WHO-EM/TFI/095/E

Report on the

Intercountry meeting on implementation of WHO Framework Convention on Tobacco Control guidelines on treating tobacco dependence

Cairo, Egypt
23–25 September 2012

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

An intercountry meeting on implementation of World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) guidelines on treating tobacco dependence was held at the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) in Cairo, Egypt, from 23 to 25 September 2012 (see Annex 1 for Programme). The meeting was attended by participants from countries of the Eastern Mediterranean Region, tobacco control experts and WHO staff (see Annex 2 for List of participants).

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, in his opening address noted that while tobacco was highly addictive, cumulative evidence had shown that tobacco cessation services could be an effective measure in reducing the use of tobacco. However, over 85% of the world's population did not have access to such services, mainly because tobacco dependence treatment services were not cheap. Yet they needed to be made widely available and accessible in order to reverse the deadly and debilitating impact of an epidemic that killed nearly six million people every year worldwide.

To achieve this, he said, WHO had developed guidelines for implementation of Article 14 of the WHO FCTC. The guidelines were a technical and practical tool in one. They told us what we need to know about tobacco dependence and provided us with a step-by-step account of how to evaluate and establish national cessation services. The MPOWER package of six evidence-based tobacco control measures provided practical assistance with country-level implementation of effective policies that had been proven to reduce tobacco use and save lives.

Political support for tobacco control was growing. Governments were actively taking steps to: ban tobacco use in public places; increase taxes on tobacco products; ban all forms of tobacco advertising, promotion and sponsorship; and implement pictorial health warnings on tobacco product packaging. This was the time to take action, he said.

As restrictions on tobacco use increased, so did the desire of tobacco users to quit, he observed. However, because tobacco dependence was a chronic condition that often required repeated interventions and multiple attempts to quit, help and support was needed for tobacco users to overcome their dependence.

He pointed out that integrating tobacco cessation interventions into well-established, well-funded health programmes improved access to effective tobacco cessation services and eventually increased the chances that a tobacco user would quit successfully. Also, providing training to health care providers in primary health care units enabled them to deliver brief tobacco interventions and offered support to tobacco users wanting to quit.

Additionally, strong evidence had shown the effectiveness of toll-free quit lines, he said. They were practical to implement and could be included in any advertisement or incorporated onto a tobacco product pack in conjunction with health warnings. Quit lines had

the greatest chance of materially impacting the rate of quit attempts and quit success at the population level when combined with other policy initiatives and measures.

For tobacco dependence treatment and cessation services to be truly effective, one single policy or measure could not work in solitude. Tobacco dependence treatment and cessation services must be part of larger national level interventions to control tobacco. Many countries in the Region had very limited resources for tobacco control, and inclusion of cessation activities into health system programmes was not yet considered a priority due to funding.

Over the coming three days, he said, participants would discuss and demonstrate how tobacco cessation can be strengthened in a cost-effective manner through: integrating such services into existing national, state and district level health structures and linking them with existing primary health care health programmes; training health care providers in existing, well-established health care settings to offer support and advice; and establishing national toll-free quit lines. They would also work to develop country preliminary plans of action with well-defined steps for implementing and improving cessation services at national level in a cost-effective manner, based on existing evidence and best practices.

Dr Alwan concluded by highlighting the financial benefits that tobacco dependence treatment carried for society: it decreased health care costs and improved productivity, and was one of the most cost-effective preventive measures to reduce tobacco use. Providing tobacco dependence treatment and cessation services was thus an obligation for Parties and non-parties alike.

Dr Haifa Madi, Director, Health Protection and Promotion and Acting Director, Noncommunicable Diseases and Mental Health, WHO/EMRO, presented an overview of the situation in the Region and the objectives of the meeting. She said that the meeting was the latest of several to support the implementation of the WHO FCTC and its guidelines. The focus was on Article 14 and its guidelines on tobacco dependence treatment, adopted by the fourth Conference of Parties in November 2010.

She noted that tobacco cessation was a legal obligation of the Convention and a component of the MPOWER package. Cessation was a priority in tobacco control because tobacco was highly addictive and there was well documented evidence that tobacco cessation services can be very effective. Studies had shown that there was demand for quitting in the Region. The Global Youth Tobacco Survey (GYTS) found that most students (aged 13–15) who use tobacco in the Region want to stop and have tried to. This situation indicated an opportunity to prevent young people from becoming adult tobacco users. However, tobacco cessation services in the Region were very limited overall, although the situation varied from country to country.

Cessation worked best when integrated in the existing health system as part of a comprehensive tobacco control scheme. It was a group of interventions that complement each

other, including integration into primary health care, health staff training, quit lines and medication, including nicotine replacement therapy (NRT).

She pointed out that health care systems should have a central role in treating tobacco dependence and existing resources and infrastructure should be used to promote counselling and treatment. Tobacco dependence treatment should be widely available, accessible and affordable, and, where appropriate, tailored to the needs of individual tobacco users. Recording of tobacco use in medical records should be mandatory. As well, countries needed to protect the process of planning and building cessation services from all commercial and the vested interests of pharmaceutical companies. Moreover, it was essential to identify funding resources for that infrastructure.

The main objectives of the meeting were to:

- present WHO guidelines on implementation of Article 14 of the FCTC
- review the status of cessation services at national levels in the countries of the Region and identify gaps
- present lessons learnt from success stories and best practices
- develop national action plans on integration of tobacco dependence treatment and development of quit lines
- develop regional recommendations on implementation of FCTC Article 14 guidelines.

The expected meeting outcomes were to: identify a way forward to bridge the existing gaps according to each country situation; draft national plans of action on integration of cessation services into primary health care and on establishing/enhancing existing quit line services; and agree regional recommendations in accordance with WHO FCTC Article 14 guidelines.

2. TECHNICAL PRESENTATIONS

2.1 WHO FCTC Article 14 guidelines

Dr Heba Fouad, Technical Officer (Surveillance), Tobacco free initiative, WHO/EMRO

The WHO FCTC Article 14 guidelines were adopted in November 2010 at the fourth Conference of the Parties. They are a very good technical tool on tobacco dependence, offering a practical step-by-step guide for countries to use for both establishing and evaluating national cessation services. Parties to the Convention are encouraged to use these guidelines to assist them in fulfilling their obligations under the WHO FCTC and in protecting public health. Countries are required to implement the cessation programme and provide tobacco dependence treatment according to their financial ability, health system structure and priorities.

The purpose of the guidelines is to encourage Parties to: strengthen or create a sustainable infrastructure which motivates attempts to quit; identify the key, effective

measures needed; incorporate tobacco dependence treatment into national tobacco control programmes and health care systems; and share experiences.

The guidelines highlight some general rules:

- Tobacco dependence treatment should be widely available, accessible and affordable
- Introduction of the different components of a comprehensive system on cessation can be simultaneous or stepwise, according to each Party's circumstances and priorities.
- Tobacco cessation 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.
- Health care systems should have a central role.
- Development of strategies to implement Article 14 should be protected from the commercial and other vested interests of the tobacco industry,
- Sharing of experience and collaboration with each other will greatly enhance Parties' abilities to implement the guidelines.
- Monitoring and evaluation are essential components of successful tobacco cessation programmes.
- Active participation of and partnership with civil society are essential.

Countries need to undertake a situation analysis and develop a strategic plan in coordination with other health programmes. A national coordinating mechanism or focal point is required to facilitate the strengthening/creation of a programme on tobacco cessation and tobacco dependence treatment. Sustainable funding needs to be identified, possibly from tobacco-related taxes, penalties, fees and licences.

Support can be offered to tobacco users in a wide variety of settings and by a wide variety of providers, and can range from a population-wide approaches like brief advice and quit lines to more intensive behavioural support delivered by specialists. Scientific evidence shows that behavioural support and medications are effective and cost-effective, separately and combined, and that they are more effective when combined.

Tobacco cessation guidelines need to be developed and disseminated taking into account national circumstances and priorities, including a national cessation strategy, to be used by those responsible for funding and implementing policies and programmes, and national treatment guidelines to be used by those who will deliver the service.

Using existing infrastructure, such as primary health care and programmes such as those for tuberculosis and HIV/AIDS, will provide the greatest possible access for tobacco users. Recording of tobacco use status in all medical and other relevant notes should be mandatory, as well as recording of tobacco use in death certification. It is also essential that governmental and nongovernmental organizations work in partnership to achieve rapid progress.

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. Tobacco control and tobacco cessation should also be incorporated into the training curricula of all health professionals. Health care workers should stop using tobacco themselves and set a good example that helps to reduce the social acceptability of tobacco use. Smoking bans need to be enforced in all health care facilities.

Population-level approaches such as mass communication and education will ensure that the population is well informed about the availability and accessibility of tobacco dependence treatment services and encouraged to make use of them. Quit lines providing advice on how to quit should be widely publicized, such as on tobacco product packaging, and adequately staffed, to ensure that tobacco users can always receive individual support.

In discussion, it was observed that tobacco cessation programmes should be tailored to country contexts and, where appropriate, should address smokeless tobacco use. The need to build country databases, involve local communities in prevention and tailor cessation interventions to social/cultural/religious contexts was noted. The difficulty in obtaining medications, their cost, the need for them to be licensed by health ministries and the need for country-specific solutions to identifying the required funds to make them available was also discussed. Guidelines are needed for treating young people under 18 given the legal and health considerations involved, it was noted. Increasing political commitment for cessation and communication activities that encourage the perception that tobacco use is a disease that needs to be treated were seen to be crucial.

2.2 Tobacco dependence treatment challenges and gaps in countries of the Eastern Mediterranean Region

Dr Heba Fouad, Technical (Surveillance), Tobacco free initiative, WHO/EMRO and Dr Mahmoud El Habiby, Faculty of Medicine, Ain Shams University, Egypt

Tobacco use is still a significant problem in the Eastern Mediterranean Region with increasing prevalence, including among youth and women, low tobacco prices, weak implementation of tobacco control policies, lack of resources for tobacco control, tobacco industry interference in tobacco control efforts and low levels of awareness about tobacco's harms.

The tobacco epidemic is shifting from the developed to the developing world. Of the 1.1 billion smokers globally, 800 million are in the developing world. This increased tobacco use prevalence has been attributed to: an increase in consumption among new groups (females and young people); population growth; aggressive marketing of tobacco products especially to youth; and the introduction of new tobacco products (such as shisha and smokeless tobacco).

According to the GYTS, the Region has the lowest prevalence of cigarette smoking among boys and girls aged 13–15 compared to other WHO regions (7% of boys and 2% of girls smoke cigarettes), but it has the highest prevalence of other tobacco product use (14%

among boys and 9% among girls). However, there are concerns over the validity of the data for girls given the stigma attached to female tobacco use in the Region. Whatever the true figure, the gap between boys and girls tobacco use appears to be narrowing.

Studies show that most tobacco users want to quit, including over two-thirds of young people. The FCTC and MPOWER technical package provide evidence-based solutions to reduce the demand for tobacco, including through cessation and treatment for tobacco dependence. The FCTC has now been ratified by most of countries of the Region. However, there are severe challenges in the Region, including political changes, financial constraints and social attitudes to tobacco use.

WHO recommends three treatment services: tobacco cessation advice incorporated into primary health care services; easily accessible and free quit lines; access to low-cost pharmacological therapy. But of the countries in the Region:

- 16 have public and/or private tobacco cessation clinics, 8 have tobacco cessation clinics in most primary health care facilities, hospitals and clinics, and 5 have government support for the full cost of the service;
- four (4) have toll-free telephone quit lines;
- 13 have legally-available NRT (patch, gum, lozenge, spray or inhaler) purchased in pharmacies without prescription, 4 have added NRT to the essential medicines list and 7 have the cost covered by national/federal health insurance or the national health service, with partial support by health insurance in 2 other countries.

Prevalence studies among health profession students in the Region, such as the Global Health Profession Students Survey (GHPSS), have found that while many have used tobacco, most believe that health professionals should serve as role models for their patients, have a role in giving advice about smoking cessation to patients, and should get specific training on cessation techniques. However, most had received no formal training in smoking cessation approaches.

It is therefore essential that tobacco dependence and cessation is incorporated into the core curriculum and continuing professional training of medical, dental, nursing, pharmacy and other relevant undergraduate and postgraduate courses and in licensing and certifying examinations. Health care facilities should be smoke-free and health care workers (and other sector workers where appropriate) trained to give brief cessation advice and supported to quit their own tobacco use. Tobacco use should be recorded in medical notes and other relevant notes at all levels of care.

Treatments used for tobacco dependency should be evidence-based. This is lacking for many treatments used in the Region such as e-cigarettes, acupuncture, complementary medicine, toxin-removal devices, hypnosis and laser therapy. Pharmaceutical company influence in many countries over treatment medications and services, such as quit lines, and scientific meetings, needs to be addressed.

There is a limited evidence base for tobacco dependency treatment in the Region, including on the role of social/cultural factors, levels of nicotine dependency and the dosing, efficacy, side-effects and acceptability of medications. Studies should be funded by neutral organizations (not pharmaceutical companies). A regional evidence base is needed, including on smokeless and water pipe tobacco and the quality/efficacy of services.

There is a lack of experience of quit lines in the Region and they are often not based on best practice or easily accessible and are sometimes infiltrated by pharmaceutical companies. Group treatment can be cost effective and easily applied, but is not common in the Region due to cultural considerations (such as inhibitions about speaking in groups and mixed-gender groups) and the lack of trained personnel.

Campaigns for treatment can increase awareness of smoking as a disease rather than a "habit" and provide information on cessation services. It is important that they offer help rather than threats for smokers, and should be free from tobacco and pharmaceutical company influence. Cessation services should prepare for an increase in demand after campaigns.

Specialized cessation services are costly but can be useful for advocacy, dealing with resistant cases, disseminating new treatment approaches, quality improvement issues, and training and supporting non-specialized health professionals. Identifying the most appropriate funding mechanism for cessation is very important (public, health insurance, a special fund, work place, community-based).

2.3 Developing and improving national toll-free tobacco quit line services: A WHO manual

Dr Dongbo Fu, Tobacco Free Initiative, WHO headquarters

The WHO FCTC Article 14 guidelines recommend the following.

> "All Parties should offer quit lines in which callers can receive advice from trained cessation specialists. Ideally they should be free… Quit lines should be widely publicized and advertised, and adequately and adequately staffed… Parties are encouraged to include the quit line number on tobacco product packaging. "

The WHO manual has been developed as a result to provide a global standard to critique current practices, recommend proper quit line procedures, and evaluate and improve quit line services and outcomes. Over 30 people from quit lines around the world helped write and review it, including from the Eastern Mediterranean Region.

A WHO situational analysis in 2009 found that there were 53 national quit lines in the world. Most (32, 60%) were in high-income countries offering a combination of proactive and reactive services, high population coverage and a wide range of services. There were 21 in low- and middle-income countries that offered a reactive service, had lower population coverage and provided limited services. The manual is therefore mainly targeted for the use of low- and middle-income countries.

The manual identifies 10 steps to the setting up of a national quit line service. These are as follows.

- Step 1: Identify a quit line expert (who knows the culture of your country).
- Step 2: Assess the specific needs for a quit line service in your country.
- Step 3: Determine the place and role of the quit line services in your national tobacco control strategy.
- Step 4: Determine the goals of the quit line: high reach with minimal counselling; high effectiveness (quit rate) with lower reach; or high reach and high effectiveness (impact).
- Step 5: Determine the range of services and desired utilization rates. Core services: telephone counselling, self-help materials and referrals to local in-person services. Additional services: internet and cell phone-based services, cessation medication.
- Step 6: Determine strategies for creating demand for your quit line e.g. take advantage of policy changes, do mass media promotions, create brand identity.
- Step 7: Determine which sponsors could fund and oversee the quit line: needs to be reliable and could include the ministry of health, health insurance, employers, nongovernmental organizations and foundations. Avoid caller-funding.
- Step 8: Determine a project management plan for implementation including: identification of minimal standards and the critical milestones; clarification of the role of different project partners; a timeline for each action step; a monitoring and evaluation plan.
- Step 9: Determine which organization will deliver services.
- Step 10: Determine who is accountable for ensuring the success of the quit line.

The manual also provides recommendations for operational challenges, including about enrolment and counselling protocols, quality of service, hours of operation, space needs, telephone requirements and computer system requirements.

2.4 Video presentation on quit lines: Challenges and opportunities

Dr Tim McAfeee, Director, Office on Smoking and Health, U.S. Centers for Disease Control and Prevention

Quit lines present an opportunity to increase the number of quit attempts. They help stimulate quit attempts, increase the success rate of quit attempts, increase the acceptability of tobacco control by being well-regarded and tangible services, and provide data that can be used in tobacco control advocacy. Funding is a challenge but tobacco taxes bring in huge revenues, only a tiny fraction of which are spent on cessation; yet cessation is much cheaper than treating tobacco-related diseases.

Quit lines and health services are mutually-beneficial. Health care staff can, in turn, help motivate patients to want to quit and provide the number and encouragement to call. Quit lines can provide referrals for health care services and help increase the number and successfulness of quit attempts, including through usage of medication. Integrating quit lines

with health services will improve the long-term impact of cessation efforts overall. Quit lines work best when they are part of a comprehensive tobacco control programme.

Mass media campaigns can help promote quit attempts and increase the number of callers to quit lines. They help “naturalize” calling quit lines. It is important that campaigns do not just scare tobacco users but offer a way to quit. In the US, campaigns have focused on lesser known health issues related to tobacco use and provide a quit line number and a message encouraging quitting as a positive choice. A recent campaign generated 200 000 extra quit line calls over the three months it lasted. The next campaign will contain the message to “ask your doctor” (for help to quit).

In discussion, the importance of considering the global evidence-base and understanding the specific situation in countries was noted. Asking callers why they call and recording the data can be useful in this respect. The experience in Brazil, Egypt and Thailand was that many callers were prompted by pictorial health warnings on tobacco packaging. It was recognized that many tobacco users want to quit but do not know how.

There was debate on whether services should be provided for free given that tobacco products are paid for and that people may value better services they pay at least “symbolic” fees for (possibly after an initial free consultation). However, the experience from Thailand was that initial charges for calls to the quit line were found to discourage service users.

The skills required of quit line helpers were discussed and it was pointed out that they do not need to be medically-qualified but need communication skills, a basic knowledge of services and treatment, and behavioural counselling skills. On-the-job experience and continuous training and supervision can provide this. In Egypt, the quit line staff comprises social workers and psychologists.

2.5 A best practice: Establishing a national toll-free quit line service in Thailand

Jintana Yunibhand, Director, Thailand National Quitline, Chairman, Asia Pacific Quitline Network

Smoking prevalence among Thais has declined from 32% in 1991 to 21.36% in 2011 (41.7% among men and 2.14 among women). However, two-thirds of current smokers in the country are estimated to want to quit. In response, the Thai national quit line was initiated by the Thai Wellbeing Foundation in 2007, as a joint project of the Ministry of Public Health, National Health Security Office and Thai Health Promotion Foundation. It was given US$ 1 million for two years.

The quit line is for people who are thinking about quitting or proxy callers on their behalf. Its hours of operation are Monday to Friday, 07:30–20:00. Weekend, holiday and after hours calls are tape recorded and called back. Calls used to cost a small fee (3 Baht) but have been free since February 2012. The service now has 30 lines.

The call system involves different responses to smokers and proxy callers. Proxy callers receive brief advice and information while smokers either receive brief advice or in-depth counselling followed by the option of setting a quit date and agreeing to future services including protocol-based proactive call backs for relapse prevention (six follow-up calls made over the following year). This information is recorded in an electronic database. A guideline-based referral system is in place with partners, including cessation clinics, using a form sent by email or fax.

Calls made by smokers to the quit line in 2009 were mainly from males (91.7%), while proxy callers were mainly female (87.9%). In terms of age, 43.6% are in the 25 to 40 age group, 24.4% are aged 41 to 59, and 18.9% are aged 19 to 24. Quit line promotion includes TV advertisement, posters, promotional activities and a web site. In 2010, the quit line number was placed on cigarette packs ("Want to quit? Call 1600") leading to an increase in calls. Since 2009 there has been a year-on-year increase in callers to over 25 500 per month in 2012. Research suggests a 49.45% quit rate at 6 months follow-up.

The quit line's key success factors include:

- providing quality, comprehensive (reactive, proactive and integrated) tobacco cessation services by experienced and qualified counsellors
- using an evidenced-based clinical practice protocol (practical quitting information, skills building, confidence and motivation enhancement, and social support)
- using up-to-date technology for the database and call centre
- quality monitoring for improving the system and outcome-based/research-based management
- having adequate resources and technical support.

The phone counsellors are often retired nurses but include other health professionals such as clinical psychologists and medical social workers. Both group and individual training are done, including theory, counselling techniques and clinical practice. However, individual training is recommended over group training. This includes self-instruction and individual tutorial sessions as well as clinical practice. This was found to lead to higher satisfaction, a shorter training programme and lower costs than group training.

In August 2011, a quality monitoring system was introduced. This involves continuous monitoring by clinical experts, evaluation of counselling sessions and regular individual and team meetings. Outcome-based management is used based on indicators such as incoming calls, completed calls, abandoned calls, outgoing calls, client characteristics, etc. The outcomes are reported to the executive board and staff.

To increase service accessibility and reduce abandoned calls, in November 2011 a "call takers system" was introduced. Call takers screen all incoming calls for prank calls, proxy calls, ex-smokers, no-intention-to-treat callers and intention-to-treat callers and then provide brief advice and refer where appropriate.

In discussion, the issue of caller confidentiality was raised and it was explained that the Thai quit line had a caller agreement process involving a recorded message informing users that calls would be recorded for quality control and permission was asked before call-backs. It was pointed out that callers did not have to give their real names. It was clarified that proxy callers were mainly family members wanting to help tobacco users to quit; they were not counselled but encouraged to get the tobacco users to call for themselves.

It was noted that referrals to the line are mainly from primary health care services and a key challenge is to improve integration with health services. Follow-up of referrals is important and they do so with 48 hours. It was felt that the line complements the work of cessation clinics and can be combined with medication, but that the latter was expensive and had to be prescribed. Currently, the web-based client service is weak, it was noted. The line does not use volunteers but has full and part time workers.

2.6 Introduction to the WHO module on integration of cessation services into primary health care

Dr Heba Fouad, Technical Officer (Surveillance), Tobacco free initiative, WHO/EMRO

WHO recommends three core tobacco cessation services: integration of brief advice into existing primary health care; quit lines; and pharmacological therapy. The integration of brief tobacco interventions into existing primary health care services is recommended as the minimum requirement because it is effective, can reach the majority of tobacco users (particularly the poor) and is more cost-effective than other interventions because it uses exiting structures and staff.

Integrating brief tobacco interventions into primary health care is the quickest and most efficient way for a country to begin to develop a comprehensive tobacco dependence treatment system. If behavioural and pharmacological interventions are routinely offered, 80% of all tobacco users can be reached per year, triggering 40% to make a quit attempt, and helping 2%–3% of those receiving brief advice to quit successfully. Many opportunities and entry points exist in the primary health care system to reach and provide a variety of patients with brief tobacco interventions. This includes programmes dealing with tuberculosis, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and maternal and child health.

Brief advice involves identifying tobacco users and giving them advice to quit. The “5 As” counselling approach is recommended for patients who are willing to quit tobacco use. The 5 As are as follows.

- Ask patients about their tobacco use.
- Advise them to quit.
- Assess their willingness to make a quit attempt.
- Assist in their attempt to quit.
- Arrange follow-up with them.

For patients unwilling to quit tobacco use, the following “5 Rs” are recommended.

- Relevance: Encourage the patient to indicate why quitting is personally relevant to him or her.
- Risks: Ask the patient to identify potential negative consequences of tobacco use.
- Rewards: Ask the patient to identify potential benefits of quitting tobacco use.
- Road blocks: Ask the patient to identify obstacles to quitting.
- Repetition: Repeat the intervention every time an unmotivated patient visits the primary health care setting.

The objective of the WHO primary health care systems strengthening approach for treating tobacco dependence is to achieve universal coverage of brief tobacco interventions in a country: providing a brief intervention to every tobacco user at every primary health care visit. Primary health care systems strengthening is a complicated process involving all key actors in a health system. The WHO Health System Framework is a useful tool to assist policy-makers in this. The six health system building blocks identified by WHO are; service delivery; health workforce; information; medical products, vaccines and technologies; financing; leadership/governance.

Key implementation strategies for integrating tobacco cessation services into primary health care in the Region include the following.

- Developing national policy to support integration of effective tobacco cessation interventions into well-funded health programmes.
- Increasing awareness among health care professionals, administrators and policy-makers of both the benefits and cost effectiveness of tobacco cessation interventions relative to other health care interventions.
- Advocating for including tobacco use status in the registration and information system.
- Providing training to health care providers in primary health care units to enable them to deliver brief tobacco interventions (“5 As” and “5 Rs”) effectively.
- Strengthening tobacco dependence treatment in the Practical Approach to Lung Health (PAL) implementation where appropriately integrated in the primary health care system.
- If appropriate, offering and making accessible a full range of effective behavioural and pharmacological treatments to all addicted tobacco users who wish to quit.

Brief interventions may be delivered anywhere – in the hospital setting, in the out-patient clinic or in the community. They take a few minutes, but if done routinely, they can significantly increase the numbers of people quitting and save lives.

2.7 Integration model: tuberculosis and tobacco

Dr Dongbo Fu, WHO/HQ

Tobacco use is a confirmed risk factor for tuberculosis. Active and passive tobacco smoking is significantly associated with tuberculosis infection and tuberculosis disease, and

active smoking is significantly associated with recurrent tuberculosis and tuberculosis mortality. It is estimated that a 1% decrease in smoking prevalence per year would avert 27 million smoking attributable deaths from tuberculosis by 2050.

Tuberculosis treatment programmes can help reach a large number of tobacco users: DOTS has the potential to reach more than a million tobacco users a year. The Practical Approach to Lung Health (PAL) programme has the potential to reach 20%–35% of all patients in primary health care settings.

WHO and the International Union Against Tuberculosis and Lung Disease recommend tuberculosis programmes provide tobacco cessation interventions using a whole-system approach. In particular, they recommend:

- providing treatment of tobacco dependence for tuberculosis patients
- providing brief advice (5As, 5Rs)
- intensive behavioural support
- pharmacological interventions
- making the clinic where tuberculosis patients are treated smoke-free
- taking managerial decisions to overcome barriers in the health system to support tobacco control activities.

Models of the integration of brief advice into tuberculosis care at primary health care level include successful projects in Brazil (an operational clinical trial of smoking cessation in DOTS clinics), India (a national pilot project on tuberculosis tobacco integration), Nepal (a WHO pilot project on implementing smoking cessation through PAL) and Sudan (a feasibility study of brief tobacco cessation advice for tuberculosis patients). These projects found that integration of tobacco cessation into DOTS and PAL was both feasible and successful, leading to improved treatment outcomes and quit rates.

In Nepal the project secured support from policy-makers, included the 5As and 5Rs into the PAL guidelines, trained health staff and integrated smoking status into the PAL register. It found that 59.1% of respiratory disease patients were smokers; 22.2% of these smokers were given brief counselling to quit smoking and 23% of those who had received the brief counselling had quit smoking at six months follow-up. As a result of this success, the project is being expanded to 25 districts during 2010–2015.

In discussion, it was noted that tobacco is a risk factor for many conditions and that tobacco cessation can be integrated into a range of health programmes in addition to tuberculosis services, such as those for adolescents or pregnant women. It was further observed that in some countries, such as Sudan, primary health care services, including tuberculosis services, were not always reliable, and therefore specialist cessation services may be required. However, it was pointed out that while different country contexts would entail different approaches, in general specialist clinics have a smaller population reach, but can act as useful resource centres. However, brief advice in health care services was a better place to start than medications and psychotherapy for most countries. The WHO training

manual on integration of cessation services into primary health care was noted to be a useful tool for primary health care workers.

2.8 Smoking cessation services and tobacco free initiatives

Christine Goodair, International Centre for Drug Policy, St George's, University of London

In 1997, the Government of the United Kingdom recognized that smoking was the single largest preventable cause of premature death in the country, and that the number of adults smoking had stopped falling and numbers of young people smoking were increasing. A desire to help existing smokers quit and to prevent young people from taking up smoking, and to improve the health of the population, resulted in legislation, the setting up of services, and public education programmes. Legislation has included bans on cigarette advertising, sale to minors, smoking in enclosed work and public places, and tobacco displays in shops.

Prevalence has fallen in the United Kingdom over the past four decades: 45% of adults in the country were cigarette smokers in 1974 compared to 20% in 2010. In the United Kingdom, 100 000 smokers die from smoking-related causes each year. The economic burden of tobacco use is estimated at £13.74 billion a year. The National Health Service (NHS) Stop Smoking Services spends £83.4 million on services to help people stop smoking and £65.1 million on tobacco cessation medication. These services are delivered through local stop smoking services and a national quit line. Services include: local/national helplines; face-to-face counselling; drop-in clinics; educational materials; specialist services for particular groups; and nicotine replacement therapy and pharmaceutical products.

Public health education includes paid media advertising, media advocacy and press briefings, and specific campaigns such as a No Smoking Day, "quit kits" sent to quit line callers and smokers urged to quit for a month ("Stoptober"). A "Smoke-free" website provides signposting to services.

In 2011/2012, 816 444 people set a quit date through NHS Stop Smoking Services. This is a 4% increase from 2010/11.The percentage of people who successfully quit in 2011/12 was 49%, the same percentage of successful quitters seen in 2009/10 and 2010/11. Although, rates of smoking have continued to decline over the past decades, tobacco use is still one of the United Kingdom's most significant public health challenges.

Government plans for next five years include stopping the promotion of tobacco (including plain packaging requirements), making tobacco less affordable, regulation of tobacco products, helping tobacco users to quit, reducing exposure to second hand smoke (such as in cars and homes) and effective communications for tobacco control.

The International Centre for Drug Policy and St George's smoking cessation work includes the Reduction in Tobacco Addiction (RETAD) study programme, a multi-component, multi-setting intervention that focuses on motivating smokers to quit within a hospital setting. RETAD provides guidance on implementing hospital-based stop smoking

services and smoke-free policies, and a training manual for health care professionals has been developed. There is a local quit line and a drop-in cessation clinic at St George's for visitors, staff and patients, along with specialist respiratory nurses, advice and support provided to ward patients and a non-smoking environment.

Other work includes the Tobacco Free Initiative training courses run in collaboration with the WHO Regional Office for the Eastern Mediterranean since 2002. The courses aim to provide clinicians and policy-makers with a tobacco free "toolkit" and to provide a broad range of learning experiences to meet individual needs in relation to country contexts, including the setting up of cessation services and providing cessation training.

In discussion, it was clarified that the Tobacco Free Initiative training courses run at St George's have 12–15 participants from the Region each year and that the course could be brought to countries as had been done with a drug control course that was run in the Islamic Republic of Iran.

2.9 Article 14 guidelines and their implementation

Tibor Szilagyi, FCTC Secretariat

The guidelines for Article 14 of the FCTC were developed by a working group comprised of 50 members and adopted in 2010. Parties report on their implementation. A key recommendation is the inclusion of tobacco cessation and treatment of tobacco dependency in national tobacco control programmes and the development of national guidelines on tobacco cessation and treatment of tobacco dependency. Nearly 50% of Parties have now done this, including Jordan from the Eastern Mediterranean Region. These can act as templates for those wishing to develop their own. Over 50% of Parties have also now integrated tobacco cessation into their national health care structures, including into primary health care. Most (around two-thirds) Parties have adopted this approach, with a much lower proportion developing specific tobacco cessation services. It involves training of all health professionals (including physicians, dentists and nurses) in tobacco use diagnosis, recording tobacco use in medical records and cessation advice. Pharmacological therapy can be made available by including NRT in the national essential medicines list. The 2012 global report of Parties on FCTC implementation will be available soon.

In discussion, it was noted that most WHO Member States are now Parties to the FCTC and that Parties are committed to full implementation of the Convention, with deadlines for some measures. The guidelines give information on integration at the different levels of the health system using the existing infrastructure. The guidelines advise a stepwise approach that recognizes that while quit lines are a good first step they are best combined with developing cessation guidelines for health professionals and integration into primary health care. There are some good examples of funding sources for cessation in the guidelines for consideration. While the guidelines refer to new and emerging tobacco products there is no information provided on the much-debated role of electronic cigarettes as cessation aids, although this topic will be discussed at the next Conference of Parties and a document on it (and on smokeless tobacco) is available on the FCTC website.

3. COUNTRY PRESENTATIONS

3.1 Afghanistan

Afghanistan currently does not have a national strategy or guidelines on tobacco cessation and tobacco dependence treatment, and has no integration of tobacco cessation into primary health care, access to tobacco dependence treatment medications or tobacco quit lines. Tobacco use data is not collected in medical records. However, the country does have some tobacco use data from 25 schools surveyed as part of the GYTS in 2004 and 2010, and youth counselling and information centres in 10 provinces provide information on the harms of tobacco and have been given guidelines on tobacco control counselling. Draft tobacco control legislation has been developed and a tobacco control strategy is being developed, although funds are needed for a comprehensive tobacco control programme.

3.2 Bahrain

Since 2004, a tobacco cessation clinic has been run by the Ministry of Health, in line with recently updated national guidelines. It is staffed by a physician, a health promotion specialist and a nurse, and is open one day and two evenings a week. The services it provides include consultations, measurement of lung function and carbon monoxide levels, demonstrations about the hazards of smoking and ways to quit smoking, information materials, free gum and patch NRT medication (NRT is not yet on the essential medicines list), teeth cleaning and follow-up. A free subscription to a health club is also given. Patients can self-register or are referred by health services. Up to August 2012, the clinic has seen 1550 patients, mostly men aged 19 to 45, and there has been a 24% success rate. Future developments will include the opening of five more clinics, covering every governorate, and expanding the medical teams to include a social worker, a fully-equipped specialist nurse and a data entry specialist.

3.3 Egypt

Tobacco cessation services are a priority for the national tobacco control programme. Integration of cessation services into the health care system, including cessation clinics, is planned to start in 2013 and cessation guidelines are currently being developed. There is currently no availability of tobacco dependency treatment medication. Since November 2010, Egypt has had a tobacco quit line. It started with one line and currently has five, with five more planned. It is staffed by 12 social workers trained by experts from Ain Shams University. The quit line deals with 200–250 calls per day, but this is only 60% of those received. The line operates from 08.00 to 18.00 and call numbers are highest from Cairo. As well as phone counselling, the quit line can play a positive role in promoting the planned tobacco cessation clinics and referring callers to them.

3.4 Islamic Republic of Iran

Tobacco cessation is a priority component of the tobacco control strategy for the Iranian Ministry of Health and Medical Education and national guidelines have been developed. This is in response to tobacco use data that shows around 10 million tobacco users nationally and increases in rates between 2003 and 2007 amongst adolescents aged 13–15, particularly for water pipe tobacco. Six million tobacco users are estimated to have made unsuccessful attempt to quit. The first tobacco cessation clinic was established following the tobacco control decree in 1997. In 2002, to support the integration of tobacco cessation into primary health care, tobacco cessation training was provided to tobacco control focal points, including physicians and other health professionals, from 10 provinces.

Currently, there is at least one tobacco cessation clinic in each province, with around 158 clinics nationally. These clinics offer one month group therapy (six sessions) and individual therapy in certain cases. NRT is provided free at the clinics, and is available through pharmacies and included on the essential medicines list. The average success rate of the clinics is 60% at the end of one month, with around a 35% success rate after one year. Tobacco use is recorded in medical records and cessation has been partially integrated into the health system and is progressing area by area, but family physicians still need to be included. A quit line exists in Tehran and attempts are being made to involve the private sector in tobacco cessation and to include it within health insurance.

3.5 Jordan

Data from the GYTS in Jordan show that around 11.5% of adolescents aged 13–15 smoke cigarettes and 21.4% use other forms of tobacco, mainly by water pipe. In addition, data from the GHPSS show that over 40% use tobacco. A tobacco control law in 2008 introduced a number of measures including penalties for smoking in public places and rotating pictorial health warnings on cigarette packs. A national tobacco control committee has been established and tobacco control focal points appointed. Tobacco cessation clinics exist in three cities, including Amman, and 142 health officers have been trained covering all governorates. Ten physicians have been sent for tobacco cessation training at St Georges Hospital in London, and 10 have been trained within Jordan.

3.6 Lebanon

Lebanon has a high prevalence of tobacco use among both men (45%) and women (35%), with GYTS showing 15% among boys and 7% among girls aged 13–15. Tobacco control legislation has existed since 1995 but has proven hard to implement and enforce. Prices and taxes for tobacco are low. Following FCTC ratification in 2005, a new law was issues in 2011. Tobacco cessation services are only provided through the private sector with no public or health insurance coverage. This includes small cessation programmes, using counselling and pharmacological therapy, at the American University in Beirut and several hospitals that charge a fee, have their own guidelines and only serve small numbers. Tobacco cessation medication is available through pharmacies (but not bupropion). There is therefore

the need for a national programme including a quit line, campaigns to build public support, research, free public hospital cessation clinics and integration of cessation into the health system, including the private sector. To initiate this, a survey has been conducted and a pilot free cessation clinic held with 200 people attending.

3.7 Libya

Since the recent conflict in Libya, there has been a collapse of the health system and in government control, including regarding tobacco. It is estimated that the 49.6% of adults who were previously identified as being smokers has now risen to 60%. NRT is only available from government pharmacies, with 18 out of 25 visited in a recent survey stocking it. There is currently a lack of the funds and trained human resources needed for tobacco control and cessation activities.

3.8 Morocco

Tobacco use prevalence is estimated at 31% in Morocco. There is no national tobacco control strategy, but tobacco use is included in the 2010 cancer control plan. Around 90% of hospitals and health centres have free tobacco cessation clinics. NRT is not included in the essential medicines list and is costly. Future plans, after ratification of the FCTC, include increasing the number of cessation clinics targeting youth, adding NRT to the essential medicines list and integrating cessation into primary health care.

3.9 Oman

Oman became a Party to the FCTC in 2005 but currently does not have a tobacco cessation strategy and only limited cessation services are provided, with cessation not being integrated into the health system. There is a national tobacco control committee currently working on a national tobacco control law. No cessation guidelines have been developed and training has been provided to only a limited number of health staff. NRT is available in private pharmacies (along with bupropion but not varenicline) but is costly. A pilot cessation clinic has been provided with free medication by the Nizwa Healthy Lifestyle Project (NHLP) since 2009. The programme has had 120 clients, with a 57% quit rate after a year. There is no quit line. The cost of cessation services remains a concern to policy-makers.

3.10 Pakistan

Pakistan has an estimated 22 to 25 million tobacco users (out of a population of 120 million), with an estimated prevalence of 32% among men and 9% among women. The FCTC was ratified in 2004 and tobacco control legislation passed in 1979 and 2002. Very limited cessation services exist, mainly provided by the private health sector and nongovernmental organizations. There is no national cessation strategy or national cessation guidelines, and no quit lines exist. However there has been approval by the federal government to provide cessation services. NRT is not on the essential medicines list but is available without prescription in pharmacies.

In 2013, Pakistan will take part in the Global Adult Tobacco Survey (GATS). This will inform a national assessment and the development of a cessation policy and guidelines that will be incorporated in the curriculum of 80 medical colleges. This should lead to the building of a cessation infrastructure through: integrating cessation into the existing health system at primary health care level; providing cessation training; allocation of resources for cessation from the tobacco product taxes; and monitoring and evaluation activities.

3.11 Palestine

Tobacco use is a significant problem in the occupied Palestinian territory, exacerbated by the high levels of stress in the population. Tobacco use includes water pipe use and there is significant use by women. A tobacco control committee exists and a law banning smoking in public places has been passed, but implementation remains weak. No tobacco cessation clinics or quit lines exist. Useful experience has been gained with a “swine flu” hot line that was established, but funding from donors is required to move forward on tobacco cessation. A tobacco control short film has been made as an advocacy tool that includes interviews with tobacco users and health professionals (part of the film was shown).

3.12 Saudi Arabia

In Saudi Arabia, there are 59 Ministry of Health cessation clinics (in hospitals and primary health care centres) and 13 non-Ministry clinics (provided by the private health sector, charities and the Ministry of Higher Education). Ministry of Health clinic staff include a physician, a heath technician and a counsellor. The programme’s content involves registration, assessment, physical examination, counselling, pharmacological therapy and follow-up for a year. The counselling sessions have four stages: nicotine addiction, management of nicotine addiction, health consequences of smoking, and relapse management. They are delivered by a physician or counsellor and last between 15–20 minutes. Both NRT and non-NRT (bupropion and varenicline) pharmacological therapy are available. Guidelines for tobacco cessation services have been developed and seven training courses provided for 200 health professionals.

Development of 20 existing and 28 new Ministry of Health clinics is planned, as well as a quit line, an e-clinic, monitoring and evaluation of services and inclusion of tobacco use in medical records. Challenges include the lack of tobacco control coverage by health insurance schemes and the need for a better referral system, greater community awareness and political support.

3.13 Sudan

Sudan, with a population of 33 million, has currently no cessation services within the health system. Pharmacological treatment is not widely available and is limited to only one or two pharmacies in Khartoum State. A tobacco research centre, established in 1982, is no longer functioning. Recently, the Federal Ministry of Health, Khartoum State Ministry of Health, the army hospital and police health services have discussed a strategic plan to

establish cessation services in Khartoum State (which has a population of seven million). There will be 14 cessation units, with two in each locality. Selected universities, hospitals and health centres in the state will be identified as sentinel sites. The planed budget is US$ 140 000 to cover the cost of NRT, equipment, materials, training manual development and training. A toll free quit line is also under development by the Ministry of Health and police/army hospital services. Challenges for tobacco cessation in Sudan include a lack of funds for tobacco control, the need to address the local smokeless tobacco (*tombak*), the availability of cheap tobacco and the lack of cooperation in combating the illicit trade in tobacco from neighbouring countries.

3.14 Syrian Arab Republic

In 2004, the Syrian Arab Republic became Party to the FCTC and from 2010 smoking in public places and the advertising and promotion of tobacco products has been banned. In terms of tobacco cessation, 66 doctors, nurses and community health educators have been trained in the last two years including on counselling skills and pharmacological therapy. There are 12 cessation clinics: 8 run by the Ministry of Health and 4 run by nongovernmental organizations. These clinics employ physicians, nurses and social workers and provide clinical examination, testing, education and medication. Varencline and bupropion are locally-produced and available through pharmacies but are costly. Data on tobacco use are being added to national health records and field studies have been carried out, in collaboration with WHO, on tobacco and youth and school staff. Tobacco cessation is still not included in medical education and NRT is not included in the essential medicine list. There are plans to use tobacco-related fines to fund tobacco cessation services. However, the priority of the Ministry of Health is currently on the emergency services.

3.15 Tunisia

Adult tobacco use prevalence in Tunisia is around 33%–35% and has risen slightly since the revolution. Tunisia takes part in the GYTS, GHPSS and Global School Personnel Survey (GSPS), with the GATS planned for 2013.The GYTS found a prevalence of tobacco use of 30.8% among boys and 8% among girls aged 13–15. Since its establishment in 2007, the national tobacco control programme has included a tobacco cessation component, along with legislation, public awareness and health education, surveillance and monitoring. Prior to 2009 there were 21 cessation clinics in tertiary hospitals, but from 2009 (designated as the year of tobacco control), 2000 physicians working in primary health care have been trained on tobacco control including counselling and brief advice. Specific training has also been provided for 300 physicians in tobacco cessation and communication techniques and a training manual developed and disseminated for trainees. In primary health care and hospitals where cessation clinics exist, there is weekly group therapy facilitated by trained personnel. There is recording of tobacco usage data in medical records.

NRT is included in the national essential medicine list and is given free to heavy smokers, smokers with chronic illnesses, pregnant smokers, students and hospitalized smokers but bupropion and varenicline are not available. There is currently no toll-free quit

line, although a quit line was attempted by a nongovernmental organization in 2010 but did not last due to a lack of trained staff. Current challenges include training health staff on smokeless tobacco, addressing e-cigarettes, improving motivational interviewing techniques in primary health care, advocacy for social security coverage of cessation medications and reintroduction of varenicline, and the introduction of cessation in the curriculum of health professionals.

3.16 United Arab Emirates

The United Arab Emirates has an advanced tobacco cessation programme that includes nine cessation clinics, providing free medication, counselling and behavioural therapy. Forty-five health staff (physicians and nurses) have been trained in tobacco cessation and some tobacco use data is recorded in medical records. However, this needs to be improved and more staff need to be trained.

3.17 Yemen

Helping smokers to quit is one of the objectives of the 2005 Yemeni tobacco control law and the integration of cessation services into primary health care is included in the national tobacco control strategy. However, due to the current conflict in the country this has not been implemented yet. Cessation medications are not included in the national essential medicines list and only nicotine lozenges are found in private pharmacies. No quit lines exist in Yemen.

The first and only cessation clinic in Yemen was established on May 2011 at Mukalla, in Hadhramut Governorate, by the Cancer Control Association. Two nurses and the clinic supervisor are available from 10.00 to 20.00. Services include testing of nicotine and carbon monoxide levels and lung functioning, behavioural and psychological support and counselling, and six sessions of the “silver touch machine” (similar to acupuncture) in order to decrease withdrawal symptoms. Follow-up is done for at least six months, and often for a year. The number of patients registered with the clinic has been 115 over the first year, with a 21% success rate. NRT is not available at the clinic, but is planned for the future. Challenges for tobacco cessation in Yemen include very weak political support, the lack of a budget, the lack of trained staff and the expensive cost of NRT and other medications.

4. GROUP WORK

4.1 Integration of cessation into primary health care services

Participants were divided into four working groups to discuss the scale-up of tobacco dependence treatment in primary health care settings as a key component of national tobacco control programmes.

Integrating tobacco cessation into primary health care settings was seen by the working groups as an essential part of tobacco control, an obligation under the WHO FCTC and high

priority for countries given the high health and economic costs of the tobacco epidemic. Moreover, as tobacco control legislation is increasingly implemented the demand for cessation services will increase.

Primary health care was viewed as a key setting for cessation services due to its availability, widespread service coverage and population reach, acceptability to communities and cost-effectiveness. Cessation needs to be integrated into the existing primary health care structures and programmes, such as those on noncommunicable diseases, health promotion, mother and child health, and tuberculosis. National cessation guidelines are needed for this.

Integration requires training of existing staff that should focus on brief advice (the 5 As and 5 Rs). Training on cessation should also be included in medical school curricula. Incentives or awards for service providers to encourage cessation integration could be considered. Improving the national database on tobacco use is also needed. Tobacco use information can be integrated into existing databases and should be recorded in medical records and death certificates, and become a standard part of patient registration. Adding cessation medications to national essential medicines lists would also support cessation integration.

Specific funding for cessation needs to be identified as part of the health system to support sustainable services, possibly from tobacco-related taxes, licences, penalties and/or fines. The role of health insurance coverage for cessation also needs to be looked at. Ministries of health should have the lead role and responsibility for the process of integration, with local health managers involved in the planning process, but coordination with the private sector, local communities and civil society is also needed. Lack of political support and funds, and potential service provider resistance and lack of availability, were potential challenges to the integration of cessation.

4.2 Quit lines

Participants were then asked to form a second working group to discuss the development, or improvement, of national toll-free quit lines for tobacco dependence as a key component in tobacco dependence treatment.

Quit lines were seen to be essential components of tobacco control with the potential to reach the whole population, including people living in rural areas, and women and young people who might not access other cessation services due to the stigma attached to tobacco use. The anonymity provided by quit lines can help to overcome this stigma. They can also be available outside normal working hours.

Quit lines offer information, advice, support, counselling and referrals and are accessible, effective, cost-effective (e.g. compared to medication), population-based services that allow for easy data collection and follow-up services. They complement existing cessation services and can provide and receive referrals to/from other services. They should be accountable to the ministry of health but can be provided by the public sector or a private

or nongovernmental organization, but should avoid tobacco or pharmaceutical company involvement.

It was felt that while quit lines compliment other cessation services, facilitating referrals, they are evidence-based cessation interventions in their own right and can be established on their own. Each call is an attempt to quit and quit lines may be especially useful in reaching “hidden” smoking populations in the Region such as women. Currently, there is a lack of an evidence-base on quit lines in the Region, although some do exist and helplines have been set up for other issues (such as “swine flu”). There is therefore a need to look at experience from other Regions and to build a regional evidence base.

To establish and maintain a quit line: funds need to be identified; an expert recruited to run it; a situation analysis done; the line’s scope and role defined and goals and indicators set; project management structures put in place; technical equipment set up; a database created; staff recruited, trained (including in communication skills) and supervised for quality assurance; and demand for the line created, possibly through campaigns and inclusion of the number in tobacco packaging health warnings.

4.3 Development of country plans of action

Participants were divided into working groups to develop individual country plans of action for tobacco cessation services as part of their overall tobacco control strategies, including integration of cessation into primary health care and toll-free quit lines, based on existing needs and gaps in their countries and in light of Article 14 of the WHO FCTC and its guidelines.

5. RECOMMENDATIONS

To Member States

1. Promote implementation of cessation services and tobacco dependence treatment within a comprehensive tobacco control programme, as recommended by the guidelines for implementation of Article 14 of the WHO FCTC.
2. Develop a national tobacco cessation and tobacco dependence treatment strategy and action plan according to the country situation, priorities and available resources, and submit the final plans to the Regional Office by the end of 2012.
3. Integrate cessation services and tobacco dependence treatment as part of the existing health system within primary health care and, where appropriate, into existing health programmes such as tuberculosis, respiratory disease, cardiovascular disease, cancer, diabetes, healthy lifestyles, adolescent health and maternal health programmes, by the end of 2013.
4. Mandate the recording of tobacco use within the patient registration and information system, including in patient medical records and death certificates.

5. Adapt the WHO training package on integration of cessation services into primary health care for policy-makers, service managers and service providers, and finalize it by the second half of 2013.
6. Train health care providers within primary health care on provision of brief tobacco interventions based on the WHO training package.
7. Establish tobacco cessation toll free telephone quit lines based on the WHO manual and guidelines, as a quick step forward in cessation and as part of a comprehensive tobacco cessation strategy along with other services.
8. Include tobacco control and cessation treatment within the curricula of medical and paramedical schools by the end of 2014.
9. Make tobacco cessation medication accessible and affordable, according to available resources, with NRT being added to national essential drug lists, by 2014.
10. Ensure sustainable sources of funding for tobacco cessation and treatment for tobacco dependence. This may include funds from tobacco-related taxes, fees, licenses and penalties.
11. Develop a monitoring and evaluation plan for tobacco cessation and treatment of tobacco dependence policies and programmes, including follow-up of patient quit attempts.

To WHO

12. Provide the appropriate technical support to all Member States according to their needs.
13. Provide regional training tailored according to the situation of countries to address their needs based on the WHO training package.
14. Share experiences and best practices in tobacco cessation within the Region and document success stories.
15. Share the recommendations with the League of Arab States as a proposed agenda item of the next meeting of the Council of Ministers of Health.

Annex 1

PROGRAMME

Sunday, 23 September 2012

08:30–09:00	Registration	
09:00–09:15	Address of Dr Ala Alwan, Regional Director, WHO/EMRO	
09:15–09:30	Overview and objectives	*Dr Haifa Madi, Director, Health Protection and Promotion*
09:30–10:30	Introduction of participants and election of officers	
10:30–11:00	Introduction of guidelines for Article 14 of the WHO Framework Convention on Tobacco Control: demand reduction measures concerning tobacco dependence and cessation	*Dr Heba Fouad, Technical (Surveillance) Officer, Tobacco Free Initiative, WHO/EMRO*
11:00–11:30	Gaps and needs in the Eastern Mediterranean Region	*Dr Heba Fouad, Technical (Surveillance), Tobacco Free Initiative, WHO/EMRO, Dr Mahmoud El Habiby, Faculty of Medicine, Egypt*
11:30–12:00	Developing and improving national toll-free tobacco quit line services: A WHO manual	*Dr Dongbo Fu, WHO/HQ*
12:00–12:00	Video presentation on quit lines: challenges and opportunities	*Dr Tim McAfee, Director, Office on Smoking and Health, U.S. Centers for Disease Control and Prevention*
12:30–13:00	A best practice: Establishing a national toll-free quit line service in Thailand	*Dr Jintana Yunibhand, Director, Thailand National Quit line Center*
13:00–16:00	Country presentations on the status of cessation services at national level	*Country representatives*

Monday, 24 September 2012

09:00–09:15	Introduction of the WHO HQ module on integration of cessation services into primary health care	*Dr Heba Fouad, Technical (Surveillance), Tobacco Free Initiative, WHO/EMRO*
09:15–10:00	Integration model: tuberculosis and cessation	*Dr Dongbo Fu, WHO/HQ*
10:00–11:00	UK experience in cessation services	*Ms Christine Goodair, St*

	and quit lines	*George's Medical School, United Kingdom*
11:00–13:00	Working groups on integration of cessation into primary health care services: Assessing the situation: status and gaps, Way forward	
13:00–14:45	Outcomes of working groups on integration of cessation into primary health care services	
14:45–15:00	Introduction to the second working group	
15:00–16:00	Working groups on quit lines: Assessing the situation: status and gaps; Way forward	
16:00–17:00	Outcomes of working groups on quit lines	

Tuesday, 25 September 2012

09:00–10:30	Working group on development of country plan of action
10:30–11:30	Working group on development of country plan of action
11:30–13:30	Feedback and presentation from the working group
13:30–14:30	Recommendations and closure

Annex 2

LIST OF PARTICIPANTS

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