

climate change and reduces climate resilience, wasting resources and damaging ecosystems necessary for human society.

Although the environmental burden falls on countries least able to cope with it, the profits are made by transnational tobacco companies that are based in higher-income countries.

Reducing tobacco consumption needs to be identified as a key lever for achieving all of the Sustainable Development Goals,^{4,5} not just those directly related to health.

We declare no competing interests.

**Nicholas S Hopkinson, Deborah Arnott, Nick Voulvoulis*
n.hopkinson@ic.ac.uk

National Heart and Lung Institute, Imperial College, London SW3 6NP, UK (NSH); Action on Smoking and Health, London, UK (DA); and Centre for Environmental Policy, Imperial College London, London, UK (NV)

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Foundation for a Smoke-Free World: independent and making progress

Tess Legg and colleagues¹ make unsubstantiated claims about the Foundation for a Smoke-Free World's progress and independence. They cite disclosures made in our 2018 tax

return² to suggest we are struggling.¹ However, the authors' assessment disregards the substantial progress outlined in our annual report,³ which was released alongside the tax return. The Foundation is where it was projected² to be when we launched in 2017.⁴

The tax return reflects our grant-issuance status as of December, 2018, as required by law. The annual report shows that our Board, after review by and with the support of our independent advisory boards, has approved more than US\$130 million in research grants involving 130 researchers worldwide.³

Our grantees have published independent global reports on smoking cessation and the science of tobacco harm reduction. We have established a Center for Agricultural Transformation to address Malawi's debilitating tobacco dependence.⁵ We published results from a survey done in 13 countries of 17 000 people to guide communications to identify why people who smoke struggle to achieve their goal of quitting and means to help them achieve this goal. Our communications and legal costs from the first year are commensurate with building a foundation from scratch. These early start-up costs have shifted markedly to grant making this year.

Independence is a central tenet to the Foundation's success. Legg and colleagues¹ noted that Cohen and Zeller's criteria are the gold standard for guiding acceptance of tobacco industry funding. In a Viewpoint I wrote in 2017,⁴ I indicated that the Foundation has enshrined these principles in its core governance documents and legal structure. We are therefore independent of our funder. This is not a claim; it is a legal, ethical, and non-negotiable fact.

DY is President of the Foundation for a Smoke-Free World. The Foundation received US\$80 million in contributions from Philip Morris International (PMI) in both 2018 and 2019. PMI has pledged to contribute \$80 million annually for the next 10 years. The Foundation's bylaws and pledged

agreement preclude DY, other Foundation staff, and board members from accepting any remuneration from PMI. PMI and the tobacco industry, generally, are precluded from having any control or influence over how the Foundation spends its funds or focuses its activities.

Derek Yach
derek.yach@smoke-free-world.org

Foundation for a Smoke-Free World, Southport, CT 06890, USA

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Victorian systems will not solve modern prison health problems

We commend Kim Price and Barry Godfrey¹ for their thoughtful work on prison health, looking to the period since the 19th century and showing the remnants of the Victorian past in today's prison health in the UK. Particularly, we support their approach towards mental health care for prisoners. However, we would like to add two essential elements that are important for preventing infection in the prison population, both of which are unfortunately missing in prisons in the UK and many other parts of the world.

Shared use of injected drugs is an undeniable reality inside prisons and the single most prominent risk factor for transmission of major infections in these settings worldwide.² The UK

is not an exception to this rule.³ The efficacy of the National Institute for Health and Care Excellence's Needle and Syringe Programme (NSP)⁴ as a solution to this problem is well known. Countries with prisons that have implemented the NSP show a reduction in the prevalence of blood-borne infections in prisons without any additional harm, such as increases in the frequency of drug use and injection, overdose, or putting prisoners or prison staff at risk to second-hand needles from customers of NSP. As a substantial amount of international evidence reinforces the efficacy of NSP in prisons,⁵ the insufficient extent of NSP implementation in UK prisons is concerning.

Unprotected sex is another fact inside prisons.⁶ Despite the effectiveness of condoms to control sexually transmitted infections, only 57 countries worldwide distribute condoms in their prisons.⁷ In almost 70% of countries, including the UK, prisoners do not have access to condoms and other accessories for safe sex. The misbeliefs that provision of condoms will encourage prisoners to have sex and that condoms will be misused as tools to smuggle drugs prevent some prison authorities from implementing such evidence-based programmes.⁸ It is up to us, the researchers, to educate the policy makers.

We believe that reform in the UK prison health system is overdue. Prisoners are among the most vulnerable populations in the UK and worldwide and deserve more financial investments. As most prisoners eventually return to the community, prison health should be seen as public health. Ignoring the risk and delaying implementation of evidence-based strategies will tax the public. Evidence is beyond denial, so the action should not be delayed any further. However, some of the attitudes described by Price and Godfrey of medical prison officers still prevail, making poor health care a part of the prisoners' punishment,

although prisoners have the right to the same level of health care as the general population. A country is only equitable to the extent that the health of its prisoners is seen as a human right.

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**Babak Moazen, Shervin Assari, Heino Stöver, Florian Neuhaus*
babak.moazen@uni-heidelberg.de

Heidelberg Institute of Global Health, Heidelberg University, Heidelberg 69120, Germany (BM, FN); Department of Health and Social Work, Institute of Addiction Research, Frankfurt University of Applied Sciences, Frankfurt-am-Main, Germany (BM, HS); and Department of Family Medicine, Charles R Drew University of Medicine and Science, Los Angeles, CA, USA (SA)

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Air disinfection in measles transmission hotspots

Measles is the most contagious airborne infection. The long-term solution to the increasingly common outbreaks of measles is to re-establish herd immunity through vaccination.

Although immunisation is the optimal approach to preventing measles, upper-room germicidal ultraviolet (GUV) air disinfection, a readily available environmental intervention with proven efficacy, should be used in selected paediatric waiting rooms, school classrooms, cafeterias, and other group settings that are key sites of transmission.

GUV air disinfection works by rapidly disinfecting upper-room air, which continuously then exchanges with contaminated lower-room air, resulting in highly cost-effective protection for room occupants.

Before immunisations were available for common childhood respiratory viruses, and antibiotics for tuberculosis, shielded, upper-room GUV fixtures were widely distributed to reduce airborne transmission in schools, hospitals, and other congregate settings.

Between 1937 and 1941, Wells and colleagues¹ studied the efficacy of upper-room GUV to control measles in classrooms in two schools in suburban Philadelphia, PA, USA. The average infection rate was 53.6% among more resistant, older children (grades 5–12) in classrooms without GUV air disinfection, compared with the average infection rate of 13.3% among more susceptible, younger children (grades K–4) in classrooms with GUV air disinfection (appendix).

However, when GUV air disinfection was distributed to schools in rural upstate New York, NY, USA and in urban London, UK there was no protective effect.^{2,3} In both locations GUV air disinfection was installed in classrooms and common areas, but unlike in suburban Philadelphia, children rode home on school buses in rural upstate New York and played together in crowded tenements in urban London.

The important lesson learned was that environmental controls are only effective when they target the principal sites of transmission. The application of upper-room GUV air



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See Online for appendix



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