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ARE THE RECENT ANTISMOKING LAWS IN THE UAE WORKING: AN OBSERVATORY STUDYOF THE SITUATION INTHE EMIRATE OF ABU DHABI?

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Abstract: *The UAE Ministry of Health recently announced a series of laws on tobacco and these new laws came into force on 21 January. There is anecdotal evidence suggesting that a number of tobacco users and venders are directly and indirectly flouting the legislation. This study investigates compliance in restaurants, hotels and other eateries. It is the conclusion of the study that the said bans on smoking could reduce cancer morbidity and mortality, especially those related to trachea, bronchus and lung. It is the further conclusion of this study that a need exists to strengthen the legislation to ban smoking rooms in hotels as hotels are public or major buildings.*

INTRODUCTION

Throughout the world, smoking has been noted as a leading cause of morbidity and mortality in many countries. It is common knowledge that Smoking is linked to various types of malignant neoplasms and, in particular, trachea, bronchus and lung cancer. According to the World Health Organisation (WHO), smoking is a major risk factor. WHO (2015) adds further that smoking is not only a major risk factor, but that it is also a preventable risk factor. It is therefore clear that a substantial proportion of avoidable morbidity and mortality can be attributed to smoking. Indeed, WHO (2015, 101) writes: "The prevalence of current smoking is an important predictor o of the future burden of tobacco related diseases". Tobacco use is a major risk factor for numerous diseases.

For decades, the use of tobacco has been a major part of life in the United Arab Emirates (UAE). This is largely manifest in cigarette smoking, Shisha inhaling and in other ways. With the availability of most forms of tobacco in the country, the burden of disease from tobacco use has been high. As indicated later in this study, smoking is, by and large, responsible for various types of cancer in the UAE. For the total population, the leading type of cancer death is breast cancer, followed by colorectal and trachea, bronchus and lungs. Further analysis reveals that, for males, the leading cause of cancer death in 2011 was trachea, bronchus and lung. Smoking has contributed to these preventable mortality.

Following consistent epidemiological data alluding to the high prevalence of smoking related diseases in the country, the UAE Government took decisive action to reduce the incidence and prevalence of trachea, bronchus and lung cancer and other smoking related diseases, and bring the burden from those diseases down. The Ministry of Health announced a series of laws to that effect.

The present study is not a smoking prevalence study. The purpose of the present study is to investigate if the new anti-smoking laws are working, i.e. if individuals and various corporate entities are complying with the recently introduced laws. The strong contribution of tobacco use to mortality in the UAE presupposes a need to undertake such an investigation. This is the rationale behind this study. The fact that no such investigated has been conducted in the country provides an added significance to the present study.

DATA AND METHODOLOGY

Data for this study has come from the statistical sources of Health Authority Abu Dhabi (HAAD). HAAD collects, analyses and publishes on diverse aspects of health in the Emirate of Abu Dhabi. It is the Abu Dhabi Government's health regulatory authority. The methodology involves an epi-statistical analysis of epidemiological data (Yeboah, 2015) and the collection and analysis of survey data. An observatory survey of over 200 individuals and entities was undertaken to establish the level of compliance with the new anti-smoking laws. The analysis of data from the observatory study is used to answer the research question "Are the new anti-smoking laws working in Abu Dhabi Emirate"?

LITERATURE REVIEW

Like many areas in health, very little published research is available on smoking in the UAE. Raven (2002) discussed the intersection of healthcare organizational ethics, pointing out that healthcare providers are business organizations with ethical issues. Gulf News (2011c) discussed ethical issues surrounding Doctors being remunerated by commission instead of salary, while Gulf News (2011b) reported warnings from health professionals regarding the sale of prescription medication over the counter.

National Newspaper (2011:1) pointed out the growing problems with waiting lists for various health procedures in the UAE while Yeboah (2007) examined population growth and the demand and provision of health services in the UAE up to 2006. He found that

population growth was accompanied by new medical centers and increased number of public and private health services.

Okaida (2003) examined mental health in the Arab world while Zafar (2003) focused on women empowerment in the Arab world. Bener et al. (1993) investigated variables affecting health in the UAE, focusing on primary health care. They examined the 1986-1991 health strategy and concluded that health care had improved in the UAE. In addition, Matthew (2001) studied obesity in the UAE, indicating that there was a need to target obesity in the UAE. He concluded that obesity has a far greater impact in the UAE than acknowledged. UAE Ministry of Health (2001) presented professional code of conduct for health professionals, defining clearly what ethical practices were expected from medical practitioners and other health professionals. Ethical issues in health care have not received any attention in the published research literature on the UAE.

More recently, Yeboah (2014) investigated the over the counter sale of prescription only medicines in Abu Dhabi and found an endemic practice of selling and buying medicines over the counter without prescription as required by law.

THE PRESENT STUDY

The present study focuses on 4 areas namely the new anti-smoking laws, the population of Abu Dhabi Emirate, Cancer deaths (especially deaths from trachea, bronchus and lung) and observatory study results.

New anti-smoking laws

In the last 2 years, the UAE Government through the Ministry of Health enacted and implemented a number of anti- smoking laws in the country with the ultimate objective of reducing tobacco use and the associated burden of tobacco related diseases. The salient features of the new anti-tobacco laws include the following (Emirates 24/7, 2016; National, 2015):

- A ban on smoking in all public and private buildings and all enclosed or indoor facilities;
- A ban on smoking and sale of tobacco products near educational institutions;
- A ban on smoking near entrances to major building (public and private);
- A ban on corporate entities providing designated smoking rooms in their premises, albeit outdoor designated rooms were allowed;

- The new laws also stipulated that all ash trays should be removed from premises and no smoking signs displayed in enclosed public places;
- In addition, the new anti-smoking laws required corporate entities to provide visible comment boxes for public comments on the new anti-smoking laws;
- Tobacco products cannot be displayed near products for children.

Prior to the enactment of these laws, the Government had banned smoking around children including smoking in cars when children were present and, the removal of Shisha outlets from residential areas and schools. The anti-smoking laws were mandatory and all individuals and corporate entities were required to oblige or comply. To ensure compliance, the new laws were accompanied by sanctions including hefty fines for no compliance. For example, violators could face a fine of 500AED.

Population

Table 1 shows that, of the 2,422,400 population in the Emirate of Abu Dhabi, 433,785 (17.9%) were Nationals and 1,988,615 (82.1%) were Expatriates. The table shows further that the population was unevenly distributed across the 3 regions of Abu Dhabi Emirate, with Abu Dhabi City accounting for 73.9% of the total population of the Emirate.

Table 1 Population by Region and Nationality, Abu Dhabi, 2011

Region	Nationals	% of Total	Expatriates	% of Total	Total
Abu Dhabi	228,228	12.8%	1,560,966	87.2%	1,789,194
Al Ain	177,117	36.5%	307,590	63.6^	484,707
Western	28,440	19.2%	120,059	80.8%	148,499
Total	433,785	17.9%	1,988,615	82.1%	2,422,400

Source: HAAD, 2011

Mortality

Generally, the leading causes of death in Abu Dhabi have been Diseases of the circulatory system, Neoplasms and Endocrine, nutritional and metabolic disorders (table 2). These diseases were the leading causes of death during the 5 year period from 2007 to 2011. Another salient finding in table 2 is that Diseases of the circulatory system was the leading cause of death every year and increased by 115.2% during the 2007 -2011 period. Ban on the display of tobacco products near products for children was fully complied with by the malls and shops visited (100%).

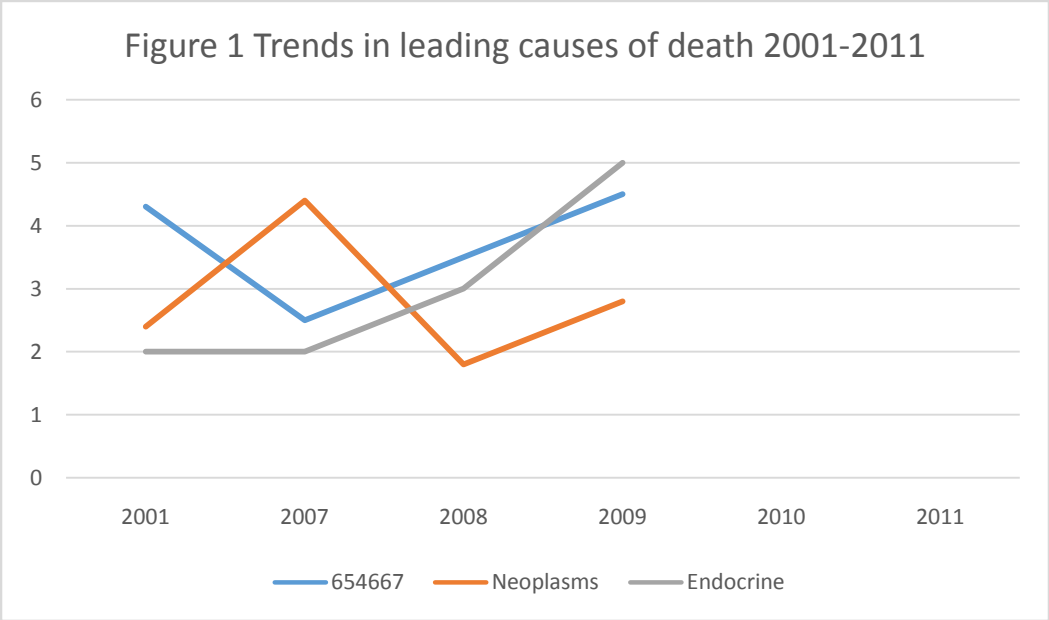
Table 2 Leading causes of death, Abu Dhabi, 2007-2011

Causes	2007	2008	2009	2010	2011	%change 2007-2011
Disease of the circulatory system	506	697	707	762	1089	115.2
Neoplasms	370	360	397	461	461	24.6
Endocrine, Nutritional and metabolic disorders	201	79	210	194	98	-51.2
Congenital abnormalities	177	120	199	144	72	-59.3
Total	2742	2949	2917	2879	2902	5.8

Source: Derived from HAAD statistics

Total includes a number of other causes of death which have not been listed in the table.

Figure 1 shows the trends and patterns in mortality in Abu Dhabi Emirate between 2001 and 2011. Mortality from the 3 leading causes of death were higher in 2011 than 2001, albeit some fluctuations are discernible.



Mortality from malignant neoplasms

Of the 403 cancer deaths in 2011, 137 were accounted for by Nationals (34%) and 266 by Expatriates (66%).229 males (56.8%) and 174 females (43.2%) died from various neoplasms in the UAE in that year. Table 3 shows that the cancer mortality rate per 100,000 National male population (36.3) was almost 4 times the corresponding rate for the Expatriate male population (9.9). Table 3 shows further that difference in cancer mortality rate for National

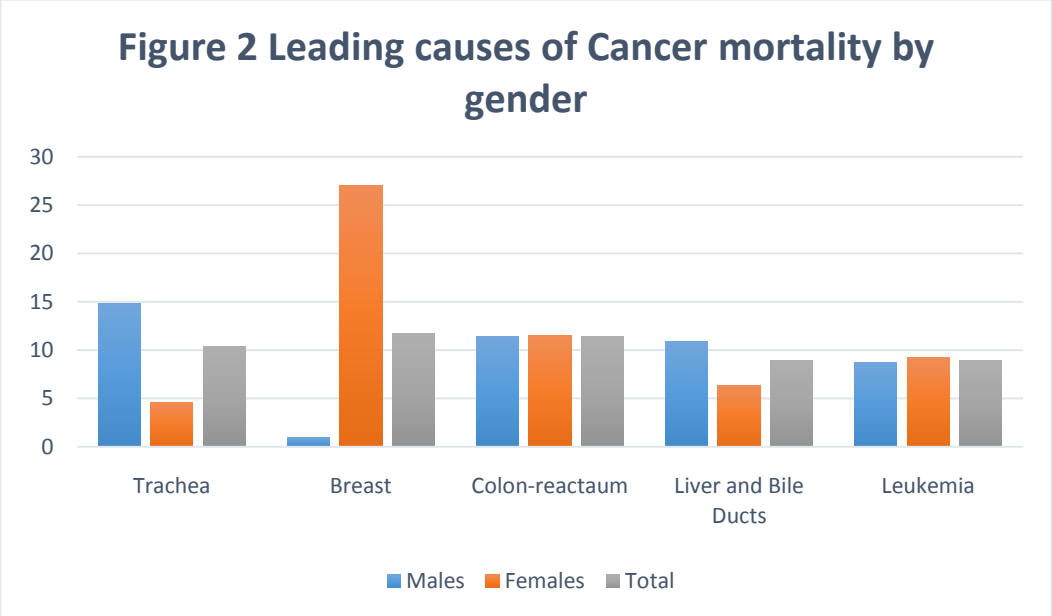
female population (26.9 per 100,000 population and Expatriate female population (24.9 per 100,000 population) was marginally small.

Table 3 Cancer mortality per 100,000 population, Abu Dhabi, 2011

	Males	Females
National	36.3	26.9
Expatriates	9.9	24.9
Total	23.1	25.9

Source Derived from HAAD 2011

According to HAAD (2011), the leading cause of cancer mortality for the Emirate as a whole in 2011 was Breast cancer (11.7%), followed by Colon-rectum (11.4%) and Trachea, Bronchus and Lung cancer (10.4%).Figure 2 shows the leading causes of cancer deaths for male and females in the Emirate of Abu Dhabi. Males recorded higher mortality rates for Trachea, bronchus and lung category and female breast cancer category. The rates were about even for colon-rectum and Leukemia, while slightly more male deaths occurred from Liver and Intrahepatic bile duct conditions.



Observatory survey

Table 4 presents the results of the observatory survey conducted to establish the level of compliance with the anti-smoking legislation. The main components of the legislation covered in the survey were

- A ban on smoking in all public and private buildings and all enclosed or indoor facilities;

- A ban on smoking and sale of tobacco products near educational institutions
- A ban on smoking near entrances to major building (public and private)
- A ban on corporate entities providing designated smoking rooms in their premises, albeit outdoor designated rooms were allowed;
- Ban on display of tobacco products near products for children.

Table 5 shows that the level of compliance the recent anti-smoking legislation was, by and large,high. Hotel restaurants, especially some of the big hotels, have designated nonsmoking and smoking sections and compliance level was just 17%. Small cafes and eateries recorded a higher compliance percentage of over 86 (Table 5) while the corresponding proportions for malls and shopping centers were 100%. The ban on smoking and sale of tobacco products near educational institutional institutions achieved 100% compliance while restaurants outside hotels (non-hotel restaurants) recorded almost 91% compliance. Ban on smoking near entrances to major buildings was mostly complied with, but the lowest level of compliance occurred in relation to hotel buildings. All the hotels observed had smoking and non-smoking rooms, yielding a compliance level of 0% (Table 5).Ban on display of tobacco products near products for children was fully complied with by all the malls and shops visited (100%).

Table 5. Compliance with the anti-smoking legislation

Legislation	**Was compliance observed**		**Compliance %**
	Yes	No	
Ban on smoking in restaurants - Hotels	12	58	17.1
Ban on smoking -Small cafes and eateries	78	12	86.7
Ban on smoking-Malls and related shopping centers food courts	35	0	100
Ban on smoking restaurants –non hotels	50	5	90.9
Ban on smoking and sale of tobacco near educational institutions	90	0	100
Ban on smoking near entrances to public and private buildings	217	23	90.4
Ban on smoking in buildings			
Hotels	0	70	0
Other buildings	75	0	100

Source: Survey data

DISCUSSION

The population of the Emirate of Abu Dhabi has been increasing rapidly and this has been accompanied by an increase in the incidence and prevalence of various diseases. Increasing prevalence of morbidity presupposes a need to improve the provision of health care and Abu Dhabi has excelled in that area. Indeed, the interrelationships between population growth and health care provision in the UAE have been noted in the research literature (Rosling, 1999; Yeboah, 2007). Prominent among these diseases are disease of the circulatory system, neoplasms of all sites, and endocrine, nutritional and metabolic disorders. These 3 groups of diseases constitute the leading causes of death in the Emirate. A glance at neoplasms reveals that 3 types stand out. For the country as a whole, breast cancer is the leading cause of cancer death and it is also the leading cause of cancer deaths for female the population in the Emirate of Abu Dhabi. For males, the cancer group trachea, bronchus and lung is the leading cause of death from malignant neoplasms in Abu Dhabi Emirate.

While smoking is now believed to contribute strongly to various types of cancer morbidity and mortality, it contributes more to trachea, bronchus and lung disease than any other disease. Smoking is also the reason for the very disparity between deaths from cancer for Nationals (36.3 per 100,000 population) and Expatriates (9.9 per 100,000 population). Anecdotal evidence suggests that a substantial proportion of Nationals uses tobacco in various forms including cigarette, “shisha” and so on.

Following consistent epidemiological data manifesting the rising incidence and prevalence of cancer in the country as a whole, it became imperative for the Ministry of Health to initiate necessary actions to address the widespread use of tobacco. With the support of the UAE Government, the Ministry announced a series of bans which were listed earlier in this study. An identifiable objective of the anti-tobacco legislation is to eliminate or drastically reduce passive smoking especially around children, even though reducing the overall level of smoking was the primary objective...

Overall, compliance with the legislation is very good albeit mixed results were found in this study. It was clear from the study that compliance was well achieved in parts of the law which could easily be enforced and verified, including ban on smoking in malls, in or near schools and near the entrance to major buildings. In these places, even members of the

general public can file a complaint or report noncompliance because it would appear visible to them.

With regards to noncompliance, the hotels (especially the big ones) were the main violators. All the hotels in the observational study breached the ban on smoking in major buildings. All the hotels had smoking and nonsmoking rooms for their clients. It was not immediate clear if this contravenes the law but it is an area of concern. Some hotels also had smoking sections in the enclosed restaurants. The situation was exacerbated by the fact that children were present in some of the restaurants. There was very good compliance with the ban on smoking near the entrances. The only recorded problem was that some smokers violated the ban by smoking at a point not far away from the entrance as stipulated by the legislation. Many of those smokers were actually not aware of the distance required and smoked just a few meters from the entrances.

This leads to the question on how noncompliance can be addressed. The 1st issue is enforcement (see Yeboah, 2014). The anti-tobacco bans have to be fully enforced and sanctions should be applied to violators, especially repeat violators. While the Police cannot be present everywhere, a certain level of surveillance would serve as a deterrent and improve compliance. It was evident that a number of people were also not fully aware of the tenets of the law (for example distance from the entrance where smoking can take place). The study suggests some kind of public education to draw attention to the laws and their details. This has the potential to reduce the incidence of breaches, but also enable the public to file complaints with confidence.

CONCLUSION

The study found that there was a very good level of compliance with the new legislation albeit a few problems still existed. It is the conclusion of the study that the said bans on smoking could reduce cancer morbidity and mortality, especially those related to trachea, bronchus and lung.It is the further conclusion of this study that a need exists to strengthen the legislation to ban smoking rooms in hotels as hotels are public or major buildings.

The study contends that a need exists to educate the public about the new bans and encourage the public to report breaches. Enforcement is a key issues as there is no need to enact laws if they are not be enforced. The study concludes that due consideration be given to increasing the level of enforcement by both the Police and health authorities.

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