

The International Tobacco Control Policy Evaluation Project

ITC Kenya National Report



FINDINGS FROM THE WAVE 1 AND 2 SURVEYS (2012-2018)

MAY 2021




**TOBACCO SMOKING
IS PROHIBITED
IN THIS BUILDING
AND ITS COMPOUND**
BY ORDER



Findings from the ITC Kenya Wave 1 and 2 Surveys (2012-2018)

ITC Kenya National Report

Suggested Report Citation

ITC Project. (May 2021). *ITC Kenya National Report. Findings from the Wave 1 and 2 Surveys (2012-2018)*. University of Waterloo, Waterloo, Ontario Canada; Ministry of Health [Kenya], Kenya Medical Research Institute, International Institute for Legislative Affairs, and University of Nairobi, Nairobi, Kenya.

Foreword



The ITC Kenya Survey is part of the International Tobacco Control Policy Evaluation Project (the ITC Project) – an international cohort survey conducted in 29 countries, designed to measure the impact of key policies of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). In 2012 and 2018, two waves of the ITC Kenya Survey were conducted among a cohort of tobacco users and non-users in the country (approximately 1500 tobacco users and 600 non-users at each wave). The ITC Kenya Survey is a nationally representative probability sample of respondents aged 15 years or older, conducted through face-to-face household interviews using methods designed by the ITC Project research team at the University of Waterloo in Canada.

The results indicate that in 2018, the majority of Kenya tobacco users (89% of smokers and 75% of smokeless users) regret that they started smoking cigarettes or using smokeless tobacco. Only one-third (37%) of those who visited a doctor or health professional in the last 6 months in 2018 received advice to quit. These findings point to the need to enhance access to cessation support through physicians or health professionals and affordable cessation services and treatments. Global evidence demonstrate the importance of high tax rates to reduce demand of tobacco products. The ITC survey shows that tobacco products in Kenya, particularly smokeless and hand-rolled cigarettes, are inexpensive, and this high affordability is a major barrier to reducing tobacco use in our country. The survey findings point to the need to strengthen enforcement on the ban on the sale of loose cigarettes as the majority of smokers (82%) last purchased loose (single) cigarettes rather than in a pack.

We are pleased to learn that an increasing number of Kenyans reported that smoking is not allowed in their homes (86% in 2018). In addition, secondhand smoke exposure continued to be low in hospitals, educational institutions, public transport, and in restaurants. However, exposure to secondhand smoke is still high in bars, where more than half of respondents noticed people smoking during their last visit. About two-thirds of Kenyans support a complete ban on smoking in bars so there is very strong public support for strengthening smoke-free laws, even among smokers. An additional challenge is that smoking in indoor workplaces increased from 11% in 2012 to 16% in 2018. There is clearly more that needs to be done to reduce harmful secondhand smoke, which the WHO has identified as a major cause of disease and death globally.

ITC Survey findings show that there is strong compliance with the comprehensive ban on tobacco advertising, promotion, and sponsorship (TAPS): less than 10% of tobacco users and non-users reported noticing tobacco products being advertised in various venues in the last 6 months. However, there was some evidence of the need for stronger enforcement of existing TAPS bans in certain areas, such as the entertainment media where about 1 in 4 respondents noticed the use of tobacco products in the last 6 months.

Findings show that the new cigarette pictorial health warnings have had substantial benefits. After their introduction, smokers were more likely to state that because of the warnings, they thought about the health risks of smoking (from 28% to 43%), and that the warnings made them “a lot” more likely to quit (from 24% to 38%). Three-quarters (75%) of smokers who saw the new pictorial health warnings agreed that they made smoking seem more dangerous. Additionally, knowledge of many of the specific health effects caused by tobacco increased among all respondents between 2012 to 2018. ITC evidence suggests that increasing the size of the pictorial health warnings on cigarette packs and implementing pictorial health warnings on smokeless tobacco would further increase the impact of tobacco health warnings in Kenya.

The Kenya Government wishes to acknowledge the contribution of those institutions who were responsible for the successful completion of the 2018 ITC Kenya Survey and the preparation of this landmark report, including the University of Nairobi, Kenya Medical Research Institute, the International Institute of Legislative Affairs, the Ministry of Health, and our partners in Canada at the University of Waterloo.

The report provides evidence that the majority of Kenyans support greater action to tackle the harm done by using tobacco. We anticipate that the findings of this report will further assist us to build on our progress in tobacco control and to continue to plan and implement evidence-based policies and programmes to curb tobacco use and its devastating consequences in Kenya.



SEN. MUTAHI KAGWE, EGH

CABINET SECRETARY, MINISTRY OF HEALTH

Preface



We are extremely pleased to release this landmark report on findings of the International Tobacco Control (ITC) Kenya Wave 2 Survey. The ITC Kenya Survey was conducted in 2018 among 1500 Kenyan tobacco users and 500 non-users. This report is a follow up to the ITC Kenya Wave 1 Report, which was released in Kenya in 2015.

The findings provide a rigorous assessment of the impact of changes in the tobacco control policy landscape in Kenya between 2013-2018, including implementation of the Tobacco Control Regulations, 2014.

The Report presents evidence of Kenya's achievements in tobacco control. For example, after the implementation of new pictorial warnings in 2016, more smokers thought about the health risks of smoking "a lot" (increasing from 28% to 43%) and were "a lot" more likely to quit (increasing from 24% to 38%). Smokers also became more knowledgeable of the health effects of tobacco use. Findings also show strong compliance with the comprehensive ban on tobacco advertising, promotion, and sponsorship with fewer than 10% of respondents noticing tobacco marketing in stores, print and electronic media, and public places. Smoking in restaurants and public transport has remained low (less than 10%) between 2012 and 2018 and more tobacco users reported having home smoking bans (increasing from 50% to 61% of tobacco users).

However, Kenya is committed to further strengthening tobacco control measures and the Report provides evidence that Kenyans are supportive of stronger policies. More than 4 out of 5 respondents support having more information on cigarette and smokeless tobacco packs, a ban on tobacco advertisements in stores, a complete smoking ban in restaurants and workplaces, and tobacco tax increases.

I thank the ITC Project research team at the University of Waterloo and the ITC Project collaborators in Kenya for your dedication to this project and for bringing these important research findings to our attention. We look forward to continued collaboration in undertaking future ITC surveys to further improve tobacco control and the implementation of the FCTC in Kenya. 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 are grateful for the dedication of the following individuals from University of Waterloo – Prof. Geoffrey Fong (Chief Principal Investigator of the ITC Project), Dr. Mary Thompson, Dr. Anne Quah, and Dr. Susan Kaai; from the Ministry of Health – Ms. Dorcas Kiptui and Ms. Anne Kendagor; as well as Ms. Emma Wanyonyi (formerly of ILA), Dr. Lawrence Ikamari (UoN), and Dr. Jane Ong'ang'o (KEMRI).

The ITC Kenya Survey findings have great potential to accelerate and strengthen our implementation of the World Health Organization Framework Convention on Tobacco Control and to curb the tobacco epidemic in Kenya

A handwritten signature in black ink, appearing to read "S. Mochache". The signature is written in a cursive style with a colon at the end.

SUSAN MOCHACHE, CBS

PRINCIPAL SECRETARY, MINISTRY OF HEALTH

Acknowledgements



The International Tobacco Control Policy Evaluation Project (the ITC Project) in Kenya was created in 2010 by an international research team in Canada and Kenya to evaluate the impact of Kenya's tobacco control policies and to guide future evidence-based legislative efforts enacted under the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). We are grateful for the dedicated work of the project partners in planning and conducting the Wave 2 Survey in April to June 2018 and for the continued collaboration of the team in preparing this important report to disseminate the survey findings among the tobacco control community in Kenya.

The Government of Kenya would like to thank the following collaborating organizations:

- University of Waterloo — Canada
- University of Nairobi — Kenya
- Kenya Medical Research Institute — Kenya
- Ministry of Health — Kenya
- International Institute for Legislative Affairs – Kenya

Financial support is provided by the Canadian Institutes of Health Research (MOP-115016 and FDN-148477), Ontario Institute for Cancer Research (OICR), and the U.S. National Cancer Institute (NCI) (P01 CA138389 and P01 CA200512).

Our deepest gratitude goes to co-principal investigators Dr. Lawrence Ikamari of the Population Studies and Research Institute (PSRI) at the University of Nairobi (UON) and Dr. Jane Rahedi Ong'ang'o of the Kenya Medical Research Institute (KEMRI), Dr. Richard Mutuku of the University of Nairobi (PSRI), and Ms. Emma Wanyonyi (formerly of the International Institute for Legislative Affairs (IILA)) for their expertise and guidance to ensure that the ITC Kenya Survey fieldwork was conducted successfully. We especially recognize and appreciate the immense technical support and guidance of the team at the University of Waterloo: Dr. Geoffrey T. Fong, Chief Principal Investigator of the ITC Project; Dr. Mary E. Thompson and Dr. Christian Boudreau, and Ms. Grace Li of the Data Management Core; and Dr. Susan Kaai, ITC Research Scientist/Project Manager and Dr. Anne C.K. Quah, ITC Waterloo Managing Director/Senior Research Scientist, who played vital roles in the planning, management, and execution of the Wave 2 Survey.

We thank the team of collaborators who contributed to the preparation of this report at the University of Waterloo: Dr. Genevieve Sansone, Dr. Gang Meng, Ms. Yingchen Fan, Ms. Lorraine Craig, Dr. Susan C. Kaai, Dr. Eunice O. Indome, Dr. Anne C.K. Quah, and Dr. Geoffrey T. Fong. We also appreciate the contribution of those who provided peer review comments on drafts of the report: Dr. Lawrence Ikamari (UON), Dr. Jane Rahedi Ong'ang'o (KEMRI) and Ms. Anne Kendagor and Ms. Dorcas Kiptui (MOH), and Ms. Emma Wanyonyi (formerly of the IILA).

Finally, immense gratitude goes to the Project Manager, Data Manager, Data Entry Clerks, Regional Supervisors, Field Supervisors, Interviewers, and all of the respondents who participated in the collection of ITC Project data that are so important to evaluating and guiding tobacco control efforts in Kenya.

A handwritten signature in blue ink, appearing to read 'Patrick Amoth', is centered on the page.

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2. EXECUTIVE SUMMARY

Evaluation of Tobacco Control in Kenya: the ITC Kenya Survey

This report evaluates Kenya's progress in the implementation of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) and its guidelines. The findings are based on research conducted by the International Tobacco Control Policy Evaluation Project (the ITC Project) – an international cohort survey conducted in 29 countries, designed to evaluate the impact of global tobacco control policies. In 2012 and 2018, two waves of the ITC Kenya Survey were conducted among a cohort of adult tobacco users and non-users in the country (approximately 1500 tobacco users and 600 non-users at each wave). The Wave 1 ITC Kenya Report was released in December 2015 (see <https://itcproject.org/findings/reports/itc-kenya-national-report-wave-1-2012-december-2015/>). This new Wave 1 to 2 Report assesses Kenya's progress in tobacco control from 2012 to 2018, and compares findings from Kenya to other ITC countries around the world.

Key Findings and Recommendations from the ITC Kenya Wave 1 to 2 Report

Kenya ratified the FCTC in 2004, and the treaty became effective in 2005. Since the FCTC came into force over fifteen years ago, Kenya has taken important steps to strengthen tobacco control efforts, backed by strong political support and civil society engagement. Kenya's main tobacco control legislation, the 2007 Tobacco Control Act (TCA), took effect in 2008 and includes several key provisions to reduce tobacco use, such as a complete ban on tobacco advertising, promotion, and sponsorship, a partial ban on smoking in public places and workplaces, and text warnings on tobacco packages. The legislation was strengthened with the passage of the 2014 Tobacco Regulations, which mandated pictorial health warnings and imposed further restrictions on smoking in public places, among other measures. In addition, tobacco tax reforms have been introduced to reduce the affordability of tobacco products, and strong measures have been implemented to help control illicit trade in the country.

Findings from the ITC Kenya Survey show that tobacco control policies implemented thus far have been effective in some policy domains, such as curbing direct forms of tobacco advertising, promotion, and sponsorship, raising awareness of the health risks caused by tobacco use, and providing protection in some public places from the harms of secondhand smoke. However, despite these important policy achievements, the findings also highlight areas where stronger action by the government is needed, as described below. Therefore, Kenya must build on its progress thus far and continue to accelerate the implementation of evidence-based tobacco control measures in line with the WHO FCTC and its guidelines in order to fully protect the current and future health of its population from the harms of tobacco.

Based on the ITC Kenya Wave 1 to 2 Survey findings, the research team offers the following recommendations for strengthening tobacco control in Kenya:

1. Design and implement more public education campaigns to reduce misperceptions of the harms of tobacco products and decrease the social acceptability of tobacco use.

The ITC Kenya Wave 2 findings suggest that although most tobacco users have negative perceptions of tobacco companies and the majority (75% of smokeless users and 89% of smokers) express regret for using tobacco, smoking remains more socially acceptable in Kenya compared to other countries. In fact, Kenya has the lowest percentage of smokers (53%) who think society disapproves of smoking among 11 ITC LMICs. The Wave 2 results also show that many tobacco users hold incorrect beliefs about the harms of certain tobacco products, such as smokeless tobacco, compared to regular cigarettes. For example, despite the evidence that smokeless tobacco is less harmful than combustible cigarettes, the majority of smokers believe that smokeless tobacco is either more harmful (23%) or equally harmful (64%). These findings suggest that there is a need to increase efforts to denormalize tobacco use in Kenya and to raise awareness of the relative harms of various tobacco products through sustained public education and mass media campaigns.

2. Introduce a ban on menthol cigarettes to help reduce tobacco consumption and initiation, particularly among youth.

Menthol is a common flavouring agent added to cigarettes to mask the harsh properties of tobacco smoke. The prevalence of menthol cigarette smoking in Kenya was found to be higher than in most high-income countries - about one-fifth (20%) of smokers in Kenya who had a regular brand of cigarettes in 2018 smoked menthol cigarettes, and menthol use was more common among females. In addition, even though all conventional cigarette brands are equally harmful, over two-thirds (66%) of smokers in Kenya believe that menthol cigarettes are less harmful than regular cigarettes. These findings are concerning, particularly for youth, as menthol has been found to promote smoking initiation and reduce the likelihood of quitting. Kenya could benefit by following the lead of more than 30 countries and jurisdictions including Senegal, Nigeria, Uganda, Ethiopia, Canada, United Kingdom, Moldova, Turkey, and the European Union by implementing a progressive ban on menthol cigarettes.

3. Enhance access to cessation services to support tobacco users who want to quit, including increased training of physicians and health care providers.

It is well established that receiving advice to quit from a physician or health professional is a powerful motivator for quitting; yet only one-quarter (23%) of Kenyan tobacco users visited a doctor or health provider in the last 6 months in 2018, and only one-third (37%) of those who visited received advice to quit - the lowest percentage of smokers who received cessation advice among all 11 ITC LMICs. In addition, the Wave 2 findings show that most tobacco users have no immediate plans to quit and have not made a quit attempt. For example, only 16% of smokers and 13% of smokeless users plan to quit in the next month or next 6 months. These findings demonstrate the need to enhance access to physicians and other affordable cessation services and treatments for Kenyan tobacco users, such as Nicotine Replacement Therapies (NRTs) and quitline services, in order to increase quit attempts and successful quitting.

4. Increase the impact of the current health warnings by implementing the full set of all 15 rotating PHWs on both smoked and smokeless tobacco packages, and increasing the size of health warnings to at least 50% of both sides of the pack.

The Wave 2 findings show significant improvement in some measures of the cognitive and behavioural impact of health warnings on cigarette packages after the partial implementation of 3 of the 15 mandated pictorial health warnings (PHWs) in 2016. For example, the percentage of smokers who thought about the health risks of smoking “a lot” because of warnings increased from 28% at Wave 1 to 43% at Wave 2, and the percentage who said the warnings made them “a lot” more likely to quit increased from 24% to 38%. The salience of Kenya’s new PHWs is also much greater than text-only warnings in other ITC LMICs.

The Wave 2 findings also showed a strong impact of the new PHWs on increasing smokers’ awareness of the harms of smoking, as about three-quarters of smokers who had seen the new warnings agreed they made smoking seem more dangerous. In addition, there was an increase in knowledge of many of the specific health effects caused by tobacco among all respondents between 2012 and 2018.

However, while the change from text-only to PHWs is an important step, there was no change in the size of warnings (30% of the front and 50% of the back of packs) and thus the current PHWs still do not meet the recommendation of the FCTC Article 11 Guidelines of at least 50% of both sides of the pack. Findings from other ITC countries that have implemented larger PHWs suggest that Kenya would benefit even further by increasing the size of the PHWs and rotating or revising the warnings periodically to maintain salience and enhance the impact of warnings on behaviours that could lead to quitting. The survey findings also show the need to strengthen health warnings on smokeless tobacco packages, which remain text-only (or come without any warning labels), as few smokeless users reported noticing smokeless warnings often (12%).

5. Consider moving forward with plain packaging legislation along with larger PHWs as part of a comprehensive strategy to further increase the impact of health warnings and reduce the appeal of tobacco, which has been successfully implemented in Australia and many other countries.

Tobacco packages are one of the few remaining channels for tobacco companies to market and promote their products. In order to restrict the tobacco industry’s ability to use packaging elements to appeal to and mislead consumers, a growing number of countries have adopted – or are in the process of implementing – plain packaging legislation, as recommended by the WHO FCTC. Plain or standardised packaging refers to the removal of all branding (images and text) from tobacco packages and the standardization of all other packaging elements, including colours, font, shape and size. Evidence from ITC Surveys and other global studies have clearly demonstrated the effectiveness of plain packaging, particularly in reducing the appeal of tobacco packages and enhancing the salience and impact of health warnings. ITC evidence from other countries also shows that support for plain packaging laws is high and increases after implementation. This evidence, along with the recent ruling by the World Trade Organization (WTO) affirming Australia’s plain packaging law as scientifically and legally sound, should encourage Kenya and other countries to accelerate implementation of similar legislation.

6. Strengthen the current smoke-free law by making all public places and workplaces 100% smoke-free without exceptions, accompanied by a rigorous enforcement effort to ensure compliance.

Global evidence clearly demonstrates that only a comprehensive smoke-free law can fully protect the public from exposure to harmful tobacco smoke. Smoking has been prohibited in public places and workplaces in Kenya since 2008; however, even after new regulations were introduced in 2014 to expand the smoking ban to cover more areas, Kenya's legislation is not fully compliant with the FCTC Article 8 Guidelines as it still allows for designated smoking areas.

The Wave 1 to 2 findings show that there have been some decreases in exposure to secondhand smoke (SHS) in public places from 2012 to 2018. Indoor smoking has remained low in some places, such as hospitals, educational institutions, and public transport, and a minority of respondents (7%) noticed people smoking in restaurants at Wave 2. In addition, the majority of respondents (86%) reported that smoking is not allowed in their homes, and there was an increase in home smoking bans among tobacco users from 2012 to 2018.

However, Kenyans are still being exposed to SHS in other public places - especially bars, where two-thirds of smokers reported smoking indoors themselves and 57% of all respondents noticed other people smoking during their last visit. While the prevalence of smoking in bars has decreased since 2012 in Kenya, it is still higher compared to most other ITC countries. There was also no improvement in the level of observed smoking in indoor workplaces, which increased from 11% in 2012 to 16% in 2018. These findings suggest the need to improve enforcement of existing smoke-free policies and strengthen smoke-free legislation by implementing a comprehensive national smoking ban.

7. Strengthen enforcement of the ban on TAPS to decrease exposure to tobacco marketing in the entertainment media and in retail environments even further.

In Kenya, all forms of tobacco advertising, promotion and sponsorship (TAPS) are prohibited under the 2007 TCA, including product displays. The ITC Kenya Survey findings show that overall compliance with the comprehensive TAPS ban is strong and has improved in some areas since 2012. For example, less than 10% of tobacco users and non-users noticed tobacco products being advertised in various venues in the last 6 months (e.g. stores, print and electronic media, public places), with a decrease in noticing advertising in shops and store windows since 2012. Kenya has the third-lowest percentage of smokers and quitters (4%) who noticed any tobacco promotion "often" in the last 6 months among 10 ITC LMICs. A minority of respondents also reported noticing various types of tobacco promotion, such as branding, discounts, and sponsorship.

However, there was some evidence of the need for stronger enforcement of existing TAPS bans in certain areas, such as the entertainment media and retail environments – which remain the most common sources for noticing tobacco advertising and promotion. About one-quarter (22%) of respondents noticed people using tobacco products in the entertainment media in the last 6 months, which previous studies have shown to be a factor in encouraging youth smoking. Comprehensive restrictions covering all direct and indirect forms of TAPS with monitoring and

enforcement mechanisms are essential in order to reduce tobacco consumption and protect non-smokers from exposure to tobacco industry marketing in Kenya.

8. Simplify the tobacco tax structure by applying a uniform specific tax rate so that all tobacco products are taxed equally to discourage switching between brands or products, and implement regular tax increases which translate to price increases at the retail level in order to make tobacco products less affordable over time.

Increasing tobacco taxes and prices is known to be one of the most effective tobacco control measures to reduce tobacco use, particularly among youth. Guidelines for Article 6 of the WHO FCTC recommend using the simplest and most efficient tax system with all tobacco products taxed at a uniform rate. However, Kenya has a history of complex excise tax systems, which have had little impact on reducing the affordability of tobacco products. Starting in 2012, Kenya has made some progress in introducing reforms in the tax administration system, including simplifying the tax structure and implementing a new track-and-trace system to help control illicit trade. While previous research evidence shows that these measures have helped to reduce cigarette consumption, current tobacco taxes remain well below the WHO's recommendation of 70% of the retail price, and the ITC Kenya Wave 2 findings suggest tobacco products are still affordable for the majority of Kenyans - especially smokeless tobacco and hand-rolled cigarettes. The findings also suggest that tobacco prices are not a strong motivator for quitting - Kenya has the fourth-lowest percentage of smokers who stated that the price of cigarettes was a reason for thinking about quitting (39%) among all 26 ITC countries. However, an encouraging finding is that tobacco users have become increasingly concerned about the costs of their tobacco use from 2012 to 2018, and these concerns are leading about half of smokers to reduce their consumption (55%) and consider quitting (49%) in order to save money.

These findings suggest that Kenya should continue to build on recent progress to improve tobacco tax systems by implementing additional tax policy reforms and price increases to make all tobacco products even less affordable and accessible for consumers and motivate more smokers to quit.

9. Strengthen enforcement of the ban on the sale of cigarettes by single sticks.

Banning the sale of single cigarettes is an important tobacco control measure for reducing access to tobacco products among youth. The availability of loose cigarettes and smokeless tobacco products also reduces the impact of health warnings on tobacco packages. In Kenya, all cigarettes are required to be sold in minimum packages of 10 sticks under the 2007 TCA. However, findings from the Wave 2 Survey show that the majority of smokers in Kenya (82%) last purchased cigarettes in loose (single) form rather than a pack, and this percentage has not changed since 2012. These findings suggest that there is a need to improve compliance with the existing legislation to eliminate the availability of single cigarettes.

In Kenya, both tobacco users and non-users support stronger tobacco control policies.

An important and consistent finding from the ITC Kenya Wave 2 Survey is that the majority of respondents – including tobacco users themselves – support stronger tobacco control measures across key policy domains:

- The majority of respondents support greater action by the Kenyan government on tobacco control in general - 89% of tobacco users and 95% of non-users think the government should do more to tackle the harm done by using tobacco; and 76% of tobacco users and 91% of non-users think tobacco products should be more tightly regulated.
- Almost all respondents (91% of tobacco users and 96% of non-users) would support a total ban on tobacco products in 10 years if the government provided assistance to help smokers quit.
- Even though new PHWs were partially introduced on cigarette packs in 2016, the majority of Kenyans would still support enhanced health warnings that meet Article 11 Guidelines on all tobacco packages. Overall, 85% of respondents think there should be more health information on cigarette packs and 92% think there should be more health information on smokeless tobacco packs.
- Support for smoking bans in public places has remained high and has increased over time for certain public indoor and outdoor places, including bars and outdoor eating areas. Overall, 90% of respondents would support a complete smoking ban in restaurants and workplaces; 64% support smoke-free bars; and 94% or more support smoke-free hospitals, educational institutions, and public transport.
- There is strong and growing support for more effective enforcement of existing TAPS restrictions to further decrease exposure to tobacco advertising and promotion in retail settings. Overall, 86% of respondents agree “a lot” with the ban on tobacco advertisements in stores and 86% agree that displays of tobacco products should be completely banned.
- The findings showed strong support for raising tobacco taxes across all products. Overall, 89% of respondents support a tax increase on cigarettes, and 88% support tax increases on hand-rolled tobacco and smokeless tobacco. Support was higher among non-users compared to tobacco users (e.g. 93% of non-users vs. 60% of smokers support a tax increase on cigarettes).

3. 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 Framework Convention on Tobacco Control (WHO FCTC) in more than 29 countries.

The ITC Kenya Survey is a face-to-face survey of a nationally representative cohort sample of approximately 1,500 tobacco users and 600 non-users. The Wave 1 Survey was conducted October to December 2012. Wave 2 was conducted from April to June 2018. This report presents the results from the most recent wave (Wave 2) of the ITC Kenya Survey and compares progress on tobacco control in Kenya against other ITC countries.

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ITC Kenya Project Funding

- Canadian Institutes of Health Research (MOP- 115016 and FDN-148477)
- Ontario Institute for Cancer Research (OICR)
- U.S. National Cancer Institute (NCI) - P01 CA138389 and P01 CA200512)

Acknowledgements

This report was prepared by a team of collaborators at the University of Waterloo: Dr. Genevieve Sansone, Dr. Gang Meng, Ms. Yingchen Fan, Ms. Lorraine Craig, Dr. Susan Kaai, Dr. Eunice O. Indome, Dr. Anne C.K. Quah, and Dr. Geoffrey T. Fong; and the ITC Kenya team:

Dr. Lawrence Ikamari of the University of Nairobi, Dr. Jane Rahedi Ong'ang'o of Kenya Medical Research Institute. Ms. Anne Kendagor of the Kenya MOH and Ms. Emma Wanyonyi formerly of the International Institute for Legislative Affairs also provided peer review comments.

4. BACKGROUND AND METHODS

4.1 Background on Tobacco Use and Tobacco Control in Kenya

Tobacco use continues to pose an enormous threat to public health, killing over eight million people globally, and more than 8000 people in Kenya alone each year.^{1,2} In order to protect current and future generations from the devastating consequences of tobacco, the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) obligates Parties to implement strong, evidence-based measures to prevent and reduce tobacco consumption and to monitor the magnitude and patterns of tobacco use. 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 the country, including text health warnings on packages, a ban on tobacco advertising, promotion, and sponsorship (TAPS), and a ban on smoking in public places and workplaces.

While tobacco use is declining in most high-income countries, recent national surveys in Kenya suggest that prevalence of tobacco use has decreased only slightly since 2003 (see Table 1). Tobacco use remains much more common among Kenyan males (about one-fifth currently use tobacco) compared to females (less than 5%).

Table 1: Prevalence of tobacco use in Kenya from national surveys (2003-2015)

Survey	Year	Overall Tobacco Use† Prevalence	Current Tobacco Use Among Males vs. Females
Kenya Demographic Health Survey	2003	n/a	Males 25%; females <3%
	2008-09	n/a	Males 19%; females <2%
	2014	n/a	Males 18%; females <2%
ITC Kenya Wave 1 Survey	2012	16%	Males 27%; females 5%
Global Adult Tobacco Survey (GATS)	2014	12%	Males 19%; females 4.5%
STEPS survey	2015	13.5%	Males 23%; females 4%

† Tobacco use in each survey is defined as current use of any smoked or smokeless tobacco products; although definitions of current use may vary across surveys.

Kenya has an active tobacco control community; however, the strong presence of the tobacco industry in Kenya and opposition from groups with powerful economic interests in tobacco have created a challenging environment in which to build capacity for tobacco control and to implement and enforce the Act.³

In 2014, the Tobacco Control Regulations were introduced in Kenya with the aim of strengthening the existing tobacco control law. The Regulations included: new pictorial health warnings; a ban on smoking in cars with children; and a ban on smoking on streets/walkways near public places. Additionally, the Regulations included measures to address tobacco industry interference, including: prohibiting the tobacco industry from contributing to the development of public health policies; a ban on corporate social responsibility (CSR) activities; limitations on any interactions between public authorities and the tobacco industry; and requiring full disclosure of any contribution or affiliation between government officials and the tobacco industry. These measures have made Kenya a leader in the implementation of the WHO FCTC Article 5.3 guidelines, which obligate Parties to protect public health policies from the harmful influence of the tobacco industry.⁴

The new regulations were to be implemented in June 2015, but were suspended prior to this date due to a legal challenge by British American Tobacco (BAT). After two more legal challenges in the Court of Appeals and Supreme Court, the tobacco industry was finally defeated in November 2019 and the 2014 Regulations were upheld.

4.2 ITC Project

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 tobacco control policies of the WHO FCTC. Since 2002, the ITC Project has conducted longitudinal surveys in 29 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. Each ITC survey includes key measures across several FCTC policy domains, which are identical or functionally similar across ITC countries to facilitate cross-country comparisons. The longitudinal design of the ITC surveys also allows for a rigorous evaluation of whether the introduction of new policies in a country led to greater impact on tobacco use behaviour. For a more detailed description of the conceptual model and objectives of the ITC Project, see Fong et al. (2006)⁵; for a description of the survey methods, see Thompson et al. (2006)⁶.

4.3 ITC Kenya Survey

The ITC Project in Kenya (the ITC Kenya Survey) was created in 2010 by an international research team in Canada (the University of Waterloo) and Kenya (the International Institute for Legislative Affairs, the Kenya Medical Research Institute, the Ministry of Health, and the University of Nairobi). The purpose of the ITC Kenya Survey is to evaluate the impact of tobacco control policies implemented in the country and provide an evidence base to guide future legislative efforts enacted under the FCTC.

Two waves of the ITC Kenya Survey have been completed among a cohort of tobacco users and non-users – the first wave was conducted from October to December 2012, and the second wave was conducted from April to June 2018. The Wave 1 ITC Kenya National Report was released in December 2015 (see <https://itcproject.org/findings/reports/itc-kenya-national-report-wave-1-2012-december-2015/>). This new Wave 1 to 2 Report assesses Kenya's progress in

tobacco control approximately 14 years after Kenya ratified the FCTC and 10 years after the national Tobacco Control Act (TCA) came into force.

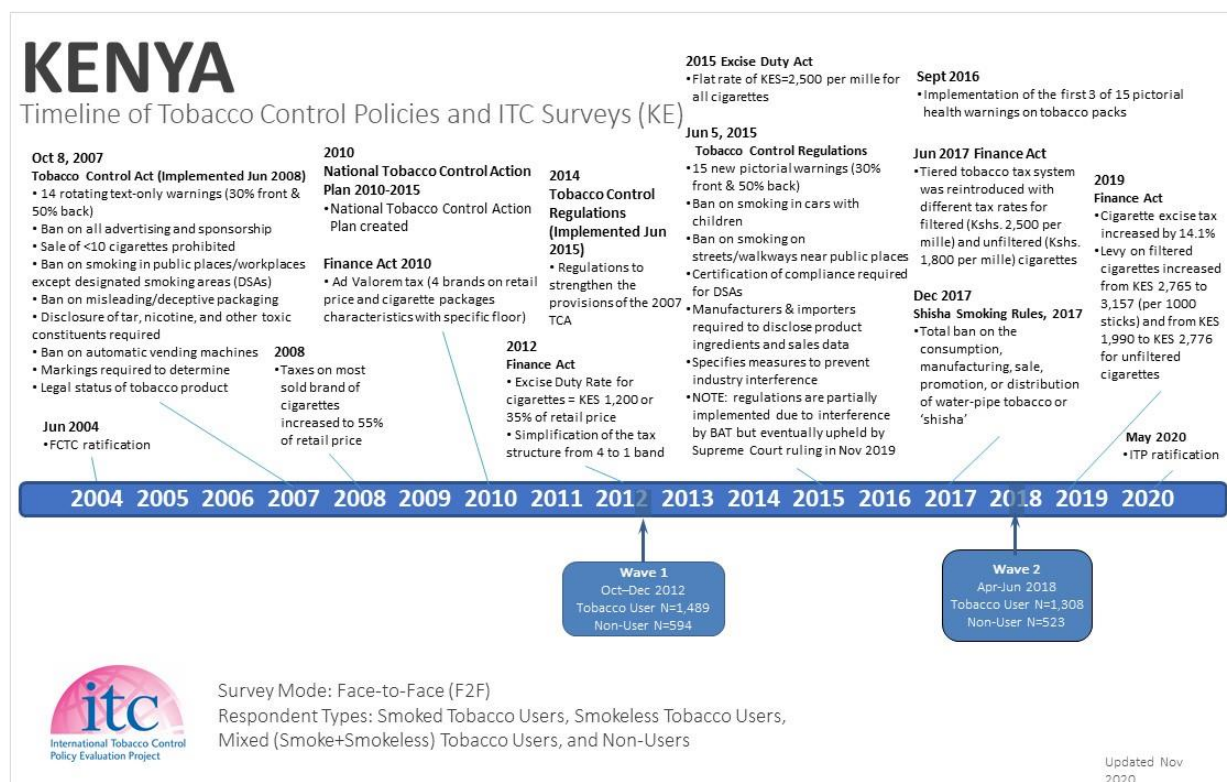
The ITC Kenya Wave 1 (2012) Survey was conducted approximately four years after the implementation of the TCA. The ITC Kenya Wave 2 (2018) Survey was conducted six years after Wave 1. The following tobacco control policies were implemented between the Wave 1 and Wave 2 Surveys:

- **December 2014:** the *Tobacco Control Regulations, 2014* were published and were to take effect in six months' time (but were delayed due to a legal challenge from the tobacco industry)
- **2015:** the *Excise Duty Act* simplified the tobacco tax system to a uniform specific excise tax structure
- **September 2016:** 3 of the 15 prescribed new pictorial health warnings were implemented on cigarette packages
- **June 2017:** tiered tobacco tax system was reintroduced with different tax rates for filtered (Kshs. 2,500 per mille) and unfiltered (Kshs. 1,800 per mille) cigarettes
- **December 2017:** ban on the import, manufacture, sale, use, advertising and promotion, and distribution of Shisha under the *Public Health (Control of Shisha Smoking) Rules, 2017*

After the Wave 2 Survey, Kenya implemented further price and tax increases under the Finance Act in 2019 and on May 4, 2020 Kenya ratified the Protocol to Eliminate Illicit Trade in Tobacco Products (ITP).

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

Figure 1: Timeline of tobacco control policies in Kenya and ITC Kenya Surveys



4.4 Wave 2 Sampling and Survey Design

The ITC Kenya Survey is a nationally representative probability sample of approximately 1,500 tobacco users and 600 non-users of tobacco aged 15 years or older, selected through a multi-stage clustered sampling design. The survey was developed in English by an international transdisciplinary team of tobacco control experts and was then translated into Kiswahili by a qualified translator. The Wave 2 Survey consisted of a set of parallel questionnaires tailored for each of the following groups, and were conducted face-to-face by trained interviewers:

- Smoked tobacco users – respondents who smoke cigarettes and/or bidisⁱ at least once a month
- Smokeless tobacco users – respondents who use smokeless tobacco products at least once a month
- Mixed tobacco users – respondents who use BOTH smoked tobacco (cigarettes and/or bidis) AND smokeless tobacco at least once a month
- Non-users – respondents who do not smoke tobacco (cigarettes and/or bidis) or use any smokeless tobacco products at least once a month

ⁱ Note: At Wave 1, smoked tobacco users included those who smoked cigarettes and/or bidis at least once a month. Due to the extremely low prevalence of bidi smoking at Wave 1, it was decided that Wave 1 bidi smokers could be recontacted at Wave 2, but no bidi smokers would be recruited in the replenishment sample if they did not also smoke cigarettes.

- Quitters – respondents who were tobacco users in Wave 1 but had completely quit tobacco (cigarettes/bidis, or/and smokeless tobacco) at Wave 2

Further details on the sampling design and survey methods are available in the ITC Kenya Waves 1 and 2 technical reports, available at <https://itcproject.org/methods/technical-reports/?country=kenya> Full copies of the survey questionnaires are also available on the ITC Project website at <https://itcproject.org/surveys/survey-directory/>

4.5 Sample Size

Excluding invalid samples, in Wave 1, a total of 1,370 effective samples of tobacco users and 550 effective samples of non-tobacco users aged 15 and older were collected via face-to-face interviews. For the Wave 2 Survey, the sample constructed in Wave 1 was re-contacted for participation in Wave 2. Respondents who were lost to follow-up at Wave 2 were replaced by adults of the same tobacco use status in newly enumerated households, within the same EA, sampled using the same procedure as in Wave 1. In Wave 2, 598 Wave 1 tobacco users and 252 Wave 1 non-users were re-contacted (retention rate of 43.6% for tobacco users and 45.8% for non-users). However, 101 of those tobacco users had transitioned to non-users at Wave 2 and 13 non-users had transitioned to tobacco users. In addition, to replace those tobacco users and non-users who could not be reached at Wave 2, 565 new tobacco users and 222 new non-users were randomly selected for participation. This resulted in a total of 1,076 tobacco users and 562 non-users (total sample size of 1,637 respondents) that were included in the Wave 2 sample for the analyses in this report (see Table 2).

Table 2: Wave 2 Sample Size

	Wave 1 Status	Wave 2 Status		Total
		Tobacco User	Non-User	
Recontact Sample	Tobacco User	497	101	598
	Non-User	13	239	252
Replenishment Sample	n/a	565	222	788
Total		1,075	562	1,637

Table 3 presents the demographic characteristics of the Wave 1 and 2 ITC Kenya survey respondents.

Table 3: Demographic characteristics of the ITC Kenya Wave 1 and 2 Survey respondents

Characteristics	Wave 1		Wave 2	
	%	%	N	%
Gender				
Female	508	26.5	413	25.2
Male	1412	73.5	1223	74.8
Not Stated	0	0	1	<0.1
Age Group				
18-24	234	12.2	88	5.4
25-39	775	40.4	548	33.5
40-54	484	25.2	483	29.5
55-max	427	22.2	518	31.6
Income Level				
Low	953	49.6	917	56.0
Medium	373	19.4	318	19.4
High	86	4.5	163	9.7
Not Stated	508	26.5	239	14.6
Education Level				
Low	274	14.3	210	12.8
Medium	880	45.8	827	50.5
High	755	39.3	585	35.7
Not Stated	11	0.6	15	0.9
Religion				
Roman Catholic	561	29.2	507	31.0
Protestant/Other Christian	1028	53.5	808	49.4
Muslim	131	6.8	146	8.9
Hindu	2	0.1	0	0.0
No Religion	164	8.5	141	8.6
Other	25	1.3	32	2.0
Not Stated	9	0.5	3	0.2

4.6 Analytic Approach

4.6.1 Kenya Wave 1-2 analyses

The ITC Kenya Wave 1 and Wave 2 Surveys employed a stratified multistage cluster sampling design. To adjust for potential disproportionate selection of adult tobacco users and non-users in sub-groups, survey weights were computed for each respondent. Estimates of descriptive statistics (i.e., means and proportions) reported here are derived from the survey samples weighted by the inflation sampling weights (or analytical weights derived from the inflation sampling weights), unless otherwise stated. The sampling weight for a given respondent is interpreted as the number of people in the population represented by that respondent at the time of recruitment.

Data from both waves of the ITC Kenya Survey were used to fit longitudinal models to assess temporal changes in policy relevant measures. Wave 2 only data were also used to fit cross-sectional models to assess the status quo of desired measures in Kenya. The weighted estimates for proportions and means and their temporal changes were calculated using survey logistic regression models incorporating generalised estimating equations (GEE). A nested structure that includes survey design information (the strata, and the primary sampling units) and the respondent IDs was used in the GEE models to adjust for potential design effects and within-individual correlations due to repeated measures at each wave. Prevalence estimates for sub-groups are adjusted for sex, age, user type (tobacco user vs. non-user), wave, and the interaction of user type and wave.

For longitudinal analyses, respondents' Wave 1 tobacco use status was used to construct the GEE analytical weights for recontacted respondents at Wave 2 in order to maintain population proportions. Otherwise, for Wave 2 only cross-sectional estimates, all respondents' Wave 2 tobacco status were used with the inflation weights to represent the populations of tobacco users and non-users at Wave 2. Quitters were only included in the analysis where the measure of interest was especially relevant for quitters. Analyses of binary, categorical and continuous outcomes were conducted with the RLOGIST, MULTLOG, and REGRESSION procedures respectively in SAS-callable SUDAAN V11. The predicted marginal standardisation method in the SUDAAN GEE models (PREDMARG) was used for estimating means and proportions. General linear contrasts of the predicted marginals in corresponding models were specified to test the significance of between-wave changes in means or proportions. All confidence intervals (CIs) and statistical significance tests were computed at the 95% confidence level.

4.6.2 Cross-country analyses

For cross-country comparisons, the same type of adjustment was applied because the composition of the sample of smokers also varied across ITC countries. Multi-country comparisons are based on smokers in each country (which may include bidi smokers in Bangladesh, India, and Zambia) and quitters where relevant and control for differences in age, gender, smoking status (daily vs. non-daily smokers), and time-in-sample (number of waves completed by each respondent). All rescaled cross-sectional weights were further rescaled separately within smokers and within quitters within each of the original scaling groups in each country to ensure all countries are comparable (i.e. countries that recruited quitters vs. those that have recontacted quitters or do not have quitters).

It should also be noted that adjusted percentages for Kenya presented in cross-country comparisons may vary slightly from the Wave 2 Survey results provided for the same measures due to differences in adjustment methods.

FINDINGS

5. TOBACCO USE BEHAVIOUR AND BELIEFS

5.1 Background

The ITC Kenya Wave 1-2 Surveys measure tobacco use behaviour and beliefs among the Kenyan adult population from 2012 to 2018. The survey findings presented in this section describe tobacco consumption patterns including cigarettes and smokeless tobacco, and the use of alternative nicotine delivery systems such as electronic cigarettes (e-cigarettes). The surveys also measure attitudes, opinions, and perceptions about tobacco use and tobacco regulation among tobacco users and non-users.

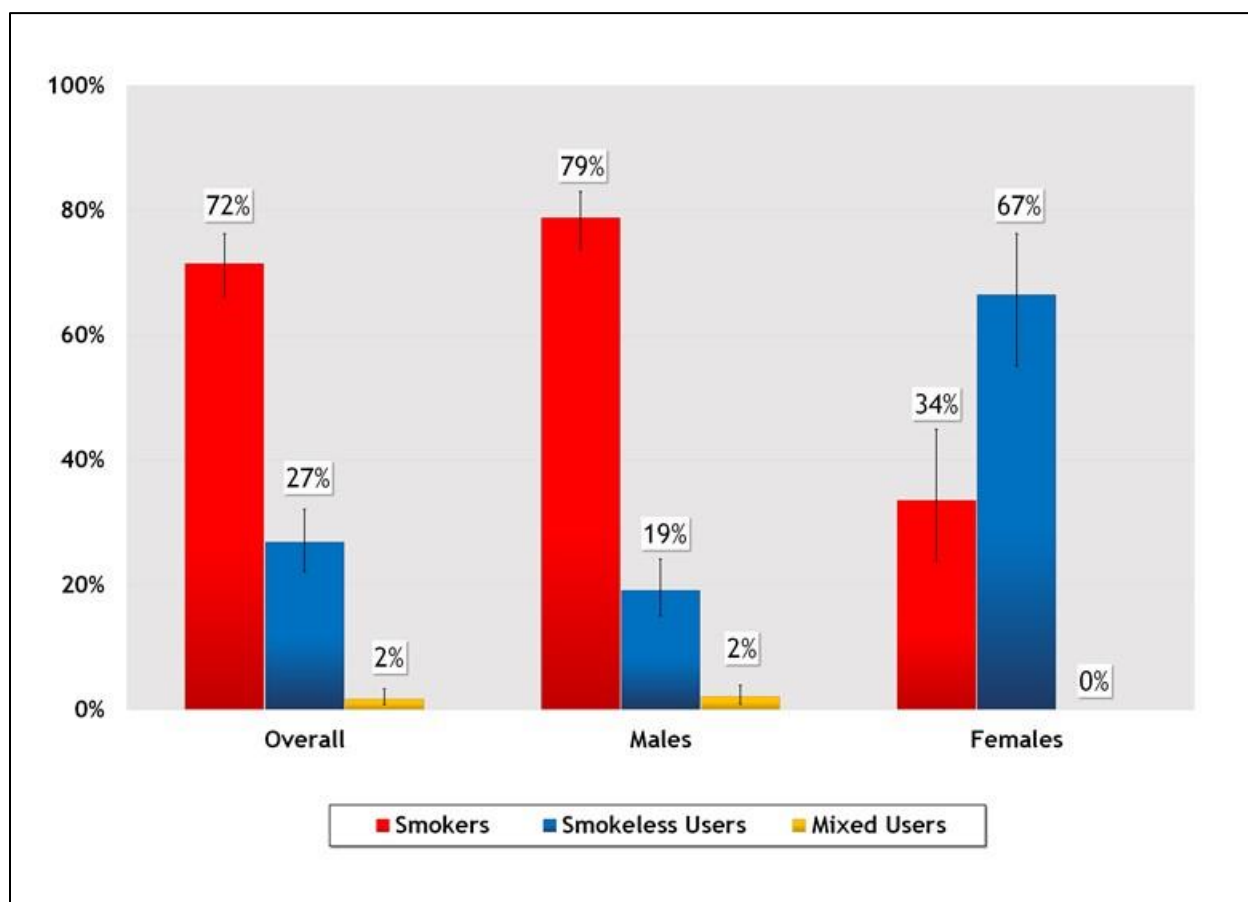
5.2 Tobacco Use Behaviours

5.2.1 Overview of tobacco use patterns at Wave 2

Among the overall sample at Wave 2 (n=1,636; 1223 males and 413 females), two-thirds (66%, n=1,076) of respondents were tobacco users and one-third (34%, n=561) were non-users. Among tobacco users, about two-thirds were cigarette smokers (72%), and about one-third (27%) were smokeless tobacco only users (i.e. oral snuff, nasal snuff, and Kuber). Very few respondents (2%) were mixed tobacco users (i.e. currently use both smoked and smokeless tobacco).

However, tobacco use varied between men and women at Wave 2. Among the overall sample, males had a higher proportion of tobacco users (79%, n=912) than non-users, compared to females (34% tobacco users, n=163). Among tobacco users, the type of tobacco product used also differed between men and women: as shown in Figure 2, the majority of Kenyan male tobacco users (79%) smoked cigarettes, while the majority of female tobacco users (67%) used smokeless tobacco products.

Figure 2: Percentage of tobacco users who were smokers, smokeless users, and mixed users at Wave 2 (2018), by gender



5.2.2 Cigarette smoking

At Wave 2, the majority of smokersⁱⁱ (91%, vs. 92% at Wave 1) reported that they smoked cigarettes daily or almost daily. The average number of cigarettes smoked per day (CPD) was 8.9% (vs. 9% at Wave 1). ITC data from other countries indicates that this average daily consumption among male smokers is similar to other LMICs like India (7 CPD), Zambia (8 CPD), and Bangladesh (9 CPD), but much lower than in HICs.⁷

Cigarette smokers were also asked about the type of cigarettes they usually smoke. The majority of smokers at Wave 2 (87%, vs. 82% at Wave 1) 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 at Wave 2. The majority of smokers (88%, vs. 90% at Wave

ⁱⁱ In this report “smokers” include those who currently smoke cigarettes (and may also smoke other tobacco products such as bidis or pipes), as well as “mixed users” (those who smoke both smoked and smokeless products), unless otherwise stated. “Smokeless users” include those who currently only use smokeless tobacco products, as well as mixed users, unless otherwise stated.

1) also reported that they had a regular brand, that is, a brand of cigarettes that they usually smoke.

5.2.3 Other smoked products

Overall, the use of other types of smoked tobacco products besides cigarettes is low in Kenya: at Wave 2, very few tobacco users reported that they also smoked hookah (n=8), cigars (n=4), bidis (n=3), pipe (n=2), or chutta (n=1). There were no smokers of hooklis, kreteks, cheroots, or cigarillos.

5.2.4 Smokeless tobacco

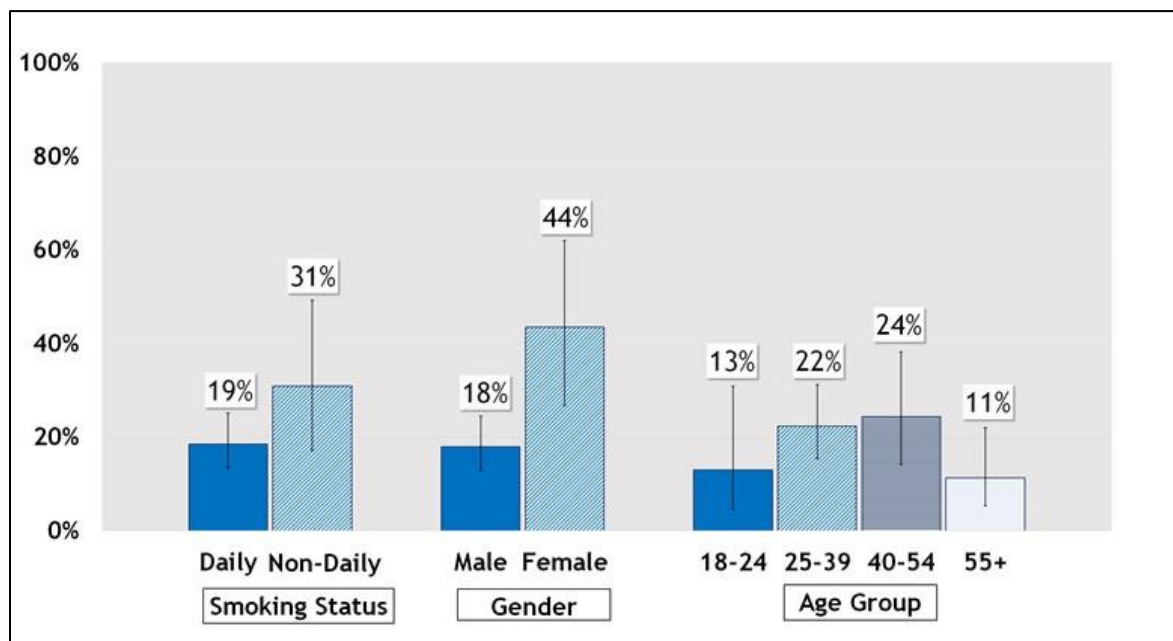
Smokeless tobacco users (30% of all tobacco users) were asked how often they used their usual smokeless product. Most (85%, vs. 94% at Wave 1) reported that they used smokeless tobacco products daily or almost every day. Among all smokeless users at Wave 2, almost half reported using oral snuff (40%) or nasal snuff (49%) at least once a month. Use of other types of smokeless tobacco at least monthly was less common, such as Kuber (9%) and plain chewing tobacco (11%).

5.3 Menthol Use and Perceptions

5.3.1 Prevalence of menthol use

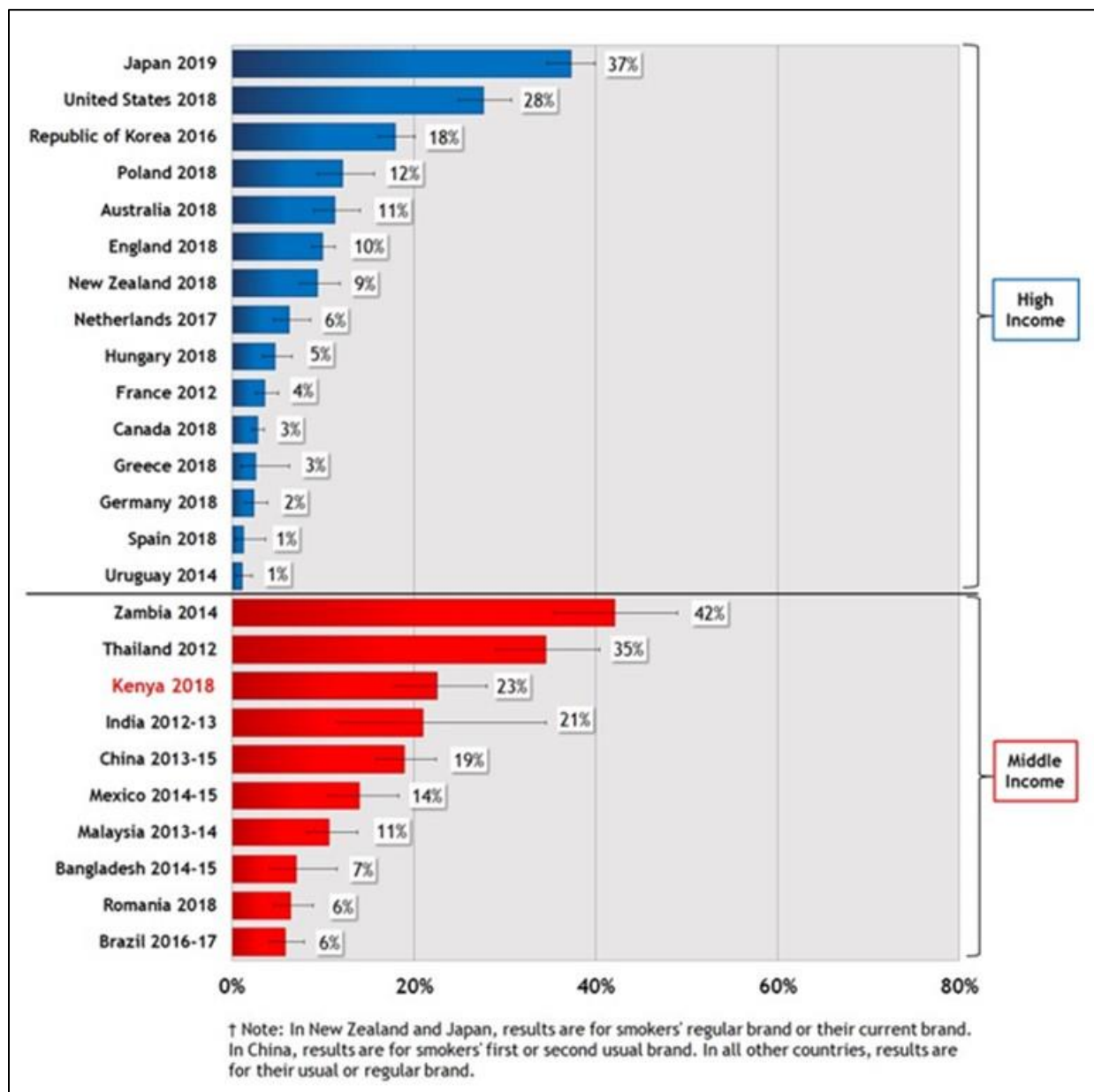
Smokers who had a usual brand of cigarettes were asked what flavour they used (response options included “none”, “menthol”, “sweet menthol”, or “other”). About one-fifth (20%) of respondents who had a usual brand (vs. 22% at Wave 1) reported that their usual cigarette brand was menthol flavoured. As shown in Figure 3, daily smokers were less likely to smoke menthol cigarettes than non-daily smokers (19% vs. 31%), and males were less likely than females (18% vs. 44%).

Figure 3: Percentage of smokers who smoked menthol cigarettes at Wave 2 (2018), by smoking status, gender, and age group



ITC cross-country comparisons indicate that the level of menthol use in Kenya is comparable to other LMICs – Kenya has the third highest percentage of smokers who smoke menthol cigarettes (23%) among 10 ITC LMICs (see Figure 4). In general, smokers in most HICs are less likely to report smoking menthol cigarettes.

Figure 4: Percentage of smokers who smoke menthol cigarettes, among those who have a regular brand of cigarettes, by country



5.3.2 Perceptions of menthol and light cigarettes

World wide the tobacco industry continues to falsely promote the use of alternative types and flavours of cigarettes, such as “light”, “mild”, “low tar” and menthol cigarettes as a harm reduction strategy, encouraging health-concerned smokers to switch to these products rather than quitting. Menthol cigarettes are often perceived by smokers as being smoother than regular cigarettes and therefore less harmful.^{8,9}

The Wave 2 Survey assessed smokers' perceptions of the harmfulness of menthol cigarettes and light cigarettes relative to regular cigarettes. The results showed the need to reduce

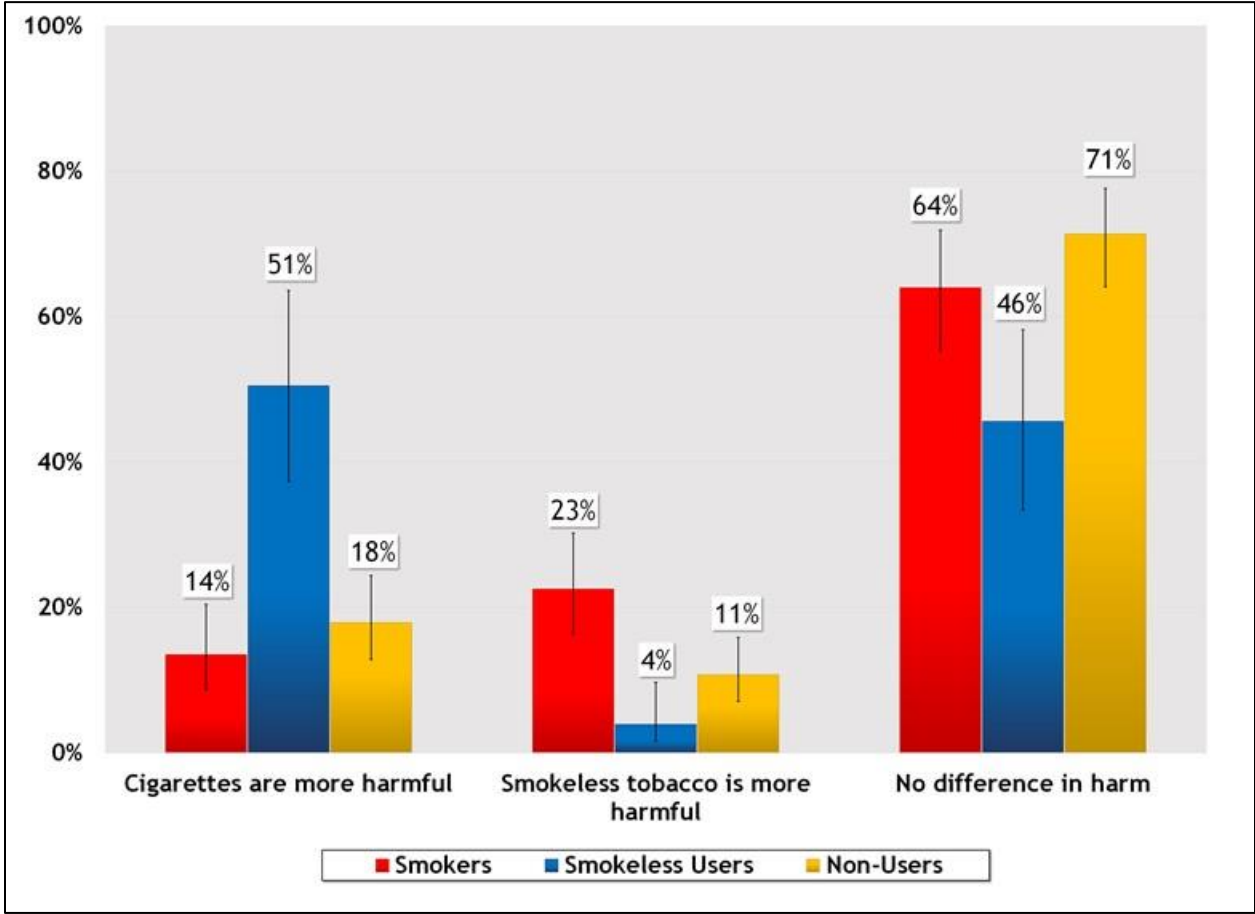
misperceptions about menthol cigarettes in Kenya, as over two-thirds of smokers (66%) “agreed” or “strongly agreed” that menthol cigarettes are less harmful than regular cigarettes. Misperceptions about the harms of light cigarettes still exist among Kenyan smokers, i.e., about one-third of smokers (30%) agreed that light cigarettes are less harmful than regular cigarettes.

5.4 Perceptions of Cigarette and Smokeless Tobacco Harms

While the majority of Kenyan tobacco users and non-users are generally aware that smoking is harmful to health, the Wave 2 findings show that there are some differences in perceptions of harm between users and non-users of each type of tobacco product.

At Wave 2, about three-quarters (69%) of all respondents (vs. 72% at Wave 1) said there is no difference in harm between smoking cigarettes and using smokeless tobacco, despite the evidence that smokeless tobacco is less harmful than combustible cigarettes. However, responses differed between smokers and smokeless users, as shown in Figure 5.

Figure 5: Perceptions of harm of cigarettes vs. smokeless tobacco at Wave 2 (2018), by user type



About half of smokeless users (51%, vs. 58% at Wave 1) correctly believed that using smokeless tobacco is less harmful than cigarettes, while the other half (46%, vs. 39% at Wave 1) said that they are equally harmful, and only 4% at each wave incorrectly said that using smokeless tobacco

is more harmful. Additionally, about half of smokeless users (54%, vs. 64% at Wave 1) believed that the smokeless tobacco product they use might be “a little less harmful” than other brands/types of smokeless products. These results suggest that there has been some improvement in awareness of the relative harms of smokeless tobacco compared to smoked tobacco between Wave 1 and 2, but there is still a need to educate people in Kenya further about the health risks of using any form of smokeless tobacco.

On the other hand, cigarette smokers had more negative perceptions of the harm of smokeless tobacco (and less negative perceptions of the harms of smoking). The majority of smokers (64%, vs 65% at Wave 1) said that there is no difference in harm between cigarettes and smokeless tobacco, and 23% (vs 22% at Wave 1) of smokers incorrectly believed that smokeless tobacco is more harmful than cigarettes. In addition, one-third of smokers at Wave 2 (34%, vs. 40% at Wave 1) thought that the cigarette brand they use is “a little less harmful” than other brands/types of cigarettes.

These findings are generally consistent with the previous ITC research demonstrating not only that smokers tend to underestimate their own risk of harm from smoking, but also that tobacco users perceive less risk of harm from using their own product compared to other products, in countries such as India and Bangladesh where multiple types of tobacco use are common.^{10,11,12}

The Wave 2 Survey also asked about perceptions of harm for hand-rolled versus factory-made cigarettes. Overall, most respondents (83%, vs. 91% at Wave 1) believed that hand-rolled cigarettes are more or equally harmful to health than factory-made cigarettes. Non-users were more likely to say that hand-rolled cigarettes are more/equally harmful than smokers (85% vs. 94%).

5.5 Beliefs and Perceived Norms about Tobacco Use

5.5.1 Regret for smoking and smokeless use

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 to live your life again, you would not have started smoking cigarettes.” Previous studies in other countries have shown that smokers’ experience of regret for ever having started smoking is an important indicator of societal norms about tobacco use and a key predictor of future quitting behaviour.¹³

The Wave 2 findings show that regret for smoking is high in Kenya - the majority of smokers (89%, vs. 84% at Wave 1) “agreed” or “strongly agreed” with this statement. These findings support previous global evidence demonstrating that despite claims from the tobacco industry that smokers enjoy smoking, most smokers actually do not want to smoke. The level of regret in Kenya is also similar to other ITC countries, where studies have found that about 90% of smokers in high-income Western countries and 74%-93% of smokers in Asian countries expressed regret for smoking.^{13,14}

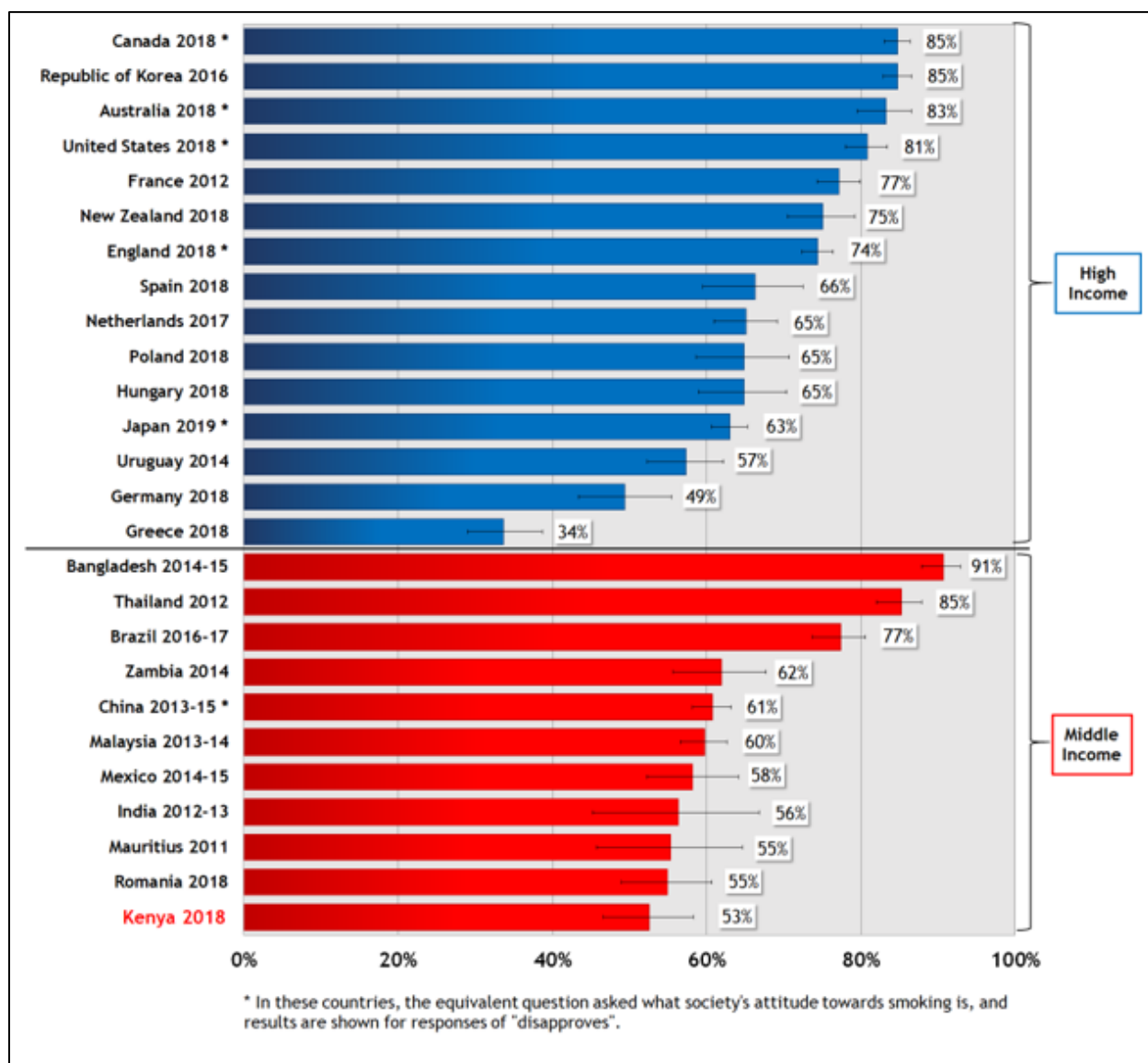
Regret was slightly lower among smokeless tobacco users in Kenya – 75% of smokeless users at Wave 2 (vs. 60% at Wave 1) “agreed” or “strongly agreed” with this statement regarding their use of smokeless tobacco products.

5.5.2 Social acceptability of smoking

The Wave 1-2 Surveys measured the acceptability of tobacco use in Kenyan society by asking respondents whether they think society disapproves of both smoking and smokeless tobacco use. The results showed that most respondents think that society disapproves of any tobacco use, although perceived disapproval decreased from Wave 1 to 2, suggesting that tobacco use has become more acceptable. At Wave 2, approximately two-thirds of all respondents (65%) “agreed” or “strongly agreed” that society disapproves of smoking (a decrease from 77% at Wave 1), and 59% agreed that society disapproves of smokeless use (a decrease from 70% at Wave 1).

ITC cross-country comparisons further suggest that smoking is more acceptable in Kenya than in other countries. As shown in Figure 6, Kenya has the lowest percentage of smokers (53%) who “agree” or “strongly agree” that society disapproves of smoking among 11 ITC LMICs and the third-lowest percentage overall among 26 countries.

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



5.6 E-Cigarette Awareness, Use, and Perceptions

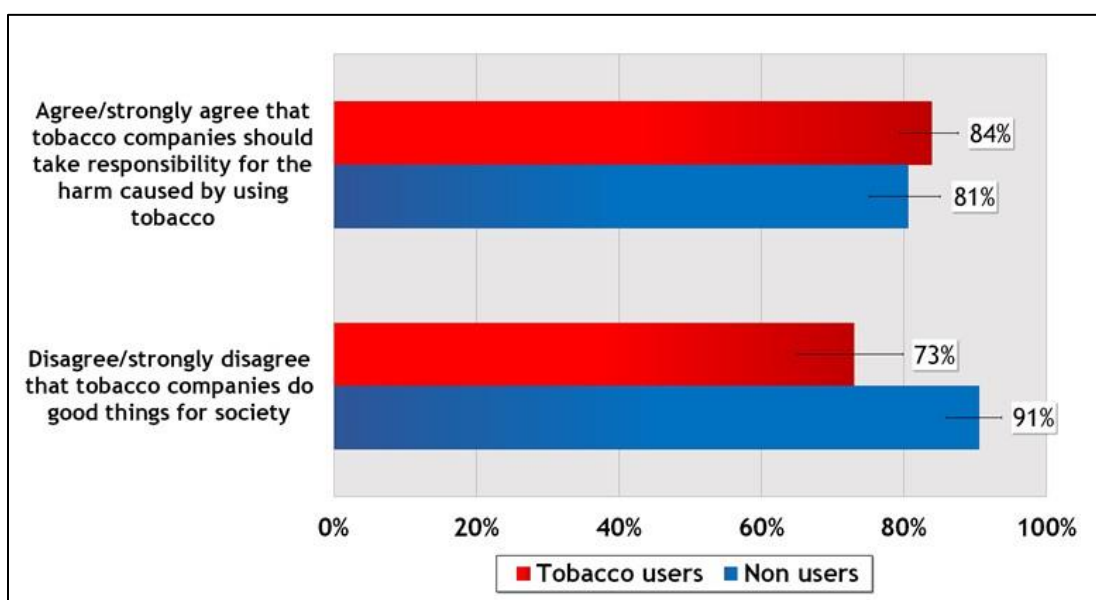
In recent years, the use of e-cigarettes has become increasingly popular in many HICs across North America and Europe. E-cigarettes, also known as electronic nicotine delivery systems (ENDS), are battery-operated devices that vaporize different concentrations of nicotine, flavourings, vegetable glycerine and/or propylene glycol, and other chemicals into a mist, which can then be inhaled in the same manner as regular cigarettes. While a growing number of countries have introduced legislation to regulate the sale and use of e-cigarettes, Kenya does not have any policies regulating e-cigarettes. Currently, rates of e-cigarette use in Kenya are still low in comparison to rates of use in HICs but gaining popularity.

The ITC Kenya Wave 2 Survey asked several questions to assess awareness, use, and beliefs about e-cigarettes. Findings showed very low levels of awareness and use of e-cigarettes in Kenya in 2018. Only 2% of tobacco users and 0.4% of non-users said they had ever heard of e-cigarettes, and less than 2% had ever used one. Among those who have heard of e-cigarettes (n=20), only 24% said they thought e-cigarettes are less harmful than regular cigarettes and 32% said they thought e-cigarettes are less addictive. A minority of respondents (15%) said they think it is socially acceptable to use e-cigarettes, while 35% said it is unacceptable and 50% had no opinion.ⁱⁱⁱ

5.7 Opinions about Tobacco Companies

As shown in Figure 7, tobacco users and non-users in Kenya have a negative opinion overall of tobacco companies. At Wave 2, the majority of both tobacco users (84%) and non-users (81%) “agreed” or “strongly agreed” that tobacco companies should take responsibility for the harm caused by using tobacco. Similarly, the majority of respondents “disagreed” or “strongly disagreed” that tobacco companies do good things for society, although non-users had a more negative opinion than tobacco users (91% vs. 73%).

Figure 7: Tobacco users’ and non-users’ opinions about tobacco companies at Wave 2 (2018)



5.8 Support for Government Action

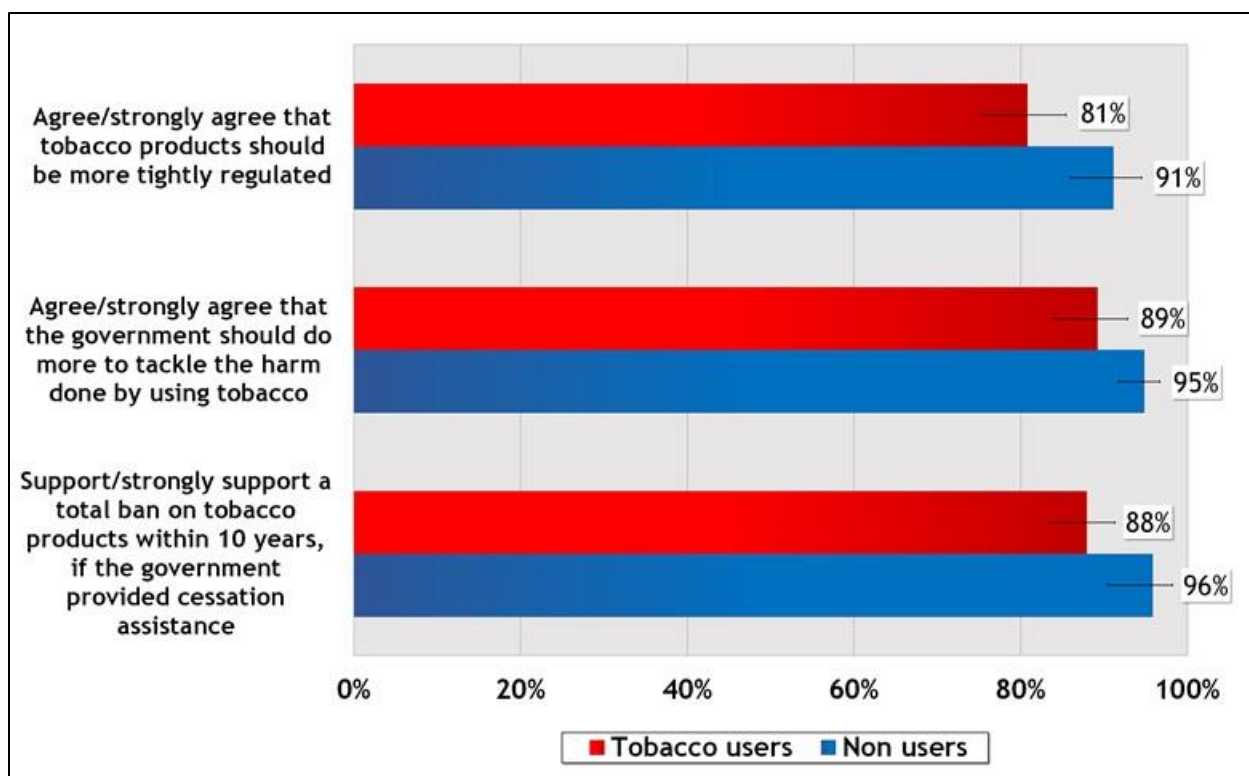
It is important to note that the vast majority of tobacco users themselves support stronger action on tobacco control by the Government of Kenya. The Wave 2 findings demonstrate that the strong majority of both tobacco users (89%) and non-users (95%) “agreed” or “strongly agreed” that the government should do more to tackle the harm done by using tobacco (see Figure 8). In addition,

ⁱⁱⁱ Note: these results are based on a small sample of respondents who had heard of e-cigarettes and were able to answer questions about these products. Due to the small sample size, the results are unadjusted.

over three-quarters (81%) of tobacco users and 91% of non-users “agreed” or “strongly agreed” that tobacco products should be more tightly regulated.

The survey also asked tobacco users and non-users whether they would support a total ban on tobacco products in 10 years, if the government provided assistance to help smokers quit, such as cessation clinics. Overall, almost all respondents (94%) at Wave 2 said they would “support” or “strongly support” this policy measure – an increase from Wave 1 (91%). As shown in Figure 8, support was higher among non-users than tobacco users at Wave 2 (96% vs. 88%).

Figure 8: Tobacco users’ and non-users’ opinions about government responsibility at Wave 2 (2018)



5.9 Conclusions

The Wave 2 results show that cigarette smoking remains a significant threat to Kenyans’ health, as most tobacco users were cigarette smokers, and smoking is perceived to be more socially acceptable in Kenya compared to other ITC countries. The findings suggest that although most tobacco users have negative perceptions of tobacco companies and express regret for using tobacco, there is a need to increase efforts to denormalize tobacco use in Kenya and to reduce misperceptions of the harm of various tobacco products, such as smokeless tobacco and menthol cigarettes. While the use of e-cigarettes is currently quite low in Kenya, it should be monitored and regulated as the popularity of such products may rise if they become more accessible to consumers, and as manufacturers expand global promotion efforts. The findings also indicate that the vast majority of both tobacco users and non-users are supportive of stronger tobacco control measures by the Government.

6. TOBACCO CESSATION

6.1 Background

Article 14 of the FCTC obligates Parties to take effective measures to promote cessation of tobacco use and provide adequate treatment for tobacco dependence. Access to effective tobacco dependence treatment interventions is critical to improve cessation outcomes among smokers and reduce tobacco-related harms.

Guidelines for Article 14 state that treatment should be widely available, accessible, and affordable and recommend a broad range of cessation interventions including population-based approaches with wide reach (mass communication, brief advice from health care providers, and quitlines) as well as more intensive individual approaches (specialized treatment services like behavioural support and medications). While these interventions work best in combination, a “stepwise approach” is also recommended in countries where resources to implement a comprehensive cessation strategy are more limited.¹

Cessation efforts were identified as a priority for tobacco control in Kenya under the 2007 TCA and tobacco dependence treatment was included as part of the 2010-2015 National Tobacco Control Action Plan.¹⁵ In 2017, Kenya developed National Guidelines for tobacco dependence, treatment and cessation, however, the Guidelines have not been implemented widely. A comprehensive cessation program has not yet been developed and systematic cessation services are lacking.¹⁶ According to the 2019 *WHO report on the global tobacco epidemic*, 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.¹⁷ Nicotine replacement therapies (NRT) are available from private pharmacies in Kenya without a prescription, and bupropion is available with prescriptions. However, these medications are not covered by the national health insurance, and many smokers cannot afford them. Kenya has one 24-hour drug helpline established in 2012 by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), but it is not well-known.¹⁶

The ITC Kenya Wave 1-2 Surveys collected information on tobacco users’ intentions to quit, past quit attempts, and reasons to quit tobacco use. The Surveys also assess tobacco users’ experiences with and effectiveness of cessation services.

6.2 Quit Intentions and Quit Attempts

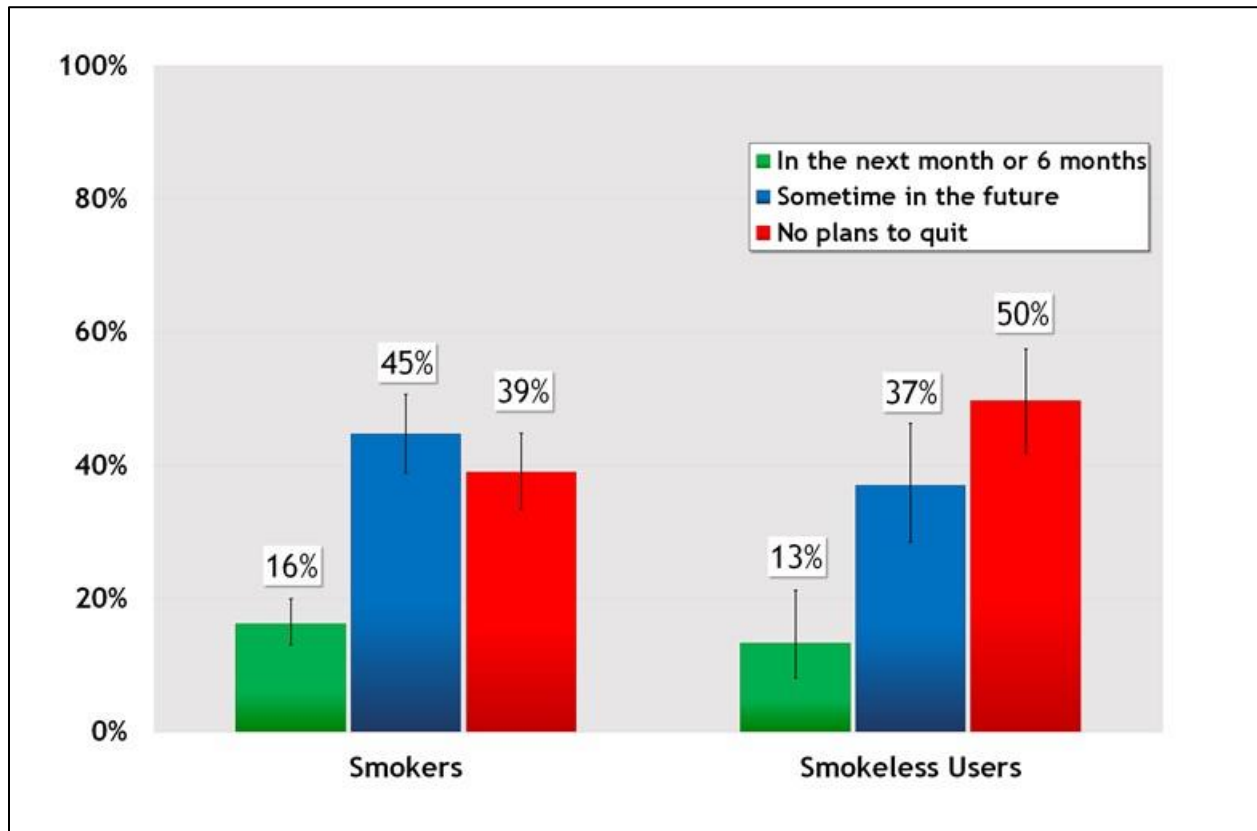
ITC research from other countries has shown that past quit attempts and quit intentions are important predictors of future quit attempts as well as success in quitting.^{18,19} The ITC Kenya Wave 2 Survey asked smokers and smokeless users about their previous quit attempts, whether they currently plan to quit, and in what timeframe.

6.2.1 Smokers

The Wave 2 findings showed that a minority of smokers had made quit attempts in the past. Only 39% of smokers (vs. 39% at Wave 1) reported that they had ever made a serious attempt to stop smoking cigarettes.

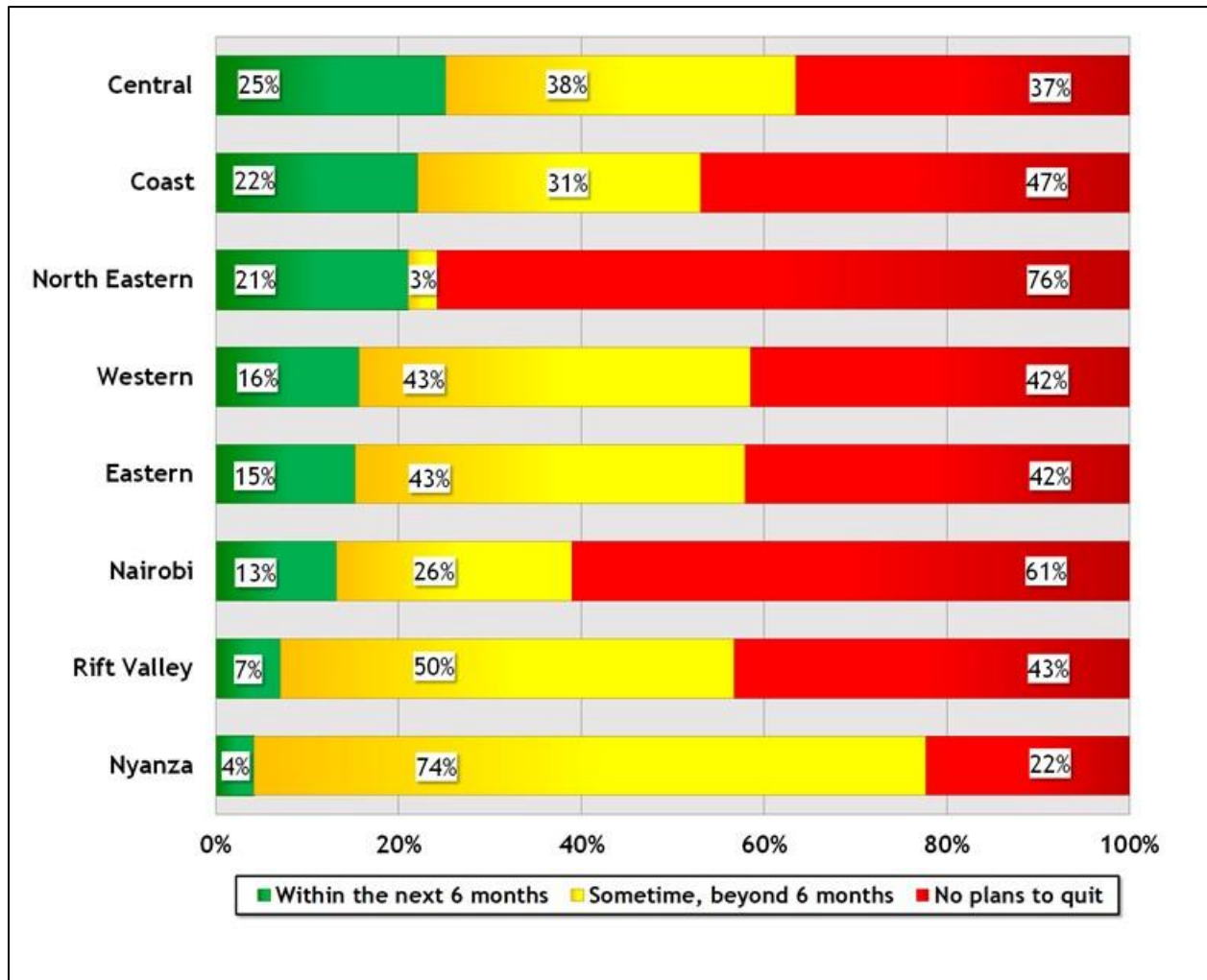
In addition, only 16% of smokers at Wave 2 (vs. 15% at Wave 1) said they plan to quit smoking within the next month or next 6 months, while 45% (vs. 50% at Wave 1) said they plan to quit “sometime in the future” (see Figure 9). It is concerning that over one-third of smokers (39%) said they have no plans to quit smoking at Wave 2 (vs. 35% at Wave 1).

Figure 9: Intentions to quit among smokers and smokeless users at Wave 2 (2018)



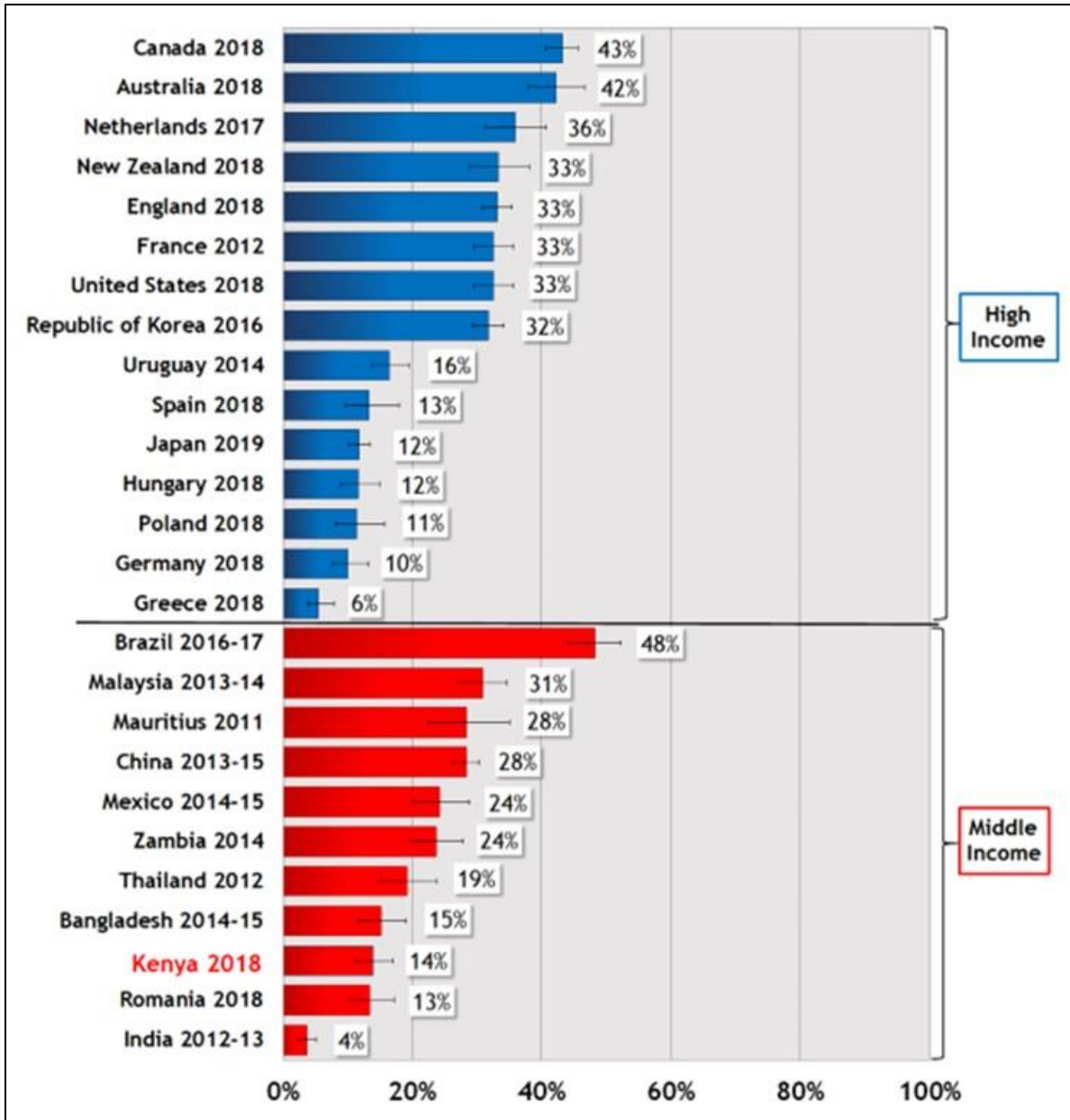
However, there was large variation in quit intentions across regions. The percentage of smokers who plan to quit in the next month or 6 months ranged from only 4% in Nyanza to 25% in Central province (see Figure 10).

Figure 10: Percentage of smokers who plan to quit smoking in the next 6 months, sometime in the future, or not at all at Wave 2 (2018), by province



ITC cross-country comparisons also indicate that the percentage of smokers in Kenya who plan to quit is low compared to other countries. Kenya has the third-lowest percentage of smokers (14%) who plan to quit within the next 6 months among 11 ITC LMICs, and the seventh-lowest overall among 26 countries (see Figure 11).

Figure 11: Percentage of smokers who plan to quit smoking in the next month or next 6 months, by country



6.2.2 Smokeless users

Compared to smokers, smokeless users were less likely to have made a previous quit attempt and more likely to have no plans to quit. Less than one-third (29%, vs. 23% at Wave 1) of smokeless users had ever made a serious attempt to stop using all smokeless tobacco products.

Even fewer smokeless users at Wave 2 said they plan to quit smokeless use in the next month or 6 months (13%, vs. 11% at Wave 1), while 37% (vs. 40% at Wave 1) planned to quit

sometime in the future, and half (50%) had no plans to quit (vs. 49% at Wave 1). Male smokeless users were more likely to plan to quit in the next month/6 months than females (12% vs. 7%), while females were more likely to plan to quit “sometime in the future” (40% vs. 33%).^{iv}

6.3 Reasons to Think about Quitting

The ITC Kenya Wave 2 Survey asked all tobacco users which of several reasons have led them to think about quitting smoking or smokeless tobacco use, regardless of whether they reported having specific plans to quit.

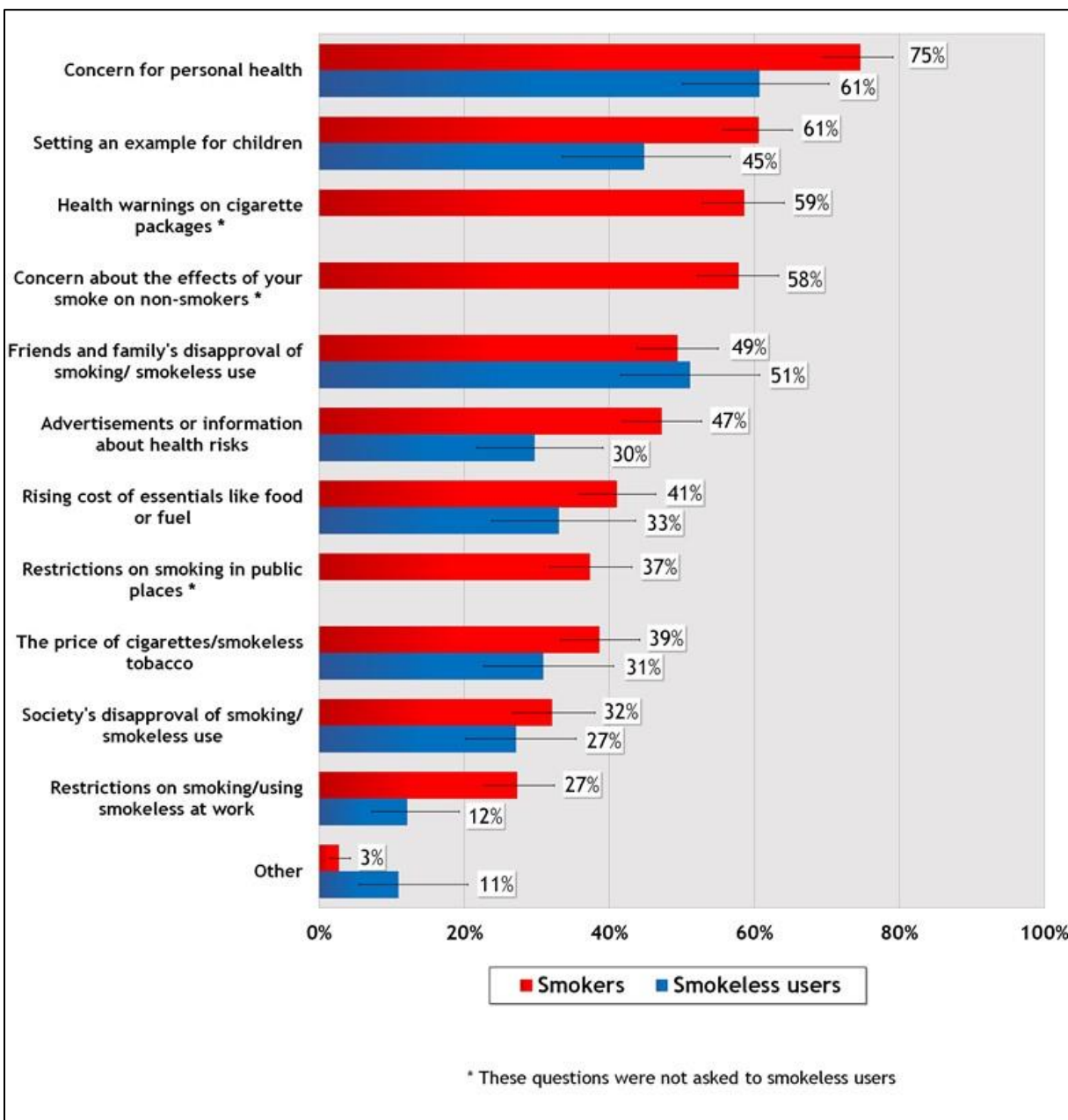
Among all smokers, the most commonly mentioned reasons for thinking about quitting were related to concerns about health effects and the impact of smoking on others such as family. As shown in Figure 3, three-quarters of smokers (75%) said that concern for personal health led them to think about quitting; about two-thirds (61%) cited setting an example for children and health warnings on cigarette packages as reasons; and over half cited concern about the effects of their smoke on non-smokers (58%) and friends and family’s disapproval of their smoking (49%).

Other than health warnings, less than half of smokers cited other policy-relevant factors, such as anti-tobacco information, smoking restrictions in public places and workplaces, and cigarette prices as reasons for thinking about quitting. This represents a potential missed opportunity for motivating more Kenyan smokers to quit through effective tobacco control measures, as international evidence shows that such policies (i.e. larger pictorial health warnings, comprehensive smoke-free laws, and tax increases that raise the price of tobacco products) are among the most effective strategies to reduce smoking prevalence and encourage quitting.

The most common reasons for thinking about quitting among smokeless users at Wave 2 were similar to smokers: concern for personal health (61%), friends and family’s disapproval (51%), and setting an example for children (45%) (see Figure 12).

^{iv} Note that due to small sample sizes, it was not possible to examine differences in intentions to quit among smokeless users across provinces.

Figure 12: Percentage of smokers and smokeless users who said that various reasons led them to think about quitting at Wave 2 (2018)



6.4 Availability and Use of Cessation Services

6.4.1 Advice to quit from health providers

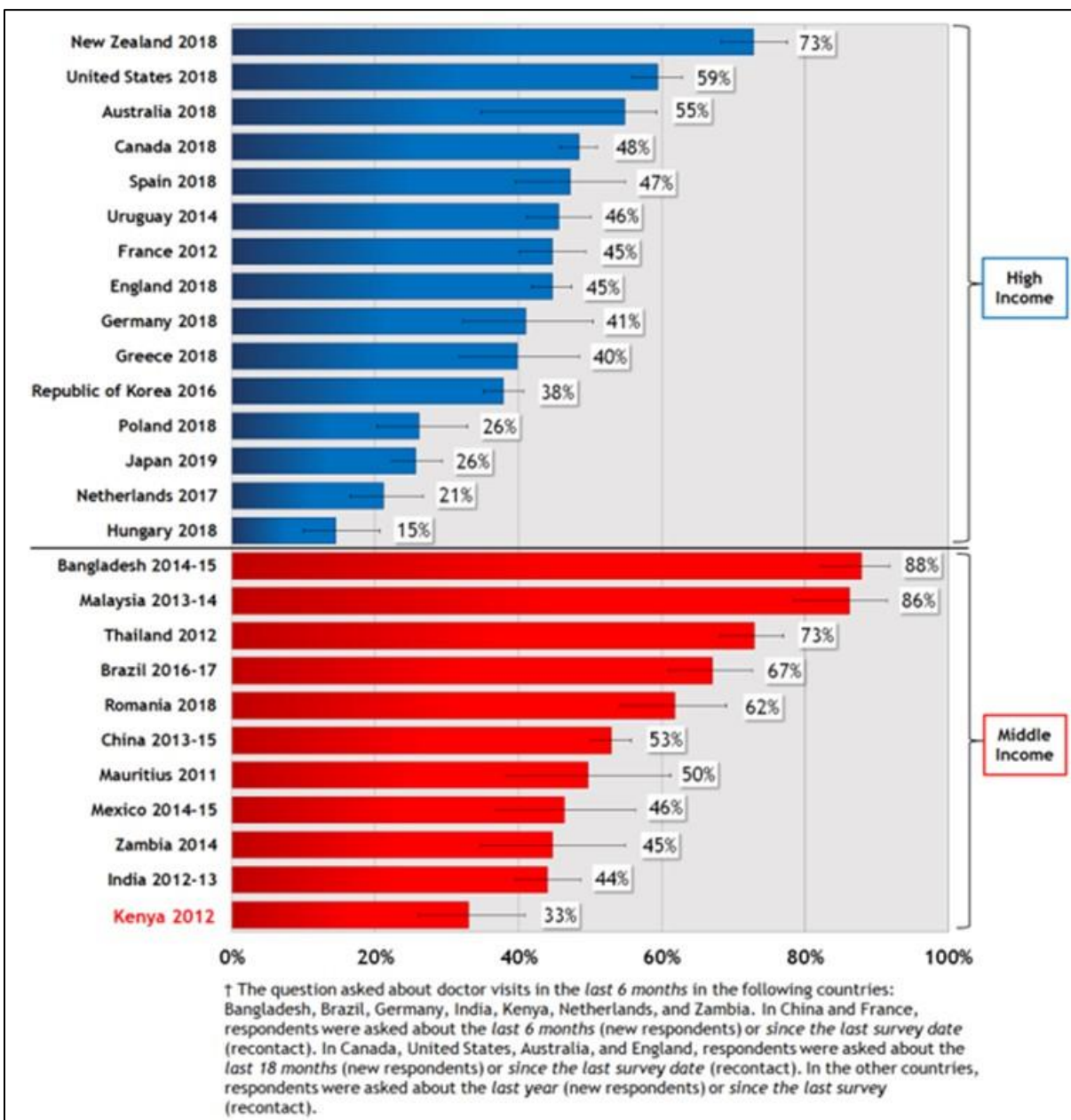
Doctors in some LMICs including Kenya often lack formal training on cessation strategies and do not routinely provide advice to smokers on how to quit.^{20,21} The ITC Kenya Survey evaluated the provision of cessation advice from health providers by asking tobacco users who had visited a doctor or other health professional in the last 6 months if they received various types of support for smoking cessation during any visit.

At Wave 2, about one quarter of all tobacco users (23%, vs. 21% at Wave 1) reported that they had visited a doctor or health provider in the last 6 months. Among those who had visited a doctor, only about one-third (37%, vs. 35% at Wave 1) were given advice to quit all tobacco products.

Research evidence shows that advice from health professionals can help smokers to quit, and that even brief simple advice can increase cessation rates by 1% to 3%.²² The ITC Kenya Wave 2 findings support previous research showing that advice to quit from a physician or health professional is a powerful motivator for quitting. While only one-third of tobacco users received advice to quit, almost all (93%) of those who received advice reported that this advice made them think about quitting – an increase from Wave 1 (76%).

Comparisons with other ITC countries further demonstrate the need to enhance the provision of cessation advice from health providers in Kenya. As shown in Figure 13, Kenya has the lowest percentage of smokers (33%) who reported receiving advice to quit from a doctor among 11 LMICs. In many other countries, over half of smokers who visited a doctor received advice to quit. 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.

Figure 13: Percentage of smokers who received advice to quit smoking by a doctor or health professional, among those who visited a doctor, by country



6.4.2 Other cessation assistance

Few tobacco users reported receiving other types of cessation assistance at Wave 2. Only 14% of tobacco users who had visited a doctor in the last 6 months reported receiving pamphlets or brochures on how to quit (vs. 3% at Wave 1) and more than half (56%) received additional help or a referral to another service to help them quit tobacco (vs. 3% at Wave 1).

In addition, only 4% of tobacco users at each wave reported that they received advice or information about quitting from telephone or quitline services in the last 6 months.

These findings suggest that tobacco users in Kenya are receiving referral cessation assistance that they need to successfully quit tobacco use, and in addition, interventions such as increased physician training and enhanced quitline services are needed to improve quit outcomes.

6.5 Conclusion

The ITC Kenya Wave 2 findings show that most tobacco users in Kenya have no immediate plans to quit and have never made a quit attempt. The percentage of smokers in Kenya who plan to quit is lower than in most other ITC LMICs, and even fewer smokeless users plan to quit. In addition, only about one-third of tobacco users who visited a doctor or health provider received advice to quit – the lowest percentage among 11 ITC LMICs. These findings highlight the urgent need to strengthen policies to motivate quitting among tobacco users in Kenya and to enhance access to population-level, affordable cessation services to support those who want to quit, as recommended by the WHO FCTC Article 14 guidelines

7. PACKAGING AND LABELLING OF TOBACCO PRODUCTS

7.1 Background

Article 11 of the WHO FCTC requires Parties to implement large, visible, rotating health warnings on tobacco product packaging within 3 years of entry into force of the Treaty (by February 2008 for Kenya). Guidelines for the implementation of Article 11, adopted in November 2008, call for warnings that include full-colour pictures covering at least 50% (and no less than 30%) of the top of the front and back (or on all main faces if there are more than two) of the package, in the country's principal language(s).

There is strong global evidence that large pictorial health warnings on tobacco packages that align with the FCTC guidelines reduce tobacco consumption, increase cessation, and raise awareness about the harms of tobacco use.^{23,24}

Health warnings on tobacco packages were required in Kenya under the 2007 Tobacco Control Act, which came into effect in July 2008 (just after the 3-year timeline for implementation). However, the warnings did not meet the minimum requirements of the FCTC, as they were text-only and covered less than 50% of the principal display areas of the package (30% front, 50% back). In December 2014, the Ministry of Health tabled a new set of regulations to the Act which included a set of 15 rotating pictorial health warnings (PHWs) on packages of smoked and smokeless tobacco, with no change to the warning size. The new regulations were to be implemented in June 2015 but were suspended prior to this date due to a legal challenge by British American Tobacco (BAT). After two more legal challenges in the Court of Appeals and Supreme Court, the tobacco industry was finally defeated in November 2019 and the 2014 regulations were upheld. Furthermore, three of the proposed warnings were released on cigarette packs (but not smokeless packs) in September 2016 in the midst of the legal battle, thus some of the PHWs were in circulation prior to the ITC Kenya Wave 2 Survey in 2018.

While the change from text-only to pictorial health warnings is an important step, the current PHWs still do not meet the size recommendation of the Article 11 Guidelines of at least 50% of both sides of the pack.

7.2 Implementation of Health Warnings in Kenya



Kenya has implemented two rounds of health warnings in 2008 and 2016 as described below:

- **July 2008 (Round 1 Warnings):** Provisions of the 2007 Tobacco Control Act were implemented, requiring text warnings on 30% of the front of tobacco packs (in English) and 50% of the back (in Kiswahili), on the lower portion of the package. The Act required the word "WARNING" to appear in capital letters and the rest of the message to be printed in size 17-point font. Each pack was required to display two warning labels of the same health message, in both English and Kiswahili, rotated through a 12 month period (with a total of 13 different warnings for both smoked and smokeless tobacco products).

- September 2016 (Round 2 Warnings):** In December 2014, the “Tobacco Control Regulations, 2014” were gazetted, including 15 new full-colour pictorial health warnings covering 30% of the front and 50% of the back of smoked and smokeless tobacco packages. The warnings on each side include both an image and a text message starting with the word “WARNING”, with the message on the front appearing in English (in white font on a black background), and the message on the back appearing in Kiswahili (in black font on a white background). The regulations were to be implemented in six months’ time, by June 2015, but were suspended due to a legal challenge from BAT, which claimed that the regulations were unconstitutional. After an initial High Court ruling that the warnings could come into force in September 2016, manufacturers began printing three of the proposed warnings on cigarette packs. The 3 warning messages with pictorials in circulation were:
 - Tobacco use causes cancer^v
 - Tobacco use causes mouth cancer (includes smokeless tobacco products)
 - Tobacco use causes impotence

After hearing the case brought by BAT in November 2019, the Supreme Court ruled against the tobacco company and upheld the 2014 regulations. However, as of October 2020, the remaining 12 PHWs had not yet been implemented on tobacco packs.

Figure 14: Health warnings in Kenya, 2008-present

Round 1 Warnings (July 2008 to September 2016)	Round 2 Warnings (September 2016 – present)
	
Text-only on 30% of the front (English) and 50% of the back (Kiswahili)	Pictorial and text on 30% of the front (English) and 50% of the back (Kiswahili)

^v Note: the regulations included two proposed PHWs with the same message “Tobacco use causes cancer”. The image that appeared on packs was of a woman with neck cancer.

7.3 Impact of Cigarette Health Warnings

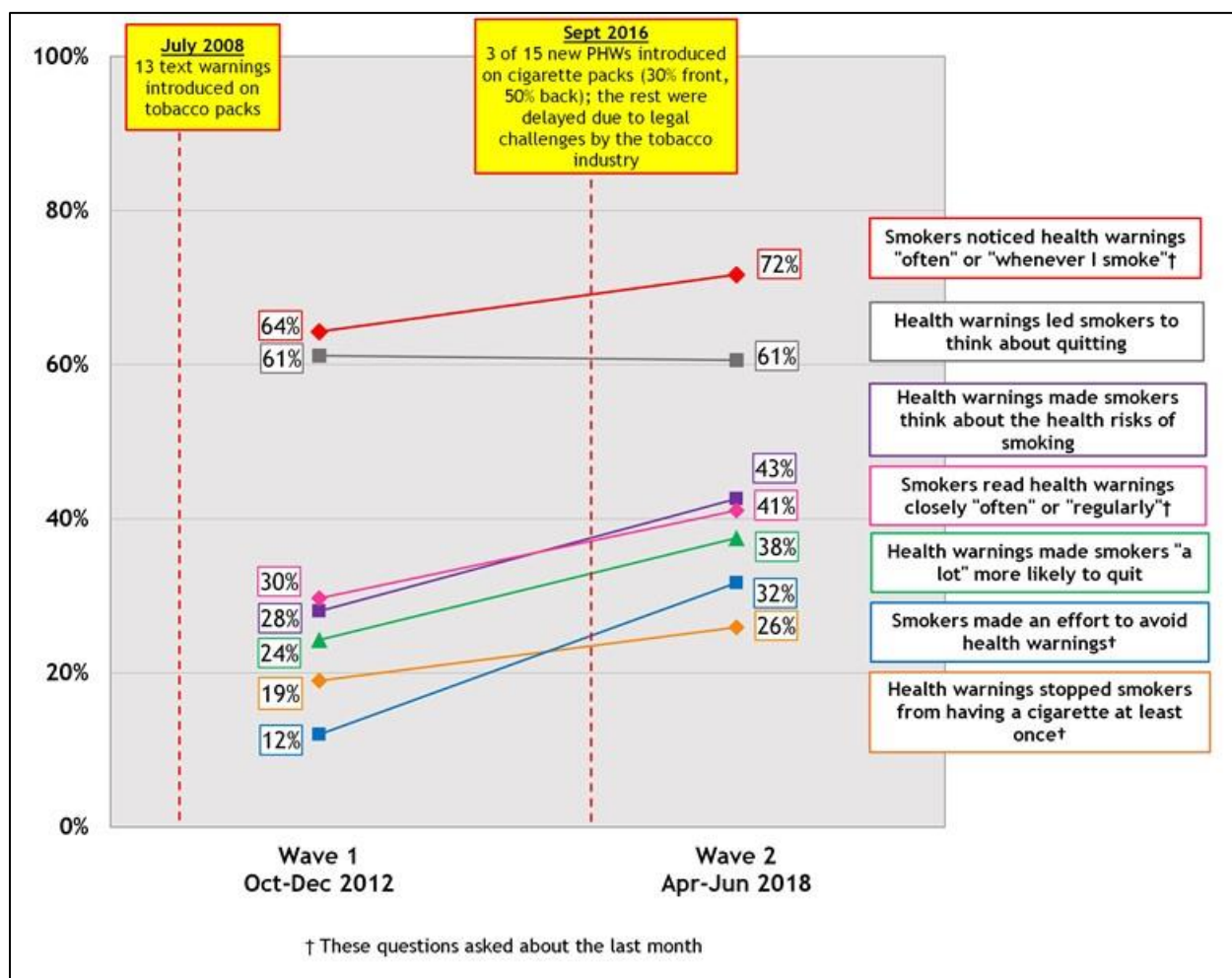
The ITC Kenya Wave 1-2 Surveys include a broad set of questions to assess the effectiveness of health warnings that were on tobacco packages at the time of each survey wave. The Wave 1 findings demonstrate the weak impact of the text-only warnings that had been in place on cigarette packages since 2008. Data from Wave 2 (2018) was used to evaluate the change from text to pictorial health warnings on cigarette packs in September 2016. As the new PHWs had not been implemented on smokeless tobacco packages by the time of the Wave 2 Survey, the Wave 2 findings can be used to compare the impact of the PHWs on cigarette packs to the text-only warnings that remained on smokeless packs.

Figure 15 shows the trends in impact of the cigarette health warnings on smokers' cognitions and behaviours over time.^{vi} Awareness of the new health warnings on cigarette packages is fairly high among Kenyan smokers, with 72% of smokers at Wave 2 stating that in the last month, they noticed health warnings on cigarette packs "often" or "whenever I smoke" (compared to 64% at Wave 1). The salience of the health warnings on cigarette packs was lower among non-smokers – only about one-quarter (25%) of non-smokers (including smokeless users and non-tobacco users) noticed the warnings "often" in the last month at Wave 2.

The Wave 1-2 findings suggest that the introduction of new health warnings on cigarette packages had a positive impact on smokers' cognitions and behaviours (see Figure 15). For example, the percentage of smokers who said they read or looked closely at the warnings "often" or "regularly" in the last month increased from about one-third of smokers at Wave 1 (30%) to 41% of smokers at Wave 2. In addition, there was an increase in the percentage of smokers who thought about the health risks of smoking "a lot" because of the health warnings (from 28% to 43%), and who said that health warnings made them "a lot" more likely to quit (from 24% to 38%). The percentage of smokers who reported avoiding the health warnings in the last month also increased from 12% to 32%. It is important to note that greater avoidance of health warnings is an indication of the effectiveness of the warnings, as evidence from population-based surveys has shown that avoidance of warnings has a positive impact on quit attempts.²⁵ In addition, almost two-thirds of smokers (61%) at each wave said that health warnings on cigarette packages had led them to think about quitting. However, only one-quarter (26%) of smokers reported that the warnings stopped them from having a cigarette (vs. 19% at Wave 1).

^{vi} Note: At Wave 1, there was an additional question that first asked whether respondents were aware of the warnings, and if they answered no, they skipped all subsequent questions about the warnings. In order to make the data between the two waves comparable, those who answered no to this question at Wave 1 were included in the denominator for all other questions.

Figure 15: Impact of health warnings on cigarette packages among smokers in Kenya, by wave

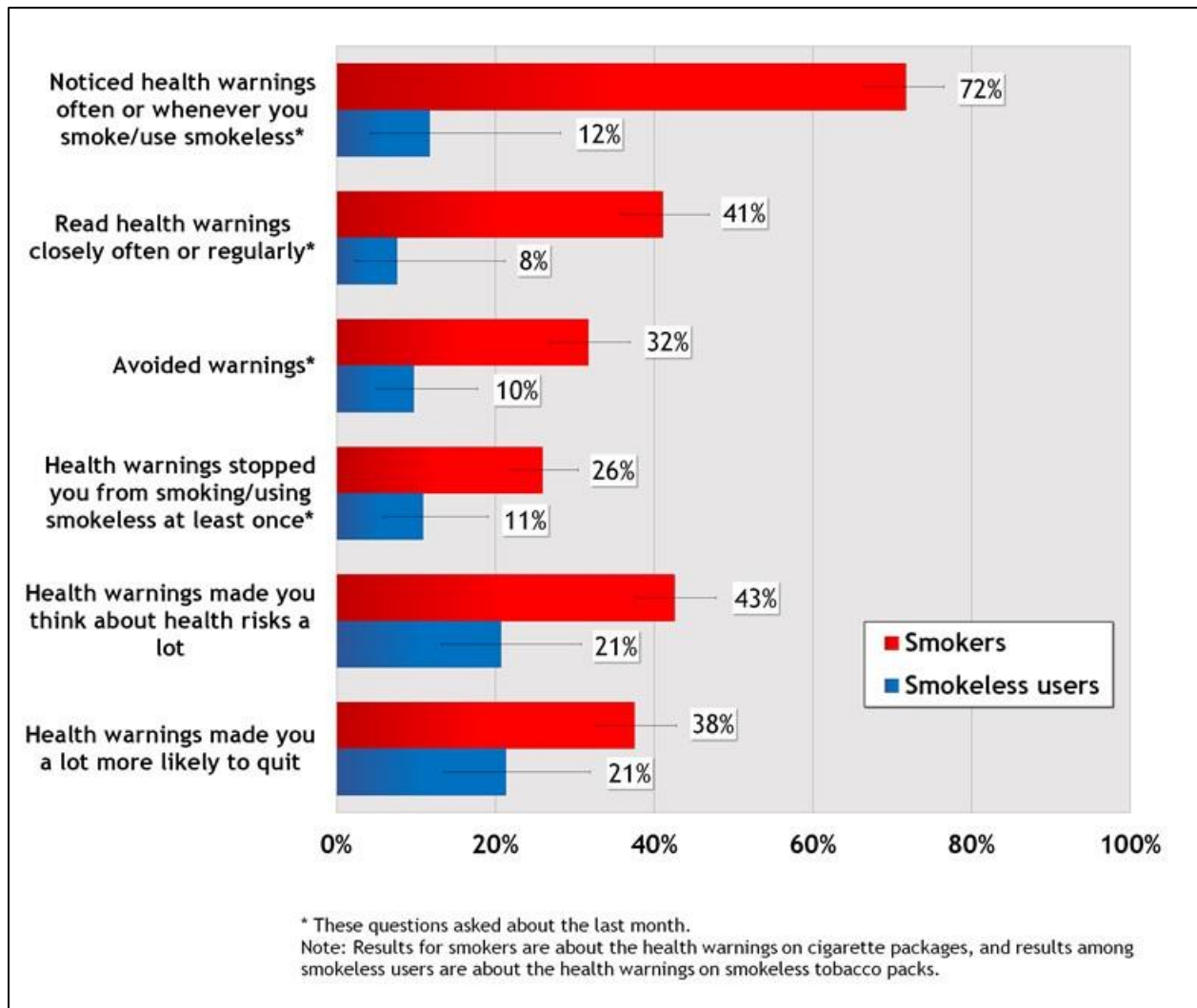


The ITC Kenya Wave 2 findings also demonstrate the greater impact of the PHWs on cigarette packages compared to text warnings that appeared on smokeless packs at the same time. As shown in Figure 16, each of the measures of impact of the health warnings was greater among smokers than smokeless users in 2018. For example, only 12% of smokeless users reported noticing warnings on smokeless tobacco packages “often” or “whenever I use smokeless” in the last month (vs. 72% of smokers). The PHWs on cigarette packs also had a much stronger impact on behavioural measures such as avoiding the warnings (32% of smokers vs. 10% of smokeless users) and giving up a cigarette/smokeless product because of the warnings (26% of smokers vs. 11% of smokeless users). Finally, the PHWs were more likely to make smokers think about the health risks of smoking “a lot” (43%, vs. 21% of smokeless users) and to report being “a lot” more likely to quit (38% vs. 21%) compared to the text warnings on smokeless products.

However, it should be noted that the low levels of salience and other measures of impact of the smokeless warnings may also partly be due to the fact that that most smokeless tobacco in Kenya is sold in loose form instead of packaged (which is more likely for imported smokeless

tobacco), and thus does not have any health warnings at all. In addition, the implementation of pictorial warnings on smokeless tobacco packages has lagged behind that of cigarettes such that most packages do not yet have pictorial warnings.

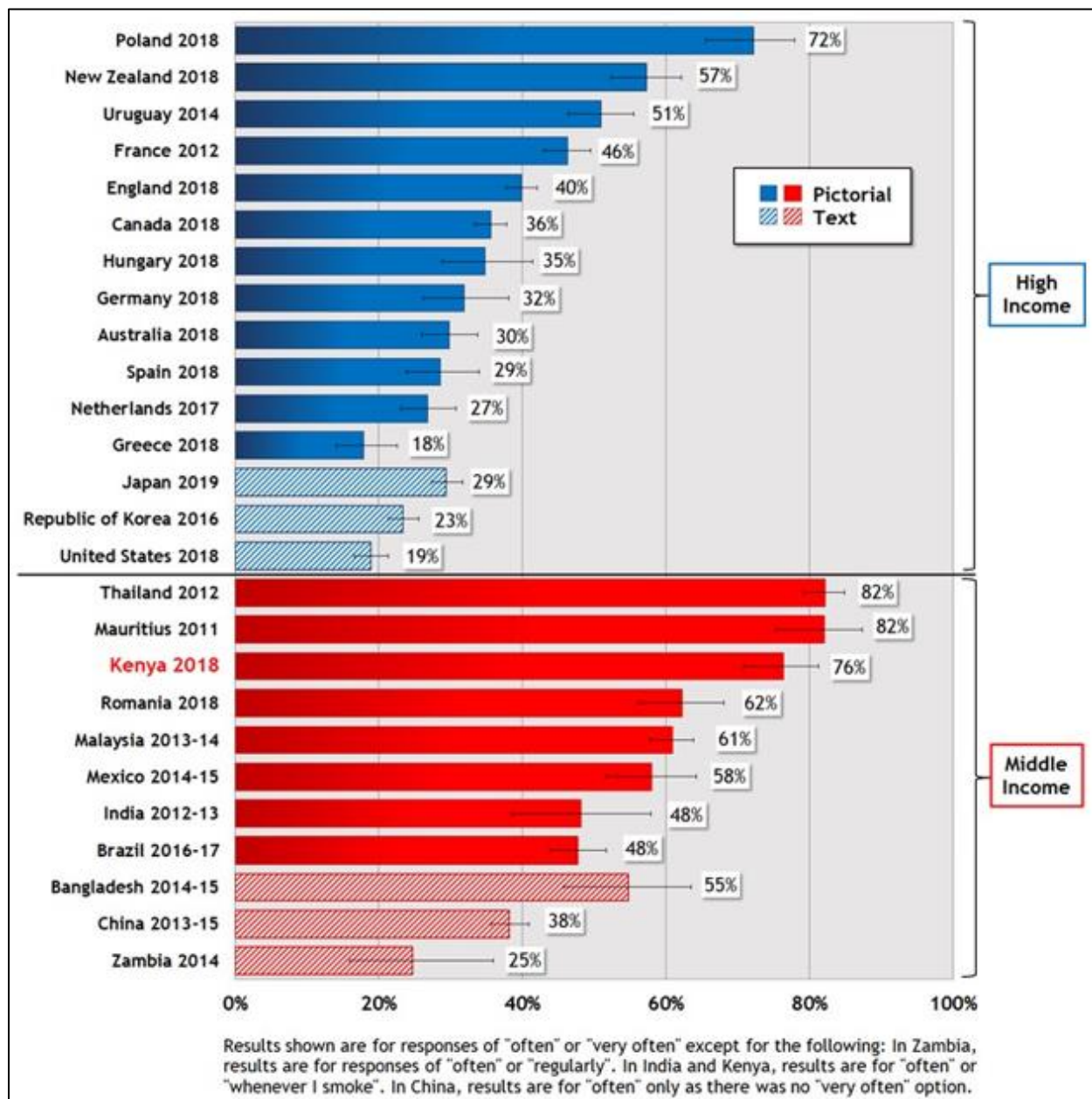
Figure 16: Impact of health warnings on cigarette vs. smokeless tobacco packs at Wave 2 (2018)



These findings are consistent with ITC results from other countries demonstrating the effectiveness of large PHWs compared to text warnings. For example, after Malaysia replaced text warnings with pictorial warnings on 40% of the front and 60% of the back of packs in 2009, there were greater increases in almost every measure of warning impact compared to China, where only text warnings were implemented over the same period.²⁶ Similarly, after Mauritius became the first African country to implement pictorial warnings in 2009 covering 60% of the front and 70% of the back of packs, there was a pronounced increase in all indicators of warning effectiveness, including salience, cognitive and behavioural reactions among smokers.²⁷

ITC cross-country comparisons also demonstrate that Kenya’s health warnings are noticed fairly often compared to health warnings in other countries. Kenya has the third highest percentage of smokers (76%) among all 26 ITC countries who noticed the warnings on cigarette packs “often” or “very often/whenever I smoke” in the last month (see Figure 17). The salience of Kenya’s new PHWs is much greater than text-only warnings in other LMICs such as Bangladesh, China, and Zambia – where only 25-55% of smokers noticed the warnings often.

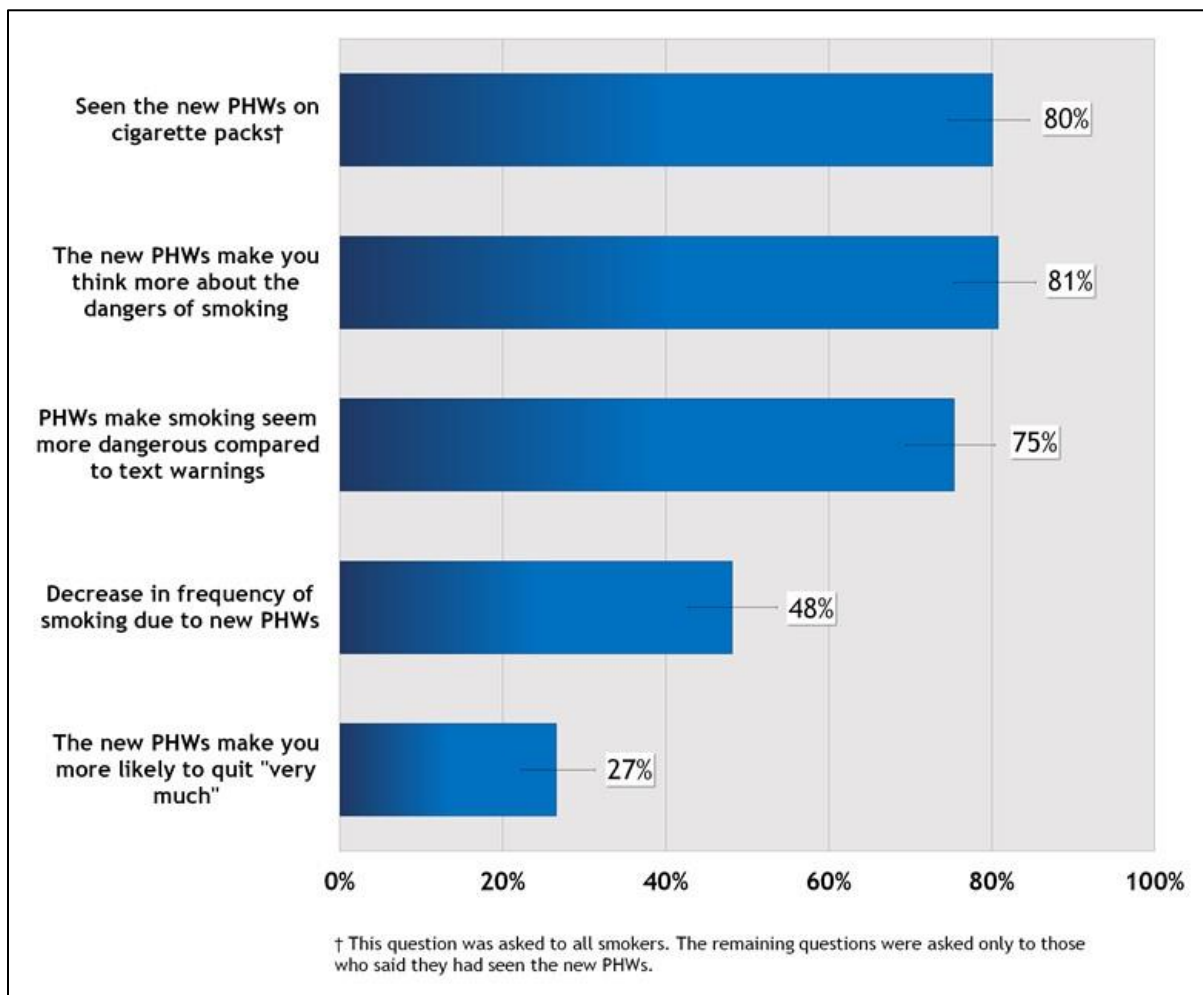
Figure 17: Percentage of smokers who noticed warning labels on cigarette packages “often” or “very often” in the last month, by country



7.4 Other Measures of PHW Impact

The ITC Kenya Wave 2 Survey included several new measures to evaluate the PHWs that began to appear on cigarette packs starting in September 2016. The findings showed a strong impact of the new health warnings on increasing smokers' awareness of the harms of smoking. The majority of smokers (80%) reported seeing the new PHWs on cigarette packs, and over three-quarters of those respondents who noticed the new PHWs reported that the warnings made smoking seem more dangerous than text-only warnings (75%) and that the warnings made them think more about the dangers of smoking (81%) (see Figure 18). In addition, almost half of smokers who noticed the new PHWs (48%) reported reducing their frequency of smoking because of the warnings, and over one-quarter (27%) said the new PHWs made them "very much" more likely to quit.

Figure 18: Impact of the new PHWs on smokers at Wave 2 (2018)



Smokers at Wave 2 were also asked to show their current cigarette pack if they had one as an additional measure to evaluate implementation of the new PHWs. The results showed that implementation of the new warnings on cigarette packs was strong - of those smokers who had a cigarette pack with them at the time of the survey (n=111), almost all packs shown (92%) had

one of the new PHWs, compared to a text-only warning (6%) or no health warning (2%). This suggests that by the time of the Wave 2 Survey in 2018, the majority of the old text warnings had successfully been phased out.

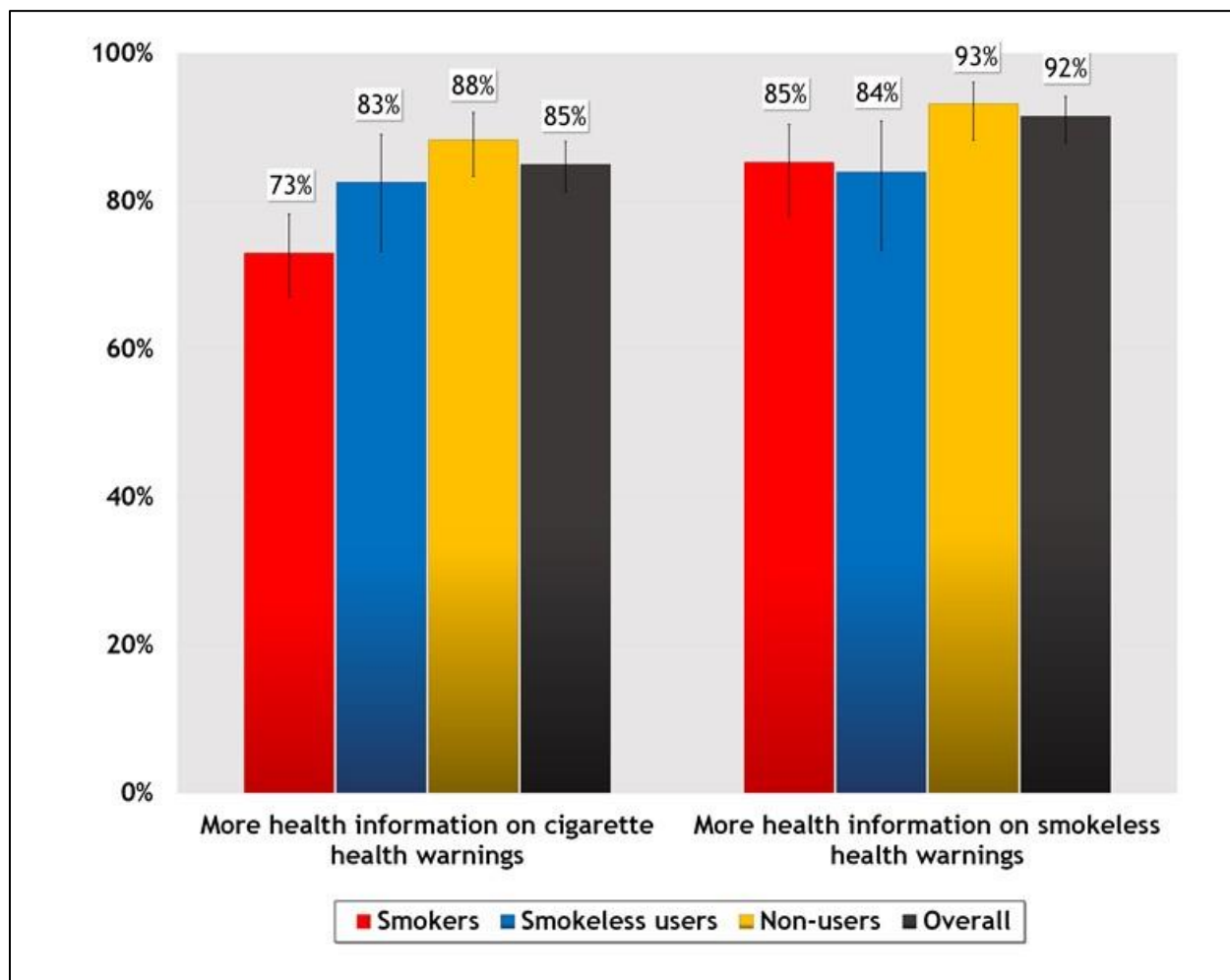
7.5 Support for Enhanced Health Warnings

The ITC Kenya Survey asked all respondents whether they think there should be more health information, less health information, or the same amount on cigarette and smokeless tobacco packages. The findings show that even after the new PHWs were introduced in 2016, the majority of respondents at Wave 2 still think there should be more health information on tobacco packages, demonstrating high levels of support for enhanced health warnings that meet the Article 11 Guidelines on all tobacco packages in Kenya.

Figure 19 shows the levels of support for enhanced health warnings at Wave 2 among each user type. There is strong support for more health information on all packs, particularly on smokeless tobacco packages – which had only text warnings in place (or no health warnings at all for traditional, loose forms of smokeless tobacco). Overall, 85% of respondents said there should be more health information on cigarette packages and 92% of respondents said there should be more health information on smokeless packs.^{vii} Support for stronger health warnings was higher among non-users overall compared to tobacco users at Wave 2. Smokeless users were also more likely to want more health information on cigarette packs than smokers.

^{vii} Note that comparisons on this measure between Waves 1 and 2 were not possible due to differences in the filters at Wave 1, which resulted in different denominators for the samples across the two waves.

Figure 19: Percentage of respondents who think there should be more health information on cigarette and smokeless tobacco packages at Wave 2 (2018), by user type



7.6 Impact of Warnings on Health Knowledge

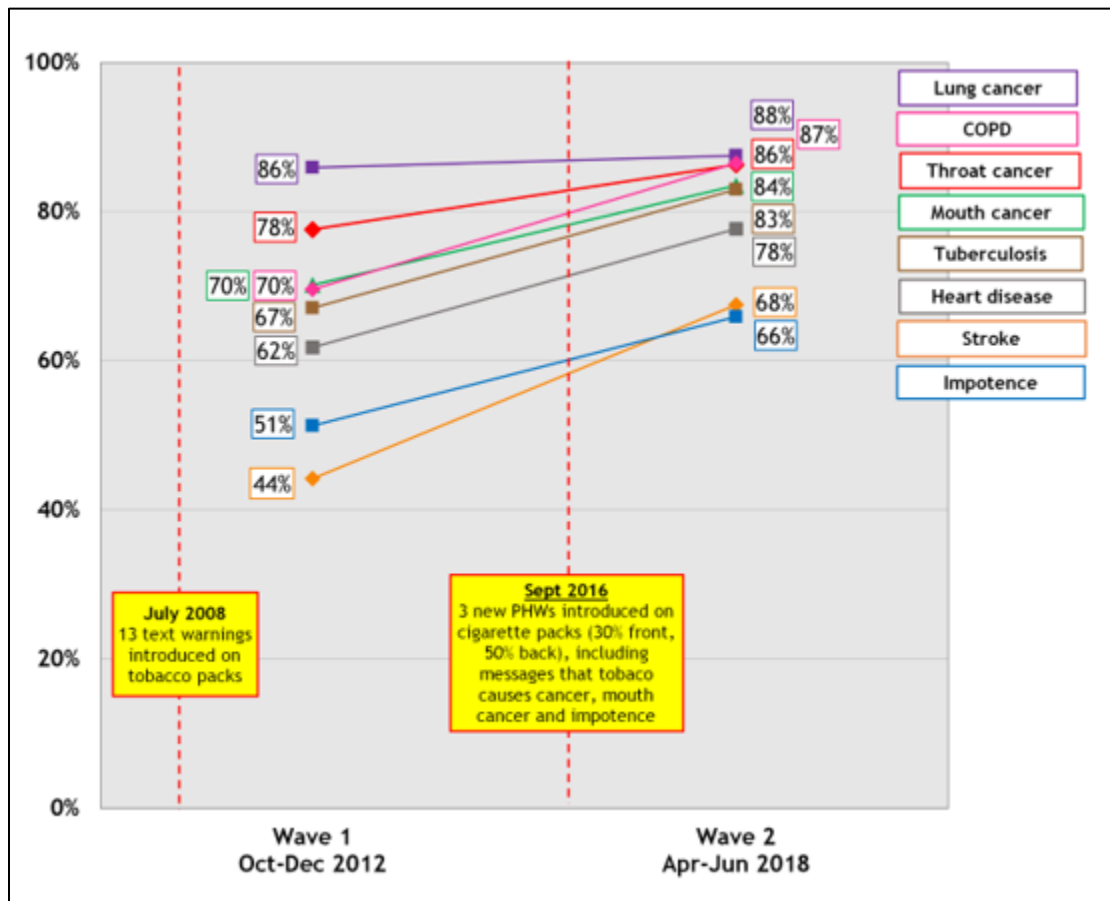
Health warnings on tobacco packages are an important and cost-effective strategy for reducing tobacco use and increasing awareness of the harms of tobacco – especially for those with lower SES and lower literacy levels. Greater awareness of the health risks has been shown to be strongly associated with smoking and quitting behaviour.^{28,29,30}

Of the three new PHWs that were introduced in September 2016, two included messages specific to certain health risks posed by tobacco use – mouth cancer (also for smokeless tobacco) and impotence, while the third PHW was more general (tobacco use causes cancer). The ITC Kenya Survey assesses the level of awareness for a range of health risks associated with tobacco use, which can be used to evaluate any potential impact of the new warnings on knowledge of these two health effects between the two survey waves.

The Wave 1-2 findings indicate that knowledge that tobacco use causes mouth cancer and impotence did increase among smokers from 2012 to 2018, as shown in Figure 20. The

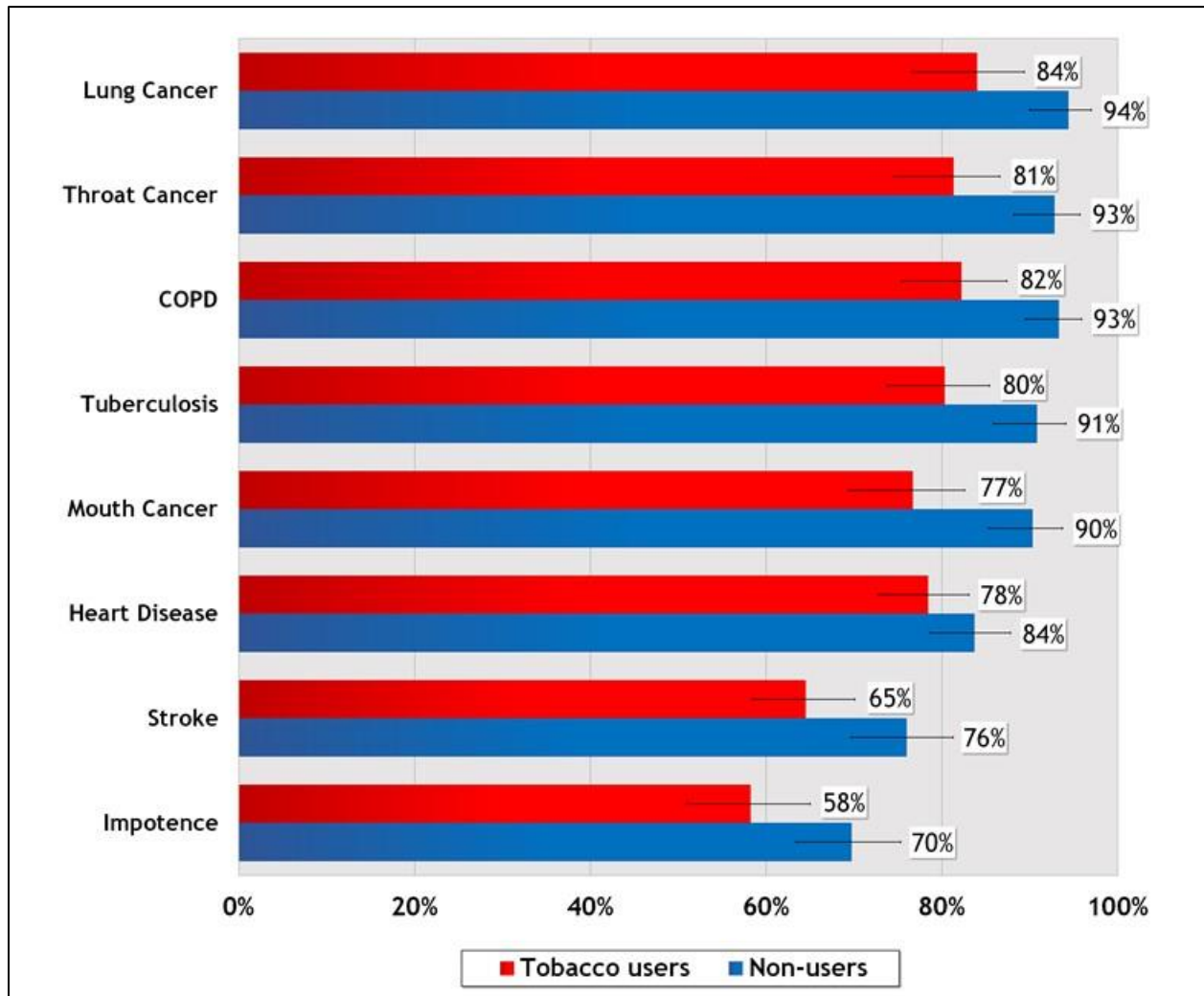
percentage of smokers who believed that smoking causes impotence increased from 51% to 66%, and the percentage of smokers who believed that smoking causes mouth cancer increased from 70% to 84%. Knowledge increased among both tobacco users and non-users, but was higher among non-users at Wave 2 for each health effect (see Figure 21).

Figure 20: Percentage of smokers who know or believe that smoking causes various health effects, by wave



While the PHWs may have contributed to the increase in awareness that smoking causes mouth cancer and impotence, the findings indicate that awareness among all respondents also increased significantly for all other health effects caused by both smoking and smokeless tobacco use from Waves 1 to 2 (except for lung cancer). Therefore, there may have been other factors associated with the overall increase in knowledge in Kenya over this period besides the warnings, such as public education efforts and mass media campaigns – including a four-month national campaign launched by the Ministry of Health (with technical support from the World Lung Foundation) in December 2014. This campaign, called “Tobacco Kills – Quit Now!”, aimed to raise awareness among Kenyans about the harmful effects of smoking and particularly the harms of secondhand smoke to the unborn, babies and young children; and to encourage smokers to heed the country’s smoke-free laws and to quit smoking.³¹

Figure 21: Percentage of tobacco users vs. non-users who know or believe that smoking causes various health effects at Wave 2 (2018)



7.7 Conclusion

Findings from the ITC Kenya Wave 1-2 Surveys show significant improvement in some measures of the impact of health warnings on cigarette packages approximately two years after three of the full set of 15 legislated PHWs were introduced (in September 2016). The impact appeared to be greater on measures of salience and cognitive impact of the warnings than on behavioural measures that could lead to quitting. There was also an increase in knowledge of the health effects caused by tobacco among all respondents between 2012 and 2018. However, the Wave 2 findings also show that the majority of respondents support even stronger warnings that include more health information on packs. These findings suggest that full implementation of the regulations including the release of all 15 rotating PHWs on smoked and smokeless tobacco packages would have an even stronger impact on behavioural measures that could lead to successful quitting.

8. SMOKE-FREE POLICIES

8.1 Background

Article 8 of the WHO FCTC calls on Parties to adopt effective measures to protect the public from exposure to tobacco smoke. Guidelines for Article 8, adopted in 2007, recommend a comprehensive ban on smoking in indoor public places, workplaces, public transport, and other public places as appropriate without exceptions within 5 years after entry into force of the Convention (by 2010 for Kenya).

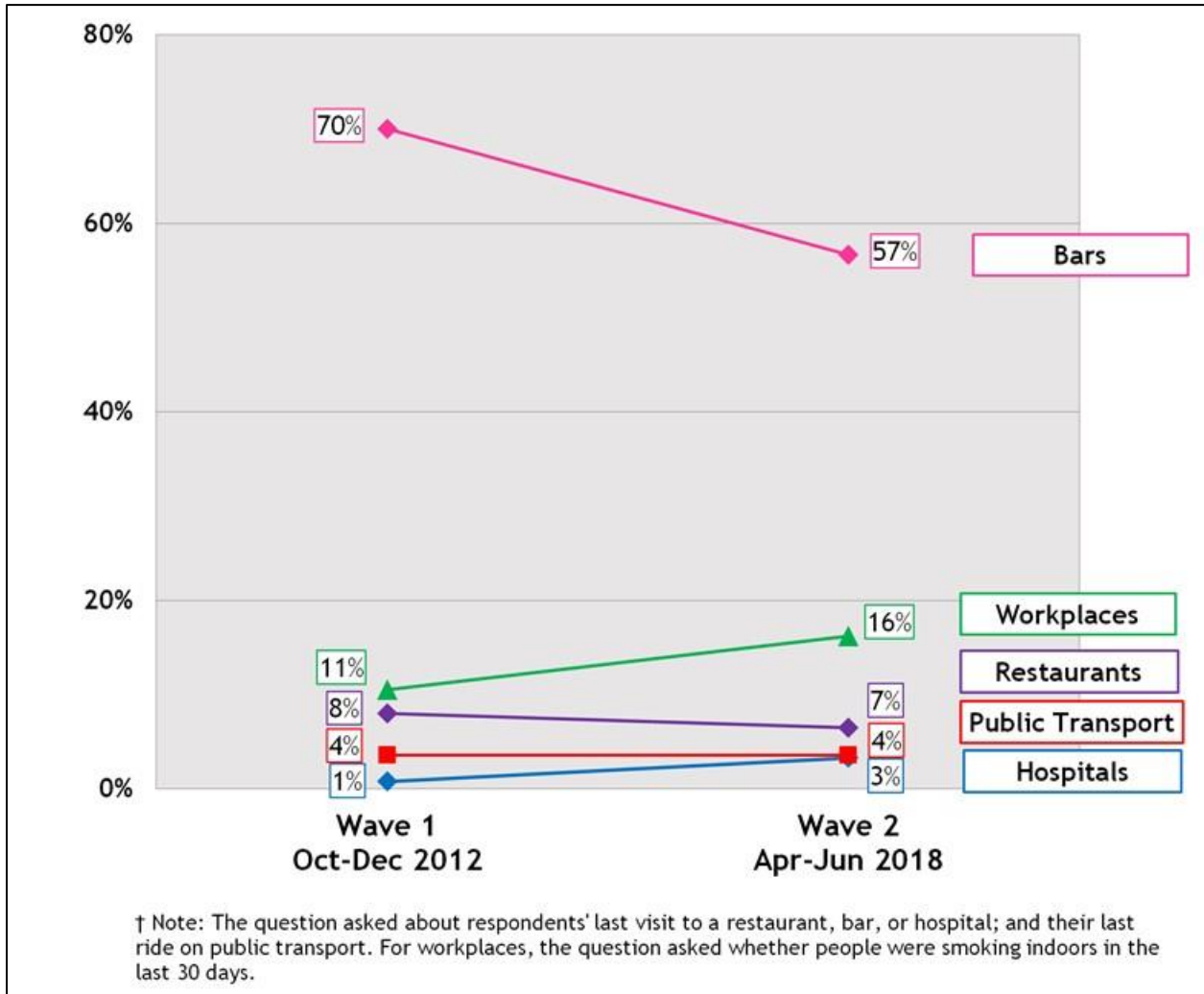
In Kenya, smoking is prohibited in all public places and workplaces under the 2007 Tobacco Control Act (TCA), except in specially designated smoking areas. Because of this provision for designated smoking areas, the law is not fully compliant with Article 8 Guidelines, which recommend 100% smoke-free public places. New regulations to strengthen smoke-free legislation were introduced under the 2014 Tobacco Control Regulations, including a ban on smoking in cars with children, a ban on smoking on streets/walkways near public places, and a certificate of compliance required for designated smoking areas. However, Kenya has not yet implemented a comprehensive national smoke-free law.

8.2 Smoking in Public Places

The ITC Kenya Waves 1-2 Surveys evaluate the effectiveness of existing partial smoke-free policies in public places by asking all respondents who have visited public places (i.e. restaurants, bars, hospitals) or used public transportation in their local area whether smoking is allowed inside, and by asking those who work inside a building what the smoking rules are inside their workplace. Tobacco users and non-users were also asked whether they noticed people smoking in public places the last time they visited these venues, or in the last month for workplaces.

The Wave 1 to 2 findings show that indoor smoking has remained low in some public places, such as hospitals and public transport, but smoking still occurs in other public places, especially bars (see Figure 22). These findings demonstrate the need for a comprehensive national smoking ban without exceptions.

Figure 22: Percentage of respondents who noticed people smoking in public places, among those who visited these places†, by wave

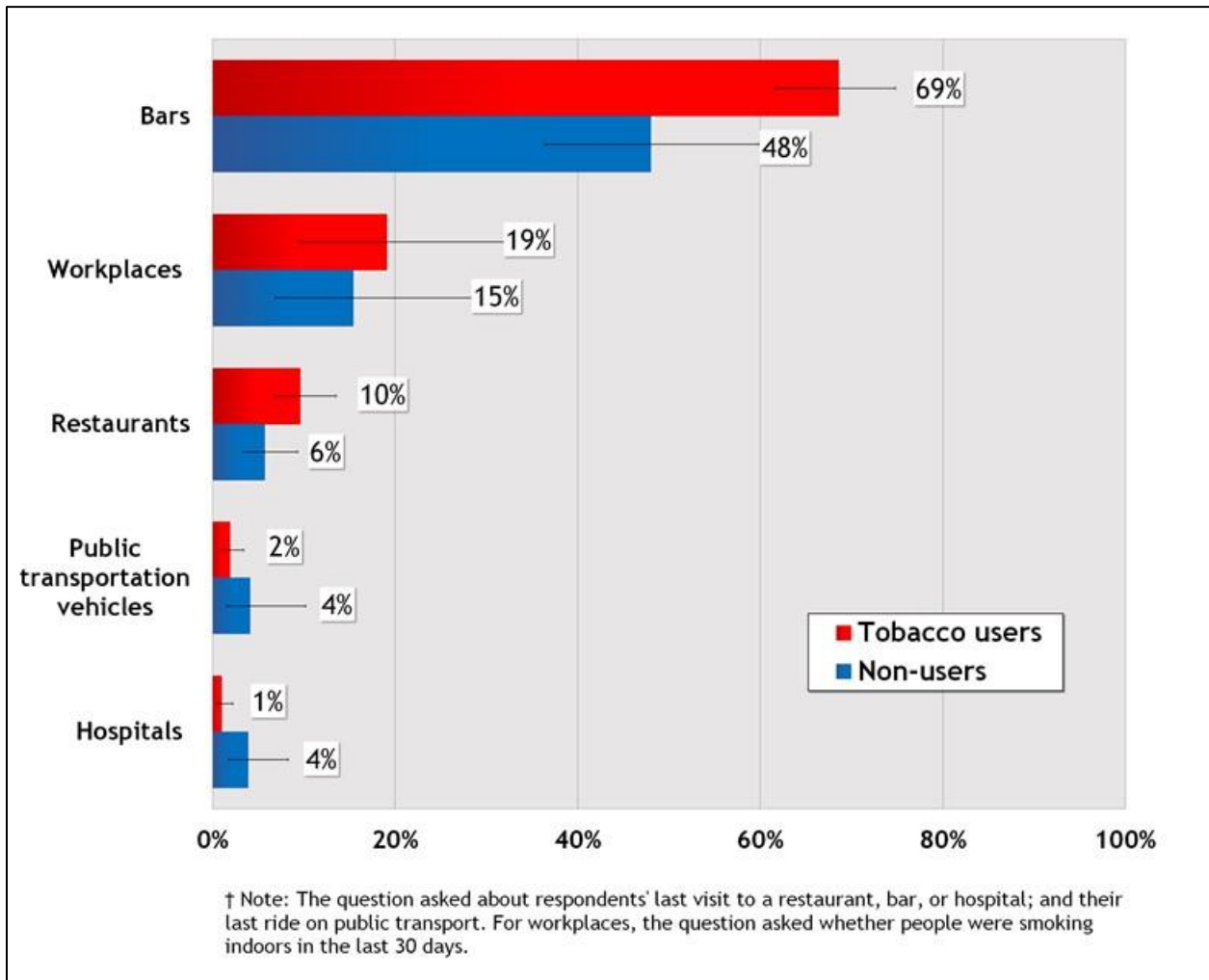


8.2.1 Smoking in Workplaces

The findings from the ITC Kenya Waves 1-2 Surveys show that the partial ban on smoking in workplaces under the 2007 TCA has not been effective, as many Kenyans who work indoors are still exposed to SHS in their workplaces, with no improvement since 2012.

Overall, the majority of the respondents who work indoors (85% at Wave 2 vs. 84% at Wave 1) stated that smoking was not allowed inside their workplace. Among those who worked inside a building (n=206 at Wave 2), the percentage of respondents who reported noticing people smoking in their workplace in the last month increased from 11% at Wave 1 to 16% at Wave 2, as shown in Figure 22. Almost one-fifth (19%) of tobacco users and 15% of non-users noticed people smoking at work at Wave 2 (see Figure 23).

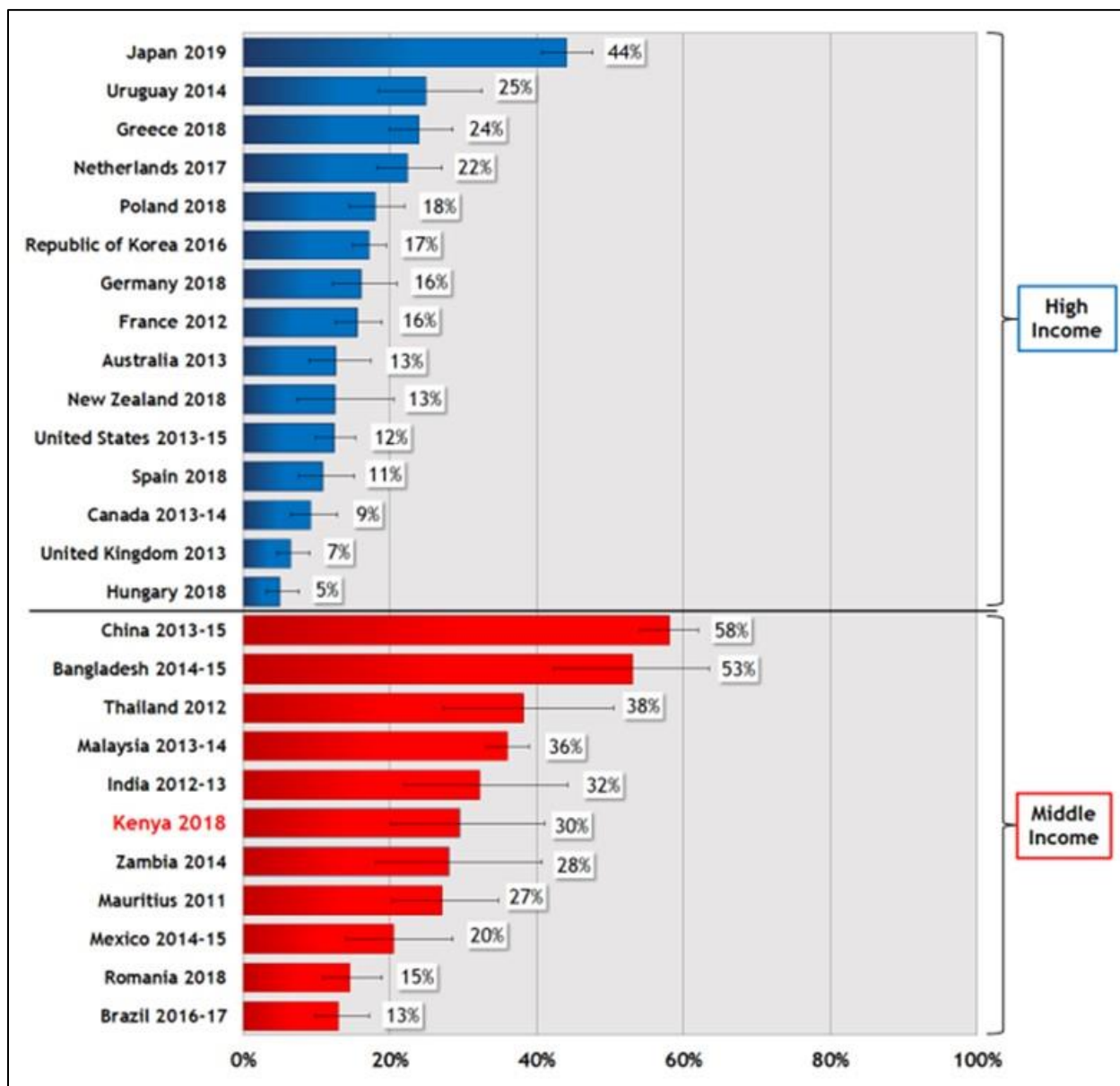
Figure 23: Percentage of tobacco users vs. non-users who noticed people smoking in public places, among those who visited these places at Wave 2 (2018)



In addition to the SHS exposure from other people smoking in the workplace, over one-quarter of smokers (28%) reported that they smoked inside their workplace in the last 30 days at Wave 2 (vs. 15% at Wave 1).

ITC cross-country comparisons show that Kenya falls in the middle of all LMICs in the level of smoking observed in workplaces. Among smokers who work indoors, Kenya has the sixth highest percentage (30%) who noticed people smoking in their workplace in the last month out of 11 LMICs (see Figure 24). In contrast, smoking in workplaces is lower in all HICs, with the exception of Japan (44%).

Figure 24: Percentage of smokers who noticed people smoking in their indoor workplace in the last 30 days, among those who work indoors, by country



8.2.2 Smoking in Bars

The ITC Kenya Wave 2 Survey found high exposure to SHS in bars, although there has been some progress since Wave 1, as demonstrated by the following findings. At Wave 2, less than half (41%) of all respondents who go to bars (n=991) stated that smoking was not allowed in any indoor areas of these venues, although the percentage of bars with a complete ban increased from Wave 1 (22%).

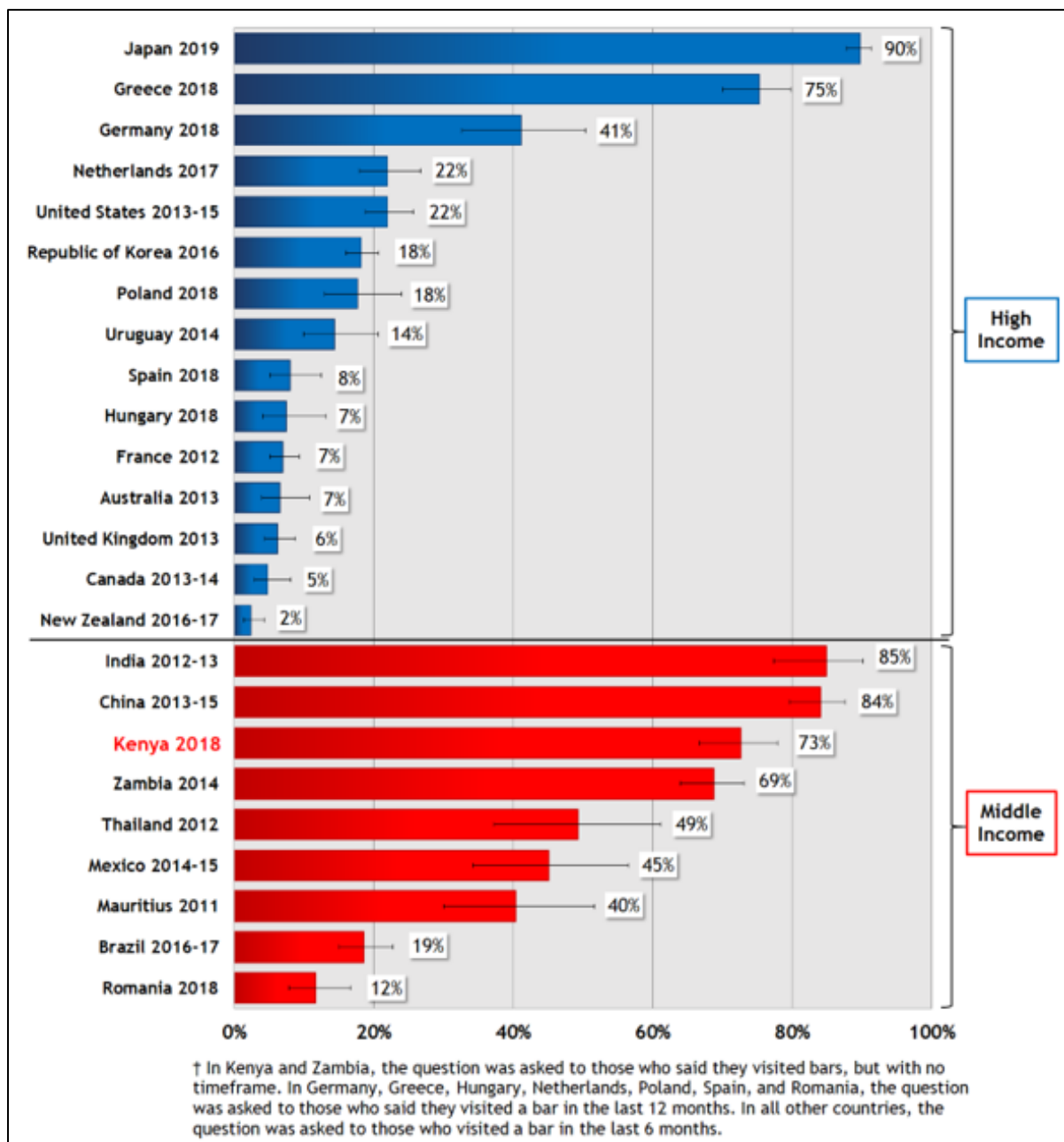
Bars had the highest prevalence of smoking compared to any other venue at Wave 2. Among all respondents who had visited a bar at Wave 2, 57% reported that they noticed people smoking

inside the bar during their last visit, although smoking in bars decreased from Wave 1 (70%), as shown in Figure 22. The majority of both tobacco users and non-users noticed smoking in bars at Wave 2, with higher levels reported by tobacco users (69% vs. 48%) (see Figure 23).

Additionally, about two-thirds (65%) of smokers at Wave 2 said that they smoked inside the bar during their last visit – a decrease from Wave 1 (76%).

While smoking in bars has decreased in Kenya since 2012, ITC cross-country comparisons show that Kenya still has a high level of smoking in bars compared to other countries. The percentage of smokers in Kenya who noticed people smoking inside the last time they visited a bar (73%) was the third highest percentage among 9 LMICs, and the fifth highest percentage overall among 24 ITC countries (see Figure 25).

Figure 25: Percentage of smokers who noticed people smoking in bars/pubs at their last visit, among those who visited a bar/pub, by country



8.2.3 Smoking in Restaurants

Public exposure to SHS in restaurants is low in Kenya. At Wave 2, the majority of the respondents who went to local restaurants (92%, vs. 89% at Wave 1) indicated that there is a complete ban on smoking inside these restaurants, despite the allowance under the TCA for designated smoking areas.

Among those respondents who visited restaurants at Wave 2 (n=1424), less than 10% of both tobacco users and non-users (7% overall, vs. 8% at Wave 1) reported that they noticed people smoking inside the restaurant during their last visit (see Figures 22 and 23).

In addition, there was no change in the percentage of smokers who reported that they smoked inside restaurants at their last visit (from 12% at Wave 1 to 8% at Wave 2).

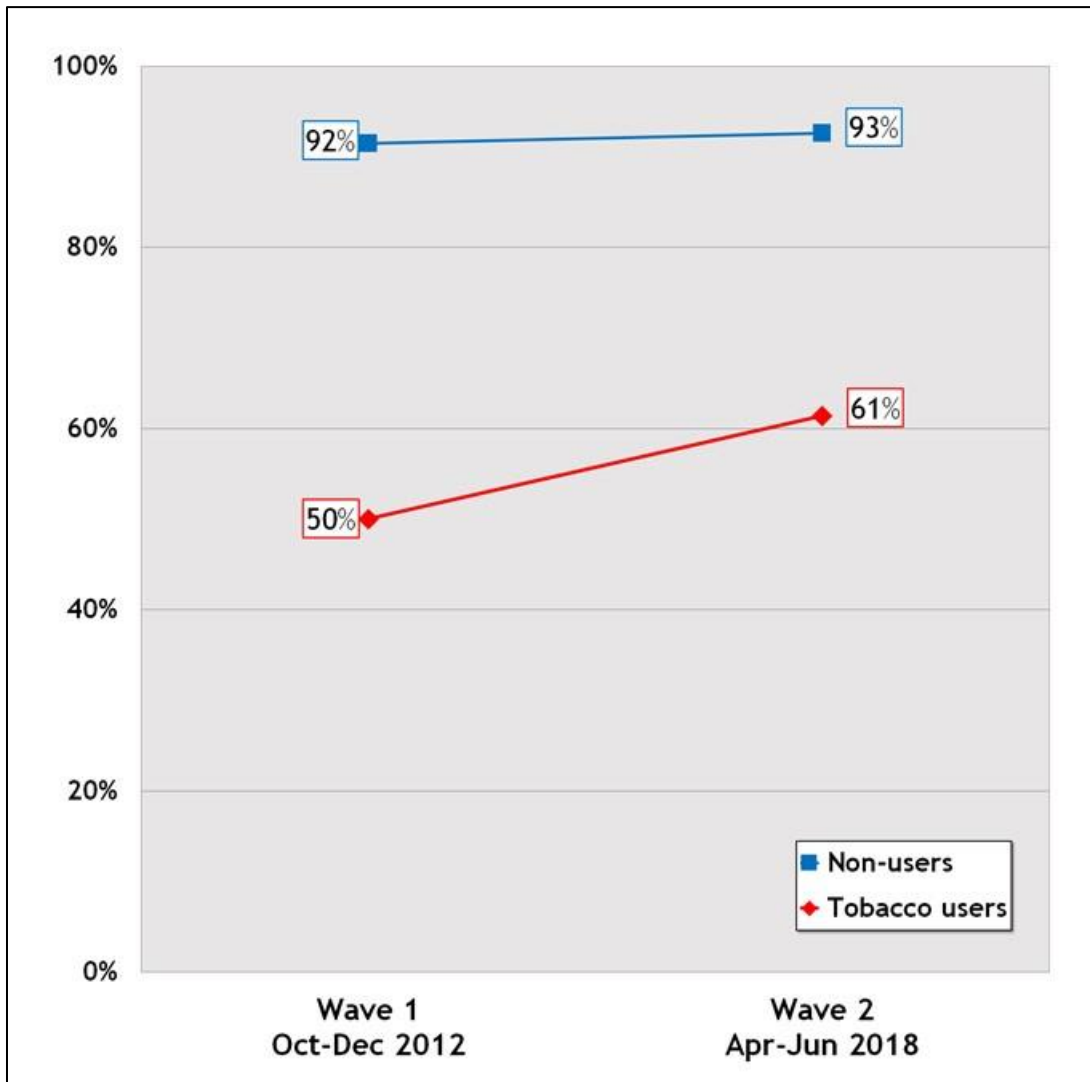
8.2.4 Smoking in Other Public Places

The ITC Kenya Wave 2 findings show strong compliance with indoor smoking bans in other public places, such as hospitals and educational institutions. Almost all respondents reported that smoking is not allowed on any public transport, such as buses, ferries, trains, and matatus (99% at both waves) or inside local hospitals (97% at Wave 2 vs. 99% at Wave 1). Accordingly, very few respondents reported noticing people smoking inside hospitals at their last visit (3% at Wave 2 vs. 1% at Wave 1), and only 4% of all respondents who used public transportation each wave (n=1613 at Wave 2) reported noticing people smoking inside a bus, ferry, train, or matatu during their last trip (see Figure 22). In addition, almost no tobacco users (less than 1% at Wave 1 and 2) reported that they smoked inside public transport on their last trip.

8.2.5 Smoking in the Home

In order to assess whether the implementation of smoke-free policies influences smoking in the home, respondents were also asked about rules on smoking in their home. The ITC Kenya Wave 2 Survey findings show that home smoking bans are common in Kenya – the majority of all respondents (86% at Wave 2, vs. 83% at Wave 1) reported that they have a complete ban on smoking inside their home. As shown in Figure 26, non-users were much more likely to have a home smoking ban compared to tobacco users (93% vs. 61% at Wave 2), but there was a greater increase in home smoking bans from 2012 to 2018 among tobacco users (from 50% to 61%).

Figure 26: Percentage of tobacco users and non-users who reported having a complete ban on smoking in their home, by wave



8.3 Public Support for Smoke-Free Laws

The ITC Kenya Survey assesses the level of support for smoke-free laws by asking tobacco users and non-users whether they think smoking should be allowed in each of several public venues. Figure 27 shows that support has remained high for smoking bans in most public places at Waves 1 and 2, and has increased over time for certain public indoor and outdoor places.

Figure 27: Percentage of respondents who think smoking should not be allowed in any indoor or outdoor areas of public places, by wave

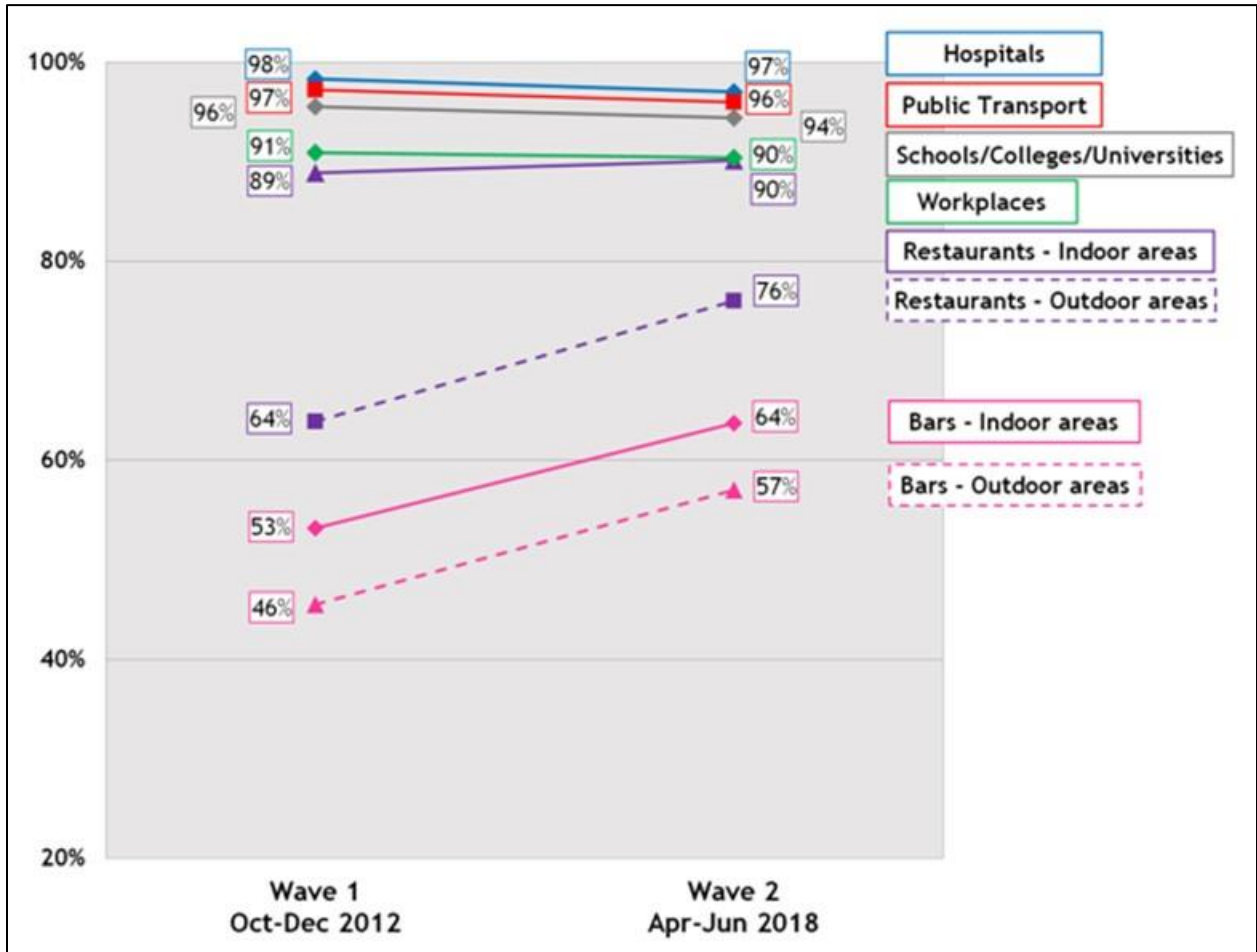
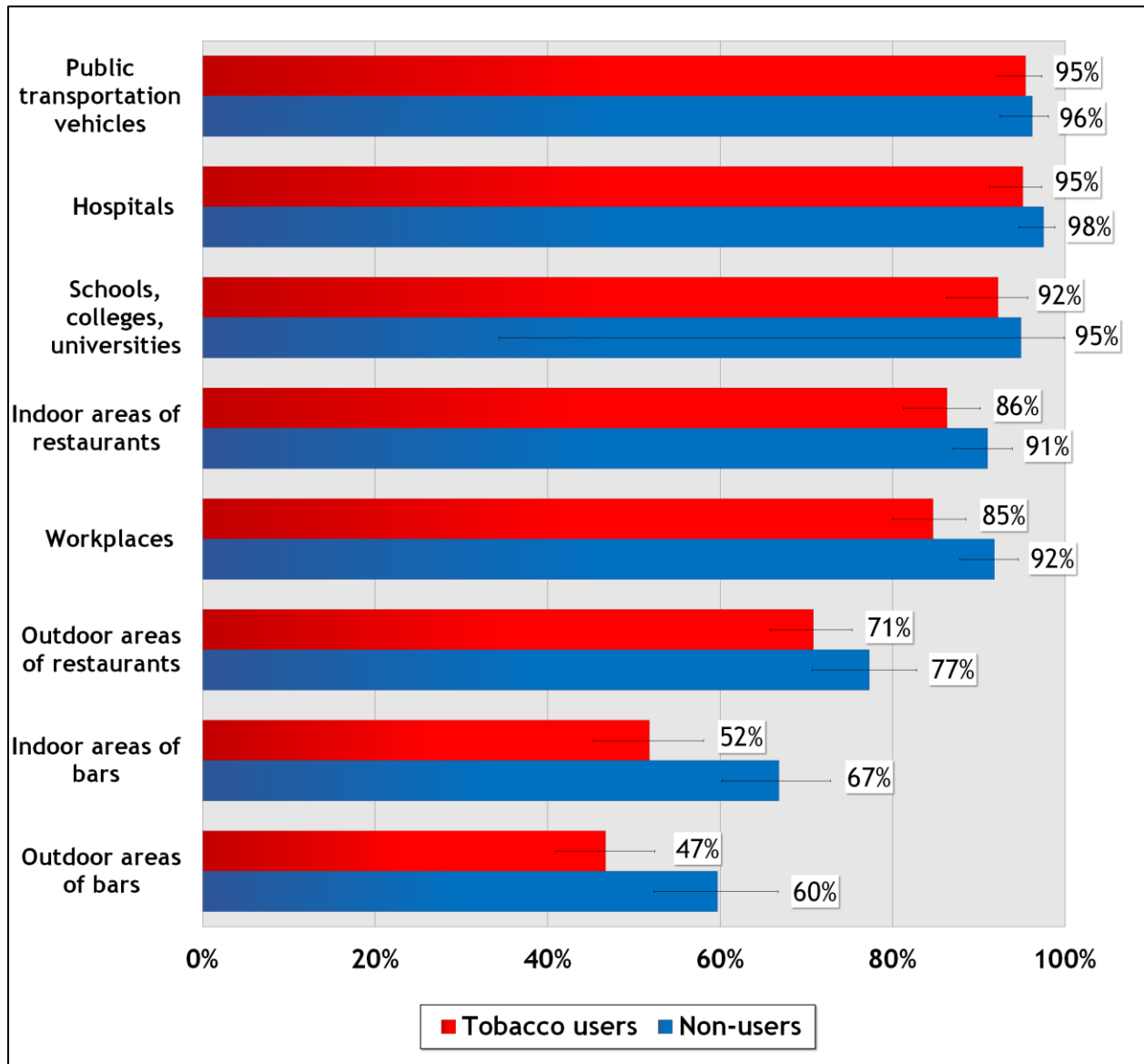


Figure 28 also summarizes the level of support among tobacco users vs. non-users at Wave 2. For almost all venues (except hospitals and public transportation), support was higher among non-users compared to tobacco users.

Figure 28: Percentage of tobacco users vs. non-users who think smoking should not be allowed in any indoor or outdoor areas of public places, at Wave 2 (2018)



8.3.1 Support for Smoke-Free Workplaces

The findings from the ITC Kenya Survey indicate that although many workplaces still had smoking in 2018, most Kenyans want their workplace to be completely smoke-free, as 91% of respondents at Wave 1 (vs 90% at Wave 2) said they think smoking should not be allowed in any indoor areas of workplaces (see Figure 27). Support was higher among non-users compared to tobacco users at Wave 2 (92% vs. 85%) (see Figure 28).

8.3.2 Support for Smoke-Free Bars and Restaurants

Support for smoking bans inside and outside of bars was lowest overall at Wave 2 compared to support for smoking bans in other venues, but has increased since 2012. Almost two-thirds (64%) of all respondents at Wave 2 said they think smoking should not be allowed in any indoor areas of bars – an increase from Wave 1 (53%), as shown in Figure 27. Support was higher among non-users than tobacco users at Wave 2 (67% vs. 52%) (see Figure 28). A similar pattern was found for support for a complete ban on smoking in *outdoor* areas of drinking establishments (increase from 46% overall at Wave 1 to 57% at Wave 2).

The majority of the respondents (90% overall at Wave 2, vs. 89% at Wave 1) support a complete ban on smoking in indoor areas of restaurants (see Figure 27). As shown in Figure 28, support was higher among non-users compared to tobacco users at Wave 2 (91% vs. 86%). Support was lower overall for a complete smoking ban in *outdoor* eating areas of restaurants and tea stalls, although there was an increase in support from Wave 1 to Wave 2 (64% to 76%).

8.3.3 Support for Other Smoke-Free Public Places

As shown in Figures 27 and 28, an overwhelming majority of the respondents (92% or more of tobacco users and non-users at Waves 1 and 2) support the complete ban on smoking in public transportation, hospitals, and schools, colleges, and universities.

8.4 Conclusion

Evidence from the ITC Kenya Waves 1-2 Surveys shows that there has been some improvement in providing protection from secondhand smoke (SHS) from 2012 to 2018, including an increase in home smoking bans among tobacco users and a decrease in smoking in bars. However, the findings indicate that the smoke-free legislation must be strengthened, as Kenyans are still being exposed to harmful SHS in indoor public places – especially bars and workplaces. Moreover, the majority of Kenyans support complete smoking bans in public places, and evidence indicates that support is growing – particularly for smoke-free bars and outdoor areas of eating and drinking establishments.

9. TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP

9.1 Background

Article 13 of the WHO FCTC calls for Parties to implement a comprehensive ban on all direct and indirect forms of tobacco advertising, promotion, and sponsorship (TAPS) within 5 years of entry into force of the treaty (by 2010 for Kenya).

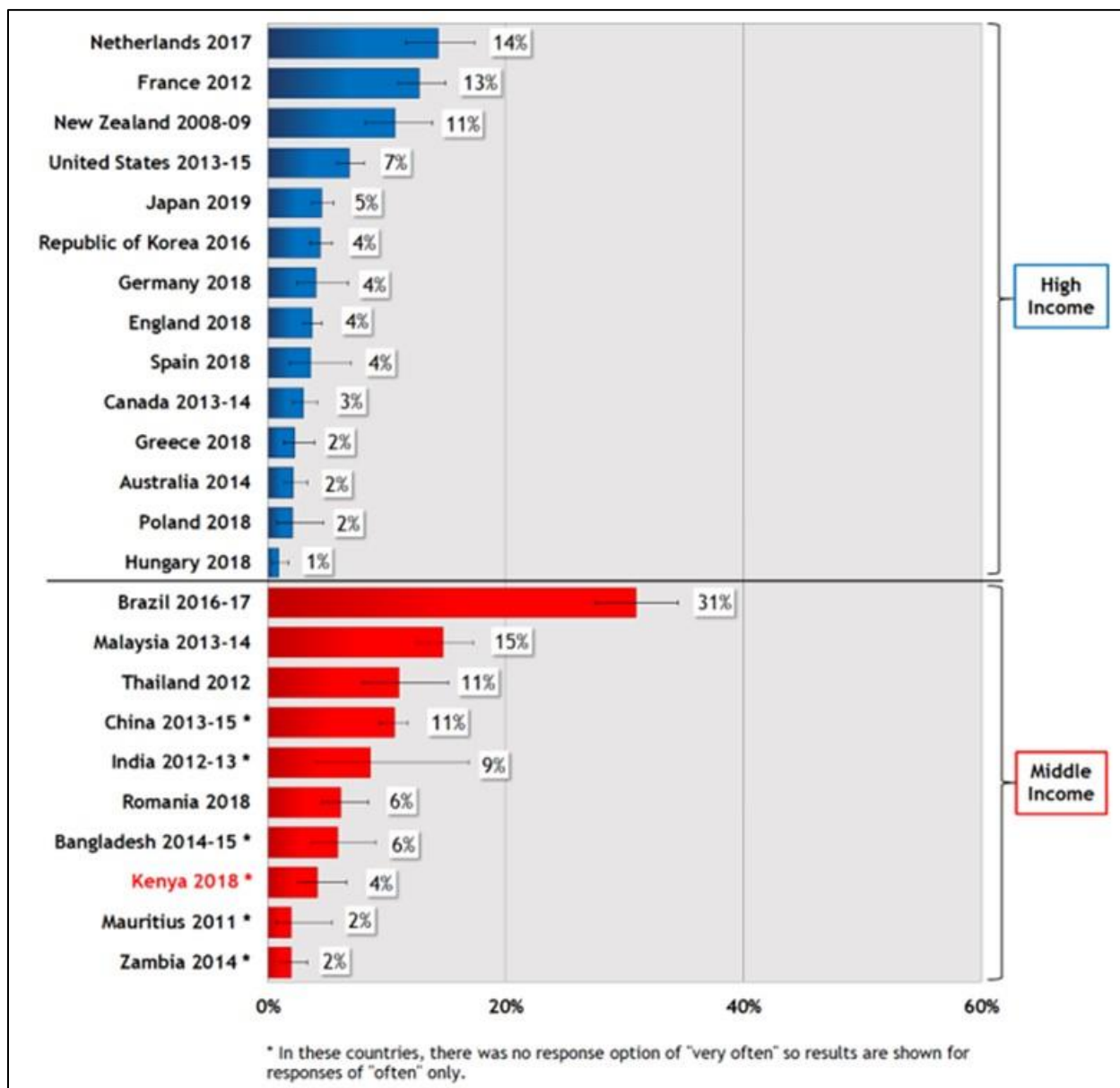
In Kenya, all forms of TAPS are prohibited under the 2007 Tobacco Control Act, including point of sale (POS) advertising and promotion such as product stacking and product displays of any kind. The Act also includes measures to ban product promotion in the entertainment and broadcast media. These measures were in force at the time of both the Wave 1 and Wave 2 ITC Kenya Surveys.

9.2 Tobacco Advertising

The ITC Kenya Survey asked tobacco users and non-users whether they had noticed any form of tobacco advertising or promotion in the last 6 months. At Wave 2, only 8% of all respondents (vs. 11% at Wave 1) said that they noticed things that are designed to encourage tobacco use at least once (vs. 'never') in the last 6 months. There was no difference in noticing tobacco promotion between tobacco users and non-users at Wave 2 (8% for both user types).

ITC cross-country comparisons indicate that tobacco advertising and promotion is less common in Kenya compared to other LMICs. The percentage of smokers and quitters in Kenya who noticed things that promote tobacco use "often" (4%) was the third-lowest among 10 ITC LMICs (see Figure 29).

Figure 29: Percentage of smokers and quitters who noticed things that promote smoking or tobacco use “often” or “very often” in the last six months, by country

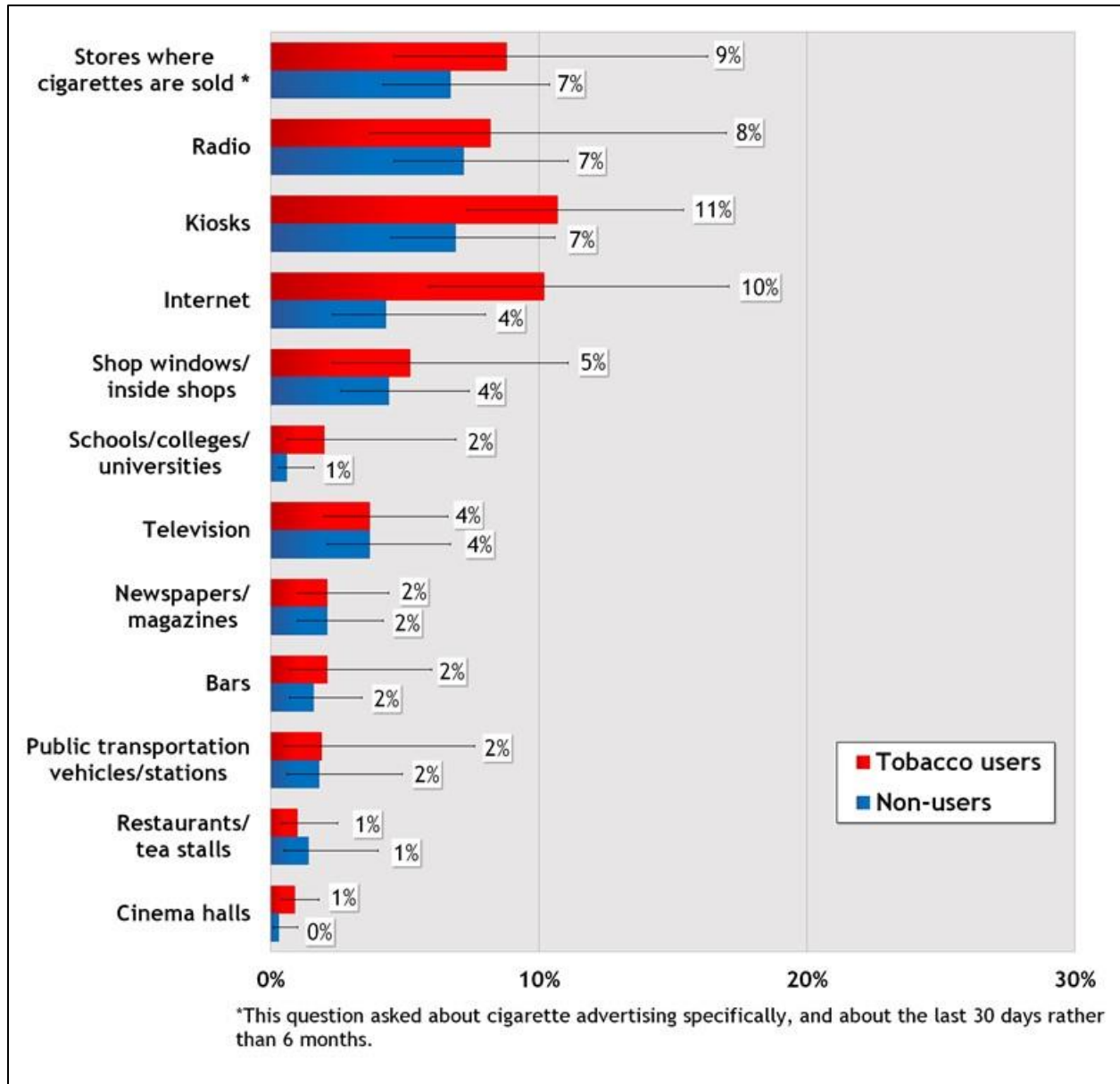


Tobacco users and non-users also reported whether they noticed tobacco products being advertised in a variety of specific venues or sources in the last 6 months. As shown in Figure 30, tobacco users most commonly noticed cigarette or tobacco advertising in the following places at Wave 2: in stores where cigarettes are sold (9%), radio^{viii} (8%), kiosks (11%), the Internet (10%), and in shop windows or inside shops (5%). Less than 5% of tobacco users and non-users noticed tobacco advertising in other sources, such as television, newspapers/magazines, bars and restaurants, cinema halls, public transport, and educational

^{viii} Note that the results for noticing tobacco advertising on 'radio' may refer to foreign radio stations, as advertising is banned on local stations in Kenya.

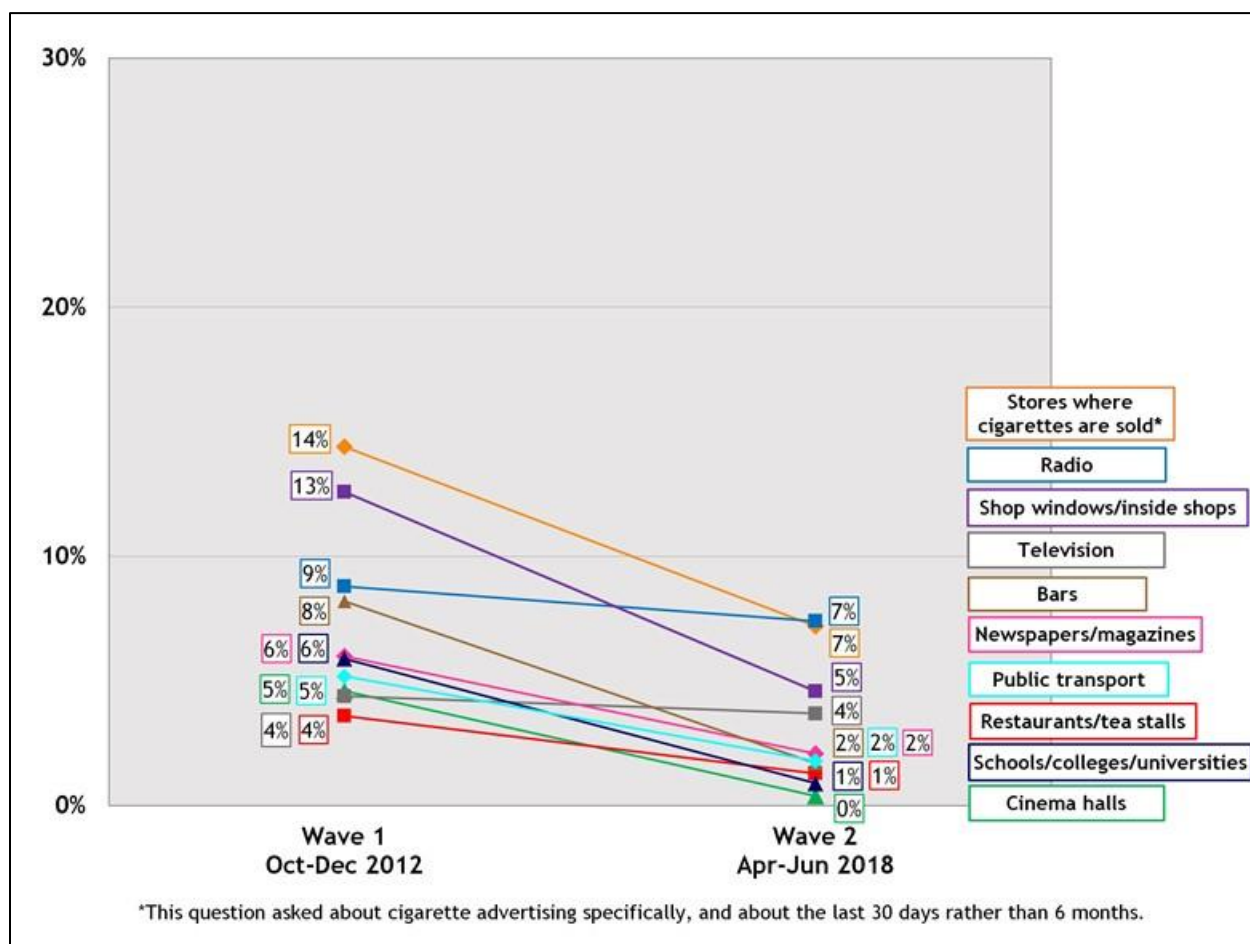
institutions. There were no differences between tobacco users and non-users in noticing advertising in any of the sources.

Figure 30: Percentage of tobacco users and non-users who noticed tobacco products being advertised in various venues in the last 6 months at Wave 2 (2018)



Comparisons between the Wave 1 and 2 Surveys show that overall tobacco advertising awareness has significantly decreased in the following places over time: in shop windows or inside shops (from 13% to 5% of all respondents), bars (from 8% to 2%), schools, colleges, and universities (from 6% to 1%), and cinema halls (from 5% to 0%) (see Figure 31). There was also a significant decrease in noticing cigarette advertising or signs in stores (from 14% to 7%).

Figure 31: Percentage of respondents who noticed tobacco products being advertised in various venues in the last 6 months, by wave



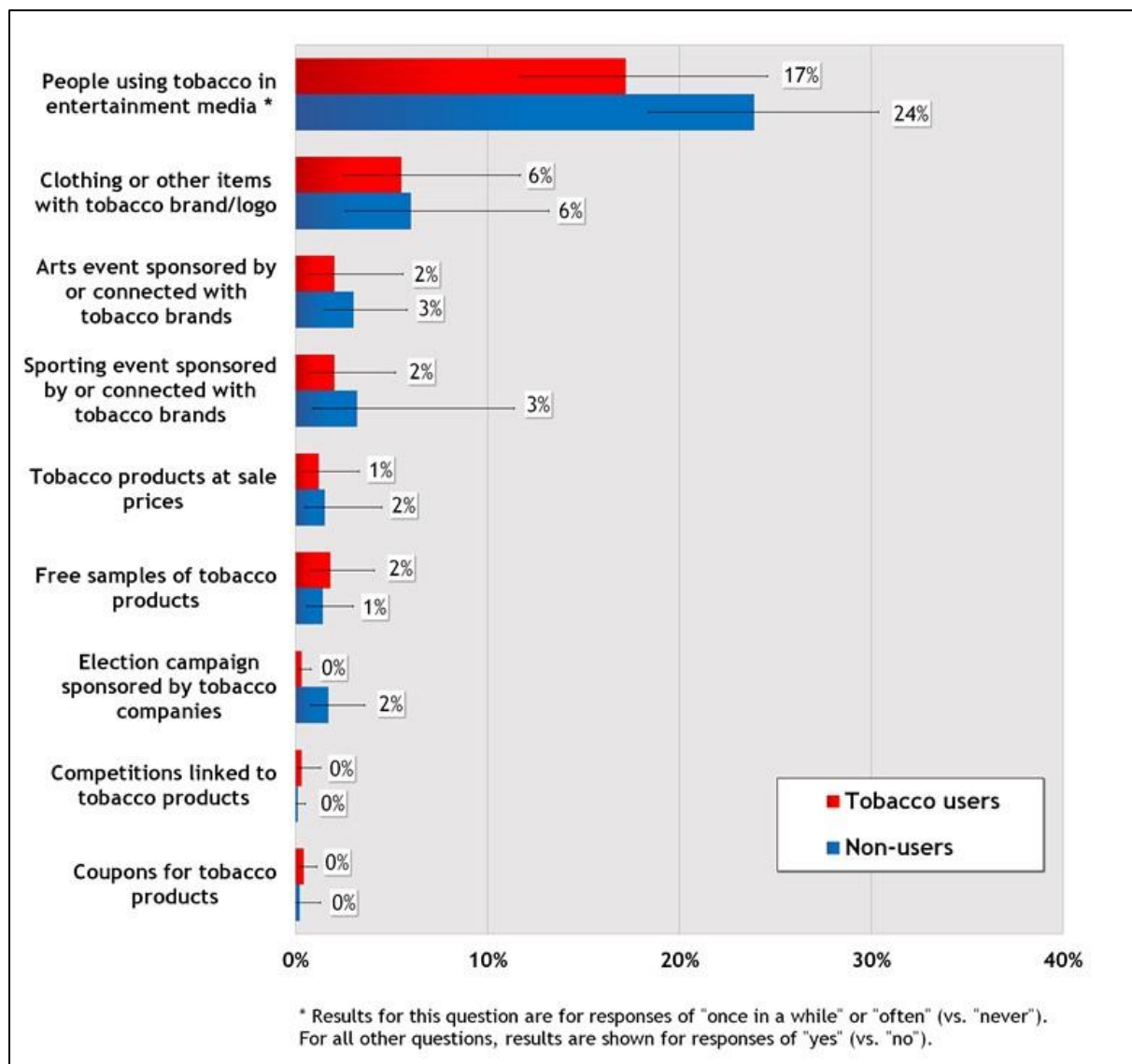
9.3 Tobacco Promotion and Sponsorship

While most forms of tobacco promotion are rare in Kenya, the Wave 2 findings showed that tobacco products are still being promoted through the media, as one-quarter (22%) of all respondents at Wave 2 (vs. 28% at Wave 1) stated that they saw people using tobacco products in the entertainment media (e.g., movies, TV, and magazines) “often” or “once in a while” in the last 6 months. 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 and progression to regular smoking.^{32,33}

Findings from the ITC Kenya Wave 2 Survey suggest strong compliance with the ban on other forms of tobacco promotion. A minority of tobacco users and non-users (6% or less) noticed the following types of tobacco promotion in the last 6 months: arts or sporting events sponsored by tobacco brands, clothing or other items with a tobacco product brand or logo, competitions linked to tobacco products, free samples or coupons for tobacco products, tobacco products on sale, or election campaigns sponsored by tobacco companies (see Figure 32). There were generally no differences in noticing tobacco promotion between tobacco users and non-users at Wave 2 (except for noticing in the entertainment media and election campaigns). The findings

also showed little change overall in noticing various forms of tobacco promotion from Waves 1 (2012) to 2 (2018), except for competitions linked to tobacco products (from 3% to 0% overall).

Figure 32: Percentage of tobacco users vs. non-users who noticed various types of tobacco promotion in the last 6 months at Wave 2 (2018)



9.4 Support for TAPS Bans

Respondents were also asked whether they support complete bans on tobacco advertisements and displays of tobacco products in shops and stores. Although stores remained one of the most common sources of tobacco advertising at Wave 2, the findings showed that the majority of respondents supported complete bans in these locations, and that support has significantly increased since 2012. Overall, 86% of respondents said they support a complete ban on all tobacco advertisements in stores "a lot" (vs. 82% at Wave 1), and 86% supported a complete ban on displays of all tobacco products "a lot" (vs. 79% at Wave 1) (see Figure 33). Support for

complete bans was significantly higher among non-users than tobacco users at Wave 2 (see Figure 34).

Figure 33: Percentage of respondents who support complete bans on tobacco advertisements and displays at shops and stores “a lot”, by wave

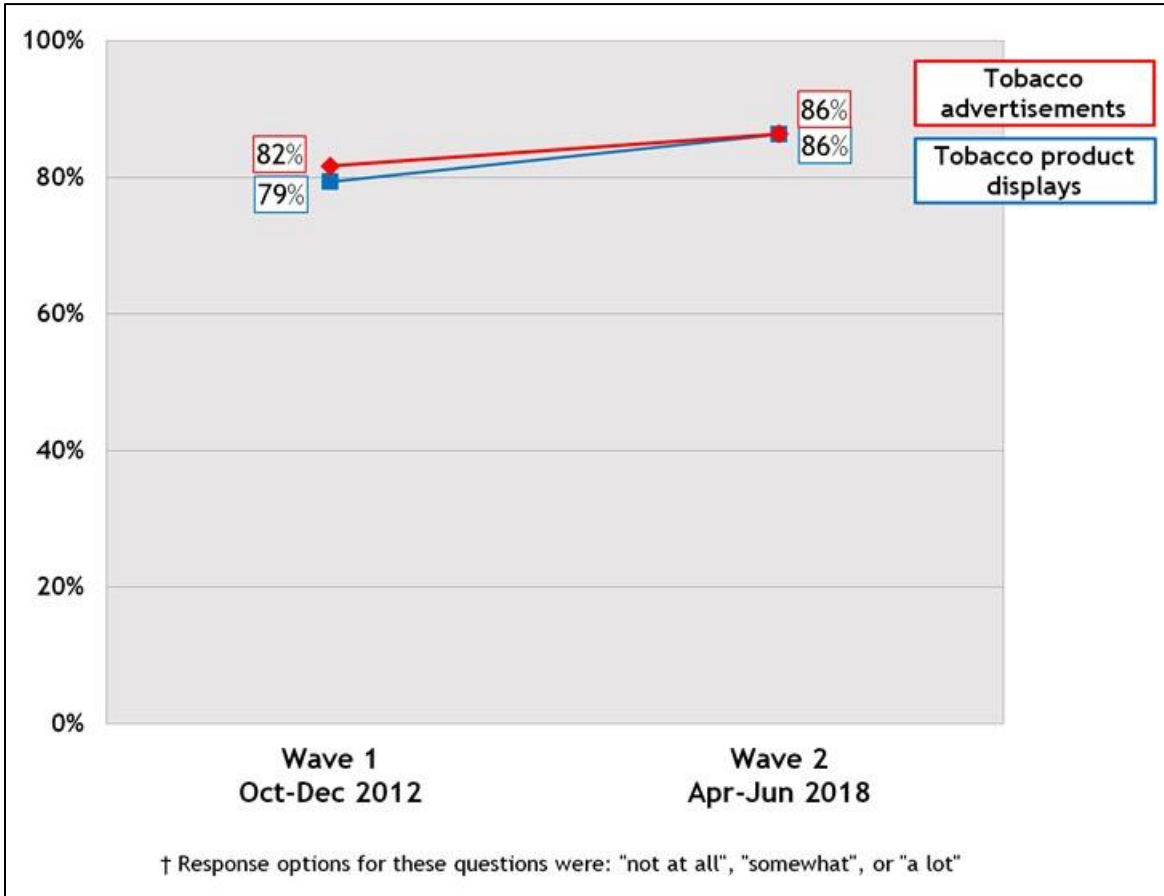
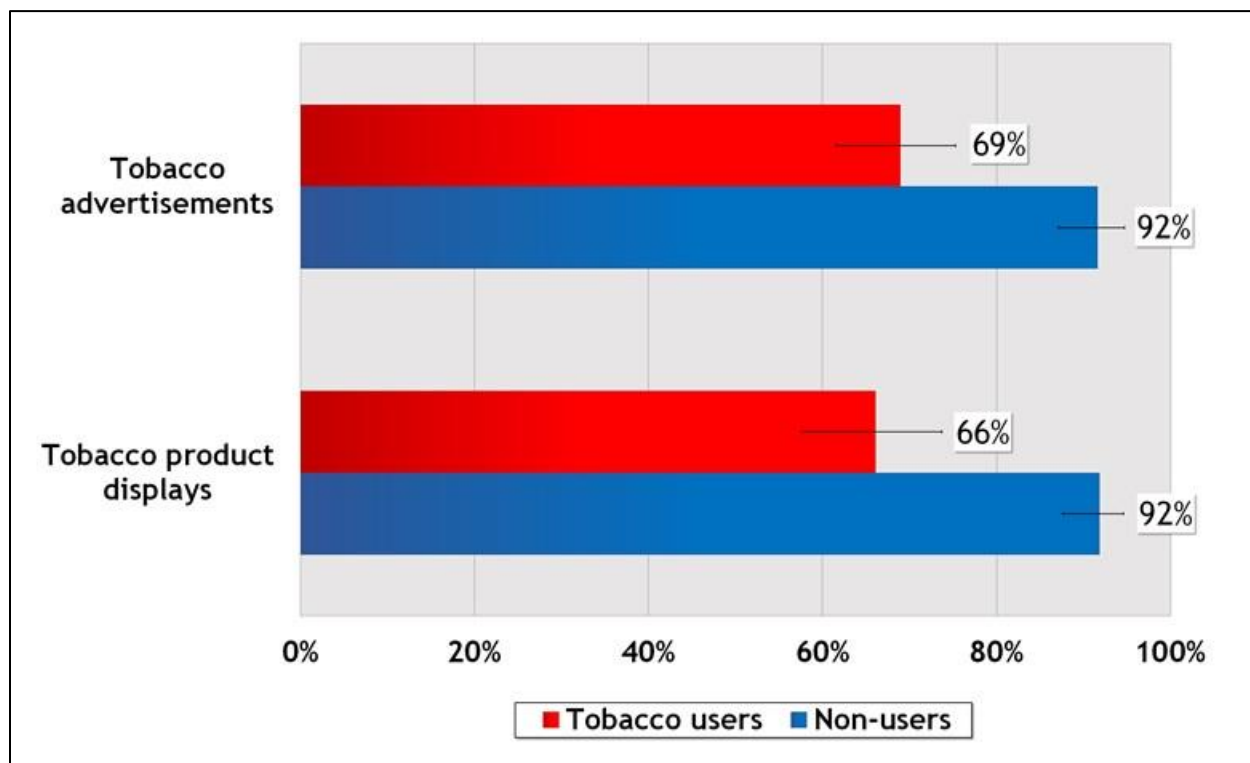


Figure 34: Percentage of tobacco users vs. non-users who support complete bans on tobacco advertisements and displays at shops and stores “a lot” at Wave 2 (2018)



9.5 Conclusion

The ITC Kenya Wave 1-2 Survey findings show that overall compliance with the comprehensive TAPS ban is strong and has improved in some areas since 2012. Few tobacco users and non-users reported noticing various forms of tobacco advertising, promotion, and sponsorship in 2018. However, there was some evidence of the need for stronger enforcement of existing TAPS bans in certain areas, such as the entertainment media and retail environments – which remain the most common sources for noticing tobacco advertising and promotion. The findings also provide evidence of strong and growing support among Kenyans for more effective TAPS restrictions to decrease exposure to tobacco advertising and promotion in retail settings even further.

10. TOBACCO PRICE AND TAXATION

10.1 Background

Tobacco taxation is widely known as one of the most effective and cost-effective tobacco control measures. Increasing taxes and prices on tobacco products represents a “win-win” strategy - not only does it achieve the public health goal of reducing tobacco use by encouraging quitting and discouraging non-smokers from starting to smoke, but it also increases government revenue at the same time. Recognizing that effective tobacco taxes and prices lower tobacco consumption, improve population health, reduce health inequities, and are economically efficient and provide an important source of revenue, the WHO FCTC obligates Parties to adopt tax and price policies to reduce tobacco prevalence. Guidelines for Article 6 of the FCTC recommend using the simplest and most efficient tax system, considering specific or mixed excise systems over ad valorem systems, taxing all tobacco products in a comparable way, and re-evaluating tax rates regularly to adjust for inflation.

Kenya has a history of using complex excise tax systems for tobacco products, with various tiered systems in place from 1993 to 2010.³⁴ The 2007 TCA obligated the Minister of Finance to implement tax and price policies in line with the objectives of the Act; however, progress on taxation was slow up until 2012. Evidence has shown that despite the adjustments to tax rates, prices of cigarettes decreased, and thus cigarettes became more affordable from 2005 to 2013.^{34,35}

Starting in 2012, Kenya has made some progress in introducing reforms in the tax administration system, including simplifying the tax structure and introducing a new track-and-trace system to help control illicit trade. The Finance Act of 2012 increased the rate of excise duty for cigarettes to 35% of the retail price or Kshs 1,200 per 1000 cigarettes (whichever was higher), with a single rate to ensure that all tobacco products were taxed equally. In 2015, the government introduced the Excise Duty Act, which further simplified the tax system by switching from an ad valorem structure to a uniform specific excise tax structure and more than doubling the rate of excise duty from 1,200 to 2,500 Kshs per 1000 cigarettes. This resulted in a decrease in cigarette consumption and an increase in revenues.³⁶

However, in the June 2017 budget, Kenya once again reverted to a tiered system with different tax rates for filtered (Kshs 2,500 per mille) and unfiltered (Kshs. 1,800 per mille) cigarettes.³⁶ By taxing different cigarette brands at different rates, smokers are encouraged to switch to cheaper brands after a tax increase rather than quitting.

Table 4: Excise Duty Rates in Kenya, 2003-2018

INDICATOR	2003–04	2005	2006	2007	2008–10	JULY 2011– NOVEMBER 2015	DECEMBER 2015– MARCH 2017	APRIL 2017–18
Rates	450–1,400	495–1,540	495–1,650	500–2,000	700–2,500	1,200 or 35% of retail selling price	2,500 for filtered	2,500 for filtered; 1,800 for nonfiltered
Tax system	4 specific progressive tiers based on price	4 specific progressive tiers based on price	4 specific progressive tiers based on price	4 specific progressive tiers based on price	4 specific progressive tiers based on price and pack's physical features	Uniform specific with minimum ad valorem floor	Uniform specific	2 specific tiers based on a physical feature

K Sh per 1,000

Sources: EM 2017a; ERC 2015; Government of Kenya 2015, 2017; Ngeywo 2013.

Note: July 2011: K Sh 1,200 per 1,000 or 35 percent of the retail selling price, whichever is higher (specific system with minimum ad valorem floor); the minister had the power to adjust the rates for inflation without parliamentary approval. The calculation of retail selling price has been legally challenged. December 2015: a uniform specific tax of K Sh 2,500 per 1,000. The specific rate of excise duty is to be adjusted for inflation at the beginning of every financial year. April 2017: reinstatement of the two-tiered system. The specific rate of excise duty is to be adjusted for inflation every two years.

Source: World Bank, 2019 ³⁷

As this tiered system is still in place, Kenya's tax system does not meet the FCTC Article 6 guidelines, which recommend a simple structure with a specific tax that is uniformly applied to all tobacco products. In 2018, at the time of the ITC Kenya Wave 2 Survey, total taxes on the most sold brand equaled 52.3% (38.5% specific tax plus 13.8% VAT), which remains well below the minimum of 70% recommended by WHO.¹ Kenya also has not earmarked tobacco tax revenues for health.

The ITC Kenya Survey examines the impact of tobacco price and tax measures in the country by asking tobacco users about their purchases of tobacco products (including the type and source of last purchase), reasons for brand choice, and monthly spending on tobacco products. The Survey also evaluated tobacco users' concerns about money spent on tobacco and behaviours to reduce spending, including thinking about quitting because of the price of tobacco products, as well as support for tax increases among tobacco users and non-users. The Wave 2 Survey was conducted after the switch from a uniform tax system back to a tiered system.

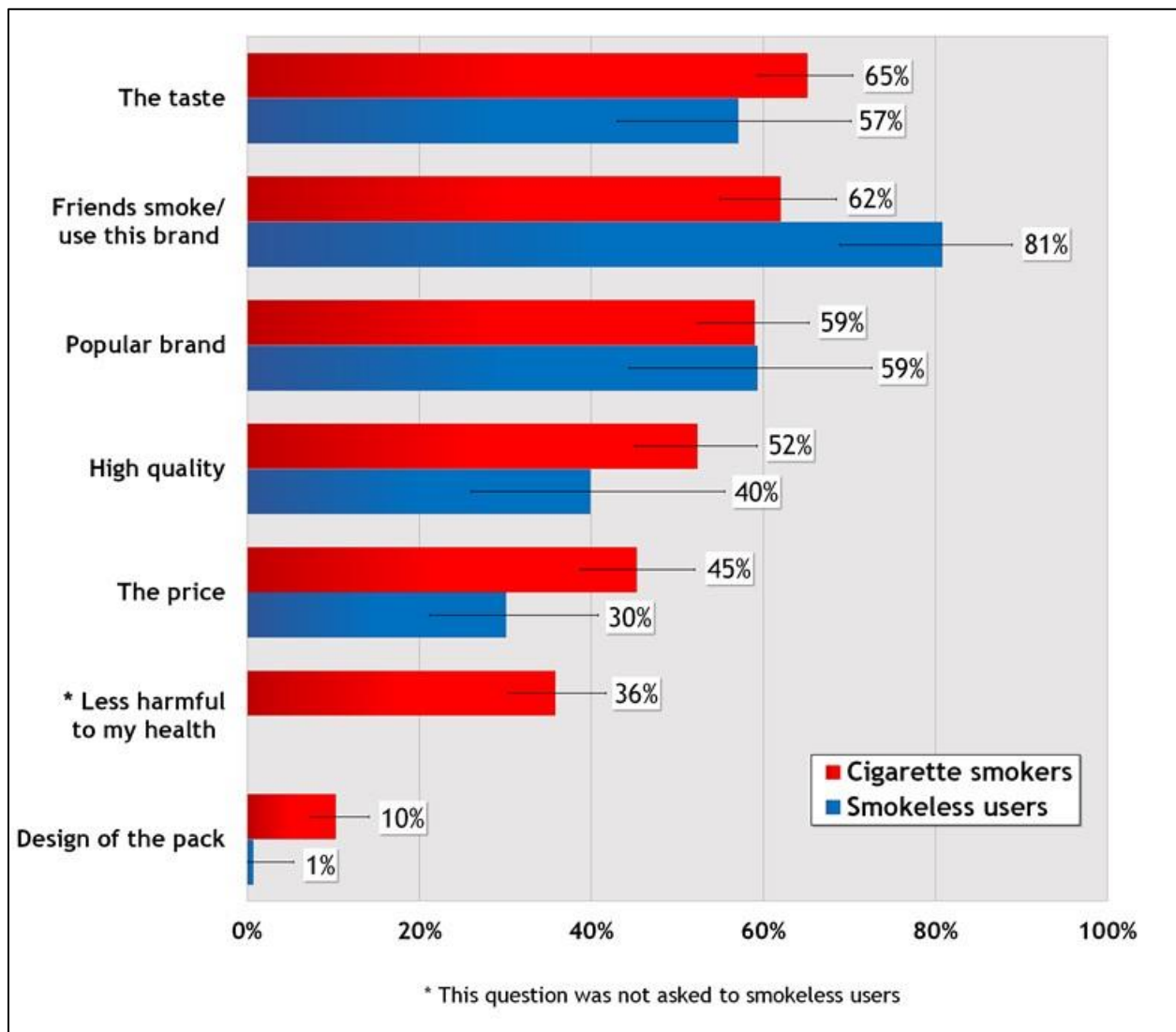
10.2 Reasons for Choosing a Specific Brand or Type of Tobacco

10.2.1 Reasons for choosing a cigarette or smokeless tobacco brand

Tobacco users who reported having a regular brand of cigarettes or smokeless tobacco at Wave 2 were asked which reasons were part of their decision to choose that brand.

As shown in Figure 35, the most commonly cited reasons for choosing one’s brand among both cigarette smokers and smokeless users were for the taste, their friends smoke/use the same brand, and the popularity of the brand. The least common reason was the design of the pack, which is not surprising given that many tobacco users in Kenya purchase loose cigarettes or smokeless tobacco. In addition, about half of cigarette smokers (45%) and one-third of smokeless users (30%) stated the price as a reason for choosing their brand.

Figure 35: Reasons for choosing one’s brand among cigarette smokers vs. smokeless users at Wave 2 (2018), among those who have a regular brand



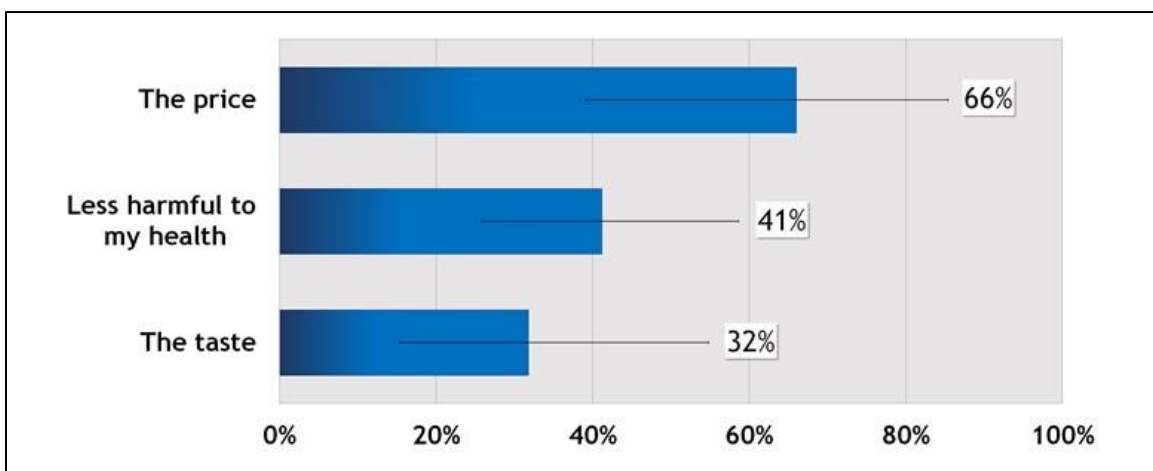
Comparisons between Waves 1 and 2 showed a significant decrease in choosing one’s cigarette brand for the following reasons: the price (from 57% to 45%), high quality (from 66% to

52%), and the taste (from 79% to 65%). Among smokeless users, the only change was a decrease in choosing one's smokeless brand for the taste (from 74% to 57%).

10.2.2 Reasons for choosing hand-rolled cigarettes

Smokers who reported that they mainly or only smoke hand-rolled (RYO) cigarettes rather than factory-made cigarettes (13% of smokers at Wave 2) were also asked which reasons led them to choose these cigarettes. The findings show that price is a strong motivator for smoking hand-rolled cigarettes, as the majority (66%) of those who smoke hand-rolled cigarettes said that price was a reason (see Figure 36). Less than half of RYO smokers said they chose hand-rolled cigarettes because they are less harmful (41%) or because of the taste (32%). There were no significant changes between Waves 1 and 2 in reasons for choosing hand-rolled cigarettes.

Figure 36: Reasons for choosing hand-rolled cigarettes over factory-made cigarettes at Wave 2 (2018)



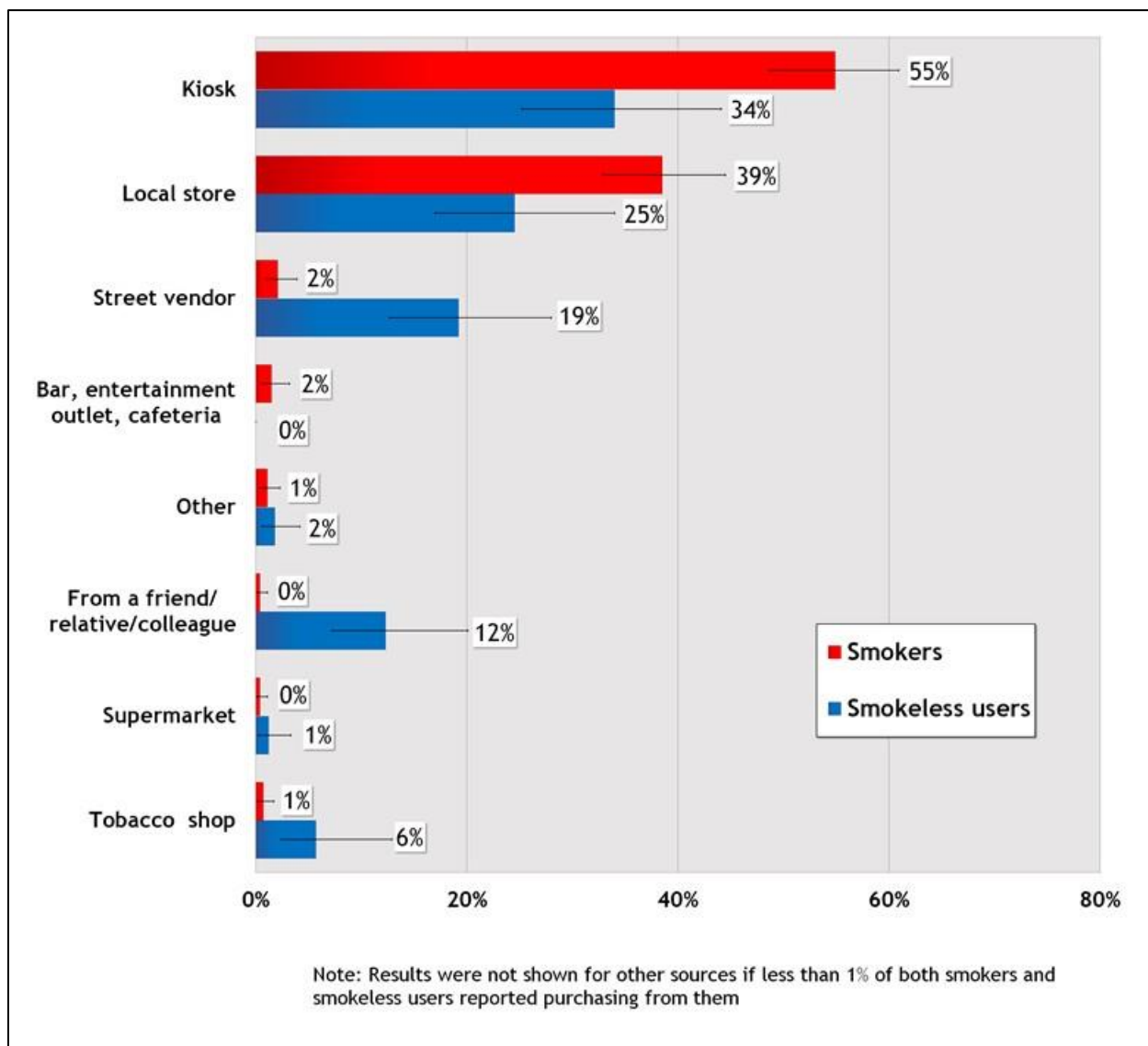
10.3 Last Purchase of Tobacco Products

10.3.1 Source of last purchase

At Wave 2, smokers were asked where they last purchased cigarettes for themselves. The findings showed that most smokers purchased cigarettes from kiosks (55%) and local stores (34%) (see Figure 37). Few smokers (2% or less) reported purchasing cigarettes from other sources, such as vendors, supermarkets, bars, tea stalls, hotels, duty-free shops, or from other people. There was an increase in purchasing cigarettes from kiosks from Waves 1 to 2 (from 41% to 55%) and a decrease in purchasing from stores (from 52% to 39%).

Similarly, the most common sources of purchasing smokeless tobacco at Wave 2 were also from kiosks (34%) and local stores (25%), although smokeless users were more likely to purchase from other sources such as street vendors (19%) and friends (12%) compared to smokers.

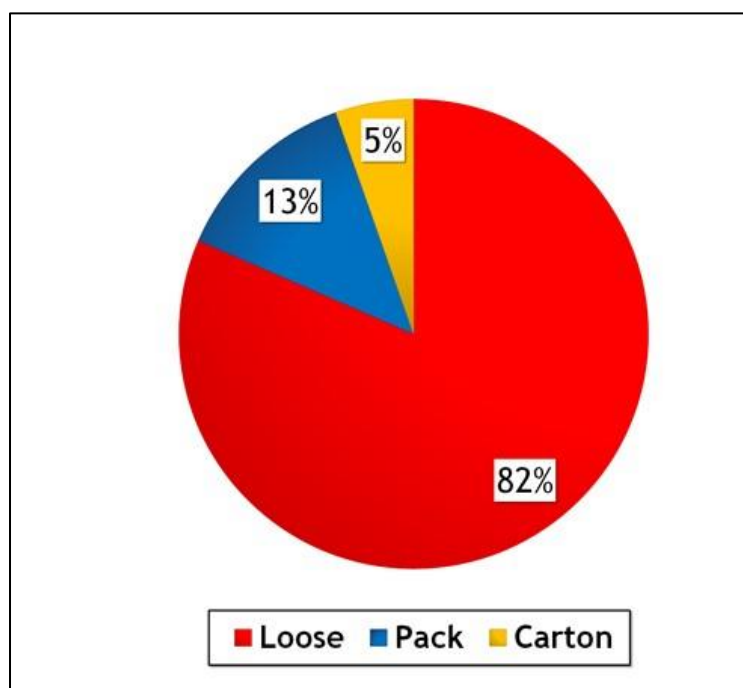
Figure 37: Source of last purchase of cigarettes or smokeless tobacco among tobacco users at Wave 2 (2018)



10.3.2 Form of last purchase

Smokers were also asked whether their last purchase of cigarettes was in the form of a pack, carton, or loose (single) cigarettes. Findings showed that despite the ban in Kenya on the sale of single cigarettes, the majority of smokers (82%) last purchased loose cigarettes (see Figure 38), with no change from Wave 1 (82%). Therefore, there is a need to improve compliance with the 2007 TCA which requires cigarettes to be sold in minimum packages of 10 sticks.

Figure 38: Form of last purchase of cigarettes among smokers at Wave 2 (2018)



10.4 Money Spent on Tobacco

10.4.1 Concerns about money spent

The ITC Kenya Survey asked tobacco users whether they believe they spend too much money on cigarettes or smokeless tobacco. The Wave 1-2 findings showed an increase in concerns about money spent on tobacco from 2012 to 2018, although money concerns are still greater for cigarettes than smokeless tobacco. The percentage of smokers who “agreed” or “strongly agreed” that they spend too much money on cigarettes increased from 62% at Wave 1 to 81% at Wave 2, and the percentage of smokeless users who said they spend too much money on smokeless tobacco increased from 42% to 70%.

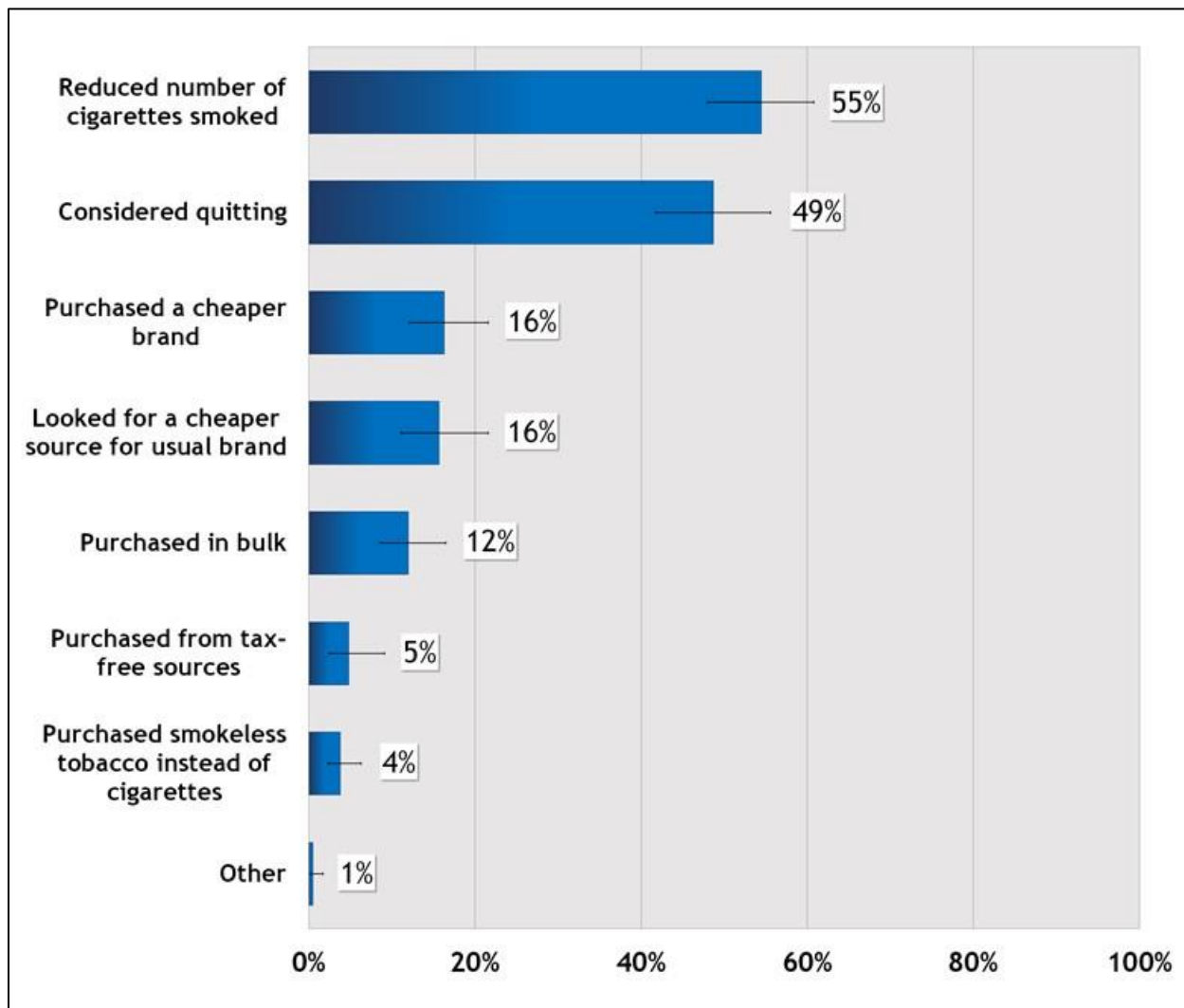
There was also an increase in the percentage of tobacco users who said there has been a time when the money they spent on cigarettes or smokeless tobacco resulted in not having enough money for household essentials like food – from 32% to 46% among smokers and from 19% to 28% among smokeless users.

10.4.2 Strategies to save money

The Wave 2 Survey also asked smokers whether they have used any strategies to save on the amount they spent on cigarettes in the last 6 months. As shown in Figure 39, approximately half of smokers reported that they had reduced the number of cigarettes they smoked (55%) and considered quitting smoking (49%). Less than one-fifth of smokers reported using other strategies such as purchasing a cheaper brand (16%), looking for a cheaper source of purchase for their usual brand (16%), purchasing in bulk (12%) or from tax-free sources (5%), and

purchasing smokeless tobacco instead (4%). There were no significant changes between Waves 1 and 2 in any of the strategies to save money.

Figure 39: Percentage of smokers at Wave 2 (2018) who used various strategies to save on the amount they spent on cigarettes in the last 6 months



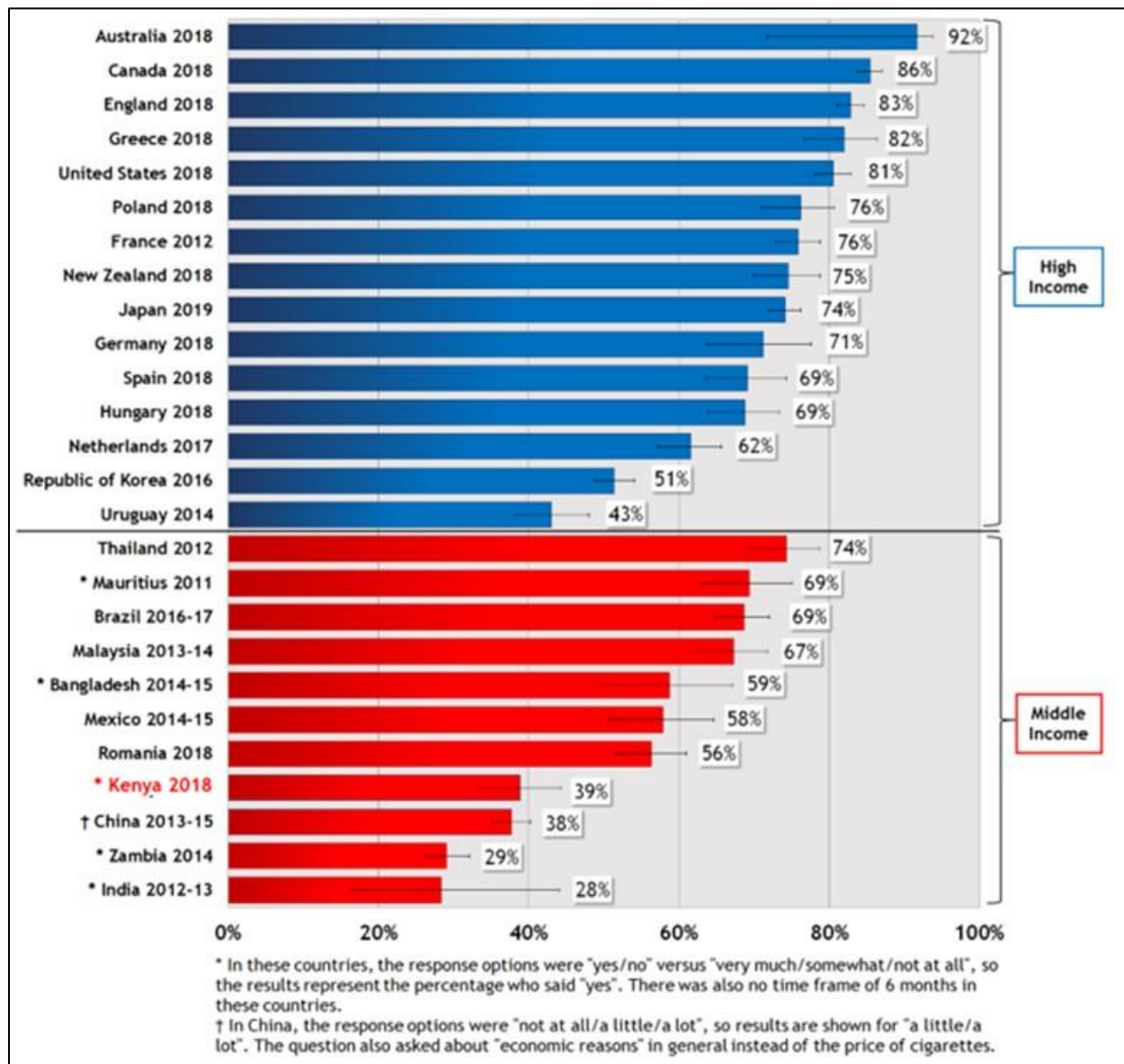
10.5 Price as a Reason to Quit

As reported in the Cessation chapter, only one-third of tobacco users in Kenya reported that the price of cigarettes or smokeless tobacco was a reason for thinking about quitting. Overall, price was one of the least frequently cited reasons for thinking about quitting.

ITC cross-country comparisons further demonstrate that price is not a strong motivator for quitting in Kenya – Kenya has the fourth-lowest percentage of smokers (39%) who said that the price of cigarettes led them to think about quitting among 26 ITC countries (see Figure 40). 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. Global evidence shows that higher tobacco taxes that increase prices (across all tobacco products) and thus reduce

affordability of tobacco products would help to motivate more cessation thoughts and behaviours in Kenya.

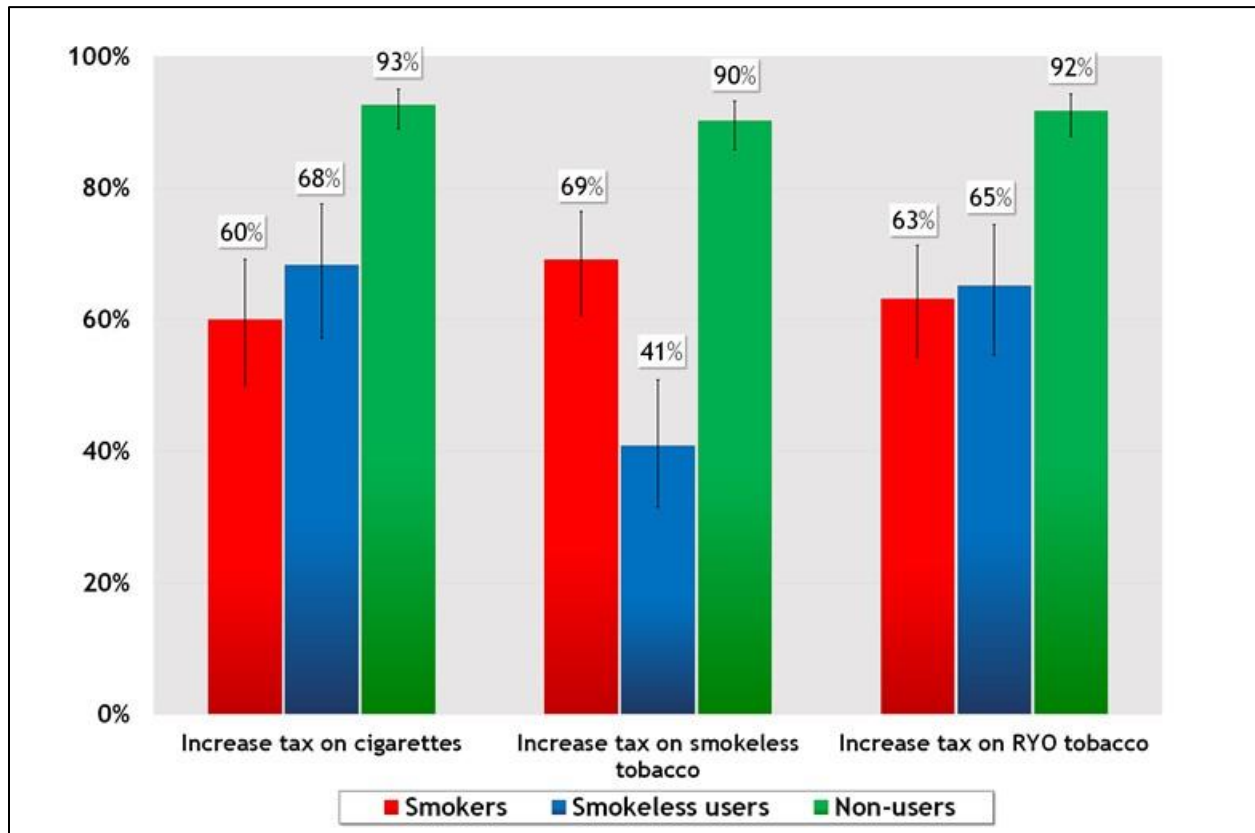
Figure 40: Percentage of smokers who said they price of cigarettes led them to think about quitting “somewhat” or “very much” in the last six months, by country



10.6 Support for Tax Increases

The Wave 2 Survey asked all respondents whether they think the Kenyan Government should increase the tax on different tobacco products. The findings showed strong support overall for raising tobacco taxes, including from tobacco users. Overall, 89% of respondents supported a tax increase on cigarettes, 88% supported tax increases on hand-rolled tobacco, and smokeless tobacco (87%). Support varied by tobacco user type, with higher support among non-users compared to tobacco users for each type of tax increase (see Figure 41).

Figure 41: Percentage of respondents who think the government should increase the tax on cigarettes, smokeless tobacco, and RYO tobacco at Wave 2 (2018), by user type



10.7 Tax Evasion

Illicit tobacco makes tobacco products more affordable and accessible for smokers and undermines the impact of tobacco taxation policies to reduce smoking. Article 15 of the WHO FCTC requires Parties to implement effective measures against all forms of illicit trade in tobacco products including smuggling, illicit manufacturing, and counterfeiting. In addition to the FCTC, the Protocol to Eliminate Illicit Trade in Tobacco Products (ITP) was developed in 2012 and entered into force in September 2018, after being ratified by 40 Parties. The ITP requires Parties to implement key policy measures to eliminate illicit trade, including licensing of tobacco manufacturers, security measures, record keeping, and an effective tracking and tracing system.³⁸

As the centre of the tobacco trade in the East African region, it is important for Kenya to implement strong measures to control illicit trade and tax evasion. Kenya ratified the ITP in May 2020 and has instituted various measures to curb illicit trade over the years. For example, in 2010, Kenya introduced an electronic cargo monitoring system (ECMS) to monitor imports and exports between neighbouring countries, and a new excisable goods management system (EGMS) to track tobacco products was implemented in 2013. Under the EGMS, all cigarette packs produced or imported into Kenya must have electronic digital stamps, which are more secure and very difficult to counterfeit or remove.³⁹ These stamps replaced the previous paper-

based tax stamps, which were introduced on cigarette packs by the Kenyan Ministry of Finance in 2003. Finally, a new national action plan to combat all forms of illicit trade in the country was launched in June 2019.

Evidence thus far indicates that legitimate cigarettes sales increased and the proportion of illicit cigarettes on the market decreased after implementation of the EGMS.^{37,39} As credible data on illicit trade is difficult to obtain, it is important to continue to monitor the impact of these measures in Kenya. Kenya's experience should also encourage other countries to adopt a tracking and tracing system as recommended by the ITP. Indeed, if more countries in the East African region were to work together to coordinate a region-wide system, the impact would be expected to be even greater.

The ITC Kenya Survey evaluates compliance with the tracking and tracing system by assessing the presence of tax stamps on cigarette packs where possible. At each survey wave, smokers were asked to voluntarily show the interviewers their current cigarette pack and the presence and condition of any tax stamp was recorded. The Wave 2 Survey was conducted after the implementation of the new tax stamps. Among smokers who were willing to show their cigarette pack at Wave 2 (n=109), the majority (89%) displayed at least part of a tax stamp. Only 11% of the packs (vs. 10% at Wave 1) did not have a visible tax stamp, nor any sign that a stamp was ever present. In comparison, the ITC Zambia Wave 2 Survey in 2014 found that 22% of cigarette packs did not have a tax stamp. In addition, for the packs that did have a tax stamp with the country of issue visible, the interviewer recorded whether the tax stamp was issued by Kenya or another country. At Wave 2, all packs with a tax stamp were from Kenya's Ministry of Finance.

10.8 Conclusion

The ITC Kenya Wave 2 findings suggest tobacco products are still affordable for the majority of Kenyans, especially smokeless tobacco and hand-rolled cigarettes, and that price is not a strong motivator for quitting smoking. In fact, Kenya has the fourth-lowest percentage of smokers who stated that the price of cigarettes was a reason for thinking about quitting among all ITC countries. However, the findings also indicate that tobacco users are also becoming more concerned about the cost of their tobacco use, and these concerns are leading about half of smokers to reduce their consumption and consider quitting.

In addition, the findings on tax evasion provide some evidence that efforts to reduce illicit trade of tobacco in Kenya could be having an impact, as few smokers reported purchasing cigarettes from tax-free sources and the majority of smokers' cigarette packs had the appropriate tax stamp in place. However, further studies are needed to fully understand the effectiveness of measures to counter illicit trade.

Overall, the survey findings suggest that Kenya should continue to build on recent progress to improve tobacco systems and implement stronger tax and price policies to reduce the affordability of tobacco products and motivate more smokers to quit. These efforts should include greater enforcement of the ban on the sale of loose cigarettes, which remain the most

common form of purchase in 2018. Moreover, the Wave 2 results show that the majority of Kenyans – including tobacco users themselves – would support tax increases on all tobacco products.

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International Tobacco Control (ITC) Policy Evaluation Project: www.itcproject.org

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