JOINT NATIONAL CAPACITY ASSESSMENT
ON THE IMPLEMENTATION OF
EFFECTIVE TOBACCO CONTROL POLICIES IN THE
PHILIPPINES
Joint national capacity assessment on the implementation of effective tobacco control policies in the **Philippines**
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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>BLES</td>
<td>Bureau of Labour &amp; Employment Statistics</td>
</tr>
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<td>BTIS</td>
<td>brief tobacco cessation intervention skills</td>
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<tr>
<td>BWC</td>
<td>Bureau of Working Conditions</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CPGs</td>
<td>Clinical Practice Guidelines</td>
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<tr>
<td>CSC</td>
<td>Civil Service Commission</td>
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<tr>
<td>DOH</td>
<td>The Department of Health</td>
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<td>IACT</td>
<td>Interagency Tobacco Control Committee</td>
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<tr>
<td>IEC</td>
<td>information – education – communication</td>
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<tr>
<td>DOLE</td>
<td>Department of Labour and Employment</td>
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<tr>
<td>DND</td>
<td>Department of National Defence</td>
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<td>FDA</td>
<td>Food and Drug Administration</td>
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<td>FHIS</td>
<td>Field Health Information System</td>
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<td>LGUs</td>
<td>Local Government Units</td>
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<td>MC</td>
<td>Memorandum Circular</td>
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<td>MDGs</td>
<td>The Millennium Development Goals</td>
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<td>FNRI</td>
<td>Food and Nutrition Research Institute</td>
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<td>NEC</td>
<td>National Epidemiology Centre</td>
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<td>NCDs</td>
<td>noncommunicable diseases</td>
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<td>NTCCO</td>
<td>National Tobacco Control Coordination Office</td>
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<tr>
<td>NGOs</td>
<td>nongovernmental organizations</td>
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<tr>
<td>OSHC</td>
<td>Occupational Safety and Health Centre</td>
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<tr>
<td>POS</td>
<td>Point-of-sale</td>
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<tr>
<td>PNP</td>
<td>Philippine National Police</td>
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<tr>
<td>PAPA</td>
<td>Philippine Ambulatory Paediatrics Association</td>
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<tr>
<td>SDA</td>
<td>Seventh Day Adventists</td>
</tr>
<tr>
<td>SHS</td>
<td>Second-Hand Smoke</td>
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<tr>
<td>SWAT</td>
<td>Sector-Wide Anti Tobacco Committee</td>
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<tr>
<td>TAPS</td>
<td>tobacco advertising, promotions and sponsorship</td>
</tr>
<tr>
<td>TI</td>
<td>tobacco industry</td>
</tr>
<tr>
<td>WHO</td>
<td>The World Health Organization</td>
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<tr>
<td>WHO FCTC</td>
<td>The WHO Framework Convention on Tobacco Control</td>
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Executive summary

The Republic of the Philippines is a tobacco growing country that has been involved in curbing the epidemic since 1987. Since then, despite the strong lobbying of the tobacco industry, the country has successfully passed the Republic Act 9211 (Tobacco Regulation Act of 2003) which aimed to promote smoke-free areas, to inform the public of the health risks of tobacco use, to restrict tobacco advertising, promotion and sponsorship, to regulate labelling of tobacco products, and to protect youth from being initiated to smoking. By ratifying the WHO Framework Convention on Tobacco Control in June 2005, the Philippines became a Party to the Convention. The present government is determined to continue strengthening its tobacco control efforts to face the many challenges that tobacco use poses for public health.

Despite the tobacco control efforts in the country, 17.3 million Filipinos smoke and almost two thirds of the adults and children are exposed to second hand tobacco smoke. The tobacco epidemic is rising in the country as shown by the fact that the number of Filipinos aged 13-15 years old that are currently smoking increased to 22.7% from its level in 2003 of only 15.9%, especially among young girls. As a consequence, tobacco kills approximately 87,600 Filipinos per year (240 deaths every day); one third of them are men in the most productive age of their lives. The economic costs of tobacco use were in 2005 over PHP148 billion while the revenue from tobacco industry generated in taxes, duties and other fees from tobacco leaf production, and the manufacture and sale of cigars and cigarettes is about PHP25.65 billion.

In this context, between 3 and 12 May 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 for assessing the country’s tobacco control efforts in implementing the WHO FCTC. The assessment team 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 considers that the Philippines have many achievements in tobacco control. The country has:

- Ratified the WHO FCTC
- Committed to controlling NCDs, many attributable to tobacco use, under an MDG Max framework as part of the universal health coverage strategy
- Committed officials to tobacco control in DOH
- 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
- Strong and vibrant civil society organizations devoted to tobacco control
Authorities are aware 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:

- **Cigarettes are highly affordable in the Philippines, largely due to low taxes and a complex tax structure.** Little of the revenues from these taxes have been used for health purposes and policy makers appear not to fully appreciate the health consequences of the existing tobacco tax system. 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. For five years through 2010, 2.5% of the revenues from a tobacco tax increase were devoted to PhilHealth and another 2.5% of these revenues went to disease prevention efforts. There is considerable interest in using tobacco revenues to support universal health coverage.

- **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. 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 – which is important but underutilized.

- **The lack of a coordinated national cessation infrastructure/system and the paucity of cessation providers that hamper the implementation of the national cessation policy.** A national cessation policy that is unimplemented is a major gap in tobacco control efforts in the Philippines. Cessation programmes exist, but these are few in number, 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 quitline. The paucity 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. Many physicians still smoke. Moreover, cessation drugs are of limited availability.

- **Mass media activities are irregular and use weak, ineffective content.** 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 behaviour change. Additionally, IEC materials do not generally make use of graphic imagery about the
harm 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 behaviour 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.

- **Graphic health warnings on all tobacco packages** (introduced by DOH AO2010-13) can be implemented even though court cases are pending.

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 its powers to promote general welfare including health and safety.

- **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.

To ensure the sustainability of current initiatives and further progress, there are key recommendations that were considered as critical and have the best potential for success in the short term. The following recommendations should be implemented by the DOH in collaboration with the relevant stakeholders (with the exception of the tobacco industry and its front groups and allies) within the next twelve months.

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 capacity and evidence in order to provide technical advice to influential policy makers who make decisions regarding tobacco taxes.

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 nongovernmental organizations.**

   These 100% smoke-free LGU initiatives should be sustained through: (i) public awareness programmes, (ii) dedicated staffing, (iii) training & 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. 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 counselling, and when appropriate, drug therapy. Because health service delivery is a direct function of LGUs, this tiered cessation system should exist within each LGU. This cessation system should be implemented first in those LGUs with a high demand for cessation and have strong smoke-free and other tobacco control policies. Counselling formats other than face-to-face programmes, such as quitlines, should be considered especially as demand for cessation services increases. Cessation aids covered by health insurance need to be incorporated into the national formulary.

4. Initiate a sustained programme 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 programmes 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 through 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.

5. Given the scientific evidence supporting the use of graphic health warnings, 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 warnings into law.

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 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.
- A dedicated regular budget both allocated on the NTCCO and relevant offices.
- Position 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.
- Establish mechanisms of collaboration with local governments and key stakeholders including the civil society with the exception of the participation of tobacco industry representatives.

Other recommendations offered by the team of experts for each of the tobacco control policies assessed are included in the final report.
1. Introduction

The Republic of the Philippines is a tobacco growing country that has been involved in curbing the epidemic since 1987. Tobacco use is responsible for a high burden of noncommunicable diseases particularly heart diseases, COPD, stroke and cancer. To reduce the use of tobacco and tackle its serious consequences, the Philippines started tobacco control efforts in 1987 and have intensified it over time. Since then, despite the strong lobbying of the tobacco industry, the country has successfully passed the Republic Act 9211 (Tobacco Regulation Act of 2003) which aimed to promote smoke-free areas, inform the public of the health risks on tobacco use, ban all tobacco advertisement and sponsorship and restrict promotions, regulate labelling of tobacco products, and protect youth from being initiated to smoking. The country ratified the WHO Framework Convention on Tobacco Control in 2005. The key facts on tobacco control in the country are illustrated in Figure 1.1.

Figure 1.1: Philippines Tobacco Control Timeline – 1987 - 2011

The present government is determined to continue strengthening its tobacco control efforts to face the many challenges that tobacco use poses for public health. Among these are the following:

- The 2009 Global Youth Tobacco Survey (GYTS) shows that the epidemic is still on the rise in the country, with the number of Filipinos ages 13-15 years old that are currently smoking increased to 22.7% from its level in 2008 of only 15.9%.

- An estimated 17.3 million Filipinos smoke and 13.8 million of these individuals smoke cigarettes every single day.

- The 2009 Social Weather Station survey has shown that 60% of adults over 18 years old were inhaling SHS daily. Furthermore, the GYTS 2007 found that 65% of 13-15 years old students said they were exposed to SHS in places outside their home. GATS 2009 reported that 91.6% adults believe that breathing other people’s smoke causes serious illness.

- The tobacco epidemic kills approximately 87,600 Filipinos per year or at least 240 deaths due to tobacco related illness per day.

- The WHO Tobacco and Poverty study in the Philippines concludes that the economic costs of tobacco use are over PHP148 billion a year on smoking related diseases and deaths while the revenue from tobacco industry generated in taxes, duties and other fees from tobacco leaf production and the manufacture and sale of cigars and cigarettes is about PHP25.65 billion.
The problem is indeed enormous for the Philippine Government and the population as a whole. The burden is on the country’s Department of Health (DOH) to ensure policies, programmes and services are in place to halt or arrest the epidemic and hopefully reverse it before the end of the decade. In this context, a team led by WHO performed a joint assessment on the national capacity of the Philippines to implement the WHO MPOWER package of selected demand reduction measures that supports the implementation of the WHO FCTC. At the request of the Philippine Government, WHO, through its country office in the Philippines and the WHO Western Pacific Regional Office, worked together with the DOH to organize and conduct the joint capacity assessment.

From 3 to 12 May 2011, a group of 14 national, international and WHO health experts reviewed existing tobacco epidemiologic data, as well as the status and present development efforts of key tobacco control policies. The pool of experts, along with observer-representatives from the Philippine DOH, were divided into five (5) teams that went around the capital city of Manila to undertake key informant interviews from pre-selected groups, agencies or individuals that represented sector-wide stakeholders on tobacco control as well as representatives from the pharmaceutical industry, civil society organizations and the media. The team also conducted 128 interviews with key informants from the central government and some of Philippine DOH Regional Offices (Fig. 1.2).

Figure 1.2: Map of the Philippines

The group also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control, programme management and coordination, intersectoral and intrasectoral partnerships and networks, and human, financial resources and infrastructure. Finally, the experts group made recommendations based on the key findings of their analysis to further develop the following tobacco control policies:

- **M**onitor tobacco use and interventions,
- **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,
- **R**aise taxes on tobacco and Develop sustainable alternatives to tobacco-growing.

For each policy, the report comprises of three sections.

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1 See list of institutions and key informants in Annex 1.
• **Policy status and development.** A brief introduction is given on the present status and future development of the policy in question, based on a thorough review of all documents made available by the coordinating team from the capacity assessment prior to the country visit (tobacco control country profile, the WHO report on the global tobacco epidemic 2009, legislation in force, results and conclusions of previous studies and reports, etc.) and interviews with key informants.

• **Key findings.** A summary providing the most important facts discovered by the assessment team after conducting the visits and interviews. This is based on an analysis of key factors for success in implementing present policies and developing future ones, such as political will, programme management and coordination, partnerships and networks for implementation and provision of funds and human resources.

• **Key recommendations.** These address the actions required, in the opinion of the assessment team, to improve the design, implementation and enforcement of the policy examined. Unless otherwise noted, the suggested time for implementing the recommendations is twelve (12) months.

WHO is grateful to the Government of the Philippines and the tobacco control nongovernmental organizations in the Philippines for leading the way by carrying out the joint national tobacco control capacity assessment. Many other WHO Member States will follow and benefit from the lessons learned in this assessment.
2. Coordination and implementation of tobacco control interventions

2.1. POLICY STATUS AND DEVELOPMENT

2.1.1. Government implementing agencies
The Government of the Philippines coordinates and implements 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 Programme, it was only in 2007 when the DOH officially designated the National Center for Diseases Prevention and Control (NCDPC) as the coordinating unit for tobacco control. In 2010, the Health Secretary appointed the National Center for Health Promotion (NCHP) as lead office for the newly established National Tobacco Control Coordinating Office (NTCCO). This office, led by the Director of the NCHP, is part of the Policy Standards, Development and Regulation Cluster and benefits from management support of Division Chiefs in this cluster (figure 2.1). Several offices at the DOH have mandates in tobacco control.

Figure 2.1: Membership of the DOH

Government agencies other than the DOH have also been involved in tobacco control. A fundamental role was played in recent years by the Civil Services Commission (CSC), an independent constitutional body that issued 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. They contributed to awareness raising campaigns by using the existing communication materials as well as to smoking cessation activities.

2 The Department of Health DO 2011-0029
### 2.1.2. Implementing tobacco control: civil society

The Philippines 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 nongovernmental (NGO) sector includes advocacy groups, faith based organizations, academia and 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). Due to limited funds, the workforce active within these NGOs is often based on a voluntary approach. Figure 2.2 includes a few examples of active nongovernmental groups.

**Figure 2.2: Some Philippine NGOs active in tobacco control**

<table>
<thead>
<tr>
<th>Nongovernmental organisation</th>
<th>Brief description of tobacco control work</th>
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<tbody>
<tr>
<td>FCTC Alliance Philippines (FCAP)</td>
<td>Started in 2001. Composed of health professionals, faith-based groups, academy and environmental groups. Worked closely with DOH: (1) for the country's position during the WHO FCTC negotiations (2001-2004); (2) for achieving the WHO FCTC ratification by the Senate in 2005; (3) for staging Tobacco-Free SEA Games; (4) for introducing and enforcing ordinances in local government units (e.g. 100% smoke-free places; banning tobacco advertising, promotion and sponsorship/TAPS); (5) for lobby and advocacy of Congress (14th and 15th) for graphic health warning, for tobacco tax reform (also with AER, HJ) and building constituency support to tobacco tax across the country; (6) for the development of coalition of health professionals for tobacco control (also in collaboration with PAPA). Also collaborated with PMA on their “Roadmap for tobacco control”; worked with PAPA &amp; 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).</td>
</tr>
<tr>
<td>Health Justice (HJ)</td>
<td>Think-tank that 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. Provided legal and media support for various NGOs, individual advocates/ spokespersons, and LGUs.</td>
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<tr>
<td>Philippine Medical Association (PMA)</td>
<td>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.</td>
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<tr>
<td>New Vois Association of the Philippines</td>
<td>Recently engaged in tobacco control. Majority of its members, who are people affected by tobacco, became “the face” of tobacco control advocacy.</td>
</tr>
<tr>
<td>Tobacco Free Philippines (TFP)</td>
<td>Active in tobacco control as early as 1980's, TFP pushed for the passage of a tobacco control law in the Philippines. Its tobacco control efforts slowed down from 2000 onwards.</td>
</tr>
<tr>
<td>Faith Based Organizations (Seventh Day Adventist &amp; Jesus Christ of Latter Day Saints)</td>
<td>Active members of FCAP working primarily on creating smoke-free places and banning TAPS by local government units (LGUs) across the country; one of the few organizations involved in tobacco cessation using primarily counselling techniques.</td>
</tr>
<tr>
<td>Eco Waste Coalition</td>
<td>Active partner of FCAP since 2008 in relation to environmental issues.</td>
</tr>
<tr>
<td>Action for Economic Reform (AER)</td>
<td>Primarily concerned with transparency and taxation issues. Since 2009, AER is engaged in advocacy to the Congress for the tobacco taxation reform (together with FCAP, DOH &amp; HJ).</td>
</tr>
<tr>
<td>University of the Philippines College of Law Development Foundation (UPCLDF)</td>
<td>Primarily composed of lawyers recently engaged in tobacco control (2008). Worked with some LGUs to effectively enforce RA 9211 through (1) training of enforcers (2) development of tools for monitoring and enforcement including guidelines. Also provides legal assistance to DOH on legal issues.</td>
</tr>
<tr>
<td>Filipino Consumers Will (BILMAKO)</td>
<td>Primarily a consumers’ protection group. In 2004 it conducted a study on the effectiveness of RA 9211 in relation to the WHO FCTC.</td>
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</table>
2.1.3. Tobacco control coordinating bodies

2.1.3.1. 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 is split among the different offices according to their role in the DOH and are outlined in DO 2011-0029 (Figure 2.3). Recently, DC 2011-0101 has set rules and regulations of the FDA (after Administrative FDA Act 9711-2009) tasking the FDA (under its article 3) 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 labelling, 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 central and subnational level for planning, building capacity, and training. Lately the Development Academy of the Philippines joined these efforts.

2.1.3.2. Coordination within the Government:

An Interagency Tobacco Committee (IACT) was established through RA 9211 to oversee the administration and implementation of the law. The IACT is chaired by the Department of Trade while the DOH’s role is of a vice-chair. It involves different government sectors including the National Tobacco Administration of the Department of Agriculture, as well as representatives of the tobacco industry. (Figure 2.3).

Figure 2.3: Interagency Tobacco Committee (RA 9211 - Memorandum Circular No 1 s.2004

| Interagency Tobacco Committee (RA 9211 / Memorandum Circular No. 1s.2004) |
| Department of Trade and Industry (Chair) |
| Department of Health |
| Department of Justice |
| Department of Agriculture |
| National tobacco Administration |
| Department of Environment and Natural Resources |
| Department of Education |
| Department of Science and Technology |
| Bureau of Customs |
| Bureau of Internal Revenue |
| Philippines Tobacco Institute |
| FCTC Alliance Philippines (FCAP) |
RA 9211 was enacted before the ratification of the WHO FCTC. Therefore 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 Anti Tobacco Committee/SWAT). Ten out of eleven sub-committees of this sector wide structure were organized and are already operational with terms of reference 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. The SWAT sub-committees and proposed responsible agencies are listed in Figure 2.4.

Figure 2.4: Proposed Sector Wide Anti Tobacco Committee (SWAT)

<table>
<thead>
<tr>
<th>SWAT Sub-committee according to WHO FCTC articles</th>
<th>SWAT Sub-committees</th>
<th>Proposed Responsible National Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWAT 5.3</td>
<td>Sub-committee on Tobacco Industry Interference</td>
<td>Civil Service Commission</td>
</tr>
<tr>
<td>SWAT 6</td>
<td>Sub-committee on Price Tax measures</td>
<td>Department of Health (HPDPD)</td>
</tr>
<tr>
<td>SWAT 8</td>
<td>Sub-committee on Smoke-free</td>
<td>Department of Health (HPDPD)</td>
</tr>
<tr>
<td>SWAT 9&amp;10</td>
<td>Sub-committee on Regulation of the contents of tobacco products and tobacco products disclosure</td>
<td>Department of Health (FDA)</td>
</tr>
<tr>
<td>SWAT 11</td>
<td>Sub-committee on Packaging and Labelling of tobacco products</td>
<td>Department of Health (FDA)</td>
</tr>
<tr>
<td>SWAT 12</td>
<td>Sub-committee on Education, Communication, Training and Public Awareness</td>
<td>Department of Health (NCHP)</td>
</tr>
<tr>
<td>SWAT 13</td>
<td>Sub-committee on Tobacco Advertising, Promotion and Sponsorship</td>
<td>Department of Health (FDA)</td>
</tr>
<tr>
<td>SWAT 14</td>
<td>Sub-committee on Tobacco Dependence Treatment</td>
<td>Department of Health (NCDPC)</td>
</tr>
<tr>
<td>SWAT 15</td>
<td>Sub-committee on Illicit Trade of tobacco products</td>
<td>Department of Finance (Bureau of Customs)</td>
</tr>
<tr>
<td>SWAT 17&amp;18</td>
<td>Sub-committee on Alternative Livelihoods</td>
<td>Department of Agriculture</td>
</tr>
<tr>
<td>SWAT 20</td>
<td>Sub-committee on Surveillance and Research</td>
<td>Department of Health (NEC)</td>
</tr>
</tbody>
</table>

The documents and policies related to the coordination of tobacco control in the Philippines and protection of the undue interference of the tobacco industry can be found at Figure 2.5.
Figure 2.5: Ordinances, memoranda, guidelines, executive orders from governments on the tobacco control coordination and protection of public health from undue interference of the tobacco industry can be found in Figure 2.5.

<table>
<thead>
<tr>
<th>Year</th>
<th>Document</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>RA 9211</td>
<td>Establishes the Interagency Tobacco Committee.</td>
</tr>
<tr>
<td>2008</td>
<td>DOH Health Policy Notes 3:2</td>
<td>Recommends the creation of the Sector-Wide Anti-Tobacco Council.</td>
</tr>
<tr>
<td>2009</td>
<td>AO 2009-0004 (administrative order)</td>
<td>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.</td>
</tr>
<tr>
<td>2009</td>
<td>DOH DM 2009-0142 (department memorandum)</td>
<td>Institutionalizes the adherence to the DOH policy 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.</td>
</tr>
<tr>
<td>2009</td>
<td>DOH DM 2010-0126 (department memorandum)</td>
<td>Prohibits DOH and its attached agencies’ interactions (unless strictly necessary for regulatory purpose), partnerships and contributions through corporate social responsibility activities (CSR) of the tobacco industry, and sets the frame for conflict of interest; for regulatory purpose only specific protocols for meeting tobacco industry are provided.</td>
</tr>
<tr>
<td>2010</td>
<td>CHED Memorandum from the Executive Director dated 14 January 2010</td>
<td>Commission on Higher Education Executive Office directed all central and regional office directors to reject any contribution from the tobacco industry and avoid partnerships with them.</td>
</tr>
<tr>
<td>2010</td>
<td>CSC-DOH No. 2010-01 (Joint Memorandum Circular Civil Service Commission and DOH)</td>
<td>It promulgates the policy on protection of the bureaucracy from tobacco industry interference, covering all national and local government officials and employees, including government-owned and controlled corporations, original charters, state colleges and universities.</td>
</tr>
<tr>
<td>2010</td>
<td>DOH CHD4A and DILG 4A Joint Memorandum Circular No. 2010-01</td>
<td>First memorandum circular jointly issued by the DOH and Department of Interior and Local Government Unit (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.</td>
</tr>
<tr>
<td>2011</td>
<td>DOH DO 2011-0029 (department order)</td>
<td>Appoints the National Center 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. Sub-committee 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.</td>
</tr>
<tr>
<td>2011</td>
<td>DC 2011 – 0101</td>
<td>Sets rules and regulations of the FDA (compliant with RA 9711 or the FDA Act of 2009) tasking FDA under article 3 to regulate tobacco and tobacco products.</td>
</tr>
</tbody>
</table>
2.1.3.3. Organization of sub-national activities

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 for health workers at regional level (TOT) and then regional DOH staff organize 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.

2.1.3.4. The tobacco industry

Philip Morris Fortune Tobacco Corporation (PMFTC) became the largest company in the Philippine cigarette market after Philip Morris Philippines Manufacturing Inc and Fortune Tobacco Corp merged in 2010. It currently holds almost 90 percent of the domestic market. Other tobacco companies operating in the Philippines are Japan Tobacco, La Suerte Cigar and Cigarette Factory, Mighty Corporation and Anglo-American. Their interests are usually represented by the Philippine Tobacco Institute which is an association formed by local cigarette manufacturers and importers.

2.2. KEY FINDINGS

2.2.1. The NTCCO has at the moment neither a coordinator nor a full time staff.

Although there is no formal assignment of a NTCCO coordinator, the coordination of the national tobacco control work is undertaken by the NCHP director. Currently, eight (8) staff from the NCHP allocates 25 to 75% of their full time employment to tobacco control. In addition, three (3) staff dedicated to tobacco control currently work full time as part of the staff dedicated for implementing the Bloomberg Initiative Project OC-401. Some departments other than NCHP allocate staff working on tobacco control based on demand. The NTCCO has not yet convened regular coordination and implementation meetings with NTCCO members.

2.2.2. The NTCCO has insufficient funds to match the tobacco control needs.

The NCHP budget for 2011 was approved as part of the Healthy Lifestyle budget, which is currently PHP25 million (USD555,000). Around PHP10 million (USD 222,000) is allocated to tobacco control and this is roughly divided into communication materials and work with the regional structures (i.e. support for the Red Orchid Awards, grants, training programmes and other technical assistance to Centers for Health Development (CHDs) and Local Government Units (LUGs). Other sources include contributions in kind from WHO and international donors. The National Center for Pharmaceutical Access and Management (NCPAM) provides limited amounts of assorted medicines for winners of the Red Orchid Award and also some support to the Civil Service Commission for the implementation of smoke-free places. There is currently limited or no funds allocation from other units of the DOH.
The regional DOH CHDs allocate annual funds for the implementation of health programmes, and as tobacco control is included in the regional workplans for the noncommunicable disease (NCD) programmes, a certain amount from the NCD budget has the likelihood to be directed to tobacco control. This allocation appears to be limited, uneven from region to region and competes with other priorities. Mostly, these funds are dedicated to training programmes for the regional / local health workers.

2.2.3. The National Tobacco Control Strategy (2011-2016) and Medium Term Plan (2011-2013) are still to be developed.

The National Objectives for Health for 2005-2010 aimed to reduce the morbidity and mortality from lifestyle- related diseases and improve the quality of life of those suffering from such diseases by reducing the prevalence of risk factors such as tobacco use. Nevertheless, a national tobacco control strategy and a plan of actions with a medium and long term vision and goals are still not agreed upon by the different tobacco control stakeholders. Currently, the NTCCO is in charge of developing a strategy and its plan through a consultation process, while the Development Academy of the Philippines is in charge of facilitating the process.

2.2.4. The composition of the Interagency Committee on Tobacco (created by RA 9211) is blatantly in conflict with WHO FCTC Article 5.3.

The trade-oriented constituency of the Interagency Committee on Tobacco (IACT) includes the chairmanship by the Department of Trade and Industry and the participation of the National Tobacco Administration (from the Department of Agriculture) and the Philippine Tobacco Institute. This composition of the committee misrepresents the legitimate tobacco control interests and ultimately undermines the health of the Filipinos.

However, the other committee that was established by the DOH (SWAT Committee) has no tobacco industry representation, addresses the country public health interests by having a comprehensive scope, membership and operational implementation targets on the various WHO FCTC articles. There is a tendency for some DOH CHDs to create regional coalitions on tobacco control mirroring the IACT membership with the exception of the tobacco industry participation and including regional nongovernmental organizations.

2.2.5. The pervasive influence of the tobacco industry was identified by all interviewed stakeholders as a key obstacle for advancing effective tobacco control interventions in the Philippines.

The tobacco industry appears to be highly influential in the Philippines having a long record of strategies that resulted in commercial concerns prevailing over the public health ones. Partly due to its official membership in the intersectoral committee, the tobacco industry claims right of voice over public health measures. Its influence in drafting RA 9211 as well as its successful persuasion to some parliamentarians and politicians is largely recognized and seen as an obstacle for the approval of effective tobacco control legislation. The industry appears to exert influence also through front groups and directly through the tobacco growers, who are particularly sensitive to the industry’s claims that tobacco control measures threaten their livelihoods. Many public schools conducted educational campaigns named “Youth Smoking Prevention Programmes”, usually funded by tobacco industry as part of its corporate social responsibility work that aims to deliver subtle messages that ultimately result in encouraging, instead of discouraging teenagers to smoke.
Under the circumstances, many initiatives were undertaken by the Philippines Government for preventing the undue influence of the tobacco industry. DOH administrative order (AO) 2009-0004 on the DOH code of conduct, rule 4, prohibits officials and employees from accepting TI donations, sponsorships or gifts. Joint Memorandum Circular 2010-01 was recently issued to establish some basis for implementing Article 5.3 of the WHO FCTC by protecting the bureaucracy against tobacco industry interference. The recently established FDA also has provisions to protect the agency against the tobacco industry interference (DC 2011-0101). Despite these efforts, it was clearly stated by the interviewed stakeholders that the tobacco industry’s ubiquitous presence in the decision making process could be the main obstacle in taking the effective tobacco control measures to protect the health of the Filipinos.

2.2.6. Policies and strategies that target and involve regional and local governments are considered a golden opportunity in advancing tobacco control agenda in the Philippines.

Regional and local governments focused their attention in implementing smoke-free policies, while many of them have taken even more stringent measures than RA 9211 with successful outcomes. The DOH CHDs collaborate with the local government authorities (LGUs) for covering training needs for health workers in their jurisdiction. However, the interest is mostly limited to smoke-free policies, while cessation services and awareness raising campaigns are still not fully addressed. The DOH Red Orchid Awards is perceived as a good inducement strategy for involving local governments to create smoke-free environments.

2.3. KEY RECOMMENDATIONS

2.3.1. 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).

A full time focal point at national level would be able to plan, prepare and conduct regular meetings among the DOH teams at regional/ local teams and other relevant departments, as well as with the civil society (when appropriate) to strategise tobacco control efforts, avoiding overlapping and ensuring continuity. In this way, the NTCCO could respond to the following functions:

- development and coordination of national strategy, oversight and evaluation;
- cross-sectoral collaboration (public, private, civil society organizations);
- secretariat support for the SWAT committee;
- liaison and coordination of tobacco control work with DOH CHDs and LGUs;
- coordination of marketing and communication for tobacco control;
- developing standard and systems specification for monitoring and enforcement;
- coordination of legislative process for tobacco control (initiating and drafting legislation, ensuring consultations and giving advice on initiatives of other relevant sectors, etc.)

The assigned NTCCO coordinator would benefit decisional support from the senior level DOH officials to whom he/she should report regularly. In the capacity of secretariat for the SWAT committee, the NTCCO coordinator could ensure that sub-committees interact, do not duplicate activities and that public health concerns are prioritized. The NTCCO coordinator could therefore be easily identified by the media and interest groups as the central position responding to the tobacco control aspects and having an essential role in administering and identifying additional sources of funding for the programme.
2.3.2. The DOH should ensure dedicated and regular funding for tobacco control within the DOH budget, at central and regional levels, based on needs identified by the NTCCCO/NCHP and the regional tobacco control structures.

This allocation of dedicated funds would ensure that tobacco control activities are conducted with priority and continuity. While various funds may continue to be allocated to different structures within the DOH (FDA, NEC and NCDPC as well as all CHDs) for their specific tobacco control work (e.g. training, information – education – communication materials, enforcement, regulatory work, etc.) as part of the DOH overall tobacco control strategy, the NCHP should also have an annual budget allocated for regular coordination and implementation work.

As the LGUs are currently in the frontline of collaboration with the 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.

The NTCCCO could take the lead in raising additional funds from donors at national and international levels (except from the tobacco industry) in collaboration with the Bureau of International Health Cooperation. A source of additional funds could be pursued by reverting to earmarking tobacco excise taxes for the health needs, out of which some funds could be directed to support DOH tobacco control work, especially the one that traditionally could not be covered from the DOH budget, such as work for developing and conducting regular mass media campaigns as part of the national tobacco control action plan.

2.3.3. 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.

Experience and best practice from several countries worldwide have shown that a national plan of action based on the WHO FCTC provisions, involving the different stakeholders from government and civil societies and addressing the country’s specificities could provide a roadmap for a common vision and efforts among stakeholders for saving lives from the tobacco epidemic. For the Philippines, building the national strategy and its plan of action will also serve as a basis for similar exercises at sub-national level in accordance with local needs and priority but also with the national objectives and planned actions. Periodic reviews of the national strategies and plans of action endorsed by competent authorities as part of their regular work and supported by dedicated budgetary lines will maintain the tobacco control agenda as part of the national official governmental agenda, in line with the country’s obligations to implement the international tobacco control treaty.

2.3.4. Utilize SWAT with competence of an official national committee to facilitate legally binding obligations of the Philippines to the WHO FCTC implementation and reporting.

The work through SWAT that has been formally assigned to focus on various articles of the WHO FCTC through multisectoral coordination would reaffirm the natural leading role of the DOH for tobacco control. 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. IACT has a current mandate of action by law and even if this mandate has been assigned by a law that was passed before the country’s ratification of the WHO FCTC, it is anticipated that this committee will continue to exist. However, to prevent competition among IACT and SWAT, as soon as it will be found as politically appropriate, the DOH and the other governmental stakeholders should pursue amending the RA 9211 in the sense of providing DOH with the coordinating role of a national tobacco control intersectoral structure that excludes the tobacco industry from its work.
2.3.5. Enforcing the Memorandum Circular 2010-01 as well as pursuing the activities of the SWAT Committee on 5.3 should be considered as a priority for the governmental structures in their efforts to protect public health from the tobacco industry interference.

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 which could preferably be conducted by a civil society organization and co-funded by the government to ensure consistency, transparency and sustainability.

In addition to this, regular awareness campaigns displaying tobacco industry strategies should be implemented in order to increase public and policy-makers’ familiarity and vigilance for the subject, and indirectly to increase the participation and compliance with existing tobacco control laws. Fostering partnership with relevant groups could contribute in countering the industry’s influence (e.g. with the Philippine Legislators’ Committee on Population and Development Foundation, etc.).

The tobacco growing areas, which are more prevalent in the north of the Philippines, should be targeted by specific programmes. Research programmes could identify beliefs and attitudes of farmers in these areas and eventually awareness raising initiatives could give the opportunity to these farmers to understand the risks for health posed by their current farming activities to their families and also to the entire population. Apart from exploring potential alternative livelihoods, the LGUs should establish direct communication channels with the tobacco growers for increasing their understanding, trust and participation to the tobacco control cause.

2.3.6. The DOH should collaborate and strongly support the LGUs efforts in tobacco control as essential players in advancing the WHO FCTC compliance in the Philippines.

Strengthening tobacco control efforts at sub national levels represents a golden opportunity and should be pursued through continuous collaboration between the NTCCO and the LGUs (facilitating technical assistance for various areas of expertise, providing training and support for other capacity building initiatives, and convening annual meeting to discuss advances, setbacks and reframe collaboration according to local needs). 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 quitlines) and coordinating initiatives with civil society. Also, the collaboration regarding the Red Orchid Award strategy should include evaluation of multisectoral 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.
3. Monitoring and evaluation

3.1. POLICY STATUS AND DEVELOPMENT

Monitoring and evaluating programmes must provide both overarching and specific information on the tobacco epidemic and the response to it (tobacco policies and programmes). Effective surveillance and monitoring systems must track several components, including (i) prevalence of tobacco use; (ii) impact of policy interventions; and (iii) tobacco industry marketing, promotion, public relations strategies and lobbying. These three components were examined by the assessment team.

3.1.1. The tobacco surveillance function of DOH

Tobacco Surveillance is being conducted in the Philippines since 1989 and DOH is deeply involved in this effort. The responsible structure at DOH for tobacco surveillance is the National Epidemiology Centre (NEC) as established by the DOH Department Order (DO) No. 29 of February 7, 2011. This order makes NEC responsible for conducting the GATS, GYTS and other surveillance activities as well as for the development and institutionalization of a national reporting and surveillance for the tobacco control programme. NEC also leads the work of the subcommittee on surveillance of the SWAT. NEC has about 70-80 staff mostly devoted to public health surveillance. Within NEC, the Surveys, Risk Assessment and Evaluation division is in charge of doing tobacco surveillance activities. This division has four (4) full-time equivalent (FTE) technical FTEs with one staff devoted to tobacco surveillance 50% of the time while the rest devote about 25% of their time.

DOH partially funds the GYTS (conducted in 2000, 2003 and 2007). The DOH also conducted the Global Health Professions Student Survey (GHPSS) for Pharmacy (2005) and Medical Students (2009). The DOH and National Statistics Office (NSO) have conducted the Global Adult Tobacco Survey (GATS) in 2009. DOH occasionally pays to have some questions included in the Social Weather Station surveys (mostly nationwide in scope with the cost of Php80,000-200,000 per question), while other tobacco surveillance they conduct is mostly funded by external sources. The DOH, through NEC, has also monitored tobacco related diseases mortality and morbidity statistics as part of its annual Field Health Information System (FHIS). The DOH and the University of the Philippines have documented the economic burden and health care costs of tobacco related diseases in 1999, 2008 and 2010.

At regional level, the DOH has epidemiology surveillance units which implement surveillance at local level in coordination with LGUs and sometimes with the regional NCD/tobacco control programme coordinators.

3.1.2. Tobacco industry monitoring

Under the CSC-DOH Memo, all government agencies must include information regarding instances of tobacco industry interference in their annual reports. In addition, the DOH-FDA has the legal mandate to require the tobacco industry to disclose information regarding marketing, promotion and sale of tobacco in accordance with the new FDA Law. On the other hand, some information related to the tobacco industry can be made available through various agencies e.g. Department of Social Welfare and Development (all donations made to the government in the guise of corporate social responsibility).
3.1.3. Other tobacco data collection efforts outside the DOH.

The Food and Nutrition Research Institute (FNRI) of the Department of Science and Technology regularly conducts a five-year interval national nutrition and health surveys (NNHeS) with questions on tobacco prevalence and consumption among adults (20 years and older) using the WHO STEPwise methodology. They have conducted the NNHeS in 1998, 2003, 2008 with PHP100M funding from the government appropriations including that by the DOH funds as well as other private institutions particularly medical societies. The NSO had regularly conducted the 3-year interval Family Income and Expenditure Surveys (2000, 2003, 2006, and 2009).

A variety of agencies have produced data on the economic burden of the disease, health care cost, tobacco production and tax data. For example, the Department of Trade and Industry can easily monitor all investments made by the tobacco industry, and the Bureau of Internal Revenue and the Bureau of Customs the volume of tobacco sales and revenue from tobacco taxes.

3.2. KEY FINDINGS

3.2.1. The Philippines has recent, representative and periodic tobacco surveillance data for both adults and youth. However, sustainability is a challenge.

The main challenges to sustainability prevalence surveillance are two:
- Although DOH partly funds some surveys like the GYTS and the NNHeS, funding for tobacco surveillance is still largely 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. GATS, which is an internationally validated survey, is not sustainable in its present form. The complete GATS survey cannot be integrated into other existing adult surveys in full. A core set of question from GATS has been developed by WPRO (Core Adult Tobacco Survey or CATS) to facilitate its integration in existing adult surveillance efforts.

3.2.2. Efforts devoted to translate existing surveillance data into action are insufficient.

Although 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.

3.2.3. Efforts to monitor strategies and actions of the tobacco industry to undermine public health are at initial phase.

There are some activities geared towards the development of a database as collaborative activity of government organizations led by Civil Service Commission and civil society to monitor some of the tobacco industry actions to undermine public health. However, as mentioned above, these efforts are limited and are not part of an overall surveillance plan.

3.2.4. There is no system to monitor the implementation/enforcement of national and local tobacco control policies.

Some LGUs have established their own system to report on violations and fines but there is no national system in place to produce comparable data. Also, there is neither formal nor informal communication regarding the data on monitoring of compliance or on the enforcement actions between the LGUs and
DOH CHDs. Due to the lack of data collection and reporting, the public cannot be informed on the compliance and enforcement rates, and strategies to improve existing law compliance cannot be developed. The effort by the IACT to produce a common standard form to report complaints is too complicated to be applicable and plan to implement it and create a reporting system is lacking.

3.2.5. The DOH/NEC allocates inadequate human resources for consolidating an integrated national tobacco surveillance system.
Existing staff at NEC’s SRAE division and DOH regional surveillance units is not sufficient for responding to the challenges of the around three following years needed for consolidation of a sustainable and integrated tobacco surveillance system that would cover the gaps enunciated in the above findings.

3.3. KEY RECOMMENDATIONS

3.3.1. Ensure sustainability of existing surveillance efforts by integrating a core set of questions and methods from GATS into ongoing surveys.
GATS constitutes a very important effort to measure prevalence and other indicators. To guarantee sustainability, NEC needs to select a core set of the GATS questions and integrate them into ongoing large-scale national surveys, such as the National Health Survey or the Family Structure Survey. The assessment team recommends the use of the Core Adult Tobacco Survey (CATS), which was developed by 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.

3.3.2. Use better the existing surveillance and monitoring data to transform collected data into information relevant for action.
NEC needs to take the leadership in transformation of the collected data into information that would be relevant for the decision makers and understandable for the public which would result to facilitation of policy change and support of the population in implementing the necessary measures. According to the DOH DO 29 of February 7th, 2011, NEC has the mandate to develop and institutionalize a national reporting and surveillance for the tobacco control programme. In this regard, NEC needs to seek for additional partners’ support and use their capacity through the work of the SWAT sub-committee on surveillance.

3.3.3. Strengthen and systematize the activities on tobacco industry monitoring.
Each country needs to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of its activities that have a negative impact on tobacco control efforts. The guidelines of WHO FCTC Article 5.3 recommend a series of activities to prevent the influence of the tobacco industry to public health. Monitoring the implementation of Article 5.3 of the Convention and of these guidelines is essential for ensuring the introduction and implementation of efficient tobacco control policies. Existing models and resources for monitoring the tobacco industry’s strategies and activities should be used, such as those outlined by the WHO Tobacco Free Initiative (see WHO TFI reports and publication for monitoring the tobacco industry).

3.3.4. 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.

A system for monitoring the implementation of tobacco control policies could function through multi-sectoral collaboration in the government and between government and civil society. Such system would empower the responsible governmental agency to propose further periodic plans of actions based on the results and impact of current efforts, and it would also serve as basis for the decision process in investing in those measures and policies that have greater impact in combating the epidemic. As LGUs, in compliance with WHO FCTC provisions, enact local ordinances to create smoke-free environments in all indoor workplaces and public places and ban tobacco advertising, promotion and sponsorship, these local governments must also establish local systems to monitor the implementation of local tobacco policies with their own funds.

Such local monitoring systems should be developed with the technical support of DOH CHDs and regional surveillance units as part a national standardized monitoring system.

3.3.5. Provide additional human resources to NEC for consolidating a national tobacco surveillance system.

In order to sustain and enhance existing surveillance efforts and add other basic surveillance components as recommended by the above sections, additional human resources need to be allocated to NEC, for at least first three years of action. Once the system is consolidated and sustainable, the number of human resources could return to existing levels. The necessary funds could be allocated by DOH either regularly through creation of dedicated budget line for the tobacco control programme under the General Appropriations Act or hiring of contractual staff.
4. Smoke-free environments

4.1. POLICY STATUS AND DEVELOPMENT

Scientific evidence has firmly established that there is no safe level of exposure to second-hand 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.

The WHO FCTC Guidelines on protection from exposure to tobacco smoke were adopted by the Conference of the Parties consistent with other provisions of the Convention and aim to assist Parties in meeting their obligations under Article 8 of the Convention. Fundamental principles that guide the implementation of the guidelines state that any approaches other than 100% smoke-free environments have repeatedly been shown to be ineffective, and that there is conclusive evidence that engineering approaches, including ventilation, air filtration and the use of designated smoking areas (whether with separate ventilation systems or not) do not protect against exposure to tobacco smoke. All people should be protected from exposure to tobacco smoke and therefore all indoor workplaces and indoor public places should be smoke-free.

The Philippines has a range of policies designed to meet the nation’s obligations under WHO FCTC Article 8. The Tobacco Regulatory Act or R.A. 9211 prohibits smoking in public places including medical facilities and educational facilities, yet it allows the establishment of designated smoking areas in restaurants, bars, public transport, and other public places. As of 2010, government buildings and premises and public transport vehicles and terminals should be 100% Smoke-Free, in accordance with Memoranda issued by the respective government agencies. The Departments of Health, Education, and Commission on Higher Education have also issued orders to ensure that their facilities are smoke-free. Relevant national-level policies are summarized in Table 4.1.

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6 WHO FCTC Guidelines on protection from exposure to tobacco smoke. Available at: http://www.who.int/fctc/cop/art%208%20guidelines_english.pdf
### Table 4.1: Policies relevant to protection from second-hand smoke in the Philippines

<table>
<thead>
<tr>
<th>Law / Policy</th>
<th>Policy Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>R.A. 8749 (Clean Air Act of 1999)</td>
<td>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.</td>
</tr>
<tr>
<td>R.A. 9211 (TRA of 2003), Sec. 5 &amp; 6</td>
<td>Prohibits smoking in all centres of youth activity (schools and recreational facilities), elevator 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.</td>
</tr>
<tr>
<td>Dept of Interior and Local Government MC No. 2004-85</td>
<td>Implementation of Smoking Ban in Public Places in compliance with RA 9211 and IRR.</td>
</tr>
<tr>
<td>Commission on Higher Education (CHED) M.O. No. 63 s. 2007</td>
<td>Bans smoking in higher education institutions.</td>
</tr>
<tr>
<td>Philippines Civil Service Commission Memorandum Circular (M.C.) No.17 Series 2009</td>
<td>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.</td>
</tr>
<tr>
<td>Department of Transportation and Communication (DOTC)- Land Transportation Franchising and Regulatory Board (LTFRB) M.C. No. 2009-036</td>
<td>Imposes a 100% Smoke-Free Policy on all public utility vehicles and public land transportation terminals.</td>
</tr>
<tr>
<td>Department of Health Administrative Order (A.O.) No. 2009-0010</td>
<td>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.</td>
</tr>
<tr>
<td>Department of Education Order No. 73 s. 2010</td>
<td>Bans smoking in public schools, including open or covered spaces around school buildings.</td>
</tr>
<tr>
<td>DOH CHD4A and DILG 4A Joint Memorandum Circular No. 2010-01</td>
<td>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.</td>
</tr>
<tr>
<td>DILG Memorandum: 1 Feb 2011</td>
<td>Implementation of Smoking Ban in compliance with RA 8749 or the Philippine Clean Air Act of 1999.</td>
</tr>
<tr>
<td>Religious Rulings</td>
<td>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).</td>
</tr>
<tr>
<td>Local Ordinances (not exhaustive list)</td>
<td>LGUs with Anti-Smoking Ordinances or that have passed Smoke-Free Legislation in support of WHO FCTC or have good implementation of ordinances: Provinces: Nueva Vizcaya in Cagayan Valley; 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; Municipalities: Umingan in Pangasinan, Northern Luzon; Calatagan 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; Dumaguig in Zamboanga del Sur, Zamboanga Peninsula; Talisay in Misamis Oriental, Northern Mindanao.</td>
</tr>
</tbody>
</table>
4.2. KEY FINDINGS

4.2.1. 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.

The DOH, as the agency with the main responsibility for promoting and protecting health, is not yet at full capacity to play a stronger role in promoting social norms that are more supportive of smoke-free environments and less tolerant of exposure to SHS. The “voice of the citizen” on this issue is not yet strong throughout government agency organizational culture and policy development. 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) the Civil Service Commission (CSC) has huge potential to improve population health through its role with all civil service employees, and notably through its Memorandum Circular [M.C.] No.17 Series 2009. But this potential is not being realized due to lack of human, financial and technical resources;

b) Neither the Department of National Defence (DND), nor the Occupational Safety and Health Centre (OSHC) currently have policy instrument or Memorandum Circular (MC) specifically on tobacco/smoking;

c) the Department of Labour and Employment (DOLE) has no policy instrument although it has relevant mechanisms available for monitoring both policy development and smoking status of employees (e.g. the Bureau of Labour & Employment Statistics [BLES] through survey mechanisms; the Bureau of Working Conditions by including Tobacco/Smoke-free items within its checklist for monitoring health related standards);

d) the Philippine National Police (PNP), although being in the frontline of providing examples of conduct to the wider community, has no policy instrument yet.

4.2.2. Effective Local Government efforts lack technical support and financial sustainability.

The Assessment Team found examples of promising practices in smoke-free policy development and implementation at Local Government Unit (LGU) level, in many cases supported by the DOH. However, these promising practices have not yet been fully exploited for optimal health gain. This is because [i] some proven initiatives (such as the smoke-free initiative implemented by CHD for Metro Manila) have not been maintained beyond a first phase or taken to the necessary scale; [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. Although the smoke-free policy measures are included in the requirements for tertiary hospital accreditation by the Philippine Health Insurance Corporation at the national level, the opportunity to influence the local government units where the health facilities are geographically located is not being exercised by relevant health human resources.

4.2.3. Existing national policies for smoke-free environments are not being enforced or monitored.

Recent reliable scientific data show that neither R.A. 9211 nor Memoranda issued by government agencies have been effective in protecting the public from exposure to second-hand smoke:

- The 2009 Global Adult Tobacco Survey (GATS) found that the exposure to second-hand smoke (SHS) in public places in the Philippines is high despite all the relevant policies summarized in Table 4.1. 
  - Adults reported exposure to SHS in public transport, restaurants, government offices, and health care facilities, with highest levels of exposure on public transport and in restaurants over half, and over a third of adults exposed to SHS, respectively;
  - One in four adults reported exposure in government offices;
  - Even in health care facilities, where R.A. 9211 prohibits smoking, 7.6% reported SHS exposure;

- One in four adults reported exposure in government offices;
- Even in health care facilities, where R.A. 9211 prohibits smoking, 7.6% reported SHS exposure;
• Research conducted by the DOH and World Lung Foundation in 2008-09 found that smoking was commonplace in restaurants, bars, indoor offices and indoor workplaces [IPSOS & WLF 2009; DOH & WLF 2008].
• In the 2009 national Social Weather Station survey, 60% of adults over 18 reported inhaling SHS daily [Philippines DOH 2010].
• The exposure of children to SHS is indicative of the entire population’s exposure; in 2007, 65% of 13-15 year old students surveyed in the Global Youth Tobacco Survey (GYTS) said that they were exposed to SHS in places outside their home, increasing from 59% in 2004 [Philippines DOH/GYTS 2007].

Although the WHO FCTC Article 8 Guidelines states that “the implementation of smoke-free legislation, its enforcement and its impact should all be monitored and evaluated” the above data show lack of effective enforcement and with no systematic approach to compliance monitoring and reporting.

4.2.4. Current laws allowing the establishment of designated smoking areas in public places do not effectively protect public health.
Evidence showed that no safe levels of exposure to second-hand smoke exist, and, as previously acknowledged, engineering approaches, such as ventilation, air exchange and the use of designated smoking areas, do not protect against exposure to tobacco smoke. Protection should be provided in all indoor or enclosed workplaces, including motor vehicles used as places of work (for example, taxis, ambulances or delivery vehicles). 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. The assessment team was also informed that the Tobacco Industry is attempting to undermine the LGUs’ efforts to protect their citizens from SHS exposure in line with the WHO FCTC Art Guidelines by using R.A. 9211 provisions for arguing against stricter LGU ordinances than the national laws.

4.2.5. The health services sector is not yet fully involved in smoke-free policy implementation and in mobilizing public support for it.
Although there are opportunities for the health services sector (public and private alike) to promote social norms supportive of smoke-free environments and to strengthen policy implementation, the health services are not yet 100% smoke-free [as previously acknowledged in GATS results] and smokers are not advised of the grave health risks posed by smoking and exposure to it. Medical bodies such as the Philippine Medical Association (PMA) and the Philippine Ambulatory Paediatrics Association (PAPA), although having important leadership roles to offer through their own policies & position statements, have not exerted sufficient efforts to influence medical training curricula and continuing medical education (CME) accreditation processes.

4.3. KEY RECOMMENDATIONS

4.3.1. 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.
Options for implementation include:
  i. provide the CSC with the necessary human resources and systems to (a) support national government agencies with their responsibilities under MC17; (b) use existing data on employee smoking status to help design cessation service programmes for civil service employees and to monitor policy impact on smoking rates;
ii. encourage the PNP to adopt its smoke-free policy for protecting the health and well-being of PNP employees, and to provide a very positive and salient example for the wider community;
iii. request the OSHC to develop, monitor and ensure compliance of smoke-free policy in the workplace, and also include it within its training modules;
iv. request the DOLE – together with its 12 attached agencies – to develop smoke-free policy and ensure compliance monitoring; liaise with the BLES biennial (and other) surveys to monitor the status of smoking policies; liaise with the Bureau of Working Conditions on the incorporation of smoke-free policy monitoring item(s) on their checklist for health related standards; and
v. support the DND to develop smoke-free policy and compliance monitoring across all sections of the armed forces; re-enlistment medical check-ups could be used more systematically to reinforce the smoke-free cultural norm and to identify any personnel in need of cessation services; the provision of free (or subsidized) pharmacotherapy for smoking cessation could be considered for the armed services.

4.3.2. Local Governments should expand and sustain their smoke-free policy initiatives through dedicated financial and technical support for: (i) public awareness programmes, (ii) dedicated staffing; (iii) training & 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.

Options for implementation include:

i. DOH through the Centers for Health Development could provide financial incentives to LGUs using criteria which include (but are not limited to) full compliance with WHO FCTC Article 8 Guidelines in their ordinances and other measures to protect their populations from exposure to tobacco smoke;

ii. DOH could intensify and expand to national scale the pilot CHD/LGU Smoke-free Metro Manila campaign, which was coordinated by CHD-MM and comprised of (i) public education to ensure accurate knowledge of the law and of the health effects of SHS; (ii) capacity building for enforcement of effective smoke-free ordinances in LGUs; (iii) use of a telephone hotline/ SMS and data system for reporting of violations by members of the public. The national campaign could be coordinated by the DOH in partnership with national government agencies, local government units and civil society organizations; an initial 2-year campaign period is recommended comprising two suggested phases of media in Year 1 and a third suggested phase of media in Year 2 with sufficient weight of media placement to achieve at least 70% prompted recall of key campaign messages.

iii. DOH could sponsor fora and fund the compilation of case studies to disseminate LGU good practices in imposing higher business permit fees to retailers of cigarettes which have been proven effective in promoting smoke-free environments.

4.3.3. The government at large, regardless whether national or local, should ensure countrywide enforcement and monitoring of national policy for smoke-free environments.

Adequate resources for provision of human resources, training and capacity building, tools and data systems could be mobilized for the implementation options outlined below:

i. mobile inspection teams: LGUs should configure mobile teams with capacity and mandate for inspection of compliance with local smoke-free ordinances under the auspices of the local government operations officer of the Department of Interior and Local Government (tools, systems for monitoring, data reporting, best practices) – this should be in addition to item (ii);

ii. skilled LGU enforcement staff: undertake intensive capacity building initiatives to ensure the necessary establishment of human resources, with the necessary knowledge and skills for effective enforcement;
iii. central coordination and support: for the DOH to provide a central hub of expertise, resources and tools to support national government agencies in their enforcement and compliance monitoring obligations; 
iv. standard system specifications and data items: develop standard specifications for public reporting of violations (duties of compliance widely disseminated to public and local companies/institutions, coordinated toll free hotline for reporting of law violations, SMS, email arrangements), inspection and monitoring tools, data reporting items, databases and reporting formats to enable comparable data reporting of (a) compliance monitoring (rate of inspections, rate of violations), (b) enforcement (rate of issuance of warnings/prosecutions/fines).

4.3.4. The DOH should pursue collaboration with all relevant stakeholders for ensuring that the Republic of the Philippines meets its obligations under the WHO FCTC Article 8.

The WHO FCTC Article 8 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”. The Article 8 Guidelines clarify that it creates an obligation to provide universal protection by ensuring that all indoor public places, all indoor workplaces, all public transport and possibly other (outdoor or quasi-outdoor) public places are free from exposure to second-hand tobacco smoke. No exemptions are justified on the basis of health or law arguments. In addition, if a Party is unable to achieve universal coverage immediately, Article 8 creates a continuing obligation to move as quickly as possible to remove any exemptions and make the protection universal. Each Party should strive to provide universal protection within five years of the WHO FCTC entry into force for that Party. In order to meet and achieve this goal, the legislators in the Philippines should remove the provisions for designated smoking areas (DSAs) from national laws and policies as early as possible. The Philippine Society of Mechanical Engineers through intensive advocacy by the DOH should be engaged in the revision of the National Building Code. 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.

4.3.5. Strengthen implementation of smoke-free policy through the support of health services and medical associations and by improving access to smoking cessation services.

The DOH in collaboration with the professional health associations and other relevant organizations should collaborate in achieving this recommendation. Options for implementation include:

i. implement site-specific policies to ensure that all health services are 100% smoke-free;
ii. through practice protocols and guidelines for health professionals, and IEC materials, ensure that all hospital patients and health service users are advised of the grave health risks and the consequent need to protect themselves and their children from exposure to SHS;
iii. provide support for the Philippines Medical Association (PMA), the Philippines Ambulatory Paediatrics Association (PAPA) and other medical associations as appropriate to include smoke-free and other tobacco control content within medical training curricula and within continuing medical education (CME) accreditation processes;
iv. improve access to smoking cessation via health service providers in support of smoke-free policy development and implementation (please refer also to specific smoking cessation recommendations made elsewhere in this report).
5. Offer help to quit tobacco use

5.1. POLICY STATUS AND DEVELOPMENT

Recent data from the Global Adult Tobacco Survey (GATS) conducted in 2009 indicate that over half of all adult smokers attempted to quit in the past year and over 60% are interested in quitting. The Global Youth Tobacco Survey (GYTS) shows that among youth, the proportion wanting to quit is even higher at 86%, and over 87% have actually tried to quit in the past year. Furthermore, over half of adult daily smokers have a cigarette within 30 minutes of waking up and one in five have a cigarette within five minutes of waking up. These data indicate high levels of physical dependence on nicotine, even among young tobacco users, and highlight the addictive nature of tobacco use. Taken together with consistently high interest in quitting, it is clear that effective cessation programmes can play a significant role in reducing tobacco consumption within the country.

Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC) requests Parties to this Convention to promote cessation and the treatment of tobacco dependence. The WHO FCTC Conference of the Parties (COP) also adopted guidelines for the implementation of Article 14 of the Convention. As a Party to the WHO FCTC, the Philippines is obligated to fully implement Article 14.

In 2003, the Philippines enacted Republic Act 9211, an “Act Regulating the Packaging, Use, Distribution and Advertisements of Tobacco Products and for Other Purposes,” requiring the Department of Health (DOH) to establish “withdrawal clinics.” 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. Local Government Units (LGUs) and other institutions with health facilities and other government and private agencies, while not covered under the mandate, were encouraged to participate. By 2004, an evaluation of the AO implementation conducted by the National Epidemiology Centre (NEC) Field Epidemiology Training Program in 69 pilot areas in Luzon revealed that 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.

The Philippine Heath Insurance Corporation (PhilHealth) issued Circular 17 in 2007 authorizing overseas Filipino workers to avail of smoking cessation counselling without any co-payment. To date, this is the only coverage available for smoking cessation services. No equivalent for Philippine-based services exists. RA 9211 mandates PhilHealth to cover outpatient cessation counselling for minors, but this remains unimplemented.

WHO recommends countries incorporate nicotine replacement therapy, specifically nicotine gum and patch, in the list of essential drugs. At present, these are not included in the national formulary of the Philippines. The essential drug list is now under the National Centre for Pharmaceutical Access and Management of the DOH in collaboration with the PhilHealth.

Guidelines for implementation of Article 14 of the WHO Framework Convention on Tobacco Control (Demand reduction measures concerning tobacco dependence and cessation. Available at: http://www.who.int/fctc/Guidelines.pdf
In response to the rising popularity and aggressive marketing of electronic cigarettes as a “safer cigarette,” the DOH issued a health advisory on electronic cigarettes/electronic nicotine delivery systems in 2010 stating: “there is insufficient evidence that e-cigarettes are safe for human consumption.” The other cessation-related advisory issued by the DOH Food and Drug Administration (FDA) in 2008 involves warnings on the use of varenicline consistent with the advisory issued by the US FDA on its effects in high-risk users.

Recently, the Philippine Medical Association (PMA), an umbrella group covering all medical specialties in the country, issued a Resolution on Anti-smoking (October 2010) calling on all physicians to (1) refrain from smoking; (2) inform all patients about the harmful effects of tobacco use and the benefits of quitting; (3) include smoking status in history taking; and, (4) provide brief cessation advice to all tobacco users. The Philippine Ambulatory Paediatrics Association (PAPA) has taken this a step further and is training all of its members in brief advice, and incorporating the assessment of tobacco use and delivery of brief advice in all patient encounters.

5.2. KEY FINDINGS

5.2.1. The lack of a coordinated national cessation infrastructure/system and the paucity of cessation providers hamper the implementation of the national cessation policy.

5.2.1.1. Cessation programmes exist, but these are few in number, institution-based with no mechanisms to link to the community at large, and run independently of each other.

Moreover, the emphasis is on clinical models of service delivery rather than on population approaches to cessation. There are a few professional organizations that have begun to promote the use of brief advice, such as the PMA and the PAPA. But in general, institutions offering cessation services use stand-alone “cessation clinics” that are often housed within hospitals (e.g. Lung Center of the Philippines, Philippine General Hospital) and other health care facilities. These clinics are not linked to other relevant health programmes and usually do not have a mechanism for identifying smokers ready to quit from the population at large. Instead, they rely on referrals from within their patient population. Thus the referral base is limited, and consequently, the reach of these “clinics” is not optimized. 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) who have established cessation programmes where the lung specialists oversee cessation pharmacotherapy but link their services with psychologists or psychiatrists providing counselling.

5.2.1.2. There is no national quitline.

Global evidence confirms that phone-based cessation counselling programmes are cost-effective in reducing tobacco consumption.

5.2.1.3. The paucity 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 mandating smoke-free policies have limited access to assistance with quitting.

This has been repeatedly confirmed by interviews with key informants at the local government units (LGUs), who consider cessation services pivotal to support smoke-free policies.
5.2.1.4. Moreover, cessation drugs are of limited availability.
Currently, only nicotine patches and varenicline are available, and nicotine patches may be pulled out of the market shortly. However, nicotine gum may be introduced in the Philippines within the near future. None of the cessation medications are on the essential drug list despite previous efforts to get them included in the national formulary. Thus cessation pharmacotherapy remains ineligible for insurance coverage at the moment.

5.2.2. At present, there are no national cessation clinical practice guidelines and standard cessation models to guide the delivery of cessation services.
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 DOH Substance Abuse Prevention programme created a tobacco cessation manual during the time of Health Secretary Dr Romualdez for use in drug rehabilitation clinics, but this manual was not widely disseminated to other programmes and has fallen out of use. The DOH is reportedly working on developing Clinical Practice Guidelines (CPGs) for cessation, although the content of these guidelines is said to focus predominantly on operational issues rather than on cessation approaches. The PCCP attempted to develop standard guidelines on cessation in 2008 and convened cessation practitioners, but has not issued formal guidelines to date. Some health professionals have turned to the private sector, particularly the Seventh Day Adventists (SDA), who uses a cessation module called “Breathe Free.”

5.2.3. A national strategy to institutionalize cessation capacity building among health care workers does not exist.
Although DOH AO No. 122 addresses training as a component of the National Smoking Cessation Program, this has not been operationalized in a systematic fashion. Some professional groups, including the University of the Philippines College of Nursing and some universities belonging to the University Belt Consortium have begun incorporating tobacco control modules into their curricula, but these cover general information about tobacco control and do not always include cessation skills acquisition, particularly brief cessation advice. An exception is the PAPA, which recently adapted the brief tobacco cessation intervention skills (BTIS) training module from Guam and is conducting BTIS training among its members. Two pilot training of trainers workshops using the Guam BTIS training module and the Mayo Clinic-based intensive counselling training module were conducted with a mixed group of physicians and other health professionals through the WHO Western Pacific Regional Office Tobacco Free Initiative, PCCP, PAPA and FCAP. However, training in cessation, including brief advice, has yet to be incorporated into the mandatory curricula for all health care professionals.

5.2.4. Cessation services are not covered under current health insurance schemes.
Outside of Philhealth Circular 17, which provides for cessation counselling for overseas Filipino workers and family members, there is no insurance coverage for cessation services in the Philippines. RA 9211 mandates PhilHealth to cover outpatient cessation counselling 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.
Philippine Business for Social Progress (PBSP), a corporate group that has Philip Morris Philippines Manufacturing, Inc. as one of its members, has been promoting a workplace-based Quit Smoking Support (QuitS) Program since 2008, and Youth Smoking Prevention (YSP) programme in schools. These tobacco industry-funded programmes de-emphasize evidence-based cessation interventions. Global experience with similar tobacco industry-led cessation and prevention programmes indicate they are ineffective in reducing tobacco consumption and in facilitating cessation.

5.2.5. Advocacy for cessation has not been optimized to raise public and political awareness and support for cessation.

The controversy surrounding the various bills for increasing tobacco taxes and the ongoing legal challenges to the implementation of graphic health warnings have pushed cessation lower down the list of tobacco control advocacy priorities. The Tobacco or Health/Air Pollution council within the PCCP has ~ 30 active members who conduct information dissemination and advocacy campaigns for cessation, but a larger critical mass of cessation advocates is needed to raise the population’s awareness of cessation’s role in tobacco control. Moreover, the addictive nature of nicotine remains under-recognized and people mistakenly believe that quitting tobacco use is difficult. The general population is also not familiar with existing cessation resources.

5.3. KEY RECOMMENDATIONS

5.3.1. 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 those LGUs where the demand for cessation already exists, and where smoke-free policy support is strong.

5.3.1.1. 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.

A three-tiered system is envisioned that incorporates:

a. First, a broad base of health and non-health service providers identifying tobacco users who are ready to quit from the general population and delivering brief advice to them;

b. Secondly, a more limited number of counsellors and health professionals providing intensive counselling for tobacco users who need more than brief advice through face-to-face programmes, a quitline or other alternative mechanisms for service delivery (e.g. online cessation programmes, text-based programmes, etc.);

c. Thirdly, health professionals capable of overseeing treatment of highly addicted tobacco users, including those with co-morbidities, with supervision of medical treatment using cessation drugs; and, finally

d. A coordinating mechanism that allows members in any of the three tiers to cross-reference each other for effective utilization of services and coordination of care.
5.3.1.2. **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.**

5.3.1.3. **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.**

For example, paediatrician-members of PAPA in a specific LGU should be tapped to form the core of brief advice providers (1st tier), and if an SDA “Breathe Free” cessation programme exists in that LGU, it should be included as a provider of intensive counselling (2nd tier). Physician members of PCCP practicing within that locality should be recruited to supervise cessation drug treatment (3rd tier). All of these providers should be aware of each other and their contact details, and should readily refer across the tiers. Their services should be broadly advertised to the local community, especially those government agencies and private sector entities wanting to support their smoke-free policies with cessation support to assist smokers and other tobacco users.

5.3.1.4. **Counselling formats other than face-to-face programmes should be considered, especially as demand for cessation services increases.**

Quitlines are proven to be cost-effective in reaching large populations who require counselling support to quit tobacco use. The DOH and the LGUs should collaborate for ensuring establishment and full functioning of either a national quitline or regional quitlines that are toll-free and equipped with trained and motivated staff.

5.3.1.5. **Making cessation drugs more available should be addressed. These cessation aids need to be incorporated into the national formulary.**

In addition, the possibility of manufacturing or parallel importation of generic cessation drugs should be explored.

5.3.2. **Finalize, endorse and widely promote a standard set of tobacco cessation practice guidelines and service delivery models.**

Pharmaceutical companies should not be involved or engaged when developing cessation policies and guidelines but could assist in implementing and disseminating established guidelines and in smoking cessation training. The work initiated by the DOH for reviewing the evidence-based cessation interventions with professional groups like the PMA and PCCP and the academe and for eventually establishing a set of cessation practice guidelines and models needs to be accelerated, guidelines finalized and endorsed and also widely disseminated across the entire health system, in both the private and public sectors, and across all relevant programmes.
Opportunities to integrate these guidelines into relevant health and other programmes (i.e. cancer control programmes, maternal and child health programmes, TB control programmes, as well as poverty alleviation programmes, workplace wellness programmes, social welfare programmes) should be explored and utilized. Options of such integration activities include:

- Counselling and provision of brief advice to be incorporated into the Noncommunicable Disease (NCD) control and prevention programme’s screening and prevention services and included in the counselling sections of Directly Observed Treatment Strategy (DOTS) within the tuberculosis control programme;
- Adoption of these guidelines, screening for tobacco use and providing brief cessation advice during pre-enlistment and re-enlistment physicals by departments that provide health services other than the DOH, e.g. the Department of National Defense (DND);
- PhilHealth could use the official endorsement of these guidelines as a prerequisite to begin financial coverage of cessation services;
- DOH could advocate to PhilHealth to identify the provision of cessation services by using these guidelines as a core indicator for accreditation of hospitals, health facilities and providers.

Although the pharmaceutical companies in the Philippines have expressed interest in assisting with the development of cessation policies and guidelines, given the for-profit nature of these entities, and the inherent conflict of interest they present when it comes to promoting cessation drugs, these companies should not be involved or engaged when developing cessation policies and guidelines. However, the pharmaceutical companies may assist in implementing and disseminating the guidelines established by the DOH.

5.3.3. Cessation training should be incorporated into the mandatory curricula and ongoing capacity building initiatives of health professionals.

5.3.3.1. The incipient efforts of academic societies and institutions of higher learning to integrate cessation training into educational curricula should be scaled up to encompass all health professional training curricula. At a minimum, all health-related programmes should include training in brief advice.

Options include the following:

a. For students, this could be implemented through a directive issued by the Commission on Higher Education (CHED).

b. For practitioners, completion of training in brief advice could be mandated as
   - A requirement for continuing medical education in their professional societies (such as the Philippine Medical Association, the Philippine College of Chest Physicians, and the Philippine Ambulatory Paediatric Association);
   - A prerequisite for licensing and license renewal (through the Philippine Regulatory Commission); and/or,
   - A requirement for board certification (through subspecialty societies).

c. Within the DOH and its attached agencies, hospitals and other health facilities, training in brief advice should be identified as a core competency area for all programme staff.

d. Opportunities to incorporate cessation training in continuing education programmes should likewise be explored and utilized to augment the national pool of trained cessation providers.

5.3.3.2. Additional health providers should be actively recruited in identifying tobacco users who are ready to quit and providing brief advice.

Midwives, pharmacists, traditional healers, practitioners of complementary medicine and community health workers reach and interact with a large number of the community. Involving them in the provision
of brief advice would expand the workforce at the 1st tier of the cessation infrastructure. Other potential targets for basic cessation capacity building include workplace safety officers, human resource personnel, and school counsellors.

5.3.3.3. The DOH should continue its efforts on training of trainers that initiated already in several Centers for Health Development (CHD).
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, employees respectively (e.g. the CSC). In parallel, health professional societies could also designate cessation trainers to handle cessation capacity building in the private sector.

5.3.3.4. The DOH should adopt a set of standardized national training modules and tools.
Several training models from various sources already exist, and a few [e.g. pilot DOH Smoking Cessation Training Manual for Primary Health Care, Guam BTI training model] have been adapted for use in the Philippines. The DOH and other institutions and agencies interested in spearheading cessation capacity building should consider reviewing these locally adapted materials, and jointly selecting the most appropriate for dissemination and scaling up.

5.3.4. 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 counselling such as through a national quitline and, to the extent possible, pharmacotherapy for those who are heavily addicted to tobacco.
Tobacco industry sponsored cessation programmes should not be supported. Providing coverage for this range of essential cessation treatments removes a major barrier to accessing these services. To accomplish it, the following elements are needed:
1. Once cessation clinical practice guidelines are issued by the DOH, it appears that Philhealth would be able to start covering these services. Thus, speeding up the finalization of these guidelines and advancing the target date for their official release should be prioritized by DOH.
2. At the same time, strategies to expand cessation coverage to encompass private insurance companies should be pursued, to harmonize the financing of cessation across both private and public sectors.
3. Tobacco cessation should be framed as a core prevention intervention, and incorporated into other related covered benefits, such as primary health care, the tuberculosis Directly Observed Treatment Strategy (TB DOTS) package and maternity care. This builds on the current DOH priority for expanding universal health coverage, which could be leveraged to ensure that cessation is incorporated into the basic package of paid essential health services.
4. Tobacco cessation drugs should be identified as part of the essential drug list, to qualify for insurance coverage. This is consistent with WHO recommendations, which identifies nicotine replacement therapy, specifically nicotine patches and nicotine gum, as essential drugs for national formularies.
5. Tobacco users living in marginal economic situations should be priority targets for cessation services. They often have higher risks for tobacco dependence and adverse tobacco-related health effects and are more vulnerable to the negative socio-economic impact of tobacco-related diseases. DOH could advocate that the Department of Social Welfare and Development (DSWD) incorporate strategies to promote tobacco cessation into their conditional cash transfer “Pangtawid Pamilyang Pilipino” programme for the poorest of the poor, such as a prohibition of the use of supplemental income for the purchase of tobacco products, and linkage of this programme with PhilHealth financial coverage for cessation services.
6. Sustainable funding for cessation services should be incorporated into the tobacco tax increase, ideally by earmarking a portion of the tax revenues specifically to finance the essential package of cessation treatments. If resources are limited, an incremental approach to cessation coverage could be attempted, with brief advice and counselling as the initial covered services, and future expansion to include drug treatment.

5.3.5. DOH should promote cessation with systematic advocacy campaigns.

Cessation advocacy support could be given with priority to those agencies, LGUs and other entities where demand for cessation exists and cessation infrastructure and capacity building are supported by environmental policies and political will. Advocacy messages should emphasize that tobacco use is an addiction, that smokers are victims and not the enemy, that quitting tobacco use is beneficial and can be done, and that proven interventions exist to help tobacco users quit. A shift in popular perception is required to frame the tobacco industry’s role in intentionally marketing and promoting an addictive product and in countering effective tobacco control interventions, including effective cessation. While linking advocacy messages to cessation resources in the community, components of advocacy should include:

a. Adverse effects of tobacco use and benefits of cessation for general population;
b. Action-oriented cessation messages linked to existing cessation resources;
c. Awareness of both the benefits and cost effectiveness of smoking cessation interventions relative to other health-care interventions, especially for health-care professionals, administrators, and policy-makers;
d. Physicians as tobacco-free role models; and,
e. Complementary nature of cessation and other tobacco control interventions, such as smoke-free policies and tobacco tax increases.

Creative use of media, including new and emerging media such as social networking sites, SMS systems and online websites, should be explored to broaden the reach of advocacy efforts. Once cessation programmes and quitlines are established, tobacco control advocacy materials should provide links to these.

Tobacco-free health care professionals, especially physicians, are a critical nonverbal advocacy mechanism to promote cessation. As the behaviour of physicians who smoke negates cessation advocacy messages, those physicians should be targeted intensively to quit their tobacco use. Physicians and other health professionals in general should be actively recruited as cessation advocates for the public.
6. Warn people about the dangers of tobacco

6.1. PACKAGING AND LABELLING

6.1.1. POLICY STATUS AND DEVELOPMENT

Despite conclusive evidence on the dangers of tobacco, few tobacco users worldwide understand the full extent of the health risks. Effective warning labels, anti-tobacco advertising and the proactive use of media to influence the public and policymakers are three key ways to communicate the health risks of tobacco. It is a critical function of government broadly and of DOH specifically to inform Filipino citizens about the devastating risks tobacco poses to personal health and the health of their families, colleagues and fellow citizens.

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 11 of the Convention within a period of three years after entry into force, and to propose measures that Parties can use to increase the effectiveness of their packaging and labelling measures. For the Philippines as a party to the WHO FCTC, effective measures on packaging and labelling should have been implemented by September 2008.

Substantial international evidence support the effectiveness of graphic health warnings compared to text as a means of warning smokers. Pictorial warning labels influence initiation and motivate tobacco users to quit. After Australia introduced pictorial labels with quitline information in 2006, the rate of quitline callers doubled from the previous two years. After New Zealand implemented pictorial warning labels, more smokers recognized the national quitline number than when the quitline information was on the text-only labels (61% vs. 37%). After New Zealand introduced pictorial labels with quitline information in 2008, the number of new quitline callers increased, the rate doubled from 12% to 27% the first month and then remained at 30% thereafter. In the Philippines, 38% of current smokers who recalled seeing pack warnings (text only) thought about quitting because of the warning label (GATS 2009).

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.”.

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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 Warnings 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 RA9211 provision with WHO FCTC and “to ensure product packaging and labelling 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 (AO2010-13) in May 2010. This Order enables DOH to implement rotating evidence-based graphic health warnings (30% of front & 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. (See Annex 2 on p. 64)

6.1.2. KEY FINDINGS

6.1.2.1. DOH’s authority to issue health warnings is under attack by the tobacco industry.
Misinformation through legal challenges is an attempt of the tobacco industry to cause confusion about which government agencies are responsible for regulating tobacco, and in this way to delay the process of placing on the market the tobacco packages carrying pictorial warnings. DOH, however, 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.

6.1.2.2. Despite the tobacco industry’s attack, 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. These pending cases are a barrier to fully implement the AO, and also a barrier to implementing one of the most cost-effective tobacco control measures (that would result in effective warning of the population with very low cost for the government).

6.1.2.3. FDA urgently needs support to upgrade its capacity for implementing pictorial health warnings established by the DOH AO 2010-13.
Currently, FDA does not have adequate staff, tools or financial resources to effectively implement this administrative order. Furthermore, the LGUs are the agencies in charge for effective monitoring of the distribution of cigarette packs, but a mechanism of coordination between LGUs and DOH/FDA is not developed to ensure implementation.

6.1.2.4. 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. Current legislation (RA9211) lacks a provision to warn Filipinos about the harms of tobacco at the POS. This is a critical marketing point for the tobacco industry. POS 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.

6.1.3. KEY RECOMMENDATIONS

6.1.3.1. The DOH in collaboration with the other relevant government agencies should assert authority prominently in defense of the health of the Filipino people. The DOH is the national government agency with a formal mandate to lead the health sector towards assuring quality health care in promoting and protecting the health of Filipinos. It is responsible for maintaining regulatory, policy, and planning functions, and for providing leadership for health nationally. DOH’s vision is to be “the leader of health for all in the Philippines” and its mission to “guarantee equitable, sustainable and quality health care for all Filipinos, especially the poor, and to lead the quest for excellence in health”. Therefore, 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.

6.1.3.2. 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. In the longer term, the DOH should initiate and propose a bill that enacts the use of graphic health warnings into law and so it could ensure that all Filipinos have the chance to be exposed to the pictorial health warnings regardless of place of residence.

6.1.3.3. The DOH should invest in the FDA for upgrading its capacity to fulfil its responsibilities and coordinate related work with the Department of Interior and Local Government (DILG). The DOH should create a monitoring team within FDA that should be professionally motivated, well trained, financially sustained and equipped with necessary tools for boosting the department’s capability to implement the administrative order. Coordination and engagement with the DILG could facilitate implementation from the regional to the local levels.

6.1.3.4. 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 could allocate funding and technical assistance resources to print and distribute to establishment owners, and also to ensure appropriate enforcement of the local ordinances. 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.

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13 Guidelines for implementation of Article 12 of the WHO Framework Convention on Tobacco Control (Education, communication, training and public awareness). Available at: http://www.who.int/fctc/guidelines/Decision.pdf
6.2. PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS

6.2.1. POLICY STATUS AND DEVELOPMENT

WHO FCTC Article 12 request 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.

Public awareness of tobacco-control issues is essential to ensure social change. Tools to raise public awareness are important means of bringing about change in the behavioural norms around tobacco consumption and exposure to tobacco smoke. Comprehensive tobacco-control programmes contain research-based tools in education, communication and training – the three pillars of public awareness. Anti-tobacco advertising in all forms of media can help publicize the full extent of tobacco’s dangers. When exposed to graphic anti-tobacco messages on television, smokers are more likely to quit. Campaigns using graphic images that demonstrate the physical harm caused by tobacco use are especially effective in convincing users to quit. Effective public education campaigns are a vital component of any comprehensive tobacco control programme that aims to reduce the acceptability of exposure to second-hand smoke, and change the social context of tobacco use so that pro-tobacco messages are no longer dominant.

RA 9211 provides for public education programmes to be implemented by the DOH but there is no specific mention of the use of mass media as an intervention to warn people about the harms of tobacco. Article 2, Section 15 of the Constitution states that it is the duty of the state to promote the right to health of the people and instil health consciousness among them. DOH Administrative Order (AO) 58 (2001) further clarified the role of the National Center 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.

6.2.2. KEY FINDINGS

6.2.2.1. Anti-tobacco advertising in mass media are not sustained and conducted on regular basis.

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. According to the Global Adult Tobacco Survey [2009], an overall 80% of people noticed anti-cigarette advertisements, mostly on TV or in health-care facilities. 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. Non-smokers were more likely to notice anti-cigarette messages than smokers, an indicator that messages may not be adequately targeted to smokers.

14 MPOWER brochures. Warn about the dangers of tobacco. Available at: http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_w.pdf
6.2.2.2. **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, therefore materials are not supplied to regions in sufficient quantity and no national campaign is possible with 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. Other government agencies (e.g. PIA) and broadcast companies (ABS-CBN, GMA) have technical capacity, access to media and some financial resources to conduct mass media campaigns but there is little coordination or concerted effort to maximize these resources for tobacco control campaigns. Certain private sector media companies have also indicated that partnerships maybe possible.

6.2.2.3. **The messages of current campaigns content are generally not delivered in a strong powerful way, and thus ineffective.**
Information-Education-Communication (IEC) materials do not generally make use of graphic imagery about the harms of tobacco, a technique which have been shown to prompt smokers to make an attempt to quit smoking. International evidence suggests that graphic campaigns showing the physical and emotional harms of tobacco are most effective in increasing knowledge, changing attitudes and prompting behaviour 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.

6.2.2.4. **Although current media campaigns do not focus on integration of communication components, many opportunities exist in the country beyond mass media.**
It appears that the campaigns currently run by the DOH do not target sub-groups that could be influential to change in the behavioural norms, such as medical professionals, civil service staff, LGUs, professional societies, university consortia, and journalists, and so do not use this effective way to disseminate warning messages to large segments of the population. DOH, through its large network of hospitals and medical facilities can also disseminate IEC materials at little or no cost. Journalists and students of mass communication and journalism can also be conduits for dissemination of messages about the harms of smoking and second-hand smoke.

6.2.3. **KEY RECOMMENDATIONS**

6.2.3.1. **The DOH should go beyond World No Tobacco Day. Integrate media campaigns to the wider tobacco control programme as part of a long-term strategic plan.**
Mass media tools should be designed to enhance and improve the impact of other tobacco control interventions, e.g. the introduction of new legislation, availability of stop smoking services and cessation products, etc. Therefore, the DOH could disconnect its efforts on campaigns from being done only in accordance with national health events, develop a strategic communication plan involving consideration of the initiatives that need to be taken, and gain consensus on this plan from stakeholders (on the objectives, audiences and activities of the campaign). In this way the campaigns could be done more frequently and be run for many years so that the messages that continue over time are refreshed regularly and have an impact on the population.
6.2.3.2. 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 DOH should coordinate provision of funding, air time or media space with PIA, and broadcast companies. 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. Unpaid media or “earned” media bring complementary benefits to a campaign, by generating more target audience exposure to the message, placing the message in new and different media and environments (e.g. the evening news), appearing to come from new, independent and authoritative sources (e.g. an editorial article in a respected newspaper), responding quickly to any issues arising as a result of the campaign and ensuring opinion formers and stakeholders are aware of the campaign, even if they are not the primary target audiences.

6.2.3.3. The DOH should focus on using campaign content that works.

Hard-hitting campaigns can compel tobacco users to quit, increase knowledge of the health risks of tobacco use, and promote behaviour change in both smokers and non-smokers. The use of 2008 international campaign materials could be initiated as research study identified them as effective with Filipino audiences. The research provides at least 10 campaigns that could be adapted for local use at relatively low cost to the government. DOH can initiate 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.

6.2.3.4. 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. Examples of action in this regard could be:

- distribute graphic campaign materials through DOH and civil service facility networks;
- train journalists on the harms of tobacco and develop a public relations programme targeting media with information about the harms of tobacco and the benefits of tobacco control policies;
- influence LGU to support and participate in the Red Orchid awards.

The strategies identified in this report particularly in the cessation section, should be pursued, to engage the medical community and other influential groups.
7. Enforce bans on advertising, promotion and sponsorship

7.1. POLICY STATUS AND DEVELOPMENT

Comprehensive bans on direct and indirect advertising, promotion and sponsorship protect people – particularly youth – from industry marketing tactics and can substantially reduce tobacco consumption. Comprehensive bans significantly reduce the industry’s ability to market to young people who have not started using tobacco and to adult tobacco users who want to quit. Comprehensive bans can be achieved by following the international best practice standards outlined in the Guidelines for implementation of Article 13 of the WHO Framework Convention on Tobacco Control (WHO FCTC). A comprehensive ban on all advertising and promotion reduces tobacco consumption by about 7%, independent of other interventions. Some countries have seen consumption drop by as much as 16%.

WHO FCTC Article 13 requires Parties, in accordance with constitution or constitutional principles, to undertake, within five years after entry into force of the Convention for each respective party, a comprehensive ban of all tobacco advertising, promotion and sponsorship (TAPS), that includes a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory, as well as at the point-of-sale. For the Philippines, the time frame is 2010.

RA 9211 bans direct advertising of tobacco in all mass media, but not all other forms of direct and/or indirect advertising. Since 1 July 2008, a comprehensive ban on advertising in mass media, cinema, and outdoor advertising has been in place. However, RA 9211 allows advertising “inside the premises of point-of-sale establishments” and allows some forms of promotion and sponsorship (promotion to minors is restricted, but tobacco companies are left free to distribute products, samples, and merchandise to all others, as long as the merchandise does not contain a logo or name of the tobacco company that is visible when the product is worn, i.e., company logos and advertising can still be printed on merchandise that is not worn or on parts that are not outwardly visible). (R.A. 9211; SEATCA, 2008).

The regulating powers according to the Tobacco Regulation Act and its subsequent policy issuances belong mainly to the DOH, DTI, and IACT. Recently, FDA has been mandated with regulatory functions over tobacco but the operational guidelines are not yet developed. The LGUs, PNP and DOH CHDs are the enforcing agencies.
Table 7.1: Policies relevant to tobacco advertising, promotion and sponsorship in the Philippines

<table>
<thead>
<tr>
<th>National Law / Policy</th>
<th>Policy Details</th>
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| R.A. 9211            | • 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 merchandise with logo or name visible when worn. |
| Dept of Interior and Local Government Memorandum Circular No. 2007-126 | 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 they are within their premises. |
| Dept of Health Department Memorandum No. 2009-0142 | • Ban on Promotion, Advertisements and Sponsorship of Tobacco Products.  
• DOH Policy of not granting applications for advertisements, promotion and sponsorships. |
| RA 9211 Interagency Committee on Tobacco Memorandum Circular No. 1s. 2008 | • 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 No. 2010-01 | • 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 favour, entertainment or anything of monitoring 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. |
| DOH Dept Order 2011-0029 | • 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 Sub-committee formally established but no plan of action yet. |
| DILG Memorandum Circular 2007-126 | • 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. |

Source: 2009 Philippines’ Global Adult Tobacco Survey (GATS)

7.2. KEY FINDINGS

7.2.1. The enforcement of 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 a strong enforcement mechanism.

7.2.1.1. Violations of TAPS restrictions are many.
According to the GATS results released in 2010, 71.2% of all respondents (adults) stated that they “noticed any advertisements for cigarettes”, while 53.7% have noticed any signs of advertisements in stores. Based on the current legislation there is no other permission for placing advertisements other than at the 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.
7.2.1.2. **TAPS are not a priority for the existing national coordinating mechanism for tobacco control.**

IACT’s Secretariat has the mandate of collecting and compiling the reports on law compliance into one annual Compliance Monitoring Report to be submitted to the President of the Philippines, yet, anecdotally, there is no formal initiative to monitor TAPS ban enforcement.

7.2.1.3. **FDA carries the central responsibility for TAPS restrictions enforcement but lacks capacity.**

The FDA has nationwide functions and responsibilities for TAPS restrictions enforcement and monitoring of compliance, which are likely to be further clarified/strengthened by current reorganizational development. During this process of reorganization the FDA lacks the enforcing capacity.

7.2.1.4. **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 forces as well the local PNP police officers), the provisions are fragmented within many policy issuances, thus creating confusion and resulting to lack of action based on the assumption that other agencies are enforcing the TAPS ban. Although the Tobacco Act does not have 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 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 only few local jurisdictions that have introduced and started implementation of local ordinances. 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 reporting mechanism among the enforcing institutions and to the public.

7.2.1.5. **Data on law compliance are not regularly reported and collected.**

It is difficult to understand the real size of the law violation phenomenon nationwide due to very limited available data on compliance and enforcement. No data could be collected from central levels and very limited data from a scarce number of LGUs that have introduced local ordinances. It appears that, in practice, the majority of regional DOH CHDs can collect at least some data on compliance at request from the regulatory officers. However, without a clear responsibility mentioned in the local ordinances for this action, the requests may not result in a regular collection of information. The regulatory officers mostly focus on hospitals, pharmacies and food. There are no inspection protocols and guidelines to include TAPS (e.g. no concrete empowerment and protection for the inspectors, no TAPS in check-lists etc). 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.

7.2.1.6. **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 phone line. IACT produced a “complaint form” that can be used by citizens to report a law violation, yet this form is complicated, not known by the general population and by the public agencies, therefore not utilized. It is not clear what departments within the enforcing agencies should receive these complaints.
FCAP conducts some awareness building and advocacy at grass roots levels in the communities for reporting on law violations, but since the mechanism is not yet functional the results are minimal.

7.2.1.7. No specific training on TAPS enforcement exists.
Several tobacco control training programmes 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 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 yet the concrete enforcement of TAPS restrictions is not part of it). Other organizations have conducted training of the police officers (FIDS, etc.). Reports of evaluation of training have not been made available.

7.2.1.8. 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.

7.2.1.9. 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 stronger enforcement of RA 9211), but not mainstreamed into the national tobacco control coordination initiatives of the DOH. There are experiences from the NGO community in partnership with local governments and national agencies implementing smoke-free environments and capacity building for TAPS ban in developing tools and instruments that can help in supporting a coordinated and coherent monitoring and enforcement mechanism, e.g. UP College of Law Development Foundation, Inc. RA 9211 Handbook. Also, there are various projects supported through international grant mechanisms that aim, among others, advocacy efforts and capacity building in support of the TAPS ban monitoring and enforcement (e.g. FCAP rapid response grant 2007-2008 that aims to instigate enforcement and voluntary compliance of retail store owners by ensuring media coverage on removal of outdoor ads by mayors in pilot cities; SEATCA in collaboration with national NGOs conducted industry surveillance study in ASIAN countries).

7.2.2. The Tobacco Act and its subsequent regulations do not fully meet the obligations of the Philippines to implement the WHO FCTC Art 13, i.e. to undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship.

7.2.2.1. The Philippines has not met the five years deadline for undertaking a comprehensive TAPS ban.
The Art 13 of the Convention requires that each Party “shall [...] undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship that shall include [...] a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory”. A period of five years after the entry into force of the Convention is required for undertaking appropriate legislative, executive, administrative and/or other measures. In the case of the Philippines, September 2010 was the deadline for meeting the requirements of Art 13.
7.2.2.2. The restrictions on tobacco advertising although very comprehensive, still allow an exception: advertising at the points-of-sale (POS).

The Tobacco Act includes a ban on tobacco advertising starting 1 July 2008; however, an exception is still allowed at the point-of-sale (POS). Also, it is not clear whether cross-border advertising is banned or not. 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. The circumvention of RA 9211 was also possible due to the Memorandum Circular issued by the DILG (126 s. 2007) interpreting Rule III, Section 1.18 of the Implementing Rules of RA 9211, as defining “premises” as a “tract of land and the building or buildings thereon, including the open spaces between the buildings located on the same tract of land and within the perimeters of the said tract of land.” So, according to the DILG advisory of 2007 the tobacco ads may be made inside as well as “outside” the POS, as long as it is within the premises. Some small retail stores or in several cases the tobacco industry challenged the enforcement of TAPS on the argument that “inside premises” covers everything within the perimeter of the POS retail establishment. 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.

7.2.2.3. 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. 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.

7.3. KEY RECOMMENDATIONS

7.3.1. Strengthen the enforcement mechanism of the current TAPS’ restrictions, through coordinated action at local jurisdictions, under the DOH leadership and coordination

7.3.1.1. Action on law violations and monitoring of compliance could be shared between central and regional levels.

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 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 local LGU enforcing agents with reporting duties to the DOH, as well as to the public, that could be implemented in connection with the 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.

7.3.1.2. Allocation of dedicated funds and human resources to enhance enforcement of TAPS restrictions could also be shared between central and regional levels.

The funds and human resources for increasing the TAPS’ restrictions enforcement could be generated by the DOH, but also by the DOH CHD (through their NCD programmes), e.g. DOH central office could
allocate funds for introducing a mechanism of centralized collection of data on law violations and monitoring of compliance in collaboration with all regions, while the regional DOH CHDs could allocate funds for producing the guidelines and protocols for inspection, check-lists and reporting forms, empowering/motivating regulatory officers etc.

7.3.1.3. The FDA should pursue immediate issuance of the RA 9211 implementing rules and regulations and operational guidelines, which could clarify on concrete roles and tasks on both regulatory and monitoring work with appropriate capacity for these functions (well trained designated staff, with annual dedicated budget).

The capacity building process can be conducted in collaboration with national and international agencies relying on shared experience and models of practice from other countries.

7.3.1.4. 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 (by building internal capacity for this action or alternatively by commissioning other entities, NGOs, academia, etc. to conduct it).

7.3.1.5. Regular training should be included in the DOH regulatory officers with a focus on the TAPS ban enforcement, as well as to the police forces.

The training strategy should include regular evaluation of effectiveness and performance.

7.3.1.6. DOH should establish a complaint-line for citizens, toll free and 24/7.

The phone line could be the same one for other tobacco control policies (smoke-free, graphic health warnings, etc.), well equipped with technical and administrative staff.

7.3.1.7. FCAP and other NGOs should increase their efforts for awareness building and advocacy at grass roots levels, in the communities, for reporting on law violations.

Since the mechanism is not yet functional, the current results are minimal.

7.3.2. 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.

The DOH has been mandated by the IACT Memorandum Circular No. 01 on the Monitoring and Enforcement Guidelines of the Tobacco Regulatory Act of 2003 as a pilot agency responsible for the monitoring and enforcement of the TAPS ban, therefore the ban could be initiated by the DOH under a concrete plan of action with a concrete time frame. Collaboration for developing and implementing such a plan should be pursued with DTI, DILG, LGUs, FCAP and other NGOs etc. The TAPS ban should be as comprehensive as possible in order to avoid inevitable shifts of the TI’s expenditure to other advertising, promotion and sponsorship strategies, with creative, indirect ways to promote tobacco products and tobacco use, especially among young people. All forms of TAPS should be covered as recommended by the WHO Article 13 Guidelines, without exceptions (including Internet, social marketing, international cross border advertising, promotion, sponsorship, etc.). A ban on tobacco advertising, promotion and sponsorship is effective only if it has a broad scope. This is recognized in Article 13 of the Convention, which lays down the basic obligation to ban tobacco advertising, promotion and sponsorship. According to Article 13.1 of the Convention, “Parties recognize that a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products”.
7.3.2.1. Remove the advertising permissions at the POS.

Display of tobacco products at points-of-sale in itself constitutes advertising and promotion. Young people are particularly vulnerable to the promotional effects of product display so any promotional elements should be removed with no visibility of tobacco products at points of sale, including fixed retail outlets and street vendors. A ban of the POS advertisement can allow textual listing of products and their prices, without any promotional elements. The POS advertising may be removed from RA 9211 by an amendment, which may be pursued on medium term period while, in the meantime, or eventually, this gap on TAPS ban may be resolved by the LGUs through the inclusion of the ban on TAPS at POS in the "local ordinances", monitored and enforced by LGUs in collaboration with DOH-CHDs. For this action, the DOH should take the lead in commissioning relevant agencies for building of an evidence base to complete the advertising/marketing ban needs:

a. Analyse the revenue collected by tobacco vendors from point-of-sale advertisement: usually, cigarette retailers receive payment for displaying tobacco industry advertising, although the number of tobacco retailers who receive payment and the amount received are unknown. A study of the financial benefit to retailers should include the probable minimal benefit to them. Conveying this message could neutralize opposition from cigarette retailers or other tobacco industry groups.

b. Collect and analyse data on point-of-sale advertisements that circumvent the legislation: collect information on, for example, incidents in which banners are separated from the places where cigarettes are sold or in which warnings are less visible than the advertisement. Design a system for finding the party responsible for displaying advertisements that are not in compliance.

c. Explore partnerships to compile evidence of the impact of existing national and international advertising, marketing and promotional activities: partnerships can be established to conduct studies with academe, civil society and international groups. Partnerships reduce the burden on the government, while establishing Philippines-specific evidence.

d. Build a broad coalition for advocating broader advertising, marketing and promotion restrictions, under the coordination of the National Center for Health Promotion (DOH).

e. Involve not only DOH, SWAT and other central agencies but also LGUs and nongovernmental organizations: entities that are not yet involved in enforcing the advertising ban should be invited to participate. In particular, the involvement of nongovernmental organizations should be expanded, as the issue has broad implications for the protection of children, young people and consumers in general. It is important to reach the advertising industry and those who currently benefit from sponsorship.

f. Build public support and provide evidence of support [e.g. public opinion polls]: evidence of the aggressive tactics of the tobacco industry and their substantial impact can be publicized. Secretive or indirect promotional tactics can be exposed. In particular, targeting of young people can be used to raise parental and social support for a comprehensive ban.

g. Until the ban on POS advertising will be achieved, the LGUs could include in their local ordinances the duty to post clear, conspicuous health warnings and even graphic health warnings at POS as counter-advertising strategy.
8. Raise tobacco taxes and prices

8.1. POLICY STATUS AND DEVELOPMENT

8.1.1. Current Tobacco Tax Structure
As stipulated in Republic Act 9334 or the Sin Tax Law of 2004, a four-tier excise tax system is currently implemented for cigarettes. The amount of excise tax per pack of cigarettes depends on the net retail price (NRP) of the product. The multi-level tax structure, provides different specific tax rates for each price classification (P2.72, 7.56, 12.00, 28.30). 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 gap between higher and lower price classes of cigarettes. In addition, a 12% value added tax is applied to the retail price inclusive of excise taxes. Finally, import duties are applied to imported cigarettes, which account for less than one percent of the Philippines cigarette market. The President has announced that there will be “no new taxes” until after 18 months into his administration (until December 2011). Several bills have been introduced that will raise tobacco taxes once this moratorium ends.

Table 8.1 Current Cigarette Taxes, Philippines

<table>
<thead>
<tr>
<th>Price Classification</th>
<th>Tax Rate</th>
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</thead>
<tbody>
<tr>
<td>i) Cigarettes packed by hand (each pack with 30 pieces)</td>
<td>PhP 2.72</td>
</tr>
<tr>
<td>ii) Cigarettes packed by machine (each pack with 20 pieces)</td>
<td>PhP 2.72</td>
</tr>
<tr>
<td>NRP below PhP 5 per pack (low-priced)</td>
<td>PhP 2.72</td>
</tr>
<tr>
<td>NRP of PhP 5 to PhP 6.50 per pack (medium-priced)</td>
<td>PhP 7.56</td>
</tr>
<tr>
<td>NRP above PhP 6.50 to PhP 10 per pack (high-priced)</td>
<td>PhP 12.00</td>
</tr>
<tr>
<td>NRP of above PhP 10 per pack (premium-priced)</td>
<td>PhP 28.30</td>
</tr>
</tbody>
</table>

The price classification freeze maintains the price classification of “old” cigarette brands (those brands classified on or before January 1, 1997, listed in Annex “D” of Republic Act 8240 and amended by Republic Act 9334). These brands make up 90% of the market and include the most popular cigarette brands in the country. 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. This benefits companies that have operated in the Philippines market for many years, including Philip Morris International and Fortune Tobacco, and disadvantages new entrants, such as British American Tobacco.

8.1.2. Earmarking of Tobacco Tax Revenues for Health Purposes
For a period of five years, through 2010, 2.5 percent of the incremental revenues from the excise tax on alcohol and tobacco products was remitted directly to Philhealth (for the purpose of meeting and sustaining the goal of universal coverage of the National Health Insurance Program) while another 2.5 percent of the incremental revenue from the excise tax on alcohol and tobacco products was credited to the account of the DOH and constituted as a trust fund for its disease prevention programme. Some currently pending tobacco tax bills include health-related earmarking provisions.
The President strongly supports universal health care coverage and promotion of the healthcare for the poor. There have been recent Cabinet level discussions on linking increases in tobacco taxes to financing health reform.

8.1.3. Earmarking of Tobacco Tax Revenues for Other Purposes
In total, it is estimated that tobacco-producing provinces receive PHP1.6 billion annually from excise taxes on tobacco products. Republic Act (RA) 7171 sets aside 15 percent of the total excise taxes collected on locally manufactured Virginia-type cigarettes to Virginia-producing provinces. The allocated amount is estimated by National Tobacco Administration (NTA) and released by the Department of Budget and Management (DBM), which is mandated by law to remit said funds to the beneficiary provinces. Virginia tobacco constitutes 58 percent of the total tobacco area.

Provinces producing burley and native tobacco are also given their share of the revenue from excise tax. RA 8240 allocates 15 percent of the incremental revenue collected from excise tax of tobacco products to the LGUs of these provinces. RA9211 provided for programmes to encourage alternative livelihood, specifically, financial support for tobacco growers and tobacco workers (displaced workers) who wish to shift to another livelihood.

8.1.4. Tax Administration
Section 6 of Bureau of Internal Revenue Regulations No. 1-97 stipulates that there shall be conspicuously printed or affixed an internal revenue stamp whether of a bar code design on each pack and on both sides of boxes of cigars and cartons/reams of cigarettes or fusion stamp which must be heat fused on each pack of cigar and cigarette in a manner prescribed by the Commissioner of Internal Revenue. Tax stamps appear only on imported cigarettes but not on locally produced ones. The Bureau of Internal Revenue is in the process of reviewing options for a secure tax marking system and three companies have submitted proposals (SICPA, PM, and a Chinese company). Subject to the constraints under the National Internal Revenue Code, the Commissioner of BIR shall recommend a uniform, practical and economical manner of evidencing payment by means of the bar code or fusion method.

8.2. KEY FINDINGS

8.2.1. Cigarettes are highly affordable in the Philippines, in large part the result of 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. The low tax rates on cigarettes, particularly on low priced brands and older brands for which the tax is set under the price classification freeze, are a key factor in explaining the low prices. Total taxes account for less than half of retail prices on most brands, with cigarette excise taxes on older popular brands accounting for as little as 20% of retail price, well below the 70% target set by WHO. As a result of the tier tax structure and the price classification freeze, there are considerable price gaps between high and low priced brands, creating opportunities to switch down to cheaper brands as taxes and prices are increased. This is seen in the growing market share of economy brands in recent years. The availability of these low priced brands keep cigarettes affordable for those on low incomes and, together with the widespread availability of cigarettes sold individually, makes cheap cigarettes readily available to children.
Eight bills addressing tobacco product taxation have been filed in the current Congress. Several of these bills would address the problem of highly affordable cigarettes in the Philippines by significantly increasing taxes and greatly simplifying the existing, complex tax structure. As part of the legislative process, these bills will be consolidated into a single bill. Within the legislature, there exists a potentially powerful but quiet advocacy group that supports significant tobacco tax increases, creating optimism that taxes will be increased significantly and the existing tax structure simplified. All tobacco companies oppose bills that significantly raise existing tobacco product excise taxes. In contrast, some companies – most notably the British American Tobacco Company – support efforts to simplify tax structure by reducing the number of tax tiers and eliminating the price classification freeze.

8.2.2. Discussions are still in progress about earmarking tobacco tax revenues for health purposes.

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 were earmarked for PhilHealth and 2.5% was earmarked for disease prevention. However, earmarked funds have not been released to these programmes, and the earmarking provisions expired at the end of 2010. Some of the existing bills include provisions to earmark tobacco tax revenues for health promotion. Discussions are still in progress about expanding earmarking of tobacco tax revenues for attainment of Millennium Development Goals and establishment of effective health promotion mechanisms and structures. Of particular interest is earmarking tobacco tax revenues for health sector reform and a universal health care programme.

8.2.3. Opponents of tobacco tax increases overstate the impact of tax increases on employment.

Concerns about the impact of tobacco tax increases on employment are a barrier to tobacco tax increases. Opponents of tobacco tax increases argue that there will be significant job losses and economic hardship if tax increases that significantly reduce tobacco use are adopted. However, their arguments overstate the employment impact of tax increases. While there will be some job losses in sectors dependent on tobacco (tobacco farming and tobacco product manufacturing) as a result of declining tobacco use, experiences in other countries like the Philippines show that there will be offset by job gains in other sectors. As a result, there will almost certainly be either no net impact or small job gains overall. Those deterred from smoking by higher taxes and prices will use the money they once spent on tobacco to buy other goods and services, creating jobs in other sectors. Similarly, government will spend the new tax revenues generated by the tax increase, creating additional jobs.

Additionally, some of the revenues generated by tobacco taxes can be used to support efforts to move those in tobacco-dependent jobs into alternative livelihoods, further minimizing the employment impact of higher taxes. In the Philippines, tobacco tax revenues are currently earmarked for tobacco growing regions but not for helping farmers or others employed in tobacco manufacturing and distribution make the transition to alternative livelihoods. Fifteen percent of total tax revenues generated from Virginia tobacco have long been returned to provinces that grow Virginia tobacco. Fifteen percent of the new revenues resulting from tobacco tax increases implemented in 2004 are returned to provinces that grow native and burley tobacco. 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 programmes that support tobacco farmers’ efforts to move out of tobacco farming and into alternative livelihoods. A short-lived programme (2003-2008) to assist tobacco farmers interested in alternative livelihoods was funded by general revenues, but had little discernible impact in reducing the number of tobacco farmers.
8.2.4. 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. This tax evasion includes underreported domestic production, with smuggling accounting for a small share and limited to a few locations. According to the Bureau of Customs, smuggling hotspots include duty free zones and foreign trans-shipment points. Particularly problematic are cigarettes that are marked as intended for export or sale in duty free shops that are re-imported and sold without paying any taxes. 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 programmes 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 elsewhere have been demonstrated to be effective in addressing illicit trade in tobacco products do not exist in the Philippines.

Weak tax administration is a major contributor to tobacco tax evasion. 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 lack of a tax stamp and other pack markings facilitates tax evasion and enforcement efforts are weak or nonexistent. The lack of licensing for those involved in tobacco distribution and the presence of many small tobacco product vendors facilitates the distribution of cigarettes that have evaded taxes, with nearly 60% of cigarettes sold in sari-sari [retail] stores or by street vendors. 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.

8.2.5. Efforts to support tobacco tax policy and health promotion have been initiated through the academe and NGOs.
Research initiated by the academe and civil society, in coordination with DOH, on increasing tobacco taxes to meet health objectives is being disseminated and has formed the basis for some of the bills pending in Congress. The DOH requires further technical capacity to advocate with legislators and policymakers in other departments (Finance, Customs, Internal Revenue). Key policy makers, particularly in the Ways & Means Committee, do not fully appreciate the health consequences of the existing, complex tax structure and the health benefits of simplifying this structure and raising tobacco taxes.

On the other hand, DOH, in coordination with CSOs, is engaged in ongoing research and discussions relating to appropriate health promotion mechanisms. Policy-makers in the Appropriations Committee need to be fully informed about the cost-effectiveness of health promotion financing.

8.3. KEY RECOMMENDATIONS

8.3.1. 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. A uniform specific tax eliminates opportunities for tax avoidance through misclassification of brands and sends the clear message that all cigarettes are equally harmful. Existing proposals that do this through a short-term transition from four to two tiers on the way to a single uniform tax should be supported. Related to this, taxes on other tobacco products should be set so as to make
these taxes equivalent to those on cigarettes. Equating taxes on all tobacco products reduces incentives to substitute from higher taxed products to lower taxed products, maximizing the health and revenue impact of these taxes.

Significantly increase cigarette and other tobacco product taxes in the Philippines, particularly those on the lowest priced products. By raising prices, 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. At the same time, higher tobacco taxes will result in increased government revenues.

Specific taxes should be annually increased so that they keep pace with inflation. In addition to indexing, over time taxes should be regularly increased with the goal of tobacco excise taxes accounting for at least 70% of average retail prices. Once that goal is achieved, subsequent increases that are sufficient to further reduce the affordability of tobacco products should be adopted.

8.3.2. Earmark tobacco tax revenues for health purposes, including health promotion and tobacco control.

Earmarking of tobacco tax revenues specifically for health purposes and generally for the attainment of the Millennium Development Goals and universal health care increases public support for tax increases and adds to the impact of these tax increases on health and development. Particularly important is the earmarking of tax revenues for the prevention and control of diseases and for efforts to promote healthier behaviours. 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 programmes that include, but are not limited to, support community level interventions, engage in public education campaigns about the harms from tobacco use, provide support to smokers trying to quit smoking and to prevent young people from taking up tobacco use, and that monitor tobacco use and evaluate the impact of tobacco control interventions lead to reductions in tobacco use and its consequences that are greater than those that result from the tax increase alone. A clear process for transferring earmarked tobacco tax revenues from the excise revenue department to these programmes needs to be established so as to ensure that the funds are used for the intended purposes.

8.3.3. Earmark tobacco tax revenues for programmes that help those employed in tobacco-dependent sectors make the transition to alternative livelihoods.

Acreage devoted to tobacco growing in the Philippines has been declining over time and local tobacco companies are increasingly using imported tobacco leaf, particularly from China, in the manufacture of tobacco products. Similarly, tobacco product manufacturing has become more capital intensive. Nevertheless, concerns about the impact on tobacco farmers and those employed in tobacco manufacturing and distribution of the reductions in tobacco use that result from higher tobacco product taxes are a significant barrier to tax increases. As demonstrated by experiences in other countries, earmarking a portion of tobacco tax revenues for programmes that help tobacco farmers and others employed in tobacco-dependent sectors make the transition to alternative livelihoods minimizes the impact of higher tobacco taxes on the agricultural sector. A clear process for transferring earmarked tobacco tax revenues to these programmes needs to be established so as to ensure that the funds are used for the intended purposes and to assess the impact of these programmes in helping those employed in tobacco-dependent sectors transition to alternative livelihoods.
8.3.4. **Strengthen tobacco tax administration, increase enforcement, and tax duty free sales of tobacco products in order to reduce tax evasion and avoidance.**

Several steps should be undertaken to strengthen tobacco tax administration in the Philippines. Firstly, a well-established monitoring system should be put in place 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. Tax authorities should adopt a production monitoring system that enables them to accurately assess production levels independent of claims filed by tobacco manufacturers. The government’s initial investment in these technologies would almost certainly more than pay for itself through the revenues collected on products for which taxes would otherwise not have been paid.

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. When done in combination with the adoption of the technologies discussed above, licensing would be highly useful in enforcement efforts and allow customs to more easily identify illicit product and to identify those higher up in the distribution chain that are responsible. Severe administrative penalties should be imposed on those caught engaging in tax evasion so as to significantly increase the swiftness and severity of these penalties, making them a greater deterrent. The government’s investment in enhanced enforcement efforts would almost certainly more than pay for themselves through the increased taxes collected from previously untaxed products.

All taxes should be applied to tobacco products sold in duty free outlets. Doing so increases the public health impact of higher tobacco taxes by raising all tobacco product prices and by reducing opportunities for tax avoidance and evasion, while at the same time generating additional revenues.

8.3.5. **Efforts to support the tobacco tax reforms and health promotion financing mechanisms need to be sustained and expanded by building further capacity and generating further evidence with the support of stakeholders such as the academe, CSOs, and other pertinent government agencies.**

The Department of Health should build on existing efforts to strengthen capacity and evidence for influential policy makers who make decisions regarding tobacco taxes. These efforts should focus on pointing out the health consequences of the existing low taxes and complex tax structure and on demonstrating the health benefits of a simplified tax structure and higher tobacco taxes.

The Department of Health, in coordination with CSOs and academic institutions, should also initiate the development of a constituency for a health promotion advocacy as an initial step towards an effective mechanism for health promotion.
Annex 1. List of institutions and key-informants

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution / Organization</th>
<th>City</th>
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<tbody>
<tr>
<td>Exec. Sec. Edwin Lacierda</td>
<td>Office of the President</td>
<td>Manila</td>
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<tr>
<td>Dir. Vero Librojo</td>
<td>Department of Agriculture (DA)</td>
<td>Quezon</td>
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<tr>
<td>ASEC Geronimo Sy</td>
<td>Department of Justice (DOJ)</td>
<td>Manila</td>
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<tr>
<td>Atty Jack Sarita</td>
<td>Civil Service Commission (CSC)</td>
<td>Quezon</td>
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<tr>
<td>Ms Choc Ricafort</td>
<td>Civil Service Commission (CSC)</td>
<td>Quezon</td>
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<tr>
<td>Dr Lourdes Salud</td>
<td>Makati City Health</td>
<td>Makati</td>
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<tr>
<td>Atty Julito D. Vitriolo</td>
<td>Commission on Higher Education (CHED)</td>
<td>Quezon</td>
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<tr>
<td>Mr Armand Suratos</td>
<td>Development Academy of the Philippines (DAP)</td>
<td>Pasig</td>
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<tr>
<td>Dr Ma. Teresita S. Cucueco</td>
<td>Occupational Safety and Health Center (OSHC)</td>
<td>Quezon</td>
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<tr>
<td>Atty Ma Paz Luna</td>
<td>Health Justice (HJ)</td>
<td>Pasig</td>
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<tr>
<td>Atty Bernadette Esguerra</td>
<td>Office of the Solicitor-General (OSG)</td>
<td>Makati</td>
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<tr>
<td>Dr Oscar Tinio</td>
<td>Philippine Medical Association (PMA)</td>
<td>Quezon</td>
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<tr>
<td>Dr Leo Mendoza</td>
<td>Philippine National Police (PNP)</td>
<td>Quezon</td>
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<tr>
<td>Atty Deborah Sy</td>
<td>Health Justice</td>
<td>Pasig</td>
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<tr>
<td>Gen. Luizo Ticman</td>
<td>PNP-Project Management Office</td>
<td>Quezon</td>
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<tr>
<td>Annabelle G. Verdote</td>
<td>FEU Center for Studies on the Urban Environment</td>
<td>Manila</td>
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<tr>
<td>ASec. Rolando Acosta</td>
<td>Department of Interior and Local Government (DILG)</td>
<td>Quezon</td>
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<tr>
<td>Atty Jemina Sy-Flores</td>
<td>Bureau of Customs</td>
<td>Manila</td>
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<tr>
<td>Gen Eduardo S.L. Oban, Jr.</td>
<td>Armed Forces of the Philippines (AFP)</td>
<td>Quezon City</td>
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<tr>
<td>Ms Elsa Agustin</td>
<td>Department of Finance (DOF)</td>
<td>Manila</td>
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<tr>
<td>Atty Rowena Daroy Morales</td>
<td>UP-College of Law Development Foundation (UPCLDF)</td>
<td>Quezon</td>
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<tr>
<td>Dir. Priscilla Vilia</td>
<td>Department of Social Welfare and Development (DSWD)</td>
<td>Quezon</td>
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<tr>
<td>Atty Juan C. Sta. Ana</td>
<td>Philippine Ports Authority (PPA)</td>
<td>Manila</td>
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<td>ASec Danilo Augusto Francis</td>
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<tr>
<td>Dr Francis Domingo</td>
<td>Novartis Healthcare Philippines,Inc.</td>
<td>Makati</td>
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<td>Mr Philip Bravo</td>
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<tr>
<td>Mr Wilfredo Malonzo</td>
<td>Novartis Healthcare Philippines,Inc.</td>
<td>Makati</td>
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<tr>
<td>Health Secretary Dr Kadir Sinolinding</td>
<td>Autonomous Region of Muslim Mindanao</td>
<td>Cotabato</td>
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<tr>
<td>Bro Narciso S. Erquaiza</td>
<td>De La Salle University-Manila</td>
<td>Manila</td>
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<tr>
<td>Dr Marilyn Ong-Mateo</td>
<td>Philippine College of Chest Physicians (PCCP)</td>
<td>Quezon</td>
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<tr>
<td>Ms Ma. Regina Reyes</td>
<td>ABS-CBN</td>
<td>Quezon</td>
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<td>Pastor Romeo Mangilima</td>
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Debriefing meeting of the assessment team members with national stakeholders – 12 May 2011

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<td>Tes Cucueco</td>
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### Debriefing meeting of the assessment team members with national stakeholders – 12 May 2011

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Annex 2. Chart status of cases filed by the tobacco industry assailing DOH A.O. 2010-0013

Date: March 17, 2011

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| 1. Fortune Tobacco v. DOH | The Marikina Regional Trial Court denied the DOH’s Omnibus Motion to dismiss Fortune’s petition for declaratory relief and dissolve the writ of injunction. The DOH thus filed a Petition for Certiorari in the Supreme Court. On March 12, 2011 the Supreme Court ordered Fortune to file its Comment to the DOH’s Petition for Certiorari.  
The DOH’s application for the issuance of a Temporary Restraining Order against the Marikina Regional Trial Court was held in abeyance pending the resolution of the main Petition. |
| 2. Mighty v. DOH    | The Bulacan Regional Trial Court granted Mighty’s application for preliminary injunction against the DOH without any hearing. Thus, the DOH filed a Petition for Certiorari in the Supreme Court, asking the Court to nullify the injunction and to restrain the Bulacan court from proceeding with the case.  
Five former Health Secretaries filed a Motion to Intervene and Petition-in- Intervention in the Supreme Court case, to which Mighty filed its Opposition.  
The Supreme Court granted the Motion to Intervene and took note of the Petition-in-Intervention. Parties have been requested to comment on the Petition-in-Intervention. |
| 3. JT v. DOH        | JT filed a Motion for Summary Judgment in the Pasig Regional Trial Court but recently withdrew the same Motion.  
Pre-Trial is set on June 6, 2011. |
| 4. PFMTC v. DOH     | The Tanauan Regional Trial Court initially dismissed the PMFTC’s petition for prohibition, but subsequently reversed itself and ordered the DOH to file its Answer or Comment. The DOH filed a Motion for Reconsideration of the Order reversing the dismissal. This Motion is still pending resolution.  
The DOH filed its Comment Ad Cautelam to the PMFTC’s Petition, to which the PFMTC filed its Reply Ad Cautelam. |
| 5. La Suerte v. DOH  | The Paraaque Regional Trial Court held that A0 2010-0013 is invalid. The DOH elevated the case to the Court of Appeals. |
Annex 3. List of assessment team members

**ASSESSMENT TEAM MEMBERS:**

1. Atty Elizabeth Aguiling-Pangalangan, University of the Philippines College of Law
2. Mr Jorge Alday, World Lung Foundation, New York, USA
3. Prof. Bill Bellew, The Union, Sydney, Australia
4. Dr Ma Encarnita Blanco-Limpin, Executive Director, FCTC Alliance, Manila, Philippines
5. Dr Frank Chaloupka, WHO Consultant, Chicago, USA
6. Dr Vera da Costa e Silva, WHO Consultant, Rio de Janeiro, Brazil
7. Dr Annette David, WHO Consultant, Guam, USA
8. Prof. Marilyn Ellorin-Crisostomo, Manila, Philippines
9. Prof. Ma Lourdes Genato-Rebullida, University of the Philippines College of Social Sciences and Philosophy, Manila, Philippines
10. Dr Alberto Romualdez Jr., Former Secretary, Dept of Health, Manila, Philippines
11. Dr Paulyn Jean Rosell-Ubial, Assistant Secretary, Dept of Health, Manila, Philippines
12. Dr Luminita Sanda, Tobacco Free Initiative, WHO, Geneva, Switzerland
13. Dr Armando Peruga, Tobacco Free Initiative, WHO, Geneva, Switzerland
14. Dr Florante Trinidad, Tobacco Free Initiative, WHO, Manila, Philippines

**DOH OBSERVERS WHO ALSO CONTRIBUTED TO THE ASSESSMENT:**

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Ms Ellen Gisala, Media Production Specialist, NCHP, Manila, Philippines
Ms Luz Tagunicar, Supervising Health Program Officer, NCHP, Manila, Philippines
Ms Edna Nito, Health Education Promotion Officer IV, NCHP, Manila, Philippines
Dr Ma. Luningning Villa, Project Team Leader, Bloomberg Project OC-401, Manila, Philippines

Support from Health Justice was also provided.

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16 in alphabetical order
Annex 4. List of all recommendations, chapter by chapter

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 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. 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. Enforcing the Memorandum Circular 2010-01 as well as pursuing the activities of the SWAT Committee on 5.3 should be considered as a priority for the governmental structures in their efforts to protect public health from the tobacco industry interference.
6. The DOH should collaborate and strongly support the LGUs efforts in tobacco control as essential players in advancing the WHO FCTC compliance in the Philippines.

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.
5. Provide additional human resources to NEC for consolidating a national tobacco surveillance system.

PROTECT PEOPLE FROM TOBACCO SMOKE - SMOKE-FREE ENVIRONMENTS

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 programmes, (ii) dedicated staffing; (iii) training & 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, regardless whether 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 meets its obligations under the WHO FCTC Article 8.

5. Strengthen implementation of smoke-free policy through the support of health services and medical associations and by improving access to smoking cessation services.

**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 those LGUs where the demand for cessation already exists, and where smoke-free policy support is strong.
   a. 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.
   b. 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.
   c. 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.
   d. Counselling formats other than face-to-face programme should be considered, especially as demand for cessation services increases.
   e. 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. Cessation training should be incorporated into the mandatory curricula and ongoing capacity building initiatives of health professionals.

4. 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 counselling such as through a national quitline and, to the extent possible, pharmacotherapy for those who are heavily addicted to tobacco.

5. DOH should promote cessation with systematic advocacy campaigns.

**WARN PEOPLE ABOUT THE DANGERS OF TOBACCO**

1. **Packaging and labelling**
   1. The DOH in collaboration with the other relevant government agencies should assert authority prominently in defence of the health of the Filipino people.
   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 DOH should invest in the FDA for upgrading its capacity to fulfil its responsibilities and coordinate related work with the Department of Interior and Local Government (DILG).
   4. The LGUs should use their legal competences to ensure placement of counter-advertising/health warnings at the point-of-sale.
2. Public awareness and mass-media campaigns
1. The DOH should go beyond World No Tobacco Day, integrate media campaigns to the wider tobacco control programme, as part of a long-term strategic plan.
2. The DOH should pursue the expansion of the financial resources to produce and air mass media campaigns.
3. The DOH should focus on using campaign content that works.
4. The DOH should pursue alternative channels for disseminating warning information.

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.

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 programmes 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. Efforts to support the tobacco tax reforms and health promotion financing mechanisms need to be sustained and expanded by building further capacity and generating further evidence with the support of stakeholders such as the academe, CSOs, and other pertinent government agencies.

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