Report

Tobacco control in Bahrain: an overview

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مكافحة التبغ في البحرين: نظرة عامة

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الخلاصة: بدأت مداخلات مكافحة التبغ في البحرين منذ أواخر سبعينات القرن العشرين، وبدأ سَنُّ التشريعات المتعلِّقة بالتبغ في عام 1994. ويعتمد أسلوب مكافحة التبغ على الاستراتيجيات الدولية المُوصَى بها من قِبَل مجلس التعاون الخليجي ومنظمة الصحة العالمية. وقد تمت مؤخراً مراجعة خطة مكافحة التبغ والتشريعات المتعلِّقة به، وطرحت خطة وطنية شاملة جديدة لتنفيذها من قِبَل وزارة الصحة. ويناقش هذا التقرير أسلوب مكافحة التبغ في البحرين، مع التركيز على التشريعات المتعلِّقة بالتبغ، وتدخين الشباب، وتدخين الشيشة، وترصُّد التبغ، وخطة الإقلاع عن التدخين. كما يناقش التقرير عدداً من التوصيات بُغْيَةَ التحسين.

ABSTRACT Tobacco control interventions in Bahrain started in the late 1970s and tobacco legislation was introduced in 1994. The tobacco control approach incorporated the international recommended strategies according to the Gulf Cooperation Council and World Health Organization. Recently the tobacco control plan and tobacco legislation were reviewed. A new national comprehensive plan is put forward for implementation by the Ministry of Health. This report examines the Bahrain tobacco control approach, focusing on tobacco legislation, youth smoking, waterpipe smoking, tobacco surveillance and the smoking cessation plan. A number of recommendations for further improvement are discussed.

La lutte contre le tabagisme à Bahreïn : synthèse

RÉSUMÉ À Bahreïn, les premières interventions contre le tabagisme ont été lancées dès la fin des années soixante-dix et la législation antitabac est entrée en vigueur en 1994. Cette politique de lutte contre le tabagisme a intégré les recommandations stratégiques, de portée internationale, émises par le Conseil de Coopération du Golfe et l'Organisation mondiale de la Santé. Le plan et la législation antitabac ont récemment fait l'objet d'une révision. Le Ministère de la Santé propose la mise en œuvre d'un nouveau plan global national. Le présent rapport analyse le plan d'action du Bahreïn contre le tabagisme, s'attachant tout particulièrement à la législation antitabac, au tabagisme chez les jeunes, à l'utilisation du narguilé, à la surveillance du tabagisme et au programme de sevrage tabagique. Différentes recommandations pour l'amélioration de certains aspects sont discutées.

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Introduction

Tobacco use has been identified as one of the major avoidable causes of morbidity and mortality in society [*1,2*]. Tobacco use is a known cause of cancer, heart disease, stroke and chronic obstructive pulmonary disease [*2*]. In Bahrain, despite decades of health promotion and tobacco control legislation, tobacco use is still prevalent among adults and teenagers.

The national family health survey in Bahrain in 1995 reported that the overall prevalence of smoking among Bahraini male adults was 22.8% and among adult females was 8.8% [*3*]. The latest global health professional survey in 2004 showed that 23.8% of Bahraini male physicians were cigarette smokers, while only 0.9% of Bahraini female physicians were smokers [*4*]. This is lower than earlier studies, in which 26.6% of male physicians and 6.9% of female physicians were smokers [*5,6*].

Moreover, the prevalence of smoking among youth appears to be rising [*7*]. Smoking among high-school males has risen from 14.8% in the early 1980s to 25.8% in the late 1990s, although the reasons for this increase are unclear [*8,9*]. In a more recent survey, 33.5% of young males and 11.9% of young females reported being smokers [*10*]. Smoking is prevalent among medical students, with 27.5% of male medical students and 2.3% of female students reporting being smokers [*11*].

The recent trend towards waterpipe smoking is also a source of concern. Anecdotal evidence suggests a rise in the prevalence of this type of tobacco use in Bahrain, particularly among women and teenagers. The prevalence of waterpipe smoking was 9.7% among Bahraini male physicians and 3.1% among Bahraini female physicians [*4*].

The aim of this report is to describe the tobacco control approach in Bahrain, focusing on tobacco legislation, youth and waterpipe smoking, tobacco surveillance, and smoking cessation, exploring the main limitations and suggesting action for further improvement.

Tobacco control strategy

The history of tobacco control in Bahrain dates back to 1978, when a number of control measures were implemented for the first time, including raising custom duties on cigarettes to 70%, regulating the permissible level of tar and nicotine per cigarette and restricting cigarette advertising. The following year (1979) a nongovernmental organization (NGO), the Bahrain Antismoking Society, was formed [*12*]. The society works in collaboration with the Bahrain government to advocate for tobacco control through prevention activities and lobbying for law review and law enforcement.

In 1994 a tobacco control decree was issued by the Emir of Bahrain to reinforce the antismoking measures [*13*]. It stated the following:

- No tobacco to be cultivated in Bahrain.
- Smoking to be banned in closed public transport and aeroplane flights.
- Smoking to be banned in closed public places, government institutions, hospitals, educational institutions and airports.
- No sponsorship by tobacco companies to be allowed for any kind of sports or competitions.
- No tobacco factories to be built.
- No vending machines for cigarettes to be allowed.
- No sale of tobacco to under 18-year-olds.

The law also called for the formation of a committee to include members represent-

ing different parties involved in the tobacco control plan. The National Tobacco Control Committee was established in 1995. The committee was headed by the Minister of Health and members of various ministries involved in tobacco control plus NGO representatives. The committee was assigned various responsibilities, such as identifying the upper limit for nicotine, tar and other toxic substances in cigarettes, limiting advertisements and putting warning signs on advertisements. Despite having been inactive from 1997 until 2005, the committee finally resumed its operation with new members.

It is worth noting that the tobacco control approach in Bahrain incorporates the Gulf Cooperation Council, World Health Organization and other internationally recommended strategies of legislation and health promotion. In general, primary prevention activities dominated the tobacco control plan in Bahrain. Activities such as media advocacy, school education and community awareness are dominant. The implementation plan is multisectoral, involving the Ministry of Health as the leader, plus other members (Ministry of Education, Ministry of Information, municipal government, NGOs, private companies, etc.).

In terms of tobacco research, Bahrain has participated in two global tobacco surveys, the Global Youth Tobacco Survey in 2003 and the Global Health Professional Tobacco Survey in 2002 [*10,14*]. In addition, a few local studies [*5,6,8,9,11*] and a national survey [*3,15*] have been carried out to assess the prevalence of smoking in Bahrain.

Bahrain participates at regional and international level conferences and meetings concerned with tobacco control and lately at the negotiations for the WHO Framework Convention on Tobacco Control (FCTC) [*16*]. However, as Bahrain hosts the Formula One motor racing sport, which is sponsored by the tobacco industry, ratification the FCTC has been delayed. The text is currently being submitted to a special ministerial committee for consideration and approval [*12*].

Youth smoking

Smoking uptake in youth is of particular concern for tobacco control programmers [*10,14*]. Data show that around three-quarters of ever-smokers, including current smokers and ex-smokers, reported that they started to smoke regularly between the ages of 15 and 18 years. A further 1 in 5 of these said they started to smoke before age 15 years [*14*].

Intervention directed at youth smoking in Bahrain is focused on risk awareness and education on the negative consequences of smoking. A number of school-based programmes have been implemented in recent decades, plus mass media messages and other community-focused programmes [*17*].

The latest survey among youth in Bahrain indicated that the prevalence of smoking is 33.5% among male high-school students and 11.9% among females (Table 1) [*10*]. The mean age at which smoking began has been reported to be 16.8 (SD 1.1) years [*8*]. The survey showed that over half (52.4%) of under-18-year-olds purchase their cigarettes from local stores, and 75.3% were not stopped from purchasing because of their age. With regards to mass media campaigns, it appears that 7 in 10 teenagers saw pro-tobacco messages in the media [*7*].

Based on the above data, it is evident that there has been a failure of tobacco legislation and there is a need to review the current strategies and legislative ac-

Table 1 **Percentage of students aged 13–15 years who use tobacco by sex from the Global Youth Tobacco Survey, Bahrain, 2003 [*10*]**

Variable	Males	Females	Total
Ever smoked cigarettes[a]	41.5	14.1	28.4
Currently smoke			
Any tobacco product	33.5	11.9	23.3
Cigarettes	23.1	4.6	14.3
Other tobacco products	24.9	10.6	18.2

[a]*Even 1 or 2 puffs.*

tion focused on youth smoking, and devise with new interventions. Evidence elsewhere shows that legislative strategies and penalties are important for reducing youth smoking [*18*]. This can discourage both uptake and continuation of tobacco use.

Waterpipe smoking

Smoking tobacco in a waterpipe (*shisha, nargile, hookah*) seems to be a rising trend among both sexes and teenagers and is a major concern to the public health system [*10,19,20*]. Anecdotal evidence in Bahrain indicates that waterpipe smoking has increased in popularity in Bahrain recently, particularly among women and teenagers. In contrast to cigarette smoking, waterpipe smoking has become an accepted social behaviour and has gained more public tolerance [*4*]. The majority of smokers believe that waterpipe smoking is not damaging to health and many cigarette smokers switch to the waterpipe while they attempt to quit [*21–23*].

There are few studies concerned with waterpipe smoking and its patterns and trends in Bahrain. Data from the national morbidity survey showed that waterpipe smoking is more prevalent among females (8.9%) compared with males (2.0%) (Table 2) [*24*]. The Global Youth Tobacco Survey showed that among young people the prevalence of tobacco consumption in the category "other tobacco products" was 18.2% [*10*]; this is likely to comprise mostly waterpipe use.

Tobacco market

Bahrain does not grow tobacco or manufacture cigarettes, and thus all cigarettes available in the market are imported, almost exclusively from Europe and North America. There are four main types of tobacco available in Bahrain (cigarette, waterpipe, cigar and pipe) and two types of tobacco are used in waterpipes (*narjeela* and *kadu*). Females smoke *narjeela* compared with males who commonly use *kadu*. The local

Table 2 **Type of smoking by sex from the National Morbidity Survey, Bahrain, 1981–83 [*15*]**

Type of smoking	Males		Females	
	No.	%	No.	%
Cigarette	981	27.7	19	0.5
Waterpipe	69	2.0	315	8.9
Cigar	3	0.1	0	0.0
Mixed	29	0.8	3	0.1
Non-smoker	2455	69.4	3211	90.5
Total	3537	100.0	3548	100.0

tobacco used in waterpipe smoking (*muasal*) is flavoured and processed in Bahrain. The popularity of Bahrain *muasal* is increasing in the local and regional market [*19,25*].

For cigarettes in Bahrain, by law the maximum permissible limits of nicotine, tar, and carbon monoxide are 0.6 mg, 10 mg and 12 mg per cigarette respectively [*26*]. However, the main challenge here is the absence of local resources to assess the required specification for the new type of imported cigarettes and tobacco, making it difficult to enforce the law in this area. Moreover, random checking on the cigarettes available in the local market is not in operation.

Reviewing the available data [*27*] and Ministry of Health reports [*28*] shows that periodic data on consumption, import and export of tobacco and on smoking locations are missing. Such information is critical for monitoring and evaluating the control plan. Thus, one of the first initiatives is to maintain an effective tobacco surveillance and reporting system with other ministries, such as the Ministry of Commerce, the Ministry of Education and other licensing bodies, such as the local municipality.

Legislative action

Despite the Emiri decree for tobacco control in 1994, law enforcement is weak in general, and special enforcement activities, such as conducting a regular retail compliance check or restrictions on advertising for tobacco and frequent checks on tobacco specifications, are not in operation. Although the 1994 law stated that Ministry of Health inspectors can issue an injunction for law breakers, since then, apart from three warning letters issued by the Ministry of Health, no injunctions have been issued.

Publicity in the media suggests that public pressure is growing against the harmful effects of second-hand cigarette smoke and the smoking of waterpipes in closed public places [*19,24*]. On the other hand, personnel shortages at the Ministry of Health have delayed action and the enforcement of the law in most cases. In addition, the current legislative charges imposed on companies who break the law are hardly significant in terms of business profit for these activities.

Smoking cessation plans

Interventions targeted at individual smokers are only part of the much broader spectrum of strategies to reduce the prevalence of smoking. A wide variety of smoking cessation programmes have been developed and studied over recent years. The two main interventions are pharmacotherapy and behavioural therapy. These contribute about equally to success in quitting. Most evidence indicates that a combination of both methods is the most effective intervention [*29*].

In Bahrain, an anti-smoking clinic was set up by the Bahrain Anti-smoking Society. However, as it operated on a voluntary basis it has been unable to maintain its services over time. In 2004 a smoking cessation clinic was set up by the Ministry of Health, but the clinic operates on a part-time basis on limited resources.

Nicotine replacement therapy and bupropion hydrochloride tablets are available in the local market; however, their use is very limited because they are expensive and the price is not subsidized.

Recently an attempt has been made to formulate national guidelines for smoking cessation [*30,31*]. Building local capacity with regards to smoking cessation interventions is still a big challenge. Affordability

and acceptability need to be addressed. The new tobacco control plan suggested by the Chronic Diseases Control Section of the Bahrain Ministry of Health recommended widening the smoking cessation services and integrating them into primary care services [*32*].

Training of health care staff on measures for dealing with smokers is being given priority. Recently a number of workshops organized by the Ministry of Health and NGOs focused on national capacity-building in tobacco control [Ministry of Health, Bahrain, Quit smoking workshop, unpublished, 2005].

Monitoring and surveillance evaluation

Ongoing surveillance will document any positive future changes. In Bahrain, tobacco use surveillance has been monitored through population surveys and tobacco-specific surveys; these include:

- Global Youth Tobacco Survey, 2003 [*14*];
- Global health professionals survey [*4*];
- Census data and health statistics;
- National family health survey, 1995 [*3*];
- National morbidity survey of 4.5% of the households in Bahrain [*24*].

Individual research has been carried out on different population groups (school-based youth tobacco surveys, surveys of adults, school administrators, teachers, opinion leaders and health care providers, etc.) [*5,6,8,10,11,33*].

Inconsistent methods and irregular survey intervals are two of the issues that have made it difficult to know exactly how smoking patterns are changing in Bahrain.

Furthermore, two significant challenges were noted. First, liaison with other ministries is weak regarding the tobacco market (import, export) and specific data on the amount of tobacco consumed, the type of tobacco permitted, the number of permitted smoking places and other tobacco-related activities. Thus, maintaining collaboration and proper reporting channels with other parties involved in tobacco control are being addressed. A special reporting format is been created and will be processed soon. This would allow for a proper surveillance system to be put in place. Second, baseline data on patterns and trends in waterpipe smoking and second-hand smoke are insufficient.

Giving the importance of the above data for monitoring the tobacco control interventions, further research is required.

Conclusion

Tobacco use still constitutes a public health problem in Bahrain and imposes a huge burden with its associated morbidity and mortality. Although tobacco legislation plays a major role in tobacco control policy, in Bahrain there exist two main limitations facing tobacco legislation: first, the failure to enforce the law in the majority of cases and a lack of qualified manpower to do this; second, the delay in ratification of the FCTC.

Upward trends in youth smoking prevalence highlight the need to diversify the approaches within the tobacco control plan. New legislation and enforcement of existing legislation take priority, and there is a need to reduce availability of tobacco products to young people and regulate supply. In addition, teenagers need an alternative to occupy their free time, particularly at school breaks; therefore it is highly recommended to provide special programmes focused on youth during the breaktime. The implemen-

tation of such programmes would minimize the peer pressure effect on tobacco intake.

The smoking cessation plan needs to be strengthened within the context of primary health care. However, implementation of a cessation plan requires adequate staff training and more resources, such as medication to support smokers who want to quit. It is essential as well to equip medical students and other health professional students with the skills to help smokers to quit smoking.

Implementation of a tobacco control plan is multisectoral, involving government and NGOs. Hence, it is recommended to maintain collaboration and surveillance through periodic reporting systems, with the Ministry of Health taking the leadership role. Data collated from various implementation agencies should be analysed and disseminated for policy use.

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