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

Morocco

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

Morocco is a middle-income country with a population of more than 32 million in 2011 *(2)*, of which 57% live in urban areas *(3)*. Based on the World Health Survey conducted nationwide in 2003, the current tobacco smoking rate (ages 18 and above) is 32.0% for men and 0.2% for women *(4)*. Based on data from other countries in the Region, *Abridged SimSmoke* set the smoking rate for those aged 15–17 to half the rate of ages 18–29.

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, Morocco had smoke-free legislation covering health care facilities, educational facilities and universities, government facilities and indoor offices. There was no smoke-free legislation covering restaurants, pubs and bars, and public transport. Smoke-free laws did not change between 2007 and 2012. The compliance score was 5 out of 10 in 2012. Smoke-free policies were at the second lowest level in 2012.

Offer help to quit tobacco use

In 2012, there was no toll-free quit line with a live person to discuss tobacco cessation in Morocco. Nicotine replacement therapy could be purchased in a pharmacy with a prescription, but was not cost-covered. Bupropion and varenicline were both legally sold. Smoking cessation support was available in some health clinics or other primary care facilities, some hospitals and some offices of a health professional, but not in the community or elsewhere. National health insurance did not cover the cost of support in any of these places. Cessation programmes were at the second lowest level in 2012.

Warn about the dangers of tobacco

In 2012, Morocco had a law mandating that health warnings appear on tobacco packages, but there is no requirement that they cover 50% of the package or that they be rotating and graphic. This had not changed since 2007. Morocco did not have a national anti-tobacco mass media campaign in 2011–2012. For 2012, there was a national agency/technical unit for tobacco control and one full-time equivalent staff. Government expenditure on tobacco control was not reported. Health warnings and mass media campaigns were at the lowest level in 2012.

Enforce bans on tobacco advertising, promotion and sponsorship

In 2012, Morocco had bans on direct tobacco advertising on national/international television and radio, televisionand local magazines and newspapers. However, there were no bans on international magazines and newspapers, billboards and outdoor advertising, point-of-sale and internet advertising. For indirect advertising, there were bans on the free distribution of tobacco products, promotional discounts and appearance of tobacco brands and products in television and films (product placement). However, there were no bans on non-tobacco goods and services identified with tobacco brand names, brand name of non-tobacco products used for tobacco products, appearance of tobacco brands and products in television and films (non-product placement) and sponsored events. The compliance score of both direct and indirect advertising bans was 10 out of 10. Advertising bans were at the second highest level in 2012.

Raise taxes on tobacco

WHO's comparable estimate for the price of a pack of 20 cigarettes of the most sold brand was17.5 Moroccan dirhams for 2008 and 17.5 Moroccan dirhams for 2012; in terms of international dollars (purchasing power parity) the price increased from US$ 3.49 to US$ 3.51. WHO's comparable estimate for taxes as a percentage of retail price was 66.0% for 2008 and 68.0% for 2012, with 52% in ad valorem excise taxes and 16.0% value added taxes.

Key findings

The *Abridged SimSmoke* model for Morocco estimates more than 3.3 million smokers (around 3.3 million men and 17 000 women) in 2010, and projects nearly 1.7 million premature deaths of smokers (more than 1.6 million men and 8000 women) alive in that year. Without proper implementation of MPOWER tobacco control policies, smoking prevalence rates will remain relatively stable and smoking-attributable deaths are likely to continue to rise.

- Increasing cigarette excise taxes to 75% of the retail price would prevent much youth smoking and reduce smoking prevalence by 18.9% within 5 years, increasing to 37.7% in 40 years, and ultimately avert about 640 000 premature deaths.
- Stronger enforcement of comprehensive smoke-free laws is predicted to reduce smoking prevalence by 6% in 5 years, increasing to 7% in 40 years, and avert more than 120 000 premature deaths.
- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 2% within 5 years, increasing to 5% in 40 years, and prevent more than 85 000 premature deaths.
- Strong health warnings can reduce smoking prevalence by 7% within 5 years, increasing to 14% in 40 years, and prevent more than 225 000 premature deaths.
- A high-level mass media campaign is projected to reduce smoking prevalence by 6.5% in 5 years, increasing to 8% within 40 years, and avert more than 130 000 premature deaths.
- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 4% in 5 years, increasing to 5% within 40 years, and avert more than 85 000 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 37% within 5 years, increasing to 49% within 20 years and 59% within 40 years. Almost 1 million premature deaths could be averted. The *Abridged SimSmoke* model incorporates synergies in implementing multiple policies. A large tax increase accompanied by comprehensive marketing restrictions, a comprehensive cessation programme and a mass media campaign would reduce smoking prevalence about 46% 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 shisha (waterpipe) and smokeless tobacco use. If tax increases and other policies are only directed at cigarettes, there may be a substitution to other forms of tobacco, which would counteract some of the health effects. In addition, if the newly implemented policies are targeted toward use of non-cigarette products, then substitution to these products may be reduced.

- Projections for Morocco are based on smoking prevalence data from 2006 and population data from 2010. The model does not consider any additional initiation or cessation that would have occurred after that date in the absence of policies. Stronger policies have been implemented in recent years, which may have reduced the smoking rates.
- As a middle-income country, the effects of reductions in tobacco use on smoking-attributable deaths may be lower than projected for Morocco, due to higher background health risks and lower smoking intensity and duration. Using the relative risks for middle-income countries, the number of deaths (when policies are implemented in combination) of those alive today is more than 1 million and the number of lives saved is more than 600 000.

References

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4. World health survey: Report of Morocco. Geneva: World Health Organization; 2003 (http://www.who.int/healthinfo/survey/whsmar-morocco.pdf, accessed 25 April 2018).
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