

correctly cites as odds ratio of 1.15, but the confidence intervals were wide enough to extend well below unity (95% CI 0.69–1.93). Further, the point estimate from matched analysis was 1.01/100 Bq m⁻³, not 1.02 (the CIs cited were correct).

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What should be done in acute emergencies?

SIR—Davis (Sept 28, p 868)¹ convincingly challenges the assumption that children under age 5 years can be singled out as the most vulnerable group during acute emergencies and that, as a result, emergency public health interventions can be reduced to a standard package of child survival measures. We have witnessed in refugee camps how such focused strategies channelled a disproportionate share of scarce resources towards inefficient intensive feeding programmes for under-5s, in situations in which drinking water was lacking and diarrhoea rampant. In a highly absurd instance a 5-year-old marasmic child, not belonging to the target group of under-5s, was excluded from supplementary feeding.

Age is often not the most important determinant of vulnerability—social factors are. Members of disrupted families (eg, female-headed households² and unaccompanied minors) often suffer disproportionately, irrespective of age. That these result often from an adult death, be it before, during, or after flight, only adds to the arguments put forward by Davis.¹ His focus is on emergency public health measures when survival is at stake, because of extreme crowding, lack of drinking water, basic shelter, and food. However, if the response to an emergency is adequate, then the situation can be brought under control within weeks, rather than months; and mass population displacement does not always result in a serious health crisis, especially when severe overcrowding can be avoided.³ Nevertheless, displacement-inducing situations tend to be long. The three case studies presented by Davis¹ are still unresolved more than 2 years after their onset, and similar situations have rarely found a solution in less than a decade.³ Most of the world's refugees and displacees are thus not facing an acute emergency. Most are living under conditions which could be qualified as chronic instability, be it in refugee camps, or as self-settled migrants. In these chronic situations, problems of displacement through flight are similar to those faced by those uprooted by development. The impoverishment can be understood through eight crucial dimensions: landlessness; joblessness; homelessness; marginalisation; increased morbidity and mortality; food insecurity; loss of access to common property assets; and social disarticulations.⁴

The type of assistance needed is not always well-known, but refugees usually have resilience and develop their own coping strategies. When their strategies for survival require mobility, external assistance—which demands they remain in one place—often undermines their ability to cope. As a consequence, many refugees and displacees choose not to be assisted and flee the protection granted by the aid-umbrella.⁵ In such situations targeting under-5s is probably even more counterproductive than in the emergency phase.

Understanding people's own coping mechanisms in unstable situations, and developing appropriate measures to

support them, is as important as focusing on emergency public health interventions. The task of preserving and reconstructing livelihoods in complex and unstable situations should be tackled as soon as the real emergency is over.

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- 2 Sapir DG. Natural and man-made disasters: the vulnerability of women-headed households and children without families. *World Health Stat Q* 1993; **46**: 227–33.
- 3 Van Damme W. Do refugees belong in camps? Experiences from Goma and Guinea. *Lancet* 1995; **346**: 360–62.
- 4 Cernea MM. Understanding and preventing impoverishment from displacement: reflections on the state of knowledge. *J Refugee Studies* 1995; **8**: 245–64.
- 5 Harrell-Bond B. An alternative to refugee camps: pitch the tents. Washington: The New Republic; September 1994: 15–19.

Smoke in the face, diet, and harm to the heart

SIR—Hopkins' Sept 7 news report¹ of coronary heart disease incidence in non-smokers exposed to tobacco smoke from their spouses is incomplete. The authors of the study² she cites concluded that their results were consistent with earlier reports that never-smokers currently exposed to environmental tobacco smoke have about 20% higher coronary heart disease mortality. However, the cited authors noted: "Our data do not show consistent dose response trends and are possibly subject to confounding by unmeasured risk factors". Hopkins does not mention these last two important conclusions. The following is an example of one confounding risk factor.

Numerous epidemiological studies since 1939 have reported that smokers tend to have low plasma concentrations of vitamin C and β -carotene. Smokers also tend to consume lower quantities of fruit and vegetables, and they have higher intakes of saturated animal fat than non-smokers; both these dietary patterns are risk factors for coronary heart disease. The very small increased relative risks reported by Steenland and colleagues² (1.22, 1.10) could equally be due to smoke-exposed non-smokers sharing the same higher risk diet as the smoking partner. This hypothesis is supported by five studies which include significant dose response trends reporting an inverse relation between spousal smoke exposure and intake of β -carotene or fruit and vegetables.^{3,4} In another study of 4018 spouse pairs, the β -carotene intake of the wives was significantly correlated with that of the husbands ($r=0.46$, $p<0.0001$).⁵ Steenland and colleagues reported² that there is no increased risk of coronary heart disease with exposure to tobacco smoke in the workplace and other settings; in such settings there would be no confounding by a common diet. In general, the extent of workplace exposure is likely to be greater than the extent of spousal exposure.

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