Analysis and comment

Public health

Influence of Islam on smoking among Muslims
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Smoking prevalence is generally high among Muslims. An awareness of their religious beliefs and rulings might increase the effectiveness of antismoking campaigns

A fifth of the world’s population is Muslim, and most Muslims live in areas where the prevalence of smoking is high and often increasing. But even among the many Muslims living in Europe, smoking prevalence (particularly among men) remains high. For example, in England in 2004 the overall prevalence of smoking was 40% in Bangladeshi men and 29% in Pakistani men compared with 24% among the male general population. Smoking related disease represents a substantial burden on health services in Western countries, and is estimated to cost the NHS £1.7bn (€2.5bn; $3bn) a year. Reducing smoking prevalence is thus a priority for Western (and many other) governments. Knowledge of Muslim religious beliefs and customs is important to understanding smoking behaviour and considering how best to deliver appropriate health promotional messages and interventions.

Smoking patterns

The table summarises available data on smoking prevalence for the 30 countries with the highest proportion of Muslims, identified through the 2005 US Central Intelligence Agency World Factbook and IslamicWeb. Direct comparison of reported smoking prevalence between countries may be difficult because different studies, even if conducted in the same year, tend to use different methods for sampling, defining smoking, and ascertaining smoking status. Despite these limitations, the prevalence of smoking for most countries is higher than in the United Kingdom (where overall smoking prevalence in 2001 was 27%, 28% in men and 26% in women). India, which has a sizeable Muslim population (estimated at 144,755,428 in 2002) but Muslims are in a minority (13.4% of the total population), has a smoking prevalence of 29.5% in men and 2.5% in women; data are unavailable by religious grouping.

The World Health Organization data are likely to underestimate overall tobacco use in South Asia. Although cigarettes are the most common form of smoked tobacco, other forms such as kareti (indigenous cheroots containing tobacco, cloves, and cocoa) and bidis (blended tobacco, wrapped in tendu leaves) are also smoked. Additionally, chewing of tobacco products, in the form of gutka (a mixture of tobacco, betel nut fragments, fennel, and spices) and paan (a leaf in which several products including tobacco and betel nut are wrapped), is also common.

Difference between sexes

Smoking prevalence in each of these 30 countries is significantly higher among men than women, the prevalence among women typically being in single figures. The highest recorded rates among men are in Indonesia and Yemen, where over two thirds smoke. Yemen also has the highest prevalence of smoking among women, almost a third of whom smoke.

The striking differences between the sexes reflect strong social pressures. In many of these countries, men are regularly confronted with macho images of smoking—for example, through the Bollywood film industry and sponsorship of sporting events—whereas smoking by women is often construed as a vice that undermines the social standing of the family.
Women may try to conceal their habit through fear of being ostracised by their community, resulting in underestimation of smoking prevalence. Another issue is the social space occupied by women as in many Muslim communities. Women have restricted access to public places and are thus less likely to have access to the public places where cigarettes are traditionally smoked, such as markets and cafes.

Sacred law and tobacco smoking

Islam is both a spiritual and a legal tradition and impacts extensively on Muslim thinking and social customs. The central aims of the Islamic legal framework are to minimise the risk of harm to society and individuals and, simultaneously, maximise the opportunities for collective and individual wellbeing. The core objectives of religious law are to maintain life, protect belief, maintain intellect, preserve honour and integrity, and protect property. Islamic law has as its basis three main sources:

- The Koran, believed to be the direct word of God
- The Sunna, a large collection of recorded mannerisms, statements, and actions of the prophet Mohammed, and
- Ijtihad, the law of deductive logic, which, drawing on the above sources, allows trained scholars to consider the merits of novel issues and developments. It is this process of intellectual endeavour that provides Islamic law with its inherent evolutionary capacity.

All human affairs are classified into one of five categories: fard (mandatory), mustahib (encouraged), mubah (neutral), mukrooh (discouraged), and haram (prohibited). Actions that fall under the first four categories are considered religiously lawful, whereas actions that fall under the fifth category are considered unlawful.

The general underlying principle of Islamic law is that everything is permitted, except that which is explicitly prohibited, and since there is no direct mention of tobacco smoking in either of the primary sources of law (the Koran and Sunna), jurists have historically regarded tobacco smoking as an acceptable sociable activity. Up until the early 20th century, most Muslim jurists believed smoking did not have any adverse effects on health and therefore it was considered a neutral activity, although some, believing that smoking aided digestion or reduced stress, encouraged its use. With emerging evidence of the risks associated with smoking, however, it invariably became classified as an activity that was lawful but discouraged.

In many parts of the Arabic speaking world, the legal status of smoking has further changed during recent years, and numerous religious edicts or fatwas, including from notable authorities such as Al-Azhar University in Egypt, now declare smoking to be prohibited. The reasons cited in support of the reclassification of smoking as prohibited include Islamic law’s general prohibition of all actions that result in harm. For example, the Koran says, “And
they smoke themselves. May be (understandably) reluctant to pass rulings if sections of their communities as partaking in an own legal schools and an unwillingness to cast large edent rulings prohibiting smoking from within their own such position statement has emerged.

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南省, Libya, United Arab Emirates, Saudi Arabia, Egypt, Senegal, Jordan, Syria, Mali, Bangladesh, and Niger), with two further countries (Oman and Azerbaijan) hav- ing accession status. In the absence of national data, it is difficult to know whether the governments of Muslim countries are enforcing antismoking legislation. The limited anecdotal information that we have been able to uncover suggests that it is being enforced in some cases, although it could equally represent showcase attempts to divert potential criticisms of gov- ernment inertia. For example, within days of introduc- ing a ban on smoking in public places in Bangladesh, one man had already been fined for smoking in public." Similarly, at least one man has been arrested for flouting a ban on smoking in public. In contrast, the Pakistani government will forcefully implement their ban on smoking in public only later this year. It will be interesting to see whether Indonesia (which has the largest Muslim population in the world) will implement the proposed ban on cigarette smoking, as Indonesia relies considerably on revenue from the tobacco industry. In addition, the tobacco industry is Indonesia's second largest employer, employing up to 17 million people. The Indonesian example highlights the challenges facing tobacco growing countries and may explain why some Muslim countries remain reluctant to ratify the WHO Framework Convention on Tobacco Control.

Antismoking legislation

We were able to identify information on legislation for 27 of the 30 countries in the table (see bmj.com). Twenty countries had a complete ban on smoking in educational and healthcare facilities, with three of the remaining seven countries implementing a restricted ban; only Algeria, Afghanistan, Senegal, and Niger have no such ban in place. Only two countries, Iran and Syria, have a complete ban of smoking in public places (including mosques), although Indonesia is considering such a ban. Fourteen countries have a restricted ban on smoking in public places. Only seven countries had an identifiable ban on tobacco sales to minors, Kuwait having a lower age limit of 21, Egypt, Jordan, Pakistan, Syria, and Turkey having a limit of 18, and Bangladesh a limit of 16 years. The WHO's antismoking treaty, the Framework Convention on Tobacco Control, came into force on 27 February 2005, and has been ratified by 104 coun-
tries. Of the 30 Muslim countries studied, only 14 have ratified the treaty (Muritania, Turkey, Iran, Pakistan, Libya, United Arab Emirates, Saudi Arabia, Egypt, Senegal, Jordan, Syria, Mali, Bangladesh, and Niger), with two further countries (Oman and Azerbaijan) hav- ing accession status. In the absence of national data, it is difficult to know whether the governments of Muslim countries are enforcing antismoking legislation. The limited anecdotal information that we have been able to uncover suggests that it is being enforced in some cases, although it could equally represent showcase attempts to divert potential criticisms of gov- ernment inertia. For example, within days of introduc- ing a ban on smoking in public places in Bangladesh, one man had already been fined for smoking in public." Similarly, at least one man has been arrested for flouting a ban on smoking in public. In contrast, the Pakistani government will forcefully implement their ban on smoking in public only later this year. It will be interesting to see whether Indonesia (which has the largest Muslim population in the world) will implement the proposed ban on cigarette smoking, as Indonesia relies considerably on revenue from the tobacco industry. In addition, the tobacco industry is Indonesia's second largest employer, employing up to 17 million people. The Indonesian example highlights the challenges facing tobacco growing countries and may explain why some Muslim countries remain reluctant to ratify the WHO Framework Convention on Tobacco Control.

Looking ahead

We believe it is only a matter of time before South Asian scholars rule that smoking is prohibited, and these rulings percolate through South Asian Muslim communities globally. Religious rulings alone, how- ever, are unlikely to have much effect on rates of smoking. Patterns of smoking in Middle Eastern and North African countries are largely unchanged since clear religious rulings prohibited tobacco smoking. This is perhaps not surprising considering the highly addictive nature of tobacco.

Nevertheless, such religious rulings could help if incorporated into a more strategic approach to tackling smoking. Muslim countries should be encour- aged to sign up and adhere to the Framework Conven-

Action on Smoking and Health—Information on quitting and UK policies: www.cash.org.uk

Religious information on smoking and other contemporary issues: www.islamonline.net

Asian Quitline—Smoking cessation advice and support for South Asians, including material in other languages: www.asianquitline.org

Information to help stop smoking

International information on smoking: www.tobacco.org

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Summary points

Smoking prevalence remains unacceptably high among Muslim communities globally

Numerous religious scholars and institutions in Middle Eastern and North African countries have recently declared smoking to be haram (prohibited)

South Asian religious authorities need to follow the leadership shown by their Arab speaking counterparts

Antismoking legislation is often poorly enforced in Muslim countries

Religious rulings need to be backed up by advertising bans and support to stop smoking

We thank Asim Gholi for help with collecting data and the many religious scholars and health professionals who have shared their views with us. Thanks also to Scott Murray, Hilary Pinnock, and Brian McKinstry for their helpful critiques.

Contributors and sources: This article is based on government data, a Medline search, and searches of specialist Fatwa banks and discussions with religious scholars and organisations representing a range of ethnic, linguistic, and ethico-legal perspectives. AS conceived the idea for this review and oversaw data collection, interpretation, and writing of the paper. NG and MA undertook searches, extracted data, and drafted the paper. AS is guarantor.

Competing interests: AS chairs the research committees of the Muslim Council of Britain and the British Thoracic Society.

Ethics

Conscientious objection in medicine
Julian Savulescu

Deeply held religious beliefs may conflict with some aspects of medical practice. But doctors cannot make moral judgments on behalf of patients

Shakespeare wrote that “Conscience is but a word cowards use, devised at first to keep the strong in awe” (Richard III, V, iv, 1.7). Conscience, indeed, can be an excuse for vice or invoked to avoid doing one’s duty. When the duty is a true duty, conscientious objection is wrong and immoral. When there is a grave duty, it should be illegal. A doctors’ conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient’s good and the patient’s informed desires (box). If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.

Problem of conscientious objection

Doctors have always given a special place to their own values in the delivery of health care. They have always had greater knowledge of the effects of medical treatment, and this fostered a belief that they should decide which treatments are appropriate for patients—

12 Dvi AR, Shariali. The Islamic law London: Ta Ha, 1984:2-84.
(Accepted 8 October 2005)