LETTERS TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, 10 references, and one table or figure, and should be sent to Simon Chapman, Deputy Editor, at the address given on the inside front of this issue. Responding to articles or correspondence published in the journal should be received within six weeks of publication.

Integrating smoking cessation into con- ceptional care

To the Editor—In Hungary, a network of con- ceptional care known as the Optimal Family Planning Service (OFPS), was established in the 1980s. It consists of three steps performed or supervised by qualified personnel: a checkup of reproductive health, a three-month preparation for conception, and efforts to protect women better in the early postconceptional period based on counsel- ing, examinations, and medical interven- tions. This new primary health care strategy seems to be appropriate for smoking cessation among women to prevent this habit from affecting fertility, fetal development, and women’s health.1

The first visit of couples includes the checkup examination and the launch of a three-month preparation for conception. Included in the latter is a low-intensity smoking cessation program. The smoking status of women and men is ascertained at an interview at the first visit and checked at three subsequent visits by the nurse: the second (at the end of the three-month preparation period), the third (at the time of pregnancy confirmation, generally in the third to fourth weeks of gestation), and the fourth (after this “fateful” meeting, pregnant women are referred to the antenatal clinics with the OFPS discharge summary). Smoking among men is checked by questioning their partners at the second, third, and fourth visits.

Three categories of participants are differ- entiated: never, former, and current smokers. In former smokers, the duration of smoking, number of cigarettes smoked per day, and the year of quitting are recorded. The data on smoking duration and daily cigarette consumption are also obtained for current smokers, who are informed about the reproductive risks of smoking, encouraged to stop smoking, and advised how to do so.

We report here on a population composed of 8837 women and 7600 men who participated in the OFPS study between 1 February 1984 and 21 January 1993. The mean (+SD) age of women and men was 25.9 (+3.6) and 29.2 (+3.8) years, respectively. The proportion of primiparas was 83.6%.

Smoking prevalence among women showed a highly significant reduction across the four visits (table). In Hungary the smoking rate among women of reproductive age is about 35%.3 The lower figure found among prospective mothers in this study is explained partly by their quitting smoking after the decision to have a pregnancy and partly by selection bias (women with strong smoking addiction probably did not join the OFPS).

<table>
<thead>
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<th>Visit 2</th>
<th>Visit 3</th>
<th>Visit 4</th>
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<tbody>
<tr>
<td>Total n</td>
<td>8837</td>
<td>8837</td>
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<tr>
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<td>8837</td>
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<td>8837</td>
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<tr>
<td>Men</td>
<td>7600</td>
<td>7600</td>
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<tr>
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<tr>
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</table>

Smoking prevalence among men decreased significantly only between the first and second visits (table). The proportion of men who smoke is about 45% in Hungary.4

Smoking status for all women who had their third meeting in September 1994 was checked by examination of cotinine in the urine.5

A total of 106 women were classified into four groups, according to urinary cotinine levels:

(a) none: smoking less than 5 ng/ml; 6

(b) exposed to environmental tobacco smoke: 5–49 ng/ml; 7

(c) light smokers: 50–99 ng/ml; 8

(d) heavy smokers: $100 ng/ml.

One of 67 never-smokers and two of 25 former smokers had cotinine levels above the threshold (≥50 ng/ml). The proportion of ‘nondisclosure’ smokers was 3.3% (3/92). Of 14 current smokers, three had negative urine cotinine figures (<50 ng/ml), two being deemed occasional smokers.

Conversely, with some male partners, a significant reduction in smoking prevalence was achieved among women. This effect appears likely to be due to the programme. The drawbacks of the low-intensity smoking cessation program in the OFPS were the following:

(1) Participants were informed about quitting techniques, but had no training in course in cessation.

(2) They had no social support for quitting.

(3) A special programme was not developed to prevent relapse.

(4) The absence of a control group limits the ability to draw conclusions about the efficacy of the programme.

Nevertheless, the experience of the OFPS suggests that the programme may be effective in reducing smoking among prospective mothers. In 1994 a smoking cessation programme was introduced in the OFPS.

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6 Matsuki H, Yagisawa Y, Spengler J. Urinary cotinine measurements for passive smoking using gas chromatography and flame thermoc-\n2

3

7 Feyerabend C, Bryant AE. Determination of cotinine in physiological fluids by gas chromato-\n4

graphy: Environmental carcinogens, meth-\n5


Self-service tobacco displays and consumer theft

To the Editor—We were interested to read the paper by Wildey et al on self-service tobacco displays in the tobacco products in the San Diego area.2 We note that several communities in the United States have banned or limited the use of self-service, free-standing tobacco displays (FSTDs) in retail stores in an attempt to restrict minors’ access to tobacco products. However, many communities continue to allow the use of smaller tobacco-product dis- \n6

plays on counter-tops, near checkout counters.

Massachusetts communities have been especially active in restricting cigarette vending machines and large FSTDs: as of March 1994, 46 communities limited (41 prohibited) vending machines, and 14 communities limited (13 prohibited) FSTDs (source: Group Against Smoking Pollution, Boston). However, few regulations have focused on the more ubiquitous consumer problem of smaller tobacco counter-top displays. Although restricting the use of large FSTDs might partially reduce minors’ access to tobacco products, we hypothesized that the continuing use of any self-service display in retail stores presents a powerful temptation for the illegal purchasing or even theft of tobacco products by minors. It is well known that shoplifting is a significant source of cigarettes for minors.3

We surveyed 28 convenience stores in Massachusetts and New Hampshire from March to May 1994 to ascertain the presence of self-service tobacco displays and reported theft of tobacco products. The stores we inter- \n7

viewed were privately owned and operated and not associated with large chains (such as Seven-Eleven). At each store we asked if shoplifting was a problem. We then asked which items were commonly stolen. Tobacco-product theft was recorded only if it was volunteered by the store owner. We independently counted the number of self-service FSTDs and counter-top tobacco-product displays in each store.

Of the 28 stores surveyed, 27 (96%) mentioned shoplifting as a problem in their store. Of these, 16 (57%) specifically mentioned cigarette theft as a problem. Nineteen of 28 (68%) stores had accessible cigarette counter-top displays and six (21%) stores had FSTDs with or without counter-top displays.
Of the eight stores with neither FSTDs nor self-service tobacco counter-top displays, only one reported cigarette theft as a problem. Of the 20 stores with either FSTD or cigarette counter-top displays, 15 (75%) reported cigarette theft.

We also assessed the relationship between the number of tobacco-product counter displays and racks, and the probability of cigarette theft. There was a strong relationship between the number of tobacco-product counter displays (figure 1) and racks (figure 2), and the probability of tobacco-product theft. The odds ratio (OR) of tobacco product theft for each additional counter was 1.41 (95% confidence interval [CI]=1.11 to 1.78) while the OR of theft for each additional rack was 1.14 (95% CI=1.0 to 1.3).

Our data suggest that the smaller tobacco-product counter-top displays are a major inducement to theft. The greater the number of tobacco-product counter displays, the higher the probability of tobacco products being stolen. Given the association of theft with the use of self-service FSTDs and tobacco-product counter-top displays, why do retailers continue to use them? The only economically sensible answer is that retailers are sufficiently compensated by tobacco companies for maintaining the self-service FSTDs and counter displays. Stores report that they receive the most compensation for self-service cigarette displays closest to the cash register.

We have identified a potentially important loophole through which minors could continue to obtain tobacco products. Public health professionals concerned with restricting minors' access to tobacco products should not only promote the removal of large FSTDs, but all self-service tobacco displays. We therefore recommend that states and local municipalities ban all forms of self-service tobacco product displays, not just large FSTDs.

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