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Analysis of Non-Communicable Disease Prevention Policies in Kenya



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Abbreviations

ADCA	Alcoholic Drinks Control Act
AIDS	Acquired Immunodeficiency Syndrome
BAT	British American Tobacco
CSO	Civil society organization
CVD	Cardiovascular diseases
DMS	Director of Medical Services
DNCD	Division of Non-Communicable Diseases
HIV	Human Immunodeficiency Virus
FAO	Food and Agriculture Organization
FBO	Faith-based organization
FSNP	Food Security and Nutrition Policy
FCTC	Framework Convention on Tobacco Control
GYTS	Global Youth Tobacco Survey
ILA	Institute of Legislative Affairs
KEBS	Kenya Bureau of Standards
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KHSSP	Kenya Health Sector Strategic Plan
KRA	Kenya Revenue Authority
LMIC	Low and middle-income countries
MDG	Millennium development goals
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health



NNAP	National Nutrition Action Plan
MTPII	National medium-term plan
MSA	Multi-sectoral approach
NACADA	National Campaigns against Drug Abuse
NCD	Non-communicable disease
NGO	Non-governmental organization
NCD	Non-communicable diseases
NFSCC	National Food Safety Coordination Committee
NHSSP	National Health Sector Strategic Plan
NNAP	National Nutrition Action Plan
NTFIC	National Tobacco Free Initiative Committee
NTCAP	National Tobacco Control Action Plan
NTSA	National Transport and Safety Authority
PERAK	Pubs, Entertainment and Restaurant Association Kenya
SSA	Sub-Saharan Africa
STEPS	STEPwise approach to Surveillance
SUN	Scale Up Nutrition
TCA	Tobacco Control Act
TCR	Tobacco Control Regulations
TCB	Tobacco Control Board
TWG	Technical working groups
UNDAF	United Nations Development Assisted Framework
UNICEF	United Nations Children's Fund
WHO	World Health Organization



Executive Summary

This Kenyan case study report is part of a broader study examining the existence of non-communicable disease prevention policies and the extent to which multi-sectoral approaches were applied in the policy development and implementation processes in five sub-Saharan African countries: Kenya, South Africa, Cameroon, Nigeria, and Malawi. In particular, the study focused on policies addressing the World Health Organization (WHO) “best buy” interventions for non-communicable disease (NCD) prevention. These interventions address the four major NCD risk factors, namely: tobacco use, harmful alcohol consumption, unhealthy diet, and physical inactivity.

A case study design was used to capture rich descriptions of major policies related to each risk factor. Data was collected through document reviews and key informant interviews with decision-makers from various sectors, then coded and analyzed with the aid of NVivo, a qualitative data analysis software. Analysis was guided by the policy triangle, which looked at the contextual factors influencing policy adoption, policy processes, and those involved in the processes.

In terms of policy, participants identified various global and local contextual factors that influenced NCD prevention policy process in Kenya, including public health, political, socioeconomic, and epidemiological factors. In particular, there was increased global advocacy and political commitment to address NCDs in recent years. These efforts include global policies such as the Framework Convention on Tobacco Control (FCTC), which catalyzed the development of the tobacco control policy in Kenya. Another major global advocacy effort was the United Nations Political Declaration on the Prevention and Control of NCDs, which was followed by the 66th World Health Assembly endorsement of the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 (resolution WHA66.10). Kenya is a signatory to these UN declarations and therefore most of the policies on NCD prevention and their risk factors comply with the global guidelines.

The prevalence of NCDs and the risk factors at local level is high and on the rise. Kenya's health care system is not adequately responsive to the prevalence of NCDs and their risk factors. The health sector faces many challenges, including inadequate financing and infrastructure, leadership and governance challenges, as well as human resources challenges that hinder effective management and service provision. As a result, care for people living with NCDs is often inadequate and too costly for the majority of Kenyans. The increasing number of people suffering from NCDs has also put more pressure on the already weak health care system. In addition to health systems challenges, the policies were developed in the context of other local, social, economic, and cultural challenges.

Kenya, like many other African countries, developed and implemented various NCD prevention policies, some of which address the WHO best buy interventions. Tobacco policy addresses the WHO best buy interventions such as tax increases, bans on tobacco advertising, and warnings on the dangers of tobacco. The Alcoholic Drinks Control Act (ADCA) is also in place and addresses best buy interventions including taxation and restriction to alcohol access, although implementation is weak. Physical activity policies are not well developed. Food and nutrition security policies exist, but they do not adequately address best buy interventions for unhealthy diet and food. More recently, the Ministry of Health, with partner support, developed the nutrition action plan, which puts increased emphasis on promoting healthy diet and reducing



malnutrition. In addition, the country developed national NCD strategic plans in line with the Global Action Plan for the Prevention and Control of NCDs. Generally, the implementation of best buys is weak, lacking adequate funding and human resource capacity.

The policy process for most of the policies (apart from alcohol) were adopted following the global policy agenda. Although the alcohol policy agenda is locally driven, the policy statements and contents were framed in the context of a global agenda for alcohol control. The formulation processes were consultative, involving many stakeholders. Consultative meetings and technical working groups were formed to draft the policies. However, most of the actors involved in the policies' development were from the health sector. The policy process for some risk factors was slowed by inadequate resources to support the process as well as inadequate political commitment from various sectors. In many cases, the policy development process was supported by various non-state actors, including international bilateral organizations such as WHO as well as civil society organizations (CSO).

In terms of actors, the findings reveal that NCD policy development has a multi-sectoral approach (MSA) in the study countries, but the level of sector engagement varies from passive to active. There was higher sector engagement during the development of tobacco policies, followed by alcohol policies. Unhealthy diet policies had medium participation of different sectors in their formulation, with most of the actors coming from the health sector. Physical activity policies are not well developed, resulting in a lack of effective physical activity policies. The findings illustrate various facilitators and barriers in bringing sectors together to develop policies that address the increasing burden of NCDs in the region. Some of the key facilitators to MSA in NCD policy development in Kenya included advocacy by NGOs and CSOs and champions to drive the process. The main barriers were sectors' unawareness of their potential contribution, inadequate sector commitment, conflict of interest in the case of tobacco and alcohol policies, low political will, coordination complexity, and inadequate resources.

Even though various policies were developed to address the major NCD risk factors, there is need for more government commitment and allocation of funding to facilitate implementation. Funding is needed for enforcement, monitoring, evaluation and review of policies. There is need for a better coordination mechanism to enable engagement and actions by relevant sectors. This engagement will require clear roles and responsibilities, including a designated leader to oversee the processes. Enhancing multi-sectoral action is key, however: it is important to consider differing perspectives of stakeholders (e.g., industry) whose goals might be counter to the policy process. Finally, it is also important to incorporate implementation, monitoring and evaluation into the policy development process.



1.0

1.0 | Introduction



Introduction



The burden of non-communicable diseases (NCDs) and their risk factors are increasing in sub-Saharan Africa (SSA) (1-3). NCDs account for 63% of mortality globally, and 80% of NCD-related deaths occur in low and-middle income countries (LMIC) (4, 5). Current projections indicate that by 2020, the largest increase in NCD-related deaths will occur in Africa. By 2030, NCD-related deaths will exceed the combined deaths from communicable diseases, nutritional, maternal and neo-natal deaths by 75% (6). Four NCDs – cardiovascular diseases, diabetes, cancers and chronic respiratory illnesses – were identified as being responsible for the majority (75%) of NCD-related mortality (3). These four NCDs also share the same set of risk factors: tobacco use, unhealthy diet, harmful alcohol use and physical inactivity. These factors are linked to an increase in preventable morbidity and disability in the region, and currently cause more than 36 million deaths annually worldwide. More than a quarter of these deaths – 9 million people – occur before age 60 (6-8).

The First global ministerial conference on healthy lifestyles and NCDs control, held in Moscow in April 2011, set the stage for the UN's High-level Meeting on Non-communicable Diseases in New York and the subsequent political declaration in September 2011 (6). The Moscow Declaration on NCDs, which emanated from the ministerial conference, contained a commitment from governments to develop multi-sectoral public policies that create equitable health-promoting environments. The doctrine enables individuals, families and communities to make healthy choices and lead healthy lives while prioritizing NCD prevention and control, ensuring complementarity with other health objectives and strengthening engagement of other sectors (8). In this regard, governments pledged to promote, establish or strengthen, and implement multi-sectoral national policies and plans for the prevention and control of NCDs by 2013, taking into account the WHO 2008-2013 Action plan for the global strategy for the prevention and control of non-communicable diseases. This plan identifies the multi-sectoral approach (MSA) as a cornerstone for NCD prevention at population level. It also identifies several WHO “best buy” interventions for NCD prevention – including measures to reduce common risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol – that would deliver the greatest benefit in reducing population level risks in a cost-effective manner (9). Table 1 provides examples of the NCD prevention best buys interventions. It is evident that the implementation of best buys requires MSA. For example, raising taxes and enforcing advertising bans/restrictions on tobacco and alcohol will require the involvement of ministries of finance, health, and information, as well as the legislative arms of government, law enforcement, and the media.

Table 1: WHO-recommended “best buy” interventions for NCD prevention and control

Risk factor	Best buy interventions
Tobacco use	Raise taxes on tobacco Protect people from tobacco smoke Warn about the dangers of tobacco Enforce bans on tobacco advertising
Harmful use of alcohol	Raise taxes on alcohol Restrict access to retailed alcohol Enforce bans on alcohol advertising
Unhealthy diet and physical inactivity	Reduce salt intake in food Replace trans-fat with polyunsaturated fat Promote public awareness about diet and physical activity (via mass media)

Evidence exists for successful MSA on tobacco control in several settings (10, 11). However, there is limited evidence on the application and success of MSA for the control of other risk factors (i.e., harmful use of alcohol, physical inactivity, and unhealthy diets) in SSA. Evidence also exists on the use of MSA in improving population-level health outcomes. A systematic review of multi-sectoral interventions to address social determinants of health while improving health



equity was recently conducted (11). The review, which provided a comprehensive overview of the state of evidence on MSA, in general, found there were successful examples of MSA that resulted in health impacts, but had substantial limitations in that most interventions did not specifically address the social determinants of health. Instead, the MSA only included developed countries; focused on interventions in specific settings, such as schools; provided little detail about process; and often did not articulate how relationships between sectors contributed to outcomes.

This study is part of a broader study (12) that was implemented in six countries – South Africa, Malawi, Nigeria, Kenya, Cameroon and Togo – on the extent to which MSA is used in the formulation and implementation of NCD prevention policies, specifically those linked to WHO best buys interventions. This report focuses on the Kenya case study. The specific objectives for this study were:

1. To examine existing NCD prevention policies related to the four major risk factors, namely tobacco control, alcohol control, nutrition and unhealthy diets and physical activities in Kenya;
2. To assess the state of implementation of NCD best buys interventions, facilitators and barriers to their full implementation in Kenya; and
3. To examine how, and to what extent, MSA is used in the formulation of NCD prevention policies related to WHO best buys interventions in Kenya, as well as barriers and facilitators to application of MSA in policy processes.

1.1 Kenyan context

Epidemiological context

In Kenya, NCD accounts for more than 50% of total hospital admissions and more than 55% of hospital deaths (13). The cost of care for NCDs dominates health care budgets. One objective in the third and current health sector strategic plan is to halt and reverse the rising burden of NCDs (13). According to the recent steps survey, cardiovascular disease is the leading cause of mortality, with a rate ranging from 6.1% to 8% of overall national mortality (13). Cancer was the second-leading cause of mortality, accounting for 7% of national mortality. The prevalence of diabetes in adults is estimated to be about 4.6%, amounting to almost 750,000 people and 20,000 annual deaths (13). Finally, mental illnesses such as depression are rising and associated with other NCDs, such as such diabetes and cardiovascular disease, as well as risk factors such as obesity and physical inactivity. These rates vary among communities.

The prevalence of NCD risk factors is also high. Findings from the Global Youth Tobacco Survey (GYTS) in 2013 revealed a tobacco prevalence of 9.9%: 12.8% among boys and 6.7% among girls (14). The most recent STEPS approach to Surveillance (STEPS) survey in Kenya revealed that 13% of Kenyans use some form of tobacco product (13). The prevalence was highest in men (23%) compared with women (4.1%). The survey also revealed that 19.3% (33.8% male and 5.4% female) adults drink alcohol, with 12.7% being heavy episodic drinkers. About 6.5% of Kenyans (6.3% men; 6.8% women) did not engage in the recommended amount of physical activity, while 94% of Kenyans consume less than the WHO recommendation of five servings of fruits and vegetables a day for most days in a week. About a quarter of Kenyans add salt to their food, while 28% always add sugar to their beverage (13).

Despite the high and increasing prevalence of NCDs and their risk factors, Kenya's health care system has not adequately responded to this change. The health sector has faced challenges that hinder provision of both preventive and curative health services. Inadequate infrastructure, resources, leadership, and governance are all hindering factors to developing and providing effective disease prevention and management services, therefore care for people living with



NCDs is often inadequate and too costly for the majority of Kenyans. In addition, the increasing burden of NCDs puts more pressure on the already weak health care system.

Socio-economic context

Kenya is now a mid-income country with an economy that is fairly better than most of the countries in the region, but its economic growth is very slow. While some efforts were made to reduce poverty and increase income, the majority of the population lives in poverty. Absolute poverty remains at 46% (15). In addition, income has mainly improved in urban areas, where only about 20% of the population lives. There are also differences within urban areas, where about 60% of the urban population live in slums. Poverty has implications on NCDs due to the fact that the poor might not be able to afford healthy food or access quality care due to the high cost of preventive and curative health services for NCD-related conditions. While local agricultural production contributes much to the economy, market liberalization made unhealthy products easily available at reduced prices, which causes negative health outcomes.

The poor economic status is also a result of inadequate financial allocation to the health sector. During the past few years, the Kenyan government allocated only about 4% of the national budget to the health sector (16) (17). Despite increasing health care costs, NCDs continue to be under-prioritized in the health sector budget.

Kenya has a market-based economy that promotes economic competition and encourages foreign investment, therefore the existence of industries, including multinationals, influences production and consumption of tobacco and alcohol products. In addition, the socio-economic effects of poverty, child labor and health complications arising from tobacco farming are documented (18). All these factors are attributable to the increase of NCDs in the country.

Political context and guiding policies

Since 2013, Kenya has implemented a devolved system of government, whereby the national government is responsible for the development of policy instruments, and the sub-national level (i.e., the 47-county government) is largely responsible for policy implementation. This structure was designed to enhance better governance that ensures effective policy implementation at grassroots levels. This has implications on NCD policy formulation and implementation, given that policies take time to diffuse from one level to the next, and the growing pains of a new governance system might affect the ability of a country to implement even the most well-intentioned and well-supported policies.

In addition to the challenges of a new political governance structure, the Kenyan government developed several laws and policies to improve the health of the population, which have implications on NCD prevention and control. The current macro-level policies touch on all sectors. They include the Kenyan Constitution 2010, which emphasizes the right to health, and Vision 2030, which is the national long-term development policy that aims to transform Kenya into a newly industrializing, middle-income country, providing a high quality of life in a clean and secure environment to all its citizens by 2030. These high-level policies create an enabling environment for the formulation of the right policies to address health issues, including NCDs (19). In addition, the Public Health Act (Revised Edition 2012) has implications on developing policies and interventions to address NCDs.

Furthermore, there are health sector-based policies that support implementation of effective interventions to address health and well-being. These policies include the Health Policy Framework 2012-2030, which provides guidance on ensuring significant improvement in health status in line with Vision 2030. This policy framework emphasizes the need to halt/reverse rising trends and the burden of NCDs in the context of health sector reforms. The Kenyan Health Sector Strategic and Investment Plan 2013-2018 emphasized the need to address NCDs. In addition, the Kenyan



government prioritized NCD prevention and control in its National Health Sector Strategic Plan (KNSSP) 2014-2018 and National Medium-Term Plan (MTP II) 2014-2018. Prioritization also came from the United Nations Development Assisted Framework (UNDAF) 2014-2018 for Kenya; and the Kenya third-generation WHO Country Cooperation Strategy (2014-2019) (20). In general, the country currently has a conducive policy environment through which additional sector-specific and disease-specific policies can be formulated and implemented.

Further, the Kenya recently launched its main national-level NCD policy document, the National NCD Strategic Plan 2015-2020, which provides a blueprint for addressing NCDs in the next five years (13). This document launched at the time of study data collection, so has not yet been implemented. The document was adapted from the WHO Global NCD Action Plan 2013-2020, which aims to reduce global premature mortality from NCDs by 25% by 2025. The National NCD Strategic Plan aims to reduce morbidity and mortality due to NCDs and promote well-being through prevention and control interventions (13). It outlines interventions to address the four major risk factors: tobacco control, harmful alcohol use, poor nutrition and diet, as well as physical inactivity. The document emphasizes coordinated multi-sectoral engagement and actions involving both health and non-health sectors in order to tackle major NCD risk factors. Other approaches recommended include a life-course approach, human rights approach, equity-based approach, evidence-based approach and integration from policy development to service delivery (13).

1.2 Guiding framework

The study was guided by the Walt and Gilson framework of policy analysis (21), which focuses on four factors: i) The policy content, which includes the policy objectives, the way the policy is designed, whether there is an accompanying implementation plan and specific mechanisms through which the policy should be actualized; ii) the policy actors, which looks at who was involved in the policy processes, their roles, and who else ought to have been involved; iii) the policy processes, which include various stages of the policy-making process and the strategies employed to involve different actors; and iv) the policy context, which might include changes in political climate and management structures, socio-cultural, economic or technological changes, as well as changes in the global context that could drive development agendas between governments and development partners. The analysis described these four elements (12).

2.0



2.0 | Methods



Methods



2.1 Study design

The study adopted a retrospective case study design (22), which is appropriate to answer the 'why' and 'how' questions of events and processes that researchers have little control over. Kenya was considered a case study in which all risk factor policies were analyzed and described as part of a single case, looking at commonalities and differences across all policies across the country. This case study involves comparison across risk factors.

2.2 Data collection

Data was collected from 2014 to 2016 through document reviews and qualitative interviews.

Document reviews

The review aims to obtain information related to NCD prevention policy context and content, identify existing policies and gaps therein, and understand the policy development processes and implementation status. The review also collates country-specific findings from surveys detailing the prevalence of NCDs and risk factors. The review covered Kenya-specific NCD-related policy documents as well as policy documents from the SSA region. The documents were identified from relevant ministry websites including policy documents and reports from meetings and events. In addition, interviewees recommended documents and drafts of policy statements. Other sources included academic journals and various search engines databases (e.g., PubMed, HINARI etc., including open access journals); relevant donor/NGO and development partner websites for NCD program reports; libraries; and relevant search engines (e.g., Google/Scirus). An excel template extracted relevant information relating to policy process, context, content, and actors involved in the policy processes. The extraction focused on statements relating to the NCD major risk factors and the best buys interventions addressed.

Interviews

Interview guides were developed collaboratively by the study teams from all six study countries during a methodology workshop for the teams. Interview guides include questions for each policy identified during the document review stage related to the four key best buys interventions, including the context in which the policy was developed, the policy content, actors involved in the process, and the implementation status of each policy. In addition, data on how MSA was employed or not, the processes undertaken to ensure MSA, the challenges encountered, what worked and what did not work, was collected. The interview guide was first piloted in Nigeria and Kenya, and subsequently revised based on field experiences. During the field worker training, each team piloted the guide, and the interview guide was revised based on pilot feedback. Each country then used the final interview guide with minor adjustments to fit their context as necessary. The final interview guide is elaborated in the study is annexed (See Annex 1).

2.3 Sampling and recruitment of participants

Participants were selected using a combination of purposive and snowball sampling (23). First, sectors and institutions were identified for inclusion during an initial stakeholders meeting, then individuals within those sectors/institutions were identified. Institutions were selected based on their expected roles in NCD policy formulation and implementation. A balance was ensured between line government sectors, as well as the actors from the state and non-state spheres in each of the sectors. Individual research participants contacted were those who participated in the policy-making as well as those expected to have participated in the process, such as senior decision-makers in the selected sectors, such as department/division heads or program managers; heads of NGOs or other actors involved in NCD prevention programs or projects;



and heads of private sector institutions or departments and programs within those institutions involved in NCD prevention. We identified key individuals whose names are in the public domain and sent invitations to participate through telephone or email. If they agreed to participate, we sent an information sheet and outline of the interview in advance of the scheduled interview time. Follow-ups were made through telephone calls to those willing to participate.

We conducted the interviews at times and venues mutually agreed upon by the research team and respondents in venues that ensured privacy and were free from distractions and other security risks. All interviews were digitally recorded and lasted between 60 to 90 minutes.

2.4 Ethical considerations

We obtained informed consent from the participants prior to interview, which were conducted in private at places convenient for them. We assigned identification codes to all individual records, including audiotapes, transcripts and demographic information. Participants were not identified in the study findings; specifically, quotes used to support certain findings are not attributable to identifiable study participants. We stored all raw data and transcripts on a password-secured hard drive. The Kenya Medical Research Institute (KEMRI) Ethical Review Board, a nationally accredited body mandated to conduct such reviews, granted ethical approval.

2.5 Data analysis

Transcribed interviews were imported into qualitative data management software NVivo. A code book, collaboratively created by all country study teams, guided the coding. We conducted content analysis of the coded data. The key content areas were pre-determined based on the policy making framework developed by Walt and Gilson (1994). We also included emerging themes outside the established framework. Analysis involved identifying text linked with each content area and key themes, which were further analyzed by adding or discarding themes. Extracted document review data was analyzed and integrated with the interview data.



3.0 | Findings

3.0



Findings

3.1 Data sources

Documents reviews

In total, we reviewed 84 documents, which included national policy documents, published journal articles, reports from international organizations, such as WHO, and grey literature. See Table 1 for a detailed description of these documents.

Table 2: Types and number of documents reviewed

Type of document reviewed Policy area	National NCD policy documents	Published journal articles relating to NCDs prevention in Kenya	Reports from international organizations	Total
Harmful use of alcohol	13	4	4	21
Tobacco control	5	4	15	24
Physical activity	7	4	2	13
Diet and nutrition	8	4	1	13
National NCD strategy	3	3	7	13
Total	36	19	29	84

Number and types of respondents

Initially, 45 potential participants were identified for interview and 39 participated, as shown in Table 2. The majority of the participants were from the health sector, while others came from agriculture, education, NGOs, and private sectors, because during interviews we referred to individuals from various Ministry of Health (MoH) divisions who participated in development of specific policies.

Table 3: Number of respondents interviewed by sector

	Government including parastatals and academia	CSOs including CBOs, NGOs	Bilateral organizations	Private sector (including industry)	Total
Health	8	3	1	1	13
Agriculture	1	1	2	0	4
Education	1	0	0	0	1
Media and communication	0	0	0	1	1
Trade	2	0	0	0	2
Law enforcement	1	0	0	2	3
Parliament	3	0	0	0	3
Finance	1	0	0	0	1
Other sectors	5	5	0	1	11
Total	22	9	3	5	39

Organization of findings

We first describe the global NCD policy context, then the policy context in Kenya. We describe the NCD prevention policies related to alcohol control, tobacco control, unhealthy diets, as well as promotion of physical activity based on their assessment against the elements of the Walt and Gilson framework, i.e. context, content, actors and process (21). In addition, we present the findings on the key barriers and facilitators to the formulation and implementation of each policy, as well as barriers and facilitators to MSA in the process of formulating and implementing the relevant policies.



3.2. Overall global NCD policy context

This study revealed that the increasing global burden of non-communicable diseases was partly the driving force for countries to act in addressing NCDs. The increasing burden of NCDs was attributed to several factors, including globalization; increasing urbanization; population growth resulting in trends towards higher consumption of unhealthy diets; higher rates of physical inactivity; and increased consumption of tobacco and alcohol (24). A global push for better policies for NCD prevention resulted, including more advocacy at country level for governments to do something about the increasingly visible NCD epidemic.

Several international meetings, resolutions and political commitments on NCDs took place in the past five years; most were led by WHO and supported by advocacy efforts spearheaded by civil society in the global north. The resultant actions, such as the formulation of the NCD Global Action Plan and monitoring framework, prompted several countries to develop policy documents that include strategic and action plans for NCD prevention and control. Kenya, as a WHO member country, was not left behind. Some of the most recent global initiatives that have driven NCD prevention policy development in Kenya include:

- Moscow declaration at the first ministerial conference on healthy lifestyles and NCD control in 2011;
- political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (A/RES/66/2, 2011);
- the WHO action plan on Non-Communicable Diseases 2008-2013, which provided global community guidance to act in a coordinated and coherent manner;
- the Global Action Plan for the Prevention and Control of NCDs 2013-2020;
- global strategy on diet, physical activity and health (resolution WHA57.17); and
- global strategy to reduce the harmful use of alcohol (resolution WHA63.13).

Study participants said that while there was high global political commitment to NCD prevention, the same could not be said of the in-country political will. Much as Kenya was a signatory to the global commitments to address NCDs, the country did not allocated sufficient resources to NCD prevention or even put the right policies in place, resulting in a slow process of policy formulation, largely supported by non-state actors.

In the following sections, we present the different case studies organized according to the main risk factor being addressed. We describe the NCD prevention policies related to alcohol control, tobacco control, and unhealthy diets, as well as promotion of physical activity based on assessments against the Walt and Gilson framework (i.e. context, content, actors and process) (21). In addition, we present findings on the key barriers and facilitators to the formulation and implementation of each policy, as well as the barriers and facilitators to MSA in the process of formulating and implementing the relevant policies. Information quoted directly from interview participants or policy documents is italicized and identified by its source.

3.3 Alcohol control policies

3.3.1 Contextual factors influencing alcohol policy development in Kenya

Global context

Global concerns about alcohol consumption and its negative health effects are increasing, with some actors calling for better national-level alcohol control policies (25). The WHO's Global Status Report on Alcohol (2014) indicates that about 16% of drinkers aged 15 years or older



engage in heavy drinking. More than 200 disease and injury conditions in individuals can be attributed to alcohol consumption, most notably alcohol dependence, liver cirrhosis, cancers, and injuries. From 2008, WHO drafted a global strategy to reduce harmful use of alcohol consumption. The strategy was endorsed in the Sixty-third session of the World Health Assembly after adoption by consensus (resolution WHA63.13) (26). The strategy recommends 10 target areas, including: leadership; health services' response; community action; drunk-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; monitoring and surveillance. Four priority areas identified for global action included public health advocacy and partnership; technical support and capacity building; production and dissemination of knowledge; and resource mobilization.

To strengthen national responses to alcohol-related public health problems, the WHO co-hosted a Global Alcohol Policy Conference, "From the Global Alcohol Strategy to National and Local Action", in February 2012. The conference provided a global platform for information exchange, sharing experiences, building new partnerships to raise awareness of the public health problems attributable to alcohol, and advocating for implementation of the global strategy at all levels. WHO also co-sponsored a follow-up Global Alcohol Policy Conference in 2013, "Alcohol, Civil Society and Public Health: From Local and National Action to Global Change". Kenya was represented at each conference.

However, country-level responses to this call are slow. The push for alcohol control policies in Kenya began before the WHO strategy came into place, suggesting there is a limit to the effect of global initiatives on the initiation and formulation of national-level policies. Nonetheless, global factors influenced the drafting of the policy content. Some participants acknowledged that the best practices in the policy were developed based on internationally known practices emerging from worldwide conventions and regulations.

Institutions such as the World Health Organization ... came much, much later, but of course, in terms of the literature, the standards and so on, we have had to look back at their literature and standards. — Parastatal Representative

We have the developed world (which already has policies in place) so we have to benchmark from what they had ... their best practices. I would want to believe that the policies that Kenya has initiated were informed by international best practice. — Ministry of Trade Representative

Local context

Historically, alcohol problems in Kenya and the need for policy began in the colonial era (27) to increased consumption, particularly traditional brews. The Local Spirit Prohibition Act and the African Drinks Control Act were enacted to control the increasing indigenous alcohol production and consumption. Several acts of parliament were put in place to touch on different sectors and agencies, as shown in Table 4. These regulations were used until a more comprehensive Alcoholic Drinks Control Act (ADCA) – famously known as the Mututho Law, named after the champion of the process – was drafted and signed into law on 13 August 2010. Study participants emphasized that the Kenyan government drove the alcohol policy development, not international pressure.

I must say that the issue of alcohol particularly ... the major thrust of work has been driven by the Kenyan government. There has been very little push from external partners as far as I can decipher from the records here. Our chairman who spearheaded this activity in parliament I think had [a] personal commitment to this, and talking to him, he ... narrates stories of how his very close family members were affected by alcohol, so his own personal experiences were a big driving force. — NACADA Representative



This quote highlights the role of local champions driven to action by the prevailing wider context. Several local contextual factors driving Kenyan alcohol policy development included public health concerns as well as social and economic factors. The alcohol-related public health problems rose in prevalence among NCDs associated with harmful alcohol consumption, including chronic diseases such as liver cirrhosis (15). Even in the absence of up-to-date research, such as evidence on the role of drunk driving in the increase in road traffic accidents (28), policy makers recognized these as issues that needed addressing.

From the health perspective we know that NCDs are on the increase ... in Kenya and one of the major risk factors for NCDs is alcohol use. So we really had to have policies to prevent and control alcohol use because NCDs are on the increase, they are very expensive to control and the best approach is primary prevention. — Academia Representative

Public health concerns resulted from a perceived increase in the consumption of illicit adulterated local brews. Frequent media reports about heavy consumption reported consequences such as sudden blindness and even death. This situation led to calls for legalization of local brews to regulate the informal alcohol market, although it was done without considerations for public health consequences (29).

I think it came as a result of people over-drinking. Let me say the way I remember is that there were so many people dying because of drinking alcohol that had poisonous chemicals in it, and so because of the deaths, and also accidents along the road that were attributed to drinking of alcohol, Mututho decided to come up with restrictions to try and curb the situation. — Ministry of Health Representative

Alcohol misuse was also associated with increased cases of domestic violence. A national survey of women in reproductive age found that alcohol was a key factor. Violence was two to three times more prevalent among women whose husbands overconsumed regularly compared with those whose husbands did not drink. Wives of often-drunk men were twice as likely to experience emotional, physical, or sexual violence as opposed to those whose spouses do not drink (30). Cases of domestic violence against men were also often reported in areas affected by high consumption of illicit local brews. Some of the study participants attributed the push for alcohol control to an increase in youth crime, which was thought to be driven by the easy availability of spirits, especially in small sachets.

For us, it was more of alcohol running amok, it was more of a lot of youth involved, a lot of the damage alcohol was doing, and this necessitated some agitation from parliament and also from the Ministry of Health, provincial administration, and the office of the president. So the agitation started with local brews. You would hear people say 'let's legalize chang'aa' [a potent locally distilled spirit]. That is where the heat started. — Ministry of Health Representative

The economic context relates to Kenya's alcohol industry growth, which increased in the past 30 decades with high beer production. The government taxes registered alcohol manufacturers. However, by 2011, only 45% of the alcohol consumed in Kenya was taxed; the rest fell outside the formal tax bracket (MoH 2011). The alcohol industry provides employment in manufacturing, bars and restaurants, which brings in foreign currency for exported beverages and generates tax revenues for the government (MoH 2011). There was also concern about the negative economic consequences of alcohol misuse. In many countries, alcohol control efforts are often hampered by economic arguments, whereby strict control is thought to negatively affect tax revenues and job creation. In Kenya, however, the perceived negative micro-economic and societal consequences of excessive alcohol consumption became key factors in the calls for strict alcohol control.

Societal costs associated with the alcohol misuse outweighed the benefits associated with production, sale and use, such as reduced productivity and alcohol-related absenteeism. Kenya's alcohol policy was formulated to address its negative societal effects.



I can remember the former president really lamenting that people were drinking when they are supposed to be working, so it was actually meant to stop people from drinking when they are supposed to be working to enhance productivity in the country. It was meant to ensure that working hours are not wasted on drinking and that people should go and work during working hours. They were times when even some of our teachers could come to class drunk ... people would just disappear from the office ... someone leaves their coat there and then he comes an hour or 2 hours later and is not himself. So it was now for us to protect our country economically. — Civil Society Representative

The multi-dimensional association between poverty and misuse of alcohol was another factor. Poverty was seen as a driver for brewing the illicit drinks by people who had no other means to earn a living. On the other hand, poverty was seen as the reason for increased consumption among the lower economic class who could not afford more conventional drinks.

Look at the [gross domestic product] — it's like everyone is poor. And when everyone is poor, some are brewing alcohol to earn their daily living. And some instead of going for the healthy, well-packaged, researched or the good alcohol, they are going for the "kill-me-quicks", the ones that are cheap and poorly made and you are not sure whether it is ethanol or methanol. So I think poverty and social economic status of the majority of Kenyans as a whole is another contributing factor. (NGO Rep 140620)

Other participants mentioned the alcohol industry's push for the government to regulate production, which was seen as a way to boost profit rather than prevent NCDs.

The push for strong alcohol control policies was driven by a multitude of factors, of which the recognition of effects on NCDs was one, and perhaps not the most important. There was a general public outcry to implement effective policies to prevent excessive drinking and related negative consequences. In addition, advocacy by stakeholders, including politicians, pushed the government to develop alcohol policies, including protecting the public from deceitful advertising.

3.3.2 Policy content

The Alcohol Control Act seeks to mitigate negative health, social, and economic impact resulting from excessive consumption and adulteration of alcoholic drinks (31). As stated in the policy document, the purpose of the act was to control production, sale, and use of alcoholic drinks.

Specifically, it aims to:

- a. protect the health of the individual from excessive consumption of alcoholic drinks;
- b. protect consumers of alcoholic drinks from misleading or deceptive inducements and inform them of excessive consumption risks;
- c. protect the health of persons under age 18 by preventing access to alcoholic drinks;
- d. inform and educate the public on the harmful health, economic, and social consequences of alcohol consumption;
- e. adopt and implement effective measures to eliminate illicit trade in alcohol, including smuggling, illicit manufacturing and counterfeiting;
- f. provide and promote treatment and rehabilitation programs for those addicted or dependent on alcoholic drinks; and
- g. promote research and dissemination on the effects of alcohol consumption, in particular the health risks that might arise from it.



The policy addresses the following WHO best buy interventions for alcohol control:

1. prohibit sale of alcoholic drinks to people under age 18;
2. ban alcohol advertising; and
3. restrict access to retail alcohol.

The act was amended in 2014 to comply with the Constitution of Kenya. In May 2015, the president signed into law the Alcoholic Drinks Control (Amendment) Act 2015, which introduced a remission of excise duty at 90% for beer made from sorghum, millet and cassava. The amendment also included establishment of treatment and rehabilitation programs that recognize alcoholism as a disease.

Table 4: List of other policy instruments related to alcohol control

Act	Areas covered
Customs and Excise Tax Act (2010)	Prohibitions include: Manufacture, packaging and distillation of spirits (Section 99 to Section 107); restrictions on importation of methanol; time of delivery determines rate of excise duty; duty on spirits – attenuation charge; ascertainment of strength, weight, and volume of spirits (sections 134-36).
Traffic Act (2012)	Section 44 defines and regulates drink driving, stipulates a fine of not less than a 100,000 Kenyan shillings or imprisonment for a term not exceeding two years, or both, for anyone found guilty.
Standards Act (revised 2012)	Creates the Kenya Bureau of Standards (KEBS) and empowers it through the Council to declare any specification or code of practice as a Kenya Standard, including standards for alcohol.
Weights and Measures Act (2012)	Under the sixth schedule, this Act describes the specific weights of alcoholic beverages for retail sale as follows: 250ml, 300ml, 330ml, 340ml, 355ml, 500ml, 750ml ,and 1 litre.
Food, Drugs and Chemical Substances Act (1992; revised 2012)	Section 3 outlines prohibition of the sale of unwholesome, poisonous or adulterated food. Alcohol is here considered a food product.
Trade Descriptions Act (1980; revised 2012)	Prohibits inaccurate descriptions of goods, services, accommodation and facilities in trade.
Pharmacy and Poisons Act (revised 2015)	Sections 35A and 35B relate to the control of products ideally used for production of medicinal drugs and prohibits their use for narcotics or production of alcoholic drinks.
Methylated Spirit Act	Section 11 prohibits methylated spirit as a beverage or medicine, curtailing production.
Anti-counterfeit Act (revised 2012)	Production and sale of counterfeit alcoholic is prohibited under section 32(b), which states it is an offence to manufacture, or produce any counterfeit goods.
Public Health Act (Cap 242)	This act requires mandatory inspection of all eating/drinking venues by health practitioners before licenses are issued. Section 127 provides rules on construction and regulation of buildings used for food storage.
Betting, Lotteries and Gaming Act (1966)	Section 26 prohibits sale or consumption of alcohol at betting and gaming premises.
The Police Act	Empowers the police to be principal enforcers of alcohol-related laws in Kenya.



Although these regulations and acts were designed to control aspects of alcohol production, sale and consumption, implementation was not effective (32). The current Act provides a more harmonized comprehensive policy that is expected to provide overall guidance in alcohol regulation. Hence the findings presented in this section focus on the Alcoholic Drinks Control Act 2010, which is the principal act in the control of alcohol production, sale and consumption in Kenya.

3.3.3 Policy process

Agenda setting and policy formulation

Unlike tobacco control policy, which is described later, participants said the alcohol control policy agenda was more locally driven. This is due to the local contextual factors described earlier. However, participants found the policy in line with the global agenda for NCD prevention, stating that it was aligned to the global agenda of reducing harm due to excessive alcohol consumption.

... the effects on the country majorly influenced alcohol policy development as opposed to the tobacco control policy that began globally. — Ministry of Health Representative 2

Mostly policies emanate as [a] gap in either the implementation of the previously existing laws or regulations.... We enacted ours before we even had the global alcohol control policies coming in place. For us it was more of alcohol running amok. — Ministry of Health Representative 3

Formulation process

The drafting of the policy document was led by the National Campaigns against Drug Abuse (NACADA), established in 2001 to initiate education campaigns against drug abuse among youth, including alcohol (32). NACADA was housed under the Department of Internal Security and Provincial Administration within the office of the President. The policy was formulated through a consultative process with stakeholders. In October 2006, NACADA initiated a stakeholder consultation workshop to develop a national strategy to regulate drug and substance abuse, including alcohol abuse. This strategy emphasized the need to develop a policy to regulate alcohol beverages. A stakeholders' workshop followed in March 2007, which led to the development of the current alcohol policy document. Participants said the subsequent policy development process followed a consultation as required by the Kenyan constitution.

You know, ideally, ideas originate from a single mind. Yes and you put a draft down and you share it out for people to perfect it. Then you now engage stakeholders, key stakeholders you table what your intention is and you give reasons as to why you want this policy, what it should do ... and how the draft policy looks like. And then you seek views so that these people can perfect it. They can tell you no, this one is hard, this one is okay ... Once you perfect it, you table it to parliament to be discussed. That way we have balanced views of everybody. You moderate them and you come now with a law which is by and large acceptable to the community. — Ministry of Trade, Tourism and EA representative

The process also involved engagement of policy champions at higher levels in government. The stakeholder identified champions in the government to enhance ownership. Participants mentioned that even though many stakeholders were involved, the ownership remained with the government. Various organs of the government were involved including the legislature.

Ultimately the ownership must be with the government. Once we agreed with the policy owners, we engaged with the legislative framework, we engaged with parliament which we approached in



a number of ways. First you need to identify the policy champion otherwise it will just collapse and in this case we identified Hon Mututho who worked closely with NACADA on this, and spearheaded its passage through parliament. Beyond him we also engaged with the parliamentary committee on security and administration because alcohol just like drugs are seen as a national security issue. — Parastatal Representative

The participants also noted that the policy was amended as issues emerged following the initial approval by parliament. The final formulation stage involved preparing a bill that was debated in parliament, passed, and then enacted into law.

3.3.4 Status of implementation

The participants said ADCA is partially implemented. The best buys intervention includes taxation, bans on alcohol advertising, and restricted access. Other elements implemented included prohibition of packaging and distribution of alcohol in sachets, licensing, and prohibition of sales to people under age 18.

Taxation

The government placed excise taxes on alcoholic products to raise the price of the product and thereby reduce the total quantity of alcohol consumed in Kenya. Even though specific figures were not provided, participants mentioned there were annual but slow tax increases for beer and spirits in the past few years. While the value of increasing taxes on alcohol is recognized, there are concerns that high taxes will make alcohol from licensed manufacturers too expensive, pushing consumers to unlicensed products. Some participants mentioned that the taxation process slowed because when tax on beer increases, people turn to local drinks, which are much cheaper but more harmful.

So for this year's budget, we implored them not to touch taxes on alcohol and maybe that's why they never added anything. When you add duty it becomes very expensive, so what happens [is] Kenyans who still want to drink will go for the cheap illicit brew, which is now more lethal and toxic. I think that's why [taxes] have not increased. — Parastatal Representative

Advertising

Event sponsorship for sports tournaments and music concerts by alcohol producers and importers declined since the ADCA. In addition, alcohol advertising is restricted, for example, adverts can only be aired from 8.30pm on TV and from 2pm on radio to reduce exposure to young people. Point-of-sale advertising is not clear in the legislation, therefore is not well implemented and most stores continue it.

Restricted access to retailed alcohol

Alcohol is easily accessible, given formal and informal brewing. A 2012 national survey by NACADA showed that out of the different types of alcoholic drinks, traditional liquor is the most easily accessible, followed by wines and spirits (31). Restrictions were made on alcohol sales to children under age 18, although there is no evidence this restriction is monitored. Restricted access is also achieved through regulation of bar opening hours. The ADCA restricts alcohol sales to 5-11pm in bars. Alcohol is also only sold in separate sections of shops and supermarkets where children are not allowed to enter. Participants also mentioned that alcohol from supermarkets or retail outlets is only sold during certain daytime hours. The ADCA's provisions were implemented in major towns including Nairobi, although participants noted drinkers find their way around these restrictions.



I think a fair amount of action is taking place [to restrict alcohol abuse]. Though there is still some room for improvement. We do know, for example, that alcohol is from supermarkets or retail outlets is only sold within certain hours. I think it is around 11am or 10am up to 8pm. — NGOs Representative 2

Licensing

According to the participants, issuing licenses to those who want to sell alcohol is ongoing. With the implementation of devolution, licensing alcohol was transferred to the county government, who now issue licenses to alcohol dealers, manufacturers, wholesalers and retailers. Some participants mentioned that this process is not well-coordinated at the county levels.

Drunk driving

The National Transport and Safety Authority (NTSA) is implementing a drunk driving policy. In Kenya, it is illegal for any person to drive while under the influence of alcohol. NTSA works closely with the media to warn against drunk driving through messages on radio, television, billboard and print media advertisements. However, strict implementation of this law has only been observed in some parts of Nairobi in the past few years.

Further implementation involves campaigns and education on the effect of drugs and alcohol. NACADA works with the ministry of health, ministry education, NGOs and CBOs to organize public education activities targeting youth.

The act has been implemented to some degree because we have seen offenders arrested and punished; we have also seen a lot of public education especially in the print and electronic media. We have also had education especially for the school-going children. — NGOs Representative 3

Challenges in implementation

Participants noted several weaknesses in implementation of other policy elements and a lack of a clear implementation strategy. Many participants felt ADCA implementation was disjointed and the approach was more reactive approach than proactive.

They lack an implementation strategy. I think they are now trying maybe because of what happened. As you know in Kenya we react; we are not proactive, we are reactive. So maybe after some time they'll stop but ideally they are supposed to do constant surveillance. Check the liquor outlets, pick samples, have them tested and act on the results. For me, since that issue [people died from taking adulterated illicit brews] happened up to now, I have not heard anybody arrested, charged or jailed. — Parastatals Representative 2.

Initially, when the law came into force, they were very active. But now, over time, we have relaxed. Once we opened a window of, if you are a tourist, you can take alcohol, we created problems. Like now, if you are in the coast region, you can take because it is a tourist point. You can take beer anytime, so people keep taking beer. — Ministry of Trade, Tourism and EA Representative

The implementation has been weak and not involving everybody, so there must be a space for people to come in. Secondly, I don't think the public in general has heard enough about the various aspects of alcohol. It's like we are only looking at drunk driving and then the occasional news of blindness after consumption of illicit brew. But other than that, the public have not realized the many social and economic ills of excessive drinking and the health implications, so I think a lot more advocacy is needed. — NCD Alliance Representative

The other thing about the implementation is that we focus too much on clamping down on the chang'aa and the illegal/unlicensed producers, closing hours of bars, and all those, but we



forget about prevention. The NCDs war will not be won by downstream policies, it should also be upstream where we can prevent. For example, we need to make sure that youth don't enter into the habit. It will be easier then than when a youth is already addicted and we try to reverse that. It is easy to change the course of a river at the source. So we want to move our policies upstream to prevention and promotion. — Ministry of Health Representative 4

In addition, participants noted other weaknesses in implementation of most alcohol-related laws, such as over-reliance on the police, who are the main law-enforcing body. They also noted that surveillance of alcohol standards across the counties was weak because Kenya's standards bureau lacks capacity to oversee such a wide scope of operations on top of its other mandates.

3.3.5 Funding

Participants mentioned that adequate funding was not allocated for ACDA implementation. What funding channeled to NACADA and the Ministry of Interior and Coordination of National governments is inadequate and meant for specific operations. However, there is a provision for how money collected from alcohol licensing should be shared among actors involved in alcohol control. Funding was allocated for treatment and rehabilitation of alcohol abusers in a few areas, but the exact amounts are unknown.

The fund is for implementation of demand reduction activities including education. The funds that go to assist in the enforcement of the law is collected from license fees on an annual basis. For example, in the 2012-2013 financial year, we collected about close to KES 800 million from licensing of alcoholic drinks. Now the act specifies that 50% of that money must be sent back to the district alcohol control committees to fund enforcement activities. It also specifies that 15% of the funds collected must go to civil society organizations (CSO) so they can conduct public education programs. The rest (35%) of the money remains here with NACADA to implement the policy, standards and so on and provide support to the county governments. Last year alone we dispatched about KES 99 million to 150 CSOs. — Parastatal representative 2

While the NACADA board takes responsibility for overall resources, an external national fund management committee oversees how funds are dispatched and used, ensuring a mechanism for obtaining and distributing financial resources for ACDA implementation exists. This committee includes the ministries of Devolution and Planning; Interior and Coordination of national Governments; Health; faith-based organizations like the Catholic Church secretariat; and the Treasury. What needs to be done is increase available resources by tapping into sources other than licensing fees.

3.3.6 Multi-sectoral action in alcohol policy formulation and implementation

Various actors are involved in the alcohol policy formulation process. The policy document intends to pursue a multi-sectoral approach using strategic partnerships to mainstream alcohol-harm minimization activities in all key sectors (32). Some actors participated in specific stakeholder workshops either to contribute to or to endorse the document.

Actors in alcohol policy formulation

The government departments involved included: the Ministries of Health, Education, Trade and Youth Affairs; a large number of stakeholders representing government parastatals and civil society organizations (CSO); and the law and enforcement representatives, private sector, faith-based organizations, professional associations and the media.

This act was prepared through multi-sectorial consultations involving a wide range of government officials from relevant government ministries, industry and other private sector institutions and



stakeholders involved directly or indirectly in all aspects of alcohol control. It was intended to provide a framework through which interventions that address all aspects of the misuse of alcohol in the country could be rationalized and coordinated. — Ministry of Health Representative 2

Some stakeholders, participating in their individual capacity, gave their experience. Actors from key sectors, representing different arms of the state (including the community), were not adequately involved at policy formulation but were involved at a later stage before the Act was amended.

Before we got it through to enactment, there was the issue of community participation. That is a critical element of policy formulation and what we did was to go beyond the outside ministries to engage through regional meetings, with the regional leaders, including community leaders, out there. We subjected this draft to their inputs. — Parastatal Representative

Among the many sectors and actors who participated in meetings to develop the alcohol policy, other existing institutions and agencies were created via acts of parliament related to alcohol control interventions. These institutions are presented in Table 5 with their specific functions.

Table 5: Institutions and agencies involved in ADCA development

Institution/sector	Established by	Principal function in alcohol control
MoH	—	Policy development; training implementers; education campaigns
NACADA	Alcoholic Drinks Control Act 2010	Coordinate a multi-sectoral public education and awareness campaign against alcohol and drug abuse in Kenya
KEBS	Standards Act	Develop, promote and enforce standards in the alcohol industry and commerce
Police	The Police Act	Enforcing all laws, including alcohol-related laws
County Alcoholic Drinks Regulation Committee	Alcoholic Drinks Control (Amendment) Act 2013	Development and implementation of county policies relating to the licensing of alcoholic drinks and the mitigation of negative impacts resulting from production, sale consumption and promotion
Department of Weights and Measures	Weights and Measures Act	Set the national standard weightings in consultation with the Cabinet Secretary
Pharmacy and Poisons Board	Pharmacy and Poisons Board	Determine awarding of licenses to producers of medicines and controlling misapplication of drugs
Kenya Film Classification Board	Films and Stage Plays Act	Regulate creation, broadcasting, possession, distribution and exhibition of alcohol-related films/advertisements
Anti-counterfeit Agency	The Anti-counterfeit Act	Restrict production, sale of counterfeit alcohol-related products
NGOs working in youth matters	—	Public awareness, health education, advocacy and campaigns against excessive alcohol consumption/harmful use of alcohol

Participating international NGOs include WHO, UNAIDS, United Nations Office on Drugs and Crimes, and SIDA. The policy also referenced WHO materials, and technical and statistical support during the process, and strengthened capacity of local actors in areas such as effective



dissemination strategies and how to form strong-lasting collaborations with international organizations.

Strategies employed to bring actors together

Stakeholder involvement in policy development is grounded in the Kenya Constitution of 2010, therefore alcohol policy development strategies include stakeholder mobilization through direct engagement, consultative meetings and workshops, as well as requests for written input into different versions of the draft document.

We have two to three strategies, really: the first one is direct engagement, which means that we talk on needs basis with specific stakeholders; the second strategy is through consultative meetings; the third one is to involve them in our processes like for example in the licensing process. For renewal of licenses we insist that we must have certificates from different departments. So they participate in different ways through written input into our processes but also in implementation. — Parastatal Representative

Actors in implementation

According to the participants, the government actors involved in implementation include: the District Alcoholic Drinks Regulation Committee, law enforcement officers, Kenya Revenue Authority, Kenya Bureau of Standards, District Public Health Officers, District Physical Planning Officers, NACADA, Alcoholic Drinks Control Fund members, Ministry of Education and Ministry of Health.

NACADA works closely with other non-state actors to implement the alcohol policy, including regulation of alcohol production and consumption, as shown in Table 5. NGOs and CSOs support alcohol control efforts through public awareness and education.

Our role has been especially that one of public education. In some parts of Western Kenya and even in some of these slums there is evidence that people use very funny things like methanol and Jik (a bleach detergent). In some areas, they even use formalin, and very little of the real substance just to bring that smell, but what people are taking is not even alcohol. People are taking very dangerous substances so long as they will make one drunk. Teaching the public on the harmful effects of drinking, teaching them about responsible drinking and trying to enlighten them on the various drinks and their effects, so that it is not just you drink everything that comes your way. —NGO representative 1

Participants said some actors not involved in the formulation and implementation of ACDA are still very important, such as community-level religious leaders and village elders, because people listen to these stakeholders.

I think there is a lot of power, particularly with religious groups ... There is also a lot of strength [from] village health committees ... and village elders. They can help with the implementation. They can also monitor because the police cannot reach everywhere where these things are being brewed. The village people know exactly who is brewing so they can form themselves into outfits that can enforce the law and report ... With empowerment they can even assess the alcohol products that are being made. — NGO representative 2

Other actors who should be involved include specific NGOs, women's organizations such as Maendeleo ya Wanawake, bar owners, school-going groups and alcohol retailers.

MSA enabling factors

Factors enabling different actors to work together to develop the ACDA include “sector wide approach policy” and the current constitution, which emphasizes multiple sector/actor



engagement in policy development and action. The presence of a national policy framework promoting and demanding MSA is an important factor.

The enabling factor which I can mention today is that there has been an approach towards sector wide approach to planning. This was adopted some years back ... we prioritize our areas and then present to a multi-stakeholder forum for discussion and input. — Ministry of Representative 3

The most important thing is the constitutional law, which demands that policies are formulated in a consultative manner and with all stakeholders. — Parastatal Representative 3

Improved communication and shared interest among different actors was another factor. As alcohol issues affect everybody, there was a recognized need for different stakeholders to address it.

The improved communication among the players made it easier to work together and the other one is a shared interest really because you know the taxpayers want to be facilitated. — Parastatal Representative 2

Strong leadership and availability of a champion was another factor. Participants saw the chair of NACADA as a leader and a champion who moved the policy agenda forward.

Our chairman, who spearheaded this activity in parliament, I think had personal commitment to this and talking to him he goes back and narrates stories of how his very close family members were affected by alcohol and so his own personal experiences were a big driving force. — Parastatal Representative

Factors hindering multi-sectoral action

The participants highlighted many factors that could hinder MSA, particularly lack of political will and adequate funding. The cost of bringing people together for many days to deliberate on draft documents was considered high. Even though the government was supportive of multi-sectoral action in policy-making, no budget was allocated to ensure the process was as multi-sectoral as possible. In addition, implementation of formulated policy is hindered by a lack of joint planning and budgeting, even for policies that are clearly multi-sectoral in nature. This makes key actor engagement in policy implementation difficult, or at best disjointed. Some stakeholders did not see the economic benefit of getting involved.

For example ... Ministry of Health would prefer that people do not drink at all. They can even say, 'close all the factories' and don't, even ban, let it be illegal. Yet Treasury will be interested in getting money to fund the budget because one of our core mandate[s] is getting money to fund budgets, so we will need to tax more. Kenya Association of Manufacturers have a different interest they want their members to be comfortable, and so they should not be taxed so much. Because of this Policy, they have their core mandate, their interest is completely different. — Ministry of Finance Representative

Participants said competing interests and priorities among actors was another factor. Many sectors have interests and priorities that can hinder full participation in policy formulation and implementation processes. Specific sector priorities are at times not aligned with the priorities of the alcohol control policy. There is need to develop separate strategic plans and performance outcomes so each sector and actor clearly understands their roles.

We have many competing priorities ... you will find that for example this week the ministry is preoccupied at the Counties with polio campaign. If there was a stakeholder meeting for the ACDA some people may not come. — Ministry of Health Representative 4

Kenya is unique in the sense that alcohol control prevention efforts are largely driven by the need to address the issue of illicit brews and their adverse health, social and economic



consequences. The majority of consumers taking alcohol from the informal sector overrides economic considerations of lost government revenue and taxes, so government and industry do not have much to lose by advocating stringent alcohol control measures. The growing NCD epidemic played a minor role in the urgency to enact and implement alcohol control policies.

3.4 Tobacco control policies

3.4.1. Contextual factors influencing tobacco policy development in Kenya

Global context

The international increase in tobacco consumption and resulting harm from continued use (33) drives international tobacco policy. In 2015, more than a billion people worldwide smoked tobacco, causing about 6 million preventable deaths annually (34). Tobacco is responsible for an estimated 5% of NCD-related deaths in Africa (35). If the current trend continues, deaths will increase to 10 million each year, and the majority will occur in low and middle-income countries (LMICs) (36, 37). While tobacco use is either declining or stable in the developed world, it is on the increase in LMICs because the tobacco industry aggressively markets in these countries. There is enough evidence to show that tobacco products cause health problems and result in death or disability (35), yet many SSA countries do not have policies to halt increasing use. Fortunately, there is an ongoing push to develop new and/or update existing tobacco control policies in Africa as a result of international tobacco control efforts.

The development of the current Kenyan tobacco legislation was largely influenced by the Framework Convention on Tobacco Control (FCTC), adopted in 2003 at the World Health Assembly (38), which outlines how to halt the tobacco use epidemic worldwide. This framework was the first global public health treaty aiming “to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke” (37). This treaty was adopted by the 56th World Health Assembly in 2003 and there are currently 180 countries party to the treaty; the most recent is Zimbabwe, which joined in 2016. In 2004, Kenya made history by being the second country (after Norway) to sign and ratify the WHO FCTC on the same day. The signature and ratification played a major role Kenya adopting the Tobacco Control Act (TCA), which was passed in Kenya in 2007.

In line with the WHO FCTC, we developed the framework with proposed sections of the TCA, which were actually supposed to be reflected in the policy statements. And the issues included reduction of on demand tobacco use, awareness creation, taxation and illicit trade. — Ministry of Health Representative 2

The FCTC was negotiated across until 2004 when it was signed and Kenya ratified it, so from that point we started developing the act. — Ministry of Health Representative 3

...when you sign and ratify you are obligated to do what the [WHO FCTC] framework says, so Kenya is one of the countries that had signed and ratified and therefore it was obligated to make sure that it domesticates the treaty. That's why the TCA is actually just the mirror image of the FCTC. — Bilateral Official 3

The Protocol to Eliminate Illicit Trade in Tobacco Products 2012 is a WHO treaty designed to combat the worldwide illicit tobacco trade and is supplementary to the FCTC. The formulation of this additional global policy was also critical in Kenya's push for a domestic policy.

I think the other one was about illicit trade issues because as we begin to control tobacco here, what measures are we taking to ensure that there is no illicit trade? — Ministry of Health Representative 2



Kenya has signed the protocol to eliminate illicit trade in tobacco products, which is a global policy, and already Kenya Revenue Authority is implementing a lot of the provisions of that protocol. So it is combating illicit trade to reduce loss of government revenue, secondly it ensures that cheap tobacco products do not flood the market, making tobacco products affordable for many people. — Ministry of Health Representative 5

Other than FCTC ratification, the push for domestic policy was supported by local evidence (39) that showed tobacco use was prevalent in most parts of Kenya and the trends among sub-populations (40-42). Local evidence made the case for implementing the act since the economic benefits of control would potentially outweigh the losses while improving public health.

Local context

Although tobacco policy formulation efforts are largely driven by international efforts, epidemiological factors also play an important role in Kenyan tobacco policy development. Tobacco consumption in Kenya is fairly high: before the policy was enacted, the 2003 Kenya Demographic Health Survey (KDHS) showed about 25% of men and less than 3% of women used tobacco (42). The Global Adult Tobacco Survey (GATS) conducted among those aged 15 years and older in 2014 revealed that Kenya's tobacco use was fairly high at 11.6% (19.1% among men and 4.5% among women) (43). This survey showed an alarming rate of tobacco use in women, unlike previous surveys. According to the 2014 KDHS, smoking among 15-49 year olds was 17% for men and 1% for women (15). According to the Global Youth Tobacco Survey (GYTS), there are promising trends in reducing youth tobacco use. The 2007 GYTS showed that 15.1% of students aged 13-15 used any type of tobacco product (boys 14.9%, girls 14.5%) (44); while overall tobacco prevalence in 2013 was 9.9% (boys 12.8%, girls 6.7%) (14). In Kenya's first-ever STEPs survey in 2015, smoking prevalence was 13.3% (men 23%, women 4%). Men always have a higher prevalence of tobacco use compared with women, but there is an increasing trend among women tobacco users (13).

Tobacco use is a public health concern in Kenya, and there is a heightened awareness that tobacco use causes more harm than good to the population and the general environment. In addition, economic analyses show the cost of treating tobacco-related illnesses is higher than the monetary benefits the government received from tobacco sales taxes (39). Many key informants consistently reported that a lot of money is spent on treatment compared with the revenue generated by the tobacco industry.

People were seeing it as a public health issue, people were seeing it as an issue that was affecting them, affecting the masses. — Academia Official 1

In addition to the disease or health effects of tobacco we also have the environmental effects, especially in tobacco-growing areas where it causes deforestation, the leaching of the soil, contamination of the water, pollution of environment, the soil the water and the air. — MoH Official 5.

As convinced as participants were about the public health impact of tobacco from both local and global studies, some felt there wasn't enough up-to-date, contextual data. This data gap was mentioned as a barrier to magnifying the tobacco problem.

The other big gap we have is data. When you are trying to do a research on NCDs you realize that the biggest challenge you will have is data. How many people really drink alcohol, how many people are smokers etc. — MoH Official 3

Economic context

Tobacco was introduced to Kenya in the early 1900s and the industry grew. Until the 1980s, the big player in Kenya's tobacco industry was a multi-national industry named British American



Tobacco (Kenya), Ltd (BATK), which began in 1965 (39). A local company, Mastermind Kenya, joined the tobacco market after the liberalizations in the 1980s. According to Patel et al, BATK enjoys high political connections and the Kenyan government is a known shareholder in the company (45). In 2002, BATK's market share was 71%, while Mastermind Kenya's was 22% (39). BATK serves the high-end brands while Mastermind serves the low-end brands.

Much of the tobacco used in Kenya is locally produced. Production is increasing, but it has been variable, especially between the years 2000-2008 (46). According to a report from the Institute of Legislative Affairs, Kenya produced 12 billion sticks of cigars and cigarettes in 2008, compared with about 6.6 billion sticks in 1990 (47). Nonetheless, tobacco does not feature among the top 10 products that contribute to the agriculture sector's marketed production, contrary to what the tobacco industries portray (46) (47). Increased tobacco consumption is linked to their affordability. Kenya is a net exporter of tobacco: its products are mainly for export and hence they do not attract duty.

Tobacco use in Kenya exerts a considerable health burden on the economy. More money could be spent on treating tobacco-related diseases, considering the revenue generated for the government in spite of the tobacco industry's claims to the contrary. The industry is thought to exaggerate and provide false information on the taxes it pays and the employment it creates.

We get about 6 billion or so in terms of earnings, or let's say, simply put, for every dollar we get from the tobacco taxation, we spend about three dollars trying to sweep whatever mess it has caused in terms of cancers, in terms of environmental degradation, in terms of destroying our water catchment areas. Tobacco causes a lot of damage, so now we understand that there is less to gain from the industry. In terms of money, coin for coin, we are losing. – MoH Official 3

Political context

According to participants, the former First Lady was responsible for Kenya's tobacco control bill. In 2004, the First Lady toured the largest referral public hospitals' children's cancer wards and was touched by the children's cases. Immediately following her tour, she arranged for the placement of the WHO FCTC as an agenda in a cabinet meeting for approval. Surprisingly — and a first for Kenya in terms of ratification of international convention — the cabinet approved the WHO FCTC, and it was signed and ratified the same day. As 2007 was an election year, the Tobacco Control Act 2007 being signed into law was unexpected.

The process to formulate tobacco control policies was largely driven by global context factors. A strong and binding WHO FCTC, and its accompanying instruments, played a major role in catalyzing the process. However, strong local evidence on the economic cost of tobacco provided the needed impetus for actors in different sectors to push for the policy. Understanding of the harmful effects of tobacco on health, unlike other NCD risk factors, meant that most people did not need convincing about the public health benefit of tobacco control. The availability of evidence in the public domain on the harmful effects of tobacco growing and production on the environment also contributed to the holistic argument for control. The high political influence that provided the needed push for the signing and ratification of the WHO FCTC bill is also noteworthy. Unlike the previously discussed alcohol policy, a combination of a strong global, local and political factors contributed to the formulation of the policy. It is well known that tobacco is a strong risk factor for NCDs, and to a lesser extent, acute respiratory infections among children, so one could assume that NCDs awareness played a greater role in tobacco control policy formulation than it did in alcohol control policies.



3.4.2 Policy content and history

Kenya's efforts in tobacco control started as early as 1992 when the country participated in campaigns that marked the World No Tobacco Day celebrations. The first tobacco control bill was developed 1998 before WHO FCTC ratification. Study participants said the pre-FCTC 1998 tobacco control bill was weak. In 2003 the focus shifted to ratification of the WHO FCTC, and when the WHO FCTC was signed and ratified in 2004, its domestication began.

Currently, the Tobacco Control Act (TCA) 2007 (48) is the principal law governing tobacco control in Kenya. It covers topics including but not limited to: bans on all forms of advertisement, promotion and sponsorship; bans on smoking in public places; and the packaging and labeling of tobacco products. The law also addresses public education and information campaigns; prohibition of tobacco sales to minors; and law enforcement. These regulations are consistent with the WHO best buys interventions for tobacco control mentioned in the global tobacco action plan (38). TCA specifically aims to:

- (a) protect the health of the individual in light of conclusive scientific evidence implicating tobacco production, use and exposure to tobacco smoke and tobacco products, in the incidence of debilitating illness, disease, disability and death;
- (b) protect consumers of tobacco products from industry's misleading and deceptive information;
- (c) protect the health of persons under age 18 by preventing access to tobacco products;
- (d) inform, educate and communicate the harmful health, environmental, economic and social consequences of growing, handling, exposure to, and use of tobacco products and smoke to the public;
- (e) protect and promote the right of non-smokers to live in smoke-free environments;
- (f) protect and promote the interests of tobacco growers by providing viable alternative crops;
- (g) adopt and implement effective measures to eliminate illicit trade in tobacco, including smuggling, illicit manufacturing and counterfeiting;
- (h) promote and provide for rehabilitation and cessation programs for tobacco consumers; and
- (i) promote research on the hazardous effects of tobacco production and use, including exposure to tobacco products and smoke, in particular health risks such as addictive characteristics of consumption and exposure to smoke.

Key elements and highlights of Kenya's tobacco control policy efforts are summarized in Table 6. After TCA was passed, a training manual on its enforcement (49) was developed in the same year (2007). The manual has four modules discussing the rationale for tobacco control, legal provisions, prosecution, and the implementation and enforcement of TCA. To facilitate the implementation of its key recommendations, the National Tobacco Control Action Plan 2010 (NTCAP) (50) was developed in 2010. NTCAP focuses on evidence-based interventions drawn from WHO FCTC and TCA 2007. The goal of NTCAP is to reduce the prevalence of tobacco use, its associated diseases, disability and deaths in Kenya. The strategies include: public information, education, banning the advertising and promotion of tobacco products, enforcing existing legislation on sales of tobacco to children, and widespread adoption of smoke-free policies in workplaces and public spaces.

The Finance Act 2012 was gazetted in early 2010 to raise excise duty rates on tobacco products, followed by the Tobacco Control Regulations 2014 (TCR) in December 2014. These regulation requirements were to become enforceable six months after the gazette notice and would strengthen implementation of WHO FCTC and TCA 2007. However, in 2015 Kenya's high



court ordered a temporary suspension of these regulations until the case placed by British American Tobacco (BAT) was heard. More than a year later, a ruling was made in favor of TCR and the regulations were to go into effect from September 2016. Although BAT filed an appeal, the High Court ruled it had no merit and affirmed the decision of the lower court.

Key informants mentioned these and other interventions in tobacco policy. Most of the respondents' contents seemed in line with WHO's best buys intervention for tobacco control.

The FCTC and therefore the [TCA] have the demand reduction and supply reduction measures. The demand reduction measures ensure that people are empowered enough not to demand products, while supply measures or policies intended to suppress the supply of tobacco products, so all these are geared towards reducing the consumption of tobacco and therefore the reduction of morbidity and mortality due to tobacco use. — MoH Official 5

Key informants also said TCA had provisions to protect non-smokers, as there was recognition that tobacco use also affects those who do not smoke.

Table 6: Elements of tobacco control efforts in the available policies in Kenya

Policy /Year	Elements in the policies
Tobacco Control Act 2007 (came into effect 2008)	Restricts smoking in public places Prohibits tobacco advertisement, promotion and sponsorship Requires health warnings and messages on tobacco products Recommends raising tobacco excise taxes to 70% of retail prices Enforcement
The National Tobacco Control Action Plan 2010 – 2015	Outlines public health policy on tobacco control for Kenya and Facilitates implementation of key recommendations of the TCA
Finance Act 2012	Raises excise duty rates on tobacco products
Tobacco Control Regulations (tabled 2014)	Requires cigarette packaging to have no brand names or trademark Requires cigarette packaging to have health warnings and visual pictograms in color

The TCA and NTCAP are rather comprehensive and include most aspects of WHO best buys interventions for tobacco control, and as such there were no identifiable gaps. These two main policies are complemented by the Finance Act 2012, which supports the raising of excise duty taxes on tobacco products. These instruments are also supported by other legal measures stipulated in the Public Health Act and by local municipal laws.

3.4.3 Tobacco policy process

Agenda setting and policy formulation

According to document reviews, discussions about Kenya's tobacco policy agenda began in 1992 when it participated in World Tobacco Day campaigns. Key steps in the tobacco policy process include development of the first tobacco control legislation in 1998 and the creation of the National Tobacco Free Initiative Committee (NTFIC) in 2001 by the Ministry of Health (MoH), followed by signing and ratification of WHO FCTC in 2004. After ratification, a bill was prepared and presented in parliament every year, but only adopted in 2007.

And so the framework convention of tobacco control was negotiated across until 2004 when it was signed and Kenya ratified it so from that point we started developing the act. — MoH Official 2



When you sign and ratify, you are obligated to do what the [WHO FCTC] framework says, so Kenya is one of the countries that had signed and ratified and therefore it was obligated to make sure that it domesticates the treaty. That's why the Tobacco Control Act is actually just the mirror image of the issue FCTC. — Bilateral Official 3

And also in line with the WHO FCTC, after that we had the framework regarding the sections of the Tobacco Control Act, which were actually supposed to be reflected in the policy statements. And the issues included on reduction on demand, awareness creation, taxation, etc. — MoH Official 2

It should be noted that parallel policies affecting tobacco control were in effect at different times, even as a comprehensive tobacco control policy was in development. The policy process was rather ad hoc and iterative, with parallel policies in development and implementation at different times. For instance, tobacco taxes were levied before TCA was formulated. Reforms in tax policy also took place separately from the process culminating in TCA. In addition, alternative cropping policies in the agriculture sector encouraged farmers to reduce growing tobacco. The push for a comprehensive policy was partly a result of obstacles encountered while enforcing aspects of the older law, Public Health Act (CAPS 242, 1982 & 1990). BAT successfully challenged municipal authorities in the major cities such as Nairobi, Eldoret, Nakuru and Mombasa from banning smoking in public places anyway under the Local Government Act (municipal bylaws 2006-07). A comprehensive policy was needed to support these measures and to expand enforcement efforts beyond the large municipalities. TCA's formulation and subsequent amendments were an opportunity to harmonize these policy initiatives.

The tobacco policy process – that is, the policy to develop a comprehensive TCA as well as a technical policy – gained momentum after Kenya signed and ratified WHO FCTC in 2004. In addition, the process of getting the technical policy led by the responsible line ministry worked in reverse: the legal instrument needed to support enforcement of the technical policy came before the act was enacted and before a comprehensive tobacco control policy or action plan were in place anywhere in government.

The Tobacco Control Act came into force into 2007... We have worked the reverse way because the act came into place, then the development of a ministry of health policy... that could address the non-communicable diseases. — MoH Official 2

Participants said the tobacco policy process was challenging and took a long time before it was enacted into law. However, poor documentation of the process meant that most respondents could not recall the steps they went through during TCA's formulation.

Part of the process I think was taking place at this level but what I know is that it went through the normal legislative process up to parliament. But what I can say is that it was challenging that is why it took from 2004 to 2007 quite a number of years. — MoH Official 2

The resistance from the tobacco industry was strong and their interference could partly explain the delay in the process of formulating the TCA and actual development of a comprehensive tobacco control policy this is described in greater detail in other sections. Lack of funding was also cited as a reason for the slow pace at which the policies were formulated. Actors need financial and human resources with the right expertise and experience to drive the policy formulation process. Lack of dedicated funds for meetings, travel, accessing information, and networking can hinder progress.

3.4.4 Implementation of tobacco control measures in Kenya

From participant's views and document reviews, some of TCA's provisions and most of the WHO best buys interventions for tobacco use were implemented to some extent.



The Act has been implemented. On a scale of 1-10, I would give it at 7 going to 8. — MoH Official 3

We have already implemented health warnings in the tobacco products. We have also implemented smoke free environments, so our implementation of the FCTC is first the development of the act, and then we have national laws that ban smoking in public places so that is one of the implementation. — MoH Official 5

Tax regimens changed since TCA came into effect. Recently, the Finance Act raised the excise duty rates on tobacco products at a rate of KSH 1200 per 1000, or 35% of the retail selling price — although it remains lower than the WHO tax recommendation of 70% — which is also reflected in the TCA. Tobacco use in all public places is prohibited and enforced in most areas.

Tobacco advertisement, promotion and sponsorship is also prohibited. However, outdoor advertisements on billboards and buildings still occur in several parts of Kenya (18). Tobacco packaging contains health information and warnings, which cover up to 50% of the front and back of tobacco packages. The government also trained media and CSOs and enforcement officers to support the implementation efforts. Training increased awareness, leading to removal of tobacco advertising billboards in major cities. The current focus is on sensitizing lower level implementation partners on the TCA requirements within the law. Training is also being conducted to guide enforcement agents.

There are efforts now to launch the Tobacco Control Act in different counties. I know it has happened; the first county was Kiambu (recently) and there are many more that are lined up. There is ongoing sensitization of the counties, so counties are going to be involved because implementation of policies is no longer a national function. — MoH Official 3

We have developed a training manual for enforcement agents and this manual we use it to train agents on enforcement of the Tobacco Control Act. — MoH Official 4

In addition, questions on tobacco use were added to several surveys, including the Kenya Demographic and Health Survey (2003, 2008-09, 2014), Global Tobacco Youth surveys (2007, 2013) and Global Adult Tobacco survey (2014).

No pictorial warnings or regulations were a hindrance to the policy process as the implementation could not happen without them. Study participants said that without the regulations, deliberations among stakeholders would not be fruitful because the same issues would be repeatedly discussed without moving forward.

Absence of regulations will remain a major hindrance in the implementation of what we are saying, so even these sectors coming together, they will come together to deliberate, and you know the deliberations will keep going round. — CSO/NGO/CBO Official 4

If the pictorial warnings are not ready, the regulations are not going to be gazette, so that has been an impediment — the fellows concerned with pictorial warnings are not completing their work. So every time we ask why can't we implement, we are told where are the pictorial warnings, then they are not there, and when they go to sit to deliberate on the pictorial warnings, it is like the industry has bought some people there, so you put pictures on the table like 'this one can it work', somebody says 'no, no, no, no', so they come out not having agreed on which photos ... you see the techniques that are being used. — CSO/NGO/CBO Official 4

The participants noted that with Kenya's devolved system, county-level goodwill and leadership is key to the implementation of the tobacco policy. They also noted that most counties began developing county-specific tobacco policies and training.

Another barrier to implementation mentioned was that policy impact was not felt or seen quick enough, which might deter actors from engaging with the tobacco control team.



Challenges in implementation

Although study participants stated that implementation of the activities was happening, they thought the pace at which it was happening was very slow. Many attributed this to the lack of funding required for the implementation of activities. Funding has continued to pose a challenge in the tobacco policy process. Lack of funds has been cited as the reason behind the long process of getting the policy in place and also the slow progress in implementation.

According to a shadow WHO FCTC report by the Institute of Legislative Affairs (ILA), the Tobacco Control Fund set up under TCA did not receive budgetary allocations from the Ministry of Finance (51) to support implementation of the act's provisions. The fact that it was not done is a manifestation of the policy's partial implementation. This is unlike what happens in alcohol control, where there is an established mechanism for raising and distributing funds (through licensing fees).

The Tobacco Control Board has never been financed since 2009, when it was put in place. The tobacco control fund established under section 7 of the act has not been operationalized, and this is the Ministry of Finance's responsibility. And I will tell you, this government commitment is not tested by the policies that it passes; it is tested by the resources it allocates to those functions. — CSO/NGO/CBO Official 3

There have never been any funds allocated by the Ministry of Health dedicated for tobacco control. But sometimes we write a proposal and say that there is money here for NCDs, and tobacco control is part of prevention of NCDs, so we justify that to use the money for NCDs. — MoH Official 5

First and foremost, there are very limited funds for implementing tobacco control, almost nil allocation for the implementation of TCA. — MoH Official 5

There was some confusion as to whether the Tobacco Control Board (TCB) received funding or not. Some participants mentioned that about KES33m (USD \$330,000) was allocated, which was considered very little but showed a level of commitment from the government's part. The budget was only for national purposes, such as development of policies, manuals, training, law revisions. Participants also mentioned that newly created county governments were expected to allocate funds towards county-level tobacco control, although some maintained that no funds were used and that allocation did not result in disbursement.

There is no funding, as such ... We have the tobacco control fund, which is supposed to be controlled by the TCB, but it has never received funds from the government. During [2014] World No-Tobacco Day, the cabinet secretary stressed that funds had been allocated, but from the time the act came into force, that is, in 2007, no funding has ever gone to the TCB, yeah, it is not funded. There is one person who receives her normal salary as a worker in the Ministry of Health ... she is the one handling the tobacco control unit. Yeah, so she is just funded as a staff handling that area, but there are no funds to implement activities. — CSO/NGO/CBO Official 4

(As) we speak today, there is no single government budgetary allocation for tobacco control ... for this financial year [2014] ... that we have been promised. When the team that represented the ministry came, the feedback that we got is that there is [KES] 33 million allocated for tobacco control, but we have not received funds. — MoH Officer 2

Funding was received for different policy formulation activities from other stakeholders, not the government. For instance, WHO, CSOs, and NGOs supported the tobacco policy process by providing funding for meetings, travel and other activities. This highlights the critical role civil society and development partners play in the tobacco control fight across the region, and how small funding amounts catalyzed and sustained the policy formulation process in many countries for both tobacco and alcohol control.



[CSOs] also provided us with funds in many ways to undertake what we were supposed to undertake. They funded meetings; they gave us materials that we could use — we didn't have that in the MoH and the other government departments. — MoH Official 5

In addition, participants cited a lack of human resources as a hindering factor in policy implementation. There are few staff in the MoH tobacco control unit; staff turnover or reassignment affect policy implementation. It is unclear whether people are assigned to tobacco control roles in other ministries outside the health sector, which is a reflection of the limited funding allocated to tobacco control generally.

Another challenge was lack of enforcement by those who charged with its responsibility.

It is the law that has to be enforced and the police are not good in this country in enforcement ... now the law is very clear about what needs to be done ... but you find people breaking that law and police are just watching. You find guys hawking one cigarette by one, even in the traffic jam, [though] it is illegal to sell cigarettes in sticks. The law says you can only sell in a packet, but now you find people hawking in sticks. You are supposed to put health warnings [on packages] but if you sell in sticks, it means that at the point of sale, you don't have health warnings. The mechanism for enforcing that is not there ... enforcement is the challenge. — MoH Official 4

The lack of proper enforcement might be partly attributed to the lack of resources experienced by other players in tobacco control, including the TCB, which has not received funding since 2009. It might also be a result of lack of awareness by law enforcement agents of their role, given their limited participation in policy formulation, unlike what happened in alcohol control. A planned sensitization exercise might close this awareness gap.

That is one thing that is very bad, and as I have said, limited resources also interfere. There are times the enforcement officers are unable to move, maybe because they don't have a vehicle, or they find that these distances are long, it becomes another issue, and because we don't have the regulations yet, that could still be a hindrance. — CSO/NGO/CBO Official 4

A lack of clarity on NCD roles of Tobacco Control Unit within the MoH and the TCB undermined utilization of the little funding that tobacco control received and led to delayed funding disbursements from the government.

It is also because of ... disorganization in the ministry, there [have] been a lot of problem[s] in the ministry where it is not clear what the board should do, what should the tobacco boss of that unit do ... and then there is the non-communicable disease division. What should it do, and yet the boss of the non-communicable diseases section is the secretary to the board? The board looks like it works separately from the division, so that kind of who-should-do-what and who-belongs-where has been a problem and that has made it hard to allocate funds, because it is like, who will control the funds? — CSO/NGO/CBO Official 4

Then they receive some money from donors – the board received some money from donors – but then that money cannot be enough for the activities that are required. — CSO/NGO/CBO Official 3

3.4.5 Actions by the tobacco industry

Unsurprisingly, the tobacco industry plays a key role in the poor implementation of Kenya's tobacco control policies. Their interference includes bribery, violations of existing policies, and challenges to the roll-out of new policies and amendments.

Participants cited several examples of the industry violating advertising provisions and peddling influence. Tobacco manufacturers somehow continue to advertise their products in local newspapers despite banning of this practice.



The tobacco industry advertised in the newspapers. They have done on three consecutive days, or four. They put an advert in the papers that says ‘this stick is like this and that and this is like this’, you know, so you find that violation is a big issue. That’s an issue, so the tobacco industry tries all ways to make sure things don’t move. — Bilateral Official 3

Industry interference makes it very hard ... Like now, the industry has been violating the law by advertising in the papers, they have recently had – I can’t recall the date well, but about one month ago – BAT placing Embassy [tobacco product] in The Nation of a Friday and then The Standard of Saturday [largest local daily newspapers] showing the changes that they have made on their product. — CSO/NGO/CBO Official 4

Participants noted that tobacco policy development and implementation took so long because the industry used delaying tactics to slow the process down, such as compromising officials with bribes like luxurious holidays and retreats for the ministry employees.

I think people were getting compromised by industry. We [MoH] refused to be compromised. — MoH Official

First of all, tobacco industry has always been against tobacco control not directly because they always claim that they are not but they, they watered down the tobacco control bill that we had. The tobacco control act that we have today is not what we had proposed in the first place because they just, they influenced the content that went into the act. — MoH Official 4

We agree on this as we go away, they [tobacco industry] send a booklet with information contradicting what we have agreed on, and then we start from square (one) again. It went on and on: I am sure you know of how the industry was supporting the politicians because we were developing a bill which should go to the parliament to be debated before it is passed into an act. The industry also went to the politicians. — Bilateral Organization Official 3

Participants said the tobacco industry was powerful mainly because it has money the ministries working on the tobacco policies didn’t have. The industry disguises itself or hides behind pro-tobacco policy NGOs to distort policy process. Participants also accused the industry of deliberate misinformation to slow down the process. Some felt that NGOs receive funds from the industry and as such advance the industry’s cause by bringing up arguments in meetings.

They have influenced because they have money, when we do not have money for tobacco control, so they are able to things that we are not able to do. — MoH Official 5

Yeah of course when it came to tobacco control, they in so many ways used delaying tactics to ensure that they raise questions that they were not consulted. We want this one put this way, we give them six months, they say no six months is not enough, they want us to give them two years. — MoH Official 4

There are companies and NGOs that are pro-tobacco control, they have the face of tobacco control and they come in and they fund us, but along the way they have very subtle way[s] of interfering in that: they introduce some arguments like economic arguments and keep us arguing and arguing, and diverting us, so they are with us but they are actually not. Behind them, the distant end support comes from the tobacco industry, because the tobacco industry understands if it funds you, and you come in, and one of your funders is BAT, we will definitely kick you out, so they hide their connections. — MoH Official 4

Another tactic the tobacco industry used is taking advantage of changes in government. It pushes its agenda to the new government even if a decision had already been settled.

When government changed in 2007 going into 2008, the same industry turned round and approached the leadership of the new government that they want[ed] that warning of ‘not for sale



in Kenya' removed because it was giving the impression that these were inferior products that Kenyans didn't want to be used in Kenya. We had to put our foot down and say they were being hypocritical, because this was their compromise proposal, and now when government changed ... they go against their own proposals and tarnish, give it a very negative commutation ... that is how the industry moves. — Ministry Official 4

The tobacco industry generated public sympathy through a campaign of exaggerated negative publicity, misleading the public to sympathize that the industry – despite being employers, philanthropists and event sponsors – was subject to unfair treatment.

They have tried to paint a picture, a good picture about their company, their industry, so they were giving donations, huge donations, and huge sponsorships. They created in the minds of the population that they were a good industry, so the population at one point, when we tried to do tobacco control, they thought that we were being unfair to this good company ... but we shared information about their products and how they do their business to just kill half of their users of their products, then the public's perception turned, and now there is support for the government in tobacco control. — MoH Official 5

3.4.6 Multi-sectoral action in tobacco control policy formulation and implementation

From participant's views and document reviews, tobacco policy formulation and implementation process followed a consultative approach involving multiple government sectors and other stakeholders. MoH and TCB, which consisted of various sectors, led the policy process, with CSOs strongly engaged in the policy-drafting stage.

The Ministry of Health took the stewardship of guiding them you know, what they need to do, it was government leading the way. — MoH Official 4

Actually the [Tobacco Control] Board took the leading role, and normally the secretary of the board guides activities such as this. — MoH Official 2

"Kenya Tobacco Control Act was drafted by CSOs and majorly KETCA, so we were just using the legal channels that are required, but it was actually the product of the CSOs. —CSO/NGO/CBO Official 4

Informant interviews reveal participation of actors from different health and government sectors. The NGO/CSO/CBO and private sectors also made a considerable contribution to the policy process. Participants said that tobacco policy was a success because it attracted a lot of interest, and so many worked on policy development and implementation. Of the invited stakeholders, those who had interest participated.

I think for tobacco control, participation was very wide. We included women groups, youth groups under the civil society, religious groups, the government departments, research institutions, so we did involve a wide variety of people and groups, and probably that is why we have made such tremendous achievements so far. — MoH Officer 5

The only thing I would say is that if they were left out, they were informed, but [if] they didn't have interest, it was hard to bring them into it. For some, I think the sensitization didn't convince them, so some people didn't take it seriously. But otherwise, we involved quite a number of those ministries, even trade. — Parastatal Official 1

Talking tobacco control, you know NCDs, the determinants of NCDs, are beyond the health sector. For example, I have given an example of enforcement, for us to enforce things that are put there, we need to go to the law enforcement agency; for us to pass the information we need



the media and other actors. By the way, I forgot to say that we train, we even trained journalists. We have journalists against tobacco. In fact, in our stakeholders committee, because we were a multi-sectoral committee, we had even journalists who were in it, and we would involve them in everything we do. — MoH Official 4

The new Kenyan constitution demands stakeholder participation, so the study participants initially focused on all stakeholders who added positive value to the policy. At the last meeting, they invited stakeholders who would have negative value, such as industry, to fulfill the constitutional requirement.

You will realize that for the final stakeholders meeting, we brought in the stakeholders who would affect the process negatively. And those are the industry themselves. But this was a requirement of the constitution. We felt that should be exhaustive and that would give Kenyans the policy they ... require to safeguard health. — MoH Official 2

Actors Involved in Formulation of Tobacco Control Policy

Participants mentioned actors' roles including spearheading the drafting process, attending meetings to provide input on drafts and implementation, and guiding the process to meet WHO FCTC guidelines. Table 7 is a summary of roles played by the different institutions, sectors and stakeholders mentioned in the study.

Table 7: Roles of actors in tobacco control policy development process

Institutions/Sectors/ Stakeholders	Roles in policy formulation and implementation
Ministry of Health	Led formulation and implementation processes, spearheaded policy process, drafted policy documents, trained enforcement officers and health workers to implement TCA, facilitated government departments to implement their roles, provided technical expertise to stakeholders involved in policy formulation, fundraising
Ministry of Finance	Provided information on revenue amounts generate from industry; engaged in taxation discussions
Ministry of Agriculture	Provided suggestions to tobacco growers on alternative cropping, results from soil economic analysis studies on which crops would give higher yields
Ministry of Education	Contributed to policy process; expected to protect and educate children and include this in their education policy
AMREF	Provided research findings on tobacco studies; contributed to the process
Ministry of Trade	Increased taxes on tobacco; reduced illicit cigarettes
EAC ministry	Ensured harmonization of trade and tax regimens across East Africa to avoid illicit trade of tobacco products
Tobacco industry	Provided information on product contents
Kenya Revenue Authority	Involved in process to track tobacco products for tax purposes
Pubs, Entertainment and Restaurant Association Kenya (PERAK)	Participated in process to provide industry with guidance on how law/policy compliance



Police	Implemented law, followed up on contraband tobacco products
Children's department	Provided information on early initiation of drugs in schools
Ministry of Environment (NEMA)	Provided environmental laws on environmental pollution and environmental degradation due to tobacco curing
KEMRI	Provided research, participated in the meetings, contributed to bill content and led baseline situational analysis
AG office	Advised on regulations with reference to legal requirements of a policy document; legal advisors to the government; assisted drafting and implementation of legislation; advised on bill structuring and statutes before law could be drafted
LSK	Legal entity representing the general public, also acts as government watchdog. Supplemented attorney general perspective and advice and verified AG prescriptions in line with practice norms
Business community (KAM)	Employs a large number of population
Consumer information network (CIN)	Organization that empowers consumers through education and advocacy, research on consumer concerns and to effectively serve as a center of integrity on consumerism
NGOs – KETCA	Drafted TCA; assisted in outreach such as public education, rallies and processions; raised awareness via social media; conducted research and disseminated findings; monitored industry violation and interference; monitored Ministry of Health and enforcement officers to ensure duties were carried out; monitor CSO implementation; nationwide training of enforcement officers and local leaders; participated in county-level legislation process; assisted drafting county-level regulations; asked Kenya to take part in international anti-tobacco process
Local government (provincial administration)	Implementation work, for example: designation of smoking zones, destruction of the tobacco advertising billboards
CSOs – civil societies (ILA)	Advocated for tobacco control; lobbied; funded meetings; monitored compliance (enforcement); mobilized people and supporters; raised awareness
Bilateral organization (WHO)	Provided technical support; advised on policy; suggested what to emphasize; ensured proposals were line with FCTC guidance; provided funding
Academia	Provided research findings; justified policy's importance; compared international tobacco policies
Other international organizations (US, Denmark, etc.)	Provided information on how anti-tobacco law implementation is successful in their countries
Members of Parliament	Supported the bill; assisted pushing bill through parliament
Media	Messaging

Relevant actors not involved in tobacco policy process

Participants highlighted what sectors should have been involved in the policy formulation process but were not, such as law enforcement, which partly explains implementation weaknesses. The participants felt that the police and the magistrate needed to be sensitized on the law to properly



carry out appropriate enforcement, ensuring the courts fine appropriate to the violation. Courts are penalizing with minor fines as low as KES 100 (USD \$1) and sentencing violators to cut grass instead.

The law enforcers, the lawmakers we had lawyers with us, and I believe I would call them lawmakers, but the enforcers were not strongly there, but we later brought them in as when we got the act. — Parastatal Official 1

Some participants noted the lack of involvement from the Ministry of Agriculture, tobacco farmers and religious bodies.

I'll want to believe that they have not been involved in the mainstreaming of MSA. The public health unit, which is under the Ministry of Health, is going alone, is not bringing on board the Ministry of Agriculture. So the Ministry of Agriculture should also look for its own resources to implement the acts. We are concerned about tobacco consumption at national level and at secondary level ... about the cigarette but not the source of the cigarette. If the growers can be told there is an alternative crop, and they stop growing it, the industries will die a natural death. — Other Ministry Official 3

In addition, some felt the public outside the big cities was not involved, and if they had, there would be more awareness of the policy. Others felt that without the involvement of community and local leaders, cross-border illicit trade of cheap cigarettes not manufactured in Kenya would continue to thrive.

These are people to be involved so that they are aware of what is supposed to be taking place, even the communities, especially [those] around the border, should be sensitized because we have a lot of cross-border business ... illicit trade. It is illegal trade going on, like now, if you come to Western (Kenya) and get in touch with people on the ground. You will find cigarettes that are not manufactured in Kenya being sold very cheaply and they come through Uganda, so if people come to learn that this is illegal, they will help. So we need to sensitize local leaders so as to help in the implementation. — CSO/NGO/CBO Official 4

The participants had mixed views on media involvement. Some said they were not involved in the policy formulation process, although others said they were but whether it was formulation or implementation is unclear. County-level governments were not involved in the initial tobacco process but there are plans to involve them in the next round of sensitization meetings.

The county level, the county governments now, I think we have left them out, but we are planning in this financial year ... to be able to disseminate the act and devolve tobacco control to the county governments, where they can actually take hands-on and implement and enforce the act. — MoH Official 5

Participants' views were mixed on industry involvement in tobacco policy development. Many believed the industry was not involved in any control formulation processes until the last stakeholder meeting, however, others believe the industry attends meetings in disguise and distorts any agreements made. One respondent specifically noted that the industry is invited to the last stakeholders' meeting to meet constitutional requirements involving all relevant stakeholders in policy processes.

FCTC says that the ... tobacco industry must be aware of what is going on, so they were coming for the meetings. — Bilateral Organization Official 3

Some participants felt industry should not be involved in the policy process as it is a conflict of interest. They said FCTC regulations did not allow for pro-control groups to sit alongside the industry to deliberate on tobacco control. Although most study participants said they were against the industry being a stakeholder, others argued that industry was involved one way or another in policy development.



It is very clear that if an organization is involved in the production, distribution or marketing [of] a product that is harmful to health, we don't entertain them when we are formulating policies for public health because there is a conflict of interest. So we ensure we don't invite industry, industry-like parties, particularly tobacco production industry. You cannot invite tobacco manufactures to discuss with you how you are going to formulate a law to curtail their product. — MoH Official 4

In the spirit of the FCTC, we cannot sit down with the tobacco industry; we have irreconcilable and fundamental differences. There is conflict of interest between public health and tobacco industry, we cannot ... there is nothing in common. — MoH Official 4

Tobacco industry has always wanted to have a seat at the table, which means they want to be part of the decision-making and policy development in tobacco control, and that is wrong. Because actually, you are making policies for tobacco control; they cannot be party to that, but they always claim that they are stakeholders in tobacco control, but really, in my opinion, they are not. — MoH Official 5

The industry is not a stakeholder in matters of health because they are the enemies of health ... you cannot get somebody who causes disease and ... say that is a stakeholder on issues that concern health. But there are those who insist the industry is a stakeholder, so there are times we have even had meetings where the industry is invited, depending on who is convening the meeting, and then it becomes difficult ... to transact business because ... we start fighting over [whether] ... the industry should ... be here, and the others are saying no they should, we should hear their side. — CSO/NGO/CBO Official 4

Strategies used to bring the actors together

Public stakeholder forums, also known as Town Hall meetings, were the main strategy used to bring actors together. They were held in City Hall and anyone could attend, including the industry. Three public stakeholder forum meetings were held: two were organized by NACADA and one was by MoH. Forum organizers used newspapers to advertise that all who had a stake in tobacco control were invited to attend the meetings.

Another strategy was NTFIC, a multi-sectoral coordinating committee, bringing together all relevant actors and sectors involved in tobacco control. NTFIC convened several meetings to discuss tobacco control strategies and activities. All relevant government departments, civil society organizations, private sector and relevant bodies were invited to these meetings except industry. The NTFIC formed smaller technical working groups (TWG) for policy drafting and held breakfast meetings with religious bodies to loop them into the coordinating committee. CSO funding was quite instrumental in funding all NTFIC meetings.

Participants mentioned several other strategies used to bring stakeholders together during the formulation and implementation of the tobacco control policies, including invitations. Using this mode of invitation was deemed to give importance to the meeting and as a result more people would attend. Another strategy used during implementation of the tobacco policy was training the implementation officers. Other strategies mentioned by key informants included the involvement of many stakeholders in the policy process and also letting stakeholders know their roles, responsibilities and their expected outcomes in the policy process.

Factors that facilitated multi-sectoral action

Facilitating factors in MSA formulation and implementation of the tobacco policy were political commitment and strong leadership. The MoH played a big role in taking the lead, but a strong civil society was critical to the initiation and sustenance of the process.



I think there was a common understanding among people in the movement against tobacco. We did not have a challenge of their coordination because the MoH took the stewardship of guiding them. It was government leading the way and they were coming in to contribute. You see, until 2007, people had struggled to get a law to control tobacco; every time they tried to do it, it just died off... but that year we managed to get [one].” —MoH Official 4

My experience has been that it requires a lot of political good will from the government ... political commitment to the issue, that's number one. Number two is a strong coordination mechanism that ensures at the end of the day that everybody participates, everybody owns the process, and everybody contributes to the process, so that you don't have stakeholders who feel that they are passengers on this process. — CSO/NGO/CBO Official 3

Having a stakeholder coordination mechanism, with people guiding the process, was key in the successful participation of many stakeholders. NTFIC was developed about the same time as TCA; convened by the NTFIC chairman who heads the MoH Division of Non-Communicable Diseases (DNCD). The committee was also chaired from time to time by the Director of Medical Services (DMS). The mechanism served three purposes: information-sharing, discussion of strategy, and coordination of activities. The committee also had wide representation from the relevant tobacco control sectors, including government, civil society, religious bodies and the private sector.

I think if we have a coordination mechanism that all players meet, that all players plan together and allocate resources and allocate responsibilities then we can actually go far in joint planning, implementation and also resource mobilization. — MoH Official 5

The coordination committee (NTFIC) would meet once a month to discuss and agree on strategy, coordination of the various activities by civil society and government departments (in lobbying, media advocacy, drafting, education and awareness, how to engage with industry, etc.), and allow sharing of information. The team met once a month and if there was something special to discuss, a special meeting would be called. There was no funding to support this at the time and the Ministry of Health availed its board room. — CSO/NGO/CBO Official 7

You first have to agree what the strategy is ... then you allocate various activities to people and coordinate them. — CSO/NGO/CBO Official 7

Passion and commitment is important for MSA and were mainly seen in champions or advocates, which is how they kept the tobacco policy environment vibrant.

It requires a lot of commitment and passion by the tobacco control advocates. — MoH Official 5

Then we have the TCB, which has individuals and characters who are very passionate ... about tobacco control. So the environment has been kept vibrant because of the passion of the players. Also the TCB, which the act gives an advisory role, has really done their part. — MoH Official 3

Participants also echoed that common goals and understanding, interests and vision, were very important, and once stakeholders knew what their roles were, it was easier for them to work towards that common goal.

It is the general consensus that tobacco is harmful to human health, and that we need to control tobacco consumption. That was a basic understanding, and therefore, the act was hatched and now it is a law. — Other Ministries Official 3

A lot of people agree tobacco is harmful. I mean, it is not like alcohol, where you have to convince the policymakers that we should regulate this. We have reached a point where we have seen now people coming, coalescing around tobacco control. — MoH Official 3



Resources to run the process was another facilitator of MSA. These include funding and expertise from both the government and the international community. A clear budgetary allocation to support activities was also a facilitator.

The Ministry of Health ... has been very supportive both in terms of resources and expertise, so we have worked together so well. The other one is a lot of support from the international community, because most of the activities we have undertaken have been funded by partners from outside. — CSO/NGO/CBO Official 4

Awareness of key actors in the health sector came out as an important factor to facilitate MSA. Many respondents from the health sector were aware that they needed to work with other sectors to achieve their objectives.

It requires you to work with other sectors because number one, tobacco control is not a health problem – it is also an economic problem, it is a social problem, it is an agriculture problem. Yeah, it is a consumer problem, it is an environmental problem, and so you need the other people to work with you for you to achieve, and MoH being [a] focal point for tobacco control does not mean that it is MoH legislation. You have to convince the other sectors to do what they need to do to help you achieve your objective. — MoH Official 5

The determinants of NCDs are beyond the health sector. For example, I have given an example of enforcement: for us to enforce things that are put there we need the law enforcement agency; for us to pass the information we need the media and other actors too. — MoH Official 4

Study participants felt stakeholders needed to be engaged early in the process otherwise it would be difficult to get their buy-in or it would take a long time to bring them up to speed with all the earlier discussions and decisions. Also, having an accountability mechanism was seen as key as it brought a measure of responsibility.

You do and also to be responsible for our actions because at some point you realize that even the government has to be accountable to the public and say that have, we said this and we have done this. — MoH Official 5

Kenya's constitution requires consultation of all stakeholders. As the TCA subsidiary policies were developed after the new constitution was in place, participants mentioned said they had to bring all stakeholders together, including the tobacco industry, to fulfil the constitutional requirement.

Barriers to multi-sectoral action

One of the barriers to MSA was lack of full understanding of the aims, scope and role of the policy by relevant stakeholders. It was noted that all actors agreed that tobacco control was good but they lacked a common goal given their different mandates. A few of the stakeholders had a different expectation from what the tobacco policy was trying to achieve. This led to conflicts between actors. It was mentioned that the ministry of health and ministry of trade had differences in opinions when it came to tobacco control issues. Many conflicts were mentioned to occur among the different stakeholders and this was also linked back to coordination.

The Ministry of Trade had an expectation of promoting Kenya tobacco farmers association. They were also involved but their expectations were contrary to the expectation of the process.... those who are stakeholders who are affecting the process negatively. — MoH Official 2

The other thing is conflict between the Ministry of Health and Ministry of Trade. Just like we have a performance contract to sign that we have kept people healthy, the trade ministry has a contract to ensure that all industries are vibrant and they are doing well, that includes the tobacco industry and so sometimes health look like you are standing in our way so we need to clear that. — MoH Official 3



Lack of clarified roles and dual centers of power and leadership affected the tobacco policy. Respondents said there were overlapping roles between MoH and TCB and this brought confusion.

Sometimes there is some conflict between the board and the ministry also the implementation partners the public health guys down here. I think roles were not very well stipulated and some roles overlapped and that is a cause for conflict. — MoH Official 3

There is a weak coordination element ... for instance, the TCB should work with the Tobacco Control Unit, but that coordination – we are not sure who is coordinating what. —Ministry of Agriculture Official 1

Other barriers probably would be wars amongst many implementation partners the TCB, this division, the public health people down here for enforcement, many civil societies which we have out there, so if there is no proper coordination, we would fight amongst ourselves, and the enemy becomes bigger. — MoH Official 3

Poor documentation and lack of adequate staffing were also barriers in sustaining the needed effort in managing multi-sectoral partnerships, especially with the frequent turnovers in the key sectors leading the process.

Another thing is turnover. We have an officer here – if he leaves, he has a wealth of experience in tobacco control matters – if he leaves, what happens? There is no succession. We need to spread that out so that we have more training, more people – we are very understaffed. — MoH Official 3

3.4.7 Conclusion and recommendation

The initial process for developing comprehensive tobacco control policy in Kenya was protracted, but it aligns with the current global efforts. Implementation is in the early stages, and the slow progress is mainly attributed to a lack of funds, which need to be allocated as implementation is in the most critical phase. Results from the study show MSA is adequate in the formulation phase but not the implementation phase. Continuous engagement with all relevant stakeholders in the implementation stage is critical.

3.5. Nutrition policies

3.5.1 Contextual factors influencing nutrition and dietary policy development in Kenya

Global context

Many SSA countries reported unacceptable malnutrition rates in the past few decades (52). For this reason, there is a global movement addressing the issue of inadequate food production in many parts of the world to prevent malnutrition and stunting of children. In 1992, following the World Food Summit, many countries developed effective national food and nutrition policies. Due to the global push, many countries in Africa, including Kenya, developed national food and nutrition security policy documents in the past decade. Even though Kenya realized food insecurity was a national issue since independence, the government focused on enhancing agricultural food production without comprehensive policies to address other aspects of nutrition, such as those related to NCDs. As a result, this global movement influenced development of the Kenyan food and nutrition security policy in 2011.



Meeting Millennium Development Goals (MDGs) was another driver (53). Meeting MDG 1 required more advocacy for better nutrition and food security policy. From document reviews, the food and nutrition security policy document of 2011, and the National Nutrition Action Plan developed in 2012, increased efforts to achieve the MDGs through implementation of high-impact nutrition interventions such as exclusive breastfeeding; timely complementary feeding; iron folate, vitamin A and zinc supplementation; hand-washing, deworming; food fortification; and management of moderate and severe malnutrition. The proposed activities aligned with the efforts to meet these goals. The two documents provide a framework to guide nutrition interventions.

I have mentioned about the MDG number 1 – reduction of poverty and hunger and also the response of the whole world looking for ways whereby we can become food secure, because in sub-Saharan Africa most countries are not food secure and we suffer from food shortage. — MoH Official 6

I think there was a recognition that we needed to have an implementation framework for the policy and we needed to have a document that all of us could sign up to and agree to and monitor progress against. And this is also one of the key indicators, you know, when you are joining the global movement, you need to have [these] documents in place, so it made us put this document in place, but it was a deficiency in the sector and we needed an action plan. — Bilateral Organizations 10

Several other international events led to the development of nutrition policies in many African countries, including Kenya. Given the realization of food and nutrition crisis, the UN Secretary-General established the High-Level Task Force on Food and Nutrition Security in 2008. The same year, the Lancet series on maternal and child nutrition provided a new evidence base for action on nutrition, highlighted issues such as the high personal and economic costs of stunting as well as the fragmented and dysfunctional international architecture unable to deal with it (54). This enhanced global efforts to address global nutrition crises. Further, Scale Up Nutrition (SUN), the global UN movement initiated in 2009 to support maternal and child nutrition efforts, is now a world movement, with strategies to end world malnutrition by 2030. Kenya joined and is working with partners to develop malnutrition programs.

We have now signed up the current global nutrition movement that is moving the nutrition agenda ... we have the high impact nutrition interventions to address, because it advocates for all that the fortification, nutrition education the supplementation, so this is important, because Kenya is a signatory to this a global movement, which was set up in 2008 as a result of constant high levels of stunting and the fact that people weren't addressing nutrition as a development priority. And it was set up by Ban Ki Mon by the UN, but they called on member states and all these countries to sign up to the movement and the movement basically when you sign up, you say you are committed to addressing nutrition in a multi-sectoral way in our country. And Kenya was the 30th country to sign up in November 2012. — Bilateral Organization 11

The policy documents highlight factors that sustain food insecurity such as global warming, oil crises, and global food and financial crises (55). Climate change is associated with increasing drought and floods in many parts of Kenya, as well as erratic rainfall and an increase in pests that affect crop production.

The emerging issue of nutrition transition, particularly in developing nations, is another reason for global nutrition advocacy. While the SSA experiences a nutrition transition, with changing dietary patterns documenting increases in fat and salt consumption (56, 57), many countries failed to formulate specific policies in response to this epidemiological trend.



The new focus on nutrition policies led to the establishment of the MoH nutrition unit to address nutrition issues. With this development, the country also received external support for nutrition programs, such as the global strategy diet for physical activity and health (52)

National context

Enhancing food production through agriculture is a main area of government focus since independence, therefore food and nutrition security always appears in government development policies and plans. Earlier policy documents focused on food production with inadequate attention to enhancing better nutrition and addressing nutrition-related disease, which contributed to the most recent policies.

Since independence, Kenya, being an economy which depends so much on agriculture, we've always had a food policy. We are always talking about food production. I think now there is new thinking which came in the year 2000s and afterwards. People were saying, okay, we are talking about food policy, is it just about food policy? So that is when now we, the Ministry, were challenged by other sectors, and then we had an MSA to look at food security – they said there is something missing. We need a food and nutrition policy. So the people who were conversant with the issue that is UNICEF; World Vision were brought on board. — Bilateral Organization 8

Socio-economic factors such as poverty affected food and nutrition security in many parts of Kenya, with majority of the population having inadequate access to healthy food (58). Kenya is frequently affected by food shortages and bouts of famine, especially in the north. In some parts of the country, poverty affects both food production and purchase; in other areas, poverty and drought regularly affect food production. A large proportion of people living in the country's arid and semi-arid areas rely on relief food to achieve food security and production. The cycle of drought and famine, followed by relief efforts that do not address the underlying causes of poverty and food insecurity, result in dependency. The need to break this cycle spurred stakeholders to develop comprehensive food and nutrition policies to make the country food secure.

Most of our populations are dependent on donor-funded projects like UNICEF. People who work in food programs give people food instead of showing them how to produce, and that is why ... we need as a country to come up with a policy that is going to help this country become food secure. — MoH Official 6

The chronic levels of high of food insecurity and malnutrition in Kenya – I think it became huge priority, and I think you know the frequent crises... we all remember the 2011 one. — Bilateral Organization 11

Environmental factors exacerbate chronic food shortages. Although Kenya has the capacity to produce enough food for its citizens and for export, unpredictable weather patterns and dependence on rain-fed agriculture result in poor production (55). Climate change is also a factor hindering food production and affecting availability (55). Changes in rainfall patterns negatively affect crop and livestock production.

Inadequate production and general economic challenges led to steep food price increases, with many people being unable to afford healthy foods (55). Kenya developed a food policy to enhance food production.

Epidemiological factors include malnutrition, which is common in Kenya, with stunting rates reported at 35% in 2012. While this has long been a driver for nutrition policies, the double burden of malnutrition in the country is now evident. While still grappling with the effects of under-nutrition, Kenya experiences a rise in diet-related non-communicable diseases, such as diabetes, cancer, kidney and liver complications are attributed to the consumption of low-fiber



foods high in fats and sugar (58). KDHS (2008) reported an increase in obesity, hypertension, and diabetes among women of the reproductive age. Although these diseases are rising, there was little attention in the 1990s with regard to nutritional aspects of prevention. Kenya needs a comprehensive framework to guide policy implementation addressing nutrition.

As a country, we realized that Kenya was facing what we call double burden of diseases ... we were faced by the burden of communicable diseases, malaria, HIV, TB ... and at the same time we had the burden of non-communicable diseases going up: that is, diabetes, hypertension, cardiovascular diseases, obesity. They are going up and one of the major reasons, or one major risk factor for the non-communicable diseases, was unhealthy diets. — MoH Representative 6

Despite its nutrition challenges, Kenya was slow to develop effective nutrition policies. The global push to address nutrition issues was complemented by national context ripe for interventions. This led to the drafting of food and nutrition policies and action plans. There was also increased funding to develop nutrition policy and programs as well as systems-strengthening. The government and development partners worked together to develop nutrition programs.

3.5.2 Nutrition policy content

Despite past nutrition policies, participants in this study focused on the most recent policy documents, such as the National Food and Nutrition Security Policy, which was developed in 2011 (55). This policy is the current blueprint for food and nutrition policy in Kenya. The policy objectives are: to achieve good nutrition for optimum health for all Kenyans; increase the quantity and quality of food available, accessible and affordable to all Kenyans; and to protect vulnerable populations using innovative and cost-effective safety nets linked to long-term development. The document framework covers multiple dimensions of food security and nutrition and addresses associated issues of chronic, poverty-based food insecurity and malnutrition, as well as the perpetuity of acute food insecurity and malnutrition associated with frequent and recurring emergencies.

Most of the participants stated that the policy does not promote healthy diet. It promotes food security with an aim of enhancing local food production. Following the development of the national food and nutrition policy, a National Nutrition Action Plan (NNAP) 2012-2017 was developed (MoH 2012). NNAP provides a framework for coordinated implementation of nutrition intervention activities by the government and nutrition stakeholders.

It's under a section on food security, but you see, food security does not tackle issues of non-communicable diseases. Food security talks about how we are going to produce food, how we are going to feed Kenyans, how are we going to make sure that every person has food on their table, that is food security. But in terms of looking at how will this impact on the health of the Kenyans in terms of development of non-communicable diseases or prevention of non-communicable diseases they are not articulated very well. — MoH Representative 6

I think again there was a recognition that we needed to have an implementation framework for the policy and we needed to have a document that all of us could sign up to and agree to and monitor progress against. — Bilateral Organization 1

The plan has 11 strategic objectives aimed at realizing the goal of promoting and improving nutrition status of all Kenyans (58). Strategic objective 6 addresses the need to promote healthy diets and physical activity across the population, using the lifecycle approach to reverse the rising NCD trends.

Other nutrition related-policies developed in Kenya in the past few years are summarized in Table 8.



Table 8: Nutrition related policies in Kenya

Policy	Objectives
National Nutrition Action Plan 2012-2017	To operationalize the strategies outlined in the Food and Nutrition Security Policy 2012; provides a roadmap for coordinated implementation of nutrition interventions by the government and nutrition stakeholders across development sectors for maximum impact; sets out activities to scale up implementation of high-impact nutrition specific interventions (HINI), which are incorporated in the health system
National Strategy for the Prevention and Control of NCDs 2015	Provide a roadmap to reduce the preventable morbidity disability and mortality due to NCDs and to improve the quality of life of all Kenyans in line with vision 2030; emphasize multi-sectoral collaboration at county and national levels; mentions nutrition interventions related to WHO best buys interventions for NCDs
National food and nutrition security policy 2011	Achieve adequate nutrition for optimum health of all Kenyans; increase quantity and quality of available food, making it accessible and affordable to all Kenyans at all times; and protect vulnerable populations using innovative and cost-effective safety nets linked to long-term development; focus on adding value, building synergies and assisting with the implementation of existing national and sectoral policies and strategies to effectively address issues of food insecurity and malnutrition
Food Security and nutrition strategy 2008	Ensure all Kenyans have access affordable, nutritious and personally acceptable foods; guarantee a sustainable, safe and high quality food supply; promote food consumption patterns that maximize health and minimize disease
National Plan of Action for Nutrition 1994	Assess, analyze and monitor nutrition situations; incorporate nutrition objectives into development programs and policies; improve household food security
Kenya's second National Food Policy (Sessional Paper No. 2 of 1994)	Promote a market-driven approach to food security
First National Food Policy (Sessional Paper No. 4 of 1981),	Maintain broad self-sufficiency in major foodstuffs and ensure equitable distribution of food of nutritional value to all citizens, to be achieved through government interventions such as setting grain prices, state monopoly of input distribution, and across-the-board fertilizer subsidies
Kenya School Nutrition and Meals Strategy (Revised 2016 (Draft)	Increase intake and awareness of adequate, culturally appropriate nutritious meals among school-age children; focus on nutrition in school curriculum and school feeding programs

WHO best buys interventions addressed in the policy

The main WHO best buys intervention for nutrition and diet include salt reduction, replacement of trans-fat with polyunsaturated fat, and promotion of public awareness about healthy diets. From the policy documents, particularly the broader nutrition policies, these interventions were not given adequate attention. The food and nutrition policies developed so far focus on addressing food security and under-nutrition, without giving adequate attention to issues relating to NCD prevention as mentioned in best buys interventions. At the time of data collection, the division of nutrition drafted guidelines on healthy diet and physical activity that were neither finalized nor implemented. A review showed they emphasize healthy eating and prevention of malnutrition. The NCD strategy launched in 2015, which has not yet been implemented, mentions several interventions, including those addressing WHO NCD best buys such as developing and implementing legislation and regulations on salt, saturated and trans fatty acids and refined sugar content of processed foods, as well as awareness creation in the communities.



3.5.3 Nutrition policy process

Agenda setting

Emphasis and discussion about more comprehensive food and nutrition policies came in the late 2000s with the increased push to enhance food production and to achieve food and nutrition security MDGs. This renewed commitment started with the formulation of the food and nutrition security policy led by the Ministry of Agriculture. The MoH nutrition unit led the development of the Kenya Nutrition Action Plan, which was followed by the development of other nutrition guidelines for nutrition promotion and malnutrition prevention. The process was further enhanced by emerging evidence of malnutrition and the increase in nutrition-related NCDs.

Formulation of food and nutrition security policy

The drafting of the food and nutrition security policy document was led by the Ministry of Agriculture with the support of MoH and other development partners after a situation analysis. The participants mentioned that this consultative process involved reaching out to other stakeholders, including farmers.

So we did a situational analysis, we looked at the background information and then we also subjected it to the field, so a few times we went to the field and brought in stakeholders who were relevant to the food and nutrition policy. Key stakeholders included farmers and the population so we also asked for their opinion ... What they thought about food and nutrition, what were their problems, what would they like to be involved in? What should be included in the policy ... so it was consultative. — Ministry of Agriculture Official 8

Several meetings and consultations were held in the policy process from 2007 until completion of the policy document. There was an initial high-level first meeting, attended by senior policymakers including ministers, regional and country-level representatives. UN agency heads introduced the national policy and generated commitment to a comprehensive, workable strategy. A working meeting with participants from several government ministries, consultants from FAO and UNICEF, and specialists from various international non-governmental organizations and national groups, collaborated on the strategy for moving the policy forward.

MoH was brought in with UNICEF, WFP, FAO, and other major partners to clarify the role of nutrition, so in the situational analysis, there was a description of food security, but then also of nutrition security. So that they are not separated ... when we look at vulnerability, we are looking at the full picture of vulnerability. — Bilateral Organization 1

Formulation of the Nutrition Action Plan

The health sector, through the Department of Nutrition, developed the nutrition action plan, which was completed in 2012. This policy was necessary because policy focused more on food production. The department drafted the nutrition action plan following a situation analysis. It was then presented to stakeholders for feedback, including representatives from agricultural, education and relevant NGOs. Several consultative meetings and workshops were held. The stakeholders were initially invited to contribute to the situation analysis and later to build consensus on strategic areas for the plan. The department also developed guidelines on healthy diet following the nutrition policy as an instrument for implementing the action plan.

Even though participants mentioned the process was consultative, we did not get detailed information or minutes of what happened during the meetings. The policy documents provided a list of stakeholders involved and those who engaged in implementation of both documents.



3.5.4 Implementation

According to participants, nutrition policies were not adequately implemented. The broader food and nutrition security policy of 2011 was neither fully disseminated nor implemented. The nutrition action plan launched at the time of data collection and partners implemented activities based on the action plan. The diet guidelines were not launched at the time of data collection. The MoH nutrition division worked with other development and implementing partners, particularly NGOs, to support nutrition programs addressing under-nutrition but the programs were not directly linked to WHO best buys interventions. Study participants did not mention sugar, fat and salt reduction as action areas.

Funding was another challenge that hindered implementation. Unlike other emergency issues, nutrition was not a government priority.

If you look at this document, there is an institutional and legal framework and financing and we had implementation monitoring and evaluation frameworks. We had mentioned partners that we would work with [...] but we develop documents, after that we don't follow up in terms of implementation. How are we going to mobilize resources, who are going to target, who are we going to work with? ... You see implementation beyond the developers of the document, whom do we involve, how do we actualize our roadmap? It is like planning that you are going to Mombasa next month and you have a very nice plan and you even book a bus or air plane ticket and you pack your bags but after packing your bags you just sit down and say that I am going to Mombasa! You will never reach there and this is what happens. We develop documents with good guidelines and then we sit down and say we have a roadmap but are have not we even started igniting the car to move on and those are the things that affect implementation in this country. — MoH Official 2

One of the challenges is funding, and the other is implementation of the document once the document had been finalized. The biggest problem we have in this country is that we have very nice documents but then ... once we have launched the document, what is next? Those are the challenges, who implements, how is it going to be actualized. So those are the challenges that we face as a country. — MoH Official 6

The national food and nutrition security policy proposed a secretariat be created to ensure broad, cross-sectoral implementation, coordination and monitoring mechanisms. The inter-ministerial body National Food Safety Coordination Committee (NFSCC) was established to raise awareness about the impact of food safety and quality and initiate revision and harmonization of all the relevant Acts of Parliament including enactment at county levels. This study did not established the extent to which this agency is functional nor how its activities promote healthy diet.

3.5.5 Funding

Participants stated the government did not allocate a budget for food and nutrition security policy implementation. The Ministry of Agriculture was responsible for allocating funding but its resources are limited. Most policy development funding came from UNICEF and FAO, and others.

The majority of participants they noted that the government expected more funding from development partners.

There is ... quite significant funding from [a] donor group that works on resilience ... it's made up of major donors from the USA, the European Union, the World Bank.... The major donors to the nutrition sector are DFID, the UKAID, UK government, ECHO the humanitarian office, also the Development Office for Foreign Disaster Assistance for the American government – they would



be the three biggest – and more recently, the World Bank in terms of commodity procurement. — Bilateral Organizations 1

Participants noted very limited funding for the nutrition action plan driven by the health sector, although it is new and implementation was under development at the time of study. The participants were concerned that the policy might not be fully implemented as it has become the norm in Kenya to develop and shelve policies. With regards to implementation of nutrition guidelines within the health sector, participants said some funding from partners was available to support programs to address child malnutrition.

Nutrition has a lot of funding, but it is more for under nutrition and child nutrition than adult nutrition and nutrition looking at wellness. UNICEF, World Food Programme (...) have a lot of money for (mal) nutrition. But nutrition as a component of preventing and treating NCDs has very little funding, the closest we had to that is funding which was given to diabetes programme mainly for training nutritionists on healthy diets, prescribing healthy diets and preaching healthy diets. In the department of public health here and health promotion they have a small budget of preaching about healthy diets, health promotions ... but not in a structured manner. So I think funds are there but again as I said the benefits of such a health promotion process for example for diets would not be seen in 2- 3 years; it would be seen in 30 years. Meaning even county governments if you go, to them promoting healthy diets not with children, for the adults it is not a quick thing they would do. — Bilateral Organizations 10

3.5.6 Multi-sectoral action in nutrition and diet policy

Several actors were involved in the development of the food and nutrition security policy led by Ministry of Agriculture and supported by the MoH nutrition department. Ministries such as Water, Trade and Education provided input on the objectives and priorities for the policy. The Ministry of Education was involved particularly because of the school feeding program. Other actors included academic and research institutions.

It was inclusive, eight ministries are incorporated in that document, but the Ministry of Agriculture were the custodians, the ones who moved that agenda. So we [MoH] really had no control in terms of the time frame or the dissemination. — MoH Official 23

UNICEF, WFP, FAO and other NGOs implementing nutrition programs like World Vision were involved. NGOs provide technical advice on various aspects of nutrition, including the needs in urban versus arid areas, as well as the needs of different age groups.

The international organizations provided technical support and brought in the global perspectives including good practice from other countries.

These are people who have enough knowledge, they have global perspective and so they were bringing in the global perspective, what the other countries are doing. What we are supposed to do as a nation and what we are not supposed to do so their input was about global perspective in this area of healthy diet and physical activities and also they have technical officers who have worked in this area for a very long time so advising us. For example WHO has a technical officer in charge of physical activity and healthy diet so these were people who were advising us not to go this way and not to drop this one and take up this one. — MoH Official 6

In particular, UNICEF played a major role in providing financial support for meetings and technical support in nutrition and policy processes. In addition, UNICEF provided statistics on malnutrition in Kenya. USAID also provided funding for meetings and consultations.

UNICEF had a lot of information they were bringing in the global picture to the policy. Bringing their other experiences from the world, because they are very strong in the area of nutrition. So



they brought a lot of wealth of information and also experience in policy process, the same with World Vision. They were bringing on the table their experiences and also their expertise in the area of food security and also in area of nutrition. — MoA Official 8

To drive the nutrition agenda in the country, the Nutrition Interagency Coordinating Committee was established under MoH. All actors in nutrition attend the forum and share proposals on what they want to do in any part of the country. According to the participants the committee:

We have what we call Nutrition Interagency Coordinating Committee, and then below it we have what we call the National Technical Forum, this forum brings on board all these people, like in this unit before you come up with any project or activity you have to present it to this forum. They are the ones who approve and also slot the area where you are going to implement that activity. You cannot just come with anything and say I have the money, I want to go and implement in this and this area, and also you have to present the whole project proposal to them, yeah for them to see if it is viable, or not, if it is not viable even if you have money they will tell you ... not here and in that way it has really brought some sanity in the nutrition unit, the partners and other line ministries as well. — MoH Official 6

Strategies used to bring actors together

Strategies to bring the actors together during policy formulation include: meetings and workshops, organizing technical working groups, and:

I just know ... there was a lot of consultation, a lot of meetings, and the final outcome I think was that people felt very happy with the outcome. They felt it was an inclusive process and the fact that it is actually an integrated policy, there is a very few countries that have an integrated policy, so I think it's something ... quite positive. — Bilateral Organizations

Finding somebody who can coordinate, and then the regular, frequent meetings, and then probably working in thematic working group ... coming together to share experiences and lessons so that we can put this draft together to enrich, but the best so far is when you keep in touch through the regular meetings. ... Regular communication and feedback, even if it is through keeping in touch, having a working group, because sometimes when it is a large group, it is a bit difficult to coordinate. So sometimes you single out those who are passionate about the work and kind of use that as your working group. — Bilateral Organizations 10

Actors involved in Implementation

The food and nutrition policy document envisions a MSA that involves the Ministries of Agriculture, Livestock Development, Cooperative Development and Marketing, Fisheries Development, Water and Irrigation, Lands, Regional Development Authorities, Environment and Mineral Resources, Forestry and Wildlife, State for the Development of Northern Kenya and Other Arid Lands. Regional bodies such as EAC, NEPAD and COMESA were also engaged, as were CSOs and development partners. Although these stakeholders are mentioned, MSA was not followed in implementation, as each partner carried out its own work. This was partly attributed to “weak” implementation, monitoring and evaluation frameworks.

Actors from other sectors involved in formulation were not involved in implementation. However, actors who should have been involved, but were not, include ministries like Finance, Labor, Gender and Social Protection, and planning, and key development partners like Japan International Cooperation Agency (JICA). The MoH department on NCDs was also not involved. Outside the government and development partners, potential implementers of the policy, such as the food and service industry, were not and have not been involvement.



The hotel managers, restaurant managers, pub owners, “nyama choma” joint owners, then you can bring them together so that they know the do’s and don’ts. In my opinion I find cooking at the relatively lower level more healthy. — Private Association

Facilitators to MSA

The participants said advocacy was one facilitator for the development of national food and nutrition policy. It was carried out by partners and the process brought in many actors and sectors. Another facilitator was planning regular meetings and in particular having a working group and a coordinator for the group consisting of those who are passionate about the issue.

Finding a home – somebody who can coordinate – and then the regular meetings, frequent meetings as they would be, and then probably working in thematic groups.... We were all working on different pieces of work, so that coming together to share experiences, we could put this draft together to enrich it, but the best so far is when you keep in touch through the regular meetings. Full day meeting, half day meeting or be it a workshop, that is a good strategy. Regular communication and feedback even if it is through keeping in touch ... because sometimes when it is a large group, it is a bit difficult to coordinate. So sometimes you single out those who are passionate about the work. I talked of sharing experiences and lessons and I think, I have seen, you can also have as parts of the lessons learnt, even visits to various areas where that work is being done. — Bilateral Organizations

Another factor was political change. The MoH split into the Ministry of Public Health and Sanitation (MORPHS) and Ministry of Medical Services (MOMs). MORPHS prioritized preventive services, so the nutrition department was housed under this ministry. This influenced the development of the nutrition policy as the ministry was more concerned with disease prevention and health promotion. However the two ministries merged in 2013 with the new government and nutrition returned to MoH.

I think what really spearheaded it was, first of all, a very strong leadership in MORPHS and a very strong commitment to nutrition. So we had a very strong political will and still do, a very strong Head of Nutrition in the MoH and I think it is under her leadership actually that the opportunity came up. (Bilateral organizations-11)

Barriers to MSA

Poor coordination was one barrier in achieving MSA nutrition policy development. The participants felt it was difficult to bring together people from many sectors given their different mandates, making coordination difficult. Some sectors sent representatives from different units within the sector.

Other barriers included lack of interest and commitment as nutrition is seen as a health issue under the nutrition department. Some sectors also felt that it would be an additional burden. Government funding to support the process, and dependency on development partners to host meetings, was also mentioned.

Because I think everybody else was depending on the Ministry of Agriculture to do that all the others, there was not like a budget line from every ministry that this what we have. So occasionally, okay FAO would chip in, UNICEF would chip in, you know the ministry would chip in. So there wasn’t like a set budget for this work because I think if it, if there were it would have gone faster. — Ministry of Agriculture Official 8

One of barriers is cost constraints because when you call people you have to maybe to cater for them, when you call a technical working group you want to take them away from Nairobi



so that they can work, you need to provide for them transport, accommodation, out of pocket allowance and so those things probably hindered the involvement of bigger stake holders in development of the policy. — MoH Official 16

There was no clear framework to guide working with other sectors. Even though many actors were involved in the formulation and had roles in addressing under- and over-nutrition, there was no clear framework to guide roles and responsibilities for implementation.

Okay for example they could say Ministry of Agriculture, Ministry of Education, Ministry of Water are involved, there should be a formal way of instituting that structure so that you know it, everybody feels that it is my responsibility to do, you don't belong to a structure which has been made and I have to make contribution and I have to be committed. — Ministry of Agriculture 8

Food policy in Kenya needed to focus both on malnutrition and on the reduction of fat, salt, and sugar that contributed to NSAs. Although there were multiple government agencies and NGOs involved, policy development and implementation efforts were hampered by a lack of clear goals, roles and responsibilities of each actor as well as poor leadership. The policy formulation was not adequately multi-sectoral both in the formulation of the initial National Food and Nutrition Security policy or the subsequent NNAP. The need to review and develop other supplementary documents for a policy that was hardly a year old and the process being led by two different ministries demonstrates the struggle to define roles and leadership on an issue that requires multi-sectoral cooperation. Finally, as with other policies discussed, a lack of government funding to support the process and dependency on development partners to host meetings created additional challenges.

3.6 Physical activity policies

3.6.1. Contextual factors influencing physical activity policy development in Kenya

Global factors

There is a worldwide push to develop policies and programs that support physical activity and healthy living. Globally, about 31% of adults aged 15 and over were insufficiently active in 2008, while 3.2 million deaths every year are attributed to physical inactivity (59). The high rates of physical inactivity worldwide necessitated the World Health Assembly to endorse a Global Strategy on Diet, Physical Activity, and Health in May 2004. This strategy addressed unhealthy diets and physical inactivity as the two main risk factors for cardiovascular disease (CVD), cancer and diabetes. Review of the National Physical Activity Action Plan 2015-2020 shows that Kenya endorsed this strategy, and it might have triggered development of this policy although the endorsement date was not mentioned.

Some participants noted that the UN General Assembly meeting listed school health as a major agenda, so this facilitated development of school health policy. Kenya borrowed heavily from the UN/WHO documents to develop national guidelines on healthy diets and physical activity. The development of this document begun in 2012 and it is still in draft form.

The WHO met under the UN General Assembly and NCDs were recognized as one of the epidemics of the 21st century. People met at WHO in Geneva and we had member states from more I think they were 153 countries. They met and agreed that not unless we address the risk factors of non-communicable diseases, populations in the world are going to be decimated or even be disabled by the rise of NCDs. And in that assembly unhealthy diets and physical activities were recognized as risk factors for NCDs and that is why as a country [Kenya] we felt that in response to the United Nations general assembly call for nations to develop guidelines addressing healthy diets and physical activities,.... we needed to domesticate and come up



with our own document. WHO developed their own documents, global action plan on physical activities and healthy diets. — MoH Official 8

Local factors

Physical activity surveillance, policy and research in Kenya is in its infancy. Physical activity gained traction as a fundamental part of the public health agenda. One local contextual factor driving discussion is the need to promote healthy lifestyles to achieve the country's development goals. Even though there is no national physical activity/inactivity data in Kenya, small scale specific group data shows that Kenya shows signs of a physical activity transition characterized by a shift from high-activity lifestyles to sedentary lifestyles (60). Similarly, ISCOLE study results among 9-11-year-olds reveal that only 6.5% of participating children were meeting the daily moderate-to-vigorous physical activity guidelines (61). The ISCOLE results fed into the formulation of the Kenyan National Strategy for the Prevention and Control of NCDs (62), which has a specific section in promoting physical activity. A 2010 population-based household survey conducted among an urban poor population (63) revealed high levels of work-related physical activity. Although the recent 2015 Kenya Steps survey might affect formulation of the current physical activity policies, the results can be used to shape future national legislation and policies. The Steps survey revealed that 27.9% of Kenyans are overweight and obese (19% overweight, 8.9% obese) while 6.5% of Kenyans are insufficiently physically active (6.3% men, 6.8% women) (13).

The increasing burden of NCDs, as well as the threat of rising obesity, contributed to the development of healthy diets and physical activity policies. There was also realization that if nothing was done, in the coming years more people will have several communicable diseases and the morbidity and mortality from these NCDs will rise.

Obesity, which in Nairobi accounts to about 41%, has really now made the ministry see to it that we have to do something to at least prevent the many deaths we are seeing ... as a result of non-communicable diseases. — MoH Official 9

One respondent specifically noted that physical activity is not a nationally promoted activity therefore many people do not engage in it.

Kenya's economy steadily grows, and there are reported improvements in incomes. With these changes, large shifts occur in diets and physical activity patterns. Participants said that as people became financially stable, they tend to gravitate towards unhealthy habits, mainly because they can afford such a lifestyle, so healthy diets and physical activity guidelines are needed.

And most of our families become economically stable, people tend to go and eat unhealthy foods. These unhealthy diets are made available through our supermarkets, through our markets, through our shops and food outlets. As a country we realized that unless we sit down and develop a document or guideline and address the issue of healthy diets and physical activity, ... by the time we ... [reach] 2030 more than 10% of Kenyans will be living with one or two NCDs, and most of them are going to die. The morbidity and the mortality from NCDs is going to increase. And that is why as a country we felt there is a need for us to come up with a guideline that is going to address health diets and physical inactivity. — MoH Official 8

3.6.2 Policy content

Although Kenya does not have a comprehensive, stand-alone national physical activity policy, there are policies that mention physical activity. These include: the Kenya National Youth Policy (2007), which aims to enhance youth participation in national development goals and ensure that programs are well-coordinated to address the interests of youth (64); the Sports Policy, which is aimed at meeting national development goals (65); the National School Health Policy, which



is aimed at enhancing the quality of health in schools by creating a healthy and child-friendly environment for teaching and learning (66); the National School Health Guidelines developed to operationalize the National School Health Policy (67); the Kenya National Strategy for the Prevention and Control of Non-Communicable Diseases, which proposes a comprehensive and innovative approach to harnessing and synergizing NCDs prevention and control at all levels of health care service delivery by engaging all government sectors and non-governmental organizations (62); and the National Guidelines for Healthy Diets and Physical Activity (68).

Table 9: Physical activity policy content and alignment to WHO best buys interventions

Policy	Content/objectives	Alignment to physical activity best buys interventions
The Kenya National Youth Policy 2007	Sensitize policymakers to mainstream youth issues in national development; empower and engage youth in economic development	Only addresses physical activity among youth in regards to sports and recreation facilities
Sports Policy 2013	Manage talented sports in Kenya	Encourages physical activity for competitive sports for the purposes of national development
National School Health Policy developed in 2009	Expects schools to instill the value of physical and sporting activities through integration of physical activity in the curriculum; establishing adequate, safe and suitable physical education facilities; allocating time for physical activities; making sporting and recreation activities accessible to all children, including those with disabilities	This policy addresses the school going population. States physical activity is part of healthy lifestyles recommended to avoid non-communicable diseases
National School Health Guidelines 2009	Guidelines comprise eight thematic areas, including disease prevention and control.	Physical activity is only encouraged within the school context.
Kenya National Strategy For The Prevention And Control Of Non-Communicable Diseases 2015-2020	The strategy has 10 strategic objectives, including implementation of national legislations, policies and guidelines that promote physical activity and create public awareness of the health benefits of physical activity in NCD prevention and control	Proposed interventions are in line with WHO best buys interventions. Creation of public awareness on the health benefits of physical activity is stated in the strategy document
Guidelines for Healthy Diets and Physical Activity 2015	Draft copy not available.	According to a key informant, the document emphasizes nutrition part and is scant on physical activity.

All physical activity policies discussed here mentioned WHO best buys interventions for physical inactivity through public sensitization. However, most focused on specific segments of the population, such as the youth, particularly those talented in sports, and children in school. A standalone National Physical Activity Action Plan (2015-2020), drafted in 2015 (69), focuses on the whole population but has not yet launched. The objectives of the action plan are to:

1. create awareness among in Kenya about the benefits of physical activity;
2. increase physical activity by 10% in all age cohorts by 2020;
3. develop national legislation, regulations and guidelines on physical activity;
4. increase capacity for effective implementation of physical activity interventions;
5. establish a nationwide multi-sectoral, multi-disciplinary coordinating body of physical activity; and
6. build an evidence base for policy development and implementation.



Most study participants were unaware of any national physical activity policy in Kenya, including the National Physical Activity Action Plan under development. However, most referred to the national school health policy and the sports policy, which they acknowledged were mainly for people talented in sport. Some participants were familiar with the physical activity policy within the school health strategy, which they say specifies about 120 minutes of physical activity for children.

As a far as am concerned there is no physical activity policy in this country, it is not there. — Academic Official 1

First of all, they are just small pieces: within there is no substantive physical activity or a policy or guidelines, so it is just a small mention in different pieces of legislation or pieces of policy. So we don't have a substantive physical activity policy and that is a big gap and we are hoping to correct that. — MoH Official 3

I know that the government requires physical education [P.E.] to be taught in schools, and it is supposed to be timetabled ... kids are supposed to accumulate 120 minutes per week doing P.E., which means three lessons of P.E. Compliance varies from school to school. In some schools, time for P.E. is used to teach examinable subjects. — Academia Official 1

The draft nutrition and physical activity guidelines were not completed at the time of data collection so have inadequate information on physical activity. Several respondents acknowledged that the physical activity part in the policy was not as in depth as the diet section, because key experts were not involved in the guideline's development.

3.6.3 Physical activity policy process

Agenda setting and policy formulation

Although there is no comprehensive national physical activity policy in Kenya, there is a comprehensive draft, and other population-specific, non-comprehensive physical activity policies exist. The rest of the sections focus on a few policies described by key informants and those that had documents available for review.

Participants view the WHO NCD strategy as a key driver in jump-starting physical activity policy talks. According to the draft, Kenya does not have any policy on physical activity. The current draft action plan (2015-2020) responds to the urgent need for a comprehensive strategy for promoting physical activity in Kenya. In addition, the policy agenda gains momentum as NCD risk factors rise and government realizes that if nothing is done, more people will be affected by NCDs. Recognizing physical activity as an important element in addressing NCDs is why it is mentioned in other NCD-related strategies and guidelines (62). The formulation processes of these overarching NCD prevention policies is described elsewhere.

Even though the study participants did not clearly establish the sectoral involvement in the policy process, there are benefits of involving stakeholders, such as obtaining a global perspective from experienced stakeholders who worked on similar policies in other countries. Some stakeholders provided advice based on international experiences, which many regarded as a benefit. Additionally, engaging different stakeholders was beneficial for sectors/stakeholders to get to know their roles in the process. Another reported benefit was sectors sharing best practice. Strategies to bring stakeholders/sectors together include holding internal meetings and technical working group meetings. Participants also reported that they were unable to hold large stakeholder meetings due to funding constraints, so these potential benefits were unrealized.



3.6.4 Implementation status

Since there is no comprehensive policy on physical activity, implementation of physical activity programs were implemented in Kenya on a national scale. The National Physical Activity Action Plan 2015-2020 is still in draft. Participants described the sports policy implementation as 'partial'. In addition, the healthy diets and physical activity guidelines had not launched at the time of study hence implementation has not begun.

The [healthy diet and physical activity guidelines] have not been printed, so it's still a finished copy. They are looking for funds to disseminate in the next few months so they have not been implemented. — MoH Official 9

Implementation of other physical activity-related policies is weak. The school health policy with a physical activity component is not disseminated at the county levels so it is not clear whether it is being implemented. A lack of funds, but also lack of strong champions, hampers development and implementation of a physical activity policy. Study participants felt that even in the absence of committed government funding, it is still possible to implement a national policy if it had a strong champion with national gravitas.

Our biggest challenge is implementation ... enforcement and the motivation to do the implementation. If we had a political leader who is conscious and is willing to take up the mantel ... you could see a very big difference. When the First Lady started to do that campaign you know ... the Beyond Zero campaign.... you just saw the response. Some entities had been trying to organize annual marathons, annual runs, annual walks for years and they had not met the kind of success the First Lady had when she started the Beyond Zero campaign for the first time. And now it is going to be an annual affair. The moment we have leaders or political representatives taking up leadership and pushing some of these agenda then you meet with success. — CSO/NGO/CBO Official 1

Respondents noted that implementation of the school health policy's physical activity component is not fully adhered to because there are no playgrounds or recreational space in some schools to allow children their regular physical activity. Respondents consistently confirmed time allocated for physical activity is not always available and that that physical education (P.E.) lessons are regularly substituted for lessons in examinable subjects/courses.

If you look even at the School Health Policy, P.E. used to be a lesson like any other when we were in school. But today, teachers compete on finishing the curriculum of mathematics, Geography, History & Civics (G.H.C) so children sometimes don't get enough time to do physical activity because as much as it is healthy and part of their growth, it is not seen as part of their education. Their education has been reduced to getting marks in math and science and all those subjects. — MoH Official 3

With the emphasis on passing of exams ... you know schools have almost abandoned [physical education]. — CSO/NGO/CBO Official 2

The Sports Act is fairly new and its implementation began but it is hampered by lack of funds.

In terms of implementation, I would say to a small extent, simply because like the sports act is just like one year old ... but the implementation is ongoing I would say. We cannot really judge the implementation because it has just started, but on the other hand, there are challenges that have been encountered ... of course the funding bit of it. — MoH Official 2

Some respondents felt that before promoting physical activity, the environment should provide safe spaces for exercise, walking or cycling, which is currently not the case, especially in Nairobi. While some of Nairobi's newer roads have walkways, this provision now needs to be expanded to all areas. Not having purpose-built environments to facilitate physical activity is



considered a barrier to the development and subsequent implementation of physical activity policies.

3.6.5 Funding

Very little information was found either in document reviews or shared by key informants regarding funding for physical activity policies. This section only focuses on the healthy diets and physical activity guidelines and the National School Health Strategy.

Study participants acknowledged there was minimal funding for policy development of the healthy diets and physical activity guidelines, and that the guidelines did not launch because of lack of funds. Plans by the MoH's NCD unit to put money aside for a comprehensive national physical activity policy did not happen. Study respondents reported that the funding source for this particular policy came from the government and other partners. One participant said there was funding for nutrition and physical activity under the NCD umbrella but it was not enough.

I am sorry to say that ... the funding for development was very minimum. And the reason it has not been launched is because we have no funding. — MoH Official 9

Participants said there is no budget and no amount allocated in the National School Health Strategy policy documents.

There is no major funding that comes in for the school health as a budget line. At the implementation, which is being done by other partners, other partners have put in a lot of resources. That may not be from the government perspective. The government may have also put in terms of the personnel, which may not be quantified. — Ministry of Education Official 1

3.6.6 The role of MSA in the physical activity policy process

Little information was found in the policy document about MSA for physical activity policies. Most MSA information was available for the National School Health Policy and its subsequent guidelines; healthy diets and physical activity guidelines; and the Sports Act.

From key informant interviews, MoH and MoE were the only ministries involved in developing the National School Health Policy and the National School Health Guidelines. Both ministries coordinated formulation and implementation processes. Other stakeholders in the policy process include: WHO, UNICEF, World Food Program, and local NGOs and CSOs. Study participants said WHO provided technical support while the Ministry of Education mainly coordinated the policy development process. UNICEF, WFP, NGOs and CSOs provided technical as well as logistical support. Potential implementers were not fully involved in the formulation of the school health policy and guidelines. Reportedly uninvolved stakeholders include: grassroots-level activists; teachers; children; private sector players in education; and school inspectors. County-level education and health sector officials were also uninvolved in formulation and implementation of the school health policy.



Table 10: Sectors involved in formulation of physical activity policies

Policy	Sector leading development	Other sectors/actors involved in policy development
Sports Act 2013	Ministry of Sport	MoH; civil society organizations dealing with sports issues; the newly formed county governments
School Health Policy 2009	MoH; Ministry of Education led the process	Unclear on involvement of others
National School Health Guidelines 2009	MoH; Ministry of Education led the process	Unclear on involvement of others
Guidelines for Healthy Diets and Physical Activity 2015	MoH NCD unit in collaboration with the nutrition division	WHO, UNICEF, Food and Agriculture Organization, USAID, Academia-University of Nairobi, NGOs, CSOs, Ministry of Education played technical support in drafting guideline

Workshops and meetings with key stakeholders were the key strategies to bring sectors and stakeholders together during development, as was the formation of coordinating steering committees who deliberated on a common work plan among involved ministries.

Other sectors not involved but who should have been include: academia (Kenyatta University, which is key in physical activity); Ministry of Agriculture; Ministry of Trade; Ministry of Planning; Ministry of Transport; Ministry of Security; food industries; and NGOs that deal with older adults. Some sectors/actors who should have been involved in the Sport Act formulation process were not include educators, physicians and health sectors.

For example, we have Kenyatta University, which has a very big program on physical activity and I even think they do it at ... postgraduate level and we didn't involve them in terms of addressing us, and that is why we have a deficit in that area of physical activity, because ... as nutritionists, we mostly thought about healthy diets. — MoH Official 8

Facilitators to MSA

Study participants could not specifically identify facilitators to MSA, possibly because there was no comprehensive physical activity policy at the time of data collection. Participants talked in more general terms about factors that would facilitate a physical activity policy.

Participants mentioned facilitators to policy development including having an inter-agency committee that brings the stakeholders together. Because of this committee, a list of members received invites to meetings each quarter. Although no major factors facilitated MSA, participants thought that having national champions such as marathon runners could be a strong factor in future policies.

We need to develop champions. If you are talking about physical activity and active transport, we want the policy to revolve around Kenya runners, we want them to drive the agenda. As a researcher I know what needs to be done, but I want to see Paul Tergat, Catherine Ndereba, David Rudisha talking ... about healthy diets. I excel in 800 meters because I do exercises, I train and I eat a healthy diet; if Rudisha could say that on the national television that would be a big, big thing. We need to take advantage of our strengths ... bring in rugby players, soccer players, and not just the current athletes. Include sports heroes from a long time ago, 1960s people like Nyandika Mayoro. They went to the Commonwealth games, those kind of people. Profile them and let them talk; that resonates with their constituencies. — Academia Official 1

Key informants also reported that a political leader willing to champion physical activity was beneficial. The Kenyan first lady received much success during her Beyond Zero campaign to



reduce maternal and newborn deaths. This initiative was followed by a marathon that is now an annual event. Respondents believe political leadership advocating for physical activity policies and initiatives amounts to successful policies.

Barriers to MSA

Participants cited a lack of necessary resources to engage actors in the policy formulation process as a barrier. Funding for bigger stakeholder meetings or technical working groups. In addition, there were personnel challenges as people from different ministries felt they should be in charge. Partners reportedly funded their own activities, which were not necessarily in sync with the needs of the policy.

The other challenge that was encountered, or could have been encountered, is of course the issue of funding. Sometimes you need to call for more stakeholders, but you don't have the funding to do that. You would want to reach as many people as possible, but the resources might not be there ... for you to do that. So I believe some of the stakeholders that were left out, it could be probably be lack of resources. — MoH Official 2

Another barrier was a lack of awareness of the need to involve others in the policy development process. While stakeholder consultation in policymaking is enshrined in the Constitution, not all players are fully aware of which sectors to involve and how. Alternatively, different institutional mandates was also a challenge. For instance, some sectors did not see why they needed to be involved in the formulation of the Sports Act.

These are sectors that have different mandates, and therefore, to bring them on board is sort of a challenge because that is not what they do on a daily basis – they have other activities that they do. So ... convincing them that we need to move in this direction itself is a challenge. — MoH Official 2

Competition among implementing stakeholders was another factor. It led to duplication of key activities and was considered a waste of resources that could have been allocated elsewhere under the same policy framework.

In implementation, one of the main problems is competition. This is especially so when you look at the NGOs; there is lot of competition and duplication. You find one NGO is doing the same thing that the other one is doing, instead of focusing on different areas and different activities. That way, there would be no resource duplication and overlap. —Ministry of Education Official 1

The difficulty in coordinating heads of the required ministries was also a barrier. While mid-level technocrats often work together to develop a policy, getting ministers to sign on to the developed policies takes time and sometimes stalls the policy- and decision-making processes.

3.6.7 Summary and conclusion

There is no comprehensive national standalone physical activity policy in Kenya, although there is a national physical activity policy draft and a few group-specific policies. Kenya conducted several studies and surveys and is making significant progress towards promoting physical activity, public health research, and surveillance. However, there are several opportunities for improvement, putting physical activity as a priority on the public health agenda, and to call for a MSA in promoting physical activity.





4.0 | Discussion

4.0



Discussion



Global factors, particularly guidance from international organizations such as the WHO, help facilitate NCD policy development in Kenya. The country faces unique challenges in developing policies, for example:

- (1) integrating tobacco growers into the conversation highlighted conflict between wanting to reduce NCDs and the government's obligation to economically support tobacco growers;
- (2) alcohol policies could not focus on alcohol misuse contributing to NCDs because of challenges regarding dangerous homemade alcohol;
- (3) to reduce NCDs, diet policies must focus on increasing food security and nutrition by facilitating use of healthy foods, and reducing fat, salt, and sugar in prepared foods; and
- (4) physical activity policies are not well developed due to MSA challenges and lack of clear goals.

Tobacco policy development is challenged by industry interference. Further, the government has a conflict of interest as it invests heavily in some tobacco companies. A persistent set of stakeholders formulate and implement tobacco policies based on WHO best buys interventions to reduce tobacco consumption. Challenges include the prevalence of single-stick sales, which prevent dissemination of health warnings; the increasing number of women users; and the early ages at which youths become addicted. Integrated support for tobacco legislation and –despite industry efforts to derail progress – continued focus on best buys interventions is likely to stem the increase in tobacco use and subsequently reduce tobacco-associated NCDs.

Alcohol policy development was facilitated by near-universal awareness of the dangers of homemade alcohol, which leads to blindness and other physical maladies. Given this impetus, policies were enacted, but have yet to be fully implemented and enforced. The lack of focus on alcohol policies to reduce NCDs might lead to challenges when the problem of unsafe alcohol products is reduced.

Both diet and physical activity policies addressing the WHO best buy interventions are less prominent despite committed stakeholders. These policies have a somewhat less clear mandate, as well as a wide variety of stakeholders and continued lack of governmental funding to facilitate policy development and implementation. Further, there might be a perception these are low-priority policies given Kenya's current health climate.

Country-level responses to global calls are slow. For example, Kenya's push for alcohol control policies began before the WHO global strategy came into place, suggesting there is a limit to the effect of global initiatives on the initiation and formulation of national-level policies. Nonetheless, international factors influence how policy is drafted. Some participants acknowledge that the best practices in the policy were developed based on internationally known practices emerging from worldwide conventions and regulations. Rather than being a catalyst, global contextual factors are an enabling factor.

A key finding regarding implementation was that formulating a policy is only the beginning. Even in instances when effort is put into developing the necessary accompanying documents –such as the implementation plans, monitoring and evaluation frameworks, and financing frameworks – implementation is not guaranteed. Lack of funding for specific issues and programs, like nutrition, is initially manifest in the absence of robust policies. When development partners provide funding to develop policies, the low priority of the issue does not necessarily change and programs still struggle with implementation.



4.1 Multi-sectoral approach

This project identifies the extent to which MSA is used in six sub-Saharan countries' of NCD policy implementations. In Kenya, MSA was attempted for some of the best buys interventions to varying degrees of success. Since alcohol policies are driven more by the need to eliminate harmful homemade alcohol than by international pressure, local coalitions addressed social circumstances. Tobacco implementation began with MSA, but encountered challenges. Agents struggled with engaging partners, such as industry members, whose goals were inconsistent with limiting tobacco use. The policy activities, and accordingly MSA, were much more limited for both diet and physical activity best buys interventions.

Several aspects within each policy realm facilitated MSA use. The most significant facilitators were clear goals and next steps, government focus and funding, and an international guidance or mandate for change that stakeholders could rally around. Goals and next steps were often facilitated by international guidance, such as WHO's Framework Convention for Tobacco Control, which identified both the content of proposed policy initiatives and methodology for implementation at a local level. Further, as an international treaty, WHO and the global community provided an impetus to compel countries, NGOs, and other parties to work together. Government buy-in was also a significant facilitator. On alcohol, for example, local governments' interest in eliminating deaths and blindness from homemade alcohol products was key to their participation. Further, resources to assist in organization communication were mentioned by numerous stakeholders as a way to further encourage meetings by providing administrative support, meeting space, and additional evidence of governmental support.

The most significant barrier to MSA in NCD policy development was lack of funding for policy development and a lack of specific goals and leaders. As previously discussed, management funding makes logistics easier and provides additional enforcement of the government's commitment. Lack of specific goals and leaders was a challenge. Although WHO documents identify best buys interventions, diet policies were viewed as a more diffuse target. Reducing salt in food requires a more comprehensive approach than limiting a single product with only a few suppliers, such as tobacco. The conflict between public health goals and economic goals regarding tobacco, such as supporting the industry and government-invested farms, also created an MSA barrier. For all policies, MSA was instrumental in policy implementation and less fruitful in policy evaluation. Getting organizations together to create policies was highly challenging; it is recommended that future conversations include specific clarification of enforcement, penalties, monitoring, evaluation and parties' roles and responsibilities in these efforts as a delineated part of the policy itself.

Based on this case study, MSA to complete policy formulation is most likely to be successful when the following are in place: (1) strong government support in terms of a mandate, established leader to facilitate the policy development process, and funding to support the meetings and consultations to develop the policy; (2) clear, specific, compelling goals about what is to be achieved; (3) deliberate connection of the larger scope of public health goals to the local problems so creating the policies addresses both levels; (4) external international body support (e.g., WHO) to provide an impetus for action; and (5) government support, including enforcement, penalties, monitoring, evaluation and parties' roles and responsibilities in the policy itself.

4.2 Limitations

This study included document review and interviews with key stakeholders, but it is always possible that some important documents or stakeholders were inadvertently excluded. Further, some key players might not be available as they have retired or relocated. Given the degree to which we reached saturation, in which interviewees' reports are consistent and not revealing new information, we are confident these findings reflect the main issues present in the use of MSA in implementing NCD policies in Kenya.



5.0

5.0 | Conclusions



Conclusions



We drew the following conclusions based on the study's findings:

- MSA facilitates development of policies to address WHO best buys interventions to reduce NCDs in Kenya. Awareness of international recommendations as well as country-specific needs is critical to crafting policies that address both international and local needs.
- The visibility of NCDs as a major public health problem is still low given the predominance of major infectious disease epidemics in global health discourse. Countries must emphasize the broader impact of NCDs to build political will to enact NCD policies.
- MoH staff generally took a lead on policy development; policies are greatly strengthened with the inclusion of representatives from other ministries, NGOs and community stakeholders who can support policy development.
- There is tension between the health and economic goals for some of the best buys interventions, such as tobacco industry and farmers' interests vs. state desire to limit tobacco consumption, or state investment in tobacco companies vs. state desire to limit tobacco consumption. These tensions can be managed with transparency, reducing conflicts of interest, and thoughtful conversations about how to proceed in the best interest of the country.
- Emphasizing the role of the risk factors (alcohol misuse, tobacco use, poor diet, and lack of exercise) in increasing the social burden of health care costs, work absences, and injury/accidents, as well as NCD development, can be useful a strategy to engage immediate stakeholder action. Combining multiple local rationales with international guidance to appeal to stakeholders for change also builds support.



6.0 | Recommendations

6.0



Recommendations



To successfully develop and implement policies, it is important to consider the following recommendations:

1. There is need for the government to allocate adequate funding to support sectoral policy development, review and planning meetings, and research. Funding is also needed for enforcement, monitoring, evaluation, and continuance of policies.
2. Integration of stakeholders in multi-sectoral action is key; however, it is important to consider differing perspectives of some stakeholders (such as industry) whose goals might counter the policy process.
3. There is a need for dedicated staff to coordinate; clear roles and responsibilities, including a designated leader to oversee the process, must be defined.
4. It is also important to incorporate implementation, monitoring and evaluation into the policy development process. Policy creation is less meaningful if there are no means to implement or enforce.

7.0



7.0 | References



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8.0 | Annexes

8.0



Annexes



8.1 Final interview guide

ANALYSIS FOR NCDs PREVENTION POLICIES IN AFRICA (ANPPA) PROJECT

KEY INFORMANTS INTERVIEW GUIDE

Introduction

Good (morning/afternoon/evening), My name is _____; I work for the African Population and Health Research Center. Today I will be conducting research to analyze the non-communicable disease prevention policies in Kenya.

This study aims to understand how policies have been formulated and implemented to prevent non-communicable diseases in Kenya. The major non-communicable diseases we are focusing on include cardiovascular disease (including hypertension), cancers, chronic respiratory diseases and diabetes.

The preventive interventions focus on tackling major risk factors. For this study the risk factors we are focusing on include tackling tobacco use, harmful alcohol use, unhealthy diets and physical inactivity.

In particular, we would like to understand who and which sectors have been involved with non-communicable disease prevention policy development and implementation in Kenya.

In terms of policy, we are interested in higher-level policies such as laws, regulations, national strategic plans, as well as lower level policy guidelines and action plans related to NCD prevention and program implementation strategies.

To obtain reliable information we request that you answer the questions that follow as frankly as possible. Your views are important in this research. There is no right or wrong answer. It is your knowledge and opinion that count. The information you give to us will be kept confidential. You will not be identified by name or address in any of the reports we plan to write.

The interview will take 60-90 minutes

PLEASE REQUEST INFORMED CONSENT

Demographics, TAKE NOTES (identifying information to be kept separate from interview transcripts)

Just to confirm that I have your details right: (USE THE SEPARATE FORM TO COMPLETE THE INFORMATION BELOW)

- a. Participant's name and organization and email/ contact details (fill in beforehand if possible):
- b. Participant's title/designation and primary responsibilities:
- c. What year did you start working in this organization? What year did you start in this particular position?

REQUEST TO TURN ON RECORDERS AT THIS POINT



Alcohol Policies

A. Policy Context

1. What is your opinion on alcohol policy development in this country?
 - a. Which alcohol policies are you aware of in this country?
2. What was the rationale for formulation of the alcohol policy? (For each policy mentioned)
 - a. What issues within the Kenyan context that led to development of the policy (Probe for: whether there were political changes, health sector reforms, organizational changes, fiscal policies, and changes in government)
 - b. What issues at the Global level influenced the formulation of alcohol policies (probe for global movements, declarations, meetings)

B. Actors in policy formulation

3. To what extent were you involved in the formulation of these alcohol policies? (Probe for each policy mentioned)
 - a. What was your role in the formulation of the alcohol policy
 - b. Please describe your experience as you participated in the formulation of the policy (What in your opinion went well? What could have been done differently?)
 4. Which other sectors were involved in the formulation of the policies (Probe for: Which Ministries, heads, NCD heads, Civil societies, parliamentarians, manufacturers, industries, farmers, women groups, NGOs etc. were involved?)
 - a. Who led the process in formulating the alcohol policies
 - b. What was the role of the sectors that were involved? (Probe for the sectors mentioned)
 - c. Who else should have been involved in formulating the policy yet they were not involved?
- I. Why do you think they were not involved?
- II. How in your view would their involvement have shaped or influenced the policy?
- d. What strategies were used to bring the different stakeholders/sectors to work together in formulating these alcohol policies?
 - e. What were the benefits of involving different sectors in the policy formulation processes?
 - f. What were the challenges encountered in bringing the different sectors together in formulating the alcohol policies?

C. Policy Implementation

5. To what extent have the alcohol policies been implemented (probe for each policy mentioned?)
 - a. How were you involved in the implementation of the alcohol policies?
 - b. Which other sectors/ stakeholders were involved in the implementation?
 - c. Who else should have been involved and yet they were not involved in implementing the policy?



- I. _____ Why do you think they were not involved?
- II. What in your view would have been the impact on the policy if they had been involved?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in implementation these alcohol policies?
 - e. What factors enabled different sectors to work together in implementing these alcohol policies
 - f. What were the challenges encountered in bringing the different sectors together in implementing the alcohol policies (Probe for challenges in bringing several sectors together to support implementation)
6. Please comment on how alcohol industry influenced the alcohol policy development process (negatively or positively).
 - a. How did you overcome any challenges that industry interference may have generated?
7. What kind of funding is available for implementation of the alcohol policies mentioned?

Probe: For amount of funding; Sources of funding)

Probe: Are there arrangements such as joint budgeting and delegated financing aimed at addressing alcohol issues?

8. What factors in your view will facilitate the working together of different sectors in formulating /implementing alcohol policies in future? (Probe for recommendations to facilitate different sectors in working together in implementing of alcohol programs?)
9. What factors in your view will hinder the working together of different sectors in formulating/ implementing alcohol policies?

Tobacco Use Policies

A. Policy Context

1. What is your opinion on tobacco policy development in this country?
 - a. Which tobacco use policies are you aware of in this Country?
2. What was the rationale for formulation of the tobacco policy (For each policy mentioned)
 - a. What issues within the Kenyan context that led to development of the policy (Probe for: whether there were political changes, health sector reforms, organizational changes, fiscal policies, and changes in government
 - b. What at the Global level influenced the formulation of tobacco policies (probe for global movements, declarations, meetings)

B. Actors in Policy formulation

3. To what extent were you involved in the formulation of these tobacco policies? (Probe for each policy mentioned)
 - a. What was your role in the formulation of the tobacco policy
 - b. Please describe your experience as you participated in the formulation of the policy (What in your opinion went well? What could have been done differently?)



4. Which other sectors were involved in the formulation of the policies (Probe for: Which Ministries, heads, NCD heads, Civil societies, parliamentarians, manufacturers, industries, farmers, women groups, NGOs etc. were involved?)
 - a. Who led the process in formulating the tobacco policies
 - b. What was the role of the sectors that were involved? (Probe for the sectors mentioned)
 - c. Who else should have been involved in your view and why?
 - i. _____ Why do you think they were not involved?
 - ii. _____ How in your view would their involvement have shaped or influenced the policy?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in formulating these tobacco policies?
 - e. What were the benefits of involving different sectors in the policy formulation processes?
 - f. What were the challenges encountered in bringing the different sectors together in formulating the tobacco policies?

C. Policy Implementation

5. To what extent have the tobacco policies been implemented (probe for each policy mentioned?)
 - a. How were you involved in the implementation of the tobacco policies?
 - b. Which other sectors/ stakeholders were involved in the implementation of the policies?
 - c. Who else should have been involved and yet they were not involved in implementing the policy?
 - I. _____ Why do you think they were not involved?
 - II. _____ What in your view would have been the impact on the policy if they had been involved?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in implementation these tobacco policies?
 - e. What factors enabled different sectors to work together in implementing these tobacco policies
 - f. What were the challenges encountered in implementing the tobacco policies (Probe for challenges in bringing several sectors together to support implementation)
6. Please comment on how tobacco industry influenced the tobacco policy development process (negatively or positively).
 - a. How did you overcome any challenges that industry interference may have generated?
7. What kind of funding is available for implementation of the tobacco policies mentioned?

Probe: For amount of funding; Sources of funding)

Probe: Are there arrangements such as joint budgeting and delegated financing aimed at addressing tobacco issues?
7. What factors in your view will facilitate the working together of different sectors in formulating /implementing tobacco policies in future? (Probe for recommendations to facilitate different sectors in working together in implementing of tobacco programs?)



8. What factors in your view will hinder the working together of different sectors in formulating/ implementing tobacco policies?

Policies Promoting Physical Activity

A. Policy Context

1. What is your opinion on promoting physical activity policy development in this country?
 - a. Which physical activity policies are you aware of in this country?
2. What was the rationale for formulation of physical activity policies?(For each policy mentioned)
 - a. What issues within the Kenyan context led to development of the policies on physical activity (Probe for: whether there were political changes, health sector reforms, organizational changes, fiscal policies, and changes in government)
 - b. What issues at the Global level influenced the formulation of physical activity policies (probe for global movements, declarations, meetings)

B. Actors in policy formulation

3. To what extent were you involved in the formulation of these physical activity policies? (Probe for each policy mentioned)
 - a. What was your role in the formulation of the physical activity policy
 - b. Please describe your experience as you participated in the formulation of the policy (What in your opinion went well? What could have been done differently?)
4. Which other sectors were involved in the formulation of the physical activity policies (Probe for: Which Ministries, heads, NCD heads, Civil societies, parliamentarians, manufacturers, industries, farmers, women groups, NGOs etc. were involved?)
 - a. Who led the process in formulating the physical activity policies
 - b. What was the role of the sectors that were involved in the formulation of the policies? (Probe for the sectors mentioned)
 - c. Who else should have been involved in formulating the policy yet they were not involved?
 - I. _____ Why do you think they were not involved?
 - II. How in your view would their involvement have shaped or influenced the policy?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in formulating these promoting physical activity policies?
 - e. What were the benefits of involving different sectors in the policy formulation processes?
 - f. What were the challenges encountered in bringing the different sectors together in formulating the promoting physical activity policies?

C. Policy Implementation

5. To what extent have the physical activity policies been implemented (probe for each policy mentioned?)
 - a. How were you involved in the implementation of the physical activity policies?



- b. Which other sectors/ stakeholders were involved in the implementation?
 - c. Who else should have been involved and yet they were not involved in implementing the policy?
 - I. Why do you think they were not involved?
 - II. What in your view would have been the impact on the policy if they had been involved?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in implementation these alcohol policies?
 - e. What factors enabled different sectors to work together in implementing these physical activity policies
 - f. What were the challenges encountered in implementing the physical activity policies (Probe for challenges in bringing several sectors together to support implementation)
6. What kind of funding is available for implementation of the physical activity policies mentioned?
Probe: For amount of funding; Sources of funding)

Probe: Are there arrangements such as joint budgeting and delegated financing aimed at addressing promoting physical activity issues?
7. What factors in your view will facilitate the working together of different sectors in formulating /implementing physical activity policies in future? (Probe for recommendations to facilitate different sectors in working together in implementing of physical activity programs?)
8. What factors in your view will hinder the working together of different sectors in formulating/ implementing physical activity policies?

Policies Promoting Healthy Diet

A. Policy Context

My last set of questions is about policies related to promoting healthy diet.

1. What is your opinion on healthy diet policy development in this country?
 - a. Which healthy diet policies are you aware of in this country?
2. What issues led to the development of the healthy diet policies?(For each policy mentioned)
 - a. What issues within the Kenyan context led to the development of the healthy diet policies (Probe for: whether there were political changes, health sector reforms, organizational changes, fiscal policies, and changes in government
 - b. What issues at the Global level influenced the formulation of healthy diet policies (probe for global movements, declarations, meetings)

B. Actors in policy formulation

3. To what extent were you involved in the formulation of these healthy diet policies? (Probe for each policy mentioned)
 - a) What was your role in the formulation of the healthy diet policy
 - b) Please describe your experience in participating in the formulation of the policy (What in your opinion went well? What could have been done differently?)



4. Which other sectors were involved in the formulation of the policies
 - a) Who led the process in formulating the healthy diet policies
 - b) What was the role of the sectors that were involved? (Probe for the sectors mentioned)
 - c) Who else should have been involved in formulating the policy yet they were not involved?
 - I. Why do you think they were not involved?
 - II. How in your view would their involvement have shaped or influenced the policy?
 - a. What strategies were used to bring the different stakeholders/sectors to work together in formulating these healthy diet policies?
 - b. What were the benefits of involving different sectors in the policy formulation processes?
 - c. What were the challenges encountered in bringing the different sectors together in formulating the healthy diet policies?

C. Policy Implementation

5. To what extent have the healthy diet policies been implemented (probe for each policy mentioned?)
 - a. How were you involved in the implementation of the healthy diet policies?
 - b. Which other sectors/ stakeholders were involved in the implementation?
 - c. Who else should have been involved and yet they were not involved in implementing healthy diet policies?
 - I. Why do you think they were not involved?
 - II. What in your view would have been the impact on the policy if they had been involved?
 - d. What strategies were used to bring the different stakeholders/sectors to work together in implementation these healthy diet policies?
 - e. What factors enabled different sectors to work together in implementing these healthy diet policies
 - f. What were the challenges encountered in implementing the healthy diet policies (Probe for challenges in bringing several sectors together to support implementation)
6. What kind of funding is available for implementation of the healthy diet policies mentioned?

Probe: For amount of funding; Sources of funding)

Probe: Are there arrangements such as joint budgeting and delegated financing aimed at addressing healthy diet issues?
7. What factors in your view will facilitate the working together of different sectors in formulating / implementing healthy diet policies in future? (Probe for recommendations to facilitate different sectors in working together in implementing of healthy diet programs?)
9. What factors in your view will hinder the working together of different sectors in formulating/ implementing healthy diet policies?

Is there anything else significant about the development of NCD policy /program in Kenya that we have not discussed so far?

Ask for relevant documents and names of other potential respondents.

Thank you for participating in this study. Your responses will be very helpful to our understanding of NCD prevention policies and how to enhance MSA in developing the policies

This is the end of our discussion today.

8.2 Ethics review certificate



KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840-00200, NAIROBI, Kenya
Tel (254) (020) 2722541, 2713349, 0722-205901, 0733-400003; Fax: (254) (020) 2720030
E-mail: director@kemri.org info@kemri.org Website: www.kemri.org

KEMRI/RES/7/3/1

January 23, 2014

**TO: DR. KYOBUTUNGI CATHERINE,
PRINCIPAL INVESTIGATOR
SENIOR RESEARCH SCIENTIST,
AFRICAN POPULATION AND HEALTH RESEARCH CENTRE (APHRC)**

Dear Madam,

RE: NON-SSC PROTOCOL NO. 420 (INITIAL): ANALYSIS OF NON-COMMUNICABLE DISEASES PREVENTION POLICIES IN AFRICA (ANPPA): KENYA COUNTRY CASE STUDY

This is to inform you that during the 223rd meeting of the KEMRI Ethics Review Committee held on 21st January, 2014, the above referenced application was discussed.

The Committee noted that the above referenced study seeks to promote multi-sectoral approaches to policy-making for NCD prevention by providing evidence on the effectiveness of these approaches in the implementation of Best Buys in Kenya.

After careful consideration, the Committee concluded that the following need to be clarified/ addressed before a final decision on the study can be reached:

- 1. Document Version Control:** Please ensure that the document has a version number and date e.g. Version 1.1 dated 20th January 2014 if the document is finalized on 20th January 2014. This facilitates tracking of the document of record
- 2. Attach table of contents and list of abbreviations used in the proposal**
- 3. Selection Criteria:** Please provide a precise inclusion and exclusion criteria of participants to be included in this study

Please address the issue raised and remit **two (2)** copy of the revised proposal to the ERC Secretariat by **21st February, 2014** for further action.

Yours faithfully,

**DR. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI/ETHICS REVIEW COMMITTEE**

In Search of Better Health



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KEMRI/RES/7/3/1

February 11, 2015

**TO: DR. KYOBUTUNGI CATHERINE,
PRINCIPAL INVESTIGATOR
SENIOR RESEARCH SCIENTIST,
AFRICAN POPULATION AND HEALTH RESEARCH CENTRE (APHRC)**

Dear Madam,

**RE: NON-SSC PROTOCOL NO. 420 (REQUEST FOR ANNUAL RENEWAL):
ANALYSIS OF NON-COMMUNICABLE DISEASES PREVENTION POLICIES IN
AFRICA (ANPPA): KENYA COUNTRY CASE STUDY**

Thank you for the continuing review report for the period **February 2014 to December 2014**.

This is to inform that during the 236th A meeting of the KEMRI/Scientific and Ethics Review Unit (SERU) held on 10th of February 2015, the Committee **conducted the annual review and approved** the above referenced application for another year.

This approval is valid from **11th February 2015** through to **February 10, 2016**. Please note that authorization to conduct this study will automatically expire on **February 10, 2016**. If you plan to continue with data collection or analysis beyond this date please submit an application for continuing approval to **SERU** by **December 30, 2015**.

You are required to submit any amendments to this protocol and other information pertinent to human participation in this study to SERU for review prior to initiation.

Yours faithfully,

**PROF. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI/ETHICS REVIEW COMMITTEE**

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KEMRI/RES/7/3/1

February 11, 2015

**TO: DR. KYOBUTUNGI CATHERINE,
PRINCIPAL INVESTIGATOR
SENIOR RESEARCH SCIENTIST,
AFRICAN POPULATION AND HEALTH RESEARCH CENTRE (APHRC)**

Dear Madam,

**RE: NON-SSC PROTOCOL NO. 420 (REQUEST FOR ANNUAL RENEWAL):
ANALYSIS OF NON-COMMUNICABLE DISEASES PREVENTION POLICIES IN
AFRICA (ANPPA): KENYA COUNTRY CASE STUDY**

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This approval is valid from **11th February 2015** through to **February 10, 2016**. Please note that authorization to conduct this study will automatically expire on **February 10, 2016**. If you plan to continue with data collection or analysis beyond this date please submit an application for continuing approval to **SERU by December 30, 2015**.

You are required to submit any amendments to this protocol and other information pertinent to human participation in this study to SERU for review prior to initiation.

Yours faithfully,

**PROF. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI/ETHICS REVIEW COMMITTEE**

In Search of Better Health



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KEMRI/RES/7/3/1

March 15, 2017

**TO: DR. CATHERINE KYOBUTUNGI, PRINCIPAL INVESTIGATOR,
DIRECTOR OF RESEARCH, APHRC**

Dear Madam,

**RE: NON SSC NO. 420 (RESUBMISSION REQUEST FOR ANNUAL RENEWAL AND
PROTOCOL DEVIATION): ANALYSIS OF NON-COMMUNICABLE DISEASES
(NCD) PREVENTION POLICIES IN AFRICA**

Reference is made to your letter dated March 8, 2017. The KEMRI/SERU Secretariat acknowledges receipt of the revised application on 10th March 2017.

This is to inform you that the Committee notes that the issue raised at the 260th Committee C meeting of the KEMRI/SERU held on **23rd February 2017** has been adequately addressed.

Consequently, the study is granted approval for continuation effective **15th March 2017**. Please note that authorization to conduct this study will automatically expire on **14th March 2018**. If you plan to continue with data collection or analysis beyond this date, please submit an application for continuing approval to the SERU Secretariat by **31st January, 2018**.

You are required to submit any proposed changes to this study to the SERU for review and the changes should not be initiated until written approval from the SERU is received. Please note that any unanticipated problems resulting from the implementation of this study should be brought to the attention of SERU and you should advise SERU when the study is completed or discontinued.

You may continue with the study.

Yours faithfully,

Bele
For: **DR. EVANS AMUKOYE,
ACTING HEAD,
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT**

In Search of Better Health



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