

**Effects of meeting  
MPOWER  
requirements  
on smoking rates  
and  
smoking-attributable  
deaths**

# Afghanistan

This factsheet presents estimates of the effect of implementing MPOWER policies consistent with the WHO Framework Convention on Tobacco Control (WHO FCTC). The estimates are based on the *Abridged SimSmoke* model (1).



**World Health  
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**

## Smoking prevalence

Afghanistan is a low-income country with an estimated population (ages 15 and above) of 9.4 million males and 8.7 million females in 2015 (2). Around 79% of workers were employed in agriculture and 12% were unemployed in 2008 (3). A modified STEPwise survey conducted in Kabul in 2011–2012 found an overall smoking prevalence (ages 40 and above) of 5.1% (14.7% of men and 0.3% of women), and smokeless tobacco use of 24.4% in men and 1.3% in women (4). A study in Jalalabad found 7.6% of respondents (ages 25–65) were current smokers who on average smoked 12 cigarettes per day, and 13.3% used smokeless tobacco (5). It was suggested that the high rate of smokeless tobacco use was due to its low price relative to cigarettes. A survey carried out in Kabul in 2010 on 554 randomly selected men (ages 15 and above) found a smoking prevalence of 35.2% (6). *Abridged SimSmoke* uses this estimate for male smoking rates, since the survey was specific to cigarette use. An estimate of 2.1% is used for female smoking rates, based on the 2014 Pakistan GATS survey (7).

## Tobacco control policies

### *Protect people from tobacco smoke*

Based on the 2015 WHO report on the global tobacco epidemic (8), which includes data from 2014, Afghanistan has smoke-free legislation covering health care facilities, education facilities and universities. Legislation does not cover government facilities, indoor offices, restaurants and public transport. There are no fines for violations, subnational bans do not exist, there are no funds dedicated for enforcement, and no space for citizen complaints and investigations. The compliance score is 2 out of 10.

### *Offer help to quit tobacco use*

According to 2014 data, nicotine replacement therapy is available in Afghanistan; however, it is not cost-covered. There are no quit lines or other cessation services available. Cessation programmes are classified at level 2 out of 4.

### *Warn about the dangers of tobacco*

According to 2014 data, Afghanistan is classified at level 1 out of 4 (minimal) for health warnings. There is no law mandating that health warnings appear on cigarette packages. Therefore, there are no warnings on the principal display area of each package, or any outside packaging and labelling used in the retail sale, describing the harmful effects of tobacco use on health. Government expenditure on tobacco control is not reported, and there is no tobacco control campaign.

### *Enforce bans on tobacco advertising, promotion and sponsorship*

According to 2014 data, Afghanistan has bans on direct tobacco advertising on national television and radio, and local magazines and newspapers. However, there were no bans for international television and radio, international magazines and newspapers, billboards and outdoors, point-of-sale and internet advertising. Afghanistan does not administer fines for violations of these bans. The compliance score for direct advertising bans was 2 out of 10. For indirect advertising, there are bans on the appearance of tobacco brands in television and/or film (product placement). However, there are no bans on the free distribution of tobacco products, appearance of tobacco products in television and/or films (non-product placement), sponsored events, promotional discounts, non-tobacco goods/services identified with tobacco brand names, brand names of non-tobacco goods/services used for tobacco products, display at point of sale, tobacco companies/industry/other entities publicizing their activities, tobacco companies funding or making contributions to smoking prevention media campaigns including those directed at youth, and there is no

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requirement to present prescribed anti-tobacco adverts before, during, or after the broadcasting or showing of any visual entertainment. There are no fines for violations of indirect advertising bans. The compliance score for indirect advertising bans was 5 out of 10. The overall compliance score for advertising bans was 4 of 10.

## *Raise taxes on tobacco*

In accordance with MPOWER policies, *Abridged SimSmoke* considers the effect of increasing cigarette excise taxes (including ad valorem taxes or specific taxes directly on cigarettes) to 75% of the retail price. Value added tax applies to all goods, not just cigarettes, but amplifies the effect of an excise tax on cigarette price. The change in excise taxes is first translated into the implied percentage change in price. The prevalence elasticity is applied to the percentage change in price to obtain the percentage change in prevalence. In Afghanistan, a pack of cigarettes is 20.00 Afghanis (US\$ 0.35), of which 2.8% is taxes (all taxes are import duties) according to data from 2014.

## **Key findings**

Based on current smoking rates of 35.2% among men and 2.1% among women, smoking-attributable deaths are predicted to be more than 1.74 million (1.6 million men and 92 000 women) of the 3.5 million smokers alive today, and the numbers are likely to continue to rise each year in the absence of stronger policies.

- Increasing cigarette excise taxes from a current level of 2.8% to 75% of the retail price would prevent much youth smoking and reduce smoking prevalence by 18.5% within 5 years, increasing to 37.0% in 40 years, and ultimately avert more than 646 000 premature deaths.
- Comprehensive smoke-free laws are in place, but stronger enforcement is predicted to reduce smoking prevalence by 2.6% in 5 years, increasing to 3% in 40 years, and avert 57 430 premature deaths.
- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 1.1% within 5 years, increasing to 3% in 40 years, and avert 47 900 premature deaths.
- Strong health warnings can reduce smoking prevalence by 7% within 5 years, increasing to 14% in 40 years, and avert over 260 000 premature deaths.
- A high-level mass media campaign is projected to reduce smoking prevalence by 6.5% in 5 years, increasing to almost 8% in 40 years, and avert over 136 000 premature deaths.
- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 6% in 5 years, increasing to 7.5% within 40 years, and avert 34 000 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 36% within 5 years, increasing to 46% within 20 years and 57% within 40 years. Almost 1 million deaths could be averted. A large tax increase accompanied by comprehensive marketing restrictions, a comprehensive cessation programme, strong health warnings and a mass media campaign would reduce smoking prevalence about 48% by 2025, thus meeting the global target.

## **Limitations**

*Abridged SimSmoke* has been developed based on an extensively validated simulation model, providing support for the estimates given above. However, the model has certain limitations.

- It does not consider tobacco products other than cigarettes, such as smokeless tobacco, e-cigarettes and shisha (waterpipe). Afghanistan has a high rate of smokeless tobacco use. If tax increases and other policies are only directed at cigarettes, smokers may substitute to other tobacco products, which would offset some of the health gains from reduced smoking. If policies are also targeted toward the use of non-cigarette products, then substitution to these products may be reduced.
- Smoking prevalence data for Afghanistan are from 2010. However, as a low-income country, smoking rates may increase as incomes rise, especially among women.
- It does not include deaths from second-hand smoke exposure. In addition, there are costs associated with morbidity and productivity loss due to premature death.
- Mortality risks for smoking are based on studies for the United States of America. As a low-income country, the effects of reductions in tobacco use on smoking-attributable deaths may be lower than projected for Afghanistan, due to higher background health risks and lower levels of smoking intensity and duration. Using a lower attribution risk, we estimate 1.1 million rather than 1.6 million deaths among smokers alive today.
- It has been developed to use data from the biennial WHO global tobacco epidemic reports. The tobacco control policy data are restricted to a specific set of policies and definitions. The model does not consider policies directed at cost-minimizing behaviour, enforcement against smuggling, product regulation and youth access.

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## References

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