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Recommendations for the implementation of WHO Framework Convention on Tobacco Control Article 14 on tobacco cessation support

Article 14 of the Framework Convention on Tobacco Control recommends provision of evidence-based support for tobacco cessation. However, it is being implemented very slowly in most countries, so that by 2014 only a small minority of the world's tobacco users had access to appropriate cessation support, according to the World Health Organization (WHO). This editorial, endorsed by more than 70 global leaders in tobacco cessation as it went to press (see online version; contact the lead author for the latest list of endorsers), sets out actions that countries can take to remedy the situation, focusing on low-cost, broad-reach interventions.

INTRODUCTION

Stopping tobacco use is a vital element in any comprehensive approach to tobacco control. It saves lives, prevents debilitating illnesses and is beneficial economically [1], not least by reducing health-care costs [2]. Recognizing this, the World Health Organization (WHO) oversaw the development of the world's first global health treaty, the Framework Convention on Tobacco Control (WHO FCTC), which entered into force in 2005, and includes an Article on tobacco cessation (Article 14). The FCTC is one of the most widely supported of all United Nations (UN) treaties. At the time of writing 179 countries (180 Parties), representing 90% of the world's population, have ratified the Treaty [3]. In 2010 the fourth Conference of the Parties to the Treaty adopted guidelines to assist Parties in implementing Article 14 of the Treaty on tobacco dependence and cessation [4].

Since 2010, several important international initiatives have provided further impetus for the implementation of the FCTC and Article 14 of the Treaty:

- In 2011 the United Nations General Assembly held a special session at which it adopted a political declaration on non-communicable diseases (NCDs), which recognized tobacco as one of the four main NCD risk factors and committed governments to accelerated implementation of the FCTC [5].
- In 2013 the World Health Assembly adopted voluntary global targets on NCDs, including a 25% decrease in premature mortality from NCDs by 2025 and a 30% relative reduction in tobacco use by the same year [6] compared with a 2010 baseline.
- In 2015 world leaders agreed to an ambitious set of Sustainable Development Goals (SDGs). Goal 3 ('Ensure healthy lives and promote well-being for all at all ages') includes a target of reducing premature mortality from NCDs by 33% by 2030, and goal 3a is to strengthen implementation of the FCTC in all countries [7].

Thus, there is strong international support to strengthen and accelerate full implementation of the WHO FCTC. While preventing people from starting smoking and using other forms of tobacco will save lives 20 years and more from now, only effective tobacco cessation will have a sufficient effect on mortality in the few years left to reach the UN/WHO goal of a 25% reduction in premature mortality from NCDs by 2025. Failure on that front will surely thwart the global aspiration for success in NCD control and fail to save millions of current smokers' lives [8].

A NEGLECTED ARTICLE

The 2014 WHO Global Progress Report notes that, in general, good progress is being made in FCTC implementation (although it notes that only 19% of Parties have implemented it to the 'highest level'), but that some Treaty articles are being implemented more quickly than others [9]. The report shows that by 2014 the strongest focus was on Articles 8 (restrictions on smoking in public places), 16 (restrictions on sales to minors), 11 (large health warnings) and 12 (educational programmes), which motivate tobacco users to seek treatment for tobacco dependence. Only half of Parties reported that they were implementing Article 14 on tobacco dependence and cessation, a finding consistent with that of another survey suggesting slow implementation of Article 14 [10]. Evidence from the survey suggests that perceived cost may be one reason for hesitation in addressing tobacco treatment support. Another reason may be lack of clarity about the effectiveness and cost-effectiveness of tobacco dependence treatment.

There is little doubt that implementation of FCTC Article 14 and its guidelines will bring health and

Editor's note: Very rarely, *Addiction* publishes longer editorials. In this case the greater length was considered to be justified by the importance of the topic and need for a fuller explication than could be achieved in the standard length.

economic benefits to countries [1]. Helping smokers to stop is a highly cost-effective health-care intervention which saves lives [11–15], improves population health by reducing both morbidity and mortality [16–18] and can reduce health-care costs [2]. Every day that smokers aged more than 35 years continue to smoke they lose approximately 3–6 hours of life [19], so for the world's estimated 1 billion current smokers [1], approximately half of them aged more than 35 [20], 62 million days of life are lost every day. Some of these will stop unaided. Many others will stop only after repeated attempts over time. Many more smokers will never stop and will die before they can stop [21], mainly because tobacco use is so addictive [4,22–24]. Arguably treatment support should be provided, along with measures such as restrictions on smoking in public places and other measures mentioned in the FCTC [25]. While other tobacco control policies, such as tax increases and smoke-free air laws, primarily increase quit attempts, evidence shows that comprehensive cessation treatment policies primarily affect quit success [12]. Combining cessation treatment with other policies creates a synergistic impact that improves the effect of other policies. The unaided tobacco cessation rate at 6–12 months is low, only approximately 3–5% [26]. Adding comprehensive cessation support can increase this considerably, at least doubling it [12,18,27,28], but even brief advice improves cessation rates significantly. Its long-term rate is much lower, but applied at population level it would still result in significant population health gain [27]. One reason why so many people who eventually end up as ex-smokers have stopped without help is not because attempting to quit without help is the most effective method, but simply because many of them had no access to help. If they had had access to support they may have stopped sooner, and many life years could have been saved. Additionally, many smokers who never stopped might have managed to do so if support had been available and accessible. According to WHO, just 15% of the world's population have access to appropriate cessation support [29], and even among this 15% many do not use the support that is available [30]. Although less is known about smokeless tobacco use, clearly a comprehensive approach is required for cessation [31,32].

There is thus a significant unmet need for tobacco cessation support. Although some tobacco users stop unaided, many more would stop if they had access to effective support. The FCTC Article 14 Guidelines recommend how to address this need in a way that is appropriate to the situation of the country, and which makes best use of existing resources. Improving cessation support need not be expensive, and helping smokers stop sooner rather than later will not only save many lives but improve the quality of life of those who do stop.

Because of these considerations, and because the FCTC Article 14 Guidelines contain clear and feasible recommendations, we believe the time has come to re-evaluate the role of cessation support, especially because effective, low-cost, broad-reach approaches exist that can be implemented quickly [27]. Revenue could be raised for tobacco control and cessation from tobacco tax increases [1,33,34] and evidence from some countries suggests that public support for such tax increases is stronger if some of the money is spent offering support to tobacco users who need it, many of whom are poor and for whom tobacco use is a financial strain [35].

SOME UNDERLYING PRINCIPLES

The FCTC Article 14 Guidelines include the following key underlying principles:

- Implementing cessation support measures in conjunction with population-level interventions covered by other FCTC articles will have a synergistic effect and maximize their impact.
- Some Parties will want or need to follow a stepwise approach in developing tobacco cessation support that focuses first on what is feasible and affordable, and then on what can be added when more resources are available.
- To develop tobacco dependence treatment as rapidly as possible and at as low a cost as possible, Parties should use existing resources, work-force and infrastructure including, for example, community health workers, frontline primary care providers and tuberculosis services.
- Parties are encouraged to create a sustainable infrastructure which motivates attempts to quit, ensures wide access to support and provides sustainable resources for such support, which should be affordable.
- Tobacco cessation support is a key component of a comprehensive, integrated tobacco control programme; offering tobacco users support for their cessation efforts will reinforce other tobacco control policies by increasing support for them and increasing their acceptability.
- Healthcare systems should play a central role in the delivery of cessation support.
- Parties should follow the evidence base and also keep up with new developments.
- Tobacco cessation and treatment strategies should be based on the best available evidence; there is clear scientific evidence that tobacco dependence treatment is effective, is a cost effective healthcare intervention, and thus a worthwhile investment for healthcare systems.
- Tobacco cessation and treatment strategies should be as inclusive as possible, considering the needs of vulnerable groups.

RECOMMENDATIONS

FCTC Article 14 states that 'each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence'.

The FCTC Article 14 Guidelines set out detailed recommendations for implementation of this Article, including on developing infrastructure, the key components of a national treatment system and a stepwise approach to developing cessation support. We urge all stakeholders to use these guidelines to guide their thinking about cessation support.

Eventually, all Parties should implement all aspects of the FCTC, and the FCTC Article 14 Guidelines encourage Parties to implement measures beyond those recommended by the guidelines (in accordance with the provisions of Article 2.1 of the Convention). However, they also acknowledge clearly that different countries will be at different stages and will need to implement Article 14 according to their own priorities and resources. Thus, we recommend measures that we believe all countries can begin implementing now, and then measures to be implemented as resources become available.

We recommend that countries consider implementing these six core measures immediately:

- Conduct a national situation analysis, as recommended in the FCTC Article 14 Guidelines.
- Develop and implement an evidence-based national cessation strategy and national cessation guidelines.
- Mandate recording tobacco use of all patients in all medical notes.
- Train healthcare workers to record tobacco use and give brief advice.
- Help healthcare workers to quit tobacco use.
- Integrate brief advice to all tobacco users into the healthcare system.

Some of these measures are relatively low cost [27], and we believe some are essential if healthcare systems are to play an active role in helping tobacco users to stop. For example, healthcare workers raising the issue and giving brief advice will be more likely if tobacco use is recorded in medical notes, yet only 20% of countries mandate this [10]. The Article 14 Guidelines emphasize strongly using existing infrastructure as far as possible, both to keep costs down and to ensure as broad a coverage as possible. They mention infrastructure such as the primary healthcare system and services to treat tuberculosis and HIV/AIDS, and in some countries dental services and NCD programmes could also be involved. The first WHO Report on the Global Tobacco Epidemic (the MPOWER package) recommends that tobacco cessation advice be incorporated into primary health-care services [36]. We believe that whatever stage countries are at in implementing other articles of the FCTC, they could be implementing these six core measures.

We recommend that as resources become available countries implement these additional measures:

- Offer mobile phone text messaging support and other evidence-based web support (very low cost and accessible).
- Make evidence-based affordable cessation medicines and less harmful forms of nicotine more available.
- Offer evidence-based telephone quitlines and put the number on pack warnings.
- Expand training to include other healthcare workers; for example, village health workers.
- Offer specialist face-to-face cessation support.
- Establish mass communication and education programmes that encourage cessation and promote cessation support.

KEEPING UP-TO-DATE WITH THE SCIENTIFIC EVIDENCE

The FCTC Article 14 Guidelines urge Parties to follow the evidence base, keep under review the emerging scientific evidence and be open to innovative approaches to promote tobacco cessation [4]. Since the Article 14 Guidelines were adopted in 2010, for example, new research has emerged on text messaging and on less harmful forms of nicotine delivery. Thus national cessation guidelines need to be reviewed and updated periodically to include new interventions. An increasing body of evidence demonstrates the effectiveness of text messaging, a measure with enormous potential because of its possible population reach and low cost. Research is also developing on different forms of nicotine delivery. Clearly, any cessation guideline published in 1980 would be seriously out of date by 1990 because of the advent of nicotine replacement therapy (NRT)—itself an alternative form of nicotine delivery when it was first licensed, and now affordable in many countries—and on the WHO Essential Medicines List [37]. Two recent authoritative publications recognize the continuum of risk from using nicotine products [38,39]. Based on this idea, differential taxes have been proposed that discourage use of the most dangerous forms of nicotine-yielding products [40]. We therefore urge countries to remember that it is the nicotine in tobacco products that keeps people using them, but it is primarily the toxins in the tobacco and tobacco smoke that cause the illness and death, and to keep under review all potential options for tobacco cessation including, for some, the continued use of nicotine.

FOCUSING ON AFFORDABILITY

Many tools exist to help countries implement or improve their provision of tobacco cessation support, including the recommendations of the FCTC Article 14 Guidelines themselves (for example to include the quitline number on tobacco packaging) [4], WHO resources [41–43] and tools to help countries conduct a national situation analysis—recommended in the Article 14 Guidelines—and access other related resources [44]. West and colleagues have published a review of effectiveness and affordability, which includes an Excel calculator that permits a country to input its own national data in order to calculate the affordability of a cessation intervention [27]. Potentially low-cost evidence-based medications are available [45]; countries should also examine how to make medications more affordable, through bulk buying for example, and by including some on their national essential medicines lists. Many countries base their national lists on WHO's essential medicines list [37], which includes nicotine chewing gum and nicotine patch. We also urge countries to consider increasing funding for tobacco control and cessation support through earmarked tax increases [34], a measure recommended in the FCTC Article 6 Guidelines.

Obviously, a key challenge in providing specialist face-to-face cessation support is cost, but another issue is reach. Even in some countries that provide specialist support it is only accessible to a small fraction of the population. This is why the Article 14 Guidelines encourage Parties to consider using existing, rather than creating new, infrastructures. However, many countries have the resources to offer specialist support, and the Article 14 guidelines include a number of recommendations for these, including that it could be delivered by a variety of healthcare or other trained workers, in a wide variety of settings, should be easily accessible to tobacco users and where possible should be provided free or at an affordable cost. The guidelines also emphasize the importance of mass communication programmes that promote cessation.

CONCLUSIONS

Implementation of FCTC Article 14 has been slow. Accelerating its implementation to complement implementation of other Articles, including those promoting tax increases, smoke-free public places and graphic health warnings, will save lives, prevent numerous debilitating illnesses and bring economic benefits. The availability of effective, broad-reach, low-cost interventions and tools to help countries select affordable treatments [27] will remove significant barriers to the development of tobacco cessation support and make Article 14 implementation both eminently feasible and a significant contributor to global health.

Declaration of interests

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Supporting Information

Additional Supporting Information may be found online in the supporting information tab for this article.

Appendix S1 Contains the list of organizations and individuals who had endorsed these recommendations when they went to press. The latest version, which is being continuously updated, can be obtained from the first author.

