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

Tunisia

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

Tunisia is a middle-income country with a population of about 10.6 million in 2010 *(2)*, of which about 10% is employed in agriculture *(3)*. The World Health Survey conducted in 2003 estimated smoking rates of 50.1% for men and 1.5% for women *(4)*. A nationwide survey conducted in 2005–2006 found current tobacco smoking rates (ages 35–70) of 48.4% for men and 8.2% for women; there was little difference between the daily cigarette smoking rate (about 90% of overall rate) and the tobacco smoking rate, suggesting that most tobacco users smoke cigarettes *(5)*. Based on the 2005 survey, the WHO standardized rate for smoking prevalence is 52% for men and 11% for women. Abridged SimSmoke uses data from the 2003 World Health Survey, which may underestimate the smoking rates for women.

Tobacco control policies

Protect people from tobacco smoke

Based on the 2013 WHO report on the global tobacco epidemic (6), which includes data from 2012, Tunisia had smoke-free legislation covering health care facilities, educational facilities and universities, government facilities, indoor offices, restaurants, cafés, pubs and bars, and public transport; however, smoking was allowed in ventilated areas and there was limited compliance with legislation.

Offer help to quit tobacco use

In 2012, there was no toll-free quit line with a live person to discuss smoking cessation in Tunisia. Nicotine replacement therapy was legally sold and could be purchased in a pharmacy with a prescription, but it was not cost-covered and was not on Tunisia's essential drug list. Bupropion and varenicline were not legally sold. Smoking cessation support was available in most health clinics or other primary care facilities and in most hospitals. It was available in some offices of a health professional and in other places, but not in the community. National health insurance partially covered the cost of this support in all places where services are provided.

Warn about the dangers of tobacco

In 2012, Tunisia had weak health warnings on tobacco packages. There was 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; it was pre-tested with the target audience and research about the target audience was conducted. The campaign was aired on television or radio, used media planning to purchase or secure air-time or placement, and was promoted using public relations. For 2011, there was a national agency/technical unit for tobacco control and one full-time equivalent staff. Government expenditure on tobacco control is not reported. Tunisia is considered to have a low level tobacco control campaign.

Enforce bans on tobacco advertising, promotion and sponsorship

In 2012, Tunisia had bans on direct tobacco advertising on national/international television and radio, local/international magazines and newspapers, billboards and outdoors. However, there were no bans on point-of-sale or internet advertising. The compliance score of direct advertising bans was 9 out of 10. For indirect advertising, there were bans on the free distribution of tobacco products, promotional discounts, non-tobacco goods and services identified with tobacco brand names, brand name of non-tobacco products used for a tobacco product, and appearance of tobacco brands/products in television and/or films (product placement and non-product placement); however, there was no ban on sponsored events. The compliance score of indirect advertising bans was 7 out of 10. Tunisia is considered 50% of a full ban (level 4) and 50% of a direct advertising ban (level 2), with an overall compliance score of 8 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 1.70 Tunisian dinars for 2008 and 2.25 Tunisian dinars for 2012. WHO's comparable estimate for taxes as a percentage of retail price 78% for 2012, of which 70% was excise taxes.

Key findings

Without proper implementation of MPOWER tobacco control policies, smoking prevalence rates will remain relatively stable or increase from 53% for men and 2% for women, and smoking-attributable deaths are likely to continue to rise. There are an estimated 2 million smokers in Tunisia, around half of which will die from smoking-related diseases.

- Increasing cigarette excise taxes from 70% to 75% of the retail price will reduce smoking prevalence by 5% in 5 years, increasing to 9.4% in 40 years, and avert about 95 500 premature deaths.

- Smoke-free laws are in place, but allow smoking in ventilated spaces.Comprehensive laws with strong enforcement are predicted to reduce smoking prevalence by 10% in 5 years, increasing to 12% in 40 years, and avert about 123 000 (120 000 male and 3500 female) premature deaths.

- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 2.7% within 5 years, increasing to 6.6% in 40 years, and prevent 67 500 premature deaths.

- Strong health warnings can reduce smoking prevalence by 6% within 5 years, increasing to 12% in 40 years, and prevent 122 000 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 67 000 premature deaths.

- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 3% in 5 years, increasing to 3.6% within 40 years, and avert more than 37 000 deaths.

- Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 28% in 5 years, increasing to 32% in 20 years and 41% in 40 years. Almost 420 000 deaths could be averted. *The Abridged SimSmoke* model incorporates synergies in implementing multiple policies. Enforcing smoke-free laws accompanied by strong health warnings, comprehensive marketing restrictions, a comprehensive cessation programme and a mass media campaign would meet the global target of reducing smoking prevalence by 35% by 2025.

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.

- 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 Tunisia, 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

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