Challenges and opportunities for tobacco control in the Islamic countries—a case-study from Bangladesh

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التحديات القائمة والفرص المتاحة لمكافحة استعمال التبغ في البلدان الإسلامية
دراسة حالة من بنغلاديش

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يتزايد تدخين السجائر بمعدلات سريعة في كل البلدان الإسلامية . وفي البلدان الإسلامية بإقليم شرق المتوسط ، تضاعف معدل تدخين السجائر ٢٢٤ مرة فيما بين سنة ١٩٦٣ وسنة ١٩٩٠ . وفي بنغلاديش ، ثانية أكبر الدول الإسلامية في العالم ، يقدّر أن ما بين ٦٠ و٧٠٪ من الرجال البالغين وما بين ٢٠ و٣٠٪ من النساء البالغات ، يستعملون التبغ بطريقة أو بأخرى . إن إدراج التبغ على قائمة المواد المسببة للإدمان هي تذكِرة بأن الإسلام يحُرم تعاطيه ، لذا ينبغي اعتبار التدخين سلوكاً غير سويّ في المجتمع المسلم . وهكذا فإن الدول الإسلامية تملك سلاحين ماضيين في حربها ضد تعاطي التبغ : الأدلة العلمية ، والتعاليم الإسلامية . ولو استخدم هذان السلاحان كما ينبغي فسوف تنجح جهود المكافحة .

Cigarette consumption is rapidly increasing in all Muslim countries. In Muslim countries in the Eastern Mediterranean Region, cigarette consumption has increased by 224 percent between 1963 and 1990. In Bangladesh, approximately 60 to 70 per cent of adult males and 20 to 30 percent of adult females consume tobacco in some form or other. The fact that tobacco has been accepted as an addictive substance, is a reminder that in Islam it is strictly forbidden; and smoking should not be considered normal behaviour in a Muslim society. Muslim countries thus have both the scientific evidence and Islamic teachings as two powerful instruments in their fight against tobacco, which if properly used, can bring success.

La lutte antitabac dans les pays musulmans: défis et perspectives d'avenir - Etude de cas: le Bangladesh

La consommation de cigarettes augmente rapidement dans tous les pays musulmans. Dans les pays musulmans de la Région de la Méditerranée orientale, elle a augmenté de 224% entre 1963 et 1990. Au Bangladesh, environ 60 à 70% des hommes d'âge adulte et 20 à 30% des femmes d'âge adulte consomment du tabac sous une forme ou une autre. Le tabac est maintenant reconnu comme une substance toxicomanogène; de ce fait, il est strictement interdit dans l'islam et le tabagisme ne devrait pas être considéré comme un comportement normal dans une société musulmane. Les pays musulmans disposent donc de la preuve scientifique et des principes islamiques, qui sont tous deux des armes puissantes, dans la lutte qu'ils mènent contre le tabac. Ces armes peuvent conduire au succès si elles sont utilisées convenablement.

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Introduction

Cigarette smoking is a common and widely practised social habit in Muslim countries, especially among adolescents and even children [*1*]. Consumption is rapidly increasing. In Muslim countries in the Eastern Mediterranean Region, cigarette consumption has increased by 224 percent between 1963 and 1990 [*2*], and in the Muslim world as a whole it has more than doubled during the past 25 years [*3*]. One half of the population of Turkey smokes. In Nigeria, more than a third of men and 40 percent of boys in secondary schools in one big city were found to smoke [*4*]. A survey conducted in four villages in Malaysia showed that 56% of men and 20% of women were regular smokers [*5*]. In Egypt, cigarette consumption in total and per capita is increasing; the adult per capita figure is 1800 cigarettes annually. In Syria, 3000 tons of tobacco are used for purposes other than cigarette manufacture annually; smoking the *narghila* (water pipe) in Syria is a popular pastime. In Tunisia, cigarettes and snuff are used by both men and women; smoking prevalence in Tunisia was estimated at 58% for males and 6% for females [*6*]. Several Muslim countries plan to use more land and resources for tobacco growing in order to meet their own needs and for export purposes. In Jordan, 65% of the tobacco is home grown; annual per capita consumption was 1000 cigarettes in the 1960s, increased to 1500 in 1970s and to 1800 in the first half of the 1980s [*6*]. In Libya, annual per capita cigarette consumption is 2500 cigarettes, while in Morocco, it is over 1000 cigarettes. Tobacco is grown in Oman. Between 1986 and 1990, the average annual production was 1850 tons. In Qatar, in addition to widespread cigarette smoking, a significant amount of tobacco is used in cigar smoking, for smoking the water pipe and for chewing. The average per capita consumption of cigarettes is about 1600 cigarettes per adult per annum.

In Bangladesh, which is the second largest Muslim country in the world, with a population of 110 million, cigarette consumption has been increasing rapidly. Tobacco is also consumed in various other forms such as chewing "pan" (betel leaf), "bidi" as a form of cigar (rolled tobacco leaf), locally made raw tobacco ash and in a water pipe. One study indicated that the production of cigarettes in Bangladesh has increased at a phenomenal rate—a 300% increase during the period 1972–1984 [*7,8*]. About 70% of the ownership of tobacco production belongs to multinationals, many of which escape regulations concerning tobacco promotion in their parent countries and thrive in the "free" market of Bangladesh.

The challenge

The challenges for Bangladesh and other Islamic countries are in no way different from those facing other countries, irrespective of their religion. These are briefly:

Ignorance

Poor and low-income smokers are not fully aware of the dangers of smoking and tobacco use. Many cannot recollect how they acquired the habit; others would say that they acquired it from their parents and never thought it could be bad in anyway when the elders used it.

Promotional activities by the tobacco industry

Alluring publicity with pictorial presentations attract the illiterate. Very large advertisements in print and electronic media carrying the messages of success behind smoking are tempting. In most Muslim

countries publicity is quite liberal and more aggressive than in the West, presenting smoking as a socially desirable habit and relating it to success in life.

Easy access

Tobacco is readily available everywhere and at affordable prices. Even prohibited brands find their way through various unauthorized channels. Consequently, both the rich and the poor can have cigarettes and all forms of tobacco at their doorstep, even in rural areas. It is consumed in other forms beside cigarettes, as chewing tobacco in a potent mixture known as "pan", as a form of cigar known as "bidi" and as a pipe tobacco, smoked in a water pipe known variously as a *hookah, narghila, shisha* or "hubble-bubble".

Smokeless tobacco

Approximately 60 to 70% of the adult male population and 20 to 30% of the adult female population consume tobacco regularly in Bangladesh. Younger people hesitate to smoke before their elders; they never consume before their parents and seniors [7]. Smokeless tobacco is an exception. Chewing "pan", which consists of sliced betel nut, catechu quid and various amounts of other spicy ingredients in a betel vine leaf, is considered normal social behaviour. Besides, these are considered as a symbol of hospitality in the rural areas [6–8]. Even the poor would feel embarrassed if this were not offered to a guest. One study indicates that 20 to 30% of women in rural areas use smokeless tobacco; consequently, oropharyngeal cancer in this group is significantly higher than average [7].

Addiction

Nicotine dependency through cigarette smoking is not only the most common form of drug addiction but the one that causes more death and disease than all other addictions combined [9].

Opportunities for control

So far as the opportunities are concerned, the Muslim countries enjoy a great advantage over others. The status of tobacco from a religious point of view is clear. The controversy whether tobacco is *halal* (permissible) or *haram* (strictly forbidden) should not exist. In 1988, WHO's Regional Office for the Eastern Mediterranean issued a publication entitled *Health education through religion—Islamic ruling on smoking* [10]. It gives the conclusions of all fatwas and religion opinions given by highly esteemed religious scholars in respect of the Islamic ruling on smoking. It includes also the full text of the fatwas to enable the reader to follow the reasoning used by the scholars in arriving at these conclusions. The publication indicates that "it has become abundantly clear that, sooner or later, smoking, in whichever form and by whichever means, causes extensive health and financial damage to smokers. It is also the cause of a variety of diseases. Consequently, and on this evidence alone, smoking would be forbidden and should in no way be taken up by Muslims."

Furthermore, the obligation to preserve one's health and wealth, as well as that of the society as a whole and the medical evidence now available on the dangers of smoking, further support this view. It should be considered *haram* [9,10].

Utilizing opportunities

Smoking control is now a major problem facing Muslim countries [10–12]. There

needs to be a drastic change in public opinion on smoking in the light of Islamic principles and the health consequences of smoking or tobacco use. Governments of Muslim countries need to avoid dependence on tobacco production, which will do little for long-term prosperity and will only lead to disaster.

The following facilities may conveniently be utilized:

- The network of mosques should be used for various health care and mass educational programmes.
- Tobacco control is a social as well as a health care programme. The imams spread all over Muslim countries can cover almost the entire population. If they are motivated and mobilized for tobacco-control programmes, the outcome is most likely to be highly satisfactory.
- The imams are respected by the people who follow them. If the imams were to inform and advise people in general, and those coming to the mosques in particular, about the status of tobacco from the religious point of view, the true believers would not be able to continue smoking or take up the habit. Admittedly many of them are not fully aware of the status of tobacco in Islam, so they should be properly educated on this aspect. There are over 200 000 mosques in Bangladesh with an equal number of imams and nearly the same number of muezzins. The muezzins in the mosques also have an important role to play. *Haram* being strictly avoided by most Muslims, the message of religious injunction has a very strong force behind it.
- Muslim doctors have a special responsibility, by their own example, by the advice they give to others and by the collective advice they give their governments through their responsible professional bodies. They also have to urge their governments to introduce legislative measures to control smoking. Special attention should be given to children at primary and secondary schools, where most smokers start the habit. Preventive measures taken at this stage would do much to improve the health of future generations.
- Educational programmes should be conducted to discourage initiation of smoking by young people, and encourage consumers to quit smoking. These programmes should be conducted in educational institutes as early as primary classes. Electronic and print media should be used as extensively as possible in motivational programmes. Posters and billboards carrying messages against tobacco should be displayed. Religious principles, propagated through all these channels, will have a lasting impact.

References

1. Al-Khateeb M. *Smoking in the Eastern Mediterranean Region* [Unpublished Paper]. Eighth World Conference on Tobacco and Health. Buenos Aires, Argentina, 1992.
2. Rothwell K. *Control of tobacco use in the countries of the Eastern Mediterranean Region* [Unpublished Report]. Alexandria, Egypt, World Health

Organization Regional Office for the Eastern Mediterranean, 1993.

3. Taha A. *The growing threat: smoking and the Muslim world.* London, Islamic Medical Association, 1980.

4. Eleybeleye OO, Femi-Pearsc D. Incidence and variables contributing to onset of cigarette smoking among secondary and medical students in Lagos, Nigeria. *British Journal of Preventive and Social Medicine*, 1976, 30:66–7.

5. Rothwell K. *Smoking in the Eastern Mediterranean Region* [Unpublished Report]. Alexandria, Egypt, World Health Organization Regional Office for the Eastern Mediterranean, 1992.

6. Rothwell K. *Control of tobacco use in the countries of the Eastern Mediterranean Region* [Unpublished Report]. Alexandria, Egypt, World Health Organization Regional Office for the Eastern Mediterranean, 1994.

7. McBudden HN. Anti-smoking public places as envisioned by Bangladesh smokers and non-smokers. *International Quarterly of Community Health Education*, 1986–87, 7(3):201–10.

8. Abdullah S. *Dhumpan.* Rose Printer, Dhaka, 1993, 754.

9. *Preventing tobacco use among young children. Report of the US Surgeon General.* Washington, DC, US Government Printing Office, 1994.

10. *Health education through religion—Islamic rulings on smoking* [In Arabic]. Alexandria, Egypt, World Health Organization Regional Office for the Eastern Mediterranean, 1988.

11. Islam N. *Utilizing religious leaders for tobacco control* [Unpublished Report]. Eighth World Conference on Tobacco and Health, Buenos Aires, Argentina, 1992.

12. Kazi HG. *The health hazards of tobacco use* [Unpublished Report]. Hyderabad, Sindh, Pakistan, 1990.

Goal 10

To enable all people to adopt and maintain healthy lifestyles and healthy behaviour.

Target 10.1

All people will have access to information and opportunities to promote health-enhancing lifestyles and decrease health damaging behaviour.

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