TOBACCO CONTROL
FACT SHEET

Serbia

Health impact of tobacco control policies in line with the WHO Framework Convention on Tobacco Control (WHO FCTC)

Based on the current level of adult smoking in Serbia *(1)*, premature deaths attributable to smoking are projected to be more than 1.2 million of the almost 2.5 million smokers alive today (Table 1) and may increase in the absence of stronger policies.

TABLE 1.
Initial smoking prevalence and projected premature deaths

Smoking prevalence (%)		Smokers (n)	Projected premature deaths of current smokers (n)					
Male	Female	Total	Male[a]	Female[a]	Total[a]	Male[b]	Female[b]	Total[b]
37.9	31.6	2 456 896	656 239	572 209	1 228 448	426 555	371 936	798 491

[a] Premature deaths are based on relative risks from large-scale studies of high-income countries.

[b] Premature deaths are based on relative risks from large-scale studies of low- and middle-income countries.

Source: Boričić et al *(1)*.

Key findings

Within 15 years, the effects of individual tobacco control policies when fully implemented in line with the WHO FCTC *(2)* are projected to reduce smoking prevalence by:

- **16%** by increasing excise cigarette taxes from its current level of 61% to 75% and prevent much youth smoking;
- **7%** with more comprehensive smoke-free laws and stronger enforcement;
- **6.3%** by increasing from a low-level to a high-level mass media campaign;
- **6.2%** by banning just some forms of direct and indirect advertising to have a comprehensive ban on advertising, promotion and sponsorship that includes enforcement;
- **4.5%** by requiring strong, graphic health warnings added to tobacco products; and
- **3.6%** by increasing from minimal provision to a well-publicized and comprehensive tobacco cessation policy.

With this stronger set of policies and consistent with the WHO FCTC *(2)*, smoking prevalence can be reduced by 29% within 5 years, by 37% within 15 years and by 44% within 40 years. Almost 535 000 deaths could be averted in the long term (Table 2). The SimSmoke tobacco control model *(3)* incorporates synergies in implementing multiple policies (e.g., strong media campaign with smoke-free laws and tobacco cessation policies).

TABLE 2.

Effect of tobacco control policies (individual and combined) on initial smoking prevalence and smoking-attributable deaths

Tobacco control policy	Relative change in smoking prevalence (%)		Reduction in smokers in 40 years (n)	Reduction in smoking-attributable deaths in 40 years (n)					
	5 years	40 years	Total	Male[a]	Female[a]	Total[a]	Male[b]	Female[b]	Total[b]
Protect through smoke-free laws	–6.1	–7.6	**187 476**	50 075	43 663	**93 738**	32 549	28 381	**60 930**
Offer tobacco cessation services	–2.0	–5.1	**125 064**	33 405	29 127	**62 532**	21 713	18 933	**40 646**
Mass media campaigns	–5.5	–6.6	**162 155**	43 312	37 766	**81 078**	28 153	24 548	**52 701**
Warnings on cigarette packages	–3.0	–6.0	**147 414**	39 374	34 333	**73 707**	25 593	22 316	**47 909**
Enforce marketing restrictions	–5.2	–6.8	**166 086**	44 362	38 681	**83 043**	28 835	25 143	**53 978**
Raise cigarette taxes	–10.6	–21.3	**523 132**	139 729	121 837	**261 566**	90 824	79 194	**170 018**
Combined policies	–28.6	–43.5	**1 069 121**	285 563	248 997	**534 560**	185 616	161 848	**347 464**

[a] Smoking-attributable deaths are based on relative risks from large-scale studies of high-income countries.
[b] Smoking-attributable deaths are based on relative risks from large-scale studies of low- and middle-income countries.

→ Monitor tobacco use

The prevalence of current adult smokers (15 years and older) was 34.7% in 2013 (men: 37.9%; women: 31.6%) *(1)*.

→ Protect people from tobacco smoke

Health care facilities, education facilities including universities, government facilities and public transport in Serbia are completely smoke free (Table 3). Smoking violations consist of fines on the establishment and the patron. Funds are dedicated for enforcement; however, no system is in place for citizen complaints and further investigations *(4)*.

TABLE 3.

Complete smoke-free indoor public places

Health care facilities	Education facilities except universities	Universities	Government facilities	Indoor offices & workplaces	Restaurants	Cafés, pubs & bars	Public transport	All other indoor public places
✓	✓	✓	✓	⊖	⊖	⊖	✓	⊖

Source: WHO *(4)*.

✓ = completely smoke-free; ⊖ = not completely smoke-free.

→ Offer help to quit tobacco use

Smoking cessation services are available in some health clinics or other primary care facilities, and the national health service or the national health insurance fully covers its costs. Nicotine replacement therapy can be purchased over the counter in a pharmacy but is not cost-covered, and no toll-free quit line is available *(4)*.

→ Warn about the dangers of tobacco

Health warnings are legally mandated to cover 30% of the front and 40% of the rear of the principal display area, whereby 12 health warnings are approved by law. They describe the harmful effects of tobacco use on health, rotate on packages and are written in the principal language(s) of the country. The law also mandates font style, font size and colour for package warnings. However, the health warnings do not include a photograph or graphics and are not mandated to appear on each package and any outside packaging and labelling used in the retail sale *(4)*.

Total tobacco control expenditures, which may include mass media campaign expenditures, amount to US$ 117 224 in Serbia, which is less than US$ 0.05 per capita and is, therefore, classified as a low level of funding *(4)*.

→ Enforce bans on tobacco advertising, promotion and sponsorship

Serbia has a ban, through a law adopted in 2005 *(5)*, on several forms of direct and indirect advertising (Table 4). The law requires fines for violations of these direct and indirect advertising bans *(4)*.

TABLE 4.

Bans on direct and indirect advertising

Direct advertising		Indirect advertising	
National television and radio	✓	Free distribution in mail or through other means	✓
International television and radio	✓	Promotional discounts	✓
Local magazines and newspapers	✓	Non-tobacco products identified with tobacco brand names	⛔
International magazines and newspapers	✓	Appearance of tobacco brands in television and/or films (product placement)	✓
Billboards and outdoor advertising	✓	Appearance of tobacco products in television and/or films	⛔
Advertising at point of sale	⛔	Sponsored events	⛔
Advertising on internet	✓	Tobacco products display at point of sale	⛔

Source: WHO *(4)*.

✓ = banned; ⛔ = not banned.

Serbia does not have:

- bans on tobacco companies/tobacco industry publicizing their activities;
- bans on entities other than tobacco companies/tobacco industry publicizing their activities;
- bans on tobacco companies funding or making contributions (including in-kind contributions) to smoking prevention media campaigns including those directed at youth; and
- a requirement to present prescribed anti-tobacco advertisements before, during or after the broadcasting or showing of any visual entertainment *(4)*.

→ Raise taxes on tobacco

In Serbia, a pack of cigarettes costs 170 RSD[1] (US$ 1.95), of which 77.92% is tax (16.67% is value added and 61.25% is excise taxes) *(4)*.

[1] The currency code is according to International Organization for Standardization, ISO 4217 currency names and code elements.

About the SimSmoke model

The abridged version of the SimSmoke tobacco control model, developed by David Levy of Georgetown University, United States of America, projects the reduction in smoking prevalence and smoking-attributable deaths as a result of implementing tobacco control policies (individually and in combination) *(3)*. Specifically, the model projects the effects from:

- protecting from secondhand smoke through stronger smoke-free air laws
- offering greater access to smoking cessation services
- placing warnings on tobacco packages and other media/educational programmes
- enforcing bans on advertising, promotion and sponsorship
- raising cigarette prices through higher cigarette taxes *(6)*.

For the SimSmoke model, data on smoking prevalence among adults were taken from the most recent nationally representative survey that covered a wide age range, and data on tobacco control policies were taken from the *WHO report on the global tobacco epidemic, 2015 (4)*.

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References[2]

1. Boričić K, Vasić M, Grozdanov J, Gudelj Rakić J, Živković Šulović M, Jaćović Knežević N et al. Results of the national health survey of the Republic of Serbia 2013. Belgrade: Institute of Public Health of Serbia; 2014 (http://www.batut.org.rs/download/publikacije/2013SerbiaHealthSurvey.pdf).
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3. Levy DT, Fouad H, Levy J, Dragomir AD, El Awa F. Application of the Abridged SimSmoke model to four Eastern Mediterranean countries. Tob Control. 2015. doi:10.1136/tobaccocontrol-2015-052334 [Epub ahead of print].
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6. Tobacco Free Initiative MPOWER [website]. Geneva: World Health Organization; 2016 (http://www.who.int/tobacco/mpower/en/).

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[2] Websites accessed on 20 March 2016.