GATS | Kenya

GLOBAL ADULT TOBACCO SURVEY - 2014
EXECUTIVE SUMMARY

MINISTRY OF HEALTH
TOBACCO CONTROL UNIT

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EXECUTIVE SUMMARY

The Global Adult Tobacco Survey (GATS) is the global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators. GATS Kenya isa nationally representative household survey of non-institutionalized men and women aged 15 years and older. The survey was designed to produce internationally comparable data for the country as a whole, and by gender and place of residence (urban/rural).

GATS Kenya was conducted by the Kenya National Bureau of Statistics (KNBS) under the coordination of the Ministry of Health. Technical assistance was provided by the World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention (CDC). Financial support wasprovided by the Bill & Melinda Gates Foundation and program support wasprovided by the CDC Foundation.

GATS enhances a country's capacity to design, implement and monitor effective tobacco control programs and policies. It also fulfills Kenya's obligations under the WHO Framework Convention on Tobacco Control (WHO FCTC), ratified in June 2004,to generate tobacco use data that are comparable within and across countries. WHO has identified a set of six evidence-based tobacco control strategies, summarized by the acronym MPOWER,that are most effective in reducing tobacco use.
These include:

Monitor tobacco use & prevention policies

Protect people from tobacco smoke

Offer help to quit tobacco use

Warn about the dangers of tobacco

Enforce bans on tobacco advertising, promotion, & sponsorship

Raise taxes on tobacco

METHODOLOGY

GATS uses a standard survey protocol across countries. In Kenya, GATS was conducted in 2014 as a household survey of persons 15 years of age and older, and was the first stand-alone survey on tobacco use. A multi-stage stratified cluster design was used to obtainnationally representative data. Survey information was collected using electronic handheld devices. A total of 5,376 households were sampled, and one individual was randomly selected from each participating household to complete the survey. There were a total of 4,408 individuals completed interviews. The overall response rate, a combined household and person-level response rate,was 87.1%. The response rate in urban areas was 85.6% and in rural areas was 88.8%.

The survey collected information on background characteristics, tobacco use (smoking and smokeless), cessation, secondhand smoke exposure, economic indicators, exposure to tobacco advertising and promotion, as well asknowledge, attitudes and perceptions towards tobacco use.

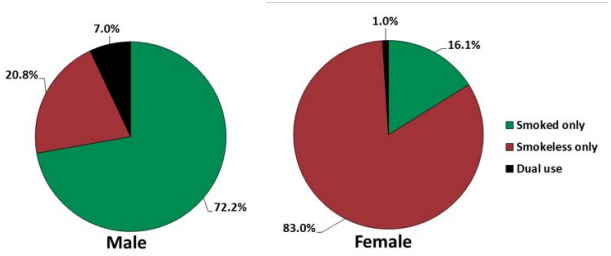
TOBACCO USE

Tobacco use is one of the most common risk factors for non-communicable diseases (NCDs). According to the Kenya Ministry of Health, NCDs contribute to nearly 50% of all admissions in public hospitals countrywide. In Kenya, 69 per 100,000 deaths for individuals aged 30 and above result fromtobacco use. Five percent of all non-communicable deaths in Kenya result from tobacco use, and 55% of all deaths from cancers of the trachea, bronchitis, and lung are attributable to tobacco.

The survey found that:

- 19.1% of men, 4.5% of women, and 11.6% overall (2.5 million adults) currently used tobacco (smoking and/or smokeless tobacco).
- 15.1% of men, 0.8% of women, and 7.8% overall (1.7 million adults) currently smoked tobacco.
- 5.3% of men, 3.8% of women, and 4.5% overall (1.0 million adults) currently used smokeless tobacco.
- 72.0% of daily tobacco users use tobacco (smoking and/or smokeless tobacco) within 30 minutes of waking up.
- Overall, 6.0% of the adults were daily tobacco smokers, 1.8% were occasional tobacco users, while 92.2% were non-smokers. An estimated 6.7% and 4.5% of the rural and urban
  residents, respectively, were daily tobacco smokers.
- Overall, 41.3% of current smokers initiated smoking between 20-24 years of age, while 32.3% initiated between 17-19 years, 13.5% between 15-16 years, and 7.5% when they were less than 15 years of age.
- Among tobacco users, 61.0% used smoked tobacco only (72.2% of men and 16.1% of women), 33.2% used smokeless tobacco only (20.8% of men and 83.0% of women) and 5.8% used both smoked and smokeless tobacco (7.0% of men and 1.0% of women). The majority of men smoked tobacco while most female tobacco users used smokeless tobacco (Figure 1).

Figure1: Type of Tobacco Use by Gender, GATS Kenya, 2014



CESSATION

Tobacco cessation refers to the process of stopping the use of any tobacco products, with or without assistance. Tobacco is highly addictive, and therefore it is essential to strengthen health care systems to promote tobacco cessation. Health care providers play a key role in early identification of tobacco use and have a responsibility to intervene by advising users to quit.

The survey found that:

- Over half (52.4%) smokers attempted to quit smoking in the past 12 months.
- Of those who attempted to quit, 7 in 10 smokers tried to quit without any assistance.
- Of smokers who visited a healthcare provider in the past 12 months, only 3 in 10 were advised to quit smoking.
- 77.4% of current smokers planned to or were thinking about quitting.

SECONDHAND SMOKE

Exposure to secondhand smoke (SHS), also known as Environmental Tobacco Smoke (ETS), causes tobacco-related diseases similarly to active smoking. SHS is composed of 2 forms of smoke from burning tobacco: sidestream smoke that comes from the lit end of a cigarette, pipe, or cigar; and mainstream smoke exhaled by a smoker. According to the Tobacco Control Act (TCA) 2007, smoking is prohibited in public places and workplaces except in specially designated smoking areas. The Act also declares that there is no safe level of exposure to SHS.The survey examined information on SHS exposure at work, at home, or when visiting various public places in the past 30 days among those who visited those places. It also inquired if respondents support laws prohibiting smoking in various public places.

The survey found that:

- 17.6% of adults who worked indoors (0.7 million adults) were exposed to tobacco smoke at the workplace.
- 14.3% of adults (3.1 million adults) were exposed to tobacco smoke at home.
- 21.2% of adults (2.1 million adults) were exposed to tobacco smoke when visiting restaurants.
- 86.1% of adults (3.1 million adults) were exposed to tobacco smoke when visiting bars or nightclubs.
- 30.2% of adults (0.5 million adults) were exposed to tobacco smoke when visiting universities.

ECONOMICS

The survey examined economic aspects of tobacco use by current smokers of manufactured cigarettes, based on information from the most recent purchase that included source of last cigarette purchase; expenditure on cigarettes; unit and type of exchange of last cigarette purchase; and perception of cigarette prices.

The survey found that:

- The most common source of purchase of manufactured cigarettes was shops (65.2%), followed by kiosks (30.7%), bars or nightclubs (1.8%) and street vendors (1.4%).
- Shops(65.0%) and Kiosks (30.9%) were the main source of cigarette purchase for Kenya males.
- Most of the cigarette smokers in rural areas (68.5%) purchased their last cigarettes from shops, compared to 59.2% of those in urban areas.
- Current cigarette smokers spent an average of Ksh[1] 1,072.00 per month on manufactured cigarettes, representing 14.7%of the monthly per capita gross domestic product (GDP) [2013][2].
- The mean amount spent on 20 manufactured cigarettes was Ksh102.7 and the mean cost of 100 packs (or 2000 sticks) of manufactured cigarettes as a percentage of GDP [2013] was 11.7%.

MEDIA

Mass media plays an important role in the campaigns for and against tobacco products. It is therefore an effective means of disseminating information on the ill effects of tobacco products and discouraging their use. Similarly, it is used in the advertisement, sponsorship, and promotion of tobacco products. Tobacco Advertising, Promotion, and Sponsorship (TAPS) is prohibited in Kenya through the Tobacco Control Act 2007. The Act prohibits false, misleading, or deceptive promotion; advertising/promotion through testimonials or endorsements; promotion by advertisements; and promotion by sponsorship. GATS Kenya collected information about noticing both anti-smoking information and TAPS in the past 30 days.

The survey found that:

- 53.4% of adults noticed anti-cigarette smoking information on television or radio.
- 55.9% of current smokers thought about quitting because of health warning labels on cigarette packages.
- 5.2% of adults noticed cigarette advertisements in stores where cigarettes are sold.
- 25.2% of adults noticed any cigarette advertisements, sponsorship, or promotion.

KNOWLEDGE, ATTITUDES AND PERCEPTION

The survey provides information on respondents' knowledge, attitudes, and perceptions of the dangers of smoking and tobacco exposure. Specifically, it asked if respondents believe that tobacco use causes serious illness and disease such as stroke, heart attack, lung cancer, high blood pressure, bladder cancer, throat cancer, stomach cancer, miscarriage, infertility, impotence, bone loss (osteoporosis), premature birth, and low birth weight. Lastly, the survey collected information onawareness of the 2007 Tobacco Control Act and support for increasing taxes on tobacco products.

[1]Kenyanshilling.
[2]Based on the 2013 annual per capita GDP figures (Shilling 87,542.715) from the International Monetary Fund.

The survey found that:

- 92.8% of adults believed smoking causes serious illness.
- With respect to specific diseases, 90.2% believed that smoking causes lung cancer, 70.4% believed it causes heart attack, 60.9% stomach cancer, 48.8% stroke, 54.4% premature births, 51.6%
  bladder cancer and 44.1% bone loss.
- About nine out of ten adults (88.0%) believed that exposure to SHS causes serious illness (88.6% of women and 87.5% of men).
- 97.3% of adults (97.2% of current smokers) reported support for the law prohibiting smoking inside restaurants.
- 80.1% of adults favored increasing taxes on tobacco products

RECOMMENDATIONS

GATS is the first comprehensive survey on tobacco use conducted in Kenya. It provides essential information on key tobacco controlindicators by gender and place of residence. GATS results describe the background environment for tobacco control in Kenya. Sustained tobacco control efforts arenecessary to minimize tobacco useand to prevent potential increases. The findings can inform public health policy by providing data relevant to existing and futuretobacco use interventions. Using the six categories in the MPOWER strategy package, the following policy implications arise from the survey findings:

1. Prioritize tobacco control by enhancing both human and financial resources for effective tobacco control interventions as stipulated in the Tobacco Control Act of 2007.
2. Develop strategies to establish tobacco cessation programs to support tobacco usersplanning to quit. Increase access toNicotine Replacement Therapy as part of the cessation program.
3. Develop health promotion and communication strategies to address and raise health awareness at the county and community levels.
4. Raise awareness on the social, environmental, economic, and health effects of tobacco use and exposure to tobacco smoke at institutions of higher learning. Educate people, especially in rural settings,on the dangers of smokeless tobacco.
5. Enhance enforcement of smoke-free work environment; of pictorial health warnings on tobacco packaging, including smokeless tobacco; and of the Tobacco Control Law provision on prohibiting cigarette sale by stick.
6. Increase import taxes on all tobacco products.
7. Establish tobacco control education programand develop anti-tobacco messages for the media.
8. Improve health services to effectively address tobacco-related diseases.

Table 1: MPOWER Summary Indicators, GATS Kenya, 2014

		Gender		Residence	
Indicator	Overall	Male	Female	Urban	Rural
M: Monitor tobacco use and prevention policies*					
Current tobacco use	11.6	19.1	4.5	9.1	12.9
Current tobacco smokers	7.8	15.1	0.8	7.1	8.1
Current cigarette smokers	7.7	15.1	0.7	7.1	8.1
Current manufactured cigarette smokers	6.9	13.5	0.6	7.0	6.9
Current hand-rolled cigarette smokers	2.1	4.3	0.1	0.4	3.0
Current smokeless tobacco use	4.5	5.3	3.8	2.5	5.6
Average number of cigarettes smoked per day	9.4	9.7	--	8.3	9.9
Average age at daily smoking initiation among daily smokers of age 20-34 years	18.8	18.8	--	19.1	18.6
Time to first tobacco smoke within 30 minutes from waking	72.0	72.8	68.8	77.6	70.3
Former daily tobacco smokers among ever daily smokers	28.5	27.2	47.7	35.9	25.3
P: Protect people from tobacco smoke*					
Exposure to secondhand smoke at home at least monthly	14.3	16.8	12.0	13.0	15.0
Exposure to secondhand smoke at work†	17.6	23.0	11.5	17.9	17.2
Exposure to second hand smoke in public places†:					
Government buildings/offices	12.5	15.2	7.9	11.5	13.4
Health care facilities	8.5	10.2	7.2	8.8	8.4
Restaurants	21.2	24.2	16.8	24.9	18.6
Public Transportation	12.4	14.1	10.5	16.6	9.2
Bars and night clubs	86.1	88.2	76.1	87.2	85.1
O: Offer help to quit tobacco use					
Made a quit attempt in the past 12 months	52.4	52.5	51.9	57.2	50.2
Advised to quit smoking by a health care provider	34.1	30.0	--	25.3	38.8
Attempted to quit smoking using a specific cessation method:					
Quit without assistance	70.8	72.3	--	76.2	68.0
Pharmacotherapy	4.3	4.4	--	8.4	2.2
Counseling/advice	10.6	7.9	--	12.5	9.6
Interest in quitting smoking	77.4	77.8	69.7	79.3	76.5
W: Warn about the dangers of tobacco*					
Belief that tobacco smoking causes serious illness	92.8	92.9	92.7	95.1	91.5
Belief that smoking causes stroke	48.8	51.1	46.7	48.9	48.8
Belief that smoking causes heart attack	70.4	69.8	71.0	70.3	70.5
Belief that smoking causes lung cancer	90.2	91.2	89.2	94.3	88.0
Belief that breathing other peoples' smoke causes serious illness	88.0	87.5	88.6	92.3	85.7
Belief that smokeless tobacco use causes serious illness	83.4	85.0	81.8	86.0	81.9
Noticed anti-cigarette smoking information at any location†	61.5	61.9	61.2	65.1	59.6
Thinking of quitting because of health warnings on cigarette packages	55.9	56.1	51.8	65.2	51.5
E: Enforce bans on tobacco advertising, promotion, and sponsorship*					
Noticed any cigarette advertisement, sponsorship or promotion†	25.2	29.1	21.4	28.7	23.3
Noticed any cigarette advertisements in the stores where cigarettes are sold†	5.2	7.1	3.3	5.5	5.0
R: Raise taxes on tobacco					
Average manufactured cigarette expenditure per month					
(Average manufactured cigarette expenditure per month (local currency)	1,072.0	1,113.0	786.1	1,225.4	
Average price paid for a pack of 20 manufactured cigarettes (local currency)	102.7	104.4	--	94.5	105.8
Last manufactured cigarette purchase was in a shop	65.3	65.1	--	59.5	68.5
Last manufactured cigarette purchase was from a kiosks	30.7	30.9	--	36.0	27.8
Last manufactured cigarette purchase was from a kiosks	30.7	30.9	--	36.0	27.8

Notes:
† In the last 30 days.
Indicates estimate based on less than 25 unweighted cases and has been suppressed.

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