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Family Physician Corner

Smoking Cessation in Bahrain, the Evolving Strategy - Part II

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Benefits of Quitting Smoking

Because smoking is addictive, patients should not be discouraged from unsuccessful quitting attempts. It is well-known in the literature that quitters undergo several failure attempts before they finally quit. Repeated attempts, nevertheless, are fruitful, not only for the individual smoker, but also for his/her family and society[1].

Table 1 lists some of the physical and psychological benefits of smoking cessation[2]. It is important to note that even smokers who quit in their 60s experience not only a better quality of life, but also a longer life expectancy compared with those who continue smoking.

Table 1: Physical and Psychological Benefits of Smoking Cessation[1]

Short-Term Benefits	Long-Term Benefits
Blood pressure returns to pre smoking levels within 20 minutes	Lung functions return to 30% within 2-3 months
Carbon Dioxide levels drop within hours	Risk of coronary heart disease is reduced by 50% after 1 year
Money is saved each day	Risk of stroke is similar to that of non-smoker within 5 to 15 years
Sense of smell and taste improve within days	
Patient earns greater self-respect because of a real sense of accomplishment in quitting	Patient enjoys increased self-esteem due to quitting

Dealing with smokers

Numerous smoking cessation strategies have been developed and tested over the past years. The two main interventions are pharmacotherapy and behavioural therapy. These contribute about equally to success in quitting. Recent evidence shows that a combination of both methods is the most effective intervention[3].

Three levels of care could help smokers, see figure 1.

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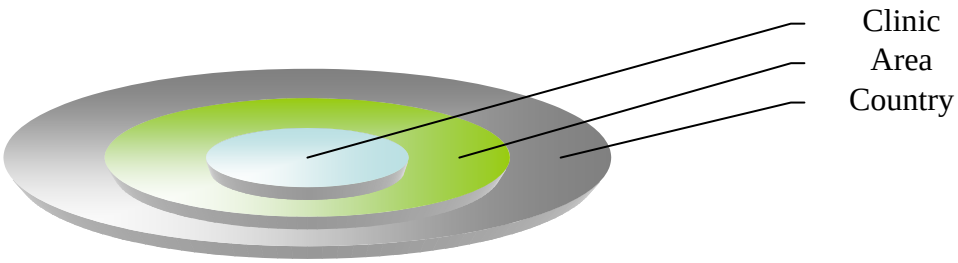

Figure 1: Levels of Care

A. Setting Smoking Cessation Help in a Clinic

A mini-scaled approach screening and smoking cessation help could be initiated in a clinic. It included the following points, see Table 2.

1. A team is formed including the health educator, an administrator and a family physician.
2. Posters and flyers in the clinic are displayed, identifying the risk of smoking.
3. Screening of the clients to evaluate their personal history including their charcteristic data, age at starting smoking, smoking habits and behavior, reasons for continued smoking and financial status.
4. Evaluating the readiness or the willingness of every smoker to quit through the famous **five A's (Ask, Asses, Advice, Assist, and Arrange)**[4].
5. Clients are stratified according to their willingness to quit into three main categories, see Figure 2.
6. Those unwilling to quit are motivated through the **five R's: Relevance, Risk, Rewards, Roadblocks (barriers) and Repetition.**
7. Special time is set up for interested clients for face to face or group consultation[5].
8. If patient needs behavioral and pharmacological help, Smoking cessation clinic would be asked provide.
9. The help clinic activity is periodically evaluated through structured audits, indicators include: number of visitors to the clinic and percentage of referrals to smoking cessation clinic.

Table 2: Evidence Based Evaluation of Physician Intervention[3]

• Physician training in smoking cessation is beneficial. Trained physicians produce increased cessation of smoking compared to untrained physicians.	Level I
• Health professionals who receive training are much more likely to intervene with smokers than those who are not trained.	Level I
• Even brief, routine advice to stop smoking in primary practice can have a positive impact on long-term smoking cessation.	Level I
• Patient-centered, behavior-oriented counseling is the most effective strategy in changing smoking behavior.	Level I
• Brief provider intervention (two to five minutes) and a self-help manual may be superior to usual care in motivating attempts to quit.	Level I
• It is important to feel confident in exploring smoking issues with those patients who are less motivated to quit, patient-centered counseling can reduce defensiveness.	Level I
• Smokers who cannot stop smoking with brief physician intervention should be offered specialized help, such as referral to a smokingcessation specialist.	Level III

The following is a proposed flow chart to approach patients in a clinic:

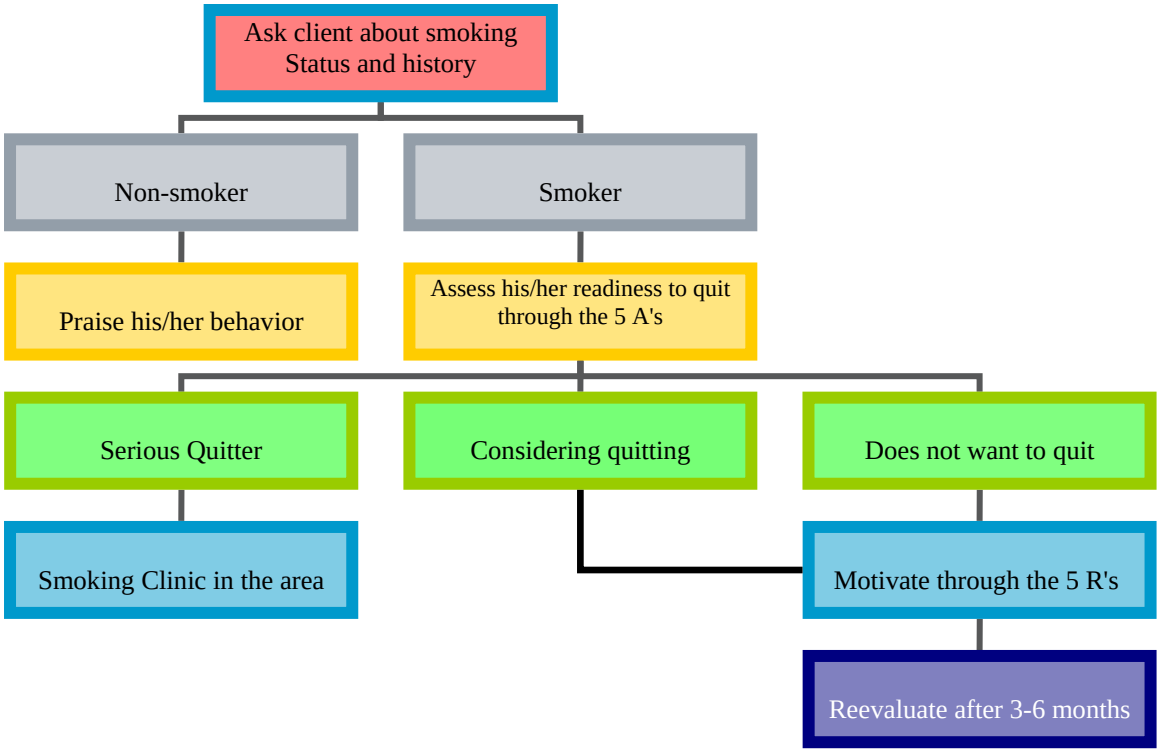

Figure 2: Flowchart for Quit Smoking Help in the Clinic

B. Regional Help in Dealing with Smokers

Smoking is increasing especially in younger age group. Traditional coffee shops make smoking easier especially water pipe "Sheesha". The health center could combat the increase through formulating a health promotion plan, which includes schools, youth clubs, work places, and religious places. The campaign could include smoking-free days, smoking therapeutics exhibitions and referral to smoking cessation clinic. This campaign has certain timeline and monitoring indicators.

WHO strategy include: **Monitor** tobacco use and prevention policies to **Protect** people from tobacco smoking hazards, to **Offer** professional help to quit the habit of tobacco use, to nationally **Warn** about the dangers of tobacco, to **Enforce** general bans on tobacco advertising, promotion and sponsorship and **Raise** taxes on tobacco industry. The strategy is stratified into stages in order to help set up a timeline or schedule upon which each country should benchmark itself and put new goals for each stage[2].

Bahrain has fulfilled many of the items shown below in Table 3. Bahrain needs to put stringent legislation, taxes, education and accessible professional services in primary care.

Table 3: Policies and Interventions of the Package[2]

MONITOR TOBACCO USE **Crosscutting Activity M1** Obtain Nationally representative and population based periodic data on key indicators of tobacco use for youth and adults	**PROTECT** PEOPLE FROM TOBACCO SMOKE		
	P	**Intervention P1**	Enact and enforce completely smoke-free environments in health-care and educational facilities and in all indoor public places including workplaces, restaurants and bars
	OFFER HELP TO QUIT TOBACCO USE		
	O	**Intervention O1**	Strengthen health systems so they can make tobacco cessation advice available as part of primary health care. Support quit lines and other community initiatives in conjunction with easily accessible, low cost pharmacological treatment where appropriate
	WARN ABOUT THE DANGERS OF TOBACCO		
	W	**Intervention W1**	Require effective package warning
		Intervention W2	Labels implement counter-tobacco advertising
		Intervention W3	Obtain free media coverage of anti-tobacco Activities
	ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP		
	E	**Intervention E1**	Enact and enforce effective legislation that comprehensively bans any form of direct tobacco advertising, promotion and sponsorship
		Intervention E2	Enact and enforce effective legislation to ban indirect tobacco advertising, promotion and sponsorship
	RAISE TAXES ON TOBACCO PRODUCTS		
	R	**Intervention R1**	Increase tax rates for tobacco products and ensure that they are adjusted periodically to keep pace with inflation
		Intervention R2	Strengthen tax administration to reduce the illicit trade in tobacco products

CONCLUSION

The ultimate goal of smoking cessation services is to end the tobacco problem; in other words, to reduce smoking substantially that it is no longer a significant public health problem. It is hoped to implement tobacco-counseling measures at the level of the physicians; establish a community-based programs to approach the problem at regional level. Aggressive policy initiatives will be necessary to end the tobacco problem. Any slackening in the public health measures may reverse efforts of progress in halting tobacco-related disease and death.

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