

NATIONAL TOBACCO CONTROL STRATEGY (2011 - 2016)



**REPUBLIC OF THE PHILIPPINES
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**Primer on the
National Tobacco
Control Strategy
2011-2016**





Introduction

In the September 2011 United Nation (UN) Summit, the UN Member States, recognizing the challenge imposed by noncommunicable diseases (NCDs), stated in the “Political Declaration of the United Nation on the Prevention and Control of Noncommunicable Diseases” the urgent need to tackle cancer and other NCDs on a global scale. They pointed out that the NCDs, rising in epidemic proportion, have direct impact on social and economic development, contributing to poverty, and threatening the achievement of the Millennium Development Goals (MDGs).

In the Philippines, chronic NCDs (diseases that are slow to progress and of long duration) also dominate the major causes of death. Of the ten top causes of deaths identified by the Department of Health (DOH) in 2004 - namely: heart diseases, vascular system diseases, malignant neoplasm, pneumonia, tuberculosis, chronic lower respiratory diseases, diabetes mellitus, certain conditions originating in the perinatal period, nephritis/nephrosis, and accidents - tobacco contributes to or aggravates all of these causes except for the last two (nephritis/nephrosis and accidents).

Tobacco use is the leading preventable cause of death globally, and its health, social, and economic effects are devastating. In the Philippines, the annual productivity losses from premature deaths resulting from tobacco-related diseases ranged from US\$65.4 M to US\$ 1.08 B, according to conservative 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.

The Philippines, a tobacco-growing country, has high prevalence of tobacco use. The 2009 Philippine Global Adult Tobacco Survey (GATS) shows that overall, 28.3% (17.3 million) of the Philippine population aged 15 years and above currently smoke tobacco. Add to this is the fact that the country is geographically located in the Western Pacific Region (WPR), which, according to the World Health Organization (WHO), is where one-third of the world’s smokers reside.

Tobacco control efforts in the Philippines reeled off in 1987. Despite the strong lobbying of the tobacco industry, the country has successfully passed the Republic Act (RA) No. 9211 (Tobacco Regulation Act of 2003) on 23 June 2003 as the first comprehensive national legislation on tobacco control.

The WHO WPR also developed the first Regional Action Plan (RAP 1990-1994) for the Tobacco Free Initiative in the early ‘90s. Since then, the Region has seen continuous progress in tobacco control initiatives, the highlight of which was the entry into force of the WHO Framework Convention on Tobacco Control (WHO-FCTC).

As a member of the WPR and an eligible Party to the WHO FCTC, the Philippines is obliged 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. The Philippines became a signatory to FCTC on 23 September 2003 and the Philippine Senate ratified the treaty on 06 June 2005. 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.

For the Philippines to implement the WHO-FCTC, the country, under the leadership of the Department of Health (DOH), engaged all relevant sectors of government, civil society, and non-governmental organizations to take action within their social, cultural, occupational, and political networks and spheres of influence, and came up with the Philippine National Tobacco Control Strategy (NTCS) 2011-2016. The NTCS 2011-2016 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.



About the Primer

The Primer on the Philippine National Tobacco Control Strategy 2011-2016 was developed to equip the local government units (LGUs) with essential information and knowledge about the strategy for tobacco control in the country. Using a question-and-answer format, it surfaces the fundamental data on the country's involvement and management in drawing up the set of strategies that responds to the challenges in controlling tobacco use in the Philippines.

The Primer contains two sections:

- The NTCS 2011-2016: **Background** – takes up the general information on the background of the NTCS: why there was a need for the NTCS, the vital force behind the activities, the actors and their roles. It also tackles the findings and recommendations resulting from the national capacity assessment, which were part of the inputs to the overall plan to draw up the NTCS.
- The NTCS 2011-2016: **Summary of Details** – discusses the “VMGO” statements or the expression of the NTCS vision, mission, goals, and objectives. This part is followed by the detailed discussion of the key actions under each sub-strategy of each strategy.



BACKGROUND

THE NTCS 2011-2016:

What is the Philippine National Tobacco Control Strategy (NTCS) 2011-2016?

The Philippine National Tobacco Control Strategy (NTCS) 2011-2016 contains the plans of the Philippines for implementing an effective national tobacco control program. It is the country's response to the call of the World Health Organization Framework Convention on Tobacco Control (WHO-FCTC) to implement the international regulatory framework to control tobacco use.

What is the WHO-FCTC?

The WHO-FCTC is the first public health treaty negotiated under the World Health Organization, which reaffirms the “right of all people to the highest standard of health” as mentioned in the 1946 Preamble to the Constitution of the WHO. This was developed in response to the globalization of tobacco epidemic and represents a new approach in international health cooperation, using a global legal framework to address a globalized epidemic. The Philippines became a signatory to FCTC on 23 September 2003. The Senate of the Philippines, in turn, ratified this treaty on 06 June 2005.

What is WPR? (visual: Map showing the WPR)

WPR stands for Western Pacific Region, one of the six geographical regions identified by the World Health Organization and home to approximately 1.6 billion people, nearly one-third of the world's population. The Philippines belongs to the WPR. According to the WHO, it is in the WPR where most smokers world-wide reside: one-third of them. Comparatively, that is the greatest number among the six WHO regions.

What is latest prevalence of tobacco smoking in the Philippines?

Being a tobacco-growing country, the Philippines is one of the WPR countries with high prevalence of tobacco use. Based on the 2009 Philippine Global Adult Tobacco Survey (GATS), 28.3% (17.3 million) of the population aged 15 years old and above in the Philippines 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), meanwhile, shows that about 27.3% currently uses any tobacco product (34.4%, men, and 19.6%, women).

What other data show prevalence of tobacco use in the Philippines?

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

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

What about data on deaths resulting from tobacco-related diseases?

Among the identified risk factors contributing to NCDs – tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol – tobacco is considered responsible for more than two-thirds of lung cancer, 40% of chronic respiratory diseases, and 10% of cardiovascular diseases. An estimated six million people die from tobacco use each year, causing nearly 10% of all deaths worldwide -- that's two million more than AIDS, malaria, and tuberculosis combined.

Smoking kills up to half of all lifetime users. It is an epidemic that kills ten Filipinos every hour. Tobacco use was responsible for over 58,000 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. Of the estimated 6-8% deaths in the country attributable to the four tobacco-related diseases (cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases), about 23,000 up to 35,000 deaths per year are related to tobacco use.

What are the tobacco control policies in the country?

Tobacco control efforts in the country were started in 1987 and intensified over time.

The following tobacco control policies are being implemented:

RA 8749 Clean Air Act of 1999- included provisions for protection from secondhand smoke. It also identified cigarette smoke as a pollutant and instituted smoke-free indoor laws.

RA 9211 Tobacco Regulation Act of 2003- included landmark legislation with provisions that 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.

AO No. 122 s. 2003 Smoking Cessation Program to Support the National Tobacco Control and Healthy Lifestyle, issued by the DOH on 10 December 2003, 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 A.O. provides the specific guidelines in implementing a National Smoking Cessation Program (**NSCP**) for such provisions.

WHO-FCTC of May 2003 – was adopted by the 56th World Health Assembly, was made an international law on 27 February 2005, and was ratified by the Philippines on 06 June 2005. 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 plans.

What other policies on Tobacco Control were made after the ratification of the WHO-FCTC?

AO 2007-0004 National Tobacco Prevention and Control Program (NTPCP) - defines the roles and responsibilities of the different DOH offices and other departments.

AO 2009-0010 Rules and Regulations Promoting a 100% Smoke-free Environment – requires a 100 % smoke-free environment in all DOH offices/units at the Central Office, Centers for Health Development, hospitals, and attached agencies in all levels of local government. This administrative order became the basis of the Red Orchid Award, an incentive given to local governments with 100% tobacco-free environment. The red orchid was used by the WHO as a symbol of a tobacco-free world and a campaign to end the tobacco epidemic.

AO No. 2010-0013 Graphic Health Information – requires graphic

health information on tobacco product packages.

Department Circular 2011-0101 - sets the rules and regulations of the Food and Drug Administration (after Administrative FDA Act 9711-2009) tasking the FDA (under Article III) to regulate tobacco.

What other initiatives were done by the Department of Health?

Universal Health Care (UHC), which is the present administration's health agenda, 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.” One of UHC's strategic thrusts is the so-called “MDG-max” targets on lifestyle-related noncommunicable diseases such as cerebro-vascular diseases, diabetes mellitus, chronic obstructive pulmonary diseases, and cancers.

Bloomberg Project – started in 2009, the project, entitled “Moving to the Next Level in the Philippines: Complete Implementation of the WHO Framework Convention on Tobacco Control (WHO-FCTC),” is tasked to supplement the country's tobacco prevention efforts. The project's key initiatives include: a) development of the comprehensive NTCS 2011-2016 and Medium-Term Plan 2011-2013; b) creation of the National Tobacco Control Coordinating Office (NTCCO) within the DOH; and c) the formation of the DOH Tobacco Control Team (TCT) and the Sector-Wide Anti-Tobacco (SWAT) Committee and its 11 sub-committees.

National Tobacco Control Strategy 2011-2016 – this strategy is the country's response to its commitment for the complete implementation of the WHO FCTC to protect public health from the devastating effects 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.

What roles did DOH-NTCCO and DOH-TCT play in assessing the country's tobacco control effort?

The DOH-NTCCO synchronized all tobacco control efforts of the various DOH sectors; while the DOH-TCT which consists of relevant DOH offices and DOH attached agencies are responsible for the full implementation of tobacco control laws. The latter also joined the national assessment team as observers to evaluate the country's tobacco control efforts in implementing the WHO-FCTC.

The national assessment team held individual interviews with 128 individuals representing 78 institutions and reviewed existing tobacco epidemiologic data and present development efforts of key tobacco control measures undertaken by the government with other sectors between 3 and 12 May 2011.

What were the findings of the national assessment team?

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

- Ratified the WHO-FCTC
- Committed itself to controlling non-communicable 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.

What did the team consider as the most significant challenges to the continued progress of tobacco control in the Philippines?

The team also found the following to be the most significant challenges to the continued progress of tobacco control in the country:

- a. Raise taxes and prices of tobacco – cigarettes are highly affordable in the Philippines due to low taxes and a complex tax structure; add to this the fact that little of the revenue from these taxes has been used for health purposes and that policy makers do not seem to fully appreciate the health consequences of the existing tobacco tax system.
- b. Protect people from tobacco smoke – although effective local government efforts for creating smoke-free environments exist and important NGO contributions are made, there is a lack of financial and technical support necessary for the sustained countrywide reach for delivering potentially large health benefits.
- c. Offer help to quit tobacco use – the lack of a coordinated national cessation infrastructure and cessation providers hamper the implementation of a national cessation policy.
- d. Warn people about the dangers of tobacco – mass media activities have been found irregular and the content weak and ineffective. Graphic Health Information (GHI) on all tobacco packages (introduced by DOH AO 2010-0013) can be implemented even though court cases are pending.
- e. Develop coordination and implementation mechanisms - the

NTCS 2011-2016 and the Medium-Term Plan 2011-2013 are still to be developed. Coordination and funding are neither defined nor regularly allocated, and the SWAT committee has yet to be fully constituted.

- f. Sustain monitoring and evaluation – although the Philippines has recent, representative, and periodic tobacco surveillance data for both adults and youth, sustaining these is a challenge. Sustainability may be ensured by integrating a core set of GATS questions and methods into ongoing surveys.
- g. Enforce bans on tobacco advertising, promotion, and sponsorship (TAPS) – the enforcement of the current restrictions on TAPS is weak mainly due to poor clarification of agencies, rules, and regulations and lack of a strong enforcement mechanism. This mechanism may be enforced through the coordinated action at local jurisdictions under the DOH leadership and coordination.

What were the key recommendations given by the national assessment team?

The following recommendations were considered as critical and have the best potential for success in the short term:

- a. 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; and earmark revenues from tobacco taxes for health priorities.
- b. At least double the number of local government units (LGUs) with 100% smoke-free policy initiatives (no designated smoking areas indoors) through dedicated financial and technical support and with active involvement of NGOs.
- c. 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.
- d. Initiate a sustained programme of quarterly public awareness

- campaigns with content proven as effective in the Philippines.
- e. Given the scientific evidence supporting the use of graphic health information, LGU implementation should be encouraged and supported by the DOH.
 - f. The DOH should finalize and officially make a national strategy and plan of action that will be reviewed regularly. The plan of action should include the following:
 - A full-time staff for the National Tobacco Control Coordination Office (NTCCO) and dedicated staff and focal points from the different DOH offices. In particular, the Food and Drug Administration (FDA) and the Philippine Health Insurance Corporation (PhilHealth) should be fully involved in the implementation process
 - A regular budget allotted for the NTCCO and relevant offices
 - 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
 - Collaboration mechanisms established with local governments, key stakeholders, and civil society with the exception of the tobacco industry

Following the national capacity assessment, what did the DOH do next?

Through its National Center for Health Promotion (NCHP) via the Bloomberg Project, the DOH worked with the Development Academy of the Philippines (DAP) in conducting consultation workshops – three at the national level and three at the regional level. Representatives from government agencies, advocacy groups,

non-governmental organizations (NGOs), and local government units (LGUs) provided inputs to the planning for the Philippine National Tobacco Control Strategy for 2011-2016 (NTCS 2011-2016).

What other inputs were considered in these consultation workshops?

Four key documents helped achieve the overall plan to draw up the NTCS:

- a. **Regional Action Plan (RAP)**, a plan for tobacco-free initiatives for WPR 2010-2014, which contained a comprehensive plan of action that set indicators and targets for all levels for tobacco control and strengthened national coordinating mechanisms of countries. This five-year plan endorsed by the Regional Committee in Hong Kong in September 2009 also provides a menu of recommended specific objectives, action points, and indicators at all levels for WHO and Member States.
- b. **MPOWER Package**, a series of six proven policies aimed at reversing the global tobacco epidemic: **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 ban 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.
- c. **Results of the 12 May 2011 National Capacity Assessment for Implementing WHO FCTC**, which showed significant challenges and progress of the country's tobacco control programme's implementation.
- d. **Draft Resolution of the UN Summit on NCDs-Political Declaration (September 2011)**, which aimed to address the prevention and control of noncommunicable diseases worldwide, with focus on developmental and other challenges and social and economic impacts of NCDs particularly for developing

countries.

- e. These four documents, along with the inputs from the consultative workshops, were refined and finalized, resulting in the final draft of the NTCS 2011-2016.

Aside from DOH, are there other organizations involved in tobacco control?

Other government agencies that play key roles in tobacco-control efforts include the Civil Service Commission (CSC), Land Transportation Franchising Regulatory Board (LTFRB), Philippine National Police (PNP), Metropolitan Manila Development Authority (MMDA), and the Development Academy of the Philippines (DAP).

At the sub-national level, the local government units (LGUs) have the mandate to ensure proper enforcement of RA No. 9211 along with members of the PNP and other stakeholders. The DOH regional structure (Centers for Health Development) conduct tobacco control activities through their focal point for health promotion and for NCDs, especially in those regions and districts where local ordinances for creating smoke-free environments were introduced.

What about the civil society? Does it play a role in the control of tobacco use?

The country's large and active civil society network also plays an important role in this effort. Non-governmental organizations (NGOs) include advocacy groups, faith-based organizations, academia, health professional groups, and local branches of international organizations.



SUMMARY OF DETAILS

THE NTCS 2011-2016:

What is the vision of the NTCS?

The NTCS vision is to achieve a “Tobacco-free Philippines: Healthier People, Communities, and Environments.”

It has a realistic view of a nation being freed from the bondage of tobacco use and people being relieved from the burden of tobacco-related diseases through well-planned and well-defined strategies.

What is the mission of the NTCS?

The mission of NTCS is to advocate, enable, and mobilize multisectoral support for stronger tobacco policies and programs in line with the WHO FCTC.

What are the goals and objectives of the NTCS?

The NTCS goals are

1. To attain the lowest possible prevalence of tobacco use, and
2. To attain the highest level of protection from secondhand smoke.

For the first goal, the objectives are

1. To reduce the prevalence of adults' current tobacco use by 2% per year, and
2. To reduce the prevalence of youths' current tobacco use by 2% per year.

For the second goal, the objectives are

1. To increase the level of protection from secondhand smoke by 2% per year among adults, and
2. To increase the level of protection from secondhand smoke by 2% per year among 13-15 years old.

How are these goals and objectives to be achieved?

These goals and objectives are to be achieved through these strategies:

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

Strategy 2: Mobilize for public action

Strategy 3: Strengthen the organizational capacity

How is Strategy 1 achieved?

Strategy 1 - **Promote** and advocate for the complete implementation of the WHO FCTC-is achieved upon the successful implementation of Strategy 2 and Strategy 3

How is Strategy 2 achieved?

Strategy 2 - **Mobilize** for public action- is achieved through the following sub-strategies:

- Legislation and policies
- Tobacco taxation
- Governance and local enforcement
- Alliances and partnerships

How is Strategy 3 achieved?

Strategy 3 – **Strengthen** the organizational capacity – is achieved through the following sub-strategies:

- Investment planning and resources management
- Leadership training and human resource development
- Surveillance, monitoring, and knowledge management
- Public awareness, information, education and communication (IEC), and advocacy
- Smoking cessation and tobacco dependence treatment

On the following page is the Philippine NTCS 2011-2016 Framework which shows a visual summary of its vision and mission statements, its goals and objectives, and its strategies and sub-strategies.

How do the sub-strategies help achieve Strategy 2 and Strategy 3?

Key actions have been identified to help accomplish each sub-strategy. Under Strategy 2, for instance, the first sub-strategy (Legislation and Policies) has five key actions; the second sub-strategy (Tobacco Taxation) has four key actions; the third sub-strategy (Governance and Local Enforcement) has two key actions; and the fourth sub-strategy (Alliance and Partnership) has two key actions.

THE PHILIPPINE NATIONAL TOBACCO CONTROL STRATEGY-2011-2016 FRAMEWORK

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



So, what are the key actions under Legislation and Policies?

The five key actions are as follows:

1. Develop a tracking and monitoring system for illicit trade of tobacco products.

It has been noted that a weak tax administration encourages tax evasion. Because tax authorities do not effectively monitor cigarette production, many cigarettes get sold illicitly, that is, these are sold domestically even if these are reported to be intended for export or for sale in duty-free outlets. Hence, the government loses much from tax evasion. About 20% of cigarette production is estimated to evade all domestic taxes. In addition, the government has neither anti-smuggling programs that specifically target tobacco products nor regional partnerships that address illicit trade of tobacco products.

The country's multi-tiered structure also encourages tax avoidance as many brands are misclassified into lower tax tiers; add to this the price classification freeze.

2. Review and develop policies related to product ingredients' regulations.

Tobacco control policies that regulate contents, emission, and product disclosures would help reduce tobacco products' attractiveness, addictiveness (or dependence liability), and overall toxicity.

3. Push for the legislation of packaging and labeling pending in the Congress

By virtue of the Constitution and the Administrative Code of 1987, the DOH has the authority to ensure propagation of health information, and through its AO 2010-0013, it has the right to implement rotating evidence-based graphic health information (i.e., 30% in front of package and 60% in back) in all jurisdictions except those currently

under legal dispute (namely, Tanauan of Southern Luzon; Malolos of Central Luzon; and the cities of Marikina, Pasig, and Paranaque of Metro Manila). The DOH argues that the legal basis of the AO is the Consumer Protection Act, which is a national law, and the WHO FCTC.

There is also a need to review and study how AO 2010-0013 (Graphic Health Information) may be enforced.

4. Amend RA 9211 (Tobacco Regulation Act) to make it WHO FCTC compliant

For RA No. 9211 to be amended, the SWAT Committee, which is mandated to direct and facilitate the implementation and reporting of the Philippines' legal binding obligation to the WHO FCTC, would first need to be convened. This would enable the committee to identify provisions to be amended, as well as recommendations and proposed actions, and to advocate and lobby for the amendment of RA 9211.

5. Address tobacco industry interference

This entails identifying the areas in FCTC Art. 5.3 not covered by DOH-CSC Joint Memorandum Circular (JMC) 2010-01 and other laws and come out with a legislative proposal. In particular, LGUs and other civil society organizations co-funded by the government should conduct regular monitoring of strategies employed by the tobacco industry to undermine, delay, and hinder tobacco control efforts of the country.

Awareness campaigns displaying tobacco industry strategies may also be conducted to increase the public's and the policy makers' familiarity with and vigilance to this concern. The whole bureaucracy

may also need to be oriented on the provisions of Article 5.3.

What are the key actions under Tobacco Taxation?

The four key actions are as follows:

1. Simplify the tobacco taxation structure and significantly raise tobacco taxes with indexation of prices for inflation

A four-tier excise tax system as stipulated in RA No. 9334 (Sin Tax Law of 2004) is currently implemented for cigarettes. With this system, low-priced cigarettes are taxed low while high-priced cigarettes are taxed high, thus creating a wide price gap between high-priced and low-priced classes of cigarettes. Replacing this with a uniform specific tax on all cigarettes would eliminate opportunities for tax avoidance through misclassification of brands. It would also send the clear message that all cigarettes are equally harmful.

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

2. Allocate from tobacco taxes revenues for health priorities, social health insurance coverage, and health promotion.

Earmarking of tobacco tax revenues for health purposes has been small in recent years. In 2008, for instance, 2.5% from the tax increase was earmarked for PhilHealth and 2.5% for disease prevention. Discussions are ongoing to dedicate a portion of tobacco tax revenues for comprehensive tobacco control programs that include, but not limited to, support community level interventions, engage in public education campaigns about the harms of tobacco use, provide support to smokers who want to quit, and prevent young

people from taking up tobacco use.

3. Increase the licensing fee of retail sales of tobacco products.

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

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

Several steps should be undertaken to strengthen Philippine tax administrators' capacity for tracking and tracing. These may include licensing all involved in tobacco production, allocating resources for enforcing tax policies, and employing new technologies such as hard-to-counterfeit tax stamps and tracking systems that can follow tobacco products through the distribution chain.

What are the key actions under Governance and Local Enforcement?

The two key actions are as follows:

1. Enforce existing policies on Tobacco Advertising, Promotion, and Sponsorship (TAPS) ban.

At the local level, enforcement falls under the authority of the DOH-CHD regulatory officers, and the city and municipal officials (i.e., mayor's police force and local Philippine National Police). Although the Tobacco Regulation Act does not have a clear mechanism for enforcement, monitoring for compliance, and reporting, the LGUs have the competencies and the authority to introduce "local ordinances" that may clarify roles among enforcing agencies, coordination, duties of compliances, enforcing actions, and others.

2. Develop guidelines for effective monitoring of TAPS based on WHO FCTC

DOH-FDA may enforce certain provisions in the Tobacco Act (e.g., TAPS ban on internet, TV, radio, etc) while DOH-CHD teams at the

local level, in collaboration with LGUs, could focus on their areas of authority within their respective jurisdictions.

What are the key actions under Alliance and Partnership?

The two key actions are as follows:

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

Organizing an RTCN/RCTC in every region would ensure an efficient and effective multisectoral implementation of the national tobacco control program. Network members may come from government and non-government agencies, civil society organizations, academe, specialty societies, and LGU representatives.

2. Organize a SWAT Committee

In accordance with DO 2011-0029, the Sector-Wide Anti-Tobacco (SWAT) committee and its 11 sub-committees were organized to implement the provisions of the WHO FCTC. The SWAT was established without any representation from the tobacco industry to ensure that the tobacco industry will neither participate nor interfere in SWAT's work.

What are the sub-strategies under Strategy 3?

As for Strategy 3, there are five sub-strategies, namely: Investment Planning and Resource Management, which has four key actions; Leadership Training and Human Resource Development, which has one key action; Surveillance, Monitoring, and Knowledge Management, which has five key actions; Public Awareness, Education, Communication, and Advocacy, which has two key

actions; and Dependence Treatment and Smoking Cessation, which has three key actions.

So, what are the key actions under Investment Planning and Resource Management?

The four key actions are as follows:

1. Strengthen the capacity of the National Tobacco Control Coordinating Office (NTCCO)

The DOH should ensure the assignment of a full-time coordinator as well as focal points for tobacco control in other DOH departments at the national and local levels. The 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.

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

There is a need to work towards, and advocate for, increasing the current levels of funding for tobacco control and expanding 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 funds, and social health insurance.

3. Strengthen the capacity of local governments to include tobacco control in their Annual Investment Plan for health (AIPH)

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. Likewise, the LGUs, being in the frontline

of collaboration with the DOH-Centers for Health Development (DOH-CHDs) for implementing various policies, should also do the same as part of their province-municipality-city-wide health investment plans.

4. Establish incentive mechanisms for LGUs with strong tobacco control efforts (e.g., Red Orchid Award), and ensure funding for the incentives.

The DOH should collaborate and strongly support LGUs' efforts in tobacco control (e.g., enforcement work and local initiatives for raising awareness) and include opportunities for providing cessation support (via toll-free quit lines) and coordinating initiatives with civil society.

As for the Red Orchid Award, collaboration should include an evaluation of multisectoral participation and local impact. Also, LGUs may look into PhilHealth as a possible source of funds for their tobacco control activities.

What is the key action under Leadership Training and Human Resource Development?

The key action is to:

1. Increase the capacity of key stakeholders and LGUs in leading TC activities in the country including resistance to tobacco industry interference (TII)

In the last two years, several training programs on tobacco control were conducted for regional health workers and some LGUs. The training under the broad framework of MPOWER is conducted by core trainers from the DOH Central Office, in partnership with civil society organizations, based on a module prepared by the DOH-Health Human Resource Development Bureau (DOH-HHRDB) and enhanced by partners from academe and civil society. Concrete enforcement of TAPS restrictions, however, is yet to be part of the training, and reports of training evaluation have not been available. The DOH-CHDs collaborate with the LGUs for covering training

needs for health workers in their jurisdiction. Topics are mostly on smoke-free policies; those on cessation services and awareness-raising campaigns are still not fully addressed.

What are the key actions under Surveillance, Monitoring, and Knowledge Management?

The five key actions are as follows:

1. Develop national research surveillance and monitoring agenda.

Developing the agenda would result in the inclusion of the tobacco control research in the National Unified Research Agenda (NUHRA). This would be achieved if the following steps are pursued:

- a. Collaborate with the World Health Organization in developing guidelines for collection, analysis, and dissemination of tobacco-related surveillance data;
- b. Initiate and cooperate with competent international and regional intergovernmental organizations and other bodies in the conduct of research and scientific assessments;
- c. Promote and strengthen training and those engaged in tobacco control activities including research, implementation, and evaluation;
- d. 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;
- e. Facilitate financial and technical assistance from international and regional intergovernmental organizations and other bodies for epidemiological surveillance and information exchange; and
- f. Provide an opportunity for exchange of information on the results of research studies and surveys among members of the subcommittees.

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

This key action is fully supported by FCTC Article 20 (#3), which states that “The Parties to the Convention recognize 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.”

Likewise, FCTC Article 20 (#5) 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.”

3. Conduct research regularly

Although the Philippines has recent, representative, and periodic surveillance data for adults and youth, it is still faced with two concerns: a) funding for tobacco surveillance is still largely dependent on external sources, particularly GATS, which in its present form is an expensive survey, and b) GATS, which is used to measure adult prevalence, is not sustainable in its present form.

CATS (Core Adult Tobacco Survey), developed by WPRO based on GATS, is being recommended by the national assessment team. Through CATS, periodic tobacco surveillance data would be collected without any need for additional funding, and made available to the institutions responsible for implementing the tobacco control policies.

4. Strengthen the use of evidence for policy and action

Agencies, such as the National Epidemiology Center (NEC), have produced significant tobacco surveillance data, and yet majority

of these data has not been translated into information relevant to decision makers and the public. There is a need to disaggregate national data into regional data for better appreciation by LGUs.

5. Disseminate research and surveillance data results

The DOH-NEC needs to take the leadership in transforming collected data into information that would be relevant for decision-makers and understandable for the public. The NEC may also seek for additional partners' support and use their capacity through the work of the SWAT subcommittee on surveillance.

What are the key actions under Public Awareness, Education, Communication, and Advocacy?

The two key actions are as follows:

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

This particular key action could be accomplished by the SWAT subcommittee on Article 12 through the following:

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

- strategies, and its products; and
- g. Monitor, evaluate, and revise education, communication, and its measures.

2. Ensure funding for implementation of a communication and advocacy plan

With the limited financial resources of DOH – approximately PHP 10 million, with 60% NCHP budget for campaigns at the regional level and 40% for DOH activities including materials' production testing, media buying, etc – it should pursue the expansion of its financial resources by designating a part of tax revenues for the production and airing of mass media campaigns. The DOH could initiate high level engagement with the private sector (media companies and cinemas) to secure free or highly discounted air time and space.

What are the key actions under Tobacco Dependence Treatment and Smoking Cessation?

The three key actions are as follows:

1. Develop and implement national CPG for tobacco dependence treatment (smoking cessation)

The 2004 NEC cessation evaluation study showed the need to accelerate the development of national clinical practice guidelines (CPGs) in order to successfully implement the national cessation policy. Guidelines need to be finalized, endorsed, and widely disseminated across the entire health system and across all relevant programs.

The DOH should continue its efforts on training of trainers to expand its pool of trainers to assist LGUs and government entities- e.g., the Civil Service Commission- in providing cessation services to their employees. Along this line, the DOH should also adopt a set of standardized training modules and tools. Health professional societies could also designate cessation trainers to handle cessation capacity building in the private sector.

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 a smoke-free ordinance and continue with a program for tobacco cessation.

Opportunities to integrate these smoking cessation guidelines into relevant health and other programs (i.e., cancer control programs, poverty alleviation programs, etc.) should be explored and utilized.

3. Ensure financing for treatment of tobacco dependence under PhilHealth

Cessation services are not covered under health insurance schemes, except for PhilHealth Circular 17, which provides for cessation counseling for overseas Filipino workers and family members.

RA No. 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, despite its being a pre-requisite for PhilHealth coverage. This presents a financial barrier for smokers who want to quit, many of whom belong to the lower socio-economic class and who rely on PhilHealth to cover costs of preventive health care. In response, PhilHealth maintains it is waiting for the DOH to issue official CPG before it can establish the coverage rules for cessation services.

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



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