مبادرات محمد بن راشد آل مكتوم العالمية
Mohammed Bin Rashid
Al Maktoum Global Initiatives

كليـــة محـمـــد بن راشـــد
للإدارة الحكـــــومـــيـــة
MOHAMMED BIN RASHID
SCHOOL OF GOVERNMENT

Mohammed Bin Rashid School Of Government
Policy Paper
September 2022

ABSTRACT

Comprehensive smoke-free Legislation immediately and sustainably promotes public health, reduces the public›s exposure to second-hand smoke (SHS), helps to decrease cigarette consumption and aids those trying to quit smoking, brings public attention to tobacco, denormalizes smoking, and discourages children from starting to smoke themselves (Greenhalgh, EM et al., 2020). Despite recent progress, much of the world's population continues to be exposed to SHS in the workplace, public places, or at home due to the main issues - weak implementation mechanism and enforcement.
Therefore, comprehensive smoke-free policies and carefully planned educational efforts for business owners and the public to understand the purpose of the law and what is necessary to comply with the regulations are the critical elements of governmental strategies.

The UAE Smoke-Free Policy Review: Smoke-free 2030 is possible?

Irina Godchaux-Berezhnova
& Immanuel Azaad Moonesar

Executive Summary

Second-hand smoke and its harmful health & environmental and economic impacts are one of the Dubai Health Strategy and United Arab Emirates (UAE) Vision objectives. This document suggests how to fully ban smoking in public in the country. One of the proposed policy's elements is to amend the existing Smoke-Free Legislation by introducing 100% Smoke-Free and develop the guidelines on how to implement and enforce it.

Another vital component is to run a population media campaign to educate about the implications of second-hand smoking and using Electronic Nicotine Delivery Systems/ Electronic Non-Nicotine Delivery Systems. It is also essential to bring business structures as important stakeholders by providing some incentives to the businesses involved in implementing a smoking ban in the workplaces and hospitality venues. Another critical element in strengthening the evidence on the negative effects of second-hand smoking and vaping, is collecting data, and using them for education and further policy development and improvement. This review document will offer a comprehensive report on policy and regulatory suggestions to help the government achieve Smokefree 2030 and address smoking-related health inequities.

The Policy Problem

Tobacco smoking epidemics are bringing us nearly 7 million deaths annually, 22% of global cancer deaths, 71% of all lung cancer deaths, 90% of deaths from Chronic Obstructive

Pulmonary Disease (COPD), and many other important losses (WHO Report on Global Tobacco Epidemics, 2021).

If the current smoking patterns remain, thèse numbers will primarily increase, exceeding 8 million in a few décades (WHO Report on Global Tobacco Epidemics, 2021). Second-hand smoke combines smoke from the burning end of a cigarette and the smoke breathed out by smokers (Center for Disease Control).

Second-hand smoke contains more than 7,000 chemicals, of which hundreds are toxic, and about 70 can cause cancer (U.S. Department of Health and Human Services, 2014).

Second-hand tobacco smoke causes serious health risks such as heart disease, lung cancer, and chronic respiratory problems and also linked to fertility problems, accelerated ageing, decreased bone density, arthritis, cataracts, gum disease, and ulcers (U.S. Department of Health and Human Services, 2006).

Global Burden of Disease (GBD) estimates that smoking accounted for 7.1 million deaths in 2017, with an additional 1.2 million deaths attributed to second-hand smoking (Koronaiou K, Al-Lawati JA, Sayed M, et al. 2017).

There is no risk-free level of second-hand smoke exposure; even brief exposure can harm health (U.S. Department of Health and Human Services, 2006). Comprehensive smoke-free policies have successfully protected those who do not smoke and are the only way to protect their health (WHO). The only way to adequately protect both smokers and non-smokers from second-hand smoke is to entirely eliminate indoor smoking (WHO Report on Tobacco Epidemics, 2021).

The health care costs associated with tobacco-related illnesses are extremely high.

Many studies have estimated the health-related costs of smoking. These costs include medical expenditure on drugs and administration, smoking-attributable morbidity and mortality, medical expenses attributable to passive smoking, maternal smoking, and children smoking. Other direct costs include sickness/invalidity benefits attributable to tobacco abuse. Other health care expenditure indicators include smoking-induced emergency, general practitioner visits for adults and children, and use of nursing homes and home-based care.

Smoking-related health expenditures and productivity losses account for 1.8% of the world's GDP. The estimated cost of smoking and SHS as a fraction of GDP (1.04%) in the Gulf Cooperation Council (GCC) countries was lower than that reported for other high-income countries, such as Australia (2.1% to 3.4%), Canada (1.4% to 1.9%), and Greece (3.4%), but similar to estimates from the USA (1.0%).

It is also important to acknowledge the environmental tobacco threat. These include the fact that it allows us to gauge some of the risks caused by tobacco products which are currently excluded from estimates of tobacco mortality (such as poor air quality and pesticide use), and its impact more broadly on development – including economic stability, food security, and gender equality.

In addition, recognizing the harmful of tobacco in terms of indoor pollution and biodiversity turns tobacco from an issue (Tobacco and its environmental impact: an overview. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO).

Article 8 of the Framework Convention on Tobacco Control mandates all signatory countries to "protect citizens from exposure to tobacco smoke in workplaces, public transport, and indoor public places." Unfortunately, even though there has been great progress in the implementation of Article 8, still most of the world's population remains exposed to second-hand smoke (SHS).

Nevertheless, evidence from the countries successfully implementing Article 8 FCTC requirements suggests that implementing tobacco-free not only helps create environments free of tobacco but also encourages people to quit smoking or reduce the number of cigarettes.

Tobacco can no longer be categorized simply as a health threat – it is a threat to human development as a whole. Therefore, this issue requires a total government and whole society approach and engagement.

Problem statement

The policy problem is the harm related to second-hand smoking and its effects on health, environment, and development.

The solution is to develop, implement and enforce a comprehensive ban on smoking in public across the country, especially in workplaces and hospitality venues. WHO defines comprehensive smoke-free policies as smoke-free policies with no exemptions for particular venue types or allowances

for designated smoking areas (WHO report on the Global tobacco epidemic, 2017). This policy change will help create Smoke-Free environments, improve health outcomes in all population groups, and contribute to a few developmental outcomes.

Therefore, this review and assessment document will offer a comprehensive report on policy and regulatory suggestions to help the government achieve UAE Smokefree 2030 and address smoking-related health inequities.

Size of the Problem

In the UAE, tobacco use amongst UAE nationals is reported to be approximately 24% in men and much lower in women (0.8%) (Razzak et al. 2020).

Tobacco use has been reported to be highest in young men between the ages of 30–39 (28%), Arab expatriate men (31.4%), and non-Arab expatriate women (10.7%) (Al-Houqani M. 2018). Among UAE Nationals, smoking rates for men were highest among 20–29-year-olds (29%) and 30–39-year-olds (32%), and rates were very low among UAE women (0.7%) (Razzak et al. 2020).

According to the study on the active & second-hand smoking costs in the GCC by Koronaiou et al. 2021, the total cost of smoking and SHS was estimated to be purchasing power parity (PPP) $34.5 billion USD in 2016, equivalent to 1.04% of the combined gross domestic product (GDP). SHS accounted for 20.4% of the total cost.

The highest indirect costs resulted from smoking in men and middle-aged people. The main causes of morbidity costs from smoking and SHS were chronic respiratory diseases and Type 2 diabetes mellitus. Cardiovascular diseases were the main contributor to smoking and SHS exposure mortality costs. Including musculoskeletal disorders increased the total cost to PPP$ 41.3 billion (1.25% of the combined GDP).

Underlying factors

Governance

The UAE signed and ratified the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) in 2006. And since the FCTC ratification, the country has been progressively implementing the measures by enacting Bill No 15 issued in 2009, which approved strong policy measures. The law forbids and penalizes smoking in private cars when a child under 12, houses of worship, educational institutions, health and sports facilities, and other closed public places. However, the law makes exceptions for some locations. It provides separate designated locations such as restaurants, bars, and hotels for smoking guests, which defines this smoking ban as partial.

In addition, the law requires fines for smoking, and in 2010, the amount for individuals violating the smoking ban in indoor public places was 500 AED (US$ 160).

Much higher fines were payable by the owners of establishments permitting smoking, namely AED 1000-10,000 (US$ 390 to US$ 3900).

However, according to the WHO Report on the Global Tobacco Epidemics, 2021, the level of compliance reported for the UAE is quite low (about 10%) and needs attention and further policy measures.

Stakeholders

The agencies that are involved in Policy development, implementation and evaluation of its compliance include governmental agencies (Ministry of Health and Prevention), local entity Departments of Health, UAE's National Tobacco Control committee, Environmental agencies, Ministry of Education, Ministry of transport/Roads & Transport Authority (RTA), Dubai Tourism & Culture Authority, Municipalities, National Bureau of Statistics, World Health Organisation, Local NGOs, representatives of hospitality (Hotels/restaurants – food and beverage business), medical insurance companies, Police as an enforcement agency, academicians.

The primary beneficiary of the Smoke-Free policies and the full smoking ban is the general population of the UAE, who is going to be protected from the adverse effects of tobacco smoking and its environmental consequences.

However, some population groups may oppose the total ban on smoking in public– smokers and users of electronic nicotine delivery systems. Opposition to smoke-free policies in all countries is concerned; these policies will increase revenues and costs in hospitality workplaces, especially restaurants and bars.

Opponents maintain that revenues will decrease because smokers will visit smoke-free venues less frequently or for shorter periods, and that costs will increase because businesses will need to establish ventilation systems to maintain smoking and

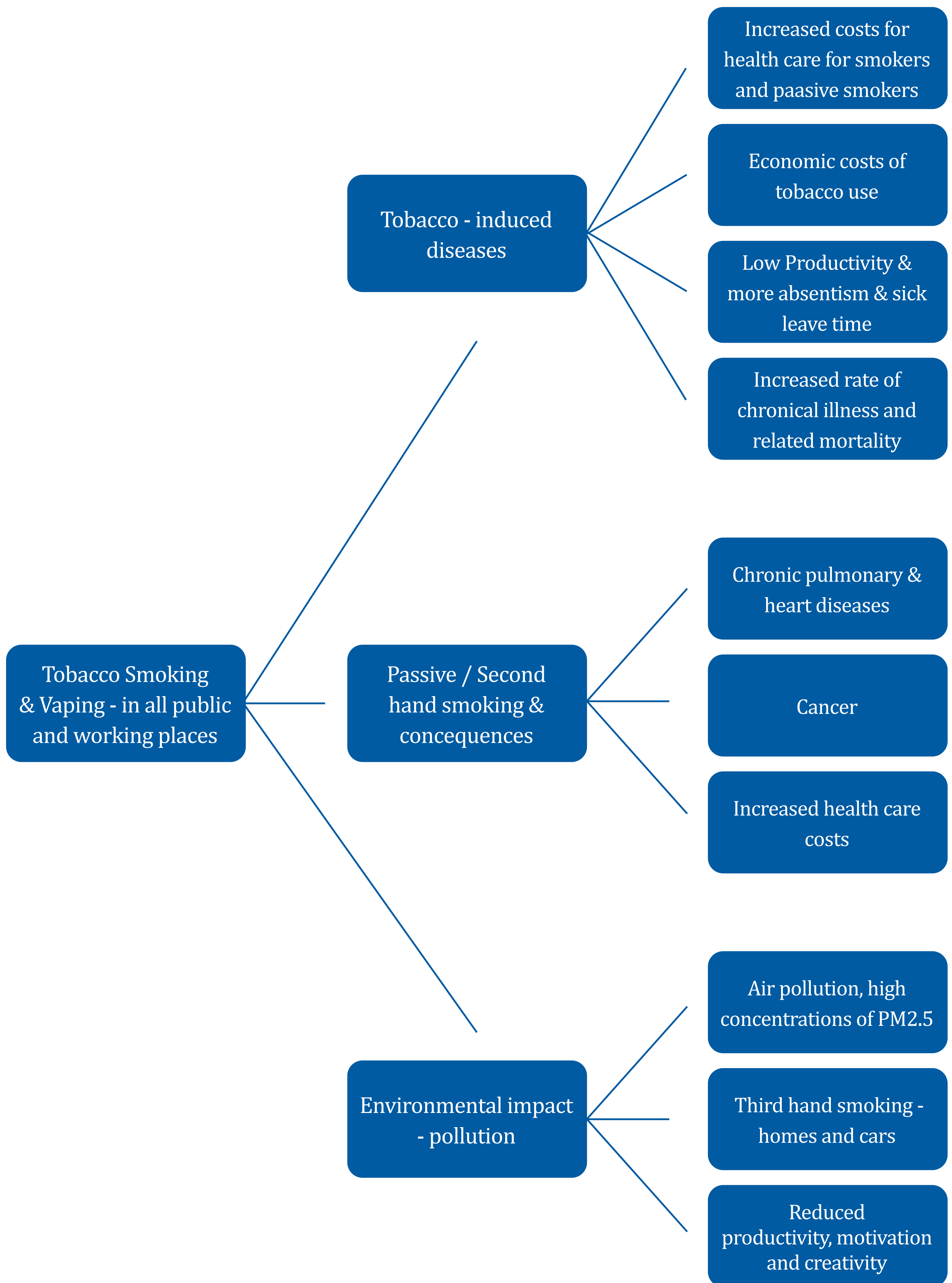

Figure 1: *Issues Tree on Smoke-free environments – Indoors and Outdoors*

nonsmoking sections and follow other requirements to enforce the policies. However, the evidence clearly demonstrates that smoke-free policies do not cause adverse economic outcomes for businesses, including restaurants and bars (IARC Handbook 2009, Chapter 6: The impact of Smoke-Free policies).

Some business representatives will be supporting the smoking ban – insurance companies and the pharmaceutical industry. Proposed Policy change reduces health risks, improves people's health, reduces doctors' visits & reduces the hospitalizations rate making a better income for all insurance companies.

Tobacco industry cannot be considered a stakeholder in this case as per Article 5.5 WHO FCTC the producers of tobacco must be excluded from any regulation of their products due to the conflict of interests.

Financing

Raising tobacco taxes and applying all or some (at least one percent) of the additional funds raised to tobacco control is one approach to meeting this challenge in a fair, logical, and cost-effective way (Union Position Paper – Sustainable Funding models for Tobacco Control, 2014).

In addition, increasing tobacco taxes and directing funds to tobacco control through establishing a foundation or similar entity can also address several WHO FCTC obligations. In particular, it can facilitate directing funds generated by price and taxation measures to implement education, communication, and intervention strategies and, more broadly, support the building of tobacco control capacity in the workforce. This can be particularly advantageous in LMICs that may struggle to fund public health campaigns and other aspects of tobacco control advocated by the WHO FCTC.

Policy Theory of Change

The intended policy objectives are to improve Smoke-Free by mandating the total ban on smoking in public places; to increase the implementation and enforcement of those legislations via strengthening the capacity of responsible agencies and education campaigns for the population. The intended results would be positive trends in compliance (short-term) and improvement of health indicators (tobacco-induced diseases' morbidity and mortality – long-term), reference to Figure 1.

Using routine health, behavioural and economic data, we can assess the smoke–free Legislation's impact–knowledge, attitudes, SHS exposure, compliance, smoking prevalence, and tobacco consumption, tobacco-related morbidity and mortality, and economic effects on the hospitality sector.

Delivery

Based on the academic reviews of the literature analyzing lessons learned on smoke-free policies' development and implementation (M Justin Byron et al.,2019;) it is critical to have the following attributes in the current policy proposal:

-
- Comprehensive Legislation and good stakeholder engagement and collaboration;
- Public education and outreach through the population media campaigns;
- Adequate resources for implementation, including finance and human resources;
- Transparent and available data for analysis, evaluation, additional policy-making & strengthening.

Policy Options/ Elements to address the issue

As shown in Table 1, based on the lessons learned from the best countries' experience (France, Scotland, Ireland, Australia, New Zealand, and others) in accelerating toward smoke-free air, we suggest the following policy options/elements (Global Smoke-Free Partnership. "Smoke-Free Air Law Enforcement: Lessons from the field", 2009; M.Justin Byron et al, 2017).

Element 1: Amendment to the existing Smoke Smoke-Free Legislation: introducing a full ban on smoking in public and workplaces. Amendments on Vaping/ENDS/ ENNDS

It is a control, and regulatory measure that consists of rules and implementation guidelines for all public places, transport, workplaces, and hospitality sector venues. It is expected to achieve the objectives by creating smoke-free environments in all public places, protecting people from SHS, and encouraging people to quit smoking and vaping.

Policy instruments	Policy tool 1 (Control & regulatory instrument)	Policy tool 2 (Advocacy/Persuasion Education campaign)	Policy tool 3 (Economic incentives)	Policy tool 4 (Control & regulatory instrument)
Brief description of the policy tool	Amendment on the existing Smoke-Free Legislation: a full ban on smoking in public and working places. Amendments on Vaping/ ENDS/ENNDS	Population campaign on SHS (health implications of second-hand smoking, incl. exposure and work, and environmental issues) & health effects of vaping	Economic incentives to the responsible companies/businesses stimulating workers to quit (workplace cessation programs/interventions)	Creating evidence-based on the impact of smoking & vaping
What type of instrument is it?	Control and regulatory: Rules and implementation guidelines for all public places, transport, working places, and hospitality sector venues	Informational & educational campaign for general population (radio/ TV/Internet - based)	Economic incentives	Advocacy/Persuasion or Education
How will it achieve the policy's intended results?	By creating Smoke-Free environments in all public places, protecting people from SHS, and encouraging people to quit smoking and vaping	By helping the target audience to learn more about health risks and what actions to take	Encouraging people to quit/reduce the quantity by providing a more extended holiday period, etc.	It will help educate and train people, professionals in the medical universities, health educators, etc. It will help provide evidence to the governments, manufacturers, and patients.
How can it be implemented?	Enforcement guidelines to be followed by RTA (transport venues), Dubai Municipality (hospitality sector & Tourism and Culture), And Labour Department (working places)	By changing person's beliefs, knowledge, attitudes, and practices – seeking help	Encourage companies to develop and implement internal workplace policies and update their code of conduct to stimulate smoke-free behavior. To generate rewards for those who quit or do not smoke (e.g., free tickets to the gym or additional days to the or annual leaves)	By coordinating universities, research institutions, and academia in the UAE/ GCC.
How can it be monitored?	Internal Smoke-Free policies issued; Number of complaints; Number and amount of fines	People reported change in knowledge and attitude about SHS&vaping after seeing the campaign materials;	Reports of internal check-lists/surveys: % or # of companies who have developed the health policies, % or # of people who quit	Research Reports
Initial high-level cost estimate	Consultations Meetings with stakeholders, Academia	Design, testing & Production of campaign materials; Pre-and post-campaign research survey.	Consultations with experts; Meetings with stakeholders.	Consultations with experts, management of the universities, academics, etc.; Research-related costs (design, testing, interviewing, analyzing, etc.)

Table 1: *Policy Options/ Elements to address the issue*

Enforcement guidelines to assign a lead enforcement agency that oversees and coordinates all involved in inspection and enforcement (transport authorities, municipalities economy, and tourism departments).

Element 2: Population campaign on SHS (health implications of second-hand smoking, incl exposure and work and environmental issues) & health effects of vaping

Informational & educational campaign for the general population to drive awareness, radio/TV as the most trusted (Market insights trust in media, June 2020) about health risks by changing people's beliefs, knowledge, attitudes, and practices – seeking for help. The campaigns must have sufficient intensity (McAfee et al., 2017).

Element 3: Economic incentives to the responsible companies/businesses stimulating workers to quit (workplace cessation programs/interventions)

It is a set of measures encouraging companies to do workplace interventions, for example, developing and implementing internal smoke-free policies, updating their code of conduct to stimulate smoke-free behavior or introducing cessation programs or any other form of providing social or psychological support (V Ekpu, et al., 2015).

Element 4: Creating evidence-based on the impact of smoking & vaping

WHO FCTC required all Parties to collect and share the national data on tobacco use and the effectiveness of the measures taken. It is an integral part of the WHO Global MPOWER strategy to fight tobacco epidemics. It helps governments to have data on the results of policy implementation to register the trends and strengthen the policies further. Therefore, UAE policymakers need to have access to the data for the evidence-based decisions, as well as for education and training purposes and for sharing with universities, research institutions, medical professionals, and others.

Category of finding	Element 1 – Full ban on smoking
Benefits	High positive impact on health, environment, and development by 2030.
Potential harms	Difficult to ensure compliance.
Cost and/ or cost-effectiveness in relation to the status quo	The cost is low for Smoke-Free Policies interventions / Shown to be cost-effective (V Ekpu et al, 2015, de Kinderen et al., 2018; M.Kent Ranson et al. 2002 and Greenhalgh, EM, 2020; IARC Handbooks, 2004).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	The many countries' experience well proves the benefits including Australia, United Kingdom, France, and Ireland.

Category of finding	Element 2 – Population campaign on SHS (health implications of second-hand smoking, incl exposure and work and environmental issues) & health effects of vaping
Benefits	Contributes to the behavior change by focusing on the health harms of smoking and motivating people to quit & prevent the debut by 2030.
Potential harms	It takes time to change the behavior of people.
Cost and/ or cost-effectiveness in relation to the status quo	Relatively high costs as TV or Radio placement is expensive. Here are examples from the UK: the funding for mass media campaigns had fallen by 90% in monetary terms from £23.3 million in 2008/9, to around £2.16 million in 2018/19 and £1.78 million for 2019 (Delivering a Smoke-Free 2030, 2021).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	The campaign should be intense (efficient coverage) and long enough to have an outcome (knowledge and behavior change).

Category of finding	Element 3 – Economic incentives to the responsible companies/businesses stimulating workers to quit (workplace cessation programs/interventions)
Benefits	This approach helps reward those who decrease quantity or totally quit smoking, which will be beneficial for the companies as there will be less absenteeism and healthcare expenditures (V Ekpu, et al., 2015).
Potential harms	Takes time to change the behavior of people, so these measures are effective over a long period (Greenhalgh, et al. 2020; IARC handbook Evaluating the Effectiveness of Smoke-Free Policies, 2009).
Cost and/ or cost-effectiveness in relation to the status quo	Low costs.
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	It will not cover those who are not formally employed/not working or freelancers.

Category of finding	Element 4 – Creating evidence database on the impact of smoking & vaping
Benefits	Builds capacity on Tobacco and Health policy issues and questions. It will help to educate and train people, professionals in the medical universities, health educators, etc. by 2030. It will help to provide evidence to the governments, manufacturers, and patients. Creating evidence by conducting research studies on the local situation of vaping, using ENDS/ ENNDS in different age groups will help design prevention programs and develop the new health policies.
Potential harms	It takes time to change the behavior of people.
Cost and/ or cost-effectiveness in relation to the status quo	Low cost (IARC Handbook, 2009).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	The many countries' experience well proves the benefits, including Australia, the United Kingdom, France, and Ireland.

Implementation considerations and counterstrategies

Level	Barriers	Elements	Counterstrategies
Individual	Reluctance to comply or to change behaviour.	1, 2	
Professional	The reluctance of the food and beverage & hospitality owners to comply.	1	Cost-benefit analysis for policymakers.
Organizational	Lack of commitment to the healthy behavior/ health promotion.	3	
System	Not enough enforcement resources	1	Encourage civic compliance mechanisms (via different platforms – apps, social media)

Conclusion

SHS exposure is a significant cause of disease and death among children and adults and imposes substantial external costs on individuals, governments, and societies. Critical information failures, including inadequate public knowledge of the health hazards of SHS exposure and inefficiencies in the tobacco market, provide an economic rationale for governments to intervene to reduce the harms caused by SHS exposure (IARC Handbooks, 2009). Progress must be made immediately to expedite the implementation of tobacco-free Legislation, identify the most critical lessons learned, investigate alternate enforcement methods, and strengthen the will to enforce the laws by 2030.

References

1. Al-Houqani M, Leinberger-Jabari A, Al Naeemi A, Al Junaibi A, Al Zaabi E, Oumeziane N, et al. (2018) Patterns of tobacco use in the United Arab Emirates Healthy Future (UAEHFS) pilot study. PLoS ONE 13(5): e0198119. https://doi.org/ 10.1371/journal.pone.0198119
2. American Cancer Society (2022). Retrieved from: www.cancer.org
3. Barnoya J, Monzon JC, Briz P, et al. Compliance to the smoke-free law in Guatemala 5-years after implementation. BMC Public Health 2016;16:318.doi:10.1186/s12889-016-2960-x pmid:http://www.ncbi.nlm.nih.gov/pubmed/27138959
4. Bosdries J, Willemsen M, Stronks K. Tobacco control policy development in the European Union: do political factors matter? Eur J Public Health 2015;25:90–194.
5. Byron MJ, Cohen J E, Fattarolli Sh, et al. Implementing Smoke-free policies in low-and middle-income countries: a brief review and research agenda. Tob. Indus. Dis. 2019;17(August):60.
6. De Kinderen R, Rombouts T. Social cost-benefit analysis of tobacco control policies in the Netherlands. Tob.Indus. Dis. 2018;16(Suppl 1):A141
7. Delivering a Smokefree 2030: The All-Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021. London: APPG on Smoking and Health. 2021.
8. EBU. Market insights trust in media 2020. Media intelligence service June 2020.
9. Effroymson D, Alam SM. Enforcement of tobacco control law: A guide to the basics. Ottawa, ON: HealthBridge; 2009.
10. Ekpu VU, Brown AK. The Economic Impact of Smoking and of Reducing Smoking Prevalence: Review of Evidence. Tob Use Insights. 2015 Jul 14;8:1-35. DOI: 10.4137/TUI.S15628. PMID: 26242225; PMCID: PMC4502793.
11. Greenhalgh, EM, Hurley, S, & Lal, A. 17.4 Economic evaluations of tobacco control interventions. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2020.
12. Haw SJ, Gruer L, Amos A et al. Legislation on smoking in enclosed public places in Scotland: how will we evaluate the impact? Journal of Public Health, Volume 28, Issue 1, March 2006, Pages 24–30.
13. Hira Abdul Razzak, Alya Harbi and Shaima Ahli . Tobacco Smoking Prevalence, Health Risk, and Cessation in the UAE. Oman Medical Journal, [2020], Vol. 35, No. 4: e165
14. Hira Abdul Razzak, Alya Harbi, and Shaima Ahli. Tobacco Smoking Prevalence, Health Risk, and Cessation in the UAE. Oman Med J. 2020 Jul; 35(4): e165.
15. Hoe C, Kennedy R D, Spires M, et al. Improving the implementation of tobacco control policies in low- and middle-income countries: a proposed framework. BMJ Global Health 2019;4:e002078.
16. IARC Handbooks of Cancer Prevention. Impact of smoke-free policies on businesses, the hospitality sector, and other incidental outcomes.
17. International Agency for Research on Cancer (IARC). Evaluating the effectiveness of smoke-free policies. IARC handbooks of cancer prevention: tobacco control. Vol. 13. Lyon, France: World Health Organization, International Agency for Research on Cancer; 2009.
18. Kent M R, Jha P, Chaloupka F J, Nguyen S N . Global and regional estimates of the effectiveness and cost-effectiveness of price increases and other tobacco control policies. Nicotin and Tobaccco Research (2002) 4, 311-319.
19. Koronaiou K, Al-Lawati JA, Sayed M, et al. Economic cost of smoking and second-hand smoke exposure in the Gulf Cooperation Council countries. Tobacco Control 2021;30:680-686.
20. Koronaiou K, Al-Lawati JA, Sayed M, et al. Economic cost of smoking and second-hand smoke exposure in the Gulf Cooperation Council countries. Tobacco Control 2021;30:680-686.
21. M Mc Kee, H Hogan, A Gilmore. Why we need to ban smoking in public places now? Journal of Public health, Vol 26, No 4, pp325-326.
22. M. C Farrelly, W. N Evans, A E S Sfekas. The impact of workplace smoking bans: results from a national survey. Tobacco Control 1999; 8:272-277.
23. McAfee T, Davis KC, Shafer P, et al. Increasing the dose of television advertising in a national antismoking media campaign: results from a randomised field trial. Tobacco Control 2017;26:19-28.

24. Mohammed Al-Houqani M, Raghib Ali R, and Cother Hajat C.Tobacco Smoking Using Midwakh Is an Emerging Health Problem – Evidence from a Large Cross-Sectional Survey in the United Arab Emirates. PLoS One. 2012; 7(6): e39189
25. Semple S, Dobson R, O’Donnell R, et al. Smoke-free spaces: a decade of progress, a need for more? Tobacco Control 2022;31:250-256.
26. Sustainable funding models for Tobacco Control: a Discussion Paper. International Union Against Tuberculosis and Lung Diseases, September 2014.
27. Tobacco and its environmental impact: an overview. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.
28. Tobacco and its environmental impact: an overview. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.
29. U.S. Department of Health and Human Services. Let’s Make the Next Generation Tobacco-Free: Your Guide to the 50th Anniversary Surgeon General’s Report on Smoking and Health. [PDF–795 KB] Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2022 Jun 11].
30. U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
31. Whincup PH, Gilg JA, Emberson JRetal. Passive smoking and risk of coronary heart disease and stroke: a prospective study with cotinine measurement. Br Med J 2004; 329: 200–205.
32. WHO report on the global tobacco epidemic 2021: addressing new and emerging products. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO

Author(s) and Citation

This Policy Paper was authored by:

Irina Godchaux-Berezhnova
Non-Resident Research Fellow
Mohammed Bin Rashid School of Government, Dubai, United Arab Emirates.

Immanuel Azaad Moonesar
Associate Researcher
Mohammed Bin Rashid School of Government, Dubai, United Arab Emirates.

This Policy Paper should be cited as: Godchaux-Berezhnova, I. & Moonesar, I.A. (2022). The UAE Smoke-Free Policy Review: Smoke-free 2030 is possible?. Mohammed Bin Rashid School of Government, Dubai, United Arab Emirates, September 2022.

The views expressed in this report are those of the author(s) and do not necessarily reflect those of the trustees, officers and other staff of the Mohammed Bin Rashid School of Government (MBRSG) and its associated entities and initiatives.

Acknowledgements

The author(s) wish to express personal appreciation to the following individuals for their input to the different stages of producing this working paper and for providing essential input and assistance into the report and its related materials:

Engy Shibl | Shuaib Kunnoth | TABEER.NET

This policy report document has been adapted from the K2P Center template in order to provide access to optimally packaged, relevant, and high-quality research evidence for decision-making. We would like to acknowledge the Alliance for Health Policy and Systems Research at the World Health Organization for support as part of the Knowledge to Policy (K2P) Center Mentorship Program [BIRD Project].

Copyright Information

Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License

Readers are free to copy, re-distribute, transmit and adapt the work, on the following conditions: You must attribute ownership of the work to the Mohammed Bin Rashid School of Government; you must not use the work for commercial purposes; and, if you share, alter, transform or build upon the work, you must distribute the resulting work only under the same or similar conditions. These conditions may be waived if you obtain written permission from the Mohammed Bin Rashid School of Government. Where the work or any of its elements is in the public domain under applicable law, that status is in no way affected by the license. For further copyright information, please visit the website: www.mbrsg.ac.ae or contact the author.

For reprints or permissions regarding using any of the material included in the publication, please get in touch with MBRSG through: permissions@mbrsg.ac.ae

The Mohammed Bin Rashid School of Government

The Mohammed Bin Rashid School of Government (formerly Dubai School of Government) is a research and teaching institution focusing on public policy in the Arab world. Established in 2005 under the patronage of HH Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the United Arab Emirates and Ruler of Dubai, in cooperation with the Harvard Kennedy School, MBRSG aims to promote good governance through enhancing the region's capacity for effective public policy.

- Applied research in public policy and management;
- Master's degrees in public policy and public administration;
- Executive education for senior officials and executives; and,
- Knowledge forums for scholars and policy makers.

The MBRSG Research Department focuses on the following seven priority policy areas:

1. Future Government and Innovation
2. Education Policy
3. Health Policy
4. Public Leadership
5. Social Policy, Wellbeing and Happiness
6. Sustainable Development Policy
7. Economic Policy

For more information on research at the Mohammed Bin Rashid School of Government, please visit: http://www.mbrsg.ae/home/research.aspx

Health Policy at the MBRSG:

The health policy research area aims to explore healthcare policy and policy for health in the UAE. It also addresses the health policy the policy implications, needs and challenges related to the provision of health services in accordance to the UAE National Agenda.

كليـــة مـحـمـــد بن راشـــد
للإدارة الحكـــومـــيـــة
MOHAMMED BIN RASHID
SCHOOL OF GOVERNMENT

Mohammed Bin Rashid School of Government
Convention Tower, Level 13, P.O. Box 72229, Dubai, UAE
Tel: +971 4 329 3290 - Fax: +971 4 329 3291
www.mbrsg.ae - info@mbrsg.ae