



**FCTC**

WHO FRAMEWORK CONVENTION  
ON TOBACCO CONTROL

S E C R E T A R I A T

# **Good country practices in the implementation of WHO FCTC Article 14 and its guidelines**

**Report commissioned by the Secretariat  
of the WHO FCTC and the Protocol**

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The pictures included in this report were submitted to the Secretariat by the respective countries' focal points that drafted the country case studies.

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# Contents

## Acknowledgements

## Abbreviations

## Introduction

## Country case studies

### Framework

-  Uruguay: mainstreaming tobacco cessation in national health priorities
-  Azerbaijan: legislative framework for tobacco cessation
-  Mexico: developing evidence-based guidelines for tobacco cessation

### Cessation infrastructure

-  Panama: integrating tobacco cessation into the public health system
-  Myanmar: training of health workers in tobacco cessation
-  Saudi Arabia: building infrastructure for tobacco cessation
-  Ireland: tobacco cessation for vulnerable groups

### Resources

-  France: public financing and infrastructure for tobacco cessation
-  Malaysia: innovative cessation promotion through public–private partnerships
-  Colombia: international cooperation for training health professionals in cessation

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## Abbreviations

BHS	basic health staff
COP	Conference of Parties of the WHO FCTC
GATS	Global Adult Tobacco Survey
GYTS	Global Youth Tobacco Survey
HSE	Health Services Executive
NCD	noncommunicable disease
NGO	nongovernmental organization
NRT	nicotine replacement therapy
PAHO	Pan American Health Organization
PHRC	Public Health and Reforms Center
RHC	Rural Health Centre
Secretariat	Secretariat of the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products
STEPS	WHO STEPwise approach to Surveillance
TFC	Tobacco Free Campus
WHO FCTC	World Health Organization Framework Convention on Tobacco Control
WNTD	World No Tobacco Day

## Introduction

Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC) stipulates obligations of Parties concerning tobacco dependence and cessation. The Secretariat of the WHO Framework Convention on Tobacco Control and the Protocol to Eliminate Illicit Trade in Tobacco Products (hereinafter called as “the Secretariat”) established a Knowledge Hub on International Cooperation in Montevideo, Uruguay, that works to promote implementation of this article by the Parties, among other cooperation activities.

The *2018 Global progress report on implementation of the WHO Framework Convention on Tobacco Control*<sup>1</sup> indicates a 51% average implementation rate of this Article among the 142 Parties to the WHO FCTC that reported in this reporting cycle – a 21% relative increase over 2016 reports submission. The Parties’ reports on their progress in implementation indicate several innovative practices in the implementation of Article 14 and its guidelines.

A key stated purpose of the *Guidelines for implementation of Article 14*<sup>2</sup> is for Parties to share their experiences to inform tobacco cessation and dependence treatment. In line with this objective, in 2018 the Secretariat commissioned this report, entitled “*Good country practices in the implementation of WHO FCTC Article 14 and its guidelines*”.

### Guidelines for implementation of Article 14

#### Purpose

“(iii) urge Parties to share experiences and collaborate in order to facilitate the development or strengthening of support for tobacco cessation and tobacco dependence treatment.”

## Objectives of the report

This report has the following objectives:

- to inform the implementation of Article 14 through documenting and disseminating good country practices;
- to identify good practices in population-based and individual approaches to tobacco cessation;
- to strengthen the work of the Secretariat’s Knowledge Hub on International Cooperation in promoting tobacco cessation.

## Article 14 of the WHO FCTC and its guidelines for implementation

WHO FCTC Article 14 pertains to demand reduction measures concerning tobacco dependence and cessation. It requires Parties to develop evidence-based guidelines, and promote cessation and tobacco dependence treatment. The Article lays emphasis on cessation at specific locations, on integrating cessation in national health plans and programmes, and on collaboration to facilitate tobacco dependence treatment in an accessible and affordable manner.

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<sup>1</sup> 2018 Global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2018 ([https://www.who.int/fctc/reporting/WHO-FCTC-2018\\_global\\_progress\\_report.pdf](https://www.who.int/fctc/reporting/WHO-FCTC-2018_global_progress_report.pdf), accessed 26 August 2019).

<sup>2</sup> Guidelines for implementation of Article 14. Demand reduction measures concerning tobacco dependence and cessation. Geneva: World Health Organization; 2010 ([https://www.who.int/fctc/treaty\\_instruments/adopted/Guidelines\\_Article\\_14\\_English.pdf](https://www.who.int/fctc/treaty_instruments/adopted/Guidelines_Article_14_English.pdf), accessed 26 August 2019).

The *Guidelines for implementation of Article 14* provide detailed recommendations for developing an infrastructure to support tobacco cessation and dependence treatment. They also elaborate key components of a system to help tobacco users quit.

### Methodology

The Secretariat commissioned an expert consultant with experience in WHO FCTC implementation and documentation to develop the report. The WHO FCTC implementation database constituted the key source of information for the report. Parties’ reports from the 2018 reporting cycle on their progress in the implementation of the WHO FCTC were perused to identify 10 countries with evidence-based and innovative practices in the implementation of Article 14 and its guidelines. Efforts were made to include countries from different regions and diverse tobacco use patterns. Attention was given to include a broad range of experiences in implementing the diverse provisions of Article 14 and its guidelines.

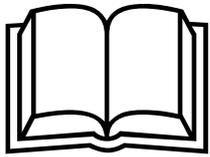
The consultant approached the WHO FCTC Focal Points of the identified Parties to verify and supplement information in their WHO FCTC reports. The tobacco control teams of Parties provided additional information through interviews or in writing during June–July 2018. Based on the information in the Party reports and inputs from the country teams, the consultant developed the country case studies. The report was finalized with the country teams and the Secretariat.

### The report

The report presents 10 case studies of good country practices in the implementation of Article 14, including building policy and programmatic frameworks for tobacco cessation and developing treatment guidelines, equipping the health workforce for service delivery, fine tuning programmes for vulnerable groups, resourcing tobacco cessation services and leveraging international cooperation for tobacco cessation (see Fig. 1). The case studies will inform Parties in their initiatives to build frameworks, infrastructure and resources in the implementation of Article 14 and its guidelines.



Fig. 1: Structure of the report



# **Country case studies**

# Framework

## Uruguay: mainstreaming tobacco cessation in national health priorities

### Background

Uruguay's National Drugs Board (Junta Nacional de Drogas) estimated that nearly a third of the country's adult population uses tobacco, with the prevalence being higher among men than women. Among younger people (13–17 years old), the prevalence of tobacco use was 30.2% in 2003. Notably, the prevalence among girls was higher than among boys for this age group. Uruguay set up its first smoking cessation service at a general hospital in Montevideo in 1998. Since 1999, the Honorary Commission for the Fight against Cancer and, from 2004, the National Resources Fund (Fondo Nacional de Recursos) have conducted annual training courses for health professionals.

#### Article 14 of the WHO FCTC

Para 2(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...”

The movement to advance tobacco control policies and Uruguay's WHO FCTC ratification gained momentum in early 2000. As the country ratified the WHO FCTC in 2004, the National Resources Fund began resourcing the establishment of a network of cessation services across the country and tobacco dependence treatment for its citizens. The Ministry of Public Health also set up the Tobacco Control Advisory Commission, comprising governmental institutions and nongovernmental organizations (NGOs), to advise on treaty implementation.

In 2008, Uruguay enacted comprehensive tobacco control legislation requiring 100% smoke-free environments, health warnings on tobacco packs, prohibition of tobacco advertising and promotion, and provision of tobacco dependence treatment. These measures acted in a synergistic manner prompting smokers to quit tobacco use. The resultant increase in demand for cessation services called for increased accessibility of tobacco dependence treatment and a standardized approach in delivery across service providers.

### Prioritizing cessation in national health objectives

In 2009, Uruguay developed the *Clinical guide to address tobacco smoking* (Guía Nacional para el Abordaje del Tabaquismo)<sup>3</sup> with inputs from health professionals and cessation experts across the country, to guide health professionals in tobacco cessation.

The adoption of the Article 14 guidelines at the 4th session of the Conference of Parties (COP) in Punta del Este, Uruguay in 2010, provided valuable guidance to the country in advancing action on cessation. In 2014, the Ministry of Public Health approved the National Tobacco Cessation Strategy to promote quitting.

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<sup>3</sup> Guía Nacional para el Abordaje del Tabaquismo. Uruguay: Ministerio de Salud Pública; 2009 (<http://www.treatotobacco.net/en/uploads/documents/Treatment%20Guidelines/Uruguay%20treatment%20guidelines%20in%20Spanish%202009.pdf>, accessed 26 August 2019).

As required by Article 14, Uruguay's tobacco control law had also specifically stipulated the

**Box 1. National tobacco control law – Article 10**

“Public *and* private health services shall incorporate the diagnosis and treatment of tobacco dependence into their national primary health care programs, plans and strategies...”.

inclusion of tobacco dependence treatment in national health plans and strategies. The development of the National Health Objectives 2020 (Objetivos Sanitarios Nacionales 2020)<sup>4</sup> presented a unique opportunity for the inclusion of tobacco control specific targets in the national health framework. This document sought to identify and address major problems facing the country with a view to improving population health.

The Advisory Commission for Tobacco Control of the Ministry of Public Health advanced recommendations to promote tobacco control measures, including cessation, through this framework. The National Health Objectives 2020, therefore, included a target of reducing smoking prevalence by 20% by 2020.

### **National Health Objectives 2020 cessation stipulations**

The National Health Objectives 2020 mandates public and private health service providers to offer tobacco dependence treatment to all tobacco users. It further stipulates that the treatment should follow the recommendations of the national clinical guidelines. Tobacco users are to be given brief quitting advice, treatment or referral services. The service providers are to register the smoking status of clients/patients and maintain the records.

### **Outcomes**

The obligation of service providers to give treatment, coupled with the existence of a wide network of service providers at the national level, increased the accessibility and affordability of cessation treatments. From 2017, compliance with this requirement has been monitored.

The first National Noncommunicable Diseases (NCDs) Risk Factors Survey<sup>5</sup>, using the STEPwise approach to Surveillance (STEPS), conducted in 2006, showed a smoking prevalence of 32.7% in the population aged 25–64 years. In 2009, the Global Adult Tobacco Survey (GATS)<sup>6</sup> reported a prevalence of 25% in the same population – a relative decline of 23.6% between 2006 and 2009. Since then, Uruguay's National Institute of Statistics has introduced three tobacco-related questions from the GATS in its regular household survey (Encuesta Continua de Hogares). These surveys show a continuing decline in adult smoking prevalence since 2009. A similar trend is observed in youth smoking prevalence as measured

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<sup>4</sup> Objetivos Sanitarios Nacionales 2020. Uruguay: Ministerio de Salud; 2015 ([https://www.paho.org/uru/index.php?option=com\\_docman&view=download&alias=475-osn-librillo-objetivos-nacionales&category\\_slug=publicaciones&Itemid=307](https://www.paho.org/uru/index.php?option=com_docman&view=download&alias=475-osn-librillo-objetivos-nacionales&category_slug=publicaciones&Itemid=307), accessed 26 August 2019).

<sup>5</sup> 1ª Encuesta Nacional de Factores de Riesgo de Enfermedades Crónicas No Transmisibles. Uruguay: Ministerio de Salud Pública; 2009. (<https://www.gub.uy/ministerio-salud-publica/comunicacion/publicaciones/primera-encuesta-nacional-de-factores-de-riesgo-de-enfermedades-cronicas>, accessed 26 August 2019).

<sup>6</sup> Global Adult Tobacco Survey (GATS) 2009. Uruguay; 2010. ([https://www.who.int/tobacco/surveillance/fact\\_sheet\\_of\\_gats\\_uruguay\\_2010.pdf](https://www.who.int/tobacco/surveillance/fact_sheet_of_gats_uruguay_2010.pdf), accessed 26 August 2019).

by the National Survey of Drug Use in Secondary Students (Encuesta Nacional de Consumo de Drogas en Estudiantes de Enseñanza Media)<sup>7</sup>, conducted by the National Drugs Board in the population aged 13–17 years (see Table 1). These results indicate the impact of Uruguay’s comprehensive tobacco control programme, which includes cessation support.

**Table 1. Youth smoking prevalence Uruguay, 2003–2014**

Year	Prevalence 30 days
2003	30.2%
2005	24.8%
2007	22.0%
2009	18.4%
2011	13.1%
2014	9.2%

*Source:* National Survey of Drug Use in Secondary Students, 2003–2014

### Challenges and mitigating strategies

A lack of funding has constrained the professionals trained in tobacco cessation from actively working on the issue. Uruguay’s National Integrated Health System, financed by the National Health Fund, pays health service providers for their services. These payments are increased based on the performance of the health settings on certain predetermined targets. One such target is cessation training for the entire health team, comprising medical and non-medical staff. Another being cessation promotion among the population covered by the setting.

It has often been a challenge to motivate the teams at health settings to promote cessation among their visitors. The Ministry of Public Health has developed three videos on the basics of cessation to sensitize and support health workers in promoting cessation.

The non-availability of nicotine replacement therapy (NRT) in patches continues to be a challenge to Uruguay’s cessation efforts. Currently it is being supplied only as chewing gum.

### Future plans

In addressing the gaps in cessation services, Uruguay intends to further:

- promote cessation intervention by all health-care professionals
- update the national clinical guidelines to address smoking
- strengthen monitoring of the cessation programmes for improved compliance.

<sup>7</sup> VI Encuesta nacional sobre consumo de drogas en estudiantes de enseñanza media 2014. Uruguay: Observatorio Uruguayo de Drogas, Junta Nacional de Drogas; 2016. ([https://www.gub.uy/junta-nacional-drogas/sites/junta-nacional-drogas/files/2018-01/VI\\_Encuesta\\_Nacional\\_Consumo\\_Drogas\\_Estudiantes\\_Ense%C3%B1anza\\_Media.pdf](https://www.gub.uy/junta-nacional-drogas/sites/junta-nacional-drogas/files/2018-01/VI_Encuesta_Nacional_Consumo_Drogas_Estudiantes_Ense%C3%B1anza_Media.pdf), accessed 26 August 2019).

# Azerbaijan: legislative framework for tobacco cessation

## Background

In line with the underlying consideration of Article 14 and its guidelines for a synergistic tobacco control programme, Azerbaijan integrated its tobacco cessation efforts with the rest of the measures in its national tobacco control legislation.

The smoking-related surveys conducted by the Public Health and Reforms Center (PHRC) of the Ministry of Health informed the legislative process. The 2016 Global Youth Tobacco Survey (GYTS)<sup>8</sup> revealed that 10% of the country's students aged 13–15 years have ever smoked cigarettes, while almost 30% were exposed to other's smoke at home and 40% in public places. Almost 7 in 10 current youth smokers had tried to stop smoking in the 12 months prior to the survey. About 70% of them thought they would be able to stop if they wanted. However, only 26% ever received help/advice from a programme or professional to quit smoking.

Meanwhile, the second National Survey on Risk Factors for Chronic NCDs in 2017 showed an adult smoking prevalence of 24%, with the prevalence significantly higher for men (48.8%) than women (0.2%). The exposure to second-hand smoke for men was found to be highest at workplaces (28.4%), while for women it was in their homes (23.3%). Nearly half of the male smokers had tried to stop smoking during the previous year. However, only 31.2% of those who attempted to quit had visited a doctor or health worker for smoking cessation in that period.

The significant smoking rates among men and young people, the high quit attempts and the evident gaps in cessation support, pointed to the need for a comprehensive approach combining legislation and individualized interventions to reduce smoking among adults and youth. Therefore, Azerbaijan decided to amend its tobacco control law and to regulate indirect tobacco advertising and promotion, ban smoking in public places, prohibit tobacco sales to youth under 18 years, incorporate effective health warnings on tobacco packs, and provide services for tobacco dependence treatment.

### Guidelines for implementation of Article 14

#### Underlying considerations

Para 8. **“It is important to implement tobacco dependence treatment measures synergistically with other tobacco control measures.** The promotion of tobacco cessation and treatment of tobacco dependence are key components of a comprehensive, integrated tobacco control programme. Support for tobacco users in their cessation efforts and successful treatment of their tobacco dependence will reinforce other tobacco control policies, by increasing social support for them and increasing their acceptability. Implementing cessation and treatment measures in conjunction with population level interventions covered by other articles of the WHO FCTC, will have a synergistic effect and thus maximize their impact.”

<sup>8</sup> Global Youth Tobacco Survey (GYTS) 2016. Azerbaijan ([https://untobaccocontrol.org/impldb/wp-content/uploads/azerbaijan\\_2018\\_annex\\_1\\_GYTS\\_factsheet\\_2016.pdf](https://untobaccocontrol.org/impldb/wp-content/uploads/azerbaijan_2018_annex_1_GYTS_factsheet_2016.pdf), accessed 26 August 2019).

## Strategies for building public and political support for tobacco cessation in legislation

### Build team capacity

The National Tobacco Control Coalition (NTCC) of governmental and nongovernmental partners was formed in 2009 to steer advocacy for the national law. As the nodal centre for tobacco control activities in the country, the PHRC built its team capacity through tobacco control leadership training, a study visit to learn from Turkey's tobacco cessation clinics in 2010 and WHO Regional Office for Europe training on tobacco cessation for the Commonwealth of Independent States in the Russian Federation in 2016. In 2012, the PHRC developed the National Clinical Protocol on Smoking Cessation for its health professionals.

### Sensitize the public

The PHRC frequently uses the opportunity of World No Tobacco Day (WNTD) to sensitize various stakeholders and promote quitting. In 2012, a photo competition themed “Life without tobacco: make it your choice” was organized, and No Smoking Film Festivals were conducted



the next two years on WNTD. In 2015, a nationwide social media campaign “Make every day no tobacco day” was launched, along with an accompanying website and online selfie generator to attract youth. These helped to sensitize the public and politicians about the relevance of the law and tobacco cessation.

As the legislation was coming up for parliamentary discussion in 2017, a large cessation consultation desk and public opinion poll was set up at a popular public place to mobilize the public towards tobacco cessation. During the year's WNTD, they ran a special campaign in public places, “Apples instead of cigarettes”, encouraging people to quit.

“Apples instead of cigarettes” public campaign

### Leverage NCD momentum to advance tobacco cessation

In December 2015, the President of Azerbaijan signed the National Strategy for the Prevention and Control of Non-Communicable Diseases 2015–2020<sup>9</sup> and the associated Operational Plan. This brought added impetus to tobacco control efforts in the country. The PHRC developed the Operational Plan to implement the provisions of the national strategy, including tobacco control. An interministerial working group set up for the implementation of

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<sup>9</sup> Azerbaijan National Strategy for the Prevention and Control of Non-Communicable Diseases 2015–2020. ([https://extranet.who.int/ncdccs/Data/AZE\\_B3\\_NCD%20AZERBAIJAN%202015-2020.pdf](https://extranet.who.int/ncdccs/Data/AZE_B3_NCD%20AZERBAIJAN%202015-2020.pdf), accessed 26 August 2019).

the national strategy met the same year and made recommendations to the Cabinet for improving the law.

### **Conduct legislative analysis to identify gaps**

The PHRC's 2016 comparative analysis of Azerbaijan's legislation identified key provisions including tobacco cessation, to be included in amendments to the law for better compliance with WHO FCTC requirements. Tobacco cessation was among the areas identified for a legislative response to reduce tobacco use in the country.

### **Build the case through pilot intervention**

Meanwhile, the PHRC made a concrete case for tobacco cessation by organizing smoking "quit line" (telephone counselling) as a two-month pilot project and installing consultation cabins in its health facility for behavioural counselling. Following its wide promotion in the media, 38 women and 91 men dialled into the quit line during the pilot phase. Of these callers, 42 people visited the associated facility for counselling and 27 quit smoking. The consultation cabins also had information stands and video materials to sensitize the visitors.

### **Stakeholder advocacy**

The PHRC, the NTCC and a multisectoral technical advisory group undertook several activities combining local expertise with international experience to move the legislative process forward. They organized NCD working group meetings, held meetings with parliamentarians, and organized roundtables in the Parliament with representatives from relevant parliamentary committees, ministries and agencies. Separate roundtable discussions were held for representatives from academic institutions, the mass media and NGO to elucidate the benefits of the proposed amendments, in line with international experience and WHO FCTC obligations. Visible public activities were organized in three prominent public places involving stakeholders, public figures, NGOs, the media and the general public, to advocate and mobilize support for the law. Partner organizations participated in television debates and raised the issue in the media.

### **Sensitizing parliamentarians**

On WNTD 2010, the PHRC arranged a high-level roundtable discussion on tobacco control in the National Parliament. While parliamentarians were supportive of the proposed tobacco control law, there were concerns about the mechanisms required for its implementation. In response to these matters, parliamentarians visited Turkey and the Russian Federation to learn about their implementation mechanisms, which helped in strengthening the law through subsequent readings. The PHRC team lead addressed the Parliament and provided solutions to address its concerns.

### **Outcomes**

After three rounds of deliberations, the Parliament enacted the amended law No. 887-VQ on 1 December 2017. Presidential Decree No. 1774 of 29 December 2017 enforcing the new law requires other related legislative instruments to be brought in line with the new tobacco control law.



### Parliament discussing tobacco control law

The law stipulates a tobacco advertising, promotion and sponsorship ban, creation of smoke-free places and provision of support for smoking cessation. It also provides a legislative basis for protection of population health, including the promotion of healthy lifestyles, the reduction of the harmful effects of tobacco use and environmental tobacco smoke, and the provision of support for smokers to quit. Besides cigarettes, hookahs and electronic cigarettes also fall within the scope of this law.

#### **Box 2. Tobacco dependence treatment in Azerbaijan law**

Article 15 of the newly adopted Azerbaijan Law on Restriction of Tobacco Use provides that:

- appropriate medical care be given to people who approach medical facilities for quitting smoking, treatment of tobacco dependence, and treatment of diseases caused by tobacco;
- citizens receive free medical care to stop smoking, including prevention, diagnosis and treatment of tobacco dependence and tobacco use;
- health-care specialists provide patients with recommendations on cessation of tobacco use and information on medical services that may be available, regardless of the reason for visiting the health facility.

### Ongoing and future work

Other tobacco-related laws are currently being reviewed to bring them in line with the amended tobacco control legislation. Furthermore, the clinical protocol for tobacco dependence treatment has been distributed to all medical facilities to aid the provision of services at the local level.

# Mexico: developing evidence-based guidelines for tobacco cessation

## Background

Mexico's National Survey of Drugs, Alcohol and Tobacco Consumption (Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco, ENCODAT) 2016–2017<sup>10</sup> indicates that 17.6% of the population aged 12–65 years currently smokes, which translates to 14.9 million people. The survey also suggests that nearly three quarters of current male and female smokers are interested in quitting. However, only a quarter reported having received recommendations to quit smoking, while over half had tried to quit at least once in the previous year.

In response to this need, Mexico's tobacco control legislation specifically designated the Ministry of Health, among other things, to develop guidelines for early detection and cessation, and to organize services for those who wish to quit smoking.

### Guidelines for implementation of Article 14

#### Develop and disseminate comprehensive guidelines

Para 23. "Parties should develop and disseminate comprehensive tobacco dependence treatment guidelines based on the best available scientific evidence and best practices, taking into account national circumstances and priorities. These guidelines should include two major components: (1) a **national cessation strategy**, to promote tobacco cessation and provide tobacco dependence treatment...; and (2) **national treatment guidelines** aimed principally at those who will develop, manage and provide cessation support to tobacco users."

## Situation analysis to inform comprehensive cessation guidelines

In line with the recommendation of the *Guidelines for implementation of Article 14*, Mexico conducted a situation analysis of the existing cessation services. The Diagnostic Questionnaire for Cessation Services in Mexico was developed and then validated by the WHO Country Office in 2015. A broad range of agencies of relevance to cessation helped disseminate the survey and collect data from their collaborators. The collaborating agencies included the following: the General Hospital of Mexico (HGM), the School of Medicine of the National Autonomous University of Mexico (UNAM), the National Institute of Cancer (INCan), the National Institute of Respiratory Diseases (INER), the Secretariat of National Defence (SEDENA), the Institute for Social Security and Services for State Workers (ISSSTE), the Mexican Social Security Institute (IMSS), the National Polytechnic Institute (IPN), Petróleos Mexicanos (PEMEX), Stop Smoking Clinics in Querétaro and Sonora, the InterAmerican Heart Foundation Mexico (FIC), the National Alliance for Tobacco Control (ALIENTO) and the National Commission against Addictions (CONADIC). These agencies met to review the survey in October 2016.

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<sup>10</sup> Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco 2016-2017. Ciudad de México, México: Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz; Comisión Nacional contra las Adicciones; 2017 (<https://encuestas.insp.mx/ena/encodat2017.php>, accessed 26 August 2019).



The survey brought to light the broad health service infrastructure that was available to support tobacco cessation. However, it pointed to the need to equip the primary health care service to refer tobacco users who require treatment or intervention to a specialized treatment centre. The survey also recommended:

- strengthening timely detection and brief advice at the primary health care level;
- training primary health care staff in brief counselling for cessation;
- advising physicians on the prescription of specialized

pharmacotherapy as a complementary treatment for the cessation of tobacco use;

- standardizing cessation services for tobacco consumption;
- expanding the cessation services across the country.

The national NGOs organized a press conference to disseminate the results of the survey to the public through the media in February 2017. This created public support for the development of the tobacco cessation guidelines, public policies and training of medical staff in brief counselling and cessation.



Press conference in Mexico City

### **Box 3. Legislative framework for cessation support in Mexico**

Highlights of the General Law for Tobacco Control (Ley General para el Control del Tabaco)<sup>11</sup>

In Article 9, the law mandates the Ministry of Health to coordinate tobacco control activities; promote and organize early detection services, guidance and care for smokers who wish to quit consumption; investigate causes and consequences of tobacco use; promote healthy lifestyles in the family, community and at work; and develop deterrents to tobacco use, especially by children, adolescents and vulnerable groups.

In Article 10, sections I, II, III and VI, the law requires that the Secretariat of Health establish guidelines for the execution and evaluation of the Anti-Tobacco Programme, which will include: the promotion of health; diagnosis, prevention, treatment and rehabilitation for smoking-related conditions; education on the effects of smoking on health, aimed especially at the family, children and adolescents, through individual, collective or mass communication methods, including sensitizing the public to refrain from smoking inside the smoke-free spaces established by the law; and the design of advertising campaigns that promote cessation and reduce the likelihood of individuals starting the consumption of tobacco products.

## **Competency standards for primary health care services**

Building on the survey results, it was found necessary to develop a competency standard for primary health teams in providing brief advice for tobacco cessation. The standard was primarily intended to serve as a reference for the evaluation and certification of people who provide brief counselling for the cessation of alcohol and tobacco consumption. It was also anticipated to provide a reference for the development of training programmes for the health teams.

The Competency Standard EC 0897 was developed with inputs from medical and psychology experts, and social service institutes who regularly train and appraise primary health care teams. The brief intervention includes:

- an interview using a questionnaire tool to identify tobacco and alcohol users;
- advice on the consequences of alcohol and tobacco use;
- discussing ways to quit tobacco and alcohol use;
- sharing advantages of cessation;
- an evaluation.



**Evaluation of a psychologist on the competency standard**

<sup>11</sup> Ley General para el Control del Tabaco. México: Cámara de Diputados del H. Congreso de la Unión; 2010 ([http://www.conadic.salud.gob.mx/pdfs/ley\\_general\\_tabaco.pdf](http://www.conadic.salud.gob.mx/pdfs/ley_general_tabaco.pdf), accessed 26 August 2019).

The standard, intended for doctors, psychologists, nurses, dentists and health educators, among others, was published in the Official Gazette of the Federation (DOF) in July 2017.<sup>12</sup>

## **Tobacco cessation guidelines**

It was important to develop standardized protocols on cessation delivery that aligned with the provisions of the Official Mexican Standard NOM-028-SSA2-2009<sup>13</sup>. CONADIC set out to develop the *Guidelines for the operationalization of tobacco cessation services* (Lineamientos Nacionales para el Funcionamiento de los Servicios para la Cesación del Consumo de Tabaco)<sup>14</sup> with the aim of ensuring uniformity and quality in the health system's delivery of cessation services. To develop the guidelines, the agency organized extensive consultations drawing on the expertise of Youth Integration Centres, cessation experts, medical and psychology departments, social security institutes and all those involved in the situation analysis described earlier.

The guidelines detail validated modalities of care, the procedures for providing brief quitting advice, the protocols for administering tobacco dependence treatment and the requirements for cessation clinics. They also elaborate the criteria for confidentiality and monitoring, and specifications for alternative methods of quitting tobacco use.

The guidelines were launched and discussed at a meeting of key health agencies, civil society organizations, the media and the public in March 2017.



**Public event introducing national guidelines for cessation**

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<sup>12</sup> Estándar de Competencia: Proporcionar consejo breve para la cesación del consumo de alcohol y tabaco en el primer nivel de atención en salud. México: Conocer; 2017 ([http://www.conocer.gob.mx/contenido/publicaciones\\_dof/2017/EC0897.pdf](http://www.conocer.gob.mx/contenido/publicaciones_dof/2017/EC0897.pdf), accessed 26 August 2019).

<sup>13</sup> Norma Oficial Mexicana NOM-028-SSA2-2009, Para la prevención, tratamiento y control de las adicciones. México: Secretaría de Salud; 2009. ([http://www.conadic.salud.gob.mx/pdfs/norma\\_oficial\\_nom.pdf](http://www.conadic.salud.gob.mx/pdfs/norma_oficial_nom.pdf), accessed 26 August 2019).

<sup>14</sup> Lineamientos Nacionales para el Funcionamiento de los Servicios para la Cesación del Consumo de Tabaco. México: Secretaría de Salud, Comisión Nacional contra las Adicciones; 2016 ([https://www.gob.mx/cms/uploads/attachment/file/235016/Lineamientos\\_nacionales\\_para\\_el\\_funcionamiento\\_de\\_los\\_servicios\\_para\\_la\\_cesacion\\_del\\_consumo\\_de\\_tabaco.pdf](https://www.gob.mx/cms/uploads/attachment/file/235016/Lineamientos_nacionales_para_el_funcionamiento_de_los_servicios_para_la_cesacion_del_consumo_de_tabaco.pdf), accessed 26 August 2019).

# Cessation infrastructure

## Panama: integrating tobacco cessation into the public health system

### Background

In Panama, cardiovascular diseases and cancers are the most prevalent causes of tobacco-associated mortality.

In response, Panama's tobacco control legislation (Law 13 of 24 January 2008) required its public health authorities, comprising the Ministry of Health and the Social Security Fund, to offer tobacco dependence treatment. Both agencies therefore set out to establish tobacco cessation centres in the hospitals and other health facilities under their jurisdiction.

### Building on existing systems

Panama decided to utilize its existing public health infrastructure and human resources to offer cessation support. Accordingly, tobacco cessation centres were set up in the public health facilities of the Ministry of Health and Social Security Fund.

These centres have been integrated into the Mental Health Programme and operate in outpatient facilities, such as at health centres and Minsa Capsi<sup>15</sup> (primary care). They also operate out of polyclinics (secondary care) and public hospitals that are part of the Ministry of Health and the Social Security Fund health-care infrastructure (tertiary care).

### Equipping the mental health workforce

The multidisciplinary team in the mental health programme, comprising psychiatrists, clinical or general psychologists, mental health nurses and trained general practitioners, first receive tobacco cessation training. The invitations are sent to the director of the health programme in each health region in the country. The mental health teams at hospitals in the region are given the opportunity to volunteer to be part of the cessation programme in their health facilities. If

#### Guidelines for implementation of Article 14

##### Use existing systems and resources to ensure the greatest possible access to services

Para 34. "Parties should use existing infrastructure, in both health-care and other settings, to ensure that all tobacco users are identified and provided with at least brief advice."

Para 35. "Parties should use existing infrastructure to provide tobacco dependence treatment for people who want to stop using tobacco. Such treatment should be widely accessible, evidence based, and affordable."

Para 36. "Parties should consider using existing infrastructure that would provide the greatest possible access for tobacco users, including but not limited to primary health care and other services...."

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<sup>15</sup> Health centres with diagnostic facilities.

no one volunteers, the director of the facility identifies someone to join the initiative. The training includes inputs on tobacco addiction, available treatment options, dealing with patients and addressing resistance to quit. They also receive insights into pharmacological aspects of tobacco dependence treatment, such as adverse effects, indicators and contra-indicators of frequently used drugs.

Mental health nurses have been found to be well positioned to motivate smokers to quit and to provide prescriptions by physicians. About 50 nurses each from the Ministry of Health and the Social Security Fund have been trained so far in cessation. Nearly 80% are involved in cessation activities across the health system.



In 2017, the Mental Health Programme, in conjunction with the Virtual Campus for Public Health of the Pan American Health Organization (PAHO), launched the first virtual course on “Prevention, diagnosis and treatment of smoking in primary care” aimed at health professionals of the Social Security Fund and Ministry of Health. Ten in-country trainers and a professor from Uruguay facilitated the online learning. A total of 40 out of the 118 enrolled students successfully passed the course.

**Mental health nurse counselling tobacco user**

## **Operationalizing tobacco cessation through the health system**

Community health workers support the recruitment, referral and treatment of smokers at health clinics. Psychologists, social workers and mental health nurses identify smokers among the patients visiting their facilities, offering brief counselling and conducting group therapy. They can also support general physicians in treatment of tobacco cessation. Smokers are then referred to doctors for pharmacological treatment, when it is needed. As the same human resources and infrastructure are used in running the health facilities and tobacco cessation clinics, the latter normally run once a week according to a fixed schedule.

Currently, Panama has 47 smoking cessation clinics across the country, with at least 1 in 13 of the 15 health regions in the country, which offer free tobacco dependence treatment. The clinics have the capacity to work with up to 20 smokers at a time, with about 10 smokers per group. Their efficiency varies between 60% to 90%, with a quit rate of 20% to 40%. Every year, on average, about 10 smokers access each treatment facility at the primary health care level and about 100 in tertiary care hospitals.

While there are no formal channels of communication between the private and public health care systems, private sector hospitals can refer smokers to public health facilities and vice versa. Private patients can access drugs for free at the public health facilities.

## Promoting cessation clinics



The Ministry of Health runs a comprehensive communication campaign encouraging people to quit tobacco use and promoting available cessation services. Cessation clinics are advertised through flyers, official vehicles and websites, as well as inserts in cigarette packs. Health facility staff promote cessation among visiting patients. Each clinic also promotes its services to the professionals and the community around it. During the celebration of WNTD in May and the National No Smoking Day in October, tobacco cessation and related services are promoted intensely on television and radio.

## Promoting cessation via tobacco pack labels

NGOs are also involved in sensitizing the public about government cessation services.

## Tobacco cessation in medical records

The diagnosis of smoking among the population is made available in all facilities of the public and private health system. Further, it is mandatory for health facilities to record tobacco use in the Electronic Health Information System before closing a clinical file. This enables identification of tobacco users for brief counselling and referrals to cessation clinics.

Additionally, a specific module has been developed for smoking cessation clinics in the Electronic Health Information System to register the intensity of tobacco use, the level of dependence, the interventions offered and the progress of each smoker towards quitting the habit. Similarly, successful quitting and those who leave the programme are also recorded.

### Guidelines for implementation of Article 14

#### Make the recording of tobacco use in medical notes mandatory

Para 37. "Parties should ensure that the recording of tobacco use status in all medical and other relevant notes is mandatory...."

## International collaboration to promote strengthening of health systems

In 2016, Panama hosted a South–South cooperation workshop and shared the country's experience in the implementation of Article 14 of the WHO FCTC. Subsequently, Panama served as a facilitator in two international workshops for the implementation of Article 14, one in Uruguay for countries in South America and another one in Geneva for African countries.

## Financing tobacco cessation

With the cessation clinics being part of public health facilities, their infrastructure and human resource costs are subsumed under health facility budgets. The investment needed is therefore just for pharmacological treatment, office supplies and devices such as spirometers. These are

funded through the Ministry of Health's tobacco control budget, which in turn comes from earmarked tobacco taxes.

### **Implementation challenges**

The programme often faces challenges in recruiting staff to volunteer for cessation services in health facilities. The programme provides opportunities and incentives to elicit interest in the programme. For instance, cessation professionals are offered free registration at the international tobacco control conference Panama hosts biannually.

### **Future plans**

A tobacco cessation programme is being promoted to become part of Panama's Occupational Health Programme carried out in workplaces. The tobacco control law also prohibits tobacco use in open and closed sports areas.

Despite the promotion of smoking cessation clinics in the media and other health promotion activities, there is still a need for broader community outreach and participation, in order to identify tobacco users and support access to cessation services. The need for more local anti-tobacco councils and the activation of a referral system have been identified. A technical concept for online cessation support has been prepared and is expected to be implemented soon.

# Myanmar: training of health workers in tobacco cessation

## Background

The latest WHO STEPwise approach to chronic disease risk factor surveillance effort<sup>16</sup> reports a high prevalence of tobacco use among adults (25–64 years) in Myanmar. In 2014, 44% of men and 8% of women smoked tobacco. The prevalence of smokeless tobacco use was higher among both men (62%) and women (24%). In fact, Myanmar has the highest prevalence of smokeless tobacco use in Southeast Asia, where smokeless tobacco use is the most prevalent among WHO regions. However, the smoking prevalence among youth is almost 11%, whereas smokeless tobacco use is about 6%, as reported by the GYTS<sup>17</sup>. The survey also indicates high intentions among school students to quit tobacco.

In 2017, the Ministry of Health and Sports developed its four-year National Health Plan (NHP) 2017–2021<sup>18</sup>. It focused on infrastructure development and defined an essential package of health services to be provided during the years of the plan. In line with the NHP, the NCD unit in the ministry planned to provide a Package of Essential Noncommunicable Disease Interventions (PEN) at primary health care level. To respond to the high prevalence of tobacco use, the PEN included brief advice for tobacco cessation.

In Myanmar, the Ministry of Health and Sports is the major provider of health-care services, with primary health care services provided by basic health staff (BHS) through rural health centres (RHC) and subrural health centres (SubRHC). Across Myanmar's 17 states and 330 townships, curative services are mainly provided by government hospitals including township hospitals and station hospitals.

As nearly 70% of the population of Myanmar resides in rural areas, BHS constitute the major health-care providers at primary care level. Tobacco cessation services are planned to be delivered through township hospitals and BHS at RHCs and Sub-RHCs. This required capacity building of BHS in tobacco cessation.

### Guidelines for implementation of Article 14

#### Develop training capacity

Para 28. "In most countries the health-care system and health-care workers should play a central role in promoting tobacco cessation and offering support to tobacco users who want to quit...."

Para 29. "All health-care workers should be trained to record tobacco use, give brief advice, encourage a quit attempt, and refer tobacco users to specialized tobacco dependence treatment services where appropriate."

<sup>16</sup> Report on National Survey of Diabetes Mellitus and Risk Factors for Non-communicable Diseases in Myanmar (2014). Myanmar: Ministry of Health; 2014. ([https://www.who.int/ncds/surveillance/steps/Myanmar\\_2014\\_STEPS\\_Report.pdf](https://www.who.int/ncds/surveillance/steps/Myanmar_2014_STEPS_Report.pdf), accessed 26 August 2019).

<sup>17</sup> Global Youth Tobacco Survey. Myanmar; 2016 ([https://untobaccocontrol.org/impldb/wp-content/uploads/myanmar\\_2018\\_annex-2\\_GYTS\\_factsheet\\_2016.pdf](https://untobaccocontrol.org/impldb/wp-content/uploads/myanmar_2018_annex-2_GYTS_factsheet_2016.pdf), accessed 26 August 2019).

<sup>18</sup> National Health Plan (2017-2021). Myanmar: Ministry of Health and Sports ([https://www.mohs.gov.mm/cat/NHP%20\(2017-2021\)](https://www.mohs.gov.mm/cat/NHP%20(2017-2021)), accessed 26 August 2019).

## **Training objectives**

Training programmes were developed for BHS with a view to:

- improving their knowledge about the country's NCD burden and trends, and management of major NCDs at primary health care level;
- building the capacity of participants to implement PEN interventions.

## **Training design**

A team comprising the manager of the Diabetes Mellitus Control Programme, academics from the University of Public Health (UOPH), representatives of the central NCD unit of the Department of Public Health, and public health experts from HelpAge International<sup>19</sup> jointly developed the training curriculum and manual. Academic experts then field-tested the manual.

After a few trainings, the central trainers conducted monitoring visits of trainings at selected health facilities, and their findings and feedback were incorporated into subsequent trainings.

## **Training content**

The training curriculum included analysing the township health situation, developing an action plan, conducting advocacy meetings, guidance for health education and counselling on risk behaviours, information on screening and treatment of uncomplicated cases, and advice on early referral, monitoring, supervision and evaluation.

The training package included a sample agenda, PowerPoint presentations and a training manual in English for township medical officers, and another in Burmese language for BHS.

## **Trainers**

Training on the clinical aspects of cessation was provided by medical experts, whereas representatives from the Ministry of Health and Sport's NCD unit and UOPH covered the prevention, screening, cessation, reporting, and supervision and monitoring parts of the training curriculum.

## **Recruiting participants**

Initially, the central NCD unit sensitized the state/regional level and township level health offices, and secured multistakeholder support for local training workshops. The first 90 townships for training were then selected based on the recommendations of respective state/regional health offices. Accessibility for supervision and monitoring were a consideration in the choice of townships.

Given the limited human resources, training of trainers (TOT) workshops were conducted in 10 states. These were for state health teams, comprising deputy health directors, NCD focal points (medical doctors), township medical officers, township health nurses and health assistants (level I) from each township.

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<sup>19</sup> HelpAge International is an international civil society alliance working to advance the rights of the elderly.



**PEN training of trainers workshop for subnational health teams**

These participants in turn conducted the multiplier trainings for BHS, comprising health assistants, lady health visitors and public health supervisor (levels I and II) at the township level. The education status of BHS ranges from matriculation to graduation in community health. The trainings have so far covered about 27% of the total number of BHS.

### **Budget and funding for the training programme**

The main costs involved were for training manuals and travel, as well as other allowances of participants and trainers. HelpAge International financed the development of training manuals and the costs for TOT workshops. The multiplier trainings at township level were supported by a World Bank loan.

For 2018–2019, the multiplier training in 130 townships will require about 235 191 906 Myanmar kyat (US\$ 147 858). The planned budget for township level advocacy is 73 880 000 Myanmar kyat (US\$ 46 446).

### **Future plans**

The Ministry of Health and Sports is planning to develop detailed guidelines on cessation for BHS to be incorporated into the PEN manual. These guidelines will be used in the training for the next 130 townships and in the refresher trainings for the previously trained BHS.

# Saudi Arabia: building infrastructure for tobacco cessation

## Background

Saudi Arabia’s *Vision 2030*<sup>20</sup> lays out its roadmap for economic and developmental growth. The vision, among other targets, aims to reduce smoking prevalence by 2% by 2020.

The country had previously initiated several measures to promote quitting among tobacco users. The Royal Anti-Smoking Law banned smoking in public places in 2015. The smoking ban comprehensively covered the use of tobacco and its derivatives, such as cigarettes, cigars, tobacco leaves, tobacco molasses and any product containing tobacco, whether in the form of cigarettes or cigars, or by using pipe or shisha, or by sniffing or chewing, or any other method.

Meanwhile, a country-wide survey of 10 224 participants conducted in 2017 by the National Committee for Tobacco Control indicated community-wide support to regulate shisha and hookah bars in residential areas (see Table 2).

**Guidelines for implementation of Article 14**

**Key components of a system to help tobacco users quit**

Para 47. “**Specialized tobacco dependence treatment services.** Tobacco users who need cessation support should, where resources allow, be offered intensive specialized support, delivered by specially trained practitioners. Such services should offer behavioural support, and where appropriate, medications or advice on the provision of medications. The services may be delivered by a variety of health-care or other trained workers, including doctors, nurses, midwives, pharmacists, psychologists, and others, according to national circumstances. These services can be delivered in a wide variety of settings and should be easily accessible to tobacco users. Where possible they should be provided free or at an affordable cost. Specialized treatment services should meet national or

**Table 2: Public opinion survey on shisha/hookah smoking**

Issue	Percentage in agreement
Prohibit shisha in restaurants and cafes	77%
Family not taken to places offering shisha	85%
Shisha cafes in residential areas increase smoking	86%

In line with public opinion, the Ministry of Municipal and Rural Affairs prohibited shisha cafes in residential areas on public health and safety grounds. The country undertook a series of measures to assist smokers who wished to quit tobacco use in response to these policy interventions.

<sup>20</sup> National Transformation Program 2020. Kingdom of Saudi Arabia; 2016 (<http://extwprlegs1.fao.org/docs/pdf/sau170026.pdf>, accessed 26 August 2019).

## Tobacco cessation initiatives

### Cessation guidelines

The initiative began with the development of preliminary guidelines for tobacco cessation services in 2011, which were also updated in 2018. The *Saudi clinical guidelines for tobacco cessation services 2018* provides comprehensive guidance for addressing specific target groups, such as those with mental health challenges, pregnant and lactating women, light smokers and prisoners, among others.

### Training health professionals

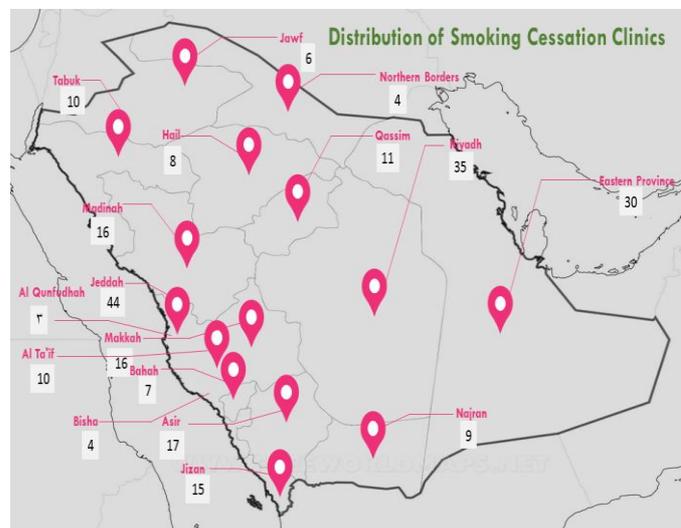
In 2012, the country focused on developing a training manual for certified tobacco treatment specialists. It further embarked on equipping the health workforce in cessation through training of health professionals the same year. The training curriculum covers major components of the treatment plan, such as nicotine addiction, cognitive behaviour treatment, pharmacotherapy, relapse prevention and a follow-up schedule. Across 200 workshops, each spanning about 2 days, about 5000 health providers have been trained in tobacco cessation treatment. The health providers include doctors, nurses, counsellors, psychologists and specialists in health education.

### Quit line

A quit line provides 24/7 medical consultation, and also books appointments with tobacco cessation clinics.

### Cessation clinics

The Ministry of Health began establishing tobacco cessation clinics in 2003. Currently, Saudi Arabia has about 265 affiliated fixed clinics spread across the cities and provinces of the country. Additionally, it has about 10 mobile clinics that are set up in malls and other public places where people gather, in cities like Riyadh, Jeddah, Mecca, Medina, Taif, and the capitals of provinces such as Eastern Province, Asir, Jizan and Najran (see Fig. 2). All clinics provide free consultation, cognitive and behavioural therapy, medication for quitting tobacco use and follow-up.



**Fig. 2: Distribution of smoking cessation clinics**

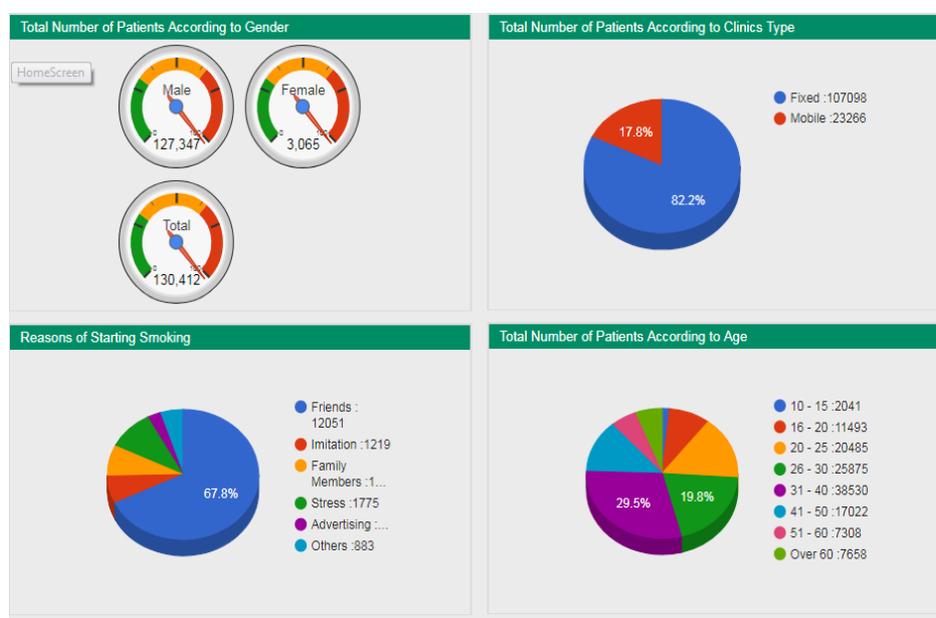
By the end of 2018, the Ministry of Health aimed to have 450 clinics – 50 truck clinics, 100 mobile clinics and 300 fixed clinics.

## Electronic health record system



Mobile cessation clinic in a mall

In 2013, the country invested in an electronic patient record system to register smoker data, treatment and follow-up details. The patient record includes more than 60 variables like smoking risk, diagnosis and past medical history. The electronic data system facilitates supervision of cessation clinics, ensures the delivery of high-quality service to smokers, facilitates smoker follow-up at clinics across the country, provides quick reports to determine data trends, and serves as a tool for monitoring and evaluating the outcomes and effectiveness of cessation services.



Electronic cessation record dashboard

## Population reach measures

Following the adoption of the Royal Decree No 56, Anti-Smoking Law in 2015, the country established mobile clinics and banned the sale, import and trade in electronic cigarettes, electronic shisha and similar devices. A national quit line was launched in 2018. The Smoke-Free Work Environment campaign with private companies and institutions helps to protect non-smokers and improve cessation attempts among smokers. It helps those who wish to quit smoking by providing behavioural interventions and pharmacotherapy.

## Use of social media

As social media use is widely prevalent in the country, the Ministry of Health engages a wide range of social media platforms such as Facebook, Twitter, Snapchat, YouTube and Instagram

to share messages to motivate quitting tobacco use. The hashtag TcpMoh is used across these platforms to build brand familiarity in the population.

### **Human and financial resources**

The various cessation services employ about 650 staff and the government invests about US\$ 26 635 500 into these services.

### **Future plans**

The health minister has written to the insurance companies advising coverage of therapeutic services for those with health insurance and raising insurance charges for tobacco users.

The tobacco control programme is now developing an online training blackboard for health providers.

Saudi Arabia informed manufacturers and importers of tobacco products to get ready for applying plain packaging on all forms of tobacco products from 2019. This presents opportunities to utilize tobacco pack surfaces for messages that encourage quitting and advertise cessation services beyond the existing tobacco packs.

# Ireland: tobacco cessation for vulnerable groups

## Background

Tobacco use is the largest contributor to health inequalities between the richest and poorest sections of society in Ireland. A recent report, *The state of tobacco control in Ireland*,<sup>21</sup> published by the country's Health Service Executive (HSE) in 2018, estimates that half of the difference in mortality between the highest and lowest social strata of the population is due to differences in smoking behaviour.

The report also identifies a wide gap in smoking behaviour related to mental health status: people with a probable mental health problem are 1.6 times more likely to be current smokers than those without.

Irish studies confirm a social class patterning of smoking in pregnancy: mothers with lower educational attainment and lower income more commonly report smoking in pregnancy than mothers with higher educational attainment and higher income.

The findings of national smoking prevalence surveys (Healthy Ireland)<sup>22</sup> and the aforementioned reports led Ireland to develop cessation programmes to address the specific needs of such vulnerable groups.

### Guidelines for implementation of Article 14

#### The underlying considerations

Para 11. **“Tobacco cessation and tobacco dependence treatment should be inclusive.** Tobacco cessation strategies and tobacco dependence treatment should take into account factors such as gender, culture, religion, age, educational background, literacy, socioeconomic status, disability, and the needs of groups with high rates of tobacco use. Tobacco cessation strategies should be as inclusive as possible, and should where appropriate be tailored to the needs of individual tobacco users.”

## Programme framework

The Irish tobacco control strategy, Tobacco Free Ireland,<sup>23</sup> sets out the actions envisioned to achieve a tobacco-free society, with a target of less than 5% national smoking prevalence, by 2025. The Irish health service is in charge to implement the health service specific actions outlined in this strategy. Actions 4.7–4.7.9 in the Programme's Implementation Plan 2018–2021<sup>24</sup> specifically describe the work to be undertaken to reduce smoking prevalence among lower socioeconomic groups, pregnant women and mental health service users. The plan currently includes key performance indicators (KPIs) for the number of tobacco users receiving intensive cessation support (13 000) and quitting at one month (45%).

<sup>21</sup> The state of tobacco control in Ireland. Dublin: Health Service Executive; 2018 (<https://www.hse.ie/eng/about/who/tobaccocontrol/tobaccofreeireland/state-of-tobacco-control.pdf>, accessed 27 August 2019).

<sup>22</sup> Healthy Ireland Survey 2019. Ireland: Department of Health; 2019 (<https://assets.gov.ie/41194/5fc2c8bfae3041b7a4b7a46751113b4e.pdf>, accessed 26 August 2019).

<sup>23</sup> Tobacco Free Ireland. Dublin: Department of Health; 2013 (<https://health.gov.ie/wp-content/uploads/2014/03/TobaccoFreeIreland.pdf>, accessed 27 August 2019).

<sup>24</sup> HSE Tobacco Free Ireland Programme Implementation Plan 2018-2021. Ireland: Health Service Executive; 2018 (<https://www.hse.ie/eng/about/who/tobaccocontrol/hse-tfi-2018-2021-plan/hse-tfi-plan-2018-2021-final.pdf>, accessed 26 August 2019).

The Tobacco Free Ireland Programme engages in the annual health service planning process. In 2018, the programme applied for investment in dedicated smoking cessation services specifically for maternity and mental health services. The outcome of the planning process is awaited.

## **Training health service staff in tobacco cessation**

Until the beginning of 2018, the HSE National Service Plan contained a KPI with an annual target of 1350 key front-line health staff to be trained in Brief Intervention for Smoking Cessation (BISC).<sup>25</sup> This training was a one-day face-to-face national training programme which aimed to increase confidence to raise the issue of smoking in routine and regular conversations with patients, and support them to make a quit attempt. The behaviour change intervention uses an empathic approach, emphasizing self-efficacy, personal responsibility for change and information giving, including details of resources available to support change. In 2018, BISC was replaced by the online training programme Making Every Contact Count.<sup>26</sup> One of its five behavioural change brief intervention modules specifically addresses tobacco use. A follow-up, face-to-face skill practice module is available on completion of the online training. The training is now included in the HSE National Service Plan 2018 targets – with 2700 front-line staff to complete the online training modules and 270 staff to complete the face-to-face module.

In addition to training in brief interventions, health-care staff can also complete the modules provided by the National Centre for Smoking Cessation and Training (NCSCT) in a certified intensive smoking cessation programme, as well as modules specifically for developing skills to support smoking cessation for those with mental health issues and those who smoke in pregnancy. An online module on second-hand smoke is also available. The HSE has secured a licence from the NCSCT for unlimited access to this dedicated online training and assessment programme. To date, about 203 health-care practitioners have received the full certification; 70, the mental health certification; 60, the certification for supporting pregnant women; and 31, the second-hand smoke certification.

## **Mechanisms for service delivery to vulnerable groups**

Cessation services are delivered both at a community level and in acute health-care settings. Community-based smoking cessation practitioners are located in the nine local Community Health-care Organizations spread across the country. There are also dedicated smoking cessation services located within large acute hospitals throughout the country. Smoking cessation practitioners also work to support the implementation of the HSE Tobacco Free Campus (TFC) policy in health-care settings, with a particular focus on mental health care settings in recent years. All HSE smoking cessation services are offered free of charge. NRT is provided free for all medical cardholders in Ireland.

The experience of Irish smoking cessation practitioners has shown that special populations (e.g. mental health service users) and those who smoke in pregnancy require more intensive and extended support to quit than the general population.

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<sup>25</sup> Brief Intervention for Smoking Cessation. Dublin: Health Service Executive; 2012 (<https://www.hse.ie/eng/about/who/tobaccocontrol/intervention/participantresource.pdf>, accessed 27 August 2019).

<sup>26</sup> Making Every Contact Count. Health and Wellbeing. Health Service Executive [website] (<https://www.hse.ie/eng/about/who/healthwellbeing/making-every-contact-count/>, accessed 27 August 2019).

## Cessation support in specific settings

Irish smoking cessation practitioners actively target and service vulnerable groups, those who are accessing mental health services and those in maternity settings. To begin with, the HSE implemented a TFC policy in 2012 in all its health-care facilities to provide better health outcomes for patients/service users and staff, by approaching tobacco addiction as a health-care issue. In recent years, the HSE has had a strong focus on TFC policy implementation, particularly in mental health care settings.

The HSE briefing, *Smoking cessation and mental health*,<sup>27</sup> developed in 2016, guides front-line staff in mental health service settings in their day-to-day interactions with clients and service users towards reducing tobacco use. The briefing document is a valuable reference and a tailored resource produced to address the unique challenges arising from established practices and misconceptions around mental health and smoking. The resource challenges myths and emphasizes the crucial role that staff play in reducing the prevalence of tobacco use. This resource works alongside *How to implement “HSE Tobacco Free Campus Policy”*. *Tobacco Free Campus implementation guidance document*,<sup>28</sup> a comprehensive suite of additional generic tools and resources to support smooth implementation of the policy in mental health settings.

### Box 4. Equipping mental health services for tobacco cessation

- Make mental health care settings tobacco-free for better health outcomes for users.
- Develop guidance for front-line staff for interactions with service users.
- Realize the opportunity for specialized training in smoking cessation in mental health and pregnancy contexts.
- Provide a quit line for public access to services.

Mental health service users can avail themselves of intensive smoking cessation counselling with a smoking cessation advisor, whereby a quit attempt can be supported in conjunction with ongoing behavioural support and NRT provision.

## Cessation programmes for disadvantaged women

The HSE works in partnership with the Irish Cancer Society to deliver tobacco cessation programmes using intensive smoking cessation counselling coupled with peer-to-peer support to women in lower socioeconomic groups. We Can Quit, a community-based, 12-week smoking cessation programme, aims to improve access to health and social support for women who want to quit. Women are recruited into the programme through community outreach. Peer leaders are identified and trained to become tutors within the programme.

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<sup>27</sup> Smoking cessation and mental health. A briefing for front-line staff. Dublin: Health Services Executive; 2016 (<https://www.hse.ie/eng/about/who/tobaccocontrol/smoking-and-mental-health/smoking-cessation-and-mental-health-briefing-document.pdf>, accessed 27 August 2019).

<sup>28</sup> How to implement “HSE Tobacco Free Campus Policy”. Tobacco Free Campus implementation guidance document. Dublin: Health Services Executive; 2016 (<https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco-free-campus-toolkit-guidance-document-oct-16.pdf>, accessed 27 August 2019).

A research project related to this programme, commissioned by the Irish Cancer Society, sought to identify and develop community-based smoking cessation models to support women for the We Can Quit programme.

The study was organized into five phases. The University of Stirling and Insights Social Research conducted phases 1–3, comprising an evidence review and engagement with key stakeholders to identify potential approaches for the We Can Quit delivery model. The fourth phase involved an action research project in two north Dublin communities, from September 2013. Its aims were to develop, deliver and evaluate an evidence-based smoking cessation programme for low-income women smokers who wanted to take control over their smoking and quit.

### **National quit line**

The HSE operates a national quit line which offers phone, text and email-based support free of charge to everyone in the country. The clients who call the quit line are triaged and those from vulnerable groups (e.g. pregnancy or mental health) are ideally referred to a specialized face-to-face intensive smoking cessation service, if there is one in their locality and the client is willing to attend. A personalized online quit plan is also available on an HSE website.<sup>29</sup>

The quit plan consists of an online personal quitting tracker which measures the users' level of nicotine dependence, their smoking triggers, reasons for quitting and financial savings during their quit attempt. As part of the quit plan sign up, the user is encouraged to also make use of a series of other supports, including motivational email and/or text-based supports, as well as the standard telephone support service offered through the national quit line. The preparatory and motivational emails and texts are sent daily for two weeks before the “set quit date”, on the quit date and for up to one month past the “set quit date”, followed by further less frequent emails for up to 12 months.



### **Actor fronting C2DE targeted advertisement**

Advertisements engage actors from the lower socioeconomic groups (C2DE audience), many of whom have quit smoking.

The quit line is promoted through a media campaign using a mix of paid and free media, including traditional media (TV, radio, press), social media, search, partnerships with news agencies and public relations. The aim is to warn the public about the dangers to health of smoking, to promote the benefits of giving up smoking and to signpost support services to those who wish to quit smoking. The QUIT mass media campaign<sup>30</sup> actively targets lower professional, non-manual and manual skilled sociodemographic groups. The

<sup>29</sup> Quit smoking. Health Services Executive [website] (<https://www.quit.ie>, accessed 27 August 2019).

<sup>30</sup> HSE QUIT I will survive [video]. Dublin: Health Services Executive; 2017 ([https://www.youtube.com/watch?v=NSSETW\\_zO9jc](https://www.youtube.com/watch?v=NSSETW_zO9jc), accessed 27 August 2019).

The HSE commissioned a review of the QUIT campaign in 2018. Having seen the campaign, 1 in 2 smokers claim they would be likely to quit, with a similar proportion claiming they would search for QUIT. Campaign recall is higher among the target population group (95%) compared to the general population (80%). Likelihood to interact with the QUIT campaign is also higher among the target population (42%) compared to the general population (39%).

**Table 3. Cost of providing smoking cessation in 2017**

<b>Item</b>	<b>Cost €</b>
Mass media campaigns	1.66m
Provision of pharmacotherapy <sup>a</sup>	8.5m
Smoking cessation staff	1.3m

<sup>a</sup> Medical cardholders in Ireland (means tested) are entitled to free visits to general practitioners and NRT.

## **Future plans**

In 2018, the Tobacco Free Ireland Programme applied for the creation of 21 new smoking cessation posts for both clinical and non-clinical staff, specifically to serve patients/clients in mental health and maternity settings.

Currently, the HSE National Service Plan<sup>31</sup> has no defined targets, KPIs or tracking mechanisms for cessation services to vulnerable groups. New key result areas for specific vulnerable populations were being developed in 2018 with a view to introducing new KPIs to the plan. A new electronic health behaviour referral system (National Health Behaviour Management System) is under development to enable accurate tracking of the sociodemographic characteristics of quit service users. This system is expected to inform reporting on the proposed KPIs specific to vulnerable groups within the smoking population and help evaluate targeted services.

The HSE published the *National Standard for Tobacco Cessation Support Programme*<sup>32</sup> in 2013. The standard will be reviewed in 2020 and will include a specific focus on smoking cessation among vulnerable groups (mental health, pregnancy and those in lower socioeconomic classes).

Work is also being undertaken to produce national clinical guidelines for the identification, diagnosis and treatment of tobacco addiction in health-care settings. The guidelines will include a mental health and maternity-specific focus included for patients/clients identified as tobacco users; for example, prescribing appropriate smoking cessation pharmacotherapies and referral to intensive cessation support services.

<sup>31</sup> National Service Plan 2018. Dublin: Health Services Executive; 2018 (<https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf>, accessed 27 August 2019).

<sup>32</sup> National Standard for Tobacco Cessation Support Programme. Dublin: Health Services Executive; 2013 (<https://www.hse.ie/eng/about/who/tobaccocontrol/cessation/tobaccocessationnationalstandard.pdf>, accessed 27 August 2019).

# Resources

## France: public financing and infrastructure for tobacco cessation

### Background

In the decade between 2005 and 2016, the prevalence of daily smoking in France dropped from 24.6% to 21% among higher income groups. At the same time, smoking prevalence in the lowest income group increased from 32.5% to 38.8% during the same decade. The widening gap in prevalence between the high and low-income groups raised concerns for social justice. In total, across income groups, the country had 13 million daily smokers, which alarmed public health authorities.

Meanwhile, the social cost of smoking to France in 2003 was estimated to be €47 billion, with the health cost alone accounting for €18 billion. In 2010, the French National Health Insurance Fund (CNAM) estimated that the cost of the diseases branch of the social security system was 12 billion euros a year. In 2012, the comptroller and auditor general of France remarked that the means and resources the country dedicated to smoking prevention campaigns (8 cents per person per year) were insufficient to fight the tobacco epidemic. This compelling evidence and the widening health inequality prompted the health minister in 2014 to champion the need for a comprehensive tobacco control programme, including public funding for tobacco dependence treatment in partnership with the financial and insurance sectors of the government.

The first National Smoking Reduction Programme 2014–2018 and the National Programme on the Fight against Tobacco 2018–2022<sup>33</sup> were set up to address the identified gaps in the response to the tobacco epidemic. The programme aims to make children born in 2014 the first “tobacco-free” generation in 2032, with less than 5% daily smokers at 18 years of age.

Treatment for tobacco addiction was recognized as a cost-effective public health strategy that would help the daily smokers quit, while addressing inequality. As social protection insurance exists for all income groups, the government decided to utilize its infrastructure for tobacco dependence treatment.

#### Guidelines for implementation of Article 14

#### Establish a sustainable source of funding for cessation help

Para 39. “The strengthening or creation of a national infrastructure to promote tobacco cessation and to provide tobacco dependence treatment will require both financial and technical resources and it will therefore be essential to identify funding for that infrastructure, in accordance with Article 26 of the WHO FCTC.”

<sup>33</sup> Programme National de Lutte contre le Tabac 2018-2022. France: Ministère des Solidarités et de la Santé; 2018 ([https://solidarites-sante.gouv.fr/IMG/pdf/180702-pnlt\\_def.pdf](https://solidarites-sante.gouv.fr/IMG/pdf/180702-pnlt_def.pdf), accessed 26 August 2019).

## Financing architecture of tobacco cessation

In 2016, the tobacco treatment coverage amount was increased and extended for all insured people, from €50 only for pregnant women to €150 for all insured people. Nevertheless, the flat rate covered NRT costs for only 3 months, which was not sufficient for some smokers to quit.

### Box 5. Leveraging public and private sectors for cessation

The National Programme on the Fight against Tobacco 2018–2022:

- covers cessation services accessed in both sectors;
- enlists the support of health professionals in the private sector to expand service accessibility;
- offers patient-friendly drug purchases from private pharmacies paid for by the government.

Since 2018, national insurance has covered 65% of the cost for three types of nicotine substitutes: nicotine gums, patches and lozenges. The lower socioeconomic groups get this treatment completely free through universal health insurance supported by the state. Private insurance, widely used in France, reimburses the remaining 35% for the rest of the population. Treatment in private and public health systems are covered by the insurance. Additionally, the national insurance fund also reimburses consultant charges of €25–30.

Until 2017, people had to purchase cessation drugs from private pharmacies and seek reimbursement from the national insurance fund. In 2018, the system for cessation treatment was refined whereby smokers also got

NRT free from pharmacies, which were then reimbursed by the insurance company. This made it more user-friendly, aligned it with the rest of the health system and improved accessibility of cessation treatment.

## Cessation infrastructure

### Improved access to cessation treatment

Until 2016, only doctors and midwives were permitted to prescribe treatment for tobacco addiction in the country. In 2016, the government introduced a law modernizing the health system, which extended the right to cessation prescription to a range of health professionals, including nurses, dental surgeons, physiotherapists and occupational physicians. Midwives were authorized to prescribe to the entire family of pregnant women. This opened up avenues for public access to cessation treatment provided by private and public health professionals in outpatient departments at the primary care level across the country.

Additionally, 370 state-funded Addiction Prevention and Treatment Centres across the country provide free consultation on quitting and completely free NRT treatment for up to a month.

### Communication support

France runs a nation-wide “tobacco-free month” (Mois Sans Tabac) in November every year, to encourage people to quit. The campaign uses all media platforms, ranging from television and flyers to social media, to reach out to smokers. Numerous health-care facilities, health professionals and associations are involved in activities to inform, accompany and support people quitting at national and regional levels.

France recorded a sharp drop in the prevalence of tobacco use among both low-income and high-income populations in the month following the first campaign in 2016. This sharp drop is attributed to a combination of this campaign and the momentum from the country's adoption of the European Tobacco Products Directive (TPD).<sup>34</sup> Similarly, the sale of cessation treatment products increased by 28% in 2017, after the second campaign.

### **Funding mechanism for cessation insurance**

Financial resources for coverage currently come from the National Smoking Reduction Programme. On 1 January 2017, the French government launched a €100 million fund from tobacco taxes to support its tobacco control interventions at local, national and international levels. About a third of the fund – €32 million – has been dedicated to reimbursing the costs of smoking cessation. It is proposed that the reimbursement of NRT will move out from the current prevention fund to regular medical insurance reimbursement by 2019.

### **Challenges**

The major challenge to the initiative involved securing support for the adoption of a national programme geared to reduce tobacco prevalence, which had implications for various sectors.

### **Strategies**

The initiative utilizes the following strategies:

- Generate evidence: the smoking prevalence data and the estimation of tobacco-related costs to the country proved useful in securing support for both the programme and its public funding.
- Develop advocacy tools: using the evidence, information tools were prepared for advocacy with various sectors.
- Develop consistent actions to accompany the cessation strategy, such as:
  - making tobacco products less attractive (plain packaging, enlarged health warnings);
  - expansion of smoke-free areas;
  - increasing taxes to bring the price of a packet of cigarettes to €10 euros by 2020.
- Improve communication campaign: the campaign aimed to create awareness among the public on tobacco's harmful impacts on health, denormalized tobacco use and encouraged people to quit smoking.
- Better access to cessation assistance: the programme improved access to cessation by increasing the number of service providers through an array of health professionals.

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<sup>34</sup> Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014. Official Journal of the European Union. 2014; L127 ([https://ec.europa.eu/health/sites/health/files/tobacco/docs/dir\\_201440\\_en.pdf](https://ec.europa.eu/health/sites/health/files/tobacco/docs/dir_201440_en.pdf), accessed 28 August 2019).

### **Box 6. Lessons learned**

- Inequalities in the prevalence of tobacco use, and the accessibility and affordability of services call for public financing of tobacco dependence treatment.
- Sustainable sources of funding should be identified for public coverage of tobacco cessation.
- Cessation drugs should be included in the essential medicines list and integrated with existing insurance systems.
- Flexible insurance rates are necessary to meet the varied treatment requirements of individual smokers.
- The strengths of private and public health sectors should be leveraged to maximize coverage of services.
- A range of health professionals should be authorized to prescribe cessation treatment to increase accessibility of services.
- Communication campaigns should be utilized to fully leverage the investments in cessation.
- Public and private health-care professionals should be mobilized at local, regional and national levels.
- Coordinated actions should include youth protection, denormalizing tobacco in the environment and increasing tax on tobacco alongside tobacco cessation.

## **Outcomes**

Tobacco cessation, along with other measures under the national tobacco control programme, has led to several process and impact outcomes:

- A 2.5% decrease in daily smoking among adults aged 18–75 years between 2016 and 2017. This meant 1 million less adult daily smokers in the country in a year. The decrease was prominent among men in the age groups 18–24 and 45–54, and among women aged 55–64 years. The daily smoking among youth also decreased from 32.4% to 25.1% in the 4 years since 2014.
- More importantly, the proportion of daily adult smoking among the lowest income group dropped significantly from 38.8% to 34% during the same period. This has been a major boost to the country's social justice goals.
- All provinces have elaborated a smoking cessation programme over the last three years.
- Following the initial cessation communication campaign in November 2016, twice as many people attempted to quit smoking.

## **Future plans**

The programme is planning formal training of all health professionals as part of continuing professional education. The curricula for medical and health professionals is currently under development.

Effective cessation requires a nation-wide governance structure for tobacco control. Four years into the national prevention programme, all the 17 provinces in France developed regional cessation programmes in 2018.

# Malaysia: innovative cessation promotion through public–private partnerships

## Background

The National Health and Morbidity Survey (NHMS) 2015<sup>35</sup> estimates the tobacco prevalence in Malaysia to have stagnated around 24% for nearly a decade. Most smokers are in the 25–50 years of age group. Although most of them intend to quit, they do not seek help due to a lack of awareness about available services.

In response to this situation, Malaysia adopted a new cessation policy in 2015, as part of its National Strategic Plan on Tobacco Control 2015–2020. It aimed to augment other tobacco control measures by preventing youth initiation and promoting adult cessation, with a view to reducing the overall tobacco prevalence.

Under this policy, Malaysia has been innovating to promote tobacco cessation for diverse groups with a broad range of partners. The key strategies include (i) using the media for cessation promotion, (ii) engaging with the oral health programme for smoking interventions in schools, (iii) mobilizing community pharmacies for cessation, and (iv) getting employer commitment for workplace interventions.

### Guidelines for implementation of Article 14

#### Use existing systems and resources to ensure the greatest possible access to services

Para 34. “Parties should use existing infrastructure, in both health-care and other settings, to ensure that all tobacco users are identified and provided with at least brief advice.”

Para 35. “Parties should use existing infrastructure to provide tobacco dependence treatment for people who want to stop using tobacco. Such treatment should be widely accessible, evidence based, and affordable.”

## Cessation promotion in the media

Malaysia uses a range of media platforms to promote cessation. It has developed a dedicated website<sup>36</sup> that motivates and recruits smokers to quit, providing detailed information on the benefits of quitting smoking, alternative ways to quit and successful case stories. Tobacco users are encouraged to register for quitting or to locate their nearest cessation centre to seek assistance. The website in turn is widely promoted through other mass media platforms.

The cessation website has been developed through a public–private partnership. The Ministry of Health partnered with a pharmaceutical company which built the initial website for the ministry to run. All technical content developed by partners is required to be approved by the mQuit Task Force in the Ministry of Health, which is comprised of governmental agencies and their partners in academia, professional associations and pharmaceutical companies.

<sup>35</sup> National Health and Morbidity Survey (NHMS) 2015. Volume II: Non-communicable diseases, risk factors & other health problems. Kuala Lumpur: Institute for Public Health, Ministry of Health; 2015 (<http://www.moh.gov.my/moh/resources/nhmsreport2015vol2.pdf>, accessed 26 August 2019).

<sup>36</sup> Jomquit [website] (<http://jomquit.moh.gov.my>, accessed 28 August 2019).

The Ministry of Health works with NGOs to utilize social media platforms for promoting quitting services, such as mQuit Universiti Sains Malaysia (USM), Tobacco Quitline – Perkhidmatan Berhenti Merokok, Malaysian Green Lung Association, Medical Mythbusters Malaysia, Public Health Malaysia, Selbar, and Tak Nak Merokok. The NGOs have doctors, nurses and medical assistants with specific interests and skills in managing social media. They help post the materials on social media platforms such as Facebook, in order to reach out particularly to young smokers.

The Ministry of Health's team also regularly attends talk shows on the issues, both on government and private television channels, taking the opportunity to promote the cessation website. A morning talk show provided six free slots to promote quitting services. For instance, one of the shows demonstrated logging in to the quit site and registering for cessation support, thus giving visibility to the website and drawing public attention.

### **Oral health programme for school-based smoking screening**

The school smoking check-ups in Malaysia formerly used carbon monoxide analysers, which scared away students. In 2016, Malaysia's school health programme engaged government dental doctors and dental nurses under the oral health programme for screening schoolchildren aged 7–17 years, across its 7853 primary and 2561 secondary schools.

The dentists conduct oral health screenings once a year in all schools. Their key performance indicators are primarily oral health conditions. However, they noticed that tobacco use affects oral health and causes oral cancer. They therefore developed guidelines for visual oral health screening for tobacco use, without the carbon monoxide analyser.

Those students whose oral health condition indicates tobacco use, such as in the form of nicotine stains or plaque, are then asked about tobacco use. At this point, they are provided a non-pharmacological quit intervention, which involves up to three counselling sessions and screening in the following year as a cohort. The dental doctor confidentially refers students with a smoking habit to the school counsellor.

Since its start in mid-2016, the programme has screened 2.6 million primary school students and 1.9 million secondary school students. In 2017, 1671 current smokers were detected in primary schools (0.6%), and 72 888 (3.8%) in secondary schools.

### **Community pharmacies for cessation**

Adult smoking cessation services were previously offered at government clinics at specified times of the day, which hampered access. At the same time, it was observed that smokers bought drugs for quitting from community pharmacies (private retail pharmacies), particularly around Ramadan.

The Ministry of Health identified an opportunity in this trend and engaged community pharmacies to deliver a structured intervention to smokers during their visit. It collaborated with the Malaysian Pharmaceutical Society and Academy of Pharmacy to train pharmacists in tobacco cessation. At the same time, the government made it mandatory for pharmacists to be trained and accredited in smoking cessation services. The pharmacies offer the six-month structured programme, comprising 3 months of medication and 3 months of counselling to

customers who are smokers. The intervention costs 1800 Malaysian ringgit (US\$ 385) and is paid for by the smoker. In 2016, mQuit services were expanded to 88 private mQuit providers across community pharmacies, medical institutions and private hospitals.

The smokers serviced by pharmacies are registered on the Ministry of Health database, whereby they also receive telephone counselling from the ministry's quit line based at the USM. In 2016, 572 clients registered for quit smoking services at private mQuit facilities, whereas 10 791 clients registered at public health clinics and hospitals. Over 455 clients registered to receive services via the quit line.

In 2017, the programme with pharmacies was further expanded to include more general practitioners and hospitals as cessation service providers. These centres are accredited by the Ministry of Health to offer its structured cessation intervention. They are also required to enter details of services offered and successful quits on the central database. The pharmacies, general practitioners and hospitals are in turn promoted to the public through the cessation website.

### **Employer-led workplace interventions**

As the above interventions rely mostly on smokers' motivation, the Ministry of Health launched an employer-paid initiative creating supportive work environments that facilitate quitting. The initiative, started in May 2018, has three components that are fully paid for by the employer.

Firstly, it requires employers to create 100% smoke-free environments that support quitting and maintain air quality. As a first step, the Ministry of Health has partnered with an architecture organization to include environmental tobacco smoke as a criterion to qualify for credits in the green building index certification.

Simultaneously, it is developing a consultation service to help companies to meet the criteria. Qualified public health specialists and two designated private hospitals will provide the consultancy service. However, the initiative is still in its early days. A multinational courier company and a telecommunication giant are currently discussing this certification.

Secondly, workers in interested companies will be screened for smoking behaviour using a carbon monoxide analyser and lung age assessment. A laboratory partner will help with the screening. Smoking employees then receive the screening results.

The third component offers behavioural intervention to the screened smokers. A major insurance company has come forward to support its workers cessation treatment.

Together, the three components aim to promote quitting while improving compliance with Malaysia's smoke-free policies.

### Box 7. Lessons learned

- Utilizing existing systems and players such as community pharmacies can significantly increase reach, while reducing costs of cessation.
- Oral health programmes and dental professionals are well placed to provide non-threatening, child-friendly cessation support in schools.
- Employer-led workplace interventions could potentially create supportive environments for cessation and improve compliance with smoking bans.
- Leveraging partner strengths in cessation can significantly reduce the cost to the government.
- The Ministry of Health needs to proactively direct, approve and supervise partner contributions.

## Cost sharing through partnerships

The Ministry of Health has effectively leveraged the strengths of a range of partners to cover the cost components of its cessation initiatives. The jomquit website **Error! Bookmark not defined.** was built by a pharmaceutical company, while cessation promotion has been mostly through earned or no-cost media. The training of community pharmacies in cessation has been delegated to two pharmaceutical societies, while smokers pay for the drugs. The workplace intervention is built on an employer-paid model.

The school smoking screening has been very cost-effective, as it is being carried out as an extension programme by the existing infrastructure and staff from the oral health programme. This includes nearly 180 oral health units across the states and districts. The additional cost is limited to training dental doctors and nurses in tobacco cessation intervention.

### Box 8. Terms of engagement with the private sector

Abide by the following terms:

- no trademark promotion at events
- no product endorsement or compulsions for purchase
- non-exclusive partnership
- contributions subject to approval of the Ministry of Health's task force.

### Box 9. mQuit partners

Malaysian Academy of Pharmacy  
University of Malaya  
Universiti Sains Malaysia  
Johnson and Johnson  
Translab  
Putra Specialist Hospital Melaka  
Sunway Medical Centre  
Malaysian Pharmaceutical Society  
Malaysian Green Lung Association

Altogether, Malaysia's cessation programme is run in conjunction with 10 partners outside the government. This includes a laboratory, a pharmaceutical company, two hospitals, a pharmaceutical society, an academy of pharmacy and two universities among others. The partners bring their own resources to support the initiatives. The Ministry of Health has signed a formal memorandum of understanding with each partner, and the work of the partners is reviewed at the mQuit task force meeting.

## **Challenges and strategies**

The quit website has seen a varied level of response over time. It has suffered from a shortage of human resources in following up on web queries. The Ministry of Health is currently exploring strategies to enhance the website hits and offer prompt response.

In the school smoking intervention, only 41% of secondary school smokers completed the intervention, with 12% successfully quitting the habit. The rest were due to go into follow-up in 2018. The alarmingly high smoking prevalence and programme drop outs among secondary school students raises questions about the intervention.

The Ministry of Health is examining ways to validate the dental screening protocols and intervention guidelines for improved detection and effective intervention.

In Malaysia, all students are required to be screened by law. However, the smoking intervention requires consent. As this would risk student confidentiality, the Ministry of Health has approached the smoking screening as an oral risk factor intervention, which has a legislative mandate.

## **Future plans**

Plans for future interventions include:

- mobilizing government resources for cessation promotion through the media;
- devising specialized cessation programmes for low-income households.

# Colombia: international cooperation for training health professionals in cessation

## Background

The prevalence of tobacco use among Colombia's youth (13.5% for 17–18 year olds), as reported by the 2016 National Study of Consumption of Psychoactive Substances in School Population (Estudio nacional de consumo de sustancias psicoactivas en población escolar)<sup>37</sup>, is higher than its adult tobacco prevalence (8.3%), as reported by the National Quality of Life Survey (Encuesta Nacional de Calidad de Vida)<sup>38</sup> one year later. It was recognized that tobacco cessation would complement tax and other existing tobacco control measures to further reduce prevalence among the general population and specific vulnerable groups like youth. The Colombian tobacco control law (1335/2009) also obligates the state to help smokers quit. Tobacco cessation has, therefore, found a place among the measures to reduce tobacco use in the National Public Health Plan that runs up to 2021.

Meanwhile, a national assessment of existing services identified a lack in institutional capacity for tobacco cessation. In order to address this need, adequate training of health professionals was recognized as a priority.

### Guidelines for implementation of Article 14

#### International cooperation

##### *Recommendation*

Para 69. "Parties should collaborate at the international level to ensure that they are able to implement the most effective measures for tobacco cessation, in accordance with the provisions of Articles 20, 21 and 22 of the WHO FCTC."

##### *Actions*

Para 70. "Share tobacco cessation and treatment experiences with other Parties, including strategies to develop and fund support for cessation of tobacco use, national treatment guidelines, training strategies, and data and reports from evaluations of tobacco dependence treatment systems."

### Box 10. International cooperation for Colombia's cessation training

- Uruguay lent financial and technical support for developing training materials and conducting the preliminary training for health professionals.
- The Government of the United Kingdom, the Secretariat and WHO/PAHO provided financial resources to further the training programme.
- WHO/PAHO made available its cessation training manual in Spanish.

<sup>37</sup> Estudio nacional de consumo de sustancias psicoactivas en población escolar. Colombia: Observatorio de Drogas de Colombia; 2016 ([http://www.odc.gov.co/Portals/1/publicaciones/pdf/consumo/estudios/nacionales/C003142016\\_estudio\\_consumo\\_escolares\\_2016.pdf](http://www.odc.gov.co/Portals/1/publicaciones/pdf/consumo/estudios/nacionales/C003142016_estudio_consumo_escolares_2016.pdf), accessed 26 August 2019).

<sup>38</sup> Encuesta Nacional de Calidad de Vida 2017. Bogotá, Colombia: Departamento Administrativo Nacional de Estadísticas, Dane; 2017 (<https://www.datos.gov.co/Estadisticas-Nacionales/Encuesta-Nacional-de-Calidad-de-Vida-2017/iufv-p6es>, accessed 26 August 2019).

## **Preparations for training health professionals**

The Ministry of Health and Social Protection initially contacted the Tobacco Epidemic Research Centre (CIET) in Uruguay for expert inputs in developing and conducting the training in Colombia. Across an eight-month project, a tobacco cessation expert from CIET helped in developing and conducting a training programme on short intervention through brief counselling for tobacco cessation. The WHO/PAHO tobacco cessation training manual formed the basis of this training.

The Ministry of Health and Social Protection reached out to subnational administrations and encouraged participation of committed health professionals from the provinces in the training.

## **Developing the training programme**

### **Trainee recruitment**

Information about the training workshops is posted on the Ministry of Health and Social Protection's website. Interested public health professionals from the territories voluntarily respond to the training advertisement. Workshop participants are selected based on their interest in cessation, commitment to building capacity in their institution and volunteer spirit. The trainees are mostly family physicians and lung specialists, nurses and psychologists, social workers and dentists. The participants come from both the public and private sectors. Participation in workshops is limited to 25–30 people, to facilitate involvement and interaction.

### **Training format and content**

The first training programme was conducted for about 25 public health professionals. The training aimed to improve their skills in brief intervention.

On the first of the three days of training, trainees were oriented to the overall tobacco control situation in the country, the magnitude of the problem, the broad range of tobacco control measures and the country's obligations under the WHO FCTC. Over the next two days they were provided with inputs on brief counselling and conducted group work, learning skills for communication with smokers.

After the initial South–South cooperation project between Uruguay and Colombia, the Ministry of Health and Social Protection secured the support of the PAHO Country Office to extend the training to more health professionals. The FCTC 2030 Project (funded by the Government of the United Kingdom and the Secretariat) prioritized strengthening the implementation of the National Tobacco Cessation Programme, enabling the organization of subnational workshops and building of a network of health professionals trained in cessation. This project will support tobacco cessation efforts until 2021.



**Uruguay–Colombia training workshop for health professionals**

### **Programme cost**

Excluding coordination staff time, a 2.5 day workshop for 25–30 people costs about US\$ 5000. The main costs incurred are for the training venue, participant travel, lodging, equipment and honoraria for trainers.

### **Monitoring and evaluation**

Two months after the workshop, the trainees receive a survey that seeks to identify their post-training follow-up actions in their institutions or in the training of other health professionals.

The feedback from workshops is being used to improve future trainings. For instance, the workshops have been opened up for participation by university staff to address the high youth smoking prevalence in the country, particularly among university students.

### **Outcomes of the training**

The training led to:

- a cadre of over 100 public health professionals equipped to provide brief cessation counselling;
- improved health system capacity to address gaps in cessation support, with 10% of the health professional workforce trained in brief intervention in a year's time;
- health professionals empowered at earlier workshops serving as peer educators in subsequent workshops;
- a WhatsApp group of participants to facilitate ongoing exchange of experiences, initiatives and ideas among the trained health professionals.

### **Challenges**

There are four main challenges to the sustainability of the programme:

- the sporadic nature of the training, depriving the trainees of ongoing technical support;

- the mobility of trained health professionals, leading to gaps in institutional capacity;
- changes in health leadership, delaying cessation policies;
- a lack of sustainable in-country funding for cessation activities.

## Future plans

Three more workshops with a projected target of 100 participants were planned for 2018. The target was to have 250 trained health professionals in the country by 2018, who in turn were anticipated to train others in their institutions, in order to address the country's capacity and resource gaps in cessation services.

The lessons and feedback from the workshops are being used to inform future training. Reduced resources had limited promotion of the training to an information post on the official webpage of the Ministry of Health and Social Protection. Under the FCTC 2030 project, plans are afoot to promote the training on more public and media platforms, through the development of a virtual course in cessation. Better marketing is being planned for upcoming training programmes. A communication strategy that addresses cessation training is also under development.

Partnerships with health professional bodies and universities are being explored to support the sustainability of the training programme.

## Emerging needs

Five specific needs have emerged for the capacity-building of health professionals to deliver comprehensive cessation support at population level:

- an administrative decision to provide cessation support across the health system;
- clinical guidelines on tobacco dependence treatment for daily use by health professionals;
- cessation clinics with pharmacotherapy support available;
- a budget allocation for coverage of tobacco dependence treatment in the Health Benefits Plan;
- inclusion of cessation training as an integral part of postgraduate training of health professionals.

### Box 11. FCTC 2030 Project support for cessation in Colombia

- Prioritizes monitoring of population level impact of cessation.
- Uses monitoring results to make an investment case for sustainable funding.
- Builds regional capacity in cessation support.