Part II - Module 1-A

The burden of tobacco use and the potential of tobacco cessation to save lives
Tobacco kills up to half of its users

- Smokers die 10 to 15 years earlier than non-smokers

- The tobacco epidemic kills nearly 6 million people each year, of whom:
  - more than 5 million are users and ex-users
  - more than 600,000 are nonsmokers exposed to secondhand smoke

## Costs to the society

- $500 billion: exceeds the total annual expenditure on health in all LMICs combined!

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost attributable to tobacco use (2007 or latest available data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The United States</td>
<td>167.00 billion</td>
</tr>
<tr>
<td>Japan</td>
<td>62.39 billion</td>
</tr>
<tr>
<td>Germany</td>
<td>23.75 billion</td>
</tr>
<tr>
<td>Canada</td>
<td>17.00 billion</td>
</tr>
<tr>
<td>France</td>
<td>15.30 billion</td>
</tr>
<tr>
<td>China</td>
<td>5.00 billion</td>
</tr>
<tr>
<td>Egypt</td>
<td>1.25 billion</td>
</tr>
</tbody>
</table>

*:Direct health care costs plus indirect costs, including productivity losses, absenteeism and other socioeconomic costs.

Source: Tobacco Atlas online- Cost to economy
Costs to families and individuals

- Tobacco products are expensive. The price of 20 Marlboro cigarettes could buy:
  - a dozen eggs in Panama
  - one kilogram of fish in France
  - four pairs of cotton socks in China
  - 6 kilograms of rice in Bangladesh

- Tobacco use is costly with 5-15% of tobacco user's disposable income is spent on tobacco

Source: WHO The tobacco atlas, first version
The suffering of families and individuals because of diminished quality of life, death and financial burden.

Tobacco worsens poverty among its users: money spent on tobacco reduced access to essential goods such as education and health care.

Poor households spend more on Tobacco than on Education, Health and Clothing.

Source: Tobacco and Poverty in the Philippines, WHO 2008
Part II: Training for primary care service managers: Planning and implementing system changes to support the delivery of brief tobacco interventions

WHO FCTC
- The powerful tool to reverse tobacco epidemic

- First global health treaty negotiated under auspices of WHO – adopted in 2003, entered into force on 27 Feb 2005

- 176 parties, covering about 90% of the world population
Core demand reduction provisions in the WHO FCTC

At the population level:

- Price and tax measures to reduce the demand for tobacco (Article 6) and smuggling control (Article 15)
- Protection from exposure to tobacco smoke (Article 8)
- Packaging and labeling of tobacco products (Article 11, 12)
- Ban of tobacco advertising, promotion and sponsorship (Article 13)
- Monitoring and evaluation (Articles 20, 21)

At the individual level:

- Tobacco dependence reduction and cessation (Article 14)
Article 14 of the WHO FCTC

“Each Parties…shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence… ”
Supporting current tobacco users to quit is key to achieve health gains in the short to medium term.

If adult consumption were to decrease by 50% by the year 2020, approximately 180 million tobacco-related deaths could be avoided.

Part II - Module 1-B

The rationale for promoting access to treatment of tobacco dependence in primary care settings
Primary care setting is an ideal place to identify and treat tobacco users

- The success of a service is measured by its:
  - **Reach** (number of people who receive the service/intervention)
  - **Effectiveness** (percentage of people who change their behavior as a result of the service/intervention) and
  - **Cost** per person to deliver.

- Primary care setting is a less costly setting to reach the majority tobacco users in many countries

**Reach**
- Primary care staff have a long and close contact with the community and are well accepted by local people
- It is the primary source of health care can reach the majority population in many countries
- It appears to reach the poor far better than other types of health programs and the poor smoke the most
Primary care setting is an ideal place to identify and treat tobacco users

Prevalence of tobacco use within countries and between countries of different levels of development

Note: Q1-Q5: Lowest-Highest income group

Source: World Health Survey 2006
Primary care setting is an ideal place to identify and treat tobacco users

- Primary care setting is a less costly setting to reach the majority tobacco users in many countries

**Delivery Cost**

- Primary care setting is less costly setting as primary care approach emphasizes providing as much care as possible at the first point of contact through integrated service delivery models.
- There are various opportunities and entry points exist for integrating identification and treatment of tobacco users in primary care (for example, DOTS strategy, programmes dealing with CVD, COPD, Diabetes, Maternal and Child Health).
What tobacco treatment should be routinely offered in primary care?

- **Behavioral interventions:**
  - Self-help interventions
  - Physician advice
  - Nursing intervention
  - Individual behavioral counseling
  - Group behavioral therapy
  - Telephone counseling (quitlines)
  - Quit and Win competitions

- **Pharmacologic interventions:**
  - Nicotine replacement therapy (NRT)
  - Bupropion
  - Varenicline
  - Cytisine
  - Clonidine
  - Nortriptyline
What tobacco treatment should be routinely offered in primary care?

The WHO FCTC Article 14 guidelines recommend that:

- **All Parties should aim to develop a comprehensive system to provide a range of interventions:**
  - **Population-level approaches**
    - Brief advice integrated into all health-care systems
    - Quit lines
  - **Intensive individual approaches**
    - Specialized tobacco dependence treatment
  - **Medications**
  - **Novel approaches and media**
    - Cellphone text messaging

- They should use a stepwise approach and provide at least brief advice to all tobacco users.
What tobacco treatment should be routinely offered in primary care?

Definition in the WHO FCTC Article 14 Guidelines:
- Advice to stop using tobacco, usually taking only a few minutes, given to all tobacco users, usually during the course of a routine consultation or interaction
- Used interchangeably with brief intervention.

Starting with integrating brief advice into primary care, a country can develop their treatment system as rapidly as possible and at as low a cost as possible because it has the potential to:
- Reach > 80% of all tobacco users per year;
- Trigger 40% of case to make a quit attempt;
- Help 2-3% of those receiving brief advice quit successfully;
- Form a promising referral source and create demand for more intensive tobacco cessation services.

What tobacco treatment should be routinely offered in primary care?

WHO recommends 3 treatment services for all countries:

- Tobacco cessation advice incorporated into primary care services (feasible, effective and efficient)
- Easily accessible and free quit lines
- Access to low-cost pharmacological therapy.

WHO recommends that countries should at least deliver brief tobacco interventions as part of its routine services in primary care.
Part II - Module 1-C

Brief tobacco intervention models
Primary care providers can help patients quit tobacco use by offering interventions as short as 3 minutes.

<table>
<thead>
<tr>
<th>Level of contact</th>
<th>Number of arms</th>
<th>Estimated odds ratio (95% C.I.)</th>
<th>Estimated abstinence rate (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No contact</td>
<td>30</td>
<td>1.0</td>
<td>10.9</td>
</tr>
<tr>
<td>Minimal counseling (&lt; 3 minutes)</td>
<td>19</td>
<td>1.3 (1.01, 1.6)</td>
<td>13.4 (10.9, 16.1)</td>
</tr>
<tr>
<td>Low intensity counseling (3-10 minutes)</td>
<td>16</td>
<td>1.6 (1.2, 2.0)</td>
<td>16.0 (12.8, 19.2)</td>
</tr>
<tr>
<td>Higher intensity counseling (&gt; 10 minutes)</td>
<td>55</td>
<td>2.3 (2.0, 2.7)</td>
<td>22.1 (19.4, 24.7)</td>
</tr>
</tbody>
</table>

## Effective delivery models

### 5A's for patients who are ready to quit

- **Ask** - Ask all patients if they smoke
- **Advise** - Advise smokers that they need to quit
- **Assess** - Assess ‘readiness’ to quit
- **Assist** - Assist the patient with a quit plan or provide information on specialist support
- **Arrange** - Arrange follow up contacts or a referral to specialist support

### 5R's for patients not ready to quit

- **Relevance** - How is quitting most personally relevant to you?
- **Risks** - What do you know about the risks of smoking in that regard?
- **Rewards** - What would be the benefits of quitting in that regard?
- **Roadblocks** - What would be difficult about quitting for you?
- **Repetition** - Repeat assessment of readiness to quit – if still not ready to quit repeat intervention at a later date.
How to implement 5A's and 5R's?

Ask
↓
Advise
↓
Assess
↓
Assist
↓
Arrange

Relevance
Risks
Rewards
Roadblocks
Repetition

Five R’s

Not Ready to Quit

Ready to Quit

End positively

Not Ready to Quit

Relevance
Risks
Rewards
Roadblocks
Repetition
Other models of Brief Interventions

If specialist support (quitlines, cessation clinics) is available, other models can be used

1. AAA
   - **Ask**
   - **Advise**
   - **ACT on patient's response**
     build confidence, give information, refer, prescribe; succeed with local Stop Smoking Services

2. AAR
   - **Ask**
   - **Advise**
   - **Refer**
     to quitlines and to local cessation programs

3. ABC
   - **Ask**
   - **Brief advise**
   - **Cessation**
     Make referral to the Quitline or cessation services
     Provide cessation support and medication
     Arrange follow-up within a week
Summary

Brief interventions may be delivered anywhere – in the hospital setting, in the out-patient clinic or in the community.

Brief interventions take a few minutes – but if done routinely – they can significantly increase the numbers of people quitting and save lives!

**Impact** = Reach + Effectiveness + Delivery cost
Summary

- The 5As (Ask, Advise, Assess, Assist, Arrange) summarize all the activities that a primary care provider can do to help a tobacco user within 3 to 5 minutes in primary care settings.

- You can start and stop at any step as indicated in the diagram.
5A's Model Demonstration

3 minutes video- 5A's in practice
Part II - Module 2-A

WHO Health System Framework: a tool for strengthening health systems
Six building blocks of a health system

Shows practical ways to build a well-functioning health system to support primary care providers to routinely deliver brief tobacco interventions.
Main features of a well functioning health system

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>Deliver effective, safe, high-quality personal and public health interventions to those who need them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workforce</td>
<td>There are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive, and productive</td>
</tr>
<tr>
<td>Info. support</td>
<td>One that ensures the production, analysis, dissemination, and use of reliable and timely information</td>
</tr>
<tr>
<td>Medical product</td>
<td>Access to essential medical products, and technologies of assured quality, safety, efficacy, and cost-effectiveness</td>
</tr>
<tr>
<td>Financing</td>
<td>Adequate funds for health, in ways that ensure people can use services, and are protected from financial hardship</td>
</tr>
<tr>
<td>Leadership governance</td>
<td>Strategic-policy frameworks exist and attention to coalition building, appropriate regulations, system design</td>
</tr>
</tbody>
</table>
As for tobacco dependence treatment, a well functioning health system is...

- Allows any tobacco users wherever they live and whatever their social and economic circumstances to access appropriate, good quality tobacco dependence treatment as part of primary care services (focusing on brief tobacco interventions)

- With referral to existing intensive treatments (quit line, specialist treatment) when needed

- Without the risk of financial hardship.
The WHO Health System Framework is a good tool for primary care service managers

- **A diagnostic tool** to diagnose all system problems/constraints that need to be addressed in order to improve primary care providers' performance of tobacco dependence treatment;

- **A planning tool** to plan and implement system changes to overcome the constraints to support primary care providers’ delivery of tobacco dependence treatment.
Part II - Module 3-A

How tobacco dependence treatment are integrated into primary care
### Use WHO six building blocks as a tool to plan action steps

#### Case study 1-Group Health Cooperative

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership &amp; governance</td>
<td>• Created a management team and set specific objectives</td>
</tr>
<tr>
<td></td>
<td>• Kept tobacco cessation as a priority in the organization</td>
</tr>
<tr>
<td>Service delivery</td>
<td>• Selected NCI 4A model (now 5A's)</td>
</tr>
<tr>
<td></td>
<td>• Provided group classes, individual phone-based treatment and medicines</td>
</tr>
<tr>
<td>Medical products &amp; technologies</td>
<td>• Provided access to medications</td>
</tr>
<tr>
<td></td>
<td>• Developed posters and brochures</td>
</tr>
<tr>
<td>Information systems</td>
<td>• Designed and implemented a vital sign and a reminder system</td>
</tr>
<tr>
<td>Financing</td>
<td>• Made sufficient financial resources for the program</td>
</tr>
<tr>
<td></td>
<td>• Provided &quot;rewards&quot; to motivate health care providers</td>
</tr>
<tr>
<td>Health workforce</td>
<td>• Training</td>
</tr>
<tr>
<td></td>
<td>• Engaged individuals at different levels of the organization</td>
</tr>
</tbody>
</table>
Use WHO six building blocks as a tool to plan action steps

Case study 2-Beijing Hospital

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership &amp; governance</td>
<td>• Organized a management team</td>
</tr>
<tr>
<td>Service delivery</td>
<td>• Brief interventions incorporated into physicians’ daily practice</td>
</tr>
<tr>
<td></td>
<td>• Established smoking cessation clinics</td>
</tr>
<tr>
<td>Medical products &amp; technologies</td>
<td>• Provided access to medications</td>
</tr>
<tr>
<td>Information systems</td>
<td>• Designed and implemented an electronic recording and supporting system for physicians</td>
</tr>
<tr>
<td>Health workforce</td>
<td>• Training</td>
</tr>
<tr>
<td></td>
<td>• Implemented the code of practice (smoke-free hospitals, supported hospital employees quit smoking.</td>
</tr>
</tbody>
</table>
Part II - Module 4-A
Who are stakeholders and champions?
How to ensure a system change is successful

- Gain support from stakeholders
- Identify a champion from stakeholders
- Identify or develop supportive organizational policies, regulations and incentives
Stakeholders

• Any group or individual who can affect or who is affected by an organization’s actions, objectives and policies.
Champions

Champions are stakeholders who are deeply interested in and are supportive of your project

- Help remove roadblocks
- Help get support from other stakeholders
Part II - Module 4-B

Four steps of engaging with stakeholders
Four steps to engage with stakeholders

- Identify your stakeholders
- Prioritize your stakeholders
- Understand your key stakeholders
- Determine appropriate strategies and actions to approach your key stakeholders
Step 1: Identify your stakeholders

The first step is for you to brainstorm:

- Who have influence or power over your system changes?
- Who have an interest in your system changes?
- Who are affected by your system changes?
Step 1: Identify your stakeholders

The key stakeholders may include:

- Policy makers
- Health care providers
- Patients
- Public health department/ministry of health
- NGOs
- Community members
Step 2: Prioritize your stakeholders

Influence/Interest Grid for Stakeholder Prioritization

- Low Influence, Low Interest
- High Influence, Low Interest
- Low Influence, High Interest
- High Influence, High Interest
Step 3: Understand your key stakeholders

Know about your stakeholders perspectives:

- How would this stakeholder define a positive outcome for your planned systems changes?
- What can stakeholder gain from an improved system for tobacco dependence treatment?
- What are barriers or challenges that would limit this stakeholder's participation in this program?
- What would be an incentive for this stakeholder to participate in this program?
Step 4: Determine appropriate strategies and actions to approach your key stakeholders

- **High influence, interested people**: you must fully engage and make the greatest efforts to satisfy.

- **High influence, less interested people**: put enough work in with these people to keep them satisfied, but not so much that they become bored with your message.

- **Low influence, interested people**: keep these people adequately informed, and talk to them to ensure that no major issues are arising.

- **Low influence, less interested people**: monitor these people, but do not bore them with excessive communication.
Part II - Module 4-C

Approaching the stakeholders
Approach your stakeholders
- addressing prioritizing

Number Needed to Treat
- tells you how many patients need to be treated to benefit one patient

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Outcome</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statins</td>
<td>Prevent one death over five years</td>
<td>107</td>
</tr>
<tr>
<td>Antihypertensive therapy for mild hypertension</td>
<td>Prevent one stroke, MI, death over one year</td>
<td>700</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Prevent one death over ten years</td>
<td>1140</td>
</tr>
<tr>
<td>GP brief advice to stop smoking</td>
<td>Prevent one premature death</td>
<td>80</td>
</tr>
</tbody>
</table>

Source: [http://www.devonpct.nhs.uk/documents/BM27.06.07/4.4%20LES%20for%20stopping%20smoking.pdf](http://www.devonpct.nhs.uk/documents/BM27.06.07/4.4%20LES%20for%20stopping%20smoking.pdf)
Approach your stakeholders - addressing prioritizing

- Treating tobacco supports effective treatment of other conditions, especially chronic illness

- Quitting smoking increases positive treatment outcomes:
  - Diabetes
  - Tuberculosis
  - Asthma
  - Heart Disease
  - HIV
Part II - Module 4-D

Identifying champions
Brainstorming

- How champions can effect system changes?
- How to identify champions?
- What are qualities of a successful champion?
How champions can effect system changes?

Champions can contribute to the success of the planned systems changes by:

- advocacy
- support – act like a leader, help remove roadblocks
- acting as resource persons- facilitate the implementation of system changes.
Practice ways of identifying champions

- Identifying champions through stakeholder analysis
- Sending out a call for participation
- Asking organizational or department managers to identify and nominate
Qualities of a successful champion

A successful champion should be:

- well established in their work group, knowledgeable about the group's activities, and respected by their colleagues
- helpful and approachable to their colleagues
- able to communicate effectively with peers, superiors and subordinates.
Stakeholders and champions in the health system

Health Work Force
Clinic Staff; educator; Clinic Mgrs

Information Support
Medical records managers

Service Delivery
Clinic Staff; Clinic managers

Leadership & Governance
Policy Makers; Government agencies Leaders

Finance
Business Office; Directors; Policy Makers

Medical Products/ Tech.
Pharmacists; pharmaceutical companies

Stakeholders and champions in the health system

Health Work Force
Clinic Staff; educator; Clinic Mgrs

Information Support
Medical records managers

Service Delivery
Clinic Staff; Clinic managers

Leadership & Governance
Policy Makers; Government agencies Leaders

Finance
Business Office; Directors; Policy Makers

Medical Products/ Tech.
Pharmacists; pharmaceutical companies
Part II - Module 5-A

A consumer-community continuum
**Consumer-community continuum**

- Individuals who are receiving or who have received care
- Family Members who support individuals who receive care.
- Groups of consumers who share a common experience or chronic illness
- Potential consumers – those with unmet needs or access issues
- Members of the community, including future users who benefit from health care services
- Tax payers (people who ultimately pay for services) and government agencies.
Part II - Module 5-B

The goals of community participation in promoting brief tobacco interventions
The goal of community participation

- Tobacco dependence treatment to be high on the agenda of the community
- Increasing demand from tobacco users through public education
- Utilization of community resources in supporting tobacco dependence treatment
Brainstorming

- As a service manager, how can you promote community involvement to meet these goals?
How can primary care service managers meet the goals of community participation?

- Identify, assess and promote active involvement of community partners (leadership groups/organizations)

- Identify and promote utilization of community resources.
Assessing level of involvement

- Manipulation: Communities are manipulated.
- Decoration: Communities are used as needed.
- Tokenism: Communities are used in a perfunctory or merely symbolic way to give the appearance of real participation.
- Communities are assigned but informed.
- Communities are consulted and informed.
- Communities participate in project implementation.
- Communities initiate and direct decisions.
- Communities initiate, plan, direct and implement decisions.
How to promote community involvement?

- **Information**: Keeping people informed.
- **Consultation**: Getting feedback. Listening to ideas.
- **Decision Making**: Joint decision making; **Acting together**: forming a partnership to carry plans out.
- **Supporting independent community interests**.
Part II - Module 6-A

Workplace motivation and incentives
Workplace motivation

Motivation: The tendency to initiate and sustain effort towards a goal

It has 3 components

- Perceived task **importance**: value someone places on the task
- **Self-efficacy**: the extent to which we believe we can be successful in our work
- **Expectancy** of personal reward: anticipation of what will happen to us if the work goal is reached
Self-efficacy: relates to confidence in one’s own ability to succeed in doing something
Incentives: the factors/conditions within health professionals' environments that enable and encourage them to improve their performance and to stay in their job.

Effective incentive systems should be:

- Open and transparent
- Fair
- Consistent
- Fit the purpose and based on reaching a specific goal.
- Include both financial and non-financial incentives.
- Sustainable and remain effective.
- Motivate the target population.
Low-cost methods of providing incentives

- Case studies that demonstrate low-cost methods of providing incentives:
  - Rewards to organizations and individual workers in Haiti
  - Posting job performance in Kyrgyzstan
  - Reward systems be group-based and that recognition should emphasize positive effects on the community
Using WHO building blocks to identify incentives

- Match incentives to health system building block
  - Reward success within that component of the system
  - Example: to motivate primary care providers to do “5A’s”
    - Make this part of job expectation, track performance, and provide valued incentive
Using WHO building blocks to identify incentives

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership &amp; governance</td>
<td>• Staff performance evaluations</td>
</tr>
<tr>
<td></td>
<td>• Reimburse providers</td>
</tr>
<tr>
<td></td>
<td>• Policies that support treatment</td>
</tr>
<tr>
<td></td>
<td>• Recognition</td>
</tr>
<tr>
<td>Service delivery</td>
<td>• Organizational arrangements</td>
</tr>
<tr>
<td></td>
<td>• Intervention</td>
</tr>
<tr>
<td></td>
<td>• Outcome data</td>
</tr>
<tr>
<td>Medical products &amp; technologies</td>
<td>• Develop / disseminate clinical guidelines</td>
</tr>
<tr>
<td></td>
<td>• Make education materials available &amp; accessible</td>
</tr>
</tbody>
</table>
### Using WHO building blocks to identify incentives

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information systems</td>
<td>• Easy-to-use information system</td>
</tr>
<tr>
<td>Financing</td>
<td>• Incentives for efficient service provision</td>
</tr>
<tr>
<td></td>
<td>• Build necessary budgets</td>
</tr>
<tr>
<td>Health workforce</td>
<td>• Financial Incentive</td>
</tr>
<tr>
<td></td>
<td>• Training</td>
</tr>
</tbody>
</table>
Part II - Module 7-A

Definition and steps of creating an action plan
Brainstorming

- What is action plan?
- What does an action plan look like?
Definition of an action plan

- A planned series of actions, tasks or steps designed to achieve an objective or goal.

- Action plans are written documents that individuals, groups, and organizations developed to guide their efforts in certain initiatives.
The key aspects of an action plan

- What problem do you want to resolve/what change do you want to bring about?
- Objectives
- Planned activities/solutions for your problem
- Timelines
- The expected resource needs
Five steps to create an action plan

1. Define the issue or problem to be addressed

2. Identify opportunities and challenges to bring about the desired changes

3. Set objectives

4. Construct action steps (list of actions)

5. Format your action plan
Set SMART objectives

- **Specific**: What exactly are we going to do for whom?
- **Measureable**: Can we measure it?
- **Attainable**: Can we get it done in the time we have with the resources we have?
- **Relevant**: Will this objective have an effect in achieving the goal?
- **Time-bound**: When will this objective be accomplished?
Set SMART objectives

Example:

- By 31/12/10 (time bound), increase the number of training workshops given to primary care providers on the 5A's brief tobacco intervention model (specific & relevant) from 2 to 10 (measurable & achievable).
Construct action steps

- The most crucial part of the action plan
- A realistic list of solutions and activities that will address the problem or bring about the desired change.

<table>
<thead>
<tr>
<th>What</th>
<th>By Who?</th>
<th>By When?</th>
<th>Resources needed</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Meet with the Director of a community agency</td>
<td>Primary care service manager</td>
<td>By the end of December 2011</td>
<td>A meeting room, background materials on tobacco use in the community</td>
<td>To get community agency interested in participating in tobacco dependence treatment program.</td>
</tr>
</tbody>
</table>
Format your action plan

- Your action plan will need to be put into a formal document

- The suggested action plan format:
  
  Title
  The issue or problem needs to be addressed
  Challenges and opportunities to address the problem
  Objectives
  Action steps
  Monitoring & Evaluation
Part II - Module 7-B

Closure and evaluation
Closure

Not the End…..

Just the beginning
Save Lives!

Reduce Health Care Costs!

Make a Difference!
Test & Win
Questions

Which Article of the WHO Framework Convention on Tobacco Control is related to tobacco dependence treatment? (   )

A. Article 8
B. Article 6
C. Article 14
D. None of the above
E. All of the above

C
Questions

The cost of tobacco use includes (  )
A. Costs of tobacco-related death
B. Related productivity losses
C. Health care expenditures for active and passive smokers
D. Fire damage due to careless smokers
E. All of the above combined

E
Questions

When a male smoker with breathing problems tells you that he does not want to be non smoker, what you are going to do? (    )

A. Blame him and let him go

B. Help him develop a quit plan

C. Use 5 R’s intervention to encourage him to identify the relevance of quitting to him and to identify risks of smoking on lung diseases

D. Provide him nicotine replacement therapy

C
Questions

Which of the following statements is incorrect (   )

A. Primary care staff have a long and close contact with the community and are well accepted by local people

B. The poor smoke the most

C. Primary care programs can reach the poor far better than other types of health programs

D. There are various opportunities and entry points exist for integrating identification and treatment of tobacco users in primary care

E. None of the above

E
Which policy of the WHO MPOWER technical assistance package is related to tobacco dependence treatment? (  )

A. Monitor tobacco use and prevention policies
B. Protect people from tobacco smoke
C. Offer help to quit tobacco use
D. Warn about the dangers of tobacco

C
Questions

Which of the following is a system-level intervention for treating tobacco dependence ( )

A. Including nicotine replacement therapy (NRT) in national essential drug list
B. Training primary care providers on brief tobacco interventions
C. Including smoking status as a new vital sign
D. Policy for integrating tobacco dependence treatment into TB care services
E. All of the above

E
Who are not your stakeholder for promoting tobacco dependence treatment in the community? (  )

A. Policy makers
B. Tobacco industries
C. Pharmaceutical companies
D. Community leaders
E. B and C

B
Questions

Which one is the lowest level of community involvement ( )

A. Communities are used as needed.

B. Communities are manipulated.

C. Communities are used in a perfunctory or merely symbolic way to give the appearance of real participation.

D. Communities are consulted and informed.

E. Communities initiate, plan, direct and implement decisions

B
Questions

Which of the following is not an effective workplace incentive to encourage primary care providers to treat tobacco users?

A. Only give them more money
B. Give them more money and recognize their performance.
C. Provide training to them
D. Develop toolkit to assist them in treating tobacco users
E. None of the above

A
The first step to develop an action plan is (  )

A. Set your objectives
B. Identify the issue, challenge, or problem to be addressed
C. List action steps
D. Decide monitoring and evaluation strategy
E. Identify your stakeholders

B
Questions

The Five A's consists of (   )

A. Ask, Advise, Assess, Assist and Arrange
B. Ask, Admire, Assess, Assist and Arrange
C. Ask, Anticipate, Assist, Admire and Arrange
D. Ask, Advise, Assess, Assist and Anticipate
E. None of the above

A
Which of the following is(are) not evidence-based tobacco dependence treatment(s) ( )

A. Nicotine replacement therapy
B. Brief tobacco interventions
C. Varenicline and Bupropion
D. Telephone counseling
E. Acupuncture and electronic cigarettes

E
Evaluation

Ask participants to state:

- 2-3 things you have learned
- 2-3 things you want to learn more about
- 2-3 things you will do now/how will you act on this?
Thank you for your attention