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HOW DOES THE RESEARCH ON THE EFFECT OF PASSIVE SMOKING ON CHILDREN'S HEALTH OF SMOKER PARENTS REFLECT THE LEGISLATIVE AND POLICY CHANGES AS IDENTIFIED IN WHO (1999) CONSULTATION DOCUMENT? A LITERATURE REVIEW SUBMITTED AS A PART OF MSC IN PUBLIC HEALTH.

How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in WHO (1999) consultation document?

A Literature Review Submitted as a part of MSc in Public Health.

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Abbreviations and Acronyms

BLII: British Library Information Index; CASP: Critical Appraisal Skills Program; CHD: Coronary Heart Disease; CDC: Centers for Disease Control and Prevention; CINHAL: Cumulative Index to Nursing and Allied Health Database; ETS: Environmental Tobacco Smoke; FEV: Forced Expiratory Volume; FEF: Forced Expiratory Flow; FVC: Forced Vital Capacity; MMEF: Maximum Mid Expiratory Flow; NHS: National Health Services; NGO: Non-governmental organization; O.R: Odds Ratio; R.R: Relative Risk; SCI: Science Citation Index

Abstract

Introduction: Passive smoking is the involuntary breathing of other people's tobacco smoke. Second-hand smoke also known as environmental tobacco smoke (ETS) is a combination of exhaled smoke and smoke from the burning tip of a tobacco product [1]. It is a complex mixture of more than 4,000 chemical compounds, including at least 40 known carcinogens (cancer-causing agents). Tobacco smoke also contains carbon monoxide, a gas that inhibits the blood's ability to carry oxygen to body tissues including vital organs such as the brain and heart [2]. The Environmental Protection Agency in the USA has classified environmental tobacco smoke as a class A (known human) carcinogen along with asbestos, arsenic, benzene and radon gas.

Aim and Objective: The main aim and objective of this Dissertation is to discuss how does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document? The researcher has also discussed the diseases caused by passive smoking and by smoking. The researcher has given the interventions and programmes and policies especially [3] consultation document to control the affects of passive smoking and smoking in this Dissertation. Although it is very difficult to give up the smoking habit but by the help of smoking cessation programmes and counselling services by health care workers one can control the smoking habit and live a healthy life.

Method: The researcher has done the literature review of international journal articles and health related books and websites to collect the articles and reference material for this Dissertation and to present the data to support the aim and objective of this Dissertation [4]. During the searching process, the researcher has used the Athens databases and Electronic Journal Oxford Brookes University by the help of Boolean Operators/key word searchers and some hand searched international journals to collect the related information about the harmful affects of passive smoking in children of smoker parent.

Findings: All the reviewed studies and journal articles clearly stated that passive smoking is harmful for the health of children especially for the children of smoker parents. The studies also provide the intervention strategies and intervention recommendations to reduce the smoking habits and promote the smoking cessation programmes.

Discussion: Infants and young children are more sensitive than adults to the effects of ETS. When children are exposed to ETS, they are more likely to develop sensitive airways, making them susceptible to respiratory problems and increasing their chance of being admitted to hospital [5]. Children exposed to ETS have a greater frequency of sore and/or watery eyes, sneezing, coughing, asthma, chest tightening, wheezing, slower lung growth and decreased lung function [6]. These children are also more likely to suffer from respiratory infections such as pneumonia, bronchitis, bronchiolitis, ear infections, tonsillitis and sinusitis. Tobacco smoke can be harmful to children from conception onwards. If a mother smokes during pregnancy the unborn child is exposed to the same high levels of poisons as the mother. The unborn child receives tobacco by-products through its mother's bloodstream. Evidence [5] shows that smoking during pregnancy increases the risk of miscarriage, stillbirth and death (for example, SIDS 'cot death') and illness in early infancy. Mothers who smoke are at a greater risk of having a low birth weight baby.

Intervention strategies and strict policies are needed to reduce the effects of passive smoking on children health. Every 2 in 3 parent smokers want to stop smoking. Some people can give up easily. Willpower and determination are the most important aspects when giving up smoking [7]. However, nicotine is a drug of addiction and many people find giving up a struggle. Help is available. GPs, practice nurses, or pharmacists can provide help, information, encouragement, and tips on stopping smoking. Also, many parts of the country now have specialist NHS 'Stop Smoking Clinics' which have a good success in helping people to stop smoking [7]. Your doctor may refer you to one if you are keen to stop smoking but are finding it difficult to do so. Nicotine Replacement Therapy (NRT) can help if withdrawal symptoms are troublesome. Nicotine gum, sprays, patches, tablets, lozenges, and inhalers are available [7]. A pharmacist, GP, practice nurse, or Stop Smoking Clinic can advise about NRT. A medicine called bupropion (trade name 'Zyban') is another option. It also roughly doubles your chance of stopping smoking if you really want to stop. Educating the hazards of smoking and passive smoking and the counselling services provided by health care workers helps to control the effects of passive smoking [7].

Conclusion: It is concluded from the studies that the smoking habit of parents and other family members at home put children lives in danger and in the future those children affected by passive smoking have more health problems as compare to non exposed children. Strict policies and Interventions are needed to control smoking at home. The government of UK put smoking ban on public places, cars and at work place from June 2007 this will help to control effect of passive smoking in general.


1
Chapter

Introduction

There are approximately 4000 chemicals in cigarette smoke and these chemicals, toxins and cancer causing compounds are very harmful for the health and if someone is exposed to these harmful chemicals and toxins for a long time it will badly affect the health and develop so many deadly diseases for example lung cancer, hypertension, angina pectoris and stroke [8]. It is the responsibility of governments to highlight the dangers of smoking tobacco and to give awareness to local people to stop smoking tobacco to get a healthy life style [9]. Maternal passive smoking exposure results in a 1.5-fold increase in risk of Non-Syndromic [10] Orofacial Clefts-NSOFC similar to the magnitude of risk reported for active smoking but there is marked heterogeneity between studies. Meta-analysis and meta-regression of the extracted data were performed. Egger's test was used to test for small study effects. Fourteen eligible articles were identified.

Maternal passive smoking exposure was associated with a twofold increase in risk of NSOFC (odds ratio: 2.11, 95% confidence interval: 1.54-2.89) this was apparent for both cleft lip with and without [10] palate (OR: 2.05, 95% CI: 1.27-3.3) and cleft palate (OR: 2.11, 95% CI: 1.23-3.62). The small increased risk for cleft lip with or without [11] cleft palate in the offspring of women who smoke during pregnancy observed in this study is in line with previous evidence. In contrast to some previous studies an increased risk was also apparent for cleft palate. In these U.K. data there was evidence of a dose-response effect of maternal smoking for both types of cleft [12]. The data were compatible with a modest effect of maternal passive smoking, but the study lacked statistical power to detect or exclude such an effect with confidence. It may be useful to incorporate information on the effects of maternal smoking on oral clefts into [11] public health campaigns on the consequences of maternal smoking. The results document the UK's success in [13] reducing smoking prevalence and prolonging lives thereby providing an example for other European nations.

When Framework Convention for Tobacco Control- FCTC consistent policies are also implemented, the model projects that smoking prevalence will fall by another 28% with an additional 168,000 deaths averted by 2040. A relative reduction of 23% in smoking rates over that period is attributed to tobacco control policies mainly tax increases smoke-free air laws, advertising restrictions and cessation treatment programmers. The model estimates that 210 000 deaths will be averted by the year 2040 [13] as a consequence of policies implemented between 1998 and 2010. Local councils are responsible for enforcing the new law in England. They have worked closely with businesses ensuring that everyone understands how to become smoke free [14]. Anyone who smokes in a smoke free place could face an on the spot fine of £50 (or £200 if the matter goes to court) for smoking in a smoke free place, whilst anyone in charge of smoke free premises or vehicles could face fines for two separate offences: failing to prevent smoking in a smoke free place and failing to display no-smoking signs [14].

Smoking: 'A Health Hazard' - Government Social Policy and Public Health Issues

The results document the success of Thailand [15] in reducing smoking prevalence and reducing the number of lives lost to smoking thereby showing the potential of tobacco control policies specifically in a middle-income country. Additional improvements can be realized through higher taxes stronger clean air policies comprehensive cessation treatment policies and targeted media campaigns. Tax increases on cigarettes and advertising bans had the largest impact followed by media anti-smoking campaigns clean air laws and health warnings [16]. The model estimates that the policies saved 31 867 lives by 2006 and [17] will have saved 319,456 lives by 2026. On July 1st 2007, virtually all enclosed public places and workplaces in England became smoke free (Smoke free England, 2007). This means that it is against the law to smoke in the indoor parts of places such as pubs, bars, nightclubs, cafes and restaurants, lunch rooms, membership clubs and shopping centres. At work, smoking inside has become a thing of the past, and indoor smoking rooms are no longer allowed [14]. No-smoking signs should be displayed in all smoke free premises and vehicles, to make it clear where you can and can't smoke.

Smoking ban on public places in UK took more than 50 years after the research done on smoking and cancer but it shows the change towards the healthier life style [14]. Exposure to second-hand smoke is responsible [17] for an estimated 166 ,000 child deaths each year worldwide. To protect people from tobacco, smoke the World Health Organization recommends the implementation of comprehensive smoke-free legislation that prohibits smoking in all public indoor spaces including workplaces bars and restaurants. In addition to protecting children from tobacco smoke in public the link between smoke-free legislation and improved child health is likely to be mediated via a decline in smoking during pregnancy and reduced exposure in the home environment [18]. Recent studies have found that the implementation of smoke-free legislation is associated with a substantial decrease in the number of perinatal deaths preterm [17] births and hospital attendance for respiratory tract infections and asthma in children although such benefits are not found in each study.

The government has responded to the serious harm done to England's health done by smoking in its health strategy 'The Health of Nation' [19]. It has set targets for reduction in smoking prevalence and cigarette consumption, as well as for reduction in mortality in the two smoking-related diseases, which cause most deaths, Coronary Heart Disease (CHD) and lung cancer, and has set out an action plan to achieve these targets [19]. The U.K government is now implementing total ban on smoking on public places, offices, parks, pubs and restaurants from the middle of 2007. Smoking is a risk factor for mortality from several medical causes. The hazards of smoking depend on factors such as the age at which smoking began, number of cigarettes smoked per day, cigarette characteristics, such as tar and nicotine content or filter type, and smoking behaviour, such as degree of inhalation [20]. To strengthen the scientific evidence for national and global tobacco control efforts, a consistent method is needed to estimate the health effects of smoking across different populations and different points in time.

Aims and Objectives

In this dissertation I will also explain the genuine reason which stimulates the children, teenagers and youngsters/elders to start smoking. Following are some aims and objectives of my master's Dissertation.

a) To discuss how does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?

b) To discuss and critically analyses the policies and strategies of the government to stop smoking in public places, parks, offices.

c) To explore and identify the factors that encourages teenagers and youngsters to start smoking.

d) To give the solutions to stop smoking and to encourage people to adopt healthy life style.

This Dissertation includes the detailed study and critical analysis about the harmful effects of smoking on the health of smoker and the effects of passive smoking on the health of children.

Context Setting

Researcher will mainly explain and critically analyses the 'stop smoking' policies and strategies of governments and health organizations and researcher will explain and critically analyses the effects of passive smoking on the health of children and their smoker parent's tobacco smoke.

1) The first chapter contains the main aim and objective of my Dissertation.

2) The second chapter of my Dissertation will contain mainly books, journals, papers references regarding hazards of smoking on health and the effects of passive smoking on the health of children.

3) The third chapter of my dissertation includes the discussion of literature review as a research methodology which researcher has chosen as the methodology of my master's Dissertation. It includes the inclusion/exclusion criteria of the material referenced in the thesis and selecting and justifying databases. It also includes identifying and justifying critiquing method for the research papers researcher used and various ways of analyzing other people research finding and treating their finding as data in the thesis.

4) The fourth chapter includes the discussion about the exact methods researcher have drawn from my methodology literature review. This includes the Boolean search table/key word searches.

5) The fifth chapter includes the results of the study and the presentation of the findings which includes 10 articles and papers (different articles from preliminary literature review) which will be used for Critical Literature Review (CLR) and to present the results [21].

6) The sixth chapter includes analysis of the studies reviewed in the Dissertation. It also includes the tables of aim and objective and common themes across the articles in critical literature review. Mind maps are also included in sixth chapter.

7) The seventh chapter includes the discussion of findings, which includes the implications for public health practice and benefit for community, professionals and organisation and recommendations and implications for future research. After the seventh chapter the 8th chapter is conclusion and references, bibliography, appendices come after one another.

The Dissertation includes so many references from the different articles from different journals, papers from the different health websites, reference books and newspapers so the research question for my Dissertation now is:

Research Question: How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?


2
Chapter

Preliminary Literature Review: Overview of "How Does the Research on the Effect of Passive Smoking on Children's Health of Smoker Parents Reflect the Legislative and Policy Changes as Identified in WHO (1999) Consultation Document"

What is Smoking and Passive Smoking?

Tobacco smoking is the act of burning the dried and cured leaves of the tobacco plant and inhaling the smoke for pleasure or ritualistic purposes, for self - medication, or out of habit and to satisfy addiction. The practice was common among Native Americans throughout North and South America and was later introduced to the rest of world via trade following European exploration of Americas [2]. Smoking is primarily a health problem, but it also plays a significant economic role in the community [22]. While cigarette tax is a rich source of revenue to the Treasury, the cost of smoking to the economy includes not only the expense of treating diseases caused by smoking, but also other costs such as working days lost and social security payments. The cost of smoking to industry results from lost productivity due to sickness absences, impaired productivity due to poor health, and interruption of production from time given to smoking [23]. The Royal College of physicians has estimated that smoking-induced illnesses result in the loss of 50 million working days every year.

Surveys have shown that smokers of more than 20 cigarettes a day have twice as much time off work due to illness as do non-smokers. In addition, there are cleaning and building maintenance costs. In one year, a 20 a day smoker will spend over £1,000 on cigarettes [22]. Smokers just not only put their lives in danger but they also put other people lives in danger also, because when a person who is non-smoker works at that place where people smoke or go to that park or club where smoking is not banned and non-smoker is exposed to tobacco smoke for long time then that person could develop asthma, throat infections, hypertension or sometimes lung cancer as well [24]. The US Environmental Protection Agency has declared environmental tobacco smoke a 'Class A Carcinogen' (capable of causing cancer in humans) [19]. Non-smokers are exposed to the risk of cancer, and possibly other diseases, the certainty of smelly clothes and hair, and the likelihood of irritated eyes and throat, headache, dizziness and nausea when they socialize with smokers [19].

A much research is done to find out the harmful effects of passive smoking and still more research work is in progress to explore and display the hazards and dangers of passive smoking. It is the responsibility of the people who smoke to stop smoking because it is very dangerous for their health as well as others living with them who do not smoke [19]. (See appendix 3, Environmental tobacco smoke). The more research that is done to find out the hazards of smoking/passive smoking, the more people will be aware of the harmful effects of cigarette smoke on health [25]. The second problem area associated with smoking and ill-health is that of "passive smoking" (i.e. inhaling smoke from other people's cigarettes). The subject of passive smoking is receiving an increasing amount of attention and publicity and evidence is mounting to suggest that subjecting non-smokers to smoke may be putting their health at considerable risk [26]. As the link between passive smoking and damage to health becomes more firmly established, more and more employers are acknowledging that they have a duty to protect their non-smoking employees from the hazards of tobacco smoke under the provisions of the Health and Safety at Work, Act 1974 [26].

Indeed, there have been claims that a refusal to introduce a smoking ban constitutes a breach of an employer's duty under that act. It is not surprising therefore, that many employers are already taking action by introducing designated smoking and no-smoking areas or smoking bans. Bans can cause much upset among smokers, especially as they are likely to suffer from the withdrawal symptoms outlined above if they cannot smoke at all during their hours at work. In some extreme cases heavy smokers might even be forced to resign from an organisation, which introduces a total smoking ban [26]. In the UK from approximately the middle of the year 2007 the UK Government is applying the total ban on cigarette smoking in work places, public places, pubs and in restaurants and they are trying to develop a smoke free healthy environment in UK [27].

What are the Effects of Passive Smoking on the Health of Children of Smoker Parents?

The effects of passive smoking is almost same as the effect of smoking if anyone is exposed to second hand smoke for a long time [2]. In the above discussion in literature review the researcher has briefly discussed the diseases caused by tobacco smoke to a smoker and to non - smoker exposed to ETS. The next section discusses the harmful effects of passive smoking on the health of children. Passive smoking is a threat to public health and kills more than 22,000 people a year in Europe [28]. The children of smokers are statistically much more likely to suffer from pneumonia, bronchitis and glue ear the commonest cause of childhood deafness [28]. The report claimed they run a much greater risk of

miscarriage and their children run a higher risk of dying in infancy. A 1989 Surgeon's General Report [29] showed that women who smoked during pregnancy had a higher frequency of intrauterine growth retardation and other complications [30]. The birth weight of infants was lower for mothers who smoked while pregnant than for mothers who did not. Infants of non - smoking mothers who live with smokers were also found to have lower birth weight than infants of non-smoking mothers not exposed to smokers [29].

Fontelo (1993:429) describes child abuse is defined by the Child Abuse and Prevention Act of 1973 (public law 93 - 247, amended 1978 and 1984) as:

"The physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 years by a person responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened there by".

Is exposure to environmental tobacco smoke through a parent or caregiver a form of child abuse? Does the mother's smoking during pregnancy or the exposure of non-smoking pregnant women to environmental tobacco smoke through a spouse who smokes constitute a form of child abuse? [29]. Non-smokers exposed to environmental tobacco smoke are unfairly endangered. Babies in utero, infants, and children are especially vulnerable because they cannot protect themselves [29]. The individuals who are entrusted with their welfare are the sources of the threat to their health. Informing parents that they are abusing their children by exposing them to environmental tobacco smoke may provide parents with the motivation they need to quit smoking [29]. [31] Some studies suggest an increase in risk of more than 50 percent. A mother smoking has a stronger effect than fathers' (as would be expected because, on average, young children spend more time with their mothers) [31]. Also, the more cigarettes smoked in the household, the stronger is the likelihood that the baby will suffer respiratory disease [32].

According to Wald et al (1991:7) the author of the Australian report wrote:

"……Approximately twice the incidence of respiratory….disease in smokers children in the first year of life, compared to children of non-smokers."

It noted that no study had been published which negated this observation. After reviewing the evidence, the U.S Surgeon General in 1990 concluded that as per Wald et al (1991:11):

"….Children whose parents smoke also develop respiratory symptoms more frequently and they show small but measurable differences on tests of lung function when compared with children of non-smoking parents."

According to Wald et al (1991:13) the U.S Surgeon General's Report in 1990 examined five studies and concluded that they:

"…are consistent in their demonstration of excess chronic middle-ear effusions, a sign of chronic ear disease, in children exposed to parental cigarette smoke." (See appendix 6, Wheezing and British children).

Statistics about Children Affected by Passive Smoking

Children's exposure to other people's tobacco smoke [19] (environmental tobacco smoke or ETS) is associated with a range of adverse health outcomes for children. Parental smoking is a common source of children's exposure to ETS. Older children in child care or educational settings are also at risk of exposure to ETS. Preventing exposure to ETS during infancy and childhood has significant potential to improve children's health worldwide [33]. A minority of interventions have been shown to reduce children's exposure to environmental tobacco smoke and improve children's health but the features that differentiate the effective interventions from those without clear evidence of effectiveness remain unclear [19]. The evidence was judged to be of low or very low quality as many of the trials are at a high risk of bias are small and inadequately powered with heterogeneous interventions and populations.

There is evidence that family and friends [34] influence children's decisions to smoke. There is moderate quality evidence to suggest that family-based interventions can have a positive effect on preventing children and adolescents from starting to smoke. There were more studies of high intensity programs compared to a control group receiving no intervention [35], than there were for other comparisons. The evidence is therefore strongest for high intensity programs used independently of school interventions. Programs typically addressed family functioning and were introduced when children were between 11 and 14 years old. Based on this moderate quality evidence a family [34] intervention might reduce uptake or experimentation with smoking by between 16 and 32%.

Children's exposure to other people's cigarette smoke (environmental tobacco smoke, or ETS) [36] is associated with a range of adverse health outcomes for children. Parental smoking is a common source of children's exposure to ETS [37]. Older children are also at risk of exposure to ETS in child care or educational settings. Preventing exposure to cigarette smoke in infancy and childhood has significant potential

to improve children's health worldwide. While brief counselling interventions have been identified as successful for adults when delivered by physicians, this cannot be extrapolated to adults as parents in child health settings [38]. Although several interventions, including parental education and counselling programs, have been used to try to reduce [36] children's tobacco smoke exposure, their effectiveness has not been clearly demonstrated.

Environmental, or passive, cigarette smoke has been linked with a number of serious health problems in children including upper respiratory infections, chronic cough, asthma, chronic ear infections, and sudden infant death syndrome. Now it appears that exposure to environmental tobacco smoke may also cause children with abnormal cholesterol levels - already at risk for future heart disease - to be even more likely to develop the disease at some point [39]. A study published in the 2nd September 1997 issue of Circulation showed that children who were exposed to environmental tobacco smoke at home had lower High-Density Lipoprotein (HDL) cholesterol levels that were as much as 10% lower than those of children who came from non - smoking households. HDL cholesterol, frequently called "good" cholesterol protects against heart attacks by culling fats from the blood stream, which keeps the coronary arteries free of plaque build-up. Fortunately [40], the findings also suggest that a child's HDL level can be raised by 10% if the smokey environment is cleaned up. This raise is equal to or better than many other risk - reducing strategies such as increased exercise and [39] lower fat intake.

The study was conducted by Neufeld, director of clinical hematology at Boston Children's Hospital, and colleagues, who examined a group of 103 children, aged 2 - 18 [39]. All of the children had come to the hospital for treatment of high cholesterol, and most of them had family members in the early stages of coronary disease. Neufeld says that his group originally sought to determine the extent to which patients followed the clinic's advice on leading a healthier life style and what effect following such advice had on their cholesterol problems [41]. But as remarkable correlation between tobacco smoke exposure and HDL levels emerged, Neufeld and colleagues began to target that relationship as the basis of the study, just over one - fourth of the children lives in households where some cigarette smoking were reported [39]. Children's exposure to other people's cigarette smoke (environmental tobacco smoke, or ETS) [42] is associated with a range of adverse health outcomes for children. Parental smoking is a common source of children's exposure to ETS.

Preventing exposure to cigarette smoke in infancy and childhood has significant potential to improve children's health worldwide. We searched the Cochrane Tobacco Addiction Group trials register and conducted additional searches of two health and education databases not included in this specialized register. While brief counselling interventions have been identified as successful for adults when delivered by physicians this cannot be extrapolated to adults as parents in child health settings [43]. However, there is limited support for more intensive counselling interventions for parents in such contexts. There is no clear evidence of differences between the respiratory non-respiratory [44] ill child well child and peripartum settings as contexts for reduction of children's ETS exposure [44].

Maternal Smoking and its Effects on Children Health

It is well known that maternal smoking during pregnancy and maternal pre-pregnancy overweight [45] have opposite effects on the infants' birth weight. We report on the association of the combination between both risk factors and the infants' birth weight. Of 3241 infants, 421 infants (13%) were born to smoking, non-overweight mothers, 514 (15.8%) to non-smoking, overweight mothers, 129 (4%) to smoking and overweight mothers and 2177 (67%) to non-smoking, non-overweight mothers (reference group). Infants of mothers who smoked and also had pre-pregnancy overweight had similar term birth weight [46]. Our findings suggested that the effects of maternal smoking during pregnancy and maternal pre-pregnancy overweight on infants' birth weight cancel each other out. Therefore, birth weight may not be a good indicator of an infant's health status in perinatal practice because it may mask potential health risks due to [45] these maternal risk factors when both present together.

The design timing and delivery of smoking prevention [47] and cessation services for women seeking to become pregnant and for women presenting for prenatal or pediatric care are best guided by individual characteristics, particularly maternal age preconception alcohol consumption and postpartum depression but neighborhood characteristics merit further attention for mothers at different ages. We identify five classes for mothers ages 15-25, four classes for ages 26-35, and three classes for ages 36+. Each age group presents classes of non-smokers and persistent heavy smokers [48]. Intermediate to these ends of the spectrum each age group exhibited its own smoking classes characterized by the extent of pregnancy smoking reductions and postpartum behavior. Co-resident smokers predicted nearly all smoking classifications across age groups, and selected [47] neighborhood characteristics predicted classification of younger (15-25) and older (36+) mothers.

In utero exposure to tobacco [49] smoke is associated with adverse neonatal outcomes the association with later childhood mental health outcomes remains controversial. We used a strategy involving comparison of maternal and paternal smoking reports in a sample pooling data from six diverse European countries. Data were drawn from mother (N = 4,517) and teacher (N = 4,611) reported attention deficit and

hyperactivity disorder (ADHD) symptoms in school children aged 6-11 in Turkey Romania Bulgaria, Lithuania, Germany, and the Netherlands, surveyed in 2010. Mothers report on self and husband's smoking patterns during the pregnancy period. Paternal prenatal smoking was similarly associated with probable ADHD in unadjusted models [50]. When controlled for relevant confounders, maternal prenatal smoking remained a risk factor for offspring probable ADHD based on mother report (OR = 1.44, 95 % CI 1.06-1.96), whereas the effect of paternal prenatal [49] smoking diminished (e.g., mother report: OR = 1.17, 95 % CI 0.92-1.49).

Actions taken Against Smoking and for the Prevention of Passive Smoking in U.K

Smoking is now banned in all public indoor spaces in the U.K., including pubs and restaurants from mid-2007 [51]. This is the most important advance in public health since Sir Richard Doll identified that smoking cause's lung cancer 50 years ago, said Alex Markham CEO of Cancer Research UK. However, smokers'-rights groups and the tobacco industry criticized the move for limiting personal freedom [51]. Other European nations, including Ireland and Scotland, have passed similar laws. Seventy percent of Britons said they supported the ban. Smoke-free public places legislation has been introduced in many countries to protect [52] the public from the harmful effects of second-hand smoking. While evaluations of smoke-free policies have demonstrated major public health benefits the impact on youth smoking and inequalities in smoking remains unclear. This project aims to evaluate how smoke-free public places legislation in the UK has impacted on inequalities in youth smoking uptake and how much of any impact is via changes in parental smoking behavior.

The study will constitute secondary analyses of UK data (from the British Household Panel Survey and the Understanding Society study). Merging these datasets gives coverage of the period from 1994 to 2016. Missing data will be handled using multiple imputation. The primary outcomes are the rates and inequalities in initiation, experimentation, escalation to daily smoking and quitting among youths aged 11-15 years. [52] Secondary outcomes include the prevalence of smoking among parents of these youths [9]. Tobacco products can be sold from any retail outlet, but retailers have a duty to ensure tobacco products are not sold to anyone under the age of 16. From 1 October 2007, the minimum age for the purchase of tobacco will be raised to 18 in England and Wales [53]. The Scottish Parliament is expected to pass similar legislation [9]. UK embassies and high commissions are required to take care to avoid involvement in events which advertise or promote tobacco products overseas.

There will be complete ban on smoking on public places and work places so this law will be more affective to reduce the effect of passive smoking for children and other people as well. This law is the most important and beneficial step of UK Government to improve the life of common people and their families including their children, and this step will also help the UK Government to make a healthy smoke free environment all over the UK so everyone can enjoy the healthier life style free from tobacco smoke [9]. Children are the most vulnerable because they cannot protect themselves from harmful effects of passive smoking. All the prevention efforts and laws, legislations against cigarette smoking are designed to protect children from the harmful effects of passive smoking.

Intervention Strategies for Reducing Children's Exposure to Environmental Tobacco Smoke by World Health Organization (1999) Consultation Document

Public health instruments have been under constant development and renewal for decades [54]. International legal instruments with their binding character and strength have a special place in this development. The start of the 21st century saw, in particular the birth of the first World Health Organization (WHO)-era health treaties the WHO Framework Convention on Tobacco Control (WHO FCTC) and its first Protocol. The authors analyse the potential impact of these instruments on global health governance and public health beyond the traditional view of their impact on tobacco control [55]. Overall, the very fact that globally binding treaties in modern-era health were feasible has accelerated the debate and expectations for an expanded role of international legal regimes in public health. The impact of treaties has also been notable in global health architecture as the novel instruments required novel institutions to govern their implementation [54]. The legal power of the WHO FCTC has enabled rapid adoption of further instruments to promote its implementation.

The Tobacco Convention was adopted by the World Health Organization (WHO) [56] in 2003. Nikogosian and Kickbusch examine the five potential impacts of the Tobacco Convention and its Protocol on public health. These include the adoption of the Convention would seem to unlock the treaty-making powers of WHO the impact of the Convention in the global health architecture has been phenomenal globally the Convention has facilitated the adoption of further instruments to strengthen its implementation at the national level. The Convention has led to the adoption of appropriate legal framework to combat the use of tobacco at the national level and that the impact of the Convention would seem to go beyond public health but has also led to the adoption of the Protocol to Eliminate Illicit Trade in Tobacco. However, the article by Nikogosian and Kickbusch would seem to overlook some of the challenges that may militate against the [56] effective implementation of international law including the Tobacco Convention at the national level. The World Health Organization (WHO) Framework Convention on

Tobacco Control (FCTC) is a unique global health [57] instrument since it is in the health field the only instrument that is international law.

After the 10 years of its existence an Independent Expert Group assessed the impact of the FCTC using all available data and visiting a number of countries interviewing different stakeholders. It is quite clear that the Treaty has acted as a strong catalyst and framework for national actions and that remarkable progress in global tobacco control can be seen. At the same time FCTC has moved tobacco control in countries from a pure health issue to a legal responsibility of the whole government and on the international level created stronger interagency collaboration [58]. The assessment also showed the many challenges. The spread of tobacco use, as well as of other risk lifestyles is related to globalization. FCTC is a pioneering example of global action to counteract the negative social consequences of globalization. A convention is not an easy instrument, but the FCTC has undoubtedly sparked thinking and development of [50] other stronger public health instruments and of needed governance structures.

To present findings of a narrative review on [59] the implementation and effectiveness of 17 Articles of the WHO Framework Convention on Tobacco Control (FCTC) during the Treaty's first decade. Implementation was highest for smoke-free laws, health warnings and education campaigns youth access laws and reporting/information exchange and lowest for measures to counter industry interference, regulate tobacco product contents promote alternative livelihoods and protect health/environment. Price/tax increases comprehensive smoking and marketing bans health warnings, and cessation treatment are associated with decreased tobacco consumption/health risks and increased quitting. Mass media campaigns and youth access laws prevent smoking initiation decrease prevalence and promote cessation. The FCTC has increased the implementation of measures across several policy domains, and these [59] implementations have resulted in measurable impacts on tobacco consumption prevalence and other outcomes.

Implementation of key WHO FCTC demand-reduction measures is significantly [60] associated with lower smoking prevalence with anticipated future reductions in tobacco-related morbidity and mortality. These findings validate the call for strong implementation of the WHO FCTC in the WHO's Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020 and in advancing the UN's Sustainable Development Goal 3 setting a global target of reducing tobacco use and premature mortality from non-communicable diseases by a third by 2030. Between 2007 and 2014, there was a significant global increase in highest-level implementation of all key demand-reduction measures. The mean smoking prevalence for all 126 countries was 24·73% (SD 10·32) in 2005 and 22·18% (SD 8·87) in 2015, an average decrease in prevalence of 2·55 percentage points (SD 5·08; relative reduction 10·31%).

Unadjusted linear regression showed that increases in highest-level implementations of key measures between 2007 and 2014 were significantly associated with a decrease in smoking prevalence between 2005 and 2015. Each additional measure implemented at the highest level was associated with an average decrease in smoking prevalence of 1·57 percentage [60] points (95% CI -2·51 to -0·63, p=0·001) and an average relative decrease of 7·09% (-12·55 to -1·63, p=0·011). So, two issues emerge from this PLR: 1 does the evidence on passive smoking and children continue to give us concern and 2) what interventions/recommendations and policy changes have had an effect on reducing passive smoking with a beneficial impact on children's health.

So, the research question of this Dissertation is:

Research Question: How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?


3
Chapter

Methodology

Hart (1998:28) Defines Methodology As

"A system of methods and rules to facilitate the collection and analysis of data. It provides the starting point for choosing an approach made up of theories, ideas, concepts and definitions of the topic; therefore, the basis of a critical activity consisting of making choices about the nature and character of the social world (assumptions). This should not be confused with techniques of research, the application of methodology." The methodology of this dissertation is a critical literature review. This chapter considers the following:

a) The literature review with its advantages and disadvantages.

b) The justification of the philosophical assumptions in regard to the review.

c) The objective of the review followed by the critical appraisal criteria used to critically analyse the selected studies.

Suitability of the Literature Review

Definition of Literature Review: Literature is considered by Hart (2005:154) as "…… for most master's research projects…literature… is made up of various published and non-published items including books, statistics and reports (Hart, 2005:154)."

And the word review is defined as the whole process of bringing together a body of evidence, which can be drawn from research and other sources [61]. Literature review can also be defined as the selection of the available documents (both published and unpublished) on the topic, which contain information, ideas, data and evidence written from a particular stand point to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed [62].

According to [63] literature reviews should be comprehensive and include all the pertinent and valid papers. The details of the methods and the results of the studies included should be presented in a critical manner. They should also report the method used (e.g. a computer search using Medline in relation to the topic (key words) and years searched). Literature reviews unfortunately often take the form of description, rather than critical analysis, despite the emphasis on the latter during academic and research training, and despite the existence of literature on how to undertake literature reviews and systematic reviews [63]. According to [63] when reviewing literature, the investigator should assess publications in relation to whether there is a clear statement of the problem, whether it can be answered with empirical data and whether any reviews included are comprehensive and up-to-date.

According to [62] review of the literature is important because without it researcher will not acquire an understanding of the topic. What has already been done on it, how it has been researched, and what the key issues are? [62] says, in the researcher written project writer will be expected to show that researcher understand previous research in the topic. This amount to showing that researcher have understood the main theories in the subject area and how they have been applied and developed, as well as the main criticisms that have been made of work on the topic [62]. The review is therefore a part of researcher academic development of becoming an expert in the field [62].

To give a certain level of understanding of the chosen topic area, a review of literature can also bring focus to a study in order to direct the reader about: the information that is already there and the availability of the cutting-edge theories [64]. Literature review is actually the collection of all the information about the focused research area and collection of all the required data to provide evidence to justify the research question.

According to [62] the literature review is integral to the success of academic research. A major benefit of the review is that it ensures the researchability of researcher topic before proper research commences. All too often students new to research equate the breath of their research with its value. Initial enthusiasm, combined with this common misconception, often results in broad, generalized and ambitious proposals. It is the progressive narrowing of the topic, through the literature review, that makes most research a practical consideration [62]. According to [62] one of the main reasons for conducting a literature review is to develop the skills and abilities of the researcher as well as having a public dimension; and this dimension would represent the design feature of the research. It also embodies the educational purposes of carrying out a piece of independent research. Therefore, reviewing the literature on a topic can provide an academically enriching experience, but if it is done properly.

Researcher has chosen the literature review as the methodology of this Dissertation. Researcher has provided the details about the research question. "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" after studying or reviewing the literature from different health care related books, medical journals, health articles and from different health care websites [65]. Researcher has also provided some statistics about the harmful effects of passive smoking on the health of children of smoker parents and then comparing it to the children of non-smoker parents and the result shows that children of smoker parents get more illnesses in their lives from birth till their teenage as compare to healthy children of non-smoker parents, The data is genuine and it supports researcher's research question.

According to Hart (2005:140) in his book Doing Your Masters Dissertation, the process involved in undertaking a literature-based masters dissertation differs in the details from a work-based dissertation, but have some generic stages which are outlined below:

Stage1: Definitions of the problem and research questions are set. It is argued that the relevant literature will be able to provide answers to, or better understanding of these when examined in the context of the problem. The literature is therefore identified as the main source of data for the research. Hart (2005:140).

Stage 2: Careful design of the literature search strategy is undertaken to identify the necessary sources and resources, which will be comprehensively searched. This includes clear definition of the criteria and procedures for evaluating the relevance of the literature for inclusion and exclusion from the research.

Stage 3: Critical analysis of the literature is undertaken to identify appropriate contributions to the topic problem. This consists of identifying the different ways in which the problem has been defined and approached, deconstructing the main arguments, evaluating them against the criteria set, and, if based on 'findings', assessing these on an individual and aggregate level. Hart (2005:140).

Stage 4: The elements of the analysis are synthesized into relevant categories, which are justified by being based in the literature and used to express complementary and opposing views, alongside highly relevant and confused views on the problem, to show with more clarity knowledge of the problem, its origins and development or how the literature can provide a basis of recommendations for lines of action. Hart (2005:140).

How to Search for Literature

When some researcher starts a research project researcher has to use common sense to search the focused research books, journals, articles and websites for his/her research question [66]. The researcher should not deviate or detract from the actual focused research question he/she had or decided after the agreement of the supervisor.

The first step in deciding on a topic for study is to search and review the published and unpublished literature. Non-significant research findings are rarely accepted for publication, resulting in 'publication bias' [63]. Instead, non-significant research results tend to remain in internal departmental reports, known as 'the grey literature'. Thus, the researcher needs to be aware of the mistakes done in doing searching literature and to keep in contact with experts in the field of research to avoid mistakes.

Resources Used

There are many of databases available on internet or on websites, but researcher cannot trust on the information available on every website or databases because some of the websites are not quality checked. Some of the web sites for example google search engine and Mednets and Trip database are very useful databases and search engines having much of quality information a researcher can use for references or for critical analysis [67]. They include quality internet journals for example British Medical Journal, American Journal of Public Health, Lancet Journal and Independent Journal.

Bowling (1997:79) wrote in his book Research Methods in Health about the resources used to search the literature:

"….Searching the literature has been facilitated by computerised data bases of the literature on CD-ROM in medical science (e.g. Medline, EMBASE), nursing (e.g. CINHAL: cumulative index to nursing and allied health database), for social or other sciences (e.g. Sociofile, PsycINFO and PsycLIT). There are other full indexes and citation indexes available as databases for example British library information index (BLII) and science citation index (SCI) [63]. Printed indexes are also available in university and specialist libraries (e.g. Index Medicus, Sociological Abstracts and Psychological Abstracts)."

The electronic catalogue library of Oxford Brookes University was used for literature search. This identified published articles from well-known journals about the topic of researcher interest.

Search Terms

During searching the literature the researcher should widely search the literature to find out his/her material of interest about the focused research question, the researcher should search the electronic databases and websites to find the literature of his/her interest or read books of different authors and search various journals to find the literature regarding the focused research question. Hart (1998:27) writes in his book Doing a Literature Review: "……. In the search process for information, it's important for the researcher to be flexible and search more widely or use complex combination of words and phrases as initial search may not reveal what the researcher is looking for. "

The researcher should keep all the record of how the research is done and which journal or book is used for reference and which electronic database is use for reference and the important key words and search terms used for searching the literature. Mainly the electronic catalogue library of Brookes University, Athens databases and BMJ journals are used to find and include the journal articles in this Dissertation. The researcher of this Dissertation has continued the search by using key words through Boolean searches.

Boolean operators form the basis of mathematical sets and database logic. When searching databases, operators are used to connect the searcher's seach words, either to narrow or broaden searcher's set of results. Databases are very sensitive; they follow the commands you type in and return results based on those commands. You need to be aware of the logical order in which words are connected when using Boolean operators University of Wisconsin library, [68]. Boolean searching is to broaden or narrow your search by combing words or phrases using the Boolean operators AND, OR, and NOT [69] (Figure 1).

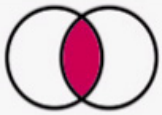
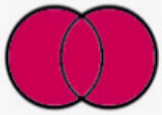
Operator	Example search	The search will find...	**Venn diagram** results shown in pink
AND	north carolina and prohibition	items containing "North Carolina" and "prohibition." AND narrows a search, resulting in fewer hits.	
OR	zimbabwe or rhodesia	items containing either "Zimbabwe" or "Rhodesia" or both. OR broadens a search, resulting in more hits.	
NOT*	mexico not new mexico	items containing "Mexico" but not "New Mexico." *Caution!* It's easy to exclude relevant items.	

Figure 1

Boolean Search Strategy, planning a search [70]:

a) Identify the concepts in your search.

b) Think of synonyms and alternative ways of expressing each concept.

c) Arrange synonyms for the same concept in a group.

d) Connect your synonyms with "or"s, and place in parentheses.

e) Connect your concepts (or groups of synonyms) with "and"s, "not"s or proximity operators.

For example, if you are looking for information on liquor laws in Ontario and Quebec, you might search as follows: (alcohol or liquor or spirits) and (law or legislation or licens) and (Ontario or Quebec) [70].

Selection Criteria and Comparison between Bray and Rees (1995) Critiquing Framework and Critical Appraisal Skills Programme (CASP)

Hart (1998:173) write in his book Doing a Literature Review about the selection of the written material the researcher must keep these questions in his mind:

a) "How can the literature review be used to justify the topic? Hart (1998:173)

b) What formats are useful for arranging the review of the literature?

c) What is meant by criticism and how can you be fair in your critical analysis?

d) How do you start to write a literature review?"

The researcher has chosen the Bray and Rees (1995) critiquing framework to do critical literature review. According to LoBiondo-Wood and Haber (2002) a critique is a careful consideration of both the strengths as well as weaknesses of published research [71]. It is on the basis of this that the reader can consider the implications for practice. Although the word critique is often linked with the word criticize, it is mean to be a constructive evaluation, and should be objective, unbiased and impartial. It should take a balance view of the work in terms of both content and the process of research followed by the author [71]. It is a way of using critical skills to reflect on, not only the whole process in which the research was undertaken, but also the thinking and assumptions on which the research was based. Critiquing is a skill that requires practice. Firstly, the reader requires knowledge of how to critique [71]. When faced with a research article the reader should consider the following three questions [71]:

a) What does it say?

b) Can I trust it?

c) How does it contribute to practice?

The first question relates to comprehension, and is concerned with such elements as what did they look at? Why did they look at it? How did they go about it? [71] What did they find? What conclusions did they come to? The second question relates to an assessment of the research process in terms of rigour – how well was it thought through, and what steps were taken to reduce problems of bias, reliability and validity? The third question relates to an evaluation of the study's contribution to professional practice – does it provide clear evidence for changing and challenging practice? Who might benefit from the study, and in what way? [71] Bray and Rees (1995) critiquing framework provides 12 sets of questions for critical literature review for both qualitative and quantitative studies important points a researcher can critique are as under:

a) Focus of the study:

b) Background:

c) Terms of references:

d) Study design:

e) Tool of data collection:

f) Ethical consideration:

g) Sample:

h) Data presentation:

i) Main findings:

j) Conclusions and recommendations:

k) Readability:

l) Implication for practice:

National Health Services (NHS) Public Health Resource Unit which is located in Oxford developed Critical Appraisal Skills Programme (CASP) in 1993 to develop an evidence-based approach in health and social care. This programme is helpful for critical evaluation of a published research paper before selecting it for reference purpose. CASP helps the researcher to improve the skills for searching and critiquing the literature and to use it for references and for helping them to put knowledge into practice (Public health resource unit, 2007). The range

of workshops and learning resources available will help support clinical governance and clinical effectiveness throughout the organisation by providing the skills to base not only clinical practice but policy and decision-making on robust evidence of effectiveness (Public health resource unit, 2007). Critical Appraisal Skills Programme (CASP) has developed different tools to help with the process of critically appraising articles of the following types of research:

a) Systematic Reviews.

b) Randomised Controlled Trials (RCTs).

c) Qualitative Research.

d) Economic Evaluation Studies.

e) Cohort Studies.

f) Case Control Studies.

g) Diagnostic Test Studies (Public health resource unit, 2007).

CASP has developed different sets of questions for each study so researcher have to used different sets of questions for critical literature review of different studies. Bray and Rees (1995) critique framework is very helpful for researcher when doing critique of research articles initially, Bray and Rees (1995) critique framework offers 12 different areas of critique with different sets of questions so, the researcher follow the questions and did not go out of focus. Bray and Rees (1995) critique framework offers to find out the aim of the study, study design for example descriptive or action research, how the data is presented in the form of raw numbers or in percentages [72]. CASP offers different sets of questions for each different type of study; although it is good to critique the research articles, but researcher have to follow different questions for critique for each different type of study. CASP framework offers detailed questions for different studies for examples for qualitative study is different questions for critique and for cohort studies different questions are available for critique.

Inclusion and Exclusion Criteria.

The researcher has used Boolean operators/keyword searches to find the focused literature and to precise the research. Researcher has found keyword search as a most important tool to collect the information required for the references. Researcher has used all the information and the article journals available in English language and excluded all the information available in other languages [73]. Researcher has included all the studies in this Dissertation which was latest for example for critical literature review post 99 studies was included in this Dissertation. All the old outdated research was excluded from this research. Studies for example Meta-analysis were also not included in the critical literature review. Boolean operators/keyword search is the most useful tool to find the latest and appropriate information and journal articles for this Dissertation.

Above all are the inclusion criteria for the researcher to follow to write up the thesis. The researcher has also considered some exclusion criteria for the research to avoid the weak written texts. Books and internet journal articles which are not available in English are not included because it's very time consuming to translate the literature and data from other languages. Also, studies with poor methodology are excluded following critical review. The researcher had used the Boolean operators/key word searchers to find out the most suitable and focused journal articles and information regarding the research question "How does the research on the effect of passive smoking on children health of smoker parent reflect the legislative and policy changes as identified in [3] consultation document?" The researcher had excluded all the articles and information which was not related to the research question.

Ethical Consideration

Hart (2005:163) wrote in his book Doing your master's Dissertation about the ethics of using the literature:

"…If you use another person's work – text, diagrams, tables, data, pictures – without their permission or fail to give proper acknowledgement (attribution) to key ideas, phrases and words or change the arrangement of words in an extract you use, then you will certainly be breaking ethical standards of authorship and may be liable under the laws governing copyright."

Hart (2005:163) also write how to prevent you from being a 'plagiarist' and to avoid the stigma and shame of being a plagiarist he writes:

"…..Make notes on where you found the main ideas, words, phrases and other materials you intend to use so that you can include in your dissertation citations which attribute the origins of those ideas, words, phrases. This shows you have a clear understanding of ethical standards, that you have done your literature search and have been able to incorporate materials. It will also protect you from claims that your ideas can not be traced and therefore from doubts about the quality of your work. Use a consistent style to cite the sources of your ideas, words and phrases. The two main styles or methods are the Harvard System and the Vancouver method. Check to see if your institution has a preferred style."

The understanding of ethical consideration is the authors, or the researchers have taken the written consents from the participants or samples of the study. The participants or samples are well informed that their answers and data for example laboratory findings of medical tests will be used for research purposes. In the case of using literature for references in Essays or in Dissertation the researcher has to use appropriate recognised referencing method for example Harvard referencing method to avoid case of plagiarism.


4
Chapter

(Methods: Search Strategy)

Data Collection

This chapter is about that how the researcher conducted the research to collect the information and data to use it for references and for critical analysis. For this dissertation the researcher had performed a wide range of search for the literature and data of focused research question "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" from different books, journals articles, medical websites and some pamphlets. Information from databases, books and journals for this Dissertation is taken from:

a) Oxford Brookes University library,

b) Electronic Library Oxford Brookes University,

c) Oxford Central Library Carfax Oxford,

d) Athens Databases,

Total 2532 studies were retrieved of which 29 met the inclusion criteria and then included in the dissertation; the 10 journal articles are included in the critical literature review and the remaining 19 articles are used for preliminary literature review and discussion. The researcher has used the last 10 years of journal articles for the references and the research about the hazards of passive smoking starts actually from 1970. Some of the studies and articles did not focus on the research question but they are included because data was needed to support the argument that smoking and passive smoking is injurious to health and causes diseases and mortality both for children and for smoker parents. Some of the journal articles focus on interventions and strategies to reduce the effects of passive smoking on children and some gives information for policies and legislation followed by governments under the recommendations of [3] consultation document (Table 1.1).

Table 1.1

Included studies	Excluded studies
· Studies focusing on research question "'how does the research on the effect of passive smoking on children health of smoker parent reflect the legislative and policy changes as identified in WHO (1999) consultation document?"	· Studies did not focus on research question "'how does the research on the effect of passive smoking on children health of smoker parent reflect the legislative and policy changes as identified in WHO (1999) consultation document?"
· Studies contain information about prevention methods from the effect of passive smoking on children and their implication and results of the interventions used.	· Studies on passive smoking but having old data for references.
· Studies contain information about WHO (1999) consultation document about the prevention methods from the effects of passive smoking.	· Studies those are not published and did not have clear methodology.
· Studies contain information about morbidity and mortality statistics due to smoking and passive smoking especially in UK and Europe.	· Studies not published in English language.
· Studies contain information about smoking cessation campaigns and prevention methods and strategies.	Total excluded studies = 19
Total included studies for CLR = 10	

The author used the academic journal articles for references which are more focused on research question "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" The computer and the internet is the most valuable tool to access electronic databases. Key words are used with concentration to get the relevant literature with the help of Boolean operators. Boolean operators provide help to find the relevant literature focusing research question. The index table of Oxford Brookes Electronic Library contains all the databases required for this Dissertation and only by clicking each database researcher entered the databases. The researcher had used the British Medical Journal website to select articles suitable for this Dissertation. The researcher of Dissertation has used key words sometimes in the form of small words and sometimes more words or small sentence because selected words for a small sentence give more focused search by Boolean operators. The table for Boolean operators/ databases, Electronic journals and Boolean search terms/ Key words used are provided:

Table 1.2:

Boolean operators/ Databases.	Health Journals for information.	Boolean search terms/ Key words/ Search Terms.
PubMed central.	British Medical Journal. Environmental Health Perspective.	Effects of passive smoking on children OR Passive smoking, Interventions AND Legislation and policies.
Oxford journal archives.	Health Education Journal, Journal of Aging and Health. International journal of epidemiology.	Legislative and policy changes regarding passive smoking OR Passive smoking and children, European research on passive smoking NOT Asian research.
Proquest medical library.	British Medical Journal. The Lancet Journal. Independent Journal.	Mortality statistics of passive smoking in UK AND Passive smoking, Children health and passive smoking AND Interventions and policies regarding passive smoking.
Biomed central.	The new England journal of medicine. American journal of infectious diseases. Journal of Adolescent Research.	Interventions to reduce affects of passive smoking in children AND Effects of passive smoking on children health, UK research on passive smoking AND European research on smoking hazards.
Cambridge journals on line.	International journal of public health.	Smoking and passive smoking AND Intervention and policies on smoking and passive smoking, Smoking ban and public health interventions.
Sage premier (NESLi 2).	Qualitative Health Research. Human and Experimental Toxicology.	Effect of passive smoking on children health, Legislations and policies on smoking hazards NOT Discussion on smoking.
Free medical journals.	British Medical Journal. American Journal of Public Health. Environmental Health Perspective.	Hazards of smoking AND Affect of passive smoking on children health.

In part of the literature review of this dissertation the statistics is used mainly from UK to give evidence that how many children are affected from passive smoking from their parent smoke, the statistics is published by the well-known journals for example BMJ journals, American journal of Public health and International journal of epidemiology [74]. The researcher had collected the literature for references for this Dissertation from various methods but mainly based on the data collected from other writers from journals and books which is more helpful and published and can be used for references.

Research nowadays shows that there are 181 different critiquing frame works available to critique a research article. In this Dissertation the researcher has used critique framework of Bray and Rees (1995) to answer all the questions of the article. Bray and Rees (1995) is a critical framework which offers 12 sets of different questions which are more focused on different parts of the articles. Bray and Rees (1995) critique framework is descriptive, but it contains all the help to analyse the research article completely and in detail. It also offers same sets of 12 questions to critique for both qualitative and quantitative studies selected for critiquing. So, Bray and Rees (1995) critique framework is more helpful than other frame works for example Critical Appraisal Framework (CASP) framework which offers different sets of questions for qualitative and quantitative studies. It takes more time of researcher to follow different sets of questions for different type of studies.

The researcher of this Dissertation has used different thematic analysis techniques to interrelate the articles. It is important to find similar themes in all 10 selected articles for critical literature review by Bray and Rees (1995) critique framework [75]. The researcher has used different thematic analysis techniques for example researcher presented tables of common themes across 10 articles selected for CLR. Researcher has presented mind maps figures which show the problems discuss in all papers and what are the solutions of those problems. The researcher has also presented the table of characteristics across all 10 articles. These were the thematic analysis techniques the researcher has used to present 10 articles selected for CLR.


5
Chapter

Results

This chapter presents the findings of the reviewed studies and critical appraisal of these studies by the use of appropriate tools.

Included and Excluded Studies:

Table 1.3: shows the results of the included and excluded studies, Boolean search/keywords used and the Boolean searchers/ databases used. Researcher has used the inclusion and exclusion criterion which is explained in Chapter 3 Methodology part of the Dissertation.

Boolean search/ Keywords/ Search Terms.	Boolean operators/ Databases.	Total of studies Retrieved.	Included studies.	Excluded studies.
Effects of passive smoking on children, Passive smoking, Interventions, Legislation and policies.	PubMed central.	957	12	945
Legislative and policy changes regarding passive smoking, Passive smoking and children, European research on passive smoking.	Oxford journal archives.	200	3	197
Mortality statistics of passive smoking in UK, Passive smoking, Children health and passive smoking, Interventions and policies regarding passive smoking.	Proquest medical library.	237	2	235
Interventions to reduce affects of passive smoking in children, Effects of passive smoking on children health, UK research on passive smoking.	Biomed central.	100	2	98
Smoking and passive smoking, Intervention and policies on smoking and passive smoking, Smoking ban and public health interventions.	Cambridge journals on line.	323	2	321
Effect of passive smoking on children health, Smoking cessation campaign, Legislations and policies.	British Medical Journal.	500	6	494
Hazards of smoking, Affect of passive smoking on children health.	Free medical journals.	115	1	114
Effect of passive smoking on children health, Legislations and policies.	Sage premier (NESLi 2).	100	1	99
		2532	29	2503

Table 1.3: shows the results of the included and excluded studies, Boolean search/keywords used and the Boolean searchers/databases used. Researcher has used the inclusion and exclusion criterion which is explained in Chapter 3 Methodology part of the Dissertation (Table 1.3).

Above table shows that researcher had found 2532 articles of different journals. The researcher had included 29 journal articles as they are focusing the research question and excluded the 2503 journal articles. The next table shows the study designs of the articles used for Critical Literature Review (CLR) (Table 2.1).

Table 2.1

Classification of studies included in this Dissertation	According to their study designs.
Number of studies included	
Qualitative studies	1
Quantitative studies	3
Cohort studies	4
Mixed qualitative and quantitative study	0
Cross sectional study	2
Total number of studies included	10

Above tables shows that 29 articles are included in this Dissertation out of which 10 journal articles are used for Critical Literature Review (CLR).

Critical Appraisals:

Those journal articles which were finally selected went through a critical appraisal. The studies were critically appraised by the use of appropriate tool (questionnaire and answer) using the critiquing framework of Bray and Rees (1995). The critiquing framework of Bray and Rees (1995) offers searcher the 12 different questions for each paper for critical analysis. The searcher has followed the critiquing framework of Bray and Rees (1995) to critically analyse each paper included for critical literature review.

Article No: 1. Showing analysis of cohort study by [76] Passive smoking as a risk factor of anaemia in young children aged 0-35 months in Jordan. BMC Paediatrics. 7(16): 1-10.

1. Focus:
The title of the article is to discuss "Passive smoking as a risk factor of anaemia in young children aged 0 – 35 months in Jordan". The title of the article is good indicator of the focus. The author of the article had provided accurate measurements and information of the selected samples to prove his statement according to the title of the article.
2. Background:
The author have clearly write down the background of the article that passive smoking unfavourably affects pregnancy, child birth and child health. Passive smoking associates with still – birth, premature birth as well as acute respiratory infection, asthma, disorder in red blood cell metabolism in children. This study examined the effects of passive smoking on anaemia in young children in Jordan.
The literature review is current and clearly justifies the research.
3. Terms of References:
In the abstract of the article the aim is clear that the study focus on the effects of passive smoking on anaemia in young children in Jordan. The study based on true facts and figures and the authors had collected the data with the help of Jordan government health department from the 2002 Jordan population and family health survey (JPFHS).
4. Study Design:
The title of the article "Passive smoking as a risk factor of anaemia in young children aged 0 – 35 months in Jordan" clearly shows that this study is a cohort study. The authors [76] used the structured interview from the mothers and haemoglobin testing of their children to find anaemia in young children aged 0 – 35 months in Jordan.
5. Tool of Data Collection:
In this study, researchers used a structured interview consisting of questionnaires included information of demography, socioeconomic status and health condition of the family. This study focus on to discuss anaemia in young children aged 0 – 35 months in Jordan due to passive smoking by giving details about the family habits. Some part of the article discuss the intervention strategies such as education, good nutritional status, safe source of drinking water and sanitation, regular medical check up to avoid anaemia in young children aged 0 – 35 months in Jordan.
This is highly appropriate use of tool.
6. Ethical Consideration:
In this study, the survey acquired inform consent from mothers of the children included in the study before asking any questions and before obtaining biologic and anthropometric measurements. The researchers has taken inform consent from mothers before taking their children haemoglobin tests.
The issues about confidentiality, privacy, and handling study data during and after study were addressed in this study.
7. Sample:
In this study, researchers chose the children included in the 2002 Jordan population and family health survey. Researchers have done retrospective cohort study with an age – stratified sample.
The analysis based on the information from 740 children aged 0 – 35 months that were tested for haemoglobin levels included in the 2002 Jordan population and family health survey. This study used multivariate logistic regression method to analyze the effect of passive smoking on anaemia in young children in Jordan, controlling for a number of risk factors and confounding factors for anaemia. The recruited subjects all lived in non – institutional settings, (their own home or family homes). The sample was selected in a two stage process, the final samples 740 children were selected after obtaining consent from their mothers about haemoglobin testing out of 5,630 children aged 0 -59 months of 5, 751 mothers from 5,590 households.

8. Data Presentation:
Researchers presented the results, most appropriately, in table form and also in text. The researchers have used tables for example odds ratio (OR) estimates of affects of passive smoking from only mother, only father, or both of parents on anaemia among children aged 0 – 35 months, Jordan 2002. This table shows percentage of smokers mothers, fathers, both of them or none of them of 740 children. The language of tables and texts about the result presentation is easy and clear to reader. The texts in results clearly show the percentages of children become anaemic in different households.
9. Main Findings:
Results indicated that independent of other risk factors and confounding factors, anaemia in young children was strongly positively associated with exposure to passive smoking from both parents (OR = 2.99, $p < 0.05$). Children age 24 – 35 months, children born to mothers age 35 – 49, and children lived in households with a hygienic toilet facility were less likely to suffer from anaemia.
10. Conclusions and Recommendations:
It is concluded from the study that, passive smoking from both parents was strongly positively associated with anaemia in young children in Jordan independent of other risk factors and confounding factors. The authors also discusses the risk factors for anaemia in children for example, child breast feeding status, micronutrient supplement, child nutritional status, maternal anaemia and nutritional status, household living condition, socioeconomic factors. The authors suggest that by controlling these risk factors childhood anaemia can be controlled.
The results support the importance of smoking prevention during and after pregnancy that prevent childhood anaemia and other morbidities in young children. The article also discusses the intervention strategies such as education, good nutritional status, safe source of drinking water and sanitation, regular medical check up to avoid anaemia in young children aged 0 – 35 months in Jordan. The authors also suggest that iron supplements can help mothers to control maternal anaemia.
11. Readability:
The article is easy to read although it was a detailed study. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and gives percentages of children having anaemia of smoker and non – smoker parents. The authors have provided the intervention strategies in easy language so every one can understand them.
12. Implication for Practice:
By avoiding smoking by parents during pregnancy and after birth of a child can help to reduce the affects of passive smoking for example anaemia in childhood.

Article No: 2. Showing analysis of cross sectional study by [77] Changes in child exposure to environmental tobacco smoke (CHETS) study after implementation of smoke-free legislation in Scotland: national cross sectional survey. British Medical Journal. 335(7619): 545-549.

1. Focus:
The title of the article is to discuss "Changes in child exposure to environmental tobacco smoke (CHETS) study after implementation of smoke-free legislation in Scotland". The title of the article is good indicator of the focus. In March 2006 Scotland introduced legislation that prohibited smoking in most enclosed public places, the authors have provided facts and figures to prove that after implementation of smoking ban on public places child exposure to environmental tobacco smoke is reduced over all.
2. Background:
The main source of exposure to second hand smoke among children is domestic, usually in the home or the car. The levels of exposure correlate with the prevalence of parental smoking. In the home protection can arise only from voluntary family based restrictions by adults. Children can also be exposed in other contexts, including public places. On 26 March 2006 Scotland introduced legislation that prohibited smoking in most enclosed public places. Studies using objective measures have found that smoke-free legislation is an effective strategy for reducing second hand smoke exposure in adults and children.
The literature review is current and clearly justifies the research.
3. Terms of References:
In the abstract of the article the aim and objective is clear that the study is to detect any change in exposure to second hand smoke among primary school children after implementation of smoke free legislation in Scotland in March 2006.

4. Study design:
The title of the article is to discuss "Changes in child exposure to environmental tobacco smoke (CHETS) study after implementation of smoke-free legislation in Scotland" and the study design was comparison of nationally representative, cross sectional, class based surveys carried out in the same schools before and after legislation. The authors [77] used the questionnaires that included question of their own smoking status and that of their friends and parent figures and recent exposure to tobacco smoke in public and private locations. The final data sets contained questionnaire and saliva samples of children in 2006 comparing questionnaire and saliva samples of children in 2007 after implementing the smoking ban in public places in Scotland.
5. Tool of Data Collection:
In this study, the authors have collected the data through completion of self report questionnaires by pupils and collection of their saliva samples in 2006 and after the smoking ban in 2007. The questionnaires included the questions of their own smoking status and that of their friends and parent figures and recent exposure to tobacco smoke in public and private locations.
This is highly appropriate use of tool.
6. Ethical Consideration:
In this study, 116 (68%) Scottish schools out of 170 schools agreed to take part in the study before the legislation in 2006. 111 (65%) Scottish schools from 116 schools in 2006 take part in the study in 2007 after the implementation of smoking ban in Scotland. School children were informed and gave consent to fill out the questionnaire and to provide their saliva samples.
The issues about confidentiality, privacy, and handling study data during and after study were addressed in this study.
7. Sample:
In this study, the researchers chose the school children up to 11 years old from 111 schools of Scotland. Researchers used a cross – sectional survey carried out in the same schools before and after legislation.
About 2559 primary school children mean aged 11 years old surveyed in January 2006 before smoke - free legislation and 2424 school children in January 2007 after the implementation of smoking ban in Scotland. The samples are chosen after taking informed consent from school and children of 111 schools of 170 approached schools.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example ETS in private and public locations before and after smoke - free legislation in Scotland. In this table the researchers classify the places home, car, café or restaurant, bus or train and indoor leisure facility where the children affected by passive smoking in 2006 and in 2007. This table clearly shows the improvement, after implementation of smoking ban in public places in 2006 in Scotland that less people smoke in the specified places. The authors have used salivary cotinine concentration provided in value ng/ml to present the results of this study. The language of tables and texts about the result presentation is easy and clear to reader. The results in the texts clearly shows the fall in salivary cotinine level of children after the implementation of smoking ban in public places in 2006 in Scotland.
9. Main Findings:
The results of the study shows that the salivary cotinine concentration in non – smoking children of 111 Scottish schools fell from 0.36 ng/ml to 0.22 ng/ml after the introduction of smoke – free legislation in Scotland – a 39% reduction.
The extent of the fall in cotinine concentration varied according to the number of parent figures in the home who smoked but was statistically significant only among pupils living in households in which neither parent figure smoked (51%) fall, from 0.14 (0.13 to 0.16) ng/ml to 0.07 (0.06 to 0.08) ng/ml) and among pupils living in households in which only the father figure smoked (44%) fall, from 0.57 (0.47 to 0.70) ng/ml to 0.32 (0.25 to 0.42) ng/ml). Little change occurred in reported exposure to second-hand smoke in pupils' own homes or in cars, but a small decrease in exposure in other people's homes was reported. Pupils reported lower exposure in cafes and restaurants and in public transport after legislation.
10. Conclusions and Recommendations:
The conclusion of the study is the Scottish smoke-free legislation has reduced exposure to second-hand smoke among children in Scotland, particularly among groups with lower exposure in the home. There is no evidence of increased second-hand smoke exposure in young people associated with displacement of parental smoking into the home. The Scottish smoke-free legislation has thus had a positive short term impact on young people's health, but further efforts are needed to promote both smoke-free homes and smoking cessation.
The authors of this article has made some intervention recommendations to improve the health of children and for healthy environment for example,
1. To raise awareness of the health risks of passive smoking.
2. To promote smoking cessation campaigns.

3. To implement smoke – free policies in the homes and cars.
4. Education and communication: that even low level of second-hand smoke exposure can pose substantial health risk to children of all ages.
11. Readability:
The article is easy to read and to understand. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and tables which are understandable. The authors have provided the intervention strategies in easy language so every one can understand them.
12. Implication for Practice:
By raising awareness and educating the people about the harmful affects of ETS we can change the behaviour of people towards stop smoking. Government implementation of smoking ban on public places also supports the idea of stop smoking.

Article No: 3. Showing analysis of qualitative study by [78] Smoking in the home after the smoke-free legislation in Scotland: qualitative study. British Medical Journal. 335 (7619): 553-558.

1.Focus:
The title of the article is to discuss the issue of Smoking in the home after the smoke-free legislation in Scotland. The title of the article is good indicator of the focus. The authors of this article have highlight the people behaviour towards stop smoking and idea of smoke – free home after implementation of smoking ban in Scotland in 2006.
2. Background:
Exposure to second-hand smoke is an important cause of premature mortality and morbidity, and children are more vulnerable than adults to the effects on health. In 2003, over 80% of children aged 8-15 years in Scotland reported being exposed to second-hand smoke and around 40% lived in a home with at least one smoker. The 2005 health education population survey found that less than half (42%) of homes in Scotland had total smoking bans. Interventions to reduce children exposure to second-hand smoke in the home have involved media campaigns or brief counselling sessions with parents and have had little success. This is perhaps not surprising as some know little about why people do or do not restrict smoking in their homes. Even less is known about influences on smoking restrictions in cars.
The literature review is current and clearly justifies the research.
3. Terms of References:
In the abstract of the article the aim and objective is clear that the study is to explore the accounts of smokers and non-smokers (who live with smokers) of smoking in their homes and cars after the Scottish smoke-free legislation; to examine the reported impact of the legislation on smoking in the home and to consider the implications for future initiatives aimed at reducing children's exposure to second-hand smoke in the home.
4. Study Design:
The title of the article is to discuss the issue of "Smoking in the home after the smoke-free legislation in Scotland". The study design and setting of this paper is qualitative cross sectional study involving semi structured interviews conducted across Scotland shortly after the implementation of the legislation on 26 March 2006.
5. Tool of Data Collection:
In this study, the researchers conducted qualitative semi structured interviews from 50 smokers and non – smokers out of 106 people selected for interviews between June and September 2006 in respondents homes. The interview questions includes smokers identified times and places where they smoke, non – smokers identified when and where they were exposed to smoke. All respondents were asked to describe any smoking restrictions in their home or car, how they had developed and were maintained, and what might lead to breaches.
This is highly appropriate use of tool.
6. Ethical Consideration:
In this study, the authors only mentioned that respondents were purposively recruited from wave 10 (September – November 2005) of the health education population survey in Scotland. They only informed the participants by letter and belief that the consent has been taken.
The issues about confidentiality, privacy, and handling study data during and after study had not been addressed.
7. Sample:
In this study, researchers chose the 50 adults across Scotland. Researchers used a qualitative cross sectional study conducted across Scotland shortly after the implementation of the legislation on 26 March 2006.

The age group was between 18 – 75 years. The target size sample was 50. Qualitative semi structured interviews was carried out with 50 smokers and non – smokers who lived with smokers across Scotland.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example details of participants interviewed about smoking in their homes. In the table the researchers had divided the 50 participants into AB (professional, managerial and technical), C1 (skilled non – manual), C2 (skilled manual), D (partly skilled and unskilled). The participants are also divided into men and women in each class. The language of tables and texts about the result presentation is easy and clear to reader. The results in the texts clearly shows the fall in smoking habit in home and cars in Scotland after the implementation of smoking ban in Scotland in 2006.
9. Main Findings:
In this study, Respondents had varied understandings of the risks of second-hand smoke, with a few rejecting evidence of such risks. Children, however, were perceived as vulnerable. Most reported that they restricted smoking in their homes, with a range of restrictions across social classes and home smoking profiles. Spatial, relational, health, and aesthetic factors influenced the development of restrictions. Children and grandchildren were important considerations in the development and modification of restrictions. Other strategies were also used to militate against second-hand smoke, such as opening windows. The meanings of the home as somewhere private and social identity were important underlying factors.
Respondents reported greater restrictions on smoking in their cars. There were diverse views on the smoke-free legislation. Few thought it had influenced their smoking in the home, and none thought it had affected how they restricted smoking in their homes.
10. Conclusions and Recommendations:
These data suggest two normative discourses around smoking in the home. The first relates to acceptable social identity as a hospitable person who is not anti-smoker. The second relates to moral identity as a caring parent or grandparent.
Awareness of the risks of second-hand smoke, despite ambivalence about health messages and the fluidity of smoking restrictions, provides clear opportunities for public health initiatives to support people attain smoke-free homes.
Researchers suggested that initiatives to reduce second hand smoke in the home could include media campaigns and tailored advice and support for individuals from health and other professionals on how to develop more effective smoke – free strategies in the home and car.
11. Readability:
The article is easy to read and to understand although some parts were boring. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
Reducing second-hand smoke in the home and car requires a coordinated approach involving national and local action aimed at reducing smoking among adults and protecting children and non-smokers from second-hand smoke in smoking homes. Comprehensive smoke-free legislation can help achieve these aims. Researcher's findings indicate that smoking restrictions in the home are shaped by a range of socio cultural influences and other factors that create enablers, and barriers for future public health initiatives on this issue.

Article No: 4. Showing analysis of cohort study by [79] maternal smoking in pregnancy, foetal development and childhood asthma. American journal of public health. 94 (1): 136-140.

1.Focus:
The title of the article is to examine the relationships among maternal smoking in pregnancy, foetal development, and the risk of asthma in childhood. The title of the article is good indicator of the focus. The authors of this article have point out that low birth weight and preterm delivery increased the risk of asthma at the age of 7 years.
2. Background:
Smoking during pregnancy is a well – established determinant of foetal growth and risk of low birth weight. Maternal smoking in pregnancy may influence the development of the foetal respiratory system, as suggested by the findings of a relation between maternal smoking in pregnancy and lung function impairment in newborns. A recent study provided suggestive evidence that low birth – weight is a predictor of subsequent child – hood asthma. There is also some evidence that maternal smoking increases the risk of childhood asthma. However, little is known about the causal pathway between maternal smoking and the risk of childhood asthma.

3. Terms of References:
In the abstract of the article the aim and objective is clear that the study is to examine the relationships among maternal smoking in pregnancy, foetal development, and the risk of asthma in childhood. The authors have find out the relationship between maternal smoking in pregnancy, low birth weight and pre – term delivery which leads to asthma in children at the age of 7.
4. Study Design:
The authors have conducted a population – based cohort study, where all 58841 singleton births were followed for 7 years using nationwide registries. Childhood health data were gathered from 5 national administrative health registries for the years 1987 through 1994.
5. Tool of Data Collection:
In this study, researchers have obtained the data of 58841 births, their birth weight, gestational age and maternal smoking habits during pregnancy from Finish Medical Birth Registry, which was established in 1987 and is run by the national research and development centre for welfare and health. These information was collected from questionnaires answered by mothers who were pregnant smoking and non – smoking and collected by medical experts of national research and development centre for welfare and health.
6. Ethical Consideration:
In this study, the researchers only mentioned that study was approved by national research and development centre for welfare and health. The authors did not mention that they send any letter or call the participants and the participants were not informed.
The issues about confidentiality, privacy, and handling study data during and after study had not been addressed.
7. Sample:
In this study, researchers chose to study 58841 singleton births born in Finland in 1987 to 1994. There childhood health data were gathered from 5 national administrative health registries.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form, figure and also in text. The researchers have used figures for example model of the effect of maternal smoking in pregnancy on childhood risk of asthma. In this diagram maternal smoking in pregnancy is directly related to foetal growth and preterm delivery leads to asthma in childhood. The results were also provided in texts in percentages which show risks of low birth weight and preterm delivery due to maternal smoking in pregnancy. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
In this study, maternal smoking increased the risk of asthma (adjusted odds ratio = 1.35, 95% confidence interval = 1.13, 1.62 for high exposure). Low birth weight and pre – term delivery increased the risk of asthma at the age of 7, whereas being small for gestational age did not.
10. Conclusions and Recommendations:
In this study, the risks of low birth weight, SGA, and pre – term delivery were strongly related to maternal smoking in pregnancy, with a distinct exposure. Low birth weight and pre – term delivery increased the risk of asthma by 83% and 64%, respectively.
Maternal smoking in pregnancy increases the risk of asthma during the first 7 year of life, and only a small fraction of the effect seems to be mediated through foetal growth.
Researchers suggested that in future education of pregnant mothers, smoking cessation campaigns, advertisement on smoking ban and about harmful affects of smoking during pregnancy on foetus health will help to control the low birth weight infants and pre – term deliveries.
11. Readability:
The article is easy to read and to understand and the figure and tables about data and results were easy. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts, figures and tables which are understandable.
12. Implication for Practice:
It is derived from the study, that by controlling maternal smoking during pregnancy the number of small for gestational age (SGA) infants, low birth weight infants, pre – term deliveries can be reduced.

Article no: 5. Showing analysis of cross sectional study by [80] Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: Cross sectional survey. 327(7409): 257-260.

1.Focus:
The title of the article is to study effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home. The title of the article is good indicator of the focus. The authors of this article have compare the effect of intervention strategies to reduce exposure to infants to environmental tobacco smoke in the home with the urinary cotinine to creatinine ratios in infants at home.
2. Background:
Exposure of infants to environmental tobacco smoke is associated with an increased risk of sudden infant death syndrome, asthma, and other respiratory conditions. In England, children's exposure to tobacco smoke has decreased since the late 1980s, but there is little evidence of reduced consumption of tobacco by parents in the presence of their children. Smoking cessation among household members is the only effective way of reducing passive smoking among young people. Changing smoking practices in the home and in the presence of young people has been suggested as a means of reducing exposure to tobacco smoke when cessation is not possible. To date the evidence on the use and effectiveness of such measures is limited and confusing.
Data on the effectiveness of harm reduction measures in households with infants are also limited. Three studies examined harm reduction interventions in households with infants. Little effect was found of the strategies as measured by the infants' urinary cotinine to creatinine ratios, although none of the studies reported the effect size for not smoking in the home.
3. Terms of References:
In the abstract of the study the aim is clear; to examine parents reported knowledge and use of harm reduction strategies to protect their infants from exposure to tobacco smoke in the home, and the relation between reported use of strategies and urinary cotinine to creatinine ratios in the infants.
4. Study Design:
This study is a cross sectional survey, in which the authors have used parents reported knowledge, use of harm reduction strategies and urinary cotinine to creatinine ratios in their infants as main outcome measures.
5. Tool of Data Collection:
Researchers used a cross sectional survey design to collect data from a sample of parents of infants living in households with one or more smokers. The parents of infants born to mothers living within the boundaries of two community NHS trusts in the West Midlands over a nine month period were asked to participate in the study by their family health visitors. Parents (98% of whom were mothers) were interviewed at home by a trained nurse using a structured schedule. Participants whose first language was not English were offered an interpreter. Interviews took place when infants were between 4 and 24 weeks old. Data were collected on knowledge and use of harm reduction strategies, tobacco consumption of household members, personal details, and characteristics of the home environment. A sample of the infant's urine was collected, by a pad inserted into the nappy, for estimation of the urinary cotinine to creatinine ratio.
This is highly appropriate use of tool.
6. Ethical Consideration:
In this study, researchers only mentioned that some of the parents out of 314 households with young infants they declined to take part in the study when all the participants were asked personally by health visitors.
The issues about confidentiality, privacy, and handling study data during and after study had not been addressed.
7. Sample:
In this study, researchers chose the target population from Coventry and Birmingham. Researchers used a cross sectional survey design to collect data of parents of infants born to mothers living within the boundaries of two community NHS trusts in the West Midlands.
There were 314 smoking households with infants involved in this study. Parents who declined to take part in the study were most likely to be younger and from a black or ethnic minority group than those who participated.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example use of measures by parents from 314 households to reduce exposure of their infants to environmental tobacco smoke at home and the authors have classified the participants used the measures and those who did not used the measures. Measures used by participants were do not smoke or allow smoking at home, stopped smoking, smoke fewer cigarettes, do not smoke or allow smoking in same room as child, do not smoke or allow smoking in living room, strict measure or less strict measure. The results and data were presented in tables and texts in easy way so reader can understand them easily.

9. Main Findings:
86% of parents (264/307) believed that environmental tobacco smoke is harmful, 90% (281/314) believed that infants can be protected from it in the home, and 10% (32/314) were either unaware of measures or reported using none. 65% of parents (205/314) reported using two or more measures, but only 18% (58/314) reported not allowing smoking in the home. No difference was found in mean log e transformed urinary cotinine to creatinine ratio in infants from households that used no measures compared with households that used less strict measures. Mean log cotinine to creatinine ratios were significantly different in households banning smoking in the home compared with those using less strict or no measures. Banning smoking in the home was independently associated with a significant reduction in urinary cotinine to creatinine ratio by a factor of 2.6 (1.6 to 4.2) after adjustment for average household cigarette consumption, tenure, and overcrowding.
10. Conclusions and Recommendations:
In this study, less than a fifth of parents in smoking households ban smoking in the home. Banning smoking was associated with a small but significant reduction in urinary cotinine to creatinine ratio in infants, whereas less strict measures compared with no measures had no effect on the infant's exposure to environmental tobacco smoke.
Banning smoking in the home has a small but significant effect on urinary cotinine levels in infants, independent of household cigarette consumption, housing tenure, and overcrowding.
Researchers suggested that by implementing intervention strategies for example smoking ban not only on public places and cars but also at home will help to reduce exposure of infants to environmental tobacco smoke in the home.
11. Readability:
The article is easy to read and to understand and the tables and texts about data and results were easy for reader. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
This is understood from this study that prevention strategies against ETS can be more affective at home if people take them seriously and apply them strictly at home. Other wise strategies were not practical and they did not protect anyone.

Article No: 6. Showing analysis of cohort study by [81] Parental smoking and infant respiratory infection: How important is not smoking in the same room with the baby? American journal of public health. 93(3): 482-487.

1.Focus:
The title of the article is to discuss "parental smoking and infant respiratory infection: how important is not smoking in the same room with the baby?" The title of the article is good indicator of the focus. The authors of this article have done this study to investigate the aetiology of sudden infant death syndrome (SIDS) and other causes of infant mortality and morbidity in Tasmania, Australia.
2. Background:
Postnatal exposure of infants to cigarette smoke is causally associated with an increased risk of lower respiratory tract infection such as bronchitis and pneumonia, increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function. The exposure also has been linked with new cases of childhood asthma and with additional episodes and increased severity of symptoms in asthmatic children. Medical authorities therefore recommend that parents provide a smoke – free environment for infants and children.
3. Terms of References:
In the abstract of the study the aim is clear; the researchers sought to quantify the effect of good smoking hygiene on infant risk of respiratory tract infection in the first 12 months of life. The authors have discussed the relationship between parent smoking habit and infant respiratory infection, ear infection and other illnesses.
4. Study Design:
This study is a cohort study, in which the authors have studied a cohort of 4486 infants in Tasmania, Australia from birth to 12 months of age for hospitalization with respiratory infection.
5. Tool of Data Collection:
In this study, researchers have used interviews to collect data on three occasions, during the 1st, 5th, and 11th weeks postpartum. During the first interview the researcher collected information on parental smoking. The second interview was conducted at a home visit at a median postnatal age of 33 days. The third interview was conducted by telephone at a median postnatal age of 80 days.

This is highly appropriate use of tool.
6. Ethical Consideration:
In this study, researchers have confirmed that families consented to the data being used to investigate infant morbidity and mortality during the first year of life. Researchers obtained ethical approval from the ethics committee of the University of Tasmania, Hobart.
The issues about confidentiality, privacy, and handling study data during and after study were addressed properly.
7. Sample:
In this study, researchers chose the cohort of 4486 infants in Tasmania, Australia was followed from birth to 12 months of age for hospitalization with respiratory infection. Case ascertainment was 98.2%. All the infant mothers were interviewed on three occasions with in 93 days to collect information about postnatal maternal smoking habit. All the participant's lives in their private homes were interviewed by trained health professionals.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example risk and relative risk of hospitalization with respiratory infection in the first 12 months of life: Tasmanian infant health survey (TIHS). The researchers have recorded the factors and risk and they have recorded the risk and relative risk in percentages. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
The results of the study were, relative to the infants of mothers who smoked postpartum but never in the same room with their infants, risk of hospitalization was 56% (95% confidence interval [CI] = 13%, 119%) higher if the mother smoked in the same room with the infant, 73% (95% CI = 18%, 157%) higher if the mother smoked when holding the infant, and 95% (95% CI = 28%, 298%) higher if the mother smoked while feeding the infant.
10. Conclusions and Recommendations:
The conclusion drawn from the study was parents who smoke should not smoke with their infants present in the same room.
The authors of this article have derived some intervention recommendations for future for example educating mothers about harmful affects of smoking during pregnancy and after pregnancy on their infant health by providing them reading literature. The authors have also discussed strictness at home for smoking especially when an infant is in at home.
11. Readability:
The article is easy to read and to understand and the tables and texts about data and results were easy for reader. The authors have used the plain and easy language for reader to understand the article. The authors have presented the true facts and figures recorded by trained health professionals. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
It is derived from the study that passive smoking in infant is responsible for respiratory tract infections, middle ear infection, and other childhood illnesses. So maternal education about the harmful affects of smoking in pregnancy and passive smoking of infant in early part of life is necessary.

Article No: 7. Showing analysis of cohort study by [82] maternal smoking and risk of hypertrophic infantile pyloric stenosis: 10 year population based cohort study. British Medical Journal. 325(7371): 1011-1012.

1.Focus:
The title of the article is to discuss "maternal smoking and risk of hypertrophic infantile pyloric stenosis: 10 year population based cohort study" The title of the article is good indicator of the focus. The authors of this article have done this study to investigate that maternal smoking is also responsible for hypertrophic infantile pyloric stenosis and sudden infant death syndrome in a population based Danish cohort.
2. Background:
Infantile hypertrophic pyloric stenosis affects 0.5 to 3.0 per 1000 live births. The aetiology is unclear, but family history and sex distribution seem important and might indicate a genetic role. However, a recently reported fall in the incidence of infantile hypertrophic pyloric stenosis suggests that environmental factors are also important. During the last decade a similar reduction in the proportion of pregnant women who smoke was reported in Denmark, raising the possibility that maternal smoking is a risk factor for infantile hypertrophic pyloric stenosis. This hypothesis is supported by the reported ecological association between infantile hypertrophic pyloric stenosis and sudden infant death syndrome.

3. Terms of References:
The aim of the study is clear; the authors were trying to find the relationship between maternal smoking and risk of hypertrophic infantile pyloric stenosis.
4. Study Design:
The study was 10 year population based cohort study. There were participants smoking mother and non smoking mother involve in this study.
5. Tool of Data Collection:
In this study the researchers have used interview with questionnaire to collect the information of participants. Researchers conducted the study between 1 January 1991 and 31 December 2000 in the Danish county of North Jutland and included data on all women who delivered a live infant after 28 weeks' gestation. The county birth registry contains information on all births since 1 January 1991. The main data comprise maternal age; self reported smoking status at the first visit to the midwife, birth order, gestational age, length and weight of neonates at birth, civil status, and civil registry numbers for both mother and child. Researcher identified all cases of infantile hypertrophic pyloric stenosis from the county hospital discharge registry, which contains data on all discharges from the hospitals since 1977, the civil registry number, dates of admission and discharge, surgical procedures performed, and up to 20 diagnoses classified according to the international classification of diseases.
6. Ethical Consideration:
In the study, the researchers did not mention that participants were consented for the study but during interviews participants were told that this data will be used for study and considered informed.
The issues about confidentiality, privacy, and handling study data during and after study were not addressed.
7. Sample:
In this study, the participants of the study were pregnant women who smoke in Denmark. Researchers conducted the study in the Danish county of North Jutland and included data on all women who delivered a live infant after 28 weeks' gestation. There were 57996 births during the study, and 16725 mothers smoked.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example risk of hypertrophic infantile pyloric stenosis according to maternal smoking status and other variables. In this table the authors have divided the table into mother smoking status, sex of child, number of pregnancies, maternal age and the table present the result in percentages. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
The results of the study were, there were 57 996 births during the study, and 16 725 (28.8%) mothers smoked. We identified 78 cases of infantile hypertrophic pyloric stenosis, yielding a cumulative incidence of 1.3%. Thirty five cases (0.2%) occurred among maternal smokers compared with 43 (0.1%) among maternal non smokers, giving a relative risk of 2.0. The adjusted odds ratio was also 2.0 (95% confidence interval 1.3 to 3.1, table). The correlation between the proportion of smokers and annual incidence of infantile hypertrophic pyloric stenosis per birth year was 0.65 (Spearman's =0.65, P=0.04). The highest incidence was 0.22% in 1991 (33% were smokers), the lowest 0.05% in 1997 (28% smokers).
10. Conclusions and Recommendations:
It was concluded from the study, that 78 cases of infantile hypertrophic pyloric stenosis found during study which was related to the maternal smoking in Denmark during this study.
Researchers suggested that educational literature provided to pregnant mother will be helpful to control the infant diseases related to maternal smoking.
11. Readability:
The article is easy to read and to understand and the article is very short in length. The tables and texts about data and results were easy for reader. The authors have used the plain and easy language for reader to understand the article. The authors have presented the true facts and figures recorded by trained health professionals. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
It is derived from the study that maternal smoking during pregnancy is responsible for so many illnesses for children. Smoking ban, education, advertisement will help to control harmful affects of passive smoking.

Article No: 8. Showing analysis of quantitative study by [83] effect of passive smoking in pregnancy on neonatal nucleated red blood cells. Paediatrics. 106(3): 1-3.

1.Focus:
The title of the article is to discuss "effect of passive smoking in pregnancy on neonatal nucleated red blood cells". The title of the article is good indicator of the focus. The authors of this article have done this study to investigate that infants born to mothers exposed to passive smoking have increased circulating absolute nucleated RBC counts compared with those of controls.
2. Background:
Cigarette smoking during pregnancy is a known risk factor for adverse outcome in the human foetus and infant; there is a warning on cigarette packs by the US Surgeon General against the effects of smoking during pregnancy. Specifically, maternal smoking significantly increases the risks of spontaneous abortion and of preterm or low birth weight delivery. It is capable of causing foetal growth restriction in the third trimester, and is associated with increased neonatal morbidity, such as neonatal asphyxia, intraventricular haemorrhage, reduced lung function, and increased incidence of perinatal death as well as sudden infant death syndrome. Maternal cigarette smoking during pregnancy also increases the risk of neurodevelopmental impairment during later childhood. Although the mechanism of foetal injury seems to involve many factors, it is likely that chronic foetal hypoxia affects the process. We recently demonstrated that a marker of foetal hypoxia, the absolute number of circulating nucleated red blood cells (RBCs), measured at birth, is increased in infants of smoking mothers.
3. Terms of References:
The aim of the study is clear; the aim of this study was to demonstrate whether maternal passive exposure to tobacco smoke during the last trimester of pregnancy is also capable of elevating the absolute number of circulating nucleated RBCs measured at birth.
4. Study Design:
As per title of the article the study is about neonatal nucleated red blood cells, this is a quantitative study.
This is an exploratory study to find out the affects of passive smoking on infants.
5. Tool of Data Collection:
In this research, the authors have studied the laboratory findings of the 2 groups (exposed vs. control) at the Lis maternity hospital Tel Aviv Sourasky Medical Centre. The lab tests for example RBC count were done and analyze by certified trained medical staff.
6. Ethical Consideration:
In the study, the researchers did not mention that participants were consented for the study and participants don't know that their lab findings were used for research.
The issues about confidentiality, privacy, and handling study data during and after study were not addressed.
7. Sample:
In this study, the researchers chose the samples from Tel Aviv Sourasky Medical Centre. Researchers compared absolute nucleated RBC counts taken during the first 12 hours of life in 2 groups of term, vaginally delivered infants, 1 group born to mothers who were routinely exposed to tobacco smoke during pregnancy (n = 55) either at home or at the workplace, and the other to mothers who were not routinely exposed to any tobacco smoke (n = 31). Researchers excluded infants of women with conditions known to elevate nucleated RBC counts.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used tables for example demographic and hematologic characteristics of the control vs. passive smokers. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
There were no differences between groups in birth weight, maternal age, gravidity, parity, maternal analgesia during labour, 1- and 5-minute Apgar scores. Gestational age was minimally higher in the control group (39.6 ± 1.1 vs. 39.2 ± .8 weeks). The median absolute nucleated RBC count in the passive smoking group was 357 × 10, 000000/L (range: 0–5091 × 10, 000000/L) versus 237 × 10, 000000/L (range: 0–1733 × 10, 000000/L) in non-smoking controls. Stepwise regression analysis that included Apgar scores, gestational age, and the passive smoking status (yes/no) as independent variables showed significant correlation of absolute nucleated RBC count only with the passive smoking status.
10. Conclusions and Recommendations:
The study concludes, At birth, term AGA infants born to mothers exposed to passive smoking have increased circulating absolute nucleated RBC counts compared with those of controls. We speculate that passive smoking in pregnancy should be avoided, because it may have subtle negative effects on foetal oxygenation.

Researchers suggested that in educating pregnant mothers about harmful affects of passive smoking and smokers what the damage they are doing on the health of pregnant mother and her foetus, this will help to control affects of passive smoking on foetus health.
11. Readability:
The article is easy to read and to understand. The tables and texts about data and results were easy for reader. The authors have used the plain and easy language for reader to understand the article. The authors have presented the true lab test results done by trained health professionals. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
Passive smoking of pregnant mother either at home or work place, in car damage the health of foetus and this is proven by the lab test results of exposed vs. control group, so its our responsibility to understand the facts and to avoid smoking at home or work place.

Article No: 9. Showing analysis of quantitative study by [84] maternal cigarette smoking during pregnancy and infant ponderal index at birth in the Swedish medical birth register. American journal of public health. 90(3): 420-423.

1.Focus:
The title of the article is to discuss "maternal cigarette smoking during pregnancy and infant ponderal index at birth in the Swedish medical birth register". The title of the article is good indicator of the focus. The authors of this article have done this study to investigate that infant born to mothers who smoke have altered body proportion and ponderal index.
2. Background:
Maternal smoking during pregnancy reduces mean birth weight and increases the risk of small-for-gestational-age infants. The ponderal index is a measure of birth weight in relation to crown–heel length and is used to classify "symmetric" growth retardation (with normal ponderal index) and "asymmetric" growth retardation (with low ponderal index). Asymmetric infants are thinner and have less birth weight per centimetre of length than symmetrical infants. Intrauterine growth–retarded infants with symmetric body proportions have higher rates of neonatal complications and higher rates of hospitalization in the first year of life than asymmetric infants, and they lag behind asymmetric infants in later physical growth.
Earlier studies of the effect of maternal smoking on infant ponderal index reported no statistically significant effect, but one investigation reported a reduction in ponderal index among the infants of smokers. Recognizing that ponderal index is strongly correlated with the degree of birth weight reduction, the present study is the first to control for both gestational age and birth weight.
3. Terms of References:
In the abstract of the study, the aim is clear that this study examined the effect of maternal smoking during pregnancy on infant body proportion.
4. Study Design:
As the study shows from its title that it is about infant ponderal index measurements and is quantitative study. This study was a descriptive study and takes long time to collect data from hospitals in Sweden.
The authors have used records of 1991 and 1992 from Swedish Medical Birth Register which contain data on more than 99% of all births in Sweden. These records were collected by trained health professionals by taking measurements of crown heel length and by taking birth weight.
5. Tool of Data Collection:
In this study, the authors have used records of 1991 and 1992 from Swedish Medical Birth Register which contain data on more than 99% of all births in Sweden. These records were collected by trained health professionals by taking measurements of crown heel length and by taking birth weight.
This is a highly appropriate use of tool.
6. Ethical Consideration:
The authors only mentioned that Sweden's National Board of Health and Welfare was informed about the studying the records of the research purpose and considered the participants informed.
The issues about confidentiality, privacy, and handling study data during and after study were not addressed.
7. Sample:
In this study, the ponderal index, defined as birth weight divided by crown– heel length cubed, was examined in 207607 infants from the Swedish Medical Birth Register for 1991 and 1992.

The original data set of all 239 251 singleton births during 1991 and 1992 was edited to exclude 8433 births with congenital malformations identified at birth; 9225 births with gestational ages of less than 24 weeks or with missing data on the key variables of birth weight, gestational age, crown–heel length, head circumference, sex, parity, or maternal age; 1238 births with either chronic or gestational hypertension; 94 births that failed to meet the National Centre for Health Statistics 1993 natality editing criteria; 788 births to women with either chronic or gestational diabetes; and 241 births because of incompatible birth weight, gestational age, crown–heel length, and head circumference values. These exclusions left a total of 208 355 births (87.1% of the initial data set). A total of 748 births before 32 weeks of gestation were excluded because there were not enough births in each 1-week gestational age group to calculate a valid birth weight score. Thus, the total population available for analysis was 207607 births.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used three different tables to compare the measurements of birth weight and crown heel length which clearly shows that the mean ponderal index actually decreased with smoking, reflecting the greater degree of growth retardation and prematurity associated with smoking in this data set. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
The results of the study is Infant ponderal index was used as the outcome variable in an ordinary least squares continuous regression, which included early pregnancy smoking status, gestational age, and birth weight among the predictors. Ponderal index increased by 0.030 (± 0.0014) among infants of moderate smokers and by 0.040 (± 0.0017) among infants of heavy smokers, showing a dose response.
10. Conclusions and Recommendations:
It is concluded from the study that, smoking differentially alters the trajectory of weight vs. length growth in the foetus.
Researchers suggest for future study about the ponderal index of foetus vs. maternal cigarette smoking latest data and research is needed with more measurements recorded in health records.
11. Readability:
The article is easy to read and to understand. The tables and texts about data and results were easy for reader and they explain all the data and results of the study. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and tables which are understandable.
12. Implication for Practice:
It is derived from the study that maternal smoking during pregnancy alters the infant body proportion.

Article No: 10. Showing analysis of quantitative study by Hovell M, Zakarian J and Pirkle J (2000) Effect of counselling mothers on their children's exposure to environmental tobacco smoke. British Medical Journal. 321 (7257): 337-342.

1.Focus:
The title of the article is to discuss "effect of counselling mothers on their children's exposure to environmental tobacco smoke". The title of the article is good indicator of the focus. The authors of this article have done this study to investigate the positive affects of intervention strategies for example education of smoking hazards on children exposure to ETS.
2. Background:
The World Health Organization has estimated that the health of almost half of the world's children is threatened by exposure to environmental tobacco smoke. In the United States the prevalence of US children living in homes with a smoker has been estimated to be 43%, with state specific estimates of exposure in the home ranging from 12% to 34%; nationally, about 15 million US children and adolescents are exposed. Similarly, about 43% of Australian children, 33% of Canadian children, and 41% of British children are exposed to environmental tobacco smoke. Exposure increases children's risk of respiratory tract infections, otitis media, asthma, and the sudden infant death syndrome. The costs to children's medical care from exposure were $703m$897m (£439m£561m) in the United States, $239.5m (£150m) in Canada, and $267m (£167m) in Great Britain (in 1997 prices). Two trials reported significant decreases in children's exposure to environmental tobacco smoke after counselling of parents. Greenberg et al decreased children's reported exposure, but infants' urine cotinine concentrations increased. Hovell and colleagues found similar reductions in reported exposure, which were sustained over two years, but did not measure cotinine concentrations. We extended our earlier research by measurement of cotinine concentrations and by testing counselling (in person and by telephone) with high risk, ethnically diverse, and low income families recruited from the US supplemental nutrition programme for women, infants, and children. We hypothesised that counselling would decrease children's exposure, decrease mothers' smoking, and increase rates of stopping smoking.

3. Terms of References:
In the abstract of the study, the aim is clear to test the efficacy of behavioural counselling for smoking mothers in reducing young children's exposure to environmental tobacco smoke.
4. Study Design:
This study is quantitative study. Researchers have done interviews of participants on three occasions to gather information about the progress of counselling mothers and positive affects.
5. Tool of Data Collection:
In this study, Interviews were conducted at baseline, at three months (after counselling), and at six and 12 months. The baseline interview was conducted in person in the mothers' homes, and follow up interviews were by telephone. The mean length of interviews was 57.2 (SD 15.8) minutes. Content included information on mothers' demographics and tobacco use and their child's exposure to environmental tobacco smoke. Mothers reported their smoking and their child's exposure on typical work days and nonwork days during the past seven days. They reported children's exposure to smoke from others living in and visiting the home, and from all smokers outside of the home. Researchers measured exposure as the number of cigarettes smoked while the child was in the same room and calculated children's weekly exposure to mother's cigarettes in the home and to all cigarettes. Acceptable test-retest reliability and validity in relation to cotinine and nicotine assays are reported elsewhere.
6. Ethical Consideration:
In this study, the researchers mentioned that all the 108 women involved in this research were informed and they signed consent forms to take part in the research.
The issues about confidentiality, privacy, and handling study data during and after study were not addressed.
7. Sample:
In this study, researchers have chosen the participant women from low income homes in San Diego County, California.
The participants were 108 ethnically diverse mothers who exposed their children (aged < 4 years) to tobacco smoke in the home.
8. Data Presentation:
Researchers presented the data and the results, most appropriately, in table form and also in text. The researchers have used different tables and chart for example flow of participants through trial shows the participants involved in the study divided into control and intervention group the women attended the counselling sessions and women withdrawn from study. The results and data were presented in tables and texts in easy way so reader can understand them easily.
9. Main Findings:
Mothers' reports of children's exposure to their smoke in the home declined in the counselled group from 27.30 cigarettes/week at baseline, to 4.47 at three months, to 3.66 at 12 months and in the controls from 24.56, to 12.08, to 8.38. The differences between the groups by time were significant (P = 0.002). Reported exposure to smoke from all sources showed similar declines, with significant differences between groups by time (P = 0.008). At 12 months, the reported exposure in the counselled group was 41.2% that of controls for mothers' smoke (95% confidence interval 34.2% to 48.3%) and was 45.7% (38.4% to 53.0%) that of controls for all sources of smoke. Children's mean urine cotinine concentrations decreased slightly in the counselled group from 10.93 ng/ml at baseline to 10.47 ng/ml at 12 months but increased in the controls from 9.43 ng/ml to 17.47 ng/ml (differences between groups by time P = 0.008). At 12 months the cotinine concentration in the counselled group was 55.6% (48.2% to 63.0%) that of controls.
10. Conclusions and Recommendations:
It was concluded from the study that counselling was effective in reducing children's exposure to environmental tobacco smoke. Similar counselling in medical and social services might protect millions of children from environmental tobacco smoke in their homes.
11. Readability:
The article is easy to read and to understand. The tables and texts about data and results were easy for reader and they explain all the data and results of the study. The authors have used the plain and easy language for reader to understand the article. The authors have explained the results in texts and tables which are understandable.

12. Implication for Practice:
It is derived from the study that counselling in medical and social services affects the people behaviour to quit/ reduce smoking in normal life. A randomised trial of counselling to reduce children's exposure to environmental tobacco smoke used measures of cotinine concentrations in addition to mothers' reports. Counselled mothers reported significantly greater decreases in exposure to environmental tobacco smoke compared with controls, and children's urine cotinine concentrations decreased slightly for counselled families while increasing substantially for controls. The findings confirm the efficacy of counselling to reduce children's exposure to environmental tobacco smoke.

Summary of Findings

As per the reviewed studies, different authors presented their results but one thing was common in all the results that second hand smoke or ETS is harmful for health passive smokers especially for the health of children. All the results presented in articles prove that passive smoking has harmful affects on the health of children, infants and foetus in utero. The authors have presented the intervention strategies to reduce the harmful affect of passive smoking in each article. In each article provided questionnaire and answers followed by Bray and Rees (1995) gives variety of different answers from each article. At the end of every article result by Bray and Rees (1995) Implication for practice is given to follow in future studies.


6
Chapter

(Analysis of the Study)

The analysis of the articles in this review was from suggestions by [85]:

".....thematic analysis is a useful approach for answering questions about the most important issues for particular groups of respondents or identifying typical responses."

The researcher is critically analysing the 10 articles selected for the Dissertation and using the thematic techniques to show the relation between the papers. The researcher is providing the table of theme/outcomes of the 10 papers and the mind maps according to the research question "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" The upcoming characteristics table of articles will provide the information about the research articles selected for this Dissertation.

Keys:

Not Rigorous	NR
Questionnaire	Qnr
Yes	+
No	_

Table 1: Characteristics of the 10 articles reviewed (Tables 2.2 & 3.1).

Table 2.2: (Articles 1 to 5).

Authors	Hong R, Betancourt J and Beltran M.	Akhtar P, Currie D and Haw S.	Phillips R, Amos A and Martin C.	Jaakkola J and Glissler M.	Blackburn C, Spencer N and Moy R.
Clear aim of research	+	+	+	+	+
Methodology	Cohort study	Cross sectional study	Qualitative study	Cohort study	Cross-sectional study
Recruitment Strategy	Randomly selected	Randomly selected	Randomly selected	Cluster sampling	Randomly selected
Tools for Collection of data	Interviews	Qnr	Interviews	Hospital records	Interviews
Collection point of data	Hospitals.	School and home.	Home.	Teaching Hospital.	Home.
Data analysis	NR	Rigorous	NR	Rigorous	Rigorous
Year of publication	2007	2007	2007	2004	2003
Subjects	Children come to hospital.	Children at Home and school.	Home.	Children at Hospital.	Home.
No of subjects	740	2559	50	58841	314
Consideration of ethics	+	+	-	-	-
Clear conclusion of the study	+	+	+	+	+

Table 3.1: (Articles 6 to 10).

Authors	Blizzard L, Ponsonby A and Dwyer T.	Sorensen H, Norgard B and Johnsen S.	Dollberg S, Fainaru O and Mimouni F.	Lindley A, Gray R and Herman A.	Hovell M, Zakarian J and Pirkle J.
Clear aim of research	+	+	+	+	+
Methodology	Cohort study	Quantitative study	Quantitative study	Quantitative study	Quantitative study
Recruitment Strategy	Randomly selected	Randomly selected	Randomly selected	Randomly selected	Randomly selected
Tools for Collection of data	Interviews	Qnr	Hospital records	Hospital records	Interviews

Collection point of data	Teaching hospital	School and home.	Teaching Hospital	Teaching Hospital	School and home.
Data analysis	Rigorous	Rigorous	Rigorous	NR	NR
Year of publication	2003	2002	2000	2000	2000
Subjects	Children at Hospital.	Children at Hospital.	Children at Hospital.	Children At Hospital.	Mothers at Home.
No of subjects	4486	57996	55 and 31	207607	108
Consideration of ethics	+	-	+	-	-

Tables of themes/outcomes of 10 articles

The following tables will show the interrelationship between the main ideas and common themes across the articles selected for this Dissertation. Table 3.2 shows themes/outcomes of the papers 1 to 6 and the relation of the ideas between them. Table 4.1 shows themes/outcomes of papers 6 to 10 and the relation of the ideas. All the papers selected for this Dissertation are interrelated and they have common ideas between them. Some of the papers provide intervention strategies and ideas for planning future strategies and almost all the papers discusses the hazards of smoking and passive smoking (Tables 3.2 & 4.1).

Table 3.2

Authors	Themes	Authors	Themes
Paper 1 by Hong R, Betancourt J and Beltran M (2007).	The main theme of this paper is that the study focuses on the effects of passive smoking on anaemia in young children in Jordan. The study based on true facts and figures and the authors had collected the data with the help of Jordan government health department from the 2002 Jordan population and family health survey (JPFHS).	**Paper 4 by Jaakkola J and Gissler M (2004).**	The main theme of the article is that the study is to examine the relationships among maternal smoking in pregnancy, foetal development, and the risk of asthma in childhood. The authors have find out the relationship between maternal smoking in pregnancy, low birth weight and pre – term delivery which leads to asthma in children at the age of 7.
Paper 2 by Akhtar P, Currie D and Haw S (2007).	The main theme of this paper is that the study is to detect any change in exposure to second hand smoke among primary school children after implementation of smoke free legislation in Scotland in March 2006.	**Paper 5 by Blackburn C, Spencer N and Moy R (2003).**	The main theme of this paper is that to examine parents reported knowledge and use of harm reduction strategies to protect their infants from exposure to tobacco smoke in the home, and the relation between reported use of strategies and urinary cotinine to creatinine ratios in the infants.
Paper 3 by Phillips R, Amos A and Martin C (2007).	The main theme of this paper is that the study is to explore the accounts of smokers and non-smokers (who live with smokers) of smoking in their homes and cars after the Scottish smoke-free legislation; to examine the reported impact of the legislation on smoking in the home and to consider the implications for future initiatives aimed at reducing children's exposure to second-hand smoke in the home.	**Paper 6 by Blizzard L, Ponsonby A and Dwyer T (2003).**	The main theme of this paper is that the researchers sought to quantify the effect of good smoking hygiene on infant risk of respiratory tract infection in the first 12 months of life. The authors have discussed the relationship between parent smoking habit and infant respiratory infection, ear infection and other illnesses.

Table 4.1

Authors	Themes	Authors	Themes
Paper 7 by Sorensen H, Norgard B and Johnsen S (2002).	The main theme of this article is that the authors were trying to find the relationship between maternal smoking and risk of hypertrophic infantile pyloric stenosis.	**Paper 9 by Lindley A, Gray R and Herman A (2000).**	The main theme of this paper is to present the finding after research that maternal cigarette smoking during pregnancy differentially alters the trajectory of weight versus length growth in the foetus.
Paper 8 by Dollberg S, Fainaru O and Mimouni F (2000).	The main theme of this paper is to present the finding after research that passive smoking in pregnancy has increased circulating absolute nucleated RBC counts compared with those of controls. The passive smoking in pregnancy should be avoided because it may have subtle negative effects on foetal oxygenation.	**Paper 10 by Hovell M, Zakarian J and Pirkle J (2000).**	The main theme of this paper is to test the efficacy of behavioural counselling for smoking mothers in reducing young children's exposure to environmental tobacco smoke.

Table of 10 common themes between 10 papers: (Tables 4.1.1 & 5.1)

Table 4.1.1

Paper/Theme	Theme 1: Parental smoking child present.	Theme 2: Childhood illness due to ETS.	Theme 3: Parental smoking during pregnancy.	Theme 4: Effects on foetus health.	Theme 5: Smoking effects economical status of family.
Paper 1	+	+	+		
Paper 2	+	+	+		+
Paper 3					+
Paper 4	+	+	+	+	+
Paper 5					+
Paper 6	+	+	+	+	+
Paper 7	+	+	+	+	+
Paper 8	+	+	+	+	+
Paper 9	+	+	+	+	+
Paper 10					

Note: Table of 10 common themes between 10 papers:

Table 5.1

Paper/Theme	Theme 6: Intervention recommendation suggested by authors.	Theme 7: Positive effects of intervention strategies.	Theme 8: Government implement smoking ban.	Theme 9: Counselling services provided against smoking to parents.	Theme 10: Positive effects of counselling provided to sample.
Paper 1	+	+		+	
Paper 2	+	+	+	+	+
Paper 3	+	+	+	+	+
Paper 4	+	+		+	+
Paper 5	+	+		+	+
Paper 6	+	+		+	+
Paper 7	+	+		+	+
Paper 8	+	+			
Paper 9	+	+			
Paper 10	+	+		+	+

(+) = Yes.

Above table shows that papers 1,2,4,6,7,8,9 had discussed that parent of children suffered passive smoking hazards and parents were chain smokers. Articles 3,5,10 shows that parents follow the counselling advice and do not continue smoking or smoke less at designated smoking areas. Articles 1,2,4,6,7,8,9 show that children suffered from respiratory illnesses because of passive smoking at home, public places or streets. All the articles show that authors have suggested intervention recommendations against smoking and by following those advices participants can improve the health of the whole family. Articles 1,2,4,6,7,8,9 shows that maternal smoking during pregnancy was present and it has an effect on foetus' health. All the articles accept 1 and 10 show that smoking affects the economical status of the family. Articles 2 and 3 show that there was smoking ban at that time. All the articles accept 8 and 9 show that there was counselling services provided to the family for the awareness of affects of passive smoking.

Table of common effects of passive smoking on children health across 10 papers and intervention recommendations discussed across 10 papers (Table 5.2).

Table 5.2

Papers/articles	Effects of passive smoking for exampleColds, Coughs, Sore throats and respiratory infections.	Effects for example Ear infections, Fluid in the ears, Chronic middle ear disease or "glue ear" and loss of smell.	Effects for example Anaemia, Low birth weight babies and Sudden infant's death syndrome (SIDS).	Intervention recommendations for example implementation of legislation and law against smoking and Education including public information, debate, advocacy and counselling.	Intervention recommendations for example Health warnings on cigarette packages, banning all advertising and promotion of tobacco products, increasing prices beyond inflation.
Paper 1	+		+	+	
Paper 2				+	+
Paper 3	+			+	+
Paper 4	+		+	+	
Paper 5				+	+
Paper 6	+	+		+	
Paper 7			+	+	
Paper 8			+	+	
Paper 9			+	+	
Paper 10				+	+

(+) = Yes.

Above table shows that in papers 1, 3, 4 and 6 the participants have affects of passive smoking for example Colds, Coughs, Sore throats and respiratory infections. Articles 1, 4, 7, 8 and 9 shows that participants were affected by anaemia, low birth weight babies and sudden infant's death syndrome (SIDS). All the 10 papers show that the intervention recommendations for example implementation of legislation and law against smoking and Education including public information, debate, and advocacy and counselling were discussed in the papers suggested by the authors. Papers 2, 3, 5 and 10 discuss the intervention recommendation for example Health warnings on cigarette packages, banning all advertising and promotion of tobacco products, increasing prices beyond inflation.

Mind maps for the common themes and factors identified across 10 papers contributing to affect the health of children in contact with passive smoking (Figures 2-4):

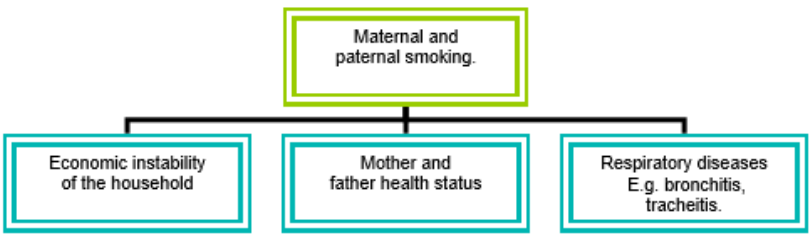


Figure 2: Mind map 1

Figure 3: Mind map 2

Figure 4: Mind map 3

1. SIDS: Sudden Infant Death Syndrome
2. IUGR: Intra-uterine growth retardation

There are various factors contributing to affect the health of children in contact with passive smoking for example ETS in home, parks and public places leads to respiratory illnesses in children. If a mother or father smoke at home or mother herself smoke during her pregnancy then it seriously affect her foetus health. Government responsibility is to make it possible that all the laws, rules and regulations against smoking will be implemented and followed by the citizens of the community to make a healthier smoke – free community.

Above mind maps derived from the study show various points which relate to children health, people behaviour towards smoking, government implementing legislation for example smoking ban and then people accepting the change for smoke – free environment. These are the summary of important intervention recommendations derived from 10 papers selected for critical literature review. All the intervention recommendations match with the [3] consultation document and as by the authors of the 10 articles by following these intervention recommendations we can make a healthy smoke – free environment.

Mind map for the intervention recommendations derived from 10 papers (Figure 5)

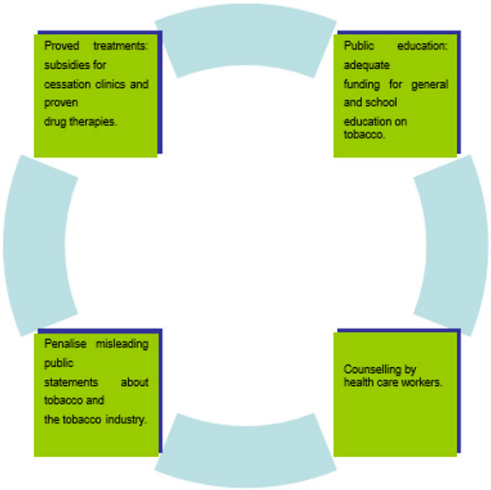


Figure 5: Mind map for the intervention recommendations derived from 10 papers:

These are the summary of important intervention recommendations derived from 10 papers selected for critical literature review. All the intervention recommendations match with the WHO (1999) consultation document and as by the authors of the 10 articles by following these intervention recommendations we can make a healthy smoke – free environment.

Mind Map for an Ideal Smoke – Free Community using Intervention Strategies Addressed by WHO (1999) Consultation Document (Figure 6)

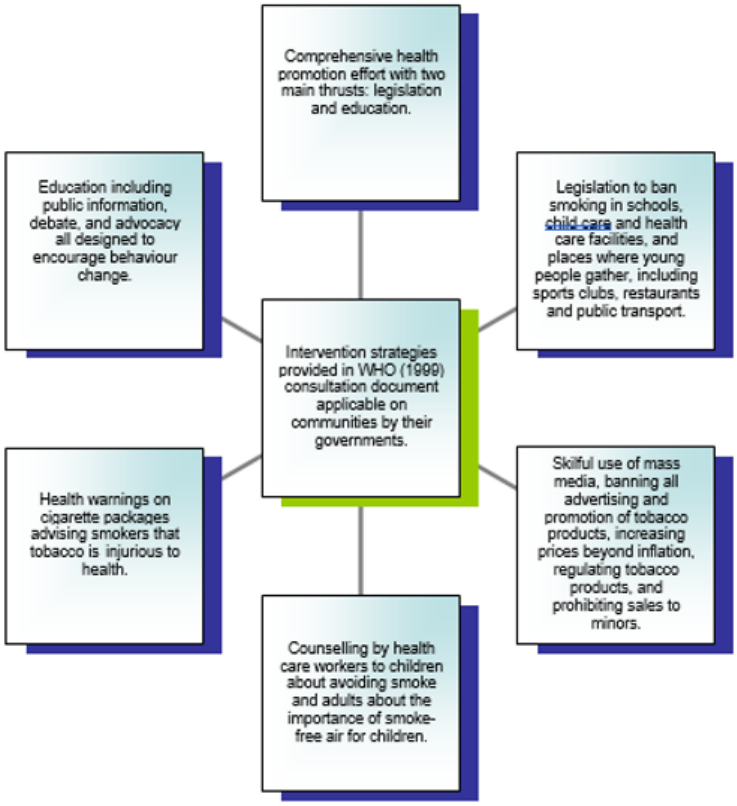


Figure 6: Mind map for an ideal smoke – free community using intervention strategies addressed by WHO (1999) consultation document

Above diagrams shows the summary of intervention strategies recommended by [3] consultation documents to make a smoke – free healthy environment. Intervention recommendations derived from the 10 articles also shows the similarity with [3] consultation document. So, one can say that governments are implementing [3] consultation document strategies to create a health smoke – free environment (Tables 6 & 7). Above table shows the comparison of the intervention recommendations of [3] consultation document and the intervention recommendations discussed in the 10 articles selected for CLR. The authors also discuss the strict implementation of legislation and laws including smoking ban in public places, cars and at work place to avoid more harm [3]. has given the strategies and interventions to follow now it's the responsibility of people to follow them and governments to strictly implement them and make it possible that if some one break the law will be prosecuted.

Table 6: Table of WHO (1999) intervention recommendations comparing Intervention recommendations derived from 10 papers selected for CLR:

WHO (1999) Intervention Recommendations.	Paper 1.	Paper 2.	Paper 3.	Paper 4.	Paper 5.
1. Comprehensive health promotion effort with two main thrusts: legislation and education to eliminate children exposure to ETS.	The author of the paper discusses the implementation of strict legislation against smoking.	Author of this article discusses the success of reduction in smoking behaviour and reduction in affect of passive smoking after implementation of smoking ban in Scotland.			The author of this article discusses the importance of strict legislation and education against smoking, and how we can prevent the children from ETS exposure.

2. Legislation encompasses all regulatory approaches to controlling where and when people can smoke. Legislation to ban smoking in places children frequent is an important first step. These include schools, child care and health care facilities, and places where young people gather, including sports clubs, restaurants (especially fast food outlets), shopping centres and public transport. Smoking ban in work place is also important.	Author of this article discusses implementation of strict legislations to stop smoking at home especially when a mother is pregnant.				
3. Education includes public information, debate, and advocacy, all designed to encourage behaviour change. Educational strategies, including education about the risks to children from ETS exposure and steps to eliminate exposure.	Author of this article emphasise on mothers education during pregnancy about the harmful effects of passive smoking on foetus health.	The author of this article discusses the need for education about smoking hazards among people especially pregnant women.		The author of this article discusses the education of smoker parents to know the hazards of smoking.	The author discusses the mother education and counselling about the effects of passive smoking during pregnancy and how to avoid them.
4. Health warnings on cigarette packages advising smokers that their tobacco smoke is injurious to children and others should be included in the range of required messages.					
5. Health care workers are an important component of any education strategy as they can counsel children about avoiding smoke and adults about the importance of smoke-free air for children. Counselling services provided to every one including pregnant mothers educating them the hazards of smoking.	Counselling of smoker parents will help to reduce smoking at home to prevent children from effects of passive smoking.		The author of this article discusses the importance of counselling of smoker parents to reduce smoking at home to prevent children from effects of passive smoking.	The author of this article discusses that counselling of smoker parents will help to reduce smoking at home to prevent children from effects of passive smoking.	
6. Intervention strategies such as WHO and other international and intergovernmental bodies recommend measures such as, banning all advertising and promotion of tobacco products, increasing prices beyond inflation, regulating tobacco products, and prohibiting sales to minors as steps towards reducing overall consumption.			The author of this article discusses the implementation of strict policies to ban all advertising and promotion of tobacco products.		

Table 7: Table of WHO (1999) intervention recommendations comparing Intervention recommendations derived from 10 papers selected for CLR:

WHO (1999) Intervention Recommendations.	**Paper 6.**	**Paper 7.**	**Paper 8.**	**Paper 9.**	**Paper 10.**
1. Comprehensive health promotion effort with two main thrusts: legislation and education to eliminate children exposure to ETS.				The author of the paper discusses the implementation of strict legislation against smoking.	

2. Legislation encompasses all regulatory approaches to controlling where and when people can smoke. Legislation to ban smoking in places children frequent is an important first step. These include schools, child care and health care facilities, and places where young people gather, including sports clubs, restaurants (especially fast food outlets), shopping centres and public transport. Smoking ban in work place is also important.		Author of this article discusses implementation of strict legislations to stop smoking at home especially when a mother is pregnant.			Author of this article discusses implementation of strict legislations to stop smoking at home especially when a mother is pregnant and stayed at home.
3. Education includes public information, debate, and advocacy, all designed to encourage behaviour change. Educational strategies, including education about the risks to children from ETS exposure and steps to eliminate exposure.	The author of this article discusses the need for education about smoking hazards among people especially pregnant women.		Author of this article emphasise on mothers education during pregnancy about the harmful effects of passive smoking on foetus health.	The author of this article discusses the education of smoker parents to know the hazards of smoking especially smoking during pregnancy.	The author of this article discusses the need for education about smoking hazards among people especially pregnant women.
4. Health warnings on cigarette packages advising smokers that their tobacco smoke is injurious to children and others should be included in the range of required messages.					
5. Health care workers are an important component of any education strategy as they can counsel children about avoiding smoke and adults about the importance of smoke-free air for children. Counselling services provided to every one including pregnant mothers educating them the hazards of smoking.	The author of this article discusses the importance of counselling of smoker parents to reduce smoking at home to prevent children from effects of passive smoking.	The author of this article discusses that counselling of smoker parents will help to reduce smoking at home to prevent children from effects of passive smoking.	Counselling of smoker parents will help to reduce smoking at home to prevent children from effects of passive smoking especially pregnant mothers.		The author of this article discusses that counselling of smoker parents will help to reduce smoking at home to prevent children from effects of passive smoking; the author also discusses in paper the achievements after counselling the mothers.
6. Intervention strategies such as WHO and other international and intergovernmental bodies recommend measures such as, banning all advertising and promotion of tobacco products, increasing prices beyond inflation, regulating tobacco products, and prohibiting sales to minors as steps towards reducing overall consumption.					


7
Chapter

Discussion

Introduction

The researcher in this Dissertation has conducted a literature review on various journal articles from UK, Europe and USA about the research topic "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" Smoking in general is very harmful for health of the smoker and the people around the smoker because it affects the same way to non-smoker if someone exposed to ETS for long time. Smoking leads to heart diseases, respiratory diseases, lung cancer, middle ear infections and other medical diseases. In 1999 WHO called a general meeting about Intervention strategies against smoking and passive smoking. The researcher has talk about [3] strategies and interventions in the preliminary literature review chapter of this Dissertation. In this Discussion chapter the researcher will discuss the implications of intervention strategies against smoking on communities and the change in behaviour towards smoking of people [86]. The researcher will discuss the achievements obtained by authors and researchers after implementing the interventions suggested by WHO in 1999.

Tobacco smoking prevalence remains low in many African countries. However, [87] growing economies and the increased presence of multinational tobacco companies in the African Region have the potential to contribute to increasing tobacco use rates in the future. This paper used data from the 2014 Global Progress Report on implementation of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) as well as the 2015 WHO report on the global tobacco epidemic to describe the status of tobacco control and prevention efforts in countries in the WHO African Region relative to the provisions of the WHO FCTC and MPOWER package. Among the 23 countries in the African Region analysed there are large variations in the overall WHO FCTC implementation rates ranging from 9% in Sierra Leone to 78% in Kenya. The analysis of MPOWER implementation status indicates that opportunities exist for the African countries to enhance compliance with WHO recommended best practices for monitoring tobacco use protecting people from tobacco smoke offering help to quit tobacco use warning about the dangers of [87] tobacco enforcing bans on tobacco advertising and promotion and raising taxes on tobacco products.

This research statistics clearly indicate [88] the effects of passive smoking on the health of children and the researchers used the Swedish data between 1958 to 2002, at that time [3] recommendations was just introduced and the data is old so the results on WHO intervention recommendations against smoking did not show that much effectiveness. If any health care plan is introduced in the community for better change it takes time to show the results. The researcher has included latest published articles in this chapter and still a lot of research is going on to find out the affect of legislative and policy changes on the research on effect of passive smoking on children. According to [79] maternal smoking in pregnancy increases the risk of asthma during the first 7 years of life, and only a small fraction of the effect seems to be mediated through foetal growth. The researcher of this Dissertation has taken this article reference which was used for CLR in this Dissertation, over the entire Dissertation focused on the research question "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" Some part of the Dissertation totally focuses on [3] intervention recommendations and some part of the Dissertation explain the implementation of those strategies and then the results monitored after the implementation [89].

WHO MPOWER aims to help countries prioritize tobacco control measures in line with the [90] WHO Framework Convention on Tobacco Control? A checklist was developed, and scores assigned based on the MPOWER indicators (maximum score 37). MPOWER data for the Region in the 2015 and 2017 tobacco control reports were extracted and scored. Data from similar analyses for 2011 and 2013 were also included. Countries were ranked by scores for each indicator for 2015 and 2017 and for overall scores for 2011 to 2017. The Islamic Republic of Iran Egypt and Pakistan had the highest scores in 2015 (33, 29 and 27 respectively) and the Islamic Republic of Iran Pakistan and Yemen had the highest scores in 2017 (34, 31 and 27 respectively) [91]. The indicators with the highest and lowest combined score for all countries were for advertising bans and compliance with smoke-free policies 67 and 18 respectively in 2015 and 73 and 15 respectively in 2017. Most countries (15/22) had higher total scores [90] in 2017 than 2015 Afghanistan Bahrain and Syrian Arab Republic had the greatest increases.

To assess the implementation of five key tobacco control policies in China protection from [92] Second-Hand Smoke (SHS) offering help to quit health warnings regarding tobacco use the enforcement of bans on tobacco advertising promotion and sponsorship; and increasing tobacco taxes and prices. Overall, 63.3% and 72.7% of adults noticed people smoking indoor workplaces and public places, respectively. Approximately 60% of smokers were not asked about their smoking habits and approximately 67% were not advised to quit on their visit to a health worker. Sixty percent of adults noticed health warning messages on cigarette packaging and in the media in the last 30 days, 63.6%

stated that they would not consider quitting [93]. Twenty percent of respondents noticed tobacco advertising, promotion, and/or sponsorship activities in the 30 days prior to the survey. Among them, 76.3% noticed the direct advertising and 50% noticed from TV programs. The average score for the implementation of the 5 policies of MPOWER in China is 37.3 points, indicating tobacco control policies [92] in China is poor and there is a large gap from the FCTC requirements.

The results of this study clearly indicates that [94] strict policy change and strict implementation of WHO intervention recommendations against smoking are needed across throughout the whole globe, this is a new published research article and the research shows although there is decrease in smoking habits and only 7% of parents in Sweden were smoking indoor and the children get respiratory illnesses. UK government has put smoking ban in public places and this smoking ban took place after 57 years of research of Sir Richard Doll, who identified the link between smoking and cancer and published his research [95]. Human behaviour did not accept change immediately it takes time to accept things and to realize the harmful effects but change always happens nothing is permanent, but the change is permanent.

Policies, Programmes and their Implications:

According to the World Health Organization Tobacco and the Convention Act on the Rights of the Child [3]:

"….Because of the enormous potential harm to children from tobacco use and exposure, States have a duty to take all necessary legislative and regulatory measures to protect children from tobacco and ensure that the interest of children take precedence over those of the tobacco industry."

[3] consultation document introduce strategies and health care plans for governments to follow and to implement these strategies to get good results in community and change in people behaviour against smoking? The researcher of this Dissertation has provided evidence and data in the PLR chapter and in CLR about the effects of passive smoking on children health and the [3] consultation document has introduced strategies and health care plans for governments to implement and include in their health care ministries and health departments [96]. The addition of these new studies strengthens the rationale for a comprehensive framework to protect children's health and prevent their recruitment to smoking in adolescence [97]. [3] consultation document comes on the screen for the governments to implement strategies for example banning all cigarette advertisement on T.V and print media and advertising the harmful affects of smoking on media. It will take time and more [98] research is needed to find the benefits of smoking ban in England, although in newspapers this is already published that 600,000 people will quit smoking this year in UK due to implementation of smoking ban.

Smoking restrictions have been shown to be associated [99] with reduced smoking but there are a number of gaps in the literature surrounding the relationship between smoke-free policies and cessation including the extent to which this association may be modified by sociodemographic characteristics [100]. Coverage by workplace smoke-free laws and self-reported workplace smoke-free policies was associated with higher odds of cessation among respondents ages 40-54. Family income modified the association between smoke-free workplace laws and cessation for women ages 25-39 (the change in the probability of cessation associated with coverage was most pronounced among lower-income women). Heterogeneous associations between policies and cessation [99] suggest that smoke-free policies may have important implications for health equity. Workplace tobacco control interventions [101] reduce smoking and second-hand smoke exposure among U.S. workers. Data on smoke-free workplace policy coverage and cessation programs by industry and occupation are limited. This study assessed smoke-free workplace policies and employer-offered cessation programs among U.S. workers by industry and occupation.

Overall, 80.3% of indoor workers reported having smoke-free policies at their workplace and 27.2% had cessation programs [102]. Employer-offered cessation programs were significantly higher among workers reporting 100% smoke-free workplace policies (30.9%) than those with partial/no policies (23.3%) and were significantly higher among indoor workers (29.2%) than outdoor workers (15.0%) [101]. Among U.S. workers 100% smoke-free policy and cessation program coverage varies by industry and occupation. Lower income women are at higher risk for preconception and prenatal smoking are [103] less likely to spontaneously quit smoking during pregnancy and have higher prenatal relapse rates than women in higher income groups. Policies prohibiting tobacco smoking in public places are intended to reduce exposure to second-hand smoke additionally since these policies promote a smoke-free norm there have been associations between smoke-free policies and reduced smoking prevalence [104]. Given the public health burden of smoking particularly among women who become pregnant our objective was to assess the impact of smoke-free policies on the odds of preconception smoking among low-income women.

Comprehensive smoke-free policies prohibiting smoking in public places and workplaces may also be associated with reductions in smoking among low-income women. This type of policy or environmental change strategy [103] may promote a tobacco-free norm and improve preconception health among a population at risk for smoking.

Government Policies and its Affects

[3] consultation document has given various strategies and legislations for governments and for people to follow. If these policies and legislations will remain in papers only and like most of the countries in this world they know [3] consultation document but this is not in their priority list. Countries for example Canada, Australia and UK has introduced smoking ban because their government believe that healthy smoke – free environment is needed for the next generation. So, weak government policies lead to rise in the smoking habits of local people and it will also harmful for pregnant women and children. The next upcoming diagram shows how some countries of the world handling this health problem so there is no improvement in people behaviour to quit smoking or to smoke in designated smoke places (Figure 7).

Figure 7

It is the responsibility of the government to give awareness to local population about the harmful affects of smoking and passive smoking. By using electronic media for example T.V, radio, and internet the advertisement campaign against smoking is very helpful to convey the message to local population. The 2002 general household survey in UK between the year 1974 to 2002 regarding success of smoking cessation campaigns and success of policies of UK Government shows remarkable reduction in cigarette smoking [105]. This is directly related to effects of passive smoking on general population including children. The result is as far as people fewer smoke cigarettes, less harmful effects on passive smokers including children.

Following are the Reference Graphs from (National Statistics, 2007) (Figure 8)

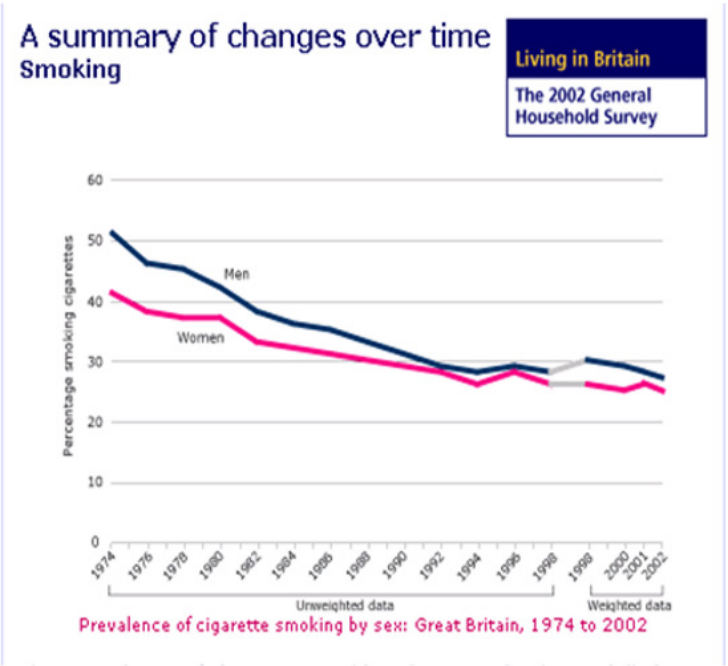


Figure 8: Following are the reference graphs from (National Statistics, 2007).

Decrease in percentage of cigarette smoking by sex and age: Great Britain, 1980 to 2002 (National Statistics, 2007) (Figure 9):

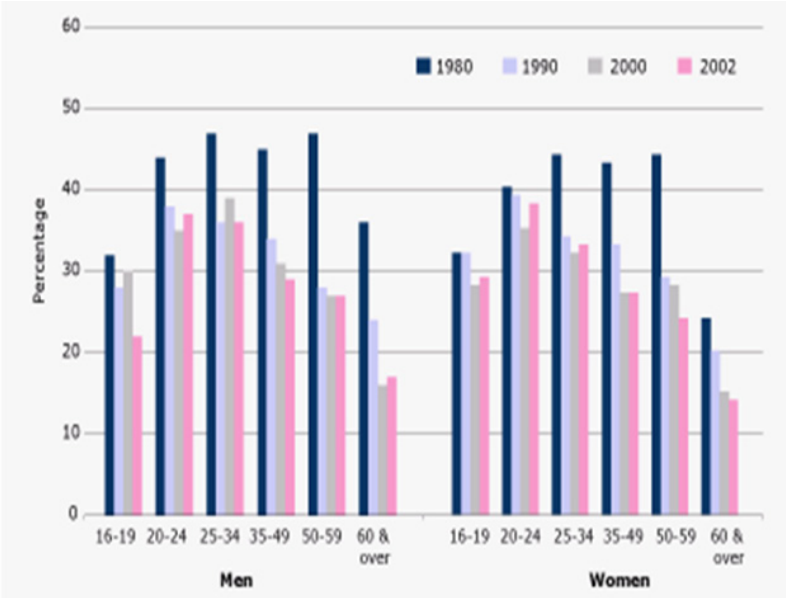


Figure 9: Decrease in percentage of cigarette smoking by sex and age: Great Britain, 1980 to 2002 (National Statistics, 2007).

Intervention Strategies for Reducing Children's Exposure to Environmental Tobacco Smoke: Here is the table of ten interventions and their importance and significance to control smoking and to reduce affects of passive smoking (Jamrozik, 2004) (Table 8).

Table 8: Here is the table of ten interventions and their importance and significance to control smoking and to reduce affects of passive smoking (Jamrozik, 2004):

Issue and initiative (Jamrozik, 2004)	Importance (Jamrozik, 2004)
1. Public places and workplaces: comprehensive smoke-free policies (Jamrozik, 2004).	Reduces passive smoking, increases cessation, lowers consumption, removes role models from children's view.
2. Price: regular increases in the real (adjusted for inflation) price of tobacco products.	Reduces consumption and prevalence; especially effective among adolescents.
3. Public education: adequate funding for general and school education on tobacco.	Sophisticated, intensive mass media campaigns increase quitting.
4. Promotion: end to exemptions for sporting events and of "product placement".	Important in re-establishing non-smoking as the norm.
5. Proved treatments: subsidies for cessation clinics and proven drug therapies (Jamrozik, 2004).	Counselling, nicotine replacement therapy, and bupropion at least double the success of attempts to quit; cost should not act as barrier to proved cessation aids.
6. Prosecution: increase and publicise efforts to enforce legislation.	Publicity has important "knock-on" effect—for example, in reducing sales to minors.
7. Point of sale: tobacco products made an under the counter item.	Closes further channel of promotion of tobacco products.
8. Products and their production: remove the exemption for nicotine in tobacco from medicines, food, or other consumer protection legislation.	Comprehensive and unified approach needed for regulation of nicotine (and other components in tobacco and tobacco smoke).
9. Packaging: move to generic tobacco smoke).	Reduces appeal of tobacco products as symbols of lifestyle, sophistication, and wealth.
10. Probity in public pronouncements: proscribe and penalise misleading public statements about tobacco and the tobacco industry (Jamrozik, 2004).	Reduces misleading information and confusion about tobacco.

From this discussion, it emerges that it is the responsibility of an individual and not only Government to control the habit of smoking to prevent other people from hazards of smoking and passive smoking specially children. All the above-mentioned intervention recommendations against smoking will reduce the harmful effects of passive smoking on children. Passive smoking, as per discussion is harmful as same as smoking if someone is exposed to ETS for long time [3]. consultation document against smoking gives strategies and legislations to follow and these legislations can be implemented by the governments of different countries.


8
Chapter

Conclusion

To conclude, the researcher believes that the information provided in this Dissertation teaches us that how much harmful is the smoking for health and how much the passive smoking or ETS is harmful and dangerous for children health. As the more results from research studies are coming from different parts of the world more researchers are now recommending strict implementation of intervention and legislation to reduce effect of passive smoking [106]. The researcher has also presented the [3] consultation document which provides the intervention recommendations for governments. The researcher has provided data and statistics to prove his objective and aim from different journal articles about the research question "How does the research on the effect of passive smoking on children's health of smoker parents reflect the legislative and policy changes as identified in [3] consultation document?" The researcher has discussed the intervention strategies against smoking and passive smoking by [3] consultation document and intervention recommendations from the research articles written by various authors, which provides more deep research and strict implementation of those intervention recommendations against smoking.

Young children are especially sensitive to the effects of second-hand smoke, due to the fact that their bodies are still growing and developing, and they breathe faster than adults and therefore may inhale more smoke. Research articles in the Chapter Preliminary Literature Review have shown that children, who grow up in a smokey household, where one or both parents smoke, have twice the amount of respiratory and lung disorders, and in some cases they even have to be hospitalized [107]. These children are usually absent from school more often than children who grow up in a smoke-free home and some studies have even suggested that children who are exposed to passive smoking are more likely to have behavioral problems and that they may not develop mentally as quickly as other children. Children from smoking homes scored lower in maths, reading, logic and reasoning tests and showed a more difficult and conflictive attitude towards their teachers and peers. These are all the harmful and dangerous effect of passive smoking on the health of children. In the Discussion chapter of this Dissertation [108] states intervention recommendations needed against smoking and passive smoking [108]. mentioned education, counselling, ban of tobacco products advertisement and increase in prices of tobacco products.

All these intervention recommendations match with recommendations of [3] consultation documents but explaining some new approaches towards stop smoking. These are the new approaches or improvements in intervention recommendations needed now in 2007 or in upcoming future to control behaviour of people towards smoking. This new approach includes strict monitoring of the implementation of smoking ban in public places, workplaces and in cars. New approach also includes fines and penalties in case of breaking the laws and legislations of [3] consultation document. The researcher of this Dissertation has tried to link the main idea of this Dissertation that passive smoking is dangerous for children and the implementation of [63] consultation document for example in Canada, Australia, Scotland, and UK. Researcher have included studies giving evidence that for example in Scotland after implementation of smoking ban people behaviour changes towards quit smoking and it is now popular in Scotland not to smoke. According to research of [76] passive smoking from both parents was strongly positively associated with anemia in young children in Jordan independent of other risk factors and confounding factors.

The results of the study support the importance of smoking prevention during and after pregnancy that prevent childhood anemia and other morbidities in young children [3]. consultation document against smoking introduced to prevent people from the entire world from hazards of smoking and passive smoking. These strategies, legislations and policies benefit all human beings against the harmful effects of passive smoking. Government responsibility is to monitor strictly the implementation of legislation against smoking to make healthy and smoke – free environment. Affects of passive smoking on children includes poor development of children and less increase in height as compare to healthy children. At birth, term AGA infants born to mothers exposed to passive smoking have increased circulating absolute nucleated RBC counts which have negative affect on foetal oxygenation [83]. Above study clearly stated the harmful effect of passive smoking on the health of children. The researcher of this Dissertation has analysed and provide results by CLR of 10 different articles and found out that in most of the articles the authors has derived intervention recommendations for future study and they have given more practical approach towards solving the problem of smoking and passive smoking.

According to studies of [76], [78] and [77] the authors of the papers discusses the implementation of strict legislation against smoking and passive smoking and [77] discusses the success of reduction in smoking behaviour and reduction in affect of passive smoking after implementation of smoking ban in Scotland [109]. The authors of the articles discuss the mother education and counselling about the effects of passive smoking during pregnancy and how to avoid them. According to [81], [82] and [84] the authors of these article discusses the education of smoker parents to know the hazards of smoking and passive smoking especially smoking during pregnancy. These authors also tell the need

for counselling by health care workers of smoking addicted parents. Most of the authors of the articles discuss the implementation of fines and penalty against those people did not follow the [3] consultation document against smoking.

As public knowledge about the health consequences increases, so support for smoking restrictions in public places also rises. It is likely that the smoking ban in workplaces, public places and cars throughout the UK will lead to a reduction in smoking in the home because government have introduced designated smoking area outside home and workplace [110]. Since legislation is inappropriate to regulate smoking in the home, educational campaigns and counselling services offer the best means of encouraging adult smokers to modify behaviour in order to protect children from ETS [3]. consultation document provides strategies and legislations to follow for example smoking in designated area outside home will help to make a healthy smoke – free home. Finally, in summary, the three key points of this Dissertation are:

- The research on the effects of passive smoking on children's health continues and confirms the negative impact found in pre-1999 studies i.e. studies pre-WHO (1999) Consultation Document.
- Researcher's post-WHO (1999) is making recommendations for both educational and legislative changes in line with the Consultation Document.
- Where educational and legislative interventions have been implemented, smoking and the concomitant passive smoking have been reduced.

All the tables included in Results or CLR of the studies and in Analysis Chapter are excluded from word count.

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Appendices

Appendix 1: (Smokers in England)

There are just over 10 million smokers in England, 26% 0f the 16+ population. There are also ½ million pipe smokers and almost 1.4 million cigar smokers. A total of 10 million former regular smokers have given up the habit, while over 18 million have never smoked. While smoking among adults is falling, children smoking prevalence is close to that of 1982 [1]. The smoking of tobacco is currently the greatest cause of ill health and disability in this country. The health problems associated with smoking are now known to be even more extensive than those described in the original report of the royal college of physicians. In England there were estimated to be 91,823 smoking-related deaths in 1988, this represents 17% of all deaths that year [2]. These are some of the statistics of the number of people smoking in England and the number of deaths due to harmful effects of smoking in England.

Appendix 2: (Percentages of People Who Smoke Cigarette)

Cigarette smoking is still as important a cause of death as the great epidemic disease of the past. The evidence of its dangers is becoming increasingly clear, but, although the dangers are more widely recognised, measures to combat them remain pitifully adequate [3]. The percentage of men and women in the professional classes who smoke cigarettes has steadily fallen since 1958 but it has not changed in working men, and in working women has continued to rise [4]. The reduction of smoking by doctors have been striking, for only 20% now smoke cigarettes compared with over 50% twenty years ago. But nurses still smoke as much as other women. British tobacco manufacturers have continued to support research in many fields related to smoking [3]. There is no co-ordination or direction of research into smoking and health by government research councils or universities and little research has been done into ways of preventing smoking or reducing its harmful effects upon health. Although a lot of people are aware about these hazards but they are continue to harm themselves and others by the smoke of tobacco.

Appendix 3: (Environmental Tobacco Smoke)

Most research on the health effects of environmental tobacco smoke compares the health of non-smokers who live with smokers with those who live with other non smokers. The independent scientific committee on smoking and health reviewed a number of studies and

concluded that there was an increased risk of lung cancer (in the range of 10-30%) in non-smokers who had experienced life time exposure to environmental tobacco smoke [1].

Appendix 4: (Children and Passive Smoking)

Babies and children who cannot avoid smoke where they live and play are at particular risk. Babies of smokers are much more likely to be taken to hospital with chest trouble in their first year of life than non-smoker's children [5]. Children of smoker parents get more sickness in their lives as compare to children of non-smoker parents this is proven by research and data is also available to support this argument [6]. It is responsibility of the parents to keep their children away from harmful affects of passive smoking by to quit smoking or to stop smoking at home.

Appendix 5: (Mortality and Diseases Due to Passive Smoking)

Research in Scotland found that mortality from all causes was higher in passive smokers than in a control group of non-smokers. A review of studies associating passive smoking with heart disease risk concluded that there was raised risk, which was likely to lead to more deaths than from lung cancer associated with passive smoking [1]. Chronic cough and phlegm are more frequent among children of parents who smoke. Middle ear effusion (glue ear) in children is associated with passive smoking. The diseases of ear are more common in children of smoker parents as compare to non-smoker parents. Some times children exposed to passive smoking for a long time in their childhood develops asthma, allergy and some times lung cancer as well.

Appendix 6: (Wheezing and British Children)

Among nearly 10,000 British children followed from birth to the age of 10, there was a 14 percent increase in childhood wheezy bronchitis when mothers smoked over four cigarettes per day, and a 49 percent increase when mothers smoked over 14 cigarettes daily [7]. A study from the medical research council epidemiology unit in Cardiff found that maternal smoking was a major determinant of wheeze in the baby. Babies born to non smoking mothers who have been exposed to environmental tobacco smoke tend to weight less than babies born to unexposed mothers. Their average weight lies between that of the babies of non-smoking women reportedly unexposed to ETS and that of the babies of women who smoke. So, in every discussion the passive smoking is proving very harmful for the human beings specially for the children who are the most vulnerable because they don't know actually what is passive smoking and what are the dangerous affects the passive smoking which they will face in present and in future if they are exposed to tobacco smoke at home either by their parents smoking or either by other people smoke at public places or in parks.

Appendix 7: (Passive Smoking and Frequent Coughs)

So here we conclude that there is a direct relationship between passive smoking at home and increase in respiratory diseases in the children who stay more time at home. So, it is the responsibility of the parents that they have to understand the hazards of passive smoking and prevent their children from these hazards so their children can spend a healthy life in future.

Appendix 8: (Growth Retardation and Respiratory Illnesses)

We investigated whether respiratory symptoms in child hood were a necessary step between passive smoking and a child's impaired growth. Our analysis indicated that this is unlikely. Respiratory symptoms before the child entered school, how ever, may have played a part [8]. Passive smoking at home, therefore, seems to affect the growth of children. The maximum difference in mean height between groups was about 1cm. this was the value reported by Butler and Goldstein in 7- and 11- year- old children whose mothers smoked during pregnancy.