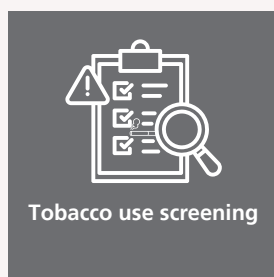
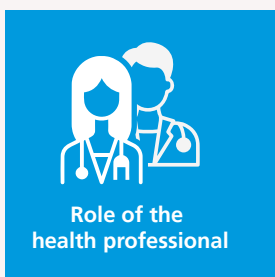


TOBACCO AND NICOTINE CESSATION

BOOKLET FOR HEALTHCARE PROFESSIONALS



Pan American
Health
Organization



World Health
Organization
Americas Region

Tobacco and nicotine cessation: Booklet for healthcare professionals

PAHO/NMH/RF/25-0019

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Abbreviations and acronyms

5As	ask, advise, assess, assist and arrange
5Rs	relevance, risks, rewards, roadblocks, and repetition
EHR	electronic health record
ENDS	electronic nicotine delivery systems
HTP	heated tobacco products
NRT	nicotine replacement therapy
PAHO	Pan American Health Organization
WHO	World Health Organization

Introduction

Importance of promoting tobacco cessation in primary care

Tobacco use remains the leading preventable cause of premature death and disability worldwide, resulting in over 7 million deaths annually. Among these, 1.6 million are attributable to exposure to secondhand smoke (1–2). The burden of tobacco-related disease spans the four main noncommunicable diseases: cardiovascular disease, chronic respiratory diseases, diabetes, and numerous forms of cancer. In addition to physical harms, it causes socioeconomic damage, due to increased costs of medical care and loss of productivity, and environmental damage.

The urgency of addressing tobacco use has been further highlighted by the COVID-19 pandemic. Smokers experience significantly worse outcomes from COVID-19 than nonsmokers, including higher rates of hospitalization and mortality (2). These findings reinforce the need to make tobacco cessation an immediate priority in global and national public health agendas.

Primary care providers are in a unique position to intervene. In most settings, primary care is the first and most trusted point of contact between patients and the health system. Over 60% of the world's adult tobacco users want to quit, but around 70% of them have no access to comprehensive tobacco cessation services (3). This gap highlights an underutilized opportunity. When clinicians do intervene, even for as little as 30 seconds, cessation outcomes improve significantly.

Evidence from meta-analyses found that very brief advice, lasting up to three minutes, increases the likelihood of tobacco use abstinence by 17%–22% (relative risk 1.17–1.22) (4). In 2022, most adults smokers in the United States of America wanted to quit and approximately half tried, but fewer than 10% were successful (5).

Most tobacco users are tobacco dependent. Tobacco dependence is based on biological, psychological, and social factors and has been defined as a chronic, relapsing condition driven by nicotine addiction. Nicotine dependence is characterized by brain changes, both structural and functional, in the reward and behavioral control circuits. In this context, brief but frequent clinical interactions at the primary level of care have a significant impact by enabling longitudinal support and patient-centered care, even during moments of relapse or ambivalence.

Primary care can address health inequalities by acting as a familiar entry point to the healthcare system, and effectively serving marginalized populations who tend to use tobacco more frequently.

The language and tone of voice used by healthcare professionals when addressing tobacco use issues are very important. Healthcare professionals should use the phrase “people who still use tobacco” instead of “smokers” and adopt a supportive and empathetic attitude, and use open-ended questions such as, “Have you thought about quitting?” or “What might help you take the next step?” Recognizing that it is difficult to quit using tobacco, affirming the patient's autonomy, and offering help fosters confidence and strengthens motivation (6).

Implementing tobacco cessation as a routine component of primary care is not just a clinical recommendation but a public health and ethical imperative. It is time-efficient, cost-effective, and life-saving. Every visit is a chance to encourage quit attempts and, through this, reduce tobacco-related morbidity and mortality and promote health equity.

Role of healthcare professionals

Healthcare professionals play eight interconnected roles in tobacco control: role model, clinician, educator, scientist, leader, opinion-builder, alliance-builder, and watchdog. Each role supports a multipronged strategy, but clinical intervention should always remain the foundation in primary care.

ROLE	BRIEF DESCRIPTION
Role model	Demonstrating tobacco-free behavior in clinical spaces
Clinician	Delivering brief interventions, prescribing cessation aids, arranging follow-up
Educator	Correcting misinformation and educating patients and communities
Scientist	Tracking quit rates, participating in research, contributing to evidence generation
Leader	Advocating for system-wide tobacco control policies
Opinion-builder	Influencing public discourse through social and professional platforms
Alliance-builder	Promoting national or local coalitions to support tobacco control and cessation.
Watchdog	Monitoring and countering harmful tobacco industry marketing

The clinical role must be prioritized. Addressing tobacco use in every encounter should be as routine as measuring blood pressure. Patients expect this type of engagement: 68% want providers to help them quit, and provider advice triples quit attempts (7).



Short interventions during teachable moments – like when discussing acute illness or lab abnormalities with a patient – can be highly effective. Clinical encounters offer privacy, trust, and continuity. Brief interventions, of between 30 seconds and 3 minutes, have been shown to encourage attempts and increase the likelihood of quitting (8).

A team-based model enhances efficiency. Medical assistants ask and document tobacco use status. Providers assess readiness and offer treatment. Nurses and case managers arrange referrals and follow-ups. The clinical intervention can be completed in less than three minutes using the ask, advise, assess, assist, and arrange (5As) or relevance, risks, rewards, roadblocks, and repetition (5Rs) model, or other similar models (9).



Skills required include basic motivational interviewing, prescribing pharmacotherapy, and making culturally sensitive referrals. These skills can be gained through brief online training or continuing professional development modules.

Clinicians can also integrate roles: deliver care while collecting data, educate through group visits, or advocate by presenting clinic data to leadership. The most effective programs link these interventions to a structured and systematic cessation protocol, which includes: quitlines, facilitated access to cessation medications, and intensive support services, when necessary.

Purpose of the booklet

This booklet is a practical guide to help primary care professionals systematically deliver effective tobacco cessation care. It distills best practices from global research (2020–2024) into tools designed for real-world clinical settings.

It equips healthcare professionals to:

- Identify all forms of tobacco and nicotine use;
- Assess readiness and motivation;
- Implement brief interventions (the 5As and 5Rs models);
- Deliver effective counseling and prescribe medication;
- Tailor strategies for special populations;
- Document care accurately and measure outcomes;
- Address health disparities with culturally adapted methods;
- Integrate cessation into chronic disease management.

The booklet covers cigarettes, smokeless tobacco, hookah, nicotine pouches, electronic nicotine delivery systems (ENDS), and heated tobacco products (HTP). **It should be noted that the World Health Organization does not recommend ENDS or HTPs as cessation tools due to limited evidence of safety and efficacy (10).**

All tools and techniques presented here can be delivered in three minutes or less and integrated into primary care workflows without creating additional burden. When implemented, these strategies increase quit rates, reduce relapse rates, and contribute to long-term disease prevention across diverse populations.



CHAPTER 1

Identifying tobacco users

The systematic identification of tobacco and nicotine users is the critical first step in effective cessation care. Although the Region of the Americas has experienced a decline in current adult tobacco consumption prevalence, in 2000 the Region reported an average prevalence of 29.6%, with some countries reporting adult tobacco use rates exceeding 40% (11). This means that millions of people still need help to quit that we need to identify who they are. **Tobacco use should be considered a vital sign and assessed at every visit.** Like blood pressure or weight, it is a key health indicator that should be systematically documented in the patient record (electronic or manual).

1.1. Universal screening protocol

The recommended screening question is: “Have you used any tobacco or nicotine products in the past 30 days?” This inclusive language captures all forms of tobacco and nicotine use. Relying only on the question “*Do you smoke?*” gathers information about the patient’s behavior but not about the cognition behind the behavior (12).

1.1.1. Integration into the clinical workflow is essential

- Reception staff or assistants can flag charts for status review.
- Screening can be incorporated into intake and prompted through electronic health records (EHR) templates.
- EHRs should include required fields for tobacco use status, type of product, and frequency of use (13).

1.1.2. Language matters

Adopt a respectful, nonjudgmental, and culturally sensitive approach:

- Use terms like “people who still use tobacco” rather than “smokers.”
- Ask open-ended questions such as “What role does tobacco play in your day?”
- Normalize difficulty through statements such as: “Many people need multiple attempts before they succeed.”

1.1.3. Comprehensive product use documentation

For each product, document:

- Frequency of use (daily, some days, rarely);
- Quantity (cigarettes per day, pods per week, sessions);
- Duration of use (years of use, initiation age, recent quit attempts) (14).

The table provides a list of common tobacco and nicotine products categorized by type and examples to aid accurate documentation and screening.

CATEGORY	EXAMPLES
Combustibles	Cigarettes, cigars, pipes, bidis, kreteks
Smokeless products	Chewing tobacco, snuff, snus, dissolvables
Water pipes	Hookah/Shisha
Electronic products	E-cigarettes, electronic nicotine delivery systems, heated tobacco products
Emerging products	Nicotine pouches, novel formulations

1.1.4. Initial assessment dimensions

Go beyond considering only the product and identifying the patient as consumer and also assess:

- **Readiness to quit:** Use a readiness ruler, analog scales (0–10 scale) or the Stages of Change model (15).
- **Motivational factors:** Explore both reasons for quitting (health, finances, family) and reasons for continuing (stress relief, social context).
- **Triggers:** Document patterns such as morning cravings, smoking after meals, stress-related use, or social triggers.

1.1.5. Secondhand exposure

Ask about:

- Household members who use tobacco;
- Smoking in cars or workplaces (16).

This is particularly important in pediatric, prenatal, and family medicine contexts, where protecting vulnerable populations can be a strong motivator for change.

1.1.6. Workflow integration

Team-based models make screening feasible:

- The front desk can flag charts for review.
- Medical staff perform intake screening.
- Providers confirm and deliver brief intervention.

System supports include EHR templates, automatic prompts, and dashboards to monitor screening and intervention rates (17).

1.1.7. Impact of systematic identification

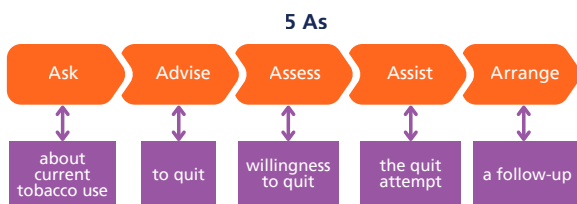
Clinics that systematically deliver very brief advice (≤3 minutes) using structured protocols achieve up to 17–22% higher quit rates than is achieved with usual care or no advice. Systematic identification of smoking status helps integrate cessation support into routine chronic disease management, reinforcing it as an essential component of patient care rather than an optional discussion point (18).

CHAPTER 2

Brief intervention framework

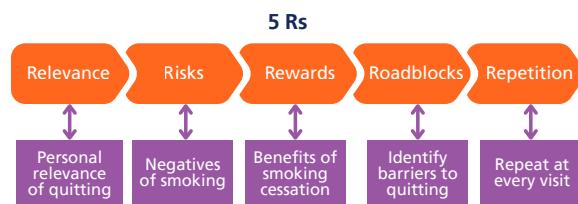
Brief interventions are effective in primary care and can be delivered within normal visit constraints. Two complementary models guide clinical practice: the 5As for patients ready to take action and the 5Rs for patients who are ambivalent or not ready. Both models improve quit attempts and long-term abstinence when used consistently (19).

The 5As model follows the steps ask, advise, assess, assist, and arrange. After identification, clinicians should provide clear, strong, and personalized advice on quitting. Advice is more effective when connected to current symptoms, test results, pregnancy, or goals that matter to the patient (20). Readiness to quit smoking can be assessed by asking the patient to answer a single question on a scale from 0 to 10. Scores closer to 10 generally indicate that the patient is more prepared to receive assistance. Assistance should include setting a quit date, ideally within 2 weeks; recommending evidence-based pharmacotherapy; teaching some strategies for coping with cravings; and referring the patient to additional support such as telephone quit lines or apps or specialized programs. The final step is arranging follow-up within 1 to 2 weeks. Even brief telephone or text follow-up increases long-term abstinence (21).



When time is limited, the ask–advise–refer approach is a valid alternative. It can be completed in about 90 seconds and triples the number of quit attempts relative to usual care without counseling (9). The key to effectiveness is making the referral concrete. Use a warm handoff to a quitline, send a text message with relevant link during the visit, or refer the patient for an e-consultation to a counselor.

For patients not ready to quit, use the 5Rs to build motivation: relevance, risks, rewards, roadblocks, and repetition. Invite the patient to provide a personal reason for quitting. Explore whether the patient knows the risks associated with that "personal reason". Highlight the significant benefits resulting from quitting tobacco, such as more energy, better sleep, a healthier family, and cost savings, and clear up any misconceptions. Revisit the conversation at each visit (22).



Cultural and linguistic adaptation improves engagement. Use the patient's preferred language, avoid idioms that do not translate well, and connect messages to values such as family responsibility, community wellness, or spiritual commitment, when appropriate. Programs that adapt content to cultural context report higher participation and quit rates than generic materials (23).

Every brief intervention should be documented. Record tobacco use status, the model used, the patient's readiness score, medications offered or prescribed, referrals made, and the agreed follow-up plan. Electronic records should support automated reminders and reporting on process measures such as percentage screened, percentage advised, and percentage with follow-up. Measurement enables improvement and helps clinics allocate resources where they are most needed (3, 9, 23).

Brief interventions are efficient and scalable. When embedded in routine workflows and supported by simple documentation and referral pathways, they allow primary care teams to deliver high-value cessation care in minutes.



CHAPTER 3

Counseling strategies

Effective counseling transforms brief clinical interactions into meaningful steps toward behavior change. Evidence shows that patient-centered counseling techniques such as motivational interviewing and cognitive-behavioral strategies improve quit rates more than directive advice alone (24).

3.1. Motivational interviewing

Motivational interviewing is based on empathy, collaboration, and support for autonomy. Providers using motivational interviewing explore ambivalence rather than confronting it. Core principles include expressing empathy, developing discrepancy between current use and personal goals, rolling with resistance rather than opposing it, and supporting self-efficacy (25).

Practical motivational interviewing techniques include:

- Asking open-ended questions such as “What would life be like without tobacco?”;
- Providing affirmations such as “It takes courage to even talk about quitting”;
- Reflecting and echoing concerns by saying “You feel tobacco helps with stress, but you also want to protect your health”;
- Summarizing and consolidating ambivalence by saying, for example, “You want to save money and breathe better, but worry about weight gain.”

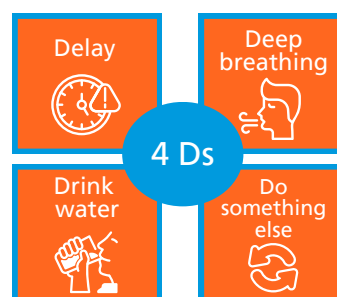
3.2. Family engagement

Involving family can double success rates (26). Creating smoke-free homes significantly improves cessation success, with studies showing 50–70% higher quit rates and up to five times greater success when smoking is prohibited at home. Begin by assessing the current home environment and establishing who knows about the quit attempt. Implement specific home-targeted interventions including counseling, self-help materials, and tobacco smoke pollution feedback (27). When family members smoke, prioritize establishing smoke-free zones and smoking restrictions. Evidence shows a well-defined link between smoke-free homes and more successful quit attempts, higher cessation rates, and reduced relapse rates.

3.3. Practical counseling and cognitive-behavioral approaches

These approaches help individuals recognize high-risk situations, anticipate challenges, and build skills to cope effectively. Practical counseling includes identifying danger situations, developing coping strategies, and providing essential information about smoking and successful quitting. Cognitive-behavioral techniques further support this process by helping patients identify and reframe unhelpful thoughts such as “I cannot handle stress without smoking.”

Encourage mapping of triggers across four domains – emotional, environmental, social, and physical – and developing alternative coping strategies such as deep breathing, substitution of tobacco use with healthy snacks, or physical activity (28). Teach practical tools like the “4 Ds” for managing cravings – delay, deep breathing, drink water, and do something else – which reinforce problem-solving and stress management skills within the counseling process.



3.4. Problem-solving and stress management

Encourage systematic problem-solving using frameworks like SOLVE (specify, options, likely outcomes, very best plan, evaluate). Teach simple stress management tools such as progressive muscle relaxation, mindfulness, and guided imagery. Promote long-term strategies like sleep hygiene, exercise, and time management.

3.5. Importance of documentation in counseling

Document motivational factors, family supports in place, cognitive distortions addressed, coping strategies agreed on, and stress management tools introduced. This ensures continuity and informs future follow-up.

CHAPTER 4

Pharmacotherapy

Pharmacotherapy doubles or triples quit rates compared with unassisted attempts, yet remains underused in practice. Every tobacco user can increase their chance of success by taking medication, unless contraindicated, shown through evidence to be effective. (29).

4.1. First-line options

4.1.1. Nicotine replacement therapy

Patches provide steady dosing. Short-acting forms (gum, lozenge, spray, inhaler) address breakthrough cravings. Combining a patch with a short-acting form is more effective than using a single therapy. (29).

4.1.2. Varenicline

Varenicline is a partial nicotine receptor agonist and is considered the most effective monotherapy. Varenicline should be initiated one week before the quit date with 0.5 mg once a day. The treatment dose is titrated to 1 mg twice daily. Common side effects include nausea and vivid dreams. Safety concerns about psychiatric effects have lessened with recent evidence (29).

4.1.3. Bupropion sustained-release treatment

Bupropion sustained-release treatment should begin one week before quit date. This treatment supports mood and reduces postcessation weight gain but is contraindicated in patients with a seizure history or eating disorders (30).

4.1.4. Cytisine (or cytisinicline)

Cytisine is a plant alkaloid and a partial nicotine receptor agonist, like varenicline. It has been used for over 60 years in eastern Europe to help people quit smoking and has recently regained popularity. It is inexpensive, well tolerated, and is taken for 25 days (31).

MEDICATION	INITIATION/ DOSING	ADVANTAGES	PRECAUTIONS
Nicotine replacement therapy (patch + short-acting)	Immediate start, 8–12 weeks	Improves quit rates	Skin irritation
Varenicline	Start one week before quit date, titrate	Most effective monotherapy	Nausea, vivid dreams
Bupropion sustained-release treatment	Start one week before quit date	Supports mood, reduces weight gain	Contraindicated in seizures
Cytisine	25-day course	Well tolerated	Variable availability

4.2. Duration of therapy

Standard treatment is 8–12 weeks. Extending treatment to up to 24 weeks benefits highly dependent patients and those at risk of relapse (32).

4.3. Managing side effects and adherence

Counsel patients on skin irritation with patches, proper chewing technique for gum, and nausea management with varenicline. Schedule early follow-up sessions to adjust doses and troubleshoot adherence problems (29).

4.4. Access and cost

Some countries have quitlines/hotlines that provide free nicotine replacement therapy (NRT) (33). Generic bupropion is inexpensive. Patient assistance programs and public health insurance schemes often cover cessation medications, in some countries (3).

4.5. Quick prescribing guide

- Offer full 12-week course at the first visit.
- Default treatment is an NRT patch plus short-acting form.
- For high dependence patients, consider varenicline or combination therapy.
- Document medication offered and accepted or declined, and the reasons for acceptance or decline.

4.6. Traditional, complementary, and alternative therapies

Evidence is insufficient to make a recommendation for or against traditional, complementary, and alternative therapies. If these therapies are utilized, ensure that they are offered as part of a comprehensive approach to supporting tobacco use cessation, that includes behavioral support and/or pharmacotherapy (3).



4.7. Follow-up and Support

Tobacco dependence is a chronic, relapsing condition requiring ongoing support beyond the quit date. Structured follow-up increases long-term abstinence rates, yet most cessation attempts fail due to inadequate postquit support. Evidence shows that systematic follow-up, combined with diverse support modalities, transforms single interventions into comprehensive chronic disease management approaches (34).

Note

According to the World Health Organization, electronic nicotine delivery systems, electronic non-nicotine delivery systems, and heated tobacco products are not recommended as cessation aids (10), as efficacy has not been demonstrated at the population level, and there is no evidence of their long-term safety, and their promotion may undermine existing tobacco control strategies. These products should not be suggested as alternatives to evidence-based cessation interventions in primary care settings.

CHAPTER 5

Special populations

Tobacco use disproportionately affects certain populations and those populations often need tailored approaches. Interventions must be culturally appropriate, accessible, and respectful of patient circumstances (35).

5.1. Pregnant women

For pregnant women, behavioral counseling is the first-line approach to tobacco cessation (36). Consider pharmacotherapy, such as NRT, only when the benefits outweigh the potential risks, and under close supervision (37). Intermittent NRT formulations, such as gums or lozenges, may be safer than continuous dosing with patches (38). Postpartum relapse prevention is essential, as approximately 50–60% of women who quit during pregnancy relapse within the first year, and more than 70% of spontaneous quitters relapse within six months post partum (39).

5.2. Adolescents

Most smokers start before age 18. Prevention is key, but when dependence is present, combine school-based approaches, family engagement, and digital tools. Limited evidence supports NRT use in adolescents; use with caution and parental consent (40).

5.3. Chronic disease

Tobacco use worsens outcomes for those with diabetes, chronic obstructive pulmonary disease, cardiovascular disease, and cancer. Emphasize the benefits of quitting, integrate cessation with disease management, and consider longer or more intensive treatment (41).

5.4. Mental health conditions

Rates of tobacco use are two to three times higher for people with mental health conditions. Coordinate with mental health teams. All medications are safe, but monitor for mood changes. Bupropion may provide dual benefits (42).

5.5. Indigenous and marginalized populations

For indigenous and marginalized populations, address historical trauma, discrimination, and targeted marketing. Partner with community leaders, distinguish ceremonial tobacco use from commercial use, and integrate traditional healing practices when appropriate (43).

5.6. People with disabilities

Ensure accessibility of counseling and materials for people with disabilities. Involve caregivers where appropriate. Adapt delivery methods to account for cognitive or physical limitations (44).

5.7. Hospitalized patients

A hospitalization event provides a teachable moment. Initiate treatment in hospital, supply discharge prescriptions, and arrange follow-up within 48–72 hours (45).



CHAPTER 6

Follow-up, support, and monitoring

Tobacco dependence is a chronic, relapsing condition. A single intervention is rarely sufficient. Systematic follow-up is necessary to maintain momentum, address challenges, prevent relapse, and support long-term abstinence (34).

6.1. Recommended follow-up schedule

48 hours Phone call or text for early support	1 week Review withdrawal symptoms and adherence	1 month Adjust treatment and reinforce motivation
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Relapse risk is highest in the first seven days. Contact within 48 hours can double success rates by resolving acute concerns and reinforcing commitment (46). Frame relapses as learning opportunities by saying, for example, “Many people make several quit attempts before succeeding. Let’s use this to improve your plan.”

6.2. Relapse prevention techniques

- Identify high-risk situations (e.g., parties or situations involving stress or alcohol).
- Practice coping skills.
- Normalize slipups: a lapse does not mean failure.
- Encourage patients to reconnect immediately for support after any use.

6.3. Support modalities

- Quitlines provide free phone coaching and often free NRT.
- Text services provide tailored daily support directly to phones via SMS.
- Apps offer behavioral tracking and tips.
- Online communities (e.g., stop smoking forums and online support groups) offer a variety of support methods.
- Group counseling offers peer support, which improves retention and accountability.

6.4. Technology integration

- Use EHR reminders and automated messages.
- Use WhatsApp or SMS for follow-up messaging.
- Offer telehealth counseling when in-person visits are limited.

6.5. Integrating interventions with chronic disease care

Combine cessation follow-up with visits related to diabetes, hypertension, or mental health. This reduces visit burden while reinforcing the chronic disease model of addiction care (47).

6.6. Documentation essentials

- Date of quit attempt and current status.
- Medication adherence and any side effects reported.
- Coping strategies in use.
- Support resources accessed.
- Follow-up plans in place.



6.7. Quality improvement, monitoring, and evaluation

To ensure tobacco cessation interventions are effective, structured monitoring and evaluation protocols must be embedded in primary care workflows. Monitoring and evaluation allows teams to assess performance, identify gaps, and drive continuous quality improvement.

INDICATOR	TARGET
Patients screened for tobacco use	≥90%
Patients who received brief intervention	≥70%
Patients initiated on pharmacotherapy	≥50%
Patients with documented quit plans	≥60%
Patients followed up within one week	≥80%
Patients abstinent after six months	≥25%

6.8. Key performance indicators

- Percentage of patients screened for tobacco use.
- Percentage of patients who received brief intervention.
- Percentage of patients initiated on pharmacotherapy.
- Percentage of patients with documented quit plans.
- Percentage of patients followed up within one week of quit date.
- Percentage of patients abstinent after six months.

6.9. Tools and methods

- Standardized EHR templates and dashboards.
- Tobacco-specific quality improvement audits every three to six months.
- Aggregated data reports for clinic performance review.
- Incorporation into chronic disease registries for integrated care.

6.10. Recommended surveys and instruments

- Tobacco questions for surveys (48), and STEPwise approach to noncommunicable disease risk factor.
- Fagerström Test for Nicotine Dependence.
- Analog (0–10) scales for example a readiness ruler and motivational scales (49).
- World Health Organization Patient Satisfaction Feedback Form (adapted for cessation care).

Note

You can find direct links to provider resources and patient education materials from the Pan American Health Organization and World Health Organization in the Appendix of this booklet.



CHAPTER 7

Resources and legal/ethical considerations

7.1. Provider resources

- Use local training modules and continuing medical education materials on tobacco cessation.
- Refer to national and regional guidelines.
- Use clinical protocols, patient scripts, EHR templates.

7.2. Patient education materials

- Print and provide brochures on the benefits of quitting, NRT use, and handling cravings.
- Use culturally adapted visuals for priority populations.
- Refer patients to mobile tools with multiple language options.

7.3. Community partnerships

- Coordinate with community health workers, social workers, and educators.
- Partner with local quitlines, pharmacies, and public health offices.
- Engage faith-based and cultural organizations to reach underserved populations.

7.4. Legal and ethical considerations

- Always obtain informed consent when treating minors or vulnerable adults.
- Document all interventions, including patient preferences and decisions to decline treatment.
- Maintain confidentiality, especially when using digital platforms.
- Respect autonomy: empower rather than coerce.

Delivering tobacco cessation care is not just clinically effective, it is a professional responsibility rooted in equity and prevention.



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Appendix

i. Tobacco questions for surveys

The full document is available via the following link:
<https://iris.who.int/server/api/core/bitstreams/4cb0d4b6-5115-4513-b478-911ec92604be/content>.

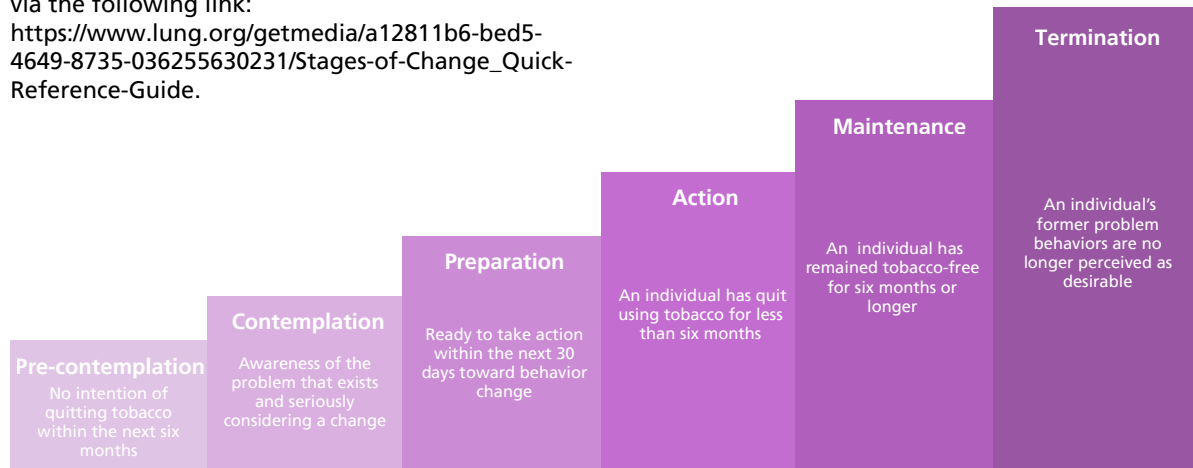
ii. Fagerström Test for Nicotine Dependence

The full Fagerström Test for Nicotine Dependence is available via the following link:
<https://cde.nlm.nih.gov/formView?tinyId=myLzkaBPx>.

Fagerström Test for Nicotine Dependence Tick one box for each question		
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes 6 to 30 minutes 31 to 60 minutes After 60 minutes	☐ 4 ☐ 3 ☐ 2 ☐ 1
Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, in the cinema?	Yes No	☐ 1 ☐ 0
Which cigarette would you hate most to give up?	The first in the morning Any other	☐ 1 ☐ 0
How many cigarettes per day do you smoke?	10 or fewer 11 to 20 21 to 30 31 or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Do you smoke more frequently during the first hours after waking than the rest of the day?	Yes No	☐ 1 ☐ 0
Do you smoke when you are so ill that you are in bed most of the day?	Yes No	☐ 1 ☐ 0
Total score		
1–2 = Low dependence 3–4 = Low to moderate dependence 5–7 = Moderate dependence 8+ = High dependence		

iii. Stages of change

You can find out more about the stages of change via the following link:
https://www.lung.org/getmedia/a12811b6-bed5-4649-8735-036255630231/Stages-of-Change_Quick-Reference-Guide.

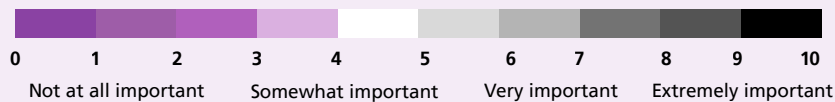


iv. Readiness rulers

You can find more information on readiness rulers via the following link:
https://www.lung.org/getmedia/c494a113-3cf0-4159-b556-834ee669293a/using-scaling-to-assess-readiness-to-quit_quick-reference-guide.

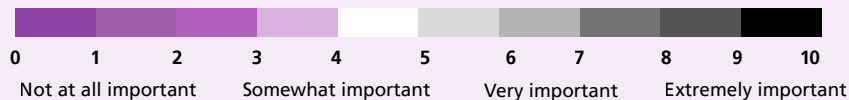
Importance

"How important would you say it is for you to quit using tobacco products, including e-cigarettes and vaping devices? On a scale from 0–10, where 0 is not all important and 10 is extremely important, where would you say you are?"



Confidence

"And how confident would you say you are, that if you decided to quit using tobacco products including e-cigarettes and vaping devices, you could do it? On the same scale from 0–10, where 0 is not at all confident and 10 is extremely confident, where would you say you are?"



v. Treatment regime for drugs mentioned

Medication	Formulation/ presentation	Initiation and dosage	Duration	Key considerations/ notes
Nicotine replacement therapy (NRT)	Patch (transdermal)	Apply one patch daily. Typical regimens: >10 cigarettes/day: 21 mg patch for 4–6 weeks → 14 mg for 2 weeks → 7 mg for 2 weeks ≤10 cigarettes/day: start at 14 mg for 6 weeks → 7mg for 2 weeks	8–10 weeks (extendable up to 12)	Combine with short-acting NRT for highly dependent smokers; rotate patch sites to reduce skin irritation.
	Gum	2 mg or 4 mg gum: chew slowly until peppery taste, then “park.” Use one piece every 1–2 hours for 4 weeks (maximum 24 pieces/day); one piece every 2–3 hours per day for 2 weeks; one piece every 3–4 hours per day for 2 weeks.	8 weeks (up to 12 weeks)	Use 4 mg if smoking within 30 minutes after waking. Avoid acidic drinks before use.
	Lozenge	2 mg or 4 mg; dissolve slowly (one lozenge every 1–2 hours). Use one piece every 1–2 hours for 4 weeks (maximum 20 pieces/day); one piece every 2–3 hours per day for 2 weeks; 1 piece every 3–4 hours per day for 2 weeks.	8 weeks (up to 12 weeks)	Do not chew or swallow whole; reduce frequency gradually.
	Inhaler/nasal spray	6–16 cartridges/day or one spray per nostril hourly. Taper as needed.	3–6 months	Useful for breakthrough cravings; may irritate throat/nose.
Cytisine (Cytisinicline)	Oral tablet	25-day tapering course: Days 1–3: one tablet every 2 hours (six/day) Days 4–12: one tablet every 2.5 hours (five/day) Days 13–16: one tablet every 3 hours (four/day) Days 17–20: one tablet every 4–5 hours (three/day) Days 21–25: one or two tablets/day	25 days	Well-tolerated, similar mechanism to varenicline.
Varenicline	Oral tablet	Start one week before quit date: Days 1–3: 0.5 mg once daily Days 4–7: 0.5 mg twice daily Day 8 onward: 1 mg twice daily	12 weeks	Most effective monotherapy. Common side effects: nausea, vivid dreams. Take with food and water.
Bupropion sustained-release	Oral tablet	Start one week before quit date. Days 1–3: 150 mg once daily Days 4–6: 150 mg twice daily (at least 8 hours apart) Day 7 (quit day): 150 mg twice daily for 12 weeks	7–12 weeks	Reduces cravings and weight gain. Contraindicated in seizure disorders or eating disorders.
Combination therapy	NRT patch + short-acting NRT (gum/lozenge)	Combine 21 mg patch daily with 2–4 mg gum or lozenge as needed for cravings.	8–12 weeks	Improves outcomes vs. single therapy.

vi. Provider resources

- WHO Clinical Treatment Guideline for Tobacco Cessation in Adults. This guideline offers evidence-based recommendations on behavioral and pharmacological tobacco cessation treatments. It supports healthcare providers in clinical and community settings. Available from: <https://iris.who.int/bitstream/handle/10665/377825/9789240096431-eng.pdf>.
- World Health Organization (WHO) e-learning course "Training for primary care providers: brief tobacco interventions." This is a self-paced, free course for primary care providers and health professionals to learn behavioral interventions using the 5As and 5Rs models for tobacco cessation. Available from: <https://campus.paho.org/en/course/brief-tobacco-interventions>.
- Pan American Health Organization (PAHO) Clinical Guidelines and Protocols Dashboard. This maps official PAHO and WHO clinical guidelines and protocols, including tobacco cessation relevant resources. Available from: <https://www.paho.org/en/better-care-ncds-initiative/regional-data-portal-better-care-ncds-initiative/clinical-guidelines>.
- WHO Framework Convention on Tobacco Control (FCTC) and accompanying tobacco cessation support and protocols. These explain provider roles and recommended measures. Available from: <https://www.who.int/westernpacific/activities/providing-tobacco-cessation-support-and-protocols>.

vii. Patient education materials

- A guide for tobacco users to quit. This self-help guide is based on WHO training packages, designed for tobacco users, and includes advice on improving readiness and planning quit attempts. Available from: <https://www.paho.org/en/documents/guide-tobacco-users-quit>.
- WHO web page "Quitting tobacco". This provides training packages and capacity-building resources to help countries establish tobacco cessation systems, including brief interventions integrated into primary care and digital tools for quitting support. Available from: <https://www.who.int/activities/quitting-tobacco>.

Tobacco use remains the leading preventable cause of premature death worldwide, claiming over 7 million lives annually. This evidence-based booklet, developed by the Pan American Health Organization, equips primary care providers with practical tools recommended by the World Health Organization to make tobacco cessation a routine part of clinical care.

It features quick, effective strategies such as the 5As (ask, advise, assess, assist, and arrange) and 5Rs (relevance, risks, rewards, roadblocks, and repetition) models, motivational interviewing techniques, cognitive-behavioral approaches, and guidance on first-line pharmacotherapies. Special considerations for pregnant women, adolescents, and patients with chronic diseases and mental health conditions are included, along with structured follow-up plans to prevent relapse.

This publication serves as a key resource to help healthcare professionals implement evidence-based cessation support measures – combining brief interventions, counseling, and pharmacotherapy into routine care to save lives and reduce disease burden.



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