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**B: MAIN SECTION OF THE RESEARCH PROPOSAL**

**Gap:** Access to effective tobacco dependence treatment (including both behavioral and pharmacologic therapies) is scarce among low-income countries. There is undoubtable and abundant evidence supporting the efficacy of tobacco cessation training programs and its value and impact at population. This project is responsive to the identified gap of lack of tobacco cessation training programs in Latin American & Caribbean countries. Currently, smoking rates in the Latin American and Caribbean region are high, and previous surveys show that health professionals do not have enough skills to help smokers to quit. In consequence, in absence of trained health professionals, many smokers who visit health care services are under-treated.

**Grant Area:** The application addresses the GlobalBridges priority to develop new healthcare professional training programs based on evidence and best practice in Low and/or Middle Income Countries.

**B.1: Overall Goal & Objectives:**

**Overall Goal:** The primary specific aim of the proposed research is **to disseminate and evaluate the adoption, implementation, and maintenance of an online evidence-based tobacco cessation training program addressed to health care professionals of three Spanish-speaking low and middle income countries (Bolivia, Guatemala, and Paraguay).** We hypothesize that the intervention will increase the knowledge, attitudes, behaviors, and level of tobacco cessation interventions at six-month follow-up, as compared to baseline conditions prior to the training. In addition, participant hospitals will exhibit greater tobacco control progression, commitment, and implementation of tobacco cessation services. Future sustainability is intended to be evaluated by exploring the needed efforts required to spread this tobacco cessation training program among other hospitals from the three participant countries. A smaller qualitative study will evaluate the experience of transferring the training program in each of the participant hospitals and the feasibility to spread this innovation among other hospitals in the same country. An extension to other Spanish speaking and low-income countries with the same gap is foreseen after a review of the project results and effectiveness.

**B.1.1: Primary Aims (A)**

A1: To adapt and calibrate the contents of the online training program to the tobacco control context and dynamics of the hospitals in Bolivia, Guatemala, and Paraguay.

A2: To offer to all health care providers in each hospital access to the 6-hour tobacco cessation course and expert implementation guidance.

A3: To attain a high level of curriculum adoption, implementation, and maintenance in each hospital.

A4: To evaluate the process approach by measuring the curriculum adoption, delivery, and maintenance.

A5: To evaluate the changes in tobacco cessation knowledge, attitudes, self-confidence, and performance (as outcome measures) before and after the intervention.

A6: To disseminate the results to health stakeholders and other hospitals in each participant country.

**B.1.2: State of art: *Smoking is prevalent in Latin American & Caribbean countries, but cessation is underdeveloped***

Tobacco consumption is shifting to low and medium income countries such as some countries in the Latin American & Caribbean (LAC) region (1). Currently more than 120 million of smokers live in these countries (2). Half of them will develop a tobacco-related disease and, consequently, they will be in need of medical and/or surgical hospital care.

In the LAC region, smoking varies by country, gender and socio-economic status (3,4). In the countries selected for this project (Bolivia, Guatemala, and Paraguay) smoking rates are 10% points higher than in the rest of LAC countries (5). Among men, smoking prevalence ranges from 42% (in Bolivia) to 22.9% (in Paraguay) (6). Among women, the prevalence is lower, but it is rapidly increasing, confirming the alarming feminization of the epidemic in LAC (6). In the overall region, smoking-related mortality accounts for 16% (6), and according to WHO, smoking-related deaths will increase by 700% by the year 2030 (7). Due to the high smoking prevalence among the three participant countries, the expected estimates are even more dramatic.

Despite the clear magnitude of the epidemic, the problem can be tackled by applying the tobacco control measures embraced by the WHO Framework Convention on Tobacco Control (FCTC) (8). These measures have demonstrated to reduce tobacco use and to increase society's awareness of its hazards (8). Bolivia, Guatemala and Paraguay early signed the WHO-FCTC and have implemented some tobacco control measures, including smoke-free legislation (Article 8) in workplaces and public places, including health care services. However, tobacco cessation services (Article 14 of the WHO-FCTC package) have not received the same recognition and attention (4). In consequence, smoking cessation interventions are not well spread among health care services and there is room to foster this component for tobacco control.

**B.1.3. First Gap: *Smokers in LAC region are under-treated***

Smokers are frequent users of health care services, and their contact with the health system is an adequate moment for quitting (9). In fact, according to a study conducted in 2002 in the United States, between 60% and 70% of smoker patients do a quit attempt while they are hospitalized (10). However, in spite of these favorable conditions, evidence-based cessation programs are hardly available in LAC countries (11,12). The most common barriers to incorporating tobacco cessation interventions into hospitals involve lack of training, expertise, and time (5). In addition, organizational and financial constraints threaten the suitability of smoking cessation interventions (5).

In LAC countries, smoking consumption among healthcare professionals is similar to that of the general population (13,14). Most doctors and nurses acknowledge that they have not received formal training in smoking and smoking cessation neither during undergraduate nor graduate education (14). They generally relate little confidence in its effectiveness to help their patients stop smoking. In consequence, given that about 70% of smokers visit health services over the course of a year, the percentage of lost opportunities to advice and start a cessation treatment remains significant.

According to Harris Interactive survey (15), doctors believe that smoking cessation is extremely important, but also extremely difficult. Findings also show there is a serious

communication gap between doctors and patients, which jeopardizes the opportunities to support smokers to quit.

#### **B.1.4: Second Gap: LAC hospital health professionals lack tobacco cessation training**

Smoking cessation interventions to help smokers quit are effective (16). A recent Cochrane review points out that training health professionals to treat tobacco dependence has noticeable effects on patients' prevalence of smoking, continuous abstinence, and professional performance (17). Therefore, evidence-based programs have the potential of increasing delivery of tobacco cessation treatments to smokers. Implementation research recommends addressing the organizational constraints in order to overcome the executive barriers when the cessation messages are delivered (18-20). Therefore, training programs obtain higher impact and sustainability when they are fostered by organizations which allocate time, promote key leaders, and provide implementation materials and resources (20).

In conclusion, tobacco cessation training programs supported by health organizations provide a unique arena for impacting professional norms and increasing access to tobacco cessation in healthcare services. Although several tobacco cessation programs have been developed for training health providers, most of them have been developed and evaluated in Anglo-Saxon and high-income countries.

In this context, Spanish-speaking training courses developed and adapted specifically to LAC countries are indispensable instruments to influence health professionals to be an active part of the tobacco cessation process (2). Whilst trainings have to follow current evidence-based international guides, they should also take into account the treatment regulation of each particular country, the existence guidance and proceedings, cultural behaviors and social aspects, together with the singular dynamics of the health organizations in each country (2).

#### **B.1.5. Practice Gap improved: Online tobacco cessation training addressed to LAC hospital health professionals will increase their tobacco cessation knowledge and performance**

Online courses allow distance-learning, are more cost-efficient, and provide modes to teach and reinforce counseling skills that often can be difficult to convey in the traditional classroom setting (21,22). Previous online tobacco cessation training courses have demonstrated an increase in the health providers' skills to counsel patients on tobacco cessation in other settings (17,23,24).

#### **B.1.6. Curriculum Development of the "Brief Intervention for Smoking Cessation" training program:**

E-oncología is an initiative of the Catalan Institute of Oncology that was set up in 2004 as an International Network of Oncology Centers thanks to a European Union program to boost networking and exchange of education with Latin America. Since 2005, over 5,000 professionals from Spain and Latin America have received training on the e-oncología campus, which has a network of almost 200 lecturers and tutors and over 1000 hours of educational content (36 courses). ICO has coordinated successful previous online tobacco cessation training courses for health care providers through the "e-oncología" platform (<http://www.e-oncologia.org/en/>). This on-line courses are based on the in-person courses

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offered during the last 10 years by the Tobacco Control Unit of the Catalan Institute of Oncology, and the curriculum was developed following valid results from meta-analysis and clinical practice guidelines (17,25-28). We created a fully referenced curriculum online, and feedback of an expert advisory group was incorporated. The curriculum and supporting materials were tested by 10 voluntary participants. Since it was launched, the course has been followed by 150 health professionals. For this project a six hour course will be adapted and developed in conjunction with the three LA participant centers of this project (Bolivia, Guatemala, and Paraguay).

### **B.1.7. Curriculum Description of the “Brief Intervention for Smoking Cessation” training program (In Spanish: “Curso de Intervención Mínima en Tabaquismo”)**

The course will be composed of 5 modules (M):

- M1 describes the tobacco epidemic, tobacco-related morbidity and mortality, secondhand smoke, and measures included in the MPOWER strategy to solve the problem.
- M2 provides orientation on how to assess the smoker, evaluate his/her tobacco dependence, willingness to quit (according to Prochaska and Di Clemente model), evaluate smoker self-efficacy, his/her previous quit attempts, and previous relapses.
- M3 introduces the efficacy of the different treatment options (e.g, cognitive behavioral, psychodynamic, medication management) and presents the clinical settings where the intervention is possible (e.g, inpatient, outpatient, ambulatory treatments). It explains in detail the 5As intervention model: (1) Ask patient about smoking status; 2) Advise clearly and strongly to quit; 3) Assess willingness of patient to quit; 4) Assist patient during cessation providing social support and pharmacological aid, if necessary; 5) Arrange follow-up contacts.
- M4 explains in detail the different tobacco cessation treatments available (nicotine replacement, bupropion, varenicline, and other treatments). Recommendations are given according to the USDHHS (29) and the national tobacco cessation guidelines (30).
- M5 provides orientation about the follow-up, strategies to improve the adherence of the treatment, how to identify withdrawal symptoms, how to deal with relapses, and so on.

The training emphasizes evidence-based hospital oriented tobacco cessation intervention in different settings (wards, ambulatory, etc). The cessation strategies are tailored to smokers at all stages of readiness to quit, and are amenable to different treatment orientations according to patient preferences. Interactive training includes: a) slides, b) review exercises, c) cases studies of 4 patients differing in demographics, diagnostic, stages of change, setting, and d) problem solving exercises.

The training provides several materials including slides, online tutorials with an expert tutor, recommendation readings, patient cessation brochures, and pharmaceutical pocket guideline, access to an ad hoc electronic medical record system, and an organizational recommendation model to facilitate the implementation of tobacco cessation services in the hospital setting (See annex 1).

Evaluation of the tobacco cessation program has been tested in Spanish hospitals by 150 health professionals. This pilot test proved the acceptability of this training model, the adequacy of its contents, and obtained a high level of satisfaction of the trainees. Training initiatives have proven to increase the level of implementation of tobacco control in

hospitals (according the self-audit questionnaire developed by the ENSH-Global Network for Tobacco free Health Care Services [www.ensh.eu](http://www.ensh.eu)) (31,32) and the engagement of health professionals (33,34). Thus, the success of the intervention is an important contribution to reducing the number of smokers, helping them quit. By doing so, health professionals become part of the epidemic solution.

## **B.2. TECHNICAL APPROACH:**

This project is intended to adapt and calibrate the contents of the online “Brief Intervention for Smoking Cessation Training Program” to the context, dynamics of the tobacco epidemic, and types of smokers in Bolivia, Guatemala, and Paraguay. As mentioned above, an original training was designed and tested in Spanish, and will be the start point for the development of this project which will be modified taking into account the specific characteristics (and also particularities of Spanish spoken in these countries) by local experts of the three selected countries. An evaluation project on the implementation, acceptability, and feasibility of the course will be tested in the selected participant hospitals afterwards.

With this approach, that optimizes previous work, we intend to cover the lack of Spanish-speaking tobacco cessation training programs in the LAC region.

By offering the course through an online platform network (called “e-oncologia”), we will reduce the cost and increase the training coverage within participant hospitals in less time. E-oncologia is an online educational platform that works with the participant LAC countries since 2004. An interactive website [www.e-oncologia.org](http://www.e-oncologia.org) supports the dissemination of courses through tutors and program administrators.

The training effort can be viewed as a vehicle for systematic dissemination of the clinical practice guidelines for treating tobacco dependence in hospitalized and ambulatory smoker patients. The proposed implementation study is responsive to the GlobalBridges (GB) research priority on developing new healthcare professional training programs, and consequently strengthening their capacity in tobacco control. In addition, ICO has included in its goals as future “WHO Collaborative Center on Tobacco Control” the dissemination of training programs to Spanish-speaking countries as a relevant part of its strategic milestones (application currently in review by WHO Headquarters).

### **Summary of the assessment of the target area:**

Smoking prevalence rates among people in Bolivia, Guatemala, and Paraguay is higher than the rest of the LAC countries. Governments and health organizations may apply tobacco control policies to decrease the burden of morbidity and mortality in our society. However, tobacco cessation services (Article 14 of the WHO-FCTC package) are not well spread in LAC countries (4). In consequence, smokers are untreated and the percentage of lost opportunities to reduce tobacco-related diseases remains significant.

### **B.2.1. Design and Methods**

Intervention design is based on the following steps 1) Commitment, 2) Adaptation, 3) Implementation, 4) Dissemination of the “Brief Intervention for Smoking Cessation” training program”.

**1) Commitment:** This project is based on a consolidated partnership among the involved organizations. Past oncology projects have been undertaken with success among the four organizations. Partners share the common objective of reducing the burden of tobacco-related diseases in their territories and they will act as stakeholders.

The experience has shown that partnership building can overcome future setbacks in the process. This partnership involves the organizations and their governments developing a strong networking alliance.

To facilitate the commitment, the participant hospitals in each hospital will engage to:

1. Conduct a baseline evaluation on tobacco control policies by means of the ENSH selfaudit questionnaire (SAQ).
2. Develop the curriculum “Brief Intervention for Smoking Cessation” training program.
3. Offer the course to all their hospital assistance staff (doctors, nurses, clinicians, etc.).
4. Our aim is to train as many professionals as possible in a six-month period.
5. Identify key hospital coordinators (between two or four depending on the size of the organization) to support the implementation of the training course and provide support to their co-workers.
6. Monitor the progress of the education within each organization.
7. Report the progress of the training dissemination within the organization, with the rest of the partners and the primary investigator.
8. Attend the in-person and virtual meetings.
9. Disseminate the initiative to national health organizations.

**2) Adaptation:** Taking the original training program developed by the Catalan Institute of Oncology and e-oncologia as a model, we will adapt its curriculum to the participant countries in order to reduce mismatches between the original characteristics of the training and those needed for the new context. Doing so, however, requires careful planning and execution, as it is possible to make changes that enhance the program’s cultural appropriateness, local acceptance, and feasibility, while undermining its effectiveness in changing risky behaviors. Therefore, the adaptation process will be grounded on Card et.al. framework to adjust programs to new contexts (35), which are: (1) selecting a suitable effective program; (2) gathering the original program materials; (3) developing a program model; (4) identifying the program score components and best-practice characteristics; (5) identifying and categorizing mismatches between the original program model or materials and the new context; (6) adapting the original program model, if warranted; and (7) adapting the original program materials.

The previous courses were originally developed in Spanish, has achieved behavioral and health status goals in Spain, and have increased knowledge, values, attitudes, skills, and intention to treat smokers in the hospital setting

Mismatches in the following areas will be examined: in cultural beliefs, norms, and values; language background; characteristics of the hospitals implementing the program,

characteristics of the community in which the program is being implemented, including social factors, such as cultural norms and values; and bureaucratic factors, such as laws, regulations, or policies. This process will be modified and adapted by local experts of the three selected countries.

Once the adapted program model will be finalized, the materials for implementing the program will be revised and piloted with 10 health care professionals.

**3) Implementation:** The training will be offered within the participant hospitals for 6 months. Several activities will plan to increase the quality of the implementation process including: launching internal communication of the training; asking for collaboration among departments, leaders, and staff; allocating time for the education; motivate, instruct and reward staff; and monitoring the implementation process. An “implementation pack” will be prepared to facilitate the work of the local coordinators whilst the carrying out of the process.

**4) Dissemination Theoretical Framework:** The dissemination plan follows Roger’s Diffusion of Innovations theory. Rogers described diffusion of innovations as the process by which an innovation is communicated through certain channels over the time among members of a social system (36). Once tested in each hospital the next step will be to disseminate the training program to other hospitals in the same country and to other countries in the LAC region, based on the success of the pilot experience.

**Participants and primary audience:** The program will target three hospitals, one in each of the following low-income LAC countries: Bolivia, Guatemala and Paraguay. All health providers in the selected hospitals, including nurses, doctors and other health professionals, will be trained. Therefore, there are two units of participation, hospitals and health professionals from each organization. Each participant hospital will report the number of health professionals, beds, units, level of attention (high technology, general, basic) and degree of commitment and development of tobacco control measures in the hospitals before launching the online training program.

**B.2.2. Evaluation Design:** Process and Outcome evaluation are planned

#### **B.2.2.1. Process Evaluation**

The **process evaluation** will assess the adoption, implementation and maintenance of the training program. We will measure the program coverage, the compliance, the fidelity with the training program, the usage of the materials and the satisfaction with the training. We will use qualitative and quantitative methods to gather this information.

**Indicators** linked to the performance of the program:

- Number of participants (absolute and % to total target of health care professionals).
- Characteristics of the participants (profession, units, gender, age).
- Number of hours devoted to the training program.
- Program performance/Fidelity to the curriculum plan (whether the students completed all the modules, the exercises as planned).
- Service utilization or dosage use of the training (time applied for undertaking the course, number of downloads of the materials, etc.).
- Opinions, experience, perceptions, satisfaction with the training course (online survey after training and in depth interviews with selected participants).



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**Evaluation Design & Methods:** both qualitative and quantitative research methods will be used in process evaluation to gather the indicators mentioned above. The following list presents the strategies to collect process level information:

- Interviews: we will use structured questionnaires with open-ended questions to know their opinions, experiences, perceptions, satisfaction regarding the smoking cessation training.
- Focus groups: using key informants; we will use semi- structured interviews. Data will be taped and transcribed for qualitative analysis.
- Survey: post evaluation survey to all the participants about their level of satisfaction with the course, attractiveness of the materials and perceived usefulness.
- Review of the records of the online training program.

**Analysis plan:** For quantitative indicators we will use descriptive statistics. Quantitative variables will be summarized by using means and other of central tendency and qualitative data will be summarized by computing their frequencies and percentages. The qualitative indicators from focus groups and interviews will be summarized by using the classical content analysis approach (creating codes and chunk of information and the researcher complements the codes with description of this code). Findings will be validated by informants to increase the reliability of the data (37).

#### **B.2.2.2. Outcome Evaluation**

The **outcome evaluation** will measure short and intermediate outcomes measuring the impact of the “Brief Intervention for Smoking Cessation” training program within the participant hospitals.

**Evaluation Design & Methods:** Pre-post evaluation by using the same sources to gather data before (baseline) and after the training (6 months after offering the training program)

- Level of implementation of tobacco control policies within the participant hospitals before and after the training by means of the Self Audit Questionnaire (Tool 1).
- Health professionals’ attitudes, knowledge and behaviors before and after the training using a questionnaire (Tool 2).

**Tools (T). T1:** To assess changes in tobacco control polices implemented within hospitals we will use the Self Audit Questionnaire (ENSH-SAQ) (31). The SAQ was developed for the ENSH-Global Network for Tobacco Healthcare Services ([www.ensh.eu](http://www.ensh.eu)). The questionnaire is composed of 10 policy standards and each standard contains a number of items for its definition: commitment (6 items), communication (4 items), education and training (4 items), identification and cessation support (8 items), tobacco control (5 items), environment (6 items), healthy workplace (5 items), health promotion (1 item), compliance monitoring (2 item), and policy implementation (1 item). Each item is scored as follows: 1=not implemented, 2=less than half of the aspects are implemented, 3= more than half are implemented, 4= fully implemented. The maximum score of the ENSH-SAQ is 168 points, as the sum of its 10 standards (31). At baseline, the SAQ provides information of the tobacco control policies undertaken within the organization. Once used to monitor the project, the instrument detects the fulfilled standards and the areas for improvement.

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**T2:** Trainers' attitudes, knowledge and behaviors will be assessed by means of a questionnaire composed by 63-items. The questionnaire has been designed according to Sheffer work (annex 2) (38). It gathers information about the provider gender, tobacco use history, previous tobacco cessation education, level of proactivity addressing tobacco use, and perceived success in helping patients stop using tobacco (38). Perceived knowledge and attitudes about treatment of tobacco use assessed including levels of: 1) motivation, 2) knowledge of tobacco cessation, 3) self-efficacy, 4) importance of providing tobacco use interventions, 5) effectiveness of interventions, 6) importance of barriers, 7) preparation, and 8) level of tobacco cessation intervention provided (assessed by the 5A's model). All items are assessed on a discrete scale of 0-10 with 0 being "none or not at all" and 10 being "the most possible". The pre-test will be administered immediately before the training. Post-training assessment is composed by a 37-item questionnaire assessing providers' knowledge, attitudes and behaviors as assessed in the pre-test. The post-test will be administered 6 months after the training.

**Analysis plan:** Usual statistics will be used to describe the sample and t-test for paired samples will be used for pre -post comparisons for tobacco control policies (measured by T1) and the trainees' knowledge, attitudes and behaviors (measured by the T2). Multivariate models to assess the combined effects of multiple variables will be used. The specific model will be selected according to the nature of the dependent variable.

**B.2.3. Expected amount of change after offering the training:** We will consider a good level of coverage of the training program if at least 60% of the health professionals in each hospital conclude the training program. We will measure the engagement of the training program with the focus groups and key informants interviews. Furthermore, we anticipate that hospitals will increase between 20-30% their tobacco control policies according to the ENSH-SAQ. In addition, we anticipate that health professionals' level of knowledge, attitudes and perception in tobacco cessation will increase between 30-40%.

**B.2.3.4 Dissemination plan:** Our results are oriented to gain scientific evidence on the effectiveness of a "Brief intervention smoking cessation" training program for Spanish-speaking health professionals in low and medium income countries LAC. Our findings will determine whether: 1) the proposed training increases hospitals' implementation and engagement with tobacco control policies, and 2) health professionals' increase their knowledge, attitudes and behaviors in tobacco cessation.

With this approach, we ultimately seek to increase the level of tobacco cessation services offered and decrease smoking rates in LAC countries.

With these results, policymakers, regulators, and administrators will have a sophisticated view of the impact of training offered within the hospital level to health professionals. In addition, results may demonstrate the feasibility of transfer this training course to other hospitals among the participant countries and to other LAC countries.

**Dissemination products:** We will make all the information related to the project (design, results for health professionals, results for the public, and core materials), available in an ad hoc website. In addition, we will write a newsletter and a policy brief with the results of the study both in English and Spanish. This document will be sent to governments, health organizations, and NGOs. To reach policy audiences, we will use our membership with the

GlobalBridges, the GlobalNetwork of Tobacco free Health Care Services and some of the most notorious South American and International Scientific Societies devoted to Non-Communicable Diseases (e.g, World Health Federation, the Union for International Cancer Control, and so on). We will present the training program and the experience of how to “Develop new healthcare professional training programs based on evidence and best practice” at the WCToH 2015.

As part of the dissemination strategy, the team will write two or three papers (on the development of the course, the evaluation of the before-after changes in outcomes) that will be submitted to journals in the first quartile of the following areas: public health, health education, and hospital administration. It is worth mentioning that our team has a long track of publications in international journals and some of the members (E. Fernandez and C. Martinez) have recognized experienced in tobacco control evaluation in hospitals.

#### **B.2.3.5. How our project relates and leverages with the GlobalBridges Community**

Other capacity building initiatives to improve smoking cessation training have been launched in LAC countries with the support of GlobalBridges and Pfizer (39). For instance, the “Health care alliance for tobacco dependence treatment”, which purpose is developing a network of health care professionals to effectively address the tobacco pandemic, has worked intensively in raising the awareness and getting the commitment of professionals and organizations in this relevant issue.

Our proposal complements and enriches the existing initiatives held by GlobalBriges in LAC countries by adapting and testing a six-hour online smoking cessation training course for health care providers. By means of our training program we will test for the first time an online training program for Spanish-speaking health providers in LAC countries. Results should demonstrate the feasibility of this training model across a variety of countries and the capacity of increasing tobacco cessation interventions and services. Ultimately, this research is intended to develop a tobacco cessation program to be offered to Spanish-speaking countries.

#### **Confidentiality and ethics:**

Approval from the Research Ethics Committee of each of the participant institutions will be sought.

#### **B.3. Work plan and Deliverables Schedule:**

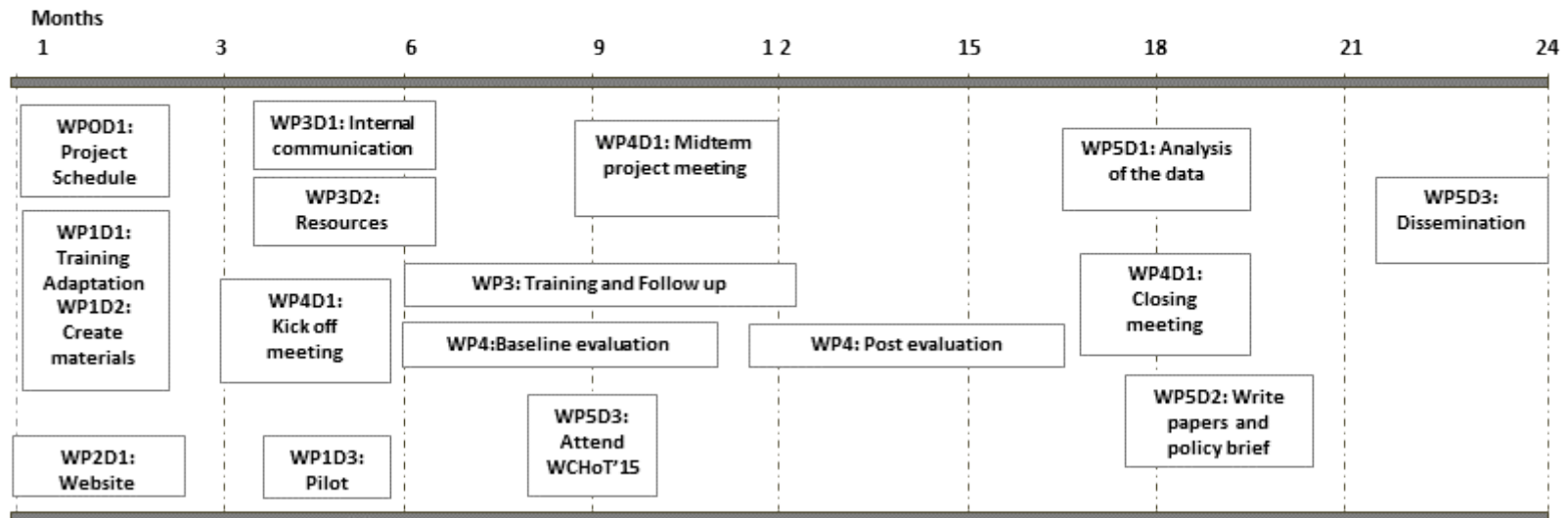
Appended there is a planning timeline (Figure 1) and a scheme (Table 1) of how the wok packages (WP), deliverables (DEL) and tasks (T) are planned, as well as the timetable for carrying out the project.

Development and Dissemination of a Tobacco Cessation Training Program for  
Healthcare Professionals in Spanish-speaking Countries

**Table 1: Work plan and Deliverables Schedule:**

		Start (S) Ends (E)
<b>WP0: Project Management:</b> Overall coordination and synchronization of the project activities		
<b>D1: Project Schedule:</b> providing the coordinators with a good understanding of the tasks to be completed the timeframes	<b>T1:</b> Review the workload of the different phases <b>T2:</b> Write a detailed document with all the tasks, requirements, and timeframe <b>T3:</b> Kick off in person meeting in Guatemala	10/01/14 S:M1 E:M2
<b>WP1: Adaptation of the training:</b> Adapt and calibrate the content of the course to the LAC region		
<b>D1: Adaptation of the training</b> Study the requirements and how to adapt the original course materials	<b>T1:</b> Review the content, materials, by the expert local experts <b>T2:</b> Study the basic cultural and lingual differences in the target audience <b>T3:</b> Recommend the required changes	S:M1 E:M2
<b>D2: Create the educational materials</b> including online course, booklets, readings	<b>T1:</b> Select, create, review the contents <b>T2:</b> Print the materials and make them available (physically and online: website)	S:M2 E:M3
<b>D3: Pilot testing of the training</b>	<b>T1:</b> Test the adapt curricula with 5 or 10 volunteers in each hospital <b>T2:</b> Evaluate the educational and pedagogical impact of the training <b>T3:</b> Evaluate the adequacy of the examples, texts, cases, materials, etc	S:M4 E:M5
<b>WP2: Creation of the website of the training program</b>		
<b>D1: Development of the website</b>	<b>T1:</b> Select, create, review the contents <b>T2:</b> Create the site diagram and navigation	S:M1 E:M2
<b>WP3: Launching and Offering of the training:</b> Overall activities related to the launching		
<b>D1: Internal communication of the project:</b>	<b>T1:</b> Inform to managers and heads about the training project <b>T2:</b> Inform all members of the hospitals through different communication channels (intranet, email, sessions) about the training course <b>T3:</b> Provide and make available the names and contacts of the coordinators <b>T4:</b> Create project champions in each unit	S:M1 E:M3
<b>D2: Resources and access to the equipment necessary</b>	<b>T1:</b> Dispose of computers in the centers with online connection <b>T2:</b> Provide accessibility to all the staff	S:M1 E:M3
<b>D3: Implementation Plan</b>	<b>T1:</b> Target health professionals <b>T2:</b> Engender champions/leaders of the project <b>T3:</b> Monitor every 4 weeks the number of trainees <b>T4:</b> Reoffer to non-participants every 2 weeks <b>T5:</b> Create working sessions with the trainees <b>T6:</b> Follow up online monthly executive team meetings	S:M6 E:M12
<b>WP4: Follow up and Evaluation of the training</b>		
<b>D1: Follow up</b>	<b>T1:</b> Follow up online monthly executive team meetings <b>T2:</b> In person meetings (Kick off M 1, Midterm M9, Closing M18)	S:M1 E:M24
<b>D2: Quantitative research: Pre-post survey</b>	<b>T1:</b> Baseline evaluation of tobacco control polices (T1) and knowledge, attitudes and behaviors of health professionals on tobacco (T2) <b>T2:</b> Post training evaluation after 6 months of the training <b>T3:</b> Evaluate clinical records	S:M6 E:M18
<b>D3: Qualitative research</b>	<b>T1:</b> Conduct focus group <b>T2:</b> In depth interviews (evaluate satisfaction, applicability, transferability to other hospitals/countries)	S:M12 E:M18
<b>WP5: Dissemination of the findings and the conclusions</b>		
<b>D1: Publish 2 or 3 papers</b>	<b>T1:</b> Analyze data and select main results <b>T2:</b> In person meeting in Bolivia to conclude and reach the conclusions <b>T3:</b> Write manuscripts and submit them to journals	S:M18 E:M24
<b>D2: Publish policy brief, emails, newsletter</b>	<b>T1:</b> Write and disseminate the findings among the stakeholders, hospital managers, administrator, politicians of the LAC by using different channels <b>T2:</b> Hold a symposium presenting the results and inviting potential key stakeholders (politicians, responsible for NGOs, Health Organizations, and so on)	S:M22 E:M24 10/01/16
<b>D3: Communicate the training program at the WCToH 2015</b>	<b>T1:</b> Present the training program and the experience of how to “Develop new healthcare professional training programs based on evidence and best practice” at the WCToH 2015 <b>T2:</b> Network with LAC representative	M7

Figure 1: Event Planning Timeline



Notes: Wok packages (WP), Deliverables (DEL) and Tasks (T)

**G.OTHER MATERIALS****G1. References:**

- (1) Mayor S. Tobacco atlas illustrates shift to low income countries. *BMJ* 2009 Mar 10;338:b981.
- (2) Muller F, Wehbe L. Smoking and smoking cessation in Latin America: a review of the current situation and available treatments. *Int J Chron Obstruct Pulmon Dis* 2008;3(2):285-293.
- (3) Tong VT, Turcios-Ruiz RM, Dietz PM, England LJ. Patterns and predictors of current cigarette smoking in women and men of reproductive age-Ecuador, El Salvador, Guatemala, and Honduras. *Rev Panam Salud Publica* 2011 Sep;30(3):240-247.
- (4) Organización Panamericana de la Salud. Informe sobre Control del Tabaco para la Región de las Américas. Washington, , 2013. DC : OPS 2014.
- (5) Ponciano-Rodriguez G. The urgent need to change the current medical approach on tobacco cessation in Latin America. *Salud Publica Mex* 2010;52 Suppl 2:S366-72.
- (6) WHO. Health Indicator. 20/01/2011; Available at: <https://apps.who.int/infobase/Indicators.aspx>. Accessed 01/03/2014, 2017.
- (7) WHO Tobacco Free Initiative. 2012 global progress report on implementation of the WHO Framework Convention on Tobacco Control. 2012.
- (8) World Health Organization. WHO Report of the Global Tobacco Epidemic, 2008: the MPOWER 2008.
- (9) Duffy SA, Scholten RL, Karvonen-Gutierrez CA. The relation of tobacco use during hospitalization to post-discharge smoking cessation among US veterans. *Prev Med* 2010 May-Jun;50(5-6):285-287.
- (10) Zack E. Smoking withdrawal and prolonged hospitalization. *Clin J Oncol Nurs* 2002 Jan-Feb;6(1):7-11.
- (11) Toll BA, Rojewski AM, Duncan LR, Latimer-Cheung AE, Fucito LM, Boyer JL, et al. "Quitting smoking will benefit your health": the evolution of clinician messaging to encourage tobacco cessation. *Clin Cancer Res* 2014 Jan 15;20(2):301-309.
- (12) Abdullah AS, Stillman FA, Yang L, Luo H, Zhang Z, Samet JM. Tobacco use and smoking cessation practices among physicians in developing countries: a literature review (1987-2010). *Int J Environ Res Public Health* 2013 Dec 30;11(1):429-455.
- (13) Smith DR, Leggat PA. An international review of tobacco smoking in the medical profession: 1974-2004. *BMC Public Health* 2007 Jun 20;7:115.
- (14) Bello S, Soto M, Michalland S, Salinas J. A national survey on smoking habit among health care workers in Chile. *Rev Med Chil* 2004 Feb;132(2):223-232.
- (15) Pfizer. SUPPORT(Smoking Understanding People's Perceptions. Opinions and Reactions to Tobacco) and STOP (Smoking: the Opinion of Physicians) studies. 2007.
- (16) Rigotti NA, Clair C, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients. *Cochrane Database Syst Rev* 2012 May 16;5:CD001837.
- (17) Carson KV, Verbiest ME, Crone MR, Brinn MP, Esterman AJ, Assendelft WJ, et al. Training health professionals in smoking cessation. *Cochrane Database Syst Rev* 2012 May 16;5:CD000214.
- (18) Hung DY, Leidig R, Shelley DR. What's in a setting?: Influence of organizational culture on provider adherence to clinical guidelines for treating tobacco use. *Health Care Manage Rev* 2013 Apr 30.
- (19) Knudsen HK, Muilenburg J, Eby LT. Sustainment of Smoking Cessation Programs in Substance Use Disorder Treatment Organizations. *Nicotine Tob Res* 2012 Nov 6.

Development and Dissemination of a Tobacco Cessation Training Program for  
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- (20) Campbell S, Pieters K, Mullen KA, Reece R, Reid RD. Examining sustainability in a hospital setting: Case of smoking cessation. *Implement Sci* 2011 Sep 14;6:108-5908-6-108.
- (21) Aggarwal R, Gupte N, Kass N, Taylor H, Ali J, Bhan A, et al. A comparison of online versus on-site training in health research methodology: a randomized study. *BMC Med Educ* 2011 Jun 17;11:37-6920-11-37.
- (22) Abutarbush SM, Naylor JM, Parchoma G, D'Eon M, Petrie L, Carruthers T. Evaluation of traditional instruction versus a self-learning computer module in teaching veterinary students how to pass a nasogastric tube in the horse. *J Vet Med Educ* 2006 Fall;33(3):447-454.
- (23) Gordon JS, Mahabee-Gittens EM, Andrews JA, Christiansen SM, Byron DJ. A randomized clinical trial of a web-based tobacco cessation education program. *Pediatrics* 2013 Feb;131(2):e455-62.
- (24) Schmelz AN, Nixon B, McDaniel A, Hudmon KS, Zillich AJ. Evaluation of an online tobacco cessation course for health professions students. *Am J Pharm Educ* 2010 Mar 10;74(2):36.
- (25) Fiore MC, Baker TB. Clinical practice. Treating smokers in the health care setting. *N Engl J Med* 2011 Sep 29;365(13):1222-1231.
- (26) West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. *Health Education Authority. Thorax* 2000 Dec;55(12):987-999.
- (27) Trinite T, Loveland-Cherry C, Marion L. The U.S. Preventive Services Task Force: an evidence-based prevention resource for nurse practitioners. *J Am Acad Nurse Pract* 2009 Jun;21(6):301-306.
- (28) Lancaster T, Silagy C, Fowler G. Training health professionals in smoking cessation. *Cochrane Rev* 2000;(3)(3):CD000214.
- (29) Fiore MC, Jaén CR, Baker TB. Treating Tobacco Use and Dependence: 2008 Update. May 2008.
- (30) Camarrelles Guillem F, Dalmau González-Gallarza R, Clemente Jiménez L, Díaz-Maroto Muñoz JL, Lozano Polo A, Pinet Ogué MC. Documento de consenso para la atención clínica al tabaquismo en España. *Medicina Clínica* 2013 3/16;140(6):272.e1-272.e12.
- (31) Martinez C, Fu M, Martinez-Sanchez JM, Ballbe M, Puig M, Garcia M, et al. Tobacco control policies in hospitals before and after the implementation of a national smoking ban in Catalonia, Spain. *BMC Public Health* 2009 May 28;9:160.
- (32) Ouranou A. Self-audit process and results from preliminar experiences of the ENSH memers. *European Network Smoke free Hospitals Newsletter* 2003;8:4-5.
- (33) Martinez C, Garcia M, Mendez E, Peris M, Fernandez E. Barriers and challenges for tobacco control in a smoke-free hospital. *Cancer Nurs* 2008 Mar-Apr;31(2):88-94.
- (34) Sarna L, Bialous S, Barbeau E, McLellan D. Strategies to implement tobacco control policy and advocacy initiatives. *Crit Care Nurs Clin North Am* 2006 Mar;18(1):113-22, xiii.
- (35) Card JJ, Solomon J, Cunningham SD. How to adapt effective programs for use in new contexts. *Health Promot Pract* 2011 Jan;12(1):25-35.
- (36) Rogers EM. Diffusion of innovations. 5th ed. New York: Free Press; 2003.
- (37) Morgan DL. Reconsidering the role of interaction in analyzing and reporting focus groups. *Qual Health Res* 2010 May;20(5):718-72

(38) Sheffer CE, Barone CP, Anders ME. Training health care providers in the treatment of tobacco use and dependence: pre- and post-training results. *J Eval Clin Pract* 2009 Aug;15(4):607-613.

(39) Zabert G.E y Sansores R.H. El control y el Tratamiento del Tabaquismo en Latinoamerica. In: Jimenez-Ruiz, editor. *Tratado de Tabaquismo*. 3rd ed.: Aula Medica; 2011. p. 525.



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**G2. Annexes****Annex 1: Tobacco cessation program contents**

<b>Online course</b> (as explained on page 5)
<b>Pocket guides and online materials</b>
<ul style="list-style-type: none"><li>• Based on the 5As counselling model to guide provider' intervention</li><li>• Brief summary of the pharmaceutical <b>indications</b></li></ul>
<b>Electronic medical record system</b>
<ul style="list-style-type: none"><li>• Use of medical record systems to trigger providers to assess and treat smoking</li></ul>
<b>Organizational recommendations to achieve a tobacco control Cultural change</b>
<ul style="list-style-type: none"><li>• Train all front-line providers about smoking cessation</li><li>• Provide a culture of care which supports smoking cessation</li><li>• Include smoking cessation protocols</li><li>• Offer treatment at all points of care, but especially during teachable moment such as immediately after diagnosis</li></ul>

## Annex 2: Trainers' attitudes, knowledge and behaviors survey

### I Datos socio demográficos

1. Fecha de nacimiento: |\_\_|\_\_| día |\_\_|\_\_| mes |\_\_|\_\_|\_\_|\_\_| año

2. Sexo:  1. Mujer  2. Hombre

3. ¿A qué colectivo pertenece?

1. Médico

2. Enfermería **ESPECIFICAR**  2.1. Grado/Diplomatura  2.2. Auxiliar

3. Psicólogo/a

4. Otros (especificar:.....).

4. ¿Cuántos años lleva ejerciendo en su profesión? |\_\_\_\_| años

5. Actualmente, ¿usted fuma?

1. Sí, fumo diariamente

2. Sí, fumo ocasionalmente

3. No, no nunca he fumado (pase a la pregunta 7)

4. No, soy ex fumador/a (pase a la pregunta 7)

6. ¿Cuántos cigarrillos (manufacturados y/o de liar) fuma al día? |\_\_\_\_| cigarrillos

7. ¿En qué tipo de organización trabaja?

1. Pública (XHUP y/o ICS)

2. Privada

3. Otros (especificar:.....).

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**8.** De los siguientes tipos de centros sanitarios, ¿usted trabaja en...?

- 1. Centro hospitalario
- 2. Centro de atención primaria (pase a pregunta 11)
- 3. Centro socio-sanitario (pase a pregunta 11)
- 4. No, no trabajo (pase a pregunta 11)
- 5. Otros (especificar:.....) (pase a 11)

**9.** ¿En qué tipo de hospital trabaja de acuerdo a la clasificación del *Servei Català de la Salut*?

- 1. Hospital de alta tecnología
- 2. Hospital de referencia
- 3. Hospital general básico
- 4. Hospital básico aislado o complementario

**10.** ¿En cuáles de las siguientes unidades trabaja en el hospital? [Respuesta múltiple si es necesario]

- 1. Unidad de hospitalización
- 2. Consultas externas
- 3. Consultas o unidades especializadas
- 4. Quirófano
- 5. Urgencias
- 6. Otras (especificar:.....)

**11.** De las siguientes áreas, ¿cuál es la que mejor define su trabajo? [Escoger sólo una respuesta]

- 1. Asistencia
- 2. Gestión/Administración
- 3. Investigación
- 4. Docencia
- 5. Otras (especificar:.....)

## II Formación previa

**12.** ¿Ha realizado formación previa para ayudar a dejar de fumar?

- 1. Sí
- 2. No (pasar a la pregunta 15)

**13.** Indique si ha recibido formación para ayudar de dejar de fumar en cada una de estas posibilidades (mediante una x) y en tal caso indique el número de horas lectivas recibidas. [Respuesta múltiple]

- Formación incluida en el currículum del grado/diplomatura/licenciatura. Especificar el n horas [.....]
- Formación incluida en formación de máster/posgrados. Especificar el n horas [.....]
- Formación incluida en otros cursos formación continuada. Especificar el n horas [.....]

**14.** Tipo de metodología que incluían los cursos que ha realizado [Respuesta múltiple]

- Sólo teórica presencial.
- Sólo práctica presencial.
- Teórico-práctica presencial
- Sólo virtual teórica
- Sólo virtual práctica
- Sólo virtual práctica y teórica
- Otros (especificar:.....)

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**III Conocimientos, actitudes y habilidades**

Por favor puntúe cada pregunta o planeamiento <b>SELECCIONANDO</b> el círculo que contenga el número más adecuado de acuerdo a su respuesta	<b>0 = No, Absoluto</b>										
	<b>Nunca</b>					<b>10=</b>					
	<b>Nada</b>					<b>Completamente</b>					
						<b>Siempre</b>					
						<b>Mucho</b>					
	0	1	2	3	4	5	6	7	8	9	10
<b>15.</b> Nivel de conocimientos en el manejo de la intervención para											
<b>16.</b> Grado de motivación para ayudar a sus pacientes a dejar de fumar											
<b>17.</b> Grado de importancia que para usted tiene la ayuda para dejar de fumar en su trabajo											
<b>18.</b> Grado de facilidad para superar las dificultades que puede experimentar cuando ayuda a sus pacientes a dejar de fumar											
<b>19.</b> Grado de seguridad que posee en su habilidad para ayudar a los pacientes a dejar de fumar											
<b>20.</b> Grado de preparación que tiene para ofrecer ayuda para dejar de fumar											
<b>21.</b> Para usted ¿Qué efectividad tienen los tratamientos para dejar de fumar?											
<b>22.</b> Frecuencia en que necesita personal y/o recursos adicionales para ofrecer ayuda para dejar de fumar en su práctica											
<b>23.</b> Grado de preparación que usted tiene en recomendar tratamiento farmacológico para dejar de fumar (sustitutivos de nicotina, bupropion, vareniclina)											
<b>24.</b> Grado de competencia que usted tiene en aconsejar de forma eficaz a sus pacientes fumadores a dejar de fumar											
<b>25.</b> Grado de seguridad que siente cuando usted trata elementos de la motivación del paciente para dejar de fumar											
<b>26.</b> Frecuencia en la que ve los efectos del uso del tabaco en la salud de sus pacientes											

## IV Actividad

Por favor puntúe cada pregunta SELECCIONANDO el círculo que contenga el número más adecuado de acuerdo a su respuesta	0 =Nunca/ Nada 10=Siempre/Completamente									
27. ¿Con qué frecuencia usted <b>PREGUNTA Y DOCUMENTA</b> el consumo de tabaco de sus pacientes?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
28. ¿Con qué frecuencia usted <b>ACONSEJA</b> dejar de fumar a sus pacientes?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
29. ¿Con qué frecuencia <b>VALORA</b> el deseo de sus pacientes para dejar de fumar?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
30. ¿Con qué frecuencia <b>AYUDA</b> a sus pacientes a dejar de fumar (usando estrategias o técnicas para propiciar el cambio, estableciendo un día para dejar de fumar y/o mediante el uso de medicamentos)?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
31. ¿Con qué frecuencia <b>RECOMIENDA/INDICA medicación para dejar de fumar</b> como tratamiento sustitutivo de nicotina, bupropion o vareniclina a sus pacientes?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
32. ¿Con qué frecuencia <b>OFRECE SEGUIMIENTO</b> a los pacientes como parte de la intervención para dejar de fumar mediante la programación de visitas sucesivas, derivando a otros profesionales, enviando una carta o recordatorio por correo, o	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
33. ¿Con qué frecuencia usted <b>REALIZA EL SEGUIMIENTO</b> de los pacientes que han iniciado un tratamiento para dejar de fumar con usted?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
34. ¿Con qué frecuencia usted <b>OFRECE SEGUIMIENTO</b> a los pacientes que han dejado de fumar con usted mediante derivación a otros profesionales o unidades?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
35. ¿Cómo de familiarizado está con las guías de práctica clínica para dejar de fumar? (Ejemplos: SEPAR, SEMFIC, etc...).	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
36. ¿Cómo de familiarizado está en recomendar a sus pacientes el uso de recursos como: “quitlines”, sistemas de ayuda por teléfono o por Internet para recibir un soporte extra durante el proceso de dejar de fumar	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
37. ¿En qué medida desea más formación para ayudar a sus pacientes a dejar de fumar?	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

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**IV Barreras**

Por favor puntúe cada pregunta SELECCIONANDO el acuerdo o desacuerdo con las siguientes afirmaciones sobre las DIFICULTADES o BARRERAS que le impiden ayudar a los pacientes a dejar de fumar.	0 = Totalmente desacuerdo de acuerdo										10= Totalmente en desacuerdo											
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
38. No es parte de mi trabajo o rol profesional	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
37. No es requerido por mis superiores (dirección, supervisión, jefe de servicio, etc).	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
38. No ayudo a mis pacientes a dejar de fumar porque mis compañeros no realizan esta actividad	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
39. Falta de tiempo para realizar la actividad	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
40. Tengo sobrecarga en el resto de mis responsabilidades durante mi jornada laboral	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
41. Falta de reconocimiento o compensación por la tarea realizada	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
42. No es una tarea protocolizada en mi organización	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
43. Faltan recursos farmacológicos a ofrecer en mi lugar de trabajo	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
44. Faltan de registros para el correcto seguimiento/control de esta intervención en mi organización	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
45. Falta de confianza en la efectividad de la ayuda que puedo ofrecer para dejar de fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
46. Creo que el paciente no está motivado o interesado	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
47. Creo que invado la privacidad del paciente	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
48. Creo que para mis pacientes dejar de fumar no es relevante	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
49. En mi opinión, no hay beneficios para la salud para mis pacientes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
50. Falta de conocimientos y habilidades adecuadas sobre cómo ayudar a mis pacientes a dejar de fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
51. Creo que mis pacientes se pueden sentir culpables por fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
52. Considero que no hay beneficio para mis pacientes que tienen mal pronóstico.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
53. Considero que puede aumentar el estrés de mis pacientes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
54. Otros (especificar:----- -----)	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

**V Oportunidades**

Por favor puntúe cada pregunta SELECCIONANDO el acuerdo o desacuerdo con las siguientes afirmaciones sobre LOS FACTORES que le MOTIVAN a ayudar a los pacientes a dejar de fumar	0 = Totalmente desacuerdo										10= Totalmente en acuerdo											
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
55. Es parte de mi trabajo y mi rol	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
56. Está protocolizado en mi centro de trabajo	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
52. Es requerido por mis superiores (dirección, supervisión, jefes de servicio, etc)	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
53. Cuento con apoyo organizativo en mi centro de trabajo para realizar la intervención	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
54. Cuento con tiempo suficiente para ayudar a mis pacientes a dejar de fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
55. He tenido experiencias gratificantes y/o exitosas con otros pacientes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
56. Confianza en la habilidad de las personas para dejar de fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
57. Recibo reconocimiento/ recompensa por el esfuerzo realizado por parte de mis superiores/de la organización	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
58. Considero que beneficia la salud de mis pacientes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
59. Los pacientes desean dejar de fumar	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
62. Considero que abandono disminuirá las recaídas y/o reagudizaciones de las enfermedades de mis pacientes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
63. Otros (especificar:.....)	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10