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ADDIS ABABA UNIVERSITY
COLLEGE OF LAW AND GOVERNANCE STUDIES
SCHOOL OF LAW

**Implementation of Tobacco Smoke-Free Laws in Addis Ababa: The Case of Four and Five-
star Hotels.**

**A Thesis Submitted for the Partial Fulfillment of the Requirements of LL.M Degree
(Public International Law Stream) to The School of Law.**

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Addis Ababa
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Approved by Board of Examiner

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Declaration

I, Freselam Yosef Herby declare that this study entitled “Implementation of Tobacco Smoke-Free Laws in Addis Ababa: The Case of Four and Five-star Hotels.” Is my original work and has not been presented in any institution before, and that all referred materials are duly acknowledged.

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Acknowledgments

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LIST OF ACRONYMS

Art	Article
Arts	Articles
AAFMHACA	Addis Ababa Food Medicine and Health Care Administration and Control Authority
COP	Conference of the Parties
EFDA	Ethiopian Food and Drug Authority
ETS	Environmental Tobacco Smoke
FCTC	Framework Convention on Tobacco Control
FDRE	Federal Democratic Republic of Ethiopia
FMHACA	Food Medicine and Health Care Administration and Control Authority
GATS	Global Adults Tobacco Survey
GA	General Assembly
HPR	House of People Representative
MOH	Ministry of Health
NCD	Non Communicable Disease
NCI	National Cancer Institute
NIE	National Tobacco Enterprise
NTCD	National Tobacco Control Directive
Para.	Paragraph
SFL	Smoke-Free Law
SHS	Second-Hand Smoker
SIDS	Sudden Infant Death Syndrome
UN	United Nation
WHO	World Health Organization

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Abstract

This study examines the implementation of Tobacco smoke-free laws in Addis Ababa by taking four and five-star hotels. The study was conducted in Addis Ababa as a case. This study employed a qualitative research methodology and both primary and secondary sources of data are used. The respondents for the interview were selected through purposive sampling method. The purpose was to select respondents who have knowledge and information about the issue under investigation. In addition, observation has also been carried out in some selected hotels to reinforce data collection through interview. The study revealed that the Tobacco smoke-free law of the Federal Proclamation No.1112/2019 is compatible with the international law of WHO FCTC and its guideline smoke-free law requirements, however due to hotel managers/owners lack of awareness about the law, the hotels compliance to the Tobacco smoke-free law requirements was low, The research noted that enforcement mechanisms used by regulatory organs are good. Finally, the study recommends that the Ethiopian government needs to increase awareness about the law and strength its regulatory organs to implement smoke-free law.

Key words: Smoke-free law, Secondhand smoke, WHO,FCTC.

CHAPTER ONE

INTRODUCTION

1.1. Background

Tobacco is the second main cause of mortality in the world and, currently it is accountable for the death of about one in ten adults worldwide.¹ Cigarette smoking is the cause of many preventable diseases, results in premature deaths and accounts for a significant proportion of many health risks.² While many of the ills caused by tobacco smoke are self-inflicted, secondhand smoke also referred to as environmental tobacco smoke (ETS) is additionally a grave danger to a non-smoker.³

Secondhand smoke (SHS) or passive smoke, is that the combination of side-stream smoke, i.e. smoke that is emitted between puffs of burning tobacco and mainstream smoke (the smoke that is exhaled by the smoker).⁴ SHS is a complex mixture of thousands of gases and particulate matter emitted by the combustion of tobacco products and from smoke exhaled by those smoking.⁵

During the year 2018, 942 million men and 175 million women aged 15 or older were exposed to tobacco globally, among which one fifth of the men and one third of the women had SHS exposure.⁶ Despite the decreasing number of smokers in the west, African countries are experiencing an increase in the use of Tobacco as tobacco industries shift their marketing focus

¹Frazer Kate and others, 'Legislative Smoking Bans for Reducing Harms from Secondhand Smoke Exposure , Smoking Prevalence and Tobacco Consumption (Review)Summary of Finding for the Main Comparision' (2016) 2 The Cochrane Database of Systematic Reviews 4.

²World Health Organization(here in after WHO),WHO report on the Global Tobacco Epidemic,(2008) p.23.

³Jessica Niezgodna, 'Kicking Ash(Trays): Smoking Bans in Public Workplaces, Bars, and Restaurants-Current Laws, Constitutional Challenges, and Proposed Federal Regulation;Note' (2007) 33 Journal of Legislation 99.

⁴Simon Chapman, *Public Health Advocacy and Tobacco Control: Making Smoking History* (Blackwell 2007).

⁵Ibid p.123

⁶Drope Jeffrey et al, *The tobacco atlas*, (6th ed. American cancer society and vital strategies 2018).

from the west to Africa.⁷ This has a potential to further increase tobacco use and tobacco related disease and death in our continent. A recent survey conducted in Ethiopia showed that about 5% of the populations are tobacco smokers.⁸

Given this devastating consequences of tobacco, Different measures have been proposed to mitigate the effects of tobacco on the public throughout the world. Legislations against the control of tobacco have been the backbone of this effort. The WHO Framework Convention on Tobacco Control (WHO FCTC) has been a pioneer in the international fight against the global spread of the tobacco epidemic. The World Health Assembly approved the convention in May 2003, and started implementation on February 2005.⁹ At international level, WHO FCTC called for the need to protect non-smokers and allow them to live in a smoke-free environment as per Article (8) of the FCTC. The Guideline for Article (8) is a useful tool for Parties; it serves as a guide for developing and implementing legislation that aims to protect people from exposure to tobacco smoke.¹⁰

Ethiopia is one of the countries in Africa that signed the convention to ratify WHO FCTC early in 2004.¹¹ Nonetheless, its implementation has been delayed until 2014 when the legislature ratified the convention.¹² Since this legislation had significant limitation to align with the WHO FCTC obligations, the HPR passed a new legislation which comprehensively banned smoking, which is known as Food and Drug Authority proclamation No.1112/2019 in 2019.¹³

⁷Jacqueline Tumwine, 'Implementation of the Framework Convention on Tobacco Control in Africa: Current Status of Legislation' (2011) 8 International Journal of Environmental Research and Public Health 4312.

⁸ Ethiopian Public Health Institute, Ministry of Health and WHO, Ethiopian STEPS Report on risk factors for chronic –non communicable disease and prevalence of selected NCDs, Ethiopia(2015)(STEPS).

⁹ WHO Framework Convention on Tobacco Control,2302 U.N.T.S.166 (adopted in May 2003, entered into force February 2005),(hereinafter WHO FCTC)

¹⁰World Health Organization, WHO report on the Global Tobacco Epidemic (2017),p.66.

¹¹ WHO Framework Convention on Tobacco Control, WHO Fact Sheet, (2019),https://www.who.int/fctc/signatories_parties/en/ accessed 20 May 2019.

¹² WHO FCTC Ratification Proclamation, 2014, proc No.822, Fed.Neg. Gaz.,2014.,year 20th 15,no.16.

¹³ Ethiopian Food and Drug Authority (hereafter EFDA)proclamation No.1112/2019,Fed.l Neg. Gaz.,year 25th ,no.39

1.2. Statement of the problem

The global estimate of smokers has surpassed the billion marks and shows no sign of decline. Currently, more than 8 million people die from tobacco-related illnesses, out of which 1.2million are non-smokers who die for being exposed to SHS.¹⁴ There is also a deep-rooted causal link between exposure to SHS and increased morbidity and mortality.¹⁵ Epidemiological and other studies have proofed that SHS exposure increases the danger of lung cancer, cardiovascular disease, stroke, asthma, and other significant health outcomes like eye and nasal irritation and among which children are most at risk as a result low birth weight.¹⁶ The low and middle-income countries are especially facing a disproportionate increase in the burden of tobacco related diseases.¹⁷ In African countries the prevalence of tobacco uses ranging from 4% in Ghana to 27.2% high in Lesotho.¹⁸

As tobacco is a serious global health problem, Smoke-free legislation is the best method of reducing exposure to SHS.¹⁹ The degree of implementation of this legislation has significant effect on the global population including both smoker and non-smokers. Optimal regulation and directives to implement this legislation at the population level will ensure long term adherence and effectiveness of the legislation. Worldwide significant improvement has been seen in developed countries implementing WHO FCTC smoke-free legislation in indoor and public places.²⁰ African countries had been condemned for not having an adequate legal framework for

¹⁴ World Health Organization, WHO report on the global tobacco epidemic (2019) p.17.

¹⁵MC Farrelly and others, 'Changes in Hospitality Workers' Exposure to Secondhand Smoke Following the Implementation of New York's Smoke-Free Law' (2005) 14 Tobacco Control 236.

¹⁶ United States. Public health office. Office of the surgeon general office on smoking and health, The Health Consequences Involuntary Exposure to Tobacco Smoke: A report of surgeon general. (Dep. of health and human and service center for disease control and prevention National center for chronic disease prevention and health promotion office of smoking and health: Atlanta, GA 2006).

¹⁷ World Health Organization, (2019) (n14) p.18.

¹⁸ Rachel Brathwaite and others, 'A Systematic Review of Tobacco Smoking Prevalence and Description of Tobacco Control Strategies in Sub-Saharan African Countries; 2007 to 2014' (2015) 10 PLoS ONE 1.

¹⁹ Alisa B Naiman, Richard H Glazier and Rahim Moineddin, 'Is There an Impact of Public Smoking Bans on Self-Reported Smoking Status and Exposure to Secondhand Smoke?' (2011) 11 BMC Public Health.

²⁰ Ibid p.2.

solving increasing tobacco problem.²¹ Besides, most of the counties in Africa also have weak law to control the increasing tobacco related problems.²²

Ethiopia, the second most populous country in Africa and a developing country, is not immune to this problem. In Ethiopia, the correct number of smokers and its effect on those who are exposed is not known. However, a 2016 study by the Global Adult Tobacco Survey (GATS) conducted in Ethiopia indicates that 5% (3.4million) of the Ethiopian smoke tobacco and nearly one-third of adult are exposed to SHS at workplace.²³ The same study reveals that the rate of exposure to second-hand smoking in bars and nightclubs was considerably high (60.4%), and is also significant in restaurants (31.1%).²⁴ The report concludes that the country is under risk of the tobacco epidemic and also admitted exposure to SHS is highly prevalent in the country. Despite the prevalence of tobacco epidemic, evidence about the previous legal and policy frameworks on tobacco control and implementation in Ethiopia is also limited.²⁵ Therefore, the time ripe to ensure the implementation of strong tobacco control measures in Ethiopia, most notably, smoke-free law in a public place is important.

The adoption of the WHO FCTC its ratification and the enactment of new legislation proclamation No.1112/2019 is aimed at comprehensively banning smoking in all indoor public places and certain outdoor areas. Under this new law, smoke-free place were established, the prohibition of smoking in all public places including hotels (bars and restaurants), workplaces, means of transport, and other outdoor spaces.²⁶ In addition, the law imposed both administrative and criminal sanctions when the smoke-free provisions violate.²⁷ The passage of the law can be

²¹William Onzivu, 'Public Health and the Tobacco Problem: Interna-Tional Legal Implications for Africa' (2001) 29 Georgia Journal of International and Comparative Law 223.

²² Ibid.p.225.

²³ Ethiopian public Health Institute, Food, Medicine, and Healthcare Administration and Control Authority, WHO; and Center for disease control, Global Adult Tobacco Survey: Executive summary, Ethiopia (2016) (GATS).

²⁴ Ibid p.3.

²⁵Daniel Asfaw Erku and Eyasu Teshome Tesfaye, 'Tobacco Control and Prevention Efforts in Ethiopia Pre- And Post-Ratification of WHO FCTC: Current Challenges and Future Directions' (2019) 17 Tobacco Induced Diseases.

²⁶ EFDA Proc.No 1112 /2019,Art.48.

²⁷ Ibid art (48) and (68).

the government's acknowledgment of the tobacco epidemic and exposure to tobacco smoke becoming a major threat to public health in Ethiopia.

The WHO FCTC smoke-free provision requires several implementation activities. The government of any state needs to 'implement, its executive, legislative, administrative and other measures'²⁸ to execute the provision fully. As a result, the Ethiopian legislature has all these duties to implement the law effectively and comprehensively ban smoking in all public places.

Despite this increasing burden of the tobacco epidemic in Ethiopia and the adoption of these very important laws, their degree of implementation has not been studied previously and thus is not known. The compatibility of the proclamation No.1112/2019 with the WHO FCTC has not been studied. This study is assessing the compatibility of the new comprehensive smoke-free law of proclamation No.1112/2019 with WHO FCTC and implementation of the law in four and five-star hotels (herein after the hotels) in Addis Ababa.

1.3. Objectives

1.3.1 General Objective

The general objective of this study is to analyze the federal proclamation No 1112/2019 comprehensive smoke-free provisions implementation and its compatibility with WHO FCTC.

1.3.2 Specific Objectives

- ✓ To analyze the compatibility of proclamation No.1112/2019 smoke-free laws with the WHO/FCTC and its guidelines requirement.
- ✓ To analyze the implementation of smoke-free laws in Addis Ababa's hotels.
- ✓ To investigate how hotels in Addis Ababa start implementing smoke-free laws and major challenges in the implementation.
- ✓ To assess how regulatory organs enforce smoke-free law.

²⁸ FCTC Art.8.

1.4. Research questions

1. Is the smoke-free law enacted by the federal government proclamation No.1112/2019 compatible with the WHO Framework Convention on Tobacco Control (WHO FCTC)?
2. How is the smoke-free law implemented Addis Ababa hotels? Do the hotels comply with the smoke-free provisions of Proclamation No. 1112/2019?
3. What are the mechanisms employed by the regulatory organs in enforcing smoke-free law in Addis Ababa hotels?
4. What are the major challenges and constraints in the implementations of smoke-free laws in hotels?

1.5. Scope of the research

Though there are several tobacco control laws, this paper is only focused on the WHO FCTC's Article 8 of the smoke-free in public places and relevant Ethiopian laws. The desk review analysis of the study is mainly focused on the evaluation of federal proclamation No.1112/2019 law adopted to implement smoke-free in commercial public places(as represented by four and five-star hotels in Addis Ababa) in light of WHO, FCTC's smoke-free provisions. Besides, the study evaluates the compliance of some the hotels in Addis Ababa with smoke-free requirements of the applicable laws.

1.6. Significance of the research

- ✓ It creates awareness to public about Ethiopian smoke-free law.
- ✓ It serves as an input to further research in the area.
- ✓ The findings and recommendations of the study will serve as a stepping stone for further review on Ethiopian smoke-free regulation.
- ✓ It helps as reference to the government authorities in adopting further laws and policies.

1.7 Limitation

The researcher had two main problems well undertaking this study. First one was the lack of previous legislative history and documents on tobacco control, and second problem was unwillingness of hotel owners and managers to give information concerning tobacco smoking.

1.8. Methodology

To address the research questions, the researcher used a qualitative methodology, used both primary and secondary source of data.

The researcher reviewed national and international tobacco control and other law documents, Interview has been conducted based on pre-set interview questions with hotel owners/managers and Semi-Structured interview with concerned Government Authority and tobacco control inspectors. In addition structured observation of selected hotels has been made by having an observational checklist to get a systematic and objective observation of the presence the ashtrays, cigarette butts remains, designated smoking areas, are used as primary source of data. Books, articles, documents, working papers, reports and also websites of related tobacco are used as a secondary source of data.

The researcher has chosen Addis Ababa four and five-star hotels, this place because the federal proclamation NO.1112/2019 has the mandate to control this hotels as the license and competence of certificate given by federal organs, and also as Addis Ababa is the seat for of Africa Union and those hotels are the symbol of Ethiopia as most of their customers are from abroad and to show how our star hotels comply with international standards. Thus, this research used purposive sampling techniques. The researcher took into consideration respondent's expertise in the field, their experience about the issue and their role in the implementation of the laws in purposively selecting sample respondents.

After data collection and organization the data analysis was done using the descriptive and explanatory data analysis method. The researcher triangulated data generated through interview, observation and document analysis to identify conflicting views and reinforce the finding of the study. Triangulations were important in clarifying some issues and identifying the reality on the ground.

1.9. Literature Review

Likely related to the newness of smoke-free laws in Ethiopia, I was unable to find literature on smoke-free laws or their implementation in Ethiopia. However, a few prior studies have examined the perception of smoking in various Ethiopian locations. Janet Chung-Hall, et al in

their worldwide study on the impact of WHO FCTC implementation in the first decade.²⁹ They analyzed that there is progress in the implementation of FCTC.³⁰ According to the authors, implementation was highest for smoke-free laws. However, in their study, they focus on the general implementation of the framework convention. Jacqueline Tumwine widely scrutinized *'the implementation of the framework convention on tobacco control in Africa'*.³¹ The author focuses on the three areas of the framework convention. One of the areas was protection from exposure from tobacco smoke. Upon analyzing smoke-free legislation in Africa an overwhelming majority of the countries were found to have a legislative provision that permits a designated smoking room.³² However when the study was conducted Ethiopia doesn't even ratify the convention so in the absence of national tobacco control legislation passed by the parliament implementation is difficult, as they lack legal backing.

The literature on the implementation of FCTC smoke-free law in Ethiopian legislation is not studied that much. Extant studies focused on the domestic practice of adult tobacco use with Khat and they are limited to some areas and other school-based cross-sectional even such studies either focus on specifically on smoke-free regulation or comparative studies with the WHO FCTC. Few studies have been conducted pertinent to smoke-free laws in Ethiopia. For instance, Edilu Shona found that banning smoking in a public place under the Ethiopian legal framework is not comprehensive and its implementation is ineffective to ensure protection of the general public from tobacco danger specially SHS.³³ However, his work is conducted well the total smoking ban in a public place was not enacted. It's difficult to conclude the implementation of smoking banned in a public place without having a comprehensive law.³⁴

²⁹Janet Chung-Hall and others, 'Impact of the WHO FCTC over the First Decade: A Global Evidence Review Prepared for the Impact Assessment Expert Group' (2019) 28 Tobacco Control S119.

³⁰ibid.6

³¹Tumwine (n 7) p .314 .

³²Ibid p 317.

³³Edilu Shona,"Banning Smoking in Public Places Under Ethiopian Legal Framework: Some Evidence From Hawassa City"(2017)(526-550)Beijing law review BLJ 8.

³⁴Ibid p. 546.

Daniel Erku, and Eyasu Teshome Tesfaye studied *'The Ethiopian tobacco control and prevention effort pre-and-post ratification of WHO FCTC'*.³⁵ In their study, the authors examine the compliance of the national tobacco control directive of Ethiopian (NTCD). They only see the National tobacco control directive. Moreover, they try to look at the general compliance of the WHO FCTC obligation in Ethiopia after the ratification of the convention. Tadesse and Zawdie examined *'non-compliance of smoke-free legislation among health care staffs in governmental Hospitals in Addis Ababa'*.³⁶ They argued by their finding that non-compliance was high. Nevertheless, their study was conducted with the law that permit's designated smoking area. Therefore, this paper adds to the existing literature on compliance of smoke-free law with WHO FCTC, the implementation of the smoke-free law in Addis Ababa hotels and the progress to be made in implementation by examining ways.

1.10. Organization of the thesis

This paper contains five chapters, divided into sections and subsections. Chapter one is an introduction. Chapter two covers overview of legal and different policies framework concerning Tobacco control and smoke-free laws internationally and in Ethiopia. Chapter three covers the analysis of the compatibility of the smoke-free law of proclamation no.1112/2019 with international law. The fourth chapter is where the result of the implementation of the law in the study area has been assessed. The final chapter of this paper is conclusions and recommendations.

³⁵Erku and Tesfaye (n 25) p.25.

³⁶Tamiru Tadesse and Belay Zawdie, 'Non-Compliance and Associated Factors against Smoke-Free Legislation among Health Care Staffs in Governmental Hospitals in Addis Ababa, Ethiopia: An Observational Cross-Sectional Study' (2019) 19 BMC Public Health 1.

CHAPTER TWO

THEORETICAL AND LEGAL FRAMEWORK OF TOBACCO CONTROL AND SMOKE-FREE LAW

2.1 INTRODUCTION

The story of the origin and spread of tobacco goes back thousands of years. In the year 1000 B.C people already has started using the leaves of tobacco plant for smoking and chewing.³⁷ The recreational use of tobacco started in the latter half of the 16th century, and at the start of the 17th century pipe smoking became popular. From the late 1800s, as a result of the developments in mechanization and transport which led to less demanding modes of production, use of tobacco increased dramatically.³⁸ In the same century, it spread across Europe and to the East Asian countries, and subsequently the Portuguese and Spanish traders took tobacco to Africa during their voyages.³⁹

In the early twentieth century, Cigarette smoking grew rapidly particularly in America with the wide spread use of modern technology for bunch production. The change of consumer culture, and grateful advertising and promotion on an unprecedented national scale also played a significant role in this era.⁴⁰ During the world War time the consumption of cigarettes became even more popular.⁴¹ As a result during WorldWar I and the end of World War II the Consumption of cigarettes increased and smoking rate was at its historical peak in developed countries of the world.⁴² These western countries further spread smoking culture through Africa

³⁷Lo Chang-fa, 'Establishing Global Governance In The Implementation Of FCTC: Some Reflections On The Current Two Pillar and One-Roof Framework.' (2006) 1 International Conference on Global Governance & Partnership 569.

³⁸Manu Raj Mathur and Dorairaj Prabhakaran, 'Tobacco and CVD: A Historical Perspective' (2012) 7 Global Heart 107.

³⁹Gene Borio, 'Tobacco Timeline' (1997) <<https://academic.udayton.edu/health/syllabi/tobacco/history2.htm#1900-1950>>accessed on 20, June 2020.

⁴⁰Richard Kluger, *Ashes to Ashes_ America's Hundred-Year Cigarette War, The Public Health, and the Unabashed Triumph of Philip Morris* - Libgen (1996).

⁴¹Ibid 41-47.

⁴²Ibid 35-45.

during their colonization of African countries.⁴³ Since, then smoking remains the most popular means of tobacco consumption worldwide.

In Ethiopia, the exact time when tobacco smoking began is not known but evidence indicates the presence of tobacco smoking in Ethiopia for many years as evidenced by numerous people in different parts of the country who use traditional tobacco in different forms, like by snuffing, chewing and pipe smoking (Gaya).⁴⁴ However, around the beginning of 20th century, the first tobacco factory was established in Dire Dawa in 1931 (1923E. C).⁴⁵

Tobacco is a major challenge for the 21 century as tobacco-related health effects are increasing and destroying generations and, unless urgent action is taken, tobacco could kill one billion people in this century.⁴⁶ Over 80% of the world's 1.3 billion tobacco users live in low- and middle-income countries, a category that Ethiopia finds itself.⁴⁷ All data's show tobacco use and its danger are increasing globally and at a national level with a similar trend.

In this chapter tobacco use and its effect on smoker, and non-smoker and, international and the national legal frameworks that can be implemented for the protection these epidemic are reviewed.

2.2 Tobacco use and public health

Tobacco products are unique in that they are the consumer goods that kill half of their user when used as intended.⁴⁸ There is no more room for contention or doubt regarding the fact that smoking kills. Tobacco smoke contains more than 7000 chemicals and compounds, among them

⁴³Ibid.

⁴⁴Zebasil Tassew, 'Levels of Nicotine In Ethiopian Tobacco Leaves' (MS Thesis, AAU 2007).

⁴⁵Ibid p.6.

⁴⁶ WHO report (2008)(n 2),p.12.

⁴⁷ World Health Organization (WHO), 'Tobacco Factsheet' <<https://www.who.int/news-room/factsheets/detail/tobacco>> accessed 25 August 2020.

⁴⁸ Ibid p.8.

approximately 70 of which are well established to be toxic and major cause for cancer and also known to impact the cardiovascular system.⁴⁹

The fact is that tobacco use can kill in numerous ways, in which it is a risk factor for six of the eight leading causes of death within the world.⁵⁰ Smoking most ordinarily results in diseases affecting the heart and lungs and is a serious risk factor for heart attacks, chronic obstructive pulmonary disease, emphysema, and cancer, particularly lung and pancreatic cancer.⁵¹ For women Tobacco is a major cause in miscarriages and the fetus can develop health problems like premature birth, low birth weight, and increased chance of sudden infant death syndrome (SIDS).⁵² For male smoker, it makes chance of male erectile dysfunction approximately 85% higher compared to non-smokers.⁵³ The use of tobacco also results in loss of income; Psychological effects due to chronic illness are other additional factors that affect family of tobacco users.⁵⁴ As a result of all this devastating effects, it becomes one of the key causes of loss of quality of life, or healthy years of life lost in the world.

2.2.1 The Health risks of tobacco on secondhand smoker

The health consequences of smoking do not end with the smoker, in that 1.2 million people who have never smoked die each year from diseases caused by being exposed to SHS.⁵⁵ SHS exposure causes serious disease and death, and even brief exposure can be harmful to health it causes a multitude of harms, including lung cancer, heart disease, respiratory illnesses. SHS exposure particularly to children increased possibility of SIDS, asthma, pneumonia and bronchitis.⁵⁶

⁴⁹ United States. Public Health Office. Office of the surgeon general office on smoking and health, The Health Consequence of smoking: 50 Years Progress National. (Dep. of health and human and service center for disease control and prevention National center for chronic disease prevention and health promotion office of smoking and health: Atlanta, GA 2014).

⁵⁰ WHO report (2008) (n 2),p.42.

⁵¹ United States. Public health office (2006) (n 8) p.123.

⁵² Ibid P. 93

⁵³ Ian Peate, 'The Effects of Smoking on the Reproductive Health of Men' (2005) 14 362.

⁵⁴ WHO Report on the Global Tobacco Epidemic (2009) p.24-26.

⁵⁵ WHO Report (2019) (n 14) p.18.

⁵⁶ United States. Public health office, (2006) (n 8) p.649.

Globally, Every major scientific body in the world, including the WHO, the International Agency for Research on Cancer, and the US Centers for Disease Control and Prevention, have reached the same conclusion that SHS is a serious health threat and a significant cause of disease and death. The US Surgeon General's 2006 Report on the Health Consequences of Involuntary Exposure to Tobacco Smoke found that SHS exposure causes disease and premature death in children and adults who do not smoke. The report concluded that "*there is no safe level of exposure to secondhand smoke.*"⁵⁷ Therefore, Health and scientific authorities around the world agree SHS is a serious threat to human health and that effective action must be taken to reduce exposure.⁵⁸ Although most of the people die by the tobacco epidemic have been developed countries since the increase tobacco consumption the consequences have rapidly spread to developing countries in the last several decades.⁵⁹

Ethiopia was one of six countries with a smoking prevalence below 5% among those over 15 years old amongst 187 countries surveyed by WHO in 2014.⁶⁰ Based on 2015, WHO tobacco use country report, 8.9% of Ethiopian men and 0.5% women age 15 years and older smoke tobacco products.⁶¹ Tobacco-related diseases such as tuberculosis, lung cancer, cardiovascular and respiratory disorders kill more than 16,800 Ethiopians every year.⁶² This all data's shows in Ethiopia, the number of consumption and health effect of tobacco is rising.

⁵⁷Ibid.

⁵⁸Ibid p.484.

⁵⁹Allyn Taylor, 'An International Regulatory Strategy for Global Tobacco Control' (1996) 21 Yale Journal of International Law 2.

⁶⁰Dr Frank Ashall, 'Frank Ashall, 'Behind the Smokescreen of Ethiopia's Surging Tobacco Production' (*Addis standard*,2015)<<http://addisstandard.com/behind-the-smokescreen-of-ethiopias-surging-tobacco-production/>> accessed 18 August 2020.

⁶¹ WHO, 'Global Health Observatory Data Repository: Tobacco Use by Country' (2015) <https://www.who.int/gho/countries/eth/country_profiles/en/> accessed 24 March 2020.

⁶²Tobacco Atlas, 'Ethiopian Factsheet' (2015) <<https://tobaccoatlas.org/country/ethiopia/>> accessed 24 March,2020.

2.3. International legal framework on tobacco control and smoke-free laws

2.3.1 The beginning of tobacco controls

During the time, when the use of tobacco consumption gaining popularity worldwide the societal religious and economic harms were also highlighted by different rulers and religious leaders, and they have started imposing different type of tobacco use restriction in their administration or among their followers.⁶³ In 1575 the Roman Catholic Church passed the first recorded legislation that prohibited smoking in any place of worship all over the Spanish colonies.⁶⁴ In the year 1624, Pope Urban VIII issued a worldwide ban on using or carrying tobacco products in any place of worship.⁶⁵ The Ottoman Empire Sultan Murad IV and Czar Michael of Russia issued legislation that bans smoking and, even violator being treated as criminals under penalty of death.⁶⁶ Hence, the main reasons for those early legislators to restrict smoking tobacco primarily were based on concerns about an adverse moral and social impact rather than specific health effects.⁶⁷

2.3.2 Tobacco control and smoke-free regulations after the 19th century

Legislation about tobacco control, specifically concerned with environmental pollution caused by smoking first appeared during the latter half of the nineteenth and the early part of the twentieth century's. This is mainly reflected in the form of ordinances or laws restricting smoking in enclosed public places, with the purpose of preventing indoor air pollution.⁶⁸ However, this initial smoking ban progress made little headway after World War I, when smoking became considered as generally acceptable form of behavior.⁶⁹ The tobacco industry

⁶³Borio (n 38) p.12.

⁶⁴ First Voyage of Columbus: Meeting the Islanders (1492) [online article]. Athena Review 1997; <<http://www.athenapub.com/coluvoy1>> Accessed august 2020.

⁶⁵Borio (n 38) p.32.

⁶⁶ Kreuter M Loddenkemper R, 'No Title' (2015) 42 The Tobacco Epidemic 1(online article) <<https://www.karger.com/Article/Purchase/369289#>>.accessed on 11,may, 2020.

⁶⁷Paul Axel-Lute, 'Legislation against Smoking Pollution'(1978).6

⁶⁸Ibid p.345.

⁶⁹A. Brandt and W Hall, 'Cigarette Century: The Rise, Fall and Deadly Persistence of the Product That Defined America', *Tobacco Control*, Book Rivew, vol 16 (2007).

was generous in providing to the Armed Services and, as a result, there was a rapid growth in cigarette smoking among young men who had no restrictions about where to smoke.⁷⁰ For some time, nonsmokers bowed to societal pressure, and either remained silent or brooked the wrath of smokers who were indignant.⁷¹ Following World War I the number of smokers increased dramatically. This trend continued further as a result of which at the end of the 2nd World War more than 70% of men and 25% of women have become smokers.⁷²

As cigarette smoking turned into prevalent and publicly acceptable, exposure to SHS became a nuisance as well; nonsmoker's capacity to sustain their rights stopped, until the health consequences of smoking were acknowledged. In the 1930s scientific evidence about ill effects of smoking started to be published, the medical community began to investigate the increase in lung cancer, and by the 1940s, scientific reports began to associate smoking with cancer, heart disease, and other adverse health effects Evidence mounted within the 1950s.⁷³ After the release of the first Surgeon General's Report on Smoking and Health in 1964, a major shift in policy approaches to control tobacco occurred.⁷⁴

In 1971, the US Surgeon General declared to the committee on smoking and health Jesse L. Steinfeld declared as follow:

*'Nonsmokers have as much right to clean indoor air as smokers have to their so-called right to smoke. It is high time to ban smoking from all confined public spaces such as restaurants, theaters, airplanes, trains, and buses. It is time that we interpret the Bill of Rights for the nonsmokers as well as the smoker.'*⁷⁵

⁷⁰Kluger (1996).101-113.

⁷¹Ibid.

⁷²David M Burns and others, 'Cigarette Smoking Behavior in the United States' (1996).

⁷³Kluger (1996).171-180.

⁷⁴ WHO International Agency for Research on Cancer(IARC) Monographs on the Evaluation of Carcinogenic Risks to Humans: Tobacco Smoke and Involuntary Smoking, vol 83 (2004).

⁷⁵Brandt and Rivew (n 69) p 83-84.

The scientific facts and the movement's of non-smoker consolidation transfer to the protection of nonsmokers led to a key new legislative agenda for tobacco control. At first, policy actions were taken as to divide smokers with nonsmokers in the same places, followed by different smoking places, and then complete bans.⁷⁶ Countries worldwide are cognizant of the harmful effects of tobacco and are trying to put in places a form of legislation which prohibits smoking in some places of a public place to reduce tobacco consumption as well as to prevent people who are nonsmokers from SHS. In 1969, Bulgaria passed legislation to ban smoking at workplaces where nonsmokers worked.⁷⁷ A year later, Singapore prohibited tobacco smoking on public transport, workplace, meeting rooms, cinemas, and specific buildings.⁷⁸

Comprehensive smoke-free law was first passed in U.S. State of California prohibited smoking in public places, including bars and restaurants, in 1998.⁷⁹ This was followed by New Zealand and became smoke-free in 2005.⁸⁰ Following, number of European countries rapidly adopted the legislation of smoke-free indoor areas.⁸¹ Australia also adopted legislation banning smoking in indoor areas.⁸² In the African region, there was not as such strong nationwide smoking ban regulation. South Africa was the first African country that passed a law making public places smoke-free but this law exempted bars and restaurants from being smoke-free in 1998, and Mauritius followed in 1999, by banning on some public place from smoking.⁸³

In the early 2000s, the enactment of smoke-free legislation by developed countries contributed to the spreading of the legislation worldwide. The implementation of these legislations shows a

⁷⁶IARC (n 74)p.91.

⁷⁷ASL Tan and others, 'Overview of Legislation and Tobacco Control in Singapore' (2000) 4 International Journal of Tuberculosis and Lung Disease 1002.

⁷⁸Ibid p.1003.

⁷⁹Brandt and Rivew (n 69) p 90.

⁸⁰Ibid p.45.

⁸¹ Zachary Cahn and others, *The Tobacco Atlas*, vol 50 (2013).

⁸²Tan and others (n 77) p.23.

⁸³Jeffrey Drope and Jeffrey M Drope, 'The Politics of Smoke-Free Policies in Developing Countries : Lessons from Africa The Politics Of Smoke-Free Policies In Developing Countries : Lessons From Africa' (2010) 5 65.

turning point in the history of smoking, and the implementation became comparatively simple to do, have many health's, societal, and economic benefits, and supported by populations.⁸⁴

2.3.3 The World Health Organization (WHO) on Tobacco control

The World Health Organization, established in 1946 with primary responsibility of improving global health situation.⁸⁵ In encouraging and supporting countries into develop domestic regulatory frameworks for tobacco control WHO have played a significant role.⁸⁶ Since 1970 the World Health Assembly recognized smoking as a critical topic and start issues a series of resolutions emphasizing WHO's priorities in tobacco control, including acknowledging the health effect of tobacco use and calling for action by member states.⁸⁷

The WHA urged members in 1976, to critically consider legislative recommendation on tobacco smoking restriction to create smoke-free areas in hospital, public transportation and work place.⁸⁸ In order to protect nonsmoker's rights to have clear unpolluted by SHS, WHA issued another resolution in 1986, which urged the Member States as a result tobacco smoke had dangerous effects to those involuntarily exposed as well.⁸⁹ In 1990 in order to strength, tobacco control WHO established the Tobacco or Health program as a separate entity within WHO.⁹⁰

In the early 1990s and late 2000 the WHO began to engage with and lead the international fight against chronic disease in a more serious manner.⁹¹ In 1993, public health scholars suggested to the WHO to make use of its treaty-making power to address the public health threat posed by tobacco use.⁹² The 9th world conference on tobacco health, held in 1994, adopted a resolution

⁸⁴Tan and others (n 77) p.25.

⁸⁵ Constitution of the World Health Organization, July 22, 1946, 62 Stat. 6349, 14 U.N.T.S. 185, reprinted in 15 DEPT ST. BULL. 211 (Aug. 4, 1946) (Constitution of WHO).

⁸⁶Taylor (n 59)p.278.

⁸⁷Ibid.

⁸⁸ Chang-fa (n 29).

⁸⁹ Ibid p.578.

⁹⁰Taylor (n 59)p.280.

⁹¹Ruth Roemer, Allyn Taylor and Jean Lariviere, 'Origins of the WHO Framework Convention on Tobacco Control' (2005) 95 American Journal of Public Health 936.

⁹²Ibid.

urging national governments and WHO to prepare an international convention. The WHO Director-General issued a brief report entitled ‘*The Feasibility of an International Instrument for Tobacco Control*,’ in 1996, which summarizes the key recommendations of the manuscript.⁹³

Toward the latter part of 2000, the WHO conducted public hearings, which garnered from public health agencies, community-based organizations, academic institutions, the major tobacco multinationals, state tobacco companies, and tobacco farming groups to make a framework convention for tobacco control worldwide. Thus, WHO is leading the battle against these far-ranging harms of tobacco first by proposing a treaty negotiated under the auspices of WHO's Article (19) of its treaty-making power in 1999.⁹⁴

2.3.4 The Framework Convention on Tobacco control/FCTC

Due to continuous impact of tobacco on people’s health and economy different states were started to take their majors, and the effort to compact the impact at international level strengthens by the WHO. It is obvious that the WHO Framework Convention on Tobacco Control is one of the majors taken at the international level for reducing tobacco use and SHS exposure through international law.⁹⁵The Convention was adopted by the 56th WHA on May 2003, entered into force on 2005. There are currently 181 Parties to the Convention, and it has become one of the most broadly embraced treaties in history of the United Nations.⁹⁶

The harm of smoking is global in scope; countries developed The Framework Convention in response to the globalization of the tobacco epidemic, and to act multilaterally to repel this global threat to public health.⁹⁷ It is an outstanding achievement in international health law and the first international legal instrument designed to promote national action and global cooperation to counter the worldwide spread of the tobacco epidemic.⁹⁸The FCTC set out,

⁹³ Ibid.

⁹⁴ Constitution of WHO (84) art. 18.

⁹⁵ Acute Coronary Events, ‘Secondhand Smoke Exposure and Cardiovascular Effects’, Secondhand Smoke Exposure and Cardiovascular Effects (2010).

⁹⁶ WHO Report (2019) (n 14) p.24.

⁹⁷ WHO Report (2008) (n 2) p.45.

⁹⁸ WHO FCTC, Article.3

internationally accepted public health standards in legally binding form. It designed to reduce deaths and diseases caused by tobacco use worldwide and protect populations from the overwhelming health, economic, social, and environmental hazards of exposure to tobacco and tobacco smoke.⁹⁹ Moreover, the Convention marks a landmark event for the protection of nonsmokers from SHS.

The Convention preamble shows how countries viewed the need to develop such a world legal document. It cites their determination ‘*to give priority to their right to protect public health*’ and therefore the ‘*concern of the international community about the devastating worldwide health, social, economic, and environmental consequences of tobacco consumption and exposure to tobacco smoke*’.¹⁰⁰ It then notes the scientific evidence for the harm caused by tobacco, the threat posed by advertising and promotion, and illicit trade, and all therefore, the need for cooperative action to tackle these problems. Articles 8 of the treaty oblige parties to protect all persons from exposure to tobacco smoke.

Tobacco control measures set by the FCTC involve all aspects, such as measures of preventing exposure to tobacco smoke, to reduce the demand for tobacco price and tax measures, regulating ingredients of tobacco products, disclosure of tobacco products, packaging and labeling of tobacco products, ban on tobacco advertisements, promotion and sponsorship and illegal trade of tobacco products, etc. Among all these measures, Article.8 is about preventing exposure to second-hand tobacco smoke.

2.3.4.1 Protection of Exposure to Tobacco Smoke under WHO/FCTC

Tobacco Smoke-free laws are widely defined as legislations including health regulation and occupational safety, which prohibit tobacco smoking in specific areas, particularly, in workplaces and other public spaces.¹⁰¹ The purpose of smoke-free laws is to protect people from health effect of tobacco, and decrease or eliminate exposure to tobacco smoke. The FCTC is a public health international treaty, which proposes to stop the danger effect of tobacco. Article .8

⁹⁹ Ibid.

¹⁰⁰ See, the preamble of WHO FCTC, Para 1 and 2.

¹⁰¹ Black’s Law dictionary (Rev.4th ed.1986)

the convention obliges members to protect citizens from exposure to tobacco smoke. Thus, the WHO's FCTC developed evidence based obligations for smoke-free legislation.

The FCTC obligates States Parties to establish smoke-free public place in order to protect population from the health, and economic effects of tobacco and exposure to SHS.¹⁰² It has arguably exerted the most significant influence on public health policy in both developed and developing countries.

Decreasing exposure to SHS helps health by significantly reducing tobacco consumption and reducing the likelihood that young people will progress to establish smoking.¹⁰³ To protect from tobacco smoke is the obligation grounded in fundamental human rights and freedoms.¹⁰⁴ Failure to protect from exposure to tobacco smoke not only undermines the right to health, but may violate a range of other human rights obligations that, in many countries, are enforceable by individuals through the courts.¹⁰⁵

The Guidelines on Protection from Exposure to Tobacco Smoke ("the Guidelines") were adopted by consensus in 2007 at the second session of the Conference of the Parties to help Parties in meeting their obligations under Article 8 of the FCTC.¹⁰⁶ They are supported on the best available scientific evidence and draw from Parties experiences in implementing measures to bring protection from exposure to tobacco smoke.¹⁰⁷ National laws should therefore enforce an entire ban on smoking so as to create 100% smoke-free environments. The Guidelines create that for Parties to meet their obligations under Article.8 of the WHO FCTC, they must require 100% smoke-free public places.¹⁰⁸ Any measures that come short of creating 100% smoke-free environments including measures allowing for designated smoking rooms with separate

¹⁰² WHO FCTC, art 3.

¹⁰³ Simon Chapman and others, 'The Impact of Smoke-Free Workplaces on Declining Cigarette Consumption in Australia and the United States' (1999) 89 American Journal of Public Health 1018.

¹⁰⁴ Guidelines for Implementation of Article 8 of the WHO FCTC: Protection from Exposure to Tobacco Smoke (hereinafter, Article 8 Guidelines) 2007: Para. 4

¹⁰⁵ Heather Selin and Javier Vasquez, Exposure to Secondhand Tobacco Smoke in the Americas 2006.

¹⁰⁶ WHO FCTC Elaboration of guidelines for implementation of the Convention (decision FCTC / COP1 (15)) Article 8 : Protection from exposure to tobacco smoke 2007 1.

¹⁰⁷ Article 8 Guidelines, Para. 1.

¹⁰⁸ Ibid Para. 6.

ventilation, air exchange, and other engineering features do not provide protection against exposure to tobacco smoke.¹⁰⁹

Under the Article 8 Guidelines, no exemptions to a 100% smoke-free law are justified on the basis of health or law arguments. The guidelines state that effective measures require total elimination of smoking and tobacco smoke in all indoor public places.¹¹⁰ To protect the public comprehensively, legislations are vital, and their implementation and enforcement should be adequately monitored and evaluated as stated in the guideline. It also provides advice on the definition of key terms in domestic legislation implementing this Article define several key terms to help shape the scope of protection to be provided. These definitions make clear that protection should extend to all indoor workplaces, including motor vehicles such as taxis and ambulances, and to all parts of indoor workplaces and public places, including corridors, stairwells, lobbies, etc.¹¹¹ this would include schools, hospitals and health care establishments, restaurants, bars, shops, train and bus stations, and airports. The guidelines are thus straight forward in establishing that the only solution to SHS exposure is enforcing 100% smoke-free public places by law.

Therefore, this all scientific reports and international legal frameworks provide a strong imperative for eliminating indoor SHS exposure and became the evidential corner stone for smoke-free regulation. Indeed, although changes in society and the emergence of the broad agenda of 'political correctness' have played their part, it is clearly the developing science that has driven the construction of laws and formulation of legal policy designed to address the issue of passive smoking. The cure for this devastating epidemic is depends not on medicines or vaccines, but on the concerted actions of government and civil society.¹¹²

Several countries have taken measures to control the use of tobacco with smoke-free laws that ban smoking in public places such as workplaces, hospitals, bars and restaurants and other public

¹⁰⁹Ibid para. 25.

¹¹⁰Art 8 of the WHO FCTC requires the adoption of effective measures to protect people from exposure to tobacco smoke in four categories of places:

¹¹¹Art 8 Guidelines, Para. 20.

¹¹²WHO report(2008) (n 2),p.7.

place reduce exposure to SHS and help some people who smoke to quit. Thus investing in tobacco control laws and implementing evidence-based legally binding laws is an affordable means of saving lives and improving health.

2.4. National legal framework on tobacco control and smoke-free legislation

2.4.1. The beginning national tobacco product controls

In Ethiopia, tobacco production factory has emerged around the beginning of the 20th century, and then in 1931, the factory was transferred to Addis Ababa which was owned by an Armenian investor.¹¹³ In 1928, the period of Empress Zewditu, Ethiopian first tobacco control regulation called Tobacco Regie was emerged.¹¹⁴ When Italian ruled Ethiopia they established another tobacco product factory for their soldiers' consumption.¹¹⁵ In 1942 Italian colonialists left the country, and the Ethiopian government declared the establishment of tobacco and matches monopole.¹¹⁶

In 1942 The Ethiopian government passed a law, which was the *Tobacco Regie* Proclamation No. 30/1942. Based on this regulation the Regie was recognized as a State Monopoly tobacco products.¹¹⁷ The Regulation carries provisions for granting a monopoly right to, manufacture, preparation, purchase, sale import and export of tobacco products from and to Ethiopia.¹¹⁸ This law was later repealed and the National Tobacco and Matches Corporation were established by Proclamation No. 197/1980 in 1980.¹¹⁹ The justification was the same, to give the government exclusive power to grow and process tobacco in Ethiopia.

In 1999, by the proclamation No. 181/1999, the monopoly right of the National Tobacco Enterprise was transferred to the National Tobacco Enterprise (NTE) shares company.¹²⁰ Based

¹¹³Tassew (n 36).6.

¹¹⁴Shona(n 33) p.534

¹¹⁵Tassew (n 36) P.6.

¹¹⁶Ibid.

¹¹⁷Shona (n 33) p.535.

¹¹⁸ Ibid.

¹¹⁹Ibid p.536.

¹²⁰Ashall, (n 60).

on this proclamation the NTE was mandated to regulate tobacco products as the only producer, importer and exporter of the product as well.

As seen earlier, Ethiopian government tobacco control regulations were intended to exclusively monopolize the market and industry of tobacco and to sustain the financial gain from tobacco products. The protection the public from the dangers of tobacco i.e. its health, environmental, economic, and social risks are in no way made for the benefit of the public as would be expected.

2.4.2 The Constitution of Federal Republic of Ethiopia

In 1994 The Federal Democratic Republic of Ethiopia (FDRE) constitution was enacted, which provides human, political, social and cultural right of the people. Among this article 44 (1) and article (92) explicitly provides that every Ethiopian should enjoy those rights.¹²¹ In the environmental rights the constitution recognized '*all persons have the right to clean and healthy environment.*'¹²² Through this, the Ethiopian government begins to show that a clean and healthy environment is a fundamental right of the people.

Since 1993, Ethiopia government started to adopt a health policy.¹²³ The health police prioritized the prevention communicable disease. In its general strategy, it promotes the revision on health legislation.¹²⁴ However, the policy gives a special concern to nutritional and communicable diseases but not tobacco related NCD. Thus, Ethiopian health policy did not strategically target tobacco-related health disease.

2.4.3 Proclamation No.661/2009

The Proclamation No.661/2009 in 2009 took the power to regulate tobacco from NTE and gave the mandate to regulate to Food Medicines and Health Care Authority (FAMACHA).The Authority was regulated the production and distribution tobacco, which includes the contents,

¹²¹ Constitution of the Federal Democratic Republic of Ethiopia,1995,Proc.No.1FederalNegarit Gazeta, No.1(hereafter FDRE Constitution).

¹²² Ibid art 44(1).

¹²³The Health Policy of the Transitional Government of Ethiopia (1993).

¹²⁴Ibid p.10

sales, use, packaging and labeling, and disposal of tobacco products.¹²⁵ Nevertheless, this proclamation tobacco regulation activity was mainly limited to regulate the production and distribution of tobacco products, and ignored, the public health implications of tobacco and prohibiting smoke-free in a public places. Therefore, the justification legislative failure to regulate tobacco products and ban smoking in any place was for the only reason of supporting the economic benefit of tobacco products under the monopoly of public enterprise.

2.4.4 Regulations 299/2013

The concept of smoke-free law, and other tobacco control regulation was first introduced in Ethiopian tobacco control history in 2013, when the implementation regulation for proclamation 661/2009 was prepared. This is the first law in Ethiopia which prohibited smoking in a public place and was a major shift to protect the public from SHS.¹²⁶ This regulation prohibited smoking *‘in a public gathering, or use place includes rooms of health institution, classrooms of an educational institution; public conveyances; dining places like hotels and restaurants; and other places.’*¹²⁷ Regulation 299/2013, gives the mandate to control for FMACHA and state government regulatory bodies at the regional level.¹²⁸ However, as smoke-free public places were determined by the regulatory organ as stated in the law, it was ineffective and it even allowed smoking in designated areas.

2.4.5 Proclamation 822/2014

Early in 2004, Ethiopia government signed the framework convention but it was ratified a decade later. This was due to the Ethiopian government economy’s strong ties with the tobacco market, as the government was the sole owner of tobacco products in the country.

The government of Ethiopia made a significant change to tobacco control when the HPR’s ratifying the WHO FCTC by Proclamation No 822/2014, in 2014.¹²⁹ This shows the government

¹²⁵ Ethiopian Food Medicine and Healthcare Administration and Control Authority (FMHACA) Proclamation No.661/2009” 2009,(art 22(2)),Fed.Neg.Gas,year 16th No.9.

¹²⁶WHO FCTC Ratification proclamation.No 822/2014.

¹²⁷Food Medicine and Healthcare Administration and Control Council of Ministers Regulation No.299/2013,Art 36, 92), a-e)and (3),reg No.11,Fed.Neg.Gaz,2014,

¹²⁸Ibid Art 3(3).

¹²⁹WHO FCTC Ratification proclamation. No. 822/2014.

decided to control the Tobacco products based on international tobacco control strategies by accepting all the controlling strategies. Thus, all tobacco control strategies incorporated in the FCTC have become part of national law, as the constitution of the country declared that any ratified international agreement is an integral part of the law of the country.¹³⁰ This proclamation gives the mandate for the implementation of FCTC to FMHACA.¹³¹

2.4.6 National Tobacco control Directives (NTCD) 28/2015

A new directive, the National Tobacco Control Directive No 28/2015 (NTCD) issued by FMHACA, was enacted to enhance the implementation of the convention following the ratification of WHO FCTC on 21 March 2015. This directive incorporates smoke-free provision by the protection of people from exposure to SHS by prohibiting smoking in any part of indoor, indoor workplaces, and public conveyances.¹³² The prohibited places cover from health and education institutions, railway stations, airports, and bus stations. In addition, it prohibited smoking anywhere within the outside premises of any place that provides services primarily to children or youth under the age 18 including playgrounds, kindergartens, education facilities, other places where children congregate, and youth centers as well.

The smoke-free public places were however subject to several exemptions and had not been comprehensive and fully enforced as exemplified by designated smoking rooms and smoking cabins in workplaces and hotels such as restaurants, bars, and pubs.¹³³ Other exemptions to smoking ban include schools in which the majority of students are over 18 years old, such as the majority of vocational schools. Smoking was also allowed in the government offices, rooms of education, and healthcare services if the owner of such place provided a designated room for smoking.¹³⁴

Despite the requirement of FCTC for 100% smoke-free places, the NTCD allowed smoking if the owner of the premises has designated smoking rooms. This is against FCTC's mandatory

¹³⁰FDRE Constitution Art.9(2).

¹³¹WHO FCTC Ratification proclamation. No. 822/2014 art.3

¹³² National Tobacco Control Directive(NTCD) No. 28/2015,Art 14(2)(a-h).

¹³³Ibid Art 15.

¹³⁴Ibid Art 15(3).

requirement and international conclusive scientific evidence which showed engineering approaches do not protect against exposure to tobacco smoke because from the designated smoking rooms smoke inevitably leaks into nonsmoking areas. Since there is no safe level of exposure to tobacco smoke, the effective way to protect people is to enact a comprehensive smoke-free law. However, the content of the directive was against this fact by allowing smoking in a designated area. Such exceptions weaken smoke-free law and incomplete smoke-free legislation might not protect from exposure to smoke.

2.4.7 The New tobacco control proclamation No.1112/2019

Ethiopia was unable to enact strong and compressive smoking prohibiting law because as seen the monopoly of the production by the government, limited political commitment, lack of awareness from the legislator about the danger of tobacco weaken to control tobacco products. Even after the FCTC has been ratified, since 2014 there was no regulation on the country level which compiles to FCTC in tobacco control, including smoke-free provisions allowed smoking in hotels, bar, and indoor public place. Because, the enacted law was lacking comprehensiveness to the tobacco control strategies put within the convention.

In Ethiopia with a population more of than 105 million, recent data shows 5% of adults use tobacco with 8.1% men and 1.8% of women, and 1.7% of adults use smokeless tobacco.¹³⁵ According to the GATS report also the exposure of SHS is 31.1% in restaurants, 60.4% in nightclubs and bars, while 11.4% in public transport vehicles and Youths aged 13 to 15 years are exposed to SHS in public areas, whereas 14.9% are exposed at home as well, a lot of people die from tobacco-related diseases within the country.¹³⁶ Furthermore, since 2016, the six largest tobacco enterprises in the world controlled the tobacco product industry in Ethiopia, and because of their extensive global market share and resources they are more capable than the government in their capital.¹³⁷ As a result, all this the prevalence of tobacco use, the burden of

¹³⁵Adult Smoking and others, 'Current Policy in Ethiopia' <<https://tobaccoatlas.org/country/nigeria/>>. Accessed on 22, August, 2020.

¹³⁶GATS report (n 23) p.2.

¹³⁷Conor Gaffey, 'Ethiopia's Capital Addis Ababa Introduces Public Smoking Ban' (*Newsweek*, 18 August 2016) <<https://www.newsweek.com/ethiopias-capital-addis-ababa-introduces-public-smoking-ban-455896>>. Accessed on 22, August 2020.

non-communicable disease, and the fear of the tobacco industry's interference motivate the government of Ethiopia to pass and implement imperative internationally applied evidence-based tobacco control regulation.¹³⁸

Ethiopian government succeeds by enacting the strongest tobacco control regulation in the country by proclamation 1112/2019 on February 27; 2019.¹³⁹ The parliament generally approved this law as one of Africa's strongest anti-tobacco laws.¹⁴⁰ The WHO FCTC, as international public health treaty, requires parties including Ethiopia to implement proven measures to reduce tobacco use, including smoke-free laws, warning labels on tobacco products, increased tobacco taxes, and a ban on tobacco advertising. This new proclamation requires 100% smoke-free public and work places to be 100% free, bans advertising and promotions of tobacco, the sale of flavored tobacco products and heated tobacco products, e-cigarettes, and shisha are banned, also prohibits sales of tobacco under the age of 21.¹⁴¹ Beside this law mandates on pictorial health warning labels covering 70% of the front and back of tobacco products. As a result of all this, it becomes comprehensive in tobacco control.

This legislation prohibited smoking in '*any part of all indoor workplaces, all indoor public places, on all means of public transport, and in all common areas within condominium housing, and other outdoor spaces within 10 meters*'.¹⁴² The proclamation additionally outlines liability and fines for any violations (non-compliance) of the laws. The earlier FAMACHA by revising its regulating mandate and changed into Ethiopia Food and Drug Authority took the implementation power at the federal level and regional regulatory organs at the state level to control and implement based on the FCTC requirements. Therefore, currently, Ethiopian government is taking steps to control tobacco products by enacting a tobacco control law to reduce its use.

¹³⁸ Ibid.

¹³⁹ Ethiopian Food and Drug Authority proclamation, proc.No.1112/2019, Fed.l Neg. Gaz., year 25th, no.39.

¹⁴⁰ Patricio V. Marquez, 'Ethiopia's New Tobacco Control Law: A Step Forward That Needs to Be Complemented by Higher Taxes!' (*worldbank.blogs*, 2019) <<https://blogs.worldbank.org/health/ethiopia-s-new-tobacco-control-law-step-forward-needs-be-complemented-higher-taxes>> accessed 18 August 2020.

¹⁴¹ Ibid.

¹⁴² EFDA Proc.No 1112 /2019(Art.48)

Conclusion

Since tobacco smoke-free laws have been justified for smoking causes massive problems of health on smokers and non-smokers, worldwide legislation has passed that ban smoking in different public places. While in Ethiopia legal restriction and regulation of tobacco products starts 50 years ago and the issue of tobacco smoke-free law has not been given concern by the government until the past ten years due to countries economic problems. But currently, the country develops its new smoke-free law proclamation No.1112/2019 which gives great concern to a smoke-free public place.

CHAPTER THREE
SMOKE-FREE PROVISIONS UNDER PROCLAMATION No.1112/2019 AND ITS
COMPATABILITY WITH WHO/FCTC

3.1 Introduction

Globally, as discussed in detail in the previous chapter, exposure to SHS results in 1.2 million deaths annually. The only way to fully protect non-smokers from the effects of smoke is to make places smoke-free by implementing comprehensive smoke-free law.¹⁴³ A number of studies, across all continents (e.g., Americas, Asia and Europe, and now more recently Africa), have shown that strong smoke-free laws lead to dramatic reductions in air pollution in indoor and public places. In the contrary, locations that do not have smoking regulations have very high levels of SHS.¹⁴⁴ According to a World Bank analysis, restrictions on smoking in public places can decrease consumption by between 4% and 10% and induce some smokers to quit smoking.¹⁴⁵ Thus, strong implementation of smoke-free law has shown to significantly reduce or eliminate SHS in key public venues, improve air quality, help smokers quit, and reduce tobacco-related illnesses, deaths, and healthcare costs.¹⁴⁶

Currently, 91% of WHO/FCTC parties had implemented measures to protect their citizens from exposure to tobacco smoke by applying a complete or partial ban on tobacco smoking in indoor workplaces, indoor public places, public transport, and as appropriate public places.¹⁴⁷ Comprehensive smoke-free law is implemented in 62 countries with 1.6 billion people (covering 22% of the world's population) with a complete smoking ban in all public places.¹⁴⁸ Among them ten African countries have implemented comprehensive smoke-free law in their country and recently Benin, Burundi, and Gambia have newly adopted complete comprehensive smoke-free

¹⁴³WHO report (2019) (n 14)p.17.

¹⁴⁴M Justin Byron and others, 'Implementing Smoke-Free Policies in Low- And Middle-Income Countries: A Brief Review and Research Agenda' (2019) 17 Tobacco Induced Diseases 1 .

¹⁴⁵Simon Chapman, 'Curbing the Epidemic: Governments and the Economics of Tobacco Control' (2000) 320 Bmj 192.

¹⁴⁶International Agency for Research on Cancer (IARC), 'Evaluating the Effectiveness of Smoke-Free Policies', vol 13 (WHO, Press 2009).

¹⁴⁷WHO report (2019) (n 14) p.7.

¹⁴⁸Ibid.

laws covering all indoor public places and workplaces. However, the other African countries have partial bans that come short of a complete ban on smoking in public places and workplaces by allowing designated smoking areas and also allowing some public places to be free.¹⁴⁹ As such, implementing comprehensive smoke-free laws that cover indoor workplaces, indoor public places and public transportation by countries as a compulsory requirement and it provides one among the most effective measures to prevent early death and health disparities.¹⁵⁰

In Ethiopia, great progress toward smoke-free law has been made in recent year when The Ethiopian government passed a new comprehensive smoke-free law to match the provision in the WHO FCTC and to meet the legal requirements of treaty ratification. The comprehensive smoke-free law, bans smoking at any indoor, some outdoor and other public places, by enacting proclamation No.1112/2019.¹⁵¹ This law includes the prohibition of smoking in all public places, hotels (bars and restaurants), workplaces, and transport. This chapter analyzes the compatibility of proclamation No.1112/2019 with Article 8 of the WHO FCTC and the guideline adopted by the WHO FCTC secretariat to implement Article 8.

3.2 Analysis of the compatibility of smoke-free provision under proclamation No.1112/2019 with WHO FCTC

Through the ratification of the WHO FCTC, countries are obligated to push for stronger legislation protecting the public from exposure to tobacco smoke as the core component of their anti-smoking activity. Accordingly, under the convention, signatory countries such as Ethiopia are required to:

‘..adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative, and/or other measures, providing for protection from exposure to tobacco smoke in indoor

¹⁴⁹ Ibid.

¹⁵⁰ WHO FCTC, Art 5.1 and 5.2.

¹⁵¹ EFDA Proclamation No.1112/2019, Art. 48(2) and (3).

*workplaces, public transport, indoor public places and, as appropriate, other public places.*¹⁵²

Since 2014, when the HPR's ratified the WHO FCTC as per proclamation 822/2014, Ethiopia has developed and implemented a partial smoke-free law that provides for smoking only in partial public spaces.¹⁵³ Recent tobacco control regulatory development has prompted the government for the introduction of a more comprehensive smoking prohibition. The comprehensive smoking ban, unlike the partial-SFL extends the prohibition to non-air-conditioned public spaces. As such, the comprehensive smoking prohibition is implemented in hospitality venues including hotels, bars, restaurants and cafes, educational, sports and cultural facilities, government buildings, public playgrounds, condominiums, airports, and public transportation.¹⁵⁴

The WHO FCTC obliged signatory states not to include any weakening provision which allows smoking in their laws, for example through including a designated smoking area. It also recommends for the definition of key terms, like public place, to be clear because the clearer the language the easier it will be to implement the law. Clear duties and responsibilities of persons responsible for premises stated and sanction clearly defined for all violation are deemed essential as well. As a party to this treaty, the federal Proclamation No.1112/2019 is obliged to adhere to and expected to fulfill all the requirements under the FCTC in order to prevent the health hazard from SHS, control a tobacco epidemic and save lives. The major obligations that all member states of the WHO FCTC including Ethiopia must fulfill are discussed in detail the following section:

3.2.1 Effective Legislation

Through the FCTC mandates, countries are obligated to push for stronger legislation protecting the public from SHS. This is usually accomplished through the passing of effective legislation that requires 100% smoke-free public places. According to FCTC, Article.8 obligated parties to

¹⁵²WHO FCTC, Art 8.

¹⁵³ National Tobacco Control Directive 28/2014, Art.15 (2).

¹⁵⁴EFDA Proclamation No.1112/2019, Art.48.

pass measures that provide universal protection from tobacco smoke in four main places.¹⁵⁵This is an essential requirement that the legislations completely prohibit smoking in all four types of places: indoor workplaces; indoor public places; public transport; and outdoor and quasi-outdoor places.¹⁵⁶Legislation that does require a complete (100%) smoke-free in those entire public place supposed to be is effective in protecting against exposure to tobacco smoke.¹⁵⁷

To be effective legislation, the implementing guideline to Art.8 of the FCTC gives broad meaning of public place, indoor and outdoor place and parties are required to make their legislation based on their meanings. As defined broadly as possible in the guideline, “public place” should be defined to cover all places accessible to the general public or places for collective use, regardless of ownership or right to access. Indoor workplace and other public places are also the main places that require protection from tobacco smoke. The definition should have to be inclusive and clear, and care should be taken in definition to avoid creating lists that may be interpreted as excluding potentially relevant indoor areas.

The definition required to include “*indoor*” areas be defined to include any space covered by a roof or enclosed by one or more walls or sides, regardless of the type of material used or structure for the roof, wall or sides no matter the sort.¹⁵⁸Therefore, when any country wants to make a smoke free law, they should include those terms, and should give a broad definition to make the law effective.

Looking into the Ethiopian law that prohibits smoking in public space, one among the purposes of the proclamation No. 1112/2019, as stated under the preamble, *‘to prevent and control the public’s health from the devastating health, social and economic consequences of a tobacco product.*¹⁵⁹ The law specifically states that intent of the legislature is to protect the people from

¹⁵⁵Article 8 Guidelines, Para. 23-24, 27.

¹⁵⁶ibid, Para 27 explains that the language “other public places where appropriate” in Article 8 refers to outdoor or quasi-outdoor places and provides that in identifying those places, Parties should consider the evidence as to possible health hazards in various outdoor and quasi-outdoor places..

¹⁵⁷Ibid Para. 6.

¹⁵⁸Ibid para.19.

¹⁵⁹ See, the preamble of EFDA Proc. No 1112 /2019.

tobacco smoke by prohibiting tobacco smoking in all indoor workplace and public transports and other public places.¹⁶⁰

This law prohibits smoking in a public place in three ways. First, as mentioned in Art 48(1) of the proclamation smoking is not allowed *‘in any part of all indoor workplace, all indoor public places, and public transport and in all common areas within condominium housings.’*¹⁶¹ This means the proclamation puts complete ban on smoking in any indoor public places. Second, sub-article 2 of the same article extends the prohibition of smoking partially up to 10 meter radius from any doorway, window to outdoor public places by limiting the length. This includes other public places like hotels, bars, restaurants and other public places the law applies to all their indoors and also their outdoor up to ten meters. Third, sub-article 3 extends the prohibition on smoking to outdoor areas by exceptionally listing places such as healthcare facilities, government institutions, schools, higher education institutions, youth centers, amusement in all this outdoor part. The proclamation accomplishes this by defining “*public place*” to include outdoor premises of health institutions, educational institutions, and children’s daycare centers.¹⁶²

Thus, the proclamation’s smoke-free provisions provide almost similar protection from exposure to tobacco smoke to WHO/FCTC smoke-free obligation by prohibit tobacco smoking in indoor public places, indoor workplaces, and public transports. The proclamation also defines relevant terms broadly and comprehensively, prohibiting smoking in those places in a way that comply with the FCTC recommendations of 100% smoke-free public place and all essential public places. From this perspective we can conclude that the Ethiopian law is compatible with the provisions of the FCTC.

3.2.2 Imposing legal Duties of compliance

Enforceable smoke-free law is not only imposing a legal duty on smokers to stop smoking in prohibited public places but it also impose primary duty to compliance with the persons in charge of the premises and means of public transport. The FCTC guideline identifies and requires that four main duties should be placed on the person in charge of the premises: those

¹⁶⁰ EFDA Proc. No 1112 /2019, Art 48(1).

¹⁶¹ Ibid Art 48 (1).

¹⁶² Ibid Art 48 (3).

are; a duty to post clear signs indicating that smoking is prohibited, a duty not to remove any ashtrays, supervise the observance of rules, and to take reasonable specified steps to discourage individuals from smoking in the premises.¹⁶³ The smoke-free provisions should have to impose those legal duties on the persons in charge of public place and means of transports.

Consistent with the FCTC, the smoke-free provisions of proclamation 1112/2019 provide a duty to enforce the tobacco smoke-free provision, as it imposes the duty on the owner or manager of a public place. In the case of the workplace, the employer or another responsible person of the public place or conveyance is duty-bound to enforce the provision.¹⁶⁴ They have to post clear no-smoking signs and are required to ensure that no person smokes in the premises, which can be interpreted as including both the duty to supervise the observance of rules, and the duty to take reasonable steps to require a person to stop smoking. Besides, the law imposes legal duties on the person in charge of the premises to post signs indicating that smoking is prohibited and to take steps to require a person to stop smoking, in one of the official languages.¹⁶⁵ The proclamation imposes legal duties and an obligation to comply with those legal duties. Thus, we can conclude that the proclamation is in line with the FCTC.

3.2.3 Providing a range of penalties

Smoke-free provisions should place a legal responsibility on both affected business establishments (i.e. the owner, manger or another person in charge of the premise) and individual smokers.¹⁶⁶ To prevent noncompliance FCTC obliges the enacted legislation should provide a range of penalties that proportionate to the seriousness of the violation and the degree of responsibility of the violator.¹⁶⁷ Article 8 of the guideline recommends monetary penalties for business establishments and leaves open to parties on whether to impose monetary penalties on individual smokers as well.¹⁶⁸ The FCTC requires that legislations enacted by member states should have to include a variety of penalties, i.e. administration measure from counsel/warning to license sanction particularly for frequent violations, fines, and, announcement of violations

¹⁶³ Article 8 Guidelines, par 31.

¹⁶⁴ EFDA Proc.No 1112 /2019,Art.50.

¹⁶⁵ Ibid Art 50 (2).

¹⁶⁶ Article 8 Guidelines, Para. 31

¹⁶⁷ Ibid, Para. 32

¹⁶⁸ Ibid, Para. 31, 32

and the measures taken to public. ¹⁶⁹Based on the violation and proper jurisdiction of the country, criminal penalties should have also imposed. ¹⁷⁰

While examining the smoke-free provision of proclamation 1112/2019, we can see that it provides measures and penalties for violation of the duties imposed in the law, including administrative measures and criminal penalties depending on the severity of non-compliance with the law. ¹⁷¹

Based on violation of the requirements different kind administrative measures are imposed in the law. ¹⁷² The criminal penalties imposed in the law include fines and/or imprisonment. ¹⁷³ Individual smokers have a duty not to smoke where prohibited and are subject to fine not exceeding one thousand Ethiopian Birr. ¹⁷⁴The proclamation stipulates that the person in charge of public places, workplace, and conveyances are subject to imprisonment not less than three months and fine from birr one thousand to ten thousand Birr when the obligation to post the sign not to smoke is not posted or smoking happened in prohibited public places and failed to take appropriate legal measures. The penalties provided for smoker and the person in charge of the premises seems enough to deter the individuals. Thus, the proclamation provides the duties and the following penalties when a breach of those duties materializes. This is consistent with the FCTC requirement recommending lesser penalties/fines for individual smokers than persons in charge of business establishments.

3.2.4 Specifying Inspectors' and Enforcement Authorities' Powers and Duties

The FCTC requires each country to establish an authority responsible for enforcement and empowered with enabling legislation. ¹⁷⁵The legislation should have to identify the responsible

¹⁶⁹ This penalty is not included in the Article 8 Guidelines but is in other FCTC Guidelines. Adverse publicity can be an effective deterrent.

¹⁷⁰ Ibid Para.33 and 34.

¹⁷¹ EFDA Proc.No 1112 /2019, Art. 65(1) and Art.67.

¹⁷² Ibid Art 65 (3)and (3).

¹⁷³ Ibid Art.67.

¹⁷⁴ Ibid Art.67(20)

¹⁷⁵ As provided in the Article 11 and 13 Guidelines, these duties should include investigating and resolving complaints.

authority or authorities (when more than one responsible organ) which has inspection powers and their duties.¹⁷⁶

The guideline requires that issues such as, authorities with the power and duty to undertake legal action to enforce the law and on inspection rights including entering the premises subject to the law and to find necessary evidence, as well the mechanisms for coordination if multiple authorities are involved should be clearly specified in the legislation enacted by the members. In addition, Art. 8 of FCTC and the Guidelines require parties to consider utilizing an inspections mechanism already in place, if possible, to monitor compliance with and enforce the provisions of smoke-free legislation.¹⁷⁷ To facilitate enforcement by the public the guidelines recommend the establishment of a toll-free telephone number those members of the public can call to report a violation.¹⁷⁸

The Ethiopian Food and Drug Authority (EFDA) is main government regulatory authority in Ethiopia, responsible for the tobacco control laws and smoke-free provisions enforcement and monitor implementation of the law as well. Proclamation No. 1112/2019 stipulates that the EFDA is responsible for at the federal level.¹⁷⁹ Also, regional health regulatory organs are empowered to impose a specific duty to enforce the law.¹⁸⁰

The inspectorial powers of an inspector under the proclamation 1112/2019, encompasses to enter at anytime where smoking is totally banned public place and during working hours in any work place ,and other tobacco smoking prohibited public place and conduct an inspection and take legal measure.¹⁸¹ An inspector shall make an observation periodically in any public place, require signage is posted, ashtray or other ashbin are present, and observe all places are compliant with the requirements of the law. There is also a toll-free telephone to report. Also in this case;

¹⁷⁶ Article 8 Guidelines, Para. 37.

¹⁷⁷ Article 8 Guidelines, Para. 36.

¹⁷⁸ Ibid para,35

¹⁷⁹ EFDA Proc.No 1112 /2019, Art. 4

¹⁸⁰ Ibid Art.63

¹⁸¹ Ibid Art .63(10)

proclamation 1112/2019 encompasses pertinent provisions that are consistent with relevant provisions of the FCTC guidelines.

3.3 Conclusions

Under the WHO FCTC smoke-free law, there are certain elements and components deemed very important in the FCTC and should be included in the laws of the signatories. In line with the WHO FCTC, Ethiopia enacted a smoke-free proclamation No.1112/2019 that completely bans smoking in all public places by imposing a legal duty and responsibility to enforce the law and specifying responsible authority to control the compliance of the law. As it has been presented in this chapter, the analysis of the various provisions of the proclamation 1112/2019 smoke-free provisions shows that it incorporates all components and provisions that are very much consistent with the WHO/FCTC requirements and obligation to be imposed in the law. The upshot is that the smoke-free law enacted by the government of Ethiopia is in line with the framework Convention of the WHO.

CHAPTER FOUR
IMPLEMENTATION OF SMOKE-FREE PROVISIONS OF PROCLAMATION
1112/2019 IN ADDIS ABABA’S FOUR AND FIVE-STAR HOTELS

4.1 Introduction

This chapter describes and explains the data collected pertaining to the implementation of the smoke-free law in study area. The chapter is begins with the general background of the study area. This is followed by the mechanisms used by regulatory organs in enforcing the law and, then implementation of the law. Finally, the challenges faced in implementation the law are discussed. The researcher largely relied on selected qualitative approach of data analysis. As mentioned in the methodology section, interviews with the owners/managers of the hotels and higher officials and inspector from the regulatory organs were used as main source of data. Finally, in order to assess their compliance, observations were carried out by filling the checklist.

4.1.1 Overview of the study area

In Ethiopia there is no exact data about the number of tobacco smokers and exposure to SHS. However based on the 2016 Global Adult Tobacco Survey (GATS) report, 3.7% (2,530,200) of adults in Ethiopia smoked tobacco.¹⁸² Exposure to SHS in different public places varies among adults who work indoor or both indoor and outdoor. In this report 29.3% (6,460,200 people) were exposed to SHS in the workplace.¹⁸³ While exposures to SHS vary between people who live in rural and urban areas, the total number of residents in rural areas who were exposed to SHS was more than double (4,484,000) compared to the number of people residing in urban areas (1,976,200), mainly because the majority of the population lives in rural areas.¹⁸⁴ In rural areas of Ethiopia Exposure to SHS was highest in bars and restaurants; ranging 60.4% and 31.1% respectively, 19.75% in government buildings, 11.4% on public transport, and 7% in health care facilities. Based on the data exposure to SHS is high in rural hospitality areas which include hotels, bars, restaurants, and cafes.

¹⁸²GATS Report (n 23) p.25.

¹⁸³Ibid p.20.

¹⁸⁴ Ibid.

According to the Minister of Culture and Tourism, most of the hotels in Ethiopia are located in Addis Ababa.¹⁸⁵ Currently, the city encompasses more than 50-star hotels. Among them, 7 are five-star and 30 four-star hotels,¹⁸⁶ and the study focus on those hotels. Since Addis Ababa is the Capital city of Ethiopia and a site for AU, ECA, and other regional and international organizations and Embassies as well, a lot of foreign and local personnel use those hotels for different purposes on a daily basis. Thus, while Hotels are one of the most frequently visited public places in the city, there is a higher exposure to SHS in Hotels located in the city, and apart from the primary smokers, nonsmokers are also involuntarily exposed to SHS.

4.2 Enforcing mechanisms used by the regulatory organ

4.2.1 Power division between Regulatory organs

Ministry of Health (MOH) has the first power and duty at the federal level to formulate the countries health sector development program, follow up and evaluate the implementation.¹⁸⁷ EFDA is one of the executive organs of MOH and responsible to tobacco control.¹⁸⁸ The MOH ensure the proper implementation of EFDA and regulatory function tobacco control and other responsibilities.¹⁸⁹

In line with the provisions of the FDRE constitution on the division of powers between the federal and regional Governments, the Food and Medicine Administration proclamation No. 1112/2019 divided regulatory powers on tobacco control between the federal and regional governments. Hence, as per Article 4(15, 16) of Proclamation No. 1112/2019 and Article (3) of FCTC ratification Proclamation No. 822/2014, the federal government, through its executive organ, the Ethiopian Food and Drug Authority (EFDA), is empowered to *'coordinate the implementation of the WHO FCTC; establish a national coordinating mechanism to follow-up effective implementation of tobacco control, work in collaboration with appropriate bodies.'*¹⁹⁰

¹⁸⁵ Ministry of Culture and Tourism, Ethiopia <<https://www.govserv.org/ET/AddisAbaba/868041033279063/Ministry-of-Culture-and-Tourism%2C-Ethiopia>>accessed on 12,September,2020.

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¹⁸⁷ Proclamation 1097/2018, Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia, Federal Negarit Gazette, 8 issue No. 12, Addis Ababa, 29th November 2018, art 27(1).

¹⁸⁸ Ibid art.33 (18(E)).

¹⁸⁹ Ibid art 27(12).

¹⁹⁰ EFDA Proc.No 1112 /2019, Art. 4 (15).

Also, proclamation No.1112/2019 provides some minimum requirements which are required to be implemented at both tiers of the government. Among these, the smoke-free provision is one.

The mandate of implementing smoke-free provisions of the proclamation No. 1112/2019 in public places like hotels and restaurants is not given to the federal government executive organ; rather it is left to the regional governments and the two city administrations. In Addis Ababa, the power to implement smoke-free provisions of proclamation 1112/2019 is bestowed on the AAFMHACA, but The EFDA has an obligation to follow-up on the effective implementation of the smoke-free provision of the Federal law. On the other hand, the Ministry of Culture and Truism has the power to issue licenses and competency certificates for hotels.¹⁹¹

Thus, since competency certificate for Star hotels is issued by a federal organ and bearing its power to oversee the nationwide implementation of the law issued by the Federal parliament, the Federal regulatory organ (EFDA) also has the power to control the status of implementation of the law in star hotels. Therefore, EFDA control whether the hotels fulfill the requirements of the proclamation since it is issued by the Federal Parliament.

4.2.2 Issuing of further enforcement regulation, directives, and guidelines

A comprehensive smoke-free law is a critical intervention for protecting public health; however, simply having a strong smoke-free law is not enough. Unless backed by a comprehensive and sustainable enforcement. If a smoke-free law is not coupled with strong legal enforcement and well-defined regulation, then the law will not bear the desired benefits of reducing tobacco use and SHS exposure. To make the proclamation implementable in more detail issuing regulation and directive is important. Beside the proclamation empowered implementing organs to issue an implementation regulations, directives and guideline to enforce a smoke-free law.¹⁹² The proclamation also identified the authorities responsible for enforcement, by monitoring implementation and prosecuting violators.

¹⁹¹ Classification of tourist facilities council of ministers, regulation No.173/2009,Article 2,16th year,No.14.

¹⁹² EFDA Proc.No 1112 /2019,Art. 71(2).

A detailed implementation Regulation and Directives are the supplementary essential requirement to enforce the smoke-free law properly. Among others, which may contain, how 10 meters outdoor requirement could be implemented, how inspections are conducted, how administrative measures are taken. Also, inspection manual or guideline outlining uniform inspectorial rules are also of need in undertaking regular inspections of the Hotels.

However, the regulatory organ spends the past one and half year after the effective date of the bill on introducing about the law and development of enforcement laws as well. As a legal expert from FDA responds '*the preparation of regulation and directive are ongoing and in a short time the regulation will come to effect.*'¹⁹³ Thus, the regulatory organ should move swiftly to make effective and detailed directives and guideline to enforce smoke-free laws and establish a coordinated enforcement system to facilitate compliance with the smoke-free law.

4.2.1 Inspection and monitoring mechanism

Monitoring includes a process for inspection of businesses for compliance by creating a new inspection system for enforcement of smoke-free legislation.¹⁹⁴ Similarly the Article.8 guideline recommends that monitoring should be based on an in general enforcement plan, and should include a process for effective training of inspectors and direction of inspection. In order to enforce smoke-free law in Addis Ababa star hotels, the federal authority has started by organizing a committee of inspectors from AAFMHACA and EFDA.¹⁹⁵ The monitoring mechanism planned initially by federal authority is assessing the most frequently tobacco smoke exposed places in the city, by dividing into sub cities and then starts inspection.¹⁹⁶ According to FCTC Article 8, Effective monitoring means combining regular inspection with an irregular inspection.¹⁹⁷ However, the authority is doing most of its inspection regularly. This means in normal working hours of the day.

¹⁹³ Interview with Dagim Alemayhu, legal expert and case team coordinator of EFDA, Addis Ababa,13,April,2020

¹⁹⁴ Article 8 Guidelines, par 36.

¹⁹⁵ Interview with Alemayehu ,Deputy Director, Addis Ababa Food, Medicine and Health Care Control Administration,Addis Ababa,27,April,2020

¹⁹⁶ Ibid.

¹⁹⁷ Ibid par.45.

WHO/FCTC recommends that a strategic approach to enforcement must be well planned and, immediately upon the entry into force of the legislation, the violator must be advised or warned of their violation. Intensified information drive and education campaign must be done prior to enforcement. The practice of EFDA shows after the coming in to force of the law information campaigns had been done for three to six months before engaging in active enforcement of the law.¹⁹⁸ Following the information campaign, close to 250 early violators of the law have been given more advice and warned of their violation.¹⁹⁹ This shows that Federal regulatory authority's early phase monitoring and inspection methods used to enforce smoke-free law are good and in agreement with the WHO recommendations.

4.3 Assessment of the Implementation of proclamation No. 1112/2019 in four and five-star Hotels

It has been discussed that under WHO/FCTC implementation of smoke-free laws involves several regulatory activities including the implementation of the obligations. All smoking cues such as ashtrays shall be removed from all public indoor locations and outdoor areas where smoking is prohibited. The person responsible for the premises must display a standardized “No-smoking sign” that’s is conspicuous, clear, prominent and representative of all languages spoken in the area, also they are responsible for the enforcement of the law against violators, as well as education and communication campaigns, to inform the public about the smoke-free laws to improve public health.

The implementation of proclamation 1112/2019 smoke-free law is done by making public place 100% smoke-free, banning smoking in enclosed public places and workplaces, including hotels. Besides, the law orders business to have a visible “No Smoking” sign and prohibits smoking sections in all hotel areas. The regulatory authority is responsible for overseeing compliance and fine businesses violating the law.

¹⁹⁸Interview with Dagim (n 192).

¹⁹⁹ Ibid.

4.3.1 Managers'/owners' awareness of Smoke-free law in the hotels

According to the director of the product safety Directorate of the EFDA, strategies used by the Authority to implement smoke-free law in star hotels were started by creating awareness about the law after the enactment of the proclamation 1112/2019.²⁰⁰ After proclamation No. 1112/2119 was adopted, the EFDA together with Regional Health organ AAFMHACA conducted awareness creation training to 175 hotels in Addis Ababa.²⁰¹

Similarly, most of hotel managers reported that they had received awareness creation training about the smoke-free law after the law was enacted and there was no stakeholder discussion before the law was adopted.²⁰² This means stakeholder consultation and discussion, which are very important in creating a sense of ownership and commitment to implement laws, were not carried out in the law. It appears that the concerned government body (EFDA) arranged a brief training which is largely informative than consultative. The government just informs the law by giving training and start enforcement.

During the interview most of the hotel managers had some level of knowledge and information about the smoke-free law, but the researcher noted that hotel managers have a little sense of ownership of the law. They rather feel that the law is a burden they are discharging only because of fear of legal consequences. Such feelings can be the result of absent participation and consultation before the legislation of the laws and thus limited understanding of the health benefits of the law for the public as well as themselves.

However, the WHO guidelines indicate that a comprehensive education should be delivered to help the general public and business owners understand the purpose and the implications of the law preceding the enactment of smoke-free legislation.²⁰³ Hotel owners and managers are important stakeholders in smoke-free law, because to implement the law properly, they must take

²⁰⁰Interview with Asnakech Alemu ,“Director of product safety Directorate” ,EFDA ,Addis Ababa, April 15,2020

²⁰¹ Ibid.

²⁰²Interview with Hotel owners/managers, Addis Ababa, May, 2020.

²⁰³WHO report (2009) (n 54) p.34.

into consideration economic factors, customer demands, and considerations, and they should have discussed this with the legislature first and reach an agreement.

4.3.2. Assessment of 100% smoke-free law in Practice

According to Proclamation No. 1112/2019, all public places should be 100%smoke-free. This means that it is prohibited smoking in all indoor areas of the hotels, outdoor up to 10 meters from windows should be smoke-free, and there should not be any designated smoking area in such a place.²⁰⁴ Pertinent to the extent of compliance to the law, all hotel managers reported that smoking is not permitted anywhere on their hotel including guest rooms, lobby, bar, and restaurant, but outdoor smoking is permitted and they did not measure the exact place, because some hotels have an outdoor place and some do not have and the measurement is not clear.²⁰⁵

Besides the researcher has observed in some hotels that guest rooms are separated as “smoking” and “non-smoking” rooms, and smoking is permitted and also smoking is allowed in the outdoor with no limitation of 10 meter radius of the hotels. One of the managers told the researcher that it is difficult to explain to the customer to not smoke in the outdoor area of the hotels. On the other hand, inspectors from regulatory organ of EFDA noted that there are hotels that allow smoking in the within 10 meter radius of outdoor area of the hotel compound.²⁰⁶Such an act can be either due to lack of understanding of the law, or a deliberate tactic to undermine the law. The inspector stated that:

“...in reality most of the hotels that I have inspected have outdoor smoking areas. Yet in the law, it bans to smoke in outdoor areas of the hotels, they must go 10 meters away from the window and door of the hotels to smoke, so this requirement alone is still not clear with hotels.”²⁰⁷

²⁰⁴ EFDA Proc.No 1112 /2019,Art .48.

²⁰⁵ Interview with Mado international four- star hotel manager, Addis Ababa, May, 2020.

²⁰⁶ interview with Bitsat Shemelis,inspector, Addis Ababa, 13, April,2020.

²⁰⁷ Interview with Teshita ,inspector,EFDA ,Addis Ababa,13, April,2020.

Moreover, while hotels may have strict rules about not smoking in specified rooms, the rules are less clear and often more permissible about smoking in hallways and outdoor areas from where tobacco smoke can enter guest rooms through doors, windows, and ventilation. This can be because of lack of understanding of outdoor prohibition. One manager said that “*it is difficult to explain to the customer ...*” This permits tobacco smoke to migrate from the smoking rooms to hallways and nonsmoking rooms, leading to SHS exposure of nonsmokers and the accumulation of tobacco smoke in nonsmoking rooms and hallways.

The researcher observed that 100% smoke-free area is implemented in most hotels indoor main areas such as restaurants, bars, and lobby areas. However, no hotel was noted to implement smoke-free law in guest rooms and outdoor areas of the hotels. Such a partial implementation of the law by hotels has resulted in the ineffective protection of nonsmokers from exposure to SHS.

Therefore, the implementation of the hotels to 100% smoke-free is less because as the FCTC and proclamation 1112/2019 obliged there should be 100% smoke-free in all indoor-outdoor up-to 10 meters from the door and windows but all four and five-star hotels manager implemented this by prohibiting smoking mainly indoor areas of the hotels plus some hotels by exceptionally permitting smoking in the guest rooms and all hotels did not implement the 100% smoke-free area in their outdoor area of the hotels.

4.3.3. Compliance of hotels with the smoke-free requirements

Compliance hotels to the smoke-free requirements was measured based on proclamation 1112/2019 by posting a sign of no-smoking sign , no one found smoking inside the hotels, a no-smoking room within the building’s of the hotels, and, no smoking equipment found such as ashtrays and ashbin inside the hotels.

In all hotels, there was a general similarity in compliance with the requirement of smoke-free areas stated under Proclamation No. 1112/2019. The researcher observed in most the hotels’ indoor areas, there was no evidence of active smoking or smoking aid. No-smoking signage was presented and there was no smoking smells. In most hotels’ indoor areas, there was no evidence of active smoking or smoking aid. No-smoking signage was presented and there was no smoking

smells. While hotels that have outdoor areas and terrace found cigarette butts, bid ends and ashbins found and, some hotels still had a designated smoking area.

This finding contradicts with Art.8 of WHO/ FCTC which said that there is no risk-free level of SHS and even brief exposure can cause immediate harm.²⁰⁸ Authoritative sources also have consistently recommended and advocated complete comprehensive smoke-free laws with no exceptions. Typical exceptions that must not be allowed include ventilation and smoking areas, whether separately ventilated from non-smoking areas or not, do not reduce exposure to a safe level of risk to protect workers and the public from SHS exposure.²⁰⁹ Most other studies concluded that No-smoking sign are very important to remind smokers not to smoke in public indoor locations, and they were effective to reduce both smoking rate and SHS.²¹⁰

Therefore, no-smoking sign requirement complied by the hotels as they stipulated in all place but, the hotels did not follow full compliance with all the requirements of smoke-free law because they are only complying with the indoor requirements, defying the outdoor once.

4.3.4. Non-compliance Penalties

Regarding measures taken by the regulatory organ to enforce the law, as the product safety directorate director reported that, *'the federal Authority focuses on creating awareness rather than start taking enforcement measures because it has been only one year since the law was enacted.'* This means there is a tendency to this year as a grace period so that the hotels get familiar with the laws rather than a serious implementation of it. Even though there were no fines or penalties taken, in some hotels, the authority began to take over 20 administrative measures like giving warring letters to four and five-star hotel owners who were not implementing smoke-free requirements.²¹¹

²⁰⁸Article 8 Guidelines, par 4(c)

²⁰⁹ United State.public health office(2006)(n 6),p.709.

²¹⁰Constantine I Vardavas and others, 'Ashtrays and Signage as Determinants of a Smoke-Free Legislation's Success' (2013) 8 PLoS ONE.

²¹¹Interview withAsnakech(n 199).

The proclamation 1112/2019 imposes a duty on people who are in charge of smoke-free premises to have legal responsibilities to prevent people from smoking on their premises.²¹² Most hotel managers said that they do not have any awareness about how to enforce the law and take measures to their customers. Thus, owners and managers of the hotels didn't implement the smoke-free law in their hotels, as a result, they failed their legal duties. As well the regulatory organ works more awareness creation about the law to hotel managers and owners when they found violating the law than taking proper measures.

4.4 The challenges in the implementation and Enforcement of smoke-free law

4.4.1. Inadequate legal framework

It has been a year since the federal proclamation No.1112/2019 comes to force and the regulation is not yet approved. As per the word of the Deputy Director, the delay of developing and approval of a detail implementing Regulation and Directives guideline by the regulatory makes the law harder to implement in hotels.²¹³ Some of the activities, like ban of smoking in outdoor area up to 10 meter in hotels, cannot kick off until the Regulation or the Directives which explain in clear and detail way stipulated are issued. The proclamation provides that smoking is prohibited in indoor and partially outdoor places.²¹⁴ Thus there is a need for a detail directive which makes clear for implementation.

The specifics should come clearly, but the actual practice shows that the hotels are still providing for designated smoking areas, despite a clear ban on it under the law. One of the hotel managers described that *'You cannot prohibit people just to smoke outdoor ...'* this shows the legal gap in providing for the specifics of the outdoor rule and the following administrative measure when non-compliance of the law is observed.

²¹² EFDA Proc.No 1112 /2019,Art .50

²¹³ Interview with Dagim (n 192).

²¹⁴ EFDA Proc.No 1112 /2019,Art 48 .

4.4.2 Limited Resource

The implementation FCTC smoke-free provision requires adequate resource which is challenging to mobilize for developing country like Ethiopia. Controlling whether four and five-star hotels smoke-free place are free from any kind of tobacco smokes and all the necessary requirements are complied is EFDA inspector's main obligation. However the inspectors work the inspection is in the normal working hour in a day before most of the hotel's bar, and restaurant reached their peak hour. As such the only thing which is done in the hotels at the normal working hour is checking only whether the requirements are fulfilled or not.²¹⁵ As per one of the inspector at EFDA:

“Most of the hotels were complying with the smoke-free requirements during the day and would stop enforcing it at night. This is because they know that the government organs do the inspection only at working hours. At inspection time in the hotels, they mostly comply with the law but at night some hotels allow smoking to their customers, to make inspection at anytime needs extra inspectors and car with driver and all this are additional costs that we cannot afford with current government budget.”²¹⁶

Further, the budget allocated is not adequate to implement the law, there is no separate budget allocated to tobacco control.²¹⁷ Therefore, one of the major challenges for monitoring the hotels at any time is the lack of adequate resource to have enough inspection and make over-time payments to undertake inspection at night in the hotels.

4.4.3. Low awareness level of the law among owner/manager of hotels

Awareness creation to hotel managers/owners on how they implement the law in their premises without affecting their business is needed. Because of poor awareness creation by the government before the start of the implementation process, most participants reported a serious lack of awareness about the smoke-free law among the hotel managers and owners. Enforcement was reported as minimal, and two managers mentioned a lack of capacity and low knowledge of the law as principal reasons.

²¹⁵Interview with Bitsat (n 205).

²¹⁶Interview with Teshita (n 206).

²¹⁷Ibid.

4.4.4 Non-Uniform implementation

The EFDA exercises proclamation No.1112/2019 at the federal level, there was no similar comprehensive smoke-free law implementation in the regional states. The EFDA controls hotels that have competence of certificate from federal ministry of culture and tourism, which are under the control of federal government. Other hotels which are not governed by federal government are not controlled by EFDA.

The smoke-free law implementation in Addis Ababa hotels becomes non-uniform, because of Ethiopian government structural system. The regulatory authority's implementation system of this law in different public places makes the hotels reluctant to implement it. One of the concerns of the hotel managers was the adverse effect on business because of exercise of inconsistent inspection activities across the hotels by the regulatory²¹⁸ i.e. as per the hotel managers, in some hotels, the inspection activity is so rigorous and rigid, and in some others, there is mild or no monitoring at all. This makes some hotels which are under the control of federal regulatory organ; lose their business as their customers shift to other hotels which are loosely controlled. This is resulting in a shift of customers and incoming business decrease in hotels adhering to the requirements of the law.

4.4.5 Lack of coordination among different government organs

Implementation and enforcement of tobacco smoke-free law in hotels require strong cooperation among different government organs. As its known EFDA the primary mandated organ but the Authority cannot alone implement and enforce the law without further concerned government organs coordination work.

4.4.6. Limited of Technical Experts

The technical experts in the EFDA at the federal level that perform the overall the inspection work are a total of six experts in the authority.²¹⁹The handling of the inspection activities at the hotels with few inspectors worsens the situation. Beside only those experts are performing not only inspection but the overall tobacco control measures in the federal government level is done.

²¹⁸ Interview with the Monarch hotel manager, Addis Ababa ,22,May 2020.

²¹⁹Interview with Teshita (n 206).

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1 Conclusion

Ethiopia had made various legal efforts to control tobacco, among them the smoke-free law of federal proclamation No. 1112/2019 is one. This law is based on the WHO FCTC requirements and each provisions of the proclamation fulfill the obligation stated in the FCTC art.8 and the guideline. However the implementation of the law in four and five-star hotels Addis Ababa are not aligned with proclamation No. 1112/2019, the WHO FCFC and its guideline. This means there is a gap in the implementation of the law and non compliance with the requirements in the study area hotels.

Two main areas of non-compliance are identified in four and five star hotels in Addis Ababa. The first one is non-compliance of the hotels to the requirement of the smoke-free law as a result of lack of adequate information about the law, and second one is the continued availability of designated smoking area and allowing of smoking within prohibited outdoor areas of the hotels, despite the comprehensive ban on this areas by the laws The latter appears to be caused by wrong interpretation of the law by the hotels.

Although the enforcement mechanisms used by the regulatory organs can be praised for preparing monitoring inspectors, working in coordination with regional organs and initiating monitoring compliance , there is still significant shortage in the number technical inspectors to carry out these vital activities.

Despite comprehensive smoke-free law, SHS is becoming a public threat in the hotels mainly because of inadequate legal framework, lack of adequate resources and limited awareness about the law among the hotel owners/managers are the main challenges. The research shows that implementation of smoke-free law of federal proclamation No.1112/2119 in Addis Ababa four and five star hotels so far has not been effective because of these limitations.

5.2 Recommendations

Based on the finding of the study, the following recommendations are made to effectively implement smoke-free law in four and five-star hotels in Addis Ababa: the recommendation are directed to legal, and institutional recommendations.

5.2.1 Legal recommendation

- An implementation detail Regulation and Directive of proclamation 1112/2019 must be enacted, which is also implementable at regional levels as well.
- The provision about outdoor smoke-free places up to 10 meter radius needs additional detailed explanation, and implementation Directive or Guideline should be issued.
- The proclamation 1112/2019 smoke-free law that prohibits tobacco smoking in hotels indoor places should extend its prohibition to hotel outdoor places as well.
- The responsible federal and regional organs such as the EFDA and regional health regulators should collaborate and coordinate with other responsible government organs to bring about effective and efficient implementation of the tobacco control laws.
- The government must have strong commitment to enforce the clearly articulated tobacco control laws and policies.
- The upcoming Ethiopian health policy must incorporate strategies on how tobacco control laws are implemented in Ethiopia.

5.2.2 Institutional recommendation

- The most important recommendation for improving implementation and compliance in Addis Ababa hotels is increasing awareness and knowledge about the details of the smoke-free law (e.g. the stipulation of signage requirements, penalties,) what is expected of them and legal consequences of failure to discharge legal obligations to stake holders.
- The regulatory organ (EFDA) should create public awareness to the general public about the danger of SHS by radio, television, billboard and social media, because those are best medium to reach the general public.
- The regulatory authority should create a uniform and practical inspection method that cover all controlled public place by making a program and dividing place by location.

- The regulatory authority should increase its human resource gap in tobacco control by recruiting the necessary technical experts.
- Start a routine monitoring system by making the inspectors work flexible hours or shifts including day and night.
- Without sufficient budgeting and allocation of resources implementing tobacco smoke-free law is impossible. To this end, the government organ should have to increase and allocate sufficient budget to implement the law effectively.

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