Quit and Win campaigns as a long-term anti-smoking intervention in North Karelia and other parts of Finland

Tellervo Korhonen, Eeva-Liisa Urjanheimo, Paula Mannonen, Heikki J Korhonen, Antti Uutela, Pekka Puska

Abstract

Objective—To evaluate Quit and Win campaigns repeated in North Karelia and rest of Finland.

Design—Repeated comparisons of participation rates, abstinence rates, and other measures between North Karelia and the rest of Finland.

Subjects—Adult daily smokers in Finland participating in the Quit and Win contests in 1986–1997.

Interventions—Quit and Win smoking cessation campaigns targeted at adult daily smokers throughout Finland in 1986, 1989, 1994, 1996, and 1997, including more intensive activities in North Karelia.

Main outcome measures—Participation rates, self reported six-month abstinence rates, other effectiveness measures (% of smokers who attended, intended, tried, and succeeded in cessation).

Results—North Karelia’s participation rates were significantly higher in each campaign compared with the rest of Finland. The abstinence rates in North Karelia were also higher, the difference being significant in 1986 and 1994 (p<0.05). In the target population in 1996 over 75% of smokers in North Karelia, compared with 40% of smokers surveyed elsewhere, reported awareness of the campaign (p<0.001). Approximately 9% of the smokers in North Karelia and 6% elsewhere intended to participate (p = NS). Over 2% in North Karelia, compared with less than 1% elsewhere, tried to quit (p<0.001). Among the targeted group, 0.3% of North Karelian smokers were complete abstainers throughout the 12 months of follow up, compared with an average of 0.1% in other areas (p<0.001).

Conclusions—The Quit and Win campaign is a feasible cessation method in long-term community-wide programmes. Intensified community activities are associated with higher success. In repeat campaigns, high participation and abstinence rates can be maintained.

(Tobacco Control 1999;8:175–181)

Keywords: smoking cessation, Quit and Win, community intervention

Introduction

The North Karelia project was launched in 1972 to develop and to evaluate a community programme that would reduce the high rates of cardiovascular disease in North Karelia, an eastern Finnish province. Reducing the high smoking rate among men was one of the main instruments. After the first five years, the project’s findings were applied nationwide. The original project was continued as a demonstration and as part of the World Health Organisation/CINDI programme. The project’s anti-smoking programme has used comprehensive and novel strategies. On the national level it has contributed to major policy reforms. Population surveys indicate a reduction of smoking among 30–59 year old men in North Karelia from 52% in 1972 to 32% in 1992. This decrease, which continued after 1992, is somewhat greater than that seen in other parts of Finland. Comparing the periods 1969–71 and 1995, the age-adjusted morality rate of coronary heart disease among 35–64 year old males has decreased by 73%. The same population also showed a 71% decrease in lung cancer. The sizeable reduction in smoking can be seen as one cause for these declines.

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international campaign was organised in 1996 with 25 participating countries. In both years an intensified campaign was organised in North Karelia. The most recent campaign was a national contest in 1997, combined with a supporter contest.

The Quit and Win model for smoking cessation has been used in other European countries—for example, the United Kingdom and Sweden—and in other parts of the world such as Australia and Japan. Although the cessation rates for Quit and Win contests have not been as high as the ones for clinical cessation methods, such campaigns offer important advantages: contests tend to draw widespread attention and to recruit high numbers of smokers in the population, resulting in large numbers of successful quitters. The number of quitters depends on the recruitment rate and the cessation rate. Since the cessation rate is likely to vary less than the recruitment rate, the latter is of particular interest in planning and evaluation.

Concerning cost-effectiveness, the Quit and Win contest compares favourably with many preventive and treatment programmes. Further, it has been suggested that the efficiency could be improved if mass media and community strategies were combined.

### Table 1 Quit and Win campaigns in North Karelia and all Finland

<table>
<thead>
<tr>
<th>Year</th>
<th>Regional in North Karelia</th>
<th>National in all Finland</th>
<th>Other countries</th>
<th>Supporters' contest included</th>
<th>Television programme included</th>
<th>Radio programme included</th>
<th>Number of participants</th>
</tr>
</thead>
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<tr>
<td>1985</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>250</td>
</tr>
<tr>
<td>1986</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>991</td>
</tr>
<tr>
<td>1989</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (Estonia)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>524</td>
</tr>
<tr>
<td>1991</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>530</td>
<td>5261</td>
</tr>
<tr>
<td>1994</td>
<td>Yes</td>
<td>Yes</td>
<td>(12 others)</td>
<td>No</td>
<td>No</td>
<td>618</td>
<td>NA</td>
</tr>
<tr>
<td>1995</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>55</td>
<td>NA</td>
</tr>
<tr>
<td>1996</td>
<td>Yes</td>
<td>Yes</td>
<td>(24 others)</td>
<td>No</td>
<td>No</td>
<td>601</td>
<td>6038</td>
</tr>
<tr>
<td>1997</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>985</td>
</tr>
</tbody>
</table>

*As part of a local cholesterol awareness campaign. NA = not applicable.

The Quit and Win model for smoking cessation was introduced to Finland in 1985. The first campaign in 1985–89 was responsible for the national Quit and Win campaign in 1994, 1996, and 1997. These campaigns were organised within the framework of Smoke Free Finland, a loose network of many health organisations including the Finnish Cancer Society, Finnish Heart Association, Association for the Pulmonary Disabled, Public Health Association Folkhälsan, and the North Karelia project. The organisations used their own media channels, but newspapers and magazines also featured the events, and short information spots were televised.

For the three latest contests the main recruiting tool was a leaflet describing the contest and its rules. Over 500 000 copies were distributed nationwide through outlets such as health services, petrol (gas) stations, pharmacies, and local organisations participating in the campaign. The leaflet included a postage-paid registration form. Several thousand posters were also distributed.

Role models were used to promote participation and the benefits of cessation. For example, the campaign for the second national contest organised jointly by Finland and Estonia in 1989 included a television series that was broadcast in both countries on the same days but at different times. The series featured eight volunteers who smoked from both countries meeting in a group that included two experts and discussing how to stop smoking. The Finnish group was from North Karelia only. To draw people’s attention to the television series and to the contest, these events were nationally publicised through newspapers and printed material. The beginning of the national smoking cessation contest was organised to coincide with the television programme. Television broadcasts and printed media invited all daily smokers aged 16 or older in both countries to participate in the contest.

In 1989 and 1997 Quit and Win was combined with a supporters’ contest. The support could be a non-smoker, ex-smoker, or current smoker of any age, professional or lay person. The main idea behind the supporter’s contest was to spread information and entry forms more effectively, to offer non-smokers the chance to participate and to strengthen community support for cessation. Supporters participated by filling in their own entry forms and sending them to the organisers for a separate draw. The supporters’ contest in 1997 gathered 19 500 registrants participating in the prize draw of US$2000.

The direct expenditure for the 1994 campaign was $62 000, plus an additional...
Quit and Win campaigns in Finland

The national costs for the Quit and Win 1996 and 1997 amounted to approximately $130,000, plus a $20,000 budget for North Karelia. The costs per participant varied from $20 to $50 in North Karelia and from $10 to $20 in other parts of Finland.

SPECIAL EFFORTS IN NORTH KARELIA

Participant recruitment has been the key issue in all Quit and Win campaigns. In North Karelia special activities took place to increase participation and to improve social support. The North Karelia project used its well established channels in promotional work—for example, with healthcare workers and voluntary lay assistants. Additional press and other campaign information were also used, such as special campaigns in supermarkets. Existing official and voluntary networks were involved as much as possible. In primary and occupational health care in North Karelia, public health nurses and physicians told their smoking patients about the campaign and recruited participants. Information and entry forms were distributed by pharmacies and the central hospital. In vocational schools, teachers, school nurses, and student unions recruited students and teachers who wanted to stop smoking. The entry forms and posters were also distributed in the university, military garrisons, rehabilitation centres, libraries, post offices, and others. Many campaign activities were carried out in collaboration with non-governmental organisations such as the Heart Association, Cancer Society, Association for the Pulmonary Disabled, Martha Organisation and the Association for the Unemployed. These organisations were active in distributing entry forms, posters, and leaflets in banks, markets, department stores, restaurants, coffee shops, post offices, libraries, sports centres, bingo halls, neighbourhoods, and at various events and meetings. The entry forms were also distributed at ice hockey and volleyball matches.

The role of mass media has been important. The registration forms were published in the main county paper, which reaches about 90% of the population. In addition to general information, behavioural journalism, application of a theory-based communication method, was used to modify the messages in the mass media. Local newspapers published role model stories about people who tried to quit with the contest, or stories about ex-smokers such as those who participated in a previous campaign. These stories provided role model messages for persuasive and skills training aimed at increasing the rates of participation and successful cessation. The behavioural journalism method also involves recruiting members of peer networks to deliver and briefly discuss messages based on the experiences of peer models who already have stopped smoking or who are planning to quit.

Special “Quit and Win” programmes were broadcast by the regional radio station and various events, such as the “Quit and Win horse race”, the “smoke-free fashion show” and the “smoke-free dancing ball” were arranged together with non-governmental organisations. Special Quit and Win events, including measurements of carbon monoxide and smoking cessation counselling, were organised in vocational education institutions, military garrisons, major places of employment, pharmacies, and meetings for the unemployed. Concerning the effectiveness of channels by which smokers learned of the contests in North Karelia, the participants of the 1996 campaign cited newspapers and magazines most often.

EVALUATING THE EFFECTS OF CAMPAIGNS

The six-step communication model developed by Rossiter and his colleagues, originally based on the classical communication-persuasion model by McGuire, has been applied in health promotion contexts by Donovan and colleagues to evaluate the effectiveness of mass media campaigns. The hierarchy of effects starts at step 1 with exposure of the target audience to the messages, which may be communicated in magazine articles, television advertisements, billboards, news items, posters, magazine articles, videos, and so on. Exposure and attention to the message lead to conscious processing of the message (step 2), involving attention to the message content, comprehension, and learning, acceptance or rejection of the message, and emotional arousal. Processing of the message results in communication effects (step 3), which are beliefs about, attitudes towards, and intentions with respect to the message topic and promoted behaviour. Step 4, behavioural effects, is facilitated by the desired communication effects. The behavioural effects include making further inquiries or actual trial of the recommended behaviour, such as a serious attempt to quit smoking. To achieve the desired outcome, step 4 should also include environmental support. The accumulation of the behavioural effects leads to the achievement of the overall outcome objectives and goals (steps 5 and 6), which in the health arena, may be stated in terms of participation rates or prevalence rates, and risk reductions or more positive life experiences.

PURPOSE OF THE STUDY

As described earlier, evaluation reports on specific smoking cessation programmes, such as Quit and Win, are accumulating. Except for experiences published in the United States and in Sweden, Jess is known about the usefulness of this method in repeated use, as part of a long-term community-based anti-smoking programme. The relatively long experience in Finland, in more intensive form in a demonstration area and nationally, gives a unique opportunity to assess the feasibility and effects over the long term.

Because mass media are most effective in the early stages of behaviour change, whereas environmental factors, such as local community actions and social support, are more influential at the later intention and behavioural stages, the model above suggested that
the effectiveness should be measured at each level starting from the targeted audience, following the measurement of the proportion exposed, attended, understood, accepted, intended, and finally of those who really tried the recommended behaviours and succeeded in their attempts. This multi-level evaluation may provide a more comprehensive picture of the effectiveness of mass media in health campaigns. We applied the model to analyse the 1996 campaign in more detail.

Methods

SURVEYS
To evaluate the awareness and intent among the adult population who were smoking daily, the data from a nationwide health behaviour survey in 1996 were used. The National Public Health Institute carried out the postal survey as part of the national behaviour monitoring system. Two independent random samples of the adult population were drawn from the national population register: 5000 nationally and 1900 from North Karelia. The response rates were 66% in North Karelia and 72% nationally. The survey was in April, one month before the contest quit date. This timing offered a valid estimate of the target population’s awareness and intent concerning the Quit and Win campaign.

For the evaluation of abstinence, follow-up surveys were conducted using a mailed questionnaire for data collection. In 1986 and 1989 follow-up surveys after six months were conducted consisting of random samples of contest registrants. In 1995 and 1997, one year after the contest, similar follow-up studies were carried out. All the participants in North Karelia were followed in addition to a random sample of 1500 participants from elsewhere in the country. The response rates for the follow-up surveys varied from 67% to 72% in North Karelia and from 65% to 74% elsewhere.

The surveys included questions concerning current smoking status, smoking before and after the contest, the smoking cessation process, and the status of abstinence at selected points in time after the quit date. The survey included the question: “When did you smoke for the very first time after the contest?” Based on the responses, it was possible to calculate the proportions of those who either had not smoked at all or who had relapsed after six months. Thus, the estimates are comparable with the abstinence rates at six months of the earlier campaigns. The 1997 campaign was followed up in spring 1998.

ESTIMATES
Two estimates were calculated to evaluate the campaigns. The first was the participation rate—the proportion of the registrants in the adult smoking population. The estimated number of adult smokers was based on the available data regarding daily smokers in the 18–64 and 65 and older age groups. In the 18–64 age group, the prevalence of daily smokers in the Quit and Win campaign years varied from 20.7% to 25.4% in North Karelia and from 23.3% to 25.7% nationwide.

The second estimate was obtained from the six-month follow-up of the campaigns, determining the rate of continued cessation. A continuous abstinence rate after six months was calculated as the proportion of complete abstainers in the follow-up sample. The abstainers were defined as those who had been totally smoke free for at least six months after the quit date. This estimate is the cautious estimate, which regards all non-respondents of the follow up as relapers.

To conduct a more detailed evaluation of the 1996 Quit and Win campaign, the six-step communication model was applied. Of the levels of the hierarchy (targeted, exposed, attended, understood, accepted, intended, tried, and succeeded), five levels were measured in this study. The target group for this evaluation was defined as daily smokers aged 18–64 in 1996 (n = 24 900 in North Karelia and 715 000 elsewhere). “Attended” was measured as the proportion of the target group who reported in a population health behaviour survey to have heard about the Quit and Win ‘96 contest. “Intended” was measured as the proportion of the target group who reported an intention to participate in the contest. The number of registrants was used to measure “tried”, where the participation rate was estimated by dividing the number of registrants by the number of estimated daily smokers in the target group. Finally, “succeeded” was measured as the proportion of the target group who completely abstained from smoking during the whole one-year follow-up period after the quit date. This estimate was based on the follow-up survey carried out one year after the quit date.

Results

PARTICIPATION RATES
The participation rate in the first national campaign was 3.2% of smokers in North Karelia and 1.6% elsewhere in the country. The second contest in 1989 recruited 1.7% of smokers in North Karelia and 0.4% elsewhere in Finland. In the international Quit and Win contests arranged in 1994 and 1996, the participation rates were 2% in North Karelia, and 0.6–0.7% elsewhere in Finland. Finally, in 1997 3% of North Karelian smokers and 1.8% of smokers elsewhere participated (figure 1).

PARTICIPANTS
In 1996 we compared the Quit and Win participants with the daily smokers in the population. The Quit and Win participants...
The proportions of smokers recruited into the Quit and Win contest have been consistently higher in North Karelia than elsewhere. The success of recruiting may partly be explained by differences in the intensity of the effort. The higher financial input for recruitment in North Karelia allowed more intensive campaigning and special activities. Another factor explaining the different participation rates may be the smoking population’s stage of change. For example in the 1996 national survey, 28% of smokers were in contemplation or preparation stages, whereas the corresponding rate was 34% in the North Karelian sample (T Korhonen et al, unpublished manuscript). The campaign may be more successful in recruiting participants from a population with a higher proportion of smokers in the preparation stage. In evaluating the effect of the campaign on the whole smoking population, it would be

### Table 2 Background information on 1996 Quit and Win participants* and daily smokers† aged 18-64 years (%)

<table>
<thead>
<tr>
<th>Variable</th>
<th>North Karelia</th>
<th>Daily smokers</th>
<th>p</th>
<th>Rest of Finland</th>
<th>Daily smokers</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>59.6</td>
<td>62.2</td>
<td>0.465</td>
<td>56.3</td>
<td>56.8</td>
<td>0.838</td>
</tr>
<tr>
<td>Women</td>
<td>40.4</td>
<td>37.8</td>
<td></td>
<td>43.7</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>18.5</td>
<td>15.1</td>
<td>0.026</td>
<td>23.3</td>
<td>15.4</td>
<td>0.000</td>
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<tr>
<td>25-34</td>
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<td>19.8</td>
<td></td>
<td>30.7</td>
<td>24.4</td>
<td></td>
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<tr>
<td>35-44</td>
<td>29.9</td>
<td>28.1</td>
<td></td>
<td>25.8</td>
<td>24.1</td>
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<tr>
<td>45-54</td>
<td>18.8</td>
<td>23.7</td>
<td></td>
<td>16.3</td>
<td>23.2</td>
<td></td>
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<tr>
<td>55-64</td>
<td>8.0</td>
<td>13.3</td>
<td></td>
<td>3.9</td>
<td>10.9</td>
<td></td>
</tr>
<tr>
<td>Years of smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-9</td>
<td>32.5</td>
<td>23.6</td>
<td>0.021</td>
<td>31.5</td>
<td>23.8</td>
<td>0.000</td>
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<tr>
<td>10-19</td>
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<td>28.4</td>
<td></td>
<td>34.0</td>
<td>31.3</td>
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<td>≥20</td>
<td>39.6</td>
<td>48.0</td>
<td></td>
<td>34.5</td>
<td>44.9</td>
<td></td>
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<tr>
<td>Cigarettes smoked/ day</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1-14</td>
<td>34.6</td>
<td>41.8</td>
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<td>33.4</td>
<td>38.5</td>
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<tr>
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<td>58.2</td>
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<td>66.6</td>
<td>61.5</td>
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<td>Previous quit attempts</td>
<td></td>
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<td></td>
<td>0.000</td>
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<tr>
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<td>6.7</td>
<td>22.6</td>
<td></td>
<td>8.4</td>
<td>27.2</td>
<td></td>
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<tr>
<td>1-2</td>
<td>40.2</td>
<td>46.9</td>
<td></td>
<td>36.2</td>
<td>43.4</td>
<td></td>
</tr>
<tr>
<td>≥3</td>
<td>53.1</td>
<td>30.6</td>
<td></td>
<td>55.5</td>
<td>29.4</td>
<td></td>
</tr>
</tbody>
</table>

*From a random sample of registrants. †From the health behaviour survey.
important to measure smokers' progress through the stages of change process.

This kind of community-based campaign using mass media may also have had positive effects on the intentions to quit among those smokers who did not register in the previous contests but were motivated by a repeat campaign. The campaign may have also had a “latent” effect on the smokers who were in the pre-contemplation stage and starting to move towards further stages of the change process. Given that these campaigns were arranged regularly, the participation rate among smokers—despite the decline after the first campaign—has become progressively higher because of an increasing resolve to quit.

A crucial question is how to increase community awareness, support, and participation, and success in abstinence. First, it seems important to create close and extensive collaboration through official and voluntary service in the community. Second, extensive distribution of registration forms is needed. Third, it is important to have community-wide information through many channels such as mass media, role models, posters, and special Quit and Win events. Finally, role model stories in the media should support the maintenance of abstinence after the contest period.

The variation by year in the numbers of smokers participating seemed to reflect changes in the rules (numbers of witnesses required, contest time, and different age limit), and the composition and organisation of the campaign itself (supporter contest, recruiting methods, marketing, and degree of involvement of collaborators). The highest results are from contests where, exceptionally, no witnesses were required for the registration (1986, 1997). In the first national campaign in 1986 many public health organisations were intensively involved and the media coverage was good, whereas during the next effort in 1989, the enthusiasm and the news value had somewhat faded. In this decade, the Finnish Centre for Health Promotion and the Smokefree Finland programme took care of the arrangements, and the main trend in the participation has been upwards, because of the development of and widening of recruiting and marketing methods. The exceptional rise from 1996 to 1997 can be explained, in addition to the lack of witnesses, by the addition of a separate supporter contest. Better targeted advertising and direct mailing probably also helped improve the results.

The more detailed evaluation of the 1996 campaign applied a modified version of Dono- van’s model, originally based on McGuire’s persuasion-communication model. The results suggested that the intensified activities in North Karelia resulted in higher proportions of smokers who attended, intended, tried, and succeeded. In both areas, however, the analysis revealed a gap between awareness of the campaign and intention to participate, as well as between intention and final attempt. This result supports the principle that Quit and Win—as a media campaign—is more effective in the early stages of the hierarchy, such as raising awareness, whereas environmental factors and other elements of the campaign mix, such as local community action, may be more influential at the later stages. This result suggests considering ways to improve these recruitment steps. Media information can be impersonal and thus effective in raising awareness, but not in leading to behavioural changes. The significantly higher participation rates in North Karelia suggested that community action combined with a mass media approach may be an effective way to improve the effectiveness of the Quit and Win campaign.

Concerning the success rates of quitters, it may be that the participants in a more intensive recruitment process include quitters with lower motivation for long-term abstinence. The experience comparing North Karelia with the rest of Finland indicated that the success rate among the participants was not dependent on the participation rate—the success rate was not lower in an area with a higher participation rate. In 1994 particularly, the abstinence rate was significantly higher in North Karelia than elsewhere in Finland. This greater success was analysed in an earlier paper, which suggested that more intensive combined support from health professionals and lay persons may partly explain the difference.

Finally, behavioural journalism may be one way of modifying the messages in the media—for example, by using role models that make the message more personal to the individual smoker. In addition, involving members of peer networks and various organisations to recruit participants might be an effective approach. The combination of mass media and community strategies were found to be effective in earlier studies. We confirmed these findings based on the long-term evidence in North Karelia.

Conclusions
Even the cautious estimates indicate satisfying abstinence rates with these campaigns. The Quit and Win campaign seems to be a feasible cessation method that can be repeated with predictable abstinence results in community-wide and national programmes. Repeat campaigns in active demonstration areas can increase effectiveness.

Quit and Win campaigns in Finland


