

THE NATIONAL ANTI-TOBACCO COMMUNICATION CAMPAIGN STRATEGY FOR NEPAL

1. INTRODUCTION

This strategy is being developed as Government of Nepal, Ministry of Health and Population, has given high priority to promotive health services by specifying health education and information as an important area of its activities. The Ministry of Health and Population in its National Health Policy 1991 specifies, "One of the main reasons for the low health standards of the people is the lack of public awareness of health matters. Therefore, health education will be provided in an effective manner from centre to rural areas. For this, political workers, teachers, students, social organizations, women and volunteers will be mobilized extensively up to the ward level". The Second Long Term Health Plan 1997-2017 (SLTHP) of the Ministry of Health clearly specifies the need for "effective IEC measures" to address public health issues including "the reduction of the prevalence of smoking" in Nepal.

In May 1999 the governing body of the WHO adopted by consensus a resolution that paved the way for starting multilateral negotiations on the WHO Framework Convention on Tobacco Control (FCTC) and possible related protocol agreements. The Convention calls for "all countries to introduce comprehensive tobacco control policies and strategies along the lines recommended by the WHO". Government of Nepal signed FCTC in 3 Dec. 2003 and House of Representatives has ratified FCTC in 7 Nov. 2006

In this strategy, attempts have been made to review and analyze tobacco and health situation with respect to advocacy and IEC and to design a national advocacy and communication campaign strategy with clearly defined interventions.

2 TOBACCO USE

2.1 Global Trends in Tobacco Use

Although people have used tobacco for centuries, cigarettes did not appear in mass-manufactured form until the 19th century. Since then, the practice of cigarette smoking has spread worldwide on a massive scale. Today, about one in three adults, or 1.2 billion people, smoke and of these, about 82 per cent lives in low-and middle-income countries.

Overall 29 per cent of the world adults smoke. Gender wise more men (47%) smoke than their female counterparts (12%). In low/middle income countries nearly half (49%) adult men smoke and about 9 per cent women do so. In contrast fewer men (39%) but about one in five women (22%) smoke in the high-income countries.

2.1.1 Tobacco smoking addiction and the disease burden

Tobacco contains nicotine, a substance that is recognized to be addictive. Nicotine fulfils the key criteria for addiction or dependence, including compulsive use, despite the desire and repeated attempts to quit. Cigarettes, unlike chewed tobacco, enable nicotine to reach the brain rapidly, within a few seconds of inhaling smoke, and the smoker can regulate the dose puff by puff.

It was estimated that in 2000 tobacco killed approximately 4 million people worldwide – 2 million each in developed and developing countries. Tobacco was responsible for one in 10 adult deaths; by 2030, the figure is expected to be one in six or 10 million deaths each year and 70 per cent of them would occur in developing countries. By 2030 tobacco is projected to become the number one killer of people.

However, there are long delays between exposure to smoke and diseases. Studies have shown that tobacco-related diseases take at least 40 years to emerge. The major chronic diseases caused by tobacco use are lung cancer, cancer of the mouth, oesophagus, larynx and pharynx, ischaemic heart disease, cerebrovascular disease and chronic obstructive pulmonary disease (COPD - this is primarily chronic bronchitis and emphysema). Consumption of *gutkha*, *khaini*, *surti* (*dry tobacco leaves*), *pan masala*, *supari*, *pan parag* and similar smokeless tobacco products cause mouth, throat and digestive tract cancers.

2.1.2 The risk from others' smoke

Smokers affect not only their own health but also the health of those around them. Women who smoke during pregnancy are more likely to lose the foetus through spontaneous abortion.

2.2 Tobacco use and smoking prevalence in Nepal

Tobacco products include smoking tobacco products such as cigarettes, bidi, Hukka and chilim or kankad. The smokeless tobacco products (STPs) include surti leaves, khaini, gutkha, pan with tobacco ingredients. 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 is heavy promotion of cigarettes. 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.

2.2.1 Tobacco use prevalence

Generally it is believed that smoking of tobacco is common in Nepal regardless of age and sex of people. Smoking prevalence rates (use of smoking tobacco products only) for some areas of the country were estimated for early 1980s by Pandey and others. In Jumla

– a high mountain district, the proportion of males aged 20 years and over smoking was found highest at 84.7% and among the females the corresponding figure was 71.7%). In the mid hill areas represented by Sundarijal and Bhadrabas villages smoking prevalence among the males was 78.3% and among their female counterparts it was 58.9%. In the Tarai represented by Parasauni (Bara district) smoking prevalence rate was the lowest -- males 62.8% and females 48.4%. The Kathmandu urban sample showed high male smoking prevalence 64.6% while among the females it was estimated at 14.2%.

A national sample survey on tobacco use covering 4,889 respondents was conducted in 10 of the 75 districts of the country at the end of 2000. A four-stage cluster sampling method was used. According to this survey the proportion of all respondents aged 15 and above ever smoked was 42.6%. The proportion of males ever smoked was 54.0% and among the females it was 31.6%. The survey also inquired about the reasons for starting to smoke among the respondents who ever smoked. 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.

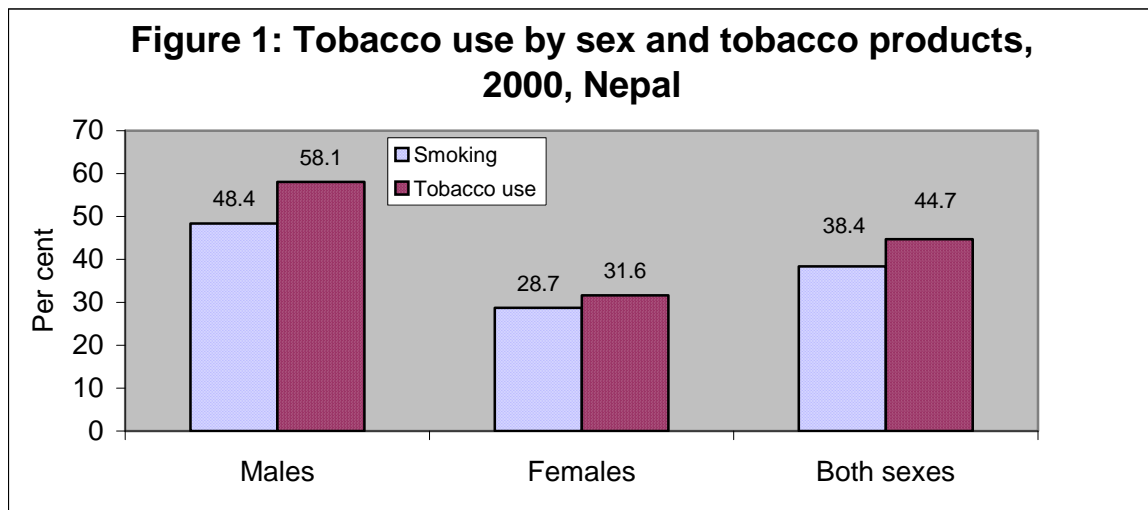
Table 1: Percentage distribution of ever smoked respondents by sex mentioning reasons for starting to smoke, 2000, Nepal

Reason for starting to smoke	Sex		Total
	Male	Female	
Because of friends	59.4	41.0	52.5
Followed parents, senior family members	15.9	23.7	18.8
Because of own inquisitiveness	8.4	6.5	7.7
Husband encouraged	--	4.5	1.7
Liked to smoke	6.8	9.7	7.9
Older brothers and sisters encouraged	0.3	1.3	0.7
Learned when lived away from the family	0.2	--	0.1
Because of worry	2.9	8.1	4.8
Other reasons	4.3	4.7	4.5
Don't know	1.8	0.5	1.3
<i>Total Per cent</i>	100.0	100.0	100.0
<i>Number</i>	1,303	782	2,085

Source: Pande, B. R., Karki, Y. B. and Pant, K. 2001. **A Study on Tobacco Economics in Nepal, 2000.** Submitted to WHO/SEARO, New Delhi.

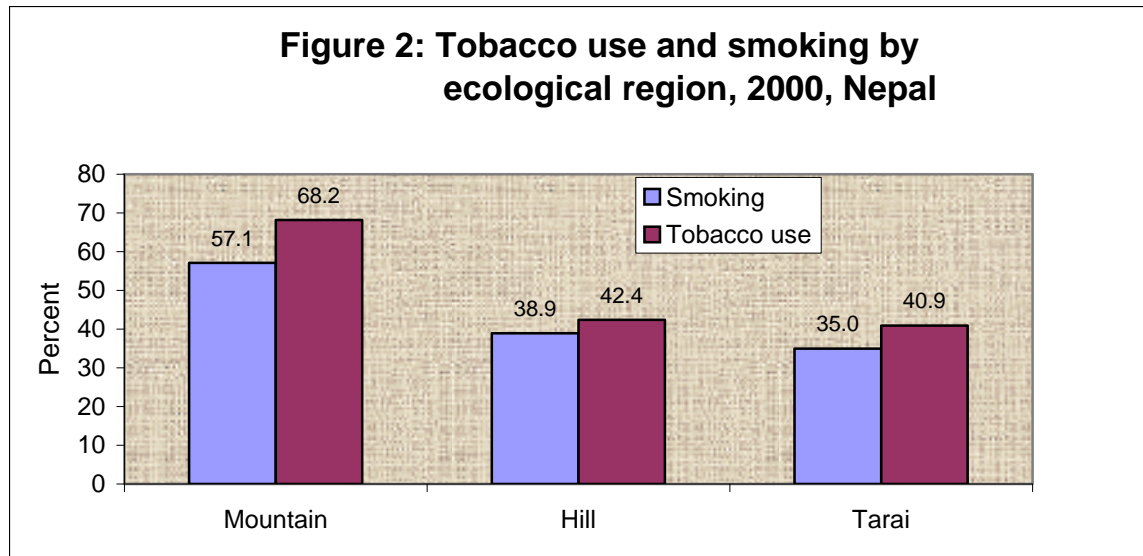
Based on the above sample survey data the estimated overall tobacco use prevalence among adults (aged 15 and over) including products such as cigarette, *bidi*, *hukka*, *sulfa*, *chilim*, *kankad*, rolled-on-tobacco, chewing tobacco (*khaini*, *pan masala*, *gutkha*, *surti*, etc.) was 44.7% and it was almost twice among males (58.1%) than among females (31.6%) ^{12/}. Smoking prevalence rate was 38.4%, (males 48.4% and females 28.7% - **Figure 1**). Translating the Nepal tobacco use and smoking prevalence rates into absolute number yields 6.4 million tobacco users (4.1 million males and 2.3 million females) and 5.5 million smokers (3.4 males and 2.1 females) in 2002. The overall tobacco use prevalence is higher in rural areas (45.8%) than in the urban areas (34.4%). Relatively fewer women consume tobacco products in the urban areas (19.9%) than in the rural areas (32.9%).

Among the three ecological regions the overall tobacco use prevalence is the highest in the mountain region (68.2%, **Figure 2**), followed by the Tarai (42.4%) and mid hills (40.9%). However, although smoking prevalence is also highest in the high mountains (57.1%), unlike tobacco use, it is higher in the hills (38.9%) than in the Tarai (35%) ^{12/}.



Source: Karki, Y. B. 2002. "High Tobacco Use in the High Hills of Nepal". **Lifeline**, Vol. 8. May, WHO/SEARO, New Delhi.

Among the females the Tarai region has smallest proportions of tobacco users (26.6%) than either the high mountain (64.3%) or the mid hill regions (30.5%- **Figure 2**). In Nepal tobacco use prevalence is high among illiterate persons (55.2%) compared to the literate population (36.1%). By gender, more males use tobacco (77.4% illiterate and 49.4% literate) than their female counterparts (44.3% illiterate and 12.6% literate).



Source: Karki, Y. B. 2002. "High Tobacco Use in the High Hills of Nepal". **Lifeline, Vol. 8**. May. WHO/SEARO, New Delhi.

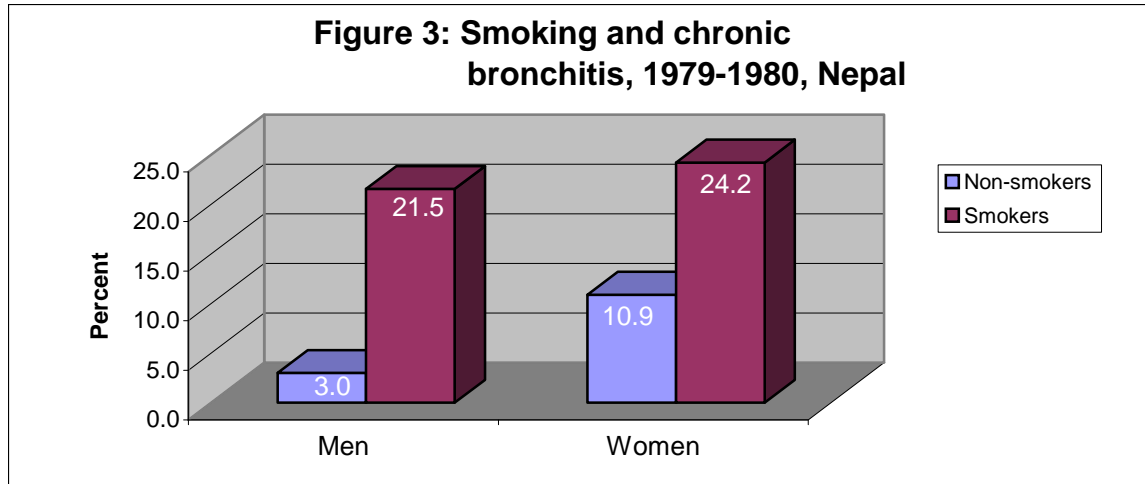
Several studies have shown inverse relationship between the number of years of schooling and smoking. In Nepal 50.6% illiterate adult population 20 years of age and over currently smoke and as years of schooling increases the proportion of current smokers declines. Another study conducted among students also shows relatively low tobacco use prevalence.

2.2.2 Age at first smoking

Information on age at first smoking reveals that smoking for some begins as early as at age 5. The average age at first smoking is estimated at 16.6 years for all respondents aged 10 and over. Women begin smoking earlier (15.8 years) than their male counterparts (17.0 years) and this is true of all regions of the country.

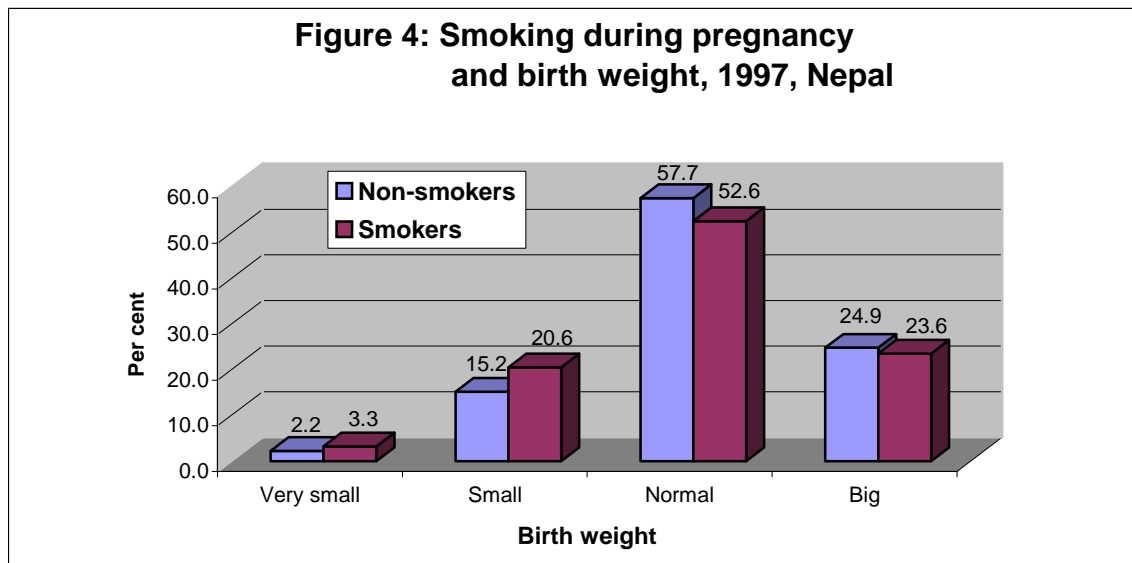
2.2.3 Health consequences of smoking in Nepal

The impact of tobacco on health has been extensively documented for developed and many developing countries of the world. In Nepal there is very little such information. Use of tobacco has been identified as one of the risk factors for contributing to a high prevalence of chronic bronchitis in Nepal. **Figure 3** shows that during the early 1980s about 22% smoking males had chronic bronchitis compared to only 3% among the non-smokers. Similarly about 24% smoking females had chronic bronchitis as against about 11% non-smoking females.



Source: Pandey, M. R. et al, 1988. Chronic Bronchitis and Cor Pulmonale in Nepal. **A Scientific Epidemiological Study**. Mrigendra Medical Trust, Kathmandu, Nepal.

The infants of mothers who smoke during pregnancy have lower average birth weight than infants born to non-smoking women. The survey of 1997 shows that proportionately more mothers gave birth to "small" (20.6%) and "very small" (3.3%) infants compared to non-smoking mothers (15.2% and 2.2% respectively -**Figure 4**). It also shows proportionately more non-smoking mothers giving birth to normal (57.7%) and big babies (24.9%) than smoking mother (52.6% and 23.6% respectively).



Source: HMG/NPC Secretariat and UNICEF/Nepal. Nepal multiple indicator surveillance. Fifth cycle. (March – May 1997). 1998.

Studies show high risks of stillbirth, neonatal death and sudden infant death syndrome greater among the offspring of women who smoke. The GoN/UNICEF survey of 1997 also shows proportionately more smoking mothers experiencing stillbirths and birth of dead infants (2.7%) than their non-smoking counterparts – 2.1%. Similarly fewer

smoking mothers (95.4%) had their infants surviving well than the mothers who did not smoke during pregnancy (96.2%).

2.2.4 Tobacco and poverty

Paradoxically the poor who toil hard everyday to make their both ends meet spend relatively more than the rich. Proportionately the poorest two income groups spend about 5 per cent of their total annual expenditures on tobacco products while their rich counterparts spend just over 2 per cent on tobacco. With respect to health and education spending, the poor comparatively spend much less, only 12.2% while the rich spend as much as 29% of the total household expenditures.

2.2.5 Smoking and deaths

Smokers would be more likely to be suffering from some major chronic diseases, such as cancers, stroke, heart diseases, COPD etc and they would be more likely to be demanding more health services such as out-patient visits, in-patient admissions and bed-days than non-smokers. Theoretically, epidemiologists have developed a formula for the estimation of population attributable risks of a disease. It is assumed that the smokers are more likely to get sick than non-smokers. According to an epidemiological theory, the proportion of people suffering from some specific disease (called Population Attributable Risk, PAR) can be estimated.

Using the above PAR smoking attributable deaths can be estimated. In Nepal the crude death rates for males and females are respectively 13 and 10 per 1000 population. Smoking attributable annual deaths for Nepal is estimated at nearly 14,000 (9,000 male deaths and 5,000 female deaths) for population aged 35 and over.

3. THE NATIONAL ANTI-TOBACCO PROGRAMME

3.1 Government tobacco policy

It appears that from the First Five-Year Plan (1956-61) to Seventh Five-Year (1985-90) Plan Government of Nepal's objective was to increase production of tobacco products (cigarettes, bidi, and tobacco leaves) so that the national market for tobacco demand is fulfilled from within the country. With assistance from a foreign country Janakpur cigarette factory was established in 1959. Tobacco Development Board was also formed so that locally harvested tobacco leaves could be increased to meet the demand of the cigarette factory. Efforts were also made to increase the productivity of tobacco harvest per hectare of land.

Now there are 38 establishments producing tobacco products and of them five are cigarette factories. GoN also argues that local tobacco establishments were encouraged with a view to minimize the smuggling of tobacco products into the country.

3.2 The national anti-tobacco programme goal

The MoHP/Government of Nepal's national anti-tobacco programme goal, as implied in the SLTHP, is to reduce the consumption of tobacco products so that morbidity and mortality resulting from tobacco consumption are decreased.

3.3 The national anti-tobacco programme objectives

In order to attain the above programme goal the MoHP's anti-tobacco programme objectives are to:

- Formulate and implement anti-tobacco policies;
- Design and implement anti-tobacco community education – schools, work places, media, to reduce the prevalence of smoking;
- Conceptualize, produce and disseminate anti-tobacco mass media (audio, audio-visual, print and inter-personal) skits, PSAs and programmes;

3.4 Measures to curb tobacco use

3.4.1 Excise tax on tobacco products

Tobacco products are levied excise tax for two reasons. One is to raise revenue and the other is to discourage consumption.

3.4.2 Information: Health warning

The first policy appears to be the requirement of putting warning labels on tobacco-product packaging and advertising. Every cigarette package carries a health warning as follows: "Smoking is injurious to health". The other tobacco products such as khaini, bidi, etc. do not appear to carry such warning.

3.4.3 Health tax on tobacco products

Since 11 July 1993 health tax of one paisa per stick of cigarette is levied. The revenue generated from such a tax is deposited in a separate account and is spent on activities relating to the prevention and treatment of cancer, tuberculosis and other diseases.

This is the first earmarked cigarette tax levied in Nepal. Government of Nepal decided that 75% of the health tax on cigarette should go to B. P. Koirala Memorial Cancer Hospital in Chitwan and 25% should be spent on the prevention of tuberculosis and other diseases.

The health tax on cigarette was doubled (two paisa per stick of cigarette) in the following year, i.e., from July 15, 1994 and since then it has not been raised.

3.4.4 Mass information

The NHEICC, MoHP is primarily responsible for anti tobacco IEC activities. It produces print, audio and audiovisual materials with the objective of educating the audience about the harmful effects of tobacco use.

Every year on 31st May World No-Tobacco Day is observed.

The NHEICC, MoHP periodically organizes workshops, forums and talk programmes focusing on the harmful effects of tobacco products.

Nepal also observed SEAAT FLAME in 2000 involving lawmakers, policy makers, decision makers, youth, students and the general public.

3.4.5 Ban on smoking in public places

After observing the World No Tobacco Day on 31st May 1992, Government of Nepal passed a resolution effective from 1st June 1992 banning smoking in the following places.

- (a) The Secretariat of GoN including the Cabinet Meeting Hall, premises of all Ministries, Departments, Offices, government owned organizations, associations/institutions, educational institutions, hospitals, health centers, and health posts.
- (b) Cinema halls, theatres, public buildings, buses, trolley buses, mini buses, and all public transports and domestic air flight.
- (c) Premises of industrial complexes.
- (d) Offices where smoking is banned are required to put up a notice stating, "Smoke free zone" and a separate place is to be assigned for smokers.

3.4.6 Ban on advertising and promotion of tobacco products

Since 14 December 1998 GoN has partially banned advertisements of tobacco products. GoN has banned the advertisement of tobacco products on the electronic media (radio and television) and has banned advertisement of alcohol until 10 pm.

3.4.7 The Smoking (Prohibition & Control) Act, 2058 (2001/02)

The National Health Education, Information and Communication Centre, Ministry of Health and Population, has drafted The Smoking (Prohibition & Control) Act, 2058. This is a comprehensive Act, which addresses many problems that hinder the control of tobacco products. This proposed Act covers many aspects of FCTC. The earlier Government of Nepal endorses this Act the better it would be in the interest of the health of the general public.

3.5 Reduction of supply of tobacco products

GoN levies import and export taxes on tobacco products. However, often there are news about smuggling of various products including tobacco products across the borders between Nepal and India and Nepal and China (Tibetan region). It is not known what

volume of tobacco products are smuggled in and out of the country. In 2001 a businessperson was fined Rs. 7.2 million for importing *Khaini* without paying VAT.

4. THE NATIONAL ANTI-TOBACCO COMMUNICATION CAMPAIGN STRATEGY

4.1 Rationale

One of the major components of the National Health Policy 1991 was health promotion and in order to translate this policy into action National Health Education, Information and Communication Centre (NHEICC) was established in 1993 under the Department of Health Services with the mandate to support the health sector through information, education and communication to encourage people to utilize health services and to motivate others so that they would adopt healthy behaviour.

As mentioned above in Nepal tobacco consumption is high and its impact on health and overall well-being is negative. In order to reduce the consumption of tobacco products the NHEICC has been carrying out several anti-tobacco mass media activities. However, these activities have been sporadic and they are not based on clear campaign strategic guidelines.

The national anti-tobacco campaign strategy will fill this gap and aim to contribute to and facilitate the accomplishment of GoN's health programme objectives. Efforts motivated by the strategy will maximise partnerships with other departments, Centres and other sectoral Ministries and other non-government and private agencies. The activities of this strategy will utilise innovative, research-based communication approaches.

4.2 The national anti-tobacco communication campaign strategy

This advocacy and education communication campaign strategy is based on the government's overall health service delivery programme and its objectives. It must be evolved and implemented according to the health programme strategy and be an integral part of it. The two strategies must necessarily be mutually supportive and reinforcing.

The national anti-tobacco communication campaign strategy refers to and is based on GoN's health programme objectives and the environment in which this programme is situated.

4.3 The national anti-tobacco communication campaign goal

The goal of anti-tobacco communication campaign is to impart knowledge to the population at large about the health hazards of tobacco consumption and other risks resulting from it. This in turn will contribute to the reduction of mortality and morbidity caused by the use of tobacco products.

4.4 The national anti-tobacco communication campaign objectives

The national anti-tobacco communication campaign seeks to decrease the proportion of people using tobacco products and thereby free people from morbidity and mortality resulting from tobacco consumption. To this end the specific objectives of the national anti-tobacco campaign will be:

1. To ensure commitment from policy makers for effective control of tobacco products.
2. To focus IEC interventions on the reduction of demand for tobacco products.
3. To ensure the development of positive attitude towards tobacco free life style among friends, relatives and family members and to emphasize the importance and benefits of understanding tobacco free life style among all people particularly among adolescents, youths and the poor.
4. To promote appropriate communication between the head of household and other family members to enable every family member to make decisions on refraining from tobacco use.
5. To facilitate appropriate behaviour in support of tobacco free lifestyle which is healthy, hygienic and free of vices.
6. To create and strengthen an institutional framework for improved co-ordination, inter-sector linkages and networking of activities among agencies involved so as to develop a synergistic relationship towards these objectives and to ensure coherence/ convergence between relevant efforts (e.g., with health, women and child development, hygiene and sanitation, and formal and non-formal adult education programmes).

4.5 The foundations of the strategy

The strategy development group recognizes several important principles of communication theory on which this communication campaign strategy document is based. These principles form the communication foundations upon which decisions regarding IEC approaches were made. In addition, operations research and multi-sector/ multi-agency IEC management experience shows that networking and a coordinated approach by collaborating agencies increases convergence of efforts and improves economies of scale.

The communication foundations on which this strategy is based include: considering research findings, audience segmentation, local community input, identifying and selecting appropriate media channels and innovative communication approaches.

In greater detail, the communication "**foundations**" of the strategy are:

4.5.1 Differential: based on audience segmentation and context

For effective campaign, each audience segment warrants a different message, message treatment, and choice of media. Further, when resources are limited, audience segmentation strategies allow for identification of the highest priority audience segments towards which most of the resources can be directed for maximum impact.

4.5.2 Research based: based on identified need and feedback

The role of research is central to the success of the strategy. This should be an on-going activity from the beginning to the end of the programme in order to develop accurately targeted, clearly defined, complete and consistent messages.

4.5.3 Decentralised: communication designs localised

Strategy must consider decentralisation and localisation of communication design so that regional needs and realities are reflected.

4.5.4 Participatory in nature: based on communication that involves the community

More direct methods of promoting people's participation are also necessary, through continuous interaction, use of local folk media, etc. While doing research to identify a set of messages the target audience can be asked to get involved actively. This will ensure local "ownership" of and commitment to project goals and activities.

4.5.5 Inclusive of Multi-media and interpersonal channels, including folk media

Currently media categories include broadcast (TV and Radio), group (video, tape-slides, sound film strips, audio cassettes, overhead projections, flip-charts, posters, pamphlets, and leaflets; as well, traditional folk media such as live-theatre and puppets may be included), and interpersonal channels (community leaders, field workers). Many years of experience emerging from field implementation of several development communication projects suggests the use of multiple channels, wherever possible, so that each medium reinforces and multiplies the importance of the others in an integrated network.

4.5.6 Innovative: open to trying new approaches, channels and messages

Stereotype approaches can hardly move the target audience. It is therefore necessary to try some new approaches, channels and messages to effectively influence the target audience. For instance, enter-educate approach has been found effective to transmit technical and sensitive messages in several countries.

In order that the above communication foundations can be maximised, the following foundations of an effective operational plan will be utilised throughout the implementation phase.

4.6 The operational “foundations” of the national anti-tobacco communication campaign strategy are:

4.6.1 Coordinated: partners share a coherent strategy, a shared vision among development partners.

At the heart of successful implementation of the strategy lies the role of co-ordination among and between concerned line Ministries, NGOs, INGOs and the development partners.

4.6.2 Networking: operations promote and facilitate the networking process

Closely related to co-ordination efforts are the activities that help networking with other partners that are involved in similar programme.

4.6.3 Convergence of efforts: limiting duplicative efforts and filling gaps

Promoting convergence of the efforts of various agencies is a key element of the strategy. Such convergence could be with all health related programmes be it within the government or outside of it.

4.6.4 Economy of scale, high coverage with low cost

Because of co-ordination, networking and avoidance of duplication of efforts the strategy will be able to gain from the economy of scale.

There are two main roles that communication campaign can serve, namely, supportive (promotive) and causative/triggering. In its promotive role, communication campaign will support positive attitudes and practices that already exist within the target audience. Here communication campaign provides reassurance, reinforcement and encouragement to "tobacco-free life style" (those who have already transited to desirable attitudes/behaviour). Through advocacy interventions, communication campaign will also seek to promote the creation of conditions that will facilitate the accomplishment of programme goals and objectives from the highest policy levels to local leadership and intra family relations.

The second role of communication campaign will seek to cause or trigger positive changes. The causative/triggering role of communication - which imparts correct knowledge to the target audience - must be given greater emphasis since it's role is to produce new attitudes and behaviours. In this role communication campaign is developed

to create information-seeking attitude among the target audience, which can contribute to the reduction of demand for tobacco products among them.

5. STRATEGY-BASED COMPONENTS FOR IMPLEMENTATION ACTION PLAN DEVELOPMENT

In order to implement the national anti-tobacco communication campaign strategy several components, which will guide IEC, development and implementation plan have been identified in the context of Nepal. However, it must be made clear that this is just a process of generating action plan from the strategy outlined above to ensure adherence to a common overall goal while providing the flexibility necessary to evolve situation-specific action plans.

5.1 Strategic planning chart

Further audience research needs to be conducted to discover what motivates individuals within the various groups to act and what they consider life benefits so that desired benefits can be positioned within a framework that is appealing and/or compelling to each target audience.

In order to make the national anti-tobacco communication campaign strategy more effective, the target audiences need to be segmented. Not all messages are relevant to everybody. Similarly, a key audience can often only be reached through another target audience, which wields power over their decision-making capacity. Therefore, to reach specific audiences with appropriate messages designed to prompt behaviour change, the target groups are segmented. Given the present context in which this strategy will be implemented in Nepal, the target audiences for national anti-tobacco communication campaign strategy have been segmented in the chart that follows.

There could be any number of other groups and ways of sub-dividing the categories indicated below. However, the list below should be adequate for the purpose of examining alternatives and narrowing the focus.

Despite audience segmentation to many audience groups core messages on major concepts like hazards of smoking and tobacco use will be considered for dissemination and promotion.

5.2 Strategy based components

To meet the programme objectives the audience has been segmented as follows:

Advocacy groups

- Decision makers/politicians
- Donors
- Media

Promotional groups

- Regional/local authorities
- NGOs/CBOs
- Health Practitioners

Beneficiary groups

- General public
- School students
- Men
- Women
- Adolescents and youth

This strategy has identified potential concerns, potential message themes, responsible organisations/ institutions and media channels to reach the target audience.

The activities that need to be performed are:

- Training of staff and service providers;
- An integrated communication campaign effort to facilitate and create appropriate behaviour;
- Partnership with appropriate agencies, so as to mobilise additional inputs and services.

6. CAPACITY BUILDING, CO-ORDINATION, RESEARCH, MONITORING AND EVALUATION

The national anti-tobacco campaign strategy can be better implemented if the institution and its resources - both human and physical resources, are strengthened. The capacity building activity is divided into two broad categories below:

6.1 Human Resource Development:

6.1.1 Training

For training purposes, standardised materials will be developed to upgrade the skills of the manpower on tobacco and its negative effects. More emphasis will be given to utilising the participatory approach while conducting the training. In addition, activities like lecturing, case studies, brainstorming, field visits, problem-solving exercises will be part of training activities. Training manuals and training aids on various aspects of tobacco products and the resulting hazards from their use will also be developed as and when necessary.

Two categories of personnel- managerial level personnel and technical manpower need to be trained periodically to strengthen the human resource needs of the programme. The managerial level personnel are in need of training on IEC management plan and innovative approaches. The technical level manpower is required for the design, development and production of IEC materials. Scriptwriters, artists, print media,

TV/video and audio production manpower need to be trained inside and outside the country.

The goal of reducing tobacco prevalence calls for the reduction in the number of people smoking and using tobacco products. The anti-tobacco IEC activities are therefore aimed at changing human behaviour. The programme design, message development and presentation need personnel who have knowledge of behaviour change communication. The MOH therefore has to strengthen the capacity of the personnel in BCC.

Both managerial and technical manpower need to work in a team to carry out IEC activities continuously and according to campaign programme schedule plan production and release of materials designed for specific audiences.

For this anti-tobacco IEC strategy, the manpower requirement will be projected and the required number of positions will be created. Appropriate manpower will be developed and recruited as and when necessary. Existing and new manpower arrangements will be made in collaboration with related organisations - government agencies, NGOs, INGOs and private sector organisations, to assure training at regular intervals. Efforts will also be made to sustain the trained manpower in the respective organisations.

6.2. Coordination and technical management

For timely and uninterrupted functioning of the IEC programme a National Technical Committee (NTC) headed by the Director of NHEICC, MoHP, will be formed. Representatives of the relevant line Ministries and their Departments, NGOs, the private sector will be the members of this Committee. The proposed members of the NTC are as follows.

<u>S. No.</u>	<u>Designation</u>	<u>Organisation</u>
1.	Director	NHEICC, MoHP
2.	Representative	Non-Communicable Diseases Division, MoHP
3.	Representative	Health Tax Committee
5.	Representative	NGO
6	Tobacco expert/ Senior Consultant	Private Sector
7.	Dr.	Cardiologist/Chest/Lung Cancer Specialist
8.	Representative	DoHS
9.	Senior Officer	Member Secretary

The NTC will meet quarterly to coordinate project activities and to see that the IEC activities are being carried out according to the time line and the objectives of the anti-tobacco IEC strategy. This will enable the IEC strategy to meet project objectives on time.

At the regional level the five Regional Health Directorates will be responsible for ensuring effective co-ordination within the districts of the region. The District Health

Office will be the focal point for co-ordination of the IEC activities in the district and at the levels below it. At the district level, a District Co-ordination Committee will be formed under the chairmanship of the District Development Committee member heading the Health Committee. The members of the DCC will be representatives from GOs, NGOs, INGOs and two members from the private sector of the district. The DHO of the district Health Office will be the member Secretary of the DCC.

At the village level IEC support activities will be closely linked with the health centres, health posts and sub-health posts located at the electoral constituencies of the district. In areas where there are many agencies operating at the community level, local co-ordination will be achieved through periodic consultation with relevant agencies and Village Development Committees of the defined area.

6.3 Research, monitoring and evaluation

Research will play a key role throughout the life cycle of the programme. A study will be carried out with the view to assess the impact of anti tobacco audio-visual IEC messages developed and disseminated by NHEICC in bringing about health awareness of the people as a means to promote/ improve health status and to prevent the spread of diseases related to tobacco consumption.

The study will specifically look into following broad and specific issues:

- Review the production and dissemination of anti tobacco audiovisual IEC messages.
- Review the strategy and guidelines adopted by NHEICC for the dissemination of IEC Messages.
- Review of different media used by NHEICC to disseminate the IEC messages.
- Review of outreach, use and importance of electronic media for disseminating the IEC messages.
- Review the awareness level of the people on anti tobacco and health issues.
- Review the overall impact of anti tobacco audiovisual IEC messages produced and disseminated by NHEICC.
- Assess the effectiveness of anti tobacco activities, IEC message in the community.
- Assess the impact of those messages in bringing about positive changes in health knowledge, attitudes and behaviours of the people of Nepal.
- Assess tobacco (smoking and smokeless products) use prevalence.
- Assess peoples' knowledge about anti tobacco measures.
- Assess the relationship between morbidity, mortality and tobacco use in the country.
- Explore and assess tobacco use among the adolescents and youths.
- Examine gender and tobacco consumption.
- Provide recommendations for the development of more effective IEC programmes and messages with a view to reduce tobacco consumption and thereby its' effect on health.

In addition, a qualitative survey will be carried out to obtain perceptions of the target populations on the above subjects and the particular needs for anti-tobacco communication campaign strategy. The findings of these studies will be utilised to develop specific messages for the target audiences. At the same time research, monitoring and evaluation activity will be designed as an in-built component of the overall anti-tobacco IEC programme. At the end of each programme year an evaluation will be carried out to find out about programme weaknesses and strengths and the results will be utilised to improve the anti-tobacco IEC programme in the subsequent year.

Finally, impact evaluation studies will be needed to verify that project activities are having the desired effects. These studies can take a variety of forms, both large-scale and small-scale. They should occur periodically over a five-year period so as to capture, not only the overall change caused by the programme, but how it evolves as well. Impact evaluation must be carefully planned from the outset, not simply appended at the end of the programme, to permit the strongest affordable evidence about causation.

Thus, research is a key component of the total system and programme strategy. The research needs are large and like other components, must be thoroughly strategized in advance.

7. IMPLEMENTATION STRATEGY

The national anti-tobacco communication campaign strategy will be implemented at a four tier level: national, regional, district, and community. In order to implement the anti-tobacco information, education and communication programme effectively the activities will be decentralised.

7.1 Priority Areas

The illiterate, poor and the marginalized sections of the population are not empowered to make fully informed decisions about their own health. Considerable efforts are needed to ensure that relevant messages are constantly brought to public attention nationwide. Also, there must be a means to teach children about the health hazards of tobacco use.

For implementation of the national anti-tobacco communication campaign strategy the followings are identified as **priority areas**:

- 7.1.1 Advocacy to endorse The Smoking (Prohibition & Control) Act, 2058. This is a comprehensive Act, which addresses many problems that hinder the control of tobacco products. This proposed Act covers many aspects of FCTC. The MoHP, The National Front Against Tobacco and other relevant international, national government organisations, non-governmental organisations (NGOs) and Civil Society Organisations should work together to endorse the proposed Act.
- 7.1.2 Advocate for other issues listed in the audience segmentation chart of the anti-tobacco communication campaign strategy such as annual incremental taxes on

- tobacco products; levy health tax on bidi and chewing tobacco products; controlling of illegal trading of tobacco products, etc.
- 7.1.3 Involve journalists to advocate for anti-tobacco activities. The print media should refrain from promoting tobacco products. Some monetary benefits to the print media from tobacco companies today carry irreparable health and other costs to individuals, communities and the nation tomorrow.
 - 7.1.4 To educate the public that ignoring harmful effects of tobacco use today will carry a high price tomorrow.
 - 7.1.5 To impart knowledge to the poor, illiterate and the marginalized sections of the population about the health hazards of tobacco consumption and other risks resulting from it.
 - 7.1.6 The poor can better utilize their hard earned resource instead of wasting it in tobacco products.
 - 7.1.7 To give knowledge to the pregnant women that tobacco consumption by her not only affects her health but also that of her child.
 - 7.1.8 Educate the current tobacco consumers that their habit can be stopped and they can be freed from all vices of tobacco consumption.
 - 7.1.9 Campaign that tobacco-free life is an exalted life style; it is healthy, hygienic and productive.
 - 7.1.10 Co-ordination and mobilisation of government organisations (GOs), NGOs, international non-governmental organisations (INGOs), private sector and the local communities.
 - 7.1.11 Research:
 - Quantitative and qualitative studies on tobacco use with special reference to IEC activities.
 - Monitoring, supervision and periodic evaluation.
 - Impact evaluation at the end of the information, education and communication (IEC) programme.

7.2 Five-year action plan

Five-year action plan (2004-2008)

Mobile teams – 3 districts – 1st year

Mobile teams – 20 Terai districts – 2nd year

Mobile teams – 20 hill districts – 3rd year

Mobile teams – 17 hill districts – 4th year

Mobile teams – 15 Mountain districts – 5th year

8. CONCLUSION

Smoking prevalence in Nepal is higher (38.4%) than the smoking prevalence in the world as a whole (29%). The pattern of sex differential smoking prevalence in Nepal is similar to that of the world. Just as in the world as a whole more men smoke (47%) than their female counterparts (12%) in Nepal too more men smoke (48.4%) than the females (28.7). However, it is clearly seen that far too many women smoke in Nepal compared to

their counterparts in the world as a whole. The high smoking prevalence in Nepal is due to several reasons:

Firstly, smoking is a part of social norm in several communities.

Secondly, there is lack of knowledge about the harmful effects of smoking on health particularly among the poor and the illiterate.

Thirdly, smoking products are cheaper than many basic necessities of life.

Fourthly, smoking products especially the modern manufactured cigarettes are aggressively promoted in nooks and corners of the country.

Fifthly, for many smoking habit is handed down from the ancestors and therefore they take smoking as a normal social behaviour.

Sixthly, anti-tobacco promotional activities through the mass media began only about a decade ago and

Seventhly, many people do not see the harmful effects of smoking immediately.

Besides smoking, consumption of smokeless tobacco products such as *surti*, *khaini*, *pan masala*, *gutkha*, *pan parag*, and similar other products have equally harmful effects on health just as smoking has as mentioned earlier in this report.

High prevalence of smoking and tobacco use is a major challenge faced by His Majesty's Government of Nepal in its endeavour to improve the health of the people. The objectives set forth in this strategy are targeted to addressing this major challenge. However, the accomplishment of these objectives is possible only with the ongoing dedication and commitment of His Majesty's Government of Nepal, implementing agencies, and donor groups, to the programme. Focus on key objectives, timely response to programme issues, and attention to skill development needs of field personnel are imperative. Rigorous execution, at the organisational level, of strategies designed to manifest these objectives will ensure that enthusiasm and dedication filter down to the larger number of field workers, resulting in improved performance at all levels.

The anti-tobacco communication campaign strategy recognises the need to re-orient and revitalise the tobacco control programme by incorporating the recommendations of the FCTC in the Nepalese context. The emphasis on access to information and quality and the recognition of the importance of innovation (new approaches) and partnerships are key components of the programme.

The role of IEC is critical in the newly envisioned programme context. The anti-tobacco communication campaign strategy, which has evolved as an integral part of the overall health programme, provides the framework for the development of a comprehensive approach to IEC activities. The conceptual framework provided in this document, will guide the development of various segments of the IEC programme.