TOBACCO DEPENDENCE MANAGEMENT AND TOBACCO CONTROL

THE GOOD, THE BAD AND THE UGLY

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PREVALENCE OF CURRENT TOBACCO USE AMONG PERSONS AGED 15+ YEARS	BY 2025, 30% RELATIVE REDUCTION ACHIEVED THROUGH FULL IMPLEMENTATION OF THE WHO FCTC, AND IN PARTICULAR DEMAND REDUCTION MEASURES

- **WE HAVE NOW A TARGET TO REDUCE TOBACCO USE PREVALENCE**

TEN YEARS OF THE WHO FCTC

- <1% of the population of LMIC compared with 36% in HIC will benefit from targeted prevalence reduction
- Countries in Africa and the Eastern Mediterranean will have and increase in prevalence. Some countries in the Western Pacific too.
- The epidemic will persist among women in some high-income countries

WILL THE TARGET BE ACHEIVED?

Bilano V et al. Global trends and projections for tobacco use, 1990–2025. The Lancet. 2015;385(9972):966-976.

- Every day that smokers … continue to smoke they lose about 3–6 h of life. Thus, for the … 500 million current adult smokers, 62 million days of life are lost every day.
- Some of these people who smoke will stop unaided, but many others will stop only after repeated attempts over time.

Time to take tobacco dependence treatment seriously

Raw M, Mackay J, Reddy S.. The Lancet. 2016;387(10017):412-413.

- Every country’s health-care system should assume responsibility for cessation programmes.
- We believe that it is time for countries to integrate tobacco dependence treatment into their tobacco control programmes.

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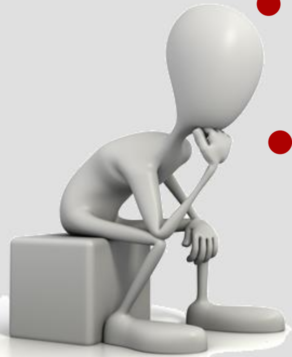
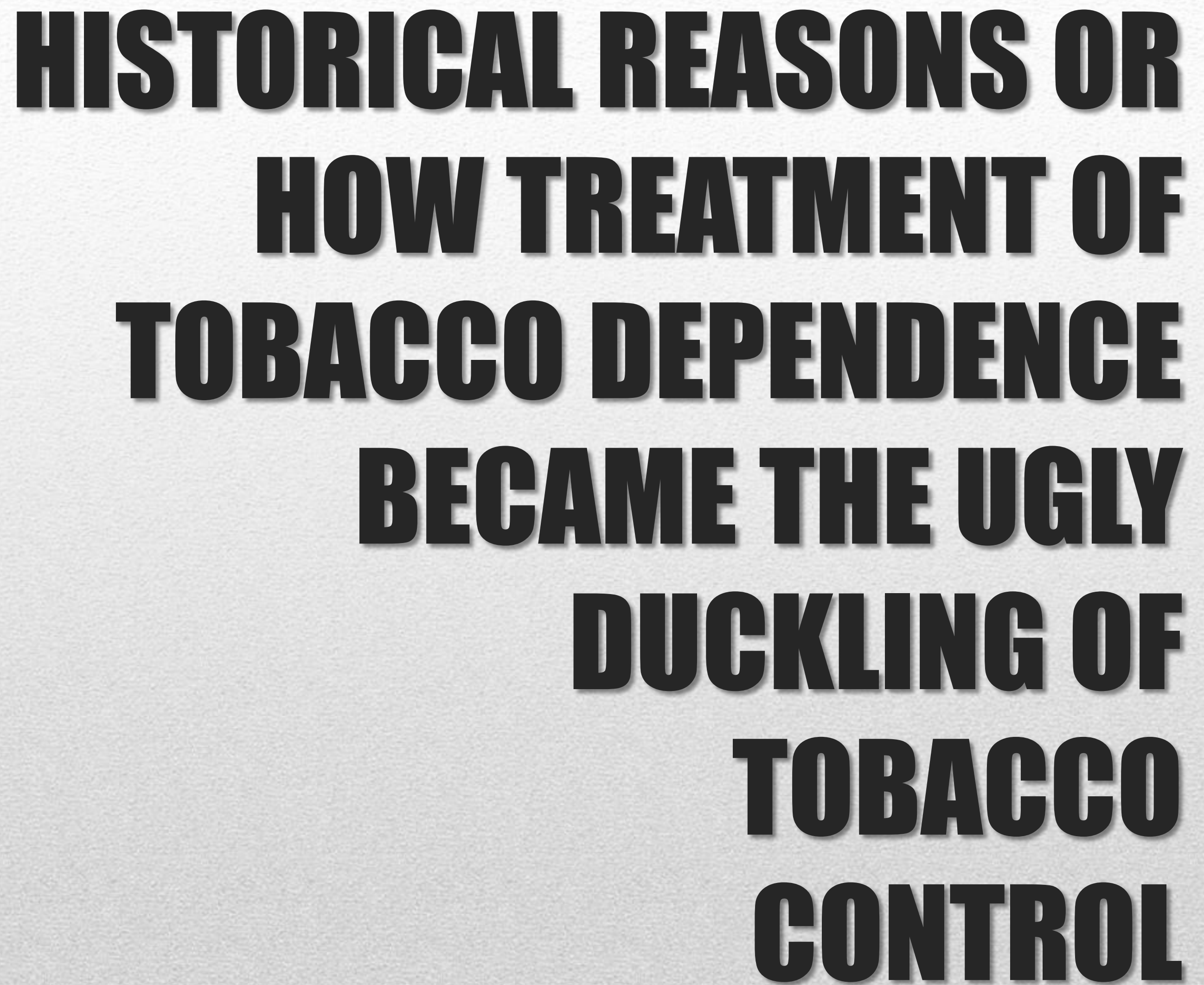
- HISTORICAL
- CONCERNS ABOUT MEDICALIZATION
- THE COMMERCIAL INTERESTS
- BELIEVES ABOUT CESSATION

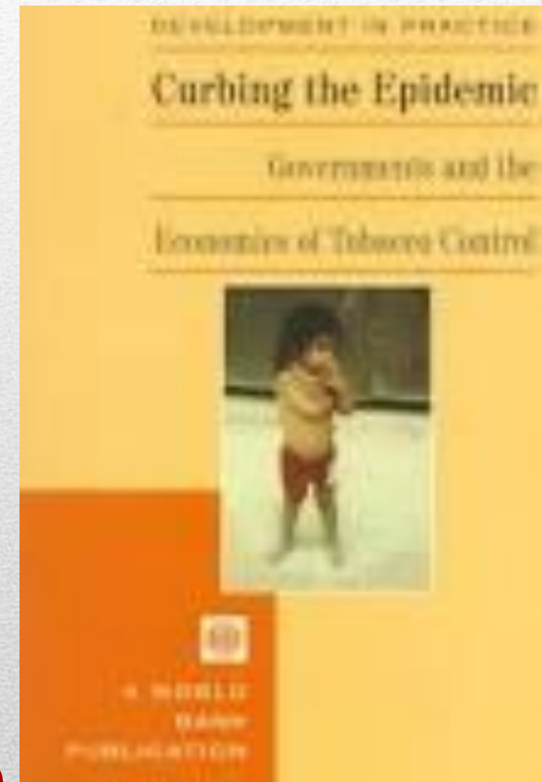


UNDERESTIMATION OF INDIVIDUAL APPROACHES


HISTORICAL REASONS OR HOW TREATMENT OF TOBACCO DEPENDENCE BECAME THE UGLY DUCKLING OF TOBACCO CONTROL

HISTORICAL REASONS

- **Once upon the time in many countries (ineffective) tobacco control consisted in**
  - preventing new smokers through school programs and
  - quitting smoking by training medical doctors.
- **Many governments have avoided taking action on higher taxes, comprehensive TAPS bans or SFEs because of concerns of negative economic consequences.**



- “the medical establishment has become a major threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic.” Iatrogenesis
- Overemphasis on treatment of smokers overlooks well-documented social influences on smoking uptake and maintenance.
- Illusion of “magic bullet”

MEDICALIZATION

- The power to redefine behavior as illness in order to increase profits
- promoting the view that quitting is difficult without medical help
- Distrust of research supported by pharmaceutical companies

COMMERCIAL INTERESTS

- Willpower and stigma
- Unassisted quitting is the ideal method to quit
- Best treatment “depends on the individual”
- Smoking is a habit

MYTHS

- 85 Parties with tobacco-control unit with >1 full time staff
- 24 Parties with ≥ 1 full time staff per million population
- Governmental per capita expenditure in tobacco control:
  - US$0.0004 in LIC 125 times less than needed for population-based demand reduction measures
  - US$0.03 in MIC 5 times less than needed
- ODA to fill this gap needed to increase at least between 5 and 15 times.

INTEGRATE TOBACCO DEPENDENCE TREATMENT INTO TC PROGRAMS

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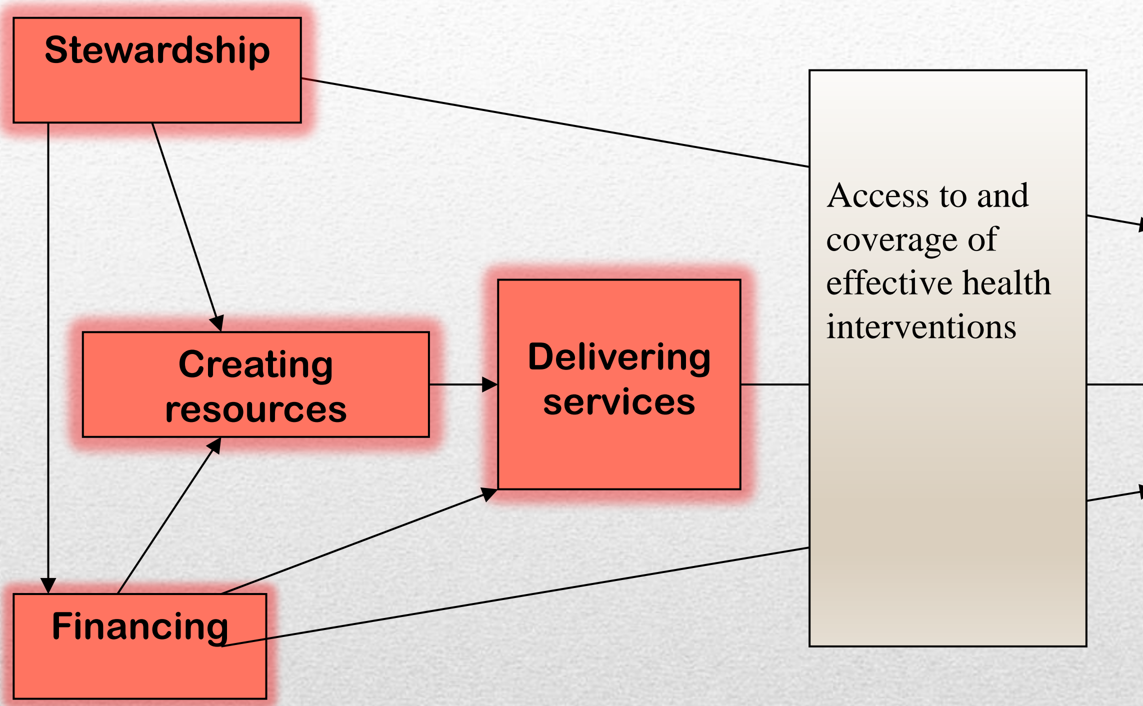
- SERVICE DELIVERY
- HEALTH WORKFORCE
- INFORMATION
- MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES
- FINANCING
- LEADERSHIP / GOVERNANCE



COMPONENTS AND FUNCTIONS IN HEALTH SYSTEMS

- Policy makers
- Service administrators
- Health care providers

Locus of control
CARE SYSTEM RESPONSIBILITY

SERVICE DELIVERY	• Form supportive policies for integrated service delivery • Governance implications of different service delivery models • Influence demand for tobacco dependence treatment
HEALTH WORKFORCE	• Form national workforce policies and investment plan
INFORMATION	• Form policy on recording & analysing tobacco use • Developing standardized tools for recording tobacco use
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES	• Develop national policy on treatment of tobacco dependence • Monitor the quality and safety of treatment tools
FINANCING	• Form national health financing policy • Ensure adequate funding for treatment of tobacco dependence
LEADERSHIP / GOVERNANCE	• Set policy guidance for treatment of tobacco dependence • Promote collaboration and coalition building

TASKS OF POLICY MAKERS

TASKS OF SERVICE MANAGERS

SERVICE DELIVERY	• Facilitate access and continuity of service delivery
HEALTH WORKFORCE	• Manage training schedules • Assess workforce performance
INFORMATION	• Implement EHR • Quality control of information
MEDICAL PRODUCTS, VACCINES & TECHNOLOGIES	• Develop national policy on treatment of tobacco dependence • Monitor the quality and safety of treatment tools
FINANCING	• Budgeting for treatment of tobacco dependence • Implement financial incentives
LEADERSHIP / GOVERNANCE	• Plan and evaluate implementation of policy guidance for treatment of tobacco dependence