

# Strengthening health systems

for treating tobacco  
dependence in  
primary care

Part III: Training for primary  
care providers



**World Health  
Organization**

### **WHO Library Cataloguing-in-Publication Data**

Strengthening health systems for treating tobacco dependence in primary care.

Contents: Part I: Training for policy-makers: developing and implementing health systems policy to improve the delivery of brief tobacco interventions; Part II: Training for primary care service managers: planning and implementing system changes to support the delivery of brief tobacco interventions; Part III: Training for primary care providers: brief tobacco interventions; Part IV: Training for future trainers: applying adult education skills to training.

1. Tobacco use disorder - prevention and control. 2. Smoking - prevention and control. 3. Smoking cessation. 4. Primary health care. 5. Delivery of health care. 6. Capacity building. 7. Teaching materials. I. World Health Organization.

ISBN 978 92 4 150541 3 (NLM classification: HD 9130.6)

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Printed in France

# **Strengthening health systems for treating tobacco dependence in primary care**

## **Part III: Training for primary care providers: Brief tobacco interventions**

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## BRIEF TOBACCO INTERVENTIONS

### INTRODUCTION

Primary care providers have several roles to play in tobacco control, including preventing non-tobacco users from starting to use, assisting tobacco users in quitting, and protecting non-tobacco users from exposure to tobacco smoke. This part of the training focuses on their roles as clinicians in helping tobacco users quit.

Despite the evidence on the effectiveness and cost-effectiveness of brief tobacco interventions, more than 50% of primary care providers, especially those in low- and middle-income countries, do not routinely deliver these interventions. The lack of knowledge and skills about tobacco and tobacco control is a major barrier to the provision of brief tobacco interventions. The Global Health Professions Student Survey (GHPSS) data showed that, while 90% of the health professions students have a desire to receive formal training in patient counselling, less than 33% of them have actually received such training.

The purpose of Part III is to improve primary care providers' knowledge, skills and confidence to:

- routinely identify tobacco users and provide brief tobacco interventions to assist them in quitting;
- educate every non-tobacco user seen in a primary care setting about the dangers of second-hand smoke and help them avoid exposure to second-hand smoke.

### LEARNING OBJECTIVES, SKILL DEVELOPMENT AND OUTCOMES

#### Learning objectives

Upon completion of this training participants will be able to:

- explain the role of primary care providers in tobacco control and tobacco dependence treatment;
- describe prevalence and patterns of tobacco use in their country;
- explain the health, social and economic consequence of tobacco use and benefits of quitting;
- explain the biological, psycho-behavioural and social causes of tobacco dependence;
- list existing effective tobacco dependence treatment methods;
- describe and deliver brief interventions to assist tobacco users routinely in quitting according to a 5A's model and a 5R's model;
- describe and deliver a brief intervention to help non-tobacco users avoid exposure to second-hand smoke according to a 5A's model;
- apply tools to assess tobacco users' levels of nicotine dependence;
- list effective tobacco cessation medications and appropriately prescribe nicotine replacement therapy (NRT) products.

#### Skills developed

1. Ability to apply the knowledge of tobacco use and its harmful effects.
2. Ability to use the 5A's brief intervention model to assist tobacco users who are willing to quit in making a quit attempt.
3. Ability to use the 5R's brief intervention model to motivate tobacco users who are unwilling to quit to make a quit attempt.
4. Ability to use the 5A's brief intervention model to help non-tobacco users avoid exposure to second-hand smoke.
5. Ability to advise on effective tobacco cessation medications and to appropriately prescribe NRT products.

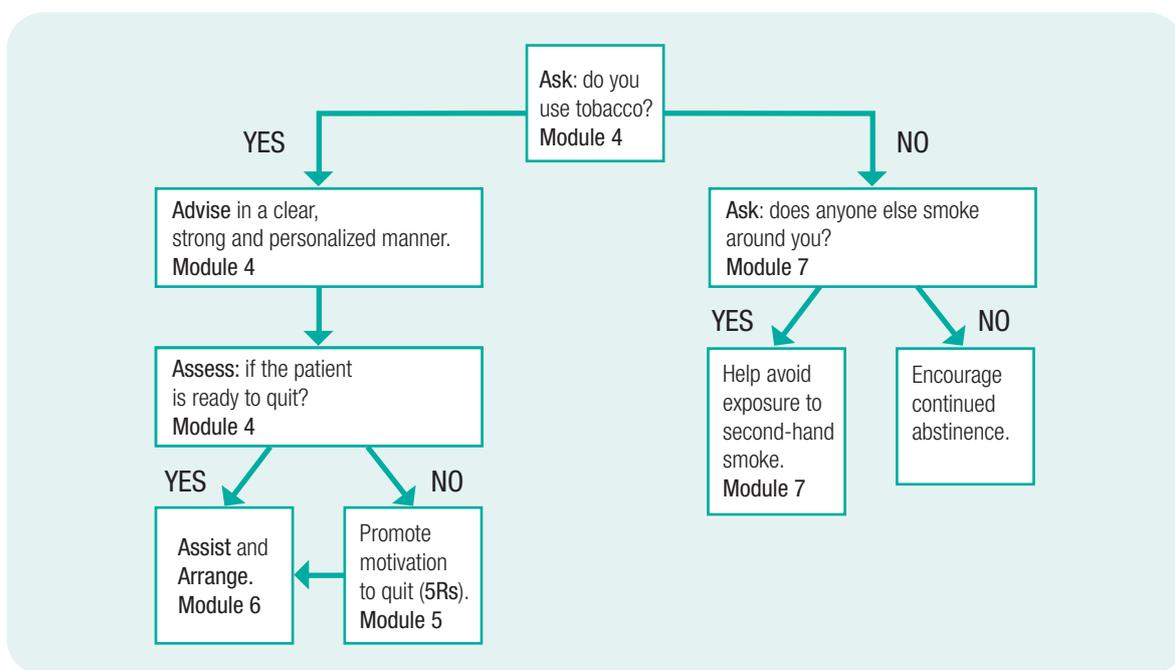
### Outcomes

1. Primary care providers become competent in routinely delivering brief tobacco interventions to help tobacco users quit.
2. Primary care providers become competent in routinely delivering brief tobacco interventions to protect non-tobacco users from tobacco smoke.

### STRUCTURE AND CONTENT

The training for primary care providers consists of nine modules. These nine modules are designed to train primary care providers with knowledge, skills and effective intervention models for delivering brief interventions to help both tobacco users and non-tobacco users in primary care settings (see Figure 1).

Figure 1. Algorithm for delivering brief tobacco interventions



Each of the nine training modules is presented in a four-step format: preparation, presentation, practice and evaluation. The modules are summarized below. Further guidance for facilitators follows in the detailed *Facilitators' guide*.

- Module 1:** The role of primary care providers in tobacco control and tobacco dependence treatment.
- Module 2:** Basics of tobacco use and tobacco dependence.
- Module 3:** Overview of brief tobacco interventions.
- Module 4:** Asking, advising and assessing readiness to quit.
- Module 5:** Dealing with low motivation.
- Module 6:** Assisting and arranging for follow-up.
- Module 7:** Addressing non-smokers' exposure to second-hand smoke.
- Module 8:** Introduction to pharmacotherapy.
- Module 9:** Promoting brief tobacco interventions in the community.

If all nine modules are used, the duration of the training workshop is 2.5 days. However, the duration and detail covered in each module should be adapted to the needs of the participants. Their needs will depend on their experience and knowledge of the issue, the availability of intensive tobacco dependence treatments, the pattern of tobacco use in the country, and the infrastructure of their health system. A sample agenda for the training workshop of 2.5 days is provided below.

<b>Day 1</b>	
8:30 – 9:00	Registration
9:00 – 9:30	Welcome and Workshop Overview Participant introductions
9:30 – 9:50	Pre-course assessment
9:50 – 10:30	<b>Module 1:</b> The role of primary care providers in tobacco control and tobacco dependence treatment (1)
10:30 – 10:45	Coffee break
10:45 – 12:00	<b>Module 1:</b> The role of primary care providers in tobacco control and tobacco dependence treatment (2)
12:00 – 13:00	Lunch
13:00 – 14:40	<b>Module 2:</b> Basics of tobacco use and tobacco dependence
14:40 – 15:00	Coffee break
15:00 – 16:30	<b>Module 3:</b> Overview of brief tobacco interventions
16:30 – 17:00	Daily wrap-up
<b>Day 2</b>	
8:30 – 9:00	Interactive discussions
9:00 – 10:45	<b>Module 4:</b> Asking, advising and assessing readiness to quit
10:45 – 11:00	Coffee break
11:00 – 12:45	<b>Module 5:</b> Dealing with low motivation
12:45 – 13:45	Lunch
13:45 – 15:30	<b>Module 6:</b> Assisting and arranging for follow-up
15:30 – 15:45	Coffee break
15:45 – 17:05	<b>Module 7:</b> Addressing non-smokers' exposure to second-hand smoke
17:05 – 17:30	Daily wrap-up
<b>Day 3</b>	
8:30 – 9:00	Interactive discussions
9:00 – 11:00	<b>Module 8:</b> Introduction of pharmacotherapy
11:00 – 11:15	Coffee break
11:15 – 12:30	Closing session Workshop evaluation

## **PREPARING FOR THE TRAINING**

Organizing a training workshop requires many practical considerations to be addressed, such as when and where the training will be provided, forming a facilitation team, setting up a workshop programme and agenda, selecting participants, and logistics and materials.

### **The facilitation team**

The training should be delivered by an expert facilitation team identified by the organizer in consultation with key local partners. The team should include:

- a lead facilitator with detailed expertise in treatment of tobacco dependence and experience in facilitating workshops;
- one or two additional facilitators with expertise in one or more aspects of tobacco control, tobacco dependence treatment and medical education;
- additional content presenters as necessary.

The facilitation team should be supported by one or more logistics assistants to facilitate logistical needs during the workshop, including production and reproduction of materials.

### **Workshop programme and schedule**

Prior to the training, the organizer and facilitators should gather as much information as possible about the country situation and the knowledge, skills and needs of participants in order to determine the training content and structure. If necessary, adjustments can be made to the content and structure to suit the situation. The organizer and facilitators will then need to design an appropriate training schedule or agenda based on the content they want to offer to the participants, the time needed for each module and the overall timeframe of the workshop. Please try to avoid creating an overcrowded schedule during the planning of the schedule.

### **Selecting participants**

The workshop is targeted at those who are providing health care services in primary care centres or in the community. They could be general practitioners, nurses, pharmacists or laboratory technicians.

It is recommended that the workshop be conducted with a maximum of 30 participants.

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### Logistics

The workshop requires standard meeting/training tools and facilities, namely:

- one main meeting room, with participants seated around small tables in small groups;
- one or two additional break-out rooms if the large room cannot accommodate small group discussions;
- flipcharts and markers (one for each small group);
- projector and screen for presentations;
- laptop computer with speakers for presentations;
- presenter's microphone;
- portable microphones for discussions (optional);
- desktop computer, printer and photocopier for document production during the workshop (optional).

### Materials

All the workshop training and background materials are provided online by WHO. These include:

- the *Facilitators' guide*;
- presentations;
- the *Participants' workbook*;
- workshop evaluation forms (see Appendix for sample evaluation form).

The Reference and Resource section contains hyperlinks to the relevant materials needed throughout the workshop. In addition to online materials, each participant should receive a binder or folder with key printed materials, particularly:

- handouts of presentations;
- key resource documents for each theme.

The facilitation team should decide which resources are most relevant to the participants and should include them in the printed materials. The facilitation team should also ensure that key materials are available in the language of the participants.

## Module 1: The role of primary care providers in tobacco control and tobacco dependence treatment

<b>Duration</b>	1 hour 50 minutes
<b>Objectives</b>	<p>Upon completion of this module, participants will be able to:</p> <ul style="list-style-type: none"> <li>– acknowledge their roles in tobacco control and tobacco dependence treatment;</li> <li>– describe the purpose of this training course;</li> <li>– describe existing effective tobacco dependence treatment methods;</li> <li>– describe the definition, effectiveness, feasibility and content of brief tobacco interventions.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
35 minutes	<p>State that tobacco use is the single most preventable cause of death in the world today, and that we as health-care providers must do our utmost to fight against tobacco.</p> <p>Ask participants to brainstorm: What is the role of health professionals in tobacco control and tobacco dependence treatment?</p> <p>Write responses on a flipchart page or whiteboard.</p> <p>Use PowerPoint slides to describe eight key roles of health professionals in tobacco control and tobacco dependence treatment, namely:</p> <ul style="list-style-type: none"> <li>– role model;</li> <li>– clinician;</li> <li>– educator;</li> <li>– scientist;</li> <li>– leader;</li> <li>– opinion-builder;</li> <li>– alliance-builder;</li> <li>– watching out for tobacco industry activities.</li> </ul> <p>Emphasize that this training course will focus on improving their knowledge, skills and confidence to play their role as clinician to assist smokers in quitting (<b>to address tobacco dependence as part of their standard care practice</b>).</p>	<p>Brainstorm possible roles that health professionals can play in tobacco control and tobacco dependence treatment.</p> <p>Refer to the workbook.</p>	<p>Workbook, flipchart/whiteboard, PowerPoint presentation <i>Part III-Module 1-A</i></p>
<b>Presentation</b>			
30 minutes	<p>State that primary care providers are in a unique position to help tobacco users quit because:</p> <ul style="list-style-type: none"> <li>• Primary care providers have a long and close contact with the community and are well accepted by local people.</li> <li>• The primary care is the primary source of health care and can reach the majority of the population, especially those living in rural areas.</li> </ul> <p>Facilitate discussion about: What tobacco dependence treatment methods can you use to help tobacco users?</p> <p>Write responses on flipchart paper or whiteboard.</p> <p>Refer participants to the workbook and use PowerPoint slides to explain that:</p> <ul style="list-style-type: none"> <li>• Various effective treatment methods exist.</li> <li>• More intensive or longer-lasting treatments are more likely to help tobacco users quit successfully.</li> <li>• Health-care providers can help patients quit tobacco successfully by offering brief tobacco interventions as short as three minutes. For instance: <ul style="list-style-type: none"> <li>– describe the definition of brief advice used in the WHO FCTC Article 14 guidelines;</li> <li>– emphasize that a brief tobacco intervention is an opportunistic intervention;</li> <li>– show the effectiveness of brief advice on quitting.</li> </ul> </li> </ul> <p>Summarize that helping patients quit tobacco as part of routine practice takes primary care providers only a few minutes and it is feasible, effective and efficient.</p>	<p>Refer to the workbook and participate in the discussion.</p> <p>Anticipated response: participants list all effective treatment methods.</p> <p>Anticipated response: participants agree with this statement.</p>	<p>Workbook, flipchart/whiteboard, PowerPoint presentation <i>Part III-Module 1-B</i></p>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Practice</b>			
25 minutes	Ask participants to pair up with the person sitting next to them to list what things they can do within 3 to 5 minutes to help tobacco users quit	Group discussion.	Workbook
<b>Evaluation</b>			
20 minutes	Reconvene and ask the participants to share their lists Invite comments from the participants and conclude that all they need to do to assist tobacco users to quit within 3–5 minutes can be summarized as 5A's: Ask, Advise, Assess, Assist, Arrange. Emphasize that, during the rest of the training, participants will learn knowledge and skills to implement the 5A's brief interventions.	Group discussion. Everyone provide comments.	Flipchart or whiteboard, PowerPoint presentation <i>Part III- Module 1-C</i>

## Module 2: Basics of tobacco use and tobacco dependence

<b>Duration</b>	1 hour 40 minutes
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– identify patterns of tobacco use (local, national, international);</li> <li>– describe the health, social and economic impact of tobacco use on tobacco users and others;</li> <li>– clarify common misconceptions held by tobacco users;</li> <li>– explain the benefits of quitting tobacco use;</li> <li>– describe why people smoke and why they don't stop.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
10 minutes	Ask participants: In order to effectively help tobacco users quit, what do they need to know about tobacco use and tobacco dependence? Emphasize that health-care providers should have some basic knowledge of tobacco use and tobacco dependence in order to assist patients in quitting more effectively. Tell participants that, in this module, they will have an opportunity to learn about the impact of tobacco use; the benefits of quitting tobacco use; the local, national and international patterns of tobacco use; and why people smoke and do not quit.	Open group discussion. Anticipate responses: participants mention the impact of tobacco use, the benefits of quitting tobacco use, and why people smoke and do not quit.	Flipchart/ whiteboard
<b>Presentation</b>			
20 minutes	Ask participants: what is the impact of tobacco use on tobacco users and others? Highlight facts and misconceptions. Continue to ask the group for views on the benefits of quitting tobacco use. Reinforce findings with fact sheet. Expand group discussion to consider health and non-health benefits.	Discuss/identify medical, social and economic impact of tobacco use. Refer to the workbook and participate in group discussion and practical exercise.	Flipchart/ whiteboard Workbook, PowerPoint presentation <i>Part III- Module 2-A</i>
10 minutes	Give an overview of local, national, worldwide patterns of tobacco use. Ask participants what impacts these trends have. Don't forget to include positive milestones (if any) (e.g. a smoking ban in public places).	Refer to the workbook.	Workbook, PowerPoint presentation <i>Part III- Module 2-B</i>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
25 minutes	Ask the group for ideas on why people smoke but do not quit? Prompt for personal experiences as well as professional ones. Present theory and evidence on the three elements of tobacco addiction: <ul style="list-style-type: none"> <li>– physical/physiological dependence;</li> <li>– emotional/psychological connection;</li> <li>– habitual and social connection.</li> </ul> Show a video on why quitting tobacco is so hard. Leave two or three minutes for brief Q&A at the end.	Anticipated responses include nicotine addiction, stress, boredom and social pressure (e.g. to fit in with friends).  Feedback and questions.	Flipchart/ whiteboard, Workbook, video, PowerPoint presentation <i>Part III-                      Module 2-C</i>
<b>Practice</b>			
20 minutes	Ask the participants to discuss with the person sitting next to them two ways in which they should use the knowledge of tobacco addiction when delivering brief interventions.	Work in pairs to list two items.	
<b>Evaluation</b>			
15 minutes	Ask the group to reconvene and invite volunteers to read out their responses.  Offer comments and invite other participants to provide feedback on responses.	Read out responses and comment on each other's responses.  Anticipated responses include: showing empathy, creating a feeling of being listened to rather than lectured, and using the information coming from the patient on why they smoke to generate quitting solutions and strategies.	Flipchart/ whiteboard

### Module 3: Overview of brief tobacco interventions

<b>Duration</b>	1 hour 30 minutes
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– describe the purpose and population impact of a brief tobacco intervention;</li> <li>– describe at least three brief tobacco intervention models;</li> <li>– role-play the 5A's brief tobacco intervention model.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	Ask participants for their experiences of talking to patients about tobacco use.  Tell participants that in this training they will have an opportunity to discuss how to talk effectively to patients about tobacco use and how to give advice in brief contacts (conducting brief tobacco interventions).	Anticipated responses include those based on participants' own responses (e.g. frustration) as professionals, as well as on the apparent responses of the patient (e.g. resistance).	Flipchart/ whiteboard

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
30 minutes	Present information on brief tobacco interventions: <ul style="list-style-type: none"> <li>• The primary purpose of a brief tobacco intervention is to encourage tobacco users to make a quit attempt.</li> <li>• The population impact of a brief tobacco intervention can be clinically significant if the intervention/service is delivered routinely and widely.</li> <li>• There are several structured brief tobacco intervention models that can guide primary care providers through the right process to talk to patients about tobacco use and deliver advice, such as the 5A's, 5R's, AAR, AAA, and ABC.</li> </ul>		Workbook, Power Point presentation <i>Part III-Module 3-A</i>
<b>Practice</b>			
30 minutes	Begin by suggesting role play and the benefit of scenario practice. Select two volunteers to role-play a brief intervention in front of the group: <ul style="list-style-type: none"> <li>• One will be a doctor who attempts to address the patient's smoking.</li> <li>• The other will be a forty-ish male satisfied smoker who is not especially keen to stop.</li> </ul>	Volunteer participants will conduct the role play as other participants observe.	Simulation
<b>Evaluation</b>			
15 minutes	Congratulate volunteers on their participation! Invite to feedback and questions. Reinforce the need for practice and assure participants that there are other opportunities during training. State that, for the rest of the course, participants will learn and practise 5A's and 5R's brief tobacco intervention models.	Participant feedback. Anticipate uncertainty in confidently handling responses.	Flipchart/whiteboard

#### Module 4. Asking, advising and assessing readiness to quit

<b>Duration</b>	2 hours 5 minutes
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– ask and advise patients about their tobacco use in an appropriate way;</li> <li>– use two ways to assess patients' readiness to quit</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	Ask participants for their thoughts on giving advice. For instance, how does giving advice on clinical issues (e.g. "you have asthma") differ from giving advice on behaviour change (e.g. "you need to quit smoking")?  Ask participants for their thoughts on how we can tell if someone is ready to quit. Inform participants that, in this module, they will discuss and practise the first three steps of the 5A's model: Ask, Advise and Assess.	Anticipated responses include: primary care providers feel more knowledgeable and confident to give advice on clinical issues, and that giving advice on behaviour change requires new skills and strategies.  Anticipated responses include those highlighting both importance and confidence as factors in motivation.	Flipchart/whiteboard

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
10 minutes	<p>Present information on how to ask about tobacco use. Make sure to include the following key points:</p> <ul style="list-style-type: none"> <li>• Ask about tobacco use at EVERY encounter.</li> <li>• Keep it simple:                             <ul style="list-style-type: none"> <li>– Do you use tobacco?</li> <li>– Does anyone else smoke around you?</li> </ul> </li> <li>• Document tobacco use status in the medical record</li> </ul> <p>Reinforce that:</p> <ul style="list-style-type: none"> <li>• Asking and recording tobacco use status is the first, but important, step towards helping patients stop tobacco use.</li> <li>• Health facilities should make a system change in order to support health-care providers by including tobacco use status in medical records as a vital sign.</li> </ul>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Part III-Module 4-A</i>
20 minutes	<p>Present the theory of why advice should be personalized and how to tailor advice for a particular patient.</p> <p>Tell participants that they will have an opportunity to practise tailoring advice to patients later on.</p>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Part III-Module 4-B</i>
20 minutes	<p>Present theories of motivation (when is someone ready to quit?) and how to assess readiness to quit.</p> <p>Make sure to include the following key points:</p> <ul style="list-style-type: none"> <li>• To be ready to quit, people need to believe two things:                             <ul style="list-style-type: none"> <li>– “I want to be a non-tobacco user”;</li> <li>– “I have a chance of quitting successfully”.</li> </ul> </li> <li>• We can then ask two questions to assess the readiness to quit:                             <ul style="list-style-type: none"> <li>– “Would you like to be a non-tobacco user?”</li> <li>– “Do you think you have a chance of quitting successfully?”</li> </ul> </li> <li>• An answer of “yes” to the first question and an answer of “yes” or “unsure” to the second question indicate that the tobacco user is READY to quit.</li> <li>• A more simple way to assess the readiness to quit is to ask just one question:                             <ul style="list-style-type: none"> <li>– “Would you like to quit tobacco within the next 30 days?”</li> </ul> </li> </ul> <p>Suggest that participants use the two-question method to assess the readiness to quit in this course because it will help them get more information from the patient to conduct appropriate motivational interventions if the patient is not ready to quit.</p>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Part III-Module 4-C</i>
<b>Practice</b>			
40 minutes	<p>Practise tailoring advice.</p> <p>The facilitator adopts the role of three fictional smokers. Each smoker will differ as to demographic background, health status, family and social circumstances, and beliefs about smoking.</p> <p>Before each role play the fictional smoker (played by the facilitator) will introduce himself or herself:</p> <ol style="list-style-type: none"> <li>1. Hamid: “I am a 57-year-old man with 10 grandchildren. I have a heart condition and breathing problems.”</li> <li>2. Lisa: “I am a 25-year-old woman and I have just married. We hope to have a large family but we do struggle financially.”</li> </ol>	<p>One participant will volunteer to play the role of the practitioner. He or she will:</p> <ul style="list-style-type: none"> <li>– ask about the patient’s smoking;</li> <li>– give some tailored advice.</li> </ul> <p>For Hamid, advice should refer to health, longer life and passive smoking of children.</p> <p>For Lisa, advice should refer to fertility and the financial impact of smoking.</p>	Flipchart/whiteboard, role play

Time	Facilitator activity	Participant activity	Audiovisual
<b>Practice</b>			
	3. Mustafa. "I am a man aged 35."	Mustafa does not give much information. The volunteer will need to recognize this and should ask Mustafa "What do you not like about being a smoker?" Once Mustafa answers, the volunteer should give advice tailored to the issue raised.	Flipchart/ whiteboard, role play
<b>Evaluation</b>			
20 minutes	Invite the group to give critique and comments on the role plays.	Feedback and questions	

### Module 5: Dealing with low motivation

<b>Duration</b>	1 hour 30 minutes
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– describe the 5R's brief tobacco intervention model;</li> <li>– respond appropriately to exhibited stop-smoking resistance, employing the 5R's model;</li> <li>– respond appropriately in cases of low motivation to quit, using motivational tools.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	Ask participants for their ideas on: <ul style="list-style-type: none"> <li>– what motivation is;</li> <li>– experiences of dealing with tobacco users who are not willing to quit.</li> </ul> Use PowerPoint slides to explain the definition of motivation in general and the definition of intrinsic motivation (a state of readiness to change). This is the key predictor of behaviour change. State that participants will learn in this module how to work with patients with low motivation to quit tobacco use.	Share understandings about motivation and experiences of helping tobacco users who are not willing to quit.	Flipchart/ whiteboard, PowerPoint presentation <i>Part III- Module 5-A</i>
<b>Presentation</b>			
15 minutes	Present the overview of the 5R's approach and where it should be inserted during a brief intervention. Use examples to explain the delivery of the 5R's. Tell participants that they will have an opportunity to practise delivering 5R's interventions later on.	Refer to the workbook.	Flipchart/ whiteboard, PowerPoint presentation <i>Part III- Module 5-B</i>
15 minutes	Explain that, in addition to talking with tobacco users, health-care providers can also use some motivational tools to motivate patients for quitting tobacco use. Introduce four types of tool for motivating patients, namely: <ul style="list-style-type: none"> <li>– cost calculators;</li> <li>– photos of smoking-exacerbated facial ageing;</li> <li>– the carbon monoxide (CO) monitor;</li> <li>– risk charts.</li> </ul> Ask participants to give comments on the advantages and disadvantages of each tool, and whether this tool would be available to them. Leave two or three minutes for brief Q&A at the end.	Refer to the workbook. Examine the tools and give comments on the advantages and disadvantages of each tool and whether they would be available. Feedback and questions.	Flipchart/ whiteboard, PowerPoint presentation <i>Part III- Module 5-C</i>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Practice</b>			
30 minutes	<p>Practise delivering 5R's interventions.</p> <p>Invite two volunteers to play the role of two practitioners who assess two fictional smokers' readiness to quit.</p> <p>The facilitator will adopt the role of the two fictional smokers. Each smoker will differ in his or her response when assessed for readiness to quit.</p> <ol style="list-style-type: none"> <li>1. Hamid: "My smoking isn't really a concern to me."</li> <li>2. Lisa: "I want to be a non-smoker but I could never quit – I'm very addicted."</li> </ol> <p>Complete the Assess questions appropriately in each case to indicate non-readiness to quit.</p> <p>In role play, Hamid should express concern about heart disease, while Lisa should express concern about her stress level while quitting.</p>	<p>For each smoker a (different) participant will assess readiness to quit (using assessment forms). They will then deliver the 5R's if appropriate.</p> <p>For Hamid, the 5R's should be delivered, focusing on risks and rewards.</p> <p>For Lisa, the 5R's should be delivered, focusing on roadblocks.</p>	Workbook
<b>Evaluation</b>			
15 minutes	Invite the group to give critique and comments on the role plays.	Feedback and questions.	

## Module 6: Assisting and arranging for follow-up

<b>Duration</b>	2 hours
<b>Objectives</b>	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> <li>– assist patients to stop tobacco use by helping them with a quit plan and providing intra-treatment social support and supplementary materials;</li> <li>– arrange follow-up contacts;</li> <li>– arrange a referral to specialist services if available;</li> <li>– deliver a full, brief tobacco intervention according to the 5A's and 5R's models.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	Ask participants for their thoughts on (if they were tobacco users) what kind of assistance they would need from the doctor to make a quit attempt.	Anticipated responses include developing a quit plan, dealing with withdrawal symptoms, social support, and pharmacotherapy recommendations.	Flipchart/whiteboard
<b>Presentation</b>			
20 minutes	<p>Present information on how to assist patients in making a quit attempt.</p> <p>Emphasize that, for the patient willing to quit, the following actions can be taken to aid him/her in quitting:</p> <ul style="list-style-type: none"> <li>• Help develop a quit plan. Strategies for this can be summarized by the acronym STAR:                             <ul style="list-style-type: none"> <li>– Set a quit date;</li> <li>– Tell family, friends and coworkers about quitting;</li> <li>– Anticipate challenges to the upcoming quit attempt;</li> <li>– Remove tobacco products from your environment.</li> </ul> </li> </ul>	Refer to the workbook.	Flipchart/whiteboard, PowerPoint presentation <i>Part III- Module 6-A</i>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
	<ul style="list-style-type: none"> <li>• Provide practical counselling to deal with challenges or difficulties while quitting and invite the group to answer the following questions asked by patients:                             <ul style="list-style-type: none"> <li>– What if I still have cravings?</li> <li>– What if I smoke after quitting?</li> </ul> </li> </ul> Facilitator provides suggested answers. <ul style="list-style-type: none"> <li>• Provide intra-treatment social support.</li> <li>• Recommend pharmacotherapy if appropriate.</li> <li>• Provide supplementary materials:                             <ul style="list-style-type: none"> <li>– Ask the group to list locally-available self-help materials.</li> <li>– Point out the limitations of self-help materials and that they should not take the place of face-to-face support.</li> </ul> </li> </ul>	Refer to the workbook.	
15 minutes	Present information on arranging follow-up contacts for the patient: when, how and what?		PowerPoint presentation <i>Part III- Module 6-B</i>
25 minutes	Review each stage of the 5A's and 5R's models Demonstrate the full brief tobacco intervention: <ul style="list-style-type: none"> <li>• Invite one participant to role-play a patient named Hamid (The participant may develop the character and dialogue as he or she wishes).                             <ul style="list-style-type: none"> <li>– <i>Hamid is a 57-year-old man with 10 grandchildren who has a heart condition and breathing problems. At the moment, he is not particularly concerned about his smoking.</i></li> </ul> </li> <li>• The facilitator will take the role of a primary care provider to deliver a full, brief intervention. The facilitator will pause at each stage to get comments and advice from the group on how to proceed.</li> </ul>	Refer to the workbook.  One volunteer participant to play the role of Hamid.  All participants provide comments and advice.	PowerPoint presentation <i>Part III- Module 6-C Demonstration</i>
<b>Practice</b>			
30 minutes	Begin by asking participants about their current level of confidence in relation to delivering a brief intervention.  Address expressions of poor confidence by referring to the evidence for the intervention, and tell them they will become confident about delivering the intervention once they have done it several times in a real situation (i.e. the need for practice).  Select two pairs of volunteers to role-play a brief intervention in front of the group (two "primary care providers" and two "patients").  The "patients" will be given brief notes on their character: <ol style="list-style-type: none"> <li>1. Hamid: a 57-year-old man with a large family. He has breathing and heart problems. He is not concerned about his smoking. He is unsure about whether he could quit if he tried.</li> <li>2. Lisa: a 25-year-old woman who is soon to marry. She wants to have a family. She wants to quit but is convinced that she can't.</li> </ol> Pause the role plays occasionally to make comments or give advice. Throughout, the importance of keeping to the 5A's and the 5R's structure should be emphasized.	Refer to the workbook.  Anticipated responses include expressions of low confidence. The source of this poor confidence may vary. Participants may have poor confidence in: <ul style="list-style-type: none"> <li>– themselves;</li> <li>– the intervention;</li> <li>– their patients.</li> </ul> The volunteer participants will conduct the role plays (starting with Hamid).  Other participants should watch the role plays and make notes.	Workbook
<b>Evaluation</b>			
15 minutes	Congratulations should be given to the volunteers for their courage.  Give constructive, and wherever possible, positive and confidence-building feedback.  Reinforce again how confidence will come with daily practice.	Participants may make comments.	Flipchart/ whiteboard

## Module 7: Addressing non-smokers' exposure to second-hand smoke

<b>Duration</b>	1 hour 20 minutes
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– describe the definition and dangers of second-hand smoke;</li> <li>– describe the brief intervention model for reducing non-smokers' exposure to second-hand smoke;</li> <li>– role-play the brief intervention to address non-smokers' exposure to second-hand smoke.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	<p>State that:</p> <ul style="list-style-type: none"> <li>• Second-hand smoke exposure causes serious health problems in children and adult non-smokers.</li> <li>• In addition to supporting the comprehensive smoke-free laws in workplaces and public places, and supporting smokers to quit, health-care providers should also educate every non-smoker seen in a primary care setting about the dangers of second-hand smoke and help them avoid exposure to second-hand smoke.</li> </ul> <p>Ask participants:</p> <ul style="list-style-type: none"> <li>• Is second-hand smoke exposure common in your country?</li> <li>• How many people are exposed to second-hand smoke in your country?</li> </ul> <p>Write responses on the flipchart or whiteboard.</p> <p>Explain that participants will discuss how to offer a brief intervention to help non-smoking patients and their families to avoid exposure to second-hand smoke in this module.</p>	<p>Anticipated responses include that second-hand smoke exposure is common in their country and a high proportion of non-smokers in their country are exposed to second-hand smoke.</p>	<p>Flipchart/whiteboard</p>
<b>Presentation</b>			
30 minutes	<p>Ask participants to brainstorm:</p> <ul style="list-style-type: none"> <li>• What is second-hand smoke?</li> <li>• What diseases are known to be caused by second-hand smoke?</li> </ul> <p>Write responses on the flipchart or whiteboard.</p> <p>Present the definition of second-hand smoke and refer participants to Figure 2 to summarize diseases caused by second-hand smoke.</p> <p>State that participants can use the 5A's model to offer a brief intervention to educate non-smokers about the dangers of second-hand smoke and advise them on avoiding the effects of second-hand smoke.</p> <p>Use examples to explain the 5A's model for addressing second-hand smoke in brief contacts:</p> <p><b>Ask</b> if the patient is exposed to second-hand smoke and record the response.</p> <p><b>Advise</b> the patient to avoid exposure to second-hand smoke.</p> <p><b>Assess</b> the patient's willingness to reduce exposure to second-hand smoke.</p> <p><b>Assist</b> the patient in making an attempt to make his/her daily life environment smoke-free.</p> <p><b>Arrange</b> follow-up for the patient to obtain support and talk about the matter again.</p> <p>Emphasize that, in order to support health-care providers to routinely help non-smokers avoid the effect of second-hand smoke, health facilities should include second-hand smoke exposure status in medical records as well.</p>	<p>Participate in the discussion and provide ideas.</p> <p>Refer to the workbook.</p>	<p>Workbook, flipchart/whiteboard, Power Point presentation <i>Part III-Module 7-A</i></p>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Practice</b>			
20 minutes	Select two volunteers to role-play the 5A's model to address non-smokers' exposure to second-hand smoke in front of the group: <ul style="list-style-type: none"> <li>• One will be a doctor who attempts to address the patient's second-hand smoke exposure.</li> <li>• The other will be a newly married woman whose husband smokes at home.</li> </ul>	Volunteer participants will conduct the role play as other participants observe.	Simulation
<b>Evaluation</b>			
15 minutes	Congratulate volunteers on their participation! Invite feedback and questions.  Reinforce the need for practice and reassure participants that they will become confident about delivering the intervention with daily practice.	Participants provide feedback. Anticipate uncertainty in confidently offering the brief intervention to address second-hand smoke.	Flipchart/whiteboard

## Module 8: Introduction to pharmacotherapy

<b>Duration</b>	2 hours
<b>Objectives</b>	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> <li>– describe effective tobacco cessation medications;</li> <li>– prescribe the available range of NRT products;</li> <li>– recommend bupropion and varenicline;</li> <li>– apply tools to assess tobacco users' levels of nicotine dependence.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	Ask group to brainstorm: What effective tobacco cessation products are currently available for tobacco users?  Write participants' responses on a flipchart page or whiteboard.  Use PowerPoint slides to summarize the two categories of medication (nicotine replacement medications and non-nicotine medications) that are currently available for treating tobacco dependence.  State that, in this module, participants will have an opportunity to discuss those tobacco cessation medications, with the focus on NRT products.	Participate in the discussion and brainstorm currently available effective tobacco cessation medications.  Anticipated response includes NRT products, bupropion and varenicline.	Flipchart/whiteboard, Power Point presentation <i>Part III-Module 8-A</i>
<b>Presentation</b>			
25 minutes	Present the following information for NRT (nicotine gum, transdermal patch, lozenge, oral inhaler and nasal spray), bupropion and varenicline: <ul style="list-style-type: none"> <li>– what those medications are;</li> <li>– the purpose of using those medications;</li> <li>– available dosage;</li> <li>– advantages and disadvantages;</li> <li>– who can use those medications;</li> <li>– general guidelines for using those medications;</li> <li>– side-effects and warnings.</li> </ul>	Refer to the workbook.	Workbook, Power Point presentation <i>Part III-Module 8-B</i>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
15 minutes	<p>State that participants need to assess tobacco users' levels of nicotine dependence before they actually prescribe or recommend dosage of NRT to tobacco users.</p> <p>Present information on how to assess the level of nicotine dependence:</p> <ul style="list-style-type: none"> <li>• <b>Method 1:</b> The Fagerström Test is the standard instrument for assessing the intensity of physical addiction to nicotine.</li> <li>• <b>Method 2:</b> Ask two simple questions:                             <ul style="list-style-type: none"> <li>– How many cigarettes do you smoke per day?</li> <li>– At what time do you smoke your first cigarette in the morning?</li> </ul> </li> </ul>	Refer to the workbook.	Workbook, Power Point presentation <i>Part III-Module 8-C</i>
15 minutes	<p>Guide participants to review the instructions for use and the dosing recommendations for each NRT product based on the level of nicotine dependence.</p> <p>Leave 2–3 minutes for brief Q&amp;A at the end.</p>	<p>Refer to the workbook.</p> <p>Feedback and questions.</p>	Workbook, Power Point presentation <i>Part III-Module 8-D</i>
<b>Practice</b>			
30 minutes	<p>Assign participants to work in small groups to recommend NRT treatment plans for two fictional smokers:</p> <ol style="list-style-type: none"> <li>1. Kate is a 55-year-old married female who has smoked two packs per day for the past 40 years.</li> <li>2. Jack is a 35-year-old male who has smoked approximately 15 cigarettes per day for the past 20 years.</li> </ol>	Review the two case studies and work in small groups to practise prescribing NRT products for Kate and Jack.	Case studies
<b>Evaluation</b>			
20 minutes	<p>Invite each group to present its NRT treatment plans for Kate and Jack by writing them on a flipchart or whiteboard.</p> <p>Facilitator prompts discussion by sharing pre-prepared NRT treatment plans.</p>	Every one adds to the discussion and gives feedback.	Flipchart/ whiteboard Workbook

## Module 9: Promoting brief tobacco interventions in the community

<b>Duration</b>	1 hour 10 minutes
<b>Objectives</b>	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> <li>– identify outreach opportunities for delivery of brief tobacco interventions to tobacco users in their homes or community settings;</li> <li>– identify referral resources within a local community for the primary care provider to deliver brief tobacco interventions.</li> </ul>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Preparation</b>			
15 minutes	<p>Emphasize that primary care providers should use every encounter in both clinical and community settings to provide brief tobacco interventions to all patients to quit tobacco use.</p> <p>Ask participants to brainstorm about the opportunity to deliver brief tobacco interventions in patients' homes and in the community.</p> <p>Write responses on the flipchart or whiteboard.</p> <p>Emphasize that primary care providers should take all of those opportunities to deliver brief tobacco interventions to patients and their families.</p>	<p>Refer to the workbook.</p> <p>Brainstorm the opportunity to deliver brief tobacco interventions in patient' homes and in the community.</p>	Flipchart/ whiteboard, Power Point presentation <i>Part III-Module 9-A</i>

Time	Facilitator activity	Participant activity	Audiovisual
<b>Presentation</b>			
15 minutes	<p>State that the community also has many existing resources to support primary care providers in delivering brief tobacco interventions to tobacco users.</p> <p>Make sure to explain the following key points:</p> <ul style="list-style-type: none"> <li>• Many community resources could be referral resources for primary care providers when they deliver brief interventions. For example:                             <ul style="list-style-type: none"> <li>– tobacco quitlines;</li> <li>– specialist services in cessation clinics;</li> <li>– local tobacco cessation classes and support groups;</li> <li>– smokers' web-based assistance;</li> <li>– free self-help materials.</li> </ul> </li> <li>• With available community resources to provide in-depth assistance and follow-up, primary care providers will be freed up to focus on identifying and motivating tobacco users to quit using a simplified brief tobacco intervention model called AAR (Ask, Advise, Refer).</li> </ul> <p>Emphasize that a list of existing referral resources in the community that the primary care providers serve will be a useful tool or resource to assist the providers in delivering brief tobacco interventions.</p>	Refer to the workbook.	Flipchart/ whiteboard, Power Point presentation <i>Part III- Module 9-B</i>
<b>Practice</b>			
20 minutes	Assign participants to small groups to compile a list of available resources for tobacco dependence treatment in their communities.	Work in small groups to compile a list of existing resources.	
<b>Evaluation</b>			
20 minutes	<p>Invite each group to share its list of available community resources.</p> <p>Conclude that the lists can help primary care providers complement and extend their brief tobacco interventions by referring patients to those resources.</p>	Everyone adds to the discussion and gives feedback.	Flipchart/ whiteboard

## Module 1: The role of primary care providers in tobacco control and tobacco dependence treatment

### Objectives

Upon completion of this module participants will be able to:

- acknowledge their roles in tobacco control and tobacco dependence treatment;
- describe the purpose of this training course;
- describe existing effective tobacco dependence treatment methods;
- describe the definition, effectiveness, feasibility and content of brief tobacco interventions.

### Agenda

1. The role of health professionals in tobacco control and tobacco dependence treatment (35 minutes).
2. The unique position of primary care providers in helping tobacco users (10 minutes).
3. Effective tobacco dependence treatment methods (10 minutes).
4. Definition, effectiveness and feasibility of brief tobacco interventions (10 minutes).
5. The content of brief tobacco interventions (25 minutes).
6. Evaluation (20 minutes).

### Preparation

#### 1. The role of health professionals in tobacco control and tobacco dependence treatment (35 minutes)

Tobacco use is the single most preventable cause of death in the world today. We as health-care providers must do our utmost to fight against tobacco.

#### Brainstorming

What is the role of health professionals in tobacco control and tobacco dependence treatment?

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Health professionals such as physicians, nurses, midwives, pharmacists, dentists, physiologists, chiropractors and other health-related professionals have eight key roles to play in tobacco control and tobacco dependence treatment. These roles include:

- **Role model:** In community and clinical settings, health professionals are expected to be role models for the rest of the population, and particularly regarding tobacco.
- **Clinician:** All health professionals in the everyday health-care setting need to address tobacco dependence as part of their standard of care practice.
- **Educator:** Health professionals can play an important role in teaching medical students about tobacco and cessation techniques.
- **Scientist:** All health professionals should be aware of science-based information about how tobacco control measures can be implemented within their scope of practice.
- **Leader:** Health professionals in positions of leadership can get involved in the policy-making process, supporting comprehensive tobacco control measures that go beyond the availability of cessation.
- **Opinion-builder:** As a citizen of a community or member of a national association for health professionals, health professionals have great potential to build opinion in support of tobacco control.

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- **Alliance-builder:** Health professionals should consider cooperation with others to support tobacco control in one way or another.
  - **Watching out for tobacco industry activities:** Health professionals, as individuals or associations, have a duty to denounce tobacco industry strategies aimed at hindering local, national or international tobacco control efforts and to demand from the authorities the adoption of policies that prioritize the health and quality of life of their people over the industry's profits.

### Summary

Health professionals have several roles in common to play in comprehensive tobacco control efforts, namely:

- preventing non-users from starting to use tobacco;
- assisting tobacco users in quitting;
- protecting non-tobacco users from exposure to tobacco smoke.

This training course will focus on their role as clinician to assist tobacco users in quitting as part of their standard of care practice.

### Presentation

#### 2. The unique position of primary care providers in helping tobacco users (10 minutes)

- Primary care staff have a long and close contact with the community and are well accepted by local people.
- The primary care is the primary source of health care and primary care providers can reach the majority of the population in many countries:
  - In Brazil, 70% of the population receives free health care from the public system.
  - In Cuba, the national health care programme addresses the needs of over 95% of the population.
  - In Fiji, 70–80% of the population has access to health services.
  - In Thailand, the universal coverage scheme provides health care for most of the country's 64 million people.
- Primary care programmes appear to reach the poor far better than other types of health programmes and the poor are the ones who smoke the most.

#### 3. Effective tobacco dependence treatment methods (10 minutes)

##### Question

What tobacco dependence treatment methods can you use to help tobacco users?

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There are various effective treatment methods or interventions (Table1).

Table 1. Summary of effectiveness data for smoking cessation interventions (abstinence at least six months) based on the latest Cochrane Reviews

Intervention	Quit rate (%)	Comparator	Odds ratio (95% confidence interval)	Increased chances of quitting successfully
Self-help interventions		No intervention	1.21(1.05–1.39)	21%
Physician advice		Brief advice vs. no advice	1.66(1.42–1.94)	66%
		Intensive advice vs. no advice	1.84(1.60–2.13)	84%
		Intensive vs. minimal	1.37(1.20–1.56)	37%
Nursing intervention		Usual care	1.28(1.18–1.38)	28%
Individual behavioural counselling		Minimal behavioural intervention	1.39(1.2 –1.57)	39%
Group behaviour therapy		Self-help programme	1.98(1.60–2.46)	98%
Telephone counselling		Without telephone counselling	1.37(1.26–1.50)	37%
		Less intensive vs. no	1.29(1.20–1.38)	29%
Quit and Win contests	8-20%	Baseline community quit rate at the 12-month assessment		
Nicotine replacement therapy (NRT)		Placebo or non-NRT	1.58(1.50–1.66)	58%
Bupropion		Placebo	1.69(1.53–1.85)	69%
Varenicline		Placebo	2.27(2.02–2.55)	127%
Cytisine		Placebo	3.98(2.01–7.87)	298%
Clonidine		Placebo	1.63 (1.22–2.18)	63%
Nortriptyline		Placebo	2.03(1.48–2.78)	103%

More intensive or longer-lasting treatments are more likely to help tobacco users quit successfully. Health-care providers can help patients quit tobacco successfully by offering brief tobacco interventions as short as three minutes (Table 2).

Table 2. Meta-analysis: efficacy of, and estimated abstinence rates for, various intensity levels of person-to-person contact (n = 43 studies)

Level of contact	Number of arms	Estimated odds ratio (95% C.I.)	Estimated abstinence rate (95% C.I.)
No contact	30	1.0	10.9
Minimal counselling (< 3 minutes)	19	1.3 (1.01–1.6)	13.4 (10.9–16.1)
Low intensity counselling (3–10 minutes)	16	1.6 (1.2–2.0)	16.0 (12.8–19.2)
Higher intensity counselling (> 10 minutes)	55	2.3 (2.0–2.7)	22.1 (19.4–24.7)

Source: Fiore MC et al. *Treating tobacco use and dependence: 2008 update*. Clinical practice guideline, 2008

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#### **4. Definition, effectiveness and feasibility of brief tobacco interventions (10 minutes)**

Brief tobacco interventions, also often called “brief advice”, have been defined in the guidelines for implementation of Article 14 of the WHO FCTC as “advice to stop using tobacco, usually taking only a few minutes, given to all tobacco users, usually during the course of a routine consultation or interaction”.

Brief tobacco interventions as part of routine practice are opportunistic interventions, which are feasible and resource-efficient ways of helping tobacco users quit. As shown in Table 2, a three-minute brief intervention has been shown to increase abstinence rates significantly by 30% compared to no advice.

#### **Summary**

Helping patients quit tobacco as part of their routine practice takes health-care providers only a few minutes and is feasible, effective and efficient.

#### **Practice**

#### **5. The content of brief tobacco interventions (25 minutes)**

Pair up with the person sitting next to you to list what things you can do within 3–5 minutes to help tobacco users quit.

Be prepared to share your list of activities in the whole group.

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#### **6. Evaluation (20 minutes)**

Please volunteer to share your list of activities that can be done within 3–5 minutes to support tobacco users to quit.

Please help provide your comments on the other participants' lists and make sure that you understand what the content areas of a brief tobacco intervention are.

#### **Summary**

All we need to do to assist tobacco users to quit within 3–5 minutes can be summarized as 5A's: Ask, Advise, Assess, Assist, and Arrange. These are the content areas of a brief tobacco intervention. During the rest of the training, you will learn knowledge and skills to implement the 5A's brief interventions.

## Module 2: Basics of tobacco use and tobacco dependence

### Objectives

Upon completion of this module participants will be able to:

- identify patterns of tobacco use (local, national, international);
- describe the health, social and economic impact of tobacco use on tobacco users and others;
- clarify common misconceptions held by tobacco users;
- explain the benefits of quitting tobacco use;
- describe why people smoke and why they don't stop.

### Agenda

1. What do we need to know on tobacco use and tobacco dependence? (10 minutes).
2. The impact of tobacco use on tobacco users and others (10 minutes).
3. The benefits of quitting tobacco use (10 minutes).
4. Overview of local, national and worldwide patterns of tobacco use (10 minutes).
5. Why people smoke and do not quit (25 minutes).
6. Applying the knowledge of tobacco addiction to deliver brief interventions (20 minutes).
7. Evaluation (15 minutes).

### Preparation

#### 1. What do we need to know on tobacco use and tobacco dependence? (10 minutes)

##### Brainstorming

In order effectively to help tobacco users quit, what do you need to know about tobacco use and tobacco dependence?

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In order to assist patients in quitting more effectively, every health-care provider should have some basic knowledge of tobacco use and tobacco dependence – such as the impact of tobacco use, the benefits of quitting tobacco use, and why people smoke and do not quit.

### Presentation

#### 2. The impact of tobacco use on tobacco users and others (10 minutes)

##### Brainstorming

What is the impact of tobacco use on tobacco users and others?

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Tobacco use will have both health and non-health impacts on tobacco users and others.

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## 2.1 Health impact

Tobacco kills up to half of its users. As a leading cause of death and illness, tobacco kills more than 5 million people who directly use tobacco (both smoking and smokeless).

Second-hand smoke also kills. Second-hand smoke causes more than 600 000 premature deaths per year.

Smoking is bad for health because tobacco smoke contains more than 7000 chemicals, of which at least 250 are known to be harmful and at least 69 are known to cause cancer. Figure 2 shows some examples of the chemicals contained in tobacco smoke. Figure 3 illustrates that tobacco use and second-hand smoke damage every part of the body.

Smokeless tobacco is also highly addictive and causes cancer of the head and neck, oesophagus and pancreas, as well as many oral diseases. There is evidence that some forms of smokeless tobacco may also increase the risk of heart disease and low-birth-weight babies.

## 2.2 Common misconceptions about health effects of tobacco held by tobacco users

Many tobacco users, especially those in developing countries, do not completely understand the dangers of tobacco due to tobacco companies' misleading data that distort the health impact of tobacco use. Below are some common misconceptions of tobacco use held by tobacco users.

### Low-tar cigarettes are safe to smoke.

There is no safe cigarette; a low-tar cigarette is just as harmful as other cigarettes. Although low-tar cigarettes can be slightly less damaging to your lungs over a long period of time, people who smoke these have been shown to take deeper puffs, puff more frequently and smoke the cigarettes to a shorter butt length. Switching to low-tar cigarettes has few health benefits compared with the benefits of quitting.

### “Rollies” are safe to smoke.

Roll-your-own (RYO) tobacco contains many of the same chemicals as manufactured cigarettes. Research suggests that RYO tobacco is at least as harmful, and possibly more harmful, than smoking factory-made cigarettes. Studies show that RYO smokers tend to make cigarettes that can yield high levels of tar and nicotine. They may also not use a filter. Both RYO-only and mixed smokers report inhaling more deeply than smokers of factory-made cigarettes. More research is required to determine the levels of chemicals inhaled by RYO smokers.

### Cutting down the number of cigarettes I smoke will reduce my health risks.

There is no safe level of cigarette consumption. Some people try to make their smoking habit safer by smoking fewer cigarettes, but most find this hard to do and quickly return to their old pattern. Although reducing your cigarette consumption will slightly reduce your risk, quitting is the only way to long-term health benefits. Just three cigarettes a day can trigger potentially fatal heart disease, with women particularly at risk.

### Only old people get ill from smoking.

Anyone who smokes tobacco increases their risk of ill-health. All age groups suffer short-term consequences of smoking that include decreased lung function, shortness of breath, cough and rapid tiring during exercise. Smoking also diminishes the ability to smell and taste, and causes premature ageing of the skin.

Smoking-related diseases often develop over a number of years before a diagnosis is made. The longer you smoke, the greater your risk of developing cancer, heart, lung and other preventable diseases. However, people in their 20s and 30s have died from strokes caused by smoking.

**Everyone who quits smoking puts on weight.**

When you stop smoking you are likely to find you have a larger appetite and be tempted to replace cigarettes with food. You can avoid weight gain after quitting by being aware of this and doing extra exercise and adopting healthy eating habits.

**2.3 Economic impact of tobacco use**

Tobacco imposes enormous economic costs on individuals, the family and the country.

Tobacco's economic costs include:

- direct costs:
  - tobacco-related death;
  - tobacco-related productivity losses;
- indirect costs:
  - health-care expenditures for smokers and people exposed to second-hand smoke;
  - employee absenteeism and reduced labour productivity;
  - fire damage due to careless smokers;
  - increased cleaning costs;
  - widespread environmental harm from large-scale deforestation, pesticide and fertilizer contamination, and discarded litter.

**2.3.1 Costs to the society**

The estimated annual cost of tobacco use to societies globally is US\$ 500 billion, exceeding the total annual expenditure on health in all low-and middle-income countries.

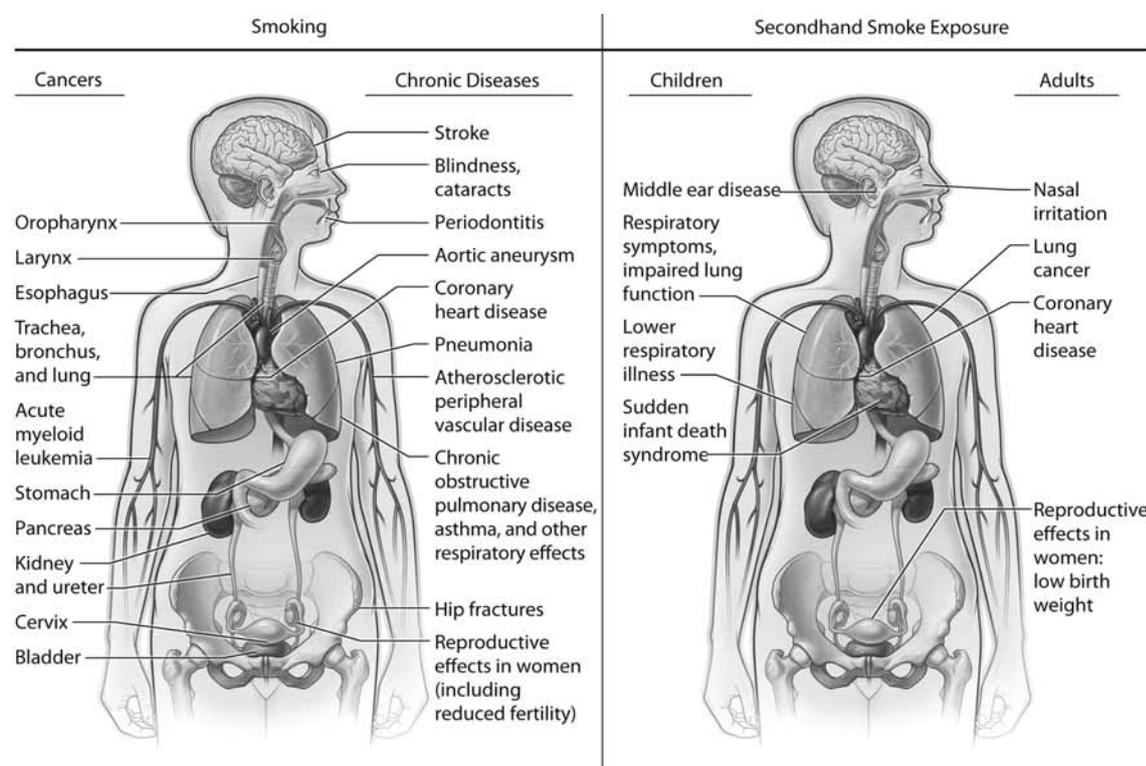
Figure 2. Chemicals in cigarette smoke



Source: WHO (2009). WHO report on the global tobacco epidemic, 2009: implementing smoke-free environments.

Every country suffers huge economic losses due to tobacco use (see some examples in Table 3). Tobacco's total economic costs reduce national wealth in terms of gross domestic product (GDP) by as much as 3.6%.

Figure 3. Diseases caused by smoking and second-hand smoke



Source: U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

Table 3. Cost\* attributable to tobacco use (US\$) (2007 or latest available data)

USA	167.00 billion
Japan	62.39 billion over one year
Germany	23.75 billion
Canada	17.00 billion
France	15.30 billion
China	5.00 billion
Egypt	1.25 billion

\* Direct health-care costs plus indirect costs, including productivity losses, absenteeism and other socioeconomic costs.

### 2.3.2 Costs to families and individuals

Another significant cost related to tobacco use is the suffering of families and individuals because of diminished quality of life, death and financial burden. "Smoking makes the poor poorer; it takes away not just their health but wealth." (Dr. Bill O'Neill, Secretary of the British Medical Association Scotland, 2004).

Tobacco products are expensive. For example, the price of 20 Marlboro cigarettes could buy:

- a dozen eggs in Panama;
- one kilogram of fish in France;
- four pairs of cotton socks in China;
- six kilograms of rice in Bangladesh.

Tobacco use is costly with 5–15% of tobacco users' disposable income spent on tobacco. Poor people often have to cut their expenditure on food and education.

### 3. Benefits of quitting tobacco use (10 minutes)

#### 3.1 Health benefits

Quitting tobacco use saves lives and money. Fact sheet 1 summarizes the health benefits of smoking cessation.

##### Fact sheet 1: Health benefits of smoking cessation

A. There are immediate and long term health benefits of quitting for all smokers.

Time since quitting	Beneficial health changes that take place
<b>Within 20 minutes</b>	Your heart rate and blood pressure drop.
<b>12 hours</b>	The carbon monoxide level in your blood drops to normal.
<b>2-12 weeks</b>	Your circulation improves and your lung function increases.
<b>1-9 months</b>	Coughing and shortness of breath decrease.
<b>1 year</b>	Your risk of coronary heart disease is about half that of a smoker.
<b>5 years</b>	Your stroke risk is reduced to that of a non-smoker 5 to 15 years after quitting.
<b>10 years</b>	Your risk of lung cancer falls to about half that of a smoker and your risk of cancer of the mouth, throat, esophagus, bladder, cervix, and pancreas decreases.
<b>15 years</b>	The risk of coronary heart disease is that of a non-smoker's

B. Benefits for all ages and people who have already developed smoking-related health problems. They can still benefit from quitting.

Time of quitting smoking	Benefits in comparison with those who continued
<b>At about 30</b>	Gain almost 10 years of life expectancy
<b>At about 40</b>	Gain 9 years of life expectancy
<b>At about 50</b>	Gain 6 years of life expectancy
<b>At about 60</b>	Gain 3 years of life expectancy
<b>After the onset of life-threatening disease</b>	Rapid benefit, people who quit smoking after having a heart attack reduce their chances of having another heart attack by 50 per cent.

C. Quitting smoking decreases the excess risk of many diseases related to second-hand smoke in children, such as respiratory diseases (e.g., asthma) and ear infections.

D. Quitting smoking reduces the chances of impotence, having difficulty getting pregnant, having premature births, babies with low birth weights, and miscarriage.

### 3.2 Economic benefits

Quitting has clear economic benefits. The quit & save exercise can help you understand how much money you can save if you quit.

#### Quit & Save

How much money can you save if you quit?

Total money spent on tobacco per day	
Amount of money spent per month	
Amount of money spent per year	
Amount of money spent in 10 years	

What you can buy with the money saved?

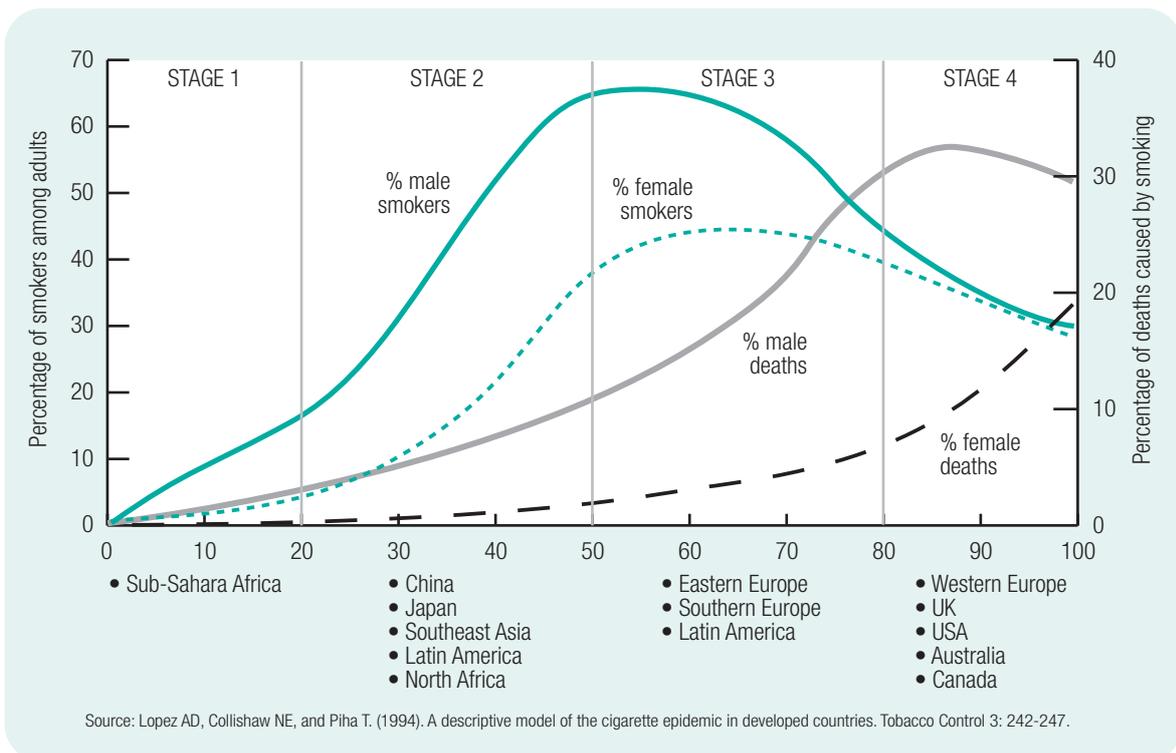


## 4. Overview of local, national and worldwide patterns of tobacco use (10 minutes)

### 4.1 Worldwide patterns of tobacco use

#### Cigarette smoking

Figure 4. Four stages of the tobacco epidemic



With respect to cigarette smoking, WHO has developed a model of the four stages of the evolving epidemic that links the various stages of the tobacco epidemic into a continuum (Figure 4) to allow virtually every country to find itself in relation to the larger pandemic. It also illustrates the connection between the indices used to monitor the epidemic in a particular country and the natural evolution involving tobacco marketing, dependence on manufactured cigarettes, and ultimately the disease burden caused by these products within and across countries.

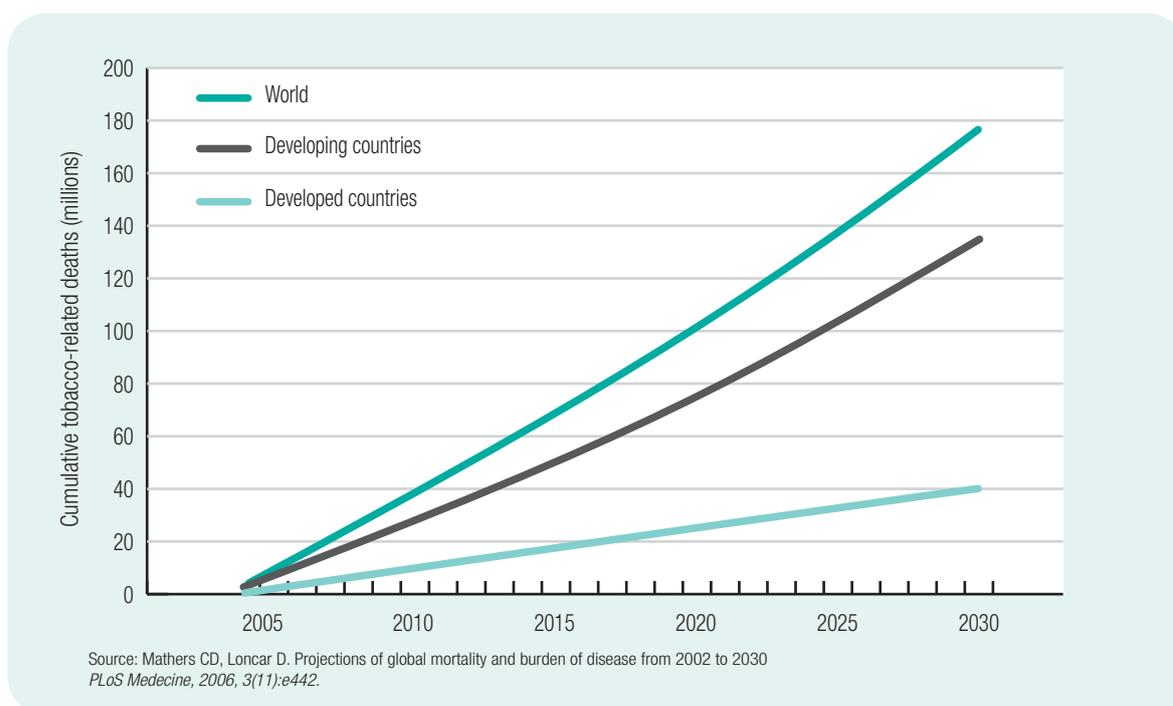
Unlike many other dangerous substances, for which the health impacts may be immediate, tobacco-related disease usually does not begin for years or decades after tobacco use starts. Because developing countries are still in the early stages of the tobacco epidemic, they have yet to experience the full impact of tobacco-related disease and death already evident in wealthier countries where tobacco use has been common for much of the past century.

There are more than one billion smokers in the world. Nearly 80% of them live in low- and middle-income countries. Unless urgent action is taken, the number of smokers worldwide will continue to increase.

### Consumption of tobacco products

Consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper-middle-income countries. Tobacco use is growing fastest in low-income countries, due to steady population growth coupled with tobacco industry targeting. Figure 5 shows that tobacco will kill over 175 million people worldwide between now and the year 2030.

Figure 5. Cumulative tobacco-related deaths, 2005 – 2030



### Tobacco use among adolescents and women

The vast majority of smokers begin using tobacco products well before the age of 18 years. Today, surveillance of tobacco use among youth in several countries has revealed that the problem is of equal concern in developed and developing countries. Statistics reveal that the use of any form of tobacco by 13–15-year-old students is greater than 10% (Table 4). In addition, almost one in four students (13–15 years of age) who ever smoked cigarettes smoked their first cigarette before the age of 10 years. Further, recent studies have revealed that there is little difference between the sexes in cigarette smoking or in use of other tobacco products.

Table 4. GYTS measures of tobacco use, by sex and WHO region, 1999 – 2005

	Current any tobacco use*			Current cigarette smoking**			Current other tobacco use***		
	Total	Boy	Girl	Total	Boy	Girl	Total	Boy	Girl
Total	17.3 (14.8-19.8)	20.1 (16.7-23.5)	14.3 (11.5-17.1)	8.9 (7.2-10.6)	10.5 (8.1-12.9)	6.7 (5.0-8.4)	11.2 (9.7-12.7)	13.8 (11.7-15.9)	7.8 (6.0-9.6)
African Region	16.8 (14.1-19.5)	19.7 (15.8-23.6)	13.9 (10.8-17.0)	9.2 (7.0-11.4)	13.0 (9.4-16.6)	5.8 (3.5-8.1)	10.5 (8.3-12.7)	10.9 (8.0-13.8)	9.9 (7.3-12.5)
Region of the Americas	22.2 (19.8-24.6)	24.0 (21.0-27.0)	20.4 (17.6-23.2)	17.5 (15.2-19.8)	17.4 (14.7-20.1)	17.5 (14.9-20.1)	11.3 (9.8-12.8)	14.8 (12.6-17.0)	7.8 (6.2-9.4)
Eastern Mediterranean Region	15.3 (12.7-17.9)	18.8 (15.2-22.4)	11.3 (8.0-14.6)	5.0 (3.3-6.7)	6.7 (4.4-9.0)	3.2 (1.1-5.3)	12.9 (10.6-15.2)	15.6 (12.4-18.8)	9.9 (7.3-12.5)
European Region	19.8 (16.6-23.0)	22.3 (18.0-26.7)	17.0 (13.8-20.2)	17.9 (15.2-20.6)	19.9 (16.1-23.7)	15.7 (13.6-18.8)	8.1 (5.8-10.4)	10.0 (6.7-13.3)	6.0 (4.0-8.0)
South-East Asia Region	12.9 (10.2-15.6)	18.4 (14.3-22.5)	7.1 (4.7-9.5)	4.3 (3.1-5.5)	5.8 (4.4-7.5)	1.9 (1.0-2.8)	13.3 (12.3-14.3)	16.4 (15.0-17.8)	8.4 (6.8-10.0)
Western Pacific Region	11.4 (9.5-13.3)	15.0 (12.2-17.8)	7.8 (5.8-9.8)	6.5 (4.9-8.1)	9.9 (7.1-12.7)	3.3 (2.1-4.5)	6.4 (5.2-7.6)	7.7 (6.1-9.3)	5.4 (3.9-6.9)

Data are prevalence (95% CI).

\* smoked cigarettes or used other tobacco products during the past 30 days.

\*\* smoked cigarettes on 1 or more days in the past 30 days.

\*\*\*used other tobacco products (e.g. chewing tobacco, snuff, dip, cigars, cigarillos, little cigars, pipe, bidis, waterpipe, or betel nut with tobacco) during the past 30 days.

Source: Warren CW et al. Global Tobacco Surveillance System (GTSS) collaborative group. Patterns of global tobacco use in young people and implications for future chronic disease burden in adults. *Lancet*, 2006, 749–753.

The rise in tobacco use among younger females in high-population countries is one of the most ominous potential developments of the epidemic's growth. In many countries, women have traditionally not used tobacco: women smoke at about one fourth the rate of men.

Because most women currently do not use tobacco, the tobacco industry aggressively markets to them to tap this potential new market.

### Smokeless tobacco

There are four major forms of oral smokeless tobacco.

- Chewing tobacco is shredded like short cut grass, generally mildly acidic and intended to be chewed throughout the day as desired.
- Snuff is chopped into particles like large coffee grounds, moistened and used by holding between gum and cheek.
- Swedish snus is a variant on snuff that is processed differently so that some variants must be kept refrigerated: it is typically more moist.
- Gutkha and other oral smokeless tobacco products are used in India and South-east Asia.

In some regions of the world, the use of oral smokeless tobacco remains the dominant form of tobacco use. For example, in India, where oral smokeless tobacco is the dominant form of tobacco use, the incidence of oral cancer is high, accounting for one third of the world burden. Smokeless tobacco is commonly used in other South-East Asian countries as well (Table 5). Its consumption is prominent in Scandinavia and the United States of America.

Table 5. Smokeless tobacco use in three South-East Asian countries

Countries	Current smokeless tobacco users (%)	Daily smokeless tobacco users (%)
India	25.9	21.4
Bangladesh	27.2	23.7
Thailand	3.9	3.4

Source: Global Adult Tobacco Survey country reports and fact sheets.

#### 4.2 Local and national patterns of tobacco use

For the profile of tobacco use in each specific country, please refer to the WHO tobacco control country profiles which were generated from data collected for the *WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco*. The country profiles provide information about tobacco prevalence in 193 WHO Member States.

In terms of local patterns of tobacco use, please contact your local health authority for detailed data.

### 5. Why people smoke and do not quit (25 minutes)

#### Brainstorming

Why do people smoke and why don't they quit?

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People smoke for many reasons. If you ask smokers, they may tell you the following reasons:

- addiction;
- social activity;
- stress relief;
- emotional support;
- boredom/filling in time;
- everyone does it;
- after a meal;
- when having coffee or tea;
- sharing of cigarettes;
- bonding/acceptance.

The list of reasons why people smoke can help us realize that smoking/tobacco addiction is made up of three elements:

- physical /physiological addiction to nicotine;
- emotional/psychological connection;
- habitual and social connection.

### 5.1 Physical/physiological addiction

#### Nicotine

Nicotine is as addictive as many illegal drugs. Nicotine has been shown to have effects on brain dopamine systems similar to those of drugs such as heroin and cocaine. Nicotine increases the number of nicotinic receptors in the brain.

Inhalation (smoking) is the quickest way for nicotine to reach brain (within 7–10 seconds). As a smoker, your brain and body get used to functioning with a certain level of nicotine. Your nicotine level will drop dramatically one or two hours after your last cigarette (the half-life of nicotine is 120 minutes), and then you will crave nicotine (cigarettes). If you stop smoking suddenly, the absence of nicotine in your brain (the nicotinic receptors in your brain are empty) will make you feel uncomfortable and cause withdrawal symptoms.

#### Nicotine withdrawal symptoms

Nicotine withdrawal symptoms refer to a group of symptoms (the physical and mental changes) that may occur from suddenly stopping the use of tobacco. Withdrawal is the adjustment of the body to living without nicotine, positively referred to as recovery symptoms. They are normally temporary (2–4 weeks) and are a product of the physical or psychological adaptation.

Most smokers know about withdrawal symptoms through hearsay or from direct experience. They can be a major barrier against staying quit, or even attempting to quit in the first place. Some common nicotine withdrawal symptoms are:

- headaches;
- coughing;
- cravings;
- increased appetite or weight gain;
- mood changes (sadness, irritability, frustration, or anger);
- restlessness;
- decreased heart rate;
- difficulty concentrating;
- influenza-like symptoms;
- insomnia.

### 5.2 Emotional/psychological connection

Smokers link feelings with cigarettes via the process of withdrawal and “operant conditioning”. Here are some of the emotional connections that may be associated with smoking: when smokers feel stressed, happy, sad or angry, they will get craving for a cigarette. In fact, using cigarettes to calm your nerves or cope with stress is misguided. It does not help solve the source of your problems.

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Other psychological factors relevant to smoking are cognitions (i.e. thoughts and beliefs). Smokers who do not want to quit may have positive thoughts and beliefs on smoking, such as:

- “It helps me relax.”
- “It’s not really that harmful!”
- “It’s cool to smoke!”
- “It keeps my weight down.”

### **5.3 Habitual and social connection**

Smoking is a tenacious habit precisely because it is so intimately tied to the everyday acts in smokers’ lives. Smokers link behaviour with cigarettes via the process of “operant conditioning”.

It is not easy to let go of something that’s been such an integral part of a smoker’s life for so long. Smoking may be associated with the following habits or behaviour: having coffee or tea, the end of meal, making a phone call, watching television, driving.

Smoking is also prone to social influences. Children and adolescents are more likely to start smoking if their parents or people they respect and admire smoke. Smoking with friends is a way to socialize with them.

### **5.4 Interactions between the three elements of tobacco addiction**

The physical, psychological and social influences are not independent of each other. All three types of factors influencing smoking need to be explored and referred to when you provide support for tobacco users to quit.

## **Practice**

### **6. Applying the knowledge of tobacco addiction to deliver brief interventions (20 minutes)**

Pair up with the person sitting next to you to list two ways in which you should use the knowledge of tobacco addiction when delivering brief interventions.

Be prepared to share your list in the whole group.

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### **7. Evaluation (15 minutes)**

Please volunteer to share your two ways of using the knowledge of tobacco addiction when delivering brief tobacco interventions.

Please help provide your comments on the other participants’ responses.

### Summary

Tobacco is the single most preventable cause of death globally. Tobacco is deadly in any form or disguise. Tobacco use and second-hand smoke damage every part of the body. Tobacco also imposes enormous economic costs on individuals, families and the country. Quitting tobacco saves lives and money. People smoke and do not quit for many reasons, which can be classified into three factors: physical, psychological, habitual and social influences. Nevertheless, with determination and a smart strategy, it is possible to quit tobacco use. Health-care providers should use the knowledge of tobacco addictions to deliver brief tobacco interventions.

## Module 3: Overview of brief tobacco interventions

### Objectives

Upon completion of this module participants will be able to:

- describe the purpose and population impact of a brief tobacco intervention;
- describe at least three brief tobacco intervention models;
- role-play the 5A's brief tobacco intervention model.

### Agenda

1. Experiences of talking to patients about tobacco use (15 minutes).
2. The purpose, impact and delivery models of brief tobacco interventions (30 minutes).
3. Pre-training role play of a brief tobacco intervention (30 minutes).
4. Evaluation (15 minutes).

### Preparation

#### 1. Experiences of talking to patients about tobacco use (15 minutes)

Question:

What are your experiences of talking to patients about smoking?

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As a health professional, you may feel frustrated as many tobacco users are resistant to change and you do not know how to reduce their resistance and support them to quit tobacco use. In this module, you will find several effective brief tobacco intervention models to help you talk to patients about quitting tobacco and deliver advice.

## Presentation

### 2. The purpose, impact and delivery models of brief tobacco interventions (30 minutes)

#### 2.1 Purpose

Generally, brief tobacco interventions are not intended to treat people with high tobacco dependence (heavy tobacco users). The primary purpose of a brief tobacco intervention is to help the patient understand the risks of tobacco use and the benefits of quitting, and to motivate them to make a quit attempt. Brief tobacco interventions can also be used to encourage those heavy tobacco users to seek or accept a referral to more intensive treatments within their community.

It is estimated that approximately 40% of tobacco users make some form of attempt to quit in response to advice from a doctor.

#### 2.2 The population impact

The success of a service or a public health programme is measured by its **reach** (number of people who receive the service/intervention), **effectiveness** (percentage of people who change their behaviour as a result of the service/intervention) and **cost** per person to deliver.

Brief tobacco interventions take a few minutes – even small effect sizes – they can have significant population impact at relatively low cost if interventions are delivered routinely and widely across a health-care system.

- Reach: in developed countries, 85% of the population visit a primary care clinician at least once per year.
- Effectiveness: the quit rate is 2% (95% confidence interval 1–3%).
- Cost: this is very low (a few minutes opportunistic intervention as part of primary care providers' routine practice).

#### 2.3 Effective brief tobacco intervention models

There are several structured brief tobacco intervention models that can guide you through the right process to talk to patients about tobacco use and deliver advice. Below are some examples of brief tobacco intervention models.

##### 2.3.1 The 5A's: Ask, Advise, Assess, Assist, Arrange (for patients who are ready to quit)

- Ask** – Systematically identify all tobacco users at every visit.
- Advise** – Advise all tobacco users that they need to quit.
- Assess** – Determine readiness to make a quit attempt.
- Assist** – Assist the patient with a quit plan or provide information on specialist support.
- Arrange** – Schedule follow-up contacts or a referral to specialist support.

**Ask:** We need to ask **ALL** of our patients if they use tobacco and make it part of our routine. Only then can we start to make a real difference to the tobacco use rates around us. Tobacco use should be asked about in a friendly way – it is not an accusation!

**Advise:** Your advice should be clear and positive. It should also be tailored to the particular patient's characteristics and circumstances.

**Assess:** This will be determined by whether the patient wants to be a non-tobacco user, and whether they think they have any chance of quitting successfully.

**Assist:** If the patient is ready to quit then he or she will need some help from us. We need to assist tobacco users in developing a quit plan or to tell them about specialist support if it is available. The support needs to be described positively but realistically.

**Arrange:** If the patient is willing to make a quit attempt we should arrange follow-up around one week after the quit attempt, or arrange referrals to the specialist support.

### **2.3.2 The 5R's: Relevance, Risks, Rewards, Roadblocks, Repetition (to increase motivation of patients who are not ready to quit)**

Tobacco users may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts.

Therefore, after asking about tobacco use, advising the tobacco user to quit, and assessing the willingness to make a quit attempt, it is important to provide the 5R's motivational intervention.

**Relevance** – How is quitting most personally relevant to you?

**Risks** – What do you know about the risks of smoking in that regard?

**Rewards** – What would be the benefits of quitting in that regard?

**Roadblocks** – What would be difficult about quitting for you?

**Repetition** – Repeat assessment of readiness to quit; if still not ready to quit, repeat intervention at a later date.

### **2.3.3 AAR: Ask, Advise, Refer**

This is an alternative protocol that takes less training and can easily be implemented. The primary care provider asks or identifies tobacco-using patients, **advises** them to quit (thus doubling the chances that they will try), and refers them to a quitline or other existing resource (see Module 9 for more information).

### **2.3.4 AAA: Ask, Advise, Act**

**Ask** about tobacco use.

A clinic-wide system will need to be put in place to ensure that tobacco-use status is obtained and recorded for every patient at every office visit.

**Advise** tobacco users to quit.

In a clear, strong, and personalized manner, urge every tobacco user to quit.

**Act** on patient's response, assist the tobacco user in developing a quit plan and give advice on successful quitting.

### **2.3.5 ABC: Ask, Brief advice, Cessation support**

**A** – **Ask** about tobacco-using status.

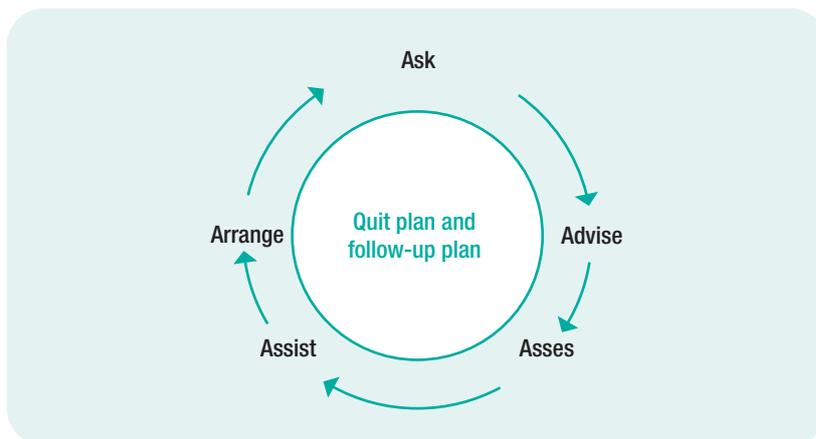
**B** – Give **Brief advice** to all tobacco users to stop using tobacco.

**C** – Provide evidence-based **Cessation support** for those who express a desire to stop.

You can take an online course about tobacco cessation and the ABC model through the link: <https://smokingcessationabc.org.nz>.

### Summary

The 5As (Ask, Advise, Assess, Assist, Arrange) summarize all the activities that a primary care provider can do to help a tobacco user within 3–5 minutes in a primary care setting. It does not mean you have to do all of these five activities/steps at every visit. In fact, you can start and stop at any step, as indicated in the following diagram, based on tobacco users' different stages of quitting. The key is that you should routinely take a few minutes to support tobacco users to quit by using the 5A's model as a guide.



### Practice

#### 3. Pre-training role play of a brief tobacco intervention (30 minutes)

Practice is important for you to improve your confidence and skills in delivering brief tobacco interventions. There will be several opportunities for you to practise 5A's and 5R's brief tobacco interventions during the course.

Volunteer to role-play a brief intervention in front of the group:

- Volunteer 1 will be a doctor who attempts to address the patient's smoking.
- Volunteer 2 will be a fortyish male satisfied smoker who is not especially keen to stop.

#### 4. Evaluation (15 minutes)

Each participant provides feedback/ questions on the volunteers' role play of the brief tobacco interventions.

### Summary

There are several structured delivery models available to guide primary care providers to deliver brief tobacco interventions in primary care settings. The main purpose of brief tobacco interventions is to motivate tobacco users to make a quit attempt and to encourage heavy tobacco users to seek or accept a referral for a more intensive treatment. Brief tobacco interventions take a few minutes – but if done routinely – they can significantly increase the numbers of people quitting and save lives!

## Module 4: Asking, advising and assessing readiness to quit

### Objectives

Upon completion of this module participants will be able to:

- ask and advise patients about their tobacco use in an appropriate way;
- use two ways to assess patients' readiness to quit.

### Agenda

1. How giving advice on clinical issues differs from giving advice on behaviour change (15 minutes).
2. How to ask about tobacco use (10 minutes).
3. How to tailor advice for a particular patient (20 minutes).
4. How to assess readiness to quit (20 minutes).
5. Role playing exercise for tailoring advice (20 minutes).
6. Evaluation (20 minutes).

### Preparation

#### 1. How giving advice on clinical issues differs from giving advice on behaviour change (15 minutes)

##### Question 1:

How does giving advice on clinical issues (e.g. "you have asthma") differ from giving advice on behaviour change (e.g. "you need to quit smoking")?

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Primary care providers may feel more knowledgeable and confident to give advice on clinical issues because they know more than patients, and they have clear instructions or advice for patients. However, giving advice on behaviour change is more than providing information and recommending solutions to patients, but involves helping patients discover their own solutions to their problems and to accept patients' choices. It requires primary care providers to establish a good relationship with patients, and to show empathy to them. The advice on behaviour change should be tailored to patients' particular circumstances.

##### Question 2:

How can we tell if someone is ready to quit?

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If someone is ready to quit, he or she should believe quitting is an important thing to do, and he or she can quit successfully.

## Presentation

### 2. How to ask about tobacco use (10 minutes)

Primary care providers should ask about tobacco use at EVERY encounter, and document tobacco use status in the medical record. Please ask simple questions like:

- Do you use tobacco?
- Does anyone else smoke around you?

Asking and recording tobacco use status is the first important step towards helping patients stop tobacco use. Health facilities should make a system change to ensure that, for every patient at every visit, tobacco use status is asked and documented. One strategy could be to include tobacco use status in medical records as a “vital sign”.

**VITAL SIGNS**

Blood pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_ Weight: \_\_\_\_\_

Temperature: \_\_\_\_\_

Respiratory rate: \_\_\_\_\_

Tobacco use (circle one): Current Former Never

### 3. How to tailor advice for a particular patient (20 minutes)

Primary care providers should advise patients to quit in a clear, strong and personalized manner.

- **Clear** – “It is important that you quit smoking (or using chewing tobacco) now, and I can help you.”  
“Cutting down while you are ill is not enough.” “Occasional or light smoking is still dangerous.”
- **Strong** – “As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.”
- **Personalized** – Tie tobacco use to:
  - *Demographics*: For example, women may be more likely to be interested in the effects of smoking on fertility than men.
  - *Health concerns*: Asthma sufferers may need to hear about the effect of smoking on respiratory function, while those with gum disease may be interested in the effects of smoking on oral health. “Continuing to smoke makes your asthma worse, and quitting may dramatically improve your health.”
  - *Social factors*: People with young children may be motivated by information on the effects of second-hand smoke, while a person struggling with money may want to consider the financial costs of smoking. “Quitting smoking may reduce the number of ear infections your child has.”

In some cases, how to tailor advice for a particular patient may not always be obvious. A useful strategy may be to ask the patient:

- “*What* do you not like about being a smoker?”
- The patient’s answer to this question can be built upon by you with more detailed information on the issue raised.

– Example:

**Doctor:** “What do you not like about being a smoker?”

**Patient:** “Well, I don’t like how much I spend on tobacco.”

**Doctor:** “Yes, it does build up. Let’s work out how much you spend each month. Then we can think about what you could buy instead!”

You will have an opportunity to practise how to provide tailored advice on smoking later on.

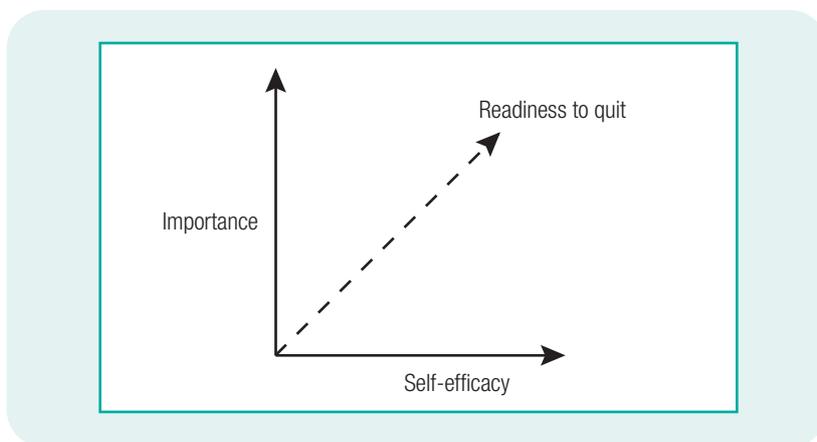
#### 4. How to assess readiness to quit (20 minutes)

##### 4.1 When is someone ready to quit?

As shown in Figure 6, readiness to quit has two key dimensions of **importance** and **self-efficacy** (confidence in one’s own ability to succeed in changing a target behaviour). To be ready to quit we need to see quitting as important and feel confident that we can quit successfully.

- A tobacco user is more likely to show a desire to be a non-user and say “**I want to be a non-tobacco user**” if he or she believes “quitting is important”.
- A tobacco user is more likely to say “**I have a chance to quit successfully**” if he or she has high level of confidence in their ability to quit.

Figure 6. The components of readiness to quit



##### 4.2 Assessing readiness to quit

**Method 1:** Ask two questions in relation to “importance” and “self-efficacy”:

“Would you like to be a non-tobacco user?”

“Do you think you have a chance of quitting successfully?”

Any answer in the shaded area indicates that the tobacco user is NOT ready to quit. In these cases we should deliver the 5R’s intervention (see Module 5 for more information).

Would you like to be a non-tobacco user?	Yes	Unsure	No
Do you think you have a chance of quitting successfully?	Yes	Unsure	No

**Method 2: Ask just one question:**

“Would you like to quit tobacco within the next 30 days?”

If the answer is “no”, this indicates that the tobacco user is NOT ready to quit and we should deliver the 5R’s intervention.

**Summary**

**Method 2** is a simpler way to assess a tobacco user’s readiness to quit, but using the two-question method (**Method 1**) can help primary care providers get more information from patients about their perceived importance and self-efficacy for change in order to conduct appropriate motivational interventions if patients are not ready to quit.

**Practice**

**5. Role-playing exercise for tailoring advice (20 minutes)**

Please volunteer to play the role of a primary care provider. You will need to:

- ask about the patient’s smoking;
- give some tailored advice using the following instructions.

The facilitator will adopt the role of three fictional smokers (Hamid, Lisa and Mustafa). Each smoker will differ as to the demographic background, health status, family and social circumstances, and beliefs about smoking. Before each role play the fictional smoker (played by the facilitator) will introduce himself or herself.

Smokers	Primary care provider
1. Hamid: “I am a 57-year-old man with 10 grandchildren. I have a heart condition and breathing problems.”	Advice should refer to health, longer life and passive smoking of grandchildren.
2. Lisa: “I am a 25-year-old woman and I have just married. We hope to have a large family but we do struggle financially.”	Advice should refer to fertility and the financial impact of smoking.
3. Mustafa. “I am a man aged 35.”	Mustafa does not give much information. The volunteer will need to recognize this and should ask Mustafa what he doesn’t like about being a smoker. Once Mustafa answers, the volunteer should add extra information on the issue raised.

**6. Evaluation (20 minutes)**

Each participant provides feedback/questions on role plays by volunteers and facilitator.

**Summary**

Asking and recording tobacco use status is the first important step towards helping patients stop tobacco use. Health facilities must implement a system change to ensure that, for every patient at every visit, tobacco use status is asked and documented.

Advice on quitting should be clear, strong and personalized. You may need to ask the patient for more information when it is not obvious how to tailor advice for a particular patient. Tobacco users’ readiness to quit depends on their beliefs about the importance of quitting and level of confidence in their ability to quit successfully. We can use two methods to assess a tobacco user’s readiness to quit.

## Module 5: Dealing with low motivation

### Objectives

Upon completion of this module participants will be able to:

- describe the 5R's brief tobacco intervention model;
- respond appropriately to exhibited stop-smoking resistance, employing the 5R's model;
- respond appropriately in cases of low motivation to quit, using motivational tools.

### Agenda

1. Definition of motivation (15 minutes).
2. Overview of the 5R's model (15 minutes).
3. Motivational tools (15 minutes).
4. Role-playing of 5R's interventions (30 minutes).
5. Evaluation (15 minutes).

### Preparation

#### 1. Definition of motivation (15 minutes)

##### Question 1:

What is motivation?

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In general, motivation is the driving force by which humans achieve their goals. The word "motivation" here refers to "intrinsic motivation": the key predictor of behaviour change. According to behavioural scientists, "intrinsic motivation" is an internal state that activates, directs and maintains behaviour towards goals. In this workbook, we define it as the state of readiness to change.

##### Question 2:

What are your experiences of dealing with tobacco users who are not willing to quit?

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Many health professionals find that it seems impossible to create positive dialogue with unmotivated patients about their behaviours. They often make patients angry and receive all kinds of excuses as to why these changes are not appropriate when they try to give advice to unmotivated patients.

In this module, you will learn and practise using the 5R's model and some other tools to deal with tobacco users who have low motivations to quit.

**Presentation**

**2. Overview of the 5R's model (15 minutes)**

The 5R's model is a brief motivational intervention that is based on principles of motivational interviewing (MI), a directive, patient-centred counselling approach.

Motivational interviewing was developed by William Miller and Stephen Rollnick in the 1980s on the basis of their experiences of working with people who had problems with drinking alcohol. MI is a relatively new cognitive-behavioural technique that aims to increase the person's intrinsic motivation for change based on the person's own personal goals and values.

Compared to traditional practitioner-centred, expert-directed counselling methods, MI is a different way of being with people:

- It is an interviewing conversation and elicits careful questioning and listening on both sides. Information is shared reciprocally and is nonjudgmental.
- It takes place in a supportive, patient-centred atmosphere, where patients feel comfortable enough to explore their own reality and conflicts.
- It keeps the tone motivational rather than argumentative and meets a patient's resistance with a different approach. Instead of confrontation or opposition, the practitioner keeps the conversation open, positive and on course.
- It centres the locus of control within the patient. Change is the choice of the patient rather than of the practitioner.

Principles of MI are: (1) express empathy, (2) develop discrepancy, (3) roll with resistance, and (4) support self-efficacy.

<p><b>Express empathy</b></p>	<p>Use open-ended questions, affirming, listening reflectively and summarizing in order to understand the patient's perspectives without judging, criticizing or blaming. Examples:                      "How important do you think it is for you to quit smoking?"                      "What might happen if you quit?"                      "So you think smoking helps you maintain your weight."                      "What I have heard so far is that smoking is something you enjoy. On the other hand, you are worried you might develop a serious disease."                      Express your willingness to accept "where" a patient is (his/her place of readiness). For instance, "I hear you saying you are not ready to quit smoking right now. I'm here to help you when you are ready."</p>
<p><b>Develop discrepancy</b></p>	<p>Use strategies to assist the patient in identifying discrepancy and move forward change.                      Highlight the discrepancy between the patient's present behaviour and expressed priorities, values and goals. For instance, "It sounds like you are very devoted to your family. How do you think your smoking is affecting your children?"</p>
<p><b>Roll with resistance</b></p>	<p>Use strategies to re-assess readiness, and for reflective listening. Example:                      "You are worried about how you would manage withdrawal symptoms."                      Emphasize personal choice and control. Example:                      "Would you like to hear about some strategies that can help you address that concern when you quit?"</p>

<b>Support self-efficacy</b>	<p>Help the patient identify and build on past successes. Example: “So you were fairly successful the last time you tried to quit.”</p> <p>Offer options for achievable small steps towards change, such as:</p> <ul style="list-style-type: none"> <li>– read about quitting benefits and strategies;</li> <li>– change smoking patterns (e.g. no smoking in the home);</li> <li>– ask the patient to share his or her ideas about quitting strategies;</li> <li>– try quitting smoking for one or two days.</li> </ul> <p>Arrange for the patient to observe role models who quit smoking successfully. Encourage and convince the patient that success is a result of self: “I have tried 16 times to quit smoking.” “Wow, you’ve already shown your commitment to trying to stop smoking several times. That’s great! More importantly you’re willing to try again.”</p> <p>Teach the patient relaxation techniques to minimize stress and to elevate mood.</p>
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## 2.1 The components of the 5R’s model

The 5R’s – relevance, risks, rewards, roadblocks and repetition – are the content areas that should be addressed in a motivational counselling intervention. Research suggests that the 5R’s enhance future attempts. Table 6 summarizes the components of the 5R’s model and provides an example of using the 5R’s model to help an unmotivated patient.

Table 6. Components and example of the 5R’s

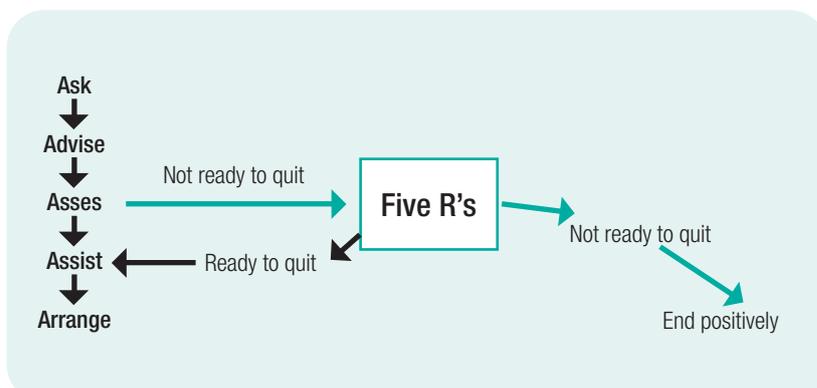
	Strategies for implementation	Example
Relevance	<p>Encourage the patient to indicate <b>how quitting is personally relevant to him or her</b>.</p> <p>Motivational information has the greatest impact if it is relevant to a patient’s disease status or risk, family or social situation (e.g. having children in the home), health concerns, age, sex, and other important patient characteristics (e.g. prior quitting experience, personal barriers to cessation).</p>	<p><b>HCP:</b> “How is quitting most personally relevant to you?” <b>P:</b> “<i>I suppose smoking is bad for my health</i>”</p>
Risks	<p>Encourage the patient to identify <b>potential negative consequences of tobacco use that are relevant to him or her</b>.</p> <p>Examples of risks are:</p> <ul style="list-style-type: none"> <li>• Acute risks: shortness of breath, exacerbation of asthma, increased risk of respiratory infections, harm to pregnancy, impotence, and infertility.</li> <li>• Long-term risks: heart attacks and strokes, lung and other cancers (e.g. larynx, oral cavity, pharynx, esophagus, pancreas, stomach, kidney, bladder, cervix, and acute myelocytic leukemia), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), osteoporosis, long-term disability, and need for extended care.</li> <li>• Environmental risks: increased risk of lung cancer and heart disease in spouses; increased risk for low birth-weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.</li> </ul>	<p><b>HCP:</b> “What do you know about the risks of smoking to your health? What particularly worries you?” <b>P:</b> “<i>I know it causes cancer. That must be awful.</i>” <b>HCP:</b> “That’s right – the risk of cancer is many times higher among smokers.”</p>
Rewards	<p>Ask the patient to identify <b>potential relevant benefits of stopping tobacco use</b>.</p> <p>Examples of rewards could include:</p> <ul style="list-style-type: none"> <li>– improved health;</li> <li>– food will taste better;</li> <li>– improved sense of smell;</li> <li>– saving money;</li> <li>– feeling better about oneself;</li> <li>– home, car, clothing and breath will smell better;</li> <li>– setting a good example for children and decreasing the likelihood that they will smoke;</li> <li>– having healthier babies and children;</li> <li>– feeling better physically;</li> <li>– performing better in physical activities;</li> <li>– improved appearance, including reduced wrinkling/ageing of skin and whiter teeth.</li> </ul>	<p><b>HCP:</b> “Do you know how stopping smoking would affect your risk of cancer?” <b>P:</b> “<i>I guess it would be lower if I quit.</i>” <b>HCP:</b> “Yes, and it doesn’t take long for the risk to decrease. But it’s important to quit as soon as possible.”</p>

	Strategies for implementation	Example
Roadblocks	<p>Ask the patient to identify <b>barriers or impediments to quitting</b> and provide treatment (problem-solving counselling, medication) that could address barriers.</p> <p>Typical barriers might include:</p> <ul style="list-style-type: none"> <li>– withdrawal symptoms;</li> <li>– fear of failure;</li> <li>– weight gain;</li> <li>– lack of support;</li> <li>– depression;</li> <li>– enjoyment of tobacco;</li> <li>– being around other tobacco users;</li> <li>– limited knowledge of effective treatment options.</li> </ul>	<p><b>HCP:</b> “So what would be difficult about quitting for you?”</p> <p><b>P:</b> “<i>Cravings – they would be awful!</i>”</p> <p><b>HCP:</b> “We can help with that. We can give you nicotine replacement therapy (NRT) that can reduce the cravings.”</p> <p><b>P:</b> “<i>Does that really work?</i>”</p> <p><b>HCP:</b> “You still need will-power, but study shows that NRT can double your chances of quitting successfully.”</p>
Repetition	<p><b>Repeat assessment of readiness to quit. If still not ready to quit repeat intervention at a later date.</b></p> <p>The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting.</p>	<p><b>HCP:</b> “So, now we've had a chat, let's see if you feel differently. Can you answer these questions again...?”</p> <p>(Go back to the Assess stage of the 5A's. If ready to quit then proceed with the 5A's. If not ready to quit, end intervention positively.)</p>

HCP: health-care provider; P: patient

### 2.2 When do we deliver the 5R's?

5R interventions will be delivered to those who are not ready to quit tobacco use after the “Assess” stage of the 5A's.



### 2.3 Tips for implementing the 5R's model

- Let the patient do the talking. Don't give lectures!
- If the patient does not want to be a non-tobacco user – focus more time on “Risks” and “Rewards”.
- If the patient does want to be a non-tobacco user but does not think he or she can quit successfully, focus more time on “Roadblocks”.
- Even if patients remain not ready to quit, end positively with an invitation to them to come back to you if they change their minds.

### 3. Motivational tools (15 minutes)

In addition to talking to the patient, we can also use some tools to motivate tobacco users to quit.

Here are some examples:

- cost calculators (cost of smoking calculator, personal savings calculator);
- photographs of tobacco-related diseases;
- visual motivational tools such as:
  - carbon monoxide monitor,
  - pulmonary function testing (spirometry),
  - “lung age” indicator (graphically show the age of the average healthy person who has an FEV1 equal to that of the patient);
- risk charts (facilitate physician-patient discussion about disease risk, e.g. WHO/ISH risk prediction charts).

Each motivational tool has its advantages and disadvantages. The tool that primary care providers will use depends on how easy it is to understand the tool and whether the tool would be available to them.

### Practice

#### 4. Role playing of 5R's interventions (30 minutes)

Please volunteer to play the role of two practitioners to assess two fictional smokers' readiness to quit.

The facilitator will adopt the role of the two fictional smokers. Each smoker will differ in his or her response when assessed for readiness to quit:

A. Hamid: “My smoking isn't really a concern to me.” In role play, Hamid should express concern about heart disease.

B. Lisa: “I want to be a non-smoker but I could never quit – I'm very addicted.” In role play, Lisa should express concern about her stress levels while quitting.

In role play, the two volunteers should:

- complete the “Assess” questions appropriately in each case to indicate non-readiness to quit;
- deliver the 5R's interventions in an appropriate way.

In the case of Hamid, the 5R's should be delivered, focusing on Risks and Rewards. In the case of Lisa, the 5R's should be delivered with the focus on Roadblocks.

#### 5. Evaluation (15 minutes)

Everyone gives feedback and comments on the role plays by the facilitator and two volunteers.

The facilitator summarizes the practice and links it to the relevant learning objectives.

### Summary

Several approaches can be used to help those who are not willing to quit tobacco use in primary care settings. The 5R's model can help primary care providers apply the spirits, principles and skills of motivational interviewing for enhancing intrinsic motivation to change behaviour in brief contacts. Primary care providers can also consider using available motivational tools to motivate tobacco users to quit.

## Module 6: Assisting and arranging for follow-up

### Objectives

Upon completion of this module participants will be able to:

- assist patients to stop tobacco use by helping them with a quit plan and providing intra-treatment social support and supplementary materials;
- arrange follow-up contacts;
- arrange a referral to specialist services if available;
- deliver a full, brief tobacco intervention according to the 5A's and 5R's models.

### Agenda

1. What kind of assistance a tobacco user will need to make a quit attempt (15 minutes).
2. How to assist patients in making a quit attempt (20minutes)
3. How to arrange follow up contacts for the patient (15 minutes).
4. The full brief tobacco intervention demonstration (25 minutes).
5. Role-playing of the full brief tobacco intervention (30 minutes).
6. Evaluation (15 minutes).

### Preparation

#### 1. What kind of assistance a tobacco user will need to make a quit attempt (15 minutes)

##### Brainstorming

If you were a tobacco user, what kind of assistance would you need from the doctor to make a quit attempt?

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A tobacco user may need the following assistance from the doctor to make a quit attempt: developing a quit plan, dealing with withdrawal symptoms, social support, and pharmacotherapy recommendations.

### Presentation

#### 2. How to assist patients in making a quit attempt (20minutes)

For the patient who is willing to quit, the following actions can be taken to aid the patient in quitting:

- help develop a quit plan;
- provide practical counselling;
- provide intra-treatment social support;
- help patient obtain extra-treatment social support;
- recommend pharmacotherapy if appropriate;
- provide supplementary materials.

##### 2.1 Help develop a quit plan

Strategies for this action can be summarized by the acronym STAR.

**S**et a quit date, ideally within two weeks.

**T**ell friends, family and coworkers of the plan to quit, and ask for support.

**A**nticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal.

**R**emove cigarettes from home, car and workplace and avoid smoking in these places. Make your home smoke-free.

## 2.2 Provide practical counselling to deal with challenges/difficulties while quitting

The US Clinical Practice Guideline: Treating tobacco use and dependence: 2008 update summarizes core components of practical counselling (Table 7).

Table 7. Common elements of practical counselling

Practical counselling (problem solving/skills training) treatment component	Examples
Recognize danger situations – identify events, internal states or activities that increase the risk of smoking or relapse.	<ul style="list-style-type: none"> <li>– negative affect and stress;</li> <li>– being around other tobacco users;</li> <li>– drinking alcohol;</li> <li>– experiencing urges;</li> <li>– smoking cues and availability of cigarettes.</li> </ul>
Develop coping skills – identify and practise coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.	<ul style="list-style-type: none"> <li>– learning to anticipate and avoid temptation and trigger situations;</li> <li>– learning cognitive strategies that will reduce negative moods;</li> <li>– accomplishing lifestyle changes that reduce stress, improve quality of life, and reduce exposure to smoking cues;</li> <li>– learning cognitive and behavioural activities to cope with smoking urges (e.g. distracting attention, changing routines).</li> </ul>
Provide basic information about smoking and successful quitting.	<ul style="list-style-type: none"> <li>– any smoking (even a single puff) increases the likelihood of a full relapse;</li> <li>– withdrawal symptoms typically peak within 1–2 weeks after quitting but may persist for months (these symptoms include negative mood, urges to smoke, and difficulty concentrating);</li> <li>– the addictive nature of smoking.</li> </ul>

**Exercise** - Answer questions asked by patients who are willing to quit:

- What if I still have cravings?
- What if I smoke after quitting?

Primary care providers can answer the first question based on the following key points:

- Cravings/urges occur even when smoking. Typically they are brief, lasting only 1–2 minutes.
- There are many ways to deal with them. One good strategy is named “4Ds”:
  - **D**elay (every time you get the urge to puff, try to delay it as long as you can);
  - **D**eep breathing (deep breathing and meditation can help you relax yourself from within until the urge fades away);
  - **D**rink water (water refreshes the body and flushes out toxins);
  - **D**o something else (take a shower).
- As time goes on, urges will occur less often and will become less intense.

Primary care providers can answer the second question as follows:

- Relapse is common. Most people make multiple attempts before they are successful.
- If you smoke after quitting:
  - don't blame yourself (none of us is perfect);
  - use the relapse as a learning experience rather than as a sign of failure;
  - just try another quit attempt.

### 2.3 Provide intra-treatment social support

Table 8 describes core elements of intra-treatment supportive interventions that you can provide to tobacco users.

Table 8. Common elements of intra-treatment supportive interventions

Supportive treatment component	Examples
Encourage the patient in the quit attempt	<ul style="list-style-type: none"> <li>• Note that effective tobacco dependence treatments are now available.</li> <li>• Note that one-half of all people who have ever smoked have now quit.</li> <li>• Communicate belief in patient's ability to quit.</li> </ul>
Communicate caring and concern	<ul style="list-style-type: none"> <li>• Ask how the patient feels about quitting.</li> <li>• Directly express concern and willingness to help as often as needed.</li> <li>• Ask about the patient's fears and ambivalence regarding quitting.</li> </ul>
Encourage the patient to talk about the quitting process	<p>Ask about:</p> <ul style="list-style-type: none"> <li>– reasons why the patient wants to quit;</li> <li>– concerns or worries about quitting;</li> <li>– success the patient has achieved;</li> <li>– difficulties encountered while quitting.</li> </ul>

### 3. How to arrange follow-up contacts for the patient (15 minutes)

#### When:

The majority of relapse occurs in the first two weeks after quitting. Therefore, follow-up contact should begin soon after the quit date. The first follow-up contact should be arranged during the first week. A second follow-up contact is recommended within one month after the quit date.

#### How:

Use practical methods such as telephone, personal visit and mail/e-mail to do the follow-up. Following up with patients is recommended to be done through teamwork if possible.

#### What:

Table 9 describes all actions that primary care providers need to take during follow-up contacts

Table 9. Actions for patients during follow-up contacts

<b>For all patients</b>	<ul style="list-style-type: none"> <li>• Identify problems already encountered and anticipate challenges.</li> <li>• Remind patients of available extra-treatment social support.</li> <li>• Assess medication use and problems.</li> <li>• Schedule the next follow-up contact.</li> </ul>
<b>For patients who are abstinent</b>	<ul style="list-style-type: none"> <li>• Congratulate them on their success.</li> </ul>
<b>For patients who have used tobacco again</b>	<ul style="list-style-type: none"> <li>• Remind them to view relapse as a learning experience.</li> <li>• Review circumstances and elicit recommitment.</li> <li>• Link to more intensive treatment if available.</li> </ul>

#### 4. The full brief tobacco intervention demonstration (25 minutes)

Please volunteer to role-play a patient. The facilitator will deliver a full, brief intervention for the patient.

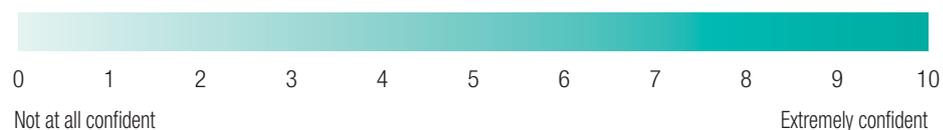
The patient is Hamid (The participant may develop the character and dialogue as he or she wishes):  
*He is a 57-year-old man with 10 grandchildren. He has a heart condition and breathing problems. At the moment, he is not particularly concerned about his smoking.*

Please provide comments and advice on how to proceed when the facilitator pauses at each stage of the 5A's or 5R's.

#### Practice

#### 5. Role-playing of the full brief tobacco intervention (30 minutes)

Please assess your current level of confidence in delivering a full brief tobacco intervention on a scale of 0 to 10. If your confidence level is less than 7, that means you will need more practice. At this stage, it is natural to not feel confident in intervention delivery. You will become really confident about delivering the intervention once you have done it several times in "real-life".



Please volunteer to role-play a brief intervention in front of the group. Four volunteers are needed: two for "primary care providers" and two for "patients".

The "patients" will be given brief notes on their "character".

- A. Hamid: *A 57-year-old man with large family. He has breathing and heart problems. He is not concerned with his smoking. He is unsure about whether he could quit if he tried.*
- B. Lisa: *A 25-year-old woman who is soon to marry. She wants to have a family. She wants to quit but is convinced that she can't.*

If you are not selected for the role plays, please carefully watch them and make notes.

#### 6. Evaluation (15 minutes)

Everyone helps provide comments and feedback on the role plays.

It is important to emphasize that you will develop your skills and confidence in delivering brief tobacco interventions with daily practice.

#### Summary

For those who are willing to quit, it is critical that you help them develop a quit plan for making a quit attempt and help them arrange follow-up contacts soon after the quit date.

In order to deliver a full brief tobacco intervention effectively using the 5A's and 5R's models, it is important that you familiarize yourself with each step of the 5A's and 5R's and practise them in real-life situations.

## Module 7: Addressing non-smokers' exposure to second-hand smoke

### Objectives

Upon completion of this module participants will be able to:

- describe the definition and dangers of second-hand smoke;
- describe the brief intervention model for reducing non-smokers' exposure to second-hand smoke;
- role-play the brief intervention to address non-smokers' exposure to second-hand smoke.

### Agenda

1. Levels of second-hand smoke exposure among non-smokers (15 minutes).
2. Definition of second-hand smoke (10 minutes).
3. Health effects of second-hand smoke (10 minutes).
4. The 5A's brief intervention model for addressing non-smokers' exposure to second-hand smoke (10 minutes).
5. Role-playing of a brief intervention to help non-smokers reduce second-hand smoke exposure (20 minutes).
6. Evaluation (15 minutes).

### Preparation

#### 1. Levels of second-hand smoke exposure among non-smokers (15 minutes)

Second-hand smoke exposure causes serious health problems in children and adult non-smokers. The only way to protect non-smokers fully is to eliminate smoking in all indoor spaces. In addition to supporting the comprehensive smoke-free laws in workplaces and public places, and supporting smokers to quit, health-care providers should also educate every non-smoker seen in a primary care setting about the dangers of second-hand smoke and help them avoid exposure to second-hand smoke.

#### Questions:

- Is second-hand smoke exposure common in your country?
- How many people are exposed to second-hand smoke in your country?

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Second-hand smoke exposure is common in many countries. Worldwide, it was estimated that 40% of children, 33% of male non-smokers, and 35% of female non-smokers were exposed to second-hand smoke in 2004. The highest proportions of people exposed were seen in European countries with high adult mortality (Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine) and countries in the WHO Western Pacific Region. More than 50% of children and adult non-smokers in those countries were exposed to second-hand smoke in 2004.

You may find the prevalence of exposure to second-hand smoke in your country through local and national health authorities, who accumulate the data, or through published journal articles.

**Presentation**

**2. Definition of second-hand smoke (10 minutes)**

**Brainstorming**

What is second-hand smoke?

Second-hand smoke (also called environmental tobacco smoke or passive smoking) is made up of

- mainstream smoke, the smoke that is exhaled by the smoker;
- side-stream smoke, the smoke that comes from the burning end of a cigarette or other tobacco products (pipe, cigar).

**3. Health effects of second-hand smoke (10 minutes)**

Second-hand smoke is present in all indoor places where smoking is permitted, and there is no safe level of exposure. Second-hand smoke causes 600 000 premature deaths per year.

**Brainstorming**

What diseases are known to be caused by second-hand smoke?

Exposure to second-hand smoke adversely affects the health of children and adults. Figure 3 shows that second-hand smoke can cause the following diseases in children and adults:

Diseases in children	Diseases in adults
<ul style="list-style-type: none"> <li>– sudden infant death syndrome;</li> <li>– acute respiratory illnesses;</li> <li>– middle ear disease;</li> <li>– chronic respiratory symptoms.</li> </ul>	<ul style="list-style-type: none"> <li>– coronary heart disease;</li> <li>– nasal irritation;</li> <li>– lung cancer;</li> <li>– reproductive effects in women (low birth weight).</li> </ul>

**4. The 5A's brief intervention model for addressing non-smokers' exposure to second-hand smoke (10 minutes)**

Primary care providers can take five steps (5As) to offer a brief intervention to educate non-smoking patients about the dangers of second-hand smoke and to protect themselves and their family from the effects of second-hand smoke:

- Ask –** Systematically identify non-smoking patients who are exposed to second-hand smoke at every visit.
- Advise –** Advise the patient to avoid exposure to second-hand smoke.
- Assess –** Determine the patient's willingness to reduce exposure to second-hand smoke.
- Assist –** Assist the patient in making an attempt to make his/her daily life environment smoke-free.
- Arrange –** Schedule follow-up contacts.

**Ask:** We need to ask **ALL** of our non-smoking patients if they are exposed to second-hand smoke (Does anyone else smoke around you?) and record their responses. We make it part of our routine.

**Advise:** We need to educate the patients about the dangers of second-hand smoke and advise them to avoid exposure to second-hand smoke. Your advice should be clear, positive and tailored to the particular patient's characteristics and circumstances. For example, "There is no safe level of exposure, it is important that you avoid exposure to second-hand smoke, which may dramatically improve your respiratory symptoms."

**Assess:** We need to determine if the patient is willing to reduce his or her second-hand smoke exposure or not. We can also assess where the patient is exposed to second-hand smoke and whether there is a possibility to reduce the patient's exposure. For example, if the patient is exposed to second-hand smoke at home, it is highly likely that the patient can reduce exposure by encouraging his or her family to quit or to smoke outside.

**Assist:** If patients are willing to make an attempt to reduce their exposure to second-hand smoke then they will need some help from us. We need to assist patients in developing action plans for what they can do. Here are some examples to share with patients (MAD-TEA):

- **Meet** friends at spaces in the community that are smoke-free.
- **Ask** family members and visitors to smoke outside.
- **Declare** their home and personal spaces (e.g. their car) to be smoke-free.
- **Talk** to family members and the people they work with about the risks of second-hand smoke.
- **Encourage** family members, friends and workmates who smoke to stop.
- **Advocate** comprehensive smoke-free laws or regulations in workplaces and public places.

**Arrange:** If the patient is willing to make an attempt, we should arrange follow-up after around one week to provide necessary support and talk to the patient about the matter again.

## Practice

### 5. Role-playing of a brief intervention to help non-smokers reduce second-hand smoke exposure (20 minutes)

Practice is important for you to improve your confidence and skills in delivering a brief intervention to address second-hand smoke exposure.

Volunteer to role play the 5A's brief interventions in front of the group:

- Volunteer 1 will be a doctor who attempts to address the patient's second-hand smoke exposure.
- Volunteer 2 will be a newly married female whose husband smoke at home.

## 6. Evaluation (15 minutes)

Each participant provides feedback/questions on volunteers' role play of the brief tobacco interventions.

### Summary

Exposure to second-hand smoke is common in many countries. There is no risk-free level of exposure to second-hand smoke. Primary care providers should routinely identify all patients who are exposed to second-hand smoke and advise them to avoid the effects of second-hand smoke. The 5A's model can guide primary care providers to offer a brief intervention to address second-hand smoke in a primary care setting.

## Module 8: Introduction to pharmacotherapy

### Objectives

Upon completion of this module participants will be able to:

- describe effective tobacco cessation medications;
- prescribe the available range of NRT products;
- recommend bupropion and varenicline appropriately;
- apply tools to assess tobacco users' levels of nicotine dependence;

### Agenda

1. Effective tobacco cessation medications (15 minutes).
2. Description of NRT products, bupropion and varenicline (25 minutes).
3. How to assess a tobacco user's level of nicotine dependence (15 minutes).
4. Recommendations for use of NRT products in the treatment of tobacco dependence (15 minutes).
5. Prescribing NRT products (30 minutes).
6. Evaluation (20 minutes).

### Preparation

#### 1. Effective tobacco cessation medications (15 minutes)

##### Brainstorming

What effective tobacco cessation medications are currently available for treating tobacco dependence in your country?

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The currently available effective tobacco cessation medications are:

- nicotine replacement therapy (NRT): nicotine gum, nicotine patches, nicotine nasal spray, nicotine inhaler, nicotine lozenges/sublingual tablets;
- non-nicotine medications: bupropion sustained release (SR), varenicline, cytisine, clonidine, triptiline.

Table 1 provides the effectiveness data for those tobacco cessation medications. According to USA clinical guidelines, NRT, bupropion and varenicline are first-line medications for treating tobacco dependence. Currently, NRT has the best balance of effectiveness, cost and safety. As a result, two forms of NRT (nicotine gum and nicotine patch) have been added to the WHO Model List of Essential Medicines.

## Presentation

### 2. Description of NRT products, bupropion and varenicline (25 minutes)

Table 10 summarizes the information on NRT, bupropion and varenicline in terms of what those medications are, the purpose of using them, available dosage, advantages and disadvantages, general guidelines for using them, side-effects and warnings.

### 3. How to assess a tobacco user's level of nicotine dependence (15 minutes)

Assessing a tobacco user's level of nicotine dependence can help primary care providers prescribe or recommend a dosage of NRT to tobacco users. There are two ways to assess the level of nicotine dependence:

#### 3.1 Using the Fagerström Test

This is the standard instrument for assessing the intensity of physical addiction to nicotine (Table 11).

##### Scoring:

- 0–2 = very low dependence
- 3–4 = low dependence
- 5 = medium dependence
- 6–7 = high dependence
- 8–10 = very high dependence.

Scores under 5: "Your level of nicotine dependence is still low. You should act now before your level of dependence increases."

Score of 5: "Your level of nicotine dependence is moderate. If you don't quit soon, your level of dependence on nicotine will increase until you may be seriously addicted. Act now to end your dependence on nicotine."

Score over 5: "Your level of dependence is high. You are not in control of your smoking - it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction."

##### Results:

Your score was: \_\_\_\_\_. Your level of dependence on nicotine is: \_\_\_\_\_.

Tobacco users whose level of dependence on nicotine is **high** or **very high** will be considered for a recommendation to use NRT.

Table 11. Items and scoring for the Fagerström Test for nicotine dependence

1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6–30 minutes	2
	31–60 minutes	1
	After 60 minutes	0
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g. in church, at the library, in the cinema, etc)?	Yes	1
	No	0
3. Which cigarette would you hate most to give up?	The first one in the morning	1
	All others	0
4. How many cigarettes per day do you smoke?	10 or less	0
	11–20	1
	21–30	2
	30 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	1
	No	0
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

Source: Heatherton TF et al. The Fagerstrom Test for Nicotine Dependence: a revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addiction*, 1991; 86:1119–1127.

### 3.2 Asking two simple questions:

- How many cigarettes do you smoke per day?  
A < 10 cpd; B 10–20 cpd; C 21–39 cpd; D ≥ 40 cpd.
- At what time do you smoke your first cigarette in the morning?  
A ≤ 30 minutes after waking up; B > 30 minutes after waking up.

## 4. Recommendations for use of NRT products in the treatment of tobacco dependence (15 minutes)

When you prescribe or recommend NRT products for tobacco users you will need to give them clear instructions and dosing recommendations. Instructions for use and dosing recommendations can be found in Table 10.

### Practice

#### 5. Prescribing NRT products (30 minutes)

Please work in small groups to recommend NRT treatment plans for two fictional smokers:

**Patient # 1:** Kate is a 55-year-old married female who has smoked two packs per day for the past 40 years. She has tried to quit several times. The only medication she has ever tried was patches. She used a 21 mg patch in the past. She said, “they helped”, but she was never able to remain abstinent for more than two days because the cravings were so strong. She is interested in the patch. She reports smoking her first cigarette immediately after waking up.

Please recommend a NRT treatment plan to Kate for the next several months.

**Patient # 2:** Jack is a 35-year-old male who has smoked approximately 15 cigarettes per day for the past 20 years. He usually smokes his first cigarette about an hour after he wakes. After discussing all medication options, he has decided he does not want the patch and he doesn't like pills. He is most interested in the lozenge.

Please make a recommendation to Jack for prescribing the lozenge.

### 6. Evaluation (15 minutes)

Each group presents its results. Everyone helps critique and give feedback.

Below are suggested NRT treatment plans for Kate and Jack:

Kate			
Nicotine patches	Dose	Quantity	Duration
	21 mg	2 patches per day (every morning)	4 weeks
	21 mg + 7mg	1 patch of each per day	2 weeks
	21 mg	1 patch per day	2 weeks
	14 mg	1 patch per day	2 weeks
	7 mg	1 patch per day	2 weeks
Jack			
Nicotine lozenge	Dose	Quantity	Duration
	2 mg	10 lozenges per day	6 weeks
	2 mg	5 lozenges per day	3 weeks
	2 mg	2 lozenges per day	3 weeks

### Summary

There are several medications available for treating tobacco dependence. Currently NRT has the best balance of effectiveness, cost and safety. As a result, two forms of NRT (nicotine gum and nicotine patch) have been added to the WHO Model List of Essential Medicines. Dosing recommendation of NRT products should be made based on the tobacco user's level of nicotine dependence.

Table 10. Description of NRT, Bupropion and varenicline

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
<b>Nicotine gum</b> (OTC) Delivers nicotine through the lining of the mouth. Available dosage: 2mg, 4mg.	<ul style="list-style-type: none"> <li>Smokers 18 years and over.</li> <li>Smokers with severe heart and circulation problems should start NRT under medical supervision.</li> <li>Pregnant or breast-feeding women if they cannot stop without NRT.</li> </ul>	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Convenient/flexible dosing.</li> <li>Faster delivery of nicotine than the patches.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>May be inappropriate for people with dental problems and those with temporomandibular joint (TMJ) syndrome.</li> <li>Should not eat or drink 15 minutes before use or during use.</li> <li>Frequent use during the day is required to obtain adequate nicotine levels.</li> </ul>	<p><b>Dosing:</b>                      Based on cigarettes/day (cpd)                      &gt;20 cpd: 4 mg gum                      ≤20 cpd: 2 mg gum                      Based on time to first cigarette of the day:                      ≤30 minutes = 4 mg                      &gt;30 minutes = 2 mg                      Initial dosing is 1–2 pieces every 1–2 hours (10–12 pieces/day).                      Taper as tolerated.  <b>Duration:</b> up to 12 weeks with no more than 24 pieces to be used per day.  <b>How to use:</b>                      It is not chewed like regular gum but rather is chewed briefly until you notice a "peppery" taste, then "parked" between cheek and gum for about 30 minutes.</p>	<ul style="list-style-type: none"> <li>Hiccups</li> <li>Jaw ache</li> <li>Stomach irritation</li> <li>Sore mouth</li> </ul>
<b>Nicotine patch</b> (OTC) Delivers nicotine through skin. Available dosage: 24 hour delivery systems 7mg, 14mg, 21mg. 16 hour delivery systems 5mg, 10mg, 15mg.	The same as nicotine gum.	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Achieve high levels of replacement.</li> <li>Easy to use.</li> <li>Only needs to be applied once a day.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Less flexible dosing.</li> <li>Slow onset of delivery.</li> <li>Mild skin rashes and irritation.</li> </ul>	<p><b>Dosing</b> (24 hour patch):                      &gt;40 cpd = 42 mg/day                      21–39 cpd = 28–35 mg/day                      10–20 cpd = 14–21 mg/day                      &lt;10 cpd = 14 mg/day                      If a dose &gt; 42mg/day may be indicated, contact the patient's prescriber.                      Adjust based on withdrawal symptoms, urges, and comfort. After 4 weeks of abstinence, taper every 2 weeks in 7–14 mg steps as tolerated.  <b>Duration:</b> 8–12 weeks.  <b>How to use:</b>                      Patches may be placed on any hairless area on the upper body, including arms and back. Rotate the patch site each time a new patch is applied to lessen skin irritation.</p>	<ul style="list-style-type: none"> <li>Skin irritation</li> <li>Allergy (not suitable if you have chronic skin conditions)</li> <li>Vivid dreams and sleep disturbances</li> </ul>

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
<b>Nicotine lozenge</b> (OTC) Delivers nicotine through the lining of the mouth while the lozenge dissolves. Available dosage: 2 mg, 4 mg.	The same as nicotine gum.	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Easy to use.</li> <li>Delivers doses of nicotine approximately 25% higher than nicotine gum.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Should not eat or drink 15 minutes before use or during use.</li> </ul>	<p><b>Dosing:</b>                      Based on time to first cigarette of the day:                      ≤30 minutes = 4 mg                      &gt;30 minutes = 2 mg                      Based on cigarettes/day (cpd)                      &gt;20 cpd: 4 mg                      ≤20 cpd: 2 mg                      Initial dosing is 1–2 lozenges every 1–2 hours (minimum of 9/day).                      Taper as tolerated.</p> <p><b>Duration:</b> up to 12 weeks with no more than 20 lozenges to be used per day.</p> <p><b>How to use:</b>                      The lozenge should be allowed to dissolve in the mouth. It should not be chewed or swallowed.</p>	<ul style="list-style-type: none"> <li>Irritation of mouth</li> <li>Irritation to stomach (nausea frequent 12–15%)</li> <li>Hiccups</li> <li>Heartburn</li> </ul>
<b>Nicotine nasal spray</b> (Rx) Delivers nicotine through the lining of the nose when sprayed directly into each nostril. Available dosage: 0.5 mg nicotine in 50 µl aqueous nicotine solution.	The same as nicotine gum plus those who do not have <ul style="list-style-type: none"> <li>Underlying chronic nasal disorders</li> <li>Severe reactive airway disease.</li> </ul>	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Flexible dosing.</li> <li>Can be used in response to stress or urges to smoke.</li> <li>Fastest delivery of nicotine of currently available products but not as fast as cigarettes.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Nose and eye irritation is common, but usually disappears within one week.</li> <li>Frequent use during the day required to obtain adequate nicotine levels.</li> </ul>	<p><b>Dosing:</b>                      1 spray in each nostril, 1–2 times per hour (up to 5 times/hour or 40 times/day)                      Most average 14–15 doses/day initially                      Taper as tolerated.                      Duration: 3–6 months.</p>	<ul style="list-style-type: none"> <li>Nasal irritation (runny nose, sneezing, burning sensation)</li> <li>Coughing</li> <li>Nausea</li> <li>Headache</li> <li>Dizziness</li> <li>Irritated throat</li> </ul>

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
<b>Nicotine inhaler (Rx)</b> Delivers nicotine to the oral mucosa, not the lung, and enters the body much more slowly than the nicotine in cigarettes. Available dosage: 10 mg cartridge delivers 4mg inhaled nicotine vapour.	The same as nicotine gum plus those who do not have <ul style="list-style-type: none"> <li>Bronchospastic disease.</li> </ul>	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Flexible dosing.</li> <li>Mimics the hand-to-mouth behaviour of smoking.</li> <li>Few side effects.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Frequent use during the day required to obtain adequate nicotine levels.</li> <li>Should not eat or drink 15 minutes before use or during use.</li> </ul>	<p><b>Dosing:</b>                      Minimum of 6 cartridges/day, up to 16/day                      Taper as tolerated (during the final 3 months of treatment).  <b>Duration:</b> up to 6 months.</p>	<ul style="list-style-type: none"> <li>Mouth or throat soreness or dryness</li> <li>Coughing</li> </ul>
<b>Bupropion SR (Rx)</b> Originally used as antidepressant. Affects the levels of neurotransmitters affecting the urge to smoke. Available dosage: 150 mg sustained release tablet.	All adult smokers except those <ul style="list-style-type: none"> <li>Pregnant or breastfeeding</li> <li>Concomitant therapy with medications or medical conditions known to lower the seizure threshold</li> <li>Severe hepatic cirrhosis.</li> </ul>	<ul style="list-style-type: none"> <li>Withdrawal symptom relief (anxiety irritability and depression).</li> <li>Abstinence.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Easy to use.</li> <li>Pill form.</li> <li>Few side-effects.</li> <li>May be used in combination with NRT.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Contraindicated with certain medical conditions and medications.</li> </ul>	<p><b>Dosing:</b>                      Take doses at least 8 hours apart.                      Start medication one week prior to the target quit date (TQD)                      150 mg once daily for 3 days, then                      150 mg twice daily for 4 days, then                      On TQD STOP SMOKING and continue at 150 mg twice daily for 12 weeks                      May stop abruptly; no need to taper.</p>	<ul style="list-style-type: none"> <li>Dry mouth</li> <li>Nervousness/difficulty concentrating</li> <li>Rash</li> <li>Headache, dizziness</li> <li>Seizures (risk is 1/1,000)</li> </ul> <p><b>Warnings:</b>                      Advise patients to stop bupropion and contact a health-care provider immediately if they experience agitation, depressed mood, and any changes in behaviour that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behaviour.</p>
<b>Varenicline (Rx)</b> Attaches to nicotinic receptors. Part blocking the reward effects of nicotine and part stimulating the nicotinic receptors. Available dosage: 0.5 mg, 1 mg tablet.	All adult smokers except those <ul style="list-style-type: none"> <li>Pregnant or breastfeeding</li> <li>Severe renal impairment (dosage adjustment is necessary).</li> </ul>	<ul style="list-style-type: none"> <li>Withdrawal symptom relief.</li> <li>Control of cravings/urges.</li> <li>Abstinence.</li> </ul>	<p><b>Pros</b></p> <ul style="list-style-type: none"> <li>Easy to use.</li> <li>Pill form.</li> <li>Generally well tolerated.</li> <li>No known drug interactions.</li> </ul> <p><b>Cons</b></p> <ul style="list-style-type: none"> <li>Nausea is common.</li> </ul>	<p><b>Dosing:</b>                      Take with food.                      Start medication one week prior to the TQD 0.5 mg once daily X 3 days, then                      0.5 mg twice daily X 4 days, then                      On TQD STOP SMOKING AND take 1.0 mg twice daily for 11 weeks.                      May stop abruptly; no need to taper.</p>	<ul style="list-style-type: none"> <li>Nausea</li> <li>Sleep disturbances (insomnia, abnormal dreams)</li> <li>Constipation</li> <li>Flatulence</li> <li>Vomiting</li> </ul> <p><b>Warnings:</b>                      The same as for bupropion.</p>

## Module 9: Promoting brief tobacco interventions in the community

### Objectives

Upon completion of this module participants will be able to:

- identify outreach opportunities for delivering brief tobacco interventions to tobacco users in their homes or community settings;
- identify referral resources within a local community for primary care provider to deliver brief tobacco interventions.

### Agenda

1. The opportunities for delivering brief tobacco interventions in a patient's home and community (15 minutes).
2. Community referral resources for primary care providers to deliver brief tobacco interventions (15 minutes).
3. Compiling a list of available community resources for tobacco dependence treatment (20 minutes).
4. Evaluation (20 minutes).

### Preparation

#### 1. The opportunities for delivering brief tobacco interventions in a patient's home and community (15 minute)

Everyone who uses tobacco should be advised to quit and primary care providers should use every encounter in both clinical settings and community settings as an opportunity to provide brief tobacco interventions to all patients who use tobacco to quit.

### Brainstorming

What are the opportunities to deliver brief tobacco interventions in a patient's home and community?

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Primary care providers may have chances to conduct outreach activities in a patient's home and community, which are the opportunities to deliver brief tobacco interventions to patients and their families.

The common outreach activities for delivering brief tobacco interventions may include:

- home visits to pregnant women, children and old people;
- home visits to patients with severe chronic diseases;
- home visits for family planning;
- community health education;
- environmental sanitation;
- health screening;
- data collection or survey in the community;
- community public campaigns (such as World No Tobacco Day).

## Presentation

### 2. Community referral resources for primary care providers to deliver brief tobacco interventions (15 minutes)

A community may have many existing resources to support primary care providers in delivering brief tobacco interventions to patients who use tobacco.

The following community resources could be the referral resources for primary care providers when they deliver brief tobacco interventions:

- tobacco quitlines;
- specialist services in cessation clinics;
- local tobacco cessation classes and support groups;
- smoker’s web-based assistance;
- free self-help materials.

With community resources available to provide more in-depth assistance and follow-up, primary care providers will be freed up to focus on identifying and motivating tobacco users to quit, and may use a simplified brief tobacco intervention model called AAR (Ask, Advise, Refer).

AAR brief tobacco intervention model	
1. A	Ask about tobacco use and document in the medical record.
2. A	Advise patients who use tobacco to quit. “Quitting is one of the best things you can do for your health.”
3. R	Refer to trusted resources. <ul style="list-style-type: none"> <li>• For patients who are ready to quit, provide referral to resources (such as a quitline) that can provide assistance and follow-up.</li> <li>• For patients who are not ready to quit, provide referral to self-help materials, and let the patients know you are available to help when they are ready.</li> </ul>

## Practice

### 3. Compiling a list of available community resources for tobacco dependence treatment (20 minutes)

A list of existing referral resources for tobacco dependence treatment in the community that your primary care organization serves will be a useful tool or resource to assist you in delivering brief tobacco interventions.

Please work in small groups to create a list of available resources for tobacco dependence treatment in your community.

### 4. Evaluation (20 minutes)

Each group should share its list of available community resources.

Everyone adds to the discussion and gives feedback.

## Summary

There are many opportunities for primary care providers to deliver brief tobacco intervention in patients’ homes and community. Communities also have referral resources available so that primary care providers may complement and extend their brief tobacco interventions by referring patients to those available community resources.

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## APPENDIX: SAMPLE EVALUATION FORM

Please select the answer you most agree with.

Please also give your written feedback in the space provided.

1. Overall I found the training workshop useful for my work

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

2. Which part of the training workshop did you find the most useful?

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3. Which part of the training workshop did you find the least useful?

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4. The workshop facilitator had a good knowledge of the subject

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

5. The workshop facilitator's skills in conveying the subject matter were good

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

6. As a result of my participation in the training workshop, I feel more confident to provide brief tobacco interventions to tobacco users

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

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7. How difficult did you find the training workshop?

- Too difficult
- Difficult
- Just right
- Easy
- Too easy

8. How could the workshop implementation be improved?

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9. How could the training materials be improved?

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10. Overall, how would you rate the workshop?

- Very good
- Good
- Average
- Poor
- Very poor

11. Any other comment, suggestion, criticism:

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**Thank you for your feedback!**

For further information, kindly contact **PND** as follows:

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**ISBN 978 92 4 150541 3**

