
Report on tobacco dependence and cessation (in relation to Article 14 of the Convention (decision FCTC/COP2(14))

1. The WHO's *International Statistical Classification of Diseases and Related Health Problems*, tenth revision (ICD-10), classifies tobacco dependence and withdrawal syndromes as substance use disorders, substantiating the experience of persons who use tobacco products that the habit is difficult to give up. From a public health perspective, if tobacco-related mortality and morbidity are to be reduced within the next few decades, current tobacco users will have to be motivated to stop and be supported in their efforts to do so. Encouraging adult tobacco users to quit will also help to deter children from taking up tobacco use, as it will be portrayed as less widespread and less socially acceptable. Stopping tobacco use brings immediate benefits, and stopping in middle age before serious diseases develop reduces the risk for tobacco-related death.
2. This report has been prepared in accordance with decision FCTC/COP2(14) of the Conference of the Parties, which requests the Convention Secretariat to elaborate, in consultation with Parties particularly interested in the issue, a first report on tobacco dependence and cessation in relation to Article 14 of the WHO Framework Convention on Tobacco Control and to submit the report to the Conference of the Parties at its third session.
3. The first draft underwent peer review by experts in all WHO regions, representatives of Parties that expressed interest in its elaboration, and nongovernmental organizations with expertise in the field. The final version reflects the input received during peer review.
4. The report covers the rationale, framework, essential elements and status of implementation of the various provisions of Article 14 of the Convention. The first part deals with the basic elements necessary for implementing measures for effective treatment of tobacco dependence, such as policies, guidelines and supporting infrastructure. The second section reviews different programmes and interventions for cessation of tobacco use and options for treatment of tobacco dependence, including the settings in which they can be successful. Another section covers the availability and affordability of cessation interventions and medications for treating tobacco dependence, with attention to ensuring access by groups of lower socioeconomic status and populations most in need.

5. The report includes an analysis of interactions between Article 14 and other relevant articles of the Convention and how parallel implementation of these measures might be synergistic. It also gives examples of how such interrelationships act.

6. Finally, the report summarizes challenges and opportunities in the treatment of tobacco dependence that Parties might experience in strengthening their policies under Article 14. The summary also covers other elements that governments and the Conference of the Parties might consider in planning national programmes and in promoting implementation of Article 14 internationally.

POLICIES AND GUIDELINES FOR CESSATION AND FOR TREATING TOBACCO DEPENDENCE

7. Article 14 requires Parties to “include diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco use in national health and education programmes, plans and strategies” and to “develop and disseminate appropriate, comprehensive and integrated guidelines” in order to take “effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence”.

Rationale and general framework

8. To decrease the harm and social costs related to tobacco use, national health and educational programmes, plans and strategies should include provisions for the diagnosis and treatment of tobacco dependence. Population-level interventions, such as legislative and administrative measures, have a wide reach and thus affect large numbers of people at low cost. They are relatively ineffective at the individual level in terms of cessation of tobacco use but can reduce the prevalence of tobacco use and daily consumption because they reach so many people. In addition, they can contribute to the de-normalization of tobacco use, thus creating a supportive social environment conducive to the introduction and implementation of cessation interventions. Although motivating and supporting tobacco users to stop incurs immediate costs, treating tobacco-related diseases is much more expensive.

9. Comprehensive, integrated guidelines on tobacco dependence and cessation that are based on scientific evidence and best practices can influence the design of national tobacco treatment strategies and persuade governments to integrate treatment in overall tobacco control strategies. National guidelines must be tailored to local needs and take into consideration factors such as differences in health-care systems, in the prevalence of tobacco use in various segments of the population and in culture, available resources and the overall status of the tobacco control policy in the country.

Essential components

10. This section presents the essential elements for implementing effective measures to promote cessation of tobacco use and to treat tobacco dependence, including policies, guidelines and supporting infrastructure.

- *Inclusion of diagnosis and treatment of tobacco dependence and provision of counselling on cessation of tobacco use in national programmes, plans and strategies.* Policies, programmes, measures and methods that reflect best practice with respect to counselling for cessation of tobacco use and treating tobacco dependence are important components of any

comprehensive, multisectoral, national tobacco control strategy, action plan and programme. Interventions should also be integrated, if appropriate, into national strategies, plans and programmes with a wider scope, such as those for primary health care, public health or health promotion and alcohol and drug control. Research on cessation of tobacco use can lead to identification of the most effective interventions and programmes under local circumstances and in accordance with local priorities. Such research should therefore also be part of national programmes.

- *Elaboration of guidelines.* Evidence-based national guidelines can prescribe the content and implementation of a national plan for cessation of tobacco use and treatment of tobacco dependence. Governments, public institutions, health professional organizations, providers of cessation services, nongovernmental organizations and, if appropriate, private enterprises should all be encouraged to participate in drawing up, endorsing and promoting such guidelines.
- *Establishment of a supporting infrastructure.* A national infrastructure is needed to promote cessation of tobacco use and to provide effective treatment. Provision of cessation services in primary (basic) medical care is most appropriate in countries with a well-developed primary care infrastructure. Most sectors of a country's health-care system might, however, be involved in providing advice on cessation and treatment of tobacco dependence, including secondary and tertiary care and specialist health care (such as for control of tuberculosis and HIV/AIDS), chest, cardiovascular and diabetes clinics, and immunization and family planning services. Recording of tobacco use as a vital sign could be made mandatory, thus obliging professionals to include tobacco use status in medical notes. Professional associations and other relevant groups, as appropriate, should be formally involved at an early stage in the design of supporting infrastructure.
- *Establishing or strengthening training programmes for professionals (service providers).* Health professionals such as physicians, nurses, dentists and pharmacists, practitioners of traditional medicine and also teachers and community and social workers should be offered training to enable them to provide treatment for tobacco dependence. Such training should be incorporated into the curricula of all health professionals at both pre- and post-qualification levels. Training programmes should take into account gender specificities in relation to cessation support.

Current status and best practice

11. In the two-year reports on implementation of the WHO Framework Convention on Tobacco Control, 39 of the 71 Party reports analysed¹ indicated that diagnosis and treatment of tobacco dependence was in place in national health and education programmes, while 42 reported that programmes had been designed and implemented to promote cessation of tobacco use. The available regional sources showed similar proportions. For example, The *European tobacco control report*

¹ Party reports available were accessed in May 2008. http://www.who.int/fctc/reporting/party_reports/en/index.html.

2007¹ stated that 60% of the Member States of that Region had reported that treatment of tobacco dependence was an integral part of their national health programmes.

12. Nearly half the two-year reports by Parties indicated that evidence-based best-practice guidelines were in place to promote cessation of tobacco use and adequate treatment of tobacco dependence. Some national cessation guidelines, such as those elaborated in Uruguay in early 2008, not only recommend multifaceted treatment (behavioural and pharmacological) but also required mandatory recording of smoking status in medical notes.

13. The recent *WHO report on the global tobacco epidemic, 2008*² states that only 9 (5%) of the 173 responding countries reported that tobacco dependence treatment services were fully available. In some countries, countrywide networks of specialized services have been established to provide advice on cessation of tobacco use and to treat tobacco dependence, such as in Hungary (more than 100 units) and in Mexico (140 units). In some countries, such as India, centres for cessation of tobacco use have been established in cancer, cardiological and addiction centres or in community-care settings. In other countries, such as the Islamic Republic of Iran, cessation interventions are provided in both the primary health-care system and specialized services.

14. Training in giving cessation advice varies widely around the world, and the provision and coverage of such training should be improved. For example, according to *The European tobacco control report 2007*, only 19 of the 53 Member States of the WHO European Region reported that training in smoking cessation techniques was an integral part of the basic medical curriculum, and nearly half (25) reported postgraduate training in smoking cessation techniques at national level. The Global Health Professionals Survey, carried out in 31 countries between 2005 and 2007 at 80 survey sites, indicated that most students in dentistry, medicine, nursing and pharmacy recognize that they are role models in society and believe that they should receive training in counselling patients to quit. In 73 of 80 sites, however, less than 40% of the students reported that they received such training, and in 32 sites less than 20% had received training.

15. Parties could consider engaging practitioners of traditional medicine, if appropriate, in giving brief advice to improve communication to tobacco users living in rural areas. Such practitioners might exert significant community influence, which might be conducive to quitting. This approach has been considered in South Africa.

PROGRAMMES AND SETTINGS

16. Article 14 requires Parties to “design and implement effective programmes aimed at promoting the cessation of tobacco use”, with health-care facilities and rehabilitation centres as a priority. It also recognizes the role of settings other than health, such as educational institutions, workplaces and sporting environments, in providing cessation programmes.

¹ World Health Organization Regional Office for Europe. *The European tobacco control report. 2007*. Copenhagen, World Health Organization, 2007.

² World Health Organization. *WHO report on the global tobacco epidemic, 2008*. The MPOWER package. Geneva, WHO, 2008. <http://www.who.int/tobacco/mpower/en/>.

Rationale and general framework

17. Efficient evidence-based programmes and interventions are available for cessation of tobacco use and treatment of tobacco dependence at both population and individual level.^{1,2,3} Such programmes encourage tobacco users to seek treatment for their dependence early, before significant health problems develop. Interventions targeted at individuals, integrated into primary health care or provided by specialized services, depending on their intensity, reach fewer people than population-level interventions, but they are more effective for heavily dependent tobacco users, who are therefore at greater risk. Effective treatment is more cost-effective than many other health-care interventions and is an excellent investment for health services, even in low-income countries, particularly if they have centrally funded national health care. In order to achieve the greatest possible efficiency, interventions should be adapted to local circumstances and tailored to individual preferences and needs.

18. Advice and support for cessation can also be given effectively through interventions in settings outside normal health care. These include telephone helplines (also known as “quitlines”), text messaging and interactive web sites. Specialist support can also be given in community environments, such as sports venues, workplaces and educational institutions. These settings are especially important for targeting vulnerable groups.

19. In addition to interventions delivered through the health-care sector, other population-level interventions can promote cessation, including promotional and educational programmes, such as mass media campaigns operating with cessation messages. Campaigns with a strong, continuing media presence (e.g., adequate weight of message and duration and frequently changing messages) or regularly repeated public awareness campaigns, some of which offer special incentives, can increase motivation to quit.

20. Health professionals have an important role and influence in cessation programmes. Avoidance of tobacco use by health professionals is critical because: (i) by using tobacco, health professionals undermine public health messages about its dangers; (ii) health professionals act as role models; (iii) physicians who use tobacco are more likely to underestimate the risks of this habit and the benefits of quitting and (iv) clinicians who smoke are less likely than nonsmoking clinicians to counsel patients to avoid tobacco use. Specific programmes promoting cessation of tobacco use among health professionals should therefore be conducted to improve their participation in the provision of support for cessation.

Essential components

21. The components listed in this section are derived from evidence-based interventions on cessation of tobacco use, including the treatment of tobacco dependence, and also population-level programmes to create a supportive environment for persons who wish to quit tobacco use.

¹While Article 14.2(b) refers to both “counselling services on cessation of tobacco use” and “diagnosis and treatment of tobacco dependence”, counselling or behavioural support is widely accepted as part of treatment of tobacco dependence. Evidence-based treatment for tobacco dependence includes pharmacotherapy, in addition to counselling.

² Cochrane Library Tobacco Reviews. http://www.cochrane.org/reviews/en/topics/94_reviews.html.

³ World Health Organization Regional Office for Europe. *The European tobacco control report 2007*. http://www.euro.who.int/InformationSources/Publications/Catalogue/20070226_1.

- *Provision of brief advice as part of routine health care.* Two well-known models exist: the “5 As” (Ask about tobacco use, Advise users to quit, Assess their interest in quitting, Assist or refer them to specialist support when available, and Arrange follow up) and “ABC” (Ask about smoking status, give Brief advice to quit, and offer Cessation treatment).
- *Provision of intensive behavioural support.* Support delivered face-to-face by a trained professional, either individually or in groups, backed up by medications, if appropriate, can be offered by tobacco cessation services or “clinics”. In addition, specialist support can be provided elsewhere, such as in the workplace. Establishment of a few model clinics offering specialist support can help to gather evidence that treatment works, provide training to health-care professionals and raise broader issues in tobacco control.
- *Making medications available.* A number of pharmacological products and treatment schemes have been shown to aid smoking cessation. Nicotine replacement therapy is available as a patch, chewing gum, nasal spray, lozenge, sublingual tablet or inhalator, some in different dosages and flavours. These supports deliver nicotine without the other constituents of tobacco, thus reducing some of the withdrawal effects. Other cessation medications do not contain nicotine but also reduce the severity of withdrawal symptoms and increase the chances of long-term abstinence. These include bupropion (an antidepressant), varenicline (a partial nicotine receptor agonist) and nortriptyline and clonidine (although the usefulness of the latter medicine is limited by a high incidence of side-effects). In some countries, cytisine is also available as a non-nicotine cessation medicine, but further research is needed to assess its effectiveness. Combining different types of nicotine replacement therapy appears to increase the prevalence of quitting, especially among dependent tobacco users. Therapy is now available in some countries to assist smokers to reduce their consumption before they attempt to quit (“reduce then stop”).
- *Establishing telephone helplines.* Telephone counselling is another example of behavioural support. Quitlines can have a wide reach if they are free. Call-back or proactive quitlines are preferable, as they are highly cost-effective from the population perspective. Combining cessation counselling over quitlines with the offer of free nicotine replacement therapy to users can increase the number of calls and can be cost-effective by inducing large numbers of smokers to attempt to quit.
- *Provision of other interactive means to support cessation of tobacco use.* Evidence for novel means of support, for example through text messaging and interactive web sites, is emerging. These interventions, which might appeal to young people in particular, appear to be promising. They may be the subject of future research but will probably be useful only in countries where telephone use and computer ownership are high.
- *Provision of a model evidence-based cessation programme wherever feasible.* A programme to control smoking of tobacco products should include routine brief advice by health professionals, supplemented by the provision of medications and referral to specialist support when available and necessary. The medications for smokeless tobacco users do not appear to have any long-term effects, but more research is needed to identify the most effective programmes for smokeless tobacco users. Programmes can be implemented in various settings, both within and outside the health-care infrastructure, including workplaces. The needs of vulnerable population groups (such as minors, women, HIV/AIDS and tuberculosis patients, patients with known respiratory conditions, disadvantaged or lower socioeconomic groups, certain minority ethnic groups, and persons living in remote rural areas) and health professionals who use tobacco should be addressed in targeted interventions. The relative

cost-effectiveness of interventions could be taken into account in designing accessible and affordable programmes, especially for low-resource countries.

- *Implementing population-level interventions.* Mass media campaigns for de-normalizing tobacco use, emphasizing the importance of quitting and indicating that professional help, including medications, are available can assist quitters if they are sustained and adequately funded. “Quit and win” contests can result in quit rates higher than baseline community rates, although their population impact is relatively low. Public awareness campaigns combining unpaid mass media with local events can also encourage tobacco users to quit, such as activities related to World No Tobacco Day or national No smoking days.

Current status and best practice

22. In the two-year reports on implementation of Framework Convention, nearly half the 71 reporting Parties indicated that they had established treatment programmes in health-care facilities and rehabilitation centres. The *WHO report on the global tobacco epidemic, 2008* found, however, that 22 (13%) of the 173 countries surveyed offered no help at all to tobacco users in the form of basic services such as counselling or pharmacotherapy.

23. In a survey in the WHO European Region in 2006, 29 (55.7%) of its 53 Member States reported having quitlines. The European Network of Quitlines, supported by the European Commission, is the umbrella organization for these national quitlines and also provides technical guidance and assistance to enhance the performance of member quitlines. A similar network of quitline operators, the North American Quitline Consortium, is available in North America. Toll-free quitlines can be coupled with novel ways of promoting cessation of tobacco use, such as the Internet blog site of the national quitline in New Zealand. The telephone numbers of quitlines could be included in health warnings on all tobacco product packaging, as in Brazil and South Africa.

24. The situation varies worldwide. In the *WHO report on the global tobacco epidemic, 2008*, only 44 countries (25%), accounting for less than 40% of the world’s population, had quitlines, and in 39 of the responding countries (23%) people cannot obtain nicotine replacement therapy, even if they can pay for it. *The European tobacco control report 2007*, however, showed that nicotine replacement therapy was available in all but one of the 43 reporting countries. Bupropion was available in 36 countries.

25. The workplace can be an effective setting for smokers to quit. As most adults spend one third of their day in a working environment, this is a setting in which large numbers of smokers can be reached for cessation interventions. Research suggests that workplace interventions, especially in conjunction with introduction of a complete workplace smoking ban, can contribute to improving public health by decreasing the prevalence of smoking. There is strong evidence that individual counselling increases the likelihood of quitting, and this can be effectively provided at the workplace. Most experience in workplace smoking cessation programmes, including provision of specialist support or group counselling, comes, however, from developed countries (Australia, Austria, Belgium, Canada, Germany, Ireland, Japan, the Netherlands, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America).

26. Little information is available about cessation programmes in other countries, and specific questions on this aspect will be introduced in the second version of the reporting instrument for the Framework Convention. Some sources indicate that novel approaches could be used to provide cessation programmes in diverse settings. Initiatives to create smoke-free hospitals usually include

provisions for cessation support, such as in the United Kingdom. The European Code of Smoke-free Hospitals, drawn up by the European Network of Smoke-free Hospitals, requests hospitals to provide cessation support for patients and staff and to ensure the continuity of support to patients after discharge. The Network coordinates programmes in more than 1300 hospitals in 20 Member States of the European Union.

27. There is limited evidence for the efficiency of cessation interventions in schools, although programmes have been pilot tested, such as in some areas of the United Kingdom of Great Britain and Northern Ireland. Tobacco control ought to be an important component of “healthy cities” initiatives. The anti-smoking campaign launched as part of the Healthy Seoul Project (Republic of Korea) includes the establishment of anti-smoking clinics in public health centres and provision of telephone counselling services. Of the cities participating in the WHO European Healthy Cities programme, over 85% have established cessation programmes. Prisons provide an important opportunity and a novel approach to promoting health; experience indicates that a cessation programme can be successful as part of comprehensive health promotion among persons in custody as well as staff.

28. Several countries have used cessation messages in mass media campaigns; their experience is summarized in a WHO report, *Smoking cessation media campaigns from around the world. Recommendations from lessons learned* (2001).¹ Combining messages on the health risks of smoking with messages to quit smoking (such as providing the telephone number of a quitline) encourages quitting, for example in Australia’s “Every cigarette is doing you damage” campaign. Those campaign materials have been used in more than 50 other countries.

29. The European Commission’s “Help: for a life without tobacco” campaign is being implemented in all 27 Member States of the European Union. As part of the campaign, tobacco users who want to quit and who register on the campaign’s web site can participate in a web-based cessation effort, receiving 25 generic e-mails containing useful advice and encouragement over a two-month period on the basis of the smoking habits reported at registration.

30. The concept of providing incentives for users who successfully quit tobacco use as part of a broader communication campaign was introduced in 1985 during the North Karelia Project in Finland. Subsequently, “Quit and win” became an international competition, implemented every second year, with more than 700 000 participants in 84 countries in 2006. Such contests may result in quit rates above baseline community rates, at both local and regional levels, and may prove to be effective for promoting tobacco cessation, particularly in countries with low resources.

¹ Schar EH, Gutierrez KK. *Smoking cessation media campaigns from around the world. Recommendations from lessons learned*. Copenhagen, WHO Regional Office for Europe and Atlanta, Georgia, Centers for Disease Control and Prevention, 2001.

Tobacco dependence treatment in England. Document WHO/NMH/TFI/FTC/03.3.
http://www.who.int/tobacco/research/cessation/en/best_practices_england.pdf

ACCESSIBILITY AND AFFORDABILITY OF TREATMENT OF TOBACCO DEPENDENCE

31. Article 14.2(d) emphasizes the importance of the accessibility and affordability of treatment of tobacco dependence, including pharmaceutical products, products to administer medicines and diagnostics when appropriate.

Rationale and general framework

32. Treatment, including services and medications, where appropriate, must be accessible and affordable to tobacco users if it is to be widely used.

33. Accessibility can be ensured by making cessation programmes and pharmaceutical products for treating tobacco dependence widely available. Experience has shown that increasing the accessibility of medications in particular, by changing where they can be obtained, allowing them to be advertised and increasing the variety available, increase quit attempts.

34. Services and medications can be made affordable by making treatment free or at reduced cost to tobacco users. For example, several studies in the United States indicated that cost could be a barrier to the use of medications like nicotine replacement therapy. The prices of medications might be reviewed, if possible, to improve their affordability and enable them to better contribute to achieving public health objectives. Treatment of tobacco dependence will require funding, and mechanisms reflecting local needs and opportunities will need to be found.

35. The cost-effectiveness of interventions and medications made available free or at low cost by health-care systems has not been studied widely. Although behavioural support in addition to nicotine replacement therapy gives the best chance of quitting, providing medication over the counter without support is still effective. Widening access to nicotine replacement therapy increases its accessibility for those who can afford to purchase it, even if intensive support is limited. The World Bank concluded^{1,2} that further local research is needed on the cost-effectiveness of public coverage of such medications in the light of evidence that increasing accessibility by liberalizing provision is far more likely to be cost-effective.

Essential components

36. This section is concerned with interventions to increase the availability and affordability of treatment interventions and medications.

- *Enabling wide access to brief advice.* Brief advice should be offered throughout the health-care sector, if possible free of charge to patients. Where resources permit, specialist support should also be offered free and after working hours.

¹ World Bank. *Curbing the epidemic. Governments and the economics of tobacco control*. Washington DC, 1999. <http://worldbank.org/tobacco>.

² Novotny TE et al. Smoking cessation and nicotine replacement therapies. In: *Tobacco control in developing countries*. Washington DC, World Bank, 2000. <http://www1.worldbank.org/tobacco/tcdc.asp>.

- *Increasing the accessibility and affordability of treatment of tobacco dependence.* Public funding of cessation programmes would improve access to effective interventions. Employers can contribute to workplace cessation programmes. Medications can be provided free of charge or at reduced cost to tobacco users trying to stop, and medications such as nicotine replacement therapy could be made available over the counter or on general sale to increase access.
- *Providing easy access to telephone helplines.* Help through quitlines should be offered free of charge through a toll-free number. To increase access, quitlines should also be accessible outside working hours. Quitlines can decrease health inequalities, as they can reach individuals in remote places and can be tailored to specific population groups (e.g., counselling in different languages).
- *Increasing the population coverage of cessation services to provide equal opportunities to vulnerable groups.* Wherever feasible, services should be distributed equitably throughout a country, so as to reach vulnerable groups and underserved rural areas or areas of deprivation.
- *Finding a sustainable source of funding for cessation interventions.* Appropriate, feasible financial mechanisms for funding should be found in each country, taking into consideration local circumstances. If appropriate, cessation of tobacco use and treatment of tobacco dependence can be included in individual (public or private) health insurance coverage. Taxation of tobacco products and earmarking a predetermined amount or percentage of collected taxes to fund programmes for cessation of tobacco use or to reimburse fully or partially the costs of treatment of tobacco dependence has been put in place in a number of countries.

Current status and best practice

37. The *WHO report on the global tobacco epidemic, 2008*, cites a report from the United States of America that three of four tobacco users who are aware of the dangers of their habit want to quit. As use of tobacco products is addictive, many users will need help to quit. Most attempts are, however, made without any help, by willpower alone. For example, in the European Union, only 18% of smokers asked for help to quit during their last attempt. Although 1% to 3% of tobacco users succeed in abstaining for at least 12 months by willpower alone, with an important impact at population level, the success rates are much higher when support is given. Some people do not seek help in quitting because in many countries most tobacco users have little or no access to cessation support or are unaware that such support exists.

38. In the two-year reports on implementation of the Framework Convention, 38 of the 71 reporting Parties stated that they had improved the accessibility and affordability of treatment of tobacco dependence, including with pharmaceutical products. The *WHO report on the global tobacco epidemic, 2008* found that only nine of the 173 reporting countries offered the highest level of cessation support, with a full range of treatment and at least partial financial subsidies for the use of cessation services and treatment. The report also indicates that people in nearly 25% of the responding countries were unable to obtain nicotine replacement therapy, even if they could pay for it. According to the *European tobacco control report 2007*, nicotine replacement therapy was available over the counter in 42 Member States (81%), but only six countries in the Region reimbursed these products partially through their national health-care systems. In general, reimbursement was limited to people in lower socioeconomic strata and those aged over 65.

39. For cessation services and medications to be more affordable, they might be provided at reduced cost or free of charge. Some Parties to the Convention reported that they offer full reimbursement of some or all pharmaceutical products to treat tobacco dependence. Free smoking cessation services (behavioural therapy and pharmaceutical products) have been introduced gradually by Brazil since 2002. Nicotine replacement therapy and bupropion are provided free of charge through the national tobacco control programme in Serbia and through the network of cessation services in Romania.

40. Some examples of Parties providing toll-free quitlines services are Brazil, the United Kingdom of Great Britain and Northern Ireland and Uruguay, while quitlines are available at reduced cost or at the cost of a local call in a number of other countries.

41. In some countries, a comprehensive set of measures is used to facilitate access to nicotine replacement therapy. The example of the United Kingdom indicates that these measures might include: making some forms of products available for general sale (e.g., in supermarkets); ensuring that all products are available over the counter in pharmacies; providing medications proven to be effective at a reduced rate or free of charge (depending on income) to smokers trying to quit through the health-care system and specialist treatment clinics; and reducing the tax on nicotine replacement products.

42. In order to ensure equality in efficient cessation interventions, programmes for vulnerable groups have been set up. For example, in Canada, interventions are available to encourage pregnant women and their families to quit tobacco use before, during and after the pregnancy. Cessation services and medications might be provided free of charge to smokers in lower socioeconomic groups, as in the United Kingdom. Evidence from that country indicates that specialist treatment can reach poorer sectors of society and thus contribute to reducing health inequalities. Other Parties provide specialized services for minority populations, such as in New Zealand.

43. The implementation of any efficient, cost-effective programme for cessation of tobacco use requires an adequate level of sustained investment. Provision of such support can be a challenge to decision-makers, who have competing priorities for funding. Examples of alternative financial mechanisms to provide support for cessation measures and programmes include earmarking a percentage of the tax collected from the sale of tobacco and alcohol products. This is the case, for example, in Romania, Serbia and Thailand. Private donations can provide financing for making nicotine replacement therapy available in smoking cessation clinics, such as in Qatar.

RELATIONS BETWEEN ARTICLE 14 AND OTHER ARTICLES OF THE CONVENTION

44. Three articles of the Convention, in addition to Article 14, make direct reference to reducing tobacco consumption, nicotine addiction, cessation or treatment: Article 5.2(b) (*General obligations*), which urges Parties to adopt and implement measures to reduce tobacco consumption and nicotine addiction; Article 12 (*Education, communication, training and public awareness*), which refers to raising public awareness of the benefits of cessation of tobacco use; and Article 22 (*Cooperation in the scientific, technical, and legal fields and provision of related expertise*), which refers to international collaboration and the sharing of technical, scientific and legal expertise and technology for identifying methods for comprehensive treatment of tobacco dependence and promotion of research to increase the affordability of such treatment.

45. Implementation of several other articles in the Framework Convention will also encourage quitting:

- Article 6 (*Price and tax measures to reduce the demand for tobacco*) and Article 8 (*Protection from exposure to tobacco smoke*). Price increases and smoke-free policies may encourage tobacco users to reduce their consumption or quit.
- Article 9 (*Regulation of the contents of tobacco products*) and Article 10 (*Regulation of tobacco product disclosures*). Awareness of the content of tobacco products or the disclosure of toxic constituents of tobacco and tobacco smoke might encourage quitting.
- Article 11 (*Packaging and labelling of tobacco products*). More prominent and pictorial warnings are likely to encourage quitting.
- Article 13 (*Tobacco advertising, promotion and sponsorship*). Reducing the availability of tobacco advertising and marketing might encourage quitting.
- Article 20 (*Research, surveillance and exchange of information*). Regular information on attitudes towards quitting and quitting behaviour can be used to tailor programmes, plans and strategies to country needs.
- Article 21 (*Reporting and exchange of information*). Sharing information on the activities under Article 14, such as advanced practices and barriers to implementation, will be important in designing successful programmes and strategies.

46. Evidence is emerging of a potential synergy between broader tobacco control measures and interventions to help tobacco users to quit. For example, when smoke-free laws are implemented (Article 8), calls to quitlines and sales of smoking cessation medications increase.

47. There is evidence that more prominent health warnings (Article 11), especially those that include pictures, encourage cessation. After pictorial warnings were introduced in Brazil, two thirds of smokers said that their desire to quit was due to these warnings. Health warnings can also be used to promote quitting by advertising quitline numbers or Internet sites offering cessation support.

48. A simulation model of the impact of tobacco control policies on reducing smoking prevalence showed that tax increases (Article 6) and advertising bans (Article 13) resulted in the greatest reduction in smoking prevalence in Thailand. There is also evidence that a comprehensive tobacco advertising ban can reduce consumption, whereas restricting promotion has little or no effect.

49. A recent systematic review of tobacco control interventions at the population level and their impact on cessation found that the strongest effect was that of price increases (Article 6). The authors noted, however, that smokers living in disadvantaged households were more likely to be dependent on nicotine, and they concluded that price measures should be accompanied by support for cessation of tobacco use for low-income households.

50. The success of cessation efforts might, in turn, increase implementation of other tobacco control policies by increasing the level of public and political support for and the acceptability of the policy measures. Research indicated that former smokers give greater support than current smokers to population-level interventions, such as tax increases (Article 6), bans on tobacco use in public places (Article 8) and public education (Article 12).

51. The scientific basis of cessation interventions and treatment of tobacco dependence, best practices and their efficiency and cost-effectiveness should be clearly communicated to the public and decision-makers, in line with the recommendations of Article 12. This might help to avoid creating the impression that cessation is more difficult than it actually is.

52. Strategic planning for better coordination of treatment of tobacco dependence with other initiatives would be an important contribution to the overall success of national policies and programmes.

CHALLENGES AND OPPORTUNITIES

53. On the basis of available information, evidence from the scientific literature and examples of best practice from Parties, this section summarizes the challenges and opportunities in cessation of tobacco use and the treatment of tobacco dependence that lie ahead as Parties strengthen their policies under Article 14.

Inclusion of diagnosis and treatment of tobacco dependence in national programmes, plans and strategies

54. Many decision-makers do not recognize that diagnosis and treatment of tobacco dependence and provision of counselling for cessation of tobacco use can be most efficient if they are part of national tobacco control programmes, plans and strategies, rather than isolated medical activities or activities that are the responsibility only of health ministries. While their integration into comprehensive tobacco control programmes will not be easy in all circumstances, evidence, approaches and examples exist for this purpose. These experiences should be analysed and shared among Parties.

Guidelines

55. Few countries have drawn up and disseminated comprehensive, integrated guidelines based on scientific evidence and best practice. Such guidelines, prepared or endorsed by relevant stakeholders, could nevertheless help to persuade governments to embed cessation counselling and tobacco dependence treatment in the national tobacco control strategy.

Training for health professionals

56. Only a fraction of health professionals receive training on cessation interventions and on the treatment of tobacco dependence during their qualification. The structure and content of the most effective training curricula and standardized training programmes have not been described. Coordinated efforts at global level might contribute to the harmonization and promotion of training curricula for health professionals, thus improving effective cessation interventions at national level.

Availability of medications

57. While medications are available in many countries, their use remains low, even though they improve the success rates of cessation attempts. The problem can be exacerbated by lack of information on the effectiveness and safety of medications for treating dependence for both the public and health professionals. The limited availability of these medications in some countries might be due to restrictive regulation of their sale and promotion or particular pricing regimes. Health professionals'

training should include the latest achievements in treatment of tobacco dependence, so that they can provide accurate information on cessation services and medications to their patients.

Telephone helplines

58. Worldwide, only one in four countries uses this cost-effective means to provide cessation counselling. This might indicate lack of awareness about its effectiveness and about good international practice in this area. Quitlines can, however, be accessed by the majority of the population and, importantly, by population groups that would not otherwise have access to cessation counselling. Gathering, analysing and disseminating experience in this area might contribute to advocacy for their establishment or strengthening in countries that do not or do not fully exploit this tool currently.

Cessation programmes in particular settings

59. Little evidence and few examples are available of cessation programmes in particular settings, especially in low- and middle-income countries. There is limited recognition of the role of settings in which large population groups spend a significant part of their daily lives (e.g., workplaces, educational facilities) or which are visited regularly (e.g., sports environments) in promoting cessation of tobacco use. Successful initiatives in workplaces and prisons have nevertheless been documented. Cessation programmes in such settings might reach population groups that are otherwise difficult to access.

Reimbursement of the costs of cessation services and medications

60. Only a few countries provide free access to cessation services, and even fewer reimburse medications used in the treatment of tobacco dependence. This limits access to effective treatment, especially for lower socioeconomic groups, thus preventing them from fully benefiting from services and medications. People who successfully quit tobacco use, however, may be more supportive to broader population-level tobacco control interventions (e.g., tax increases and smoke-free policies). More research is needed on the cost-effectiveness of policies in which medications are provided free or at reduced cost to tobacco users.

Population-level versus individual-level interventions

61. In many instances, population- and individual-level interventions are not implemented synergistically. For maximum impact, they should be implemented in parallel, for example as part of a national tobacco control programme. Harmonizing different actions in time, providing adequate funding and ensuring sustained political commitment for their implementation can be difficult. Experience indicates, however, that the more comprehensive a national programme is, the more impact it has on population health. Thus, widely available cessation programmes and efficient population-level interventions should be implemented simultaneously.

International exchange of experience

62. Most of the evidence on treatment of tobacco dependence comes from developed countries, while 80% of deaths related to tobacco use in the twenty-first century are expected to occur in low-income countries. Although these countries might benefit from improved flow of information and experience, effective mechanisms are lacking. Information exchange should also facilitate research on and the dissemination of best practices in cessation of smokeless tobacco use in low-resource countries. Information exchange could be improved by strengthening the reporting instrument of the

WHO Framework Convention in relation to Article 14, by thorough analysis of the collected information and by making it available to Parties. On-site transfer of knowledge, including field research, pilot projects and evidence-based guidelines, could introduce internationally proven opportunities to developing country Parties that lack expertise in this area.

CONCLUSIONS

63. The human and economic burden of tobacco use is immense. Half of its users will eventually die because of their addictive habit. One quarter of tobacco-related deaths occur prematurely, in people in middle age (35–69 years of age), causing an average loss of 20–25 years of life. Worldwide, if actual patterns of tobacco use remain unchanged, 450 million deaths can be expected in the first half of this century due to tobacco use. Only by encouraging tobacco users to quit and supporting them in their effort will tobacco-related mortality and morbidity drop significantly in the next few decades.

64. A vast body of evidence shows that efficient, cost-effective interventions for cessation of tobacco use and for treatment of tobacco dependence exist. They should therefore be an integral part of comprehensive tobacco control programmes,¹ as recommended in Article 14 of the WHO Framework Convention.

65. Measures outlined in several other articles of the Convention also support cessation of tobacco use, by encouraging quitting and by creating a supportive environment for implementation of cessation policies and establishment of the necessary infrastructure. More support for tobacco users in their cessation efforts and successful treatment of their tobacco dependence will influence other tobacco control policies, by increasing the level of social support for and the acceptability of these policies. Implementing cessation measures in conjunction with population-level interventions, as covered in other articles of the Convention, will have a synergistic effect and thus maximize the impact.

66. National and international data and examples of good practice on cessation indicate that the key challenges and opportunities at global level are in areas such as the inclusion of cessation programmes in national health or tobacco control programmes, plans and strategies; the drawing up and dissemination of guidelines; training on cessation and tobacco dependence treatment for health professionals; the availability and accessibility of cost-effective interventions, such as medications and telephone helplines; reimbursement of the costs of cessation services and medications and support for tobacco users in lower socioeconomic groups and those at high risk of addiction; and access to services and treatment. An accessible national infrastructure is needed for the treatment of tobacco dependence, with the widest possible population coverage.

67. Internationally agreed guidance on the status, challenges and opportunities for cessation of tobacco use and treatment of tobacco dependence would be a valuable step forward in promoting implementation of Article 14 of the Framework Convention globally, which the Conference of the Parties might wish to consider in the light of decision FCTC/COP2(14).

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¹ World Health Organization. Policy recommendations for smoking cessation and treatment of tobacco dependence. (Advancing tobacco control in the XXIst century). Geneva, World Health Organization, 2003. www.who.int/tobacco/resources/publications/tobacco_dependence/en/index.html.