WHO-EM/TFI/186/E

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

United Arab Emirates

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

United Arab Emirates is a high-income country with a population of more than 8 million in 2011 *(2)*, of which 84.4% live in urban areas *(3)*. Based on the World Health Survey conducted nationwide in 2003, the current daily smoking rate is 17.3% for men and 1.4% 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, the United Arab Emirates had smoke-free legislation covering health care and educational facilities including universities, but none covering government facilities, indoor offices, restaurants, pubs and bars, and public transport. Universities changed status from 2007. The compliance score was not available for 2012, but was 3 out of 10 in 2007. Smoke-free policies were at the second lowest level in 2012.

Offer help to quit tobacco use

In 2012, there was a toll-free quit line with a live person to discuss cessation available in the United Arab Emirates. Nicotine replacement therapy could be purchased in a pharmacy without a prescription and was partially cost-covered. National health insurance did not cover the cost of this product in 2007. Bupropion and varenicline were legally sold in 2012, but not in 2007. Smoking cessation support was available in some health clinics or other primary care facilities, in most hospitals, in some offices of a health professional, in some places in the community and some places elsewhere. Other than in offices of a health professional, none of this support was available in 2007. National health insurance partially covered the cost of support in health clinics or other primary care facilities, hospitals and in the community, but not in offices of a health professional. Cessation programmes were at the highest level in 2012.

Warn about the dangers of tobacco

In 2012, the United Arab Emirates had a law mandating that health warnings appear on tobacco packages. Warnings must cover 50% of the package and be rotating and graphic. This was a change from 2007. For 2012, there was a national agency/technical unit for tobacco control but no full-time equivalent staff. Government expenditure on tobacco control was not reported. Health warnings were at the second highest level in 2012, but data for mass media campaigns were not reported.

Enforce bans on tobacco advertising, promotion and sponsorship

In 2012, the United Arab Emirates had bans on direct tobacco advertising on national/international television and radio, local/international magazines and newspapers, billboards and outdoors, and point-of-sale. However, there were no bans on internet advertising. From 2007, bans on advertising in international magazines and newspapers changed. The compliance score of direct advertising bans was not reported in 2012, but was 9 out of 10 in 2007. For indirect advertising, there were bans on non-tobacco goods and services identified with tobacco brand names, appearance of tobacco brands and products in television and films (product placement and non-product placement) and sponsored events. However, there were no bans on the free distribution of tobacco products, promotional discounts and the brand name of non-tobacco products used for tobacco products. From 2007, bans on non-tobacco goods and services identified with tobacco brand names changed. The compliance score of indirect advertising bans was not reported in 2012, but was 4 out of 10 in 2007. 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 6.50 Emirati dirhams for 2008 and 8.00 Emirati dirhams for 2012; in terms of international dollars (purchasing power parity) the price increased from US$ 1.28 to US$ 1.51. WHO's comparable estimate for taxes as a percentage of retail price was 31.0% for 2008 and 25.0% for 2012; all taxes were import duties.

Key findings

The *Abridged SimSmoke* model for the United Arab Emirates estimates more than 843 000 smokers (about 820 000 men and 22 000 women) in 2010, and projects more than 421 000 premature deaths of smokers (about 410 000 men and 11 000 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 15% within 5 years, increasing to 30% in 40 years, and ultimately avert more than 126 000 premature deaths.
- Stronger enforcement of comprehensive smoke-free laws is predicted to reduce smoking prevalence by 13% in 5 years, increasing to 17% in 40 years, and avert more than 70 000 premature deaths.
- A well-publicized and comprehensive cessation policy can reduce smoking prevalence by 1% within 5 years, increasing to 2.5% in 40 years, and prevent more than 10 000 premature deaths.
- Health warnings are already at the strongest level.
- 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 32 000 premature deaths.
- A comprehensive marketing ban with enforcement is projected to reduce smoking prevalence by 2.5% in 5 years, increasing to 3.5% within 40 years, and avert more than 14 000 deaths.

Implementing the stronger set of policies suggested above, in line with the WHO FCTC, could reduce smoking prevalence by 30% within 5 years, increasing to 43% within 20 years and 46% within 40 years. More than 190 000 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 at least 42% 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.

- 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

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).

2. World population prospects: the 2015 revision. New York: Department of Economic and Social Affairs, Population Division; 2015.

3. World Factbook 2015. Washington DC: Central Intelligence Agency; 2015 (https://www.cia.gov/library/publications/the-world-factbook/, accessed 3 September 2015).

4. World Health Survey 2003: United Arab Emirates. Geneva: World Health Organization; 2003 (http://www.who.int/healthinfo/survey/whsare-unitedarabemirates.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).