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# Integration von Tabakentwöhnung in die Gesundheitsversorgung

## Integrating tobacco treatment interventions in routine healthcare

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**Zusammenfassung:** Weltweit leben vier von fünf Tabakkonsument\*innen in wirtschaftlich sich entwickelnden Ländern, die einer enormen Belastung durch Tuberkulose und HIV-Erkrankungen ausgesetzt sind. Tuberkulose- oder HIV-Patient\*innen, die rauchen, leiden trotz Behandlung unter schlechteren Prognosen. Verhaltensinterventionen zur Tabakentwöhnung sind in der routinemäßigen Gesundheitsversorgung eine Herausforderung. Qualität der Vermittlung und Patientenbindung müssen verbessert werden.

**Schlüsselwörter:** HIV; Länder mit niedrigem und mittlerem Einkommen; Raucherentwöhnung; Tuberkulose; Verhaltensinterventionen.

**Abstract:** Globally, four out of five tobacco users live in economically developing countries that are facing huge tuberculosis and HIV disease burdens. Tuberculosis or HIV patients, who smoke, suffer from poorer outcomes despite treatment. Behavioural tobacco treatments that are successful in supporting patients quit, are challenging to deliver in routine healthcare. Such treatments need to be simplified by enhancing quality of delivery and patient engagement.

**Keywords:** behavioural interventions; HIV; low-and-middle income countries; smoking cessation; tuberculosis.

Tobacco kills millions each year and costs society trillions of dollars. The significant reductions in smoking rates in high-income countries such as the United Kingdom are almost entirely offset by the increasing consumption in

many other countries with weaker tobacco control regulations [1]. Over 80% of the 1.3 billion tobacco users worldwide live in low- and middle-income countries (LMICs), where the burden of disease and death due to tobacco use is heaviest [2]. Many LMICs, particularly in Asia and Africa, are also facing major health challenges such as tuberculosis (TB) and HIV infection which could be exacerbated by tobacco use. For example, TB patients who smoke have poorer treatment outcomes compared to non-smokers, manifesting as slower recovery from TB, higher rates of treatment failure, higher risk of TB recurrence and death [3]. Similarly, harmful effects of tobacco are magnified and accelerated in patients with HIV infection, who develop lung cancer and airway diseases such as chronic obstructive pulmonary disease (COPD) at higher rates and at younger ages than HIV-infected non-smokers [4]. Many smokers getting treatment and care for these conditions come into regular contact with the healthcare system, creating opportunities to help them quit. Treatment of these major health conditions must therefore address tobacco use, particularly by encouraging and supporting people to quit tobacco.

Article 14 of the World Health Organisation's Framework Convention on Tobacco Control (WHO FCTC) recommends provision of evidence-based tobacco treatments [5]. However, its uptake by most countries that are party to the convention has been slow, particularly in LMICs [6]. Barriers identified include, but are not limited to, the lack of a healthcare system infrastructure, such as tobacco treatment services not being integrated into primary care, and lack of health worker training [6]. Implementation of evidence based tobacco treatment needs to be improved, with an emphasis on integrating affordable, broad-reaching interventions for all tobacco users into the healthcare system [7]. Integrating tobacco treatment within TB and HIV services offers a viable solution to reduce disease burden, particularly in countries with high TB and HIV burden where tobacco use is also high. In 2017, about 85% of TB deaths occurred in the African and the south Asian regions [8]. Worldwide TB rates could decline as much as 20% if we eliminated smoking [9]. Similarly, among people

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living with HIV, tobacco cessation can decrease all-cause mortality by 16%, and the incidence of cardiovascular events, non-AIDS related cancers and bacterial pneumonia by 17%, 34% and 18% respectively [10]. Although links between tobacco and these medical conditions have been increasingly recognized, few TB or HIV clinics have integrated tobacco treatment into their routine services. This is an urgent unmet need that must be addressed.

Behavioural treatment, alone and in combination with medication, is extensively researched and scientifically proven as effective and cost-effective for tobacco cessation [11]. It has also been found successful in supporting quitting in TB services in LMICs [12]. For people living with HIV who smoke, these treatments have been found to help them quit in the short-term, and if tailored to the population needs, they could be effective for long-term quitting [13]. Nevertheless, there are challenges in implementation of these treatments. Barriers to integrating behavioural treatments in routine care, reported by health workers, largely relate to complexity of the interventions (e.g. duration and number of sessions, and number of behaviour change elements offered), low levels of motivation, and engagement with personalised and sustained support [14]. In Nepal and Pakistan, we found that communicating key messages using a patient-facing pictorial chart was considered straight-forward and intuitive by health workers, but effective engagement techniques such as emphasising patient choice, reflective listening and tailoring advice individually, were harder to incorporate [14]. Patient communication skills of the providers as noted in our recent tobacco cessation evaluation in Bangladesh and Pakistan, remains an under-developed area [15]. Whilst, systemic barriers such as limited treatment delivery time per patient continue to be important in planning tobacco treatment integration in these countries, aligning these treatments with providers' roles, receptivity and adequate training on treatment delivery are key to its successful integration in routine healthcare [14–16].

Where resources are scarce, each contact with health workers must be optimised. Behavioural treatment interventions are complex and demanding, often loaded with content in attempts to improve outcomes [17]. Implementing such treatments in routine care will require health workers to manage too many dimensions at the same time, making it cognitively challenging for the patients to receive, and resource intense for the healthcare systems to deliver [18]. The quality of treatment delivery, that is, the way behavioural treatments are communicated to the patient, may have a potential role in moderating its effect and increasing its efficiency [19]. We found that the way behavioural treatments are delivered to smokers can

positively influence their quit behaviour [20]. We need to be more sensitive to the way in which the effect of behavioural treatments may vary due to provider attributes and interpersonal delivery styles, and to the need for developing shorter yet efficient treatments for tobacco cessation support.

Promoting techniques to facilitate delivery of behaviour change messages by providers can enrich patient experience and impact tobacco cessation and health outcomes. Simplifying content of behavioural treatments and building workforce competence in effective treatment delivery are likely to be transferable to patient-care in general. Areas for future research on promoting integration of behavioural tobacco treatment interventions in health systems in LMICs include the following:

- Simplifying content of behavioural tobacco treatment interventions
- Developing core competency training in treatment delivery approaches
- Promoting treatment delivery approaches that enhance patient communication
- Matching provider attributes and role to the specified treatment

#### **Autorenerklärung**

**Autorenbeteiligung:** Alle Autoren tragen Verantwortung für den gesamten Inhalt dieses Artikels und haben der Einreichung des Manuskripts zugestimmt. **Finanzierung:** Die Autoren erklären, dass sie keine finanzielle Förderung erhalten haben. NDM ist dankbar für die Gehaltsunterstützung aus dem Tabakkontrollkapazitätsprogramm (Grant MR/P027946/1), das von UK Research and Innovation (UKRI) mit Mitteln des Global Challenges Research Fund unterstützt wird. **Interessenkonflikt:** Die Autoren erklären, dass kein wirtschaftlicher oder persönlicher Interessenkonflikt vorliegt. **Ethisches Statement:** Für die Forschungsarbeit wurden weder von Menschen noch von Tieren Primärdaten erhoben.

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