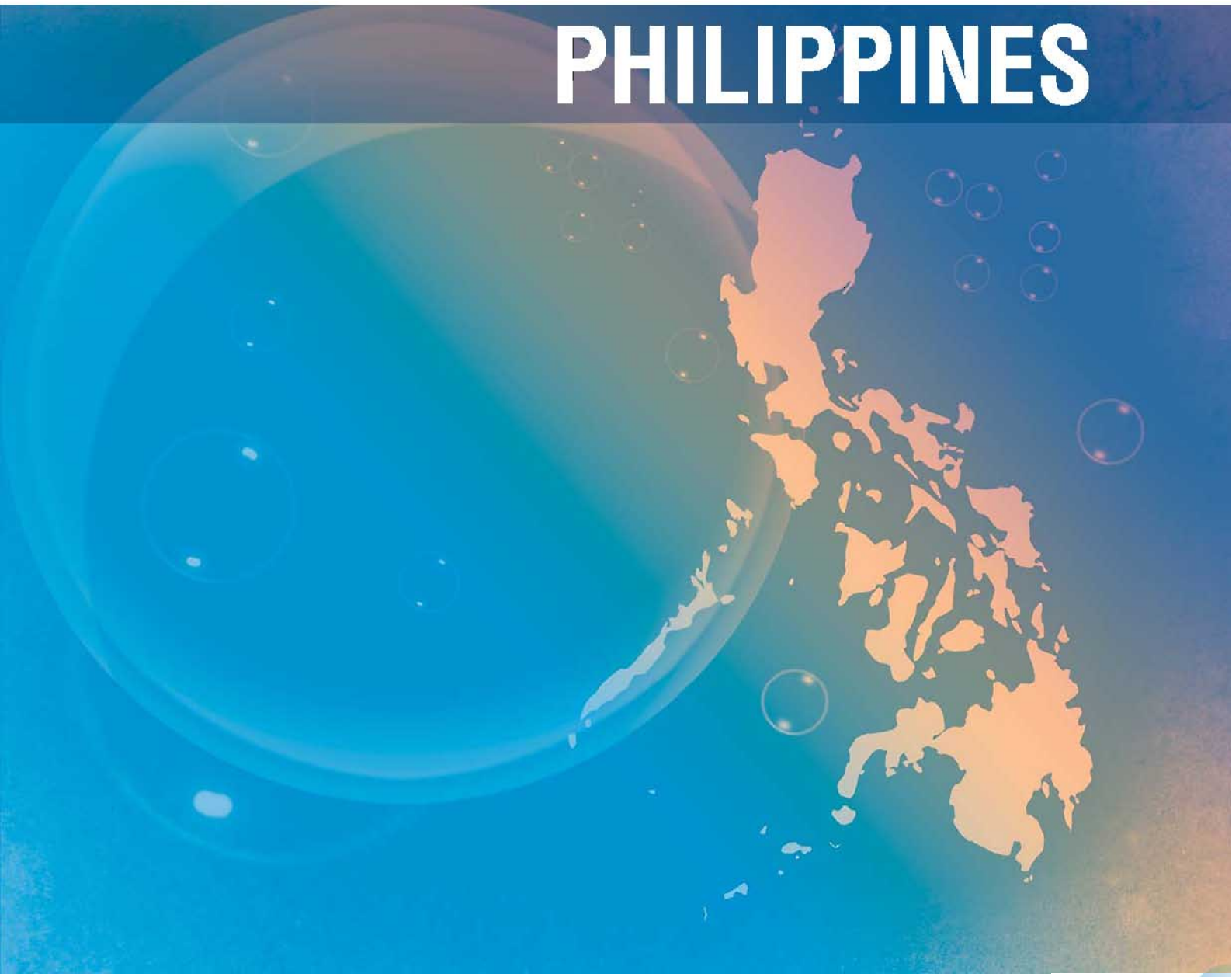
World Health Organization

JOINT NATIONAL CAPACITY ASSESSMENT ON THE IMPLEMENTATION OF EFFECTIVE TOBACCO CONTROL POLICIES IN THE PHILIPPINES



WHO Library Cataloguing-in-Publication Data
Joint national capacity assessment on the implementation of effective tobacco control policies in the Philippines.

1.Smoking - prevention and control. 2.Smoking - epidemiology. 3.Health policy. 4.Health promotion. 5.Tobacco - legislation. 6.Tobacco industry - legislation. 7.Philippines. I.World Health Organization

ISBN 978 92 4 150277 1 (NLM classification: WM 290)

Design and layout by Bernard Sauser-Hall

Printed by the WHO Document Production Services, Geneva, Switzerland

Joint national capacity assessment on the implementation of effective tobacco control policies in the **Philippines**

World Health Organization

Table of contents

Abbreviations

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

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 stake-holders 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

harms of tobacco. International evidence suggests that graphic campaigns showing the physical and emotional harms of tobacco are most effective in increasing knowledge, changing attitudes and prompting 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