

Compliance with Tobacco Control Law in Hospitals of Nicosia: An Observational Study

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Abstract

BACKGROUND/AIMS: Smoking is a global health issue causing millions of deaths each year. The World Health Organisation created the Framework Convention of Tobacco Control and launched the MPOWER initiative in 2008 to reduce this death burden. Studies conducted in developed countries show that strict tobacco control laws help reduce tobacco use. In the Turkish Republic of Northern Cyprus (TRNC), studies show a high prevalence of tobacco use, but there are no reports on the implementation of laws and adherence to them. This research aims to evaluate compliance with the tobacco control law in three hospitals in Northern Cyprus.

MATERIALS AND METHODS: This observational study was conducted in August 2025. Observers used a data collection form to assess compliance. SPSS version 31.0 (IBM Inc., Armonk, NY, USA) was used for data analysis.

RESULTS: A total of 113 departments were observed across three hospitals. Indoor no smoking compliance was high, whereas overall compliance with “no smoking” signs was low (37.4%). The highest compliance was found in the state hospital, particularly in signage placement, while private hospitals showed gaps, such as insufficient outdoor signage and the presence of smoking facilities. No enforcement officers or cessation resources were observed. Staff smoking was observed in all hospitals. A significant difference in compliance between the state hospital and the private hospitals was observed, with the state hospital having better compliance (p-value <0.001).

CONCLUSION: Compliance with the Northern Cyprus tobacco control law varied by hospital type. Major shortcomings were found in signage, enforcement, and cessation support. No hospital had trained personnel to handle violations, and hospital staff were observed smoking.

Keywords: Tobacco control law, smoke-free policy, hospital compliance, enforcement, Northern Cyprus, TRNC

To cite this article: Aşut Ö, Acar Vaizoğlu S, Çalı Ş, Ahmed Elamin AE, Ebied M, Abdullaiev E, et al. Compliance with tobacco control law in hospitals of Nicosia: an observational study. Cyprus J Med Sci. 2026;11(5):401-408

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Received: 12.02.2026

Accepted: 03.08.2026

Publication Date: 16.10.2026



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INTRODUCTION

The World Health Organisation (WHO) created the Framework Convention of Tobacco Control (FCTC) and established the MPOWER initiative in 2008.¹ This was due to the high death burden caused by smoking, which accounted for over eight million deaths annually.²

These initiatives have encouraged many countries to develop stronger tobacco control legislation; currently, 6 billion people (61% of the global population) are covered by at least one tobacco control measure aimed at reducing tobacco use. This shows a notable progress when compared to 2007, where only 1 billion (15%) had similar protection.³

Smoking rates in many developed countries have fallen sharply in the last 3 decades. In the United States, prevalence dropped from 25.3% in 1990 to 19.8% in 2022,^{4,5} while in the European Union, prevalence decreased from 32% in 2006 to 18.4% in 2022.^{6,7} This decrease is mainly due 2009 Family Smoking Prevention and Tobacco Control Act and Directive 2014/40/EU.^{8,9} However, evidence depicts that legislation alone is not sufficient; real progress depends on consistent enforcement, active monitoring, and institutional involvement.^{10,11}

A comprehensive set of smoking-control policies has been reviewed in the United States and other countries and has been shown to be effective in preventing smoking. Integrated policies, particularly strong smoking restrictions, cigarette taxation, and clean air laws, may reduce the prevalence of tobacco consumption.¹²

Real-world implementation of tobacco laws in smoke-free places, such as hospitals, can be challenging. For example, in Türkiye, Armenia, and Australia, concerns such as staff smoking on duty, insufficient signage placement, lack of outdoor enforcement, and limited cessation support materials were observed.¹³⁻¹⁵ However, Amsterdam and Catalonia showed the opposite, where enforcement was consistent and combined with active communication and cessation support.^{16,17} A report in Spain indicated that patients viewed smoke-free compliance in hospitals to be high, highlighting the need for hospitals to maintain the expected level of compliance.¹⁸

Regionally, data show unfavorable findings on smoking prevalence in healthcare settings. A study based at Nicosia General Hospital in Cyprus showed a high prevalence of smokers in the hospital (28.2%), slightly higher than the general population prevalence in Southern Cyprus.¹⁹ Greece demonstrated even poorer performance in this regard. Smoking practices among medical professionals and nursing staff in a university hospital in Greece indicated a concerning smoking prevalence of 57.8% among nurses and 34.5% among physicians, according to research conducted in 2009.²⁰

In Northern Cyprus, evidence is limited, but available studies are alarming. Two surveys of healthcare professionals in a military hospital and medical students have shown smoking prevalence of 53.4% and 33.7%, respectively.^{21,22} Another study that assessed medical students from four faculties in Türkiye and Northern Cyprus reported that 19.9% were current smokers and showed high passive smoke exposure, and poor enforcement of bans.²³ A cross-sectional survey of visitors to a primary healthcare center in Nicosia showed that 40.7% of the participants were smokers. Notably, 64% of respondents in this survey found local tobacco control efforts to be lacking.²⁴

The Turkish Republic of Northern Cyprus (TRNC) enacted its first comprehensive tobacco control legislation in 2008, banning smoking in indoor public places, restricting marketing and sales, and mandating health warnings on packages, and "no smoking" signs.²⁵

Although the 2008 legislation complies with several of the WHO FCTC's most significant requirements, implementation and enforcement of the legislation in the TRNC are commonly underreported. In the Eastern Mediterranean, the WHO states that most countries have smoke-free laws, but they are being enforced and implemented poorly.²⁶⁻²⁸

Findings from similar studies in other regions point towards weak compliance: a study at a Bangladeshi university found weak compliance with tobacco control legislation, as indicated by weak signages and weak anti-tobacco messages.²⁹ In addition, findings from observations in Delhi government hospitals showed a composite rate of only 45%, in addition to the existence of active smoking and tobacco shops on or within hospital grounds.³⁰

To our knowledge, no studies have been conducted to evaluate tobacco control compliance in hospitals in the TRNC. This is an important gap in the literature, particularly given the elevated rates of smoking prevalence identified among healthcare workers, students and the general population.²¹⁻²⁴ As no published compliance data are available, the present study attempted to establish compliance with smoke-free policies in private, university, and state hospitals in Northern Cyprus through systematic on-site surveys using a standardized checklist, thus providing an objective measure of actual compliance.

Objective

The general objective of our study is to observe and assess adherence to the TRNC tobacco control law in 3 hospital settings and to determine whether compliance differs within the same hospital or across hospitals.

Specific Aims:

1. Assess compliance within different departments.
2. Identify any violations of the law within different individual department service areas (e.g., patient ward, polyclinic, waiting rooms, and dining areas)
3. Evaluate compliance in shared service areas (e.g., dining areas and outdoor areas)
4. Assess hospital-specific checks, such as smoking signage, staff smoking, tobacco sales, staff trained to handle violations, and availability of smoking cessation resources.

MATERIALS AND METHODS

The study was conducted in three hospitals in Nicosia, Northern Cyprus. These hospitals include a state hospital, a university-affiliated private hospital, and a private non-university hospital. Field observations were done between the 6th and 12th of August 2025. A pre-test was performed on the 5th of August 2025 in a hospital other than the study hospitals.

This descriptive, observational study aimed to assess the hospitals' compliance in Nicosia, TRNC, with the Tobacco Control Law of Northern Cyprus. This study employed a data collection form developed by the researchers following a literature review.³¹

Observation Strategy

The observers were trained adequately before data collection to avoid inconsistencies. They served only as data collectors for research purposes and did not have any legal or administrative authority to enforce tobacco control laws or to intervene when violations were observed.

The observer team consisted of eleven medical students; no inspectors were appointed by the public health authority, nor were any participants from the general public included. All observations were performed directly by the trained observer team using a standardized checklist.

Observers were divided according to the number of departments in each hospital, and then gathered data using a checklist for their compliance assessment. Their observations were made during daytime hours, and their recorded data were based on observations during one week.

The departments covered were general medicine, surgical, obstetric, and laboratory units. All of their related subspecialties were also evaluated. Administrative units, pharmacies, and dental clinics were also covered.

The assessment aimed to evaluate the presence and visibility of “no smoking” signage, including whether the signs displayed only the smoking prohibition or included information on financial penalties. The assessment covered all tobacco products regulated under the TRNC tobacco control law, including electronic cigarettes and heated tobacco products. Advertisements or sales of tobacco products, staff adherence to the smoke-free law, and compliance in general areas, such as outdoor areas and around hospital entrances, were also assessed. Visual estimation was the accepted method for determining tobacco sales within 100 meters of the hospitals.

Study Variables

The dependent variable is compliance with the tobacco control law in hospitals, measured by indicators such as the presence or absence of “no smoking” signage in wards, waiting and dining areas, and staff behaviours.

Independent variables included hospital category (public, private, or university), facility type, department type, administrative measures such as trained personnel for violations, and tobacco sales.

Data Collection Form (Appendix 1)

The data collection form was divided into 4 sections: compliance in specific service locations inside the hospital (section 1), compliance in service areas outdoors (section 2), compliance in general areas (section 3), and compliance with hospital-specific checks (section 4). Sections had 34 items in total, and were answered using a “yes or no” format.

Section 1 consisted of items assessing specific service areas, including wards, polyclinics, waiting areas and dining areas for the presence of “no smoking” signs and whether active smoking is observed (none, one person smoking, or multiple smoking).

Section 2 had assessment items regarding the general service areas, including cafeterias and outdoor areas (open and semi-open spaces) with the goal of observing the presence of selling cigarettes to minors, “no sales to minors” sign, and if a signage was positioned within an eight-meter boundary from the openings and entrances.

Section 3 assesses compliance in general areas by checking if any smoking litter and ashtrays were noticed, “no smoking” signs were correctly placed, and whether or not designated smoking areas or tobacco sales were present.

Section 4 monitored specific hospital checks, ensuring that the smoking ban covered hospital gates, departments, wards, and waiting areas. Staff compliance with tobacco-use restrictions and the presence of security personnel to handle violations were observed. The presence of tobacco sales within 100 meters of hospital boundaries and the availability of smoking cessation resources, such as pamphlets, were also inspected. Visual estimation was the accepted method for determining tobacco sales within 100 meters of the hospitals.

Pre-Test

The pretest was conducted on 5 August 2025 at three hospitals, which were not included in the main study. Eleven forms were completed at these three hospitals to test the clarity and practicality. According to the pre-test, no revisions were needed in the data collection form.

Ethical Considerations

The study is based on observations and no humans were involved in the study. Thus, it was concluded that is ethical approval was not required.

Researchers

This research was conducted by eleven sixth-year medical students and three academic members of the Near East University faculty of medicine department of public health.

Data Analysis

The statistical analysis was performed using IBM SPSS version 31.0 (IBM Inc., Armonk, NY, USA) was used for data analysis. Descriptive statistics (frequencies, percentages) were generated. Comparative analyses between hospital categories (state, university-private, and non-university-private) and service areas were conducted using chi-square tests. The standard alpha level ($\alpha = 0.05$) was accepted as the threshold for statistical significance. A p-value < 0.05 was considered statistically significant. Hospitals were also grouped to compare the state hospital with the other two private hospitals.

TRNC Tobacco Control Law (Compliance Conditions)

The TRNC Tobacco Control Law sets out the requirements for compliance.

Purpose and scope: The purpose of this law is to protect individuals, including children and youth, from the harmful effects of tobacco products. The law regulates the production, importation, sale, advertising, and use of tobacco products in the TRNC. The law applies to all public and private spaces within the TRNC.

Packaging and warning labels: Tobacco product packaging must include health warnings and product content information. The packages' visible sides must display warnings such as “smoking kills” and indicate the levels of tar, nicotine, and carbon monoxide.

Smoking bans and designated areas: Smoking is banned in the indoor areas of all public buildings, educational and healthcare institutions, public vehicles, cafes, and restaurants. Exceptions are made for designated smoking areas in certain places such as prisons, care homes, and certain bars. These areas should be well-ventilated

and inaccessible to minors. Such smoking areas must not exceed 50% of the total area.

Sales restrictions: Selling tobacco products to individuals under the age of 18 is prohibited. Identity verification is mandatory. Sales through vending machines are banned. The production and sales of products that resemble tobacco, such as candy and toys, are also prohibited. Furthermore, sales locations must be arranged out of children's reach.

Advertising, promotion, and sponsorship ban: All forms of direct and indirect tobacco advertising, promotions, and sponsorships are banned. Companies or organizations cannot sponsor any event that uses tobacco brand names or symbols.

Enforcement and penalties: Inspectors appointed by the Ministry of Health are authorized to supervise the implementation. They may issue administrative fines and stop unlawful practices. Penalties are calculated as multiples of the minimum wage and may include imprisonment for repeated violations.

Education and awareness: Television and radio stations are required to broadcast at least 90 minutes of public health programming per month to raise awareness about tobacco use. Warning signs must be clearly displayed in all areas where smoking is prohibited.

RESULTS

One hundred and thirteen data points were designated across the three hospital categories. The study encompassed a variety of hospital sections to ensure sufficient data collection. Table 1 shows the distribution of the hospitals as state, non-university private, and private university, and also the distribution of the departments according to medical disciplines.

According to the analysis, the state hospital constituted the largest share of observed facilities (39.8%, n=45). It is closely followed by the university private hospital (35.4%, n=40). The non-university private hospital accounted for the smallest proportion (24.8%, n=28).

The internal medicine departments were identified as the primary sites for data collection, as over half of the observations (54.9%, n=62) occurred in this group. Surgical departments accounted for 28.3% (n=32) of the total observations, while laboratories accounted for only 8.8% (n=10). Other departments, including administrative units,

audiology, pharmacy, nutrition and dietetics, and oral and dental clinics, accounted for a small proportion (8%, n=9).

Table 2 shows the status of compliance with control measures at specific service locations within the hospitals.

Table 2 outlines observations in different hospital areas concerning indoor smoking and the presence of no smoking signage. Very high compliance with the no smoking policy was observed in all service areas of the hospitals. Dining rooms had the highest compliance (96.5%, n=109); waiting rooms had the lowest (92.7%, n=102). One-person smoking was reported in all locations, most commonly in waiting rooms (6.4%, n=7). Higher use was not observed, except in waiting and dining rooms (0.9%, n=1 each). Most locations did not have clearly visible no smoking signs, with dining rooms showing the worst compliance: only 31.9% (n=36) had relevant signs. Overall, 37.4% of these areas had "no smoking" signage.

Table 3 displays tobacco-control compliance in hospital canteens, outdoor areas, and common areas.

Table 3 presents the evaluation of compliance across three hospitals in Nicosia: a non-university private hospital, a university private hospital, and a state hospital. The table is organized into three domains: service area and outdoor compliance, general area compliance, and hospital-specific checks.

The state hospital showed high compliance by correctly placing "no smoking" signage within 8 meters of enclosed, unenclosed, and outdoor areas. The university's private hospital failed to display "no smoking" signage, reflecting low overall compliance. The non-university private hospital complied with signage placement near enclosed areas, but failed to display signage in unenclosed and general outdoor areas. None of the hospitals had "no sales to minors" signage, and only the university's private hospital lacked an enforced ban on tobacco sales in the hospital canteen.

The state and university private hospitals showed strong compliance across general areas. Both displayed legally sized "no smoking" signs at all entrances. Tobacco sales were prohibited, and no evidence of smoking or designated smoking areas was found in the state and non-university private hospitals. The university hospital allowed tobacco sales at several points on campus.

Although the non-university private hospital had no evidence of tobacco sales or advertising, it maintained a designated smoking area, failed to display signage at all entrances, and its signage did not meet legal size requirements, which constitutes a clear violation of policy.

All three hospitals lacked an enforcement sign identifying the personnel responsible for any violations.

Compliance with the hospital-specific checks was variable. A ban on smoking inside facilities was upheld across all hospital types. The state and university private hospital constantly displays "no smoking zone" signage at all hospital gates and throughout the campus.

Key limitations were noted in the enforcement of the law. Neither hospital had trained security to handle violations. Likewise, all hospitals lacked smoking cessation resources, anti-smoking pamphlets, a cessation helpline, and counselling services. Smoking among hospital staff was also a common issue across all three hospitals.

Table 1. Distribution of hospitals and departments (Nicosia, August 2025) n=113

Departments per hospital (n=113)	n	%
State	45	39.8
Private university	40	35.4
Non-university private	28	24.8
Distribution of the departments as to medical disciplines (n=113)		
Internal medical departments	62	54.9
Surgical departments	32	28.3
Laboratories	10	8.8
Others*	9	8.0
*Others include administrative units, audiology, pharmacy, nutrition and dietetics, and oral and dental clinics.		

Table 2. Compliance in service locations within the hospitals in regard to indoor smokers and no smoking signage (Nicosia, August 2025) n=113

Location	No smoker observed		One smoker observed		More than one smoker observed		“No smoking” signage exists	
	n	%	n	%	n	%	Yes	
Patient wards (n=108)	104	96.3	4	3.7	0	0	44	40.7
Polyclinic (n=108)	104	96.3	4	3.7	0	0	43	39.8
Waiting room (n=110)	102	92.7	7	6.4	1	0.9	41	37.3
Dining room (n=113)	109	96.5	3	2.7	1	0.9	36	31.9

Table 3. Compliance in canteens, outdoors, and general common areas (Nicosia, August 2025) n=3

Feature	Hospital		State		University private		Non-university private		Score	
			Yes	No	Yes	No	Yes	No	Y	N
Compliance in service areas and outdoors										
No tobacco sales in the hospital canteen			+			+	+		1	-
No sales to minors within the canteen			+			+	+		1	-
“No sales to minors” signage within the canteen				+		+		+	1	-
“No smoking” sign within 8 meters of enclosed areas			+			+	+		1	-
“No smoking outdoors” signage			+			+		+	1	-
“No smoking” sign within 8 meters from open unenclosed areas			+			+		+	1	-
“No smoking” signage outdoors			+		+		+		1	-
General area compliance										
Prohibited ash cans or ashtrays				+	+			+	1	-
Enforcement signage (responsible person displayed)				+		+		+	1	
“No smoking” signage at all entrances			+		+			+	1	-
Signage meets legal size			+		+			+	1	-
No evidence of smoking			+		+		+		1	-
No “designated smoking area”			+		+			+	1	-
No tobacco sales within the hospital premises			+			+	+		1	-
No advertisement of tobacco			+		+		+		1	-
Awareness materials displayed				+		+		+	1	-
Hospital-specific checks										
“No smoking zone” signage at all gates and entrances			+		+			+	1	-
No smoking inside hospital facilities*			+		+		+		1	-
No smoking by hospital staff				+		+		+	1	-
Trained security to handle violations				+		+		+	1	-
No tobacco sales within 100 meters			+			+		+	1	-
No street sales			+		+		+		1	-
Smoking cessation resources				+		+		+	1	-
Anti-smoking pamphlets				+		+		+	1	-
Smoking cessation helpline				+		+		+	1	-
Counselling services				+		+		+	1	-
Total score and %**			16	61.5%	10	38.5%	9	34.6%	26 (100)	

*Wards, outpatient clinic, waiting areas, intensive care unit, etc, **Row percentages.

Regarding boundary control, the state hospital was fully enforcing the ban on tobacco sales within 100 meters of the premises, while neither the university-affiliated private hospital nor the non-university private hospital was enforcing the rule. Furthermore, all hospitals complied with the prohibition on street sales outside their premises.

Moreover, a scoring system was used to evaluate the level of compliance among the three hospitals; a total of 26 compliance measures were assessed. Each hospital is awarded one point of adherence, “yes,” and zero for non-adherence, “no”. The state hospital demonstrated the highest level of compliance, achieving 16/26 points (61.5%). The state hospital demonstrates a moderate level of enforcement of tobacco

control measures. On the other hand, the university private hospital scored 10/26 points (38.5%), while the non-university private hospital scored 9/26 (34.6%), both demonstrating lower compliance.

The results shown in Table 2 demonstrate that the state hospital had the highest overall compliance, especially in signage and perimeter control. The university's private hospital met most indoor requirements, but lacked outdoor signage and permitted tobacco sales inside. The non-university private hospital demonstrated the lowest level of compliance, most notably in signage and policy enforcement. The absence of enforcement personnel and of cessation support services, together with staff smoking on duty, are major limitations.

No smoking signage was significantly more common in the state hospital compared to the two private hospitals across all areas: patient wards 80.0% (n=36) vs. 12.7% (n=8), polyclinics 95.6% (n=43) vs. 0, waiting rooms 91.1% (n=41) vs. 0, and dining rooms 77.8% (n=35) vs. 1.5% (n=1). The state hospital demonstrated markedly higher compliance, and the differences were statistically significant, as shown in Table 4 and Figure 1.

Compliance with the requirement for “no smoking zone” signage at all entrances was significantly higher in the state hospital, 77.8% than in the 2 private hospitals, 44.1% ($p<0.001$). Overall, 57.5% (n=65) of all entrances had “no smoking zone” signage (Table 5).

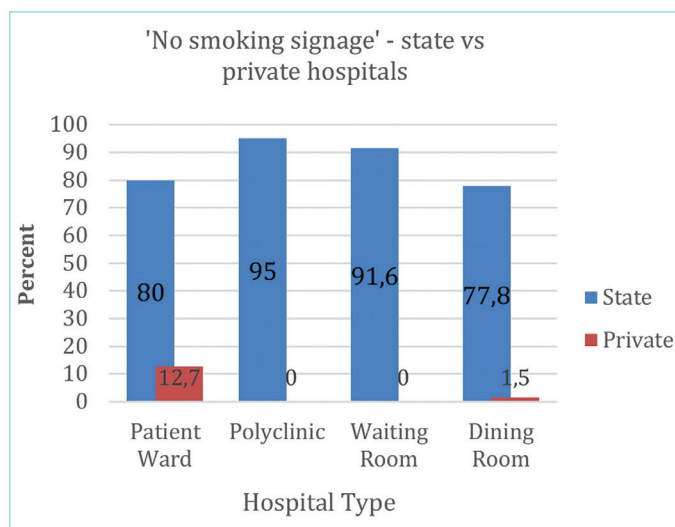


Figure 1. Presence of “no smoking” signage in the state hospital versus the two private hospitals, by area.

DISCUSSION

Research focusing on compliance with tobacco control in the TRNC is limited. This study is the first to evaluate compliance levels among hospitals in the TRNC. Global evidence shows that the implementation of indoor tobacco control policies results in a decline in violations, even in settings with weak enforcement as shown in the study from Spain.¹⁸ This matches the findings of our study, as compliance within indoor hospital areas exceeded 92%, which may explain why active smoking was rarely observed there.

The results of our study indicated inadequate “no smoking” signage in general areas, outdoor spaces, and departments, with only 37% of departments meeting the standard. Public hospitals demonstrated more consistent compliance than private hospitals, which lacked proper signage. This may be due to stronger regulatory oversight of public hospitals by the government. More research is needed to provide stronger evidence for this relationship.

Supporting this, a study in Delhi found higher compliance in tertiary hospitals that are under stronger government control.³⁰

The study found that tobacco sales occurred within 100 meters of private hospitals, while no sales were observed near the state hospital. Similarly, tobacco sales near healthcare facilities were observed in countries such as Türkiye, Armenia, and Bangladesh.^{13,14,29}

All three hospitals lacked enforcement mechanisms and cessation support. For example, none of the hospitals had trained personnel or signage indicating the personnel responsible for handling violations. No cessation support was available, in contrast to Catalonia and Amsterdam. In these regions, cessation support services lead to smoke-free policy implementation, higher compliance, and better health outcomes.^{16,17}

However, Australia showed that even with the presence of cessation support, there can still be low compliance.¹⁵ These findings indicate that cessation support services alone are insufficient and must be combined with the active enforcement of other aspects of tobacco control to be effective.

Smoking was observed among staff in all hospitals, raising concerns about the validity of enforcement and the role-model image of healthcare workers. Studies in the Eastern Mediterranean region and Cyprus showed that smoking ranged from 20% to 50% depending on the country.^{19,21-24,28} This can explain the violations observed within the hospital and indicates that cessation programs for healthcare workers should be mandatory.

Table 4. Presence of “no smoking” signage in the state versus the two private hospitals (Nicosia, August 2025) n=113

Hospital type	Private hospitals				State hospital				Total				X ² p
Presence of “no smoking” signage	Yes		No		Yes		No		Yes		No		
	n	%	n	%	n	%	n	%	n	%	n	%	
Patient ward	8	12.7	55	87.3	36	80.0	9	20.0	44	40.7	64	59.3	49.25 <0.001
Polyclinic	0	-	64	100	43	95.6	2	4.4	43	39.8	65	60.2	100.03 <0.001
Waiting room	0	-	65	100	41	91.1	4	8.9	41	37.3	69	62.7	94.41 <0.001
Dining room	1	1.5	67	98.5	35	77.8	10	22.2	36	31.9	77	68.1	72.63 <0.001

Table 5. The presence of “no smoking zone” signage at all entrances

Hospital type	“No smoking zone” sign		
		Yes	No
Private hospitals	n	30	38
	%	44.1	55.9
State hospital	n	35	10
	%	77.8	22.2
Total	n	65	48
	%	57.5	42.5
p-value	<0.001		

Studies from middle-income countries such as Türkiye, and Armenia found similar challenges as compliance was poor despite strong legislation.^{13,14} By contrast, studies from Amsterdam and Catalonia show that improvement can be achieved through institutional responsibility, active communication, and integrated cessation support.^{16,17}

Finally, the main findings highlight important public health issues. The insufficiency of visible signage and enforcement processes reduces the validity of the law, leading to partial compliance. Furthermore, the complete absence of cessation support materials in hospitals represents a missed public health opportunity, as hospitals should be places that encourage smoking cessation. Staff smoking weakens enforcement of the law since they are public role models for a healthy lifestyle. Therefore, the education and responsibility of healthcare workers are necessary to maintain support and to strengthen compliance.

Study Limitations

Our data covered only three hospitals and therefore may not be representative of all hospitals. It implies that we cannot conclude that our results are generalizable to all settings. Nevertheless, the research provides us with valuable information to understand the level of adherence to tobacco control policies, identifies areas for improvement, and guides future research.

CONCLUSION

Compliance is greater in state hospitals than in private hospitals. Observed problems included improper signage placement, staff smoking, a lack of trained staff to handle violations and issue warnings, and the absence of cessation support. The above observations imply that hospitals must improve staff training and implement a strict smoke-free policy.

Recommendations

To increase compliance with tobacco control in TRNC hospitals, we recommend the following steps:

- “No smoking” signs should be placed conspicuously at all major entrances.
- A “no smoking” policy should be implemented in outdoor areas, and the signs should be placed at strategic locations.
- Trained personnel should be present to address violations.

- Hospitals need to provide cessation support and guidelines, which need to be led by doctors and supported by other health professionals.
- Broader studies should be conducted to evaluate the effectiveness of the policy across all hospitals.

MAIN POINTS

- This is the first study to systematically examine hospital compliance with the tobacco control law within the Turkish Republic of Northern Cyprus.
- Indoor compliance is high across all hospitals.
- The state hospital exhibits the highest level of compliance overall.
- None of the hospitals had staff trained to deal with violations, and staff were observed smoking.
- Tobacco cessation initiatives or support were not available at any hospital.

ETHICS

Ethics Committee Approval: Not required, as no human participants were involved and no personal or patient-identifying data were collected.

Informed Consent: Not required, as no human participants were involved and no personal or patient-identifying data were collected.

Acknowledgements

The authors thank the medical students and faculty staff who contributed to data collection.

Footnotes

Authorship Contributions

Concept: Ö.A., S.A.V., Ş.Ç., Design: Ö.A., S.A.V., Ş.Ç., Data Collection and/or Processing: Ö.A., S.A.V., Ş.Ç., A.E.A.E., M.E., E.A., K.C., M.M.A., S.S., A.A.İ., T.M.A., G.B., M.U.D., A.Ç., Analysis and/or Interpretation: Ö.A., S.A.V., Ş.Ç., A.E.A.E., M.E., E.A., K.C., M.M.A., S.S., A.A.İ., T.M.A., G.B., M.U.D., A.Ç., Literature Search: Ö.A., S.A.V., Ş.Ç., A.E.A.E., M.E., E.A., K.C., M.M.A., S.S., A.A.İ., T.M.A., G.B., M.U.D., A.Ç., Writing: Ö.A., S.A.V., Ş.Ç., A.E.A.E., M.E., E.A., K.C., M.M.A., S.S., A.A.İ., T.M.A., G.B., M.U.D., A.Ç.

Conflict of Interest: Three authors of this article, Özen Aşut, Songül Acar Vaizoğlu and Şanda Çalı, are members of the Editorial Board of the Cyprus Journal of Medical Sciences. However, they were not involved in any stage of the editorial decision of the manuscript. The editors who evaluated this manuscript are from different institutions. The other authors declared no conflict of interest.

Financial Disclosure: The authors declared that this study received no financial support.

Declaration on the Use of Artificial Intelligence (AI): No artificial intelligence tools were used in the preparation of this manuscript.

Appendix 1: <https://d2v96fxpocvxx.cloudfront.net/beb8919b-f013-4ea1-b1c8-40332e840fe1/content-images/6f00355e-7e5b-47a5-8b8a-c4f391bd1c38.pdf>

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