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Review

Tobacco control efforts in the Gulf Cooperation Council countries: achievements and challenges

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جهود مكافحة التبغ في بلدان مجلس التعاون الخليجي: إنجازات وتحديات

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الخلاصة: تستعرض هذه الورقة الوضع الراهن لتعاطي التبغ، والالتزام الحكومي والوطني بمكافحته، وإطار التدخلات الحالية لخفض تعاطي التبغ بين المجموعات السكانية في بلدان مجلس التعاون الخليجي واليمن. كما تستعرض هذه الورقة التدخلات الهيكلية الموجَّهة بالسياسات (والتي تتماشى مع حزمة السياسات الستة MPOWER والتي تضم ستة إجراءات مسندة بالبيِّنات لمكافحة التبغ) وهي سياسات تمثل إجراءات حكومية تستهدف تقوية وتفعيل وإدارة برامج مكافحة التبغ، والتصدي للوباء المتزايد لتعاطي التبغ. وقد اتضح من النتائج أن مكافحة التبغ في بلدان مجلس التعاون الخليجي قد شهدت تقدُّماً ملموساً على مدى العقود الماضية، إلا أن هذه النتائج ما هي إلا نتائج مبكرة تشير إلى خطوات في الاتجاه الصحيح، ومن الضروري زيادة الاستثمار في تنفيذ وتفعيل الاتفاقية الإطارية بشأن تعاطي التبغ، وإصدار تشريعات صارمة لمكافحة التبغ، وإنشاء خدمات متاحة على نحو شامل للإقلاع عن التدخين، من أجل تقوية مكافحة التدخين في إقليم بلدان مجلس التعاون الخليجي.

ABSTRACT This paper reports a review into the current state of tobacco use, governance and national commitment for control, and current intervention frameworks in place to reduce the use of tobacco among the populations of the Gulf Cooperation Council (GCC) member states and Yemen. It further reviews structured policy-oriented interventions (in line with the MPOWER package of 6 evidence-based tobacco control measures) that represent government actions to strengthen, implement and manage tobacco control programmes and to address the growing epidemic of tobacco use. Our findings show that tobacco control in the GCC countries has witnessed real progress over the past decades. These are still early days but they indicate steps in the right direction. Future investment in implementation and enforcement of the Framework Convention on Tobacco Control, production of robust tobacco control legislation and the establishment of universally available tobacco cessation services are essential to sustain and strengthen tobacco control in the GCC region.

Actions de lutte antitabac dans les pays du Conseil de Coopération du Golfe : défis et succès

RÉSUMÉ Le présent article expose un état des lieux de la consommation de tabac, de la gouvernance, de l'engagement national dans la lutte antitabac, et les cadres d'intervention actuellement en place destinés à réduire la consommation de tabac dans les populations des États membres du Conseil de Coopération du Golfe et du Yémen. Il examine également les interventions structurées pour l'élaboration de politiques (conformément au programme MPOWER qui est composé de six mesures de lutte antitabac fondées sur des données probantes) qui représentent des actions gouvernementales destinées à renforcer, mettre en oeuvre et gérer des programmes de lutte antitabac et à s'attaquer à l'épidémie croissante de tabagisme. Nos résultats révèlent que la lutte antitabac dans les pays membres du Conseil de Coopération du Golfe a réalisé des progrès tangibles au cours des dernières décennies. Toutefois, il ne s'agit que d'un début montrant la voie à suivre. De nouveaux investissements dans la mise en œuvre et l'application de la Convention-cadre pour la lutte antitabac, la proposition d'une législation antitabac solide et l'offre de services de sevrage tabagique d'accès universel sont essentiels pour appuyer et renforcer la lutte antitabac dans la région du Conseil de Coopération du Golfe.

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Introduction

Tobacco use is one of the most malicious public health threats the world has ever faced *(1)* and it continues to be the leading cause of preventable deaths globally *(2)*. There is undisputable evidence that tobacco use is a major cause of both morbidity and mortality *(3,4)*, responsible for nearly 6 million deaths annually *(5)* resulting from both direct and indirect use. In 2010 alone, approximately 5.4 million people died due to tobacco-related diseases, with an additional 600 000 deaths attributed to exposure to second-hand smoke *(6)*. Tobacco is estimated to kill more than half of the people using it *(7)*.

Many countries are reinforcing their fight against tobacco. In this paper we focus our attention on the Gulf Cooperation Council (GCC) countries (i.e. the GCC member states and Yemen). This is a part of the world that harbours tobacco-related mortality rates of 12% and 2% for males and females respectively *(7)*. The GCC is primarily a political and economic alliance of 6 countries in the Middle East: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates (UAE). In 2002, Yemen participated by developing specific mechanisms for cooperation in aspects related to health, education, labour and social affairs. All the GCC countries (except for Yemen) structurally depend on foreign workers for their labour markets, in which the share of expatriates in the population reaches as high as 80–90% in Qatar and the UAE, although it is lower in the other countries *(8)*. This has important implications for the formulation and implementations of an array of policies, including those related to tobacco and health.

Tobacco smoking is an issue affecting both adults and youths. According to the Global Youth Tobacco Survey (GYTS) the GCC region harbours alarming rates of current cigarette smoking and smoking of other tobacco products among youths aged 13–15 years *(9)*. In the UAE in 2005 8.0% of youths were tobacco smokers and 28.8% used other tobacco products. In Saudi Arabia while 6.7% of youths in 2007 were smokers, a further 11.9% used other tobacco products. The picture is quite similar in Bahrain (2002), Kuwait (2009), Qatar (2007) and Yemen (2008), where the prevalences of youth smoking were 10.6%, 12.2%, 6.5% and 3.9% respectively, and of those currently using other tobacco products were 15.3%, 11.8%, 15.6% and 12.4% respectively. Only Oman (2010) had the lowest prevalence, with 1.8% of youths being current smokers and 2.2% using other tobacco products *(9)*.

Tobacco control efforts in the GCC date back to January 1979, when Saudi Arabia submitted a working paper on combating smoking in the GCC states during the 6th GCC Health Ministers' Council Conference. Since then, some GCC countries (Kuwait, Qatar, Saudi Arabia, UAE and Yemen) have signed the WHO Framework Convention on Tobacco Control (FCTC) treaty *(10)* and all member states have ratified it. Furthermore, all countries now have specific national government objectives in tobacco control in addition to a national agency or technical unit for tobacco control *(9)*. To help countries fulfil their WHO FCTC obligations, in 2008 WHO introduced the MPOWER package of 6 evidence-based tobacco control measures that are proven to reduce tobacco use and save lives. The MPOWER measures provide practical assistance to reduce the demand for tobacco via country-level implementation of effective policies. The MPOWER measures focus on demand reduction, although WHO also recognizes the importance of and is committed to implementing the supply-side measures contained in the FCTC.

The purpose of this review was to highlight the challenges faced and the efforts invested to date in tobacco control by the GCC governments: investing in evidence generation, policy-setting and strategy implementation. It set out to address the successes and failures, and attempts to offer a way forward for tobacco control in this part of the Arab world.

Methods

This paper reports an empirical analysis of a multidimensional investigation into the current state of tobacco use in the GCC countries; governance and national commitment to control; and current intervention frameworks in place to reduce the use of tobacco among the populations. It further reviews structured policy-oriented interventions in line with the FCTC's MPOWER package of 6 evidence-based tobacco control measures that represent government actions to strengthen, implement and manage tobacco control programmes and to address the growing epidemic of tobacco use. The following search methodology was adopted and data were collected as follows.

The electronic online databases *Medline*, *Embase* and *PsychInfo* were searched using the keywords (smoking OR tobacco) AND (Gulf Cooperation Council) for all published literature from inception up to 31 August 2013, the date this review was conducted. This was supplemented by iterative reviews of the reference lists of relevant published papers and searches of the grey literature, reports identified in references and reports to WHO from consultation projects. Studies were combined, examined in detail and data were extracted based on relevant information.

To examine the indices of national commitment to public health protection and curbing the smoking epidemic in these countries, we used the criteria defined by the MPOWER evidence-based indicators extracted from WHO updated country profiles [as published in the *WHO report on the global tobacco epidemic, 2011 (1)*] to evaluate and

compare the level of political adherence, as well as the degree of importance that the governments attach to the subject matter.

Findings

There has been a major political commitment to tobacco control in the GCC countries from a legislative perspective as well as a public health one *(11–14)*, but much more still needs to be done, particularly with regard to further public education and research *(15,16)*. Sustaining such commitment is key to capitalizing on the progressive momentum which many of these countries are now experiencing.

Governments' commitment to curbing the tobacco epidemic

As seen in Table 1, as of 2010 all 7 GCC countries have a specific government objective regarding tobacco control. Six countries have national agencies dedicated to tobacco control and 5 countries have smoking cessation support services available to the population (with expenses either partially or fully covered by the government). The same 5 countries have banned tobacco advertising via national media portals and on free distribution of promotional material and packages, and 2 have limited implementation of smoking bans in some public places.

Despite the aforementioned progress, areas remain where there is a lack of commitment to tobacco control measures or even regression in these. This is evidenced, for example, by reductions in taxation; between 2008 and 2010 Bahrain, Oman, Saudi Arabia, UAE and Yemen decreased the percentage of tax added to the retail price of cigarettes by 2–3%. This is counterintuitive to the legislation and public health measures of the FCTC. It is critical for these countries to realize the impact such policies will have on public purchasing and access to tobacco, and it remains imperative that the percentage of tax be raised rather than reduced, irrespective of any other smoking-cessation measures.

Trends and prevalence of disease

Our review of the available published literature demonstrated the wide variety of research in the region into smoking prevalence, morbidity and mortality attributed to smoking and tobacco consumption. A total of 19 studies were identified, 6 of which were found to be relevant (2 irretrievable, 4 irrelevant, 7 duplicates). Of the relevant studies, 3 addressed tobacco issues in the GCC countries collectively; 2 particularly focused on Bahrain and 1 on the UAE populations.

The incidence of cancer in the GCC countries between 1998 and 2001 was explored by Al-Hamdan et al. They described a reasonable correlation between the higher incidence of lung cancer in Bahrain compared with Saudi Arabia as a result of a longer history of smoking in Bahrain *(17)*.

Another important issue in the region is waterpipe smoking. From 2001–04 the GYTS data revealed a high prevalence not only of tobacco smoking but also of waterpipe use in the region, with an observed high susceptibility to initiate smoking of waterpipes by groups who had never smoked *(18)*. This makes for a worrisome outlook in terms of likely increases in the incidence of smoking-related chronic diseases and their associated mortality. It is important to note that one "head" of a waterpipe contains roughly the same amount of nicotine and tar as 10 cigarettes *(19,20)*.

Looking at the GCC as a collective unit, Hamadeh alluded to the previously mentioned risk of increased prevalence and the potential problem of tobacco 10 years earlier *(21)*, and highlighted the commendable efforts exercised by the uniform platform of the GCC Health Ministers' Council *(22)* and the early recognition of the issue.

In Bahrain, researchers studied patterns in smoking behaviours among 250 Bahrainis and non-Bahrainis aged 18+ years and the potential barriers to quitting *(23)*. They found that craving for smoking was the main barrier to quitting according to a third of the smokers, followed by enjoyment of smoking (24%) and nicotine withdrawal symptoms (11%). Also in Bahrain, and amidst attempts to highlight efforts to control tobacco use, Fadhil mapped out a clear and broad picture of tobacco control efforts thus far, in a report highlighting the limitations in enforcing laws and legislation as a critical barrier and the great need for tailored smoking cessation programmes that are integrated within a primary health-care context *(24)*.

In the UAE findings from a cross-sectional study among 288 physicians from the Department of Health and Medical Services in Dubai showed a need for the development of technical smoking-cessation capabilities among staff, as well as the advancement of smoking cessation programmes with a particular focus on physicians' participation in reducing tobacco and cigarette use among the general population.

Discussion

Despite the efforts and successes in the field of tobacco control, the latest being Oman's soon-to-be-passed legislation to stop farming tobacco within the next 5 years *(25)*, there remain many hurdles to cross. Hurdles generally present themselves in the form of lack of resistance to lobbying and pressure exerted by tobacco companies *(26)*; unsustained monitoring of enforcement of legislation; and partial implementation of tobacco curbing efforts *(27)*. Taking the recent pace of progress into consideration, it is clear that further energy needs to be exerted in legislation and law enforcement and the implementation of the current, well-structured strategies.

Table 1 National commitment to tobacco control in the Gulf Cooperation Council member states and Yemen: the situation in 2010

Initiative	Bahrain	Kuwait	Oman	Qatar	Saudi Arabia	UAE	Yemen
Specific national government objectives in tobacco control	Yes	Yes	Yes	Yes	Yes	Yes	Yes
National agency or technical unit for tobacco control	No	Yes	Yes	Yes	Yes	Yes	Yes
WHO Framework Convention on Tobacco Control status (year):							
Signed	No	Yes (2003)	No	Yes (2003)	Yes (2004)	Yes (2004)	Yes (2003)
Ratified, or legal equivalent	Yes (2007)	Yes (2006)	Yes (2005)	Yes (2004)	Yes (2005)	Yes (2005)	Yes (2007)
Any smoke-free public places covered by legislation	No	No	No	No	Yes[a]	Yes[b]	No
National law requires fines for smoking	Yes	Yes	No	Yes	Yes	Yes	Yes
Health warnings appear on tobacco packages, mandated by law	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Direct & indirect bans on tobacco advertising, promotion and sponsorship in:							
National TV and radio	Yes	Yes	No	Yes	Yes	Yes	Yes
Local magazines and newspapers	Yes	Yes	No	Yes	Yes	Yes	Yes
Free distribution of promotional material and packages	Yes	Yes	No	Yes	Yes	Yes	Yes
Smoking cessation support available	Yes[c]	Yes[d]	No	Yes[e]	Yes[f]	Yes[g]	No
Smoking cessation support free-of-charge or cost-covered (by national insurance)	Fully	Fully[h]	No	Fully[i]	Partially	Partially	No
Total taxes on the most popular brand of cigarettes (% of retail price)	29	34	31	33	29	29	53

Smoke-free public places: [a]In universities, government, health-care and educational facilities only; [b]In universities, health-care and educational facilities only. Smoking cessation support available: [c]In most health clinics or primary-care facilities, in some hospitals, in some offices of health professionals but not in the community; [d]In most health clinics or primary-care facilities, in some hospitals, in some offices of health professionals and in the community; [e]In only some health clinics or primary-care facilities, in some hospitals, in some offices of health professionals but not in the community; [f]In only some health clinics or primary-care facilities, in some hospitals, in some part of the community, but not in offices of health professionals; [g]In only some health clinics or primary-care facilities, in most hospitals, in some offices of health professionals and in some parts of the community.
Free-of-charge cessation support: [h]Except in the community, where it is only partially covered by national insurance; [i]Information on national financial coverage for smoking cessation support is only for hospitals (data not available for health clinics and primary-care facilities).

Moreover, investment in human resources development for tobacco control and top-level political engagement in support of health promotion and control of noncommunicable disease risk factors is paramount.

From a practical point of view, an array of interventions and commitments are available that can be initiated by governments to accelerate and heighten the momentum for commitment. For example, it is within reach to establish a national reference body in the GCC countries, focusing solely on tobacco prevention and protection, and within that a branch solely directed towards an agenda for women and children. Furthermore, and in line with collective health promotion efforts, a renewed commitment could be guided towards encouraging community initiatives and campaigns, particularly at workplaces, in relation to tobacco prevention and control, for both men and women. This initiative could also be strengthened with the introduction of smoking cessation services. These services should not be restricted to (para) medical staff and, with the aid of internationally available resources *(28,29)*, could use the capacity of the public to be trained as smoking cessation councillors, hence multiplying the numbers of technical support personnel to help curb smoking.

Box 1 sets out our prioritized recommendations and "best buys" that are supported by evidence and that can rapidly and concretely cement the gains achieved so far, and further build on them for stronger and sustained control of tobacco in the GCC countries. The recommendations should be supported by strong legislation supporting tobacco control measures. These

Box 1 Prioritized recommendations and best buys for stronger and sustained tobacco control in the Gulf Cooperation Council (GCC) countries

1. Introduce and enforce smoking bans in public places. The ban should include all enclosed public places and workplaces, as well as public transport and work vehicles.
2. Call upon the countries of the GCC to increase current national expenditure on tobacco control and scrutinize fiscal policy to impose heavy taxation on tobacco and its products.
3. Affirm the importance of activation of national plans, programmes and policies with an emphasis on vulnerable populations (women and children).
4. Strengthen health systems for treating tobacco dependence in primary care by building capacity for tobacco control and invest in human resources for health training for smoking cessation, as part of primary care.
5. Introduce smoking cessation services and promote public participation for active involvement.

include further investment in: awareness efforts addressing the dangers of tobacco, especially targeted on schoolchildren and young adults; awareness efforts emphasizing the rights of the public to clean air and safe care at all health-care levels (primary-care centres and public, specialized and rehabilitative hospitals); public participation; and increased involvement of multiple stakeholders for stronger cooperation. Other measure include: sustaining the monitoring efforts of tobacco control activities; encouragement and facilitation for quantitative and qualitative research focused on tobacco and its use (for example, the economics of tobacco use in the GCC region); evaluation of civil society efforts in campaigns of tobacco control; and last, but by no means least, strengthening the role of the media in tobacco control measures.

Conclusions

Tobacco control in GCC countries has witnessed palpable progress over past decades. However these are early days with only steps in the right direction; smoking cessation service delivery will need to be reconfigured to integrate the provision of preventive and promotion services and the establishment of universally available cessation services which are essential to sustain and strengthen tobacco control in the region. Implementation and enforcement of the FCTC and production of robust tobacco control legislation remain as crucial near-future investments.

Across the board, investing in evidence generation, policy-setting and strategy implementation move to the same drumbeat of progress towards a smoke-free region. To push the agenda forward, we affirm the importance of activation of national plans, programmes and policies and strengthening health systems for treating tobacco dependence and accommodating demands for smoking cessation services.

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