

TOBACCO CONTROL
FACT SHEET

Turkmenistan

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 Turkmenistan (1), premature deaths attributable to smoking are projected to be as high as 184 000 of the 368 000 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 (%)			Projected premature deaths of current smokers (n)			
Male	Female	Total	Male ^a	Female ^a	Total ^a	Total ^b
15.5	0.6	368 200	178 250	5 850	184 100	119 665

^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: WHO (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:

- 30.7% by increasing excise cigarette taxes from the current level of 12.23% to 75% and prevent much smoking among young people;
- 1.2% with stronger enforcement of comprehensive smoke-free laws that are already in place;
- 5.2% by banning most forms of direct and indirect advertising to create a comprehensive ban on advertising, promotion and sponsorship with enforcement;
- 2.3% by increasing from moderate provision to a well publicized and comprehensive tobacco-cessation policy; and
- 6.3% by increasing awareness of the harms of tobacco use through a high-level media campaign.

Strengthening health warnings may not have any additional effects on relative change in smoking prevalence, as the health-warning policy and its implementation are already at the highest level.

With this stronger set of policies and consistent with the WHO FCTC (2), smoking prevalence can be reduced by 30% within five years, 41% within 15 years and 50% within 40 years. More than 92 000 deaths could be averted in the long term (Table 2). The SimSmoke tobacco control model (3) incorporates synergies in implementing multiple policies (such as strong media campaigns 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 smoking-attributable deaths in 40 years (n)			
	5 years	15 years	40 years	Male ^a	Female ^a	Total ^a	Total ^b
Protect through smoke-free laws	-1.1	-1.2	-1.3	2 355	77	2 432	1 581
Offer tobacco-cessation services	-1.3	-2.3	-3.3	5 949	195	6 144	3 994
Mass media campaigns	-5.5	-6.3	-6.6	11 765	386	12 151	7 898
Warnings on cigarette packages	0.0	0.0	0.0	–	–	–	–
Enforce marketing restrictions	-4.3	-5.2	-5.6	9 964	327	10 291	6 689
Raise cigarette taxes	-20.4	-30.7	-40.9	72 903	2 393	75 296	48 942
Combined policies	-29.8	-40.6	-50.3	89 643	2 942	92 585	60 180

^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 (18–64 years) in Turkmenistan in 2014 was 8.3% (men: 15.5%; women: 0.6%) (1).

→ Protect people from tobacco smoke

All enclosed public places are completely smoke-free in Turkmenistan (Table 3). Smoking violations incur fines for the patron and the establishment, but no funds are dedicated to enforcement and 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 and workplaces	Restaurants	Cafes, pubs and bars	Public transport	All other indoor public places
✓	✓	✓	✓	✓	✓	✓	✓	✓

Source: WHO (4).

✓ = completely smoke-free.

→ Offer help to quit tobacco use

Smoking-cessation services are available in most health clinics and other primary care facilities, and in offices of health professionals, with costs fully covered by the national health service or national health insurance. Nicotine replacement therapy can be purchased over the counter in a pharmacy without a prescription, but is not cost-covered. A toll-free quit line is available (4).

→ Warn about the dangers of tobacco

Health warnings are legally mandated to cover 65% of the front and rear of the principal display area, with 12 such warnings approved by law. They appear on each package and any outside packaging and labelling used in retail sale and describe the harmful effects of tobacco use on health. The law also mandates font size/style and colour for package warnings and states that they must include a photograph or graphic. The position of health warnings on packages rotates and the messages are written in the principal language(s) of the country (4).

→ Enforce bans on tobacco advertising, promotion and sponsorship

Through a law adopted in 2013 (5), Turkmenistan has bans in place on most forms of direct and indirect advertising (Table 4). The law requires fines for violations of these 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 the Internet	✓	Tobacco products display at point of sale	✓

Source: WHO (4).

✓ = banned. ✗ = not banned.

Additionally, Turkmenistan has:

- bans on tobacco companies/tobacco industry publicizing their activities; and
- bans on entities other than tobacco companies/tobacco industry publicizing activities of the tobacco companies (4).

It does not, however, have:

- bans on tobacco companies funding or making contributions (including in-kind contributions) to smoking-prevention media campaigns, including those directed at young people; 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

A pack of cigarettes in Turkmenistan costs 11.65 TMT¹ (US\$ 4.09), of which 26.11% is tax (13.04% is value-added tax, 12.23% ad valorem excise tax and 0.83% import duty) (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 second-hand smoke through stronger smoke-free 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).

Data on smoking prevalence among adults for the SimSmoke model were taken from the most recent nationally representative survey covering a wide age range; data on tobacco control policies were taken from the 2015 WHO report on the global tobacco epidemic (4).

Funding

This fact sheet was made possible by funding from the Government of the Russian Federation.

References

1. Prevalence – most recent adult survey data by country. In: Global Health Observatory data repository (European Region) [online database]. Geneva: World Health Organization; 2016 (<http://apps.who.int/gho/data/node.main-euro.TOB1249?lang=en>, accessed 27 December 2016).
2. WHO Framework Convention on Tobacco Control [website]. Geneva: World Health Organization; 2016 (<http://www.who.int/fctc/en/>, accessed 27 December 2016).
3. Levy DT, Fouad H, Levy J, Dragomir A, 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.
4. WHO report on the global tobacco epidemic, 2015: raising taxes on tobacco. Geneva: World Health Organization; 2015 (http://www.who.int/tobacco/global_report/2015/en/, accessed 27 December 2016).
5. Tobacco control database for the WHO European Region [online database]. Copenhagen: WHO Regional Office for Europe; 2016 (<http://data.euro.who.int/tobacco/>, accessed 27 December 2016).
6. MPOWER. In: Tobacco free initiative (TFI) [website]. Geneva: World Health Organization; 2016 (<http://www.who.int/tobacco/mpower/en/>, accessed 27 December 2016).

Acknowledgements

Data analysis: David Levy and Jeffrey Levy, Georgetown University, Washington (DC), United States of America

Text: Kristina Mauer-Stender, Nataliia Toropova, Elizaveta Lebedeva, WHO Regional Office for Europe

Text Editing: Alex Mathieson, Edinburgh, United Kingdom

Graphic design: Carli Hyland, Hill+Knowlton Strategies, Copenhagen, Denmark