsmokers has decreased sharply in recent years, a substantial portion of nonsmokers continue to be exposed to secondhand smoke (*4*).

The smoking restrictions in effect in each of the 50 states and DC* as of December 31, 1998, and December 31, 2004, were categorized into one of four levels for each of the three settings included in this study (Table). These settings were selected because worksites are a major source of secondhand smoke exposure for adult nonsmokers (*1*), and because workers in restaurants and bars are exposed to especially high levels of secondhand smoke (*5*). The four levels are as follows: 1) no restrictions, 2) designated smoking areas required or allowed, 3) no smoking allowed or designated smoking areas allowed if separately ventilated, and 4) no smoking allowed (i.e., 100% smoke-free). (These levels apply only to indoor areas of these settings.) These data were collected from CDC's State Tobacco Activities Tracking and Evaluation (STATE) System database, which contains tobacco-related epidemiologic and economic data and information on state tobacco-related legislation (*6*). The data used for this report are collected quarterly from an online database of state laws, analyzed by using a coding scheme and decision rules, and transferred into the STATE System database. The STATE System tracks state smoking restrictions in government worksites, private-sector worksites, restaurants, commercial and home-based child care centers, and other

* For this report, DC is included among the states.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2005;54:[inclusive page numbers].

settings, including bars, shopping malls, grocery stores, enclosed arenas, public transportation, hospitals, prisons, and hotels and motels. Tobacco-control personnel in state health departments reviewed and commented on the coding of smoking restrictions in their states.

Laws enacted before December 31, 2004, but not effective until after that date are not reflected in this report. For example, Rhode Island enacted comprehensive smoke-free indoor air legislation in 2004 that did not take effect until 2005 and was therefore not included in this assessment. The report also does not reflect legislation enacted since the end of 2004. For example, during January 1–June 30, 2005, Georgia, Maine, Montana, North Dakota, Rhode Island, and Vermont enacted smoking restrictions.

During December 31, 1998–December 31, 2004, 10 states indicated changes in the level of their smoking restrictions for private-sector worksites, nine states indicated changes in the level of their smoking restrictions for restaurants, and five states indicated changes in the level of their smoking restrictions for bars, on the basis of the STATE System coding scheme. In every case, the restrictions became more stringent.

As of December 31, 1998, only one state (Maryland) banned smoking in private-sector worksites. As of December 31, 2004, six additional states (Delaware, Florida, Idaho, Massachusetts, New York, and South Dakota) had done so. In 1998, one state (California) required that private-sector worksites restrict smoking to separately ventilated employee break rooms. In 2004, two additional states (Connecticut and Oregon) had enacted smoking restrictions of this type. In 1998, 20 states required or allowed designated smoking areas in worksites. In 2004, 18 states had laws of this type in place, with two states moving from no smoking restrictions into this category and four states moving from this category into one of the more restrictive categories. In 1998, a total of 29 states had no smoking restrictions in place for private-sector worksites. In 2004, this number had decreased to 23 states.

In 1998, two states (Utah and Vermont) banned smoking in restaurants. During 1999–2004, six additional states (Delaware, Florida, Idaho, Maine, Massachusetts, and New York) did so. In 1998, one state (California) required that restaurants restrict smoking to separately ventilated employee break rooms. In 2004, one additional state (Connecticut) had enacted a smoking restriction of this type. In 1998, 27 states required or allowed designated smoking areas in restaurants; in 2004, 22 states had smoking restrictions of this type in place, with two states moving from no restrictions into this category and seven states moving from this category into one of the more restrictive categories. In 1998, 21 states had no smoking restrictions for restaurants. In 2004, this number had decreased to 19 states.

TABLE. State smoking restrictions* for private-sector worksites, restaurants, and bars, by state — United States, December 31, 1998, and December 31, 2004

State	Private-sector worksites		Restaurants		Bars	
	1998	2004	1998	2004	1998	2004
Alabama	None	Designated	None	None	None	None
Alaska	None	None	Designated	Designated	None	None
Arizona	None	None	None	None	None	None
Arkansas	None	None	None	None	None	None
California	Ventilated†	Ventilated†	Ventilated†	Ventilated†	Ventilated†	Ventilated†
Colorado	None	None	None	None	None	None
Connecticut	Designated	Ventilated†	Designated	Ventilated†	None	Ventilated†
Delaware	Designated	Smoke-free	Designated	Smoke-free	None	Smoke-free
District of Columbia	Designated	Designated	Designated	Designated	None	None
Florida	Designated	Smoke-free	Designated	Smoke-free	None	None
Georgia	None	None	None	None	None	None
Hawaii	None	None	Designated	Designated	None	None
Idaho	None	Smoke-free	Designated	Smoke-free	None	None
Illinois	Designated	Designated	Designated	Designated	None	None
Indiana	None	None	None	None	None	None
Iowa	Designated	Designated	Designated	Designated	None	None
Kansas	None	None	Designated	Designated	None	None
Kentucky	None	None	None	None	None	None
Louisiana	Designated	Designated	None	None	None	None
Maine	Designated	Designated	Designated	Smoke-free	None	Smoke-free
Maryland§	Smoke-free	Smoke-free	Designated	Designated	None	None
Massachusetts	None	Smoke-free	Designated	Smoke-free	None	Smoke-free
Michigan	None	None	Designated	Designated	None	None
Minnesota	Designated	Designated	Designated	Designated	None	None
Mississippi	None	None	None	None	None	None
Missouri	Designated	Designated	Designated	Designated	Designated	Designated
Montana	Designated	Designated	Designated	Designated	None	None
Nebraska	Designated	Designated	Designated	Designated	Designated	Designated
Nevada	None	None	Designated	Designated	None	None
New Hampshire	Designated	Designated	Designated	Designated	None	None
New Jersey	Designated	Designated	None	None	None	None
New Mexico	None	None	None	None	None	None
New York	Designated	Smoke-free	Designated	Smoke-free	None	Smoke-free
North Carolina	None	None	None	None	None	None
North Dakota	None	None	Designated	Designated	None	None
Ohio	None	None	None	None	None	None
Oklahoma§	None	Designated	None	Designated	None	None
Oregon	None	Ventilated†	Designated	Designated†¶	None	None
Pennsylvania	Designated	Designated	Designated	Designated	None	None
Rhode Island	Designated	Designated	Designated	Designated	None	None
South Carolina	None	None	None	None	None	None
South Dakota	None	Smoke-free	None	Designated	None	None
Tennessee	None	None	None	None	None	None
Texas	None	None	None	None	None	None
Utah	Designated	Designated	Smoke-free	Smoke-free	None	None
Vermont§	Designated	Designated	Smoke-free	Smoke-free	None	None
Virginia	None	None	Designated	Designated	None	None
Washington	None	None	None	None	None	None
West Virginia	None	None	None	None	None	None
Wisconsin	Designated	Designated	Designated	Designated	None	None
Wyoming	None	None	None	None	None	None

* None = no restrictions; designated = designated smoking areas required or allowed; ventilated = no smoking allowed or designated smoking areas allowed if separately ventilated; and smoke-free = no smoking allowed (i.e., 100% smoke-free).
† Restriction bans smoking in most settings, but exempts separately ventilated employee break rooms or lounges.
§ Corrected from previous report (*3*). Maryland was previously listed as having no smoking restrictions for private-sector worksites; Oklahoma was previously listed as requiring or allowing designated smoking areas in restaurants; and Vermont was previously listed as requiring or allowing designated smoking areas in bars.
¶ Restriction exempts restaurants and areas of restaurants that are posted as off-limits to minors.

In 1998, no states required bars to be smoke-free. During 1999–2004, four states (Delaware, Maine, Massachusetts, and New York) enacted laws that banned smoking in bars. In 1998, one state (California) required that bars restrict smoking to separately ventilated employee break rooms. In 2004, one additional state (Connecticut) had enacted a smoking restriction of this type. In 1998, two states required or allowed designated smoking areas in bars; this remained the case in 2004. In 1998, a total of 48 states had no smoking restrictions for bars. In 2004, this number had decreased to 43 states.

In 2004, three states (Delaware, Massachusetts, and New York) banned smoking in all three settings considered in this study, compared with no states in 1998. At the end of 2004, 16 states had no smoking restrictions in place in any of these three settings, compared with 19 states in 1998. Many other states had no restrictions, or restrictions that did not provide full protection, in some of these settings.

Reported by: *J Chriqui, PhD, J O'Connor, JD, MayaTech Corporation, Silver Spring, Maryland. S Babb, MPH, NA Blair, MPH, G Vaughn, A MacNeil, MPH, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings of this analysis indicate that the number and restrictiveness of state laws regulating smoking in private-sector worksites, restaurants, and bars increased from 1999 to 2004. This increase has provided U.S. nonsmokers with greater protection from exposure to secondhand smoke (*1,3,10*).

As of 1998–1999, 69.3% of U.S. workers reported that their workplace had an official policy that prohibited smoking in work areas and public or common areas, compared with 46.5% in 1993 (*7*). However, despite recent progress, many workers are still not protected by smoke-free workplace policies. Moreover, the proportion of workers covered by such policies during 1998–1999 varied by occupation, from 42.9% among food-preparation and food-service workers to 90.8% of primary-school teachers (*7*). The proportion of waiters (27.7%) and bartenders (12.9%) who reported being covered by smoke-free policies was lower than the proportion of food-preparation and -service workers overall (*7*). A previous study has indicated that food-service workers have a 50% greater risk for developing lung cancer than the general population, resulting in part from their higher level of occupational exposure to secondhand smoke (*8*). As a result of continuing gaps in policy coverage for many private-sector worksites, restaurants, and bars, a substantial portion of the U.S. nonsmoking population remains at risk for exposure to a known carcinogen in these settings, either as employees or customers.

In addition to protecting both workers and patrons from secondhand smoke exposure, smoke-free workplace policies also are associated with decreased cigarette consumption and possibly with increased cessation rates among workers and members of the general public (*1*). Peer-reviewed studies relying on objective indicators such as sales tax revenue and employment levels have consistently found that smoking restrictions do not have a negative economic impact on restaurants and bars (*9*). Studies have also reported high levels of public support for and compliance with these laws (*1,10*).

The findings in this report are subject to at least four limitations. First, the STATE System only captures certain types of state smoking restrictions (primarily statutory laws and executive orders) and does not capture state administrative laws, such as regulations, or implementation guidelines. As a result, the manner in which a state smoking restriction is implemented in practice might differ from how it is coded in the STATE System. For example, this report does not reflect a regulation in the state of Washington that restricts smoking in private-sector worksites and an administrative rule in Utah that imposes restrictions on smoking in certain bars. The STATE System also does not capture the extent to which state smoking restrictions are actually enforced. Second, some state smoking restrictions apply only to private-sector worksites with more than a certain number of employees, to restaurants with more than a specified number of seats, or to bars of at least a certain size. In these cases, the state laws are coded according to the level of these restrictions, even though these restrictions do not apply to venues below the relevant size limit.[†] Third, because the STATE System only collects state-level data, it does not reflect local smoking restrictions that are in place in many states. Some states with no or minimal state smoking restrictions have strong local smoking restrictions in place in many communities (*1*). State legislative provisions that do not preempt communities from enacting more stringent local laws allow continued passage and enforcement of local smoking restrictions that can establish a greater level of protection of public health (*3*). Finally, this report does not address sources of secondhand smoke exposure other than private-sector worksites, restaurants, and bars. Homes are another important source of exposure, especially for children (*1*), who on average are exposed to higher levels of secondhand smoke than adults (*4*).

The importance of smoke-free indoor air laws and policies as a component of comprehensive tobacco-control interventions is reflected by their inclusion in national health objectives for 2010 and in CDC surveillance (*1*). Although population-based data indicate declining secondhand smoke

[†] Information on worksite and restaurant size exemptions is available at http://www.cdc.gov/tobacco/statesystem. The STATE System does not track information on bar size exemptions.

exposure in the workplace over time, this exposure remains a common public health hazard that is entirely preventable (*1*). Optimal protection of nonsmokers and smokers requires a smoke-free environment (*1*).

Acknowledgments

The findings in this report are based, in part, on contributions by L Lineberger, MayaTech Corporation, Silver Spring, Maryland. D Coleman, MPH, Northrop Grumman, Atlanta, Georgia. TF Pechacek, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

References

1. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services; 2000.
2. CDC. Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 1997–2001. MMWR 2005;54:625–8.
3. CDC. State laws on tobacco control—United States, 1998. MMWR 1999;48(No. SS-3):21–62.
4. Wortley PM, Caraballo RS, Pederson LL, Pechacek TF. Exposure to secondhand smoke in the workplace: serum cotinine by occupation. J Occup Environ Med 2002;44:503–9.
5. US Department of Health and Human Services. Second national report on human exposure to environmental chemicals. Atlanta, GA: US Department of Health and Human Services; 2003. Available at http://www.cdc.gov/exposurereport/2nd/pdf/tobaccosmoke.pdf.
6. CDC. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at http://www.cdc.gov/tobacco/statesystem.
7. Shopland DR, Anderson CM, Burns DM, Gerlach KK. Disparities in smoke-free workplace policies among food service workers. J Occup Environ Med 2004;46:347–56.
8. Siegel M. Involuntary smoking in the restaurant workplace: a review of employee exposure and health effects. JAMA 1993;270:490–3.
9. Scollo M, Lal A, Hyland A, Glantz S. Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry. Tobacco Control 2003;12:13–20.
10. New York City Department of Finance, New York City Department of Health and Mental Hygiene, New York City Department of Small Business Services, New York City Economic Development Corporation. The state of smoke-free New York City: a one-year review. New York, NY: New York City Department of Health and Mental Hygiene; 2004.

Assessment of Local Health Department Smoking Policies — North Carolina, July–August 2003

Secondhand smoke is a cause of disease in healthy nonsmokers (*1–6*), and an increasing number of states have adopted laws prohibiting smoking in private-sector worksites, restaurants, and bars (*7*). However, certain state governments have provisions in their state smoking restrictions that preempt more stringent local laws (*8*). North Carolina has such a preemptive state smoking law,* passed in 1993, which mandates that 20% of the space within state-controlled buildings be designated as smoking areas. Exemptions from the law included local health departments (LHDs), providing an opportunity for public health practitioners to enact more stringent policies. To assess smoking policy gains from this exemption, a research team from the University of North Carolina at Chapel Hill (UNC) surveyed LHD directors. Results of the survey indicated uncertainty regarding the state law, with 37% of LHD directors believing they were prohibited from enacting a 100% tobacco-free policy on LHD grounds† and 20% not knowing whether they were prohibited. The North Carolina Association of Local Health Directors used these findings to work with legislators in the North Carolina General Assembly to amend the state smoking law in 2005, specifying that the exemption applies to both LHD buildings and grounds.

North Carolina has 85 county or multicounty LHD directors, representing all 100 counties in the state. Of the 85 directors, a total of 76 (89.4%) agreed to participate in the study. During July–August 2003, the LHD directors responded to a telephone survey that included questions related to their knowledge and opinions regarding 1) the effects of exposure to secondhand smoke; 2) state legislation on smoking in public spaces; 3) tobacco-use policies, enforcement provisions, and availability of smoking-cessation support services at their LHDs; and 4) perceived LHD employee support for a 100% tobacco-free policy. LHD directors also were asked whether smoking was permitted in 13 traditional smoking sites§ in the buildings or on the grounds of their LHDs. To assess the accuracy of such self-reported data on tobacco-use policies, 15 written policies were obtained at random from the LHDs and compared with the responses of their 15 respective directors. The responses were determined to be 86% in agreement with the written policies. The survey received approval by the Biomedical Institutional Review Board of the UNC School of Medicine.

* North Carolina General Statutes 143-595 to 143-601. Article 64. Smoking in public places (1993). Available at http://www.ncga.state.nc.us/sessions/1993/bills/house/html/h957v5.html.

† Defined as prohibiting the use of all tobacco products by anyone, at any time, at any place on LHD grounds, in LHD vehicles, or at LHD events or functions.

§ Indoor hallways and corridors; outdoor walkways and loading docks; waiting areas and lobbies; administrative and private offices; clinics and doctors' offices; cafeterias; break rooms and lounges; locker rooms; restrooms; LHD events and functions; outside entrances and exits; parking lots and structures; and LHD vehicles.

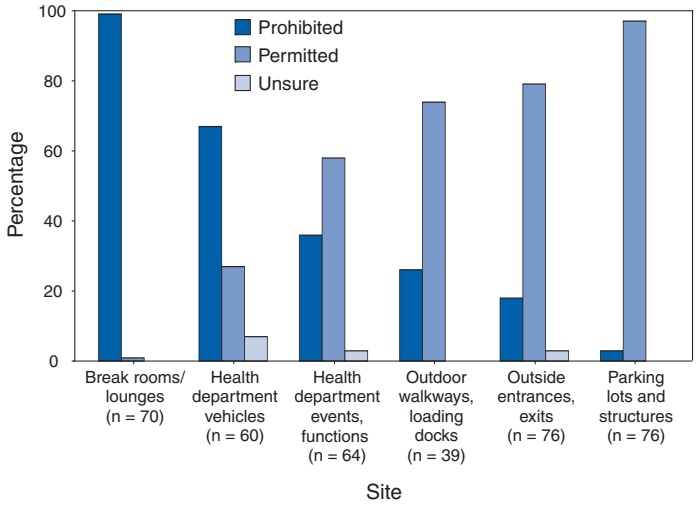
Among the 76 county or multicounty LHDs represented, the median number of employees was 85 (range: 15–600), the average number of buildings occupied was 3.2, and the median number of patients or visitors annually was 20,000 (range: 3,000–400,000). Among the 76 LHD directors, 53 (69.7%) were nonsmokers, 20 (26.3%) were former smokers, and three (3.9%) were current smokers.[¶] According to LHD director estimates, the mean percentage of current smokers among employees at the 76 LHDs was 10% (range: 1%–42%). Approximately 60% of LHD directors reported their departments did not routinely offer cessation services for employees who smoked.

High percentages of LHD directors agreed or strongly agreed that exposure to secondhand smoke can trigger asthma attacks (98.7%), cause lung cancer (97.4%) and lead to adverse short-term cardiovascular effects (84.3%). Official, written tobacco-use policies were in effect at 89.5% of the LHDs, whereas 10.5% operated with unofficial tobacco-use policies. Among 75 of the 76 LHDs, 33 (44.0%) had tobacco-use policies specific to the LHD, 33 (44.0%) operated under countywide policies, four (5.3%) operated under both LHD and countywide policies, and five (6.7%) operated under the federal Pro-Children Act of 1994.**

At 100% of the LHDs, smoking was prohibited in indoor hallways and corridors, waiting areas and lobbies, administrative and private offices, clinics and doctors' offices, cafeterias, locker rooms, and restrooms. One LHD reported having a 100% tobacco-free policy. However, among those LHD directors who answered the questions, 38 of 66 (57.6%) said smoking was permitted at LHD events and functions, 29 of 39 (74.4%) said smoking was permitted on outdoor walkways and loading docks, 60 of 76 (78.9%) said smoking was permitted outside all entrances and exits, and 74 of 76 (97.4%) said smoking was permitted in parking lots (Figure).

Among the LHD directors, 57 of 75 (76.0%) said they were very familiar or somewhat familiar with the preemptive provisions of North Carolina's state law on smoking in public places (*9*). However, 28 of 75 (37.3%) incorrectly believed the law prevented enactment and enforcement of a 100% tobacco-free policy on LHD grounds, and 15 (20.0%) said they did not know whether the law prohibited such a policy. Sixty-six of the 76 LHD directors (86.8%) believed the majority of their employees would support a 100% tobacco-free policy at their LHDs. Fifty-eight (76.3%) reported that

FIGURE. Local health department smoking policies*, by traditional smoking site — North Carolina, July–August 2003



*As reported by 76 local health directors.
†Two reported operating under the policy in effect at the host site.

no single person was officially responsible for enforcing their tobacco-use policy.

In May 2005, the North Carolina General Assembly, in response to data indicating uncertainty about exemptions and with leadership from the North Carolina Association of Local Health Directors, amended the section of the state's smoking law, enabling LHDs to implement more stringent policies. The new law specifies that the exemption applies to both LHD buildings and grounds, including areas within 50 feet of a building.[††]

Reported by: *AO Goldstein, MD, C Gray, MPH, AY Butzen, KM Ribisl, PhD, Dept of Family Medicine, School of Public Health, Univ of North Carolina at Chapel Hill.*

Editorial Note: The findings described in this report indicate uncertainty among the majority of LHD directors in North Carolina regarding whether the state's 1993 smoking law prevented them from implementing a tobacco-free policy. The North Carolina Tobacco Control Program works to implement a comprehensive tobacco prevention and control program, of which smoke-free policies are a substantial component. Achieving tobacco-free policies in North Carolina LHDs will require leadership from LHD directors, policy approval from local boards of health, and support from LHD employees. Given that 86.8% of LHD directors reported that their employees would support 100% tobacco-free policies

[¶] Current smoker was defined as a person who uses pipes, cigars, or cigarettes. Nonsmoker was defined as a person who never uses pipes, cigars, or cigarettes. Former smoker was defined as a person who has used pipes, cigars, or cigarettes but not currently.

** Pro-Children Act of 1994. Pub. L. 103-227. 20 USC 6081-6084 (March 31, 1994).

[††] North Carolina General Statute 143-599. An act to exempt from the law governing smoking restrictions local health departments and the buildings and grounds where they are located (2005). Available at http://www.ncga.state.nc.us/sessions/2005/bills/house/html/h239v4.html.

and given the known health benefits of such policies, policy gains might be possible. Implementation of such policies can reduce smoking and encourage cessation among LHD employees while protecting employees, patients, and visitors from exposure to secondhand smoke.

The findings in this report are subject to at least three limitations. First, the survey consisted of self-reported data and opinions of LHD directors regarding smoking policies; LHD directors might overestimate or underestimate the percentage of employees who smoke or employee support for tobacco-free policies. Second, although opinions of LHD directors are influential, LHD policies also are influenced by opinions from local boards of health, which might differ from those of directors. Finally, these data represent LHDs only in North Carolina. Other states already have tobacco-free policies in place at LHDs; however, such policies are not tracked.

If LHDs establish 100% tobacco-free policies, they will need to ensure enforcement. In the study described in this report, most directors reported that no single person was officially responsible for enforcement; new policies should include language and mechanisms to ensure prohibition of tobacco use in difficult-to-monitor locations such as in LHD vehicles, outside entrances, on loading docks, and at LHD events and functions. LHD employees who smoke also should be provided access to cessation-support services, which can substantially improve their odds of quitting smoking (*9*). In this study, LHD directors indicated their awareness of the adverse health effects of secondhand smoke. By implementing tobacco-free policies, they also can acknowledge the important role that LHD policies can play in modeling healthy behavior to the public and changes in social norms regarding the acceptability of smoking.

References

1. International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to humans: tobacco smoke and involuntary smoking [volume 83]. Lyon, France: IARC Working Group on the Evaluation of Carcinogenic Risks to Humans; 2004. Available at http://www-cie.iarc.fr/htdocs/monographs/vol83/02-involuntary.html.
2. National Toxicology Program. 9th report on carcinogens, 2000. Research Triangle Park, NC: US Department of Health and Human Services, National Institute of Environmental Health Services; 2000. Available at http://ntp.niechs.nih.gov/ntp/roc/eleventh/profiles/176toba.pdf.
3. California Environmental Protection Agency. Health effects of exposure to environmental tobacco smoke: smoking and tobacco control monograph No. 10. Bethesda, MD: National Cancer Institute, California Environmental Protection Agency; 1997. Available at http://cancercontrol.cancer.gov/tcrb/monographs/10/m10_complete.pdf.
4. Environmental Protection Agency. Respiratory health effects of passive smoking: lung cancer and other disorders. Washington, DC: Environmental Protection Agency; 1992.
5. Environmental Protection Agency. Setting the record straight: secondhand smoke is a preventable health risk. Washington, DC: Environmental Protection Agency; 1994. Available at http://www.epa.gov/smokefree/pubs/strsfs.html.
6. CDC. Exposure to environmental tobacco smoke and cotinine levels—fact sheet. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/tobacco/research_data/environmental/factsheet_ets.htm.
7. CDC. State smoking restrictions for private-sector worksites, restaurants, and bars—United States, 1998 and 2004. MMWR 2005;54:649–53.
8. CDC. Preemptive state smoke-free indoor air laws—United States, 1999–2004. MMWR 2005;54:250–3.
9. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000. AHQR publication no. 00-0032.

Progress Toward Poliomyelitis Eradication — India, January 2004–May 2005

Since 1988, the global incidence of polio has decreased by more than 99%, and three World Health Organization (WHO) regions (Americas, Western Pacific, and European) have been certified as polio-free (*1*). India, the largest of the six countries where polio remains endemic, experienced a large polio outbreak (1,600 cases) in 2002 (*2*). Since then, the Government of India (GOI) has accelerated its polio eradication activities by increasing the number and quality of supplementary immunization activities (SIAs),* which reduced the number of reported cases to 225 in 2003, 134 in 2004, and 18 in 2005 (as of June 18) (*3*). During 2004 and early 2005, taking advantage of the geographic restriction of wild poliovirus (WPV) circulation, GOI and its partners launched several immunization and surveillance strategies to maximize the probability of eliminating poliovirus transmission in India. With continued high-quality interventions, interruption of WPV transmission in India by the end of 2005 appears feasible. This report summarizes progress toward polio elimination during January 2004–May 2005 toward that end.

Acute Flaccid Paralysis (AFP) Surveillance

Since 2000, India has exceeded the WHO-established AFP surveillance quality targets (i.e., a nonpolio AFP rate of ≥1 case per 100,000 population aged <15 years and adequate stool

* Mass campaigns conducted during a brief period (days to weeks) in which 1 dose of oral polio vaccine (OPV) is administered to all children aged <5 years, regardless of vaccination history. The geographic extent of campaigns (national versus subnational) is determined by analysis of surveillance data. OPV can be administered at fixed sites, by mobile teams during house-to-house visits, by mobile teams at transit points (e.g., train stations or markets), or through a combination of strategies, depending on local circumstances.