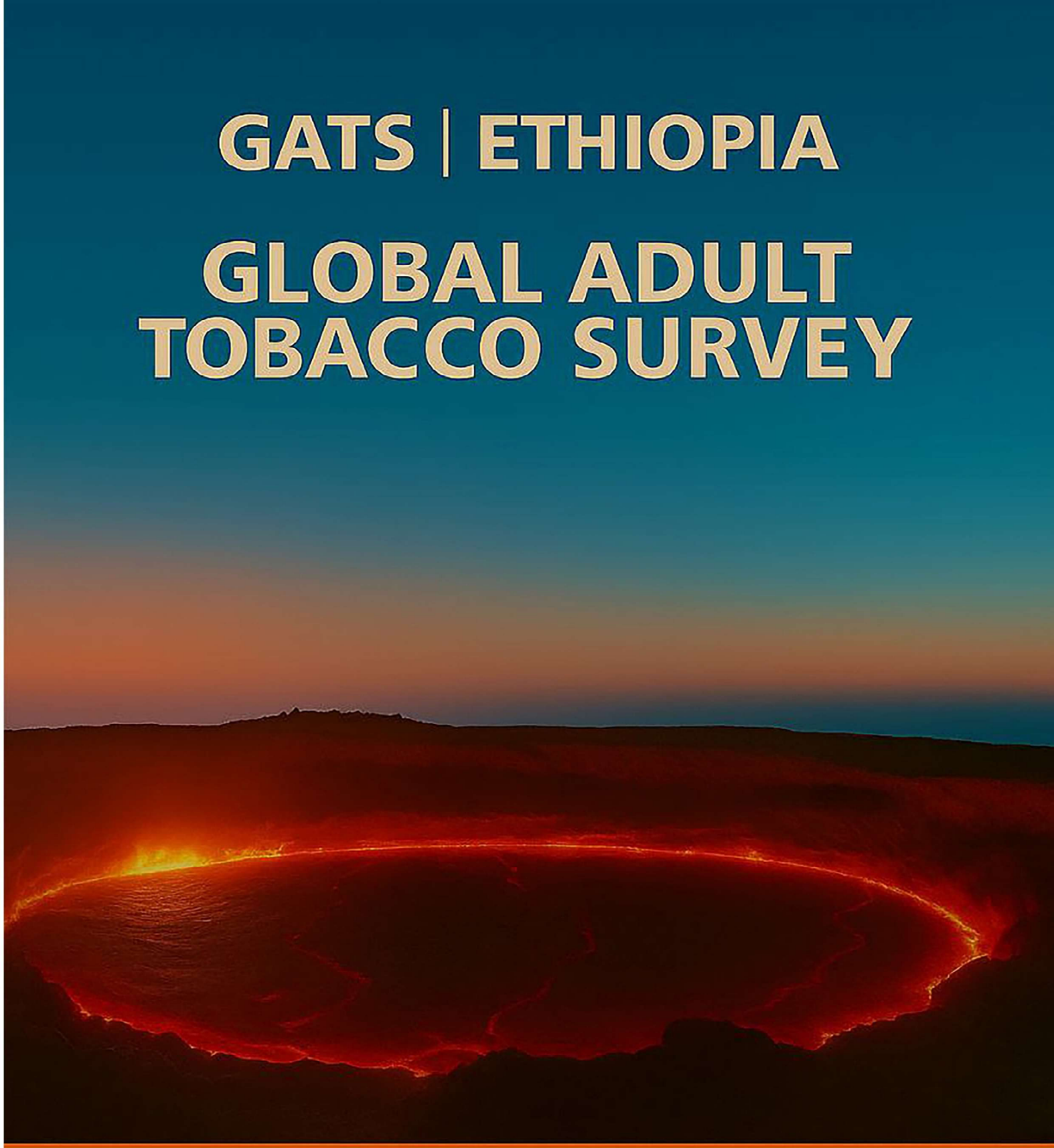
GATS | ETHIOPIA

GLOBAL ADULT TOBACCO SURVEY



EXECUTIVE SUMMARY 2024

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MINISTRY OF HEALTH, ETHIOPIA

Ethiopian Public Health Institute

EFDA
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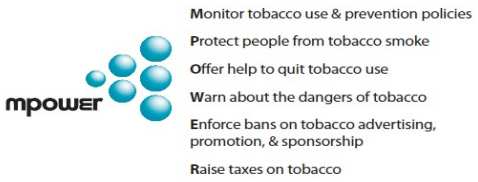
Introduction

Tobacco use is the leading preventable cause of premature mortality and disease globally **(1)**. According to the 2019 Global Burden of Diseases report, the global tobacco epidemic kills over 8.7 million people, including 1.3 million people who do not smoke who are exposed to secondhand smoke **(2)**. In Africa, where tobacco use is increasing, the public health threat continues to grow. Although Ethiopia has relatively lower smoking prevalence compared to many other countries, the risks associated with tobacco use remain significant **(3, 4)**. Preventable deaths and diseases related to tobacco use can be significantly reduced through the enforcement of stronger tobacco control measures, such as smoke-free laws, higher tobacco taxes, and public awareness campaigns **(1, 5)**. To address the tobacco epidemic, the World Health Organization (WHO) introduced the Framework Convention on Tobacco Control (FCTC), which was adopted in 2003 **(6)**. Subsequently, Ethiopia became a party to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) in 2014 and implemented its first Global Adult Tobacco Survey (GATS) in 2016 and the second round of GATS in 2024. To support the implementation of the WHO Framework Convention on Tobacco Control (FCTC), Ethiopia has adopted the WHO MPOWER measures to facilitate effective interventions aimed at reducing tobacco demand at the country level.

To support the implementation of the WHO FCTC, Ethiopia has adopted the WHO MPOWER measures to facilitate the effective interventions at reducing the tobacco demand at country level. The MPOWER package consists of six cost-effective measures for fighting the global tobacco epidemic: (1) Monitoring tobacco use and prevention policies; (2) Protect people from tobacco smoke: (3) Offer help to quit tobacco use; (4) Warn about the dangers of tobacco; (5) Enforce bans on tobacco advertising, promotion, and sponsorship; and (6) Raise taxes on tobacco. MPOWER measures have been proven to save lives and reduce healthcare costs by preventing tobacco-related illness (WHO, 2008). Hence, a systematic and efficient surveillance system is essential for monitoring tobacco product and electronic cigarette (e-cigarette) use, as well as evaluating prevention and control interventions.



GATS uses a global standard for systematically monitoring adult tobacco use (smoking, smokeless, and heated tobacco products), e-cigarette use, and tracking key tobacco control indicators. GATS is a nationally representative household survey of adults aged 15 years or older. The use of a standard questionnaire, sampling methodology, and protocols in GATS makes comparison of survey results possible across countries.

Ethiopia first implemented GATS in 2016. Since then, the country has made significant progress in tobacco control by enacting a comprehensive proclamation 1112/2019 (Ethiopian Food, Medicine and Healthcare Administration and Control Authority, 2019) aligned with the WHO Framework Convention on Tobacco Control (WHO FCTC). This proclamation includes provisions for 100% smoke-free indoor and outdoor public places, mandates that 70% of all tobacco packaging (front and back) display health warnings and imposes a complete ban on all forms of tobacco advertising, promotion, and sponsorship (TAPS). This includes point-of-sale displays, and digital marketing. The proclamation also raised the legal age for purchasing tobacco products from 18 to 21 years. It prohibits the sale of single cigarettes, and only allows cigarette packs of 20 or more. Flavored cigarettes are banned under this legislation as well. Furthermore, the law includes restrictions on electronic nicotine delivery systems (ENDS) and similar products, and prohibiting their production, distribution, and sale. Shisha products are also banned. The proclamation additionally restricts interactions between government bodies responsible for public health policies and the tobacco industry. Moreover, the Excise Tax Proclamation 1186/2020 introduces excise taxes on all tobacco products.

The second round of GATS Ethiopia was conducted in 2024 by Ethiopian Public Health Institute (EPHI) in collaboration with the Ethiopian Food and Drug Authority (EFDA), Ethiopian Statistical Service (ESS), and WHO Ethiopia. Technical assistance was provided by the U.S. Centers for Disease Control and Prevention (CDC), RTI International, and the World Health Organization (WHO). Program support was provided by the CDC Foundation.

Conducting GATS Ethiopia-2 is essential for evaluating the effectiveness of current tobacco control policies and track changes since the 2016 survey. It provides updated data on tobacco use, secondhand smoke exposure, and public awareness, helping Ethiopia to assess progress under the WHO FCTC and inform future policy actions.

Methodology

GATS collects data on respondents' background characteristics, tobacco use (smoking, smokeless, and heated tobacco products), electronic cigarette use, cessation, secondhand smoke, economics, media, and knowledge, attitudes, and perceptions towards tobacco use. In Ethiopia, GATS was conducted in 2024 as a household survey of persons 15 years of age or older by the Ethiopia Public Health Institute (EPHI) with collaborative engagement of Ethiopian Food and Drug Authority, Ethiopian Statistical Service, and WHO Ethiopia. A multi-stage, geographically clustered sample design was used to produce nationally representative data. A total of 12,209 households were sampled and one individual was randomly selected from each participating household to complete the survey. Survey information was collected electronically by using handheld devices. There was a total of 11,876 completed individual interviews, yielding an overall response rate of 97.4%.

Key Findings

Tobacco use

In 2024, 4.6% of adults (8.8% of men and 0.5% of women) in Ethiopia reported current tobacco use (self-reported current use of tobacco products on a daily or less than daily basis) in any form. Overall, 4.0% of adults (7.7% of men and 0.4% of women) currently smoked tobacco, with. Overall, 3.2% of adults (6.2% of men and 0.3% of women) currently smoked tobacco daily (data not presented in the table). Prevalence of current cigarette smoking was 3.7% among adults, 7.2% among men and 0.2% among women. Overall, 2.9% of adults (5.7% of men and 0.2% of women) smoked cigarettes daily (data not presented in the table). The prevalence of smokeless tobacco use was 1.0% overall,1.8% among men, and 0.2% among women (data not presented in the table).

Around 2.9% of adults have heard of heated tobacco products, with 3.3% of men and 2.5% of women (data not presented in the table). However, only 0.2% of adults have ever used them, and 0.2% currently used HTPs. Prevalence of HTPs use among men was 0.3% and 0.1% among women.

Electronic Cigarette use

Overall, 2.5% of adults have heard of electronic cigarettes, with 3.1% of men and 1.9% of women (data not presented in the table). Less than 0.1% of adults ever used electronic cigarettes and less than 0.1% currently used them.

Cessation

Among adults who currently smoke, 33.2% attempted to quit smoking in the past 12 months, and 55.4% were planning or thinking about quitting. Nearly half (49.2%) of adults who currently smoke who visited a healthcare provider were advised to quit in the past 12 months. Among adults who currently use smokeless tobacco, 25.5% tried to quit in the past 12 months, and 48.1% were considering quitting (data not presented in the table).

Secondhand Smoke Exposure

Among adults who worked indoors, 19.8% were exposed to tobacco smoke at the workplace (20.8% among men and 18.6% among women). Additionally, overall, 14.0% of adults were exposed to secondhand smoke at home. Among adults who do not smoke, 11.5% were exposed to secondhand smoke at home (data not presented in the table).

Among adults who visited various places, 20.2% were exposed to secondhand smoke in restaurants, 23.0% in government buildings, 10.7% in healthcare facilities, and 57.3% in bars or nightclubs. In public transportation, 11.2% of adults were exposed to secondhand smoke.

Economics

On average (mean), adults who currently smoked in Ethiopia spent 174.1 Birr on a pack of 20 cigarettes, while the average (mean) monthly expenditure for adults who currently smoke was 2,341.5 Birr. The cost of 100 packs of manufactured cigarettes represents 15.7% of Ethiopia's per capital Gross Domestic Product (GDP) in 2024.

Advertising, Promotion, and Sponsorship

Overall, 15.8% of adults reported noticing anti-cigarette messages on television or radio, with 14.1% among current smokers and 15.9% among non-smokers). On the other hand, 5.1% of adults reported noticing tobacco advertisements in stores where tobacco is sold, including 13.0% among current smokers and 4.8% among non-smokers. Furthermore, 9.2% of adults noticed any tobacco products advertisements, promotions, or sporting event sponsorship. Among adults who currently smoked tobacco, 38.7% noticed health warnings on cigarette package and 18.4% considered quitting due to warning messages.

Knowledge, Attitudes, and Perceptions

Overall, 87.9% of adults believed that smoking causes serious illness, including 74.4% of current smokers and 88.5% of non-smokers. Additionally, 80.9% of adults felt that secondhand smoke causes serious health risks to non-smokers, with 62.1% of current smokers and 81.7% of non-smokers agreeing. Among adults who currently use smokeless tobacco, 66.3% believed it causes serious illness, with 43.8% among users and 67.3% among non-users.

Changes between 2016 and 2024

- **Decrease in Tobacco Use Among Women:** The prevalence of current tobacco use among women decreased significantly, from 2.1% (95% CI: 0.8%, 5.2%) in 2016 to 0.5% (95% CI: 0.3%, 0.8%) in 2024.
- **Increase in Age of Smoking Initiation:** The average age at which daily smoking begins among adults increased from 17.0 years (95% CI: 14.7, 19.4) in 2016 to 21.2 years (95% CI: 20.4, 22.1) in 2024.
- **Reduction in Secondhand Smoke Exposure:** The percentage of adults exposed to secondhand smoke in the workplace significantly decreased from 32.2% (95% CI: 26.8%, 38.1%) to 19.8% (95% CI: 16.9%, 23.0%). Exposure to secondhand smoke (SHS) significantly decreased from 33.3% (95% CI: 28.6%, 38.5%) to 20.2% (95% CI: 18.0%, 22.7%) in restaurants; from 71.8% (95% CI: 62.3%, 79.6%) to 57.3% (95% CI: 51.2%, 63.2%) in bars/nightclubs, and from 32.8% (95% CI: 23.5%, 43.7%) to 18.6% (95% CI: 14.2%, 24.0%) in universities. Although, there were no significant changes, SHS exposure remained stable in

healthcare facilities [8.4% (95% CI: 6.1%, 11.50%) vs 10.7% (95% CI: 8.4%, 13.5%)], government buildings [22.1% (95% CI: 18.1%, 26.8%) vs 23.0% (95% CI: 20.2%, 26.0%)], and schools [13.5% (95% CI: 9.2%, 19.4%) vs 10.5% (8.3%, 13.2%).

- **Quit Attempts:** The percentage of adults who smoked tobacco and made a quit attempt in the past 12 months remained stable, with 39.9% in 2016 compared to 54.8% in 2024. Similarly, the percentage of adults who currently smoked and were advised to quit by healthcare professionals also showed little change, at 51.7% (ranging from 38.5% to 64.7%) in 2016 versus 49.2% (ranging from 38.7% to 59.8%) in 2024.
- **Health Warnings on Cigarette Packages:** The percentage of adults who currently smoked and noticed health warnings on manufactured cigarette packages remained consistent, with 38.0% in 2016 compared to 38.7% in 2024.
- **Increase in Tobacco Advertising Exposure:** The percentage of adults who noticed advertisements, promotions, or sponsorship for tobacco products (smoked and smokeless) increased significantly, from 1.9% in 2016 to 5.3% in 2024.
- **Expenditure on Cigarettes:** The average (mean) amount spent on 20 manufactured cigarettes decreased from 217.1 (30.9, 403.4) Birr in 2016 to 174.1 (30.7, 317.5) Birr in 2024, adjusted for inflation. However, the change was not statistically significant.

Conclusion

The comparison of GATS Ethiopia data from 2016 to 2024 indicates significant progress in tobacco control, possibly driven by the implementation of comprehensive policies. These include a comprehensive smoke-free policy in public places, ban on tobacco TAPS, as well as raising taxes on tobacco products. Positive changes include less exposure to secondhand smoke in many public places, and a significant decrease in tobacco use among women. There has also been an increase in the average age at which people start smoking, indicating that efforts to protect young people are making a difference. However, challenges remain, such as continued exposure to secondhand smoke in healthcare facilities, government buildings, and schools, despite greater awareness of health risks. Furthermore, the rise in exposure to tobacco advertising, despite the existing bans, highlights the need for stronger enforcement of these

policies. Ethiopia must continue to strengthen and enforce its tobacco control measures to further reduce tobacco-related harm and improve public health outcomes.

Policy implementation and recommendation

Ethiopia has made significant progress in tobacco control by implementing comprehensive policies aligned with WHO FCTC. These policies include a comprehensive ban on smoking in public places, strict regulations on tobacco, TAPS increased taxes on tobacco products, and mandatory health warnings on cigarette packages. Additionally, the sale of tobacco products to individuals under 21 years old is prohibited, demonstrating a commitment to reducing tobacco use and safeguarding public health. However, ongoing challenges underscore the need for further action to strengthen tobacco control efforts.

The following recommendations are proposed:

- Using real images of Ethiopians with tobacco-related diseases in pictorial health warnings can enhance their credibility and make the messages more relatable to the public, encouraging stronger reactions and awareness about the dangers of tobacco use.
- Creating a dedicated quit line services for tobacco cessation separating from the general service line (952), staffing with trained counselors who can provide personalized guidance and support to individuals wanting to quit tobacco, can improve access to cessation resources.
- Initiating ongoing awareness campaigns to educate the public about the harmful effects of tobacco use, the benefits of quitting, and the various resources available to help individuals stop using tobacco.
- Enhancing surveillance and enforcement efforts to ensure full compliance with existing tobacco control laws, particularly in public places and among retailers, to reduce violations and protect public health.
- Equipping healthcare providers with the necessary training to deliver tobacco cessation counseling and support during routine health care visits, ensuring that patients receive ongoing and effective support in their efforts to quit smoking.
- Continuously conducting research to track tobacco use patterns and assess the impact of existing policies can enable data-driven decisions to enhance future tobacco control efforts and interventions.

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Appendix F: MPOWER Summary Indicators – GATS Ethiopia, 2016 and 2024.									
	2016			2024			Relative change		
Indicator	**Overall**	**Male**	**Female**	**Overall**	**Male**	**Female**	**Overall**	**Male**	**Female**
M: Monitor tobacco use and prevention policies									
Current tobacco use	5.7 (4.0, 8.1)	9.2 (6.9, 12.1)	2.1 (0.8, 5.2)	4.6 (4.0, 5.3)	8.8 (7.7, 10.0)	0.5 (0.3, 0.8)	-18.1	-4.4	-74.8*
Current tobacco smokers	4.3 (3.1, 5.9)	7.0 (5.4, 9.1)	1.5 (0.6, 3.9)	4.0 (3.5, 4.6)	7.7 (6.7, 8.8)	0.4 (0.2, 0.6)	-6.2	9.4	-75.4*
Current cigarette smokers	3.3 (2.5, 4.3)	6.2 (4.8, 8.1)	0.3 (0.1, 0.5)	3.7 (3.2, 4.3)	7.2 (6.2, 8.3)	0.2 (0.1, 0.5)	13.1	15.7	-14.6
Current manufactured cigarette smokers	3.1 (2.3, 4.1)	5.9 (4.4, 7.8)	0.2 (0.1, 0.5)	3.6 (3.1, 4.2)	7.0 (6.1, 8.1)	0.2 (0.1, 0.5)	17.4	19.5	-0.5
Average number of cigarettes smoked per day[1]	24.3 (17.4, 31.2)	24.6 (17.5, 31.6)	17.8 (8.0, 27.6)	12.7 (11.1, 14.2)	12.6 (11.0, 14.2)	-	-47.7*	-48.7*	-
Average age at daily smoking initiation[2]	17.0 (14.7, 19.4)	17.9 (15.7, 20.0)	13.3 (10.9, 15.8)	21.2 (20.4, 22.1)	21.0 (20.3, 21.7)	-	24.7*	17.6*	-
Former smokers among ever daily smokers	26.0 (17.3, 37.0)	25.0 (18.2, 33.4)	30.1 (10.2, 62.0)	17.8 (13.7, 22.9)	16.8 (12.7, 21.9)	33.2 (17.2, 54.4)	-31.5*	-32.8*	10.5
P: Protect people from tobacco smoke									
Exposure to secondhand smoke at home at least monthly	15.2 (11.6, 19.6)	15.1 (11.6, 19.6)	15.3 (11.1, 20.7)	14.0 (12.3, 16.0)	14.9 (12.9, 17.2)	13.2 (11.3, 15.3)	-7.6	-1.4	-13.7
Exposure to secondhand smoke at work[§]	32.2 (26.8, 38.1)	34.4 (27.9, 41.5)	28.5 (23.0, 34.7)	19.8 (16.9, 23.0)	20.8 (17.6, 24.5)	18.6 (14.9, 22.9)	-38.5*	-39.4*	-34.8*
Exposure to secondhand smoke in public places:[3,§]									
Government building/offices	22.1 (18.1, 26.8)	24.0 (18.6, 30.3)	19.2 (14.7, 24.7)	23.0 (20.2, 26.0)	22.7 (19.6, 26.2)	23.4 (20.0, 27.1)	3.8	-5.1	21.9
Health care facilities	8.4 (6.1, 11.5)	9.5 (6.3, 14.2)	7.3 (4.7, 11.3)	10.7 (8.4, 13.5)	12.2 (9.5, 15.6)	9.3 (7.0, 12.1)	27.2	28.2	26.2
Restaurants	33.3 (28.6, 38.5)	32.7 (27.6, 38.3)	34.7 (27.9, 42.1)	20.2 (18.0, 22.7)	20.3 (17.7, 23.1)	20.1 (17.1, 23.5)	-39.3*	-38.0*	-42.0*
Bars or nightclubs	71.8 (62.3, 79.6)	72.5 (60.8, 81.8)	70.0 (58.6, 79.4)	57.3 (51.2, 63.2)	58.4 (51.4, 65.1)	55.2 (46.4, 63.6)	-20.1*	-19.5*	-21.2*
Public transportation	12.2 (10.4, 14.3)	12.6 (10.3, 15.4)	11.7 (8.9, 15.3)	11.2 (9.8, 12.8)	11.0 (9.4, 12.8)	11.5 (9.7, 13.7)	-8.1	-13.1	-1.4
O: Offer help to quit tobacco use									
Made a quit attempt in the past 12 months[4]	39.9 (28.8, 52.2)	45.0 (34.9, 55.7)	14.5 (4.8, 36.2)	33.2 (28.4, 38.4)	32.5 (27.5, 37.8)	-	-16.8	-28.0*	-
Advised to quit smoking by a health	51.7 (38.5, 64.7)	55.6 (41.3, 69.0)	38.1 (11.8, 73.9)	49.2 (38.7, 59.8)	48.1 (37.0, 59.4)	-	-4.9	-13.5	-

care provider[4,5]									
Attempted to quit smoking using a specific cessation method:[4]									
Pharmacotherapy	3.2 (0.9, 10.2)	3.4 (1.0, 10.8)	0.0 (N/A)	2.4 (1.0, 5.6)	1.9 (0.7, 4.7)	-	-24.6	-45.2	N/C
Counseling/advice	13.3 (7.6, 22.2)	11.8 (6.4, 20.8)	37.0 (10.5, 74.5)	11.7 (7.4, 18.1)	10.5 (6.3, 17.0)	-	-12.0	-11.3	-
Interest in quitting smoking[6]	66.9 (52.4, 78.7)	73.1 (63.5, 81.0)	36.5 (16.1, 63.3)	55.4 (50.0, 60.6)	55.0 (49.3, 60.5)	-	-17.2	-24.8*	-
W: Warn about the dangers of tobacco									
Belief that smoking tobacco causes serious illness	88.9 (86.0, 91.3)	91.4 (88.7, 93.5)	86.4 (82.5, 89.6)	87.9 (86.5, 89.3)	88.1 (86.4, 89.7)	87.8 (86.2, 89.2)	-1.1	-3.6*	1.6
Belief that smoking causes stroke, heart attack, and lung cancer	37.4 (33.9, 41.1)	40.0 (36.1, 44.1)	34.8 (30.9, 38.9)	46.0 (44.2, 47.8)	48.1 (45.9, 50.2)	43.9 (41.9, 46.0)	22.9*	20.2*	26.1*
Belief that breathing other peoples' smoke causes serious illness	77.0 (73.3, 80.3)	80.7 (77.3, 83.8)	73.2 (67.6, 78.1)	80.9 (79.4, 82.4)	81.8 (80.0, 83.5)	80.1 (78.3, 81.7)	5.1*	1.3	9.5*
Noticed anti-cigarette smoking information at any location[7,§]	26.6 (23.7, 29.8)	29.6 (25.7, 33.8)	23.6 (20.4, 27.1)	20.0 (18.5, 21.6)	21.8 (20.0, 23.7)	18.2 (16.5, 19.9)	-24.9*	-26.3*	-22.9*
Thinking of quitting because of health warnings on cigarette packages[§]	19.3 (10.7, 32.5)	22.9 (13.3, 36.4)	2.2 (0.5, 9.3)	18.4 (14.2, 23.4)	18.6 (14.5, 23.5)	-	-5.1	-18.7	-
E: Enforce bans on tobacco advertising, promotion and sponsorship									
Noticed any types of tobacco product (smoked and/or smokeless) promotions[8,§]	1.9 (1.5, 2.5)	1.8 (1.3, 2.5)	2.0 (1.3, 2.9)	5.3 (4.2, 6.8)	6.0 (4.6, 7.7)	4.7 (3.6, 6.0)	181.4*	228.4*	137.6*
R: Raise taxes on tobacco									
Average cigarette expenditure per month (*Ethiopian Birr*)[9,10]	2905.6 (677.5, 5133.7)	2959.9 (646.9, 5273.0)	1521.0 (158.4, 2883.7)	2341.5 (456.0, 4226.9)	2388.2 (444.2, 4332.2)	-	-19.4	-19.3	-
Average cost of a pack of manufactured cigarettes (*Ethiopian Birr*)[9,10]	217.1 (30.9, 403.4)	220.7 (28.1, 413.2)	120.7 (53.2, 188.2)	174.1 (30.7, 317.5)	177.8 (29.3, 326.3)	-	-19.8	-19.4	-
Last cigarette purchase was from a store[9]	2.9 (1.0, 8.2)	3.0 (1.0, 8.5)	0.0 (N/A)	37.1 (30.0, 44.8)	37.6 (30.6, 45.2)	-	1178.5	1146.3	N/C
Notes:									

[1] Among current daily cigarette smokers. [2] Among respondents 20-34 years of age who are ever daily tobacco smokers. [3] Among those who visited the place in the last 30 days. [4] Among past-year tobacco smokers (includes current smokers and those who quit in the past 12 months). [5] Among those who visited a health care provider in past 12 months. [6] Among current tobacco smokers [7] Locations include newspapers or magazines, television, radio, billboards, internet (included in the 2024 questionnaire but not in 2016), and any other reported sources. [8] Includes any of the following types of tobacco product (smoked and/or smokeless) promotions: (a) Free samples of tobacco products; (b)Tobacco products at sale prices; (c)Coupons for tobacco products; (d) Free gifts or special discount offers on other products when buying tobacco products; (e) any clothing or other items with a brand name or logo of the following tobacco products; (f) in the mail. [9] Among current smokers of manufactured cigarettes. [10] GATS Ethiopia 2016 cost data were adjusted for inflation for direct comparison to 2024 using the Inflation Rate for Average Consumer Prices from the International Monetary Fund's World Economic Outlook Database. [§] In the last 30 days.

* $p<0.05$

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

N/A - The estimate is "0.0".

- Indicates estimate based on less than 25 unweighted cases and has been suppressed.

N/C - The relative change was not calculated as the first round estimate was "0.0 (N/A)".

Note: Due to the prevailing security situation in the Amhara region, the selected PSUs in this region were excluded from GATS Ethiopia 2024. GATS Ethiopia 2016 results were recalculated for only the regions covered by the GATS Ethiopia 2024 for the purposes of comparison.

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Disclaimer
The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of the U.S. Centers for Disease Control and Prevention, the CDC Foundation, or the Gates Foundation.

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