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Report of WHO/EURO

Estonia

June 2012

Technical advice based
on the latest global and
regional evidence for
development of the
Green Paper on
Tobacco control policy

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Background

In 2012 the Ministry of Social Affairs initiated the development of Green Paper on Tobacco with the aim to develop detailed national roadmap for tobacco control. Technical advice was requested from WHO by the Ministry of Social Affairs to complement the draft Green Paper on Tobacco with recent global and regional evidence - scientific studies, guidelines, best practices, and the experiences from other countries to ensure that the proposed tobacco control measures are evidence based and to support the policymakers in the negotiation process with stakeholders by giving arguments to demonstrate the efficacy and effectiveness of tobacco control measures.

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1. Bans and restrictions on smoking in public places

Key points about this policy area:

- There is no safe level of exposure to tobacco smoke (US DHHS 2006) which is a serious health hazard. WHO recommends 100% smoke-free environments to protect workers and the public from second hand smoke (WHO 2007)
- Ventilation systems, separate smoking rooms and similar partial restrictions cannot protect people from ambient tobacco smoke (Wagner 2004; Pion 2004; US DHHS 2006).
- Most jurisdictions that have legislated for smoke-free public spaces have concentrated on indoor premises, since this is where the hazard is greatest. A number of jurisdictions (see below in 1.5) have also restricted smoking in outdoor public areas such as public beaches, sports grounds and stadia, children's play areas, transport stops and grounds of health premises, such as hospitals.
- Jurisdictions that have enacted and enforced comprehensive smoke free legislation have experienced declines in incidence of diseases, notably in hospital admissions for childhood asthma and cardiovascular disease (Pell et al. 2008) Recently published evidence indicates that the number of premature births has decreased in Scotland since the introduction of comprehensive legislation (Mackay et al. 2012).

1.1 Designated smoking rooms do not protect people from exposure to second hand smoke:

- Research has shown that even separately enclosed and separately exhausted, negative-pressure smoking rooms do not keep smoke from spilling into adjacent areas (US CDC 2011).
- It is almost impossible to keep air from a smoking room entering into adjacent rooms. Up to 10% of smoking room air enters an adjacent room when the door is opened and closed. Keeping the door open results in a large proportion of the smoky air entering an adjacent area (Alevantis et al. 2003).
- Airports in many countries have constructed costly smoking cabins, or rooms, to try to accommodate smoke, but these have proved ineffective. One study conducted in a US airport found that leakage of fine particles in smoke pose a hazard to both people outside the smoking room and to staff who had to enter it on a regular basis (Lee et al 2010).

1.2 Ventilation systems do not protect people from exposure to second hand smoke:

- Current air cleaning systems can remove some of the large particles in tobacco smoke, but cannot remove the gases and small particles (US CDC 2011).
- Heating, cooling and ventilation systems do not control SHS; these systems may distribute smoke particles throughout a building (US CDC 2011).
- The body responsible for setting international standards for indoor air quality, the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) says that, "At present, the only means of effective elimination of health risks associated with indoor exposure is to ban smoking activity." (ASHRAE 2005)

1.3 Making public departments smoke-free

- There is now extensive evidence that smoke-free legislation reduces exposure of smokers and non-smokers alike to tobacco smoke, with a positive impact on the health of both individuals and populations. There is consistent evidence to indicate that in such jurisdictions, exposure to secondhand smoke is reduced by 80% - 90% in public places (Pell 2009). Smoke-free legislation also influences behaviours, such as encouraging smokers to quit, and social norms, including encouraging young people to have a less positive attitude to smoking (Bauld 2011).
- Many authorities have shown their leadership in guiding public opinion by not allowing smoking, or any form of designated smoking room or area in public places under their control. Several countries and hundreds of sub-national and local jurisdictions have implemented laws to make indoor workplaces and public places smokefree without encountering serious problems (WHO 2007). This entails a complete ban on smoking in public buildings. These jurisdictions include:
 - Republic of Ireland
 - United Kingdom
 - Uruguay
 - Canada
 - Turkey
 - Mexico
 - Australia
 - New Zealand
 - United States of America
- Some countries, such as Finland and Sweden, allow designated smoking rooms in buildings, but have mandated very high technical specifications for separately ventilated rooms. These are very expensive to build, so the actual number of designated smoking rooms is small (Hara, M. personal communication 2012).

1.4 Establishing smoke-free zones around doors of public buildings

- This has been discussed in a number of jurisdictions, and some, such as sub-national jurisdictions in the USA, have specified limits (usually about six or seven meters) in local legislation. Several [Canadian provinces have regulations](#) banning smoking from between three meters (British Columbia) to five meters (Alberta) from doorways. Local municipalities in other provinces and territories have the right to enact strong local regulations (American Nonsmokers Rights Foundation 2012).
- In the countries of the United Kingdom (which have separate legislation on smoke-free public spaces) there is no regulation specifying outside areas that are smoke-free, but smoking indoors is strictly forbidden. National Health Services trusts are encouraged to regulate where visitors can smoke outside the hospital or clinic. On larger sites, this is usually in an outdoor area away from the health premises entrance.

1.5 Smokefree areas in open air spaces

- Some jurisdictions have local or national legislation forbidding smoking in some designated outdoor spaces. These can include sports stadia, transport stops, beaches, playgrounds and parks. For example, the 2008 revision of the tobacco control legislation in [New South Wales, Australia](#), will ban smoking from playgrounds, sports fields and covered bus stops from 2012.
- Smokefree campuses for health premises are becoming common, especially in those places where there are regulations about indoor smokefree areas. Research from the USA indicates that hospitals with smokefree campuses are more likely to offer smoking cessation counseling to patients (Williams et al. 2009). In other jurisdictions, like the United Kingdom, smokefree health premises and smoking cessation support for staff and patients are parts of a [comprehensive approach to tobacco control in the health service](#).
- There is an international trend for schools and colleges to have smoke-free campuses. Some, like Stanford University School of Medicine (USA) have a policy covering the entire campus and vehicles (see <http://med.stanford.edu/tobaccofree/policy/>). It is estimated that more than 700 colleges and universities in the [US have smokefree campuses](#) with no exemptions (Americans for Nonsmokers Rights Foundation 2012).
- The number of smokefree beaches around the world is growing – in Italy, Poland, Australia, New Zealand, UK and over 120 in the USA alone (American Nonsmokers Rights Foundation 2012a). It has become increasingly clear that the cigarette butts on beaches are not only a nuisance for beach-users and an additional expense for the public bodies that have to clean the beaches, but also a toxic hazard to marine life (Slaughter 2011).

2. Restricting availability of tobacco products: sales points and age restrictions

Key points about this policy area:

- The importance of the availability of tobacco products and visibility of sales points on the smoking habits of young people has become increasingly clear. As other forms of advertising and marketing have been curtailed by governments, the tobacco industry has turned to alternative media. There is a wealth of evidence of the importance of tobacco advertising and pack design to young people (Moodie 2010) and many jurisdictions are addressing this through legislation. (Point of Sale advertising and tobacco displays are dealt with in the following section.)
- Article 16 of the FCTC obliges Parties to take steps to restrict the sale of tobacco to under-aged persons. Age restrictions on purchase of tobacco are widely popular, but have not been shown to be effective in reducing youth smoking (Ling et al. 2002). The tobacco industry often pushes these programmes and even participates itself in sponsoring retailer awareness schemes. Several studies have shown that tobacco industry backed youth programmes are ineffective. Age restrictions can make it more difficult for young people to acquire tobacco products, but they can be expensive to implement and can divert resources from other, more effective tobacco control measures.

2.1 Sales of tobacco from special counters

- This has been done in some jurisdictions, for example in New South Wales, Australia where the [state tobacco Act](#) was revised in 2008 to change a number of provisions of the previous Act. One of them was to rule that only one cash point in a shop could be used to sell tobacco products, non-tobacco smoking products and smoking accessories. This cash register could be changed, but the one register being used is required to have a specified sign indicating that tobacco products are sold there. It also has to have a notification saying 'Smoking kills – call the Quitline' and giving the Quitline number.

2.2 Participation of under-aged smokers in monitoring age restriction legislation

- This is common practice when monitoring the compliance of retailers to laws restricting tobacco sales to young people. In many jurisdictions it is not thought to compromise the legal or ethical status of the young person because such research is carried out under the supervision of a responsible adult. European countries where this is done include France, Ireland and the UK (Ratte, S & Gallopel-Morvan K, personal communication). Although it is not common, young people can participate in this type of research in Germany, where about 8 in 10 retailers are believed to sell tobacco and alcohol to under-aged persons (Poetschke-Langer M & Schunk S, personal communication). It is not illegal for young people to possess tobacco in these countries, but enforcement of the legislation on sales restrictions has a fairly low priority.
- In Sweden the Ombudsman ruled a couple of years ago that local authorities should not use young people in test purchasing. Apparently, this decision has now been reversed, but it is unlikely that compliance will be monitored with young people (Haglund, M. personal communication).

3. Restricting availability of tobacco products: Point of Sale, pack warnings and attractiveness

3.1 *Banning tobacco advertising and related products at the Point of Sale (PoS)*

- Article 13 of the FCTC requires Parties to enact a comprehensive ban on tobacco advertising within five years of ratification. The FCTC defines tobacco advertising as “any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product either directly or indirectly.” The Treaty has taken a strong position on tobacco advertising, promotion and sponsorship because there is a clear relationship these activities and consumption. A UK Government review (the ‘Smee’ report) published as long ago as 1992 confirmed that tobacco advertising did increase consumption and that in countries that had banned advertising, the ban “was followed by a fall in smoking on a scale which cannot reasonably be attributed to other factors...” (UK DoH1992)
- An international overview of the effect of tobacco advertising bans on tobacco consumption concluded that “a comprehensive set of tobacco advertising bans can reduce tobacco consumption but a limited set of advertising bans will have little or no effect” (Saffer 2000). This is because tobacco companies respond to partial bans by diverting resources from the restricted to the non-restricted media.

3.1.1 *Increasing emphasis on PoS promotion*

- Tobacco companies have become increasingly reliant on eye-catching displays at retail points, particularly in those jurisdictions where tobacco advertising and promotion have been restricted. These displays include back-lit gantries and specially designed units that draw attention to the brand.
- Another tactic that has been used to increase visibility at the PoS is new variants of existing brands. For example, in the UK ‘brand families’ have grown in size since 1998 by more than 50%. Brand variants of one of the most popular brands, Benson & Hedges, increased from 4 in 1998 to 23 in 2012 (ASH 2012a). The variety of packs of essentially the same brand is designed to take up more space and draw more attention to their position on the shop shelves.
- Because of the increased emphasis on retail displays, more countries are acting to remove tobacco promotion at the point of sale. Ireland was the first EU country to ban PoS displays in 2009. In England, tobacco products were withdrawn from view in large shops in April 2012; they will be withdrawn from small shops in April 2015. The legislation for England is set out in:
[The Tobacco Advertising and Promotion \(Display\) \(England\) Regulations 2010](#). SI 2010 No. 445
[The Tobacco Advertising and Promotion \(Display of Prices\) \(England\) Regulations 2010](#). SI 2010 No. 863
[The Tobacco Advertising and Promotion \(Specialist Tobacconists\) Regulations 2010](#). SI 2010 No.446
[The Tobacco Advertising and Promotion \(Display and Specialist Tobacconists\) \(England\) \(Amendment\) Regulations 2011](#) SI 2011 No. 1256
- The other countries of the UK are also preparing to remove retail displays in the near future – Scotland was due to implement legislation before England, but because of

an unsuccessful legal challenge from the tobacco industry, it has had to revise the date that regulations will come into effect.

- This is in reaction to research that showed that in 2006, almost half (46%) of UK teenagers were aware of tobacco display at PoS and those who expressed an intention to smoke were more likely to recall brands that they had seen at the point of sale (CRUK 2008). Likewise, research in Australia (Wakefield et al 2006) and the USA (Hendrikson et al. 2002) has shown that PoS advertising of cigarettes normalises tobacco use for children and creates a perception that tobacco is easily obtainable. The presence of PoS displays encourages impulse buying, and is a greater risk to young people and those who are trying to quit (Wakefield 2007).
- An evaluation of the PoS ban in Ireland showed an immediate impact on young people's attitudes to smoking. For example, the proportion of young people believing that more than a fifth of their contemporaries smoked decreased from 62% to 46% (McNeill et al. 2010).

3.1.2 Does restricting the availability of tobacco products encourage growth of illicit tobacco trade?

This is an assertion that is used occasionally by the tobacco industry to argue against PoS display bans. They used this [argument in Ireland](#) but an economic study following the 2009 display ban showed that this was not the case (Quinn C et al. 2010). PoS display bans primarily affect young people so their impact on sales is likely to be long term rather than immediate.

3.2 Pictorial Health Warnings

Under Article 11 of the FCTC, Parties agree to adopt regulatory measures to ensure effective health warnings and labelling of tobacco products to make sure consumers have a clear and accurate idea about the consequences of tobacco use and exposure to tobacco smoke.

Key points about this policy area:

- Pictorial health warnings oppose tobacco industry use of the product pack as an advertisement for tobacco products; they increase knowledge of the risks of tobacco use; they reduce adolescents' intentions to smoke (White et al. 2008) and; they motivate smokers to quit (Hammond et al. 2007; Hammond 2008).
- Research has shown pictorial warnings to have greater impact than text-only warnings, particularly with low literacy populations and children (Hammond D et al. 2006) – both vulnerable populations in Estonia.
- Globally, some 39 jurisdictions had enacted regulations for picture warnings on tobacco products by 2011, and this number is growing steadily. By comparison, in 2001 only one jurisdiction had pictorial health warnings (Canadian Cancer Society, 2010).
- Pictorial health warning regulations have been adopted but not yet enacted by a number of countries including Poland, Russia and the USA. Picture health warnings taking up 50% of the front and back of packs and 20% of tobacco advertisements should be required in the US from September 2012, although the tobacco industry continues to challenge this.

- The EU Tobacco Products Directive (2001/37/EC) dates from 2001 and necessary revisions are currently being discussed. One of the issues under discussion is whether use of the currently optional pictorial health warnings should become mandatory for all EU countries.
- In the EU, nine Member States have finalised regulations for pictorial health warnings, with Hungary's warnings due to be introduced on tobacco packs in 2012 and Ireland's by 1 February 2013. Other EU countries with pictorial warnings include Belgium, France, Latvia, Malta, Romania, Spain and the U.K.

3.3 Banning flavoured tobacco products

Key points about this policy area:

- Flavourings such as mint, chocolate, coffee, cinnamon and fruit are increasingly used in tobacco products. These are widely considered to be 'starter' products because the flavors mask the taste of tobacco and make it easier for novice smokers to inhale. For example, studies on mainstream brands in the USA indicate that they are used primarily by young people (Conwell et al. 2003). The recent proliferation of flavoured tobacco has been attributed to the need to attract new smokers (Carpenter et al. 2005; Lewis 2006).
- Studies of other flavoured tobacco products like bidis and hookahs have found that young smokers report choosing flavoured products over cigarettes because they "taste better" and are perceived to be "safer." (Primack B et al. 2008)
- Tobacco industry documents show that strategies were devised to target young people using flavoured products. (Marketing Innovations 1972; RJ Reynolds 1974)

3.3.1 Examples of jurisdictions that have banned tobacco flavourings

- Following the recommendation in the partial Guideline on FCTC Articles 9 and 10, Brazil has become the first country in the world to impose a wide ban on ingredients that might be used to increase the palatability of tobacco products. Brazil's National Health Protection Agency (ANVISA) took the decision on 13 March 2012 that the approximately 600 additives now used by manufacturers should be cut to eight within the next 18 months. Manufacturers would have an additional six months to allow for withdrawal of flavoured products from the market. To date, flavoured products have comprised about 22% of the Brazilian cigarette market. The ban also applies to imported products.
- In the USA, sales of cigarettes with flavors other than menthol became illegal after September 2009. The Food and Drug Administration (FDA) is exploring options for regulating menthol and flavoured tobacco products other than cigarettes (CTFK 2010).
- Several Australian states, including South Australia, New South Wales and Tasmania, had already banned use of flavours in tobacco when, in 2008, the Ministerial Council on Drug Strategies announced its intention that all Australian states and territories should enact legislation to ban flavours by the end of December 2009. (Scollo 2008)

4. Regulating alternative products, including medicinal products for smoking cessation, other nicotine containing products, e-cigarettes and hookah

4.1 Regulation of nicotine containing products, including medicinal products and e-cigarettes

Key points about this policy area:

- Although there is strong evidence that a comprehensive tobacco control policy can greatly reduce population smoking, some health authorities also argue for alternative forms of nicotine delivery – a harm reduction approach - that would satisfy tobacco users, but be much less hazardous than smoking (RCP 2007).
- Arguments against this approach speculate that wider availability of nicotine delivery devices might deter smokers from quitting tobacco use completely. Given the history of tobacco marketing, some health authorities are anxious as the tobacco industry itself becomes more involved in the production of non-tobacco nicotine delivery devices.
- E-cigarettes particularly are growing in popularity and are seen by some as a reasonable alternative to smoking as they are much less hazardous than cigarettes. Tests on the original e-cigarette sold in Europe suggested they were relatively harmless compared with smoking. However, more products are now available which have not been tested (Thompson 2009). It is the responsibility of regulators to ensure that unregulated harm reduction products are not available. Also, the WHO Study Group on tobacco product regulation (TobReg) draft report noted that the uptake of nicotine (therefore the scope to satisfy smokers) and safety of e-cigarettes had not been established (WHO 2009).
- Oral tobacco and water pipe (hookah) contain tobacco and should be regulated under tobacco legislation.
- Adopting a harm reduction approach has been actively discussed in the UK for more than 15 years. The National Institute for Health and Clinical Excellence (NICE), the public body responsible for reviewing the evidence and making recommendations on pharmaceutical, clinical practice and public health measures, is currently reviewing the evidence for harm reduction and will issue guidance in 2013.
- The Medicines and Healthcare Products Regulation Agency (MHRA) in the UK has given marketing authorization for medicinal products containing nicotine to be used for cutting down, temporary abstinence or harm reduction from smoking, but a number of non tobacco based nicotine delivery products – such as e-cigarettes - are available and unregulated, except by normal consumer law. The MHRA has conducted a public consultation to determine if these products should be regulated as medicines. It is conducting consumer research and will issue a report in 2013.

4.1.1 Regulation of herbal cigarettes

- Like e-cigarettes, herbal cigarettes are largely unregulated because they do not fall under existing regulatory rules for tobacco products. For example, in the USA, the Federal Drug Agency (FDA) has had regulatory authority on tobacco since 2009, but herbal cigarettes do not contain any of the substances they have the power to regulate.

- Local authorities have passed legislation to bring herbal and e-cigarettes more in line with laws on tobacco, particularly with reference to smokefree areas, sales to minors and availability in vending machines. This has been the case in jurisdictions, like the USA, where there is no national tobacco control legislation, but many [local ordinances](#) on tobacco control. In jurisdictions with national smokefree legislation, such as the Ireland and the UK, restrictions apply to all smoked products, whether they contain nicotine or not.

4.1.2 *Over-the-counter (OTC) sales of medicinal products at with tobacco product sales points*

- It has been argued that medicinal products available OTC should be as easily available as tobacco products, and this has been the case in some countries such as Finland and the United Kingdom. One criticism is that the size of the display units for tobacco tends to dwarf the display of NRT products. The counter argument to selling NRT products along side tobacco has come primarily from those arguing against tobacco sales in pharmacies. Sale of cigarettes in pharmacies is common in the United States and advocates argue that this practice sends out a mixed message to customers when such a dangerous product is sold in what is essentially a health premise.
- The UK has one of the most liberal regimes for availability of smoking cessation medications, but only nicotine gum, patch and lozenges are available in non-pharmacy retail outlets. This tends to be mostly in supermarket chains where these products appear in the gantries next to cigarettes or on the pharmaceutical products shelves.

4.1.3 *Water pipe or hookah*

- Water pipe smoking is traditional in the Middle East, but hookah cafes are now spreading in North America, Brazil and Europe, where many see it as a social activity. Water pipe smoking is particularly fashionable among young people and it is estimated that about one in three young people in Estonia has tried it. A study of Parisian school children found that more than a quarter of 16-year olds report occasional hookah smoking (Dautzenberg 2009).
- There is a common misconception that because the smoke in a hookah is filtered through water that the harmful elements are 'filtered-out'. Also, the use of flavorings and spices masks the harshness of the tobacco and this gives the impression of a less hazardous product compared to cigarettes. In fact, the health effects appear to be comparable to those of cigarettes. Water pipe users are also at increased risk of mouth and gum disease and sharing of mouth pieces of the pipes poses a serious risk of transmission of communicable disease, including tuberculosis and hepatitis. (Maziak, et al. 2004; Eissenberg 2006)
- One of the most serious health problems with water pipe smoking is caused by second hand smoke. Research has shown that a single water pipe use session emits in the sidestream smoke approximately four times the carcinogenic PAH, four times the volatile aldehydes and 30 times the CO of a single cigarette. The authors estimate that, given a habitual smoker smoking rate of 2 cigarettes an hour, during a one-hour water pipe use session, a water pipe smoker is likely to generate ambient carcinogens and toxicants equivalent to 2-10 cigarette smokers.(Eissenberg 2006)

5. Public information, smoking cessation assistance

5.1 *Public information campaigns*

Key points about this policy area:

- There is a wealth of scientific evidence to show that public information campaigns are an important element of a comprehensive tobacco control program. They can:
 - Help to prevent uptake of smoking
 - Encourage smokers to quit and increase use of existing resources
 - Help those who have already quit to stay quit
 - Increase health knowledge, e.g. about second hand smoking
 - Change the social context of tobacco use
- Experience has shown that the most effective campaigns use multiple communication channels:
 - A variety of media: TV, radio, print, internet, social media, etc
 - Public relations/ advocacy to generate 'earned media' – news coverage
 - A program of 'outreach' involving schools, community organisations, etc.
 - Materials such as badges, tee shirts etc.
- Evidence suggests that public information campaigns can have a greater impact on cessation than clinics and other therapies because of their reach to a large proportion of the population (Biener L et al 2006)
- Public education campaigns are cost-effective as well as effective. Multiple use of evidence-based media materials has significantly cut the costs of media campaigns, especially television and cinema campaigns. The World Lung Foundation has a programme to assist health authorities by using evidence-based media developed in high income countries and adapting them for local campaigns.

5.1.1 *Cost effectiveness of public education campaigns about tobacco*

- Public education campaigns are extremely cost effective in the long term because they encourage smokers to quit, help ex-smokers to remain smokefree and deter young people from starting. The average lifetime healthcare costs of each smoker totals at least US\$16,000 more than each nonsmoker, despite the fact that smokers do not live as long (Hodgson 1992). By contrast, the U.S. Guide to Community Preventive Services found that the smoking cessation mass media campaigns evaluated cost only US\$298-US\$1,593 per quitter.
- One study calculated a cost of US\$151-328 per quality-adjusted life year (QALY) saved for a Scottish smoking cessation campaign that included mass media, telephone quitline, and information booklet. The study also found the same intervention to cost US\$298-\$655 per quitter (Ratcliffe et al. 1997).

- An analysis of various smoking cessation interventions found the cost per QALY saved for the No Smoking Day in the UK to be just £26, or £40 when discounted (US\$52 and \$80 respectively). (Parrot 2004) In comparison, the UK's National Institute for Health and Clinical Excellence (NICE) uses a threshold of £20,000-30,000 (about US\$32,000-48,000 at current rates) per QALY saved to determine cost-effectiveness of healthcare interventions.
- Another study calculated a cost of US\$333 per QALY saved for a U.S. youth tobacco use prevention mass media campaign combined with a school smoking prevention program versus the school program alone, based on a 4-year study conducted in New York, Vermont and Montana.(Secker-Walker et al. 1997) For comparison, the U.S. Guides to Community Preventive Services uses a benchmark of US\$50,000 - \$100,000 per QALY saved to determine cost-effectiveness of healthcare interventions.(US CDC 2006).

5.2 Smoking cessation services

5.2.1 Clinical and non-clinical settings

Key points about this policy area:

- Nicotine addiction is probably the most intensively researched area in tobacco control; it has become clear in the last 30 years that smoking cessation programmes can work, are effective and are cost-effective (Fiore 2008; Cochrane Library).
- The Cochrane Collaboration alone has issued 56 systematic reviews of aspects of smoking cessation, including advice from health professionals, community and workplace programmes, psychological support, pharmacotherapy, combined therapy and programmes for specific groups.
- A great deal of attention has been focused on clinical settings. Guidelines for health professionals have been issued in many countries including the USA, UK, Australia and New Zealand. Other settings thought to be useful for smoking cessation are non-clinical, especially the workplace, pharmacies and community groups. See: <http://pathways.nice.org.uk/pathways/smoking>.

5.2.2 Telephone counseling helpline or quitline

Key points about this policy area:

- Quitlines can be both very effective and cost-effective in reducing smoking;
- Quitlines can deliver assistance to groups of smokers such as low income, ethnic minority and rural smokers whom it is difficult to reach by other means. There is also evidence that women are more likely to use a quitline than are men.
- Quitlines can give primary care and other health care providers, who do not have the capacity to counsel smokers, somewhere to refer patients to quit smoking;
- As other activities to encourage smoking cessation - such as tax increases, smokefree public places and public education - increase, there will be increased demands on telephone cessation advice.

5.2.2.1 Quitlines can be effective

- Telephone counseling services have been shown to help people quit smoking and to remain abstinent (Zhu et al. 2002). A systematic review of the literature by the US

Public Health Service for its updated smoking cessation treatment guidelines found strong evidence for the effectiveness of Quitlines (Fiore et al. 2008).

- A review from the Cochrane Collaboration found that proactive telephone counseling helps smokers interested in quitting and that multiple sessions are likely to be more helpful (Stead et al 2006)

5.2.3 Internet based counseling service

- The internet is increasingly used globally as a source of information and it offers an additional means of encouraging behavior change, such as quitting smoking. Following a number of trials of internet based cessation programmes, the Cochrane Collaboration reviewed the studies and found that although more evidence was needed, internet-based programmes that provide tailored information and support may be more effective than a static website. The internet may have added benefit when used with other interventions, such as NRT or other pharmacotherapy. There was some evidence that innovative programmes might be especially attractive to young people and women (Civljak M et al. 2010).

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