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1. Summary

This Global Bridges European Scoping exercise has been carried out to identify and determine which European countries might want to receive evidence-based support and assistance to help improve tobacco dependence services; and to identify the specific support needs these countries have.

This scoping exercise included three phases of activity; phase one (web-based research), phase two (direct country contact) and phase three (face-to-face exploratory meeting with selected countries).

The face-to-face meeting was held in Birmingham, UK on 21 June 2012 and was attended by members of the Global Bridges team, the National Centre for Smoking Cessation and Training (NCSCT) and representatives from the following European countries:

- Azerbaijan
- Czech Republic
- Georgia
- Portugal
- Russia
- Spain

This report describes the activity and outcomes of all phases of work.
2. Background

Global Bridges is a worldwide science-based initiative that advocates for effective tobacco control policies while working to improve the training available to healthcare providers to treat tobacco dependence and support smokers to stop smoking.

It is evident that a wide variation in prevalence of smoking across the geographical boundaries of Europe exists, from the lowest combined adult prevalence of 18% (Iceland) to the highest of 46% (Austria). It is also clear that there are differing levels of political support for tobacco control and tobacco cessation activities across Europe; and variability across healthcare systems in terms of capacity for such activities.

Moreover, levels of knowledge among healthcare professionals, as well as prevailing attitudes and behaviours around the treatment of tobacco dependence vary widely. Although many countries do provide tobacco dependence services to support people to stop smoking these will largely be underutilised unless healthcare professionals are encouraged to offer support to all smokers; this is especially true when considering the fact that brief interventions by trained healthcare professionals double the rate of quit attempts.

The Global Bridges European Scoping exercise has been carried out to identify and determine which European countries might want to receive evidence-based support and assistance and to determine the specific support needs these countries have in improving tobacco dependence treatment services across the region. Training opportunities could include adaptation and introduction of the NCSCT Very Brief Advice on Smoking training module, and/or other approaches including guidance documents, face-to-face training courses and intervention aids.

Three phases of work have been undertaken to identify: countries that would be interested and eligible with a priority ranking and options appropriate for these countries.
3. Methods

During phase 1 existing sources of publically available data were used to provide a contextual summary of each European country, including: an overview of the country and its population; prevalence of smoking; and any publicly available information about tobacco dependence services, including access and staff training.

Each country’s Ministry or Department of Health website was searched. As well as latest prevalence data, general data about the country were gathered from web and paper-based sources with published survey data (including EQUIPP and WHO country profiles) also searched. Any websites concerning tobacco dependence were identified and used to provide further relevant information.

The contacts identified through phase 1 were approached via an initial introductory email (Box 1) in phase 2 and were asked to provide further information to either confirm or refute the gathered information summary. Those who requested that questions were posed by email were sent a follow-up email (Box 2).

**Box 1**

**Subject: Tobacco dependence services**

Good morning / afternoon (name)

I am working as part of the Global Bridges team to better understand the situation in all European countries with regards to tobacco treatment services – that is to say, health services that exist to help the citizens of your country to stop using tobacco. This project is the beginning of what we hope will be ongoing work across Europe to improve services and support health care professionals to identify and help tobacco smokers to stop. Initially we hope to use this work to identify one or more countries who would like to work with us to develop unbiased, evidence based training and development support for their health care professionals.

More information about this scoping exercise and the Global Bridges project in general can be found here: www.ncsct.co.uk/training/ncsct-training/global-bridges

I would very much like to understand the situation in your country better, and to get your opinions about this work – would it be at all possible to speak on the telephone within the next week or so? If you agree, please could you let me know when you would be free and what contact number to use and I will call you, if you are happy to talk in English? If you would rather communicate by email, I can send you a list of questions for you to answer, just let me know. Either way, it shouldn’t take more than 15 to 30 minutes to complete.

Please do let me know if you are not the correct person to ask, I would be very grateful if you could let me know who I might ask if that is the case – and apologies for taking your time.
Box 2

**Subject: Tobacco dependence services in (country)**

Good morning / afternoon (name)

Many thanks for your email. Please see below my further questions. I would be very grateful indeed if you could reply with any response by 4th May.

1. Is medication to help people to stop smoking easily and widely available? If so, how do people access it? Do you have any information about how many people use it?

2. Please could you describe the current support available for people who want to stop smoking. Please could you include how do people access it, does it have a cost, how many people use it each year, how do you monitor it and how effective is it?

3. Are there any mass media campaigns to support quitting? If so, who funds them?

4. How are health professionals trained to identify and treat tobacco dependence? Are there any campaigns/training sessions to engage doctors and nurses in brief and very brief advice giving, and then onward referral or other action and who funds/provides them?

5. Are there current national clinical standards/guidelines for identification and treatment of tobacco dependence? If so, who wrote them and when?

Many thanks for your early response,

Further clarification emails were sent as required; with those who preferred to speak on the telephone asked the same questions, plus any additional questions that were needed to clarify or further develop themes that emerged in conversation.

Phase 1 and 2 identified the countries to be invited to attend the face-to-face planning and consolidation meeting that would happen at the end of June with the Global Bridges team to confirm plans for future collaborative working.

The selection criteria for possible inclusion in Phase 3 were as follows:

- high prevalence;
- high likelihood of governmental support;
- high likelihood of health care professional organisation sign up/involvement;
- most healthcare professionals having access to the internet and having a working knowledge of English; and
- high proportion of unassisted quit attempts in countries with established cessation services
4. Phase 1 and 2 outcomes: Country information

See Appendix 1

5. Phase 3: Global Bridges European Round Table Meeting

This meeting was held on 18 June in Birmingham UK. The agenda (Appendix 3) and slide set (Appendix 4) are appended to this report.

Invited attendees were as follows:
George Bakhturidze (Georgia)
Andrey Demin (Russia – by videolink)
Carlos Jiminez Ruiz (Spain)
Eva Kralikove (Czech Republic)
Aynura Rashidova (Azerbaijan)
Sofia Ravara (Portugal)

Other attendees were as follows:
Emma Croghan (Global Bridges European scoping lead)
Richard Hurt (Global Bridges)
Katie Kemper (Global Bridges)
Andy McEwen (NC SCT)
Melanie McClvar (NC SCT)
Jennifer Tapsfield (NC SCT)
5.1 Meeting outcomes

The key themes which have emerged from this work, and were agreed at the meeting are:

1. Countries with high smoking prevalence and/or large populations offer a significant opportunity for sizeable public health gains. In many countries overall prevalence is skewed, with the relatively low female adult prevalence masking the high male prevalence. Azerbaijan is an example of one such country; it has a high male prevalence (>40%) and a very low female prevalence (<1%). Similarly, the Russian Federation has a very large population (142 million) an overall prevalence of 39% and has three in five men and one in five women smoking (half of all pregnant women in Russia smoke).

2. Some countries have a high degree of political support but lack expertise and experience in delivering tobacco control and smoking cessation services (e.g. the Russian Federation).

3. Other countries have relatively well developed programmes for reducing the burden of tobacco related diseases and have identified smoking cessation as an important public health issue but lack evidence-based training programmes. Belarus has high male prevalence (>50%), increasing female prevalence (around 9%) and has a current strategy for reducing cardiovascular disease. It has well supported professional educational programmes covering public health but does not appear to have a tobacco dependence training programme; either for brief intervention or dependence treatment.

4. There are also countries with high levels of smokers making unassisted quit attempts, showing a high potential for tobacco-dependence services interventions (e.g. Spain).

5. Finally there are countries with varying degrees of access to behavioural support and medication for smokers wanting to quit, which are underutilised. Greece has a high prevalence for both men and women and despite many of the country’s smokers wanting to quit, with 17% making a quit attempt in 2009, these are largely unassisted quit attempts. Evidence-based support and medication is available, but referral numbers are low. A similar situation can be found in Poland.

From the round table discussion, it was clear that there was a strong desire to work collaboratively to improve services and systems. The key areas identified in the meeting for further work/consideration and developments were: training; data management; financial and outcome modelling; referral management and advocacy.

5.1.1 Training

All participants stated a desire for an agreed, single set of evidence-based competences and standards for tobacco dependence treatment that could be used to deliver country-specific training, which encompassed knowledge and practice. Training is needed for those who deliver full tobacco dependence treatment as well as for referral agents (doctors, nurses, pharmacists). There is also clear opportunity to engage with medication delivery systems; in Azerbaijan, for example, no prescription is needed for any of the three tobacco cessation medications available and so pharmacists would be well placed to be trained to deliver behavioural support.

1. An exception to this is Austria where the high male prevalence (47%) is practically equalled by the female prevalence (46%).
5.1.2 Data management

Data collection and management, both in terms of prevalence and service delivery, needs to be uniform. Countries that are investing in, or delivering, tobacco dependence treatment services need to be able to identify: how many people want help; how many accessed treatment; the treatment received; and how successful this treatment was. Being able to demonstrate the effectiveness of cessation services would support an ‘invest-to-save’ model and would help make further investment/activity easier. Although the ‘invest-to-save’ case can initially be based upon academic assumptions, its effectiveness as a tool for change is greater if derived from real-time and real-population level data; and shown to have created nominal savings (this would also potentially allow a case to be made for hypothecation or other funding mechanisms).

5.1.3 Financial and outcome modelling

For many countries, it is difficult to make an objective case for investment in service delivery. A model which provides the case for an ‘invest-to-save’ argument that can be tailored and completed at individual country level would be very much welcomed. This needs to be tied to an assessment of service provision affordability so that cost benefit arguments can be developed. This is clearly related to the advocacy agenda but there is a specific need to provide objective and unbiased information about the local population, the impact of tobacco use on it, and the potential savings to the economy that will occur if effective treatment is initiated.

5.1.4 Referral management

Levels of professional knowledge, attitudes and behaviours within health and social care are an issue for many countries. Tobacco use among healthcare professionals can be high, while encouraging healthcare professionals (particularly doctors and nurses who are the most influential) to engage with tobacco dependence as a clinical issue can be difficult. There is a need to (a) encourage healthcare professionals to undertake Very Brief Advice or Brief Advice training and to identify tobacco users and to (b) support healthcare professionals by providing treatment options for their patients (including effective behavioural support and access to medication). There should be an easy (ideally not self-referral) referral pathway, as in other clinical areas of practice, so that all smokers are offered treatment.

5.1.5 Advocacy

Many of the issues discussed above would influence leaders and if implemented, and advocated, would improve services, funding and clinical knowledge. Advocacy at a national, regional and local level is needed and should be led by national and international Key Opinion Leaders (KOLs) (including politicians and clinical experts as well as local clinical leaders / influencers) to influence policy and practice in tobacco dependence treatment.
6. Recommendations and options for further work

The three phases of this work have provided an opportunity to better understand the diversity of the European region in terms of tobacco dependence treatment, as well as highlighting individual areas of high quality effective practice and areas of common need/concern.

The recommendations that can therefore be made for further action are, for Global Bridges to:

1. Provide clear resources for advocating cessation service provision. These should include a ‘pick and choose’ group of generic resources such as ‘invest-to-save’ models, online healthcare professional training programmes, affordability information, optimum care pathways, and PowerPoint presentations aimed at commissioners and providers of healthcare services.

2. Provide clear guidance on data collection, both prevalence and clinical activity, that would need to include; definitions (treated smoker, quitter, smoker, adult etc.), referral management and quality standards.

3. Develop a regional support programme to help clinicians to stop smoking and engage them as champions for tobacco control (also effectively recruiting them into collaborations such as the Global Nurse Network, once quit).

4. Develop and maintain a regional network of country leads.

5. Support and link similar issue countries together to develop groups who can work at a supranational level where there are common needs/concerns so that they can pool resources and actions.

6. Offer training solutions for clinicians that are accredited to the local CPD systems and advertise widely, including placing articles in local clinician journals to advocate the training, while also developing referral pathways for local clinicians to use in a VBA or Brief Advice system.

7. Support a European standard for the delivery of tobacco dependence services, linked to data monitoring and training.

8. Link together with other regional organisations, even if those resources are only available in part of the region, to share good practice and platforms for communications. This could include WHO, ENSH or EUPHA.

9. SRNT Europe will be held in Helsinki at the end of August 2012. It has been suggested that more European countries could attend a satellite meeting to help prioritise these recommendations. A decision on this would be needed before the August meeting to allow time to invite people and to arrange logistics.
The above are the list of actions that could follow this piece of work and could potentially impact across the region. Delivery could be undertaken in a number of ways:

1. A regional director could be appointed who could then strategically lead and coordinate a set programme of work against a set of agreed KPIs. They would also need administrative and delivery support, as well as a budget for delivery. This role would provide strategic leadership across the region and set the priority actions. They would need to be academically credible, internationally recognisable and a leader in the field.

2. Each piece of work could be commissioned by an experienced and known expert or leader in the specific field. This approach risks a ‘piecemeal’ outcome and lack of coordination but would be more defined.

Because of its well-developed national smoking cessation service, tobacco control activity and strong research base the UK is well placed to take a lead role within Europe and fulfil either of these roles.
Appendix 1: 
Phase 1 and 2 outcomes: country information

Albania

Albania is situated in South-East Europe and covers an area of 28,748 sq. km. There are 27 districts which act as local administrative divisions. The official language is Albanian. The population of Albania is 68,403. Smoking prevalence is higher amongst men than women: 60.7% of men, and 17.4% of women (38.7% of the whole population) smoke. Nearly half (45%) of households have internet access. The Albanian state healthcare system is state funded and managed and is divided into three tiers of service. The first tier and entry level to the rest of the health service is the level dealing in primary care, which includes health and hygiene and health education centres, maternity and paediatric clinics, local emergency rooms and rural hospitals. The next level provides secondary care and the final level provides tertiary care. Albania is working to establish its first National Telemedicine Centre through an USAID-funded project implemented by the International Virtual e-Hospital Foundation. The first public health policy which focused on tobacco control was developed in conjunction with Health Action Partnership International c.i.c. (Tavistock House (Entrance B), Tavistock House North, London, WC1H 9HX, United Kingdom). English is taught in schools, and younger people speak English, particularly around urban areas. According to the WHO, no medication is available to support quitting in Albania, although some support is available to help people to stop smoking; this is not funded and is not provided by health services. There is no national quit line. There is one government level employee, employed to support tobacco control development at a national level. Just under one third (30%) of Albanians made a quit attempt in 2009. In the same year 37% of smokers who saw a doctor during the year preceding the second survey received advice from healthcare providers to quit smoking; this was a decline from 2007 when 48% were advised. However, most quit attempts were unsuccessful as only 13% of ever smokers were no longer smoking in the 2009 survey.

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References
1. Albanian Adult Tobacco Survey 2009
2. Eurostat survey of internet access 2011
Andorra

Andorra is located in South-West Europe and has an area of 468 sq km. The government is a parliamentary principality. The population of Andorra is 84,864: 38% of men and 32% of women (35% whole population) smoke.¹

The official language is Catalan, although Spanish, Portuguese, and French are also commonly spoken. A large majority (81%) of households have access to the internet.²

Andorra is not a signatory of the FCTC.

There are 7 parishes, which act as administrative divisions. Healthcare in Andorra is provided to all employed persons and their families by the government-run social security system, CASS (Caixa Andorrana de Seguretat Social), which is funded by employer and employee contributions via salaries. The cost of healthcare is covered by CASS at rates of 75% for out-patient expenses such as medicines and hospital visits, 90% for hospitalisation, and 100% for work-related accidents. The remainder of the costs may be covered by private health insurance – if it is not covered by insurance, an out of pocket payment is required at point of care. Other residents and tourists require full private health insurance.

The main hospital, Meritxell, is in Escaldes-Engordany. There are also 12 primary health care centres in various locations around the Principality. NRT can be purchased over the counter in pharmacies and bupropion and varenicline are both available on prescription. At Phase 1, there do not appear to be any standardised smoking cessation services.

References

1. WHO age standardised estimates 2009?
2. Eurostat survey of internet access 2011
Armenia

Smoking prevalence stands at 55.6% of men, and 2.9% of women (28.3% of the whole population); these have all increased since 2007. The official language is Armenian, although many people also speak Russian. English is not widely spoken outside of the capital and 37% of households have internet access. Cardiovascular Disease (CVD) and cancer account for 70% of all deaths and 20% of all morbidity relates to respiratory disease. The role of the Armenia Ministry of Health has been to license, regulate, monitor and set guidelines for service provision, rather than to act as a provider of services. The Ministry addresses policy issues in four key areas: service delivery, human resources, financing and stewardship (which is essentially strategic leadership). Most services are provided through private health care systems and out of pocket payments at point of care. There is one government employee leading on tobacco control. Our contact has confirmed that nicotine gum, cytisine (Tabex), varenicline (Champix) are all now available, but are not easily accessible due to financial barriers. Only varenicline is available to smokers by prescription. The country does not collect data on the demand/use of medication. Our contact confirms that there is currently no behavioural support available at all. There is no national data collected on the use of the medications and on quitting in general, except the sporadic national surveys of prevalence which show some increasing trend for quitting among men. Very sporadic shot-term education programs were implemented by the Yerevan Medical University to provide some basic knowledge on cessation within the framework of continuing medical education for family physicians, but these are no longer provided. There are guidelines on tobacco use treatment and counseling for primary healthcare physicians endorsed by the Ministry of Health (2009). They were developed with support of the WHO, but the concordance of health care professionals and associated activity in line with the guidance is not known. Armenia would benefit from a wider package of support, starting with gaining support at the policy and health care professional leadership level for smoking cessation activity. The American University of Armenia is in a good position, and is content to coordinate activity, with support. An advocacy toolkit would be well placed to be used in Armenia.

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References

1. Armenian Health Systems Performance Assessment, 2009, WHO
2. Armenian Health Systems Performance Assessment, 2007, WHO
3. Eurostat survey of internet access 2011
Austria

Austria is located in central, mainland Europe covering an area of 83,870 sq. km. It is a federal republic, with a democratically elected government. There are nine federal states which act as administrative divisions. The population of Austria is 8,169,292, with 47% of men and 45% of women current smokers.1 The official language is German, but 58% of the population speaks English2 and 75% have access to the Internet.3 Healthcare in Austria is universal for residents of Austria and is funded by a national health insurance system.

There are cessation services, delivered by medical doctors, sometimes assisted by other HCPs, partially funded by the national health service insurance scheme, which are managed on a regional basis. Advisers receive formal training in medical schools, or ‘on the job’ training. NRT is available over the counter in pharmacies, and both Varenicline and Bupropion are available on prescription. Austria has the highest use of (unsupported) NRT in Europe. 21% of smokers made a quit attempt in 2009, 31% of these unassisted.4,5

A national quitline (www.rauchertelefon.at) provides smoking cessation advice organised by the Lower Austrian Gebietskrankenkasse and funded by a collaboration of health insurance funds, the provinces and the Federal Ministry for Health.

Brief interventions by physicians are not systematically implemented and referrals to services are most commonly self-referrals or morbidity related – i.e. the smoker has a smoking related condition.

There is no national coordinator for tobacco control or smoking cessation activity.

References
1. WHO age standardised prevalence estimates, 2009
2. MPOWER age standardised prevalence estimates, 2009
3. Eurostat survey of internet access 2011
4. TNS Opinion and Social European Commission Eurobarometer 332 Tobacco 2010
Azerbaijan

Located in Eastern Europe, the total population of Azerbaijan is 9,047,932, with 55% of the population living in urban areas. Of the total population, 41% of men and less than 1% of women smoke. The three main languages are Azeri, Russian and English, while 36% of the population have access to the internet. The main cause of death is CVD. In 2010, NRT, varenicline and bupropion were unavailable; but now NRT, cytosine and varenicline are available, with only varenicline on prescription. All are very expensive. There is no state wide provision to date available for smoking cessation. In general, health services are structured vertically to respond to diseases and health conditions, with policy making, financing, and service delivery concentrated in the Ministry of Health. Despite its oil wealth, public health expenditures were only 0.9% of GDP in 2008. Currently, there is practically no health service support available for people who want to stop smoking, nor health professionals trained to identify and treat tobacco dependence in Azerbaijan. Recently the Ministry of Health of Azerbaijan Republic has approved the National Clinical Protocol on Smoking Cessation that was developed by the Public Health and Reforms Centre. The intention, therefore, is now to work toward setting up an effective health service network available for people who want to stop smoking. However, tobacco control is an area of development in the country: ‘The Preparation of the National Strategy for Combating tobacco’ has recently been developed, funded by the Bloomberg Initiative. Action against this strategy will be coordinated through the International Union Against Tuberculosis and Lung diseases. This project is led by the Ministry of Health Public Health and Reforms Center of the Republic of Azerbaijan, Azerbaijan Health Communication Association and the Johns Hopkins University School of Public Health Communication Programs, various public institutions (the National Assembly, government agencies, non-governmental organizations, mass media, health facilities), joined by representatives of the Coalition of Azerbaijan on Combating tobacco. The coalition is active – meetings are held monthly and action is planned and reported on monthly. Tobaccocontrol.az is the national website which describes the main activities of the coalition, including the development of some primary care resources. There is a clear opportunity to work together with Azerbaijan to help them shape and deliver on their stated desire to have a national smoking cessation service.

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1. MPOWER age standardised prevalence estimates, 2009
2. Eurostat survey of internet access 2011
4. www.worldlifeexpectancy.com/country-health-profile/azerbaija
Belarus

Belarus is located in Eastern Europe and covers an area of 207,600 sq. km. It is a republic with six regions and one special municipality (Minsk) acting as the administrative divisions. The population of Belarus is 10,335,382, with more than half (52.3%) of all men and 9.3% of women smoke. The official language is Belarusian, but Russian is also widely spoken and understood while 12% of the population speak English. The internet is accessed by 32% of households.

The main cause of death is CVD, followed by cancers. Healthcare in Belarus is supervised by the Ministry of Health and funded by general taxation through the National Health Service.

NRT is available over the counter in pharmacies, without a prescription and is not funded centrally. Bupropion is not available while varenicline is available on prescription only (not funded centrally). Smoking cessation support is available in most hospitals and some primary care facilities, and this support is only partially funded by the health service. There is a state programme (2011–15) for the reduction of CVD, including prevention and treatment of risk factors.

There are several programmes of central training for issues such as ‘dietology’ and ‘physical training’. No such training is apparently available (according to the website) for tobacco control. These other public health courses are three months in duration and cost around 1.5m BYR (£878) and are aimed at doctors, nurses and doctors assistants.

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Belgium

Belgium is located in Western Europe and covers an area of 30,528 sq. km. It is governed by a parliamentary monarchy and has ten provinces and three regions as the administrative divisions. The population of Belgium is 10,274,595. Smoking prevalence stands at 33.3% of men and 24.4% of women.\(^1\) The official languages are French, Dutch and German; while 41% of the population speak English\(^2\) and 77% of households have internet access.\(^3\) The main causes of death are cardiovascular disorders, cancers and respiratory disorders.\(^4\) The healthcare system in Belgium is funded through the state sickness fund. There are four tiers of operation consisting of central government, national associations, federations of local societies, and local mutual aid societies. Healthcare in the federal Belgium is mainly a responsibility for the federal state but some matters are a responsibility of the three communities (Flemish, French and German-speaking), such as preventive healthcare. Both the Belgian federal government as the regional governments have ministers for public health. NRT is available over the counter, and is partially funded by the state. Bupropion and varenicline are both available on prescription and are not funded centrally. Smoking cessation support is available in some primary and secondary care facilities, and this support is partially funded by the health service (some services completely free). The average cost is £30 for first consultation and £20 afterwards. There are two full-time tobacco control staff at government level. There is a national free telephone quitline, Tabac Stop, run by the Foundation against Cancer. There is also a national website: www.tabacstop.be with information about stopping (including an online service iCoach). Groups and one-to-ones are available, from tabacologists and doctors. Healthcare professionals (Bac 3 level) are the only people eligible to be trained as tabacologists. The training contact is abienne.devos@fares.be. Belgium is active in the regional tobacco free hospitals movement. No information available publically regarding referral management or identification and referral approaches and training, although the Vlaams Instituut voor Gezondheidspromotie en Ziektepreventie provides online training for all healthcare professionals with help and advice on motivational interviewing. There is a national coalition for tobacco control. In 2009, 28% of smokers in Belgium made a quit attempt, 55% of them unassisted by medication or support.\(^5\)

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2. Victor, G. ‘La dynamique des langues en Belgique’ (in French) (PDF 0.7 MB). Regards économiques, Publication préparée par les économistes de l’Université Catholique de Louvain 2006
3. Eurostat survey of internet access 2011
4. www.healthofnations.com/countries/profile/belgium
Bosnia and Herzegovina

Bosnia and Herzegovina is situated in South-East Europe and covers an area of 52,129 sq. km. The population of Bosnia and Herzegovina is 3,964,388. Nearly half (48.7%) of men and over a third (38.1%) of women smoke. The official languages are Bosnian, Serbian and Croatian. English is taught in schools (mandatory) and 52% of households have internet access.

The main cause of death is CVD. There is a state-managed health insurance system but nearly half the population are not covered (as 20% live in poverty and 30% on or just above the poverty line). Services are provided in ‘health stations’ which are field posts for health centres and are known as ambulantas. There are also four types of hospitals and state pharmacies. There are just less than 300 doctors and nurses working in family medicine teaching centres. There is a high amount of smoking related disease seen in both primary and secondary care facilities.

NRT, bupropion and varenicline are all available over the counter in pharmacies, without a prescription and are not funded centrally. Smoking cessation support is available in most primary care facilities, but this support is not funded by the health service. Quit and Win programmes have been sporadically tried, with no long term evaluation data available publically.

References

1. MPOWER age standardised prevalence estimates, 2009
2. Eurostat survey of internet access 2011
3. WHO (2012) Mortality attributable to tobacco

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Bulgaria

Bulgaria is located in South-East Europe and covers an area of 110,910 sq. km. It is a republic and has eight regions and one district that makes up the administrative divisions. The population of Bulgaria is 7,621,337 and 40.4% of men and 18.9% of women smoke. The official language is Bulgarian. 21% of the population speak English and 45% of households have internet access.

In Bulgaria, the death rate from non-communicable diseases is 51 times of that from communicable diseases. The health system is provided via mandatory employee health insurance managed through the National Health Insurance Fund (NHIF), which since 2000 has paid a gradually increasing portion of primary health-care costs. Employees and employers pay an increasing, mandatory percentage of salaries, with the goal of gradually reducing state support of health care. The system also has been decentralized by making the administrative divisions responsible for their own health-care facilities, and by 2005 most primary care came from private sources. Pharmaceutical distribution also was decentralized. The National Centre for Public Health Protection is responsible for research, methodological and training activities in the field of public health protection, assessment of health risks, living environment, behaviour and lifestyle, health promotion and integrated disease prevention, foods and nutrition.

NRT is available over the counter in pharmacies, without a prescription and is not funded centrally. Bupropion is not available whereas varenicline and Tabex (cytosine) are available on prescription only (not funded centrally). Smoking cessation support is available in community and health locations, but this support is only partially funded by the health service. In 2009, 28% of Bulgarian smokers made a quit attempt in 2009, with 79% of these were unassisted by medication or support.

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References

1. HEIDI 2009 (Health in Europe: Information and Data Interface)
2. Eurostat survey of internet access 2011
3. WHO (2012) Mortality attributable to tobacco
Croatia

Croatia is located in South-East Europe and covers an area of 56,542 sq. km. It is a republic with 20 regions and two districts acting as the administrative divisions. The population of Croatia is 4,490,751. Over a third (38.5%) of men and over a quarter (29.1%) of women smoke. The official language is Croatian while nearly half (49%) of the population speak English. Nearly two-thirds (61%) of households have internet access.

The main causes of death are cardiovascular disease and cancer. The population is covered by a basic health insurance plan provided by statute and optional insurance. There are 79 hospitals and clinics with 23,967 beds. The hospitals and clinics care for more than 700,000 patients per year and employ 5,205 medical doctors, including 3,929 specialists. There are 6,379 private practice offices, and a total of 41,271 health workers in the country.

NRT, bupropion and varenicline are all available in Croatia; by over the counter purchase only- no prescription necessary. A Quitline was set up in 2002, but is no longer running at a national level. Smoking cessation behavioural support is available in some health clinics, hospitals and primary care facilities, although no publically available information is available to indicate which do. This service is only partially funded by the health insurance system. There is one government employee working in Croatia on tobacco control. The Croatian Ministry of Health is very interested in developing e health services and training packages. In 2009, 27% of Croatian smokers made a quit attempt; 72% unassisted by medication or behavioural support.

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References

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3. Eurostat survey of internet access 2011
Cyprus

Cyprus is located in South-East Europe and covers an area of 9250 sq. km. It is a republic with six districts acting as its administrative divisions. The population of Cyprus is 803,147. 38.1% of men and 10.5% of women smoke.\(^1\) The population of Cyprus is 803,147, with 38.1% of men and 10.5% of women current smokers.\(^1\) The official languages are Greek, Turkish and English: with 75% of the population speaking English\(^2\) and 53% of homes having access to the internet.\(^3\)

NRT is available over the counter in pharmacies, is on the country’s essential medicines list and is partially funded by the state. Bupropion and varenicline are not available. Smoking cessation services are provided in each of the five hospitals in Cyprus. In 2009, 29% of Cypriot smokers made a quit attempt: 67% of them with no support or medication.\(^4\) Group support is offered – with advisers being trained via a ‘train the trainer’ approach – the national coordinator having been trained in the UK, and all other providers being trained by him at a three-day workshop. Annual one-day updates are also provided by the coordinator. There are ten advisers across the country. There are smoking cessation services, but only at the service run from the main Nicosia General Hospital are both behavioural support and medication (NRT patches) freely available. Twelve week cessation rates for the government run services average 60%. There is a significant private sector delivery element (Allen Carr clinics etc.). Mass media campaigns are run by the Ministry of Health in conjunction with the National Anti-Smoking Committee (in cooperation with the Cyprus Anti-Cancer Society). They are usually timed to run in conjunction with World No Tobacco Day (May). Training is provided in London. Brief advice is dependent upon the level of interest of HCPs. There are no specific national standards, but NICE guidance is followed. The Ministry of Health is planning to put together a steering group to produce national guidelines.

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References

1. MPOWER age standardised prevalence estimates, 2009
3. Eurostat survey of internet access 2011

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Czech Republic

The Czech Republic is located in Central mainland Europe and covers an area of 78,866 sq. km. It is a republic with 72 local districts acting as the administrative divisions. The population is 10,674,947. Over a third of the population (42.5% of men and 30.1% of women) smoke. The official languages are Czech and Slovak. One in five (21%) of the population speak English and 67% of households have access to the internet.

The Czech Republic has an active leadership in tobacco control; however, this is outside of the country government. There are around 39 hospitals (out of a total of 200) where smokers can receive treatment, one of which is a full time service (the rest provide clinics on a sessional basis). They are not as geographically well spread as they could be. There is a well-developed system for training for health care professionals in both brief and full interventions, linked to the appropriate national CPD systems. Brief interventions are considered a standard activity in primary care. There are also up to date evidence based clinical guidelines available for different professional groups (nurses, pharmacists, doctors, mental health service professionals). There is a free phone quit line. NRT is available without a prescription from pharmacies; whilst bupropion and varenicline are available with a prescription. 31 smoking cessation clinics are provided across the country staffed by a doctor, nurse and (at three clinics) a psychotherapist. Specific guidelines have been developed for nurses (Czech Nurses assoc.), doctors, GPs, mental health services and pharmacists. Treatment consists of approximately 9 visits in 12 months, each costing the patient approx. 12 euros. Advisers are trained by the medical chamber with a one day course. All of these services are based in hospitals. There are some groups provided by the key organisations listed below, where support is free but there is a cost for medication. One in five (22%) of Czech smokers made a quit attempt in 2009, 59% unassisted by medication or behavioural support.

The key issues in the Czech Republic relate to funding for services, funding for mass media campaigns and governmental support to raise the profile of the services offered and to increase the geographical spread. There is a clear need for increased governmental pressure in the Czech Republic.

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References

2. Eurostat survey of internet access 2011
Denmark

Denmark is located in Northern Europe and covers an area of 43,094 sq. km. It is governed through a parliamentary monarchy and has 14 districts to provide the administrative divisions. The population of Denmark is 5,368,854. Just under a quarter (23%) of men and 19% of women (and 21% of the whole population) smoke. The official language is Danish. Most (85%) of the population speak English and 90% of households have internet access.

The main causes of death are cardiovascular disease and cancer. NRT, bupropion and varenicline are all available in Denmark, by over the counter purchase, for NRT and by prescription for all three. Smoking. The National Prevention Council was appointed by the government in 2009 to promote evidence-based prevention. Smoking cessation is a prominent focus area of the Council. The Council advises the National Board of Health under the Ministry of Interior and Health. There is a Danish quitline (www.stoplinien.dk) and websites (www.stoplinien.dk (adults) and www.xhale.dk (adolescents)) operated by the National Board of Health and Copenhagen City Health Administration and serves smokers across the country. There is a single national database for the recording of smoking cessation interventions and outcomes and around 5000 trained advisers across the country. Despite this, it is estimated that only around 10% of primary care physicians ask patients about smoking status and provide brief interventions to support cessation. A third (31%) of Danish smokers would make a quit attempt if their GP recommended it and supported them. Over a quarter (29%) of Danish smokers made a quit attempt in 2009, 46% of them unassisted by medication or support. In some hospitals, in-patients are offered cessation advice and pharmacotherapy free of charge for the duration of their stay and for two weeks after hospitalisation, or are offered a free three-month course with pharmacotherapy. Some hospitals also offer free smoking cessation courses with counselling and medication for staff. Support is available free to smokers if they choose a ‘municipal’ course – but if they attend a pharmacy or another private practice, there is a charge payable by the smoker. Cessation training is not provided in medical schools as part of the standard medical training. There are no post graduate medical courses either. Advisers receive their training from the Danish cancer society, in collaboration with the National Board Health. Advisers are qualified nurses in the main and receive a three day course with an optional annual update.

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4. Danish Regions. March 2010: Costs and activities regarding the GP sector in 2009. [In Danish]. Available at: www.regioner.dk/Sundhed/-/media/A060C00FF6348CB91F1FD2D26219399
Estonia

Estonia is located in Northern Europe and covers an area of 45,226 sq. km. It is a parliamentary republic and has 15 regions with six districts forming the administrative divisions. The population of Estonia is 1,415,681. Nearly half (46%) of men, and a quarter (25%) of women (34% of the whole population) smoke. The official language is Estonian, with Russian also widely spoken and understood. Nearly half (43%) of the population speak English and 71% of households have access to the internet. There is a national quit line. NRT is available in pharmacies without prescription, whilst varenicline and bupropion are both available from pharmacies on prescription. The health service is insurance funded and is family practice centred – all onward care is generated from the family physician team. In 2009, 43% of all smokers made a quit attempt. Smoking cessation services are available in 17 hospitals and two health centres in Estonia. They are staffed by doctors who may also have a nurse or psychologist also in attendance. Training for advisers takes two days and is provided by the National Institute of Health Development. Behavioural support at these services is free, but medicines are not reimbursed.

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<td></td>
<td>Tartu University Hospital</td>
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References

3. Eurostat survey of internet access 2011
Finland

Finland is situated in Northern Europe and covers an area of 338145 sq. km. It is a republic with five provinces and one autonomous region acting as administrative divisions. The population of Finland is 5,302,545 and 21.1% of men and 17.4% of women smoke. The official language is Finnish although Swedish, Russian and Sami are also widely spoken and understood. English is spoken by 61% of the population while 87% of households have access to the internet. Health services are provided through public funding, which provides decentralised three tiered health services (primary care, secondary care and tertiary care). There is a small private sector. Smoking cessation services are provided in the public sector free of charge, although medications are not reimbursed. NRT is available over the counter in stores, and bupropion and varenicline are available on prescription. National tobacco cessation websites are available at www.tupakka.org and www.stumppi.fi, and for adolescents at www.fressis.fi. In 2009, 38% of smokers made a quit attempt; 42% without any medication or support. Systematic tobacco dependence action is part of the standard national health service programme and includes, prevention, diagnosis and treatment for tobacco dependence. Some primary care practices have specialist nurses within the practice, or referrals can be made to specialist clinics. Waiting lists range from four weeks to several months for these clinics. Once in the clinic the service lasts for around six months. Training is included for all medical students, and there is a post graduate CPD course for physicians but uptake is not good. There is predominance in primary care for diagnosis and treatment to be offered to those who ask, or for those with smoking related conditions.

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References

1. Ages 15–64, Health Behaviour and Health among the Finnish Adult Population, 2010 daily smoking
3. Eurostat survey of internet access 2011
France

France is located in Western Europe and covers an area of 547,030 sq. km. It is a parliamentary republic with 22 regions covering 96 departments forming its administrative divisions. The population of France is 63,601,002. Over a third (35.5%) of men, and over a quarter (27.9%) women (31.6% of the population) smoke. The official language is French. Over a third (34%) speak English and 80% of households have internet access.

The health service is funded by health insurance contributions from those employed and services are not free at the point of delivery. Every hospital with more than 500 beds must have a designated lead for tobacco cessation and dependence activities (this has been the case since 2000). There is a national database of clinical activity. There is a national quit line and associated website (www.tabac-info-service.fr). Currently around 5% of all smokers are supported to make a quit attempt each year in either a secondary care based service or a service in the community or primary care system. There is not a single strategic approach to training medical or other staff in primary or secondary care as part of their general training. Stop smoking adviser (tabacologists/e/s) undertake specific tabacologie training over one year to gain a diploma level qualification – this qualification is only available to certain groups (those who have studied for at least four years or nurses and pharmacists by individual application). The course consists of 66 hours of delivered content, plus associated study. There are currently around 670 clinics available across the country. Over a quarter (26%) of smokers in France made a quit attempt in 2009, 64% of them unassisted by medication or behavioural support. NRT is available without prescription, and varenicline and bupropion are both available on prescription.

References

3. Eurostat survey of internet access 2011
Georgia

Georgia is located in Eastern Europe / Western Asia and covers an area of 69700sq km. It is a republic with 79 districts and cities and three autonomous regions. The population of Georgia is 4,960,951. Over half (51%) of men, and 4% of women (27.7% of the whole population) smoke.1 Georgia is a multi-cultural state and the national official language is Kartuli (Georgian), although Russian and Armenian are also widely spoken and understood. English is not widely spoken or known and 27% of households have access to the internet.2

There is a national quitline. NRT and varenicline are available in pharmacies without prescription. Health services are completely privatised and are paid for via private health insurance (although some financial support is available to the poorest and most vulnerable in society). In Georgia there are no services where people can get nicotine or tobacco dependence treatment. Within the primary healthcare system all GP’s duty is to provide information to their patients regarding cessation. The Ministry of Health adopted appropriate guidelines and protocols for medical practitioners in 2010, but there are considerable issues in implementation and training GPs in this. There is only one hospital in Aversi where there are only three doctors who get support and training from a pharmaceutical company.

Georgia needs support to develop and implement tobacco dependence treatment services, and to gain political and professional support for their delivery. It was recommended, due to the prevalence of smoking in the country that Georgia is invited to attend the phase 3 meeting.

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2. Eurostat survey of internet access 2011
Germany

Germany is located in Western / Central mainland Europe and covers an area of 357,021 sq. km. It is a federal republic and the administrative divisions are federal states. The population of Germany is 82,217,800. A third (33.9%) of men and just under a quarter (23.1%) of women smoke. The official language is German. Over half (53%) of the population speak English. A majority (83%) of households have internet access.

The main causes of death are cardiovascular disease and cancer. The population is covered by a basic health insurance plan provided by statute and optional insurance.

NRT and bupropion are both available in pharmacies without prescription, whilst varenicline is available in prescription only. There are five quitlines in Germany (e.g. www.rauch-frei.info). Smoking cessation behavioural support is available in some health clinics, hospitals and primary care facilities, but the support may not be evidence based. The provision of support is less available in the new federal states (ex East Germany), where prevalence is highest. Cessation services are provided by trained nurses and the support is free of charge, but the medication must be paid for by the smoker (which costs each smoker between 120–300 Euros per course).

The German Medical Board (Bundesärztekammer) has developed a training programme and qualification in tobacco cessation, which is certificated. A quarter (25%) of German smokers made a quit attempt in 2009, 89% of which were unsupported by medication or support.

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Greece

Greece is located in South-East Europe and covers an area of 131,940 sq. km. It is a parliamentary republic and has ten administrative regions. The population of Greece is 11,606,813. Smoking prevalence is contested, varying from nearly two thirds (63%) of men and nearly half (41%) of women smoke\(^1\), to far lower rates of 48% of men and 27% of women smoking daily.\(^2\) The official language is Greek, while 47% of the population speak English\(^3\), and 50% of households have internet access.\(^4\) NRT, varenicline and bupropion are all available in pharmacies with a prescription.

Smoking support is available in around 50 clinics across the country. There is a free quit line and associated website. The Hellenic Thoracic Society coordinates a service network and training to hospital specialist clinic based advisers is provided via the Universities of Athens and Thessaloniki. Medical and nursing staff do not receive general training on smoking cessation or tobacco dependence. Nearly one in four (17%) of smokers made a quit attempt in 2009, 85% unassisted by medication or behavioural support.\(^5\)

In rural areas, smokers are more likely to be seen and advised in primary care than in urban areas, which have better access to the hospital based specialist clinics. Despite this, there is no standard or official training provided for these clinicians to access.

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Hungary

Hungary is located in Central mainland Europe and covers an area of 93,030 sq. km. It is a parliamentary republic and has 20 administrative districts. Smoking prevalence is contested, varying from nearly a third (31.4%) of men and more than one in four (21.5%) women,\(^1\) to far higher rates of 43% of men and 33% of women smoking daily.\(^2\) The official language is Hungarian, with 21% of the population speaking English.\(^3\) Most (65%) households have internet access.\(^3\)

There is a national smoking cessation centre in Budapest, established in 2009, aiming to support training and implementation of smoking cessation services. It also provides a national quitline and website. In 2009, 28% of smokers in Hungary made a quit attempt in 2009, 68% of them unassisted by medication or support.\(^4\)

NRT, and varenicline are available in pharmacies with prescription, but bupropion is not available in Hungary. Respiratory physicians provide smoking cessation services, which may be very brief interventions with medication over a period of three months (essentially medication on prescription plus co monitoring). There are 100 respiratory clinics. GP engagement with tobacco dependence diagnosis and intervention is low.

Contacts

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<tr>
<th>Name</th>
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<tr>
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</tr>
</tbody>
</table>

References

1. WHO age-standardized estimated prevalence of smoking among those aged 15 years or more: 2009
2. HEIDI 2009 (Health in Europe: Information and Data Interface)
3. Eurostat survey of internet access 2011
Iceland

Iceland is located in Northern Europe and covers an area of 103,000 sq. km. It is a republic consisting of eight regions. The population of Iceland is 312,384. One fifth (20%) of men and less (15%) women smoke.\(^1\) The official language is Icelandic, but most of the population speak English as it is a standard subject at school and is an accepted second or third language for most people.\(^2\) Most (93%) households have internet access.\(^3\)

There is a national free quitline and associated website.

NRT is available in general stores and varenicline and bupropion are both available on prescription. There are some smoking cessation services provided by respiratory physicians in the main.

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<th>Name</th>
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<tbody>
<tr>
<td>Asgeir Helgason</td>
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<td>Set up Iceland quit line</td>
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<td></td>
</tr>
</tbody>
</table>

References

1. Ages 15–89, Prevalence of Smoking in Iceland,
3. Eurostat survey of internet access 2011
Ireland

The Republic of Ireland is situated in Western Europe and covers an area of 70,280 sq. km. It is a parliamentary republic with 26 counties acting as the unit of local administration. The population of Ireland is 4,234,925. A quarter (25%) of men and 22.2% of women smoke. The official languages are English and Irish (Gaelic) – 100% of the population speak English. Most (65%) of households have internet access.

Smoking cessation services are provided by the national health service, and most are based in hospitals or secondary care units, although there are also services available in primary care and the community. NRT is available in pharmacies and general stores, whilst both varenicline and bupropion are available on prescription. Health services are privately funded although many people are entitled to and receive free or subsidised services, depending on their level of income. Smoking cessation services are mainly provided by the HSE (Health Service Executive). There is a national quit line and website (www.quit.ie/en/help_me_quit). Over a third (35%) of smokers made a quit attempt in 2009, 53% with no medication or support.

Many hospitals have a smoking cessation officer who teaches other staff about tobacco dependence issues. In primary care this facility is not available although the National Cancer Control programme have been researching the feasibility of brief intervention training programmes for primary care staff. Most training is delivered by health promotion service staff.

References

1. Irish national survey 2011 (data 2010)
3. Eurostat survey of internet access 2011
Italy

Italy is located in Southern Europe and covers an area of 301,230 sq. km. It is a republic with 20 regions and 95 provinces acting as the local units of administration. The population of Italy is 60,483,521. Around a quarter (24%) of men and one in five (20%) women smoke. The official language is Italian and 28% of the population speak English. Internet access is available in 62% of households.

Smoking cessation services in Italy are privately funded at a cost of just under 40 euros for a co-monitoring visit. Medication is also privately funded: NRT is available without prescription in pharmacies, and bupropion and varenicline are available on prescription.

There are around 350 smoking cessation clinics, with a specific training requirement for advisers – however, there is no standard curricula for this training. Generally services are provided by physicians, nurses and psychologists. There is a standard programme of cessation support provided by midwives across Italy to support pregnant women. In primary care, GPs can provide smoking cessation interventions, but it is thought that this service is not often provided. There are published guidelines for service provision; however, services have been described locally as not following evidence-based practice.

Just under a quarter (23%) of Italian smokers made a quit attempt in 2009, 80% unassisted by medication or support.

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<tr>
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</tr>
</tbody>
</table>

References

1. Smoking prevalence and smoking attributable mortality in Italy, 2010.
3. Eurostat survey of internet access 2011
Israel

Israel is a parliamentary republic, located along the Eastern shore of the Mediterranean Sea with a population of 7,859,300. It covers an area of 22,072 sq. km. The official languages are Hebrew and Arabic. English is the most widely spoken second language in Israel, followed by Russian. In 2010, 77% of households had access to the internet.1

The latest population survey carried out by Israeli Central Bureau of Statistics (2009) suggested smoking prevalence of 28.4% (male); 12.6% (female) and an overall prevalence therefore of 20.9%.3

NRT is available to purchase over the counter, and Bupropion and varenicline are both available on prescription. Smoking cessation services are available, and are partially state funded.

Health services in Israel are funded through compulsory health insurance, administered by four organisations. In 2010, there were 25,542 doctors in Israel – 3.36 doctors for every 1,000 people. This ratio is one of the highest of all industrialized countries.4

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<tr>
<td>L Rosen</td>
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<td>Chair of national tobacco control council</td>
</tr>
</tbody>
</table>

References

Kazakhstan

Located in Eastern Europe, the population of Kazakhstan is 16,316,050. The official language, Kazakh, is only spoken by 65% of the population. Russian is the more widely spoken language, with about 99% of the population speaking it. Most young people know English and are taught it routinely at school. The internet is accessed by 23% of households.1

In 2006, the WHO reported male smoking prevalence as 43%, and female prevalence at 9%.2 It has not been possible in phase 1 to find an updated prevalence.

There is a freephone quitline, NRT is available over the counter and bupropion and varenicline are both available on prescription.

At phase 1, it has not been possible to identify any tobacco dependence treatment programmes or systems.

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<tr>
<td>Prof Maksut K. Kulzhanov</td>
<td>Academic</td>
<td>Email not functional</td>
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</tbody>
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References

1. Eurostat survey of internet access 2011
2. WHO country profiles, Kazakhstan
Kyrgyzstan

Kyrgyzstan is located in Eastern Europe and covers an area of 198,500 sq. km. The population of Kyrgyzstan is 5,365,167. English is spoken by a minority of the population and 14% of the population are internet users.\(^1\)

In 2005, smoking prevalence was found to be 45% for males and 1.6% for females.\(^2\) The latest World Health Organisation age standardised estimates suggest it has not changed.\(^3\)

There is a freephone quit line. NRT is available over the counter and bupropion and varenicline are not available.

To date, it has not been possible to identify any tobacco dependence treatment programmes or systems.

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<tbody>
<tr>
<td>Name: Dr Chinara Bekbasarova</td>
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References

1. www.giswatch.org/country-report/20/kyrgyzstan
2. Ages 15+, National Epidemiological Study of Tobacco Use Prevalence in Kyrgyzstan, 2005
3. WHO age-standardized estimated prevalence of smoking among those aged 15 years or more: 2009
Kosovo

Kosovo is situated in South-East Europe and has a population of 1,804,838. It is a republic with 30 municipalities that form its unit of administration. The official languages are Albanian and Serbian while most of the population speak English\(^1\) and 30\% of households have internet access.\(^2\)

Just over a third (35\%) of men and only 11\% of women smoke.\(^3\)

Health services in Kosovo are supposedly free at the point of delivery, but in reality are mainly privately funded – and despite a licensing arrangement, one eighth of the primary and secondary care service providers are not licensed.\(^4\)

There is an intense shortage of essential medications.

References

1. Use of healthcare services eight years after the war in Kosovo: role of post-traumatic stress disorder and depression
2. www.ambasada-ks.net/hr/?page=4,48
3. Eurostat survey of internet access 2011
Latvia

Latvia is located in North-East Europe and covers an area of 64,589 sq. km. The population is 2,366,515. In 2008, 48.9% of men and 20.4% of women smoked. The official language is Latvian, although Russian is widely spoken and understood. A third (30%) of the population speak English. Most (64%) households have internet access.

Health services are funded via taxation and a basic level of cover is then provided free to all. The Basic Care Programme describes the free care available for all citizens and registered foreigners in the country. It covers care of serious diseases, preventive healthcare, child and maternity care, emergency treatment, the treatment of sexually transmitted and infectious disease, surgery, rehabilitation, immunisation programmes and free prescription medicine to entitled groups. Free dental treatment is available for the under 18’s. According to this list, tobacco dependence and prevention should be included in the Basic Care Programme.

Health services are coordinated by GPs who work in health centres and refer on for specialised treatment. The smoking cessation system is reliant upon GPs identifying and referring patients on for treatment. This is underutilised as a system however; in 2008, 714 patients were identified as tobacco dependent (around 1% of all smokers) and yet no information is available as to how many were referred, or how many were treated. Nearly half (43%) of Latvian smokers made a quit attempt in 2009. Smoking cessation services in Latvia are provided by medical staff in the main (‘narcologists’ and respiratory physicians) as part of addiction services. There are five specialised outpatients services /addiction units.

NRT is available to buy over the counter without prescription; bupropion and varenicline are both available on prescription.

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</tbody>
</table>

References

1. Ages 15–64, Latvijas iedzīvotāju veselības ietekmējošā paradigma (Health Behaviour among Latvian Adult Population), 2008
3. Eurostat survey of internet access 2011
4. eSCCAN 2009
Lichtenstein

Lichtenstein is located in Central mainland Europe and covers an area of 160 sq. km. It is a parliamentary monarchy and has 11 municipalities as the unit of administration. The population of Lichtenstein is 32,842. It is unknown how many of the population are smokers or how much of the population speak English, although the official language is German. Most (80%) of households have internet access.¹

Lichtenstein has a high standard of compulsory state-funded healthcare. All employed citizens and their employers contribute to the system. The Ministry of Public Health oversees the health service and provides licences for medical and non-medical healthcare. All resident citizens are entitled by law to equal access to healthcare. The Ministry of Public Health involves creating and permanently improving the country’s health infrastructure while at the same time avoiding a surplus in supply. Addiction is an area which falls within the remit of the Ministry of Public Health. In this field, the department’s work is focused on preventing addiction – especially in children and teenagers – and reducing the excessive consumption of addictive products.

Lichtenstein is not signed up to the WHO.

Our contact has informed us that some forms of NRT are available in Lichtenstein (patches, gum and inhalator), but no other medications. There is no standard smoking cessation support available, although some employers and private providers offer this service. Quit and Win is undertaken each year, along with a school based competition. There is no specific training programme for HCPs in brief or full intervention. Further dialogue should be developed to consider how best to support Lichtenstein.

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References

1. Eurostat survey of internet access 2011
2. www.liechtenstein.li/index.php?id=54&L=1
Lithuania

Lithuania is situated in North-Eastern Europe and covers an area of 65,200 sq. km. It is a parliamentary republic and has ten districts that form its administrative units. The population of Lithuania is 3,601,138. In 2008, the national survey found 39% of men and 14% of women smoked.¹ This is due to be updated in 2012. The official languages are Lithuanian and Russian, and 38% of the population speak English.² The internet is accessed by 62% of households.³

NRT, although available, was not widely used in 2011 due to sparse advertising, with awareness of the availability of products within the area remaining very limited. The price of tobacco products increased in 2011 due to rising excise duties. Despite rising sales of smuggled tobacco products, the overall number of smokers in Lithuania fell from 701,000 to 636,000 in 2011. However, only a small fraction of people looking to stop smoking used NRT smoking cessation aids with the majority relying on abstention and willpower.⁴ In 2009, 47% of all smokers tried to stop smoking – the highest rate in the EU.⁵

Health services are state-funded, from employee health insurance contributions. GPs are prevalent and make onward referrals – there is infrastructure that would support effective cessation activity. Allen Carr is active in Lithuania.

NRT, bupropion and varenicline are all available on prescription in Lithuania.

References
3. Eurostat survey of internet access 2011
4. Euromonitor report 2011

Contacts

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Luxemburg

Luxemburg is located in Central Europe, which covers an area of 2,586 sq. km. A parliamentary monarchy, its 11 municipalities are its administrative units. The population of Luxemburg is 512,000. In 2010 a national survey found 27% of men and 20% of women smoked. The official language is German, although 59% of the population speak English, and 91% of households have internet access.

There is a standard programme for smoking cessation, (first implemented in 2007), delivered mainly by GPs, and secondary care physicians. There are also four specialist smoking cessation clinics, where the programme is delivered. The programme lasts around eight months, and each smoker sees the nurse around five times in that period. Medication use is partially reimbursed (50% up to a maximum of 100 euros).

There is a national quitline (tabac stop), and website (http://info-tabac.lu/fr/infos-pour-professionnels-de-sante). There was a training programme for primary care staff run on three Saturdays in 2007 – based on stages of change model. NRT is available over the counter, whilst varenicline and bupropion are both prescription only medications. In 2009, 27% of smokers in Luxemburg made a quit attempt, 54% of them unassisted by medication or behavioural support.

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</tr>
</tbody>
</table>

References

1. les habitudes tabagiques au Luxembourg, 2010
3. Eurostat survey of internet access 2011
**Macedonia (Former Yugoslav Republic of)**

Macedonia is located in South-Eastern Europe and covers an area of 25,333 sq. km. It is a Republic which is divided into 38 districts for administrative purposes. The population of the former Yugoslav Republic of Macedonia is 2,054,800. It is reportedly estimated that half of all adults smoke, although it has not been possible from available and published data sources to find exact figures. The official language is Macedonian, although Albanian, Turkish and Serbian are also widely spoken and understood. Many younger people speak English to some degree, although no data was found to establish the levels of English, spoken or understood. The internet is accessed by 46% of households.

NRT is available to buy over the counter in Macedonia. Varenicline and bupropion do not appear to be available.

Health services in Macedonia are state run, funded by an employee health insurance that covers the whole population and provide preventative healthcare as well as primary and secondary care services. In 2009, 36% of Macedonian smokers made a quit attempt 81% of which were unassisted.

No information has been found concerning tobacco dependence treatment programmes, further contact is required. Contact will be made to the generic email accounts of Institute for Public Health, the Ministry of Health and the State Centre for Research and Population Health.

**Contacts**

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<th>Name</th>
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</tbody>
</table>

**References**

2. Eurostat survey of internet access 2011
3. WHO 2011
Malta

Malta is an Island located in South-Eastern Europe, covering an area of 316 sq. km. It is a Republic which is divided into six districts for the purposes of administration. The population of Malta is 397,499. A 2008 national survey found 32% of men and 21% of women smoked (26% of the whole population). The official languages are Maltese and English although Italian is also widely spoken and understood. English is spoken by 86% of the population and the internet is accessed by 75% of households.

NRT is available to buy over the counter, but smokers are not always willing to purchase the medication to support their quit attempt.

There are seven health centres across the island of Malta where smoking cessation services are provided, usually as clinics running in the evening. Services are mainly groups, running for six weeks of active intervention, plus a follow up meeting, with each session lasting two hours. Training for advisers takes six weeks, in two hourly sessions and there is an additional half day seminar on the role of health care providers in smoking cessation (which in essence provides brief intervention training). Each group will have a maximum of 25 participants. There is also a national quitline. In 2009 33% of Maltese smokers made a quit attempt, 69% of them with no medication or behavioural support.

There is a stated lack of feedback to the government from clinics, which means that outcome data is not available.

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</tr>
</tbody>
</table>

References

3. Eurostat survey of internet access 2011
Moldova

Moldova is located in South-East Europe and covers an area of 33,843 sq. km. It is a Republic divided into 40 districts and ten urban districts for the purposes of local administration. The population of Moldova is 4,434,547. The 2011 estimate from the World Health organisation for prevalence of smoking in Moldova suggests 43% of men and 5% of women smoke.¹ The official languages are Moldovan, Romanian and Russian. English is spoken by 30% of the population², and 40% of households have internet access.³ NRT is available to buy over the counter, but bupropion and varenicline are not available. There are no services provided by the system to support smokers to stop, but there are three full time tobacco control employees employed at government level.

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References

1. WHO age standardised estimates 2011
2. http://wikitravel.org/en/Chi%C5%9Fin%C4%83u
3. Eurostat survey of internet access 2011
Monaco

Monaco is situated in Western Europe and covers an area of 1.95 sq. km. It is a principality. The population of Monaco is 31,987. Most (80%) of households have internet access.\(^1\) The official languages are French, Monegasue and Italian. Most (80%) of households have internet access.\(^1\)

Health services in Monaco are state funded, paid for by employee contributions. The *Caisses Sociales de Monaco* (CSM) oversee the health service and all citizens are entitled by law to equal access to healthcare. The state fund covers most medical services including treatment by specialists, hospitalisation, prescriptions, pregnancy and childbirth and rehabilitation. Health care is provided in primary care or in one of the three hospitals in the principality: a general hospital, a cardiothoracic hospital and a renal hospital.

**References**

1. Eurostat survey of internet access 2011
Montenegro

Montenegro is situated in South-Eastern Europe and covers an area of 13,812 sq. km. It is a Republic and has a population of 397,499. For the purposes of healthcare administration, it is divided into 21 municipalities. In 2000 a national survey found 48% of men and 34% of women smoked, it has not been possible to source any more up to date data to date. Most of the urban population, and most doctors, speak English.

More than half (52%) of all households have internet access.

Each municipality has a primary health care service, and there are also ‘Public health institutes’ – which provide 41 pharmacies as well as public health systems.

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References

1. WHO 2000
2. Eurostat survey of internet access 2011
The Netherlands

The Netherlands is located in Western Europe and covers an area of 41,526 sq. km. It is a parliamentary monarchy and is divided into 12 provinces for the purposes of local administration. The population of Luxemburg is 4,434,547. In 2011 a national survey found 27% of men and 23% of women smoked. The official language is Dutch and Frisian, whilst 84% of the population speak English, and 95% of households have internet access.

General practitioners in the Netherlands have been encouraged to follow a brief intervention process called the ‘Minimal Intervention Service (MIS)’ which has been shown to increase quit attempts compared to normal care. However this is not systematically applied, and there is some evidence to suggest that GPs are more likely to intervene if the patient is at high risk or has a smoking related health concern. Patients who want to stop smoking are then referred on to specialist advisers, either nurse specialists in the practice, or a specialist clinic which are usually based in hospitals.

There are 60 such clinics in hospitals in the Netherlands. STIVORO provide a national website and quit line. Most service provision is group led. Since January 2011, smoking cessation interventions, consisting of behavioural support and medication are funded by health insurance to a limit of 250 Euro per year.

There is a coalition of 25 organisations who together act as the Partnership on Smoking Cessation, which includes the Ministry of Health.

STIVORO provides training programmes and associated protocols for medical staff (STIMEDIC), and for nurses and other HCPs who come into contact with smokers at both the MIS and intervention level. In 2009 25% of Dutch smokers made a quit attempt, 71% of these were unassisted by medication or support. NRT, Varenicline and Bupropion are all available on prescription and NRT is available to buy over the counter. In 2011, 3% of smokers used medication and behavioural support together; 24% used medication alone and 6% used behavioural support only.

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References

1. Dutch foundation on smoking and health (STIVORO) 2011
3. Eurostat survey of internet access 2011
**Norway**

Norway is situated in Northern Europe and covers an area of 323,802 sq. km. It is a parliamentary monarchy which for the purposes of administration is divided into 19 provinces. The population of Norway is 4,920,305. A national survey in 2011 found that 29% of men and women smoked. The official languages are Norwegian and Sami and 91% of the population speak English. Of all households, 92% have access to the internet.

Brief advice by GPs may happen, but is not systematised. Smoking cessation services are available, but although referral by the GP is paid (i.e. the GP is paid for starting the programme of treatment), smoking cessation services may not always be reimbursed. There is a GP facing national database to facilitate intervention. Some services, provided by polyclinics, are paid for at point-of-care, but if the smoker is smoke free at 12 months, they are reimbursed. Some services are provided by NGOs and professional organisations and these are free at the point of delivery. There are some services provided in secondary care, but there is significant variation in service provision, with respiratory and cardiology services most likely to offer intervention. There are several national quitlines available, with associated patient websites.

NRT is available to buy over the counter, and bupropion, varenicline and NRT are all available on prescription.

Intervention training programmes are available for all HCPs to access, provided by the national health directorate, as well as programmes provided for GPs, provided by medical associations.

There is a stated desire to offer more brief intervention training to all HCPs and to increase the number and impact of cessation services.

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2. Eurostat survey of internet access 2011
4. Norwegian national strategy for tobacco control 2006–10
Poland

Poland is located in North-Eastern Europe and covers an area of 312,685 sq. km. It is a Republic and is divided into 49 administrative provinces and 16 regions. The population of Poland is 38,625,478. In 2010 a national survey found 37% of men and 24% of women smoked. The official language is Polish, whilst 28% of the population speak English, and 67% of households have internet access.

Health services in Poland are provided and managed at the regional level. In 14 of the 16 regions, smoking cessation services are available, and are state-funded. Each clinic is staffed by a medical doctor, a nurse and in some cases a psychologist. Services are also available in some primary care and community ‘walk in’ settings. In 2009, 40% of Polish smokers made a quit attempt – most with no support or medication (62%).

Our contact confirms that all forms of NRT, except nasal spray, are available in Poland over the counter, and varenicline, bupropion and cytosine are all available on prescription. Smoking cessation services have been in place for ten years, both in primary care, and as specialist clinics, which are available in 14/16 regions. Health care professionals are trained by a government accredited system, and only those accredited can sign the NHS contract to provide services. Data is collected but there is a lack of coordination and standard definitions. All GPS theoretically are obliged to deliver brief interventions to smokers.

Poland would benefit from some support around systems for identification of smokers outside of the primary care system; and with standard definitions and data collection /management advice and support. Training for advisers and those in primary are is well developed.

Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of contact</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magda Cedzynska</td>
<td>NGO Civil Coalition Tobacco or Health</td>
<td><a href="mailto:cedzynskam@coi.waw.pl">cedzynskam@coi.waw.pl</a></td>
</tr>
</tbody>
</table>

References

1. Ages 15+, Global Adult Tobacco Survey, 2009
3. Eurostat survey of internet access 2011
Portugal

Portugal is located in South-Western Europe and covers an area of 92,391 sq. km. It is a Republic, divided into 18 districts and two autonomous regions. The population of Portugal is 10,617,192. The 2011 age standardised estimates prepared by WHO suggest 31% of men and 12% of women smoke daily. The official language is Portuguese, and 30% of the population speak English. Over half, (58%) of all households have internet access.

NRT is available to buy over the counter, and bupropion and varenicline are both available on prescription. The National Health Service (NHS) delivers health services via five regional administrative areas. These administrations are responsible for delivery of services, including smoking cessation services. There is a network of smoking cessation services, with at least 25 services currently provided. Standard service provision consists of eight sessions, including a 52 week follow-up; however, around 40% of people do not attend the second (quit) session. Software is embedded in GP systems to encourage identification and action by GPs and primary care staff with smokers. A standard national database for cessation interventions is being developed. Most intervention services are hospital based and accessed by referral. There is a national quitline.

Most smoking cessation interventions are provided by physicians, mainly respiratory physicians, and nurse and psychologists may also be involved in service delivery. Training for advisers are provided by the National School of Public Health in Lisbon and the Portuguese society for Pneumology (4–12 hours). In 2009 17% of Portuguese smokers made a quit attempt, 71% unassisted by medication or behavioural support. NHS patients pay around 3 Euros for an appointment and medications are not reimbursed.

Contacts

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<tr>
<th>Name</th>
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<tr>
<td>Sofia Ravara</td>
<td>NGO Portuguese society of smoking treatment and prevention</td>
<td><a href="mailto:sbravara@gmail.com">sbravara@gmail.com</a></td>
</tr>
<tr>
<td>Emilia Nunes</td>
<td>Government</td>
<td></td>
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References

1. WHO age standardised estimates 2011
3. Eurostat survey of internet access 2011
4. eSCCAN 2011
Romania

Romania is situated in South-Eastern Europe and covers an area of 237,500 sq. km. It is a Republic and is divided into 41 districts for the purposes of administration. The population of Romania is 22,303,552. In 2009 a national survey found 35% of men and 22% of women smoked. The official language is Romanian, although Hungarian and German are also widely spoken and understood, and 28% of the population speak English. Out of all households, 47% have internet access.

NRT is available over the counter, and bupropion and varenicline are both available on prescription.

There is a system for tobacco dependence identification and treatment that is currently being used by 15000 people each year. In 2010/11, there was a national campaign to educate all doctors and nurses in very brief and brief advice. There are ten smoking cessation services provided in Romania, all based in University hospitals. Groups and one-to-ones are provided. All follow-up includes biochemical verification (CO monitoring). Most services (70%) are staffed by a single doctor; and 30% are staffed by a doctor and a psychologist. Advisers receive seven days training and receive certification upon completion of the course. Support is provided free, and one month’s medication is provided free of charge. If further medication is used, the patient pays for it. In 2009 38% of Romanian smokers made a quit attempt, 83% with no support or medication.

There is no standardised or computerised collection of input or outcome data. Romania would welcome continued contact and support, but at present does not require any extra intervention.

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<td>Pr Florin Mihaltan</td>
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<tr>
<td>Dr Ioana Munteanu</td>
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<td><a href="mailto:imunteanuro@yahoo.com">imunteanuro@yahoo.com</a></td>
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References

1. Ages 15+, Knowledge, attitudes and practices about active and passive smoking in Romania, 2009
3. Eurostat survey of internet access 2011
Russia

Russia is located in Eastern Europe / Northern Asia and covers an area of 17,075,200 sq. km. It is the largest country in the world and it is a presidential federation, divided into seven districts and 89 territories. The population of the Russian federation is 142,008,838. In 2009 a national survey found 60% of men and 22% of women smoked – 44 million people. The official language is Russian with 32% of the population speaking English, although now that it is a mandatory second language in schools this number is growing. Nearly half (43%) of households have internet access.

The Russian Federation has the highest number of smokers in Europe. The Federation is currently developing systems, services, guidelines and care pathways to provide smoking cessation support. The Federation is very keen to ensure that these are all based on the best available international evidence and would welcome any support available. There is clear support to engage with key professional groups and assist in local accreditation processes to ensure any training is CPD linked. NRT is available over the counter, and varenicline is available on prescription. Bupropion is not available. Russia are currently working, through the Russian Public Health Association, to develop guidelines, systems and training for smoking cessation. Because of the sheer number of smokers, the potential for public health benefit, and the expressed desire of the Federation for help and support in developing effective systems and services, it was recommended that an invitation is extended to a representative of tobacco control in the Russian Federation.

Contacts

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<tr>
<td>Andrey Demin</td>
<td>Government / medical / academic</td>
<td><a href="mailto:andrey_demin@yahoo.com">andrey_demin@yahoo.com</a></td>
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</table>

References

1. Ages 15+, Global Adult Tobacco Survey, 2009
3. Eurostat survey of internet access 2011
San Marino

San Marino is located in Southern Europe and covers an area of 61 sq. km. It is a Republic and is divided into nine ‘Castelli’ or divisions, for administrative purposes. The population of San Marino is 27,730. The official language is Italian, although many people speak English and 64% of households have internet access.1

Health services in San Marino are state provided, funded through the employee health insurance fund known as the Azienda Sanit Locale. Services are mainly provided through primary care health centres and one small hospital.

References
1. Eurostat survey of internet access 2011
Serbia

Serbia is located in South-Eastern Europe and covers an area of 77,474 sq. km. It is a federal Republic. The population of Serbia is 7,498,001. The 2011 age standardised estimate developed by WHO suggests 38% of men and 27% of women smoked.¹ The official language is Serbian, although 45% of the population speak English², and 41% of households have internet access.³

The health service in Serbia is funded by a health insurance fund. Health centers are known as domovi zdravlja. They are supplemented by smaller health stations called zdravstvene stanice.

Medical services provided by the zdravstvene stanice include general medicine, paediatrics, obstetrics and gynaecology, occupational medicine, dentistry, home care, preventive care, and laboratory services. Health centres provide public health surveillance, tuberculosis-control programs, physical and occupational therapy, maternity care, child healthcare and dental care.

NRT and bupropion are both available over the counter, and varenicline is not available. Smoking cessation services are fully funded by the health system.

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<td>Andelka Dzeletovic</td>
<td>Government</td>
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</tr>
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</table>

References

1. WHO 2011
3. Eurostat survey of internet access 2011
Slovakia

Slovakia is located in Central Europe and covers an area of 48,845 sq. km. It is a republic with a population of 5,422,366. The 2011 age standardised estimate developed by WHO suggests 39% of men and 12% of women smoke daily. Although Slovak is the official language, Hungarian and Czech are also widely spoken and understood and 30% of the population speak English. Most (71%) households have internet access.

The Slovakian Ministry of Health oversees the implementation of the health service. The Office for the Supervision of Healthcare supervises the five health insurance companies and the healthcare establishments and controls what is offered as part of the basic healthcare package, known as ‘the solidarity package’.

NRT is available over the counter, and bupropion and varenicline are both available on prescription. There is a national quitline. In 2009 29% of smokers made a quit attempt in 2009, 71% with no medication or behavioural support.

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<tr>
<td>Pr Tibor Baska</td>
<td>Institute of PH</td>
<td>baskafmed.uniba.sk</td>
</tr>
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References

1. WHO 2011
3. Eurostat survey of internet access 2011
Slovenia

Slovenia is located in Central Europe and covers an area of 20,273 sq. kms. It is a republic with a population of 2,048,847. The 2011 age standardised estimate developed by WHO suggests 26% of men and 18% of women smoke daily. The official language is Slovene, while 54% of the population speak English and 73% of households have internet access. Healthcare in Slovenia is overseen by the Health Insurance Institute of Slovenia. The Institute has ten regional units and 45 branches located across the country. There are 36 health centres throughout the country, as well as hospitals in all major towns and cities. NRT is available over the counter, and bupropion and varenicline are both available on prescription. There is a national quitline. Smoking cessation services are provided in 60 health education Centres (which are part of some Primary care Centres) across the country. The Family Physician can refer smokers to these services. Services are provided free at the point of delivery (they are paid for by health insurance). Usage data should be available on how many people use these services (it is not publicly available but is held by the Slovenian public Health Institute). Medication is available in pharmacies, NRT over the counter, and Bupropion and Varenicline are available via prescription. There are no current mass media campaigns. The Slovenian Public Health Institute has an educational programme (www.cindi-slovenija.net) which is for healthcare professionals, mainly based around brief interventions and awareness raising.

In 2009 29% of Slovenian smokers made a quit attempt, 84% unassisted by medication or support.

Slovenia would like support at a national level around mass media marketing and awareness raising amongst the general population, perhaps via an increased training programme for health and social care professionals as well as the general public.

Contacts

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<tr>
<td>Misa lovse</td>
<td>Slovenian coalition for TC (NGO)</td>
<td><a href="mailto:misa.lovse@tobak-zveza.si">misa.lovse@tobak-zveza.si</a></td>
</tr>
</tbody>
</table>

References

1. WHO 2011
3. Eurostat survey of internet access 2011
Spain

Spain is located in South-Western Europe and covers an area of 504,782 sq. km. It is a parliamentary monarchy with a population of 46,777,373. In 2009 a national survey found 31% of men and 21% of women smoked daily.¹ The official languages are Spanish (Castilian), Catalan, Basque and Galician. English is spoken by 22% of the population² and 67% of households have internet access.³

Spain has a decentralised health service, with 17 regions all responsible for local health service provision. Treatment for tobacco dependence is often provided by the GP, although there is wide variation in the provision, content and efficacy of these services. There are also ‘specialised tobacco units’ based in secondary care, which offer behavioural support plus medication, in group, one to one and virtual (telephone) settings. There are tobacco dependence treatment services, based in health centres and other community health facilities. They receive self-referrals and referrals via health care professionals – a telephone number is given by the HCP for the smoker to then self-refer. Some HCPs have been trained in smoking cessation interventions, but most who refer have not been trained. Many do not consider tobacco dependence to be a clinical issue of their concern. NRT is available on prescription or over the counter, and bupropion and varenicline are often prescribed in primary care with no, or very minimal behavioural support. In a national survey described by our contact, 10% of people who want to make a serious quit attempt go to a primary care facility to ask for support. A survey was undertaken by our contact of 25 primary care facilities where 3000 people went to ask for help and support to stop smoking. Only 12% were prescribed medication or support. There is no national system of training for brief / very brief advice, but our contact believes many HCPs are interested. There is only one accredited smoking cessation training course (Spanish Respiratory Physicians Society) – this has been available for seven years – although the Spanish GP Association is also interested. The services are provided by physicians, nurses and psychologists. There is regional variation in the amount of training advisers receive, and in how the service is provided, including whether medication and support are free of charge. Around a quarter of the smoker population made a quit attempt in 2009, 66% of these were unassisted by medication or behavioural support.⁴ Spain would benefit from (and would welcome) support to develop and implement brief / very brief advice training. Other systems are in place to support delivery of interventions. The Respiratory Physicians Society and the GP Association would be good organisations to collaborate with. Spain was considered for an invitation to the round table meeting.

Contacts

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<tr>
<th>Name</th>
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<tr>
<td>Carlos Jiminez Ruiz</td>
<td>Medical</td>
<td><a href="mailto:carlos.jimenez@salud.madrid.org">carlos.jimenez@salud.madrid.org</a></td>
</tr>
</tbody>
</table>

References

1. Ages 16+, Encuesta Europea de Salud en España, 2009
3. Eurostat survey of internet access 2011
Swedish National Institute of Public Health  
carlos.jimenez@salud.madrid.org

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<td>Mathias Jansson</td>
<td>Swedish National Institute of Public Health</td>
<td><a href="mailto:carlos.jimenez@salud.madrid.org">carlos.jimenez@salud.madrid.org</a></td>
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</tbody>
</table>

**References**

3. Eurostat survey of internet access 2011
Switzerland

Switzerland is located in Central mainland Europe and covers an area of 41,290 sq. km. It is a parliamentary confederation with 26 ‘cantons’ (districts). The population of Switzerland is 7,301,994. In 2011 a national survey found 30% of men and 24% of women smoked. The official languages are German, French, Italian and Romansh, and most of the population speak English.

Of all households, 84% have internet access.

Switzerland has a National Tobacco Programme (2008–2012) the objective of which is to reduce the level of tobacco-related death and disease. The National Stop Smoking Programme has been in existence since 2001 and is funded into 2012. It is led by the Swiss Cancer League, Swiss Heart Foundation, Swiss Association for Smoking Prevention (AT) and supported by the Tobacco Control Fund.

Behavioural support is provided free of charge, but medications are not reimbursed. There is a national quitline run by the Swiss Cancer league.

Training for advisers is provided by the Free from Tobacco programme – who also provides training for all HCPs. Training lasts for less than one day.

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<tr>
<td>Verina El Fehri</td>
<td>AT Switzerland</td>
<td><a href="mailto:verena.efehri@schweiz.ch">verena.efehri@schweiz.ch</a></td>
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</tr>
</tbody>
</table>

References

1. TM Switzerland 2011
3. Eurostat survey of internet access 2011
**Turkey**

Turkey is located in South-Eastern Europe and covers an area of 780,580 sq. km. It is a republic, which for the purposes of administration is divided into 74 provinces. The population of Turkey is 72,752,325. In 2010 a national survey found 41% of men and 14% of women smoked. The official languages are Turkish and Kurdish whilst more than 20% of the population speak English, and 43% of households have internet access.

Health services in Turkey are part state, part insurance and part patient funded (at point of care). Primary care services are provided by GPs and health centres, and secondary care is provided by health centres and by hospitals.

NRT is available over the counter, whilst bupropion and varenicline are both available on prescription. Nearly a quarter (24%) of smokers made a quit attempt in 2009, 83% of these were unassisted by medication or behavioural support.

**Contacts**

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<td>Medical</td>
<td><a href="http://www.elifdagli.com">www.elifdagli.com</a></td>
</tr>
</tbody>
</table>

**References**

1. Turkey Ministry of Health 2011
3. Eurostat survey of internet access 2011
Ukraine

Ukraine is situated in Eastern Europe and covers an area of 603,700 sq. km. The population of Ukraine is 45,396,470. In 2009 a national survey found 46% of men and 9% of women smoked daily. The official language is Ukrainian although Russian is widely spoken and little of the population speak English. Only 23% of households have internet access.

NRT is available over the counter; bupropion is available on prescription only and varenicline is unavailable.

The Ukrainian health system is state funded, funded through employee contributions. Primary care doctors are the main contact for patients with the health service.

References

1. Ages 15+, Global Adult Tobacco Survey, 2009
3. Eurostat survey of internet access 2011
United Kingdom

The United Kingdom (UK) consists of the countries of England, Wales, Scotland and Northern Ireland, and is situated in Western Europe, covering an area of 244,820 sq. km. The population of the United Kingdom is 60,587,000. Smoking prevalence was assessed in an annual survey carried out in 2010 and published in 2012, showing 21% of men and 20% of women to be daily smokers.\(^1\) The official language is English, and 83% of households have access to the internet.\(^2\)

In all countries of the UK, NRT is available to buy over the counter, but it is also available on prescription, alongside bupropion and varenicline.

Stop smoking services are provided through Primary Care Trusts (PCTs) to provide services to at least 5% of the smoking population each year. Advisers are trained and there are national competencies and standards which have been developed by the National Centre for Smoking Cessation and Training (NCSCT).

References

1. NHS IC 2012, London
2. Eurostat survey of internet access 2011
Vatican City (Holy See)

The Vatican City has a population of 900 people, in an area of just 110 acres. There is no tobacco control policy or smoking cessation activity.
## Appendix 2:
### Phase 2 Summary of contacts and outcomes

<table>
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<th>Country</th>
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Appendix 3:
Agenda for round table meeting

Global Bridges: European meeting
18 June 2012: Birmingham, UK

Objectives:
1. Understand the work of Global Bridges and the application of it to Europe
2. Describe and understand the scoping exercise
3. Consider needs, wants and opportunities for further partnership working

Agenda

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<th>Item</th>
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<td>8:15</td>
<td>Coffee and registration</td>
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<td>2.</td>
<td>8:45</td>
<td>Welcome and introductions</td>
<td>Andy McEwen</td>
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<td>3.</td>
<td>9:00</td>
<td>Global Bridges summary and regional activity to date</td>
<td>Katie Kemper / Richard Hurt</td>
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<td>4.</td>
<td>9:45</td>
<td>Overview of the scoping exercise</td>
<td>Emma Croghan</td>
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<td>5.</td>
<td>10:00</td>
<td>Participant country observations</td>
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<td>10:00 Azerbaijan</td>
<td>Aynura Rashidova</td>
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<td>10:20 Czech Republic</td>
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<td>10:40 Georgia</td>
<td>George Bakhturidze</td>
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<td>11:00</td>
<td>Break</td>
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<td>Participant country observations</td>
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<td>11:15 Portugal</td>
<td>Sofia Ravara</td>
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<td>11:35 Russian Federation</td>
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<td>11:55 Spain</td>
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<td>8.</td>
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<td>Round-table discussion on needs, wants and opportunities</td>
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<td>Lunch</td>
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<td>Further action discussion</td>
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<td>Conclusions and summary</td>
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<td>12.</td>
<td>14:30</td>
<td>Coffee and depart</td>
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Appendix 4: Slides from round table meeting

Global Bridges Round table meeting

Key objectives

- Understand the work of Global Bridges in Europe
- Describe and understand the work to date
- Consider needs, wants and opportunities for further partnership working across Europe

Welcome and introductions

Global Bridges Mission

Create and mobilize a global network of healthcare providers and organizations dedicated to advancing effective tobacco dependence treatment and advocating for effective tobacco control policy.

www.globalbridges.org

Global Bridges Objectives

- Build a network
  Create opportunities to share treatment and advocacy expertise among network members within and across regions
- Provide training
  State-of-the-art, evidence-based training in tobacco dependence treatment and advocacy
- Article 14 implementation
  Facilitate the implementation of FCTC Article 14 in every nation
- Sustain the mission
  Ensure the long-term financial sustainability of the initiative

Global Bridges: the first six months
July-Dec 2010

- New initiative, built on foundation of GHA
- Executive Team established (July)
  - Principals R. Hurt, T. Byrne, T. Hays, B. Lesher
  - Executive Director, R. Karrer
- Senior support from Mayo Clinic: M. McVea, D. Moore, B. Bory, R. O’Brien
- Mission and Objectives agreed (July)
- Names developed, tested, and agreed (August)
- Presented at Clinton Global Initiative (Sept)
- Survey of GHA membership (Sept)
- Logo finalized (Nov)
- Regional partners confirmed in 3 regions; subawards approved (Dec)
Global Bridges European Scoping Exercise Final Report: July 2012

Key Accomplishments Summary: Network Development & Training

- www.globalbridges.org launched mid 2011
- Growth in membership database
  - Original GIA list had 464 HCP members
  - GB Master Contact List includes 1680 HCPs from 204 countries
  - GB Membership is 437 (opt-in via website)
- Active collaborations with ATTUD, treattobacco.net, Global Nurses Network, American Academy of Pediatrics, Global Smokefree Partnership, Hong Kong Dept of Health, INWAT, American Association of Anesthesiologists, and others

Key Accomplishments Summary: Network Development & Training

- Presented at national, regional, and global meetings with combined attendance of over 18,000
- Meeting of regional partners and international leaders at NDC Annual Meeting in Rochester, MN (2011)
- Regional Partners have trained over 3000 HCPs from 37 countries
  - Over 10,000 person-hours of training
  - Instigating 68,000* tobacco-dependent patients
  - *Assuming 2 patients per week by each trainer; per GB 2011 survey, this number could be significantly higher

Key Accomplishments Summary: FCTC Article 14

- Collaborating with regional and/or national governments to train HCPs in support of A14 implementation
  - Trained HCPs in five provinces in Argentina, in cooperation with MGC: Buenos Aires, Entre Rios, Neuquen, Tierra del Fuego, and Salta
  - Reviewed and endorsed Argentina national treatment guidelines
  - Influencing institutional medical directors to support treatment within established code of practice
- GB database used for treatment /A14 surveys (Raw: Rigotti)
  - Actively supporting FCTC policies such as taxation & smokefree, which build demand for treatment
  - Participated in COP-4 and notified network of A14 Guidelines adoption

Key Accomplishments Summary: Sustaining the Mission

- In-kind support received from:
  - Mayo Clinic
  - American Cancer Society
  - University of Arizona
  - King Hussein Cancer Center
  - Regional Governments
  - Benefactor support through Mayo Clinic Development
  - Funding received from ACS, Legacy
  - Work in progress: ACS Global 3.0, Li Ka Shing
  - Proposals to GSK, Bloomberg Philanthropies

GB Regional Partners: Initial Concept

- Host Organization + Regional Director
- Willingness and experience to work throughout region
- Treatment and training expertise & reputation
- RD can devote about 30% of time to GB
- Administrative capability (essential)
- Middle East, Africa, and Latin America follow this model

Middle East Region

- Jordan/KHCC providing dynamic leadership for region
- Active in national and regional media
- Building a new regional network with other leaders in region: FCA, JUST, etc.
- Supporting 2 TTS scholars from Middle East each September
- Recent highlights: preconference and presentations at World Cardiology Conference, Dubai
Global Bridges European Scoping Exercise Final Report: July 2012

Africa Region
- UoP: Leading research university in South Africa
- Lekem: Member of WHO TobReg, SRNT Global Network; regional leader in tobacco dependence research
- Building a treatment network & aligning with advocates
- Recent highlight: training in Ethiopia attracted over 150 participants

Latin America Region
- IAHF is THE leadership organization for tobacco control in Latin America
- Hosted successful regional conferences in 2007 (Brazil), 2009 (Mexico), 2011 (Peru)
- Participants in Pan American Forum for Action on NCDs
- Regional journalism contests
- Steering Committee created for Global Bridges
- Recent Highlight: Workshop for Caribbean Region, Kingston Jamaica, 30-31 May
  - Co-sponsored by Healthy Caribbean Coalition
  - Media activity for WNTD

Global Bridges Training Sessions
Through May 2012

Africa and Middle East Regions

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Latin America Region

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Global Bridges: Challenges
- Different regions require different approaches
  - Regional Director model has worked in 1st 3 regions, but...
  - How can GB add unique value in US/Canada & Europe?
  - How should GB approach Asia?
- Low (or negative) profile for treatment among many in tobacco control
- "Evidence-based" curriculum
  - ATTUD is accepted best practice
- Securing sustaining resource (current funding expires at end of 2013)

New Frontiers
Distance Learning Curriculum
Global Nurses Network
cOBit 14
Regional Expansion
Distance Learning Curriculum: Vision

Design a multilevel, progressive curriculum which provides asynchronous distance learning opportunities and tracking of progress over time, and is based on best practice.

Level 4: Train the Trainer
Level 3: Skills building (interactive)
Level 2: Webinar Series
Level 1: One-hour web course

Distance Learning Curriculum: Approach

- Working with one of Canada's leaders for tobacco dependence treatment education
- CAMH (Center for Addiction and Mental Health)
- TEACH (Training Enhancement in Applied Cessation Counselling and Health)
- Develop a curriculum which busy HCPs can access any time, anywhere
- Extend reach of GB training
  - Online broadcast has greater reach than 10 years of classroom courses
  - (Timble et al., 2000)
- CME Accreditation
- Track progress to enable program evaluation

Distance Learning – Next Steps

- Confirm objectives and develop workplan (ongoing)
- Curriculum Planning workshop – Aug 2012 (4 days)
  - Develop and record 5 webinars
  - Develop detailed plan for next 12 months, incl accreditation, delivery, evaluation at multiple levels
- Deliver webinars in initial languages (English, Spanish, Arabic) Sept 2012 - March 2013
- Initial evaluation/learning assessment – March 2013

Global Nurses Network

- Over 13,000,000 nurses worldwide
- Informal network highly committed to tobacco control – but no resource. Approached GB in March to propose partnership.
  - GB funded GNN breakfast meeting at WCTOH (60 participants)
  - GB will devote website space and listserve to GNN
  - Funding network meeting ICN mtg (Melbourne, 2013)
- Huge potential to energize the nursing (and tobacco control) community!

Global Bridges

Raising the Profile of Treatment: cOalition 14

“you can’t miss the O!”

Mission: To raise the profile of tobacco dependence treatment and FTC Article 14 implementation as an essential component of comprehensive evidence-based tobacco control programs

Participants:
- Those actively engaged in treating tobacco dependence
- Those dedicated to FTC implementation
- A collaborative, non-bureaucratic group – initially coordinated by Global Bridges
**cOalition 14: Actions**

- Letter to Bloomberg about MPOWER awards
  - Sent 1 June with 27 signatures
- Journalism contest(s) about treatment
  - Announced on 29 September: World Heart Day
- Organize Quick response expert group
- Disseminate existing data and new research
- Host preconference workshops at professional meetings

**cOalition 14: Collaborators**

- Groups directly engaged in treatment:
  - Global Bridges, founding & regional partners
  - treattobacco.net
  - ATTUD
  - Global Nurses Network
  - Quitline organizations
  - Regional leaders (recruited by RDs)
- Groups engaged in FCTC implementation:
  - FCA, WHO, INWAT, others

**Regional Expansion: Asia**

- Mayo Clinic has worked with Hong Kong Dept of Health and Hospital Authority to develop and host TTS training series
  - Co-branded curriculum in English and Mandarin
  - Support from Hong Kong Academy of Medicine – 15 colleges
  - HK DHF recently became WHO Collaborating center
- Positions GB to expand into mainland China
- Potential partners in India also identified
- Additional resources (funding and staff) required for expansion of this magnitude

**Europe**

- Can we create a model for collaboration in the European region which adds unique value without duplicating existing activity?

**The European scoping exercise**

- Which European countries might be willing and able to receive evidence-based support and assistance to improve tobacco dependence treatment and systems?
- The scoping exercise included three phases of activity: Phase 1 (web search), Phase 2 (direct country contact) and Phase 3 (face to face exploratory meeting with selected countries).

**Phase 1 activity**

- Phase 1 involved collating background information on the 53 European countries from publicly available data sources.
- Web/desk based
### Phase 1 methods
- Each country’s Ministry or Department of Health website was searched.
- The latest prevalence data was searched for by country, and general data about the country was gathered from various web and paper based sources.
- Any websites concerning tobacco dependence in the country were identified and used to provide further information. Existing published survey data (including EQUIPP, Eurobarometer and WHO country profiles) were also searched.

### Phase 1 outcomes
- There is a wide variety of publicly available data about countries tobacco dependence policies, services and systems.
- However, this data is not uniformly collected or reported in terms of context and outcomes.
- There are often conflicting data available for the same countries.
- Phase 2 was necessary not only for contact/interest establishment, but to confirm data.

### Phase 2 activity
- Phase 2 used direct contact via email and telephone to supplement the information gained during Phase 1, to introduce Global Bridges to key opinion leaders in Europe and to help select countries for Phase 3 (today’s meeting).

### Phase 2 methods
- In phase 2, each contact identified in Phase 1 was sent an initial introductory email.
- Those who replied and requested that questions were posed by email were sent a follow-up email.
- Those who requested a telephone conversation to discuss the project and associated questions were called at their convenience.

### Phase 2 outcomes
- 53 countries
- 5 countries with no contact details available
- 48 countries contact attempted
- 6 email addresses not valid
- 42 valid contacts
- 25 responses received (59% response rate)
- Many of these are outside of the ‘usual’ European research
- Confirmed and enhanced understanding

### Phase 3 selection criteria
- High prevalence
- Likelihood of governmental support
- Likelihood of health care professional organisation sign up/involvement
- Most health care professionals having access to the internet and having a working knowledge of English.
- High proportion of unassisted quit attempts in countries with established cessation services
Emerging themes

- Countries with high smoking prevalence and/or large populations offer a significant opportunity for valuable public health gains. In many countries, overall prevalence is skewed as the relatively low female adult prevalence masks the high male prevalence.
- Some countries have a high degree of political support but lack expertise and experience in tobacco control and smoking cessation.
- Other countries have relatively well-developed programmes for reducing the burden of tobacco-related diseases and have identified smoking cessation treatment as a priority, but are lacking in terms of evidence-based training programmes.
- There are countries with varying degrees of access to behavioural support and medication for tobacco use, but to date, the numbers of smokers accessing these services are not optimum.
- There are also countries with high levels of smokers making unassisted quit attempts, showing a high potential for tobacco dependence services interventions.

Country observations

- Cigarette smoking is a major public health threat for Azerbaijan.
- Although the vast majority of tobacco users in Azerbaijan are men, the rate of smoking among women is rising steadily.
- The Demographic and Health Survey for Azerbaijan (Macro International 2006) found that 50% of men aged 15-59 were smokers.
- According to the European Health for-All Database, 38% of males 15 years age and older were regular daily smokers in 2007.

Azerbaijan

Aynur Rashidova
Public Health and Reforms Center (PHRC), MoH

Cessation and exposure

- The CINDI (2007) study found that the cessation rate is estimated to be less than 4% for all age groups and 2.7% among men aged 55-64 years.
- According to the Public Health and Reforms Center’s Noncommunicable Diseases Situational Analysis Report (2009) 29.5% of men and 57.9% of women indicated at least one smoker in their household.
- This survey also found that 49.6% and 22.4% of employed men and women reported being exposed to second-hand smoke in the workplace.

Background

- The State Statistical Committee of Azerbaijan reports that tobacco consumption expenditures per capita per month grew by 11.4% from 2008 to 2009.
- Data from the Survey on Health Knowledge, Attitudes and Practices in Azerbaijan (USAIAD, 2006) suggests significant readiness among society to support policy reforms that create smoke-free environments.
- According to this survey, 97% of women and 86% of men respondents believed cigarette smoking was “very harmful” to one’s health.
- Also 94% and 88% of women and men believed second-hand smoke was dangerous.
- In 2005, Azerbaijan ratified the WHO Framework Convention on Tobacco Control (FCTC).
- Smoking in public places continues to be widespread. Very few cafes and restaurants have non-smoking area. Tobacco is still widely sold to teenagers in breach of the current legislation.
Background

- A number of international and local organizations have been attempting to promote establishment of smoke-free public places, to inform the population on the harmful effects of smoking, and to encourage reduction of tobacco use but those efforts have generally been rather fragmented and uncoordinated.
- Although there have been some attempts to unite uncoordinated agencies in the battle against smoking, to date neither government agencies, non-government organizations, nor civil society groups and community activists had sufficient influence to advocate for effective tobacco control policies.

Youth survey

- In 2011 the PHRC conducted the Global Youth Tobacco Survey (GYTS) in Azerbaijan includes data on prevalence of cigarette and other tobacco use as well as information on five determinants of tobacco use: access/availability and price, exposure to secondhand smoke (SHS), cessation, media and advertising, and school curriculum. A total of 2,018 students ages 13-15 participated in the Azerbaijan GYTS.

Current plans

- Under the Bloomberg Initiative grant to Public Health and Reform Center (PHRC) of the Ministry of Health in 2009-2010 a national capacity for tobacco control was built through appropriate training of more than 40 representatives of key stakeholder organizations. A National Tobacco Control Coalition comprising governmental and non-governmental organization was established.
- A National Tobacco Control Strategy was developed as a baseline document for strengthening Tobacco Control in Azerbaijan but not yet approved.
- Currently, the PHRC is actively involved in developing new tobacco control policies. In particular, the PHRC is a major advisor and contributor to the National Parliament’s Commission working on the draft Law “On Banning of Smoking in Public Places”.
- Every year the PHRC leads the World No Tobacco Day activities at the national level coordinating its actions with the WHO Country Office in Azerbaijan. Main focus of PHRC involved in tobacco-control activities are taking part in world events regarding tobacco control issues.

PHRC

- PHRC has the capacity and expertise to implement the tobacco control activities: a key PHRC department head was intensively trained on tobacco control leadership. They received additional training through the “Global Tobacco Control - Learning from the Experts” Tobacco Control on-line training package from the John Hopkins Bloomberg School of Public Health and in 2010 traveled to Turkey in order to study Turkish achievements and lessons learned in tobacco control. This trip included meetings with officials at the Turkish Ministry of Health, with local NGOs and with other institutions involved with Turkey’s National Tobacco Control Program.
- The PHRC maintains close and influential relations with key stakeholders and agencies in the area of tobacco control.

Tobacco dependence treatment

- Today there is practically no health service support available for people who want to stop smoking, neither health professionals trained to identify and treat tobacco dependence in Azerbaijan.
- Recently the Ministry of Health of Azerbaijan Republic has approved the National Clinical Protocol on Smoking Cessation that was developed in the Public Health and Reform Center.
- Now we intend to work toward setting a health service network available for people who want to stop smoking.
- Medication is available at drug stores. No prescription is needed.

Government support

- N/A - not available
Medical and professional support

- N/A - not available

Training

- N/A - not available

Our country need

- Tobacco control requires strong political commitment as well as the participation of civil society.
- Enact and enforce completely smoke-free environments in all indoor public places including workplaces.
- Strengthen health systems so they can make tobacco cessation advice available as part of primary health care.
- Support quit lines in conjunction with easily accessible, low-cost pharmacological treatment where appropriate.
- Require effective package warning labels.
- Enact and enforce effective legislation that comprehensively bans any form of direct and indirect tobacco advertising, promotion and sponsorship.
- Increase tax rates for tobacco products.

Czech republic

Eva Kralikova

Background

- Tax: lowest level of EU, will increase in 2014 but still just to minimum level.
- Ads: still possible at point of sale, these not restricted, majority of cigarettes sold in food shops, Marlboro or Pall Mall clothing sold (with billboards that are banned for tobacco).
- Warning: no pictorial.
- Passive smoking: no ban so far in restaurants.
- Smoking cessation medication not reimbursed, but two billing codes for intensive treatment available (for 38 centres).

Tobacco dependence treatment

- Majority of doctors (about 80%) – brief intervention, at least 2A.
- Nurses being educated since 2007, about 600 passed one day course.
Government support

- No one person at Ministry of Health full time for tobacco, no plan adopted, no resources
- Barrier: majority of MPs and decision makers still believe that tobacco tax revenue is unique and much higher than potential benefit of significantly increased tax, PM report from 2001 still mentioned in media

Medical and professional support

- Nursing: Cz Assoc of Nurses adopted 2010 guidelines for treatment, same did Cz Assoc of Pharmacists. Psychologists not much involved.
- Medical Associations collaborating well, except oncology and gynaecology.

Training

- Brief advice and referral: 4 one-day-courses for doctors/year at the Czech Medical Association
- Intervention to aid cessation: Doctors and nurses from all 38 Centres for Tobacco-Dependent meet 2x/year for one-day-seminar

Our country need

- Implementation of international standards – mainly in the health insurance area.
- Attention to tobacco control at Ministry of health – creating group for TC only (not with other drugs), adopting concrete plan that will be fulfilled.

Background

- Georgia has ratified the FCTC in December 16, 2005; The FCTC entered into force for Georgia from May 16, 2006;
- Excise tax on cigarette is around 0.4 $ since Jan 2010;
- Prohibition of tobacco advertisement only in TV and Radio since April 1, 2003

Global Bridges European Scoping Exercise Final Report: July 2012
Tobacco dependence treatment
- No special tobacco dependence treatment clinic/service exists;
- GPs formal duty is to advise patients to quit smoking;
- Ministry of Health adopted appropriate guideline and protocol for GPs in 2010, but no implementation exists;
- *Aversal* Clinic has only 5 GPs trained by Pfizer funding to promote varenicline (Champix).

Government support
Government provides around 6000 $ per year for functioning of Quit-line (special phone number is written on packs of cigarettes), which is not enough for functioning of multi-channel technology.

Medical and professional support
GP's Association was involved in the adaptation of guidelines.

Training
- Trainings are not available for GPs and other medical personal who can provide cessation services;
- No training course and relevant training manual for quit-line operators.

Need
- To implement existed law on tobacco control and FCTC regulations;
- Total ban of adds and promotion;
- Tax increase and licensing of tobacco producing;
- Development of tobacco cessation services.

Need cont.
Development of tobacco cessation services:
- Trainings for GPs and other medical personal who can provide cessation services;
- Training course and relevant training manual for quit-line operators;
- Establish clinics' network to provide cessation services;
- Tobacco treatment and training center.
Global Bridges European Scoping Exercise Final Report: July 2012

Global bridges European scoping
Portugal
sbravara@fsauede.ubi.pt

Background

In 2008, Portugal implemented a partial ban, full of ambiguities and exceptions, followed by poor enforcement. This undermines social norm change and cessation*. This year the government plans to bring in an amendment to the current partial ban.

Portugal has one of the lowest crude smoking prevalence rates (20.9%) in Europe. The majority of smokers are men (52.3%); females are 18.8% of smokers. It also has one of the highest never-smoking rates in Europe**.

Nevertheless, age-gender specific prevalence is high in young adults and working population age groups***.

According to the National Health Survey of 1997-2009 (5 years), tobacco use remains stable or is increasing slightly among male age groups 15 to 54, despite decreasing in all other age groups***.

Smoking rates are steadily increasing among women in all age groups between 15 and 74 years. Another concern is the rapidly increasing rates and earlier starting age of adolescent female smokers***.


Tobacco dependence treatment

In 2009*, 239 Tobacco cessation Services (TCS) were in Primary care (PC), 139 (63%) total PC, 39 Tobacco cessation clinics (TCC) in hospitals (4.9% total hospital). However many TSC, especially in PC, are now closing due to lack of incentives and resources.

TCCs are hospital-based, generally run by respiratory physicians. Very few in mental health centers. Women are more likely to use than men. Nurses are involved, but usually only in support staff, and a few psychologists run a handful of group-oriented services.

TSC: Practitioners in PC: Organization by Regional Health Administrations (RHA).

There is no centralized stop smoking service.

Other cessation resources:

Pharmacies: provide brief intervention and NRT OTC: no data
Workplace-based programmes: no data
Private clinics and hospitals: no data


Tobacco dependence treatment

How many people use this service?

No data available (no electronically records, no national data base, no systematic data collection)

- Quit line: 750 900 smokers/year. 12-15% self-reported point abstinence 6 months. 2% smokers who quit used**
- Stop smoking Website www.smoke.net. In 2012: 1,795 smokers visited the website. 3.100 enrolled in a study, 65% males, mean age 35 years, mean age of fee 21; 32% self-reported 12 months continuous abstinence***: 0% smokers who quit used.
- Pharmacies provide brief intervention and NRT treatment no data. One study was carried out (2006): 1,200 smokers enrolled, 13.1% 3 months success rate (NRT adherence).
- 68% of quitters quit without assistance*
- 10% of quitters use NRT or other medication*

Government support

- In January 2012, the Health Minister and the Secretary of State had announced their strong commitment to promoting healthy lifestyle and a national Tobacco Control Plan, and that this was a national priority.

- However, amendments to a comprehensive smoke-free law are in discussion in the parliament.

- The government is supportive of a TG national plan and has declared that will support cessation and reimburse cessation treatment.

- The public health physician who is responsible for the TG national plan announced that cessation indicators, national and regional, would be mandatory.

Medical and professional support

- The Portuguese Medical Association has a clear commitment to Tobacco Control. The Portuguese Society of Pulmonology, the GPs Association, the Medical Dental Association and the Lung Foundation of Portugal. Most hospital-based cessation clinics have a strong network with the GPs, and the Portuguese Health System is relatively well represented.

- The National Pharmaceutical Association has a clear commitment to smoking cessation and has been active in promoting cessation training and awareness among health professionals.

- Nursing is a key role, especially in primary care, and mental health services, but further education and training are needed. There is also an increasing focus on training in these areas, especially in hospitals and women’s health and mental health.

- Smoking rates remain relatively high, but is still high among adults (20%) and rural (≥ 25%)

- Few psychologists work in cessation. The national health system lacks psychologists, thus most of them have other work priorities, and are overwhelmed.

Training

- Training may vary widely and there is no national training standard or certification system for cessation clinicians. There is a need for regular feedback and continuing education in smoking cessation. Usually training is more complete for cessation all than for brief intervention and effective referrals. Training is evidence-based and follows cessation guidelines.

- Training programs have been organized:
  - Portuguese Society of Pulmonology (SPP) for resident and Primary Care (PC) team (4-5 days).
  - Regional Health Administration for PC teams (1-2 days).
  - Quitline organizes a comprehensive course with practice training (1 day).
  - National Pharmaceutical Association regularly organizes training on brief intervention and referral and RRT assisted cessation with a 6 month follow-up (2 days).
  - They have trained 500 pharmacists. Additionally, other training programs are organized by universities.

Need

- Resources are needed to guarantee effective follow-up and cost-effectiveness including lack of human resources, enough time for consultation, proactive quitlines, e-mail, multi-model programs, electronic medical records and national data bases, national mandatory indicators on cessation and feedback in good practices. Better coordination of resources is essential. Although many healthcare professionals are trained and motivated to intervene in cessation, they lack real incentives and reimbursement.

- Lack of comprehensive tobacco control measures hinder smoking cessation services impact. Low price tobacco products, no cessation medication reimbursement, poor smoking bans and non-effective enforcement, lack of sustained public health campaigns, low funded training programs of HCP, poor incentives for HCPs to implement cessation in clinical practice.

- Poor resources and involvement of midwives, nurses, teams-based programs targeting specific population (asymptomatic, socially deprived, pregnant women, women health, teens, children health, inpaints, pre-surgery).

- Comprehensive smoke-free policies and public health education campaigns promoting cessation, smoke-free environments, tobacco dependence treatment, and social smoking susceptibility.

- The National Health system must be more engaged with cessation. Cessation indicators should be mandatory in all healthcare settings. To achieve these goals, undergraduate and graduate cessation training must be given higher priority.

- There is a need to integrate cessation resources and promote networking and feedback among and through health professionals and a more healthcare and community settings.

- More workplace-based programs (most smokers are working class).

- Social involvement and community workers participation is needed. Cessation must become national health and social priority.

- Tobacco dependence treatment reimbursement, at least for special populations and social stagnation, older people or with anomalous difficulties.
Global Bridges European Scoping Exercise Final Report: July 2012

Russia

Background.
- Russia joined the FCTC in 2008, first implementation report expected in 2013
- Legislative process in tobacco control, as well as relevant activities of private business, civil society, media continues to be dominated by the powerful tobacco industry
- Public health aspects are regulated by ineffective 2001 Law on limiting tobacco smoking
- Hope is in the new comprehensive draft law prepared by MoH, based on the FCTC, discussion of the draft in the Federal Government is expected to start by Fall 2012, before submitting to Legislature

Tobacco dependence treatment
- Prevalence of smoking is at the top of 14 GATS countries (2009): Total number of adult tobacco users is 43.9 million (appr. 40% of population), 60.2% of men and 21.7% of women smoke. 40% of pregnant women smoke
- GATS (2009): 32.1% of smokers attempted quitting during the previous year, of these 46.2% belong to 15-18 age group. 60.3% of smokers expressed willingness to quit smoking, 70.7% of women and 55.8% of men. Only 3.6% of smokers plan attempt to quit in the next month and 10.8% in the next year. 30% are not interested in quitting, 20.1% of those who attempted to quit, used medications, 3.5% psychological counseling and 3.7% non-pharmaceutical methods. Less than 31.8% of smokers who visited physician in 12 months preceding survey, reported that they received advice to quit.

TC Dependence treatment
- Vertical system of care for smokers in Russia is non-existent (Kutisheva, 2012). A few low-capacity intervention centres operate within psychiatric, cardiology, oncology service, predominantly in large cities. Brief advice and referral system is not developed. The MoH network of health centers established in 2009, is expected to provide these services to general population. No single guidelines, standard, training etc. Available services operate on ‘functional’ basis, i.e. no specific financial support
- No monitoring or data on the use of these services, estimated negligible portion of the need is met – less than 1%
- Officially approved drugs: Citobine (Takve), NRT, Venecitin, vaccine is on the trial
- In Moscow comprehensive system is developing since 2000, based on specialized center under oncological service of city health department

Government support
- “Concept of implementation of state policy on countering tobacco use for 2010-2015”, and relevant plan of measures approved by the Federal Government in September 2010, including detailed sections on “Organization of medical care for population, aimed at quitting tobacco use and treatment of tobacco dependence” and “Educating and informing population on hazards of tobacco use”
- MoH and MOCT advertising campaigns + website since 2009
- Federal Quitline 8-800-200-0-200 started by MoH in 2010 based in Saint-Petersburg, Russia (All-Russia consultative telephone centre for help in quitting smoking under SPs NII phthisiopulmonology). In the period 14/01/2012-15/6/2012 received 7000 calls, dominant age 18-34. Motivation to quit: 50% health, 5% pregnancy, 10% economic

Medical and professional support
- A few available recommendations developed by various medical specialties, communicating poorly
- Role and involvement of the national medical and professional (nursing, psychology, dental associations and their involvement in tobacco dependence treatment, is low, active are pneumology, cardiology and oncology. Resources are scarce, role of MoH is considered as crucial
- Tobacco use prevalence among health professionals is the same as in general population
- Health care facilities are not tobacco free yet
- Regional initiatives, e.g. local act on tobacco free health care, establishing system for motivating and educating health professionals (2500 in recent 2 years) in Krasnodarsk, Russia
- Russia is part in ENSP project on development of guidelines and standards
Training

- 60% of health professionals are not aware how to provide care (Levinth, 2012), only 18% reported providing relevant care to patients. 30% of professionals state lack of knowledge and training as reason for not providing care.
- Systematic training is in the beginning.
- A number of training “schools” for primary care physicians at the regional level implemented by MoH on a systematic basis since 2003.
- Low capacity training course for post graduates is functioning in L.M. Sechenov First Moscow medical university since 2008.
- Program for advanced medical training of faculty “Medical care on quitting tobacco use and treatment of smoker” adopted by FGOU “Institute for advanced medical training under FMBA” and GDU PRO “Russian medical academy for postgraduate training” in 2010.
- Data on training uptake is unavailable, estimated at less than 1% of the need.

Need

- Motivating public and professionals towards smoking cessation.
- Monitoring and denormalization of tobacco use and tobacco industry initiatives, including support to smoking pregnant women.
- Implementing FCTC, and adopting and enforcement of relevant legislation.
- Bringing together groups of specialists, including NGOs working on the issue.
- Developing a network of smoking cessation services based on modern approaches, guidelines, standards, accreditation, including for adolescents and women.
- Ensuring administrative and financial support from the Federal, regional and local governments, incorporating smoking cessation service in the package provided by health care within state guarantees.
- Tobacco-free health care legislation adoption and implementation.
- Establishing national centre and system for education and training of health professionals.

Background

- From 2005 to 2010 two national legislations have been implemented.
- Not smoking in public places is the rule.
- The understanding of smoking control has increased among Spanish general population.
- Smoking rate among Spanish health professionals has progressively decreased.

Tobacco dependence treatment

- Only 12% of Spanish smokers go to see their physicians when they want to make a serious attempt to quit.
- More than 80% of family physicians give anti-smoking advice to smokers with smoking related disorders BUT less than 30% of them give advice to those who do not have smoking related disorders.
- In primary care facilities only 7% of smokers who want to make a serious attempt to quit receive advice about using evidence based anti-smoking medications. In hospitals 10-12%.

Government support

- National government gives support to preventive measures but does not give support to treatment measures.
- Barriers
  - Economic crisis.
  - Tobacco Industry is pressing National Government to try to change the law.
- Facilitators
  - Two Spanish regions have implemented smoking treatment plans. Smokers with smoking related disorders from these regions can received anti-smoking medications for free when they go to their physicians and make a serious attempt to quit.
Medical and professional support

- National medical and professional (nursing, psychology, dental) associations say that smoking control is important BUT only Spanish Respiratory Society (SEPAR) supports the importance of setting a national plan for tobacco dependence treatment.
- Barriers
  Some Spanish national medical associations have declared to general population that the actual economic situation is not good to try to implement plan for tobacco dependence treatment. They support preventive and legislative measures.
- Facilitators
  Now more health professionals are involved in tobacco dependence treatment than five years ago.

Training

- 50% of Spanish Health professionals have received training on smoking cessation strategies. 40% nurses and 60% primary care physicians BUT only 10% of nurses and 30% of primary care physicians are considered themselves with enough training.
- There are many short training courses available all around the country BUT the contents are different and sometimes do not have high quality.
- There are 3 long training courses available. One of them is an “on line” course BUT their contents should be improved. Another course is given by the University of Madrid and the other one is given by the Spanish Respiratory Society SEPAR.

Need

- To achieve tobacco control
  To keep an eye on the accomplishment of the national legislation.
  To control indirect advertising
  To increase tobacco prices
  To develop a national plan for implementing smoking cessation strategies all over the country.
- To achieve smoking cessation
  More training for health professionals with adequatecontans. Smokers should be encourage to attend their health professionals when they want to quit.
  To have support from national and regional governments
  Reimbursement of evidence based anti-smoking medications.

COM-B model
**Background**
- 20% prevalence
- National approach from 1997 – comprehensive local action
- Funded Local Stop Smoking Services (total population coverage)
- Now tasked with treating 5-10% of the local smoking population

**Tobacco dependence treatment**
- Evidence based guidance
- NCSCT training
- Medication + behavioural support
- Outcome assessed (co) at 4 weeks post txt
- Groups/one to ones etc
- Minimum data set – mistake!

**Support**
- Government – national – local
- Clinicians – secondary care project, primary care projects etc
- Incentive schemes for clinicians

**Training**
- Not mandated
- Evidence based and assessed
- Early mistake not to have a clear ‘science and art’ approach

**Need**
- Coordinated and systematic approach
- Ask, Advise, Act
- Work together
- Data monitor and respond
**Observations**

- Progress is being made
  - Building awareness, developing capacity, establishing networks, creating and sharing resources
- Networks can serve a valuable role
  - Share experience, seek best practice, exert international pressure (taxes & smoke-free workplaces)
- Smokefree Hospitals – shared opportunity?
- High prevalence among physician and nurse smokers
- “Politicians matter” -- Advocacy is important!
- Is imperfect implementation better than none at all? (Outline in Georgia: laws not complete/enforced)
- GB HCP training is only offered when there is a sponsor commitment to incorporate treatment in code of practice

**Observations - 2**

- Andy: Importance of data
  - Establish baseline and evaluate efforts
- Sofia: Encourage HCPs to participate in surveys
- Eva: Measure and leverage cost effectiveness of treatment
  - NICE presentations at UKNSCC very compelling

**Next Steps – near term**

- Join the Global Bridges network (it’s free!)
  - [www.globalbridges.org](http://www.globalbridges.org)
  - Provide content in language for site
  - Blogs: Cut Flims (Emma), Smokefree Hospitals
- Continue curriculum development (face to face & web); define training standards & evaluation process
- Raise awareness of need for treatment – professional mgs
- Nurses site launch: late summer
- Smokefree hospitals incl. treatment for physicians and nurses who smoke
- SRNT Europe (30 Aug – 2 Sept, Helsinki) Expand the discussion about GB-EURO with additional participants
Appendix 5:
Invited attendees to the round table meeting

George Bakhturidze, MD, MPhil is Director of the FCTC Implementation and Monitoring Centre in Georgia and Chairman of the Georgian Health Promotion and Education Foundation. He is also Chairman of the Tobacco Control Alliance in Georgia. Dr Bakhturidze has undertaken tobacco control research and has been involved in Georgia’s only smoking cessation clinic. He has received awards allowing him to attend training in tobacco dependence treatment at the Mayo clinic and has also, in 2008, been awarded the Golden Honorary Award of ‘Health Promotion’ Foundation, Poland for his work.

Andrey Demin, MD is President of Russian Public Health Association, professor at I.M. Sechenov 1st Moscow State Medical University and N.I. Pirogov National Medical-Surgical Centre, physician at Federal State Budgetary Institution ‘Medical-Rehabilitation Centre’ under Ministry of Health of the Russian Federation. He graduated from O.V. Kuusinen Petrozavodsk State University as a physician in 1980, in 1987 completed postgraduate training in public health and healthcare, and in 1999 graduated from Russian Academy of civil service under the President of the Russian Federation as manager in state and municipal administration. He has served at a number of academic and research institutions under Ministries of Education and Health of the USSR and the Russian Federation and from 1992–2001 served as deputy head of department, staff consultant at the Administration of the President of the Russian Federation on environment, health and international security.

He is author and leader of a number of research and practical projects with international participation, presentations at congresses and publications. He has been active in tobacco prevention and control at the national, regional and global scale since 1992 and is the author of books on tobacco in Russia, published in 2002 and 2012. He is a Fulbright Fellow, Fulbright New Century Scholars Program ‘Challenges of Health in a Borderless World’, 2001–2002, Visiting Scholar, London School of Hygiene and Tropical Medicine, London University, 2006 and WHO Temporary adviser, 1994, 2008.

Eva Kralikova, MD, PhD is Associate Professor of Medicine at the Institute of Hygiene and Epidemiology, First Faculty of Medicine, Charles University in Prague and head of the Centre for Nicotine-Dependent at the 3rd Medical Department of the same faculty and the General University Hospital.

She has been involved in epidemiology, prevention and treatment of tobacco dependence for more than 20 years, both at a national and international level. Offering smoking cessation services to smokers since the 1980s, in 2005 Eva set up the first Centre Centre for Tobacco-Dependent in the Czech Republic which works full-time for smokers, based on the example of the Mayo Nicotine Dependence Centre. She also helped to set up the Society for Treatment of Tobacco Dependence, and works on spreading this treatment system across the country with currently 40 such centres based at hospitals. Her research is aimed at epidemiology and treatment of tobacco dependence.
Carlos A. Jiménez-Ruiz, MD, PhD is Associate Professor of Medicine at the Universidad Complutense of Madrid and Head of the Smokers Clinic of the Community of Madrid, Madrid, Spain. He is a lung physician. He developed the first Smokers Clinic located in Spain in 1989 and has been working full-time on smoking-cessation activities since 2002. He earned his MD and PhD from the Universidad Complutense of Madrid. Dr Jiménez-Ruiz has participated in several clinical trials on smoking cessation and in several international programs developing anti-smoking policies. He has also helped develop a program for the implementation of a smoking control policy in Spanish and Portuguese hospitals, which was supported by the European Community.

Dr Jiménez-Ruiz was the Founder and past President of the smoking section of the Spanish Respiratory Society and Spanish Specialists on Smoking Society. He was President of the 9th Conference of the European Branch of the Society for Research on Nicotine and Tobacco. He is the Secretary of the Assembly 6 of the European Respiratory Society, ERS. Dr Jiménez-Ruiz is the Director of Prevención del Tabaquismo, the first Spanish scientific journal fully devoted to smoking issues. He is Director for Tratado de Tabaquismo, the first Spanish scientific book to study all aspects of smoking. This book has been edited three times since 2004. Dr Jiménez-Ruiz has been the director of several other books, has authored over 95 book chapters, and has authored or co-authored over 87 articles in peer-reviewed journals including Archivos de Bronconeumologia, Respiration, CHEST, Nicotine Tobacco Research, Tobacco Control, Pediatrics and the European Respiratory Journal.

Aynura Rashidova, PhD, Head of Health Communication and Public Relation Department of Public Health and Reforms Center Ministry of Health of the Azerbaijan Republic.

As a sociologist and research scientist Aynura has 11 years’ (2000–2012) experience and is the author of more than 20 articles in scientific journals published in Azerbaijan and abroad. She is currently Head of Health Communication and Public Relation Department of Public Health and Reforms Center (PHRC) Ministry of Health of the Azerbaijan Republic. The main field of her research is health communication, smoking and tobacco control. The aim is to organize mass-media campaigns and health information delivery including the tobacco issues as well. Aynura and her team often prepare printed materials (booklets, posters, leaflets and etc.) for target groups. She is a lead author of the National Clinical Protocol on Smoking Cessation that was developed in the Public Health and Reforms Center and which was approved by the Ministry of Health of the Azerbaijan Republic. As the member of main team of PHRC involved in tobacco control activities she has, under the Bloomberg Initiative grant to Public Health and Reforms Center of the Ministry of Health in 2009–2010, intensively trained on Tobacco Control Leadership. She was one of the coordinators for the Global Youth Tobacco Survey (GYTS) in Azerbaijan.
Sofia Ravara, MD, MSc is a Portuguese respiratory physician with a masters degree in Tobacco Control and Treatment (Medical School, Cantabria University, Spain, 2006). From 1990 to 2008, Dr. Ravara has been a hospital-based physician. The initial seven years of her professional activity have been dedicated to the residence training programme in young physician graduate training and pulmonology. In 1997, Dr. Ravara obtained her degree in Pulmonology specialty and has been board certified since then. Between 1997 and 2008, Dr. Ravara worked at the Respiratory Departments of several major Lisbon Hospitals. Since October 2007 up to the present Dr. Ravara is a lecturer in Preventive Medicine and Epidemiology, at the Medical School, Health Sciences School, University of Beira Interior, Covilhã, Portugal. Dr. Ravara also holds the clinical position of Head of the Tobacco Treatment Unit of the University Hospital in Covilhã. Since 2008, Dr. Ravara collaborates with the Portuguese Quit Line and the smoking quit clinic and respiratory outpatients clinic of the National Institute of Preventive Cardiology Prof. F. Pâdua, Lisbon. During the last years she has worked as a tobacco treatment expert in hospital-based smoking quit clinics, and collaborated in workplace smoking prevention programs, in the development of the smoke-free hospitals network, as well as in health professionals training programs. Dr Ravara has also been very active in tobacco control activities in Portugal, and she is a founding member and directive board member of the Portuguese Society of Smoking Treatment and Prevention (SPT), She is also past-secretary of the tobacco working group of the Portuguese Respiratory Society (SPP), member of the Spanish Society of Specialists in Smoking Treatment and Prevention (SEDET), of the European Respiratory Society (ERS) and of the Society for Research on Nicotine and Tobacco (SRNT. She has been involved in European Tobacco Control advocacy programmes and smoking cessation networking groups.