

National Tobacco Control Action Plan



2010 – 2015

REPUBLIC OF KENYA



**NATIONAL TOBACCO CONTROL
ACTION PLAN**

2010 – 2015

National Tobacco Control Action Plan

Process supported by: Kenya Tobacco Situation Analysis Consortium

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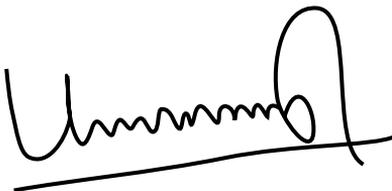
Foreword

The National Tobacco Control Action Plan 2010-2015 (NTCAP) outlines the key directions for tobacco control in Kenya over the next 5 years. It focuses on a number of evidence based interventions drawing its principles from the provisions of the World Health Organization Framework Convention on Tobacco Control (FCTC) and the Tobacco Control Act 2007. It outlines public health policy on tobacco control for Kenya and facilitates implementation of key recommendations of the Tobacco Control Act 2007.

The objective of the FCTC, its guidelines and protocols is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. It provides a legal framework of tobacco control measures to be implemented by parties in order to reduce the demand for and supply of tobacco.

Significant progress has been made in the past years to further strengthen tobacco control legislation in Kenya; The Tobacco Control Act 2007 was passed in the Kenyan parliament on 9th August 2007 and assented into law on 27th September 2007. This law introduced key tobacco control measures including a total ban on all forms of advertisement, promotion and sponsorship of tobacco products, labeling of all packages of tobacco with a conspicuous health warning, a ban on smoking in all public places and sale of tobacco products by or to minors.

The successful implementation of this law will only be realized if this Action Plan is implemented through a collective collaboration of the government, Non-government agencies and other stakeholders working together. Maintaining strong partnerships, strengthening legislation and progressing the comprehensive range of strategies outlined in the plan will ensure that the quality of life of all Kenyans is advanced.

A handwritten signature in black ink, appearing to read 'William Maina', with a horizontal line underneath it.

Dr. William Maina

Head: Division of Non-communicable Diseases

List of Abbreviations

ETS	Environmental Tobacco Smoke
FCTC	Framework Convention on Tobacco Control
GYTS	Global Youth Tobacco Survey
HCP	Health Care Providers
IEC	Information Education and Communication
IDRC	International Development Research Center
KDHS	Kenya Demographic and Health Survey
M & E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
NTCAP	National Tobacco Control Action Plan
SHS	Second Hand Smoke
SIDS	Sudden Infant Death Syndrome
WHO	World Health Organization

Executive Summary

The National Tobacco Control Action Plan 2010-2015 is an essential tool to guide tobacco control activities in Kenya for the next five years. It outlines public health policy on tobacco control for Kenya and facilitates implementation of key recommendations of the Tobacco Control Act 2007.

While the Tobacco Control Act 2007 provides a national framework for tobacco control in Kenya, various sectors in both public and private are responsible for determining the detail of their involvement in the implementation of the requirements of the Act. The National Tobacco Control Action Plan 2010-2015 focuses on those recommendations and strategies that are solely under the jurisdiction of the health sector.

Formulation of the National Action Plan 2010-2015

In response to the Tobacco Control Act 2007, the Division of Non-communicable Diseases in the Ministry of Public Health and Sanitation coordinated the development of the National Tobacco Control Action Plan 2010-2015 in consultation with a wide range of stakeholders from government and non-government organizations that have an interest in tobacco control issues.

The consultation process for development of the National Tobacco Control Action Plan 2010-2015 provided stakeholders with a number of avenues through which to contribute their feedback. These consisted of:

1. The Kenya Tobacco Situational Analysis Consortium regarding the implementation of tobacco control policies in various sectors
2. A survey on the compliance with the ban on smoking in public places in Nairobi conducted by the Kenya Tobacco Situational Analysis Consortium.
3. A consultative Core Team meetings held at the Ministry of Health headquarters in June and July 2010.
4. Distribution of a draft framework in July 2010 seeking comments.
5. A consultative Technical Working group Meeting held at ACK Guest House, Nairobi on 22nd July 2010.
6. Distribution of a draft plan in July 2010 to stakeholders seeking comments.
7. Stakeholders meeting held in August 2010 seeking further inputs.

8. Collation of stakeholder comments and recommendations August 2010
9. Finalization of the action plan by the Technical Working Group.

The National Tobacco Control Action Plan 2010-2015 is divided into three sections.

Section One provides a background of tobacco control and justification for the action plan

Section Two provides an overview of the plan and outlines the goal, objectives, action areas and priority population groups requiring special attention.

Section Three presents the implementation framework for the National Tobacco Control Action Plan. It outlines action areas and recommended activities to be employed over the next five years. Timeframes and data sources for key indicators are provided (where available) and those involved in the development and implementation of activities are identified.

Section 1

1.0 Background

Tobacco use is the largest single preventable cause of death and disease in the world today. Tobacco related diseases kill over 5.4 million people every year globally. Majority of these deaths occur in low and middle income country including Kenya. Tobacco smoking is a major risk factor for a range of disabling and fatal conditions including cardiovascular (coronary heart disease, stroke and peripheral vascular diseases), several cancers and lung diseases (asthma, chronic bronchitis and emphysema). A lifetime non-smoker is 60% less likely than a current smoker to have coronary heart disease and 30% less likely to suffer a stroke.

Men and women are at risk of developing a number of gender-specific health problems as a result of tobacco use and exposure to tobacco smoke. In women, tobacco use results in reduced fertility, menstrual problems and a greater risk of miscarriage, premature labour, and stillbirth, bearing an low birth weight baby or experiencing complications during labour. In men tobacco use leads to impotence and infertility.

Exposure to second hand tobacco smoke (SHS) is also a significant cause of disease. These diseases include cancers, cardiovascular diseases, and chronic respiratory diseases such as bronchitis, asthma and emphysema.

In children second hand tobacco smoke is considered a contributory factor in respiratory infections such as middle ear infections and pneumonia, irritation of the upper respiratory tract increases the frequency and severity of asthma symptoms. This can also trigger new cases of asthma and Sudden Infant Death Syndrome (SIDS) in babies. The 'irritant' effects associated with exposure to second hand tobacco smoke on the eyes, nose, throat and airway passages are also well known.

The benefits of reducing children's exposure to second hand smoke at home also includes reduced school absenteeism, increased school performance, reduced uptake of smoking and decreased consumption of tobacco among children who smoke.

1.1 Situation of tobacco use in Kenya.

In 2003, the prevalence of tobacco smoking in Kenya was 23% for males and 3% for females. In the same year the World Health Organization estimated the per capita consumption of cigarettes in Kenya as 200. This translated to 6.4 billion sticks of cigarettes smoked that year. The current population is about 40 million hence the current cigarette consumption has

gone up to about 8 billion sticks smoked each year in total. This has costed the smokers about 40 billion shillings, money that could have been spent on other household needs that would improve the standard of living. This misplaced budgetary allocation leads to impoverished families and communities.

In 2008 the prevalence of tobacco smoking in Kenya has been estimated at 19% for males and 2% for females. Central province is leading with 30.4%, Eastern 26%, Coast 22.6%, Nairobi 17.1%, North Eastern 15.6%, Rift valley 14.3%, Western 11.2% and Nyanza 7.9% (KDHS, 2009). These figure are for males only as most females do not disclose their tobacco use status due to social cultural inhibitions.

The Kenya Global Youth Tobacco Survey done in 2001 indicated that 13% of school going children aged between 12 to 15 years used any tobacco product (15.8% of boys and 10% of girls), 7.2% were current smokers while 8.5% use other forms of tobacco. A similar survey done in 2007 indicated that 18.6% of the students currently used any tobacco product (18.2% of boys and 18.2% of girls), 9.8% were current smokers while 12.8% used other forms of tobacco. This study revealed a 43% increase in overall tobacco use among children within a period of six years. The highest increase was for girls (82%) compared to that of boys (15.2%). The rate of smoking among school going children went up by 77.8% from 2001 to 2007.

1.2 Why we need a National Action Plan

Tobacco use is the leading cause of preventable deaths and disability globally. It is a risk factor for six of the eight leading causes of death. It is a risk factor for coronary heart diseases, stroke, cancer, respiratory diseases, diabetes and tuberculosis.

Statistics in Kenya indicate a rapid increase in tobacco use particularly among young people. This increase is even more in girls as compared to boys. Most adults who smoke commence this behaviour as adolescents. The younger someone is when they start to smoke, the more likely they are to be heavy users of tobacco and, consequently, the greater risk they have of ill health from smoking.

Besides the health effects of tobacco use by the primary consumer, the health effects of exposure to second hand smoke (SHS) are well documented and indisputable. Numerous scientific studies have demonstrated that exposure to SHS causes a number of illnesses and diseases, including heart diseases, cancers and chronic respiratory diseases.

Smokers are more prone to ill health and hence spend more time seeking health services than non-smokers. They spend a substantial proportion of their income to meet their medical expenses besides the even greater amounts they spend to purchase the tobacco products. When serious diseases strikes majority are hospitalized and their families and the community where they come from bear the burden as they struggle to support these individuals meet their health costs.

This results in huge economic loss from the direct medical cost and the indirect cost arising from lost productivity due to absenteeism from productive engagement by the individual and their family members. The suffering due to pain, distress and low quality of life are other indiscernible costs.

Chronic diseases contribute over 50% of all hospital admission in this country. They also cause over 30% of total mortality (MOH 2007). This high burden of chronic disease exerts a lot of strain on an already overstretched health system which is equally grappling with a high burden of communicable diseases. Increasing tobacco use will worsen this situation in future as tobacco related diseases continue to emerge and increase.

It is estimated that a country uses three dollars to mop tobacco related diseases for every dollar earned as tobacco revenue. Kenya collects approximately 5 billion shillings every year as tobacco revenue, it can therefore be estimated that the health sector uses 15 billion shillings to mop tobacco related diseases in the country.

Besides the health burden imposed by tobacco use, tobacco production equally imposes a heavy social and economic burden. Tobacco farming and production is a labour intensive exercise. Studies done in tobacco growing areas in Kenya reveal that women and child labour are extensively used in tobacco production which has been found to adversely affect girls' educational levels, children's nutrition, female reproductive health and women's economic and social development.

Tobacco production has far reaching negative effects on the environment. It results in impoverishment of the soil where the crop is grown, making food production impossible. This results in food insecurity in tobacco growing areas, this impact negatively on national efforts to eradicate extreme hunger and abject poverty.

Chemicals used in tobacco growing pollute the environment leading to destruction of biodiversity. Curing of the tobacco leaf requires wood fuel; as a result, trees and vegetation are cut down leading to deforestation.

Tobacco control legislation includes programs, which control the exposure of people within the community to second hand smoke, encourage non-smokers particularly young people not to start tobacco smoking and encourages smokers to quit smoking.

Improving the health of all people and reducing health inequalities is a key element of any health strategy. The factors that can cause poor health and inequalities are complex. Tobacco use particularly smoking, more than any other identifiable factor, contributes to the gap in life expectancy between those in most need and those most advantaged. Therefore, it will be particularly important to target the socially disadvantaged in the society when designing tobacco control programmes.

Section 2

2.0 Introduction

The National Tobacco Control Action Plan (NTCAP) is the first step towards developing a multi-sectoral tobacco control strategy for Kenya. The aim of this action plan is to contribute to the national efforts towards reducing the burden of diseases resulting from tobacco use and exposure to tobacco and second hand tobacco smoke.

The Action Plan identifies key intervention areas for tobacco control in this country. These include regulation, education, provision of cessation services, creation of networks and partnerships for tobacco control and research.

According to the Kenya Demographic and Health Survey conducted in 2003, over 23% of all adult males in Kenya are smokers. Whilst the report stated that less than 3% of females are smokers, this could have been an underestimation or lack of admission of female smokers (KDHS 2003). The situation has slightly changed over the last 5 years. In the 2008 demographic and health survey, adult male smokers were estimated as 19% while female smokers were at 2% (KDHS 2009).

The Global Youth Tobacco Survey (GYTS) in 2007 revealed that a fifth, 18.6% of the students currently used any tobacco product (18.2% of boys and 18.2% of girls), 9.8% were current smokers while 12.8% used other forms of tobacco. A similar study done in 2001 indicated that 13% used any tobacco product (15.8% of boys and 10% of girls), 7.2% were current smokers while 8.5% use other forms of tobacco. This study confirms an increasing trend in tobacco use among youths and in particular in girls.

A study done in Nairobi in 2007 indicated that the most prevalent mode of tobacco use is smoking (91.7%), followed by snuffing (3%) and combined snuffing and chewing (3.7%) (Wangai et al 2007). The World Health Organization estimates that the per capita cigarette consumption in Kenya could be 200 (WHO 2003). Using the population estimate of 38 million, the total number of cigarette sticks smoked in Kenya is approximately 7.6 billion. This translated to a total value of 38 billion shillings going up in smoke every year through cigarette smoking. This amount of money is equivalent to the total annual recurrent budget of the Ministry of Health. It is enough to put up 5 state-of-the-art cancer treatment centers in Kenya and train enough staff to man them.

Considering that almost a fifth of the total population above 15 years smokes, about 8 million adult Kenyans are at risk of developing tobacco related diseases at one point in their lifetimes. Half of these people will die prematurely from tobacco related diseases. The country cannot afford this loss and hence there needs to be no other justification, commercial or otherwise to delay tobacco control in this country.

2.1 Overview of the National Tobacco Control Action Plan 2010-2015

The National Tobacco Control Action Plan builds on the existing tobacco control efforts that have been put in place by various players in the past. It outlines public health policy on tobacco control for Kenya and facilitates implementation of key recommendations of the Tobacco Control Act 2007.

The National Tobacco Control Action Plan (NTCAP) is a framework that enables government, non-government organizations, individuals and community groups to work in collaboration to achieve successful tobacco control outcomes. It is an evidence based reference tool for anyone associated with tobacco control in Kenya, and is intended to contribute to the design and development of programs and activities across the country.

2.2 Context of the National Tobacco Control Action Plan 2010-2015

In Kenya, tobacco control activities are informed by the Tobacco Control Act 2007. The Act provides the legal framework within which Governmental and Non-Governmental Organization (NGO) draw their actions. The Act outlines measures to be undertaken to reduce the health and socio-economic burden imposed on Kenyans by tobacco use.

A range of agencies both Governmental and Non-Governmental conduct public education strategies that highlight the effects of tobacco on health in an effort to encourage smokers and other users to quit and deter young people from taking up smoking or use of other forms of tobacco. These public education strategies range from state-wide mass media based campaigns to community-based programs and a wide range of public advocacy on tobacco control issues.

The recommended activities in relation to this action area centre on maintaining and improving advocacy and existing education strategies, as well as ensuring a collaborative

and cooperative approach to developing and conducting community based initiatives that target priority population groups and the general community.

This action area will include a series of strategies to address the following:

- Promotion of prevention, cessation and smoke-free environment messages.
- Building the capacity of those working in tobacco control at a national, state or local level.
- Broader community engagement in tobacco control interventions and issues.
- More innovative programs to address smoking among vulnerable people and other high risk groups.

2.3 Goal

To reduce the prevalence of tobacco use, its associated diseases, disability and deaths in Kenya.

2.4 Objectives

2.4.1 To prevent people from starting to use tobacco products particularly cigarette smoking.

Preventing people, particularly children and young people, from starting to use tobacco will require a range of measures in four key areas:

- Raising awareness about the effects of tobacco smoke on smokers' and non smokers' health through:
 - Public information; and
 - Education
- Banning the advertising and promotion of tobacco products
- Enforcing existing legislation on sales of tobacco to children; and
- The widespread adoption of smoke-free policies in workplaces and places frequented by the general public.

We will aim to reduce the number of children and young people taking up smoking by:

- Providing children and young people with appropriate skills and knowledge about the harmful effects of smoking and the resilience to resist pressures to smoke, delivered through a variety of children and youth centered agencies
- Providing training for a range of staff working with young people around tobacco issues
- Reducing access to cigarettes and inducements to use tobacco products by enforcing tobacco control legislation

We will aim to reduce other forms of tobacco use by:

- Raising awareness of the health effects of tobacco
- The social and economic burden of tobacco use

2.4.2 To reduce the number of people using tobacco by helping users to quit.

Two-thirds of smokers say that they want to quit yet, despite increasing publicity about smoking related ill-health, many continue to smoke. Of the two-thirds who want to stop smoking, about one-third will try to stop in any one year. Given that, it is not easy to stop because nicotine is highly addictive and repeated attempts may be required before total abstinence is achieved.

Professional advice and support are essential to help smokers quit. Without such help, only 2% of middle-aged smokers are successful each year. In particular, young people, disadvantaged adults and pregnant women will require a range of services tailored to meet their specific needs. The needs of other disadvantaged groups, such as those from an ethnic minority background or with a disability, also need to be addressed. Cessation methods used with the general adult population should be modified as necessary with the aim of meeting such needs.

The range of effective interventions available to motivate and support those attempting to quit includes:

- Local and regional campaigns; such forum include the World No Tobacco days

- Brief advice delivered by health and social care professionals including doctors, dentists, nurses and pharmacists, as well as by allied health professionals;
- Specialist services offering advice and intensive support; and
- Other support, such as telephone help lines, self-help manuals, pharmaceutical industry.

This action area will include a series of strategies to address the following:

- Behavioural and support services.
- Pharmacotherapy.
- Counseling and referral by health professionals.

Quitting smoking remains one of the most important measures to reducing smoking-caused death and disease in Kenya.

Quitting smoking at any age results in immediate health benefits, irrespective of how long a person has been smoking. Many people find quitting difficult and usually need multiple attempts to quit successfully. It is therefore important that all smokers have access to a range of smoking cessation services and treatments that are appropriate and accessible to them in order to maximize their chances of success.

We will increase the access to cessation services through promotion of cessation services in all health institutions and also increase the numbers successfully quitting by:

- Build Capacity for Health Care Providers (HCP) to offer Tobacco Cessation Services

Training relevant staff to offer brief interventions, and ensuring that appropriate referral mechanisms are in place

- Create awareness among the community on the availability of cessation services
- Develop referral mechanisms for tobacco cessation:
 - From community to the primary health facility
 - From the primary health care facility to specialized services
- Developing a planned approach to national and local stop smoking campaigns

- Develop standardized information for cessation
- Focus on cessation during World No Tobacco Days

2.4.3 To protect non-smokers from the effects of second hand smoke (SHS).

Nicotine is highly addictive and it will take many years to achieve the overall aim of a tobacco-free society. In the meantime, the protection of the general public, particularly children, from tobacco smoke must remain a key element of any tobacco control policy. This requires partnership working and measures to promote smoke-free environments.

Tobacco smoke is a particular issue in the workplace as it can aggravate certain diseases such as asthma and chronic bronchitis and can cause discomfort to the eyes, nose, throat and chest.

It is recognized that there may be particular issues to be addressed in introducing smoking bans in hotels, pubs and other places of entertainment. Nevertheless, the wishes of the customers (and employees) who do not smoke should be respected. The introduction of no smoking policies in some public places is a welcome development but needs to become standard practice.

Occupational health services in both the private and statutory sectors have an important role to play in promoting a non-smoking environment. A key indicator of progress towards the ultimate goal of a tobacco-free society will be widespread acceptance that the provision of facilities for smokers can only be viewed as a short-term measure leading ultimately to smoke-free premises.

We aim to reduce the population's exposure to second hand smoke (SHS) by:

- Raising awareness of the public including adolescents, pregnant women and children on the dangers of exposure to second hand smoke.
- Raising awareness of the public, especially adolescents around the legalities associated with smoking in public places.
- Adoption of smoke free policies in public places, work places and institutions.
- Enforcement of ban on smoking in public places.

These objectives will be met through the coordinated efforts of key stakeholders and directed through the Technical Working Groups, whose membership reflects the diversity

required to fully develop and implement a cohesive and effective tobacco control action plan.

2.4.4 To strengthen Partnerships and coordination

Tobacco is a multi- disciplinary and multi- sectoral issue and Tobacco Control requires a balance of various interests, including Health, Trade and Economics, Environment, social cultural, Legal, Religious and Human Rights issues. While this Action Plan focuses on strategies of the Health Sector, partnerships and coordination will be sought with other concerned sectors, Government Departments and Agencies and stakeholders to ensure achievement of the Objectives of this plan. Partnerships will also be sought with non- Government stakeholders such as Civil Society and Religious organizations. These partnerships will be sought with the objectives of harnessing the resources and opportunities that the different groups can bring.

For all stakeholders to be effectively involved in the implementation of this plan, proper coordination will be needed to ensure that all the energies are geared towards common objectives. This will be done to achieve the following:

- Develop a common understanding of tobacco control between all the stakeholders
- Improve communication and information sharing for effective Tobacco Control
- Improve capacity for tobacco control
- Mobilize and concentrate Human and Financial resources to support tobacco control work in Kenya

Each player in tobacco control will be expected to understand their roles and responsibilities in tobacco control, and work in Partnership and/or coordination with other players so as to achieve the broad and specific objectives of this plan.

2.4.5 Research, Monitoring and Evaluation

Comprehensive research and evaluation activities are important for ensuring that current and proposed tobacco control programs and policies are appropriate and effective. Effective research and evaluation will assist with priority setting, identifying new and emerging trends and issues, reflecting on achievements, and establish future goals.

This action area will include a series of strategies to address the following:

- Research to develop new methodologies for tobacco control.
- Evaluation of the effectiveness of current tobacco control activities.
- Monitoring of smoking behaviour, attitudes and prevalence.
- Analysis and dissemination of research findings.

This will be undertaken by each organization involved in the delivery of the National Tobacco Control Action Plan, and where appropriate, information will be collated on a yearly basis and reported back to the Tobacco Control Working Group.

2.5 Framework of Action

The action plan has been developed by drawing together the activities already undertaken by partners in relation to tobacco control and collectively identifying further actions required to achieve the three main objectives of:

- Prevention
- Cessation
- Protecting non-smokers from the effects of Environmental Tobacco Smoke (ETS)
- Research, Monitoring and Evaluation (M &E)

SECTION 3

NATIONAL TOBACCO CONTROL ACTION PLAN 2010-2015

Goal: To reduce smoking prevalence and associated disease, disability and death in Kenya, by preventing uptake of smoking, encouraging smoking cessation and eliminating exposure to secondhand smoke.

Objective 1. To Prevent people from starting to use tobacco products particularly tobacco smoking

Expected Outcomes	Activities	Time frame	Monitoring Indicators	Resources Required	Responsible
11. Increased Promotion of prevention, cessation and smoke free environment	Develop and implement culturally relevant, timely and appropriate advocacy, educational and promotional campaigns and materials.	2010 -2015	Number of campaigns run/areas visited	Personnel Funds	DNCD /MOPHS
	Develop the tobacco control communication strategy	2010 -2011	Communication strategy in place	Personnel Funds	DNCD /MOPHS
	Produce and disseminate the IEC materials	2010 - 2015	Number of IEC materials produced	Funds to produce IEC	MoPHS, civil society organizations
	Introduction and periodic review of tobacco control messages in the school curriculum for primary and secondary level of education	2010 - 2011	No. of school materials developed	Personnel Venue Funds	MoPHS, Kenya Institute of Education
	Hold advocacy sessions with Ministry of Higher education to introduce tobacco control issues into tertiary institutions of Learning	2010 - 2015	No. of sessions held.	Personnel Funds	MoPHS, civil society, Kenya Institute of Education
Increased public awareness of the dangers of tobacco use.	Conduct public education campaigns on the effects of smoking on health in an effort to encourage smokers to quit smoking and deter young people from taking up smoking.	2011 - 2015	No. of campaigns conducted	Personnel Venue Funds	MOPHS/ Partners
	Conduct state-wide mass media based campaigns on major national and community based media	2011 - 2015	No. of campaigns conducted	Personnel Venue Funds	MOPHS/ Partners
Broader community engagement in tobacco control interventions and issues.	Advocate and implement Community-based programs and a wide range of public advocacy on tobacco control issues.	2011 - 2015	No. of programs run by community/target groups reached	Funding Materials (IEC)	MoPHS, civil society
	Develop and implement more innovative programs to	2011 - 2015	No. of campaigns	Personnel	MoPHS, civil society

	address tobacco use among marginalized and other high risk groups		conducted	Venue Funds	
Reducing access to cigarettes by enforcing tobacco control legislation	Training of enforcement officers and agencies	2010 - 2012	No. of enforcement officers and agencies trained	Funds Personnel	MoPHS, civil society
	Monitoring the enforcement of the law	2010 - 2015	No. of violations reported and prosecuted	Funds Personnel	Civil society, Public Health Officers infrastructure throughout the country
Introduction and progressive development of pictorial warnings	Enactment of legislation on pictorial warnings	2010 - 2012	Presence of legislation Pictorial warnings on tobacco products	Funds Personnel	Div of NCDs, Tobacco Control Board
Progressive increases in levels of tobacco taxation	Background research on rationale for increased taxes	2011 - 2015	Research report	Funds Experts	MoPHS, civil society
	Lobbying Min of Finance for increased tobacco tax	2011 - 2015	No. of meetings held with relevant stakeholders Tobacco tax increase each year	Personnel Funds materials	MoPHS, civil society
	Review and replacement of pictorial warnings	2012 - 2015	New pictures on packs	Funds Personnel	Div of NCDs, Tobacco Control Board
Improved capacity for tobacco	Development and dissemination of training materials Conduct trainings to build the capacity of those working in tobacco control at a national, state or local	2010 - 2012	No. of training materials developed	Personnel Funds materials	MoPHS, Local government, civil society
	Sensitization for a for the various cadres of target groups identified especially those working with children and young people	2012 - 2015	No. of fora held and people trained		

Objective 2. To reduce the number of people using tobacco by helping users to quit. - Cessation services and treatment

Expected Outcomes	Activities	Timeframe	Monitoring Indicators	Resources Required	Responsible
Improved capacity for Health Care Providers to offer Tobacco Cessation Services	Develop Tobacco cessation Curriculum for HCPs	2010 - 2011	Curriculum Document	Funds Personnel Venues	MOH / Partners
	Training of 5000 health workers on cessation - particularly those providing clinical and nursing services.	2011-2015	No. of HCP Trained	Funds Personnel Training materials Venues	MOH / Partners
Increased community awareness of the availability of cessation services	Introduce tobacco cessation into youth friendly clinics	2012 - 2015	No. of YFC providing cessation services	Funds Personnel Information materials	MOH / Partners
	Initiate cessation services in 30% of primary health care facilities	2011 - 2015	No. of PHC facilities with functional cessation programmes	Funds Personnel Information materials	MOH / Partners
	Provide relevant guidelines and management protocols for the HCPs	2010 - 2011	No. documents developed	Funds Personnel Venues	MOH / Partners
	Promote access to nicotine replacement therapy	2012 - 2015	No. of PHC facilities with functional cessation programmes	Funds Personnel supplies	MOH / Partners

	Explore other possible partners and potential groups who could be actively involved in cessation services provision.	2010 - 2011	Inventory of organizations	Funds Personnel	MOH / Partners
	Initiate community based cessation services	2012 - 2015	No. of community groups actively providing cessation support	Funds Personnel Information materials	MOH / Partners
Develop referral mechanisms for tobacco cessation	Develop information, education and communication materials for marketing the cessation services.	2010 - 2012	No. of different materials developed	Funds Personnel	MOH / Partners
	Formulate a programme for working with partners to raise awareness of the service with their clients	2010 - 2011	Joint workplan	Funds Personnel Information materials	MOH / Partners
	Develop sustainable specialist smoking cessation services	2012 - 2015	No of specialized smoking cessation facilities available	Funds Personnel Information materials Supplies	MOH / Partners
Functional national and local stop smoking campaigns	Continuous sensitization of health workers e.g. through job aids	2011 - 2015	No of sensitization sessions held.	Funds Personnel Information materials Supplies	MOH / Partners
	Develop standardized information for cessation	2010 - 2011	Education manual available	Funds Personnel Information materials	MOH / Partners
	Conduct road shows to promote cessation Use media - talk show, spots, printed supplementary	2011 - 2015	No of mass awareness campaigns conducted	Funds Personnel Information materials	MOH / Partners
	Focus on cessation during WNTDs	2011 - 2015	Reports of campaigns	Funds Personnel Information materials	MOH / Partners

Objective 3. To protect non-smokers from tobacco smoke through implementation of smoke free policies

Expected Outcomes	Activities	Timeframe	Monitoring Indicators	Resources Required	Responsible
3.1 widespread adoption of no smoking policies in public places, workplace and learning institutions	Awareness creation through workshops, courtesy calls, in the specific places	2010 - 2015	Proportion of the specified places that have adhered to ETS policies-	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Capacity building through trainings				
3.2.increased awareness of the public, including adolescents, pregnant women, children On the dangers of exposure to Environmental Tobacco Smoke	Develop and disseminate awareness materials targeting specific groups	2010 - 2015	No. of materials developed	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Conduct awareness campaigns through print media/ bill boards, electronic media- articles, talk shows,	2010 - 2015	Number of talk shows/ articles and events held	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Mobilize community groups- women and Youth Groups	2010 - 2015	Number of groups	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Conduct talk shows in schools and at school events eg drama and sports and Head teachers fora	2010 - 2015	Number of events	Human resources Funds IEC material	MoPHS CSO partners Development partners
3.1 widespread adoption of no smoking policies in public places, workplace and learning institutions	Provide health talks in health facilities	2010 - 2015	Number of people reached	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Conduct awareness creation through workshops, organized group meetings	2010 - 2015	No of institutions sensitized	Human resources Funds IEC material	MoPHS CSO partners Development partners
	Conduct Capacity building through trainings	2010 - 2015	No. of persons trained	Funds, Human resources, Materials,	MoPHS CSO partners Development partners

Objective 4. Partnerships and coordination

Expected Outcomes	Activities	Timeframe	Monitoring Indicators	Resources Required	Responsible
Increased coordination and partnership in tobacco control initiatives	Joint research ventures Peer reviews	2010 - 2015	No of Joint activities conducted	Funds, Human resources, Materials,	MoPHS, KEMRI, CSOs, Research institutes, UN Agencies
Improved communication and information sharing for effective Tobacco Control	Information sharing through meetings and conferences	2010 - 2015	No of meetings held	Funds, Human resources, Materials,	MoPHS CSO partners Development partners
Enhanced synergy between stakeholders	Mobilize and concentrate Human and Financial resources to support tobacco control work in Kenya	2010 - 2015	No of Joint activities conducted	Funds, Human resources,	MoPHS CSO partners Development partners
	Establishing networks and alliances	2010 - 2015	No of Networks established	Funds, Human resources, Materials,	MoPHS, WHO, UN Agencies

Objective 5. Research, monitoring and evaluation

Expected Outcomes	Activities	Timeframe	Monitoring Indicators	Resources Required	Responsible
Knowledge base on the cultural attachments of tobacco gathered	Research on cultural practices and attachments on tobacco use among the youth, farmers, women and special communities Kenya.	2010-2012	Baseline survey report	Funds, Human resources, Materials	GoK, MoH, KNBS, Academic institutions, Civil Society
	Innovative programs to address marginalized and other high risk groups	2010 - 2015	Research report	Funds, Human resources, Materials	GoK, Medical Research institutions, Universities
Informed strategies and interventions focusing on the youth Strategy on cessation	Conduct research on impact of smoking on health in Kenya.	2010 - 2015	Report	Funds, Human resources, Materials,	
	Research on existing programmes that address tobacco use among the marginalized groups	2010-2012	Survey report	Funds, Human resources, Materials,	GoK, CSOs, Universities, Research institutions
Status of the implementation of smoke-free level	Research on existing infrastructure on cessation	2010-2012	Quality of life, Income level	Funds, Human resources, Materials,	GoK, CSOs, Universities, Research institutions
	Research on harmful effects of tobacco use amongst the youth	2010-2012		Funds, Human resources, ,	GoK, CSOs, Universities, Research institutions
Increased operational research to strengthen implementation of the Tobacco Control Act 2007	On implementation of smoke-free policies in workplaces	2010-2012	Survey, Rates of implementation	Funds, Human resources,	GoK, CSOs, Universities, Research institutions
	Conduct studies on the economics impact of tobacco production and use	2010-2012	Changes in lifestyles, price effect	Funds, Human resources, Materials,	GoK, CSOs, Universities, Research institutions
	Conduct research to inform policy on all matters of the Tobacco Control Act	2010-2015	No. of studies done	Funds, Human resources, Materials,	GoK, CSOs, Universities, Research institutions
	Impact Taxation on tobacco products	2010-2012	Increase in tax	Funds, consultants	CSO, GoK, KNBS
	Community responses to tobacco control strategies	2010-2015	Rates of adopting new strategies	Funds, Human resources, Materials	

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