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*Smoking
Health Organization
Data collection*

GUIDELINES FOR THE CONDUCT OF TOBACCO-SMOKING SURVEYS
AMONG HEALTH PROFESSIONALS

Report of a WHO Meeting held in Winnipeg, Canada
7-9 July 1983 in collaboration with UICC* and ACS*



* UICC: International Union Against Cancer
ACS: American Cancer Society

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1. INTRODUCTION

The World Health Organization is trying to assist investigators and public health authorities in assessing the extent of the smoking problem in countries and in designing and monitoring national smoking control programmes.

One of the approaches to this aim has been to propose guidelines for the conduct of tobacco smoking surveys, including a series of standardized questionnaires that would hopefully allow intranational and international comparison of data, both time-wise and geographically. Guidelines and questionnaires for surveys of the general adult population and of young people were already published (*). Certain applicable parts of those publications are incorporated in the present document, as appropriate.

Beside the general population, however, special target groups, for instance, those who belong to professions (physicians, teachers, nurses, etc.), which have a special responsibility for anti-smoking education or other measures for the prevention of smoking-related diseases should also be studied.

In many countries tobacco-smoking surveys of health professionals have been carried out during the last 20 years. In some countries, these studies have contributed to smoking control planning and action.

The surveys of health professionals that have been carried out thus far have largely been planned within each country independently of one another and, for this reason, may not have been comparable to similar studies in other countries.

Only occasionally, surveys of smoking habits of the health professionals have been comparable to surveys of the smoking habits of the general adult population in the same country.

The purpose of the present document is two-fold:

- i) to encourage the conduct of smoking surveys among health professionals in countries which have not done such surveys previously, and to provide these countries with guidelines for planning such surveys;
- ii) to "standardize" the data collection instrument as much as feasible so as to provide for comparability of different surveys within and between countries.

A complete standardization is, of course, impossible since the exact purpose of conducting surveys may vary and since different languages may require alternate ways of asking questions to obtain the same information. Nevertheless, the basic idea behind this document is that tobacco smoking surveys would profit from cross-national comparison, despite the fact that this may occasionally interfere with complete comparability with previous national surveys. With respect to the above viewpoints, the present document should be considered as a practical model for national data collection in the field.

(*) Guidelines for the Conduct of Tobacco Smoking Surveys of the General Population. Document No. WHO/SMO/83.4, World Health Organization, Geneva. Available at no cost on request.

2. SCOPE AND AIMS OF TOBACCO SMOKING SURVEYS AMONG HEALTH PROFESSIONALS

Health professionals play a key role in health promotion including smoking control. For this reason, they have a special responsibility for setting a good example to other groups within a country. They also have a professional responsibility for promoting non-smoking behaviour. Surveys on smoking behaviour, beliefs, attitudes and professional practices among health professionals should focus on their special roles. Such surveys may thereby provide information for developing special training programmes for these professional groups and may be an important step in the formulation of an effective national smoking and health policy.

More specifically, smoking surveys among these groups are designed to collect data that can be used for at least four different purposes:

- i. To obtain basic information for the planning of activities aimed at reducing smoking in these groups. It is important that the general public be made aware of the fact that many health professionals have stopped smoking because of their acceptance of smoking as a health hazard.
- ii. To stress their role as health educators, (informing patients of the effects of smoking on their health, encouraging the patients to stop smoking, and assisting and supporting them in this effort.)
- iii. To focus on their role as decision makers with regard to hospitals and health centres as social and physical environments where smoking is discouraged.
- iv. To emphasize the role of health professionals in influencing and encouraging politicians, planners and others at national and local levels.

3. REMARKS ON METHODOLOGY AND PROCEDURES

During the planning of a survey of smoking among health professionals, experienced statisticians and/or social scientists should be involved at an early stage to ensure sound methodology and design.

3.1 Sampling

The sampling procedure and the sample size of a study depends on its purpose. If a nationwide representative sample of health professionals is to be obtained, several ways of doing this are possible. The best procedure is to use a complete list of health professionals under study in a country and to select a probability sample following a standard sampling procedure. In some countries, the Ministries of Health have such registers and update them regularly. If no such list exists, an alternate procedure would be to ask appropriate professional associations for permission to use their member files for selecting a sample. The larger the proportion of health professionals who are members of such associations, the better the sample will be.

In some countries, registers of health professionals are available only at a regional level. In this case the sample could be drawn and questionnaires distributed within each region.

If no possibility exists of using registers, other solutions should be worked out, e.g., to distribute questionnaires in hospitals and health centres.

3.2 Response Rate and Estimation

Keeping in mind that the survey is to be carried out within a specific group - health professionals - the response rate should be at least 75%. In some surveys of health professionals response rates as high as 94% have been obtained.

In order to increase the response rate multiple attempts should be made. It would be advisable to send out two or more reminder letters depending on local conditions. It may also be recommended to contact local professionals associations or other appropriate bodies to reach non-respondents. The prevalence of smoking and other characteristics of early respondents, late respondents and non-respondents should be compared to estimate possible bias.

For this reason, special efforts should be made to study a random sample of non-respondents. If there are significant differences in results obtained from the early and late respondents, relevant variables should be estimated for non-respondents and taken into account in the final calculation of results.

3.3 Cross-Sectional Studies

Cross-sectional studies provide valuable baseline information on many aspects related to the smoking habits of health professionals, such as an awareness of the harmful health consequences of smoking, attitudes towards smoking, and attempts to influence smoking behaviour in patients as well as on personal smoking practices. The information obtained from these surveys may not be sufficient to assess the trends in the variables measured over a period of time. However this can be solved by planning for a series of cross-sectional studies in which the time interval between studies is determined by outside evidence that enough change is taking place to justify a new study.

3.4 Special Studies

When the purpose of the sampling procedure is to estimate accurately the proportion of smokers within a profession in a whole country, the principles for selecting representative samples should be followed as closely as possible, and a large sample is needed. If the purpose is to study a special problem, for example, to determine the most important factors promoting or hindering health professionals in their attempts to reduce smoking by their patients, personal interviews with a limited incidental sample of doctors and nurses may be an acceptable design.

For studies measuring the effectiveness of intervention, longitudinal studies in which data from the same individuals are collected at least twice is essential. These studies can be very valuable for other purposes as well but tend to be more difficult and expensive to carry out.

3.5 Self-Administered Questionnaires

In most surveys among health professionals, self-administered questionnaires are recommended. In order to obtain a good response rate, the questionnaires should be somewhat restricted in length and should contain as few open-ended questions as possible. When a study is carried out for several different reasons, and these may conflict as far as design is concerned, the possibility of breaking it down into two or more different studies should be considered.

3.6 Selection of Items to be Included in the Survey

The proposed questionnaire form is quite extensive and often it is not practical for all users to use all items. Items to be included should be selected in terms of their relevance to the specific purposes of each survey. If modifications need to be made, this should be made by deleting items rather than by attempting to simplify, and without revising the sequence of items.

3.7 Data Processing and Presentation

The analysis of data involves data processing and data presentation. The points as listed may be helpful to individuals who are carrying out a survey on smoking habits.

- a It is essential that a person with experience in data processing and in the presentation of data, such as a statistician, an epidemiologist or a behavioural scientist, should be involved in both the survey design and in the analysis. If the survey is not well designed, it may not be possible to overcome such shortcomings at the analysis phase.
- b It is the experience of individuals who have undertaken surveys that the data processing and the analysis of data may take considerably more time than anticipated. Moreover, the analysis of a survey tends to be open-ended, and a good set of data provides opportunities for a number of valuable investigations. Hence, it is important to allow ample time and a sufficient portion of the budget for the analysis phase.
- c The first task in the analysis phase is to carry out the cleaning-up or editing of the data. This implies checking the data for consistency, and checking the responses for completeness and accuracy. Some of this work can be carried out with an appropriate computer programme, but the quality of the edited data will in many cases be higher if the responses can also be checked manually. Any manual or automatic procedure for editing responses should itself be consistent and should be described in detail in the report of the analysis.
- d A next task is to check the frequency distribution of the various variables which have been obtained in the survey. For example, it is advisable to check whether these variables are distributed unimodally, or whether variables fall into fairly well defined subgroups. Also, responses might be graded e.g. on a 1-to-5 scale and it is then useful to check whether these different types of responses occur with similar frequencies.
- e The next stage is to estimate the prevalence and intensity of smoking, according to the various sex and age groups. Prevalence implies the percentage of individuals who smoke in a certain manner, and intensity of tobacco consumption provides an estimate of the amount which is smoked. When data are tabulated, results for males and females should be presented separately. Recommended age groups are those adopted by WHO i.e. five-year groups, using the age at last birthday, namely 20-24, 25-29, 30-34, etc., and it is here recommended that the age groups over 65 should also be sub-divided into five-year age groups until the age of 80+. This procedure allows for the collapsing of data; that is, if samples are too small, age groups may be pooled, for example, under the headings of: below age 25, 25-44, 45-64 and over 64. In addition, it may be of interest to obtain similar data for individuals who use tobacco products other than cigarettes.

Tobacco consumption may be reported in various ways, but should include: a) mean number of cigarettes per day and b) the distribution of smokers by consumption levels. Following a previous proposal (*) smokers should be grouped as smoking 1-7, 8-12, 13-17, 18-22, 23-27, 28-32, 33-37, 38-42, 43-47, 48-52, 53-57, 58-62 cigarettes per day, and so on. If the groupings are small, the data may be collapsed in a way which is judged most appropriate. These categories are chosen because reported consumption usually are clustered among values which are multiples of five and ten. Next, it should be noted that it may be important to investigate the prevalence of very light smokers, e.g. smokers smoking one to two cigarettes per day, since this is a pattern which might be expected to be prevalent in a number of developing countries.

The actual tabulations should show percentages for the different smoking behaviour classes as defined in section 3.8 and for the different consumption levels as suggested above, as well as actual numbers, on which the percentages were calculated.

- f The estimation of errors. It is important that some measure of uncertainty be attached to each prevalence figure. One method of doing this is to calculate a 95% confidence interval, if this is a reasonably simple procedure given the sampling design used. However, it should be noted that such confidence intervals provide an estimate for what is referred to as the sampling error. This sampling error may be relatively small in large surveys involving randomly selected samples, while a much larger error may result from non-response bias; this occurs if non-respondents and respondents do not have similar smoking patterns and a large number of individuals have not responded. Consequently, it may be more appropriate simply to record the sample size on which each prevalence figure is based, and to report the associated percentage of non-response. In cases of moderate non-response, useful upper and lower bounds may be obtained by adding the "non-response" and "unknown" figures to each category, assuming that these individuals were either smokers or non-smokers. For example, if in a sample of 1000 there are 600 smokers, 300 non-smokers, and 100 unknown or non-responders, then the relevant ratios are $600/(900+100) = 6/10$ or $(600+100)/(900+100) = 7/10$ for the lower and upper bounds of the sample proportion of smokers. More generally, one should be aware of a large number of sources of possible non-sampling errors. Non-response is perhaps the major source. Another source of error is response variability, if on repeated interviews the answers obtained differ. Repeat interviews on a sub-sample may assist in assessing response variability. As another example, the context in which a survey is conducted may also affect results.

3.8 Smoking habits (categories of smokers)

With respect to individual smoking habits, a large number of categories could be used. The following categories - on which the present questionnaire is based - are proposed. It should be noted that these terms are sometimes loosely used and given varying and imprecise definitions. However, the working group strongly recommend that, for standardization sake, the definitions given here be applied in future studies.

- Daily smokers: Anyone who, at the time of the survey, smokes some kind of tobacco product every day.
- Occasional smokers: Anyone who smokes, but less than once a day.
- Non-smokers: Anyone who, at the time of the survey, does not smoke at all.

(*) see footnote in page 1.

Sub-groups of daily smokers which may need to be identified:

- daily cigarette smokers (this includes manufactured and hand-rolled cigarettes)
- other daily smokers.

In some instances it would be desirable to make an even more detailed breakdown of the daily smokers, such as:

- daily smokers of cigarettes only
- daily smokers of both cigarettes and other smoking materials
- daily smokers of other tobacco products only

The category of non-smokers can also be subdivided into:

- ex-smokers who have smoked daily for at least 6 months, but who did not smoke at the time of the survey and
- other non-smokers which include both those who have never smoked and those who have smoked too little (in terms of frequency and duration) to be regarded as ex-smokers.

In some developing countries it might be important to identify common groups as bidi smokers, or to take into account snuff and tobacco chewing. The important categories to identify would be the use of such tobacco products alone or in combination with some other smoking practices.

The basic information on individual tobacco consumption would be individual consumption levels recorded by asking smokers how many cigarettes, cigars, or pipefuls they usually smoke per day. Cigarette smokers might, in addition, be asked about the brand they usually smoke.

3.9 Confidentiality

The investigator should make sure that every questionnaire or interview on smoking habits start with some introductory remarks regarding confidentiality, anonymity and the sponsoring agency. These remarks should be adjusted to local circumstances, and should appear in an introductory letter or in the questionnaire.

3.10 Task force

In each country, there should be a focal point (preferably a specialized, government-approved committee or agency) for smoking and health questions which would co-ordinate the smoking surveys. In certain instances, this same body could also take responsibility for carrying out the field work aspects of the survey, which on other occasions other bodies may be involved to make up a task force. A task force should include behavioural scientists, demographers, statisticians, and trained interviewers. The focal point and the task force could be located - either together or separately - in e.g. the ministry of health, a university institute, a survey organization, the national bureau of statistics or other appropriate governmental or non-governmental institution.

QUESTIONNAIRE FOR HEALTH PROFESSIONALS

A. Background Descriptive Data

1. What is your sex? (tick one)

☐ male

☐ female

2. Please write down your age at your last birthday

_____ years old.

3. In what kind of place do you live? (tick one)

☐ city

☐ suburb

☐ town

☐ village

Write name of place: _____

4. What is your profession?
(tick one)

☐ physician

☐ dentist

☐ nurse

☐ other health profession (please specify)

_____.

5. What is your field of professional activity? (tick one or more as appropriate)

☐ general practice

☐ practising specialist

☐ administration

☐ research

☐ teaching

☐ other, please specify: _____.

6. If you are a specialist:

What is your field of specialization?

_____.

7. Please write which ethnic or cultural sub-group you belong to:

_____.

8. Which religious affiliation do you belong to, if any?

_____.

9. What is your present marital status? (tick one)

☐ married

☐ divorced/separated

☐ widow/widower

☐ single (never married)

B. Personal Smoking Behaviour

10. Have you ever smoked? (tick one)

☐ yes

☐ no (GO TO QUESTION 19)

11. Have you ever smoked daily for 6 months or more? (tick one)

☐ yes

☐ no

12. Do you now smoke daily, occasionally or not at all? (tick one)

☐ daily (at least once per day)

☐ occasionally (GO TO QUESTION 16)

☐ not at all (GO TO QUESTION 19)

13. Please write the number of items you usually smoke per day (if none, please write "0" next to the appropriate item(s)).

_____ manufactured cigarettes
(no. of)

_____ handrolled cigarettes
(no. of)

_____ bidis
(no. of)

_____ pipefuls of tobacco
(no. of)

_____ cigars/cheroots
(no. of)

_____ goza/hookha
(no. of)

14. If you smoke manufactured cigarettes, please write down the type and brand name you usually smoke.

filter tipped _____.

plain _____.

tick here if no special preference ____.

15. Compared to last year, how much do you smoke now? (tick one)

___ smoking more now.

___ smoking about the same.

___ smoking less now.

C. Other Forms of Tobacco Use, and
Variables Related to Personal Smoking Habits

16. Have you ever thought about quitting smoking? (tick one)

___ yes

___ no (GO TO QUESTION 19)

17. Have you ever made a serious attempt to stop smoking? (tick one)

___ yes

___ no (GO TO QUESTION 19)

18. How long did you actually stay off tobacco smoking the last time?
Write down the number of (one answer only):

_____ days

_____ weeks

_____ months

_____ years

19. Are there any other forms of tobacco you use which we have not mentioned? If so, please describe:

20. What do you think about your smoking habits five years from now? (tick one)

___ will most certainly smoke daily

___ will probably smoke daily

___ will probably not smoke daily

___ will most certainly not smoke daily

21. How do you personally assess the importance of the following reasons for not smoking yourself? (please tick as appropriate).

<u>Importance</u>	<u>High</u>	<u>Moderate</u>	<u>Low</u>	<u>None</u>
Occurrence of certain symptoms	_____	_____	_____	_____
To protect your health	_____	_____	_____	_____
To save money	_____	_____	_____	_____
Self-discipline	_____	_____	_____	_____
To comply with pressure from professional colleagues not to smoke	_____	_____	_____	_____
Not to create discomfort in nearby people	_____	_____	_____	_____
To set a good example for patients	_____	_____	_____	_____
To set a good example for health workers	_____	_____	_____	_____
To set a good example for children	_____	_____	_____	_____
To set a good example for adults in your social environment.	_____	_____	_____	_____

22. How often do you smoke in your office in the presence of a patient? (tick one)
- ☐ frequently
 - ☐ occasionally
 - ☐ seldom
 - ☐ never
 - ☐ not applicable (if you do not work in an office)
23. How often do you smoke while at work alone? (tick one)
- ☐ frequently
 - ☐ occasionally
 - ☐ seldom
 - ☐ never

D. Perception of Smoking as a Health Hazard

24. Do you think smoking is harmful to health? (tick one)
- ☐ strongly agree
 - ☐ mildly agree
 - ☐ no opinion/don't know
 - ☐ mildly disagree
 - ☐ strongly disagree
25. Are you concerned about the harmful effects smoking may have on your health? (tick one)
- ☐ very concerned
 - ☐ fairly concerned
 - ☐ slightly concerned
 - ☐ not concerned

26. For each of the diseases listed below, please indicate whether you think that cigarette smoking is a major cause, a contributing cause, is associated with, or has no association with the disease or condition.

(CHECK ONE BOX ACROSS FOR EACH DISEASE)

	<u>Major Cause</u>	<u>Contributory Cause</u>	<u>Associated With</u>	<u>No Assoc- iation</u>	<u>Don't Know</u>
a. Bladder cancer	_____	_____	_____	_____	_____
b. Coronary artery disease	_____	_____	_____	_____	_____
c. Lung cancer	_____	_____	_____	_____	_____
d. Chronic bronchitis	_____	_____	_____	_____	_____
e. Oral cancer	_____	_____	_____	_____	_____
f. Pulmonary emphysema	_____	_____	_____	_____	_____
g. Laryngeal cancer	_____	_____	_____	_____	_____
h. Peripheral vascular disease	_____	_____	_____	_____	_____
i. Leukoplakia (mouth/lip)	_____	_____	_____	_____	_____
j. Any soft tissue lesion (mouth/lip)	_____	_____	_____	_____	_____
k. Neo-natal death	_____	_____	_____	_____	_____

E. Actions Vis-à-Vis Patients

27. Do you routinely find out from patients whether or not they smoke? (tick one)

_____ yes

_____ no

_____ not applicable (if you do not see patients). (GO TO QUESTION 33)

28. To how many of your tobacco-smoking patients do you provide information on the harmful effects of smoking?(tick one)

☐ to over 70% of the patients
☐ between 30-70%
☐ to less than 30%
☐ to none

29. To how many of your tobacco-smoking patients with the following conditions do you provide explicit advice to stop smoking?

(CHECK ONE BOX ACROSS FOR EACH CONDITION)

patients with:	All	Over 70%	30-70%	Less 30% then	None	N.A.
Lung and pulmonary condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth or lip lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness, loss of appetite and insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any condition being treated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Do you have a "No-Smoking" sign in your waiting room? (tick one)

☐ yes
☐ no
☐ No waiting room (GO TO QUESTION 32)

31. Do you enforce it?

☐ yes
☐ no

32. How often in the following situations do you advise patients against smoking? (tick one box for each question)

	<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>Never</u>
a. When patients have symptoms/ diagnoses of smoking-related diseases.	_____	_____	_____	_____
b. When the patient himself raises the question about smoking.	_____	_____	_____	_____
c. When a patient is a smoker who has <u>no</u> symptoms/diagnoses of smoking-related diseases and does <u>not</u> himself raises the question about smoking.	_____	_____	_____	_____

F. Opinions and attitudes

33. Please indicate the extent to which you agree or disagree with each of the following statements.

(CHECK ONE BOX ACROSS FOR EACH STATEMENT)

	<u>Strongly</u> <u>Agree</u>	<u>Somewhat</u> <u>Agree</u>	<u>Neither Agree</u> <u>nor Disagree</u>	<u>Strongly</u> <u>Disagree</u>
a. It is the (doctor's) responsibility to convince people to stop smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Most smokers can stop if they wanted to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. It is annoying to be near a person who is smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. (Doctors) should set a good example by not smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Most people will not give up smoking even if their (doctor) tells them to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. (Doctors) should be more active than they have been in speaking to lay groups about smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. (Doctors) would be more likely to advise people to quit smoking if they know of a good approach that really worked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Your current knowledge is sufficient as a basis for counselling patients who want to stop smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. At every contact with a patient where it would be natural to do so, you should dissuade him from smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Footnote:(Doctors)- When the questionnaire is used with Dentists, Nurses, Primary Health Care Workers or other types of health providers the professional qualification in brackets () should be changed accordingly.

34. A number of opinions have been expressed about how to reduce smoking through legislative action. Would you agree or disagree with the following opinions? (tick one box for each opinion).

	<u>Strongly</u> <u>Agree</u>	<u>Somewhat</u> <u>Agree</u>	<u>Neither</u> <u>nor Disagree</u>	<u>Agree</u> <u>Somewhat</u> <u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>
a. There should be a health warning on cigarette packages.	_____	_____	_____	_____	_____
b. There should be a complete ban on the advertising of tobacco.	_____	_____	_____	_____	_____
c. Smoking in closed public places should be restricted.	_____	_____	_____	_____	_____
d. The price of tobacco products should be increased sharply.	_____	_____	_____	_____	_____
e. The sale of tobacco to children should be completely prohibited.	_____	_____	_____	_____	_____
f. Smoking in hospitals should be restricted to special smoking areas.	_____	_____	_____	_____	_____
g. Health professionals should get specific training on how to support patients who want to stop smoking	_____	_____	_____	_____	_____

G. Teaching

35. Do you teach at health oriented institutions?

☐ Yes

☐ No

If yes, please specify:

a) type of institution (medical, school, nursing school etc).

b) type of subject

36. If you teach, do you cover smoking and health topics?

☐ Yes

☐ No

☐ Not applicable to your field

= = =