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
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

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**Policy Recommendations for Smoking Cessation and Treatment of Tobacco Dependence**

**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: Bhumiswasd 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.
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.

References


Lando HA (2002). Future research needs and capacity building. Presentation at the WHO meeting on Global Policy for Smoking Cessation hosted by the Ministry of Health of the Russian Federation, Moscow, 14-15 June 2002.


