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

Libya

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

Libya is an upper-middle-income country with an estimated population (ages 15 and above) of 2.2 million males and 2.2 million females in 2015 *(2)*. About 17% of the population worked in agriculture and 30% were unemployed in 2004 *(3)*. Based on data from the most recent nationally representative survey, the 2009 STEPwise survey, the current tobacco smoking rate (ages 25–64) is 49.6% for men and 0.7% for women *(4)*.

Tobacco control policies

Protect people from tobacco smoke

Based on the 2015 WHO report on the global tobacco epidemic *(5)*, which includes data from 2014, Libya has smoke-free legislation covering health care facilities, education facilities and universities, government facilities, indoor offices, restaurants, public transport and all other indoor public places. There are no fines for violations and subnational bans do not exist. There are no funds dedicated for enforcement or a space for citizen complaints and investigations. The compliance score is 4 out of 10.

Offer help to quit tobacco use

Cessation treatment is provided in some health care facilities. Nicotine replacement therapy is available, but is not cost-covered. Quit lines are not available. According to 2014 data, Libya is classified at level 3 out of 4.

Warn about the dangers of tobacco

According to 2014 data, Libya is classified at level 1 out of 4 for health warnings. Health warnings are mandated to cover 25% of the principal display area. There has been one health warning approved by law. Warnings appear on each package and any outside packaging and labelling used in the retail sale, describing the harmful effects of tobacco use on health. They are rotating, and are written in the principal language(s). However, the law does not mandate font size, font style and colour of health warnings, or that the warning includes a photograph or graphic. Government expenditure on tobacco control is not given, and there is no tobacco control campaign.

Enforce bans on tobacco advertising, promotion and sponsorship

According to 2014 data, Libya is ranked 4 out of 4 for marketing restrictions. There are bans on direct tobacco advertising on national/international television and radio, televisionlocal/international magazines and newspapers, billboards and outdoors, and point-of-sale, and fines for violations of these bans. However, there is no ban on internet advertising. The compliance score for direct advertising bans is 10 out of 10. For indirect advertising, there are bans on the free distribution of tobacco products, promotional discounts, non-tobacco goods/services identified with tobacco brand names, brand names of non-tobacco goods/services used for tobacco products, appearance of tobacco brands in television and/or film (product placement and non-product placement) and sponsored events, and fines for violations of these bans. However, Libya does not have bans on 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 requirement to present prescribed anti-tobacco adverts before, during, or after the broadcasting or showing of any visual entertainment. The compliance score for indirect advertising bans is 3 out of 10. The overall compliance score for a advertising bans is 7 out of 10.

Raise taxes on tobacco

In accordance with MPOWER policies, we consider the effect of increasing excise taxes (including ad valorem taxes or specific taxes directly on cigarettes) to 75% of the retail price. Value added tax (VAT) 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 Libya, a pack of cigarettes is 3.00 Libyan dinars (US$ 8.37), of which 8.37% is tax (1.04% VAT, 0.00% excise taxes and 7.03% other taxes) according to 2014 data.

Key findings

Based on current smoking rates of 49.6.5% among men and 0.8% among women, smoking-attributable deaths are predicted to be more than 534 000 (526 000 men and 8 000 women) of the 1.1 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 0% to 75% of the retail price would prevent much youth smoking and reduce smoking prevalence by 17.0% within 5 years, increasing to 34.0% in 40 years, and ultimately avert almost 193 000 premature deaths.
- Comprehensive smoke-free laws are in place, but stronger enforcement is predicted to reduce smoking prevalence by 2.4% in 5 years, increasing to 3% in 40 years, and avert 11 900 premature deaths.
- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 2.5% within 5 years, increasing to 6% in 40 years, and avert 24 900 premature deaths.
- Strong health warnings can reduce smoking prevalence by 7% within 5 years, increasing to 14% in 40 years, and avert almost 74 000 premature deaths.
- A high-level mass media campaign is projected to reduce smoking prevalence by 5.5% in 5 years, increasing to almost 7% in 40 years, and avert over 26 000 premature deaths.
- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 2.5% in 5 years, increasing to 3.3% within 40 years, and avert more than 34 000 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 35.0% within 5 years, increasing to 50% within 20 years and 65% in 40 years. About 370 000 premature 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 50% 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). 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 Libya are from 2009. However, as an upper-middle-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 an upper-middle-income country, the effects of reductions in tobacco use on smoking-attributable deaths may be lower than projected for Libya, 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 *(5)*. 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

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