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

# Qatar

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

Qatar is a high-income country with a population of almost 2 million in 2011 *(2)*, of which 98.8% live in urban areas *(3)*. Based on the Global Adult Tobacco Survey conducted nationwide in 2013, the current tobacco smoking rate (ages 15 and above) is 20.2% for men and 3.1% for women *(4)*.

## 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, Qatar had no smoke-free legislation for health care facilities, educational facilities and universities, government facilities, indoor offices, restaurants, pubs and bars, or public transport. There has been no change in these statutes since 2007. Smoke-free policies were at the 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 cessation in Qatar. Nicotine replacement therapy could be purchased in a pharmacy with a prescription and was fully cost-covered. Bupropion and varenicline were both legally sold. Smoking cessation support was available in some health clinics or other primary care facilities, hospitals, offices of a health professional and other places, but not in the community. There was no smoking cessation support available in other places in 2007. National health insurance partially covers costs of cessation support in health clinics or other primary care facilities, fully in hospitals and fully in other places; data are not available for other categories. Cessation programmes were at the second highest level in 2012.

*Warn about the dangers of tobacco*

In 2012, Qatar had a law mandating that health warnings appear on tobacco packages and a requirement that they cover 50% of the package and be rotating and graphic. In 2007, there was no requirement that they be rotating and graphic. Qatar did not have any national anti-tobacco mass media campaigns in 2011–2012. For 2012, there was a national agency/technical unit for tobacco control and three full-time equivalent staff. Government expenditure on tobacco control was US$ 96 978 (353 000 Qatari riyals) in 2006. Health warnings were at the second highest level and mass media campaigns were at the lowest level in 2012.

*Enforce bans on tobacco advertising, promotion and sponsorship*

In 2012, Qatar had bans on direct tobacco advertising on national/international television and radio, local/international magazines and newspapers, billboard and outdoors, point-of-sale and the internet. These bans all existed in 2007. For indirect advertising, there were bans on the free distribution of tobacco products, promotional discounts, appearance of tobacco brands and products in television and films (product placement and non-product placement), non-tobacco goods and services identified with tobacco brand names, and brand name of non-tobacco products used for tobacco products; however, there were no bans on sponsored events. These bans have remained unchanged since 2007. The compliance score of both direct and indirect advertising bans is 9 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 was 6.00 Qatari riyals for 2008 and 9.00 Qatari riyals for 2012; in terms of international dollars (purchasing power parity) the price increased from US$ 1.74 to US$ 2.47. WHO's comparable estimate for taxes as a percentage of retail price was 33.0% for 2008 and 22.0% for 2012, all of which were value added taxes.

**Key findings**

The *Abridged SimSmoke* model for Qatar estimates nearly 268 000 smokers (more than 250 000 men and 9000 women) in 2010, and projects more than 133 000 premature deaths of smokers (more than 129 000 men and 4000 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 23.8% within 5 years, increasing to 47.5% in 40 years, and ultimately avert 63 000 premature deaths.
- Stronger enforcement of comprehensive smoke-free laws is predicted to reduce smoking prevalence by 15% in 5 years, increasing to 19% in 40 years, and avert more than 25 000 premature deaths.
- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 4% within 5 years, increasing to about 9% in 40 years, and prevent nearly 13 000 premature deaths.
- Strong health warnings can reduce smoking prevalence by 6% within 5 years, increasing to 12% in 40 years, and prevent over 16 000 premature deaths.
- A high-level mass media campaign is projected to reduce smoking prevalence by 5.5% in 5 years, increasing to 6.5% within 40 years, and avert nearly 9000 premature deaths.
- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 2% in 5 years, increasing to about 3% within 40 years, and avert more than 3500 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 43.5% within 5 years, increasing to 56.0% within 20 years and 66.8% within 40 years. Almost 90 000 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 by about 56% 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 (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.

- Mortality risks for smoking are based on studies for the United States of America.
- 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.
- 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**


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