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香港大學公共衛生學院

How to Evaluate Smoking Cessation Programme / Services

- Evaluation tools

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Donabedian Model

- Conceptual model for examining health services and evaluating quality of health care
- Structure, process and outcomes
- Structure: hospital buildings, clinics, staff, financing, equipment
- Process: transactions between patients and service providers
- Outcomes

Evaluation: Definitions and Purposes

- Different definitions and purposes
- Systematic, rigorous, and meticulous application of scientific methods to assess the design, implementation, improvement, or outcomes of a program. It is a resource-intensive process ...

(Ross et al 2004)

- Two functions:
 - Formative: for improving
 - Summative: short-term effectiveness or long-term impact

(Staff 2011)

(wikipedia.org)

Planning and evaluation

- Evaluation should be included before starting any services/programmes/projects
- Planning of intervention should include an evaluation plan with sufficient funding
- Evaluation of existing and on-going service/programme: difficult, haphazard
- New intervention within existing service/programme: isolated evaluation
- Expertise, experience, independence

Evaluation, aims and objectives

- Aims and objectives achieved?
- Different services/programmes/projects with different aims/objectives
- Aims/objectives not stated, not clear (not measurable), not accepted, forgotten, changing or evolving
- Disagreements: primary/secondary objectives, priorities/weighting

Aims and objectives of SC services etc

- Primary or main aim: to *help* smokers quit smoking?
- “Help”: an action, not outcome; how to define help in measureable terms?
- “Smokers”: Define (WHO)? Any smokers who come for help (more motivated)? Some smokers come only to have a look. Smokers recruited in outreach activities (less motivated)
- “Quit”: Define? Self-reported? Duration (24h, 7 days, continuous 1 month to 12 months)? At what follow up time point? Biochemical validation?

Other SC aims and objectives (1° or 2°)

- Quitting related outcomes: different definitions and sub-groups (e.g. by nicotine dependence); quit attempts, relapse, readiness to quit (stages of change), importance and confidence in quitting
- Methods of quitting
- Withdrawal symptoms and actions to overcome
- Adherence to treatment and use of materials (e.g. booklet)
- Factors associated with quitting: e.g. social support
- Smoking reduction: e.g. by half at least

Other aims and objectives

- Raise awareness of SC and harms of smoking
- Including smokers and non-smokers
- Other target groups: An SC clinic in a hospital can raise awareness of doctors, nurses and other HCP, and patients and relatives
- Out-reach publicity: Neighbourhood, schools, health & other service centres, mass media
- Beyond SC: Tobacco control advocacy; Increase tobacco tax, Smokefree legislation (e.g. monitoring and complaints)

New Challenges from new products

- E-cigarettes (EC), heated tobacco products (HTPs)
- Quitting cigarettes but not EC? Not HTPs?
- “Harm reduction” is NOT quitting
- Quitting of all products and nicotine

Effectiveness?

- Effectiveness: Difference in outcomes between intervention and no intervention (controls)
- Strongest evidence: Randomised controlled trial (RCT); Double blinded placebo RCT
- SC programme with no control group: Weak evidence of effectiveness

Quit rates comparable?

- Quit rates of different SC projects are NOT comparable, unless shown/proven otherwise
- Natural quit rate of smokers in the relevant community can be a reference, but usually not known
- Smokers who seek treatment: More motivated with higher quit rate
- Free services: Lower quit rate
- Expensive services: Higher quit rate
- Smokers recruited proactively: Lower quit rate
- Hard-core smokers: Community with very high or low smoking prevalence, lower quit rate

Evaluation and Research

- Different definitions and perceptions
- RCT: efficacy/effectiveness of an intervention, the most robust evaluation (research)
- Evaluation includes much more, and needs not, and often does not have RCT
- SC programme/services: platforms and opportunities for research
- Evidence generating; add new knowledge
- Can the SC project generate publications in international peer reviewed journals?

Cost analysis

- Direct costs for setting up and recurrent costs
- Mainly manpower, publicity and medications
- Incomes: government and other grants, fees and charges from clients
- No. of quitters/unit cost (including and excluding setting up and evaluation funding)

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Establishment and evaluation of a smoking cessation clinic in Hong Kong: a model for the future service provider

Abu Saleh M. Abdullah, Anthony J. Hedley, Sophia S. C. Chan, Winnie W. N. Ho, Tai-Hing Lam on behalf of the Hong Kong Council on Smoking and Health Smoking Cessation Health Centre (SCHC) Steering Group*

Abstract

Background In the West, the effectiveness of smoking cessation programmes is well established. Smoking cessation programmes in the East are rare. We evaluated a pilot smoking cessation health centre (SCHC) of the Hong Kong Council on Smoking and Health (COSH).

Methods The clinic operated 3 days a week from 6 to 9 pm. Smokers were recruited mainly by low cost publicity. Trained counsellors provided individual counselling and a 1 week free supply of nicotine replacement therapy (NRT). The programme was evaluated in terms of process, outcome and cost.

Results During August 2000 to January 2002, 2212 calls were received through the clinic hotline and 1203 smokers attended the clinic. Eight hundred and forty-one were successfully followed up at 12 months. Based on intention-to-treat analysis, the 7 day point prevalence quit rate at 12 months (not smoking any cigarette during the past 7 days at the 12 month follow-up) was 27 per cent (95 per cent confidence interval, CI 25-30 per cent). The average cost per quitter was US\$339 (US\$440 including NRT cost for a 1 week free supply). Other benefits included training of healthcare workers and medical students, organization of seminars, health talks and self-help groups, and promotion of research and training.

Conclusions This first evaluation of a clinic-based smoking cessation service in Asia showed that the service was acceptable to Chinese smokers. The quit rate in this pilot part-time clinic is comparable to those of full-time and better funded clinics in the West. A part-time smoking cessation clinic is a promising model for piloting smoking cessation services in the East.

Keywords: smoking cessation, health centre, Hong Kong Chinese, evaluation

Introduction

In the west, a wide variety of smoking cessation programmes have been developed over the last decade. Most programmes

achieved point prevalence abstinence rates of 10-30 per cent at 12 months, with higher rates among those which used nicotine replacement therapy (NRT).¹ However, in the East, there is a lack of smoking cessation services, and we found no such data for Chinese in the literature. Implementation and evaluation of a smoking cessation programme in the East should have important public health and policy implications for this region.

Hong Kong is the most urbanized and westernized city of China with a population of 6.5 million. Its smoking prevalence of ~15 per cent (26.1 per cent male and 3.6 per cent female)² is

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First smoking cessation services, low cost with vigorous evaluation in Hong Kong

- Smoking Cessation Health Centre (SCHC) at outpatient department, Ruttonjee Hospital, August 2000 by Hong Kong Council on Smoking and Health (in collaboration with HKU). Free of charge.
- A steering group and a clinic director (part-time 10%), a PT (25%) coordinator, and a PT (80%) support staff, 3 counsellors on duty during each session

Evaluation

Process

Comments from staff and satisfaction

Client satisfaction by questionnaire at 3 months

Outcomes

Main - self-reported 7 day point

prevalence quit rate at 12 months

Others - continuous abstinence rate, reduction
(by at least 50%) rate

Others

- No. of organisations visited
- No. of HCP and medical students trained
- No. of outreach activities
- Education and training materials developed and distributed

Client satisfaction at 3 months

Satisfied/very satisfied:

- Counselling in clinic 93%
- Telephone follow up 92%
- Booking arrangement 86%
- Getting access to hotline 77%
- Quitting self-help materials 71%
- Usefulness of NRT: patch 59%, gum 57%, inhaler 46%

Probably/definitely recommend this service to other smokers: 80%

Table 2 Smoking status using different outcome indicators among participants at the 12 month follow-up interview

	By number of clients successfully followed up <i>n</i> = 841 % (95% confidence interval)	By intention-to-treat analysis <i>n</i> = 1203 % (95% confidence interval)
<i>Main outcome</i>		
Not smoking in the past 7 days at the follow-up interview	39 (36–42)	27 (25–30)
<i>Other outcomes</i>		
Continuously abstained from tobacco smoking for 80% of the whole year prior to interview	26 (23–29)	18 (16–21)
Not smoking in the past 24 hours at the follow up points	40 (36–43)	28 (25–30)
Stopped smoking for at least 24 hours at some point prior to the interview	82 (79–85)	57 (55–60)
Had not quit but had reduced smoking by at least 50% from the baseline level	21 (18–24)	14 (13–17)
Reported any positive behavioural change toward smoking cessation*	86 (83–88)	60 (57–63)

*Positive behavioural change refers to not smoking at follow-up or having quit for at least a day or had reduced cigarette consumption by at least 50 per cent.

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Research Article

A Randomized Controlled Trial of Two Different Lengths of Nicotine Replacement Therapy for Smoking Cessation

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This study examined if 2-week free nicotine replacement therapy (NRT) would be more effective than 1-week free NRT to help smokers quit smoking at 6 and 12 months. In a single-blinded randomized controlled trial design, 562 Chinese smokers who attended a smoking cessation clinic in Hong Kong, China, were randomly allocated into two groups (A1 and A2): A1 ($n = 284$) received behavioural counselling with free NRT for 1 week; A2 ($n = 278$) received similar counselling with free NRT for 2 weeks. All subjects received printed self-help materials to support their quitting efforts. A structured questionnaire was used for data collection, including pattern of NRT use and self-reported 7-day point prevalence quit rate at 6 months and 12 months. Among the participants, the mean number of cigarettes smoked per day was 18.8 (SD = 10.9). By intention-to-treat analysis, 7-day point prevalence quit rates were not significantly different between A1 and A2 groups at 6-month (27.5% versus 27.3%; $P = 0.97$) and 12-month (21.1% versus 21.2%; $P = 0.98$) followup. The findings suggest that two-week free NRT was not more effective than 1-week free NRT to increase smoking cessation rate among Chinese smokers.

NRT use among subjects in the two groups

Duration of NRT use	A1 ($n = 284$)	A2 ($n = 278$)
2 weeks or more	41.5 [*]	53.6 [*]
4 weeks or more	22.9	24.8
8 weeks or more	7.4	6.8

Note: all of those who were not available at followup were considered as nonusers.

^{*}Significant difference between the two study groups (Chi-square = 0.54, $df = 1$, $P = 0.004$).

Quitting status using different outcome measures in the two groups at 6-month and 12-month followups, by intention to treat

Outcome measures	6 months				12 months			
	A1 (N = 284) N (%)	A2 (N = 278) N (%)	P values	OR (95% CI)	A1 (N = 284) N (%)	A2 (N = 278) N (%)	P values	OR (95% CI)
<i>Main outcome</i>								
Self-reported 7-day point prevalence quit rate	78 (27.5)	76 (27.3)	0.97	1.0 (0.7–1.4)	60 (21.1)	59 (21.2)	0.98	1.0 (0.7–1.5)
<i>Secondary outcomes</i>								
Biochemically validated (CO level in exhaled air) 7-day point prevalence quit rate	22 (7.7)	35 (12.6)	0.06	1.7 (0.9–3.0)	NA	NA	NA	NA
Self-reported 24-hour point prevalence quit rate	78 (27.5)	76 (27.3)	0.97	1.0 (0.7–1.4)	60 (21.2)	59 (21.2)	0.98	1.0 (0.7–1.5)
Self-reported continuous abstinence	71 (25.0)	69 (24.8)	0.96	1.0 (0.7–1.5)	52 (18.3)	51 (18.3)	0.99	1.0 (0.7–1.5)
Had not quit but had reduced smoking by at least 50% from the baseline level	49 (17.3)	50 (18.0)	0.48	1.1 (0.7–1.9)	39 (13.7)	44 (15.8)	0.48	1.2 (0.7–1.9)
Stopped smoking for at least 24 hours at some point prior to the interview	123 (47.9)	127 (53.1)	0.24	1.2 (0.9–1.8)	110 (38.7)	112 (40.3)	0.71	1.1 (0.8–1.5)

Note: OR: odds ratio; CI: confidence interval; NA: not applicable.

*Subjects who did not complete the intervention (withdrawn/could not be contacted) were considered not quitting. Those who had no validation were also considered as not quitting.

Experience sharing and co-learning

- Low cost, one short counselling session
- 17.5 months: 5554 calls, 1120 smokers, 872 counselled = 50 counselled per month
- Acceptable
- Quit rate at 6 months (12%): appeared comparable to others
- Appeared effective but no control group
- Provided evidence and experience for future quitline and Youth Quitline

HKU Youth Quitline
香港大學青少年戒煙熱線
2855-9557

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 yquitline@yahoo.com.hk

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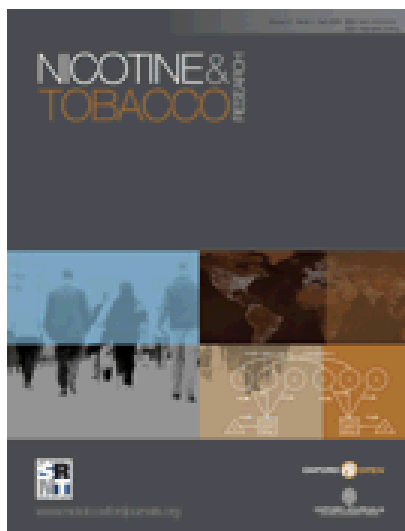
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*成功通過六個月後的身體檢查可獲三百元獎勵

Smoking Status at 6 Month Follow up (N=240)^a

	<i>n</i> (%)
Having at least one quit attempt	132 (55.0)
No smoking in the past 7 days	53 (22.1)
No smoking in the past 30 days	42 (17.5)
For current smokers at 6 months (<i>n</i> = 187)	
Reduced daily cigarette consumption by half or more	45 (24.1)

a. 240 out of 339 reached 6-month. By intention-to-treat analysis (carry-forward method).



Short-term impact of new smoke-free legislation on the utilization of a quitline in Hong Kong

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Abstract

Introduction: New smoke-free legislation implemented in Hong Kong on 1 January 2007, prohibited smoking in the vast majority of indoor workplaces and public places. Experiences of western countries indicated that the need for smoking cessation services would increase after enactment of the smoke-free legislation, but no systematic study of this issue has been undertaken in Southeast Asia. The present study aimed to examine the impact of smoke-free legislation in promoting smoking cessation through a local quitline.

Methods: The present study reports the results of a telephone survey using interrupted time-series analysis. We operated a toll-free smoking cessation hotline (quitline) for the general public from August 2005 to September 2007. The present study measured the percent change in the number of telephone calls received and handled before and after the smoke-free legislation.

Results: We evaluated the quitline for 9-month periods before (January–September 2006) and after (January–September 2007) the smoke-free legislation was implemented. The call rate in the initial period was 27.6 per month compared with 34.9 per month after enactment of the legislation, a 26% increase. Based on interrupted time-series models, the initial impact of the smoke-free legislation was to increase the number of telephone calls received and handled per week ($p < .001$), but the impact was temporal and deteriorated within 6 months.

Discussion: Implementation of the new smoke-free legislation had a short-term effect in promoting the utilization of a smok-

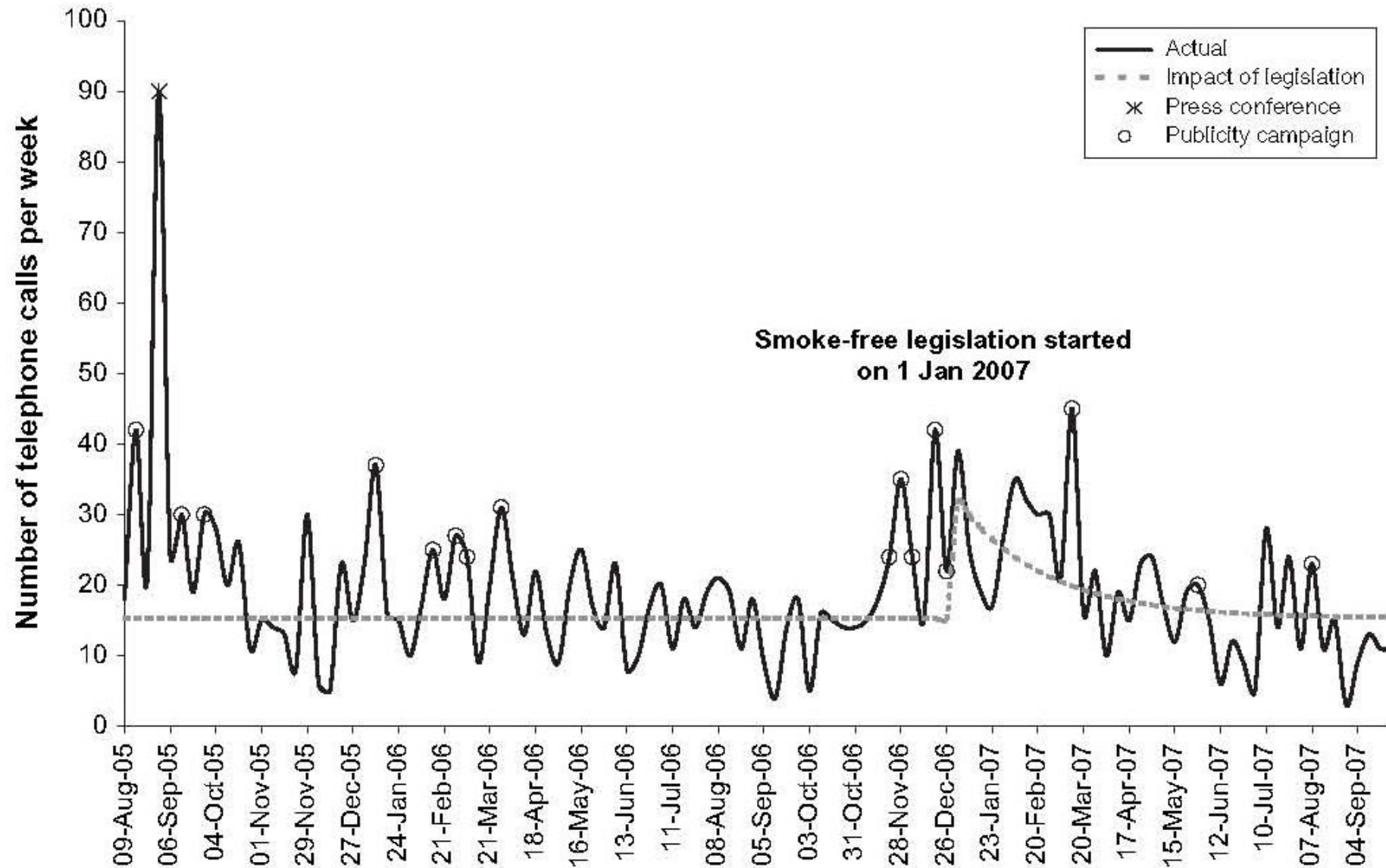
ing cessation quitline in Hong Kong. A systematic and long-term tobacco control campaign should be combined with smoke-free legislation to promote and sustain smokers' interests in smoking cessation.

Introduction

Smoking is the leading preventable cause of death in the United States, and most smokers begin to smoke in their teens (Mackay, Eriksen, & Shafey, 2006). In Hong Kong, smoking prevalence has remained steady over the past decade: 25% of males and 4% of females were daily smokers in 2005. More than 60% of daily smokers reported that they had started smoking weekly before age 20. About half of the daily smokers had never tried and did not want to quit smoking. Among smokers who were aware of smoking cessation services, less than 10% had tried/would try to use the services (Census & Statistics Department, Hong Kong SAR Government, 2006). Since smoking cessation hotlines (quitlines) have proven to be effective (Fiore et al., 2008), we started a quitline in 2005 to assist smokers in quitting at an early stage so that they could avoid developing adverse smoking-related health outcomes (Chan et al., 2008).

With public support—70% of Hong Kong residents agreed to require smoke-free restaurants (Lam, Chan, & Ho, 2000)—and with persistent promotion by the Hong Kong Council on Smoking and Health, the Hong Kong SAR Government enacted new smoke-free legislation on 1 January 2007. The legislation completely prohibited smoking in the vast majority of indoor workplaces and public places, including restaurants, offices,

Impact of legislation on the number of telephone calls received by the quitline,
8 August 2005 to 30 September 2007 (excluding case referrals)





ADDICTION

RESEARCH REPORT

SSA: SOCIETY FOR THE STUDY OF ADDICTION

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Physicians' very brief (30-sec) intervention for smoking cessation on 13671 smokers in China: a pragmatic randomized controlled trial

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ABSTRACT

Background and aims Three to 10 minutes of smoking cessation advice by physicians is effective to increase quit rates, but is not routinely practised. We examined the effectiveness of physicians' very brief (approximately 30 sec) smoking cessation intervention on quit rates among Chinese outpatient smokers. **Design** A pragmatic, open-label, individually randomized controlled trial. **Setting** Seventy-two medical outpatient departments of hospitals and/or community health centers in Guangdong, China. **Participants** Chinese adults who were daily cigarette smokers ($n = 13\,671$, 99% males) were invited by their physician to participate during outpatient consultation. Smokers who were receiving smoking cessation treatment or were judged to need specialist treatment for cessation were excluded. **Interventions** The intervention group ($n = 7015$) received a 30-sec intervention including physician's very brief advice, a leaflet with graphic warnings and a card with contact information of available cessation services. The control group ($n = 6656$) received a very brief intervention on consuming vegetables and fruit. A total of 3466 participants in the intervention group were further randomized to receive a brief booster advice from trained study personnel via telephone 1 month following their doctor visit. **Measurements** The primary outcome was self-reported 7-day point prevalence abstinence (PPA) in the intervention and control groups at the 12-month follow-up. Secondary outcomes included self-reported 30-day abstinence and biochemically validated abstinence at 12-month follow-up. **Findings** By intention-to-treat, the intervention (versus control) group had greater self-reported 7-day abstinence [9.1 versus 7.8%, odds ratio (OR) = 1.14, 95% confidence interval (CI) = 1.03–1.26, $P = 0.008$] and 30-day abstinence (8.0 versus 6.9%, OR = 1.14, 95% CI = 1.03–1.27, $P = 0.01$) at 12-month follow-up. The effect size increased when only participants who received the intervention from compliant physicians were included (7-day PPA, OR = 1.42, 95% CI = 1.11–1.74). The group difference in biochemically validated abstinence was small (0.8 versus 0.8%, OR = 1.00, 95% CI = 0.71–1.42, $P = 0.99$). **Conclusion** A 30-sec smoking cessation intervention increased self-reported abstinence among mainly male smokers in China at 12-month follow-up (risk difference = 1.3%), and should be feasible to provide in most settings and delivered by all health-care professionals.

Keywords Physicians, RCT, smoking cessation, Tobacco, pragmatic, very brief intervention.

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- RCT: 72 medical outpatient departments in Guangdong, China
- Chinese adult daily smokers (n=13671, 99% male)
- Intervention (n=7015): 30-sec physician's very brief advice, a leaflet with graphic warnings and a card on smoking cessation services
- Control (n=6656) consuming vegetable and fruit, leaflet, card
- At 12-month, self-reported 7-day abstinence 9.1% vs 7.8%; OR=1.14 (1.03-1.26, P=0.008)
- 30-day abstinence 8.0% vs 6.9%; OR=1.14 (1.03-1.27, P=0.01)

WHO Clinical Treatment Guideline for tobacco cessation in adults 2024

Very brief advice VBA based on our
mega RCT and meta-analysis



「戒煙大贏家」2012 – 戒煙比賽

2014年6月 第十六號報告書



「戒煙大贏家」2012戒煙活動

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1. 引言

香港政府統計處資料顯示，香港2012年的吸煙率為10.7%¹。每年因吸煙致死人數高達7,000人²。1998年吸煙所引起的相關醫療、長期護理開支及經濟損失高達六億八千幾萬美元³，相等於當年國民生產總值的0.6%⁴。吸煙會令人上癮，如沒有適當協助，部分吸煙者難以擺脫煙癮。香港每日吸煙者中有超過一半從未嘗試亦不願戒煙，故此他們尋求專業的戒煙服務的機會較低⁵。

對照試驗研究，比對及測試參賽者接受由已受訓的輔導員提供的即場簡短戒煙輔導(輔導組)及戒煙手機短訊(短訊組)，相對只接受自助戒煙小冊子(對照組)的成效。

2. 方法

2.1 招募詳情

委員會和協辦機構於2012年7月19日至9月30日期間，在全港18個地區舉行161場招募活動。參賽者需要經過已受訓的戒煙輔導員核實以下參賽資格後，才可參加比賽：

1. 年滿18歲及持有有效的香港身份證；
2. 在過去三個月每天吸食至少一支煙或以上；
3. 懂廣東話及閱讀中文；
4. 持有本地手提電話並可接收短訊；及
5. 一氧化碳呼氣測試結果達4ppm或以上。

在獲得參賽者的書面同意後，戒煙輔導員會於現場為參賽者填寫基線問卷，進行一氧化碳測試及向參賽者派發自助戒煙小冊子。合資格的參賽者會獲派予一個參賽號碼。符合參賽資格但不欲參與隨機對照試驗研究的參賽者仍可以參加比賽，並被納入非研究組別。如參賽者因心理或生理因素未能溝通或正在接受其他戒煙輔導，會被排除在隨機對照試驗研究。

研究使用群組隨機方式(Cluster randomization)按參加者所招募的社區分成三組：輔導組、短訊組及對照組。研究使用微軟的試算表軟體(EXCEL)的隨機功能分配十八個數字予十八個區議會分區。數字最細的六區所招募的參賽者被分配為輔導組，第7到第12的六區被分配為短訊組，餘下的分區被分配為對照組。

「戒煙大贏家」比賽提供了一個機會去接觸大量的吸煙者及在社區推廣戒煙，並提供誘因鼓勵吸煙者戒煙⁶。由2009年開始，香港吸煙與健康委員會(委員會)聯同香港大學護理學院及香港大學公共衛生學院(香港大學)舉辦「戒煙大贏家」比賽，提供簡短戒煙輔導並評估其成效。2009年的「戒煙大贏家」比賽進行三組隨機對照試驗研究，測試參加者接受簡短電話輔導或電話短訊(SMS)對改變戒煙率及吸煙行為的成效⁶。委員會在一個半月內在全港十八區中的十四個地區舉辦31場招募活動，共有1,119名吸煙者參加比賽。是次比賽在六個月跟進時，自我報告戒煙率達到22%，而三個研究組別的自我報告戒煙率沒有明顯差異。2010年委員會再次舉辦「戒煙大贏家」比賽鼓勵吸煙者戒煙，並進行兩組隨機對照試驗研究，由已受訓的輔導員即場提供簡短戒煙輔導，測試有關輔導對戒煙和改變吸煙行為的成效。在為期兩個半月的招募活動中有1,139名吸煙者報名參加比賽。在六個月跟進時，輔導組的戒煙率(18.4%)比對照組高(13.8%)，但兩組的差異只是邊緣地顯著(p值=0.08)⁷。總括而言，兩次「戒煙大贏家」比賽共吸引超過2,000名吸煙者參加，並通過簡短的戒煙輔導協助他們戒煙。

在2012年，委員會聯同香港大學、18區區議會及10個非牟利機構再次舉辦「戒煙大贏家」比賽，招募吸煙者戒煙，並提升大眾對戒煙的關注。今次比賽進行三組隨機

Quit to Win (HK COSH) 2009

- First QTW in 2009
- Evaluation integrated with research
- Grand prizes 3 x HKD10000(=USD1282) for quitters and prizes for nominators (3 x HKD3000)
- Recruitment at 16/18 districts with exhaled CO test
- RCT: (1) brief telephone counselling, (2) SMS; and (3) control
- Biochemically validated winners at 6-month follow up: Lucky draw, 3 winners and their nominators
- Follow up: 2, 6, 12 months
- 23 recruitment sessions (noon to 8pm); 1119 smokers (1003 in RCT)
- Self-reported 7-day PP abstinence at 6 months: 22.2, 20.6, 20.3% (not sig.)
- Abstinence at 2-, 6-, and 12-months follow up: Telephone group adjusted OR 1.8 (1.01-1.88, $P<0.04$)
- SMS no sig. effect

Quit to Win (HK COSH)

- 2010, 2012-2019
- Always included an RCT to test new and simple interventions
- Involving 18 District Councils and district based NGOs in publicity and recruitment of smokers
- Increasing to 1200+ smokers
- Evaluation expanded
- Publicity and recruitment events: no. of people passing by, looking at displays, asking and getting more information
- Would include participating NGOs on their experiences and interests in future SC events



A block randomized controlled trial of a brief smoking cessation counselling and advice through short message service on participants who joined the Quit to Win Contest in Hong Kong

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Abstract

The present trial examined the effectiveness of brief interventions for smokers who joined the Hong Kong Quit to Win Contest to quit smoking. A block randomized controlled trial allocated 1003 adult daily smokers to three groups: (i) The TEL group ($n=338$) received a 5-min nurse-led telephone counselling; (ii) The SMS group ($n=335$) received eight text messages through mobile phone and (iii) The CONTROL group ($n=330$) did not receive the above interventions. Participants with biochemically verified abstinence at 6-month follow-up could receive cash incentive. The primary outcome was the self-reported 7-day point prevalence (PP) of tobacco abstinence at 6-month follow-up. The abstinence rate in the TEL, SMS and CONTROL group was 22.2, 20.6 and 20.3%, respectively (P for TEL versus CONTROL = 0.32; P for SMS versus CONTROL = 0.40). When abstinence at 2-, 6- and 12-month follow-up was modelled simultaneously, the TEL group had a higher abstinence than the CONTROL group (Adjusted OR = 1.38, 95% CI = 1.01–1.88, $P=0.04$). In the Quit to Win Contest, the brief telephone counselling might have increased abstinence, but the text messages had no significant effect. Further studies on intensive intervention

and interactive messaging services are warranted.

Introduction

Quitting smoking can reduce the risk of many tobacco-related diseases, with substantial gains in quality of life and life expectancy. In China, with one-third of the world's smokers, over 75% of the smokers do not want to quit [1]. Only 8.2% of the quitters sought counselling services or used pharmaceutical therapy such as nicotine replacement therapy [2]. In Hong Kong, the most westernized and urbanized city in China and with the lowest smoking prevalence in the developed world, the proportion of hardcore smokers (defined as those who had no intention to quit, no quit attempt and consumed 15 or more cigarettes a day) increased from 21.8% in 2005 to 27.4% in 2008 [3], which was higher than several developed countries including the United States [4], Canada [5] and England [6] and was comparable to Norway and Italy [7, 8].

To attract more smokers to quit, Quit and Win contests have been organized to promote smoking cessation by using monetary and grand prizes as incentives. A systematic review, however, did not conclude about the effectiveness of such approach due to the lack of randomized controlled trials



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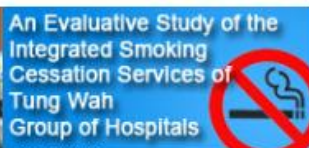


最新消息

- 2015年10月28日 第六期「識得戒」專訊已經出版，歡迎參閱。
- 2015年6月10日 本中心將於2015年10月23至25日賽馬會西貢戶外訓練營舉行「戒煙新『營』象」活動，歡迎中心戒煙人士參加，如有疑問請向輔導員查詢。
- 2015年3月1日 本中心將於3月8日銅鑼灣百德新街行人專用區舉辦「戒煙·自然·美」女性無煙宣傳活動，內容包括皮膚測試及DIY唇膏製作攤位等等，參加者只須繳好本中心專頁，即可獲贈得唇膏一支，數量有限，先到先得，歡迎有興趣的公眾人士到現場參與。
- 2014年11月20日 「戒煙自在·活得精彩-預防復吸手冊(第二版)」現已上載到本網站，歡迎參閱。
- 2014年11月12日 本中心於11月29日，中午12:30至下午4:30在荃灣悅來坊商場B1地庫舉辦「愛·無煙家庭嘉年華」，屆時設有攤位遊戲、一氧化碳測試及戒煙資訊展板等，內容豐富，費用全免，歡迎市民參加，到時見!!!!
- 2014年7月7日 本中心龍舟隊「戒煙一條龍」將於7月13日再次參與由將軍澳龍舟聯會主辦之「將軍澳龍舟比賽2014」，龍舟隊比賽時間為早上10:32的公開組A組初賽第一場及下午15:18的公開組G組初賽第二場，歡迎公眾人士到現場為戒煙者打氣，其餘賽事詳程可參閱比賽網頁。
- 2014年7月2日 搬遷通知: 上水戒煙綜合服務中心將於2014年8月1日起遷往沙田源源街9號源源健康院3字樓，如有查詢，請電2332 8977。
- 2014年5月19日 本中心將於以下地點舉辦活動推廣「5.31世界無煙日」：灣仔地鐵站A3出口外（5月20日下午3:00-5:00）；長沙灣地鐵站C1出口外元洲邨入口（5月21日下午4:30-7:30）；銅鑼灣地鐵站F出口黃金廣場外（5月31日下午2:00-5:00）；荃灣悅來酒店悅來坊商場地下（5月31日上午11:00-下午4:00），設戒煙資訊站及有獎攤位遊戲，費用全免，歡迎市民前往參觀，索取戒煙資訊。
- 2014年5月16日 本中心將設立網上互動戒煙輔導平台，由已受專業訓練的戒煙輔導員於中心開放時間為戒煙者提供網上輔導，服務將於五月三十一日「世界無煙日」正式啟用，歡迎有興趣的公眾人士瀏覽。

更多信息和資訊...

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(http://icsc.tungwahcsd.org)



Original Paper

Using WhatsApp and Facebook Online Social Groups for Smoking Relapse Prevention for Recent Quitters: A Pilot Pragmatic Cluster Randomized Controlled Trial

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Abstract

Background: Quit attempters often have episodes of smoking relapse before they eventually quit. Interactive text messaging through mobile phones has been shown to increase abstinence. This service can be potentially applied on the platform of a social networking service to help quitters maintain abstinence.

Objective: Our aim was to determine if the group discussion and reminders via the WhatsApp or Facebook social group were effective to prevent smoking relapse in quitters who had stopped smoking recently.

Methods: This was a single-blinded, parallel, 3-arm pilot cluster randomized controlled trial allocating recent quitters, who had completed an 8-week treatment and reported abstinence for at least 7 days, to WhatsApp (n=42), Facebook (n=40), and a control group (n=54). The 2 intervention groups participated in a 2-month online group discussion with either WhatsApp or Facebook moderated by a trained smoking cessation counselor and received a self-help booklet on smoking cessation. The control group only received the booklet. The primary outcome was the 2- and 6-month relapse rates, defined as the proportion of participants who smoked at least 5 cigarettes in 3 consecutive days.

Results: Fewer participants in the WhatsApp group (17%, 7/42) reported relapse than the control group (42.6%, 23/54) at 2-month (OR 0.27, 95% CI 0.10-0.71) and 6-month (40.5%, 17/42 vs 61.1%, 33/54; OR 0.43, 95% CI 0.19-0.99) follow-ups. The Facebook group (30.0%, 12/40) had an insignificantly lower relapse rate than the control group (42.6%, 23/54) at 2-month (OR 0.58, 95% CI 0.24-1.37) and 6-month (52.5%, 13/40 vs 61.1%, 33/54; OR 0.70, 95% CI 0.31-1.61) follow-ups. The WhatsApp social groups had more moderators' posts (median 60, IQR 25 vs median 32, IQR 7; $P=.05$) and participants' posts (median 35, IQR 50 vs median 6, IQR 9; $P=.07$) than their Facebook counterparts, but the difference was insignificant.

Conclusions: The intervention via the WhatsApp social group was effective in reducing relapse probably because of enhanced discussion and social support. Inactive discussion in the Facebook social group might have attributed to the lower effectiveness.

Trial Registration: Clinicaltrials.gov NCT02007369; <https://clinicaltrials.gov/show/NCT02007369> (Archived by WebCite® at <http://www.webcitation.org/6c3RbltQG>)

(*J Med Internet Res* 2015;17(10):e238) doi:[10.2196/jmir.4829](https://doi.org/10.2196/jmir.4829)

RCT: Relapse prevention using WhatsApp and Facebook

- Integrated Centre on Smoking Cessation, Tung Wah Group of Hospitals
- Single-blinded, parallel, 3-arm pilot cluster RCT
- Recent quitters after 8-week treatment and abstinence for 7+ days
- WhatsApp (n=42), Facebook (n=40), Control (n=54)
- 2 month online group discussion moderated by SC counsellor
- 6-month relapse rate
- WhatsApp 40.5% vs 61.1%, OR=0.43 (95% CI 0.19-0.99)
- Facebook 52.5% vs 61.1%, OR=0.70 (95% CI 0.31-1.61)
- WhatsApp had more moderator and participant posts than Facebook but not significant

Development and testing of a smoking cessation Clinic Evaluation Tool

- Funded by TCO, DH, HK
- HKU SPH, Smoking Cessation Clinic of China PLA General Hospital, China CDC TCO
- Minimal approach for first version

Smoking Cessation Clinic Evaluation Tool (Version 1.1)

This is a tool for healthcare organisation consultant, management, and professional assessors to evaluate and improve the quality of service of a smoking cessation clinic or to set up a new smoking cessation clinic. This tool contains four sections, including organisation assessment, environment assessment, process assessment, and outcome assessment. Please check if your clinic has fulfilled each item in this tool according to the actual situation of the clinic, and add up the points specified in the () for items with a tick. This assumes that the smoking cessation clinic or service is under a hospital or community healthcare centre or similar organization. If the clinic is an independent organization, please modify the wordings of the questions as appropriate. This tool is applicable to a Quitline smoking cessation service. If there are questions which are not applicable, please state so. The inapplicable items can be excluded or adjusted in final point calculation when the total points are converted to a percentage of the total.

Basic information

- Name of the smoking cessation clinic/service:
- Address:
- E-mail address and/or website:
- Name of the organization responsible for the above:
- Name of person completing the items below:
- Position in the smoking cessation/clinic or the organization above:

Smoking Cessation Clinic Evaluation Tool (Version 1.1)

Section 1. Organisation Assessment (17 points in total)

Organisation assessment focuses on the aspects of manpower, equipment, technology and system of a smoking cessation clinic.

-
- ☐ (1 point) 1.1. The smoking cessation clinic/service has written approval from a governmental organisation or healthcare institute for the establishment of the clinic.
 - ☐ (2 points) 1.2. The hospital or the community healthcare centre has a budget for the smoking cessation clinic/service.
 - ☐ (2 points) 1.3. The smoking cessation clinic/service has a designated person in charge of the clinic / service.
 - ☐ (2 points) 1.4. There is a designated department for the smoking cessation clinic/service. (Please specify the department: _____)
 - ☐ (2 points) 1.5. The smoking cessation clinic/service has designated healthcare personnel to provide smoking cessation services.
 - ☐ (1 point) 1.6. All healthcare personnel who service the smoking cessation clinic/service (fulltime or part-time) have received smoking cessation training.
 - ☐ (1 point) 1.7. The hospital or the community healthcare centre has a designated place for the smoking cessation clinic.
 - ☐ (2 points) 1.8. Smoking cessation clinic/service with clear signage, such as a sign showing “smoking cessation clinic/service”.
 - ☐ (1 point) 1.9. The smoking cessation clinic/service has necessary equipment for biochemical tests, such as smokerlyzer breathe carbon monoxide monitor, tests for cotinine or nicotine in biospecimens.
 - ☐ (1 point) 1.10. The smoking cessation clinic/service has relevant medical equipment, such as sphygmomanometer, body weight scale and stethoscope.
 - ☐ (2 points) 1.11. The hospital or the community healthcare centre is ready to offer smoking cessation medication.
-

Organisation assessment: ____ points

Smoking Cessation Clinic Evaluation Tool

(Version 1.1)

Section 2. Environment Assessment (14 points in total)

A smoking cessation clinic may be located in a hospital or a community healthcare center. Environment assessment focuses on the environment of the hospital or the community healthcare centre.

-
- ☐ (1 point) 2.1. The hospital or the community healthcare centre has clear signage to show the opening hours of the smoking cessation clinic/service.

 - ☐ (1 point) 2.2. The hospital or the community healthcare centre has clear signage to show the location of the smoking cessation clinic/service.

 - ☐ (1 point) 2.3. The hospital or the community healthcare centre has clear signage to show the telephone number of smoking cessation clinic/service.

 - ☐ (1 point) 2.4. The hospital or the community healthcare centre has shown exhibition board of the smoking cessation clinic/service at the front desk or the registration station.

 - ☐ (1 point) 2.5. The hospital or the community healthcare centre has shown brochure of the smoking cessation clinic/service at the front desk or the registration station.

 - ☐ (1 point) 2.6. The hospital or the community healthcare centre has shown information of the smoking cessation clinic/service via official website, social networking service (e.g. WhatsApp, WeChat, Facebook etc.), discussion forum in the website, etc.

 - ☐ (2 points) 2.7. The hospital or the community healthcare centre has shown smoking cessation promotional information via their public media system (video and bulletin board, etc) in the hospital or community healthcare centre

 - ☐ (2 points) 2.8. The hospital or the community healthcare centre has conducted onsite activities (e.g. health talk, consultations etc.) related to smoking cessation and tobacco control

 - ☐ (2 points) 2.9. Smoking cessation training is offered to all healthcare personnel in the hospital or the community healthcare centre.

 - ☐ (2 points) 2.10. The hospital or community healthcare centre has set up a system with clear requirements so that smokers can be smoothly referred to the smoking cessation clinic/service.

Environment assessment: ____ points

Smoking Cessation Clinic Evaluation Tool

(Version 1.1)

Section 3. Process Assessment (28 points in total)

Process assessment focuses on the process of development and implementation of smoking cessation services. It assesses whether a smoking cessation clinic can meet the expectations and achieve the minimum quantifiable targets.

-
- 3.1. No of sessions operated by the smoking cessation clinic/service per week (with fixed schedule, half day with at least 2 hours for 1 session) *(Please select one as appropriate from the following options)*
- ☐ (0 point) a. Less than 1 session per month or 12 sessions per year
 - ☐ (1 point) b. 1 session per month
 - ☐ (2 points) c. 2-3 sessions per month
 - ☐ (3 points) d. 1 session per week
 - ☐ (5 points) e. 2 or more sessions per week
-
- 3.2. During the past 12 months, how many smokers were served by the smoking cessation clinic/service in total? *(Please select one as appropriate from the following options)*
- ☐ (0 point) a. Less than 10 smokers
 - ☐ (2 points) b. 10-29 smokers
 - ☐ (3 points) c. 30-49 smokers
 - ☐ (4 points) d. 50-69 smokers
 - ☐ (5 points) e. 70-89 smokers
 - ☐ (6 points) f. 90-109 smokers
 - ☐ (7 points) g. 110-129 smokers
 - ☐ (8 points) h. 130 or more smokers
-
- ☐ (1 point) 3.3. The smoking cessation clinic/service keeps a record for each smoker who visits and has received services of the clinic.
-
- ☐ (1 point) 3.4. The smoking cessation clinic/service keeps a record for each smoker who has received follow-up services of the clinic.
-
- ☐ (2 points) 3.5. The smoking cessation clinic/service has educational materials (e.g., brochure, leaflet, exhibition board, etc.) about the harms of smoking.
-
- ☐ (1 point) 3.6. The smoking cessation clinic/service has educational materials (e.g., brochure, leaflet, exhibition board, etc.) about smoking cessation methods.
-
- ☐ (1 point) 3.7. The smoking cessation clinic/service has educational materials (e.g., brochure, leaflet, exhibition board, etc.) about smoking cessation medications.
-

Smoking Cessation Clinic Evaluation Tool (Version 1.1)

3.8. How many follow-up is conducted among smokers who visit and have received services of the smoking cessation clinic/service?
What is the response rate for the final follow-up survey? *(Please select one as appropriate from the following options)*

- ☐ (0 point) a. No follow-up is conducted among smokers at all, or 1 follow-up with no response rate calculated, or response rate below 10%.
 - ☐ (1 point) b. 1 follow-up only, and the response rate of the follow-up survey is 10-29.9%.
 - ☐ (2 points) c. 1 follow-up only, and the response rate of the follow-up survey is 30-59.9%.
 - ☐ (4 points) d. 1 follow-up only, and the response rate of the follow-up survey is 60% or above.
-

3.9. During the past 12 months, how many smokers were referred to the smoking cessation clinic/service from other departments in the hospital or the community healthcare centre? *(Please select one as appropriate from the following options)*

- ☐ (0 point) a. 0-4 smokers
 - ☐ (1 point) b. 5-10 smokers
 - ☐ (2 points) c. 11-30 smokers
 - ☐ (3 points) d. 31 or more smokers
-

3.10. What is the detection rate of biochemical test(s) (e.g., exhaled carbon monoxide test, etc.) among smokers at the first visit of the smoking cessation clinic/service? *(Please select one as appropriate from the following options)*

- ☐ (0 point) a. The detection rate of biochemical test(s) is not calculated or is below 50%
 - ☐ (1 point) b. The detection rate of biochemical test(s) is 50-79.9%.
 - ☐ (2 points) c. The detection rate of biochemical test(s) is 80% or above.
-

Process assessment: ____ points

Smoking Cessation Clinic Evaluation Tool

(Version 1.1)

Section 4. Outcome Assessment (11 points in total)

Outcome assessment focuses on smoking cessation or reduction outcomes after utilisation of the service of smoking cessation clinic. It assesses to what extent a smoking cessation clinic can help the smokers to quit or reduce smoking.

4.1. The smoking cessation clinic/service calculates the smokers' self-reported 7-day point cessation rate at 1-month (can be 1- or 6-month) follow-up. Please specify: _____ month, (if other duration of follow up is used, give the same points, but 2 points may be deducted)

- ☐ (0 point) a. The smoking cessation clinic/service does NOT conduct follow-up or does NOT calculate the 7-day point cessation rate at follow-up.
- ☐ (2 points) b. The self-reported 7-day point cessation rate is 5-9.9%.
- ☐ (4 points) c. The self-reported 7-day point cessation rate is 10-14.9%.
- ☐ (6 points) d. The self-reported 7-day point cessation rate is 15-19.9%.
- ☐ (8 points) e. The self-reported 7-day point cessation rate is 20% or above.

4.2. The smoking cessation clinic/service calculates the smokers' smoking reduction rate (at 1-month (can be 1- or 6-month) follow-up. Please specify: _____ month.

(smoking reduction means that the number of cigarettes that the smoker smoked has reduced for at least 50% at the last follow-up when compared to the baseline or at the first visit)

- ☐ (0 point) a. The smoking cessation clinic/service does NOT calculate the smoking reduction rate
- ☐ (1 point) b. The smoking reduction rate is 5-14.9%.
- ☐ (2 points) c. The smoking reduction rate is 15-29.9%.
- ☐ (3 points) d. The smoking reduction rate is 30% or above.

Outcome assessment: ____ points

Smoking Cessation Clinic Evaluation Tool (Version 1.1)

Final score of smoking cessation clinic evaluation|

Organization assessment + Environment assessment + Process assessment + Outcome assessment = _____ points

- Convert the total points into a percentage:

Total points assessed divided by the maximum of 70 points = ____%

- Adjusted percentage if inapplicable items are excluded:

Total points divided by (70-points excluded) = _____%



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Med** LKS Faculty of Medicine
School of Nursing
香港大學護理學院

香港大學青少年戒煙熱線 HKU Youth Quitline

HKU Youth Quitline 5111-4333

- Hong Kong's first smoking cessation service specifically for youth smoker. (Founded in 2005)
- Peer counsellors provide free telephone counselling and regular follow-up to young smokers aged 25 or below



HKU Youth Quitline
香港大學青少年戒煙熱線



>20,400

Incoming
calls



>4,100

Counselled
case*



25%

6-month
validated quit
rate



Service Hour

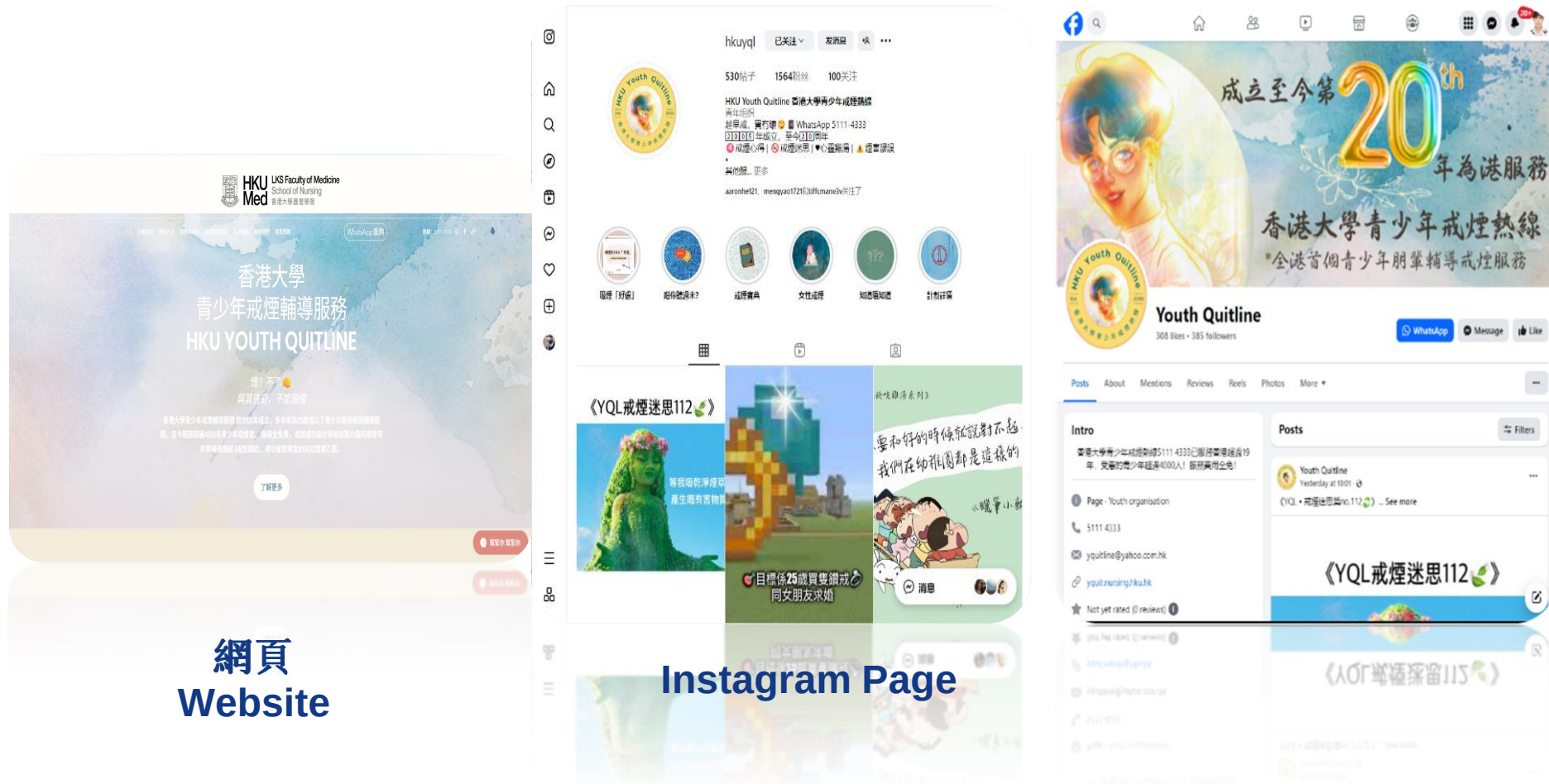
Weekday (5-9pm,)

Weekend (2-8pm)

Except Public Holiday

(*Data is calculated from August 2005 ; Quit rate from Aug 2016 to July 2024)

HKU Youth Quitline - Website and Social Media



網頁
Website

Instagram Page

HKU Youth Quitline Peer Counsellor Training Programme

LKS Faculty of Medicine

Since 2005, we have held 16 counsellor training sessions and successfully trained over 800 pre-secondary and college students to serve as peer counsellors.



2023



2025



2024

HKU Youth Quitline AI Chatbot helps youth quit smoking

港大AI聊天助青年斷癮 研究：戒煙率勝真人輔導

6個月驗證 使用者感更安心抒發感受

【明報專訊】16歲小儀（化名）3年前開始吸煙，其間曾向家人諮詢戒煙，反被介紹抽「電子煙」。她獲安排使用港大醫學院護理學院的生成式AI戒煙聊天輔導機械人，稱AI讓她更安心抒發感受，成功戒煙。港大研究發現，使用AI戒煙輔導的年輕人6個月驗證戒煙率為23%，較真人電話輔導高逾三成。

煙癮兩年多的小儀當初受家人影響，並因新冠疫情下中學面授課程停擺，患情緒問題，開始抽煙以抒發情緒。她明白吸煙有害，曾向家人提起戒煙，反而被介紹抽電子煙，稱「（電子煙）最近出咗咁新味」，使她難戒斷。幸得AI輔導，她花大半年成功戒煙。她說自己較內向，真人輔導反讓她尷尬，AI使她抒發時更安心，建議亦較實在。

諮詢家人 反被推介電子煙

港大醫學院護理學院戒煙治療研究組研發本港首個AI聊天機械人以輔導青少年戒煙，團隊去年獲政府醫療衛生研究基金資助50萬元，去年7至11月在「港大青少年戒煙熱線」開展研究。

團隊邀請154名25歲或以下、過去30日曾使用煙草產品



港大醫學院護理學院去年研發全港首個AI戒煙聊天機械人，專門輔導青少年戒煙。左起為港大護理學院名譽助理教授陸子璿、助理教授張懿德和助理院長王文炳。（李紹昌攝）

（包括傳統煙、電子煙及加熱煙）的青少年參加研究，參加者平均年齡18.3歲，並將全部人均分為兩組，分別接受AI機械人和真人電話輔導，團隊招募後3個月及6個月做「電話隨訪」，又邀請參加者做「唾液可的寧測試」，結果發現，接受AI戒煙輔導的年輕人，6個月驗證戒煙率為23%，較後者17%高逾三成。

港大醫學院團隊近年多研究

若。

學者：難代真人 惟輔導要轉型

至於AI能否取代真人做輔導，港大醫學院護理學院助理院長王文炳認為不能夠，指AI始終難主動接觸吸煙者，如要鼓勵他們接受戒煙服務，仍倚靠人手。但他稱輔導工作確實要「轉型」，包括思考如何跟受助者建立關係，並為他們提供情緒支援。

AI「I人」用真人電話輔導服務戒煙怕尷尬 16歲女生靠生成式AI機械人獲取建議成功戒煙

■ 港訊

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▲（影大偉攝）

【戒煙/港大/生成式AI戒煙機械人】自言是「I人」16歲女生透過港大研發「生成式AI戒煙機械人」成功戒煙。她形容AI機械人如同她的「心理醫生」、「不死板」，更免卻了與真人溝通的尷尬，按照對方提供的建議最終成功戒煙。

小儀受訪表示，其大部分家庭成員都會吸煙，部分人煙齡更長達30年，因家人的緣故，她早於就讀中一至中二期間首次接觸香煙，引述其家人想法，認為「佢覺得好似我係出便學壞仲不如佢教我，好過我出便學壞，即係有咁危險」，也不會在外接觸到「依托咪唑」（太空油）。

她說起初對香煙並不感興趣，每個月未必會吸食一次，但後來受朋輩及情緒影響逐漸上癮，幸好後來轉校成為了小儀戒煙的契機，加上她意識到吸煙對身體不好，便嘗試依靠意志力和「戒煙貼」戒煙，但由於她時常忘記貼戒煙貼，依靠意志力亦未能完全戒煙，最後以失敗告終。

Ming Pao
20250908

Hong Kong Economic Times
20250908

Take Home Messages

- Most ex-smokers in the world had quit cold turkey without professional help (Simon Chapman 2022)
- Will-power, determination, perseverance of smokers most important
- Some smokers are nicotine dependent with much craving and withdrawal symptoms
- But some are not very dependent with only mild craving and symptoms
- Those who have failed after receiving smoking cessation services may quit later on their own
- Support MPOWER and promote quitting always: Don't give up!

Acknowledgements

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THANK YOU

