



JOINT NATIONAL CAPACITY ASSESSMENT  
ON THE IMPLEMENTATION OF  
EFFECTIVE TOBACCO CONTROL POLICIES IN

**KENYA**

#### **WHO Library Cataloguing-in-Publication Data**

Joint national capacity assessment on the implementation of effective tobacco control policies in Kenya.

1.Smoking - prevention and control. 2.Smoking - epidemiology. 3.Health policy. 4.Health promotion. 5.Tobacco - legislation. 6.Tobacco industry - legislation. 7.Kenya. I.World Health Organization.

ISBN 978 92 4 150439 3

(NLM classification: WM 290)

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Design and layout by Bernard Sauser-Hall

Printed in



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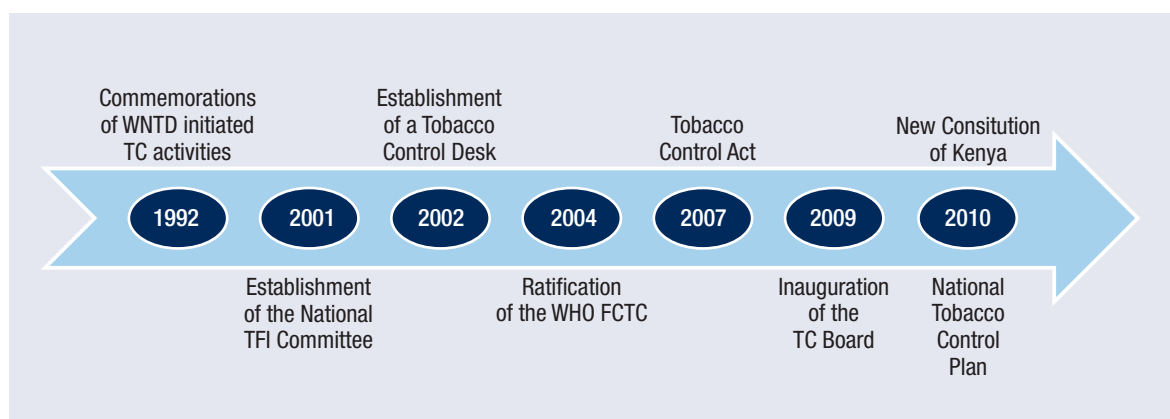
# Abbreviations

<b>COP</b>	Conference of the Parties
<b>CRDR</b>	Centre for Respiratory Diseases Research
<b>DSR</b>	designated smoking room
<b>EAC</b>	East African Community
<b>GATS</b>	Global Adult Tobacco Survey
<b>GHPSS</b>	Global Health Professionals Student Survey
<b>GYTS</b>	Global Youth Tobacco Survey
<b>HMIS</b>	Health Management and Information System
<b>IDSR</b>	Integrated Diseases Surveillance and Response
<b>IEC</b>	Information, education and communication
<b>ILA</b>	Institute of Legislative Affairs
<b>INRS</b>	Institute for Natural Resources and Technology
<b>KATOGA</b>	Kenya Anti-tobacco Growing Association
<b>KEBS</b>	Kenya Bureau of Standards
<b>KEMRI</b>	Kenya Medical Research Institute
<b>KETCA</b>	Kenya Tobacco Control Alliance
<b>KFCB</b>	Kenya Film Classification Board
<b>KHPS</b>	Kenya Health Professionals Society
<b>KRA</b>	Kenya Revenue Authority
<b>KTSA</b>	Kenya Tobacco Situational Analysis
<b>MOA</b>	Ministry of Agriculture
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>MOI</b>	Ministry of Information
<b>MOLG</b>	Ministry of Local Government
<b>MOMS</b>	Ministry of Medical Services
<b>MOPHS</b>	Ministry of Public Health and Sanitation
<b>MOYAS</b>	Ministry of Youth and Sports
<b>MTP</b>	Medium Term Plan
<b>NACADA</b>	National Agency for the Campaign Against Drug Abuse
<b>NCD</b>	Noncommunicable disease
<b>NEMA</b>	National Environment Management Authority
<b>NGOs</b>	nongovernmental organizations
<b>NRT</b>	nicotine replacement therapy
<b>NTFIC</b>	National Tobacco Free Initiative Committee
<b>SHS</b>	Second-hand smoke
<b>TAPS</b>	tobacco advertising, promotion and sponsorship
<b>TFI</b>	Tobacco Free Initiative
<b>VAT</b>	value-added tax
<b>WHO FCTC</b>	World Health Organization Framework Convention on Tobacco Control
<b>WHS</b>	World Health Survey

# Executive summary

Kenya is a tobacco-growing country that has been involved in curbing the tobacco epidemic since 1992. The country is also a regional hub for manufacturing tobacco products. Noncommunicable diseases (NCDs), for which tobacco is a risk factor, currently account for more than 55% of the mortality in the country and 50% of the public-hospital admissions. In addition to the health issue, the environmental impact of tobacco-growing is also a concern, because wood from natural forests is being burned to cure tobacco leaves. Kenya has made efforts to reduce the use of tobacco and to tackle its serious consequences, particularly tobacco-related diseases. In 1992, tobacco control campaigns were initiated in the country as part of the World No Tobacco Day celebration. In 2001, the Ministry of Health (MOH) established the National Tobacco Free Initiative Committee (NTFIC) to coordinate tobacco control activities, and a tobacco control focal point was designated. Kenya actively participated in the negotiations of the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), which it ratified in 2004. Despite the presence of a strong tobacco-industry lobby, a comprehensive Tobacco Control Act was enacted in 2007 to control the production, manufacture, sale, labelling, advertising, promotion and sponsorship of tobacco products, and a Tobacco Control Board was established to provide advice on tobacco control to the Minister responsible for public health. The key milestones in tobacco control in Kenya are shown in Figure 1.

Figure 1: Kenya Tobacco Control Timeline: 1992 – 2010



The tobacco epidemic is a growing concern for Kenya's government and its population as a whole. According to the Kenya Health Demographics Survey of 2008/2009, 19% of Kenyan males between 15 and 49 years of age use tobacco products, and 18% smoke cigarettes. Less than 2% of Kenyan women of the same age use tobacco in any form, and 1% smoke cigarettes. The Global Youth Tobacco Survey (GYTS) 2007 found that 8.2% of schoolchildren 13 to 15 years of age smoke cigarettes, and 10.1% use any form of tobacco. The fact that 12.7% of boys and 6.5% of girls consume tobacco in some form is a clear indication that young girls are smoking more than their mothers, and the prevalence trend appears to be increasing: In two GYTS surveys performed in the country in 2001, 6.6% of the 13- to 15-year-olds smoked cigarettes and 8.9% used tobacco in some form.

The Kenya MOH is responsible for strengthening the implementation of policies, programmes and services to arrest the epidemic. In this context, the Government of Kenya invited a team of experts led by WHO to jointly perform an assessment of the country's national capacity to implement the WHO FCTC, with special emphasis on the following provisions of the treaty: - **Monitor** tobacco use and interventions, **Protect** people from tobacco smoke, **Offer** help to quit tobacco use, **Warn** about the dangers of tobacco,

**Enforce** bans on tobacco advertising, promotion and sponsorship [TAPS], **Raise** taxes on tobacco, develop sustainable alternatives to tobacco-growing, control illicit trade and regulate tobacco products. At the request of the Kenya government, WHO, through its country office in Kenya and the WHO Africa Regional Office, worked with the MOH to organize and conduct the joint capacity assessment.

From 27 June to 1 July 2011, a group of 15 national, international and WHO experts, in collaboration with a team from the MOH reviewed the status of policies, laws and activities as well as current efforts to develop tobacco control policies. The experts were divided into five teams that interviewed key informants, preselected groups, key governmental agencies, district officials and individuals who represented stakeholders in tobacco control, as well as representatives of civil society organizations, the media and academia. Interviews were conducted in Nairobi as well as in Migori, a tobacco-growing area and in Nakuru, the first smoke-free city in Kenya. A total of 149 interviews were conducted with individuals representing 38 institutions, including central and local governmental agencies with regulating roles or implementing responsibilities. The assessment team also reviewed existing tobacco epidemiologic data, as well as the status of tobacco control measures undertaken by the government in collaboration with other sectors.

The group also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control, programme management and coordination, intersectoral and intrasectoral partnerships and networks, and human and financial resources and infrastructure. Finally, the group made recommendations based on the key findings of its analysis to further the development of the assessed tobacco control policies, as required by the WHO FCTC.

Kenyan authorities are aware that the progress achieved in tobacco control in Kenya can and must be accelerated. The most significant challenges to continued progress are the following:

- **There is no clear mechanism ensuring a smooth and coordinated implementation of the different aspects of tobacco control at different levels of governance.**
  - Although various stakeholders in Kenya have taken action to implement the WHO FCTC, the mechanism for coordinating the tobacco control programme within the government is unclear. Two divisions handle tobacco control in the Ministry of Public Health and Sanitation (MOPHS): the Noncommunicable Diseases Division (for coordination and policies) and the Occupational Health Division (for enforcement, and as a secretariat for the Tobacco Control Board, created in 2007 by the Tobacco Control Act). No clear mechanism for coordination could be identified, either between the two MOPHS divisions or between the MOPHS and the Ministry of Medical Services (MOMS).
  - Central-government support to the subnational level is uneven, essentially because of limited capacity; however, collaboration among local authorities is common.
  - A formal interministerial coordinating mechanism is not yet in place to ensure definition of roles and allocation of financial and human resources for planning and spearheading coordinated tobacco control activities.
  - The work of the civil society in driving policies and regulations is acknowledged, but there is no mechanism to coordinate the activities of different agencies and organizations.
  - There is a consensus that the tobacco industry tries to influence government agencies – and often succeeds.

- **Enforcement of the Tobacco Control Act 2007 is not optimal.**

According to the Act, powers of enforcement are granted to authorized officers from the health sector, local government and police, with the participation of business owners/managers. Each of the enforcement officers has a separate reporting line, and there is no coordinated mechanism for

enforcement. This results in fragmented and uneven enforcement efforts, and the harmonized monitoring and evaluation process needed for consistent planning of tobacco control policies is lacking.

- **Almost four years after the entry into force of the Tobacco Control Act 2007, important provisions have not yet been implemented.**

The law authorizes the Minister of Health to introduce graphic health warnings on tobacco packages, to prescribe further duties for ensuring enforcement of the smoking ban and to prescribe information that manufacturers shall provide to the Tobacco Control Board, including information on sales and advertising data. These actions have not been undertaken.

- **The government has already indicated its commitment to fulfil its obligation to implement Article 17 of the WHO FCTC by enacting Section 13 of the Tobacco Control Act 2007.**

Ministry of Agriculture (MOA) and other relevant ministries are responsible for developing policies that promote appropriate, economically viable alternatives to tobacco-growing. To date, however, efforts to diversify from tobacco-growing have been spearheaded by civil society. The MOA and other ministries have not developed specific policies or programmes to promote viable alternatives for tobacco growers.

To ensure the sustainability of current initiatives and make further progress, the following recommendations should be implemented by the government through collaboration of the relevant stakeholders (with the exception of the tobacco industry and its front groups and allies) within the next 12 to 18 months:

**1. A clear mechanism ensuring smooth and coordinated implementation of tobacco control policies at the different levels of governance (eventually through the mandate of a national tobacco control programme) should be put in place.**

- The MOPHS should spell out the roles of each division that currently has a role in tobacco control, as well as the relationship between the divisions and the Tobacco Control Board and the relationship between the MOPHS and MOMS.
- The linkages between the implementing divisions of the MOPHS and agencies at the subnational operational level should be strengthened and streamlined. A central reporting system should be established to facilitate feedback to the MOPHS (the focal point for tobacco control in the country), follow-up, monitoring and evaluation.
- An Intersectoral government-wide coordination mechanism for tobacco control (which would eventually include a multisectoral technical working group) should also be established as soon as

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