JOINT NATIONAL CAPACITY ASSESSMENT ON THE IMPLEMENTATION OF EFFECTIVE TOBACCO CONTROL POLICIES IN UGANDA
Joint national capacity assessment on the implementation of effective tobacco control policies in Uganda
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### Abbreviations

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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>COP</td>
<td>Conference of the Parties</td>
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<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<tr>
<td>CTCA</td>
<td>Centre for Tobacco Control in Africa</td>
</tr>
<tr>
<td>DSIP</td>
<td>development strategy and investment plan</td>
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<td>DSR</td>
<td>designated smoking room</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<td>EPRC</td>
<td>Economic Policy Research Centre</td>
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<td>GSPS</td>
<td>Global School Personnel Survey</td>
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<td>GTSS</td>
<td>Global Tobacco Surveillance System</td>
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<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IDRC</td>
<td>International Development Research Centre</td>
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<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>MAAIF</td>
<td>Ministry of Agriculture, Animal Industry and Fisheries</td>
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<tr>
<td>MOES</td>
<td>Ministry of Education and Sports</td>
</tr>
<tr>
<td>MOFPED</td>
<td>Ministry of Finance, Planning and Economic Development</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOING</td>
<td>Ministry of Information and National Guidance</td>
</tr>
<tr>
<td>MTTI</td>
<td>Ministry of Trade, Tourism and Industry</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NAADS</td>
<td>National Agricultural Advisory Services</td>
</tr>
<tr>
<td>NARO</td>
<td>National Agricultural Research Organization</td>
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<tr>
<td>NCDs</td>
<td>noncommunicable diseases</td>
</tr>
<tr>
<td>NEMA</td>
<td>National Environment Management Authority</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NTLP</td>
<td>National Tuberculosis and Leprosy Programme</td>
</tr>
<tr>
<td>RITC</td>
<td>Research for International Tobacco Control</td>
</tr>
<tr>
<td>SHS</td>
<td>Second-hand smoke</td>
</tr>
<tr>
<td>TAPS</td>
<td>tobacco advertising, promotion and sponsorship</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
</tr>
<tr>
<td>UDHS</td>
<td>Uganda Demographic Health Survey</td>
</tr>
<tr>
<td>UNHRO</td>
<td>Uganda National Health Research Organization</td>
</tr>
<tr>
<td>UHS</td>
<td>Uganda Household Survey</td>
</tr>
<tr>
<td>UNACOH</td>
<td>National Association of Community and Occupational Health</td>
</tr>
<tr>
<td>UNCST</td>
<td>Uganda National Council for Science and Technology</td>
</tr>
<tr>
<td>UNHRO</td>
<td>Uganda National Health Research Organization</td>
</tr>
<tr>
<td>URA</td>
<td>Uganda Revenue Authority</td>
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<tr>
<td>WHO FCTC</td>
<td>World Health Organization Framework Convention on Tobacco Control</td>
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</table>
Executive summary

Uganda is a Party to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), which it ratified in 2007, despite a strong tobacco industry lobby. It is a tobacco-growing country where about 22% of males and 4% of females between 15 and 49 years of age currently use tobacco products. Uganda has been involved in curbing the tobacco epidemic since 1998. While the main causes of death in the country are communicable diseases, the burden of noncommunicable diseases (NCDs), particularly heart disease, chronic obstructive pulmonary disease (COPD), stroke and cancer, is on the rise in the population. Knowing that tobacco is an underlying risk factor for NCDs, Uganda has made efforts to reduce the use of tobacco and to tackle its serious consequences for public health. Tobacco control is an established, cost-effective primary prevention intervention for countries at any stage of development. In 1998, the Ugandan Ministry of Health (MOH) established a Tobacco Control Desk to coordinate tobacco control, but it was not until 2002 that a tobacco control focal point was designated at the MOH. Tobacco control efforts have intensified over time, culminating in the establishment of the Environmental Regulations – Control of Smoking in Public Places Regulations in 2004.

The key milestones in tobacco control in Uganda are shown in Figure 1.

Figure 1: Uganda Tobacco Control Milestones

The government is determined to continue to strengthen its tobacco control efforts. Between 19 and 24 June 2011, a group of 15 national, international and WHO experts, in collaboration with a team from the MOH, held individual interviews with 124 individuals representing 38 institutions to assess the country’s efforts in implementing the WHO FCTC. The assessment team reviewed tobacco epidemiologic data, as well as the status and development efforts of key tobacco control measures undertaken by the government and other sectors. The key participating institutions included the majority of the tobacco control stakeholders in Uganda: central and local governmental agencies with regulating roles or implementing responsibilities, civil society, the media and academia.

Ugandan authorities are aware that the progress achieved in tobacco control can and must be accelerated. The assessment team considered the following to be the most significant challenges to continued progress of tobacco control in Uganda:
• **Compliance with the existing smoke-free legislation is high where smoking is banned but almost non-existent in the hospitality sector, where smoking is only restricted.** Neither the National Environment Management Authority (NEMA), which is mandated to enforce smoke-free regulations, nor the district authorities have any structured plan to monitor and enforce the regulations, despite the fact that there appears to be no active opposition to such enforcement.

• **The existing legal and coordination framework for tobacco control is inadequate to fully implement Uganda’s obligations to the WHO FCTC.** The only legislation that addresses the WHO FCTC covers smoke-free environments, health warnings and product regulation (Articles 8, 9, 10 and 11 of the WHO FCTC). Other relevant articles are currently not enforceable, including Article 13 which bans tobacco advertising, promotion and sponsorship (TAPS), the deadline for which is in 2012, and parts of Article 11, for which the deadline has already passed. Moreover, although the relevant sectors have focal persons for tobacco control, there is no formal mechanism with a mandate to plan and implement intersectoral tobacco control activities. The other relevant sectors have clearly indicated that the MOH should take the lead in spearheading tobacco control initiatives. However, the lack of a tobacco control law that is fully WHO FCTC-compliant and a national plan of action agreed upon by all major institutions and agencies, along with a scarcity of human and financial resources, hinders the progress of tobacco control.

• **The health warnings in Uganda have always been text warnings; no pictorial warnings have been prescribed for tobacco products.** The health warnings on tobacco product packages are textual, and there is no legal provision for pictorial health warnings, which are recommended in the WHO FCTC Article 11 Guidelines. The MOH made some efforts to introduce pictorial health warnings on tobacco products, but there was strong resistance from the tobacco industry.

• **The levying of taxes on tobacco products is a public finance measure rather than a public health strategy and is benchmarked on East African Community (EAC) strategies and agreements.**

• **Although the government does not provide technical or financial support to the tobacco growers, there is no government policy to implement the WHO FCTC obligation to promote sustainable, viable alternative livelihoods, including alternative crops.**

To ensure the sustainability of current initiatives and to make further progress, the assessment team made five key recommendations that are considered to be critical and to have the greatest potential for success in the short term. These recommendations should be implemented by the government in collaboration with the relevant stakeholders (with the exception of the tobacco industry, its front groups and allies) within the next 12 to 18 months.

1. **NEMA and the districts should enforce the smoke-free regulations of 2004 diligently and expeditiously, especially in the hospitality sector.** Enforcement could be achieved through a step-wise process, developing selected enforcement-best-practice districts that could serve as models for other districts. A plan of action should be developed for building capacity in districts and allocating minimal but essential resources for monitoring and enforcement.
2. A comprehensive tobacco control law should be developed, implemented and monitored by an official government intersectoral forum led by the MOH. Successful implementation of the WHO FCTC will depend on the enactment of a comprehensive law addressing all treaty provisions. Given the multisectoral nature of tobacco control, there is need for an intersectoral coordination mechanism/forum comprising relevant stakeholder ministries and agencies, including the Ministry of Finance, Planning and Economic Development (MOFPED); the Ministry of Trade, Tourism and Industry (MTTI); the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF); the Ministry of Education and Sports (MOES); the Ministry of Information and Guidance; Internal Affairs (Police); local governments; the National Bureau of Standards; NEMA; and the Uganda Revenue Authority (URA) under the leadership of the MOH. The representation at this forum should be at a high enough level to ensure that its decisions are binding on the sectors. One of the mandates of the forum would be to agree upon the key provisions in the comprehensive tobacco control law. The forum should also develop a national plan of action identifying the needed human, technical and financial resources. Appropriate measures should be taken to ensure that the tobacco Industry does not interfere with this forum.

3. The government should introduce strong pictorial warnings on the packages of all tobacco products. The literacy rate among Ugandan men is 51%, and among women it is 49%. Also, almost 14% of 13- to 15-year-old schoolchildren use tobacco products other than cigarettes. Thus there is an urgent need to introduce pretested pictorial warnings, along with textual warnings, on all tobacco product packages. The warnings should also be rotated at regular intervals.

4. The excise taxes on tobacco products should be progressively increased from the existing approximately 44% of the retail price to around 70% of the retail price, after consultation with all relevant stakeholders and taking into consideration the health and economic benefits of increasing taxes on tobacco. The government of Uganda should work towards progressively increasing tobacco taxes to around 70% of the retail price, and it should take the lead in engagement with other EAC countries in a similar joint effort to align tobacco tax principles.

5. The MAAIF should develop and support a strategy to advance sustainable, viable alternative livelihoods and crops, as part of the development strategy and investment plan (DSIP) and should also engage with national and international organizations that have relevant expertise in sustainable viable alternatives to tobacco-growing.

Other recommendations offered for each of the tobacco control policies assessed are included in this final report.
ACKNOWLEDGEMENT

We would like to thank the many individuals, including WHO staff and government representatives, who have contributed to the preparation and conduct of the capacity assessment mission.

Special thanks are due to the primary authors of this report who drew on their expertise in the context of the findings in the country: Patience Butesi, Stephne Byantwale, Vera da Costa e Silva, Liliane Luwaga, Jenninah Kabiswa, Jagdhish Kaur, Possy Mugyenyi, Sheila Ndyanabangi, Ahmed E. Ogwell Ouma, Armando Peruga, Vinayak Prasad, Luminita Sanda, Deo Sekimpi, Benjamin Sensasi, Hafsa Lukwata Sentongo, Joshua Ssebunya. Much appreciation and thanks go to the Ministry of Health in Uganda and the WHO Uganda Country Office for their support in preparing a successful assessment.

We wish to also acknowledge the tremendous contribution of Ahmed Ezra Ogwell Ouma, Vinayak Prasad and Luminita Sanda who conceptualized and published this report under the coordination and guidance of Douglas Bettcher and Armando Peruga.

Finally the Government of Uganda and WHO express their gratitude to the Bill & Melinda Gates Foundation who made the joint capacity assessment work in Uganda possible.
1. Introduction

Uganda is a Party to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), which it ratified in 2007, despite a strong tobacco industry lobby. It is a tobacco-growing country that has been involved in curbing the tobacco epidemic since 1998. While the main causes of death are communicable diseases, the burden of NCDs, particularly heart disease, chronic obstructive pulmonary disease (COPD), stroke and cancer, is on the rise in the population. Knowing that tobacco is a known underlying risk factor for NCDs, Uganda has made efforts to reduce the use of tobacco and tackle its serious consequences for public health. Tobacco control is a primary, cost-effective prevention intervention for countries at any stage of development. The Ugandan Ministry of Health (MOH) established a Tobacco Control Desk as the coordinating unit for tobacco control in 1998, but it was not until 2002 that a tobacco control focal point was designated at the MOH. Tobacco control efforts in the country have intensified over time, culminating in the establishment of the Environmental Regulations – Control of Smoking in Public Places Regulations of 2004, a milestone in counteracting the tobacco epidemic.

The challenge of reversing the tobacco epidemic is significant for the Uganda government. According to the Uganda demographic survey of 2006, 20% of Ugandan males between 15 and 49 years of age use tobacco products, and 4% of women of the same age do so. The figures for the total adult population are even higher given that the prevalence of tobacco use among people 45 or older is even higher (31.6% of males and 14.5% of females). The Global Youth Tobacco Survey (GYTS) 2007 revealed that 5.5% of students 13 to 15 years of age smoke cigarettes, and 13.9% of them use other tobacco products.

The MOH is leading the country’s efforts in developing policies, programmes and services to halt the epidemic. The Government of Uganda requested WHO to perform a joint assessment of Uganda’s national capacity to implement the WHO FCTC, with special emphasis on the WHO MPOWER1 package of effective tobacco control policies in support of the implementation of the treaty (Monitor tobacco use and interventions, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce bans on tobacco advertising, promotion and sponsorship [TAPS], Raise taxes on tobacco) and other supply-reduction measures including development of sustainable alternatives to tobacco-growing; elimination and control of illicit trade; and product regulation. WHO worked with the MOH to organize and conduct the joint capacity assessment.

From 19 to 24 June 2011, a group of 15 national, international and WHO experts, in collaboration with a team from the MOH, held 124 interviews with individuals representing 38 institutions to assess the country’s efforts in implementing the WHO FCTC. The team conducted interviews with preselected groups, key governmental agencies and district officials or individuals who represented sector-wide stakeholders in tobacco control, as well as representatives of civil society organizations and the media.

The assessment team also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control; programme management and coordination; intersectoral and intra-sectoral partnerships and networks; and human and financial resources and infrastructure. Finally, the assessment team made recommendations based on the key findings from its analysis to further the implementation of the WHO FCTC.

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1 MPOWER is a WHO technical assistance package to help countries to implement some provisions of the WHO FCTC. The package is an integral part of the WHO Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, endorsed at the 61st World Health Assembly in 2008.
For each policy, the report presents the following:

- **Policy status and development.** A brief introduction on the present status and future development of tobacco control policy, based on a thorough review of all documents made available by the coordinating team of the capacity assessment prior to the country visit (tobacco control country profile, the WHO Report on the Global Tobacco Epidemic 2009, legislation in force, results and conclusions of previous studies and reports) and interviews with key informants.

- **Key findings.** A summary of the most important facts learnt by the assessment team in the visits and interviews, based on an analysis of key factors for success in implementing present policies and developing future ones. These include political will, programme management and coordination, partnerships and networks for implementation, provision of funds and human resources.

- **Recommendations.** The actions required, in line with the WHO FCTC in the opinion of the assessment team, to improve the design, implementation and enforcement of tobacco control policy. Unless otherwise noted, the suggested time for implementing the recommendations is 12 to 18 months.

WHO is grateful to the government of Uganda and the nongovernmental organizations (NGOs) involved in tobacco control in Uganda for leading the way by carrying out the joint tobacco control capacity assessment. Many other WHO Member States will follow and benefit from the lessons learnt in this assessment.
2. Coordination and implementation of tobacco control interventions

(Article 5.1, 5.2 and 5.3 of WHO FCTC)

2.1. POLICY STATUS AND DEVELOPMENT

2.1.1. Tobacco control policy in Kenya

2.1.1.1. Policies

The tobacco control policies, laws and regulations that support the implementation of the WHO FCTC in Uganda are summarized in Table 2.1

Table 2.1: Uganda’s Legal Framework for Tobacco Control

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Relevant Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Constitution of the Republic of Uganda, 1995</td>
<td>The Constitution sets out a number of national objectives and principles. National objective XXVII deals with the environment and is enforced by Article 39, which provides that “each person has a right to a clean and healthy environment”.</td>
</tr>
<tr>
<td>WHO FCTC, 2003</td>
<td>The country became a Party to the WHO FCTC in 20 June 2007, making it legally bound by the provisions of the treaty.</td>
</tr>
<tr>
<td>National Environment Act, 1996</td>
<td>Section 58(1) states that “no person shall pollute or lead any other person to pollute the environment contrary to guidelines prescribed under the Act”.</td>
</tr>
<tr>
<td>Occupational Safety and Health Act, 2006</td>
<td>Section 13 (a) states that “it is the responsibility of an employer to take, as far as reasonably practicable, all measures for the protection of his or her workers and the general public from the dangerous aspects of the employer’s undertaking at his or her own cost”. Section 13 (b) (ii) states that “it is the responsibility of an employer to ensure, as far as reasonably practicable, that the working environment is kept free from any hazard due to pollution by employing supplementary organizational measures”.</td>
</tr>
<tr>
<td>Public Health Act, 1964</td>
<td>This Act empowers local authorities with administrative powers to take measures for preventing the occurrence of or dealing with any preventable diseases.</td>
</tr>
<tr>
<td>National Environment (Control of Smoking in Public Places) Regulations, 2004</td>
<td>Reg. 3, the regulation mandating a smoke-free environment, states that “every person has the right to a clean and healthy environment and the right to be protected from exposure to second-hand smoke (SHS). Every person has a duty to observe measures to safeguard the health of non-smokers”. Reg. 4, on prohibition of smoking in public places, states that “a person shall not smoke a tobacco product or hold a lighted tobacco product in an enclosed, indoor area of a public place specified in Part I of the Schedule”. Reg. 7, in signs where smoking is prohibited, Section 1, states that “the owner of a public place or any public service vehicle or other public transport where smoking is prohibited shall post clearly legible signs, prominently, stating that smoking is not permitted”. Reg. 9, on the obligation of owners, Section 1, states that “the owner of a public place or public service vehicle or other public transport shall take all reasonable steps to ensure that no person smokes in violation of these Regulations”. Section 4 states that “an owner shall not discriminate [against] any employee or person who asserts his or her right to a smoke-free environment, or who reports any violation under these Regulations”.</td>
</tr>
</tbody>
</table>
2.1.1.2. Structure, governance and key players

2.1.1.2.1. Government agencies

The Government of Uganda coordinates and implements tobacco control policies primarily through the MOH. In 2002, a tobacco control focal point was officially appointed, and the tobacco control activities were placed under the Mental Health and Substance Abuse Control section in the Clinical Services Department. Other MOH offices that are involved in tobacco control activities, shown in Figure 2.1, include the Health Promotion and Education Division.

Figure 2.1: Composition and Organizational Structure of the National Tobacco Control Coordinating Office

Government agencies other than the MOH are involved in tobacco control only on a demand basis. The agencies that participate in tobacco control in Uganda are listed in Table 2.2.

Table 2.2: Key Government Ministries and Agencies and Their Tobacco Control Responsibilities

<table>
<thead>
<tr>
<th>Agency</th>
<th>Tobacco control responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Finance, Planning and Economic Development</td>
<td>Tax policies and illicit trade control</td>
</tr>
<tr>
<td>Ministry of Trade, Tourism and Industry</td>
<td>Support for other ministries (but also through the nature of its responsibilities, it interacts with the tobacco industry)</td>
</tr>
<tr>
<td>Ministry of Agriculture, Animal Industry and Fisheries</td>
<td>Alternative livelihoods</td>
</tr>
<tr>
<td>Ministry of Education and Sports (MOES)</td>
<td>School health programmes and research</td>
</tr>
<tr>
<td>Ministry of Information and Guidance</td>
<td>Regulation of TAPS</td>
</tr>
<tr>
<td>Internal Affairs (Police)</td>
<td>Enforcement of laws</td>
</tr>
<tr>
<td>Local governments</td>
<td>Implementation and enforcement of tobacco control measures</td>
</tr>
<tr>
<td>National Bureau of Standards</td>
<td>Packaging and labelling and product regulation</td>
</tr>
<tr>
<td>National Environment Management Authority</td>
<td>Control of air pollution by SHS</td>
</tr>
<tr>
<td>Uganda Revenue Authority</td>
<td>Tobacco taxes and revenues</td>
</tr>
</tbody>
</table>
2.1.1.2. Civil society

Uganda has an active civil society network that has played an important role in keeping tobacco control on the government agenda. The NGO sector includes advocacy groups and health professional groups, as well as local branches of international organizations. Because of limited funding, the workforce active within these NGOs often work on a voluntary basis. Table 2.3 describes the work of a few NGOs that were interviewed during the mission. The media, especially print, have played a key role in promoting public discussions on the tobacco issue, and some individual-led initiatives have also been reported to be important in tobacco control in Uganda.

Table 2.3: Some NGOs Actively Involved in Tobacco Control

<table>
<thead>
<tr>
<th>NGO</th>
<th>Brief description of tobacco control work</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Care Centre</td>
<td>Provides cessation services</td>
</tr>
<tr>
<td>Pioneer Foundation for Youth Development Uganda</td>
<td>Awareness-raising among youth: health education and skill building</td>
</tr>
<tr>
<td>The Serenity Centre</td>
<td>Provides cessation services</td>
</tr>
<tr>
<td>Victory Rehabilitation Centre</td>
<td>Provides cessation services</td>
</tr>
<tr>
<td>The Environmental Action Network</td>
<td>Active in pushing tobacco control legislation through the Parliament</td>
</tr>
<tr>
<td>Uganda Health Communication Alliance</td>
<td>Promotes tobacco control through the media</td>
</tr>
<tr>
<td>Uganda Medical Association</td>
<td>Promotes public debates on tobacco control through awareness campaigns, research and training of doctors on cessation skills</td>
</tr>
<tr>
<td>Uganda National Association of Community and Occupational Health</td>
<td>General advocacy within communities, including schools and workplaces; dissemination of information and research</td>
</tr>
<tr>
<td>Youth Aid Uganda</td>
<td>Awareness-raising among youth: health education and skill building</td>
</tr>
</tbody>
</table>

2.1.1.3. Coordinating mechanisms

2.1.1.3.1. Coordination within the MOH

There is apparently no clear mechanism of tobacco control coordination established within the MOH. Activities are usually undertaken by the Mental Health and Control of Substance Abuse Section, and support is requested from other units as and when required.

2.1.1.3.2. Coordination within the government

An informal Tobacco or Health forum was established in 1998 and has been active since then. The forum has been instrumental in pushing a tobacco control agenda in Uganda, and some of its members participated in the negotiation of the WHO FCTC as part of the Uganda delegation. The forum comprises members of government departments, professional associations, academia, the media and civil society. There is currently no formal mechanism of coordination between the different agencies and ministries for implementation of the WHO FCTC.

2.1.1.3.3. Coordination of activities at district and local levels

Subnational activities are organized through the district health offices. Activities are limited to World No Tobacco Day celebrations because of limited awareness, lack of funds, non-prioritization and inadequate funding. There are currently no designated focal points for tobacco control in the district programmes/structure.
2.1.2. Tobacco industry
The three main tobacco companies in Uganda are British American Tobacco Uganda (BATU), Leaf Share and Commodities and Continental Tobacco. Mastermind Kenya Limited also operates in the country. BATU is the major tobacco company in the country and has been operating for more than 80 years as a value-added agro exporter. Until 2006, BATU was also involved in the manufacture of quality cigarettes for the Ugandan market. It presently has no tobacco manufacturing unit in Uganda. The manufacturing arm is managed by BAT Kenya, while BATU trades and distributes brands in Uganda. Uganda has a liberalized economy, and people are free to import and export tobacco. Most of the cigarette brands and other tobacco products are therefore imported. There is a sense in the economic sector that tobacco-growing is important in employment generation, economic growth and foreign-exchange earning. The country currently has no policy to address Article 5.3 of the WHO FCTC and Guidelines [protection of public health policies that concern tobacco control from commercial and other vested interests].

2.2. KEY FINDINGS

2.2.1. The MOH has a tobacco control focal point, but the officers assigned to it have other primary responsibilities.
Three officers are assigned to work on tobacco control, but they have other primary responsibilities.

2.2.2. Support provided by the central government to district level on tobacco control activities is weak because of limited human and financial resources and the absence of a national strategy and plan.
The districts provide very positive feedback and express willingness to participate in tobacco control activities, but there is a lack of concrete financial and technical support from the national government.

2.2.3. There is little coordination of tobacco control activities within the MOH.
Although tobacco control falls under the Mental Health and Control of Substance Section, it reports to the NCD Technical Working Group (TWG), which has not been very active, but has been revitalized only recently.

2.2.4. There is no formal national tobacco control plan with dedicated resources.
Although some of the tobacco control activities were included in the activity work plan, a national tobacco control strategy and a plan of action with medium- and long-term visions and goals are still not agreed upon by the various tobacco control stakeholders.

2.2.5. Tobacco control activities in Uganda have insufficient funds to match their needs.
The current budget for tobacco control is mainly allocated for World No Tobacco Day and some coordination meetings at national level. It amounts to US$ 12,000 per year. Furthermore, opportunities such as the tuberculosis (TB) funding framework are not utilized for tobacco control.

2.2.6. There is no formal intersectoral coordination mechanism.
Although the relevant sectors have focal persons for tobacco, there is no formal structure mandated to plan for intersectoral tobacco control activities. The other relevant sectors have clearly indicated that the MOH should take the lead in spearheading tobacco control initiatives.
2.2.7. The existing legal framework covers smoke-free environments, leaving other WHO FCTC articles unenforceable within the country’s legal system.

The regulation that addresses the WHO FCTC covers only a few topics, such as smoke-free environments, packaging and labelling, and product regulation (Articles 8, 9, 10 and 11).

2.2.8. There is no policy for dealing with undue interference from the tobacco industry.

The Bureau of Standards consults with the tobacco industry on specific tobacco control issues as part of its regular consultation process with stakeholders and is therefore vulnerable to negative influence. The industry made unsuccessful attempts to influence government positions on adopting WHO FCTC Guidelines for implementing Articles 9 and 10. There is no mechanism or law to monitor the tobacco industry.

2.2.9. There is a lack of essential information for tobacco control.

The national Health Management Information System (HMIS) does not include information on tobacco use. Information on other issues such as tobacco-growing and illicit trade is also inadequate.

2.2.10. The existing research initiatives do not provide sufficient information and are not linked

Although some research groups were identified during the interviews, there are unanswered questions that need attention, including the prevalence of other tobacco products, the presence of green-tobacco sickness among tobacco farmers and the extent of illicit trade, among others.

2.3. RECOMMENDATIONS

2.3.1. The MOH and other sectors and agencies should allocate adequate human resources for work on tobacco control at the central level.

More people should be involved in the programme planning, Intersectoral coordination, implementation, monitoring and evaluation of tobacco control activities and reporting to the WHO FCTC Conference of the Parties (COP). This is important not only for the MOH but for other sectors and government agencies as well.

2.3.2. The MOH Planning Department should ensure that planning guidelines for district work plans include tobacco control activities and provide human and financial resources.

Because tobacco is a risk factor that cuts across a wide range of NCDs, it is essential that tobacco control be featured in district work plans, in coordination with the national programme. A focal person should be identified in each district to facilitate coordination and implementation.

2.3.3. The MOH should coordinate tobacco control activities.

The Mental Health and Control of Substance Abuse section should continue to spearhead the implementation of the WHO FCTC and its provisions, with the support of the NCD TWG ensuring more visibility and the participation of other sectors of the MOH.

2.3.4. A national tobacco control plan should be developed and agreed upon by stakeholders.

An agreed national plan of action for tobacco control is needed to establish common goals and objectives, define roles and responsibilities and implement funding and monitoring mechanisms. A national tobacco control plan would also emphasize the multisectoral nature of tobacco control strategies.
2.3.5. Both the government and the donor community should allocate adequate and regular funds for tobacco control activities in Uganda.

The allocation of government funds for tobacco control is regular but grossly insufficient. Tobacco control is a poverty issue, and development agencies should therefore be invited to consider providing funding for tobacco control as a part of their primary NCD-prevention activities. Furthermore, part of the funds for diseases that have tobacco use as a risk factor, such as TB, should be allocated for tobacco control activities.

2.3.6. The government should create an official intersectoral, sector-wide coordination mechanism for tobacco control.

Given the multisectoral nature of tobacco control, there is need for an intersectoral coordination forum comprising relevant ministries and agencies, such as Finances, Trade, Agriculture, Education, Internal Affairs (Police), the Bureau of Standards and representatives of local government. The forum should be led by the MOH. Representation should be at a high enough level to ensure that decisions made by the forum are binding on all sectors. Appropriate measures should be taken to ensure that the tobacco Industry does not interfere with this forum.

2.3.7. The relevant government agencies should enforce existing tobacco control regulations while the MOH drafts a comprehensive tobacco control law.

Successful implementation of the WHO FCTC will depend on enforcement of existing laws and on the enactment of a comprehensive law addressing the articles of the treaty. The MOH should take the lead in this initiative.

2.3.8. The government should establish a clear policy preventing undue interference from the tobacco industry.

Guidance for government officials and other agencies on how to prevent undue influence from the tobacco industry should be prepared and disseminated. Mechanisms to monitor tobacco-industry activities in the country should be pursued and could be undertaken by the NGO community.

2.3.9. All government sectors and relevant agencies should routinely collect essential information to support tobacco control.

Important indicators on tobacco use should be incorporated in the national HMIS. The intersectoral coordination mechanism should agree on the key information to be collected by each sector.

2.3.10. Research Institutions should include tobacco control in their priorities.

Research institutions (such as the UNHRO, the NARO and the UBOS), as well as academic institutions (such as the EPRC and the Makerere School of Public Health) should include tobacco control in their research priorities and ensure timely dissemination of their findings to provide an evidence base for planning and decision-making.
3. Monitoring and evaluation

(Article 20 of WHO FCTC)

3.1. POLICY STATUS AND DEVELOPMENT

Tobacco control research, surveillance and information exchange.

Although there are organizations in Uganda with mandates or the capability of carrying out research in areas relevant to tobacco control, such research is very limited indeed, because of low prioritization, which translates into no allocation of funds. One civil society organization, the National Association of Community and Occupational Health (UNACOH), has carried out some tobacco control research with funding from RITC/IRDC (Research for International Tobacco Control/International Development Research Centre). The Uganda Cancer Institute, which carries out research on all cancers and keeps records on all cancer patients under its care, and the Uganda Heart Institute, which carries out research on cardiovascular diseases and keeps records on its patients, could easily develop tobacco control research.

The annual MOH report to the WHO FCTC Secretariat has been the country’s main tobacco control surveillance activity since 2008. However, Uganda’s participation in the GYTS (2007, 2009 and 2011) and the Global School Personnel Survey (GSPS) (2011), as part of the Global Tobacco Surveillance System (GTSS), also constitutes surveillance.

According to UBOS, the prevalence of cigarette smoking among adults in 2011 was 25% among males and 3% among females (Uganda Demographic Health Survey [UDHS] 2001), and in 2009/2010, the prevalence of tobacco use was 12.7% among males and 3.8% among females (Uganda Household Survey [UHS] 2009/2010). The UDHS shows a clearly higher prevalence of tobacco use in rural areas (8.9%) than in urban areas (4.5%), and an increasing prevalence with age: 0.3% for 10- to 14-year-olds, 8.1% for 25- to 29-year-olds, 15.8% for 35- to 39-year-olds and 22.7% for those older than 45.

The Uganda Cancer Registry carries out surveillance on cancer incidence in Kyaddondo County (which includes Kampala City), covering a population of around 3 million, about 10% of Uganda’s population. Lung cancer incidence has increased 10%, compared with 5% for breast cancer, 5% for prostate cancer and 3% for cervical cancer. The risk of developing lung cancer is thus increasing faster than the risk of other cancers, and tobacco smoke is known to be a key risk factor for lung cancer, as well as throat cancer.

The National Tuberculosis and Leprosy Programme and the International Union against TB and Lung Diseases (the Union) carry out surveillance on TB. Since pulmonary TB is associated with tobacco smoking, TB surveillance can indirectly monitor tobacco use as well. The HMIS can also be used to monitor other tobacco-use-related diseases such as cardiovascular diseases and cancer.

The new TWG on NCDs in the MOH is also expected to address tobacco-use-related diseases.

Reporting and exchange of information on tobacco control

The MOH has made annual reports to the WHO FCTC Secretariat since 2008.
3.2. KEY FINDINGS

3.2.1. There are no definitive policies for research and surveillance on the tobacco epidemic and the response to it.
The Uganda National Health Research Organization (UNHRO), established by an Act of Parliament in 2009, is mandated to promote and coordinate all health research, and the Uganda National Council for Science and Technology (UNCST) approves all research and research activities carried out in the country. Other organizations also have mandates to carry out research that may have bearing on tobacco control. The UBOS included questions about tobacco use in the Uganda Census 2002, Uganda Demographic and Health Surveys and Uganda Household Surveys. NARO carries out research on topics relevant to tobacco growing, including agronomy, agricultural technologies and agricultural economics. The EPRC at the Makerere University School of Economics carries out research on broad issues of the economy, including agricultural economics. University departments dealing with health, agriculture and economics also carry out research relevant to tobacco control, as do some civil society organizations.

3.2.2. There is no definitive policy for reporting and exchange of information on tobacco control.
As Uganda is a Party to the WHO FCTC, the MOH has reported to the WHO FCTC Secretariat annually on the status of the implementation of the WHO FCTC since 2008. The country also participated in the GYTS (2007, 2009 and 2011) and the GSPS (2011) as part of the GTSS.

3.3. RECOMMENDATIONS

3.3.1. The MOH should lead a coordinated tobacco control research and surveillance programme.
The country’s tobacco control research potential needs to be harnessed, coordinated and facilitated with training and funding. The recently launched Centre for Tobacco Control in Africa (CTCA), as well as research funders such as IDRC, could be asked to assist in this regard. Epidemiological and interventional studies in support of tobacco control interventions should be commissioned. The current surveillance activities should be strengthened into a permanent tobacco control surveillance programme within MOH, and the programme should have a budget. The programme should be in the form of a partnership between MOH units already involved in surveillance (Tobacco Control Programme, NCD Programme, Resource Centre, NTLP and IDSR, among others), the MTI, the MAAIF, the MOFPED, the URA, the UBOS, the Uganda Cancer Registry, the Uganda Cancer Institute, the Uganda Heart Institute, the International Union Against Tuberculosis and Lung Disease and any other relevant civil society organizations.

WHO questions for surveys should be included in all health-related surveys by the UBOS and other partners. Periodic surveys on tobacco control information, education and communication (IEC), smoke-free environments and other tobacco control issues should be carried out in sentinel sites or in model districts.

Uganda should urgently carry out a comprehensive national tobacco control household survey to provide a solid baseline for accelerated tobacco control activities and should approach WHO to arrange for a national STEPwise approach to Surveillance (STEPS).

3.3.2. The MOH should develop a coordinated tobacco control information exchange mechanism.
The MOH, in collaboration with the CTCA and other stakeholders, should give priority to developing a national tobacco control information exchange mechanism, including allocation of resources for sharing of research findings and other relevant information.
4. Smoke-free environments

(Article 8 of WHO FCTC)

4.1. POLICY STATUS AND DEVELOPMENT

Smoking is banned\(^2\) in all indoor workplaces and public places in Uganda except in the hospitality sector, where designated smoking rooms (DSRs) are allowed, provided they are fully enclosed and separately ventilated with negative pressure, and workers and non-smokers are not required to enter them. Smoking is allowed only in public means of transportation that have specially designated, distinct units for smoking. A member of the newly elected Ugandan Parliament is currently preparing to introduce a bill to improve this regulation.

Local governments have the power to pass bylaws that develop or clarify national laws, but they cannot contradict the mandate of the national law. No local government has used this power yet to enhance tobacco control.

NEMA and the local authorities are responsible for enforcement of the regulations. At the district level, enforcement is under the supervision of the District Environment Officer (DEO), the District Health Officer (DHO) and his District Health Inspector (DHI) and other officers indicated in Figure 4.1, based on the limited findings of the assessment team. Local councils have the power (renewed annually) to grant and revoke the licenses of facilities in the hospitality sector.

Figure 4.1

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4.2. KEY FINDINGS

4.2.1. Compliance with the existing legislation is high where smoking is banned but almost nonexistent in the hospitality sector, where smoking is only restricted.

There are no hard data to back up this anecdotal finding, except that the GYTS 2007 indicates that almost half of students 13 to 15 years of age reported being exposed to SHS in public places. Most public places showed a high degree of self-enforced compliance except in the hospitality sector, where neither DSRs nor any type of signage are required. Also, where incidents of smoking were spotted, no action was taken by owners.

Government efforts to enforce the smoke-free regulations of 2004 are almost nonexistent in the hospitality sector. Neither NEMA nor the district authorities have indicated plans to enforce the regulations, despite the fact that there appears to be no opposition to enforcement. In fact, the Hotel Owners’ Association of Uganda declared its willingness to cooperate in enforcement if the governmental also made an effort.

4.2.1. No local government has used the power to pass bylaws on smoke-free environments.

Local governments interviewed by the assessment team indicated limited knowledge of the smoke-free regulations of 2004. Although local governments have the power to pass bylaws to develop or clarify the regulations, none have used it. However, they showed interest in using this power, especially in relation to banning smoking in outdoor areas immediately adjacent to public places in which smoking is prohibited. Such actions would be intended to ensure that no smoke drifts through doors, windows, air intake systems or any other building openings. The specifications for establishing DSRs might also be subject to bylaw development, for example, by defining the types of doors and the amount of negative pressure required, pending any amendment to existing legislation to ban smoking in the hospitality sector.

4.2.1. The existing legislation is comprehensive and fairly advanced, but it does not provide for 100% smoke-free environments in the hospitality sector.

The special requirements for DSRs in the hospitality sector are so expensive and complicated that very few businesses could be expected to implement them even if they were fully enforced. Scientific evidence has proved that neither ventilation systems nor the establishment of DSRs provides effective protection from exposure to SHS. Therefore, despite the provisions for DSRs in the hospitality sector and on some forms of public transportation, people in these smoking areas or in the adjacent non-smoking areas would not be adequately protected from SHS.
4.3. RECOMMENDATIONS

4.3.1. The smoke-free regulations of 2004 must be enforced diligently and expeditiously.
NEMA and the districts must enforce the existing regulations, especially in the hospitality sector. This may entail:
- Allocating minimal but essential resources for enforcement.
- Reviewing, and improving if necessary, the existing legal instruments to enforce smoke-free environments covering environmental, occupational and health issues and to penalize violators.
- Educating the public on the provisions of the smoke-free regulations and the rights of non-smokers under the Ugandan Constitution.
- Educating business owners and their workers’ representatives on the provisions of the smoke-free regulations and their rights and obligations.
- Developing a plan of action to mobilize all available staff at the district and national levels to inspect facilities in the hospitality sector, to issue notices to correct violations and to fine violators.
- Building capacity in districts and mobilizing resources to implement the plan of action.
- Developing selected enforcement best practices in districts that can serve as models for other districts.

The assessment team calls on the MOH, NEMA, the Makerere School of Public Health and the CTCA to develop a proposal to implement this recommendation and discuss it with WHO for implementation.

4.3.2. Local governments should develop bylaws to effectively enforce the smoke-free regulations of 2004. This may entail:
- Developing a model bylaw that other local councils could consider for adaptation and approval.
- Advocating passing such bylaws in selected pilot districts and supporting the district councils and district authorities politically and technically.
- Building capacity in districts and mobilizing resources to implement a plan of action.

4.3.3. Revise the existing smoke-free regulations to make the hospitality sector completely smoke-free.
A bill is being proposed in the 9th Parliament that would strengthen the present regulations, but the assessment team has not had an opportunity to examine it. If the bill is compliant with Article 8 of the WHO FCTC and its Guidelines, supportive stakeholders should be involved in advocating for its passage.

The assessment team understands that changing regulations may take time even in a favourable political environment. However, the first two recommendations should be implemented immediately.
5. Offer help to quit tobacco use

(Article 14 of WHO FCTC)

5.1. POLICY STATUS AND DEVELOPMENT

Tobacco use can lead to nicotine dependence and serious health problems. It is a chronic condition that often requires repeated interventions, but effective treatments and helpful resources do exist. Cessation can significantly reduce the risk of suffering from smoking-related diseases.\(^3\) Although most of the people who want to quit eventually do so without intervention, assistance greatly increases quit rates. The GYTS conducted in Uganda in 2007 showed that the proportion of young people wanting to quit was high (70.3% of the students 13 to 15 years of age), and 76.6% had made an attempt to stop tobacco use in the previous year.

WHO FCTC Article 14 requires Parties to “develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and to take effective measures to promote cessation of tobacco use and to provide adequate treatment for tobacco dependence”. The COP has also adopted specific guidelines to assist Parties in meeting their obligations under Article 14.\(^4\) However, Uganda does not have a specific policy for promoting cessation of tobacco use, nor does it have adequate treatment for tobacco dependence.

5.2. KEY FINDINGS

5.2.1. Uganda’s efforts to help those who wish to quit, to promote cessation of tobacco use and to provide tobacco-dependence treatment are limited:

- National guidelines for the treatment of tobacco dependence exist, but health professionals and others who might be interested in providing cessation advice have limited awareness of them. The MOH adopted the WHO ASSIST\(^5\) tool for the treatment of tobacco dependence and made it available to interested professionals. However, the ASSIST manual has not been widely disseminated in the health system.

- Cessation services are scarce. A few government primary health facilities and hospitals – in particular, those dealing with mental health and other addictions (alcohol, drugs etc.) – provide tobacco-cessation support by multidisciplinary trained and self-motivated teams, including behavioural counselling. However, the scarcity of countrywide cessation services results in limited access by tobacco users. In addition, many smokers avoid seeking support in facilities that have any relation to the treatment of mental illness, because of a perceived stigma attached to them. Furthermore, the primary healthcare professionals have no consistent system for referring smokers who wish to quit to the existing services.

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\(^3\) [http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm](http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm)


\(^5\) Manuals for the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and the ASSIST-linked brief interventions. Available at: [http://www.who.int/substance Abuse/publications/media_assist/en/index.html](http://www.who.int/substance Abuse/publications/media_assist/en/index.html)
• **Provision of brief advice is not yet part of all health services.** Some health professionals are interested and active in providing brief advice to those who wish to quit, especially pregnant women and patients with TB, cardiovascular diseases and cancer. However, training for offering brief advice is not provided in a formal, strategic way. Health professionals are interested and motivated to be further involved in tobacco-cessation programmes.

• **Lack of training capacity.** No consistent training meeting national training standards is provided to health-care workers or to other professional groups. Tobacco-cessation skills are not covered in the basic training of health professionals who are already in service. However, opportunities are available within the Continuing Medical Education (CME) undertaken by Health Professional Councils and the mental health programme.

• **There are no quitlines.** The population does not have access to toll-free telephone lines with appropriate equipment and trained staff providing proactive tobacco-cessation support.

• **The current national list of essential medicines does not include tobacco-dependence treatment.** The single pharmacological treatment available over the counter is nicotine replacement gum, which most tobacco users in Uganda cannot afford. The MOH has initiated revision of the “essential drugs list” in line with the WHO list. The final decision on which drugs to include is pending.

5.3. **RECOMMENDATIONS**

5.3.1. **The MOH should develop and implement a strategy for increasing the provision of treatment for tobacco dependence to the tobacco users in the country.**

The strategy should include the following components:

1. The national guidelines as currently endorsed by the MOH (the WHO ASSIST⁶ package) for the treatment of tobacco dependence should be widely disseminated and made available at the national level to all professionals in health promotion and prevention programmes, as well as to professional organizations and associations (particularly those for psychologists, counsellors, nurses, dentists, etc.).

2. The human and financial resources in other public health programmes should be available to help users quit tobacco. These programmes include maternal and child health, stop TB, health education and promotion, prevention of substance abuse and health of youth and adolescents. Collaboration between health professionals, professional organizations and NGOs should be encouraged.

3. The provision of brief advice should be integrated into all health-care services. Brief advice should be implemented as a standard practice, and its provision should be monitored regularly. Primary health-care services should particularly integrate the provision of brief advice, as should other health-care services for pregnant women and for cardiovascular, cancer and/or TB patients, etc., in line with the National Health Policy II 2010/19 and the Health Sector Strategic & Investment Plan 2010–2011.

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⁶ Manuals for the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and the ASSIST-Linked Brief Interventions. Available at: http://www.who.int/substance_abuse/publications/media_assist/en/index.html
4. The **MOH should develop training capacity for tobacco cessation**. All health-care workers should be trained to record tobacco use, offer brief advice, encourage quit attempts and eventually, when more specialized tobacco-dependence treatment services have been established, refer tobacco users to those services. Individuals outside of health-care settings can also be trained to give brief advice and to encourage quit attempts. The local governments' health structures – in particular, “village health teams” – should be considered for regular training on offering advice to tobacco users and encouraging them to quit. Tobacco cessation should be incorporated into the training curricula of all health professionals and other relevant occupations at both pre- and post-qualification levels and in CME.

5. **Establish quitlines.** The MOH should explore with relevant partners the provision of advice and proactive support from trained staff through toll-free telephone quitlines. The quitlines could be widely publicized and advertised to ensure that tobacco users could receive individual support. Eventually, the quitline number should be included on tobacco-product packaging to inform all tobacco users about the service.

6. **Include generic cessation drugs in the upcoming revised national list of essential drugs.** The list should include low-cost, over-the-counter pharmacological treatments, such as nicotine replacement therapy in the form of gums, patches, lozenges, and nasal sprays.
6. Warn people about the dangers of tobacco

(Articles 11 and 12 of WHO FCTC)

6.1. PACKAGING AND LABELLING

6.1.1. POLICY STATUS AND DEVELOPMENT

In 1989, after negotiations with BATU, the MOH introduced the health warning “Cigarette smoking can be harmful to your health”. BATU resisted the suggestion that stronger warnings should be issued on the grounds that it did not believe cigarette smoking was harmful to health. The warning was therefore attributed as a “Ministry of Health warning”.

The UBOS is one of the key tobacco control stakeholders in the country. It has the mandate to set standards for labelling and packaging as well as content disclosure of tobacco products. The UBOS, in consultation with the MOH, revised the health warning on cigarette packages to read “Smoking causes heart disease, lung cancer and death”. The revised warning was put into effect in September 2010. It covers 30% of the principal display area of the front and back of cigarette packets and must be in bold print. It appears in black letters on a white background, in both English and Swahili. Manufacturing or importing tobacco products that do not comply with these standards is prohibited in Uganda.

Monitoring the labelling and packaging of tobacco products is done by the UBOS Food and Drug Department. As part of its work in framing and implementing standards for tobacco products, the UBOS has contacts with the tobacco industry. Because of this arrangement, it can be subject to negative influences.

There is no intersectoral coordination with stakeholders other than the MOH in development, implementation, enforcement and monitoring of labelling and packaging of tobacco products.

6.1.2. KEY FINDINGS

6.1.2.1. The health warnings are required on cigarette packages in Uganda, but not on packages of other tobacco products.

At present, the health warnings are required to be displayed only on cigarette packages. There is no provision for health warnings on other tobacco products that are available in the market.

6.1.2.2. There is no separate mechanism for implementation and enforcement of labelling cigarettes with health warnings.

There is no structured mechanism for implementation and enforcement of labelling requirements or for reporting violations of the requirements. Most of the tobacco companies have complied with prescribed labelling standards on their own, i.e. self-compliance by the industry. This self-compliance consists of reporting those who do not comply with the packaging and labelling standards to the enforcement authorities. However, there are no punitive actions for noncompliance. Also, the sale of single or loose cigarette sticks, which have no packaging, is rampant. Most of the cigarettes sold in retail are imported from Kenya.
6.1.2.3. There are no pictorial health warnings on tobacco products in Uganda. The existing warnings are textual, and there is no provision for rotating them at regular intervals. The MOH has discussed introduction of pictorial health warnings with the UBOS, but these efforts have been resisted by the tobacco industry. The MOH, however, is developing new pictorial warnings that could be shared with the UBOS.

6.1.2.4. The UBOS has to interact with the tobacco industry for its mandated work, making it vulnerable to negative influence. The UBOS mandate to set standards for testing of tobacco products and monitor their implementation requires it to interact with the tobacco industry on regular basis, which is likely to influence the implementation of health warnings.

6.1.2.5. Partial fulfilment of the Article 11 Guidelines of the WHO FCTC. Uganda has only partially fulfilled its obligations under Article 11, and the deadline for doing so is already past. The MOH should bring this to the attention of the government and the concerned ministries and departments, so that steps can be initiated towards implementation of the Guidelines.

6.1.3. RECOMMENDATIONS

6.1.3.1. Uniform standards should be developed for labelling and packaging of all tobacco products. The GYTS 2007 revealed that 5.5% of schoolchildren 13 to 15 years of age smoke cigarettes, and almost 14% of them use other tobacco products. The widespread use of smokeless tobacco and chewing tobacco is also reported. Health warnings on all tobacco product packages being sold in retail should be applied in a uniform manner. The MOH must provide a catalogue of pretested health warnings to the agency responsible for setting and enforcing standards for packaging and labelling of tobacco products.

6.1.3.2. An effective implementation and monitoring mechanism should be put in place for the packaging and labelling of all tobacco products. The UBOS should create an implementation and monitoring mechanism to ensure effective implementation of the requirements of the provisions for packaging and labelling of tobacco products. This could be done in coordination with stakeholder departments, e.g. Health, Drug & Food and Environment. Because there is a lack of separate funds and manpower for this purpose, the infrastructure of these departments could be shared under a new policy.

Sale of single or loose cigarette sticks should be prohibited.

A mechanism should be established for pretesting of health warnings and periodic evaluation/impact assessment of them.

The Department of Customs and URA should be involved in enforcement of packaging and labelling requirements for tobacco products at the point of entry into Uganda.

Strong punitive measures should be imposed for noncompliance with the provisions.
6.1.3.3. Strong, rotating pictorial warnings should be introduced for all tobacco products.
The literacy rate among men in Uganda is 51%, and among women it is 49%. Therefore, pictorial warnings
are needed along with text warning on all the packages of all tobacco products, not just cigarettes.

6.1.3.4. Enforcement agencies must avoid associating with the tobacco industry.
The tobacco industry influences decisions and initiatives for tobacco control because of its vested interest,
so the enforcement agencies must dissociate with the industry as prescribed in the recommendations
of Article 5.3 of the WHO FCTC.

6.1.3.5. Steps must be taken to fulfil all requirements under the Article 11 Guidelines of the
WHO FCTC.
The MOH must coordinate with other government agencies (including the UBOS and URA) responsible
for implementing and monitoring standards of packaging and labelling of tobacco products in order to
fully implement Article 11 of the WHO FCTC.

6.2. PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS

6.2.1. POLICY STATUS AND DEVELOPMENT

There is no policy or strategy for a sustained media campaign, education or training on tobacco control.

Cigarette smoking is banned in schools. The Ministry of Education and Sports (MOES), which is the
implementing authority, has mechanism for reporting students who smoke in school. The MOES is
willing to partner with the MOH for educational activities on tobacco control, as part of its school health
programme.

Civil society organizations have played a leadership role in bringing awareness of the dangers of tobacco
use into the national limelight through advocacy campaigns and activism on tobacco control during
World No Tobacco Day celebrations. However, the campaigns are not sustained because of the lack of
clear strategies and regular funding.

The media, both print and broadcast, have been at the forefront of disseminating and promoting infor-
mation about the WHO FCTC. The media constitute a powerful tool that enjoys public trust and has the
capacity to influence the government to implement tobacco control policies.

Media participation in tobacco control was boosted with the establishment of a “network of journalists”
in 2010, and a number of talk shows focused on tobacco control are aired. Through reports and articles,
the media have challenged the tobacco industry about its false claims of corporate social responsibility.

Private institutions, e.g. medical institutions, across Uganda are also key stakeholders in educational
activities and dissemination of anti-tobacco messages, specifically on World No Tobacco Day. Some
training of health workers on the basic dangers of tobacco consumption is also being provided by these
institutions.
6.2.2. KEY FINDINGS

6.2.2.1. Uganda has no policy for sustained activities or media campaigns to increase awareness of tobacco control policies or the harmful effects of tobacco and SHS.
A public awareness and education campaign is being led by the MOH, in collaboration with WHO. However, there is no separate division with dedicated staff and funds for IEC activities for tobacco control. The campaign is being undertaken as part of a mental health, substance abuse and health awareness promotion.

The Health Promotion division has developed a handbook that contains information on tobacco control, and some IEC materials have been developed.

Posters on tobacco control have been developed, using the themes of World No Tobacco Day.

6.2.2.2. Current education and awareness activities relate to cigarette use only.
In addition to cigarettes, tobacco products such as sheesha, smokeless tobacco and chewing tobacco are being used in Uganda. There is also evidence of smuggled smokeless tobacco products being sold in retail outlets and of their growing use disguised as “sweets/confectionaries”.

The Education Department and the media do not appear to be aware of the prevalence of use of smokeless tobacco and chewing tobacco and of their harmful effects.

6.2.2.3. The health and education systems have little capacity for training regarding tobacco control policies and the harmful effects of tobacco and SHS.
Uganda’s health professionals (medical and paramedical) and teachers are not well trained on issues related to the harmful effects of tobacco and SHS, especially the challenge posed by the growing use of smokeless tobacco and chewing tobacco.

There is also little awareness of well-tested and established tobacco control policies.

6.2.3. RECOMMENDATIONS

6.2.3.1. A national policy/strategy for a media campaign on tobacco control, including the use of mass media, Inter-Party Cooperation and behaviour change communication strategies, should be developed.

- The MOH should develop partnerships with relevant stakeholders to formulate a sustained education and media campaign on tobacco control.
- Until regular funds are available for promoting awareness of tobacco control and media campaigns, the MOH must attempt integration with ongoing campaigns relating to mental health, substance abuse, health promotion, NCDs, school health, TB and maternal and child health programmes.
- The MOH and the MOING should together explore the possibility of developing cost-effective media strategies for tobacco control using public service announcements and mobile technology. The availability of free air time for broadcasting tobacco control messages as corporate social responsibility of the media should also be investigated.
- Local governments should **decentralize planning and mobilize resources for awareness campaigns** for tobacco control. Village health teams could be involved in tobacco control education and awareness campaigns at the grass-roots level.
- The MOH should develop **high-quality IEC material** to use in its education and media campaigns.

### 6.2.3.2. The awareness/education and mass-media campaigns on tobacco control must address both smoking and smokeless forms of tobacco products.
- In view of the increasing use of tobacco products other than cigarettes, e.g. sheesha, smokeless tobacco and chewing tobacco, **awareness and media campaigns must address the harmful effects of these products**.
- The available information, statistics and technical details on the contents and harmful effects of tobacco products should be **shared by the MOH with relevant stakeholders**, e.g. the MOES, the MOI, the Media Centre, the Uganda Communication Commission, media and civil society and professional organizations, for use in their education, advocacy and media campaigns. The MOH should also take the lead in establishing intersectoral coordination with these stakeholders for regular communication and exchange of information and should jointly develop strategies for educational and media campaigns. The possibility of corporate social responsibility for media campaigns should also be explored with media houses.

### 6.2.3.3. The MOH should build the capacity of the health and education systems for developing and implementing education and training activities on tobacco control.
- The MOH should **develop training materials on tobacco control for health personnel**.
- The MOH and the MOES should plan to **train opinion leaders**, including teachers and journalists, on the harmful effects of tobacco and SHS and on tobacco control policies.
- The MOH should coordinate the **involvement of existing medical and health institutions** in developing training materials on tobacco control and on impact assessment/evaluation of them.
7. Enforce bans on advertising, promotion and sponsorship

(Article 13 of WHO FCTC)

7.1. POLICY STATUS AND DEVELOPMENT

Comprehensive bans on direct and indirect TAPS protect people – particularly youth – from industry marketing tactics and can substantially reduce tobacco consumption. Comprehensive bans significantly reduce the industry’s ability to market to young people who have not started using tobacco and to adult tobacco users who want to quit. They reduce tobacco consumption by about 7%, independent of other interventions.

Article 13 of the WHO FCTC requires Parties to undertake, within five years after entry into force of the treaty, a comprehensive ban of all TAPS, including cross-border advertising, promotion and sponsorship originating from their territory, as well as at the point of sale.

The COP adopted guidelines to assist Parties in meeting their obligations under Article 13 and to propose measures that Parties can use to increase the effectiveness of their efforts to eliminate TAPS effectively at both domestic and international levels.

Currently, Uganda does not have a specific policy banning TAPS.

7.2. KEY FINDINGS

7.2.1. Although Uganda is a Party to the WHO FCTC, it has not fulfilled its obligation to enact a comprehensive law banning tobacco, advertising, promotion and sponsorship, as required by Article 13.

Uganda has been a Party to the WHO FCTC since June 2007 and therefore should comply with requirements of Article 13 and its Guidelines by June 2012. The tobacco industry has aggressively advertised and promoted its products in past years and has sponsored various activities, especially musical galas and sports in schools. Following a statement by the health minister in favour of a complete ban on TAPS, the direct advertising on billboards and other means has decreased significantly. However, advertising and promotion are still strongly present at the point of sale. Indirect advertising, promotion and sponsorship and corporate social responsibility activities are still reported to be practices of the tobacco industry. The assessment team found a wide perception among the key interviewees that Uganda already had in place a complete ban on TAPS. At the same time, it was not clear to some participants whether accepting or declining offers or sponsorship by the tobacco industry constituted a clear conflict of interest, casting doubt on their willingness to fully comply with even this perceived ban. The absence of a law resulted also in the lack of a legal framework for monitoring tobacco-industry strategies to advertise and promote tobacco products, for understanding the real size of the phenomenon in the country and for activating mechanisms to eliminate all TAPS.

7.3. RECOMMENDATIONS

7.3.1. Uganda’s government should undertake the appropriate legislative, executive, administrative and/or other measures to enact a comprehensive ban of all TAPS.

Options for implementation of this recommendation include the following:

• The MOH, in collaboration with relevant government agencies, should ensure that any future draft of a comprehensive law regarding tobacco control includes a comprehensive ban on all TAPS, with appropriate enforcement, monitoring and evaluation mechanisms. The scope of the law should be broad and in line with the WHO FCTC Article 13 Guidelines, involving an integrated approach to banning advertising and promoting the purchase and sale of goods, including direct marketing, public relations, sales promotion, personal selling and online interactive marketing. If only certain forms of direct tobacco advertising are prohibited, the tobacco industry inevitably will shift its expenditure to other strategies, using creative, indirect ways to promote tobacco products and tobacco use, especially among young people. Therefore, the legislation should avoid providing lists of prohibited activities that are, or could be understood to be, exhaustive. Effective monitoring, enforcement and sanctions supported and facilitated by strong public education and community awareness programmes are essential for implementation of a comprehensive ban on TAPS. The enforcement mechanisms should include local governments and should focus on supporting the development of their capacity to enforce and monitor the ban and communicate with their communities.

• The law should include a comprehensive ban on cross-border advertising, promotion and sponsorship originating from its territory, subject to the legal environment and technical means available to Uganda. The MOH should explore and identify relevant partners for cooperation in the development of technologies and other means necessary to facilitate the elimination of cross-border advertising. This activity should address all persons or entities involved in the production, placement and/or dissemination of TAPS. The MOH should also take the lead in exploring with the relevant government agencies the formulation and implementation of appropriate measures to facilitate international collaboration in a comprehensive ban on cross-border TAPS.

• In setting and implementing the policy banning TAPS, the MOH should act to protect this policy from commercial and other vested interests of the tobacco industry, in accordance with WHO FCTC Article 5.3 and its Guidelines\(^8\).

• The MOH should collaborate with other central and local government agencies and NGOs, including public and private media, to expand efforts towards public education and community awareness of TAPS in all sectors of society, using all available communication tools. The public education and awareness programmes should underline the importance of a comprehensive ban, educate the public concerning its necessity and explain why TAPS by the tobacco industry is unacceptable.

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\(^8\) Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control on the Protection of Public Health Policies with Respect to Tobacco Control from Commercial and other Vested Interests of the Tobacco Industry. Available at: http://www.who.int/fctc/guidelines/article_5_3.pdf
8. Raise tobacco taxes and prices

(Article 6 of WHO FCTC)

8.1. POLICY STATUS AND DEVELOPMENT

The MOFPED is responsible for levying all direct and indirect taxes in Uganda. There is no specific tobacco control tax policy, and taxes on tobacco products are levied as a public finance measure, not as a public health strategy. Increases in taxes of tobacco products have therefore not been used as a public health intervention that could help reduce the demand for tobacco products in the country.

The tobacco tax administration is in accordance with the provisions of the Budget Act/Excise Act. It is also compliant with the EAC Customs Management Act 2004 (revised, 2009) and the EAC Model Double taxation avoidance agreement (for harmonization of domestic and common laws).

Prior to 2008, the taxes on tobacco products were levied on ad valorem basis. Since 2008, the levy has been based on three bands/tiers of excise tax. Presently, it is as follows:

- 20 000 shillings/per 1000 units for “soft cup” brands
- 22 000 shillings/per 1000 units for “hinge lid” brands
- 50 000 shillings/per 1000 units for “other cigarette brands”

In the past three years, the government has raised the rates on three occasions to adjust for inflation. The budget proposal for 2011 proposes an additional 10% levy.

The majority of the cigarettes consumed in Uganda are imported from other countries, and the imported cigarettes are subject to excise taxes, value-added tax (VAT) and 25% customs duty.

The Tax Policy Department in the MOFPED initiates the annual budget process in November (the second quarter of the fiscal year) and finalizes the budget by June (the fourth quarter). It is a consultative process, as mandated by the Budget Act. Other government sectors are engaged through their respective sector budget working groups, and the private sector, including industry associations, is engaged through national budget conferences and joint review missions.

There is presently no policy for earmarking/“ring fence” taxes levied on tobacco products to support health programmes, including tobacco control activities.

8.2. KEY FINDINGS

8.2.1. The levying of taxes on tobacco products is a public finance measure, not a public health strategy.

- The taxes on tobacco products are levied as a public finance measure, not as a strategy to reduce the demand for tobacco products, although in the past the MOFPED has used the health argument to raise taxes on tobacco products.
- There is no formal consultative process with the MOH on tobacco taxation.
8.2.2. The excise taxes and VAT on tobacco products in Uganda are presently higher than those in other EAC countries.
The tobacco taxes in Uganda are benchmarked on the EAC strategies and agreements, and efforts to substantially increase taxes on tobacco products in Uganda may not succeed without the engagement of the EAC secretariat and other EAC countries.

8.2.3. Authorities are willing to further develop appropriate tobacco tax systems and policies, subject to national priorities.
The MOFPED indicated interest in and support to further develop and implement appropriate tobacco tax policies that take into consideration the interests of all the key stakeholders and both economic and health issues. However, it lacks adequate capacity to monitor/evaluate/research the impact of tobacco taxation policy and has expressed interest in increasing this capacity.

8.3. RECOMMENDATIONS

8.3.1. Increasing tobacco taxes could be used by the government as an effective demand-reduction measure.
There is global evidence that increasing taxes on tobacco products is one of the most cost effective demand-reduction measures, especially among the youth and the poor.

The taxes on tobacco products should be progressively increased from the existing approximately 44% of the retail price to around 70% of the retail price.

The three-tier tax system should be replaced by a single-tier system, both for administrative convenience and to ensure that consumer preference is not dictated by price.

With additional tobacco taxes collected, the MOFPED should allocate more resources to public health programmes, including tobacco control programmes. Increases in the price of tobacco products, if any, due to increased taxes are not paid by the tobacco industry; they are passed along to the tobacco users/consumers.

8.3.2. The government should build consensus among EAC countries on the positive health impact and economic benefits of raising of taxes on tobacco products.
EAC Member States have agreed to harmonize their common and domestic laws. The government of Uganda could take the lead in engagement with the other EAC countries because it already levies the highest tax on tobacco products in the region.

The MOFPED will need to engage with its counterpart ministries in other EAC countries to agree on a joint effort and process of engagement with the EAC secretariat.
8.3.3. The MOFPED needs to effectively engage with the MOH and other key stakeholders.
The MOFPED needs to engage with the MOH and other relevant ministries to develop a joint understanding of the impact on health and the overall economy of changes in tobacco tax systems.

The MOFPED needs to develop partnerships with relevant entities to build empirical evidence/data, e.g. price/tax data and related impact studies. Likewise, the MOH needs to support health and economic cost studies that quantify the serious and adverse impact of tobacco consumption on society.

8.3.4. The tax policy should take into consideration all forms of tobacco, not only cigarettes.
The introduction of forms of tobacco other than cigarettes (e.g. sheesha, hookahs), smokeless tobacco (Guthka, Pan Masala), chewing tobacco etc. in the community has gone largely unnoticed. The MOH needs to share information and trends about newer forms of tobacco with the MOFPED to assist in developing appropriate tax policies for these products.
9. Elimination of illicit trade in tobacco products

(Article 15 of WHO FCTC)

9.1. POLICY STATUS AND DEVELOPMENT

URA is the nodal agency for collection and enforcement of taxes. It is also the lead agency in anti-smuggling efforts and control of illicit trade. The existing customs, excise and VAT laws have provisions for confiscation of illicit goods and also for taking penal/legal action against smuggling/illicit trade of tobacco products.

Cigarette smuggling is the most rampant form of tobacco smuggling into Uganda. More than 22.3 million sticks were seized by URA last year. Most of the smuggled cigarettes are from Kenya. They come into the country in the guise of transit to Sudan or the Democratic Republic of Congo or through re-export frauds. The smugglers are innovative and are known to use novel approaches and modus operandi.

It is URA policy to destroy all the cigarettes it seizes.

To share economic development and also to address smuggling issues, the EAC Member States have negotiated and agreed to act as a customs union for eliminating non-tariff barriers and sharing information and intelligence. In addition, URA has entered into bilateral arrangements/agreements/memoranda of understanding with a few non-EAC countries.

To combat counterfeiting and evasion of domestic taxes, the government has introduced tobacco tax stamps (2002) that contain security features (e.g. holograms). Although some tax stamp fraud cases have been detected, the stamps have been useful in combating evasion of domestic taxes.

9.2. KEY FINDINGS

9.2.1. URA is the lead agency responsible for combating smuggling/illicit trade of tobacco products.

The existing customs, excise and VAT laws are adequate to combat and eliminate illicit trade in tobacco products. Police and other enforcement agencies collaborate with URA in enforcement efforts. URA has the technical and human resources to enforce the laws against smuggling and illicit trade in tobacco products. However, some tobacco companies have attempted to influence URA and other enforcement agencies.

9.2.2. Cigarette smuggling is the most rampant form of cross-border tobacco smuggling.

Because most of the tobacco smuggling is from Kenya, URA has attempted to engage with Kenyan authorities. URA has also engaged with the local community in Western Uganda (Albertine region) to build advocacy and awareness to prevent its involvement in smuggling.

URA currently relies on BATU for information regarding smuggling and counterfeit cigarettes.
9.2.3. **URA has not participated in the ongoing negotiation of the Protocol on Illicit Trade in Tobacco Products.**

Under the auspices of the WHO FCTC, an intergovernmental panel has been set up to negotiate the Protocol on Illicit Trade in Tobacco Products. On behalf of the government of Uganda, the MOH has handled the negotiation without the participation of URA.

9.3. **RECOMMENDATIONS**

9.3.1. **URA and other enforcement agencies need to develop a strategy to effectively eliminate all forms of smuggling and illicit trade in tobacco products.**

As cigarette smuggling continues to be rampant, it is essential that URA take stringent enforcement measures to secure the supply chain of tobacco products (e.g. tracking and tracing, record keeping, customer identification).

Measures are also needed to develop the capacity of URA and other enforcement officials to tackle smuggling, including sharing of “global” best practices.

Article 5.3 of the WHO FCTC requires the government to take all necessary measures to protect enforcement agencies from being influenced by the tobacco industry.

There is need for further research on smuggling trends for new products such as sheesha tobacco, smokeless tobacco and chewing tobacco.

9.3.2. **URA needs to further engage with other EAC Member States and non-EAC countries to develop a regional strategy to combat smuggling and illicit trade.**

EAC Member States need to develop a cigarette-specific strategy to further the sharing of information, intelligence, trends etc. There is also a need to build partnerships with relevant intergovernmental and international agencies such as the World Customs Organization and the European Anti-Fraud Office.

9.3.3. **URA needs to participate, along with the MOH, in the negotiation of the Protocol on Illicit Trade in Tobacco Products under the WHO FCTC.**

The draft Protocol provides “global best practices” to eliminate illicit trade in tobacco products (e.g. measures such as tracking and tracing to secure the supply chain). URA needs to be fully engaged in the remaining process of negotiation (the final session of the Intergovernmental Negotiating Body [INB] is scheduled for March 2012).
10. Provision of support for economically viable alternative activities

(Associates 17&18 of WHO FCTC)

10.1. POLICY STATUS AND DEVELOPMENT

The MAAIF is responsible for development and implementation of agriculture policies. Agencies such as the National Agricultural Advisory Services (NAADS) also have a mandate to increase farmers’ access to information, knowledge and technology for profitable agricultural production.

Tobacco is one of the major cash crops in Uganda, so the livelihood of tobacco-growing farmers is an important issue for the government. The GYTS has found that tobacco consumption is highest in tobacco-growing districts.

The MAAIF has no formal engagement in the implementation of the WHO FCTC, including the provision on alternative livelihoods and cropping issues. However, there is a legal framework (although it is not used by executive instructions) to regulate the growing and marketing of tobacco leaf.

The MAAIF no longer supports activities, extension programmes or any market or support price mechanism for tobacco crops. As a result, it is no longer able to generate information on acreage, production or marketing of tobacco. Services and marketing for tobacco farmers are presently being supplied by the major tobacco companies, such as BATU.

10.2. KEY FINDINGS

10.2.1. The government does not provide any technical or financial support to the tobacco growers, and there is no policy to implement the obligation under the WHO FCTC to promote alternative livelihoods and alternative crops.

Although the government does not provide any direct technical or financial support through MAAIF, its overall policy does not discourage tobacco-growing. However, livelihood support for tobacco growers has been identified as an important issue that needs to be addressed while implementing the WHO FCTC.

The MAAIF presently has no formal engagement with the MOH (the national focal point for implementing the WHO FCTC).

10.2.2. The tobacco-growing farmers are being supported by BATU and other tobacco companies which do not provide access to information about the harms associated with tobacco-growing.

BATU and other tobacco companies in the region have identified Uganda as an important tobacco-growing country. In the absence of MAAIF engagement, the tobacco farmers do not have access to information regarding “green tobacco sickness” and other health problems associated with tobacco-growing. The government and other relevant stakeholders have inadequate baseline information about the number of tobacco farmers, areas under cultivation, production and marketing etc.
10.3. KEY RECOMMENDATIONS

10.3.1. The MAAIF should develop and support a strategy to advance alternative livelihoods and crops as part of the development strategy and investment plan (DSIP) and should also engage with national and international organizations that have relevant expertise.

Review of the DSIP will require the active support of and engagement with top policy-makers in the government and a consensus among major stakeholders. The existing legal framework to regulate growing and marketing of tobacco (although it is not used by some executive instructions) needs to be revised to align it with the WHO FCTC. The MAAIF and the local government extension services and NAADS, which is an agency of MAAIF with a mandate to increase farmers’ access to information, knowledge and technology for profitable agricultural production, could be an entry point for alternative cropping/livelihood programmes.

NARO, universities and NGOs working in agriculture should also be brought on board.

There is a need for cooperation with similarly placed tobacco-growing economies and also engagement with relevant intergovernmental and international organizations such as the UN Food and Agriculture Organization, the International Fund for Agricultural Development, the World Farmers’ Organization and the International Development Research Centre.

The MAAIF should research and build the health and economic arguments against tobacco-growing and explore public/private partnership models of the development of sustainable and viable alternative livelihoods/cropping systems.
Annex 1. List of assessment team members

Assessment team:

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9 in alphabetical order
Annex 2. List of all recommendations, chapter by chapter

COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS

1. The MOH and other sectors and agencies should allocate adequate human resources for work on tobacco control at the central level.
2. The MOH Planning Department should ensure that planning guidelines for district work plans include tobacco control activities and provide human and financial resources.
3. The MOH should coordinate tobacco control activities.
4. A national tobacco control plan should be developed and agreed upon by stakeholders.
5. Both the government and the donor community should allocate adequate and regular funds for tobacco control activities in Uganda.
6. The government should create an official intersectoral, sector-wide coordination mechanism for tobacco control.
7. The relevant government agencies should enforce existing tobacco control regulations while the MOH drafts a comprehensive tobacco control law.
8. The government should establish a clear policy preventing undue interference from the tobacco industry.
9. All government sectors and relevant agencies should routinely collect essential information to support tobacco control.
10. Research Institutions should include tobacco control in their priorities.

MONITORING AND EVALUATION

1. The MOH should lead a coordinated tobacco control research and surveillance programme.
2. The MOH should develop a coordinated tobacco control information exchange mechanism.

PROTECT PEOPLE FROM TOBACCO SMOKE - SMOKE-FREE ENVIRONMENTS

3. The smoke-free regulations of 2004 should be enforced diligently and expeditiously.
4. Local governments should develop bylaws to effectively enforce the smoke-free regulations of 2004.
5. Revise the existing smoke-free regulations to make the hospitality sector completely smoke-free.

OFFER HELP TO QUIT TOBACCO USE

1. The MOH should develop and implement a strategy for increasing the provision of treatment for tobacco dependence to the tobacco users in the country.
**WARN PEOPLE ABOUT THE DANGERS OF TOBACCO**

1. **Packaging and labelling**
   1. Uniform standards should be developed for labelling and packaging of all tobacco products.
   2. An effective implementation and monitoring mechanism should be put in place for the packaging and labelling of all tobacco products.
   3. Strong, rotating pictorial warnings should be introduced for all tobacco products.
   4. Enforcement agencies must avoid associating with the tobacco industry.
   5. Steps must be taken to fulfil all requirements under the Article 11 Guidelines of the WHO FCTC.

2. **Public awareness and mass-media campaigns**
   1. A national policy/strategy for a media campaign on tobacco control, including the use of mass media, Inter-Party Cooperation and behaviour change communication strategies, should be developed.
   2. The awareness/education and mass-media campaigns on tobacco control must address both smoking and smokeless forms of tobacco products.
   3. The MOH should build the capacity of the health and education systems for developing and implementing education and training activities on tobacco control.

**ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORSHIP**

1. Uganda’s Government should undertake the appropriate legislative, executive, administrative and/or other measures to enact a comprehensive ban of all TAPS.

**RAISE TOBACCO TAXES AND PRICES**

1. Increasing tobacco taxes could be used by the government as an effective demand-reduction measure.
2. The government should build consensus among EAC countries on the positive health impact and economic benefits of raising taxes on tobacco products.
3. The MOFPED needs to effectively engage with the MOH and other key stakeholders.
4. The tax policy should take into consideration all forms of tobacco, not only cigarettes.

**ELIMINATION OF ILLICIT TRADE IN TOBACCO PRODUCTS**

1. URA and other enforcement agencies need to develop a strategy to effectively eliminate all forms of smuggling and illicit trade in tobacco products.
2. URA needs to further engage with other EAC Member States and non-EAC countries to develop a regional strategy to combat smuggling and illicit trade.
3. URA needs to participate, along with the MOH, in the negotiation of the Protocol on Illicit Trade in Tobacco Products under the WHO FCTC.
ECONOMICALLY VIABLE ALTERNATIVE LIVELIHOODS

1. The MAAIF should develop and support a strategy to advance alternative livelihoods and crops as part of the development strategy and investment plan (DSIP) and should also engage with national and international organizations that have relevant expertise.