

Smoking: A Global Health Peril

This issue includes an article about the smoking patterns of Muslims in New York. Out of the respondents to the survey the authors conducted, 12.8% were current tobacco users, and 12.3% reported its prior use. Many reported exposure to second-hand smoking. Of those who were exposed, 55% received second-hand smoke from family members, 60% from friends, and 47% received their exposure at work. Many of the respondents were not familiar with cessation resources or methods.¹

These data are quite alarming, especially because the survey was carried out in 2009, more than 50 years after the federal government recognized the dangers associated with smoking and responded with multiple steps to educate the populace about the dangers of smoking and instigated several cessation programs. Especially alarming is the high exposure rate of second-hand smoking. The IMANA Public Health Committee issued a position statement on that topic in 2009, which was published in JIMA.²

Cigarette smoking remains the leading cause of preventable mortality and morbidity in the United States. As early as 1989, the U.S. surgeon general estimated that > 400,000 deaths annually are attributable to smoking.³ Several studies corroborated this and documented that these estimates are not substantially altered by adjustments for behavioral and demographic factors associated with smoking.⁴ A more recent report indicates that smoking results in an estimated 443,000 premature deaths and \$193 billion (U.S. dollars) in direct health-care expenditures and productivity losses each year.⁵ The prevalence of smoking among youth and adults has declined in the United States during the last few decades. While its prevalence varies among the different ethnic and racial groups and between men and women, it did decline from an approximate average of 50% in 1965 to an approximate average of 30% in 2008.⁶ Surveys conducted from 2006 to 2008 indicate a current smoking rate that varies by ethnicity and race, age, educational attainment, employment status, poverty status, and sex. The smoking rate was highest (37.8%) in the 26-34 age

group and lowest (9.4%) in > 65-year-old group.⁶ Along with this decline in the smoking rates, the majority of Americans work and live in smoke-free environments due to public awareness and pressure on local governments to legislate smoke-free ordinances. Many public establishments, and certainly most hospitals, do not allow smoking in their premises.

While the prevalence of tobacco use has declined in United States, it has actually increased in many of the developing countries beginning in the early 1970s. A World Health Organization (WHO) report in 1983 showed that while tobacco consumption fell by 1.1% a year in developed countries from 1976 to 1980, it rose by 2.1% in the developing countries.⁷ In 1995 it was estimated that 82% of the world's 1.1 billion smokers lived in developing countries.⁸ This increase is attributed at least in part to the aggressive marketing campaigns of the tobacco industry. Faced with the difficult business environment (lawsuits), especially in the United States, and the falling demand for cigarettes in industrialized countries, these multinational tobacco companies fiercely competed to expand sales in the developing countries where they met with little or no opposition from the local governments.⁹

In 1988 WHO reported the prevalence of smoking in many developing countries. In Egypt it was 33% in adult males and 12% in adult females. The rates were 52% and 12% in Kuwait and 58% and 6% in Tunisia, respectively. The corresponding rates in Pakistan were 44 and 16%, and in Malaysia they were 56 and 12%.¹⁰ A more recent study published in 2000 reported the prevalence of smoking in Tunisia to be 52% in men and 6% in women.¹¹ In Syria, a study published in 2002 reported that the prevalence of current smokers among high school students was 16% and 7% for boys and girls, respectively, while in adults the rates were 48 % and 9% for men and women, respectively.¹² A more recent study published in 2005 reported that 34% of Egyptians are daily smokers. Men had significantly higher rates than women, 43.4% vs. 4.7%, respectively.¹³

WHO attributes 4.9 million deaths worldwide per year to tobacco and predicts that if the current trend continues, deaths will increase to >10 million by 2030.¹⁴ Out of these deaths 70% will be in the developing world.¹⁵ These statistics prompted WHO to negotiate a Framework Convention on Tobacco Control, a global public health treaty that asks countries to implement comprehensive tobacco control programs.¹⁶ In developing countries,¹⁷ and in the Middle East specifically¹⁸ there have been proposals to curtail smoking rates that are culturally sensitive and adapted to their specific socioeconomic conditions while adopting the universal measures that proved successful in the developed countries. These measures include restrictions on advertising, labeling, increased taxation on tobacco products, and legislation for smoke-free areas.

It is noteworthy that the increasing prevalence of smoking is also evident in Muslim countries, whether or not mentioned above. This is happening despite the Islamic injunction against harming oneself. The Qur'an says:

... [M]ake not your own hands contribute to your destruction ...¹⁹

There is now unassailable evidence that smoking, whether it is active or passive, is causally related to disease and death. It is definitely harmful to oneself and the smoker contacts, especially family members.² Muslim scholars have issued many religious edicts declaring that smoking is either *ḥarām* (forbidden) or at least *makrūh* (disliked).²

While great progress has been achieved in the United States, more work needs to be done. Still many states are not mandating smoke-free restaurants and other public places. Media campaigns need to promote smoke-free homes, as this cannot be mandated by the government. Also, more emphasis needs to be laid on smoking cessation. Long-term cessation rates using current methods continue to be approximately 10%. They are costly and not covered by insurance. Raising taxes on cigarettes contributes to the success of cessation and needs to be continued.²⁰ The Federal Family Smoking Prevention and Tobacco Control Act is a step in the right direction. It gives the Federal Drug Administration (FDA) authority to regulate the tobacco industry and its products. It strengthens restrictions on advertisements,

requires new and more prominent warning labels, compels companies to disclose all ingredients in tobacco products and authorizes the FDA to restrict harmful additives and to monitor and reduce nicotine yield.²¹ The FDA has to develop protocols for testing toxicity and addictive potential of the different tobacco products. The complexities of these protocols and especially its limitations have been discussed.²⁰

Finally, it needs to be mentioned that tobacco companies are producing oral tobacco products to replace cigarettes as a means of reducing health risks. An example of such products is snus, a moist snuff that is low in tobacco specific nitrosamines. It has been widely used in Sweden with little increase in the risk of cancer and cardiovascular disease.²² The introduction of "lower risk" products is of concern as it decreases efforts to promote cessation protocols.²⁰ These protocols seem to be the most effective in combating the tobacco pandemic.

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