

The International Tobacco Control Policy Evaluation Project

# ITC Kenya National Report

FINDINGS FROM THE WAVE 1 (2012) SURVEY

DECEMBER 2015



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around children you are ex...  
to thousands of chemicals tha...  
ing them alive. Tobacco smo...  
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also linked to low birth weight, and...  
oubles the risk of sudden infant death.



Promoting Evidence-Based Strategies to Fight the Global Tobacco Epidemic



UNIVERSITY OF  
NAIROBI



Ministry of Health



International Tobacco Control  
Policy Evaluation Project



UNIVERSITY OF  
WATERLOO





Findings from the ITC Kenya Wave 1 (2012) Survey

# ITC Kenya National Report

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## 1.0 MESSAGES



### Message from James Macharia

Tobacco is the leading preventable cause of death and disease in the world today, killing about 6 million people annually. As the tobacco industry continues to seek new markets, African countries are particularly at a much higher risk of a tobacco epidemic. Without strong tobacco control measures, tobacco-related death and illnesses are certain to increase, with devastating effects on public health, social development and economic growth. The trend of non-communicable diseases (NCDs) in Kenya is alarming. Tobacco is the most preventable cause of NCDs which include cancers, heart diseases, lung diseases and diabetes. According to the WHO country atlas about 370 000 Kenyans between 30 to 70 years die each year from NCDs. The prevalence of these diseases will continue to rise if more people continue to use tobacco.

The Ministry of Health is committed to ensuring that Kenyans have access to the highest attainable standards of health and that Kenyans are able to live, socialize, and work in a smoke-free environment. The Ministry of Health recognizes the urgency of the tobacco menace and it has facilitated the accomplishments that have been made by the government.

Kenya ratified the WHO FCTC in 2004 and passed the Tobacco Control Act 2007 to control smoking in public places, ban direct and indirect advertising, and ban the sale of tobacco products to and by minors. We have made great strides in tobacco control in Kenya. For example, tobacco advertising is almost negligible in Kenya due to strong compliance with legislation to ban this practice. The national anti-smoking mass media campaign “Tobacco Kills – Quit Now” aimed at reducing tobacco use, protecting lives from secondhand smoke and educating the public about the dangers of smoking increased public awareness on the harms of tobacco use. The government has also implemented one of the most effective systems to combat illicit trade in tobacco products to reduce the affordability and access particularly by young people.

The ITC Kenya Wave 1 National Report provides evidence of our leadership in key areas of tobacco control. For example, the Tobacco Control Act has been successful in creating smoke-free public transportation and curbing tobacco advertising. However, the report also points to areas where urgent action is needed to further reduce secondhand smoke in bars and workplaces, and to increase knowledge of the harms of tobacco use.

I call upon all tobacco control actors in Kenya to implement the recommendations of this report. These recommendations will catapult our continued efforts to fully implementing the FCTC and the Tobacco Control Act towards a tobacco-free Kenya.

A handwritten signature in blue ink, consisting of several overlapping, fluid strokes.

James Macharia  
Cabinet Secretary of Health  
Government of Kenya

“The ITC Kenya Wave 1 National Report provides evidence of our leadership in key areas of tobacco control. For example, the Tobacco Control Act has been successful in creating smoke-free public transportation and curbing tobacco advertising. However, the report also points to areas where urgent action is needed to further reduce secondhand smoke in bars and workplaces, and to increase knowledge of the harms of tobacco use.”

James Macharia  
Cabinet Secretary of Health  
Government of Kenya



## Message from Dr. Khadijah Kassachoon

Kenya is committed to implementing measures to reduce consumption of tobacco products and we welcome research evidence provided by the ITC Kenya Project to help guide priorities and actions for stronger tobacco control in Kenya.

This report provides clear evidence on the need for stronger action in the areas of health warnings, tobacco taxation, and public education in Kenya. We recognise the importance of raising public awareness of the many harms of smoking and have recently launched the first nationwide media campaign through radio, television, print, and social media to encourage smokers to quit while educating the public on the harmfulness of tobacco and tobacco smoke. We also recognise that having strong enforcement measures put in place for our tobacco control legislation is necessary to reduce tobacco consumption. In collaboration with the county government we shall work towards strengthening the enforcement mechanisms for the Tobacco Control Act.

The ITC Kenya Survey findings have great potential to propel our endeavour to reverse the tobacco epidemic in Kenya. I assure you all that we shall implement the recommendations of this report. I thank the University of Waterloo ITC team and the ITC Kenya Project team for your dedication to this project and for bringing these important research findings to our attention. We look forward to our continued collaboration in undertaking future ITC surveys to further improve our policies and the implementation of the FCTC.

The Ministry of Health acknowledges the financial support of the University of Waterloo and the technical contribution of organizations such as The International Institute for Legislative Affairs (ILA), University of Nairobi (UoN), and the Kenya Medical Research Institute (KEMRI). In particular we appreciate the dedication of the following individuals from University of Waterloo – Prof. Geoffrey Fong (The Chief Principal Investigator for ITC), Dr. Mary Thompson, Dr. Anne Quah, Dr. Susan Kaai; from the Ministry of Health – Dr. Joseph Kibachio, Ms. Dorcas Kiptui, Dr. Gladwell Gathecha, Dr. Alfred Karagu; as well as Mr. Vincent Kimosop and Ms. Emma Wanyonyi (ILA), Dr. Lawrence Ikamari (UoN), and Dr. Jane Ongango (KEMRI).

This landmark report will facilitate the strengthening of the implementation of the FCTC and the Tobacco Control Act towards a further reduction in tobacco consumption and exposure to tobacco smoke in Kenya.

A handwritten signature in blue ink, appearing to be 'JK', written over a light blue circular background.

Dr. Khadijah Kassachoon  
Principal Secretary for Health  
Government of Kenya



## Message from Dr. Nicholas Muraguri

Research is critical in public health as it provides us with the evidence base on which we develop, implement, monitor and evaluate our policies. Further, it provides opportunities for knowledge-sharing among researchers and policymakers for progressive interventions. More specifically, global tobacco surveillance system surveys are critical for monitoring and tracking the tobacco epidemic. The ITC Project is unique in evaluating the implementation of tobacco control policies through longitudinal surveys of tobacco users and non-users conducted throughout the world. The ITC Kenya Wave 1 National Report has brought to our attention key areas for urgent action on tobacco control. Findings from the ITC Kenya Survey placed in the context of more than 20 other

ITC countries demonstrate to us the evidence of the urgent need to strengthen the implementation of the FCTC across several important policy domains. For instance, the recent Global Adult Tobacco Survey (GATS) indicated that approximately 2.5 million adults in Kenya currently use tobacco while the Global Youth Tobacco Survey (GYTS) showed that 9.6% of youth are tobacco users. The high prevalence of exposure to tobacco smoke in night clubs and bars, despite the ban on smoking in public places, indicates the need for stronger enforcement of smoking bans in these venues.

The ITC Kenya findings indicate that the low price of tobacco products is not deterring smokers, and smokers are not well-linked to cessation services. Although most Kenyans were aware of the text warnings, only 24% of smokers noticed these health warnings on cigarette packs and only 28% said that warnings made them more likely to quit smoking. These findings suggest a lost opportunity to motivate smoking cessation by using stronger pictorial warnings which have been found to be more effective than text-only messages in other ITC countries like Mauritius.

In addition, the Ministry of Health is deeply concerned about the rising number of premature deaths from non-communicable diseases (NCDs) including heart diseases, cancers, diabetes, and chronic respiratory diseases. NCDs account for 27% of deaths suffered by Kenyans aged between 30 and 70 years, equivalent to almost 370 000 people per year, reducing productivity, curtailing economic growth, and trapping the poorest people in chronic poverty. Tobacco use and exposure to tobacco smoke are the main risk factors for NCDs and therefore the implementation of strong tobacco control measures is critical to reducing the health and economic burden caused by NCDs.

We are pleased that ITC Kenya research evidence also indicates that the public is extremely supportive of stronger tobacco control policies. For example, the majority of tobacco users themselves support an increase in tobacco taxes.

The ITC Kenya Survey findings have great potential to propel our endeavour to reverse the tobacco epidemic in Kenya. I assure you all that we shall implement the recommendations of the survey. I thank the University of Waterloo ITC team and the ITC Kenya Project team for your dedication to this project and for bringing these important research findings to our attention. We look forward to our continued collaboration in undertaking future ITC surveys to further improve our policies and the implementation of the FCTC.

Dr. Nicholas Muraguri  
Director of Medical Services  
Government of Kenya

## 2.0 EXECUTIVE SUMMARY

Tobacco is the leading preventable cause of death and disease, killing about 6 million people annually. About 600,000 of these deaths occur as a result of exposure to secondhand smoke. It is projected that tobacco use will kill 1 billion people in the 21st century, with 80% of deaths occurring in low- and middle-income countries (LMICs). The largest expected regional increase globally will be in the African region, where smoking prevalence is expected to increase from 15.8% in 2010 to 21.9% in 2030 – a difference of nearly 39%<sup>1</sup>. Without strong tobacco control measures in African countries, tobacco-related deaths and illnesses are certain to increase, with devastating effects on public health, development, and economic growth.

The WHO Framework Convention on Tobacco Control (FCTC) and its guidelines provide an evidence-based framework for the development and implementation of effective tobacco control policies. Kenya signed and ratified the FCTC in June 2004, and the treaty became effective as of February 27, 2005. Kenya's 2007 Tobacco Control Act came into force in July 2008, providing the legal framework for the implementation of FCTC policies in Kenya.

In 2010, the International Tobacco Control Policy Evaluation Project (the ITC Project) at the University of Waterloo partnered with the International Institute for Legislative Affairs, the Kenya Medical Research Institute, the Ministry of Health, and the University of Nairobi to create the ITC Kenya Survey. The Survey was conducted from October to December 2012 among 1,427 tobacco users and 571 non-users aged 15 years and older to determine the prevalence of tobacco use in Kenya and to evaluate the effectiveness of tobacco control policies in Kenya.

The ITC Kenya Wave 1 (2012) Survey findings provide evidence that the Act is effective in some policy areas, such as curbing direct forms of tobacco advertising, promotion, and sponsorship, and providing protection in some public places from the harms of secondhand smoke. However, the implementation of the Act requires strengthening and improved enforcement to address weaknesses across key policy domains of the FCTC, including health warnings, tobacco taxation, and public education.

The Global Adult Tobacco Survey 2014 (GATS) findings suggest that policy weaknesses identified by the ITC Kenya Survey have not been resolved and public support for stronger policies continues to be strong. The ITC Survey found that about three-quarters (76%) of tobacco users are in favour of a ban on tobacco products within 10 years if the government provided assistance such as cessation clinics. They are willing to pay more for tobacco products as 70% of Kenyans, including 60% of smokers, support an increase on cigarette taxes. GATS findings indicate that support in 2014 is even stronger as 80% of adults favoured increasing taxes on tobacco products. Overall, these findings are favourable for stronger tobacco control regulations to bring Kenya into compliance with the FCTC and its guidelines.

*About three-quarters (76%) of tobacco users are in favour of a ban on tobacco products within 10 years if the government provided assistance such as cessation clinics.*

## Tobacco Use and Quitting Behaviour

The ITC Kenya Survey data suggest that tobacco use has increased since the the Kenya Demographic Health Survey (KDHS) conducted in 2008-09, which found that 19% of men and 1.8% of women use tobacco. The ITC Survey conducted in 2012 found that 16% of adults in Kenya – 27% of men and 5% of women were current tobacco product users. Tobacco use prevalence ranged from 9% in Western and Nyanza provinces to 26% in Coast province. The types of tobacco products used differ between men and women – the majority of male tobacco users (83%) mainly use smoked tobacco products (primarily cigarettes), while female tobacco users (66%) mainly use smokeless products. The majority of Kenyan cigarette smokers smoke mainly factory-made cigarettes (87%), while 12% smoke hand-rolled cigarettes, and 1% smoke both forms of cigarettes.

The survey revealed that male smokers in Kenya have a higher use of menthol and sweet menthol cigarettes (about 2 in 10 smokers of a usual brand), compared to male smokers in most other ITC countries. This is of concern for tobacco control efforts because flavourings such as menthol can produce cigarettes that deliver a smoother sensation on the respiratory system, and this smoother sensation has been shown to be strongly related to palatability and the belief that these cigarettes are less harmful, and leads to smoking initiation and youth smoking.

More than one-third (40%) of Kenyan smokers have “ever” tried to quit smoking cigarettes, and 17% of smokers plan to quit in the next 6 months. Concern for personal health was the most common reason for thinking about quitting (81% of those planning to quit) followed by setting an example for children (64% of those planning to quit). Smokeless tobacco users were even less likely to have attempted to quit – about one-fifth (21%) of smokeless users have “ever” tried to quit, and 11% plan to quit in the next 6 months. The two most common reasons for wanting to quit smokeless tobacco were the same as those for smokers – concern for health (79% of those planning to quit); and to set an example for children (54% of those planning to quit). Of concern is the finding that the price of cigarettes and smokeless products were among the least frequently cited reasons for thinking about quitting.

Tobacco users in Kenya are not well connected to sources of cessation assistance. One-fifth (20%) of tobacco users reported that they had visited a doctor or other health provider in the last 6 months. Among smokers who had visited a doctor, 35% were given advice to quit tobacco – a lower percentage than in most of the other ITC LMICs. It is well established that advice to quit from a physician or health provider is a powerful motivator for quitting. Of those who were given advice to quit, 82% reported that the advice made them think about quitting tobacco.

## Health Warnings

Kenya’s health warnings on tobacco products consist of text-only warnings in both English and Kiswahili covering 30% of the front and 50% of the back of the pack. There are 13 different warnings for smoked and smokeless tobacco products that are rotated through a 12-month period. The messages have remained the same since 2007 which evidence shows leads to wear-out effects over time. The current warnings do not meet the Guidelines for Article 11 of the FCTC – they are not at the top of the pack, they are not at least 50% of the front and back of the pack, and they do not include pictures. However, the Ministry of Health has taken steps to improve the health warnings by proposing the 2014 Tobacco Control Regulations to require pictorial warnings on 30% of the front and 50% of the back of the pack. The Regulations propose that a set of 15 rotating pictorial health warnings be required on all packages of smoked and smokeless tobacco.



**Of 14 ITC countries, Kenya had the second-lowest percentage of male smokers (66%) who believed that smoking causes heart disease in smokers. Knowledge gaps were even higher for health effects not addressed among the text warnings, such as stroke.**

Almost all (99%) smokers indicated that they were aware that tobacco packages have warning labels. Two-thirds (66%) of male smokers noticed the warnings “often” or “whenever I smoke cigarettes”. Although awareness of the presence of warnings is strong, there is evidence of gaps in tobacco users’ knowledge of specific harms of tobacco. Despite the presence of specific text warnings indicating that tobacco (including smokeless tobacco) can cause mouth cancer, heart disease, and impotence, only 38% of smokeless users were aware that smokeless tobacco causes mouth cancer, only 65% of smokers were aware that smoking causes heart disease in smokers, and only 53% of smokers and 33% of smokeless users were aware that smoking causes impotence. Of 14 ITC countries, Kenya had the second-lowest percentage of male smokers (66%) who believed that smoking causes heart disease in smokers. Knowledge gaps were even higher for health effects not addressed among the text warnings. For example, less than half (44%) of smokers were aware that smoking causes stroke. Of 20 ITC countries, Kenya had the second-lowest percentage of male smokers (47%) who believed that smoking causes stroke, higher only than China (35%).

Tobacco packages were rated as the most common source of information on the dangers of tobacco use – 71% of tobacco users and 54% of non-users reported that they noticed such information on tobacco packages in the last 6 months. However, 83% of smokers stated that their last purchase of cigarettes was in single sticks, contrary to the law banning the sale of cigarettes in single sticks. Not only does this indicate a lack of enforcement of the ban on the sale of single cigarettes, but it also suggests a huge reduction in exposure to the health warnings on packs.

## **Misleading Package Descriptors**

The 2007 Tobacco Control Act bans the promotion of tobacco by any means, including packaging, that are false, misleading or deceptive, or that are likely to create an erroneous impression about the characteristics or health effects of tobacco use. However, the Act does not specifically ban the use of false descriptors on tobacco products such as “mild” or “low-tar” as specified under Article 11 of the FCTC.

There is evidence that measures in the Act to curb misleading packaging do not go far enough. Two in five (40%) smokers who had a usual brand think that the cigarette brand that they usually smoke is less harmful compared to other cigarette brands. Among smokers who had a usual brand, 9% of male smokers reported that they smoked “light” cigarettes. This is lower than the percentage reported among male smokers in India (34%) and Zambia (29%).

## Smoke-free Policies

The 2007 Tobacco Control Act prohibits smoking in public places and workplaces, but allows the premises owner to construct separate ventilated indoor designated smoking areas (DSAs) as specified in the Act. The current law does not align with Article 8 of the FCTC nor the Guidelines which call for a comprehensive ban on smoking in workplaces and indoor public places, without allowances for ventilation, air filtration, and the use of DSAs. The 2014 Regulations include several measures aimed at strengthening the smoke-free law, such as banning smoking in cars when children are passengers. However, the Regulations fall short of meeting the Article 8 Guidelines by requiring certificates of compliance for DSAs rather than banning DSAs altogether.

The ITC Survey found that there is strong adherence to the smoking ban on public transportation – only 2% of tobacco users and 4% of non-users noticed people smoking on public transportation during their last trip. However, smoking prevalence in other public venues was higher – 14% of tobacco users and 15% of non-users who work inside a building noticed smoking inside their workplace in the last month, and 16% of tobacco users and 7% of non-users who visited a restaurant noticed people smoking indoors the last time they visited. There was a very high prevalence of smoking in bars: 86% of tobacco users and 67% of non-users who visited a bar noticed people smoking indoors during their last visit.

There is strong public support for completely smoke-free workplaces and restaurants. 85% of tobacco users and 94% of non-users indicated that they support a complete ban on smoking in workplaces. Similarly, 83% of tobacco users and 92% of non-users support a complete smoking ban inside restaurants. Kenyans are less supportive of a complete smoking ban inside bars – only 35% of tobacco users and 63% of non-users support such a ban. However, it should be noted that this level of support of smoke-free bars is higher than the level of support in Ireland before their successful smoke-free law. Almost half (49%) of smokers in Kenya reported that they do not allow any smoking inside their home. ITC studies conducted before and after the implementation of smoking bans in Australia, Canada, United Kingdom, Ireland, France, Germany, and the Netherlands show increases in support for smoke-free laws and an increase in the prevalence of smoke-free homes after smoking bans are implemented. It is expected that there would be similar increases in Kenya after smoke-free laws are strengthened.

## Tobacco Advertising, Promotion, and Sponsorship

The 2007 Tobacco Control Act prohibits all forms of direct and indirect tobacco product advertising, promotion, and sponsorship (TAPS) including point of sale advertising and promotion such as “product stacking or product displays of any kind or size”. The Act also includes measures to ban product promotion in the entertainment and broadcast media.

The Kenya Wave 1 Survey found evidence of weak enforcement of TAPS restrictions in the retail environment. 18% of tobacco users reported noticing cigarettes advertised in stores in the last 30 days and 18% noticed tobacco products advertised on shop windows in the last 6 months. There was some evidence of violations of the tobacco product advertising ban in traditional forms of media (9% of tobacco users noticed advertising on radio; 5% in newspapers/magazines; 4% on television).



Overall, 70% of Kenyans thought that the government should increase taxes on cigarettes, including more than half (60%) of smokers, 71% of smokeless users, and 89% of non-users.

Tobacco product promotion in the entertainment media is extensive – 41% of tobacco users and 29% of non-users reported noticing people using tobacco products in the entertainment media “often” or “once in a while” in the last 6 months. This is of concern as numerous studies have proven that there is a causal association between the depiction of smoking in the entertainment media and the initiation of youth smoking. The findings suggest weak enforcement of the Act in two areas: (1) the ban on cinematographic works that use or depict tobacco products or tobacco product-related brand elements; and (2) the ban on the promotion of tobacco or tobacco products by means of broadcast media originating outside Kenya.

## Education, Communication, and Public Awareness

The survey findings point to the importance of effective health warnings and media campaigns in efforts to increase public awareness of the harms of tobacco and to encourage quitting. Tobacco packages were the most frequently reported source of anti-tobacco information for 71% of tobacco users and 54% of non-users. Radio was the second most frequently reported source of information (44% of tobacco users; 53% of non-users). The findings also point to an opportunity to strengthen public education in workplaces and bars as less than a quarter (17% and 12% respectively) of tobacco users reported noticing anti-tobacco information in these venues.

## Price and Tax

Increasing tobacco taxes and prices is widely recognized as the single most cost-effective strategy to reduce tobacco use, particularly among youth and lower-income groups. The ITC Survey findings show that the price of cigarettes in Kenya is not high enough to encourage smokers to quit. Only 40% of smokers and a quarter (24%) of smokeless users who were planning to quit identified the price of the product as a reason to think about quitting. Price was one of the least frequently mentioned reasons for quitting smoking. Only about one-third (31%) of smokers reported that their spending on cigarettes resulted in not having enough money for household essentials like food – another indicator that tobacco is affordable. This result varied by province from 4% in North Eastern province to 51% in Western province.

There is strong public support for raising tobacco taxes, including from tobacco users themselves. Overall, 70% of Kenyans thought that the government should increase taxes on cigarettes, including 60% of smokers, 71% of smokeless users, and 89% of non-users. Similarly, 68% of Kenyans support an increase in taxes on smokeless tobacco – including 36% of smokeless users, 69% of smokers, and 88% of non-users.

# RECOMMENDATIONS

Based on the ITC Kenya Survey findings, the research team offers the following recommendations for strengthening tobacco control in Kenya:

1. Reduce access to and affordability of tobacco products through taxation.
2. Strengthen enforcement of the ban on the sale of cigarettes by single sticks.
3. Strengthen the current health warnings to require pictorial health warnings on at least 50% of the top part of the front and back of the pack, as called for in the FCTC Article 11 Guidelines. Replace images with a new set of health warnings every 2 years to maintain saliency and enhance impact.
4. Consider moving forward with standardized packaging (plain packaging) legislation as implemented in Australia, and recently passed in Ireland and the United Kingdom.
5. Implement a more specific ban on the use of misleading, false, or deceptive packaging and labelling, including descriptors such as “light”, “mild”, or “low tar”.
6. Strengthen the current smoke-free law to ensure universal protection from the harms of tobacco smoke.
7. Strengthen enforcement of the ban on tobacco advertising, promotion, and sponsorship to curb tobacco marketing in the entertainment media and through product displays and packaging.
8. Raise awareness of the harms of tobacco through sustained public education campaigns.
9. Establish cessation services to support tobacco users who wish to quit.

In addition to the strategies outlined above, a number of countries are setting targets and considering measures to create a tobacco-free generation, such as banning the sale and supply of tobacco products to individuals born after a certain year (i.e., 2007/2010). For example, Singapore has passed a law banning the sale of tobacco to those born after 2000. These strategies serve as models for Kenya to consider as part of a comprehensive strategy to reduce tobacco use among young people.

**“The ITC Kenya Survey findings have great potential to propel our endeavour to reverse the tobacco epidemic in Kenya....This landmark report will facilitate the strengthening of the implementation of the FCTC and the Tobacco Control Act towards a further reduction in tobacco consumption and exposure to tobacco smoke in Kenya.”**

Dr. Khadijah Kassachoon  
Principal Secretary for Health  
Government of Kenya

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## 4.0 ITC POLICY EVALUATION PROJECT IN KENYA

The International Tobacco Control Policy Evaluation Project (the ITC Project) is a multi-country prospective cohort study designed to measure the psychosocial and behavioural impact of key policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) in more than 20 countries.

In 2010, the ITC Project at the University of Waterloo partnered with Mr. Vincent Kimosop (International Institute for Legislative Affairs (ILA), Kenya), Dr. Jane Rahedi Ong'ang'o (Kenya Medical Research Institute (KEMRI)), and Dr. Lawrence Ikamari (University of Nairobi, Population Studies and Research Institute (PSRI), Kenya) to create the ITC Kenya Project. The ITC Kenya Wave 1 Survey, conducted from October 22 to December 21, 2012, was made possible with funding from the Canadian Institutes of Health Research (CIHR) and the Ontario Institute of Cancer Research (OICR). Support for the preparation of this Report was also provided by the Canadian Cancer Society Research Institute (CCSRI) through a Prevention Scientist Award to Dr. Geoffrey T. Fong.

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## 5.0 BACKGROUND

### 5.1 The ITC Project Surveys

The International Tobacco Control Policy Evaluation Project (the ITC Project) is the first-ever international cohort study of tobacco use. Its overall objective is to measure the psychosocial and behavioural impact of key national level policies of the WHO Framework Convention on Tobacco Control (FCTC). The ITC Project is a collaborative effort with international health organizations, researchers, and policymakers in more than 20 countries (see back cover) so far, inhabited by more than 50% of the world's population, 60% of the world's smokers, and 70% of the world's tobacco users. In each country, the ITC Project is conducting longitudinal cohort surveys to assess the impact and identify the determinants of effective tobacco control policies in each of the following areas:

- Health warning labels and pack descriptors
- Pricing and taxation of tobacco products
- Tobacco advertising and promotion
- Smoke-free legislation
- Education and support for cessation

ITC surveys evaluate the effectiveness of current policies (e.g., the extent to which warning labels create emotional impact in smokers; the percentage of public places where smoking is observed; and the price of cigarettes as a reason to quit) and provide evidence of successes or the need for stronger action in each of the policy domains. The longitudinal design of the ITC surveys allows for a rigorous evaluation of whether the introduction of new policies led to greater impact on tobacco use behaviour. For example, ITC research explores questions such as: did the emotional impact of warnings increase after the introduction of pictorial warnings; did a smoke-free law reduce smoking in restaurants and public transportation; and, did a tax increase lead to increases in motivation to quit or switching to lower-price brands?

In addition to policy evaluation, the ITC Project is improving the understanding of patterns of tobacco use and cessation over time and across countries, including factors that predict quit attempts and successful quitting. For example, ITC research is evaluating a broad range of influences on cessation such as policy-relevant factors, demographic factors, environmental factors, and beliefs and attitudes such as perceived risk, beliefs about the acceptability of smoking and use of other forms of tobacco, and reports of whether significant others are supportive of quitting. Such findings have important implications for the design and implementation of effective individual and population-level programs and policies to support cessation.

All ITC surveys are developed using the same conceptual framework and methods, and the survey questions, which include more than 150 questions directly relating to policy impact, are designed to be identical or functionally equivalent across all ITC countries in order to allow strong cross-country comparisons. The ITC Project aims to provide an evidence base to guide policies enacted under the FCTC, and to systematically evaluate the effectiveness of these legislative efforts.

*The ITC Kenya Survey findings presented in this report provide evidence of the impact of tobacco control policies on tobacco users in Kenya and identify strengths and weaknesses in the implementation of the FCTC.*

## 5.2 The ITC Kenya Survey

The ITC Kenya Survey is a national survey conducted by researchers from the University of Nairobi, Population Studies and Research Institute (PSRI), Kenya in collaboration with the ITC Kenya Project team centered at the University of Waterloo in Canada. The main objectives of the ITC Kenya Survey are:

1. To examine the prevalence and patterns of tobacco use behaviour in Kenya. The survey provides information about tobacco users' knowledge, beliefs, attitudes, and opinions about using tobacco.
2. To examine the impact of specific tobacco control policies that have been, or will be, implemented in Kenya, on tobacco use and tobacco-related behaviour among tobacco users in Kenya.
3. To compare the psychosocial and behavioural effects of national-level tobacco control policies and programs in Kenya with findings from more than 20 other ITC countries.
4. To provide evidence-based recommendations for strengthening tobacco control policies in Kenya.

The ITC Kenya Survey is a prospective longitudinal study of 1,427 tobacco users and 571 non-users of tobacco aged 15 and older. Wave 1 of the ITC Kenya Survey was conducted from October 22 to December 21, 2012.

The ITC Kenya Wave 1 (2012) Survey was conducted after the implementation of several major tobacco control policies in Kenya:

- On June 25, 2004, Kenya ratified the WHO Framework Convention on Tobacco Control (FCTC).
- In 2004, smoking was banned in restaurants, healthcare and educational facilities, universities, government facilities, public transit, indoor offices, other indoor workplaces, bars, and pubs.
- In August 2007, a comprehensive tobacco control legislature known as the Tobacco Control Act was passed by the Kenyan Parliament and assented into law in September 2007. The Act was implemented in July 2008. It mandated 13 rotating text warnings on 30% of the front (in English) and 50% of the back (in Kiswahili) of the package; banned promotion of tobacco products, including misleading packaging; prohibited the sale of packs containing less than 10 cigarettes; banned all tobacco advertising and sponsorship; and banned smoking in public places.
- Between 2007-2009, the government increased taxes of tobacco products to 55% of the retail price.

The ITC Kenya Survey findings presented in this report provide evidence of the impact of these tobacco control policies on tobacco users in Kenya and identify strengths and weaknesses in the implementation of the FCTC.

## 6.0 THE TOBACCO LANDSCAPE IN KENYA

This section provides an overview of tobacco use and tobacco control policies in Kenya up to the time of the ITC Kenya Wave 1 Survey (October 22 to December 21, 2012). It also summarizes the findings of tobacco control research conducted in Kenya. Kenya signed and ratified the WHO Framework Convention on Tobacco Control (FCTC) in June 2004. In 2007, comprehensive tobacco control legislation known as the Tobacco Control Act was passed in Kenya and came into force in July 2008.<sup>2</sup> This provided the legislative framework for control of the production, manufacture, sale, labelling, advertising, promotion, sponsorship and use of tobacco products, including exposure to tobacco smoke.<sup>3</sup> Kenya has an active tobacco control community; however, the strong presence of the tobacco industry in Kenya and opposition from groups with strong economic interests in tobacco have created a challenging environment in which to build capacity for tobacco control and to implement and enforce the Act.<sup>4</sup>

### 6.1 Prevalence of Tobacco Use in Kenya

Tobacco use prevalence surveys have been conducted among adults and youth in Kenya for more than 10 years. These studies indicate that the most prevalent form of tobacco use in Kenya is cigarette smoking. Data on use of tobacco products other than cigarettes is limited, however, there is some use of other forms such as smoking homemade cigars and snuffing of tobacco. The prevalence of smoking among adult males has decreased overall between 2003 and 2008-09, but data suggest that prevalence of tobacco use among youth may be increasing in Kenya, especially among females who are more likely to use smokeless tobacco. The prevalence of smoking among adult females in Kenya has always been extremely low and much lower than males; however, the accuracy of female prevalence rates is questionable as it is culturally unacceptable for women to smoke and this may result in underreporting.<sup>4</sup>

The Kenya Demographic and Health Survey (KDHS) measured tobacco use among a nationally representative sample of adults in 2003 and again in 2008-09.<sup>5</sup> In the KDHS, adult men and women were asked whether they currently smoke cigarettes or use any other tobacco products. The survey findings showed a decrease in all types of tobacco use among men aged 15-49 years from 25% in 2003 to 19% in 2008-09. Cigarette smoking among this group also decreased from 23% in 2003 to 18% in 2008-09. Among women, tobacco use of any kind continued to be low at less than 3% in 2003 and less than 2% in 2008-09. Rates of cigarette smoking among women remained the same in both surveys; at less than 1%.

In 2008-09, the highest cigarette smoking prevalence rate was among men aged 45-49 (29.6%). Male respondents who were more educated, and who were in the highest wealth quintile were less likely to smoke. Conversely in 2003, men with no education were less likely to smoke and those in the lowest and middle wealth quintiles were less likely to use tobacco products. In both surveys, men with no education had the highest rate of using other tobacco products besides cigarettes or pipes (15.8% in 2003 and 18.3% in 2008-09). In 2008-09, the Central province of Kenya had the highest rate of male cigarette smokers (30.4%), while in 2003 the Eastern province had the highest rate of male cigarette smokers (37.1%). Nyanza province had the lowest rate of smoking among men at 7.9% in 2008-09 and 11.0% in 2003.

The Global Adult Tobacco Survey (GATS), a nationally representative survey of adults across countries, was conducted in Kenya in 2014. The Survey found that prevalence of any tobacco use among men has remained the same since the 2008-09 KHDS Survey, at 19%. The rate of cigarette smoking among men had declined slightly, from 18% in 2008-09 to 15% in 2014. Current tobacco use among women increased slightly from less than 2% in 2008-09 to 4.5% in 2014, although cigarette smoking among women remained the same at less than 1%.<sup>6, 11</sup>

GATS found that the majority of adult Kenyan tobacco users were smokers: 61% of tobacco users used smoked tobacco only; 33% used smokeless tobacco only; and 6% were mixed users. The majority of smoked tobacco users were men (72%) and 16% were women, while 83% of smokeless tobacco users were women and 21% were men.<sup>6</sup>

The Global Youth Tobacco Survey (GYTS), a school-based survey of students aged 13-15, was also conducted in Kenya in 2001, 2007, and 2013.<sup>7-9</sup> Results from this survey indicate that cigarette smoking, as well as other tobacco product use, increased among both boys and girls from 2001 to 2007, but that rates of tobacco use appear to be declining among youth in recent years according to the 2013 survey. In 2001, 13% of youth used any tobacco products, which increased to 18.6% in 2007 and then decreased to a low of 9.9% in 2013. This pattern of tobacco use was similar among both boys and girls, although tobacco use in any form remains more prevalent among boys at 12.8% in 2013, compared to only 6.7% of girls.

The prevalence of cigarette smoking among youth followed a similar pattern, increasing from 7.2% overall in 2001 to 9.8% in 2007, and then decreasing again in 2013 to 4.9%. Cigarette smoking among boys was higher than girls at each survey point, with the most recent estimates in 2013 being 7.4% of boys and only 2.6% of girls. Smokeless tobacco use was slightly more common among girls in 2013 (3.3%), but less common among boys (4.3%) compared to smoking.

## 6.2 Tobacco Control Policies

The WHO Framework Convention on Tobacco Control (FCTC), the world's first public health treaty, addresses the global tobacco epidemic through a variety of measures to reduce tobacco demand and supply, including price and taxation (Article 6), smoke-free policies (Article 8), packaging and labelling of tobacco products (Article 11), tobacco advertising and sponsorship (Article 13), cessation and treatment (Article 14), illicit trade (Article 15), and sales to minors (Article 16).<sup>10</sup> With 180 member Parties as of December 2015, the FCTC is one of the most successful treaties ever established.

The following section summarizes the tobacco control policies in Kenya at the time of the ITC Kenya Wave 1 Survey. It is organized according to the tobacco control policy domains of the FCTC.

### 6.2.1 Packaging and Labelling of Tobacco Products

Article 11 of the FCTC states that each Party shall adopt and implement effective packaging and labelling measures within 3 years after ratifying the FCTC. This article calls for specific requirements on the content, position, and size of warning labels. Article 11 states that health warnings shall be rotating, large, clear, visible, and legible; should not use misleading descriptors such as "light" and "low tar"; and shall be in the country's principal language. Article 11 Guidelines, which were adopted in November 2008, state that warnings should include graphic images, cover at least 50% of the principal display areas of the pack, and include two or more sets of rotating warnings with a range of messages.<sup>12</sup>

**The strong presence of the tobacco industry in Kenya and opposition from groups with strong economic interests in tobacco have created a challenging environment in which to build capacity for tobacco control and to implement and enforce the Act.**

Health warnings on tobacco packages are among the most important sources of information about the harms of tobacco use and of secondhand smoke and are a key communication strategy to educate tobacco users and non-users about these harms. Given their tremendous reach and frequency of exposure (pack-a-day smokers are potentially exposed to warnings over 7,000 times per year<sup>13</sup>), health warnings are an extremely cost-effective public health intervention compared to other communication tools such as paid mass media advertising. Non-users also report high exposure to and awareness of health warning labels, as they are displayed each time the product is used or left in public view, and are also prominent in retail outlets in many countries. Research conducted by the ITC Project has proven that warning labels are an effective risk communication tool for:

1. Educating/informing tobacco users and non-users about the many negative health consequences of tobacco use.
2. Motivating and encouraging tobacco users to quit and non-users not to start smoking.
3. Providing information to enhance efficacy for quitting.

The 2007 Tobacco Control Act requires text health warnings to cover 30% of the front (in English) and 50% of the back (in Kiswahili) of the pack. The Act requires the word “WARNING” to appear in capital letters and the rest of the message to be printed in size 17-point font. Each pack is required to display two warning labels of the same health message, in both English and Kiswahili, that are rotated through a 12 month period (with a total of 13 different labels for both smoked and smokeless tobacco products). While text-only warnings are currently required, the Act empowers the Ministry of Health to regulate pictorial warnings. In December 2014, the Ministry of Health tabled Tobacco Control Regulations which require pictorial health warnings and changes to other areas of the 2007 Tobacco Control Act.<sup>57</sup> The regulations require a set of 15 images, each with a corresponding text warning (in English on the front and in Kiswahili on the back) to be included on 30% of the front and 50% of the back of smoked and smokeless tobacco products.

The 2007 Tobacco Control Act also requires tobacco packages to present a statement of tar, nicotine, and other constituents on the right side of the package. Actual quantities, however, must not be specified.<sup>14</sup> The message “Tobacco smoke contains tar, nicotine and other constituents” is printed on the side of all packs. While the legislation bans promotion of tobacco by any means, including packaging, that are false or misleading or deceptive or that are likely to create an erroneous impression about the characteristics, health effects or health hazards, the Act does not specifically ban false descriptors such as “mild” or “low-tar”. As the tobacco industry uses these and other descriptors such as “organic”, “natural”, and “additive free” to falsely convey tobacco products as being less harmful, it is imperative that existing legislation on tobacco product packaging and labelling is regularly reviewed to stop the tobacco industry from undermining its effectiveness.<sup>15</sup> Table 1 summarizes the requirements for labelling under the 2007 Tobacco Control Act.

The Act also states that if a person contravenes any of the provisions of these requirements, they shall, on conviction, be liable to a fine not exceeding five hundred thousand shillings, or to imprisonment for a term not exceeding 3 years, or to both.<sup>2</sup>

*The ITC Project has evaluated the effectiveness of health warnings on tobacco packages in more than 20 countries.*

**Table 1. Requirements for package labelling under the 2007 Tobacco Control Act<sup>2,16</sup>**

<b>Font</b>	“WARNING” must appear in all capital letters, size 17-point font
<b>Color</b>	Black text on white background
<b>Size and Placement</b>	Not less than 30% of total surface area of the front panel and 50% of total surface area of the rear panel
<b>Language</b>	English on the front and Kiswahili on the back of the package
<b>Label Content</b>	<p>2 warnings displayed of the same message (in both English and Kiswahili); total of 13 warnings rotated through a 12-month period</p> <ol style="list-style-type: none"> <li>i. Smoking harms people next to you</li> <li>ii. Tobacco use kills</li> <li>iii. Tobacco harms your unborn baby</li> <li>iv. Tobacco use causes cancer</li> <li>v. Tobacco use causes heart disease</li> <li>vi. Tobacco use causes lung disease</li> <li>vii. This product can cause gum disease and tooth loss (includes smokeless tobacco products)</li> <li>viii. This product can cause mouth cancer (includes smokeless tobacco products)</li> <li>ix. This product is not a safe alternative to cigarettes (for smokeless tobacco products)</li> <li>x. Tobacco use causes impotence</li> <li>xi. Tobacco uses causes miscarriages</li> <li>xii. Tobacco use causes infertility in women</li> <li>xiii. Tobacco use causes mental retardation in children</li> </ol>
<b>False Descriptors</b>	The law prohibits promotion of tobacco products “by any means, including by means of the packaging, that are false, misleading, or deceptive or that are likely to create an erroneous impression about the characteristics, health effects, health hazards, or social effects of the tobacco product or its emissions and as may be prescribed by the Minister.” The law does not specifically ban terms such as “light”, “mild”, and “low tar”. The Minister has not prescribed or prohibited any specific terms or actions.
<b>Labelling of Constituents and Emissions</b>	The law requires that tobacco products bear a statement as to tar, nicotine, and other constituents on the right-hand side of the package. The prescribed statement “shall be limited to the disclosure of the contents and not their quantities.” The statement “Tobacco smoke contains tar, nicotine and other constituents” is printed on the side of all packs. This provision aligns with FCTC Article 11 and FCTC Article 11 Guidelines with respect to a prohibition on figures for emission yields.
<b>Pictorial warnings</b>	The Act states that the Minister may prescribe picture or pictogram warnings by notice in the Gazette.

A 2014 survey conducted by the ILA found that 83% of respondents supported taxation on tobacco products, with the level of support highest (90%) in the Coast region by the border.

## 6.2.2 Price and Taxation

Increasing taxes on tobacco products is considered to be the most effective component of a comprehensive tobacco control strategy.<sup>17, 18</sup> Numerous economic studies from high-income countries (HICs) have shown that in general a 10% increase in retail price leads to about a 4% decrease in tobacco consumption, with about half of that due to lower prevalence.<sup>16, 19</sup> There is evidence that the decrease in consumption could be even higher in low- and middle-income countries (LMICs).<sup>20</sup> Therefore, if taxes are increased on tobacco products, to the extent that it is passed on as an increase in retail price, this could result in substantial reductions in tobacco prevalence and consumption. At the same time, because the relation between price and demand (i.e., consumption) of tobacco products is relatively inelastic (the percentage reduction in consumption resulting from a 1% increase in price is less than 1%) it is also the case that an increase in tax and price will lead to increases in tobacco tax revenue at the same time as it leads to decreases in tobacco use. In this way, increasing taxes on tobacco products represents a “win-win” situation – achieving health goals of reducing tobacco use while also increasing tax revenue.

Article 6 of the FCTC obligates Parties that have ratified the treaty to adopt tax and price policies aimed at reducing tobacco consumption.<sup>10</sup> Guidelines for effective implementation of Article 6 were adopted at the Sixth Session of the Conference of the Parties to the FCTC in October 2014.<sup>21</sup> This includes the principles that effective tobacco taxes (leading to higher prices) lower consumption, improve the health of the population, are economically efficient, reduce health inequalities, and are an important source of government revenue. Recommendations for implementing Article 6 include using the simplest and most efficient tax system, considering specific or mixed excise systems over ad valorem systems, re-evaluating and adjusting tax rates regularly to account for inflation and income growth, taxing all tobacco products in a comparable way to minimize shifts to cheaper products, dedicating tax revenue to tobacco control programmes, and considering sales restrictions and limitations on international travelers importing tax and duty-free tobacco products.<sup>22</sup>

Kenya’s 2007 Tobacco Control Act obligates the Minister of Finance to implement tax and price policies in line with the objectives of the Act, which include protecting the health of Kenyans, especially young people, from tobacco industry exploitation. Specifically, Section 12 of the Act states that:

- 12. The Minister for the time being in charge of finance shall-*
- (a) implement tax policies and where appropriate, price policies on tobacco and tobacco products so as to continue to the objectives of this Act;*
  - (b) prohibit or restrict, as appropriate, any sale to, or importation of tax-free tobacco products by international travelers.<sup>2</sup>*

Despite these provisions in the Act, progress on tobacco taxation in Kenya has been slow, and excise taxes on cigarettes remain lower than WHO FCTC recommendations, with minimal effect on tobacco prices. Cigarettes in Kenya are subject to import duties, value-added tax (16% in 2011), and excise taxes.<sup>23</sup> The excise tax system has been in a constant state of flux, changing from specific rates to ad valorem and back, with sometimes a mixture of both, and this inconsistency has not produced desired impacts on consumption and revenue.<sup>23, 24</sup> From 2006 to 2008, excise taxes on tobacco products increased by 10% per annum, but there was no evidence that these increases led to a decrease in consumption.<sup>23</sup> In the 2009/2010 financial year, there was no increase in tobacco tax for the first time in three years, and the excise tax on cigarettes stood at about 30% of the retail price.<sup>25, 4</sup> This excise tax system has been criticized as being overly complex, with four different tax bands based on type of cigarette and retail selling price.<sup>23</sup>

A 2011 report on tobacco taxation in Kenya by the International Institute for Legislative Affairs (ILA) found that while the nominal price of the most popular brand of cigarettes increased by 8% annually from 1990 to 2008, the real price decreased by 2.2% annually, so that cigarettes have actually become more affordable to consumers over time. The report also examined the relationship between cigarette tax revenue and cigarette consumption from 2000 to 2008 and found that the two were not correlated. Both of these findings point to the ineffectiveness of the tobacco tax system in increasing the real value of cigarette prices and reducing consumption.<sup>23</sup>

A new Finance Bill affecting tobacco taxation was proposed in 2011 and passed by the Parliament on April 27, 2012 as the Finance Act of 2012. The Act raised the rate of excise duty for cigarettes to KSh 1200 per mille (1 mille equals 1000 sticks) or 35% of the retail selling price, ensuring that all tobacco products are taxed equally to discourage switching to cheaper tobacco products. The Act also gave authority to the Minister of Finance to adjust taxes for inflation.<sup>26, 27</sup> The ILA has since encouraged the Government of Kenya to establish a clear principle upon which the excise tax will be regularly adjusted for inflation, and to continue increasing cigarette taxation in line with international standards and FCTC recommendations.<sup>27</sup>

The 2014 GATS found that cigarettes are very affordable in Kenya and there is strong support for higher prices on tobacco products. The average amount spent on one pack of manufactured cigarettes (containing 20 cigarettes) is KSh 102.7 (USD \$1.15) – less than the cost of a 2 kg pack of maize flour (unga) which is a basic household food commodity.<sup>6</sup> 80% of Kenyan adults are in favour of increasing taxes on tobacco products. A 2014 survey conducted by the ILA also found that 83% of the 2,059 respondents supported taxation on tobacco products, with the level of support highest in the Coast region by the border (90%).<sup>28</sup> These findings, along with other ITC Kenya Survey results described in the next chapter, demonstrate the need for increasing the price of tobacco products through higher taxes.

### 6.2.3 Smoke-Free Public Places and Workplaces

Article 8 of the FCTC requires the adoption of effective measures to protect the public from exposure to tobacco smoke. Guidelines for Article 8 adopted at the Second Conference of the Parties in 2007 established the core principles for achieving 100% smoke-free environments, including monitoring and evaluation of enforcement of legislation.<sup>12</sup> Article 8 Guidelines recommend a comprehensive ban on smoking in public places and workplaces, without exemptions, and specifically point out that even well-ventilated designated smoking areas do not adequately protect the public from the harms of secondhand smoke.



In Kenya, smoking is prohibited in all public places and workplaces<sup>i</sup> under the 2007 Tobacco Control Act, except in specially designated smoking areas (see Table 2 for specific definitions). Those who violate the smoke-free provisions of the Act are subject to punishment by fine (not exceeding 50,000 KSh) or imprisonment of up to 6 months, or both.<sup>2</sup> However, because of this provision for designated smoking areas, the current policy in Kenya is not fully compliant with Article 8 Guidelines, which recommend 100% smoke-free public places.

The Act also specifies that managers or owners of a public place where smoking is prohibited shall display clear and prominent no-smoking notices in both English and Kiswahili. Additional restrictions against smoking on public transportation are outlined in the National Traffic Act (Cap 403, as revised in 2009), which prohibits both passengers from smoking on board and drivers from smoking while passengers are on board.<sup>29</sup>

The main weakness in the implementation of Kenya's smoke-free legislation is enforcement. Kenya has an active civil society presence and members of tobacco control organizations have engaged with the government to improve enforcement of the existing legislation, including an initiative to train public health officers in major urban areas.<sup>4</sup> The Ministry of Public Health and Sanitation and the International Institute for Legislative Affairs have conducted training sessions with more than 1,000 enforcement officers (policy, local authorities' officers, administration police, public health officers and chiefs) and more than 100 civil society representatives, 150 media representatives, and numerous volunteers across Kenya.<sup>4</sup>

Other recent initiatives include the establishment of smoke-free cities within Kenya. Nakuru was the first city to pass and implement a sub-national bylaw requiring smoke-free public places in April 2007, before the national law came into effect. This bylaw even extended to outdoor spaces including streets, although outdoor smoking areas could be provided by the owners of public places. While this bylaw has been superseded by the Act, it set a precedent in Kenya which several other major urban centres, including the capital city of Nairobi, have followed by introducing their own bans on smoking in public places.<sup>30</sup>

A study conducted in Nairobi in 2009 to monitor compliance with the Act and enforcement of the smoke-free law found that the majority of public places had not adhered to the Act and people were still smoking cigarettes in many public places. In addition, only 34% of public places, and about 60% of educational and health facilities had "No Smoking" signs posted.<sup>3</sup> A follow-up survey in 2010 showed some improvement in the posting of "No Smoking" in public places, but smoking was still observed in public transport terminals, cinemas, bars and restaurants, with bars having the highest proportion of observed smoking.

***Article 8 Guidelines recommend a comprehensive ban on smoking in public places and workplaces without exemptions, and specifically point out that even well-ventilated designated smoking areas do not adequately protect the public from the harms of secondhand smoke.***

i. The 2007 Tobacco Control Act prohibits smoking in offices and workplaces; court buildings; factories; cinema halls, theatres, video houses, such other halls or places of performance, disco halls or any other entertainment facilities; hospitals, clinics and other health institutions; restaurants, hotels, bars or other eating places; children's homes; residential houses and such other premises where children are cared for; places of worship; prisons; police stations and cells; public service vehicles; aircrafts, passenger ships, commuter boats, trains, passenger vehicles, ferries or any other public conveyance; education facilities; railway stations, airports, air fields, ports and other public transport terminals; markets, shopping malls and retail and wholesale establishments; stadia, sports and recreational facilities; and public buildings, except in designated smoking areas.

**Table 2. Definitions in the 2007 Tobacco Control Act<sup>2</sup>**

<p><b>Public Place</b></p>	<p>Any indoor, enclosed, or partially enclosed area which is open to the public or any part of the public, or to which members of the public ordinarily have access, and includes a workplace and a public conveyance.</p> <p>This includes: offices, workplaces including corridors, lounges, escalators, foyers, toilets, laundries, court buildings, factories, prisons, hospitals, clinics and other health institutions, educational facilities, places where children are cared for, places of worship, public transportation including terminals, shopping malls, cinemas and places of entertainment, sport and recreational facilities, restaurants, and bars.</p>
<p><b>Designated Smoking Area</b></p>	<p>A room:</p> <ul style="list-style-type: none"> <li>• that is ventilated in such manner as to ensure that air from the area is directly exhausted to the outside and does not re-circulate or drift to other areas within the public facility;</li> <li>• which is separate, enclosed, and sealed from the floor to the roof with a door;</li> <li>• in which non-smoking individuals do not have to enter the area for any purpose while smoking is occurring; and</li> <li>• that is cleaned or maintained only when smoking is not occurring in the area.</li> </ul>

The Tobacco Control Regulations, 2014 extended the smoke-free law by banning smoking in private vehicles when children are passengers, as well as smoking on streets, walkways, and verandas adjacent to public places.<sup>57</sup> However, the smoke-free law still falls short of being compliant with the Article 8 Guidelines as it continues to allow DSAs with the added provision of requiring managers or owners of premises to obtain a certificate of compliance from the Director of Medical Services to ensure that DSAs meet the requirements of the Tobacco Control Act.

### 6.2.4 Education, Communication, and Public Awareness

Under Article 12 of the FCTC, Parties must promote and strengthen public awareness of tobacco control issues through education and public awareness programs on the health risks of tobacco consumption and exposure to secondhand smoke and the benefits of cessation, promoting tobacco control training programmes to health workers and educators, and providing public access to information about actions of the tobacco industry.<sup>10</sup> Article 12 Guidelines, adopted in November 2010, suggest using a variety of methods and media, building on lessons learned from other successful campaigns. The participation of civil society is emphasized, ensuring that they are not affiliated with the tobacco industry. The Guidelines emphasize monitoring and evaluation of outcomes of public education and communication. Training of a range of professionals including physicians and other health workers; community workers, media professionals, educators, decision-makers, tobacco growers/workers, and others to increase capacity is another focus of the Guidelines.<sup>11</sup>

Public education campaigns are an essential component of a comprehensive national tobacco prevention and cessation strategy, particularly as the tobacco industry devises new ways to market and promote their products. Empirical evidence demonstrating the effectiveness of well-funded public education campaigns is vast and growing. Greater exposure to mass media campaigns is associated with increased quit attempts, improved rates of smoking cessation, and reduced adult smoking prevalence and consumption.<sup>31-33</sup> In addition, recent evidence from the ITC Four-Country Survey has demonstrated that tobacco control mass media campaigns may reduce the likelihood of relapse among recent quitters.<sup>34</sup>

The Act specifically delegates to the Government of Kenya the responsibility of promoting public awareness about the addictive nature and health consequences caused by tobacco consumption and exposure to tobacco smoke. The Act also establishes the Tobacco Control Board, responsible for providing advice to the Minister of Health regarding tobacco control policies and must be consulted prior to the enactment of new tobacco control regulations. Multiple departments of the government have also been involved within tobacco control efforts in Kenya, such as the Ministry of Education by implementing tobacco education within school curriculums, the Ministry of Health through information dissemination by healthcare providers, and the Ministry of Agriculture by promoting alternative crops to tobacco farmers.<sup>4</sup>

Multiple civil society organizations have been actively involved in the tobacco control movement in Kenya. The Kenya Tobacco Control Alliance (KETCA), an umbrella organization of tobacco control NGOs, has been pivotal in increasing public education and awareness by engaging with and receiving support from a wide variety of stakeholders, including members of parliament, community-based organizations, and several professional organizations including the Pharmaceutical Society of Kenya and the Kenya Medical Association.

Other civil society organizations involved in public awareness and information dissemination include the Tobacco and Alcohol Free Initiative, the Consumer Information Network, and the Social Needs Network. Research institutions, such as the Institute for Natural Resources and Technology and the Kenyan Medical Research Institute, have also been involved in the tobacco control movement by providing evidence-based research to tobacco control advocates and policymakers.<sup>4</sup>

To support enforcement of smoke-free laws and improve awareness of the harms of secondhand smoke, the Ministry of Health and the World Lung Foundation collaborated in launching a national mass media campaign in December 2014 called “Tobacco Kills – Quit Now!”, which was adapted from New York City’s *Cigarettes are Eating Your Baby Alive* campaign. The campaign included one month of national TV and radio ads in Kiswahili and English, as well as posters distributed across the country.

## 6.2.5 Tobacco Advertising, Promotion, and Sponsorship

Article 13 of the FCTC obligates Parties to implement effective measures against tobacco advertising, promotion, and sponsorship (TAPS). Guidelines for Article 13 recommend a comprehensive ban on TAPS (or apply restrictions that are as comprehensive as possible). Included among the recommended measures are bans on: cross-border advertising, promotion and sponsorship; display of tobacco products at point of sale; tobacco product vending machines; internet sales; and attractive packaging and product features.<sup>12</sup>

Comprehensive bans on advertising, promotion, and sponsorship are required to curb the tobacco industry’s use of direct and indirect marketing strategies aimed at encouraging people, especially youth, to use tobacco, as well as increasing tobacco consumption among current tobacco users, decreasing users’ motivation to quit, and encouraging quitters to relapse. A 2001 survey of Kenyan primary schoolchildren found that 88% were exposed to tobacco advertisements.<sup>35</sup> Other studies have found that exposure to advertising/promotion among adolescents is associated with greater susceptibility to initiate smoking among both boys and girls.<sup>36</sup> A total ban on direct and indirect advertising, promotion, and sponsorship, as recommended in the Article 13 Guidelines can substantially reduce tobacco use among people of all income and educational levels.<sup>37</sup>

*To support enforcement of smoke-free laws and improve awareness of the harms of secondhand smoke, the Ministry of Health and the World Lung Foundation collaborated in launching a national mass media campaign in December 2014 called “Tobacco Kills – Quit Now!”. The campaign included one month of national TV and radio ads in Kiswahili and English, as well as posters distributed across the country.*

The 2007 Tobacco Control Act prohibits any form of tobacco brand or product advertisement, defined as “*any statement, communication, representation or reference aimed at the public and designed to promote or publicise a tobacco product or encourage its use, or draw attention to the nature, properties, advantages or uses of the product*”.<sup>2</sup> The Act also prohibits tobacco promotion in the form of print or electronic media, lifestyle advertising, sales promotions, endorsements and testimonials, or sponsorship of educational, cultural, and recreational events and activities. The display of a tobacco manufacturer or brand on a non-tobacco product is also prohibited.<sup>2</sup>

Though obvious advertising in the media no longer takes place, the Kenya Tobacco Situational Analysis (KTSA) Consortium has reported incidents of indirect advertising, promotion, and sponsorship by tobacco companies, such as providing educational grants, sponsoring schools’ music and drama festivals and trade fairs, funding sporting events, and donating to famine relief funds. A 2013 case study of the implementation of Article 13 in Kenya also found that despite enforcement of the ban on TAPS, outdoor advertising, such as billboards, and point of sale advertising still exist in several parts of the country and tobacco companies still engage in promotional activities such as distributing gifts and sponsoring radio shows.<sup>38</sup> The tobacco industry has also been involved in Social Corporate Responsibility through the development of business programs for small businesses.<sup>4, 14</sup> In order to influence public perceptions and improve corporate image, tobacco companies have often highlighted their ‘charitable’ work within the local and national community.

### 6.2.6 Cessation

Compared to HICs, the rates of smokers who want to quit and who actually try to quit are lower in LMICs; therefore, it is even more urgent for governments in LMICs to provide assistance to smokers to help them quit.<sup>39, 40</sup>

Article 14 of the FCTC obligates Parties to take effective measures to promote cessation of tobacco use and provide adequate treatment for tobacco dependence. Guidelines for Article 14 recommend a broad range of cessation interventions including population-based approaches that have wide reach (mass communication, brief advice, and quitlines) and, where resources permit, more intensive individual approaches (specialized treatment services like behavioural support and medications). Recognizing that LMICs will not have the resources to implement a comprehensive cessation strategy, the Guidelines outline a “stepwise approach” to building infrastructure for cessation and treatment for tobacco dependence.<sup>12</sup>

**A 2013 case study of the implementation of Article 13 in Kenya also found that despite enforcement of the ban on TAPS, outdoor advertising, such as billboards, and point of sale advertising still exist in several parts of the country.**

While cessation efforts have been identified as a priority for tobacco control in Kenya, a comprehensive cessation program has not yet been developed.<sup>41</sup> The need for improving access to and awareness of cessation treatment is demonstrated by a national survey conducted in Kenya in March 2007 to measure the public's views on tobacco issues.<sup>42</sup> A total of 2,021 adults aged 18 and over were interviewed in 53 districts across the 8 provinces in Kenya. The survey found that over half (52%) of current smokers had made an attempt to quit, showing that many smokers want to quit but are unsuccessful in their attempts. The survey results also showed a low level of awareness of methods of smoking cessation among the Kenyan population.

The 2007 Tobacco Control Act states that one of its objectives is to “promote and provide for rehabilitation and cessation programmes for consumers of tobacco products”. Section 7 of the Act also established a fund called the Tobacco Control Fund, which, among other initiatives, “shall be used for meeting the capital and current expenditure relating to...promoting national cessation and rehabilitation programs”.<sup>2</sup> However, prior to the Tobacco Control Regulations, 2014 the law did not specify any particular earmark for the source of the money for this fund, so it was not implemented.<sup>57</sup> The Regulations specify an annual contribution from manufacturers or importers of 2% of the value of the tobacco products manufactured in or imported to Kenya.

Despite the importance given to cessation programs, there are currently no cessation services offered in most public healthcare facilities in Kenya, although some cessation support is available in certain health clinics, hospitals, and from some health professionals. Nicotine replacement therapies (NRT) are available from private pharmacies in Kenya without a prescription, and bupropion and varenicline are available with prescriptions. None of these medications are covered by national health insurance, and they remain too costly for many smokers to afford.<sup>43, 39</sup>

There is no national toll-free quitline available specifically for smokers in Kenya; however, there is a 24-hour drug helpline that is run by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), established in 2012.<sup>39</sup> This helpline offers free counselling, information, and support for alcohol and drug abuse, which includes tobacco.<sup>44</sup>

According to the National Tobacco Control Action Plan for Kenya, “Quitting smoking remains one of the most important measures to reducing smoking-caused death and disease in Kenya”, and one of the goals of the action plan for 2010-2015 was to improve access to cessation services in all health institutions and increase the rates of successful quitters.<sup>45</sup> A number of strategies have been identified to achieve this goal, including training relevant staff and health providers to offer cessation services, creating awareness in the community, developing referral mechanisms for cessation, developing standardized information on cessation, creating a planned approach to stop smoking campaigns, and highlighting cessation on World No Tobacco Days.<sup>43</sup>

*While cessation efforts have been identified as a priority for tobacco control in Kenya, a comprehensive cessation program has not yet been developed.*

# 7.0 ITC KENYA SURVEY METHODS, CONTENT, DATA, AND ANALYTIC APPROACH

## 7.1 ITC Kenya Survey Methods

### 7.1.1 Overview

The International Tobacco Control Policy Evaluation Project (the ITC Project) is an international research collaboration across 23 countries – Canada, United States, United Kingdom, Australia, Ireland, Thailand, Malaysia, Republic of Korea, China, Mexico, Uruguay, New Zealand, France, Germany, the Netherlands, Bhutan, Mauritius, Brazil, India, Bangladesh, Kenya, Zambia, and United Arab Emirates.

The primary objective of the ITC Project is to conduct rigorous evaluation of the psychosocial and behavioural effects of national-level tobacco control policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The ITC Project is conducting large-scale annual prospective cohort surveys of tobacco use to evaluate FCTC policies in countries inhabited by over 50% of the world's population, over 60% of the world's smokers, and over 70% of the world's tobacco users. The ITC survey includes key measures for each FCTC policy domain that are identical or functionally equivalent across ITC countries to facilitate cross-country comparisons. The evaluation studies conducted from the ITC surveys take advantage of natural experiments created when an ITC country implements a policy: changes in policy-relevant variables in that country from pre- to post-policy survey waves can be compared to other ITC countries where that policy has not changed. This research design provides high levels of internal validity, allowing more confident judgments regarding the possible causal impact of the policy. For a description of the conceptual model and objectives of the ITC Project, see Fong et al. (2006)<sup>46</sup>; for a description of the survey methods, see Thompson et al. (2006).<sup>47</sup>

The International Tobacco Control Policy Evaluation Project in Kenya (the ITC Kenya Survey) was created in 2010 as a system for evaluating the psychosocial and behavioural effects of tobacco control legislation in Kenya, using methods that the ITC Project has employed in many other countries. The project objective is to provide an evidence base to guide policies enacted under the FCTC and to systematically evaluate the effectiveness of these legislative efforts. As with all ITC surveys; the ITC Kenya Survey was tailored for the tobacco control environment in the country.

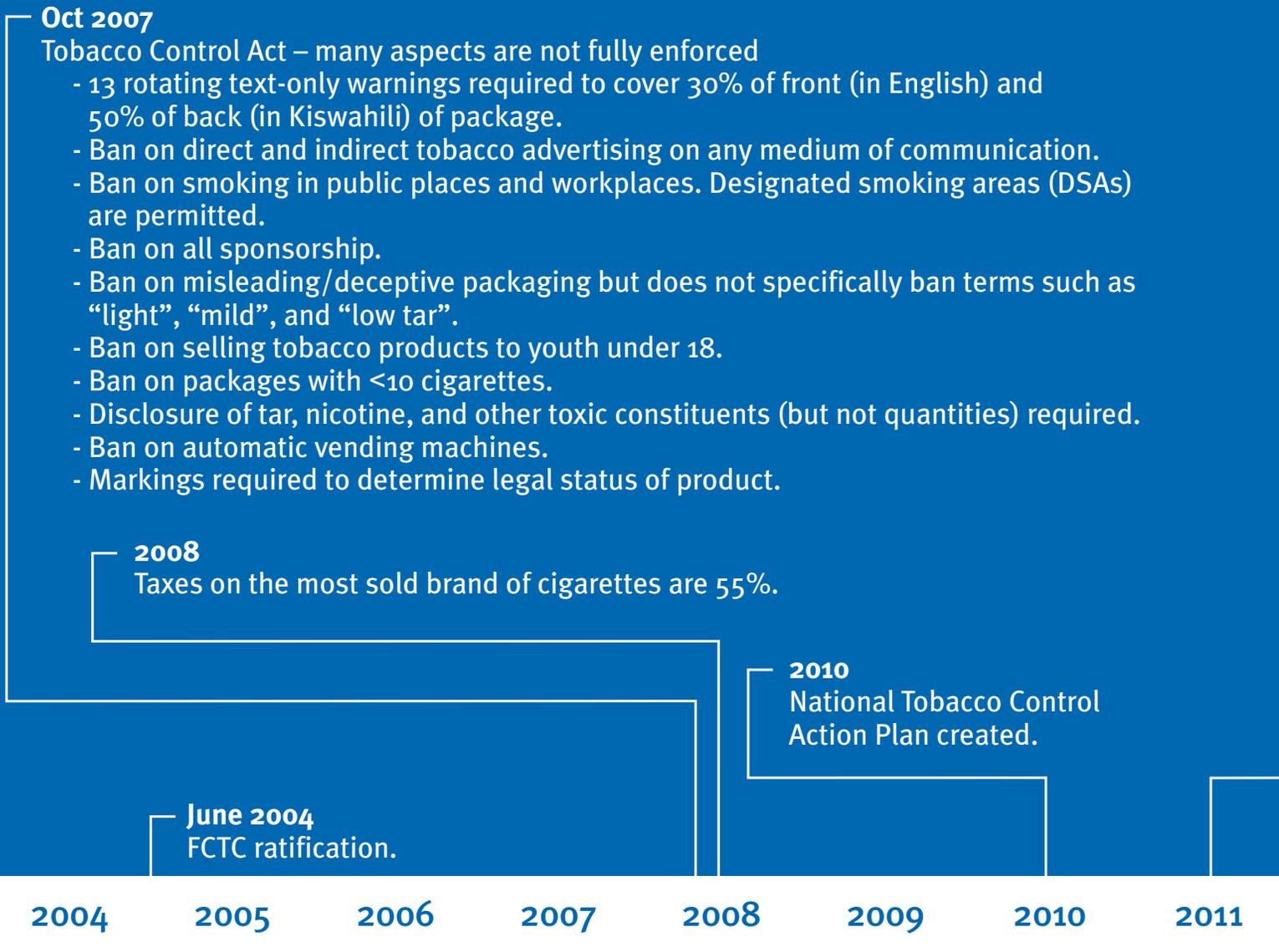
### 7.1.2 The ITC Kenya Wave 1 Survey

The ITC Kenya Wave 1 Survey was a face-to-face survey conducted by trained interviewers from the University of Nairobi, Population Studies and Research Institute (PSRI). The Wave 1 Survey included a nationally representative sample of 1,427 tobacco users and 571 non-users of tobacco aged 15 years and older, who were interviewed from October 22 to December 21, 2012. The ITC Survey is a longitudinal cohort study. Therefore, the respondents who participated in Wave 1 will be re-contacted in Wave 2 to answer the follow-up survey. For respondents that cannot be contacted, the sample will be replenished to retain the approximate numbers of tobacco users and non-users of tobacco.

Figure 1 provides an overview of the ITC Kenya Survey dates in relation to the implementation of tobacco control policies in Kenya.



Figure 1. Kenya's tobacco control policy timeline in relation to the ITC Kenya Survey



**2011**

- Simplification of tax system on cigarettes.
- Change from tiered specific tax to an ad valorem tax.
- Cigarettes are taxed at 49% of the retail price.

**June 5, 2015**

Proposed implementation of Tobacco Control Regulations, 2014:

- 15 new pictorial warnings cover 30% of front and 50% of back of pack.
- Ban on smoking in cars with children.
- Ban on smoking on streets/walkways near public places.
- Certification of compliance required for DSAs.
- Manufacturers and importers required to disclose product ingredients and sales/production data.
- Restricts public authority-tobacco industry interactions.
- Specifies measures to prevent industry interference.
- Requires manufacturers or importers to pay 2% of value of products manufactured or imported to Tobacco Control Fund annually.

2012

2013

2014

2015



Wave 1

Oct – Dec 2012

Tobacco user N=1,427

Non-user N=571

### 7.1.3 Sampling Design

The ITC Kenya Survey is a nationally representative probability sample of tobacco users and non-users of tobacco selected through a multi-stage clustered sampling design. Specifically, the design was stratified by province and sampled a total of 148 clusters/enumeration areas (EAs), allocated to the provinces in numbers proportional to population size. Design calculations were based on 2009 census data. Within each EA, approximately 10 tobacco users and 4 non-users of tobacco were interviewed. Approximately 70 households in each EA were enumerated to attain 10 tobacco users. Below is a brief description of the sampling process.

The population of Kenya was first stratified into 8 provinces. Each province was then divided into districts (or wilaya), with a grand total of 158 districts. Each district was then further divided into divisions (or taarafa), which were in turn divided into locations (or mtaa) and then sub-locations (or mtaa mdogo). Finally, each of the over 7,000 sub-locations was divided into enumeration areas (EAs). These EAs consisted on average of about 100 households, but this varied considerably.

Overall, sampling was done in five stages (See Table 3) namely, districts (Stage 1), locations (Stage 2), sub-locations (Stage 3), EAs (Stage 4), and finally individuals (Stage 5). However, several locations contained few sub-locations; yielding selection probabilities close to 1 at Stage 3. For other locations, Stage 3 selection probabilities would have been much smaller, and such a scenario would have resulted in sampling weights that would have been highly variable; thus decreasing precision. To avoid this, locations that contained too few sub-locations were pooled together or pooled with larger locations. This pooling yielded what we have called “super-locations.” In other words, super-locations were an artificially created level between divisions and locations. The same issue arose with sub-locations containing too few EAs, and a few sub-locations were thus pooled together. A detailed report of the sampling design is described in the ITC Kenya Wave 1 Technical Report at [www.itcproject.org/countries/kenya](http://www.itcproject.org/countries/kenya).<sup>48</sup>

**Table 3. The five sampling stages for the ITC Kenya Wave 1 Survey**

Hierarchy	Explanation
Strata	8 provinces
Stage 1	Sampled 2-5 Districts within province (N=21 Districts)
Stage 2	Sampled 1-2 Super-locations within District (N=37 Super-locations)
Stage 3	Sampled 2 Sub-locations within Super-locations (N=74 Sub-locations)
Stage 4	Sampled 2 EAs per Sub-location (N=148 EAs)
Stage 5	<p>Tobacco users: 4 tobacco users were sampled in every enumerated household until the quota of 10 tobacco users per EA was reached.</p> <p>Non-users: 1 Non-user was sampled in every 4th (Central and Eastern provinces), 5th (Nairobi, Coast, Rift Valley, and North Eastern provinces), 7th (Nyanza and Western provinces) enumerated household, until the quota of 4 non-users per EA was reached. Among non-users only, an alternation procedure was designed to sample an equal number of males and females.</p>

There were special considerations that were made in the selection of sampling districts (see Table 4). They are described below and in more detail in the ITC Kenya Wave 1 Technical Report:<sup>48</sup>

1. Since the North Eastern Province borders Somalia and there were various safety concerns and other difficulties in interviewing respondents in the province of North Eastern, instead of randomly sampling from the 4 districts in that province, it was decided to sample the district of Garissa with probability one (i.e., purposive sampling); see Patton (1990)<sup>49</sup> for more information on purposive sampling. Note that Garissa is one of the two largest districts of that province.
2. The districts of Migori, Kuria West, and Kuria East in the province of Nyanza are Kenya's main tobacco-growing regions. It was thus decided to sample one of those three districts since the questionnaire included questions that were specific to tobacco cultivation.
3. The districts of Mombasa, Eldoret West, Eldoret East, Wareng, Busia, Teso North, and Teso South are of particular interest because of potential tobacco smuggling which was an area of interest in this survey. It was thus decided to sample 3 of those 4 districts, one per province. The district of Mombasa is the only such district in the Coast province, and it was thus sampled with probability one (i.e., purposive sampling).

**Table 4. Sampling design for the ITC Kenya Wave 1 Survey**

Province	Sampled Districts	Sampled EAs/ Clusters (n)
Central	Murang'a South	8
	Nyandarua North	8
Coast	Kilindini	8
	Mombasa	4
Eastern	Kibwezi	8
	Machakos	8
	Meru South	8
Nairobi	Nairobi East	8
	Nairobi North	8
Nyanza	Kisii Central	8
	Migori	4
	Nyando	8
Rift Valley	Baringo	8
	Eldoret West	4
	Kericho	8
	Naivasha	8
	Narok North	8
Western	Bungoma South	8
	Lugari	8
	Teso	4
North Eastern	Garissa	4
<b>TOTAL</b>	<b>21 Districts</b>	<b>148 EAs</b>

## 7.2 CONTENT OF THE ITC KENYA SURVEY

The ITC Kenya Survey was developed by an international transdisciplinary team of tobacco control experts. Most of the survey methods and survey questions have been adapted and used in ITC surveys conducted in more than 20 countries around the world.

The ITC Kenya Wave 1 Survey consists of a set of parallel surveys tailored for each of the following population groups:

- **Smoked tobacco users:** adult respondents who smoked any tobacco products including cigarettes, bidis, hookah, cigars, etc. at least once a month but did not use any smokeless tobacco products at least once a month. These respondents were given the Smoked Tobacco User Survey (T).
- **Smokeless tobacco users:** adult respondents who used any smokeless tobacco products including paan, gutka, mishri, zarda, etc. at least once a month but did not smoke any tobacco products at least once a month. These respondents were given the Smokeless Tobacco User Survey (L).
- **Mixed tobacco users:** adult respondents who currently smoked tobacco products (including cigarettes, bidis, hookah, cigars, etc.) and currently used any smokeless tobacco products (paan, gutka, mishri, etc.) at least once a month. These respondents were given the Mixed User Tobacco Survey (M).
- **Non-users of tobacco:** adult respondents who were former tobacco users (e.g. ex-smoker or ex-smokeless tobacco user), or used tobacco less than once a month, or had never used any tobacco at all. Respondents who reported having quit in the last month before the survey were considered non-users. These respondents were given the Non-user Survey (N).

In the ITC Kenya Survey, each respondent who was categorized as a tobacco user responded to the following types of questions:

1. **Tobacco use behaviour and cessation.** Past and present use of smoked and smokeless tobacco products, tobacco dependence, cigarette/bidi/smokeless brand choice and purchasing, and quitting behaviours and use of cessation assistance;
2. **Knowledge and basic beliefs about smoking.** Knowledge of the health effects of smoking/smokeless tobacco use and important beliefs relevant to smoking/smokeless tobacco use and quitting, perceived risk and perceived severity of tobacco-related diseases;
3. **Policy-relevant questions.** Awareness of, impact of, and beliefs relevant for each of the FCTC demand reduction policy domains (warning labels, taxation/price, advertising/promotion, light/mild, and smoke-free policies);
4. **Other important psychosocial predictors** of smoking behaviour/use of smokeless tobacco products and potential moderator variables (e.g., normative beliefs, self-efficacy, intentions to quit);
5. **Individual difference variables** relevant to smoking/use of smokeless products (e.g., depression, stress, time perspective);
6. **Demographics** (e.g., age, gender, marital status, education, occupation).

Non-users of tobacco responded to a survey that was identical in many respects, but was shorter because none of the tobacco use questions (e.g., frequency of use, cessation, purchasing questions) were included.

The protocol and questionnaires of the ITC Kenya Wave 1 Survey were first developed in English and then translated into Kiswahili by a qualified translator. The translated surveys were verified by an independent bilingual Kiswahili-English translator. The average length of the Wave 1 Survey was 60 minutes for tobacco users and 30 minutes for non-users of tobacco. Full copies of the questionnaire are available on the ITC Project website at [www.itcproject.org](http://www.itcproject.org).

## 7.3 DATA PROCESSING AND CLEANING PROCEDURES

Following data collection, the ITC Kenya data were manually entered into computer files using the freely available EpiData software (<http://www.epidata.dk/>). Data entry templates were programmed by an ITC programmer at the University of Waterloo and reviewed by the in-country data manager. Data entry templates were programmed to ensure correct skip patterns were followed and to prevent data entry clerks from entering invalid values.

Data entry was performed by two separate data entry clerks. Each clerk entered the data once. Such duplicate data entry helped minimize data entry errors since it is unlikely that two different people will make the same data entry error for a given value. Once the double data entry was completed by the in-country data clerks, the data files were transferred securely to the University of Waterloo using ITC's secure internal website, which can only be accessed by users who have an account on the website. To maintain security, data files are encrypted prior to uploading them to the website as an extra security measure.

After the data were successfully transferred, the University of Waterloo data analyst commenced data cleaning. The data analyst conducted duplicate entry comparisons of the data files, using the SAS statistical software and identified discrepancies between the two data files. A list of these discrepancies was sent to the in-country data manager for verification and correction. The in-country data manager sent the corrections to the University of Waterloo data analyst for verification.

After discrepancies had been identified and corrections sent by the in-country data manager, the University of Waterloo data analyst conducted additional checks on the data to ensure that all skip patterns had been correctly followed and to ensure that the data did not contain invalid values. Respondent identifier codes were also checked thoroughly to ensure the data could be correctly linked within a survey wave and between waves over time. Any additional discrepancies that were identified were also sent back to the in-country data manager for verification. This back and forth communication between the University of Waterloo data analyst and the in-country data manager continued until the data were deemed clean by the University of Waterloo data analyst.

Following data processing and cleaning, sampling weights were constructed for the dataset and the cleaned datasets were released to the country team, by posting them on the secure internal ITC website. The

University of Waterloo data analyst used the cleaned weighted data to conduct analyses for this national report.

## 7.4 ANALYTIC APPROACH

The ITC Kenya Wave 1 Survey used a stratified multistage cluster sampling design. In order to adjust for potential disproportionate selection of adult tobacco users and non-users in sub-groups, enumeration and survey weights have been calculated for each enumerated household and survey respondent. All the proportion and mean estimates in this report are derived based on the survey samples weighted by the survey cross-sectional weight, unless stated otherwise. The survey cross-sectional weight is interpreted as the number of people in the population that a respondent represents.

To accommodate a potential design effect resulting from the complex survey design, the weight is used in conjunction with the strata (provinces) and primary sampling units (enumeration areas) information in computing estimates of proportions and means. The standard errors for the proportions or means and reported 95% confidence intervals were accordingly adjusted for the design effect. Comparisons of proportions of binary outcomes were tested for statistical significance at the 95% level using survey logistic regression models. Estimated proportions with wide confidence intervals (e.g., some of the provincial results) are due to small sample sizes and should be interpreted with caution.

Similarly, since country samples vary in their composition, survey logistic regression models are used to generate standardized or adjusted values of the descriptive statistics (proportions) in cross-country comparisons. For the cross-country comparisons, age group, smoking status, and time-in-sample were included in the model as covariates. Time-in-sample is the number of times a respondent has participated in the survey and controls for the variation in responses among respondents who are newly recruited compared to those who have completed one prior wave, who vary from those who have completed two prior waves and so on. These documented "time-in-sample" effects have been found in the ITC surveys and in many other surveys as well.<sup>50-54</sup>

Time-in-sample adjustment is not required for the Kenya Wave 1 Survey data. Beginning with the Wave 2 data, time-in-sample adjustment will be factored into the analyses. It should also be noted that the percentages for Kenya presented in cross-country comparisons may vary slightly from the Wave 1 Survey results provided in the text due to differences in adjustment methods.

## 8.0 FINDINGS

### 8.1 CHARACTERISTICS OF THE SAMPLE

The total sample of ITC Kenya Wave 1 Survey is 1,998 respondents. Table 5 shows a breakdown of the sample by province, smoking status, and gender. Smokers were defined as those who reported that they currently smoked cigarettes only, bidis only, or both cigarettes and bidis at least once a month. Further information on the sampling design, fieldwork procedures, construction of sampling weights, and cooperation and response rates is provided in the ITC Kenya Wave 1 Technical Report.<sup>48</sup>

Table 5. Total sample of respondents by province, smoking status, and gender

Sample Area (provinces)	Smoked tobacco only		Smokeless only		Mixed user		Non-user	
	Male (N)	Female (N)	Male (N)	Female (N)	Male (N)	Female (N)	Male (N)	Female (N)
Central	144	5	1	6	0	0	33	30
Coast	86	13	9	3	2	0	23	23
Eastern	158	8	18	42	3	0	52	44
Nairobi	125	17	11	0	6	1	30	32
Nyanza	136	12	12	16	4	0	37	38
Rift Valley	197	17	68	66	3	2	71	64
Western	113	19	48	17	1	0	41	38
North Eastern	32	0	4	0	2	0	7	8
<b>Subtotal A</b>	<b>991</b>	<b>91</b>	<b>171</b>	<b>150</b>	<b>21</b>	<b>3</b>	<b>294</b>	<b>277</b>
<b>Subtotal B</b>	<b>1,082</b>		<b>321</b>		<b>24</b>		<b>571</b>	
<b>Grand Total</b>	<b>1,998</b>							

*The ITC Kenya Survey is a nationally representative probability sample of tobacco users and non-users of tobacco selected through a multi-stage clustered sampling design. Specifically, the design was stratified by province and sampled a total of 148 clusters/enumeration areas (EAs), allocated to the provinces in numbers proportional to population size.*

Table 6 summarizes the demographic characteristics of the ITC Kenya Wave 1 Survey sample.

**Table 6. Demographic characteristics of the ITC Kenya Wave 1 sample**

Characteristic	Freq.	%
<b>Highest level of education</b>		
Low (illiterate/< primary)	278	13.9
Moderate (some/ completed primary)	912	45.7
High (secondary or higher)	796	39.8
Non-response	12	0.6
<b>Total</b>	<b>1,998</b>	<b>100</b>
<b>Religion</b>		
Roman Catholic	575	28.8
Protestant/Other Christian	1,080	54.0
Muslim	136	6.8
Hindu	2	0.1
Buddhist	0	0
No Religion	168	8.4
Other (specify below)	28	1.4
Non-response	9	0.5
<b>Total</b>	<b>1,998</b>	<b>100</b>
<b>Household Income</b>		
Low	974	48.7
Medium	391	19.6
High	95	4.8
Non-response	538	26.9
<b>Total</b>	<b>1,998</b>	<b>100</b>
<b>Gender</b>		
Male	1,477	73.9
Female	521	26.1
<b>Total</b>	<b>1,998</b>	<b>100</b>
<b>Age</b>		
15-17	23	1.1
18-24	239	12.0
25-39	798	39.9
40-54	499	25.0
55+	439	22.0
<b>Total</b>	<b>1,998</b>	<b>100</b>

## 8.2 TOBACCO USE BEHAVIOUR AND BELIEFS

The ITC Kenya Wave 1 (2012) Survey provides an assessment of tobacco use among the Kenyan population. It describes the population's tobacco consumption patterns, quitting behaviour, as well as its knowledge, beliefs, and attitudes about tobacco use. Wave 1 also measures levels of awareness of, experiences with, and attitudes towards cessation services among Kenyan tobacco users.

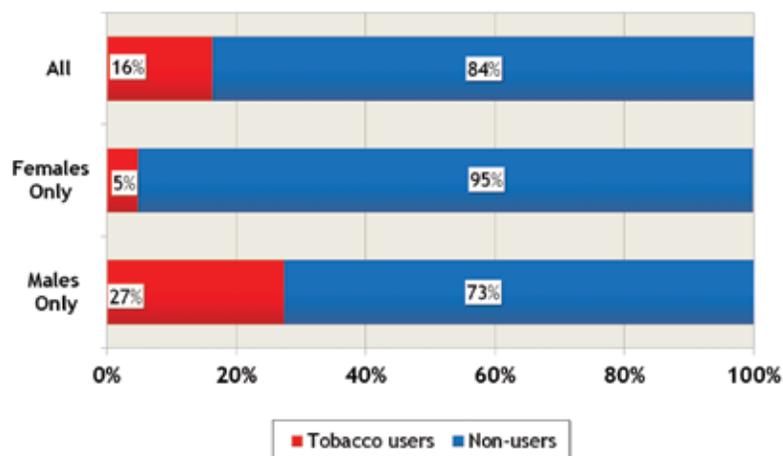
### 8.2.1 Prevalence of Tobacco Use

Tobacco is the single most preventable cause of death globally,<sup>55</sup> killing about 6 million people each year with 600,000 of these deaths resulting from exposure to secondhand tobacco smoke. More alarming is that 80% of these deaths are occurring in LMICs. There is a scarcity of tobacco use prevalence data in many African countries, including Kenya. The most recent 2008-09 Kenya Demographic Health Survey reported that 19% of men and less than 2% of women aged 15-49 years smoked cigarettes, a pipe, or used other tobacco products, with 18% of men and less than 1% of women smoking cigarettes.<sup>56</sup>

The ITC Kenya Wave 1 (2012) Survey found that 16% of adults – 27% of men and 5% of women in Kenya use tobacco products (see Figure 2). These data suggest that there has been an increase in the prevalence of tobacco use among both men and women in Kenya since 2008-09. However, caution needs to be taken when making prevalence comparisons with other national surveys because of differences in survey methodologies.

Prevalence of tobacco use varied across regions, from a low of 9% in Western and Nyanza provinces to a high of 26% in Coast province (see Figure 3).

**Figure 2. Prevalence of tobacco use in Kenya, by gender**



## 8.2.2 Tobacco Use Types

The ITC Kenya Wave 1 findings showed that most tobacco users in Kenya (74%) were smokers, 24% were smokeless tobacco users, and 2% were mixed tobacco users (i.e., use both smoked and smokeless tobacco). However, the type of tobacco product used differs between men and women: the majority of Kenyan male tobacco users (83%) smoked cigarettes, while the majority of female Kenyan tobacco users (66%) used smokeless tobacco products (see Figure 4).

“Mixed tobacco use”, that is the use of both smoked and smokeless tobacco products, is rare in Kenya (2%), unlike in India where about 10% of tobacco users are mixed users.

Figure 3. Prevalence of tobacco use in Kenya, by province

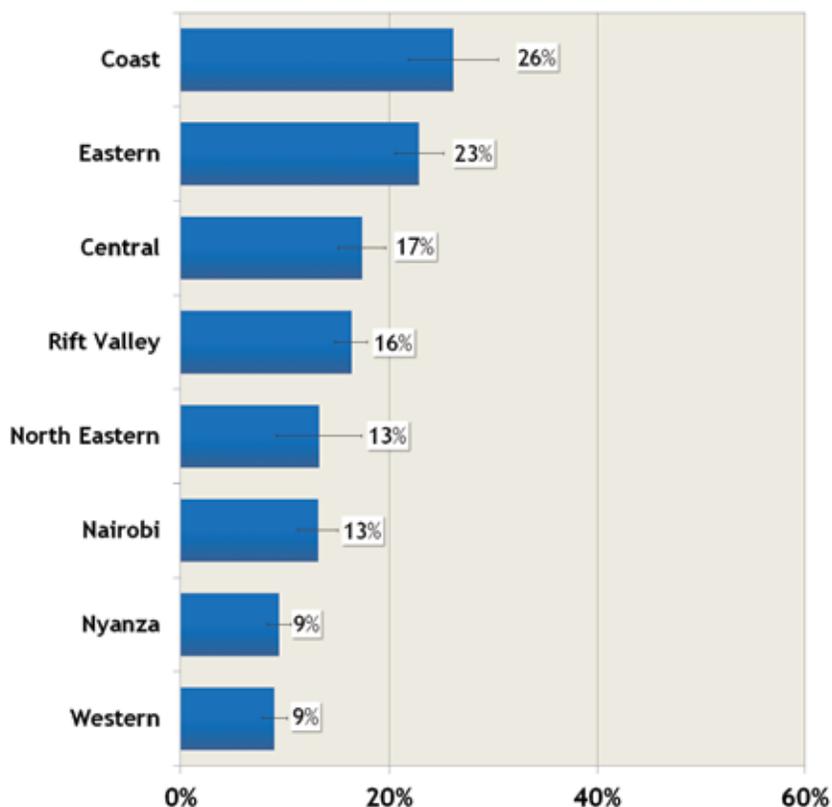
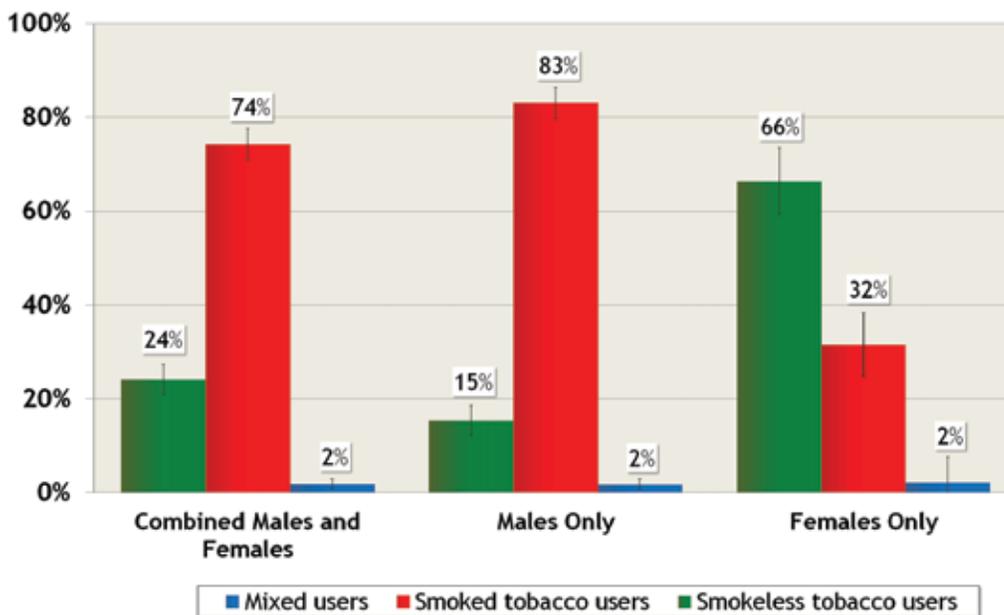


Figure 4. Type of tobacco use in Kenya, by gender



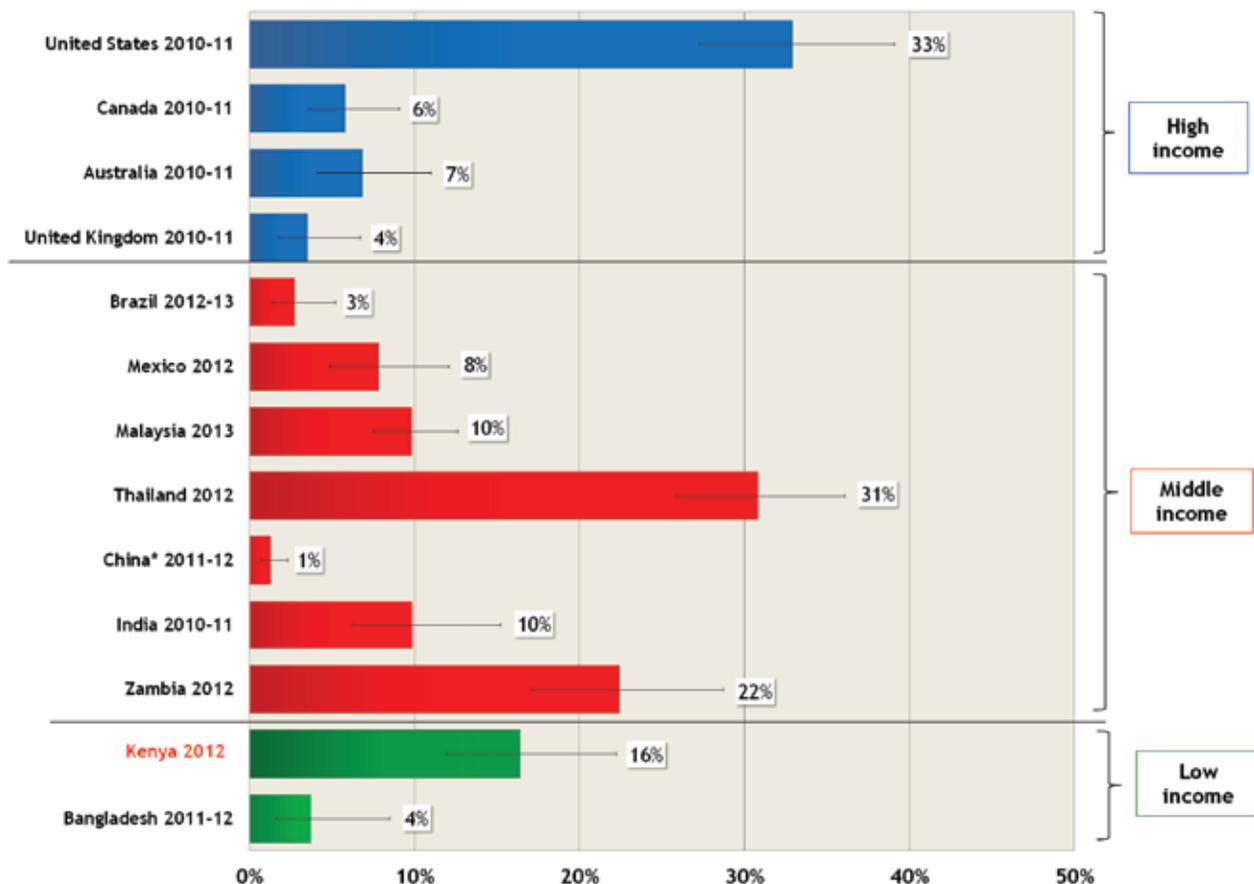
## 8.2.3 Tobacco Consumption

Almost all (91%) smokers<sup>ii</sup> and mixed tobacco users reported that they smoked cigarettes daily or almost daily. The average number of cigarettes smoked per day (CPD) was 8. ITC cross-country comparisons indicate that this average daily consumption among male smokers is similar to other LMICs like Zambia (7 CPD), India (7 CPD), and Mauritius (10 CPD), but much lower than HICs.

The majority of smokers (82%) said they normally smoke filtered cigarettes rather than unfiltered cigarettes. This corresponds with the prevalence of factory-made (87%) vs. hand-rolled (12%) cigarette smokers (see page 74). The majority of smokers (90%) reported that they had a brand of cigarette that they usually smoke. Among these smokers who had a usual brand, 18% stated that their usual variety of cigarettes was “filters” and 8% said their usual variety was “light” cigarettes.

In addition, respondents who had a usual brand were asked what is the flavour, if any, of the brand they last purchased (response options included “none”, “menthol”, “sweet menthol”, “other”). One-fifth (21%) of respondents who had a usual brand smoked menthol or sweet menthol flavored cigarettes rather than unflavored cigarettes. Cross-country comparisons of these findings with other ITC countries indicate that Kenya has the third highest percentage of male smokers who smoke menthol cigarettes (16%) among male smokers in 9 ITC LMICs (with only Zambia and Thailand having higher use), and the fourth highest use among all 13 ITC countries where menthol use was reported among those who smoke a usual/regular brand (see Figure 5).

Figure 5. Percentage of male smokers<sup>†</sup> who reported smoking menthol cigarettes among those who have a regular brand, by country



<sup>†</sup> ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* In China, the question asked about the brand the respondent reported smoking most often in the last month.

ii. In this report “smokers” are primarily cigarette smokers, but also include those who smoke bidis, or pipes, and “mixed users” include (those who use both smoked and smokeless products), unless otherwise stated. “Smokeless users” include those who only use smokeless tobacco products, as well as mixed users, unless otherwise stated.

Use of other types of smoked tobacco products is low in Kenya: very few tobacco users reported they they smoked cigars (n=55), pipe (n=4), bidis (n=4), hookah (n=3), electronic cigarettes (n=1), cigarillos (n=1), or kreteks (n=1) at least once a month.

Smokeless tobacco users (26% of all tobacco users) were asked how often they used their usual smokeless product. Most (92%) reported that they used these tobacco products daily or almost every day. About half (54%) of smokeless users used nasal snuff at least once a month. Smokeless users also reported that they used plain chewing tobacco (35%), oral snuff (32%), and kuber (8%) at least once a month. Of those smokeless users who said they have a usual brand or type, nasal snuff was the most common (39%), followed by plain chewing tobacco (30%), and oral snuff (25%).

#### 8.2.4 Opinions and Perceived Norms about Tobacco Use

Kenyans have a negative opinion about smoking. Two-thirds (66%) of Kenyan smokers and 78% of non-users “agree” or “strongly agree” with the statement “society disapproves of smoking”.

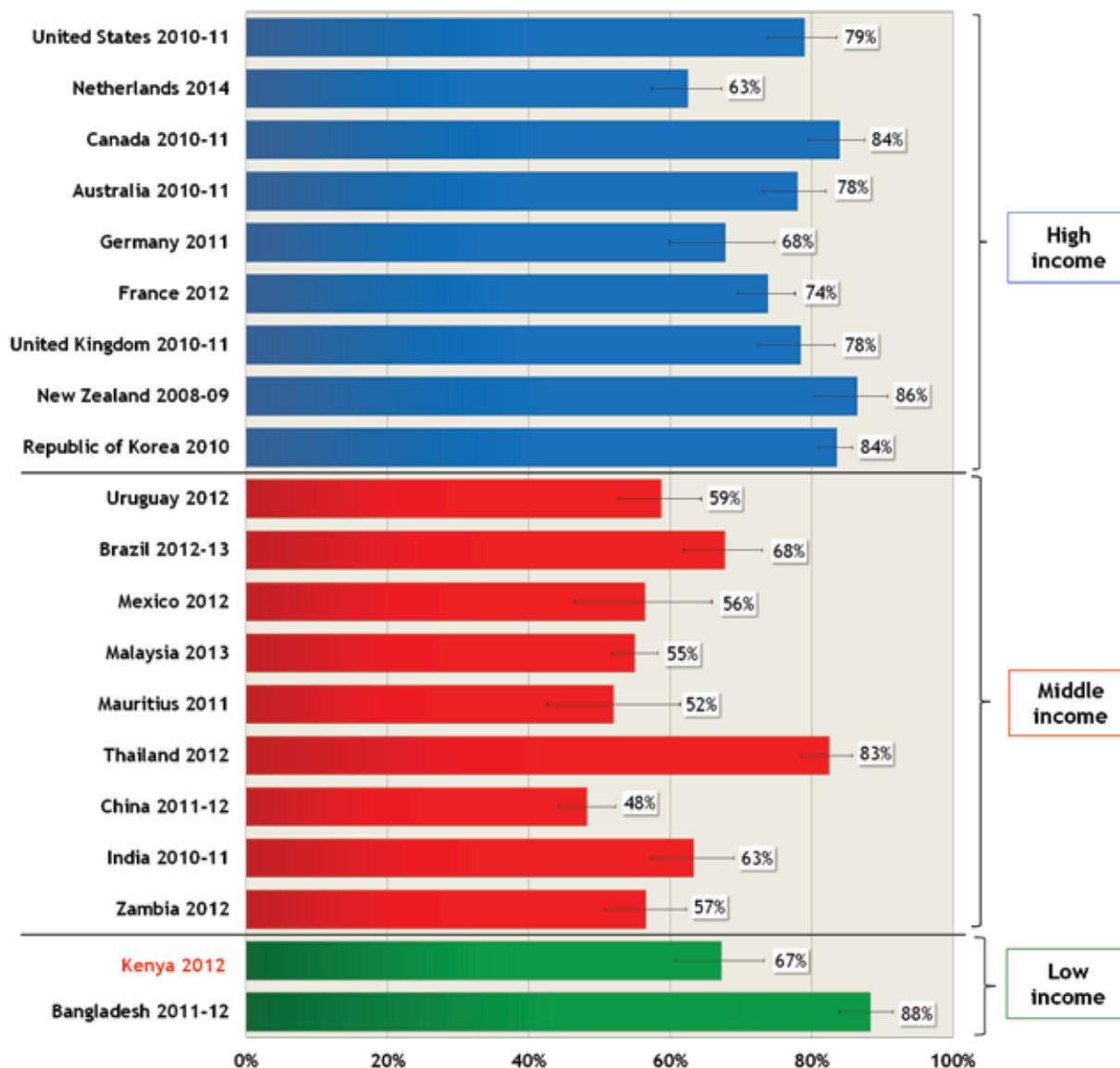
ITC cross-country comparisons reveal that the rate of perceived societal disapproval among Kenyan male smokers (67%) is similar to other LMICs, but generally lower than in HICs where tobacco control is typically more well established (see Figure 6).

The majority (82%) of smokers, smokeless users (92%), and non-users (94%) “disagree” or “strongly disagree” that female cigarette smoking is acceptable. However, it is of concern that there is already a minority (8%) of survey respondents who “agree” or “strongly agree” that female smoking is acceptable in Kenya as recent reports note that African women are disproportionally targeted by the tobacco industry using marketing strategies that present smoking as a symbol of strong women and of having modern values.<sup>1</sup> This social acceptability measure of tobacco use will be an important indicator to track over time.

The majority (73%) of smokers and non-users (85%) “disagree” or “strongly disagree” that female use of smokeless tobacco is acceptable. However, only 46% of smokeless users disagreed that female smokeless use is acceptable, and 23% of all survey respondents “agree” or “strongly agree” that female smokeless use is acceptable in Kenya. This shows that although tobacco use among females overall is not acceptable in Kenya, smokeless use among females is more acceptable than smoking.

**The majority of Kenyan male tobacco users (83%) smoked cigarettes, while the majority of female Kenyan tobacco users (66%) used smokeless tobacco products.**

Figure 6. Percentage of male smokers† who “agree” or “strongly agree” that society disapproves of smoking, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya, where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

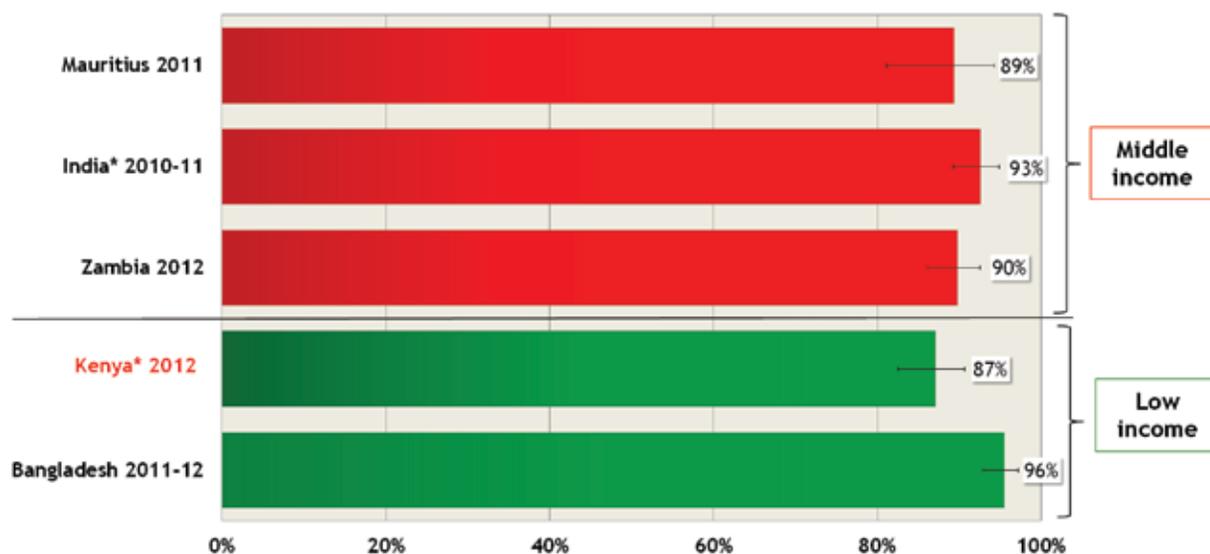
## 8.2.5 Perception of Harm

### *Perceived harm of smoked tobacco*

The majority of tobacco users and non-users are generally aware that smoking is harmful to health; however, a lower percentage of tobacco users were aware of the specific harms of tobacco (see Education, Communication, and Public Awareness section on page 66). Most smokers (86%), smokeless only users (93%), and non-users (99%) think that smoking is “not good for health.”

ITC cross-country comparisons among male smokers in other LMICs show that male smokers in Kenya (87%) are the least likely of the five countries to say that smoking is “not good for health” (see Figure 7).

Figure 7. Percentage of male smokers† who think that smoking cigarettes is “not good for your health”, by country



† ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* In India and Kenya, the question did not specify “cigarettes”, it just asked about smoked tobacco in general.

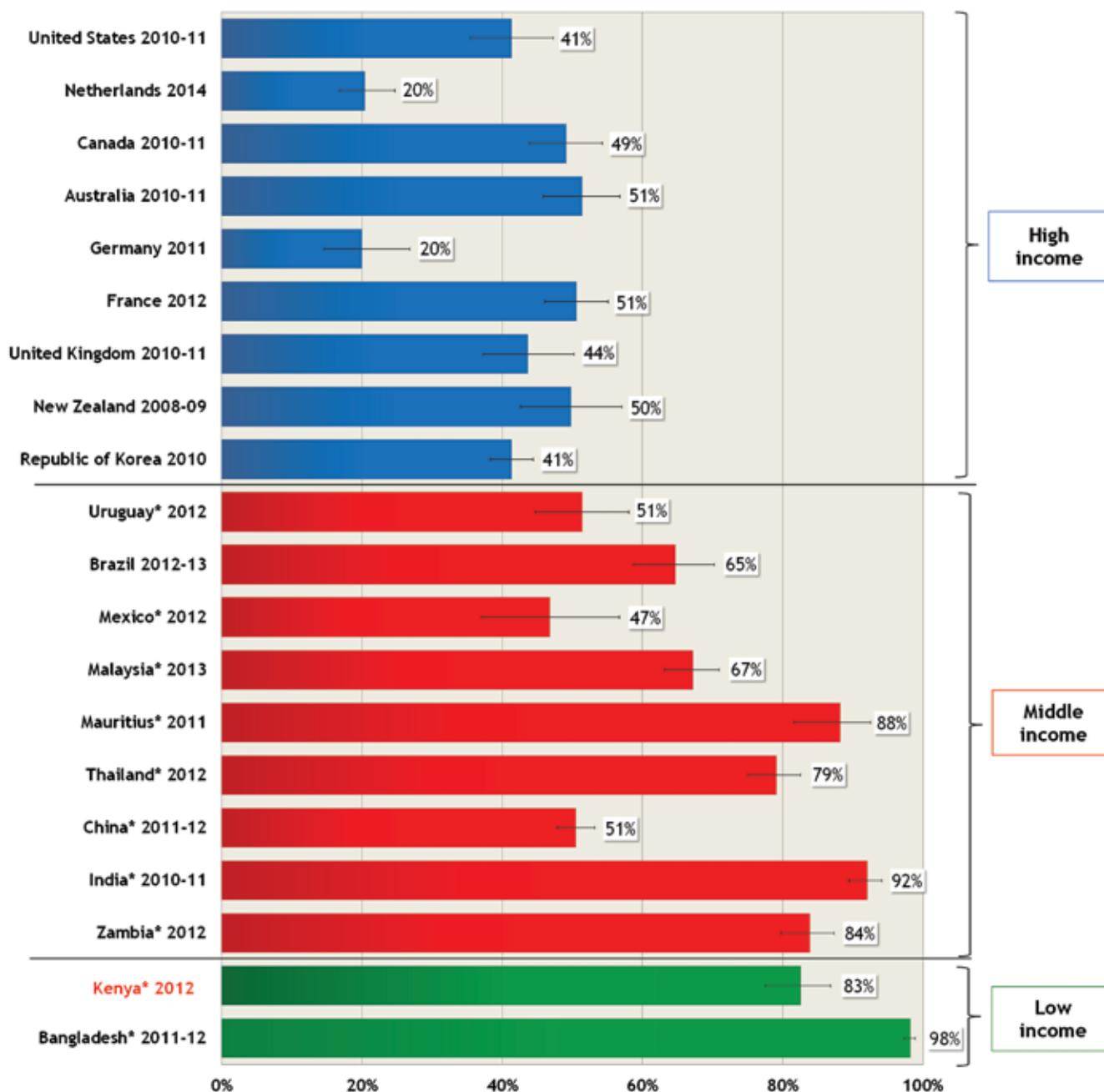
When asked about their overall opinion about smoking, 83% of smokers, 91% of smokeless only users, and 98% of non-users said that smoking cigarettes was “bad” or “very bad”.

ITC cross-country comparisons indicate that a higher percentage of male smokers in Kenya (83%) have a negative opinion of smoking compared to male smokers in Latin American countries (Uruguay (51%); Brazil (65%); and Mexico (47%)), and Southeast Asia (Malaysia (67%); Thailand (79%)) (see Figure 8). Like Kenya, more than 80% of male smokers in Zambia (84%), Mauritius (88%), India (92%), and Bangladesh (98%) have negative opinions of smoking.

Two in five (40%) smokers think that the cigarette brand they use is “a little less harmful” than other brands/types of cigarettes. The majority (78%) of smokers and 61% of smokeless users agree that hand-rolled cigarettes are more or equally harmful to health than factory-made cigarettes.

*Two in five (40%) smokers think that the cigarette brand they use is “a little less harmful” than other brands/types of cigarettes.*

Figure 8. Percentage of male smokers† whose overall opinion of smoking is “negative” or “very negative”, by country



† Smokers refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* Response options were “bad” or “very bad”.

### Perceived harm of smokeless tobacco

While the majority (86%) of smokers said that smoking was “not good” for their health, smokeless tobacco users were less negative about the harms of using smokeless tobacco products. Only 55% of smokeless users said that smokeless products are “not good” for health, compared to 86% of smokers and 97% of non-users. Smokeless users were also less likely to have a “bad” or “very bad” opinion of smokeless tobacco (51%) compared to smokers (90%) and non-users (96%).

More than half (55%) of smokers think that there is no difference in harm between cigarettes and smokeless tobacco and only 17% of smokers think that smokeless tobacco is less harmful than cigarettes. Smokeless users were more likely to perceive smokeless tobacco as less harmful – about two-thirds (63%) of smokeless users think that smokeless tobacco is less harmful than cigarettes and one-third (34%) of smokeless users think that there is no difference in harm between cigarettes and smokeless tobacco. In addition, almost two-thirds (62%) of smokeless users think that the smokeless tobacco product they use might be “a little less harmful” than other brands/types of smokeless products. This suggests the need to educate people in Kenya about the dangers of smokeless tobacco.

The majority of survey respondents – both tobacco users and non-users – are aware of the addictive properties of tobacco. Almost all smokers (99%), smokeless users (99%), and non-users (99%) “agree” or “strongly agree” that smoking is addictive. Similarly, 96% of smokers, 98% of smokeless users, and 98% of non-users “agree” or “strongly agree” that smokeless tobacco is addictive.

### 8.2.6 Regret for Using Tobacco

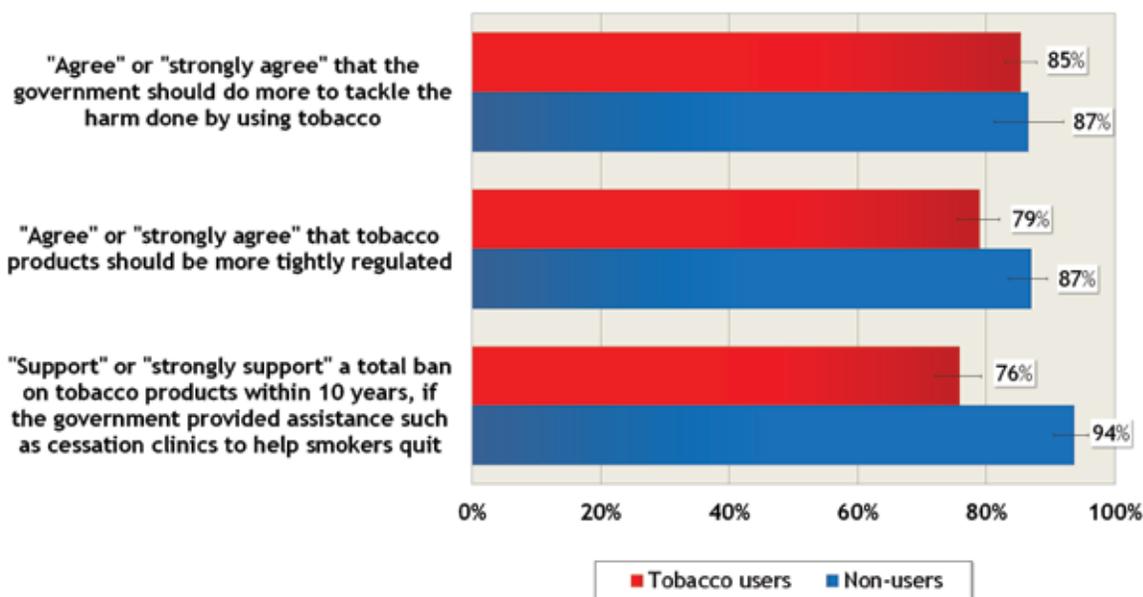
One of the most prominent findings about tobacco use is the fact that many tobacco users do not want to smoke or use tobacco.<sup>58</sup> Tobacco users’ experience of regret for ever having started smoking is an important indicator of societal norms about tobacco use and a predictor of future quitting behaviour. The ITC Kenya Survey assessed the extent to which smokers regret that they smoke by measuring the proportion of smokers who “agree” or “strongly agree” with the statement: “If you had a chance to live your life again, you would not have started smoking”. The majority (84%) of smokers “agreed” or “strongly agreed” with this statement. Data from other ITC countries suggests that this level of regret is higher than male smokers in some LMICs (e.g., Zambia (68%), India (70%), Mexico (69%)), but it still lower than most HICs and many other LMICs (e.g., Mauritius (87%), Brazil (87%), Bangladesh (89%)).

Smokeless users were less likely to regret using smokeless tobacco: 60% of smokeless and mixed users “agreed” or “strongly agreed” with the statement: “If you had a chance to live your life again, you would not have started using smokeless tobacco”.

### 8.2.7 Support for Government Action

It is important to note that the vast majority of tobacco users themselves support stronger action on tobacco control by the Government of Kenya—at levels that are quite close to the level of support of non-users (see Figure 9). Most (85%) tobacco users and non-users (87%) “agree” or “strongly agree” that the government should do more to tackle the harm done by using tobacco. About three-quarters (79%) of tobacco users and 87% of non-users “agree” or “strongly agree” that tobacco products should be more tightly regulated. About three-quarters (76%) of tobacco users and 87% of non-users “support” or “strongly support” a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics to help smokers quit.

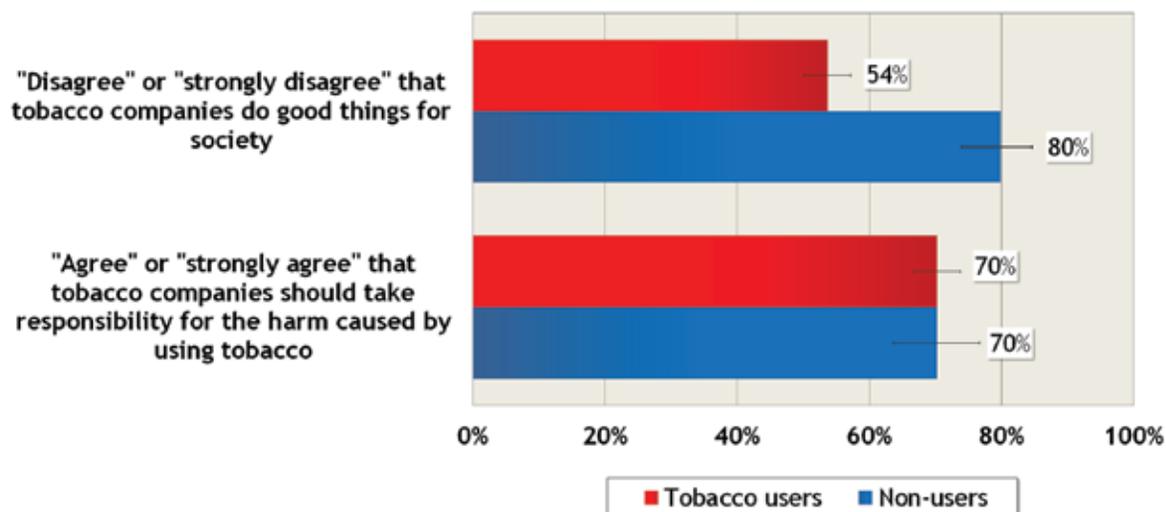
Figure 9. Tobacco users’ and non-users’ opinions about government responsibility



## 8.2.8 Opinions about Tobacco Companies

The majority of respondents have a negative opinion of tobacco companies and believe that tobacco companies should take responsibility for the harm caused by tobacco. 54% of tobacco users and 80% of non-users “disagree” or “strongly disagree” that tobacco companies do good things for society. Similarly, 70% of tobacco users and non-users “agree” or “strongly agree” that tobacco companies should take responsibility for the harm caused by using tobacco (see Figure 10).

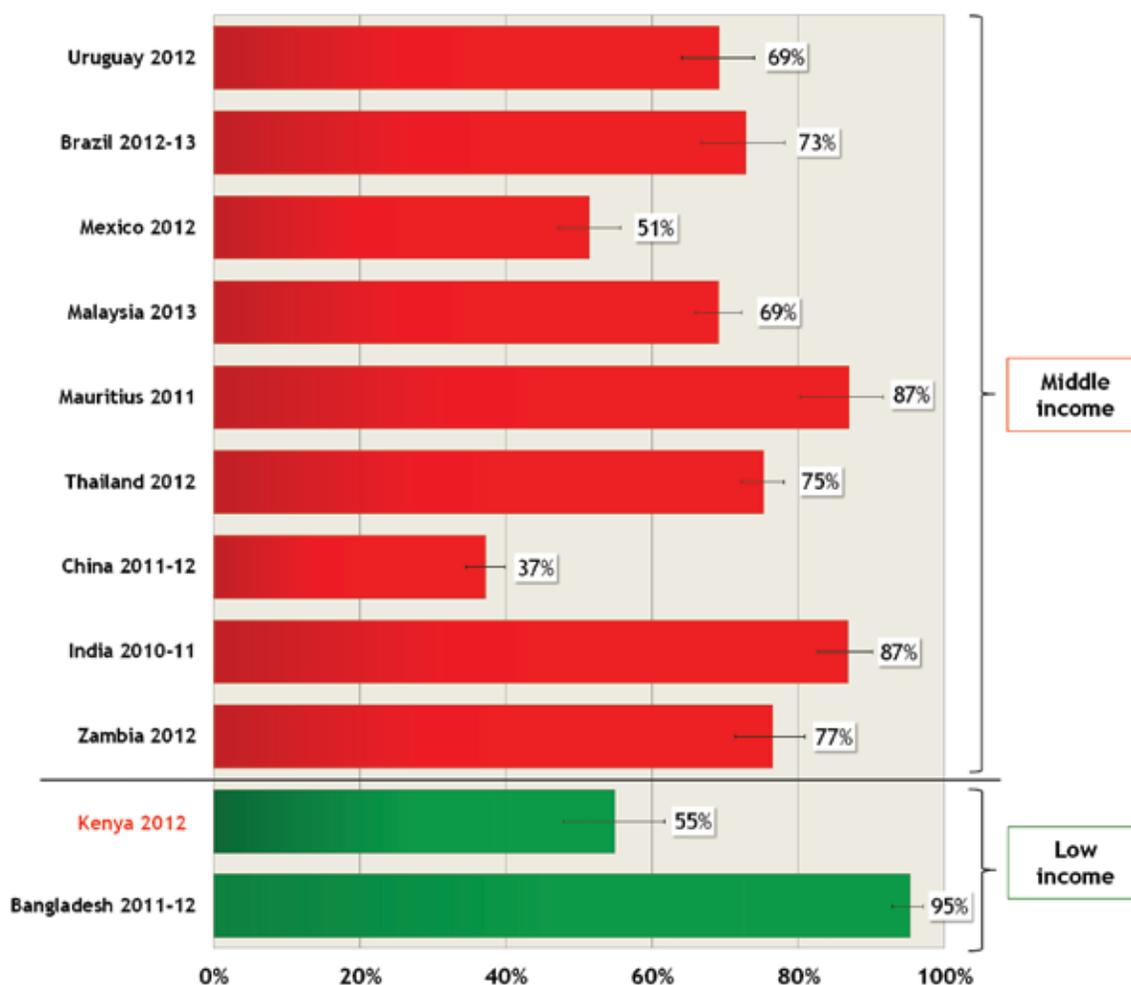
Figure 10. Tobacco users’ and non-users’ opinion about tobacco companies



ITC cross-country comparisons indicate that smokers’ opinions of tobacco companies are less negative in Kenya compared to other LMICs. Kenya has the third-lowest percentage of male smokers who “disagree” or “strongly disagree” that tobacco companies do good things for society (55%) out of 11 LMICs – higher only than China (37%) and Mexico (51%) (see Figure 11). Opinions of tobacco companies are much more negative in other African countries in the ITC Project – 77% of male smokers in Zambia and 87% of male smokers in Mauritius disagree that tobacco companies do good things for society.

*The majority of tobacco users (70%) and non-users (70%) “agree” or “strongly agree” that tobacco companies should take responsibility for the harm caused by using tobacco.*

Figure 11. Percentage of male smokers† who “disagree” or “strongly disagree” that tobacco companies do good things for society, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

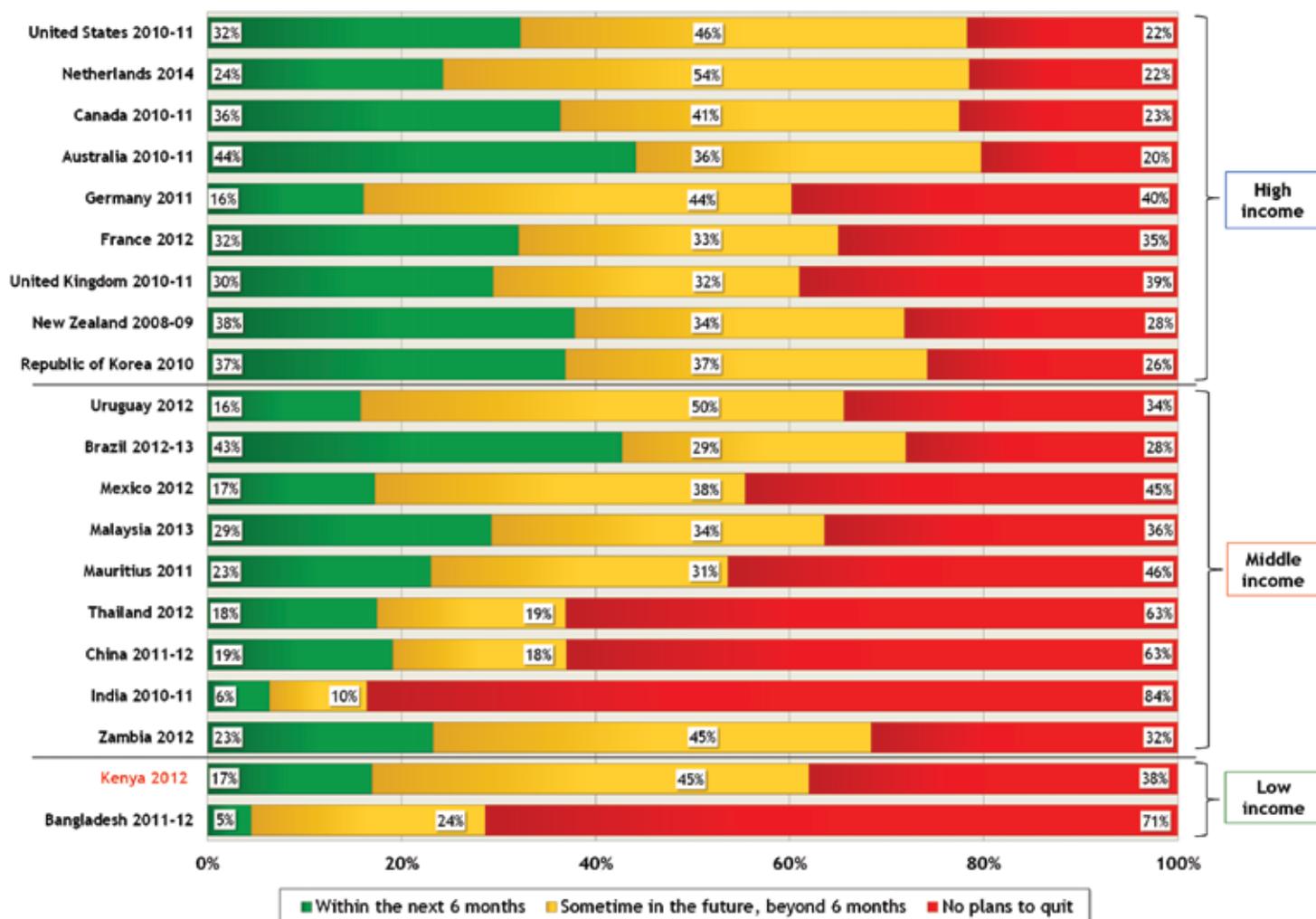
## 8.3 SMOKING CESSATION

### 8.3.1 Quit Intentions and Quit Attempts

Past attempts to quit and intentions to quit are important because they are strong predictors of future quit attempts. In Kenya, more than one-third (40%) of smokers have “ever” tried to quit smoking cigarettes.

About one-fifth (17%) of smokers reported that they plan to quit smoking cigarettes within the next month or 6 months. ITC cross-country comparisons indicate that the percentage of male smokers who plan to quit in the next 6 months in Kenya (17%) is lower than in Zambia (23%) and Mauritius (23%). It is also concerning that more than one-third (38%) of male smokers in Kenya are not planning to quit at all (see Figure 12).

Figure 12. Intentions to quit smoking among male smokers†, by country



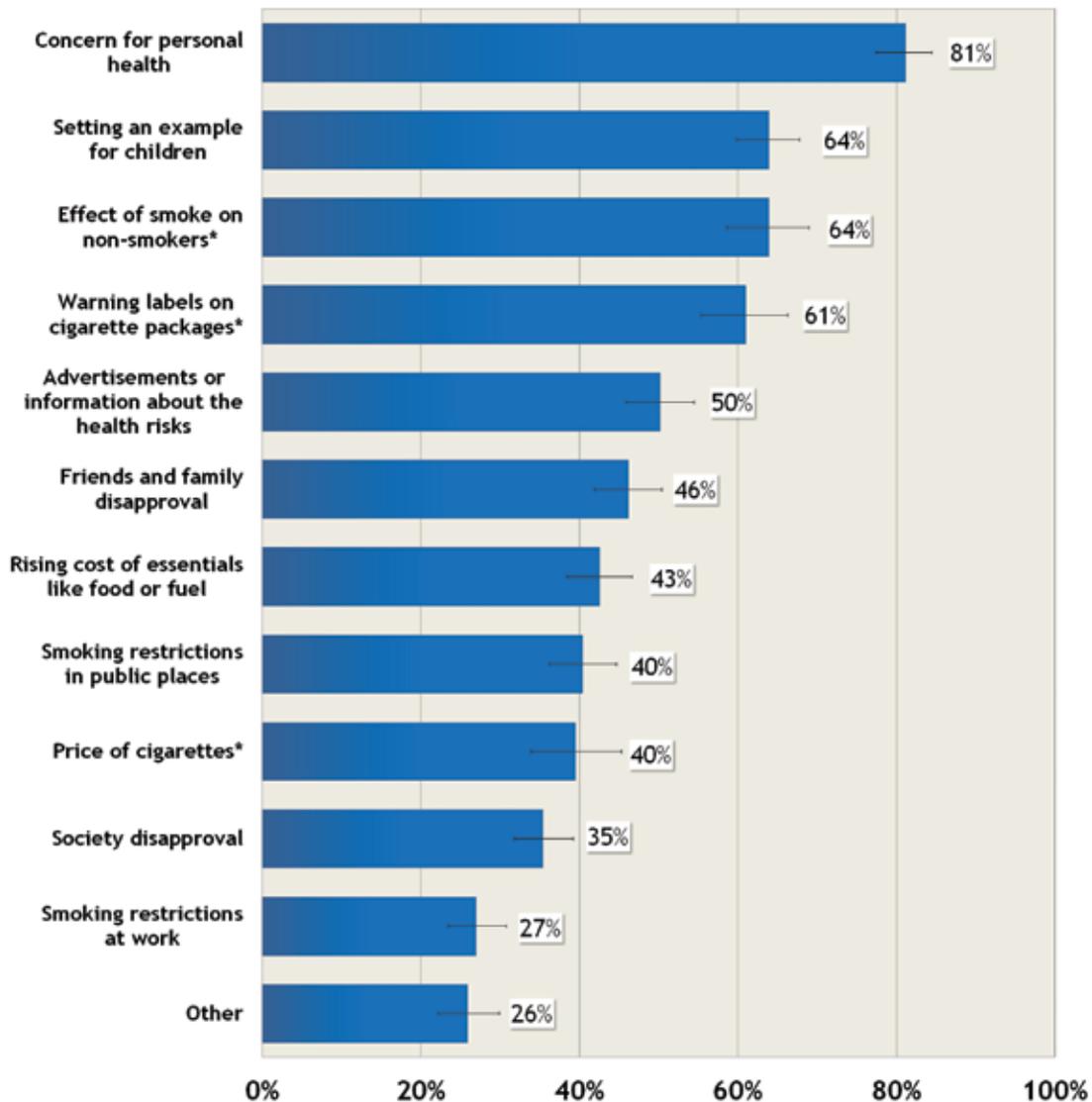
† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

## 8.3.2 Reasons to Think About Quitting

### Smokers

Smokers and mixed users were asked to indicate which of several reasons have led them to think about quitting smoking. The most commonly mentioned reasons were: concern for personal health (81%), setting an example for children (64%), concern about the effect of cigarette smoke on non-smokers (64%), and the health warnings on cigarette packages (61%) (see Figure 13). It is of concern that fewer smokers indicated the price of cigarettes (40%), society's disapproval of smoking (35%), and smoking restrictions at work (27%) as reasons to think about quitting since research shows that these policies have the potential to have the greatest impact in reducing smoking prevalence (see the Tobacco Price and Taxation section on page 77 for further discussion of price as a reason for thinking about quitting).

Figure 13. Smokers' reasons that led them to think about quitting smoking



\* Only asked to smokers who currently smoke cigarettes and who said they were planning to quit.

### Smokeless Users

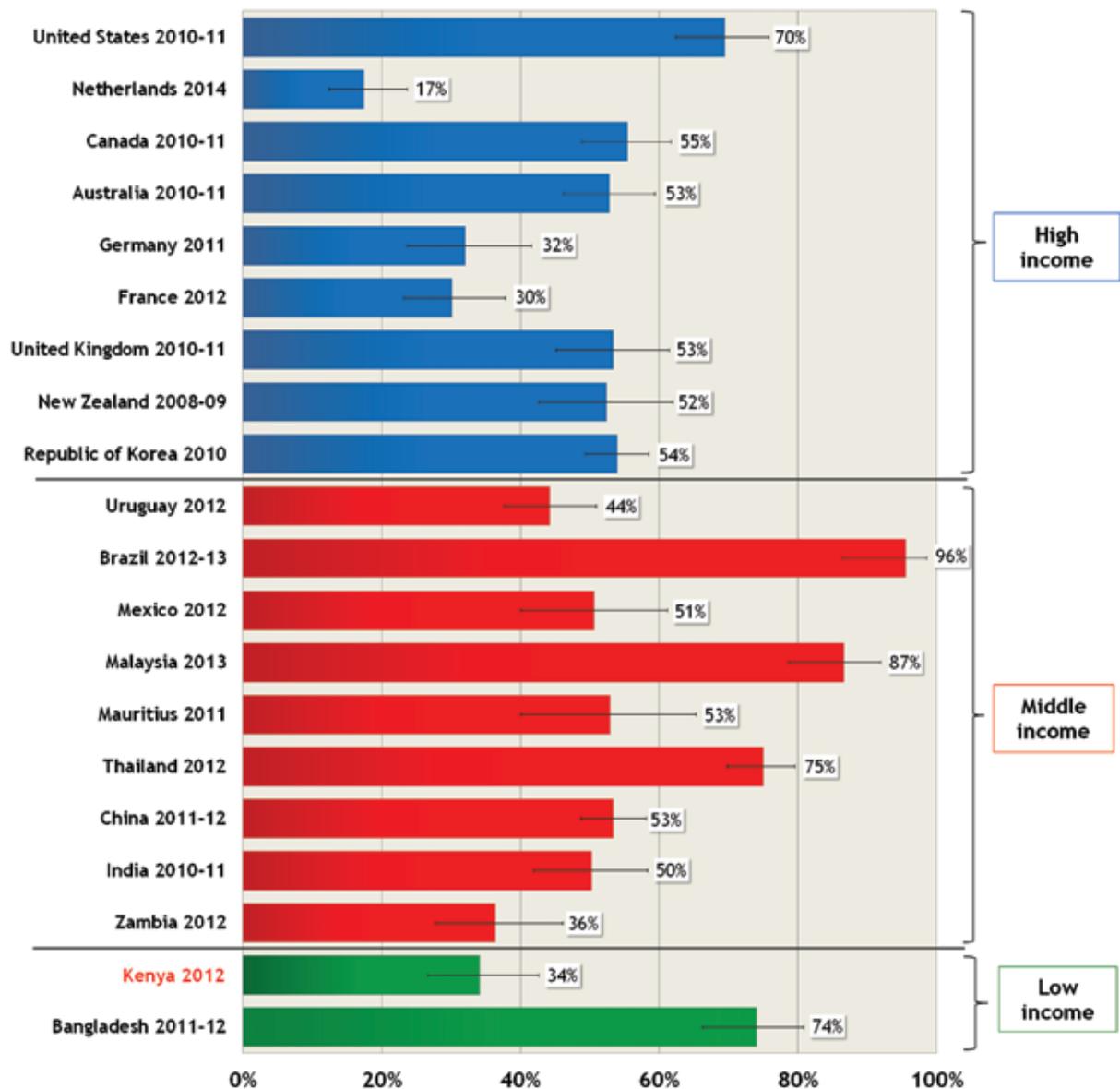
About one-fifth (21%) of smokeless users have “ever” tried to quit using smokeless tobacco. 11% of smokeless users plan to quit within the next month or 6 months, and about half (51%) have no plans to quit.

Among smokeless users who plan to quit, the most commonly mentioned reasons for thinking about quitting included: concern for their health (79%), setting an example for children (54%), disapproval by friends and family members (37%), rising costs of essentials (32%), society disapproval (29%), price of smokeless products (24%), and information about health risks (24%). It is concerning that the price of the smokeless products was among the least frequently cited reasons for thinking about quitting. This finding suggests that smokeless products are affordable in Kenya.

### 8.3.3 Availability and use of cessation services and assistance in Kenya

One-fifth (20%) of tobacco users reported that they had visited a doctor or other health provider in the last 6 months. Among smokers who had visited a doctor, 35% were given advice to quit tobacco. While this is a good starting point, ITC cross-country comparisons show that rates of closer to 50% have been achieved among male smokers in other LMICs such as Mauritius (53%), India (50%), Uruguay (44%), and Mexico (51%). In fact, the percentage of male smokers who received advice to quit in Kenya (34%), is the lowest of 11 LMICs (see Figure 14). The rate of physician advice in Kenya could be improved through greater efforts to sensitize doctors and healthcare providers on the harms of tobacco use. This is important as it is well established that advice to quit from a physician or health provider is a powerful motivator for quitting. Of those who were given advice to quit, 82% reported that the advice made them think about quitting tobacco.

Figure 14. Percentage of male smokers<sup>†</sup> who received advice to quit from a doctor or health provider, among those who visited a doctor in the last 6 months<sup>‡</sup>, by country



<sup>†</sup> 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

<sup>‡</sup> In Canada, Australia, US, and UK, the question asked either about the last 12 months, or since the last survey date.

Only 7% of smokers who had visited a doctor said that they received additional help or a referral to another service to help them quit tobacco. Overall, 15% of smokers and 2% of smokeless users reported that they had heard about medications to help people stop smoking (e.g., Nicotine Replacement Therapies like nicotine gum or the patch, or Zyban).

The majority of tobacco users (76%) and non-users (94%) “support” or “strongly support” a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics to help smokers quit (see Figure 9 on page 46).

## 8.4 PACKAGING AND LABELLING OF TOBACCO PRODUCTS

Article 11 of the WHO FCTC requires Parties to implement large, visible, rotating health warnings covering at least 50% of the principal display areas of the package in the country’s principal language within 3 years of ratification. The guidelines for the implementation of Article 11 recommend that warnings include full-colour pictures covering more than 50% of the front and back of the pack.<sup>12</sup>

The 2007 Tobacco Control Act requires text health warnings that cover 30% of the principal display areas of the cigarette pack, including 30% of the front panel and 50% of the back. Each pack is required to display two health warnings of the same health message, in both English and Kiswahili, that are rotated through a 12 month period (with a total of 13 different warnings for both smoked and smokeless tobacco products).

While text-only warnings are currently required, the Act empowers the Ministry of Health to regulate pictorial warnings. In December 2014, the Ministry of Health tabled a set of regulations to the Act which included a set of 15 images to be rotated on packages of smoked and smokeless tobacco.<sup>57</sup>

The findings from the ITC Kenya Wave 1 Survey described below provide evidence of the urgent need to improve the current text-based warnings in order for Kenya to meet its obligations to the FCTC and to most effectively provide tobacco users in Kenya with information on the harms of tobacco use.

### 8.4.1 Awareness of Health Warnings

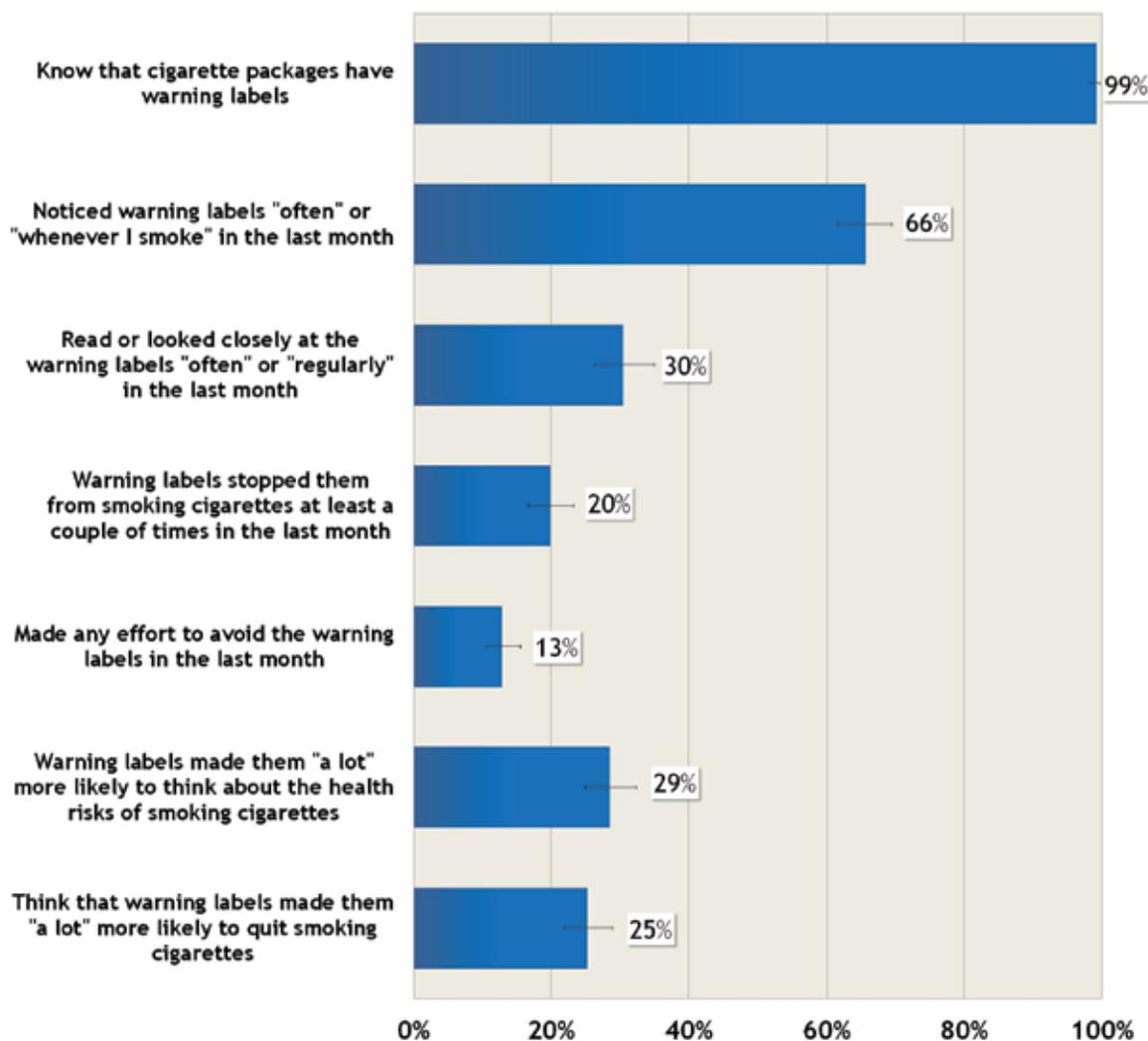
Almost all (99%) of Kenyan smokers reported that they knew that cigarette packages have health warnings (see Figure 15). There was very little disparity in awareness of health warnings (97% to 100%) across the 8 Kenyan provinces. Most non-users of tobacco (94%) and 86% of smokeless users also knew that cigarette packages have health warnings.

### 8.4.2 Impact of Health Warnings

Among smokers who knew that cigarette packages in Kenya have health warnings, two-thirds (66%) said they noticed these warnings “often” or “whenever I smoke” in the last month prior to the survey and almost one-third (30%) reported that they read or looked closely at the warnings “often” or “regularly” in the last month (see Figure 15). Almost one-third (29%) of smokers who were aware of health warnings on cigarette packages stated that the warnings made them “a lot” more likely to think about the health risks of smoking cigarettes. One-quarter (25%) of smokers reported that warnings made them “a lot” more likely to quit smoking cigarettes.

*The majority of tobacco users (76%) and non-users (94%) “support” or “strongly support” a total ban on tobacco products within 10 years, if the government provided assistance such as cessation clinics to help smokers quit.*

Figure 15. Impact of health warnings on cigarette smokers' perceptions and behaviours

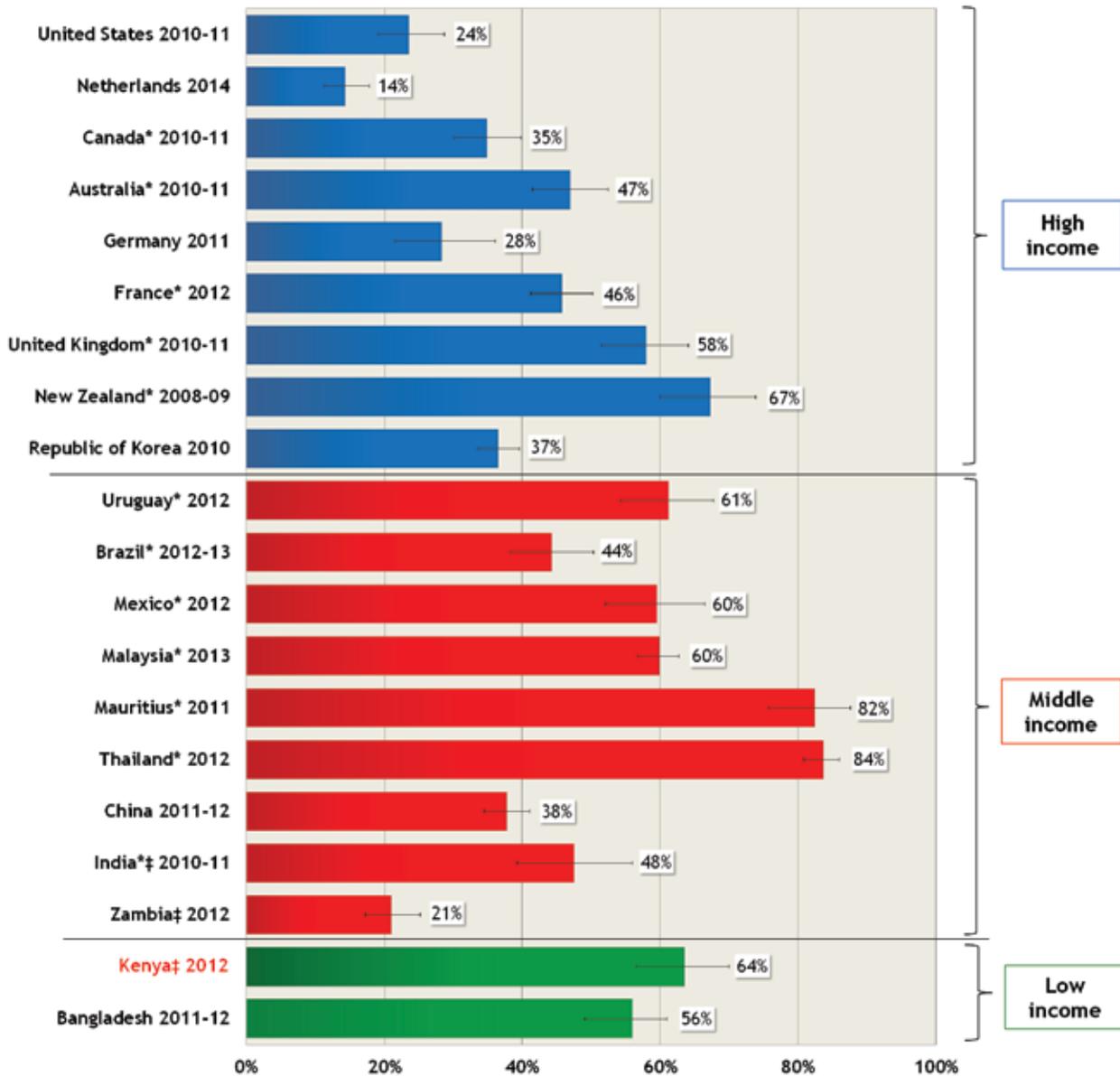


Few Kenyan smokers who were aware of health warnings (20%) stated that these warnings stopped them from smoking cigarettes a couple of times, once in a while, or many times in the last month. A minority (13%) of smokers made any effort to avoid the warnings in the last month. This finding suggests a lost opportunity to motivate smoking cessation as research conducted in Brazil has shown that avoidance of health warnings creates strong negative associations which can make tobacco products less positive in the minds of smokers and may motivate quitting.<sup>59</sup>

Of the smokers and mixed users in the survey who had a cigarette pack at the time of the survey (n=220), 95% had a visible health warning on the pack. The majority of smokers (85%) were able to read the warning easily.

ITC cross-country comparisons demonstrate that Kenya's text warnings are noticed fairly often compared to health warnings in other ITC countries. Among all male smokers surveyed, Kenya had the third highest percentage (64%) of those who "often" or "very often" noticed warnings among 11 LMICs in the ITC Survey, and the fourth highest of all 20 countries (see Figure 16). However, in Mauritius, where pictorial health warnings cover 60% of the front and 70% of the back of the pack (see images in Figure 17), 82% of male smokers noticed the warnings. This demonstrates the vast potential for increasing the effectiveness of health warnings in Kenya with the implementation of pictorial warnings.

Figure 16. Percentage of male smokers† who “often” or “very often” noticed warning labels, by country

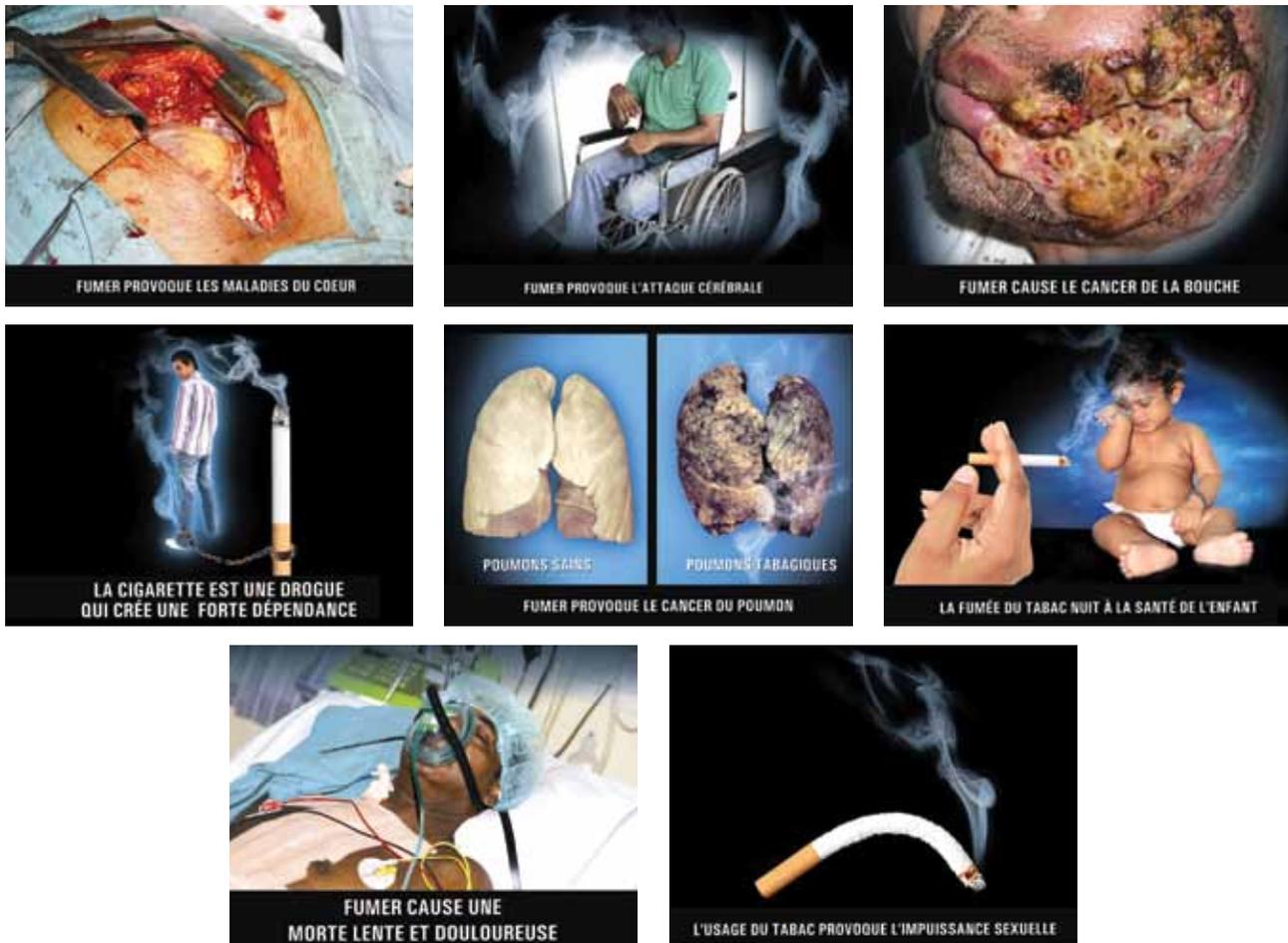


† ‘Smokers’ refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* Countries with pictorial warnings at time of survey.

‡ In India, Zambia, and Kenya, there was an extra filter that asked “As far as you know, do any smoked tobacco/cigarette packages in India/Zambia/Kenya have warning labels?”. If the respondent answered “no” then noticing warning labels was set to “never”.

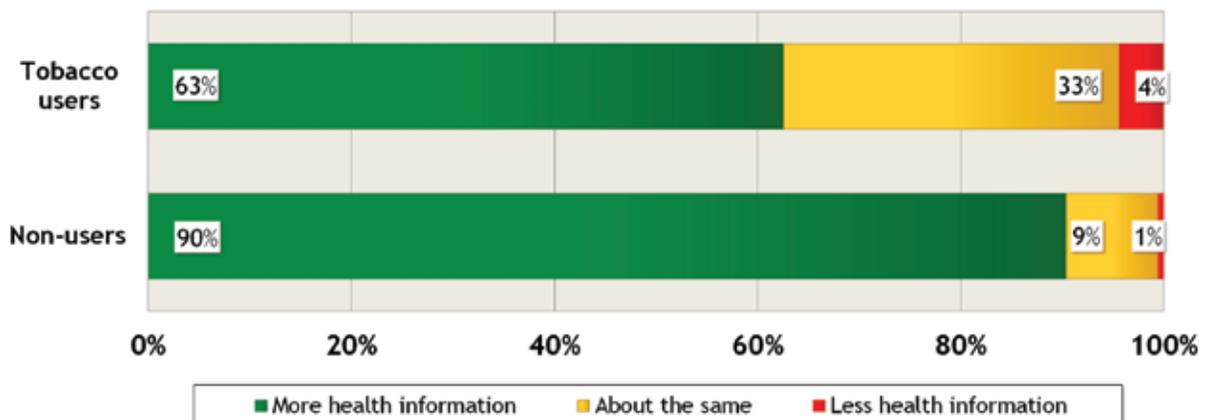
Figure 17. Set of eight pictorial health warnings implemented in Mauritius as of June 1, 2009



### 8.4.3 Support for Enhanced Health Warnings

Kenyan tobacco users and non-users support having stronger health warnings on cigarette packages. The majority of Kenyan tobacco users (63%) and non-users (90%) indicated that cigarette packages should have more health information (Figure 18).

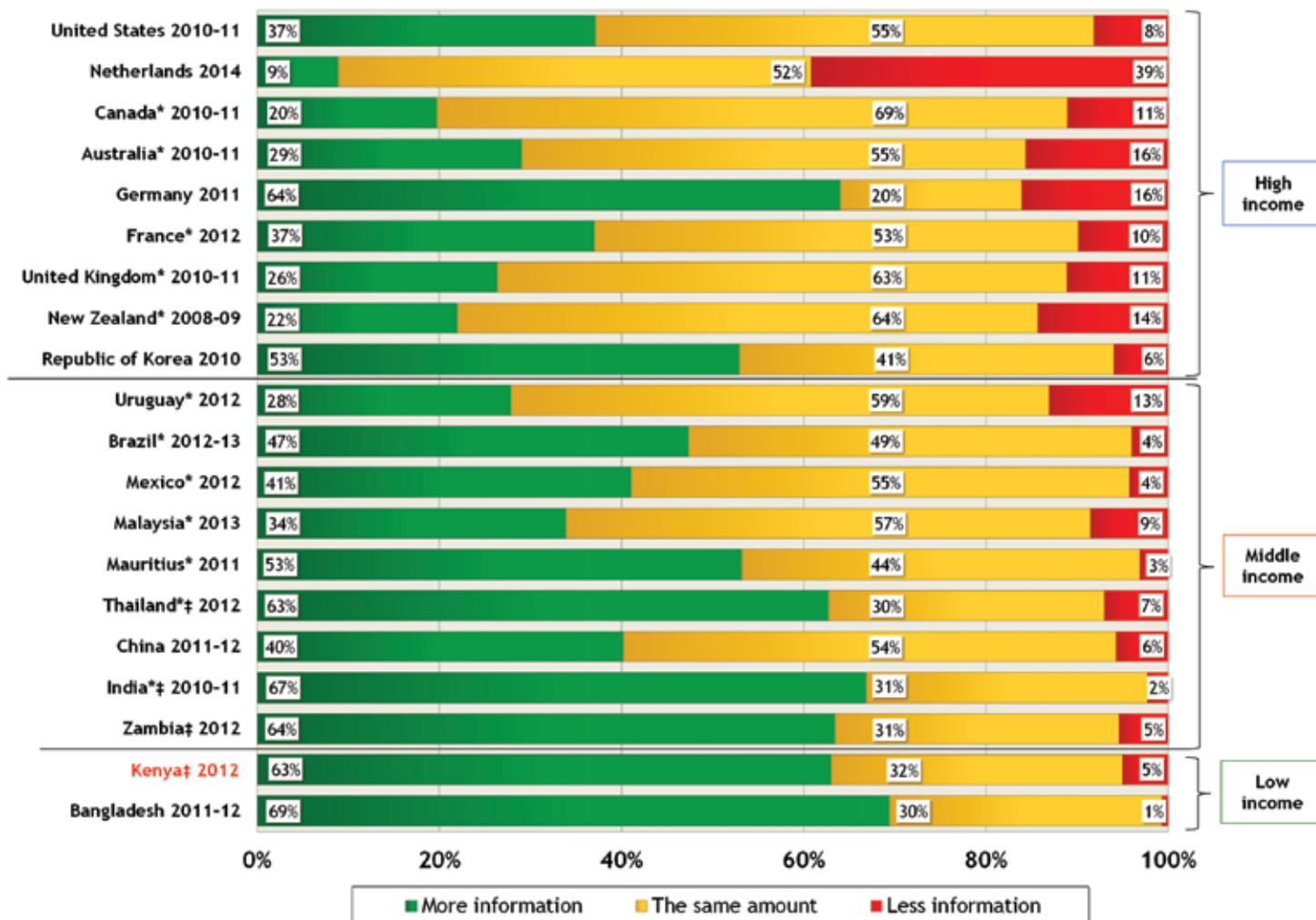
Figure 18. Percentage of tobacco users and non-users who think that cigarette packages should have more, the same, or less health information\*



\* This question was asked among those respondents that answered "yes" to the question "As far as you know, do any cigarette packages in Kenya have warning labels?"

ITC cross-county data indicate that the level of support for more health information on cigarette packages in Kenya is high compared to other countries. Kenya has the 4th highest level of support among male smokers (63%) out of 11 LMICs, and the 5th highest overall out of 20 ITC countries (see Figure 19). In general, support for enhanced health warnings is higher in countries without pictorial warnings, including Kenya and Zambia (64%).

Figure 19. Percentage of male cigarette smokers† who think there should be more, less, or the same amount of health information on cigarette packages, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* Countries with pictorial warnings at time of survey.

‡ Among respondents who answered "yes" to the question "As far as you know, do any smoked tobacco/cigarettes packages in India/Zambia/Kenya have warning labels?", or who said they had never seen the warning labels in the last 30 days in Thailand.

## 8.5 PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

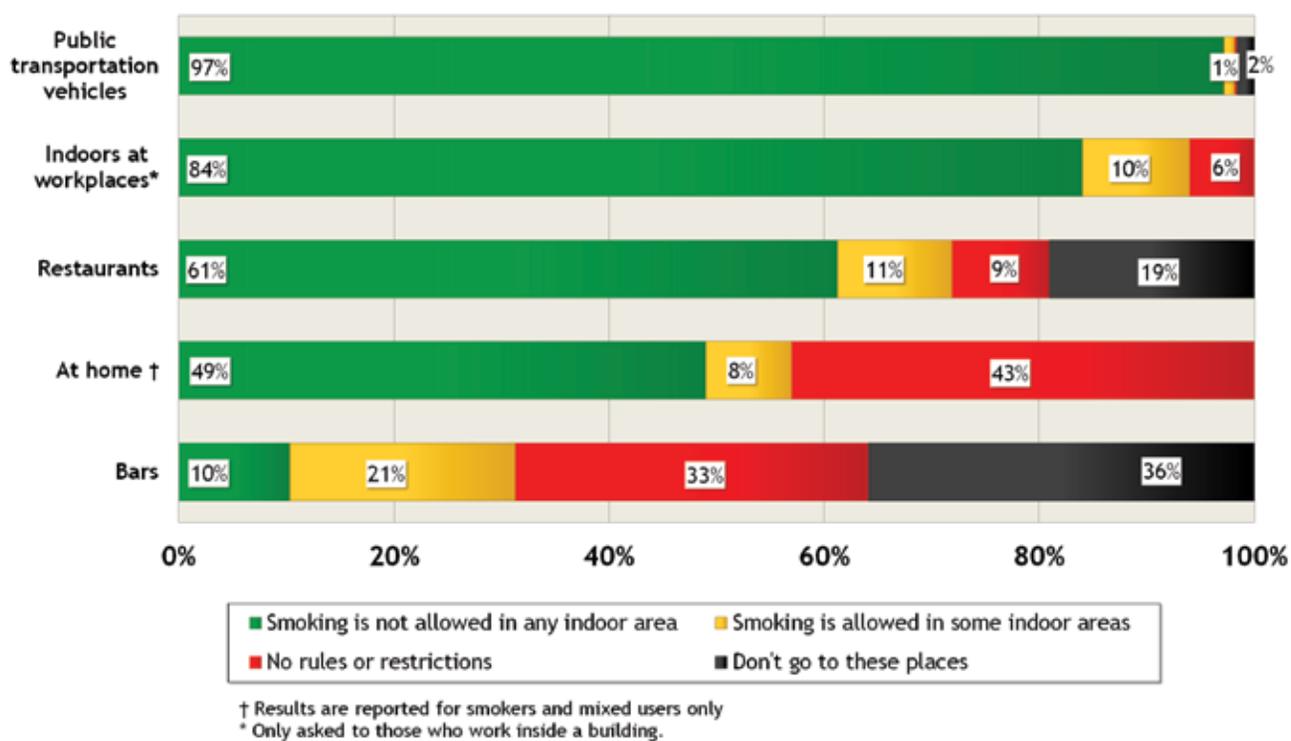
Article 8 of the WHO FCTC obligates Parties to adopt effective measures to provide protection from exposure to tobacco smoke. Guidelines for Article 8 recommend a comprehensive ban on smoking in public places and workplaces, without exemptions.

In Kenya, smoking is prohibited in all public places and workplaces<sup>iii</sup> under the 2007 Tobacco Control Act, except in specially designated smoking areas. Because of this provision for designated smoking areas, the current policy in Kenya is not fully compliant with Article 8 Guidelines, which recommend 100% smoke-free public places.

### 8.5.1 Smoking in Public Transportation

The ITC Kenya Wave 1 Survey findings show that almost all (97%) tobacco users and non-users are aware of the current smoking ban in any mode of public transport (e.g., buses, ferries, trains, and matatus) (see Figure 20).

Figure 20. Reporting of smoking bans in various venues among tobacco users

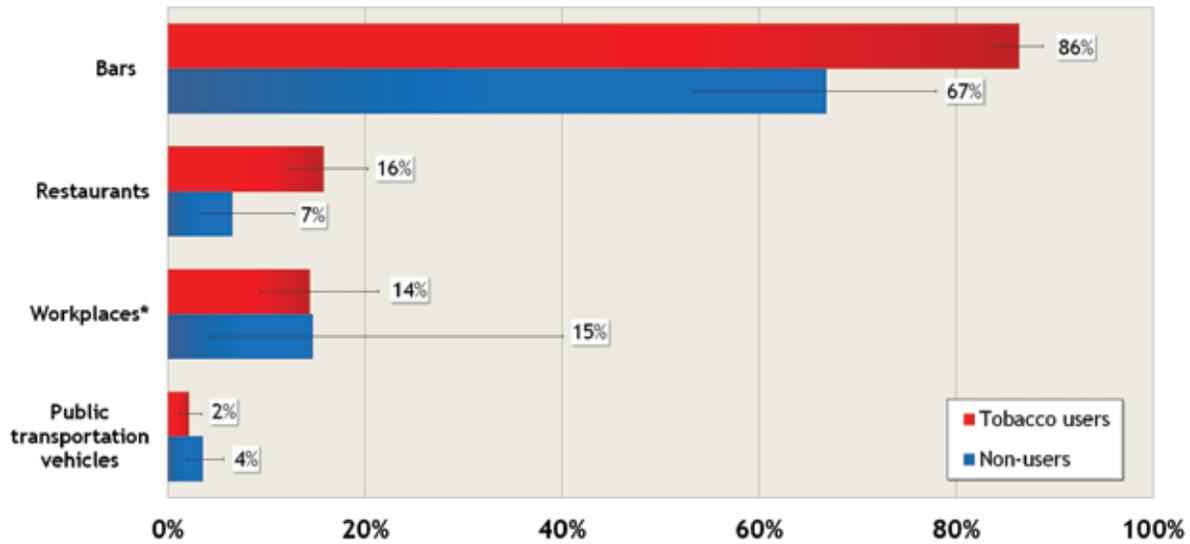


Only 2% of the tobacco users and 4% of non-users who used public transportation noticed people smoking inside during their last trip (see Figure 21). Additionally, less than 1% of smokers who used public transportation said that they smoked inside the vehicle during their last trip.

Nearly all smokers (96%) and non-users (97%) support the complete ban on smoking in public transportation vehicles (see Figure 22).

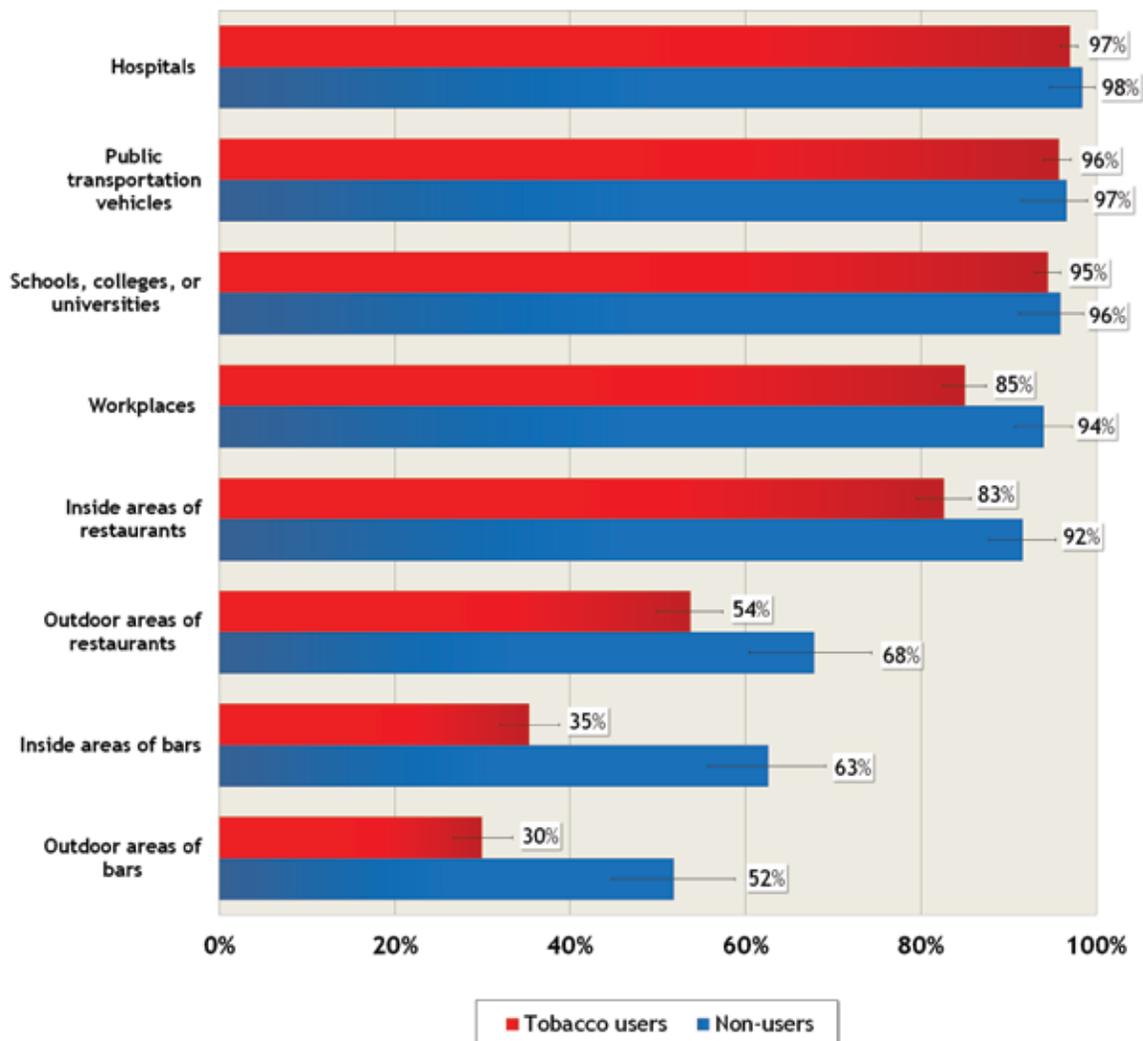
iii. The 2007 Tobacco Control Act prohibits smoking in offices and workplaces; court buildings; factories; cinema halls, theatres, video houses, such other halls or places of performance, disco halls or any other entertainment facilities; hospitals, clinics and other health institutions; restaurants, hotels, bars or other eating places; children's homes; residential houses and such other premises where children are cared for; places of worship; prisons; police stations and cells; public service vehicles; aircrafts, passenger ships, commuter boats, trains, passenger vehicles, ferries or any other public conveyance; education facilities; railway stations, airports, air fields, ports and other public transport terminals; markets, shopping malls and retail and wholesale establishments; stadia, sports and recreational facilities; and public buildings, except in designated smoking areas.

Figure 21. Percentage of tobacco users and non-users who noticed people smoking indoors in various venues at their last visit or last ride on public transportation



\* Question asked about the last month and is among those respondents who reported working inside a building.

Figure 22. Percentage of tobacco users and non-users who support complete smoking bans in various venues



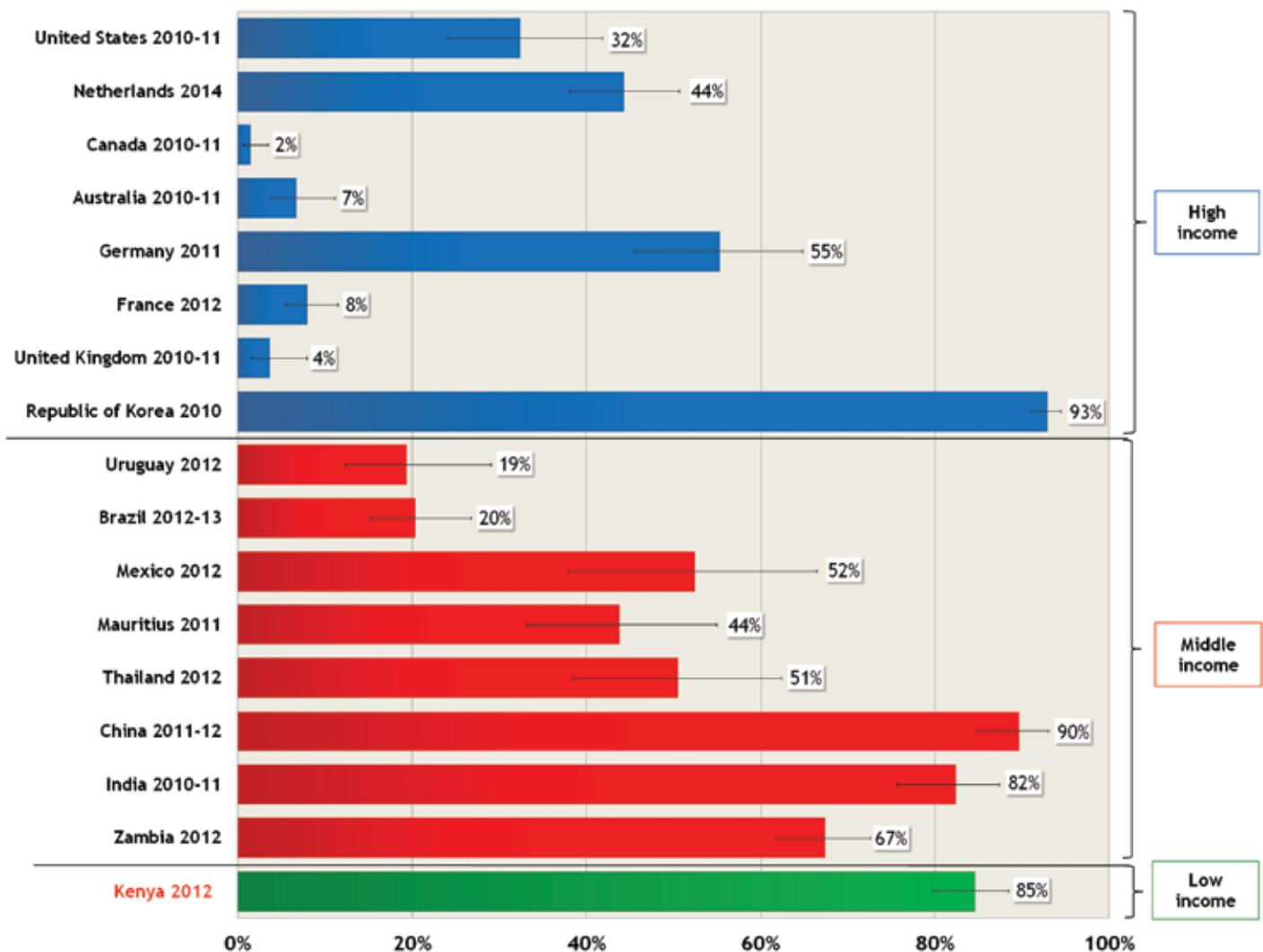
## 8.5.2 Smoking in Bars

Very few respondents (10% of tobacco users and 4% of non-users) stated that smoking was not allowed in any indoor areas of bars, while one-third (33%) of tobacco users and 10% of non-users indicated that there were no rules or restrictions regarding smoking in bars (see Figure 20).

Although about one-quarter (24%) of all respondents (tobacco users and non-users) reported that there was either a partial or complete ban on smoking indoors in bars, there is evidence for weak compliance with bans in these venues. Among those respondents who visited a bar, 86% of tobacco users and 67% of non-users reported that they noticed people smoking inside the bar during their last visit (see Figure 21). Additionally, most (76%) smokers said that they smoked inside the bar during their last visit.

Smoking in bars in Kenya is much more common than in most other LMICs – out of 17 ITC countries, Kenya had the third-highest proportion (85%) of male smokers who noticed people smoking indoors in bars, with only China (90%) and Korea (93%) having a higher proportion (see Figure 23). The percentage of observed smoking in bars in Kenya is also higher than in Zambia (67%).

**Figure 23. Percentage of male smokers† who reported noticing people smoking indoors in bars, by country**



† Smokers refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

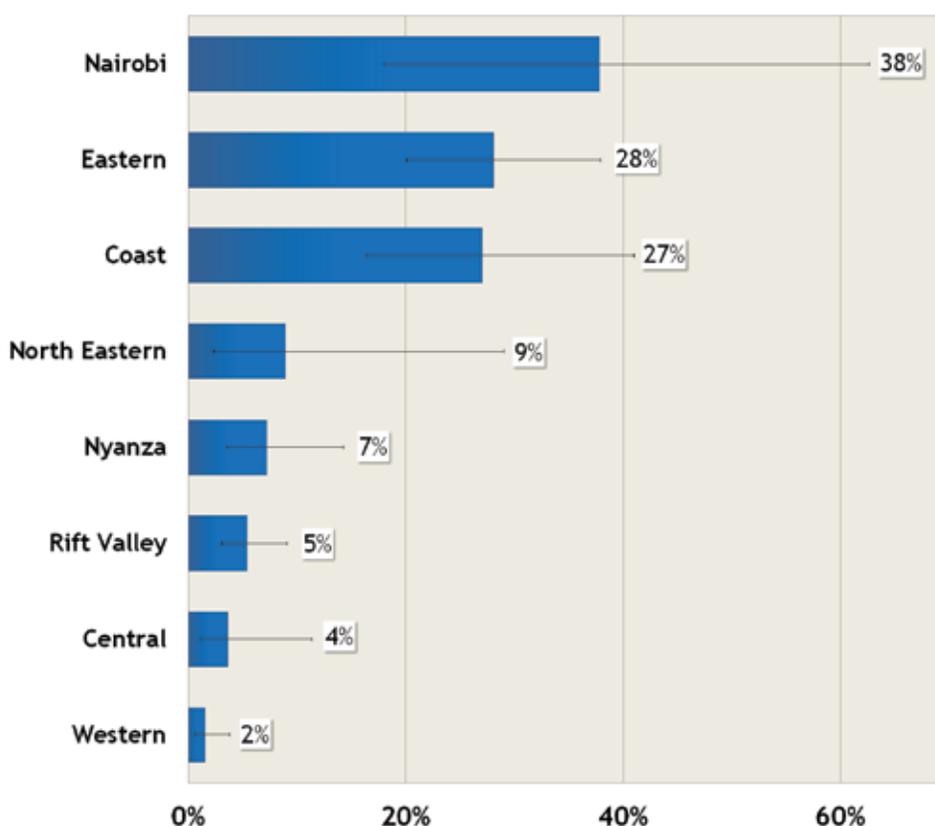
About one-third (35%) of tobacco users and 63% of non-users supported a complete ban on smoking in indoor areas in bars. In addition, less than one-third (30%) of tobacco users and 52% of non-users supported a complete smoking ban in the outdoor areas of bars (see Figure 22).

### 8.5.3 Smoking in Restaurants

About two-thirds (61%) of tobacco users and non-users (70%) indicated that there is a complete ban on smoking inside restaurants (see Figure 20).

Among those respondents who visited restaurants, 16% of tobacco users and 7% of non-users reported that they noticed people smoking inside the restaurants during their last visit (see Figure 21). Observed smoking in restaurants varied across the eight provinces, from a low of 2% in Western province to a high of 38% of Nairobi (see Figure 24). Additionally, 12% of smokers said that they smoked inside the restaurant during their last visit.

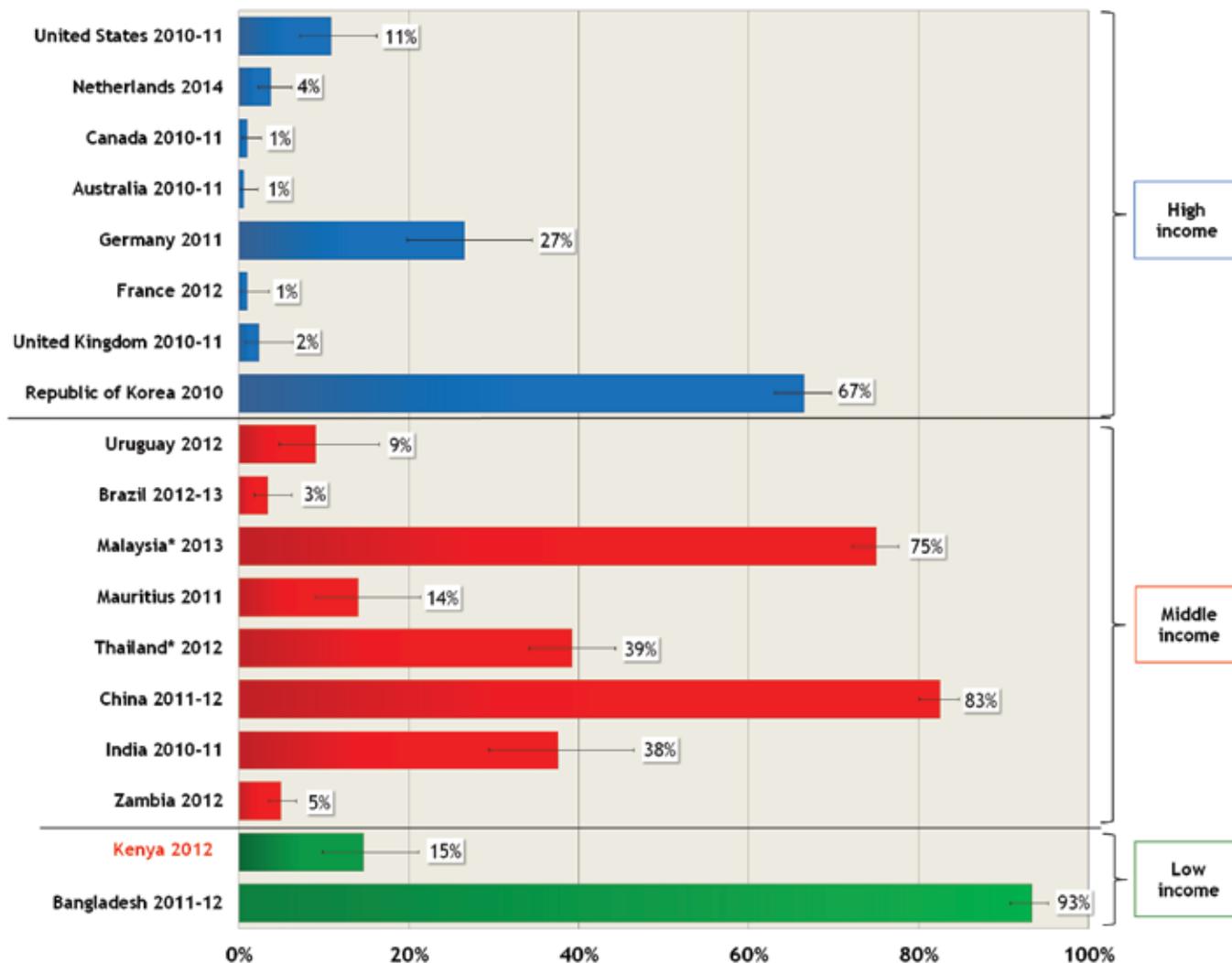
**Figure 24. Percentage of tobacco users who noticed people smoking in restaurants, by province\***



\* Due to small sample sizes, some point estimates (percentages) with wide confidence intervals should be interpreted with caution.

The amount of smoking in restaurants in Kenya is comparable to other LMICs in the ITC Project, with the proportion of Kenyan smokers who noticed people smoking in restaurants falling in the middle of the 10 LMICs where this measure was included (see Figure 25). 15% of male smokers in Kenya reported noticing people smoking inside restaurants, which is higher than Zambia (5%), but much lower than other countries such as Bangladesh (93%), China (83%), or India (38%).

Figure 25. Percentage of male smokers† who reported noticing people smoking indoors in restaurants, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* In Malaysia and Thailand, the results are the average between indoor air-conditioned restaurants and the non-smoking areas of non-air-conditioned/outdoor restaurants.

An overwhelming majority of tobacco users (83%) and non-users (92%) support the complete ban on indoor smoking in restaurants (see Figure 22). Support for a complete ban in the *outdoor* eating areas of restaurants was lower (54% of tobacco users and 68% of non-users).

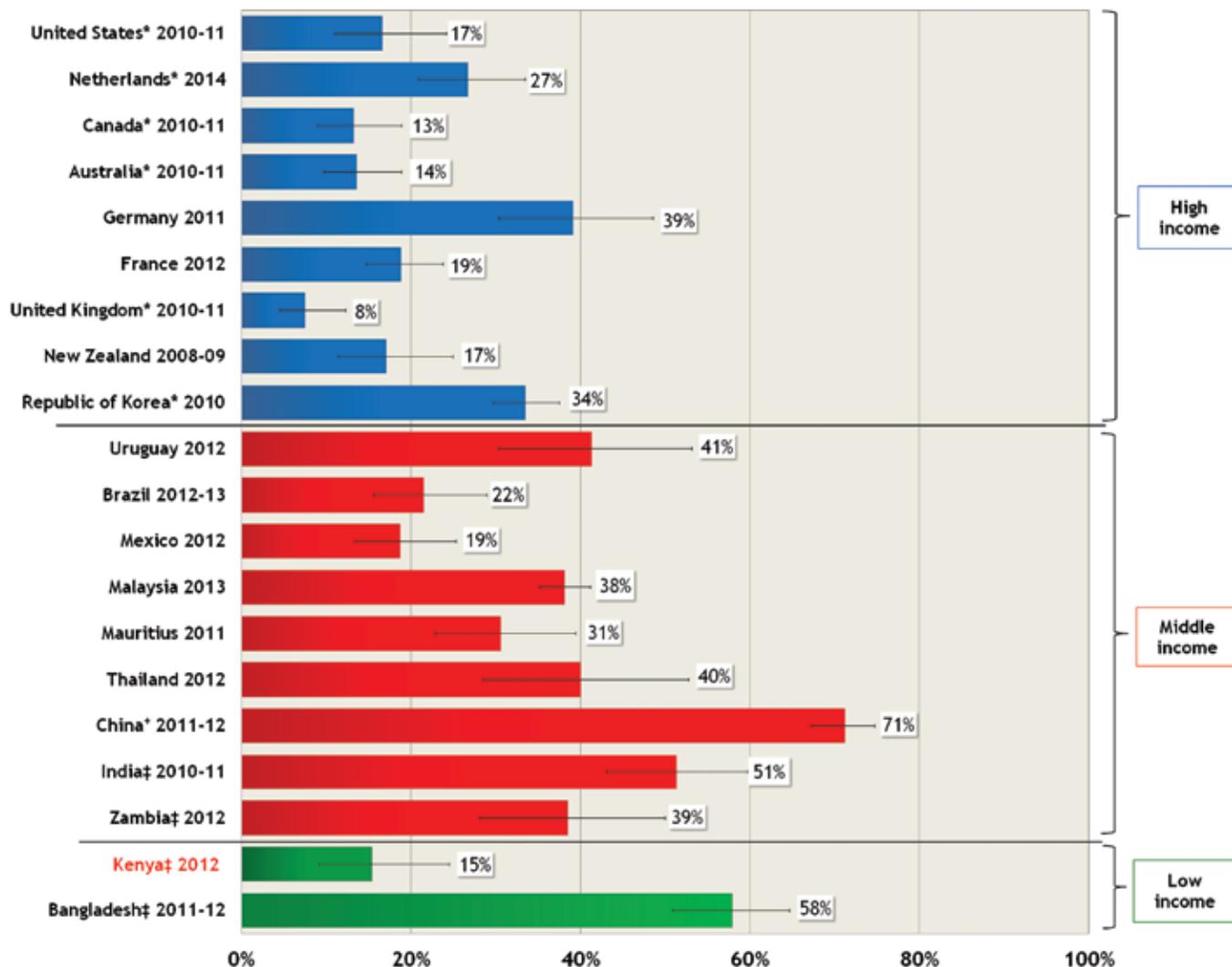
### 8.5.4 Smoking in Workplaces

The findings from the ITC Kenya Wave 1 Survey showed that 84% of tobacco users and 81% of non-users who worked inside a building were aware that smoking was not allowed in any indoor area at work (see Figure 20).

Among those who worked inside a building, 14% of tobacco users and 15% of non-users noticed people smoking indoors at work (see Figure 21). Moreover, 16% of smokers reported that they smoked in indoor areas at work in the last month prior to the survey.

In comparison to other LMICs in the ITC Project, the amount of smoking observed in workplaces in Kenya is low (15% of male smokers noticed people smoking). Kenya has the lowest proportion of smoking observed in workplaces of 11 LMICs in the ITC Project, and less than half the amount observed in Zambia (39%) (see Figure 26).

Figure 26. Percentage of male smokers† who reported noticing people smoking indoors in workplaces in the last month, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.  
 \* In these countries, responses include all those who were employed outside of home, regardless of whether the workplace was indoors or outdoors. In all other countries, respondents who worked outdoors only were excluded.  
 ‡ In these countries, the question asked about smoked tobacco in general, rather than cigarette smoke.  
 \* In China, respondents were asked about noticing smoking in the last 6 months.

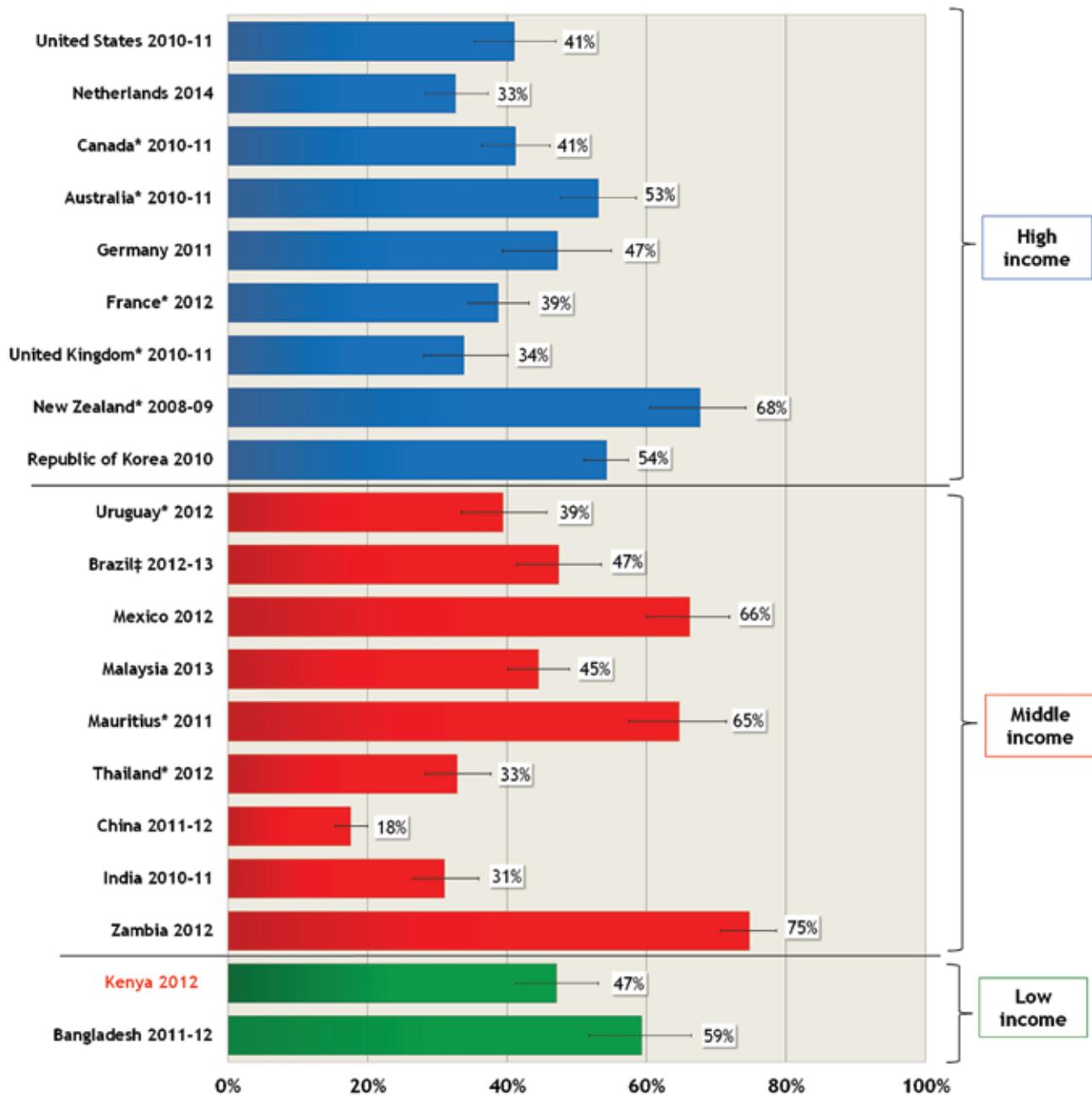
The majority of tobacco users (85%) and non-users (94%) supported the complete ban on smoking in all indoor areas at their workplace (see Figure 22).

### 8.5.5 Smoking in the Home

About three in five (61%) respondents reported that they had imposed a complete ban on smoking in the home. Specifically, 49% of smokers and 87% of non-users reported that they do not allow any smoking inside their homes (see Figure 20). In addition, 8% of smokers and 2% of non-users only allow smoking in some rooms inside the home. 43% of smokers and 11% of non-users reported that they do not have any rules or restrictions about smoking in their homes.

ITC cross-country comparisons indicate that the percentage of male smokers with home smoking bans in Kenya is comparable to other countries. Out of 20 ITC countries, the percentage of male smokers in Kenya with a home smoking ban (47%) falls in the middle of the range reported by male smokers in other countries. However, male smokers in Zambia were more likely to report having a home smoking ban (75%) (see Figure 27).

Figure 27. Percentage of male smokers† who reported that smoking is never allowed inside their home, by country



† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* Countries with complete smoking bans in bars, restaurants, and workplaces in effect at time of survey.

‡ Brazil implemented a complete smoking ban in bars prior to the time of survey, however, regulations for implementation have not been defined at time of survey.

### 8.5.6 Support for Smoking Bans in Other Public Places

Almost all tobacco users and non-users supported complete smoking bans in hospitals (97% of tobacco users and 98% of non-users) and schools, colleges or universities (95% of tobacco users and 96% of non-users) (see Figure 22).

## 8.6 TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP

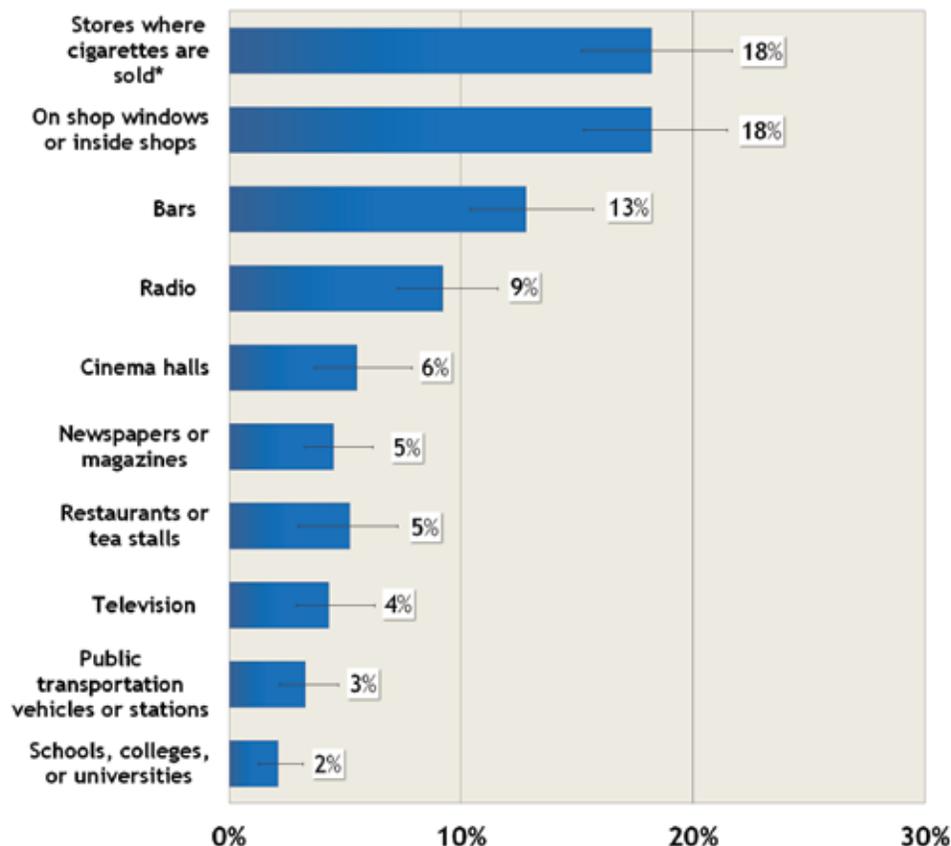
Article 13 of the WHO FCTC requires Parties to take measures to ban direct and indirect forms of tobacco advertising within 5 years of ratifying the treaty. Guidelines for Article 13 of the FCTC call for Parties to implement a comprehensive ban on tobacco advertising, promotion, and sponsorship (TAPS) (or apply restrictions that are as comprehensive as possible). The 2007 Tobacco Control Act prohibits all forms of TAPS including product stacking and product displays of any kind or size.<sup>2</sup>

### 8.6.1 Tobacco Advertising

The ITC Kenya Wave 1 Survey asked tobacco users and non-users whether they noticed tobacco products being advertised in a variety of specific venues in the last 6 months. Less than one-fifth (17%) of tobacco users and 13% of non-users reported that they noticed things that made them think about tobacco at least once in the last 6 months. Additionally, tobacco product advertisements were most commonly noticed by tobacco users in the following venues: in stores where cigarettes are sold (18%), on shop/store windows or inside shops (18%), in bars (13%), and on the radio (9%). Less than 10% of tobacco users reported noticing advertising through other listed venues including cinema halls (6%), newspapers or magazines (5%), restaurants or tea stalls (5%), television (4%), public transportation (3%), and in schools, colleges, or universities (2%) (see Figure 28).

Respondents were also asked whether they support complete bans on tobacco advertisements and displays of tobacco products. The level of support for bans on tobacco advertising was high overall. 81% of tobacco users and 96% of non-users said they support complete bans on all tobacco advertisements at shops and stores either “somewhat” or “a lot”. Similarly, 80% of tobacco users and 97% of non-users said they support complete bans on displays of all tobacco products “somewhat” or “a lot”.

Figure 28. Percentage of tobacco users who noticed tobacco products being advertised in various venues in the last 6 months

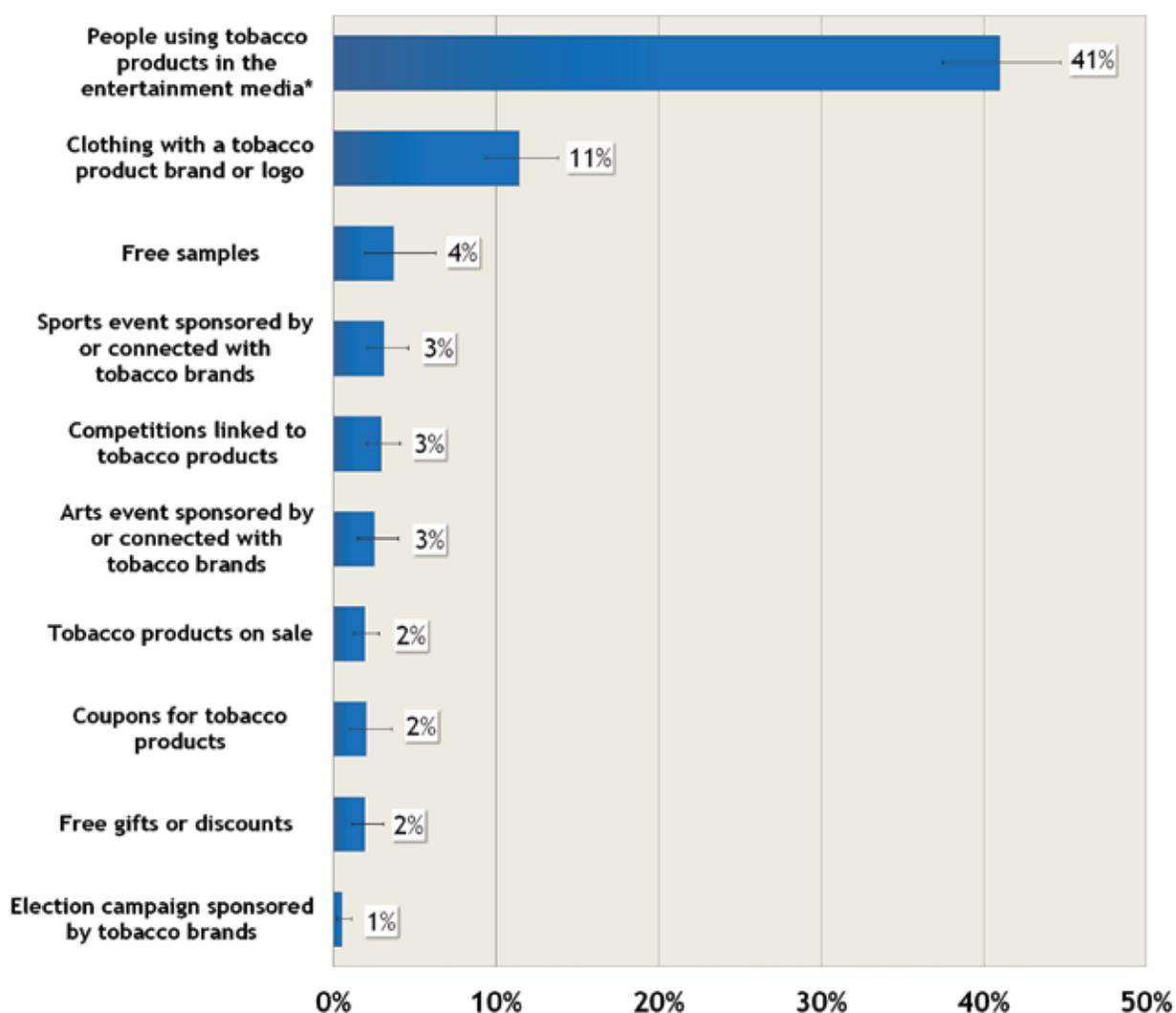


\*Question asked about cigarettes specifically and not tobacco in general and asked about the last 30 days.

## 8.6.2 Tobacco Promotion and Sponsorship

Findings from the ITC Kenya Wave 1 Survey showed that more than one-third (41%) of tobacco users and 29% of non-users said that they had seen people using tobacco in the entertainment media (e.g., TV, movies, and magazines) in the last 6 months (see Figure 29). In addition, 12% of smokers stated one of the reasons why they started smoking cigarettes was because people in the media smoked cigarettes. These findings are of concern as numerous studies have proven that there is a causal association between the depiction of smoking in the entertainment media and the initiation of youth smoking. The findings suggest strong compliance with the ban on other forms of tobacco promotion. In the last 6 months, a minority of tobacco users noticed the following types of tobacco promotion: clothing or other items with a tobacco product brand or logo (11%), free samples (4%), sporting events (3%), competitions linked to tobacco products (3%), arts events connected with tobacco brands (3%), tobacco products on sale (2%), coupons (2%), and free gifts or discounts (2%) (see Figure 29).

Figure 29. Percentage of tobacco users who noticed various types of tobacco promotions in the last 6 months



\* Estimate shown for response options "often" or "once in a while" vs. "never," rather than "yes" vs. "no."

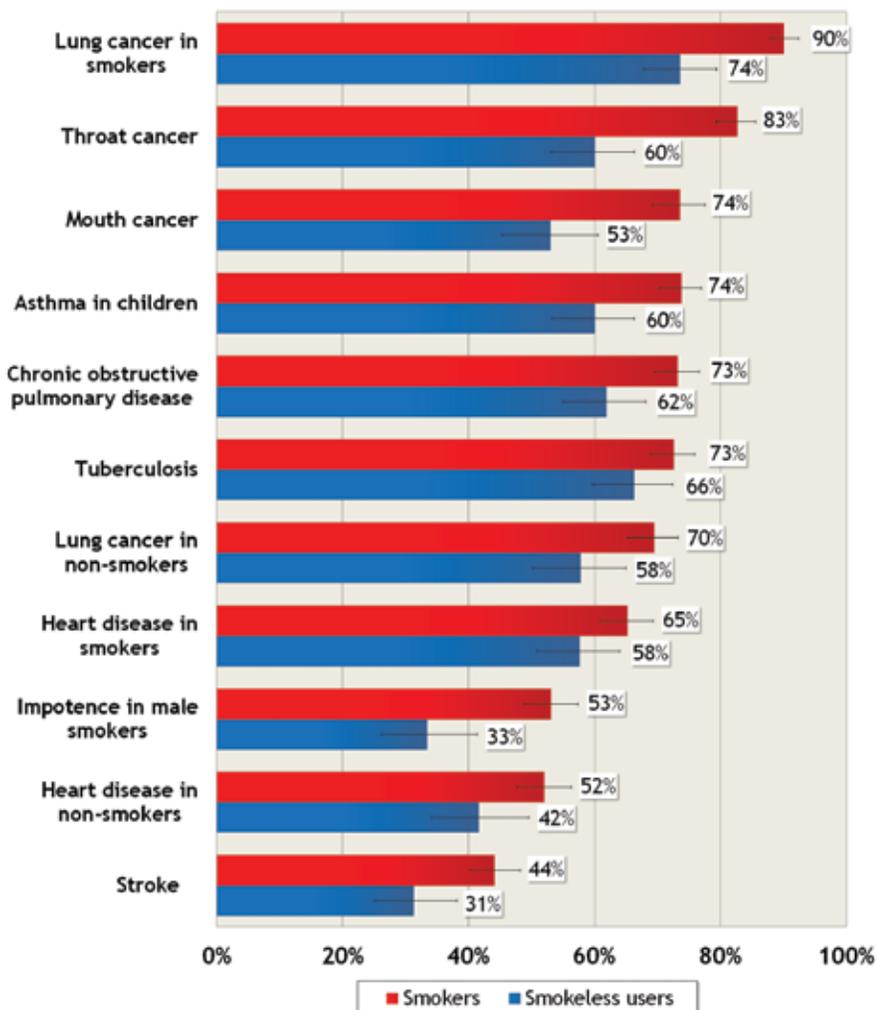
## 8.7 EDUCATION, COMMUNICATION, AND PUBLIC AWARENESS

Under Article 12 of the WHO FCTC, Parties are obligated to promote and strengthen public awareness of tobacco control issues through education and public awareness programs on the health risks of tobacco consumption and the benefits of cessation, and provide public access to information on the tobacco industry. Multiple civil society organizations have been actively involved in the tobacco control movement in Kenya, including the “Smoking Kills” anti-tobacco mass media campaign launched on December 2, 2014 by the Ministry of Health in collaboration with the World Lung Foundation and tobacco control civil society organizations. The 2007 Tobacco Control Act requires the government to undertake comprehensive nation-wide information, education and communication activities to promote public awareness of the health consequences, addictive nature, and mortal threat posed by tobacco consumption and exposure to tobacco smoke and the harmful effects of tobacco growing and handling. This includes holding education campaigns in schools, workplaces, and training for community workers, media professionals, educators, decision makers, administrators, and healthcare providers.

### 8.7.1 Knowledge of the Harms of Smoking

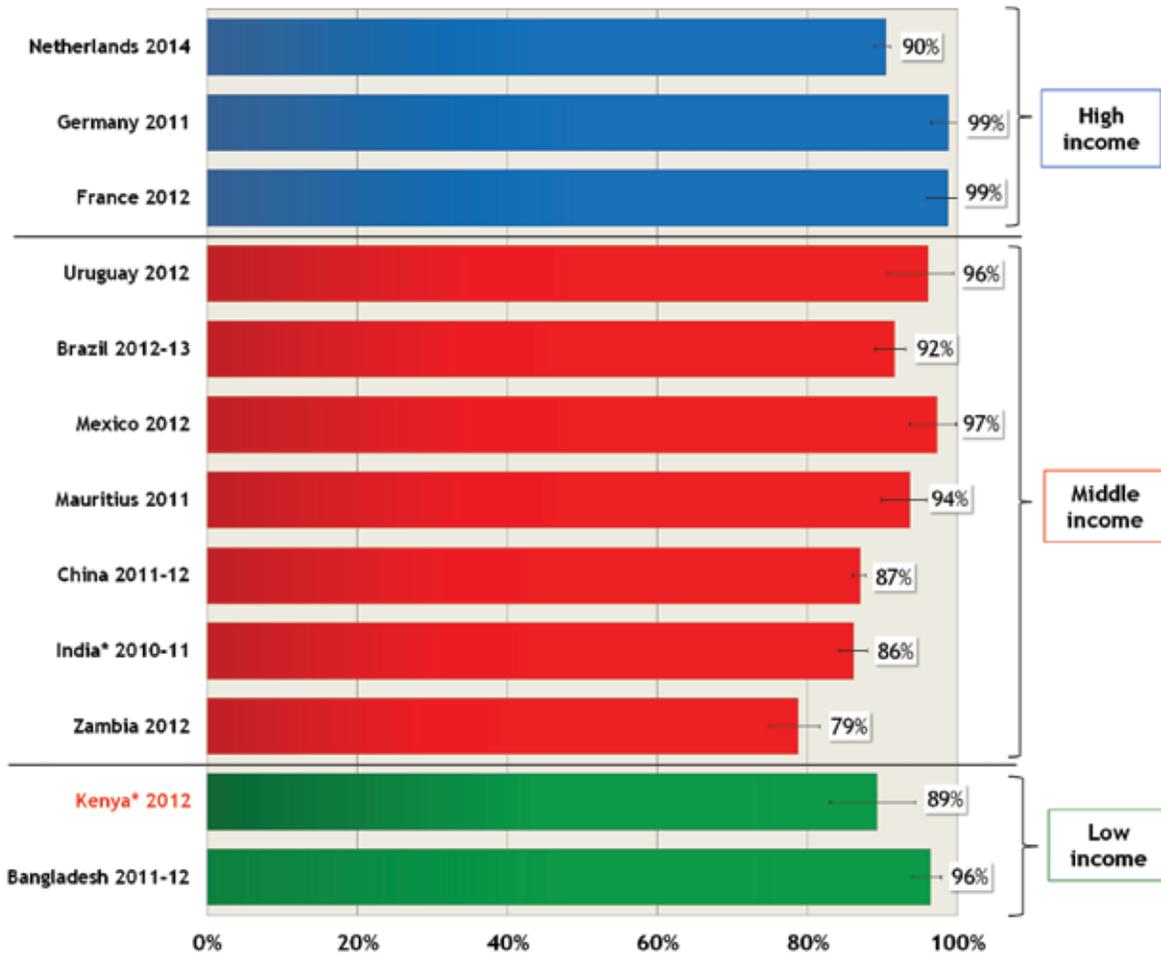
The ITC Kenya Wave 1 Survey measured tobacco users’ awareness of a range of health effects associated with smoking cigarettes. Overall, a higher percentage of smokers were aware of smoking-related health effects compared to smokeless only users (see Figure 30). Smokers correctly believed that smoking causes lung cancer in smokers (90% vs 74% of smokeless users), throat cancer (83% vs 60%), mouth cancer (74% vs 53%), asthma in children (74% vs 60%), chronic obstructive pulmonary disease (73% vs 62%), tuberculosis (73% vs 66%), lung cancer in non-smokers (70% vs 58%), heart disease in smokers (65% vs 58%), impotence in male smokers (53% vs 33%), heart disease in non-smokers (52% vs 42%), and stroke (44% vs 31%).

Figure 30. Smokers’ and smokeless tobacco only users’ knowledge of the health effects of smoked tobacco use



However, ITC cross-country comparisons reveal that a lower percentage of smokers in Kenya are aware of important smoking-related health effects than in other countries. While male smokers in Kenya were more likely to be aware that smoking causes lung cancer (89%) than male smokers in Zambia (79%), this percentage is still lower than 8 out of 11 other countries where this question was asked (see Figure 31).

Figure 31. Percentage of male smokers† who believe that smoking causes lung cancer in smokers, by country

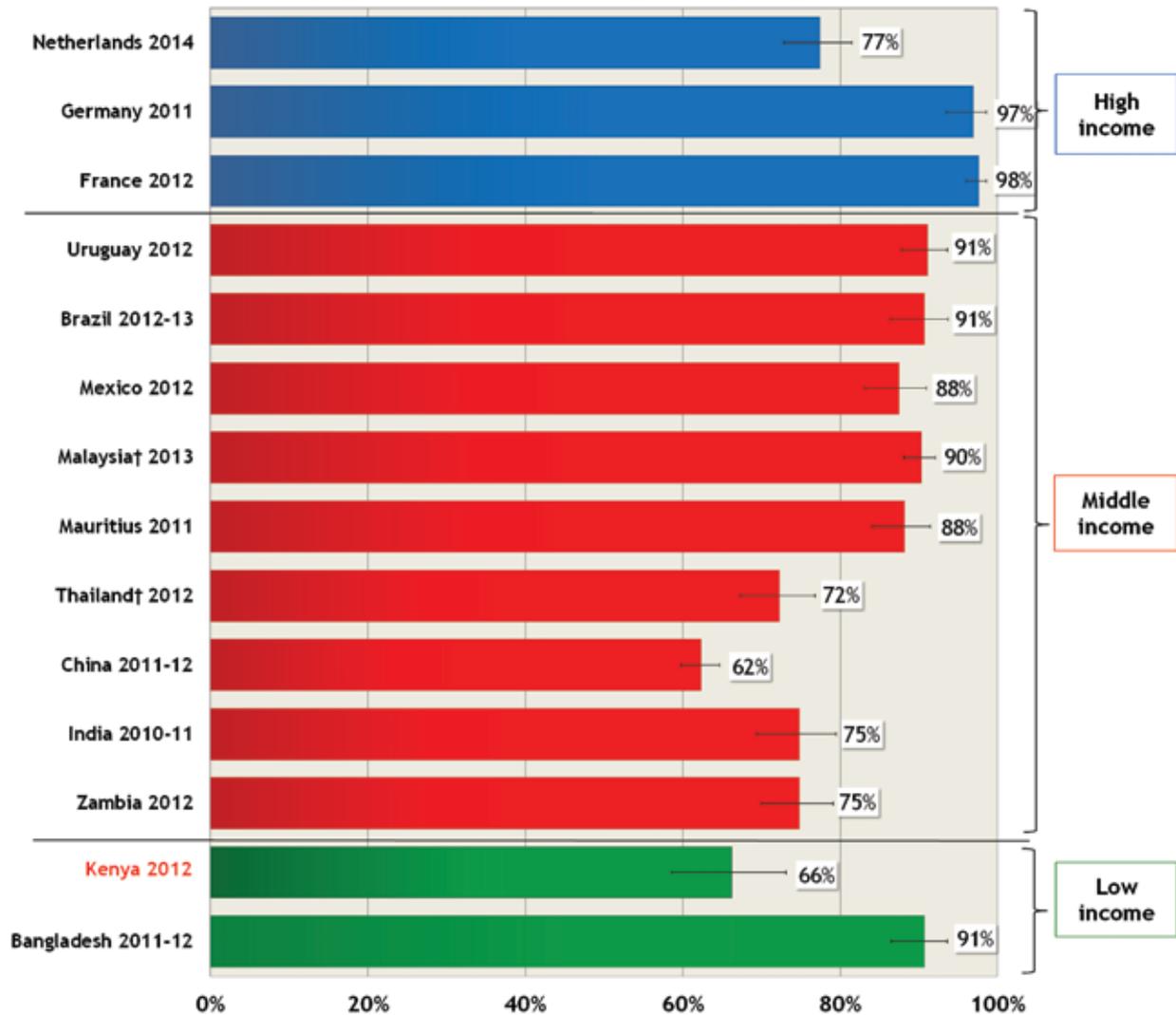


† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* In Kenya and India, the question asked about smoked tobacco in general. In all other countries, it asked about cigarettes.

Furthermore, a lower percentage of smokers in Kenya were aware that smoking causes other important health effects such as heart disease and stroke than in other countries. For example, only two-thirds of male smokers (66%) in Kenya were aware that smoking causes heart disease in smokers — the second-lowest of 14 ITC countries, higher only than China (62%; see Figure 32). Similarly, among LMICs, Kenya had the lowest percentage of male smokers (50%) who were aware that secondhand smoke causes heart disease in non-smokers (see Figure 33).

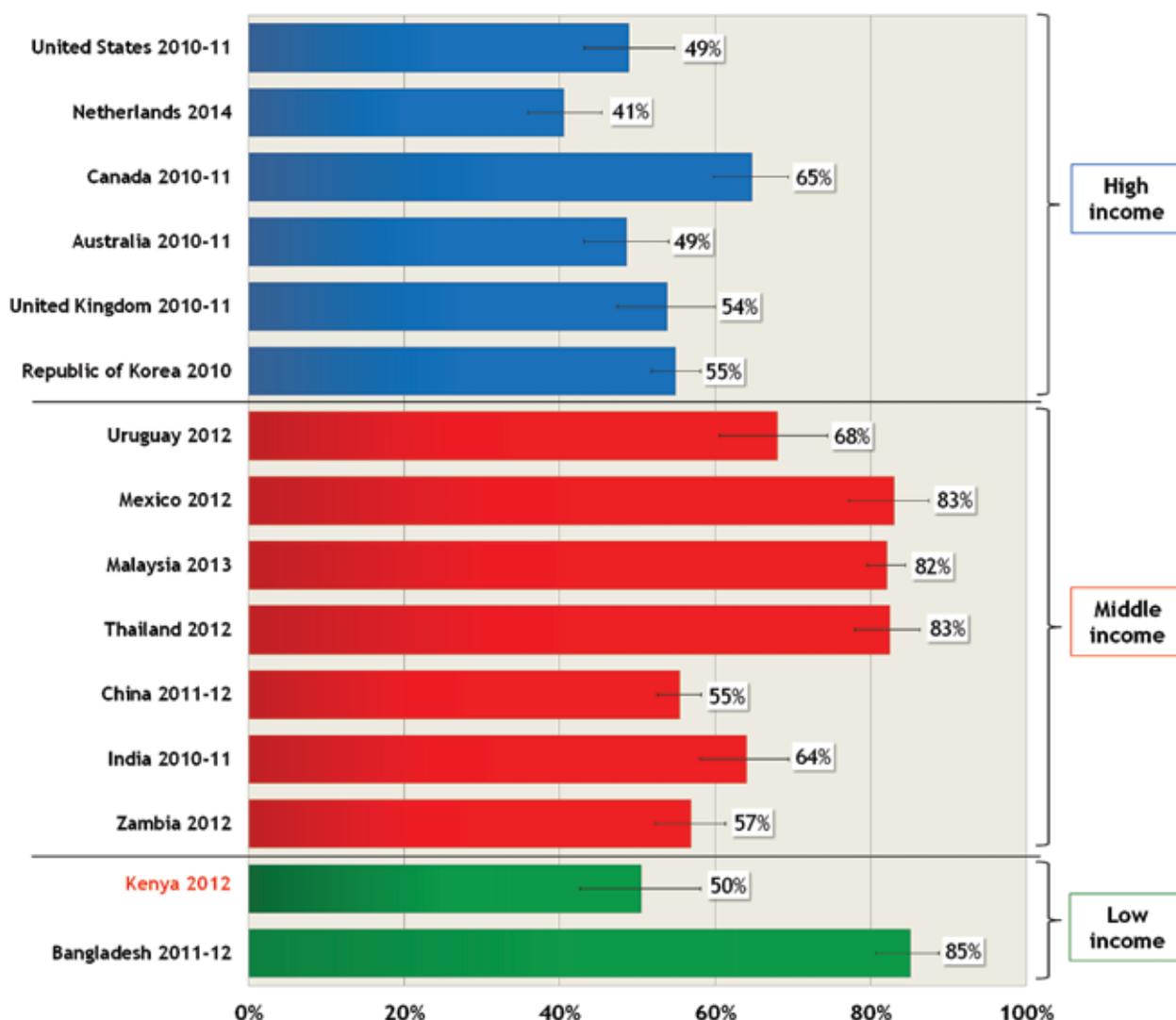
Figure 32. Percentage of male smokers\* who believe that smoking causes heart disease† in smokers, by country



\* 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.  
 † In Malaysia and Thailand, respondents were asked about 'heart failure'. In all other countries, they were asked about heart disease or CHD.

*Only two-thirds of male smokers (66%) were aware that smoking causes heart disease in smokers – the second-lowest of 14 ITC countries, higher only than China (62%).*

Figure 33. Percentage of male smokers<sup>†</sup> who believe that secondhand smoke causes heart disease\* in non-smokers, by country

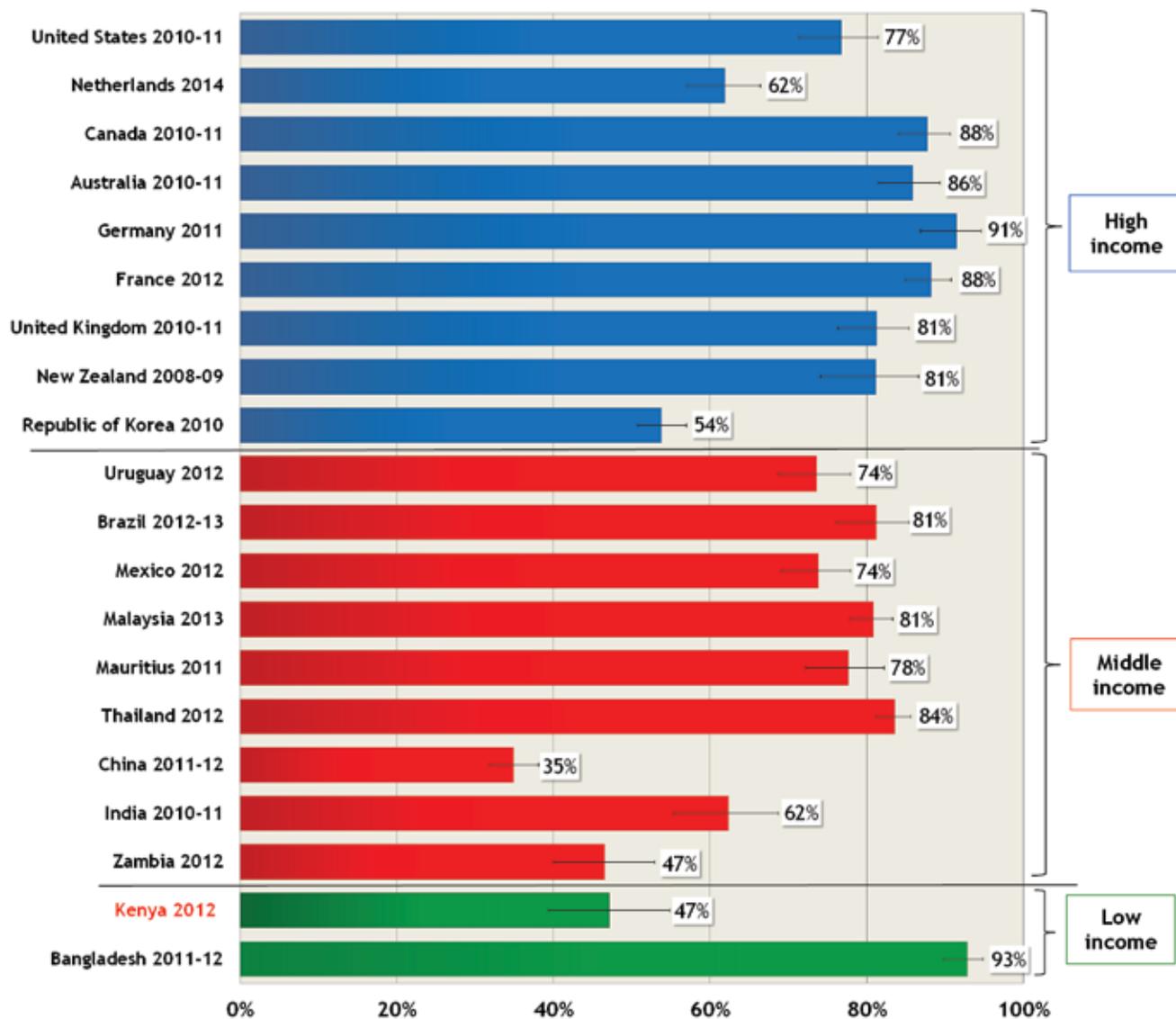


<sup>†</sup> 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

\* In Canada, Australia, UK, US, Netherlands, Korea, and China respondents were asked if second-hand smoke causes heart attack in non-smokers. In Mexico, Malaysia, Thailand, and Uruguay, they were asked if SHS causes heart disease in non-smokers. In India, Zambia, Kenya, and Bangladesh, they were asked if passive smoking causes CHD in non-smokers.

Smokers in Kenya were also less knowledgeable that smoking causes stroke compared to smokers in other countries. Less than half (47%) of male smokers in Kenya believed that smoking causes stroke – the second-lowest percentage out of 20 ITC countries, higher only than China (35%) (see Figure 34).

Figure 34. Percentage of male smokers† who believe that smoking causes stroke in smokers, by country



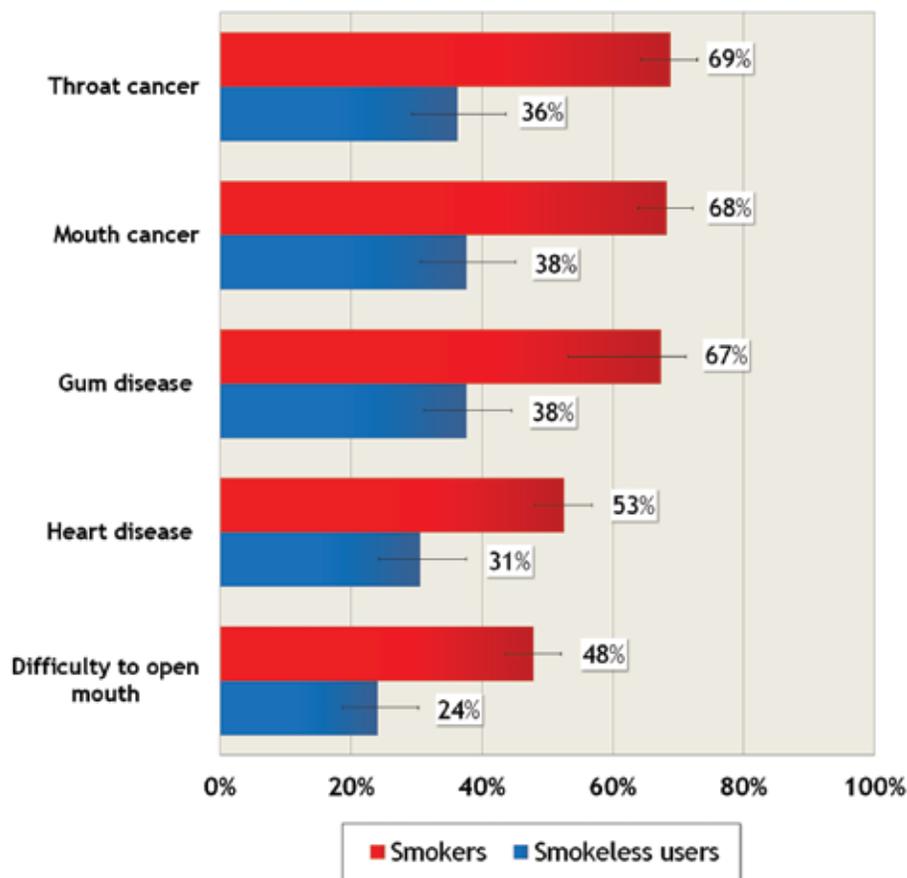
† 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

## 8.7.2 Knowledge of the Harms of Smokeless Tobacco Products

The ITC Kenya Wave 1 Survey also measured tobacco users' awareness of a range of health effects associated with using smokeless tobacco products. Overall, Kenyan tobacco users were less knowledgeable about the harms of smokeless tobacco use compared to the health effects caused by smoking. Smokers were more likely to be aware of certain health effects associated with use of smokeless tobacco products compared with smokeless users (including mixed tobacco users) (see Figure 35).

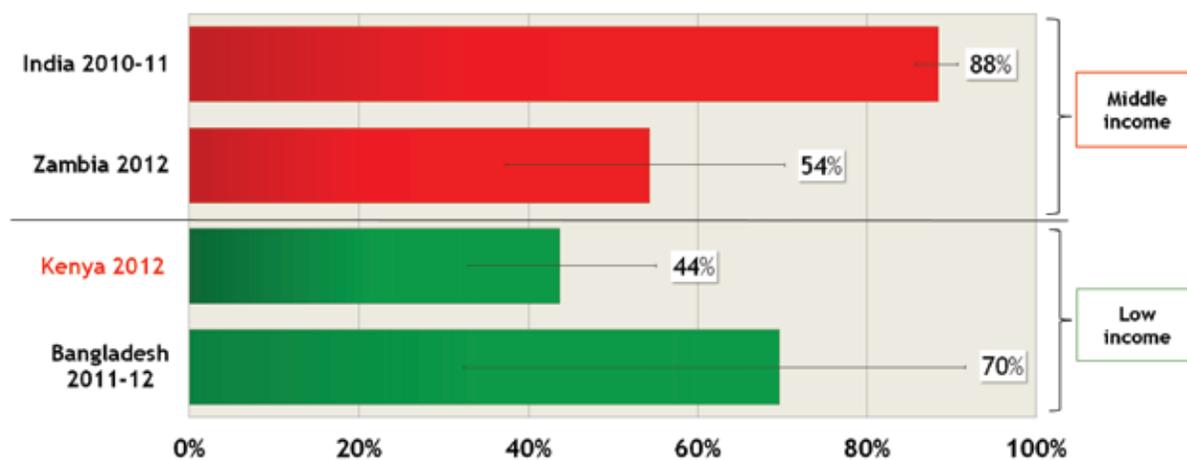
Less than half of smokeless users were aware that smokeless tobacco causes mouth cancer (38%), gum disease (38%), throat cancer (36%), heart disease (31%), and difficulty to open mouth (24%).

Figure 35. Smokers' and smokeless tobacco users' (smokeless only and mixed tobacco users) knowledge of the health effects of smokeless tobacco use



ITC cross-country data shows that a lower percentage of male smokeless and mixed tobacco users in Kenya were aware that smokeless tobacco causes mouth cancer (44%) compared to those in Zambia (54%), India (88%), and Bangladesh (70%) (see Figure 36).

Figure 36. Percentage of male smokeless tobacco and mixed tobacco users who believe that smokeless tobacco causes mouth cancer, by country

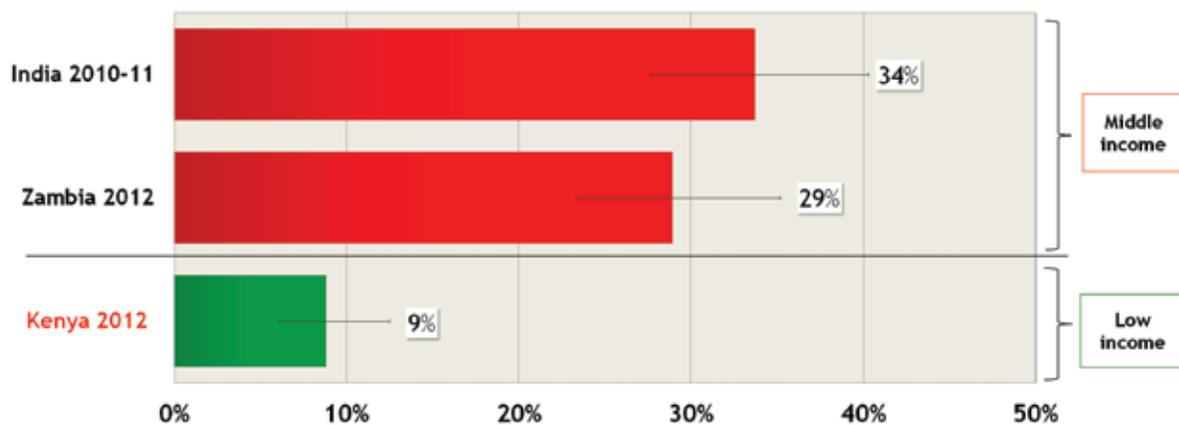


### 8.7.3 Beliefs about Light/Mild Cigarettes

The 2007 Tobacco Control Act bans the use of false or misleading or deceptive terms on tobacco product packaging, however the Act does not specifically prohibit the use of specific terms such as “mild” or “low tar” on tobacco packages as recommended in the Article 11 Guidelines. The tobacco industry uses these and other descriptors such as “organic”, “natural”, and “additive free” to falsely convey tobacco products as being less harmful.

Only 9% of Kenyan male smokers who last purchased their usual cigarette brand reported that the variety of the brand they last purchased was “lights” (other options included “regular”, “kings”, “filter”, and “other”). This is lower than the percentage of male smokers who reported smoking light or mild cigarettes in India (34%) and Zambia (29%).

Figure 37. Percentage of male smokers<sup>†</sup> who reported smoking light or mild\* cigarettes among those who have a regular brand, by country



<sup>†</sup> 'Smokers' refer to dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco).

\* The terms differed across countries - In India, the percent represents those who smoke either 'light', 'light/regular', 'mild', 'ultra mild', or 'very mild' cigarettes, whereas in Zambia it is those who smoke 'mild' or 'extra mild' cigarettes, and in Kenya it is those who reported smoking 'lights'.

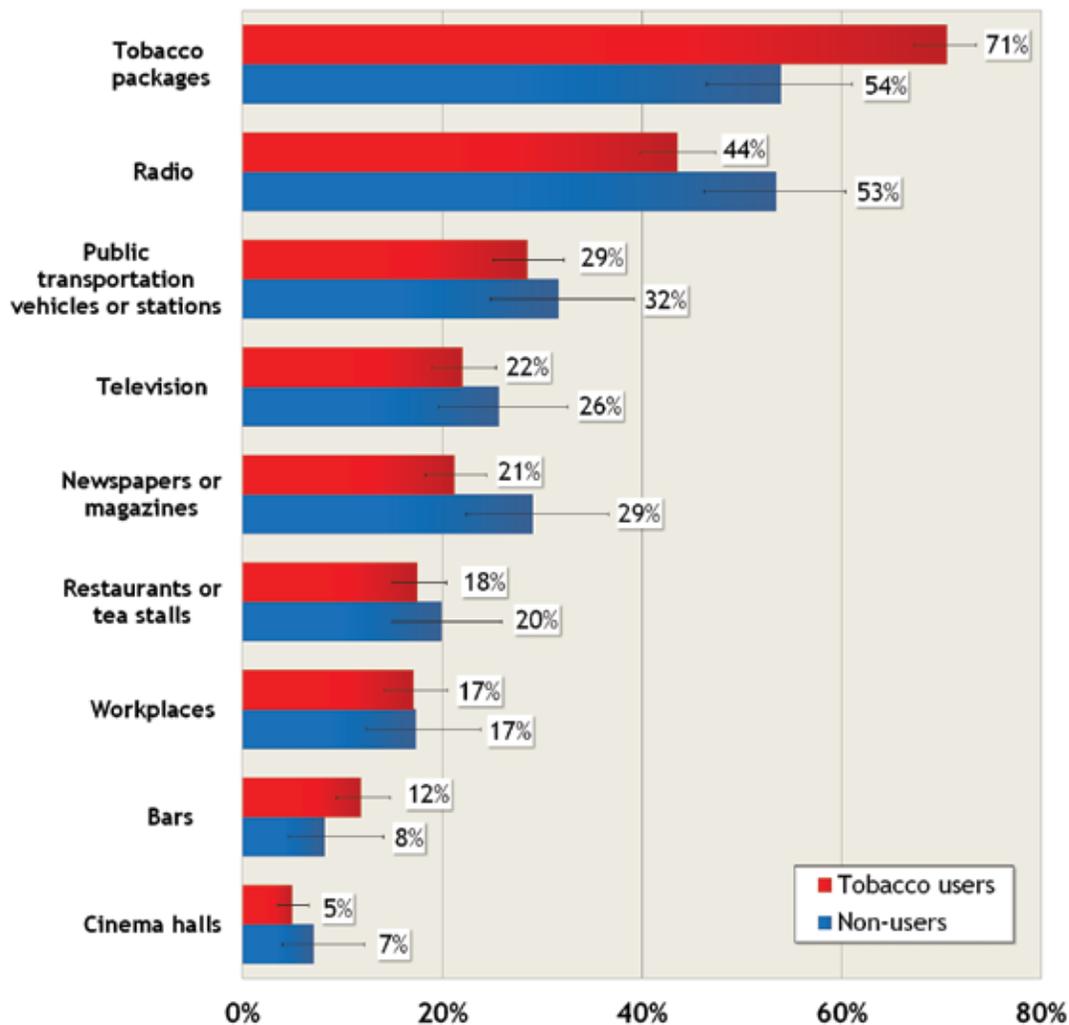
The ITC Kenya Survey findings suggest that Kenyan smokers have false beliefs about “light” cigarettes. More than half (57%) of smokers and 38% of smokeless users “agree” or “strongly agree” that light cigarettes are less harmful than regular cigarettes. Among smokers who smoked a usual brand, more than one-third (40%) think that the cigarette brand that they usually smoke is “a little less harmful” compared to other cigarette brands. However, it is well established that all conventional cigarette brands present the same level of risk to smokers – “light” and “low tar” cigarettes are no less harmful to a smoker’s health than regular cigarettes. More than two-thirds (71%) of smokers and 51% of smokeless users “agree” or “strongly agree” that “light” cigarettes are smoother on your throat and chest than regular cigarettes. More than half of smokers believe that tar numbers indicate the harmfulness (52%) and the smoothness (51%) of the cigarette.

To curb the false belief that some cigarettes are less harmful than others, Guidelines for FCTC Article 11 prohibit the display of quantitative or qualitative statements about tobacco constituents and emissions that might imply that one brand is less harmful than another. The 2007 Tobacco Control Act follows the Guidelines by requiring the prescribed statement “Tobacco smoke contains tar, nicotine, and other constituents” on the right-hand side of the package without specifying quantities of these constituents. However, the Regulations could go further by prohibiting the use of misleading deceptive terms such as “mild” or “light” or “low tar” on tobacco packages as recommended in the Article 11 Guidelines. In addition, other descriptors used by the tobacco industry such as “organic”, “natural”, and “additive free” should also be banned since they falsely convey tobacco products as being less harmful.

## 8.7.4 Exposure to Anti-Tobacco Messages

The ITC Kenya Survey respondents were asked whether they had noticed advertising or information that talks about the dangers of tobacco, or encourages quitting in several places. The most commonly cited places where tobacco users noticed or heard about anti-tobacco messages were on the tobacco packs (71%), radio (44%), public transportation (29%), television (22%), and newspapers or magazines (21%). Non-users also mainly cited tobacco packs (54%), radio (53%), public transportation (32%), newspapers/magazines (29%), and television (26%) (see Figure 38).

**Figure 38. Percentage of tobacco users and non-users who noticed advertising or information that talks about the dangers of tobacco use, or encourages quitting, in various venues in the last 6 months**



About two-thirds of tobacco users (63%) and non-users (67%) reported that the anti-tobacco advertising made using tobacco less socially acceptable. Additionally, close to half (40%) of the tobacco users said that the anti-tobacco advertising made them more likely to quit using tobacco. Overall, these findings point to the importance of using tobacco packages and radio as communication channels for alerting the public about the dangers of tobacco use.

## 8.8 TOBACCO PRICE AND TAXATION

Increasing tobacco taxes and prices is widely recognized as the single most cost-effective strategy to reduce the prevalence of tobacco use, particularly among youth. Article 6 of the FCTC encourages countries that have ratified the treaty to adopt tax and price policies aimed at reducing tobacco consumption.

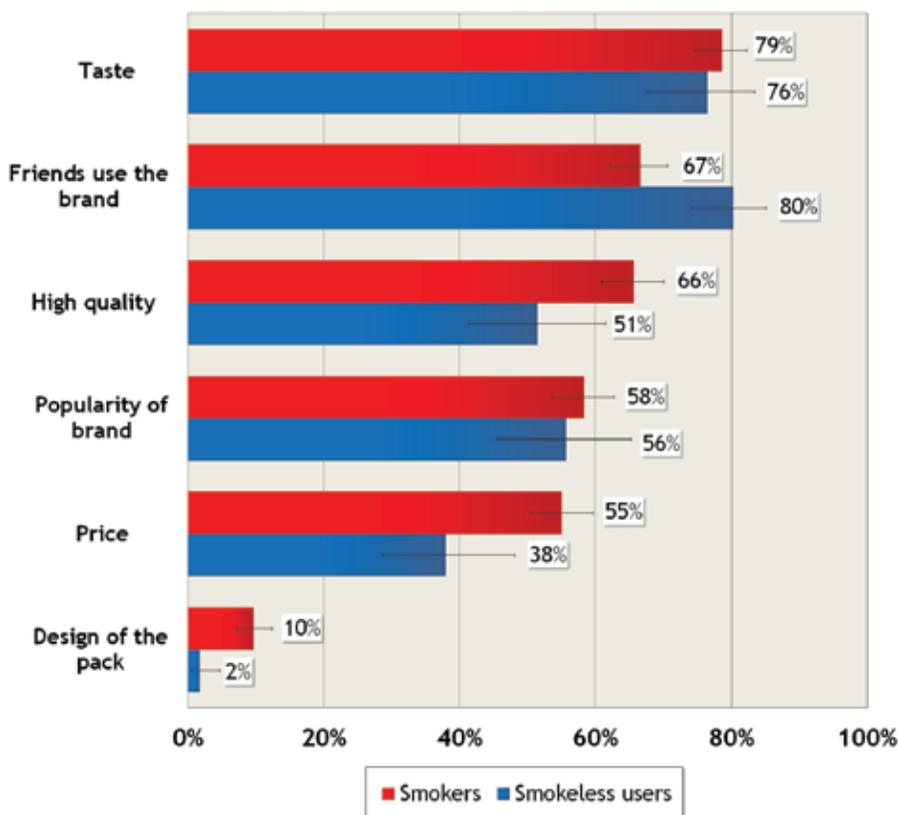
Kenya's 2007 Tobacco Control Act (Section 12) obligates the Minister of Finance to implement tax and price policies in line with the objectives of the Act. Despite these provisions in the Act, progress on tobacco taxation in Kenya has been slow, and excise taxes on cigarettes remain lower than WHO recommendations, with minimal effect on tobacco prices.

### 8.8.1 Factory-made vs. Hand-rolled Cigarettes

The majority (87%) of Kenyan smokers smoke factory-made cigarettes only or mainly factory-made cigarettes, 12% smoke only or mainly hand-rolled cigarettes, and 1% smoke both equally (see Figure 39).

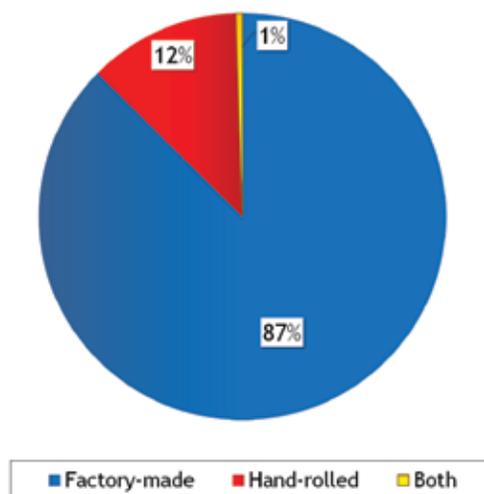
The cost savings associated with smoking hand-rolled cigarettes vs. factory-made cigarettes are evident in the finding that 84% of those who smoke mainly hand-rolled cigarettes said they do so because of price.

Figure 40. Reasons for choosing their regular brand of cigarettes and regular brand of smokeless tobacco among smokers (cigarettes only and mixed tobacco users) and smokeless users (smokeless only and mixed tobacco users), respectively\*



\* Among those tobacco users who reported that they have a regular brand of cigarettes and/or smokeless tobacco.

Figure 39. Percentage of smokers (cigarettes only and mixed tobacco users), by cigarette type



### 8.8.2 Reasons for Choosing a Specific Brand

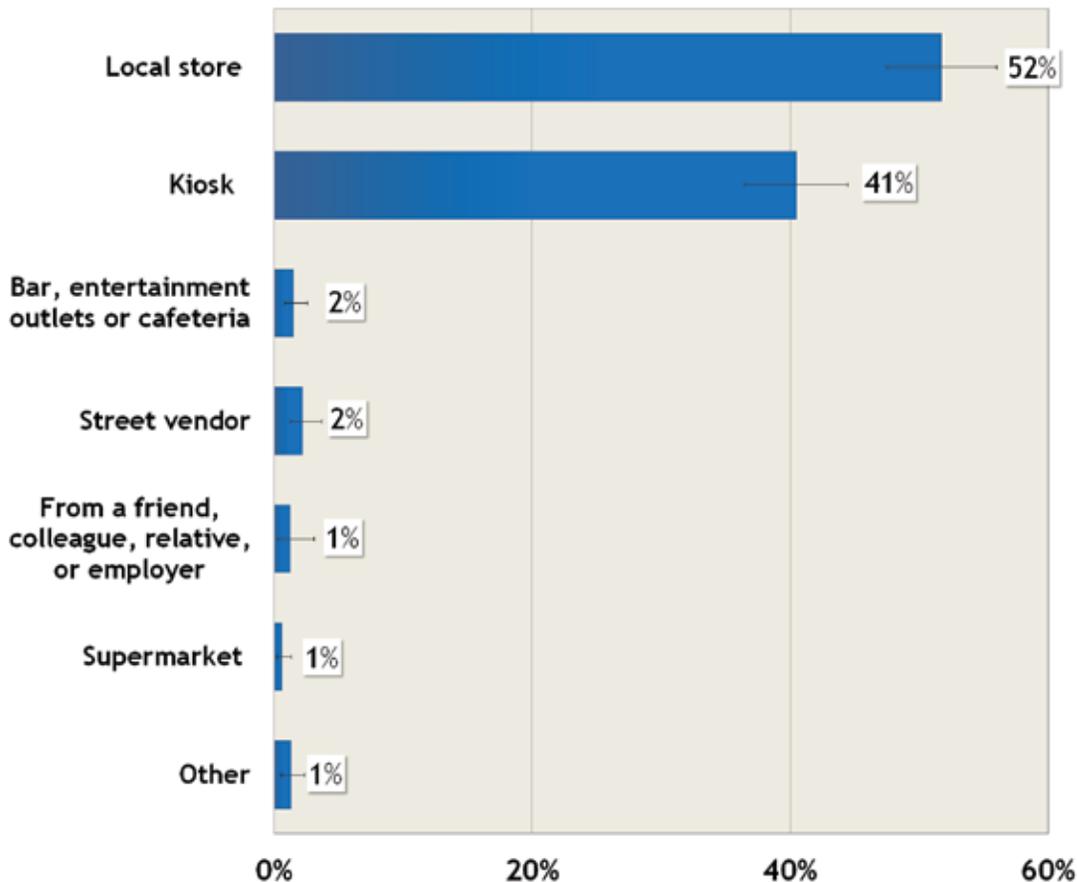
The most frequently mentioned reasons for cigarette brand selection among smokers who have a usual brand were: the taste (79%), “friends smoke the same brand” (67%), the high quality (66%), popularity of the brand (58%), and price (55%) (see Figure 40).

Among smokeless users (including mixed tobacco users) with a usual smokeless brand, the most commonly cited reasons for choosing their usual brand were: “friends use the same brand” (80%), the taste (76%), popularity of the brand (56%), and quality of the brand (51%).

### 8.8.3 Sources of Last Purchase of Cigarettes

Most smokers made their last purchase of cigarettes from local stores (52%) and kiosks (41%) (see Figure 41). Other sources such as bars (2%), street vendors (2%), supermarkets (1%), or from friends (1%) were reported by very few smokers.

Figure 41. Source of last purchase of cigarettes among smokers (cigarettes only and mixed tobacco users)\*



\* Sources where very few respondents reported last purchasing cigarettes, and thus had estimates of below 1%, are not shown in the figure. These include purchases from hotels or inns, duty-free shops, vending machines, the internet, from outside the country, from a vendor selling from a public transportation vehicle, and from a tobacco shop.

*Compliance with the ban on the sale of loose cigarettes is weak as the majority (83%) of smokers stated that their last purchase of cigarettes was loose (single) cigarettes, rather than a pack, carton, or hand-rolled cigarette.*

### 8.8.4 Loose Cigarette Purchases

The Act requires that cigarettes are sold in minimum packages of 10 sticks or at least 10 units of other tobacco products. It also bans the sale of loose (single) cigarettes. However, compliance with the law is weak as the majority (83%) of smokers stated that their last purchase of cigarettes was loose (single) cigarettes, rather than a pack, carton, or hand-rolled cigarette (see Figure 42).

### 8.8.5 Concern about Money Spent on Cigarettes

More than half (61%) of smokers “agreed” or “strongly agreed” that they spend too much money on cigarettes. Almost one-third (31%) of smokers reported that their spending on cigarettes resulted in not having enough money for household essentials like food. Figure 43 shows that the results varied by province from 4% in North Eastern to 51% in Western province.

Smokers were asked whether they had done anything in the last 6 months to save on the amount of money they have spent on cigarettes. The most common responses included reducing the number of cigarettes smoked per day (58%), considering quitting (45%), and looking for a cheaper source of purchase (15%) (see Figure 44).

Figure 42. Form of last purchase of cigarettes among smokers (cigarettes only and mixed tobacco users)

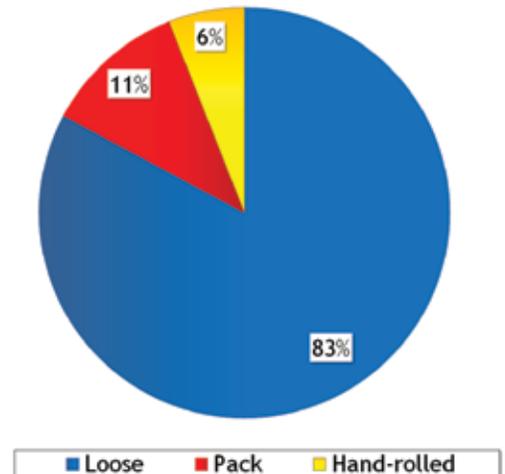
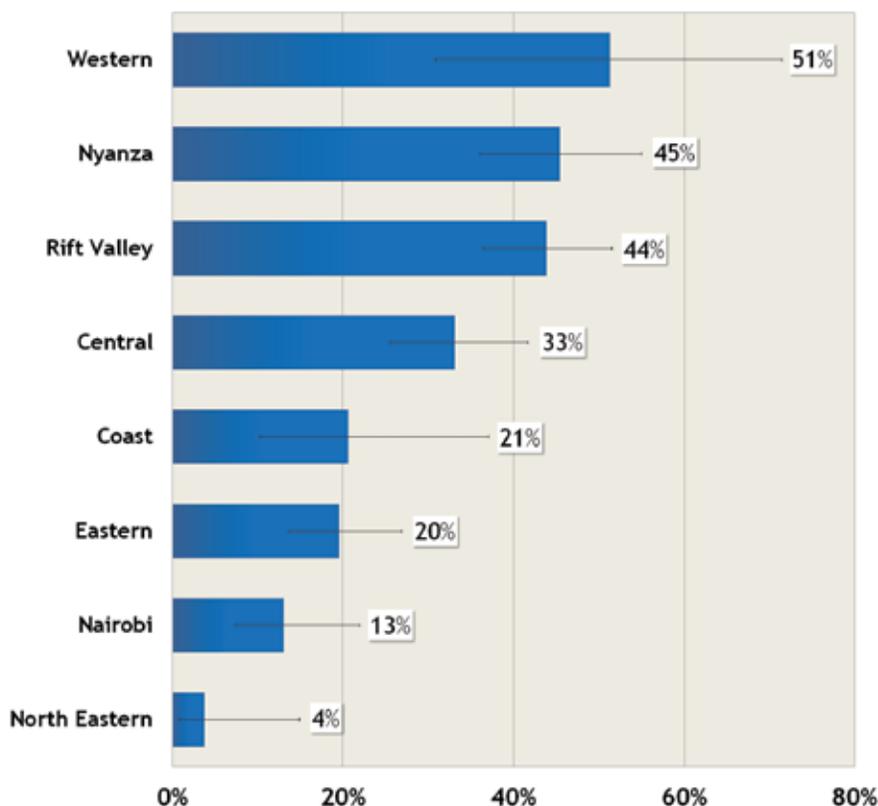


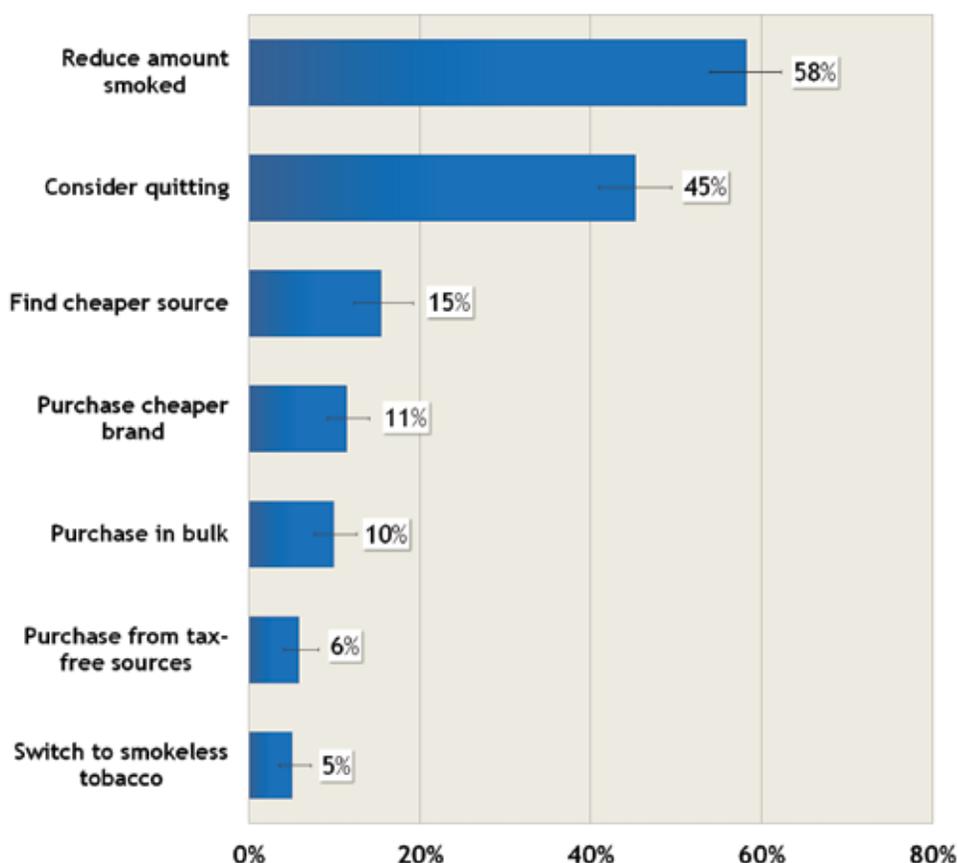
Figure 43. Percentage of smokers (cigarettes only and mixed tobacco users) who reported that there was a time in the last 6 months when the money spent on cigarettes resulted in not having enough money for household essentials like food, by province\*



\* Due to small sample sizes, some point estimates (percentages) with wide confidence intervals should be interpreted with caution.

Kenya had among the lowest percentages of male smokers (41%) who reported that price led them to think about quitting – the fifth-lowest out of 20 ITC countries. The infrequent mention of price suggests that cigarettes are very affordable in Kenya.

Figure 44. Strategies reported by smokers (cigarettes only and mixed tobacco users) to save money on cigarettes



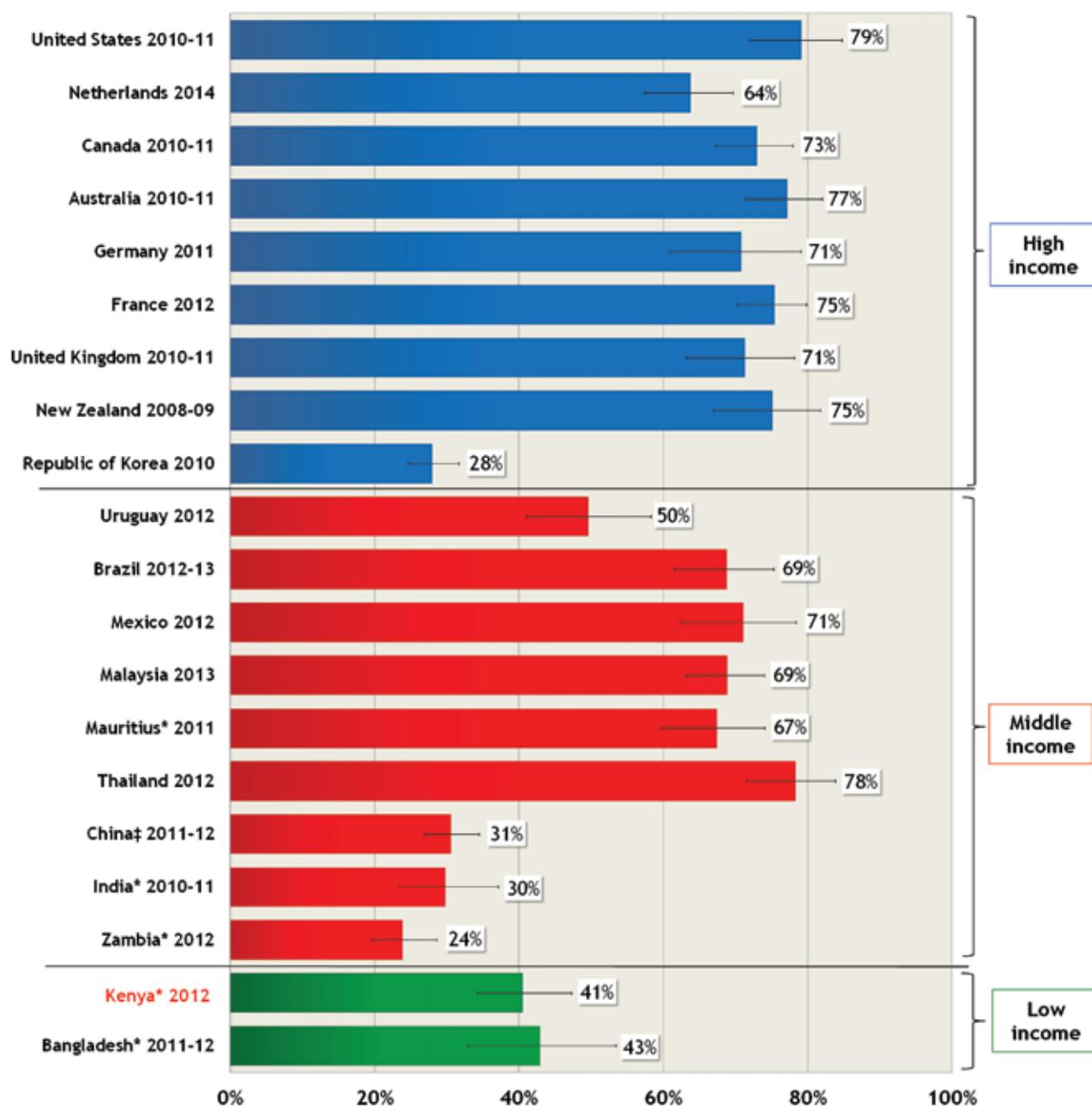
### 8.8.6 Price as a Reason to Quit Smoking

Among smokers who were planning to quit smoking, the price of cigarettes was identified by only 40% of respondents as a reason to think about quitting—one of the least frequently mentioned reasons among 12 reasons given in the survey (see Figure 13 on page 50).

In fact, ITC cross-country comparisons indicate that Kenya had among the lowest percentages of male smokers (41%) who reported that price led them to think about quitting – the fifth-lowest out of 20 ITC countries (see Figure 45).

Given the proven link between tobacco price increases and reduction of smoking initiation and increased cessation, it is of concern that the price of cigarettes was among the least frequently cited reasons for thinking about quitting. In ITC countries where there are stronger tobacco tax policies leading to higher prices, price is one of the MOST frequently cited reasons for thinking about quitting. The infrequent mention of price in Kenya suggests that cigarettes are very affordable in Kenya.

Figure 45. Percentage of male smokers<sup>†</sup> who reported that the price of cigarettes led them to think about quitting “somewhat” or “very much” in the last 6 months, among those who plan to quit, by country



<sup>†</sup> 'Smokers' refer to only cigarette users for all countries except Bangladesh, India, Zambia, and Kenya where dual tobacco users (those tobacco users who reported smoking both cigarettes and bidis) and mixed tobacco users (those tobacco users who reported smoking both smoked tobacco and smokeless tobacco) were also included in the analysis.

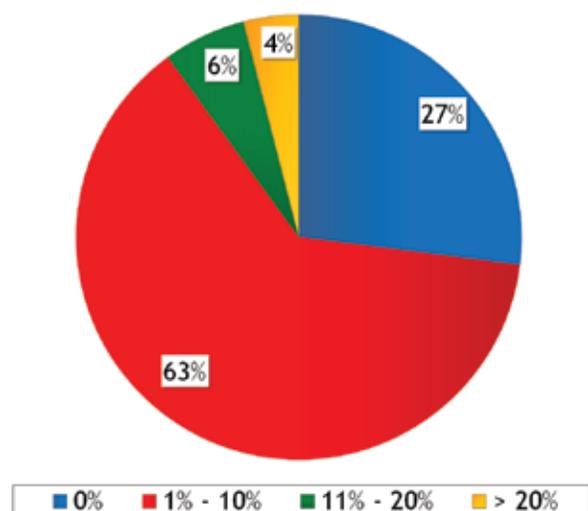
\* In Bangladesh, India, Mauritius, Zambia, and Kenya, the response options were yes/no versus very much/somewhat/not at all. The percentage of respondents who answered "yes" is shown. In these countries, there was also no time frame of 6 months.

‡ In China, instead of "somewhat" the response option was "a little".

### 8.8.7 Percentage of Total Monthly Income Spent on Smoked Tobacco

The ITC Kenya Wave 1 Survey asked the head of each household how much the whole household spent on cigarettes and hand-rolled tobacco in the last month. About three-quarters (73%) of the survey respondents reported that they spent at least some portion of their monthly income on smoked tobacco. Figure 46 shows that 63% of respondents spent between 1% and 10% of their monthly income on smoked tobacco, 6% spent between 11% and 20%, and 4% of respondents spent more than 20% of their monthly income on smoked tobacco.

Figure 46. Percentage of monthly income spent on smoked tobacco



\* The head of each household interviewed was asked how much he/she spent for the whole household on smoked tobacco. The percentages shown were calculated based on the monthly income of each household.

Figure 47. Example of Kenyan Ministry of Finance tax stamp on back of pack



### 8.8.8 Tax Evasion

Article 15 of the FCTC requires Parties to implement effective measures against all forms of illicit trade in tobacco products including smuggling, illicit manufacturing, and counterfeiting. In fact, a new treaty on illicit trade in tobacco – the Protocol to Eliminate Illicit Trade in Tobacco Products, adopted in 2012 - has been created from the FCTC and is in the process towards ratification. Kenya has signed the protocol and is in the process of ratifying it. Kenya is the centre of the tobacco trade in East Africa and the main tobacco manufacturing hub in the region. Kenya, through the Kenya Revenue Authority has instituted various measures to curb illicit trade of tobacco products in Kenya as provided for in the protocol. These measures include a tracking and tracing system, an electronic cargo-tracking system to monitor imports and exports between neighbouring countries, as well as official paper-based tax stamps issued by the Kenyan Ministry of Finance on cigarette packs (see Figure 47).

During the ITC Kenya Wave 1 Survey, respondents were requested to voluntarily show the interviewers their cigarette packs. Respondents were also requested to voluntarily give the empty cigarette packs to the interviewers. Only about one-quarter (24%) of the smokers (including mixed tobacco users) were willing to show the interviewers their cigarette packs. This may be due to fact that 83% of smokers last purchased single sticks (without the pack).

Among smokers who showed their cigarette packs (n=224), 9% of the cigarette packs did not have tax stamps, nor any sign that a stamp was ever present. For the packs that did have a visible tax stamp, almost all (99%) were from Kenya. This evidence, along with the finding that only 6% of smokers said they purchased cigarettes from tax-free sources in the last 6 months, is encouraging given the recent efforts to control illicit trade and tax evasion in Kenya. However, further comparison data to track the presence of tax stamps over time is needed to determine the overall effectiveness of these measures.

### 8.8.9 Support for Increasing Taxes

The ITC Kenya Wave 1 Survey asked respondents whether they think the government should increase the taxes on cigarettes. There is strong public support for raising tobacco taxes, including from tobacco users themselves. Overall, 70% of Kenyans thought that the government should increase taxes on cigarettes. More than half (60%) of smokers, 71% of smokeless users, and 89% of non-users supported the tax increase. Similarly, 68% of Kenyans supported an increase in taxes on smokeless tobacco – 36% of smokeless users, 69% of smokers, and 88% of non-users.

## 9.0 CONCLUSIONS AND RECOMMENDATIONS

Findings from the ITC Kenya Wave 1 (2012) Survey show that the Government of Kenya has made progress in strengthening tobacco control regulations. The passage of the Tobacco Control Act in 2007 brought the law more in line with the requirements of the FCTC, but tobacco control efforts still fall short in several domains, particularly on enforcement of the law, cessation, taxation, and public awareness.

The ITC Kenya Survey findings provide evidence that Kenya has attained a number of important tobacco control achievements, including the ban on tobacco advertising, promotion, and sponsorship, the ban on smoking in public places, and the ban on misleading packaging and labelling.

The ITC Survey also found that societal disapproval of smoking is fairly high in Kenya (66% of smokers and 78% of non-users agree that society disapproves of smoking), and higher than in other LMICs including Zambia (57% of smokers and 50% of non-users). In addition, a high percentage of smokers in Kenya (83%) have a negative opinion of smoking – also higher than in many LMICs and even many high-income countries. The majority of tobacco users support stronger action on tobacco control by the Government of Kenya – almost as high as the level of support among non-users.

However, the findings also highlight areas where the government should further strengthen tobacco control policies, including health warnings, tobacco taxation, and educational programs. For example, the results indicate that the current text-only warnings have little impact on smokers' behaviour, and that knowledge about the harms of tobacco use among tobacco users could be improved. Thus it is not surprising that a very low percentage (17%) of Kenyan smokers have plans to quit in the next 6 months.

In order to increase cessation and protect the Kenyan population from the harms caused by tobacco, greater commitment to complying with the FCTC and its Guidelines is needed. The Ministry of Health has recently tabled “The Tobacco Control Regulations, 2014”.<sup>57</sup> These Regulations are an important step towards addressing gaps and weaknesses in the current Tobacco Control Act as identified by the ITC Kenya Survey findings. However, further actions are recommended to bring Kenya into compliance with the FCTC and its Guidelines and to fully protect Kenyans from the harms of tobacco.

**Based on the ITC Kenya Survey findings, the research team offers the following recommendations for strengthening tobacco control in Kenya:**

### **1. Reduce access to and affordability of tobacco products through taxation.**

Increasing tobacco taxes and prices is recognized by the WHO as the single most cost-effective strategy to reduce the prevalence of tobacco use, particularly among youth. Article 6 of the FCTC calls on governments to increase tobacco taxes as a way to reduce tobacco consumption and achieve their health objectives. **The tobacco tax structure should be reviewed and include a progressive rise in tobacco taxes across all forms of tobacco. A percentage of the tax accrued from tobacco should be allocated to tobacco control and other public health programmes.**

## **2. Strengthen enforcement of the ban on sale of cigarettes by single sticks.**

Kenya has adopted progressive legislation in banning the sale of single cigarettes under the 2007 Tobacco Control Act; however, greater enforcement of this ban is needed in Kenya, especially because the availability of single cigarettes increases access to tobacco among youth and reduces exposure to health warnings on tobacco packages.

## **3. Strengthen the current health warnings to require pictorial health warnings on at least 50% of the top part of the front and back of the pack, as called for in the FCTC Article 11 Guidelines. Replace images with a new set of health warnings every 2 years to maintain saliency and enhance impact.**

The ITC Kenya Wave 1 Survey findings provide evidence of the urgent need to improve the current text-based warnings in order for Kenya to meet its obligations under the FCTC and to most effectively provide tobacco users in Kenya with information on the harms of tobacco products. The 2007 Tobacco Control Act authorizes the Ministry of Health to design and implement pictorial warnings. Although the new regulations for pictorial health warnings are a strong step forward, they do not meet the FCTC recommendation of covering at least 50% of the principal display areas of the pack.

## **4. Consider moving forward with standardized packaging (plain packaging) legislation as implemented in Australia, and recently passed in Ireland and the United Kingdom.**

Tobacco companies continue to use many aspects of the pack—colour, design, graphics—to make their products attractive and appealing, particularly for young people and women. To counteract this advertising and marketing strategy, Article 13 also suggests that Parties should consider adopting plain packaging (cigarette and other tobacco product packages which contain only the brand name and health warning labels, without any identifying colours or logos). Australia was the first country to require that cigarettes and other tobacco products be presented in plain and standardized packaging (no logos or color design—just the name of the brand in a standard font against a background of a drab greenish-brown package, but still with the large pictorial warnings on the pack). The evidence from the initial studies in Australia show that plain packaging is effective: appeal of the product has decreased, smoking prevalence has dropped, the warnings have become more effective, and even the reported taste of the cigarettes in the new plain packs has declined. Kenya would benefit from having such a plain packaging law.

## **5. Implement a more specific ban on the use of misleading, false, or deceptive packaging and labelling, including descriptors such as “light”, “mild”, or “low tar”.**

The evidence is clear that “light” and “mild” cigarettes are no less harmful than regular cigarettes. As the tobacco industry continues to use these and other descriptors and packaging colour and design elements to mislead consumers about the harms of their products, it is imperative that the Government of Kenya review the existing legislation on tobacco product labelling and packaging and prevent the tobacco industry from using this means of false promotion.

## **6. Strengthen the current smoke-free law to ensure universal protection from harms of tobacco smoke.**

The 2007 Tobacco Control Act bans smoking in several venues, but because it includes a provision for designated smoking areas, the current law is not fully compliant with Article 8 Guidelines, which recommend 100% smoke-free public places. Article 8 Guidelines clearly state that ventilation, air filtration, and the use of designated smoking areas (whether with separate ventilation systems or not), have repeatedly been shown to be ineffective.

ITC evaluation of smoke-free policies throughout the world have demonstrated that strong implementation and enforcement of smoke-free laws can be highly effective in reducing the public’s exposure to secondhand smoke. The Government of Kenya should take steps to strengthen the Act by removing the provision for designated smoking rooms, which even with strong ventilation systems, fail to protect the public from the harms of secondhand smoke.

In addition, it is important to ensure strong and consistent enforcement of the smoke-free law by engaging local enforcement agencies and educating both the public and local health officials about the provisions of the law, as well as the public health benefits associated with a strong smoke-free law. This should also include setting and issuing strict penalties for violations.

## **7. Strengthen enforcement of the ban on tobacco advertising, promotion, and sponsorship to curb tobacco marketing in the entertainment media and through product displays and packaging.**

Comprehensive bans on tobacco advertising, promotion and sponsorship (TAPS) are needed to prevent the tobacco industry from using direct and indirect marketing strategies aimed at encouraging people to start using tobacco and increasing tobacco consumption among current tobacco users. The current provisions against TAPS in Kenya are already comprehensive and compliant with the basic recommendations of Article 13 – the Act prohibits any form of tobacco brand or product advertising, as well as tobacco promotion in the media or sponsorship of events and activities. However, indirect forms of TAPS still take place in Kenya, and the law is not clear with respect to monitoring and enforcement of the ban against TAPS.

## **8. Raise public awareness of the harms of tobacco through sustained public education campaigns.**

ITC studies have shown that smokers in LMICs are less knowledgeable about the specific harms caused by tobacco than those in HICs. The results of the ITC Kenya Survey are consistent with this finding.

Education campaigns are a critical element of a comprehensive tobacco control strategy and are effective for denormalizing tobacco use and encouraging tobacco users to quit, while delaying and deterring initiation. The recent mass media campaign “Smoking Kills” showing the harms of tobacco use and secondhand smoke on children in Kenya is a good beginning. Additional resources are needed to develop more intense and long-term education programs and communication strategies to raise awareness of the social, environmental, economic, and health effects of all forms of tobacco use.

## **9. Establish cessation services to support tobacco users who wish to quit.**

It is well established that receiving advice to quit from a physician or health professional is a powerful motivator for quitting. Improving access to physicians and other health services is an area that is clearly in need of more resources in order to be effective in reducing tobacco use in Kenya, as the percentage of male smokers who received advice to quit from a physician in Kenya was the lowest of all LMICs in the ITC Project.

The Government of Kenya should work on developing and implementing strategies to support tobacco users who want to quit and increase access to available services. These strategies should include establishing more cessation programs and clinics, increasing access to Nicotine Replacement Therapies (NRTs) by making them more affordable and available outside of private pharmacies, expanding the reach of the current quitline, and training physicians and healthcare providers to provide informed cessation advice and offer referrals to other services.

**In addition to the strategies outlined above, a number of countries are setting targets and considering measures to create a tobacco-free generation, such as banning the sale and supply of tobacco products to individuals born after a certain year (i.e., 2007/2010). For example, Singapore has passed a law banning the sale of tobacco to those born after 2000. These strategies may serve as models for Kenya to consider as part of a comprehensive strategy to reduce tobacco use among young people.**

“We are pleased that ITC Kenya research evidence also indicates that the public is extremely supportive of stronger tobacco control policies. For example, the majority of tobacco users themselves support an increase in tobacco taxes. The ITC Kenya Survey findings have great potential to propel our endeavour to reverse the tobacco epidemic in Kenya.”

Dr. Nicholas Muraguri  
Director of Medical Services  
Government of Kenya

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The International Tobacco Control Policy Evaluation Project

# The ITC Project

## Evaluating the Impact of FCTC Policies in...

20+ countries • 50% of the world's population  
60% of the world's smokers • 70% of the world's tobacco users

Australia  
Bangladesh  
Bhutan  
Brazil  
Canada  
China (Mainland)  
France

Germany  
India  
Ireland  
Kenya  
Malaysia  
Mauritius  
Mexico  
Netherlands

New Zealand  
Republic of Korea  
Thailand  
United Kingdom  
Uruguay  
United Arab Emirates  
United States of America  
Zambia

