

BUILDING CAPACITY FOR SMOKING CESSATION AND TREATMENT OF TOBACCO DEPENDENCE

Future needs for capacity-building

Considerable progress has been made in the provision of effective treatments for tobacco dependence, both behavioural and pharmacological. For many years, behavioural interventions were the only option. Although a combination of behavioural and pharmacological treatment produces the best outcomes, behavioural treatments alone can also be effective. It is critically important that a wide range of interventions be used both in general to support tobacco cessation and specifically to support those who wish to quit tobacco use even where medication is not available (Lando, 2002).

Social support for quitting should be possible in all countries, even those with extremely limited resources (Lando, 2002). Success has proved possible from training lay facilitators to conduct group cessation clinics. Abstinence outcomes for those clinics compare favourably with outcomes obtained by doctoral students in counselling psychology. According to the United States Clinical Practice Guideline (United States Department of Health and Human Services, 2000), both social support as part of treatment (intra-treatment social support) and help in securing social support outside of treatment (extra-treatment social support) are especially effective in increasing quitting. All countries have lay persons who can provide informal social support for quitting and who can be trained to conduct more formal interventions.

There would appear to be special challenges in countries where there are relatively few ex-smokers and where tobacco prevalence rates are high among health professionals (Lando, 2002). Ex-smokers can serve as role models in encouraging quitting, and can provide social support to individuals who are attempting to quit. They also may reflect an environment in which quitting is a greater priority.

Raw et al (1998) reviewed 41 studies to compare different health professionals, such as general practitioners, cardiologists, pneumonologists, dentists, nurses, pharmacists, psychologists and social workers, in their efforts to provide smoking cessation and treatment of tobacco dependence interventions. The evidence does not strongly favour one type of health professional over another. Thus tobacco-relevant issues should be incorporated into the education of a broad range of health professionals including medical doctors and nurses (Lando, 2002).



Health professionals who receive post-certification training are significantly more likely to intervene with smokers than those who have not been trained. However, there is no evidence, so far, that these interventions change patients' smoking behaviour (Lancaster et al., 2002). Trials evaluating training by measuring patient outcomes are complex and costly to implement and very few have been conducted. Systems should support training, ensure health professionals have access to such training and support them in continuing to use their new skills. This would include proper funding, temporary replacements for the health professionals whilst they attend training, and follow-up (Raw et al., 1998).

In addition to capacity-building, collaboration should be encouraged (Lando, 2002). There should be linkages among practitioners, researchers and advocates who seek to reduce tobacco prevalence. Culturally appropriate treatments are needed and these may differ significantly both across and even within countries. National programmes should be linked with international programmes such as Quit and Win contests, tobacco-free days, and quit-lines (including support delivered to cell phones). Ideally, in addition to brief advice, there should be options for more intense intervention including medication for high-risk and medically compromised tobacco-users even in low-income countries.

To fully accomplish this, more resources are needed, however, much can be done with existing resources (Lando, 2002). Closer links with prospective funders could be helpful as could increased collaboration and contact between the research community and policy-makers. Where possible, increased excise taxes and/or use of tobacco-generated revenue to fund tobacco-cessation services could substantially increase intervention options, including medication.

Training of health professionals

Training of health professionals is an essential part of a cost-effective, evidence-based strategy on smoking cessation and treatment of tobacco dependence because of their interaction with smokers and other tobacco consumers as care providers and their role as health communicators in societies (Marin-Tuya, 2002). However, health-care providers and professionals often lack sufficient motivation to undertake smoking cessation as a means of prevention. Misinformation about effective interventions, inadequate training in all health-care settings, lack of support for routine assessment and lack of resources and government funding are a few of the many factors that impede health-care professionals from taking action.

Building capacity among health professionals also includes the integration of smoking cessation as part of training activities in other health programmes such



Training for smoking cessation Service Providers in **THAILAND**

The national committee for control of tobacco use employs three main strategies: 1) preventing the uptake of tobacco use among youth and adolescent groups; 2) helping regular smokers to quit or stop tobacco use; and, 3) protecting non-smokers from environmental tobacco smoke (ETS).

A number of smoking cessation strategies are employed within the comprehensive policy for tobacco control. There is a strong emphasis on the training component:

- A training programme for health professionals to be “anti-smoking campaigners” in urban and rural areas has been held annually since 1988;
- Smoking cessation advocates have been created among health volunteers in the villages by training them on how to motivate smokers to quit, how to promote healthy lifestyles, and how to maintain smoke-free lifestyles;
- A national conference on smoking cessation has been held, providing a forum for exchanging and updating information regarding smoking cessation among health professionals interested in setting up smoking cessation clinics;
- A handbook has been prepared on the “brave heart (quit smoking) camp”: a three-day and two-night camp for those who wish to organize such camps for people who wish to quit smoking.

Source: Bhumiswasdi V. Smoking cessation experience in Thailand. Presentation at the occasion of the WHO meeting on Global Policy for Smoking Cessation hosted by the Ministry of Health of the Russian Federation, Moscow, 14-15 June 2002.

as those relating to chronic diseases, women’s health, and child and adolescent health. The WHO Tobacco Free Initiative (TFI) is encouraging other WHO departments to integrate effective tobacco-control measures, including treatment of tobacco dependence, into their work. For example, the Cardiovascular Disease Programme (CVD) has included a Protocol for counselling on cessation of tobacco use (WHO, 2002a). Further, TFI recommended the inclusion of treatment for tobacco dependence into the Integrated Management of Adolescent/Adult Illness (IMAI) strategy (WHO, 2002b). In principle, any tobacco-control programme should include, under its smoking cessation plans and projects, a training component addressed to both health professionals and advocates, encompassing information on behavioural and pharmacological therapies and addressing components of a supportive environment for smoking cessation. Training of personnel working in opportunistic contact with smokers as in pharmacies and drugstores can also be a valuable strategy to deliver information to the public. An analysis of a trial in the United Kingdom to evaluate the effectiveness of training of pharmacy personal in techniques based on the “stages of change” model



found an effect size of 4.6 per cent reduction on nine-month continuous abstinence rates (Sinclair et al., 1999). In addition, health professional organizations such as medical organizations and those involving pharmacists, nurses, midwives and dentists among others should become involved in the training process at the international, regional, national and local levels. This could include organizing lectures at workshops and publishing articles on smoking cessation in bulletins and journals. They could thus provide basic interventions as well as background materials on smoking cessation relevant to the specific professional groups.

As a medium-and long-term strategy to overcome the present obstacles, cessation counselling will need to be incorporated into the curricula of health professionals, including physicians and nurses, around the world (Marin-Tuya, 2002). To begin with, this could be done by working with international associations such as World Medical Associations, the World Organization of Family Practitioners, and the International Council of Nurses to develop model tobacco control curriculum and course outlines for basic training in delivering smoking cessation therapies.

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THE ROLE OF WHO, ITS PARTNERS, AND THE WHO FCTC PROVISIONS¹

The role of the international community in ensuring accessibility and availability of treatment of tobacco dependence is vital (Wilson, 2002). As countries prepare to develop national policy guidelines for the treatment of tobacco dependence, the international community can help by providing a forum for sharing and distributing information, writing up guidelines and reviews on best practices, raising funds and establishing partnerships with research and academic institutions in the area of smoking cessation. This is also valid for national partners. As already discussed in chapter 5, several organization, universities and social groups can play a role in tobacco control, either by supporting environmental changes that promote non-smoking as a social norm or by specifically addressing smoking cessation. This can be particularly valid in developing countries that face funding constraints.

In this regard, the text of the final draft of the WHO Framework Convention on Tobacco Control² emphasizes in the Preamble “the special contribution of non-governmental organizations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women’s, youth, environmental and consumer groups, and academic and health care institutions, to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts”.³

The special contribution of NGOs and other members of civil society, not affiliated with the tobacco industry, was addressed by several participants at the Moscow meeting (among others: Canada, Qatar and Venezuela).

With regard to smoking cessation and treatment of tobacco dependence, the text of the final draft of the WHO Framework Convention on Tobacco Control recognizes in the Preamble that “cigarettes and some other products containing tobacco are highly

¹ *The final session of the Negotiating Body on the WHO Framework Convention on Tobacco Control was held from 17 February to 1 March 2003, when the Final Draft was agreed. The Negotiating Body also agreed to transmit this text to the Fifty-sixth World Health Assembly for its adoption in May 2003 in accordance with Article 19 of the Constitution of the World Health Organization. Therefore, during the period prior to the said adoption date, any references to specific provisions of the WHO Framework Convention on Tobacco Control in this publication are construed to refer to provisions of the Final Draft of the WHO Framework Convention on Tobacco Control.*

² *The text of the final draft of the WHO Framework Convention on Tobacco Control is found in the annex of Document A56/8; all references to that text in this chapter can be found in this document.*

³ *Document A56/8 – Annex – Preamble, paragraph 17.*



Building partnership with NGOs & the private sector for cessation services.
Selected experiences.

CANADA - The new comprehensive federal tobacco control strategy of Canada (for which the federal government of Canada committed \$ 480 million in April 2001 for a period of five years), emphasizes partnerships among government departments, and between government and voluntary health agencies and nongovernmental organizations.

QATAR - Financing for the nicotine replacement therapy provided by the smoking cessation clinic in Qatar (an integral part of the national health-care system), comes predominately from private donations.

VENEZUELA - Partnerships between the national commission for tobacco control and the private sector/pharmaceutical companies have helped to improve access to information on treatment.

engineered so as to create and maintain dependence, and that many of the compounds they contain and the smoke they produce are pharmacologically active, toxic, mutagenic and carcinogenic, and that tobacco dependence is separately classified as a disorder in major international classifications of diseases”. The draft text envisages plans by WHO to “develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and ... take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence”.⁴

The final draft of the treaty also addresses the need to “design and implement effective programmes aimed at promoting the cessation of tobacco use, in such locations as educational institutions, health care facilities, workplaces and sporting environments”.⁵

In the international arena, there are a number of avenues for health cooperation (Wilson, 2002):

⁴ Document A56/8 – Annex – Article 14(1).

⁵ Document A56/8 – Annex – Article 14(2)(a).



- **Increasing access to pharmaceutical tobacco-cessation products**

It is critical to make cessation products more affordable to those who, so far, have been unable to afford them. It might be worthwhile to organize a campaign similar to that undertaken for AIDS treatment in Africa, which placed significant international pressure on pharmaceutical companies to reconsider their pricing policies for AIDS drugs in poor African countries where the pandemic was escalating. Similarly, there is an argument to be made for making available cheap generic variants of NRT and Zyban-like products, and for the relaxation of patent laws for cessation products on the basis of the extremely high death toll exacted by smoking and other tobacco use. The final draft of the WHO FCTC addresses the affordability and availability of treatment for tobacco dependence when it states that Parties shall endeavour to “collaborate with other Parties to facilitate accessibility and affordability for treatment of tobacco dependence including pharmaceutical products pursuant to Article 22. Such products and their constituents may include medicines, products used to administer medicines and diagnostics when appropriate”.⁶

- **Involving international health professional associations to set the stage**

Health professionals and caregivers around the world need to incorporate some aspect of cessation counselling into their practices. An ideal means of accomplishing this is to incorporate cessation counselling into the training curricula of physicians and nurses worldwide. This could be initiated through work with international associations, such as World Medical Associations, the World Organization of Family Practitioners and the International Council of Nurses, to develop model tobacco-control curriculum and course outlines for basic training in delivering smoking cessation therapies. This recommendation is supported by the WHO FCTC provisions which call upon Parties to “include diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco use in national health and education programmes, plans and strategies, with the participation of health workers, community workers, and social workers as appropriate” and to “establish in health care facilities and rehabilitation centres programmes for diagnosing, counselling, preventing and treating tobacco dependence”.⁷

- **An advertising ban can help with cessation**

A comprehensive ban on advertising would be an ideal mean of helping smokers throughout the world to quit. A global effort on banning tobacco-product advertising would have a tremendous impact on smoking rates all over the world since tobacco-

⁶ Document A56/8 – Annex – Article 14(2)(d).

⁷ Document A56/8 – Annex – Article 14(2)(b) and (c).



marketing studies have proven that advertising is one of the key means of supporting the initial addiction of new smokers and of preventing current smokers from quitting (Canadian Cancer Society, 2001).

The text of the final draft of the WHO Framework Convention on Tobacco Control, recognizing that “a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products”, points to the need for each Party, “in accordance with its constitution or constitutional principles, to undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship”.⁸

- **Tobacco package warning systems could include cessation messages**

The final draft text of the WHO Framework Convention on Tobacco Control (WHO FCTC) proposes the adoption and implementation of effective measures to ensure that “tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions, including any term, description, trademark, figurative or any other sign that directly or indirectly creates the false impression that a particular tobacco product is less harmful than other tobacco products. These may include terms such as “low tar”, “light”, “ultra-light” or “mild”.⁹ The final draft of the WHO FCTC text proposes that “each unit packet and package of tobacco products and any outside packaging and labelling of such products also carry health warnings describing the harmful effects of tobacco use, and may also include other appropriate messages” providing specifics about the product characteristics.¹⁰ International organizations can provide technical support and should, for example, share good practices. In Canada, for example, leaflets with cessation information are inserted in tobacco packages (Wilson, 2002).

- **Trade agreements should not unduly hamper trade in cessation products**

Public health advocates are calling for precedence of public health over trade agreements in which tobacco is addressed. This means giving higher priority to human life than to commercial interests. Along these lines, consideration should also be given to the liberalization of trade rules where cessation products are involved. The final draft text of the WHO Framework Convention on Tobacco Control (WHO FCTC) states that the Parties to this Convention are “determined to give priority to their right to protect public health”.¹¹

⁸ Document A56/8 – Annex – Article 13(1) and (2).

⁹ Document A56/8 – Annex – Article 11(1)(a).

¹⁰ Document A56/8 – Annex – Article 11(1)(b).

¹¹ Document A56/8 – Annex – Preamble, paragraph 1.



- **Improved cost-benefit analyses of cessation interventions**

Smoking cessation treatments are deemed to be cost-effective medical treatments (Tengs et al., 1995). However, more needs to be done by way of providing improved analyses detailing the cost-benefits of global cessation interventions. In particular, the World Bank and other international partners should undertake studies worldwide to demonstrate the cost-effectiveness of various tobacco-cessation interventions.

- **Public education, financial resources and reporting requirements**

The final draft of the WHO Framework Convention on Tobacco Control (WHO FCTC) notes the need to “promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate”.¹² Public awareness about the health risks of tobacco

consumption and exposure to tobacco smoke, and about the benefits of tobacco-free lifestyles and the cessation of tobacco use are addressed in the text of the final draft treaty. Given that these types of campaigns generally involve high costs, it is critical that financial resources be made available, as provided in Article 26 of the final draft of the treaty.



“CARDS DISTRIBUTED BY A CHARITABLE ANTI-SMOKING ASSOCIATION, SAUDI-ARABIA. THE TEXT ENCOURAGES SMOKERS TO SEEK CESSATION SERVICES”

- **Research, surveillance and exchange of information**

The final draft of the WHO Framework Convention on Tobacco Control (WHO FCTC) addresses the need for countries “to develop and promote national research and to coordinate research programmes at the regional and international levels in the field of tobacco control,”¹³ while recognizing “the importance of financial and technical assistance from international and regional intergovernmental organizations and other bodies”.¹⁴

Proponents of tobacco control have underscored the need for a list of standard indicators for tobacco control, including the global reporting of tobacco trade and industrial statistics. Indicators should be broad in scope, capturing health and

¹² Document A56/8 – Annex – Article 12, chapeau.

¹³ Document A56/8 – Annex – Article 20(1).

¹⁴ Document A56/8 – Annex – Article 20(3).



socioeconomic outcomes of tobacco use and even corporate behaviour. It is critical that cessation data, such as quit rates, are captured by these indicators; it is not sufficient to capture only smoking-prevalence data. A clearinghouse-type service would prove useful for the collection of these data (Wilson, 2002).

WHO Tobacco Free Initiative

A crucial phase of the work on the WHO Framework Convention on Tobacco Control (WHO FCTC) will commence after its adoption by the WHO Member States. Member States should be supported to ratify and later implement the treaty in question. The support may be technical or other. In order to be able to respond to requests for technical assistance on legal, scientific, policy and practical steps after the adoption of the WHO FCTC, the WHO Tobacco Free Initiative (TFI) is currently actively involved in developing various guidelines for countries. The purpose of these guidelines is to provide countries working towards tobacco-control measures with evidence-based background material tailored to their specific local needs. The *Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence* are part of this activity.

Other activities that the WHO Tobacco Free Initiative envisages to encourage countries to develop and strengthen their policies and strategies for smoking cessation and treatment of tobacco dependence include: a meeting with various health professional associations on how best to take forward the policy recommendations for smoking cessation and treatment of tobacco dependence; pilot testing of the *Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence*; inclusion of these *Policy Recommendations* in regional training workshops organized to build national capacity; collection and dissemination of “good practices”; preparation of practical manuals and background materials for health professionals; and promotion of the integration of tobacco control activities, including smoking cessation and treatment of tobacco dependence strategies within other WHO technical programmes.

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The WHO/SRNT database (<http://www.treatobacco.net>)

Treatobacco.net is an essential resource for those working on the treatment of tobacco dependence throughout the world. It presents evidence-based information about the treatment of tobacco dependence, under five headings: efficacy; safety; demographics and health effects; health economics; and policy. Key findings, commentaries and supporting references have been collated and reviewed by over 40 international experts, and the evidence is periodically updated to incorporate new research. Referenced slide kits and other resources can also be downloaded from the site. **Treatobacco.net** is a collaborative initiative between public and private organizations, run jointly by the Society for Research on Nicotine and Tobacco (SRNT) and the World Health Organization (WHO) Europe. **Treatobacco.net** is currently available in nine languages, making it a genuinely international resource for those interested in treating tobacco dependence around the world.

The Partnership Project (<http://www.who.dk/tobaccofree>)

The WHO European partnership project was launched in 1999, initially as a three-year project, with the objective of reducing tobacco-related death and disease among tobacco-dependent smokers. The project brought together a mix of private and public partners, including governmental and non-governmental organizations at the international, European and country levels, representatives of professional and scientific organizations, independent scientific advisers and the pharmaceutical sector. The rationale for this mix was to encourage collaboration in working towards a common goal to increase the availability and accessibility of treatment for tobacco dependence.

The project aimed to place the treatment of tobacco dependence on public-health and tobacco-control agendas as part of a global response to reducing the harmful effects of tobacco use. The project's scope included action both at the European and country level in each of five target countries: the Czech Republic (joined in 2001), France, Germany, Poland and the United Kingdom.



Related to the project, the WHO European Office partnered with the Society for Research on Nicotine and Tobacco to produce an Internet-based treatment database, “**Treatobacco.net**”. The WHO Regional Office for Europe has also partnered with the Centers for Disease Control and Prevention, United States, to produce two broadcast-quality videos: the first to communicate a health message to smokers on why to quit smoking, and the second on how to do it.

Although the European Partnership Project ended in December 2001, many of the Project’s target countries continue to implement activities at the national level through the partnership project framework. For example, country-based partnerships have been set up in Germany and the United Kingdom. Additional countries such as the Netherlands have started their own national public-private partnerships. And many other countries, including the Czech Republic, Italy, Spain and some countries of the WHO Western Pacific Region are considering setting up similar partnerships.

The Cochrane Collaboration (<http://www.cochrane.org/>)

Health care professionals, consumers, researchers and policy makers are overwhelmed with unmanageable amounts of information. Archie Cochrane, a British epidemiologist, drew attention to our great collective ignorance about the effects of health care. He recognised that people who want to make more informed decisions about health care do not have ready access to reliable reviews of the available evidence. In 1987, the year before Cochrane died, he referred to a systematic review of randomized controlled trials (RCTs) of care during pregnancy and childbirth as “a real milestone in the history of randomized trials and in the evaluation of care”, and suggested that other specialties copy the methods used.

The Cochrane Collaboration was developed in response to Cochrane’s call for systematic, up-to-date reviews of all relevant RCTs of health care. Cochrane’s suggestion that the methods used to prepare and maintain reviews of controlled trials in pregnancy and childbirth should be applied more widely was taken up by the Research and Development Programme, to support the United Kingdom’s National Health Service. Funds were provided to establish a “Cochrane Centre”, to collaborate with others in the UK and elsewhere, in order to facilitate systematic reviews of RCTs across all areas of health care.

Cochrane reviews (the principal output of the Collaboration) are published electronically in successive issues of The Cochrane Database of Systematic Reviews. Preparation and maintenance of Cochrane reviews is the responsibility of international collaborative review groups. At the beginning of 2001, the existing review groups



covered all the important areas of health care. The members of these groups — researchers, health care professionals, consumers and others — share an interest in generating reliable, up-to-date evidence relevant to the prevention, treatment and rehabilitation of particular health problems or groups of problems. Collaborative review groups are composed of persons from around the world who share an interest in developing and maintaining systematic reviews relevant to a particular health area. Groups are coordinated by an editorial team which edits and assembles completed reviews into modules for inclusion in a Cochrane Library.

The Cochrane Tobacco Addiction Group has developed and is maintaining the following systematic reviews, the abstracts of which can be found at the Cochrane website:

- Acupuncture for smoking cessation
- Antidepressants for smoking cessation
- Anxiolytics for smoking cessation
- Aversive smoking for smoking cessation
- Clonidine for smoking cessation
- Community interventions to reduce smoking among adults
- Community interventions to prevent smoking in young people
- Enhancing partner support to improve smoking cessation
- Exercise interventions for smoking cessation
- Group behaviour therapy programmes for smoking cessation
- Hypnotherapy for smoking cessation
- Individual behavioural counselling for smoking cessation
- Interventions for preventing tobacco smoking in public places
- Interventions for preventing tobacco sales to minors
- Interventions for preoperative smoking cessation
- Interventions for smoking cessation in hospitalized patients
- Lobeline for smoking cessation
- Mass media interventions for preventing smoking in young people
- Mecamylamine (a nicotine antagonist) for smoking cessation
- Nicotine replacement therapy for smoking cessation
- Nursing interventions for smoking cessation
- Opioid antagonists for smoking cessation
- Physician advice for smoking cessation
- School-based programmes for preventing smoking
- Self-help interventions for smoking cessation



- Silver acetate for smoking cessation
- Telephone counselling for smoking cessation
- Training health professionals in smoking cessation.

The Cochrane website also shows a list of protocols outlining the introduction, objectives, materials and methods for reviews currently being prepared by the Tobacco Addiction Group:

- Community pharmacy personnel interventions for smoking cessation
- Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke
- Impact of advertising on adolescent smoking behaviours
- Relapse prevention interventions for smoking cessation
- Tobacco cessation interventions for young people
- Workplace interventions for smoking cessation

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POLICY RECOMMENDATIONS FOR SMOKING CESSATION AND TREATMENT OF TOBACCO DEPENDENCE

A review of the evidence base of effective smoking cessation and treatment of tobacco dependence demonstrates that behavioural and pharmacological therapies for tobacco dependence can contribute substantially to greater health gains. A number of authoritative bodies have reviewed efficacious and highly cost-effective treatments. These reviews advocate that all health-care personnel and clinicians should consistently deliver smoking cessation interventions to their patients. Evidence-based pharmacotherapy offers a variety of options for individuals. These include several forms of nicotine-replacement therapy (gum, lozenge, patch, nasal spray and oral inhaler) and bupropion. The general efficacy of the various evidence-based treatments is similar in providing an approximate doubling of the probability of long-term smoking cessation. Behavioural treatment can be effective in its own right and can also substantially increase the success of pharmacotherapy. A wide range of behavioural and pharmacological therapies has proved effective. However, no single approach should be emphasized to the exclusion of the others, because the therapies vary widely in their efficacy, acceptability, cost-effectiveness and their cost on an individual and population basis.

Opportunities to motivate the smoker to quit exist both in a social setting as well as within the health care systems. Working with individual smokers to change their smoking behaviour is an important goal, but it has a limited impact if the environmental factors that promote and support smoking are not also addressed. Hence, population-based interventions should be viewed as complementary approaches to individual-based behavioural or pharmacological interventions.

Public health approaches at the general population level such as mass media campaigns, Quit and Win competitions and telephone help-lines play an important role in changing societal norms and promoting smoking cessation. Mass media campaigns can increase knowledge about the health effects of smoking and the benefits of stopping. They can also change and reinforce attitudes towards stopping, provide cues to simple action and influence smoking behaviour. Quit-lines have an important role to play as part of an overall comprehensive smoking cessation programme. They provide a low-cost, easily accessible, popular and effective service. Quit and Win campaigns have been using innovative communication methods and partnerships, including the involvement of community organizations and health services, to achieve cessation rates of around 20%.



As discussed previously in the chapter on supportive environments, creating a supportive environment which is conducive to deglamourizing the cigarette and encouraging the smoker to quit is imperative for effective implementation of smoking cessation services. Smoke-free policies at workplaces and in strategic settings such as hospitals and official buildings constitute a cost-effective public health approach that encourages the important long-term goal of de-normalizing tobacco use. Taking a public health approach (i.e. population-based measures) can affect large numbers of individuals at minimal cost.

Similarly, pharmacies and drugstores are settings where the personnel can be given regular training on providing brief advice to smokers who are trying to quit; materials (e.g. pamphlets and handouts) can be given to smokers. Their brief advice provided in routine day-to-day situations could provide an effective reinforcement for the smoker seeking help. Similarly, health professionals who are members of professional associations and groups at the local and national level can educate the smoking population and encourage cessation.

An environment conducive to smoking cessation, created through general population-based measures, can motivate smokers to quit. However, this should be supplemented with “treatment” for their dependence on tobacco. Such treatment, both pharmacological and behavioural, has to be integrated within health-care systems to enable effective delivery of cessation services. Apart from the specialized units at secondary and tertiary levels of health care, which would provide the therapy, the primary health care system wherever it exists, should be actively involved in providing brief advice and tips to smokers as part of routine health education.

Human and financial resources are a prerequisite for sustaining interventions on smoking cessation and treatment of tobacco dependence at both the population and individual levels discussed above. Public health officials need to be trained to deliver the population-based measures such as campaigns and incentive-based cessation programmes. Trained human and institutional resources are also needed to provide support and counselling to smokers. Building capacity to educate and train health-care providers to advocate and implement strategies for smoking cessation and treatment of tobacco dependence is essential for ensuring success. To support this, the role of policy-makers, health professionals, and researchers will be imperative in getting tobacco cessation high on the national public health agenda.

The role of the international community in ensuring accessibility and availability of treatment of tobacco dependence is also important. It can help by providing a forum for sharing and distributing information, writing up guidelines and reviews



on best practices, raising funds and establishing partnerships with research and academic institutions in the area of smoking cessation. This will create a “global” supportive and favourable environment for cessation, which is one of the key strategies to reduce the disease burden due to tobacco use.

In order to further expand smoking cessation interventions and treatment of tobacco dependence at the national level and to make these more widely available to the population, political commitment and will are critical. National governments will need to increase their human, institutional and financial resources in support of effective population- and individual-based tobacco cessation interventions. To ensure sustainability of smoking cessation policies and programmes, governments need to incorporate these into other basic health care services. This should be done within the context of a comprehensive tobacco-control strategy employing a broad range of evidence-based policies.

Having learnt about the experiences of participating countries in smoking cessation, coupled with the expert reviews and discussions on how to assist countries in implementing the Mayo Clinic/WHO recommendations, participants of the two-day meeting in Moscow drew up the following recommendations. These are recommended as the priority elements to be undertaken by governments, intergovernmental organizations, nongovernmental organizations and health-care professionals interested in making public-health gains in the short and medium term:

- A smoking cessation and treatment for tobacco dependence policy should be part of any comprehensive tobacco-control policy if cessation efforts are to be effective and sustainable;
- A supportive environment, which includes a decrease in accessibility of tobacco products, a reduction in social acceptance of tobacco consumption and an increase in information, will increase the likelihood of tobacco users managing to quit;
- All tobacco-users should be offered effective treatment for tobacco dependence;
- Member States should develop evidence-based national policy guidelines for the treatment of tobacco dependence;
- Awareness should be increased among health-care professionals, administrators, and policy-makers of both the benefits and cost-effectiveness of smoking cessation interventions and treatment for tobacco dependence relative to other health-care interventions;
- Training should be provided to all health-care providers at primary care, community and national level to enable them to effectively deliver smoking cessation interventions and treatment for tobacco dependence;
- New partnerships are needed to increase commitment and the pooling of financial and technical support for implementing evidence-based treatment.



References

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World Bank (1999). *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington, DC, World Bank.

In March 1999, the Mayo Clinic Nicotine Dependence Center, Rochester, Minnesota, USA, hosted an expert meeting to address the “worldwide tobacco epidemic through effective, evidence-based treatment”. The participating experts from both developed and developing countries drew up a list of recommendations (known as the “Mayo Clinic Recommendations”) for governments and health professionals to reduce the likelihood of tobacco-related disease. These recommendations are:

- (1) **Make treatment a public health priority.** Governments should rank treatment as an important public health priority;
- (2) **Make treatment available.** Health care systems should offer practical interventions to all tobacco users, regardless of income level, age and sex. This includes preventing and treating tobacco use in children and adolescents, reducing family exposure to tobacco and providing medication when appropriate. This process can be facilitated by incorporating tobacco-dependence treatment into drug-abuse treatment, reproductive and maternal-child health services and other programmes;
- (3) **Assess and monitor tobacco use and provide proven treatments.** Health care providers should assess and document tobacco use and should provide treatment as an essential part of quality total health care. Health care providers should assume responsibility for learning about tobacco use and treatment, and for providing proven interventions. Providers, educators and community leaders should take advantage of teachable moments and opportunities for prevention and intervention;
- (4) **Set an example for peers and patients by ceasing tobacco use.** Governments and education systems can help this process by funding treatment and education programmes for health professionals in training;
- (5) **Fund effective treatment.** Governments and health care organizations should fund treatment based on methods that have been demonstrated to be effective, and should make treatment widely available. Increasing the institutional and human capacity for providing this service involves training health care workers to deliver treatment, implementing an appropriately developed curriculum for students in the health professions, developing resource centres, encouraging the creation and



maintenance of centres of excellence in treating tobacco dependence and reducing the barriers between tobacco users and treatment;

(6) **Motivate tobacco users to quit.** Governments, health providers and community groups share the responsibility for motivating tobacco users to quit and remain abstinent. They should educate the public about the health risks of tobacco use, encourage tobacco users to seek treatment and help make treatment available, affordable and accessible;

(7) **Monitor and regulate tobacco processing, marketing and sales.** Governments should monitor and report on tobacco use, and should tax and regulate the sale and marketing of tobacco products. These efforts can reduce initiation of tobacco use and help fund effective treatments. Responsible regulation of tobacco products reduces tobacco use and limits risk. Regulatory authorities should prohibit marketing strategies that give false reassurances that minimize the health risks and divert attention from quitting. Additionally, all possible steps should be taken to reduce the harmful effects of tobacco products. Governments should collaborate to provide meaningful and accurate ratings of nicotine and other chemicals in tobacco products, and to reduce the toxicity and addictiveness of those products. Treatment should be at least as accessible as tobacco products;

(8) **Develop new treatments.** Investing in the science and technology of treatment improves its efficacy for those in diverse populations and under-served groups. Effective treatment should be developed for groups for whom treatment has not been available, such as children and adolescents.

Universal application of all these measures is the most effective approach to tobacco treatment. The current escalation in tobacco use and in tobacco-related death and disease can only be reversed by investment in comprehensive tobacco control, which includes treatment of tobacco dependence.

Annex II

LIST OF PARTICIPANTS AT THE WHO MEETING ON GLOBAL POLICY FOR SMOKING CESSATION, MOSCOW, 14-15 JUNE 2002

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