National Tobacco Control Strategic Plan (2013-2016)

Government of Nepal
Ministry of Health and Population
National Health Education, Information and Communication Center
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FOREWORD

PREFACE

Acknowledgement

Ministry Health and Population, Government of Nepal has formulated, approved and implemented most of the tobacco control policies, which are in the process of implementation extensively. In this process, tobacco control strategic plan is essential to better implement these policies particularly legislation.

I would like to express my gratitude to Dr. Praveen Mishra, Secretary for Ministry of Health and Population and Dr. Mingmar Galzen Sherpa, Director General of Department of Health Services for their guidance.

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Badri Bahadur Khadka
Director, NHEICC

1. Introduction

1.1 Background

Use of tobacco is very common in Nepal, almost every household uses tobacco products. The smoked tobacco products include cigarettes, *bidi, Hukka and chilim or kankad*. The smokeless tobacco use is also very common particularly in Terai belt of Nepal and it is gradually spreading to other parts of Nepal. The smokeless tobacco products (STPs) include khaini, gutkha and surti leaves and pan, containing tobacco. The traditional forms of smoking such as Kankad/sulfa/chilim and Hukka are eroding fast for several reasons. Firstly, manufactured cigarettes are extensively available throughout the country. Secondly, there was heavy promotion of cigarettes in the past. Thirdly, many cigarette brands are cheap and easily available in any grocery and teashops or others sell cigarettes throughout the country. Fourthly, cigarette smoking is considered to improve social status. Fifthly, smoking of Kankad/sulfa calls for the availability of specially-processed tobacco and specially-prepared clay pipe. Sixthly, in the past, many farmers grew tobacco for their own consumption, which hardly exists these days. The 2000 Smoking Behaviour Survey found only about 0.15% households producing tobacco for home consumption (Karki et al 2000).

In May 2003, World Health Assembly passed a resolution adopting the Framework Convention on Tobacco Control (FCTC), a global treaty to control tobacco entered into force in February 2005. It is a powerful tool for dealing with tobacco-related global public health challenges. Government of Nepal signed the FCTC on 3 December 2003 and the House of Representatives ratified the framework on 7 Nov. 2006. The Tobacco Product Control and Regulatory Act, 2011 was signed by President Dr. Ram Baran Yadav on April 29, 2011. The act has incorporated key provisions of FCTC and MPOWER measures. It has provisions for smoke-free public places, work places and transportation; bans on tobacco advertising, promotion and sponsorship (TAPS), and bans on tobacco sales to minors (below 18 years). More importantly, it has a provision that 75 percent of the tobacco product's including cigarette packet must be covered with graphic warning messages.

Governmental and non- governmental organizations including public health and medical organizations are involved in the prevention and control of tobacco use. This is done through interactions, meeting, workshops, school sessions, television, radio, newspapers, magazines, posters and pamphlets. Although a large proportion of adults are aware of the hazards of smoking, a number of smokers are still not concerned about the effects on their own health, or on the health of others. The health hazards of tobacco use are also included in school textbooks.

During the Nepal Health Sector Programme-I, 2004-2009, tobacco control had not received adequate attention but in NHSP2, 2010-2015, it has received high priority particularly of demand reduction strategy (MoHP, 2010, MOHP, SOLID/Nepal, WHO 2008) in order to help prevention and control NCDs.

1.2 Prevalence of tobacco use and mortality

Despite the efforts made by the government and non government organizations, the current use of tobacco (both smoked and smokeless forms) among men has decreased slightly in the last 5 years; it has decreased from 56.5% in 2006 to 52% in 2011. Among current men users, 30 percent smoke tobacco and 38 percent use smokeless tobacco. But the proportion of current users (smoked and smokeless) among women has decreased from 19.6% in 2006 to 13.3 in 2011. Among them, 8.7 percent smoke cigarette and 6.7 percent use smokeless tobacco (MoHP, New Era, ICF International Inc, 2012). The provenance of smoking among pregnant women has decreased markedly from 10 percent in 2006 to 5% in 2011.

The rate of current smokers among the women has decreased markedly from 15.2% percent in 2006 to 8.7 percent in 2011. The prevalence of tobacco use among male adolescents (15-19) is 24.2 percent in 2011. It is evident from age cohort of NDHS 2011 that current use of smoking and smokeless tobacco among 45-49 age group is nearly three times higher (46%) than 15-19 age group (13.1%). However, it is still at alarming stage and has been remained a major public health problem in Nepal. The tobacco hits hard the poor, uneducated and rural men. The prevalence of smoking was 39% in the lowest quintile compared to 23.7% in highest quintile. The rate is nearly 3 times higher among illiterates (50 percent) compared to SLC and above (18.1%). The prevalence of smoking was higher in rural area (31%) compared to urban (25%). Topographically, the prevalence was highest (49%) in the western mountain region and lowest (21.8) in the western hill (MoHP, New Era, ICF International Inc, 2012).

World Health Organization- Non Communicable Diseases (NCD) STEPS survey in Nepal (2008) showed that the current tobacco users (both smoke and smokeless forms) in total population were 37.1 percent with the difference of 53% in men and 19 percent in women. Of them, 26.2 percent were currently smoking (35% men and 15.9 % women). Among the current smokers, 23.8 % (men 31.2% and women 15.5%) were daily smokers. One in ten (12%) young people aged 15-24 smoked compared to six in ten (60%) among 55-64 age-groups. Among current users, about one fourth (23.8%) were daily users. Population aged 15-64, smoked on average 8 sticks of cigarettes of manufactured and/or hand rolled cigarette and 9 sticks of bidis daily. The highest sticks smokers were aged 45-54, who smoked on an average of 9.7 sticks on a day. Of them, 73% consumed manufactured cigarette. In case of gender, 31% of males and 15% of females were daily smokers (MoHP, SOLID, WHO 2008, p. 22-26). The mean age of starting smoking is 20 years with confidence interval of 17.7 to 22.4 years.

The majority of respondents (52.5%) who ever smoked did so because of influence from friends. The second most important reason for smoking appears to be the influence of parents or other senior family members who smoked. Family influence appears to be more prominent among the females (23.7%) than among the males (15.9%) in encouraging people to smoke. Other reasons cited were personal inquisitiveness (7.7%), one's own liking to smoke (7.9%), worry (4.8%) and influence of siblings (0.7%). Some 4.5 per cent women started to smoke because their husbands (Pande, Karki, & Pant, 2001).

According to WHO estimate, cancer of the trachea, bronchus and lung accounted for 19 deaths per 100,000 populations and 64% of these deaths attributed to tobacco. Within the communicable disease group, deaths attributed to tobacco accounted for 6% of all lower respiratory tract infection deaths and 8% of all tuberculosis death. The death rate due to tobacco in men was (261 per 100,000 men aged 30 years and over) compared with women (25 per 100,000). The proportion of deaths attributable to tobacco was almost 15% for men and 2% for women. Among those who died prematurely, almost one in every 13 deaths among those aged 30-44 years and one in 10 among those aged 45-59 years were attributable to tobacco use. Of those who died in the 45-59 year age bracket, tobacco use accounted for 6.8% of those whose death was due to a lower respiratory infection, 17% of deaths due to the category of 'all cardiovascular diseases combined', and 60.8% of those who had died from cancer of the trachea, bronchus and lung (WHO, 2012).

2. Rationale

- Reducing the death rate due to tobacco in men (261 per 100,000) is really a greater challenge to the Ministry of Health and Population. The morbidity or impairment of health caused by tobacco is more widespread.

- Spending on tobacco products and costs of illnesses due to tobacco use are well documented. Smoking rates are higher among the poorest men (39%) than wealthiest (23.7). Almost (92%) of the people think that money spent to buy tobacco products make the people poor (MoHP, SOLID, WHO 2008). Poor disproportionately share the burden of disease due to tobacco.

- People consume tobacco at the expenses of basic necessities. Tobacco users are at much higher risk of falling ill and dying prematurely of cancers, heart attacks, respiratory or other tobacco-related diseases. These catastrophic spending pushes the people below the poverty line.

- On the environmental front, tobacco smoke pollutes the environment, tobacco growing and curing contributes significantly to deforestation. The heavy use of pesticides needed to protect the tobacco plant pollutes ground water.

- Nepal has passed the Tobacco Product (Control and Regulatory) Act, 2011 that restricts smoking and use of tobacco in airports, hotels, bar, restaurants, factories and industries, health and education institution, playing areas, religious places, department store and mini market, government offices and other such public places, work places and public transportation. It bans all types of tobacco advertising, promotion and sponsorships (TAPS) activities. In addition to this, graphic warning messages should cover at least 75% of the total tobacco pack area.

A set of aggressive interventions are essential to prevent the deaths, disability, economic loss and environmental degradation from tobacco use.

3. Target and Goal

3.1. The target of this plan for tobacco control is to reduce relatively a 30% in prevalence of current tobacco use in persons aged 15+ years.

3.2. The goal of this plan is to reduce the mortality attributable to tobacco (death rate due to tobacco in men from 261 in 2012 to 250 per 100,000 men, and from 25 to 20 per 100,000 women aged 30 years and above by the year 2016; and reduce the morbidity caused by tobacco.

4. Objectives

- To reduce prevalence of tobacco use (both smoked and smokeless forms) from 52 percent in 2011 to 40% in 2016 among the men and in case of women from 13.3% in 2011 to 10% by the year 2016.
- to reduce the smoking rates among men aged 15-19 year olds from 13.1% in 2011 to 8.5% by the year 2016 and 0.5% in 2011 to 0.1% by the year 2016 in case of women and smoking in pregnancy from 5 % in 2011 to 3% by the year 2016.
- to reduce the current tobacco use rates among boys from 24.6% in 2011 to 18.5% by the year 2016 and 16.4% in 2011 to 12.5% by the year 2016 in case of girls aged 13-15 year olds.

4.1 Specific Objectives

- To strengthen the capacities of individuals, institutions, and communities in tobacco control
- To intensify and strengthen the action against smoked and smokeless tobacco use
- To accelerate the implementation of tobacco control legislation, FCTC, and MPOWER

5. Strategies and Activities

Following strategies and activities are planned to achieve the above objectives.

5.1 Capacity Enhancement

Capacity building for tobacco control is much more complex and needs more technical, financial and other resources than what meets the eye. It is also complicated in the sense that many disciplines and sectors have to be involved in such efforts and should include agencies and individuals working at national and sub national levels. The MoHP has adapted the capacity enhancement model developed by Chris Potter and Richard Brough. It focuses on the

tools development, skills transfer, staff and infrastructure, structure, role and system development.

Individual staff capacity on legislation, monitoring and evaluation, epidemiological and economic studies for tobacco control is relatively weaker in the NHIECC and Department of Health Services. Training and orientation for non -state stakeholders will also be organized to build the capacity in controlling the use of tobacco. A toolkit will be developed and orientated to these individuals for the effective implementation of tobacco control programme. The tobacco control related public offices will be equipped for surveillance of tobacco use, and enforcement of the tobacco control legislation.

The major activities for capacity enhancement will be as follows:

- Develop toolkits for Planning, Monitoring & Evaluation,
- Train health workers on epidemiology of the tobacco and tobacco economics,
- Equip offices related to tobacco control at district, region and centre,
- Enhance capacity of non state stakeholders through training and orientation,
- Train desk officers on planning, monitoring and evaluation for tobacco control,
- Orient to law enforcement and BCC related officials,
- Review and develop tobacco control structure, roles and system (national, regional, district and below levels),
- Provide national and international exposure on tobacco control related workshops, seminars, and meetings
- Document a success stories, share in international forums and publish in international journals
- Strengthening of Tobacco Product and NCD Control Section at NHEICC

5.2 Demand reduction

The Tobacco Product (Control and Regulatory) Act 2011 has banned smoking and tobacco use at public places, workplaces and transportation; banned tobacco advertising, promotion and sponsorships (TAPS) and provision of graphic warning messages covering at least 75% of the total tobacco pack area. Raising the tax on tobacco products is also another provision of the act through health tax fund. WHO has introduced MPOWER as demand reduction strategy and this plan follows the same for controlling tobacco use in Nepal.

5.2.1. Protect people from smoking and use of tobacco

Nepal Government implemented a smoke-free law covering public places, workplaces and public transportation, effective from 7 August 2011. The Tobacco (Control and Regulatory) Act restricts smoking in airports, hotels, restaurants, government offices and other public places, workplaces and public transportation, etc. This Act forbids smoking, sale and distribution of tobacco and related products at public places. Ninety percent of people supports to banning smoking in public places and public transport (MoHP, SOLID, WHO 2008). The 'public places' defined by the Act include government bodies, educational institutions, libraries, offices, corporations, airports, public toilets, cinema halls, cultural centers, hotels, restaurants and canteens, student hostels, stadiums, public transportation stands and public transportation.

There is need to enforce existing legislation effectively and expand the coverage of non-smoking areas gradually to model communities and public buildings including the shopping malls. The major activities for protection of people from smoking will be as follows:

- Expand the coverage of non-smoking areas to model communities, and public buildings including the shopping malls,
- Study on feasibility of expansion of non -smoking areas (crowded street etc.),
- Orientation meeting to managers of public places on banning smoking and tobacco use at the public places, workplaces and public transportation
- Media activities for raising awareness of banning smoking and tobacco use in public places
- Production, distribution and display of signs of banning smoking and tobacco use in public places
- Conduct BCC special campaign in targeted areas against homemade bidi users.

5.2.2. Tobacco use cessation

Nearly two third (63%) have made attempts to give up or cut down tobacco use and over one forth (26%) of the tobacco users have thought to quit the tobacco use but, none of them have completely quit (MoHP, SOLID, WHO 2008). The termination of tobacco use is a greater challenge to the country. Experiences from neighboring countries showed that combined efforts of health care settings, school and community help to quit the tobacco use (WHO, 2011). A manual will be developed and adapted on promoting cessation for communities and schools. Similarly, manuals will be adapted for doctors, dentists and nurses, health and other professionals for cessation tobacco use in health care settings. It will also develop and adapt a national tobacco cessation guideline. Government of Nepal will establish 5 pilot community cessation clinics. In addition to these, telephone help-lines will be established and make operational to offer support for quitting tobacco use.

The major activities for tobacco use cessation will be as follows:

- Adapt/develop national tobacco cessation guidelines/manuals on promoting cession for community people, doctors, dentists, nurses, health and other professionals,
- Establishment of at least 5 tobacco cessation centers and few community cessation clinics,
- Adapt manuals on promoting cession in communities, and a document on tobacco control in schools,
- Establish national quit-lines and telephone help-lines.
- Integrate tobacco cessation program into other health and education program

5.2.3. Packaging and labeling of tobacco products

The tobacco control and regulatory act also makes it obligatory for tobacco product manufacturers to ensure that product packs carry graphic warning messages about the adverse effects of smoking and the harmful ingredients the products contain. According to the Tobacco Product (control and regulating) Act, 2011, the graphic warning messages should cover at least 75% of the total pack area. This helps to quit smoking and tobacco use, to

prevent the new smokers and educate smoker and tobacco users. The rotating graphic warning messages will be used as per the WHO FCTC and legislation.

The major activities for packaging and labeling of tobacco products will be as follows:

- Develop, pretest, produce and implement rotating graphic warning messages,
- Coordinate with Ministry of Home Affairs, Ministry of Industry, Ministry of Supply and Commerce and other concerned institutions for law enforcement,
- Explore and apply the legal measures and procedure against the litigation.
- Adopt best practices of other countries
- Assess compliance of graphic warning messages
- Monitoring of graphic warning messages printing in the pack
- Disseminate graphic warning messages in other media and methods for raising awareness
- Organize meeting, workshop and conference with concerned ministries, legal bodies, journalists, law enforcement organizations, revenue management organizations and so on for the implementation of pictorial health warning
- Conduct a survey to evaluate effectiveness of pictorial health warnings after implementation
- Updates factsheets, guidelines and monitoring tools
- Develop monitoring and reporting tool kits on pictorial health warning

5.2.4. Ban advertising, promotion and sponsorship

The Tobacco Product (Control and Regulatory) Act 2011 has banned all forms of advertising, promotion and sponsorship. The Act also prohibits advertising tobacco products and sponsoring of programme by tobacco companies in any media. If anyone is found to be circulating advertisements and broadcasting promotional messages in media, it imposes fine of up to Rs 100,000. Cigarettes and tobacco products cannot be sold to people below 18 years of age and pregnant women. There is a need of effective surveillance, monitoring and corrective actions against promotional activities. Only 1% of the people revealed that tobacco industries help sports, arts and other sector. Ninety percent of people agreed to discontinuing tobacco advertising, promotion and sponsorships by the tobacco industries (MoHP, SOLID, WHO 2008). However, the GYTS 2010 draws the attention of policy makers that there are still a few hording boards and wall paints in public places for the promotion of tobacco. These will be removed in 2012 and later.

The major activities for banning advertising, promotion and sponsorship (TAPS) will be as follows:

- Mobilize local bodies, administration, civil societies and NGOs for removing TAPS
- Monitor ban tobacco advertising, promotion and sponsorship in coordination and support of Ministry of Home Affairs, Ministry of Information and Communication and Ministry of Federal Affairs and Local Development
- Remove hording boards and wall paints on tobacco,
- Ban indirect promotion of tobacco (through public notice on price, corporate social responsibility etc),

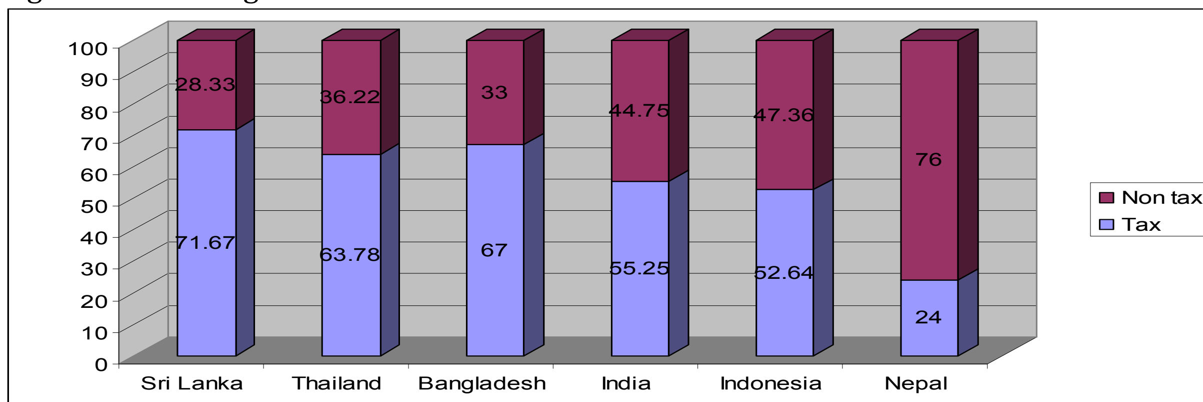
- Orient and inform media on the TAPS ban provision of tobacco control legislation
- Develop a monitoring guidelines and tools on banning tobacco advertisement, promotion and sponsorship
- Organize training and orientation for national and regional officials responsible for enforcement.
- Conduct a survey to assess a progress of compliance with TAPS ban policy

5.2.5. Increase tax on tobacco products

According to the estimate on the basis of economic surveys, Nepal could generate additional 22, 808 million between 2000 and 2010 by steady 5% additional annual increase in tobacco price using higher tax rates to raise prices. It will also contribute to decrease in consumption of smoking and tobacco, so as to decrease morbidity and mortality. Therefore, it will be win–win situation that government increases revenue by decreasing morbidity and mortality.

Excise and value added tax are also levied in tobacco products: cigarettes, bidis and other tobacco products. It has been heard during budget speech that tobacco tax has been increased marginally in July 2011. World Bank Report, 1999 suggest that the tax component of price of a pack of cigarettes needs to be between two-thirds and four-fifths of the total retail cost for consumption. Tax on tobacco is far below the international rate. It is only about 24% compared to Sri Lanka (71.67%), Thailand (63.78%) and Bangladesh (67%) that have tax rates above the 60% mark (WHO 2011). In case of Nepal, tax has little influence on the retail price.

Figure1: Percentage of tax on tobacco



Source: WHO, 2010: WHO technical manual on tobacco tax administration.

Three- forth (73%) of population supports increasing price by raising tax on tobacco. The Nepali evidence showed that 73 % smokers smoke manufactured cigarettes averaging to 8 sticks/day (MoHP, SOLID/ Nepal, WHO 2008, p.22). A conditional price elasticity of cigarette demand was estimated -0.42 and a total price elasticity - 0.88 in Nepal using household data (Karki et al, 2003). This suggests that if the price of cigarettes is increased by 10 percent, the consumption of cigarette will decrease only by 8.8 percent. Thus, there is a scope of increasing

the tax on cigarette to increase the net volume of tax by reducing the consumption of cigarette.

The tax component of price for tobacco products will be increased to 45 % in 2013 and 66% by 2016.

The major activities for increasing tax will be as follows:

- Assess price elasticity of demand for tobacco (smoked and smokeless),
- Assess tax structure on tobacco products (smoked and smokeless),
- Organize meeting , workshop of stakeholders to disseminate best practices and raise the tax on tobacco,
- Advocacy activities with evidence and best practices for raising tax on tobacco.

5.2.6. Behavior Change Communication

Behaviour change communication (BCC) is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. This approach of communication includes information, education and communication (IEC) and social marketing interventions and focuses on individual behaviour and tries to encourage people to make an informed choice. Since, use of tobacco is a harmful behavior; it could be an effective vehicle offering help to quite tobacco and warn about the dangers of tobacco use. An evidence based BCC and social mobilization models can be adapted to contribute to MPOWER. An appropriate mix of communication channels (interpersonal, group, community and mass media) will be used by understanding of the audience and effectiveness of such channels.

In addition to this, a communication for social mobilization model would be adapted to complement and supplement the BCC. It provides an opportunity for greater levels of community participation in social change. It involves planned actions to reach, influence, enable, and involve key segments of the community in order to collectively create an environment that will effect positive behaviour and bring about desired social change. Segments include influential groups or individuals as well as formal and informal leaders among those who will directly benefit from the desired social change. This approach involves strategies to shift societal norms and other environmental factors to bring about large-scale behaviour change. The process therefore is grounded in local concerns, empowers and ensures local ownership, leading to greater sustainability and impact.
Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives. It recasts the role of the communicator as 'facilitator' rather than 'expert'. BCC is proven more effective when complemented by well planned advocacy and social mobilization approaches. Interpersonal communication and counseling, defined as person-to- person or small group interaction and exchange, is a critical skill for BCC. It is especially important for health care providers, hotline call respondents, and others who have direct contact with those we are trying to reach – the target audience – in order to influence their decisions and help improve their knowledge and skills. It encompasses both verbal and non-verbal communication, negotiation, and classic counseling techniques.

The major activities for BCC will be as follows:

- Develop and implement participatory communication framework for tobacco control,
- Development, production, dissemination and distribution of BCC messages and materials on tobacco control through electronic, print and socio-cultural or folk communication media,
- Develop and implement a framework to protect people from second hand smoke,
- Incorporate tobacco free initiative in the pre- and in- service curriculum of orientation to health professionals,
- Incorporate tobacco free initiative in FCHVs manual and its review meeting,
- Develop a manual on tobacco control in line with tobacco control law and FCTC
- Incorporate tobacco free initiative in secondary education in coordination with MoE and DoE,
- Organize joint planning of BCC at national level and sub national level,
- Interact with political and social leaders on the harm of tobacco use at national, regional, district and below levels,
- Reward to the institutions for better implementation of smoke free areas

5.3 Supply reduction

Firstly, manufactured cigarettes are extensively available at any shops and all age-groups can easily buy and use both smoking and non smoking form of tobacco (surti leaves, khaini, gutkha, pan with tobacco ingredients). The use of non- smoking tobacco is higher at Terai. The traditional forms of smoking such as Kankad/sulfa/chilim and Hukka are eroding fast for several reasons. The promotion of cigarettes in the past still contributed to the supply of tobacco. Thirdly, many cigarette brands are cheap and easily available in that any shop grocery or others sell cigarettes throughout the country. Fourthly, cigarette smoking, it is said, raises status in the society. Fifthly, smoking of Kankad/sulfa calls for the availability of especially processed tobacco and especially prepared clay pipe. Such skills are eroding fast. Sixthly, in the past, many farmers grew tobacco for their own consumption, which hardly exists these days. The 2000 Smoking Behaviour Survey found only about 0.15% households producing tobacco for home consumption (NHIECC, 2008). Nepal has stopped selling tobacco products from duty free shop since 2008. The NCD risk factor survey showed that about three fourth (73.9%) of the smokers smoke manufactured cigarettes (MoHP, SOLID, WHO 2008).

Vast majority (87%) supports to banning sale of tobacco to minors and pregnant women (MoHP, SOLID, WHO 2008). The Tobacco Product Control and Regulatory Act 2011, forbids smoking, sale and distribution of tobacco and related products at public places. It fines Rs 100 to Rs 100,000 to the offenders. It also prohibits sales of tobacco products to pregnant women and people below the age of 18.

The major activities for supply reduction will be as follows:

- Coordinate with Ministry of Trade and Commerce to control the illicit trade of tobacco products,

- Advocacy for controlling illicit trade of smoked and smokeless tobacco products under SAFTA and AFTA,
- Coordinate with Ministry of Trade and Commerce to develop a framework for registering and monitoring the shops for the sales of tobacco products,
- Coordinate with Ministry of Agriculture Development to develop crop substitution strategy with seed subsidy or any other alternatives to replace tobacco crops,
- Develop implementation guidelines to prohibit for the sales of tobacco products to pregnant women and people below the age of 18.
- Adopt illicit trade protocol in the Nepalese context as passed by CoP of FCTC.
- Production, distribution and display of signs of banning smoking and tobacco use in public places

5.4 Controlling the use of smokeless tobacco

The major products of smokeless tobacco are *surti leaves, khaini, gutkha, pan* with tobacco ingredients. Use of smokeless tobacco is more common in Terai region of Nepal. It has been gradually spreading to other part of the country. Despite the efforts made by the government and non government organizations, the use of smokeless tobacco among men remained stagnant (38%) in the last 5 years. The prevalence of smokeless tobacco among men is higher (37%) than smoking (29.8%) but in case of women the rate is lower(6%) than smoking (8.7%), these demand the aggressive interventions (MoHP, New Era, ICF International Inc, 2012). The WHO- NCD STEPS survey in Nepal showed that 31% men has used smokeless tobacco products (MoHP, SOLID, WHO 2008). Vast majority (83%) of tobacco users changed their habit from smoked to smokeless tobacco ((MoHP, SOLID, WHO 2008). These indicate that use of smokeless tobacco will further increase in the days to come.

There is very little knowledge of harm of such products among the users which is a major concern. Also there is lack of research on effect of smokeless tobacco: specific risks of different smokeless products and economics of smokeless tobacco in the Terai Region.

The major activities for controlling the use of smokeless tobacco will be as follows:

- Prepare an information kit on the harm of smokeless tobacco products,
- Prepare a documentary on the harm of smokeless tobacco products,
- Conduct BCC special campaign against smokeless tobacco in targeted areas.
- Create gutkha free community and replicate it other communities
- Mobilize FCHVs and other community organizations

5.5 Innovative financing for tobacco control

The traditional financing for tobacco control is inadequate to finance the tobacco control strategies and activities. Therefore, innovative financing for tobacco control is essential.

Nepal has greater potentiality of hydropower. The hydropower tax in future will generate sizable revenues for poverty reduction. A part of the tax could be used for tobacco control. This will be an alternative financing scheme to control tobacco. The burden of tax would be relatively less if imposed to affluent groups. Tourism is growing gradually in the country and more better off people visit Nepal. A dollar tax on each international ticket can generate sizable resources for tobacco control. Students from wealthier families go abroad for further study, NRs 100.00 could be charged for no objection letters.

The telecommunications sector, for example, has become economical actor in Nepal, “one paisa tax” on the mobile phone call can generate sizable revenue to control the tobacco.

"Fat tax", or increasing the price of unhealthy foods through tax generates resource for health promotion and encourages consumers to switch to healthy alternatives. Relatively small taxes on unhealthy foods, e.g., carbonated beverages containing sugar and products high in salt, can generate significant funds and discourage production of such food. While taxation on sugar or fat is a fairly recent innovation, there still appears to be considerable scope remaining to increase existing levels of excise taxation for tobacco.

The major activities for innovative financing will be as follows:

- Feasibility study on taxing goods and services for spending tobacco control,
- Develop a guideline for allocation and use of health tax fund,
- Assess the efficiency and equity of health tax fund,
- Coordinate and advocacy with Ministry of Finance and other concerned ministries for innovative financing for tobacco control,

5.6. Watching and countering tobacco industries

Majority of the people are against the tobacco industries. During the opinion collection, over one- third said that tobacco kills the citizen, one in six told that it harms to the economy of families and the country and environment. Only 12% said that it provides job to some extent (MoHP, SOLID, WHO 2008). The GYTS, Nepal (2011) has reported a prevalence of 20.4% for any form of tobacco use among the school students of age 13-15 years. About 16.4% of never smokers are likely to initiate smoking next year (NHIECC, 2011). Adolescents and young adults of colleges are often targeted by the tobacco industry for marketing. Moreover, college age is a transition period and students are vulnerable to tobacco addiction. A counter strategy will be developed to discourage the tobacco industries.

In 2011, a total of 11 smokeless tobacco related factories (Gutkha) moved to Nepal due to the strong regulation of the boarding states of India. The investors showed their willingness to establish a cigarette factory in Tanahu district of Nepal (Kantipur dated 8 April, 2012). These indicate that Nepal should restrict to establish the new tobacco factories and discourage

existing smoke and smokeless tobacco industry. This also decreases the supply of non smoking tobacco in Nepal.

The major activities for watching and countering tobacco industries will be as follows:

- Endorse a directive in line of FCTC article 5.3 and other best practices to prevent tobacco industry interference and stop tobacco industry involvement in development of tobacco control policy.
- Update the strategies of tobacco industries (mainly promotional and production),
- Data collection on the output of factories with the support of Inland revenue offices,
- Develop and maintain anti tobacco alliance involving wider stakeholders,
- Develop and update encountering strategies,
- Media monitoring
- Appropriate litigation
- Advocacy to concerned ministries

5.7. Networking, coordination and collaboration

The Tobacco Product Control and Regulatory Committee (TPCRC) will monitor, coordinate and guide the agencies to move against the tobacco use. The national focal point for tobacco control – NHEICC and its Tobacco Product and Non-Communicable Disease Control Section will prepare a database of tobacco control related organizations and their activities and update regularly. An inter-sectoral working committee on tobacco control will be form to support the TPCRC, collaborate with I/NGOS to release the synergy.

The major activities for Networking, coordination and collaboration will be as follows:

- Prepare and update profiles of GOs/NGOs working in the area of tobacco control,
- Organize meeting of NCD IEC/BCC technical committee
- Support for and advocacy to tobacco product control and regulatory committee,
- Review meeting of anti tobacco alliance and networking,
- Prepare a collaborative annual plan of actions,
- Form sub-committees at the district level to control tobacco

5.8. Research, monitoring and evaluation

Nepal has rectified the FCTC and also passed the tobacco control and regulatory bills. These require collection of data on the magnitude, patterns, determinants and consequences of tobacco use and exposure. It also needs the surveillance data on tobacco use, exposure and related health outcomes. The national focal point should also maintain and update a comprehensive database for use in assessing tobacco product markets, conducting analyses of demand for tobacco products, and evaluating current tobacco excise taxes and the impact of increases in these taxes.

The major activities for research, monitoring and evaluation will be as follows:

- Continue routine monitoring of progress and challenges and identify counter measures on different provisions of legislation and plan
- Incorporate tobacco related data in HMIS/HSIS,
- Train health workers on research methodology for tobacco control,
- Adapt standards and scientific and evidence-based protocols for tobacco surveys,
- Conduct global youth tobacco survey(GYTS), global school personnel survey (GSPS) and global health professional student survey (GHPSS) as regular basis
- Conduct global adult tobacco survey (GATS)
- Conduct morbidity and mortality studies
- Conduct air monitoring survey
- Provide mini research grant for tobacco control related studies,
- Implement behavioral survey on smoking and tobacco use,
- Incorporate tobacco questions for survey (TQS) in any relevant national surveys
- Develop monitoring and evaluation guidelines, tools and checklist for smoke-free, TAPS ban, pictorial health warning, TI interference etc
- Conduct survey to assess compliance in regards to smoke-free, TAPS ban, pictorial health warning

6. Indicators

6.1. Outcome Indicators

- Nationwide dissemination of Tobacco Product Control and Regulatory Act 2011 and its regulation and directives
- More than 80% compliance with 100% smoke-free environments in all public places, work places and public transport
- 75% graphic health warnings in all tobacco products implemented effectively
- Complete ban on tobacco advertising, promotion and sponsorship (TAPS)
- Increased awareness and knowledge of dangers of tobacco use
- Increased behavior on prevention and cessation of tobacco use
- Increased institutional capacity and stakeholders engagement in tobacco control
- Tax component of price for tobacco products will be increased to 45 % in 2013 and 66% by 2016

6.2. Impact Indicators

- Reduction relatively in prevalence of tobacco use among people aged +15 years
- Reduced morbidity and mortality attributable to tobacco related diseases

7. Coordination and Management

7.1. Coordination: As outlined in the NHSP2 and its implementation plan, NHEICC is responsible for implementation, coordination and collaboration of tobacco control program under MoHP. The relevant coordination structures to address these needs are already in place and can be continued and improved to implement this plan. These include:

National Level:

- Tobacco Product Control and Regulatory Committee
- NCD IEC/BCC Technical Committee

District Level:

- Tobacco Product Control and Regulatory Sub-committee

The community level committee will be formed as and when needed in coordination with assistant chief district officer and local bodies. These committees will be mobilized for tobacco control and detail terms of references will be developed based on the legislation and guidelines.

7.2. Management

At national level, a national implementation plan should be developed subsequent to the endorsement of this strategic plan. Nepal Demographic and Health Survey 2011 data will be further considered during the development of the communication implementation plan.. The programming process should also take into account the division of labour between the central level and the regional and district level and below level. It should clearly lined out responsibilities and timelines in order to operationalize the strategy.

Implementing this strategic plan in the field will require strong support from governmental, non-governmental and external development partners. The existing health system coordination functions will be used at national and decentralized level of health system. As this communication strategic plan provides support to the national tobacco control program, which will be managed by DHO/DPHOs at the district level, SHP/HP/PHCs at the village level and FCHVs at community/ward level. This plan needs to be implemented in cooperation with these health system and volunteers in the decentralized health system. DHO/DPHO will roll this plan out to districts in the context of regular district planning meetings for its smooth implementation. In particular, health education officer at regional level under the leadership of regional health director and health education technician or health education focal person at district level under the leadership of DHO/DPHO will be the key to implement this plan.

Non-governmental actors and external development partners will align their projects on tobacco control with this plan. They should use this plan as a framework for their current and future projects and interventions on tobacco control. Similarly, they will coordinate with NHEICC through the relevant coordinating mechanisms and technical committees for aligning current and future projects and interventions.

8. Next Step

The specific implementation plan and necessary communication plan will be developed and implemented for addressing different components of this strategic plan. The implementation and communication plan will outline specific objectives, audiences, messages, strategies, activities, channel, timeline, responsibilities, resources, outputs and means of verifications. Similarly, national, regional, district and below level strategies and its components will be defined in the implementation and communication plan based on the endorsed national strategic plan and tobacco control legislation.

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