From “Stoptober” to “Moi(s) Sans Tabac”: how to import a social marketing campaign.

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Abstract

Purpose: In 2016, *Santé publique France* launched for the first time “*Moi(s) sans tabac*”, a positive social marketing campaign inspired by Public Health England’s (PHE) “Stoptober” campaign, the aim being to trigger mass quit attempts among smokers. Both programs include a mass-media campaign, national and local cessation help interventions, and the diffusion of various tools to help smokers quit. The purpose of this paper was to analyse the two programs’ specific national contexts and to describe resulting similarities and differences regarding campaign development. *Approach:* A contextual analysis was performed to determine differences between the two countries regarding smoking prevalence, health services and culture. *Findings*: Smoking prevalence is about twice as high in France as in the United Kingdom, leading to a lower degree of de-normalization of smoking. Moreover, cessation support services are much more structured in the United Kingdom than in France: all health professionals are involved and services are located near smokers’ residences. *Practical implications*: Campaign progress and cessation tools provided during both campaigns are quite similar. However, *Santé publique France* needed to adjust the British model by favouring a regional smoking prevention network and by building an innovative partnership strategy to reach the target. *Originality:* Our results could be useful for other countries that wish to develop a smoking cessation campaign based on the same positive messaging at local and national levels.

Keywords: social marketing, public health, smoking/tobacco, communication, local deployment, partnership

Article classification: Case study

Background

Smoking is the main cause of preventable diseases and premature death, and is estimated to be responsible for over seven million deaths worldwide per year (12% of global deaths) (World Health Organization, 2017). In Europe, according to the World Health Organization (WHO), tobacco use is responsible for 16% of deaths among adults.

Given the particularly high prevalence of smoking in France - standing at 34.5% in people aged between 15 and 75 in 2016 (Pasquereau et al., 2017) –, the French government launched in September 2014 a national plan to decrease prevalence: the National Smoking Reduction Program (known as PNRT, *Programme national de réduction du tabagisme*) (Ministère des affaires sociales de la santé et des droits des femmes, 2015). Helping smokers to quit is a key element of this plan, and the related interventions are aligned with the WHO Framework Convention on Tobacco Control (FCTC) treaty (World Health Organization, 2003). This treaty obliges countries to develop mass-media campaigns to encourage people to quit (article 12) and to promote adequate interventions for tobacco dependence, including effective programs in locations such as educational institutions, health care facilities, workplaces and sporting environments (article 14).

In relation to mass-media campaigns, several studies have shown they can be effective in encouraging people to reduce their tobacco consumption and trigger quit attempts (Wakefield et al., 2010, Durkin et al., 2012, Allen et al., 2015, Bala et al., 2017). However, to date, most research has studied anti-smoking campaigns based on messaging focused on harm to health. Few studies have analysed the effectiveness of positive message campaigns (Durkin et al., 2009, Durkin et al., 2011, Richardson et al., 2014). Moreover, very few programs involving both positive mass-media campaigns and cessation services/supportive environment (e.g. *No Smoking Day* or *Stoptober* in the United Kingdom) have been included in these studies (Kotz et al., 2011, Brown et al., 2014).

In addition, most research on mass-media campaigns comes from countries with Anglo-Saxon cultures, and it has been shown that cultural and social context, as well as smoking habits, are important factors to consider regarding the effectiveness of tobacco control policies. Some Australian campaigns have already been adapted by foreign countries (Cotter et al., 2010). Transnational antismoking campaigns are quite rare, an example being the European HELP campaign (Hassan et al., 2009, Hastings et al., 2008). Culture has an impact on risk perception, the way to control these risks and the understanding of warnings in general (Smith-Jackson, 2006). More specifically, cultural differences were found with respect to fear anti-tobacco media campaigns (Laroche et al., 2001). The French society may have a strong score of uncertainty avoidance compared to Canada or the US (Hofstede, 1983), which could lead to strong resistance to prevention messages (Peretti-Watel et al., 2007). Thus, positive messages could be more effective in the French context.

Taking into account these specificities regarding French culture and context, a social marketing campaign "*Moi(s) Sans Tabac*" was launched in 2016 in France by *Santé publique France*, the French National Public Health Agency. This campaign was inspired by the "*Stoptober*" campaign first launched by Public Heath England (PHE) in 2012. *Stoptober* and *Moi(s) Sans Tabac* both include a mass-media campaign, national and local cessation help services, and the provision of various tools to support smokers who attempt to quit. These two campaigns have common elements (which are key success factors for both) but also differences to fit with countries' culture and environment.

With regard to common elements, both campaigns principally target smokers motivated to quit. The majority of English and French smokers (67% and 60%, respectively) want to quit (West and Brown, 2012, Guignard et al., 2015). However, factors such as the highly addictive nature of smoking and pro-smoking environments make this difficult (Kotz and West, 2009). Accordingly, an external stimulus is often needed (i.e. anti-tobacco campaigns, etc.).

In addition, both *Stoptober* and *Moi(s) Sans Tabac* rely on social norm and social contagion theory (Einstein and Epstein, 1980). It has been shown that smokers are 67% more likely to quit when their spouse stops smoking too, 36% more likely when a close friend quits, and 34% more likely when someone they work with also quits (Christakis and Fowler, 2008). Thus, the principle of *Moi(s) Sans Tabac* and *Stoptober* is to use collective leverage to help smokers quit by creating a supportive environment. More specifically, their purpose is to encourage mass quit attempts by providing a collective achievable objective: staying 'smoke-free' together for one month. The strategy behind them is to recreate the "January effect" (i.e., linked to New Year resolutions) in the last quarter of the year. To that end, reasons which generally make smokers afraid to quit are discussed in a positive way. Smokers are invited to quit for only one month, in order to combat the fear of stopping forever or of failing. They are also encouraged to quit together to benefit from group support. Finally, they are invited to quit on a specific date, in order to fight against the individual-perceived need to 'wait for the right moment'. The rationale for setting a time-limited period is based on previous studies which showed that after one smoke-free month, smokers are five times more likely to stop for good and that the main inconveniences linked to smoking cessation are reduced (West and Stapleton, 2008).

France decided to import the UK campaign *Stoptober* because it was effective in increasing quit attempt rates**.** Indeed, an analysis of monthly quit attempt rates during the 2007-2012 period showed that *Stoptober* generated 350,000 additional quit attempts in England in October 2012 and saved 10,400 discounted life years (DLY) at approximately £550 per DLY considering direct costs for the Department of Health (Brown et al., 2014).

This paper aims to describe the different issues and challenges that *Santé publique France* had to face when importing the *Stoptober* social marketing campaign. Accordingly, this study could be of interest to other countries wishing to both develop a similar smoking cessation campaign based on positive messaging at local and national levels, and promote tools to help smokers in their quit attempts. Thus, the purpose of this paper is to analyse the specific contexts in which the *Stoptober* and *Moi(s) Sans Tabac* campaigns were developed and to describe the resulting similarities and differences concerning their implementations.

Methods

The adaptation of extra-national anti-smoking programs requires an appreciation of the national contexts into which they fit. For example, smoking patterns, the use of cessation support services and healthcare systems differ between countries (European Commission, 2017).

As presented above, *Stoptober* and *Moi(s) Sans Tabac* bear some similarities mainly because the latter draws from the former. In order to adapt the UK campaign to the French context, we studied literature (peer-reviewed papers as well as grey literature) about *Stoptober* and other smoking

cessation interventions and campaigns implemented in the United Kingdom (Brown et al., 2014, Fenton, 2016, Iacobucci, 2017, Kotz et al., 2011, Ussher et al., 2011, Murray et al., 2013, National Centre for Smoking Cessation and Training, 2014, National Institute for Health and Care Excellence (NICE), 2008, Public Health England, 2013). We examined PHE's website (https://www.gov.uk/government/organisations/public-health-england), as well as NHS Stop Smoking Services (https://www.nhs.uk/live-well/quit-smoking/nhs-stop-smoking-services-help-you-quit/) and NICE websites (https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/smoking-and-tobacco), together with tools distributed for smoking cessation. A contextual analysis was undertaken in terms of smoking prevalence, health services, and regional organisation, using published data (Office for National Statistics, 2017, NHS Digital, 2016, NHS Digital, 2017, Pasquereau et al., 2017, McNeill et al., 2015), reading several reports (National Centre for Smoking Cessation and Training, 2014, National Institute for Health and Care Excellence (NICE), 2008, Public Health England, 2013, Cour des Comptes, 2012, Cour des Comptes, 2016) or discussing with PHE, to determine differences between the UK and France. This comparison was useful to highlight differences which would need to be taken into account when setting up and implementing the French campaign. A meeting was organised between PHE and *Santé publique France* to share details about the UK experience in terms of communication strategy, budget, partnerships, coordination between the national and local levels, as well as on evaluation protocols.

Contextual analysis

Smoking prevalence

First of all, the smoking context differs between France and the United Kingdom. In the mid-1970s, nearly one in two adults was a smoker in both nations, the gap between men and women being greater in France. While smoking prevalence in the United Kingdom has continuously declined from that time until today, the decline has been less noticeable and less consistent in France, with a period where prevalence even rose (between 2005 and 2010) before levelling off until 2016 (McNeill et al., 2015, Office for National Statistics, 2017, Pasquereau et al., 2017). When *Moi(s) sans tabac* was launched in France, smoking prevalence in the UK (15.8%) was very low compared to the prevalence in France (34.5% in 2016). However, in both countries, prevalence is highest among the 25-34 year-old population and decreases above that age (NHS Digital, 2017, Pasquereau et al., 2017). The difference in trends observed in both countries may be partly explained by the UK's efforts to introduce comprehensive measures against tobacco use. In France, although the smoking ban in public places that was introduced in 2007-2008 substantially contributed to a reduction in smoking exposure, it did not have any short-term impact on smoking prevalence. Over the past 15 years, the UK has implemented a structured policy of no less than 3 successive action plans reinforced by new legislation, whereas the first French program against tobacco consumption was only launched in 2014 (McNeill et al., 2015, Ministère des affaires sociales de la santé et des droits des femmes, 2015). In particular, drastic measures were implemented to regulate tobacco prices in the UK, leading to very high costs for packets of cigarettes (approximately 10 euros in the UK versus 6.70 euros in France in 2016) (European Commission, 2016).

One issue common to both countries is that smoking cessation policies need to focus on the most disadvantaged and vulnerable groups. Smoking prevalence is significantly higher among people with low socio-economic status (in terms of level of income, education and employment status). For example, in 2016, 50% and 30% of unemployed adults were smokers in France and in the United Kingdom, respectively, compared with 31% and 16% of employed adults (Pasquereau et al., 2017, Office for National Statistics, 2017).

Availability of cessation support services

Greater efforts in supporting smokers to quit have been made in the United Kingdom for some time (McNeill et al., 2015). One of the biggest differences between both countries remains the major level of high quality assistance provided by Stop Smoking Services in the United Kingdom. These structures are commissioned by local authorities and are present all over the country, with a focus on more deprived areas. Stop Smoking Services are located in various places like hospitals, general practice surgeries, dental clinics, pharmacies, schools, workplaces, and prisons (NHS Digital, 2016). They provide services to their local population by delivering professional advice, support and encouragement, either in individual meetings or in groups. Local services and national campaigns can easily collaborate for mutual benefit. Services can leverage the increased motivation to quit generated by the campaign and also amplify campaign visibility locally (National Centre for Smoking Cessation and Training, 2014). In France, the provision of cessation support services is poorly identified and insufficiently developed. Support is mainly provided by general practitioners and hospital-based cessation services (Cour des Comptes, 2012, Cour des Comptes, 2016). Moreover, in France, smoking cessation consultations are only provided by tobacco specialists (health professionals with a diploma in tobacco addiction), whereas all healthcare practitioners in the UK (general practitioners, pharmacists, nurses, psychologists, social workers, etc.) can benefit from basic training (usually through distance learning) via the National Centre for Smoking Cessation and Training. The recommendations for good practice in both countries include behavioural support and pharmacotherapies (Haute autorité de santé, 2014, National Institute for Health and Care Excellence (NICE), 2008). Finally, smoking cessation resources are practically free of charge throughout the UK network while in France, they have been only partly reimbursed through a national system for nicotinic substitute treatment, with a maximum reimbursement of 150 euros per year per smoker until 2018 (in March 2018, the reimbursement of nicotinic treatments up to 65%, like other medications, was announced by the French government, with two first products on the list of reimbursable drugs). This lower level of financial cover makes it potentially harder for French smokers - especially the less privileged - to quit. The organizational differences between both countries in terms of the management of smoking cessation services must be taken into account when orienting smokers who wish to quit.

To summarize, the main country-specific differences which needed to be taken into account by *Santé publique France* when importing and adapting *Stoptober* campaign to the French context, were the level of smoking prevalence and the structure of cessation support services. Smoking prevalence is almost twice as high in France as in the United Kingdom, leading to a lower degree of de-normalization of smoking and maybe more reactance against smoking prevention messages among French smokers.

Moreover, cessation support services are poorly developed and structured in France in comparison with the United Kingdom. In the UK, all health professionals are involved in cessation care, and services are located near smokers' residences. Because of these contextual specificities, they were some minor and major differences between *Moi(s) sans tabac* and *Stoptober* that are described below.

How Stoptober was imported in France to become Moi(s) sans tabac

Minor differences between Stoptober and Moi(s) Sans Tabac

Campaign progress: quite similar designs

Stoptober and *Moi(s) Sans Tabac* mainly target smokers aged 20-49 years old who are motivated to quit. Both interventions are organised into two stages: the first stage involves a media campaign (using traditional and digital media) which encourages this sub-population to participate massively in the challenge and to register using the relevant website or the helpline. *Santé publique France* took the idea of a collective challenge for one month from *Stoptober*, but it entirely created the content of the French campaign, including the brand name *Moi(s) Sans Tabac*, its logo and its slogan ("En novembre, on arrête ensemble" / "In November, we quit together"), to fit in with the French culture and language (Figure 1). The quitting month was shifted to November to avoid competing with another French public health campaign, "*Octobre rose*", which encourages breast cancer screening. *Moi(s) sans tabac* is a pun that can mean "Month without tobacco" or "Me without tobacco".

Figure 1: the brand, logo and slogan for 'Moi(s) sans tabac'

Both campaigns deliver the same positive tone through popular and joyful messages. Both also focus on the collective and required support element of the challenge. Thus, communication actions are developed for TV, radio, the Internet, posters in the street and press reports, as well as social networks, where participants can express themselves about their consumption and the difficulties they encounter, as well as receive useful tips about stopping smoking. In addition, for the initial campaigns, road shows in several cities were created in France and in the UK to promote the campaign and to

recruit smokers directly in their environment (Public Health England, 2013). Moreover, the theme of the first French campaign in 2016 (in particular the brand name "Moi(s) sans Tabac") and some of its components (i.e., posters, cessation tools, etc.) appeared in 11 episodes of a very famous French television series ('*Plus Belle La Vie'*) in a modelling strategy in order to reach as many smokers as possible. Smokers' close friends and families were also urged to support the smokers in their quit attempts, something that was emphasized in 22 one-minute episodes of a web series.

The second stage of both interventions coincides with the operation itself in which smokers are invited to stop smoking for one month (for a full description of *Moi(s) Sans Tabac* campaign, see (Gallopel-Morvan et al., 2017).

Cessation support tools provided during both campaigns

Both campaigns provide a wide range of cessation support tools made available by *Santé publique France* and Public Health England including text supports, a mobile phone application (comprising a smoking cessation program sending regular notifications), a quitline, websites (https://smokefree.gov/ and http://www.tabac-info-service.fr/), social networks and finally a quit kit to guide smokers on their path to smoking cessation (Fenton, 2016).

Public Health England first created and evaluated the quit kit. It was developed by experts, smokers, and ex-smokers and offered practical tools and advice to facilitate quit attempts. It included a health-and-wealth wheel to calculate possible savings and health improvements when quitting smoking, several tips and MP3 downloads for use in tackling cravings, a calendar, a stress ball, information on other quitting help tools and services, such as Stop Smoking Services and a voucher for nicotine substitutes. UK studies investigating the effectiveness of the quit kit highlighted that providing this national self-help intervention was successful in generating quit attempts and maintaining short-term abstinence (Ussher et al., 2011, Murray et al., 2013).

Santé publique France borrowed the concept of this quit kit to provide daily help to French smokers in their cessation attempts. The French kit, designed in collaboration with the French NGO '*Ligue contre le cancer*' (League against cancer), contains a preparation brochure, a 30-day calendar with daily pieces of advice, a leaflet with breathing exercises, a badge, a sticker with nutritional recommendations to avoid weight gain and also a wealth wheel. However, it does not provide nicotine substitution products (Figure 2).

Figure 2: the Quit Kit

- a preparation brochure
- a 30-day calendar giving encouragement for each day
- a leaflet on how to overcome craving

- a sticker to help smokers not to gain weight
- a calculator to show how much money is saved
- a campaign' badge

Major differences between Stoptober and Moi(s) Sans Tabac

Local implementation: the need for adaptation

The distribution of national and regional health actions is pretty well established in the UK. Hence, Public Health England rely on Stop Smoking Services to collaborate in *Stoptober*, and facilitate the local implementation of the campaign. The UK operation is supported by academics and clinicians as well as by the 152 local authorities, which help make *Stoptober* well known both nationally and locally (Fenton, 2016).

To import *Stoptober, Santé publique France* needed to adapt the UK model to the specificities of the French health system, given the differences in French healthcare organization, culture and resources, and the fact that 'quit smoking' services are scarcer and payable in France. Thus, it was necessary to create very clear structuring at the national and regional levels, and help create a regional network dedicated to smoking prevention. The regional health agencies, which implement public health policy in their specific region, were involved in regional steering, and project leaders (PL) were recruited to support them to relay the operation locally. *Santé publique France* launched a call for projects and selected one PL per region with the help of the corresponding regional health agency. In 2016, 14 PL in 14 regions throughout metropolitan France and the French overseas administrative area La Réunion, participated in *Moi(s) Sans Tabac*.

For the first French campaign, the PL helped the regional health agencies to disseminate *Moi(s) Sans Tabac* by: i) promoting it to regional stakeholders (healthcare facilities, health professionals, associations, local communities for instance), ii) setting up methodological advice and iii) following up local stakeholders. The PL had to share information with the national and regional operators and report on local actions. In parallel, the roles assigned to the regional health agencies were to pilot the operation at the regional level, to coordinate the local actors and to animate the partners' network through a regional steering group. These regional agencies could also contribute financially to local actions. Moreover, to tackle social health inequalities, *l'Assurance Maladie* (the public body in charge of reimbursing health costs which is also involved in prevention and health education actions) subsidised projects targeting smoking cessation in low-income groups at a local level.

The building of partnerships

In France and in the UK, the national Public Health agencies call on partners (including health professionals, associations, companies, etc.) to increase campaign visibility, to directly target smokers in their environment (at work, at home, in the city, etc.) and to focus more on vulnerable populations.

In the UK, PHE has a whole team dedicated to the search for collaborations. It welcomes partnerships with the private sector, and boasts a comprehensive private and public partner network. These UK partners include health professionals (such as doctors, dentists, and pharmacists), prevention associations, pharmaceutical laboratories, companies, a TV-channel, universities as well as Stop Smoking Services. Among PHE's partners, 6,070 pharmacy stores and 40 national and regional employers took part in *Stoptober* in 2012. Although *Stoptober* and *Moi(s) Sans Tabac* share some partners, *Santé publique France* and PHE do not have exactly the same partner inclusion criteria. More specifically, partnerships with companies whose interests conflict with the research and work carried out by *Santé publique France* (companies working in the tobacco, alcohol and food industries for example) or which have a commercial link with the program (the pharmaceutical industry for example) are not eligible. More generally, public-private partnerships are less developed in France than in the UK. *Moi(s) Sans Tabac* 2016 mobilized a wealth of partners (around 3,000 regional and more than 100 national partners) including health professionals, insurance companies, various Ministries, private companies, cities and NGOs. Among other actions, in order to increase the campaign visibility among unemployed people, *Santé publique France* built a partnership with Pôle Emploi, the public service dedicated to benefit and assistance to return to employment. Moreover, it developed a major partnership with the National Council of the Order of Pharmacists, which enabled the delivery of quit kits at almost 18,000 pharmacy stores over the whole French territory.

The roles of the UK and French partners were quite similar: their primary tasks were to make the campaigns widely known, to organize cessation follow-ups and to set up relevant actions to encourage smokers to quit. These actions were intended for employees, clients, or both. In fact, the purpose of this network was to reach smokers and their relatives directly in their living areas, in order to create an environment propitious to smoking cessation.

Discussion

The first iteration of *Moi(s) Sans Tabac* in 2016 in France benefited from lessons learned from the implementation of *Stoptober*. As well as the overall concept, elements such as the roadshow and the quit kit for smoking cessation were taken from the UK campaign. However, all media content, including the brand name *Moi(s) Sans Tabac* and its logo, were specifically recreated for the French culture and language. Finally, the structure of local actions and partnerships had to be fully reconfigured to match the French context. First evaluation evidence shows that the concept of the intervention and its tools, imported from the UK, have been well received in France (Guignard et al., 2018b, Guignard et al., 2018a), which will be further developed in other publications. With respect to *Stoptober*, 275,000 smokers signed up for the first iteration in 2012 (Fenton, 2016). Although a large number of French smokers (180,113) signed up for the inaugural *Moi(s) Sans Tabac* in 2016, this figure is still lower than that observed for *Stoptober*.

The particularity of the *Stoptober* and *Moi(s) Sans Tabac* campaigns is their deployment at both local and national levels, in order to reach smokers directly in their environment and in their living areas. Despite the great reduction in people accessing Stop Smoking Services in the recent years, which could be due to the rise of the electronic cigarette but also to significant budget cuts (Iacobucci, 2017), PHE have been able to rely heavily on these local facilities, present all over the UK. Even if the impact of these intensive services on smoking prevalence remains uncertain, it was recently estimated that approximately 15% of the reduction in smoking prevalence during 2001-2016 may be attributable to these services (Song et al., 2019). Such services do not exist in France. Consequently, *Santé publique France* had to innovate and find a way to implement the operation over the whole territory. This local dimension meant that local stakeholders needed to be found across the country who could take action locally. It was therefore essential to involve regional health agencies and call on project leaders to work closely with them to implement the project. Project leaders had to follow several objectives set by *Santé publique France* and propose relevant actions to help smokers quit. This complex but judicious organization, combined with the broad reach of *Tabac Info Service* devices (helpline, website, application), contributed significantly to the success *of Moi(s) sans Tabac*. Other European countries wishing to adapt *Stoptober* or *Moi(s) Sans Tabac* but having no organisation like Stop Smoking Services, could thus benefit from the French experience.

In addition, partners were attributed a crucial role to make the operation widely known. As *Santé publique France* takes particular interest in the fight against health inequalities, *Moi(s) sans Tabac* was built with the objective of helping the most disadvantaged populations. This involved disseminating a simple, understandable and encouraging message to smokers, setting specific actions for them, and recruiting relevant partners (at regional and national levels) more likely to interact with these populations.

Finding relevant partners was a much more difficult issue for *Santé publique France* than for Public Health England, due to the scarcity of pre-existing structures dedicated to smoking cessation guidance. The second version of *Moi(s) sans Tabac* in 2017 aimed at increasing and improving the partners' network in order to get even closer to smokers and to better reach and support vulnerable populations. Examples of events, challenges, etc. implemented in 2016 are provided in a dedicated and open-source database (http://www.oscarsante.org/national/moissanstabac/index.php). In addition, *Santé publique France* categorized campaign partners, distinguishing between stakeholders (organizations, associations, etc.) who could use non-customized *Moi(s) Sans Tabac* tools (e.g., an unchanged campaign poster) available on the *Tabac info service* website, and national and regional partners who could customized the campaign's tools after signing a charter. The latter could display their own logo on the campaign media tools (e.g., posters) and be associated with *Santé publique France*. Nevertheless, tobacco, alcohol and pharmaceutical industries as well as organizations with a direct business interest were still excluded.

Health professionals, in particular family doctors, are among the most important partners for smoking cessation interventions. However, *Moi(s) Sans Tabac* 2016 was not well known or used by general practitioners in their practice (i.e., few posters, flyers etc. were ordered), and the campaign did not seem to have generated much discussion with patients. This could be partly explained by the fact that a non-negligible part of French general practitioners are themselves smokers, which does not encourage talking about quitting with patients (Pipe et al., 2009). In fact, in 2015, 16% of French doctors were smokers versus only 4% in England in 1999 (McEwen and West, 2001, Andler et al., 2018).

Another difference between both countries is that smoking cessation support is mainly provided by tobacco specialists in France while such support in the UK comes from professionals in various fields. Some other French health professionals (such as nurses, pharmacists, physiotherapists and midwives) showed interest in participating in *Moi(s) Sans Tabac*. Thus, after placing the emphasis on general practitioners in 2016, *Santé publique France* aimed at engaging other types of healthcare professionals in 2017. It also aimed to make *Moi(s) Sans Tabac* more widely known to family doctors. The substantial differences between France and the UK can explain why more UK smokers registered online for *Stoptober*.

Conclusion

Like *Stoptober*, initial results for *Moi(s) sans Tabac* 2016 indicated it was a great success in France, beyond cultural and contextual differences between both countries. Key success factors of this intervention included: building a partnership-based strategy to reach the target population; identifying key stakeholders to implement the campaign at different levels (i.e., national and regional); providing smokers with fun-based tools; relying on the collective dimension of the one-month quitting challenge; and putting in place an evaluation system early enough, in order to quickly gather information about smokers' expectations for the development of subsequent stages of the campaign.

Two of the biggest challenges for future editions are to encourage even more smokers and health practitioners to take part, especially smokers with the greatest socioeconomic difficulties, and to better fulfil participants' expectations. *Santé publique France* can do this by capitalizing on evaluation results of previous versions of the campaign and by continuing to ask for advice from Public Health England. Public Health England showed similar interest in receiving feedback from *Santé publique France* about *Moi(s) sans Tabac*. If other European countries engaged with France and the UK by developing similar campaigns, it could be the beginning of a collective agency-based international initiative to fight smoking in a coordinated way. To do this, country-specific smoking contexts and health system organizations, and more generally cultural differences, have to be acknowledged.

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