“At Face Value”: age progression software provides personalised demonstration of the effects of smoking on appearance

The Task Force for Tobacco-Free Women and Girls in New York State is utilizing a computer software program that provides personalised, science-based illustrations of how smoking can affect facial appearance. The task force developed this program at the urging of young people who entered a 1998 essay contest in which middle and high school students were asked to submit their ideas for strategies to help girls resist tobacco. Twenty-four per cent of the 2000 entrants from across the state advised that knowledge of the unattractive effects of tobacco use would deter girls from smoking. Their idea is supported by studies suggesting that self-image and perception of smoker stereotype can play a role in the decision to initiate smoking. Several of the students specifically recommended the use of computer imaging.

Task force members reviewed available literature on the association between smoking and premature facial wrinkling and provided parameters for customisation of the APRIL (age progression image launcher) program by its creators at C.O.R.E. Digital Productions, Inc in Toronto, Ontario, Canada. The original version of this program ages a picture of an 8-year-old child to approximately 80. The “At Face Value” adaptation is produced by C.O.R.E. Digital Productions, Inc in Toronto, Ontario, Canada.

The software program that provides personalized, interactive demonstration of how smoking affects the aging process is called APRIL. The “At Face Value” adaptation is provided as a stand-alone adaptation. The software is designed to be used with an LCD projector to show images to a class of students or a larger audience, but smaller groups are preferred. Most people want to see their own picture and several peers’ pictures and then move on. Approximately 10 feet by 10 feet (3 x 3 m) of floor space is needed, in an area where light from the backdrop, and two photography lights with compatible digital camera with tripod, a black backdrop, and two photography lights with stands and dimmers. Each software license is US$5000.

Participating middle, high school, and college students completed surveys before and after being photographed, to establish their prior experiences with tobacco and to detect changes in attitudes toward smoking. The demonstration appears to affect current smokers and never smokers in different ways. In early data, smokers have shown significant change between pre- and post-demonstration responses to the questions: “Do you think that you will smoke a cigarette anytime during the next year?” (86.7% answered “yes” pre; 73.3% post; p = 0.000) and “I think that becoming a smoker reflects poorly on me” (33.3% answered “yes” pre; 43.5% post; p = 0.028). Never smokers, on the other hand, have indicated a change in attitude on the questions: “Do you think that people risk harming themselves if they smoke one or less than one cigarette per day?” (79.2% answered “yes” pre; 92.1% post; p = 0.001) and “Does concern about your appearance affect the choices you make from day to day?” (68.4% answered “yes” pre; 78.5% post; p = 0.043).

This intervention tool often evokes strong reactions from young people. Shrieks, laughter, and exclamations of “I’m never going to look like that!” are frequent. Stunned silence is also common. Many participants’ comments in their “aged” versions resemble an older relative, supporting the software’s projection of future appearance.

P E Hysert, A L Mirand, G A Giovino, K M Cummings, C L Kuo
Roswell Park Cancer Institute, Buffalo, New York, USA

Correspondence to: Patricia Hysert, Roswell Park Cancer Institute, Elm and Carlton Streets, Buffalo, New York 14263-0001, USA. Pat.Hysert@RoswellPark.org

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Subsidised nicotine replacement therapy

Miller et al present results from a workplace based smoking cessation study where 39% of nicotine replacement therapy (NRT) volunteers were redeemed for NRT patches for half the recommended retail price (RRP SUS10, subsidised to US$85). However, the authors conclude that cost may not be a barrier to accessing NRT. The New Zealand experience shows that heavily subsidised NRT (92%)...
provided through an existing Quitline service considerably enhances access to NRT for smokers.

A nationwide programme to provide subsidised NRT was implemented from November 2000 through the New Zealand Quitline, a free telephone service for people wanting to quit smoking. Long term cessation rates have been found to improve when NRT is used as part of a behavioural intervention such as counselling.

When smokers call the New Zealand Quitline they are assessed for their eligibility to receive vouchers for subsidised NRT (patches or gum). Eligibility criteria include being a “heavier” smoker (10+ cigarettes/day), being motivated to quit; and 18+ years of age. The subsidisation reduces the cost of NRT to the smoker from a maximum of NZ$199 (US$110) for eight weeks’ product to NZ$10 (US$5.40) for the first four weeks’ supply, and NZ$10 (US$5.40) for the second four weeks’ supply. This fee covers dispensing costs and provides a means of encouraging some degree of motivation to quit among smokers. Redemted NRT vouchers are claimed by pharmacists through the Ministry of Health’s Health Payments, Agreements and Compliance Unit.

There was significant media interest as a result of the government coordinated NRT media release in November 2000 and the Quitline service was flooded with calls following the launch. Since this time calls have levelled to 9000 per month. Currently, around 41 000 smokers a year register with the Quitline to give up smoking and are issued with vouchers for NRT (from a national smoker population of 740 000). This is a large increase on the number of smokers accessing the Quitline only service before the introduction of the NRT voucher scheme.

Redemption analysis shows that 73% of vouchers redeemed through the Quitline are redeemed, considerably higher than that experienced by Miller et al.1 (39%). Additional New Zealand research found that delivery of the voucher programme through the Quitline is cost-effective to NRT.1 A survey of Quitline callers who were positively assessed for NRT found that the process of receiving vouchers and redeeming these for nicotine patches and gum ran smoothly for respondents. Of the respondents who had the NRT, they were quick to start using it (80% started using their first four week supply within three days of receiving it) and they appeared to have a good understanding about how to use the patches and gum appropriately. Overall, there was little wastage of the nicotine patches and gum. Of those who redeemed their first voucher most (70%) reported using the whole four week course.

The enhancement of the New Zealand Quitline service through the provision of subsidised NRT has been viewed positively by smokers using the service and has greatly increased the number of people accessing the Quitline. Research results indicate that considerable subsidisation of NRT (92% in New Zealand’s case) as part of an enhanced Quitline counselling service indeed provides an incentive to smokers who want to quit.

M Grigg, H Glasgow

The Quit Group, Wellington, New Zealand

Correspondence to: Ms Michele Grigg, The Quit Group, PO Box 12 605, Wellington, New Zealand, michele.grigg@quit.org.nz

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Smoking among workers from small companies in the Paris area 10 years after the French tobacco law

Since the introduction of a tobacco law in 1991, smoking in enclosed public areas, including the workplace, has been forbidden in France. At the time this law was introduced we conducted several studies concerning smoking behaviour and the implementation of smoking regulations in the workplace. We believed that it was interesting to repeat this study 10 years later: (1) to assess the prevalence of active smokers in small companies in the Paris area; (2) to assess the prevalence of passive smokers in these companies; (3) to describe the impact of the French tobacco ban in these places of work.

In the French occupational health system, every worker undergoes a medical examination at least once a year regardless of whether they are exposed to occupational hazards. The occupational physician is required to spend one third of his time studying each worker’s work station. The data were collected among a population of 3 065 workers employed in all job categories in the Paris area. These workers belonged to companies employing between one and 3500 workers. The mean number of employees was nine, indicating that most of these companies were very small. We choose a double observation method: one in the physician’s office and the other in the workplace. During September 2001, 173 physicians interviewed 3 065 workers selected at random. A total of 3 044 questionnaires were suitable for analysis. The sample consisted of 1 654 men (53.4%) and 1 390 women (45.7%). The mean (SD) age was 36 (11) years (range 15–77 years).

In the whole sample, the prevalence of regular smokers was 36.9%, the prevalence of smokers exposed to environmental tobacco smoke at work was 14.6%, and the prevalence of workers who were disturbed by environmental tobacco smoke at work was 18.3%. Nearly all regular smokers smoked cigarettes (98%) and the mean (SD) consumption was: (8) cigarettes per day (range 1–60 cigarettes). The 296 non-smoking workers (9.7%) who were exposed to a tobacco smoke environment at work were considered to be passive smokers. Over two thirds (68.4%) of the workers were banned from smoking at their work station, with the highest rate among clerks (72.2%). About three quarters (76%) of workers worked in a public room. Thirty eight per cent of workers stated that their direct supervisor was a smoker.

During the same period, 160 occupational physicians completed 690 questionnaires in workplaces selected at random, 678 of which could be analysed. The physician noted whether smoking was banned in every workplace (company or agency). Several questionnaires were completed for a single workplace if it included several departments (offices, workshops, etc). Smoking was banned in 66% of workplaces (n = 461). Bans were most prevalent in shops, workshops, and warehouses. Smokers and non-smokers worked together in 66% of the workplaces visited (n = 447). Smoking was banned in the whole company for 51% of them, and more often in those employing more than 300 workers (76.2%).

The results allowed us to address our three objectives:

1. The prevalence of smokers (37%) in small companies in the Paris area has decreased with time. The prevalence was 44% in 1979, 12% in 1987, and 43% in 1991.1 During this 12 year period the prevalence remained stable; however, it seemed to fall by about 6% between 1991 and 2001.
2. The prevalence of passive smokers in these small companies was 9.7%, according to our restrictive definition of passive smoking. This restrictive definition did not make it possible to compare our data with those published in the literature. Several factors were significantly associated with passive smoking being male, being a blue collar worker, being 25–34 years old, and having a supervisor who smoked.
3. The ban on smoking at the work station was mentioned by 68% of the workers and smoking was banned in 68% of the workplaces visited. This percentage is higher than that reported by Grizeau and Baudier in 1995 (59%). This difference may be explained by progress in the last six years since the application of the French tobacco law.

The 1991 French tobacco law, the initial purpose of which was to protect non-smokers, seems to have led to a decrease in the prevalence of smoking and to a decrease in cigarette consumption, as shown by other studies on smoking policies.1 The prevalence of regular smokers decreased by 6% in accordance with the conclusions of Farrelly et al that “the ban on smoking in all workplaces should reduce the prevalence of smokers by 10%.” In the Paris area, real progress in the fight against smoking in the workplace was only made after the introduction of a national smokefree legislation, as in Finland.1 This situation could probably be enhanced further if the authorities boosted the French tobacco ban by introducing new stronger national smoking legislation.

J Alcouffe, P Fau-Prudhomot, P Manillier, E Lidove, P-Y Monteleon

Association interprovisoire des centres médicaux et sociaux de la région Île-de-France

Correspondence to: Dr Jacques Alcouffe, 55 Rue Rouget de Lisle, 92158 Suresnes cedex, France; monteleon@acms.asso.fr

www.tobaccocontrol.com
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One suggestion for Philip Morris . . . err, sorry, Altria’s new logo . . .