

Subject Review

Smoking Cessation: A Current Update from FCTC Article

14 Adoption in Thailand

Thayaroch Tipyawong¹ and Punchatorn Tipyawong²

¹Princess Mother National Institute on Drug Abuse Treatment (PMNIDAT); ²Professional Division, Royal Thai Army Medicine Department

Abstract: In recent years, the political recognition of the role of the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) as a catalyst in the Thai health agendas is growing, including the promotion of multi-sectorial transnational cooperation, as the prevention and control of non-communicable diseases (NCD) from tobacco risk factors. This reviews the effect of tobacco control policies on the evidence-based 2nd strategies, with the aim of providing guidance on implementing National strategy tobacco control policy 2010 – 2014. Based on previous studies, we estimate the magnitude of effects of major tobacco control policies, how the successful campaigns have implemented a combination of tobacco control policies, how the effects depend upon the manner in which the policies are implemented, and the barriers. The study employed a mixed methods design including review of documentation and policy reports, and an analysis of research productivity. Results reveal problem, obstacles, challenges and recommendation to be mentioned, outlining present tobacco control lessons learnt from FCTC article 14 adoption in Thailand, including integrated mass media of tobacco-control issues that are essential to ensure social change, enforcement and formulation of the responsible structure that takes action for conducting the highly-effective and simple surveillance activities and, all systematic accessible tobacco cessation health-care services and tobacco cessation drugs.

RTA Med J 2015;68:181-92.

Introduction

The Thai demographic survey of smoking habits in 2013, the National Statistical Office revealed that the number of smokers aged 15 and older was 10.77 million, or 19.97%¹. An additional study showed that the smoking situation (conducted by the Tobacco Research Control and Knowledge Management Center - TRC) of Thai people aged 15 and older in 1991, 1996, 2001, 2004,

2007, 2009, and 2011 comprised 32.0%, 28.81%, 25.57%, 22.98%, 21.22% 20.70%, and 21.36% respectively². From the year 2009 to 2013, results showed that smoking rate decrease slightly and the goals of smoker reduction rate were ineffective. Smoking can result in adverse health consequence, which is the third risk factor of Burden of Disease (First is alcohol use, and second is dangerous sexual behaviors)¹. The research also says economic impact costs 52,189 million baht, or 0.54% of the GDP¹.

The implementation of tobacco control in Thailand comprises multilateral government, subsequent agreement(s), NGO parties and regional community. The Thai

Received 25 September 2015 Accepted 18 October 2015

Requests for reprints should be addressed to Col. Punchatorn Tipyawong, Professional Division, Royal Thai Army Medicine Department, Phrayatai Rd., Ratchatavee Dist., Bangkok 10400

government became a signatory to the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) showing that it recognizes that tobacco use is a serious problem, (the 36th of 168 countries) February 27, 2005³. Despite the greater reduction in tobacco-use functioning, the domestic legal, political, social and cultural circumstances and resource levels indicate more high-level progression. Changes of Thai social context have resulted in new social processes and structures resulting in new social conflict. These factors are more associated with more complicated tobacco-control issues. The National Strategy on Tobacco Control Policy 2010 - 2014 has been established to achieve its goals. The plans included eight strategies, in which the second strategy: consumer promotion to tobacco use reduction and quit, have been adopted from FCTC article 14, will be discussed further⁴.

The purpose of this article is discussion of the effectiveness of tobacco control and problem when these policies have been fully implemented in Thailand. This part will focus on the second strategy: consumer promotion to tobacco use reduction and quit, by gathering information from the literature review, and related secondary data.

Results

National Tobacco Control has been operating more than 30 years. The operations have resulted in concrete enactment of 2 important national tobacco control laws, i.e., the Non-smokers Health Protection Act year 1992, and the Tobacco Products Control Act year 1992. March 30, 2010 the 19th Health Regulations regarding the names or types of public places with protection of the health of non-smokers was announced. Part of or all public places were labeled smoking or non-smoking areas, as according to the Non-Smokers Health Protection Act year 1992. Because the government had

signed a decree, the Framework Convention on Tobacco Control (WHO FCTC), the WHO in collaboration with its Member States has established the commitment and guidance for members to raise awareness and prevent and resolve serious public health issues resulting from tobacco use⁴.

What is FCTC?

The WHO Framework Convention on Tobacco Control (FCTC) is the first coordinated global effort to reduce tobacco use. With 179 parties as of July 2014, the FCTC is one of the most widely adopted treaties in the United Nations system. This is also the first treaty negotiated under the auspices of the WHO and is one of the most widely adopted treaties in the United Nations system. The FCTC entered into force February 27, 2005 and requires parties to implement evidence-based measures to reduce tobacco use and exposure to tobacco smoke¹.

FCTC/ Conference of the Parties (COP) 4⁸

Guidelines have been established to implement Article 14 of the WHO FCTC demanding reduction measures concerning tobacco dependence and cessation.

Objectives of Article 14⁽¹⁰⁾

All parties recognize that tobacco use is highly addictive, that implementing tobacco dependence measures should occur in conjunction with other effective tobacco control measures required by the FCTC, and that treatment should be accessible and affordable. Further, all parties agree that implementing measures should be protected from all commercial and vested interests of the tobacco industry and, to the possible extent, use and strengthen existing healthcare systems.

The Article 14 Guidelines identify numerous specific actions that parties should take to effectively implement Article 14, including the three listed below.

1. Develop an infrastructure to support tobacco

cessation and tobacco dependence treatment by conducting a national situation analysis and developing a national tobacco cessation strategy and tobacco dependence treatment guidelines based on the best available scientific evidence and practices.

2. Establish population-level approaches such as mass communication programs and quit-lines in addition to more intensive individual treatment services, accessible and affordable medications, and other novel approaches to cessation and treatment.

3. Monitor and evaluate all related strategies and programs.

The Article 14 guidelines build upon a political declarations that promote the development, implementation and evaluation of tobacco cessation services, promoting and/or guiding into the national health insurance system, promoting and facilitating the exchange of information to the public, coordinating and cooperating with relevant organizations and bodies of the national system, moreover, other international and regional intergovernmental organizations and non-governmental organizations and bodies collaborate efforts as a means of strengthening and implementing strategies, plans, programs, policies, legislation and other measures to decrease tobacco consumption. On the whole, the guidelines succeed in providing practical tobacco cessation guidance and set national implementation by a professional team. Also, these guidelines emphasize accessibility, convenience, fastness, and inexpensiveness⁵.

The standardized guidelines of the Tobacco-dependence Treatment Framework should be considered to include all systematically identified tobacco users into public tobacco dependence and cessation programs by complementing national policies. To deliver tobacco cessation counseling in clinical practice is to build competency among the health professionals integrating

the provision of brief cessation counseling into daily practice, and raising health professionals' awareness about their roles in tobacco control. Formulating a model is valuable to assess a person's readiness, including the patient's current smoking status, readiness to change, motivation to quit, barriers to quitting smoking history, psychosocial factors (social support, friends), patients' preferences and overall psychiatric and general medical support. Also, appropriate access to tobacco-cessation drugs, treatments and medical necessity should also be included. Follow-up is extremely important to reinforce motivation through re-counseling, considered necessary to prevent a relapse. This can be arranged by networks of health professionals to offer short training courses on knowledge and skills on smoking cessation. Telephone contact or the National Quit-line Center "Quitline 1600" has been generated with the goals of treating and assessing a person's smoking status. Reviewing the effectiveness of various smoking cessation measures to evaluate how prudent health care smoking cessation helps to identify the experience and problems and anticipate future challenges for developing a sustainable system to build the capabilities of health professionals in the treatment of tobacco use and dependence.¹¹⁻¹³

Why promote a national tobacco control strategy in Thailand?

After the arrival of the tobacco industry in Thailand, in 1935, with British American Tobacco, tobacco seeds were initially planted in northern Thailand, following which the industry originated the production of tobacco. Then in the mid-20th century following scientific revelations, tobacco became condemned as a health hazard, and eventually became identified as a cause for cancer, as well as other respiratory and circulatory diseases.

In 1957, Dr. Roger Nelson, physician of Mission

Hospital, started the first non-smokers campaign in Thailand, and continued for many years. In 1992, the Parliament approved the Tobacco Product Control Act. The act banned advertising, promotion and sponsorship. In addition, tobacco was not to be sold to persons under the age of 18 or sold by vending machine. It also included provisions for health warnings and ingredient disclosure of tobacco products¹⁴. From 1991 - 2009, the Thai smoking rate has been decreasing and statistically significant results have been shown at the age 15 and older.

The reduction rate slightly decreased, due to the lack of deepening transnational party coalitions and the sharing of data between government and nongovernmental organizations (NGOs). The Royal Thai Government views tobacco control as an important part of its narcotics control activities specified in the 9th National Economic and Social Development Plan (2002-2006). Tobacco control has been included in the Health Behavior Modification Program. The WHO - FCTC, through its terms and the institutions and processes, has raised the profile of tobacco control, and the tobacco industry politically and legally. Since the treaty entered into force, the COP met in Bangkok, in 2007. In 2009, Thailand developed a National Tobacco Control Policy 2010-2014 with the ultimate goals to: reduce tobacco use prevalence, reduce tobacco consumption; and protect the health of nonsmokers from secondhand smoke exposure. By ratifying the FCTC of the WHO, Thailand has an obligation to implement tobacco control policies enacted under this treaty¹². Future actions to protect people from the preventable consequences of smoking through the 2010-2014 National Tobacco Control Policy are underway include the following strategic areas.³

Strategic area 1: Prevention of new tobacco consumers: Prevention of smoking initiation through both

supply and demand reduction strategies aimed towards youth and young adults

Strategic area 2: Consumers Promotion to Tobacco Use Reduction and Quitting: Helping smokers quit through improving all forms of cessation services including nicotine replacement therapy

Strategic area 3: Tobacco Products Harm Reduction: Reducing the danger of tobacco products through product testing and harm reduction such as minimizing ignition propensity

Strategic area 4: Smoke-free Environment Creation: Establishing smoke-free environments by changing social values and norms, increasing community and multisectoral participation in developing smoke-free public and work places

Strategic area 5: Strengthening and Developing Capabilities in the Implementation of Tobacco Control: Strengthen national tobacco control capacity by strengthening political commitment and leadership, networks, tobacco control management, promotion of tobacco control knowledge management and capacity building for all relevant sectors

Strategic area 6: Illegal Trade of Tobacco Products Control: Regulation and control of tobacco illicit trade

Strategic area 7: Tobacco Control by Tax Measures: Improve tobacco taxation measures

Strategic area 8: Surveillance and control of the tobacco industry: Prevent and thwart tobacco industry's interference with tobacco control activities

How to reduce the number of tobacco consumers

The principle concept of tobacco consumer reduction involves preventing the initiation of new tobacco consumers and reducing the number of new smokers. This article discusses the compilation of The National strategy tobacco control policy 2010 - 2015 to reduce the number of current smokers. Strategic area 2: Consumers Promotion to Tobacco Use Reduction and Quit in-

volves helping all smokers quit by improving all forms of cessation services including nicotine replacement therapy and aiming to encourage them to gain access to tobacco cessation services. To reduce the number of tobacco consumers, five strategies listed below are employed.

1: Promotion of the cessation of tobacco use: consists of 2 activities;

1. Social denormalization: Denormalizing tobacco use through social norm change that “pushes tobacco use out of the charmed circle of normal, desirable practice” has been a key component of tobacco control, motivating smokers to quit¹⁵. Management of tobacco cessation consists of educational campaigns designed to create awareness and motivate smokers or new-smokers to quit; the significant adverse health effects of smoking-related diseases and multimedia campaigns will include advertisements that will be placed nationally¹¹. Advertisements will include a prompt for smokers to call Quitline 1600 for free help to quit. Main activities include coordinating and cooperating with relevant organizations and bodies of national systems such as the Thai Health Promotion Foundation (Thai-Health) and Action on Smoking and Health Foundation (ASH). All interventions aim to continue stop-tobacco messages and counter emerging media applications to shift attitudes and influence behavior.

2. The activities on tobacco health monitoring are strengthened and systematized to identify and subsequent interventions and deliver evidence-based care. Additionally, tobacco systems to be linked quality improvement and provider feedback mechanisms improves adherence to best practices, including documenting tobacco use status and cessation services referrals¹⁶. The Office of the Permanent Secretary of the Ministry of Public Health is restructuring its organization for initiating and generating the

system in Thailand.

The difficulties encountered comprise a lack coordination and cooperation among various ministries and their departments and frequently acts as a deterrent to effective tobacco control at national and subnational levels. Also, mass media activities are irregular and mutual cooperation and coordination between relevant parties are not harmonized. National budgets should accord greater priority to support their tobacco control activities. The method of EHRs formation is too formal for intersectoral approaches among government and other agencies to ensure effective implementation, and resource budget allocation is not sufficiently supported for the high-cost EHRs system and computer-based assistance remains a major problem.

2: Promotion and support for the development of human resources and networks to have sufficient knowledge to help with the cessation of tobacco use

Reviews of relevant agency processes of health care facilities of involving cessation of tobacco use were not totally synergistic. For instance, while practitioners lack of knowledge, no strong and vibrant civil society organizations devoted to tobacco control exist. All health services do not enforce tobacco cessation tasks as major priorities.

Information and relevant knowledge must regularly be reviewed by trained health-care professionals including primary healthcare physicians, specialists, medical residents, nurses and alliance practitioners, such as community leaders, teachers, local leaders, students, and youth concerning the latest advances in treating tobacco addiction. Standardizing effective, “Stop Smoking Training Programs,” to can help advise and offer quitting support to current smokers so that they will be competent, confident and inspired to promote help for smokers to quit, also attempt quittings and achieve long-term quitting success.

In 2005, Thai Health supported the formation of the Thai Health Professionals Alliance against Tobacco (THPAAT) including doctors, nurses, dentists, pharmacists, public health and other health professionals, while the TATN includes primary and secondary school teachers throughout the country. This support has produced greater involvement of health professionals in tobacco control research as evidenced by their increasing participation in tobacco control conferences regionally and internationally¹⁷. In 2010, the THPAAT organized national level training courses to help smokers quit for all health professionals who work in any referral-level hospital⁶.

1) The training program is Thai Tobacco Cessation Workshop (TTC) courses comprising of Basic Tobacco Cessation Level Course

2) Advanced Tobacco Cessation Level Course

3) Training of Trainers Course

Since 2010, THPAAT has generated smoking cessation training programs for health professional alliance networks. THPAAT has dedicated all health-care services to set up tobacco cessation counseling services called “Blue Sky Clinic” as outpatient programs with 321 branches nationwide.

However, health-care providers and professionals often lack sufficient motivation to undertake smoking cessation as a means of prevention and exhibit inadequate training in all health-care services. Lack of sufficient health-care professionals, high workloads, overlooking the tobacco problem, considering it an unimportant issue, and lack of resources and government funding are some affective factors that impede taking action.

3: Promotion and support for the provision of tobacco cessation services through networking in the government and in private setting.

Advocacy efforts by tobacco control bodies are insuf-

ficient to implement effective tobacco control policies. Cooperation from other sectors, NGOs and government departments, through relevant ministries and other private part is necessary. Consequently, the need exists to engage health professionals, health-care alliances and volunteers alike from many sectors other than health to intellectually engage with and operationally accommodate tobacco control through intersectoral collaboration, cooperation and capacity building¹⁸. The tobacco control community with phone-based cessation counseling programs or “Quitline 1600” need to provide unity and its philanthropic supporters must connect to the development community or network to exchange information and expertise and to provide an immersion experience to each other. That will result in a better integration with broader health goals that might be achieved.

The key recommendations comprise two important parts.

1. Tobacco cessation services in hospitals. The Ministry of Public Health enforced setting up its services in the hospitals with plans to expand to covers all areas. A total of 830 tobacco cessation services are available in hospitals nationwide⁷, implementing the 5A5R protocols, i.e., the Five A. (Ask, Advise, Assess, Assist and Arrange) and Five R's (Relevance, Risk, Rewards, Repetitions, Roadblocks). The service is a five- to fifteen-minute research-based counseling approach that has proven global success. Medications available for tobacco cessation can be divided broadly in two groups: Nicotine Replacement Therapy (NRT) and Non-nicotine Replacement Therapy. Alternative medications include the use of herbs, e.g., Vamonia Cinerea (L), a medicinal herb selected with approval from the List of Herbal Products AD 2011. From 2010-2011 the National Health Security Office supported 581 tobacco cessation services in all hospitals, treating

patients with chronic medical illness providing particularly effective screening and treatment covering 6 groups of chronic diseases - diabetes, hypertension, asthma, emphysema, heart disease, and stroke - to alleviate symptoms⁽⁸⁾.

2. Quitline 1600. Telephone-based tobacco cessation services, commonly known as quit-lines, have shown that the potential advantage is their accessibility. Telephone operation eliminates many of the barriers of traditional cessation classes, such as having to wait for classes to form or needing to arrange for transportation. It is particularly helpful for people with limited mobility and those who live in rural or remote areas. The Royal Thai Government set up the Thailand National Quitline: "Quitline 1600," with financial support from The Thai Health Promotion Foundation in 2009. They provide Reactive Service or "call-ins" which offer 20-minute consultation to callers' immediate requests for assistance, and Proactive Service, "call-out," the rather comprehensive services through "outbound" calls. The outbound services, often entailing multiple follow-up sessions (relapse prevention and follow-up), are typically scheduled by agreement with the smokers or call backs to check "how-are-you-doing" with smokers with a referral system (call-refer).⁹

Throughout the 1990s, Thai tobacco control advocates became more adept at leveraging available international research findings to achieve policy change¹⁷. Thailand had legislated two tobacco control laws, enforced since 1992 (B.E. 2535). They are the Tobacco Products Control Act B.E. 2535 and the Non-smokers' Health Protection Act 1992 (B.E. 2535), the details of which virtually cover all of those appearing in the FCTC. It should be said that tobacco control in Thailand is comprehensive. The Thai Physician Alliance Against Tobacco (TPAAT) has set up a development plan for Thai hospitals to be 100% smoke-free and has

implemented the plan starting 2007, aiming that the hospitals could act as role models of a smoke-free environment and center of a non-smoking community in Thailand¹⁸. Other implementation activities are promoted in limited structural support or resources, such as supporting quit-smoke programs for smokers in health services, increasing non-smoking areas for non-smokers, and public policy development.

Tobacco cessation is an outpatient system during office hours. The setting can be run by a team that consists of a trained physician, counselor, social worker attendant, or trained nurse. A pharmacist or health worker can also provide counseling services. Using the cessation program's Brief Interventions & the 5 A's approach provides a brief, goal-directed method to more effectively address tobacco use among patients with the goal of meeting tobacco users' needs in terms of readiness to quit.

Ask – illicit questions of smoking behavior and record in the personal data file;

Advise – provide suggestions to quit smoking and change behavior;

Assess – re-evaluate the smokers;

Assist – provide assistance and suggestions to smokers;

All smokers are trying to quit except those in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications; smoking less than 10 cigarettes/day, pregnant, and adolescent smokers. Herbs such as "Varnonia Cinerea (L)," sodium nitrate solution and nicotine gum are used for smoking cessation. Arrange - follow up and monitor how the smokers change their behavior; Quitline 1600, a telephone-based tobacco cessation services tracks about six months to one year. Very rare cases have been referred to services of delivery mechanisms.

The problems include the documentation process, which was time-consuming. It only indicated the governmental structure policies, without rewards for focal points of tobacco control individual indicators and evidence. Policies and strategies that target and involve regional and local governments were not considered. Advocacy for cessation has not been optimized to raise public and political awareness, and support for cessation depends very much upon the attitude of the chief manager of each party and the practitioners.

4: Development of national standards for the management of tobacco dependence to be used as guidelines for effective management

In the past, management of tobacco dependence in Thai healthcare facilities also lacked synergistic or systematic cessation models to guide the referral of cessation services. Therefore, conducted activities were effective and under the national standard framework at all central and subnational levels. In 2008, a team led by WHO FCTC conducted a joint assessment on the selected national demand reduction measures of Thailand, integrating a core set of sustainability of effective national clinical cessation practice guidelines and standard cessation models to guide the delivery of cessation services.

In addition, from transnational tobacco corporations, they developed Clinical Practice Guidelines (CPGs) for cessation. Those are the standard operating procedures for tobacco cessation health professionals. Five manuals have been produced including; National Guidelines of Tobacco Dependence Treatment in Thailand for Physicians and Other Health Professionals, Clinical Practice Guidelines on Treating Tobacco Use and Dependence for Nurses, Guidelines of Tobacco Cessation for Physical Therapists, Manuals of Dental Physicians and Manuals of Quitting Smoking for Pharmacists: Treatment and Suggestions⁸. Thus, the purpose of these

manuals is for health professionals and practitioners to gain counseling skills and adequate knowledge in the treatment of tobacco use and dependence. Effective government efforts lack technical support and financial sustainability.

However, these promising practices have not yet been fully exploited for optimal health gain. This is because (i) some activities have not been maintained and; (ii) have not been being supported by relevant and sufficient health human resources.

5: Promoting, supporting and facilitating accessibility to pharmaceutical products for the cessation of tobacco use

Increasing access to pharmaceutical tobacco-cessation products.

Increasing access to tobacco cessation products is a vital strategy. WHO recommends countries incorporate nicotine replacement therapy, specifically nicotine gum and patch, in the list of essential drugs. At present, these are not included in the National List of Essential Medicines of Thailand. This presents a significant financial barrier for smokers, many of whom belong to the lower socio-economic classes that avail of smoking cessation counseling without any co-payment. To date, this is the only coverage available for smoking cessation services. No equivalent Thailand-based services exist. Some cover outpatient cessation counseling for minors, but some remain unimplemented. The enforcement for tobacco cessation medications as Over-The-Counter drugs (OTC) will help smokers increase smoking cessation drug accessibility. Several herbs have a traditional reputation for helping Thais quit smoking. The ongoing situations from enforcement tobacco cessation medications for selection as essential drugs have now been considered by the National Committee of the National List of Essential Medicine of Thailand. That requires an incremental approach

balancing evidence-based populations, and clinical interventions for making cessation drugs that should be addressed.

Conclusion and Recommendations

As mentioned above, only one part of the 2010-2014 National Strategic Plan for Tobacco Control could succeed due to all of the Strategic Plans of the National Tobacco Control to ensure the sustainability of current initiatives and further progress. Key recommendations that were considered critical have the best potential for success in the long term. Coordination within the Thai Royal Government collaborates and implements tobacco control policies mainly through the administration and implementation of the strategic planning law on national tobacco control from 2010-2014, and respectively conducted the effectiveness of tobacco control. Article 14 of the WHO FCTC demands signatory parties to “take effective measures to promote the cessation of tobacco use and adequate treatment for tobacco dependence”. By ratifying the WHO FCTC WHO, Thailand has an obligation to implement tobacco control policies enacted under this treaty to implement the National Strategy Tobacco Control Policy 2010-2014. To create strategies, in line with the nation’s obligations to implement the international tobacco control treaty involves building effective goals, national plans of action, or procedures for their specific tobacco control work, e.g., training, information, education, communication materials, enforcement, regulatory work, etc. This will also serve at national and sub-national levels in accordance with the specific committees, and relevant sectors are organized and are already operational with terms of reference defining scope of work and expected outputs. The Department of Disease Control, Ministry of Public Health played key roles of working with other sectors to

synchronize and evaluate tobacco control efforts, under the WHO FCTC framework as part of the universal health coverage strategy.

This article has discussed only Strategy 2: helping smokers quit through improving all forms of cessation services, including nicotine replacement therapy. Some operations have succeeded, while some are under formulation. Recommendations are listed below.

1. Public media on tobacco-control issues are essential to ensure social change. The mass communication sectors should integrate media campaigns to the wider tobacco control program, as part of a long-term strategic plan. The expansion of financial resources allows effective national mass media campaigns. Hard-hitting campaigns can compel tobacco users to quit, increase knowledge of the health risks of tobacco use, and promote behavior change in both smokers and non-smokers. Journalists can be trained on the harms of tobacco and develop a public relations program to target media with information about the harms of tobacco and the benefits of tobacco cessation policies, and where the nearest tobacco cessation services are available. These sectors focus on using campaign content that could be adapted for local lifestyles and pursue alternative channels for disseminating warning information.

2. Enforcement and formulation are responsible structures that take action to conduct surveillance activities as well as develop and institutionalize a national reporting and surveillance system for the tobacco control programs. By developing a convenient system, users can easily access by internet and simple tables and graphs are most useful for summarizing and presenting data. Methods exist for conducting tobacco screening in primary care. The vital signs screening is simple, efficient and well-accepted, and this intervention, when combined with clinician prompting, increas-

es tobacco screening and intervention rates. Importantly, the tobacco assessment prompts increased tobacco interventions²⁰. A variety of agencies have produced data on the economic burden of the disease, health care cost, tobacco production and tax data. This is to provide additional human resources for the NEC to consolidate a national tobacco surveillance system.

3. A standard set of tobacco cessation practice guidelines through national referral health services should be finalized, endorsed and widely promoted. Responsible national fiscal sectors should expand the insurance coverage to cover a package of essential cessation services that includes brief advice at the primary health care level, access to intensive counseling such as through a national quit-line and, to the possible extent, pharmacotherapy for those who are heavily addicted to tobacco. Health sectors should promote cessation with systematic accessible campaigns.

4. Tobacco cessation drugs should be identified as part of the essential drug list, and to be qualified for insurance coverage. This is consistent with WHO recommendations, which identifies nicotine replacement therapy, specifically nicotine patches and nicotine gum, as essential drugs for national formularies. Cessation services should be covered under current health insurance schemes. Cessation of tobacco use can reduce the risk of tobacco-related disease, even among those who have used tobacco for decades and also save money. Tobacco use is estimated to cost Thais close to one billion baht annually in excess medical expenses and lost productivity.

Acknowledgements

This study was supported by a grant from the Tobacco Control Research and Knowledge Management Center [TRC]. The authors are grateful for the assistance of the following clinicians who participated in the study:

Verachai V. (Thanyarak Institute), Pitayarangsarit S. (TRC), Department of Disease Control. Ministry of Public Health.

Reference

1. 2014 National tobacco risk factors annual report. Bangkok: Tobacco control research and knowledge management center (TRC); 2014.
2. Pitayarangsarit S, Iamanan P, Punkrajang P. 2012 National tobacco consumption control annual report. 3rd ed. Bangkok: Tobacco Control Research and Knowledge Management Center (TRC); 2012.
3. Ministry of public Health Department of Disease Control. The National strategy tobacco control policy 2010 - 2014. Nonthaburi: Ministry; 2010.
4. FCTC who framework convention on tobacco control. [Internet]. Geneva, Switzerland: WHO, [2003]. [Updated 2015 May 15; cited 2015 Apr 10]. Available from: <http://whqlibdoc.who.int/publications/2003/9241591013.pdf>
5. FCTC/COP4(8) Guidelines for implementation of articles 14 of the WHOFCTC. [Internet]. Geneva, Switzerland: WHO, [2003]. [Updated 2015 May 15; cited 2015 Apr 10]. Available from: www.who.int/fcto/Guidelines.pdf
6. Rungruanghiranya S. Manual of tobacco dependence treatment basic levels. Bangkok: Thai Physicians Alliance against Tobacco; 2010.
7. The Quitline 1600. [Internet]. Bangkok: Sanook Online, 2009. [Updated 15 May 2015; cited 2011 Aug 20]. Available from: <http://www.news.sanook.com/767013/>
8. National Health Security Office. Annual report 2011. Nonthaburi: Ministry; 2011.
9. Tobacco Control Research and Knowledge Management Center. Conference on tobacco and health 9th; 9-10 August 2010. Bangkok; 2011.
10. International Legal Consortium at the Campaign for Tobacco-Free Kids. [Internet]. Washington, DC: Campaign for Tobacco-Free Kids, 2014. [Updated 15 May 2015; cited 2015 Apr 10]. Available from: <http://global.tobaccofreekids.org/en>
11. Kumar R, Prasad R. Smoking Cessation: An Update. Indian J Chest Dis Allied Sci 2014;56:161-9.
12. Preechawong S, Vathesathogkit K, Suwanratsamee S. Effects of Tobacco Cessation Counseling Training on Thai Professional Nurses' Self-efficacy and Cessation Counseling Practices. Pacific Rim Int J Nurs Res 2011;15:3-12.

13. Sarayuthpitak J, Kritpet T, Nakornkhet K. *Smoking Cessation Program for Thai Male Adolescents. Pacific Rim Int J Nurs Res* 2011;15:111-24.
14. Vathesatogkit P, Charoenca N. *Tobacco control: Lessons learnt in Thailand. Indian J Public Health. Indian J Public Health* 2011;55:228-33.
15. McDaniel PA, Malone RE. *Understanding Community Norms Surrounding Tobacco Sales. Niederkröthaler T, ed. PLoS ONE* 2014;9:106-61.
16. Jansen AL, Capesius TR, Lachter R, Greenesid LO, Keller PA. *Facilitators of health systems change for tobacco dependence treatment: a qualitative study of stakeholders' perceptions. BMC Health Serv Res* 2014;14:575.
17. Hamann SL, Mock J, Hense S, Charoenca N, Kungskulniti N. *Building tobacco control research in Thailand: meeting the need for innovative change in Asia. Health Res Policy Syst* 2012;10:3.
18. Reddy KS1, Yadav A, Arora M, Nazar GP. *Integrating tobacco control into health and development agendas. Tob Control* 2012;21:281-6.
19. Vitavasiri C, Pausawasdi S. *Implementation of 100% Smoke-Free Hospital in Thailand. J Med Assoc Thai* 2010;93:860-4.
20. Seale JP, Shellenberger S, Velasquez MM, Boltri JM, Okosun I, Guyinn M, et al. *Impact of vital signs screening & clinician prompting on alcohol and tobacco screening and intervention rates: a pre-post intervention comparison. BMC Fam Pract* 2010;11:18.

บทความพิเศษ

การส่งเสริมให้ผู้บริโภคและเลิกใช้ยาสูบโดยตามนโยบายควบคุมยาสูบของ FCTC 14 ในประเทศไทย

ธรรช ทิพย์วงษ์¹ และ ปุณชพร ทิพย์วงษ์²

¹สถาบันบำบัดรักษาและฟื้นฟูผู้ติดยาเสพติดแห่งชาติบรมราชชนนี (สถาบันธัญญ์) ²กองวิทยาการ กรมแพทยทหารบก

บทคัดย่อ ห้วงรอบปีที่ผ่านมาบทบาทของ WHO FCTC เป็นบทบาทที่สำคัญในวาระแห่งชาติของการสร้างเสริมสุขภาพในประเทศไทยที่มีการส่งเสริมความร่วมมือในประเทศหลายรายสาขา เช่นการป้องกันและควบคุมโรคไม่ติดต่อ (NCD) ที่เกิดจากความเสียหายในการบริโภคยาสูบ ในบทความนี้แสดงให้เห็นของผลลัพธ์เชิงประจักษ์ที่เกิดขึ้นจากนโยบายการควบคุมยาสูบตามการดำเนินการตามกลยุทธ์แห่งชาตินโยบายควบคุมยาสูบปี พ.ศ. 2553-2557 ในส่วนของการดำเนินงานในกลยุทธ์ที่ 2 ทั้งนี้จากการศึกษาทบทวน เราได้ประเมินการผลของการควบคุมการบริโภคยาสูบที่สำคัญ ว่ามีนโยบายหรือโครงการที่ประสบความสำเร็จ ที่ดำเนินการตามนโยบายการควบคุมยาสูบ การดำเนินการและอุปสรรคที่เกิดขึ้น การศึกษาใช้วิธีการตรวจสอบเอกสารรายงานการดำเนินนโยบายของประเทศ รวมถึงการทบทวนเอกสารและรายงานเชิงวิเคราะห์ ผลการศึกษาได้กล่าวถึงปัญหาอุปสรรค ความท้าทายและข้อเสนอแนะในข้อสรุปตอนท้ายของบทความ โดยสรุปการดำเนินงานตามกรอบนโยบายควบคุมยาสูบของ FCTC 14 ในปัจจุบันมีดังนี้ : การบูรณาการงานสื่อสารมวลชนของปัญหาการควบคุมยาสูบในประเทศไทยเป็นสิ่งจำเป็นเพื่อให้แน่ใจว่า มีการดำเนินกิจกรรมในเรื่องการเฝ้าระวังในการบริโภคยาสูบโดยใช้เปลี่ยนแปลงทางสังคม การบังคับใช้และการกำหนดโครงสร้างผู้รับผิดชอบที่จะดำเนินการอย่างชัดเจน และมีประสิทธิภาพ และสร้างระบบที่สามารถเข้าถึงง่ายของระบบบริการและยาที่ช่วยการเลิกยาสูบ

เวชสารแพทยทหารบก 2558;68:181-92.