

Tobacco cessation: The role of health professionals

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Tobacco use has been identified as the leading cause of preventable deaths in the world, giving rise to an estimated 5 million deaths per year. By the year 2020, this is expected to nearly double with 70% of the deaths occurring in the developing countries (1). To prevent the projected number of deaths, many attempts are being made by the World Health Organization (WHO) and the government bodies from the different parts of the world to curb the current smoking patterns. In South Africa, the Tobacco Products Control Amendment Act of 1999 was formulated and has resulted in the decreasing prevalence of smoking (2).

This paper discusses approaches to smoking cessation and proposes a context for action by all health care professionals. We suggest changing the social acceptability of smoking, strengthening community participation, integrating tobacco cessation with other healthcare services and specifying the role of healthcare professionals to increase tobacco use cessation.

Tobacco dependence as the basis for treatment

According to DiFranza and colleagues, smokers can be divided into three groups: a rapid onset group, a slow onset group and a resistance group. The rapid onset group are those who develop tobacco dependence immediately when they become monthly users (smoking at least 2 cigarettes within a two-month period, including daily smokers). The slow-onset group requires prolonged years of exposure to tobacco to become tobacco dependent while those in the resistance group smoke up to 5 cigarettes a day for many years but develop no dependence (3).

It should be noted that although not all smokers are dependent or addicted to nicotine, all tobacco users face significant health risks. Tobacco dependence is characterized by tolerance, cravings, feeling a need to use tobacco, withdrawal symptoms during periods of abstinence and loss of control over the amount or duration of use (4). As articulated in the recently adopted guidelines for the implementation of Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC) on treatment for tobacco dependence, nicotine dependence is indeed a chronic condition that needs to be treated. Tobacco dependence has been identified as one of the strongest predictors of successful attempts to quit (5). It is this dependence on tobacco, brought on by the addictive properties of nicotine and other ingredients in the various products, which makes quitting such a challenge (6). However, in addition to the biological effects of nicotine i.e. the physiological dependence, there are other elements of tobacco dependence that need to be addressed, namely the psychological aspects and behavioural pattern of tobacco use.

Tobacco cessation interventions

The understanding of tobacco dependence provides the basis for the three approaches to treatment namely: pharmacotherapy (addresses the physiological part), counselling (addresses the psychological aspects) and self-management (addresses the behavioural pattern associated with use). Pharmacotherapy used in tobacco cessation may include nicotine replacing (gum, lozenges, patches and nasal sprays) and non-nicotine therapy (tablets). Combination therapy may also be of use. Behavioural interventions include the 5 A's (see box below) and more intensive interventions such as motivational interviewing. Experiences have also shown that some of those who are highly dependent may also be more motivated to quit and those motivated to quit are more likely to be able to find solutions to their barriers to quitting and thus succeed in their attempt to quit.

5 A's of "brief advice"

- ASK about smoking
- ADVISE to quit
- ASSESS willingness to quit
- ASSIST to make quit attempt
- ARRANGE for discussing matter again at next visit

Suggested interventions by the health care system

Seeing as smoking is already prevalent among health professionals, any cessation strategy should attempt to reach these population groups first, so that they can serve as role models for others and also promote cessation services in the healthcare settings (7). Initiatives to increase awareness of the hazards of tobacco use to change the societal values towards tobacco may reduce the prevalence of smoking. In SA the law requires that manufacturers place warning labels on tobacco products packaging (8). This in turn may make tobacco socially unacceptable due to its known undesirable effects.

At the community level, smaller, cost effective efforts by community based organisations, clinics or health centres could promote smoking cessation by promoting a smoke free environment, providing social support to smokers as they try to quit and financing tobacco dependence treatments for those who cannot afford it (7). Decreasing out-of-pocket expenses for tobacco cessation may be more favourable towards tobacco users and render them more likely to quit.

What health professionals can do

Even though the most important factor among the determinants of quitting is for the individual to make a decision to quit or to have motivation to quit, in order to prevent relapse, a high level of determination to quit is needed (9). Self-effort alone, however, does not guarantee successful quitting; it has to be done alongside with counselling and / or pharmacotherapy (10). It is recommended that clinicians should counsel patients who use tobacco products on a regular basis (11).

Studies have shown that simple advice to quit smoking is an effective intervention; it is also one that can be effectively provided by a variety of health professionals (12). An attempt should be made to encourage health professionals of all types (dentists, pharmacists, physiotherapists, nurses etc) to identify tobacco users and provide brief advice to quit, in spite of the challenges imposed by the fragmented healthcare systems in these countries (7). Service providers and policy makers need to determine how to integrate brief cessation advice and more intensive cessation services and products within the health service delivery system in resource poor countries and how to encourage people to use these services. Hospitals may be a good setting in which to begin since patients receive treatment in a more systematic way in this setting.

Clinical smoking cessation interventions are strong in the US. However, the US experience suggests that targeted smoking cessation clinics are not well used and have limited impact (13). Integrating smoking cessation into other healthcare programmes such as tuberculosis, HIV/AIDS, cancer control, cardiovascular disease control, or family planning and maternal health may be more feasible and cost effective (14). Providing smoking cessation services such as counselling, medication, education materials, and follow up arrangements in the same way as interventions for other chronic diseases (15) may be a way of integrating treatment for smoking into the general delivery of health care. This would also form a basis for partnerships between the health practitioners in the public and private sectors.

In conclusion, tobacco cessation, as a component of tobacco control, is essential to improve population health. Integrating brief counselling into other healthcare services (such as maternal and child health, tuberculosis and HIV programmes) is a cost-effective action that can be implemented immediately to drive tobacco cessation. This intervention calls on the health professional (medical doctor, dentist, oral hygienist, occupational therapist, pharmacist etc) at all levels to play the critical role of supporting and assisting a client/smoker manage their progress towards being an ex-smoker. Considering that quitting confers substantial and immediate health benefits at any age, the level of intervention by health professionals will complement other actions towards reducing the disease burden of tobacco use.

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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