World Health Organization
REGIONAL OFFICE FOR Europe

Photo: Registan Square, Uzbekistan, Robert Wilson, 2015

TOBACCO CONTROL
FACT SHEET

Uzbekistan

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 Uzbekistan *(1)*, premature deaths attributable to smoking are projected to be as high as 1.4 million of the 2.8 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]	Total[b]
26.8	1.4	2 884 800	1 366 800	75 600	1 442 400	937 560

[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:

- 31.6% by increasing excise cigarette taxes from the current level of 15.86% to 75% and prevent much smoking among young people;
- 11.6% with more comprehensive smoke-free laws and stronger enforcement;
- 5.5% by banning most forms of direct and indirect advertising to create a comprehensive ban on advertising, promotion and sponsorship with enforcement;
- 6.8% by requiring that strong graphic health warnings be added to tobacco products;
- 4.3% by increasing from moderate provision to a well publicized and comprehensive tobacco-cessation policy; and
- 7.5% by increasing from a low- to high-level media campaign.

With this stronger set of policies and consistent with the WHO FCTC *(2)*, smoking prevalence can be reduced by 41% within five years, 53% within 15 years and 63% within 40 years. More than 900 000 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	–10.1	–11.6	–12.6	171 736	9 499	181 235	117 803
Offer tobacco-cessation services	–2.5	–4.3	–6.2	84 792	4 690	89 482	58 163
Mass media campaigns	–6.5	–7.5	–7.8	106 610	5 897	112 507	73 130
Warnings on cigarette packages	–4.5	–6.8	–9.0	123 012	6 804	129 816	84 380
Enforce marketing restrictions	–4.6	–5.5	–6.0	81 735	4 521	86 256	56 066
Raise cigarette taxes	–21.1	–31.6	–42.2	576 440	31 884	608 324	395 411
Combined policies	–41.0	–52.9	–62.6	855 484	47 318	902 802	586 822

[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 Uzbekistan in 2014 was 14.4% (men: 26.8%; women: 1.4%) *(1)*.

→ Protect people from tobacco smoke

Public transport is completely smoke-free in Uzbekistan (Table 3). Smoking is prohibited in all other enclosed public places, except in designated areas and premises for the use of tobacco. Smoking violations incur fines for the patron but not the establishment. 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. ⛔ = not completely smoke-free.

→ Offer help to quit tobacco use

Smoking-cessation services are available in some health clinics and other primary care facilities, with costs fully covered by the national health service or national health insurance. Cessation support is also available in some hospitals with costs partially covered. Nicotine replacement therapy can be purchased over the counter in a pharmacy without a prescription, but is not cost-covered. No toll-free quit line is available *(4)*.

→ Warn about the dangers of tobacco

Health warnings are legally mandated to cover 40% of the front and rear of the principal display area, with seven 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 position of health warnings on packages rotates and the messages are written in the principal language(s) of the country. The law does not mandate font size/style and colour for package warnings, and warnings do not include a photograph or graphic *(4)*.

→ Enforce bans on tobacco advertising, promotion and sponsorship

Through laws on advertising (adopted in 1998 and amended several times since) and limitation of alcohol and tobacco products (adopted in 2011) *(5)*, Uzbekistan has bans in place on some forms of direct and indirect advertising (Table 4). The law does not require 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, Uzbekistan has a requirement to present prescribed anti-tobacco advertisements before, during or after the broadcasting or showing of any visual entertainment *(4)*. It does not, however, have:

- bans on tobacco companies/tobacco industry publicizing their activities;
- bans on entities other than tobacco companies/tobacco industry publicizing activities of the tobacco companies; and
- bans on tobacco companies funding or making contributions (including in-kind contributions) to smoking-prevention media campaigns, including those directed at young people *(4)*.

→ Raise taxes on tobacco

A pack of cigarettes in Uzbekistan costs 2 200 UZS[1] (US$ 0.94), of which 32.53% is tax (16.67% is value-added tax and 15.86% 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 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. Uzbekistan STEPS survey 2014. Fact sheet. Geneva: World Health Organization; 2014 (http://www.who.int/chp/steps/Uzbekistan_2014_STEPS_FactSheet_EN.pdf, 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