NATIONAL TOBACCO CONTROL STRATEGIC PLAN 2023-2030/31)

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ETHIOPIAN FOOD & DRUG AUTHORITY

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Some of TWG members posed for group Photo

ACRONYMS AND ABBREVIATIONS

AASFI	Addis Ababa Smoke Free Initiative
CDC	Centers for Disease Control and Prevention
CBT	Cognitive Behavioral Therapy
COVID-19	Corona Virus Disease-19
CSOs	Civil Society Organizations
DALYs	Disability Adjusted Life Years
EDHS	Ethiopian Demographic and Health Survey
EFDA	Ethiopian Food and Drug Authority
EHSP	Ethiopia Essential Health Services Package
ENDS	Electronic Nicotine Delivery System
EPHCCG	Ethiopian Primary Health Care Clinical Guideline
EPHI	Ethiopian Public Health Institute
ETB	Ethiopian Birr
FCTC	Framework Convention on Tobacco Control
FDRE	Federal Democratic Republic of Ethiopia
FPC	Federal Police Commission
HEP	Health Extension Program
HEW	Health Extension Workers
HFs	Health Facilities
ITP	Illicit Trade Protocol
GATS	Global adult tobacco survey
GTCR	Global tobacco control report

GYTS Global youth tobacco survey

M&E Monitoring and Evaluation

MOA Ministry of Agriculture

MOCIT Ministry of Communication Information Technology

MOCS Ministry of Culture and Sports

MOE Ministry of Education

MOF Ministry of Finance

MOFA Ministry of Foreign Affairs

MOI Ministry of Industry

MOIT Ministry of Innovation and Technology

MOH Ministry of Health

MOJ Ministry of Justice

MOLSA Ministry of Labor and Social Affairs

MOR Ministry of Revenue (MoR); Ministry of Innovation and Technology

MOT Ministry of Tourism

MOTRI Ministry of Trade and Regional Integration

MOWSA Ministry of Women and Social Affairs

NCDs Non-Communicable Diseases

NRT Nicotine Replacement therapy

PHCU Primary Health Care Unit

WHO World Health Organization

HSRTP Health Sector Regulatory Transformation Plan

HSTP Health Sector Transformation Plan

NCCP National cancer control plan

NTCCC National tobacco control coordination committee

IRT Integrated Refreshment training

PHCU Primary Health Care Unit

PHW Pictorial Health Warning

SFE Smoke Free Environment

STEP STEP wise approach to surveillance

TAPS Total Adverting Promotion and Sponsorship

TIMR Tobacco Industry Monitoring Response

TC Tobacco Control

FORWARD

Ethiopia implemented the first Tobacco Control Strategic Plan from 2017/18-2019/20, during which significant milestones were registered in strengthening tobacco control. The Government of Ethiopia signed the WHO Framework Convention on Tobacco Control (FCTC) on 25 February 2004 and ratified it on 21 January 2014. The convention provides legally binding measures that Ethiopia must fulfil by enacting national legislation. In Feb 2019, Ethiopia adopted FCTC measures in its Food and Medicine Administration Proclamation 1112/2019. The Food and Medicine Administration Proclamation No. 1112/2019 is one of the world's most robust tobacco control law. The Food and Medicine Administration Proclamation can be an excellent example of demonstration of the government's political commitment to address the growing use of tobacco. It introduced several measures besides domesticating FCTC's mandatory provisions.

Among others, it introduced 100% smoke-free public places, ban all tobacco advertising, promotion, and sponsorship (TAPS), requires 70% Pictorial Health Warning (PHW), prohibited the sale of single sticks and sale to anyone under the age of 21, and mandated a licensing scheme for the wholesale, distribution, and sale of any tobacco product. The sale of tobacco products within hundred meters of the premise of health institutions, schools, and youth centers is also totally banned. Moreover, the legislation outlaws the sale of flavored tobacco products, shisha, Electronic Nicotine Delivery System ENDS, new cigarette resembling technology products, and any corporate social responsibility activity by the tobacco industry.

In 2020, Ethiopia also passed a landmark mixed-excise system on cigarettes as part of the 2020 Excise Tax Proclamation. The main aims of the tax increase have been to increase retail prices of cigarettes and influence smokers to reduce their consumption behavior.

Related to the enforcement and implementation efforts, encouraging progress has been made in the application of the first-ever implementation of Graphic Health Warnings (GHW) on all local cigarette brands, strengthening of engagement of sectors in tobacco control, enforcing 100% smoke-free environment laws in public and workplaces, raising public awareness creation, the

establishment of regional tobacco control coordination committees and training of partners to build their capacity to plan and execute tobacco control activities. The integration of tobacco control messages in the fight against COVID-19 was also commendable, as smoking and chronic diseases were one of the underlying factors for the increased risks of dying of many people from COVID-19.

Despite all progress, mortality and morbidity from non-communicable diseases (NCDs) and injuries are increasing alarmingly, posing a triple burden of diseases for the health system. Tobacco is the leading cause of NCDs. Globally, more than eight million people die of tobacco-related diseases; more than 1.2 million people die from exposure to secondhand smoke. Although the prevalence of tobacco use (5%) appears to be small, considering the number of people smoking, gearing up our efforts to intensify enforcement and implementation requires concerted efforts. This is important as 2030 we need to meet the target of reducing tobacco consumption by 30% in 2030. Our endeavors to reach this target will have enormous implications for meeting our Sustainable Development Goals.

As this strategic plan is developed based on a review of the first strategic plan performance, its successes, and challenges, strengthening control of illicit tobacco trade and combating the tobacco industry, interference remains a huge task ahead.

This strategic plan aligns well with the WHO MPOWER, HSTPII (2020/21-2024/25) and the National Stratgic Action Plan for Prevention and Control of Major Non-communicable Diseases (2018-2025). It creates opportunities for integration, capitalizing on various initiatives and platforms (multisectoral coordination), and fostering partnerships. Khat chewing and the harmful use of alcohol are associated behaviors for tobacco use that require joint collaborative work. The place where evidence generation, continual assessment, and multisectoral collaborative approach are given suggests that the strategic plan is comprehensive and in line with other policy-level achievements.

Lia Tadesse, M.D., MHA
Minister
Ministry of Health

FORWARD

In February 2014, the House of Peoples' Representative (HPR), through Proclamation 822, ratified the FCTC. This was Ethiopia's first attempt to toughen its legislation to reduce tobacco use and save the lives of Ethiopians. The 2015 Tobacco Control Directive, intended to implement the FCTC, takes a step by including some of the key measures under FCTC. However, it lacks the critical measures such as lack of enforcement and would give a favourable ground for tobacco companies to reap the benefits of weak tobacco control laws. Amid formidable interferences from the tobacco industry, the parliament adopted The Food and Medicine Administration Proclamation No. 1112/2019.

The WHO FCTC compliant measures and other bans introduced by Proclamation No. 1112/2019 are necessary and proper public health measure. The legislation can be an effective tool to curb the favorable market potential for a booming tobacco business in the second most populous nation in Africa. However, its full implementation requires the further adoption of implementing strategies and regular enforcement, particularly by the Ethiopian Food and Drug Authority (EFDA) and regional health authorities.

The release of this second phase of the National Tobacco Control Strategic Plan (2023-2030/31) makes it unique in that it incorporates tested and elaborated strategies, well founded with documented success stories and evidence from past achievements. The plan presents a review of the previous strategic plan by strategic objectives presenting accomplishments, lessons, and challenges which served as solid bases for crafting the strategies. Analysis of national and regional socio-economic and cultural contexts presents opportunities and threats within which the strategic plan will be adapted and implemented in different contexts.

The next three years of implementation will demand innovative and intensive ways of meeting national targets. The strategic plan presents eight key objectives that will help if implemented effectively, protect the present and future generations from tobacco use harm and improve quality of life.

Each strategic objective has specific strategies to accomplish the expected outcome that leads to the achievement of the major objective. As the purpose of the strategic plan is to guide tobacco control program managers, experts, and coordinators in the planning, executing, monitoring, and evaluating, a series of familiarization workshops will be needed to help intended users develop context-specific activities considering the lessons, challenges, and failures of the past.

The success of the past does not ensure sustainability; their effectiveness diminishes unless further evidenced-based interventions are taking place. The strategic objective that focuses on monitoring is critical, for example, to promote further research and generate evidence for tobacco surveillance, monitor trends and tobacco industry interference, and identify factors for non-compliance to the enforcement of a 100% smoke-free environment in public and works places. The same is true for identifying bottlenecks in the enforcement of single-stick sales, banning point-of-sale advertisements, sales to and by minors, etc.

The strategic objectives on access to cessation embrace appropriate strategies to promote and advocate integrating services into primary health facilities with access to NRTs. The strategic objectives focusing on graphic health warnings must be supported with innovative ways to understand smokers' perceptions and behavior changes for quitting through continual assessment to develop a more comprehensive array of GHWs.

The strategic objectives related to tobacco taxation and illicit tobacco trade present strategies that can remarkably produce good results. As per capita GDP continues and inflation is growing, the effectiveness of the 2020 taxation is diminishing; hence, further action for policy dialogue using practical tools and approaches is to be considered. The illicit tobacco trade is becoming a much more challenging factor. Therefore, it demands a breakthrough intervention to speed up accession of the protocol for eliminating the illicit tobacco trade.

The strategic plan highlights strategic objectives on creating enabling conditions and fostering partnerships as goes without saying tobacco control is achievable only with the engagement of political leaders and various government sectors and all partners. To these ends, we will call upon Government leaders, Civil societies, UN organizations, International non-governmental organizations, the general public, and the tobacco control community to fully engage for the successful implementation of the strategic plan.

Finally, I would like to commend the FDA team and Technical Working Group for the hard work and series of consultations for realizing this critical time to embark on its implementation.

Heran Gerba Borta
Director-General
Ethiopian Food and Drug Authority

Executive summary

At global Level Tobacco kills more than 8 million people each year and more than 7 million of those deaths are the result of direct tobacco use while around 1.2 million are the result of non-smokers being exposed to second-hand smoke. Tobacco is a developmental challenge that cost the global economy US$ 1.4 trillion each year. In Ethiopia According to GATS 2016 findings 3.4 million (5%) of Ethiopians use tobacco and 2.2 million (3.2%) of citizens smoke tobacco on daily basis and it causes more than 17,000 deaths. The Government of Ethiopia signed the WHO Framework Convention on Tobacco Control (FCTC) on 25 February 2004 and ratified it on 21 January 2014. Ethiopia implemented the first Tobacco Control Strategic Plan from 2017/18-2019/20, during which significant milestones were registered among other in Feb 2019, Ethiopia adopted FCTC measures in its Food and Medicine Administration Proclamation 1112/2019. This proclamation introduced stringent measures besides domesticating FCTC's mandatory provisions.

Among others, it introduced 100% smoke-free public places, ban all tobacco advertising, promotion, and sponsorship (TAPS), requires 70% Pictorial Health Warning (PHW), prohibited the sale of single sticks and sale to anyone under the age of 21. Moreover, the legislation outlaws the sale of flavored tobacco products, shisha, Electronic Nicotine Delivery System (ENDS) and any corporate social responsibility activity (CSR) by the tobacco industry. The country also made significant policy change in tobacco taxation through adoption of proclamation number 1186/2020. WHO estimated that this Excise tax legislation will increase the tax share of the average retail price of cigarettes to around 54%.

Ethiopia Tobacco control also made additional achievements during the previous strategic Period. The key progress made during the previous strategic period among other

- As part of 100 % SFE enforcement and regular inspections of public places conducted and, more than 500,000 public places checked for smoke free status and appropriate actions taken. Public places that fully met the standards were awarded with certificate of smoke free status while those that have partially met the standards were advised and motivated to do more while managers and owners of public places that breached the law were fined. There were SF enforcement in major universities too. There were also routine inspections and SF enforcements around public places, government institutions and hotels. EFDA has conducted assessment in four regions (Sidama, SNNPR, Harari and Oromia) on the implementation of SF legislation.

- EFDA has also launched Addis Ababa Smoke Free initiative (AASFI) in April 2021 targeting two Sub cities. EFDA later in March22, 2022 scaled up AASFI in all eleven sub cities in Addis Ababa.
- Ministry of Health has trained health professionals on brief tobacco intervention for more than 2,000 health facilities across the country using the Ethiopian Primary Health care Clinical Guidelines (EPHCCG). Brief Tobacco cessation intervention was also incorporated within Integrated Refresher Training Manual for Health Extension workers training. MOH has also further incorporated tobacco cessation interventions in national guidelines for clinical and programmatic management of major NCDs. counselors who work at MOH 952 toll free lines were trained on telephone counseling protocol to help create access for smokers who wish to quit smoking.
- Proclamation 1112/2019 avowed rotating graphic health warnings covering at least 70% of the front and back of tobacco product packaging in Ethiopia. Its implementation directive 334/2019 was also issued in 2019 by EFDA. Following this directive four warnings have been issued and effective since May 2020 and rotated equally within each batch of a tobacco product brand over a 24-month period. The second round of PHW is also effective starting from December 2022.
- EFDA/MoH submitted the illicit trade protocol for Council of Ministers to be endorsed by Ministry of Foreign Affair for the country to enact legislation to reduce illicit trade in tobacco
- National Tobacco Control Coordination Committee (NTCCC) is actively engaged in TC response and being expanded its committee across all regions in the country. Tobacco Industry Monitoring and Response team (TIMR) established under the NTCCC.

Despite Ethiopia has made significant stride in tobacco control policy change and implementation in first phase of strategic plan period. There are gaps interms of implementation and universal enforcement of tobacco control measures. The country also posed with significant multinational tobacco control industry inferences challenges. These require multisectoral response to ensure the engagements of all sectors through NTCCC and its regional TCCC. There are also gray areas that require policy measures including the accentuation and ratification of illicit trade protocol and its instruments to eliminate illicit tobacco product. The country also requires improving monitoring mechanism to ensure compliance of all MPOWER measures. This includes periodic survey, targeted assessment and generating fresh evidence to measure and improve interventions. This next phase of strategic plan will cover nearly 8 years and will address the above gaps beside capitalizing on previous success. This plan also supports the country to initiate activities toward more advanced tobacco control interventions to end tobacco epidemic.

CHAPTER I

1. COUNTRY PROFILE

1.1. GEOGRAPHY AND CLIMATE

Ethiopia is one of the oldest civilized African countries. Ethiopia, officially known as the Federal Democratic Republic of Ethiopia, is a landlocked country situated in the Horn of Africa. It shares borders with Eritrea to the north, Djibouti to the northeast, Somalia to the east and southeast, Kenya to the south, South Sudan to the west, and Sudan to the northwest. Ethiopia lies between the Equator and Tropic of Cancer, between the 30^{o} N and 150^{o} N Latitude and 330^{o} E and 480^{o} E longitude.

The country occupies total area of 1.1 million km^2 and the water bodies occupying 7,444 km^2. Ethiopia consists of rich geographical diversity which includes rugged mountains, flat - topped plateaus, deep gorges, and river valleys. Over the ages, erosions, volcanic eruptions, and tectonic movements have contributed to the nation's diverse topography that made the country a known tourist attraction site. More than half of the geographic area of the country lies 1,500 m above sea level. The geographic area extends from the highest altitude Ras Dashen (4,620m above sea level) to the lowest altitude at Danakil (Dalol) depression (1,500m below sea level). The country is made up of eleven regional states and two chartered cities, Addis Ababa, and Dire Dawa. The regions vary enormously in area and population.

Figure 1: Regional state of Ethiopia

The four major seasons summer 'kiremt' (June –August), autumn 'Tsedey' (September-November), winter 'Bega' (December-February) and spring 'Belg' (March-May) make Ethiopia a lovely, ever ventilated and a famous thirteen months of sunshine country to live and enjoy climatic variations.

1.2. DEMOGRAPHIC SITUATION

Ethiopia is home to 117 million citizens and is the 12th most populous country in the world and the 2nd most populous in Africa after Nigeria composed of various ethnic diversities, with more than 80 different spoken languages. The country is characterized by rapid population growth (2.6%), young age structure, and a high dependency ratio, with a high rural-urban differential. Ethiopia has a high total fertility rate of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. The average household size is 4.6 (CSA 2022). It has a very young population with children under age 15 years and individuals in the age group of 15-65 years account for 47% and 49% of the population, respectively. Only 4% of the population is above the age of 65 years. The sex ratio between males and females is almost equal (0.96 to 1), and women of reproductive age constitute about 23% of the population. Nearly 80% of the population lives in rural areas and mainly depend on subsistence agriculture. The population of Ethiopia is estimated to reach 143 million by 2037. If it follows its current rate of growth, the population will reach 125 million by 2025 and 190 million by 2050.

With perceived commitment of the country to reduce infant and child mortality, improve reproductive health and family planning, and the subsequent fertility decline, Ethiopia is on track to a population age structure that may enable a demographic dividend. However, harnessing this dividend depends on the country's ability to scale up investments in human capital by addressing disparities among different equity dimensions. Effective implementation of supporting policies, strategies, and reform agendas is crucial to tap from the opportunity of demographic dividend; otherwise, the flipside of this may be a concern leading to social instability.

1.3. SOCIO-ECONOMIC SITUATION

Ethiopia is engaged in rapid, comprehensive development activities to transit from poverty to sustainable, reliable growth and prosperity. Since 1991, the country has implemented several macroeconomic policies, including a market-based and agriculture-led industrialization. The government has introduced initiatives to ensure successful transformation from an agrarian to industry-led economy. The country has registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty head count, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB, and malaria.

Ethiopia is a low-income country with a gross domestic product (GDP) per capita (current US$) of $772 in 2018, up from about $340 in 2010. It is one of the fastest-growing economies in Africa, with 6.3% growth in FY2020/21. However, it is also one of the poorest, with a per capita gross national income of $960. Ethiopia aims to reach lower-middle-income status by 2025. Over the past 15 years, Ethiopia's economy has been among the fastest growing in the world (at an average of 9.5% per year). The main contributors to the economic growth are agriculture, industry, and service sectors. According to Ethiopia's poverty assessment report, household poverty rate has diminished remarkably, by around 20%, between 2011 and 2016 (World Bank 2019). Women's empowerment has been an important feature of Ethiopia's economic reform. The Ethiopian Constitution recognizes the principle of equality of access to economic opportunities, employment, and property ownership for women. According to a report by the CSA, the national income inequality coefficient increased from 0.298 in 2010/11 to 0.328 in 2015/16.Between 2000 and 2017, Ethiopia's Human Development Index value increased from 0.283 to 0.463, an increase of 63.5%. However, it remains below the average of 0.504. Ethiopia's Human Capital Index is 0.38, making Ethiopia 135th of 157 countries (The World Bank, 2019). The road coverage has increased by six-folds compared to 1990, with total road length reaching 105,000 kms. Under the Universal Rural Road Access Program, about 10,765 rural kebeles are now connected, creating better access to health care for millions of mothers and children. Connectivity via modern communication devices has improved tremendously, with 32 million mobile phone subscribers, which expands opportunities for digital health.

1.4. HEALTH POLICY AND NCDIs

The Health Policy of the Transitional government of Ethiopia developed in early 1993 placed promotive and preventive health care as the main priority through democratization and decentralization of health care delivery as its pillars. Mental health and prevention of chronic conditions (NCDs) were mentioned in the policy as secondary priorities to communicable, maternal, neonatal, and nutritional (CMNN) disorders.

The prevention and control of NCDs first appeared in the Health Sector Development Programs (HSDP) III from 2005-2010, though there was no meaningful implementation of the NCD Program at that time, and in the subsequent HSDP IV from 2010-2015 some NCD prevention and control efforts were initiated at national level. NCDs were considered as one of the major disease control priorities in the Health Sector Transformation Plan 2015/16-2019/20, with elaborate strategies and costed interventions. It addressed four major NCDs (namely cardiovascular disease [CVD], chronic respiratory disease [CRD], diabetes mellitus [DM)] and cancer) and four main risk factors for NCDs (namely physical inactivity, unhealthy diet, harmful use of alcohol, and tobacco use) as the main strategy. Twelve out of 176 indicators were also included to monitor the epidemiology and service coverage of NCDs.

Non-communicable diseases (NCDs) are the leading causes of death globally, killing more people each year than all other causes combined. NCDs cause 71% of all deaths globally and 85% of "premature" deaths in low- and middle-income countries. NCDs and injuries constitute 51% of the deaths in Ethiopia (WHO 2018). Specifically, cardiovascular diseases accounted

,16%, cancers, 7%, and diabetes ,2%, of death. NCDs found to contribute to the substantial loss of total DALYs in Ethiopia (46.1%). Most noncommunicable diseases are the result of four behaviors (tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol) that lead to four key metabolic/physiological changes (raised blood pressure, overweight/obesity, raised blood glucose and raised cholesterol).

In the past couple of decades, major health care reforms were introduced, resulting in exponential expansion of infrastructure and human resources that led to a significant improvement of the health status of the people. Primary health coverage has now reached 95%.

1.5. THE HEALTH REGULATORY BODY

Ethiopian Food and Drug Authority (EFDA) is the National Regulatory Body of Ethiopia which is under the Ministry of Health. The Authority is responsible to ensure the quality, safety and/or efficacy of medicines, food, cosmetics, medical devices, and tobacco control. To this end, great efforts have been made to fulfill the responsibilities assigned to the sector by formulating and enforcing proclamations, regulations, standards, and directives for the development of the Health and Health Related Services and Inputs Control.

CHAPTER II

2. TOBACCO CONTROL CONTEXT

2.1 GLOBAL SITUATION

Tobacco use is currently one of the leading causes of preventable deaths in the world. The tobacco epidemic is one of the biggest public health threats the world has ever faced. Tobacco kills more than 8 million people each year. More than 7 million of those deaths are the result of direct tobacco use while around 1.2 million are the result of non-smokers being exposed to second-hand smoke. Over 80% of the world's 1.3 billion tobacco users live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest. In response to the globalization of the tobacco epidemic, the WHO formulated the first evidence based international public health treaty with cost-effective strategies, the Framework of Convention on Tobacco Control (FCTC). It was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. As of March 2021, 182 countries become member of Parties covering more than 90% of the world population. The FCTC promotes evidence-based tobacco control policies in nearly every country worldwide.

To help make effective tobacco control a reality, WHO introduced the MPOWER measures. These measures are intended to assist in the country-level implementation of effective interventions to reduce the demand for tobacco, contained in the WHO FCTC. The MPOWER signifies lifesaving measures such as monitoring tobacco use, creating smoke-free public places, offering help to quit smoking, requiring graphic pack warnings, banning tobacco advertising and increasing tax on tobacco products, and are part of the commitment of practically all governments in the world.

Reports show that tobacco industry interference remains the single greatest obstacle to implementing lifesaving measures to curb smoking. There is a fundamental and irreconcilable conflict between the tobacco industry’s interests and public health policy interests. The tobacco industry recognizes the impact of these measures and actively fights against these efforts because of their negative effect on its sales. Time and time again, the industry has used its resources to halt these public health policies where it can, water them down when it cannot stop them altogether, and undermine their enforcement when they are adopted. The WHO FCTC spells out that tobacco control policies must be protected against tobacco industry interests. Article 5.3 of the FCTC requires all Parties when setting and implementing their public health policies with

respect to tobacco control to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law".

Fortunately, the global community is making progress toward improving tobacco control. The efforts of governments, civil society and the international community, including through the WHO FCTC, are having life-saving effects in many countries. Despite recent slight declines in overall global tobacco consumption, there are alarming trends in tobacco use among youth and in lower-income countries, including in sub-Saharan Africa. Governments must implement stronger tobacco control policies to prevent a surge in tobacco-related harm.

2.2 NATIONAL CONTEXT

According to GATS 2016-Ethiopia findings, 3.4 million (5%) of Ethiopians use tobacco and 2.2 million (3.2%) of citizens smoke tobacco on daily basis. Across regions, percentages of people who smoked any tobacco product ranged from 15.5% in Afar to 0.7% in Tigray. Five regions had smoking rates higher that the national estimate of 3.7%: 15.5% in Afar, 11.2% in Gambella, 7.2% in Harrari, 6.6% in Benishangul Gumz, 6.5% in Somali, 4.4% in Oromiya, 4.5% in SNNPR, and 4.4% in Dire Dawa. This figure puts the country as one of the Sub-Saharan countries with low tobacco smoking prevalence. Nonetheless, the absolute number of tobacco users is significant due to the country's large population size. Every year, more than 17,000 Ethiopians die due to tobacco-related causes. To mitigate tobacco-related problems through the implementation of the WHO-FCTC, the Government of Ethiopia signed the treaty on February 25, 2004, and ratified the convention on January 21, 2014 through Proclamation No. 822/2014.

In February 2019, the Ethiopian parliament ratified one of the strongest FCTC compliant and most comprehensive proclamations in the African region. Ethiopia also introduced a mixed-excise tax system on cigarettes in line with the recommendations of the WHO. This involves a 30% tax rate of the cost of producing cigarettes, in addition to a specific excise rate of 8 ETB (USD$ 0.25) on each individual packet. WHO estimated that this legislation will increase the tax share of the average retail price of cigarettes from 33% to around 54%.WHO has estimated that the tax increase would reduce the rate of cigarette smoking among adults by as much as 10%, and reduce the number of deaths attributable to smoking by around 91,000 people. The increased tax on cigarettes will also increase cigarette tax revenues by as much as 81%, meaning an additional (ETB) 925 million (USD$28.7 million) that can be spent on public health or education programs.

To assist in the enforcement, EFDA which is the mandated body of government to regulate tobacco products prepared a detailed implementing TC directive for proclamation 1112/2019 and entered into action. EFDA also drafted and disseminated a model law for the regional counterparts to use it as a basis for drafting their respective law and enhance uniform enforcement across all the regions.

Furthermore, EFDA developed a PHW directive No. 334/2019 and selected four different pictures along with the health warning texts both in Amharic and English languages for the first round of PHW implementation. The four pictures illustrated heart disease, lung cancer, abortion and oral cancer. The PHW directive puts a 2-year rotation requirement and the implementation period for the first round of PHW ended up in March 2022. Similarly, four pictures illustrating low birth weight, stroke, breast and mouth cancer for the next round of implementation (till March 2024) were prepared and entered into action. Under the regulatory jurisdiction of AAFMHACA, EFDA in collaboration with other government and CSO partners initiated the Addis Ababa Tobacco Smoke Free Initiative (AATSFI). The AATSFI started in two sub-cities namely Bole and Arada as a pilot and progressed with launching to City wide involvement through strong engagement and involvement of higher government officials.

A multi-sectoral National Tobacco Control Coordinating Committee (NTCCC) exists at the federal level. Members included relevant several ministries, civil society organizations and agencies to ensure multi-sectoral implementation of the WHO-FCTC. This committee meets on a regular quarterly basis. The coordination team also exists at the level of regional counterparts. A national Tobacco Industry Monitoring and Response (TIMR) team which is the sub-committee of the NTCCC was established to monitor and provide timely and proactive responses to the emerging TII aimed at influencing TC acts.

Despite this strong TC legal framework and efforts to enforce, challenges persist. Weak enforcement of the existing proclamation, delay in approval of implementing regulations by regional counterparts and increased interference strategies from the TI undermines the country's new policies and poses a threat to public health. The speed with which the tobacco industry is interfering with the TC process is a daunting challenge impeding the safeguard of public health and the full implementation of tobacco control policies.

CHAPTER III

3. PROGRESS IN NATIONAL TC IMPLEMENTATION

The government of Ethiopia has been committed to protect the public health by strongly regulating tobacco products. Comprehensive system, appropriate and strong legal framework has been introduced in this regard. As part of the HSTP, it was expected that 75% of public places would be tobacco smoke free. Despite the encouraging performances have been made, the percentage of tobacco smoke free public places in 2018/19 was 42.3% as compared to the plan (60%). In addition, EFDA, in collaboration with other organizations and stakeholders that claim to be harmful to tobacco use, has made extensive efforts to prevent the spread of tobacco in the media, print, broadcasting, and online media. However, much work has been done in the media to educate the public about the dangers of tobacco use, to focus on tobacco control initiatives, and to prevent misinformation in the tobacco industry. Well-designed and sustained media campaigns have been implemented, policies have been enacted, effective legal frameworks have been put in place by EFDA to control the content and emissions of tobacco products and administrative measures have been taken against the tobacco trade.

During the previous tobacco control strategic plan implementation time, Ethiopia made significant stride in tobacco control. Among other this include approval of the Ethiopian Food and Drug Administration Proclamation Number 1112/2019 by the Ethiopian Parliament in February 2019. This proclamation provision includes among others, 100 % SFE, Pictorial Health Warning covering 70% of the front pack, 100% Ban on TAPS, prohibition of sale to and by minor below 21 years of age were among the key provisions. The country also made significant policy change in tobacco taxation through adoption of Proclamation Number 1186/2020. WHO estimated that this Excise tax legislation will increase the tax share of the average retail price of cigarettes to around 54%, this landmark progress enables the recognition of Ethiopian

Parliament, EFDA and CSOs for World No Tobacco Day Award by WHO. Here below the key progress made during the previous strategic plan period are highlighted.

3.1 STRATEGIC PROGRESS

SO1: Protecting people and the environment from tobacco exposure

Protecting people from the harmful effects of secondhand smoke is critical for saving the lives of people dying and suffering from various cancers, heart diseases, etc. that are attributed to tobacco smoke. In the previous tobacco control strategic plan strategies implemented to help achieve protection of people from tobacco exposure included 1) awareness and advocacy for promoting smoke-free laws, 2) enforcing laws to create smoke-free public and workplaces and 3) protecting the environment and persons from hazards of tobacco cultivation and manufacturing.

Efforts so far implemented as part of the strategies resulted in remarkable improvements that put Ethiopia to be one of the countries providing protection at the best-practice level. A major progress was also made from smoke-free laws that allowed designated smoking areas in public places to a comprehensive law that embraced complete ban on smoke in public and workplaces in 2019. Adoption of 1112/2019 proclamation that includes strong and FCTC compliant laws was complemented by national and region-wide awareness creation campaign and familiarization of the law through public media and community-based platforms. To help enforcement of the smoke free law, thousands of law enforcers, regulators, journalists, health extension workers, members of civil societies, and representatives of various public sector officers oriented on the importance of smoke free laws and their enforcement to protect the health of people. The training was designed with the tools that help them work on how to inspect and monitor public and workplaces for smoke-free status. Through sudden and regular inspections of public places, more than 500,000 public places checked for smoke free status and appropriate actions taken. Public places that fully met the standards were awarded with certificate of smoke free status while those that have partially met the standards were advised and motivated to do more while managers and owners of public places that breached the law were fined. There were SF enforcement in major Universities (Addis Ababa, Hawassa, Adama, Arsi, Bahar Dar, Mekele, Haromaya, Dire Dawa Universities etc).There were also routine inspections and SF enforcements around public places, government institutions and hotels. EFDA has conducted assessment in four regions (Sidama,

SNNPR, Harari and Oromia) on the implementation of SF legislation. No Smoking stickers and enforcement measures were also taken in different places. EFDA has also launched Addis Ababa Smoke Free initiative (AASFI) in April 2021 focusing on Bole and Arada Sub Cities. EFDA later in March 22, 2022 scaled up AASFI in all eleven sub cities in Addis Ababa.

There have been, however, challenges to persistently support effective enforcement of the law that included among others, related to lack of empowered code enforcers, sustained engagement of sectors, and capacity to translate fine measures.

SO2: To reduce the number of people using tobacco.

To contribute to the achievement of reduced number of people using tobacco products, the strategic plan included two strategies:

1. Promoting creation of supportive environment and

2. Increasing access to tobacco cessation services.

With respect to increasing access to tobacco cessations services, lots of activities have been implemented although there are long standing challenges to make the real changes. Ministry of Health has trained health professionals on brief tobacco intervention for more than 2,000 health facilities across the country using the Ethiopian Primary Health Care Clinical Guidelines (EPHCCG). Brief Tobacco cessation intervention was also incorporated within Integrated Refresher Training Manual for Health Extension workers training. Two rounds of Master TOT provided for HEWs using this manual. MOH has also incorporated tobacco cessation interventions in national guidelines for clinical and programmatic management of major NCDs. This will help to guide health professionals implement tobacco cessation services. Moreover, the General framework for how to do brief intervention using 5A'swas also incorporated within the national hypertension training manual for health care workers. It is also worth mentioning that 'Current smoking' is one of the five or six variables required to perform CVD risk assessment in hypertensive patients in particular as clearly indicated in the national CVD risk assessment protocol adopted from WHO. With financial support provided by WHO, 119 health professionals selected from 80 health centers and hospitals from Dire Dawa, Oromiya and Addis Ababa have been trained by MOH and WHO experts. In addition, 38 counselors who work at MOH 952 toll free lines were trained on telephone counseling protocol to help create access for smokers who

wish to quit smoking. This training would empower them to provide intensive behavioral Counseling across the country. Public campaign in promoting quitting and creating demand for tobacco cessation services by smokers has been implemented in Dire Dawa, Addis Ababa, and several other regions from 2020 to 2022.However, the unavailability of Nicotine Replacement Therapy (NRT) still remains the major challenge to avail the full package of tobacco cessation services in the country.

SO3: To warn about the dangers of tobacco

One of the requirements of Proclamation 1112/2019 is rotating graphic health warnings covering at least 70% of the front and back of tobacco product packaging in Ethiopia. Its implementation directive 334/2019 was also issued in 2019 by EFDA. Following this directive , warnings have been issued and effective on May 2020 and are required to be rotated equally within each batch of a tobacco product brand over a 24-month period. This graphic health warning depicted the harm caused by Tobacco on (Heart, lung, Fetus and Mouth cancer).

Fig2: The first Pictorial health warning

Fig3: The Second Round PHW introduced by EFDA

SO4: To enforce bans on tobacco advertising, promotion & sponsorship

Proclamation 1112/2019 prohibited all indirect or direct forms of tobacco advertising and promotion. During this strategic plan period no major violation of this provision was observed. However, some of subtle advertising activities by the industry using certain promotional materials like T-shirts, umbrella, plastic bag, clock, bags, key holders etc. were observed. Sometimes, actor's scene with smoking character observed in drama, films and theater released by some of the entertainment industry. Proclamation No. 533/2007 on Broadcasting Service empowers the Broadcast Authority to license broadcasters (TV and radio), print media, and advertising agencies, among other entities and enforces compliance with tobacco advertising violations along with the Ethiopian Food and Drug Administration. However, unlike to the prohibition of the direct promotion, the compliance rate is poor as the above stated indirect form of promotion is not strictly prohibited.

SO5: To discourage demand for tobacco through price and tax measures

Increased price and tax on tobacco products is one of the effective measures with best practices around the world in reducing tobacco consumption. Ethiopia had among the lowest-priced cigarettes in the world even compared to other African countries.

Low prices, rising incomes and inflation make cigarettes more affordable and contribute to a high rate of smoking. The tax rate and structure were insufficient to impact the price.

Following the ratification of the WHO FCTC in 2014, efforts began to influence tobacco tax policy changes. Through long years of effort, the House of Peoples Representatives of Ethiopia adopted tobacco taxation policy change as part of the new excise tax proclamation in February 2020. The change in the tax base and the adoption of a specific rate of 8 ETB per pack of cigarettes alongside with a 30% ad valorem tax on the production cost is remarkable progress after the tobacco control proclamation of 2019.

Two years after the adoption of tobacco tax increase, an impact analysis on tobacco tax increase consulted and results showed an encouraging outcome in the reduction of tobacco sales volume and increasing tobacco tax revenue. The objectives of tobacco tax were to reduce tobacco consumption by making retail cigarette prices unaffordable, while also increase government revenue. The revenue increase on yearly basis since 2019 increased from 583.67 million to 695.29 million in 2020 and in 2021 to 871.79 million birr. Compared to the first half-year of 2019, the sales volume reduced respectively by 29% in first six months of 2020 and 48% in the first six months 2021, while the sales volume in 2021 reduced by 27% as compared to the first half of 2020 (WHO, Tobacco tax impact analysis, 2021).

Whether these increases have influenced in the reduction of tobacco consumption is yet to be studied. On the other hand, there is a growing challenge from the tobacco industry to reverse the increase or prevent a yearly increment of a 10% tobacco tax increase as per the bill by arguing fuel of illicit trade due to increased tobacco taxation.

SO6: To reduce supply of tobacco products

EFDA/MOH submitted the illicit trade protocol for Council of Ministers to be endorsed by Ministry of Foreign Affair for the country to enact legislation to reduce illicit trade in tobacco products (counterfeit and contraband cigarette and authorizing seizure of illicit tobacco). The country also enacted a legislative measure to prevent sales of tobacco to and by minors below 21

years of age. There is still little or no progress on the implementation of this provision. There is also no significant improvement in changing the livelihood of tobacco workers, growers, and sellers towards other economically viable alternative activities. The number of tobacco farms increase from four to five during this strategic period (Bilate, Shewa Robit, Hawassa, East Shewa and Wolaita). There has been also low attention for the protection of persons and the environment in tobacco cultivation and manufacturing settings but a positive lesson from Sidama regions provided encouraging impetus to scale up across the nation, which EFDA has conducted a successful health education campaign for tobacco growers.

SO7: To promote partnerships & coordination for sustained tobacco control

The country has active National Tobacco Control Coordination Committee (NTCCC) that contributes to multisectoral tobacco control response. EFDA expanded this committee across all regions in the country. Robust Tobacco Industry Monitoring and Response team (TIMR) established under the NTCCC. There is also increasing strong collaboration among government, non-governmental and intergovernmental organizations. WHO and the World Bank provided technical and financial assistance for tobacco control effort in the country. Other international partners like Gates and Bloomberg support also sustained the tobacco control effort in the country.

SO8: Integrated Communication

Awareness creation, sensitization, social mobilization, and advocacy are the core elements to influence behavior change in quitting smoking, policy, and legislative actions that create enabling environment. In these regards, extensive work has been implemented in all regions. Mainstream and social media have been used to promote healthy lifestyle promotion, raising awareness of the harmful effects of tobacco and other substances use including khat and alcohol. Approximately, more than 20 million people have been reached with messages involving 5 national and regional TVs (Amhara, Addis Ababa, Dire Dawa, Gambella, and Afar) and also 6 FM radios.

EFDA with WHO raised awareness on the harms of tobacco use and promote quitting and healthy lifestyle promotion for the prevention of NCDs, more than 800health extension workers in 7 regions (Oromia, Amhara, Addis Ababa, Somali, Afar, Gambella, and Benishangul) trained

that contributed to reaching tens of thousands of families. Other activities to strengthen communities' involvement in support of smoke-free laws and influencing behavior change in communities, more than 700 law enforcers and more than 200 members of CSOs engaged in the same regions.

Promotional materials such as IEC/BCC, billboards, posters, social media, and the involvement of celebrities engaged to widely promoting and advocating policy and legislation changes. A few civic societies have been engaged and actively reaching universities and schools to involve adolescents and young people to be aware of the harms of tobacco and other substance abuse. Sustaining public awareness creation activities is constrained by lots of barriers including shortages of funds, and capacity to monitor and study the impacts of various activities implemented.

SO9: To strengthen generation of evidence through survey and research.

Ethiopia conducted the Global Adult Tobacco Survey (GATS) in 2016. This household level survey collected data on non-institutionalized men and women ages 15 years and older using a standardized methodology for selected households. It surveyed 10,150 persons ages 15 and older with an overall response rate of 93.4%. The survey indicated 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). Overall, 3.7% (2.5 million) of adults (6.2% among men and 1.2% among women) currently smoked tobacco. Overall, 3.2% of adults (2.2 million) smoked tobacco daily (5.2% among men and 1.1% among women) and 0.5% (350,000) smoked tobacco occasionally (0.9% among men and 0.1% among women). The country also further conducted Tobacco excise tax modeling with the World Bank and WHO support. An empty pack survey was also conducted in 2018 with CTFK support to assess the level of illicit trade in the market. On the other hand, additional evidences were generated by different partners on illicit trade, tobacco tax impact assessment, TAPS, Tobacco Industry Monitoring and Smoke Free Environment. The current tobacco control contest requires more evidence for program improvements these include GYTS studies, updated empty pack Survey, GATS, Tax impact assessment etc.

CHAPTER IV

4. MANDATE AND STRUCTURE IN TOBACCO CONTROL

4.1. MANDATE OF EFDA AND REGIONS IN TOBACCO CONTROL

The Ethiopian Food and drug Authority (EFDA) is a federal government agency established under definition of powers and duties of the federal government executive organs proclamation No. 1263/2021(see article 66(1) of the proclamation). Before re-establishment under proclamation No. 1263, the Authority has been established under regulation No. 189/2009 and named as the Ethiopian Food, Medicine, and Health care Administration and Control Authority. Under this regulation and the food and medicine administration proclamation No. 661/2009, the Authority was mandated to regulate product (food, medicine, cosmetics, tobacco, etc.), professional (health professional, technical managers etc.), premises (regulated products establishments) and practice (professional activities in the health sector). However, these activities are broad and challenging to regulate effectively given the structure of the Authority and the federal structure the country is following. Therefore, the Food and Medicine Administration Proclamation No. 1112/2019 was enacted in 2019 to address the challenges.

While the EFDA is the regulatory agency at the federal government, there are regional health regulators mandated in similar aspects at their respective region. EFDA is the key government organization of Ethiopia in the public health sector and tobacco control. Following the adoption of the food and medicine administration proclamation No. 1112 and EFDA Structure, Powers and Duties Regulation No. /2023, the mandate of the Authority is limited to product regulation. Accordingly, in tobacco control, the Authority is mandated to issue special regulatory license to tobacco product manufacturer, import, export and wholesale. It also mandated to control the content of the product through requiring disclosure of content of tobacco products and their emission. Further, it is empowered to inspect, investigate, including retail, any place or establishment in regions and collect sample of tobacco products that entered into the market with recognition of the Authority or illicit product. To strengthen the national tobacco control effort,

the Authority has the responsibility to coordinate the implementation of the World Health Organization Framework Convention on Tobacco Control (FCTC) and its implementing guideline; establish national coordinating mechanism to follow-up effective implementation of tobacco control, and work in collaboration with appropriate bodies. This includes to regulate the content and product disclosure, manufacturing, packaging, labeling, design, import, storage, distribution, advertisement, promotion and sponsorship, and related aspects of tobacco products in line with the World Health Organization FCTC and its guidelines. Proclamation No. 1112/2019 provides comprehensive tobacco control provisions consistent with the FCTC and its guidelines. The detailed provisions of the proclamation manifest the MPOWER strategies. The proclamation is implementable across the country while regions have the mandate to adopt their own tobacco control law without deviating the basic objectives, criteria and principles of the proclamation. The proclamation provides protection from tobacco smoke at work and public places, public transport and communal places of condominium housing. The requirement to display graphic health warning at 70% of front and back of the principal display area of tobacco pack is one of the key provisions in the law. The government of Ethiopia adopted the Excise Tax Proclamation No. 1186/2020 and raised tax on tobacco products. In addition to these MPOWER measures, the proclamation has included prohibition of sale to/by person under age of 21, sale at public and work places, comprehensive ban of tobacco advertisement, promotion and sponsorship (TAPS), forbid interaction of partnership between tobacco control organization and the industry.

In regard to the enforcement, the Authority is empowered to conduct market surveillance, collect sample and undertake laboratory test, suspend or revoke license it has issued, seize, recall or confiscate the product. Further, it has the mandate to order for disposal or return to the country of origin a product not compliant to the requirements of the law. When the violation contained criminal element, the Authority notify the relevant body (police and public prosecutor) to undertake the investigation and prosecution.

In addition to EFDA, regions have broad mandate in regional tobacco control activities. The Authority mandate is limited to import, export and manufacturing and wholesale for cross regional aspect. The remaining activities such as enforcing the prohibition of smoking in work and public places, public transport; prohibition of sale to/by a person under the age of 21;

prohibition of single stick sale, outdoor and advertisement limited to the region; prohibition of display at point of sale; etc. shall be enforced by regional health regulators. In fact, the Authority has the mandate to inspect the product including at retail establishment and take administrative measures against the product while the regional counterpart take measures against the establishment. As a leading agency and responsible body to coordinate national committee, the Authority have the responsibilities to provide technical support to regions and ensure compliance to the national law and international obligation (FCTC). Overall, the Ethiopian tobacco control activities shall be undertaken through the EFDA and regional counterparts. These bodies are mandated to control tobacco in their respective jurisdiction and protect public health of the country.

4.2. NATIONAL TOBACCO CONTROL STRUCTURE

Ethiopia has federal government structure. Accordingly, the structure of tobacco control enforcing bodies structured at federal and regional government levels. The EFDA is part of the federal government and accountable to the Ministry of Health. It is a leading agency at federal government in product regulation including tobacco. The regulatory structure at regional level varies from region to region. For instance, the regulatory body in Addis Ababa City Administration is an independent body established by law and accountable to the Health Bureau while in Amhara region the regulatory is established as a department within the Health Bureau. Though this kind of structure is the result of positive dimension of federalism government structure, it has its own impact in harmonizing the national to region and region to region efforts of tobacco control. This particularly related to resource allocation and communication.

Notwithstanding the challenges, the Authority and regional regulators have been making tremendous effort to achieve tobacco control policy. They have established joint platform where they can discuss the challenges and success in undertaking their responsibilities. Beyond the regulators joint platform, there is health joint steering committee that composes the Authority, regional regulators, regional health bureau and the ministry of Health. This platform used to discuss the challenges and evaluate overall achievement of the implementation of health policy of the country. Accordingly, the leaderships take the responsibilities to address the challenges and put direction. Beyond this platform, the National Tobacco Control Coordination Committee

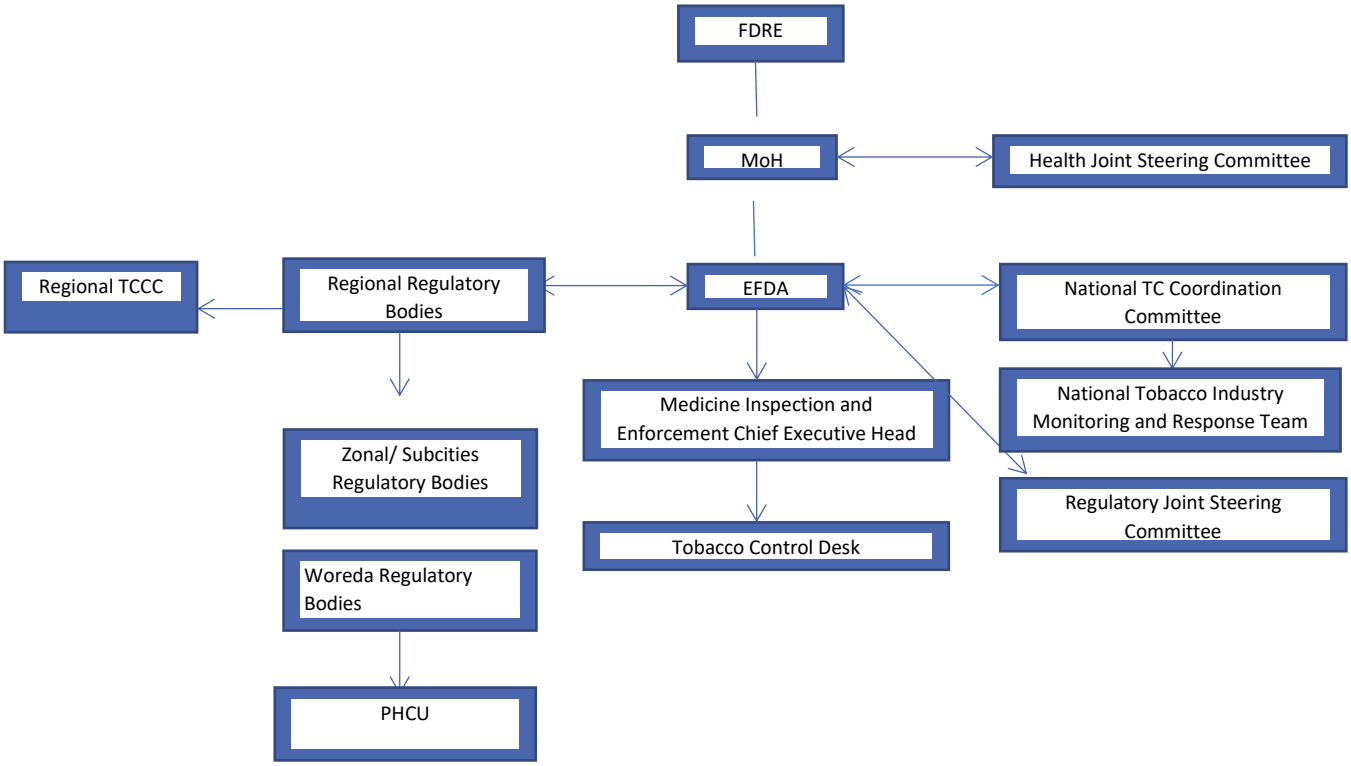
(NTCCC) established through tobacco control Directive 771/2020. NTCCC is composed of federal government organizations, WHO and local civil society organizations.

Concerning internal structure, the Authority has tobacco control team under product safety directorate. This team is responsible to coordinate tobacco control activities in relation to mandate given to the Authority. The inspection directorate and legal directorate provide support to the team in their respective competency. As we have seen above, the structure of tobacco control in regions varies from region to region. But, in overall understanding, tobacco control structured at regional level mostly within in Health Bureau, and woreda level. The following chart illustrate the current Ethiopian tobacco control body's structure.

Table1: Ethiopian Tobacco Control Milestones in Adoption of FCTC

	Year/ Period/Date	Tobacco Control Legislation/Policy
1	2004/ Feb/25	Ethiopia signed the WHO FCTC
2	2014/ Jan/21	WHO FCTC ratified In Ethiopia
3	2014	Proclamation No.822/2014 legal framework gave mandate to EFDA and regional regulators to regulate tobacco and coordinate implementation of the WHO-FCTC
4	2015/Mar/20	Tobacco control directive no.28/2015 endorsed
5	2017/Oct/31	GATS assessment Conducted and Tobacco Control Strategic Plan launched
6	2019/Feb/05	EFDA Proc.1112/2019 endorsed with very strigent WHO FCTC provisions
7	2020/Mar/17	Excise Tax Proclamation No. 1186/2020
8	2021/Apr/13	Federal Tobacco Control Directive no.771/2021

Fig 4: EFDA Structure



4.3 ROLE OF MOH AND RHBS

Tobacco as a major NCDs risk factor pose significant challenges on Public Health. 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 play crucial roles in implementation of some of the key FCTC components. These include but not limited to tobacco dependence cessations; generate evidence on effect of tobacco on health, especially on NCDs and health services; health education on the harms of tobacco in health institutions; educating, healthy life style promotion and monitoring of tobacco-free households through health extension workers; advocacy and monitoring of tobacco-free health institutions and health offices; and inter-sectoral collaboration with different stakeholders in the tobacco control.

CHAPTER V

5. STRATEGIC ANALYSIS FOR TOBACCO CONTROL

5.1. SLOT ANALYSIS

SLOT (Strengths, Limitations, Opportunities, and Threats) analysis is used as framework for this strategic plan to evaluate the status of Tobacco control landscape in Ethiopia and develop strategic planning. This SLOT analysis presented internal and external factors, as well as current and future potential. This provides a new perspective on accomplishments, challenges and opportunities to pursue. The key findings during SLOT analysis is presented in the following matrix with four-quadrant table.

Table 2: Strengths, Weaknesses, Opportunities and Threats

Strengths	Weaknesses
▪ Enactment of comprehensive legal frameworks- TC proclamations (1112/2019), Excise Tax proclamation (1186/2020), regulations and TC directive (771/2021), PHW Directive (46/2020)) ▪ Effort to adopt 1112/2019 by regional governments ▪ Good progress in the implementation of MPOWER measures ▪ Commitment and concerted effort in Implementation of TC proclamation by federal and regional governments ▪ Availability of established Tobacco control desk in EFDA and focal persons at regional and zonal/sub city levels. ▪ Incorporation of TC annual plan by the regional regulators ▪ Tobacco Control activities and intervention incorporated in national	▪ Insufficient evidence on health, social and economic impact of tobacco as well as on the program progress ▪ Lack of impact assessment for tobacco taxation and TC law (adjustment is required based on inflation and GDP growth) ▪ Inadequate implementation of the demand and supply reduction measures of proclamation 1112/2019 for tobacco control ▪ Inadequate mobilization, engagement and ownership of community and other stakeholders. ▪ Lack of adequate budget allocations to Tobacco control due lack of allocation tobacco Taxation revenue to tobacco control activities. ▪ Legal loophole in the implementation of the proclamation such as indirect promotion, enforcement in the parks (public places), illegal products like hookah & ENDS (Electronic Nicotine Delivery System) ▪ Awareness gap and weak collaboration among law enforcers in enforcing the TC law ▪ Inadequate knowledge and capacity of health care workers on brief tobacco intervention model for quitting tobacco. ▪ Human resources limitations to implement TC program at the national and regional level ▪ Technical constraints (e.g. laboratory)hindering the tobacco control ▪ Share and replicate success in tobacco control

health policy, HSTP, HSRTP, National Strategic Action for Prevention and Control of major NCDs, EPHCCG, HEP IRT Modules, NCDs Guidelines, Hypertension training manual etc.; ▪ Active National Tobacco Control Coordinating Committee (NTCCC) and Tobacco control Industry Monitoring and Response Team (TIMR). ▪ Growing evidence on tobacco control for programmatic decisions from GYTS, GATS, STEP wise EDHS, Empty Pack Survey, TIMR etc. ; ▪ Presence of monitoring (GTCR) and evaluations mechanism such as periodic review meetings at EFDA to measure the progress in Tobacco control program. ▪ Tobacco quitting introduced with Hotline Number 952 integrated with other counseling services ▪ Presence of COC in FDA to monitor the interaction with TI ▪ Model measure for SFE enforcement and compliance such as AASFI ▪ Inclusion of NRT in essential medicines list	▪ Inadequate stakeholders' engagement, commitment and inter-sectoral collaboration ▪ Limitations in systematic investigations of tobacco industry interference tactics (Adoption of Article 5.3 across all ministries) ▪ Misconduct of certain regulators and law enforcers ▪ Lack of NRT in the formal market
Opportunities	**Threats**
▪ Presence of political commitment at national and regional levels ▪ Technical and financial support from global and regional partners ▪ Growing global concern of working on NCDs risk factors such as Tobacco. ▪ Inclusion of Tobacco control target under Sustainable Development Goal 3 (SD-3) and WHO strategic Plan. ▪ Growing role of the public and private health sector in the clinical care of NCDs ▪ Growing number of health professional training institutions (colleges of health sciences,	▪ Lack of accountability and transparency by sector organizations ▪ Growing tobacco industry interference and lack of proactive response. ▪ Inadequate awareness, misconception of the community, and social & behavioral changes related to the harmful impacts of tobacco. ▪ Global threat like COVID 19, Donor uncertainties, poverty, instability, natural disaster, and global economic downturn ▪ Lack of tobacco disposal system ▪ Lack of accentuated ITP and Inadequate control of illicit tobacco products ▪ Presence of Multinational TI company and its Monopoly right ▪ Lack of Alternative livelihood for Tobacco farmers, retailors and others

universities) ▪ Growing engagement of international and local CSO to work on Tobacco control. ▪ Government plan to increase the number of rehabilitation services for substance use disorder ▪ Presence of strong cultural values for tobacco impact ▪ Improved media engagement on TC programs	

5.2 STAKEHOLDER ANALYSIS

Tobacco control is development challenges that affect almost all Sustainable Development Goals (SDGs). Thus, multi-sectoral response is required to circumvent the pandemic. A multi-sectoral response that involves sectors is mandatory; these include actions within and between sectors, at the local, regional, national, and global levels. This response incorporates action including formulating and implementing policy: Inter-Sectoral Action, Health Public Policies and Health in all Policies. 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 also boldly highlighted in the FCTC as one of its guiding principles. This strategic Plan addressed stakeholder analysis in an effort efforts to understand the role of multi-sectoral collaborators , their interests, intentions, and the nature and level of capacity in terms of expertise and resources for strengthening tobacco control program (see 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 tobacco control.

CHAPTER VI

6. STRATEGIES TO DRIVE CHANGE

6.1. VISION, MISSION, GOAL

Visions	To see “tobacco-free” Ethiopia
Mission	To protect Ethiopians from tobacco harm through comprehensive and multi-sectoral collaborative implementation of the national TC laws and FCTC
Goal	To reduce morbidity, and mortality caused by Tobacco burden and its socio-economic impact in Ethiopia

6.2 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 Teamwork

6.3 STRATEGIC OBJECTIVES AND STRATEGIES

Strategic Objectives

SO1: Monitoring tobacco use in Ethiopia

SO 2: Protecting people from tobacco smoke

SO 3: To reduce the number of people using tobacco by helping users to quit

SO 4: To warn about the dangers of tobacco smoking

SO 5: To enforce bans on tobacco advertising, promotion and sponsorship

SO 6: to discourage demand on tobacco products by adjusting and enforcing tax laws

SO 7: To reduce supply of tobacco products

SO 8: To promote partnership and coordination for sustained tobacco control

SO 9: Revision of the current proclamation

Strategy 1.1: Generating evidence on policy implementation status monitoring
Strategy 1.2: Tobacco industry Monitoring
Strategy 1.3:Disclose ingredients of tobacco products
Strategy 2.1: Enforce and implement SFE laws
Strategy 2.2: Support regional governments to customize national SF laws into their context
Strategy3.1: Promote creation of supportive environment
Strategy 3.2: Increase access to cessation services
Strategy 4.1: *Sustain* effective graphic Health warning
Strategy 4.2: Generate local pictorial health warning
Strategy 4.3: Enhance public awareness on harm of tobacco
Strategy 5.1: Enforce all forms of direct and indirect TAPS on tobacco marketing
Strategy 6.1: Increase and adjust tax rates for tobacco products
Strategy6.2 : Financing tobacco tax for tobacco control program
Strategy 7.1: Curb illicit trade in tobacco products
Strategy 7.2: Enforce single stick sale prohibition
Strategy 7.3: Regional Ban on sale of tobacco to and by less than 21 years
Strategy 7.4 Support alternative livelihoods to tobacco
Strategies:8.1. Establish and strengthen a national and regional coordination mechanism
Strategies: 8.2 mobilize resources for tobacco control program implementation
Strategy9.1 Revistion of the current Proclamation

CHAPTER VII

7. STRATEGIC RESULT MEASUREMENTS

This tobacco control plan designed based on WHO MPOWER Framework. These frameworks are intended to assist a country-level implementation of effective interventions to reduce the demand for tobacco, contained in the WHO FCTC and proclamation 1112/2019. These package of MPOWER –includes:

- **M**onitor tobacco use and prevention policies;
- **P**rotect people from tobacco smoke;
- **O**ffer help to quit tobacco use;
- **W**arn about the dangers of tobacco;
- **E**nforce bans on tobacco advertising, promotion and sponsorship; and
- **R**aise taxes on tobacco.

The Stakeholders has developed a results framework indicating all the changes including output, outcome and impact expected from the implementation of the strategic plan. It also set appropriate indictors required to measure the changes. The program activities will have a desk reviewed baseline data which will indicate for all indicators. In the lifecycle of the program, there will be continuous joint supportive supervisions to enhance the progress of the program in order to achieve the outcome. In addition to these activities, Inspection will be conducted continuously to check whether there are good progresses made on creating 100% SFE in the mentioned areas. The program will also conduct cross learning review meeting with relevant stakeholders to assess the effectiveness of the program outcome. The program will track the program output and outcome during the implementation and make all the necessary adjustment as per progress if found to be necessary with common understanding with all stakeholders. The program progress and challenges in the implementation will be periodically updated for

stakeholders with the scheduled reporting timelines. Hence, periodic reports from all responsible stakeholders will be submitted to EFDA and monitored. This program will have a midterm and terminal evaluation at the midlevel and final period of the program respectively.

Table 3: Strategic Objectives, Strategies, Targets and Indicators for tobacco control

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
Strategic Objective 1: Monitoring tobacco use in Ethiopia									
Strategy 1.1: generating evidence on policy implementation status monitoring	**14**	**7**	**Out come**	**Number of reports developed for generating evidence on the impact of tobacco**	**6**	**4**	**4**	**EPHI, EFDA**	**Study Reports, 14 documents on the evidence**
1- Report generated by GATS (Prevalence, Exposure to Tobacco smoke, Cessation, Economic Impact and KAP)	1	1	Out put	# Of report generated by GATS	1			EPHI, EFDA	Report
2- Report Generated by GYTS (13-15 years of age)	1	1	Out put	# of report generated by GYTS		1		EPHI, EFDA	Report
3- Report Generated by GTCR	3	1	Out put	# of report generated by GTCR	1	1	1	EPHI, EFDA, WHO	Report
4- Report Generated on the impact of tax and pricing	2	1	Out put	# Of report generated to show the impact of Tax and pricing	1		1	EPHI, EFDA, WHO	Report
5- Report Generated on	1	0	Out put	# Of report generated to			1	EFDA, Partners	Report

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
Social impact of Tobacco				show the impact of social impact of tobacco					
6- Report Generated for morbidity and mortality impact of Tobacco	1	1	Out put	# of report generated to show mortality and morbidity of Tobacco		1		EFDA, WHO, EPHI, MOH	Report
7- Additional surveys/ SFE Assessments	1	1	Out put	# of report generated on SFE Monitoring	1			EFDA, EPHI, Partners	Report
	3	1	Out put	# of report generated on tobacco sustainability index	1	1	1		
Strategy 1.2- Tobacco industry Monitoring	**10**	**3**	**Out come**	**# of country level reports developed that shows all the interferences of the industry and its countering mechanisms used.**	**2**	**3**	**2**	**EFDA, Partners**	**Annual country report**
1- Identifying TI interferences encountered	7	TBD	Out put	Number of Tobacco industry interference identified by the industry is making to increase the image by the community	3	2	2	EFDA, Partners	Published articles, reports
2- Countering of the Interferences from the industry	7	TBD	Out put	# of countering mechanism developed and applied to minimize the image of the industry by the society	3	2	2	EFDA, Partners	Published articles, letter written, reports

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
3- Annual report on TIM	7	4	Out put	Number of reports developed per annum on TIM	3	2	2	EFDA, Partners	Report
4- Annual Tobacco Interference Index	7	3	Out put	# of report generated on tobacco interference index annually	2	2	3	EFDA, Partners	Report
Strategy 1.3- disclose ingredients of tobacco product	**5**	**01**	**Out come**	**# of disclosure reports per annum developed to check the ingredients of tobacco products**	**2**	**2**	**1**	**EFDA, EPHICSOs**	**Disclosure Report**
1- laboratory testing on tobacco ingredients/contents	3	0	Out put	# of tests conducted on the available ingredients of tobacco products per annum	1	1	1	EFDA, EPHI, ENAO (Ethiopian National Accreditation Organization)	Lab result, report
2- Report on the ingredients of tobacco products per reporting period	3	0	Out put	# of report submitted by the industry on the ingredients of tobacco from Accredited laboratory center	1	1	1	EFDA, EPHI, CSO	Report
Strategic Objective 2: Protecting people from tobacco smoke									

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
Strategy 2.1: adopt law and advocate for the enforcement by regional governments	**12 regions and two city administration**	**1**	**Out come**	**Number of regions and city administration adopted TC regulations**	**4**	**4**	**6**	**EFDA, Regional FMHACA, Partners**	**Number of regulations/ directives adopted**
1- Support regions to develop regulation/directive	14	2	Out put	# of regions & city administration supported/ followed to develop TC regulations	14			EFDA, Regional FMHACA, RHRB, Partners	Regulation, directives adopted
2- Review meetings	7	2	Out put	# of review meetings conducted in a year	2	2	3	EFDA, Regional FMHACA, RHRB, Partners	Minutes, Annual Report
Strategy 2.2: Enact and enforce 100% SFE	**60%**	**30%**	**Out come**	**% of SFE implantation applied that complies with the proclamation of the country**	**40 %**	**50 %**	**60 %**	**EFDA, Regional FMHACA, Partners**	**FDA Assessment, Inspections reports**
1-Hospitality industries including bars, restaurants, and lounges that on 100% SFE implementation	TBD	TBD	Out put	Number of hospitality sectors including bars, restaurants and lounges that created 100% SFE	TBD	TBD	TBD	EFDA, Regional FMHACA, Regional Health Regulatory Bodies (RHRB) Partners, Law Enforcement Offices (LEO)	Inspections reports
2- Transportation sectors on 100% SFE implementation	TBD	TBD	Out put	Number of transportation area and service sectors that achieved 100% SFE	TBD	TBD	TBD	EFDA, Regional FMHACA, RHRB, Partners, MOTL,	Inspections reports

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
								Regional Transport Authority, LEO	
3- Private and governmental health institutes on 100% SFE implementation	TBD	TBD	Out put	Number of health institutes (Government hospitals and health centre) that created 100% SFE	TBD	TBD	TBD	EFDA, Regional FMHACA, RHRB Partners, MOH, Regional Health Bureau, Health facilities, LEO	Inspections reports
4 – Governmental organizations on 100% SFE implementation	TBD	TBD	Out put	Number of governmental organizations in the country that created 100% SFE	TBD	TBD	TBD	EFDA, Regional FMHACA, Partners, GOs, LEO	Inspections reports
5 – Private and governmental educational institutes on 100% SFE implementation	TBD	TBD	Out put	Number of educational institutes in the country that created 100% SFE	TBD	TBD	TBD	EFDA, Regional FMHACA, RHRB, Partners, MOE, Regional Educational Bureaus, LEO	Inspections reports
Strategy 2.3: Enhance public awareness on the harm of tobacco	**30% from the baseline by 2030**	**TBD**	**Out put**	**% Public awareness and knowledge enhanced**	**10 %**	**10 %**	**10 %**	**EFDA, Partners**	**Reports, Medias used**
1 – Capacity building session provided for law enforcement officials	7	0	Out put	# of capacity building on the proclamation/ the impact of tobacco harm provided per year for law enforcement officials	2	2	3	EFDA, Regional FMHACA, Partners	Capacity Building documents,

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
2- Awareness creation to the public	7	0	Out put	# of awareness creation created to the public on the harms of tobacco/ proclamation	2	2	3	MOH, EFDA, Partners	
2- MOU signed b/n regional Police commission and regulatory bodies	14	1	Out put	# of regions and city administration signed MOU b/n regulatory bodies and police commissions to implement the proclamation on TC	14			FDA, Regional FMHACA and Regulatory bodies	MOU
Strategic Objective 3: ***To reduce the number of people using tobacco by helping users to quit***									
Strategy 3.1: **Promote creation of supportive environment**	**1,848**	**0**	**Out come**	**Number of clients supported with free line/quit rate**	**616**	**616**	**616**	**EFDA, MOH**	**Report 22% of 8400**
1- Intensive Training for new professionals recruited working on toll freeline for Tobacco quitting counseling in MOH	70	10	Out put	# of Professionals trained on Tobacco quitting counseling	25	25	20	MOH, EFDA	Training reports, attendances
2- Tobacco quitting Counseling of clients using toll freeline	8400	TBD	Out put	# of clients received counseling per year through the toll line	2400	3000	3000	MOH, EFDA	Registration book / tally sheet, Report 1200 per year (Plan of MOH)
Strategy 3.2: Increase access to cessation services	**50%**	**TBD**	**Out come**	**% of cessation service provided in the country**	**10 %**	**30 %**	**50 %**	**MOH, EFDA**	

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
1- Integrate brief intervention at Primary Health Care Unit (PHCU) by 2030/31	14,556	TBD	Out put	Number of PHCU providing integrated brief interventions	4,852	4,852	4,852	MOH, EFDA	Units opened, Registrations, Report
2- Integrate intensive intervention at Hospital by 2030/31	492	TBD	Out put	Number of Hospital providing integrated intensive interventions	164	164	164	MOH, EFDA	Units opened, Registrations, Report General (159), primary (305) and comprehensive specialized (28) hospitals
3- Tobacco quitting counseling of clients at the health facilities	1,140,000	0	Out put	# of clients who received tobacco quitting counseling at the health facilities	380,000	380,000	380,000	MOH, EFDA	Registration, Report
4- Quit rate after counseling at the health facility	182,400	0	Out put	# of clients who received counseling in the health facilities who quit tobacco smoking	60,800	60,800	60,800	MOH, EFDA	Report 16% of 1,140,000
5- HFs started NRT	28	0	Out put	Number of comprehensive Hospital provided NRT	0	14	14	MOH, EFDA, PFSA	Services availability Report
Strategic Objective 4: To warn about the dangers of tobacco smoking									
Strategy 4.1- sustain effective graphic Health warning	**100%**	**TBD**	**Out come**	**Percentage of tobacco packs with the required health warning maintained to Sustain 70% of PHW on tobacco products**	**100**	**100**	**100**	**EFDA**	**Survey and reports**

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
1 - Revise the graphical health warning	12	8	Out put	# GHW communicated with the industry for printing	4	4	**4**	EFDA, Partners	Developed PHWs, Reports
Strategy 4.2: generate local pictorial health warning	**24 local PHW**	**0**	**Out come**	**# of PHW produced**	**8**	**8**	**8**	**EFDA, Partners**	**PHW in data base, Report (We will use the better 12 pictures from the collected 24 Pics)**
1- reach Agreement with Hospitals to have a local based PHW	5	0	Out put	# of Hospitals that signed MOU to provide PHW	2	2	1	EFDA, Selected Hospitals	Signed MOU
Strategic Objective 5: To enforce bans on tobacco advertising, promotion and sponsorship									
Strategy 5.1- enforce all Forms of direct and indirect TAPS on tobacco marketing	**100% TAPS by 2030/31**	**TBD**	**Out come**	**Percentage of directive advertisement, sponsorship and promotion banned**	**100**	**100**	**100**	**EFDA, Regional FMHACA, Partners**	**Survey and reports**
1- Monitoring of continuous TAPS done by the industry	3	TBD	Out put	#of reports developed that shows continuous monitoring on TAPS in a year	1	1	1	EFDA, Regional FMHACA, Partners	Report
2- Conduct national anti-tobacco campaigns on TAPS	7 nationwide campaigns	TBD	Out put	Number of nationwide campaigns on TAPS conducted	2	2	3	EFDA, Regional FMHACA, Partners	Survey and reports
Strategic Objective 6: To discourage demand on tobacco products by adjusting and enforcing pricing and tax laws									

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
Strategy 6.1: Increase and adjust tax rates for tobacco products	**75% increment**	**54**	**Out come**	**Percentage of Excise Tax from retail sale price Specific increased**	**60**	**70**	**75**	**EFDA, MOF**	**Tax policy adjustment based on GDP and Inflation**
1- Implementation of tax and its adjustment rate on tobacco products	75%	54	Out put	% of adoption made by regions	60	70	75	EFDA, MOF, Regional FMHACA	Report
Strategy 6.2: Financing of tobacco control program	**20% revenue for Tobacco**	**zero**	**Out come**	**Percentage of resource allocated for tobacco control programs from different sources**		**10**	**20**	**EFDA, FMOH, MOF**	**Financial Report**
Strategic Objective 7: To reduce supply of tobacco products									
Strategy 7.1: Curb illicit trade in tobacco products	**1**	**TBD**	**Out come**	**Number of Protocol ratified on the Accession of ITP and its instruments by 2025**	**1**			**EFDA, MOH, MOJ, MOFA, COM, HPR, Partners**	**Ratified ITP protocol**
1- Facilitate the ratification of ITP protocol	1	0	Out put	# of protocol developed to eliminate ITP	1			EFDA, MOH, MOJ, MOFA, COM, HPR, Partners	ITP Protocol
2- Follow-ups of Implementation of ITP law	100	0	Out put	Percentage implementation of tracking & tracing and tax stamp		100	100	EFDA, MOF, Revenue Authority,	ITP Protocol, report
Strategy 7.2: Enforce single stick sale prohibition	**100% prohibition sales of tobacco in single stick**	**TBD**	**Out come**	**Percentage of compliance and enforcement**	**100 %**	**100 %**	**100 %**	**EFDA, MOH, Regional FMHACA**	**Inspection report**
1-Regions adopting and	14	**0**	**Out put**	# of regions and city	**4**	**9**	**14**	EFDA, MOH, Regional	Inspection report

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
implementing Single sale enforcement				administration adopting and implementing single sale enforcement				FMHACA	
Strategy 7.3: Regional Ban on sale of tobacco to and by less than 21 years	**14**	**0**	**Out come**	**# of regions and city administration applied ban on sale of tobacco to and by less than 21 years**	**4**	**9**	**14**	**EFDA, MOH, Regional FMHACA**	Inspection report
1- Awareness creation in the regions on the ban of sales by minors	14	0	Out put	# of regions and city administration participated in creating awareness on bans of sales by minor per annum	**4**	**9**	**14**	EFDA, Medias, Partners	Report, Medias used
2- Enforcement single cell prohibition by all regions	14	0	Out put	# of regions and city administration ban of sales by minor by regions	**4**	**9**	**14**	EFDA, Regional FMHACA	Inspection report
Strategy 7.4: Support alternative livelihoods to tobacco	**120**	**0**	**Out come**	**# of farmers that changed their tobacco farm to other alternatives from the 5 farming sites**	**40**	**40**	**40**	**EFDA, MOH, MOA, MOLS Partners**	**Report, Case Stories**
1- Capacity building on alternative livelihood to farmers	7	0	Out put	# of awareness creation sessions created for farmers on the impact of tobacco per annum	2	2	3	EFDA, MOH, Partners	Training reports
2- Agreement with MOA and Ministry of Labour	1	0	Out put	# of MOU signed to come up with	1			EFDA, MOA, MOLS	Signed MOU

Strategic Objective and Strategy	**Measurement**							**Responsible Organization**	**Means of verification**
	Total Target	**Baseline**	**Indicator**		**Detail Targets**				
			Type	**Description**	**23-25/26**	**26-27/28**	**28-30/31**		
and Skill on the livelihood to tobacco				alternative livelihood with MOA					
	1	0	Out put	# of MOU signed to come up with alternative livelihood with Ministry of labour and skill	1				
2- Alternative livelihood for tobacco farmers	120	0	Out put	# of farmers that changed their tobacco farm to other alternatives	40	40	40	EFDA, MOA, Partners	Case stories, reports
Strategic objective 8: To promote partnership and coordination for sustained tobacco control									
Strategies 8.1. Establish and strengthen a national and regional coordination mechanism	**14 National & Regional TCCC**	**13**	**Out come**	**# of federal & regional committee Strengthened for national coordination Committees**	**14**	**14**	**14**	**EFDA, Partners, stakeholders**	**Annual report, Minutes of the meetings**
	5 sub committees created in 14 regions and City Admin	**1**	**Out Come**	**Number of sub committees established for TIMR, TAX, PHW, IT, TAPS in 12 regions and 2 city administration**	**5**	**10**	**14**	**EFDA, Partners, stakeholders**	
Strategies 8.2 Resources mobilization and allocation for tobacco control program implementation	**TBD**	**TBD**	**Out come**	**Amount of Resource mobilized and allocated for TC implementation program**	**TBD**	**TBD**	**TBD**	**EFDA, Partners, MOH**	**Mobilization Report**
Objective 9- Revision of the current proclamation									
Strategy 9.1- Revision of 1112/2011	**1**	**1**	**Out come**	**# of proclamation revised to**			**1**	**EFDA, MOH, MOJ, COM, HPR**	**Revised proclamation**

Strategic Objective and Strategy	Measurement							Responsible Organization	Means of verification
	Total Target	Baseline	Indicator		Detail Targets				
			Type	Description	23-25/26	26-27/28	28-30/31		
				implement comprehensive TC program					

7.1 MONITORING AND EVALUATION OF THE PROGRAM

The implementation of the strategic plan will be monitored on a regular basis by collecting and reporting data. For this purpose, annual and semi-annual monitoring and reporting cycles will be followed. The monitoring reports will give a summarized comparison of planned activities and achieved outputs and utilization of resources.

Quarter, Biannual and Annual Regional and NTCCC Program Review Meeting: A reviewing process provides an auspicious opportunity for assessing progress in program implementation, exchange views and experiences and facilitate problem solving and possible reorientation of programs. To these ends, EFDA and respective regulatory bodies will arrange annual review meetings.

Mid Term and final Evaluation of the strategic plan: The evaluation of progress made in implementing the Strategic Plan will be undertaken at mid-course by the key stakeholders. The objective of this mid-course evaluation is to review the progress being made. It is also to assess how resources are used, checks whether planned activities are carried out and objectives are being met. The mid-term evaluation should enable the EFDA and key government bodies to review its intervention, determine which activities have not been completed, and formulate a revised operational plan for completing all activities and strategies outlined in the main plan document. The final evaluation will be conducted by an external evaluator towards the end of the strategic plan period so that the feedbacks from these evaluators will feed into the preparation of the next Strategic Plan.

Table 4: Monitoring and Evaluation plan

S/N	M and E and learning	Timeline	Output /Outcome indicators	Means of verification.
1.	Periodic reporting	Annual	#of reports submitted	Report
2.	Quarter and Biannual Regional and NTCCC meetings	Quarter and biannual	#of meeting report generated	Report
3.	Annual Program Review Meeting	Annual	#of Program Review meeting conducted	Report
4.	Midterm Evaluation and Revision of SPM	Mid 2025/27	Evaluation conducted at the mid-level	Report
5.	Terminal Evaluation	2031	Terminal evaluation conducted	Report

CHAPTER VIII

8. RISK ASSESSMENT AND MITIGATION STRATEGIES

Tobacco Control Strategic Plan anticipate a risk while navigate through the strategic plan timeline. The table below indicated the anticipated risks with their mitigation strategies.

Table5: Ethiopian Tobacco Control Strategic Plan Anticipated Risks and Mitigation Strategy

S/N	Anticipated risks and Assumptions	Mitigation Strategies
1	Tobacco Industry Interference	Strengthening Tobacco Industry Monitoring and Response Team by systematic capacity-building that proactively strive to realize the muli-sectoral response to protect tobacco control policies from commercial and other vested interests of the tobacco industry
2	Emergence of new and novel tobacco products such as e-cigarettes and heated tobacco products globally	Strong enforcement of the proclamation 1112/2019 that prohibit the manufacture, wholesale, distribute, sell, or offer to sell or import to trade any electronic nicotine delivery system or other related cigarette resembling technology product.
3	The depiction of tobacco in entertainment media products, such as films, theatre and games, providing the tobacco industry with multiple loopholes to promote their products.	Strengthening the enforcement of requiring certification that no benefits have been received for any tobacco depictions, prohibiting the use of identifiable tobacco brands or imagery, requiring anti-tobacco advertisements and implementing a ratings or classification system that takes tobacco depictions into account.
4	The addictive properties of nicotine that makes cessation difficult.	Developing systematic cessation guidelines and program addressing the cessation of all tobacco products including smokeless tobacco and water pipes, and availing NRT and pharmacologic treatment for nicotine addiction.
5	Illicit trade of tobacco products	Accentuating Protocol to Eliminate Illicit Trade in Tobacco Products which is an international treaty with the objective of eliminating all forms of illicit trade in tobacco products through a package of measures to be taken by countries acting in cooperation with each other.
6	Weak Surveillance, monitoring and research	Strengthening the surveillance, monitoring and research to provide the national and regional database that will guide future actions and track progress, particularly in policy enforcement, helping to ensure compliance at the highest achievable level
7	Effective tobacco control necessitates muli-sectoral participation, strong partnerships and networking	At the national level EFDA must engage with other government ministries, agencies, CSO, and at regional level RRHB must engage with other regional bureaus, agencies and CSO and religious leaders to fully address the comprehensive nature of

		tobacco control. Within society in general, the public sector needs to work collaboratively with appropriate private sector counterparts for effective advocacy and community mobilization to support tobacco control policies and program.
8	Political instability, and insecurity	Communicate and closely work with local government bodies. Monitor security situation and mitigate risk this include identify areas high security concern. It will also collaborate with other partners/stakeholders for updated information exchange. Improve regional engagements.
9	Insufficient funding sources including external source	Update and improve the strategy for domestic resource mobilization. Mapping new potential donors and develop fit to purpose projects. Maintain and comply with existing donors to have funding mechanism dedicated to national tobacco control activities. Additionally, to have tobacco control policies and interventions integrated into related health in identifying tobacco control as a priority in national non-communicable disease plans and non-health program.

CHAPTER IX

9. FINANCING THE STRATEGIC PLAN

This TC strategic Plan is expected to cost equivalent to 600 million ETB. The financing of this strategic plan includes government allocation of TC Budget and Partners financing for Tobacco Control. The detailed Budget for tobacco control summarized in the table below

Table 6: Summery of Estimated Budget for Implementation of strategic Plan

Strategic Objective 1: Monitoring tobacco use in Ethiopia	Budget 2023-2025	Budget 2025-2031	Total Budget	Source	Remark
Strategy 1.1: Generating evidence on policy implementation status	6,000,000	12,000,000	18,000,000	EFDA, EPHI, CSO, WHO	
Strategy 1.2 Tobacco industry Monitoring	7,000,000	14,000,000	21,000,000	EFDA, CSO, WHO	
Strategy 1.3 Disclose ingredients of tobacco products	2,000,000	6,000,000	8,000,000	EFDA, CSO, WHO	
Strategic Objective 2: Protecting people from tobacco smoke					
Strategy 2.1: Enforce and implement SFE laws	15,000,000	30,000,000	45,000,000	EFDA, MOH, CSO, WHO	
Strategy 2.2: Support regional governments to customize national SF laws into their context	7,000,000	14,000,000	21,000,000	EFDA, CSO, WHO	
Strategic Objective 3: To reduce the number of people using tobacco by helping users to quit					
Strategy3.1: Promote creation of supportive environment	7,500,000	16,000,000	23,5000,000	EFDA, CSOs, WHO	
Strategy 3.2: Increase access to cessation services	20,000,000	40,000,000	60,000,000	EFDA, MOH, CSO, WHO	
Strategic Objective 4: To warn about the dangers of tobacco smoking					
Strategy 4.1: *Sustain* effective graphic Health warning	3,000,000	9,000,000	12,000,000	EFDA, CSO, WHO	

Strategy 4.2: Generate local pictorial health warning	1,000,000	3,000,000	4,000,000	EFDA, CSO,	
Strategy 4.3: Enhance public awareness on harm of tobacco	23,000,000	50,000,000	73,000,000	MOH, EFDA, EPHI, CSO, WHO	
Strategic objective 5: To enforce bans on tobacco advertising, promotion and sponsorship					
Strategy 5.1: Enforce all forms of direct and indirect TAPS on tobacco marketing	7,000,000	15,000,000	22,000,000	EFDA, CSO, WHO, Media	
Strategy 5.2: Conduct national anti-tobacco campaigns on TAPS	20,000,000	40,000,000	60,000,000	EFDA, CSO, WHO	
Strategic Objective 6: to discourage demand on tobacco products by adjusting and enforcing tax laws					
Strategy6.1: Ensure implementation of tax and adjustment rate on tobacco products	7,000,000	10,000,000	17,000,000	EFDA, CSO, WHO	
Strategic Objective 7: To reduce supply of tobacco products					
Strategy 7.1: Curb illicit trade in tobacco products	6,000,000	14,000,000	20,000,000	EFDA, CSO, WHO	
Strategy 7.2: Advocate for the policies that most effectively reduce illicit tobacco trade	9,500,000	15,000,000	24,500,000	EFDA, CSO, WHO	
Strategy 7.3: Enforce single stick sale prohibition	13,000,000	20,000,000	33,000,000	EFDA, CSO,	
Strategy 7.4: Regional Ban on sale of tobacco to and by less than 21 years	9,000,000	15,000,000	24,000,000	MOH, EFDA, SCO, WHO, Media	
Strategy 7.5: Support alternative livelihoods to tobacco	22,000,000	40,000,000	62,000,000	EFDA, CSO, MOA	
Strategic objective 8: To promote partnership and coordination for sustained tobacco control					
Strategies: 8.1. Establish and strengthen a national and regional coordination mechanism	10,000,000	20,000,000	30,000,000	EFDA, CSO, WHO	
Strategies: 8.2 allocate and mobilize resources for tobacco control program	7,000,000	15,000,000	22,000,000	EFDA, CSO, WHO	
Total cost	**202,000,000**	**398,000,000**	**600,000,000**		

CHAPTER X

10. CONCLUTIONS

This national tobacco control strategy is an important strategic action for tobacco control responses in Ethiopia .The time span of implementation is from 2023 to 2030/31.The strategic responses designed to meet and incorporate WHO MPOWER package interventions .It will act as roadmap for Ethiopian government effort for sustainable tobacco control response to meet SDGs targets. The overall cost for the implementation of the strategic plan estimated to be 600Million ETB. The major source of these budget will be financed by the government allocation at federal and regional level. The remaining amount will be covered from resources mobilized by partner for tobacco control response. The implementation of the plan further requires joint concerted effort from all stakeholder and relevant sectors. The interventions also require further close monitoring through survey and tailored assessments. This will advance the implementation status and produce high impact. The plan with ignite collaborations among all concerted stakeholders and it will move forward the Tobacco Control program in Ethiopia .It will ultimately aim to safeguard the public from hazard posed by tobacco and contribute to end the epidemic.

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ANNEXURE

Annex I: Stakeholder Analysis Matrix

Stakeholder	Their interest	Regulator's interest	Resistance level	importance	Response of the Authority
House of the Peoples' Representatives	○ Draft legal frameworks ○ Executing the authority and responsibility properly ○ Timely submission of plan and performance report ○ Implementation of feedbacks	○ Policies and legal framework that strengthens and support the sector ○ Leadership support ○ Follow up the implementation of legal enforcement ○ Follow up tobacco control activity plans and reports ○ Giving orders to all government ministries to implement or enforce tobacco plans	○ Loss of trust on the sector ○ Putting accountable for not executing its mandate	High	○ Strong monitoring and evaluation of plan and performance ○ Proper execution of authority and responsibility ○ Corrective actions based on feedback obtained

Council of Ministers (PMO)	○ Need/expect Draft Proclamation and Regulation ○ Need to insure the controversy of the proclamations with other sectors proclamation. It means whether the proclamations are affected by or it affects the other sectors policies. ○ Implementation of authority and responsibility ○ Gap Identification in the area of tobacco rule and regulations. ○ Strong M&E on implementation of tobacco control.	○ Review/Evaluation and approval of proclamation and regulation timely ○ Evaluation of the draft proclamation and regulation timely and resend the feedback to the authority ○ Leadership support ○ Intervention of policies regarding tobacco. ○ Follow up and support the leadership of the authority	○ Dissatisfaction and loss of trust ○ Dissatisfaction and loss of trust ○ Putting as accountable	High	○ Strong monitoring and evaluation of performance system ○ Strong information exchange system ○ Designing accessible legal framework
Ministry of Revenues and Customs Commission	○ Collaboration and integrated work ○ Timely inspection and port clearance ○ Joint work on control of illegal trade ○ Technical support ○ Information exchange	○ Integrated effort ○ Following the prerequisite of port clearance ○ Timely information exchange ○ Joint work on control of illegal trade ○ Avoiding redundancy	○ Being Uncooperative ○ Not Willing to exchange information ○ Not following appropriate procedure	High	○ Providing technical support and awareness creation ○ Continuous follow up ○ Strengthen joint work on control of illegal trade ○ Provision of current and reliable information

		of system for ensuring the disposing of unfit for use health products			
Ministry of Trade	○ Collaboration and integrated activities ○ Issuance of business license for tobacco factory, importer, exporter and wholesalers based on certificate of competence ○ Up-to-date information exchange on regulatory measures ○ Strong regulatory system ○ Awareness on regulatory laws	○ Integrated activities ○ Joint work on illegal trade ○ Joint control of illegal trade of health products ○ Up-to-date information exchange on regulatory measures ○ Implementation of regulatory measures ○ Enforce tobacco product sellers in the market ○ Enforcement of laws ○ Enforcement of duty free tobacco sell	○ Weakness of collaboration and integration activities ○ Loss of trust/ confidence	High	○ Participation on standard development ○ Provision of Up-to-date information on regulatory measures ○ Joint work on illegal trade ○ Strengthen integrated work
Ministry of Health	○ Plan and performance report on time ○ Execute authority and responsibility ○ Need based and implementable standards ○ Integration and Collaborative activities ○ Information exchange	○ Integration and Collaborative activities ○ Leadership support and Reliable and up-to-date information ○ Participation in the preparation of tobacco	○ Accountability ○ Denial of leadership support ○ Dissatisfaction and loss of trust ○ Loss of trust/ confidence ○ Abstain from	High	○ Strong monitoring and evaluation of performance system ○ Strong information exchange system ○ Strengthening system of relation ○ Reinforcing joint forums

		implementation activity ○ Preparation in performance review meeting ○ Building/Establish quitting institution ○ Risk based research finding ○ Trained health professionals ○ Replacement therapy medicine	collaboration and integration activities		
Minister of Tourism	○ Quality health and health related products • Up-to-date and Reliable information ○ Quick response	○ Active participation ○ To become owner the regulatory system (sense of regulatory ownership) ○ Educating the tourist ○ Informing tobacco legal instrument	o Loss of credibility o Dissatisfaction o Collaborate with illegal practice o Accountability	High	○ Ensuring the community participation and mass mobilization ○ Provisioning of up-to-date and reliable information ○ Ensuring the quality of health and health related Products & services ○ Provision of adequate response for public queries
Ministry of Justice	○ Clear, and understandable Draft legal framework ○ Comprehensive Legal Study or detail information about the draft law, ○ Participation on the development of legal	○ Integrated work ○ Technical support for having clear and understandable legal framework ○ Fast response on court cases ○ Proper interpretation,	○ Not compassionate ○ Being uncooperative	High	○ Participation on the development of legal framework ○ Strengthen cooperation and integrated works

	framework(not mandatory) ○ Clear and complete evidence ○ Technical support	enforcement and monitoring of regulatory laws			
Ministry of Finance	○ Plan and performance report on time ○ Submission of Program budget request on time	○ Approval of requested Program and budget ○ Exchange of performance report on and information ○ Technical support ○ Collecting tobacco tax	○ Abstain from collaboration and integration activities ○ Accountability	High	○ Strong monitoring and evaluation of performance system ○ Strong information exchange system ○ Effective and proper budget utilization ○ Correcting financial utilization, material handling and use based on feedback
Ministry of Education	○ Integrated works ○ Participation on the preparation of continuous professional development ○ Participation on the development and revision of health sciences training fields curriculum	○ Integrated works ○ Quality health sciences training and quality health professionals ○ Quality regulatory science course in training curriculum ○ Information on quantity and type of graduate health professionals ○ Ensuring the quality of health sciences training institutions ○ Incorporate the program in the	○ Withdraw from collaboration and integrated works	High	○ Participating in control and professional competence development activities

		education book/ curriculum ○ Research on tobacco effects			
Ministry of Agriculture	○ Integrated and collaborative activities ○ Information exchange	○ Integrated and collaborative activities ○ Information exchange ○ Participation on preparation of legal basis for food regulation ○ Issuance of veterinary certificate for agricultural products ○ Minimizing the tobacco agricultural products on the land ○ Change tobacco growers to other household products	○ Loss of trust/ confidence ○ Abstain from collaboration and integration activities	Medium	○ Strengthen collaboration and integrated activities
Ministry of Women and Social Affairs	○ Create Tobacco free working area/office ○ Enhancing the capacity of youth by Educating people, especially young people to monitor tobacco use & Making young people abstain from smoking tobacco ○ Awareness &Mobilization about Tobacco impact	○ Integrated work ○ Information exchange ○ Educate the community	○ Loss of trust/ confidence ○ Abstain from collaboration and integration activities	Medium	○ Strengthen collaboration and integrated activities

	○ By Mobilizing the community Create Tobacco free Youth Personality Centres & Youth Organizations				
Ethiopian Airport Authority	○ Collaboration and integrated work ○ Conduct inspection and inspection and timely authorizing port clearance ○ Technical support ○ Information exchange	○ Integrated work ○ Proper handling and storage of food and medicines ○ Respect prerequisite for port clearance ○ Joint work on the control of illegal trade ○ Ensuring vaccination of international travelers ○ Information communication to the travelers about Ethiopian tobacco legal framework	○ Not cooperative ○ Practicing inappropriately	High	○ Strengthen integrated works ○ Provision of awareness training ○ Strengthen joint work on the control of illegal trade
Ethiopian Broadcast Authority	○ Support and collaboration on implementation of advertisement proclamation ○ Information exchange on media related activities ○ Awareness on control of promotion of health products and services ○ Memorandum of understanding and	○ Integrated work ○ Control of medias that breaching the directive ○ Participation on the development of legal instruments regarding promotion of health products ○ Working on the Film industry	○ Not giving focus	High	○ Involving on the development of legal instruments regarding promotion of health products ○ Familiarization of legal instruments on promotion of health products and services

	recognition on joint work about media	○ Working on Tobacco TAPS legal enforcement			
Federal Police Commission	○ Accusation ○ Detailed legal framework ○ Awareness on legal instruments ○ Technical support ○ Exchange of current and reliable information ○ Strong Collaboration and Joint work on Criminal investigation and illegal trade	○ Enforcing the laws ○ Technical support ○ Integrated work on illegal trade ○ Cooperation on the control of narcotic drugs and psychotropic substances ○ Joint work on control of drug trafficking	○ Being uncooperative ○ Not willing to exchange information	High	○ Strengthen integrated works ○ Provision of technical support ○ Provision of awareness training on legal instruments
Ethiopian Public Health Institutions	○ Collaborative work ○ Efficient issuance of certificate of competence ○ Fast response ○ Awareness on legal frameworks ○ Technical advice and support ○ Information exchange	○ Research based findings on the requirements of legal frameworks ○ Suggestion on the service provision ○ Joint work on control of tobacco use ○ Building institutions and trained professionals ○ Provision of quality services/quitting places ○ Information exchange	○ Breaching laws ○ Uncooperative for control of illegal trade	High	○ Ensuring good governance and efficient service delivery ○ Continuous provision of awareness on legal frameworks ○ Provision of feedback on the comments obtained ○ Establishing motivational schemes
Civil Society Organization	○ Good performance on international conventions about narcotic drugs and psychotropic substances	○ Technical and Financial support ○ Current information on tobacco use and	○ Making accountable ○ Deny cooperation ○ Deny technical	High	○ Enforcing international conventions about narcotic drugs and psychotropic substances

	○ Report on demand and consumption of narcotic drugs, psychotropic substances and precursor chemicals ○ Enforcing international conventions about narcotic drugs and psychotropic substances	industry interference ○ Information about the situation of tobacco neighboring countries	and financial support		○ Submitting up to date and reliable report on demand and consumption of narcotic drugs, psychotropic substances and precursor chemicals ○ Up to date and reliable report
Associations of Health Professionals	○ Collaborative work ○ Good governance and efficient services delivery ○ Participation on activities of the sector ○ Awareness on legal frameworks ○ Reporting the fruits of their technical support to the sector ○ Information exchange	○ Integrated works and collaboration ○ Promoting legal frameworks to their members ○ Building their capacity to take part in professionals licensing ○ Participation in different advisory committees ○ Up-to-date information exchange ○ Research and training	○ Uncooperative and unresponsive for integrated activities ○ Dissatisfaction ○ Poor and unethical practise	High	○ Ensuring good governance and efficient services ○ Continuous provision of awareness on legal frameworks ○ Provision of feedback on the comments obtained ○ Participatory approach in place ○ Establishing motivational schemes
Nongovernmental Organization	○ Competent and efficient regulatory system the ensures primary healthcare ○ Good performance on International Health Regulation ○ Cooperation and integrated works	○ Cooperation and integrated works ○ Technical and Financial support ○ Research and community mobilization	○ Making accountable ○ Deny cooperation ○ Deny technical and financial support	Medium	○ Up to date and reliable report

	○ Rational Medicine Use				
Ethiopian Investment Agency	○ Integrated works ○ Efficient issuance of certificate of competence ○ Awareness on legal frameworks ○ Timely information exchange	○ Collaboration and Integrated work ○ Participation on the development of legal frameworks ○ Timely information exchange ○ Not giving extra land to tobacco investments	○ Uncooperative and unresponsive for integrated activities	Medium	○ Strengthen integrated works ○ Awareness on existing legal frameworks ○ Strengthen information exchange
Federal Civil Service Commission	○ Ensuring work place safety in civil service organizations ○ Creating smoke free civil servant to enhance productivity and service delivery ○ Work on the execution of proc.no. 1112/2011 in the civil service organizations.	○ Mobilization and awareness creation	Unable to address the whole civil service organizations to bring behavioural change.	Medium	Well organized report

Annex II: Stakeholders Consultation

Participants/stakeholders list during Tobacco Control Strategic Plan consultation meeting on June 5-7/2023

Venue: KM International Hotel at Adama Town

No	Name of participants	Organization	Region
1.	Ramadan Ibrahim	Harer regional health Bureau	Harer
2.	Shami Muhid	Harer regional health Bureau	Harer
3.	Nebil, Muluneh	Harer regional health Bureau	Harer
4.	Eline Kelemwork	Harer regional health Bureau	Harer
5.	Mulugeta Koye	EFDA Bahir Dar Branch	Amhara
6.	Asia Nur	Afar regional health Bureau	Afar
7.	Ahmed Mohamed	Afar regional health Bureau	Afar
8.	Yenus Mohamed	Afar regional health Bureau	Afar
9.	Sargius Pal	Gambela regional health Bureau	Gambela
10.	Man Moon	Gambela regional health Bureau	Gambela
11.	Shiferaw Deresa	B/Gumuz regional health Bureau	Benishangul Gumuz
12.	Fekadu Banzo	B/Gumuz regional health Bureau	Benishangul Gumuz
13.	Getachew Addisu	B/Gumuz regional health Bureau	Benishangul Gumuz
14.	Birkti G/Egziabeher	EFDA Mekelle Branch	Tigray
15.	Juhar Abegaz	EFDA Kombolcha Branch	Amhara
16.	Mulatu Tesefaye	EFDA Drie Dawa Branch	Drie Dawa
17.	Mesfine Teshome	EFDA Drie Dawa Branch	Drie Dawa

18.	Yosef Abun	EFDA Kombolcha Branch	Amhara
19.	Damaye Gabisa	EFDA Jimma Branch	Jimma
20.	Getahune Teshome	EFDA Jimma Branch	Jimma
21.	Semeter Ahmed	Somali regional health Bureau	Somali
22.	Kedir Ahmed	Somali regional health Bureau	Somali
23.	Ismehan Ahmed	Somali regional health Bureau	Somali
24.	Tesfamikael Bayeh	Amhara region EPSS	Amhara
25.	Mesfine Liben	Amhara region EPSS	Amhara
26.	Berhanu Alemayehu	SW regional health Bureau	South West
27.	Alemtsega Ayele	SW regional health Bureau	South West
28.	Adane Kocheto	SW regional health Bureau	South West
29.	Abebe G/Selase	Tigray regional health Bureau	Tigray
30.	Bahre Teka	Tigray regional health Bureau	Tigray
31.	Teame Aredom	Tigray regional health Bureau	Tigray
32.	Solomon Asayehegne	EFDA Mekelle Branch	Tigray
33.	Serido Omar	Drie Dawa regional health Bureau	Drie Dawa
34.	Zewdu Kidane	Drie Dawa regional health Bureau	Drie Dawa
35.	Isemael Ali	Drie Dawa regional health Bureau	Drie Dawa
36.	Ramadan Nurie	Drie Dawa regional health Bureau	Drie Dawa
37.	Getenet Sentayehu	Amhara regional health Bureau	Amhara
38.	Hailu Merekebu	Amhara regional health Bureau	Amhara
39.	Muluneh Guadie	Amhara regional health Bureau	Amhara
40.	Agerie Tarekegne	Amhara regional health Bureau	Amhara
41.	Yeneshet Bekel	Oromia regional health Bureau	Oromia

42.	Zelalem Mengistu	MWECS	Addis Ababa
43.	Eskndir Ketema	EFDA	Addis Ababa
44.	Heran Gerba	EFDA	Addis Ababa
45.	Asnacech Alemu	EFDA	Addis Ababa
46.	Baharu Zewdi	EFDA	Addis Ababa
47.	Yonas Mekie	EFDA	Addis Ababa
48.	Sisay Endale	Addis Ababa University	Addis Ababa
49.	Betelehem Dagnachew	EFDA	Addis Ababa
50.	Tesefa Marew	Addis Ababa University	Addis Ababa
51.	Teshome Wogaso	Sidama regional health Bureau	Sidama
52.	Tigst Bedada	Addis Ababa FMHACA	Addis Ababa
53.	Moges Ketema	SNNP regional health Bureau	SNNP
54.	Teshager Fikere	Sidama regional health Bureau	Sidama
55.	Belay Kassu	SNNP regional health Bureau	SNNP
56.	Tigest Tesfay	Addis Ababa FMHACA	Addis Ababa
57.	Mahlet wubeshet	Addis Ababa FMHACA	Addis Ababa
58.	Markos Mamo	Sidama regional health Bureau	Sidama
59.	Tsega Kokebe	SNNP regional health Bureau	SNNP
60.	Debalke Fentaw	EFDA	Addis Ababa
61.	Amogne Manaye	EFDA	Addis Ababa
62.	Demoz Aman	EFDA	Addis Ababa
63.	Belay Beyene	EFDA	Addis Ababa

64.	Gedamnesh Aseferaw	Addis Ababa EPSS	Addis Ababa
65.	Wondie Alemu	EFDA	Addis Ababa
66.	Wondwosen Hailu	EFDA	Addis Ababa
67.	Bisrat Fantaye	FMOH	Addis Ababa
68.	Emebet Wondmu	EFDA	Addis Ababa
69.	Shimeles Mengistu	EFDA	Addis Ababa
70.	Dawit Dikasso	EFDA	Addis Ababa