Report on Tobacco Control for the Region of the Americas 2022

PAHO Pan American Health Organization
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Preface

The Pan American Health Organization (PAHO) celebrates the important milestone of its 120th anniversary in 2022. It is an opportune time for the world's oldest international public health organization to reflect on the numerous achievements it has made over the past century. Furthermore, the Organization looks forward to celebrating many more successes in the years to come, particularly as it champions attempts to achieve comprehensive tobacco control within its 35 Member States and beyond.

Tobacco remains the only legal consumer product that kills up to half of those who use it as intended by the manufacturers. Globally, tobacco accounts for more than 8 million deaths annually, of which 7 million deaths are the result of direct use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke. The use of tobacco is considered a cross-cutting risk factor for six of the eight leading causes of death in the world as well as the four most preventable and prevalent noncommunicable diseases: cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases. All forms of tobacco are harmful, and there is no safe level of exposure to tobacco smoke. This makes the tobacco epidemic one of the greatest public health threats the world has ever faced, and therefore the response must be equally aggressive.

The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) is considered to be one of the greatest achievements in the field of promotion of public health. It is an evidence-based treaty that advocated for the rights of individuals to attain the highest standard of health. It also provides legal dimensions for international health cooperation as it sets ambitious standards for compliance.

Since this treaty entered into force more than 15 years ago, the Region of the Americas has demonstrated continuous progress in implementing the practical, cost-effective MPOWER package of policies introduced to scale up the demand reduction provisions of the WHO FCTC. Each measure corresponds strategically to at least one provision of the WHO FCTC. Remarkably, in 2020, South America became the first subregion within the Region of the Americas to be categorized as smoke-free, indicating that more than 400 million people are protected from exposure to second-hand smoke. This comes at a time when the available evidence suggests that smokers face a 40% to 50% higher risk of developing severe disease and death from COVID-19. Of equal importance is the fact that tobacco use is the only cross-cutting risk factor for the four main categories of noncommunicable diseases that has been linked to increased severity of COVID-19 illness. The pandemic has highlighted the urgent need to adopt robust and effective tobacco control measures. Therefore, it is now even more essential that we scale up efforts to raise awareness about the importance and cost-effectiveness of supporting the implementation of tobacco control measures.

While governments have focused on protecting their population's health during these especially challenging times, the tobacco industry has in fact increased its efforts to interfere with the adoption and

implementation of comprehensive tobacco control measures in the Americas. A major threat has come from industry efforts to enhance its reputation and secure validation of its role as an essential player in the COVID-19 response. The tobacco industry's constant efforts to produce misinformation about the real effects of tobacco and nicotine consumption, especially in relation to the marketing of new and emerging tobacco and nicotine products as contributions to public health and tobacco control, and to block regulations that restrict the use of its products in the interest of public health have resulted in steadfast activities to ensure that momentum is maintained in advancing the tobacco control agenda. This report highlights the progress that the Region continues to make amid all the hardships and reflects the commitment of the Region to ensuring that tobacco control remains a priority for public health.

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Abbreviations and Acronyms

CARICOM	Caribbean Community
CDC	Centers for Disease Control and Prevention
COP	Conference of Parties
COVID-19	coronavirus disease 2019
DALY	disability-adjusted life year
ENDS	electronic nicotine delivery system
ENNDS	electronic non-nicotine delivery system
FCTC	WHO Framework Convention on Tobacco Control
GATS	Global Adult Tobacco Survey
GDP	gross domestic product
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HTP	heated tobacco product
NCD	noncommunicable disease
NRT	nicotine replacement therapy
PAHO	Pan American Health Organization
TAPS	tobacco advertising, promotion, and sponsorship
TQS	Tobacco Questions for Surveys
TQSY	Tobacco Questions for Surveys of Youth
UN	United Nations
UNDP	United Nations Development Programme
VAT	value added tax
WHO	World Health Organization

Executive Summary

Overview

Tobacco control is highly relevant for accelerating progress toward the United Nations Sustainable Development Goals given the burden tobacco products place on health, the economy, the environment, and societies in general. Tobacco remains the only legal consumer product that kills up to half of those who use it as intended by the manufacturers and is a risk factor for the four most prevalent noncommunicable diseases worldwide.

Globally, tobacco accounts for more than 8 million deaths annually, of which 7 million deaths are the result of direct use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke.[1] Since monitoring of the progress of tobacco control began, approximately 13 years ago, heralded by the publication of the first World Health Organization (WHO) Report on the Global Tobacco Epidemic in 2008, notable milestones, both worldwide and regional, have been recorded.

The present Report on Tobacco Control for the Region of the Americas 2022 provides a detailed overview of the status of tobacco control within the Region of the Americas for the measures contained in the WHO MPOWER package: monitoring the prevalence of tobacco use and tobacco control policies (M), protection from exposure to tobacco smoke (P), offer help to quit (O), warn about the dangers of tobacco (W), enforce bans on tobacco advertising, promotion, and sponsorship (E), and raise taxes on tobacco products (R).[2]

The Region of the Americas saw a decrease in the prevalence of current tobacco consumption from 28% in 2000 to 16.3% in 2020, ranking the second lowest prevalence of current tobacco consumption in the world. Along with the WHO European Region, the Americas also shows the smallest difference in the prevalence of current tobacco consumption between adult males and females. In the Americas, the ratio of men to women is 1.9 (21.3% men and 11.3% women) compared with the global ratio of 4.7 (36.7% men and 7.8% women), reaffirming the need for the Region to strengthen the gender aspect of tobacco control policies and strategies. In 2020, the prevalence of current tobacco use in adults continued to be highest in Chile (29.2%) and lowest in Panama (5.0%), when taking into account the number of countries with comparable, age-standardized data.

Regarding the youth population (individuals aged 13 to 15 years), among the 35 Pan American Health Organization (PAHO) Member States Brazil reported the lowest prevalence (6.9%) while

1 World Health Organization. Geneva: WHO; 2021 [cited 26 July 2021]. Tobacco. Available from: https://www.who.int/news-room/fact-sheets/detail/tobacco.

2 For measures relating to monitoring the prevalence of tobacco use as well as tobacco control policies (M) and offer help to quit (O), the data in this report reflect the period from 1 January 2017 to 31 December 2020. For those measures relating to protect from exposure to tobacco smoke (P), warn about the dangers of tobacco (W), and enforce bans on tobacco advertising, promotion, and sponsorship (E), the data correspond to the period 1 January 2018 to 31 December 2021. For measures relating to raising tobacco taxes (R), progress is reported from 1 August 2016 to 31 July 2020.

Dominica reported the highest prevalence (25.3%). According to the 2021 WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition,[3] the average proportion of the population consuming tobacco in the Region of the Americas is 11.3% compared with the global average of 10.3%. Of the 26 countries in the Region with information about electronic cigarettes (e-cigarettes), the United States of America has the highest prevalence of current consumption of e-cigarettes by young people in the Region (19.6%), and Brazil has the lowest (0.2%). In all countries with available data, e-cigarette use is most prevalent among male adolescents, with the exception of Venezuela (Bolivarian Republic of) and Colombia, where the prevalence of e-cigarette use is almost equal among young females and males.

The Region of the Americas is on track to achieve Goal 5 of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, which stipulated a relative reduction of 30% in the prevalence of tobacco use among individuals aged 15 years and older. The Region is expected to record a 14.9% prevalence in current tobacco use and, based on estimates from current trends, it is likely a regional prevalence of 14.3% will be achieved, thereby exceeding the goal of a relative reduction of 30% between 2010 and 2025.[4]

Globally, the number of countries in the world that have adopted at least one measure of the MPOWER package at the highest level of implementation has increased from 44 countries in 2008 to 146 countries in 2020, covering more than 5 billion of the world's population.[5]

There are now 101 countries classified as having attained the highest level of application with respect to health warnings on tobacco products (covering 60% or 4.7 billion of the world's population). The W measure of the MPOWER package has the highest population coverage as well as the highest number of countries implementing this measure, with 17 of these countries adopting legislation that mandates plain packaging for tobacco products. Increasing tobacco prices through taxation remains the policy with the lowest population coverage, at 13%, with no recorded increase since 2018.

In total, 26 of the 35 countries of the Region have achieved the highest level of application of at least one measure of the MPOWER technical package, representing a population coverage of 96% (Figure ES1). Regarding the implementation of measure P at the highest level of application, as of 31 December 2021, the Americas has the highest number of countries doing this compared with
the other WHO regions (24 out of 35, 23 of which are Parties to the WHO FCTC). It is noteworthy that this Region has had the largest number of Member States implementing this measure at the highest level of application since the 2009 edition of the WHO Report on the Global Tobacco Epidemic. The number of countries implementing measure W at its highest level of achievement has increased to 22, with various countries implementing other measures at their highest level of application: measure M (10 countries), measure O (6 countries), measure E (9 countries), and measure R (3 countries).

Key findings and conclusions

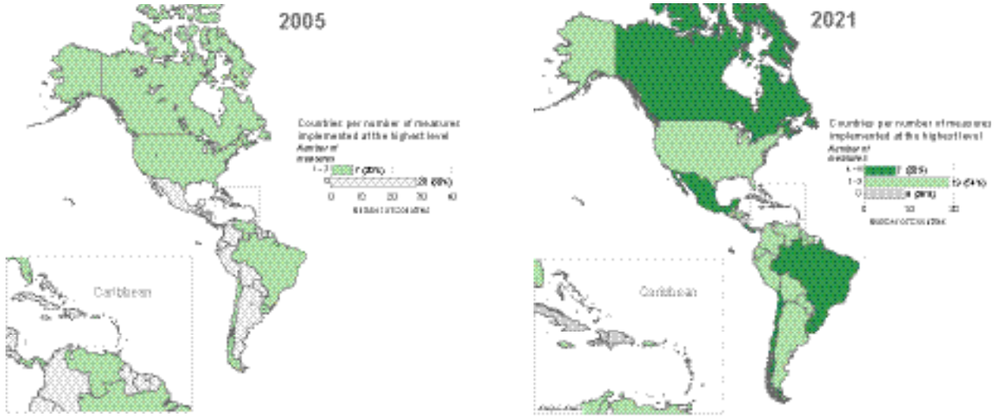
The Region of the Americas is expected to record a 14.9% prevalence of tobacco consumption by 2025, which signifies that the Region is on track to achieve Goal 5 of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020; i.e., a 30% relative reduction in the prevalence of tobacco use among individuals aged 15 years and older.

Ten countries within the Region have surveillance systems with recent, periodic, and representative data for tobacco consumption in adult and youth populations, resulting in 65% of the regional population covered by tobacco consumption monitoring policies at the highest levels of achievement. Nevertheless, five Member States (Barbados, Belize, Dominica, Haiti, and Saint Kitts and Nevis) do not have recent representative data for the prevalence of tobacco use in adults and youths.

The Region has the highest number of Member States implementing the P measure at the highest level of application compared with other Regions globally, since the 2009 edition of the WHO Report on the Global Tobacco Epidemic (Table ES1). Since 2018, five countries have enacted comprehensive smoke-free policies to bring the total to 24 countries within the Region implementing measures to protect people from exposure to second-hand smoke at the highest level of application.

FIGURE ES1

Changes in the application of a selected group of WHO Framework Convention on Tobacco Control (FCTC) measures in the Region of the Americas, 2005–2021



Notes: Cutoff dates: Region of the Americas: measure R, 31 July 2020; measures M and O, 31 December 2020; measures P, W, and E, 31 December 2021.

Source: World Health Organization. Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition. Geneva: WHO; 2021 Available from: https://www.who.int/publications/i/item/9789240032095, as well as data from the PAHO Regional Tobacco Control Team.

[3] World Health Organization. WHO global report on the trends in prevalence of tobacco use 2000–2025. 4th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240039322.

[4] World Health Organization. Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Geneva: WHO; 2013. Available from: https://www.who.int/publications/i/item/9789241506236.

[5] World Health Organization. WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

The ascension of Paraguay to a smoke-free Member State in 2020 heralded South America becoming the first smoke-free subregion within the Region (Table ES2).

Just six Member States (Brazil, Canada, El Salvador, Jamaica, Mexico, and the United States of America) have established national toll-free quitlines, accessible nicotine replacement therapy, and cessation support services offered to the population, thereby enabling them to implement measures related to offer help to quit tobacco at the highest level of application (Table ES2).

There are 22 countries now implementing measures to warn about the dangers of tobacco through graphic health warnings on the packaging of tobacco products, after the United States of America joined the group in 2020, preceded by Antigua and Barbuda in 2018, and Honduras in 2017. In 2019, Uruguay and Canada enacted policies that now mandate plain packaging of tobacco products (Table ES2).

Antigua and Barbuda (2018), Venezuela (Bolivarian Republic of) (2019), and Mexico (2021) now have comprehensive bans on the advertising, promotion, and sponsorship of tobacco products (TAPS). This brings the total to nine countries in the Region of the Americas that implement measures relating to TAPS at the highest level of application. A total of 21 Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC) within the Region have since passed the five-year deadline established for implementation of this measure (Table ES2).

Just three countries are implementing measures to ensure that the threshold of total indirect taxes represents 75% or more of the retail price of tobacco products (Table ES2).

The Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022[6] establishes four strategic lines of action: implementation of measures for the creation of completely smoke-free environments and the adoption of effective measures on the packaging and labeling of tobacco products (Articles 8 and 11); implementation of a ban on the advertising, promotion, and sponsorship of tobacco products and the adoption of measures to reduce their availability (Articles 6 and 13); ratification of the FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products by the Member States that have not yet done so; and strengthening Member States' capacity in terms of public health policies to counter attempts at interference by the tobacco industry and those who work to further its interests (Article 5.3). Thus far, during the implementation of the mandates of the Strategy, there has been significant progress in many areas of tobacco control; however, it is likely that the targets established through these strategic lines of action will not be achieved when the life of the Strategy expires at the end of 2022.

Novel and emerging products such as e-cigarettes (electronic nicotine and non-nicotine delivery systems, ENDs and ENNDS) and heated tobacco products (HTPs) are becoming more widely available and accessible, thereby posing a threat to tobacco control. The tobacco and related industries employ various strategies to market these products as having reduced risk and claim they are effective cessation aids in a bid to provide a "solution" to the tobacco epidemic; however, in reality this is just a ploy to continue their existence and hook new users to maintain their markets.

Regarding ENDS/ENNDS, as early as the sixth session of the Conference of the Parties (COP6) to the WHO FCTC, Decision FCTC/COP6(9)[7] invited Parties to consider "Prohibiting or regulating them, including as tobacco products, medicinal products, consumer products, or other categories, as appropriate, taking into account

TABLE ES1

Number of countries in the WHO regions recording implementation of measure P at the highest level of application

REGION	2008	2009	2011	2013	2015	2017	2019	2021
Africa (AFR)	4	3	4	5	6	7	9	11
Americas (AMR)	1	5	9	14	17	19	20	24[a]
South-East Asia (SEAR)	3	1	3	3	3	2	2	2
Europe (EUR)	8	3	8	9	10	13	13	9
Eastern Mediterranean (EMR)	1	2	3	5	5	6	7	8
Western Pacific (WPR)	1	3	4	7	7	9	9	9

Notes: [a]According to the cutoff dates indicated in the Technical Notes in the reference (WHO Report on the Global Tobacco Epidemic 2021: Addressing new and emerging products, 8th edition), except for Region of the Americas measures P, W, and E (cutoff date as of 31 December 2021). At the time of publication of the aforementioned WHO Report on the Global Tobacco Epidemic 2021: there were 23 Member States in the Region implementing measure P, 22 measure W, and 8 measure E at the highest levels of application.

Source: World Health Organization. WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package. 1st edition. Geneva: WHO; 2008. Available from: https://apps.who.int/iris/handle/10665/43818.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2009: Implementing smoke-free environments. 2nd edition. Geneva: WHO; 2009. Available from: https://www.who.int/publications/i/item/9789241563918.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2011: Warning about the dangers of tobacco. 3rd edition. Geneva: WHO; 2011. Available from: https://apps.who.int/iris/handle/10665/44616.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2013: Enforcing bans on tobacco advertising, promotion and sponsorship. 4th edition. Geneva: WHO; 2013. Available from: https://apps.who.int/iris/bitstream/handle/10665/85380/9789241505871_eng.pdf.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2015: Raising taxes on tobacco. 5th edition. Geneva: WHO; 2015. Available from: https://apps.who.int/iris/handle/10665/178574.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2017: Monitoring tobacco use and prevention policies. 6th edition. Geneva: WHO; 2017. Available from: https://apps.who.int/iris/handle/10665/255874.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2019: Offer help to quit tobacco use. 7th edition. Geneva: WHO; 2019. Available from: https://www.who.int/publications/i/item/9789241516204.

World Health Organization. WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

[6] Pan American Health Organization. Strategy and plan of action to strengthen tobacco control in the Region of the Americas 2018-2022. 29th Pan American Sanitary Conference, 69th Session of the Regional Committee of WHO for the Americas; 25–29 September, 2017; Washington, DC. Washington, DC: PAHO; 2017 (document CSP29/11). Available from: https://iris.paho.org/handle/10665.2/34441.

[7] World Health Organization Framework Convention on Tobacco Control. Sixth session of the Conference of the Parties to the WHO FCTC. Moscow, Russia; 13–18 October, 2014. Available from: https://fctc.who.int/who-fctc/governance/conference-of-the-parties/sixth-session-of-the-conference-of-the-parties-to-the-who-fctc.

TABLE ES2

Status of the WHO Framework Convention for Tobacco Control (FCTC) in the Region of the Americas and summary of application of the MPOWER package, 2021

	WHO FCTC ART. 20	WHO FCTC ART. 8	WHO FCTC ART. 14	WHO FCTC ART. 11	WHO FCTC ART. 13	WHO FCTC ART. 6	NUMBER OF BEST BUY MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL	NUMBER OF MPOWER MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL
				BEST BUY	BEST BUY	BEST BUY		
COUNTRY	M MONITORING	P SMOKE FREE ENVIRONMENTS	O CESSATION SERVICES	W PACKAGING AND LABELING	E BAN ON TAPS	R RAISE TOBACCO TAXES	PWER	MPOWER
Antigua and Barbuda		2018	↓	2018[a]	2018	13.1%	3	3
Argentina		2011		2012		76.6%	3	3
Bahamas	2018					43.2%	0	1
Barbados	↓	2010		2017		…	2	2
Belize	↓					34.7%	0	0
Bolivia (Plurinational State of)		2020↓		2009		35.7%	2	2
Brazil	2015	2011	2002	2003	2011	81.5%	4	6
Canada	2007 or earlier	2007	2008	2011[b]		61.7%	2	4
Chile	2007 or earlier	2013		2006		80.0%	3	4
Colombia	↓	2008			2009	73.1% ↓	2↓	2↓
Costa Rica	2007 or earlier	2012	2020↓	2013		53.6%	2	4↓
Cuba						…	0	0
Dominica						22.7%	0	0
Dominican Republic						44.3%↓	0	0
Ecuador	2016	2011		2012		66.9%	2	3
El Salvador		2015	↓	2011		46.5%	2	2↓
Grenada		↓				…	0	0
Guatemala	↓	2008				49.0%	1	1
Guyana		2017		2018	2017	27.5% ↓	3	3
Haiti						…	0	0
Honduras	↓	2010		2017		42.6%	2	2
Jamaica		2013	2016	2013		42.6%	2	3
Mexico		2021↓	2013	2009	2021↓	67.6%	3	4

TABLE ES2 *(continued)*

	WHO FCTC ART. 20	WHO FCTC ART. 8	WHO FCTC ART. 14	WHO FCTC ART. 11	WHO FCTC ART. 13	WHO FCTC ART. 6	NUMBER OF BEST BUY MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL	NUMBER OF MPOWER MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL
				BEST BUY	BEST BUY	BEST BUY		
COUNTRY	M MONITORING	P SMOKE FREE ENVIRONMENTS	O CESSATION SERVICES	W PACKAGING AND LABELING	E BAN ON TAPS	R RAISE TOBACCO TAXES	PWER	MPOWER
Nicaragua						69.4%↓	0	0
Panama	2012	2008		2005	2008	56.5%	3	4
Paraguay		2020↓				18.3%	1	1
Peru	2007 or earlier	2010		2011		67.7%↓	2	3
Saint Kitts and Nevis						…	0	0
Saint Lucia		2020↓		2017		51.3%	2	2
Saint Vincent and the Grenadines						23.1%	0	0
Suriname	↓	2013		2016	2013	26.5%	3	3↓
Trinidad and Tobago		2009		2013		25.7%	2	2
United States of America	2007 or earlier		2008	2020[c]↓		40.0%	1	3
Uruguay	2007 or earlier	2005		2005[b]	2014	65.9%	3	4
Venezuela (Bolivarian Republic of)	↓	2011		2004	2019 ↓	73.4%	3	3
	10	24	6	22	9	3	10	7

Notes: For the definitions and the colors of the classification of the interventions, please see the Technical Note (Chapter 6). Cut-off dates: Region of the Americas: measure R, July 31, 2020; measures M and O, December 31, 2020; measures P, W and E, December 31, 2021.
[a]Regulations pending.
[b]Plain packaging is mandated.
[c]Provision adopted but not implemented by 31 December 2020.
↓ ↓ Indicates a change in the rating from the WHO Report on the Global Tobacco Epidemic 7th to 8th editions.
BEST BUY - Interventions where a WHO choice analysis found an average cost-effectiveness ratio of ≤US$ 100 per DALY averted in low- and lower-middle-income countries.
… Data not reported/not available.

Source: Based on: World Health Organization. WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095, as well as data from the PAHO Regional Tobacco Control Team.

a high level of protection for human health." This advocacy has continued in successive COP sessions and, to date, within the Region of the Americas, seven countries have banned the sale of e-cigarettes. However, as the ban on sales does not eliminate the possibility of these products entering the market illegally, five of these countries have also opted to regulate their use to be consistent with legislation on smoke-free environments or on TAPS. Eighteen countries

have regulated the sale, use, and advertising of ENDS/ENNDS, 11 regulate them as tobacco products or tobacco related product, six regulate them as consumer products, and three regulate them as therapeutic products. Fifteen countries do not impose any form of regulatory framework.

As per Decision FCTC/COP8(22) of the eighth session of the Conference of the Parties to the WHO FCTC,[8] "heated tobacco products are tobacco products and are therefore subject to the provisions of the WHO FCTC." Parties were reminded "to regulate, including restrict, or prohibit, as appropriate, the manufacture, importation, distribution, presentation, sale and use of novel and emerging tobacco products, as appropriate to their national laws, taking into account a high level of protection for human health." To date, 3 countries within the Region have banned the sale of HTPs, 25 regulate them as tobacco products, and 7 countries do not have any regulatory mechanisms in place for this category of products.

The recent COVID-19 pandemic has posed a further threat to the progress made in tobacco control, as the illness itself has worse outcomes for individuals living with noncommunicable diseases, including those who have risk factors for noncommunicable diseases, especially tobacco use. The pandemic also provided an opportunity for the tobacco industry to interfere with existing tobacco control policies in a bid to weaken them while attempting to improve the image of the industry as one that is socially responsible and caring.

It is evident that there has been significant progress made in advancing the tobacco control agenda within the Region, although challenges that can impede this progress will always appear. Therefore, countries must reiterate their commitments to remain steadfast and vigilant and to place public health as a priority to ensure that their people are protected from the dangers of tobacco. PAHO stands committed to supporting countries in achieving these targets.

8 World Health Organization Framework Convention on Tobacco Control. Eighth session of the Conference of the Parties to the WHO FCTC. Geneva, Switzerland; 1–6 October, 2018. Available from: https://fctc.who.int/who-fctc/governance/conference-of-the-parties/eight-session-of-the-conference-of-the-parties/decisions/fctc-cop8(22)-novel-and-emerging-tobacco-products

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Introduction

The 2022 edition of the Regional Report on Tobacco Control for the Region of the Americas offers an overview of the current situation and trends of the tobacco epidemic in the Region and the implementation of effective policies to combat it in its 35 Member States. As in previous editions, the report presents up-to-date and validated data on the prevalence of tobacco use and its trend. It also describes the progress made in adopting legislation and policies to implement the six tobacco control measures recommended by the World Health Organization (WHO), known as the MPOWER package.

This report demonstrates the resilience and commitment of Member States in relation to tobacco control, especially at a time when the world is facing the effects of the COVID-19 pandemic, with those suffering from noncommunicable diseases as well as those who are at risk of developing such considered vulnerable to becoming infected with this devastating illness. Unfortunately, it is also a time when interference on the part of the tobacco industry has crossed many boundaries in a bid to assert its presence and take advantage of the vulnerability that many Member States have since been exposed to.

During the pandemic, there has been an increased need for Member States to honor their commitments to Article 14 of the WHO Framework Convention on Tobacco Control (FCTC) to offer help for people to quit tobacco. As such, providing cessation services and resources was the hallmark of the agenda of the World No Tobacco Day 2021 activities.

The Day's observance extended into a year-long campaign to help 100 million people quit tobacco under the theme "Commit to Quit," which reaffirmed the importance of creating healthier environments conducive to quitting tobacco, not only by advocating for strong tobacco cessation policies and increasing access to cessation services but also by making sure that all indoor public places and workplaces are smoke-free. However, the evolution of novel and emerging nicotine and tobacco products surged, and with this came numerous challenges for tobacco control, primarily in the areas of quitting tobacco and smoke-free environments.

This report is divided into five chapters. Chapter 1 gives an overview of regional and global trends in the tobacco epidemic as outlined in the WHO

Global Report on Trends in the Prevalence of Tobacco Use 2000–2025. Chapter 2 reports the progress in the Region in implementing each of the six cost-effective tobacco control measures in the MPOWER package. This chapter also includes a complete regional overview to easily identify which countries have implemented the most measures, as well as the measures with which the Region has made the most progress. Chapter 3 provides an update on the progress of implementation of the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022, as well as the other regional mandates and activities that are aimed at strengthening tobacco control within the Americas.

Chapter 4 focuses on the challenges that have threatened the progress of tobacco control. These include novel and emerging nicotine and tobacco products within the context of implementing effective tobacco control legislation, as well as the COVID-19 pandemic and its role in increasing the obstacles that threaten progress in tobacco control. This chapter also highlights some of the specific areas in which work remains to be done, especially in the areas of tobacco taxation, to curb the tobacco epidemic. Chapter 5 provides the conclusion of the report. The report also has Country Profiles (published separately), which detail the status of implementation of the six MPOWER measures in each of the 35 Member States of the Region. This is depicted in two summary pages per country—one on the implementation of the MPOWER package and the other specifically on tobacco prices and taxes.

It is undeniable that overall progress has been made in tobacco control, and much of the experience gained is leading to action on other risk factors for noncommunicable diseases. However, this progress is far from enough throughout the world and in the Americas in particular. It is hoped that this report will help policymakers, activists, researchers, and other stakeholders to determine the most urgent work to be done so they can channel efforts and allocate resources to accelerate the full implementation of the FCTC in the Americas. This will help achieve the targets established through the United Nations Sustainable Development Goals (UN SDGs) (1) and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases and reduce premature deaths from noncommunicable diseases (NCDs).

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CHAPTER 1

The tobacco epidemic: globally and in the Region of the Americas

When monitoring the situation and changes in the tobacco epidemic, it is crucial to make decisions based on information that is collected systemically and periodically. This chapter presents information about the current status and trends of the tobacco epidemic at the global and regional levels based on data for the prevalence of tobacco use in youths and adults and an analysis of the trends in the prevalence in adults during the period 2000 to 2025.

1.1. Current situation

Around the globe, smoking is one of the most challenging threats to public health, causing the deaths of more than 8 million people annually, of whom it has been established that 1.2 million are non-smokers who have been exposed to tobacco smoke (2). Thus far, the evidence collected has established that all tobacco products are harmful to health and that there is no safe level of exposure to tobacco smoke. Some of the diseases and health risks associated with the consumption of such products include the onset of noncommunicable diseases, complications during pregnancy, and low birthweight of the newborn. The consumption of tobacco, alcohol, and unhealthy diets, as well as a sedentary lifestyle coupled with air pollution, are the main risk factors for noncommunicable diseases.

The most prevalent noncommunicable diseases globally are cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, among which tobacco use is the only common risk factor (3). This group of diseases accounts for 71% (41 million) of all deaths worldwide each year, of which 33% (15 million) occur in individuals between the ages of 30 and 70 years. Unfortunately, in the Region of the Americas this percentage is even higher, where noncommunicable diseases cause 81% of all deaths annually (4). Some estimates suggest that tobacco consumption is specifically responsible for 15% of deaths worldwide and 14% in the Region (5). This section of the report analyzes the prevalence of the use of tobacco products among young people and adults around the globe and within the Region.

Almost two decades after the WHO FCTC entered into force – a widely supported international public health treaty that was negotiated with the objective of addressing the global tobacco epidemic – it is noteworthy that to date a considerable impact has been observed in the

reduction in the prevalence of tobacco use. In 2020, the global prevalence of current tobacco use in adults aged 15 years and older was 22.3% compared with 32.7% in 2000 (Figure 1). This downward trend is repeated in all six WHO regions. In the same period, the Region of the Americas saw a decrease in prevalence from 28% in 2000 to 16.3% in 2020, ranking second lowest for the prevalence of current tobacco consumption in the world, preceded only by the African Region, at 10.3% (Figure 2). These statistics present an encouraging scenario. In absolute numbers, from 2000 to 2020, the total number of tobacco users has shown a continuous decrease. However, among males the decrease in absolute numbers is only evident in the projections from 2018, with the assumption that all countries maintain their efforts in tobacco control (6).

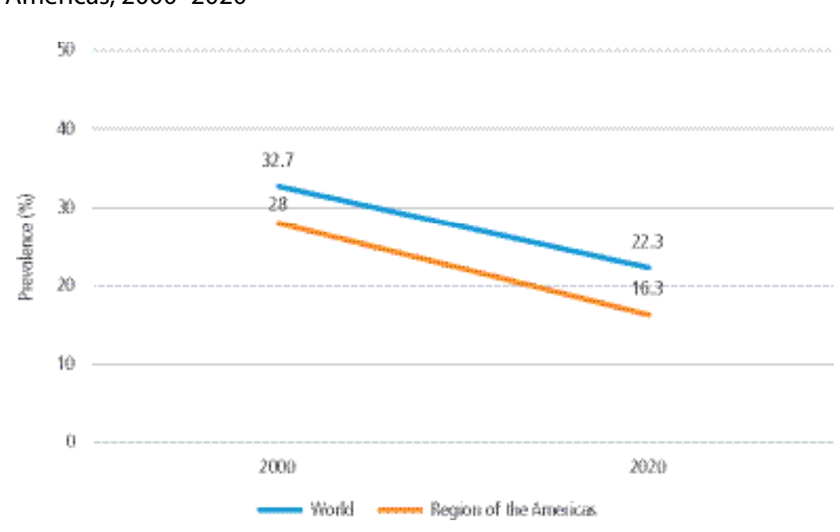
For its part, each year the tobacco industry invests more than US$ 9 billion in advertising, aimed at new consumers such as girls, boys, young people, and women. Consequently, it is important to observe the consumption patterns of men versus women, and adults versus young people, in the statistics presented above.

In terms of the adult population, the regions of Europe and the Americas show the smallest difference in the prevalence of current tobacco consumption in adult males and females. In the Americas, the ratio of men to women is 1.9 (21.3% of men and 11.3% of women). Worldwide, the ratio is 4.7 (36.7% of men and 7.8% of women). For the prevalence of current tobacco consumption among women, it is notable that in the WHO regions of South-East Asia and Western Pacific, which have some of the highest prevalence in the world, consumption among women is approximately four to 13 times lower, respectively, than that of adult men. These data confirm the need for the countries of the Region of the Americas to strengthen the gender aspect in their tobacco control policies and strategies (Figure 2).

The Region of the Americas shows a wide variation among its Member States in terms of the prevalence of tobacco use. Among the 24 of the 35 countries that produce comparable, standardized data, in 2020 the prevalence of current tobacco use in adults continued to be highest in Chile (29.2%) and lowest in Panama (5.0%) (Figure 3). In the following chapters of this report, associations will be drawn based on the results obtained against the tobacco control measures adopted by each country in the Region.

FIGURE 1

Prevalence of current tobacco use among adults, globally and in the Region of the Americas, 2000–2020

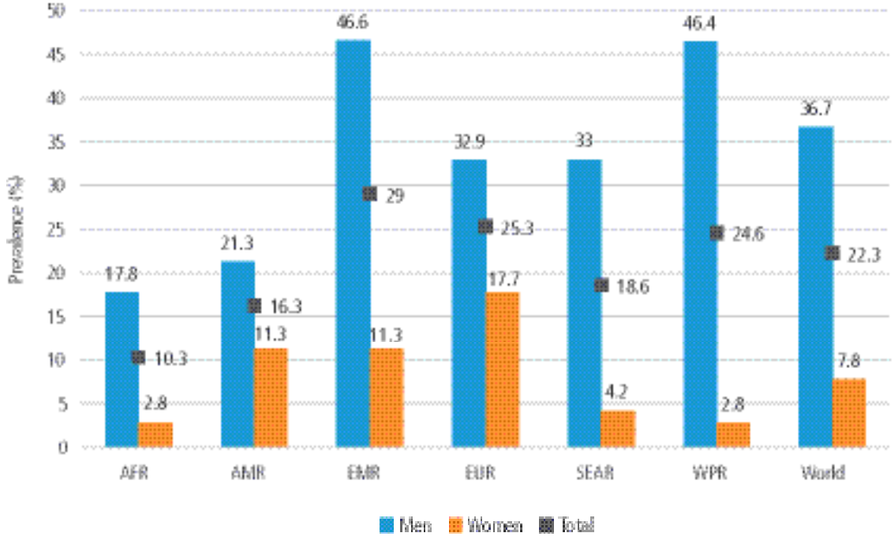


Notes: The prevalence of current tobacco use refers to the percentage of the adult population (people aged 15 years and older) who used a tobacco product (smoked or smokeless) in the 30 days prior to the survey; it includes both daily and occasional smokers. Data were standardized by age for 2020. For more details, see Technical Note II of reference (7) (WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition).

Source: Based on the WHO Global Report on the Trends in the Prevalence of Tobacco Use 2000–2025, 4th edition (7).

FIGURE 2

Global prevalence of current tobacco use in adults by sex and WHO region, 2020

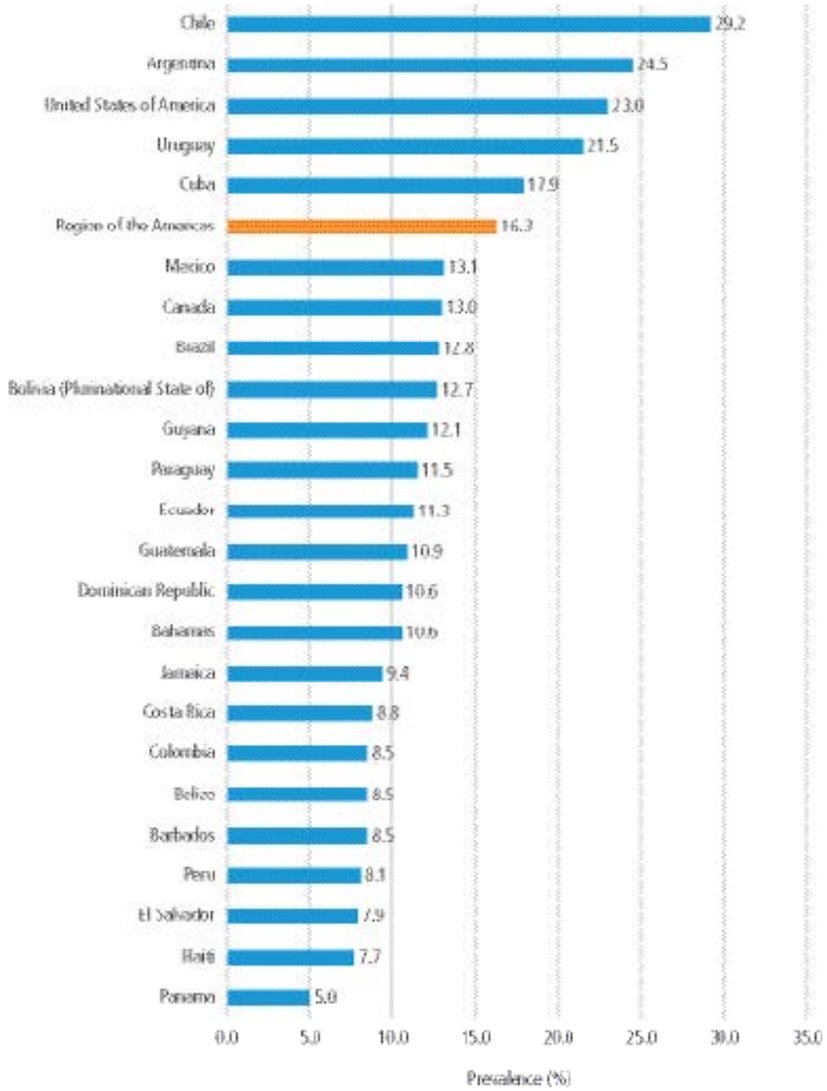


Notes: The prevalence of current tobacco use refers to the percentage of the adult population (people aged 15 years and older) who used a tobacco product (smoked or smokeless) in the 30 days prior to the survey; it includes both daily and occasional smokers. Data were age-standardized for 2020. For more details, see Technical Note II of reference (7) (WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition).

Source: Based on the WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition (7).

FIGURE 3

Prevalence of current tobacco use among adults in selected countries of the Region of the Americas, 2020



Notes: The prevalence of current tobacco use refers to the percentage of the adult population (people aged 15 years and older) who used a tobacco product (smoked and smokeless) in the 30 days prior to the survey; it includes both daily and occasional use. Data were age-standardized for 2020. These data should be used strictly for comparison purposes and not to calculate the absolute number of tobacco users in a given country. Data were either not available or the necessary information for standardization could not be obtained for Antigua and Barbuda, Dominica, Grenada, Honduras, Nicaragua, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, or Venezuela (Bolivarian Republic of).

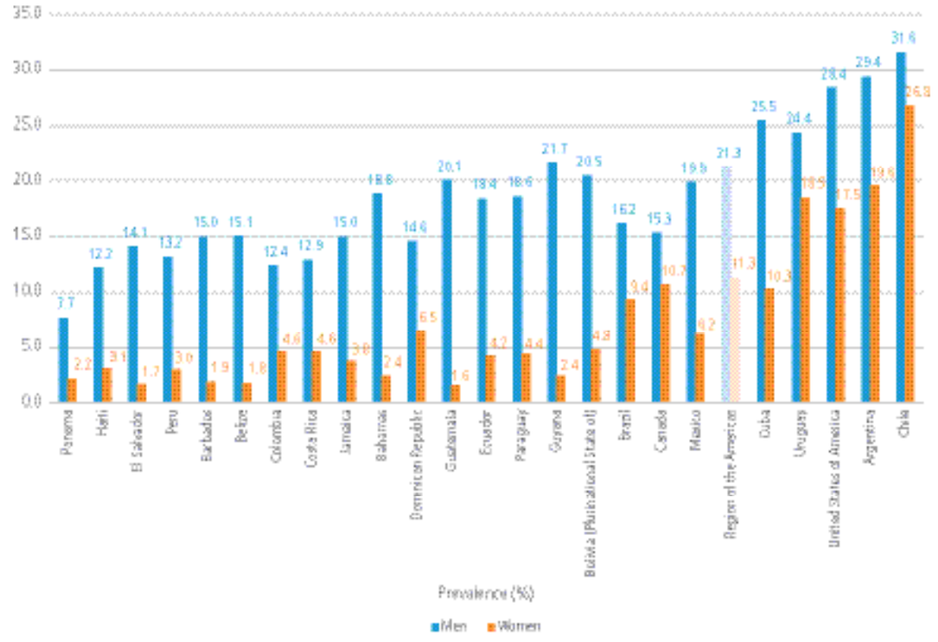
Source: Based on the WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition (7).

In the 24 Member States with available comparable data, the prevalence of current tobacco consumption is higher in men. However, there are large between-country variations in the size of the gap between men and women (Figure 4). In six of the Member States of the Region, the ratio of males to females is less than 2 (Argentina, Brazil, Canada, Chile, United States of America, and Uruguay); i.e., for every two males who consume tobacco, there is at least one woman who also consumes tobacco. The Member States with the greatest difference in prevalence between the sexes are in the Caribbean and Central America.

A country's surveillance systems need to produce data with a certain periodicity to obtain recent data that reflect the current situation of any given condition being monitored. The more up to date the available data are, the more robust the calculations for comparable prevalence estimates and projections for trend analysis will be. In the Region of the Americas, 11 countries have insufficient data to allow the calculation of comparable estimates, either

FIGURE 4

Prevalence of current tobacco use among adults by sex, Region of the Americas, 2020



Notes: The prevalence of current tobacco use refers to the percentage of the adult population (people aged 15 years and older) who used a tobacco product (smoked and smokeless) in the 30 days prior to the survey; it includes both daily and occasional use. Data were age-standardized for 2020. These data should be used strictly for comparison purposes and not to calculate the absolute number of tobacco users in a given country. Data were either not available or the necessary information for standardization could not be obtained for Antigua and Barbuda, Dominica, Grenada, Honduras, Nicaragua, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, or Venezuela (Bolivarian Republic of).

Source: Based on the WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition (7).

because the data are not representative of the entire population or the corresponding age group, or they were collected more than 20 years ago, or they do not yet meet other requirements of the estimation methodology described in the Technical Note of the WHO Global Report on Trends in the Prevalence of Tobacco Use 2000–2025, 4th edition (7).

Regarding the youth population, all countries of the Region of the Americas have data corresponding to the population of students between the ages of 13 and 15 years; however, these data are not recent in all cases. The oldest data are from Haiti, dating from 2005, while between 2014 and 2020, 28 countries collected new data. Another aspect that must be taken into consideration is that for Canada and Chile the data presented in this report correspond to the prevalence of smoked tobacco consumption, while for Colombia and the United States of America the data only relate to cigarette consumption. In the remainder of the countries the data relate to the current consumption of smoked and smokeless tobacco products. Of this group of countries, Brazil reported the lowest prevalence (6.9%), while Dominica reported the highest prevalence (25.3%). According to data from the most recent WHO trends report, the average prevalence of tobacco consumption in the Region is 11.3%. Of the 35 Member States, 19 recorded a prevalence above this average (Figure 5) (7, 8).

Unlike the pattern among adults, there is practically no difference in the prevalence of tobacco consumption by sex in the youth population. In all countries other than Belize and Suriname, the ratio of the prevalence between the sexes is less than 2; in Argentina, Brazil, Chile, and Uruguay, the prevalence of consumption is higher among adolescent females (Figure 6). In addition, it should be emphasized that the gap between the prevalence in young men and women has been decreasing considerably, confirming the need to strengthen policies aimed at adolescent girls within the Region.

The growing consumption of novel and emerging tobacco products, especially among young people, is a new challenge for public health. Data collection regarding electronic cigarettes (e-cigarettes), the most commonly used electronic nicotine delivery system (ENDS) among young people in the Region, began in 2014 and data are available for 26 Member States. Regarding the most up-to-date information, the United States of America has the highest prevalence of current consumption of e-cigarettes among young people in the Region (19.6%), and Brazil has the lowest (0.2%). In all countries with available data, e-cigarette use is generally most prevalent among male adolescents, with the exception of Colombia and Venezuela (Bolivarian Republic of), where the prevalence of e-cigarette use is practically the same among male and female adolescents (Figure 7).

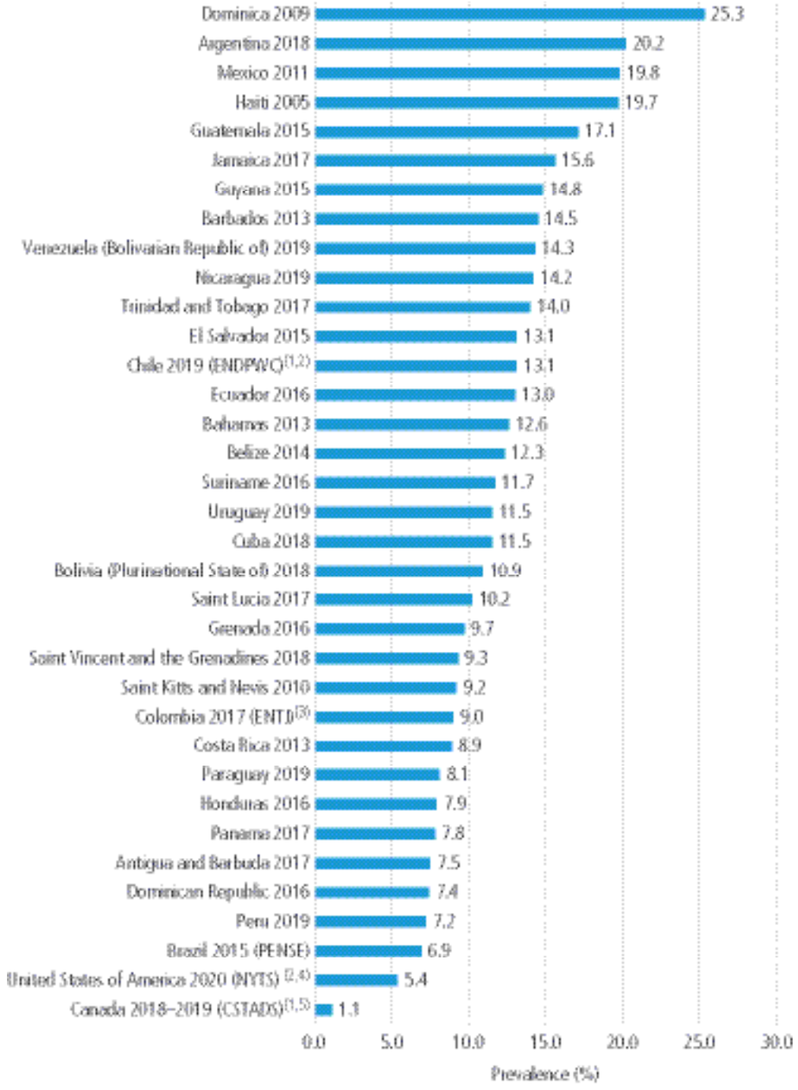
1.2. Analysis of tobacco use trends in the Region of the Americas

The Region of the Americas is on track to achieve Goal 5 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (9), which stipulated that a relative reduction of 30% in the prevalence of tobacco use among individuals aged 15 years and older is expected by 2025. Within the same plan, the goal is that, by 2025, 26 countries in the Region will reduce the prevalence of current tobacco use in individuals aged 15 years and older from the level established in their respective national baselines to the level established in the interim report of the WHO Global Monitoring Framework, thus contributing to the global target of a relative reduction of 30% by 2025 (9).

To identify progress in achieving this goal, since 2016 WHO has been actively undertaking analyses

FIGURE 5

Prevalence of current tobacco use among young people in the Region of the Americas (data from the most recent survey)



Notes: The prevalence of current tobacco use refers to the percentage of the adolescent population (aged 13 to 15 years) who used a smoked or smokeless tobacco product at least once in the 30 days prior to the survey. In all countries, except for Brazil, Canada, Chile, Colombia, and the United States of America, data come from the Global Youth Tobacco Survey (GYTS). It should be noted that the surveys were conducted in different years.
(1) Smoked tobacco use, (2) 13–17 years old, (3) cigarette smoking, (4) high-school students, and (5) grades 7–9.

Source: Prepared based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

FIGURE 6

Prevalence of current tobacco use among youths by sex in the Region of the Americas (data from the most recent survey)

Notes: The prevalence of current tobacco use refers to the percentage of the adolescent population (aged 13 to 15 years) who used a smoked or smokeless tobacco product at least once in the 30 days prior to the survey. In all countries, except for Brazil, Canada, Chile, Colombia, and the United States of America, data come from the Global Youth Tobacco Survey (GYTS). It should be noted that the surveys were conducted in different years.
(1) Smoked tobacco use, (2) 13–17 years old, (3) cigarette smoking, (4) high-school students, and (5) grades 7–9.

Source: Prepared based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

FIGURE 7

Prevalence of current use of electronic cigarettes among youths by sex in the Region of the Americas (data from the most recent survey)

Notes: The prevalence of current use of electronic cigarettes refers to the percentage of the adolescent population (aged 13 to 15 years) who used an electronic cigarette at least once in the 30 days prior to the survey. In all countries, except for Brazil, Canada, Colombia, and the United States of America, data come from the Global Youth Tobacco Survey (GYTS). It should be noted that the surveys were conducted in different years.
(1) High-school students; (2) Grades 7–9.

*Data not available for Barbados, Bahamas, Chile, Costa Rica, Dominica, Haiti, Honduras, Mexico, and Saint Kitts and Nevis.

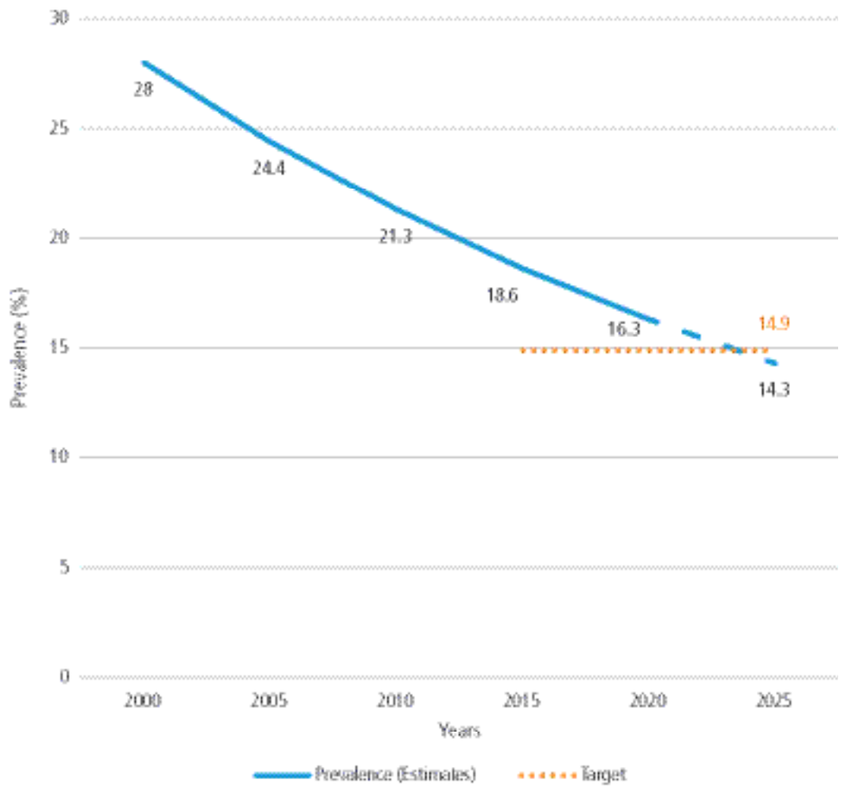
Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

of estimated trends in the prevalence of tobacco use in adults during the period 2000 to 2025. Periodic updates of this trend analysis have been published, in 2018, 2019, and 2021.

According to these calculations, the goal for the Region of the Americas by the year 2025 is to record a 14.9% prevalence in current tobacco use. However, according to the trends observed, it is estimated that this target is likely to be surpassed to achieve a regional prevalence of 14.3%, thereby exceeding the goal of a relative reduction of 30% between 2010 and 2025 (Figure 8). Should this projection become a reality by 2025, the prevalence of tobacco consumption in adults would have been reduced to half of what it was in 2000 (28%). Despite these encouraging trends, it should be noted that they

FIGURE 8

Estimated trend in current tobacco use prevalence among adults in the Region of the Americas, 2000–2025



Notes: The prevalence of current tobacco use refers to the percentage of the adult population (people aged 15 years and older) who used tobacco products (smoked and smokeless) in the 30 days prior to the survey; it includes both daily and occasional users. Data were age-standardized for 2020. For more details, see Technical Note II for reference (7).

Source: Prepared based on the WHO Global Report on the Trends in Prevalence of Tobacco Use 2000–2025, 4th edition (7).

BOX 1

The Global Tobacco Surveillance System

Epidemiological surveillance permits the collection and dissemination of information about disease, risk factors, trends, etc. to the wider public. To this end, in 1999, WHO and the United States Centers for Disease Control and Prevention (CDC) created the Global Tobacco Surveillance System (GTSS), to assist countries in establishing effective monitoring and surveillance programs on tobacco use. The objective of the GTSS is to improve the capacities of countries to design, implement, and evaluate tobacco control interventions and monitor the key articles of the WHO FCTC and the components of the WHO MPOWER technical package (*10*).

It is important to mention some of the key features of an effective surveillance system. To begin with, a surveillance system must be simple, flexible, standardized, systematic, and continuous. In this way, costs will be reduced, available resources will be used appropriately, any opportunities that arise during execution will be taken advantage of, and comparative analyses can be carried out over time and in a timely manner. To achieve this, it is necessary to have valid, reliable, and representative data, obtained through clear research protocols (*11–12*).

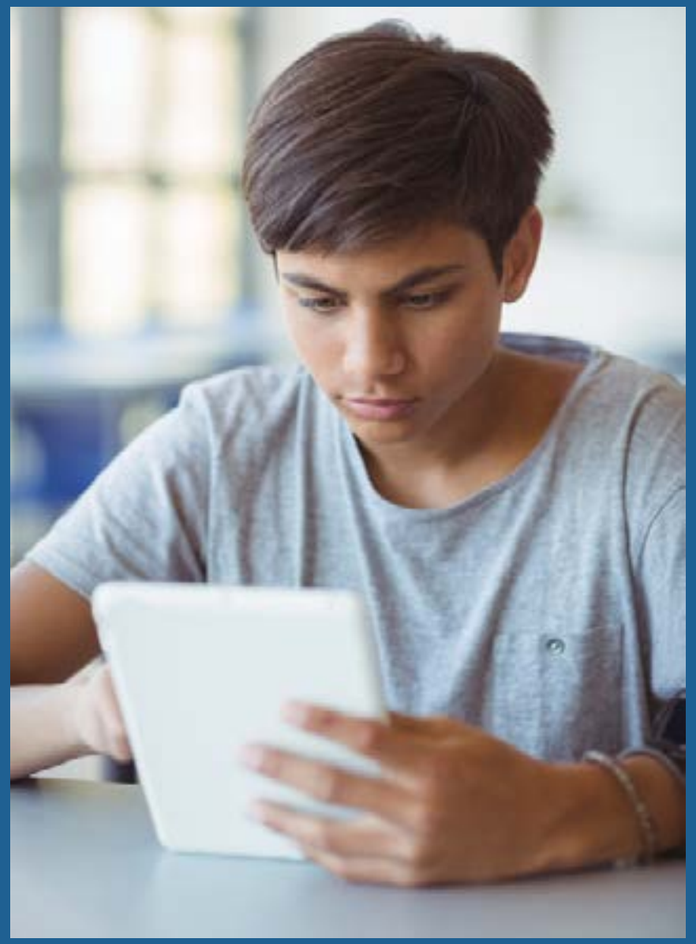
Initially, in 1999, the Global Youth Tobacco Survey (GYTS) was developed as part of the GTSS, which to date has been implemented in more than 185 countries worldwide. In the Region of the Americas, 33 countries have conducted at least one round of the survey since its launch. The implementation of this survey has technical support and financial resources guaranteed through technical cooperation agreements between PAHO, WHO Headquarters, and CDC. Thus, countries are encouraged to execute new rounds of surveys at regular intervals of 4 to 6 years (*13*).

In 2008, the GTSS launched the Global Adult Tobacco Survey (GATS). GATS is the global standard for the systematic monitoring of adult tobacco use and key tobacco control indicators. To date, more than 20 countries around the world have conducted GATS. In 2008, Brazil was the first country in the Region to conduct this survey. Another five countries have since carried out this survey (Argentina, Costa Rica, Mexico, Panama, and Uruguay); Mexico and Uruguay have carried out two rounds of this survey (*12*). As with GYTS, CDC and PAHO are responsible for providing technical assistance to countries throughout the survey implementation process, regardless of whether the survey receives funding from the CDC Foundation or whether it is carried out with resources allocated by the respective national authorities, as was the case in Costa Rica and Panama.

Tobacco Questions for Surveys (TQS) was released in 2011 as a tool to strengthen GTSS. This is a set of questions drawn from GATS that can be included in national health or related surveys so tobacco use can be investigated. The objective is to improve the comparability of the indicators over time and contribute to the harmonization of these indicators according to the global frameworks for monitoring and surveillance of tobacco. The adoption of TQS allows a complete picture of the key measures for tobacco control in any population of interest to be obtained. Brazil and Mexico have included TQS in their national health surveys. The TQS manuals are available in the four official languages of PAHO (*10*).

Given the global acceptance and success of TQS, in 2019 the Tobacco Questions for Surveys of Youth (TQSY) was launched. As with TQS, TQSY is a subset of key questions drawn from the GYTS. To date, only one country in the Region, Costa Rica, has adopted TQSY in its national surveys (*13, 14*).

Tobacco surveillance must form part of any public health surveillance system and be a component of comprehensive tobacco control programs. GTSS provides the necessary tools for countries to structure their tobacco surveillance systems. PAHO and the global partners of GTSS are at the disposal of countries to provide the necessary technical assistance for the development of sustainable tobacco surveillance systems. GTSS results and tools can be accessed via the portal: https://www.cdc.gov/tobacco/global/gtss/gtssdata/index.html and on the GTSS Academy website: https://www.gtssacademy.org/.



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are projections based on calculated mathematical models using data from national surveys and with the statistical assumption that countries will continue to strengthen their tobacco control policies and there will be no setbacks or delays, as these could negatively impact the projections described above.

In 2020, the Americas ranked as the region with the second-lowest prevalence of current tobacco use in adults around the world. However, the data in relation to the prevalence of tobacco use among young people and adults urge continued action toward the continuous guarantee of protection of the population against the effects of tobacco and in compliance with relevant international commitments.

It is also necessary to consider the growing acceptance of consumption of different forms of tobacco and nicotine products, including new and emerging products used by young and adult women in the Region, which will require targeted and effective initiatives. This, therefore, contributes to the urgency required for many countries of the Region to strengthen their tobacco control programs in line with the provisions of the WHO FCTC and the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022 (15). Such actions will allow the Region to obtain data that enable systematic monitoring and make it possible that the estimated trend in the prevalence of tobacco use can not only be achieved but can exceed what is forecast by 2025.

In this regard, the application of available tools presented in this chapter, such as those provided by GTSS, WHO, and other institutions, will contribute to implementing sound, evidence-based decisions. Nevertheless, as will be described in greater detail in the upcoming chapter, just 10 countries in the region have implemented tobacco control surveillance systems at the highest level of application, and just 24 countries have sufficient data to enable the calculation of estimated and projected prevalence in adults aged 15 years and older. Therefore, strengthening surveillance systems for tobacco control within the Region of the Americas must be prioritized.

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CHAPTER 2

Progress in the implementation of the MPOWER technical package in the Region of the Americas

2.1. The MPOWER technical package

With the objective of supporting countries in their efforts toward full implementation of the WHO FCTC, in 2007 WHO launched the MPOWER technical package (Table 1), a set of tools to accelerate the implementation of tobacco control measures globally (16, 17). This chapter presents progress in the Region of the Americas in tobacco control, framed by the implementation of the MPOWER technical package, as follows:

- For measures relating to monitoring the prevalence of tobacco use as well as tobacco control policies (M) and offer help to quit (O), the data in this report reflect the period from 1 January 2017 to 31 December 2020.

- For measures relating to protection from exposure to tobacco smoke (P), warnings about the danger of tobacco (W), and enforcing bans on tobacco advertising, promotion, and sponsorship (E), the data correspond to the period 1 January 2018 to 31 December 2021.

- For measures relating to raising tobacco taxes (R), progress is reported from 1 August 2016 to 31 July 2020.

This report also provides data that rank the progress made by each country toward implementing the measures of the MPOWER package (Country Profiles, published separately) according to the data compiled, validated, and approved by each respective Member State.

2.1.1. Progress in the implementation of the MPOWER measures at the global and regional levels

As reflected in the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), progress in

tobacco control continues to be made even during the COVID-19 pandemic, which has disrupted health services around the globe, threatening the advancement of tobacco control in its wake.

Considering the year in which the MPOWER measures were introduced as the baseline (2007), the number of countries around the world that have adopted at least one measure at the highest level of implementation has increased from 44 to 146 countries, covering more than 5 billion people (69% of the world's population). At the same time, in 2020 the population now covered by at least two measures has increased to 4.4 billion (8). Steady progress continues to be made. More countries that previously had not registered any best practice measures have sought to take action to achieve the highest levels of application, either in single or multiple measures.

There are 101 countries now classified as having attained the highest level of application with respect to health warnings on tobacco products. This translates into 60% or 4.7 billion of the world's population now being warned about the dangers of tobacco use through large, graphic health warnings with all the recommended characteristics featuring on tobacco packaging (Figure 9). This has contributed to measure W of the MPOWER package having the highest population coverage as well as the highest number of countries implementing this measure, with 17 of them adopting legislation that mandates plain packaging.

There are now 1.8 billion people in 67 countries covered by comprehensive, smoke-free indoor public places, workplaces, and public transport, resulting in measure P being the second most adopted MPOWER measure in terms of the number of countries covered. Following closely, bans on tobacco advertising, promotion, and sponsorship (TAPS) cover 1.6 billion people across 57 countries globally. Of these countries, 31 are middle income, accounting for 30% of all countries classified as such; however, there are also 12 low-income countries implementing this measure at the highest level of application, accounting for 41% of the total low-income category.

In light of evidence suggesting that smokers are more vulnerable to experiencing severe COVID-19 infection, even with more countries implementing cessation services, accessibility to such services is still not sufficient to cover the population in need, and just 26 countries have implemented this particular measure at the highest level of application. However, population coverage amounts to a third of the world's population (2.5 billion), resulting in measure O being the second most adopted MPOWER measure in terms of population coverage.

TABLE 1

The MPOWER technical package

M (Monitor)	Monitor tobacco use and prevention policies
P (Protect)	Protect against exposure to tobacco smoke
O (Offer)	Offer help to quit tobacco use
W (Warn)	Warn about the dangers of tobacco
E (Enforce)	Enforce bans on tobacco advertising, promotion, and sponsorship
R (Raise)	Raise taxes on tobacco

Source: Based on MPOWER package of data driven tobacco control measure helps protect up to 5 billion lives (17).

Understandably, monitoring tobacco use, or measure M of MPOWER, has been hugely affected by the pandemic, as data collection efforts were completely thwarted and the results of previously conducted surveys could not be released.

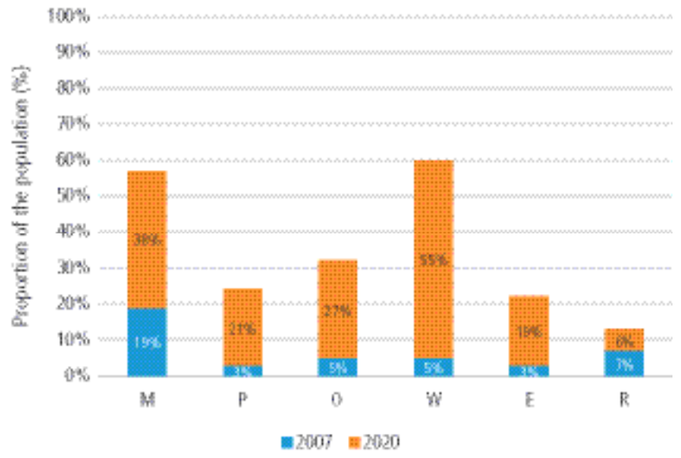
Increasing the price of tobacco through taxation continues to be the policy with the lowest population coverage, at 13%, even though it is the most cost-effective single measure to reduce tobacco consumption. There has been no recorded increase in this measure since 2018.

Among the WHO regions, as of 2020 there was a wide variation in the number of Member States implementing the MPOWER measures at the highest level of application compared with the total number of Member States within the respective regions. As it pertains to measure M, Europe had the highest number of countries (42/53) with a surveillance system that produced periodic, recent, and representative data for adults and young people, while there were no countries in Africa that had implemented this measure at the highest level of application (Table 2).

Regarding measure P, South-East Asia has the lowest number of countries (2/11) that have adopted smoke-free policies at their highest level of application (8). As of 31 December 2021, the Americas had the highest number of countries that have adopted smoke-free policies at their highest level of application (24/35, 23 of which are Parties to the WHO FCTC). The Americas has had the greatest number of Member States implementing this measure at the highest level of application since 2009 (Table 3). Simultaneously, the number of Member States within the Region

FIGURE 9

Proportion of the world's population covered by tobacco control policies implemented at the highest level of application, 2007–2020



Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

TABLE 2

Number of countries by WHO region that implement the MPOWER technical package of measures at the highest level of application

REGION	MEMBER STATES	M	P	O	W	E	R
Africa (AFRO)	47	0	11	0	14	21	2
Americas (AMRO)	35	10	24[a]	6	22[a]	9[a]	3
South-East Asia (SEARO)	11	3	2	1	6	2	2
Europe (EURO)	53	42	9	8	40	9	28
Eastern Mediterranean (EMRO)	22	6	8	4	6	12	4
Western Pacific (WPRO)	27	15	9	6	14	5	1

Note: [a]According to the cutoff dates indicated in the Technical Notes in the reference 8 (WHO Report on the Global Tobacco Epidemic 2021: Addressing new and emerging products, 8th edition), except for the Region of the Americas, measures P, W, and E (cutoff date as of 31 December 2021). At the time of publication of the aforementioned WHO Report on the Global Tobacco Epidemic 2021, there were 23 Member States in the Region implementing measure P, 22 measure W, and 8 measure E at the highest levels of application.

The numbers in bold font highlight the corresponding WHO region which has the greatest number of countries implementing the specific MPOWER measure at the highest level of application.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), and data from the PAHO Regional Tobacco Control Team.

TABLE 3

Number of countries by WHO region recording implementation of measure P at the highest level of application

REGION	2008	2009	2011	2013	2015	2017	2019	2021
Africa (AFRO)	4	3	4	5	6	7	9	11
Americas (AMRO)	1	5	9	14	17	19	20	24[a]
South-East Asia (SEARO)	3	1	3	3	3	2	2	2
Europe (EURO)	8	3	8	9	10	13	13	9
Eastern Mediterranean (EMRO)	1	2	3	5	5	6	7	8
Western Pacific (WPRO)	1	3	4	7	7	9	9	9

Note: [a]According to the cutoff dates indicated in the Technical Notes in reference (WHO Report on the Global Tobacco Epidemic 2021: Addressing new and emerging products, 8th edition, except for the Region of the Americas measures P, W, and E (cutoff date 31 December 2021). At the time of publication of the aforementioned WHO Report on the Global Tobacco Epidemic 2021, there were 23 Member States in the Region implementing measure P, 22 measure W, and 8 measure E at the highest levels of application.

Source: WHO Report on the global tobacco epidemic, 2008 (16), 2009 (18), 2011 (19), 2013 (20), 2015 (21), 2017 (22), 2019 (23), and 2021 (8).

of the Americas implementing smoke-free policies at the highest level of achievement has been progressively increasing over the years, and there have been no downgrades recorded to date.

A small number of countries implement tobacco cessation services (offer help to quit, or measure O) at the highest level of application (Table 2). Europe has the highest number of countries (8/53) offering such services at the highest level of application, while none of the 47 countries within the Africa Region has implemented this measure at the highest level of application. The European Region has the highest number of countries (40/53) that implement measure W at the highest level of application (Table 2), specifically in the use of graphic health warnings on tobacco product packaging. In absolute numbers, the South-East Asia and Eastern Mediterranean Regions had the lowest numbers of countries that applied measure W at the highest level of application, with 6 countries each out of 11 and 22, respectively (8).

Regarding measure E, which tracks the implementation of bans on tobacco advertising, promotion, and sponsorship as it corresponds to Article 13 of the WHO FCTC, 21 of 47 countries in Africa have achieved the highest level of implementation in comparison with 2 of 11 countries in the South-East Asia Region. However, the progress in implementing measure E continues to be a cause for concern, as overall the numbers are fairly low in the other WHO regions (Eastern Mediterranean, 12; Europe, 9; the Americas, 9 [as of 31 December 2021]; and the Western Pacific, 5) (Table 2).

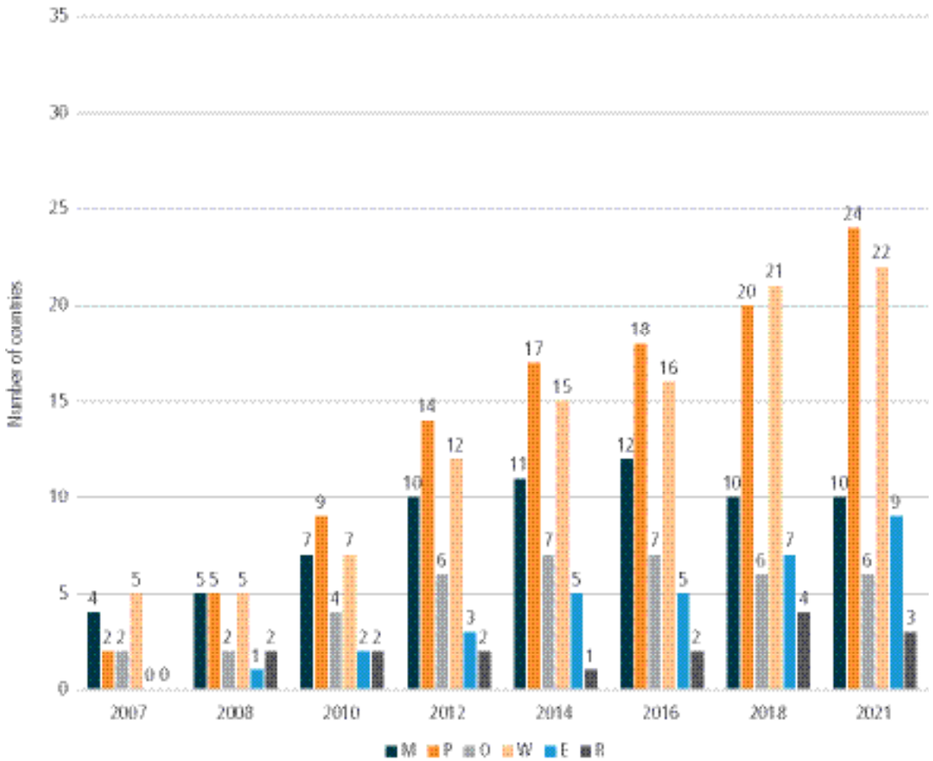
The numbers continue to be low for measure R, for raising taxes on tobacco products (Table 2). In Europe, 28 of the 53 Member States implement total indirect taxes representing at least 75% of the retail sale price of the most sold brand of cigarettes, which is the highest level of achievement for this measure, while the remaining regions only have between one and four countries that have achieved this measure at the highest level of application (8).

In the Region of the Americas, 26 of the 35 countries have achieved the highest level of application of at least one measure of the MPOWER technical package, representing a population coverage of 96%. The measures that are most commonly implemented at the highest level of application within the Region are P (24 countries) and W (22 countries). Ten countries implement measure M at the highest level of application, followed by measure O in six countries, measure E in nine countries, and measure R in three countries. The adoption of policies related to taxes and the illicit trade of tobacco products remains a challenge in the Region; however, 2018 saw the highest number of countries implement measure R at the highest level of application since 2008. Since the Report on Tobacco Control for the Region of the Americas 2018, the number of countries implementing each measure in the MPOWER technical package at the highest level of application has increased, with the exception of measures O and R, which each both decreased in one country. Measure M remained unchanged, P increased by five countries, W by four, and E by three (Figure 10).

Brazil is the only country in the Region that has implemented the entire MPOWER technical package at its highest level of application. From 2005 to the end of 2021, good progress has been made in the Region in terms of the number of measures that have been implemented at the highest level (Figure 11). In 2005, 28 countries had not implemented even one measure of the MPOWER package. Seven countries had implemented between one and three measures, while no country had implemented between four and six measures. By 2021, 9 countries are yet to implement at least one measure, 19 countries apply between one and three measures, and 7 countries apply between four and six measures.

FIGURE 10

Trend in the implementation in the Region of the Americas of MPOWER tobacco control measures, by number of countries, 2007–2021



Notes: Only measures at the highest level of achievement were considered (see the definitions of categories in the Technical Note). One of the countries at the highest level of achievement did not provide data for measure R in 2010 or 2014. M: monitor tobacco use and prevention policies; P: protect people from tobacco smoke; O: offer help to quit tobacco use; W: warn about the dangers of tobacco; E: enforce bans on tobacco advertising, promotion, and sponsorship; R: raise taxes on tobacco.

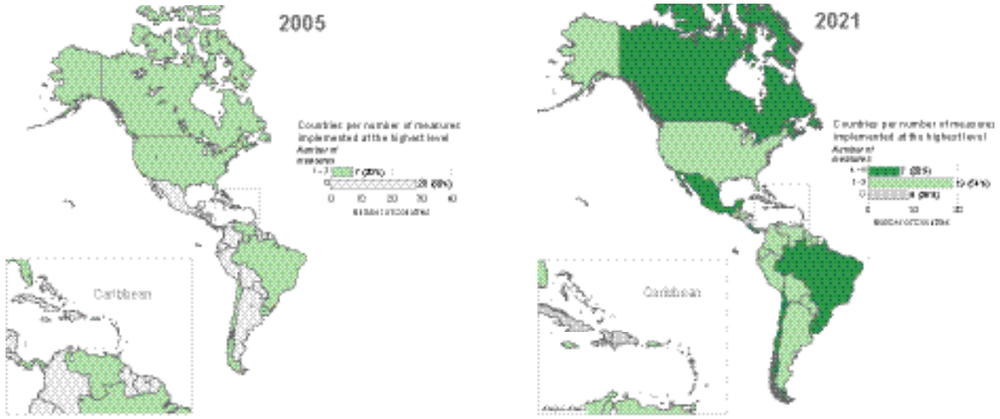
Cutoff dates: Region of the Americas: measure R, 31 July 2020; measures M and O, 31 December 2020; measures P, W, and E, 31 December 2021.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), and data from the PAHO Regional Tobacco Control Team.

Considering the population of the Region of the Americas covered by each tobacco control policy implemented at its highest level of application, since 2007 the percentage of the population covered by at least one MPOWER measure has significantly increased (Figure 12). More than 60% of the population is covered by measures M, P, O, and W, implemented at the highest levels. The

FIGURE 11

Changes in the application of a selected group of WHO FCTC measures in the Region of the Americas, 2005–2021

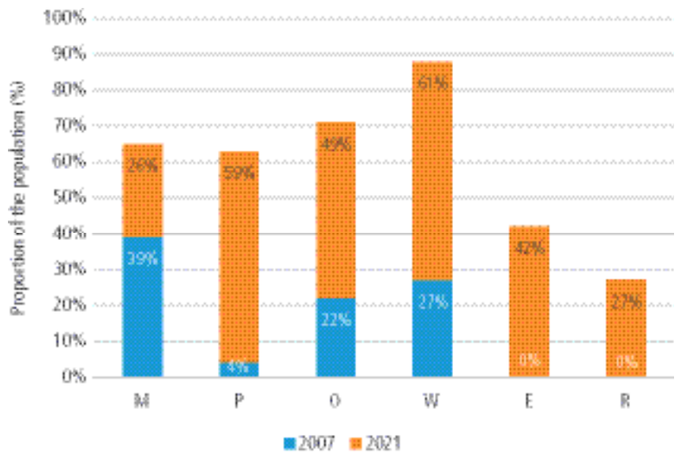


Cutoff dates: Region of the Americas: measure R, 31 July 2020; measures M and O, 31 December 2020; measures P, W, and E, 31 December 2021.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition, and data from the PAHO Regional Tobacco Control Team (8).

FIGURE 12

Proportion of the population of the Region of the Americas covered by each tobacco control policy implemented at its highest level of application, 2007–2021



Notes: Coverage estimates for the 35 PAHO Member States were made by the PAHO Regional Tobacco Control Team. The 2020 population data were obtained from the United Nations Department of Economics and Social Affairs, Population Division (2021) and World Population Prospects: 2021 Edition.

Cutoff dates: Region of the Americas: measure R, 31 July 2020; measures M and O, 31 December 2020; measures P, W, and E, 31 December 2021.

Source: For M, O, W, and R, based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8). P, W, and E were prepared based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), and data from the PAHO Regional Tobacco Control Team.

most significant increase in population coverage was seen for measure W, with a 61% increase from 2007 to 2021, reaching a coverage of almost 90%. This was closely followed by measure P, with a 59% increase in population coverage. As mentioned previously, measure R saw the lowest coverage, covering just 27% of the population of the Region.

Since 2017, the number of countries in the Region implementing measure M at the highest level of achievement has remained unchanged to date. The Region continues to present these same ten countries with a surveillance system that complies with periodic, recent, and representative data for adults and young people in terms of tobacco control. For measure P, Guyana (2017), Antigua and Barbuda (2018), Bolivia (Plurinational State of) (2020), Paraguay (2020), Saint Lucia (2020), and Mexico (2021) have all taken the requisite steps to protect their respective populations through the implementation of comprehensive smoke-free legislation.

Unfortunately, no additional countries have implemented measure O at the highest level of application. For measure W, Barbados, Honduras, and Saint Lucia (2017), Guyana along with Antigua and Barbuda (2018), and the United States of America (2020) all established the use of graphic health warnings on tobacco product packaging, in compliance with Article 11 of the WHO FCTC. For measure E, Guyana (2017), Antigua and Barbuda (2018), Venezuela (Bolivarian Republic of) (2019), and Mexico (2021) all enacted legislation to completely ban the advertising, promotion, and sponsorship of tobacco products. However, in Colombia, the price for the most sold brand of cigarettes increased substantially while specific excise taxes increased only slightly, resulting in the total tax share falling below the 75% threshold in this country in 2020. Table 4 shows a summary of the status of the WHO FCTC in the Region of the Americas as well as the implementation of the measures contained within the MPOWER technical package, corresponding to the year 2021.

2.2. Monitor tobacco use and prevention policies

> "... The Parties shall establish, as appropriate, programs for national, regional, and global surveillance of the magnitude, patterns, determinants, and consequences of tobacco consumption and exposure to tobacco smoke … Towards this end, the Parties should integrate tobacco surveillance programs into national, regional, and global health surveillance programs so that data are comparable and can be analyzed at the regional and international levels as appropriate ..."
> Article 20 WHO FCTC

TABLE 4

Status of the WHO Framework Convention for Tobacco Control in the Region of the Americas and a summary of the application of the MPOWER package, 2021

	WHO FCTC ART. 20	WHO FCTC ART. 8	WHO FCTC ART. 14	WHO FCTC ART. 11	WHO FCTC ART. 13	WHO FCTC ART. 6	NUMBER OF BEST BUY MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL	NUMBER OF MPOWER MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL
		BEST BUY		BEST BUY	BEST BUY	BEST BUY		
COUNTRY	M MONITORING	P SMOKE FREE ENVIRONMENTS	O CESSATION SERVICES	W PACKAGING AND LABELING	E BAN ON TAPS	R RAISE TOBACCO TAXES	PWER	MPOWER
Antigua and Barbuda		2018	↓	2018[a]	2018	13.1%	3	3
Argentina		2011		2012		76.6%	3	3
Bahamas	2018					43.2%	0	1
Barbados	↓	2010		2017		…	2	2
Belize	↓					34.7%	0	0
Bolivia (Plurinational State of)		2020↓		2009		35.7%	2	2
Brazil	2015	2011	2002	2003	2011	81.5%	4	6
Canada	2007 or earlier	2007	2008	2011[b]		61.7%	2	4
Chile	2007 or earlier	2013		2006		80.0%	3	4
Colombia	↓	2008			2009	73.1%↓	2↓	2↓
Costa Rica	2007 or earlier	2012	2020↓	2013		53.6%	2	4↓
Cuba						…	0	0
Dominica						22.7%	0	0
Dominican Republic						44.3%↓	0	0
Ecuador	2016	2011		2012		66.9%	2	3
El Salvador		2015	↓	2011		46.5%	2	2↓
Grenada		↓				…	0	0
Guatemala	↓	2008				49.0%	1	1
Guyana		2017		2018	2017	27.5%↓	3	3
Haiti						…	0	0
Honduras	↓	2010		2017		42.6%	2	2
Jamaica		2013	2016	2013		42.6%	2	3
Mexico		2021 ↓	2013	2009	2021↓	67.6%	3	4
Nicaragua						69.4%↓	0	0
Panama	2012	2008		2005	2008	56.5%	3	4
Paraguay		2020↓				18.3%	1	1

TABLE 4 *(continued)*

	WHO FCTC ART. 20	WHO FCTC ART. 8	WHO FCTC ART. 14	WHO FCTC ART. 11	WHO FCTC ART. 13	WHO FCTC ART. 6	NUMBER OF BEST BUY MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL	NUMBER OF MPOWER MEASURES IMPLEMENTED AT BEST PRACTICE LEVEL
		BEST BUY		BEST BUY	BEST BUY	BEST BUY		
COUNTRY	M MONITORING	P SMOKE FREE ENVIRONMENTS	O CESSATION SERVICES	W PACKAGING AND LABELING	E BAN ON TAPS	R RAISE TOBACCO TAXES	PWER	MPOWER
Peru	2007 or earlier	2010		2011		67.7%↓	2	3
Saint Kitts and Nevis						…	0	0
Saint Lucia		2020↓		2017		51.3%	2	2
Saint Vincent and the Grenadines						23.1%	0	0
Suriname	↓	2013		2016	2013	26.5%	3	3↓
Trinidad and Tobago		2009		2013		25.7%	2	2
United States of America	2007 or earlier		2008	2020[c]↓		40.0%	1	3
Uruguay	2007 or earlier	2005		2005[b]	2014	65.9%	3	4
Venezuela (Bolivarian Republic of)	↓	2011		2004	2019↓	73.4%	3	3
	10	24	6	22	9	3	10	7

Notes: For the definitions and the colors of the classification of the interventions, please see Chapter 6: Technical Note.
[a]Regulations pending.
[b]Plain packaging is mandated.
[c]Provision adopted but not implemented by 31 December 2020.
↓ ↓ Indicates a change in the rating from the 7th to the 8th edition of the WHO Report on the Global Tobacco Epidemic.
BEST BUY – Interventions where a WHO choice analysis found an average cost-effectiveness ratio of ≤US$ 100 per disability-adjusted life-year (DALY) averted in low- and lower-middle-income countries.
… Data not reported/not available.

Cutoff dates: Region of the Americas: measure R, 31 July 2020; measures M and O, 31 December 2020; measures P, W, and E, 31 December 2021.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), and data from the PAHO Regional Tobacco Control Team.

WHO defines surveillance as the collection, analysis, and systematic and continuous interpretation of health data for the purpose of planning, analyzing, and evaluating practices in that sphere. Therefore, the strengthening of tobacco control surveillance is essential to combat the tobacco epidemic as well as strengthen the WHO FCTC.

The gathering of surveillance data provides much-needed evidence for policymakers to enable strong advocacy for broader tobacco control efforts as well as the necessary resources required to enable comprehensive implementation.

National surveillance systems are classified as having the highest level of achievement if they comply with the following:

- Provide recent data (5 years or less);
- Periodic information (every 4 or 5 years);
- Based on nationally representative surveys of both adult and youth populations.

For tobacco-use surveillance, key products to track during the data collection process include:

- Cigarettes and other forms of smoked tobacco products;
- Smokeless tobacco products;
- Novel and emerging tobacco products such as e-cigarettes and heated tobacco products;
- Non-tobacco forms of nicotine.

As trends and patterns of tobacco use periodically evolve, it is helpful to identify and understand these changes; therefore, a surveillance system requires a long-term commitment. Taking this into account, PAHO/WHO and the United States Centers for Disease Control and Prevention (CDC) developed the Global Tobacco Surveillance System (GTSS), which comprises the Global Youth Tobacco System (GYTS) and the Global Adult Tobacco Survey (GATS). The GTSS produces indicators and data about the patterns of use of various tobacco products, as well as data for evaluating the implementation of the MPOWER package of policies. The components of the GTSS are described in further detail in Box 1 in Chapter 1.

A total of 33 PAHO/WHO Member States (all except for Canada and the United States of America) have conducted at least one round of the GYTS with nationally representative samples or in the main regions of the country, including their capitals, as in Brazil, Chile, and Colombia. In 12 countries (Antigua and Barbuda, Bahamas, Barbados, Costa Rica, Grenada, Guyana, Jamaica, Panama, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago), the GYTS has been carried out four times, producing nationally representative data in all rounds of the survey.

Article 20.2 of the WHO FCTC and measure M of the MPOWER technical package refer to the monitoring of tobacco consumption and the application of tobacco control policies. Many countries currently have several tools for tobacco control surveillance, such as the GTSS. In addition, there are other instruments that include questions about tobacco, such as the Stepwise Approach to Chronic Diseases Surveillance (STEPs) survey developed by WHO, Surveys on Drug Consumption and Addictions, Demographic Health Surveys, and the WHO Global School Health Survey (GSHS), among others (8).

Worldwide, 78 countries monitor tobacco consumption within their respective populations (2.8 billion people) through surveillance systems that collect recent, periodic, and representative data about adults and young people. Globally, 46 countries are classified as high-income countries according to World Bank criteria; however, 25% of these countries still do not implement measure M at the highest level of application. On a more positive note, all but 37 countries globally are implementing some form of monitoring of tobacco use and prevention policies.

As mentioned previously in this chapter, 10 countries within the Region of the Americas have surveillance systems with recent, periodic, and representative data for tobacco consumption

FIGURE 13

Status of tobacco control surveillance systems in the Region of the Americas, 2020

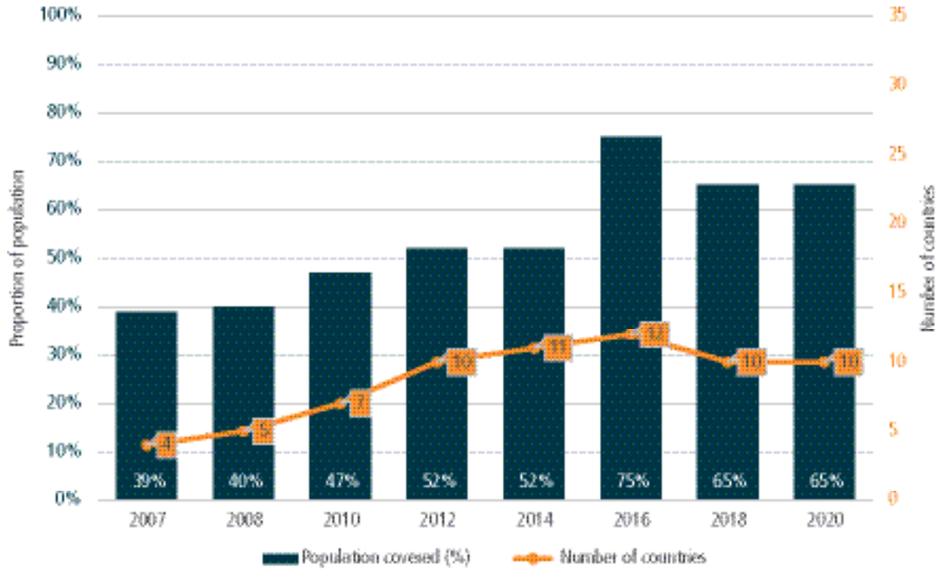
Note: Based on data available to 31 December 2020. For more information, see Technical Note (Chapter 6).

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

in adult and youth populations (Figure 13). Taking 2008 as the baseline year, as of 31 December 2020, the number of countries that have implemented measure M at the highest level of application has increased from 4 to 10; however, no additional countries have joined their number since 2017. With the exception of five countries in the Caribbean Community (CARICOM) (Barbados, Belize, Dominica, Haiti, and Saint Kitts and Nevis), all other countries in the Region have some form of recent and representative data regarding the prevalence of tobacco use in adults and young people, and 65% of the regional population is covered by tobacco consumption monitoring policies at a reasonable level of good practice (Figure 14).

FIGURE 14

Change in the number of countries and proportion of the population covered by surveillance systems for tobacco at the highest level of achievement in the Region of the Americas, 2007–2020



Note: The numbers on the line indicate the total number of countries that implemented the measure at its highest level of achievement by 31 December of the year indicated.

Source: Prepared by the authors and based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

2.3. Protect people from tobacco smoke

"To protect people from tobacco smoke" constitutes the P of the MPOWER acronym, and its mandate is set out in Article 8 of the WHO FCTC.

The COVID-19 pandemic has highlighted the vulnerability of those exposed to tobacco and suffering from smoking-related diseases and underscored the importance of tobacco control for population health. Tobacco control policies, especially smoke-free legislation, encourage smokers to quit and remain abstinent while reducing other people's exposure to second-hand smoke. Smoke-free environments have also been shown to reduce cigarette consumption among smokers and act as a trigger for renewed attempts to quit among those who have previously tried to quit.

As observed in previous global and regional reports, this measure continues to be the one in

> "... Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative, and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places …"
> Article 8 WHO FCTC

which most progress has been made within the Region, where most countries have implemented it since 2008. In total, 24 countries have achieved the highest level of application of this measure, through the implementation of comprehensive legislation to ensure smoke-free environments in indoor public spaces, in workplaces, and on public transportation (Figure 15). Antigua and Barbuda joined the group of smoke-free countries in 2018. A further major achievement occurred in 2020 when three countries approved laws to ensure smoke-free environments: Bolivia (Plurinational State of) in February, Saint Lucia in June, and Paraguay in December.

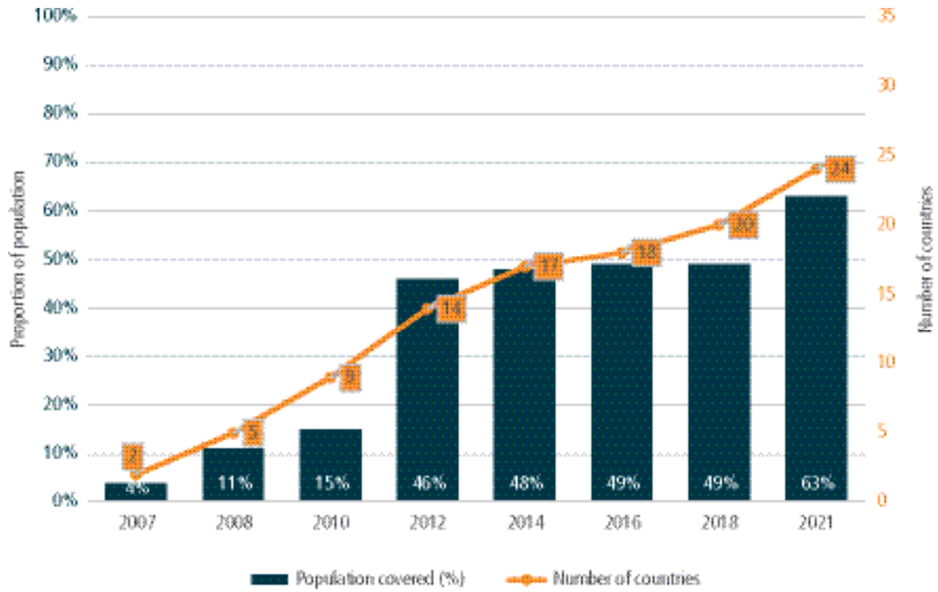
The ascension of Paraguay to becoming a smoke-free Member State is seen as one of the most important milestones within the Region to date, as this marked South America becoming the first subregion within the Americas to be completely smoke-free, resulting in 434 million people now protected from tobacco smoke in enclosed public spaces and workplaces. In December 2021, Mexico became the most recent Member State to approve a national law that resulted in the country being categorized as 100% smoke-free and increasing the population coverage of measure P within the Region to 63% (Figure 15 and 16).

The guidelines for the implementation of Article 8 recommend that Parties should "strive to provide universal protection within five years of the WHO FCTC's entry into force for that Party" (24). At present, there are seven Parties to the Convention (Bahamas, Belize, Dominica, Grenada, Nicaragua, Saint Kitts and Nevis, and Saint Vincent and the Grenadines) that have not yet implemented this measure at the highest level, and their deadlines have now passed.

The evidence supporting this measure is very straightforward, as there are no known safe levels of exposure to second-hand smoke (24). Additionally, exposure to second-hand smoke causes many serious diseases of the cardiovascular and respiratory systems in both children and adults and can often result in death. The 2014 United States Surgeon General's Report elaborated on the health consequences of smoking and cerebrovascular incidents, and such incidents were added to the list of diseases causally related to exposure to second-hand smoke (25).

FIGURE 15

Change in the number of countries and proportion of the population covered by smoke-free environment regulations, at the highest level of achievement, in the Region of the Americas, 2008–2021



Note: Available data up to 31 December 2021. The numbers on the line indicate the total number of countries that implemented the measure at its highest level of achievement by 31 December of the year indicated. The selected years correspond to the cutoff date for measure P (protect the population from exposure to tobacco smoke) of the MPOWER package, according to WHO reports on the global tobacco epidemic based on data up to 2008, 2010, 2012, 2014, 2016, and 2018.

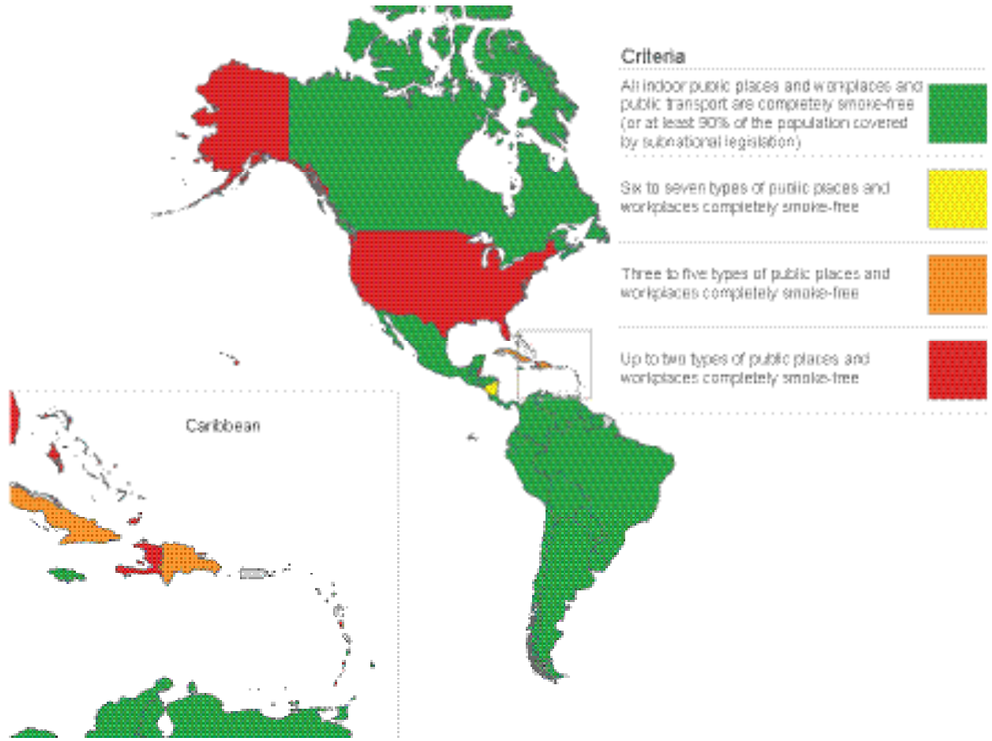
Source: Prepared by the authors and based on the WHO Report on the Global Tobacco Epidemic, 2021:Addressing new and emerging products, 8th edition (8), as well as data from the PAHO Regional Tobacco Control Team.

The implementation of complete bans on smoking is a requirement of the WHO FCTC, with the expectation that this should be extended beyond indoor places to cover "other" public spaces such as outdoor spaces. Some countries within the Region have acted accordingly and banned smoking in open areas of educational or health centers, or in places where children are allowed.

Meanwhile, the tobacco industry continues to propose alternatives to 100% smoke-free places, such as installing ventilation and setting up designated smoking areas. Additionally, emphasizing baseless negative economic impacts, by the tobacco industry and those who work to further its interests, has been the hallmark of arguments opposing the implementation of smoke-free environments within the Caribbean and Central America. The industry continues to generate new ideas to establish alternative products that can provide loopholes so they are not subject to the rules of smoke-free policies.

FIGURE 16

Status of policies to protect the population against exposure to tobacco smoke in the Region of the Americas, 2021



Note: Available data as of 31 December 2021. For more information, see the Technical Note.

Source: Prepared by the authors and based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data from the PAHO Regional Tobacco Control Team.

These actions are not taken into account within the guidelines for implementation of Article 8 of the WHO FCTC, which also warns about the ineffectiveness and lack of adequate protection associated with the adoption of voluntary smoke-free measures. The core principles of the Article 8 guidelines highlight instead the need for legislation to ensure protection for all people against exposure to tobacco smoke and further stipulate that such legislation must be simple, clear, and binding to be effective.

Table 5 shows the types of indoor public places and workplaces that are completely free of tobacco smoke according to the current national law in each country within the Region. An environment is considered completely free of tobacco smoke when smoking is banned at all

TABLE 5

Smoke-free regulations in the Region of the Americas, 2021

COUNTRY AND YEAR OF LEGISLATION[a]	HEALTH CENTERS	EDUCATIONAL FACILITIES (EXCEPT UNIVERSITIES)	UNIVERSITIES	GOVERNMENT OFFICES	OFFICES	RESTAURANTS	BARS AND PUBS	PUBLIC TRANSPORTATION	ALL OTHER INDOOR PUBLIC SPACES
Antigua and Barbuda (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Argentina (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Bahamas	–	–	–	–	–	–	–	–	–
Barbados (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belize	–	–	–	–	–	–	–	–	–
Bolivia (Plurinational State of) (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Brazil (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Canada (2007)[b]	Yes	Yes	Yes	Yes		Yes	Yes	Yes	
Chile (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Colombia (2008)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Costa Rica (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cuba	Yes	Yes	Yes					Yes	
Dominica	–	–	–	–	–	–	–	–	–
Dominican Republic	Yes	Yes	Yes						
Ecuador (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
El Salvador (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Grenada	–	–	–	–	–	–	–	–	–
Guatemala (2008)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Guyana (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Haiti	–	–	–	–	–	–	–	–	_
Honduras (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

TABLE 5 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	HEALTH CENTERS	EDUCATIONAL FACILITIES (EXCEPT UNIVERSITIES)	UNIVERSITIES	GOVERNMENT OFFICES	OFFICES	RESTAURANTS	BARS AND PUBS	PUBLIC TRANSPORTATION	ALL OTHER INDOOR PUBLIC SPACES
Jamaica (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mexico (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nicaragua	Yes	Yes	Yes	Yes	Yes			Yes	
Panama (2008)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Paraguay (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Peru (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–
Saint Lucia (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Saint Vincent and the Grenadines	–	–	–	–	–	–	–	–	–
Suriname (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Trinidad and Tobago (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
United States of America[c]				Yes					
Uruguay (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Venezuela (Bolivarian Republic of) (2011)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Notes: Information available as of 31 December 2021. The year indicated in parentheses is the year the Member State first implemented this measure at the highest level of application.
[a]Only for laws that established a total smoking ban in indoor public places, workplaces, and on public transport.
[b]Although no national law exists, at least 90% of the population is protected by 100% of subnational laws in relation to smoke-free places.
[c]Although the Federal Law is not complete, complete laws exist covering smoke-free environments at the subnational levels.
– There is no legislation in place for smoke-free regulations.
Bold, italic font indicates the countries implementing measure P of the MPOWER technical package at the highest level of application. Empty cell indicates that legislation does not cover the specified criteria listed.

Source: WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data collected by the PAHO Regional Tobacco Control Team.

times, in all interior areas, and is not allowed under any circumstances.

2.4. Offer help to quit tobacco use

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

Article 14 of the WHO FCTC establishes provisions regarding tobacco dependence and cessation. It mandates that each Party must develop and implement programs that offer tobacco cessation services based on scientific evidence and characterized by being comprehensive, accessible, and appropriate to the context of the population. WHO has prioritized the offering of cessation services as an essential element in tobacco control programs by ensuring its incorporation into the MPOWER technical package under measure O.

Additionally, in line with the SDGs, the Political Declaration at the High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases in 2011 established nine voluntary global goals to reduce mortality caused by this group of diseases. Concerning tobacco control, a relative reduction of 30% in the current prevalence (daily and occasional) of tobacco use in people aged 15 years and older was established as the target for the period of 2010 to 2025 (26). Subsequently, to strengthen this initiative, WHO launched the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (9) and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the Americas 2013–2019 (27).

Meeting the goal of reducing tobacco use requires countries to work to prevent tobacco use but to also ensure that most tobacco users quit in an exponentially increasing manner. It is never too late to quit tobacco use and benefit from the long-term positive changes associated with this lifestyle change. In addition to increased life expectancy, achieving the best quality of life possible is indisputable. Such habits not only transform into positive outcomes for individuals but also for the general population, as well as the overall economy nationally, regionally, and globally through lower health care costs and increased productivity. These aspects are especially relevant in the current context of the COVID-19 pandemic.

It is important to recognize that cessation medications and professional support based on scientific evidence offered to individuals who wish to quit tobacco use can increase the chances of a successful attempt to quit. There is a series of recommended interventions available to help this process, including brief intervention advice,

toll-free telephone quit lines, text messages, individualized and group sessions with specialists, cessation clinics, substitution therapies, and nicotine replacement therapies (28).

One of the main limitations to implementing this measure at the highest level of application, however, is the availability of human and financial resources. This is the main reason progress in this regard remains stagnant in the Region of the Americas.

As of 2020, just six countries had implemented smoking cessation services at the highest level of application: Brazil, Canada, El Salvador, Jamaica, Mexico, and the United States of America (Figure 17).

The criteria used to analyze the level of implementation of these types of services are the scope, i.e., the number of people who receive this type of service; the effectiveness, i.e., the percentage of people who successfully quit

FIGURE 17

Status of the availability of tobacco dependence treatment and the coverage of costs in the Region of the Americas, 2020

Note: Available data as of 31 December 2020. NRT, nicotine replacement therapy. For more information, see Chapter 6: Technical Note.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

tobacco use as a result of the intervention; and the costs (both to the country in terms of reducing the health care burden and increasing productivity and to the individual in relation to the social determinants of health).

It is necessary to recognize that the progress made by countries in relation to other tobacco control measures is usually measured through the verification of national legislation; however, in the case of measure O of the MPOWER technical package, the relevant data are usually reported by countries through the WHO FCTC Conference of the Party (COP) reporting cycle (for those that are Parties to the WHO FCTC) and via verification of prefilled data sheets by national authorities that are not Parties to the WHO FCTC.

The evidence collected to date affirms that primary health care settings can be a potentially useful space to implement rapid interventions that would reach the majority of tobacco users. The administration of cessation interventions in primary health care settings can therefore further double the chances of the person successfully quitting tobacco use. It is necessary, therefore, for countries to also adopt comprehensive tobacco control policies, as this further facilitates closer interactions between the other measures, such as smoke-free environments and bans on advertising, promotion, and sponsorship of tobacco products, as these also contribute to reducing the affordability and appeal of tobacco to users as well as nurturing a supportive environment for tobacco cessation.

To 2020, 14 countries in the Region had implemented national toll-free telephone quit lines. Eight countries cover all costs, and four countries partially cover the costs associated with the provision of cessation services to those who wish to quit tobacco use. Twelve countries have included pharmacological treatment for cessation within the list of essential medicines in their respective countries (Table 6).

Smoking cessation support was evaluated according to the setting where the service was offered, whether in primary care facilities,

TABLE 6

Availability of tobacco dependence treatment and coverage of costs in the Region of the Americas, 2020

COUNTRY AND YEAR OF LEGISLATION[a]	TOLL-FREE QUIT LINE	NICOTINE REPLACEMENT THERAPY		
		AVAILABLE AT	COST COVERAGE	INCLUDED IN THE LIST OF ESSENTIAL MEDICINES
Antigua and Barbuda		Pharmacies	No	
Argentina	Yes	Pharmacies	No	Yes
Bahamas		Pharmacies	No	
Barbados		Pharmacies	No	Yes
Belize		Not available	---	
Bolivia (Plurinational State of)		Not available	---	
Brazil (2002)	Yes	Pharmacies	Full	Yes

TABLE 6 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	TOLL-FREE QUIT LINE	NICOTINE REPLACEMENT THERAPY		
		AVAILABLE AT	COST COVERAGE	INCLUDED IN THE LIST OF ESSENTIAL MEDICINES
Canada (2008)	Yes	Pharmacies	Partial	
Chile	Yes	Pharmacies with Rx	No	
Colombia		Pharmacies	Partial	
Costa Rica	Yes	Pharmacies	Full	
Cuba	Yes	Not available	---	
Dominica		Not available	---	
Dominican Republic		Pharmacies	No	
Ecuador	Yes	Not available	---	
El Salvador (2016)	Yes	Pharmacies with Rx	Full	
Grenada		Not available	---	
Guatemala		Pharmacies	No	
Guyana		Pharmacies	No	Yes
Haiti		Not available	---	
Honduras	Yes	Not available	---	
Jamaica (2016)	Yes	Pharmacies with Rx	Full	Yes
Mexico (2013)	Yes	Pharmacies	Partial	Yes
Nicaragua		Pharmacies	No	Yes
Panama		Not available	Full	Yes
Paraguay	Yes	Not available	---	Yes
Peru	Yes	Pharmacies with Rx	No	
Saint Kitts and Nevis		Pharmacies	No	
Saint Lucia		…	No	
Saint Vincent and the Grenadines		Not available	---	
Suriname		Pharmacies	No	Yes
Trinidad and Tobago		Pharmacies	Full	Yes
United States of America (2008)	Yes	General stores	Partial	
Uruguay		Pharmacies	Full	Yes
Venezuela (Bolivarian Republic of)		Pharmacies	Full	

Notes: Data available as of 31 December 2020.
[a]Only for countries that meet all the requirements according to the Technical Note (Chapter 6).
Rx, prescription.
… Data not reported or available.
--- Not applicable.
Bold, italic font indicates countries implementing measure O of the MPOWER technical package at the highest level of application.

Source: WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data collected by the PAHO Regional Tobacco Control Team.

hospitals, offices of health care professionals, at the level of the community, or in other settings.

Regarding the levels of care that are obliged to provide cessation services, five countries implement these services in most of their primary health care centers while 15 countries offer them in some primary health care settings. Regarding hospitals, five countries offer these services in most of their hospitals, while 15 countries are only able to offer them in some of their hospitals.

When it comes to the private offices of health care professionals, three countries reported that cessation services are offered in most of these establishments, while in 12 countries cessation support services are offered in some offices of health care professionals. Countries may also consider community infrastructure as a space where cessation services can be offered; however, just one country has been able to use most of their community infrastructure to offer cessation support services, while 11 countries are able to offer some of their community infrastructure to do so (Table 7).

Of note is the experience of Ecuador, which implemented brief interventions in its primary health care setting and was ultimately successful in transferring this service to communities with priorities in public health. In 2018, the Ecuador Ministry of Public Health, in collaboration with PAHO/WHO and the European Respiratory Society, trained approximately 120 health professionals to routinely identify individuals using tobacco and

TABLE 7

Availability of tobacco dependence treatment at different levels of care, along with coverage of costs, in the Region of the Americas, 2020

COUNTRY AND YEAR OF LEGISLATION[a]	PRIMARY CARE		HOSPITALS		OFFICES OF HEALTH CARE PROFESSIONALS		COMMUNITY		OTHER	
	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE
Antigua and Barbuda	No	---	No	---	No	No	No	---	No	---
Argentina	In some	Fully	In some	Fully	In some	Partially	In some	Partially	No	---
Bahamas	In some	Fully	In some	Fully	No	---	No	---	In some	Fully
Barbados	No	---	No	---	In some	No	In some	No	In some	Fully
Belize	In some	Partially	In some	No	No	---	No	---	In some	Partially
Bolivia (Plurinational State of)	No	---	No	---	No	---	No	---	No	---
Brazil (2002)	In some	Fully	In some	Fully	No	---	In some	No	No	---
Canada (2008)	In most	Partially	In most	Partially	In most	Fully	In some	No	In some	Partially
Chile	No	---	No	---	No	---	No	---	No	---
Colombia	In some	Fully	In some	Fully	In some	No	No	---	In some	No
Costa Rica	In some	Fully	In most	Fully	In some	Fully	In some	Fully	In some	Partially

TABLE 7 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	PRIMARY CARE		HOSPITALS		OFFICES OF HEALTH CARE PROFESSIONALS		COMMUNITY		OTHER	
	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE	AVAILABLE	COST COVERAGE
Cuba	In most	Fully	In most	Fully	In most	Fully	In most	Fully	In some	Fully
Dominica	No	---	No	---	No	---	No	---	No	---
Dominican Republic	No	---	No	---	In most	No	No	---	In some	No
Ecuador	In some	Fully	In some	Fully	No	---	No	---	No	---
El Salvador (2016)	No	---	No	---	No	---	No	---	No	---
Grenada	No	---	No	---	No	---	No	---	No	---
Guatemala	No	---	In some	Partially	In some	No	No	---	In some	No
Guyana	In some	Fully	In some	Fully	No	---	No	---	In some	Partially
Haiti	No	---	No	---	No	---	No	---	No	---
Honduras	In some	Fully	In some	Partially	In some	Partially	No	---	In some	Partially
Jamaica (2016)	In most	Fully	In most	Fully	In some	Partially	In some	No	In some	Partially
Mexico (2013)	In most	Fully	No	---	No	No	In some	Partially	In some	Fully
Nicaragua	No	---	No	---	No	---	No	---	No	---
Panama	In some	Partially	In some	Partially	In some	Partially	No	---	In some	Partially
Paraguay	In some	Partially	In some	Fully	In some	Fully	No	---	In some	Partially
Peru	No	---	In some	Fully	No	---	No	---	No	---
Saint Kitts and Nevis	No	---	No	---	No	---	No	---	No	---
Saint Lucia	In some	Fully	No	---	No	---	No	---	In some	Partially
Saint Vincent and the Grenadines	No	---	No	---	No	---	In some	…	No	---
Suriname	No	---	No	---	No	---	In some	No	No	No
Trinidad and Tobago	In some	Fully	In some	Partially	No	---	No	---	No	---
United States of America (2008)	In some	Partially	In some	Partially	In some	Partially	In some	Partially	No	---
Uruguay	In most	Fully	In most	Partially	In some	Fully	In some	No	In some	Partially
Venezuela (Bolivarian Republic of)	In some	Fully	In some	Fully	In some	Fully	No	---	In some	Fully

Notes: Data available as of 31 December 2020.
[a] Only for countries that meet all the requirements according to the Technical Note (Chapter 6).
Rx, prescription.
… Data not reported or available.
--- Not applicable.
Bold, italic font indicates the countries implementing measure O of the MPOWER technical package at the highest level of application.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data collected by the PAHO Regional Tobacco Control Team.

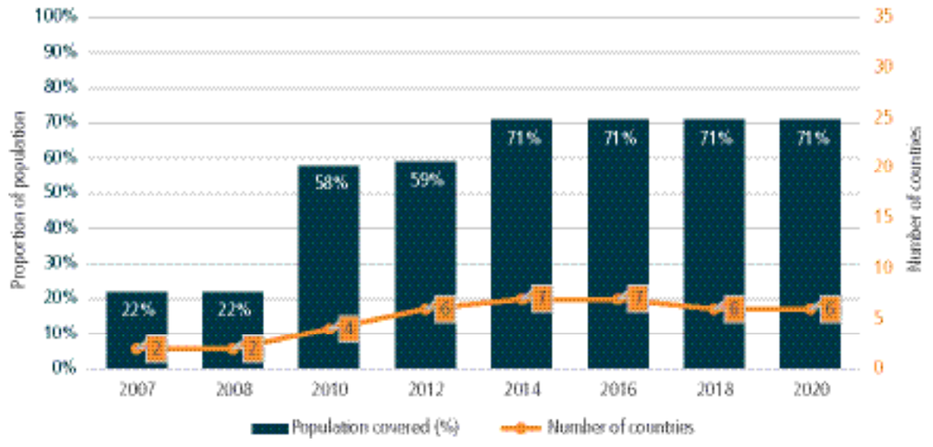
discuss with them the cessation services available through the "Doctors of the Neighborhood" program (in Spanish, "Medico del Barrio"). The immediate results of this initiative were promising, as between March and November 2018, 3,916 individuals with recorded tobacco consumption benefited from the program. Of these, 57.2% of the 2,069 patients who completed a 4-month cessation program reported abstinence in the 7 days prior to the survey being executed, while 48.9% of the 968 patients who completed the 6-month version of the program reported complete abstinence.

The progress in the implementation of this measure from 2008 to 2020 exhibited the same trend in population coverage growth as the other measures of the MPOWER technical package. However, in absolute numbers, it did not have the same scope, which may explain why there was a slower rate of progress. In 2008, just two countries had implemented cessation services at the highest level of application according to Article 14 of the WHO FCTC. This number had increased to four by 2010 and to seven in 2016, although by 2018 the number had dropped back to six and has remained at this number since. The population coverage has remained at 71% since 2016 (Figure 18).

The countries within the Region of the Americas must accelerate the adoption of measure O. Although the progress since 2008 has been remarkable, it is unfortunate to report that

FIGURE 18

Change in the number of countries that provide assistance to quit tobacco use at the highest level of achievement, and the proportion of the population covered, in the Region of the Americas, 2007–2020



Note: Data available as of 31 December 2020. The numbers on the line indicate the total number of countries that had the measure at the highest level of application as of 31 December of the corresponding year. Some numbers differ from previous reports due to adjustments in the data provided by the countries.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

there has been a decrease in the total number of countries implementing this measure at the highest level of application. There could be an opportunity to improve this, however, as the COVID-19 pandemic has led to demands that smoking cessation services be strengthened globally, both through face-to-face interactions and by virtual means (Box 2).

BOX 2

The COVID-19 pandemic has further highlighted the need to offer tobacco cessation services

In December 2019, the first case of COVID-19 (coronavirus disease 2019) was reported in Wuhan, China. This infectious disease, caused by the novel coronavirus SARS-CoV-2, caused a pandemic affecting every country in the world. The most common symptoms of COVID-19 include fever, dry cough, and general body fatigue, while other less frequent symptoms include nasal congestion, headaches, conjunctivitis, sore throat, diarrhea, loss of taste and smell, and skin rashes (*29*).

About 80% of individuals with COVID-19 can overcome the illness without requiring hospital care; however, the remaining 20% can present with more severe clinical manifestations, including breathing difficulties. The population most vulnerable to severe complications with this infection is older persons and those with underlying medical conditions (*29*).

The use of tobacco products contributes to the deterioration of lung function and capacity and is a known risk factor for the onset of noncommunicable diseases, which likely explains why severe symptoms and the risk of dying from COVID-19 are increased among smokers (*29–31*). The act of consuming tobacco in public places may also increase the risk of infection, as it may cause the user to neglect to use recommended precautionary safety measures, such as wearing a face mask or avoiding touching the mouth, eyes, and nose when one's hands are not clean.

For these reasons, WHO recommends quitting tobacco use and has moved to further motivate countries to strengthen cessation services based on scientific evidence and supported by communication facilities and technologies currently available. At the same time, WHO has emphasized the importance of developing systematic research studies to investigate the relationship between COVID-19 and tobacco use (*32, 33*).

The benefits of quitting tobacco use can be experienced within 20 minutes of the user making such an important decision in respect of their health, as blood pressure, heart rate, and the temperature of the limbs begin to stabilize. In the following 12 to 72 hours, the body starts to normalize the concentration of carbon monoxide and oxygen in the blood, thereby reducing the risk of suffering a stroke. The perceptions of taste and smell begin to regain normal functioning, while the relaxation of the bronchioles improves respiration. Between the first and ninth week after quitting, cough and dyspnea greatly improve, while between the second and tenth week of abandoning tobacco use, pulmonary and circulatory functions improve by almost 30% (*34*).

2.5. Warn about the dangers of tobacco

> "Each Party shall, within a period of three years after entry into force of this Convention for that Party, adopt and implement, in accordance with its national law, effective measures to ensure that: a) tobacco product packaging and labeling do not promote a tobacco product by any means that are false ...; and b) each unit packet and package of tobacco products and any outside packaging and labeling of such products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages ..."
> Article 11 WHO FCTC

This measure, the "W" in the MPOWER acronym, has also seen major successes since 2016, as there are now 22 countries that apply health warnings at the highest level of achievement (Figure 19).

These 22 countries have graphic health warnings that occupy 50% or more of the main display areas of tobacco packaging and fulfill all the recommendations established in Article 11 and the guidelines for its implementation. The most recent provision (laws or regulations) relating to this measure was implemented in the United States of America, when the Food and Drug Administration (FDA) issued a new rule in March 2020 mandating that 11 new warnings about various health conditions must occupy the top 50% of the front and rear of tobacco packages and at least 20% of the top of cigarette advertisements. The warnings include a wide variety of text as well as graphic images. In 2017, Honduras was successful in achieving the highest level of application of this measure, when new regulations were issued that required images to appear on the packaging of tobacco products. Suriname reverted to fulfilling the obligation of warning about the dangers of tobacco when the decision was made in 2018 to implement health warnings in Dutch, the country's national language. In 2018, Antigua and Barbuda also joined the list of countries achieving the highest level of application of measure W.

This measure showed the highest percentage of population coverage as of 2020, with almost 90% of the population in the Region now exposed to large, graphic health warnings on tobacco packages, in compliance with Article 11 of the WHO FCTC (Figure 20).

The selected years correspond to the cutoff date for measure W (warn about the dangers of tobacco) of the MPOWER package, according to the WHO reports on the global tobacco epidemic

FIGURE 19

Status of policies on health warnings in the Region of the Americas, 2021

Note: Available data as of 31 December 2021. For more information, see Chapter 6: Technical Note.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data from the PAHO Regional Tobacco Control Team.

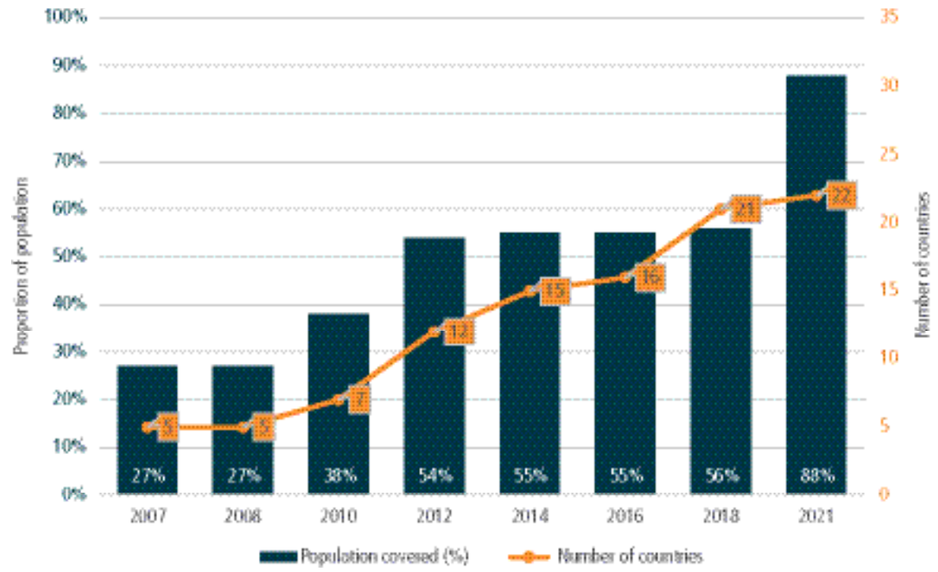
based on data up to 2008, 2010, 2012, 2014, 2016, and 2018. The cutoff date for measure W was 31 December 2021.

The WHO FCTC requires each Party to adopt measure W within three years of the entry into force of the treaty in a country. To date, 10 Parties (Bahamas, Belize, Colombia, Dominica, Grenada, Guatemala, Nicaragua, Paraguay, Saint Kitts and Nevis, and Saint Vincent and the Grenadines) have yet to meet the minimum requirements of the Convention, although the deadline for doing so has now passed for all of them.

The guidelines for the implementation of Article 11 provide a more detailed description of the packaging display characteristics that are required to ensure that the health warnings are more effective. Evidence has proved that the effectiveness of warnings and messages increase with their size; therefore, the guidelines recommend that the warnings and health

FIGURE 20

Change in the number of countries and proportion of the population covered by laws requiring health warnings at the highest level of achievement in the Region of the Americas, 2007–2021



Note: Data available as of 31 December 2021. The numbers on the line indicate the total number of countries that had the measure at the highest level of application as of 31 December of the year indicated.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data from the PAHO Regional Tobacco Control Team.

messages occupy more than 50% of the main display areas and should aim to "cover as much of the main display areas as possible." Further to this, the guidelines also address other characteristics of design, including a rotating schedule of health warnings and message contents.

The implementation of this measure has numerous benefits. Applying warning labels to packaging is relatively inexpensive for governments. This provides a two-fold benefit by increasing the sensitization of the public to the harms associated with tobacco use, as graphic health warnings on tobacco product packages reliably reach tobacco users each time they use the products (35–37), with the cost mainly borne by the tobacco industry. Warnings should refer to specific health effects related to tobacco use, and they are more effective when they are pictorial, graphic, comprehensive, and strongly worded (38, 39). It is important that the warning is large, covering at least half of a tobacco package's surface, and rotates on a regular basis (40, 41).

Uruguay has the largest warnings in the Region, covering 80% of both the front and back of

tobacco packages. There are other countries that have health warnings occupying more than 50% of the principal display areas, such as Canada (75%) and Barbados, Ecuador, Guyana, and Jamaica (60%). Brazil, Mexico, and Venezuela (Bolivarian Republic of) have warnings that occupy 100% of one of the principal surfaces and 30% of the surface of the opposite side.

The guidelines for the implementation of Articles 11 and 13 of the WHO FCTC, which define plain packaging, state that Parties are encouraged to consider adopting measures to "restrict or prohibit the use of logos, colors, brand images, or promotional information on packaging other than brand names [...]." Following this, in 2019, Uruguay became the first country in the Region of the Americas to adopt and implement plain packaging legislation, with Canada following suit in the same year.

Plain packaging is instrumental in increasing the effectiveness of health warnings, which help to correct the market's imperfect information on the magnitude of the health risks posed by tobacco use (Article 11), and it prevents the packaging from being used to promote the product or mislead consumers about its characteristics (Article 13). Other countries that have implemented plain packaging legislation include Australia in 2012 and Saudi Arabia and Thailand, both in 2018.

Table 8 shows the specific requirements established in each country in the Region of the Americas for health warnings on tobacco packaging.

TABLE 8

Characteristics of the health warnings on cigarette packaging in the Region of the Americas, 2021

COUNTRY AND YEAR OF LEGISLATION[a]	PERCENTAGE OF MAIN SURFACES COVERED (AVERAGE FRONT/ BACK)[b]	NUMBER OF WARNINGS SPECIFIED IN THE LAW[b]	DOES IT APPEAR ON THE ENTIRE PACKAGE FOR RETAIL SALES?[b]	DOES IT DESCRIBE THE HARMFUL EFFECTS OF TOBACCO ON HEALTH?[b]	FONT SIZE AND COLOR SPECIFIED BY LAW?[b]	ARE THE MESSAGES ROTATING?[b]	WRITTEN IN THE LANGUAGE OF THE COUNTRY[b]	DOES IT INCLUDE IMAGES?[b]	ARE DECEPTIVE TERMS PROHIBITED?
Antigua and Barbuda (2018)	50-50/50[c]	[c]	[c]	[c]	[c]	[c]	[c]	[c]	[c]
Argentina (2012)	50-50/50	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bahamas	[d]	[d]	Yes						
Barbados (2017)	60-60/60	16	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belize	[d]	1			Yes		Yes		
Bolivia (Plurinational State of) (2009)	60-60/60	8	Yes	Yes	Yes	Yes	Yes	Yes	Yes

TABLE 8 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	PERCENTAGE OF MAIN SURFACES COVERED (AVERAGE FRONT/ BACK)[b]	NUMBER OF WARNINGS SPECIFIED IN THE LAW[b]	DOES IT APPEAR ON THE ENTIRE PACKAGE FOR RETAIL SALES?[b]	DOES IT DESCRIBE THE HARMFUL EFFECTS OF TOBACCO ON HEALTH?[b]	FONT SIZE AND COLOR SPECIFIED BY LAW?[b]	ARE THE MESSAGES ROTATING?[b]	WRITTEN IN THE LANGUAGE OF THE COUNTRY[b]	DOES IT INCLUDE IMAGES?[b]	ARE DECEPTIVE TERMS PROHIBITED?
Brazil (2003)	65-30/100	9	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Canada (2011)	75-75/75	16	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chile (2006)	50-50/50	4	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Colombia	30-30/30	6	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Costa Rica (2013)	50-50/50	12	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cuba	30[e]	5	Yes	Yes	Yes	Yes	Yes		Yes
Dominica	–	–	–	–	–	–	–	–	–
Dominican Republic	[d]	1	Yes		Yes		Yes		
Ecuador (2013)	60-60/60	6	Yes	Yes	Yes	Yes	Yes	Yes	Yes
El Salvador (2011)	50-50/50	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Grenada	–	–	–	–	–	–	–	–	–
Guatemala	13-25/0	6	Yes	Yes	Yes	Yes	Yes		
Guyana (2018)	60-60/60	8	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Haiti	–	–	–	–	–	–	–	–	–
Honduras (2017)	50-50/50	8	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Jamaica (2013)	60-60/60	16	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mexico (2009)	65-30/100	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nicaragua	50-50/50 [g]	6[g]	Yes		Yes	Yes [g]	Yes	[g]	Yes
Panama (2005)	50-50/50	5	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Paraguay	40-40/40	4	Yes	Yes		Yes	Yes	Yes	Yes
Peru (2011)	50-50/50	12	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–
Saint Lucia (2017)	50-50/50	16	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Saint Vincent and the Grenadines	–	–	–	–	–	–	–	–	–

TABLE 8 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	PERCENTAGE OF MAIN SURFACES COVERED (AVERAGE FRONT/ BACK)[b]	NUMBER OF WARNINGS SPECIFIED IN THE LAW[b]	DOES IT APPEAR ON THE ENTIRE PACKAGE FOR RETAIL SALES?[b]	DOES IT DESCRIBE THE HARMFUL EFFECTS OF TOBACCO ON HEALTH?[b]	FONT SIZE AND COLOR SPECIFIED BY LAW?[b]	ARE THE MESSAGES ROTATING?[b]	WRITTEN IN THE LANGUAGE OF THE COUNTRY[b]	DOES IT INCLUDE IMAGES?[b]	ARE DECEPTIVE TERMS PROHIBITED?
Suriname (2016)	50-50/50	6	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Trinidad and Tobago (2013)	50-50/50	24	Yes	Yes	Yes	Yes	Yes	Yes	Yes
United States of America (2020)	50-50/50[c,f]	11[c, f]	Yes[c, f]	Yes [c, f]	Yes [c, f]	Yes [c, f]	Yes [c, f]	Yes [c, f]	Yes [c, f]
Uruguay (2005)[h]	80-80/80	4	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Venezuela (Bolivarian Republic of) (2004)	65-30/100	12	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Notes: Data available as of 31 December 2020 Empty cell indicates that legislation does not cover the specified criteria listed. Bold, italic font indicates the countries implementing measure W of the MPOWER technical package at the highest level of application.
[a]Only countries with major health warnings and all the characteristics, according to the Technical Note (Chapter 6).
[b]Characteristics used for classification of the regulations, in accordance with the Technical Note.
[c]Regulation pending.
[d]Not specified in law.
[e]By law, the warnings must occupy 30% of each main surface or 60% of one of them.
[f]Regulation adopted but not implemented as of 31 December 2020.
[g]Regulation was adopted in 2010, but it has not been regulated or implemented as of 31 December 2020.
[h]Only a single presentation per brand is allowed, and plain packaging is now required by law.
– The law does not establish health warnings.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as from data collected by the PAHO Regional Tobacco Control Team.

2.6. Enforce bans on tobacco advertising, promotion, and sponsorship

Enforcing bans on tobacco advertising, promotion, and sponsorship is another measure in which the Region has made very little progress. Just nine countries (Antigua and Barbuda, Brazil, Colombia, Guyana, Panama, Mexico, Suriname, Uruguay, and Venezuela [Bolivarian Republic of]) have legislation implementing this measure at the highest level of application (Figure 22). From 2017 to date, there have been just two additions with regard to compliance with this measure: Antigua in 2018 and Venezuela (Bolivarian Republic of) in 2019. Most recently, in December 2021, Mexico enacted legislation in compliance with Article 13 of the WHO FCTC. With respect to the population coverage for this measure, between 2018 and 2021 the population covered by policies banning tobacco advertising, promotion, and sponsorship in the Region of the Americas almost doubled (Figure 20).

> "Each Party shall, in accordance with its constitution or constitutional principles, prohibit all forms of tobacco advertising, promotion, and sponsorship that promote a tobacco product by any means that are false, misleading, or deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions […] within the period of five years after entry into force of this Convention for that Party."
> Article 13.2 WHO FCTC

As with the other measures, the WHO FCTC established a 5-year deadline for the implementation of this measure. Of the 21 Parties in the Region that have still not complied with this mandate, the 5-year deadline since the entry into force of the Convention has elapsed for all of them. Nine countries have implemented partial bans on tobacco advertising, promotion, and sponsorship, while 17 countries have made very few or no advances in this regard. See Table 9 and 10 for information on the current status of regulations banning tobacco advertising, promotion, and sponsorship in the Region of the Americas.

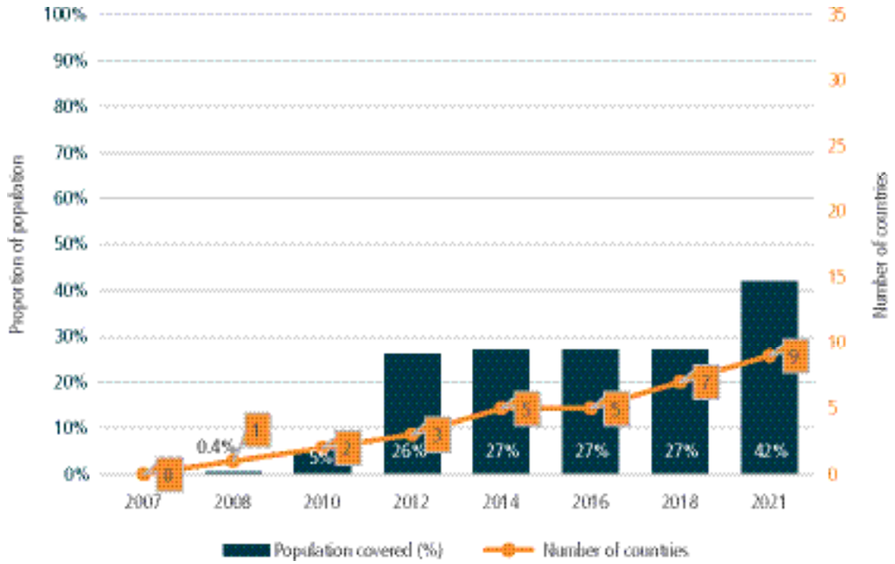
Evidence and information from the tobacco industry's own internal documents show that the recruitment of new smokers through advertising, promotion, and sponsorship is crucial for the survival of the industry (42). This is the industry's strategy, which is employed to target their main customers; i.e., young people, who are more susceptible to starting the habit, and women, who use tobacco less frequently and therefore constitute an attractive niche market.

The advertising, promotion, and sponsorship of tobacco products tend to link certain lifestyle characteristics, such as happiness, entertainment, beauty, physical attractiveness, and sporting events, with tobacco use. This in turn augments the appeal of the product to the target audiences. Additionally, the widespread presence of tobacco on various media platforms makes an enormous contribution to "normalizing" tobacco use because it is depicted as simply another consumer product and its adverse effects are obscured.

The tobacco industry attempts to avoid regulation by adopting weak, voluntary advertising codes, discrediting the evidence base for restrictions, and using both lobbyists and litigation to avoid bans, as well as promulgating the belief that these various so-called corporate social responsibilities only serve to improve the lives of those who are especially vulnerable. During the COVID-19 pandemic, this scenario has been particularly common in some places, where the industry sought to use the vulnerability caused by the pandemic as a strategy to permeate regulatory frameworks through offering medical equipment, supplies, and even academic scholarships to governments and to young people from poor

FIGURE 21

Change in the number of countries and proportion of the population covered by regulations completely banning tobacco advertising, promotion, and sponsorship at the highest level of achievement in the Region of the Americas, 2007–2021



Notes: Available data up to 31 December 2021. The numbers on the line indicate the total number of countries that implemented the measure at its highest level of achievement by 31 December of the year indicated. The selected years correspond to the cutoff date for measure E (enforce bans on tobacco advertising, promotion, and sponsorship) of the MPOWER package, according to the WHO reports on the global tobacco epidemic based on data up to 2008, 2010, 2012, 2014, 2016, and 2018.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data collected by the PAHO Regional Tobacco Control Team.

socioeconomic backgrounds. The guidelines for the implementation of Article 13 reaffirm the notion that only a total ban on tobacco advertising, promotion, and sponsorship is effective. Contemporary forms of marketing integrate advertising and promotion through the sale of products. This includes direct marketing and public relations activities, as well as personal or interactive online marketing. If only certain forms of direct advertising are prohibited, this creates an opportunity for the tobacco industry to redirect its spending to boost other forms of advertising and communication strategies; it will also resort to more creative and indirect modalities to promote tobacco consumption, especially among young people (42).

It is for such reasons that the guidelines elaborate on atypical elements that are not usually recognized as forms of tobacco advertising,

FIGURE 22

Status of policies banning tobacco advertising, promotion, and sponsorship in the Region of the Americas, 2021

Note: Available data as of 31 December 2021. For more information, see Chapter 6: Technical Note.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as from data collected by the PAHO Regional Tobacco Control Team.

promotion, and sponsorship. These can include brand stretching as well as brand sharing, tobacco product or brand placement on entertainment media platforms, corporate social responsibility of the tobacco industry, and, of course, the packaging of tobacco products. The guidelines also recommend that legislation should use clear, uncomplicated language and unambiguous definitions and should avoid providing lists of prohibited activities that are, or could be understood to be, exhaustive.

The concept of "brand stretching" refers to when the brand name, emblem, trade name, logo, commercial decoration, or any other distinctive feature, including its color combinations, of a tobacco product is linked to a non-tobacco product or service to convey an association

between the tobacco product and the non-tobacco related product and/or service. "Brand sharing" is the opposite, where the name of a brand, emblem, commercial trademark, logo, commercial insignia, or any other distinctive feature, including the color combinations, of a non-tobacco product or service is linked to a tobacco product or company to establish an association between the two.

The quest continues for tobacco companies to create an image of good corporate citizenship by engaging in activities whereby their business policies are perceived to be "socially responsible." The industry capitalized on the recent COVID-19 pandemic by partnering with governments to procure health equipment and even facilitate research into vaccines. The guidelines recommend the total prohibition of all forms of such contributions by the tobacco industry as they constitute a form of sponsorship.

Displaying tobacco products at points of sale also constitutes a form of advertising and promotion. In places where many advertising and promotion activities are prohibited, the product continues to be displayed, and this is estimated to increase sales by between 10% and 28% as a result, often due to impulse purchases (43–48). The guidelines recommend that Parties completely ban all point-of-sale display and visibility of tobacco products, including in fixed retail outlets and by street vendors. Eight countries in the Region—Colombia, Costa Rica, Guyana, Panama, Suriname, Trinidad and Tobago, Uruguay, and Venezuela (Bolivarian Republic of)—have banned point-of-sale displays (Table 9).

TABLE 9

Regulations banning tobacco advertising, promotion, and sponsorship in various media in the Region of the Americas, 2021

COUNTRY AND YEAR OF LEGISLATION[a]	DIRECT ADVERTISING					PRODUCT DISPLAY AT POINTS OF SALE
	NATIONAL TELEVISION AND RADIO[b]	LOCAL MAGAZINES AND NEWSPAPERS[b]	BILLBOARDS AND OPEN-AIR ADVERTISEMENTS[b]	INTERNET[b]	POINTS OF SALE[b]	
Antigua and Barbuda (2018)	Yes	Yes	Yes	Yes	Yes	
Argentina	Yes	Yes	Yes	Yes		
Bahamas	Yes					
Barbados						
Belize						
Bolivia (Plurinational State of)	Yes	Yes	Yes	Yes		
Brazil (2011)	Yes	Yes	Yes	Yes	Yes	
Canada	Yes	Yes	Yes	Yes		
Chile	Yes	Yes	Yes	Yes	Yes	
Colombia (2009)	Yes	Yes	Yes	Yes	Yes	Yes
Costa Rica	Yes	Yes	Yes	Yes	Yes	Yes
Cuba						

TABLE 9 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	DIRECT ADVERTISING					PRODUCT DISPLAY AT POINTS OF SALE
	NATIONAL TELEVISION AND RADIO[b]	LOCAL MAGAZINES AND NEWSPAPERS[b]	BILLBOARDS AND OPEN-AIR ADVERTISEMENTS[b]	INTERNET[b]	POINTS OF SALE[b]	
Dominica						
Dominican Republic						
Ecuador	Yes	Yes	Yes	Yes	[c]	
El Salvador	Yes	Yes	Yes	Yes		
Grenada						
Guatemala						
Guyana (2017)	Yes	Yes	Yes	Yes	Yes	Yes
Haiti						
Honduras	Yes	Yes	Yes			
Jamaica	Yes					
Mexico (2021)	Yes	Yes	Yes	Yes	Yes	Yes
Nicaragua	Yes		Yes			
Panama (2008)	Yes	Yes	Yes	Yes	Yes	Yes
Paraguay	Yes	Yes	Yes	Yes		
Peru	Yes			Yes		
Saint Kitts and Nevis						
Saint Lucia						
Saint Vincent and the Grenadines						
Suriname (2013)	Yes	Yes	Yes	Yes	Yes	Yes
Trinidad and Tobago	Yes		Yes			Yes
United States of America	Yes					
Uruguay (2005)	Yes	Yes	Yes	Yes	Yes	Yes
Venezuela (Bolivarian Republic of) (2019)	Yes	Yes	Yes	Yes	Yes	Yes

Notes: Available information as of 31 December 2021.
[a]Only for countries with a complete ban on tobacco advertising, promotion, and sponsorship.
[b]Features used for the classification, according to the Technical Note.
[c]Advertising at points of sale is only allowed inside, cannot be seen on the outside, and it cannot be larger than 1 m^2.
Bold, italic font indicates the countries implementing measure E of the MPOWER technical package at the highest level of application.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), and from data collected by the PAHO Regional Tobacco Control Team.

TABLE 10

Regulations banning tobacco advertising, promotion, and sponsorship through different forms of indirect advertising in the Region of the Americas, 2021

COUNTRY AND YEAR OF LEGISLATION[a]	DISTRIBUTION FREE BY MAIL OR OTHER MEANS[b]	PROMOTIONAL DISCOUNTS[b]	BRAND STRETCHING[b]	BRAND SHARING[b]	TOBACCO BRAND PLACEMENT ON TELEVISION OR IN FILMS[b]	TOBACCO PRODUCT PLACEMENT ON TELEVISION OR IN FILMS[b]	BAN ON PUBLICIZING FINANCIAL OR OTHER SPONSORSHIP, OR SUPPORT FROM TOBACCO INDUSTRY FOR EVENTS, ACTIVITIES, OR INDIVIDUALS[b]
Antigua and Barbuda (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Argentina	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bahamas							
Barbados							
Belize							
Bolivia (Plurinational State of)	Yes	Yes	Yes	Yes	Yes		Yes
Brazil (2003)	Yes	Yes	Yes	Yes	Yes		Yes[c]
Canada	Yes	Yes			Yes		Yes
Chile	Yes	Yes	Yes		Yes		
Colombia (2009)	Yes	Yes	Yes	Yes[d]	Yes	Yes	Yes
Costa Rica			Yes	Yes	Yes	Yes	Yes
Cuba							
Dominica							
Dominican Republic							
Ecuador	Yes	Yes	Yes		Yes	Yes	Yes
El Salvador			Yes	Yes	Yes	Yes	Yes
Grenada							
Guatemala	Yes	Yes					
Guyana (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Haiti							
Honduras							
Jamaica							

TABLE 10 *(continued)*

COUNTRY AND YEAR OF LEGISLATION[a]	DISTRIBUTION FREE BY MAIL OR OTHER MEANS[b]	PROMOTIONAL DISCOUNTS[b]	BRAND STRETCHING[b]	BRAND SHARING[b]	TOBACCO BRAND PLACEMENT ON TELEVISION OR IN FILMS[b]	TOBACCO PRODUCT PLACEMENT ON TELEVISION OR IN FILMS[b]	BAN ON PUBLICIZING FINANCIAL OR OTHER SPONSORSHIP, OR SUPPORT FROM TOBACCO INDUSTRY FOR EVENTS, ACTIVITIES, OR INDIVIDUALS[b]
Mexico (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nicaragua							
Panama (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Paraguay	Yes		Yes	Yes			Yes
Peru							
Saint Kitts and Nevis							
Saint Lucia							
Saint Vincent and the Grenadines							
Suriname (2016)	Yes	Yes	Yes	Yes	Yes		Yes
Trinidad and Tobago					Yes		Yes
United States of America							
Uruguay (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Venezuela (Bolivarian Republic of) (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Notes: Available information as of 31 December 2021.
[a]Only for regulations completely banning tobacco advertising, promotion, and sponsorship.
[b]Features used for classification according to the Technical Note (Chapter 6).
[c]The law prohibits the sponsorship of cultural and sports activities. However, the law does not prohibit the sponsorship of other types of events, activities, or individuals.
[d]Although the law does not explicitly prohibit the use of non-tobacco product brand names (brand sharing), nor does it define tobacco product advertising and promotion, we understand that brand sharing falls within the current ban on all forms of advertising and promotion because this country is a Party to the FCTC, and it is understood that the FCTC definition applies.
Bold, italic font indicates the countries implementing measure E of the MPOWER technical package at the highest level of application.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as from data collected by the PAHO Regional Tobacco Control Team.

2.7. Raise taxes on tobacco

> "... implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption ..."
> Article 6 WHO FCTC

Tobacco taxes are considered to be the single most cost-effective intervention in reducing tobacco use (17, 49), while at the same time there are no high costs attached to their implementation and generating increased government revenues. However, this measure continues to see the least progress since 2008, both regionally and globally. The most recent edition of the WHO Report on the Global Tobacco Epidemic, in 2021 (8), reported that, at the global level, just two new countries had joined the list implementing this measure at the highest level of application since the previous report in 2019. Neither of these was a low-income country. Since the publication of the first edition of the WHO Report on the Global Tobacco Epidemic 13 years ago, just 17 countries have been added to the list of countries with tax rates at 75% or more of the price of tobacco products.

In the Region of the Americas, between 2008 and 2012 only two countries had implemented this measure at the highest level of application. The picture continued to fluctuate, but a considerable jump was noted between 2016 and 2018, when four countries were implementing measures to ensure that the threshold of total indirect taxes represented 75% or more of the retail price of tobacco products (Figure 23). However, since 2018, the price for the best-selling brand of cigarettes has increased substantially, while in one of the four countries specific excise taxes only increased slightly, resulting in the total tax share falling below the 75% threshold in this country and decreasing the total to three countries for 2020 (Figure 24).

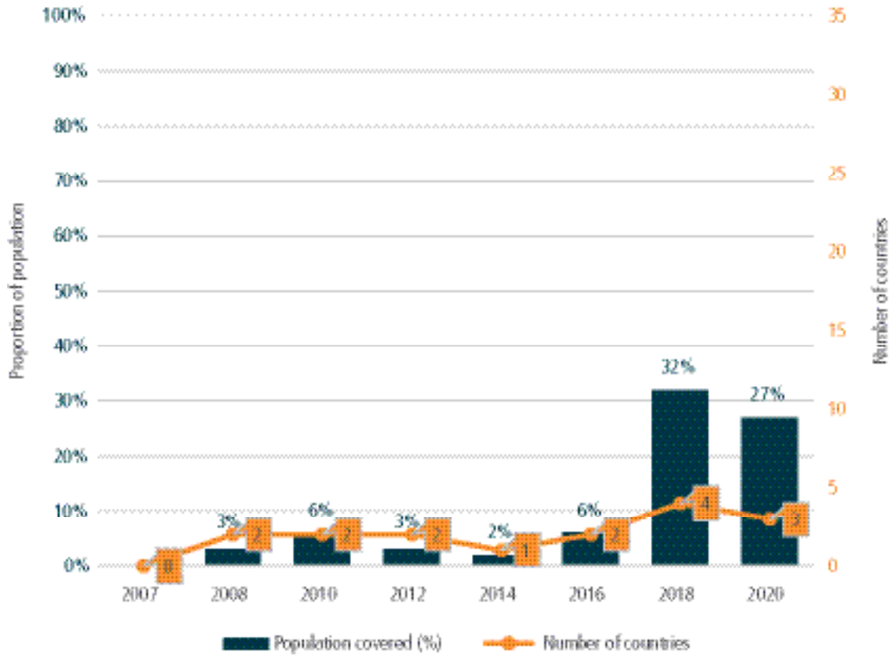
WHO carries out biannual tracking of tobacco taxes using a standardized tax-share indicator, defined as the total percentage that indirect taxes represent of the retail price of the most-sold brand of cigarettes. The highest level of achievement, considered to be best practice, corresponds to the situation where total indirect taxes represent 75% or more of the price of tobacco products. However, other indicators can complement the WHO indicator, to capture multiple dimensions of policies aimed at making tobacco products less affordable. As such, WHO also monitors affordability and price indicators, as well as information on the structure and administration of tobacco taxes. Additionally, Tobacconomics recently published a Cigarette Tax Scorecard, which uses a five-point scale across four scoring components and can provide policymakers with a comprehensive and actionable assessment of their tobacco tax policy (50).

The guidelines for the implementation of Article 6 contain six key principles:

1. Determining tobacco taxation policies is a sovereign right of the Parties.

FIGURE 23

Change in the number of countries and proportion of the population covered by tobacco taxes at the highest level of implementation in the Region of the Americas, 2007–2020



Notes: The numbers on the line indicate the total number of countries that had the measure at the highest level of application as of 31 July of the corresponding year.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as from data collected by the PAHO Regional Tobacco Control Team.

2. Effective tobacco taxes (that lead to higher real consumer prices) significantly reduce tobacco consumption and prevalence.

3. Effective tobacco taxes are an important source of revenue.

4. Tobacco taxes are economically efficient and reduce health inequalities.

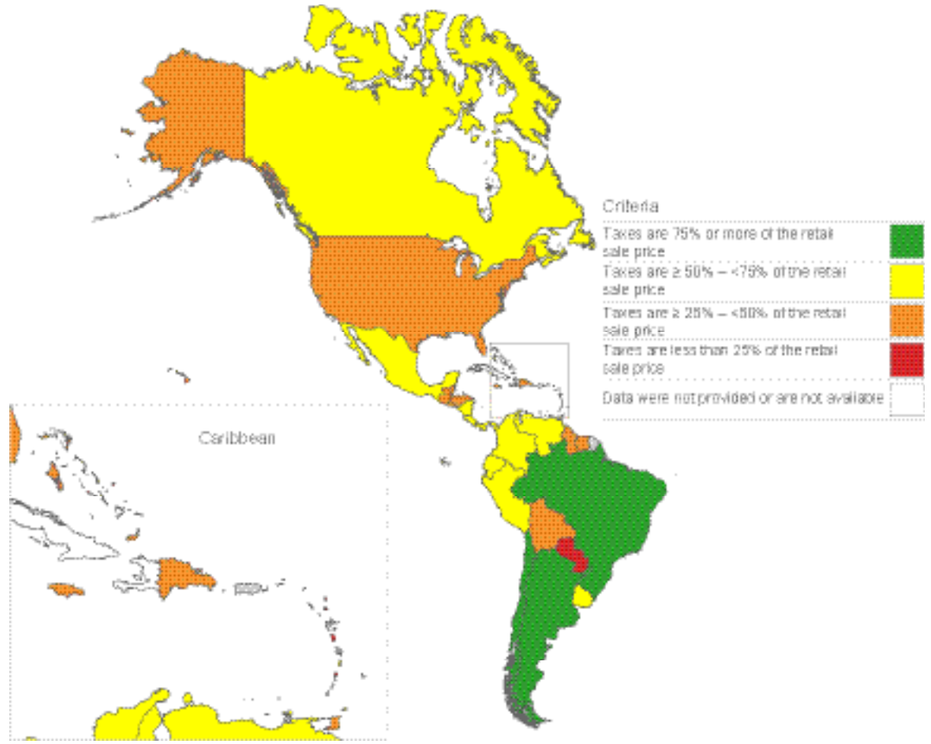
5. Tobacco tax systems and administration should be effective and efficient.

6. Tobacco tax policies should be protected from the vested interests of the tobacco industry.

The guidelines also offer recommendations on the design and administration of tobacco taxes.

FIGURE 24

Status of tobacco taxes in the Region of the Americas, 2020



Note: Available data as of 31 July 2020. For more information, see Chapter 6: Technical Note.

Source: Based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

Regarding the design, the following considerations should be taken into account:

1. When establishing or increasing their national levels of taxation, Parties should take into account, among other things, both price elasticity and income elasticity of demand, as well as inflation and changes in household incomes, to make tobacco products less affordable over time in order to reduce consumption and prevalence. Therefore, Parties should consider having regular adjustment processes or procedures for the periodic reevaluation of tobacco tax levels.

2. Parties should implement the simplest and most efficient systems that meet their public health and fiscal needs, while taking into account their national circumstances. Parties should consider implementing specific or mixed excise systems with a minimum specific tax floor, as these systems have considerable advantages over purely ad valorem systems.

3. Tax rates should be monitored, increased, or adjusted on a regular basis, ideally annually, taking into account inflation and income growth developments in order to reduce consumption of tobacco products.

4. All tobacco products should be taxed in a comparable way, as appropriate, especially where the risk of substitution exists, to ensure that tax systems are designed in a way that minimizes the incentive for users to shift to cheaper products in the same product category or to purchase cheaper tobacco products.

The guidelines provide additional recommendations regarding tax administration, the use of tax revenue to finance tobacco control, and tax-free sales:

1. Ensure that transparent license or equivalent approval or control systems are in place.

2. Adopt and implement measures and storage and production warehouses to facilitate excise controls over tobacco products.

3. Domestic excise taxes should be imposed at the point of manufacture, importation, or release for consumption from storage or production warehouses, to reduce the complexity of tax collection.

4. Tax payments should be required by law to be remitted at fixed intervals and should include a report on production and/or sales volumes and price by brand, taxes due and paid. The report can also include the volume of raw material inputs.

5. Tax authorities should allow for the public disclosure of the information contained within the reports, through available media, including online media, taking into account rules of confidentiality in accordance with the national laws.

6. Implementation of anti-forecasting measures, which include but are not limited to restricting the release of excessive volumes of tobacco products immediately prior to a tax increase and levying new tax on products already produced or kept in stock but not yet supplied to the final consumer, including retail products (floor-stock or inventory tax).

7. To require the application of fiscal markings to increase compliance with tax laws.

8. The designation and granting of appropriate powers to tax enforcement should be clear and precise and should provide for information sharing among enforcement agencies as well as establishing a range of penalties to deter non-compliance with tax laws.

9. To consider dedicating revenue from tobacco taxes to tobacco control programs.

10. Prohibiting or restricting sale to and/or importation by international travelers of tax free or duty-free products.

These recommendations emphasize the existing need for control and oversight measures to prevent illicit trade, such as those contained within the Protocol to Eliminate Illicit Trade in Tobacco Products (50). This further debunks the arguments put forward by the tobacco industry regarding higher taxes being a precursor to smuggling and other types of tax evasion. Simultaneously, to increase awareness of the tactics used by the industry, WHO has coined the acronym SCARE (S, Smuggle; C, Court challenges; A, Anti-poor rhetoric; R, Revenue reductions; and E, Employment reductions/impact). Tobacco industry opposition and interference has been a frequent and major

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challenge faced by countries in the process of policy formulation and implementation to increase tobacco taxes. Table 11 shows a comparative analysis of the changes in the affordability of cigarettes during the period from 2008 to 2020.

The implementation of the MPOWER package is one useful indicator for the overall assessment of tobacco control. Tobacco taxation works best if it is implemented as part of a comprehensive MPOWER package. The tax share in the retail price of a selected tobacco product is one indicator of the effectiveness of tax policy, but a more important indicator is affordability, that is, whether tax increases lead to price increases that are above income and general price increases. The experience with tobacco taxes makes a strong case for the benefits of developing standardized indicators measuring taxation levels, affordability, and prices alongside complementary tax structure and tax administration information (50–51). Table 12 illustrates the changes in the taxes and prices for the most sold brands of cigarettes in the Region of the Americas from 2008 to 2020.

It is important to applaud the countries within the Region that have established the use of tax revenues specifically for health programs. This move further consolidates the fact that increasing tobacco taxes is indeed the most cost-effective mechanism to control tobacco use.

TABLE 11

Changes in the affordability of the most sold brand of cigarettes, by country, 2010–2020

COUNTRY	PERCENTAGE OF PER CAPITA GDP NEEDED TO PURCHASE 2,000 CIGARETTES OF THE MOST SOLD BRAND[a]						HAVE CIGARETTES BECOME LESS AFFORDABLE SINCE 2010?	DID CIGARETTES BECOME LESS AFFORDABLE BETWEEN 2018 AND 2020?
	2010	2012	2014	2016	2018	2020		
Antigua and Barbuda	1.77	1.74	2.12	1.90	1.76	3.69	No change[c]	Yes
Argentina	1.32	1.27	1.35	2.12	1.84	2.37	Yes	Yes
Bahamas	0.92	1.64	2.27	2.76	…	3.33	Yes	…
Barbados	3.39	3.45	4.18	4.43	4.12	…	…	…
Belize	5.85	5.59	5.40	5.32	4.25	7.36	No change[c]	Yes
Bolivia (Plurinational State of)	4.32	4.38	4.71	5.18	4.70	5.27	Yes	Yes
Brazil	1.63	1.75	2.01	2.04	1.51	1.57	No change[c]	Yes
Canada[e]	1.77	1.61	1.64	1.83	1.96	2.27	Yes	Yes
Chile	1.82	2.20	2.04	2.33	2.65	3.01	Yes	Yes
Colombia	1.57	1.59	1.55	1.54	2.02	2.60	Yes	Yes
Costa Rica	1.86	2.60	2.82	2.68	2.73	3.26	Yes	Yes
Cuba	…	10.77	9.81	8.68	14.17	…	…	…
Dominica	1.86	2.29	2.13	1.96	2.26	2.40	No change[c]	Yes
Dominican Republic	5.74	5.27	5.07	4.33	4.85	7.08	No change[c]	Yes
Ecuador	3.67	4.59	4.88	8.60	8.55	10.72	Yes	Yes
El Salvador	5.87	5.69	5.57	5.25	7.10	8.30	Yes	Yes
Grenada	3.77	…	3.24	3.22	3.05	…	…	…
Guatemala	5.95	5.47	6.41	6.28	6.28	6.25	No change[c]	No[b]
Guyana	3.84	2.74	2.69	2.92	2.99	2.10	No[d]	No[b]
Haiti	…	…	…	18.92	…	…	…	…
Honduras	7.50	7.97	7.78	8.23	8.38	9.13	Yes	Yes
Jamaica	13.54	13.60	14.12	15.34	16.47	16.46	Yes	No[b]
Mexico	2.56	2.97	3.10	2.90	2.68	3.75	No change[c]	Yes
Nicaragua	8.69	6.85	7.84	8.32	7.05	19.46	No change[c]	Yes
Panama	4.04	3.49	3.33	2.96	2.87	2.84	No[d]	No
Paraguay	0.63	0.66	0.56	0.67	0.61	0.67	No change[c]	Yes
Peru	3.15	3.08	3.33	5.04	6.95	5.96	Yes	No[b]
Saint Kitts and Nevis	1.63	1.89	1.74	1.67	1.64	…	…	…

TABLE 11 *(continued)*

COUNTRY	PERCENTAGE OF PER CAPITA GDP NEEDED TO PURCHASE 2,000 CIGARETTES OF THE MOST SOLD BRAND[a]						HAVE CIGARETTES BECOME LESS AFFORDABLE SINCE 2010?	DID CIGARETTES BECOME LESS AFFORDABLE BETWEEN 2018 AND 2020?
	2010	2012	2014	2016	2018	2020		
Saint Lucia	2.68	3.41	2.64	2.88	2.87	3.39	No change[c]	Yes
Saint Vincent and the Grenadines	3.21	3.22	3.36	3.16	5.04	4.21	Yes	No[b]
Suriname	2.66	2.80	2.91	5.02	5.71	6.91	Yes	Yes
Trinidad and Tobago	1.48	1.58	1.77	2.41	2.59	2.74	Yes	Yes
United States of America[f]	1.18	1.18	1.13	1.11	1.09	1.16	No change[c]	Yes
Uruguay	2.94	2.47	2.02	2.41	2.68	2.77	No change[c]	Yes
Venezuela (Bolivarian Republic of)	4.49	5.39	8.96	15.31	82.02	…	…	…

Notes: Available data as of 31 July 2020.
[a]Calculated using the price (in local currency) of a pack of 20 cigarettes of the most brand from different editions of this report, and estimates of per capita GDP from the database of the World Economic Outlook of the IMF, October 2020 (http://www.imf.org/en/Publications/WEO/weo-database/2020/October) with additional adjustments.
[b]Cigarettes became less affordable between 2016 and 2018 but then became more affordable between 2018 and 2020.
[c]There has been no change in affordability since 2010. No change is when the growth rate of the least-squares is not statistically significant at the level of 5.
[d]The most sold brand of cigarettes has become more affordable since 2010.
[e]WHO has used subnational rates and national excise tax rates to reflect an average taxation rate for Canada. Consequently, the reported taxation rates are different from the rates stated here. The price shown is a sales-weighted average of the price of the most sold brand in Canada.
[f]Taxation data for the United States contains weighted average of Federal (or national) and non-Federal (or non-national) sources and therefore cannot be approved by the Federal (or national) authorities.
... Data not available.

Source: Prepared based on the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

TABLE 12

Taxes and prices for a pack of 20 cigarettes of the most sold brands in the Region of the Americas, 2008–2020

COUNTRY	2008			2020		
	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)
Antigua and Barbuda	3.77	0.00	14.77	6.88	0.00	13.14
Argentina	2.36	62.60	69.20	4.83	54.54	76.62
Bahamas	2.66	31.23	31.23	11.26	30.00	43.21

TABLE 12 *(continued)*

COUNTRY	2008			2020		
	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)
Barbados	5.52	34.18	47.77	…	…	…
Belize	4.27	48.00	57.17	4.20	23.64	34.75
Bolivia[d] (Plurinational State of)	2.18	29.50	41.00	4.39	24.15	35.65
Brazil	1.98	25.79	57.15	2.29	38.57	81.55
Canada[d,e]	6.31	58.79	64.55	10.78	52.81	61.71
Chile[d]	3.49	60.40	76.37	7.06	64.07	80.04
Colombia[d]	1.68	23.80	34.31	3.67	57.17	73.13
Costa Rica[d]	2.54	44.22	41.57	6.30	43.03	53.62
Cuba	…	75.00	75.00	…	…	…
Dominica	1.99	12.57	25.61	2.90	9.68	22.72
Dominican Republic[d]	5.83	43.24	57.03	13.30	29.02	44.27
Ecuador	3.55	53.57	64.29	11.38	56.14	66.85
El Salvador	2.90	29.97	41.47	6.97	35.05	46.55
Grenada	3.26	0.00	40.50	…	…	…
Guatemala	3.09	41.07	51.79	5.17	38.27	48.98
Guyana	2.38	14.25	28.04	3.65	13.16	27.54
Haiti	…	…	…	…	…	…
Honduras[d]	2.12	32.20	45.25	5.06	17.89	42.64
Jamaica	9.26	29.63	43.88	16.82	27.89	42.58
Mexico[d]	4.03	48.13	61.17	7.04	53.77	67.57
Nicaragua[d]	2.81	6.74	19.79	10.59	56.33	69.37
Panama	4.02	21.33	36.59	8.53	43.48	56.52
Paraguay[d]	0.49	6.42	15.52	0.84	9.22	18.31
Peru[d]	2.86	25.21	41.18	6.86	52.46	67.71
Saint Kitts and Nevis	2.85	6.52	18.20	…	…	…
Saint Lucia	3.79	28.25	30.08	4.65	39.33	51.29
Saint Vincent and the Grenadines[d]	3.11	3.11	16.15	5.17	6.88	23.11
Suriname	3.42	48.40	57.49	10.10	21.88	26.53

TABLE 12 *(continued)*

COUNTRY	2008			2020		
	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)	PRICE OF A 20-PACK OF CIGARETTES OF THE MOST SOLD BRAND (INTERNATIONAL DOLLARS PPP)[a]	EXCISE TAXES ON THE MOST SOLD BRAND[b] (AS PERCENTAGE OF SALES PRICE)	TOTAL SHARE OF TAX IN THE MOST SOLD BRAND[c] (PERCENTAGE OF SALES PRICE)
Trinidad and Tobago	3.24	23.64	36.69	7.12	14.60	25.71
United States of America[f]	4.58	31.55	36.57	7.33	34.79	39.97
Uruguay[d]	3.49	47.79	65.82	5.91	47.88	65.92
Venezuela (Bolivarian Republic of)	6.07	68.16	70.79	…	66.79	73.37

Notes: Available data as of 31 July 2020.
[a]PPP: international dollars with purchasing power parity.
[b]Includes specific and ad valorem excise taxes.
[c]Includes excise taxes, applicable customs rates, value-added tax (VAT), and other consumption taxes.
[d]The country has raised tobacco excise taxes since 2018; however, due to price variability, the effect is not necessarily apparent in the tax indicators.
[e]WHO has used subnational rates and national excise tax rates to reflect an average taxation rate for Canada. Consequently, the reported taxation rates are different from the rates stated here. The price shown is a sales-weighted average of the price of the most sold brand in Canada.
[f]Taxation data for the United States contains weighted average of Federal (or national) and non-Federal (or non-national) sources and therefore cannot be approved by the Federal (or national) authorities.
... Data were not reported or were not available.

Source: Prepared based on the WHO Report on the Global Tobacco Epidemic, 2019 and 2021 (8, 23).

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CHAPTER 3

Strategy and plan of action to strengthen tobacco control in the Region of the Americas 2018–2022

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first international treaty to be negotiated under the auspices of WHO in an effort to provide a global response to the tobacco epidemic. The WHO FCTC entered into force on 27 February 2005 and includes all the measures that have proved effective in reducing the epidemic of tobacco use. However, several years after its enactment and even though 30 Member States of the Region of the Americas are Parties to the FCTC, the measures have not been uniformly implemented across the Region (15, 52).

Since 2008, WHO, through the WHO Report on the Global Tobacco Epidemic, has tracked the progress made by countries in tobacco control as it relates to the six key provisions of the MPOWER technical package (the status of application is presented in Chapter 2 of this report). Four of these measures correspond to four "best buys" in relation to tobacco control as per the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 (9), which means that they are considered as cost-effective best buys to reduce the preventable and avoidable burden of morbidity, mortality, and disability due to NCDs.

A summary of progress in tobacco control within the Region of the Americas is as follows:

- Brazil is the only Member State and FCTC Party to have implemented all six of the six MPOWER measures and the four NCD best buys related to tobacco control as per the Global Action Plan for NCDs.
- Six FCTC Parties (Canada, Chile, Costa Rica, Mexico, Panama, and Uruguay) have all implemented four MPOWER measures.
- Eight FCTC Parties (Antigua and Barbuda, Chile, Guyana, Mexico, Panama, Suriname, Uruguay, and Venezuela [Bolivarian Republic of]) and one

non-State Party (Argentina) have implemented three NCD best buys related to tobacco control as per the Global Action Plan for NCDs.

- Nine countries, seven FCTC Parties (Antigua and Barbuda, Ecuador, Guyana, Jamaica, Peru, Suriname, and Venezuela [Bolivarian Republic of]), and two non-States Parties (Argentina and the United States of America) have implemented three MPOWER measures.

In a bid to prioritize these key provisions of the FCTC and accelerate its implementation to achieve the targets established for reductions in tobacco use and premature deaths from NCDs, in 2017 all Member States in the Region approved the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022.

"The Strategy and Plan of Action is aligned with the commitments of the States Parties to the FCTC and with the Declaration of Port-of-Spain of the Caribbean Community (CARICOM) (2007), the Political Declaration of the High-level Meeting of the United Nations General Assembly (2011), the PAHO Strategic Plan 2014–2019, the Global Plan of Action for the Prevention and Control of NCDs 2013–2020 and the Regional Plan of Action 2013–2019, and the United Nations 2030 Agenda for Sustainable Development." The strategy also contributes to the global targets for tobacco control and NCDs (53, 54).

Notably, the Strategy and Plan of Action 2018–2022 establishes the strategic line of action 4: "Strengthening of Member States' capacity in terms of public health policies to counter attempts at interference by the tobacco industry and those who work to further its interests" (Table 13). Reinforcing the implementation of national plans, programs, and multisectoral coordinating mechanisms for tobacco control contributes to accelerating the adoption of other measures that are also promoted in the Strategy and Plan of Action 2018–2022 and are related to smoke-free environments; tobacco product packaging and labeling; tobacco advertising, promotion, and sponsorship; and reducing the affordability of tobacco products.

TABLE 13

Strategic lines of action 2018–2022

STRATEGIC LINES OF ACTION	DESCRIPTION
Strategic line of action 1	Implementation of measures for the creation of completely smoke-free environments and the adoption of effective measures on the packaging and labeling of tobacco products (Articles 8 and 11)[a]
Strategic line of action 2	Implementation of a ban on the advertising, promotion, and sponsorship of tobacco products and the adoption of measures to reduce their availability (Articles 6 and 13)[a]
Strategic line of action 3	Ratification of the FCTC and the protocol to eliminate illicit trade in tobacco products by Member States that have not yet done so
Strategic line of action 4	Strengthening Member States' capacity in terms of public health policies to counter attempts at interference by the tobacco industry and those who work to further its interests (Article 5.3)

Note: [a]Measures considered as "best buys" by WHO and the MPOWER technical package.

Source: Elaborated from the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022: Midterm review (53).

3.1. Status of the implementation of strategic lines of action

3.1.1. Strategic line of action 1: implementation of measures for the creation of completely smoke-free environments and the adoption of effective measures on the packaging and labeling of tobacco products

Regarding strategic line of action 1, 6 new countries have joined the baseline of 18, bringing the total to 24 countries that have passed legislation creating smoke-free environments in all enclosed public areas and workplaces and on public transportation. Also, 6 new countries have joined the baseline of 16, bringing the total to 22 countries that have approved regulations establishing the mandatory inclusion of large, visually striking health warnings on all tobacco packaging. As it concerns plain packaging and/or single presentation by brand, the total number of countries has moved from one at baseline to two (Table 14).

TABLE 14

Objectives of strategic line of action 1 and corresponding status

OBJECTIVE 1.1: ENACT SMOKE-FREE ENVIRONMENT LEGISLATION THROUGHOUT THE REGION OF THE AMERICAS	
INDICATOR, BASELINE, AND TARGET	STATUS
1.1. Number of countries with national regulations creating 100% smoke-free environments in all enclosed public and workspaces and public transportation. Baseline (2016): 18 Target (2022): 35	Six countries have joined the 18 baseline countries, bringing the total to 24.
OBJECTIVE 1.2: INCLUDE HEALTH WARNINGS ON THE PACKAGING OF TOBACCO PRODUCTS	
INDICATOR, BASELINE, AND TARGET	**STATUS**
1.2.1. Number of countries with graphic health warnings on tobacco packaging that meet the criteria of the WHO Report on the Global Tobacco Epidemic. Baseline (2016): 16 Target (2022): 35	Six countries have joined the 16 baseline countries, bringing the total to 22.
1.2.2. Number of countries adopting a policy of plain and/or single presentation by brand. Baseline (2016): 1 (single presentation) Target (2022): 6	Two countries have since joined the baseline by implementing plain packaging; however, this only brings the total to two. This is because the country at the baseline had implemented a single presentation at that time.

Source: Elaborated from the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022: Midterm review (53), as well as data from the PAHO Regional Tobacco Control Team.

3.1.2. Strategic line of action 2: implementation of a ban on the advertising, promotion, and sponsorship of tobacco products and the adoption of measures to reduce their affordability

Regarding strategic line of action 2, four new countries passed regulations that completely ban all forms of tobacco advertising, promotion, and sponsorship. In two of these countries, this ban also prohibits the display of tobacco products at points of sale. Three countries adopted measures that increased the tax burden on tobacco products and two countries reached a tax burden greater than 75% of the retail price. The two measures included in this strategic line of action have been the ones most opposed by the tobacco industry since the WHO FCTC came into effect in 2005 (Table 15).

TABLE 15

Objectives of strategic line of action 2 and corresponding status

OBJECTIVE 2.1: IMPOSE A TOTAL BAN ON THE ADVERTISING, PROMOTION, AND SPONSORSHIP OF TOBACCO PRODUCTS	
INDICATOR, BASELINE, AND TARGET	STATUS
2.1.1. Number of countries with a total ban on the advertising, promotion, and sponsorship of tobacco products. Baseline (2016): 5 Target (2022): 20	Four countries have joined the baseline countries, bringing the total to nine.
2.1.2. Number of countries whose ban on the advertising, promotion, and sponsorship of tobacco products includes a ban on the display of these products at the point of sale. Baseline (2016): 4 Target (2022): 19	Four countries have joined the baseline countries, bringing the total to eight.
OBJECTIVE 2.2: REDUCE THE AFFORDABILITY OF TOBACCO PRODUCTS BY INCREASING EXCISE TAXES ON TOBACCO	
INDICATOR, BASELINE, AND TARGET	STATUS
2.2.1. Number of countries in which total taxes represent 75% or more of the final retail price, or in which the increase has been substantial enough to promote a change in the category of classification. Baseline (2016): 2 Target (2022): 10	One country has joined the baseline and implemented fiscal policies to ensure that total taxes on tobacco products represent 75% or more of the final retail price, and two countries recorded substantial increases to promote change in the category of classification, bringing the total to five.
2.2.2. Number of countries that have increased excise taxes on tobacco products in a way that promotes an increase in the affordability index presented in the WHO Report on the Global Tobacco Epidemic, 2015.[a] Baseline (2016): 0 Target (2022): 20	12 countries.

Note: [a]Percentage of per capita GDP needed to purchase 100 packages of the country's most popular brand of cigarettes.

Source: Elaborated from the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022: Midterm review (53), as well as data from the PAHO Regional Tobacco Control Team.

3.1.3. Strategic line of action 3: ratification of the FCTC and the protocol to eliminate illicit trade in tobacco products by Member States that have not yet done so

Regarding strategic line of action 3, no progress has been made on ratifying the WHO FCTC. However, the protocol on the elimination of illicit trade in tobacco products was ratified by two more countries (Table 16).

3.1.4. Strategic line of action 4: strengthening Member States' capacity in terms of public health policies to counter attempts at interference by the tobacco industry and those who work to further its interests

Regarding strategic line of action 4, the Pan American Sanitary Bureau has been supporting actions to implement measures to protect the design and implementation of tobacco control policies from commercial and other vested interests of the tobacco industry and those who work to further its interests.

Several countries have been making efforts to implement conflict of interest management mechanisms for government officials. In the absence of standardized information to report on progress, as there is no global indicator on this issue, the Pan American Sanitary Bureau has developed an instrument to collect comparable data on this subject from PAHO Member States. These data will be featured in the final report of the strategy in 2023 (Table 17).

As per the resolution approving the Strategy and Plan of Action 2018–2022 at the 29th Pan American Sanitary Conference in September 2017, Member States requested that the PAHO Secretariat promote partnerships with other

TABLE 16

Objectives of strategic line of action 3 and corresponding status

OBJECTIVE 3.1: ACHIEVE RATIFICATION OF THE FCTC	
INDICATOR, BASELINE, AND TARGET	STATUS
3.1.1. Number of countries that are States Parties to the FCTC. Baseline (2016): 30 Target (2022): 33	No additional countries have joined the baseline countries. The total remains at 30.
OBJECTIVE 3.2: ACHIEVE RATIFICATION OF THE PROTOCOL TO ELIMINATE ILLICIT TRADE IN TOBACCO PRODUCTS	
INDICATOR, BASELINE, AND TARGET	STATUS
3.2.1. Number of States Parties to the FCTC that are also States Parties to the protocol to eliminate illicit trade in tobacco products. Baseline (2016): 4 Target (2022): 20	Two countries have joined the baseline countries, bringing the total to six.

Source: Elaborated from the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022: Midterm review (51), as well as data from the PAHO/WHO Regional Tobacco Control Team.

TABLE 17

Objectives of strategic line of action 4 and corresponding status

OBJECTIVE 4.1: ESTABLISH EFFECTIVE MECHANISMS TO PREVENT INTERFERENCE BY THE TOBACCO INDUSTRY OR THOSE WHO WORK TO FURTHER ITS INTERESTS	
INDICATOR, BASELINE, AND TARGET	STATUS
4.1.1. Number of countries that have mechanisms in place for the identification and management of conflict of interest for government officials and employees with responsibility for tobacco control policies. Baseline (2016): Unavailable Target (2020): 20	Number of countries: unavailable[a]

Note: [a]The indicator has been developed and appropriate data have been collected, which will be reported in 2023 in the final report of the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022.

Source: Elaborated from the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022: Midterm review (53), as well as data from the PAHO Regional Tobacco Control Team.

international organizations and subregional entities as well as members of civil society at the national and international levels, to assist in the implementation of the strategy (54). In response, the Secretariat of PAHO has, in an unprecedented way, mobilized resources for tobacco control as well as renewed partnerships.

In 2020, for the first time, the Bloomberg Initiative to Reduce Tobacco Use (55), through WHO, earmarked funds specifically to accelerate the implementation of the MPOWER package in the Region of the Americas. This manifested through a project executed during the period 2021 to 2022, considering the mandates of the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022. This significant influx of funds has allowed the PAHO Secretariat to scale up its technical assistance, tailored to specific countries' needs, and address specific opposing arguments made against national legislative initiatives.

Also, since 2016, PAHO has been collaborating with the Convention Secretariat to implement the FCTC 2030 project in the Region of the Americas, in partnership with the United Nations Development Programme (UNDP) and experts from civil society and academic institutions. The project is currently in its third phase. Several countries of the Region of the Americas submitted applications in response to the project's global call, and five Member States were selected by the Secretariat of the WHO FCTC: Colombia and El Salvador started implementing the project in 2017 (Phase 1), Costa Rica and Suriname in 2019 (Phase 2), and Panama in 2021 (Phase 3). The project focuses on the:

1. Implementation of tobacco control governance, in accordance with WHO FCTC Article 5 as aligned with the strategic line of action 4 in the strategy.

2. Strengthening tobacco taxation, in accordance with WHO FCTC Article 6 (strategic line of action 2 in the strategy).

3. Implementation of time-bound measures, in accordance with WHO FCTC Articles 8, 11, and 13 (strategic lines of action 1 and 2).

4. Implementing other articles of the Convention according to national priorities.

5. Promoting treaty implementation as part of the 2030 Agenda for Sustainable Development.

BOX 3

South America free of tobacco smoke

In the Region of the Americas, the countries of South America constitute the first subregion to have become completely free from tobacco smoke, with the recent adoption of 100% smoke-free environments in 2020: in Bolivia (Plurinational State of) in February and Paraguay in December. Notably, both countries have included within the scope of this ban the use of electronic nicotine delivery systems, such as electronic cigarettes and heated tobacco products, in enclosed public spaces and workplaces.

Smoke, exhaled by a smoker and/or from lit tobacco products, contains thousands of chemicals; many of these are known to be carcinogens. WHO has warned that the only way to guarantee the protection of the population from exposure to tobacco smoke is by establishing an absolute ban on smoking in enclosed public spaces and workplaces. Article 8 of the WHO Framework Convention on Tobacco Control (WHO FCTC) warns that there is no safe level in relation to the exposure to this risk, which can cause diseases, disabilities, and even death.

Smoke-free environments not only protect non-smokers but are also instrumental in promoting cessation among smokers and in encouraging the denormalization of tobacco use among children and young people. The experience of countries that have implemented this measure at the highest level of application affirms that it does not harm the commercial activities of those sites that have thus far adopted its implementation.

Additionally, smokers of tobacco products (such as cigarettes, water pipes, bidis, cigars, and heated tobacco products) are known to be more vulnerable to COVID-19 infection, due to the physical and physiological practices involved in smoking, as well as its harmful effects on health, such as reduced lung capacity. In this context, the need is therefore emphasized for all countries in the Region of the Americas to adopt and implement 100% smoke-free environments at the highest level.

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CHAPTER 4

Challenges in tobacco control

This chapter provides details regarding the many challenges that impede the progress of tobacco control at both the regional and global levels. The first section includes information concerning novel and emerging nicotine and tobacco products, as they are a major contributor to the hurdles in the area of tobacco control. A visual representation outlining the status of regulation of these products is also included. The second section of the chapter describes some of the continuing challenges disrupting the much-needed progress in tobacco control.

4.1. Novel and emerging nicotine and tobacco products

4.1.1. General overview

Amid the considerable efforts that have been made globally and regionally to address the tobacco epidemic, tobacco control continues to remain a priority and a challenge as novel and emerging nicotine and tobacco products become more available and accessible, with misleading marketing that negates existing evidence of the health risks associated with the use of these products and promotes an environment with lax or no regulation.

Tobacco products

Article 1 of the WHO FCTC defines tobacco products as "products entirely or partly made of leaf tobacco as the raw material, which is manufactured to be used for smoking, sucking, chewing, or snuffing."

Novel and emerging nicotine and tobacco products

The leading novel and emerging nicotine and tobacco products can be classified into three main categories:

1. electronic nicotine delivery systems (ENDS);
2. electronic non-nicotine delivery systems (ENNDS);
3. heated tobacco products (HTPs).

Electronic nicotine delivery systems (ENDS) are devices that heat a liquid to create an aerosol that is inhaled by the user. The liquid contains nicotine (but not tobacco) and other chemicals that are toxic to human health (56).

Electronic non-nicotine delivery systems (ENNDS) are similar to ENDS except

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that they do not contain nicotine. The mode of use is similar to ENDS but the heated solution that is delivered as an aerosol through the device usually does not contain nicotine. In practice, however, many e-liquids marketed as containing "zero nicotine" have been found to contain nicotine when tested. Depending on the device used, the user can choose e-liquids that either do or do not contain nicotine, or the user can add nicotine to an e-liquid that was formulated as nicotine-free, making it almost impossible to distinguish between ENDS and ENNDS (56).

ENDs and ENNDS are collectively referred to as electronic cigarettes (e-cigarettes) (56). These almost indistinguishable products can be classified as being either open systems or closed systems. Open systems are devices for which users can make their own mixes of the e-liquids they buy, which could be with no nicotine, various concentrations of nicotine, and/or flavors. Closed systems come with a prefilled container (called a cartridge, pod, or tank) with no possibility for the user to make his or her own mixes.

Heated tobacco products (HTPs). HTPs are tobacco products that produce aerosols by heating tobacco or by activating a device that contains tobacco; these aerosols contain nicotine and other toxic chemicals (57, 58).

4.1.2. Status of evidence on novel and emerging nicotine and tobacco products

The tobacco industry markets novel and emerging nicotine and tobacco products as "reduced risk" or "reduced harm" products. This is based on the notion that smokers of conventional cigarettes, who are unwilling or unable to quit nicotine, should have a less harmful alternative. In fact, for some years now, novel products that are claimed to reduce exposure and risks have been continuously introduced, including products such as smokeless tobacco (59).

There are, however, no tobacco or nicotine products the consumption of which is safe for the population. Therefore, terms such as reduced harm or reduced risk tend to confuse people and provide a false sense of security in circumstances where there is no scientific evidence to demonstrate that the consumption of so-called reduced-harm products is safe for health. Most of the available data are from reports published by the tobacco industry, which "tend to be biased towards favorable conclusions on the benefits of the switch to e-cigarettes and HTPs" (60, 61). There is still insufficient data to conclude whether these novel and emerging products are less harmful than conventional products, and certainly there are not enough data at this time on the effects of emissions from these products on second-hand smokers, given the fact that they contain both harmful and potentially harmful chemicals.

The tobacco industry proposes that the presence of so-called less harmful alternatives contained within these newer products can ultimately assist in lowering the prevalence of tobacco use and improve the health of the population globally. The evidence surrounding this claim, however, remains inconclusive. For the purpose of clarity, cessation is the term used when a person has completely desisted from using any form of tobacco and/or nicotine product (62). Switching to the use of other forms of tobacco and nicotine cannot therefore be considered cessation. There is also the question of what the duration of use of these newer products must be before one can be classified as having "successfully" quit the use of tobacco and/or nicotine. It must be highlighted that this group of newer products usually plays a complementary role to the use of conventional products, which thus indicates a case of "dual-use or consumption," exposing users to higher concentrations of nicotine and thereby establishing a route to sustain dependency (8).

One school of thought entertains the notion that these newer products can be considered to be nicotine replacement therapies (NRTs). However, when employing genuine NRTs in cessation treatments, these products have been designed so that exposure to nicotine concentrations is exponentially lowered over a determined period of time, allowing the user to become less dependent on nicotine until they can function without it. Conversely, novel and emerging nicotine and tobacco products are subjected to less scrutiny by national authorities and therefore do not benefit from the same degree of quality assurance as approved NRTs.

The main objective of the marketing strategies for these products, however, is ultimately to attract new users while being able to satiate current tobacco users who wish to quit. There is also a greater effort on the part of the industry to propagate misinformation to the public about the risks associated with the use of these products, taking advantage of the absence of available evidence to corroborate the extent of harms associated with them (63, 64).

WHO notes that "e-cigarettes are especially dangerous for children and adolescents. Nicotine is a highly addictive product, and the brains of young people continue to develop into their mid-twenties. ENDS increase the risk of heart disease and other illnesses. Their use also carries

considerable risks for pregnant women as they impair the growth of their fetuses" (65). In fact, most ENDS users do not quit smoking combustible cigarettes but rather use both ENDS and combustible cigarettes, which, at the very least, maintains the substantial health risks associated with cigarette smoking and may increase them (8). Additionally, as their name suggests, HTPs are tobacco products and therefore fall within the same category as conventional cigarettes; their usage will result in similar adversities to those associated with the use of conventional tobacco products. Therefore, promoting these new nicotine and tobacco products as harm reduction measures is just another way in which the tobacco industry attempts to mislead people about the inherently dangerous nature of its products (8).

4.1.3. Regulation of novel and emerging products: decisions of the FCTC Conference of the Parties and global and regional status

Considerable progress in tobacco control has been made over the years, resulting in more than 5.3 billion people being protected from the harm of tobacco by at least one MPOWER measure (8). With advances in design and the use of technology, however, it is not always easy to distinguish conventional and novel products from each other when comparing them. Prior experience has also demonstrated differences in the composition of e-liquids compared with the information posted on packaging labels and advertisements. As a result of this, legislation and regulatory mechanisms are failing to keep pace with the continuous changes in design and functionality (8).

Marketing strategies aimed at the younger population can result in these younger people eventually becoming hooked on more lethal forms of nicotine and tobacco, as well as illegal substances. Also, due to the absence of smoke emitted when using these categories of products, many people find favor in this characteristic as it enables smoke-free restrictions to become porous. Some of these products allow for the mimicking of the hand-to-mouth movement associated with the smoking of conventional products, which could increase the acceptance of smoking behavior within society, at the same time serving as a trigger to former smokers who may be inclined to resume their habit (66–68).

4.1.4. Decisions of the Conference of the FCTC Parties

As per its mandate in the control of the global tobacco epidemic, over the years the Conference of the Parties (COP) to the WHO FCTC has taken several distinctive approaches toward establishing clearer pathways to address the surge in these new nicotine and tobacco products. Discussions date back to the third session, in 2009 (COP3), as these products have created another stratum of interference by the tobacco industry and its related allies and are viewed as a major barrier to progress in the implementation of the FCTC. All the COP's decisions are further reinforced through Article 5.2 of the WHO FCTC, which obliges Parties to implement effective measures aimed at preventing and reducing tobacco consumption, nicotine addiction, and exposure to tobacco smoke. Later in this chapter, the objectives and options for regulating these products based on the COP decisions above will be elaborated.

With regard to ENDS/ENNDS, the COP6 Decision FCTC/COP6(9) invited Parties "to consider prohibiting or regulating ENDS/ENNDS, including as tobacco products, medicinal products, consumer products, or other categories, as appropriate, considering a high level of protection for human health." Consumer products are those that are bought for use by the average consumer, while therapeutic products are those that comprise nicotine-containing e-liquid and cannot be sold without a pharmaceutical license. In such instances, this form of regulation acts as a de facto ban, as no brands have received the necessary registration for commercialization or sale as medicinal products (58).

Later, the COP7 Decision FCTC/COP7(9) (69) invited Parties "to consider applying regulatory measures (such as those referred to in document FCTC/COP/7/11) to prohibit or restrict the manufacture, import, distribution, presentation, sale, and use of ENDS, as appropriate to their national laws and public health objectives."

Regarding HTPs, at COP8, the Parties to the WHO FCTC recognized that "heated tobacco products are tobacco products and are therefore subject to the provisions of the WHO FCTC." Decision FCTC/COP8(22) also reminded the Parties about their commitments under the WHO FCTC when addressing the challenges posed by novel and emerging tobacco products and to consider prioritizing, among other measures, the protection of tobacco control policies and activities from all commercial and other vested interests related to novel and emerging products, including the interests of the tobacco industry.

4.1.5. Status of regulation of novel and emerging nicotine and tobacco products

Novel and emerging nicotine and tobacco products have evolved over time partly because of loopholes within the existing regulatory environment, both globally and regionally. Factors such as demographic contexts and markets have contributed to the widening of these loopholes, which is threatening to overturn the numerous strides that have been made in tobacco control (8). These factors are exacerbated by attempts by the tobacco industry and its partners to mask differences between the three novel and emerging product categories and create confusion over their associated risks, while deflecting from the regulatory framework that already exists (66–68).

Countries have, however, taken steps over the years to circumvent these gaps and address the surge in these new products. Countries that have thus far championed tobacco control have opted to enact bans that aim at prohibiting the manufacture, importation, exportation, and/or commercialization of these products as per the mandates of the decisions of the COP. Others have opted to subject these products to established classifications, as tobacco or tobacco-related products, and have therefore applied the measures outlined in the MPOWER technical package. However, there are still many countries that have yet to enact some form of measure to address these novel and emerging products.

Commercialization bans, limiting the possibilities for the possession of novel and emerging products by minors, as well as restrictions on advertising, promotion, and sponsorship, are possible options to consider preventing initiation of tobacco use, especially among youths. In cases where sales or commercialization bans are enforced, the other requirements that apply to conventional tobacco products, such as packaging and labeling, taxation, and content regulations, do not apply, as the products are not legally sold within the jurisdiction (69, 70). Governments and other regulating entities are encouraged to test heated and inhaled flavorings to determine their safety and to subject the novel products to the regulations outlined in Article 8 to protect both users and non-users from any potential health

TABLE 18

Applying MPOWER to novel and emerging nicotine and tobacco products

DEMAND REDUCTION MEASURES	
M	Governments are recommended to use their existing tobacco surveillance and monitoring systems to assess developments in ENDS and nicotine use by sex and age.
P	Non-users of ENDS should be protected from exposure to ENDS emissions. Indoor smoke-free places should never exempt ENDS (or ENNDS or HTPs) from a ban.
O	Evidence on the use of ENDS as a potential tobacco use cessation aid is still under debate, and there is insufficient evidence to support their use at the population level, as compared with proven approaches. Countries should also use evidence-based approaches to support ENDS users who wish to quit.
W	Strong, graphic health warnings should be mandated for all ENDS products, in line with overall tobacco control strategies, to deter their use by young people.
E	Given that the same promotional elements that make ENDS attractive to adult smokers could make them attractive to children and non-smokers, effective banning of ENDS advertising, promotion, and sponsorship should be enforced.
R	ENDS themselves carry health risks. Therefore, taxes should be applied to these products, in line with national standards, to prevent their uptake, particularly among children and adolescents.

Notes: ENDS, electronic nicotine delivery system; ENNDS, electronic non-nicotine delivery system; HTP, heated tobacco product.

Source: Adapted from the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

risks. Table 18 describes how the six MPOWER measures can be applied to the newer class of products.

Overview of the regulations in place for electronic nicotine and non-nicotine delivery systems at the global and regional levels

Global status

Globally, 32 countries currently ban the manufacture, importation, and/or sale of ENDS/ENNDS (8). In addition to the countries that ban sales, three countries have adopted a ban on all flavors, excluding tobacco flavor, and six countries have banned selected flavors. Age restrictions on the sales of these products are implemented in 69 countries (Table 19). While some countries have imposed restrictions on the manufacturing, importing, and/or sale of these products, they have also banned their use in public places.

However, it remains a matter of concern that 84 countries have no legislation that addresses ENDS/ENNDS in any of the aforementioned domains (8).

Regional status

Global and regional markets are increasing with regard to demand for novel and emerging nicotine and tobacco products. However, the demand within the Region of the Americas, although increasing, is considerably smaller compared with other regions of the world. This can be viewed as a positive for the Region and should cause the Member States to consider the long-term effects if this demand were to increase and result in a new epidemic of tobacco and nicotine usage. This is therefore a worthy reason for regulators to heed the mandates of the WHO FCTC COP, which reaffirm the advice to either ban or regulate these new products (71).

TABLE 19

Number of countries implementing the MPOWER technical package measures for electronic nicotine and non-nicotine delivery systems (ENDS/ENNDS) at the global level, 2020

Bans on manufacture, importation, exportation, and/or sales	• 32 countries currently ban the manufacture, importation, and/or sale of ENDS and ENNDS.
REGULATIONS IMPLEMENTED	
P	• 30 countries have fully implemented the measures. • 45 countries have partially implemented the measures (8).
W	• 8 countries fully apply health warnings on these products (in 2 countries, the warnings apply to devices only.) • In 45 countries, criteria are only partially met for health warnings (in 9 countries the partial criteria are applied to e-liquids only and in 2 countries to devices only (8).
E	• 22 countries have imposed full bans on the advertising, promotion, and sponsorship of ENDS/ENNDS (4 countries only apply the full ban to devices and 3 countries only apply the full ban to e-liquids). • 52 countries have imposed partial bans (2 countries apply the bans to devices only and 1 country applies the ban to e-liquids only (8).
R	• 51 countries with data for open-system ENDS (23 countries impose an excise tax on open-system e-liquids). • 44 countries with data available for closed-system ENDS (19 countries impose excise taxes on closed-system e-liquids [commonly sold as pods]). • For closed-system e-liquids, no country applies taxes as high as 75% of the price of the cheapest brand of closed-system ENDS (8). • (In countries where an excise tax is imposed on ENDS e-liquids, the tax is generally low, with only three countries levying taxes equal to or more than 75% of the price of the cheapest brand for open-system e-liquids.)
MONITORING E-CIGARETTE USE	
M	• 87 countries include this within the school surveys used to monitor tobacco use among adolescents. This means that there is an equal proportion of the population where no monitoring is being undertaken (8).

Source: Based on information contained within the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

Canada and Chile regulate this category of products as therapeutic; however, in Canada, this only applies if the advertising claims a medicinal or therapeutic benefit. Otherwise, it is regulated as a consumer product.

Bans on manufacture, sales, and imports

Within the Region of the Americas, ENDS and/or ENNDS are banned in seven countries (8). In five of these countries, however, the ban on commercialization does not eliminate the

possibility of these products entering the market illegally, so they have also opted to regulate their use to be consistent with legislation on smoke-free environments.

Table 20 shows the status of the regulatory framework for ENDS and ENNDS for the Region of the Americas as of 2021. In 15 countries, these products are not regulated under any of the domains listed in Table 20.

Heated tobacco products

Global status

COP8 of the WHO FCTC recognized HTPs as tobacco products and noted that they should therefore be subject to the provisions of the WHO FCTC and monitored and regulated in the same way as any other tobacco products. Based on data collected for the WHO Report on the Global Tobacco Epidemic, 2021, 8th edition, HTPs are banned (a sales ban or another type of ban that restricts their availability) in 11 countries. In the remaining 184 countries, HTPs are either implicitly or explicitly regulated as tobacco products or explicitly regulated in other categories. There is a need for further analysis in the future to understand better how these products are addressed by each country (8).

Regional status

Three countries within the Region of the Americas have implemented complete bans on the sale of HTPs, and another five countries regulate them as tobacco products with explicit mention of HTPs. In 19 countries, definitions and/or provisions are broad enough to include heated tobacco products, which therefore implies their regulation. The remaining seven countries have no form of regulation in place for HTPs.

Table 21 shows the status of the regulatory framework for HTPs in the Region of the Americas as of 2021.

Various approaches can be used to regulate both ENDS and ENNDS, as well as HTPs, including short- and long-term approaches. In the interim, bans can be temporary, or these products can be classified according to an existing category (tobacco, pharmaceutical, or consumer products), thus allowing them to be regulated accordingly (8).

In the shorter term, countries can opt to amend existing regulations to include these novel and emerging nicotine and tobacco products and classify HTPs as tobacco products, except in circumstances where such classification could result in more lenient regulations or undermine existing tobacco control provisions. Where they are not banned, classifying HTPs explicitly as tobacco products would ensure these products are subjected to all of the regulatory mechanisms of the WHO FCTC, ensuring that public health objectives are protected and regulatory loopholes are avoided; this should include the extension of legal definitions to cover product designs and be adaptable to future product innovations.

As the initiation of use of electronic delivery systems, especially among young people, raises concerns for regulators, this is even more reason why these products should be subjected to the same regulatory framework as that for tobacco. Consideration should also be given to refusing to permit systems in which users can control the features of a device and its liquid ingredients (open systems) (8).

TABLE 20

Status of the regulation of electronic nicotine and non-nicotine delivery systems (ENDS/ENNDS) in the Region of the Americas, 2021

COUNTRY	TOTAL BAN ON SALES	REGULATION OF PRODUCTS	REGULATION			REGULATION OF USE AND ADVERTISING			R MEASURES	M MEASURES	
										ADULT	YOUTH
			REGULATED AS A THERAPEUTIC PRODUCT	REGULATED AS A TOBACCO PRODUCT	REGULATED AS A CONSUMER PRODUCT	REGULATED THROUGH SAME LAWS AS P[b]	REGULATED THROUGH SAME LAWS AS W[b]	REGULATED THROUGH SAME LAWS AS E[b]			
Antigua and Barbuda	No	No	–	–	–	–	–	–		No	Yes
Argentina	Yes	a*	–	Yes	–	Yes	–	Yes		Yes	Yes
Bahamas	No	No	–	–	–	–	–	–		No	No
Barbados	No	Yes			Yes	Yes	No	No[c]		No	No
Belize	No	No	–	–	–	–	–	–		No	Yes
Bolivia (Plurinational State of)	No	Yes**	–	Yes**	–	Yes**	Yes**	Yes**		Yes	Yes
Brazil*	Yes	a	–	–	Yes	Yes	–	Yes		Yes	Yes
Canada*	No[d]	Yes	Yes[e]	No	Yes	No[f]	No[f]	No[f]		Yes	Yes
Chile	No	Yes	Yes	–	–	–	–	–		Yes	No
Colombia	No	No	–	–	–	–	–	–		Yes	Yes
Costa Rica	No	Yes	No	Yes	No	Yes*	Yes	Yes	Yes*	Yes	No
Cuba	No	No	–	–	–	–	–	–		No	Yes
Dominica	No	No	–	–	–	–	–	–		No	No
Dominican Republic	No	No	–	–	–	–	–	–		No	Yes
Ecuador	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
El Salvador	No	Yes	No	No	Yes	Yes	No	No		No	Yes
Grenada	No	No	–	–	–	–	–	–		No	Yes
Guatemala	No	No	–	–	–	–	–	–		No	Yes
Guyana*	No	Yes	–	No	Yes	Yes	No	Yes		No	Yes
Haiti	No	No	–	–	–	–	–	–		No	No
Honduras*	No	Yes	No	Yes	No	Yes	Yes	Yes		No	No
Jamaica	No	Yes	No	Yes	No	Yes	Yes	Yes		No	Yes
Mexico	Yes*	a	–	Yes	–	Yes	–	–		Yes	No
Nicaragua	No	No	–	–	–	–	–	–		No	Yes
Panama*	Yes	a	–	–	Yes	Yes	No	No		Yes	Yes
Paraguay*	No	Yes	–	Yes	–	Yes[g]	No[g]**	Yes[g]		No	Yes
Peru	No	No	–	–	–	–	–	–		No	Yes
Saint Kitts and Nevis	No	No		–	–	–	–	–		No	No

TABLE 20 *(continued)*

COUNTRY	TOTAL BAN ON SALES	REGULATION OF PRODUCTS	REGULATION			REGULATION OF USE AND ADVERTISING			R MEASURES	M MEASURES	
										ADULT	YOUTH
			REGULATED AS A THERAPEUTIC PRODUCT	REGULATED AS A TOBACCO PRODUCT	REGULATED AS A CONSUMER PRODUCT	REGULATED THROUGH SAME LAWS AS P[b]	REGULATED THROUGH SAME LAWS AS W[b]	REGULATED THROUGH SAME LAWS AS E[b]			
Saint Lucia	No	Yes	–	Yes	–	Yes	Yes	–		No	Yes
Saint Vincent and the Grenadines	No	No	–	–	–	–	–	–		No	Yes
Suriname*	Yes	–	–	–	–	–	–			No	Yes
Trinidad and Tobago	No	No	–	–	–	–	–	–		No	Yes
United States of America	No	Yes	Yes[h]	Yes	No	No	No[i]	No[i]		Yes	Yes
Uruguay*	Yes	[a]	–	Yes	–	Yes	–	Yes		Yes	Yes
Venezuela (Bolivarian Republic of) *	Yes	–	–	–	–	–	–	–		No	Yes
Total	7	18	3	11	6	15	6	10	2	12	26

Notes: Data available as of 31 December 2021.
[a]As the ban on sales does not eliminate the possibility of these products entering the market illegally, some countries have also opted to regulate their use to be consistent with legislation on smoke-free environments and/or their advertisement, promotion, and sponsorship.
[b]According to the measures of the MPOWER technical package: P, protect people from exposure to tobacco smoke; W, warn about the dangers of tobacco; E, enforce bans on tobacco advertising, promotion, and sponsorship.
[c]The advertisement, broadcast, or publication of electronic smoking devices cannot promote, encourage, or induce the use of electronic smoking devices as a safe alternative to smoking tobacco products.
[d]The sale of products that contain more than 6.6% (66 mg/mL) of nicotine is prohibited.
[e]Only if the advertising claims a medicinal or therapeutic benefit; otherwise, it is regulated as a consumer product.
[f]The Tobacco and Vaping Products Act (TVPA) of 2018 provides additional regulations under measures P, W, and E.
[g]Resolution 630/2019 provides specific provisions for electronic cigarettes with regulations under measures P, W, and E. Health warning labels are still pending.
[h]Only if the advertising claims a medicinal or therapeutic benefit; otherwise, it is regulated as a tobacco product.
[i]There are partial requirements in relation to measure W and partial bans in relation to measure E.
* ENNDS are treated the same as ENDS.
** Regulations are pending.
– Not applicable.

Source: Based on the WHO Report of the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), as well as data from the Regional Tobacco Control Team.

However, in the long term, countries should make every effort to ensure that their tobacco control policies are sufficiently comprehensive to regulate all forms of novel and emerging nicotine and tobacco products and to avoid any possible loopholes that could result in the tobacco industry being able to market and sell these products in the future and threaten the progress made by countries in tobacco control.

TABLE 21

Status of the regulatory framework for heated tobacco products (HTPs) in the Region of the Americas, 2021

STATUS	MEMBER STATES	TOTAL
Sale of heated tobacco products is banned	Brazil, Mexico, and Panama	3
Regulated as tobacco products with explicit mention of HTPs	Bolivia (Plurinational State of), Canada, Costa Rica, Guyana, Jamaica, Paraguay, Saint Lucia, Trinidad and Tobago, United States of America, and Uruguay	10
Regulated as tobacco products[a]	Antigua and Barbuda, Argentina, Barbados, Chile, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Peru, Suriname, and Venezuela (Bolivarian Republic of)	15
No regulation	Bahamas, Belize, Dominica, Haiti, Grenada, Saint Kitts and Nevis, and Saint Vincent and the Grenadines	7

Notes: Data available as of 31 December 2021.
[a]The existing law or regulation includes a definition or provisions that are broad enough to include heated tobacco products and therefore implies their regulation.

Source: Prepared with data approved by the respective national authorities and from the WHO Report on the Global Tobacco Epidemic: Addressing new and emerging products, 2021, 8th edition (8).

4.2. Other challenges in tobacco control

4.2.1. Tobacco control and the COVID-19 pandemic

The COVID-19 pandemic continues to pose considerable challenges to public health across the world through its devastating impact on health systems and national economies, which forces countries to divert valuable resources to address this situation. Available evidence has established strong links between this disease and noncommunicable diseases, with tobacco control being one of the major cross-cutting risk factors influencing the severity and risk of fatality from COVID-19 (72). Tobacco consumption increases the risk of transmission and results in more severe health outcomes for those who become infected. Smokers are more susceptible to both bacterial and viral infections, including Middle East respiratory syndrome coronavirus (MERS-CoV), which is remarkably similar to SARS-CoV-2. Hand-to-mouth contact is acknowledged as being one route to becoming infected with COVID-19, and this form of contact occurs frequently and repeatedly when smoking. Smokers are unable to keep a face mask on while smoking. Smoking in public places where other unmasked smokers congregate will increase the likelihood of becoming infected.

SARS-CoV-2 enters human cells through a receptor in the respiratory tract known as ACE-2. Smoking can upregulate the ACE-2 receptors, providing more entry points for the virus (73). This may make smokers more susceptible to contracting COVID-19. Multiple studies have also documented

those smokers infected with COVID-19 are at risk of more severe disease and are more likely to require ventilation support (74, 75).

The tobacco industry has used the COVID-19 pandemic as an opportunity to aggressively disseminate misleading research findings, often conducted by authors who have received funding and other support from the tobacco industry and its partner organizations, that claim, ironically, a protective role for nicotine in COVID-19 infections. These studies, some of which have been shown to have serious methodological flaws, attempt to downplay tobacco use as a risk factor for serious and potentially fatal disease (76, 77), thereby harming measures to strengthen tobacco control.

The pandemic has shown that there is a need for support in every sector, including business and private industries. The tobacco industry has exploited this fact to burnish its role as a socially responsible corporate agent and enhance its reputation, making it easier to market its lethal products and augment lobbying efforts to weaken tobacco control regulatory frameworks (78, 79). Civil society organizations have exposed this situation, continue to monitor the industry's efforts to interfere during the COVID-19 pandemic, and have exposed the various activities taking place around the world. Experience has shown that the tobacco industry has tried to permeate every sector in a bid to be permitted to exert influence. Some of the most common activities observed during this period include targeted donations of personal protective equipment (PPE) and ventilators, in addition to funding public health initiatives to tackle COVID-19. Astonishingly, the industry further explored means to manipulate the vulnerability of governments during this time through the funding of vaccines and by offering scholarships to young people. These two activities have the potential to create a positive perception of the image of the tobacco industry over an extended period, with the eventual possibility of being perceived as "champions" of public health.

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4.2.2. Tobacco industry interference

Evidence shows that for decades the tobacco industry and its allies have deployed a series of tactics and strategies to prevent States Parties from implementing tobacco control measures that would improve the health conditions of their populations (79). Pursuant to this effort, the tobacco industry has devoted considerable resources aimed at influencing public policy by challenging effective tobacco control laws and regulations, disputing public health facts, and using litigation before national and international courts to challenge the national implementation of measures such as those promoted by the WHO FCTC (80, 81). This was especially visible during the COVID-19 pandemic, as described above.

The tobacco industry uses a variety of strategies not only to intimidate governments and prevent them from adopting tobacco control regulations but also to weaken those regulations that are already in place. The tobacco industry also seeks, through litigation, to make the implementation of tobacco control measures more expensive, to delay the process of implementing a measure, and to dissuade other governments from following the lead of more robust regulations. Prior knowledge of the tobacco industry's legal strategies helps Member States to anticipate arguments, strengthen their legal positions, and design more solid and resilient laws and regulations (82).

The strategies and tactics used by the tobacco industry to challenge tobacco control policies are often similar all over the world, especially in low- and middle-income countries. These tactics include challenging existing and proposed legislation, influencing science and research, undermining the efforts of public health experts, and collaborating with lobby groups, among others. The industry has also challenged, before several national and international courts, the process followed by governments when adopting tobacco control regulations or used arguments about other types of commercial rights allegedly endangered by them, such as commercial speech or the right to run a business (83, 84).

One tobacco control policy that has been widely challenged is the one that aimed to ban or regulate the way companies can depict and advertise their products on the market. This is the mandate to incorporate messages or warnings that provide more and better information to the population about the real, harmful effects derived from the consumption of their products; e.g., through the adoption of graphic health warnings or the establishment of restrictions or bans on advertising, promotion, and sponsorship of tobacco products. Both are tobacco control measures that have been subject to heavy judicial scrutiny due to the industry's actions.

A number of legal challenges has led several governments to have to defend themselves before national and international courts in situations where they have determined to implement strict restrictions on the way tobacco companies identify and promote their products; e.g., through the implementation of plain packaging of tobacco products (82). However, it is essential to note that the arguments used by the tobacco industry before the courts are not only baseless but have also been rejected by various courts around the world. Many governments have successfully faced down the legal challenges brought by the tobacco

industry, and the right of Member States to implement tobacco control measures that protect the health of their people has been widely upheld by courts, as was the case with Uruguay versus Philip Morris International.

4.2.3. Pending agenda of the MPOWER technical package

Policies surrounding smoke-free environments and pictorial health warnings are being implemented at a reasonable pace within the Region of the Americas. There is still a lot more work to be done, however, especially in garnering political will at the highest levels, required to enforce such legislation to achieve compliance within the respective jurisdictions.

For measures relating to the monitoring of tobacco consumption and prevention policies, offering help to quit, enforcing bans on tobacco advertising, promotion, and sponsorship, and increasing tobacco taxes, the gap is much wider. The opposition by the tobacco industry and its allies, through their use of baseless economic and legal arguments, remains the greatest obstacle for countries moving forward and setting up regulatory frameworks in line with the FCTC. Countries also lack resources to implement cessation programs and execute nationally representative surveys, a crucial obstacle to overcome in supporting those who wish to quit and to achieve an updated and clear landscape of the tobacco epidemic at the country level. However, governments can close this gap by implementing one of the most cost-effective tobacco control interventions, i.e., tobacco taxation, which represents a "win-win" situation, both for public health and for public finances (85).

Tobacco taxation, however, remains the least implemented measure within the Region of the Americas, primarily due to misleading information about the negative impact raising taxes would have, e.g., on increasing illicit trade of tobacco. The tobacco industry also exaggerates (or even presents results that do not match reality) multiple factors when discussing tobacco taxation. For example, the level of illicit trade has been continuously proved by independent research to be much lower than the estimations the industry presents.

For more than a decade, tobacco control has been monitored globally through the various editions of the WHO Report on the Global Tobacco Epidemic. In the face of numerous challenges, which are larger rather than smaller, tobacco control has continued to make considerable progress within the Region of the Americas. These accomplishments have gained ground through the strong collaborative efforts of those who are dedicated to the aim of seeing tobacco control continuing to be a priority for public health. However, amid the resounding successes noted thus far, the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022 is about to conclude, and those targets that were established as part of the strategy are yet to be achieved.

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CHAPTER 5

Conclusion

Globally, 5.5 billion people are now protected by at least one MPOWER measure. This figure has more than quadrupled since the first WHO Report on the Global Tobacco Epidemic, in 2008. Within the Region of the Americas, 977 million people are covered by at least one MPOWER measure; however, this translates as 41 million people who remain unprotected by any of the MPOWER measures.

At the time of publication of the first measure of progress in tobacco control through the MPOWER technical package in 2008, the Region of the Americas had just one Member State that had implemented measures to protect people from exposure to second-hand smoke (P) at the highest level of application. Since then, progress has been continuous, and the Region of the Americas has now seen the greatest number of countries of any Region implement this measure at the highest level. This eventually resulted, in 2020, in South America becoming the first smoke-free subregion within the Region of the Americas. However, there are 11 countries within the Region of the Americas that still need to adopt legislation that is fully aligned with Article 8 of the WHO FCTC. Of this number, seven are Parties to the WHO FCTC who have now passed the deadline since ratifying the implementation of this provision.

The second most implemented MPOWER measure within the Region of the Americas is measure W, to warn about the danger of tobacco. To date, 22 Member States are implementing this measure at the highest level of application, leading to the Region ranking second at the global level. There are still 13 Member States yet to implement this measure at the highest level, of which 10 are Parties to the WHO FCTC.

Lamentably, progress has been less forthcoming with regard to the other four measures: monitor tobacco use and prevention policies (M); offer help to quit (O); enforce bans on tobacco advertising, promotion, and sponsorship (E); and raise taxes on tobacco (R). Just 10 Member States (9 Parties) have periodic, recent, and representative data relating to tobacco consumption among both adult and youth populations. Six Member States have national toll-free quit lines, nicotine replacement therapy, and cessation counseling support to treat tobacco dependence. Five of these Member States are Parties to the WHO FCTC. Nine Parties to the WHO FCTC are

implementing measure E at the highest level of application. In terms of raising taxes on tobacco, three Member States (two Parties) have achieved a 75% tax share on the retail price of tobacco products. The numbers for these four measures mean the Region of the Americas ranks third, globally, for the M, O, E, and R measures.

The development and subsequent implementation of the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022, which was approved by all Member States within the Region, has allowed notable strides in tobacco control, made in many countries within the Region, to be monitored. This has also highlighted that there remains even greater room for improvement in tobacco control. However, the tobacco industry and those who work to further its interests continue their attempts to thwart these potential achievements. The trend in novel and emerging tobacco products is no doubt acting as a major obstacle in the progress of tobacco control. Sales bans on these products are only in effect in a small proportion of Member States (seven for e-cigarettes and three for HTPs). In those countries where these products are subject to regulation, the tobacco industry is actively working to reverse these gains through intense lobbying and litigation in an effort to weaken the respective regulatory frameworks. The COVID-19 pandemic has been the greatest of all the challenges to tobacco control to date, however, with the tobacco industry managing once again to use a debilitating situation to its benefit.

There remains much more work to be done to achieve the commitments to reduce and ultimately end tobacco consumption that countries have made through the WHO FCTC, the Strategy and Plan of Action to Strengthen Tobacco Control in the Region of the Americas 2018–2022, the Sustainable Development Goals, and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases. Countries must commit to remaining vigilant and placing public health as a priority to ensure that their people are protected from the dangers of tobacco. The Pan American Health Organization and the World Health Organization stand committed to supporting countries in achieving these targets.

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CHAPTER 6

Technical note

The data presented in this document are from the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8), updated with data compiled in 2021 by the Pan American Health Organization (PAHO) Regional Tobacco Control Team where so indicated. The methodology used to calculate each indicator is described in this Technical Note.

The tobacco taxation data (R of the MPOWER package) were data that were available for PAHO Member States as of 31 July 2020. For tobacco surveillance and cessation (M and O of the MPOWER package), the data presented were up to 31 December 2020. For protecting people from tobacco smoke, warning about the dangers of tobacco, and enforcing bans on tobacco advertising, promotion, and sponsorship (measures P, W, and E, respectively, of the MPOWER package), the data reflect the state of the legislation adopted to 31 December 2021, which was an established effective date and was not the subject of any legal dispute that may have affected the implementation date. Laws and regulations that were not in force as of 31 December 2021 carry a footnote that indicates this.

6.1. Evaluation of existing policies

6.1.1. Data sources

The data compiled for the MPOWER package of measures came from the following sources:

- For all areas: official reports by the Parties to the FCTC to the Conference of the Parties (COP) and accompanying background documents.
- M (monitor tobacco use and prevention policies): tobacco prevalence surveys available in official reports to the COP, both through the Regional Office in Washington, D.C., and PAHO country offices. The indicators used to characterize the prevalence of tobacco use are shown in this Technical Note.
- P (protect people from tobacco smoke): tobacco control laws, including their regulations, adopted by Member States with regard to smoke-free environments. If a law was adopted before 31 December 2021 but was not yet implemented, the respective law was examined and a note was added to clarify that a law was

adopted but was not implemented as of 31 December 2021.

- O (offer help to quit tobacco): data not reported via the COP reporting mechanism were mainly collected through WHO regional and country offices.

- W (warn about the dangers of tobacco): tobacco control laws, including their regulations, adopted by Member States with regard to packaging and labeling of tobacco products. If a law was adopted before 31 December 2021 but was not yet implemented, the respective law was examined and a note was added to clarify that a law was adopted but was not implemented as of 31 December 2021.

- E (enforce bans on tobacco advertising, promotion, and sponsorship): tobacco control laws, including their regulation, adopted by Member States with regard to tobacco advertising, promotion, and sponsorship. If a law was adopted before 31 December 2021 but was not yet implemented, the respective law was examined and a note was added to clarify that a law was adopted but was not implemented as of 31 December 2021.

- R (raise taxes on tobacco): tobacco tax laws, including their regulations, adopted by Member States. Data on prices and tax revenues were obtained from countries through their ministries of finance or other government agencies.

6.1.2. Validation of technical data

Two experts, one from WHO Headquarters and another from the PAHO Regional Tobacco Control Team, reviewed the data on country legislation. Any inconsistencies were resolved with a third expert who did not participate in the original legislative evaluation. This method produced consensus on each piece of data. Any disagreements in the interpretation of the legislation were resolved by: (i) checking the original text(s) of the legislation; (ii) seeking to obtain consensus from the two expert staff involved in the data collection; (iii) seeking to obtain clarification from judges or lawyers in the country concerned; and (iv) the decision of the third expert in cases where differences remained. Data were also checked for completeness and logical consistency across variables.

6.1.3. Final data approval

The validated data for each country were submitted to the respective governments as a summary information sheet for each country, for their review and final approval. If the national authorities requested changes, the WHO and PAHO experts reviewed the legislation and the clarifications requested by the national authorities, which resulted in them either updating the data or not. If agreement was not reached with the national authorities, this was reflected in the appropriate box on the country's information sheet.

More information on the processing of the data can be found in the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition (8).

6.1.4. Analysis of data and highest level of achievement of the measures

The report describes the status of implementation of the MPOWER package in each country of the Region of the Americas. It should be emphasized that the data in the report are based on existing legislation and reflect the status of rules adopted, although not necessarily implemented, as long as the law establishes a date of entry into force and is not subject to a legal challenge.

The level of implementation of each measure is classified into one of four categories, identified by the colors green, yellow, orange, and red. Green indicates the highest level of implementation of the measure in question. The year in which the highest level of implementation was reached for each measure is shown in Table 4 for the measures M, P, O, W, E, and R.

6.2. Indicators and data used to characterize the status of implementation of the MPOWER package of measures

6.2.1. M: monitor tobacco use and prevention policies

Classification criteria

The strength of a national tobacco surveillance system was assessed by the frequency and periodicity of nationally representative youth and adult surveys in a country. The indicators used to characterize the prevalence of tobacco use are shown in Table 22. A country was placed in the top monitoring category (M) when all criteria listed below were met for both youth and adult surveys:

TABLE 22

Indicators used to characterize the prevalence of tobacco use

AGE GROUP	INDICATOR
YOUTH[a]	
Current tobacco use	Use of any tobacco product (smoked and/or smokeless) in the 30 days prior to the survey
Current tobacco smoking	Use of any smoked tobacco product (cigarettes or other) in the 30 days prior to the survey
Current cigarette use	Cigarette use in the 30 days prior to the survey
Current smokeless tobacco use	Use of any smokeless tobacco product in the 30 days prior to the survey
Current electronic cigarette use	Electronic cigarette use in the 30 days prior to the survey
ADULTS[a]	
Current tobacco use	Use of any tobacco product (smoked and/or smokeless) in the 30 days prior to the survey; includes daily and occasional users
Current tobacco smoking	Use of any smoked tobacco product (cigarettes or other) in the 30 days prior to the survey; includes daily and occasional smokers
Current cigarette use	Cigarette use in the 30 days prior to the survey; includes daily and occasional smokers
Current smokeless tobacco use	Use of any smokeless tobacco product in the 30 days prior to the survey
Current electronic cigarette use	Electronic cigarette use in the 30 days prior to the survey; includes daily and occasional users

Note: [a]The definition of age groups is detailed in each survey.

- Whether a survey was carried out recently.
- Whether the survey was representative of the country's population.
- Whether a similar survey was repeated within five years (periodic).
- Whether the youth and adult populations were surveyed through school-based and household population-based surveys, respectively.

Surveys were considered recent if conducted in the past five years. For this report, this means 2015 or later. Surveys were considered representative only if a scientific random sampling method was used to ensure nationally representative results. (Although they can provide useful information, subnational surveys or national surveys of specific population groups provide insufficient information to enable tobacco control action for the total population.) Surveys were considered periodic if the same survey or a survey using the same or similar questions was repeated at least once every five years.

The following definitions were applied for youth and adult surveys:

- Youth survey: school-based survey of students (male and female) in grades that included individuals aged 13 to 15 years. The questions should provide indicators that are consistent with the Global Youth Tobacco Survey (GYTS) and its manuals.
- Adult survey: household surveys that provide indicators for adults aged 15 years and over, consistent with those of the Global Adult Tobacco Survey (GATS) and its manuals.

	There are recent, representative, and periodic data for both adults and youths.
	There are recent and representative data for both adults and youths.
	There are recent and representative data for either adults or youths.
	There are no recent data, or data are neither recent nor representative.

6.2.2. P: protect people from tobacco smoke

Classification criteria

Laws with regard to smoke-free environments were evaluated to verify whether they provide a totally smoke-free indoor space, at all times, in the following eight types of places:

- Health centers;
- Educational facilities other than universities;
- Universities;
- Government buildings/facilities;
- Indoor offices and workplaces not considered in any other category;
- Restaurants (or places that primarily serve food);
- Bars and pubs (or places that primarily serve drinks/beverages);
- Public transportation.

Countries with no complete smoking ban at a national level but where at least 90% of the population was covered by complete, subnational smoke-free laws were grouped in the top category.

Totally smoke-free space: a space in which smoking is prohibited at all times, in all areas, and under all circumstances.

	All public places, indoor workplaces, and public transportation are totally smoke-free (or at least 90% of the population is covered by subnational legislation).
	Six to seven types of public spaces and workplaces are completely smoke-free.
	Three to five types of public spaces and workplaces are completely smoke-free.
	Complete absence of bans or up to two types of public spaces and workplaces are completely smoke-free.

6.2.3. O: offer help to quit tobacco use

Classification criteria

The status of nicotine dependence treatment was evaluated according to the availability of the following components:

- Nicotine replacement therapy (NRT);
- Smoking cessation support;
- Reimbursement for the costs of the aforementioned components;
- Existence of a national toll-free quit line.

Cessation services: cessation support was available at health centers or other primary care services, hospitals, offices of health professionals, or in the community.

Availability of the services: "in most" means that access was not an obstacle to treatment; "in some" indicates that lack of availability of the services was often a barrier to treatment.

	There is a national quit line, nicotine replacement therapy, and some cessation services are available; the full costs are covered.
	Nicotine replacement therapy or some cessation services are available; costs for at least one of them are covered.
	Nicotine replacement therapy or some cessation services are available; costs are not covered.
	None.

6.2.4. W: warn about the dangers of tobacco

Classification criteria

Health warnings were evaluated according to their size and the following characteristics:

- The health warnings were required by law;
- They appeared on all retail packaging;
- They described the harmful effects of tobacco on health;
- The font, the size, and the color were mandated by law;
- The warnings were rotated;
- The warnings were written in the language or languages of the country;
- The warnings included images or pictograms.

	Large warning (covers an average of at least 50% of the front and the back of the packaging) with all the appropriate characteristics.
	The same as the previous category, except the regulations are pending.
	Medium-sized warning (covers an average of 30%–49% of the front and back of the packaging) with all the appropriate characteristics, or a large warning, which lacks one to three of the appropriate characteristics.
	Medium-sized warning that lacks one or more of the appropriate characteristics, or a large warning in which four or more appropriate characteristics are lacking.
	No warning or a small warning (on average less than 30% of the front and back).

6.2.5. E: enforce bans on tobacco advertising, promotion, and sponsorship

Classification criteria

Regulations were evaluated in terms of whether there was a ban on the following types of activities:

Direct advertising

- National television and radio;
- Magazines and local newspapers;
- Billboards and open-air ads;
- Advertising at points of sale.

Indirect advertising

- Promotion:
  - Distribution free by mail or other means;
  - Promotional discounts;
  - Brand stretching;
  - Brand sharing;
  - Tobacco brand placement or appearance of tobacco products on television or in films.
- Sponsorship:
  - Contribution (financial or other support) to any event, activity, or individual;
  - Corporate social responsibility (CSR).

Complete bans on tobacco advertising, promotion, and sponsorship usually start with bans on direct advertising in national media and progress to bans on indirect advertising as well as promotion and sponsorship. The basic distinction for the two lowest groups (colored in orange and red) was whether bans covered national television, radio, and print media, and the remaining groups were constructed based on how comprehensively the law covered bans of other forms of direct and indirect advertising included in the data collection questionnaire for the WHO Report on the Global Tobacco Epidemic, 2021: Addressing new and emerging products, 8th edition.

In cases where the law did not explicitly address cross-border advertising, it was interpreted that advertising at both domestic and international levels was covered by the ban only if advertising was totally banned at a national level. Countries where at least 90% of the population was covered by subnational legislation completely banning tobacco advertising, promotion, and sponsorship were grouped in the highest category.

The characteristic that determined the prohibition of promotion was that, at the very least, the legislation banned the publicizing of financial or other sponsorship or support from the tobacco industry for events, activities, or individuals.

	Ban all forms of direct and indirect advertising.
	Ban on advertising on national television, radio, and in the print media, as well as some but not all other forms of direct and indirect advertising.
	Ban only on national television, radio, and in the print media.
	Complete absence of a ban, or a ban that does not at least cover national television, radio, and print media.

6.2.6. R: raise taxes on tobacco

Classification criteria

The status of tobacco taxation was evaluated according to the percentage of the total retail price that comprised taxes on tobacco. The taxes analyzed included excise tax, value-added tax (VAT), import duties, and any other tax on tobacco. Only the price of the best-selling cigarette brand was considered for each country.

The affordability of cigarettes was calculated as the percentage of per capita GDP required to purchase 2,000 cigarettes of the best-selling brand in each year of the report, from 2008 to the present.

	Taxes represent ≥75% of the retail sale price.
	Taxes represent ≥ 50% – <75 of the retail sale price.
	Taxes represent ≥ 25 – <50% of the retail sale price.
	Taxes represent <25% of the retail sale price.
	Data were not provided or were not available.

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Annexes

Annex 1
Prevalence of current tobacco use, tobacco smoking, and cigarette smoking among adults, most recent surveys (data provided by countries)

COUNTRY	SURVEY NAME	YEAR	AGE GROUP	CURRENT TOBACCO USE			CURRENT TOBACCO SMOKING			CURRENT CIGARETTE SMOKING		
				BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
Antigua and Barbuda	…	…	…	…	…	…	…	…	…	…	…	…
Argentina	Encuesta Nacional de Factores de Riesgo Para Enfermedades No Transmisibles	2018	18+	…	…	…	…	…	…	22.2	26.1	18.6
Bahamas	Bahamas STEPS	2019	18–69	17.5	32.5	3.7	17.4	32.4	3.6	…	…	…
Barbados	Health of the Nation	2011–12	25+	…	…	…	9.2	15.5	3.7	…	…	…
Belize	Multiple Indicator Cluster Survey (MICS)	2015	15–49	…	16.4	2.1	…	…	…	…	…	…
Bolivia (Plurinational State of)	STEPS Survey	2019	18–69	17.8	30.0	5.8	17.7	29.8	5.6	…	…	…
Brazil	Pesquisa Nacional de Saúde (National Health Survey)	2019	18+	12.8	16.2	9.8	12.6	15.9	9.6	…	…	…
Canada	Canadian Tobacco and Nicotine Survey	2019	15+	14.0	15.9	12.0	11.9	12.7	11.1	11.9	12.6	11.0
Chile	Estudio Nacional de Drogas en Población General de Chile	2018	12–64	…	…	…	…	…	…	31.1	33.4	28.8
Colombia	Estudio Nacional de Consumo de Sustancias Psicoactivas en Colombia	2019	12–65	…	…	…	9.8	13.8	6.0	…	…	…
Costa Rica	Global Adult Tobacco Survey (GATS)	2015	15+	9.1	13.6	4.5	8.9	13.4	4.4	8.8	13.1	4.4
Cuba	Encuesta de Indicadores Múltiples por Conglomerados (MICS)	2019	15–49	…	23.4	10.5	…	23.4	10.5	…	22.7	10.4

COUNTRY	SURVEY NAME	YEAR	AGE GROUP	CURRENT TOBACCO USE			CURRENT TOBACCO SMOKING			CURRENT CIGARETTE SMOKING		
				BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
Dominica	Dominica STEPS Survey	2007–08	15–64	10.4	17.0	3.2	10.2	16.6	3.2	…	…	…
Dominican Republic	Demographic and Health Survey	2013	15–59 (men) 15–49 (women)	…	12.8	4.6	…	…	…	…	9.2	3.9
Ecuador	STEPS Survey	2018	18–69	13.7	23.8	4.0	13.7	23.8	4.0	10.7	19.3	2.5
El Salvador	Encuesta Nacional de Enfermedades Crónicas no Transmisibles en Población Adulta	2014–15	20+	…	…	…	7.8	15.1	2.3	…	…	…
Grenada	Grenada STEPS	2010–11	25–64	…	…	…	18.7	30.7	6.5	…	…	…
Guatemala	VI Encuesta Nacional de Salud Materno Infantil	2014–15	15–49	…	21.6	1.6	…	…	…	…	21.5	1.5
Guyana	Guyana STEPS Survey	2016	18–69	…	…	…	15.4	26.6	3.3	14.5	25.4	2.8
Haiti	Enquête Mortalité, Morbidité et Utilisation des Services en Haïti	2016–17	15–64	…	…	4.5	…	9.8	1.7	…	9.6	1.7
Honduras	Encuesta Nacional de Demografía y Salud ENDESA	2011–12	15–59 (men) 15–49 (women)	…	24.6	1.8	…	…	…	…	24.2	1.7
Jamaica	Health and Lifestyle Survey III	2016–17	15+	…	…	…	15.0	26.0	5.0	…	…	…
Mexico	Encuesta Nacional de Salud y Nutrición	2018	20+	…	…	…	…	…	…	17.9	28.4	9.2
Nicaragua	Encuesta Nicaraguense de Demografía y Salud	2001	15–49	…	…	…	…	…	5.5	…	…	5.2
Panama	Encuesta Nacional de Salud	2019	15+	5.0	8.1	1.9	4.9	8.0	1.8	…	…	…
Paraguay	Encuesta Nacional de Factores de Riesgo de Paraguay (STEPS)	2011	15–74	…	…	…	14.5	22.8	6.1	…	…	…
Peru	Encuesta Demográfica y de Salud Familiar	2019	15+	…	…	…	…	…	…	1.6[b]	2.4[b]	0.6[b]
Saint Kitts and Nevis	STEPS Survey	2007–08	25–64	8.7	16.2	1.1	8.7	16.2	1.1	…	…	…
Saint Lucia	Saint Lucia STEPS Survey	2012	25–64	14.7	25.5	4.0	14.5	25.3	4.0	…	…	…
Saint Vincent and the Grenadines	National Health and Nutrition Survey	2013–14	18–69	…	…	…	12.2	21.9	2.5	…	…	…
Suriname	STEPS Survey	2013	25–65	…	…	…	20.1	34.0	6.5	20.0	34.0	6.5
Trinidad and Tobago	Pan American STEPS Noncommunicable Diseases and Risk Factors Survey	2011	15–64	21.2	33.5	9.6	21.1	33.5	9.4	…	…	…
United States of America[a]	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health	2019	18+	22.8	28.6	17.4	20.8	24.9	17.1	18.1	20.3	16.1
Uruguay	Encuesta Continua de Hogares	2019	15+	…	…	…	19.7	23.5	16.1	…	…	…
Venezuela (Bolivarian Republic of)	Estudio Nacional de Drogas en Población General	2011	18–65	21.5	28.9	14.4	…	…	…	19.4	25.2	13.9

Notes: [a]For details on the products included in or excluded from each indicator, please refer to the published documentation of the source survey.
[b]Daily cigarette smoking.
… Data not reported or not available.
Source: World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

Annex 2
Prevalence of smokeless tobacco use and e-cigarette use among adults, most recent surveys (data provided by countries)

COUNTRY	TITLE OF SURVEY	YEAR	AGE GROUP (YEARS)	CURRENT SMOKELESS TOBACCO USE PREVALENCE (%)			CURRENT E-CIGARETTE USE PREVALENCE (%)		
				BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
Antigua and Barbuda	…	…	…	…	…	…	…	…	…
Argentina	Encuesta Nacional de Factores de Riesgo Para Enfermedades No Transmisibles	2018	18+	…	…	…	1.1	…	…
Bahamas	Bahamas STEPS	2012	25–64	0.5	0.9	0.1	…	…	…
Barbados	Barbados STEPS Survey	2007	25+	0.3	0.0	0.6	…	…	…
Belize	…	…	…	…	…	…	…	…	…
Bolivia (Plurinational State of)	STEPS Survey	2019	18–69	…	…	…	0.7	1.0	0.5
Brazil	Pesquisa Nacional de Saúde (National Health Survey)	2013	18+	0.3	0.5	0.2	…	…	…
Canada	Canadian Tobacco and Nicotine Survey	2019	15+	0.4	0.7	<1[a]	4.7	5.8	3.6
Chile	Estudio Nacional de Drogas en Población General de Chile	2018	12–64	…	…	…	1.5	2.0	1.1
Colombia	Estudio Nacional de Consumo de Sustancias Psicoactivas en Colombia	2019	12–65	…	…	…	0.7	1.0	0.4
Costa Rica	Global Adult Tobacco Survey (GATS)	2015	15+	0.1	0.1	0.0	1.3	1.6	0.9
Cuba	…	…	…	…	…	…	…	…	…
Dominica	Dominica STEPS Survey	2007–08	15–64	0.8	1.6	0.0	…	…	…
Dominican Republic	Demographic and Health Survey	2007	15–49	…	1.9	0.3	…	…	…
Ecuador	STEPS Survey	2018	18–69	0.0	0.0	0.0	2.2	1.7	4.8
El Salvador	…	…	…	…	…	…	…	…	…
Grenada	Grenada STEPS	2010–11	25–64	1.2	2.2	0.3	…	…	…
Guatemala	…	…	…	…	…	…	…	…	…
Guyana	…	…	…	…	…	…	…	…	…
Haiti	Enquête Mortalité, Morbidité et Utilisation des Services en Haïti	2016–17	15–64	…	…	3.1	…	…	…
Honduras	…	…	…	…	…	…	…	…	…
Jamaica	…	…	…	…	…	…	…	…	…
Mexico	Encuesta Nacional de Salud y Nutrición	2018	20+	…	…	…	1.2	1.9	0.7
Nicaragua	…	…	…	…	…	…	…	…	…
Panama	Encuesta Nacional de Salud	2019	15+	0.1	0.1	0.1	0.4	0.8	0.1
Paraguay	Encuesta Nacional de Factores de Riesgo de Paraguay (STEPS)	2011	15–74	2.3	3.0	1.6	…	…	…
Peru	…	…	…	…	…	…	…	…	…
Saint Kitts and Nevis	STEPS Survey	2007–08	25–64	0.2	0.3	0.1	…	…	…
Saint Lucia	Saint Lucia STEPS Survey	2012	25–64	0.8	1.3	0.2	…	…	…
Saint Vincent and the Grenadines	National Health and Nutrition Survey	2013–14	18–69	0.1	0.2	0.0	…	…	…
Suriname	…	…	…	…	…	…	…	…	…
Trinidad and Tobago	Pan American STEPS Noncommunicable Diseases and Risk Factors Survey	2011	15–64	0.4	0.5	0.3	…	…	…
United States of America	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health	2019	18+	3.3	6.2	0.6	…	…	…
Uruguay	Global Adult Tobacco Survey (GATS)	2016–17	15+	0.1	0.3	0.0	0.2	0.3	0.2
Venezuela (Bolivarian Republic of)	Estudio Nacional de Drogas en Población General	2011	18–65	3.5	6.2	0.9	…	…	…

Notes: [a]High sampling variability; although an estimate may be determined from the table, data should be suppressed.
… Data not reported or not available.
Source: World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

Annex 3
Prevalence of current tobacco use, tobacco smoking and cigarette smoking among youth (aged 13–15), most recent surveys (data provided by countries)

COUNTRY	TITLE OF SURVEY	YEAR	AGE GROUP (YEARS)	CURRENT TOBACCO USE			CURRENT TOBACCO SMOKING			CURRENT CIGARETTE SMOKING		
				BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
Antigua and Barbuda	Global Youth Tobacco Survey	2017	13–15	7.5	7.9	7.0	6.1	6.3	5.9	1.4	1.5	1.2
Argentina	Global Youth Tobacco Survey	2018	13–15	20.2	18.7	21.4	19.5	17.6	21.1	18.0	15.5	20.0
Bahamas	Global Youth Tobacco Survey	2013	13–15	12.6	16.1	8.4	10.7	13.8	6.9	3.8	4.6	2.6
Barbados	Global Youth Tobacco Survey	2013	13–15	14.5	17.4	11.4	12.6	15.7	9.3	7.0	8.8	5.0
Belize	Global Youth Tobacco Survey	2014	13–15	12.3	16.6	8.2	11.5	15.7	7.5	7.8	10.4	5.4
Bolivia (Plurinational State of)	Global Youth Tobacco Survey	2018	13–15	10.9	13.6	8.1	9.3	11.6	6.9	6.9	8.6	5.2
Brazil	Pesquisa Nacional de Saúde do Escolar (PENSE)	2015	13–15	6.9	6.7	7.0	…	…	…	5.4	5.3	5.6
Canada	Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS)	2018–19	Grades 7–9	…	…	…	1.0	1.1	0.9	…	…	…
Chile	Estudio Nacional de Drogas en Población Escolar de Chile	2019	13–17	…	…	…	15.2	13.1	17.3	…	…	…
Colombia	Encuesta Nacional de Tabaquismo en Jóvenes	2017	13–15	20.2	20.6	19.6	…	…	…	9.0	9.2	8.6
Costa Rica	Global Youth Tobacco Survey	2013	13–15	8.9	9.7	8.1	8.3	9.0	7.6	5.0	5.7	4.3
Cuba	Global Youth Tobacco Survey	2018	13–15	11.5	13.0	9.7	9.8	11.8	7.6	8.7	10.2	7.1
Dominica	Global Youth Tobacco Survey	2009	13–15	25.3	30.4	19.8	…	…	…	11.6	13.8	8.9
Dominican Republic	Global Youth Tobacco Survey	2016	13–15	7.4	8.3	6.0	4.4	4.2	4.0	2.4	2.4	1.8
Ecuador	Global Youth Tobacco Survey	2016	13–15	13.0	15.3	10.7	11.8	13.9	10.0	8.0	8.9	7.0
El Salvador	Global Youth Tobacco Survey	2015	13–15	13.1	15.3	10.7	12.2	14.7	9.4	9.9	11.4	8.2
Grenada	Global Youth Tobacco Survey	2016	13–15	9.7	12.5	7.1	8.4	11.0	6.1	5.4	6.7	4.1
Guatemala	Global Youth Tobacco Survey	2015	13-15	17.1	19.5	14.4	15.7	18.0	13.2	12.9	14.7	11.1
Guyana	Global Youth Tobacco Survey	2015	13-15	14.8	19.0	10.4	11.7	16.1	7.5	8.6	13.3	3.8
Haiti	Global Youth Tobacco Survey	2005	13-15	19.7	20.3	19.2	…	…	…	14.0	14.1	13.8
Honduras	Global Youth Tobacco Survey	2016	13-15	7.9	9.6	6.4	6.1	7.6	4.8	5.2	6.1	4.4
Jamaica	Global Youth Tobacco Survey	2017	13-15	15.6	15.9	15.0	14.4	14.4	13.9	11.2	11.1	10.9
Mexico	Global Youth Tobacco Survey	2011	13-15	19.8	21.6	17.7	18.1	19.8	16.1	14.6	15.8	12.9
Nicaragua	Global Youth Tobacco Survey	2019	13-15	14.2	16.4	11.8	12.6	14.7	10.4	10.9	12.9	8.9
Panama	Global Youth Tobacco Survey	2017	13-15	7.8	7.9	7.4	5.9	6.2	5.4	3.9	4.2	3.5
Paraguay	Global Youth Tobacco Survey	2019	13-15	8.1	8.8	7.2	7.2	7.4	6.8	3.0	2.7	3.3
Peru	Global Youth Tobacco Survey	2019	13-15	7.2	8.4	5.9	6.4	7.1	5.6	4.9	5.4	4.5
Saint Kitts and Nevis	Global Youth Tobacco Survey	2010	13-15	9.2	10.4	7.8	…	…	…	4.0	4.8	3.2
Saint Lucia	Global Youth Tobacco Survey	2017	13-15	10.2	12.4	8.1	7.9	9.4	6.4	6.3	7.3	5.3
Saint Vincent and the Grenadines	Global Youth Tobacco Survey	2018	13-15	9.3	9.9	8.7	8.4	8.9	7.9	4.1	4.1	4.1
Suriname	Global Youth Tobacco Survey	2016	13-15	11.7	17.1	7.3	11.1	16.1	7.0	8.7	12.8	5.3
Trinidad and Tobago	Global Youth Tobacco Survey	2017	13-15	14.0	17.3	10.8	11.0	13.6	8.6	6.7	8.6	4.9
United States of America[a]	National Youth Tobacco Survey	2020	High-school	…	…	…	…	…	…	4.6	5.4	3.9
Uruguay	Global Youth Tobacco Survey	2019	13-15	11.5	9.7	13.6	10.3	8.3	12.7	8.6	6.9	10.5
Venezuela (Bolivarian Republic of)	Global Youth Tobacco Survey	2019	13-15	14.3	15.9	12.3	10.1	11.0	9.0	7.6	8.2	7.0

Notes: [a]This survey reports additional indicators; please refer to https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6950a1-H.pdf.
… Data not reported or not available.
Source: World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

Annex 4
Prevalence of current of smokeless tobacco use and e-cigarette use among youth (aged 13–15), most recent surveys (data provided by countries)

COUNTRY	TITLE OF SURVEY	YEAR	AGE GROUP (YEARS)	CURRENT SMOKELESS TOBACCO USE PREVALENCE (%)			CURRENT E-CIGARETTE USE PREVALENCE (%)		
				BOTH SEXES	MALE	FEMALE	BOTH SEXES	MALE	FEMALE
Antigua and Barbuda	Global Youth Tobacco Survey	2017	13–15	2.1	2.6	1.6	4.0	4.0	3.7
Argentina	Global Youth Tobacco Survey	2018	13–15	1.5	2.3	0.8	7.1	8.1	6.2
Bahamas	Global Youth Tobacco Survey	2013	13–15	2.8	4.0	1.6	…	…	…
Barbados	Global Youth Tobacco Survey	2013	13–15	2.9	2.9	3.0	…	…	…
Belize	Global Youth Tobacco Survey	2014	13–15	2.3	2.9	1.7	6.5	8.9	4.1
Bolivia (Plurinational State of)	Global Youth Tobacco Survey	2018	13–15	2.8	3.6	2.0	7.4	9.7	5.0
Brazil	Pesquisa Nacional de Saúde do Escolar (PENSE)	2015	13–15	…	…	…	0.2	0.2	0.1
Canada[a]	Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS)	2018–19	Grades 7–9	0.6	0.8	0.5	11.1	11.7	10.4
Chile	…	…	…	…	…	…	…	…	…
Colombia	Encuesta Nacional de Tabaquismo en Jóvenes	2017	13–15	3.9	4.2	3.5	9.0	9.0	8.8
Costa Rica	Global Youth Tobacco Survey	2013	13–15	1.6	1.7	1.6	…	…	…
Cuba	Global Youth Tobacco Survey	2018	13–15	2.3	1.9	2.6	6.1	7.6	4.2
Dominica	Global Youth Tobacco Survey	2009	13–15	8.4	10.2	6.4	…	…	…
Dominican Republic	Global Youth Tobacco Survey	2016	13–15	3.1	4.2	2.3	7.7	7.9	6.9
Ecuador	Global Youth Tobacco Survey	2016	13–15	2.1	2.5	1.8	10.7	12.7	8.7
El Salvador	Global Youth Tobacco Survey	2015	13–15	2.0	2.1	2.0	2.7	3.3	2.1
Grenada	Global Youth Tobacco Survey	2016	13–15	1.8	2.0	1.6	7.2	9.7	4.9
Guatemala	Global Youth Tobacco Survey	2015	13–15	2.4	3.0	1.8	5.6	5.7	5.2
Guyana	Global Youth Tobacco Survey	2015	13–15	4.1	4.6	3.0	9.0	9.3	8.0
Haiti	…	…	…	…	…	…	…	…	…
Honduras	Global Youth Tobacco Survey	2016	13–15	2.2	2.7	1.9	…	…	…
Jamaica	Global Youth Tobacco Survey	2017	13–15	2.6	2.8	2.5	11.7	13.7	9.7
Mexico	Global Youth Tobacco Survey	2011	13–15	4.9	5.9	3.9	…	…	…
Nicaragua	Global Youth Tobacco Survey	2019	13–15	3.5	4.0	2.9	8.6	10.1	7.2
Panama	Global Youth Tobacco Survey	2017	13–15	2.3	2.2	2.4	6.4	7.1	5.2
Paraguay	Global Youth Tobacco Survey	2019	13–15	1.7	2.0	1.3	12.5	14.0	11.1
Peru	Global Youth Tobacco Survey	2019	13–15	1.9	2.2	1.5	6.3	7.1	5.4
Saint Kitts and Nevis	…	…	…	…	…	…	…	…	…
Saint Lucia	Global Youth Tobacco Survey	2017	13-15	3.5	4.5	2.4	11.0	15.0	6.6
Saint Vincent and the Grenadines	Global Youth Tobacco Survey	2018	13-15	2.5	3.0	2.0	8.1	8.4	7.8
Suriname	Global Youth Tobacco Survey	2016	13-15	1.1	1.7	0.6	5.9	7.4	4.6
Trinidad and Tobago	Global Youth Tobacco Survey	2017	13-15	4.1	5.0	3.2	17.2	21.7	12.9
United States of America	National Youth Tobacco Survey	2020	High-school	3.1	4.8	1.4	19.6	20.4	18.7
Uruguay	Global Youth Tobacco Survey	2019	13-15	1.7	2.0	1.5	13.9	16.8	10.7
Venezuela (Bolivarian Republic of)	Global Youth Tobacco Survey	2019	13-15	7.5	9.8	5.0	9.5	9.6	9.5

Notes: [a]Moderate sampling variability, interpret with caution (female smokeless use only).
… Data not reported or not available.
Source: World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

Annex 5
Administration of the Global Youth Tobacco Survey (GYTS) in the Region of the Americas 1999–2021

COUNTRY	SURVEY YEAR				
Antigua and Barbuda	2000	2004	2009	2017	
Argentina	2000	2003	2007	2012	2018
Bahamas	2000	2004	2009	2013	
Barbados	1999	2002	2007	2013	
Belize	2002	2008	2014		
Bolivia (Plurinational State of)	2000	2003	2012	2018	
Brazil	2002	2006	2009	2011	
Chile	2000	2003	2008	2016	
Colombia	2001	2007			
Costa Rica	1999	2002	2008	2013	
Cuba	2000	2004	2010	2018	
Dominica	2000	2004	2009		
Dominican Republic	2004	2011	2016		
Ecuador	2001	2007	2016		
El Salvador	2003	2009	2015	2021[a]	
Grenada	2000	2004	2009	2016	
Guatemala	2006	2008	2015		
Guyana	2000	2004	2010	2015	
Haiti	2000	2005			
Honduras	2003	2016			
Jamaica	2000	2006	2010	2017	
Mexico	2003	2005	2006	2011	
Nicaragua	2003	2014	2019		
Panama	2002	2008	2012	2017	
Paraguay	2003	2008	2014	2019	
Peru	2000	2003	2007	2014	2019
Saint Kitts and Nevis	2002	2010			
Saint Lucia	2000	2007	2011	2017	
Saint Vincent and the Grenadines	2000	2007	2011	2018	
Suriname	2000	2004	2009	2016	
Trinidad and Tobago	2000	2007	2011	2017	
Uruguay	2000	2007	2014	2019	
Venezuela (Bolivarian Republic of)	1999	2003	2008	2010	2019

Notes: This table shows the year in which countries conducted the GYTS.
Brazil, Canada, Chile, Colombia, and United States of America produce nationally representative data on youth tobacco use through a surveillance system other than the Global Tobacco Surveillance System.
[a]El Salvador conducted a new round of GYTS in 2021 using an electronic data collection tool as a pilot project. Data were not yet available as of the publication of this report.

The blue cells indicate when a subnational survey was conducted. There are no nationally representative estimates available.

The light green cells indicate when the national survey was conducted providing nationally representative estimates.

The dark green cells indicate when national and subnational surveys were conducted. Nationally representative estimates are available and they can be disaggregated by subnational level according to the established sample drawing parameters.

Annex 6
Year in which the highest level of achievement of MPOWER package measures M, P, O, W, and E was attained in each country

COUNTRY	M (MONITOR TOBACCO USE AND PREVENTION POLICIES)	P (PROTECT PEOPLE FROM TOBACCO SMOKE)	O (OFFER HELP TO QUIT TOBACCO USE)	W (WARN ABOUT THE DANGERS OF TOBACCO)	E (ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP)
Antigua and Barbuda		2018		2018[a]	2018
Argentina		2011		2012	
Bahamas	2018				
Barbados		2010		2017	
Belize					
Bolivia (Plurinational State of)		2020		2009	
Brazil	2015	2011	2002	2003	2011
Canada	2007 or earlier	2007	2008	2011[b]	
Chile	2007 or earlier	2013		2006	
Colombia		2008			2009
Costa Rica	2007 or earlier	2012	2020	2013	
Cuba					
Dominica					
Dominican Republic					
Ecuador	2016	2011		2012	
El Salvador		2015		2011	
Grenada					
Guatemala		2008			
Guyana		2017		2018	2017
Haiti					
Honduras		2010		2017	
Jamaica		2013	2016	2013	
Mexico		2021	2013	2009	2021
Nicaragua					
Panama	2012	2008		2005	2008
Paraguay		2020			
Peru	2007 or earlier	2010		2011	
Saint Kitts and Nevis					
Saint Lucia		2020		2017	
Saint Vincent and the Grenadines					

COUNTRY	M (MONITOR TOBACCO USE AND PREVENTION POLICIES)	P (PROTECT PEOPLE FROM TOBACCO SMOKE)	O (OFFER HELP TO QUIT TOBACCO USE)	W (WARN ABOUT THE DANGERS OF TOBACCO)	E (ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP)
Suriname		2013		2016	2013
Trinidad and Tobago		2009		2013	
United States of America	2007 or earlier		2008	2020[c]	
Uruguay	2007 or earlier	2005		2005[b]	2014
Venezuela (Bolivarian Republic of)		2011		2004	2019

Notes: The year in which the highest level of achievement of measure R (raise taxes on tobacco) was attained is not included in this table.
[a]Regulations pending.
[b]Plain packaging is mandated.
[c]Provision adopted but not implemented by 31 December 2020.
Source: Adapted from: World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021 and supplemented with information from the PAHO Regional Tobacco Control Team.

Annex 7
Additional data on tobacco taxes

	I. TAX STRUCTURE/LEVEL					II. AFFORDABILITY		III. TAX ADMINISTRATION	
COUNTRY	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED (YES: UNIFORM; NO: TIERED OR WITH VARIABLE RATES)	GREATER DEPENDENCE ON SPECIFIC TAX IN HYBRID SYSTEMS	MINIMUM SPECIFIC TAX APPLIED IN AN AD VALOREM TAX SYSTEM	RETAIL SALE PRICE USED AS BASIS OF THE AD VALOREM COMPONENT IN AN AD VALOREM OR HYBRID TAX SYSTEM FOR RETAIL SALE PRICE EXCLUDING VAT	PERCENTAGE OF PER CAPITA GDP REQUIRED TO PURCHASE 2,000 STICKS OF THE MOST SOLD BRAND IN 2020 (THE HIGHER THE PERCENTAGE, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE SINCE 2010	TAX STAMPS OR BAR CODES USED ON TOBACCO PRODUCTS[b]	BAN OR LIMIT ON DUTY FREE PURCHASES BY TRAVELERS
Antigua and Barbuda	No excise	—	—	—	—	3.69%	No change	No	No
Argentina	Ad valorem excise	Yes	—	Yes	No	2.37%	Yes	Yes	No
Bahamas	Specific excise	Yes	—	—	—	3.33%	Yes	No	. .
Barbados	. . .	. . .	. . .	. . .	. . .	. . .	. . .	No	. . .
Belize	Specific excise	Yes	—	—	—	7.36%	No change	No	No
Bolivia (Plurinational State of)	Specific excise	No	—	—	—	5.27%	Yes	Yes	No
Brazil	Mixed excise	Yes	Yes	No	Yes	1.57%	No change	Yes	No
Canada	Specific excise	Yes	—	—	—	2.27%	Yes	Yes	No
Chile	Mixed excise	Yes	Yes	No	Yes	3.01%	Yes	No	No
Colombia	Mixed excise	Yes	Yes	No	Yes	2.60%	Yes	No	Yes
Costa Rica	Mixed excise	Yes	Yes	Yes	No	3.26%	Yes	No	No
Cuba	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Dominica	Specific excise	Yes	—	—	—	2.40%	No change	No	No
Dominican Republic	Mixed excise	Yes	Yes	No	No	7.08%	No change	Yes	No
Ecuador	Specific excise	Yes	—	—	—	10.72%	Yes	Yes	Yes
El Salvador	Mixed excise	Yes	No	No	No	8.30%	Yes	No	No
Grenada	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .	. . .
Guatemala	Ad valorem excise	Yes	—	No	No	6.25%	No change	No	No

COUNTRY	I. TAX STRUCTURE/LEVEL					II. AFFORDABILITY		III. TAX ADMINISTRATION	
	TYPE OF EXCISE TAX APPLIED	UNIFORM EXCISE TAX APPLIED (YES: UNIFORM; NO: TIERED OR WITH VARIABLE RATES)	GREATER DEPENDENCE ON SPECIFIC TAX IN HYBRID SYSTEMS	MINIMUM SPECIFIC TAX APPLIED IN AN AD VALOREM TAX SYSTEM	RETAIL SALE PRICE USED AS BASIS OF THE AD VALOREM COMPONENT IN AN AD VALOREM OR HYBRID TAX SYSTEM FOR RETAIL SALE PRICE EXCLUDING VAT	PERCENTAGE OF PER CAPITA GDP REQUIRED TO PURCHASE 2,000 STICKS OF THE MOST SOLD BRAND IN 2020 (THE HIGHER THE PERCENTAGE, THE LESS AFFORDABLE)	CIGARETTES LESS AFFORDABLE SINCE 2010	TAX STAMPS OR BAR CODES USED ON TOBACCO PRODUCTS[b]	BAN OR LIMIT ON DUTY FREE PURCHASES BY TRAVELERS
Guyana	Specific excise	Yes	—	—	—	2.10%	No	Yes	No
Haiti	…	…	…	…	…			…	…
Honduras	Specific excise	Yes	—	—	—	9.13%	Yes	Yes	No
Jamaica	Specific excise	Yes	—	—	—	16.46%	Yes	No	No
Mexico	Mixed excise	Yes	No	No	No	3.75%	No change	Yes	…
Nicaragua	Specific excise	Yes	—	—	—	19.46%	No change	No	…
Panama	Ad valorem excise	Yes	—	Yes	No	2.84%	No	No	Yes
Paraguay	Ad valorem excise	Yes	—	No	No	0.67%	No change	Yes	No
Peru	Specific excise	Yes	—	—	—	5.96%	Yes	No	No
Saint Kitts and Nevis	…	…	…	…	…			No	…
Saint Lucia	Specific excise	Yes	—	—	—	3.39%	No change	No	No
Saint Vincent and the Grenadines	Specific excise	Yes	—	—	—	4.21%	Yes	No	No
Suriname	Specific excise	Yes	—	—	—	6.91%	Yes	Yes	No
Trinidad and Tobago	Specific excise	Yes	—	—	—	2.74%	Yes	No	No
United States of America[a]	Specific excise	Yes	—	—	—	1.16%	No change	No	No
Uruguay	Specific excise	Yes	—	—	—	2.77%	No change	No	No
Venezuela (Bolivarian Republic of)	Ad valorem excise	…	—	No	Yes			No	Yes

Notes: [a]Information not approved by the national authorities.
[b]According to the data reported in: World Health Organization. WHO report on the global tobacco epidemic, 2019: offer help to quit. Geneva: WHO; 2019. Available from: https://www.who.int/publications/i/item/9789241516204.
… Data not reported/not available.
— Information not required/not applicable.
Source: Prepared based on information in the WHO Report on the Global Tobacco Epidemic 2019 and 2021. World Health Organization. WHO report on the global tobacco epidemic, 2019: offer help to quit tobacco use. 7th edition. Geneva: WHO; 2019. Available from: https://www.who.int/publications/i/item/9789241516204. World Health Organization. WHO report on the global tobacco epidemic, 2021: addressing new and emerging products. 8th edition. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240032095.

The Report on Tobacco Control of the Region of the Americas 2022 presents the progress of the implementation of the MPOWER technical package during the period of 2018-2021. While there has been significant progress noted, the report also highlights the gaps in the acceleration of the tobacco control agenda both at the global and regional levels. Collectively, 26 of the 35 Member States within the Region are implementing at least one measure of the MPOWER technical package at the highest level of application, accounting for 96% of the Region's population being protected from the harms of tobacco. The report also details how the global COVID-19 pandemic is seen as being one of the most important threats to the tobacco control agenda. The increasing development and accessibility of the category of novel and emerging tobacco and nicotine products add to the challenge of accelerating tobacco control both globally and regionally. Yet, despite these obstacles, the Region of the Americas now ranks the second lowest prevalence of tobacco consumption globally and a 100% smoke-free South America.

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