International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

Tobacco Control at The Union
United for a tobacco-free future

Factsheet 06

Smoking cessation

KEY FACTS

- If adult cigarette consumption were to decrease by 50% by 2020, approximately 180 million deaths could be prevented by 2050.
- Most smokers want to quit but few succeed.
- Cessation brings immediate and long-term health benefits.
- Cessation advice, quit lines, pharmacological and behavioural therapies are effective interventions.
- Smoking cessation services are fully available to only 5% of people worldwide.
- Cessation services should be part of a comprehensive tobacco control programme.

The need for smoking cessation programmes

Tobacco is the second biggest cause of death worldwide. Unless urgent action is taken, the number of annual deaths is expected to increase to eight million by 2030.[1] Active smoking causes a wide range of health conditions and fatal diseases, including cancer, respiratory disease and heart disease.[2]

Tobacco use is highly addictive, and tobacco dependency is recognised as a medical condition.[3] When smokers quit, they are very likely to start again.[4] So providing assistance for smoking cessation and tobacco dependency treatment are key tobacco control measures. The introduction of tobacco control legislation around the world has encouraged many smokers to quit.

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Health benefits of smoking cessation

Smoking cessation brings immediate health benefits for smokers, whether or not they have a tobacco-related disease. For example, the decline in lung function stops within 48 hours of cessation. Former smokers live longer than continuing smokers. Cessation reduces the risk of cancer, heart disease, stroke and respiratory diseases. It also brings reproductive health benefits in women.[5]

People who quit smoking before developing a tobacco-related illness can reduce most of the associated risks within a few years of quitting. These smokers, if they quit before the age of 35, have a life expectancy that is not significantly different from non-smokers. Smokers quitting after the age of 35 will substantially reduce the risk of tobacco-related disease compared to continuing smokers.[6]

Difficulties in quitting smoking

Most smokers want to quit but few succeed. A poll of US smokers in 2006 found that three quarters of them want to quit. However, the success rate among attempted quitters is very low.[7 8] Cigarettes are addictive, primarily because they deliver nicotine rapidly to the brain. Powerful urges to smoke, and adverse mood and physical symptoms that occur during abstinence from nicotine are relieved by using tobacco.[9]

Interventions

There are several types of intervention for smokers wanting to quit: 1. Smoking cessation advice; 2. Free telephone quit lines; 3. Pharmacological therapies; 4. Behavioural interventions.[1]

Smoking cessation advice

This involves integrating cessation advice into primary healthcare services. Smokers are reminded at every medical visit that tobacco harms their health and the health of those around them. Repeated advice reinforces the need to quit. It is a relatively inexpensive intervention.[1]

Quit lines and internet-based support

Telephone quit lines are inexpensive to run, easy to access and can operate beyond normal business hours. They can reach people in remote areas, can introduce smokers to other therapies, and can be tailored to target groups. Quit lines linked to counselling services are more effective. Continuous support for smoking cessation can also be provided via the internet,[1] and four recent studies have shown that internet-based support can be effective.[10 11 12 13] Other communication technologies, such as text messaging can provide important support.[14]

Pharmacological interventions

The main categories of medical intervention are as follows:

1. Nicotine replacement therapy (NRT) – low levels of nicotine are delivered to the body (in the form of skin patches, chewing gum, lozenges/sublingual tablets, nasal sprays and inhalers) in order to help with withdrawal symptoms. NRT can increase a smoker's chances of quitting by 1.5 to 2 times.[15]

2. Sustained–release bupropion tablet – an antidepressant medication that reduces withdrawal symptoms and increases the smoker's chance of quitting twofold.[16] Another antidepressant, nortryptiline, has also been shown to double the chances of quitting.

3. Varenicline tablet – it reduces the need to smoke and also makes cigarettes less satisfying. A 2007 study found that varenicline increases the likelihood of a smoker quitting threefold.[17]

Combinations of different NRTs are effective, and no side effects of toxicity have been reported.[18 19 20] NRT is usually available without prescription, but the other medications require one.

Best practice

- Integrate smoking cessation services into government healthcare services.
- Make NRT products available without prescription.
- Adopt tax/price policies that make cessation products affordable.
- Require that cessation products and counselling are covered by private and government health insurance.
- Make available funding for smoking cessation programmes.
- Make smoking cessation services part of a comprehensive tobacco control programme.

Behavioural interventions

Behavioural interventions for smoking cessation can be effective.[21 22] A combination of structured behavioural support and one of the medication options described above is believed to be the most effective way of helping smokers to quit.[23]

Additional support can help to further increase the smoker's chances of successfully quitting. It includes supervision of medication use, psychological support over the telephone or face-to-face, and group counselling. For young people the focus is largely on preventing them from starting using tobacco.[24] Interventions to treat tobacco dependence should be adapted to local conditions and cultures, and tailored to individual preferences and needs.[1]

Availability of smoking cessation services

Cessation therapies are not available in all parts of the world, but availability is increasing.[14] Services to treat tobacco dependence are fully available in only nine countries, 5% of the world's population. Of the 173 countries who responded to a World Health Organization (WHO) questionnaire, 22 do not offer any basic services such as counselling or pharmacotherapy. Nicotine replacement therapy is not available in 39 countries, even for people with the means to pay for it. Only 44 countries, or 40% of the world's population, have access to telephone quit lines.[1]

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FCTC requirements

Under Article 14 of the WHO Framework Convention on Tobacco Control (FCTC), parties must:[25]

- develop comprehensive guidelines based on evidence and best practice.
- adopt measures to promote smoking cessation and treatment of tobacco dependence.

Draft guidelines for the implementation of Article 14 are currently being developed.[26]

For more information visit www.theunion.org www.tobaccofreeunion.org
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