# SMOKING CESSATION CLINICAL GUIDELINES FOR GHANA


**MINISTRY OF HEALTH GHANA**
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# FOREWORD

Treating tobacco dependence has been well studied and seen to be cost effective. Tobacco cessation support delivered by healthcare workers trained in tobacco cessation techniques can greatly benefit tobacco users who are trying to quit. Health facilities including hospitals are a good opportunity to offer tobacco users some help at a time of personal vulnerability, which may make individuals more receptive to tobacco cessation messages.

Access to specific training, skills and knowledge by healthcare workers and other interested groups working in the health sector is therefore essential. This will result in improvements in service delivery to those who need it.

In October 2012, Ghana adopted a Public Health Act (Act 851 2012) whose provisions in Part 6 (Tobacco Control Measures) among others has age limitation for those who can buy and sell tobacco products, bans tobacco advertising, promotion and sponsorship; warns the public against the harmful effects of tobacco use and provides information and education to the public and an opportunity for those smoking who wish to quit to have access to service. These measures go hand in hand with other efforts aimed at addressing the tobacco use epidemic.

These clinical guidelines therefore offer a most important tool in our efforts to reduce tobacco use in Ghana. I encourage health workers to make use of this document to benefit the people of Ghana.

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## Acknowledgements and Authors

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## Abbreviations

| | |
|---|---|
| 5As | Ask, Advise, Assess, Assist, Arrange |
| 5Rs | Relevance, Risks, Rewards, Roadblocks, Repetition |
| FCTC | Framework Convention on Tobacco Control |
| FDB | Food and DrugsBoard |
| FTND | Fagerstrom Questionnaire for Nicotine Dependence |
| GHS | Ghana Health Service |
| GTCR | Global Tobacco Control Report |
| MOH | Ministry of Health |
| NRT | Nicotine Replacement Therapy |
| OTC | Over the Counter |
| WHO | World Health Organization |

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## Executive Summary

Ghana has made strides in her tobacco control efforts by implementing various initiatives including: Advocacy leading to the signing and ratification of the WHO Framework Convention on Tobacco Control (FCTC) in 2004;conducting the Global Youth Tobacco Surveys in 2000, 2006 and 2009;the Global School Personnel Survey; regular awareness creation such as marking the World No-Tobacco Day; formulation of policies such as Smoke-Free Public Places; introduction of tobacco cessation programs such as Quit and Win Ghana; display of text health warnings on Tobacco Packs; Passing of a Public Health Act (Act 851, 2012) that requires the Ministry of Health (MOH) and the Ghana Health Service (GHS) to establish the requisite systems to protect the populace from the harmful effects of tobacco as well as assisting tobacco users to stop tobacco use and instituting regular increases in the taxation of tobacco products to reduce consumption.

In an effort to fill the gap in implementation of Article 14 of the WHO FCTC and to provide support to health workers providing tobacco cessation services, the Government of Ghana with support from the WHO Regional Office for Africa has developed this tobacco cessation clinical guideline. This guideline provides information on the various forms of cessation support from brief intervention to the more detailed pharmacological interventions.

The 5As (Ask, Advise, Assess, Assist, Arrange) is an evidence-based model for health care providers to use when intervening with tobacco users. The intervention is intended to prompt the healthcare professionals and other staff to identify tobacco users and offer them resources, services, and programs to help in the tobacco users quitting process. Implementing the 5As requires changes in the way the health care systems operate. For example, processes must be instituted to routinely identify tobacco users and track patient tobacco use status and collecting the required data to monitor the effectiveness of tobacco cessation services.

## Introduction

Tobacco is the foremost preventable cause of disease and death in the world today (1). It kills nearly 6 million people globally of which about0.6 million premature deaths can be attributed to exposure to second-hand smoke(2).Tobacco use can cause cancer almost anywhere in the body(3). Majority of the cardiovascular diseases and lung disorders are directly attributable to tobacco use. Other diseases, which are associated with tobacco use, are stroke, cataract, and peripheral vascular diseases. Smoking causes about 90% of all lung cancer deaths in men and women. In fact more women die from lung cancer each year than from breast cancer. About 80% of all deaths from chronic obstructive pulmonary disease (COPD) are caused by smoking. The risk of developing diabetes is 30-40% higher for active smokers than nonsmokers. The use of smokeless tobacco is associated with cancers of oral cavity, esophagus, stomach, pancreas and throat. Tobacco use by pregnant women leads to low birth weight of babies, pregnancy complications, premature deliveries, stillbirths and birth defects (4).Inhalation of Second Hand Smoke is harmful and hazardous to the health of the general public and particularly dangerous to children. It increases the risk of serious respiratory problems in children, such as greater number and severity of asthma attacks and lower respiratory tract infections, and increases the risk of middle ear infections. Inhaling second-hand smoke causes lung cancer and coronary heart disease in nonsmoking adults (5).

Ghana has different tobacco products including cigarettes, snuff and Bonto (leaves for chewing). These products are used by both adults and the youth. It is estimated that 10.8% of adult males and 4% of females, aged 25 years and older smoke tobacco products(6).More than 1 in 10 students currently use any form of tobacco; 2.7% of the students currently smoke cigarettes; while 10.4% currently use tobacco products other than cigarettes. Environmental exposure is high - nearly 1 in 7 students live in homes where others smoke, and almost one third of the students are exposed to smoke around others outside of the home; 8.7% of the students have a parent who smokes, and almost 4.6% of the students have friends who smoke(7).

Treatment of tobacco use and dependence is mandated in Article 14 of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) as a key component of comprehensive tobacco control strategy. Tobacco dependence treatment is also recommended by WHO as part of a comprehensive package of essential services for prevention and control of non-communicable diseases (NCDs) in primary care in accordance to the revised draft of the WHO Global Action Plan for the Prevention and Control of NCDs (2013-2020). Yet many healthcare professionals lack the proper knowledge and skills to treat tobacco dependence(8,9).

A National Tobacco Control Steering Committee (NTCSC) was established by the Minister of Health on 14 January 2002 to support the Ministry in its policy development, advocacy for tobacco control and to advise on effective intervention strategies for the successful implementation of a National Tobacco Control program. The NTSCS drafted the tobacco control part of the Public Health Act. The Ghana Health Service was appointed the secretariat of the Committee. A tobacco control focal point is currently housed in the Research and Development division, Ghana Health Services under Ministry of Health.
In October 2012, Ghana adopted a Public Health Act (Act 851 2012) whose provisions in Part 6 (Tobacco Control Measures) among others has age limitation for those who can buy and sell tobacco products and offers help to those who want to quit.

Implementing population level tobacco control policies as contained in the Act can motivate people to stop tobacco use and increase their demand for tobacco dependence treatment. Quitting has the potential to save lives in the short and medium-term.Providing support for tobacco users to quit can also help reduce tobacco users' resistance to the implementation of population-level tobacco control policies. Health Professionals have a prominent role to play in the everyday health-care setting by addressing tobacco dependence as part of their standard of care practice.

## Purpose of guidelines

These guidelines aim to assist healthcare professionals to identify tobacco users, assess their level of dependence and assist them to stop tobacco use through evidence-based interventions for tobacco dependence management and cessation.

### Objectives

#### General
To promote implementation of evidence based tobacco cessation strategies in routine healthcare work.

#### Specific
1. To identify tobacco users at all healthcare levels
2. To provide a standardized approach to tobacco dependence treatment and cessation among tobacco users
3. Promote protection of the population from second-hand tobacco smoke and creation and maintenance of smoke-free environments

### Target audience
These guidelines are intended for all healthcare professionals operating at all levels of care. Healthcare professionals play an important role in educating and motivating tobacco users as well as assessing their dependence on nicotine and providing assistance to quit.

### Tobacco dependence

#### Tobacco dependence: Why people smoke but don't quit?
Nicotine, a chemical found in tobacco, is a highly addictive substance that is responsible for tobacco dependence, and makes it difficult to stop tobacco use once initiated. This property of nicotine is similar to those of heroin and cocaine. Nicotine is quickly absorbed into the bloodstream when tobacco products are used. Nicotine activates the reward pathways - the brain circuitry that regulates feelings of pleasure. Within 10 seconds of entering the body, nicotine reaches the brain. A key brain chemical involved in mediating the desire to consume drugs is then released - the neurotransmitter dopamine. Research has shown that nicotine increases levels of dopamine in the reward circuits,

creating a buzz of pleasure and energy. However, the acute effects of nicotine dissipate quickly, as do the associated feelings of reward, which causes the smoker to continue using tobacco and in progressively higher doses to maintain the drug's pleasurable effects and prevent withdrawal. This increase in tolerance and cravings will result to brain changes in the long-term, induced by continued nicotine exposure thus leading to addiction.

The Diagnostic and Statistical Manual of Mental Disorders the 5th edition(DSM-V)(10) criterion for tobacco withdrawal includes any four of the following when caused by the lack of nicotine: - depressed mood, insomnia (lack of sleep), irritability, frustration, anger, anxiety, cravings, difficulty in concentration, restlessness, decreased heart rate and increased appetite or weight gain. These symptoms should not be due to any other general medical condition or disorder. Tobacco withdrawal symptoms typically resolve over 10 to 14 days but can last up to 4 weeks and association that causes the person to think about smoking (triggers) can make it persist for longer.

## Assessment for Nicotine dependence

Nicotine dependence is a substance related disorder. The degree of tobacco dependence may be assessed by a range of measures. These include the frequency and quantity of tobacco consumed; biochemical markers (levels of cotinine in saliva) and self-reported tobacco use behaviour.

The Fagerstrom Test for Nicotine Dependence is a standard instrument for assessing the intensity of the physical addiction to nicotine. The higher the Fagerstrom score, the more intense the patient's physical dependence on nicotine. Higher scores indicate that to treat withdrawal symptoms, in most cases nicotine replacement therapy will be an important factor in the patient's plan of care.

**Scoring:**

0-2 Very low dependence
3-4 Low dependence
5 Medium dependence
6-7 High dependence
8-10 Very high dependence

Result: level of dependence as'high or very high' will be considered to use NRT

## Items and Scoring for Fagerstrom Test for nicotine

| | | |
|---|---|---|
| 1. How soon after you wake up do you smoke your first cigarette? | Within 5minutes | 3 |
| | 6-30 seconds | 2 |
| | 31-60 seconds | 1 |
| | After 60 seconds | 0 |
| 2. Do you find it difficult to refrain from smoking in places where it is forbidden e.g. in church, at the library, in cinema? | Yes | 1 |
| | No | 0 |
| 3. Which cigarette would you hate most to give up? | The first one in the morning | 1 |
| | All others | 0 |
| 4. How many gigarettes / day do you smoke? | 10 or less | 0 |
| | 11-20 | 1 |
| | 21-30 | 2 |
| | 30 or more | 3 |
| 5. Do you smoke more frequently during the first hours after waking up than during the rest of the day? | Yes | 1 |
| | No | 0 |
| 6. | Yes | 1 |
| | No | 0 |

## Benefits of quitting

Quitting tobacco use produces immediate and long-term benefits. Education about these benefits is a useful motivational tool. Positive health changes occur almost immediately when a personstopsusing tobacco.

| TIME AFTER QUITTING | CORRESPONDING EFFECT |
|---|---|
| 20 minutes | Blood pressure and pulse rate return to normal. |
| 8 hours | Nicotine and carbon monoxide levels in blood reduce by half; oxygen levels return to normal. |
| 24 hours | Carbon monoxide is eliminated from the body. Lungs start to clear out mucus and other smoking debris. |
| 48 hours | There is no nicotine left in the body. Ability to taste and smell is greatly improved. |
| 72 hours | Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase. |
| Long term | Health and quality of life improves. Improved general health, food taste, better sense of smell, improvement in physical activity, reduction of wrinkling/ageing of skin, having healthier babies, setting a good example for the family, improved personal image, no foul smell, white teeth |

### Barriers to quitting

Barriers to quitting are important for all tobacco users. Providing information and correcting misconceptions in advance can be very effective in helping tobacco users overcome their barriers.

The common barriers to quitting include: Withdrawals and cravings (Irritability, Insomnia, Coughing, headaches, nose bleeds), stress, past failed quit attempts, peer pressure and fear of weight gain. The healthcare providers should individualize counteracting coping activities to the presenting patients.

## Intervention for tobacco dependence

Tobacco cessation interventions associated with Non communicable disease like hypertension and cancers are less costly than other routine medical interventions. Health care professionals should document tobacco use status of each patient and also screen those who use tobacco to establish their level of dependence. All patients who visit any healthcare facility should be offered at least a brief tobacco cessation intervention.

The Fagerstrom Test for Nicotine Dependence(11) is a standard instrument for assessing the intensity of the physical addiction to nicotine. This test helps healthcare professionals document the indications for prescribing medication for nicotine withdrawal. The higher the Fagerstrom score, the more intense the patient's physical dependence on nicotine. Higher scores indicate that to treat withdrawal symptoms, in most cases nicotine replacement therapy will be an important factor in the patient's plan of care.

Categories of tobacco dependence treatment and cessation interventions:

There are three main categories of intervention:

i) Brief advice by a healthcare professional,
ii) Behavioral support and
iii) Pharmacotherapy. (12,13,14).

### i) Brief Advice (The 5As and 5Rs model)

Brief therapyis the focused application of therapeutic techniques specifically targeted to a symptom or behavior and oriented toward a limited length of treatment. Tobacco cessation research (15,16) strongly supports the use of a comprehensive, clinic-based approach to tobacco cessation, known as the 5A's- ask, advise, assess, assist, and arrange follow-up. The following steps are recommended as the "5As" for effective intervention for tobacco cessation in current users.

**Step 1: Ask-** about tobacco use at every clinic visit. Whether the patient uses tobacco currently, has used tobacco in the past, and, if so, whether they are currently interested in stopping.

**Step 2:Advice-** on the benefits of stopping tobacco use and the health risks of continued use of tobacco should be given in a personalized manner.

**Step 3: Assess- Motivation to quit smoking.**
Does the patient want to stop tobacco use? How important is it for the patient to stop using tobacco? Would the patient be prepared to stop tobacco use in the next 2 weeks?

Not ready to quit

**The 5Rs for low motivation include:**

**Relevance -** How is quitting most personally relevant to you?

**Risks -** What do you know about the risks of tobacco use?

**Rewards** - What would be the benefits of quitting?

**Roadblocks** - What would be difficult about quitting for you? Any challenges?

**Repetition**
Repeat assessment of readiness to quit if still not ready to quit repeat intervention at a later date.

Not ready to quit? End positively.

Ready to quit

**Step 4: Assist-Help the tobacco user in quitting**

- Set a quit date, ideally in 2 weeks
- Provide actual counseling ;motivational interviewing
- Discuss possible nicotine withdrawal symptoms and their management
- Identify triggers for tobacco use
- Ask family and friends for support
- Make a personalized action plan with treatment recommendations.
- Offer self-help materials like leaflets, booklets

**Step 5: Arrange - a follow-up contact.**

- First follow up visit near the quit date, preferably during the first week, with a second visit within the first month.
- Telephone contact may also be helpful.
- At each follow-up, contact success should be congratulated, and problems and difficulties should be identified to help facilitate the patient's attempt.

Ideally, cessation should be validated in 1 month and then again in 3, 6 and 12 months.

## ii) Behavioral support

Behavioral support aims at changing thought processes and beliefs. A change in the way someone feels about tobacco use, will trigger a change in behavior. The healthcare provider helps the person to deal with negative feelings and assists the clients in identifying triggers or barriers to tobacco cessation and anticipating coping mechanisms to the triggers by setting realistic goals to avoid failure.

Behavioral strategies that can support a client to cope with the triggers and high-risk situations for tobacco use include:

a) Face to face support
   - Individual behavioral counseling
   - Group behavior therapy

b) Telephone counseling or quit lines
c) Self-help materials

While providing the face to face support; the healthcare practitioner should offer a warm environment and positive regard to all clients, establish rapport to ensure successful follow up, Offer individual personalized support to each client, Conduct no less than 4 sessions, in the understanding that the greater the number of sessions the better the result, Assign specific time to provide support in tobacco cessation treatments and promote and reinforce a positive attitude toward tobacco cessation by emphasizing the relationship between tobacco use and the patient's current condition.

During the telephone counseling/quit lines support; the healthcare provider should use telephone follow-up to help recover clients in case of relapse or loss of motivation, Keep a record of all calls relating to tobacco cessation and interventions offered, Categorize them as quit support, follow up or relapse and Refer the caller to a face-to-face service

## Practical counseling in Face to face support and telephone counseling

| Practical counseling (Problem solving/ skills training) | Examples |
|---|---|
| Recognize danger situation -<br><br>*Identify events, internal states or activities that increase the risk of smoking or relapse.* | • Negative effects and stress<br>• Being around other tobacco users<br>• Drinking alcohol<br>• Experiencing urges to smoke<br>• Availability of cigarettes and other things that reminds one of smoking |
| Developing coping skills -<br><br>*Identify and practice coping or problem solving skills. Typically these skills are intended to cope with danger situations* | • Learning to anticipate and avoid temptation and trigger situations<br>• Learning cognitive strategies that will reduce negative moods<br>• Accomplishing lifestyle changes that reduce stress, improve quality of life and reduce exposure to smoking cues<br>• Learning cognitive and behavioral activities to cope with smoking urges. |
| Provide basic information -<br><br>*Provide basic information about smoking and successful quitting* | • The fact that any smoking (even a single puff) increases the likelihood of a dull relapse.<br>• Withdrawal symptoms typically peak within 1-2 weeks after quitting but may persist for months. E.g. Negative moods, urges to smoke and difficulty concentrating. |

### c. Self-help materials

Access to self-help materials like booklets and brochures detailing tobacco effects, available interventions and contact information for further support should be readily availed to clients as they visit healthcare practitioners. The clients could also be directed to websites and support groups or other media platforms that have this information.

## iii) Pharmacological interventions

Tobacco users who have difficulty quitting tobacco use on their own or through brief interventions due to withdrawal symptoms and craving will benefit from pharmacological interventions to increase their cessation success.

The pharmacological interventions include:

1. Nicotine replacement therapies
    - Nicotine gums
    - Nicotine patches
    - Nicotine lozenges/sublingual tablets
    - Nicotine inhalers
    - Nicotine nasal spray

2. Non-Nicotine replacement therapies
    - Bupropion
    - Varenicline

### Nicotine Replacement Therapy (NRT)

Nicotine replacement therapy is the replacement of nicotine by means other than tobacco. This is to protect the person making a quit attempt from the effects of the other thousands of chemicals found in tobacco products. NRTs reduce withdrawal symptoms associated with nicotine addiction, allowing the tobacco user to focus on the psychosocial aspects of quitting tobacco use. The best results are achieved when combined with behavioral advice and follow-up. Some available tobacco pharmacological interventions include:

| Name | Mechanism of action | Duration | Dosage |
|---|---|---|---|
| **Nicotine gum** | Delivers nicotine through the lining of the mouth | Up to 12 weeks or as needed | 2mg, 4 mg<br>One piece every 1-2 hours; not to exceed 24 pieces daily |
| **Nicotine inhaler** | Delivers nicotine through the lining of the nose | Up to 6 months; taper at the end | 10 mg cartridge delivers 4mg inhaled nicotine vapor<br>6-16 cartridges per day, tapering at end of treatment |
| **Nicotine lozenges** | Delivers nicotine through the lining of the mouth | 3-6 months | 2mg, 4 mg<br>At least 9 lozenges per day in first 6 weeks; not to exceed 20 lozenges daily |
| **Nicotine nasal spray** | Delivers nicotine through the lining of the nose | 3-6 months; taper at the end | 0.5 mg nicotine in 50 ?l aqueous nicotine solution<br>Minimum dose = 8 doses daily; Maximum dose = 40 doses daily |
| **Nicotine patch** | Delivers nicotine through skin | 8-12 weeks | 24 hour delivery systems 7mg, 14mg, 21mg<br>16 hour delivery systems<br>21 mg daily, first four weeks; 14 mg daily, next two weeks; 7 mg daily, next two weeks |

**Non-Nocotine replacement Therapies**

| Drug | Mechanism of action | Duration | Dosage |
|---|---|---|---|
| **Varenicline** | Varenicline is orally administered. It operates in two ways. (i) As an antagonist" it blocks nicotine's connection to receptors in the brain, making smoking less satisfying and desirable. (ii) As an "agonist" it mimics the effects of nicotine, therefore reducing the cravings and withdrawal symptoms. If lapses occur, current dose should be continued as well as efforts to quit tobacco use. Varenicline is not recommended for pregnant and lactating mothers. | It is usually started 1-2 weeks before the quit date. It is taken for 12 weeks | 0.5mg, 1 mg tablet |
| **Bupropion** | Bupropion is an extended-release medication that reduces symptoms of nicotine withdrawal. It acts on chemicals in the brain that are related to nicotine craving, but it does not contain nicotine. It is effective for both genders and has been shown to aide cessation in depressed patients. Treatment with bupropion begins while the user is still using tobacco, one week prior to the quit date. | Tablet taken at least 7 weeks to 12 weeks. An interval of at least 8 hours between successive doses is advised. The quit attempt should occur during second week of | 150mg sustained release tab. 150 mg/day, given every morning for the first 3 days 300 mg/day, given as 150 mg twice daily (morning and evening). |

## Smoking interventions in special groups

There are tobacco users that are seen to be special as they have high tobacco use rates, have special barriers to their access to tobacco cessation interventions and they are also the group where research as to the most effective approaches to assist them is often limited.

Some of these populations that are described as 'special groups' are discussed below:

| Special groups | Effects | Intervention |
|---|---|---|
| Pregnant and lactating women | Women who use tobacco are at risk of :<br>1. Miscarriages and stillbirths,<br>2. Higher rates of sudden infant death syndrome than the general public.<br>3. Infants born to tobacco users are also at a higher risk of brain damage, low birth weight, and respiratory disorders.<br>4. Children exposed to secondhand smoke are more likely to suffer from health problems, including pneumonia, bronchitis, ear infections, and asthma. | • Offer or refer the women to more intensive and ongoing counseling.<br>• Interventions should be tailored to the specific needs of the woman and address the effects of tobacco use during pregnancy.<br>• NRT can be considered for use in pregnancy and during breastfeeding if one is unable to quit on their own. |
| Younger tobacco users | 1. The younger the age of uptake of tobacco use, the greater the harm is likely to be- because early uptake is associated with subsequent heavier tobacco use, higher levels of dependency, a lower chance of quitting, and higher mortality (17 ).<br>2. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke. | • Screen pediatric and adolescent patients and their parents for tobacco use. Provide a strong message regarding the importance of totally abstaining from tobacco use.<br>• Counseling and behavioral interventions shown to be effective with adults should be considered for use with children and adolescents.<br>• Offer tobacco use cessation advice and interventions to parents to limit children's exposure to secondhand smoke |

| | | |
|---|---|---|
| Patients with mental illness | People with a mental health disorder have significantly higher tobacco use rates than the general population and there is growing evidence to show a strong association between tobacco use and mental health disorders (18) | • Screen patients for tobacco use.<br>• Offer to help by providing proven cessation interventions.<br>• Mental health professionals should be especially aware of the behavior changes that may occur with withdrawing from nicotine, and should make sure that their patients are aware of them.<br>• Medicines used to treat mental illness may need to be monitored and adjusted for those who are trying to quit tobacco use. |
| Patients with other substance addictions | Drug and alcohol abusers have been shown to use tobacco more than the general public and therefore have an extremely high rate of nicotine dependence. | • Screen all patients with substance addictions for tobacco use<br>• Offer effective cessation strategies<br>• Concurrent treatment for tobacco and other substances is effective, and combining treatments is a useful and successful way to treat concurrent addictions. (19) |

| | | |
|---|---|---|
| Smoking intervention for hospitalized tobacco users | A hospitalized patient offers a good opportunity for cessation advice and support. The time they spend in the hospital ward should be utilized to support them make a quit attempt. It is often the ward nurses who are relied on to recognize the symptoms (increased appetite, insomnia, coughing, irritability, and dizziness) and make the appropriate referral. | • Offer cessation information and treatment.<br>• Withdrawal from nicotine needs to be recognized and treated appropriately.<br>• Offer NRT treatment and motivational interviewing as appropriate. |
| Second hand smokers | 1. There are more than 7000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 70 are known to cause cancer. Exposure to secondhand smoke therefore exposes someone to all these chemicals and causes premature death and disease in children and adults who do not smoke.<br>2. There is clear evidence of the harms of exposure to environmental tobacco smoke in pregnancy, to children (higher rates of respiratory and middle ear infections, meningococcal infections and asthma) and adults (increased risk of lung cancer and coronary heart disease)( 20,21 ). | • Awareness creation on effects of second hand smoke<br>• Supporting the smokers who are exposing others to make a successful quit attempt;<br>• Urging smokers not to smoke in the presence of non-smokers;<br>• Effective laws to protect members of the public from secondhand smoke. |

## RELAPSE PREVENTION

Relapse can be said to be when a former tobacco user returns to the habit of tobacco use months/years after quitting. Most tobacco users have difficulty quitting. As such it is important to ensure that relapse prevention strategies are included in tobacco cessation interventions to prevent relapse. Some of the factors that can trigger a relapse include:

- Negative moods (stress, frustrations, anxiety, loneliness)
- Positive mood (Euphoria, Excitement, Happiness)
- Interpersonal conflicts (Marriage, friendships, employments)
- Social pressure (Being in the presence of tobacco users)
- Specific activities (drinking alcohol Caffeine consumption)
- Not complying with medication

Relapse prevention strategies also aim to prevent a lapse from occurring or if it occurs from becoming a full relapse to tobacco use.
Suggested relapse prevention strategies include:

- Identifying high-risk tobacco use situations and important triggers
- Planning of coping strategies in advance
- Considering lifestyle changes that may reduce the number of high-risk situations encountered (stress management, reduction in alcohol consumption)
- Encouraging clients to have a plan for how to deal with a slip to prevent it becoming a full relapse
- Develop support structures and networks of family and friends

## MONITORING AND EVALUATION

Every healthcare provider should ensure that tobacco dependence treatment and cessation services within their facilities are continuously monitored and evaluated. This will be done through routine tracking of the key elements of program performance and periodic assessment of the change in targeted results that can be attributed to an intervention.

Outcomes of both monitoring and evaluation should be used to improve tobacco dependence treatment and cessation services.

Careful M&E methods should be built-into the programs to provide the data necessary for continual improvement. The collected data should be analyzed routinely by all healthcare providers to ensure meaningful interpretation of the data is achieved. Feedback should be given to all necessary authorities at each level.

Tobacco use information should be incorporated into the existing data collection tools. Every healthcare provider for tobacco cessation services should ensure that information on tobacco use is well captured.

### Supervision support

Supervision of tobacco cessation services should be integrated into the existing supervisory structures.

### Health education and promotion

All clients visiting any health facility should be provided with the opportunity of accessing information on the dangers of tobacco use and exposure to smoke.

Methods of health communication include:

1) Health talks
2) Information education and communication materials
3) Audio-visual

### Tobacco-free champs

Tobacco-free champs are individuals or entities that are easily recognized and respected in a community/nation. These include any providers who offer smoke free option; businesses that help their employees quit smoking, groups that promote tobacco free living policies and individuals who support others to steer clear of smoking, chewing and use of other tobacco products.

Tobacco-free champs will be championing promotion of tobacco-free recreation, creating supportive environments for clients making the journey to tobacco-free living, lobbying for tobacco-free policies, forming youth clubs championing tobacco-free activities and commitment to support clients with multiple challenges for example mental illness.

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