World Health Organization
Western Pacific Region

Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)

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ABBREVIATIONS

ASEAN	Association of Southeast Asian Nations
COP	Conference of Parties
CSR	corporate social responsibility
ENDS	electronic nicotine delivery systems (e-cigarettes)
FCTC	Framework Convention on Tobacco Control
GATS	Global Adult Tobacco Survey
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
MPOWER	A set of measures that correspond to one or more of the demand reduction provisions in the WHO FCTC. *The acronym MPOWER stands for:* • **M**onitor tobacco use and prevention policies; • **P**rotect people from tobacco smoke; • **O**ffer help to quit tobacco use; • **W**arn about the dangers of tobacco; • **E**nforce bans on tobacco advertising, promotion and sponsorship; • **R**aise taxes on tobacco.
NCD	noncommunicable disease
NRT	nicotine replacement therapy
PEN	Package of Essential Noncommunicable Disease Interventions for Primary Health Care
SHS	second-hand smoke
STEPS	WHO Stepwise Approach to Surveillance
TAPS	tobacco advertising, promotion and sponsorship
TFI	Tobacco Free Initiative
TQS	Tobacco Questions for Surveys
UN	United Nations
UNDAF	United Nations Development Assistance Framework
WHO	World Health Organization
WTO	World Trade Organization

FOREWORD

Tobacco is the world's deadliest preventable killer. Tobacco kills 6 million people every year. Second-hand smoke causes 600 000 deaths, including 130 000 children.

The Western Pacific Region is home to 26% of the world's population but 36% of the world's tobacco users. Two people die per minute in the Region from tobacco-related diseases. Globally, tobacco stands to kill 1 billion lives in the 21st century–unless we act to curb the epidemic.

The WHO Framework Convention on Tobacco Control (WHO FCTC), which came into force in 2005 as the first global health treaty of its kind, provides a complete package of measures to reduce tobacco consumption and save lives. All Western Pacific Member States are parties to the WHO FCTC.

To guide Member States in accelerating implementation of the WHO FCTC with support from WHO, the Regional Committee for the Western Pacific endorsed the Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019) at its sixty-fifth session in October 2014. Building on our experiences, the new regional action plan is structured around three pillars: strengthening sustainable institutional capacity; developing comprehensive legislation and regulation; and facilitating consistent enforcement through a whole-of-society approach. For each of these strategic outcomes, the regional action plan identifies clear objectives and critical steps to be taken by countries and WHO.

While we should be encouraged and empowered by the progress in tobacco control under the WHO FCTC, we must pick up the pace. We must synergize our efforts and remain ready to respond to emerging threats from the tobacco industry.

The 1.8 billion people of the Western Pacific Region are counting on us.

Shin Young-soo, MD, Ph.D.
Regional Director

EXECUTIVE SUMMARY

Tobacco use continues to be the single greatest preventable cause of death in the world. It is the cause of 22% of all cancers and 70% of lung cancers. In the Western Pacific Region, two people die every minute from tobacco-related diseases.

There are proven, cost-effective ways to combat this deadly epidemic. Actions to reduce tobacco use are described in the WHO Framework Convention on Tobacco Control (WHO FCTC). All Western Pacific Member States are parties to the WHO FCTC.

The WHO in the Western Pacific Region, in consultation with all Member States, has been developing five-year regional action plans for the past two decades to guide the development of national action plans and optimize collaborative activities at the regional level for accelerated implementation of the WHO FCTC.

In the previous *Regional Action Plan 2010–2014 for the Tobacco Free Initiative (2010)* in the Western Pacific Region, a set of strategic actions were agreed for countries and for WHO to reach targets including an overall 10% reduction in smoking prevalence for adults and adolescents, for both males and females.

Significant progress has taken place including development of laws and policies and enforcement mechanisms.

In this new action plan, countries and areas in the Western Pacific Region and WHO are encouraged to work towards accelerated WHO FCTC implementation to achieve strategic outcomes:

- establishment of sustainable institutional capacity for tobacco control;
- effective legislation and regulations; and
- engagement of constituencies for enforcement of tobacco control.

For each of these strategic outcomes, the action plan identifies objectives and suggests actions and indicators for countries and areas, and for WHO to achieve these objectives.

Consistent with the *Global Action Plan for the Prevention and Control of NCDs 2013–2020,* the target for the Region for the next five years is a 10% relative reduction in prevalence of tobacco use for smoked and smokeless tobacco by men, women, girls and boys.

STRATEGIC OUTCOME	Summary of suggested actions
1. SUSTAINABLE INSTITUTIONAL CAPACITY FOR TOBACCO CONTROL	**1.1** Ensure policy coherence in national action plans for tobacco control through all-of-government approaches and multisectoral stakeholder engagement. **1.2** Expand tobacco-control leadership development, capacity-building and training. **1.3** Increase investments and ensure sustainable funding for tobacco control and accelerated WHO FCTC implementation. **1.4** Establish sustainable government-funded tobacco surveillance systems. **1.5** Raise public awareness on the harms of tobacco use, especially among vulnerable and at-risk groups, and systematically disseminate the provisions of Article 5.3. **1.6** Create sustainable cessation services and systems. **1.7** Integrate tobacco control in national NCD action plans and apply approaches learned in tobacco control to overall strategies for risk reduction for NCDs.
2. LEGISLATION AND REGULATIONS	**2.1** Raise tobacco taxes and use a percentage of revenues for tobacco control and NCD prevention. **2.2** Develop legal instruments and policies to protect from exposure to second-hand smoke. **2.3** Develop legal instruments and policies to implement effective packaging and labelling measures. **2.4** Develop legal instruments and policies to ban advertising, promotion and sponsorship of tobacco products. **2.5** Ratify the Protocol to Eliminate Illicit Trade in Tobacco Products. **2.6** Regulate the contents and emissions of tobacco products. **2.7** Regulate electronic nicotine delivery systems (ENDS). **2.8** Develop legal instruments and policies to implement effective minimum age restrictions for selling and purchasing of tobacco products. **2.9** Protect tobacco-control policies and legislation from tobacco industry interference: WHO FCTC Article 5.3 implementation.

STRATEGIC OUTCOME	Summary of suggested actions
3. CONSTITUENCIES FOR ENFORCEMENT	3.1 Work with mayors, other local government authorities and community leaders. 3.2 Expand smoke-free World Heritage Sites and support efforts towards smoke-free tourism. 3.3 Accelerate actions for Tobacco Free Pacific 2025 with a strategic focus on 100% smoke-free places. 3.4 Support the global movement for smoke-free workplaces. 3.5 Empower organizations of women and youth. 3.6 Reach out to vulnerable and marginalized groups. 3.7 Work with organizers of sports, arts and cultural mega events. 3.8 Work with the entertainment industry to ban scenes with the use of tobacco products and ban tobacco product placement in television shows and movies. 3.9 Create mechanisms for partnership with public health lawyers and policy and regulatory experts' networks. 3.10 Sustain and expand partnerships with tobacco-control advocates and civil society. 3.11 Work with health professionals and academics in tobacco control.

1. Introduction

1.1 Why we need "cohesive and sustainable systems" for tobacco control

Tobacco use kills approximately 6 million people each year worldwide. More than 600 000 of these deaths – including more than 130 000 children – are due to second-hand smoke exposure. Of all cancers, 22% are due to tobacco use. Seventy per cent of lung cancer is attributable to smoking. The WHO Western Pacific Region is home to one quarter of the world's population, but one third of its smokers. In the Region, tobacco use is the most important underlying risk factor for premature deaths from noncommunicable diseases (NCDs). Although cigarettes are the most common type of tobacco consumed, other tobacco products contribute to the mortality burden. For example, several Pacific island countries and areas have some of the world's highest rates of mortality from oral cancer. These deaths are attributed to the habit of chewing of betel nut mixed with tobacco.

Global and regional policy imperatives are in place to regulate tobacco use. The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) is a legal instrument that affirms the right of all people to the highest standard of health. The WHO FCTC provides an evidence-based mix of demand- and supply-reduction interventions to curtail tobacco use. All parties to the WHO FCTC share an obligation to implement the treaty. The Western Pacific is the only WHO region where all eligible parties have ratified the treaty.

Growing recognition of the critical role of NCD prevention and control in countries' overall development increases the pressure on governments to comply with the WHO FCTC. In a historic high-level meeting to address the worldwide NCD epidemic, the United Nations General Assembly in 2011 called on governments to act on their commitment to "accelerate the implementation by States Parties of the

WHO Framework Convention on Tobacco Control". In 2013, the Sixty-sixth World Health Assembly endorsed the *WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* and nine voluntary targets[1], including a relative reduction in NCD-related premature mortality by 25% and a relative reduction of tobacco use prevalence of 30% by 2025.

The entry into force of the WHO FCTC in 2005 catalysed global progress on tobacco control. According to a recent study, 7.4 million premature deaths were averted between 2007 and 2010 due to MPOWER[2] measures being adopted and fully enforced. Advocacy by national leaders for NCD prevention and control has reinforced the importance of the WHO FCTC, drawing more attention to the effectiveness and relevance of tobacco control in NCD prevention.

Tobacco-control legislation and policies, supported by multisectoral action and vigilance of civil society partners, are gradually changing the social norms surrounding tobacco use. However, completely changing people's views on tobacco will require much more work over time. Meanwhile, new threats are emerging that may undo public health gains achieved by steady implementation of the WHO FCTC. These threats include the introduction of a growing range of products such as electronic nicotine delivery systems (ENDS). To ensure irreversible gains and benefits for health, WHO FCTC implementation must be accelerated through sustainable tobacco control systems. A cohesive tobacco control system incorporates and coordinates actions from multisectoral stakeholders, going beyond the health sector to include trade, commerce, finance, customs, education, agriculture, women's affairs and other sectors in tobacco control. Multisectoral policy dialogues that result in clear, time-bound tasks are needed to ensure policy coherence. This process will be key to address ongoing and emerging issues, challenges and barriers to WHO FCTC implementation.

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1. Voluntary global targets of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 are: 1) 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases; 2) 10% relative reduction in the harmful use of alcohol, as appropriate within the national context; 3) 10% relative reduction in prevalence of insufficient physical activity; 4) 30% relative reduction in mean population intake of salt and sodium; 5) 30% relative reduction in prevalence of current tobacco use in people aged 15+ years; 6) 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances; 7) halt the rise in diabetes and obesity; 8) at least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes; and 9) 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities.

2. MPOWER is a set of tobacco demand-reduction measures that correspond to one or more of the demand-reduction provisions included in the WHO FCTC. They provide countries with practical assistance to reduce demand for tobacco in line with the WHO FCTC. MPOWER stands for: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco.

1.2 Where we are

With the support of the Member States and the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2010–2014),* the Western Pacific Region became the first WHO region to set a measurable target (10% reduction in relative prevalence in five years) for smoking and other tobacco use. The target of 10% prevalence reduction every five years is consistent with the *WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.*

Since the inception of the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2010–2014),* around 25% of countries and areas in the Region have met the 10% reduction target for adult male and female current smoker populations, according to trend estimates conducted by WHO (unpublished data). With regard to youth[3] smoking, prevalence rates for boys are steady or going down, but smoking among girls is slowly increasing. Surveys and research results in many countries show in-country inequities with higher rates of tobacco use among poorer and vulnerable populations, such as indigenous peoples and communities displaced due to emergencies and disasters.

Country progress reports attribute the reduction in smoking prevalence to improvements in tobacco control arising from the implementation of the WHO FCTC. **Sustained declines in smoking rates are more likely when combinations of evidence-based actions of MPOWER are introduced through policy or legislation, followed by effective enforcement.** WHO has created five categories describing the level of achievement for each MPOWER measure.[4] Based on the *WHO Report on the Global Tobacco Epidemic 2013* and considering the two highest categories of achievement, out of the 27 countries in the Western Pacific Region, 52% have recent and representative surveillance data, 37% have policies for smoke-free public places, 67% have cessation services, 29% have implemented health warnings on tobacco product packaging, 78% have bans on advertising, promotion and sponsorship, and 48% have raised taxes to at least 51% of retail price (see Fig. 1).

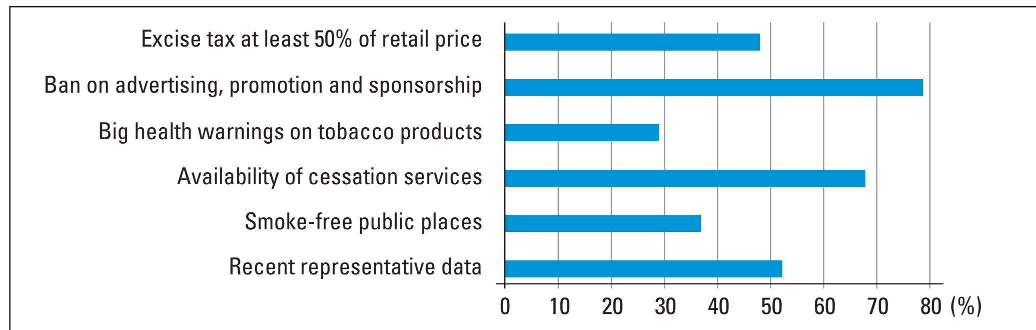
Progress at the national level has been encouraging (Fig. 2). All countries report having established national coordination mechanisms. Almost 90% of countries have national tobacco control laws or are working towards legislation consistent with the WHO FCTC. Eighty per cent of countries report a direct linkage of national tobacco-control efforts to overall national health plans. All countries report strong

3. Age range for youth differs according to the various surveys conducted. For those countries that conducted Global Youth Tobacco Survey (GYTS), the data for youth correspond to the 13–15 age group.

4. Please refer to the Technical Note 1 of the 2013 WHO Report on the Global Tobacco Epidemic, http://www.who.int/tobacco/global_report/2013/technical_note_i.pdf for description of the different categories.

and successful partnerships with civil society and about 75% of countries have successfully worked with their ministry of finance to raise tobacco prices and taxes.

FIGURE 1. Percentage of WHO FCTC Parties in the Western Pacific Region that have achieved the top two categories for demand-reduction measures as reported in the *WHO Report on the Global Tobacco Epidemic 2013*



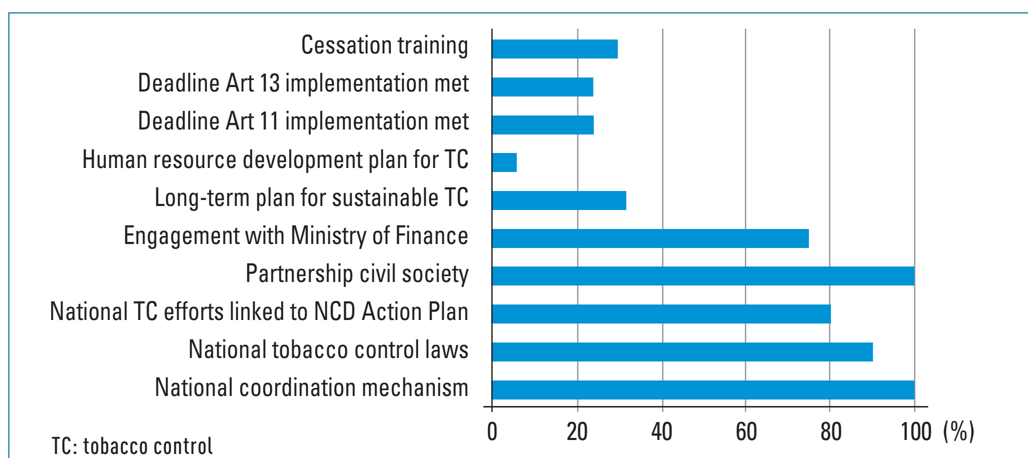
Timely implementation of the WHO FCTC with respect to meeting deadlines for national legislation consistent with Article 11 (Health warnings) and Article 13 (Bans on tobacco advertising, promotion and sponsorship) remains a challenge. To date, only 25% of countries have met their deadlines. Implementation of Article 8 (Protection of people from second-hand smoke) is not covered by a time-bound clause in the WHO FCTC, but it is critical in the denormalization of tobacco use. WHO FCTC guidelines for this article state that each Party should strive to provide universal protection from exposure to second-hand smoke within five years of the WHO FCTC entry into force. Over the past five years, an increasing number of local jurisdictions have passed subnational legislation that surpass national standards; for example, several cities in China, Malaysia and the Philippines have become smoke-free and have instituted enforcement measures more in compliance with the WHO FCTC than the national legislation.

Only one third of countries report long-term plans for sustainable infrastructure for tobacco control. Most countries cannot state the amount of budgetary resources that are allocated for tobacco-control programmes. Only 7% of countries report that they have human resource development plans for tobacco control.

Work on cessation systems, while promising, is still at a very early stage, and only 30% of countries are able to conduct training on cessation.

Half of the countries in the Region are undertaking tobacco surveillance activities, but most of these activities are funded through donor support and are not part of mainstream information systems of the ministry of health.

FIGURE 2. Baseline indicators of tobacco-control progress in the Western Pacific Region



1.3 The changing context and challenges for tobacco control

The landscape for tobacco control is constantly changing. This calls for vigilance, flexibility, and quick and creative responses to emerging threats to the public health gains that have been achieved through progressive implementation of the WHO FCTC.

Tobacco industry interference in policy-making is the most daunting challenge. In countries where national laws have not been passed, the tobacco industry has been directly influencing the legislative process or has worked with front organizations and subsidiary companies to campaign against legislation. When laws are passed, the tobacco industry continues to subvert enforcement at local levels, through loopholes and exemptions. In some countries, such as Australia, the industry pursued litigation to stop the implementation of the tobacco plain-packaging law. When litigation failed, the industry shifted to invoking legal technicalities related to bilateral trade agreements and the provisions of World Trade Organization (WTO) agreements.

Comprehensive bans on tobacco advertising, promotion and sponsorship have been overtaken by viral campaigns of the industry on social media and the Internet. Point-of-sale displays, when allowed within countries, have been exploited through billboards, “cigarette walls” and other creative advertising gimmicks to greatly expand tobacco marketing visibility. The tobacco industry has also used promotional trade fairs and related events within the Region as a means to advertise tobacco products in South-East Asia.

Disaster areas and communities displaced by tsunamis, earthquakes and floods have become an easy target for distribution of free cigarettes and other promotional materials that accompany food and clothing for survivors. In these dramatic circumstances, the tobacco industry is often among the first to give money for disaster relief as part of its corporate social responsibility (CSR) activities – another way of advertising.

The insidious increase in use of other tobacco products is another reason for concern. Tobacco water pipes or "shisha" smoking has slowly crept into many bars and restaurants. Hand-rolled and loose tobacco provides a cheaper alternative to manufactured cigarettes in Cambodia, the Lao People's Democratic Republic and many Pacific island countries and areas. Tobacco products in bright colours, packaged for girls and young women, are becoming more common. Chewed tobacco with betel nut, and its enhanced addictiveness, is a serious problem among adults and youth of both sexes in several Pacific island countries and areas, and among cultural subgroups of women in Cambodia and the Lao People's Democratic Republic.

The public health community is viewing with caution the recent surge of new products, such as ENDS, more commonly known as "e-cigarettes" which are rapidly invading the market globally. **Most ENDS products being sold have not been tested and are unregulated in many countries.** Although they are being marketed and advertised as smoking cessation aids, there is still very limited evidence on their efficacy and advantage over existing smoking cessation treatments. WHO recommends regulation of these products within countries to: (1) impede ENDS promotion to and uptake by non-smokers, pregnant women and youth; (2) minimize potential health risks to ENDS users and non-users; (3) ensure that no unproven health claims are made about ENDS; and (4) protect existing tobacco-control efforts from commercial and other vested interests of the tobacco industry.

1.4 Initiatives that are gaining momentum and investment opportunities for tobacco control

The Western Pacific is the first WHO region to set a target of 10% prevalence reduction in smoking and other tobacco use every five years. This is consistent with the *WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.* If current actions are strengthened and sustained, this goal can be achieved.

Recently, several countries in the Region set higher prevalence-reduction targets, striving for bolder actions against tobacco. New Zealand, for example, agreed to a longer-term goal of reducing smoking prevalence and tobacco availability to minimal levels, thereby making New Zealand essentially a smoke-free nation by 2025. Health ministers from Pacific island countries and areas have also announced a Tobacco Free Pacific goal to reduce adult tobacco consumption to below 5% by 2025. Following the success and publicity around smoke-free World Heritage Sites, several countries in the Association of Southeast Asian Nations (ASEAN) are working toward a political statement for a smoke-free ASEAN.

Setting targets in order to prevent premature NCD deaths paves the way for discussions about sustainable tobacco-control systems. In the future, tobacco-control efforts need to be clearly positioned as a non-negotiable component of country efforts to achieve universal health coverage and national goals for NCD prevention and control. Advocacy efforts might be stepped up to show how NCD goals will not be achieved if universal health coverage fails to invest in strong measures to prevent tobacco use, protect people from second-hand smoke exposure and enable current smokers to quit.

This will require the provision of budget line items for tobacco-control programmes in ministries of health as well as ensuring that cessation services, including quit lines, are provided for free or are covered through national health insurance schemes. Brief advice[5] on smoking cessation, as an evidence-based intervention that is known to increase quit attempts among smokers, should be given to all smokers who consult for any type of health concern, especially in primary health-care facilities. **Nicotine replacement therapy (NRT) as well as other cessation medications should be included in the National List of Essential Medicines.**

It is of critical importance that countries invest in tobacco-control surveillance as an integral part of national disease and risk surveillance and reporting. Monitoring the progress in tobacco control through appropriately spaced surveillance activities is essential to tracking progress and measuring the impact of policy interventions. Countries are encouraged to use "standardized" questions[6] that will allow for better comparability across countries.

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5. Brief advice is a short intervention (five minutes maximum) that has proven to be effective in attempting tobacco cessation. It can be carried out by any trained health professional (doctor, nurse, social worker, health worker, etc.).

6. The Global Tobacco Surveillance System (GTSS) developed by WHO, the United States Centers for Disease Control and Prevention, and other partners provides standardized questions for adults in the Global Adult Tobacco Survey (GATS) and in Tobacco Questions for Surveys (TQS): a subset of questions from GATS, and for youth in the GYTS. TQS core and optional questions have been incorporated into the WHO STEPwise survey and are available for incorporation into other national and subnational health surveys.

These questions might be embedded in national census activities or in various surveys including health, social, demographic or household expenditure surveys. Tobacco taxes and prices need to be reviewed yearly or biannually with the finance sector. Adjustments need to be made on a yearly basis taking into account inflation so as to gradually decrease affordability and continue to discourage young people from starting smoking and to encourage smokers and other tobacco users to quit.

Additionally, investments are needed in tobacco control leadership development. New tobacco control champions can be found in local jurisdictions and other sectors such as sports, tourism, women's organizations and workplaces. Local government officials, like the mayors, can play a key role in enforcement of smoke-free policies and bans on advertising.

The success of smoke-free World Heritage Sites in Cambodia, the Lao People's Democratic Republic, Malaysia and Viet Nam can be replicated in other tourist areas. Tobacco-free sports and mega events, as exemplified by the Beijing Olympics, the World Expo in Shanghai and the smoke-free Southeast Asian Games held in the Lao People's Democratic Republic, point to new norms, standards and expectations from the public in special events. Smoke-free workplaces initiated by the private and public sectors can document the benefits to worker productivity and reduction in lost hours from sick leave.

Article 19 of the WHO FCTC provides guidance on liability and lawsuits against the tobacco industry and can be considered as a powerful tool in tobacco control. Countries can use litigation against the tobacco industry to advance tobacco control. In the Western Pacific Region, the National Health Insurance Service of the Republic of Korea sued the tobacco industry for compensation for the health costs incurred when treating tobacco-related diseases.

Countries need to invest in developing a pool of lawyers and public health policy experts who can work in tandem on legal and trade matters that are pivotal to tobacco control and counter legal challenges to WHO FCTC implementation. Moreover, dialogue needs to be initiated within countries on health and trade to achieve policy coherence with respect to the WHO FCTC, the WTO and other international treaties or agreements.

All these efforts will require systematic and strategic analysis of tobacco-control systems in each country, appropriate capacity-building programmes and dedicated resources to ensure that tobacco control is integrated not only in public health but also in all policies of government.

1.5 How this regional action plan can help

The *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)* aims to guide countries in further developing their national action plans for accelerated implementation of the WHO FCTC. It also seeks to optimize collaborative activities for tobacco control at the regional level. This regional action plan provides Member States, international partners and WHO with a road map which, when implemented collectively by all partners, will contribute to reducing the burden of tobacco use in the Western Pacific Region and to achieving the 2025 global targets, including a 30% relative reduction in prevalence of tobacco use, as well as regional, subregional and country targets.

The regional action plan calls on Member States to strengthen national coordinating mechanisms and ensure that national action plans contribute towards accelerated implementation of the WHO FCTC and to consider sustainable systems with adequate resources to support action.

Accelerated implementation of the WHO FCTC can only be achieved through engagement of all relevant sectors of government, civil society and nongovernmental organizations, as well as new partners at the national, regional and global levels to take action within their social, cultural, occupational, and political networks and spheres of influence.

The *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)* sets revised regional targets that will be used by WHO to monitor and assess progress of the Tobacco Free Initiative programme at the regional and country levels. These targets are in line with the NCD global targets. Actions for countries are provided as a menu that may be used to further enhance and strengthen national plans of action. Actions for WHO will be used to guide development of biennial work plans and implementation of the *One WHO Work Plan on NCDs,* which includes all three levels of the Organization. Qualitative and quantitative indicators are provided and are highly recommended to monitor implementation at the regional and country levels and to help countries report to the UN General Assembly on NCDs in 2018 on progress made towards the achievement of the NCD voluntary targets.

1.6 How this plan was developed

The *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)* is the product of a series of consultations that began in May 2012 when the national tobacco-control focal points from Member States convened in Manila, Philippines, for the midterm progress review of the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2010–2014).* In October 2013, the national tobacco-control focal points and delegates from Parties in the Western Pacific Region participated in a meeting entitled Strengthening the Effectiveness of Tobacco Control Measures, held in Manila, Philippines, to address aspects of tobacco control that needed to be strengthened to ensure progress towards targets set in the regional action plan for 2010-2014. Delegates also discussed future directions and strategies for the development of the regional action plan for 2015–2019. In January 2014, tobacco control focal points from WHO country offices met in Manila for the *One WHO Work Plan on NCDs* meeting. Further assessment and evaluation were conducted.

Based on these consultations, a draft document was produced and circulated for comments by experts, partners and counterparts in WHO headquarters and regional offices in February 2014. In April 2014, the draft document was circulated to national focal points for in-country discussions. This was followed by the Consultative Meeting on the Draft Regional Action Plan for the Tobacco Free Initiative in the Western Pacific Region (2015–2019) held in Fiji in May 2014, with participation of national focal points, representatives of civil society, WHO and the Convention Secretariat and international organizations, like the Secretariat of the Pacific Community (SPC). The final draft included comments and input from this multistakeholder consultation.

2. Vision, mission, goal, and overall indicators

VISION: A world free of tobacco: tobacco-free people, communities and environments.

MISSION: To advocate and enable accelerated implementation of the WHO Framework Convention on Tobacco Control through sustainable systems for tobacco control.

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

The Regional Action Plan was developed based on the following overarching principles:

1. Empowerment of people and communities
2. Evidence-based strategies
3. Life-course approach
4. Management of real, perceived or potential conflicts of interest
5. Applying equity-enhancing, gender-responsive, culturally appropriate and human rights-based approaches
6. Multisectoral involvement
7. National action and international cooperation and solidarity

2.1 Approaches and ways of working

1. Strengthening and implementing tobacco-control systems – recognizing and leveraging the roles and functions of health, trade, commerce, finance, customs, education, agriculture, women's affairs and other sectors in tobacco control.
2. Updating, strengthening and implementing national tobacco-control plans and coordinating mechanisms by addressing sustainability issues (e.g. budgets, human resources, and monitoring and evaluation) of tobacco-control systems.
3. Linking of activities, targets and prevalence indicators to the NCD action plan, universal health coverage and national development plans.

2.2 Overall targets for 2019

1. All countries have strengthened sustainability of their national tobacco-control programmes and systems.
2. All Parties in the Western Pacific Region have successfully complied with Articles 5.3, 8, 11 and 13 of the WHO FCTC.
3. All countries have government-funded surveillance systems in place for reliable data on adult and adolescent tobacco as well as ENDS use (as appropriate).
4. A 10% relative reduction in prevalence of current tobacco use (smoked and smokeless) among adult (men and women) and adolescent (boys and girls) from the estimated baseline of 2014.

3. Strategic outcomes, objectives, actions, indicators and regional targets

Strategic outcomes

Member States in the Western Pacific Region will work towards reduced tobacco consumption by:

- establishment of sustainable institutional capacity for tobacco control;
- effective legislation and regulations; and
- engagement of constituencies for enforcement of tobacco control.

For each of these strategic outcomes, the Regional Action Plan has identified a number of objectives and suggests actions and indicators for countries and for WHO to achieve these objectives.

See figure 3 for a summary of the objectives under each strategic outcome.

FIGURE 3. Strategic outcomes to accelerate the complete implementation of the FCTC and objectives

STRATEGIC OUTCOMES TO ACCELERATE THE COMPLETE IMPLEMENTATION OF THE FCTC		
1. Sustainable institutional capacity	**2. Effective legislation and regulations**	**3. Engagement of constituencies for enforcement**
OBJECTIVES		
1.1 All-of-government and multisectoral approaches	2.1 Raise tobacco prices and taxes	3.1 Mayors and local government authorities
1.2 Leadership development capacity guiding and training	2.2 Protect from exposure to second-hand tobacco smoke	3.2 Smoke-free World Heritage Sites
1.3 Sustainable funding	2.3 Implement effective packaging and labelling	3.3 Tobacco Free Pacific 2025
1.4 Government-funded tobacco surveillance systems	2.4 Ban advertising, promotion and sponsorship of tobacco products	3.4 Smoke-free workplaces
1.5 Raise public awareness	2.5 Ratify the Protocol on Elimination of Illicit Trade in Tobacco Products	3.5 Organizations of women and youth
1.6 Create sustainable cessation services and systems	2.6 Regulate the contents and emissions of tobacco products	3.6 Vulnerable and marginalized groups
1.7 Integrate tobacco control in national NCD action plans	2.7 Regulate ENDS	3.7 Sports and mega events
	2.8 Minimum age restrictions for selling and purchasing of tobacco products	3.8 Entertainment industry
	2.9 Tobacco industry interference	3.9 Lawyers
		3.10 Civil Society
		3.11 Health professionals and academics

STRATEGIC OUTCOME 1

Sustainable institutional capacity for tobacco control

OBJECTIVE 1.1 **Ensure policy coherence in national action plans for tobacco control through all-of-government approaches and multi-sectoral stakeholder engagement.**

National tobacco action plans for regulation of tobacco and other related products are best implemented through all-of-government approaches. This requires strong leadership and facilitation by the health sector to ensure health in all policies. A conscious effort is needed to recognize and leverage the roles and functions of different sectors as part of a "cohesive tobacco control system" comprised of health, trade, commerce, finance, customs, education, agriculture and others. Recent developments point to the urgent need for pro-active dialogue on policy coherence among these sectors. Other sectors that deal with public information and labour are also important. The participation of multisectoral stakeholders, civil society, women's groups and the community in these processes is of critical importance. These processes must be protected from vested interests of the tobacco industry, consistent with the provisions of Article 5.3 of the WHO FCTC.

Regional targets

a. One hundred per cent of countries have initiated policy coherence dialogues on tobacco control in relation to health, trade, commerce, finance, education, agriculture and women's affairs.

b. No change in current status with 100% of countries having established a tobacco-control national coordinating mechanism or equivalent.

> **2014 Baseline:** 100% of Western Pacific Region countries have a national coordinating mechanism for tobacco control.

c. One hundred per cent of countries conduct public recognition of outstanding contributions of allies and partners.

> **2014 Baseline:** 45% of Western Pacific Region countries recognize outstanding tobacco-control partners and allies.

ACTIONS FOR COUNTRIES

1. Convene proactive policy dialogues through the national coordinating mechanism or equivalent to implement national tobacco-control action plans and to address the need for tobacco-control policy coherence in relation to health, trade, foreign affairs, finance, customs, education, agriculture, women's affairs and other sectors.
2. Strengthen the mechanism to ensure tobacco-control policy coherence across health programmes within the health sector.
3. Integrate national tobacco control plans within the United Nations Development Assistance Framework (UNDAF).
4. Enable and support multisectoral stakeholder engagement on tobacco control, including civil society groups, faith-based groups, traditional leadership, as appropriate and other tobacco control advocates and communities.
5. Develop, disseminate and implement measures and guidelines to keep policy development free from tobacco industry interference.
6. Share information on tobacco control issues and initiatives with stakeholders.
7. Develop a system to publicly recognize outstanding contributions of allies and partners, and reinforce social mobilization efforts.

Country indicators

a. Evidence that a national all-of-government approach to tobacco control has been established and documented and is working towards the implementation of a national action plan for tobacco control, such as a formal mechanism with terms of reference for multisectoral engagement in tobacco control.

b. Evidence that measures to keep policy development free from tobacco industry interference have been implemented.

ACTIONS FOR WHO

1. Provide technical guidance, tools and assistance for countries and partners to implement national action plans and improve tobacco-control policy coherence in relation to health, trade, foreign affairs, finance, customs and agriculture, with emphasis on proactive policy dialogues and ensuring protection of these processes from commercial and vested interests of the tobacco industry.

2. Create opportunities to expand partnerships and build stronger alliances and coalitions for tobacco control at the national, regional and subregional levels, including other key United Nation agencies and programmes.
3. Develop a network of partners in the Region to share information regularly.

WHO indicators

a. Number of countries that receive technical guidance, tools or assistance on implementation of national action plans and improvement of policy coherence and all-of-government approaches consistent with Article 5.3 of the WHO FCTC.

b. Updated information across a network of partners in the Region is available.

OBJECTIVE 1.2 **Expand tobacco-control leadership development, capacity-building and training.**

Expanded leadership development, capacity-building and training on tobacco control among strategic sectors and different disciplines will complement efforts to achieve all-of-government approaches and policy coherence on tobacco control. Leadership development needs to encompass both formal and informal systems of leadership, including community leaders and traditional leaders. Tobacco control needs to be included in the national health human development plan to address the NCD epidemic.

Regional targets

a. One hundred per cent of countries have participated in regional leadership training programmes for tobacco control.

> **2014 Baseline:** 80% of Western Pacific Region countries have participated in regional leadership training programmes for tobacco control.

b. One hundred percent of countries have conducted training on tobacco control in support of the national NCD action plan or other relevant action plans.

2014 Baseline: 90% of Western Pacific Region countries have conducted local tobacco-control training to support their NCD action plan and/or other relevant action plans.

ACTIONS FOR COUNTRIES

1. Identify training needs and facilitate and execute a national human resource development strategy for tobacco-control leadership that builds capacity within strategic sectors of government such as health, trade, foreign affairs, finance, customs, education, agriculture and women's affairs, and among civil society and community/traditional groups and media.
2. Prioritize the training of lawyers and legal champions for accelerated implementation of the WHO FCTC.
3. Include tobacco control in the national health human resource development plan in support of the national NCD prevention and control plans and other health promotion efforts, including training of health workers in hospitals and health facilities.
4. Incorporate, integrate and expand tobacco control in the course curricula for health workers and professionals and for relevant sectors.

Country indicators

a. Evidence of the availability of a national human resource development plan for tobacco-control leadership, capacity-building and training for tobacco control, including the assessment of training needs and the availability of training resources.

b. Number of lawyers trained and engaged in acceleration and support of WHO FCTC implementation.

c. Number of training opportunities in tobacco-control leadership that have been provided for health workers, traditional leaders, community leaders, media and other tobacco control champions.

d. Curriculum for health-care workers that include tobacco-control principles and evidence based best practices has been developed and implemented.

ACTIONS FOR WHO

1. Sustain implementation of regional tobacco-control leadership training programmes.
2. Provide technical guidance, tools and assistance for countries to train lawyers and other legal professionals in tobacco control.
3. Provide technical guidance, tools and assistance for countries to incorporate training in tobacco control within national NCD human resource development plans and to support the development of tobacco-control training models in hospitals and health facilities, and settings where community and traditional leaders, media and other potential tobacco control champions operate.
4. Support the development of models for integration of tobacco control in the curriculum of health professionals, health administrators and health workers, including continuing education requirements.

WHO indicators

a. Five regional programmes for leadership training on tobacco control are implemented.

b. A regional consortium for training on tobacco control composed of training and academic institutions in the Region has been established.

OBJECTIVE 1.3 Ensure adequate and sustainable funding for improved tobacco control and accelerated WHO FCTC implementation.

Sustainable development requires healthy people, and healthy people are tobacco free. Investing in prevention through tobacco control will reduce health-care costs related to cancer, cardiovascular disease, stroke, respiratory diseases and diabetes. Investments in tobacco cessation, quit lines and the treatment of tobacco dependence will reduce morbidity, premature mortality and improve workforce productivity. Investing in tobacco control may also reduce poverty as tobacco consumption contributes to poverty. Tobacco control is fundamental to meeting sustainable development goals, and is an essential component of the post-2015 development agenda.

International best practices may be used to calculate adequate per capita investments for tobacco control. Tobacco-control funding sources could include national and local budgetary allocations, health insurance, free airtime from government media networks, and tobacco and alcohol taxes, among others. Investments in tobacco control should include an equity focus, aiming to reduce disparities in tobacco consumption in population groups with a high smoking prevalence and consequences across population subgroups.

Sustainable financing of tobacco control will depend on improved efficiencies in spending (focusing on policies and legislation), higher levels of funding (especially for mass media campaigns and public education) and greater diversification of funding sources. Concurrently, strict implementation of Article 5.3 of the WHO FCTC will be needed to ban tobacco industry contributions to health projects, poverty alleviation, disaster response and other forms of corporate social responsibility that undermine comprehensive tobacco-control policies.

Regional target

a. One hundred per cent of countries have established sufficient funding for tobacco control and are working towards sustainable financing of their national tobacco control programmes.

> **2014 Baseline:** 35% of Western Pacific Region countries have adequate funding from national or local sources for tobacco control.

ACTIONS FOR COUNTRIES

1. Use international best practices to estimate per capita investment needs and provide a budget line item for tobacco control in national and local budgets and health investment plans.
2. Improve efficiency and effectiveness of tobacco-control programmes by focusing on policy, legislation and enforcement.
3. Consider, where applicable, the use of a percentage of tobacco taxes for tobacco control including enforcement of tobacco-control measures, health promotion and disease prevention, including universal health coverage.
4. Consistent with universal health coverage, work towards insurance coverage or government support of tobacco cessation and treatment of tobacco dependence.

Country indicators

a. Funding for tobacco control available in the government budget is sufficient as referenced to international best practices in per capita investment.

b. Tobacco control is funded through multiple sources.

c. Cessation services and treatment of tobacco dependence is covered by the health financing scheme.

ACTIONS FOR WHO

1. Provide technical guidance, tools and assistance for countries to estimate and provide per capita investment needs to support national tobacco control and accelerated implementation of the WHO FCTC.
2. Provide technical guidance, tools, models and assistance for tapping other sources of funds for tobacco control, e.g. tobacco taxes, health insurance, health promotion boards, etc.
3. Work with other United Nations agencies, financial institutions, international organizations, philanthropists and other donors to secure additional and new funding for tobacco-control work in countries.

WHO indicator

a. Number of countries that have received technical guidance, tools or assistance to estimate investment needs, prepare budget items and increase investments, sources and levels of funding for tobacco control.

OBJECTIVE 1.4 Establish sustainable government-funded tobacco surveillance systems.

Monitoring progress in tobacco control through appropriately spaced surveillance activities should be part of national health information reporting systems and services. In low- and middle-income countries, donor-supported surveys will be useful for providing baseline information and introducing standardized questions that enable comparability with other countries. In the long run, efforts need to be

made to incorporate tobacco-control questions in other health surveys. Surveillance results and research findings from hospital and health facilities, as well as other sources of information such as opinion polls, inform policies and programmes, especially in relation to identifying vulnerable groups. It is essential to monitor the tobacco epidemic and progress in tobacco control in relation to the social determinants of health to ensure equitable policies. It is also essential to track and monitor progress over time and to correlate the impact of policy interventions on tobacco use prevalence rates.

Regional targets

a. One hundred per cent of countries with reliable and comparable population-level adult tobacco use (smoking and smokeless) prevalence data by sex and age.

> **2014 Baseline:** 75% of Western Pacific Region countries have completed a national survey which includes tobacco prevalence questions.

b. One hundred per cent of countries with reliable and comparable adolescent tobacco use (smoking and smokeless) prevalence data by sex and age.

> **2014 Baseline:** 90% of Western Pacific Region countries have completed a nationally representative survey of tobacco use amongst adolescents.

c. One hundred per cent of countries have funded (in total or partially) their tobacco surveillance activities.

> **2014 Baseline:** 70% of Western Pacific Region countries have at least partially funded tobacco surveillance.

d. One hundred per cent of countries monitor the enforcement of tobacco-control policies.

> **2014 Baseline:** 60% of Western Pacific Region countries include enforcement monitoring in tobacco surveillance.

e. One hundred percent of countries monitor the tobacco industry.

> **2014 Baseline:** 80% of Western Pacific Region countries monitor the tobacco industry.

ACTIONS FOR COUNTRIES

1. Ensure that tobacco control surveillance is undertaken regularly, and when appropriate, using the Tobacco Questions for Surveys (TQS) model to collect reliable and comparable population-level data for adults and adolescents covering tobacco and other related products, including ENDS.
2. Work towards a medium- and long-term surveillance plan for tobacco control and provide government resources for tobacco surveillance by establishing a budget line item for national and local surveillance.
3. Map the social and economic inequities and determinants and use this to improve targeting and design better tobacco-control programmes.
4. Strengthen use of evidence for policy and action that target decision-makers, partners and the general public (e.g. through data application projects).
5. Ensure that academic and research institutions or entities conducting research, do not accept financial, technical and in-kind support for research activities from the tobacco industry or any organization affiliated with the tobacco industry.
6. Develop, implement and evaluate a strategy to monitor tobacco industry activities (e.g. tobacco industry marketing, product development and attempts to influence political decision-making).

Country indicators

a. Reliable and comparable population-level adult tobacco use (smoking, smokeless) and ENDS prevalence data by sex, age and socioeconomic status are regularly collected and reported.

b. Reliable and comparable adolescent tobacco use (smoking and smokeless) and ENDS prevalence data by sex and age are regularly collected and reported.

c. Government-funded medium- and long-term tobacco surveillance activities are in place.

d. Evidence that inequities have been highlighted and appropriate action has been recommended based on data.

ACTIONS FOR WHO

1. Develop and provide technical guidance, support tools and assistance for countries for capacity-building to implement and scale up sustainable surveillance systems and activities for tobacco control, including the use of the full TQS in the WHO STEPwise Approach to Surveillance (STEPS).
2. Promote the use of information and communications technology to improve reporting and dissemination of information gained through surveillance and research activities, as appropriate.
3. Develop and implement a regional tobacco control research agenda in partnership with relevant research stakeholders in the Region and countries.
4. Strengthen effective knowledge management at the Regional Office and country offices.
5. Standardize data to make it comparable and promote timely and relevant information exchange between countries.
6. Develop and provide technical guidance, support tools and assistance for countries to implement and evaluate strategies for tobacco industry monitoring.

WHO indicators

a. Number of countries that have received technical guidance, tools or assistance for strengthening the use of evidence for policy and action.

b. Number of countries that have received technical guidance, tools and assistance for standardization of data and preparation of WHO FCTC Conference of Parties (COP) reporting instruments and *WHO Report on the Global Tobacco Epidemic.*

OBJECTIVE 1.5 **Raise public awareness on the harms of tobacco use, especially among vulnerable and at-risk groups, and systematically disseminate the provisions of Article 5.3.**

Awareness of the harms of tobacco use is steadily growing. Mass media campaigns and events around World No Tobacco Day have provided important opportunities to disseminate information and change social norms. Despite this, there are vulnerable

and at-risk groups that need special attention, among them, indigenous populations, poor and underserved groups, women, and boys and girls. To undermine bans on tobacco advertising, promotion and sponsorship, the tobacco industry is using new ways (e.g. social media, Internet advertising) to target evolving markets.

Based on Article 12, the public needs to be appropriately informed about the potential harms of ENDS, shisha and tobacco water pipes, as well as smokeless tobacco products. Systematic dissemination of the provisions of Article 5.3 is of critical importance. Efforts should be exerted to inform the public of how the tobacco industry is finding innovative ways to recruit and entice new smokers, especially youth.

Regional target

a. One hundred per cent of countries have developed and implemented national communication and advocacy campaigns.

> **2014 Baseline:** 35% of Western Pacific Region countries met the criteria for the highest rank for mass media campaigns in the *WHO Report on the global tobacco epidemic, 2013.*

ACTIONS FOR COUNTRIES

1. Develop, implement and secure appropriate funding for an evidence-based communication and advocacy plan for the different measures for tobacco control.
2. Mobilize communities and role models such as health professionals, policy-makers, traditional and community leaders, celebrities, athletes, educators and others in advocacy campaigns for comprehensive tobacco control.
3. Develop and implement training programmes on strategic communication and advocacy for tobacco control.
4. Support education and information campaigns that target women, youth and children, and vulnerable populations using innovative strategies and technologies.
5. Work with the media and strategic communication specialists, such as schools of mass communication, to sensitize journalists on tobacco-control issues and industry tactics in influencing policy- and decision-making.
6. Implement mass media (including paid media) and community-level anti-tobacco campaigns.

7. Use World No Tobacco Day activities to highlight tobacco-control issues and progress in the country.

Country indicators

a. Strategic communication and advocacy plans are developed and implemented and evaluated.

b. Number of national tobacco-control awareness and advocacy activities have been conducted during World No Tobacco Day.

ACTIONS FOR WHO

1. Support national communication and advocacy plans through capacity-building, regional events, campaigns and public education activities, including World No Tobacco Day activities and other tobacco-control advocacy opportunities in countries.
2. Advocate with stakeholders for the inclusion of tobacco control in the global, regional and national health and development agendas (e.g. post-2015 sustainable development goals, Convention on the Rights of the Child, Convention for the Elimination of All Forms of Discrimination Against Women and the Millennium Development Goals), and country UNDAF.
3. Develop and provide technical guidance, tools and assistance for creating awareness about tobacco industry interference with public health policy processes.

WHO indicators

a. Number of countries that have received support for World No Tobacco Day activities.

b. Number of countries that have received guidance, tools and assistance on counteracting tobacco industry interference with public health policy-making processes.

OBJECTIVE 1.6 Create sustainable cessation services and systems.

To address premature mortality and tobacco-related diseases among the estimated 450 million current smokers in the Western Pacific Region, additional attention and effort is needed to provide affordable and appropriate cessation services. As countries succeed in effectively implementing tobacco-control measures, the demand for support for quitting is also increasing. A sizable percentage of the population may be able to quit on their own or with minimal counselling support. However, in countries where severe nicotine addiction is prevalent, programmes and services that provide specialized counselling and medications (e.g. NRTs) may be addressed through health delivery systems and through universal health coverage. Countries are encouraged to build cessation systems in a step-wise manner, according to their needs, resources and cultural contexts. All countries can easily begin to include brief advice, quit lines, smoking cessation and treatment of tobacco dependence at the primary health-care level as part of the Package of Essential Noncommunicable Disease Interventions (PEN) for Primary Health Care. To the extent possible, this could be free of charge or covered by health financing schemes.

Regional targets

a. Sixty per cent of countries have trained primary health-care service managers and workers to offer brief cessation advice.

> **2014 Baseline:** 30% of Western Pacific Region countries have conducted training for primary health-care service managers and workers to provide brief cessation advice.

b. Fifty per cent of countries have incorporated smoking cessation and treatment of tobacco dependence in universal health coverage targets.

> **2014 Baseline:** 40% of Western Pacific Region countries have incorporated smoking cessation and treatment of tobacco dependence in universal health coverage targets.

ACTIONS FOR COUNTRIES

1. Develop and implement national consensus guidelines for tobacco cessation and tobacco dependence treatment, for example, by scaling up cessation services with PEN.

2. Integrate smoking cessation and treatment of tobacco dependence in primary and district health-care services, appropriate strategic and relevant public health programmes, e.g. NCD prevention and control, tuberculosis control, and safe motherhood.
3. Advocate to policy-makers and train health service managers to integrate tobacco dependence treatment into health-care systems.
4. Develop policy for training of primary health-care workers (e.g. doctors, nurses, dentists, optometrists, physical therapists) and other stakeholders and community groups to provide brief cessation advice.
5. Establish or strengthen behavioural intervention services and quit lines to support smoking cessation and treatment of tobacco dependence, as appropriate.
6. Increase availability, accessibility and affordability of NRTs and other medications for treatment of tobacco dependence and include these in the National Drug Formulary.
7. Work towards securing appropriate health financing for tobacco dependence treatment (e.g. social health insurance coverage, employees, local government allocations).

Country indicators

a. National consensus guidelines for tobacco dependence treatment has been developed or adapted from existing global guidelines, and disseminated nationally, and incorporated into PEN where appropriate.

b. Tobacco cessation, as a covered service under government-funded health services, has been implemented.

ACTIONS FOR WHO

1. Provide technical support to countries to develop and/or adapt, implement, monitor and evaluate national consensus guidelines for tobacco dependence treatment and, where appropriate, to include these guidelines in PEN.
2. Develop models for and support scale-up of integration of smoking cessation and treatment of tobacco dependence interventions in appropriate strategic programmes particularly NCD prevention and control, tuberculosis control and safe motherhood.

3. Develop advocacy modules for health-care policy-makers and training modules for health-care service managers on integrating cessation services into health-care systems, and for health-care workers and other stakeholders to provide brief cessation advice in primary health care and appropriate community settings.
4. Support the collection of data on the availability of and accessibility to tobacco dependence treatment services.
5. Analyse and disseminate information on effective and efficient tobacco dependence treatment practices across the Western Pacific Region.

WHO indicators

a. Number of tools and guidance developed to support development/adaptation and implementation of national consensus guidelines for tobacco dependence treatment and, as part of PEN, as appropriate.

b. Number of training materials developed and disseminated on the integration of cessation services in health systems and on offering brief cessation advice as well as other modes of tobacco dependence treatment.

c. Regional data on tobacco cessation treatment have been analysed, summarized and disseminated.

OBJECTIVE 1.7 Integrate tobacco control in national NCD action plans and apply approaches learned in tobacco control to overall strategies for risk reduction for NCDs.

Tobacco use is a risk factor for the four main types of NCDs: cardiovascular disease and stroke, diabetes, cancer, and chronic respiratory disease. This is reflected in the United Nations Political Declaration on NCDs and progress on tobacco control will be reported to the UN General Assembly in 2018. Tobacco-control efforts can be integrated in national NCD action plans and relevant approaches and strategies for risk reduction can be applied to other risk reduction targets. Other risk factors that occur with tobacco use may include harmful use of alcohol, obesity and overweight, as well as physical inactivity. Convergence of risk factors for NCDs in individuals and groups at risk may require integrated approaches for risk factor reduction. Smoking cessation and treatment of tobacco dependence may be linked to initiatives on mental health, nutrition and physical activity.

Regional target

a. One hundred per cent of national NCD action plans integrate tobacco-control strategies to achieve the goals and targets of the *WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.*

> **2014 Baseline:** 80% of Western Pacific Region countries report national tobacco control strategies included in their national NCD action plans (or national health plans which include NCDs).

ACTIONS FOR COUNTRIES

1. Include tobacco control and WHO FCTC implementation in the national action plans for NCD prevention and control.
2. Promote and advocate for the application of successful tobacco-control strategies and approaches to the reduction of other NCD risk factors.
3. Where other risk factors in combination with tobacco use are identified (e.g. harmful use of alcohol, overweight and obesity, physical inactivity, and mental disorders) consider the use of integrated approaches to risk reduction.
4. Report on tobacco use prevalence as part of the global initiative to attain the nine voluntary NCD targets by 2025.

Country indicators

a. Tobacco control is integrated in the national NCD action plan.

b. Models for integrated risk factor reduction have been developed and/or adapted, and evaluated especially for vulnerable groups and populations.

ACTIONS FOR WHO

1. Develop and provide technical guidance, tools and assistance for countries to integrate tobacco control in national NCD action plans.
2. Support the development and/or adaptation of models for integrated risk factor reduction in vulnerable groups and populations.

WHO indicator

a. Number of countries that have received assistance in the integration of tobacco control in national NCD action plans.

STRATEGIC OUTCOME 2

Legislation and regulations

OBJECTIVE 2.1 **Raise tobacco taxes and use a percentage of revenues for tobacco control and NCD prevention.**

Increasing tobacco prices by increasing taxes continues to be the single most effective measure to reduce tobacco consumption. Evidence from countries of all income levels shows that price increases on cigarettes are highly effective in reducing demand. Higher prices that reduce affordability prevent initiation of tobacco use, reduce consumption and induce cessation among current users, and decrease relapse among those who have quit. On average, a 10% price increase on a pack of cigarettes would be expected to reduce demand for cigarettes by about 4% in high-income countries and by 4–8% in low- and middle-income countries, where lower incomes tend to make people more sensitive to price changes. Children and adolescents are also more sensitive to price increases than adults, allowing price interventions to have a significant impact on this age group.

International best practices for price and tax measures to reduce tobacco consumption include the adoption of a relatively simple tax system that applies equivalent taxes to all tobacco products, with at least a 70% excise tax share in the retail price and tax increases that keep pace with increases in inflation and incomes, to reduce the affordability of tobacco products.

Increasing taxes is a win–win proposition: tobacco consumption drops as governments increase their revenue. A percentage of revenue from tobacco taxes may be appropriated to health promotion and tobacco control in some countries through autonomous infrastructure, such as health promotion foundations, boards or councils, or tobacco-control funds.

Regional targets

a. Fifty per cent of countries have taxes on all tobacco products that are at least 70% of retail price.

> **2014 Baseline:** 10% Western Pacific Region countries have tobacco taxes that are at least 70% of retail price.

b. One hundred per cent of countries are working towards using a significant percentage of tobacco tax for health promotion and NCD prevention, including tobacco control.

> **2014 Baseline:** 70% of Western Pacific Region countries are working towards utilizing tobacco tax revenues for health promotion and NCD prevention, including tobacco control.

ACTIONS FOR COUNTRIES

1. Work towards an excise tax on all tobacco products at a minimum level of 70% of the retail price[7] and review, maintain or increase this level once achieved, on a yearly basis.
2. Consult and work with a multidisciplinary group of technical experts (e.g. finance ministries, health economists) to review existing tobacco prices, tax structure and policy options, and develop, implement and monitor a strategy for effective tobacco taxation and pricing.
3. Strengthen the capacity of the health and finance ministries to work together towards an efficient tobacco tax administration regime.
4. Work towards using a percentage of tobacco tax revenue for health promotion and NCD prevention, including tobacco control.

Country indicators

a. Policies and legislation are in place that will result in an increase in taxes on all tobacco products, primarily increasing excise taxes to 70% or more of the retail price, subject to yearly review and adjustment in relation to reducing affordability and achieving public health objectives.

b. Mechanism is in place to use a percentage of tobacco tax revenue for health promotion and NCD prevention, including tobacco control.

ACTION FOR WHO

1. Provide technical guidance, support tools and assistance for countries for effective design, implementation, administration, and monitoring of tobacco tax and price strategies.

7. Global best practices document that raising tobacco taxes so that they account for at least 70% of retail prices leads to significant price increases, which in turn, result in decreased tobacco consumption. See, WHO Technical Manual on Tobacco Tax Administration, 2011.

WHO indicator

a. Number of countries that have received technical guidance, tools and assistance for effective tobacco tax and price strategies.

OBJECTIVE 2.2 **Develop legal instruments and policies to protect from exposure to second-hand tobacco smoke.**

Second-hand smoke (SHS) is classified as a carcinogen and contains at least 70 chemicals known to cause cancer, including arsenic, benzene, beryllium, cadmium, chromium, ethylene oxide, nickel, polonium and vinyl chloride. Allowing smoking in public places increases the risks for cancer and other serious and potentially fatal diseases. Governments have an obligation to enact legislation to protect individuals from unnecessary exposure to carcinogens. For many workers in restaurants, bars and entertainment industries, SHS is an occupational hazard that increases their risks for cancer, cardiovascular and respiratory disease. Special attention must be given to the most vulnerable and less empowered, such as children and women who are also exposed to SHS at home.

Article 8 of the WHO FCTC and its guidelines call for ensuring effective protection from SHS through the creation of 100% smoke-free places. Other approaches, such as ventilation, air filtration and designated smoking areas, do not protect against the hazards of SHS. Voluntary agreements have been shown to be ineffective. Legislating 100% smoke-free places is the only way to protect the population from second-hand tobacco smoke.

Regional target

a. Eighty per cent of countries have legislation and policies compliant with WHO FCTC Article 8 and its guidelines.

> **2014 Baseline:** 25% of Western Pacific Region countries meeting criteria for highest rank for smoke-free policies in the *WHO Report on the global tobacco epidemic, 2013.*

ACTIONS FOR COUNTRIES

1. Develop legislation and related policies, regulations, ordinances, administrative issuances and other measures to ensure timely compliance with the guidelines for implementation of Article 8 of the WHO FCTC, and support strategies to reduce exposure to SHS in the homes and other settings.
2. Ensure adequate and sustainable enforcement of smoke-free policies by developing an enforcement plan involving different sectors of the community and looking for innovative enforcement mechanisms.
3. Involve civil society and cancer prevention groups as active partners in the process of developing implementing and enforcing smoke-free legislation.
4. Conduct activities to raise awareness among public and key stakeholders to ensure that the public understands and supports legislative action.
5. Conduct community-based activities to empower and protect the most vulnerable, especially women and children, from exposure to SHS.

Country indicators

a. Legislation and policies on protection from exposure to SHS are compliant with the definition of 100% indoor smoke-free settings (e.g. workplaces, public transport, indoor public places) and, as appropriate, other public places, in accordance with WHO FCTC Article 8 and its guidelines.

b. Enforcement mechanisms for smoke-free policies that engage multisectoral partners are in place.

c. A system to assess smoke-free policy compliance exists.

ACTIONS FOR WHO

1. Provide technical guidance, tools and assistance for countries to effectively draft laws and policies to comply with Article 8 of WHO FCTC provisions and guidelines.
2. Provide technical guidance, tools and assistance for countries to consider social determinants and equity issues (e.g. poverty, children, gender, urban-rural residence) in relation to SHS exposure.
3. Integrate smoke-free policies into the Healthy Cities Initiative, mega events, and other settings and initiatives.

WHO indicator

a. Number of tools developed and disseminated to support countries in the development of legal instruments and policies regarding WHO FCTC Article 8 and its guidelines.

OBJECTIVE 2.3 Develop legal instruments and policies to implement effective packaging and labelling measures.

Many tobacco users misunderstand or underestimate the risks for disease and premature death from tobacco use. International experience demonstrates that well-designed health warnings, including pictorial or graphic warnings, and health messages on tobacco product packages are a cost-effective means to increase public awareness of the health effects of tobacco use and can reduce tobacco consumption. As laid out in guidelines to Article 11 of the WHO FCTC, warnings should appear on both the front and back of the packaging, be large and clear, and describe specific illnesses or health effects caused by tobacco. Warnings that include images of the harm that tobacco causes are particularly effective at communicating risk and motivating behavioural changes, such as quitting or reducing tobacco consumption. Tobacco manufacturers must also display relevant statements on each unit packet or package about the emissions of the tobacco product. These should not contain misleading claims (e.g. "less harmful", "safer", "mild" and "light").

Regional target

a. Eighty per cent of countries have legislation and policies compliant with WHO FCTC Article 8 and its guidelines.

> **2014 Baseline:** 25% of Western Pacific Region countries meeting criteria for highest rank for smoke-free policies in the *WHO Report on the global tobacco epidemic, 2013*.

ACTIONS FOR COUNTRIES

1. Develop legislation to ensure that pictorial health warnings and messages appear on all tobacco packages and are large (50% or more of the pack's principal display area), clear, visible, legible, have pictures and are rotating.

2. Conduct research into the types of warnings that are most effective for high-risk groups, and adapt the messages accordingly.
3. Conduct formative research to assess the effectiveness of the health warnings.
4. Develop and implement legislation to ensure that each unit packet and package of tobacco products contains information on relevant constituents and emissions of tobacco products as defined by national health or other competent authorities in accordance with the WHO FCTC Article 11 Guidelines.
5. Consider introducing other innovative measures regarding location, including, but not limited to, requiring health warnings and messages to be printed on the filter overwrap portion of cigarettes and/or on other related materials, such as packages of cigarette tubes, filters and papers, as well as other instruments, such as those used for water pipe smoking.
6. Consider introducing plain packaging of tobacco products in order to enhance the efficacy of health warnings and prevent the use of misleading colours, terms, and images and advertising by the tobacco industry.
7. Develop legislation and regulations to prevent the tobacco industry making false and misleading claims about tobacco products, i.e. using terms such as "less harmful", "safer", "mild" and "light".

Country indicators

a. Health warnings that cover over 50% of the main display areas on tobacco product packaging are in place.
b. Graphic health warnings on tobacco product packaging are in place.

ACTIONS FOR WHO

1. Provide technical guidance and assistance for countries to effectively develop legislation to comply with Article 11 of WHO FCTC provisions and guidelines.
2. Provide examples and facilitate sharing of images for graphic health warnings.

WHO indicator

a. Number of countries that have received technical guidance, tools and assistance for WHO FCTC Article 11.

OBJECTIVE 2.4 Develop legal instruments and policies to ban advertising, promotion and sponsorship of tobacco products.

A comprehensive ban on all tobacco advertising, promotion and sponsorship (TAPS) is required under Article 13 of the WHO FCTC for all Parties within five years of the entry into force of the WHO FCTC. Evidence shows that comprehensive advertising bans lead to reductions in the numbers of people starting and continuing smoking. These bans should include indirect forms of TAPS, such as brand stretching, point-of-sale display of product and tobacco industry sponsored CSR programmes. A total ban on direct and indirect advertising, promotion and sponsorship, including the implementation of plain packaging of tobacco products, as provided in guidelines to Article 13 of the WHO FCTC, is one of the most cost effective ways to reduce tobacco demand and decrease tobacco consumption.

Regional target

a. One hundred per cent of countries have legislation and policies compliant with WHO FCTC Article 13 provisions and guidelines.

> **2014 Baseline:** 25% of Western Pacific Region countries have met deadlines for national legislation consistent with Article 13 (Bans on tobacco advertising, promotion and sponsorship).

ACTIONS FOR COUNTRIES

1. To develop legislation and related policies, regulations, ordinances, administrative issuances and other measures to ensure timely compliance with Article 13 of the WHO FCTC and its guidelines, including banning all cross-border and point-of-sale advertising and display.
2. Involve civil society as an active partner in the process of developing and ensuring compliance with laws.
3. Create awareness and work with all sectors of government to ensure that contributions from tobacco companies to any other entity for "socially responsible causes" are not accepted.

ACTIONS FOR WHO

1. Provide technical guidance, tools and assistance for countries to effectively draft laws and policies to comply with Article 13 of WHO FCTC provisions and guidelines.
2. Provide support and assistance for countries to denormalize CSR activities by the tobacco industry.
3. Provide technical support and legal assistance to countries considering tobacco plain packaging in addressing packaging.
4. Increase awareness about cross-border advertising and provide practical guidance to countries for relevant actions.
5. Facilitate international cooperation to monitor and address cross-border advertising.

WHO indicators

a. Number of countries that have received technical guidance, tools and assistance for WHO FCTC Article 13.

b. Number of countries working toward plain packaging.

OBJECTIVE 2.5 Ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products.

The Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to the WHO FCTC, was adopted on 12 November 2012 at the Fifth session of the Conference of the Parties in Seoul, Republic of Korea. The protocol was open for signature by all Parties to the WHO FCTC from 10 January 2013 until 9 January 2014. At the time it was closed for signature, 53 states and the European Union had signed the protocol.

The Protocol is subject to ratification, acceptance, approval or accession by States and to formal confirmation or accession by regional economic integration organizations that are Party to the WHO FCTC (Article 44).

To become a Party to the Protocol, Parties to the WHO FCTC that have signed the Protocol need to deposit an instrument of ratification (or acceptance or approval) with the Secretary-General of the United Nations at United Nations Headquarters in New York, the Depositary for the Protocol.

Parties to the WHO FCTC that have not signed the Protocol need to deposit an instrument of accession in order to become a Party.

The Protocol will enter into force on the 90th day following the date of deposit of the 40th instrument of ratification, acceptance, approval, formal confirmation or accession with the Depositary (Article 45).

The new treaty aims to eliminate all forms of illicit trade in tobacco products by requiring Parties to take measures to control the supply chain of tobacco products effectively and to cooperate internationally on a wide range of matters.

Countries are encouraged to become Parties to this protocol and to work towards its full implementation.

Regional target

a. Thirty per cent of Parties adopt (ratify or accede to) the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products.

> **2014 Baseline:** 0% of Western Pacific Region countries have adopted (ratified or acceded to) the WHO FCTC Protocol to Eliminate Illicit Trade in Tobacco Products.

ACTIONS FOR COUNTRIES

1. Conduct an evaluation of their legal, regulatory and policy frameworks in view of the requirements of the protocol in order to scope technical assistance and capacity-building needs.

2. Actively participate in the WHO FCTC process and activities of the COP and subsidiary bodies, and coordinate with other relevant sectors, particularly to ensure ratification of or accession to the Protocol to Eliminate Illicit Trade in Tobacco Products.

Country indicator

a. An instrument of ratification (or acceptance or approval) or accession is deposited with the United Nations Depository Library for the Protocol, the United Nations Secretary General at United Nations Headquarters in New York City.

ACTIONS FOR WHO

1. Provide Parties with technical guidance, tools and assistance on the Protocol to Eliminate Illicit Trade in Tobacco Products, in coordination with the WHO FCTC Secretariat.

2. Facilitate international information sharing on the protocol and a regional approach to tracking and tracing of tobacco products, in coordination with the WHO FCTC Secretariat and other relevant regional organizations.

WHO indicator

a. Number of countries that have received technical guidance, tools and assistance for becoming a Party to the Protocol to Eliminate Illicit Trade in Tobacco Products and ensuring implementation.

OBJECTIVE 2.6 Regulation of the contents and emissions of tobacco products.

The tobacco industry has been strategically designing tobacco products to make them more addictive, more attractive and more palatable in order to encourage their uptake and use. From the perspective of public health, there is no justification for

permitting the use of ingredients, such as flavouring agents, which help make tobacco products attractive and more palatable. Parties should consider tobacco product regulation, which has the potential to contribute to reducing tobacco-attributable disease and premature death by reducing the attractiveness and palatability of tobacco products, reducing their addictiveness and reducing their overall toxicity, in accordance with WHO FCTC Articles 9 and 10 Partial Guidelines.

Regional target

a. One hundred per cent of Parties adopt legislative measures to regulate contents and emissions of tobacco products.

> **2014 Baseline:** 70% of Western Pacific Region countries have legislation regulating the contents and emissions of tobacco products.

ACTIONS FOR COUNTRIES

1. Require manufacturers and importers of tobacco products to disclose information on contents and emissions of products to governmental authorities at specified intervals, and as appropriate, including the results of tests conducted by the tobacco industry and relevant regulatory authorities.
2. Take legislative or policy measures to regulate the contents and emissions of tobacco products and the disclosures of such, in accordance with WHO FCTC Articles 9 and 10 Partial Guidelines.

Country indicator

a. The country has adopted and implemented legislative, executive, administrative or other measures to regulate the contents and emissions of tobacco products and the disclosures of such, in accordance with WHO FCTC Articles 9 and 10 Partial Guidelines.

ACTION FOR WHO

1. Provide technical guidance, tools and assistance to regulate tobacco products in accordance with Articles 9 and 10 Partial Guidelines.

WHO indicator

a. Number of countries that have received technical guidance, tools and assistance to regulate and measure the contents and emissions of tobacco products.

OBJECTIVE 2.7 Regulation of electronic nicotine delivery systems (ENDS).

Recently, an increase in availability and affordability of electronic nicotine delivery systems (ENDS), known as electronic cigarettes or e-cigarettes, has been observed. Transnational tobacco companies have entered the ENDS market and are aggressively competing with smaller companies for market share.

Despite increased availability, most ENDS products are unregulated and have not been tested.

With limited evidence available, the use of ENDS requires further research to address serious public health concerns, including: (a) health risks to users and non-users; (b) efficacy in helping smokers to quit smoking and ultimately nicotine dependence; and (c) interference with tobacco-control efforts and implementation of the WHO FCTC.

Based on the evidence, ENDS should be adequately regulated by all countries:

- to impede promotion and uptake by non-smokers, pregnant women and youth;
- to minimize potential harms to ENDS users and non-users;
- to prevent unproven health claims about ENDS; and
- to protect tobacco control efforts from tobacco industry interference.

In order to implement these objectives, countries must take into account available national regulatory frameworks to provide solid regulatory grounds.

Regional target

a. One hundred percent of Parties adopt measures to regulate ENDS products.

> **2014 Baseline:** 25% of Western Pacific Region countries have regulatory measures for ENDS products.

ACTIONS FOR COUNTRIES

1. Undertake legislative or policy measures that prohibit unproven health claims for ENDS, ban the use of ENDS in public places, ban the sale of ENDS to minors, include health warnings with proven health risks of ENDS, and ban advertising, promotion and sponsorship of ENDS.

2. In countries that allow ENDS products, require manufacturers and importers of ENDS products to disclose information on the contents of products to governmental authorities at specified intervals and, as appropriate, include the results of tests conducted by the ENDS industry and regulatory authorities.

Country indicators

a. The country has adopted and implemented legislative, executive, administrative or other measures to prohibit unproven health claims for ENDS, banned the use of ENDS in public places, banned sales to minors, and banned/restricted advertising, promotion and sponsorship of ENDS.

b. The country has adopted and implemented legislative, executive, administrative or other measures to regulate the contents and emissions of ENDS products and related disclosure.

ACTIONS FOR WHO

1. Provide technical guidance, tools and assistance to support countries to regulate ENDS products.
2. Facilitate international information sharing and collaboration on regulation of ENDS products.

WHO indicator

a. Number of countries that have received technical guidance, tools and assistance to regulate and measure the contents and emissions of ENDS.

OBJECTIVE 2.8 Develop legal instruments and policies to implement effective minimum age restrictions for selling and purchasing of tobacco products.

Article 16 of the WHO FCTC requires all Parties to adopt and implement effective legislative, executive, administrative and other measures at the appropriate government level to prohibit the sales of tobacco products to people under the age set by domestic law, national law or 18 years of age. There is evidence that shows that

there is a relatively small window in life when an individual is at a greater risk of becoming addicted to tobacco. Over 80% of smokers started smoking before the age of 18. The tobacco industry is very aware of this fact and uses all kinds of strategies to get young people to experiment tobacco and become addicted

Regional target

a. One hundred per cent of countries have national policy and enforcement mechanisms to ban sales of tobacco products to minors.

> **2014 Baseline:** 35% of Western Pacific Region countries have a national policy to ban sales of tobacco products to and by minors.

ACTIONS FOR COUNTRIES

1. Ban the sale of tobacco products to or by individuals under the age of 18 (or minimum age set by domestic law or national law).

2. Ban the use of automatic tobacco-vending machines or at least ensure that tobacco-vending machines are not accessible to minors.

3. Ban the sale of cigarettes in small packets containing less than 20 cigarettes ("kiddie packs") or single sticks.

4. Establish a formal mechanism for the enforcement and monitoring of the compliance with the prohibition of sales to and by minors.

Country indicators

a. The country has adopted and implemented legislative action to ban sales of tobacco products to and by minors.

b. The country has a mechanism in place to ban sales of single sticks or small packets.

ACTIONS FOR WHO

1. Assist countries in the establishment and implementation of policies to ban sales to and by minors and sales of single sticks and small packets.

2. Share examples and best practices from other countries.

WHO indicators

a. Number of countries that have received WHO assistance to establish or enact policies that address sales to and by minors.

b. Number of countries that have banned and enforced sales of single sticks or small packets.

OBJECTIVE 2.9 **Protection of tobacco-control policies and legislation from tobacco industry interference: WHO FCTC Article 5.3 implementation.**

Article 5.3 of the WHO FCTC requires all Parties, when setting and implementing their public health policies with respect to tobacco control, to: "...act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law". Recognizing the fundamental and irreconcilable conflict of interest between the interests of the tobacco industry and those of public health, Parties to the WHO FCTC adopted Article 5.3 Guidelines in 2008. The guidelines highlight the critical importance for Parties to implement measures preventing interference by the tobacco industry in all branches of government that may have an interest in, or the capacity to affect, public health policies with respect to tobacco control.

Regional targets

a. One hundred per cent of countries have national policy, (i.e. legislation, codes of conduct, guidelines, etc.) and enforcement mechanisms to implement WHO FCTC Article 5.3 Guidelines.

> **2014 Baseline:** 30% of Western Pacific Region countries have a national policy to address tobacco industry interference.

b. One hundred per cent of countries are monitoring the tobacco industry.

> **2014 Baseline:** 80% of Western Pacific Region countries report activities related to monitoring the tobacco industry.

ACTIONS FOR COUNTRIES

1. Countries should formulate, adopt and implement a code of conduct for public officials, prescribing the standards with which they should comply in their dealings with the tobacco industry and enforcement mechanism for public agencies' engagement with the tobacco industry, conduct of officials in dealings with industry and management of conflicts of interest.

2. Establish a formal mechanism for monitoring and responding to the tobacco industry's activities, consistent with Article 5.3 Guidelines.

3. Engage and seek support from civil society and build partnerships with nongovernmental organizations to utilize their expertise and experience in monitoring and responding to tobacco industry interference.

Country indicators

a. The country has adopted and implemented legislative, executive, administrative or other measures consistent with Article 5.3 and its guidelines.

b. The country has a mechanism in place to monitor compliance with Article 5.3 Guidelines.

ACTIONS FOR WHO

1. Disseminate guidelines and templates to facilitate full implementation of WHO FCTC Article 5.3 Guidelines.

2. Assist countries in the establishment and implementation of WHO FCTC Article 5.3 policy instruments and compliance monitoring systems.

WHO indicators

a. Number of countries that have received WHO assistance to establish or enact policies that address tobacco industry interference in tobacco control, consistent with WHO FCTC Article 5.3 Guidelines.

b. Number of countries that have received WHO assistance to establish policy instruments and compliance monitoring systems to monitor the tobacco industry.

STRATEGIC OUTCOME 3

Constituencies for enforcement

OBJECTIVE 3.1 Work with mayors, other local government authorities and community leaders.

National government authorities can strengthen tobacco-control enforcement by engaging with local government authorities and community leaders. Mayors and city authorities are emerging as staunch supporters of tobacco control and may have administrative and political power to pass, enforce and upgrade tobacco regulations. An increased number of mayors are enforcing smoke-free regulations that surpass national legislation, comprehensive bans on advertising, bans on sales to minors, and they also are investing in quit lines and other cessation services. Community leaders, on the other hand, can mobilize grassroots support for tobacco-control policy enforcement. Where appropriate, securing the buy-in from traditional leaders in the community guarantees enhanced public compliance with tobacco-control laws and regulations.

Protecting people from SHS is a strategic starting point for local authorities. Good planning and adequate resources are essential for successful implementation and enforcement of smoke-free legislation. Mayors or city authorities should involve the different municipal authorities such as local police, health agents, civic organizations and local news or media agencies to achieve their goal.

It is not enough for the public to know about regulations. Publicizing actions taken on violations of tobacco-control regulations and informing the public about the fines or consequences for violations is a key to effective enforcement.

Local governments tend to learn from each other. City-to-city learning has proven to be one of the most effective ways to disseminate best practices.

Regional target

a. One hundred per cent of countries have at least one major jurisdiction (e.g. city, town, island) with smoke-free ordinances that are compliant with Article 8 of the WHO FCTC.

> **2014 Baseline:** 95% of Western Pacific Region countries with at least one jurisdiction enacting smoke-free ordinances compliant with Article 8 of the WHO FCTC.

ACTIONS FOR COUNTRIES

1. Identify cities that are leading the way as smoke-free cities and work with them to support other local governments in developing ordinances, regulations and enforcement strategies for tobacco-control measures involving the various stakeholders with clear definitions, roles and responsibilities in accordance with the guidelines for implementation of WHO FCTC Articles 5.3, 8, 11 and 13.

2. Support local government authorities to develop communication campaigns and public service announcements as part of the enforcement strategy to raise awareness of harm caused by tobacco and SHS and of the existing laws and policies.

3. Support local jurisdictions to establish legal responsibilities for compliance for both affected business establishments and individual smokers and provide fixed penalties for violations, where appropriate.

4. Support local jurisdictions to ensure training and resources for police or other enforcement agents.

5. Support local jurisdictions to involve media and civil society in city activities.

6. Support local jurisdictions to establish a system for publicizing enforcement and consequences on violators for offences.

7. Support local jurisdictions to monitor and report the enforcement of tobacco-control measures and determine reasons for non-compliance.

Country indicators

a. A national plan is in place to mobilize cities and local government authorities for tobacco control.

b. Number of smoke-free cities, towns, islands, and other local jurisdictions in the country.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools.

2. Create opportunities for city-to-city learning. Share success stories and materials from other cities.

3. Support and engage with networks of tobacco-free or smoke-free cities in countries and other relevant alliances and networks in countries.

4. Support countries in their efforts to mobilize resources for city- and community-based tobacco-control efforts.

WHO indicator

a. Number of countries that have been assisted to establish tobacco-free cities and communities.

OBJECTIVE 3.2 Expand smoke-free World Heritage Sites and support efforts towards smoke-free tourism.

World Heritage Sites attract hundreds of thousands of tourists throughout the Region. Tobacco control programmes protect people and minimize environmental risks and hazards, such as fires. Enforcing tobacco-control laws and regulations at these sites and in their surroundings shows the public that establishing 100% smoke-free public places is possible and is a good example that can be replicated.

Regional targets

a. Seventy-five per cent of countries to have smoke free World Heritage Sites.

> **2014 Baseline:** 60% of countries have smoke free World Heritage sites.

b. Fifty per cent of countries have incorporated smoke-free policies into their tourism plans.

> **2014 Baseline:** 30% of Western Pacific Region countries with smoke-free policies incorporated into their tourism plans.

ACTIONS FOR COUNTRIES

1. Encourage all World Heritage Sites and other tourist sites in the country to become smoke free and to ban the sales and advertising of tobacco products.
2. Provide financial and material resources for World Heritage Sites to go smoke free.

3. Ensure that "No Smoking" signs or other relevant signs are clearly shown at the entrance of the site and at other appropriate areas.
4. Set up a mechanism for reporting violations taking enforcement action.
5. Publicize and recognize achievements at national and international events using the "Blue Ribbon Awards" that were introduced at the World Conference on Tobacco or Health in 2012 or equivalent programmes.
6. Share the initiative with other World Heritage Sites in the Region and around the world.
7. Engage with tourism authorities to implement smoke-free measures as part of their overall tourism plan.

Country indicators

a. Proportion of World Heritage Sites in the country that are tobacco free.

b. Number of tourism sites that have become smoke free.

c. Smoke-free policies have been introduced into the development and implementation of tourism plan.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools for smoke-free World Heritage Sites and other tourist sites.
2. Support capacity for "Blue Ribbon Awards" or equivalent programmes in countries.
3. Share success stories and materials from other countries.
4. Engage and work with tourism authorities.

WHO indicators

a. Number of countries that have received technical and legal assistance from WHO on smoke-free World Heritage Sites.

b. Number of countries that have been assisted to incorporate smoke-free policies into their tourism plans.

OBJECTIVE 3.3 Accelerate actions for Tobacco Free Pacific 2025 with a strategic focus on 100% smoke-free public places.

The Pacific island countries and areas played a key role in the entry into force of the WHO FCTC. Steady progress is being made, particularly in the area of tobacco taxation. A number of countries have yet to update their national tobacco-control laws. Greater efforts are needed to regulate 100% smoke-free policies, not only to protect non-smokers from the effects of exposure to second-hand smoke but also to denormalize the use of tobacco. Governments can immediately declare public places controlled by the government such as all government offices and buildings, other workplaces, hospitals, health facilities, schools, public transport tourist sites, and other public places 100% smoke-free and prohibit government officials to smoke in public. This will create irreversible progress to create momentum for comprehensive tobacco control. Some countries still have unacceptably high rates of tobacco use. Tobacco chewing with betel nut is a specific concern that needs attention. In response to this, at the 2013 biennial meeting of Pacific health ministers, the ministers agreed to adopt a collective goal of Tobacco Free Pacific by 2025, which is defined as achieving an adult tobacco use prevalence of less than 5% in each country. While this is an ambitious goal, given the scale and size of some countries, strong political support for a "cohesive tobacco-control system" with participation of relevant sectors including health, trade, commerce, finance and customs is possible and each Pacific island country and area can come up with specific laws, regulations and enforcement measures that can be implemented with support from community and local leaders. Furthermore, these countries can help each other in reaching their common goal by sharing success stories and practices that work in the Pacific countries.

Regional target

a. All Pacific island countries and areas are on track in reducing smoking prevalence consistent with country specific goals for Tobacco Free Pacific 2025.

> **2014 Baseline:** None of the Pacific island countries and areas have tobacco consumption prevalence of 5% or below.

ACTIONS FOR COUNTRIES

1. Accelerate the work towards the passing of national 100% smoke-free legislation.

2. In the absence of legislation to ban smoking in public places, declare all government offices and buildings, hospitals, health facilities, schools, public transport and tourist sites, and other government controlled public places completely smoke-free.
3. Participate in the establishment of the Tobacco Free Pacific Network.
4. Use WHO FCTC country needs assessment recommendations to update legislation and enforcement.
5. Mobilize youth and sports for tobacco control efforts.
6. Promote and expand smoke-free environments ("Blue Ribbon campaigns" or other such campaigns).
7. Review and raise tobacco taxes as needed.
8. Conduct policy dialogues on betel nut and tobacco chewing.
9. Establish accessible cessation services.
10. Establish mechanisms for monitoring and evaluating progress.
11. Address the issue of locally grown and untaxed loose leaf tobacco.

Country indicator

a. A plan towards Tobacco Free Pacific 2025 has been developed and implemented highlighting taxation, smoke-free policies, tobacco advertising promotion and sponsorship bans and graphic health warnings.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines and recommendations to support Pacific island countries and areas in developing their Tobacco Free Pacific 2025 plans.
2. Facilitate the development of the Tobacco Free Pacific Network.
3. Share success stories and materials from other countries.
4. Support countries in their efforts to mobilize resources for a Tobacco Free Pacific 2025.

WHO indicator

a. Number of Pacific island countries and areas supported to implement and enforce WHO FCTC compliant legislation and to develop action plans to reach 2025 objectives.

OBJECTIVE 3.4 Support the global movement for smoke-free workplaces.

Partnerships between private sector companies, local governments and tobacco-control advocates toward smoke-free workplaces are slowly gaining ground in several countries. Employers are seeing the benefits in terms of worker productivity, decreases in medical claims and reduction in absenteeism due to tobacco-related disease.

Regional target

a. One hundred per cent of countries have smoke-free workplace policies that are compliant with the WHO FCTC.

> **2014 Baseline:** 85% of Western Pacific Region countries with national legislation mandating smoke-free workplaces.

ACTIONS FOR COUNTRIES

1. Develop and implement smoke-free legislation to include all workplaces.
2. Support and engage with employers and private sector companies that desire to implement smoke-free workplaces.
3. Ensure that smoke-free workplaces are addressed in the national tobacco-control plan.
4. Promote the use of "No Smoking" signs at all relevant sites, such as entrances of the site and at other needed areas.
5. Set up internal mechanisms for reporting violations and enforcing penalties.
6. Publicize and recognize achievements at national and international events.
7. Share smoke-free workplace initiatives and best practices with other countries.

Country indicator

a. A national smoke-free workplace campaign is implemented with partners from the private and public sectors.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools for smoke-free workplaces.
2. Facilitate sharing of success stories and materials from other countries.

WHO indicator

a. Number of countries that have received technical and legal assistance from the WHO in relation to smoke-free workplaces and are working towards smoke-free policies in workplaces.

OBJECTIVE 3.5 Empower organizations of women and youth.

The rise in tobacco use among women and girls is noted in almost all countries in the Western Pacific Region. This is not surprising as it is strongly linked to increased marketing and advertising that targets women. Similarly, girls and boys are often the target audience for the tobacco industry marketing. Public awareness about this problem and the mobilization of organized groups that advocate for the rights, health and well-being of women, girls and boys will help strengthen advocacy efforts and enforcement of laws and regulations on marketing, promotion, advertising and sale.

Regional target

a. One hundred per cent of countries are actively working with organizations for women and youth as part of their national action plan for tobacco control.

> **2014 Baseline:** 75% of Western Pacific Region countries actively working with organizations for women and youth as part of their national action plan for tobacco control.

ACTIONS FOR COUNTRIES

1. Identify organizations of women and youth that are concerned with rights, health and well-being and show them data about increasing trends of use of tobacco products and the associated harms.

2. Provide financial and material resources for education and enforcement campaigns in the community and public places in partnership with these organizations.
3. Conduct public awareness campaigns that highlight the issue of aggressive marketing of tobacco products targeted at women and girls.
4. Set up a mechanism for reporting marketing, promotion, advertising and retail that targets women and youth.
5. Publicize and recognize achievements at national and international events.
6. Share the initiative with counterparts in other countries.

Country indicator

a. The national tobacco-control plan includes engagement with organizations that advocate for rights, health and well-being of women and youth.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools for organizations that advocate for the rights, health and well-being of women and youth.
2. Share success stories and materials from other countries.

WHO indicator

a. Number of countries that have received technical and legal assistance from WHO on working with organizations for women and youth.

OBJECTIVE 3.6 Reach out to vulnerable and marginalized groups.

Vulnerable and marginalized groups and populations are at high risk for tobacco advertising, promotion and marketing. Smoking prevalence rates are invariably higher among vulnerable and disadvantaged groups, even in countries where national smoking prevalence is declining. Equity-enhancing, gender-responsive and human rights-based approaches are therefore needed. Special efforts are needed to reach out to indigenous groups, informal settlers, the urban and rural poor, migrants, communities displaced by disasters and emergencies among others. The tobacco industry has used CSR as a justification for donating funds, food, relief and even tobacco products to vulnerable and marginalized groups to promote their corporate image. This violates Article 5.3 of the WHO FCTC and should be resisted.

Regional target

a. One hundred per cent of countries include vulnerable and marginalized groups in their national tobacco-control action plans.

> **2014 Baseline:** 60% of Western Pacific Region countries address vulnerable and marginalized groups in their national action plan for tobacco control.

ACTIONS FOR COUNTRIES

1. Identify areas or population groups within the country where tobacco use is above the national average and try to understand underlying reasons and factors that contribute to this.

2. Provide financial and material resources for targeted information campaigns and services to implement laws or provide quit support.

3. Set up a mechanism for monitoring industry advertising, promotion and retailing among vulnerable and marginalized groups, including CSR.

4. Engage communities and families in understanding vulnerability and risks for tobacco use.

Country indicator

a. The national tobacco-control plan includes analysis of high-risk populations and actions to address aggressive marketing among vulnerable and marginalized groups.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools for visualizing and addressing inequities inside the country and addressing these.

2. Share success stories and materials from other countries.

3. Provide mechanism for monitoring CSR activities across countries, reporting and sharing of information.

WHO indicators

a. Number of countries that have received technical and legal assistance from WHO on addressing tobacco-control inequities.

b. A regional mechanism for monitoring and disseminating CSR activities is in place.

OBJECTIVE 3.7 Work with organizers of sports, arts and cultural mega events.

Global, regional, national and local sports competitions and events, such as the Southeast Asian Games, the Pacific Games in July 2015 and again in 2019, and the 2020 Olympic Games, create good opportunities to advocate for tobacco-free events. Tobacco and sports should not mix and advocacy may be needed to ensure that venues for sports are completely smoke-free to protect athletes and spectators. Mega events such as exhibits, trade fairs, expositions and similar events draw people to crowded venues where SHS exposure could pose serious harm to health. Sports and mega events are usually covered by media. Advertising and promotion of tobacco should not be allowed at these events. Comprehensive bans on smoking in venues should be enforced. Counter-advertising and public service announcements that promote health should be encouraged.

Regional targets

a. One hundred per cent of countries are working toward policies on tobacco-free sports and mega events.

> **2014 Baseline:** 60% of Western Pacific Region countries with policies on tobacco-free sports and mega events.

b. Smoke-free policy in effect for the Pacific Games in 2019, Southeast Asian Games by 2020 and the 2020 Olympic Games in Japan.

ACTIONS FOR COUNTRIES

1. Ensure that all sports, arts or cultural mega events organized in the country are smoke-free regardless of the existing national tobacco-control laws or regulations. This means that tobacco will not be sold, advertised or used in the event premises or surroundings during the whole duration of the event or in public transportation vehicles to and from venues.

2. Develop a communication plan making the policy known to the public prior and during the event.

3. Ensure that the mega event organizers have the capacity to enforce the tobacco-free event by having trained staff and volunteers so that they can communicate and enforce the tobacco-free policy and report violations.

4. Ensure that signage is displayed appropriately.

5. Record the experience and share with other sports and mega event organizers in the country.

6. Develop national policies declaring sports and mega events as tobacco-free.

Country indicator

a. A plan is in place and implemented towards ensuring that all sports and mega events are tobacco free.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools on tobacco-free sports and mega events.

2. Engage national, regional and international sports bodies in developing and implementing policies for smoke-free sports events.

3. Share success stories and materials within and across countries.

WHO indicator

a. Number of countries that have received technical and legal assistance from WHO on tobacco-free sports and mega events.

OBJECTIVE 3.8 Work with the entertainment industry to ban scenes with the use of tobacco products and ban tobacco product placement in television shows and movies.

Where comprehensive bans on tobacco advertising on radio and television have been implemented, the tobacco industry has resorted to indirect product placement through images and scenes in films, television shows, reality shows, soap operas and Internet games. Legislation and other regulatory measures are needed to ban indirect advertising in movies and television as part of Article 13 compliance. On-screen smoking and other tobacco use benefits the tobacco industry and increases youth smoking initiation. Therefore, measures to limit exposure of young people to images with smoking, other tobacco use or tobacco product placement should be part of enforcement of Articles 11 and 13. Policy-makers must take into account the rapid evolution of media and the emergence of new media platforms in order to provide "future-proof" solutions.

Regional target

a. One hundred per cent of countries have national tobacco-control plans that include a policy to engage with the film industry to ban the portrayal of tobacco use in TV or films.

> **2014 Baseline:** 40% of Western Pacific Region countries with policies that ban the portrayal of tobacco use in TV or films.

ACTIONS FOR COUNTRIES

1. Establish dialogue with national film producers, the television industry and theatre companies to create awareness about the harmful effect of showing tobacco use and tobacco products in media.
2. Work with the entertainment industry to identify and promote tobacco-free role models for youth and to voluntarily remove harmful content at the source ("upstream").
3. Rating ("downstream") through "for adults only" though less desirable, may also be considered to protect young people from exposure to tobacco products indirect advertising.
4. Consider incentives such as tax breaks to movies and television networks that eliminate the portrayal of smoking or use of other tobacco products.

Country indicator

a. The national tobacco-control plan addresses engagement with the local entertainment industry to ban scenes with tobacco use or tobacco product placement, and to include health warnings when such scenes are shown.

ACTIONS FOR WHO

1. Explore and assess international opportunities and actions for working with the international film industry to promote tobacco-free movies.
2. Provide technical assistance, guidelines, recommendations and tools for tobacco-free movies and television programmes.
3. Share success stories and materials from other countries.

WHO indicator

a. Number of countries that receive support from WHO on tobacco-free movies and television programmes.

OBJECTIVE 3.9 **Create mechanisms for partnership with public health lawyers and policy and regulatory experts' networks.**

As tobacco-control laws are passed and regulations are enforced, there will be an increasing need for legal support as the tobacco industry will use legal and trade issues to derail policy and enforcement and to litigate against governments to divert resources from WHO FCTC implementation. The trade arena and the WTO in particular has been the platform for a dispute on tobacco plain packaging. Bilateral trade agreements have also been used to oppose tobacco control across borders.

Furthermore, initiating lawsuits against the tobacco industry is an effective tobacco-control measure consistent with Article 19 (Liability) of the WHO FCTC.

Working with public health legal experts and networks of lawyers will help anticipate and respond to obstacles that are created by the tobacco industry.

Regional target

a. Institutionalized partnerships through memoranda of understanding (MoUs), agreements and declarations.

> **2014 Baseline:** 90% of Western Pacific Region countries where the national tobacco-control team has ready access to legal experts.

ACTIONS FOR COUNTRIES

1. Ensure that the national tobacco-control team has ready access to legal expertise.
2. Facilitate capacity-building on legal issues in tobacco control among government staff.
3. Consider opportunities to implement Article 19 (Liability) of the WHO FCTC.

Country indicators

a. The national tobacco-control team has accessed the necessary legal expertise to address legal issues regarding tobacco-control policy development and/or implementation.

b. Number of government staff members who have received training in legal issues in tobacco control.

ACTIONS FOR WHO

1. Facilitate opportunities for training in legal issues in tobacco control.
2. Create and facilitate a platform for discussion, exchange of information and best practices in legal strategies when governments are sued by the tobacco industry as well as implementation of Article 19 of the WHO FCTC on liability and lawsuits against the tobacco industry.
3. Create a regional roster of lawyers and experts in legal issues in tobacco control who would be willing to assist countries.
4. Provide technical support for the implementation of Article 19 (Liability) of the WHO FCTC.

WHO indicators

a. Number of government officials that have participated in training in legal issues in tobacco control and are sponsored through WHO.

b. A platform for exchange of information on legislative and policy and best practices has been created.

c. A regional roster of lawyers trained in legal issues relating to tobacco control has been created.

OBJECTIVE 3.10 Sustain and expand partnerships with tobacco-control advocates and civil society.

Civil society and tobacco-control advocates play a central role in national tobacco control efforts. Partnership between government and civil society is fundamental and should be recognized as a key element for success. Civil society has taken the lead in tobacco-control efforts for decades. The ability of civil society to engage, mobilize and advocate for policy change, enforcement and upgrading of tobacco-control efforts is crucial.

Regional targets

a. Formalize partnerships with civil society groups through MoUs agreements and declarations in 50% of countries.

> **2014 Baseline:** 100% of Western Pacific Region countries report strong and successful partnership with civil society.

b. One hundred per cent of countries from the Pacific are working with civil society partners in the development of the Tobacco Free Pacific Network.

> **2014 Baseline:** 65% of Pacific island countries and areas working with civil society partners in the development of the Tobacco Free Pacific Network.

c. One hundred per cent of ASEAN countries are working with civil society towards Smoke-Free ASEAN.

> **2014 Baseline:** 85% of ASEAN countries working with civil society partners in the establishment of a Smoke-Free ASEAN.

ACTIONS FOR COUNTRIES

1. Work closely with civil society groups in policy development and in enforcement efforts of the various tobacco control measures at national and regional levels (e.g. Tobacco Free Pacific Network, Smoke-free ASEAN, among others).
2. Work collaboratively with partners to strengthen tobacco-control efforts and provide logistical, material and financial support.
3. Ensure wide engagement and broad participation of civil society and communities in policy dialogues and international events.
4. Encourage and enable civil society partners to lead and activate support from other organizations and stakeholders.

Country indicator

a. Civil society partners are involved in policy development and implementation strategies.

ACTIONS FOR WHO

1. Provide technical assistance, guidelines, recommendations and tools to help government improve on engagement with civil society partners.
2. Share success stories and materials from other countries.
3. Facilitate the interaction and collaboration among civil society groups from various countries.

4. Involve civil society partners in planning implementing and evaluating regional activities.

WHO indicator

a. Number of civil society groups that are actively engaged in planning, implementation and evaluation of the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019).*

OBJECTIVE 3.11 Health professionals and academics.

Health professionals have a pivotal role in tobacco control. Across the world, health professionals are often highly respected community leaders who have "the greatest potential of any group in society to promote a reduction in tobacco use, and thus, in due course, a reduction in tobacco-induced mortality and morbidity."[8] Physicians, nurses and other health professionals can assist in sustaining progress in tobacco control in several ways:

- as prominent community members, by serving as tobacco-free role models for their communities;
- as clinicians, by providing brief tobacco cessation advice and more intensive cessation therapies consistently to all their patients;
- as researchers and academicians, by directing the conduct of evidence-based surveillance and research into the tobacco epidemic and the impact of tobacco-control measures on their population;
- as leaders of their professional organizations and health institutions, by ensuring the adoption of a code of practice consistent with the goals and articles of the WHO FCTC and the 2004 WHO Code of Practice on Tobacco Control for Health Professional Organizations;[8] and
- as opinion leaders and health experts, by publicly supporting and advocating for full implementation of the WHO FCTC.

Specific actions that health professional organizations can implement to contribute actively to reducing tobacco consumption and to promote tobacco control and the WHO FCTC in the national public health agenda are outlined in the *2004 WHO Code*

8. Simpson D., Doctors and Tobacco: Medicine's Big Challenge, Tobacco Control Resource Centre, 2000.

of Practice on Tobacco Control for Health Professional Organizations. Actions related to cessation, health professional education, and research and surveillance are covered in the previous sections of this plan of action.

Regional targets

a. One hundred per cent of regional health organizations have adopted the *2004 WHO Code of Practice for Health Professional Organizations* or a similar code of practice.

> **2014 Baseline:** To be determined.

b. One hundred per cent of countries have participated in a regional leadership-training workshop for health professionals.

> **2014 Baseline:** To be determined.

ACTIONS FOR COUNTRIES

1. Engage with key health professionals and health professional organizations to ensure their participation in tobacco-control policy development and enforcement, as well as advocacy against the tobacco industry.

2. Advocate for widespread adoption of the *2004 WHO Code of Practice for Tobacco Control for Health Professional Organizations* across the various health professional groups, educational institutions and health-related academic organizations.

3. Invest in tobacco control leadership capacity-building among influential members of the health professional community, including health professionals who hold political office, heads of health professional societies and organizations, deans of medical and allied medical colleges and universities, hospital administrators, health facility managers, and others.

Country indicators

a. A critical mass of health professional groups, educational institutions and other health-related organizations have adopted the *2004 WHO Code of Practice for Health Professional Organizations* or a similar code of practice that ensures tobacco-free organizational practices and infrastructures.

b. Influential health professionals within the country have undergone tobacco-control leadership capacity-building.

ACTIONS FOR WHO

1. Assist countries in widely disseminating and promoting the adoption of the *2004 WHO Code of Practice for Tobacco Control for Health Professional Organizations.*

2. Convene tobacco-control leadership training workshops targeted towards influential health professionals in an effort to build their capacity as tobacco-free community role models, WHO FCTC advocates, cessation service providers, experts to counter tobacco industry tactics/deception, and tobacco-control opinion leaders.

WHO indicators

a. Number of health professional organizations and their national counterparts that have adopted the *2004 WHO Code of Practice for Health Professional Organizations* or similar code of practice.

b. A tobacco-control leadership curriculum specifically for health professionals has been developed and rolled out for dissemination across the Western Pacific Region.

4. How the regional action plan will be implemented, supported and evaluated

All three levels of WHO (headquarters, the Regional Office and country offices) will work with countries and other partners towards accelerated implementation of the WHO FCTC.

Regional nongovernmental organizations (NGOs) such as Southeast Asia Tobacco Control Alliance (SEATCA) and the Framework Convention Alliance (FCA) will play an essential role in working with countries and WHO in the implementation of the Regional Action Plan (RAP).

Tobacco control is a fundamental component of achieving timely implementation and achieving targets of the regional and global NCD action plans. Tobacco control will also be a key aspect of the work that WHO is doing with other United Nations agencies, in particular with the United Nations interagency task force for the prevention and control of NCDs, and other intergovernmental organizations such as Secretariat of the Pacific Communities (SPC) and ASEAN for the complete implementation of the WHO FCTC and towards the achievement of the national regional and global targets.

A midterm evaluation of the progress achieved in the implementation of the *Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015–2019)* will be conducted in 2017 and reported to the Regional Committee.

Orchids thrive only in smoke-free air.
So do your lungs.

World Health Organization
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