Tobacco or Oral Health

World Health Organization

FDI World Dental Federation

An advocacy guide for oral health professionals

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The FDI World Dental Federation

The FDI World Dental Federation is the authoritative worldwide organisation of dentistry representing more than 700,000 dentists in 137 countries around the globe. Founded over a hundred years ago in Paris, the FDI is a federation of national member associations that gather once a year in a general assembly, the World Dental Parliament. The FDI is in official relations with the World Health Organization, the United Nations and other international organisations. The promotion of optimal oral and general health is a major aim of FDI's activities; including the promotion of WHO policies.
www.fdiworldental.org

The World Health Organization (WHO)

The World Health Organization, the United Nations specialised agency for health, was established in 1948. WHO's objective, as set out in its constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." WHO is governed by 192 Member States through the World Health Assembly.
www.who.int or www.who.int/oral_health

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Contents

Executive Summary

This Guide, developed jointly by the FDI World Dental Federation (FDI) and the World Health Organization (WHO), provides tobacco facts, highlights the involvement of the FDI and the WHO in tobacco control initiatives, discusses the role of dentists and other oral health professionals in tobacco control, examines the role of advocacy, and provides a number of wide ranging recommendations to move the tobacco control agenda forward.

It is now accepted that helping tobacco users to quit is part of the role of health professionals, including dentists and other oral health professionals. It is also formally recognised that tobacco cessation is part of the practice of dentistry. In addition, oral health professional organisations have a responsibility to engage in tobacco control initiatives, including supporting political processes that lead to an environment favourable to health.

The guide is divided into 5 main chapters. **Chapter 1** provides a startling reminder of the dangers posed by tobacco consumption. Tobacco is the second major cause of death in the world. The death toll from tobacco consumption is now 4.9 million people a year. This figure is expected to climb to 10 million deaths by 2020, with most deaths occurring in developing countries. The impact of tobacco use on oral health is also illustrated. Tobacco use and its connection with oral diseases is a significant contributor to the global oral disease burden. The clear link between oral diseases and tobacco use provides an ideal opportunity for oral health professionals to become involved in tobacco control initiatives, including smoking cessation programmes.

In **Chapter 2** World Health Organization's Tobacco Free Initiative (WHO TFI) illustrates its role and the role of health professionals in tobacco control. The approach of the WHO Oral Health Programme is detailed and policy approaches are highlighted.

Chapter 3 suggests that urgent and concerted action is required to reduce the disease, suffering and premature death which directly results from tobacco use. The dental team has a significant role to play in tobacco control initiatives. A guideline that provides clear advice for oral health professionals to become involved in smoking cessation programmes is detailed. Oral health professionals can easily incorporate this model into their daily clinical practice by following a simple step-wise approach. Barriers for the limited involvement of oral health professionals in tobacco cessation programmes are identified and ways to address these barriers

are presented. Practical tips about setting up the dental office in order to engage in clinical tobacco interventions are also illustrated.

Chapter 4 discusses how and why advocacy should be part of all oral health professionals' toolkit. The role of oral health professional associations is emphasised and it is suggested that the first step to shape the organization's own policies. The FDI Statement on Tobacco in Daily Practice is illustrated, as is a Code of Practice in Tobacco Control. A number of country case studies are provided including testimonies from Kenya, Germany, India, South Africa, Sweden and Fiji.

Chapter 5 proposes recommendations to oral health organisations at the global, national, and local levels. There is an urgent need to put tobacco control initiatives, including cessation programmes, on the oral health agenda. The World Health Organization and FDI World Dental Federation are providing the leadership and support for this action.

> All health professionals - individually and through their professional associations - have a prominent role to play in tobacco control. Health professionals have the trust of the population, the media and opinion leaders, and their voices are heard across a vast range of social, economic and political arenas

Preamble

Judith Mackay

Judith Mackay
Director,
Asian Consultancy
on Tobacco Control,
Senior Policy Advisor
WHO

The first cultivation of tobacco is thought to have been around 6000 BC, with earliest reports of use amongst indigenous Americans around the first century BC. By the 16th century it was being used worldwide. With 1.3 billion current tobacco users in the world predicted to rise to 1.6 billion by 2030, this is not an epidemic that is going to go away in the lifetime of present readers of this preamble.

There was no shortage of early warnings on the harmfulness of tobacco on dental health. For example, Dr Joel Shew wrote in 1849 in a book entitled Tobacco: Its History, Nature, and Effects on the Body and Mind (1).

"The pernicious effects of tobacco on the teeth are easily proved … the teeth of tobacco chewers, who have continued the practice for a considerable length of time, are generally bad, as any one may observe. It was once said in the presence of clergyman of our acquaintance, that tobacco was good for preserving the teeth, upon which he answered, 'That is not true, for on one side my teeth are perfectly good, while on the other side, the one in which I have always kept my cud, there is not a stump left.'"

A PubMed online search in May 2005 for "tobacco" and "oral" yields over 2,500 published articles in medical journals, but 150 years ago Dr Shew identified most of the oral health effects of tobacco as we know them today - on the teeth, gums, throat, taste, voice, and including cancer, albeit much of his evidence was anecdotal.

He also identified the struggle to quit tobacco use: "I have known some well-meaning, pious people brought into the habit, and when once it is fixed upon them, not one of a hundred has the power to leave it off." He thus identified the need for primary prevention.

The FDI combines a summary of the health effects with suggested action in the following statement on its website: "The effects of tobacco use on the population's oral health are alarming. The most significant effects of smoking on the oral cavity are: oral cancers and pre-cancers, increased severity and extent of periodontal diseases, as well as poor wound healing. The clear link between oral diseases and tobacco use provides an ideal opportunity for oral health professionals to partake in tobacco control initiatives and cessation programmes.

Dental professionals might well study Sun Tzu's "Art of War", written in the 6th century B.C., because this classic work on military strategy, tactics, logistics and espionage has great relevance to today's tobacco war. The objectives of reducing tobacco are similar to those of all wars:

- To protect countries from being invaded and overpowered (eg by the transnational tobacco companies)
- To save people from being killed
- To return land to growing food
- To improve the economy
- To protect the environment

Many dental professionals will focus on saving people from being killed, and from ill health, by offering individual advice to patients. It may seem a leap away from clinical practice for you to challenge the tobacco industry, examine alternative crops, engage in economic surveys to show that tobacco is a debit to the economy, support tobacco tax increases, protect the environment by supporting smoke-free areas, or lobby governments to ratify and implement WHO's first international treaty – the Framework Convention on Tobacco Control.

Both approaches are vital and complementary, and the FDI has a long history of supporting measures that will lead to reduced tobacco use in communities. And, in addition, dentists themselves can be role models – by being non-smokers.

Dr Judith Mackay, FRCP (Edin) / FRCP (Lon), is a public health consultant for several international organisations. She has lived in Hong Kong since 1967, and has conducted health-related missions in over 35 mostly developing countries worldwide.

Dr Judith Mackay is a British medical doctor and Senior Policy Advisor to the World Health Organization. She is based in Hong Kong where she is the Director of the Asian Consultancy on Tobacco Control. After an early career as a hospital physician, she became a health advocate. Her particular interests are tobacco use among women, and in developing countries. She is a Fellow of the Royal Colleges of Physicians of Edinburgh and London, and holds professorships at the Chinese Academy of Preventive Medicine, Beijing, China and the Department of Community Medicine, University of Hong Kong. She has delivered 360 conference papers world wide on varied aspects of tobacco control and other topics of public health. In addition to 160 academic papers and several books or chapters of books, she is the author of several atlases: "The State of Health Atlas," "The Atlas of Human Sexual Behaviour," 'The Tobacco Atlas' and "The Atlas of Heart Disease and Stroke" and is currently working on "The Cancer Atlas."

Dr Mackay has received many international awards including the WHO Commemorative Medal, the Fries Prize for Improving Health, the Luther Terry Award for Outstanding Individual Leadership, the International Partnering for World Health Award, the US Surgeon General's Medallion, a royal award from the King of Thailand, and the Founding International Achievement Award from the Asia Pacific Association for the Control of Tobacco. She regards it as a great compliment to have been identified by the tobacco industry as one of the three most dangerous people in the world."

Forewords

HR Yoon and JT Barnard, FDI

HR Yoon,
President,
FDI World Dental Federation

JT Barnard,
Executive Director,
FDI World Dental Federation

Tobacco use is one of the major challenges to international health and all health professionals have an important part to play in helping to stop the global tobacco epidemic. The FDI has for a long time advocated for a close involvement of the dental team in such activities and we are very pleased to note the changes and developments in many countries.

However, much remains to be done and the urgently needed changes are challenging the traditional role models of dentists and other team members. They also challenge the role of professional organisations and their involvement in political decision processes.

This publication, jointly developed by the FDI and the World Health Organization Oral Health Programme, provides the platform for greater dental commitment in tobacco control initiatives, including advocacy and smoking cessation programmes.

Oral health care teams acknowledge that helping tobacco users to quit the habit is part of their role and it is now formally recognised that smoking cessation is part of the practice of dentistry. In addition, oral health professional organisations have a responsibility in supporting political processes that lead to an environment conducive to health and that includes strong tobacco control policies.

The FDI welcomes and fully supports the WHO Framework Convention on Tobacco Control (FCTC) as part of the political and legal activities needed to effectively address the tobacco issues. It is one of our tasks as a non-governmental health organisation in official relations with WHO to promote WHO policies and to collaborate on issues of common interest. We highly welcome the initiative of WHO to dedicate World No Tobacco Day 2005 to the important role of health professional organisations in tobacco control that was initiated through a workshop that the FDI and the World Medical Association organised during the 12th World Conference Tobacco or Health in 2003 in Finland.

We sincerely hope that this guide for dentists and oral health organisations will be helpful in increasing awareness and in facilitating tangible engagement in tobacco control on the individual patient level as well as in the broader political context. The FDI is prepared to assist and support this process wherever possible.

Poul Erik Petersen, WHO

Unhealthy lifestyles such as smoking and other tobacco use are among the important risk factors for many chronic diseases, including several oral diseases and conditions. Globally, the risk factors approach is recommended being the leading principle in public health work since the Ottawa Charter for Health Promotion was adopted in 1986. The charter identified five health promotion action areas for modern public health:

(1) build healthy public policy;

(2) create supportive environments;

(3) develop personal skills;

(4) strengthen community action, and

(5) reorient health services towards prevention and health promotion.

The WHO Framework Convention for Tobacco Control (WHO FCTC) is a major new platform for building health policies and creating oral health supporting environments. WHO FCTC provides an important context for ensuring policies for oral health through tobacco control becomes an integral part of national health programmes, emphasising the inter-relationship between oral health and general health.

Reorientation of oral health services towards prevention and health promotion may contribute significantly to the development of personal skills of patients and likewise oral health professionals can be most instrumental in community-based public health programmes oriented towards tobacco cessation.

Tobacco prevention starts with developing healthy lifestyles among children and youth. The WHO Oral Health Programme has designed a model for including oral health promotion within the framework of the Health Promoting Schools, and this initiative also gives emphasis to tobacco and oral health. Oral health professionals have an important role to play in the implementation of school oral health programmes worldwide and the challenges including tobacco prevention are high particularly in countries with growing tobacco consumption.

On the basis of the WHO No Tobacco Day 2005, the WHO and FDI have embarked on tobacco control with the intention of preventing tobacco-related oral disease and promoting health and wellbeing. The "Tobacco or Oral Health - an advocacy guide for oral health professionals" is a most valuable tool in our joint work for better health for all. Combined efforts on tobacco control by the networks of oral health professionals, public health administrators and policy makers at local, national and international levels may guarantee success in disease prevention and hopefully this manual may stimulate the sharing of experiences.

I sincerely hope that this advocacy guide will be helpful in increasing tobacco prevention activities on the individual patient level and increasing awareness of tobacco and oral health within the community and at political level.

Poul Erik Petersen,
Chief,
Global Oral
Health Programme,
WHO Geneva


“Every 6.5 seconds one tobacco user dies from a tobacco-related disease somewhere in the world”

1 Introduction:
The Extent of the Problem

Basic Facts About Tobacco

Carmen Audera-Lopez

Currently, there are an estimated 1.3 billion smokers in the world. The total global prevalence in smoking is 29% (47.5% of men and 10.3% of women over 15 years of age smoke). Of the 1.3 billion smokers, more than 900 million live in developing countries (2).

Tobacco is the second major cause of death in the world. It is currently responsible for the death of one in ten adults worldwide. Every 6.5 seconds one tobacco user dies from a tobacco-related disease somewhere in the world (2). Cigarettes kill half of all lifetime users and half of those die in middle age (35-69 years), losing an average of 20 to 25 years of life (3).

The death toll from tobacco consumption is now 4.9 million people a year; if present consumption patterns continue, the number of deaths will increase to 10 million by the year 2020, 70% of which will occur in developing countries (4). With current smoking patterns, approximately 500 million people alive today will eventually be killed by tobacco use. By 2030, tobacco is expected to be the single biggest cause of death worldwide, accounting for about 10 million deaths per year.

As research on the effects of tobacco on health continues and the number of affected people increases, the list of conditions caused by tobacco has expanded. There is nowadays evidence that almost every organ in the body is affected by tobacco consumption and now it also includes cataracts, pneumonia, acute myeloid leukemia, abdominal aortic aneurysm, stomach cancer, pancreatic cancer, cervical cancer, kidney cancer, and periodontitis. These diseases add on to the already known such as lung, oesophagus, larynx, mouth and throat cancer, chronic pulmonary and cardiovascular diseases, as well as negative effects on the reproductive system and sudden infant death syndrome (5).

Non-smokers also suffer the health consequences of tobacco. There is conclusive scientific evidence that shows that involuntary exposure to tobacco smoke puts non-smokers at a greater risk of lung cancer, respiratory and cardiovascular diseases, and increases the risk of asthma, respiratory conditions, ear infections and sudden infant death syndrome in infants (6).

...Tobacco is the second major cause of death in the world...

The costs of tobacco go far beyond the tragic health consequences. Tobacco is also a significant economic burden on families and societies and is a major threat to sustainable and equitable development (7).

Despite the current knowledge of the harm caused by tobacco, consumption continues to increase. The tobacco epidemic is shifting from industrialized to developing countries (Figure1). There are two main reasons for this phenomenon. Firstly, nicotine is extremely addictive so it is very difficult to quit tobacco consumption in spite of the willingness of many tobacco consumers to quit. The other main reason is the marketing strategies of the tobacco industry. The tobacco industry needs to replace consumers that die prematurely or who succeed in quitting consumption. The industry uses all kinds of strategies to create new markets, targeting those that do not consume tobacco yet, such as young people and men and women in developing countries.

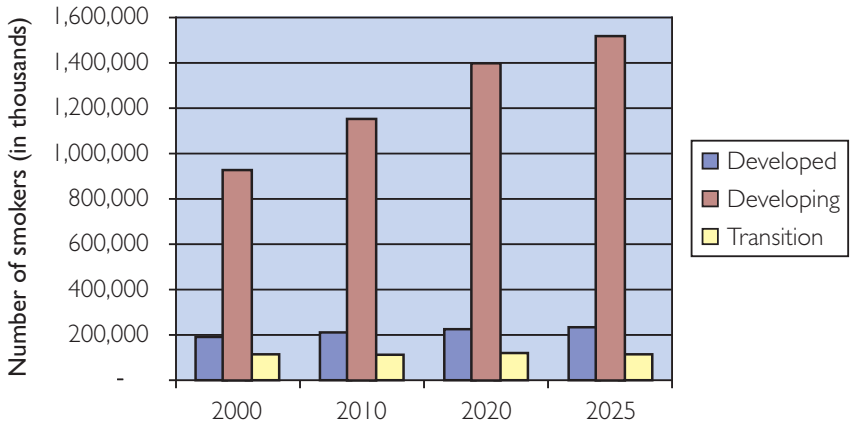


Figure 1. Current and future estimates of number of smokers in the world

Source: Guindon GE & Boisclair D. Past, Current and future Trends in Tobacco Use. HNP Discussion Paper No.6, Economics of Tobacco Control Paper No. 6. WHO and The World Bank, 2003.

Recent findings of the Global Youth Tobacco Survey (GYTS), the largest global survey on adolescents aged 13 to 15 and tobacco, show that, although young people's use of cigarettes and other tobacco products varied dramatically by site, young girls are smoking almost as much as young boys and that girls and boys are using non-cigarette tobacco products such as spit tobacco, bidis, and water pipes at similar rates. These findings suggest that projections of future tobacco-related deaths world wide might be underestimated because they are based on current patterns of tobacco use among adults, where women are only about one-fourth as likely as men to smoke cigarettes (8). Nearly 24% of all young smokers started by the age of ten, when they are far too young to understand or resist social expectations (9).

Basic Facts About Tobacco and Oral Health

Rob H Beaglehole

The effects of tobacco use on the population's general health have been well illustrated. However, the effects of tobacco on oral health are also important to take into consideration. The most significant effects of smoking on the oral cavity are oral cancers and pre-cancers, increased severity and extent of periodontal diseases, and poor wound healing.

Tobacco use and its association with oral diseases is a major contributor to the global oral disease burden, responsible for up to half of all periodontitis cases among adults (10). The clear link between oral diseases and tobacco use provides an ideal opportunity for oral health professionals to take part in tobacco control and cessation programmes. Some of the most common diseases and problems are described in the table below.

Table 1: Tobacco induced and associated conditions (11)

Oral cancer

Leukoplakia – lesions which are potentially malignant:

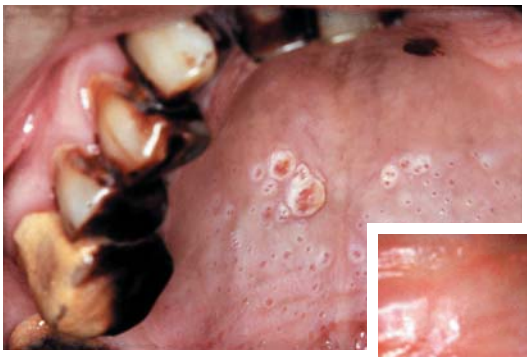
- Nodular leukoplakia
- Verrucous leukoplakia
- Speckled leukoplakia
- Erythroplakia

Oral mucosal conditions:

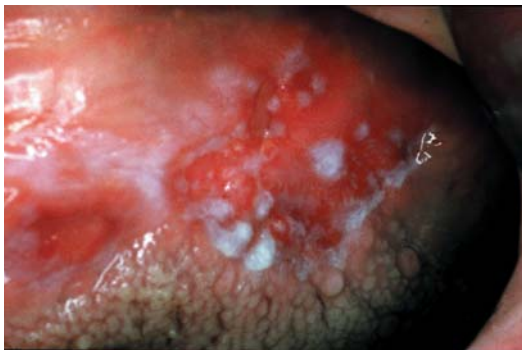
- Smoker's palate
- Smoker's melanosis

Tobacco associated effects on the teeth and supporting tissues:

- Periodontal diseases
- Premature tooth loss
- Acute Necrotising Ulcerative Gingivitis
- Staining
- Halitosis



"Smoker's palate (formerly called nicotinic stomatitis of palate) in a heavily smoking farmer of Northern Thailand (see also the black stains on teeth)



Non-homogeneous leukoplakia of the lateral border of tongue (speckled leukoplakia). Transformation of this type of leukoplakia is very likely.

Photos courtesy of
Prof Peter Reichart, Berlin

Oral mucosal diseases

Smoking is associated with several changes in the oral mucous membrane and has a direct carcinogenic effect on the epithelial cells of the oral mucous membranes. Indeed, smoking is the major risk factor of developing oral cancer (12). The most common type of oral cancer is squamous-cell carcinoma, which includes about 90% of oral malignancies (13).

Amongst men, oral cancer is the eighth most common cancer worldwide. Incidence rates of oral cancer are high in developing countries, particularly in some areas of South Central Asia where it is among the three most prevalent types of cancer (12). Leukoplakia, which is the most common of the potentially malignant lesions of the oral mucous membranes, occurs approximately six times more frequently in smokers than in non-smokers.

Smoker's palate, smoker's melanosis, and oral candidosis all occur more frequently in smokers than in non-smokers (14).

Periodontal diseases

A clear association between tobacco use and the prevalence and severity of periodontal disease exists (15). Periodontal bone loss, periodontal attachment loss, as well as periodontal pocket formation are all associated with tobacco use. Numerous studies also indicate that smoking adversely affects the outcome of periodontal therapy. Smokers have been reported to show poorer success rates in periodontal therapy in comparison to non-smokers (16).

Evidence also suggests that a dose-response relationship exists between smoking and periodontal health (17).

Wound healing

Tobacco is a peripheral vasoconstrictor that influences the rate at which wounds heal within the mouth. Thus, healing among smokers is slower and not as successful following oral surgery. The resulting absence of blood clotting that follows the removal of teeth occurs four times more frequently in smokers than in non-smokers. In addition, smoking has an adverse effect upon the healing of extraction wounds (18).

Dental implants

An abundance of evidence exists to suggest that smoking is detrimental to both the initial and long-term success of dental implants, and that smoking cessation can be beneficial in improving implant success rates (14). In one study, the most significant factor predisposing to implant failure was smoking. Smokers had more than twice the failure rate in comparison to non-smokers (19).

Smell and taste

Smoking has been shown to affect both taste and smell acuity. Tobacco, whether chewed or smoked, can cause halitosis (14).

Aesthetics

Tobacco stains can penetrate into enamel, dental restorations and dentures creating unsightly brown to yellow darkening of teeth. Halitosis and tooth staining, which are both visible and reversible, have been shown to be common concerns of smokers and can be used as motivations for quitting (20).

2. The World Health Organization and Tobacco Control

Tobacco Free Initiative

Annemieke Brands

The WHO Tobacco Free Initiative (TFI) was established in 1998 to focus international attention, resources and action on the global tobacco epidemic.

TFI's objective is to reduce the global burden of disease and death caused by tobacco, thereby protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. To accomplish its mission, TFI:

- Provides global policy leadership;
- Encourages mobilization at all levels of society; and
- Promotes the WHO Framework Convention on Tobacco Control (WHO FCTC), encourages countries to adhere to its principles, and supports them in their efforts to implement tobacco control measures based on its provisions.

According to the WHO, effective tobacco control interventions do not only focus on changing the behaviour of individual tobacco consumers. Instead, they take a broader and more comprehensive approach targeting the environment and promoting social norm change. A comprehensive mix of measures is required to efficiently and effectively prevent and control the use of tobacco, protect non-smokers from the exposure to tobacco smoke, and, regulate tobacco products.

Experience has shown that there are many cost-effective tobacco control measures that can be used in different settings and that can have a significant impact on tobacco consumption. The most cost-effective strategies are population-wide policies, such as bans on direct and indirect tobacco advertising, tobacco tax and price measures, smoke-free environments in all public and workplaces, and large clear graphic health messages on tobacco packaging. All these measures - both demand and supply side measures - are included in the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC).

The WHO Framework Convention on Tobacco Control (FCTC)

The WHO FCTC is an international legal instrument designed to control the global tobacco epidemic. It is the first public health treaty negotiated under the auspices of the WHO. After nearly four years of negotiations, the text of the treaty was agreed upon on 1 March 2003. The World Health Assembly unanimously adopted it on 21 May 2003. On 29 November 2004, 40 countries had deposited their instrument of ratification or legal equivalent - the number of contracting parties required for the Convention to enter into force 90 days later. Since 29 November 2004, many more countries have ratified (63 Countries on 19 April 2005), making it one of the most rapidly embraced UN treaties in history.

The WHO FCTC and related protocol approach is a dynamic model of global standard setting. The term 'framework convention' is used to describe a variety of legal agreements that establish broad commitments and a general system of governance for a particular issue. With the WHO FCTC in place, national public health policies, tailored around national needs, can be advanced without the risk of being undone by transnational phenomena (e.g. smuggling as well as cross-border advertising, promotion and sponsorship).

The Preamble of the WHO FCTC specifically mentions the role of health professionals in tobacco control. Article 12 on 'Education, communication, training and public awareness' and Article 14 on 'Demand reduction measures concerning tobacco dependence and cessation' are also of particular interest for health professionals.

PREAMBLE OF THE WHO FCTC

"…Emphasizing the special contribution of nongovernmental organisations and other members of civil society not affiliated with the tobacco industry, including health professional bodies, women's, youth, environmental and consumer groups, and academic and health-care institutions, to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts…"

Tobacco control efforts are more likely to be sustained when incorporated into existing national, state and district level health structures and linked with existing positions and accountability processes. Involvement of the governmental health sector is expected to increase awareness among health personnel and contribute to developing sustainable tobacco control programmes at the country level. Such a systematic approach will also pave the way for multisectoral acceptance of tobacco control efforts in countries.

"The WHO FCTC negotiations have already unleashed a process that has resulted in visible differences at country level. The success of the WHO FCTC as a tool for public health will depend on the energy and political commitment that we devote to implementing it in countries in the coming years. A successful result will be global public health gains for all."

Dr Jong-Wook Lee, Director-General, World Health Organization

The Role of Health Professionals in Tobacco Control

All health professionals - individually and through their professional associations - have a prominent role to play in tobacco control. Health professionals have the trust of the population, the media and opinion leaders, and their voices are heard across a vast range of social, economic and political arenas.

At the individual level, health professionals should be tobacco-free role models. They should help tobacco users overcome their addiction and educate the population on the harm of tobacco use and exposure to second-hand smoke.

At the community/local level, health professionals can be initiators or supporters of some of the policy measures described above, by engaging, for example, in efforts to: promote smoke-free workplaces and smoke-free public transport; persuade local governments to ban tobacco advertising and promotion; to make sports

events tobacco-free; and, to extend the availability of tobacco cessation resources. Campaigns may also be needed to increase compliance with existing laws, such as a ban on sales to minors. Health professionals may further organize a special day to encourage and assist people to quit tobacco, and visit schools to discuss the impact of tobacco and industry tactics with students, staff and even with parents. Health professionals may regularly contribute to health related columns in local newspapers and/or by appearing on the local radio and television.

At the national and international levels, health professionals and their organisations can add their voice and their weight to national and global tobacco control efforts like tax increase campaigns and become involved at the national level in promoting the WHO FCTC and the development of a national plan of action for tobacco control.

In addition, health professional organisations can show leadership and become role models for other professional organisations and society by embracing the tenants of the Health Professional Code of Practice on Tobacco Control.

…show leadership and become role models…

Health professional organisations are responsible for action within and outside their organisations. Within their organisations, they should raise awareness about tobacco among their individual members. If awareness is already high, new scientific research findings, new developments in cessation, and new policy developments could be shared. If awareness is low, health professional associations could highlight the available scientific evidence, the politics and economics of tobacco, and the way tobacco promotion works in a more through and wide-ranging effort. Among the membership, health professional organisations could:

- Carry out regular surveys of health professional tobacco consumption habits and attitudes towards tobacco consumption;
- Disseminate the results among the members;
- Set up a tobacco control group within the professional association;
- Educate members about tobacco;
- Make the premises and meetings smoke- and tobacco-free;
- Brief health journalists on tobacco related issues and encourage regular inclusion of news stories and features about tobacco in the health professional press;
- Keep the members up to date and trained on cessation methods; raise the issue of litigation and establish links with those pursuing legal action;
- Review investment portfolios of their organisations to eliminate tobacco holdings;
- Refuse tobacco company representatives' donations for events or congresses or their participation as presenters or speakers because their intention is to confound the audience through their good-will speech and raise doubts about scientific research on tobacco risks and harms; and

- Maintain awareness of any tobacco company strategy to try to influence their institution or to take part in any scientific initiative, thus protecting their association or society from tobacco industry influence.

Outside their own organisation and membership, health professional organisations could:

- Contribute to the formulation of national plans of action for tobacco control;
- Work with other health professional organisations to develop a common position on tobacco control and consider establishing a coalition;
- Use the news media and work with politicians to make them feel that it is in their interest to accept invitations to meetings and other events that focus on tobacco control issues;
- Campaign for smoke-free/tobacco-free health care facilities to make non-smoking the norm;
- Influence the content of health professional education and motivate students by setting up a tobacco control body;
- Carry out surveys and prepare regular reports on tobacco related issues highlighting tobacco control priorities; and
- Lobby for public and private reimbursement for cessation counselling.

Health professionals can intervene in all of these areas. They reach a high percentage of the population. Health professionals have the opportunity to help people change their behaviour and they can give advice, guidance and answers to questions related to the consequences of tobacco use, they can help patients to stop smoking. Studies have shown that even brief counselling by health professionals on the dangers of smoking and the importance of quitting is one of the most cost-effective methods of reducing smoking.

Medical doctors have paved the way in a number of countries, including the UK where the Royal College of Physicians were responsible for the groundbreaking report in 1962, which acknowledged that smoking causes cancer. They later helped established and provided early financial support to ASH (Action on Smoking and Health), the tobacco control advocacy non governmental organisation (NGO).

According to *Doctors and Tobacco: Medicines Big Challenge,* health professionals probably have "the greatest potential of any group in society to promote a reduction in tobacco use, and thus, in due course, a reduction in tobacco-induced mortality and morbidity".

David Simpson (21)

Approach of the Oral Health Programme, WHO

Poul Erik Petersen, WHO

The Tobacco Epidemic

The epidemic of tobacco use is one of the greatest threats to global health today. Approximately one-third of the adult population in the world use tobacco in some form and of whom half will die prematurely. This huge death toll is rising rapidly, especially in low-income and middle-income countries where most of the world's 1.3 billion tobacco users live. Developing countries already account for half of all deaths attributable to tobacco (22). This proportion will rise to 7 out of 10 by 2025 because smoking prevalence has been increasing in many low- and middle- income countries even though it is decreasing in high-income countries.

...Tobacco use is a common risk factor to several chronic and oral diseases...

Worldwide the prevalence of tobacco use is highest amongst people of low educational background and among the poor and marginalised. In several developing countries there have been sharp increases in tobacco use especially among men. As the tobacco industry continues to target youth and women there are also concerns about rising prevalence rates in these groups. The shift in the global pattern of tobacco use is reflected in the changing burden of disease and tobacco deaths. Sadly, the future appears worse. Because of the long time lapse between the onset of tobacco use and the inevitable wave of disease and deaths that follow, the full effect of today's globalisation of tobacco marketing and increasing rates of usage in the developing world will be felt for decades to come.

Tobacco use is a common risk factor to several general chronic diseases and oral diseases and the negative impact relates not only to smoking but use of smokeless tobacco. Most recently, the International Agency for Research on Cancer observed that there is sufficient evidence that smokeless tobacco causes oral cancer and pancreatic cancer in humans (23). Chewing tobacco is known as plug, loose leaf and twist. Pan masala or betel quid consists of tobacco, areca nuts and staked lime wrapped in a betel leaf. They can also contain other sweeteners and flavouring agents. Moist snuff is taken orally while dry snuff is powdered tobacco that is mostly inhaled through the nose. In comparison to smoking habits, the pattern of use of smokeless tobacco is less documented, particularly in developing countries (24, 25).

Tobacco-induced oral disease

Tobacco-induced oral diseases contribute significantly to the global oral disease burden (26, 27). Tobacco is a risk factor for oral cancer, oral cancer recurrence, adult periodontal diseases, and congenital defects such as cleft lip and palate in children whose mother smokes during pregnancy. Tobacco use suppresses the immune system's response to oral infection, retards healing following oral surgical and accidental wounding, promotes periodontal degeneration in diabetics and adversely affects the cardiovascular system. These risks increase when tobacco is used in combination with alcohol or areca nut. Most oral consequences of tobacco use impair quality of life be they as simple as halitosis, as complex as oral birth defects, as common as periodontal disease or as troublesome as complications during healing.

Oral and pharyngeal cancers pose a special challenge to oral health programmes particularly in developing countries. Cancer of the oral cavity is high among men, where oral cancer is the eighth most common cancer in the world (Figure 2) (28). Incidence rates of oral cancer are high in developing countries, particularly in areas of South Central Asia where cancer of the oral cavity is among the three most frequent types of cancer. Meanwhile, dramatic increases in incidence rates of oral/pharyngeal cancers have been reported in countries or regions such as Germany, Denmark, France, Scotland, Central and Eastern Europe, and rates are on the increase in Japan, Australia, New Zealand and in the USA among non-whites (28).

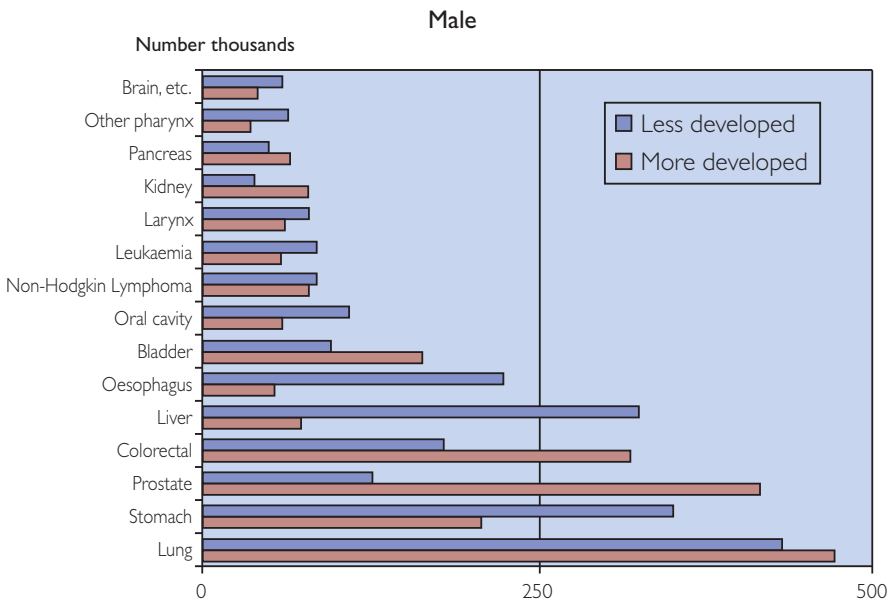
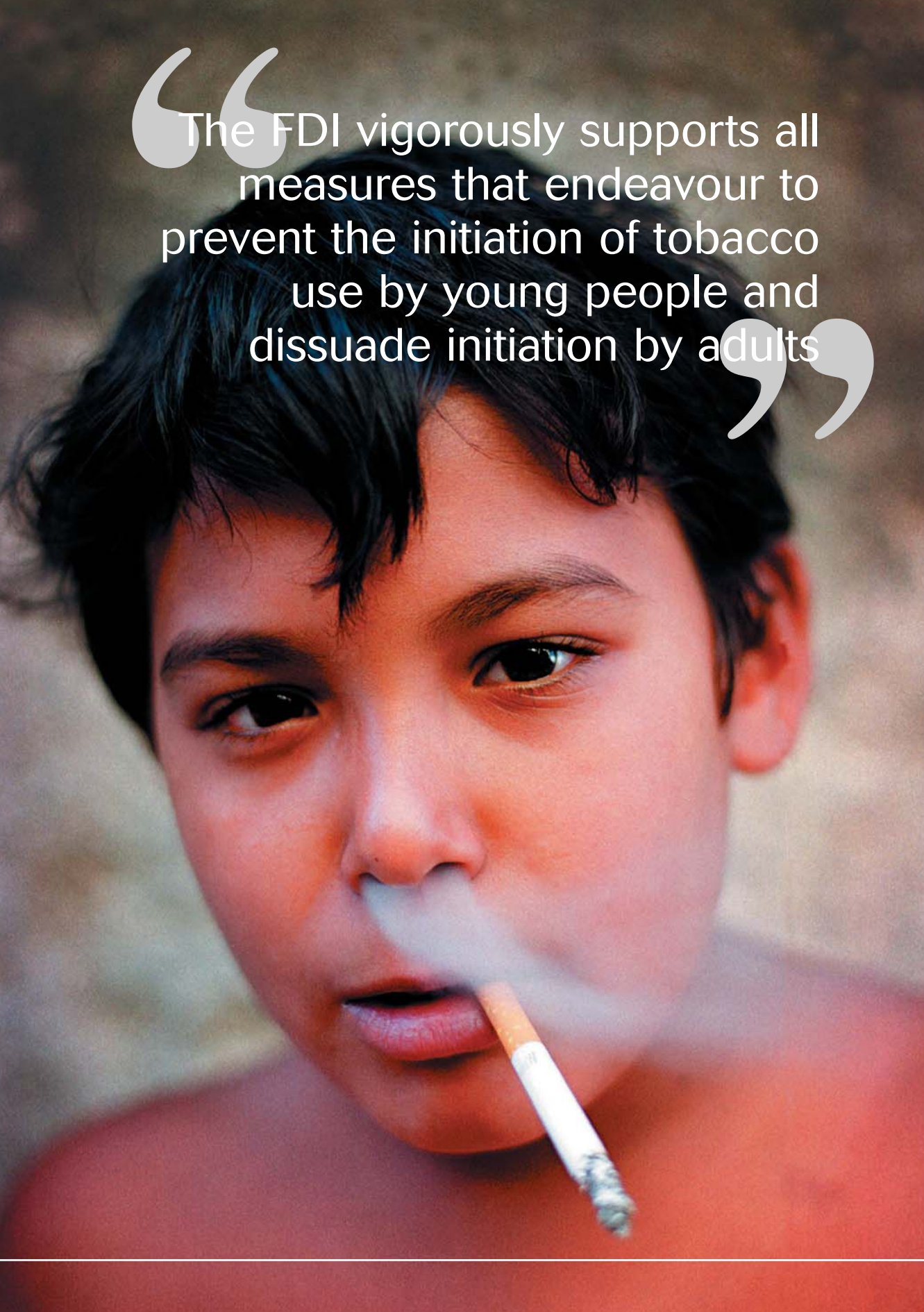


Figure 2. Comparison of the most common cancers in more or less developed countries in 2000 (28)


“The FDI vigorously supports all measures that endeavour to prevent the initiation of tobacco use by young people and dissuade initiation by adults”

National cancer control programmes

The WHO's approach to chronic disease prevention places emphasis on the rising impact of tobacco-related diseases in low-income and middle-income countries and the disproportionate suffering it causes in poor and disadvantaged populations. The WHO has initiated a number of public health actions. In 2002, the WHO stimulated the process for promoting and reinforcing the development of national cancer control programmes as the best known strategy to address the cancer problem worldwide (29). This initiative also includes prevention of oral cancer. In addition to strong comprehensive tobacco control measures, dietary modification is another approach to cancer control. A national cancer control programme is a public health programme designed to reduce cancer incidence and mortality and improve quality of life of cancer patients, through the systematic and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment and palliation, making the best use of available resources. Thus, conducting a cancer prevention programme, within the context of an integrated non communicable disease prevention programme, is an effective national strategy. Tobacco use, alcohol, nutrition, physical activity and obesity are risk factors common to other non communicable diseases such as cardiovascular disease, diabetes and respiratory diseases. As emphasised by the World Health Report 2002 (22) on reducing risks and promoting healthy life, chronic disease prevention programmes can efficiently use the same health promotion mechanisms.

WHO Framework Convention for Tobacco Control and Oral Health

At the World Health Assembly in May 2003 the Member States agreed on a groundbreaking public health treaty to control tobacco supply and consumption. The text of the WHO Framework Convention on Tobacco Control (FCTC) covers tobacco taxation, smoking prevention and treatment, illicit trade, advertising, sponsorship and promotion, and product regulation (30). The convention is a real milestone in the history of global public health and in international collaboration. It means nations will be working systematically together to protect the lives of present and future generations, and take on shared responsibilities to make this world a better and healthier place.

As emphasized in the World Oral Health Report 2003 (31), there are several ethical, moral and practical reasons why oral health professionals should strengthen their contributions to tobacco-cessation programmes, for example:

- They are especially concerned about the adverse effects in the oropharyngeal area of the body that are caused by tobacco practices;
- They typically have access to children, youths and their caregivers, thus providing opportunities to influence individuals to avoid all together, postpone initiation or quit using tobacco before they become strongly dependent;
- They often have more time with patients than many other clinicians, providing opportunities to integrate education and intervention methods into practice;
- They often treat women of childbearing age, thus are able to inform such patients about the potential harm to their babies from tobacco use;
- They are as effective as other clinicians in helping tobacco users quit and results are improved when more than one discipline assists individuals during the quitting process; and
- They can build their patient's interest in discontinuing tobacco use by showing actual tobacco effects in the mouth.

...Children and youth are important target groups in tobacco prevention...

World Health Assembly 2003 where the WHO FCTC was approved by the Ministers of Health

Oral health professionals and dental associations worldwide should consider this platform for their future work and design national projects jointly with health authorities. Tobacco prevention activities can be translated through existing oral health services or new community programmes targeted at different population groups.

Children and youth are important target groups in tobacco prevention. The Health Promoting School provides an effective setting for tobacco prevention and the WHO Oral Health Programme has developed a manual for implementation of oral health promotion through schools (32). Guidelines are given for organisation of tobacco prevention activities based on healthy environments and health education.

Tobacco control and the WHO Global Oral Health Programme

The WHO Global Oral Health Programme aims to control tobacco-related oral diseases and adverse conditions through several strategies (31). Within the WHO, the Oral Health Programme forms part of the WHO tobacco-free initiatives, with fully integrated oral health related programmes. Externally, the Oral Health Programme encourages the adoption and use of WHO tobacco cessation and control policies by international and national oral health organisations. Primary partners are NGOs who are in official relations with the WHO, i.e. the FDI World Dental Federation and the International Association for Dental Research (IADR).

The priority areas in relation to tobacco control given by the WHO Global Oral Health Programme are outlined in Table 2. Firstly, state-of-the-science analysis and development of modern, integrated information systems will provide an important new platform for public health initiatives in tobacco control. Secondly, the Programme provides assistance to countries in risk behaviour analysis and surveillance in order to help countries include oral health aspects in tobacco prevention programmes. Thirdly, the WHO Oral Health Programme supports the translation of knowledge into action, e.g. tobacco prevention activities in schools or by involving oral health professionals in national or community-based tobacco control.

Fourthly, the WHO Oral Health Programme has intensified the work towards development of surveillance, monitoring and evaluation systems. Operational research may provide for outcome and process evaluation of community approaches for tobacco control and such research may then help sharing experiences across countries (33). In particular, emphasis is given by the WHO Oral Health Programme to development of national tobacco programmes in low-income and middle-income countries. Worldwide, strong networks and effective collaboration may facilitate activities with NGOs such as the FDI World Dental Federation.

The WHO Oral Health Programme continues strengthening work for tobacco control, particularly through encouraging and supporting countries to incorporate oral health in their tobacco prevention policies. Evaluation and sharing experiences from tobacco cessation programmes are important for such global initiatives and the WHO Oral Health Programme appreciates the expanded collaboration with the oral health community in this activity. This joint WHO/FDI Tobacco Control Advocacy Guide, which is to be launched on World No Tobacco Day 2005, provides a constructive platform for tobacco control programmes in the future.

Table 2. WHO Oral Health Programme objectives and activities carried out in relation to tobacco control

State-of-the-science and new knowledge	• Analysis of existing knowledge about oral health – general health and relationships to tobacco use • Update of the WHO Global Oral Health Data Bank, including periodontal disease data (CPI) and data on oral cancer • Integration of oral health data bank into other WHO databanks on chronic disease, common risk factors and tobacco use • Update of the WHO Oral Health Surveys Basic Methods, including guidelines for recording risk factors/tobacco use and tobacco-induced oral diseases and conditions
Assistance to countries in risk behaviour analysis and risk surveillance	• Development of indicators and tools for assessment of tobacco use and their impact on oral health, as part of national health programmes • Tests of instruments in selected countries
Translation of knowledge into action programmes in countries/ communities	• Analysis of policy in relation to tobacco use and oral health • Effective use of schools in tobacco prevention among children and adolescents, based on Health Promoting Schools principles • Guidelines on tobacco prevention and oral health for pregnant women and young mothers • Effective involvement of oral health professionals in tobacco cessation programmes – analysis of barriers and constraints
Evaluation, monitoring and surveillance	• Operational research in tobacco behaviour modification • Development of community/country specific goals for tobacco prevention, incorporating oral health • Development of models for evaluation of community-based oral health promotion programmes, including tobacco control • Outcome and process evaluation of community demonstration projects for sharing experiences • Development of tools for surveillance and monitoring tobacco control programmes

3. The Dentist and Tobacco Control

Rob H Beaglehole

Urgent and concerted action is required in order to reduce the disease, suffering and premature death which directly results from tobacco use. The WHO Framework Convention on Tobacco Control (WHO FCTC) highlights the impact tobacco control programmes can have on reducing this burden. These measures include tobacco cessation programmes. The WHO recently acknowledged the importance of integrating tobacco control programmes into health systems (34). Dental professionals have been identified as having a significant role to play in supporting smokers who indicate a desire to quit. A decline in tobacco use would improve both general and oral health, and would also help to reduce widening inequalities across populations.

> All health providers must be involved (in treatment of tobacco dependence), including oral health professionals who, in many countries, reach a large proportion of the healthy population.
>
> The World Health Report 2003 (34)

The dental team has a major role to play in smoking prevention. Evidence suggests that smoking cessation interventions are both effective (35) and cost-effective (36). A brief intervention will often result in significant health gain and, in the long term, reduce smoking-related health-care costs to countries. Unfortunately, advice on quitting smoking is still not a routine part of clinical practice for many oral health professionals. Nor are many National Dental Associations (NDAs) involved in tobacco control (37). This document encourages both clinicians and oral health professionals to scale up their involvement in tobacco control activities, including advocacy and smoking cessation programmes.

The involvement of oral health professionals in smoking cessation will help contribute to wider tobacco control strategies. Changing patient expectations means there is less likelihood of a defensive reaction to questions about smoking. Strong evidence to support the introduction of this activity in primary dental care now exists. Providing help for those patients wishing to quit can offer substantial

oral and general health benefits. The time is right to ensure that what is known about tobacco control is translated into action and becomes routine in the job of the dental team.

The dental profession has an important role to play in combating the tobacco epidemic. Apart from supporting wider tobacco control measures, oral health professionals can help patients to stop using tobacco. This may be the single most important service dentists can provide for their patients' overall health (38).

...Oral health professionals are in a unique position to contribute to tobacco control...

Getting Oral Health Professionals Involved

Oral health professionals are in a unique position to contribute to tobacco control in a number of complementary ways: as role models by not smoking; in counselling patients not to smoke; in referring patients to smoking cessation services; in speaking out publicly; and lobbying for comprehensive public policies to control tobacco use (39). National Dental Associations and oral health organisations are also ideally placed to mobilise other health care professionals, such as doctors, nurses and pharmacists, to become involved in tobacco control initiatives.

In many countries dentists have higher smoking rates than the general population, thereby acting as negative role models. Encouraging dentists to quit smoking can greatly enhance tobacco control initiatives as they become more likely to engage in tobacco control advocacy. They also act as positive role models for their patients.

It is important to target dental students by motivating and encouraging them to become more engaged in tobacco control as they are the most open to a new understanding of their professional responsibilities. It is also beneficial to target deans of dental schools, professors teaching at universities and others who have influence with oral health professionals, such as Ministries and Departments of Health, Ministers of Health, senior public health officials and national dental councils and boards.

It is imperative that oral health professionals recognise that their professional duty

extends beyond the treatment and cure of tobacco-caused disease to include prevention and cessation. This lack of recognition is reinforced by health insurance schemes that rarely pay for counselling or cessation services.

Smoking is linked to a number of oral health problems, as previously discussed. The oral health effects of smoking can be a useful indicator and motivator for smokers to quit, as these effects provide a visual and clear illustration of the damage smoking has on the body. Very limited time is required to assist those smokers interested and willing to stop. It has been shown that even a few minutes of advice to a patient can be effective (40).

Dentists have regular contact with patients, are the first to see the effects of tobacco in the mouth and are the only health professionals who frequently see 'healthy' patients. Dentists are thus in an ideal position to reinforce the anti-tobacco message, as well as being able to motivate and support smokers willing to quit (41).

How to Help Patients Stop

A number of evidence-based guidelines provide advice for oral health professionals to become involved in smoking cessation programmes. One such guide that is orientated at the dental team provides a clear and effective way forward for oral health professionals to become engaged in this important and relevant area of prevention (39).

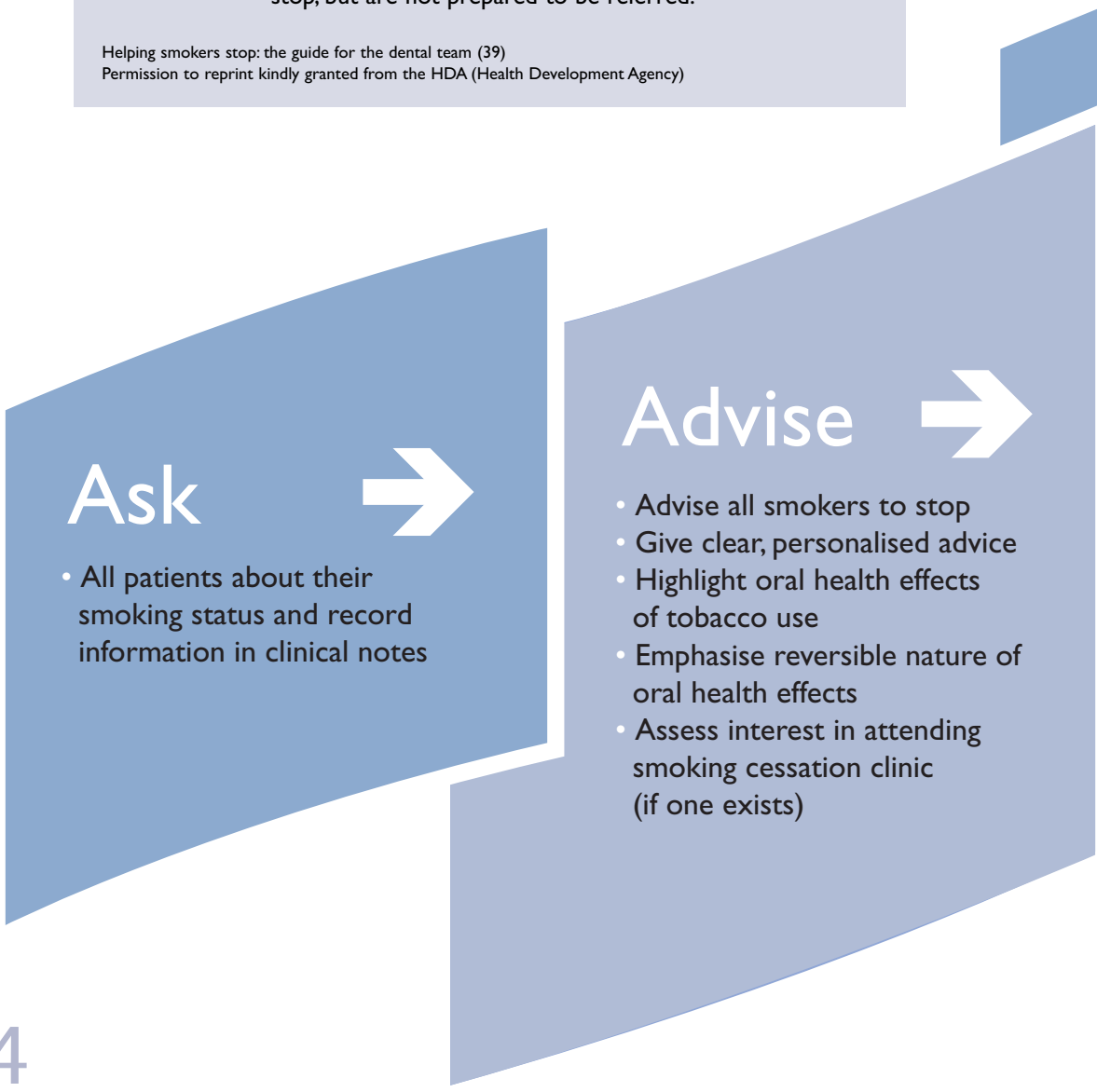
The 4As Model

The 4As model is an example of a method that is a straight-forward and quick means of identifying smokers who want to quit and how best to help them to be successful. Dentists can easily incorporate this model into their daily clinical practice by following the step-wise approach as illustrated in Table 3.

Table 3: The 4As Model

ASK	All patients should have their smoking status checked at regular intervals.
ADVISE	All smokers should be advised on the value of quitting.
ARRANGE	Refer motivated smokers to the local Smoking Cessation Service.
ASSIST	Support should be offered to those smokers who want to stop, but are not prepared to be referred.

Helping smokers stop: the guide for the dental team (39)
Permission to reprint kindly granted from the HDA (Health Development Agency)



Arrange

- If interested refer to local smoking cessation clinic
- Provide encouragement and information on services
- Stress oral health benefits of quitting

Assist

- If interested in quitting but not keen of attending clinic, provide support and encouragement to quit
- Review past experiences of quitting
- Set quit date
- Identify preparation required
- Encourage use of NRT and Zyban® as necessary
- Assess progress at next appointment

Review

- Re-assess smoking status at next recall appointment

The Team Approach

In order to achieve the greatest success in helping smoking patients quit the entire team at the dental practice should be committed to smoking cessation. It is important to stress the need for good communication between team members, the need for regular meetings and access to training in smoking cessation advice.

It is essential that roles and responsibilities are delegated for each team member in the practice. For example the practice manager can encourage effective communication amongst the dental team and ensure a non-smoking practice policy, the receptionist may be able to ask new patients about smoking status and provide information on their local Smoking Cessation Service; and dentists and hygienists can discuss the 4As approach.

…smoking cessation interventions require 3 minutes or less of direct clinical time...

Overcoming Barriers

Numerous barriers have been identified for the limited involvement of dental professionals in tobacco cessation programmes. The most frequent barriers cited are: the amount of time required for staff, lack of adequate reimbursement, and lack of knowledge and skills (37).

Possible barriers to smoking cessation activities in the dental setting (42)

- Lack of time
- Lack of reimbursement mechanisms
- Lack of confidence and skills
- Concerns over effectiveness of support
- Lack of readily accessible patient education materials
- Expected patient resistance

However, these perceived barriers are not insurmountable. The following points review how these barriers can be addressed.

Lack of time:

It has been recommended that brief smoking cessation clinical interventions require 3 minutes or less of direct clinical time. The recommended protocol need not take a great deal of clinical time for the dentist, especially if they work together with other members of the team.

Lack of reimbursement mechanisms:

This is an issue that needs to be addressed. Recognition of the very limited clinical time involved may provide some reassurance.

Lack of confidence and skills:

Confidence and skills can be built and developed with appropriate training. Many health organisations now offer smoking cessation training courses for primary health care professionals. These courses are tailored for different levels of activity.

Concerns over effectiveness of support:

Reviews of the evidence reveal that smoking cessation advice is one of the most effective forms of health promotion support. By following the recommended protocol advice given by the dental team can have a significant effect.

Lack of readily accessible patient education materials:

This Guide has been designed to inform and encourage the dental team to become involved with smoking cessation initiatives for their patients. Many NDAs and Ministries of Health provide other patient education and waiting room material.

Expected patient resistance:

Surveys of dental patients have revealed that many patients believe that dentists should actively encourage smoking cessation (43). This is encouraging as it means that patients actually expect their dentist to be concerned about their overall health, including their smoking status.

Setting Up Your Practice for Clinical Tobacco Intervention

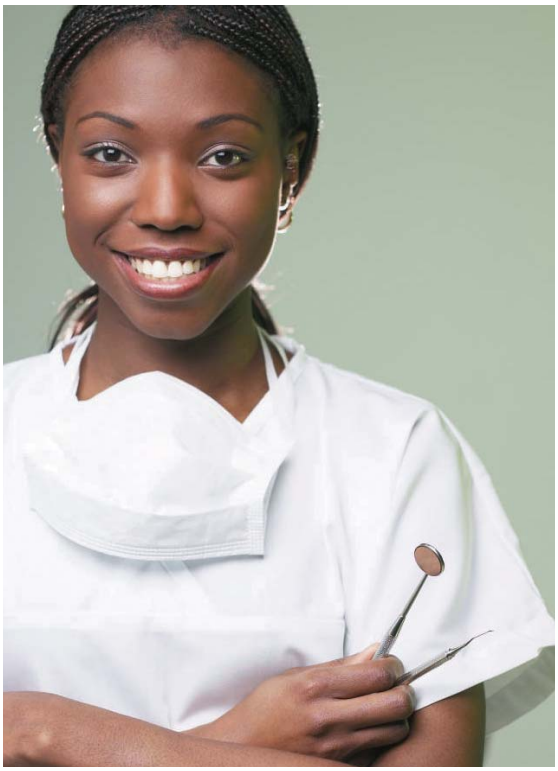
The dentist's office is an ideal place to give people personalised messages about their health, offer long-term follow-up, prescribe stop smoking medication (in some countries), and offer supportive encouragement. Doing this may sometimes require changes in clinical style, communication style, dental record system, appointment system, and duties of staff members.

However, the rewards of delivering effective clinical tobacco intervention are very satisfying; they include saving lives, preventing unnecessary illness and costs, and helping patients free themselves from a deadly addiction.

Modifying your office environment to facilitate clinical tobacco intervention will prompt you and your staff to discuss smoking with every patient. Your NDA or National Tobacco Control Group may be able to supply your office with smoking status labels and educational materials.

Involve your office staff in labelling patient's charts

Your office staff can assist you by asking all patients about their smoking status and then labelling the patient's chart with a smoking-status label. This will help remind you on follow-up to discuss smoking with each patient. It has been shown that repeated brief discussions about smoking are more effective in helping patients quit than one intensive session.



Provide materials in your waiting area

Have stop-smoking posters and pamphlets in your dental practice for patients to read while they are waiting to see you. This may encourage them to quit, or at least to consider quitting. It may also provoke questions that will lead to a quit attempt. The local or national stop-smoking programme can supply you with educational materials. Most of the printed materials are usually free to health professionals.

Follow-up

Once a patient has decided to quit, you can help them to remain motivated and smoke-free by scheduling follow-up visits or phone calls. Your office staff can help here too by mentioning smoking at dental visits for several years after the patient has quit.

Counselling

For patients who need it, provide counselling sessions. Discuss their feelings and concerns about quitting. Suggest methods of dealing with cravings, avoiding weight loss and using stop-smoking medications if applicable.

If the patient need further help it is best to refer the patient to a smoking cessation

clinic if one exists. However, the majority of countries will not have specialised smoking cessation clinics. Here is an opportunity for oral health professional organisations, in combination with the other health professional organisations to advocate for the establishment of evidence-based national smoking cessation clinics.

Stop-Smoking Medication

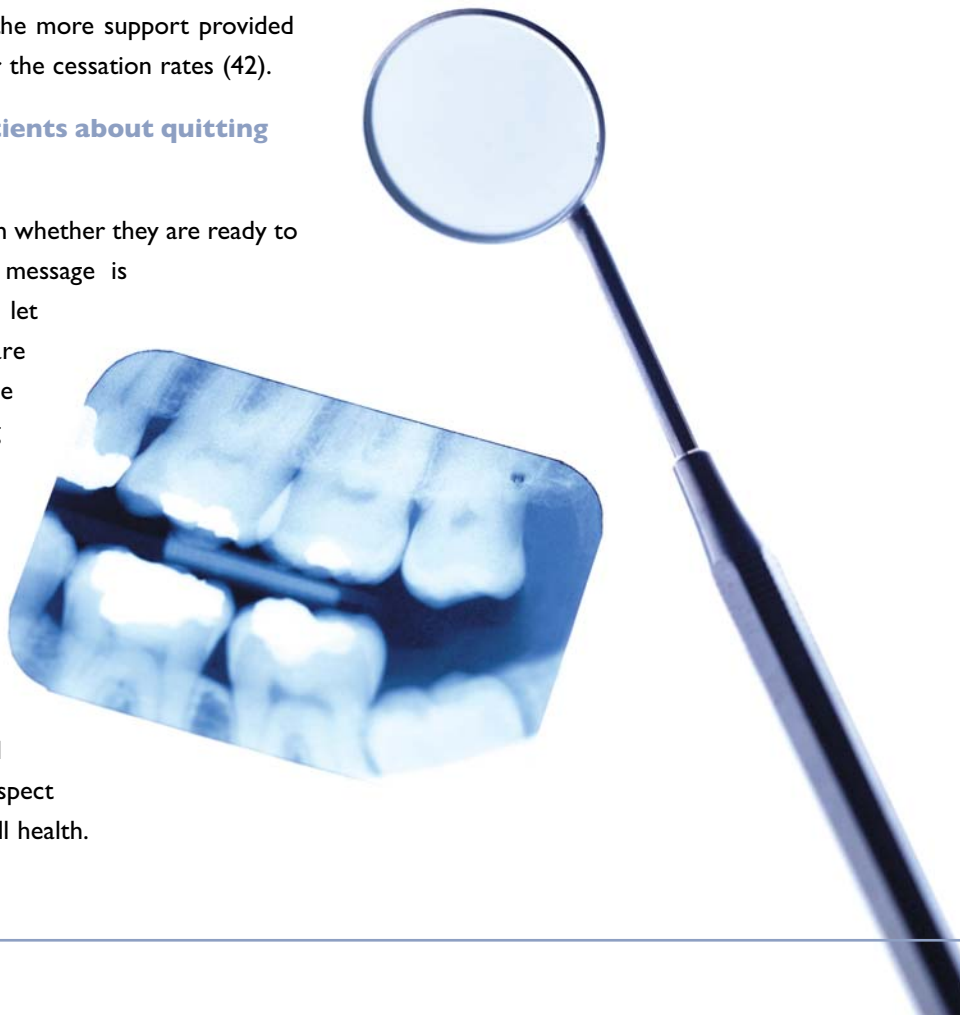
If the local legislation permits you can prescribe or recommend stop-smoking medications when appropriate, and advise your patients on how to best use them.

Nicotine Replacement Therapy (NRT) is the use of a product containing nicotine to replace the nicotine previously taken in by smoking. NRT decreases withdrawal symptoms and improves cessation outcomes for many people. NRT is not the mainstay of smoking cessation but is an effective supplement to behavioural interventions and good support. NRT is available as nicotine patches, nicotine gum, nicotine nasal spray and nicotine inhaler.

It is known that NRT approximately doubles the chance of success in stopping smoking. Behavioural support on top of pharmacokinetics further increases the chance of success. In fact, research indicates that the more support provided to the patient the higher the cessation rates (42).

Talk to smoking patients about quitting at each visit

Even if you only ask them whether they are ready to quit at each visit, the message is clear. As their dentist, let them know you are concerned about the health risks of continuing to smoke. Mention the conditions caused by smoking that are relevant to each patient. A patient who is not interested in quitting smoking may change their mind when faced with the prospect of improving their overall health.



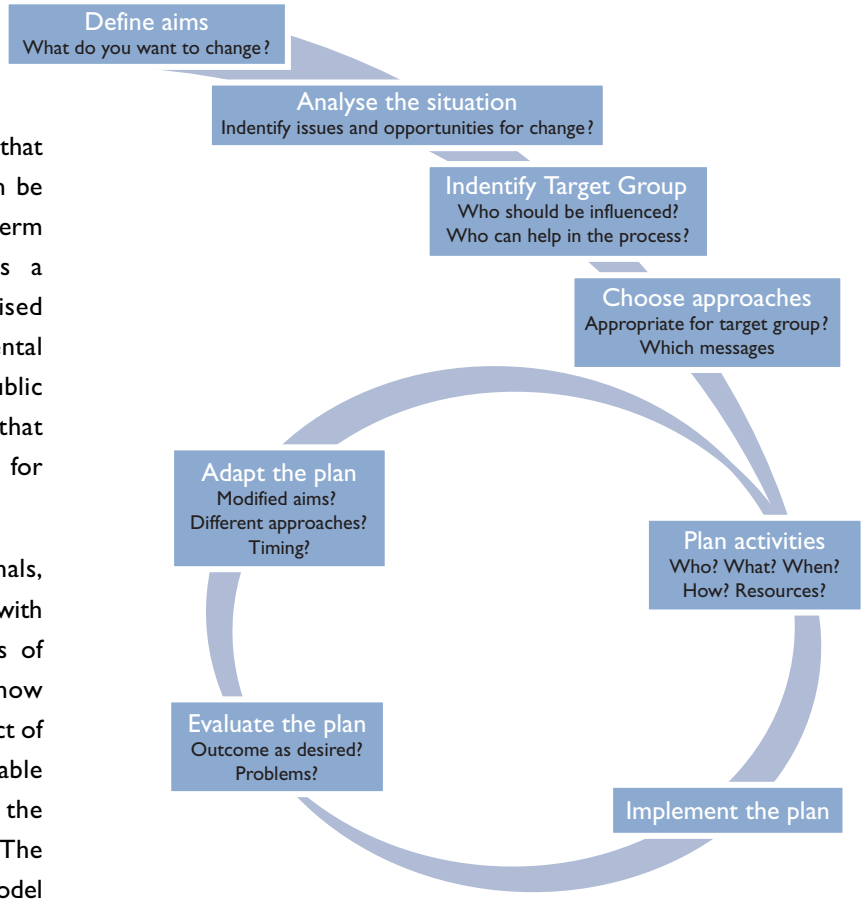
“...advising patients to quit smoking can be the single most important service dentists can provide for their patient’s overall health...”

4. Oral Health Professional Associations and Tobacco Control

Advocacy in Public Health

Rob H Beaglehole & Habib M Benzian

Influencing behaviour, public opinion or a government policy and encouraging actions that promote good health can be summarised under the term "advocacy". Advocacy is a respected and recognised tool for non-governmental organisations and public health professionals that helps in their activism for better health.



Many health professionals, however, are not familiar with the techniques and tools of advocacy and don't know how to increase the impact of their work with suitable approaches from the "advocacy tool kit". The advocacy cycle offers a model to start the planning process for any campaign.

Advocacy can be done on a number of different levels such as: media work, public campaigns, press releases, policy statements, personal meetings, organising hearings and consultations etc. But the key to successful advocacy lies in recognising that change is more likely to come about if many people and organisations are actively involved.

Advocacy can be done and may be effective on different levels:

- Individual – direct counselling and support to patients;
- Workplace – creating a smoke free environment, encouraging colleagues to stop smoking;
- Community – promoting smoke free public places, developing local policies
- National – influencing national legislation and policies, creating awareness for the problem; and
- International – supporting and promoting strong international policy framework to counter the tobacco epidemic.

...Change is more likely to come about if more people and organisations are involved...

Since advocacy is also about getting involved in politics it is essential to have a good understanding of political decision processes related to health and the different interest groups and key stakeholders involved. In formulating arguments for the anti-tobacco cause it is also important to communicate effectively by using the right language and appropriate, evidence-based information because the language of politics can differ greatly from the medical or public health jargon.

Key approaches to effective tobacco control

Interventions targeted at individual smokers are only part of the broader spectrum of strategies to reduce the prevalence of smoking. The following summarises some key strategies that can make significant contributions to smoking cessation and help to prevent people from starting to smoke.

Tobacco control involves a range of supply, demand and harm reduction strategies that aim to improve the health of a population by reducing or eliminating their consumption of tobacco products and exposure to tobacco smoke. Such a comprehensive approach could include the following measures (44):

1. Banning tobacco advertising, promotions and sponsorship because they increase demand, especially among young people;
2. Raising taxes and prices because they effectively lower consumption. This policy also helps smokers quit and has a particularly higher impact on poor society groups who smoke more;

3. Tackling tobacco smuggling because it undermines the health policy, supports organised crime and increases tobacco demand;
4. Moving towards smoke-free places because of the impact on non-smokers and children who face increased risks of serious disease;
5. Running a mass communications campaign to take away any belief that smoking is glamorous, normal or desirable;
6. Developing smoking cessation in health care. Tobacco dependency is treatable with support and drugs such as nicotine replacement therapy and bupropion.
7. Treating tobacco dependency is cost-effective and is every health care professional's responsibility;
8. Addressing consumer protection issues by improving packaging, using health warnings and providing ingredient information; and
9. Reducing harm to those that continue tobacco or nicotine use. The first aim should be to stop tobacco use altogether, but less hazardous methods of providing nicotine should be developed.

...The first step in involving a dental association in tobacco control is to shape the organisation's own policies...

Oral Health Professional Associations and Tobacco Control

Habib M Benzian

Oral health teams, like other health professionals, acknowledge more and more that helping smokers stop is part of their role and one of their key health responsibilities. It is now formally recognised in many countries that smoking cessation is part of the practice of dentistry and many oral health professional organisations have implemented appropriate polices to support this.

The first step in involving a dental association in tobacco control is to shape the organisation's own policies. There are various examples and templates available for doing this, some of them have been developed and are provided by the FDI.

The FDI World Dental Federation and Tobacco Control

The FDI Mission to "*promote optimal oral and general health for all peoples*" includes by implication a commitment to tobacco control. Acting on behalf of National Dental Associations on the international level, the FDI has recognised the importance of engaging the dental profession in tobacco control issues.

In 1996 a Special Committee for Tobacco was established advising the FDI on action required. One of the first steps was the development of a Policy Statement on tobacco that has since become the basis of activities and reference for many member associations of the FDI.

The key points of the statement are the recognition of tobacco as a serious risk to health and oral health, the necessity to integrate tobacco issues in all education and the protection of children by preventing early initiation and exposure to tobacco smoke.

FDI POLICY STATEMENT ON TOBACCO
TOBACCO IN DAILY PRACTICE

The use of tobacco is harmful to general health as it is a common cause of addiction, preventable illness, disability and death. The use of tobacco causes an increased risk for oral cancer, periodontal disease and other deleterious oral conditions and it adversely affects the outcome of oral health care.

The FDI urges its Member Associations and all oral health professionals to take decisive actions to reduce tobacco use and nicotine addiction among the general public.
The FDI also urges all oral health professionals to integrate tobacco use prevention and cessation services into their routine and daily practice.

TOBACCO IN ALL EDUCATION

Brief interactions, for example, by identifying tobacco users, giving direct advice, supportive material and follow-up, all have a significant impact on the patients' use of tobacco products.
The FDI urges all oral health institutions and all continuing education providers to integrate tobacco-related subjects into their programmes.

PROTECT THE CHILDREN

The adverse consequences of environmental tobacco smoke are particularly severe for children - and life long.
The FDI strongly endorses and promotes public and professional education and policies that prevent and/or reduce the exposure to tobacco smoke for infants, children and young people.

PREVENT THE INITIATION

More than eighty percent of adults who use tobacco, started their use of tobacco before the age of eighteen. Use of tobacco among children and youths easily produces a nicotine dependency, the risk of which is vastly underestimated by young people.
The FDI vigorously supports all measures that endeavour to prevent the initiation of tobacco use by young people and dissuade initiation by adults.

The FDI is an active member of the Framework Convention Alliance (FCA), the global network of international and civil society organisations that gave input to WHO FCTC and follow the implementation process critically. The FDI has participated in the negotiating and advocacy process from the beginning, including all preparatory meetings and hearings. The FDI fully endorses the objective of the WHO FCTC "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke." The FDI has organised and participated in numerous national and international conferences and tobacco control issues are a regular feature at all Annual World Dental Congresses.

As part of the international activities the FDI supports member associations in their tobacco control activities by providing sample letters, advice and guidance in national advocacy issues and by promoting the WHO policies in this regard.

National Dental Associations and Tobacco Control

A recent survey clearly indicated that there is an urgent need to place tobacco control initiatives on the oral health policy agenda of both National Dental Associations (NDAs) and Ministry's of Health (45). A range of policy opportunities exists to facilitate greater involvement of the dental profession in tobacco control activities.

A number of NDAs have made promising progress in raising tobacco control issues amongst their members. However, the opportunity clearly exists for this role to be expanded to other countries around the world (46). NDAs are in an ideal position to influence both the behaviour and attitude of their members. Importantly, they are also able to act as advocates for policy development in tobacco control policy more generally. The WHO has outlined a variety of actions that NDAs can implement in support of tobacco control (47).

The conditions need to be created in which the dental team are enabled to become more actively involved in tobacco control. This requires leadership and appropriate action from NDAs. Dissemination of models of good practice in countries where some progress has been achieved would make a valuable contribution in moving the agenda forward.

The Code of Practice for oral health professional organisations in tobacco control

This FDI Policy Statement is based on a set of recommendations developed by the World Health Organization. The statement outlines 14 very tangible and practical steps that every dental association can take on the way to engage effectively in tobacco control.

The Code of Practice includes preventative aspects, organisational measures (tobacco free environments & congresses), research aspects (evaluation of tobacco habits), financial (allocate a budget to tobacco control activities), advocacy (political work, World No Tobacco Day) and other issues that every dental association can implement.

Code of Practice on tobacco control for oral health professional organisations

In order to contribute actively to the reduction of tobacco consumption and include tobacco control in the public health agenda at national, regional and global levels, it is recommended that oral health organisations will:

1. Encourage and support their members to be role models by not using tobacco and by promoting a tobacco-free culture.
2. Assess and address the tobacco consumption patterns and tobacco-control attitudes of their members through surveys and the introduction of appropriate policies.
3. Make their own organisations' premises and events tobacco-free and encourage their members to do the same.
4. Include tobacco control in the agenda of all relevant health-related congresses and conferences.
5. Advise their members to routinely ask patients and clients about tobacco consumption and exposure to tobacco smoke by using evidence-based approaches and best practices and give advice on how to quit smoking and ensure appropriate follow-up of their cessation goals.
6. Influence health institutions and educational centres to include tobacco control in their health professionals' curricula, through continued education and other training programmes.
7. Actively participate in World No Tobacco Day every 31 May.
8. Refrain from accepting any kind of tobacco industry support – financial or other – from investing in the tobacco industry, and encourage their members to do the same.
9. Whenever possible, organisations will give preference to partners who have a policy indicating that they refrain from accepting any kind of tobacco industry support – financial or other – from investing in the tobacco industry and encourage their members to do the same.
10. Prohibit the sale or promotion of tobacco products on their premises, and encourage their members to do the same.
11. Actively support governments in the process leading to signature, ratification and implementation of the WHO Framework Convention on Tobacco Control.
12. Dedicate financial and/or other resources to tobacco control – including dedicating resources to the implementation of this code of practice.
13. Participate in the tobacco-control activities of health professional networks.
14. Support campaigns for tobacco-free public places.

Kenya: International advocacy helped in the WHO FCTC ratification

The fight against tobacco is difficult because the tobacco industry is always corrupting scientific information and amplifying perceived economic benefits of their trade. Sound evidence on the negative health effects of tobacco is nevertheless available from health professionals and trusted organisations that are leaders in their respective fields. Their opinions and recommendations are taken seriously and their persistent involvement in advocacy is therefore invaluable.

The FDI, for example provided solid support during the period prior to Kenya's signing and ratification of the WHO FCTC. Other professional bodies also sent petitions to our Ministry and such support strengthened our case for ratifying the WHO FCTC. The credibility of a professional organisation is valuable currency in advocacy and it should be used when the need arises. In Kenya we know only too well how that value impacts on decision making. Kenya's respect for science and professionalism led us to be the only African country (and one out of two in the world) to sign and ratify the WHO FCTC on the same day!

I would urge professional bodies to emulate the FDI in its involvement in lobbying governments to make policy decisions that improve the health environment for their citizens. I can confirm that this approach works and is one of the best ways for us to impact on public health.

Dr Ahmed Ogwell
Head, Division of Noncommunicable Diseases and Head of Secretariat,
National Tobacco-Free Initiative Committee (NTFIC),
Ministry of Health,
Nairobi, Kenya

Germany

The prevention of tobacco use, particularly in children and adolescents, presents one of the most important responsibilities health profession organisations have world-wide. The epidemiological data on morbidity and mortality as a result of tobacco consumption are well known. The influence of tobacco use on general health is also well documented. In comparison, the effects of tobacco use on oral health, such as periodontal disease and oral cancer receive less attention.

The German Dental Association has been supporting the FDI for several years on an international level. For example, by participating in the negotiation of the WHO FCTC. In 2002, the German Dental Association's Policy Statement on Tobacco was adopted. Political lobbying concerning tobacco control programmes occurred primarily at the Ministerial level.

Apart from advocacy at this level, the training of oral health professionals in smoking cessation advice is also very important, since dentists are the most frequently consulted specialists in Germany. Therefore dental practitioners are ideally placed to provide information on consumption of tobacco and alcohol, on changing behaviour and on early detection of diseases. The integration of evidence-based tobacco control initiatives into dental education and health professional's curricula is also very worthwhile and should be encouraged by National Dental Associations around the world.

Dr. Dietmar Oesterreich
Vice President
German Dental Association
Berlin, Germany

India: Collaboration between the NDA, Government and WHO for Tobacco Control

Far too few health professionals are actively engaged in tobacco control. Health care professionals need to hear messages from other health professionals who are already active in tobacco control. Dentists will be receptive to messages that come from their professional organisations.

The Indian Dental Association, which has 45,000 active and 10,000 student members, has drafted a tobacco control strategy and advocacy plan. The goal of the plan is to get members involved in a full range of tobacco control activities. The Association is planning on running one-day tobacco cessation training courses. Publishing scientific articles on the effectiveness of dentist delivered tobacco cessation interventions in journals and newsletters is another way of encouraging involvement. The need to conduct national wide surveys of association members is also to be encouraged. Questions should be asked about self-use of tobacco, the extent to which they provide tobacco counselling and cessation treatment, and their training requirements in tobacco control interventions.

There are both direct and indirect ways that the FDI, WHO, Health Ministry, and the Government of India can do to encourage and enlist dentists into taking more responsibility for tobacco control. The Health Ministry and WHO are trying to advocate and fund training programmes for dentists on tobacco counselling and cessation in association with the Indian Dental Association. The Health Ministry will also coordinate and guide new curricula that will be introduced into dental colleges in India, including tobacco control activities/advocacy and tobacco cessation treatment.

Dr Mihir N. Shah
Professor of Periodontology and Public Health,
Ahmenabad, India

South Africa

South Africa is in a fortunate position regarding tobacco products in that the support received from the Government has been fantastic. Laws have been passed which outlaw tobacco advertising on TV and radio, and all packaging for tobacco products has to include health warnings. Tobacco, although still relatively cheap by world standards, has increased dramatically in price due to increasing tobacco taxes. It is illegal to sell tobacco to minors (under 18 years of age).

The South African Dental Association's position on tobacco is based directly on the FDI tobacco policy statement. We are active participants on World No Tobacco Day and have been attendees at various functions organised to celebrate the day and to draw public attention to the evils of smoking. The South African Dental Journal has often reported on the risks of oral cancer and periodontal disease with possible tooth loss as a result from smoking. I am periodically able to get an oral health perspective into the lay media around World No Tobacco Day, as journalists are keen for input from all healthcare providers around this occasion.

Along with the good news we have to report some bad. Our northern neighbour, Zimbabwe, has huge economic problems and is a large producer of tobacco. A lot of tobacco products are smuggled into South Africa thereby decreasing the impact of South Africa's restrictive legislation. We are keen to see a strict and rapid implementation of the WHO FCTC with its clauses on tobacco smuggling. This will help in cutting down the thriving black market that is providing cheap tobacco.

Dr Neil Campbell
Executive Director,
South African Dental Association,
Houghton, South Africa

Fiji: Personal experience of a dental student in quitting

"I had been smoking for 11 years and started when I was in the first year of secondary school. Influenced by the pride of a "step further" in my education and the pressure from my relatives and peer group, I took up smoking. This habit became worse due to the increased freedom I got in secondary school. I had been enrolled at the Fiji School of Medicine for three years in 2004 but despite listening to lecturers and friend's advice on quitting, I continued to smoke. The turning point was when I became a group member from my dental class that was actively involved in producing the smoking cessation related aids for the health festival. This activity, together with developing our skills of communication, collaboration and management within groups, improved our understanding of the hazardous effects of smoking on oral health, screening for oral cancer and most importantly how we as dental personnel can help patients quit. It was during this exercise of gathering evidence-based information for our learning portfolio and realizing the effect of smoking on my health that I quit. It took me almost a week to refuse a cigarette and during the last week of smoking I had decreased numbers greatly until I stopped completely. It was not easy but I am proud to have quit and to have become a living role model. My group members were fascinated to see me go through the process of successfully quitting. I hope you can quit too!"

Testimony provided by

Dr Bernadette Pushpaangaeli
School of Public Health & Fiji Dental Associaiton,
Suva, Fiji

Dentistry Against Tobacco, a Swedish organisation for oral health professionals

Dentistry against Tobacco (DAT) works as a uniting body for employees in dentistry who in their profession, wish to work actively to reduce the use of tobacco in society and spread knowledge among colleagues about the complex nature and causes of tobacco habits as well as its adverse effects. We also try to make tobacco education a part of the curricula in the basic training and education of oral health professionals.

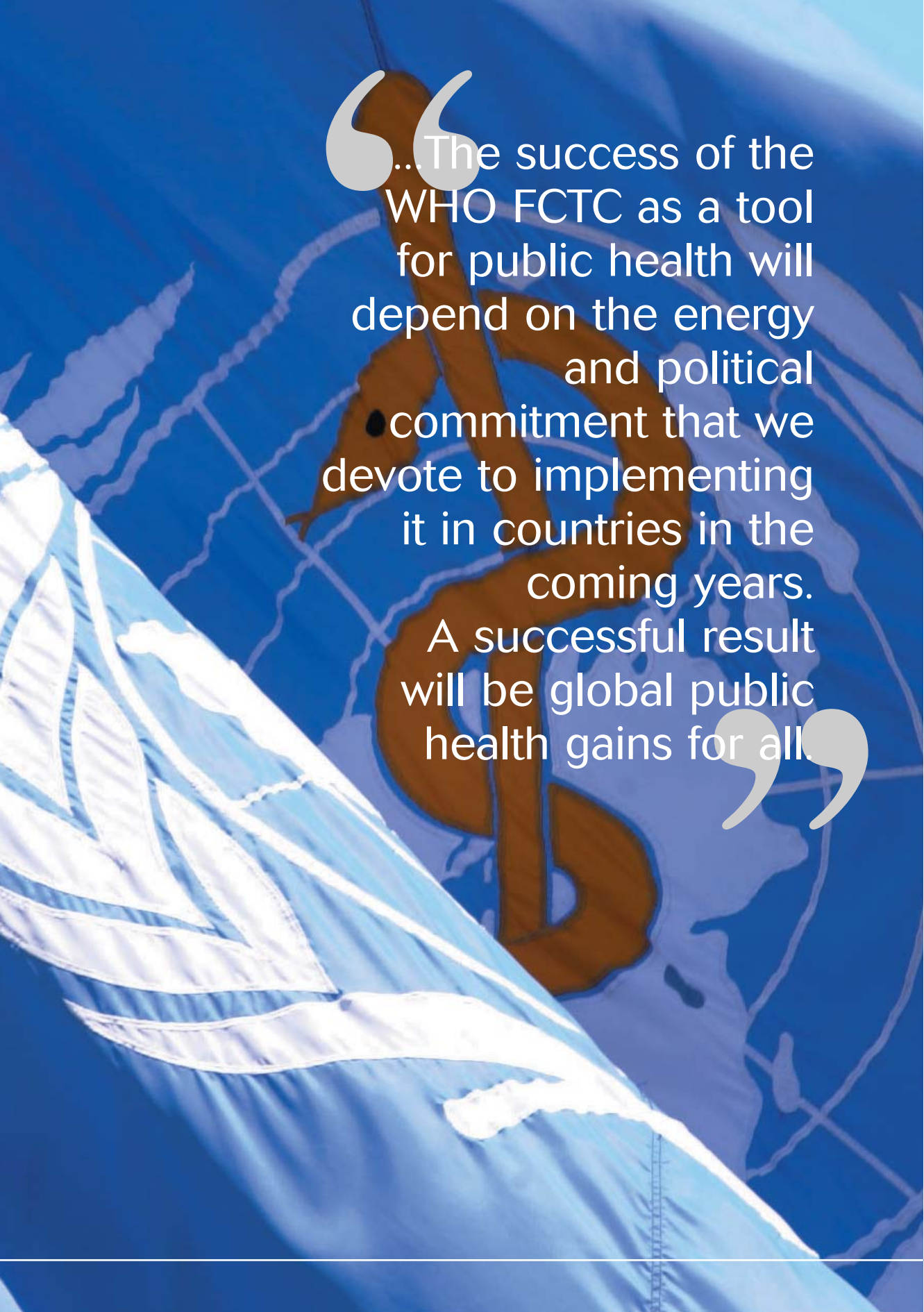
Since 1992 DAT has been an active part of the Swedish national network against tobacco use. DAT is in close co-operation with the FDI and is also a member of the Framework Convention Alliance in connection with the WHO FCTC negotiations.

At annual Swedish dental congresses, DAT has arranged meetings on tobacco issues with national and international participation, sometimes presenting studies and results done with economic support from the organisation. We have produced material that makes it possible to participate and influence participants at this and other oral health congresses.

Tobacco or Health (Tobak eller Hälsa) is the name of the journal published quarterly by five health promotion organisations, in which DAT contributes with written material. This journal is sent to private clinics and to every County Council for distribution among dental clinics. DAT initiated and was also one of the publishers behind the handbook "Tobacco and Teeth", the so-called "Monkey-book" (the cover consisted of a big-smiling monkey showing all its teeth!) which was sent to all active dentists and hygienists nation-wide.

In the education of dental hygienists in Stockholm, knowledge about tobacco and its adverse effects have been on the curricula for the past two years and is highly appreciated by the students. DAT participate with lectures and material in other courses, for example post graduate, on tobacco and its adverse effects on the national and regional levels.

Dr Örjan Åkerberg
Secretary, Dentistry against Tobacco-Sweden,
Stockholm, Sweden


...The success of the WHO FCTC as a tool for public health will depend on the energy and political commitment that we devote to implementing it in countries in the coming years. A successful result will be global public health gains for all.

5. Recommendations to Oral Health Professional Organisations

Rob H Beaglehole, Habib M Benzian & Poul Erik Petersen

National Dental Associations have an important advocacy role to play in promoting policy reforms and by highlighting the important role dental professionals can play in tobacco control. It is suggested that where possible countries should produce guidelines for oral health professionals, modelled on the recent – Helping smokers to stop: a guide for the dental team (48). In addition, more in depth training at both undergraduate and continuing education levels is required to expand the skills and knowledge of oral health professionals.

Recommendations to oral health organisations at the global, national, and local levels are proposed. There is an urgent need to put tobacco control initiatives, including cessation programmes, on the oral health agenda. The World Health Organization and FDI World Dental Federation can provide the leadership for this action.

The following recommendations are made to national oral health organisations:

Global

- That oral health professional organisations and their members play a leading role in ensuring the implementation of the WHO FCTC at a national level;
- That tobacco cessation programmes are placed on the global oral health agenda by FDI and WHO.

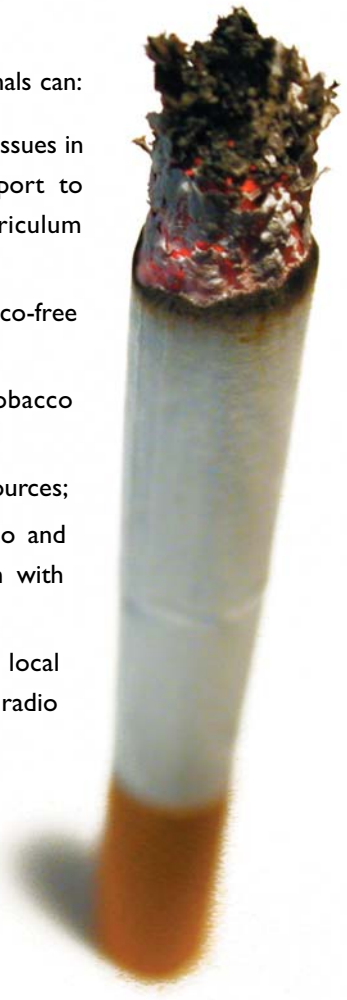
National

- That NDAs advocate for oral health as an integral part of general health;
- That the NDA facilitates the development of guidelines and practices, especially around smoking cessation activities;
- That the whole oral health team is encouraged and trained by NDAs in tobacco prevention activities;

- That adequate training on tobacco control and cessation initiatives be given in dental schools;
- That NDAs lobby governments so that dentists can prescribe NRT free or at subsidised rates;
- That a national committee of experts on tobacco issues within the NDA is established at national level; and
- That NDAs should link with other health professional organisations to share experiences, plan joint activities and increase impact in advocacy. Such a group could be formalised as a "National Tobacco Advocacy Group", a model that has been very successful in some countries (i.e. Sweden, Canada).

At the individual level, oral health professionals:

- Should be tobacco- free and act as positive role models; and
- Should help tobacco users overcome their addiction and educate the population on the harm of tobacco use and exposure to second-hand smoke.



At the community/local level, oral health professionals can:

- Work for inclusion of tobacco and oral health issues in school health programmes and provide support to school teachers and other staff in curriculum development;
- Promote tobacco-free workplaces and tobacco-free public transport;
- Persuade local governments to ban tobacco advertising and promotion;
- Extend the availability of tobacco cessation resources;
- Visit schools to discuss the impact of tobacco and industry tactics with students, staff and even with parents; and
- Contribute to health related columns in local newspapers and/or by appearing on the local radio and television.

Health professional organisations are responsible for action within and outside their organisations. Among the membership, it is recommended that oral health organisations:

- Carry out regular surveys of members' tobacco consumption habits and attitudes towards tobacco consumption;
- Disseminate the results among the members;
- Set up a tobacco control group within the professional association;
- Educate members about tobacco;
- Make the premises and meetings smoke- and tobacco-free;
- Keep members up to date and trained on cessation methods; and
- Review investment portfolios of their organisations to eliminate tobacco holdings.

Outside their own organisation and membership, it is recommended that oral health organisations:

- Contribute to the formulation of national plans of action for tobacco control;
- Work with other health professional organisations to develop a common position on tobacco control and consider establishing a coalition;
- Campaign for tobacco-free health care facilities to make non-smoking the norm;
- Influence the content of health professional education and motivate students by setting up a tobacco control body;
- Carry out surveys and prepare regular reports on tobacco related issues highlighting tobacco control priorities; and
- Lobby for public and private reimbursement for cessation counselling.

Glossary of Terms

ASH	Action on Smoking and Health
CDO	Chief Dental Officer
CPI	Community Periodontal Index
DAT	Dentistry Against Tobacco
ENSP	European Network for Smoking Prevention
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control
FDI	FDI World Dental Federation
GYTS	Global Youth Tobacco Survey
HDA	Health Development Agency
IADR	International Association for Dental Research
NCD	Non Communicable Disease
NDA	National Dental Association
NGO	Non governmental organisation
NRT	Nicotine Replacement Therapy
TFI	WHO Tobacco Free Initiative
UICC	International Union Against Cancer
USDHHS	US Department of Health and Human Services
WHA	World Health Assembly
WHO	World Health Organization
WNTD	World No Tobacco Day

Resources and Links

www.ash.org.uk
An excellent source of up to date information on all aspects of smoking, with numerous links to relevant resources and documents.

www.cdc.gov/tobacco
This website provides practical information for those who want to stop smoking as well as an overview of tobacco information.

http://www.ensp.org/
The European Network for Smoking Prevention (ENSP) aims to create greater coherence among smoking prevention activities and to promote comprehensive tobacco control policies at both the national and European level.

http://factsheets.globalink.org/
Tobacco Control fact sheets from Globalink.

www.fdiworldental.org
The website of the FDI World Dental Federation gives detailed information and background on tobacco use, oral health and the involvement of the dental profession.

www.givingupsmoking.co.uk
The UK Department of Health tobacco control website which provides details of NHS Stop Smoking Services and other useful information.

http://news.globalink.org/
Get the latest tobacco news on the Internet in: English | Français | Deutsch | Español

http://www.paho.org/ENGLISH/HPP/HPM/TOH/tobacco.htm
The Pan American Health Organisation (PAHO) has produced a document on the WHO FCTC - The Framework Convention on Tobacco Control: Strengthening Health Globally.

www.quitnow.info.au
Helpful advice on quitting is provided by this excellent website of the Australian National Tobacco Campaign.

http://strategyguides.globalink.org/
The website has been designed as a "One Stop" resource for tobacco control advocates planning and working to achieve strong, comprehensive tobacco control laws. The website contains two complementary strategy-planning guides: *Strategy Planning for Tobacco Control Advocacy*, and *Strategy Planning for Tobacco Control Movement Building*. Each guide, continuously updated, provides both practical guidance and links to other useful guides and resources.

www.tobacco-control.org
The website of the Tobacco Control Resource Centre which works in partnership with national medical associations across Europe, supporting them in their efforts to educate their members, help patients and inform public policy with respect to tobacco.

http://www.tobaccopedia.org/
The Online Tobacco Encyclopaedia

http://www.who.int/tobacco/en/
The tobacco section of the WHO website which providing a wealth of information on tobacco.

http://www.who.int/tobacco/resources/publications/tobaccocontrol_handbook/en/
The WHO Tobacco Free Initiative (TFI) has launched a new publication in the series 'Tools for advancing tobacco control in the 21st century' with the title: Building blocks for tobacco control: a handbook.

http://www.who.int/oral_health
The strategies and approaches to oral disease prevention and health promotion recommended by the WHO Global Oral Health Programme are outlined. Tobacco-related oral diseases are priority issue and the efforts to control such disease are detailed. Several policy reports and publications are available.

Francophone tobacco links:

http://www2.gosmokefree.ca/francais/index.asp
Site contre le tabagisme de Santé Canada, also in English.

http://cnct.org
Comité National contre le Tabagisme, France.

http://www.at-suisse.ch
Association Suisse pour la prévention du tabagisme (also in German and Italian).

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Appendix 1

Advocacy Letter Example

Oral Health Organisation letter heading

Dear xxx (please insert title as appropriate),

Tobacco kills more than xxx (number) people each year in xxx (your country) and smoking remains the largest single cause of preventable death and disease in the developed countries. On the occasion of World No Tobacco Day (31 May 2005), (oral health professional organisation) wish to urge you to take the following action:

1. Increase accessibility to tobacco cessation treatment for smokers (including the training of health professionals and the development of a national network of tobacco cessation treatment services) as well as improving accessibility to nicotine-replacement therapies and removing inequalities in the provision of these services;

2. Successfully implement and enforce the most stringent measures within the WHO Framework Convention on Tobacco Control in order to protect public health (ADD link);

3. Take the required action to fully protect non-smokers from the detrimental effects of tobacco smoke, because tobacco smoke is a toxic, carcinogenic mutagen and also a repro-toxic substance.

The xxxx (country) Oral Health Professional Organisation comprising xxx (number) members committed to reducing death and disability as the result of tobacco use, demand that the government enacts through policies to address tobacco use with the aim of protecting all citizens from a lifetime of preventable addiction and disease.

Yours faithfully,

Health Professional Organisation xx
Name of Signatory
Number of Members
Signature

From the WHO FCTC Ratification Planning Guide

This guide was developed by the Framework Convention Alliance to support NGOs and other organisations in their activities. By answering the key questions listed below as part of the planning and advocacy cycle the planning and implementation of tobacco control activities may become easier and more effective. More information can be found at www.fca.org

1. *Describe your advocacy objective as specifically as possible*
2. *Who has the direct authority to make it happen? [Identify the target audience]*
3. *What do they need to hear to persuade/cause/force them to make it happen? [Messages]*
4. *How do we make these messages speak both to the brain and to the heart of the target audience?*
5. *Who are the most effective messengers for our target audience? Who will the authorities most trust or listen to?*
6. *What are the most effective means for delivering our messages? Lobbying? Focused media advocacy? Protest? A combination of these?*
7. *What are effective ways to gain the media's attention with stories that best convey our messages?*
8. *What other materials might we need to develop for our ratification campaign?*

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Tobacco or Oral Health

An advocacy guide for oral health professionals

World Health Organization