



## European smokefree class competition: a measure to decrease smoking in youth

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## LETTERS

### European smokefree class competition: a measure to decrease smoking in youth

This letter corrects misleading and incorrect statements about the smokefree class competition (SFC) in a recent paper.<sup>1</sup>

**Statement 1.** "Modified versions of this competition should be developed, using ... group influence in a positive way. For instance, a non-smoking contest is being developed in Geneva using student's creativity and peer support in the class" (p. 759).

- The authors fail to say that one of them is involved in the initiative they promote.
- What they describe as "new approach... to smoking prevention" (p. 759) is a copy of SFC: classes have to stay smokefree for several months and can win prizes.
- Their assumption that "using of student's creativity" is a new component in their version of SFC is wrong: this component was added to SFC years ago and most of the participating countries apply it.

**Statement 2.** "The competition is based on a logic of exclusion, suspicion, and mistrust" (p. 759). "...the central principle is ... to apply negative peer pressure upon teenage smokers" (p. 757).

- Empirical data indicate different conclusions: in a representative population based sample of 6887 Swiss students and 440 teachers there was no difference regarding violence among classes participating in SFC and non-participating classes. Compared with non-participating classes, classroom climate was better in classes participating in SFC.
- In a study with 2695 pupils from Wales, 33.6% in the SFC group reported having been victims of bullying, compared with 38.4% in the comparison group.
- The authors assert that negative peer pressure is a central principle in SFC. At the same time, they presume that their copy of SFC provokes "group influence in a positive way" (p. 759). As copy and original SFC are almost identical, they should provoke the same kind of group influence.

**Statement 3.** "Non-voluntary test of saliva cotinine to detect tobacco use" (p. 758).

- This paragraph has nothing to do with the European SFC; none of the European Member States partners of SFC has applied tests of salivary cotinine.

**Statement 4.** "Scarce evidence for ... efficacy" (p. 757).

- Two controlled and two RCTs evaluated the campaign,<sup>2-5</sup> three of them indicating short term effects regarding smoking initiation.

All studies were published in peer reviewed journals, one being classified as number 1 study in the Cochrane review.

**Statement 5.** "Lack of a theoretical basis" (p. 759).

- The theoretical foundation of SFC and the copy of the competition in Geneva are identical: social learning theory.

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## European smokefree class competition: a measure to decrease smoking in youth – authors' reply

We are honoured by the response of an impressive international panel of stakeholders of the smokefree class competition to our recent comment on this programme.<sup>1</sup> It is true that one of us (PB) is involved in a local initiative developing a classroom contest, but this is an unimportant detail, not a central point of our 2006 paper. This modest project

only intends to be an opportunity to think about this issue on a concrete basis. Rather, we expected Hanewinkel *et al* to use more convincing arguments and challenge the central points of our criticisms, namely that the evidence for the efficacy of the smokefree class competition is not established beyond the short term, and that this approach raises serious ethical issues. The Cochrane review summarises the situation when it concludes that: "incentives and competitions do not appear to enhance long term cessation rates, with early success tending to dissipate when the rewards are no longer offered."<sup>2</sup> We can understand that this conclusion is difficult to accept for the stakeholders of this programme. Hanewinkel *et al* do not reject our assertion that the central principle of this competition is to apply negative peer pressure on smokers. Rather, they cite two studies, from Switzerland and Wales, suggesting that bullying and violence were not higher in participating classes than in control classes. However, the Swiss study compared classes that chose to participate with classes that chose not to. Thus it is not clear whether these results are attributable to the competition itself or to selection bias. No reference is given for the study in Wales, which apparently is not a randomised trial either.

For a programme of this importance (600 000 participants and millions of euros every year), conducted for so many years, the absence of an in-depth evaluation of its potential adverse effects is a serious shortcoming—in particular because negative peer pressure is applied on youthful smokers, who represent a more psychologically vulnerable group than non-smokers. As for the other points, non-voluntary cotinine tests were conducted in Switzerland until 2004, and we maintain that this competition lacks a sound basis in behaviour theory. Our hope is that this interesting exchange will raise renewed interest in the psychosocial and ethical issues in school prevention, and stimulate a commitment to seriously evaluate the positive and negative effects of the smokefree class competition.

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## BOOK REVIEW

### Social injustice and public health

Edited by Barry S Levy, Victor W Sidel. Published by Oxford University Press, Oxford, 2006, £35.99 (hardback), pp 529. ISBN 0-19-517185-3

This edited collection is divided into four parts. Part I, consisting of only one chapter authored by the editors, provides a useful and necessary summary of the nature of social injustice and public health. This includes relevant definitions and useful reference material—for example, a copy of the Universal Declaration of Human Rights. Part II outlines the ways in which the health of specific population groups is affected by social injustice. The chapters in this section focus on both well-described populations—for example, those from lower socioeconomic groups, ethnic minorities and women—and more marginalised groups who generally receive less attention. The inclusion of chapters focusing on incarcerated people, homeless people and forced migrant populations from a public health perspective makes for a refreshing change.

Part III considers the process by which social injustice can affect health. Chapters focus on medical care, infectious diseases and occupational safety, among other issues. A real strength of the book comes in part IV, in which several perspectives on "what needs to be done" are outlined. This series of chapters attempts to make explicit links, obviously based on particular political viewpoints, between explanatory models of social injustice and health, to public health practice. This is the

element that is often missing within the inequalities literature.

The collection of chapters fits together very well despite the large number of authors involved and the wide range of topics covered. A real strength of the book is that the chapters can be used as stand-alone texts, the understanding of which does not depend on having read previous sections. Generally, the chapters are well written, using good examples and a wide range of presentation styles (eg, graphs, tables and figures) to keep the reader engaged. The chapters provide good summary overviews of the topics under discussion and provide a good start for further reading. One potential criticism is the strong American focus; although most chapters do make attempts to draw upon international examples, the strong use of Americanised definitions and data is apparent. The book offers itself to several audiences, including both practitioners and students over a wide range of disciplines, including medicine, nursing, social services and law. This is perhaps the case, but more so in the US than for an international audience.

Joy Adamson

## CORRECTIONS

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M S Kaplan, N Huguet, B H McFarland, *et al*. Suicide among male veterans: a prospective population-based study (*J Epidemiol Community Health* 2007;**61**:619–24). In the second sentence of the Results section of the Abstract of this paper "(adjusted hazard ratio 2.04, 95% CI 1.10 to 3.80)" should be "(adjusted hazard ratio 2.13, 95% CI 1.14 to 3.99)".

doi: 10.1136/jech.2006.052670corr1

K Harkonmäki, K Korkeila, J Vahtera, *et al*. Childhood adversities as a predictor of disability retirement (*J Epidemiol Community Health* 2007;**61**:479–84). The author affiliation of Markku Koskenvuo was published incorrectly; it is actually University of Helsinki. We apologise for this error.

## Webcast: International Forum on Quality and Safety in Health Care

Plenary sessions at this year's International Forum on Quality and Safety in Health Care were filmed and broadcast live over the internet. The sessions are still available to view free, on demand and at your own convenience at <http://barcelona.bmj.com>. Each session is accompanied by a panel discussion.

The webcast includes the following, in either English or Spanish translation:

- **Donald M Berwick**: Can health care ever be safe?
- **Richard Smith**: What the quality movement can learn from other social movements
- **Lucian Leape and Linda Kenney**: When things go wrong: communicating about adverse events
- **John Prooi and Harry Molendijk**: Partnering for patient safety