Special report

Strengthening tobacco cessation across the primary health sector in the Americas: progress, gaps, and opportunities since 2007

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ABSTRACT

Objective. Tobacco use is a major modifiable risk factor for the four main noncommunicable diseases (NCDs) globally—cardiovascular diseases, chronic respiratory conditions, cancer, and diabetes. Addressing tobacco use through cessation interventions is therefore a cornerstone of comprehensive NCD prevention and control efforts. In this context, strengthening cessation support within primary health care has emerged as a high-impact and cost-effective strategy to accelerate progress toward NCD targets.

Methods. Despite advances in tobacco control, cessation support remains insufficiently implemented across much of the Region of the Americas. This article examines progress made between 2007 and 2024 in implementing the World Health Organization (WHO)-recommended tobacco cessation measures, with a focus on the availability, cost coverage, and integration of services within health systems.

Results. Only 7 of the 35 countries in the Americas achieved the highest level of cessation support, which combines national free quit lines, the availability of nicotine replacement therapy (NRT), and the provision of cessation services with partial or full cost coverage. Although these countries represent over 70% of the population, disparities persist—particularly in the Caribbean and in lower-middle-income countries. Findings show that NRT and other pharmacological treatments are inconsistently available, treatment costs are often not covered, and quit lines operate in only 40% of countries. These gaps underscore the urgent need for stronger policies, sustainable financing, and improved health system coordination.

Conclusion. Tobacco cessation must be prioritized as an essential health service, integrated into national NCD strategies, and supported by legal and institutional frameworks guaranteeing equitable access. Strengthening cessation is essential to reducing tobacco use and its health and economic burden across the Americas.

Keywords   Tobacco use cessation; tobacco control; tobacco use; nicotine replacement therapy.

Despite remarkable progress in reducing tobacco use prevalence from 33.1% in 2000 to 19.5% in 2024 (1), the epidemic remains responsible for approximately 11% of all deaths and 15% of noncommunicable disease (NCD)-related deaths globally (2). While tobacco use prevalence has declined, population growth has led to an increase in the absolute number of smokers worldwide—from 0.99 billion in 1990 to 1.14 billion in 2019. Additionally, approximately 302 million people globally use smokeless tobacco products (3). In the Americas, the percentages of deaths attributable to tobacco are slightly lower than global figures—7.5% of all deaths and 11% of NCD-related deaths (2). Nevertheless, the region is estimated to have 115 million tobacco users aged 15 years and older, including 110 million adult smokers, as well as 4.3 million tobacco users aged 13 to 15 years old, with significant variation across the 35 Pan American Health Organization (PAHO) Member States (1).

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Reducing tobacco use, a key target established in the Global NCD Action Plan 2013–2020 (4) and the 2030 Agenda for Sustainable Development Goals (5), requires not only preventing initiation (frequently among youth) but also supporting cessation efforts (6, 7).

Without cessation support, the health and economic burden of tobacco will keep rising. Already, tobacco use is a major driver of premature mortality and disability, responsible for nearly 8 million deaths and 200 million disability-adjusted life years (DALYs) globally in 2019. Most of these deaths are caused by NCDs, including heart disease, cancer, chronic respiratory disease, and stroke (3). The estimated global economic loss due to tobacco use is US$1.4 trillion annually, underscoring the urgent need to scale up cessation efforts as a core component of tobacco control and the prevention of NCDs (8).

Tobacco cessation is defined as the process of stopping the use of tobacco products, with or without assistance, and tobacco dependence treatment is a key component of a comprehensive, integrated tobacco control program.

Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC) and its guidelines mandates parties to promote cessation and ensure adequate treatment for nicotine dependence (9, 10). To support the WHO FCTC implementation, in 2008, the World Health Organization (WHO) launched the MPOWER package, which includes "offering help to quit tobacco" as one of six demand-reduction measures (11).

Cost-covered, population-wide support for tobacco cessation, including brief advice, national toll-free telephone quit lines, and mCessation—has been recognized as a WHO "best buy" for NCD prevention (12). Cessation has also been prioritized at the primary health care (PHC) level through the Better Care for NCD: Accelerating Actions in PHC initiative, launched by PAHO's Director in September 2023 (13), and in the recently approved Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2025–2030 (14).

This article presents the evolution of cessation support in the Americas from 2007 to 2024 and identifies persisting barriers and opportunities to strengthen tobacco cessation efforts in the region.

METHODS

WHO-Recommended Tobacco Cessation Interventions

In 2024, WHO launched its clinical treatment guideline for tobacco cessation in adults (15), presenting evidence-based behavioral and pharmacological interventions to be implemented as part of a comprehensive tobacco control approach that can be delivered at the PHC level. The following are the most recommended interventions:

- **Brief counseling** lasting 30 seconds to 3 minutes, routinely delivered to all tobacco users in health care settings.
- **More intensive behavioral support** for individuals interested in quitting, delivered individually or in groups, in person or by phone.

- **Pharmacological treatment** with first-line medications such as nicotine replacement therapy (NRT), varenicline, bupropion, and cytisine (where available).
- **Combined behavioral and pharmacological interventions**.
- **Systematic documentation** of tobacco-use status and cessation support in medical records, promoting evidence-based treatments.
- **Training of all health care providers** in delivering evidence-based cessation interventions to all adult users interested in quitting.
- **Providing evidence-based cessation support** to all tobacco users interested in quitting, ideally free of charge, or at a reduced cost.

RESULTS

Progress in Implementing WHO "Offering Help to Quit Tobacco" Measure in the Americas from 2007 to 2024

The Region of the Americas has made significant progress since 2007 in implementing the WHO FCTC, including improvement of tobacco cessation, the "O" component of MPOWER. While only seven countries in the region have reached the highest level in "O," 71% of the regional population, including the United States, Brazil, and Mexico, is covered by comprehensive cessation services (i.e., partially or fully cost-covered NRT, cessation support, and a national toll-free quit line) (16). El Salvador, Mexico, and Jamaica have strengthened their services and achieved the highest category, demonstrating that improvement is possible. This figure, while not meeting the desired level, is nonetheless above the global average of 16% of Member States (16).

Globally, the "offer help to quit" remains the least implemented measure in terms of the number of countries, despite the fact that the population coverage increased from 5% in 2007 to 33% in 2024 (16). In the Americas, it is the second least implemented at the highest level, surpassed only by "R" (raising taxes). In 2024, 15 countries—10 in the Latin America subregion and 5 in the Caribbean subregion[1]—were missing only one component to reach best-practice implementation (16).

The following summary describes the key cessation components, with supplementary information presented in Tables 1 and 2 based on data from the *WHO Report on the Global Tobacco Epidemic, 2025* (16):

Availability of national toll-free quit lines
Between 2007 and 2024, the number of countries with quit lines increased from 8 (22%) in 2007 to 14 (40%). In Latin America, the number doubled, representing significant progress. In relative terms, the regional figures remain similar to global percentages.

Availability of cost-covered NRT
In 2007, NRT was legally sold in 30 countries (85%), but only 4 countries (13%), all from Latin America, offered cost coverage. Globally, NRT was available in 136 countries (70%), yet only 26 (19%) provided cost coverage.

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[1] PAHO subregions considered in this article: North America (Canada and United States); Latin America (Mexico, Central America – except Belize, Latin Caribbean, Andean Area, Brazil and Southern Cone); and Caribbean (Non-Latin Caribbean and Belize).

As of 2024, NRT is no longer legally available in 11 countries, seven of which are in the Caribbean. Currently, 20 countries (57%, compared to 60.5% globally) legally sell NRT, and 13 countries (65%) offer full or partial cost coverage (two in North America, seven in Latin America, and four in the Caribbean). Globally, 49% of countries with NRT provide cost coverage.

Although four forms of NRT were added to the WHO Model List of Essential Medicines (17), only 12 countries, seven in Latin America and five in the Caribbean, include NRT in their national essential medicine lists.

Availability of tobacco cessation support

WHO monitors cessation support across five settings. The current analysis includes the following three settings: health clinics or other PHC facilities, hospitals, and community settings. In 2007, 24 of 35 countries in the Americas (69% vs. 59% globally) offered cessation support in at least one of these settings, though only half provided cost coverage. By 2024, 24 countries continued to offer services, with 19 providing full or partial cost coverage.

Availability of non-nicotine pharmacotherapy for treating tobacco dependence

Although not part of the best-practice criteria, WHO also monitors the availability of recommended medications for tobacco dependence: bupropion, varenicline, and cytisine. Bupropion was legally available in 27 countries in 2007 and in 25 in 2024, but cost coverage increased from 5 to 16 countries. Varenicline availability decreased from 26 countries in 2007 to 14 in 2024. This decline is likely related to a product recall by the primary varenicline manufacturer due to the presence of N-nitroso-varenicline, a nitrosamine impurity, at levels exceeding acceptable daily intake limits. Of the countries that currently offer varenicline, eight provide full or partial cost coverage. In relative terms, the availability of these medications in the Americas has consistently been above the global average.

Cytisine has been monitored since 2016. Only the Bahamas and Canada report its legal availability, with no cost coverage. Globally, only 37 countries have reported this product as available, and in just two cases, the costs are covered.

Evaluation of the Advances and Gaps

Throughout the 17-year analysis period, the panorama in the region has not changed significantly, with no more than seven countries ever achieving best-practice implementation of cessation support. Service disruptions have affected key components, such as national quit lines (e.g., Uruguay and Panama) and NRT coverage. A major barrier remains the lack of sustainable funding, which limits universal access and often competes with other control measures (18).

Toll-free quit lines are the least-implemented component regionally and globally. Although they can help promote quitting, limited funding restricts both service delivery and outreach. The Caribbean shows the largest gap: out of the 14 countries, only Jamaica has an operational quit line (16).

Seven Latin American countries (37%) and six Caribbean countries (43%) still lack access to NRT. Among the 18 countries where NRT is available, seven (39%) do not cover its costs. Access to other first-line medications—such as varenicline, bupropion, or cytisine—is also often unavailable or unaffordable (16).

The integration of tobacco treatment into PCH is uneven. Five of the 14 Caribbean countries do not offer cessation support in any of the three evaluated settings. In Latin America, six countries do not provide cost-covered services, although El Salvador and Guatemala had done so at some point during the analysis period. Recently, El Salvador reinstated services in other settings with full cost coverage and achieved the best-practice level (16).

The Caribbean remains the most impacted by the lack of cessation services. Five of the seven countries without any cessation support are located there (Antigua and Barbuda, Dominica, Grenada, Haiti, and Saint Kitts and Nevis), with the other two being from Latin America (Bolivia and Guatemala) (16).

Addressing these gaps requires systematic training of health professionals at all levels, including primary care physicians, nurses, pharmacists, and community workers. Policies should focus on both the availability and sustainability of services, ensuring public financing and operational continuity (19). In many Caribbean and Latin American countries, progress has been constrained by multiple and interrelated barriers, including insufficient funding and the small scale or fragmentation of health systems. Additional challenges—such as workforce shortages, competing priorities within health agendas, and cultural norms that continue to normalize tobacco use—also hinder sustained implementation (20, 21). Overcoming these barriers requires stronger leadership from ministries of health, the integration of cessation efforts within broader NCD and PHC frameworks, and the sustained technical cooperation from PAHO/WHO and other regional partners to build institutional capacity and ensure long-term sustainability of cessation services (21, 22). Tobacco cessation interventions in the Americas present significant geographic inequalities, gaps in service sustainability, and poor integration with primary care. To achieve a real impact on the burden of NCDs and advance the Sustainable Development Goals, it is essential to comprehensively and equitably strengthen tobacco cessation support strategies.

Emerging Technologies

Emerging technologies have been widely used in tobacco cessation interventions since the early 2000s, with notable advancements and broader adoption. The internet and mobile phones, particularly text messaging, have been used to deliver information and support to tobacco users, alongside traditional methods such as quit lines (23).

In 2012, the WHO and the International Telecommunications Union (ITU) launched the Be He@lthy, Be Mobile initiative to support countries in implementing mobile health (mHealth) strategies for NCD prevention and treatment, which introduced mCessation programs in countries such as Costa Rica, India, Burkina Faso, the Philippines, and China (24).

The expansion of mCessation, evidence-based mobile messaging, and other digital solutions can help increase access to cessation support, particularly in rural or underserved areas.

TABLE 1a. Status of the elements to achieve best-practice implementation in offering help to quit tobacco use in 2007 and 2024, Region of the Americas

| | | | | Availability of NTR | | | | | | |
| | | Availability of a telephone quit line | | NRT legally sold in the country | | Cost covered by the national/federal health insurance or the national health service | | NRT on the country's essential drugs list | | Health clinics or other primary care facilities | |
Subregion	PAHO Member States	2007	2024	2007	2024	2007	2024	2024	2007	2024	2007
Caribbean	Antigua and Barbuda	No	No	Yes	No	No	—	No	No	No	—
Latin America	Argentina	Yes	Yes	Yes	Yes	No	No	Yes	Yes in some	Yes in some	Fully
Caribbean	Bahamas	No	No	Yes	Yes	No	No	No	No	Yes in some	—
Caribbean	Barbados	No	No	Yes	No	No	—	Yes	No	No	—
Caribbean	Belize	No	No	Yes	No	No	—	No	No	Yes in some	—
Latin America	Bolivia (Plurinational State of)	No	No	Yes	No	No	—	No	No	No	—
Latin America	**Brazil**	Yes	Yes	Yes	Yes	Fully	Fully	Yes	Yes in some	Yes in some	Fully
North America	**Canada**	Yes	Yes	Yes	Yes	No	Fully	No	Yes in some	Yes in most	No
Latin America	Chile	No	Yes	Yes	Yes	No	No	No	Yes in some	No	No
Latin America	Colombia	No	No	Yes	Yes	No	Fully	Yes	Yes in some	Yes in some	No
Latin America	**Costa Rica**	No	Yes	Yes	Yes	No	Fully	No	Yes in some	Yes in some	Fully
Latin America	Cuba	Yes	Yes	No	No	—	—	No	Yes in most	Yes in most	Fully
Caribbean	Dominica	No	No	Yes	No	No	—	No	Yes in most	No	No
Latin America	Dominican Republic	No	No	Yes	Yes	No	No	No	No	No	—
Latin America	Ecuador	No	Yes	No	No	—	—	No	No	Yes in some	—
Latin America	**El Salvador**	No	Yes	Yes	Yes	Partially	Fully	No	No	No	—
Caribbean	Grenada	No	No	No	No	—	—	No	No	No	—
Latin America	Guatemala	No	No	Yes	No	No	—	No	No	No	—
Caribbean	Guyana	No	No	Yes	Yes	No	Fully	Yes	No	Yes in some	—
Caribbean	Haiti	Yes	No	Yes	No	No	—	No	No	No	—
Latin America	Honduras	Yes	Yes	Yes	No	No	—	No	No	Yes in some	—
Caribbean	**Jamaica**	No	Yes	Yes	Yes	No	Fully	Yes	Yes in some	Yes in most	Fully
Latin America	**Mexico**	No	Yes	Yes	Yes	No	Partially	Yes	Yes in most	Yes in most	Partially
Latin America	Nicaragua	No	No	Yes	Yes	No	No	Yes	Yes in most	No	No
Latin America	Panama	No	No	Yes	No	No	—	Yes	Yes in some	Yes in some	Fully
Latin America	Paraguay	No	Yes	No	No	—	—	Yes	Yes in some	Yes in some	Partially
Latin America	Peru	No	Yes	Yes	Yes	No	No	No	No	Yes in some	—
Caribbean	Saint Kitts and Nevis	No	No	Yes	No	No	—	No	No	No	—
Caribbean	Saint Lucia	No	No	No	Yes	—	Fully	No	No	Yes in some	—
Caribbean	Saint Vincent and the Grenadines	No	No	Yes	No	No	—	No	No	No	—
Caribbean	Suriname	No	No	Yes	Yes	No	No	Yes	Yes in most	No	No
Caribbean	Trinidad and Tobago	No	No	Yes	Yes	No	Fully	Yes	No	Yes in some	—
North America	**United States of America**	Yes	Yes	Yes	Yes	No	Partially	No	Yes in some	Yes in some	No
Latin America	Uruguay	Yes	No	Yes	Yes	Fully	Fully	No	Yes in some	Yes in most	Fully
Latin America	Venezuela (Bolivarian Republic of)	No	No	Yes	Yes	Fully	Fully	No	Yes in some	Yes in some	Fully

Source: World Health Organization (WHO). WHO report on the global tobacco epidemic, 2025: warning about the dangers of tobacco. Geneva: WHO; 2025. https://iris.who.int/bitstream/handle/10665/381685/9789240112063-eng.pdf?sequence=1
Note: Highlighted in bold: countries that, in 2024, have adopted comprehensive tobacco cessation measures at the highest level of best practice. — Not applicable; … Data not available.

As technology has evolved, new digital tools, such as mobile apps, chatbots, and social media platforms, have emerged to support tobacco cessation.

During the COVID-19 pandemic, WHO accelerated the deployment of these innovations, launching resources like the digital health worker "Florence," the WHO Quit Tobacco app, and the "WHO Quit Challenge" to help people quit tobacco (25). Florence provides personalized advice on quitting tobacco and nicotine, counters misinformation, and guides users through evidence-based strategies to stop tobacco use (26). Building on this global experience, WHO also launched S.A.R.A.H. (Smart AI Resource Assistant for Health), a multilingual virtual resource designed to engage users through interactive conversations that promote healthy behaviors and support tobacco cessation. These virtual assistants exemplify how AI-driven tools can strengthen digital health interventions, offering scalable, cost-effective, and personalized support to complement traditional cessation services (27).

TABLE 1b. Status of the elements to achieve best-practice implementation in offering help to quit tobacco use in 2007 and 2024, Region of the Americas

Tobacco cessation support available at								
Cost covered by the national/federal health insurance or the national health service		Hospitals		Cost covered by the national/federal health insurance or the national health service		In the community		Cost covered by the national/federal health insurance or the national health service
2024	2007	2024	2007	2024	2007	2024	2007	2024
—	No	No	—	—	No	No	—	—
Fully	Yes in some	Yes in some	Fully	Fully	Yes in some	Yes in some	No	Partially
No	No	Yes in some	—	No	No	No	—	—
—	No	No	—	—	No	Yes in some	—	No
Partially	No	Yes in some	—	No	No	No	—	—
—	No	No	—	—	No	No	—	—
Fully	Yes in some	Yes in some	Fully	Fully	Yes in some	No	No	—
Fully	Yes in some	Yes in most	No	Fully	Yes in some	Yes in some	No	No
—	Yes in some	No	No	—	No	No	—	—
Fully	Yes in some	Yes in some	No	Fully	No	No	—	—
Fully	No	Yes in most	—	Fully	No	Yes in some	—	Fully
Fully	Yes in some	Yes in most	Fully	Fully	Yes in some	Yes in most	Fully	Fully
—	Yes in most	No	. . .	—	No	No	—	—
—	No	No	—	—	No	No	—	—
Fully	Yes in some	Yes in some	No	Fully	No	No	—	—
—	Yes in some	No	Partially	—	Yes in some	No	No	—
—	No	No	—	—	No	No	—	—
—	Yes in some	No	Fully	—	No	No	—	—
Fully	Yes in some	Yes in some	. . .	Fully	No	No	—	—
—	No	No	—	—	No	No	—	—
Fully	Yes in some	Yes in some	No	Partially	No	No	—	—
Fully	Yes in some	Yes in most	Fully	Fully	Yes in some	Yes in some	No	No
Fully	Yes in some	Yes in some	Partially	Fully	Yes in some	Yes in some	Partially	Partially
—	Yes in most	No	No	—	No	No	—	—
Partially	No	Yes in some	—	Partially	No	No	—	—
No	Yes in some	Yes in some	Partially	Fully	Yes in some	No	Partially	—
Partially	Yes in some	Yes in some	. . .	Partially	No	No	—	—
—	No	No	—	—	No	No	—	—
Fully	No	No	—	—	No	Yes in some	—	No
—	Yes in some	No	. . .	—	Yes in some	Yes in some	. . .	. . .
—	Yes in most	No	No	—	Yes in some	Yes in some	No	No
Fully	No	Yes in some	—	Partially	No	No	—	—
Partially	Yes in some	Yes in some	No	Partially	Yes in some	Yes in some	No	Partially
Fully	Yes in some	Yes in most	Fully	Fully	Yes in some	Yes in some	No	No
Fully	Yes in some	Yes in some	Fully	Fully	No	No	—	—

Despite the growing use of digital tools for tobacco cessation, the tools often operate in isolation, disconnected from quit lines or clinical follow-up services. Access remains uneven, particularly in rural areas or due to issues with connectivity, digital literacy, or language barriers. Many providers also lack training or motivation to recommend these tools, and clear guidelines for integrating them into routine care are still largely absent (28).

Beyond virtual assistants, the use of data science and artificial intelligence in digital health can generate additional benefits for tobacco cessation strategies. According to WHO's *Global Strategy on Digital Health 2020–2025*, the systematic use of health data and analytics can help identify priority populations, personalize support, and optimize resource allocation (29). Such approaches can improve the efficiency and sustainability of cessation programs by reducing operational costs and increasing the accuracy of outreach and monitoring. In many countries, monitoring and evaluating the effectiveness of digital cessation tools remains a challenge, as there

TABLE 2. Status of the availability of recommended medicines for treating tobacco dependence in 2007 and 2024, Region of the Americas

Subregion	PAHO Member States	Bupropion				Varenicline				Cystisine	
		Legally sold in the country		Cost covered by the national/federal health insurance or the national health service		Legally sold in the country		Cost covered by the national/federal health insurance or the national health service		Legally sold in the country	Cost covered by the national/federal health insurance or the national health service
		2007	2024	2007	2024	2007	2024	2007	2024	2024	2024
Caribbean	Antigua and Barbuda	Yes	No	No	—	Yes	No	. . .	—	No	—
Latin America	Argentina	Yes	Yes	No	Partially	Yes	Yes	No	Partially	No	—
Caribbean	Bahamas	Yes	Yes	No	No	Yes	Yes	No	No	Yes	No
Caribbean	Barbados	No	No	—	—	No	No	—	—	No	—
Caribbean	Belize	No	Yes	—	No	No	No	—	—	No	—
Latin America	Bolivia (Plurinational State of)	Yes	No	No	—	Yes	No	. . .	—	No	—
Latin America	**Brazil**	Yes	Yes	Fully	Fully	Yes	No	No	—	No	—
North America	**Canada**	Yes	Yes	No	Fully	Yes	Yes	No	Fully	Yes	No
Latin America	Chile	Yes	Yes	No	No	Yes	Yes	No	No	No	—
Latin America	Colombia	Yes	Yes	No	Fully	Yes	Yes	No	Fully	No	—
Latin America	**Costa Rica**	Yes	Yes	No	Fully	Yes	Yes	No	Fully	No	—
Latin America	Cuba	No	No	—	—	No	No	—	—	No	—
Caribbean	Dominica	Yes	No	No	—	Yes	No	No	—	. . .	. . .
Latin America	Dominican Republic	Yes	Yes	No	No	Yes	Yes	No	No	No	—
Latin America	Ecuador	Yes	Yes	No	No	Yes	No	No	—	No	—
Latin America	**El Salvador**	Yes	Yes	Partially	Fully	Yes	No	Partially	—	No	—
Caribbean	Grenada	Yes	No	No	—	Yes	No	No	—	No	—
Latin America	Guatemala	Yes	No	No	—	Yes	No	No	—	No	—
Caribbean	Guyana	Yes	Yes	Partially	Fully	Yes	No	Partially	—	No	—
Caribbean	Haiti	No	No	—	—	No	No	—	—	. . .	. . .
Latin America	Honduras	Yes	Yes	No	No	Yes	No	No	—	No	—
Caribbean	**Jamaica**	Yes	Yes	No	Fully	Yes	Yes	No	No	No	—
Latin America	**Mexico**	Yes	Yes	No	Partially	Yes	Yes	No	Partially	No	—
Latin America	Nicaragua	No	Yes	—	No	No	Yes	—	No	No	—
Latin America	Panama	Yes	Yes	No	Fully	Yes	No	No	—	No	—
Latin America	Paraguay	Yes	Yes	No	Fully	Yes	No	No	—	No	—
Latin America	Peru	Yes	Yes	No	Fully	Yes	Yes	No	Fully	No	—
Caribbean	Saint Kitts and Nevis	Yes	No	No	—	No	No	. . .	—	No	—
Caribbean	Saint Lucia	. . .	Yes	. . .	No	. . .	No	. . .	—	No	—
Caribbean	Saint Vincent and the Grenadines	No	No	—	—	No	No	—	—	. . .	. . .
Caribbean	Suriname	No	Yes	—	No	No	Yes	—	No	No	—
Caribbean	Trinidad and Tobago	Yes	Yes	No	Fully	Yes	No	No	—	No	—
North America	**United States of America**	Yes	Yes	No	Partially	Yes	Yes	No	Partially	No	—
Latin America	Uruguay	Yes	Yes	Fully	Fully	Yes	No	No	—	No	—
Latin America	Venezuela (Bolivarian Republic of)	Yes	Yes	Fully	Fully	Yes	Yes	Fully	Fully	No	—

Source: World Health Organization (WHO). WHO report on the global tobacco epidemic, 2025: warning about the dangers of tobacco. Geneva: WHO; 2025. https://iris.who.int/bitstream/handle/10665/381685/9789240112063-eng.pdf?sequence=1
Note: — Not applicable; … Data not available.

are limited mechanisms to track user engagement, completion of cessation processes, or quit outcomes over time (30). Strengthening national data systems and integrating monitoring frameworks based on digital health indicators could help assess how effectively these tools support tobacco users throughout their quit journey and ensure continuous improvement. Leveraging data-driven insights will therefore be essential to strengthen evidence-based planning and ensure equitable access to cessation support across health systems (28).

DISCUSSION

The implementation of cessation services in the Americas continues to face important gaps due to the overall weakness of health systems and the underutilization or poor performance of the existing tobacco cessation services. These challenges include insufficient and unstable financing, limited integration of cessation within PHC, and weak coordination within health systems and between national tobacco control programs and broader NCD or mental health strategies.

There is an urgent need to expand and improve cessation services in the region by using resources more effectively. Countries must adopt a system-wide approach that prioritizes integration, sustainability, and innovation, while recognizing cessation as a core component of health care. The approach must build on the existing infrastructure to ensure that all tobacco users are identified and provided with at least brief advice (10). Strengthened technical cooperation, regional collaboration, and capacity-building initiatives are essential to help countries overcome these institutional and operational constraints and accelerate implementation of effective cessation policies (19).

Key recommendations include integrating tobacco cessation into PHC as part of broader strategies, such as the Better Care for NCDs initiative, in alignment with the WHO 2024 guidelines. This process involves recording tobacco use in medical records, training health personnel in brief counseling and referrals, and ensuring continuous access to treatments. Leveraging existing health infrastructure is essential to expand services, aligned with other tobacco control efforts that support and encourage quitting.

Countries should prioritize three population-level interventions: brief advice in PHC, national toll-free quit lines, and mCessation services. Promoting innovation through digital tools is crucial to expanding the program's reach and improving outcomes, particularly through digital tools and emerging technologies.

Global evidence demonstrates that investing in cessation is both effective and cost-efficient. According to WHO estimates, just US$1.68 per capita over 10 years (2021–2030) could result in 152 million successful tobacco quitters by 2030 and nearly 3 million lives saved by age 65. Over the long term, these interventions could save up to 16 million lives, yielding a return of US$7.50 for every dollar invested (8).

Strengthening national capacity through a systems approach—encompassing policy, financing, and service delivery, especially at the PHC level—is fundamental to ensuring the sustainability and scalability of tobacco cessation support.

To ensure equitable and sustained access to treatment, countries should establish a legal and regulatory framework that includes mandatory technical standards for cessation support within health systems, legal provisions for financial coverage of cessation medications, and the integration of cessation services into national NCD and cancer control plans.

Implementing regional training programs for health professionals is crucial to developing sustainable capacity. These efforts should promote regional collaboration and knowledge exchange. Practical tools, such as the virtual course "Training for Primary Care Providers: Brief Tobacco Interventions" (a WHO e-learning course) available through the PAHO Virtual Campus, offer valuable support for building skills at scale.

Additionally, PAHO/WHO will continue to provide technical assistance—both directly and through a network of collaborating centers and knowledge hubs—to ensure countries have the resources and guidance needed to implement effective cessation strategies. Addressing subregional disparities requires targeted technical cooperation, particularly for Caribbean countries and lower-middle-income nations, where health system capacity remains more limited.

Emerging technologies have transformed tobacco cessation interventions, offering new avenues for reaching tobacco users, providing tailored support, and improving overall cessation outcomes. Digital tools, including mobile applications, telemedicine, and social media, are particularly promising for engaging younger populations and expanding access to cessation services.

Both cessation services and tobacco taxation remain among the least implemented MPOWER measures in the Americas (16). Promoting coordinated approaches that, for example, allocate a portion of tobacco tax revenues to finance cessation programs and other health-promoting activities (such as physical activity or health education) could generate long-term benefits. Such synergies not only reinforce demand reduction but also ensure sustainable funding for cessation, reducing inequities in access to treatment, and increasing public acceptance of tax measures (31).

Continuous monitoring and evaluation of national cessation efforts, using benchmarks such as the *WHO Report on the Global Tobacco Epidemic*, are essential to guiding progress and informing strategic decisions.

Conclusion

Although progress has been made, especially in countries with larger populations, significant gaps persist, especially the lack of national strategies, dedicated personnel, integration into primary care, availability of national quit lines, cost coverage, and budgets to support cessation.

Supporting tobacco cessation is one of the most cost-effective strategies for reducing the burden of tobacco use. Quitting tobacco prevents premature deaths, reduces disease, and lowers long-term health costs. It is not only cost-effective but also an ethical obligation.

Ending the tobacco epidemic requires sustained and coordinated investment in cessation support, alongside other MPOWER measures.

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Fortalecimiento de las medidas de cesación del tabaco en la atención primaria en la Región de las Américas: avances, deficiencias y oportunidades desde el 2007

RESUMEN

Objetivo. El consumo de tabaco es un factor de riesgo importante y modificable para las cuatro principales enfermedades no transmisibles a nivel mundial: enfermedades cardiovasculares, trastornos respiratorios crónicos, cáncer y diabetes. Por lo tanto, abordar el consumo de tabaco mediante intervenciones para dejar abandonar el tabaco constituye una piedra angular de los esfuerzos integrales de prevención y control de las enfermedades no transmisibles. En este contexto, el fortalecimiento del apoyo para abandonar el tabaco en la atención primaria de salud se ha convertido en una estrategia de gran impacto y costo-efectiva para acelerar el progreso hacia los objetivos relacionados con las enfermedades no transmisibles.

Método. A pesar de los avances en el control del tabaco, el apoyo para abandonar el tabaco es aún insuficiente en gran parte de la Región de las Américas. En este artículo se examinan los avances logrados entre el 2007 y el 2024 en la aplicación de las medidas recomendadas por la Organización Mundial de la Salud (OMS) para abandonar el tabaco, centrándose en su disponibilidad, la cobertura del costo y la integración de los servicios en el sistema de salud.

Resultados. Solo 7 de los 35 países de la Región de las Américas alcanzaron el nivel máximo de las medidas de apoyo para abandonar el tabaco, que combinan líneas telefónicas nacionales específicas gratuitas para ayudar a dejar de fumar, la disponibilidad de terapia de reemplazo de nicotina y la prestación de servicios de cesación con cobertura parcial o total del costo. Aunque la población de estos países representa más del 70% del total de la Región, persisten las disparidades, sobre todo en el Caribe y en los países de ingresos bajos y medianos. Los resultados muestran que la terapia de reemplazo de nicotina y otros tratamientos farmacológicos no están disponibles de manera uniforme; los costos del tratamiento no suelen estar cubiertos para la población; y solo en el 40% de los países hay líneas telefónicas de ayuda para dejar de fumar. Estas deficiencias ponen de relieve la necesidad urgente de contar con políticas más sólidas, un financiamiento sostenible y una mejor coordinación del sistema de salud.

Conclusiones. El abandono del consumo de tabaco debe ser una prioridad como servicio de salud esencial, estar integrada en las estrategias nacionales contra las enfermedades no transmisibles y contar con el respaldo de marcos jurídicos e institucionales que garanticen un acceso equitativo. Fortalecer las medidas para dejar de fumar es esencial para reducir el consumo de tabaco, así como su carga para la salud y económica en toda la Región de las Américas.

Palabras clave Cese del uso de tabaco; control del tabaco; uso de tabaco; terapia de reemplazo de nicotina.

Fortalecimento da cessação do uso do tabaco na atenção primária à saúde na Região das Américas: progresso, lacunas e oportunidades desde 2007

RESUMO

Objetivo. O uso do tabaco é um dos principais fatores de risco modificáveis para quatro doenças crônicas não transmissíveis (DCNTs) em nível mundial – doenças cardiovasculares, doenças respiratórias crônicas, câncer e diabetes. Portanto, o combate ao uso do tabaco por meio de intervenções de cessação é um dos pilares dos esforços mais amplos de prevenção e controle das DCNTs. Nesse contexto, o fortalecimento do apoio à cessação ao uso do tabaco na atenção primária à saúde é uma estratégia custo-efetiva de alto impacto que pode acelerar o progresso rumo às metas para as DCNTs.

Métodos. Apesar dos avanços no controle do tabaco, o apoio à cessação continua sendo insuficiente em grande parte da Região das Américas. Este artigo analisa o progresso observado entre 2007 e 2024 na implementação das medidas recomendadas pela Organização Mundial de Saúde (OMS) para a cessação do uso do tabaco, com foco na disponibilidade, na cobertura dos custos e na integração de serviços nos sistemas de saúde.

Resultados. Apenas 7 dos 35 países da Região alcançaram o nível mais alto de apoio, oferecendo apoio telefônico em nível nacional com chamada gratuita para deixar de fumar, terapia de reposição de nicotina (TRN) e serviços de cessação do uso do tabaco com cobertura parcial ou total dos custos. Embora esses países somem mais de 70% da população regional, as disparidades ainda persistem, sobretudo no Caribe e em países de baixa e média renda. Observa-se falta de oferta regular de TRN e de outros tratamentos farmacológicos, cobertura insuficiente dos custos do tratamento e apoio telefônico para deixar de fumar disponível em apenas 40% dos países. Essas lacunas apontam a necessidade premente de políticas mais robustas, financiamento sustentável e melhor coordenação do sistema de saúde.

Conclusão. A cessação do uso do tabaco precisa ser priorizada como serviço de saúde essencial, integrado às estratégias nacionais de DCNTs e amparado por marcos institucionais e legais que garantam acesso equitativo. Fortalecer a cessação é fundamental para reduzir o uso do tabaco e sua carga para a economia e para a saúde na Região das Américas.

Palavras-chave   Abandono do uso de tabaco; controle do tabagismo; uso de tabaco; terapia de substituição da nicotina.