Although the United Arab Emirates (UAE) has managed to defeat many of the infectious diseases that still affect other parts of the region, obesity and associated non-communicable diseases (NCDs) remain a major issue. Like its fellow members of the Gulf Co-operation Council (GCC), the UAE hovers near the top of global obesity charts. According to the Global status report on noncommunicable diseases 2014 by the World Health Organisation (WHO), obesity prevalence (age-standardised adjusted) reached more than 37% in the UAE in 2014, the third-highest rate in the Middle East region (see Table 1) and well above the European average of around 20%. Particularly worrying is the high share of obese women in the UAE—and in other GCC states, for that matter—which reached 45% in 2014.¹

<table>
<thead>
<tr>
<th>Both sexes</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qatar</td>
<td>42.3</td>
<td>40</td>
</tr>
<tr>
<td>Kuwait</td>
<td>39.7</td>
<td>35.5</td>
</tr>
<tr>
<td>UAE</td>
<td>37.2</td>
<td>33.8</td>
</tr>
<tr>
<td>Bahrain</td>
<td>35.1</td>
<td>30.5</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>34.7</td>
<td>29.9</td>
</tr>
<tr>
<td>Lebanon</td>
<td>31.9</td>
<td>26.3</td>
</tr>
<tr>
<td>Oman</td>
<td>30.9</td>
<td>27.2</td>
</tr>
<tr>
<td>Jordan</td>
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<tr>
<td>Egypt</td>
<td>28.9</td>
<td>20.3</td>
</tr>
<tr>
<td>Iran</td>
<td>26.1</td>
<td>20.1</td>
</tr>
<tr>
<td>Iraq</td>
<td>23.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Syria</td>
<td>23.5</td>
<td>17.4</td>
</tr>
<tr>
<td>Yemen</td>
<td>17.2</td>
<td>11.1</td>
</tr>
</tbody>
</table>

Notes: Obesity is defined as a body mass index (BMI) of ≥30. Age-standardised adjusted estimates for population aged 18+. For the purpose of this report, data for Cyprus, Israel, Palestine and Turkey are not included.


Meanwhile, with nearly one-third of the population below the age of 15, growing rates of childhood obesity present a looming threat to the UAE’s health budget and the wider economy. Some 18% of boys aged 13-15 and just under 12% of girls in that age group were found to be obese in a 2010 global school-based health survey, according to the WHO.² The percentage of students who were overweight increased to 38.4% in 2010, from 21.5% in 2005, despite the fact that reported levels of physical activity rose in the same period.³
CONFRONTING OBESITY IN THE UAE
WORKING TOWARDS A MULTIDISCIPLINARY APPROACH

COMPLEX CAUSALITIES

The causes for the significant rise in obesity in the UAE are complex. Like many of its Gulf neighbours, the UAE has undergone a remarkable transition over the past 50 years, from a largely rural, agricultural lifestyle based on a Mediterranean diet to a society dominated by modern, hi-tech cities and dramatically increased standards of living for the native population.

As part of this evolution, lifestyles have become more sedentary, aided by the low cost of domestic help and increased dependence on cars, at the same time as diets have become less healthy owing to a prevalence of fast foods high in fat, sugar and carbohydrates. “One significant issue is that obesity in the US is a disease of the poor, while in the Middle East it is a disease of the rich,” says Abdishakur Abdulle, associate director of the Public Health Research Centre at New York University’s Abu Dhabi campus.

As in neighbouring countries, the UAE’s obesity problem is exacerbated by a number of region-specific factors, experts say, including an underdeveloped primary-care sector, a lack of data on the most useful evidence-based approaches to obesity in the region, and an inability among the general population to recognise obesity as a disease in its own right. According to Dr Abdulle, this is particularly true in the case of childhood obesity, with 63.5% of parents of overweight/obese children in one study failing to identify their child as overweight/obese.

It is this lack of awareness of the biological underpinnings of the condition that is preventing a more comprehensive and integrated approach to treating it, notes Nadia Ahmad, an internal medicine and obesity specialist and director of the Obesity Medicine Institute in Dubai.

RISING COSTS

The economic costs of obesity in the UAE are already significant, highlighting the need for effective policy action. In early 2015 the McKinsey Global Institute estimated the annual economic burden of obesity in the UAE at Dh22bn (US$6bn), or 1.6% of GDP.

Against this background of rising childhood obesity, the costs are set to increase further. The signs of a crisis are already there, especially in light of the growth of chronic diseases such as diabetes and hypertension, which have been linked to obesity. According to the International Diabetes Foundation, the UAE has one of the highest comparative prevalence rates of diabetes in adults in

3 Ibid., p. 8
the world (19% in 2014), well above the already high average (by global standards) for the Middle East and North Africa (MENA) region (11.3%).

THE FOCUS IS INCREASINGLY ON PREVENTION

The UAE is nonetheless aiming to take a leading role among the GCC states in trying to confront the epidemic, says Dr Abdulle. “It is one of the key national agendas recognised by health authorities and health-delivery services. There are enormous efforts being made to reduce obesity, but to have an effect on the population level will take a considerable amount of time.”

Given the relatively recent recognition of the threat posed by high obesity rates, and particularly childhood obesity, policymakers in the UAE have focused on prevention and awareness programmes. For example, Abu Dhabi’s Weqaya programme has helped to boost screening for various cardiovascular disease risk factors, such as a high body mass index (BMI).

The key strategic priorities the WHO has identified for the UAE as part of its co-operation agenda and development of the health sector in 2012-17 include strengthening and harmonising the governance of the health sector through the streamlining of strategies, norms, standards and regulations; strengthening primary healthcare and referral systems, including for the provision of care for NCDs; strengthening NCD prevention and control programmes; and collaborating on health-promoting schools and adolescent health.

UNICEF has developed a series of programmes to combat childhood obesity in collaboration with government-related partners such as the Princess Haya Initiative for the Development of Health, Physical Education and School Sports; the government of Dubai’s Knowledge and Human Development Authority; and private-sector sponsors such as Fitness First and Virgin Megastores. The first of these programmes—the three-month awareness-raising Fat Truth Campaign—used a number of media education campaigns to reach both UAE nationals and expatriates.

In 2010 the Ministry of Education passed a law banning the sale of unhealthy food items, including sugary drinks, in school canteens, and made health education sessions a mandatory part of the new school curriculum. The follow-up Child Obesity Prevention Project, implemented in eight schools in the UAE in 2011-12, aimed to teach students, school staff and parents how to adopt a healthy lifestyle. A wider sugar tax has also been mooted in recent years.


6 IDF, IDF Members – Middle East and North Africa. Available at: http://www.idf.org/membership/mena/

7 Health Authority Abu Dhabi, Weqaya, October 2011. Available at: http://www.who.int/tobacco/mhealth/weqaya.pdf

8 WHO, Country Co-operation Strategy, p. 19
THE NEED FOR A MORE CO-ORDINATED, STRATEGIC APPROACH

There is a move towards public-health preventive strategies, including raising awareness of the importance of a healthy lifestyle and providing the kind of environment and infrastructure that supports healthy living in most communities. However, as in most countries in the world, UAE policymakers tend to conflate prevention and treatment, Dr Ahmad says. “It is so important to understand that obesity is a disease with an underlying biology, and for those already suffering from it, it is too late for primary prevention—they need treatment. We need to have parallel tracks for prevention and treatment if we are going to get this epidemic under control.”

UAE nationals, who make up between 10% and 15% of the population, have access to lifestyle, medical and surgical interventions; dieticians are increasingly popular (to the extent that some have mini-celebrity status); and the fitness trend is growing in popularity. There are fewer data available about the country’s foreign population, which includes guest workers from parts of Asia and expatriates from the US, Europe and other parts of the Middle East, most of whom use private health providers. However, Dr Ahmad says that she sees Egyptians, Jordanians, Lebanese, South Asians, Europeans and Americans among the patients at her clinic and observes that she is witnessing severe obesity in “many of those patients”.

Yet each of the preventive and treatment options is only likely to work on a small section of the obese population, Dr Ahmad notes, adding that even in the case of bariatric surgery “some people lose 100% of their excess weight and some lose 30%”. Both she and Dr Abdulle emphasise that better data would help to offer more targeted treatments to individual patients, and that conducting national surveys, as in the UK and the US, would enable the governments of the UAE and other countries in the region to measure the impact of interventions.

Surgical options are comparatively popular in the UAE among both adults and increasingly also children. In Abu Dhabi, where health authority statistics have shown that nearly 30% of school children are overweight or obese, bariatric surgery has been performed on teenagers as young as 13. However, since awareness of the obesity problem is relatively recent, surgical interventions have yet to be considered as part of a more co-ordinated, strategic approach to treating obesity in the UAE.

In particular, although international guidelines generally recommend the use of surgery for patients with a BMI of more than 35 and type 2 diabetes, the impact of these recommendations has yet to be seen in the UAE, Dr Ahmad says. “Bariatric surgery is still not understood by parents.”

many providers, and certainly not by most patients, as a metabolic procedure. However, the application of surgery in the treatment of diabetes should help to change that.”

Bariatric surgery, like other interventions, is more tightly regulated and standardised within the government health sector, which covers the vast majority of the UAE’s indigenous population, according to Dr Ahmad. Yet those who can afford to do so, and much of the large foreign population, use private providers, who are far less tightly controlled. “We should acknowledge that the standardisation is not there and is needed, and there should be emphasis on evidence-based medicine,” Dr Ahmad says.

She adds that the private surgical practice remains extremely competitive, and that there is little consistency in determining patient eligibility or in surgical follow-up. “These are good surgeons, but they have to be given the infrastructure,” she says. Although the Dubai Health Authority has recently introduced new guidelines for bariatric surgery, “a lot needs to be done to provide training and provide integrated, multidisciplinary care”.

The UAE is already making progress in developing a strong primary-care sector, which provides an invaluable opportunity to incorporate prevention and obesity care as part of primary care, according to Dr Ahmad. Ultimately, the creation of a more integrated approach to obesity is likely to involve further development of the country’s primary-care system to reflect this approach, she adds.

The health system could also look at other countries that have developed innovative approaches to diagnosing obesity and standardising medical intervention. In the Netherlands, for example, the Partnership Overweight Netherlands (PON) has developed a chronic disease-management model for children and adults with obesity, including strategies for detecting and diagnosing the condition in high-risk individuals and offering integrated lifestyle interventions, including additional medical therapies.11

CONCLUSION

The UAE’s high levels of obesity and chronic disease highlight a broader regional problem, but the government’s leadership role in recent years could provide a model for its GCC neighbours.

At the same time, the UAE suffers from the same lack of data on the efficacy of current approaches as most of the rest of the region. In addition, it needs to strengthen the regulatory

10 American Diabetes Association, “Obesity Management for the Treatment of Type 2 Diabetes”, Diabetes Care, 2016 Jan; 39(Supplement 1): S47-S51. Available at: http://care.diabetesjournals.org/content/39/Supplement_1/S47
environment to create more standardised approaches to obesity care, including rules around the selection and post-operative treatment of patients undergoing metabolic surgery.

Finally, policymakers in the UAE have yet to adopt the multidisciplinary approach to treating obese patients that is increasingly gaining traction in the US and in some parts of Europe, such as the Netherlands. Making this transition will require health providers and society as a whole to accept the multifaceted causes of obesity.

11 EIU, Confronting obesity in the Netherlands: Taking action to change the default setting, February 2016. Available at: https://www.eiuperspectives.economist.com/healthcare/castudy/confrontingobesity-netherlands