

FINAL PROPOSAL TO GLOBAL BRIDGES

A. Title page

Project ID: 25678413

Project title: Category 1: Capacity Building - Teaching the teachers of primary healthcare professionals to treat tobacco dependence

Organisation: International Primary Care Respiratory Group

Main collaborators:

- Bulgarian General Practice Society for Research and Education
- Centre for Family Medicine, Medical Faculty, University Ss Cyril and Methodius, Skopje
- Kyrgyz Thoracic Society
- RespiRo (National Centre for Studies in Family Medicine and the National Society of Family Doctors)

Abstract:

The project goal is to develop a sustainable network of teachers who will increase the capacity of healthcare professionals working in primary care to treat tobacco dependence in four countries: Romania, Bulgaria, the Republic of Macedonia and the Kyrgyz Republic. These four countries in the WHO European Region have high rates of smoking and experience similar challenges in the provision of evidence-based treatment for tobacco dependence. The World Health Organization has called for smoking cessation to be integrated into primary healthcare globally. This requires primary care professionals have the capacity, opportunity and motivation to provide treatment and are able to prescribe pharmacotherapy that is affordable to patients. However, in the four participating countries, evidence shows provision of treatment and access to pharmacotherapy is low.

Over two years the project will equip 1,000 primary healthcare professionals with the knowledge and skills to treat tobacco dependence confidently in their community, using a cascading “Teach the Teachers” model, developed and used successfully by IPCRG. Participants will be recruited by IPCRG’s partner organisations in each of the four countries that are established providers of continuing medical education (CME). These primary healthcare professionals will see more than 165,000 patients who are current smokers every year. The project will contribute to an increase in quit attempts and improving access to pharmacotherapy by increasing knowledge of and demand for it. It will also contribute to spreading and sustaining education on treatment for tobacco dependence by ensuring the modules it develops are recognised by CME providers.

B.	Table of Contents	
A.	Title page	1
B.	Table of Contents	2
C.	Reviewer Comments	3
D.	Main Section of the proposal (not to exceed 15 pages)	3
1	<i>Overall Goal & Objectives</i>	3
2	<i>Current Assessment of need in target area</i>	4
3	<i>Target Audience</i>	8
4	<i>Project Design and Methods</i>	11
5	<i>Evaluation Design</i>	13
6	<i>Detailed Workplan and Deliverables Schedule</i>	14
E.	References	17
F.	Organizational Detail (not to exceed 3 pages)	19
1	<i>Organizational Capability</i>	19
2	<i>Leadership and staff capacity</i>	21
G.	Detailed Budget	22
H.	Staff Biosketches	23
I.	Letter(s) of Commitment (1 page limit per letter):	32

C. Reviewer Comments

None received.

D. Main Section of the proposal (not to exceed 15 pages)

1 Overall Goal & Objectives

The goal is to develop a sustainable network of teachers who will increase the capacity of healthcare professionals working in primary care to treat tobacco dependence¹ in four countries: Romania, Bulgaria, the Republic of Macedonia and the Kyrgyz Republic.

This goal aligns with the Request for Proposals (RFP) focus as it includes four countries within the WHO European Region and supports the Global Bridges approach to promoting collaboration across multiple countries. The project will build capacity, which includes capability, motivation and opportunity, for primary healthcare professionals to treat tobacco dependence, using the approach outlined in the International Primary Care Respiratory Group's (IPCRG) Education Strategy.¹ This approach stresses that education programmes must engage health professionals in their learning, provide ongoing support and be sensitive to local circumstances. The project will extend a successful IPCRG 'Teach the Teacher' initiative, and will also adapt existing IPCRG educational and clinical resources to the needs of new contexts and audiences.

The project aligns with the IPCRG's aim to support primary care professionals to provide better quality respiratory diagnoses, treatment and care. It also aligns with the aims of our four collaborating national organisations who will deliver the project activities in each country as these organisations are providers of continuing medical education (CME) with their members in primary care.

The objectives of the project are:

1. To teach and develop a sustainable network of primary care teachers from four countries, skilled in the management of tobacco dependence and to assist them to develop systems that best support implementation in routine practice
2. To support these teachers in developing and implementing country based programmes to spread this knowledge in the on-going education of primary healthcare professionals, including the development of distance learning resources.
3. To adapt existing resources on the treatment of tobacco dependence to the local contexts in these four countries.
4. To increase the capacity of a range of primary healthcare professionals, including GPs, nurses and community pharmacists, in treating tobacco dependence.
5. To improve the health outcomes of patients with tobacco dependence seen in primary care by increasing the number of quit attempts and the number of successful quits.

¹ Throughout this proposal we use the phrase "*tobacco dependence*". The project will be particularly focused on cigarette dependence as this is by far the most widespread means of tobacco consumption in the participating countries.

These objectives meet the need established in research literature for smoking cessation to be integrated into primary healthcare by improving and increasing the capacity of primary healthcare professionals to provide advice and support for smoking cessation. It does so in four European countries that have been identified as facing particular challenges, as outlined in the following section. Primary healthcare is provided by family physicians (FPs) who have undertaken vocational training in primary care and general practitioners (GPs) who have not undertaken vocational training. GPs, FPs and other professionals including medical assistants, nurses and community pharmacists who play a key role in delivering primary healthcare are the audience for the project. The beneficiaries are the patients with tobacco dependence they see in regular primary care consultations.

2 *Current Assessment of need in target area*

The World Health Organization (WHO) has called for smoking cessation to be integrated into primary healthcare globally, as it is the most suitable health system 'environment' for providing advice and support on smoking cessation.² Helping smokers quit is one of the most cost-effective interventions available to clinicians.³ Success rates are low for unaided attempts to quit.⁴ Large numbers of patients are seen within primary care and primary care professionals have on-going relationships with their patients. Primary health care encounters represent frequent and important opportunities to help people quit because it is the most prevalent chronic condition, and a risk factor for so many non-communicable diseases.⁵ Research has shown that around 90% of smokers used primary care at least once in a 12-month period.⁶

Primary care professionals can provide 'Very Brief Advice' (VBA) to all attending patients who smoke using a "make every contact count" approach. This is most effective when it includes clear, strong and personalised advice to quit from healthcare practitioners as part of general medical care which primary care professionals are well placed to deliver. Advice from health professionals, who are generally highly respected, about the risks of tobacco use and the benefits of cessation are usually well received. Pharmacological treatment of tobacco dependence can double the likelihood that someone will successfully quit, and this likelihood increases further if the medication is administered in conjunction with behavioural support.^{7, 8}

This approach requires that primary care professionals are motivated to provide smoking cessation advice and treatment and have the capacity, capability and opportunity to do so. It also requires that they are able to prescribe pharmacotherapy for nicotine addiction, are knowledgeable about the medications and can support patients with their use of them. It also requires that this medication is affordable to patients. This in turn requires that pharmacotherapy for tobacco dependence is licensed, available and subsidised and/or reimbursable as part of public financing systems for prescribed medications so it is accessible and affordable for patients.

However, there is a well documented 'practice gap' in the implementation of smoking cessation support by practitioners in routine clinical settings. International studies have documented that only between 40% and 70% of smokers report having been told to quit by practitioners and fewer than 20% of practitioners provide specific assistance with quitting, such as behavioural support and medications.⁹ This practice gap is particularly pronounced in the four countries where the proposed project will work: Romania, Bulgaria, the Republic of Macedonia and the Kyrgyz Republic. In each of these countries recognition of primary

care and family medicine as a specialism is relatively new and consequently the status of primary care tends to be lower than in more developed specialties. In addition, healthcare systems are relatively hierarchical and under-financed.¹⁰ Romania, Bulgaria and the Republic of Macedonia are categorized as upper-middle income countries and the Kyrgyz Republic as a lower-middle income country.

In Macedonia specialisation in family medicine started in 2010 and in 2011 a retraining programme for existing general practitioners was developed. So far around 260 doctors have completed this additional training in family medicine (20% of primary care practitioners). In Bulgaria primary healthcare is provided in individual or group medical practices, with around 40% of GPs being specialists in family medicine. In Romania general practice became known as family medicine in 1999 with a major reform of the primary health care system. At this time they ceased to be state employees, functioning instead as independent practitioners, contracted by the public health insurance fund but privately operating their medical offices.¹¹ In the Kyrgyz Republic 80% of patients attend primary healthcare, which is provided by family physicians trained in a national post-graduate vocational scheme, medical assistants and nurses.

In all four countries, evidence indicates that motivation, opportunity and capability for primary care professionals to provide advice and support on smoking cessation remains low. A key factor is the smoking habits of the doctors. In Macedonia a survey carried out in 2014 about the attitude of medical doctors towards smoking found declining prevalence of smoking amongst doctors over the past decade from 42% to 29%.¹² However, based on international comparisons this remains high.¹³ Anecdotal information from Romania, the Kyrgyz Republic and Bulgaria suggests similarly high rates of prevalence of smoking amongst doctors in these countries. This is important both because doctors are seen as public health exemplars and because their own smoking reduces the motivation of doctors to provide support to quit to their patients. It is also a marker of knowledge deficits of the harmful effects of smoking. The same survey in Macedonia also found that more than 46% stated that during their education they did not learn about the need to use educational materials to help patients quit smoking and 19% responded negatively to the question "Do health workers need to advise patients who smoke cigarettes to quit?".¹⁴

Although there has been little investment to date in increasing capacity of primary care professionals to treat tobacco dependence in these four countries, resources for medical education for primary care professionals and the infrastructure for delivering these are now being developed. There is also a growing awareness of and willingness to participate in medical education initiatives. This offers an opportunity to ensure the need to develop capacity and capability on treating tobacco dependence is included in Continuing Medical Education (CME) for primary care professionals in these four countries. This project is designed to use this opportunity to full advantage.



A GP using a carbon monoxide breath monitor to determine smoking status at a recent IPCRG workshop

Low cost pharmacotherapy has been shown to be effective, including cytisine which is actually produced in Bulgaria.^{15, 16} However, access to pharmacotherapy for nicotine addiction in each of the four countries is limited, which is a factor contributing to the need identified by the project. In Macedonia nicotine replacement therapy (NRT) is available in a pharmacy without a prescription but the national health insurance fund does not cover the cost of this product because NRT is not on the country's essential drugs list. Other treatment, including bupropion and varenicline, cannot be legally purchased in the country.¹⁷ In Romania NRT is generally available in urban pharmacies but is expensive and not subsidised.¹⁸ Bupropion and varenicline are available but are not subsidised. Interventions tend to be limited to brief advice for patients with a diagnosed concomitant chronic disease,¹⁹ and few family physicians refer patients to smoking cessation specialists.¹² In Bulgaria doctors in primary care are not permitted to prescribe medication for tobacco dependence and it is not reimbursed by the National Health Insurance Fund. In the Kyrgyz Republic smoking cessation treatment and support is not available in primary healthcare. There is only one specialised smoking cessation facility at the National Centre of Cardiology and Therapy, which has very limited treatment capacity.

This lack of capacity to support smoking cessation within primary care is all the more urgent because of the high rates of smoking and relatively low levels of awareness about the dangers of tobacco smoke amongst the public in Romania, Bulgaria, the Republic of Macedonia and the Kyrgyz Republic. All four countries have recently introduced smoking bans for certain enclosed public places. This has created an immediate opportunity for smoking cessation interventions.

The Republic of Macedonia has a population of 2.06 million and smoking rates of 46% for men and 26% for women.²⁰ A study in 2008 showed that 11.8% of adolescents (13-15 years old) were current smokers and 26% had smoked cigarettes. Two thirds of children are exposed to environmental tobacco smoking at home and 66% in public places.²¹ Tobacco is the largest agricultural export and there are large government subsidies to encourage production. There is no national strategy for smoking cessation. Smoking is “socially accepted”, unlike alcohol or psychoactive substances and is a unique example of the

implementation of a contradictory dual policy, with a restrictive smoking ban in accordance with EU regulations in place along with high agricultural subsidies aimed at stimulating tobacco production.

Bulgaria has a population of 7.36 million with smoking rates of 41% for men and 32% for women. Public awareness of the health risks of tobacco is low. It has one of the highest rates of tobacco consumption in the world at 2,822 cigarettes per inhabitant per year.²² An estimated 23% of deaths amongst males were caused by tobacco on 2010. Rates of smoking amongst children are very high with 24% of boys and 31% of girls using tobacco daily.²³

Romania has a population of 19.5 million. Smoking rates are 37% men and 16.7% women. According to WHO figures, 77% of all deaths in Romania in 2008 were caused by diseases for which tobacco smoking is the main risk factor.²⁴ 17% of Romanian adults aged 15 or over who smoke daily started their daily smoking habit at less than 15 years of age. Rural residents (25%) were twice as likely as urban residents (13%) to begin their daily smoking before the age of 15.²⁵ According to some 2015 country reports smoking tobacco is expected to grow over the forecast period, mainly due to the fact that “roll your own” tobacco is seen by Romanian consumers as a convenient and legal cheaper alternative to cigarettes. The growing range of brands available and strengthening brand visibility in stores may also stimulate demand for these products.²⁶ Romania is the EU country where people are most exposed to tobacco smoke at work.²⁷

The Kyrgyz Republic has a population of 6 million with smoking rates of 36% for men, 3% for women and the highest standardised mortality rate due to respiratory diseases in the European Region. An estimated 17% of deaths amongst males were caused by tobacco on 2010. There is a lack of awareness of the harmful effects of tobacco among the population and an absence of any information about the necessity of treatment. Rates of tuberculosis (TB) are very high. Tobacco use has direct and indirect effects on TB and the WHO has strongly recommended co-ordination between national TB and tobacco control programmes.²⁸



Staff and patients outside a primary care facility in the Kyrgyz Republic during a recent IPCRG visit

3 Target Audience

The target audience for the project are primary healthcare professionals in each of the four participating countries: Romania, Bulgaria, the Republic of Macedonia and the Kyrgyz Republic. Table 1 below summarises estimated participant and beneficiary numbers. The project will reach this audience using a cascading 'Teach the Teachers' model. The first level of this model involves teaching a small group of five teachers from each country who are involved in continuing medical education, the skills and knowledge required to provide effective support for smoking cessation in primary care interventions. This initial teaching will take place at an international teachers' workshop, designed and delivered by an Expert Faculty convened by the project. Teachers to participate in the international teachers' workshop will be recruited by our project partner in each of the four countries. This will be done through open announcement of the project and the opportunity to participate in each partners' network. Excellent English language skills will be a requirement as the international teachers' workshop will be conducted in English.

The second level of the "Teach the Teachers" model involves these teachers then teaching other primary healthcare educators in their own countries the skills and knowledge they acquired at the international workshop. This will be done at in-country workshops that will be organised using the established CME systems in each country. In doing so, they will use resources which have been adapted for their own context and take place in the local language. The primary healthcare educators participating at this level will be recruited from the existing networks of our project partners who are providing CME.

The third level of the "Teach the Teachers" model is the primary healthcare educators then providing modules to improve the knowledge, skills and confidence for treating tobacco dependence in their community for GPs, FPs, medical assistants, nurses and pharmacists. The primary healthcare professionals that participate will use the new skills and knowledge in their daily interactions to provide tobacco dependence treatment to patients who are smokers. These patients are the beneficiaries of the project. It is not possible to determine exact numbers of patient beneficiaries as this depends on the size of the patient list of the primary healthcare professionals who participate, the percentage of these who are current smokers and the frequency with which they visit their primary healthcare provider. As the previous section of this proposal has explained, smoking rates in each of the four countries are high and evidence shows the vast majority of smokers see their primary healthcare provider at least once a year. Table 1 below includes average patient list size and uses this to estimate the potential number of current smokers who are likely to benefit from consultations with primary care professionals who have participated in the project. The estimate uses the following conservative assumptions: patients smoke at the same rate as current smoking rates in each country; patients are made up equally of men and women; 20% of patients are children under 18 who are non-smoking; 50% of these smokers will see their FP/GP once a year. Even using these conservative estimations it is clear that many thousands of patients who are current smokers will benefit from consultations with GPs and FPs who have increased capacity to treat tobacco dependence as a result of their participation in the project.

Because the project builds a network of teachers embedded in existing CME networks, the teaching on tobacco dependence treatment will be sustained after this project is completed. In addition, our project partners will negotiate the accreditation of the modules developed

by the project for CME and their incorporation into postgraduate education through the relevant academic, policy and professional bodies in each country.

Table 1: estimated participant and beneficiary numbers

Activity	Macedonia	Bulgaria	Romania	Kyrgyz Republic	Total
Participants in the international teachers' workshop (1 st level)	5	5	5	5	20
Participants in the in-country teaching other teachers (2 nd level)	15 -20	15-20	15-20	15-20	60-80
Primary healthcare professionals taught (3 rd level)	250	250	250	250	1,000
Average patient numbers per GP/FP	1,500	1,300	1,600	800 – 1500	
Estimate of patients who smoke per GP/FP	432	379	344	172	
Potential total numbers of patients benefiting each year	54,000	47,375	43,000	21,500	165,875

Our project partners in each of the four countries are experienced in providing CME and have the necessary networks to recruit the teachers and the participants. The project partner in the Republic of Macedonia is the Centre for Family Medicine which has 60 educators in all towns in Macedonia who are providing CME in their regions. It has experience of developing and implementing a programme for retraining existing general practitioners in Macedonia. The in-country education will be regionally organized, providing enough teachers to cover the medical professionals in each of the regions in the country. These teachers will then provide teaching in their community. This teaching will be offered to all specialists in family medicine as a CME. An estimated 250 professionals will participate. Family medicine doctors are paid by capitation and on average they have 1500 patients. Our project partner will negotiate with the Health Insurance Fund to put smoking cessation as an objective of GPs and FPs, so the doctors can be incentivised to implement their knowledge.



Bulgarian FPs and GPs at a recent educational event supported by IPCRG

In the Kyrgyz Republic the project partner is the Kyrgyz Thoracic Society, which has a large number of members from different fields of medicine. It has experience in the training of family physicians. It will recruit teachers to participate in the international teachers' workshop and the in-country teaching from the National Center of Cardiology and Therapy, Kyrgyz Thoracic Society, the Kyrgyz State Medical Academy, Kyrgyz - Russian Slavic University. Medical assistants and community nurses will be included as they play a key role in the delivery of primary care in the Kyrgyz Republic. The participants all contribute to the training of family doctors and nurses at the primary health care level in all regions of the country. In the Kyrgyz Republic every GP, FP or medical assistant has around 800 - 1500 people in their service area whom they regularly see.

In Romania the project partner is the Romanian Primary Respiratory Group (RespiRo) that operates under the auspices of the National Centre for Family Medicine Studies (CNSMF) and the Romanian National Society of Family Medicine (SNMF). Participants in the international teachers' workshop will be selected from among its members. The infrastructure of both organisations will be used to go on to teach other teachers in-country. Primary care professionals targeted for the teaching will include family doctors and nurses. This existing infrastructure includes two national conferences, eight regional conferences and over 30 workshops, symposia, summer school and courses each year. In addition the on-going Lifestyle project coordinated by the CNSMF (<http://cnsmf.ro/proiecte-in-derulare/proiect-lifestyle/>) opens access to a network of 100 primary care offices actively involved in prevention. The average list of registered patients is 1600 per family doctor.

In Bulgaria the project partner is the Bulgarian General Practice Society for Research and Education (BGPSRE). It has experience in developing and delivering many educational

programmes, for example depression and anxiety in general practice, family planning, tuberculosis and diabetes. It will invite five teachers to participate in the international teachers' workshop from among its members who come from all over Bulgaria. The BGPSRE is well placed to do so because it is actively involved in postgraduate and CME education. The teachers who have participated in the international workshop will then go on to teach other members of the Society who are engaged in professional development. All members of the BGPSRE are experienced, motivated and engaged in a great variety of educational programmes. The FPs and GPs who are members of the organization are practising actively. The average number of patients per FP/GP is 1300 patients, of which about 80% see their GP yearly.

4 *Project Design and Methods*

The project design uses an IPCRG model, 'Teach the Teacher', which has been used successfully in diverse primary care contexts for difficult to manage asthma.²⁹ This is based on a cascading model whereby the international Expert Faculty teaches a small group of teachers who then go on to teach other teachers in their own countries. These teachers then teach primary care professionals new skills and knowledge to confidently treat tobacco dependence. This design develops a sustainable network of teachers and enables a larger number of professionals to benefit from the teaching. By using existing IPCRG partners who are already engaged in CME in the four countries included in the project, we will make use of existing infrastructure and relationships to ensure we can recruit participants as planned.

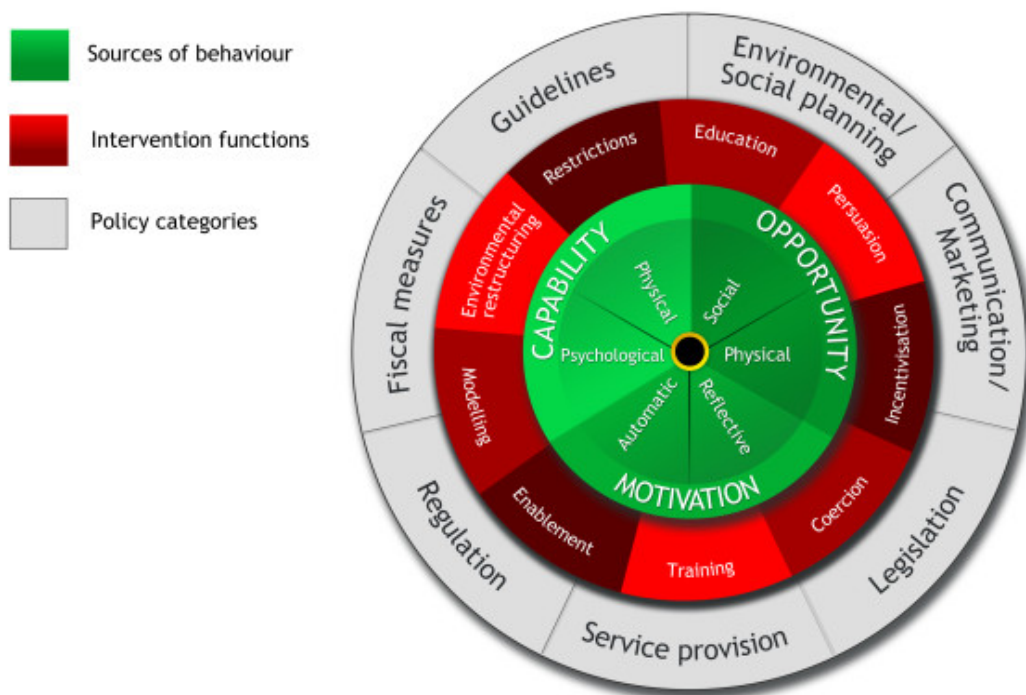
The content and method of the teaching will be designed to address all the factors identified as contributing to the practice gap described in section D.2 above. In particular, this project design recognises that CME methods should encompass the complex principles of adult learning and behaviour change, in addition to teaching new knowledge and skills. Tacit knowledge, relationship building, collaborative learning, confidence building and thought leadership are all important in ensuring that education can be used to change clinical practice in ways that apply known evidence in practice. Teaching the teachers of primary healthcare professionals the principles of adult learning, as well skills and knowledge around treating tobacco dependence, is therefore essential.

The project design also reflects that the content of teaching on treating tobacco dependence must be based on what the evidence shows about which smoking cessation interventions in primary care have been shown to work and on making the most of available resources. The National Centre for Smoking Cessation Training (NCSCT) has explored the evidence for effective behaviour change techniques for smoking cessation. The behaviour change techniques contained within the NCSCT Very Brief Advice (VBA) on smoking training module are supported by meta-analyses.³⁰ This VBA approach has three elements: establishing and recording smoking status (ASK); advising on how to stop, including advising the best way of stopping smoking with a combination of medication and specialist support (ADVISE); and offering help, which includes building confidence, giving information and providing support, referring to other services where available and prescribing pharmacotherapy (ACT).

The behaviour change framework that informs this approach is the 'behaviour change wheel'. This recognises that capability, opportunity, and motivation interact to influence behaviour, known as the 'COM-B' system. Capability includes having the necessary knowledge and skills. Motivation is defined as all those brain processes that energise and direct behaviour, not just goals and conscious decision-making. It includes habitual

processes, emotional responding, as well as analytical decision-making. Opportunity is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it.³¹ The COM-B forms the hub of a 'behaviour change wheel' around which are positioned the nine intervention functions aimed at addressing deficits in one or more of these conditions. These illustrate how our project can have an impact on some of the behaviours, but will need to be supported by the other six policy categories, in addition to service provision, that influence behaviour. The delivery of this education project and data about impact it generates can also be used to influence these other policy categories. The COM-B model can apply equally to the dependent smoker and the primary care clinician.

Figure 1: The behaviour change wheel (Michie et al, 2011)



The IPCRG will convene an Expert Faculty to advise on the project methodology, including the educational content of the international and in-country workshops and the adaptation of educational and clinical resources. Attention will be given to ensure that there is fidelity to the key educational content, while allowing for adaptation to local contextual and cultural factors within in each country. Bio-sketches for the Expert Faculty members are provided in section H of this proposal.

Dissemination will include publication of the project's outcomes in a peer reviewed journal and presentations at national and international conferences on smoking cessation, respiratory health and non-communicable diseases.

The project draws and extends existing IPCRG approaches and initiatives. In 2008 it published the first Consensus Statement as practical smoking cessation guidance for primary care. Since then there has been a great deal of activity by the IPCRG and others in tobacco dependence treatment implementation research, including how to build capacity to treat in primary care in different settings. IPCRG recently produced an updated desktop helper and is

testing new interventions through two major programmes, a Global Bridges funded project in Training community health workers in rural Uganda (<https://www.globalbridges.org/news/blog/2015/02/10/training-community-health-workers-in-rural-uganda/#.VvzgR4SKDrc>) and a Horizon 2020 funded FRESH AIR programme of work (www.theipcr.org/freshair). IPCRG is already working closely with the WHO on primary care education about the prevention and treatment of chronic lung disease as part of its non-communicable disease programme and it is important we offer practical guidance to support the WHO's stated ambition for the primary care diagnosis and treatment of tobacco dependence (http://www.who.int/tobacco/publications/building_capacity/training_package/treatingtobaccodependence/en/).

The IPCRG draws on the best global knowledge and practice to develop evidence based approaches to educational programmes that are adapted for local use by local teams.³² It has invested in building the educational capacity of its network and member countries and has a proven track record in supporting educational implementation.³³ It recognises that primary care clinicians must be involved as teachers because they recognise local barriers and can identify ways to overcome them. Innovations include the 'Teach the Teacher' programme that this project will use.

Although the project builds on existing IPCRG initiatives, it does not duplicate current or previous activities. We have not previously used the 'Teach the Teacher' methodology for treating tobacco dependence and our smoking cessation resources have not been adapted for these four countries. The project will lead to the development of a range of resources to support primary healthcare professionals treating tobacco dependence, including Desktop Helpers and educational materials translated into local languages and adapted for contextual differences. These will be made publically available at no cost.

5 Evaluation Design

We will conduct a comprehensive evaluation to ensure we capture and share the learning generated through our activities and to evidence impact. This is particularly important because all four participating countries are categorised as middle income countries (MICs) and the evidence base around effectiveness and cost effectiveness of stopping tobacco use interventions in MICs is less developed than that for high income countries, although in general smoking rates are much higher. Because there is no standardised way of evaluating tobacco cessation training programmes for health care staff in varied healthcare contexts, our project will use a framework which considers five critical levels of evaluation.³⁴

1. Participant reaction - initial satisfaction with the training experience

- Usually a post training questionnaire conducted with level 1 (international teachers), level 2 (in-country teachers) and at level 3 (primary healthcare professional).

2. Participant learning – was there an increase in skills and knowledge?

- Pre- and post-training assessment of the knowledge of tobacco dependence treatment and locally available resources to support this, levels 1-3.

3. Organisational change & support – variables which helped or hindered training and changes in professional practice

- Feedback on local contextual factors which influenced training and implementation. On-line survey or qualitative accounts from level 2 teachers and level 3 healthcare professionals.

4. Participant use of knowledge and skills - transfer of knowledge, skills, development of professional practice

- On-line surveying of the level 3 healthcare professionals who have been taught by the level 2 teachers three and six months after their participation to explore how their clinical practice has changed as a result.

5. Patient impact and outcomes - overall impact

- We will have baseline data on numbers of patients per doctor and numbers of smokers.
- We will attempt to define indicators and gather data on: provision of VBA, behavioural support, prescribing practice and quit attempts at practice level.

The IPCRG has a track record of designing and conducting evaluations of partnership projects funded through multiple sources, including collecting qualitative and quantitative research data in diverse contexts and publishing evaluation findings in peer reviewed academic journals. The Expert Faculty, which is made up of senior medical educationalists, behaviour change experts and clinicians, will design the evaluation. The evaluation will be conducted by our project team, with Juliet McDonnell, an experienced educationalist, as lead evaluator.

We will disseminate the learning, resources and outcomes from the project widely including through:

- Updates on the Global Bridges network throughout the duration of the project.
- An end-of-project webinar to share the learning from the project on the Global Bridges network.
- Updates on the IPCRG knowledge platform which currently has almost 1,500 users.
- Integration of learning into IPCRG successful tools such as Desktop Helpers.
- An article on the learning from the project submitted to a peer reviewed journal, and country specific reports in national journals of the four countries.
- Presentations at national professional and specialist conferences in each of the four countries.
- Social media.
- Presentations at international conferences (including the IPCRG scientific conference in May 2017 and the European Respiratory Society international congresses) and local national conferences in the four countries.

6 Detailed Workplan and Deliverables Schedule

The proposed project has seven workstreams. Each of these workstreams, the activities involved, the timescale for completion and the deliverables are described below.

Workstream 1: Convening and supporting an Expert Faculty

Activities: IPCRG will convene an Expert Faculty made up of:

- Dr Andy McEwen, an expert in evidence-based behaviour change techniques and Executive Director of the National Centre for Smoking Cessation & Training³⁵;
- Dr Noel Baxter, a GP and Clinical Lead for Stop Smoking;
- Dr Jaime Correia de Sousa, a senior academic teacher for family medicine;
- Darush Attar-Zadeh, an experienced community pharmacist and trainer for smoking cessation services;

This Expert Faculty will design the educational materials, develop and deliver a two-day workshop for the teachers and provide support throughout. It will also support the development a mechanism to ensure the fidelity of the core educational content of the in-country workshops. Regular webinars will be held with the Country Leads in each of the four countries to support the planning and implementation of the in-country teaching of teachers and teaching primary healthcare professionals. One member of the Expert Faculty will also visit each county once to participate in in-country teaching of teachers' events.

Timing: The Expert Faculty will be convened in month 2 of the project and will continue to work throughout the project.

Deliverables: Design of educational materials, delivery of the international teachers' workshop, support for the in-country teaching.

Workstream 2: The international teachers' workshop

Activities: IPCRG will organise a two-day workshop for 20 teachers, five from each of the four participating countries, which will take place in month 4 of the project. The country partner organisations will be responsible for recruiting and selecting the participants. The workshop will be led by the Expert faculty, who will continue to be available to support the in-country phases of the work.

Timing: Month 4

Deliverables: Design of educational materials for the workshop, delivery of the international teachers' workshop

Workstream 3: Adaptation of educational and clinical resources

Activities: Existing educational and clinical resources will be adapted for each country.³⁶ Using existing resources will ensure that approaches taught by the project are evidence based and that the content of the teaching remains consistent.

Timing: Months 4 to 8

Deliverables: Educational and clinical resources available free online.

Workstream 4: In-country teaching of teachers

Activities: Country based partner organisations will work with teachers who have attended the international teachers' workshop to develop and deliver the teaching to around 15 to 20 primary healthcare educators in their own countries. The participants and specific activities will vary, depending on primary care infrastructure. Wherever possible use will be made of existing events and communications.

Timing: Month 6 to month 18

Deliverables: Country based plans for in country teaching of teachers; in-country workshops; input into CME events and specialist conferences

Workstream 5: Teaching primary healthcare professionals

Activities: Each partner organisation will work with the teachers in their country to design and run a programme that builds the capacity of primary care professionals for tobacco dependence treatment. The participants and specific activities will vary, depending on primary care infrastructure. The Expert Faculty will provide on-going support.

Timing: Month 10 to month 20

Deliverables: Country based plans for in country teaching of primary healthcare professionals; in-country workshops; input into CME events and specialist conferences

Workstream 6: Evaluation

Activities: Design of participant evaluation questionnaires, on-line follow-up survey, analysis and preparation of findings, submission to a peer review journal.

Timing: On-going throughout the project; publication by month 28

Deliverables: Publication of the project evaluation in a peer review journal.

Workstream 7: Project coordination

Activities: Project management, liaising with country partners, financial management, progress reporting to the IPCRG Education Committee and Global Bridges Project Board which will ensure quality; progress reporting to Global Bridges. Regular teleconferences will be convened with the Country Leads in each of the four countries to co-ordinate progress.

Timing: Month 1 onwards

Deliverables: Regular progress reports including a mid-term report at M12 and a final report at M24

The table below summarises the deliverables from the project and the schedule for their completion.

Deliverable	Completion by
Monthly teleconferences of IPCRG and country leads	On-going
Expert Faculty convenes	M2
Programme and content for international teachers' workshop	M3
2-day international workshop for 20 teachers	M4
Country based plans for in-country teaching of teachers produced	M6
Adapted resources to each country's needs available	M8
Country based plans for in-country teaching of primary health-care professionals produced	M10
One Expert Faculty member visits each country	M12
Mid term project report for Global Bridges	M12
Completion of in-country teaching of teachers	M18
Completion of in-country teaching of primary health-care professionals	M20
Final project report for Global Bridges	M24
Evaluation publication in peer reviewed journal	M28

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