WHO FRAMEWORK CONVENTION
ON TOBACCO CONTROL

Provisions of tobacco cessation support in the Americas

REGIONAL STUDIES SERIES PAPER R/1

Acknowledgements

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Introduction

The WHO Framework Convention (WHO FCTC) *(1)* was adopted by the World Health Assembly in May 2003 and entered into force on 27 February 2005. The Convention contains a number of articles related to reducing the demand for tobacco, including Article 14, which requires that each Party shall "develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence". Parties are also required to endeavour to implement effective programmes aimed at promoting cessation of tobacco use in a range of locations including educational institutions and health care facilities, and to include diagnosis and treatment of tobacco dependence and counselling services on cessation in national health and education programmes, plans and strategies.

The guidelines on implementation of Article 14, adopted by the Conference of Parties in 2010, *(2)* expand on these obligations and provide more detailed recommendations for a sustainable and comprehensive integrated system to promote tobacco cessation and treat dependence. Measures implemented can be simultaneous or stepwise, as it is recognized that the circumstances and priorities of each Party will be different. The guidelines also emphasize the importance of using existing infrastructure, in both health-care and other settings to ensure that all tobacco users are identified and provided with at least brief advice, and that recording of tobacco use in medical notes should be mandatory.

The WHO FCTC Article 14 guidelines also highlight the importance of implementing tobacco dependence treatment measures synergistically with other tobacco control measures, and that cessation support is a key component of a comprehensive integrated tobacco control programme. Cessation support for tobacco users will reinforce other tobacco control policies by increasing social support for them and increasing their acceptability. Likewise, implementing other tobacco control policies such as strong smoke-free policies, communication campaigns and tax policies will increase the demand for help in quitting tobacco use. Implementing cessation and treatment measures in conjunction with population level interventions (such as Articles 6, 8, 11, 12, and 13) will have a synergistic effect and help achieve maximum impact.

Although progress has been made towards implementation of Article 14, a recent global survey suggests that the provision of cessation support is not yet very high on the agenda of most countries *(3,4).* This paper reports on the current status of implementation of Article 14 of the WHO FCTC in the Americas Region of WHO and offers some suggestions for next steps. These suggestions are based on the information reviewed, the recommendations of WHO FCTC Article 14 guidelines, and the discussions on Article 14 which took place at the regional meeting on the implementation of the WHO FCTC in the Americas, held in Bogota, Columbia, from 3 to 6 September 2013.

Prior to the regional meeting, information was reviewed to get a clearer understanding of current cessation support in the Americas. The principal data source used was the implementation

reports of the Parties to the WHO FCTC submitted to the Convention Secretariat during the 2012 reporting cycle *(5)*. In this paper, only data for the Americas are discussed. Additional data for the Americas were extracted from a recently published survey of cessation support in 121 countries around the world by Piné-Abata et al. *(3,4)* (See technical note in Annex 1.) A summary of data from these sources is given in Annex 2 of this document.

Current status of cessation support in the Americas

Tobacco cessation strategy

WHO FCTC implementation data from Parties in the Americas *(5)* are presented in Table 1 with selected findings summarised here in the text. The findings reported in the text are from the implementation reports unless otherwise stated. Percentages reported are of the Parties that answered (see cautionary note in Annex 1). Of these, 43% reported that they have national cessation guidelines, 57% reported that they run media campaigns promoting cessation, and almost all reported running local events such as World No Tobacco Day. Fifty two percent said that tobacco dependence treatment (hereafter referred to as treatment) is part of their tobacco control strategy, 59% said that treatment is part of their health strategy and 70% reported that treatment is integrated into their healthcare system.

In 2010 the Guyana Ministry of Health, working in partnership with PAHO and the Guyana Chest Society, approved an official cessation strategy. Plans have been established to roll out the cessation programme nationally with the establishment of 16 permanent sites and 40 staff trained in tobacco cessation.

In their 2008 law, Uruguay made it mandatory for all health sectors and professionals to implement the national cessation guidelines. Uruguay is currently reviewing its national strategy with a view to developing an official, written, national tobacco cessation strategy within its overall tobacco control policy. Tools developed include National Cessation Guidelines, guidance for primary care intervention, and an easy-to-follow algorithm for each clinic. The national guidelines recommend the ABC approach: **a**sk about smoking, give **b**rief advice, provide **c**essation support.

National cessation guidelines

According to the combined data from the implementation reports by Parties and the Piné-Abata et al survey, which agree very well, 12 countries (41%) in the Americas have national cessation guidelines (Table 3). Thus, fewer than half of Parties in the Americas have implemented Article 14.1 of the Convention. However, various tools have been developed recently to assist Parties so that they can more effectively implement Article 14 of the Convention.

One of the recently developed tools is a concise review of the cessation evidence *(6).* This review can serve as the evidence base for guidelines and thus should help Parties develop national guidelines more quickly and efficiently. It includes a spreadsheet which allows the inputting of country data to estimate affordability of an intervention in that country. This review of the evidence will be periodically updated and made available online. Currently, many countries reference or base their guidelines on those of other countries *(3),* presumably, inter alia, to save time and money. When the other countries have very similar healthcare systems, cultures and resources, this might be beneficial. However, traditionally, many guidelines have had two sections:

1. a review of the cessation literature – the evidence base – which is often very long; and
2. recommendations for action.

If countries use this new concise review of the evidence (6), as an up-to-date evidence base, their guidelines can then be concise and action focused (7) rather than the very long and complex literature reviews they often have been. This may also help ensure that when guidelines are produced they are relevant, widely disseminated and implemented. The review can also be used to estimate the likely affordability of interventions before a country finalises its national cessation strategy and national guidelines. A brief summary of the key messages of the review is available in English and Spanish *(8,9)* and is annexed to this paper.

The Piné-Abata survey found that almost all guidelines closely followed the evidence base, with all recommending brief advice, intensive specialist support and medications, and half recommending quitlines, and three-quarters were for the whole healthcare system and all health professionals. Almost 90% were peer-reviewed, clearly stated who funded the guidelines, and received financial support from government or public health organisations. Only 25% were developed with support received from the pharmaceutical industry.

Treatment provision

In their implementation reports 65% percent of Parties said that treatment is offered in primary healthcare, 76% that it is offered in secondary and tertiary healthcare, 64% that it is offered in specialist healthcare systems, and 40% that it is offered in rehabilitation services. Between 60% and 64% said that these treatment services in primary, secondary and tertiary healthcare and in specialist healthcare systems are publicly funded, and 38% said that treatment in cessation centres is publicly funded.

Canada reported that of the jurisdictions that responded to a survey 50% provided tobacco cessation services in specialised cessation centres and 40% reported providing cessation counselling in rehabilitation centres.

Uruguay now provides cessation support in all of its 19 Departments (sub-national jurisdictions).

Colombia plans to have cessation clinics in 80% of its Departments (sub-national jurisdictions) by 2021.

Involvement of health professionals in treatment

In their implementation reports, Parties reported that the following professionals are involved in offering cessation treatment: Physicians (94%), family doctors (69%), dentists (31%), pharmacists (50%), nurses (81%), midwives (20%), and community workers (31%).

> Canada reported that of responding jurisdictions, 71% said community workers are involved in treatment, 62% said social workers are, and 50% said that practitioners of traditional medicine are.

Training

Parties were asked if there are training programmes in medical schools (45% of Parties said yes), dental schools (17%), pharmacy schools (17%) and nursing schools (14%).

> Chile has smoking cessation training through e-learning as well as face-to-face workshops in the primary care system.
>
> Columbia has developed a virtual course on healthy lifestyles that has a module on smoking module. The course is aimed at health professionals.

Medications

Nicotine replacement therapy (NRT), buproprion and varenicline were reported as being available by over three-quarters of Parties. Three-quarters of Parties also said they have taken steps to make medications accessible and affordable. Rates of public funding, full or partial, of medications were relatively low. Twenty five percent of Parties said that NRT was fully or partially funded, 41% said buproprion was fully or partially funded and 18% reported that varenicline was fully or partially funded.

Additional data from Piné-Abata et al survey *(3,4)* concerning the Americas

Just over a third of countries said that they have an official national treatment strategy, just over half that there is an officially identified person responsible for treatment, 30% said that a budget had been clearly identified for treatment, and 25% said they offer help to healthcare workers to stop using tobacco. Twenty percent said that it is mandatory to record tobacco use in medical notes and 30% reported having a national telephone quitline. Fifty five percent of countries said that they promote or encourage brief advice in existing healthcare services. Two countries reported having specialist treatment facilities, defined as "experts or units/clinics offering individual or group support delivered by trained professionals" covering the whole country, 12 countries said they had specialist treatment facilities in selected areas, and 6 countries (30%) reported no specialist treatment facilities services at all.

NRT was rated as being easily affordable to most tobacco users in 54% of countries, bupropion in 66% and varenicline in 27% (the questionnaire item requested a simple, subjective rating). Finally, survey respondents were asked if tobacco users can easily get help to stop in various settings. The results are shown in Figure 1. The most striking finding is how few countries reported that tobacco users could *easily* get help in any setting, meaning that in most countries tobacco users do not have easy access to cessation support.

Achievements and challenges in providing cessation support in the region

The selected achievements and challenges summarised below are based on the data from the implementation reports of Parties and the Piné-Abata et al study.

Selected achievements

1. Over half of Parties run media campaigns promoting cessation and almost all run local events, such as on the occasion of World No Tobacco Day.
2. Just over half promote cessation in workplaces and almost two thirds promote cessation in healthcare facilities.
3. Just over half promote brief advice in existing healthcare services.
4. Treatment is part of the healthcare system of 70% of Parties.
5. Treatment is offered in the primary healthcare systems of 65% of Parties, and in secondary and tertiary care of 76% of Parties.
6. From 60% to 70% of Parties reported that the treatment services are publicly funded in primary, secondary and tertiary, and specialist healthcare systems.
7. Almost all Parties reported that physicians are involved in treatment. Nurses were involved in treatment in 81% of countries, family doctors in 69% of countries, and pharmacists in 50% of countries.
8. Sixty percent of countries have specialised treatment facilities in selected areas (major cities for example).
9. NRT, bupropion and varenicline are available in most countries, and nortriptyline in 40%.

Selected challenges

1. Most Parties do not have an official national cessation strategy.
2. Only about half of Parties have developed national guidelines.

3. Most Parties do not have a clearly identified budget for treatment.
4. One third report that they do not promote cessation in healthcare facilities.
5. Treatment is part of the tobacco control strategies of just half of Parties.
6. A third of Parties do not offer treatment in primary healthcare.
7. Almost two thirds of Parties do not publicly fund treatment in cessation centres.
8. Two thirds of Parties say that dentists are not involved in treatment.
9. Half of Parties say that pharmacists are not involved in treatment.
10. Eighty percent of Parties say that midwives are not involved in treatment.
11. Few Parties report training on treatment in dental, pharmacy and nursing schools and less than half in medical schools.
12. Public funding of medications for treatment of tobacco dependence is not very common.
13. Most Parties do not offer help to healthcare workers to stop using tobacco.
14. Most Parties do not mandate recording tobacco use in medical notes.
15. Most Parties do not have a telephone quitline.
16. Brief advice is promoted in existing services by only about half of Parties.
17. One third of Parties report no specialised treatment services at all.
18. Affordability of medications is an issue.
19. Few countries report that it is easy for tobacco users to get cessation help in any settings; the highest were 20% in family medicine and addiction services.

Regional priorities and strengthening implementationof WHO FCTC Article 14 in the Americas

Neither the Party implementation reports *(5)* nor the Piné-Abata et al data *(3,4)* provide very detailed information about measures for cessation support, however they do present a broad and consistent picture throughout the region. Despite the progress made, Parties in the region still need to take the next steps in developing or scaling up the provision of cessation support to strengthen its implementation of Article 14 of the Convention. This review highlights several areas in which Parties have made progress in providing cessation support, and others where there is much to be done.

The WHO FCTC Article 14 guidelines *(2)* set out clear recommendations on developing cessation support and on how to select priorities. In light of the Article 14 recommendations and this review of the regional situation, it is important to consider which issues need to be addressed in order to improve the provision of cessation support in the region.

Developing basic infrastructure

The WHO FCTC Article 14 guidelines recognize that other tobacco control measures which reduce demand for tobacco will promote tobacco cessation by encouraging quitting and creating a supportive environment for the implementation of measures that support cessation, thereby having a synergistic effect.

The Article 14 guidelines provide recommendations for a comprehensive integrated system to promote tobacco cessation and treat dependence, which can be simultaneous or stepwise, depending on the circumstances and priorities of each Party. The following are key components of a basic infrastructure to support tobacco cessation:

- Conduct a national situation analysis.
- Create or strengthen national coordination.
- Develop evidence based guidelines which include a national cessation strategy and an implementation plan.
- Help healthcare workers to give up tobacco use.
- Develop training capacity.
- Use existing systems and resources to ensure the widest possible access to help.
- Make it mandatory to record tobacco use in medical notes.
- Establish sustainable funding for cessation support.

Key components of a cessation system

In recommending the key components of a system to help tobacco users quit, the WHO FCTC Article 14 guidelines emphasise broad reach lower cost interventions:

- Mass communication and education programmes
- Brief advice
- Quitlines

The Article 14 guidelines also discuss provision of more intensive specialised treatment services. It is worth remembering that these services will be more expensive, require training and at least

some regulation or quality control. They clearly play an important role, but before investing considerable resources in specialized treatment services, countries might consider first ensuring that suitable infrastructure first be put in place, which includes brief advice, access to low cost medications, training programmes, and the securing of adequate and sustainable funding for treatment of tobacco dependence.

The Article 14 guidelines recommend that Parties should keep under review the developing scientific evidence of new approaches to promoting tobacco cessation and providing tobacco dependence treatment. This is one important reason why national cessation guidelines need to be periodically updated. Two recent research developments are relevant to providing low cost broad reach interventions. However, as they are fairly new, they are unlikely to be recommended in many current guidelines. One reports promising results for increasing cessation rates through the use of telephone text messaging *(10).*

There is also growing evidence for the use of cytisine as an aid for treating tobacco dependence *(11,12).* Cytisine, an alkaloid found in the golden rain tree, acts similarly to nicotine and has been used as an inexpensive smoking cessation aid in Eastern Europe for over 40 years.[1] However, it is not yet approved for use for tobacco cessation outside of Central and Eastern Europe. Although there is only one randomised controlled trial (RCT) of cytisine published to date to modern scientific standards, numerous studies have been published in Eastern Europe in the past decades. Cytisine provides an example of the need for countries to explore ways to establish the efficacy and safety of cessation products, potentially through the sharing of existing data among Regions. WHO FCTC Article 22 urges Parties to cooperate in transferring technical and scientific expertise, and this includes the transfer of technology and promoting appropriate research to increase the affordability of treatment for nicotine addiction. It is recommended that Parties take actions to ensure such cooperation so that tobacco users in all countries have timely access to safe, affordable cessation aids.

Recommendations for the Parties in the Americas

These are some possible next steps for Parties in the region based on the data reviewed and on the recommendations of WHO FCTC Article 14:

1. Conduct a situation analysis.
2. Strengthen national coordination for cessation.
3. Identify and allocate sustainable funding for cessation support.
4. Develop a national cessation strategy and national cessation guidelines.
5. Address the issue of tobacco use in healthcare workers.

[1] For further information about cytisine see www.treatobacco.net

6. Ensure that tobacco use is recorded in medical notes.
7. Integrate brief advice into the primary healthcare system and other relevant systems.
8. Establish a free proactive quitline and text messaging.
9. Ensure that medications are available and affordable.
10. Ensure that stakeholders work together in order both to share the workload and ensure effective change.

Key issues and resources identified during the discussions at the regional meeting

Affordability of medications is a significant concern in the region and many Parties expressed a desire to work with subregional organizations and WHO/PAHO on a collective approach to acquire medications at the lowest possible cost, as recommended in the guidelines for implementation of Article 14 of the Convention.

It is important that Parties in the region be made more aware of the various tools that exist to assist them in implementing Article 14, especially:

- The WHO training package "Strengthening health systems for treating tobacco dependence in primary care"[2].
- A set of newly developed tools – currently piloted with Uruguay, and with interest expressed by several other countries from the Region – aimed at helping Parties to conduct a national situation analysis and develop a national cessation strategy and national treatment guidelines quickly, cheaply and easily. Most of these tools are completed and available now in English and Spanish, and all will be made available at www.treatobacco.net.
- National treatment guidelines developed and implemented by other Parties to the Convention are available on the Convention Secretariat's website as attachments of the implementation reports submitted by the Parties. Many examples of such guidelines, including several Spanish language guidelines, can also be accessed on the following website: www.treatobacco.net. Such examples might be used as templates for the development of treatment guidelines in the countries which have not yet initiated this process if they have very similar healthcare systems (see above). Attention should also be given to the regular updating of these guidelines, to capture and reflect upon new evidence and effective practices.

[2] This package of materials can be downloaded from the WHO website at: http://www.who.int/tobacco/publications/building_capacity/training_package/treatingtobaccodependence/ (accessed 24 October 2013)

- The WHO Manual on "Developing and improving national toll-free tobacco quit line services" includes technical advice and case examples for establishing and operating a national quit line service, with a focus on choosing appropriate service delivery options, optimizing population coverage and utilization, and partnerships with health-care systems. This manual has particular relevance for low- and middle-income countries in the early stages of quit line development.[3]

[3] This manual can be downloaded from the WHO website at: http://www.who.int/tobacco/publications/smoking_cessation/quit_lines_services/en/(accessed 7 March 2013)

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ANNEXES

Annex 1

Technical note on the data

Party report data: There are 56 indicators related to tobacco cessation for which data are available in the WHO FCTC Implementation Database *(5).* Table 1 below shows the 2012 data for the Americas for a number of indicators. The language of the questions has also been simplified in the table in order to present what is being measured in a concise and clear way. The bases for the percentages in bold are the number of Parties that answered that question. As not all questions were answered by all Parties these percentages probably over-estimate the true figures as nonresponses are more likely to be negative than positive. The final column of the table shows the number of non-responders for that indicator and the adjusted percentages assuming all answered negatively. The true percentages will probably be somewhere between the two percentages shown here. Nine indicators are not presented in the table either because no data were reported or because the question was open ended and sufficient details were not available. At the time of writing, 29 countries from the WHO Region of the Americas were Parties to the Convention.

Piné-Abata et al survey *(3,4)*: This survey was conducted from late 2011 to the middle of 2012 by research teams from the United Kingdom (UK) Centre for Tobacco Control Studies at Nottingham University and Harvard Medical School. The sample for the survey published by Pine-Abata et al was all Parties to the WHO FCTC at the time of the survey. There were 174 Parties to the WHO FCTC, including the European Union (EU). The EU was excluded, and it was not possible to find contacts for 10 Parties, thus 163 Parties were surveyed. The UK consists of four entities, England, Northern Ireland, Scotland and Wales, each with separate healthcare systems and treatment guidelines, so all four were surveyed individually. The final sample, therefore, consisted of 166 surveys. The response rate was 73% globally and 69% for the Americas. Table 2 and Figure 1 present the results for the Americas.

Annex 2

Summary of cessation related data from the Americas

Table 1. Data from Party reports

Indicator	Yes	Percentage of positive responses[a]	No	Number of non-responders and recalculated percentage (assuming negative responses for non-responders)[b]
Have you implemented guidelines?	10	**43**	13	6 (34)
Do you run media campaigns?	13	**57**	10	6 (45)
Do you run local events like WNTD?	21	**91**	2	6 (72)
Do you promote cessation in:				
Educational institutions?	12	**52**	11	6 (41)
Healthcare facilities?	15	**65**	8	6 (52)
Workplaces?	12	**52**	11	6 (41)
Sporting environments?	6	**26**	17	6 (21)
Is treatment part of your:				
Tobacco control strategy?	12	**52**	11	6 (41)
Health strategy?	13	**59**	9	7 (45)
Educational system?	7	**30**	16	6 (24)
Healthcare system?	16	**70**	7	6 (55)
Is treatment offered in:				
Primary healthcare	11	**65**	6	12 (38)
Secondary and tertiary healthcare	13	**76**	4	12 (45)
Specialist healthcare systems	9	**64**	5	15 (31)
Rehabilitation services	6	**40**	9	14 (21)

Indicator	Yes	Percentage of positive responses[a]	No	Number of non-responders and recalculated percentage (assuming negative responses for non-responders)[b]
Are the treatment services offered in these setting publicly funded:				
Primary healthcare	8[c]	**62**	5	16 (28)
Secondary and tertiary healthcare	9	**60**	6	14 (31)
Specialist healthcare systems	7	**64**	4	18 (24)
Cessation centres	5	**38**	8	16 (17)
Rehabilitation services	3	**23**	10	16 (10)
Are the following involved in treatment:				
Doctors	15	**94**	1	13 (52)
Dentists	5	**31**	11	13 (17)
Family doctors	11	**69**	5	13 (38)
Traditional practitioners	2	**13**	13	13 (7)
Other medical practitioners	5	**56**	4	20 (17)
Nurses	13	**81**	3	13 (45)
Midwives	3	**20**	12	14 (10)
Pharmacists	8	**50**	8	13 (28)
Community workers	5	**31**	11	13 (17)
Social workers	6	**38**	10	13 (21)
Other professionals (not specified)	4	**80**	1	24 (14)
Are there training programmes on treatment in:				
Medical schools?	9	**45**	11	9 (31)
Dental schools?	3	**17**	15	11 (10)

Indicator	Yes	Percentage of positive responses[a]	No	Number of non-responders and recalculated percentage (assuming negative responses for non-responders)[b]
Nursing schools?	4	**14**	14	11 (14)
Pharmacy schools?	3	**17**	15	11 (10)
Have you taken steps to make medications accessible and affordable?	14	**74**	5	10 (48)
Are these medications available?				
Nicotine replacement therapy (NRT)	14	**78**	4	11 (48)
Buproprion	16	**94**	1	12 (55)
Varenicline	13	**72**	5	11 (45)
Are these medications publicly funded?				
Nicotine replacement therapy (NRT)	4[c]	**25**	12	13 (14)
Buproprion	7	**41**	10	12 (24)
Varenicline	3	**18**	14	12 (10)
Other products (not specified)	19		0	10 (66)

[a] Number of "Yes" responses divided by base of 23 Parties that responded

[b] No data = no response, with in brackets the re-calculated percentage as a proportion of all 29 Parties assuming that all non-responders would have answered negatively.(See Annex 1 text for more detailed explanation)

[c] All responses to these indicators were partially, fully or none; partially and fully have been added together.

Table 2. Data from the Pine-Abata et al survey

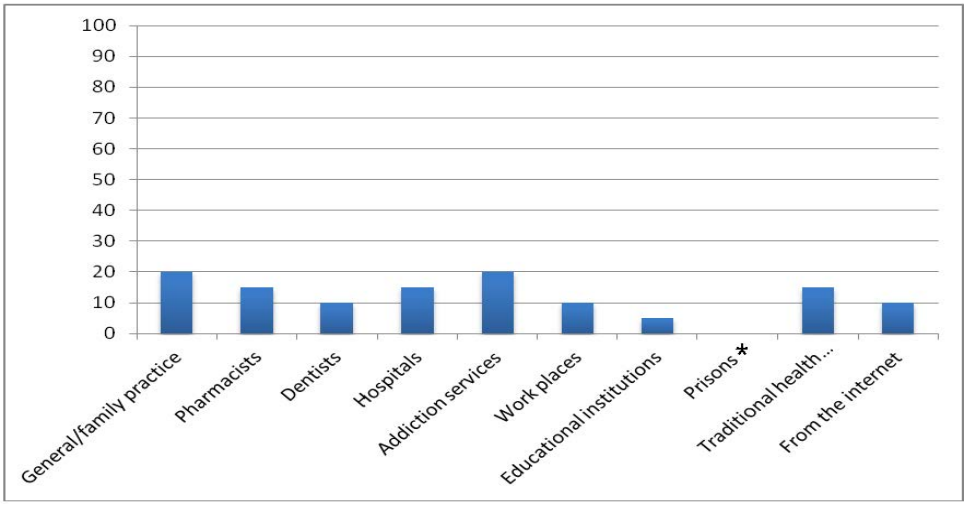
Question	% yes
Is there an officially identified person who is responsible for tobacco dependence treatment?	**55**
Does your country have a clearly identified budget for treatment?	**30**
Does your country have an official national treatment strategy?	**35**
Does your country have national guidelines for the treatment of tobacco dependence?	**40**
Does your country offer help to healthcare workers to stop using tobacco?	**25**
Does your country have mandatory recording of patients' tobacco use status in medical notes?	**20**
Does your country promote/encourage brief advice in existing services?	**55**
Does your country have a telephone quitline?	**30**
Countries with network of specialised treatment facilities covering the whole country	**10**
Countries with treatment facilities in selected areas	**60**
Countries with no specialised treatment at all	**30**

Base = 20; Ns: 11, 6, 7, 8, 5, 4, 11, 6, 12, 2, 6.

Percent of respondents who said nortriptyline is available	**40**
Percent of respondents who said NRT easily affordable	**54**
Percent of respondents who said buproprion easily affordable	**66**
Percent of respondents who said varenicline easily affordable	**27**

Varying bases; n and bases: NRT 7/13; buproprion 2/3; varenicline 3/11.

Figure 1. Estimate of ease of getting help to stop in the following settings (Americas data from Pine-Abata et al)



(**Prisons: 0% of respondents*)

Percent of respondents who said tobacco users could easily get help in those settings.

Table 3. Countries with guidelines

Party	Party reports	Pine-Abata et al
Brazil	Yes	Yes
Canada	Yes	Yes
Chile	No	Yes
Costa Rica	Yes	---
Guyana	Yes	No
Honduras	Yes	No
Mexico	Yes	Yes
Panama	Yes	Yes
Paraguay	Yes	Yes
Peru	No	Yes
Trinidad and Tobago	Yes	No
Uruguay	Yes	Yes

Table notes: Party report question: Have you adopted and implemented, where appropriate, legislative, executive, administrative or other measures or have you implemented, where appropriate, programmes developing and disseminating appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices? Pine-Abata et al question: Does your country have national guidelines for the treatment of tobacco dependence? Costa Rica was not in the Pine-Abata et al survey. At the time of writing all guidelines except Costa Rica, Guyana, Honduras and Trinidad and Tobago are posted on www.treatobacco.net

Annex 3

Key messages of the Effectiveness and Affordability Review (EAR)

Full title: Healthcare interventions to promote and assist tobacco cessation: a review of efficacy, effectiveness and affordability for use in national guideline development. Robert West, Martin Raw, Ann McNeill, Lindsay Stead, Paul Aveyard, John Britton, John Stapleton, Hayden McRobbie, Subhash Pokhrel, Ron Borland (manuscript under preparation).

The **EAR** summarises in a concise format the evidence for tobacco cessation support, with estimates of affordability. It is designed to be used as the evidence base for national guidelines, and to help countries choose what interventions to prioritise with the resources available. It includes a calculator into which country data can be inputted, in order to calculate the cost effectiveness and affordability of an intervention in the country. The following methods were used: Cochrane reviews of RCTs of major healthcare smoking cessation interventions were used to derive *efficacy* estimates in terms of percentage-point increases relative to comparison conditions in 6-12 month continuous abstinence rates. This was combined with analysis and evidence from 'real world' studies to form a judgement on the likely *effectiveness* of each intervention in different settings. The *affordability* of each intervention was assessed for sample countries in each World Bank income category. Based on WHO criteria, an intervention was judged as affordable for a given income category if the estimated cost per life-year saved was less than the per-capita GDP for that category of country.

The EAR has been reviewed and revised in the light of feedback from an international panel: Lekan Ayo-Yusuf, South Africa; Mahmoud Elhabiby, Egypt; Vimla Moody, South Africa; Javier Saimovici, Argentina; Dennis Rada, Bolivia; Elma Correa, Mexico; Tom Glynn, USA; Feras Harawi, Jordan; Jagdish Kaur, India; Oleg Salagay, Russian Federation; Hom Lal Shresha, Nepal; Dan Xiao, China; Caleb Ngirarengei, Palau.

Key results

Brief advice from a health worker given opportunistically to smokers attending healthcare services can promote smoking cessation and is affordable for countries in all World Bank income categories ('globally affordable'). Telephone support, automated text messaging programmes, and printed self-help materials can assist smokers wanting help with a quit attempt and are affordable globally. Multi-session, face-to-face behavioural support can increase quit success for cigarettes and smokeless tobacco and is affordable in middle and high income countries. Nicotine replacement therapy, bupropion, nortriptyline, varenicline and cytisine can all aid quitting smoking when given with at least some behavioural support. Of these just cytisine and nortriptyline are affordable globally.

Conclusions of the Effectiveness and Affordability Review

Brief advice from a health worker, telephone helplines, automated text messaging, printed self-help materials, cytisine and nortriptyline are globally affordable healthcare interventions to promote and assist smoking cessation. Evidence on smokeless tobacco cessation suggests that face-to-face behavioural support can promote cessation.