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Food, Medicine and Health Care Administration and Control Authority of Ethiopia
(FMHACA)

# Ethiopia Tobacco Control Strategic Plan 2010-2012 E.C(2017/18-2019/20)

**Addis Ababa**
**October 31, 2017**

# Contents

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## Acronyms and Abbreviations

| | |
|---|---|
| **CDC** | Centers for Disease Control and Prevention |
| **CBT** | Cognitive Behavioral Therapy |
| **EDHS** | Ethiopian Demographic and Health Survey |
| **EFMHACA** | Ethiopian Food, Medicine and Health Care Administration and Control Authority |
| **EHSP** | Ethiopia Essential Health Services Package |
| **EPHA** | Ethiopian Public Health Association |
| **EPHI** | Ethiopian Public Health Institute |
| **ERCA** | Ethiopian Revenue and Customs Authority |
| **FAG** | Federal Attorney General |
| **FCTC** | Framework Convention on Tobacco Control |
| **FDRE** | Federal Democratic Republic of Ethiopia |
| **FPC** | Federal Police Commission |
| **HIs** | Health Institutions |
| **HSDP** | Health Sector Development Program |
| **MOPS** | Ministry of Public Service |
| **MOCT** | Ministry of Culture and Tourism |
| **MOD** | Ministry of Defense |
| **MOE** | Ministry of Education |
| **MOFEC** | Ministry of Finance and Economic Cooperation |
| **MOH** | Ministry of Health |
| **MOIC** | Ministry of Information and Communication |
| **MOLSA** | Ministry of Labor and Social Affairs |
| **MOTr** | Ministry of Transport |

| | |
|---|---|
| **MOT** | Ministry of Trade |
| **MOWC** | Ministry of Women and Children |
| **NCDs** | Non-Communicable Diseases |
| **NRT** | Nicotine Replacement therapy |
| **PHCU** | Primary Health Care Unit |
| **WHO** | World Health Organization |

## Definition of terms

**"Authority"** means the Ethiopian Food, Medicine and Health Care Administration and Control Authority;

**"Content or Ingredients"** include tobacco, components including materials used to manufacture those components, additives, processing aids, residual substances found in tobacco, and substances that migrate from the packaging material into the product.

**"Earned media"** refers to publicity gained through promotional efforts other than advertising, as opposed to paid **media**, which refers to publicity gained through advertising.

**"Health warning"** means texts or color pictures prescribed by the Authority to be displayed on tobacco packaging and labeling that convey the health consequences of tobacco use and exposure to tobacco smoke.

**"Indoor or enclosed"** means any space covered by a roof or one or more walls or sides, regardless of the type of material used and regardless of whether the structure is permanent or temporary.

**"Label"** means required messages written on or affixed to packaging of tobacco products and includes health warning.

**"Public conveyance"** means any form of transportation that carries members of the public, whether locally or internationally, and includes conveyances for employees' transportation.

**"Public place"** means any place which is open to the public or any part of the public, or to which members of the ordinary public have access, including a workplace.

**"Second-hand tobacco smoke"** means the smoke emitted from the burning end of a cigarette or from other tobacco products usually in combination with the smoke exhaled by the smoker;

**"Tobacco product"** means product entirely or partly made of the tobacco leaf as a raw material which is then manufactured to be used for smoking, sucking, chewing or snuffing"; this includes shisha.

**"Tobacco advertising and promotion"** means any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly.

**"Workplace"** means any place where one or more persons perform work duties; it includes any common area which is used by such persons during the course of their working hours.

## Message from His Excellency Minister of Federal Ministry of Health

Every year tobacco kills nearly 7 million people worldwide out of whom 890,000 are secondhand smokers. Approximately one person dies every six seconds due to tobacco and this accounts for one in 10 adult deaths. Up to half of current users will eventually die of a tobacco-related disease. Of all deaths, 70% are caused by NCDs, for which tobacco use is one of the biggest risk factors.

Tobacco use causes as high as 90% of all lung cancer deaths in men and 80 % of all lung cancer deaths in women. An estimated 90% of all deaths from chronic obstructive lung disease are caused by tobacco use. The epidemic of tobacco-related diseases and deaths has just begun because there is a lag of several years between when people start using tobacco and when their health suffers. Tobacco users who die prematurely deprive their families of income, raise the cost of health care and hinder economic development.

Tobacco use is a function of several determinants such as access/availability and price, environmental tobacco smoke exposure, cessation, media and advertising, and school curriculum. Yet as the determinants of tobacco use are beyond the health sector and influenced by powerful actors, the situation requires sustained level of intervention and engagement of all relevant stakeholders to prevent the spread of tobacco use, promote healthy lifestyle and establish enabling environment for the addicted to quit and rehabilitate from its harmful effects.

**T**he 1993 Ethiopian health policy cited as one of its IEC strategy "discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug use and irresponsible sexual behavior". Even though, tobacco is not treated separately, it has been addressed as part of the drug abuse control components, National Drug Master Plan and National Strategic Plan for the Prevention and Control of NCDs.

To mitigate the tobacco-related problems through the implementation of the of the WHO-FCTC and its protocols, the Government of Ethiopia signed the convention for control of tobacco on 25 February 2004, ratified the convention on 21 January 2014 and entered into force on 17

February 2014. A concerted effort is required in order to combat the tobacco epidemic at national and regional levels. In order to effectively implement the WHO-FCTC, the need for Multi-sectoral Strategic Tobacco Control Plan is imperative. In order to ensure the multi-sectoral involvement and implementation of the WHO-FCTC, key stakeholders with relevant mandates have been identified through sound stakeholder analysis. National Tobacco Control Coordinating Committee comprising of key stakeholders established to oversee the implementation of WHO-FCTC.

This multi-sectoral strategic plan with the vision of "tobacco-free Ethiopia" includes 9 strategic objectives and 24 strategies that would enable the country to comprehensively implement the demand and supply reduction provisions and achieve the objectives of the WHO-FCTC. The global commitment to reduce tobacco prevalence among adults is by 30% by 2025. Accordingly, the Federal Ministry of Health has set a national target of 15% to reduce prevalence of tobacco use in persons aged 15 and above years of age by 2020. The implementation of this strategic plan thus will be a thrust to achieve national targets.

I would like to use this opportunity to reaffirm my Ministry's continued commitment to collaboratively work with key stakeholders and provide the necessary support for the successful implementation of this strategic plan. I call upon also stakeholders and partners to provide their technical and financial support to strengthen tobacco control in Ethiopia.

His Excellency Professor Yifru Birhan
Minister,
Federal Ministry of Health
Federal Democratic Republic of Ethiopia

## Message from the Director General of EFMHACA

The National Tobacco Control Strategic Plan outlines key directions for tobacco control in Ethiopia over the next 3 years in line with the WHO-FCTC and National Legal Framework. It presents a number of evidence-based interventions based on the principles from the provisions of the WHO-FCTC and the Tobacco Control. The objective of this strategic plan is to guide program managers, public health professionals, partners and stakeholders in their efforts to plan and implement tobacco control strategies to attain the objective of the WHO-FCTC which aims at protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

Strengthening the implementation of this FCTC is also clearly indicated in the newly introduced Sustainable Development Goal three (SDG3).

Significant progress has been made in the past years to further strengthen tobacco control implementation in Ethiopia. The country ratified the WHO-FCTC in January 2014. Following this, various legal frameworks on tobacco control measures have been put in place. These include a total ban on all forms of advertisement, promotion and sponsorship of tobacco products, health warnings, a ban on smoking in all public, work and indoor places, and public conveyance, sale of tobacco products to minors and so on. Following the ratification of the WHO-FCTC, there has been growing momentum to intensify tobacco control activities, facilitate the formation of the National Tobacco Control Coordination Committee, development and implementation of Tobacco Control Directive, advocacy seminars and workshops for parliamentarians, journalists, regional health bureaus and regulatory bodies, different ministerial offices, other stakeholders, and public communication and mobilization on tobacco control.

The successful implementation of the legal frameworks will only be realized if this tobacco control strategic plan is implemented through concerted efforts of the government, non-government agencies and other stakeholders.

The strategic plan has been developed with active involvement of National Tobacco Control Coordinating Committee and key stakeholders, enriched and validated through a series of workshops and endorsed by EFMHACA. I hope every concerned party will work effectively and

collaboratively in the implementation of this multi-sectoral tobacco control strategic plan. It gives me a great pleasure to introduce this National Tobacco Control Strategic Plan which would serve as a road map for sustainable tobacco control in Ethiopia for the next seven years.

Finally, I would like to take this opportunity to thank the National Tobacco Control Coordinating Committee, development partners and others who participated in the development and validation of this strategic plan. I would also like to use this opportunity to reiterate that the Authority is committed to closely work with all stakeholders for the realization of this strategic plan and request the key stakeholders for similar commitment.

Yehulu Denekew Alemenehe
Director General,
Ethiopian Food Medicine Healthcare Administration Control Authority

## Executive Summary

Tobacco use is the largest single preventable cause of death, disease and devastating social, economic and environmental effect in the world. Tobacco contains about 50 to 250 harmful constituents which are addictive, carcinogenic, respiratory, cardiovascular, and reproductive toxicants. Tobacco use is estimated to cause about 71% of lung cancer, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease. Currently, it is expected that 1.3 billion people are using tobacco worldwide. Tobacco is also responsible for 7 million premature deaths annually, both from direct tobacco use and second-hand smoking. If the current trend is not curbed, by 2030, this number will increase to 10 million, accounting for 10% of all deaths. Majority of these deaths will occur in low and middle-income countries including Ethiopia. It is evidenced that for every one death due to tobacco, about 20 tobacco users and secondhand smokers suffer from chronic diseases related to tobacco annually.

To mitigate the devastating effects of tobacco, WHO-FCTC has been developed under the auspices of WHO. This convention has also been ratified and implemented by about 180 countries. The objective of the convention and its protocols is to protect the present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure. The WHO-FCTC two major parts are Core demand reduction and Core supply reduction.

Comprehensive, evidence-based population-level data was not available in the country to show the magnitude, trends, and impact of the tobacco epidemic in Ethiopia. The only nationally representative evidence on tobacco use was generated by the EDHS (2005 &2011) and NCD STEPS (2015) survey on non-communicable diseases in Ethiopia.

However, thanks to the support of partners WHO and CDC, Ethiopia conducted the first Global Adult Tobacco Survey (GATS) in 2016 which could generate standardized and comparable data closing the gaps that the tobacco control program was deficient. Result of the survey showed that in 2016, 5.0% (3.4 million) of adults currently use tobacco products [8.1% among men and 1.8% among women; 3.8% in urban areas and 5.3% in rural areas]. Exposure to Secondhand Smoke: Among adults who work indoors or both indoors and outdoors, 29.3% (6.5 million) were exposed to secondhand smoke in their workplace in the past 30 days; among non-smokers, the estimate was 27.1% (5.7 million). Overall, 12.6% (8.4 million) of adults were exposed to secondhand smoke at home. Among non-smokers, 9.9% (6.3 million) were exposed to secondhand smoke at home. There were significant differences across regions that used

tobacco products: Afar 15.5%, Gambella 11.2%, Harrari 7.2%, Benushangul Gumz 6.6%, Somali 6.5%, Oromiya, SNNPR, Dire Dawa each 4.4%, 4.5%, 4.4% have prevalence more than national average. The median amount spent on a pack of 20 manufactured cigarettes among daily smokers was ETB 18.4, and the average cost of 2000 manufactured cigarettes (100 packs) as a percentage of per capita Gross Domestic Product (GDP) [2016] was 11.3%.The EDHS (2011) revealed that about seven percent of men aged 15-49 used tobacco products of some kind; six percent reported that they had been smoking cigarettes. Tobacco was also higher among men in the older age group. Tobacco smoking prevalence was found to be high in men residing in Harari (27%), Somali and Dire Dawa (both 24%), and Afar (20%) compared to other administrative regions and city councils.

In 2013, WHO projected more than 100,000 children and 2,326,000 adults in Ethiopia continue to use tobacco each day. According to the 2015 STEPS survey, 4.2% of adults were smoking tobacco during the survey─3.5% smoke daily. The prevalence of shisha, cigars and piped tobacco was higher among women than men. The STEPS survey indicated 0.8% of adults currently used smokeless tobacco (snuff by mouth, snuff by the nose, chewing tobacco, and others). It was also revealed that 10.3% of adults were exposed to second-hand smoke at home (11.4% of men and 8.9% of women), and 12.6% at the workplace (15.1% of men and 9.7% of women).There is a paucity of information on tobacco-related morbidity and mortality and its grave effects on society and economy in Ethiopia. In 2010, 1.9% of deaths among men and 0.8% of deaths among women were caused by tobacco (Tobacco Atlas). Every year, more than 9,600 Ethiopians die of tobacco-related diseases. (Tobacco Atlas).

To mitigate tobacco-related problems through the implementation of the WHO-FCTC, the Government of Ethiopia signed the WHO-FCTC treaty on February 25, 2004 and ratified the convention on January 21, 2014 through Proclamation No. 822/2014. Also, the existing Ethiopian health policy cites as one of its IEC strategies "discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug use and irresponsible sexual behavior." Even though tobacco is not treated separately, it has been addressed as part of the drug abuse control components, National Drug Master Plan and National Strategic Framework for the Prevention and Control of Chronic NCDs. Moreover, Ethiopia has adopted legal frameworks that include the FMHACA's Proclamation No.661/2009, the Council of Minister's regulation No 299/2013, the Advertisement Proclamation No.759/2012, and Directive No. 28/2015 issued to control tobacco products. These legal frameworks gave the necessary mandate to the Authority and its regional regulatory counterparts to regulate tobacco and coordinate implementation of

the WHO-FCTC. Accordingly, EFMHACA and its regional regulatory counterparts have been doing their level best to implement these legal frameworks.

These developments necessitated the establishment of National Tobacco Control Coordinating Mechanism and the development of a joint multi-sectoral tobacco control strategic plan and monitoring and evaluation of its implementation. Following the entry into force of WHO-FCTC Ratification by Proclamation in 2014, a multi-sectoral National Tobacco Control Coordinating Committee (NTCCC) was established at the federal level. Members included relevant several ministries, civil society organizations and agencies to ensure multi-sectoral implementation of the WHO-FCTC. This multi-sectoral strategic plan is developed with a vision to see "tobacco-free Ethiopians", and with the mission of protecting Ethiopians from the harm caused by tobacco through comprehensive and multi-sectoral collaborative implementation of the provisions of the WHO-FCTC, and goal of reducing the prevalence of tobacco use, its associated diseases, disability and deaths as well as its social and economic consequences in Ethiopia. The strategic plan has set a target of reducing the current tobacco use prevalence by 15% by the end of 2020 and achieving the targets set for each of the strategic objectives. The strategic plan has implementation and monitoring and evaluation framework.

Over a period of 3 years from 2017/18 to 2019/20 (2010 to 2012 Eth. Cal) it is expected to mobilize resources estimated at US$ 5,000,000.00 (ETB 135,000, 000.00 to support the implementation of the strategic plan.

# Chapter One: Introduction

Globally, tobacco use killed 100 million people in the 20th century (Tobacco Atlas 2015).Tobacco use is the largest single preventable cause of premature death and disease in the world today. The latest research suggests that smoking related mortality has risen to 7.2 million lives annually, killing more people than HIV/ AIDS, malaria and tuberculosis combined. Equally alarming is the fact that the epicenter of this epidemic has moved to the developing world, both from direct tobacco use and second-hand smoking (WHO 2017). By 2020, this number will increase to 10 million, accounting for 10% of all deaths. Smoking is estimated to cause about 71% of lung cancer, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease. It is evidenced that for every one death due to tobacco about 20 tobacco users and secondhand smokers suffer from chronic diseases related to tobacco annually (WHO 2014). Tobacco smoking is the fourth most common risk factor for disease and the second major cause of death worldwide. Tobacco use causes more than half a trillion dollars in economic damage each year. If the current trend is not curbed, it will be responsible for 1 billion deaths at the end of this century. Tobacco use disproportionately affects the poorest people. More than 80% of the world smokers leave in lower-middle-income countries. It harms health income, sustainable economic growth and social development (WHO, 2015).

Majority of these tobacco related deaths occur in low and middle income countries, including Ethiopia. Tobacco use has a devastating impact on one's health, social, economic and environmental affairs. It has impacts at individual, community and national levels. Tobacco smoking is a major risk factor for a range of disabling and fatal conditions, including cardiovascular (coronary heart disease, stroke and peripheral vascular diseases), several cancers and lung diseases (asthma, chronic bronchitis and emphysema).

Non-communicable diseases (NCDs) are the leading cause of mortality in the world and are a growing burden; however, they often remain invisible**.** There are several risk factors that contribute to the increasing burden of the NCDs. The risk factors are majorly modifiable ones particularly use of tobacco and alcohol, unhealthy diet, insufficient physical activity, being

overweight or obesity and elevated blood pressure, blood sugar and cholesterol. As the leading cause of death globally, NCDs were responsible for 38 million (68%) of the world's 56 million deaths in 2012. More than 40% of them (16 million) were premature deaths under age 70 years. Almost three quarters of all NCD deaths (28 million), and the majority of premature deaths (82%), occur in low- and middle-income countries(WHO 2014) Four major NCDs (cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) are responsible for 82% of NCD deaths. In the Africa Region, there are still more deaths from infectious diseases than NCDs. However, the prevalence of NCDs has been rising rapidly and is projected to cause almost three-quarters as many deaths as communicable, maternal, prenatal, and nutritional diseases by 2020 (WHO, 2008).

To mitigate the devastating impact of tobacco use, the FCTC, the first international treaty negotiated under the support of the WHO entered into force in 2005. It is an evidence-based treaty that reaffirms the right of all people to the highest possible standard of health which represents a paradigm shift in developing a regulatory strategy to address tobacco. It asserts the importance of demand and supply reduction strategies. This Convention aims to guide parties in their efforts to strengthen tobacco control program in their respective countries. To date, about 180 parties including Ethiopia have pledged their international solidarity and commitment by signing the Convention. Ethiopia ratified the convention on 21 January 2014.

This multi-sectoral strategic plan is developed taking into consideration the provisions[1] provided in the WHO-FCTC and its protocols.

[1] WHO FCTC

# Chapter Two : National Situational Aanalysis

## 2.1. National context

**Demographic situation:** Ethiopia is the second most populous country with more than 95 million (CSA 2015) people in Africa. About 83.64% of the population lives in rural areas. This makes Ethiopia one of the least urbanized countries in the world. The population is predominantly young with 45% falling under 15 years of age, over half (52%) between 15 to 65 years, and only 3% are over the age of 65 years. The ratio between male and female is almost equal.

**Government and Administration:** The Federal Democratic Republic of Ethiopia (FDRE) is structured as a federal state with a bicameral parliament, with the House of Peoples' Representatives having the highest authority of the federal government and the House of Federation representing the common interests of the nations, nationalities and peoples of the state. The country has 9 regional states, namely Tigray, Afar, Amhara, Oromia, Somali, Southern Nations, Nationalities and Peoples' Region (SNNPR), Benishangul-Gumuz, Gambella, and Harari; and 2 chartered cities─ Addis Ababa and Dire Dawa. Each regional state is autonomous and is headed by a state president elected by the respective regional council. The judiciary is constitutionally independent. The regional states and city administration councils are further subdivided into zones, 836 administrative districts and 17,000 Sub-districts (kebeles). Kebele is the lowest administrative unit.


**Figure 1 Map of Federal Democratic Republic of Ethiopia**

**Socio-economic situation:** The country follows a market–based and agriculture-led industrialization economic policy for the development and management of the economy. Agriculture accounts for 83.4% of the labor force, about 43.2% of the Gross Domestic Product (GDP) and 80% of exports. Over the last 10 years, Ethiopia has registered an impressive economic growth above 10%; particularly the agriculture and industry sectors as well as the social services have registered growth rates above their targets set for the year. The GDP per capita of the country is about 700 USD Percentage of population living under poverty line has decreased from almost 50% to 26%. The country has developed GTP2 and started its implementation for the next five years. The GTP2 is designed to enable the economy to grow at an average of 11% a year to enable structural transformation of the economy.

**Education**: According to the 2006 Etc. (2013/14) the number of primary, and secondary schools has reached 30,800 and 2,333 respectively. According to FMOE (2014), 21.2 million children attended in primary and secondary schools in 2013/14 academic year, more than 1.7 million youth in higher education in 1312 TVETs and 33 universities. More than 3.5 million adults benefited in adult education program and 6.6 million are currently in the program.

**Health Sector:** Ethiopia has a National Health Policy that guides the health sector. To realize the health policy, the country has been implementing a 20-year health sector development program (HSDP I-IV). The health sector is developing a long term strategy (envisioning Ethiopia marching towards universal health coverage through primary health care). Currently the country has started implementing new health sector transformation plan and revising its health policy. The health sector has been organized into different echelons such as health service provider, purchaser and regulator

The health system has a three-tier health system. The *primary health care units* (PHCUs) are comprised of health posts, health centers, and primary hospitals. They are structured to provide health services to 3,000-5,000, 15,000-25,000 and 60,000-100,000 populations, respectively. The secondary health service delivery structure consists of *general hospitals* that serve 1-1.5 million people; and the tertiary health care delivery is provided by *specialized hospitals* that serve 3.5 - 5 million population. There has been massive expansion of public and private health and pharmaceutical institutions.

This health extension program which has deployed over 38 000 health extension workers supported by the health development army links the health system with the community level and creates easy access for the population.

## 2.2 Overview of tobacco use in Ethiopia

According to the 2011 EDHS, seven percent of men in the ages of 15-49 use tobacco products of some kind; Six percent say they smoke cigarettes. The smoking rate is by far higher in men than among women. Tobacco use is also higher among men in the older age group.

Huge disparities of tobacco use across the parts of the country do exist. For example, tobacco use is 27 percent in Harari Region, 24 percent in both Somali and Dire Dawa Regions and 20 percent in Afar Region. The number of cigarettes consumed by men aged 15-49 had the largest proportion (34 percent) which means they smoke three to five cigarettes in 24 hours, while 29 percent smoke 10 or more cigarettes in 24 hours preceding the survey.

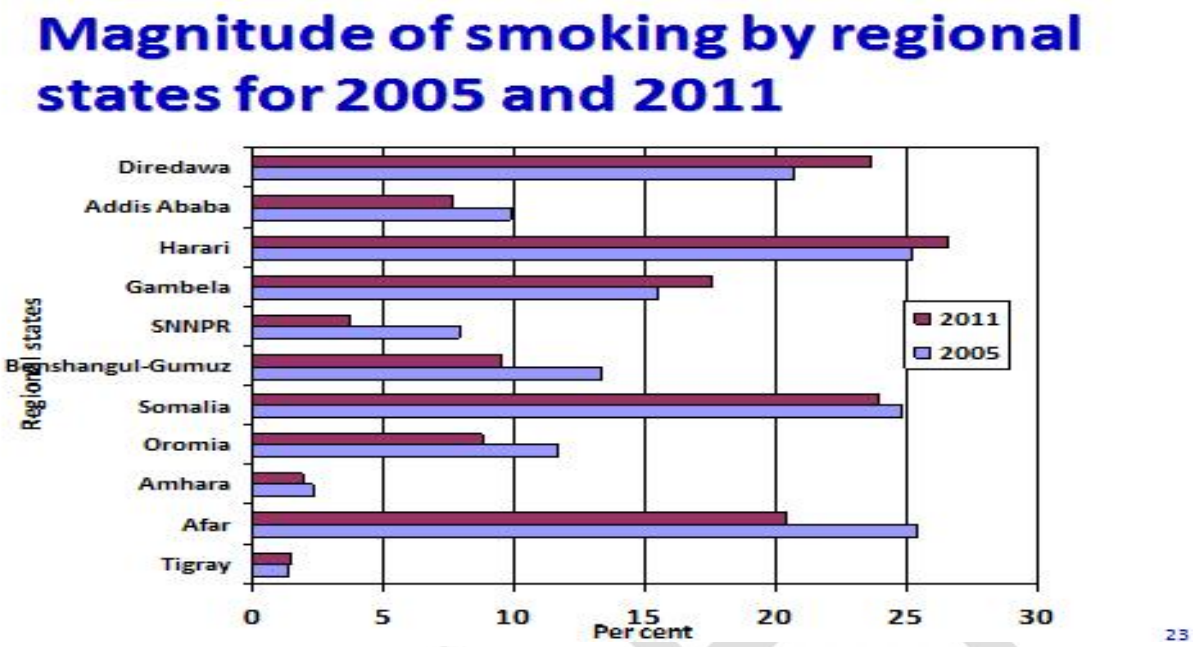



Figure 2- Magnitude of smoking by regional states and city administration councils

The Global Youth Tobacco Survey conducted in 2003 showed that the prevalence of tobacco use was higher in men than women and that it was also higher among the youth than adults (See table below).

Table 1 Global Youth Tobacco Survey 2003

**Tobacco use data from the latest survey results available to WHO as at 31 December 2012**

| | Among youth | | Among adults | | | |
|---|---|---|---|---|---|---|
| **Smoked tobacco prevalence (%)** | **Current tobacco use** | **Current cigarette use** | **Current tobacco smoking** | **Daily tobacco smoking** | **Current cigarette smoking** | **Daily cigarette smoking** |
| Male | 9.9 | 2.5 | 6.3 | 5.3 | . . . | 4.5 |
| Female | 4.9 | 0.7 | 0.5 | 0.4 | . . . | 0.1 |
| Total | 7.9 | 1.9 | 3.3 | 2.8 | . . . | 2.2 |

Youth: Global Youth Tobacco Survey, 2003; Subnational, ages 13-15
Adult: World Health Survey, Ethiopia, 2003; National, ages 18+

In 2013 more than 100,000 children and 2,326,000 adults in Ethiopia continue to use tobacco daily. The recent Ethiopia STEPS Survey of 2015 has produced new data of tobacco use. According to this study, 4.2% of adults currently smoked tobacco, of which 7.3% of males and 0.4% of females do currently smoke tobacco whereas 3.5% smoke daily; of these 6.2% are males and 0.2% females.[2] 15.3% use hand-rolled cigarettes, 9.4% use cigars, 7.4% use Shisha, 7.1% use pipe tobacco, whereas 3.7% use other types of tobacco products. The prevalence of cigars, Shisha and piped tobacco is higher among women than men. The STEPS 2015 survey revealed that 0.8% of adults use smokeless tobacco (snuff by mouth, and nose, chewing tobacco and others).

The 2016 Ethiopia GATS findings revealed that 5.0% (3.4 million) of adults currently use tobacco products [8.1% among men and 1.8% among women; 3.8% in urban areas and 5.3% in rural areas]. Exposure to Secondhand Smoke: Among adults who worked indoors or both indoors and outdoors, 29.3% (6.5 million) were exposed to secondhand smoke in their workplace in the past 30 days; among non-smokers the estimate was 27.1% (5.7 million). Overall, 12.6% (8.4 million) of adults were exposed to secondhand smoke at home. Among non-smokers, 9.9% (6.3 million) were exposure to secondhand smoke at home. There were significant differences across regions that used any tobacco products: Afar 15.5%, Gambella 11.2%, Harrari 7.2%, Benushangul Gumz 6.6%, Somali 6.5%, Oromiya, SNNPR, Dire Dawa each 4.4%, 4.5%, 4.4% have prevalence more than national average. The median amount spent on a pack of 20 manufactured cigarettes among daily smokers was ETB 18.4, and the average cost of 2000 manufactured cigarettes (100 packs) as a percentage of per capita Gross Domestic Product (GDP) [2016].

[2] Ethiopia PENS Survey fact sheet, EPHI, 2015 .

Table 2: percent of adults >15 years old by detailed of tobacco use status and gender, GATS Ethiopia, 2016

| **Status** | | **Over all** | **Male** | **Female** |
|---|---|---|---|---|
| **Current** | Tobacco use | 5% (3.4 million) | 8.1% | 1.8% |
| | Tobacco smokers | 3.7% (2.5 Million) | 6.2% | 1.2% |
| | Cigarette smokers | 2.9% (1.98 Million) | 5.5% | 0.2% |
| | Smokeless tobacco users | 1.7% (1.2 million) | 2.6% | 0.8% |
| **Daily** | Tobacco smokers | 3.2% (2.2 million) | 5.2% | 1.1% |
| **Occasionally** | Tobacco smokers | 0.5% (0.34 million) | 0.9% | 0.1% |

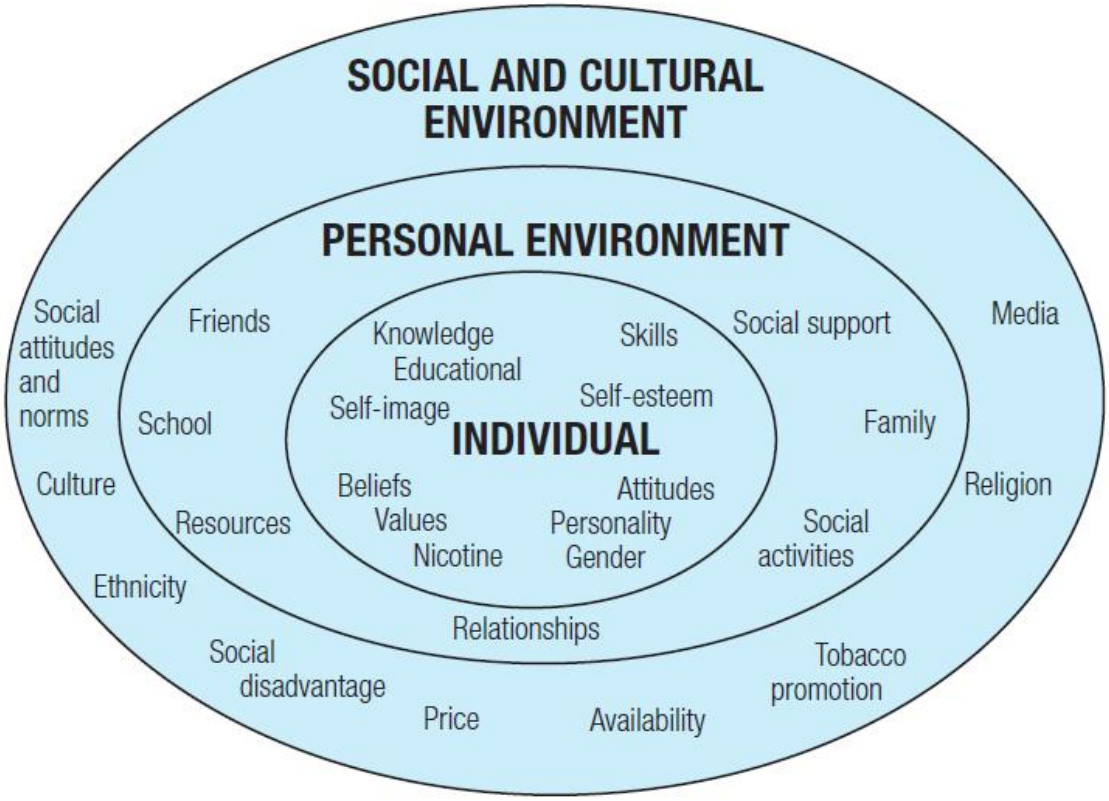
**Predictors of tobacco use:** Underlying factors associated with tobacco use include male sex, increasing age, peer pressure, low educational and low income status. A study conducted in Tigray by Alemayehu et al (2014) showed being predominantly from rural setting is protective against tobacco use and Khat chewing whereas higher educational status, income and stressful conditions such as feeling nervousness were found to be risk factors for tobacco smoking. Given smoking is widely practiced in various cultures, further studies to understand contributory factors are important.

**Tobacco supply in Ethiopia:** Local production of tobacco products and import trade constitute the main sources of tobacco products. The country has one tobacco manufacturing industry partially owned by government. Ethiopia obtains 30% of its tobacco leaf supply from four National Tobacco Enterprise owned farms in different parts of the country. These are namely, Shewarobit in the Amhara Regional State and three farms in Hawassa, Wolayeta and Belate in the SNNPR. The remaining 70% of tobacco leaf supply is obtained through importation. In 2011/12 fiscal year 72 tons of tobacco products were imported at the cost of 220,752 dollars mainly from Brazil and India.

There are a few number of importers and more than 100 wholesalers of tobacco products. It is very difficult to estimate the actual number of tobacco retail outlets as retailing of tobacco is done by every retailers and even outfitter without license.

In conclusion, although the prevalence of tobacco use seems to be low compared to other countries, considering the absolute number of people smoking in the country, the situation compels serious attention.

**Factors for tobacco use:** The major factors why people use tobacco are of diverse nature and can be organized under Social and Cultural environment, personal and individual environment as shown below:




Knowing the contributing factors for tobacco use is very important to design and implement intervention strategies to prevent and control use of tobacco.

Tobacco use is a function of complex factors at individual and societal levels. Factors driving the increasing demand for tobacco products and the supply are usually fuelled by local production, import trade and illicit trade.

**Tobacco-related morbidity and mortality in Ethiopia:** The 2008 WHO NCD estimates indicated an annual NCDs-related death rate of 34% in Ethiopia (WHO, 2010a). In the report, cardiovascular diseases accounted for 15%, cancers for 4% and respiratory diseases for 4% of all causes of death. Furthermore, diabetes accounted for 2% of causes of deaths in the same year.

A number of local small-scale studies reinforce the estimates above. For example, a study from Addis Ababa, investigating cause of death using verbal autopsy, showed that 51% deaths were due to non-communicable diseases (Misganaw, Mariam & Araya, 2012). In the same study, cardiovascular disease was the leading cause of death (24%), followed by malignant neoplasms (10%); respiratory tract diseases (9%); and type1 and type2 diabetes (5%).

Even though there is no a study showing the association of tobacco use and exposure to the above-mentioned NCDs in Ethiopia, It is possible to conclude from the global hard fact that tobacco is the single largest preventable risk factor for NCDs in Ethiopia.

In 2010, 1.9% of deaths among men and 0.8% of deaths among women were caused by tobacco. Every year, more than 9,600 Ethiopians die of tobacco-related diseases. It is possible to extrapolate about 200,000 users and second-hand smokers suffer from tobacco-related diseases annually.

## 2,3. Status of Tobacco Control Program in Ethiopia

**WHO-FCTC Ratification:** To mitigate the grave tobacco-related health, social and economic consequences and achieve the objective of the convention and its protocols, and to implement its provisions, the government of Ethiopia has signed the convention on 25 February 2004 and ratified on 21 January 2014. The House of Peoples' Representatives passed a bill for ratifying the convention known as Proclamation No 822/2014. This was published in "Negarit Gazetta" on 17 February 2014.

The ratification has been a milestone in the history of Ethiopia's Tobacco Control Program. It has paved the way to undertake and implement various measures to strengthen the program. One of these is the tobacco control strategic plan development to guide the planning and implementation of activities towards the vision of tobacco-free society. The strategic plan deals with the intensification of the anti-tobacco campaign, inclusion of national and regional institutions in the introduction of measures to counter tobacco use in their programs, and budgeting for these interventions.

**Policy and legal framework for Tobacco Control:** The National Health Policy lays considerable emphasis on health promotion and disease prevention and considers basic treatment and rehabilitation as priorities. The health policy highlights IEC strategy "discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug use and irresponsible sexual behavior". In line with the policy intentions, WHO-FTCT strategies have been addressed in various legal frameworks.

The country has developed legal frameworks that include the Food, Medicines and Healthcare Administration and Control proclamation No.661/2009, council of ministers regulation No 299/2013, the advertisement proclamation No.759/2012 and tobacco control directive no.28/2015 for the control of tobacco. The directive for the control of tobacco endorsed in March 20, 2015 and comprehensively encompasses the core demand and supply reduction provisions of the FCTC which is currently in the process of implementation. Proclamation No.822/2014 legal frameworks give mandate to the Authority and regional regulatory bodies to regulate tobacco and coordinate the implementation of the WHO-FCTC. Accordingly EFMHACA and regional regulatory bodies have been controlling tobacco as per the legal frameworks. The Authority is empowered to control the content, disclosure of tobacco information, manufacture, import, export, distribution, sales, use, smoke-free public place, advertisement, promotion and sponsorship, packaging, and labeling-health warning and disposal of tobacco products.

### 2.4 Mainstreaming tobacco control:

Sustainable and meaningful impact in reducing tobacco use and its burdens is achieved through multi-sectoral involvement. This will also further expand access to tobacco control interventions in order to reach target populations and put in place protection mechanisms.

The country has attempted to integrate some of the tobacco control strategies into the drug abuse control, National Drug Master Plan, National Strategic Framework for the Prevention and Control of NCDs and National Cancer Control Plan.

As the success of tobacco control depends on the involvement of various sectors, a national coordination body has been established involving representatives of various Ministries. To this end, remarkable efforts to build capacity of focal points in tobacco control mainstreaming have

been undertaken. Encouraging results have been attained in role clarification of each sector pertaining to specific articles related to their organizational functions and in making workplaces smoke-free. Nevertheless, more is to be done to enable sectors to fully engage to see meaningful impact of their contributions.

Some of challenges in mainstreaming tobacco control activities include, but not limited to:

- Infantile mainstreaming and implementing stage of tobacco control;
- Unavailability of joint strategic plan on tobacco control;
- lack of adequate evidence and data on prevalence, sectoral effects of tobacco and effectiveness of the interventions;
- Inadequate awareness and advocacy for mobilization of community and other stakeholders;
- Inadequate commitment;
- Inadequate financial, and technical resources;
- Inadequate strategic partnership and concerted efforts;
- Unavailability of monitoring and evaluation system.

## 2.5 Justification

It has been evidenced that tobacco use is showing an increasing trend. The factors fuelling tobacco epidemic have complex nature and are also rising rapidly from time to time. The burden of diseases related to tobacco use such as cardiovascular diseases, cancers, chronic obstructive respiratory diseases and mental health problems are becoming evident in Ethiopia. The social and economic consequences of tobacco epidemic are rising increasingly. Thus, taking into account the existing situation, it is imperative to urgently combat tobacco use and its aforementioned consequences.

In order to protect the population from tobacco-related health, social and economic consequences, it is quite unequivocal that the country has to realize the implementation of the WHO-FCTC. To date concrete steps including the ratification of the WHO-FCTC and identification of a mandated institution to lead and coordinate the implementation of the FCTC at national level have been conducted. Ethiopia's concrete steps to fully and effectively implement

WHO FCTC require the establishment of a functional directorate in the EFMHACA as well as units and focal persons in regions and districts, respectively and strengthening them by providing the necessary human resources. Realization of the WHO-FCTC also demands a multi-sectoral response to effectively and efficiently control tobacco use and thus increased participation of stakeholders should be given a critical attention.

To realize the multi-sectoral response, under the auspice of the Ethiopian Food, Medicine, and Healthcare Administration Control Authority (EFMHACA), the national tobacco control coordinating committee has been formed. The committee is comprised of potential stakeholders from different sectors with clear and defined roles and responsibilities (Annex I list of members of the NTCCC). The involvement of these stakeholders is a critical milestone in institutionalizing and mainstreaming all tobacco control efforts in their respective institutions.

Mobilization of resources by all responsible bodies is highly imperative to meet the goals and objectives set in realizing WHO-FCTC because it is one of the yardsticks used in measuring institutional commitment and mainstreaming. In order to create a platform for concerted efforts by different stakeholders and to have a clear roadmap on who should do what and how to control tobacco, a national strategic plan has to be developed. Furthermore, the plan clarifies institutional roles and arrangements for the coordination and implementation and increased involvement.

# Chapter three Vision, Mission, Values, Goal and objectives

### 3.1. Vision

To see "tobacco-free" Ethiopia

### 3.2. Mission

To protect Ethiopians from harm of tobacco through comprehensive and multi-sectoral collaborative implementation of the provisions of the WHO-FCTC

### 3.3. Values

This strategic plan for tobacco control is governed by the following core values

Comprehensiveness:

Commitment:

Ownership:

Accountability:

Transparency:

Evidence-based:

Integrity:

Confidentiality:

Interdependence:

Justice:

Collaboration and Team work:

## 3.4 Goal

To reduce the prevalence of tobacco use, its associated diseases, disability and deaths as well as its grave social and economic consequences in Ethiopia.

### 3.5. Strengths, Weaknesses, Opportunities and Threats

| **Strengths** | **Weaknesses** |
|---|---|
| Availability of mandated government bodies at federal and regional levels for enforcement and coordination of implementation of Tobacco Control activities;<br>Tobacco Control strategies reflected in national health policy, HSTP,NCCP, National NCD framework, NCD Guidelines etc;<br>Establishment of National Tobacco Coordinating Committee(NTCC);<br>Availability of legal frameworks- proclamations, regulation and directive for Tobacco Control;<br>Increasing efforts to implement WHO-FCTC at federal and regional levels such as in Tigray;<br>Availability of some evidence on tobacco prevalence from GYTS,GATS STEP wise and EDHS;<br>Presence of monitoring mechanism such as periodic review meetings at EFMHACA to measure the progress of the program. | Inadequate data and evidence on health social and economic impact of tobacco as well as on the program progress;<br>Inadequate implementation of the various demand and supply reduction of tobacco control articles of WHO-FCTC;<br>Inadequate mobilization, engagement and ownership of community and other stakeholders;<br>Unavailability of tobacco cessation and rehabilitation services for quitting tobacco;<br>Finical constraints and other competing priorities of the government;<br>Financial constraints hindering the implementation of WHO-FCTC)<br>Delay in the review of tobacco taxation;<br>Inadequate control of illicit trade of tobacco |
| **Opportunities** | **Threats** |
| There is growing global concern of working on NCD risk factors such as Tobacco;<br>Presence of global goals such as Sustainable | Growing Tobacco industry interference;<br>Economic gain from tobacco products;<br>Illicit tobacco trade; |

| | |
|---|---|
| Development 3 (SD3);<br>Recent initiative for high level political commitment at global and regional levels;<br>Growing role of the public and private health sector in the clinical care of non-communicable diseases;<br>Growing number of health professional training institutions (colleges of health sciences, universities);<br>Growing interest of international and local CSO to work on Tobacco;<br>Tobacco tax push from partner organizations. | Inadequate commitment and inter-sectoral collaboration;<br>Lack of resources due to competing priorities of the government to other development challenges such as infectious diseases and nutritional problems;<br>Inadequate awareness, misconception of the community, behavioral challenge, and cultural issues related to the harmful impacts of tobacco. |

### 3.6. Stakeholder analysis

The realization of the goals and objectives of tobacco control is largely dependent on the collective efforts and roles played by the different stakeholders. The importance of multi-sectoral involvement for the reduction in the use of all tobacco products, prevention of the incidences of diseases, early disability and deaths is highlighted in the FCTC as one of its guiding principles.

To produce effective tobacco control, interventions need to focus across the lines of its production, distribution, consumption and effects. Thus organizations, groups of people and individuals that have either the power and influence or that could be influenced or have an interest in the implementation of the tobacco control have been identified following sound stakeholder analysis. During the stakeholder analysis efforts have been made to understand their interests, intentions, and the nature and level of capacity in terms of expertise and resources for strengthening tobacco control program (Annex II).The process of stakeholder analysis helps not only to foster partnership, mobilize partners and advocate for greater participation and involvement of stakeholders but also to take countermeasures with organizations whose interest and action antagonize what is intended to be achieved through the tobacco control program. The

degree of stakeholder influence on tobacco control varies depending on their span of control over the generation and allocation of resources; level of political power; scope of participation in the sector; and range in the use of services provided by the sector.

The list of the identified key stakeholders and their roles in tobacco control has been clearly articulated under the institutional framework.

# Chapter Four: Strategic Objectives and strategies

***Strategic Objective 1: To protect people and environment from to tobacco exposure***

The aim of this strategic objective is to create tobacco and smoke-free environments in all public and workplaces as well as public conveyance. Completely smoke-free environments are the only proven way to protect people adequately from the harmful effects of second-hand smoke. Smoke-free environments not only protect non-smokers, they also help smokers who want to quit. The persons and environment involved in cultivation and manufacturing of tobacco should be protected from tobacco hazards. This strategic objective requires enactment and enforcement of laws that dictate completely smoke-free environments and protecting persons involved in cultivation and manufacturing of tobacco. This strategic objective will be achieved through the implementation of the following 3 strategies.

***Strategy 1: Sensitize, familiarize and advocate for enforcement of laws***

Sustainable awareness creation interventions in the general public and business owners about the benefits of smoke-free workplaces, including the fact that they do not harm business, can reduce opposition from the business community. Informing business owners that enforcing this law will not have negative impacts on business is imperative.

This strategy should address the issues related to the grave consequences of tobacco products and importance of tobacco smoke-free work and public places and indoor spaces in a persuasive manner. It should also address protection of persons and environment involved in cultivation and manufacturing of tobacco from tobacco hazards.

***Strategy 2. Enact and enforce smoke-free public place and environment***

Legislation is required to implement smoke-free places, as voluntary policies have proven ineffective. Ventilation and separate smoking rooms do not reduce exposure to second-hand tobacco smoke to an acceptable or safe level. Once enacted, laws establishing smoke-free places must be well enforced. It may be necessary to enforce smoke-free policies and legislations more actively in the period immediately after smoke-free laws are enacted in order to demonstrate the government's commitment to ensuring compliance.

Enact and enforce completely tobacco smoke-free environments in all public, work and indoor places as well as in public conveyances. All public, work and indoor places as well as public conveyance should be smoke-free. The WHO -FCTC stresses the importance of making all indoor workplaces smoke-free by law. Uniform implementation of smoke-free laws within a sector ensures the level of commitment and implementation.

In high-income countries, smoke-free public places and workplaces have shown to reduce tobacco consumption by 3–4%. Smokers who work in smoke-free workplaces are more than twice as likely to quit smoking as those who work where smoking is permitted.

Placing the responsibility for enforcing smoke-free places on the owners and management of facilities is the most effective way to ensure compliance with the laws. In many countries, business owners have a legal duty to provide safe workplaces for their employees. Enforcement of legislation and its impact should be monitored regularly. Economic data can be used to counter false tobacco industry claims that establishing smoke-free places causes economic harm.

***Strategy 3: Protect environment and persons from hazards of tobacco cultivation & manufacturing***

Health of persons involved in tobacco cultivation, processing and manufacturing should be protected through behavioral change communication, use of protective devices, regular medical check-up and health care provisions to reduce tobacco-related ailments. Environment should also be protected from hazards of tobacco cultivation and manufacturing by reducing the land used for cultivation and volume of fuel wood used for tobacco curing. Occupational health and environment-friendliness should be ensured through implementation of the law. Regular occupational health and environmental impact assessment need to be undertaken.

**Strategic objective 2: To reduce the number of people using tobacco**

The purpose of this objective is to reduce the number of smokers by helping them and creating enabling environment to quit tobacco use. Among smokers who are aware of the dangers of tobacco, nearly three out of four want to quit (2016 Ethiopia GATS). There are situations when tobacco users need the support of others to quit and most people benefit from help and support to

overcome their dependence. Countries' health-care systems hold the primary responsibility for treating tobacco dependence.

A comprehensive strategic framework on smoking cessation and treatment of tobacco dependence includes a mix of three main approaches:

- A public health approach that seeks to change the social climate and promoting a supportive environment;
- A health systems approach that focuses on promoting and integrating clinical best practices (behavioral and pharmacological, which help tobacco-dependent consumers increase their chance of quitting successfully)into a sustainable health care system; and
- A surveillance, research and information approach that promotes the exchange of information and knowledge so as to increase awareness of the need to change social norms.

This strategic objective will be achieved through implementation of the following 2 strategies.

***Strategy 4: Promoting creation of supportive environment***

Tobacco cessation can only be ensured by promoting of the creation of supportive environment through effective implementation of comprehensive tobacco control strategies. Creating a supportive environment which is conducive to deglamourizing the cigarette and encouraging the smoker to quit is vital for effective implementation of smoking cessation services. Smoke-free policies at public, work and indoor places as well as public conveyance encourage long-term goal of de-normalizing tobacco use. Population-based measures can affect large numbers of individuals at minimal cost.

***Strategy 5: Increasing access to tobacco cessation services***

The country should have a policy recommendation for smoking cessation and treatment of dependence. Working with individual smokers to change their smoking behavior is an important goal, but it has a limited impact if the environmental factors that promote and support smoking are not also addressed. Hence, population-based interventions should be viewed as complementary approaches to individual-based behavioral or pharmacological interventions.

**Public health approaches** at the general population level such as mass media campaigns and telephone help-lines play an important role in changing societal norms and promoting smoking cessation. Mass media campaigns can increase knowledge about the health effects of smoking and the benefits of quitting. Quit-lines have an important role to play as part of an overall comprehensive smoking cessation program. They provide a low-cost, easily accessible, popular and effective service.

**Both pharmacological and behavioral** treatments have to be integrated with health-care systems to enable effective delivery of cessation services. Behavioral treatments alone could also be effective. Apart from the specialized units at secondary and tertiary levels of health care, which would provide the therapy, the primary health care system should be actively involved in providing brief advice and tips to smokers as part of routine health education. In this regard, the role of health extension workers and health development army at the community level cannot be underestimated. There should be options for more intense intervention including medication for high-risk and medically-compromised tobacco-users even in low-income countries.

Capacity building and human and financial resources are a prerequisite for sustaining interventions on smoking cessation and treatment of tobacco dependence at both the population and individual levels. Public health officials need to be trained to deliver population-based measures such as campaigns. Trained human resources are also needed to provide support and counseling to smokers. Building capacity to educate and train healthcare providers to advocate and implement strategies for smoking cessation and treatment of tobacco dependence is essential for ensuring success.

Systems should support training, ensure health professionals have access to such training and support them in continuing to use their new skills. This would include proper funding, temporary replacements for the health professionals whilst they attend training, and follow-up. Where possible, increased excise taxes and/or use of tobacco generate revenue to fund tobacco-cessation services could substantially increase intervention options, including medication.

Pre - and in-service training of health professionals is an essential part of a cost-effective, evidence-based strategy on smoking cessation and treatment of tobacco dependence because of their interaction with smokers and other tobacco consumers as care providers. As a medium- and long-term strategy, cessation counseling will need to be incorporated into the curricula of health professionals, including physicians; health officers, nurses and others. Comprehensive practice guidelines for clinical treatment should be developed in consistence with other accepted standards.

**Strategic Objective 3: To warn about the dangers of tobacco**

The aim of this strategic objective is to create high level of awareness on the health risks of tobacco use across all age groups, sexes and places of residence.

Most people know generally that tobacco use is harmful but are unaware of the wide spectrum of specific illnesses caused by tobacco, both smoke and smokeless, the likelihood of disability and death from long-term tobacco use, the speed or degree of addiction to nicotine or the harmfulness of second-hand smoke. This objective will be achieved through the implementation of the following three strategies.

***Strategy 6: Ensuring effective pack warning labels***

Warning labels on tobacco packs are a cost-effective method of advertising the dangers of tobacco use, providing direct health messages to tobacco users and non-users. The health warning should also be displayed on smokeless tobacco. This intervention can be implemented at virtually no cost to the government.

The content and graphic presentation of pack warning labels should be legislatively mandated to be visible and clear and ideally should cover at least 30-50% of principal pack display areas. Warning labels should also describe specific health effects and diseases caused by tobacco use and should be periodically rotated to continue attracting the attention of the public. Pictorial warnings are effective for all smokers and smokeless tobacco users and are particularly important for persons who cannot read or for young children whose parents smoke or use smokeless tobacco. In addition, these labels should not be permitted to include any wording or other indication that suggests a particular tobacco product is less harmful than others, such as

claiming it is “low tar”, “light”, “ultra-light” or “mild”. No cigarettes are safe, and the use of these terms suggests incorrectly that some products are less harmful.

In terms of trade mark and name, the tobacco industry should preclude use of outstanding, magnificent, elegant, naming after endemic animals, public figures etc. ,e.g. trade names and marks such as Nyala, Eleni etc..

In terms of Packaging and labelling of tobacco products the FCTC standard is expected to be implemented by the competent authority, as stipulated under Article 11(b)(i). Therefore, EFMHACA should craft the necessary strategy to approve the packaging and labelling of Tobacco as per the stipulated standard.

***Strategy 7: Implementing counter-advertising campaigns***

Information about the health risks of tobacco use should be presented clearly, with the same quality and persuasive power as tobacco industry advertising and marketing materials.

Counter-advertising campaigns can be costly. However, by obtaining low-cost prime-time television and radio time if possible, and increasing a country’s budget for tobacco control, it is possible to implement sustained, effective, highly visible anti-tobacco messages that encourage many tobacco users to quit. Young teens exposed to effective television anti-tobacco messages are less than half as likely to become established smokers, and adult smokers who are exposed to anti-tobacco campaigns are more likely to quit smoking. In addition to paid advertising, anti-tobacco educational campaigns can be disseminated in the media through public relations efforts that promote television and radio coverage, news stories in print, broadcast and online media as well as letters to the editor and opinion articles. This process, sometimes, referred to as “earned media”, can be a highly effective and inexpensive way to educate the public about the harms of tobacco, increase attention on tobacco control initiatives and counter tobacco industry misinformation.

Well-designed and sustained media campaigns and implementation of policies such as smoke-free places, counter-marketing and pack warnings can generate substantial free media coverage. Press releases highlighting anti-tobacco policy positions should be issued any time there is a

development in tobacco control, such as when laws are introduced or passed or new research findings are released.

***Strategy 8: Regulation and disclosure of the content of tobacco products***

Chemical ingredients of tobacco products should be disclosed to EFMHACA so that appropriate feedback would be given to the manufacturers and importers. Effective legislative, executive and administrative measures should be taken by EFMHACA to regulate content and emission of tobacco products. Appropriate technology and testing method should be used by EFMHACA to determine and regulate the content and emission of tobacco products with expense of tobacco industry. Public disclosure of information about toxic constituents and emission of tobacco products may be needed to inform the public of the health hazards and mortal threat posed by exposure to tobacco. EFMHACA should work in collaboration with international bodies to regulate the content and emission of tobacco.

**Strategic objective 4: To enforce bans on tobacco advertising, promotion & sponsorship**

The aim of this strategic objective is to create complete absence of direct and indirect tobacco advertising, promotion and sponsorship as these are highly effective in reducing smoking among people of all income and educational levels. Partial advertising, promotion and sponsorship bans have little or no effect on smoking prevalence.

The tobacco industry spends tens of billions of dollars worldwide each year on advertising, promotion and sponsorship; a key component of tobacco control, therefore, is a comprehensive ban on every form of marketing of tobacco products.

Bans on advertising, promotion and sponsorship should give special attention to marketing channels to which these groups are exposed. Enactment of legislation prohibiting tobacco industry advertising, promotion and sponsorship may potentially face resistance because some businesses, besides tobacco manufacturers, benefit from advertising expenditures. This strategic objective should also address control of cross-border advertisement.

Government intervention through well-drafted and well-enforced legislation is required because the tobacco industry has substantial expertise in circumventing advertising bans. The tobacco

industry often touts advertising and promotion as a means of market competition among brands for current tobacco users, thereby disguising its primary purpose of attracting new users. Penalties for violations of marketing bans must be high to be effective. This objective will be achieved through the following two strategies.

***Strategy 9: Enact and enforce effective legislation banning all forms of direct tobacco marketing advertisement***

To be effective, bans on direct advertising should be comprehensive and cover all types of media and advertising including control of cross border advertisement. Otherwise the tobacco industries will find alternative advertising vehicles to carry their message to target populations.

If advertising is prohibited in a particular medium, the tobacco industry merely shifts expenditures to places where advertising is permitted. Bans should include, but not be limited to, newspapers and magazines, radio and television, billboards and the Internet. It is also important to ban point of sale advertising in retail stores, including product displays and signage. Regulation of several cross-border advertisements in collaboration with international communities and countries should also be adequately addressed. EFMHACA, ERCA, Ministry of Information and Communication Affairs and Federal Police Commission should collaboratively work with international communities in designing and implementing some mechanisms direct and indirect control of cross-broader advertising and promotion.

***Strategy 10: Enact and enforce effective legislation banning indirect tobacco advertising, promotion and sponsorship***

The strategic directions should be reviewed periodically to determine what changes should be made to reflect socioeconomic, health promotion, research, and Indirect tobacco advertising, promotion and sponsorship associating tobacco use with desirable situations or environments and showing tobacco use in films and television, sponsoring music and sporting events, using fashionable non-tobacco products or popular celebrities to promote tobacco and provide messages that involve statements of identity. Indirect marketing improves the public perception of tobacco and tobacco companies.

Monitoring tobacco industry strategies is important for establishing effective counter-measures. Ongoing monitoring can identify new types of marketing and promotional activities that circumvent even the most clearly written comprehensive bans. New media types and social trends such as text messaging and underground nightclubs that are advertised solely through word-of-mouth will need to be monitored, in addition to monitoring traditional media and marketing channels.

**Strategic Objective 5: To discourage demand for tobacco through price and tax measures**

The objective of this strategy is to advocate for progressively less affordable tobacco products through price and tax increase measures. Raising the price of tobacco and tobacco products through tax increases is the most effective way to reduce smoking and use of other forms of tobacco. Higher cigarette prices reduce the number of smokers and induce those who continue to smoke to consume fewer cigarettes per day. Due to inelastic demand and the low share of total taxes in retail prices, FCTC compliant tax system increases a country's tax revenues, at least in the short- and medium-terms, even if reduced consumption is taken into consideration. The sale of single piece of cigarette should also be discouraged. Duty-free tobacco sale should also be prohibited.

Indeed, some countries have imposed tobacco taxation rates in excess of 75% of the retail price. It is estimated that for each 10% increase in retail prices, consumption is reduced by about 8% in low- and middle income countries. Smoking prevalence is reduced by about half those rates, with variations associated with income, age and other demographic factors. Higher tobacco taxes are particularly effective in preventing or reducing tobacco use among teenagers and the poor. Young people and low-income smokers are two to three times more likely to quit or smoke less than other smokers after price increases, because these groups are the most economically sensitive to higher cigarette prices.

This objective will be achieved through the following two strategies.

***Strategy 11: Increase and adjust periodically tax rates for tobacco products***

If tax increases do not result in increases in real cigarette prices and do not rise faster than purchasing power, then tobacco becomes relatively cheaper and more affordable. As a result,

consumption rises and the prevalence of tobacco use increases. Furthermore, if taxes increase the prices of higher-end products but do not significantly increase prices of cheaper ones, then the poor will be less likely to reduce consumption since they are more likely to smoke cheaper products. To maximize the impact of taxation as a public health intervention, some increased tax revenues resulting from increased tobacco taxation can be earmarked to enhance tobacco control and other public health and social programs.

Dedicating a larger share of these funds to tobacco control increases the popularity of tobacco taxes and results in significantly increased funding for implementation of tobacco control programs.

Different tobacco taxation schemes including Excise taxes, value added taxes, and import duty should be applied to have a significant impact on affordability and consumption. Using different taxation schemes may raise the same amount of revenue yet may either greatly reduce or have little impact on tobacco use, depending on what products are taxed, in what way and at what levels.

The different taxation schemes have a greater capacity to reduce tobacco consumption, particularly if automatically adjusted for inflation. Specific taxes should keep pace with inflation and should be periodically adjusted to account for increased consumer purchasing power to maintain the same effect on reducing tobacco consumption.

Excise taxes applied at the manufacturer level and certified by a stamp on the cigarette pack are the most practical method of levying taxes. This procedure facilitates tax collection by reducing the administrative work required of distributors and retailers, many of whom are smaller businesses that do not have the capacity to account accurately for taxes received. For tobacco imports, excise taxes are often applied at the port of entry as with any other custom duty. Sales taxes or value added taxes (VAT) can also be collected at the port of entry or at the retail sales level, as is the case with other products.

**Strategic Objective 6: To reduce supply of tobacco products**

The purpose of this strategic objective is to advocate for elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting, and protecting

minors from tobacco products through adopting, developing and implementing effective legislative, executive, administrative or other measures in line with WHO-FCTC and Protocols in order to ensure all tobacco products marketed in the country are in compliance with country regulatory requirements. Licensing and inspection should be undertaken and strengthened at federal, regional and district levels to control or regulate the production and distribution of tobacco products in order to prevent illicit trade. To reduce the supply of tobacco there should be restrictions on circulation and market accessibility in educational institutions, health institutions, religious, sport and other recreational and public places. This objective can be achieved through the implementation of the following four strategies.

***Strategy 12: Curb illicit trade in tobacco products***

Illicit trade in tobacco products can be genuine products manufactured by the authority of a trademark owner and sold without payment of applicable taxes such as import duties, excise tax, VAT or in noncompliance with labeling and other regulatory requirements, or else counterfeit tobacco products that have been manufactured without the permission of the trademark owner.

The illicit trade in tobacco harms governments, consumers, and manufacturers. Strict regulatory and enforcement measures and related governmental actions to prevent all forms of illicit trade in tobacco products, including tracking, tracing, labeling, recordkeeping requirements, and implementation of strict licensing systems should be considered in relevant jurisdictions at national, regional, and district levels. Incentive measures on curbing illicit trade in tobacco products to those providing information and tackling smugglers should be introduced and implemented.

Inspection using state of the art technology, better communication among ERCA officials, and a high level enforcement are essential to reducing the incentives of illicit trade. Mandatory use of pack warnings in the local language are other effective means of reducing the incentives of illicit trade. All these measures require strong government commitment. Global collaboration against tobacco smuggling should also be strengthened.

Effective licensing and inspection of legally authorized manufacturers, importers and distributors should be enforced to ensure control supply chain of tobacco and compliance with legal framework for tobacco control.

Curbing tobacco illicit trade requires ratification of the protocol for elimination of tobacco illicit trade. It requires also to coordinate for concerted efforts of different stakeholders such as EFMHACA, ERCA, Police, MoTr, MoT, and MoJ. The country should also work collaboratively with international and regional communities and countries to curb illicit trade of tobacco.

***Strategy 13: Ban sale of duty-free tobacco products***

Sales of tobacco without appropriate taxation and discount sales should be prohibited. Banning the sale duty-free tobacco product provides tools for preventing and counteracting illegal tobacco products at national and international levels. Appropriate measures should be implemented to control the supply chain and prohibit sale by internet, telecommunications and evolving technology, as well as duty-free sales, and implementing control measures in free zones and international transit points.

To circumvent duty-free tobacco products, government shall establish a number of regulatory and enforcement measures. Banning the sale of duty-free tobacco products requires concerted efforts.

***Strategy 14: Ban sale of tobacco to and by minors***

Effective legislative, executive, administrative or other measures should be implemented at different levels to prohibit the sale of tobacco products to minors. Any temptation that encourages the sale and use of tobacco products directly or indirectly to and by minors should be prohibited. Appropriate key stakeholders should monitor the implementation of such prohibitions.

Restrictions in circulation and market accessibility in the areas of educational institutions, health institutions, religious, sport and recreational places and other public places to reduce supply of tobacco should be backed by legal framework and enforcement.

Effective enforcement of ban of sales of tobacco products to and by minors and any temptation that encourages sale and use of tobacco products directly or indirectly to and by minors requires collaborative effort of different stakeholders.

***Strategy 15: Design and support alternative livelihoods to tobacco***

People whose income depends on growing and selling tobacco need to be supported to have alternative livelihoods. They need to be supported to own other income generating schemes. Tobacco growers need to shift to cultivation of alternative farming in order to support themselves and their families.

Advocacy for evidence-based alternative development for tobacco workers, growers and even individual sellers to protect them from an eventual loss of their livelihood from tobacco in the future should be developed and instituted in appropriate sectoral strategies.

**Strategic Objective 7: To ppromote partnerships & coordination for sustained tobacco control**

The control of tobacco involves different key stakeholders as per the stakeholder analysis. Therefore this strategic plan requires a multi-sectoral nature of interventions to realize the vision and mission of tobacco control.

This strategic objective aims to**:**

- Initiate multi-sectoal response and mainstream tobacco control focusing on the identified stakeholders;
- Enhance capacity for tobacco control at federal, regional and district level and;
- Mobilize resources (technical and financial) in support of tobacco control.

This objective can be achieved through the implementation of the following two strategies.

***Strategy: 16. Strengthen a national and eestablish regional coordination mechanism***

A robust and strong partnership of stakeholders is essential to harness the resources and opportunities from the identified various stakeholders. There is a need to place a mechanism to bring together and coordinate allies to design and implement complementary interventions for the effectiveness of this strategic plan.

FMHACA and Regional Regulatory Counterparts should play a coordination role for the better implementation of the strategy by different stakeholders at federal and regional levels, respectively. FMHACA and Regional Counterparts in collaboration with the different stakeholders should mobilize technical and financial resources for the effective implementation of this strategic plan.

Therefore, effective and sustainable implementation of tobacco control strategies and legal framework as per the WHO-FCTC requires enhancing the capacity of EFMHACA, regional and district wide regulatory bodies to have the capacity to provide consistent enforcement, guidance and coordination for comprehensive tobacco control activities.

***Strategy 17: Mainstreaming of tobacco control and strengthening networking***

Comprehensive and effective implementation of the strategy for Tobacco control requires multi-sectoral involvement of different stakeholders as tobacco issues are negatively affecting every segment of the population and cross-cutting. Therefore, stakeholders should mainstream the strategic objectives, strategies and strategic initiatives and activities as per their respective roles. The stakeholders should implement the tobacco control by developing detailed plan and mobilize resources as per this strategic plan. The different stakeholders should be networked and their capacity need to be strengthened in the area access to information, education, training etc. in order to implement this strategic plan.

MOLSA and the Ministry of public service and human resources development should prepare mainstreaming guidelines for the sectors accountable to them especially for ensuring tobacco-free workplaces.

**Strategic Objective 8: Integrated Health Promotion and Communication**

Health promotion and communication constitute key interventions of the tobacco control strategic plan in raising awareness of the harmful effects of tobacco use, thus it remains to be an important vehicle to reach out all at risk and in particular the young who are about to start or before starting tobacco use or cigarette smoking, to persuade them to stop smoking , to promote protection of people and individuals from secondhand smoking, motivating those who suffer from tobacco use and addiction to quit smoking and advocate for the creation of an enabling environment through adoption of legislative and administrative measures.

The complex nature and continuum of tobacco cultivation, production, trade and consumption process, the interests of different groups all along these lines and the strength of promotion and marketing tactics entail the need for designing effective strategic communication and networking through the following four strategies.

***Strategy 18: Promoting engagement of communities in tobacco control initiatives***

Sustainable and effective tobacco control can only be achieved by promoting engagement and ownership of tobacco control by communities.

While addressing the communities, the focus should be on the special segment of the vulnerable groups of the community especially youth in and out of school, women, HDA, youth association, women association, cancer and other NCD societies and community and religious leaders.

The engagement and the empowerment of the community can be promoted through different, existing social structures like youth associations, women's associations, cancer and NCD societies and community and religious leaders.

Such segments of the community should also be used to increase awareness and mobilization of the community at large. The Community should be actively involved in joint planning, implementation, and monitoring and evaluation of tobacco control programs at various levels.

Appropriate information, education and communication (IEC) materials including posters, brochures, bill boards, spots, leaflets, stickers, and others should be developed and promoted using every appropriate means of dissemination and communication to raise awareness of

harmful effects of tobacco use, promote healthy life style and behavioral change in the community. In this strategy the best technology including electronic and digital media which created a wide awareness among the society should be used and monitored appropriately.

***Strategy 19: Children and Adolescent tobacco awareness raising programs***

This segment of population constitutes a large proportion of the total population. They are in a group highly vulnerable to tobacco exposure and its grave consequences. Since they are future generation responsible for growth and economic development of the country, they should be protected against tobacco. Their awareness of the harmful effects of tobacco should be widely and sustainably raised. These interventions should be implemented in and out of school, colleges and universities.

Tobacco and its grave consequences should also be addressed in curricular and extra-curricular activities in schools, colleges and universities including the school health package recently launched, driving license training, health extension program and others to address the most vulnerable groups of the community. Anti-tobacco clubs should be established and strengthened especially in schools, universities and colleges as well as youth recreational centers.

***Strategy 20: Advocating for increased political commitment and mobilization***

Increasing awareness of political leaders at federal, regional and district levels on tobacco and its grave health, social and economic consequences will increase political commitment, support and mobilization of resources for the control of tobacco at all levels. It will also strengthen political support and monitoring and evaluation of tobacco control strategies by different governmental offices, community and institutions as a cross-cutting issue.

***Strategy 21: Development of integrated tobacco control database and networking***

Integrated database software should be developed for reporting, compilation and analysis of data regarding implementation and achievement of the major supply and demand reduction of WHO-FCTC/ this strategic plan. Implementation and achieved result reports should be reported using standardized format and be submitted manually or using this database software by stakeholders to EFMHACA. Appropriate feedback should be provided by EFMHACA. All stakeholders at

different federal, regional and district levels should be networked through the integrated database.

**Strategic Objective 9: To strengthen generation of evidence through survey and research**

Ongoing data and information generation on local tobacco situation including the burden of diseases, social and economic impacts remain important not only to inform the strategies but also to assess progress of tobacco control implementation. This strategy therefore encourages establishment of federal and regional level tobacco control evidence generating system. Basic and operational research should also be promoted. Engagement and collaboration of various research bodies including CSA, research institutes, academia, professional associations, researchers and others is of paramount importance. This strategic objective can be achieved through the implementation of the following strategies.

***Strategy 22: Establishing and strengthening national tobacco surveillance system***

National and regional research on tobacco use prevalence, tobacco-related health, social and economic effects, including Global Adult Tobacco Survey and Global Youth Tobacco Survey should be undertaken to generate data and information that should be used to determine baseline and assess progress of tobacco control implementation.

A national and regional state level tobacco surveillance system should be established under the umbrella of Ethiopian Public Health Institute. This strategy encourages basic and operational research such as GYTS, GATS, STEPS as well as other studies. The strategy should ensure engagement and collaboration of Central Statistics Agency, academia, research institutes and researchers, line ministries and agencies and their regional counterparts and professional associations.

***Strategy 23: Dissemination and use of findings of generated evidence***

Evidence generated from routine surveillance reports on the basis of key indicators of this strategic plan, basic and operational researches, surveys, studies etc should be regularly disseminated to the stakeholders using various means at federal, regional and district level. Such evidence should be used for improvement of the tobacco control interventions at all level

including in generating institutions. While EFMHACA, EPHI, MOH and regional counterparts should play and continue a leading and coordinating role in disseminating and ensuring utilization of such evidence, partnerships with universities and research institutes need to be created and strengthened to generate evidences. The evidence should be fed into the integrated database and networked.

## *Target*

At the end of the strategic plan period the country needs to achieve the below mentioned targets.

Tobacco Use Prevalence will be reduced from the current 5% to 4.25% (by15%) by the end of 2020.

| Strategic Objectives and Strategies | Targets |
|---|---|
| | |
| Strategic Objective 1: To protect people from tobacco exposure | |
| **Strategy 1:** sensitize, familiarize and advocate for enforcement of laws | 100% of smoke-free indoor public place, work place and public transports by 2020 |
| **Strategy 2:** Enact and enforce completely smoke-free environments | |
| **Strategy3:** Protect environment and persons from hazards of tobacco cultivation and manufacturing | 30% Public awareness and knowledge enhanced from the baseline by 2020 |
| | Policy measures to limit and reduce government involvement in tobacco plant cultivation and production by 2020. |
| Strategic objective 2: To reduce the number of people using tobacco by helping users to quit | |
| **Strategy 4:** Promote for placement of supportive environment | Establish national toll-free quit line by 2020<br>Integrate brief intervention at 30% Primary Health |

| Strategic Objectives and Strategies | Targets |
|---|---|
| | |
| **Strategy 5:** Increase the access to cessation services | Care Unit (PHCU) by 2020<br>Establish 9 CBT and 4 NRT tobacco cessation and rehabilitation centers at General and Specialized Hospitals |
| Strategic Objective 3: To warn about the dangers of tobacco smoking | |
| **Strategy 6:**Ensure effective pack warning labels | 100% of the available tobacco products with required health warning by 2019 |
| **Strategy 7**: Implement counter-advertising campaigns | **100**% counter-advertising campaigns |
| **Strategy 8:** Disclose ingredients of tobacco products | 100% of disclosure of ingredients of tobacco products marketed in the country by 2020 |
| Strategic objective 4: To enforce bans on tobacco advertising, promotion and sponsorship | |
| **Strategy 9**: Enact and enforce effective legislation banning all forms of direct tobacco marketing | 100% ban of direct tobacco advertisement, promotion and sponsorship by 2020 |
| **Strategy 10**: Enact and enforce effective legislation to ban indirect tobacco advertising, promotion and sponsorship | 95% ban of in direct tobacco advertisement, promotion and sponsorship by 2025 |
| Strategic Objective 5: To discourage demand for tobacco products through price and tax increase measures | |
| **Strategy 11**: Increase and adjust periodically tax rates for tobacco products | FCTC compliant tax increment measures by 2020 |
| Strategic Objective 6: To reduce supply of tobacco products | |
| **Strategy 12**: Curb illicit trade in tobacco products | Ratification of the protocol for the elimination of tobacco illicit trade 2019 |
| | 50% Illicit tobacco trade will be curbed from (41%) |

| Strategic Objectives and Strategies | Targets |
|---|---|
| | |
| | by 2020 |
| | 100% Standard label marking and tax stamping of unit package of tobacco product enforced by June 2020 |
| **Strategy 13:** Ban sale of duty-free tobacco products | 100% duty-free tobacco product ban by June 2020 |
| **Strategy 14**: Ban sale of tobacco to and by minors by 2025 | 100% ban of tobacco product sale to and by minors by 2020 |
| | 100 % prohibition of the sale of tobacco in single sticks |
| **Strategy 15**: Design and support alternative livelihoods to tobacco | 50% of target groups reached for awareness of alternative livelihood activities to tobacco production and imparted by June 2020 |
| | Policy measure in support of alternative livelihood scheme for people engaged in tobacco cultivation and sale by minors. |
| Strategic objective 7: To promote partnership and coordination for sustained tobacco control | |
| **Strategies: 16.** Establish a national and regional coordination mechanism | Strengthened national coordination Committee<br>Established 11 regional and city administration coordination Committee |
| **Strategy 17:** Mainstreaming of tobacco control and strengthening networking | 30% of key stakeholders will actively implement tobacco control activities |
| Strategic Objective 8: Integrated communication | |
| **Strategy 18:** Promote engagement of communities in | Increased community and stakeholder ownership of |

| Strategic Objectives and Strategies | Targets |
|---|---|
| the control of tobacco | tobacco control |
| **Strategy 19:** Children and Adolescent tobacco awareness raising programs | 30% school-based tobacco awareness program by 2020<br>20% out of school awareness program by 2020 |
| **Strategy 20**: Advocating for increased political commitment, support and resource mobilization | Increased political ownership of tobacco control at federal, regional and district levels |
| **Strategy 21**: Development of integrated tobacco control database and networking | 100% tobacco control activities will be reported and networked |
| Strategic Objective 9: To strengthen to generate evidence through research | |
| **Strategy 22:** Establish and strengthen tobacco surveillance system | 1 GYTS will be conducted |
| | 2 other studies on tobacco control |
| | Establishment of Federal and Regional Tobacco surveillance system by 2020 |
| **Strategy 23:** Dissemination and use of findings of generated evidence | 100% of evidence will be used for improvement of tobacco control |

Chapter Five: Institutional Framework

# Roles of the Key Stakeholders in Tobacco Control

Effective implementation of this multi-sectoral strategy of tobacco control requires defining the role of the key stakeholders that should emanate from this multi-sectoral strategic plan and the relevant mandate of each stakeholder. The major roles of the key stakeholders are summarized as shown below. Stakeholder should mainstream their roles and responsibilities with the multi-sectoral strategic plan for control of tobacco, plan, allocate and mobilize budget, establish or assign unit or focal person and undertake monitoring of the implementation of their plan.

## Parliament, Council of Ministers and Regional Governments

These high level political leaders are responsible for FCTC ratification, formulation of tobacco control policy, promulgation of proclamation, and regulations for control of tobacco, overseeing and evaluation enforcement and implementation of the WHO-FCTC, national legal frameworks and policy and this strategic plan at federal, regional and district level. They should also ensure allocation of adequate budget and implementation of the WHO-FCTC by different stakeholders as cross-cutting issues.

## Communities

Community should participate, engage, and own tobacco control. They should also free themselves from tobacco use and exposure. The key stakeholders should mobilize community against tobacco through various behavioral change communication and involvement in planning, implementing, monitoring and evaluation of tobacco control.

## FMHACA and Its Regional Counterparts

The Ethiopian Food, Medicine and Health Care Administration and Control Authority is legally responsible for regulating the manufacture, import, export, distribution, use, content, information disclosure, packaging and labeling-health warning, advertisement, promotion and sponsorship of tobacco. It is also legally mandated as a focal office for coordination of the multi-sectoral implementation of the FCTC by different stakeholders through development and mainstreaming of a multi-sectoral strategic plan, including implementation and monitoring and evaluation jointly with different stakeholders. It will also service as information center for tobacco. It should generate and collect evidence on tobacco, grave consequences, implementation and impact of interventions on tobacco control.

The regional health regulatory counterparts in collaboration with woreda regulatory bodies are also mandated to control and monitor the enforcement of the various demand and supply reduction provisions of tobacco control mainly controlling tobacco-free public and work places, and public conveyance , proper packaging and labeling-health warning, sale of tobacco that meets WHO-FCTC requirement, protecting minors from tobacco, advertisement sponsorship and promotion, illegal trade of tobacco, etc. in their catchment areas. They are also responsible for coordinating multi-sectoral implementation of the FCTC at their level.

## Ministry of Health and Regional Health Bureaus

The health and health services are the most affected sector by tobacco use. MOH and Regional Health Bureaus (RHBs) are responsible for the provision of quality promotive, preventive and basic curative and rehabilitative health services. The MOH and RHBs are the major stakeholders responsible for implementation of the FCTC, especially in tobacco dependence secession; generate evidence on effect of tobacco on health, especially on NCD and health services; health education on tobacco in health institutions; educating, advocacy and monitoring of tobacco-free households through health extension workers and HADs; advocacy and monitoring of tobacco-free health institutions and health offices; and inter-sectoral collaboration with different stakeholders in the control of tobacco.

## Research institutes

Central Statistic Agency (CSA), Ethiopian Public Health Institutes (EPHI), academia, universities, health professional associations, social and economic research institutes and other research institutes as well as line ministries, agencies and their regional counterparts should generate evidence on prevalence and effect of tobacco on health especially on NCD and health services as well as its devastating effects on social and economy. They should also generate evidence on the implementation of the major demand and supply reduction provisions of WHO-FCTC as well as the out-come and impact of the interventions.

## Ministry of science and technology

The ministry should consider tobacco and its control as one of research priority area as it is a predominate health, social and economic risk factor affecting all segment population of Ethiopia. The ministry therefore should encourage research on tobacco through allocation of adequate fund and disseminating findings of such researches.

## Ministry of Education and Regional Education Bureaus

Ministry of education and regional education bureaus are responsible for provision and regulating quality of education of the country in public and private pre-primary, primary, secondary and tertiary schools, universities, colleges and others. Ministry of Education and its regional education bureaus are the major stakeholders in ensuring effective implementation of WHO-FCTC in both public and private schools especially in addressing of more than 27 million

students and school communities that are prone to tobacco exposure and its devastating effects. They should educating the students and teaching institutions staffs about tobacco and its devastating effects; inclusion of tobacco and its devastating effect in curricular and extracurricular activities; advocacy and monitoring tobacco-free Schools, universities and colleges and education offices; generate evidence on the prevalence of tobacco in the education sector; develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of culture and tourism and Its Regional Counterparts

The Ministry of Culture and Tourism is the part of the Government of Ethiopia responsible for developing and promoting the tourist products of Ethiopia both inside the country and internationally. In doing so the Ministry closely works together with different national and jj.

It publicizes the country's resources of tourist attractions and encourages the development of tourist facilities. It also licenses and supervises establishments of tourist facilities such as hotels, restaurants and tour operators, and sets the standards for them.

The ministry and its regional counterparts shall be responsible in the monitoring and enforcement of tobacco-free hotels, restaurants, tour operators and tour offices. It should also disseminate information on tobacco devastating health, social and economic consequences to national and international tour communities. The Ministry and its regional counterparts as major stakeholders should collaboratively work with EFMHACA, MOT, ECRA and their regional counterparts in tobacco control. They should develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of Women and children and Its Regional Counterparts

The Ministry and its regional counterparts are responsible to safeguard the right of children and women including protecting them from harmful habits such as substance of abuse, tobacco, Khat, alcohol and others. They are the major stakeholders in effective implementation of WHO-FCTC especially addressing the children and women in and out of schools in collaboration with federal and regional youth and women associations. They should collaboratively work with MOE,

MOH, EFMHACA, MOLSA, agencies and regional counterparts, youth and women associations in educating on tobacco and its grave consequences; advocacy and monitoring protecting minors, youth and women from tobacco; advocacy and monitoring of tobacco-free public and workplaces. The ministry and its regional counterparts monitor the enforcement of prohibition of sale of tobacco by and to minors and collaboratively work in the development and implementation of strategy for alternative development for minors involved in tobacco sale to make their livelihood. They should develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of transport and Its Regional Counterparts

The ministry and its regional counterparts are the major stakeholders in implementation of WHO-FCTC especially in the transport sector. The Ministry and its regional counterparts should play major role in advocacy and monitoring and enforcement of tobacco-free public conveyances including air-plane, train, car, other transportation services and stations as well as their offices. They should also include tobacco and its grave consequence in the driving licensing training curriculum; educating drivers and passengers on tobacco through various means; and collaboratively working with EFMHACA, line ministries, and agencies and their regional counterparts on tobacco control. They should develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of labor and social affairs (MOLSA) and Its Regional Counterparts

The ministry and its regional states counterparts are legally mandated to ensure workplace safety. They can play advocacy and monitoring and enforcement role to ensure tobacco-free public and private workplaces; they should collaboratively work with ministry of public service and human resource development and line ministries, agencies and regional counterparts in the implementation of WHO-FCTC in public and private workplaces. They develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of Public Service & its regional counterparts

The Ministry and its regional counterpart are legally mandated to ensure efficiency and effectiveness of civil servants as well as workplace safety. They can play advocacy and

monitoring and enforcement role to ensure tobacco-free government workplaces. They should collaboratively work with EFMHACA, line ministries, agencies and their regional counterparts in the capacity building and implementation of WHO-FCTC especially in government workplaces. The ministry and its regional counterparts should ensure mainstreaming of tobacco control especially tobacco-free workplace by the safety officer in line ministries and agencies and their regional counterparts. It should collaboratively work with ministry of labor and social affairs especially in ensuring tobacco-free public and private workplaces.

The ministry of public service and human resources development and MOLSA should ensure assignment of human resources to handle tobacco control activities and mainstreaming of tobacco control in public and private workplaces. They should develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ethiopian Revenue and Customs Authority (ERCA)

ERCA is legally mandated for control of import and export, collection of tax, and illegal trade of tobacco. Hence ECRA is major stakeholder in the implementation of illegal trade control including smuggling and counterfeiting of tobacco. It is expected that ERCA will support ratification of the WHO protocol for elimination of tobacco illicit trade. Other roles that the authority will play a role include enforcement of current taxation and ban of duty-free sell of tobacco; advocacy and monitoring tobacco-free ERCA offices and ports of entry and exit; collaboratively working with EFMHACA, Federal Police Commission, Ministry of Trade, Ministry of Finance and Economic Cooperation, and other line ministries and their regional counterparts in the control of tobacco. ERCA should establish and implement incentive measures on curbing illicit trade in tobacco products for those providing information and tackling smugglers. The Authority should develop and implement strategic intervention and monitor and evaluate the effect of the intervention.

## Ministry of Trade and Its Regional Counterparts

Ministry of Trade and its regional counterparts are responsible for the registration and licensing of tobacco manufacturing, import, export and distribution trade after getting a special permit from the appropriate organ. Hence they are the major stakeholder in the control of illegal tobacco

trade, including manufacturing, import, export, wholesale and retail of tobacco products without special permit as well as control of smuggling and counterfeiting of tobacco products. The Ministry and its regional counterparts should discourage investment in tobacco plantation and manufacturing of tobacco products. They should collaboratively work with EFMHACA, FPC, ERCA and their regional counterparts in the implementation, monitoring and evaluation of the Muliti-sectoral strategic plan for tobacco control, especially in the enforcement and advocacy of the legal frameworks and WHO-FCTC. They should advocate and monitor tobacco smoke-free public places, trade houses and Ministry of Trade and regional counterpart offices.

The Ethiopian Consumer Protection Agency under the ministry should advocate and monitor tobacco-free trade public places, marketing of tobacco products, including health warning, ban of direct and indirect advertisement, promotion and sponsorship and related tobacco control activities as per the WHO-FCTC. The agency should collaboratively work with EFMHACA, line ministries, agencies and regional counterparts in mobilizing the general public in the control of tobacco.

## Ministry of Agriculture and Natural Resource and Its Regional Counterparts

Thirty percent of the country's tobacco leaf supply is obtained from a farm in Shewarobit in the Amhara Regional State, and three other farms in Hawassa, Wolayeta and Belate in the Southern Regional State; the remaining 70% is imported. The country imported 72tns of tobacco for 220,752 dollars in the 2011/12 fiscal year, mainly from Brazil and India. Implementation of the convention in the long run is expected to result in reduction of consumption of tobacco which may in turn affect the economy of the growers.

Hence the Ministry and its regional state counterparts need to advocate for evidence-based alternative development for tobacco growers and workers; educating of households/ communities using Agricultural Extension Workers in collaboration with HEW and Community Development Army; Advocacy and Monitoring of tobacco-free agricultural offices and commercial farming sites. The Ministry and its regional counterparts should collaboratively work with line ministries, especially with MOH, MOI, EFMHACA and their regional counterparts in the implementation

of WHO-FCTC, especially in the agricultural sector to seek alternative development options for tobacco growers.

Alternative development is aimed to ensure provision of support for economically viable alternative livelihoods to tobacco workers, growers, and even individual sellers and to protect them from an eventual loss of their livelihood from tobacco in the future. The Ministry should scale down and then phase out tobacco plantation with food security productivity, cash crops or discourage tobacco plantation with tight regulations and implementation alternatively development strategy.

## Ministry of Environment, Forest and Climate Change

The ministry and its regional counterparts are the key stakeholders in the control and prevention of negative environmental impacts of tobacco plantation, processing and manufacturing. They are the ones that should undertake regular environmental impact assessment and take appropriate corrective measures. They should also work with the Ministry of Agriculture and Natural Resource, Investment Agency and others in the development of alternative development for the tobacco growers.

## Ministry of Finance and Economic Cooperation and Its Regional Counterparts

The Ministry and its regional counterparts should regularly review increment of high tax on tobacco raw and finished products and ensure enforcement of tax, ban of duty-free sales of tobacco and ban discount sales. As such the Ministry is expected to collaboratively work with partners such as WHO to assess compliance of the tobacco tax levied to ensure that it meets the public health objectives as enshrined in the WHO FCTC. The ministry and its regional counterparts should play vital roles in advocacy, monitoring and enforcement of tobacco-free policies in sectoral offices. They should also allocate and mobilize and prioritize financial resources for the implementation of multi-sectoral strategy for tobacco control at all levels. The ministry should advice the government to withdraw from tobacco plantation and manufacturing.

The Ministry and its regional counterparts should ensure sustainable tobacco fund for effective control of tobacco.

They should collaboratively work with line ministries, and agencies and their regional counterparts in the implementation, monitoring and evaluation of multi-sectoral strategic plan for tobacco control.

## Federal Police Commission and its Regional Counterparts

The Federal Policy Commission and its regional counterparts are responsible for the controlling illicit tobacco trade, including manufacture, import and distribution without special permit from the appropriate organ, counterfeiting, adulteration, and smuggling. They should also work in the advocacy and training on tobacco, its devastating health, social and economic effects, legal frameworks and FCTC for the uniformed and civil staff working in the sector. They should also play vital roles in advocacy, monitoring and enforcement of tobacco-free sectoral offices, police stations, correctional centers. They should collaboratively work with EFMHACA, MOJ, ERCA and their regional counterparts in the implementation, monitoring and evaluation of the Muliti-sectoral strategic plan for tobacco control, especially in the enforcement and advocacy of the legal frameworks and FCTC.

## Federal Attorney General

The Attorney General is responsible in advising all legal matters which pertinent to tobacco control; it has also responsibilities to assist in the preparation of draft laws helping to implement the Framework convention on Tobacco Control (FCTC) and other relevant laws as required by EFMHACA, based on its power and duty. It is responsible to create legal awareness and conduct training through the use of various methods with the view to raising public consciousness and capacity building training in relation to the reduction of demand and supply of tobacco. Within its power and duties, in collaboration with EFMHACA and appropriate organs, the ministry is also responsible for the implementation of FCTC and other relevant laws applicable to control tobacco.

The Attorney should also play a vital role in advocacy, monitoring and enforcement of tobacco-free federal and regional sectoral offices.

## Civil Societies

Civil societies, which are free from conflict of interest, include various professional associations, associations of segments of communities, including Ethiopian Youth Women, Ethiopian Cancer Society, Asthmatic Patients Association, etc. Maximum efforts should be made to use such potential to reach to the community. The civil societies can play vital roles as activists in advocacy, promotion and implementation of the various strategies and legislation for control of tobacco as per the WHO-FCTC. They can support and positively advice the government of Ethiopia in the development of various tobacco-related policy, strategies and legal frameworks and promotion and implementation of the same.

Civil societies should build public support for compliance with the law, hold government accountable for failing to strictly enforce the law; monitor the tobacco industry and expose its deceptions as it opposes and seeks to undermine the law; and document the success of the law and sharing lessons learned with tobacco control advocates worldwide.

## Ministry of Youth and Sports and Its Regional Counterparts

The ministry and its regional are responsible for the expansion and development of sports and protection of youth from harmful habits are one of the major stakeholders in the implementation of tobacco control as per the WHO-FCTC. The ministry and its regional counterparts shall be responsible for the advocacy, monitoring and enforcement of tobacco-free sports and youth recreational places. They should collaboratively work with MOE, MOCT, MOH, EFMHACA, MOLSA, agencies and regional counterparts, youth associations in educating on tobacco and its grave consequences; advocacy and monitoring protecting minors, youth and adults from tobacco; and control advertisement, promotion and sponsorship of tobacco in sports. The Ministry and its regional counterparts should have strong linkage with tobacco cessation centers in order to ensure access to such services by the youth.

## Ministry of Federal and Pastoralists Development Affairs

The Ministry is established to bring equitable development in the less developed regions, to prevent and resolve conflicts, strengthen the federal system, uphold good federal-regional relations in the country. It is responsible for the administration of correctional centers. It can play advocacy and monitoring roles in creating tobacco-free correctional centers. It should collaboratively work with line ministries, agencies and their regional counterparts in capacity building and implementation of FCTC, especially in correctional centers and related offices and designing tobacco control intervention in pastoralist community.

## Ministry of Defense

The Ministry is one of the key stakeholders in advocacy, monitoring and enforcement of tobacco-free military, military training centers, schools and offices. The Ministry should collaboratively work with EFMHACA and MOH in the educating the army and civil staff in the defense sector on tobacco and its grave health, social and economic consequences. The ministry should also include the devastating effects of tobacco in the training curriculum of the military and undertake study and research on prevalence of tobacco and impact of the tobacco control intervention.

## Ministry of Government Communication Affairs Office & Its Regional Counterparts

The ministry and its regional counterpart should play sustained, effective, highly visible role in the dissemination of anti-tobacco messages and media campaigns role in order to raise community awareness of devastating effects of tobacco on health, social and economy, the various demand, supply and harm reduction using tobacco control strategies. They should provide free media coverage for tobacco control activities, new research findings and development in tobacco control. They should collaboratively work with EFMHACA, line ministries, agencies, civic societies and their regional counterparts in the dissemination of information and communication on tobacco, monitoring of direct and indirect advertisement, promotion and sponsorship and other related issues. They should advocate and monitor and enforce tobacco-free workplaces.

In addition to monitoring, in collaboration with EFMHACA the ministry shall organize training and workshops for journalists on new scientific findings, data and reporting tobacco-related news and stories.

**Ethio-telecom**

Currently quite significant proportion of Ethiopians has access to mobile cell phone which can also be used to inform and educate the public on tobacco-related issues. The Ethiopian Telecom is one of the key stakeholders in the mobilization of the community against tobacco and controlling of electronic marketing, advertisement, promotion and sponsorship of tobacco. It should also provide SMS, voice message delivery and other mobile services at an affordable price or free in the fight against tobacco. Ethio-telecom should work in close collaboration with Information, Network and Security Agency (INSA) in the control of electronic marketing, advertisement and sponsorship. Moreover, the organization can monitor tobacco-free working office*s*.

**Faith-based organizations (FBOs) and community leaders**

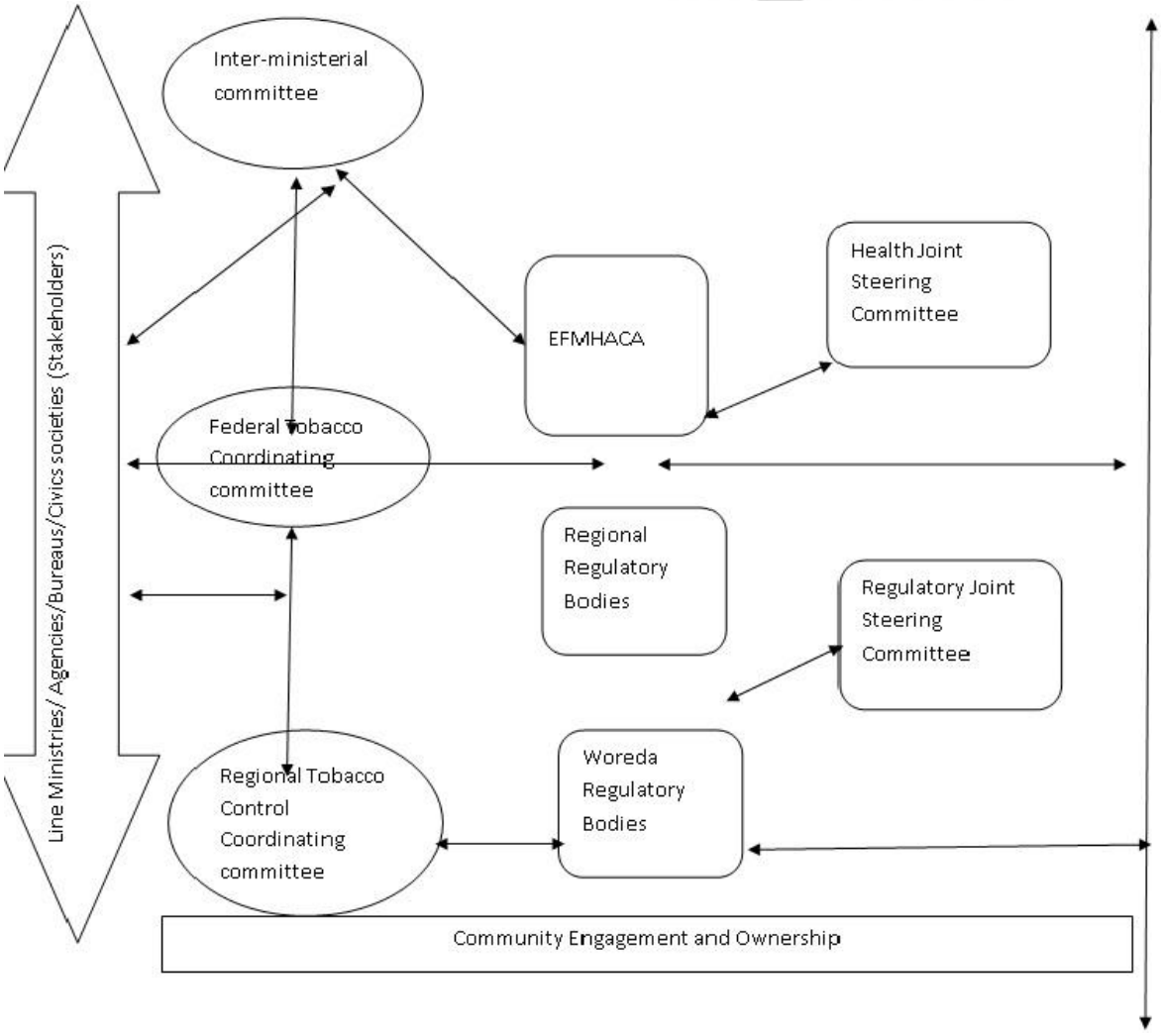
FBOs and community leaders should be active in mobilizing communities against tobacco through increasing awareness creation on tobacco and its grave consequences. They can also play an active role in the control of tobacco. They should collaboratively work with EFMHACA, MOH, FPC, MOE, MOWV, others and their regional counterparts in the control of tobacco. Faith-based organizations and community leaders can actively involve in and contribute to tobacco cessation program, especially through counseling.

## Non-Governmental Organizations (NGOs)

The role that NGOs in Ethiopia play and contribute to the improvement of health and social development is widely acknowledged. In addition to the leading role in the planning and implementation of the tobacco control strategic plan with respect to specific articles by sector ministries with respect specific WHO FCTC articles, mapping of NGOs who can contribute to the strategic plan need to be made and efforts to create strong partnership through advocacy deemed necessary.

## Institutional arrangement for ensuring implementation of tobacco control

Emphasizing that tobacco use is a multi-sectoral problem which calls for multi-sectoral cooperation, and coordinating structure that will serve as an umbrella body for coordination of the roles and responsibilities of all stakeholders, framing institutions to fight tobacco use is very important.




The tobacco control governance should be developed within the context and framework of the political system in the Federal Democratic Republic of Ethiopia with involvement of key stakeholders, including development partners, civic societies, etc. This institutional arrangement/ organizational structure will be used to jointly oversee, monitor and evaluate implementation of the strategic plan and its effects as per the WHO-FCTC.

Noting the seriousness of the tobacco use problems and the need of concerted efforts, federal and regional tobacco control coordinating bodies and committees should be established and strengthened to ensure multi-sectoral enforcement of tobacco control and to oversee and give advice to the government on the national tobacco control issues.

## Strengthening Federal and Regional Tobacco control coordinating agencies

FMHACA and Regional Regulatory Bodies are legally mandated to enforce and coordinate tobacco control activities as per the WHO-FCTC and the legal framework. These organizations need to be strengthened comprehensively in the areas of organization, staffing, logistics and ICT to adequately discharge their coordinating and enforcement role.

## Inter-ministerial committee

The existing inter-ministerial committee for the control of substance of abuse will also oversee the overall implementation of the FCTC in the country and approve the strategic plan and give direction for its implementation and resource mobilization.

## Federal and Regional Tobacco Control Coordination Committees (NCTC)

In view of the existing tobacco use problems, a nationally coordinated effort on both the demand and the supply reduction strategies are much needed. Interventions to combat illicit trade and tobacco use require broad participation and ownership of all government institutions, Non-Governmental Organizations, the business sector and civil societies. This should be complemented by action to broaden international, national and regional cooperation. Global experience shows that tobacco control is a multi-sectoral problem which calls for a multi-sectoral cooperation.

For this reason, federal and regional /city administration council Tobacco Control Coordination Committees should be established and strengthened. These committees whose coordinating structure will serve as an umbrella body for coordination of the roles and responsibilities of all stake holders (Annex I), should include all role-players in the fields of prevention and treatment, education, community action, legislation and law enforcement and policy making. It serves as a

consultative body on tobacco issues of federal and regional concern and makes recommendations to push forward the tobacco agenda at national and regional levels.

Action to fight tobacco use requires well-framed broad participation by all spheres of government, Non-Governmental Organizations, the business sector and civil societies.

This should be complemented by action to broaden regional cooperation between regional governments.

As mentioned above, the institutional framework works in such a way that all the stakeholders should prioritize and make a commitment to fight the use of tobacco. All the organizations that are part of the national coordination committee and other concerned organizations should put in place a system to tackle tobacco and give attentive measures on decreasing the supply, demand and harm reduction strategies. Even though the Ethiopian Food, Medicine and Healthcare Administration and Control Authority has the power to coordinate the implementation of the FCTC, it is important to note that each organization should work towards the reduction of the tobacco use based on the mandates given by the government. Nobody should have the interference on the normal mandates given by their respective legislations.

# Chapter Six Human resources Analysis

The human resources required for coordination and implementation of this multi-sectoral strategic plan for control of tobacco as per the WHO-FCTC are estimated as shown below.

EFMHACA and Regional counterparts along with their woreda (district) and kebele (sub-district) should play enforcement and coordination roles. Key stakeholders, including line ministries and agencies and their regional counterparts, civic societies, health institutions and teaching institutions, public conveyance, etc. should have appropriate staffing for proper implementation of the strategic plan.

**EFMHACA:** is responsible for enforcement and coordination of the implementation of the WHO-FCTC and the strategic plan at country level. Currently EFMHACA is enforcing tobacco control in the country in an integrated manner through its existing structure. The advocacy and coordination of multi-sectoral implementation of the WHO-FCTC is done in collaboration with different stakeholders through the legal preparation and medico-legal directorate using experts from information development and dissemination team. These experts are not dedicated only to tobacco control. Hence this multi-sectoral strategic plan on tobacco control requires a dedicated unit staffed with 5-7 experts of different professional mix which may include addiction psychologists, psychiatric nurses, health officers/medical doctors, pharmacists, monitoring and evaluation experts, environmental health professionals and others for coordination and monitoring and evaluation of its implementation. At EFMHACA branch office a focal expert for coordinating and liaising with regional regulatory bodies should be assigned.

**Regional State and City Administration Council regulatory body:** the 11 regional states and city administration councils are responsible for the enforcement and coordination of the WHO-FCTC and so the strategic plan in their respective setup. Currently tobacco control enforcement and coordination at regional states and city administration councils are at varying levels that requires strengthening and capacity building. As in the case of EFMHACA, the enforcement of tobacco control could be integrated with the existing structure at regional states and city administration councils as well as the woreda (district) level.

Advocacy and coordination of multi-sectoral implementation of this strategic plan for tobacco control as per WHO-FCTC at regional state and city administration council levels requires creating a dedicated unit of 2-3 experts with different professional backgrounds that may include psychiatric nurses, health officers/medical doctors, pharmacists, or environmental health professionals.

**Woreda regulatory bodies:** the district regulatory bodies in the 9 regional states and 2 city administration councils are responsible for the enforcement and coordination of the WHO-FCTC and this strategic plan in their respective districts. The woreda/district regulatory bodies should be responsible for the enforcement of tobacco control and they should work in close collaboration with kebele/sub-district and others enforcement bodies. The enforcement of tobacco control could be integrated with other enforcement regulatory activities at woreda regulatory body levels.

At a woreda regulatory level, a focal expert (health officer, environmental health personnel, nurse or pharmacy personnel) should be assigned for advocacy and coordination of multi-sectoral implementation of this strategic plan for tobacco control as per WHO-FCTC. The district regulatory body should also work in close collaboration with NCD coordinating program at woreda level.

**Line ministries, agencies and regional counterparts:**

Depending on the expected volume of work in the control of tobacco as per the strategic plan for tobacco control and WHO-FCTC line ministries, agencies and regional counterparts should establish a unit or assign a focal person for the implementation of this strategic plan.

**Ministry of health and regional health bureaus** could integrate tobacco control as per the WHO-FCTC into the concerned structure responsible for health promotion and prevention and control of NCD and health extension program.

**Ministry of public services and Ministry of labor and Social Affairs:**

These ministries and their regional counterparts should have a structure with necessary staff for advocacy and monitoring tobacco-free public and private workplaces. This could be integrated with workplace health and safety monitoring activities.

**Ministry of Education and Regional Education Bureaus:** These ministries and their regional counterparts should have a structure with necessary staff for advocacy and monitoring tobacco-free initiatives that also include tobacco free schools, colleges and universities and ensuring inclusion of tobacco in the curricula and extra-curricular activities. The ministry and regional education bureaus could establish a unit or integrate the tobacco control-related activities into units or sections dealing with substance abuse and other health-related problems affecting quality of education in schools, universities and colleges.

**Ministry of transport and its regional counterparts:** the ministry and its regional counterparts, being responsible for monitoring of tobacco-free public conveyance and incorporating tobacco use into driving license curricula, should create a focal unit or integrate the tobacco-related activities into units or sections dealing with control of substance of abuse and related substances affecting safety of driving and public conveyance.

**Ministry of culture and tourism and Its Regional Counterparts:** the ministry and its regional counterparts responsible for control and monitoring tobacco-free entertainments, hotels, bars, tourist destinations, etc. should create a focal point or integrate the tobacco-related activities into units or sections dealing with licensing and inspection of relevant processes.

**Other ministries, agencies and regional counterparts:** These ministries, agencies and their regional counterparts should assign focal person, workplace health and safety experts, to advocate and monitor tobacco-free workplaces and educate their staff on tobacco control.

**Health institutions:** Provision of tobacco cessation services in health institutions could be integrated with other health services such as drug dependence treatment. Health institutions such as hospitals, health centers, and different level private health institutions should assign focal environmental health professional(s) or other(s) for monitoring tobacco-free health institutions and conducting and coordinating tobacco education as part of health education. Tobacco control should be incorporated into the health extension program.

**Schools:** primary, secondary and tertiary schools should create and monitor tobacco-free compounds and educate students and other school community members on the harmful effects of

tobacco products. Each school should assign a focal person for coordinating tobacco control in the school. Tobacco-free clubs as part drug-free clubs could also be used for control of tobacco.

In general tobacco control is a cross-cutting issue negatively affecting the health, social and economic wellbeing of communities. Tobacco control should be given priority and depending of the roles that should be played by each stakeholder an appropriate unit staffed with the necessary professional mix and/ or assigned focal person should be used for effective implementation of tobacco control.

# Chapter Seven: Monitoring and Evaluation

The objectives of monitoring and evaluation are to measure progress of implementation, outcome and impact of the strategic plan and evaluate its effectiveness and learn lessons for sustainable tobacco control implementation and outcomes.

The capacity of the different stakeholders at federal, regional and district levels should be built in monitoring and evaluation of tobacco control. Monitoring and Evaluation remains imperative to continuously and consistently improve the effectiveness of tobacco control related communication. Key indicators of tobacco control should to be identified to collect and analyze data for continued improvement in the implementation and achievement of the multi-sectoral strategic plan. Certain Indicators such as brief intervention, tobacco cessation services need to be identified and incorporated into the HMIS and other indicators will be incorporated into the health regulator information system.

On the basis of the input and process, output, outcome and impact indicators (see table 6), information related to the implementation and achievements as well as outcome and impact of the intervention on tobacco control need to be collected following the Monitoring and Evaluation framework.

Regular report on the implementation of the strategy for control of tobacco by key stakeholders should be sent to EFMHACA and regional counterparts depending on the level of implementation. Such reports need to be summarized and analyzed at regional and federal levels. Such reports and achievement need to be verified by integrated supportive supervision, survey and surveillance and evaluation.

Quarterly and annual multi-sectoral regular review meetings on the implementation and achievement of tobacco control should be held at regional and federal levels.

Multi-sectoral mid-term and terminal evaluation for the assessment of outcomes and impact of the implementation of the strategic plan should be undertaken.

Monitoring and Evaluation findings and recommendations should be used for better implementation and achievement of the convention. The list of key of inputs, processes, outputs,

outcomes and impact indicators included in the Monitoring and Evaluation framework, together with their baseline and target in the strategic plan period, is presented in the matrix below. The matrix presents strategic objectives including strategies under each objective, indicator, and means of verification, budget, responsibility and time frame.

## *Table3:- Strategic objectives, strategies, targets and indicators for tobacco control*

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| ***Strategic Objective 1: To protect people and environment from tobacco*** | | | | | | | | | | | | |
| **Strategy 1**: sensitize, familiarize and advocate for enforcement of laws<br>**Strategy 2:** Enact and enforce completely smoke-free environments | 100% of smoke-free indoor public place, work place and public transports by 2020 | | Outcome | Percentage of indoor public places free from tobacco smoke | 25 | 85 | 100 | | | | | Survey and reports |
| **Strategy3:** Protect the environment and persons from hazards of tobacco | 30% public awareness and knowledge enhanced from the baseline by 2020 | | Output | Number of awareness campaigns | 10 | 20 | 30 | | | | | Reports |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| cultivation and manufacturing | Policy measures to limit and reduce government involvement in tobacco plant cultivation and production by 2020. | 0 | Output | Number of policy document | | | 1 | | | | | Document |
| **Strategic objective 2:** ***To reduce the number of people using tobacco by helping users to quit*** | | | | | | | | | | | | |
| ***Strategy4:*** Promote creation of supportive environment | Establish one national toll-free quit line by 2020 | **0** | **Output** | Number of quite lines | | | 1 | | | | | Survey and reports |
| **Strategy 5:** Increase access to cessation services | Integrate brief intervention at 30% Primary Health Care Unit (PHCU) by 2020 | **0** | **Outcome** | Number of PHCU providing integrated brief interventions | **05** | **20** | **30** | | | | | |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| | Establish 9 CBT and 4 NRT tobacco cessation and rehabilitation centers at | **1** | | number of tobacco cessation and rehabilitation centers with CBT | **1** | **6** | **9** | | | | | |
| | General and Specialized Hospitals | | | number of tobacco cessation and rehabilitation centers with NRT | **1** | **3** | **4** | | | | | |
| **Strategic Objective 3: To warn about the dangers of tobacco smoking** | | | | | | | | | | | | |
| **Strategy 6:** *Ensur*e effective pack warning labels | 100% of tobacco packs with the required health warning labels by 2019 | **0** | **Outcome** | Percentage of tobacco packs with the required health warning | | | **100** | | | | | **Survey and reports** |
| | | **0** | **Outcome** | Percentage of tobacco packs with plain package | | | | | | | | |
| ***Strategy 7:*** Implement counter-advertising | **100**% counter-advertising campaigns | **0** | **Output** | Number of counter-advertising | | | **100** | | | | | **Reports** |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| campaigns | **100%** | | | campaigns conducted | | | | | | | | |
| **Strategy 8:** Disclose ingredients of tobacco products | 100% of disclosure of ingredients of tobacco products marketed in the country by 2020 | **0** | **Output** | Number of independent analytical reports providing chemical ingredients of tobacco products | | | **100** | | | | | **Reports** |
| **Strategic objective 4:** ***To enforce bans on tobacco advertising, promotion and sponsorship*** | | | | | | | | | | | | |
| **Strategy 9**: Enact and enforce effective legislation banning on all forms of direct tobacco marketing | 100% ban on direct advertisement, promotion and sponsorship by 2020 | | Outcome | Percentage of ban on directive advertisement, sponsorship and promotion | | | 100 | | | | | Survey and reports |
| **Strategy 10:** Enact and enforce effective legislation to ban indirect tobacco advertising, promotion and sponsorship | 95% ban on indirect advertisement, promotion and sponsorship by 2020 | | Outcome | Percentage of ban on indirect advertisement, sponsorship and promotion | | | 100 | | | | | Survey and reports |
| ***Strategic Objective 5: To discourage demand for tobacco products through price and tax increase measures*** | | | | | | | | | | | | |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| **Strategy 11:** Increase and adjust tax rates for tobacco products | FCTC compliant tax increment measures by 2020 | **0** | **Outcome** | FCTC compliant tax increment | | | 100 | | | | | Survey and reports |
| **Strategic Objective 6 To reduce supply of tobacco products** | | | | | | | | | | | | |
| **Strategy 12**: Curb illicit trade in tobacco products | Ratification of the protocol for the elimination of tobacco illicit trade 2019<br>50% Illicit tobacco trade will be curbed by 2020 | | **Outcome** | Protocol ratification | | | 100 | | | | | Survey and report |
| | 100% Standard label marking and tax stamping of unit package of tobacco | **0** | | Percentage of unit packets and packages of tobacco products labelled | | | **100** | | | | | |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| | product enforced by June 2020 | | | appropriate as per requirements | | | | | | | | |
| **Strategy 13**: Ban sale of duty-free tobacco products | 100% duty-free tobacco product ban by June 2020 | **0** | **Output** | Number of dealers transformed from duty-free to non-duty-free tobacco dealers | | | **100** | | | | | **Survey and Report** |
| **Strategy 14**: Ban sale of tobacco to and by minors | 100% ban of tobacco product sale to and by minors by 2020 | **0** | **Outcome** | Percentage of ban on tobacco sales to and by minors by 2020 | | | **100** | | | | | |
| | 100 % prohibition sales of tobacco in single stick | **0** | **Outcome** | Proportion of shops that stopped selling tobacco in single stick | | | **100** | | | | | **Survey and Report** |
| **Strategy 15**: Support alternative livelihoods to tobacco | 50% of target groups reached for awareness of alternative | **0** | **Output** | Percentage of target groups with raised awareness | | **25** | 50 | | | | | **Survey and Reports** |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| | livelihood activities to tobacco production and imparted by June 2020 | | | | | | | | | | | |
| | Policy measure in support of alternative livelihood scheme for people engaged in tobacco cultivation and sale by minors. | **0** | **Output** | Number of policy measure | | | | | | **1** | | **Survey and Reports** |
| **Strategic objective 7: To** ***promote partnership and coordination for sustained tobacco control*** | | | | | | | | | | | | |
| **Strategies: 16.** Establish a national and regional coordination mechanism | Strengthened national coordination Committee | | **Outcome** | Strengthened national coordination Committees | 1 | | | | | | | **Survey and Reports** |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| | | | | | | | | | | | | |
| | Established 11 regional and city administration coordination Committee | | **Outcome** | Number of established coordination Committees | 1 | 6 | 11 | | | | | |
| **Strategy 17:** Mainstreaming of tobacco control and strengthening networking | 30% of key stakeholders will actively implement tobacco control activities | | | percentage of sectors office involved mainstreamed tobacco control activities | **10** | **20** | **30** | | | | | |
| ***Strategic Objective 8: Integrated communication*** | | | | | | | | | | | | |
| **Strategy 18:** Promoting | Increased community and | **0** | **Outcome** | Improvement of KAP and | | | | **1** | | | **1** | **Survey** |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| engagement of communities in the control of tobacco | stakeholders ownership of tobacco control | | | ownership of tobacco control | | | | | | | | |
| **Strategy 19:** Children and Adolescent tobacco awareness raising programs | 30% school-based tobacco awareness program by 2020 | | **Outcome** | Proportion of children and adolescents with knowledge of | 10 | 20 | 30 | | | | | **Survey and Reports** |
| | 20% out of school awareness program by 2020 | | | dangers of tobacco products and benefits of not using it | | 10 | 20 | | | | | |
| **Strategy 20**: Advocating for increased political commitment, support and resource mobilization | Increased Political ownership of tobacco control at federal, regional and district level | **0** | **Outcome** | Increased political ownership of tobacco control | * | * | * | | | | | Survey and Reports |
| **Strategy 21**: Development of integrated tobacco | **30**% tobacco control activities will | | Output | Percent of activities reported and | 10 | 20 | 30 | | | | | Reports |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| control database and networking | be reported and networked | | | networked | | | | | | | | |
| **Strategic objective 9:** ***To generate evidence through surveillance and research*** | | | | | | | | | | | | |
| **Strategy 22**: Establishing and strengthening tobacco surveillance systems | Establishment of federal and regional Tobacco surveillance system | 1 | Output | Monitor federal and regional surveillance systems | | | 1 | | | | | Reports |
| | | | Output | Presence of active tobacco control database for surveillance system at all levels | | | 1 | | | | | |
| | 1 Global Youth Tobacco Surveys | 0 | Out put | Number of GYTS | | | 1 | | | | | |
| | Other 3 studies | 0 | Output | Number of other studies | | 1 | 3 | | | | | |
| **Strategy 23**: Dissemination and use of findings of generated evidence | 100% of evidence will be used for improvement of tobacco | | Outcome | Percentage of generated evidence used for tobacco | 100% | 100% | 100% | 100% | 100% | 100% | 100% | Survey and reports |

| **Strategic Objective and Strategy** | **Measurement** | | | | | | | | | | | **Means of verification** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Target** | **Baseline** | **Indicator** | | **Yearly target** | | | | | | | |
| | | | **Type** | **Description** | **17/18** | **18/19** | **19/20** | | | | | |
| | control | | | control improvement | | | | | | | | |
| **Monitoring and evaluation** | | | | | | | | | | | | |
| • Development and promotion of implementation guidelines and standards | Development of implementation guidelines and standards | 0 | Output | Number of guidelines and standards developed | | | | | | | | Reports |
| • Integrated supportive supervision (ISS) | 2 Integrated Supportive Supervision (ISS) undertaken annually at all levels | 0 | Output | Number of ISS | 2 | 2 | 2 | | | | | Survey and reports |
| • Regular review meetings | 2 review meetings annually at federal and regional level | 0 | Output | Number of reviewing meetings | 2 | 2 | 2 | | | | | |
| • Midterm evaluation | One midterm evaluation | 0 | Output | Number of midterm evaluations | | | 1 | | | | | Reports |
| • Terminal evaluation | One terminal evaluation | 0 | | Number of terminal evaluations | | | | | | | 1 | Reports |

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Table 4:- NATIONAL TOBACCO CONTROL IMPLEMENTATION MATRIX

| | Measurement | | | | Responsible | Budget (US$ 1000) | Source of fund | **Time frame (2010-2012E.C) 2017 /18-2019/20** | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Objective and Strategy | Target | Indicator | | Means of verification | | | | **17/18** | **18/19** | **19/20** |
| | | Type | Description | | | | | | | |
| **Strategic Objective 1: To protect people and environment from tobacco** | | | | | | 200 | | | | |
| **Strategy 1**: sensitize, familiarize and advocate for enforcement of laws | 100% of smoke-free indoor public place, work place and public transports by 2020 | Outcome | Percentage of indoor public places free from tobacco smoke | Survey and reports | EFMHACA and Regional counterparts, Line ministries, agencies and regional counterparts | 100 | MOFEC/ Gov and development partners | X | X | X |
| **Strategy 2:** Enact and enforce completely smoke-free environments | | | Percentage of indoor work places free from tobacco smoke | | | 50 | | X | X | X |
| | | | Percentage of | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | public conveyance free from tobacco smoke | | | | | | | |
| **Strategy3:** Protect the environment and persons from hazards of tobacco cultivation and manufacturing | 80% public awareness and knowledge enhanced from the baseline by 2020 | Output | Number of awareness raising campaign | Reports | | 50 | | X | X | X |
| | Policy measures to limit and reduce government involvement in tobacco plant cultivation and production by 2020. | Output | Number of policy document | reports | | | | | | |
| Strategic objective 2: To reduce the number of people using tobacco by helping | | | | | | 800 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| users to quit | | | | | | | | | | |
| ***Strategy4:*** Promote creation of supportive environment | Establish national toll-free quit line by 2020 | Output | Number of quit line | Survey and reports | FMOH, RHBs and line ministries | 50 | | | | X |
| **Strategy 5:** Increase access to cessation services | Integrate brief intervention at 90% Primary Health Care Unit (PHCU) by 2020 | Output | Number of integrated PHCUs providing integrated brief interventions | | | 50 | | X | X | X |
| | Establish 27 CBT and 13 NRT tobacco cessation and rehabilitation centers at General and Specialized | Outcome | number of tobacco cessation and rehabilitation centers with CBT | | | 700 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Hospitals | | number of tobacco cessation and rehabilitation centers with NRT | | | | | | | |
| **Strategic Objective 3: To warn about the dangers of tobacco smoking** | | | | | | **400** | | | | |
| **Strategy 6:** *Ensur*e effective pack warning labels | 100% of tobacco packs with the required health warning labels by 2019 | Outcome | Percentage of tobacco packs with the required health warning<br>Percentage of tobacco packs with plain package | Survey and reports | EFMHACA,RRBs, in collaboration with stakeholders | 50 | | X | X | X |
| ***Strategy 7:*** Implement counter-advertising campaigns | **100** counter-advertising campaigns | Output | Number of counter-advertising campaigns conducted | Reports | FMHACA, EPHI and RRBs | 50 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategy 8:** Disclose ingredients of tobacco products | 100% of disclosure of ingredients of tobacco products marketed in the country by 2020 | Output | Number of independent analytical reports providing chemical ingredients of tobacco products | Reports | EFMHACA | 300 | | | X | X |
| Strategic objective 4: To enforce bans on tobacco advertising, promotion and sponsorship | | | | | | 50 | | | | |
| **Strategy 9**: Enact and enforce effective legislation bans on all forms of direct tobacco marketing | 100% ban on direct advertisement, promotion and sponsorship by 2020 | Outcome | Percentage of ban on direct advertisement, sponsorship and promotion | Survey and reports | EFMHACA, RRBs, | 20 | | X | X | X |
| **Strategy 10:** Enact and enforce effective legislation to ban | 100% ban on direct advertisement, promotion and sponsorship by | Outcome | Percentage of ban on indirect advertisement, sponsorship | Survey and reports | EFMHACA, RRBs, | 30 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| indirect tobacco advertising, promotion and sponsorship | 2020 | | and promotion | | | | | | | |
| **Strategic Objective 5: To discourage demand for tobacco products through price and tax increase measures** | | | | | | 50 | | | | |
| **Strategy 11:** Increase and adjust tax rates for tobacco products | FCTC compliant tax increment measures by 2020 | Outcome<br>Outcome | FCTC compliant tax increment | Survey and reports | MOFEC and regional counterparts | 50 | | X | X | X |
| Strategic Objective 6 To reduce supply of tobacco products | | | | | | 600 | | | | |
| **Strategy 12**: Curb illicit trade in tobacco products | Ratification of the protocol for the elimination of tobacco illicit trade 2019<br><br>50% Illicit tobacco trade will be curbed by 2020 | Outcome | Protocol ratification | Survey and Reports | EFMHACA, ERCA, MoT, MoJ police in collaboration with key stakeholders | 50 | | | X | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | Percentage of smuggled and counterfeit tobacco products impounded | | | | | | | X |
| | 100% Standard label marking and tax stamping of unit package of tobacco product enforced by June 2020 | | Percentage of unit packets and packages of tobacco products labelled appropriate as per requirements | | | | | X | X | X |
| **Strategy 13**: Ban sale of duty-free tobacco products | 100% duty-free tobacco product ban by June 2020 | Output | Number of dealers transformed from duty-free to non-duty-free tobacco dealers dealers | Report and surveys | MOFEC, ERCA and MoT | 20 | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategy 14**: Ban sale of tobacco to minors | 100% ban of tobacco product sale to and by minors by 2020 | Outcome | Percentage of ban on tobacco sales to and by minors by 2020 | | | 30 | | | X | X |
| | 100 % prohibition sales of tobacco in single stick | Outcome | Proportion of shops that stopped selling tobacco in single stick | Survey and reports | EFMHACA, MOT and police with relevant key stakeholders | | | | X | X |
| **Strategy 15**: Support alternative livelihoods to tobacco | 80% of target groups reached for awareness of alternative livelihood activities to tobacco production and imparted by June 2020 | Output | Percentage of target groups with raised awareness | Survey and Reports | MOH, MOA, MOFEC, and other key stakeholders | 500 | | | X | X |
| | Policy measure in support of alternative | Outcome | Percentage of target groups with access to | Survey and reports | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | livelihood scheme for people engaged in tobacco cultivation and sale by minors | | alternative livelihood. | | | | | | | |
| **Strategic objective 7: To promote partnership and coordination for sustained tobacco control** | | | | | | 1100 | | | | |
| **Strategies: 16.** Establish a national and regional coordination mechanism | Strengthened national coordination Committee | Outcome | Number of established coordination Committees | Survey and reports | All stakeholders | 100 | | X | X | X |
| | Established 11 regional and city administration coordination Committee | | | | | | | | | |
| **Strategy 17:** Mainstreaming of tobacco control and strengthening | 95% of key stakeholders will actively implement tobacco control activities | | percentage of sectors office involved mainstreamed | | | 1000 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| networking | | | tobacco control activities | | | | | | | |
| **Strategic Objective 8: Integrated communication** | | | | | | 2000 | | | | |
| **Strategy 18:** Promoting engagement of communities in the control of tobacco | Increased community and stakeholder ownership of tobacco control | Outcome | Improvement of KAP and ownership of tobacco control | Survey and reports | | 1200 | EFMHACA, and all stakeholders | X | X | X |
| **Strategy 19:** Children and Adolescent tobacco awareness raising programs | 90% school-based tobacco awareness program by 2020<br>60% out of school awareness program by 2020 | Outcome | Proportion of children and adolescents with knowledge of dangers of tobacco products and benefits of not using it | Survey and reports | EFMHACA, MOE, MOWC, Women and MOYS associations, and other stakeholders | 500 | | X | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategy 20**: Advocating for increased political commitment, support and resource mobilization | Increased political ownership of tobacco control at federal, regional and district levels | Outcome | Increased political ownership of tobacco control<br>FCTC compliant stringent Tobacco control proclamation | Survey and Reports | EFMHACA, MOH, MOLSA, MOWC,MOYS, Youth Association, Women Association | 150 | | X | X | X |
| **Strategy 21**: Development of integrated tobacco control database and networking | 100% tobacco control activities will be reported and networked | Output | Percent of activities reported and networked | Reports | All stakeholders | 150 | | X | X | X |
| **Strategic objective 9: To generate evidence through surveillance and research** | | | | | | ***600*** | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Strategy 22**: Establishing and strengthening of tobacco surveillance system | Establishment of federal and regional Tobacco surveillance systems | Output | Established federal and regional surveillance systems | Reports | | 500 | | X | X | X |
| | | | Presence of active tobacco control database for surveillance system at all levels | | | | | | | |
| | 1 Global Adult Tobacco Survey | Output | Number of GATS, undertaken | | | | | | | |
| | 2 Global Youth Tobacco Surveys | | Number of GYTS | | | | | | | |
| | Other 10 studies | | Number of other studies | | | | | | | |
| **Strategy 23**: | 90% of evidence | Outcome | Percentage of | Survey and | | 100 | | | X | X |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Dissemination and use of findings of generated evidence | will be used for improvement of tobacco control | | generated evidence used for tobacco control improvement | reports | | | | | | |
| **Monitoring and evaluation** | | | | | | 400 | | | | |
| Development and promotion of implementation guidelines and standards | Development of implementation guideline and standards | Output | Number of guidelines and standards developed | | EFMHACA, Regional counterparts and relevant stakeholders | 50 | | X | X | |
| Integrated supportive supervision (ISS) | 2 ISS undertaken annually at all levels | Output | Number of ISS | | | 100 | | X | X | X |
| Regular review meetings | 2 review meetings annually | Output | Number of reviewing meetings | | | 100 | | X | X | X |
| Midterm evaluation | One midterm evaluation | | Number of midterm evaluations | | | 50 | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Terminal evaluation | One terminal evaluation | | Number of terminal evaluations | | | 100 | | | | |
| | | | | | | 5000 | | | | |

## *Financial resources*

The budget required for implementation of such multi-sector strategic plan for control of tobacco is estimated to be US$ 8,710,000.00 (180, 297, 000.00 Birr). These financial resources need to be mobilized from government and development partners as well as creating Tobacco fund (tobacco-tax) at federal and regional state and city council levels. Appropriate financial management needs to be in place to ensure effective and efficient utilization as well as mobilization of all financial resources.

# Summary

Tobacco use is the largest single preventable cause of death and disease with devastating social, economic and environmental consequences in the world today. To mitigate the devastating effects of tobacco the WHO-FCTC has been developed, ratified and implemented by about 180 countries. The objective of the convention and its protocols is to protect the present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

According to the evidence generated from the Ethiopia Demographic Health Survey 2005 and 2011, GYTS, STEPS 2015 and GATS tobacco use prevalence is a major problem in Ethiopia. Besides these, various small-scale studies undertaken in different parts of the country and the data from the national tobacco manufacturing enterprise reports show the tobacco use prevalence is increasing. To mitigate the tobacco-related problems through the implementation of the WHO-FCTC and its protocols, the government of Ethiopia signed the convention for the control of tobacco on 25 February 2004, ratified it on 21 January 2014 following which it entered into force on 17 February 2014.

This strategic plan for control of tobacco is developed to realize effective and comprehensive multi-sectoral implementation of tobacco control as per the WHO-FCTC by key stakeholders to ensure concerted efforts. The strategic plan has a vision of seeing tobacco-free Ethiopian and goals of reducing the prevalence of tobacco use, its associated diseases, disability and deaths as well as its social and economic consequences in Ethiopia.

The strategic plan includes 9 strategic objectives and 23 strategies. The summary and results of the strategic objectives and strategies and their results are as shown in the table below.

Table 5:-Summary of strategic objectives and their results

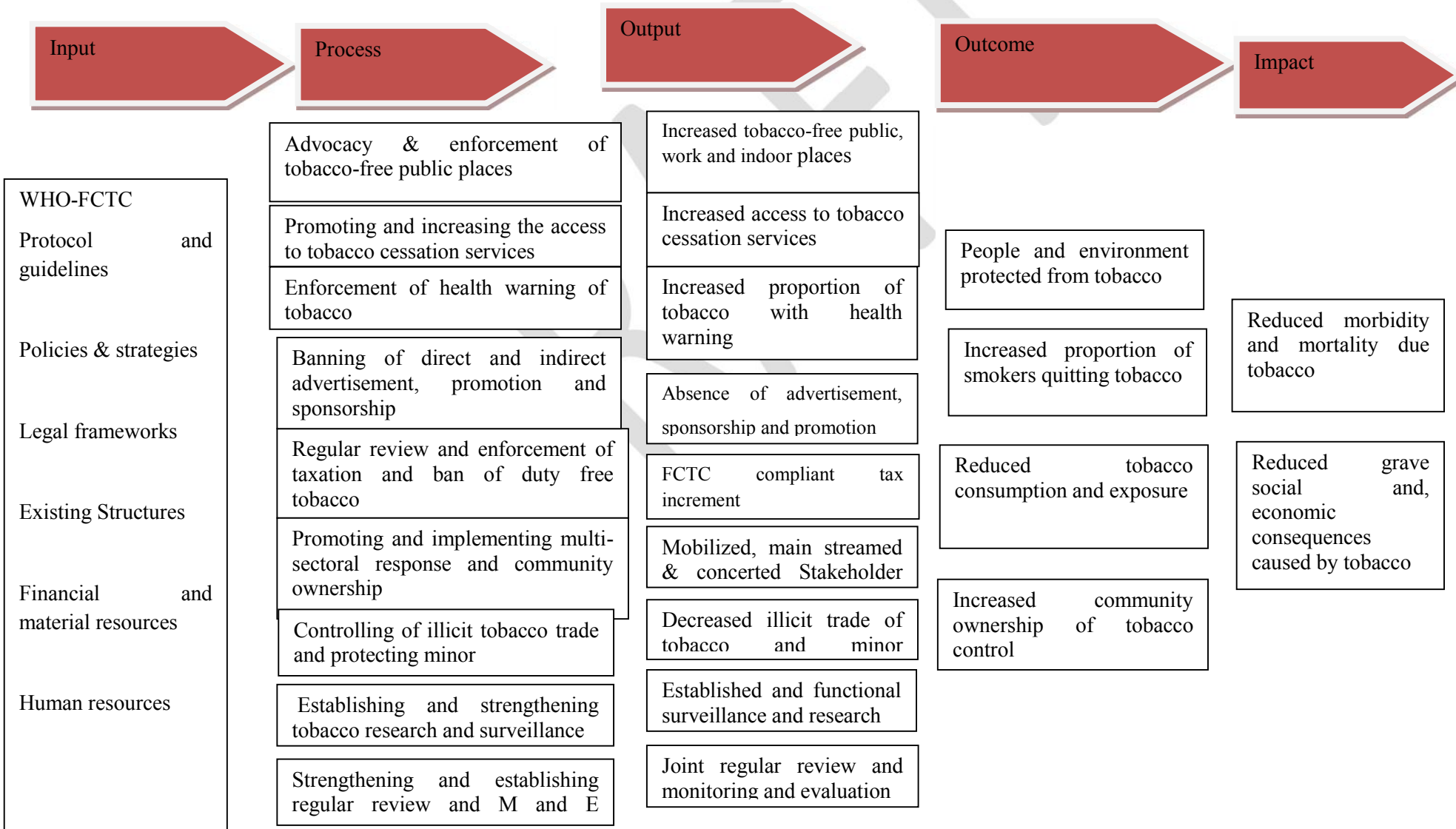
| Ser No | Strategic Objectives and strategies | Results |
|---|---|---|
| 1 | Strategic Objective 1: Protecting people and environment from tobacco | People will live and work in tobacco-free environments |
| | *Strategy 1:* Sensitize, familiarize and advocate for enforcement of laws | |
| | Strategy 2: Enact and enforce smoke-free public places and environment | |
| | Strategy3: Protecting the environment and persons from hazards of tobacco cultivation and manufacturing | |
| 2 | Strategic Objective 2: Reducing the number of people using tobacco | Significant proportion of smokers will quit smoking |
| | Strategy 4: Promoting creation of supportive environments | |
| | Strategy 5: Increasing access to tobacco cessation services | |
| 3 | Strategic Objective 3: Warning about the dangers of tobacco | Community awareness of the harmful effect of tobacco will increase |
| | Strategy 6: Ensuring effective pack warning labels | resulting in significant reduction in tobacco consumption and exposure |
| | Strategy 7: Implementing counter-advertising campaigns | |
| | Strategy 8: Disclose ingredients of tobacco products | |
| 4 | Strategic Objective 4: Enforcing bans on tobacco advertising, promotion and sponsorship | All forms of tobacco advertisement, promotion and sponsorship will |
| | Strategy 9: Enact and enforce effective legislation banning all forms of direct tobacco marketing advertisement | banned resulting in reduced tobacco consumption and its grave |
| | Strategy 10: Enact and enforce effective legislation banning indirect tobacco advertising, promotion and sponsorship | consequences. |
| 5 | Strategic Objective 5: Using price and tax measures to discourage tobacco use<br>Strategy 11: Increase and adjust periodically tax rates for tobacco products | Tobacco use will be reduced due to un-affordability |

| Ser No | Strategic Objectives and strategies | Results |
|---|---|---|
| | | |
| 6 | Strategic Objective 6: Promoting multi-sectoral response and sustainability of tobacco control | Tobacco control will improved quite significantly through concerted efforts |
| | Strategy 12: Establish a national and regional coordination mechanism | |
| | Strategy 13: Mainstreaming of tobacco control and strengthening networking | |
| 7 | Strategic Objective 7: to reduce supply of tobacco products | Reduced illegal tobacco consumption |
| | Strategy 14: Curb illicit trade in tobacco products | and reduced exposure to tobacco by |
| | Strategy 15: Ban sale of duty-free tobacco products | minors. |
| | Strategy 16: Ban sale of tobacco to minors | |
| | Strategy 17: Design and support alternative livelihoods to tobacco | |
| 8 | Strategic Objective 8: Integrated communication | Reduced tobacco consumption through increased awareness and |
| | Strategy 18: Promoting engagement of communities in the control of tobacco | concerted efforts |
| | Strategy 19: Children and Adolescent smoking awareness raising programs | |
| | Strategy 20: Advocating for increased political commitment, support and resource mobilization | |
| | Strategy 21: Development of integrated tobacco control database and networking | |
| 9 | Strategic Objective 9: Generating evidence through surveillance and research | Sustainable evidence-based intervention will be assured |
| | Strategy 22: Establishing and strengthening of national tobacco research and surveillance system | |
| | Strategy 23: Dissemination and use of findings of generated evidence | |

This strategic plan also includes targets and monitoring and evaluation framework for measuring the implementation and effectiveness including outcome and impact of tobacco control activities. Financial and human resources required for effective implementation and achievement of the strategic plan are included in the strategic plan. The financial resources, US$ 8,710,000.00 (180, 297, 000.00 Birr) will be mobilized from government and development partners as well as creating tobacco fund. Roles of stakeholders have been identified and every stakeholder should mainstream and implement their role. Each stakeholder should create or use the existing structure or assign focal experts for effective implementation of the strategic plan. Joint monitoring and evaluation of the implementation, outcome and impact should be undertaken on regular bases and findings should be used for improvement.

Logic Model for Strategic Plan for Tobacco Control

**Problem:** Tobacco use is the largest single preventable cause of death and disease and devastating effect in social, economic and environmental spheres in the world and Ethiopia today. To mitigate the devastating effects of tobacco Ethiopian has ratified the WHO-FCTC. It has then developed this strategic plan to ensure comprehensive and multi-sectoral implementation of the WHO-FCTC and its protocols in order to protect the present and future generations of Ethiopia's from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure.



Annex I Members of National Tobacco Control Coordinating Committee

| Ser No | Name of member | Organization |
|---|---|---|
| 1 | YENESHET BEKELE | Oromia Regional Health Bureau |
| 2 | MULUKEN ADEMASU | Ministry of Children and Women |
| 3 | SELAMAWIT ZERBERUKE | Ethiopian Youth Federation |
| 4 | SEGNI BOBO | Ministry of Communication and Technology |
| 5 | W/RO FERIHOT LEGGESE | Ministry of public services |
| 6 | GIRMA TAMERU | Ministry of Agriculture and Natural Resources |
| 7 | MULUGETA BERHAN | Ministry of Labor and Social Affairs |
| 8 | ZELALEM MENGISTU | Mathews Woldu Cancer Society |
| 9 | Dr. ALEMAYEHU BEKELE | Ethiopian Public Health Association |
| 10 | WASIHUN MELAKU | World Health Organization |
| 11 | BINIYAM KEMAL | Addis Ababa Food, Medicine and Health Care Administration and Control Authority |
| 12 | YENEAYEHU ZERIHUN | Communication Affairs Office |
| 13 | MILLION KEBEDE | Youth Association |
| 14 | KOMANDER MENGISTEAB BEYENE | Federal Police Commission |
| 15 | DESETA LAMBEBO | Ministry of Finance and Economic Cooperation |
| 16 | ADEMASU TSEGAYE | Ministry of Youth and Sports |
| 17 | Dr. MUSSE G/MICHAEL | Federal Ministry of Health |
| 18 | MUSSE TESEFAWU | Ministry of Education |
| 19 | FASIKA GETACHEWU | Ministry of Transport |
| 20 | SAMSON TEGENE | Federal Attorney general |

| | | |
|---|---|---|
| 21 | AHEMED MUHAMMED | Ethiopian Revenue and Customs Authority |
| 22 | TESEFAYE AYELE | MOEFC |
| 23 | SISAY DERESO | Ethiopian Public Health Institute |
| 24 | WERKU SENDEKE | Ministry of Federal Affairs |
| 25 | MEGERSA BOSHE | Ministry of Foreign Affairs |
| 26 | ABRHET GIDEY | EFMHACA |
| 27 | MENGISTAB W/AREGAY | WHO/EFMHACA |
| 28 | ASNAKECH ALEMU | EFMHACA |
| 29 | BISTAT SHIMELSE | EFMHACA |
| 30 | BAHARU ZEWDIE | EFMHACA |
| | | |

Annex II Table 1 Matrix of Stakeholder Analysis

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| Community | Participation, engagement in and ownership of the control of tobacco | Protection from tobacco and ownership | Inadequate collaboration in tobacco control | High | Community mobilization and ownership of tobacco control |
| Parliament, Council of Ministers, Regional Governments | Tobacco Control Proclamation and Regulation Promulgation<br>Resource allocation<br>Monitoring and evaluation of enforcement of tobacco control | Evidence-based situational analysis<br>Reports on implementation and impact of tobacco control on national development | Administrative measures<br>Organizational restructuring<br>Influence on budget allocation | High | Put in place strong monitoring and evaluation system and comprehensive capacity building mechanisms |
| FMHACA and Regional Regulatory counterparts | Enforcement and coordination of tobacco control<br>Monitoring and evaluation of tobacco control collaboratively | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Inadequate priority and focus<br>Inadequate collaboration and coordination | High | Put in place effective multi-sectoral planning, monitoring and evaluation of tobacco control<br>Effective coordination |
| Ministry of | Health and community education on | Evidence-based situational | Inadequate collaboration | High | Effective multi-sectoral |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| Health and RHBs | tobacco control<br>Provision of Tobacco dependence cessation services<br>Community mobilization against tobacco through HEW/HDA<br>Monitoring of tobacco-free health institutions and health offices | analysis<br>Technical recommendations and reports<br>Effective coordination | Poor integration of tobacco control in the health sector | | planning and monitoring and evaluation implementation<br>Strong coordination<br>Capacity building |
| Ministry Of Finance and Economic Cooperation and regional counterparts | Budget allocation<br>Regular review of tobacco price and tax<br>Monitoring and evaluation enforcement of tobacco taxation<br>monitoring tobacco and smoke-free workplace | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination<br>Capacity building | Poor collaboration<br>Accountability<br>Inadequate budget allocation | High | Timely performance and multi-sectoral evaluation report<br>Effective budget utilization |
| Ethiopian Revenue and Customs Authority | Effective enforcement and collection tobacco taxation<br>Effective control of illegal tobacco and collaboration | Evidence-based situational analysis<br>Technical recommendations and reports | Poor collaboration<br>Inadequate focus on the control of illegal tobacco | High | Strong collaborative planning, monitoring and evaluation<br>Capacity building |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| | Enforcement tobacco and smoke-free workplace | Effective coordination<br>Capacity building | | | |
| Ministry of Trade and regional counterparts | Inter-sectoral collaboration in licensing and certification of tobacco trade<br>Mainstreaming of tobacco control measures<br>Participation in and control of illegal tobacco trade<br>Monitoring tobacco and smoke-free workplace<br>Participation in enforcement of tobacco and smoke-free trade institutions | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Poor collaboration<br>Inadequate focus on illegal tobacco control | High | Strong collaborative monitoring and evaluation<br>Collaboration<br>Capacity building |
| Ministry of Education and regional education bureaus | Inter-sectoral collaboration<br>Educating students and school community on tobacco<br>Development and implementation of curricula and extracurricular activities on | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination and | Inadequate collaboration<br>Inadequate focus on tobacco control and use prevention in teaching institutions | High | Strong collaborative monitoring and evaluation<br>Capacity building |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| | tobacco control<br>Promote tobacco cessation programs<br>Monitoring of tobacco and smoke-free schools and related institutions | collaboration<br>Capacity building | | | |
| Ministry of Labor and Social Affairs and regional counterparts | Inter-sectoral collaboration<br>Monitoring of tobacco products and smoke-free workplaces<br>Educating employers and employees on tobacco<br>Promote tobacco cessation programs | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Inadequate collaboration<br>Inadequate focus on monitoring tobacco-free public and private workplaces | High | Effective multi-sectoral monitoring and evaluation<br>Strong coordination<br>Capacity building |
| Ministry of Public Service & Human Resources Development | Development and implementation of mainstreaming guidelines | | | High | |
| Ministry of Children and Women and | Inter-sectoral collaboration<br>Mobilization youth, children and women against tobacco | Evidence-based situational analysis<br>Technical recommendations | Inadequate collaboration<br>Inadequate<br>mobilization of children | High | Effective multi-sectoral monitoring and evaluation |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| regional counterparts | Monitoring tobacco and smoke-free workplaces | and reports<br>Effective coordination | and women against tobacco | | Strong coordination<br>Capacity building |
| Ministry Of Culture and Tourism and regional counterparts | Inter-sectoral collaboration<br>Capacity building<br>Monitoring tobacco-free workplaces, hotels, bars, restaurants, theatre, film house, other recreational centers, tourist facilities<br>Collaboration in the advocacy of tobacco control | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Inadequate collaboration<br>Inadequate focus on monitoring tobacco-free work and recreational places | High | Effective multi-sectoral monitoring and evaluation<br>Strong coordination<br>Capacity building |
| Ministry of Agriculture and Natural Resources and regional counterparts | Developing and promoting implementation strategies for alternative development schemes for tobacco plant growers<br>Collaboration with MOH and RHBs – HEW in educating rural communities on tobacco control | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Inadequate collaboration<br>Inadequate focus on tobacco control | High | Effective multi-sectoral monitoring and evaluation<br>Strong coordination<br>Capacity building |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| Federal Environment and Forest Protection Authority and regional counterparts | Monitoring tobacco-free workplaces<br>Protecting environment from tobacco and related damage | | | High | |
| Federal attorney General | Inter-sectoral collaboration<br>Development and revision of proclamation and regulation of tobacco<br>Monitoring of efficient and effective Interpretation of legal framework (Judicial)<br>Monitoring tobacco free offices and courts | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination | Inadequate collaboration<br>Inadequate monitoring and interpretation of tobacco laws<br>Failure of timely reviewing of proclamation and regulation | High | Effective multi-sectoral monitoring and evaluation<br>Strong coordination<br>Capacity building |
| Ministry of Transport and regional | Monitoring tobacco smoke-free workplaces, public conveyance (cars, ships, trains, stations), | Evidence-based situational analysis<br>Technical recommendations | Inadequate collaboration<br>Inadequate focus on tobacco control | high | Effective multi-sectoral planning, monitoring and evaluation of |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| counterparts | Monitoring tobacco-free work offices<br>Inclusion and training in tobacco and its grave consequences in the training curricula of drivers, pilots, navigators and transport staff<br>Collaboration in illegal tobacco trade with different stakeholders | and reports<br>Effective coordination<br>Capacity building | Poor monitoring of Tobacco-free transport vehicles | | tobacco control<br>Strong coordination<br>Capacity building |
| Ethiopian Federal Police Commission and regional counterparts | Collaboration with stakeholders in enforcement of legal frameworks<br>Monitoring tobacco-free correctional places, police stations and workplace<br>Collaboration in educating of inmates, uniformed and other staff<br>Monitoring of illicit trade of tobacco | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination<br>Capacity building | Inadequate collaboration<br>Poor involvement in illicit tobacco trade | High | Effective multi-sectoral monitoring and evaluation<br>Strong coordination<br>Capacity building |
| Ministry of Defense | Intersect oral collaboration<br>Monitoring tobacco smoke-free workplace, army health and teaching institutions, among uniformed and civil | Evidence-based situational analysis<br>Technical recommendations | Inadequate collaboration<br>Poor involvement in border illicit tobacco trade | High | Effective multi-sectoral monitoring and evaluation |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| | staff<br>Collaboration in educating of uniformed and other staff on tobacco control<br>Participate in border Illicit tobacco control | and reports<br>Effective coordination<br>Capacity building | Poor monitoring of tobacco-free military and workplaces | | Strong coordination<br>Capacity building |
| CSO Professionals' Association (EPHA) | Participation in advocacy and training in tobacco<br>Evidence generation<br>Play activist role in the control of | Evidence-based situational analysis<br>Technical recommendations and reports | Dissatisfaction<br>Poor collaboration | High | Effective multi-sectoral planning, monitoring, and evaluation of tobacco control |
| Faith-based organizations and community leaders | tobacco control | Effective coordination<br>Capacity building | | High | Strong coordination<br>Capacity building |
| Government Communication Affairs and regional counterparts | Monitoring illegal tobacco advertisement, promotion and sponsorship<br>Active engagement in mobilizing communities against tobacco | Evidence-based situational analysis<br>Technical recommendations and reports<br>Evidence-based situational | Dissatisfaction<br>Poor collaboration and free air time allocation | High | Evidence-based situational analysis<br>Technical recommendations and reports |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| | Generate evidence on tobacco control<br>Monitoring tobacco smoke-free workplaces | analysis<br>Technical recommendations and reports<br>Effective coordination<br>Capacity building<br>Responsiveness | | | Effective coordination<br>Capacity building<br>Responsiveness |
| Public and private media | Active engagement in raising public awareness and community mobilization against tobacco<br>Monitoring illegal tobacco advertisement, promotion and sponsorship<br>Generate evidence on tobacco control | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination<br>Capacity building<br>Responsiveness | Dissatisfaction<br>Poor collaboration<br>Closed door policy on free air time | High | Information dissemination, advocacy and media programs |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| Community (Public, individuals) | Inter-sectoral collaboration in the control of tobacco<br>Behavioral change and adoption of healthy life style –free from tobacco<br>Engagement in and ownership of tobacco control<br>Mobilizing of community, youth, and women against tobacco | Evidence-based situational analysis<br>Technical recommendations and reports<br>Effective coordination<br>Capacity building<br>Responsiveness | Dissatisfaction<br>Inadequate collaboration | High | Effective community engagement in and ownership of tobacco control<br>Multi-sector planning, monitoring and evaluation of tobacco control |
| Youth Association | Collaboration in the control of tobacco<br>Engagement in and ownership of tobacco control<br>Mobilizing of community, youth, and women against tobacco<br>Behavioral change and adoption of healthy life style –free from tobacco<br>Play activist role in against tobacco | Evidence-based situational analysis<br>Effective coordination<br>Capacity building<br>Responsiveness | Dissatisfaction<br>Inadequate collaboration | high | Effective youth and women mobilization against tobacco<br>Put in place strong Joint planning, monitoring and evaluation of tobacco control<br>Effective Coordination |
| Women Association | | | | high | |
| The private for | Understanding impact of tobacco | effective tobacco regulation | interest to maintain | Medium | Effective enforcement of |

| Stakeholders | Desired behavior | Their interest | Resistance issue | Their influence | Institution Response |
|---|---|---|---|---|---|
| profit | Collaboration in control of illicit tobacco trade | | revenue and profit vis-à-vis tobacco control<br>engagement in illicit tobacco trading | | tobacco<br>Transparency,<br>Collaboration<br>Advocacy, |

Annex III Major Demand and Supply Reduction Provisions of WHO-FCTC addressed in Ethiopia legal framework

The major demand and supply reduction provisions addressed in the directive 2015 include:

Special permit to import, export, and distribution of tobacco;

Non-price measures to reduce the demand;

Protection of public places from exposure to tobacco smoke –Indoor smoking are prohibited in Health institutions; schools, Universities, and colleges; Day care centers; public transport-cars, airplanes, trains (rails), ships, others and their stations; Hotels, bars, pubs, night clubs; restaurants and other feeding places; Prisons and police stations; offices and workplaces; market/trade centers; cinema, Theater, video-houses, meeting halls; stadium, youth centers, and other sport and recreational centers.

- Regulation of the contents for tobacco products;
- Regulation of tobacco product disclosures;
- Packaging and labeling of tobacco products- health waning in English, and or Amharic;
- Ban of Tobacco advertising, promotion and sponsorship;
- Regulation of Illicit trade in tobacco products;
- Ban of electronic cigarette and flavored tobacco- Shisha;
- Protecting of minors from tobacco- no person shall directly or indirectly sell to or create temptation up on a minor to use tobacco products;
- Administrative measures

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