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

Lebanon

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
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Smoking prevalence

Lebanon is a middle-income country with a population of about 4.3 million in 2010 *(2)*, of which about 5% is employed in agriculture *(3)*. Based on the Lebanese National Tobacco Programme survey conducted nationwide in 2010, the current tobacco smoking rate (ages 25–64) is 43.2% for men and 33.8% for women, and 21% of adults smoke shisha (waterpipe) *(4)*. *Abridged SimSmoke* assumes that 30% of men and 15% of women aged 65 and above smoke cigarettes. The analysis was confined to those aged 25 and above.

Tobacco control policies

Protect people from tobacco smoke

Based on the 2013 WHO report on the global tobacco epidemic *(5)*, which includes data from 2012, Lebanon had smoke-free legislation covering health care facilities, educational facilities and universities, government facilities, indoor offices, restaurants, cafés, pubs and bars, and public transport, but none covering other public places. Stronger smoke-free laws were implemented between 2010 and 2012. The compliance score was 8 out of 10. Workplaces, restaurants and bars were considered smoke-free, but other public places were at 50%.

Offer help to quit tobacco use

In 2012, there was no toll-free quit line with a live person to discuss smoking cessation in Lebanon. Nicotine replacement therapy was legally sold and could be purchased in a pharmacy without a prescription, but it was not cost-covered and was not on Lebanon's essential drug list. Bupropion and varenicline were legally sold and could be purchased in a pharmacy with a prescription, but were not cost-covered. Smoking cessation support was available in some hospitals, offices of a health professional and elsewhere in the community, but not in health clinics, other primary care facilities, or other places. National health insurance partially covered the cost of support in offices of health care professionals and in the community. The law's provisions increased slightly between 2007 and 2010.

Warn about the dangers of tobacco

In 2012, Lebanon had a law mandating that health warnings appear on tobacco packages. Warnings must cover 40% of the package, but they are not graphic. The warnings became bigger between 2010 and 2012. Health warnings were considered to be strong (level 2) in 2012. Lebanon had at least one national anti-tobacco mass media campaign in 2011–2012. It was an evidence-based planning campaign that was part of a comprehensive tobacco control programme. The campaign was aired on television and/or radio, used media planning to secure placement and media/public relations were used to promote the campaign. For 2011, there was a national agency/technical unit for tobacco control and four full-time equivalent staff. Government expenditure on tobacco control was US$ 30 000. Lebanon is considered to have a low level tobacco control campaign.

Enforce bans on tobacco advertising, promotion and sponsorship

In 2012, Lebanon had bans on direct tobacco advertising on national television and radio, local/international magazines and newspapers and point-of-sale. The compliance score of direct advertising bans was 10 out of 10. For indirect advertising, there were bans on the free distribution of tobacco products, brand name of non-tobacco products used for a tobacco product, appearance of tobacco brands and products in television and/or films (product placement), and sponsored events; however, there was no ban on promotional discounts. The compliance score of indirect advertising bans was 8 out of 10. Lebanon is considered 50% of a full ban (level 4) and 50% of a direct advertising ban (level 2), with an overall compliance score of 6 out of 10.

Raise taxes on tobacco

WHO's comparable estimate for the price of a pack of 20 cigarettes of the most sold brand was 2000.00 Lebanese pounds for 2008 and 2750.00 Lebanese pounds for 2012. WHO's comparable estimate for taxes as a percentage of retail price was 44.0% for 2008 and 43.4% for 2012 (9.1% value added taxes, 33% ad valorem taxes and 2% import duties).

Key findings

Without proper implementation of MPOWER tobacco control policies, prevalence rates will remain relatively stable or may increase from about 40% for men and 30% for women, and smoking-attributable deaths are likely to rise. There are 900 000 smokers in Lebanon, around half of which will die from smoking-related diseases.

- Cigarette excise taxes are at 33% and value added tax is 9.1%. Increasing cigarette excise taxes to 70% of the retail price would prevent much youth smoking and reduce smoking prevalence by 18.1% within 5 years, increasing to 36% in 40 years, and ultimately avert almost 166 000 deaths.

- Comprehensive smoke-free laws are in place, but stronger enforcement is predicted to reduce smoking prevalence by 3.9% in 5 years, increasing to 4.9% in 40 years, and avert 23 000 premature deaths.

- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 3.2% within 5 years, increasing to 8.1% in 40 years, and prevent 37 000 premature deaths.

- Stronger health warnings with graphic pictorials can reduce smoking prevalence by 4.5% within 5 years, increasing to 9% in 40 years, and prevent 41 000 premature deaths.

- A high-level mass media campaign is projected to reduce smoking prevalence by 5.5% in 5 years, increasing to 6.6% within 40 years, and avert 30 000 premature deaths.

- A well-enforced marketing ban would reduce smoking rates by 3.6% in 5 years, increasing to 4.7% in 40 years, and avert 21 000 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 34% in 5 years, increasing, to 44% in 20 years and 55% in 40 years, averting 252 000 deaths. The Abridged SimSmoke model incorporates synergies in implementing multiple policies. Increasing taxes, enforcing smoke-free laws, stronger health warnings, enforcing marketing restrictions, a comprehensive cessation programme and a mass media campaign would reduce smoking prevalence by 40% 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. The model has certain limitations.

- It does not consider tobacco products other than cigarettes, such as smokeless tobacco, e-cigarettes and shisha. 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.

- Much of the smoking population uses shisha. It is important to also raise the price of these products through taxes.

- 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 middle-income country, the effects of reductions in tobacco use on smoking-attributable deaths may be lower than projected for Lebanon, due to higher background health risks and lower levels of smoking intensity and duration.

- 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.

References

1. Levy DT, Fouad H, Levy J, Dragomir AD, El Awa F. Application of the *Abridged SimSmoke* model to four Eastern Mediterranean countries. Tob Control. 2016;25(4):413–21. doi:10.1136/tobaccocontrol-2015-052334 (http://tobaccocontrol.bmj.com/content/25/4/413, accessed 24 April 2018).

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4. WHO Report on the Global Tobacco Epidemic, 2013. Country profile: Lebanon. Beirut; Ministry of Health; Geneva: World Health Organization; 2013 (http://www.databank.com.lb/docs/WHO%20Report%20on%20the%20Global%20Tobacco%20Epidemic-%202013.pdf, accessed 25 April 2018).

5. WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85380/1/9789241505871_eng.pdf?ua=1, accessed 3 September 2015).