

STRATEGY FOR TOBACCO CESSATION IN SRI LANKA

2020-2025



Ministry of Health,
Nutrition & Indigenous Medicine



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National Authority on Tobacco & Alcohol



World Health
Organization

Sri Lanka

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**National Authority on Tobacco and Alcohol,
Ministry of Health, Nutrition and Indigenous Medicine,
Sri Lanka**

**World Health Organization,
Country Office for Sri Lanka**

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Strategy for Tobacco Cessation in Sri Lanka: 2020-2025

1. Preamble

This strategy aims to implement Article 14 the WHO Framework Convention on Tobacco Control (FCTC) in a manner which suits the context of Sri Lanka.

Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC) states that “each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, considering national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence”.

Article 14 Guidelines assist Parties to meet their obligations under the treaty, based on the best available scientific evidence and considering national circumstances and priorities. Supporting quitting tobacco use is an evidence-based measure to reduce demand of tobacco as advocated under WHO MPOWER package.

This strategy approaches tobacco use cessation using the two complementary approaches of community and clinical cessation. The success shown in Sri Lanka with regards to community cessation and the recent reductions of smoking following policy and statutory changes were taken as lessons learned in formulating this strategy.

The strategy was formulated following an Expert Consultative Meeting held in March 2019 in Colombo Sri Lanka. It was agreed that community cessation would be more cost effective compared to clinical services.

2. Community Tobacco Cessation

Community tobacco cessation goes beyond cessation by individuals in a clinical or community setting. It encompasses a broad array of actions driven by the participation of the communities to reduce the use and harm of tobacco. The advantage of this model is that a large number of people will quit tobacco use within a short period of time. Whilst the people who quit benefit most from this approach, the whole community becomes aware of, and gains the ability to address the determinants of tobacco use, that otherwise goes unnoticed in clinical settings. The advances made are also more sustainable.

A wide array of activities can be carried out as part of a community cessation programme. The different levels at which such activities should take place are the national, divisional and community or village levels.

1. National level cessation programmes can be promoted through the both government non-government agencies. Political and public commitment should emphasized and the regional level agencies should be encouraged to undertake promoting quitting all forms of tobacco use in communities. The overall aim is to create a national trend in quitting and rejecting of all forms of substance abuse including tobacco. There are many evidence based measures that can be used for this purpose, which are specified in the WHO MPOWER package.
2. Divisional level community cessation strategies should be carried out at the level of the Divisional Secretariat and the Medical Officer of Health (MOH) Area level.
3. Village and community level community cessation activities should be facilitated, for example, by any interested group of people or through government or non-government agencies. This include encouraging, supporting and fostering activities carried out by the tobacco users, general public and civil society that promote quitting.

3. Cessation Services in Clinical Settings

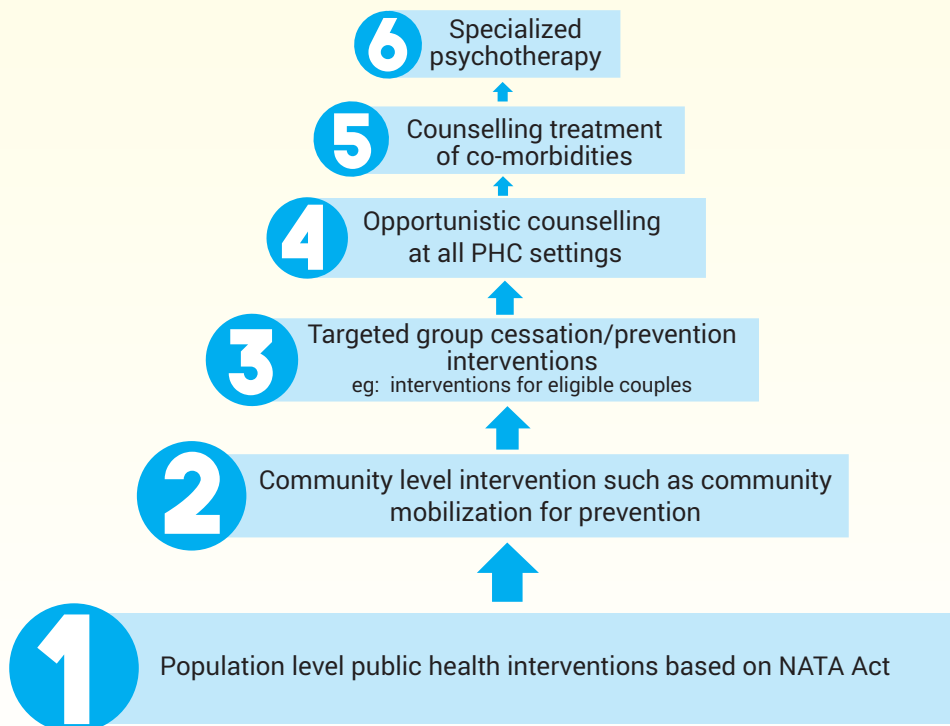
Sometimes, persons with addiction problems seek treatment. Some clinicians also expect the availability of such services for the management of patients having major co-morbid medical conditions (e.g. diabetes, tuberculosis, disorders of the heart, lungs etc.) and psychiatric conditions. Hence, it is appropriate to strengthen the clinical services for tobacco cessation available throughout the country. The cessation services required at the clinical settings will consist of the following:

1. Clinicians delivering brief interventions to all tobacco users.
2. Opportunistic screening and offering treatment (including counselling) to all the patients identified as users of tobacco at the first contact or primary care.
3. Targeted interventions for high risk groups such as those with medical conditions and psychiatric disorders.

4. Specialist level clinical interventions provided at dedicated de-addiction clinics, which will be staffed by clinical psychiatry staff and will be available at the Base Hospitals throughout the country.

The Experts' consensus at the Consultative Meeting was to recommend conducting clinical cessation services as non-pharmacological treatment services which usually include counseling and specific forms of psychotherapies. This decision was reached considering the successes shown in the absence of medications such as Nicotine Replacement Therapy (NRT) as well as the low effectiveness of such medications. This however, does not restrain prescribing such medications for co-morbid medical conditions and psychiatric disorders.

The following is a hierarchical approach for cessation services appropriate for integration of clinical and population-based interventions. The clinical services such as Quitline counselling services and the clinics at Base Hospitals could easily be linked.



When implementing programs for promotion of quitting in the country, care should be exercised in preventing contradiction of, or undermining the effects and efforts of other programs. For example, too much of emphasis on counselling and clinical services would run the risk of damaging the self-efficacy of the large number users who attempt to give up tobacco on their own, that consists of the vast majority of successful quitters.

Tobacco cessation counselling and treatment should be made available for individuals who seek treatment from health care settings. The initial phase should cover the general population of tobacco users, who attend hospitals for any kind of illness. This approach should aim to help as many users to quit or change their patterns of use with minimal intervention from the health care workers. Mainstreaming provision of brief advice for tobacco cessation in other related health programmes such as noncommunicable disease (NCD) prevention, oral health, drug de-addiction, tuberculosis control, mental health etc. is important in this respect. Such low cost interventions have been found to be helpful in many primary care settings.

Appendix 1

Community Cessation: Activities and Examples

As community tobacco cessation have been shown to be effective and cheaper, the public health apparatus of the Ministry of Health (MoH) in collaboration with other organizations such as schools, universities, local government agencies and NGOs should work towards creating tobacco free zones at village and regional levels. These initiatives will create a conducive environment and enhance demand for tobacco cessation.

Specific suggestions and examples:

1. The overall aim should be to create a culture of cessation of all forms of tobacco (and all forms of substances of abuse), and enable all users and those affected by tobacco to understand and deal with the determinants of tobacco use.
2. Identification of tobacco as a phenomenon existing due to an industrial vector should be acknowledged in all community cessation activities. Communities should also understand and identify strategies used by the tobacco industry to undermine the successes that have been achieved.

3. The NCD Unit, Mental Health Directorate, NATA, WHO and NGOs should collaborate to organize a national-level quit campaign, led by the highest level authorities.
4. Technically correct approaches should be adopted in conducting community cessation programs. This should essentially prevent glamorizing tobacco use inadvertently when implementing community programs.
5. Recruitment of the Health Promotion Officers (HPOs) who would be placed under the supervision of Medical Officers of Health should be expedited. These officers should be used to encourage to conduct community cessation activities as well as health promotion activities in relation to NCD.
6. Community tobacco cessation should be integrated into all NCD prevention and treatment programs, and de-addiction programmes for alcohol and substance use.
7. Monitoring and mapping community cessation programmes should be conducted by the NCD Directorate.
8. Medical Officer of Health units should include community cessation in their routine work for addressing NCD.
9. The field officers at the Divisional Secretariats could be used as resource personal in conducting community cessation programs. These networks outside the Ministry of Health should be utilized to carry out their own community cessation programs. The relevant training should be provided by NATA and the Ministry of Health.
10. All types of workplaces should be made free of all forms of tobacco use. All workers in a given workplace should be empowered to counteract the determinants of tobacco use.
11. Institutions and workplaces that engage in effective community cessation and other tobacco control initiatives should be publicly recognized and rewarded.
12. Competitions should be organized among agencies that work for community cessation in order to encourage and popularize effective community cessation activities.
13. The best examples of community cessation should be showcased to promote mutual learning.

14. School children should be encouraged to become an active force in promoting community cessation rather being passive recipients of health education services.
15. Divisional Secretaries, Grama Niladharis and Samurdhi Officers and other government officials should be sensitized and given specific responsibilities to promote community cessation activities.
16. Community Policing Committees should be formally recruited as agencies of change with regards to community cessation. A formal link with the Police Department and NATA or NCD Directorate should be established and used for continuous implementation and monitoring of such programs.
17. Liaisons should be formed with specific village level organizations such as “Maranadara Samithi” to carry out community cessation activities.

Appendix 2

Cessation in Clinical Settings: Activities and Examples

The following stepwise approach is suggested clinical services on cessation of tobacco use:

1. Director-General of Health Services should issue instructions in relation to improving the identification of tobacco related problems among all the patients who attend government hospitals in Sri Lanka either as in-ward patients or as out-patients.
 - a. All male patients should be questioned on tobacco use including use of smokeless tobacco. Female adult patients who are likely tobacco users should be questioned on tobacco use as well. Women and Children who are not suspected of using tobacco should not be questioned on use, as it will contribute to generalization of tobacco use. Exposure to second-hand smoke should be ascertained in women and children who have specific signs or symptoms related to such exposure.
 - b. All users of substances including tobacco should be advised on stopping use, at a time that she or he is assessed for any kind of illness, whether at the OPD or at a ward setting.
 - c. All health staff should be given a training on tobacco cessation. This should be done over a period of time, with the aim of covering the whole country at an appropriate level. The Directors and the Medical Officers in Charge (MOICs) of respective health institutions will be responsible for implementing cessation services and reporting back to the NCD Directorate.
 - d. The training of full-time General Practitioners (GPs) on tobacco cessation should be carried out as a professional development activity with the Independent Medical Practitioners Association and the College of Family Medicine, Sri Lanka.
2. Addiction clinics should be set up at Base Hospitals where a Consultant Psychiatrist is available. At present, the focus should be on motivating people to quit and the provision of ongoing individual and group counselling, in that order.
3. Staff in all the dental clinics including dental doctors in should be trained in Brief Interventions.

4. A refresher course on tobacco cessation for all practicing psychiatrists in the Base Hospitals and at District level should be offered as a Training of Trainers (ToT) in order to facilitate trainings in (3) above, and to facilitate intervention programs. This should be carried out by NATA or the Mental Health Directorate with the collaboration of the Sri Lanka College of Psychiatrists. The respective psychiatrists will train the staff of the NCD cells in the respective catchment areas.
5. The existing Quitline should be expanded to include 10 stations. The “proactive” aspect of the Quitline should be redefined and should go beyond the 5A (Ask, Advise, Assess, Assist, and Arrange), 5R (Relevance, Risks, Rewards, Roadblocks, and Repetition) and STAR (Set quit date, Tell family and friends, Anticipate challenges, Remove tobacco products) activities. The theoretical basis should include making the users identify and address the environmental factors which lead to initiation, maintenance and relapse of tobacco use. This should include dealing with the behaviour of the vector (the tobacco industry) as well.
6. The Quitline should be linked to the respective Medical Officer of Mental Health clinic or the respective addiction clinic depending on the facilities available. This will enable the caller to be directed to the nearest one-on-one counselling facility, if required.
7. The provision of nicotine replacement therapy (NRT) or any other medication should not be considered as essential right now.

Appendix 3

Monitoring of the Implementation of the Strategy

Monitoring of Community Cessation Component

The Directorates of Non Communicable Disease and Mental Health of the Ministry of Health and the National Authority on Tobacco and Alcohol (NATA) should be primarily responsible for monitoring, recording and documenting these activities. Medical Officer of Health, Divisional Secretariat or other area-level mapping should be used to map the implementation. The data should essentially reflect the number of villages, Grama Niladhari areas etc. which are carrying out community-wide cessation activities.

The estimated amount of money saved in the area could be taken as an indicator of success. Likewise, the number of outlets which have stopped selling tobacco and the number of workplaces where all forms of tobacco is discouraged could be counted as well.

Monitoring Clinical Services

The Addiction Services have to be monitored for their effectiveness in a rigorous manner. As this is an area where inadvertent harm occur, careful evaluation of programs should be carried out on a scientific basis.

The following aspects are suggested to be monitored - infrastructure and facilities, staff (including training) and outcome at individual patient level. Monitoring of effectiveness should take into account of the referrals, number of patients seen, number of patients offered specific forms of treatment, follow up rate and method and quit rates (short term, medium term and long term).

Cessation treatment is a small component of the total tobacco cessation program. In the context of Sri Lanka where most smokers use few cigarettes a day (around to 3 or 4), the supply of NRT and other medications could be unnecessary at best and harmful at worst. The introduction of, wide publicity given to NRT and smoking cessation aid medications have been identified by experts as something which interferes with the self-efficacy of the large number of tobacco users who want to quit.