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Banning shisha smoking in public places in Iran: an advocacy coalition framework perspective on policy process and change

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Abstract

Introduction Shisha smoking is a widespread custom in Iran with a rapidly growing prevalence especially among the youth. In this article, we analyze the policy process of enforcing a federal/state ban on shisha smoking in all public places in Kerman Province, Iran. Guided by the Advocacy Coalition Framework (ACF), we investigate how a shisha smoking ban reached the political agenda in 2011, how it was framed by different policy actors, and why no significant breakthrough took place despite its inclusion on the agenda.

Methods We conducted a qualitative study using a case study approach. Two main sources of data were employed: face-to-face in-depth interviews and document analysis of key policy texts. We interviewed 24 policy actors from diverse sectors. A qualitative thematic framework, incorporating both inductive and deductive analyses, was employed to analyze our data.

Results We found that the health sector was the main actor pushing the issue of shisha smoking onto the political agenda by framing it as a public health risk. The health sector and its allies advocated enforcement of a federal law to ban shisha smoking in all public places including teahouses and traditional restaurants whereas another group of actors opposed the ban. The pro-ban group was unable to neutralize the strategies of the anti-ban group and to steer the debate towards the health harms of shisha smoking. Our analysis uncovers three main reasons behind the policy stasis: lack of policy learning due to lack of agreement over evidence and related analytical conflicts between the two groups linked to differences in core and policy beliefs; the inability of the pro-ban group to exploit opportunities in the external policy subsystem through generating stronger public support for enforcement of the shisha smoking ban; and the nature of the institutional setting, in particular the autocratic governance of CHFS which contributed to a lack of policy learning within the policy subsystem.

Conclusions Our research demonstrated the utility of ACF as a theoretical framework for analyzing the policy process and policy change to promote tobacco control. It shows the importance of accounting for policy actors' belief systems and issue-framing in understanding how some issues get more prominence in the policy-making process than others. Our findings further indicate a need for significant resources employed by the state through public awareness campaigns to change public perceptions of shisha smoking in Iran which is a deeply anchored cultural practice.

Keywords: Advocacy Coalition Framework (ACF), Iran, policy change, policy process, shisha smoking, tobacco control

Key Messages

- Without exploiting opportunities external to the policy subsystem, most importantly public support, any change in tobacco control policies, including shisha smoking, is unlikely.
- Our research demonstrated the utility of ACF as a theoretical framework for analyzing the policy process and policy change to promote tobacco control.
- By using an ACF lens to explore the policy process in shisha case, we realized the importance of accounting for policy actors' belief system and issue-framing in understanding how some issues get more prominence in the policy-making process than others.

Introduction

Shisha (also known as hookah, narghile, or water-pipe) smoking is a strongly embedded custom in the Middle East (Chaouachi 2009). It appears to be replacing cigarette use and is considered the most popular mode of tobacco use in the region (Ward 2015). Similar trends are observed worldwide; e.g. cigarette smoking has dropped by 33% among American high school students over the last decade while at the same time use of non-cigarette tobacco products, including shisha smoking, has increased by 123% (Kumar *et al.* 2014; Ward 2015). The high prevalence of shisha smoking, especially among the youth in the Middle East (Akl *et al.* 2011; Akl *et al.* 2015), is attributed to the introduction of easier-to-use and industrially flavored tobacco (Maassel), a growing cafe culture in the region, the evolution of mass communication media, and the absence of strong regulatory/policy frameworks specific to this form of tobacco use (Akl *et al.* 2015; Maziak *et al.* 2014; Ward 2015).

The health impacts of shisha smoking are similar to that of cigarette smoking (Akl *et al.* 2010; Jawad *et al.* 2013). Systematic reviews have demonstrated a significant association between shisha smoking and lung cancer, respiratory illness, low birth weight and periodontal disease (Akl *et al.* 2010; Chaouachi 2009; El-Zaatari *et al.* 2015). Iran is one of the countries in the Middle East with a very high rate of youth shisha smokers (Baheiraei *et al.* 2015; Ziaei *et al.* 2016). Similar to other parts of the Middle East, shisha cafes (including teahouses/coffeehouses) in Iran operate in a market environment in which regulations are not enforced (Jawad *et al.* 2013; MOHME 2016). Shisha cafes and other public places are crucial sites in the fight against tobacco use when considering that about 60% of Iranian youth are first introduced to smoking tobacco in public areas (Ziaaddini *et al.* 2007).

To develop and implement effective tobacco control policies in the area of shisha smoking, policy makers and practitioners need to better understand the drivers of the policy process leading to stasis or change (Breton *et al.* 2008; Catford 2006). In Iran, shisha smoking (like all forms of smoking) in public places has been banned at the federal level, but there have been numerous debates whether or not teahouses and traditional restaurants should be considered public places (discussed later in this article). Since 2013 shisha smoking in all public places, including teahouses and traditional restaurants, has been officially banned by the federal government but the ban has never been properly implemented or enforced and shisha smoking remains a popular pastime. Guided by the Advocacy Coalition Framework (ACF) (Sabatier and Weible 2014), we investigate a failed advocacy intervention strategy in support of enforcing and implementing the federal law to ban shisha smoking in all public places in Kerman Province, Iran. We found ACF to be a good conceptual fit for our case study as it was developed to assess challenging policy problems in which there are substantial goal conflicts amongst competing coalitions, important technical disputes and a broad range of actors involved in the policy process (Sabatier and Jenkins-Smith 1999). We specifically aimed to understand how the issue of shisha smoking reached the provincial political agenda, how it was framed by different policy actors, and why no significant progress was made despite its inclusion on the political agenda. To achieve these aims, we focused our analysis on the Council of Health and Food Security (CHFS) in Kerman Province, in which the case of shisha smoking was addressed four times since 2011 but failed to engender any lasting policy change.

Conceptual framework

The Advocacy Coalition Framework (ACF), initially proposed by Jenkins-Smith and Sabatier (Jenkins-Smith and Sabatier 1993), views the policy process as a competition and interaction between coalitions of actors who, based on their belief systems, advocate for their definition of policy problems and the implementation of their solutions. Coalitions are groups of actors with similar beliefs (including interest groups, state actors at various levels of government, and NGOs), which are mostly informal (Heaney 2006), and which aim to convince policy makers to amend a policy (Sabatier and Weible 2007). Competition and interaction take place within a policy subsystem, in our case tobacco legislation and regulation in Iran. Two or three coalitions are normally present in a policy subsystem (Sabatier and Weible 2007). The ACF emphasizes the dynamics of coalitions of the proponents or opponents involved in a new policy field (Breton and de Leeuw 2011; Fleury *et al.* 2014). One coalition usually predominates in a policy subsystem through enforcing its vision of problems and solutions. A policy is therefore the byproduct of the belief system of the dominant coalition. Public policies and policy changes can emerge as a result of confrontations and negotiations between different coalitions of actors in the policy subsystem (Jenkins-Smith *et al.* 2014). In this process, the ACF highlights the importance of policy broker/s who act/s as a mediator or a political intermediary in charge of finding an acceptable compromise and limiting conflicts between coalitions.

The two factors chiefly responsible for policy change are policy-oriented learning within the policy subsystem and non-cognitive drivers external to it that can impact resource distribution of actors. Policy learning can lead a coalition to refine and adapt its belief system in order to achieve its objectives more efficiently, in turn influencing perceptions of the problem and proposed solutions among

coalition members. In the tobacco subsystem, for example, the tobacco industry may realize that it can no longer argue against the evidence regarding the harm of smoking on health and therefore adjusts its strategy to stress the economic consequences of tobacco control legislations (Breton *et al.* 2008). Jenkins-Smith (1988) argues that policy-oriented learning leading to policy change mostly happens as a result of strategic interactions in analytical policy debates among competing coalitions within policy subsystems. Through these analytical policy debates, coalition actors learn to realize or defend the core aspects of their belief system. Belief systems include the value systems (values related to policy issue at hand; e.g. equity, economic efficiency) and a set of causal assumptions believed to underlie the problem (e.g. relation between smoking and health) by coalition actors (Sabatier 1988). By linking a set of manipulable policy instruments to policy outcomes (e.g. regulation and/or user tax to halt smoking) the belief system is linked to policy; this way, coalition actors can connect policy options to likely outcomes and attribute relative valuation to those outcomes.

The value systems and the causal relationships embedded in the belief system are divided into a three-tiered hierarchal belief system: deep core, policy core, and secondary beliefs (Weible *et al.* 2009). Deep core beliefs are the broadest and most stable beliefs including general normative and ontological assumptions about human nature (e.g. humans are inherently good versus inherently bad), the relative priority of different groups' welfare, proper role of government versus market, and relative priority of values like liberty and equality. Policy core beliefs include normative beliefs that help guide strategic behavior of a coalition and help join allies and divide opponents (Sabatier and Weible 2016). These beliefs are moderate in scope and are less resistant to change compared to deep core beliefs. The secondary beliefs are very narrow in scope, are more empirically based, and are least resistant to change (Weible *et al.* 2009). Change in value systems (or their weights) and causal assumptions can change the coalition actors' understanding of, and policy prescription for, the policy issue. Although belief systems are subject to revision on the basis of feedback and experimentation (Brewer 1973), policy-oriented learning primarily affects the secondary aspects of a belief system due to the rigidity of deep and policy core beliefs (Weiss 1977). The degree of consensus among coalition actors with respect to core elements of its belief system is the key to coalition stability (Jenkins-Smith 1988). Therefore, small incremental changes to policies usually involve only changes in secondary beliefs whereas significant policy changes usually involve a change of coalition actors dominating the policy subsystem (Sabatier 2007).

Another driver for policy change in a policy subsystem includes non-cognitive factors/drivers that originate from outside the policy subsystem which can influence policy change by shifting the power distribution among, and resource endowments of, coalition members. According to the ACF, major significant policy changes are most likely to happen due to non-cognitive drivers (Cairney 2007; Sabatier and Weible 2014). Non-cognitive drivers include the evolution of relatively stable parameters (e.g. institutional context like federalism, centralization, decentralization) (Gagnon *et al.* 2007) and external drivers (e.g. changes in socioeconomic conditions or public opinion) (Weible *et al.* 2009; Sabatier and Weible 2016) that constitute the broader political environment in which policy subsystems operate and influence the stability and defection of coalitions. Institutional context (i.e. formal and informal norms that facilitate or limit political actors' behavior) (Ostrom 2009) influences formation of coalitions, their stability and maintenance, strategies they use, and resources available to them (Fischer 2015). The institutional dimension also refers to the official structure including the procedural and regulatory aspects specific to a policy subsystem (Gagnon *et al.* 2007). The broader political environment can also function as a stabilizer, for example when fundamental values and customs conflict with new policies or when political or constitutional structures have a conservative policy bias (Sabatier and Weible 2014). Figure 1 below demonstrates how we applied key ACF concepts to our shisha smoking case study.

The ACF framework has been widely employed in analyzing tobacco policies in different countries (e.g. Breton *et al.* 2008; Sato 1999; Smith *et al.* 2015), but to date has not been used in the case of shisha smoking. It has also been successfully employed to study public health policy (Gagnon *et al.* 2007) but has not been applied to explore the policy process, or policy change, in a multi-sector collaboration for health, for example in a Health in All Policies (HiAP) context. Lastly, except in a few cases, the ACF has not been applied to non-western political traditions (Weible *et al.* 2009).

Methods

Data collection and sampling

Our study adopted a qualitative research methodology and a case study approach. We focused on the Council of Health and Food Security (CHFS), a provincial governance structure established in 2006 to operationalize the concept of Health in All Policies (HiAPs) in Kerman Province. HiAP is a way of working across government sectors to encourage non-health sectors to consider the health impact of their policies and to foster collaboration for improving population health through addressing the social determinants of health (SDHs) (Leppo *et al.* 2013). The CHFS is chaired by the provincial governor and is composed of 34 official members from diverse health and non-health sectors (e.g. agriculture, education, industry and trade, media and broadcasting, environment), mostly affiliated with the government (Khayatzadeh-Mahani, *et al.* 2016). We relied on two main sources of data: face-to-face in-depth interviews and key policy texts. We employed purposeful and snowball sampling to identify our interviewees and policy documents. We developed a list of 29 participants based on CHFS Secretariat Office staff recommendations, names appearing in the CHFS meeting reports, and recommendations by each participant interviewed. All participants had attended at least two meetings of CHFS in which shisha smoking had been discussed, and 24 out of 29 members accepted to participate in our research. All interviews were conducted in the interviewees' work place between September 2014 and July 2015. Except for one participant who was not willing to have his views audio-recorded, all interviews were digitally recorded and fully transcribed in Persian but translated and analyzed in English. Quotes presented in the results section are translated from Persian by the principal investigator (AKM) and edited for readability. Each interview lasted an average of 60 min and written permission to record the interview was sought in all cases. Ethical approval was obtained from the authors institute.

In addition, we analyzed the following policy documents: the Supreme Council of Health and Food Security (an equivalent of CHFS at the federal level) bylaws; Kerman province CHFS bylaws as well as all its meeting reports; and all national laws/regulations related to tobacco in general and shisha smoking in particular. We searched for CHFS and SCHFS documents since their launch in 2006 and for national laws/regulations since 1997 when the first national law banning smoking in public places was approved by the cabinet and parliament. Most national laws/regulations and policy documents are accessible from the websites of the Iranian Ministry

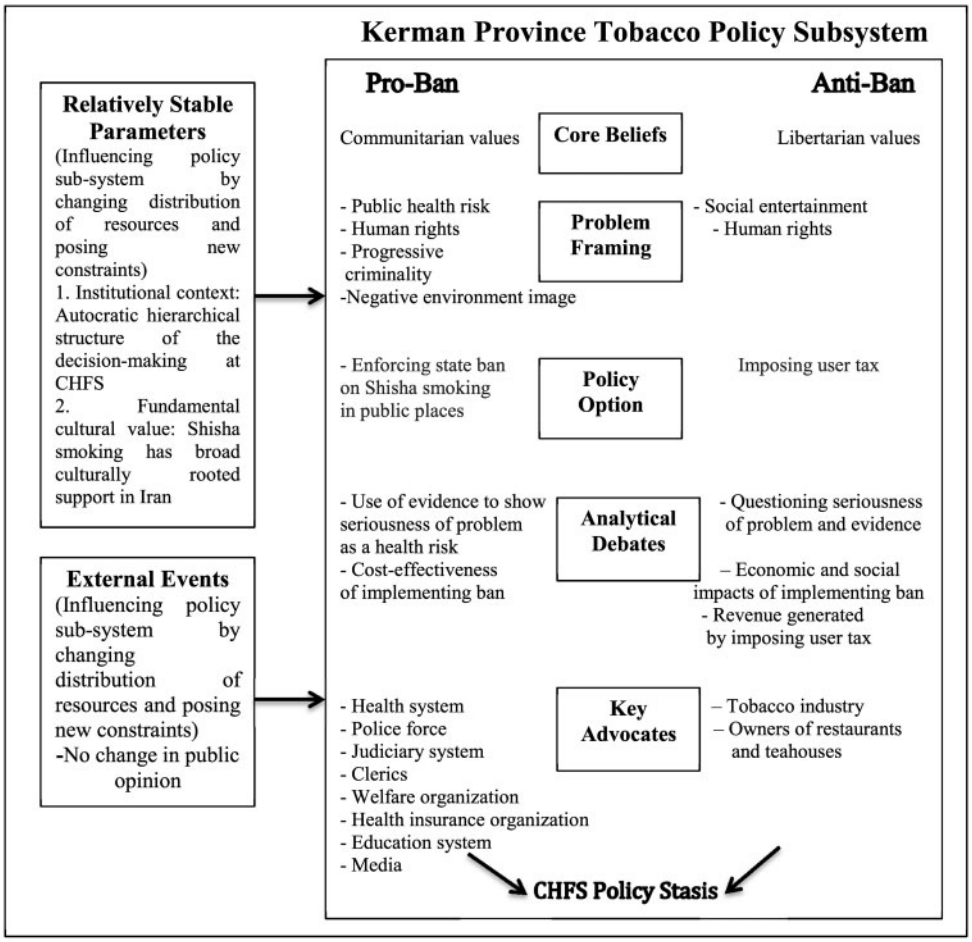

Figure 1. Position of pro- and anti-ban groups in the policy subsystem and external events imposed on the subsystem

of Health and Medical Education (MOHME 2016), the Iranian Anti-Tobacco Association (IATA 2016), and the Iranian Parliament (Parliament 2016). Most of our data (e.g. actors belief systems, their policy preferences, and their strategic interactions) was extracted from interview transcripts. However, policy documents helped us explore administrative procedures, content of the policy proposed, evidence used by actors, changes in the institutional settings, and political structure opportunities (e.g. governance and decision making process at the CHFS).

Data analysis

We employed a qualitative thematic framework analysis, which is a matrix-based method (Bryman 2008; Ritchie *et al.* 2013), focusing on the factual statements expressed in our interview data and policy documents' excerpts (Silverman 2013). The data analysis initially took an *a priori* thematic approach (Bryman 2008) in line with the analytical framework method (Ritchie and Spencer 2002). A thematic conceptual framework based on the research questions guided by the ACF theory was developed at an early stage of the analysis (Ritchie *et al.* 2013). An adapted version of Ritchie and Spencer's (2002) thematic framework approach was used for data analysis, which entailed 6 steps including: familiarization, developing a thematic framework, indexing and charting, summarizing and synthesizing, mapping and interpretation, and finally conceptualization. Conceptualization of the data was further enriched by applying constant comparative methodology inherent to a grounded theory approach (Glaser and Strauss 2009; Strauss and Corbin 1998; Corbin and Strauss 2014). This allowed novel theoretical insights to emerge from our interview data and policy texts, drawing on both deductively developed codes (based on the ACF), and inductively emerging codes directly from the data. Gale *et al.* (2013) note that the framework approach can be adapted for both deductive and inductive qualitative analysis. We used a combined approach (both deductive and conductive analyses) as we hoped to discover other unexpected and emergent aspects of our participants' experience or how they assign meaning to their position and their experiences (Gale *et al.* 2013). Once we developed coding categories (e.g. coalition formation, policy subsystem, belief system, policy change, policy-oriented learning, non-cognitive drivers), we performed a micro analysis by scrutinizing interview transcripts and policy texts line by line to identify major ideas of a sentence and categorized them to develop additional codes and concepts (i.e. open coding). Following open coding, we used axial coding to introduce our own interpretations by connecting the concepts and analyzing their patterns. Finally, we linked concepts to core categories through selective coding (Denzin and Lincoln 2011; Corbin and Strauss 2014), yielding three key categories (i.e. agenda setting, problem framing, and drivers of policy stasis).

Results

In what follows, we first provide a brief overview of the anti-smoking laws/regulations in Iran. We then present the results on

how shisha smoking moved onto the Kerman CHFS agenda, how diverse policy actors framed the issue, and why no policy changes took place. Since some members felt uncomfortable to be quoted using their organizational affiliation, we use the codes PB (i.e. pro-ban) and AB (i.e. anti-ban) to maintain anonymity in presenting quotations.

National anti-smoking laws

Iran follows a centralized mode of policy-making which explains why most tobacco laws, regulations, legislations, and policies are developed at the federal level. In 1992, for the first time, the Iranian Anti-Tobacco Association (IATA), founded in 1983, proposed to the federal Cabinet a legislation to ban smoking in public places. It took five years for the law to be approved by both Cabinet and Parliament, but by 1997 all types of smoking, including shisha, were banned in all indoor public places (e.g. workplaces, traditional restaurants, teahouses, hotels, cinemas). In 2005, the law was amended through a note to exempt teahouses and traditional restaurants from the ban, thereby permitting shisha smoking in such places. This amendment was the result of lobbying by opponents of the ban, including mainly the tobacco industry and the association of restaurants and teahouses. By 2006, the pro-ban advocates successfully pressed the Cabinet to abandon the amendment note, reinstating the ban on shisha smoking in all public places, including restaurants and teahouses. In 2011 that decision was reversed yet again as a result of the opponents' influence. In 2013 the judiciary system used its power through the Administrative Court of Justice (one of the components of the Iranian judiciary system) and abandoned the amendment note a second time; since 2013 shisha smoking has remained banned in all public places in Iran. However, while banned *de jure*, there has been no enforcement. Our document analysis showed that despite the ebbs and flows in the influence of the proponents and opponents of the ban to include or exclude teahouses and traditional restaurants from public places, in practice there was no clear role and responsibility for any organization to take responsibility for enacting the law/regulation.

Iran is one of the countries that signed the WHO FCTC treaty in 2003 and has developed a Comprehensive National Tobacco Control Law ratified by the Parliament in 2006, but it is yet to be fully enforced and implemented. This law covers all six policies introduced by the WHO MPOWER package (see Table 1). Ministry of Health and Medical Education has recently proposed an amendment to Article 5 of this law asking for change of pictorial/graphical warning label every 6 months and researchers at the Ministry are currently seeking public opinion on the most effective warning signs/labels. Compared to other countries in the region (Middle East), Iran has shown stronger tobacco control programs (Heydari *et al.* 2014). WHO MPOWER package report (WHO 2013) has also assigned a good score to Iran in terms of adopting tobacco control programs such as banning smoking on flights (in 1992) and other public places (in 1997), and banning tobacco advertisement (in 1994) (Heydari *et al.* 2016).

How did shisha smoking move onto the CHFS agenda?

Kerman is a province in the southeast of Iran with a high prevalence of tobacco smoking, a high rate of opium addiction, especially among the youth, and a 42.5% prevalence of shisha smoking among university students (Sabahy *et al.* 2011). Having conducted some surveys on the prevalence of tobacco smoking and addiction in Kerman city (e.g. Nakhaee *et al.* 2009; Sabahy *et al.* 2011), the health sector, led by Kerman University of Medical Science (KUMS), pushed the issue of implementing the shisha smoking ban onto the CHFS agenda, using a dedicated policy broker with expertise in the areas of social determinants of health (SDH) and addiction. This policy broker was a permanent member of CHFS, attending almost all CHFS meetings since its launch. In his role as a policy broker, he had previously advanced two policy issues onto the Council agenda, salt reduction and wheat regulation in bread production at bakeries, followed by successful implementation of both policies. In the case of shisha smoking, the policy broker started lobbying with different members of CHFS in early 2011 and established allies including members from the police force, judiciary system, clerics, welfare organizations, health insurance organizations, the education system, and media. The issue was raised at four meetings of Kerman CHFS (see Table 2) and resulted in proposing some policy instruments that we have classified into three categories: regulations, direct government action, and advocacy (see Table 3).

Framing of shisha smoking at CHFS

Seventeen out of 24 of our research participants were in favor of overseeing the implementation of the smoking ban, while seven participants were against it. The pro-ban group used four different frames to describe shisha smoking as a public problem with the singular policy objective of enforcing and implementing the federal law. The four frames include: 'public health risk', 'human rights', 'progressive criminality', and 'negative environment image'.

The dominant frame used by the pro-ban group was the 'public health risk' frame, with special emphasis on the threat that smoking poses to Iranian youth. 12 out of 17 participants of the pro-ban group used phrases and terms such as 'causing cancer', 'life threatening', 'disease', 'sickness', 'serious health risk', 'risk to children health', and 'youth health' to describe shisha smoking as a public health risk. Our document analysis showed that this group used evidence and statistics to show the magnitude of the problem as the following excerpts from the 45th CHFS meeting report show.

> "*…We found in our research that at least 56% of high school children in our city [Kerman] have experienced shisha smoking. According to the recent report of the health ministry, the health risks of smoking shisha are 40 times higher than cigarette…recent research findings published in the leading medical journals show a positive association between shisha smoking and lung cancer and respiratory illnesses…..smoking shisha for 45 minutes equals to smoking 70 cigarettes…*".

Seven of the 17 members of the pro-ban group perceived shisha smoking as a 'human rights' issue and used this discourse to frame the problem while simultaneously promoting a 'public health risk' frame. Amongst those, three members specifically referred to citizens' entitlement to state provision of programs that contribute to good health.

> "*…everybody in this country is entitled to the clean air and environment in order to have a better life and health. We as public servants have the duty to make this happen and to help improve population health*". PB14

Four members of the pro-ban group further argued that citizens have the right to be protected from other people's activities that damage their health. They made several references to the rights of people exposed to second-hand smoke, especially children.

> "*…we as the guardians of health have to develop plans to protect public rights especially the right of children to be away from the health risks of smoking in public places*". PB8

Table 1. Components of the Iranian Comprehensive National Tobacco Control Law categorized by the WHO MPOWER policies (Source: IATA, 2016)

MPOWER Policy	Art.	Iranian Comprehensive National Tobacco Control Law
Advertising Ban	3	Any type of direct and indirect tobacco advertising, which stimulates tobacco smoking is strictly banned.
	10	Any kind of tobacco advertising and promotion which violates this Act and its bylaw is considered an offence and is subject to a fine from 500,000 RIs to 50,000,000 RIs. The fine may be increased depending on the inflation rate (once every three years), following announcement of the Iranian Central Bank and approval of the Cabinet. The court should also issue a verdict to collect all the advertising products.
Secondhand smoke protection	13	According to the article 18 of the Administrative Violation Code, tobacco use in all public places, including government office places is forbidden and is subject to the punishment as below: If the violator is a government employee, according to the Supervisory Board to the Administrative Violation, he/she is subject to one of the penalties as laid down in the Notes A and B of Article 9 of the Administrative Violation Act. If the violator repeats the offense three times, he/she is subject to the penalty, as laid down in the Note C of the article 9. A cash fine between 70,000 RIs to 100,000 RIs for other violators. **Note 1:** In compliance with the Code, a cash fine of 50,000 RIs to 100,000 is applied to anyone who smokes in public places. **Note 2:** The Cabinet reserves the right to regulate the cash fine based on the inflation rate once every three years.
Raising taxes	8	Every year, the price of tobacco products increases by 10% through a tax increase. Up to 2% of the income raised from taxation is transferred to the Treasury Department and is then allocated to public organizations, charity foundations and Non-Governmental Organizations (NGOs) in the form of annual budgets following legal proceedings. This helps these institutions to strengthen their educational, research and cultural activities in tobacco control and prevention programs.
Warning dangers	5	Health warnings labels should be pictorial and cover not less than 50% of each side of the cigarette package (whether produced inside the country or imported). **Note:** Using misleading terms such as "mild," "light" and the like are prohibited.
Help Quit	9	The Ministry of Health and Medical Education (MOHME) should provide preventive, treatment, and rehabilitative services to tobacco users and offer them cessation-counseling services. MOHME should also support NGOs involved in tobacco cessation counseling and treatment.
Monitoring	4	Policy making, supervision and issuing license to import various tobacco products should be arranged by the federal government only.
Sale	6	All tobacco products should be supplied in packages displaying serial numbers, and the manufacturing company logo. Having the statement "the Sales only allowed in Iran" is mandatory on any importing tobacco products.
	7	The license to sell tobacco products is issued by the Ministry of Commerce. **Note:** Distribution of tobacco products by people who have no license is prohibited.
	11	Selling and supplying cigarette and other forms of tobacco, sale of the products which carry no serial number or approved logo and repeating tax evasion are subject to a cash fine from 500,000 RIs to 30,000,000 RIs. The amount may be increased (once every three years) depending on the inflation rate, in accordance with the announcement of the Iranian Central Bank, and approval by the Cabinet.
	12	Sale of cigarette to and by children under 18 years is subject to a fine from 100,000 RIs to 500,000 RIs. Repeating the offence is subject to a fine of 10,000,000 RIs in cash.
	14	Selling, marketing, carrying and/or holding the contraband tobacco products by all people are strictly forbidden and are subject to the regulations related to Good Smuggling.
	15	Printing any kind of logo or brand name of tobacco products on other non-tobacco products—or vice versa—is strictly forbidden.
	16	Retailers should sell tobacco products in packages according to article 6. Selling non-packaged tobacco products is forbidden. Those violating the rule are subject to a cash fine from 50,000 RIs to 200,000 RIs.

Note: RIs stands for Rials (Iranian currency); at the time of writing (2 November 2016) 1US$=30500 Iranian RIs.

> "*…in our constitution, health is a right for all citizens; so we need to do our best to prevent things that impair population health*". PB13

Interestingly, human rights discourse was also invoked by members of the anti-ban group as members argued that smokers' rights to freedom should be respected.

> "*…if people, no matter young or old, are enjoying their time smoking shisha we are not allowed to interfere and violate their freedom*". AB6

Eight members of the pro-ban group also perceived shisha smoking as a 'gateway' to other types of smoking and an addiction that leads eventually to criminal activity. These participants made several references to the terms like 'social deviance', 'order', 'law', 'crime', 'police, 'repression', 'force', 'theft', and 'criminals' to describe and frame shisha smoking as 'progressive criminality', displaying a strong belief in the use of state authority and coercive measures in order to correct such behavior.

> "*…smoking shisha is a gate for many crimes. Today, you smoke shisha, next you try cigarette, then heroin, and you know how the story moves on…*" PB1

There were, however, five members in the pro-ban group who disagreed with the idea of highlighting shisha smoking as a public health risk; they feared that doing so could result in people feeling threatened and disregarding the policy, as it challenges deep

Table 2. Kerman CHFS meetings and decisions on shisha smoking

Meeting No	Meeting Time	Decisions
45	December 2011	To ban shisha smoking in indoor public places a committee with the following members should be formed: provincial government, police force, city council, trade organization, health sector (i.e. KUMS). The committee has to set a comprehensive plan for the gradual termination of shisha delivery during 2–3 years. The plan should be built upon the following policies: • Centers without license to deliver shisha should be banned from delivery. • Trade organization should no longer issue any license for delivery of shisha. • Centers with a license should be limited to serving shisha with classic tobacco not fruit flavored ones.
49	April 2012	All centers with a license to deliver shisha have to display the poster showing the health warning of shisha smoking in a visible place. This poster will be provided by the health sector.
65	June 2014	To control the use of shisha in society the following measures should be taken: • No new license for shisha delivery should be issued by the trade organization. • The previously-issued licenses should not be extended. • A proposal on setting high tax on shisha service should be submitted to the SCHFS. • Police force should take more serious coercive measures in dealing with tobacco smuggling. • The media (TV, radio, local newsletters) should collaborate in educating public on the harmful effects of tobacco use in general and shisha smoking in particular. • Taking more coercive measures on centers serving shisha without license.
68	February 2015	To combat shisha smoking and its harmful effects on health the following measures should be seriously taken into account: • Banning shisha smoking in all teahouses and traditional restaurants irrespective of having license or not. • Improving public awareness through media of the serious negative health impacts of shisha smoking • Gathering and producing more scientific research evidence on the harmful impacts of shisha smoking on health

Table 3. Policy instruments proposed by the Kerman CHFS

Category	Proposed Policy Instruments
Regulations	Banning shisha serving in centers without license
	Not issuing new license for shisha delivery
	Not extending previously-issued licenses
	Licensed centers (until licenses expire) can offer unflavoured tobacco, but must immediately stop permitting use of flavoured tobacco
	Setting user tax on shisha smoking (separate from a general tobacco tax)
	Coercive measures to deal with tobacco smuggling
	Coercive measures on centers serving shisha without a license
Direct government actions	Producing more scientific evidence on the harmful impacts of shisha smoking on health
Advocacy	Improving public awareness of the health risks of shisha smoking through media
	Preparing posters displaying health warnings of shisha smoking and requiring shisha cafes to display them in a visible place

culturally and socially entrenched practices and norms in the country. Instead, they framed the problem as a 'negative environment image' and argued that shisha smoking in public places, especially in urban settings, creates a bad image among visitors and tourists and causes a social nuisance linked to the smell of tobacco flavours.

> "*. . .everywhere around the city, in parks, restaurants, teahouses, even inside cars, you can see a group of young people smoking shisha. These all develop negative images of the city to tourists and outsiders*". PB6

The anti-ban group, mostly members from the tobacco and entertainment industries, neither perceived shisha smoking as a public problem nor agreed with the proposed policy solution of enforcing the ban on shisha smoking in all public places. Despite widespread evidence, most members of this group did not believe in the health risks of shisha smoking, questioned the reliability of evidence, and perceived it as a relatively safe practice compared to other types of tobacco use.

> *"To me smoking shisha has no negative impacts on your health the way health authorities magnify it. The smoke travels through the water where the nicotine is absorbed, so no danger to health. . ."*. AB5

Members of this group displayed a strong belief in the core values of individual freedom and autonomy, disagreed with coercive measures, and considered a complete ban of shisha smoking as breaching individual liberty and rights. They argued that smoking shisha is a private matter and an issue of personal choice and responsibility, and that the state has no role to play in this. In contrast, some members of this Group (3 out of 7) believed that CHFS should

concentrate its efforts on the root causes of shisha smoking, including lack of youth entertainment, as well as the high rate of youth unemployment.

> *"How many cinemas, theatre venues, or museums are there in this city? Then you expect the young not to go to teahouses. What else can they do in their leisure time?"* AB3

Interestingly, members of the pro-ban group also viewed youth unemployment and lack of youth social entertainment as the root causes of shisha smoking.

In summary, the anti-ban group used two frames: 'social entertainment' and 'human rights'. This group did not view shisha smoking as an addictive practice but rather as an important source of social entertainment for Iranian youth. There was a commonly held belief among members of this group that banning shisha service at teahouses and other public places will result in the growth of underground shisha teahouses. The main policy advocated for by this group was to impose a user tax, increasing the price of shisha smoking, which was shared by five out of seven members. In these members' view, if the aim is to halt the growth of shisha smoking, then increasing the price best serves that purpose. This group tried to magnify the revenue that the government will earn by imposing a user tax on shisha smoking.

> "*...in all meetings they [anti-ban members] tried to magnify the huge costs like unemployment that implementing ban will pose on the government and instead the large benefits that setting taxes will bring*". PB16

Drivers of policy stasis

Our research revealed that the main players in the pro-ban group lobbied with top officials and influential figures (e.g. clerics, politicians) in the city of Kerman. In addition, they had private meetings with the provincial governor in 2014 and early 2015 to convince him of the serious health impacts of shisha smoking and to urge him to use executive power in order to enforce and implement the federal law of shisha smoking ban. Members of this group noted that they knew that the governor is the most influential and powerful member of CHFS. There were indirect references to the autocratic governance of CHFS characterized by a lack of participatory decision making and an imbalance of power distribution among CHFS members as the following quote indicates:

> *"...He [the provincial governor] makes the first and last decisions at the council; once he decides, others simply nod their heads in agreement with him"*. PB13

The governor was eventually convinced and in the February 2015 meeting of the CHFS announced the decision to enforce the federal ban on shisha smoking in all teahouses and traditional restaurants. This was a victory for the pro-ban group but did not last even a day. A member of the pro-ban group described how the governor felt uneasy about the decision.

> *"You could see fear in the eyes of the governor. Once he announced the decision, he looked at all attending members and sought their support by asking them if they will all back him with the decision."* PB3

Once the meeting ended, the health sector informed the media about the decision, including local newspapers. According to other pro-ban advocates this rapid announcement was a mistake; the day after the meeting, the CHFS Secretariat Office was contacted by the governor's office demanding a stop to the implementation of the policy. Secretariat Office staff found this action of the provincial government unprecedented and could not recall such a reaction since the CHFS's launch in 2006.

Our participants believed that one main reason behind this policy reversal was concern about the wider economic impact of enforcing the ban. They argued that shisha smoking is the main source of income for many families in the province, and that enforcing the ban would have significant negative economic consequences for involved families which would, in turn, lead to political pressure on the provincial government.

> *"...they [health sector] claim that there are at least 250 centers in this city [Kerman] that serve shisha. Let alone the large number of shops that sell shisha instruments. You can imagine the number of jobless people and the huge economic impact on many families"*. AB4

Participants described that in all CHFS meetings on shisha smoking, it was only the anti-ban members who highlighted the economic burden of implementing the ban. The pro-ban group admitted the economic dislocations due to the ban but they had a solution: supporting owners of teahouses and shops that serve shisha through subsidies and low-interest loans by the government to start a new legal business.

> "*...we know the provincial government offers many low-interest loans for different purposes; so, why not for this purpose*". PB

The pro-ban group also challenged the anti-ban group's arguments about economic hardships posed by the ban, by arguing that such hardships are common in smoking control efforts everywhere. Participants mentioned how the policy broker had employed economic evaluation concepts using evidence to convince others of the cost-effectiveness of implementing the ban. In response, the anti-ban group presented counterarguments on the efficiency of user tax intervention, without however providing empirical evidence.

> "*...when he [policy broker] presented the results of few studies in other countries showing that enforcing ban on cigarette smoking in public places had resulted in considerable lives saved and significant decrease in healthcare costs, Mr. X [an anti-ban member] quickly reacted that increasing user prices could bring the same or even better results"*. PB

Another reason participants gave for the policy reversal was the acceptability of shisha smoking as a social norm with a long tradition and culture in Iran. Participants, however, also believed that this social norm had changed in terms of user types and purpose of shisha smoking: in the past it was mostly used at special occasions, such as funerals, by the elderly. More recently, shisha smoking had increasingly become a common form of social entertainment amongst the youth. Pro-ban advocates suggested that a final reason for policy stasis might have been that the general public did not recognize shisha smoking as a problem and was not well informed about its health risks, and that efforts should be concentrated on educating the general public about such risks.

> *"...there are superstitious beliefs among the public that smoking shisha is safe. We have to educate our people. If they know of the health risks of this practice, they will then demand change"*. PB7

Discussion

In applying the ACF to the case of tobacco control policy in Kerman province, we could identify two competing groups within the

tobacco policy subsystem, one advocating and the other opposing enforcement of the federal law on shisha smoking in all public places. Although the pro-ban group outweighed the other group in terms of membership, it was unsuccessful in engendering (or at least sustaining) any policy change. Weible and Carter (2015) categorize the key explanations of policy change as: policy learning (Sabatier and Weible 2007) or collective learning (Heikkila and Gerlak 2013), influence of policy brokers (Mintrom and Norman 2009), diffusion of ideas (Berry and Berry 2014), and external events (Jenkins-Smith *et al.* 2014). In our case, we suggest that the main reasons for policy stasis include: lack of policy learning due to lack of agreement over evidence and related analytical conflicts between the two groups; the static distribution of resources between the two groups, including the inability of the pro-ban group to exploit opportunities in the external policy subsystem through generating stronger public support for enforcement of the shisha smoking ban; and the nature of the institutional setting, in particular the autocratic governance of CHFS which contributed to a lack of policy learning within the policy subsystem.

Policy-oriented learning, as defined by ACF, involves "relatively enduring alternations of thought or behavioural intentions that result from experience and/or new information and that are concerned with the attainment or revision of policy objectives" (Sabatier and Weible 2007). In our case, the pro-ban group utilized information, mostly through a policy broker, including scientific evidence on the harmful impacts of shisha smoking on health and cost-effectiveness of implementing a smoking ban. However, this evidence was contested and ignored by the anti-ban group and politicians alike; this is common in developing countries where policies are often not evidence based (Behague *et al.* 2009). For example, the evidence for the health impacts of shisha smoking, which is generally well accepted (e.g. Akl *et al.* 2010; Chaouachi 2009; El-Zaatari *et al.* 2015), was questioned by the anti-ban group, and the council surprisingly asked for the collection of more scientific evidence on the link between shisha smoking and health (see Table 2); although the council call for collection of more evince could be understood as seeking support to further legitimize its actions in the absence of public support. In previous research on tobacco control from an ACF perspective, acknowledgement of certain attributes of tobacco smoking has been found to be important factors for facilitating progressive tobacco legislation. In particular, an acknowledgement of its health hazards and its addictive properties have been singled out as important normative preconditions for successful anti-tobacco legislation (Breton *et al.* 2008).

We suggest that the strategic interactions and the analytical policy debates between the two competing groups did not result in any policy-oriented learning due to a lack of consensus over deep core and policy core beliefs. However, we acknowledge that deep core and policy core beliefs are very resistant to change in light of new information (Weiss 1977), while secondary beliefs are more susceptible to policy-oriented learning as they are narrow in scope and require less evidence to be changed (Sabatier and Weible 2007). The pro-ban group used four different frames/discourses based on its belief/value system which seemed to follow communitarian principles/values, such as prioritizing society/community over the individual, and assigning a more prominent role to the government rather than the market. The pro-ban group also held a set of causal assumptions about the link between shisha smoking and health. The main policy option advocated by this group was to enforce the state ban on shisha smoking in all public places. The anti-ban group, who seemed to follow libertarian principles/values privileging individual autonomy and freedom, felt aggrieved by the proposed policy and challenged the pro-ban group arguments by: 1) questioning the data/evidence related to the seriousness of the problem, 2) challenging the causal link between shisha smoking and health, and 3) highlighting the economic (job loss) and social (growth of underground shisha teahouses) consequences of implementing the ban. The anti-ban group proposed an alternative policy option, imposing a user tax, and tried to highlight the revenue this option would generate. This is a common strategy as smoke-free indoor regulations/policies, despite their positive public health impacts, have long been debated and contested by the powerful tobacco industry (Nguyen *et al.* 2013, Macdonald and Glantz 1997; Mowery *et al.* 2012). The anti-ban group also used the 'human rights' frame to defend the autonomy and liberty of smokers; the same arguments had emerged towards cigarette regulations and discourse from the tobacco industry (e.g. Dresler *et al.* 2012; Reubi 2012; Thomas and Gostin 2013). Both groups tried to win the analytical policy debate and convince key policy decision makers that their belief system and their preferred policy was the appropriate one. However, without any convergence in their belief systems, neither group in the debate felt compelled to modify its behaviour. Without a secondary belief consensus, i.e. agreement on specific policy instruments, interactions appeared to be employed more as a political tool than as a source of learning and persuasion (Heintz and Jenkins-Smith 1988; Jenkins-Smith 1988).

In addition, policy learning, according to some, only occurs over a long time with the gradual accumulation of information and personal experiences of coalition members (Sabatier and Jenkins-Smith 1999). Compared to external shocks/events that can lead to rapid policy change, policy learning may take ten years or more to generate consensus and lead to lasting policy change. The short period of argumentative engagement between the pro- and anti-ban groups could thus be considered a major limitation, contributing to the lack of policy learning. Policy learning is also restricted as individuals may face cognitive constraints as they either filter or avoid belief-conflicting information (Weible 2007). The widespread and deeply rooted practice of shisha smoking in Iranian culture represents such as cognitive constraint, contributing further to the lack of policy learning and has arguably functioned to undermine efforts to ban shisha smoking in Iran (Baheiraei *et al.* 2015; Ziaei *et al.* 2016). Another potential explanation for the lack of policy learning in our case could be that, as Sabatier and Weible (2007) note, for groups driven by material interest, such as the anti-ban group whose members generate a profit from tobacco related activities, self-interest is more important than policy core beliefs. Policy learning for these groups represents a strategic engagement to defend their material interests.

According to Kingdon (1995) skillful leaders or policy brokers, who act as coalition leaders, should be able to navigate a coalition towards policy change. A key aspect of success is whether or not policy brokers play a neutral role in mediating between competing coalitions and interests (Sarvašová *et al.* 2013). In our case, however, both the scientific institution (i.e. KUMS) and the policy broker were the main organizers of the pro-ban group and therefore could not play a neutral, mediating role between the two groups. Policy brokers are argued to help articulate a coherent belief system among coalition members (Weible 2007) which enables coalition members to share the same vision of a policy problem (Jenkins-Smith *et al.* 2014; Fleury *et al.* 2014; Sabatier 1988). In our case, however, there was no common vision of the problem shared by all pro-ban group members; instead four competing frames, promoted by different members, emerged within this group, which also explains why a proper coalition in the sense theorized by the ACF was

not formed. As such, in the absence of a shared single frame the pro-ban group could not easily enforce its policy vision, by promoting it throughout the entire policy subsystem. According to Goldstein *et al* (2010) framing tobacco control in a way that appeals to many actors within a coalition is a key to achieving policy change. Fischer (2015) also argues that coalition cohesiveness and its internal agreement play an important role in policy change.

Apart from the use of information and a policy broker, which both failed to trigger a policy change, the pro-ban group was unable to attract additional resources. We discuss here how the use of public opinion (or opinion polls) and mobilizable troops which occur outside the subsystem (i.e. external events that are essential for major policy change according to the ACF) could help the pro-ban group to achieve greater influence in the policy subsystem. This is especially important given the limited research in Iran (e.g. Janghorbani *et al.* 2004) showing that, despite shisha smoking's cultural embeddedness, there is a high level of public support for the cigarette smoking ban in public places. Janghorani *et al.* (2004) in a telephone survey on the implementation of cigarette smoking ban in restaurants with 897 participants in the city of Isfahan Iran found that 94.9% of participants supported a smoking ban in restaurants, with 60.9% of participants expecting to increase their restaurant use after a complete smoking ban. The pro-ban group could have conducted similar surveys to gauge public views on enforcing the shisha smoking ban in public places. Breton and colleagues (2008) note that one of the key reasons for the adoption of Quebec Tobacco Act (1998) was the results of population surveys that showed people were backing the anti-tobacco policy measures. Public opinion is a major resource for coalitions (Sabatier Paul and Weible Christopher 2007), and is agued to have been central to the diffusion and enforcement of anti-smoking legislation across the United States (Pacheco 2012). However, in our case the pro-ban group did not reach the public to raise their awareness of the consequences of shisha smoking on health, and the economic and social burden it imposes on society. The lack of public engagement failed to counterbalance the powerful organized interests within Kerman province which were opposed to the ban. The pro-ban group could have encouraged public supporters to participate in events/public demonstrations or to engage in letter-writing campaigns in order to help achieve its policy objectives as policy change often hinges on the mobilization of public supporters (Baumgartner and Jones 2010; Weible 2007). In addition, they could have reached other key stakeholders including owners of teahouses and traditional restaurants to reassure them of the benefits of smoke free places in terms of new customers. Such tactics are likely to change the power balance and mobilize resources and could facilitate policy change; but this would also require directly challenging the social acceptability of shisha smoking in Iran, which could take some time.

Other factors with the potential to condition a policy subsystem and to influence stability and strategies of coalitions include institutional setting and political opportunity structures (Meyer and Staggenborg 1996; Sabatier and Weible 2016; Zhan and Tang 2013), which we believe contributed significantly to policy stasis in our case. We suggest that the nature of governance arrangements at the CHFS, in particular the autocratic hierarchical structure of the decision-making process that reflects the dominant centralized decision making model at the state level, accompanied by the culture of deference to higher levels of authority, led to an imbalance of power among members of the CHFS, a lack of participatory decision-making, and a lack of interaction and dialogue among members of the two groups. Together, these institutional features likely contributed to a lack of policy learning within the policy subsystem.

In analyzing the passage of smoke-free policy across 13 counties in the State of Indiana from an ACF perspective, Mayers 2016 points to the importance of seeking support of all key political players, especially mayors who have the veto power over ordinances in those community, similar to the provincial governor in our case, and to educate them in favor of a smoke-free policy. He further notes that due to the high rate of smokers in Indiana (who are defensive about their addiction), which resembles the high rate of shisha smokers in our case (Kerman province), politicians avoid becoming champions of smoke-free policy and putting themselves in the line of fire as they are wary of smokers' outrage. Only politicians who "have no intention of running for office again and therefore have little to lose" have opted to be smoke-free champions (Myers 2016). This argument is important given that in our case the content of policy (see Table 2) seems to be grounded more on the prohibition to smokers instead of protection of non-smokers (e.g. by seeking coercive measures to ban shisha serving completely in all public places), despite in their interventions the pro-ban group used frames like 'human rights' in reference to protecting to protect non-smokers.

Another institutional failure that we contend contributed to policy stasis relates to the membership of CHFS's shisha smoking regulation forum. In all CHFS meetings, members from the tobacco industry were present, which is clearly a violation of the WHO Framework Convention on Tobacco Control (FCTC) Article 5.3 that asks for protection of tobacco control policies from industry interests (FCTC 2008). This is, however, a common problem in many countries (e.g. Balwicki *et al.* 2015). In Poland, for example, the tobacco industry unethically used three tactics to influence tobacco policies: expressing willingness to partake in the policy-making process, creating a positive attitude, and exerting pressure. The industry also overstated its contribution to the government revenues and economy, misrepresented the illicit cigarette problem, and misused the scientific evidence (Balwicki *et al.* 2015).

Study limitations

A possible limitation of our research relates to the timeframe employed to explore policy change. To understand policy processes and change, researchers who use the ACF are encouraged to adopt a long-term perspective of ten years or more (Sabatier and Weible 2014). Although the issue of shisha smoking first reached the agenda of Kerman CHFS in 2011, various national laws have been enacted in the country since 1997 but with no evidence of policy change. However, similar to other researchers (e.g. Fleury *et al.* 2014), we believe this framework is also useful to analyze short-term policy processes. Jenkins-Smith (1988), for example, argues that prospects of analytical debates and policy learning can be analysed in short frames as little as two to three months.

Conclusions

In this qualitative study, we used the ACF to investigate the reasons behind a failed advocacy intervention strategy in support of enforcing and implementing a shisha smoking ban in all public places in Kerman Province, Iran. The ACF provided a useful lens to help explain why, without adequately exploiting opportunities offered by external drivers to the policy subsystem, most importantly generating broader public for enforcing the Shisha ban, and without utilizing multiple potential coalition resources and venues, no major policy change can be expected. Our analysis further suggests that the nature of the governance arrangements of a policy subsystem

within which policy actors advocate for a specific solution impacts policy outcomes, with more equitable governance structures more likely to engender policy change.

Finally, we suggest some lessons that could be applied in future attempts to ban shisha smoking in public places. As a first step, the health hazards of shisha smoking need to be more widely and better understood within Middle Eastern societies. Agreement on the central attributes of a policy problem (i.e. problem definition) in a policy subsystem is a basic requirement for the formation of a successful advocacy coalition. This will require significant resources employed by the state through public awareness campaigns to change public perceptions of shisha smoking in Iran which is a deeply anchored cultural practice.

Ethical issues

The study received ethics certification from the Ethics Committee at Kerman University of Medical Sciences.

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