

NATIONAL TOBACCO CONTROL STRATEGY (2011 - 2016)



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EXECUTIVE SUMMARY

Noncommunicable diseases (NCDs) are defined as diseases of long duration and are generally slow in progression. They are the leading causes of adult mortality and morbidity worldwide.¹

The UN Member States recognize the challenge imposed by noncommunicable diseases (NCDs) rising in epidemic proportion and having a direct impact on social and economic development, contributing to poverty, and threatening the achievement of Millennium Development Goals (MDGs). In September 2011, the UN Summit on NCDs released a statement in the *'Political Declaration of the United Nation on the Prevention and Control of Noncommunicable Diseases,'* where member States realized the need to tackle cancer and other NCDs on a global scale. Among the interventions identified were the multi-sectoral responses and the integration of NCD policies and programmes into the broader health and development agenda.²

In the Philippines, chronic noncommunicable diseases also dominate the major causes of death. In 2004, the Department of Health (DOH) data³ showed that the ten top causes of deaths were diseases of the heart; diseases of the vascular system; malignant neoplasm; pneumonia; accidents; tuberculosis; chronic lower respiratory diseases; diabetes mellitus; certain conditions originating in the perinatal period; and nephritis and nephrosis. Among these, tobacco contributes to, or aggravates all of the causes except for accidents and nephritis.⁴

¹Noncommunicable Diseases in the Southeast Asia Region: 2011 Situation and Response

²UN Summit on NCDs-Political Declaration, September 2011

³Health Statistics, Department of Health (DOH-NEC 2004)

⁴Tobacco in the Philippines: Comprehensive Country Profile (Draft.) July 2010

Globally, tobacco use is the leading preventable cause of death and its effects –health, social, and economic – are devastating. In the Philippines, the annual productivity losses from premature deaths for four smoking-related diseases - lung cancer, cardiovascular diseases, coronary artery disease, and chronic obstructive pulmonary diseases – ranged from US\$ 65.4 million to US\$ 1.08 billion using the conservative Peto-Lopez estimates (“Tobacco and Poverty Study in the Philippines,” GATS 2009). If current global trends continue, it is likewise estimated that tobacco will kill more than eight million people annually by 2030, with three-quarters of deaths being in low and middle-income countries.⁵

According to the World Health Organization (WHO), one-third of the world’s smokers reside in the Western Pacific Region (WPR), which comparatively has the greatest number of smokers among the other five WHO regions.⁵ The Philippines, being a tobacco-growing country, is one of the countries in the Western Pacific Region with high prevalence of tobacco use. The 2009 Philippines Global Adult Tobacco Survey (**GATS**) shows that overall, 28.3% (17.3 million) of the population aged 15 years old and over in the Philippines currently smoke tobacco.⁶

The Philippines started tobacco control efforts in 1987 and since then, despite the strong lobbying of the tobacco industry, the country successfully passed the **Republic Act 9211 (Tobacco Regulation Act of 2003)** on June 23, 2003 as the first comprehensive national legislation on tobacco control. Among the main thrusts of the law are: (a) Promotion of a healthful environment; (b) Dissemination of information regarding the health risks associated with tobacco use; (c) Regulation and subsequent ban of all tobacco advertisements and sponsorships; (d) Regulation of the labeling of tobacco products; and (e) Protection of the youth from starting a life-long addiction to tobacco use by prohibiting the sale of tobacco products to minors.

The WHO WPR had also developed the first Regional Action Plan (**RAP 1990-1994**) for the Tobacco Free Initiative in the early ‘90s. Since then, there has been a continuous progress in tobacco control initiative in the Region highlighted by the entry into force of the WHO Framework Convention on Tobacco Control (**WHO-FCTC**) in 2005.

The Philippines, being in the WPR and an eligible Party to the WHO-FCTC, is obligated to implement the treaty in order to realize the vision of the people, the communities, and the environments in the Region to be freed from tobacco.⁵ The Philippines became a signatory to FCTC on September 23, 2003. The Senate of the Philippines, in turn, ratified this treaty on June 06, 2005.

From the treaty’s first preambular paragraph, which states, “**...the Parties to this Convention are determined to give priority to their right to protect public health,**” the treaty has been

⁵Regional Action Plan for Tobacco Free Initiative in Western Pacific Region, 2010-2014

⁶Philippines 2009 Global Adult Tobacco Survey (GATS)

the most widely embraced treaty in the history of the United Nations that acknowledges the right of all people to the highest standard of health.⁷ Now with 174 countries as parties to the convention (WHO-FCTC report, 2012), the treaty focuses on marketing bans, public awareness, raising taxes, preventing sales to minors, and control of the illicit trade of tobacco products.⁸

The full implementation of the WHO-FCTC can only be achieved through engagement of all relevant sectors of government, civil society, and non-government organizations to take action within their social, cultural, occupational, and political networks and spheres of influence.⁵ Through a national initiative between May 3 and 12, 2011, a group of 14 national, international, and WHO health experts, in collaboration with a team from the DOH, held individual interviews with 128 individuals representing 78 institutions in order to assess the country's tobacco control efforts in implementing the WHO-FCTC.⁹

The assessment team reviewed the existing tobacco epidemiologic data as well as the status and present development efforts of key tobacco control measures undertaken by the government in collaboration with other sectors. The assessment team has perceived the following to be the most significant challenges to continued progress of tobacco control in the Philippines: (1) Cigarettes are highly affordable in the Philippines, largely due to low taxes and a complex tax structure; (2) Effective local government efforts for creating smoke-free environments exist and non-governmental organizations are making important contributions; (3) The lack of a coordinated national cessation infrastructure/system and cessation providers hampers the implementation of the national cessation policy; (4) Mass media activities are irregular and use weak, ineffective content; (5) Graphic health information on all tobacco packages (introduced by DOH AO 2010-0013) can be implemented even though court cases are pending; and (6) The National Tobacco Control Strategy (**NTCS 2011-2016**) and Medium Term Plan (**MTP 2011-2013**) are still to be developed.⁹

Following the National Capacity Assessment for Tobacco Control, the Philippine National Tobacco Control Strategy for 2011-2016 (**NTCS 2011-2016**) was developed by the team of experts from the Department of Health and other sectors of the government, with the structure and content of the plans being consistent with the strategic approach of the WHO-FCTC. The **Vision** is to achieve and reinforce a social environment that will help build a “Tobacco-free Philippines: Healthier People, Communities, and Environments” through well-planned and definite strategies; and the **Mission** is to advocate, enable, and mobilize multi-sectoral support for stronger tobacco policies and programs in line with the WHO-FCTC.

The three main **Strategies** are to focus on the following: (1) promote and advocate for the complete implementation of WHO-FCTC in the country; (2) mobilize for public action; and

⁷ Manual for the Implementation of RA 9211 (Tobacco Regulation Act of 2003), UP College of Law Development Foundation, 2010

⁸ Council on Foreign Relations: Global Action on Non-Communicable Diseases, September 2011

⁹ Joint National Capacity Assessment on the Implementation of Effective Tobacco Control Policies in the Philippines, May 2011

(3) strengthen the organizational capacity. The first strategy will largely be dependent on the two other strategies. Specific strategies under strategies 2 and 3 were determined based on the gaps identified by the following: a) National Capacity Assessment team; b) the WHO-RAP country actions and indicators; and c) WHO-MPOWER package, the last item of which refers to a series of six proven policies aimed at reversing the global tobacco epidemic.

Under Strategy 2, sub strategies were laid down on: (1) Legislation and Policies; (2) Tobacco Taxation; (3) Governance and Local Enforcement; and (4) Alliances and Partnerships.

As for Strategy 3 the NTCS specifies the following: (1) Investment Planning and Resource Management (Medium term Plan on Tobacco Control); (2) Leadership Training and Human Resource Development; (3) Surveillance, Monitoring and Knowledge Management; (4) Public awareness, education, communication and advocacy; and (5) Smoking cessation and tobacco dependence treatment.

The National Tobacco Control Strategy reflects the government's political commitment for the complete implementation of the WHO-FCTC to protect public health from the devastating effect of tobacco use; it builds on the premise that future generations of Filipinos will be given the right to live in a protected environment and communities freed from the bondage of tobacco use and relieved from the socio-economic burden of tobacco-related diseases.



INTRODUCTION

CONCEPT AND RATIONALE

The World Health Organization (WHO) estimates that about 4 million people die every year of tobacco-related diseases.¹⁰ If current global trends continue, it is estimated that tobacco will kill more than eight million people annually by 2030, and three-quarters of these deaths will be in low and middle-income countries.¹¹

One-third of the world's smokers reside in the Western Pacific Region (WPR), which comparatively has the greatest number of smokers among the other five WHO regions.⁵ The Philippines, being a tobacco growing country, is one of the countries in the Western Pacific Region with high prevalence of tobacco use with over 81 billion cigarettes being sold in the Philippines in 2008.²

The many social, economic, and health burdens from tobacco use pose a major challenge to the Philippine government to strengthen its tobacco control efforts. Tobacco kills approximately 87,600 Filipinos per year (240 deaths every day), one-third of them men in the most productive age of their lives.⁹ In 2005, the economic costs of tobacco use were over PHP148 billion while the revenue from tobacco industry was about PHP25.65 billion.⁹

All eligible parties in the WPR have ratified the WHO Framework Convention on Tobacco Control (WHO-FCTC), the first public health treaty negotiated under the auspices of WHO. The treaty is an instrument that reaffirms the “right of all people to the highest standard of health” (Preamble to the Constitution of the WHO, 1946).

¹⁰ Advancing Tobacco Control through Evidence-Based Programs, CDC, 2010

¹¹ Tobacco Burden Facts in the Philippines, 2008

The Philippines, being an eligible Party in the WPR, is bound to meet the obligations to the WHO-FCTC and to develop an effective national tobacco control program. The Philippine National Tobacco Control Strategy is the country's response to protect public health from the damaging effects of tobacco use. The time to act is NOW.

Prevalence of Tobacco Use in the Philippines

Overall, 28.3% (17.3 million) of population aged 15 years old and over currently smoke tobacco. Of these, 14.6 million (47.7%) are men, and 2.8 million (9.0%) are women. The 2007 Philippine Global Youth Tobacco Survey (GYTS) further shows that about 27.3% currently use any tobacco product (34.4%, men and 19.6%, women).¹²

Exposure to secondhand smoke (SHS) is likewise high. In the Philippine GATS 2009 survey, among the 61.3 million adults aged 15 and older, 48.8% (29.8 million) claimed to allow smoking in their home; while in the GYTS 2007 survey, it shows that 57.8% of youths live in homes where others smoke in their presence, and another 67.9% are around others who smoke in places outside their home.¹³

Among those who work indoors or in enclosed areas, 36.9% (6.1 million) were exposed to SHS at work, including 30.8% (3.7 million) non-smokers. In public transport, exposure to SHS was 55.3%; in restaurants, 33.6%; in government buildings, 25.5%; and in health care facilities, 7.6%.¹⁴

Cigarette smoking has a wide range of effects, for it affects not only the smoker, but secondhand smokers as well.

Health Effects of Tobacco Use: Morbidity and Mortality of Tobacco-Related Diseases

Four main diseases are generally considered to dominate NCD mortality and morbidity: (1) cardiovascular diseases (including heart disease and stroke); (2) diabetes; (3) cancers; and (4) chronic respiratory diseases, including chronic obstructive pulmonary disease (COPD) and asthma. These four NCDs are caused, to a large extent, by four modifiable behavioral risk factors: tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.¹⁵

Among the identified risk factors contributing to NCDs, tobacco is considered responsible for more than two-thirds of lung cancer; 40% of chronic respiratory diseases; and 10% of

¹² Philippines Global Youth tobacco Survey (GYTS)

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Noncommunicable Diseases in the Southeast Asia Region: 2011 Situation and Response"

cardiovascular diseases. An estimated six million people die from tobacco use each year, causing nearly 10% of all deaths worldwide, two million more than AIDS, malaria, and tuberculosis combined.¹⁶

Smoking kills up to half of all lifetime users.¹⁷ It is an epidemic that kills ten Filipinos every hour.¹⁸ Tobacco use was responsible for over 58 thousands deaths or nearly 12% of all deaths in the Philippines in 2004, according to the WHO calculations. Almost 80% of these deaths caused by tobacco was among men.¹⁹ An estimated 6-8% of all deaths in the country are attributable to the four tobacco-related diseases causing between 23,000-35,000 tobacco-related deaths per year.

These damaging effects of tobacco to life will continue until its use is controlled. Urgent action must be taken to reduce and reverse the morbidity and mortality from tobacco-related diseases.

¹⁶ Council on Foreign Relations: Global Action on Non-Communicable Diseases, September 2011

¹⁷ American Cancer Society; 2006

¹⁸ Manual for the Implementation of RA 9211 (Tobacco Regulation Act of 2003), UP College of Law Development Foundation, 2010"

¹⁹ Tobacco in the Philippines: Comprehensive Country Profile (Draft.) July 2010"



TOBACCO CONTROL POLICIES IN THE PHILIPPINES

Government Agencies Implementing Tobacco Control

To reduce the use of tobacco and tackle its serious consequences, the Philippines started tobacco control efforts in 1987 and has intensified these over time.

Prior to 2000, tobacco control was only a component program of the National Cardiovascular and Cancer Control Programs in the Philippines. In 1999, the Philippine parliament passed the **Clean Air Act** or **Republic Act 8749** which included provisions for protection from SHS. The Clean Air Act identified cigarette smoke as a pollutant and instituted smoke-free indoor laws.²⁰

In June 2003, **Republic Act 9211**, also known as the **Tobacco Regulation Act of 2003**, became a law in the Philippines. The law included landmark legislation with provisions on effective tobacco control in the country, which aimed to: (a) Promote smoke-free areas; (b) Inform the public of the health risks on tobacco use; (c) Ban all tobacco advertisement and sponsorship and restrict promotions; (d) Regulate labeling of tobacco products; and (e) Protect youth from being initiated to smoking.

In May 2003, the WHO-FCTC was adopted by the 56th World Health Assembly; on February 27, 2005, it was made an international law (WHO-FCTC, 2003). The treaty calls for countries to establish programs for national, regional, and global tobacco surveillance; it also encourages countries to develop and implement tobacco control action plans. On June 06, 2005, the Philippines ratified the WHO-FCTC. *(Please refer to **Annex 7** of the document for the details on WHO-FCTC.)*

²⁰ Philippines 2009 Global Adult Tobacco Survey (GATS)

The Government of the Philippines continues to coordinate and implement the tobacco control policies mainly through the Department of Health (DOH). Despite the fact that unofficial initiatives for tobacco control at the DOH started back in 1994 as part of the Noncommunicable Diseases Control Program, it was only in 2007 when the DOH officially designated the National Centre for Diseases Prevention and Control (**NCDPC**) as the coordinating unit for tobacco control.²¹

The DOH, together with the other agencies of the government, has issued administrative orders and joint memoranda to address the problem on tobacco use. **Administrative Order 2007-0004** or the National Tobacco Prevention and Control Program (**NTPCP**) was issued to define the roles and responsibilities of the different offices under DOH and of other departments. The lead office for tobacco control is the DOH-National Center for Disease Prevention and Control (**NCDPC**).

In 2009, the DOH started implementing the **Bloomberg Project** entitled, “*Moving to the Next Level in the Philippines: Complete Implementation of the WHO-Framework Convention on Tobacco Control (WHO-FCTC.)*” The project is tasked to supplement the country’s tobacco prevention efforts, in congruence with the DOH-National Center for Health Promotion (**NCHP**), and to enforce of WHO-FCTC effectively.

The key initiatives of the project include the development of a comprehensive National Tobacco Control Strategy (**NTCS 2011-2016**) and Medium Term Plan (**MTP 2011-2013**), creation of the National Tobacco Control Coordinating Office (**NTCCO**) within the DOH, as well as the formation of the DOH Tobacco Control Team (**TCT**) and Sector-Wide Anti-Tobacco (SWAT) Committee and its 11 Sub-committees for the implementation of WHO-FCTC provisions. The **NTCCO** is in charge of working with other sectors of the DOH to synchronize tobacco control efforts. The Development Academy of the Philippines (DAP), through the **DOH- Bloomberg Initiative Project OC-401**, was commissioned to facilitate the development of the National Tobacco Control Strategy (**NTCS**) for 2011-2016 through the DOH-NCHP starting May 2011.

Among the other DOH initiatives are: (1) Passage of Administrative Order (**AO No. 122 s. 2003**) on ‘Smoking Cessation Program to Support the National Tobacco Control and Healthy Lifestyle’ in 2003; (2) Passage of Administrative Order (**AO 2009-0010**) promoting a 100% Smoke-free environment in 2009, which became the basis of the DOH Red Orchid Awards; (3) Issuance of an Administrative Order (**AO No. 2010-0013**) on Graphic Health Information in 2010; (4) Passage of **Department Circular 2011-0101** which has set rules and regulations of the Food and Drug Administration (after **Administrative FDA Act 9711-2009**) tasking the FDA (under its article III) to regulate tobacco; and (5) Formulation of the National Tobacco Control Strategy (**NTCS 2011-2016**) in 2011.

²¹ Joint National Capacity Assessment on the Implementation of Effective Tobacco Control Policies in the Philippines, May 2011

The Universal Health Care (**UHC**), which is the health agenda of the present administration, is directed towards “ensuring the achievement of the health system goals of better health outcomes, sustained health financing, and responsive health system by ensuring that all Filipinos, especially the disadvantaged group in the spirit of solidarity, have equitable access to affordable health care.” Among the strategic thrusts of UHC is the achievement of the “MDG max” targets on lifestyle-related Noncommunicable diseases such as cerebro-vascular diseases, diabetes mellitus, chronic obstructive pulmonary diseases, and cancers. This makes tobacco control and prevention strategies one of the cornerstones in achieving the National Objectives for Health (NOH) of the DOH on NCDs.

Aside from DOH, other government agencies have been involved in tobacco control. The Civil Service Commission (CSC), an independent constitutional body played fundamental role in recent years by issuing several joint memoranda with the DOH. Similarly, the Land Transportation Franchising Regulatory Board (**LTFRB**), Philippine National Police (**PNP**), Development Academy of the Philippines (**DAP**), and Metropolitan Manila Development Authority (**MMDA**) played key roles focusing on smoke-free places initiatives. Using the existing communication materials, they contributed to awareness-raising-campaigns and smoking-cessation activities.²²

At the sub-national level, the local government units (**LGUs**) also play an important role in the law implementation and have the mandate to ensure proper enforcement of RA-9211 along with members of the Philippine National Police (**PNP**) and other stakeholders. The DOH regional structures (**Centers for Health Development**) conduct tobacco control activities through their focal point for health promotion and for NCDs, especially in those regions/districts where local ordinances for creating smoke-free environments were introduced and enforced.²³ *(Please see **Annex 1** for the LGU tobacco interventions and best practices).*

Civil Society Implementing Tobacco Control

The Philippines also has a large and active civil society network that has proven to have an important role in keeping tobacco control in the government agenda. The non-governmental (**NGO**) sector includes advocacy groups; faith based organizations; academia; health professional groups; as well as local branches of international organizations. *(Please see **Annex 1** for the list of Non-Government and civil society group active in Tobacco Control.)*

*(For the other tobacco control interventions by government and non-government institutions, including those of the LGUs’ and the Red Orchid awards, please refer to Annexes 1 and 3 of the document. The Tobacco Control Coordinating bodies and other DOH initiatives can be accessed in **Annexes 2 and 3**, respectively. Policies and Ordinances pertaining to undue Tobacco industry Interference, Smoke-Free initiatives, and on Tobacco Advertising Promotion and Sponsorship can be accessed in **Annexes 4, 5, and 6**, respectively.)*

²²National Capacity Assessment on the Implementation of Effective Tobacco Control Policies in the Philippines, May 2011

²³Ibid.



THE NATIONAL CAPACITY ASSESSMENT FOR TOBACCO CONTROL

As a party to the WHO-FCTC, the government, represented by a DOH team joined a group of 14 national, international, and WHO health experts to assess the country's tobacco control efforts in implementing the WHO-FCTC between May 3 and 12, 2011.

The assessment team held individual interviews with 128 individuals representing 78 institutions and reviewed existing tobacco epidemiologic data as well as the status and present development efforts of key tobacco control measures undertaken by the government in collaboration with other sectors. The key informant institutions included the majority of the tobacco control stakeholders in the country, including central and regional/local governmental agencies with regulating roles or implementing responsibilities, the Senate and the Congress, the Office of the President, civil society, pharmaceutical sector, media, and academia.

The assessment team found that the Philippines has made a number of achievements in tobacco control. The country has, for its part, done the following:

- Ratified the WHO-FCTC
- Committed to control noncommunicable diseases (NCDs), many of which are attributable to tobacco use, under an MDG Max framework as part of the universal health coverage strategy
- Passed RA 9211 - which was a progress of its time
- Introduced important restrictions in advertising, promotion, and sponsorship
- Implemented smoke-free indoor environments in many government agencies
- Approved strong graphic warnings
- Produced good and updated tobacco surveillance data for both adults and youth

- Introduced effective mechanisms to monitor the influence of the tobacco industry on government
- Achieved great progress of local government in passing smoke-free ordinances that do not allow smoking areas indoors and in public places

In addition, the country's DOH officials and its strong and vibrant civil society organizations have committed themselves to tobacco control.

Furthermore, the assessment team has perceived that the progress achieved in tobacco control in the Philippines can and must be accelerated.

The Assessment Team considers the following to be the most significant challenges to continued progress of tobacco control in the Philippines:

1. RAISE TAXES AND PRICES OF TOBACCO

Cigarettes are highly affordable in the Philippines, largely due to low taxes and a complex tax structure. Little of the revenue from these taxes has been used for health purposes, and health consequences of the existing tobacco tax system appear not to be fully appreciated by policy makers.

2. PROTECT PEOPLE FROM TOBACCO SMOKE

Effective local government efforts for creating smoke-free environments exist and non-governmental organizations are making important contributions. However, there is a lack of financial and technical support necessary for the sustained countrywide reach required to deliver potentially large health benefits.

3. OFFER HELP TO QUIT TOBACCO USE

There is a need for a coordinated national cessation infrastructure/system; in addition, the lack of cessation providers hampers the implementation of the national cessation policy.

4. WARN PEOPLE ABOUT THE DANGERS OF TOBACCO

Mass media activities are irregular and use weak, ineffective content. Graphic health information on all tobacco packages (introduced by DOH AO 2010-0013) can be implemented even though court cases on this issue are pending.

5. DEVELOP COORDINATION AND IMPLEMENTATION MECHANISMS

The National Tobacco Control Strategy (NTCS 2011-2016) and Medium Term Plan (MTP 2011-2013) are still to be developed. Coordination and funding mechanisms are not yet defined and regularly allocated, and the Sector-Wide Anti-Tobacco (SWAT) Committee has yet to be officially constituted.

6. SUSTAIN MONITORING AND EVALUATION EFFORTS

The Philippines has recent, representative, and periodic tobacco surveillance data for both adults and youth. However, sustainability is a challenge. Ensure sustainability of existing surveillance efforts by integrating a core set of GATS questions and methods into ongoing surveys.

7. ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP

The enforcement of the current restrictions on the tobacco advertising, promotion, and sponsorship is weak, mainly due to poor clarification of agencies, rules and regulations, and lack of strong enforcement mechanism. Strengthen the enforcement mechanism of the current TAPS' restrictions, through coordinated action at local jurisdictions, under the DOH leadership and coordination.

To ensure the sustainability of current initiatives and further progress, the DOH identified the following key recommendations as critical and have the best potential for success in the short term.

1. Simplify the existing tobacco tax structure, significantly raise tobacco product excise taxes, and index taxes to inflation in order to raise tobacco product prices and reduce tobacco use. Also, earmark revenues from tobacco taxes for health priorities.
2. At least double the number of LGUs with 100% smoke-free policy initiatives (no designated smoking areas indoors) through dedicated financial and technical support and active involvement of non-governmental organizations.
3. Develop a coordinated national cessation infrastructure that incorporates both population and clinical approaches in a stepwise manner; build on and augment existing resources and service delivery mechanisms; commence implementation in those LGUs where the demand for cessation already exists and where smoke-free policy support is strong.
4. Initiate a sustained programme of quarterly public awareness campaigns with content proven as effective in the Philippines.
5. Given the scientific evidence supporting the use of graphic health information, the DOH should encourage and support LGU implementation.

6. Finalize and officially make a National Strategy and Plan of Action that will be reviewed regularly. Key highlights of the Plan of Action would include:
 - a. A full-time staff in charge of the National Tobacco Control Coordination Office (NTCCO) and dedicated staff and focal points from the different DOH offices. Food and Drug Administration (FDA) and Philippine Health Insurance Corporation (PhilHealth) have a key role in the implementation and enforcement of tobacco control measures and should be fully involved in the implementation process.
 - b. A dedicated regular budget allocated for the NTCCO and relevant offices.
 - c. The Sector-Wide Anti-Tobacco (SWAT) Committee as an official national body with clear composition and mandate to direct and facilitate the implementation and reporting of Philippines legal binding obligations to the WHO-FCTC.
 - d. Mechanisms of collaboration established with local governments and key stakeholders including the civil society with the exception of the participation of the representatives from the tobacco industry.

*(Complete findings and recommendations by the National Assessment Team can be accessed in the National Capacity Assessment Report for Tobacco Control – The Philippines, May 2010 and partly presented in **Annex 8** of this document.)*



PHILIPPINE NATIONAL TOBACCO CONTROL STRATEGY (2011-2016): THE COUNTRY'S RESPONSE

The full implementation of the WHO-FCTC can only be achieved through engagement and partnerships with all relevant sectors of government, civil society and non-government organizations. The Philippine National Tobacco Control Strategy (**NTCS 2011-2016**) is the government's response to its political commitment for the complete implementation of the WHO-FCTC.

Following the National Capacity Assessment for Tobacco Control, the DOH-NCHP in partnership with DAP held a series of expert consultation workshops through the DOH-Bloomberg Initiative Project OC-401, where representatives from the government agencies, advocacy groups, NGOs and local government units (LGUs) participated and provided inputs to the planning for the Philippine National Tobacco Control Strategy for 2011-2016 (**NTCS 2011-2016**).

The planning commenced on May 25-26, 2011 with the Experts' workshop on 'Drafting the National Tobacco Control Strategy'; this was followed by three other Regional workshops for Luzon, the Visayas, and Mindanao.

The workshops took into consideration the following documents to achieve the overall objectives of the plan and to come up with the National Tobacco Control Strategy:

- 1. Regional Action Plan (RAP) for Tobacco Free Initiatives for WPRO (2010-2014).** This plan is a product of consultative activities that began in August 2008 to sustain action on the implementation of WHO-FCTC. It consists of a comprehensive plan of action which puts emphasis on the importance of setting indicators and targets for all levels for tobacco control and on strengthening national coordinating mechanisms of countries.

2. **The MPOWER package.** This is a set of six proven policies aimed at reversing the global tobacco epidemic and includes: **M**onitor tobacco use and prevention policies; **P**rotect people from tobacco smoke; **O**ffer help to quit tobacco use; **W**arn about the dangers of tobacco; **E**nforce bans on tobacco advertising, promotion, and sponsorship; and **R**aise taxes on tobacco. The package was identified in 2008 to serve as a platform to support the implementation of WHO-FCTC in countries.
3. **Report of the National Capacity Assessment for Implementing WHO-FCTC in May 12, 2011.** This contains the recent findings of the National Assessment Team which showed significant challenges and progress of the tobacco control programme's implementation in the country. The Team used the MPOWER package as guide or reference for the assessment.
4. **UN Summit on NCDs-Political Declaration, September 2011.** This contains the draft resolution on the Political Declaration of the High-level Meeting on the Prevention and Control of Noncommunicable Diseases during the United Nations' General Assembly on 19 to 20 September 2011. The resolution aimed to address the prevention and control of noncommunicable diseases worldwide, with a particular focus on developmental and other challenges and social and economic impacts of NCDs, particularly for developing countries.²⁴

Following the refinement of the outputs of the five (5) consultative workshops together with the result of the National Capacity Assessment for Tobacco Control in May 2011, and another consultative meeting on the Finalization of the NTCS and Development of Monitoring and Evaluation (M & E) Framework in February, 2012, the result was the final NTCS 2011-2016 which included all outputs during the consultation process. (See Figure 1)

The **Vision** is to achieve a “Tobacco-free Philippines: Healthier People, Communities, and Environments,” with a **realistic view** of a nation freed from the bondage of tobacco use and people relieved from the burden of tobacco-related diseases through well-planned and well-defined strategies.

The **Mission** is to advocate, enable, and mobilize multi-sectoral support for stronger tobacco policies and programs in line with the WHO-FCTC.

To achieve these, two primary **goals** were identified, namely: (1) to attain the lowest possible prevalence of tobacco use and (2) to attain the highest level of protection from secondhand smoke (SHS).

In order to attain the first goal of having the lowest possible prevalence of tobacco use, two **objectives** have been identified: (1a) reduce the prevalence of adults' current tobacco use by 2% per year and (1b) reduce the prevalence of youths' current tobacco use by 2% per year.

²⁴ Noncommunicable Diseases in the Southeast Asia Region: 2011 Situation and Response

For the second goal, which is to attain the highest level of protection from secondhand smoke (SHS), two **objectives** have been identified: (2a) increase the level of protection from secondhand smoke by 2% per year among adults and (2b) increase the level of protection from secondhand smoke by 2% per year among 13-15 years old (y/o).

Three (3) main **Strategies** were also determined, namely: (1) promote and advocate for the complete implementation of WHO-FCTC in the country; (2) mobilize for public action; and (3) strengthen the organizational capacity.

STRATEGY 1: This overarching strategy aims to promote and advocate at the highest levels of government the complete implementation of the WHO-FCTC.

This overarching strategy can only be achieved when strategies 1 and 2 are implemented.

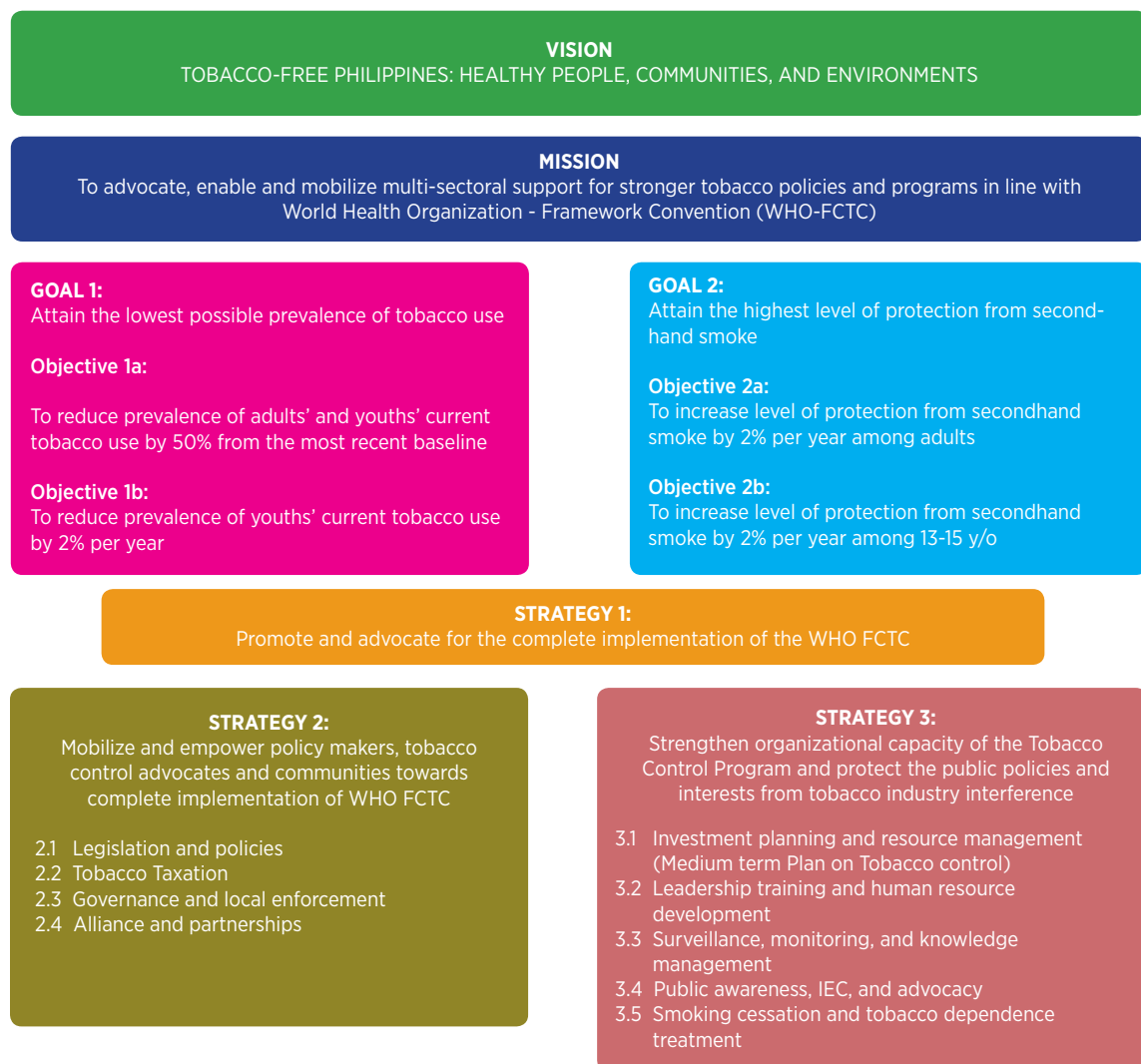
Strategy 2 was further broken down into four (4) sub strategies, Strategy 3 into other five (5) sub strategies (see below).

Specific objectives, action plans, and indicators under Strategies 2 and 3 were based on the country's needs consistent with the WHO-FCTC and WHO RAP for 2010-2014. The results of the Experts' and Regional Consultation Workshops, the recommendations by the National Capacity Assessment team, and the WHO MPOWER packages were also used as bases for the formulation of the strategies. (See **Annexes 8, 9 and 10** for details.)

PHILIPPINE NATIONAL TOBACCO CONTROL STRATEGY (2011-2016) FRAMEWORK

THE PHILIPPINE NATIONAL TOBACCO CONTROL STRATEGY (2011-2016)

Figure 1: National Tobacco Control Strategy (2011- 2016) Framework



VISION: Tobacco-Free Philippines: Healthier People, Communities, and Environments

MISSION: To advocate, enable, and mobilize multi-sectoral support for stronger tobacco policies and programs in line with World Health Organization Framework Convention on Tobacco Control (WHO-FCTC).

GOAL 1: Attain the lowest possible prevalence of tobacco use

Objective 1a: To reduce prevalence of adults' current tobacco use by 2% per year

Objective 1b: To reduce prevalence of youths' current tobacco use by 2% per year

GOAL 2: Attain the highest level of protection from secondhand smoke (SHS)

Objective 2a: To increase level of protection from secondhand smoke by 2% per year among adults

Objective 2b: To increase level of protection from secondhand smoke by 2% per year among 13-15 y/o

STRATEGY 1: Promote and advocate for the complete implementation of the WHO-FCTC

STRATEGY 2: Mobilize for public action

Strategy 2.1: Legislation and policies

Strategy 2.2: Tobacco taxation

Strategy 2.3: Governance and local enforcement

Strategy 2.4: Alliances and partnerships

STRATEGY 3: Strengthen organizational capacity

Strategy 3.1: Investment planning and resource management (Medium Term Plan on Tobacco control)

Strategy 3.2: Leadership training and human resource development (Regular GATS/ GYTS, surveillance, and other Research activities)

Strategy 3.3: Surveillance, monitoring, and knowledge management

Strategy 3.4: Public awareness, IEC, and advocacy

Strategy 3.5: Smoking cessation and tobacco dependence treatment

The following table shows the specific objectives²⁵, key action points, and indicators of the different strategies under **Strategy 2**.

²⁵Source: RAP for the Tobacco Free Initiative in the WPR (2010-2014)

Table 1: Strategies, Key Actions and Performance Indicators under Strategy 2

STRATEGY 2: MOBILIZE FOR PUBLIC ACTION		
Strategies	Key Actions	Performance Indicators
<p>2.1. Legislation and policies in compliance with WHO-FCTC</p> <p><i>Specific objective:</i> To develop legislation and related policies, regulations, ordinances administrative issuances and other measures to ensure timely compliance with all provisions of the WHO-FCTC, with specific reference to WHO-FCTC articles that have deadlines, approved guidelines or protocols. Legislation and policy components clearly stated in national action plans</p>	2.1.1 Develop tracking and monitoring system for illicit trade of tobacco products	<ul style="list-style-type: none"> • Policy for the infrastructure and system in place • Data available for action
	2.1.2 Review and develop policy related to product ingredients' regulations.	<ul style="list-style-type: none"> • Policy approved and implemented
	2.1.3 Push for legislation of packaging and labeling pending in the Congress	<ul style="list-style-type: none"> • Passage of legislation
	2.1.3.1 Review and study how to enforce AO 2010-0013 (Graphic Health Information)	<ul style="list-style-type: none"> • Recommendations for action on how to enforce AO 2010-0013
	2.1.4 Amend RA 9211 (Tobacco Regulation Act) to make it WHO-FCTC compliant	<ul style="list-style-type: none"> • Draft bills amending RA 9211 submitted to Congress
	2.1.5 Address Tobacco Industry Interference	<ul style="list-style-type: none"> • WHO-FCTC Article 5.3 incorporated in tobacco control (TC) ordinances in 50% of cities and municipalities • Legislative proposal submitted to Congress on areas where WHO-FCTC Art. 5.3 are not covered by JMC and other laws
2.1.5.1 Identify areas in WHO-FCTC Art. 5.3 not covered by DOH-CSC Joint Memorandum Circular (JMC) 2010-01 and other laws, and draw up a legislative proposal		
<p>2.2 Tobacco taxation</p> <p><i>Specific Objectives:</i> To introduce and implement tax and price measures that will result in the reduction of tobacco consumption; and to dedicate a significant proportion of the revenue from tobacco taxes to health promotion and tobacco control, including treatment for tobacco dependence.</p>	2.2.1 Simplify the tobacco taxation structure and significantly raise tobacco taxes with indexation of prices for inflation	<p>Law passed with the following elements:</p> <ul style="list-style-type: none"> • Increase in tobacco taxes • Index of price for inflation • Unitary tax rate • Removal of price classification freeze (1996)

	2.2.2 Allocate from tobacco taxes revenues for health priorities, social health insurance coverage, and health promotion	<ul style="list-style-type: none"> • Increased percentage of proportion of revenue from tobacco taxes allocated to health promotion and social health insurance coverage • Tobacco taxes revenues allocated for health priorities, and included in the consolidated tobacco tax bill • Health Promotion Foundation (HPF) established with funding from tobacco tax (included in the legislation)
	2.2.3 Increase the licensing fee of retail sales of tobacco products.	<ul style="list-style-type: none"> • 100% increase in licensing fee/business permit in 50% of LGUs
	2.2.4 Strengthen the multi-disciplinary mechanism to implement and monitor a strategy for effective tobacco tax and pricing to reduce tobacco consumption	<ul style="list-style-type: none"> • Monitoring tool/s and results
Governance and local enforcement Specific objectives: To implement and enforce laws and policies through national coordinating mechanisms or their equivalent, protect policies and programmes from the influence and interference of the tobacco industry, and promote good governance measures (i.e. strategic vision, participation, transparency and accountability, with specific reference to healthy cities, and islands, communities, and settings) to achieve tobacco control. ¹⁵	2.3.1 Enforce existing policies on Tobacco Advertising, Promotion, and Sponsorship (TAPS) ban	<ul style="list-style-type: none"> • 25% of municipalities and cities enforcing TAPS ban
	2.3.2 Develop guidelines for effective monitoring of TAPS based on WHO-FCTC	<ul style="list-style-type: none"> • Guidelines on monitoring TAPS ban
Alliance and partnership Specific objective: To work with relevant tobacco control stakeholders to achieve comprehensive and sustainable tobacco control and avoid interference from the tobacco industry. ¹⁵	2.4.1 Organize Regional Tobacco Control Network (RTCN)/ Regional Committee on Tobacco Control (RCTC) in every region	<ul style="list-style-type: none"> • Memorandum of Understanding (MOU) signed • RTCN/RCTC in all regions
	2.4.2 Organize Sector-Wide Anti-Tobacco (SWAT) Committee	<ul style="list-style-type: none"> • MOU signed

STRATEGY 2: MOBILIZE FOR PUBLIC ACTION

This is to mobilize and empower policy-makers, tobacco control advocates and communities towards complete implementation of the WHO-FCTC through legislation and policies, tobacco taxation, governance and enforcement, and alliances and partnerships for changing social norms.²⁶

STRATEGY 2.1: LEGISLATION AND POLICIES IN COMPLIANCE WITH WHO-FCTC

2.1.1 Develop tracking and monitoring system for illicit trade of tobacco products²⁷

Tax authorities do not effectively monitor cigarette production, and many cigarettes reported to be intended for export or sale in duty free outlets are sold domestically. The government loses significant revenues because of tobacco tax evasion and avoidance. **Over 20%** of cigarette production is estimated to evade all domestic tobacco taxes.

Weak tax administration is a major contributor to tobacco **tax evasion**. While there have been recent efforts to **address illicit trade**, these have been undertaken as part of a broader anti-smuggling agenda in the Bureau of Customs and there are no programs that specifically target tobacco products.

While there have been some seizures of cigarettes as part of these anti-smuggling efforts, addressing illicit tobacco trade and other tobacco tax evasion activities appears to be a low priority. Moreover, the regional partnerships that have been demonstrated to be effective elsewhere in addressing illicit trade in tobacco products do not exist in the Philippines.

In addition to tax evasion, there are also significant opportunities for **tax avoidance**. The multi-tiered tax structure facilitates tax avoidance as many brands are misclassified into lower tax tiers, a problem exacerbated by the price classification freeze.

Performance Indicators:

- Policy for the infrastructure and system in place
- Data available for action

2.1.2 Review and develop policy related to product ingredients' regulations

Strengthen tobacco control policies through regulation of the contents and emission of tobacco products and through regulation of product disclosures. Tobacco regulation has the potential to contribute to reducing tobacco-attributable disease and premature death by reducing the

²⁶ Regional Action Plan for Tobacco Free Initiative in Western Pacific Region, 2010-2014

²⁷ National Capacity Assessment, section VIII.2.4.

attractiveness of tobacco products, reducing their addictiveness (or dependence liability), or reducing overall toxicity (WHO-FCTC).

Performance Indicator:

Policy approved and implemented

2.1.3 Push for legislation of packaging and labeling pending in the Congress²⁷

DOH issued Administrative Order 2010-13 (AO 2010-0013) in May 2010. This Order enables DOH to implement rotating evidence-based Graphic Health Information (GHI) (30% of front and 60% of back of package). The AO requires Graphic Health Information on tobacco product packages, adopting measures to ensure that tobacco product packaging and labeling do not promote tobacco by any means that are false, misleading, deceptive, or likely to create an erroneous impression and matters related thereto.

Despite the tobacco industry's interference, the DOH may push forward on implementing pictorial health warnings. It has the authority to implement the AO in all jurisdictions except those that are currently under legal dispute. By virtue of the Constitution and the Administrative Code of 1987, DOH has the authority to ensure propagation of health information. Pending final resolution of court cases, DOH could assert its authority everywhere except in Tanauan, Southern Luzon, Malolos, Central Luzon and in the Metro Manila cities of Marikina, Pasig, and Parañaque.

DOH argues that the legal basis of the AO is both the Consumer Protection Act, a national law, and made consistent with WHO-FCTC and its guidelines.

Performance Indicator:

Passage of legislation

2.1.3.1 Review and study how to enforce AO 2010- 0013 (Graphic Health Information)

DOH should issue guidelines on Graphic Health Information (GHI) and misleading descriptors; ensure that effective, distinct, and highly visible graphic health information is placed on tobacco product packages; and ensure that tobacco product packaging and labeling do not promote a tobacco product by any means that is false, misleading, deceptive, or likely to create an erroneous impression about the product and its characteristics, health effects, hazards, or emissions.

²⁷ National Capacity Assessment, section VI.1.2.2

Given the scientific evidence supporting the use of graphic health information, LGUs should be encouraged to implement and promote this initiative with support from DOH.

Performance Indicator:

Recommendations for action on how to enforce AO 2010- 0013 (Graphic Health Information)

2.1.4 Amend RA 9211 (Tobacco Regulation Act) to make it WHO-FCTC compliant

The Sector-Wide Anti-Tobacco (SWAT) Committees should review and identify the gaps and loopholes in RA No. 9211 to make it compliant to WHO-FCTC. Key actions to support any amendment should include the following, among others:

- Convene the SWAT Committee;
- Identify provisions to be amended, as well as recommendations and proposed actions; and
- Strongly advocate and lobby to amend RA No. 9211.

Performance Indicator:

Draft bills amending RA 9211 submitted to Congress

2.1.5 Address Tobacco Industry Interference

2.1.5.1 Identify areas in WHO- FCTC Article 5.3 not covered by DOH-CSC Joint Memorandum Circular (JMC) 2010-01 and other laws, and draw up a legislative proposal²⁸

Enforcing the Civil Service Commission (**CSC**) and **Department of Health (DOH) Joint Memo Circular No. 2010-01** as well as pursuing the activities of the **SWAT Committee on Art. 5.3** should be considered as a priority for the governmental structures in their efforts to protect public health from the tobacco industry interference (TII). CSC-DOH Joint MC No. 2010-01 bans all government officials and employees from interacting with the tobacco industry, unless when strictly necessary for effective regulation, supervision, or control.

Monitoring and identifying the strategies employed by the tobacco industry to undermine, delay, and hinder the tobacco control efforts of the country should be a regular activity and preferably conducted by LGUs and other civil society organization co-funded by the government to ensure consistency, transparency, and sustainability.

²⁸ National Capacity Assessment, section II.3.5/III.3.3

In addition, regular awareness campaigns displaying tobacco industry strategies should be implemented in order to increase public and policy-makers' familiarity with and vigilance to the subject; and to increase indirectly their participation and compliance with existing tobacco control laws.

Another essential element of a supportive environment that would promote the proper implementation of Article 5.3 is for the whole bureaucracy of the government to be oriented about the provisions of Article 5.3.

Soliciting commitment to support and comply with provisions of Article 5.3 should also be done. In this way, interference by the tobacco industry could be thwarted, especially if the violations become part of the code of ethics of the whole bureaucracy. This strategy aims to widen the adoption of Article 5.3 not only in the government agencies under the executive branch, but also in offices under the legislative and judiciary branches of government, including the presidential appointees. It is expected that the entire bureaucracy, from the national level and regional levels to the field offices, adopt and comply with said provisions.

This can be achieved by implementing the following measures:

1. Increase the number of national government agencies and other government institutions adopting and implementing Joint Memorandum Circular-Civil Service Commission and DOH (CSC-DOH JMC No. 2010-01) policy and guide; and
2. Forge partnership with other relevant agencies not covered by the JMC to adopt Article 5.3.

Performance Indicators:

- WHO-FCTC Article 5.3 incorporated in Tobacco Control ordinances in 50% of cities and municipalities
- Legislative proposal submitted to Congress on areas where WHO-FCTC 5.3 are not covered by JMC and other laws.

STRATEGY 2.2: TOBACCO TAXATION

2.2.1 Simplify the tobacco taxation structure and significantly raise tobacco taxes with indexation of prices for inflation²⁹

As stipulated in Republic Act 9334 or the Sin Tax Law of 2004, a four-tier excise tax system is currently implemented for cigarettes. With this system, lower priced cigarettes are taxed at a low rate while higher priced cigarettes are taxed at a high rate, thus creating a wide price

²⁹ National Capacity Assessment, section VIII.3.1 /VIII. 1.1

gap between higher and lower priced classes of cigarettes. Replacing the Philippines' existing multi-tiered specific cigarette excise tax structure with a uniform specific tax on all cigarettes would eliminate opportunities for tax avoidance through misclassification of brands and send the clear message that all cigarettes are equally harmful.

Eight bills addressing tobacco product taxation have been filed in the current Congress that would address the problem of highly affordable cigarettes in the Philippines by significantly increasing taxes and greatly simplifying the existing, complex tax structure; such tax increases will prevent smoking initiation, promote cessation, lower consumption among continuing smokers, and reduce the death, disease, and economic costs that result from smoking.

Performance Indicators:

- Law passed with the following elements:
- Increase in Tobacco Taxes
- Index of price for inflation
- Unitary tax rate
- Removal of price classification freeze (1996)

2.2.2 Allocate from tobacco taxes revenues for health priorities, social health insurance coverage, and health promotion³⁰

Earmarking of tobacco tax revenues for health purposes has been small in recent years – 2.5% of the new tax revenues from the 2008 tax increase was earmarked for Philippine Health Insurance (PhilHealth) and 2.5% was earmarked for disease prevention. Discussions are ongoing about expanding the earmarking of tobacco tax revenues to attain the Millennium Development Goals and establish effective health promotion mechanisms and structures. Of particular interest is the earmarking of tobacco tax revenues for health sector reform and a universal health care program.

These efforts should take into account the changing patterns of disease associated with economic development and concerns about the health and other inequities that are exacerbated by tobacco use. This includes dedicating a portion of tobacco tax revenues for comprehensive tobacco control programs that include, but are not limited to: supporting community level interventions; engaging in public education campaigns about the harms from tobacco use; providing support to smokers trying to quit smoking; and preventing young people from taking up tobacco use.

³⁰ National Capacity Assessment, section VIII.3.2.

This strategy shall ensure that the percentage of revenues as agreed by Department of Budget and Management (DBM) and DOH from tobacco taxes is allocated for tobacco control programs, specifically for health priorities, social health insurance coverage, and health promotion.

Performance Indicators:

- Increased percentage of proportion of revenue from tobacco taxes allocated to health promotion and social health insurance coverage
- Tobacco taxes revenues allocated for health priorities, and included in the consolidated tobacco tax bill
- Health Promotion Foundation (HPF) established with funding from tobacco tax (included in the legislation)

2.2.3. Increase the licensing fee of retail sales of tobacco products³¹

An increase in the licensing fee of retail sales would result in rise by retailers on the prices to compensate for the cost. Therefore, higher tobacco prices would lead to a decrease in tobacco consumption.

Local government units should be encouraged to increase the licensing fee/business permit of the retail sales of tobacco products by 100% based on the existing fee.

Performance Indicator:

100% increase in licensing fee/business permit in 50% of LGUs

2.2.4. Strengthen the multi-disciplinary mechanism to implement and monitor a strategy for effective tobacco tax and pricing to reduce tobacco consumption³²

Philippine tax administrators' capacity for tracking and tracing should be further strengthened by licensing all involved in tobacco production and distribution, and resources should be allocated to enforcing tax policies.

Several steps should be undertaken to strengthen tobacco tax administration in the Philippines. A well-established monitoring system should be put in place, one that employs new technologies for monitoring the production and distribution of tobacco products. These new technologies include adoption of the new generation of more sophisticated, hard-to-counterfeit tax stamps and a tracking-and-tracing system that can follow tobacco products through the distribution chain.

³¹National Capacity Assessment, section VIII.3.4.

³²Ibid.

This strategy would create a proactive and working multi-disciplinary body that shall develop, implement, and monitor a strategy for effective tobacco taxation and pricing which would result in reduced tobacco consumption. The body should collaborate with other partners, especially non-governmental organizations and media, to gain support for tobacco tax measures.

Performance Indicator:

Monitoring tool/s and results

STRATEGY 2.3: GOVERNANCE AND LOCAL ENFORCEMENT

2.3.1 Enforce existing policies on Tobacco Advertising, Promotion, and Sponsorship (TAPS) ban³³

At local levels, the enforcement falls under the authority of the DOH-CHD regulatory officers and the city and municipal officials (Mayor’s police force as well the local PNP police officers). Although the Tobacco Regulation Act does not have a clear mechanism for enforcement, monitoring of compliance, and reporting, the LGUs have competencies to introduce “local ordinances” that may introduce clarification of roles among enforcing agencies, coordination, duties of compliances, enforcing actions, monitoring of compliance, reporting etc.

So far, the assessment team could find only one Joint Memorandum Circular (JMC) between DOH and Department of Local and Interior Government (DILG) (DOH CHD 4A and DILG 4A/2010) covering region 4A. The model local ordinance recommended by the Joint Memorandum includes mechanism for enforcement, with coordination and roles among institutions, duties of compliances, enforcing actions, monitoring of compliance. However, the model does not include a reporting mechanism among the enforcing institutions and to the public.

Performance Indicator:

25% of municipalities and cities enforcing TAPS ban

2.3.2 Develop guidelines for effective monitoring of TAPS based on WHO-FCTC³⁴

There is a need to strengthen the enforcement mechanism of the current **TAPS’ restrictions**, through coordinated action at local jurisdictions, under the DOH leadership and coordination.

³³ National Capacity Assessment, section VII.2.1.4

³⁴ National Capacity Assessment, section VII.3.1.1

There are certain provisions included in the **Tobacco Act** that may be enforced nationwide by **DOH FDA** (e.g., ban of **TAPS** on internet, TV, radio, cross-border TAPS, etc.), while at the local level the **DOH-CHD teams**, in collaboration with the LGUs, could focus on their areas of authority within the respective jurisdictions.

The **DOH** should take leadership in the development of **monitoring tools** to collect information on TAPS restrictions enforcement actions, monitoring compliance that can be implemented at local levels by the regional DOH CHD regulatory officers and local health workers, in collaboration with LGU enforcing agents with reporting duties to the DOH and the public.

Inspection check lists should include TAPS ban and eventually, the score cards could add indicators on TAPS. Action on law violations and monitoring of compliance could be shared between central and regional levels.

Performance Indicator:
Guidelines on monitoring TAPS ban

STRATEGY 2.4: ALLIANCE AND PARTNERSHIP

2.4.1 Organize Regional Tobacco Control Network (RTCN)/ Regional Committee on Tobacco Control (RCTC) in every region

To ensure an efficient and effective multi-sectoral implementation of the National Tobacco Control Program, a RTCN/RTCC shall be organized in every region. Members of the RTCN/RTCC shall be composed of tobacco control advocates from government agencies, non-governmental organizations, other civil society organization, academe, specialty societies, and representatives from LGUs. RTCN/RTCC should oversee the planning, implementation and monitoring of tobacco programs and activities (pertaining to FCTC Articles) at the regional level.

Performance Indicators:
Memorandum of Understanding (MOU) signed
RTCN/RCTC in all regions

2.4.2 Organize SWAT Committee³⁵

Department Order (DO) 2011-0029 proposed a functional structure, the Sector Wide Anti-Tobacco Committee (SWAT Committee), to be responsible for implementing the WHO-FCTC provisions. This committee has no tobacco industry representation and addresses the country public health interests by having a comprehensive scope, membership, and operational implementation targets on the various WHO-FCTC articles.

Eleven sub-committees of this sector wide structure were organized and are already operational with terms of reference (TOR) defining scope of work and expected outputs. SWAT members are government stakeholders, civil societies, and the academia. The tobacco industry and its front groups were not invited to be part of SWAT.

In this regard, DOH needs to clearly and formally define the SWAT mandate, roles, and membership; ensure clear policies to prevent tobacco industry participation and interference with its work; and enable collaboration with other government authorities in both decision taking and technical levels. (See Annexes 2 and 3 for the composition of the SWAT sub-committees).

Performance Indicator:

Memorandum of Understanding (MOU) signed

Table 2 below presents the specific objectives, key action points, and indicators of the different strategies under Strategy 3.

Table 2: Strategies, Key Actions, and Performance Indicators under Strategy 3

STRATEGY 3: STRENGTHEN ORGANIZATIONAL CAPACITY		
Strategies	Key Actions	Performance Indicators
3.1. Investment planning and resource management Specific objective: To develop multi-year financial plans for government-supported tobacco control programmes, including mechanisms that raise levels of funding through multiple sources, e.g. tobacco taxes, private sector support, donor aid, community funds, and social health insurance. ¹⁵	3.1.1 Strengthen the capacity of the National Tobacco Control Coordinating Office (NTCCO)	Budget included in General Appropriation Act (GAA)
	3.1.2 Establish mechanisms for collaboration with other key stakeholders (which include government and non-government) regarding funding for tobacco control initiatives	<ul style="list-style-type: none"> Written guidelines for collaboration Memorandum of Understanding (MOU)
	3.1.3 Strengthen the capacity of local governments to include Tobacco Control (TC) in their Annual Investment Plan for Health (AIPH)	<ul style="list-style-type: none"> Template for Tobacco Control Annual Investment Plan for Health Inclusion of TC activities with dedicated budget in AIPH of LGUs Number of LGUs with tobacco control included in the Investment plan No. of LGUs with TC Committee

³⁵ National Capacity Assessment, section II.2.4.

Strategies	Key Actions	Performance Indicators
	<p>3.1.4 Establish incentive mechanisms for LGUs with strong Tobacco Control efforts (i.e., Red Orchid Award)</p> <p>Ensure funding for the incentives</p>	<ul style="list-style-type: none"> Red Orchid Award (ROA) sustained Grants to LGUs effectively implementing TC
<p>3.2 Leadership training and human resource development</p> <p>Specific Objective: To support implementation of WHO-FCTC provisions by developing and enabling champions, leaders, and advocates at multiple levels to lead tobacco control efforts and to continuously train and provide tobacco control programme implementers with appropriate skills and competencies.¹⁵</p>	<p>3.2.1 Increase capacity of key stakeholders and local government units in leading TC activities in the country including resistance to Tobacco Industry Interference (TII)</p>	<ul style="list-style-type: none"> Number of training programs conducted Database of TC leaders/ advocates produced from the training programs with the goal of successfully enacting TC ordinance
<p>3.3 Surveillance, Monitoring, and knowledge management Specific</p> <p>Objectives: To generate reliable and updated information and evidence to guide programme planning, implementation, monitoring, and evaluation; and to gather intelligence and monitor industry actions.¹⁵</p>	<p>3.3.1 Develop national research surveillance and monitoring agenda</p> <p>Include tobacco control research in the National Unified Health Research Agenda (NUHRA)</p>	<ul style="list-style-type: none"> National research surveillance, monitoring, and evaluation agenda developed Number of TC researches included in the NUHRA
	<p>3.3.2 Ensure funding support for the conduct of research surveillance and monitoring agenda</p>	<ul style="list-style-type: none"> Inclusion in the DOH as well as other agencies (development partners) funding for the research agenda Inclusion of TC research in NUHRA budget Number of development partners providing funding support for the agenda.
	<p>3.3.4 Conduct research regularly</p>	<ul style="list-style-type: none"> GYTS, GATS, National Nutrition and Health Survey
	<p>3.3.5 Strengthen the use of evidence for policy and action</p>	<ul style="list-style-type: none"> Number of policy issuances using as evidence surveillance, monitoring, evaluation research data
	<p>3.3.5 Disseminate research and surveillance data results</p>	<ul style="list-style-type: none"> Number of fora conducted Number of policy brief developed and distributed

Strategies	Key Actions	Performance Indicators
3.4 Public awareness, education, communication, and advocacy Specific Objectives: To inform different audiences of (a) the hazards of tobacco use and exposure and (b) effective interventions; and to mobilize stakeholders to change social norms and eventually eliminate tobacco use in society. ¹⁵	3.4.1 Develop and implement evidence-based communication and advocacy plans including evaluation of effectiveness	<ul style="list-style-type: none"> Evidence-based communication plan implemented (Effective implementation of communication and advocacy plan through KAP surveys)
	3.4.2 Ensure funding for implementation of communication and advocacy plan	<ul style="list-style-type: none"> Regular budget on IEC for Tobacco Control (Inclusion in the DOH National Center for Health Promotion (DOH-NCHP) as well as other development agencies' funding for such plan)
3.5 Tobacco dependence treatment and smoking cessation Specific objective: To develop and integrate treatment of tobacco dependence in the health care system with particular emphasis on primary health care. ¹⁵	3.5.1 Develop and implement National Clinical Practice Guidelines (CPGs) for smoking cessation	<ul style="list-style-type: none"> National CPGs developed and fully implemented Number of health workers trained on CPGs
	3.5.2 Establish/ strengthen the infrastructure and referral system for tobacco dependence treatment and other related services	<ul style="list-style-type: none"> Policy for treatment and referral for tobacco dependence treatment and related services Number of functional smoking cessation clinics Number of TB DOTS facilities with integrated smoking cessation services
	3.5.3 Ensure financing for treatment of tobacco dependence under the Philippine Health Insurance Corporation (PhilHealth)	<ul style="list-style-type: none"> Financing scheme on the treatment of tobacco dependence developed and implemented Number of smokers who availed of the benefit Number of facilities that availed of the benefit

STRATEGY 3: STRENGTHEN ORGANIZATIONAL CAPACITY

This is to strengthen organizational capacity of government tobacco control programmes to protect public health policy processes from tobacco industry interests and interference and to move towards complete implementation of the WHO-FCTC through improvements in: (a) investment planning and resource management; (b) leadership training and human resources development; (c) surveillance, monitoring, and knowledge management; (d) public awareness, education, communication, and advocacy; and (e) tobacco dependence treatment and smoking cessation.

STRATEGY 3.1: INVESTMENT PLANNING AND RESOURCE MANAGEMENT

3.1.1 Strengthen the capacity of the National Tobacco Control Coordinating Office (NTCCO)³⁶

The DOH should ensure the necessary human resources for coordinating the NTCCO work (a full time coordinator that could be newly assigned or identified from existing staff, and also focal points for tobacco control in other DOH departments at national and local level). The Food and Drug Administration (FDA) and the Philippine Health Insurance Corporation (PhilHealth) have a key role in the implementation and enforcement of tobacco control measures and should be fully involved in the implementation process.

Performance Indicators:

Budget included in General Appropriations Act (GAA)

3.1.2 Establish mechanisms for collaboration with other key stakeholders (which include government and non-government) regarding funding for tobacco control initiatives

To ensure that all activities and outputs are implemented and accomplished based on the agreed timeline, there is a need to work towards and advocate for increasing the current levels of funding for tobacco control and expanding the sources of funds, to include but not limited to, national and local government budgets, contributions from external support organizations, and funds from the private sector, community, and social health insurance. (RAP for Tobacco Free Initiative in the WPR, 2010-2014)

Performance Indicators:

- Written guidelines for collaboration
- Memorandum of Understanding (MOU)

3.1.3 Strengthen the capacity of local governments to include Tobacco Control in their Annual Investment Plan for Health (AIPH)³⁷

The DOH should ensure dedicated and regular funding for tobacco control within the DOH budget, at the central and regional levels, based on needs identified by the NTCCO/NCHP and the regional tobacco control structures. As the Local Government Units (LGUs) are currently in the frontline of collaboration with the DOH-Centers for Health Development (DOH-CHDs) for implementing various policies, they should also dedicate tobacco control funding on a regular basis as part of their province-, municipality- or city-wide investment plans for health.

³⁶ National Capacity Assessment, section II.3.1.

³⁷ National Capacity Assessment, section II.3.2

Performance Indicators:

- Template of Tobacco Control Annual Investment Plan for Health
- Inclusion of Tobacco Control (TC) activities with dedicated budget in Annual Investment Plan (AIP) of LGUs
- No. of LGUs with TC included in the AIP
- No. of LGUs with TC Committee

3.1.4 Establish incentive mechanisms for LGUs with strong Tobacco Control efforts (i.e., Red Orchid Award) and ensure funding for the incentives³⁸

The DOH should collaborate with the LGUs, they being the essential players in advancing the WHO-FCTC compliance in the Philippines, and strongly support their efforts in tobacco control.

Apart from enforcement work and local initiatives for raising awareness, major opportunities of the LGUs should include increasing collaboration with local health services in providing cessation support (toll free quit lines) and coordinating initiatives with civil society.

Also, the collaboration regarding the **Red Orchid Award strategy³⁹** should include evaluation of multi-sectoral participation and of local impact. Regular funding from local governments should be made available for tobacco control implementation and enforcement initiatives. PhilHealth could be pursued as a possible source of funds for the LGUs' tobacco control activities.

Performance Indicators:

- Red Orchid Award (ROA) sustained
- Grants to LGUs effectively implementing Tobacco Control

STRATEGY 3.2: LEADERSHIP TRAINING AND HUMAN RESOURCE DEVELOPMENT

3.2.1 Increase capacity of key stakeholders and local government units in leading TC activities in the country including resistance to Tobacco Industry Interference (TII)⁴⁰

Several tobacco control training programs that include a TAPS section were conducted in the last two years, especially targeting health workers at regional level and some from the local government unit level. The training under the broad framework of **MPOWER** is conducted by core trainers from the DOH Central Office in partnership with civil society based on a

³⁸ National Capacity Assessment, section II.3.6

³⁹ This refers to special citation on Implementation of 100% Tobacco free Environment

⁴⁰ National Capacity Assessment, section VII.2.1.7/ II.2.6.

module prepared by the DOH Health Human Resource Development Bureau (**DOH-HHRDB**) and enhanced by partners from academe and civil society, in the form of training of trainers. Concrete enforcement of TAPS restrictions is yet to be part of the training. Other organizations have conducted training of the police officers (FIDS, etc.). Reports of evaluation of training have not yet been made available as of this writing.

The DOH CHDs collaborate with the local government authorities (LGUs) for covering training needs for health workers in their jurisdiction, mostly limited to smoke-free policies, while cessation services and awareness raising campaigns are still not fully addressed.

Performance Indicators:

- No. of training programs conducted
- Database of TC leaders/advocates produced from the training programs with the goal of successfully enacting TC ordinance

STRATEGY 3.3: SURVEILLANCE, MONITORING, AND KNOWLEDGE MANAGEMENT

3.3.1 Develop national research surveillance and monitoring agenda

3.3.1.1 Include tobacco control research in the National Unified Health Research Agenda (NUHRA)

This would entail developing a national research agenda on tobacco control. To support this, the following Sub-Committee on Article 20⁴¹ strategies should be pursued:

- Collaborate with World Health Organization (WHO) in the development of general guidelines or procedures for defining collection, analysis, and dissemination of tobacco-related surveillance data;
- Initiate and cooperate with competent international and regional intergovernmental organizations and other bodies in the conduct of research and scientific assessments;
- Promote and strengthen the training of and the support for all those engaged in tobacco control activities, including research, implementation and evaluation;
- Facilitate/Provide inputs in the development of the national surveillance system for determining the magnitude and patterns of determinants and other social, economic, and health indicators related to the consequences of tobacco consumption and exposure to tobacco smoke;
- Facilitate financial and technical assistance from international and regional intergovernmental organizations and other bodies for epidemiological surveillance and information exchange; and

⁴¹TOR on SWAT Sub-Committee on Article 20, Department of Health

- Provide an opportunity for exchange of information on the results of research studies and surveys among the members of the sub-committees.

Performance Indicators:

- National research surveillance, monitoring, and evaluation agenda developed
- No. of TC researches included in the NUHRA

3.3.2 Ensure funding support for the conduct of the research surveillance and monitoring agenda

FCTC Article 20 (#3) states that “The Parties to the Convention recognizes the importance of financial and technical assistance from international and regional intergovernmental organizations and other bodies where each shall endeavor to establish progressively a national system for the epidemiological surveillance of tobacco consumption and related social, economic, and health indicators.”

FCTC Article 20 (#5) also states that “Parties should cooperate with regional and international organizations and financial and development institutions, to promote and encourage provision of technical and financial resources to the Secretariat to assist developing country Parties and Parties with economies in transition to meet their commitments on research, surveillance, and exchange of information.”

Performance Indicators:

- Inclusion in the DOH as well as other agencies (development partners) funding for research agenda
- Inclusion of TC research in NUHRA budget
- Number of development partners providing funding support for the agenda

3.3.3 Conduct research regularly⁴²

The Philippines has recent, representative and periodic tobacco surveillance data for both adults and youth. Two main challenges to sustain prevalence surveillance have been identified:

Although DOH partly funds some surveys like the Global Youth Tobacco Survey (GYTS) and the National Nutrition and Health Survey (NNHS), funding for tobacco surveillance is still largely

⁴² National Capacity Assessment section III.3.1.

dependent on external sources. This is relevant especially in the case of GATS, which in its present form is an expensive survey.

Adult prevalence data is a key to monitor the tobacco epidemic. However, the existing surveys to measure adult prevalence use methodologies that produce non-comparable data. Global Adult Tobacco Survey (GATS), which is an internationally validated survey, is not sustainable in its present form.

The national assessment team recommends the use of the Core Adult Tobacco Survey (**CATS**), which was developed by the WHO Western Pacific Regional Office (WPRO) based on the GATS survey under the framework of Tobacco-Free Plan-It. In this way, periodic tobacco surveillance data will be collected with no need for additional funding and made available to the institutions responsible for implementing the tobacco control policies.

Performance Indicator:

GYTS, GATS, National Nutrition and Health Survey

3.3.4 Strengthen the use of evidence for policy and action⁴³

Although the National Epidemiology Center (NEC) and other agencies have produced significant amounts of tobacco surveillance data, relatively small efforts are done to translate these data into information relevant to the decision makers and to the public and by these to facilitate concrete action and policy change. There is still a need to disaggregate national data into regional data for better appreciation by local government units.

Performance Indicator:

No. of policy issuances using as evidence surveillance, monitoring, evaluation research data

3.3.5. Disseminate research and surveillance data results⁴⁴

The DOH National Epidemiology Center (NEC) needs to take the leadership in transforming collected data into information that would be relevant for the decision makers and understandable for the public, which would result in the facilitation of policy change and support of the population in implementing the necessary measures.

⁴³ National Capacity Assessment section III.2.2.

⁴⁴ National Capacity Assessment section III.3.2.

According to the DOH Department Order (DO) No. 29 of February 7, 2011, NEC has the mandate to develop and institutionalize a national reporting and surveillance for the tobacco control program. In this regard, NEC needs to seek for additional partners' support and use their capacity through the work of the SWAT subcommittee on surveillance.

Performance Indicators:

No. of policy issuances using as evidence surveillance, monitoring, evaluation research data

STRATEGY 3.4: PUBLIC AWARENESS, EDUCATION, COMMUNICATION, AND ADVOCACY

3.4.1 Develop and implement evidence-based communication and advocacy plans including evaluation of effectiveness

To promote and strengthen public awareness of tobacco control issues, there is a need to develop and implement evidence-based communication and advocacy plans and programs using all available communication tools. In relation to this, the SWAT Sub-Committee on Article 12³⁵ should:

- Prepare an integrated and cohesive plan for communication, education, and training on Tobacco Control in coordination with the other sub-committees on FCTC Articles;
- Establish an infrastructure to support education, communication, and training;
- Facilitate leveling of key messages on tobacco control among the stakeholders and advocates for tobacco control;
- Use all available means to raise awareness, provide enabling environments, and facilitate behavioral and social change;
- Actively involve the civil society in the relevant phases of public awareness programs;
- Ensure that education, communication, and training programs include a wide range of information on tobacco industry, its strategies, and its products; and
- Monitor, evaluate, and revise education, communication and its measures.

Performance Indicator:

Evidence-based communication plan implemented (Effective implementation of communication and advocacy plan through Knowledge Attitude and Practice or KAP surveys)

⁴⁵ TOR SWAT Sub-Committee on FCTC Article 12, Department of Health

3.4.2 Ensure funding for implementation of communication and advocacy plan⁴⁶

DOH has limited financial resources (approx. PHP10 million) to produce materials and purchase air time, therefore materials are not supplied to regions in sufficient quantity and no national campaign is possible with the existing funds. Currently, approximately 60% of NCHP budget for campaigns goes to the regions while the remaining 40% goes to DOH for all other activities, including materials' production, testing, media buying, etc. The DOH should pursue the expansion of the financial resources to produce and air mass media campaigns. A possible means to mobilize more resources to produce and air mass media campaigns could be through the designation of a part of tax revenues to this purpose. The department should initiate high level engagement with the private sector (e.g. media companies and cinemas) to secure free or highly discounted time and space.

Performance Indicator:

Regular budget on IEC for Tobacco Control (inclusion in the DOH-National Center for Health Promotion (NCHP) as well as other development agencies' funding for such plan)

STRATEGY 3.5: TOBACCO DEPENDENCE TREATMENT AND SMOKING CESSATION

3.5.1 Develop and implement national Clinical Practice Guidelines (CPGs) for tobacco dependence treatment (smoking cessation)⁴⁷

The 2004 NEC cessation evaluation study identified the lack of standard cessation operating procedures as a contributory factor to the failure to implement the national cessation policy.

The work initiated by the DOH for reviewing the evidence-based cessation interventions with professional groups like the Philippine Medical Association (PMA) and Philippine College of Chest Physicians (PCCP) and the academe and for eventually establishing a set of cessation practice guidelines and models needs to be accelerated. Guidelines need to be finalized and endorsed, and widely disseminated across the entire health system (in both the private and public sectors), and across all relevant programs.

The DOH should continue its efforts on training of trainers, several of which have been initiated in Centers for Health Development (CHDs). In this way, there will be an expanded pool of cessation trainers to assist LGUs and other government entities for providing cessation services to their population and employees, e.g. the Civil Service Commission (CSC). In parallel, health

⁴⁶ National Capacity Assessment sections VI 2.2.2/ VI.2.3.2

⁴⁷ National Capacity Assessment sections V.2.2/V.3.2/V.3.3.3.

professional societies could also designate cessation trainers to handle cessation capacity building in the private sector. The DOH should adopt a set of standardized national training modules and tools.

Performance Indicators:

- National Clinical Practice Guidelines (CPGs) for smoking cessation developed and fully implemented
- No. of health workers trained on CPGs

3.5.2 Establish/strengthen the infrastructure and referral system for tobacco dependence treatment and other related services

There is a need for a coordinated national cessation infrastructure that incorporates both population and clinical approaches in a stepwise manner, and builds on and augments existing resources and service delivery mechanisms. The program shall start with LGUs with Smoke-Free ordinance and with existing demand and/or program for tobacco cessation.

There is a need to strengthen the smoking cessation infrastructure and referral system for providing smoking cessation and tobacco dependence treatment strategy, especially among LGUs.

Opportunities to integrate these smoking cessation guidelines into relevant health and other programs (i.e., cancer control programs, maternal and child health programs, TB control programs, as well as poverty alleviation programs, workplace wellness programs, social welfare programs) should be explored and utilized.

Performance Indicators:

- Policy for treatment and referral for tobacco dependence treatment and related services
- No. of functional smoking cessation clinics
- No. of TB DOTS facilities with integrated smoking cessation services

3.5.3 Ensure financing for treatment of tobacco dependence under PhilHealth⁴⁸

Cessation services are not covered under current health insurance schemes. Outside of Philippine Health Insurance Corporation (PhilHealth) Circular 17, which provides for cessation counseling for overseas Filipino workers and family members, there is no insurance coverage for cessation services in the Philippines.

⁴⁸ National Capacity Assessment, section V.2.4

RA 9211 mandates PhilHealth to cover outpatient cessation counseling for minors, but this remains unimplemented. Moreover, neither nicotine replacement therapies nor non-nicotine based cessation drugs are included in the national formulary (a pre-requisite for PhilHealth coverage).

This presents a significant financial barrier for smokers who want to quit, many of whom belong to the lower socio-economic classes and rely on PhilHealth to cover the costs of preventive health care. PhilHealth maintains that it is waiting for the DOH to officially issue cessation clinical practice guidelines before it can establish the coverage rules for cessation services. At present, private health insurance companies do not include cessation in their list of covered services.

PhilHealth should expand the insurance coverage to cover a package of evidence-based essential cessation services that includes brief advice at the primary health care level, access to intensive counseling such as through a national quit line and, to the extent possible, pharmacotherapy for those who are heavily addicted to tobacco.

Performance Indicators:

- Financing scheme on the treatment of tobacco dependence developed and implemented
- No. of smokers who availed of the benefit
- No. of facilities that availed of the benefit

LIST OF ACRONYMS AND ABBREVIATIONS

AdBoard	Advertising Board of the Philippines
AER	Action for Economic Reforms
AFP	Armed Forces of the Philippines
AFTPTC	ASEAN Focal Points on Tobacco Control
AO	Administrative Order
ASEAN	Association of Southeast Asian Nations
ATBP	Anti Tobacco Behavior Program
BAT	British American Tobacco
BIR	Bureau of Internal Revenue
BOC	Bureau of Customs
CHDMM	Center for Health Development Metro Manila
CHED	Commission on Higher Education
CAD	Coronary Artery Disease
COPD	Chronic Obstructive Pulmonary Disease
CPG	Clinical Practice Guidelines
CSC	Civil Service Commission
CVD	Cardiovascular Diseases
DA	Department of Agriculture
DAP	Development Academy of the Philippines
DECS	Department of Education, Culture and Sports
DENR	Department of Environment and Natural Resources
DepEd	Department of Education
DDB	Dangerous Drugs Board
DILG	Department of Interior and Local Government
DLSU	De La Salle University
DO	Department Order
DOF	Department of Finance
DOH	Department of Health
DOH BLHD	Department of Health Bureau of Local Health Development
DOH BIHC	Department of Health Bureau of International Health Cooperation
DOHHHRDB	Department of Health Health Human Resource Development Bureau
DOH HPDPB	Department of Health Health Policy Development and Planning Bureau
DOHNCHP	Department of Health National Center for Health Promotion

DOHN-CDPC	Department of Health National Center for Disease Prevention and Control
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DOST	Department of Science and Technology
DOTC-LTFRB	Department of Transportation and Communication Land Transportation Franchising and Regulatory Board
DSWD	Department of Social Welfare and Development
DTI	Department of Trade and Industry
DTI-BTRCP	Department of Trade and Industry – Bureau of Trade and Consumer Protection
ESHUT	Environmentally Sustainable Healthy Urban Transport
FCAP	Framework Convention on Tobacco Control Alliance, Philippines
FDA	Food and Drug Administration
GATS	Global Adult Tobacco Survey
GYTS	Global Youth Tobacco Survey
GHI	Graphic Health Information
HJ	Health Justice, Philippines
HSO	Health Service Office
IACT	Interagency Committee on Tobacco
IEC	Information, Education and Communication
IPCAP	Integrated Professional Counselors Association of the Philippines
ITGA	International Tobacco Growers' Association
JMC	Joint Memorandum Circular
JTI	Japan Tobacco International
KBP	Kapisanan Ng Mga Brodkaster Ng Pilipinas
LCP	Lung Center of the Philippines
LGU	Local Government Unit
LTFRB	Land Transportation Franchising & Regulatory Board
MIAA	Manila International Airport Authority
MMDA	Metro Manila Development Authority
MTP	Medium Term Plan
NBI	National Bureau of Investigation
NCDPC	National Center for Disease Prevention and Control
NCAC	National Consumer Affairs Council
NCD	Noncommunicable Diseases
NCHP	National Center for Health Promotion
NGO	NonGovernment Organization
NTA	National Tobacco Authority
NTCCO	National Tobacco Control Coordinating Office
NTPCP	National Tobacco Prevention and Control Program

NTRC	National Tax Research Center
NYC	National Youth Commission
OSG	Office of the Solicitor General
OSHC	Occupational Safety and Health Center
PAP	Psychological Association of the Philippines
PCCP	Philippine College of Chest Physicians
PCG	Philippine Coast Guard
PCHRD	Philippine Council for Health Research and Development
PCP	Philippine College of Physicians
PCS	Philippine Cancer Society
PGH	Philippine General Hospital
PHIC	Philippine Health Insurance Corporation/PhilHealth
PIA	Philippine Information Agency
PLC	Philippine Lung Center
PLCPD	Philippine Legislators' Committee on Population and Development
PMI	Philip Morris International
PMFTC	Philip Morris Fortune Tobacco Corporation
PMA	Philippine Medical Association
PNP	Philippine National Police
PN	Philippine Navy
POS	Point of Sale
PSC	Philippine Sports Commission
PTGA	Philippine Tobacco Growers' Association
R.A.	Republic Act
RAP	Regional Action Plan
SAMMEC	Smoking Attributable Mortality and Economic Costs
SDA	Seventh Day Adventist
SEATCA	Southeast Asia Tobacco Control Alliance
SHS	Secondhand Smoking
SMIC	South Manila InterInstitutional Consortium
SWAT	Sectorwide AntiTobacco
TAPS	Tobacco Advertising, Promotion and Sponsorship
TCT	Tobacco Control Team
TESDA	Technical Education and Skills Development Authority
TWG	Technical Working Group
UHC	Universal Health Care
ULAP	Union of Local Authorities of the Philippines
UPCLDF	University of the Philippines College of Law Development Foundation
UPCPH	University of the Philippines College of Public Health
WHO	World Health Organization
WHO-FCTC	World Health Organization Framework Convention on Tobacco Control
WPRO	Western Pacific Regional Office

GLOSSARY OF TERMS

Behavioral support³⁹ - refers to support, other than medications, aimed at helping people stop their tobacco use. It can include all cessation assistance that imparts knowledge about tobacco use and quitting; provides support and teaches skills and strategies for changing behavior.

Brief advice⁴⁰ - refers to advice to stop using tobacco; usually takes only a few minutes; and given to all tobacco users, usually during the course of a routine consultation or interaction.

Contents⁴¹ - refers to constituents with respect to processed tobacco; and ingredients with respect to tobacco products.

Design feature⁴² - a characteristic of the design of a tobacco product that has an immediate causal link with the testing and measuring of its contents and emissions. For example, ventilation holes around cigarette filters decrease machine-measured yields of nicotine by diluting mainstream smoke.

Emissions⁴³ - substances that are released when the tobacco product is used as intended. For example, in the case of cigarettes and other combusted products, emissions are the substances found in the smoke. In the case of smokeless tobacco products for oral use, emissions are the substances released during the process of chewing or sucking; in the case of nasal use, emissions refer to substances released by particles during the process of snuffing.

Expanded tobacco⁴⁴ - is tobacco that has been expanded in volume by quick volatilization of a medium such as dry ice.

Framework Convention on Tobacco Control⁴⁵ - is the first international treaty negotiated under the auspices of World Health Organization which represents a paradigm shift in developing a regulatory strategy to address addictive substances. In contrast to previous drug control treaties, the WHO-FCTC asserts the importance of demand reduction strategies as well as

³⁹ WHO Framework Convention on Tobacco Control: Guidelines for Implementation (Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; and Article 14. 2011 edition;; p 114.

⁴⁰ Ibid p. 114

⁴¹ Ibid p. 34

⁴² Ibid p. 35

⁴³ Ibid p. 35

⁴⁴ Ibid p. 35

⁴⁵ World Health Organization. WHO Framework Convention on Tobacco Control, WHO Press: Geneva. 2005.

supply issues. The WHO-FCTC was developed in response to the globalization of the tobacco epidemic. The spread of the tobacco epidemic is facilitated through a variety of complex factors with cross-border effects, including trade liberalization and direct foreign investment.

Graphic Health Information⁴⁶ - refers to statements, and/or other information with accompanying full-color picture or pictograms, describing the contents and ingredients of tobacco products. It also gives information regarding health dangers and problems related to tobacco products, tobacco consumption, exposure to tobacco smoke, and/or other effects of tobacco use.

IAC-T⁴⁷ - refers to the Inter-Agency Committee on Tobacco established under Section 29 of RA 9211.

IAC-T Member Agencies/Organization⁴⁸ - refers to the agencies/organizations which compose the Inter-Agency Committee on Tobacco under Section 29 of RA 9211.

Illicit trade⁴⁹ - refers to any practice or conduct prohibited by law which relates to production, shipment, receipt, possession, distribution, sale or purchase, including any practice or conduct intended to facilitate such activity.

Indoor or Enclosed Areas⁵⁰- “indoor” (or “enclosed”) areas include any space covered by a roof or enclosed by one or more walls or sides, regardless of the type of material used for the roof, wall or sides, and regardless of whether the structure is permanent or temporary.

Ingredients⁵¹ - include tobacco; components (e.g. paper, filter), including materials used to manufacture those components; additives; processing aids; residual substances found in tobacco (following storage and processing); and substances that migrate from the packaging material into the product. Contaminants are not part of the ingredients.

Promotion of tobacco cessation⁵² - refers to population-wide measures and approaches that contribute to stopping tobacco use, including tobacco dependence treatment.

Public Places⁵³ - these shall cover all places accessible to the general public or places for collective use, regardless of ownership or right to access.

⁴⁶ Republic of the Philippines. DOH Office of the Secretary. AO No. 2010-0013 “Requiring Graphic Health Information on Tobacco Product Packages, Adopting Measures to Ensure that Tobacco Product Packaging and Labeling do not Promote Tobacco by Any Means that are False, Misleading, Deceptive or Likely to Create an Erroneous Impression, and Matters Related Thereto.” Sta. Cruz, Manila. 2010

⁴⁷ R. A. No. 9211 (Tobacco Regulation Act of 2003); Inter-Agency Committee-Tobacco Memorandum Circular No. 01 s2004: Monitoring and Enforcement Guidelines of the Tobacco Regulation Act and its Implementing Rules and Regulations. 2008.

⁴⁸ Ibid p. 2

⁴⁹ World Health Organization. WHO Framework Convention on Tobacco Control; WHO Press: Geneva; 2005.

⁵⁰ WHO Framework Convention on Tobacco Control: guidelines for implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 - 2011 edition.

⁵² Ibid p. 35

⁵³ WHO Framework Convention on Tobacco Control: Guidelines for Implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 - 2011 edition. P.114

Public transport⁵⁴ - this shall include any vehicle used for the carriage of members of the public, usually for reward or commercial gain. This would include taxis.

RA 9211⁵⁵- this refers to Republic Act No. 9211, otherwise known as the Tobacco Regulation Act of 2003.

Reconstituted tobacco⁵⁶ - is a paper-like sheet material comprised mainly of tobacco.

Secondhand tobacco smoke or environmental tobacco smoke⁵⁷ - refers to “the smoke emitted from the burning end of a cigarette or from other tobacco products usually in combination with the smoke exhaled by the smoker.”

Smoke free air⁵⁸ - refers to air that is 100% smoke free. This definition includes, but is not limited to, air in which tobacco smoke cannot be seen, smelled, sensed or measured.

Smoking⁵⁹ - refers to the act of being in possession or control of a lit tobacco product regardless of whether the smoke is being actively inhaled or exhaled.

Tobacco addiction/dependence⁶⁰ - refers to a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated tobacco use and that typically include: a strong desire to use tobacco; with difficulties in controlling its use; with persistence in tobacco use despite harmful consequences; with a higher priority given to tobacco use than to other activities and obligations; with increased tolerance; and sometimes with a physical withdrawal state.

Tobacco advertising and promotion⁶¹ - refers to any form of commercial communication, recommendation, or action; the aim of which is to effect or likely to effect promoting a tobacco product or tobacco use either directly or indirectly

Tobacco cessation⁶² - refers to the process of stopping the use of any tobacco product, with or without assistance.

Tobacco Control⁶³ –refers to a range of supply, demand and harm reduction strategies that

⁵⁴ WHO Framework Convention on Tobacco Control: Guidelines for Implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 - 2011 edition. P. 22

⁵⁵ WHO Framework Convention on Tobacco Control: Guidelines for Implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 - 2011 edition P. 23

⁵⁶ WHO Framework Convention on Tobacco Control: Guidelines for implementation Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14 - 2011 edition. P. 35

⁵⁷ Ibid. P. 21-22

⁵⁸ Ibid p.22

⁵⁹ Ibid p. 22

⁶⁰ WHO Framework Convention on Tobacco Control: Guidelines for implementation Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13 and Article 14- 2011 edition. P. 114

⁶¹ World Health Organization. WHO Framework Convention on Tobacco Control; WHO Press: Geneva. 2005.

⁶² WHO Framework Convention on Tobacco Control: Guidelines for implementation Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13 and Article 14- 2011 edition. P. 114

aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke.

Tobacco dependence treatment⁶⁴ - refers to the provision of behavioural support, medications, or both to tobacco users, to help them stop their tobacco use.³

Tobacco user⁶⁵ - refers to a person who uses any tobacco product.

Tobacco Industry⁶⁶- shall refer to organizations, entities, associations, individuals and others who work for or in behalf of tobacco manufacturers, wholesalers, distributors, importers of tobacco products, growers, and other individuals, or organizations that work to further the interest of the tobacco industry, such as front groups and retailers.

Tobacco Products⁶⁷ – refers to products entirely or partly made of leaf tobacco as raw material, which are manufactured to be used for smoking, sucking, chewing, or snuffing, or by any other means of consumption.

Tobacco Sponsorship⁶⁸ – refers to any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly.

⁶³ World Health Organization. WHO Framework Convention on Tobacco Control. WHO Press: Geneva. 2005. 4

⁶⁴ WHO Framework Convention on Tobacco Control: Guidelines for implementation Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, and Article 14-2011 edition. P. 114

⁶⁵ WHO Framework Convention on Tobacco Control: Guidelines for implementation Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, and Article 14-2011 edition. P. 114

⁶⁶ Republic of the Philippines. Department of Health. Office of the Secretary. Department Memorandum No. 2010-0126: "Protection of the Department of Health including all of its Agencies Regional Offices, Bureaus or Specialized/Attached Offices/Units against Tobacco Industry Interference". Sta. Cruz, Manila. 2010. 2

⁶⁷ Republic of the Philippines. Department of Health. Office of the Secretary. Administrative Order No. 2010-0013: "Requiring Graphic Health Information on Tobacco Product Packages, Adopting Measures to ensure that Tobacco Product Packaging and Labeling do not Promote Tobacco by Any Means that are False, Misleading, Deceptive or Likely to Create an Erroneous Impression, and Matters Related Thereto: Sta. Cruz Manila, 2010.

⁶⁸ World Health Organization. WHO Framework Convention on Tobacco Control. WHO Press: Geneva. 2005 4

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The background is a vibrant, abstract composition of swirling, wavy lines in shades of red, orange, and yellow. The lines vary in thickness and direction, creating a sense of movement and depth. The overall effect is reminiscent of a textured surface or a close-up of a natural material like wood or stone, but with a more dynamic, organic feel. The colors are saturated and warm, contributing to a bold and energetic aesthetic.

ANNEXES



ANNEX 1

TOBACCO CONTROL INTERVENTIONS IN THE PHILIPPINES

1. Government Agencies Implementing Tobacco Control

A. Implementation at the National Level

In 1999, the Philippines' parliament passed the **Clean Air Act** or **Republic Act 8749**, which included provisions for protection from second hand smoke (SHS). The Clean Air Act identified cigarette smoke as a pollutant and instituted smoke-free indoor laws; unfortunately, the Act allowed designated smoking areas in enclosed public places and other indoor areas.¹

In June 2003, **Republic Act 9211**, also known as the **Tobacco Regulation Act of 2003**, became a law in the Philippines. The Tobacco Regulatory Act included landmark legislation with provisions on effective tobacco control in the country, including: (a) promotion of a healthful environment; (b) provision of information to the public on health risks associated with cigarette smoking and tobacco use; (c) regulation and subsequent banning of all tobacco advertisements and sponsorships; (d) regulation of placing health warning labels on tobacco products; (e) prohibition of the sale of tobacco products to minors¹; (f) provision of assistance and encouragement for Filipino tobacco farmers to cultivate alternative agricultural crops to prevent economic dislocation²; and (g) creation of an Inter-agency Committee on Tobacco (IAC-Tobacco) to oversee the implementation of the provisions of this Act.²

The **DOH** issued on 10 December 2003 **AO No. 122** entitled, "A **Smoking Cessation Program** to support provisions of **RA 9211** and the National Healthy Lifestyles Program." **Section 33-(b) and (c) of the tobacco law** required that the DOH establish "withdrawal clinics," and this AO provides the specific guidelines in implementing a National Smoking Cessation Program (**NSCP**) for such provisions.¹

An Interagency Committee on Tobacco (**IAC-T**) was established through **RA 9211 Memorandum Circular No. 1s.2004** to oversee the administration and implementation of the law. The IAC-T, chaired by the Department of Trade (**DTI**) with DOH as vice-chair, involves different government

¹2009 Philippines Global Adult Tobacco Survey (GATS)

²Manual for Implementation of RA 9211 (Tobacco Regulation Act of 2003), UP College of Law Development Foundation, 2010

sectors, including the National Tobacco Administration of the Department of Agriculture (**DA**) as well as representatives of the tobacco industry.

Interagency Committee on Tobacco (IAC-T) Members:

1. Department of Trade and Industry (Chair)
2. Department of Health
3. Department of Justice
4. Department of Agriculture
5. National Tobacco Administration
6. Department of Environment and Natural Resources
7. Department of Education
8. Department of Science and Technology
9. Bureau of Customs
10. Bureau of Internal Revenue
11. Philippines Tobacco Institute
12. FCTC Alliance Philippines (FCAP)

In 2007, the DOH issued **Administrative Order 2007-0004** on the National Tobacco Prevention and Control Program (**NTPCP**) to define the roles and responsibilities of the different offices under DOH and of other departments. The lead office for tobacco control is the DOH-National Center for Disease Prevention and Control (**NCDPC**).

In 2009, the DOH started to lodge major roles and responsibilities to the DOH-National Center for Health Promotion (**NCHP**). The NCHP started with its Health Promotion Plan called Anti-Tobacco Behavior Program (**ATBP**). The ATBP Program has four-pronged strategies, namely: (1) rally the influential people through political advocacy and social mobilization; (2) re-orient providers of health and social services through networking and partnership; (3) involve the youth through education and entertainment; and (4) bombard the media through social marketing.

Besides the ATBP Program, the DOH-NCHP launched the **Red Orchid Award**, which aims to search for the national, regional, and local offices that implement a 100% tobacco-free environment. The NCHP also joined the Planning Meeting of the ASEAN Focal Points on Tobacco Control (**AFPTC**), which has the goal of ensuring that effective tobacco control measures are in conformity with the ASEAN Social Cultural Blueprint.

The AFPTC, encompassing a two-year action plan on four (4) key tobacco control issues, tasked each member to take a lead in the enforcement of the activities. The issue assigned to the Philippines and its partner, Lao, is the Tobacco Advertising, Promotion, and Sponsorship (**TAPS**).

In 2009, the DOH started implementing the **Bloomberg Project** entitled, *“Moving to the Next Level in the Philippines: Complete Implementation of the WHO-Framework Convention on Tobacco Control (WHO-FCTC).”* The project is tasked to supplement the country's tobacco prevention efforts, in congruence with the DOH-NCHP, and to enforce WHO-FCTC effectively.

The key initiatives of the project include the development of a comprehensive **National Tobacco Control Strategy (2011-2016)** and **Medium Term Plan (2011-2013)**, creation of the National Tobacco Control Coordinating Office (**NTCCO**) within the DOH, and formation of the DOH Tobacco Control Team (**TCT**) and eleven Sector-wide Anti-Tobacco (**SWAT**) sub-committees for the implementation of WHO-FCTC provisions. The **NTCCO** is in charge of working with other sectors of the DOH to synchronize tobacco control efforts. The division of functions, outlined in **DO 2011-0029**, is split among the different offices in accordance with their role in the DOH.

The health agenda of the present administration focus on Universal Health Care (**UHC**), which promotes healthy lifestyle for the prevention of noncommunicable diseases; hence, tobacco prevention is included in the National Objectives for Health (**NOH**) of the DOH.

Other government initiatives include: (1) the passage of **FDA Law (RA 9711)** in 2009; (2) issuance of Administrative **Order No. 13 on Graphic Health Information** in 2010; and (3) formulation of the **National Tobacco Control Strategy (NTCS 2011-2016)** in 2011.

The DOH-NCHP partnered with the Development Academy of the Philippines (**DAP**) to facilitate the development of the National Tobacco Control Strategy (**NTCS**) for 2011-2016. Through the **DOH- Bloomberg Initiative Project OC-401**, DAP had undertaken a series of consultation workshops starting May 2011, with experts consultation workshop, three regional (Luzon, Visayas, and Mindanao) workshops, technical working group workshop, and another consultative meeting on the Finalization of the NTCS and Development of Monitoring and Evaluation (M&E) Framework in 2012. Representatives from government agencies, advocacy groups, NGOs and local government units (**LGUs**) participated in the workshops and provided inputs to the NTCS, which will serve as a strategy map to achieve the desired goals of the National Tobacco Control Program.

Aside from DOH, other government agencies have been involved in tobacco control. The Civil Service Commission (**CSC**), an independent constitutional body, played a fundamental role in recent years by issuing several joint memoranda with the DOH. Similarly, the Land Transportation Franchising Regulatory Board (**LTFRB**), Philippine National Police (**PNP**), Development Academy of the Philippines (**DAP**), and Metropolitan Manila Development Authority (**MMDA**) played key roles focusing on smoke-free places initiatives. Using the existing communication materials, they contributed to awareness-raising campaigns and smoking cessation activities.³

³National Capacity Assessment Report for Tobacco Control – The Philippines, May 2011

Other Government Agencies' Efforts (Source: DOH)

1. CSC and DOH Joint Memo Circular No. 2010-01

- Protection of the bureaucracy against tobacco industry interference Prohibitions:
 - a. Unnecessary interaction with the tobacco industry
 - b. Preferential treatment to the tobacco industry
 - c. Accepting gifts, donations, and sponsorship
 - d. Financial interest in the tobacco industry
 - e. Conflict of interest with the tobacco industry

2. DOH Administrative Order No. 2009-0010

- Rules and Regulations Promoting a 100% Smoke-Free Environment

3. LTFRB Memo Circular 2009-036_

- 100% Smoke-Free Public Utility Vehicles and Public Land Transportation Terminals

4. CSC Memo Circular No. 17 s. 2009_

- Smoking Prohibition based on 100% Smoke-Free Policy

5. DepEd Order No. 73 s. 2010

- Smoking Ban in Public Schools

6. DepEd Order No. 62 s. 2007

- Integration of Instructions on the Hazardous Effect of Smoking in the School Curricula

7. DOH Dept Memo No. 2009-014

- Ban on Promotion, Advertisements, and Sponsorship of Tobacco Products

8. DOH Administrative Order No. 122 s. 2003

- A Smoking Cessation Program to Support the National Tobacco Control and Healthy Lifestyle Program_

9. DOH Dept Memo No. 2010-0191

- Health Advisory on Electronic Nicotine Delivery Systems (ENDS)/E-Cigarettes
- DOH warns the public on the use of these products. There is insufficient evidence that

ENDS are safe for human consumption.

B. Implementation at the Local Level

At the sub-national level, the local government units (**LGUs**) play an important role in the law implementation and have the mandate to ensure proper enforcement of RA 9211 along with members of the Philippine National Police (**PNP**) and other stakeholders.

The DOH regional structures (**Centers for Health Development**) conduct tobacco control activities through their focal point for health promotion and for NCD, especially in those regions/districts where local ordinances for creating smoke-free environments were introduced and enforced.

These staff are usually oriented and trained by DOH Central Office. The DOH organizes training of trainers (TOT) for health workers at regional level and then regional DOH staff organizes training at provincial, municipal, city, and barangay level. Several training workshops were organized every year mainly on the policies in **MPOWER package** as well as some cessation workshops.

In addition, training of policy makers is conducted by the DOH. The **DOH regional offices** also conduct training for the local government units.

Most of the enforced legislation on exposure to SHS has been done in Local Government Units (LGUs). Among the LGUs with existing Anti-Smoking Ordinances or that have passed smoke-free legislation are the cities in the National Capital Region: Makati, Manila, Pasay, Marikina, and Quezon City; Legaspi City in Southern Tagalog Region; Cebu City in Central Visayas Region; Iloilo City in Western Visayas Region; and Davao City in Eastern Mindanao Region. Recently, municipalities in Talisayan, Misamis Oriental in Northern Mindanao Region and in Amlan, Negros Oriental in Central Visayas Region have passed and implemented 100% smoke-free jurisdictions. In addition, the FCAP reports that several municipalities and cities in Luzon, Visayas, and Mindanao have initiatives under review calling for smoke-free ordinances and/or administrative orders banning smoking in public places, invoking 100% smoke-free jurisdictions¹. *(Please also refer to **Annex 5** for the list of LGUs with Smoke-free Ordinances).*

The Local Government Best Practices (Source: DOH)

- 1. Nueva Vizcaya Ordinance No 2010-049:** Smoking is prohibited in enclosed or partially enclosed public places, workplaces, public outdoor spaces, public conveyances, or other public places.
- 2. Amlan Municipal Ordinance No. 3 s. 2009:** No person shall smoke in any part of any enclosed or partially enclosed public place, workplace, including bars and restaurants, form of public conveyance or public outdoor space.
- 3. Umingan Municipal Ordinance No. 24 s. 2008:** No person shall smoke in any part of any enclosed or partially enclosed public place, workplace, including bars and restaurants, form of public conveyance or public outdoor space.
- 4. Talisayan Municipal Ordinance No. 724-2008:** It shall be unlawful for any person to smoke or for a person in charge to allow smoking in enclosed or partially enclosed public places and public facilities, public places, all forms of public conveyances, workplaces, public outdoor spaces.

2. Civil Society Implementing Tobacco Control

The Philippines also has a large and active civil society network that has proven to have an important role in keeping tobacco control in the government agenda. The non government organization (**NGO**) sector includes advocacy groups; faith-based organizations; academia; health professional groups; as well as local branches of international organizations.

So far the NGOs' resources relied on external sources (e.g., **Bloomberg Philanthropies** through the Bloomberg Initiative) or on international organizations (e.g., **SEATCA**).

Some Philippine NGOS active in tobacco control:

1. FCTC Alliance Philippines (FCAP)

Started in 2001, FCAP is composed of health professionals, faith-based groups, academe, and environmental groups. The group worked closely with DOH for: (1) the country's position during the WHO-FCTC negotiations (2001-2004); (2) achieving the WHO-FCTC ratification by the Senate in 2005; (3) staging Tobacco-Free SEA Games; (4) introducing and enforcing ordinances in local government units (e.g., 100% smoke-free places; banning tobacco advertising, promotion, and sponsorship/TAPS); (5) lobbying through Congress (14th and 15th) and advocating for graphic health warning and for tobacco tax reform (also with AER and HJ) and building constituency support to tobacco tax across the country; (6) and developing a coalition of health professionals for tobacco control in collaboration with the Philippine Ambulatory of Pediatrics Association (PAPA).

FCAP also collaborated with Philippine Medical Association (PMA) on their "Roadmap for tobacco control"; worked with PAPA and the Philippine College of Chest Physician (PCCP) to move forward tobacco cessation services; and filed cases against Philip Morris on its violation of text health warning provision of RA 9211 (still pending in DOJ and Court of Appeals)

2. Health Justice (HJ)

Considered as a think-tank, this group focuses its work on litigation, economics and drafts and briefs policy and legal documents. It provided key technical and legal support to the DOH for health warnings, monitoring tobacco industry interference, and advice on law enforcement by various government agencies e.g., CSC, LTFRB, FDA, and DOH.

It also provided key economic research to support tobacco tax and illicit trade policy reform and developed various templates for tobacco control legislation. The toolkits that are currently in use by advocates and government partners were developed by HJ. The group also provided

legal and media support for various NGOs, individual advocates/spokespersons, and LGUs.

2. Philippine Medical Association (PMA)

This group of medical practitioners passed an anti-smoking resolution in 2010 for physicians to be role-models for stopping smoking, for including smoking status in history taking, and giving brief advice to patients on how to quit smoking.

4. New Vois Association of the Philippines

The group was recently engaged in tobacco control. Majority of its members, who are people affected by tobacco, became “the face” of tobacco control advocacy.

5. Tobacco-Free Philippines (TFP)

Active in tobacco control as early as the 1980s, TFP pushed for the passage of a tobacco control law in the Philippines. Its tobacco control efforts, however, slowed down from 2000 onwards.

6. Faith Based Organizations (Seventh Day Adventist & Jesus Christ of Latter Day Saints)

The group consists of active FCAP members are working primarily on creating smoke-free places and banning TAPS by local government units (LGUs) across the country; it is one of the few organizations involved in tobacco cessation using primarily counseling techniques. .

7. Eco Waste Coalition

The coalition has been an active partner of FCAP since 2008 in relation to environmental issues.

8. Action for Economic Reform (AER)

The group is primarily concerned with transparency and taxation issues. Since 2009, AER has engaged in advocacy through Congress for the tobacco taxation reform (together with FCAP, DOH, and HJ).

9. University of the Philippines College of Law Development Foundation (UPCLDF)

The group is primarily composed of lawyers recently engaged in tobacco control (2008). They worked with some LGUs to effectively enforce RA 9211 through (1) training of enforcers and (2) development of tools for monitoring and enforcement including guidelines. It also provides legal assistance to DOH on legal issues.

10. Filipino Consumers Will (BILMAKO)

The group is primarily a consumers’ protection group. In 2004, it conducted a study on the effectiveness of RA 9211 in relation to the WHO-FCTC.



ANNEX 2

TOBACCO CONTROL COORDINATING BODIES

Coordination within the DOH

The **NTCCO** is in charge of working with other sectors of the DOH to synchronize tobacco control efforts. The division of functions, outlined in **DO 2011-0029**, is split among the different offices in accordance with their role in the DOH.

Recently, **DC 2011-0101** has set rules and regulations of the FDA (after **Administrative FDA Act 9711-2009**) tasking the **FDA** to regulate tobacco. Additionally, **DM 2009-0142** states that the **FDA** has become responsible for the enforcement of existing laws on tobacco product packaging and labeling, and on restricting tobacco advertising, promotion, and sponsorship (TAPS).

The Philippine Health Insurance Corporation (**PhilHealth**), the national health insurance provider, has included enforcement of smoke-free policy within the premises of health care institutions as one of the requirements for tertiary hospital accreditation.

The **NCHP** conducted activities under the framework of the **MPOWER** policies at the central and sub national levels for planning, building capacity, and training. Lately the Development Academy of the Philippines (**DAP**) joined these efforts.

Coordination within the Government

RA 9211 was enacted before the ratification of the WHO-FCTC; as such, many measures requested by the treaty's implementation process were not yet included in RA 9211. **Department Order (DO) 2011-0029** proposed a functional structure to be responsible for implementing the WHO-FCTC provisions (**Sector-Wide Ant- Tobacco Committee/SWAT**).

Eleven sub-committees of this sector-wide structure were organized and are already operational with terms of reference (TOR) defining the scope of work and expected outputs. **SWAT members** are government stakeholders, civil societies, and the academia. The tobacco industry and its front groups were not invited to be part of SWAT. The SWAT sub-committees and proposed responsible agencies are listed in Table 3.

Table 3: Sector Wide Anti-Tobacco Committee (SWAT)

SWAT Subcommittee according to WHO-FCTC articles	SWAT Sub-committees	Proposed Responsible National Agency
SWAT 5.3	Sub-committee on Tobacco Industry Interference	Civil Service Commission
SWAT 6	Sub-committee on Price Tax Measures	Department of Health (HPDPD)
SWAT 8	Sub-committee on Smoke-free	Department of Health (HPDPD)
SWAT 9 & 10	Sub-committee on Regulation of the Contents of Tobacco Products and Tobacco Products Disclosure	Department of Health (FDA)
SWAT 11	Sub-committee on Packaging and Labelling of Tobacco Products	Department of Health (FDA)
SWAT 12	Sub-committee on Education, Communication, Training, and Public Awareness	Department of Health (NCHP)
SWAT 13	Sub-committee on Tobacco Advertising, Promotion, and Sponsorship	Department of Health (FDA)
SWAT 14	Sub-committee on Tobacco Dependence Treatment	Department of Health (NCDPC)
SWAT 15	Sub-committee on Illicit Trade of Tobacco Products	Department of Finance (Bureau of Customs)
SWAT 17&18	Sub-committee on Alternative Livelihoods	Department of Agriculture
SWAT 20	Sub-committee on Surveillance and Research	Department of Health (NEC)

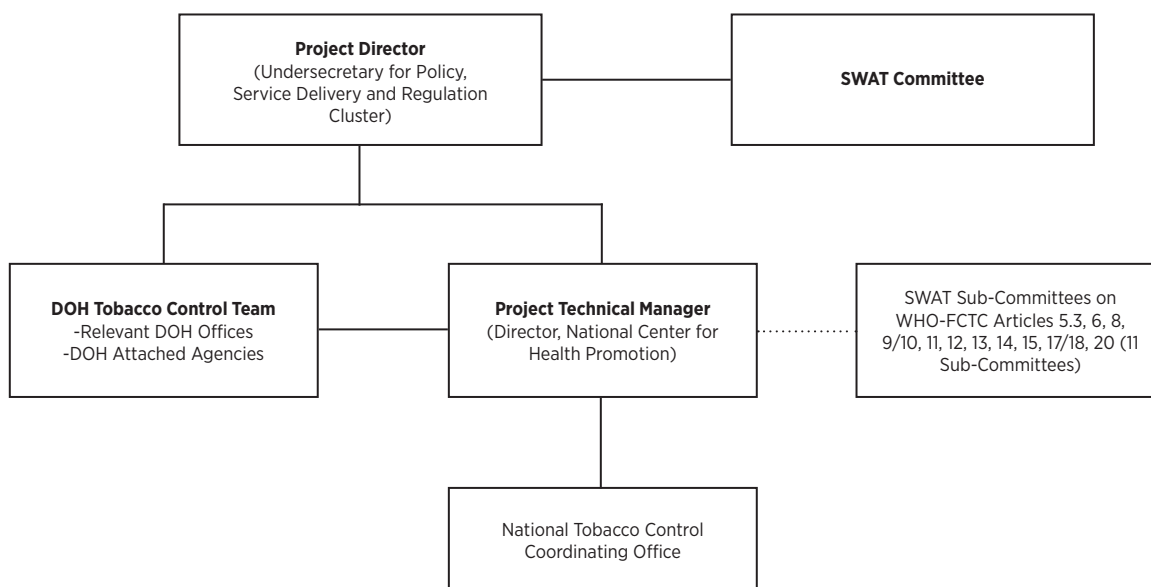


ANNEX 3 OTHER DOH TOBACCO CONTROL INITIATIVES

A. DOH Tobacco Control Team

The Department of Health increased its efforts in tobacco control by creating the Tobacco Control Team (TCT) which legally makes sure the implementation of law. The team is composed of different offices composed of highly respectable directors and technical persons with a wide array of knowledge and expertise on tobacco control.

Figure 2: Tobacco Control Multi-Sectoral Coordination Structure



Source: DOH-NCHP Bloomberg Initiative Project OC-401

B. DOH-NCHP Bloomberg Initiative Project OC-401

The Bloomberg Initiative Project started in 2006 to support an effective evidence-based tobacco control intervention. It generally provides funds to government agencies, non-governmental organizations, civil society organizations and universities in different countries. The core objective of the Initiative is to “reverse the global epidemic of tobacco use by enhancing tobacco control capacity throughout the world’s low and middle income countries.”

The two-year project is managed by the DOH National Center for Health Promotion (NCHP) with the goal of consolidating the country’s effort in tobacco control through sector-wide participation and involvement and implementation of the National Tobacco Control Strategy (**NTCS**). The project is tasked to supplement the country’s tobacco prevention efforts, in congruence with the DOH-National Center for Health Promotion (**NCHP**), and to enforce WHO-FCTC effectively.

The key initiatives of the project include the development of a comprehensive National Tobacco Control Strategy (**NTCS 2011-2016**) and Medium Term Plan (**MTP 2011-2013**); creation of the National Tobacco Control Coordinating Office (**NTCCO**) within the DOH; and formation of the DOH Tobacco Control Team (**TCT**) and eleven Sector-wide Anti-Tobacco (**SWAT**) sub-committees for the implementation of WHO-FCTC provisions.

The development of Sector-wide Anti-Tobacco (**SWAT**) Council with its committees will ensure the implementation of FCTC provisions. Eight out of 11 SWAT committees are headed by the Department of Health office

C. DOH Technical Working Group

The DOH Technical Working Group for the smoking cessation program was created under the Department Order 70-e s 2002 and was repealed by D.O. 193 s 2002. The primary duty of TWG is to effectively implement the National Tobacco Control and Lifestyle Program, which has the following components: 1) advocacy, education, and promotion; 2) smoking cessation and healthy lifestyle; and 3) epidemiology, surveillance, and research.

D. DOH Red Orchid Awards

The Department of Health launched the Red Orchid Awards, an incentive given to locales with 100% tobacco-free environment. The search covers the Central Office, Regional Offices, DOH hospitals, and Local Government Units. Red orchid was used by the World Health Organization as a symbol of a tobacco-free world and a campaign to end the tobacco epidemic.

Table 4: Sector Wide Anti- Tobacco Committee Structure

FCTC Article	SWAT COMMITTEES	LEAD AGENCY	MEMBER AGENCIES
Article 5.3	Tobacco Industry Interference Committee	CSC DOH-NCHP	FCAP, HJ, SEATCA , MMDA, HPDPB, CHD-MM, MMDA, UPCLDF
Article 6	Price Tax Measures	DOH-HPDPB DOF	DOF, BIR, NTRC, FCAP, HJ, AER, UP College of Law , PLCPD, STOP Exploitation
Article 8	Smoke-Free	DOH-HPDPB PMA CSC	PNP, MMDA, COSH, ULAP, PSC, FCAP, PCCP, UP-CLDF, HJ, DILG, LTFRB, MARINA, SEATCA, DOLE, MIAA , TESDA
Article 9 & 10	Regulation of Content/ Disclosure	DOH (FDA) DDB	DTI-BTRCP, SEATCA, HJ, FCAP, OSG, DOJ, NCAC, NCHP
Article 11	Packaging & Labeling of Tobacco Products	DOH (FDA) DTI-BTRCP	SEATCA, HJ, FCAP, OSG, DOJ, NCAC, NCHP
Article 12	Education, Communication, Training & Public Awareness	DOH (NCHP) DepEd AdBoard	PIA, DSWD, NYC, FCAP, PCP, PMA, PCS, CHED, TESDA, PCCP, Media
Article 13	Ban on Tobacco Advertising, Promotion and Sponsorship	DOH (FDA) DOJ	DTI-BTRCP, SEATCA, HJ, FCAP, OSG, NCAC, NCHP
Article 14	Tobacco Dependence Treatment	DOH (NCDPC) LCP, FCAP	PCCP, PMA, SDA, PSC, WHO, IPCAP, AT, PAP, PCGAI PGH, PLC, OSHC, PHIC
Article 15	Illicit trade in Tobacco Products	BOC DOH (Legal Service)	OSG, PCG, DOJ, HJ, PN, BIR , AFP, NBI, PNP
Article 17&18	Alternative Livelihood	DA DOLE	TESDA, DOLE, DSWD, FCAP, DOF
Article 20	Surveillance & Research	DOH (NEC)	DOST, FCAP, PCCP, HJ, SEATCA, UP CPH, U-Belt Consortium, SMIC, PCHRD

Source: Bloomberg Initiative Project OC-401, National Center for Health Promotion, DOH

Nominees are selected by Interagency Committee based on their strengths to implement a 100% smoke-free environment in line with the WHO-MPOWER initiative. Municipalities, cities, health facilities, workplaces and provinces are encouraged to participate by enforcing effective measures that protect people from tobacco smoke.

For the past three years, the Red Orchid Awards project has been giving a Php 500,000 grant to each winner from Local Government Units, Government Hospitals, Government Offices, and DOH-Centers for Health Development. (See below for the list of awardees in 2010).

DOH Red Orchid Awards 2011: Special Citation on Implementation of 100% Tobacco-Free Environment in Government Offices, Hospitals, CHDs, Provinces, Cities, and Municipalities (Source: DOH)

1. Government Offices:

- MMDA
- DepEd - Reg. 1
- LTO - Reg. 10
- CSC – Reg. 1
- Pop Com – CAR
- DTI – CAR

2. CHDs: SOCCSKSARGEN, Cagayan Valley, Eastern Visayas, MIMAROPA, CAR, Bicol, and Metro Manila

3. Hospitals:

- Cotabato Regional & Medical Center
- Ospital ng Palawan
- Luis Hora Memorial Regional Hospital
- Tagaytay Treatment & Rehabilitation Center
- Quirino Memorial Medical Center
- Western Visayas Sanitarium
- Mariano Marcos Memorial Medical Center
- Corazon Locsin Montelibano Regional Hospital

4. Province: Nueva Vizcaya Province

5. Cities: Maasin City, Davao City, Roxas City, Balanga City, Legaspi City

6. Municipalities: Amlan, Negros Oriental; Calatrava, Romblon; Pintuyan, Southern Leyte; Alamada, North Cotabato; Talisayan, Misamis Oriental; Tantangan, South Cotabato; Naval, Biliran; Dupax del Norte, Nueva Vizcaya; Buenavista, Guimaras; Veruela, Agusan del Sur; Solano, Nueva Viscaya; Calauag, Quezon

E. Other Efforts by the Department of Health

Among the other efforts of the DOH are the following:

- MPOWER trainings conducted by the DOH-Health Human Resource Development Bureau;
- Food and Drug Authority (FDA) screening and non-issuance of permits to promotions of tobacco products;

- National Center for Disease Prevention and Control's passage of DOH issuances, specifically the National Tobacco Prevention and Control Program AO 2007-0004;
- National Center for Disease Prevention and Control's leadership in tobacco cessation programs in some DOH hospitals and medical centers; and
- RA 9211 implementation in 12 pilot provinces by the Health Policy Development and Planning Bureau.



ANNEX 4
ORDINANCES, MEMORANDA,
GUIDELINES, EXECUTIVE ORDERS
ON THE TOBACCO CONTROL,
COORDINATION, AND PROTECTION
OF PUBLIC HEALTH FROM UNDUE
INTERFERENCE OF THE TOBACCO INDUSTRY

Year	Document	Detail
2008	DOH Health Policy Notes 3:2	Recommends the creation of the Sector-Wide Anti-Tobacco Council
2009	AO 2009-0004 (administrative order)	Revised DOH policy - Code of Conduct stipulating that DOH officials and employees should not accept any direct or indirect offer (gift, donation, sponsorship) from tobacco companies
2009	DOH DM 2009-0142 (department memorandum)	Institutionalizes the adherence to the DOH policy of not granting applications of the tobacco industry for advertising, promotion, and sponsorship, since this mandate rests with the Food and Drug Administration (formerly DOH Bureau of Food and Drugs) in accordance with the Consumer Act of 1991 or RA 7394
2010	DOH DM 2010-0126 (department memorandum)	Prohibits DOH and its attached agencies' interactions (unless strictly necessary for regulatory purpose), partnerships and contributions through corporate social responsibility (CSR) activities of the tobacco industry, and sets the frame for conflict of interest; for regulatory purposes only specific protocols for meeting tobacco industry are provided
2010	CHED Memorandum from the Executive Director dated 14 January 2010	Commission on Higher Education (CHED) Executive Office directed all central and regional office directors to reject any contribution from the tobacco industry and avoid partnerships with them.
2010	CSC-DOH JMC No. 2010-01 (Joint Memorandum Circular Civil Service Commission and DOH)	It promulgates the policy on protection of the bureaucracy against tobacco industry interference, covering all national and local government officials and employees, including government-owned and controlled corporations, original charters, and state colleges and universities.
2010	DOH CHD4A and DILG 4A Joint Memorandum Circular No. 2010-01	First memorandum circular jointly issued by the DOH and Department of Interior and Local Government Unit (DILG/LGU) enjoining provinces, cities, and municipalities in Region 4A to address the inadequacies of the national law on tobacco control to make it more protective of public health

Year	Document	Detail
2011	DOH DO 2011-0029 (department order)	Appoints the National Centre for Health Promotion (NCHP) as the lead office for the newly established National Tobacco Control Coordinating Office (NTCCO). Establishes Sector Wide Anti Tobacco Committee (SWAT) which is responsible for implementing the WHO-FCTC provisions and its sub-committees (some of which are already operational, e.g., Subcommittee for Art. 5.3). The members of SWAT are government stakeholders, civil society, and academia. The tobacco industry and its front groups were not invited to be part of the Committee.
2011	DC 2011 - 0101	Sets rules and regulations of the FDA (compliant with RA 9711 or the FDA Act of 2009) tasking FDA under article III to regulate tobacco and tobacco products.



ANNEX 5

POLICIES RELEVANT TO PROTECTION FROM SECONDHAND SMOKE IN THE PHILIPPINES

Law/ Policy	Policy Details
R.A. 8749 (Clean Air Act of 1999)	Declares the right of every citizen to breathe clean air, prohibits smoking inside enclosed public places including public vehicles and other means of transport, and directs local government units to implement this provision.
R.A. 9211 (TRA of 2003), Sec. 5 & 6	Prohibits smoking in all centers of youth activity (schools and recreational facilities), elevators and stairwells, locations in which fire hazards are present, buildings and premises of public and private hospitals and other medical facilities, public conveyance (airplanes, buses, taxicabs, etc.) and public facilities (restaurant and conference halls), except for separate smoking areas and in food preparation areas. The law allows establishment of designated smoking areas.
Dept of Interior and Local Government MC No. 2004-85	Implementation of Smoking Ban in Public Places in compliance with RA 9211 and IRR.
Commission on Higher Education (CHED) M.O. No. 63, s. 2007	Bans smoking in higher education institutions.
Philippines Civil Service Commission Memorandum Circular (M.C.) No.17 Series 2009	Mandates that all government agencies, LGUs, government-owned corporations, state universities and colleges adopt a 100% Smoke-Free Policy and Smoking Prohibition in government premises, buildings, and grounds except for open spaces designated as smoking areas.
Department of Transportation and Communication (DOTC)- Land Transportation Franchising and Regulatory Board (LTFRB) M.C. No. 2009-036	Imposes a 100% Smoke-Free Policy on all public utility vehicles and public land transportation terminals.
Department of Health Administrative Order (AO) No. 2009-0010	Adopts a 100% Smoke-Free Environment Policy in all health facilities, hospitals, and all DOH-attached agencies nationwide and recommends adoption of this policy to all LGUs and private health facilities nationwide.

Law/ Policy	Policy Details
Department of Education Order No. 73 s. 2010	Bans smoking in public schools, including open or covered spaces around school buildings.
DOH CHD4A and DILG 4A Joint Memorandum Circular No. 2010-01	Enjoining Provinces, Cities and Municipalities in Region 4A to Enact the "Model Smoke-Free Ordinances"; Prohibited Acts include smoking in enclosed or partially enclosed public places, workplaces, public conveyances.
DILG Memorandum: 1 Feb 2011	Implementation of Smoking Ban in compliance with RA 8749 or the Philippine Clean Air Act of 1999.
Religious Rulings	Islamic Fatwa on Smoking issued by the Supreme Council of Darul Ifta of the Philippines declaring that cultivating, selling, smoking tobacco or cigarette is haram (forbidden).
Local Ordinances (not exhaustive list)	<p>LGUs with Anti-Smoking Ordinances or that have passed Smoke-Free Legislation in support of FCTC or have good implementation of ordinances:</p> <p>Provinces: Nueva Vizcaya in Cagayan Valley;</p> <p>Cities: Makati, Pasig in National Capital Region, Metro Manila; Balanga City in Bataan, Central Luzon; Legazpi City in Albay, Bicol Region; Roxas City in Capiz, Western Visayas; Maasin City in Southern Leyte, Eastern Visayas; Davao City in Davao Region;</p> <p>Municipalities: Umingan in Pangasinan, Northern Luzon; Calatrava in Romblon, MIMAROPA; Buenavista in Guimaras, Western Visayas; Amlan and Zamboanguita in Negros Oriental, Central Visayas; Naval in Biliran and Pintuyan in Southern Leyte, Eastern Visayas; Dumingag in Zamboanga del Sur, Zamboanga Peninsula; Talisayan in Misamis Oriental, Northern Mindanao.</p>



ANNEX 6

POLICIES RELEVANT TO TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP (TAPS) IN THE PHILIPPINES

National Law/ Policy	Policy Details
R.A. 9211	<ul style="list-style-type: none"> Restricts tobacco advertising in all mass media (TV, radio, cinemas, print advertising, internet, outdoor advertising) except inside the premises of point-of-sale establishments Bans sponsoring of events Restricts promotion and sampling to persons over 18 years old and prohibits merchandize with logo or name visible when worn
Dept of Interior and Local Government Memorandum Circular (DILG MC No. 2007- 126)	<ul style="list-style-type: none"> Advisory on the implementation of Section 22 of RA 9211, otherwise known as the Tobacco Regulation Act of 2003 Tobacco advertisements may be made inside or outside point-of-sale retail establishments as long as it is within their premises
Dept of Health Department Memorandum No. (DOH DM No. 2009-0142)	<ul style="list-style-type: none"> Ban on Promotion, Advertisements, and Sponsorship of Tobacco Products DOH Policy of not granting applications for advertisements, promotion, and sponsorships
RA 9211 Inter-Agency Committee on Tobacco Memorandum Circular (I-ACT MC No. 1 s. 2008)	<ul style="list-style-type: none"> Monitoring and Enforcement Guidelines of the Tobacco Regulation Act of 2003 and its Implementing Rules and Regulations Designated the Department of Health as pilot agency in the implementation of provisions on Healthful Environment and Advertising and Promotions
DOH CHD4A and DILG 4A CSC and DOH Joint Memorandum Circular (JMC No. 2010-01)	<ul style="list-style-type: none"> Enjoining Provinces, Cities and Municipalities in Region 4A to Enact the "Model Smoke-Free Ordinances" Model Ordinance's Prohibited Acts include placing cinema and outdoor advertisements of tobacco products and placing, posting, or distributing advertising materials outside the premises of point-of-sale establishments and even if inside the POS when establishments are not allowed to sell or distribute tobacco products. Public officials and employees shall not solicit or accept directly or indirectly any gift gratuity or favor, entertainment or anything of monetary value in the course of their official duties or in connection with any operation being regulated by, or any transaction which may be affected by the functions of their office from any person or business related to the TI

National Law/ Policy	Policy Details
DOH Dept Order 2011- 0029	<ul style="list-style-type: none"> • Designating the NCHP as the NTCCO in the DO and its Coordinating Mechanism • Implements standardized reporting systems and processes to underpin capability to monitor performance and outputs across the sector and subcommittees. Art 13 has also a subcommittee formally established but no plan of action yet
DILG Memorandum Circular2007-126	<ul style="list-style-type: none"> • Advisory on the implementation of Section 22 of RA 9211, otherwise known as the “Tobacco Regulation Act of 2003” • Tobacco advertisements may be made inside or outside the point-of-sale establishments as long as it is within their premises



ANNEX 7

THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL (WHO-FCTC)

A. Background

The WHO Framework Convention on Tobacco Control (WHO-FCTC) was adopted by the 56th World Health Assembly in May 2003 and became an international law on 27 February 2005. It opened for signature from 16 to 22 June 2003 in Geneva, and thereafter at the United Nations Headquarters in New York, the depository of the treaty, from 30 June 2003 to 29 June 2004 (WHO- FCTC 2003).

Now with 174 countries as parties to the convention (WHO-FCTC report, 2012), the treaty focuses on marketing bans, public awareness, raising taxes, preventing sales to minors, and control of the illicit trade of tobacco products (Council on Foreign Relations: Global Action on Non-Communicable Diseases, 2011).

The FCTC calls for countries to establish programs for national, regional, and global tobacco surveillance. It has initiated the formulation of policies in different parts of the globe focusing on the health implications of tobacco and on the importance of tobacco control. It also encourages countries to develop and implement tobacco control action plans to include public policies, such as bans on direct and indirect tobacco advertising, tobacco taxes and price increases, promoting smoke-free public places and workplaces, and including health messages on tobacco packaging.

The Philippines became a signatory on 23 September 2003 and the Senate in turn ratified this treaty on 06 June 2005. .

B. FCTC Goals and Objectives

The FCTC is a regulatory strategy aimed to address the tobacco epidemic. The objective of the Convention and its protocols is to protect present and future generations from the devastating health, social, environmental, and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be

implemented at the national, regional, and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke (WHO-FCTC 2005).

The WHO-FCTC is divided into core demand reduction provisions and core supply reduction provisions.²

C. FCTC Provisions with Corresponding Articles

1. Protection

Article 5.3. Protection of public health policies from the interests of the tobacco industry

Article 8. Protection from exposure to secondhand smoke

Article 18. Protection of the environment and the health of persons

2. Demand Reduction

Article 6. Price and tax measures to reduce the demand for tobacco

Article 7. Non-price measures to reduce the demand for tobacco

Article 9. Regulation of the contents of tobacco products

Article 10. Regulation of tobacco product disclosures

Article 11. Packaging and labelling of tobacco products

Article 12. Education, communication, training, and public awareness

Article 13. Tobacco advertising, promotion, and sponsorship

Article 14. Tobacco dependence and cessation

3. Supply Reduction

Article 15. Illicit trade in tobacco products

Article 16. Sales to and by minors

Article 17. Provision of support for economically viable alternative activities

4. Exchange of Information

Article 20. Research, surveillance and exchange of information

Article 21. Reporting and exchange of information

Five out of the eight core demand reduction provisions and two out of the three core supply reduction provisions of the WHO-FCTC were addressed in RA 9211. The core demand reduction provisions have several stipulations that are not provided for in RA 9211, such as the price, non-price, and tax measures to reduce the demand for tobacco.²


Another addition in the WHO-FCTC treaty is the mechanisms for scientific and technical cooperation and exchange of information which are set out in Articles 20- 22. The WHO-FCTC also provides for regulation of the contents of tobacco products, which are not touched by RA 9211.² Lastly, Articles 9-10 of the WHO-FCTC specifically provides that the adoption and

implementation of measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products be in accordance with the party's national law. Unfortunately, RA 9211 does not address the regulation of tobacco product emission and toxic constituents.²

With the core supply reduction provisions, stipulations on the illicit trade in tobacco products are an added aspect in the WHO-FCTC, which is not included in RA 9211.²

Since the implementation of RA 9211 preceded WHO-FCTC, not all provisions or articles of the FCTC were covered in RA 9211. The national government and its agencies and local government units have created lawful mandates in response to salient calls of some of the articles of the treaty. There is a need to amend the law by new legislation that will address critical aspects of FCTC. This includes Article 5.3 (protection of public policy from interference of the tobacco industry), Article 6 (price and tax measures to reduce the demand for tobacco), Article 8 (protection from exposure to tobacco smoke), Article 11 (use of Graphic Health Information), and Article 13 (ban on point of sale advertising), among others.

FCTC Priority Measures	
5.3	Tobacco Industry Interference
6	Taxes
8	Smokefree Environments
11	Product Regulation and Packaging
12	Education
13	Access Restriction & Advertising Bans
14	Tobacco Cessation
15	Illicit Trade
17 & 18	Alternative Livelihood
20	Surveillance and Research



Source: DOH



ANNEX 8

THE NATIONAL CAPACITY ASSESSMENT TEAM KEY FINDINGS AND RECOMMENDATIONS

A. KEY FINDINGS/ CHALLENGES TO CONTINUED PROGRESS OF TOBACCO CONTROL IN THE PHILIPPINES:3

1. Cigarettes are highly affordable in the Philippines, largely due to low taxes and a complex tax structure. Little of the revenue from these taxes has been used for health purposes and health consequences of the existing tobacco tax system (WHO-FCTC Art 6) appear not to be fully appreciated by policy makers.

Cigarette prices in the Philippines are among the lowest in the world. A tiered tax structure that imposes low taxes on inexpensive brands is a significant cause of this problem, which is exacerbated by the price classification freeze that applies to many brands and taxes them based on their prices in 1996. The health impact of this is poorly understood by policy makers. While tobacco taxes generate significant revenues, few of these revenues have been used for health purposes. From 2005 to 2010, 2.5% of the revenues from a tobacco tax increase was devoted to PhilHealth and another 2.5% went to disease prevention efforts. There is a considerable interest in using tobacco revenues to support universal health coverage.³

a. Key Findings on WHO-FCTC Article 6 Implementation

(FCTC Article 6: Price and tax measures to reduce the demand for tobacco)

1. Cigarettes are highly affordable in the Philippines, in large part due to low taxes and a complicated tax structure. The Philippines has among the lowest cigarette prices in the world. Some brands sell for as little as PhP8 per pack of 20 cigarettes, while many popular brands sell for between PhP12 and PhP25. Please see comment on page 40.
2. The availability of these low priced brands keeps cigarettes affordable for those on low incomes and, together with the widespread availability of cigarettes sold individually, makes cheap cigarettes readily available to children.

3. Earmarking of tobacco tax revenues for health purposes has been small in recent years – 2.5% of the new tax revenues from the 2008 tax increase was earmarked for PhilHealth and 2.5% was earmarked for disease prevention.
4. Earmarked funds are distributed to local governments and used for a variety of activities, including infrastructure development and efforts to improve tobacco farming. None of the funds, however, are directly returned to tobacco farmers or are used for programs that support tobacco farmers' efforts to move out of tobacco farming and into alternative livelihoods.
5. The price classification freeze maintains the price classification of 'old' cigarette brands (i.e., those brands classified on or before January 1, 1997, listed in Annex 'D' of Republic Act 8240 and amended by Republic Act 9334).

Current Tobacco Tax Structure

i) Cigarettes packed by hand (each pack with 30 pieces)	PhP 2.72
ii) Cigarettes packed by machine (each pack with 20 pieces)	
NRP below PhP 5 per pack (low-priced)	PhP 2.72
NRP of PhP 5 to PhP 6.50 per pack (medium-priced)	PhP 7.56
NRP above PhP 6.50 to PhP 10 per pack (high-priced)	PhP 12.00
NRP of above PhP 10 per pack (premium-priced)	PhP 28.30

6. The freeze fixes the tax according to the brands' net retail prices as of October 1, 1996. Even if the actual net retail price exceeds the range corresponding to its original price class, it remains in its original price class and is taxed at a rate which is lower than if it were taxed according to its current net retail price.
2. Effective local government efforts for creating smoke-free environments exist and non-governmental organizations are making important contributions. However, there is a lack of financial and technical support necessary for the sustained countrywide reach required to deliver potentially large health benefits (FCTC Art 8).

Some LGU ordinances have achieved consistency with WHO-FCTC Art. 8 Guidelines by requiring 100% smoke-free indoor public places (i.e., without designated smoking areas). These promising practices are supported by the DOH, but they have not yet been fully exploited for optimal health gain. This may be because (i) some proven initiatives (such as the smoke-free initiative implemented by CHD for Metro Manila) have not been maintained beyond the first phase or taken to the necessary scale; and/or (ii) variability in the quality of ordinances and lack of electronic data systems for comparability of enforcement and compliance data are undermining progress; and (iii) in some cases, data are being provided (e.g., by CHD-MM to LGUs) but apparently are not being utilized for enforcement action. Smoke-free policy measures can be included

*within licensing arrangements at national and local levels, but these are not always utilized; an example is the LGU role of licensing local businesses – it is important but underutilized.*³

b. Key Findings on WHO-FCTC Article 8 Implementation

(FCTC Article 8: Protection from exposure to tobacco smoke (protection from SHS))

1. Scientific evidence has firmly established that there is no safe level of exposure to secondhand tobacco smoke (SHS), a pollutant that causes serious illnesses in adults and children. There is also indisputable evidence that implementing 100% smoke-free environments is the only effective way to protect the population from the harmful effects of exposure to SHS.
2. Despite existing smoke-free national and local policies, social norms supportive of smoke free environments and specific institutional policies are not yet strongly promoted and supported.
3. Despite the prime opportunities for many of the national agencies to use national policy directives (such as M.C.17) to develop, implement, and monitor agency-specific smoke-free policies covering their own premises, employees and (as relevant) members of the public, not all of these agencies have yet done so. Examples include: a) Civil Service Commission (CSC); b) Department of National Defense (DND); c) Occupational Safety and Health Centre (OSHC); d) Department of Labor and Employment (DOLE); and e) Philippine National Police (PNP).
4. Effective Local Government Units (LGUs) efforts lack technical support and financial sustainability.
5. Existing national policies for smoke-free environments are not being enforced or monitored.
6. Current laws allowing the establishment of designated smoking areas in public places do not effectively protect public health.
7. RA 9211 specifically mentioned air conditioning and ventilation standards in accordance with Presidential Decree No. 1096 or the National Building Code and with the Philippine Society of Mechanical Engineers Code. These are clearly and evidently outdated guidelines in relation to the WHO-FCTC provisions.
8. The health services sector is not yet fully involved in smoke-free policy implementation and in mobilizing public support for it.
9. Medical bodies such as the Philippines Medical Association (PMA) and the Philippines Ambulatory Paediatrics Association (PAPA), although having important leadership roles to offer through their own policies and position statements, have not exerted sufficient

efforts to influence medical training curricula and continuing medical education (CME) accreditation processes.

10. Some LGU ordinances have achieved consistency with WHO-FCTC Art. 8 Guidelines by requiring 100% smoke-free indoor public places (i.e., without designated smoking areas).

These promising practices are supported by the DOH, but they have not yet been fully exploited for optimal health gain. This may be because (i) some proven initiatives (such as the smoke-free initiative implemented by CHD for Metro Manila) have not been maintained beyond the first phase or taken to the necessary scale; and/or (ii) variability in the quality of ordinances and lack of electronic data systems for comparability of enforcement and compliance data are undermining progress; and (iii) in some cases, data are being provided (e.g., by CHD-MM to LGUs) but apparently are not being utilized for enforcement action. Smoke-free policy measures can be included within licensing arrangements at national and local levels, but these are not always utilized; an example is the LGU role of licensing local businesses – it is important but underutilized.

3. The lack of a coordinated national cessation infrastructure/system and cessation providers hampers the implementation of the national cessation policy (FCTC Art 14).

A national cessation policy that is unimplemented is a major gap in tobacco control efforts in the Philippines. Cessation programs exist, but these are few in number, are institution-based with no mechanisms to link to the community at large, and run independently of each other. The emphasis is on clinical models of service delivery rather than on population approaches to cessation. There is no national quit line. The lack of cessation providers, especially within the public sector, is perceived as a barrier to the full implementation of smoke-free laws, because smokers in settings that mandate smoke-free policies have limited access to assistance with quitting. Moreover, cessation drugs are of limited availability.³

c. Key Findings on WHO-FCTC Article 14 Implementation

(FCTC Article 14: to promote cessation and the treatment of tobacco dependence)

1. In response, the DOH issued Administrative Order (AO) No. 122 specifying guidelines to implement a National Smoking Cessation Program within all DOH offices, attached agencies, DOH-retained hospitals and health facilities and fixed or mobile units.
2. Only ten pilot areas had implemented cessation clinics and only two were operationalized. The establishment of smoking cessation clinics nationwide was a strategic area of work for the DOH in the National Objectives for Health 2006-2010.
3. The various existing cessation clinics also are not linked to each other or to health professionals

offering brief advice, in any systematic way, with the exception of a few members of the Philippine College of Chest Physicians (PCCP) that have established cessation programs where lung specialists oversee cessation pharmacotherapy.

4. Establishing a coordinated national cessation system in a developing country setting like the Philippines requires an incremental approach that balances evidence-based population and clinical interventions.

4. Mass media activities are irregular and use weak, ineffective content (FCTC Art 12)

Campaigns developed and conducted by the DOH are generally done only in May (World No Tobacco Day) and June (No Smoking Month). Substantial evidence from other countries suggests campaigns must be done multiple times per year with sufficient reach and frequency in order to effectively promote behavior change. Additionally, IEC materials do not generally make use of graphic imagery about the harms of tobacco. International evidence suggests that graphic campaigns showing the physical and emotional harms of tobacco are most effective in increasing knowledge, changing attitudes, and prompting behavior change. An extensive pre-testing project conducted in 2008 confirmed such messages and specific materials are effective with Filipino audiences. Other than through one campaign conducted by CHD-Metro Manila in 2008, the study results and associated materials have been largely underutilized.³

WHO FCTC Article 12 requests Parties to promote and strengthen public awareness of tobacco control issues, using all available communication tools, as appropriate. Consistent with other provisions of the WHO Framework Convention on Tobacco Control and the intentions of the COP to the Convention, specific guidelines were adopted to assist Parties in meeting their obligations under Article 12 of the Convention.

DOH Administrative Order (AO) 58 (2001) further clarified the role of the National Centre for Health Promotion (NCHP), establishing it as the communication arm of DOH and a clearing house for all health-related information. DOH AO 58 is in the process of revision to specify the role the private sector can play in disseminating such health information.

d. Key Findings on WHO-FCTC Article 12 Implementation

FCTC Article 12 (Education and Communication)

1. Anti-tobacco advertising in mass media is not sustained and conducted regularly. The anti-tobacco campaigns developed and conducted by DOH are generally related to the World No Tobacco Day in May and to the No Smoking Month in June. However, similarly to warnings on cigarette packages, persons over 65, those with no formal education, and those in the poorest wealth quintiles were least likely to have noticed anti-tobacco messages.
2. DOH does not have enough funding to conduct effective national mass media campaigns.

DOH has limited financial resources (approx. PHP10 million) to produce materials and purchase air time; as such, materials are supplied to regions but not in sufficient quantity and no national campaign is possible with existing funds. Please see comment on page 52

3. The DOH should pursue the expansion of the financial resources to produce and air mass media campaigns. A possible means to mobilize more resources to produce and air mass media campaigns could be through the designation of a part of tax revenues to this purpose.
4. The DOH should pursue alternative channels for disseminating warning information. Different communication techniques can complement each other, such as advertising plus public relations, community-based campaigns and events. The impact of the whole can be much greater than the sum of the parts.
5. Graphic Health Information on all tobacco packages (introduced by DOH AO 2010-0013) can be implemented even though court cases are pending. (Art 11, 13)

The DOH has the authority to implement the AO in all jurisdictions except those that are currently under legal dispute. Local government units may also implement the AO in accordance with the Local Government Code, Section 16, which states that local government units shall exercise their powers to promote general welfare including health and safety.³

FCTC Article 11 focuses on tobacco packaging and labelling measures, specifically ensuring maximum visibility of health warnings and messages on tobacco products. It indicates that health warnings and messages be large, clear, visible and legible, and should be 50% or more but no less than 30% of the principal display areas. Parties should consider the use of pictorial health warnings positioned on principal display areas (on both the front and back of each unit packet; and at the top rather than at the bottom to increase visibility) of products packaging. It shall also be in full color rather than black and white, with rotating messages.

Rotation of health warnings and messages and changes in their layout and design are important to maintain saliency and enhance impact. (Parties should consider establishing two or more sets of health warnings and messages to alternate after a specified period, such as every 12-36 months). Parties should provide phase-in-period for rotation between sets of health warnings and messages, during which time both sets may be used concurrently.

Pictorial warning labels influence initiation and motivate tobacco users to quit. In the Philippines, 38% of current smokers who recalled seeing pack warnings (text only) had thought about quitting because of the warning label.

Currently, RA 9211 governs the implementation of health warnings on cigarette packs. The law states that rotating text warnings are required (30% of front display) and no other printed

warnings shall be placed on packages of tobacco products. It also states such warnings should be in either English or Filipino.

The following warnings are mandated: "GOVERNMENT WARNING: Cigarette Smoking is Dangerous to Your Health"; "GOVERNMENT WARNING: Cigarettes are Addictive"; "GOVERNMENT WARNING: Tobacco Can Harm Your Children"; "GOVERNMENT WARNING: Smoking Kills."

Tobacco control advocates have proposed bills to legislate graphic warnings but those bills were not passed into law (e.g., House Bill 3364, the Graphic Health Information Bill - rejected by the Committee of Health in 2008 on the basis of economic arguments that would affect the livelihood of tobacco farmers).

To harmonize this RA 9211 provision with WHO-FCTC Article 11, and "to ensure product packaging and labeling does not promote tobacco by any means that are false, misleading, deceptive or likely to create an erroneous impression," DOH issued Administrative Order 2010-13 (AO 2010-13) in May 2010. This Order enables DOH to implement rotating evidence-based Graphic Health Information (30% of front and 60% of back of package), which are more effective and can be more easily understood by segments of the population that are illiterate or cannot read English.

The tobacco industry subsequently filed lawsuits in five venues asserting that the order is unconstitutional based on the fact that international law such as WHO-FCTC must be implemented by legislation, not administrative order. DOH argues that the legal basis of the AO is both the Consumer Protection Act, a national law, and made consistent with WHO-FCTC and its guidelines. (Please see National Capacity Assessment For Tobacco Control, Philippines, May 2011- Annex II on p. 62)

e. Key Findings on WHO-FCTC Article 11 Implementation

(FCTC Article 11: Packaging and labelling of tobacco products)

1. DOH has a clear mandate in all matters related to public health and is defending this mandate in court and through advocacy.

The Food and Drug Administration (FDA) has the authority to issue licenses and regulate any product that impacts the health of Filipino citizens (RA 9711). Also, the Interagency Committee on Tobacco Memorandum Circular No.1 designates DOH as being responsible for warnings on cigarette packs.

Despite the tobacco industry's interference, the DOH may push forward on implementing

pictorial health warnings. By virtue of the Constitution and the Administrative Code of 1987, DOH has the authority to ensure propagation of health information. Pending final resolution of court cases, DOH could assert its authority everywhere except in Tanauan, Southern Luzon; Malolos, Central Luzon; and in the Metro Manila cities of Marikina, Pasig, and Parañaque.

While the tobacco industry is still allowed to advertise tobacco at the point of sale, the Filipinos are not getting the health warnings on the danger of these products.

This is a critical marketing point for the tobacco industry. Point-of-sale advertising is a powerful form of advertising used by the tobacco industry to sell its products and is especially effective with youth and smokers trying to quit. Evidence shows that increases in counter-advertising reduce consumption.³

WHO-FCTC Article 13 states that "parties recognize that a comprehensive ban on advertising, promotion, and sponsorship would reduce the consumption of tobacco products." Article 13 focuses on achieving comprehensive bans, removing point-of-sale (POS) advertising and dealing with cross-border and other non-traditional forms of advertising and promotion.²¹

f. Key Findings on WHO-FCTC Article 13 Implementation

FCTC Article 13: Ban on tobacco advertising, promotion, and sponsorship (TAPS)

1. The enforcement of the current restrictions on the tobacco advertising, promotion, and sponsorship is weak, mainly due to poor clarification of designated agencies' roles and functions, and lack of strong enforcement mechanism.
2. Violations of TAPS restrictions are many. Based on the current legislation there is no other permission for placing advertisements other than at the point-of-sale (POS); therefore, there is a significant number of respondents that were exposed to tobacco advertisements in other places than the POS. This may be attributed to the poor enforcement of the TAPS ban.
3. Local implementation of TAPS restrictions is possible but not yet implemented in many regions. At local levels, the enforcement falls under the authority of the DOH-CHD regulatory officers as well as under the city and municipal officials (Mayor's police force as well the local PNP police officers) in the form of "local ordinances."
4. So far, the assessment team could find only one Joint Memorandum Circular (JMC) between DOH and DILG (DOH CHD 4A and DILG 4A/2010) covering Region 4A. The model provided by this JMC as a local instrument in implementing the Tobacco Act does include most of the components of a concrete enforcement mechanism, apart from the requirement on sharing data and reporting among institutions and to the public. At the moment there are

currently only few local jurisdictions that have introduced and started implementation of local ordinances.

5. The regional / provincial performance 'score cards' do not include TAPS. Police officers (Mayor and PNP) are not enforcing TAPS except in some committed LGUs that included TAPS restrictions in the local ordinances with more clear enforcing mechanism.
6. Active participation of citizens in enforcement is not utilized. No complaint hotline exists, although the mode for the local ordinances recommends the introduction of such a phone line.
7. No specific training on TAPS enforcement exists. The training under the broad framework of MPOWER is conducted by core trainers from the DOH Central Office in partnership with civil society based on a module prepared by the Health Human Resource Development Bureau (HHRDB) and enhanced by partners from academe and civil society in the form of training of trainers -TOT (and yet the concrete enforcement of TAPS restrictions is not part of it). Please see pp 55 for other comment
8. Dedicated funds for enforcing, monitoring, and evaluating the impact of the TAPS restrictions seem not to be allocated. Whether they exist or not, reports are not made available to the assessment team.
9. Potential for active coalition on TAPS exists. Governmental agencies (FDA, PNP), in collaboration with WHO CO as well as NGO community (FCAP, FIDS, etc.), run grant projects with international funding that include TAPS in their objectives (basically advocacy for a stronger enforcement of RA 9211) but are not mainstreamed into the national tobacco control coordination initiatives of the DOH.
10. The Philippines has not met the five-year deadline for undertaking a comprehensive TAPS ban.
11. The restrictions on tobacco advertising, although very comprehensive, still allow an exception: advertising at the points-of-sale (POS). Point-of-sale tobacco promotion including cigarette displays is a powerful form of advertising that is especially effective with youth and smokers trying to quit. Currently the tobacco industry takes full advantage of the misinterpretation of the law as allowing advertisements at the POS and even circumvents the current legal requirements by placing advertisements at both inside and outside the POS.
12. Moreover, the current law does not require a health warning to be placed at the POS as counter advertising measure to the existing tobacco advertising. The restrictions on tobacco promotion and sponsorship still allow many exceptions. Various exceptions are

- allowed by law based on age of audience and location of the promoting action.
13. Also, although DOH Memorandum 2009-0142 restricts sponsorship of any sport, concert, cultural, or art event, it still allows mentioning the name of the company in the roster of the sponsors, and the applications for sponsorship and promotion are banned only within the scope of the DOH authority.
 14. The National Tobacco Control Strategy (2011-2016) and Medium Term Plan (2011-2013) are still to be developed. Coordination and funding mechanisms are not yet defined and regularly allocated and the Sector-Wide Anti-Tobacco (SWAT) Committee has yet to be officially constituted.

Experiences in different sectors and in several countries have shown that a national plan of action based on the WHO-FCTC provisions and addressing the countries specificities provides a roadmap for a common vision on tobacco control strategies.

The national strategy and plans will also serve as a basis for similar exercises at sub-national level. Dedicated funds, clear mechanisms of collaboration, and the involvement of the different health and non-health stakeholders are keys for successful outcomes.³

B. KEY RECOMMENDATIONS

1. Simplify the existing tobacco tax structure, significantly raise tobacco product excise taxes, and index taxes to inflation in order to raise tobacco product prices and reduce tobacco use; earmark revenues from tobacco taxes for health priorities.

The existing tax structure should be simplified by eliminating the price classification freeze and by reducing the number of price tiers with the goal of applying a uniform tax on all cigarettes. Tobacco taxes should be increased significantly in order to raise prices and reduce tobacco use, with a goal that tobacco excise taxes account for 70% of prices. Tobacco taxes should be regularly increased with inflation so as to maintain the value over time. The revenues generated by these taxes should be used for health purposes, including universal health coverage, health promotion, and tobacco control. The DOH should strengthen its capacity and evidence in order to provide technical advice to influential policy makers who make decisions regarding tobacco taxes.³

a. Key Recommendations on Taxation

1. Simplify the existing tobacco tax structure, significantly raise tobacco product excise taxes, and index taxes to inflation in order to raise tobacco product prices and reduce tobacco use. Replace the Philippines' existing multi-tiered specific cigarette excise tax structure with a

- uniform specific tax on all cigarettes.
2. Earmark tobacco tax revenues for health purposes, including health promotion and tobacco control. These efforts should include dedicating a portion of tobacco tax revenues for comprehensive tobacco control programs. There must be a clear process for transferring earmarked tobacco tax revenues from the excise revenue to ensure that the funds are used for the intended purposes.
 3. Earmark tobacco tax revenues for programs that help those employed in tobacco dependent sectors make the transition to alternative livelihoods.
 4. Strengthen tobacco tax administration, increase enforcement, and tax duty free sales of tobacco products in order to reduce tax evasion and avoidance. Put in place a well-established monitoring system that employs new technologies for monitoring the production and distribution of tobacco products. These new technologies include adoption of the new generation of more sophisticated, hard-to-counterfeit tax stamps and a tracking-and-tracing system that can follow tobacco products through the distribution chain.
 5. Sustain and expand efforts to support the tobacco tax reforms and health promotion financing mechanisms by building further capacity and generating further evidence with the support of stakeholders such as the academe, civil society organizations (CSOs), and other pertinent government agencies.

2. At least double the number of LGUs with 100% smoke-free policy initiatives (no designated smoking areas indoors) through dedicated financial and technical support and with the active involvement of non-governmental organizations.

These 100% smoke-free LGU initiatives should be sustained through: (i) public awareness programs, (ii) dedicated staffing, (iii) training and capacity building, (iv) data systems to underpin compliance monitoring and evaluation, and (v) development of business licensing models as sustainable means of promoting smoke-free environments.³

b. Key Recommendations on Smoke-Free Policies

1. The Department of Health and other national government agencies should provide stronger commitment and leadership to promote social norms in support of 100% indoor smoke-free environments.
2. Local governments should expand and sustain their smoke-free policy initiatives through dedicated financial and technical support for: (i) public awareness programs, (ii) dedicated staffing; (iii) training and capacity building, (iv) data systems to underpin compliance monitoring and evaluation, and (v) development of business licensing models as a

sustainable means of promoting smoke-free environments.

3. The DOH should pursue collaboration with all relevant stakeholders for ensuring that the Republic of the Philippines meet its obligations under the WHO-FCTC Article 8, which requires the adoption of effective measures to protect people from exposure to tobacco smoke in (1) indoor workplaces, (2) indoor public places, (3) public transport, and (4) “as appropriate” in “other public places.”
4. The DOH should take the leadership in proposing amendments of the national laws and policies and facilitate the debate in the government and Parliament as well as with the public to strengthen the implementation of smoke-free policy.

3. Develop a coordinated national cessation infrastructure that incorporates both population and clinical approaches in a stepwise manner, and build on and augment existing resources and service delivery mechanisms. Commence implementation in those LGUs where the demand for cessation already exists and where smoke-free policy support is strong.

Establishing a coordinated national cessation system in the Philippines requires an incremental approach that balances evidence-based population and clinical interventions with brief advice, intensive counseling, and when appropriate, drug therapy. Because health service delivery is a direct function of LGUs, this tiered cessation system should exist within each LGU and implemented first in those LGUs with a high demand for cessation and have strong smoke-free and other tobacco control policies. Counseling formats other than face-to-face programs, such as quit lines, should be considered especially as demand for cessation services increases. The cessation aids covered by health insurance need to be incorporated into the national formulary.

c. Key Recommendations on Tobacco Cessation

1. Initiating this cessation system should be implemented first in those LGUs where the demand for cessation already exists, reinforced by sound smoke-free and other tobacco control policies.
2. Making cessation drugs more available should be addressed. These cessation aids need to be incorporated into the national formulary.
3. A standard set of tobacco cessation practice guidelines and service delivery models should be finalized, endorsed, and widely promoted. Opportunities to integrate these guidelines into relevant health and other programs (i.e. cancer control programs, maternal and child health programs, TB control programs, as well as poverty alleviation programs, workplace wellness programs, social welfare programs) should be explored and utilized.
4. Additional health providers should be actively recruited in identifying tobacco users who

are ready to quit and providing brief advice.

5. DOH efforts on training of trainers such as those initiated in several Centers for Health Development (CHD) should be continued.
6. Tobacco cessation should be framed as a core prevention intervention, and incorporated into other related covered benefits, such as primary health care, tuberculosis Directly Observed Treatment Strategy (TB-DOTS) package, and maternity care.

4. Initiate a sustained program of quarterly public awareness campaigns with content proven as effective in the Philippines.

Campaigns should be done several times per year in order to have an impact on the population. The sustained program must go beyond health observances such as World No Tobacco Day and No Smoking Month. A 2008 research study tested and found 10 specific international campaigns to be effective with Filipino audiences. Adapting these materials could substantially reduce production cost and development time for DOH. Ideally, national campaigns should be developed and aired through government associated media, paid media, and DOH networks. Alternatively, DOH can take the lead in developing campaign packages that can be disseminated to the regions and through its own networks. It can provide technical assistance in aspects of production, media planning, and campaign evaluation.³

5. Given the scientific evidence supporting the use of Graphic Health Information, LGU implementation should be encouraged and supported by the DOH.

Local governments have the authority to implement administrative orders under the local government code. In the longer term, propose a bill that enacts the best-practice use of Graphic Health Information into law.³

d. Key Recommendations on Graphic Health Information (GHI)

1. The DOH in collaboration with the other relevant government agencies should assert authority prominently in defense of the health of the Filipino people.

The department should continue to pursue its legal position and seek opportunities to publicize the evidence-based rationale for graphic pack warnings, as well as to expose misinformation of the industry.

2. The DOH should implement the pictorial health warnings established through DOH AO 2010-13 among the tobacco companies that have not filed for an injunction and in all jurisdictions except those that are currently under legal dispute.
3. The LGUs should use their legal competencies to ensure placement of counter advertising/

health warnings at the point-of-sale.

In the short term, while the point - of - sale tobacco advertising is still allowed, the DOH could develop a model ordinance for LGUs to place large, visible health warnings at point of sale and LGUs, under the Local Government Code. In a longer term strategy the DOH should initiate and propose an amendment to the national law to ban completely the tobacco advertising at the point-of-sale.

e. Key Recommendations on TAPS ban

1. Under its leadership and coordination, DOH should strengthen the enforcement mechanism of the current TAPS' restrictions, through coordinated action at local jurisdictions.
2. The DOH should take leadership in the development of monitoring tools to collect information on TAPS restrictions enforcement actions, monitoring compliance that can be implemented at local levels by the regional DOH CHD regulatory officers and local health workers in collaboration with local LGU enforcing agents regarding efforts for enforcing the smoke-free environments at the LGU level. Inspection check lists should include TAPS ban, and eventually the score cards could add indicators on TAPS.
3. The central and regional levels should share in the allocation of dedicated funds and human resources to enhance enforcement of TAPS restrictions.
4. The FDA should pursue immediate issuance of the RA 9211 implementing rules and regulations and operational guidelines. According to its current mandate, the FDA should ensure that information concerning TI marketing strategies are regularly collected and made available to the implementing agencies and then eventually to the public.
5. DOH should conduct regular training for its regulatory officers as well as the police force. The training strategy, which should focus on the TAPS ban enforcement, should also include regular evaluation of effectiveness and performance.
6. FCTC Alliance Philippines (FCAP) and other non government organizations (NGOs) should increase their efforts for awareness building and advocacy for reporting law violations at grass roots levels and in the communities.
7. Relying on its current formal mandate for monitoring and enforcing a ban on TAPS, the DOH should advocate for it and take the lead in initiating and proposing a complete ban on TAPS, without any exceptions.

8. The DOH, having been mandated by the IAC-T Memorandum Circular No. 01 on the Monitoring and Enforcement Guidelines of the Tobacco Regulatory Act of 2003 as a pilot agency responsible for monitoring and enforcing the TAPS ban, should initiate it through concrete plan of action with a concrete time frame.
9. Any display of tobacco products at point-of-sale constitutes advertising and promotion. In view of this, DOH should remove the advertising permissions at the POS by amendment of RA 9211 which may be pursued on medium term period. Meanwhile, the LGUs may resolve this gap on TAPS ban through the inclusion of the ban on TAPS at POS in the 'local ordinances,' monitored and enforced by LGUs in collaboration with DOH-CHDs.

6. The DOH should finalize and officially make a National Strategy and Plan of Action that will be reviewed on a regular basis. Key highlights of the Plan of Action would include:

- a. A full-time staff in charge of the National Tobacco Control Coordination Office (NTCCO) and dedicated staff and focal points from the different DOH offices. FDA and PhilHealth have a key role in the implementation and enforcement of tobacco control measures and should be fully involved in the implementation process.
- b. A dedicated regular budget both allocated on the NTCCO and relevant offices.
- c. The Sector-Wide Anti-Tobacco (SWAT) Committee positioned as an official national body with clear composition and mandate to direct and facilitate the implementation and reporting of Philippines legal binding obligations to the WHO-FCTC.
- d. Mechanisms of collaboration established with local governments and key stakeholders including the civil society with the exception of the participation of the representatives from the tobacco industry.
- e. DOH needs to clearly and formally define the SWAT mandate, roles, and membership; ensure clear policies to prevent tobacco industry participation and interference with its work; and enable collaboration with other government authorities in both decision taking and technical levels.

C. SUMMARY OF ALL RECOMMENDATIONS, CHAPTER BY CHAPTER

I. Ensure Coordination and Implementation of Tobacco Control Interventions

1. The DOH should ensure the necessary human resources for coordinating the NTCCO work (a full-time coordinator that could be newly assigned or identified from existing staff, and also focal points for tobacco control in other DOH departments at national and local level).
2. The DOH should ensure dedicated and regular funding for tobacco control within the DOH budget, at the central and regional levels, based on needs identified by the NTCCCO/NCHP and the regional tobacco control structures.
3. The DOH should urgently facilitate the finalization, approval, and public dissemination of a National Strategy and Plan of Action for tobacco control. This strategy should be regularly monitored, evaluated, and reviewed.
4. The DOH should utilize SWAT with competence of an official national committee to facilitate legally binding obligations of the Philippines to the WHO-FCTC implementation and reporting.
5. Government structures should prioritize enforcing Memorandum Circular 2010-01 and pursuing the activities of the SWAT Committee on 5.3 in their efforts to protect public health from the tobacco industry interference.
6. The DOH should collaborate with the LGUs, they being the essential players in advancing the WHO-FCTC compliance in the Philippines, and strongly support their efforts in tobacco control.

II. Sustain Monitoring and Evaluation

1. Ensure sustainability of existing surveillance efforts by integrating a core set of questions and methods from GATS into on-going surveys.
2. Use better the existing surveillance and monitoring data to transform collected data into information relevant for action.
3. Strengthen and systematize the activities on tobacco industry monitoring.

4. Establish a system to monitor the implementation of tobacco control policies, in particular the enforcement of local ordinances on smoke-free environments and on bans of tobacco advertising, promotion and sponsorship (TAPS).
5. Provide additional human resources to NEC for consolidating a national tobacco surveillance system.

III. Protect People from Tobacco Smoke/ Create Smoke-Free Environments

1. The Department of Health (DOH) and other national government agencies should provide stronger commitment and leadership to promote social norms in support of 100% indoor smoke-free environments.
2. Local governments should expand and sustain their smoke-free policy initiatives through dedicated financial and technical support for: (i) public awareness programs, (ii) dedicated staffing; (iii) training and capacity building, (iv) data systems to underpin compliance monitoring and evaluation, and (v) development of business licensing models as a sustainable means of promoting smoke-free environments.
3. The government at large-national or local-should ensure countrywide enforcement and monitoring of national policy for smoke-free environments.
4. The DOH should pursue collaboration with all relevant stakeholders for ensuring that the Republic of the Philippines meet its obligations under the WHOFCTC Article 8
5. Strengthen implementation of smoke-free policy through the support of health services and medical associations and improved access to smoking cessation services.

IV. Offer Help to Quit Tobacco Use

1. Prioritize the development of a coordinated national cessation infrastructure that incorporates both population and clinical approaches in a stepwise manner, and builds on and augments existing resources and service delivery mechanisms. Operationalize this first in LGUs where the demand for cessation already exists and where smoke-free policy support is strong.
 - Establishing a coordinated national cessation system in a developing country setting like the Philippines requires an incremental approach that balances evidence-based population and clinical interventions.
 - Initiating this cessation system should be implemented first in LGUs where the demand for cessation already exists, reinforced by sound smoke-free and other tobacco control policies.
 - A cessation resources mapping should precede the establishment of the cessation

infrastructure/system at the local level, and existing cessation resources should be absorbed or incorporated within the tiered system.

- Counseling formats other than face-to-face programs should be considered, especially as demand for cessation services increases.
 - Making cessation drugs more available should be addressed. These cessation aids need to be incorporated into the national formulary.
2. Finalize, endorse, and widely promote a standard set of tobacco cessation practice guidelines and service delivery models.
 3. Incorporate cessation training into the mandatory curricula and ongoing capacity building initiatives of health professionals.
 4. Expand PhilHealth insurance coverage to cover a package of evidence-based essential cessation services that includes brief advice at the primary health care level, access to intensive counseling such as a national quit line and, to the extent possible, pharmacotherapy for those who are heavily addicted to tobacco.
 5. Promote cessation with systematic advocacy campaigns.

V. Warn People about the Dangers of Tobacco

1. Packaging and Labelling

- a. The DOH, in collaboration with other relevant government agencies, should assert authority prominently in defense of the health of the Filipino people.
- b. The DOH should implement the pictorial health warnings established through DOH AO 2010-13 among tobacco companies that have not filed for an injunction and in all jurisdictions except those that are currently under legal dispute.
- c. The DOH should invest in the FDA for upgrading its capacity to fulfill its responsibilities and coordinate related work with the Department of Interior and Local Government (DILG).
- d. The LGUs should use their legal competences to ensure placement of counter-advertising/health warnings at the point-of-sale (POS).

2. Public Awareness and Mass-Media Campaigns

- a. The DOH should go beyond World No Tobacco Day, integrating media campaigns to the

wider tobacco control program as part of a long-term strategic plan.

- b. The DOH should pursue the expansion of the financial resources to produce and air mass media campaigns
- c. The DOH should focus on using a campaign content that works.
- d. The DOH should pursue alternative channels for disseminating warning information.

VI. Enforce Bans on Advertising, Promotion, and Sponsorship

1. Strengthen the enforcement mechanism of the current TAPS' restrictions, through coordinated action at local jurisdictions, under the DOH leadership and coordination.
2. Relying on its current formal mandate for monitoring and enforcing a ban on TAPS, the DOH should advocate for it and take the lead in initiating and proposing a complete ban on TAPS, without any exceptions.

VII. Raise Tobacco Taxes and Prices

1. Simplify the existing tobacco tax structure, significantly raise tobacco product excise taxes, and index taxes to inflation in order to raise tobacco product prices and reduce tobacco use.
2. Earmark tobacco tax revenues for health purposes, including health promotion and tobacco control.
3. Earmark tobacco tax revenues for programs that help those employed in tobacco-dependent sectors make the transition to alternative livelihoods.
4. Strengthen tobacco tax administration, increase enforcement, and tax duty free sales of tobacco products in order to reduce tax evasion and avoidance.
5. Sustain and expand efforts to support the tobacco tax reforms and health promotion financing mechanisms by building further capacity and generating further evidence with the support of stakeholders such as the academe, CSOs, and other pertinent government agencies.

(Note: Complete findings and recommendations by the National Assessment Team can be accessed in the National Capacity Assessment Report for Tobacco Control – The Philippines, May 2010)



ANNEX 9

REGIONAL ACTION PLAN FOR TOBACCO FREE INITIATIVE IN THE WESTERN PACIFIC REGION (2010-2014)

“Moving towards the next level: complete implementation of the WHO Framework Convention on Tobacco Control”

VISION: Tobacco-free people, communities, and environments

MISSION: To advocate, enable, and support complete implementation of the WHO Framework Convention on Tobacco Control

GOAL: To attain the lowest possible tobacco use prevalence and the highest level of protection from second-hand smoke

THREE-POINT STRATEGY OF THE RAP 2010-2014

1. Promote and advocate for complete implementation of the WHO-FCTC
2. Mobilize for public action
3. Strengthen organizational capacity

STRATEGY 2: MOBILIZE FOR PUBLIC ACTION

This is to mobilize and empower policy-makers, tobacco control advocates and communities towards complete implementation of the WHO-FCTC through legislation and policies, tobacco taxation, governance and enforcement, and alliances and partnerships for changing social norms.

APPROACHES:

2.1 Legislation and Policies in compliance with FCTC

Specific Objective:

To develop legislation and related policies, regulations, ordinances administrative issuances and other measures to ensure timely compliance with all provisions of the WHO-FCTC, with specific reference to WHO-FCTC articles that have deadlines, approved guidelines, or protocols. Legislation and policy components are clearly stated in national action plans.

RAP Country Indicators:

- Measures to protect public health from commercial and vested interests of tobacco industry are in place and in accordance with WHO-FCTC Article 5.3 and its guidelines
- Legislation and policy on protection from exposure to SHS compliant with the definition of 100% indoor SF settings in accordance with Article 8 and its guidelines
- Legislation and policy on packaging and labelling are in accordance with deadlines for compliance and in accordance with the provisions of Article 11 and its guidelines
- Legislation and policy on comprehensive ban on TAPS are in accordance with deadlines for compliance and in accordance with Article 13 and guidelines

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Develop national action plans	(-)
Consider gender and equity in legislation and policies	(-)
Actively participate in FCTC processes and INB	Yes, but with representation from tobacco industry
Deter tobacco industry representatives from attending WHO meetings	(-)
Identify champions in legislative bodies and provide technical support	Some legislators identified and support provided
Articulate rules to avoid government official's conflict of interest with tobacco industry	Memo circular and code of conduct for government officials available
Work with other ministries and agencies to address supply issues	NTA active in working groups in violation of FCTC obligations; BOC for illicit trade

2.2. Tobacco Taxation

Specific Objectives:

To introduce and implement tax and price measures that will result in the reduction of tobacco consumption and to dedicate a significant proportion of the revenue from tobacco taxes to health promotion and tobacco control, including treatment for tobacco dependence.

RAP Country Indicators:

- All tobacco products are subject to excise taxation
- Policies and actions are focused on achieving, maintaining, or increasing excise tax on tobacco to 60% or more of the retail price
- Significant proportion of the revenue from tobacco is dedicated to health promotion and tobacco control, including treatment for tobacco dependence
- Protocol on Illicit Trade is ratified

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Excise tax 60% of retail price	Questionable data reported in GTCR
Significant amount of revenue dedicated for health promotion and tobacco control	Draft legislation on equivalent of health promotion foundation did not progress in last Congress; DOH pronouncement on proposed structure

2.3. Governance and Local Enforcement

Specific Objectives:

To implement and enforce laws and policies through national coordinating mechanisms or their equivalent, protect policies and programmes from the influence and interference of the tobacco industry, and promote good governance measures (i.e., strategic vision, participation, transparency and accountability, with specific reference to healthy cities, islands, communities, and settings) to achieve tobacco control.

RAP Country Indicators:

National action plan or equivalent implemented, and strive to evaluate progress as defined by the following measures:

- Percentage of healthy islands, cities, settings, communities with enforcement on 100% tobacco-free regulations and that also address equity issues
- Percentage of government departments, officials and government projects that have refused direct or indirect voluntary contributions from TI with reference to Article 5.3 and its provisions and guidelines
- Reduction of adult exposure to SHS in enclosed workplaces to 0% with reference to Article 8 and its provisions and guidelines
- Reduction of youth exposure to SHS in public places to 0% with reference to Article 13 and guidelines
- Reduction of youth exposure to TAPS to 0% with reference to Article 11 and guidelines
- 100% compliance with Article 11 and guidelines
- 100% compliance with Article 15 provisions and protocol
- Actions that support economically viable alternatives for tobacco workers and growers

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Implement national action plan	N/A
Enhance national or sub-national coordinating mechanism (NCM)	Current mechanism includes industry representatives; SWAT committees
Enforce 100% smoke-free indoor settings	Smoke-free in selected cities and municipalities
Enforce comprehensive ban on TAPS	All TAPS banned except at POS
Enforce packaging and labelling	Textual health warnings; legislation on GHI re-filed
Promote good governance principles at national and local levels	Challenging to eliminate tobacco industry's political influence
Enforce measures to protect public health polices from tobacco industry interests	(-)
Address equity issues	Pilot projects done in Navotas and Sta Rosa City
Engage affected groups and target population in tobacco control programme development and services	Youth not actively involved
Promote economically viable alternatives	Congressional block in the North poses barrier
Work towards elimination of all forms of illicit trade	BOC joined the INB

2.4. Alliance and Partnerships

Specific Objective:

To work with relevant tobacco control stakeholders to achieve comprehensive and sustainable tobacco control and avoid interference from the tobacco industry

RAP Country Indicators:

- Updated list of existing and potential stakeholders relevant to TC
- Annual meetings, at a minimum, of multisectoral partners and relevant TC stakeholders to plan and evaluate their NAP
- Annual public recognition, at a minimum, of outstanding contribution of allies and partners in the implementation of NAP

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Identify and map relevant stakeholders	New NGOs unable to mobilize hard core tobacco advocates; newly created Asia-Pacific Alliance on Child Health and Tobacco Control
Establish or enhance coordination with stakeholders	DOH is trying to enhance sector-wide coordination through SWAT committees
Engage stakeholders in national action plan development and implementation	Relevant stakeholders beginning to get involved
Actively share information and initiatives	On track
Keep alliances and partnerships free from industry interference	Limited
Support multisectoral activities	Limited
Publicly recognize outstanding contributions of allies and partners	Red Orchid Awards for 100% tobacco-free environment

STRATEGY 3: STRENGTHEN ORGANIZATIONAL CAPACITY

This is to strengthen organizational capacity of government tobacco control programmes to protect public health policy processes from tobacco industry interests and interference and to move towards complete implementation of the WHO-FCTC through improvements in: (a) investment planning and resource management; (b) leadership training and human resource development; (c) surveillance, monitoring, and knowledge management; (d) public awareness, education, communication, and advocacy; and (e) treatment of tobacco dependence.

APPROACHES:

3.1 Investment Planning and Resource Management

Specific Objective:

To develop multi-year financial plans for government-supported tobacco control programmes, including mechanisms that raise levels of funding through multiple sources, e.g., tobacco taxes, private sector support, donor aid, community funds, and social health insurance.

RAP Country Indicators:

- Multi-year tobacco control budgetary needs estimated
- Increased allocation of dedicated taxes or other revenue for tobacco control
- Increase in the proportion of GNP and GDP allocated for tobacco control

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Estimate multi-year budgetary needs and prioritize budget items	(-)
Map funds at national and local levels	(-)
Advocate to increase the level of fund and expand sources of fund	Limited
Enact laws and policies for sustainable infrastructure and financing	(-)

3.2. Leadership Training and Human Resource Development

Specific Objective:

To support the implementation of WHO-FCTC provisions by developing and enabling champions, leaders, and advocates at multiple levels to lead tobacco control efforts and to continuously train and provide tobacco control programme implementers with appropriate skills and competencies.

RAP Country Indicators:

- Availability of and at least an annual evaluation of a national plan for human resource development for tobacco control, including the assessment of training needs and the availability of training resources
- Conduct of priority trainings in tobacco control

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Identify training needs and trainees on competencies for FCTC implementation	(-)
Invest in and conduct leadership development	(-)
Organize and conduct training	MPOWER training for LGUs
Develop a multi-year human resources plan	(-)
Expand access to training on FCTC and its guidelines	(-)
Expand access of MPOWER training	MPOWER training conducted and comprehensive training modules developed
Incorporate tobacco control in health workers' curriculum	(-)

3.3 Surveillance, Monitoring, and Knowledge Management

Specific Objectives:

To generate reliable and updated information and evidence to guide programme planning, implementation, monitoring, and evaluation, as well as to gather intelligence and monitor industry actions.

RAP Country Indicators:

- Reliable and comparable adult tobacco use (smoking and smokeless) prevalence data by gender and age available and reported nationally
- Reliable and comparable youth tobacco use (smoking and smokeless) prevalence data by gender and age available and reported nationally
- Mortality data and if available morbidity data attributable to tobacco use reported in national statistics
- Tobacco industry marketing, product development, and other activities monitored and reported
- Data clearly linked to programmes and policies (e.g. TCDAP)

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Establish, strengthen and sustain surveillance system	Trend GYTS data available, sustaining GATS remains challenging
Monitor tobacco epidemic and impact of interventions	Less monitoring on the impact of interventions
Map the social and economic determinants of tobacco use and use data gathered for NCD	Little study on the social and economic determinants
Adapt and adopt evidenced-based practices	DOH is strong on surveillance
Develop and implement national research agenda to include interventional evaluation and outcomes research	National research agenda to be developed
Strengthen use of evidence for policy and action	Data application project implemented; Tobacco-Free Plan-It conducted in some LGUs
Ensure no industry support to academic and research agencies	Not sure
Monitor tobacco industry activities with strategy	Strategy to be developed and implemented

3.4 Public Awareness, Education, Communication, and Advocacy

Specific Objectives:

To inform different audiences of : (a) the hazards of tobacco use and exposure and (b) effective interventions; and 2) to mobilize stakeholders to change social norms and eventually eliminate tobacco use in society.

RAP Country Indicators:

- Strategic communication and advocacy plans developed and implemented
- Effectiveness and reach of communication campaigns increased and evaluated
- High profile activities conducted on World No Tobacco Day (WNTD)
- Measures to counteract subliminal advertising and promotion of tobacco use in movies, television shows, and other forms of mass media are in place.

RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Develop, implement, and secure funding for a national strategic communication and advocacy plan	(-)
Mobilize communities and role models in support of change of social norms	Some legislators and actors support tobacco control
Develop and implement training on strategic communication and advocacy	(-)
Work with media and communication specialists	Good projects; no programme
Conduct mass media and community anti-tobacco campaigns	Some campaigns in Metro Manila and BI project sites in 12+ provinces
Observe WNTD to highlight tobacco control and progress	(+)

3.5. Tobacco Dependence Treatment

Specific Objective:

To develop and integrate treatment of tobacco dependence in the health care system with particular emphasis on primary health care

RAP Country Indicators:

- National consensus guidelines for tobacco dependence treatment developed and disseminated nationally
- At least 70% of health professionals and health care workers working in primary health care trained to provide brief cessation advice

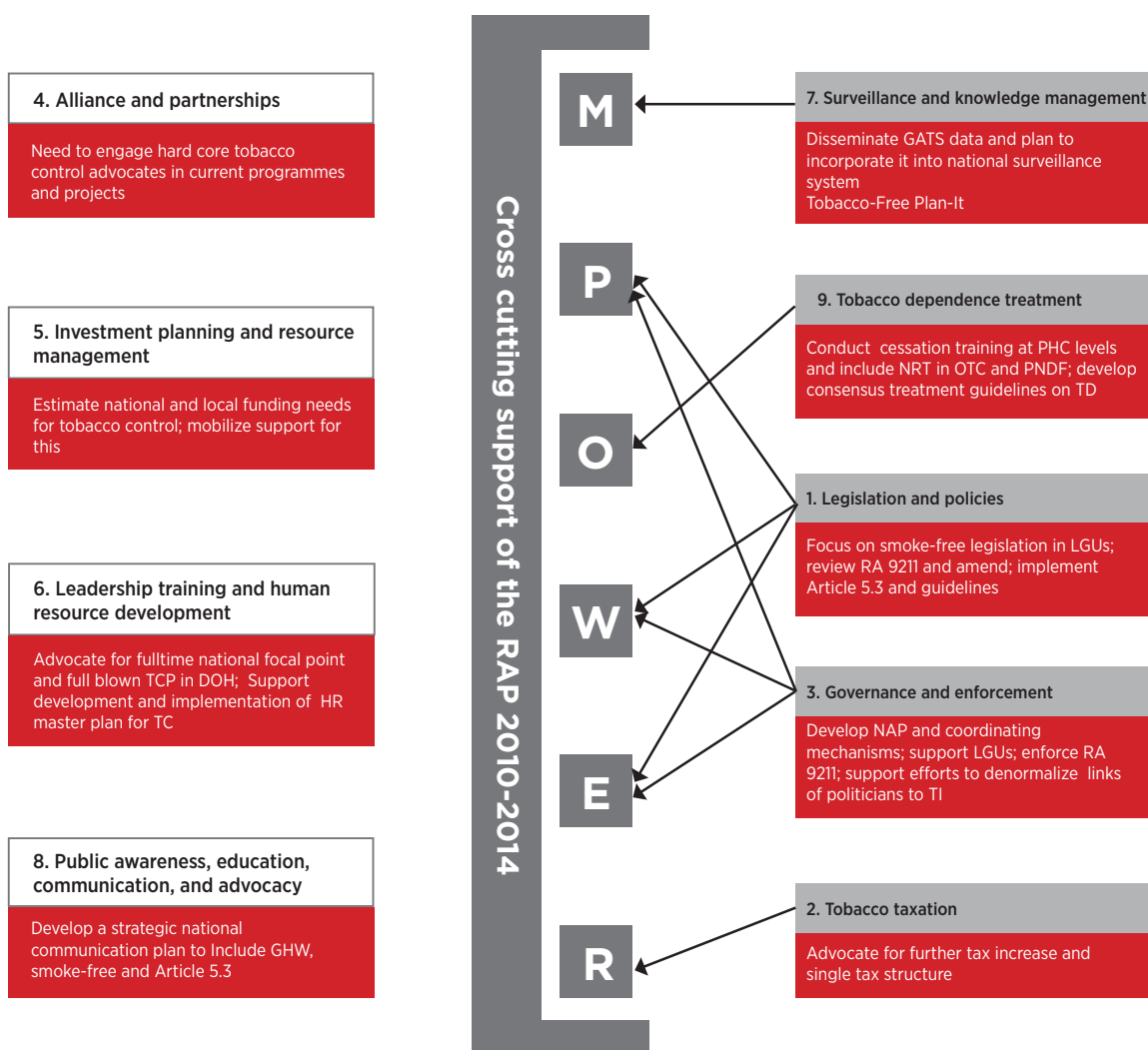
RAP country actions and current Philippine status:

RAP COUNTRY ACTIONS	PHILIPPINES
Develop and implement national consensus guidelines	(-)
Establish or strengthen behavioral intervention services	(-)
Increase availability, accessibility, and affordability of NRT	WHO is advocating DOH to include NRT into essential drugs list; NRT at present in exclusion list
Train stakeholders to provide brief cessation advice	MIND and BASC training ongoing
Secure health financing for tobacco dependence treatment services	Limited to OFW and dependents but poor utilization
Develop, adopt, and evaluate effective tobacco dependence treatment program	(-)
Integrate tobacco dependence treatment into other strategic programmes	Some integration with the TB DOTS programme
Create synergies with other cessation approaches. e. g., mass media and education	(-)



ANNEX 10

FRAMEWORK FOR INTERFACE BETWEEN RAP 2010-2014 AND MPOWER IN THE PHILIPPINES



Framework for interface between the RAP 2010-2014 and MPOWER in countries

The MPOWER package is a series of six proven policies aimed at reversing the global tobacco epidemic and include: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion, and sponsorship; and Raise taxes on tobacco. (GATS 2009)



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