

WHO European strategy for smoking cessation policy

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WHO European Strategy for Smoking Cessation Policy

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ABSTRACT

The WHO European Strategy for Smoking Cessation Policy aims to provide guidelines and support to the Member States in building capacity to strengthen their smoking cessation activities. It is the first publication in the new series of strategy documents following the adoption of the European Strategy for Tobacco Control. Although this document focuses on interventions within the health system designed to help smokers stop, these interventions should still be embedded within a comprehensive tobacco control strategy employing a broad range of policies.

The document describes the effectiveness of the measures influencing the demand for tobacco products and of the different interventions directly targeted to facilitate the changes in tobacco users' behaviour or attitudes. The document proposes priorities in smoking cessation policy for countries in the initial and transitional phases of tobacco control policy and for countries having, or developing, comprehensive tobacco control programmes. It presents different elements for building national capacity for smoking cessation policy and reiterates the need for evaluation and for international collaboration describing, in particular, the role of WHO.

Keywords

SMOKING – prevention and control
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TOBACCO – legislation
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Summary

The WHO European Strategy for Smoking Cessation Policy aims to provide guidelines and support to the Member States of the WHO European Region in building capacity to strengthen their smoking cessation activities. It is the first publication in the new series of strategy documents following the adoption of the European Strategy for Tobacco Control. Although this document focuses on interventions within the health system designed to help smokers stop, these interventions should still be embedded within a comprehensive tobacco control strategy employing a broad range of policies.

Smoking cessation is one of the important components of a comprehensive tobacco control policy that, as emphasized by the Warsaw Declaration for a Tobacco-free Europe and the European Strategy for Tobacco Control, strongly contributes to a decrease in smoking prevalence. The Framework Convention on Tobacco Control sets out general obligations to develop and disseminate guidelines based on scientific evidence and best practices and to implement effective programmes and services for treating tobacco dependence.

The rationale for smoking cessation policy takes into consideration that the vast majority of projected deaths caused by tobacco use in the next quarter century will be among people who are currently smoking or using tobacco products. Thus, the number of deaths will rise if no adults quit or if there is solely a reduction in young adults taking up smoking. Adult smoking cessation is therefore essential to improving public health relatively quickly.

The document describes the effectiveness of the measures influencing the demand for tobacco products (in particular, taxation and legislation) and of the different interventions (such as mass media communications campaigns, Quit and Win competitions, telephone help-lines and tobacco dependence treatments) directly targeted to facilitate the changes in tobacco users' behaviour or attitudes.

In terms of cost-effectiveness, data shows that taxation has the greatest impact. Based solely on health considerations, the higher the rate of taxation, the better is the smoking prevalence reduction. To attain even greater improvements, the combination of taxation, legislation and information is affordable and very cost-effective in the different mortality strata of the European Region. Adding nicotine replacement therapy (NRT) certainly increases the cost of the smoking cessation policies but improves effectiveness as well.

The document proposes priorities in smoking cessation policy for countries in the initial and transitional phases of tobacco control policy and for countries having, or developing, comprehensive tobacco control programmes. It presents the elements for building national capacity for smoking cessation policy based on the experience of countries such as the United Kingdom which has a long established and well developed capacity in this area. It addresses important issues such as developing human resources, content, training capacity, reaching priority groups, making smoking cessation policy more gender-specific, integrating treatment into the health system, research, regulating nicotine, and opportunities and challenges.

Finally, the document reiterates the need for evaluation and for international collaboration describing, in particular, the role of WHO. The target audience is policy makers, health professionals, health system administrators and professional organizations.

1

Introduction

This document aims to provide guidelines and support to the Member States of the WHO European Region in building capacity to strengthen their smoking cessation activities. Smoking cessation is one of the important components of a comprehensive tobacco control policy which, as emphasized by the Warsaw Declaration for a Tobacco-free Europe (1) and the European Strategy for Tobacco Control (2), strongly contributes to a decrease in smoking prevalence. The Framework Convention on Tobacco Control sets out general obligations to develop and disseminate guidelines based on scientific evidence and best practices and to implement effective programmes and services for treating tobacco dependence (3).

Several policies influence smokers' motivation to stop smoking and their success in stopping. Tobacco control measures such as taxation, advertising bans, smoke-free areas and information and education campaigns increase smokers' motivation to stop and encourage them to make attempts to stop and access treatments if they are available. They also help to create a climate that makes it easier for former smokers to remain abstinent.

Although this document focuses on interventions within the health system designed to help smokers stop, these interventions should still be embedded within a comprehensive tobacco control strategy employing a broad range of policies. If they are not, then there is unlikely to be much demand for them, as smokers must first be motivated to stop before they seek help in stopping smoking.

In addition, interventions should be based on strong evidence of effectiveness to make the best use of scarce resources. Thus, in considering which interventions to introduce, a country should take

account of the strength of evidence in support of that intervention and of how it may be affected by specific cultural factors when introduced into the country's own system. Thus, for example, an advertising campaign is unlikely to be suitable if simply imported from another country; it should be tested for impact and adapted as necessary for the new country.

OBJECTIVE AND RECENT DEVELOPMENTS

The overall objective of this document is to provide national and local policy-makers, health system administrators and health professionals with new opportunities to develop effective smoking cessation policies and interventions to reduce tobacco-related morbidity and mortality.

The document addresses the barriers to developing and implementing effective policies and interventions – mainly the lack of knowledge on the effectiveness and on the cost-effectiveness of the different cessation interventions and methods, the lack of an adequate framework and support for implementing smoking cessation policies and activities.

The interventions analysed are those directly targeted to smokers, particularly through the health system (such as mass media communications campaigns, Quit and Win competitions, telephone help-lines and tobacco dependence treatments). Additional attention is given to policies and interventions more generally influencing the demand for tobacco products (in particular, taxation and legislation).

The WHO European Strategy for Smoking Cessation Policy takes into consideration existing knowledge and the latest developments:

- The provisions of the Framework Convention on Tobacco Control concerning tobacco dependence and cessation (3).
- The recommendations of the European Strategy for Tobacco Control, which was adopted by the fifty-second session of the Regional Committee for Europe (2). A document on smoking cessation policy was recommended to be the first to be published in the new WHO series of strategy documents following the European Strategy for Tobacco Control.

- The WHO European evidence-based recommendations on the treatment of tobacco dependence published in 2001 (4,5).
- The latest review on the effectiveness of the available treatments (6) as well as the recommended strategies to reduce risk to health presented in *The world health report 2002* (7).

The development of the Strategy has followed an iterative process of drafting, review and discussion. Martin Raw and Ann McNeill, well known international experts in this field, prepared a draft document, and a panel of WHO national counterparts and selected networks and experts reviewed it. After comments and suggestions were incorporated, a second draft was reviewed by a WHO collaborating centre and experts. The final draft was reviewed by the renewed network of WHO European national counterparts acting as an international advisory body to the European Strategy for Tobacco Control. The orientation and development process were under the general direction of the Tobacco-free Europe programme of the WHO Regional Office for Europe in cooperation with other units.

The strength of evidence varied according to a gradient ranging from strong evidence to expert consensus or case studies.

The following definitions apply to this document.

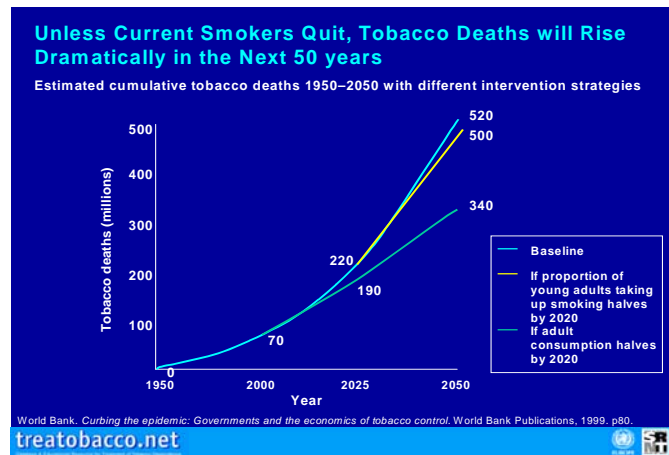
Tobacco dependence is a chronically relapsing condition. A minority of tobacco users – whether they smoke or use smokeless products – achieves permanent abstinence in an initial attempt to quit. Most tobacco users who want to quit go through multiple periods of relapse and remission. As with other chronic disorders, people with tobacco dependence should be provided with effective and adequate treatment.

Tobacco dependence treatment includes (singly or in combination) behavioural and pharmaceutical interventions such as brief advice and counselling, intensive support and administration of pharmaceuticals that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole (4,5). The interventions described are relevant to the different forms of tobacco use (smoked or not).

THE RATIONALE FOR SMOKING CESSATION POLICY

The European Region of WHO, with only 15% of the world's population, faces nearly one third of the worldwide burden of tobacco-related diseases. *The world health report 2002 (7)* has presented new figures by attributing 1.6 million deaths to tobacco for the year 2000 and showing a substantial increase in recent years. The vast majority of projected deaths caused by tobacco use in the next quarter century will be among people who are currently smoking or using tobacco products. According to Peto and Lopez (8), halving global cigarette consumption per adult by the year 2020 would prevent about one third of the tobacco deaths in 2020 and would almost halve tobacco deaths in the second quarter of the century. Such changes could avoid between seven and ten million tobacco deaths by 2025 in the European Region.

Increasing tobacco cessation in adults is critically important to improving public health in the short to medium term. This is because smokers die from tobacco-related disease in middle age (defined by epidemiologists as 35 to 69 years) as a result of the 25- to 30-year delay between smoking and the development of serious disease. Thus, measures aimed at persuading young people not to start smoking will not have an effect until they become middle aged – about 30 to 50 years in the future. Adult smokers, in contrast, are that much closer to developing smoking-related disease. Thus, the number of deaths will rise if no adults quit or if there is solely a reduction in young adults taking up smoking. Adult smoking cessation is therefore essential to improving public health relatively quickly. This is illustrated in Fig. 1, which shows how the worldwide number of deaths will rise in the first 50 years of this century if no adults quit in the next 20 years or if there is solely a reduction in young adults taking up smoking.



A huge, international body of research shows that smoking cessation policies and interventions are effective and cost-effective (9). They include two broad categories of activities:

- mass population policies and activities aimed to persuade smokers to stop smoking, such as higher prices through taxation, restrictions on smoking in public places and mass media educational campaigns; and
- policies and activities designed to help dependent smokers who are already motivated to stop.

These approaches should not be considered alternatives but complementary because they reach different populations and because, without broader population-oriented approaches, smokers will not be motivated to stop.

The first category of interventions makes an important contribution towards encouraging smokers to stop. These policies help to convert smokers who are not interested in stopping into smokers who are interested in stopping (10).

The approaches that offer treatment help smokers to overcome their dependence. Tobacco use is primarily a way of self-administering nicotine which WHO (11) and the American Psychiatric Association (12) recognize as being an addictive drug provoking nicotine dependence, which is a chronic relapsing disorder. This is the main

reason why only a small percentage of smokers each year (0.5–5%) achieve lasting abstinence without help or support, even in countries where tobacco control policies are well advanced and where the health consequences of tobacco use are broadly understood (13).

The effectiveness of smoking cessation policy

Accumulated experience shows that interventions designed to help dependent smokers are most effective when they are embedded within a comprehensive tobacco control strategy employing a broad range of policies and activities.

MASS POPULATION APPROACHES

Raising taxes on tobacco products is one of the most effective components of a comprehensive tobacco control policy. Continually increasing real prices reduces consumption and the prevalence of use of tobacco products. According to the World Bank, on average, a price rise of about 10% on a pack of cigarettes would reduce the demand for cigarettes by about 4% in high-income countries and by about 8% in low- and middle-income countries. Researchers estimate that half of the effect of a price increase would be on prevalence: a 2% reduction of prevalence in high-income countries and a 4% reduction in low- and middle-income countries. The other half of the reduction would be on the number of cigarettes smoked by those smokers who continued (9).

Regulations on exposure to environmental tobacco smoke could also reduce the average consumption of tobacco and smoking prevalence. However, the effectiveness of restrictions on smoking depends on their enforcement and the mobilization of public opinion through comprehensive information campaigns. In the United States, various estimates have shown that the development of legislation banning smoking in public places and its strict enforcement could

reduce the average consumption of tobacco by between 4% and 10% and induce a significant number of smokers to quit (9).

Mass media campaigns can increase knowledge about the health effects of smoking and the benefits of stopping, change and reinforce attitudes towards stopping, increase political acceptance of policy measures (such as those on taxation and environmental tobacco smoke) and provide cues to simple action (14). Mass media campaigns can also promote and support the delivery of and facilitate access to smoking cessation services.

Community-wide stop-smoking contests such as Quit and Win aimed at motivating smokers to stop have now been carried out in several countries worldwide. In the WHO European Region, 33 countries participated in the 2000 campaign. Follow-up studies have shown that after one year, on average 20% of the participants have remained tobacco-free, although recruitment strategies, participation rates, abstinence rates and hence the effects on the population varied widely from country to country (15).

INTERVENTIONS DESIGNED TO HELP MOTIVATED SMOKERS TO OVERCOME THEIR DEPENDENCE

Telephone help-lines use two main approaches: reactive – in which smokers can simply telephone the line, and proactive – in which counsellors ring callers back and give ongoing telephone support. Proactive telephone counselling can be effective compared to an intervention without personal contact. Some evidence suggests that telephone help-lines are a useful part of a treatment service for smokers (16).

Tobacco dependence treatment

The evidence supports three main categories of intervention: brief opportunistic advice to stop smoking from a health care professional, face-to-face behavioural support and pharmacotherapy, especially nicotine replacement therapy (NRT) and bupropion.

Brief opportunistic advice from a physician is effective and extremely worthwhile from a public health perspective. There is strong evidence that face-to-face behavioural support, individual and in groups, is

effective in its own right, as is pharmacotherapy. The evidence shows a correlation between the amount of treatment and the success rates achieved (long-term abstinence). Broadly speaking, less intense interventions achieve lower success rates. They usually potentially reach more people. The evidence so far suggests that individual and group support have similar effectiveness (5,17,18). Table 1 presents the effectiveness of the main forms of smoking cessation interventions

Table 1. Abstinence rates of the main forms of interventions

Intervention/control group	Estimated odds ratio (95% C.I.)	Estimated abstinence rate in the intervention group (95% C.I.) [%]	Estimated abstinence rate in the control group [%]
Physician high intensity counselling (> 10 minutes) versus no person-to-person contact	2.3 (2.0, 2.7)	22.1 (19.4, 24.7)	10.9
Bupropion versus placebo	2.1 (1.5, 3.0)	30.5 (23.2, 37.8)	17.3
Nicotine patch versus placebo	1.9 (1.7, 2.2)	17.7 (16.0, 19.5)	10.0
Combination of two NRTs versus one NRT	1.9 (1.3, 2.6)	28.6 (21.7, 35.4)	17.4
Nicotine gum versus placebo	1.5 (1.3, 1.8)	23.7 (20.6, 26.7)	17.1
Group counselling versus no special format	1.3 (1.1, 1.6)	13.9 (11.6, 16.1)	10.8
Physician advice to quit (average length of intervention ≤3 minutes) versus no advice to quit	1.3 (1.1, 1.6)	10.2 (8.5, 12.0)	7.9
Proactive telephone counselling versus no special format	1.2 (1.1, 1.4)	13.1 (11.4, 14.8)	10.8
Self-help interventions versus no special format	1.2 (1.02, 1.3)	12.3 (10.9, 13.6)	10.8

Data obtained from: Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence. Clinical Practice Guideline*. Rockville, MD, U.S. Department of Health and Human Services. Public Health Service, 2000.

The Odds Ratio is defined as the ratio of the probability of abstinence among subjects in the intervention group divided by the probability of abstinence among subjects in the control group.

The table shows results from different meta-analyses with different population-groups and/or different duration of follow-up with no less than five months. Estimated abstinence rates can therefore only give a rough indication of the relative effectiveness of each intervention when compared. However, the estimated odds ratio in the second column is more indicative in terms of the relative effectiveness of interventions.

A recent review of international evidence shows that all the commercially available NRT products are effective as part of a strategy to promote smoking cessation, increasing the average six month quit rates by about 1.5 to 2-fold (19,20).

3

The cost–effectiveness of smoking cessation policy

Smoking cessation policies and interventions are effective, but introducing them into health systems still costs money, and the competition for funding in publicly and privately funded health systems means that the survival of new treatments increasingly depends on cost–effectiveness. In each country, it will be essential to argue the benefits of smoking cessation treatment on cost–effectiveness grounds. Explaining the distinction between effectiveness and cost–effectiveness to those who commission and pay for health services is thus critical. Several studies show just how cost-effective tobacco dependence treatment is.

A 2000 report by the US Surgeon General emphasizes that smoking cessation is one of the most cost-effective of all health care treatments (21). The data show that smoking cessation is considerably more cost-effective than most health care interventions. This means that, in time, introducing smoking cessation into health care systems will release resources for other needs.

An analysis of the cost–effectiveness of implementing the 1996 clinical practice guideline of the US Agency for Health Care Policy and Research *Smoking cessation* showed that the cost per quality-adjusted life–year saved ranged from US \$1100 to US \$4500 versus US \$23 300 for hypertension screening among 40-year-old men and US \$61 700 for annual mammography for 40- to 49-year-old women. A similar estimate in the United Kingdom showed the cost per additional life–year of introducing a comprehensive system for the treatment of tobacco dependence ranged from £210 (US \$315) to £870 (US \$1300). Again this was compared with a range of 310 medical

treatments from an international review, which found an average of US \$25 500 per life year gained (22). Further, comprehensive publicly funded treatment services for smokers have now been in place for over three years in some parts of the United Kingdom, and their actual cost–effectiveness has been estimated. Using conservative assumptions, the cost–effectiveness of the new services was estimated at just over £600 (US \$960) per life–year gained for treated smokers aged 35–44 years and £750 (US \$1200) for those aged 45–54 years (23). Evaluation of effectiveness in the Russian Federation showed that extensive cessation programmes could increase life expectancy by an average of three years and reduce the risk for early mortality (24).

The World Bank has estimated the cost–effectiveness of publicly funded NRT with 25% coverage at just under US \$250 per disability-adjusted life–year in eastern Europe and central Asia and at just under US \$300 per disability-adjusted life–year in low- and middle-income countries (9).

The WHO CHOICE project (25) has been developed to provide a standardized set of methods and tools that can be used to analyse the costs and population health effects of current and possible new interventions to tackle major risk factors. The estimates of the benefits of smoking cessation interventions have been calculated for three mortality strata in the WHO European Region. Table 2 reports costs–effectiveness in terms of international US dollars (adjusted for purchasing power parity) per disability-adjusted life–year gained by intervention.

Table 2. Analysis of the cost–effectiveness (in US dollars per disability-adjusted life–year) of smoking cessation interventions according to mortality stratum^a in the WHO European Region

Intervention	EURO A	EURO B	EURO C
A1 Global average tax to 44% of final retail price	44	70	43
A2 Tax increase up to 75% of final retail price	18	37	22
A3 Tax increase up to 89% of final retail price	13	31	18
A4 Clean indoor air law enforcement	358	283	201
A5 Comprehensive advertising ban	189	198	129
A6 Information dissemination	337	327	243
A7 Nicotine replacement therapy ^b	2 164	2 476	3 689
A8 Combination 1 (A3+A6)	45	91	55
A9 Combination 2 (A3+A4+A6)	79	135	84
A10 Combination 3 (A3+A5+A6)	58	108	64
A11 Combination 4 (A3+A5)	28	60	34
A12 Combination 5 (A3+A4+A5)	63	112	67
A13 Combination 6 (A3+A4+A5+A6)	90	146	90
A14 Combination 7 (A3+A4+A5+A6+A7)	274	453	488

Source: WHOSIS database, 2002.

^aMortality stratum: to aid in analysing death, the Member States of WHO have been divided into different mortality strata based on their levels of mortality for those under five years of age and for those 15–59 years old. For the European Region, Member States were grouped as follows:

EURO A (very low child and adult mortality): Andorra, Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

EURO B (low child and low adult mortality): Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Georgia, Kyrgyzstan, Poland, Romania, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan.

EURO C (low child and high adult mortality): Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine.

^b Nicotine replacement therapy: 20 mg/day treatment with nicotine gum for three months, plus regular visits to a GP or health centre (1 per month) and a nurse counsellor (1.5 per month)

In terms of smoking cessation interventions, WHO's CHOICE model shows that taxation has the greatest impact. Table 2 presents the cost-effectiveness of different rates of taxation increases in order to achieve respectively: 44%, 75% and 89% of the final retail price of tobacco products. Based solely on health considerations, the higher the rate of taxation, the better.

To attain even greater improvements, the combination of taxation, legislation and information is affordable and very cost-effective in the different mortality strata of the European Region. Adding NRT interventions certainly increases the cost of smoking cessation policies but improves effectiveness as well. The additional expense is justified on purely cost-effectiveness grounds (7).

All these figures emphasize that smoking cessation policies and interventions are cost-effective and that it will save health systems considerable expenditure by avoiding some of the costs of treating lung cancer and heart disease and other smoking-related diseases in the future. Experience suggests that cost-effectiveness arguments, as well as evidence of effectiveness, are essential in persuading governments to allocate funding for smoking cessation policies and interventions.

4

Setting priorities in smoking cessation policy according to different tobacco control approaches

The Framework Convention on Tobacco Control contains specific obligations concerning tobacco dependence and cessation. It imposes the parties to this Convention to endeavour to:

- a) 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;
- b) 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;
- c) establish in health care facilities and rehabilitation centres programmes for diagnosing, counselling, preventing and treating tobacco dependence; and
- d) 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.

The European Strategy for Tobacco Control has categorized the tobacco control approaches of Member States according to their comprehensiveness, sustainability, progressiveness, length and history of implementation and impact on reducing smoking prevalence. To significantly reduce the prevalence of tobacco use in all population groups, most countries are urged to go beyond their current approach to tobacco control: countries that have adopted approaches generally considered to weakly influence reducing tobacco use should be encouraged to adopt the more effective transitional approaches. Those currently in the transition phase should adopt the stronger approaches that have generally proved to reduce tobacco use, and countries already advanced in tobacco control should sustain and reinforce their efforts.

Broadly speaking, however, in order to motivate smokers to stop, countries in the transition phase need to develop or strengthen a broad tobacco control programme with population approaches (including taxation, restrictions on smoking in public places and information and education campaigns) before they develop comprehensive services to treat tobacco dependence. When treatment services are developed, they must be backed up by mass media advertising campaigns that push smokers towards the help they may receive from the services.

COUNTRIES IN THE INITIAL AND TRANSITIONAL PHASES OF TOBACCO CONTROL POLICY

For countries in the initial and transitional phases of tobacco control policy, governments should consider increasing taxation and banning advertising as their first priority. These policies are relatively inexpensive to implement and indicate government commitment to tobacco control. Such policies also help emphasize the seriousness of the health effects for the general public.

For cessation, countries should begin with educational campaigns and community-level projects to raise awareness about the risks of smoking. Until this is done, smokers will probably have little demand for help in stopping. Unpaid media and advocacy techniques can be used in addition to paid advertising, when resources permit this. These will help inform the public about the dangers of smoking and can act

as an umbrella for other cessation activities such as telephone help-lines and Quit and Win competitions.

An early priority should also be educating medical and other health professionals who will probably lead the tobacco control campaign, or at least initiate it. This can be done through professional bodies such as medical associations. Curricula for health professionals should include smoking and smoking cessation, and health professionals who smoke should be offered support in stopping. Physicians are highly credible and trusted in many countries, and having them lead by example in not smoking is especially important. Related to this is the issue of smoking among health professionals, the prevalence of which is very high in many countries. In the mid-1990s, 35% of general practitioners in the European Union were smokers (26). Health professionals should be educated about the risks of smoking, encouraged and helped to stop with appropriate guidelines (27), probably through their professional organizations, although this may vary from country to country. They should also be encouraged to ask about smoking at least once a year and to advise smokers to stop. Health care establishments should also be smoke free: this should be a priority, although implementation can be difficult. Mobilizing nongovernmental organizations (NGOs) is also important (see below). Arguing and presenting the evidence that smoking is an addiction (11, 12) is likely to be important in engaging health professionals at the early stages of cessation policy. It will help health professionals and the public to understand that treatment should be routinely offered to smokers and that smokers are not weak-willed in seeking treatment to help them stop. In some countries, comparing nicotine addiction with addiction to other drugs may help, as many countries offer treatment through their health care systems to people with alcohol problems and those addicted to “illicit” drugs.

COUNTRIES HAVING OR DEVELOPING COMPREHENSIVE TOBACCO CONTROL PROGRAMMES

In these countries, as smokers become more motivated to stop, being able to offer them support in doing so is important. Several different cessation interventions can be employed depending on resources and expertise in the country.

Encouraging and training primary care professionals to intervene. Health professionals should be strongly encouraged and motivated to

ask about smoking at every possible opportunity and to advise smokers to stop.

Making pharmaceuticals easily accessible. NRT approximately doubles the chances of succeeding and should be made available to smokers. NRT is safe and offers a safer form of nicotine delivery for smokers. For this reason NRT should be at least as widely available as cigarettes. In addition, however, countries might want to consider subsidizing the cost of pharmaceuticals using public funds. This has been done in countries where smoking is becoming more concentrated in lower-income groups, such as the United Kingdom, although targeting these services to poorer smokers is a challenge for any country. This is another area where further research on cost-effectiveness is needed in low- and middle-income countries. Engaging the regulators in this debate is important, and encouraging them to make NRT as widely accessible as possible should be a priority.

Setting up specialist services. Specialist services are important to give the intensive support that more dependent smokers need to be able to stop. These services are managed and the interventions delivered by dedicated staff paid to do this work as their employment. The availability of specialist services also means that those offering routine advice have someone to whom they can refer smokers who need more help in stopping. This can be especially useful for busy primary care professionals, who can find it difficult to find the time to give extended support. Intensive specialist services can also act as centres of excellence investing in research and providing training.

Offering telephone help-lines. Telephone help-lines (28) can be started relatively simply and inexpensively, but as demand increases, a professional service is needed, which increases costs.

Running Quit and Win competitions. These community-wide smoking cessation contests or population-wide strategies can be relatively inexpensive to initiate and vary according to the recruitment strategy used. Quit and Win is supported by WHO and has several international partners (29).

Ensuring that training is available and follows the best evidence base. Some industrialized countries are focusing resources on this

area, such as the United Kingdom. Other countries can learn from their experience and develop an evidence-based training framework (30).

Developing research. Each country probably does not need to replicate studies showing the impact of smoking on certain diseases (although this need may vary from country to country) or that intensive support will increase success rates. However, research into new treatment options for tobacco dependence and addiction and how to make support accessible and attractive to smokers, especially women and young people, remains a priority in many cases. More research is also needed on the cost-effectiveness of providing free treatment (such as intensive support and NRT) to poorer smokers.

Embedding treatment for nicotine dependence in the national health system. This should be part of a national cessation policy with dedicated funding for services and all health professionals routinely asking about smoking.

These suggested priorities should not be applied rigidly, and each country should assess its tobacco control programme and introduce measures in accordance with that assessment.

THE UNITED KINGDOM AS A CASE STUDY

Historically, in the United Kingdom, support for smokers in quitting started before national health education campaigns but never became part of the health care system until years of educational campaigns had raised awareness of the issues and a group of experts produced evidence-based cessation guidelines (22,31) that were strongly supported by the professions. The educational campaigns only started after years of active campaigning by the medical profession (especially the Royal College of Physicians). So the (simplified) sequence was:

- publication of the original work on smoking and lung cancer (1950s);
- Opening of the first smokers' clinic (1956);
- Publication of the first Royal College of Physicians report in 1962 (32);

- creation of ASH (Action on Smoking and Health) by the Royal College of Physicians (1971);
- publication of research showing the effect of brief advice by general practitioners (1979);
- the British Medical Association joined the tobacco control movement (1984);
- acceptance by government of price increases through taxation as a health measure (early 1990s);
- development by government of an official tobacco control policy (1998);
- publication of professionally endorsed evidence-based treatment guidelines (1998);
- development by government of an official policy on the treatment of dependent smokers (1998);
- implementation and funding by government of a national treatment service for dependent smokers (2000); and
- a comprehensive ban on advertising (2003).

Building capacity for smoking cessation policy

PEOPLE AND ORGANIZATIONS: DEVELOPING THE HUMAN RESOURCES

Based on the experience of countries that have long established and well developed capacity in smoking cessation, the following groups of people and organizations are important in getting cessation onto the political agenda (this is not an exhaustive list and there will be local variation).

Leadership. Leadership is absolutely critical, although it can come from coalitions of committed organizations. In many countries leadership has come from government organizations and in some cases from the medical profession, NGOs, research centres and individuals. Leadership is vital and should preferably be exercised, first of all, by the health ministry.

Scientists. The publication of authoritative research can influence policy-makers; research by itself is not enough, however, and people and organizations need to communicate it and argue its implications for policy. Although it would probably help if individual countries published their own research, it is probably not critical, and resources such as GLOBALink make it easy to capitalize on research from other countries and to develop publicity from it in your own country. Local work in cost-effectiveness is important, and outside support could help develop skills (for example, training economists) and research.

Centres of excellence. Establishing well-resourced centres, such as addiction research centres or smoking cessation research centres or

teams, can help if the resources are available. This probably requires one interested and committed individual to initiate it.

Physicians and other health professionals. Health professionals are crucial in doing the research or sponsoring it, in communicating the results and in lobbying policy-makers, including politicians.

Professional organizations. Professional bodies have a critical role in educating and supporting health professionals as well as in advocacy.

NGOs, quasi-governmental organizations and media. A radical, preferably independently funded campaigning body can be extremely effective, not only in raising the issue, but in advocating advanced measures.

Governments. The political will of the government is critical. Governments may allocate and sustain a significant part of fiscal revenues, included those from tobacco taxes, to increase, stimulate and support the capacity of national and local smoking cessation programmes. The health ministry should establish a surveillance and evaluation system to monitor the achievements of the programmes and to control financial accountability.

DEVELOPING CONTENT: WHAT CAN BE DONE (AND BY WHOM)?

A tobacco control programme and getting smoking cessation onto the agenda require a wide range of activities. Without being prescriptive, the following are likely to play an important role, with likely or possible advocates and actors in parentheses:

- national mass media health education campaigns (government and public health associations);
- community-based campaigns, including Quit and Win-type contests (local governments and NGOs, led by the health service locally and other community organizations);
- advocacy and unpaid media (NGOs and health professional bodies);
- workplace cessation policies and treatment (companies and organizations);

- smoke-free public places (government and NGOs);
- smoke-free health care premises (government, health administration and professionals);
- written self-help resources for smokers (government, health professionals and private enterprise);
- telephone help-lines (government and NGOs);
- intensive specialist support services that can also help to encourage, facilitate and support routine opportunistic advice by health professionals (interested health professionals, health authorities and governments); and
- training materials (government, local health services and private enterprise).

TRAINING CAPACITY

To develop a smoking cessation treatment service, it will be necessary to train specialist smoking cessation counsellors to deliver support to primary care and other health professionals to raise the issue of smoking, assess interest in stopping and then give brief advice and/or refer to specialist treatment. The skills involved (as opposed to country-specific information, including about treatment systems) are universal, so that countries with well developed treatment systems may be able to help in developing training capacity in other countries. Basic standards should be set for training within each country and adequate training capacity should be ensured before developing the services. The US Public Health Service (33) suggested that lectures, seminars and in-service training should be offered on a regular basis with continuing medical education and/or other credits for tobacco dependence treatment.

Three factors were highlighted that would promote the training of clinicians in tobacco intervention activities:

- including education and training in tobacco dependence treatment in the required curricula of all clinical disciplines;
- including questions on effective tobacco dependence treatment in licensing and certification exams for all clinical disciplines; and

- getting specialty societies to adopt a uniform standard of competence in tobacco dependence treatment for all members (32).

The WHO Regional Office for Europe has produced a pack on smoking cessation for trainers; experienced trainers can adapt and use this in their own countries (30).

REACHING PRIORITY GROUPS

Many countries have a marked socioeconomic gradient in smoking prevalence, with higher levels among those on low incomes. The efficacy of smoking cessation programmes with more deprived smokers has been insufficiently researched, but the evidence-based smoking cessation services should be implemented flexibly to ensure that they are accessible to these smokers. Similarly, cessation interventions should be accessible to smokers of all ages and both genders.

MAKING SMOKING CESSATION POLICY MORE GENDER-SPECIFIC

Some evidence indicates that the same treatment benefits both men and women, although research suggests that some types of treatment are less efficacious in women than in men.

Pregnant women or women considering becoming pregnant may be especially receptive to tobacco dependence treatment. However, the rate of relapse in the postpartum period is important even when abstinence has been maintained for six months or more during pregnancy (34).

Smoking cessation policies need to be made more gender-sensitive. Further research is therefore required to increase the efficacy of tobacco dependence treatment among women, especially during pregnancy, and to prevent relapse.

INTEGRATING TREATMENT INTO THE HEALTH SYSTEM

Integrating treatment for tobacco dependence into the health system is likely to take time and repeated argument and persuasion of those

responsible for funding the system. Since health systems vary across the European Region, no one model can be proposed for how to get treatment integrated into the health system, but experience suggests that the cost-effectiveness arguments are crucial and will probably have to be repeated again and again until health service funders accept them. Most health systems are oriented towards treatment rather than prevention, and the importance and benefits of supporting smokers in stopping smoking in all areas of the health system will need to be emphasized. In any system with limited funds and competing priorities, this will probably take years. It will also depend crucially on government commitment – for funding and for developing the mechanisms to ensure integration. The United Kingdom offers a good example of the process of integration or mainstreaming (35).

REGULATION

Regulation is extremely important in making cessation treatment, including the pharmacotherapies, as accessible as possible to smokers. This should be at least as accessible as the currently most dangerous forms of nicotine delivery devices – cigarettes.

However, the framework in which pharmacotherapies – particularly NRT – are regulated does not currently adequately consider the risks and benefits of NRT use in situations in which its use is qualified, restricted or contraindicated. The regulatory framework considers the risks of the medication but not the risks of failure to stop smoking (36,37). Regulatory bodies need to be made aware that use of NRT by a smoker can improve the chances that they will stop smoking and will greatly reduce or eliminate many smoking-related risks.

UNDERPINNING RESEARCH

Not all countries have the capacity or money to do much research, but utilizing research from other countries, where feasible, is important. In some countries, research on cost-effectiveness may have been the critical factor in persuading government of the value of smoking cessation. Among other things, researchers established that nicotine is addictive, which has had huge implications for the treatment of dependent tobacco users, and showed why education and population approaches do not achieve widespread cessation in many users. Opinion polls can be very useful in ascertaining whether people

appreciate the health consequences of smoking, benefits of quitting, whether smokers want to stop, or are offered advice routinely, etc.

OPPORTUNITIES AND CHALLENGES

The health systems in most countries contain the raw materials needed – the people who usually start raising the issue but often need support from the global community to get started. There is substantial international evidence and research that health professionals in different countries can use to encourage smokers to stop. The principal challenge is for the global smoking cessation community to give them this initial support. Funding is also an issue for NGOs and others (addressed later).

Many countries in the European Region have very limited resources for tobacco control, and getting the development of cessation activities on the agenda is a struggle. The key challenge is to mobilize the partners within and outside these countries that can help support the development of cessation policy.

Ultimately, through cost-effectiveness arguments, governments should be able to give priority to funding through their own budgets. One way of achieving this is to earmark or dedicate a percentage of revenue obtained by taxing cigarettes to provide support to smokers wanting to stop.

Another challenge is engaging the regulators in debates about the accessibility of pharmaceutical treatment.

6

Evaluation of smoking cessation policy

Evaluating the provision of treatment interventions is important, as it provides evidence for the further investment of resources in cessation. Population surveys are important for establishing a baseline against which change can be measured. These can be quite costly with random samples, but if resources are tight, regular opinion polls can be conducted relatively inexpensively, especially by adding questions onto an existing survey framework.

Surveys should assess knowledge of the health effects of smoking and perception of risk, the motivation of smokers to quit, how frequently smokers attempt to stop and what methods smokers use when attempting to stop. At a later stage, physiological measures such as cotinine collection can be added to establish the prevalence of dependence in the population.

These national surveys can also help to evaluate national policies such as increasing the availability of pharmaceutical treatment. Those offering intensive support should follow up smokers for at least three months, but preferably one year, to assess whether they remain abstinent.

Those managing smoking cessation services should also monitor their effectiveness. Standards have been suggested for evaluating methods of quitting smoking (38). Ideally, this should involve assessing the proportion of people who begin treatment and who are still not smoking either six months or one year later, with people dropping out of treatment or who cannot be traced being counted as smokers. Preferably, short-term assessments such as end-of-course follow-up

should not be used. Biochemical measures such as hand-held carbon monoxide monitors should be used to verify all self-reported claims of abstinence (39).

Monitoring the national implementation of smoking cessation interventions is important. For brief advice, this could be done by surveying smokers, as outlined previously, or by auditing smoking cessation activity of health professionals. The US Public Health Service (33) recommended that data from chart audits, electronic medical records, and computerized patient databases could be examined to evaluate the degree to which clinicians were identifying, documenting and treating patients who used tobacco. They also recommended that feedback be provided to clinicians about their performance. They also suggested that tobacco dependence interventions could be included in the job descriptions and performance evaluations of salaried clinicians and specialists.

The implementation of smoking cessation services could be evaluated using several indicators, such as:

- the number of specialist services available;
- the geographical or demographic coverage of service delivery;
- the proportion of services evaluating their effectiveness;
- the number of trained smoking cessation specialists; and
- the budget dedicated to providing smoking cessation services.

International collaboration and the role of WHO

In 1999, the WHO European Partnership Project to Reduce Tobacco Dependence (1999–2002) was launched with the objective of reducing tobacco-related death and disease among tobacco-dependent smokers. The partners in the project included government and NGOs at the international, European and country levels, representatives of professional and scientific organizations, independent advisers and the pharmaceutical sector. Over the three years, the project produced several tools to improve the treatment of tobacco dependence, including: WHO-recommended questions and survey methods for tracking smokers' intentions to change; WHO European best practice recommendations and guidelines on the regulation of treatment products for tobacco dependence (36); an analysis of the existing regulation of tobacco products in Europe; WHO European recommendations on implementing a smoke-free policy at the workplace (40,41); WHO European recommendations on the treatment of tobacco dependence (4) and a WHO *Helping smokers change* trainers' pack (30).

WHO established the Scientific Advisory Committee on Tobacco Product Regulation in March 2000, to facilitate access to scientific information and to guide international policy development on the regulation of tobacco products (42). Among its functions, the Committee monitors and makes recommendations on products for treating tobacco dependence.

The European Strategy for Tobacco Control, adopted by the WHO Regional Committee for Europe in 2002, provides a strategic framework for action in the Region, to be carried out through national

policies and international cooperation. In particular, the Strategy outlines the action needed in the field of smoking cessation, emphasizing the need for sufficient funding and affordability of treatment for low-income smokers.

Several Regional Office programmes, in addition to Tobacco-free Europe, contribute to supporting international cooperation in the area of smoking cessation policies and interventions:

- the countrywide integrated noncommunicable disease intervention (CINDI) programme;
- the WHO Healthy Cities project;
- the European Network of Health Promoting Schools;
- the WHO Health Promoting Hospitals project; and
- the EuroPharm Forum.

WHO will continue to provide guidance and support to Member States in strengthening their policies, particularly by facilitating and coordinating the development of tools and mechanisms to support international cooperation on smoking cessation policies and interventions. Specific international actions, mechanisms, and tools include:

- facilitating the regular exchange of information and documentation on the technical, policy and legal implications of smoking cessation policies and interventions;
- promoting research on the effects of the different interventions on use and quitting rates, especially over long periods of time and among young people, women and groups with lower socioeconomic status;
- promoting best practice and coordinated action, to provide internationally standardized training and to develop evidence-based recommendations for the European Region, particularly for women, young people and groups with lower socioeconomic status; and
- developing a European monitoring system, including standardized tools for surveillance of the use, determinants and impact of tobacco dependence treatment.

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ADDITIONAL RESOURCES

The WHO/SRNT database www.treatobacco.net summarizes evidence on the effectiveness, safety, economics, policy and demographics of tobacco dependence treatment. The database has an independent editorial board and peer review of its contents, draws on authoritative sources including the cessation guidelines of the United States, United Kingdom and WHO Europe, the Cochrane reviews and other key sources.

The WHO Regional Office's Tobacco control database presents information on different issues relevant to smoking cessation for the countries of the WHO European Region. (<http://cisid.who.dk/tobacco/Consolidated/TCP16.asp?TS=16&PY=2001>).

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Finally, the following Web sites can be useful:

GLOBALink tobacco control network (<http://www.globalink.org>)

Action on Smoking and Health UK (<http://www.ash.org.uk>)

Tobacco control on-line (<http://www.tobaccocontrol.com>)

British medical journal on-line (<http://www.bmj.com>)

Society for Research on Nicotine and Tobacco (<http://www.srnt.org>)

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