A tool to assess the available services for smoking cessation at the country or regional level

Country	Organisation	Name
Italy	UniTS – Università del Terzo Settore	Antonella Cardone, Project Coordinator
Cyprus	School of science and Engeneering	Caterine Demoliou
Czech Republic	Czech Coalition against Tobacco	Katerina Langrova
Czech Republic	National Institute of Public Health	Hana Sovinova
Denmark	Danish Cancer Society	Hans Henrik Storm
France	Association Tabac & Liberté	Jean Daver
Greece	Hellenic Cancer Society	Maria Pilali
Italy	Consulta Italiana sul Tabagismo	Maurizio Laezza
Latvia	Health Promotion Care	Iveta Bluka
Netherlands	STIVORO	Ingrid Stevens
Netherlands	Stop Met Roken	Fleur Von Bladeren
Poland	Health Promotion Foundation	Witold Zatonski Magdalena Cedzynska
Poland	The College of Family Physicians Poland	Artur Mierzecki
Portugal	Instituto Da Qualidade em Saude	Antonio Vaz Carneiro
Romania	Romanian Society of Pneumology	Mihaltan Florin
Romania	Association Aer Pur Romania	Magdalena Ciobanu
Slovakia	Stop Smoking NGO	Tibor Baska
Slovenia	University of Ljubljana - Faculty of Medicine	Tomaz Caks
Spain	Directorate General of substance abuse and AID of the Department of Health and social security of the Autonomus Government of Catalonia	Esteban Salto Cerezuela
Sweden	Centre for Tobacco Prevention	Hans Gilljam
Switzerland	Swiss Cancer League	Verena El Fehri
Turkey	Turkish Thoracic Society	Elif Dagli
UK	Royal College of Nursing	Jennifer Percival
UK	Department of Health	Paul Hooper

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INTRODUCTION

One half of all people who regularly smoke will die from cigarettes, half in middle age and half in older age [1]. Tobacco use is killing approximately five million people worldwide each year [2]. There are benefits at all ages to stopping smoking, although the benefits become progressively greater with younger ages of quitting [3]. In a 30-50 year time frame, it is impossible to reduce tobacco related deaths, unless adult smokers are encouraged to quit [4]. This can be achieved through price measures, non-price measures and through increased availability of treatment for tobacco dependence. It has been suggested that treatment can produce more immediate and probably larger short-term public health gain than any other component of a comprehensive tobacco control programme [5]

Treatment for tobacco dependence includes (singly or in combination) behavioural and pharmacological interventions such as education, brief counselling and advice, intensive support, administration of pharmaceuticals or other interventions that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole [6]. Treatments for tobacco dependence are highly effective [7][8] and are amongst the most cost effective of all health care interventions [9-13], leading to immediate health gain [14-18]. The key to increasing the cost effectiveness even further is to increase the availability of services [5]. Clinical guidelines and recommendations have called for an increase in the availability, affordability and accessibility of high quality services for the treatment of tobacco dependence [19-22].

Since harmful tobacco use and tobacco dependence are recognized clinical disorders within the WHO ICD-10 Classification of Mental and Behavioural Disorders [23], Member States of the Organization are obliged to provide treatment, particularly when it is effective and highly cost effective. The Framework Convention on Tobacco Control requires its signatories to develop and disseminate appropriate, comprehensive and integrated guidelines for the treatment of tobacco dependence, and to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence [24].

However, despite the obligation to provide treatments for tobacco dependence, there is no framework for health care planners and managers that enables the organization of, or allows for an assessment of what constitutes an effective service. Although clinical guidelines are a step in this direction, they are only one, although essential, aspect, of an effective tobacco dependence treatment service. An effective service can only be defined when all the aspects and partners that play a role in it are taken into account.

This paper describes a tool to organize, assess, and ultimately improve treatment services for tobacco dependence (see Annex). The tool, whose remit is treatment rather than prevention of tobacco dependence, is premised on four principles: 1) tobacco dependence is a chronic relapsing clinical disorder requiring treatment like any other recognized disorder, condition or illness [21]; 2) tobacco dependence is an environmentally responsive clinical disorder, and thus any treatment service has to be embedded in effective tobacco policy that regulates the price, marketing and availability of tobacco products [4]; 3) treatment services for tobacco dependence should be based on evidence-based health care policy and health care management [25-27]; and 4) article 14 of the framework convention on tobacco control provides a minimum standard by which all smoking cessation services should be judged [24].

METHODS

Construction of the tool
Based on a systematic review of the existing tobacco dependence treatment literature, a comprehensive model was developed to describe the elements and conditions contributing to effective treatment of tobacco dependence. The domains for effective treatment identified in the model, relevant to quality, accessibility and affordability, were adopted as the framework for the assessment tool, Figure 1.
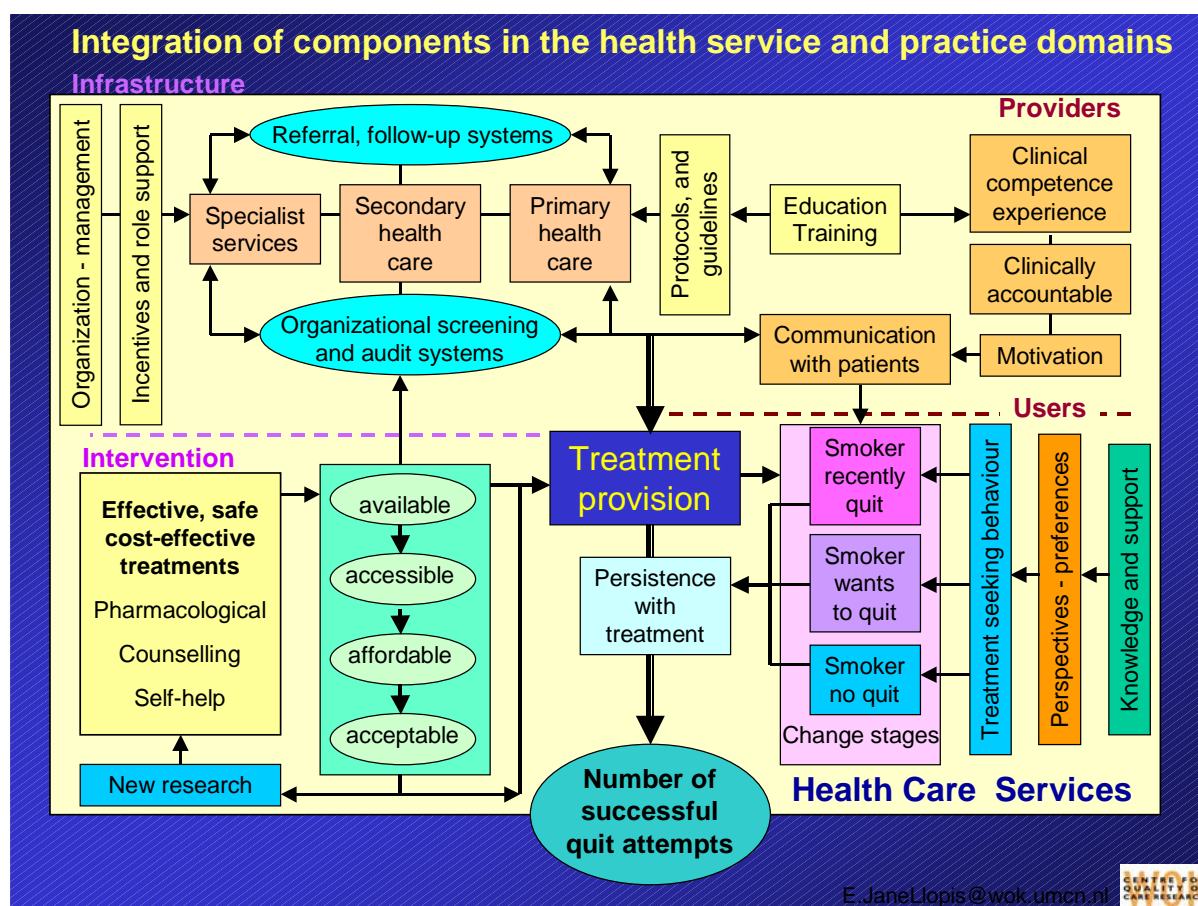
Figure 1. Components of health service domains

Specific items for inclusion within each of these domains were then identified using existing questionnaires and surveys relevant to the treatment of tobacco dependence that had been identified in a systematic review of the existing tobacco dependence treatment literature.

The identified items were organised into the previously identified domains to produce the first draft of the tool.

Face and content validity of the tool
The only relevant existing questionnaires and surveys identified by the literature review were those prepared by the World Health Organization [28-31]. Based on the comprehensive model and on the World Health Organization questionnaires, a total of 150 potentially relevant items were identified to form the first draft of the tool.

In addition to the basic level of content validity derived from basing the construction of the measure on the previously developed model and relevant published literature, face and content validity were further enhanced by seeking specific input from relevant experts, in three phases.

In phase one, a panel of three experts in quality assessment and quality improvement, based at the Centre for Quality of Care Research (WOK), University Medical Centre, Nijmegen, Netherlands commented on the selection of the domains and items. Specifically, they were provided with a copy of the draft tool and asked to consider each item in terms of its apparent relevance and comprehensibility, and to provide their views and feedback on the overall content and organisation of the assessment tool.

In phase two, the draft tool was examined by a national expert panel, once the suggested changes made by the experts based at the Centre for Quality of Care Research (WOK) had been incorporated. This second panel comprised eight members of the Dutch Research Consortium of the Partnership Project (PPP) to reduce tobacco dependence[1]. The Research Consortium comprised Dutch researchers who were known to be active in tobacco dependence treatment research, six of whom had been commissioned to undertake work by the PPP to inform the Dutch clinical guidelines on the treatment of tobacco dependence. The national experts were mailed a copy of the draft tool and, using focus group methodology, were asked to review the tool using the same criteria specified for the WOK-based experts.

In phase three, the draft tool was examined by a European expert panel, once the suggested changes made by the national experts of the Dutch Research Consortium of the Partnership Project to reduce tobacco dependence had been incorporated. The European experts were country representatives of a European Commission funded project to increase the engagement of health professionals in the treatment of tobacco dependence and members of the Society for Research on Nicotine and Tobacco. The six experts came from five countries, Austria, Catalonia, England, Italy and Germany. The European experts were mailed a copy of the draft tool and were invited to attend a meeting hosted by the Institute of Health Sciences, Oxford University, England. Using focus group methodology, the European experts were asked to review the tool using the same criteria specified for the WOK-based experts.

In phase one, items were excluded because they were redundant, appeared to be of insufficient relevance or were likely to be incomprehensible. Based on similar criteria, further items were excluded or re-worded in phases two and three. This process reduced the number of questions from 150 to 48, ranging from one to 13 questions for each domain. The 48 questions generated 386 variables of independent information.

Feasibility, readability and reliability of the tool
Following these three phases to assess face and content validity, the feasibility of implementing the tool was assessed in two phases.

In phase one, three individuals in the Netherlands were asked to complete the tool. The individuals were the senior official in the Ministry of Health responsible for tobacco policy; the Director of STIVORO who was also the chair of the PPP; and a lung physician who was a practising clinician, a chair of one of the guideline groups, and a member of the Research Consortium. In completing the measure, they were specifically asked to consider the feasibility and readability of the tool and to identify potentially ambiguous questions.

In phase two, once the required changes identified in phase one were incorporated, eleven individuals from Austria (n=1), Catalonia (n=4), England (n=2), Italy (n=1), Germany (n=1) and the Netherlands (n=2) were asked to complete the tool. They were chosen on the basis

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[1] http://www.partnershipstopmetroken.nl/index.htm.

of being representative of the target audience for completing the tool. In completing the tool, they were also asked specifically to consider the feasibility and readability of the tool and to identify potentially ambiguous questions. All specific modifications suggested by expert reviewers' were incorporated into the tool.

The reliability of the tool was measured by calculating the agreement in responses to the variables by respondents within countries (Catalonia, England and the Netherlands). Of the 386 variables, the two respondents from England completed 63% and 74%, the two respondents from the Netherlands 78% and 80%, and the four respondents from Catalonia 74%, 74%, 81%, and 72%. Of the 386 variables, identical answers (including non-response) was achieved for 80% of the variables by the two English respondents, for 73% by the two Dutch respondents and 30% by the four Catalan respondents.

No further items were excluded after the feasibility assessment. In phase two, the respondents reported the tool as unambiguous and clear in identifying the information sought.

Piloting the questionnaire
Finally, the questionnaire was piloted in 18 European countries by the partners of the Health Professionals and Smoking Cessation project. Based on the results of the pilot, and in partnership with the Danish Cancer Society, the questionnaire was reduced where it was possible to get data from other sources. Ambiguous questions were removed or clarified, and clear definitions were made. This led to a final tool comprising 30 questions with 365 items of information across five domains: Infrastructure; treatment support; treatment provision; health providers; and health users.

Completion of questionnaire
The questionnaire was completed by the country partner members in 18 European countries.

Development of scales
Five sub-scales were prepared based on each of the five domains, with a higher score in each sub-scale indicative of a more comprehensive service.

The infrastructure sub-scale comprised 16 questions and 53 items sub-divided into 7 domains: integrated health care system, structures for quality of care, research and knowledge for health, health care policies and strategies for smoking cessation, structures to manage the implementation of treatment within health services, and funding health service and allocating resources. Items were dichotomized as present or not. Extra weight was given to the presence of a country coalition or partnership on smoking cessation, a written government policy on smoking cessation, an identified government official responsible for smoking cessation services, government funding for services, and stability of government funding.

The support for treatment sub-scale comprised 5 questions and 116 items sub-divided into 3 domains: screening and quality assessment systems, protocols and guidelines, and reimbursement for health care providers. Items were dichotomized as present or not. Extra weight was given for the presence of guidelines, and assessment of their adherence.

The intervention and treatment sub-scale comprised 5 question and 84 items sub-divided into 1 domain: availability and accessibility. Items were dichotomized as present or not. Extra weight was given to the availability of a specialist service for smoking cessation.

The health care providers sub-scale comprised 2 questions and 21 items sub-divided into 2 domains: clinical accountability and treatment provision. The clinical accountability domain

included 10 items seeking a response on a 10-point scale. Items in the treatment provision domain were dichotomized as present or not.

The health care users sub-scale comprised 4 questions and 52 items sub-divided into 4 domains: media education, knowledge, treatment seeking behaviour, and smoking behaviour and intentions to quit. Items were dichotomized as present or not.

Each scale was re-scaled to total a maximum score of 50 points. The sub-scales were added to an overall scale, with a maximum score of 250 points. The reliability of the scale was estimated using the reliability procedure of SPSS 11.5. Maps were plotted using SPSS 11.5 mapping procedure for Europe, distributing the countries into scale score ranges of approximately equal size. T-tests were used to test for differences between the scales.

RESULTS

The overall results are shown in Table 1. A higher score indicates a more comprehensive service.

**Table 1.** Score for each of the sub-scales and the overall scale.

	Infrastructure	Treatment support	Treatment provision	Health providers	Health users	Overall scale
Cyprus	18	5	9	16	10	58
Czech Rep	22	11	17	8	13	71
Denmark	8	27	27	24	22	108
Germany	11	17	21	8	17	74
Greece	33	27	21	15	11	107
France	44	24	31	10	20	129
Italy	10	28	23	17	20	98
Latvia	17	5	12	9	6	49
Netherlands	24	29	26	33	25	137
Poland	38	17	26	32	35	148
Portugal	20	16	26	2	6	70
Romania	13	13	9	13	29	77
Slovak Rep	20	19	18	11	12	80
Slovenia	14	11	6	17	9	57
Sweden	6	16	23	29	20	94
Switzerland	29	27	20	14	10	100
Turkey	11	17	15	21	13	77
United K	30	39	32	33	33	167

[Sweden = Stockholm County; United Kingdom=England]

Health care infrastructures
Responses ranged from 6 to 44 (mean 20.4, SD=10.8), with France and Poland having the highest scores, Figure 2.
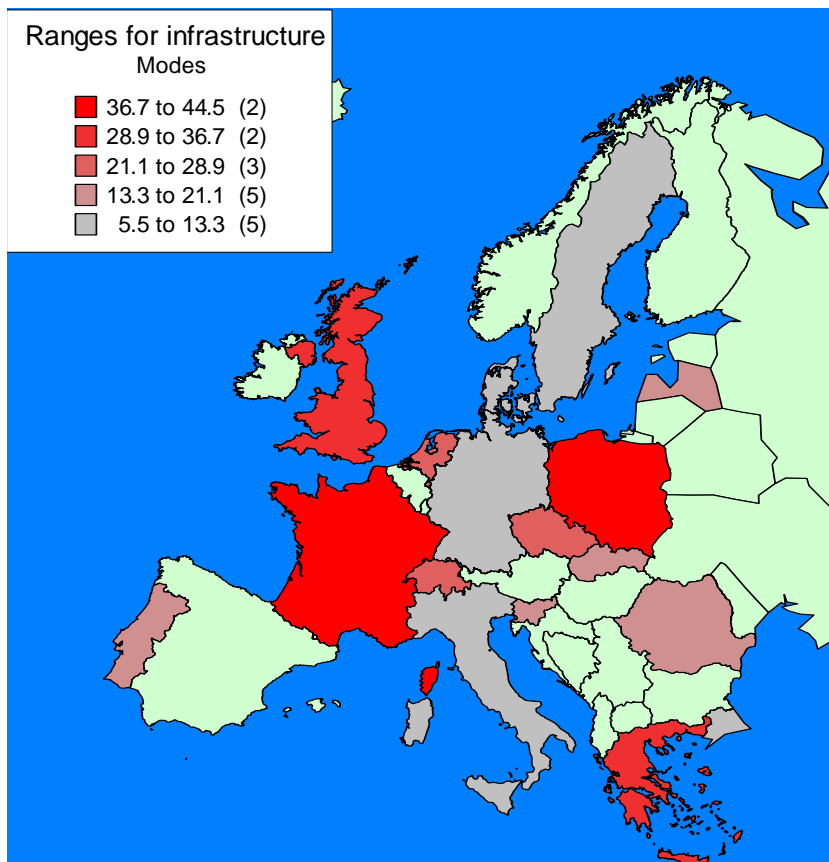
Figure 2 Health infrastructures scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

16 countries had a smoking cessation coalition or partnership in the country, Table 2. In 11 countries, smoking cessation was considered to be integrated in the health care system. Six countries had a formal research programme for smoking cessation, 7 had an official government policy on smoking cessation, and 9 had an identified government official responsible for smoking cessation services. In 13 countries, there was government funding for smoking cessation services, and, in one country (Poland), hypothecated tobacco taxes were used to fund smoking cessation services.

Table 2 Health care infrastructure, selected items.

	Is there a coalition or partnership?	Is smoking cessation integrated in the Health Care System?	Is there a research programme for smoking cessation	Are there official policies from the Government or Ministry of Health	Is there an identified person who oversees smoking cessation services	Is there government funding for services for smoking cessation	Is a proportion of tobacco taxes specifically earmarked or allocated to fund the costs of smoking cessation services
Cyprus	*	*			*	*	
Czech Rep	*				*	*	
Denmark						*	
Germany	*		*	*			
Greece	*	*	*	*	*	*	
France	*	*	*	*	*	*	
Italy	*	*					
Latvia	*				*	*	
Netherlands	*	*		*		*	
Poland	*	*	*	*	*	*	*
Portugal	*	*			*	*	
Romania	*	*				*	
Slovak Rep	*				*	*	
Slovenia	*	*				*	
Sweden							
Switzerland	*	*	*	*	*		
Turkey	*						
United K	*	*	*	*		*	

* = yes.
[Sweden = Stockholm County; United Kingdom=England]

Support for treatment provision.
Responses ranged from 5 to 39 (mean 19.3, SD=9.0), with England having the highest
score, Figure 3.
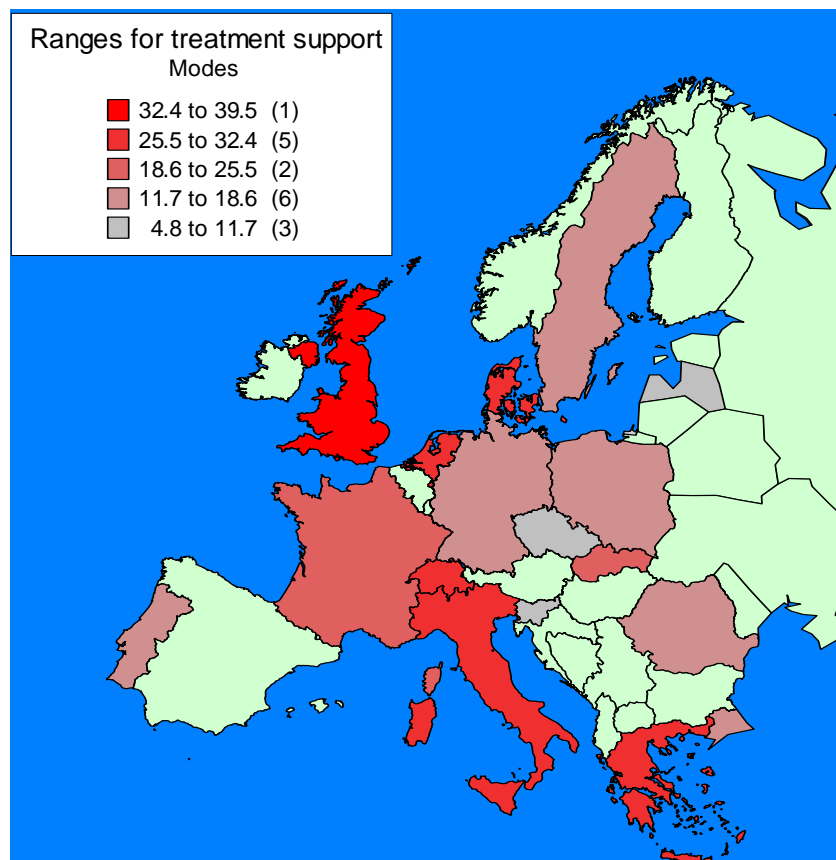
Figure 3 Treatment support scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

Whereas 14 countries had multidisciplinary guidelines for smoking cessation, in only one
country (England), had there been any studies on the implementation of guidelines, Table 3.
In 13 countries, screening tools were available to identify smoking status in general practice,
in 10 countries, case notes to record smoking status were available, in 10 countries, protocol
charts for cessation were available, in 12 countries, support for managing cessation was
available, and in 5 countries, systems to follow-up patients were available. In 11 countries,
smoking cessation was within the terms of service and part of the normal salary of the GP,
but only in one country (England), were GPs reimbursed for providing smoking cessation.

Table 3 Treatment support, selected items.

	Are there multidisciplinary clinical guidelines?	Studies in your country on implementation or adherence of cg?	Screening tools to identify smoking status in GP	Case notes to record smoking status in GP?	Protocol charts for cessation in GP?	Support for managing cessation in GP?	Systems to follow-up patients in GP?	GP reimbursed	GP within terms of service and part of normal salary
Cyprus									
Czech R	*		*			*			
Denmark	*		*	*		*			*
Germany	*		*		*	*			
Greece	*		*			*			*
France	*			*	*	*	*		*
Italy	*		*	*	*	*	*		*
Latvia									
Netherlands	*		*	*	*		*		*
Poland	*		*	*	*	*			*
Portugal	*		*		*				*
Romania			*	*					
Slovak Rep	*			*		*			*
Slovenia	*		*			*			*
Sweden			*	*	*	*			*
Switzerland	*		*	*	*	*	*	*	
Turkey	*				*				
United K	*	*	*	*	*	*	*	*	*

* = present.
[Sweden = Stockholm County; United Kingdom=England]

Provision of treatment

Responses ranged from 6 to 32 (mean 20.1, SD=7.6), with Denmark, England and France having the highest scores, Figure 4.
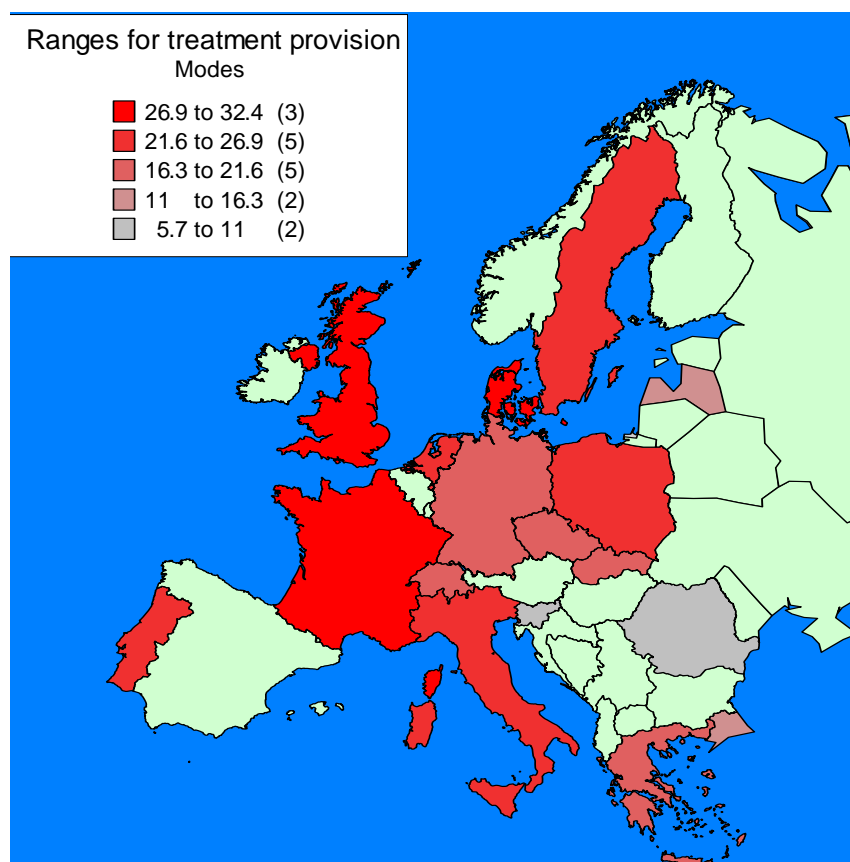
Figure 4 Treatment provision scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

Smoking cessation help was obtainable from general practice in 14 countries, from pharmacists in 13 countries, from community clinics in 8 countries and from telephone counselling in 13 countries, Table 4. Help from all four sources was available in seven countries. NRT 4mg gum was available in general stores (for example, supermarkets) in 3 countries, on prescription in 4 countries and could be advertised in television in 16 countries, Table 5. Bupropion was not available in general stores in any country, was available on prescription in 17 countries and could be advertised on television in one country. The costs of treatment were fully covered for NRT 4mg gum in 1 country, for bupropion in no countries, for brief counselling in 7 countries, and for intensive counselling in four countries, Table 6.

Table 4 Treatment provision, obtainable help for smoking cessation, selected items.

Smoking cessation help is obtainable from:				
	General/Family practice	Pharmacists	Community based clinics	Telephone counselling
Cyprus				∗
Czech Rep		∗		
Denmark	∗	∗	∗	∗
Germany	∗	∗	∗	∗
Greece	∗	∗		∗
France	∗	∗		∗
Italy	∗	∗	∗	∗
Latvia		∗		∗
Netherlands	∗	∗	∗	∗
Poland	∗	∗	∗	∗
Portugal	∗	∗	∗	∗
Romania				
Slovak Rep	∗		∗	
Slovenia	∗			
Sweden	∗	∗		∗
Switzerland	∗	∗		∗
Turkey	∗			
United K	∗	∗	∗	∗

∗ = yes
[Sweden = Stockholm County; United Kingdom=England]

Table 5 Treatment support, availability and advertising of selected pharmacological treatments.

NRT 4mg gum and Bupropion is available from and can be advertised on TV:						
	NRT 4mg			Bupropion		
	General sale	Prescription	TV advertising	General sale	Prescription	TV advertising
Cyprus			∗			
Czech Rep			∗		∗	
Denmark	∗		∗		∗	
Germany			∗		∗	
Greece			∗		∗	
France		∗	∗		∗	∗
Italy					∗	
Latvia			∗		∗	
Netherlands	∗	∗	∗		∗	
Poland			∗		∗	
Portugal			∗		∗	
Romania			∗		∗	
Slovak Rep		∗	∗		∗	
Slovenia			∗		∗	
Sweden			∗		∗	
Switzerland			∗		∗	
Turkey					∗	
United K	∗	∗	∗		∗	

∗ = yes
[Sweden = Stockholm County; United Kingdom=England]

Table 6 Treatment support, costs free of charge of selected items.

The costs of the following are free of charge or fully reimbursed				
	NRT 4mg	Bupropion	Brief counselling	Intensive counselling
Cyprus				
Czech Rep				
Denmark			∗	
Germany				
Greece				
France	∗		∗	
Italy				
Latvia				
Netherlands				
Poland			∗	
Portugal				
Romania				
Slovak Rep			∗	∗
Slovenia				
Sweden				∗
Switzerland			∗	
Turkey			∗	∗
United K			∗	∗

∗ = yes.
[Sweden = Stockholm County; United Kingdom=England]

Health care providers
Responses ranged from 2 to 33 (mean 17.3, SD=9.4), with England, Poland, Netherlands, and Sweden having the highest scores, Figure 5.
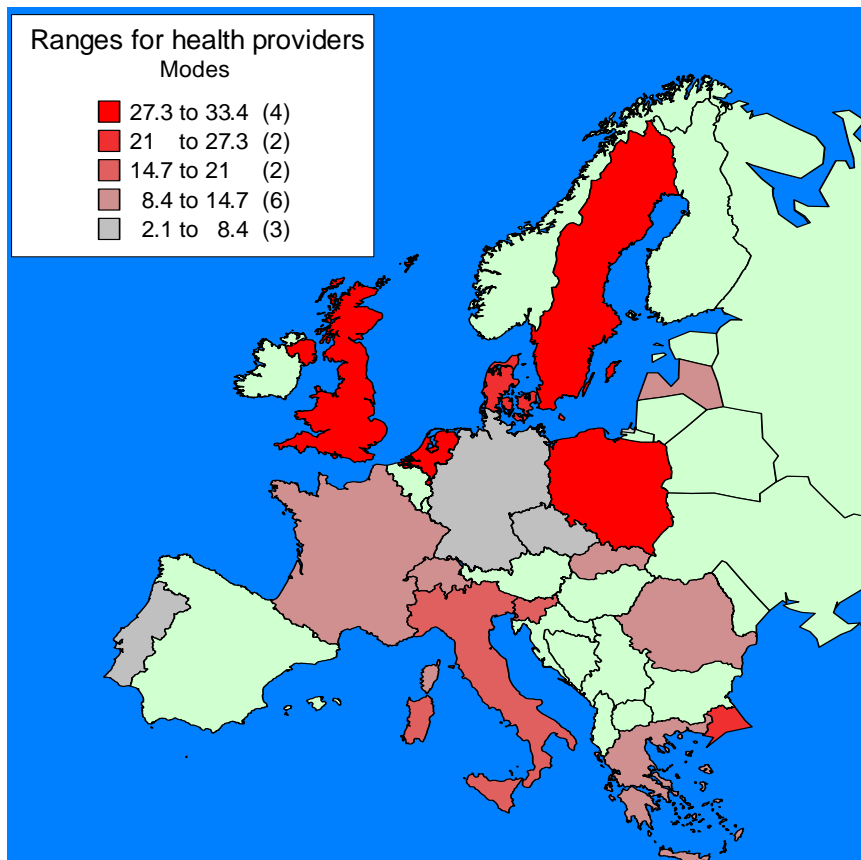
Figure 5 Health providers scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

The extent to which treatment providers considered smoking cessation advice as a part of their routine clinical practice is estimated on a ten-point scale from 0, not at all to 10, fully in Table 7. Of ten support systems, the quality of treatment provided had been measured for seven systems in two countries, for six systems in two countries, and for 5 systems in two countries, Table 8.

Table 7 Clinical accountability.

To what extent do you estimate on a ten-point scale that treatment providers consider smoking cessation advice as a part of their routine clinical practice, from 0, not at all to 10, fully?									
	GP or Family Doctors	Nurses working in general practice	Pharmacists	Midwives	Dentists	Oncologist	Cardiologist	Lung physician	ENT	Paediatrician
Cyprus	7	5	5	5	5	8	9	9	6	8
Czech Rep	2	1	4	2	4	5	5	4	4	2
Denmark	9	9	9	6	6	4	8	9	4	6
Germany	3	1	2	2	2	4	5	8	2	4
Greece	6	4	4	6	6	7	7	7	7	7
France	5	3	8	4	1	3	5	8	5	2
Italy	5	1	5	7	1	8	6	9	4	7
Latvia	2	1	3	5	3	5	5	6	3	5
Netherlands	6	7	3	6	6	6	7	9	5	5
Poland	7	7	3	6	5	8	7	8	6	6
Portugal	9	Did not answer								
Romania	6	2	3	1	7	6	8	9	7	6
Slovak Rep	5	1	1	3	1	8	8	10	8	3
Slovenia	4	3	2	1	3	4	4	6	4	2
Sweden	8	9	6	9	0	4	2	4	4	5
Switzerland	Did not answer									
Turkey	2	2	2	2	3	5	5	9	4	5
United K	8	8	8	7	3	5	7	8	3	2

[Sweden = Stockholm County; United Kingdom=England]

Table 8 Treatment support, measures of quality available.

Have there been any studies, surveys or publications on the following or similar outcomes in primary health care?	Patients screened	Advised to quit	Assessed Willingness to quit	Assisted with quitting	Quality treatment	Protocols followed	Pharmacotherapy recommended	Abstinence assessed	Followed-up	Smokers stopped in last year
Cyprus										
Czech Rep										
Denmark	∗	∗		∗						
Germany										
Greece										
France										
Italy		∗								∗
Latvia										
Netherlands	∗	∗	∗	∗		∗	∗		∗	
Poland	∗	∗		∗		∗	∗			∗
Portugal										
Romania										
Slovak Rep										
Slovenia	∗	∗		∗			∗			
Sweden		∗		∗	∗		∗		∗	∗
Switzerland	∗	∗	∗	∗			∗			
Turkey	∗	∗	∗						∗	∗
United K	∗	∗		∗			∗	∗	∗	∗

∗ = yes
[Sweden = Stockholm County; United Kingdom=England]

Health care users

Responses ranged from 6 to 35 (mean 17.3, SD=8.9), with England and Poland having the highest scores, Figure 6.
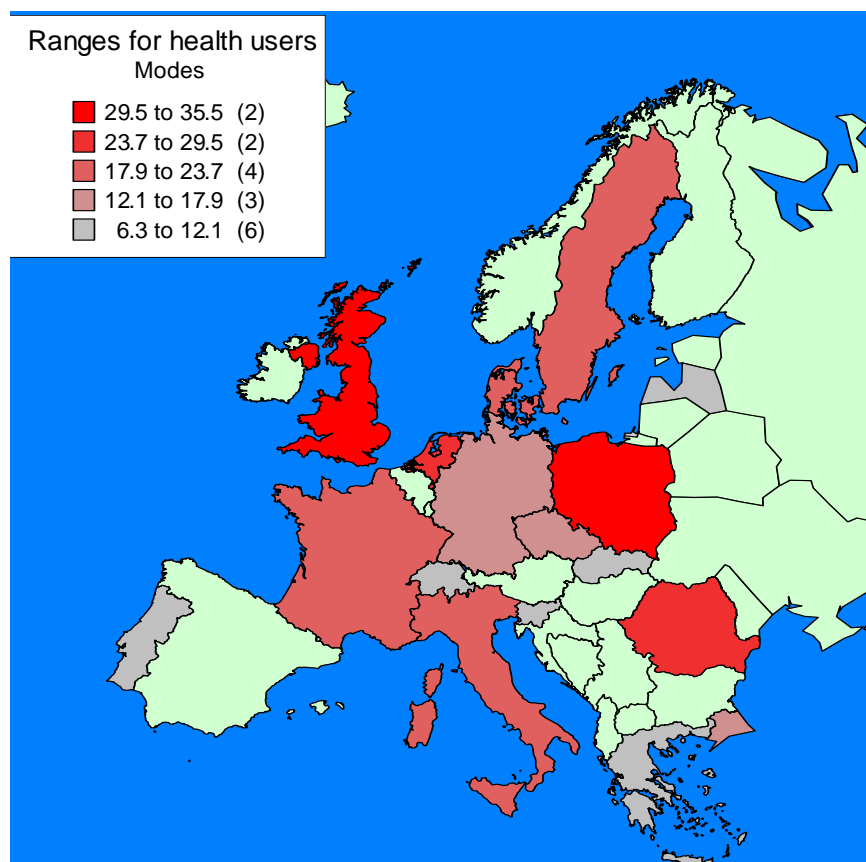
Figure 6 Health users scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

Public education campaigns providing information about why smokers should quit had been undertaken during the previous two years on TV in 14 countries, on radio in 13 countries, and in newspapers in 15 countries, Table 9. Public education campaigns providing information on how to quit had been undertaken during the previous two years on TV in 9 countries, on radio in 9 countries, and in newspapers in 11 countries. Only two countries had undertaken surveys on the use of help from 4 out of 6 sources, Table 10. Fifteen countries had undertaken surveys measuring the prevalence of current smokers, 8 had undertaken surveys measuring plans to quit, and 3 had undertaken surveys measuring successful quitting.

Table 9 Public education campaigns on TV, radio and in newspapers in previous 2 years providing information about why smokers should quit smoking or providing information on how to quit.

	TV		Radio		Newspaper	
	Why	How	Why	How	Why	How
Cyprus	∗		∗		∗	
Czech Rep	∗		∗	∗	∗	∗
Denmark		∗	∗		∗	
Germany	∗		∗		∗	
Greece	∗		∗		∗	∗
France	∗	∗	∗	∗	∗	∗
Italy	∗	∗	∗	∗	∗	∗
Latvia	∗		∗		∗	
Netherlands	∗	∗		∗		∗
Poland	∗	∗	∗	∗	∗	∗
Portugal					∗	
Romania	∗	∗	∗	∗	∗	∗
Slovak Rep	∗		∗		∗	∗
Slovenia			∗	∗		
Sweden	∗	∗			∗	∗
Switzerland						
Turkey	∗	∗		∗	∗	∗
United K	∗	∗	∗	∗	∗	∗

∗ = yes
[Sweden = Stockholm County; United Kingdom=England]

Table 10 Health care users, surveys measuring selected items.

	Surveys undertaken measuring help obtained from:						Surveys measuring:		
	doctor	nurse	pharmacist	dentist	NRT products	Bupropion	current smokers	considering to quit	successfully quit
Cyprus	*								
Czech Rep	*						*	*	
Denmark	*		*		*	*	*	*	
Germany						*	*	*	
Greece							*		
France							*	*	
Italy							*		
Latvia									
Netherlands						*	*	*	
Poland	*		*		*		*	*	*
Portugal							*		
Romania							*	*	
Slovak Rep							*		*
Slovenia							*		
Sweden	*				*		*		*
Switzerland					*		*	*	
Turkey	*					*			
United K	*		*		*	*	*		

* = yes.
[Sweden = Stockholm County; United Kingdom=England]

Overall results
The overall scale ranged from 49 to 167 (mean 94.5, SD=33.2), with England and Poland having the highest scores, Figure 7.
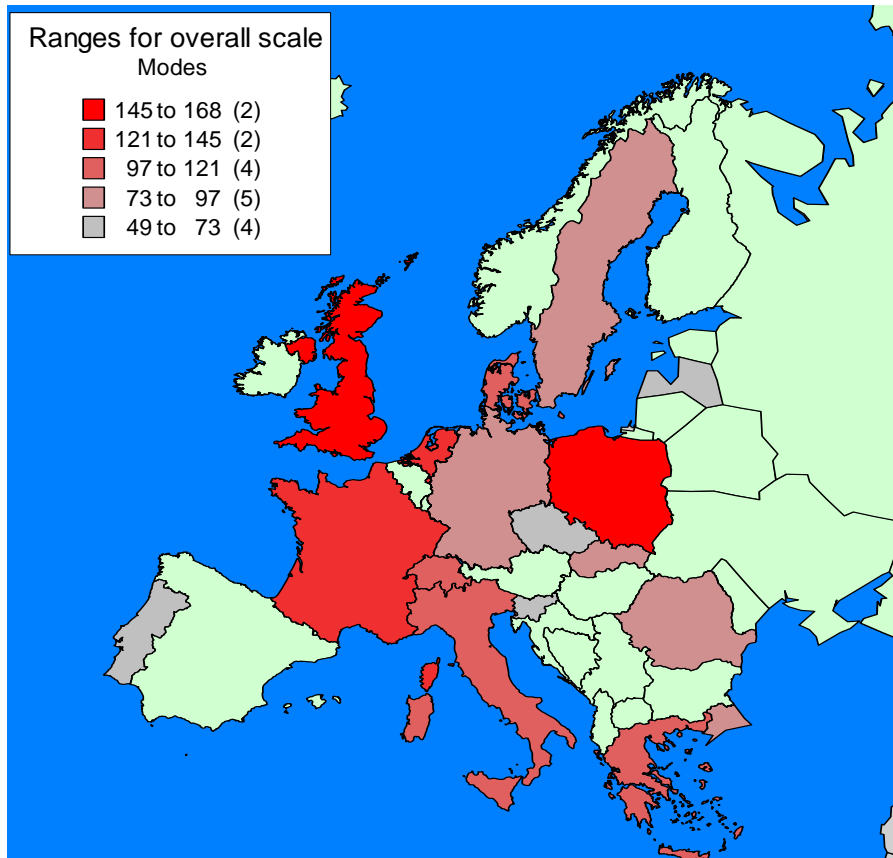
Figure 7 Overall scale.
[SPSS maps do not separate Cyprus from Greece, and only show the north-western tip of Turkey]
[Sweden = Stockholm County; United Kingdom=England]

The contribution of each of the subscales to the overall scale is shown in Figure 8.

There were significant correlations between the treatment support scale and the treatment provision scale (correlation = 0.77, p<0.001) and between the health providers and the health users scale (correlation = 0.70, p<0.001).

The reliability analysis of the overall scale as measured by Cronbach's alpha was 0.77. There was no evidence that the different sub-scales contributed unequally to the overall scale (analysis of variance, Cochran's Q= 3.24, p=0.52), and the intraclass correlation coefficients were highly reliable (average measure =0.77, 95% CI= 0.55-0.90, p<0.0001).

T-tests found no differences between the mean scores of any of the sub-scales.
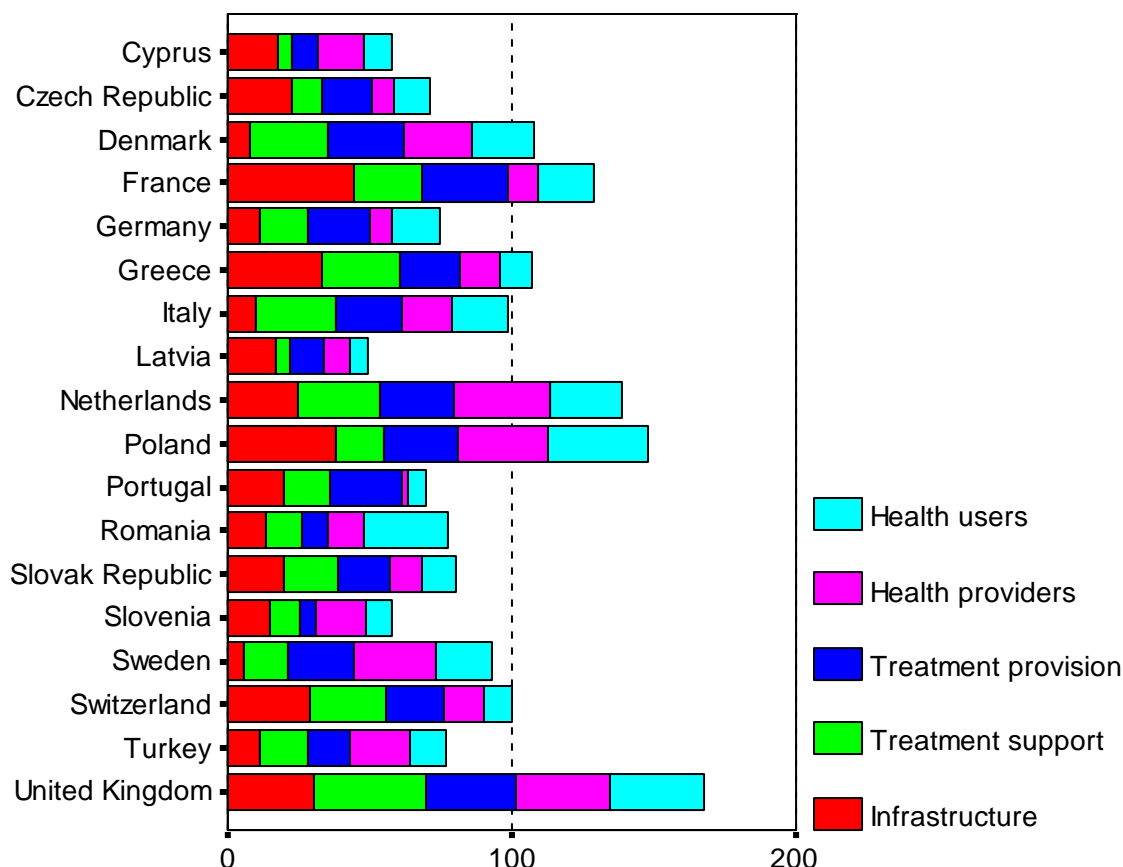
Figure 8 Contribution of sub-scales to overall scale.
[Sweden = Stockholm County; United Kingdom=England]

DISCUSSION

Methodological considerations
The tool is requesting information on the availability of services for the treatment of tobacco dependence. Since, there is often no objective alternative source of this information, the validity of the answers cannot always be guaranteed. Further, there is no agreed gold standard of what overall identifies a good or acceptable service for the treatment of tobacco dependence. Thus, based on the responses, it can be difficult to conclude whether or not the existing service is acceptable or of a high standard.

Main findings
The tool has provided an overall assessment of the availability of services for smoking cessation in 18 European countries. It found that activity was available, to a varying extent across countries, in all five of the sub-scales, infrastructures for treatment, support for providing treatment, treatment provision itself, activities of health care providers, and knowledge of health care users, with no evidence for any one of the sub-scales being overall deficient.

Next steps
Since, within countries the knowledge of the available services for the treatment of tobacco can vary according to the respondent completing the questionnaire, it could be recommended that different professionals should answer different parts of the assessment

tool to provide as much accurate information as possible. This could be achieved, as was done by a number of countries, by creating a coalition of professionals that share information on tobacco issues and resolve disagreements on responses to items where these occur. This coalition could benefit from a country-based database that would compile the information needed to define an effective service for the treatment of tobacco dependence.

The tool can be seen as a facilitating tool that can help to map health services at the policy and environmental levels as well as at the more specific treatment provision and health services structural levels. However it is important that the tool is used in a staged process and completed by different professionals from different backgrounds. All the information could be systematized in a national or regional database that would set out profiles of the country situation and provide recommendations for treatment improvement. The tool can form a baseline measure of services for treatment of tobacco dependence. Completion of the tool on a yearly or two yearly basis would enable the monitoring of improvement or lack of improvement of treatment services for tobacco dependence and the achievement of the long term goals of article 14 of the framework convention on tobacco control.

REFERENCES

1. Doll, R., Peto, R., Wheatley, K., Gray, R., Sutherland, I. Mortality in relation to smoking: 40 years' observations on male British doctors. British Medical Journal 1994; 309: 901-911.

2. Peto, R., Lopez, A.D., Borehma, J. & Thun, M. (2003). Mortality from smoking in developed countries 1950-2000. www.ctsu.ox.ac.uk/~tobacco/

3. Peto, R., Darby, S., Deo, H., Silcocks, P., Whitley, E and Doll, R. Smoking, smoking cessation, and lung cancer in the UK since 1950: combination of national statistics with two case-control studies. British Medical Journal 2000 321 323-329.

4. World Bank (1999). Curbing the Epidemic. Governments and the Economics of tobacco control. Washington: World Bank. www.wordlbank.org

5. Eriksen, M.P. (2000). Best practices fro comprehensive tobacco control programs: opportunities for managed care organizations. Tobacco Control 2000 9 (suppl I) 11-14.

6. World Health Organization (2000). European recommendations on the treatment of tobacco dependence. Copenhagen, WHO Regional office for Europe.

7. Sutherland, G. (2003) Evidence for counselling efficacy. Journal of Clinical Psychiatry 18 22-34.

8. Fagertsron, K. (2003) The endurance of pharmacological efficacy. Journal of Clinical Psychiatry 18 35-40.

9. Cromwell J, Bartosch WJ, Fiore MC, et al. Cost-effectiveness of the clinical practice recommendations in the AHCPR guideline for smoking cessation. JAMA 1997; 278: 1759-1766.

10. Warner KE. Cost-effectiveness of smoking cessation therapies: interpretation of the evidence and implications for coverage. Pharmacoeconomics 1997; **11**: 538-549.

11. Parrott, S., Godfrey, C., Raw, M. et al. Guidance for Commissioners on the Cost Effectiveness of Smoking Cessation Interventions. Thorax 1998; 53 (suppl 5, Part2) S1-S38.

12. Parrott, S. and Godfrey, C. (2003) The Cost Effectiveness of Smoking Cessation Services. Journal of Clinical Psychiatry 18 50-57.

13. van Reenen, H.H., Feenstra, T.L., Hoogenveen, R.T., & Rutten-vanMölken, M.P.M.H. (2003). Cost-effectiveness of smoking interventions in the Netherlands: a modelling study. Rotterdam: Institute for Medical Technology Assessment, Erasmus Medical Center.

14. Lightwood JM, Glantz SA. Short-term economic and health benefits of smoking cessation. Circulation 1997;96:1089.96.

15. Lightwood JM, Phibbs CS and Glantz SA. Short-term health and economic benefits of smoking cessation: low birth weight. Pediatrics 1999; 104: 1312-1320.

16. Möller, A.M., Villebro, N., Pederesn, T. et al. (2002). Effect of preoperative smoking cessation on postoperative complications: a randomized clinical trial. Lancet 359 114-117.

17. Institute of Medicine (2001). Clearing the Smoke. Assessing the science base for tobacco harm reduction. Washington, D.C., National Academy Press. www.iom.edu.

18. Tonstad, S. (2003) Analysing the benefits and risks of tobacco cessation treatments. Journal of Clinical Psychiatry 18 41-49.

19. Raw, M., McNeill, A. and West, R. Smoking cessation guidelines for health professionals. Thorax 1998 53 (Suppl 5, Part 1) S1-S18.

20. West, R., McNeill, A. and Raw, M. Smoking cessation guidelines for health professionals: an update. Thorax 2000 55 987-999.

21. Fiore, M.C., Bailey, W.C., Cohen, S.J. et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

22. Kwaliteitsinstituut voor de Gezondheidszorg CBO (2003). Conceptrichtlijn behandeling van tabaksverslaving. Utecht, CBO.

23. World Health Organization (1992). The ICD-10 Classification of mental and behavioral disorders. Geneva, World Health Organization, www.who.int.

24. World Health Organization (2003). WHO Framework Convention on Tobacco Control. http://www.who.int/gb/fctc/

25. Sackett, D.L., Straus, S., Richardson, W.S., Rosenberg, W. & Haynes, R.B. (2000). Evidence-Based Medicine: How to Practice and teach EBM. London: Churchill Livingstone.

26. Gray, J.A.M. (2001). Evidence-based Health Care. London: Churchill Livingstone.

27. Evidence-Based Health Care Tool Box (2003). http://www.shef.ac.uk/~scharr/ebhc/intro.html

28. Blanke, D. Ed. (2003). Tobacco Control Legislation. Geneva: World Health Organization.

29. Hafey, O., Dolwick, S. & Guindon, G.E. (2003). Tobacco Control Country Profiles. Atlanta, Georgia, US: American Cancer Society.

30. World Health Organization (2003). WHO European Country Profiles on Tobacco Control. Copenhagen: World Health Organization Regional Office for Europe.

31. World Health Organization (2000). Report of the second WHO European meeting on evidence-based treatment of tobacco dependence. Copenhagen: World Health Organization Regional Office for Europe.

32. World Health Organization. (2000). Second Conference on the regulation of tobacco dependence treatment products. Copenhagen, World Health Organization Regional office for Europe.

33. World Health Organization (2001). Regulation of nicotine replacement therapies: an expert consensus. Copenhagen, WHO Regional office for Europe.

34. World Health Organization (2002). Reducing Risks, Promoting Healthy Life. World Health Report 2002. Geneva, World Health Organization. www.who.int.

35. World Health Organization (2003). Policy recommendations for smoking cessation and treatment of tobacco dependence. Geneva, World Health Organization.

36. World Health Organization (2003). WHO European Strategy for Smoking Cessation. Copenhagen, World Health organization Regional Office for Europe.

THE ASSESSMENT TOOL

A tool to assess the available services for smoking cessation[2]

at the country or regional level

This tool has been designed to assess the available services for smoking cessation at the country or regional level.

Within each country or region, it is suggested that one person is nominated for ensuring that the tool is completed and returned.

It is suggested that the tool is completed by country or regional coalitions or partnerships that are set up to support the development of services for smoking cessation. If no such coalition or partnership exists, it is suggested that a coalition is formed, with its first task to complete the tool. The tool can also be completed through meetings with individual experts. The tool can be divided into separate sections for different experts to complete. Certain questions require opinion or expert judgement; in this case, consensus can be achieved at meetings of coalitions or partnerships.

The tool:

> Provides a baseline measurement of services for smoking cessation, identifying areas where services may require development or strengthening;
> Provides a mechanism for monitoring service provision over time;
> Provides a mechanism to monitor implementation of Article 14 on smoking cessation of the framework convention on tobacco control (http://www.who.int/gb/fctc/PDF/inb6/einb62.pdf);
> Allows sharing of information and examples of practice between countries and regions; and
> Provides a mechanism for coalitions or partnerships to discuss and have a shared view on smoking cessation services.

Certain questions of the tool ask respondents to provide document and organizational references. When asked to do so please complete the attached document and organization reference templates, a separate template for each document and organization.

Completion of the tool[3]

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[2] Smoking cessation is the term used throughout this tool. It is synonymous with tobacco dependence treatment, which, as defined by the World Health Organization, includes (singly or in combination) behavioural and pharmacological interventions such as education, brief counselling and advice, intensive support, administration of pharmaceuticals or other interventions that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole.

It is preferable that you complete the tool electronically as a word document.

Within the tool there are text boxes. Just place the cursor in the text box and type. (Pressing the tab key moves you from box to box). You can also cut text from other documents and paste them into the text boxes. There are no limits to the size of the text boxes.

Within the tool, there are check boxes. Just place the cursor in the check box that you want to mark and left click the mouse. If you want to correct the check box, just left click the mouse again.

Where data is not available, please do not collect or estimate it, but mark that it is not available. Where the answer is not known, please indicate this in the extra comments box that is placed after each question.

The timetable is that the tool should be completed and returned to Peter Anderson by e-mail by 31st December 2004: pdanderson@compuserve.com. It is preferable to return the form if it is 90% to 95% completed, rather than waiting for it to be 100% completed.

If you have any queries, please contact Peter Anderson by e-mail.

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[3] The tool was first developed in 2003 by Eva Jané-Llopis, Peter Anderson and Annelies Jacobs of the Centre for Quality of Care Research, of the University Medical Centre of Nijmegen, for the Dutch Partnership Project on Smoking Cessation. It has been revised in 2004 for the European Commission funded Health Professionals Project, with assistance from Hans Storm and Inge Haunstrup Clemmensen of the Danish Cancer Society and the partners of the Project.

THE ASSESSMENT TOOL

A tool to assess the available services for smoking cessation
at the country or regional level

Please cross the box, place a cross in the table or type your answer where indicated.

PART I

Personal details of contact person for completion of tool

Name:

Organization and position:

Address (name and number of street, postal code, town):

Telephone:

Fax:

Email:

Website:

Country:

If you are answering for a jurisdictional[4] region rather than a country as a whole, which jurisdictional region is it?

Please note: unless you state otherwise in the tool, it will be assumed, if you are completing the questionnaire for a jurisdictional region other than a country, that all your answers are for this jurisdictional region.

Population size of the country/region:

Date of completing the tool (dd-mm-yy):

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[4] Such a jurisdictional region could be a region within a country or a municipality

Is there a country-wide or region-wide formal or informal smoking cessation coalition or partnership?

☐ Yes
☐ No

If yes:

What is the name of the coalition?

When was it established?

Please describe the aim of the coalition in one sentence:

Please provide a separate word document listing the members of the coalition or partnership, including the following information:

Name of member organization or individual:

One sentence description of organization or individual: (e.g. "national scientific body representing general practitioners", or "recognized expert")

PART II

A. LEGISLATIVE MEASURES

This section will provide the completed country specific WHO European profiles of tobacco control, and the completed country specific profiles of the ENSP project on tobacco control policies as attachments. The files will be sent separately and at a later date.

Respondents will be asked to check and update the data, and provide an assessment of implementation and enforcement.

There is no need to do anything at present.

If completing for a region, please state when the answers apply for the country and not the region

B. COMMUNITY ACTION AND MEDIA EDUCATION

1. What is the percentage of health professionals in your country or region who smoke?

	% who are daily smokers **Please write NO, if information not available**	Date of survey	Please provide filename for document reference (and complete document reference template)
1.1. Doctors overall			
1.2. Nurses overall			
1.3. General practitioners			
1.4. Nurses in general practice			
1.5. Nurses in general hospitals			
1.6. Pharmacists			
1.7. Midwives			
1.8. Dentists			
1.9. Oncologists			
1.10. Cardiologists			
1.11. Lung physicians			
1.12. Surgeons			
1.13. Gynaecologists			

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

2. Have there been public education campaigns implemented in your country or region in the past 24 months in the listed media that provide information about why smokers should quit smoking, or provide information on how to quit? If so, were they publicly funded?

	Provide information about why smokers should quit smoking	Provide information on how to quit	Were the campaigns publicly funded		
			Fully	Partial	No
Television	☐	☐	☐	☐	☐
Radio	☐	☐	☐	☐	☐
Newspapers and magazines	☐	☐	☐	☐	☐
Billboards	☐	☐	☐	☐	☐
Other (please state)	☐	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

C. HEALTH CARE INFRASTRUCTURE

Integrated health care system

3.   Would you say that smoking cessation is integrated in the health care system, including co-operation or relationships between primary health care and secondary health care, similar to that for other chronic diseases such as asthma?

☐ Yes, widely

☐ Yes, partially

☐ No

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Structures for quality of care

4. For each topic in the table, is there a formal governmental organization, or organization appointed or contracted by the government that:

	Yes	No	If yes, please provide filename for organizational reference (and complete organization reference template)
4.1. Licenses drugs for smoking cessation?	☐	☐	
4.2. Has the responsibility of preparing clinical guidelines for smoking cessation?	☐	☐	
4.3. Monitors health outcomes at the population level from smoking cessation?	☐	☐	
4.4. Monitors the quality of care provided for smoking cessation?	☐	☐	
4.5. Reviews the cost effectiveness of smoking cessation interventions?	☐	☐	
4.6. Can deal with cases of clinical negligence in smoking cessation (like clinical negligence in other areas of medicine, such as failing to diagnose and treat tuberculosis)l?	☐	☐	
4.7. Reviews the safety of pharmacological treatments for smoking cessation?	☐	☐	
4.8. Provides information on smoking cessation to health care providers?	☐	☐	

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Research and knowledge for health

5. Is there a formal research programme for smoking cessation with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the tobacco industry)?

☐ Yes, from governmental organizations

☐ Yes, from government appointed organizations

☐ Yes, from non-governmental organizations

☐ No

Please add any extra comments here

6. Is education on smoking cessation formally part of the curriculum of undergraduate/basic professional training of the following health care providers?

	Undergraduate/ basic professional training		Postgraduate professional training		Continuing medical education	
	Yes	No	Yes	No	Yes	No
Medical students	☐	☐	☐	☐	☐	☐
Nursing students	☐	☐	☐	☐	☐	☐
Pharmacy students	☐	☐	☐	☐	☐	☐
Dentistry students	☐	☐	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Health care policies and strategies for smoking cessation

7. Are there official written policies on smoking cessation from the Government or Ministry of Health? Please mark all that apply:

☐ Yes, a governmental written stand alone policy on smoking cessation

☐ Yes, a governmental written policy on smoking cessation which is part of an overall tobacco control policy

☐ No, but there is a governmental policy on smoking cessation in preparation

☐ No, there are no governmental policies on smoking cessation

If yes,

Please give filename for document reference:
(and complete document reference template)

Please add any extra comments here

8. If available, the governmental policy on smoking cessation includes:

	Yes	No
A strategy on training for health professionals	☐	☐
A national funded research strategy for smoking cessation	☐	☐
A strategy to support interventions by primary care professionals	☐	☐
Intensive support for smoking cessation in specialised treatment facilities	☐	☐
A position on promoting the use of pharmaceutical products	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Structures to manage the implementation of treatment within health services

9. Is there an identified person within the Department of Health or Government, or who is contracted by the Department of Health or Government, who oversees or manages smoking cessation services?

☐ Yes

☐ No

Please provide his/her contact details:

Name:

Organization and position:

Address:

Telephone:

Email:

Website:

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Funding health services and allocating resources

10.   Is there government funding for services for smoking cessation?

☐ Yes

☐ No

If no,

☐ Funding is being prepared

11.   Is the amount of funding reviewed from time to time?

☐ Yes

☐ No

☐ Do not know

If yes,

☐ Annually reviewed

☐ Reviewed every 2 to 5 years

☐ Reviewed every 5 years or longer

☐ Other (please specify):

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

12. Is a proportion of tobacco taxes specifically earmarked or allocated (this means hypothecated) to fund the costs of smoking cessation services?

☐ Yes

☐ No

13. If yes, please state the proportion:

14. Is yes, is the money raised from the tax actually spent on the costs of smoking cessation services?

☐ Yes

☐ No

15. Is the proportion of tax allocated for smoking cessation services reviewed from time to time?

☐ Yes

☐ No

If yes,

☐ Annually reviewed

☐ Reviewed every 2 to 5 years

☐ Reviewed every 5 years or longer

☐ Other (please specify):

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

D. SUPPORT FOR TREATMENT PROVISION

Screening, quality assessment, referral and follow-up systems

16. In your opinion, are the following screening and support systems available for health care providers in smoking cessation?

	Available in general practice			Available in hospitals		
	Yes, widely	Yes, partially	No	Yes, widely	Yes, partially	No
Screening instruments to identify smoking status	☐	☐	☐	☐	☐	☐
Case notes or computer records to record smoking status	☐	☐	☐	☐	☐	☐
Protocol charts or diagrams as an aid for smoking cessation	☐	☐	☐	☐	☐	☐
Support by facilitators or advisors for smoking cessation	☐	☐	☐	☐	☐	☐
Systems to follow-up patients for monitoring and treatment	☐	☐	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Protocols and guidelines

17. Are there multidisciplinary clinical guidelines for smoking cessation in your country/region that have been approved or endorsed by at least one health care professional body?

☐ Yes

☐ No

If yes:

☐ Stand alone guidelines for smoking cessation

☐ Part of other clinical care guidelines (e.g. asthma guidelines)

If yes, please provide filename for document reference(s):
(and complete document reference template(s))

If no:

☐ Guidelines are being prepared

Please add any extra comments here

18. If there are endorsed clinical guidelines for smoking cessation, have there been any studies in your country on their implementation or adherence?

☐ Yes

☐ No

If yes, please provide filename for document reference(s):
(and complete document reference template(s))

If no:

☐ Studies are being prepared

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

19. Are the following health care providers reimbursed for smoking cessation, or is smoking cessation within their terms of service (contract) and part of their normal salary?

	Reimbursed for providing smoking cessation		Smoking cessation within terms of service and part of normal salary	
	Yes	No	Yes	No
General practitioners	☐	☐	☐	☐
Nurses working in general practice	☐	☐	☐	☐
Doctors in hospital	☐	☐	☐	☐
Nurses in hospitals	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐
Dentists	☐	☐	☐	☐
Addiction specialists	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

20. For the following professional groups, are there specialized guidelines or protocols, a written policy on smoking cessation by the professional association, smoking cessation training within professional vocational education and smoking cessation training within accredited continuing medical education?

For the following professional groups, are there the following for smoking cessation:								
	Specialized guidelines or protocols		Written policy on smoking cessation by professional association		Smoking cessation training within professional vocational training		Smoking cessation training within accredited continuing medical education	
	Yes	No	Yes	No	Yes	No	Yes	No
General practitioners	☐	☐	☐	☐	☐	☐	☐	☐
Nurses in general practice	☐	☐	☐	☐	☐	☐	☐	☐
Nurses in general hospitals	☐	☐	☐	☐	☐	☐	☐	☐
Specialist nurses	☐	☐	☐	☐	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐	☐	☐	☐	☐
Midwives	☐	☐	☐	☐	☐	☐	☐	☐
Dentists	☐	☐	☐	☐	☐	☐	☐	☐
Oncologists	☐	☐	☐	☐	☐	☐	☐	☐
Cardiologists	☐	☐	☐	☐	☐	☐	☐	☐
Lung physicians	☐	☐	☐	☐	☐	☐	☐	☐
Ear, nose and throat specialists	☐	☐	☐	☐	☐	☐	☐	☐
Internal medicine specialists	☐	☐	☐	☐	☐	☐	☐	☐
Surgeons	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatrists	☐	☐	☐	☐	☐	☐	☐	☐
Counsellors in specialist services	☐	☐	☐	☐	☐	☐	☐	☐
Telephone quit line counsellors	☐	☐	☐	☐	☐	☐	☐	☐
Counsellors in community clinics	☐	☐	☐	☐	☐	☐	☐	☐
Obstetricians	☐	☐	☐	☐	☐	☐	☐	☐
Paediatricians	☐	☐	☐	☐	☐	☐	☐	☐
Addiction specialists	☐	☐	☐	☐	☐	☐	☐	☐
General/national that cover all disciplines	☐	☐	☐	☐	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

E. INTERVENTION AND TREATMENT

Availability and accessibility

21. In your opinion, is patient help for smoking cessation available and obtainable (obtainable means that patients can get the help) in the following settings?

Smoking cessation is available and obtainable:	Available in:			Obtainable from:		
	Yes, widely	Yes, partially	No	Yes, easily	Yes, with some difficulty	No
General/family practice	☐	☐	☐	☐	☐	☐
Hospital clinics	☐	☐	☐	☐	☐	☐
Work places	☐	☐	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐	☐	☐
Specialist clinics	☐	☐	☐	☐	☐	☐
Addiction services	☐	☐	☐	☐	☐	☐
Community based clinics	☐	☐	☐	☐	☐	☐
Dentists	☐	☐	☐	☐	☐	☐
Schools	☐	☐	☐	☐	☐	☐
Prisons	☐	☐	☐	☐	☐	☐
Telephone quit-lines	☐	☐	☐	☐	☐	☐
Country or regional internet sites	☐	☐	☐	☐	☐	☐

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

22. Are the following products licensed for use? In what way are they available and, can they be advertised on the television?

Are these products licensed and available from:	Licensed for use?			General sale (e.g. in supermarkets)			From pharmacies (over the counter)			Doctors' prescription			Can be advertised on television		
	Yes	No	Plan to do so	Yes	No	Plan to do so	Yes	No	Plan to do so	Yes	No	Plan to do so	Yes	No	Plan to do so
NRT 2 mg gum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT 4 mg gum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT Patch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT Sub-lingual tablet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT Lozenge	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT Inhaler	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NRT Nasal spray	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bupropion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other pharmaceuticals (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other pharmaceuticals (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please add any extra comments here

Affordability

23. Are the costs of smoking cessation or the following pharmacological products available free of charge or fully reimbursed to users by the health care system or other third party payers (insurance companies)?

Smoking cessation advice and treatment is free of charge or fully reimbursed	Yes, totally	Yes, partially (indicate the proportion covered)	Only by paying the full cost	Plan to do so
NRT 2 mg gum	☐	☐	☐	☐
NRT 4 mg gum	☐	☐	☐	☐
NRT patch	☐	☐	☐	☐
NRT sub-lingual tablet	☐	☐	☐	☐
NRT lozenge	☐	☐	☐	☐
NRT inhaler	☐	☐	☐	☐
NRT nasal spray	☐	☐	☐	☐
Bupropion	☐	☐	☐	☐
Other pharmaceuticals (please specify)	☐	☐	☐	☐
Brief counselling interventions	☐	☐	☐	☐
Intensive counselling interventions	☐	☐	☐	☐

Please add any extra comments here

24. What is the unit cost in local currency (please state currency) for one 4mg piece of gum and one tablet of bupropion, and, if the information is available, what are the quantities sold (either in volume or in the costs of total sales) in your country/region

	Unit cost	Number of units sold (please state year)	Cost of total sales (please state year)
NRT 4 mg gum			
Bupropion			

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

25.   Are there specialist services (i.e., specialist or specialist clinic) for smoking cessation available in the country/region?

☐ Yes

☐ No

If yes,

☐ Only by referral

☐ Only by self-referral

☐ By both referral and self-referral

If yes, is it reimbursed for the patient?

☐ Yes

☐ No

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

F. HEALTH CARE PROVIDERS

Clinical accountability

26. To what extent do you estimate on a ten-point scale that treatment providers consider smoking cessation advice as a part of their routine clinical practice?

Advice is routine in clinical practice:	Not at all Fully
General practitioners/ Family doctors	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Nurses working in general practice	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Pharmacists	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Midwives	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Dentists	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Oncologists	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Cardiologists	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Lung physicians	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
ENT (ear, nose and throat) specialists	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Paediatricians	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

If there are any publications on this topic, please provide the filenames for the document reference(s) and complete the document reference template(s):

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Treatment provision

27. Have there been any studies, surveys or publications on the following or similar outcomes in primary health care (general practice/family practice), and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
Patients are asked or screened about their smoking status			
Smoking patients are given advice to quit			
Smoking patients are assessed their willingness to quit			
Smoking patients are assisted with quitting			
Treatment meets quality criteria			
Practice protocols are followed			
Pharmacological products are recommended			
Pharmacological products are prescribed			
Abstinence is assessed at the end of treatment			
Patients making a quit attempt are followed- up			
Smoking patients stopped in the last year			

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

G. HEALTH CARE USERS

Knowledge

28. Have there been any studies, surveys or publications that provide answers for the following or similar information concerning smoking and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
People know that smoking is dangerous to their health			
People know that living with someone who smokes increases their own risk for health problems			
People think that cigarette dependence is a behaviour that you can simply choose to stop (a habit)			
People think that cigarette dependence is a behaviour that is difficult to stop even when you want to (an addiction)			
People know about effective treatment methods			

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Treatment seeking behaviour

29. Have there been any surveys, studies, or publications which provide information on the proportion of smokers who have ever used one of the following methods to stop smoking and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
Help from a doctor			
Help from a nurse			
Help from a pharmacist			
Help from a dentist			
Help from friends or family			
NRT products overall			
Nicotine gum			
Nicotine patches			
Other nicotine products, such as lozenges, tablets, Inhaler or nasal spray			
Bupropion tablets			
Herbal remedies			
Hypnotherapy or acupuncture			
Leaflets, books, articles or videos on how to stop smoking			
Advice from the Internet			
Stop smoking competitions			
Stop smoking clinic or group			
Smoking help line telephone service			
Willpower alone			

Please add any extra comments here

If completing for a region, please state when the answers apply for the country and not the region

Smoking behaviour and intentions to quit

30. Have there been any surveys, studies, or publications which provide information on smoking status or intentions to quit, and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Definition of adult	Proportion of adults (%) who are	Please provide filename for document reference (and complete document reference template, one for each document)
Current smokers:				
Males				
Females				
Total				
Tobacco dependent smokers according to e.g. Fagerström score:				
Males				
Females				
Total				
Ex-smokers:				
Males				
Females				
Total				
Attempted to quit over a 1 year period				
Males				
Females				
Total				
Considering to quit in next 6 months				
Males				
Females				
Total				
Successfully quit for at least 1 year during last 2 years				
Males				
Females				
Total				

If there is data breaking down the above information in more detail by age or socio-economic group, please provide the data.

If completing for a region, please state when the answers apply for the country and not the region

Please add any extra comments here