



GATS | UGANDA

GLOBAL ADULT TOBACCO SURVEY: EXECUTIVE SUMMARY 2023



EXECUTIVE SUMMARY

1.0 Introduction

Uganda ratified the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) ([Tobacco: WHO Framework Convention on Tobacco Control](#)) in 2007. Following this, Uganda enacted the Tobacco Control Act in 2015 and the Tobacco Control Regulations in 2019. The Act prohibits smoking in public places and bans tobacco advertising, promotion, and sponsorship (TAPS). It also restricts and prohibits the production, importation, and sale of certain tobacco products, including shisha, e-cigarettes, heated tobacco products, smokeless tobacco, and flavoured tobacco. Additionally, the law mandates that graphic health warnings cover 65% of the principal display areas on cigarette packages. Other preventive measures include a ban on sales to minors and restrictions on tobacco advertising.

The Global Adult Tobacco Survey (GATS) ([Noncommunicable Disease Surveillance, Monitoring and Reporting](#)) is the global standard for monitoring adult tobacco use (smoked, smokeless tobacco, and heated tobacco products) and tracking tobacco control indicators. It helps countries, including Uganda, strengthen their capacity to design, implement, and evaluate tobacco control programs. GATS collects data on smoking, smokeless tobacco use, cessation, secondhand smoke exposure, and factors like media and public perceptions. The data supports Uganda in fulfilling its obligations under the WHO FCTC and provides comparable data across countries using the WHO MPOWER policy package to guide tobacco control strategies.

In Uganda, GATS was first conducted in 2013 and repeated in 2023. Both waves of the survey were implemented as nationally representative household surveys of adults aged 15 years and older, using multistage stratified cluster sample designs. GATS is designed to gather data on tobacco use and key tobacco control measures among non-institutionalized men and women aged 15 years or older. The survey follows a standard protocol and methodology, facilitating cross-country comparisons and disaggregation of data by gender and place of residence (urban/rural).

The data from GATS can assist Uganda to enhance its capacity to design, implement, and evaluate tobacco control programs and to fulfill its obligations under the WHO FCTC. The two rounds of GATS Uganda provide comparable data within and across countries using the WHO MPOWER policy package which summarizes tobacco control approaches contained in the WHO FCTC as follows:

- Monitor tobacco use and prevention policies**
- Protect people from tobacco smoke**
- Offer help to quit tobacco use**
- Warn about the dangers of tobacco**
- Enforce bans on tobacco advertising, promotion, & sponsorship**
- Raise taxes on tobacco**

2.0 Methodology

GATS Uganda used a standardized methodology to systematically monitor adult tobacco use and track key tobacco control measures. It includes information on respondents' background characteristics, use of various tobacco products (including manufactured cigarettes, roll-your-own cigarettes, cigars, smokeless tobacco products, and heated tobacco products), water pipe, electronic cigarette use, tobacco cessation, secondhand smoke exposure, media, economics, knowledge, attitudes, and perceptions towards tobacco use.

GATS Uganda 2023 adopted a similar survey design to the GATS Uganda 2013 for the purpose of comparing results and tracking performance. A multi-stage stratified cluster sampling design was used to produce nationally representative data using the 2014 population census. Sampling was conducted across all 146 districts and 11 cities in the country. A total of 10,582 households were sampled, and one individual was randomly chosen from each selected household to participate in the survey. A total of 10,177 interviews were completed, yielding an overall response rate of 97.6%. Survey information was collected electronically using handheld devices that were specifically programmed for this purpose.

3.0 Key Findings

a) Tobacco Use: In 2023, 6.7% (1.6 million) Ugandan adults aged 15 years or older currently used tobacco products, with 11.3% of men and 2.6% of women using tobacco. Overall, 5.6% (1.4 million) of adults, including 10.0% of men and 1.5% of women, currently smoked tobacco. Additionally, 3.8% (0.9 million) of adults (7.7% of men and 0.4% of women) currently smoked manufactured cigarettes.

Overall, 3.8% of adults (0.9 million) smoked daily (7.0% of men and 0.8% of women), while 1.8% (0.44 million) smoked occasionally (3.0% of men and 0.7% of women). Among adults who smoked cigarettes daily, the average consumption was 7.7 cigarettes per day (8.5 cigarettes per day in urban areas and 7.4 cigarettes per day in rural areas). Additionally, 48.1% of men aged 20-34 years who had ever smoked daily began smoking daily before the age of 20. The average age of initiation was 18.4 years (95% CI: 17.9-18.9) among adults aged 20-34 years who had ever smoked tobacco.

The prevalence of current use of smokeless tobacco products was 1.5% (0.4 million) of adults with 1.9% of men and 1.3% of women.

b) Smoking Cessation: Over 60% (61.0%) of adults who currently smoked tobacco were interested in quitting smoking (including those who planned to quit in the month, next 12 months, or in the future). Among adults who smoked tobacco (including adults who currently smoked tobacco and those who formerly smoked tobacco), 43.9% attempted to quit smoking in the past 12 months. Of those who smoked in the past 12 months and attempted to quit,

more than three out of four (78.5%) adults tried to quit without any assistance, while 15.3% attempted to quit through counselling and advice (data not presented in the table).

Overall, 43.3% of adults who currently or formerly smoked tobacco and visited a health care provider received advice to quit smoking in the past 12 months. Among adults who currently used smokeless tobacco, 51.0% were planning or thinking of quitting. About one in five (22.5%) adults who currently or formerly used smokeless tobacco had been advised by a healthcare provider to quit.

c) Exposure to Secondhand Smoke: Overall, 15.3% (0.6 million) of adults were exposed to secondhand smoke (SHS) in their workplace in the past 30 days. Among those who did not smoke tobacco, 13.8% (0.54 million) were exposed to SHS. An estimated 9.5% (2.3 million) of adults were exposed to SHS at home. Among adults who did not smoke tobacco, 6.6% (1.5 million) were exposed to SHS at home, with 5.3% of men (0.5 million) and 7.8% of women (0.9 million) affected.

Among adults who had visited bars and night clubs in the past 30 days, 62.9% (3.7 million) were exposed to SHS. SHS exposure was also reported in other public places: 6.4% in public transportation, 8.3% in government buildings, 11.8% in restaurants, 3.8% in health-care facilities, 9.0% in universities, and 1.7% in schools.

d) Economics of Tobacco Smoking: The five most purchased brands of manufactured cigarettes were: Supermatch (62.2%), Sportsman (26.1%), Oris (4.5%), Rex (3.1%), and Safari (1.5%). Overall, 53.4% of adults who smoked manufactured cigarettes purchased their cigarettes from kiosks.

The average cost of a pack of 20 manufactured cigarettes was 3,503.4 Ugandan shillings (UGX), with a monthly average expenditure of 22,837.5 Ugandan shillings (UGX). The cost of 2,000 manufactured cigarettes (100 packs) represented 8.1% of per capita Gross Domestic Product (GDP) in 2023.

In general, 82.4% of adults favoured increasing taxes on tobacco products.

e) Media: In the 30 days prior to the survey, 52.9% of adults (52.5% current smokers and 52.9% non-smokers) noticed anti-cigarette smoking information at any locations. Overall, 72.5% of adults who currently smoked manufactured cigarettes noticed health warnings on cigarette packages, and 49.0% thought about quitting because they noticed a warning label. The percentage of adults who noticed any tobacco product (smoked and/or smokeless) advertising, promotion, or event sponsorship in the last 30 days was 10.5% (17.8% of smokers and 10.0% of non-smokers).

f) Knowledge, Attitudes, and Perceptions: Overall, 94.5% of adults believe that smoking causes serious illnesses, with 93.9% of males and 95.0% of females expressing agreement. Additionally, 43.9% of adults recognize that smoking can lead to stroke, heart

attack, and lung cancer. Furthermore, 90.3% of adults agree that exposure to secondhand smoke also causes serious health issues, including 90.9% of males and 89.8% of females.

4. Changes between 2013 and 2023

- Overall, the prevalence of tobacco use decreased, but not significantly, from 7.9% in 2013 to 6.7% in 2023, representing a 14.9% relative percent decline. The prevalence of tobacco use among women significantly declined from 4.6% in 2013 to 2.6% in 2023 (43.6% relative decrease); there was no significant change among men.
- Overall, the prevalence of smokeless tobacco use decreased significantly from 2.4% in 2013 to 1.5% in 2023 (significant decline from 3.0% to 1.3% among women who currently used smokeless tobacco and no significant change among men). This represents an overall 34.4% relative percent decline in smokeless tobacco use, with a 57.9% relative decline for women.
- Overall, exposure to tobacco smoke at home declined significantly from 13.0% in 2013 to 9.5% in 2023, representing a relative change of 27.1%. Similarly, exposure to tobacco smoke in workplaces declined significantly from 20.7% in 2013 to 15.3% in 2023, reflecting a relative change of 26.2%.
- Among adults who visited various public places, exposure to tobacco smoke declined significantly in restaurants (from 16.2% in 2013 to 11.8% in 2023, representing a relative change 27.2%) and schools (from 4.7% in 2013 to 1.7% in 2023, representing a relative change 64.1%). Prevalence of exposure to tobacco smoke remained largely unchanged in bars or night clubs (62.3% in 2013 and 62.9% in 2023) and in government buildings (5.9% in 2013 and 8.3% in 2023).
- Smoking cessation and health seeking behavior among adults who currently smoked and those who made quit attempts in the last 12 months remained stagnant. Among adults who smoked in the past year, 44.2% made a quit attempt in 2013 and 43.9% in 2023. Among adults who smoked in the past year and visited a healthcare provider, 44.3% were advised to quit by a healthcare provider in 2013 compared to 43.3% in 2023.
- The percentage of adults who noticed anti-cigarette smoking information at any location significantly declined from 70.6% in 2013 to 52.9% in 2023, (relative decrease of 36.5%). Among adults who currently smoked tobacco, the percentage declined from 56.4% in 2013 to 45.0% in 2023 (relative decrease of 20.1%), while among adults who did not smoke, it declined from 68.8% in 2013 to 43.2% in 2023 (a relative decline of 37.3%).
- Overall, there was a significant decline in the percentage of adults who noticed any cigarette/tobacco product advertising, sponsorship, or promotion, from 25.4% in 2013 to 10.5% in 2023 (a relative decrease of 58.8%). In-store cigarette/tobacco product advertising or promotion also significantly declined, from 11.0% in 2013 to 4.5% in 2023 (a relative reduction of 59.2%).
- The percentage of adults who currently smoked tobacco and noticed health warnings on

cigarette packages remained relatively unchanged, from 49.1% in 2013 to 58.0% in 2023. Similarly, the percentage who considered quitting because of the warning labels slightly increased from 31.7% in 2013 to 39.3% in 2023.

- There was a significant decrease in the average monthly cigarette expenditure, with an inflation-adjusted mean expenditure declining from UGX 33,024.1 in 2013 to UGX 22,837.5 in 2023, representing a relative change of 28.1%.

5. Conclusions

Uganda has made progress in tobacco control efforts, which have likely contributed to reduced exposure to SHS, a decrease in tobacco advertising, promotion, and sponsorship, and a decline in tobacco use prevalence among females. Additionally, there was an increase in prices of manufactured cigarettes. However, when comparing GATS 2013 and GATS 2023, the percentage of adults who smoked and were advised by a healthcare provider to quit remained about the same, while the proportion of those noticing anti-cigarette smoking messages in the media significantly declined. Furthermore, support for increased taxes on tobacco products also decreased compared to the 2013 GATS survey.

6. Policy Implications and Recommendations

Uganda's progress in tobacco control and prevention can be attributed to the adoption and implementation of effective tobacco control policies, regulations, and interventions. To sustain this progress, it is crucial to strengthen the enforcement of tobacco control measures, raising taxes to increase the retail price of tobacco products, and expanding support for tobacco cessation services. These steps are essential for achieving the global target of reducing tobacco use prevalence by 30% by 2030.

Recommendations include:

- **Monitor and strengthen tobacco control laws:** Continuous monitoring of tobacco and nicotine product use, along with tobacco control policies, is essential for evaluating the effectiveness of current interventions and identifying areas for improvement. Regular tracking of tobacco consumption, SHS, and compliance with tobacco control regulations could inform decision-making and help adjust strategies to better address emerging tobacco-related challenges. Ongoing monitoring and evaluation are crucial for ensuring that tobacco control efforts remain effective and aligned with public health objectives, ultimately contributing to the reduction of tobacco use and its harmful effects.
- **Enforce smoke-free laws:** Strengthening the enforcement of tobacco control laws, including strict compliance with smoke-free regulations in public places, workplaces, and healthcare facilities, could protect the public from the harmful effects of SHS,

reduce tobacco consumption, create healthier environments, and demonstrate the government's commitment to safeguarding public health and upholding tobacco control policies.

- **Expand support for tobacco cessation services:** Increasing access to counselling, nicotine replacement therapies, and other evidence-based cessation programs is essential to helping individuals who want to quit smoking or using tobacco to succeed. Enhancing the capacity of healthcare providers to offer effective tobacco cessation support is crucial for improving quit rates and overall public health outcomes. This could be achieved through comprehensive training programs for healthcare professionals on knowledge and skills to assess tobacco use, provide tailored cessation advice, and recommend appropriate treatment options.
- **Enhance tobacco control media efforts:** Implementing anti-tobacco advertising campaigns to encourage cessation and prevent tobacco use initiation, along with evaluating their effectiveness, could significantly help reduce tobacco use and prevent initiation, particularly among youth. Leveraging social media could help reach a wider audience and disseminate tobacco control messages. By integrating these messages across various media platforms and targeting high-risk populations, particularly young people, the effectiveness of tobacco control efforts could be enhanced.
- **Increase health education:** The development and implementation of public health programs could be essential to educating the public about the dangers of tobacco use, particularly its connection to chronic conditions. These initiatives could promote smoking cessation and prevent the initiation of tobacco use. Additionally, health education programs could help address the risks associated with both new and banned tobacco products, including electronic cigarettes and waterpipes (shisha).

MPOWER Summary Indicators – GATS Uganda, 2013 and 2023.

Indicator	2013			2023			Relative change		
	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
M: Monitor tobacco use and prevention policies									
Current tobacco use	7.9 (6.9, 9.1)	11.7 (10.4, 13.1)	4.6 (3.4, 6.2)	6.7 (6.0, 7.6)	11.3 (10.0, 12.8)	2.6 (2.0, 3.3)	-14.9	-2.9	-43.6*
Current tobacco smoking	5.8 (5.1, 6.6)	10.3 (9.1, 11.7)	1.7 (1.3, 2.4)	5.6 (4.9, 6.3)	10.0 (8.8, 11.4)	1.5 (1.2, 2.0)	-3.7	-2.9	-11.2
Current cigarette smoking	5.3 (4.6, 6.1)	9.7 (8.4, 11.0)	1.4 (1.0, 2.0)	4.9 (4.3, 5.5)	9.2 (8.1, 10.4)	1.0 (0.7, 1.3)	-8.2	-5.3	-30.5
Current manufactured cigarette smoking	3.8 (3.3, 4.5)	7.8 (6.7, 9.0)	0.4 (0.2, 0.6)	3.8 (3.3, 4.4)	7.7 (6.7, 8.8)	0.4 (0.2, 0.6)	-0.3	-1.1	1.8
Average number of cigarettes smoked per day ¹	6.5 (5.7, 7.2)	6.9 (6.1, 7.7)	3.7 (2.8, 4.5)	7.7 (6.6, 8.7)	8.1 (7.0, 9.2)	3.9 (2.7, 5.1)	18.6	17.5	5.0
Average age at daily smoking initiation ²	18.3 (17.6, 18.9)	18.2 (17.5, 18.9)	-	19.9 (19.1, 20.6)	19.8 (19.0, 20.6)	-	8.7*	9.1*	-
Former smokers among ever daily smokers	43.1 (38.4, 47.8)	38.3 (33.0, 43.9)	61.5 (51.7, 70.5)	32.6 (28.7, 36.8)	27.8 (23.5, 32.7)	53.8 (44.6, 62.8)	-24.3*	-27.3*	-12.6
P: Protect people from tobacco smoke									
Exposure to secondhand smoke at home at least monthly	13.0 (11.8, 14.4)	14.3 (12.6, 16.1)	12.0 (10.5, 13.6)	9.5 (8.3, 10.8)	10.5 (9.1, 12.1)	8.6 (7.2, 10.2)	-27.1*	-26.1*	-28.3*
Exposure to secondhand smoke at work ⁶	20.7 (18.0, 23.8)	26.4 (22.1, 31.3)	13.9 (11.1, 17.2)	15.3 (12.9, 18.1)	18.4 (14.9, 22.6)	12.2 (9.3, 15.8)	-26.2*	-30.3*	-12.0
Exposure to secondhand smoke in public places. ^{3,5}									
Government building/offices	5.9 (4.7, 7.4)	6.9 (5.2, 9.2)	4.4 (2.9, 6.6)	8.3 (6.1, 11.4)	9.9 (7.0, 13.8)	6.2 (4.0, 9.3)	40.9	42.8	39.5
Health care facilities	4.6 (3.7, 5.7)	4.9 (3.7, 6.6)	4.3 (3.4, 5.4)	3.8 (3.2, 4.6)	4.1 (3.0, 5.6)	3.6 (2.9, 4.5)	-16.3	-16.9	-15.5
Restaurants	16.2 (14.0, 18.5)	17.5 (14.4, 21.0)	14.0 (11.4, 17.0)	11.8 (10.1, 13.7)	11.2 (9.2, 13.6)	12.7 (10.0, 16.1)	-27.2*	-35.9*	-8.7
Bars or nightclubs	62.3 (59.1, 65.3)	64.2 (60.8, 67.5)	58.5 (53.5, 63.3)	62.9 (59.5, 66.1)	65.1 (61.6, 68.5)	57.5 (51.8, 63.0)	1.0	1.5	-1.7
Public transportation	7.9 (6.9, 9.1)	9.3 (7.6, 11.5)	6.5 (5.4, 7.9)	6.4 (5.3, 7.8)	6.9 (5.3, 8.9)	6.0 (4.6, 7.7)	-18.8	-26.5*	-8.1
Universities	12.7 (9.1, 17.5)	13.5 (8.6, 20.5)	11.6 (6.7, 19.1)	9.0 (5.5, 14.4)	9.4 (4.7, 17.7)	8.6 (4.1, 17.2)	-29.1	-30.6	-25.7
Schools	4.7 (3.8, 5.8)	5.7 (4.4, 7.4)	3.6 (2.7, 4.9)	1.7 (1.2, 2.3)	1.7 (1.1, 2.6)	1.7 (1.0, 2.7)	-64.1*	-70.0*	-54.0*
O: Offer help to quit tobacco use									
Made a quit attempt in the past 12 months ⁴	44.2 (39.1, 49.4)	45.2 (39.7, 50.8)	38.7 (27.5, 51.3)	43.9 (39.2, 48.8)	44.4 (39.0, 49.9)	41.3 (30.4, 53.1)	-0.6	-1.8	6.6
Advised to quit smoking by a health care provider ^{4,5}	44.3 (38.1, 50.8)	43.7 (36.8, 50.8)	47.0 (31.0, 63.6)	43.3 (35.5, 51.5)	46.9 (37.9, 56.2)	29.4 (16.7, 46.4)	-2.4	7.4	-37.4
Attempted to quit smoking using a specific cessation method: ⁴									
Pharmacotherapy	5.4 (2.6, 10.8)	6.0 (2.9, 12.2)	1.6 (0.4, 6.8)	4.5 (2.6, 7.7)	3.6 (1.9, 6.6)	10.9 (3.8, 27.6)	-16.7	-40.8	570.0
Counseling/advice	12.5 (8.2, 18.5)	12.8 (8.4, 19.2)	10.3 (4.1, 23.5)	15.3 (9.6, 23.7)	14.0 (7.9, 23.6)	23.9 (11.9, 42.2)	22.9	9.5	132.2
Interest in quitting smoking ⁶	62.9 (57.3, 68.1)	65.6 (59.7, 71.1)	48.3 (35.1, 61.8)	61.0 (55.1, 66.7)	62.3 (56.1, 68.1)	53.8 (40.0, 67.0)	-2.9	-5.1	11.3

MPOWER Summary Indicators – GATS Uganda, 2013 and 2023.

Indicator	2013			2023			Relative change		
	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
W: Warn about the dangers of tobacco									
Belief that smoking tobacco causes serious illness	94.6 (93.8, 95.3)	95.2 (94.3, 96.0)	94.0 (92.8, 95.0)	94.5 (93.6, 95.2)	93.9 (92.5, 95.0)	95.0 (94.2, 95.8)	-0.1	-1.4	1.1
Belief that smoking causes stroke, heart attack, and lung cancer	54.8 (52.8, 56.8)	56.6 (53.9, 59.2)	53.2 (50.8, 55.6)	43.9 (41.5, 46.2)	43.9 (41.1, 46.7)	43.8 (41.2, 46.5)	-20.0*	-22.4*	-17.6*
Belief that breathing other peoples' smoke causes serious illness	89.4 (88.2, 90.5)	91.0 (89.6, 92.3)	88.0 (86.3, 89.5)	90.3 (89.4, 91.1)	90.9 (89.5, 92.0)	89.8 (88.6, 90.8)	1.0	-0.2	2.0
Noticed anti-cigarette smoking information at any location [§]	70.6 (68.9, 72.2)	73.6 (71.6, 75.5)	67.9 (65.7, 70.0)	52.9 (50.2, 55.5)	56.3 (53.2, 59.2)	49.8 (47.0, 52.6)	-25.1*	-23.5*	-26.6*
Thinking of quitting because of health warnings on cigarette packages ^{7,§}	42.5 (36.2, 49.2)	43.3 (36.7, 50.1)	-	49.0 (42.1, 56.0)	50.3 (43.1, 57.5)	25.1 (11.0, 47.4)	15.2	16.3	-
E: Enforce bans on tobacco advertising, promotion, and sponsorship									
Noticed any cigarette/tobacco product advertisement, sponsorship, or promotion ^{8,§}	25.4 (23.5, 27.4)	30.6 (27.9, 33.4)	20.8 (18.8, 22.9)	10.5 (9.2, 11.9)	13.1 (11.3, 15.0)	8.1 (6.9, 9.6)	-58.8*	-57.3*	-60.8*
R: Raise taxes on tobacco									
Average (mean) cigarette expenditure per month (Ugandan shillings) ^{7,9}	33024.1 (24632.9, 41415.2)	33544.9 (24728.8, 42360.9)	-	22837.5 (18272.5, 27402.4)	23161.6 (18446.9, 27876.4)	-	-30.8*	-31.0*	-
Average (mean) cost of a pack of manufactured cigarettes (Ugandan shillings) ^{7,9}	4255.1 (3339.0, 5171.3)	4271.1 (3323.2, 5219.1)	-	3503.4 (3050.6, 3956.2)	3532.0 (3067.3, 3996.6)	-	-17.7	-17.3	-
Last cigarette purchase was from a store ⁷	70.9 (63.8, 77.0)	71.1 (64.0, 77.3)	-	19.6 (14.0, 26.7)	19.1 (13.4, 26.4)	-	-72.4*	-73.1*	-

¹ Among adults who currently smoked cigarettes daily. ² Among adults 20-34 years of age who smoked tobacco daily. ³ Among those who visited the place in the last 30 days. ⁴ Among adults who currently smoked tobacco in the past year (includes adults who currently smoked and those who quit in the past 12 months). ⁵ Among those who visited a health care provider in past 12 months. ⁶ Among adults who currently smoke tobacco, those who plan to quit within the next month, in the next 12 months, or at some point in the future. ⁷ Among adults who currently smoked manufactured cigarettes. ⁸ In 2013, the questions asked about cigarette marketing while in 2023, the questions asked about marketing of any tobacco products (smoked and/or smokeless). ⁹ GATS Uganda 2013 cost data were adjusted for inflation for direct comparison to 2023 using the Inflation Rate for Average Consumer Prices from the International Monetary Fund's World Economic Outlook Database. [§] In the last 30 days.

- Indicates estimate is suppressed due to unweighted sample size less than 25.

* p<0.05

Results for prevalence estimates / averages and 95% CIs are rounded to the nearest tenth (0.1). The relative changes are calculated using un-rounded prevalence estimates and might be different if calculated using rounded prevalence estimates shown in this table.

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