**ISLAM AND MOTIVATION TO QUIT SMOKING**

**Abstract**

A debate opened within the WHO Eastern Mediterranean Regional Office some 10 years ago on a ‘religiously-inspired approach’ to tobacco use. Since that time, there has been inadequate research to move this debate forward. This paper argues that it is necessary to review the role which Islamic beliefs and teachings play (1) in influencing individual motivation to quit smoking and (2) in gaining support for public policies to reduce the incidence of tobacco use.

Ramadan and *Hajj* are taken as key points. These, we argue, are times when Muslin religious motivation to quit is strongest. The smoking behaviour of those who quit, only to resume smoking afterwards, indicates a religious rather than a health concern about smoking at these specific times. We propose the application of a simple questionnaire to determine the extent of smoking reduction during Ramadan as an indicator of individual religious motivation.

**Key words: religiously-inspired; motivation; individual and social orientation.**

**Background**

There is no *prima facie* reason why Islamic beliefs and teaching should not be considered as having a role to play in any strategy to combat tobacco use in the Middle East region. However, it is essential to determine exactly what constitutes a ‘religiously inspired approach’ (WHO, 2011) in the region towards tobacco use, as opposed to giving simple health advice and treatment. Only when that becomes clear can the role of the health professional in smoking cessation in the region be clarified. The implication may be that the health professional continues to give advice and assistance as before to help smokers to quit. However, the alternative implication is that more resources are devoted, or diverted, to campaigns and strategies to persuade, or enforce, smokers to quit on religious grounds, based on the spiritual and legal foundations of Islam. These foundations themselves are, as shown in this paper, open to interpretation.

A fundamental question has been raised by Maziak (2004) and by Jabbour & Fouad, (2004), which concerns the need to provide evidence for the effectiveness of public health campaigns on tobacco use – whether or not they are based on religion. These campaigns are funded by public money – in the case of the WHO by international money. Resolutions and programmes in themselves do not justify public health strategies. Years of work and research are required to assess what works in terms of public health and evidence must be collected and evaluated through meta-analysis and peer expert systematic reviews. The lack of clarity over the precise nature of the ‘religiously-inspired approach’ is linked to this lack of an evidence base.

The situation is further complicated since religious motivation to quit smoking is itself based on teachings which proscribe tobacco use on grounds of self-endangerment of health. The teachings of the Prophet refer to the displeasure to God caused by acts of self-harm which are known to endanger health. So, the religious message is, at the same time, a health message. However, it is a message which has a more complex orientation than the direct, secular message of the health consequences of smoking.

Religion has a strong influence in the Middle Eastern region – it is part of the daily life of individuals. This is the preamble for the statement of the World Health Organization (WHO) Eastern Mediterranean Regional Office (EMRO):

*Tackling tobacco use from a religious perspective is a key component of the Tobacco Free Initiative programme. It started in 1996 with the release of the first edition of ‘The Right Path to Health: Health education through religion – Islamic ruling on smoking’.* (WHO, EMRO, 2014)

In fact, the strategy was first proposed earlier than this, by the 37th World Health Assembly in 1984. The Assembly called upon WHO member states to include a spiritual element in their health policies. (WHO, 1984). The origins of this WHO strategy for the Eastern Mediterranean region also include a reference in the Report on the Meeting on Tobacco and Religion held in May 1999 in Geneva. The May 1999 Report begins with the statement:

*Religion represents a new frontier for public health in terms of partnership opportunities.* (WHO, 1999).

In his presentation to the meeting, the chairman Dr Khayat, then Deputy Regional Director for the WHO EMRO, explained the role of religion more explicitly. Religion provides the *‘spiritual dimensions of health and the ethical values underpinning public health actions in tobacco control’* (WHO, 1999). It would do this through the key role which religion plays in education. In the context of Dr Khayat’s address, this perspective clearly applies to the role of Islam in health education in the Middle East region.

It would be easy to misinterpret the original idea behind the contribution which Islam might make towards the promotion of smoking cessation. That original idea was not based on prohibition edicts or *fatwas.* In his presentation to the meeting, Tariq Ramadan of the Islamic Centre of Geneva stated the role which Islam should play:

*Accusatory statements, denigration and messages designed to inspire feelings of guilt are fruitless and serve only further to relegate “religious issues” or “religion” to a role of “prohibition”. What is needed today is a clear message based on three pillars: awareness, responsibility and justice. This means that the approach must be primarily, and almost exclusively, educative.* (WHO, 1999).

These three pillars involve *awareness* of the dangers of tobacco use, developing a sense of personal *responsibility* in the light of one’s religious faith and promoting social *justice* so that those farmers who grow tobacco are helped to produce alternative subsistence crops.

**The teachings of Islam on smoking**

The first point of debate is a very fundamental one – whether Islamic teaching on smoking is itself seen to be unequivocal. In Islamic culture, the influence of Islam plays a fundamental role in society, not simply in moral but also in legal terms (Ghouri, Atcha & Sheikh, 2006). As both a spiritual and legal tradition, Islam impacts extensively on Muslim thinking and social customs (Batran, 2003) and, more specifically, on the adoption of tobacco control policies themselves in many countries. Underpinning the Islamic legal framework are the principles of minimising the risk of harm to society and to individuals and to maximise the opportunities for collective and individual wellbeing. Islamic law has three basic sources: the Quran, believed to be the direct word of Allah; the Sunna, a collection of the sayings and acts of the prophet Mohammed and the Ijtihad which, drawing on the above sources, allows scholars to consider the merits of new issues and developments. (Ghouri et al, 2006). All human affairs are classified into one of five categories: *fard* (mandatory), *mustahib* (encouraged), *mubah* (neutral), *mukrooh* (discouraged) and *haram* (prohibited). Actions that are *haram* are considered unlawful. There is no single category imposed on all Muslims in every country of the world. Among Muslim scholars, in some countries (notably the Indian subcontinent) smoking is now considered *mukrooh,* while in others it is considered *haram*.

Until medical research proved the contrary, most Muslim jurists considered that smoking was not harmful to health but, in the light of increasing evidence, the legal status of smoking has changed, and numerous *fatawa* now declare smoking to be *haram* (Dien, 2004).Islam teaches that if a person becomes a habitual smoker, he is indirectly poisoning himself slowly and, for a Muslim, that is akin to practising self-harm (Hameed, Jalil, Noreen, Mughal & Rauf, 2002). Among the references cited by scholars is the instruction: ‘Kill not yourselves, for verily Allah has been to you most merciful’ - Quran 3:29. Another verse states: ‘And spend of your substance in the cause of God, and make not your own hands contribute to your own destruction’ - Quran 2: 195. This reclassification of smoking has been on the basis of the prohibition in Islamic law of all actions that result in harm to self or others. The Council of Islamic Ideology meeting in Islamabad in May 2000 declared the use of tobacco as an un-Islamic act. It is clear that health awareness about the dangers of tobacco use forms the basis of its categorisation as *haram* or *mukrooh.*

Knowledge of Muslim beliefs is important in understanding smoking behaviour and considering how to intervene effectively to promote smoking cessation in the region. (Ghouri et al, 2006; Islam & Johnson, 2003; Radwan et al, 2003). In the province of al-Qassim in Saudi Arabia, Al-Haddad, Al-Habeeb, Abdelgadir, Al-Ghamdy & Qureshi (2003) collected data from over 1700 patients at 25 randomly selected PHCCs (Primary Health Care Centres). The results indicated confusion on the status of smoking according to Islamic beliefs. The attitudes of respondents in Cairo at the same period (Radwan et al, 2003) revealed a similar confusion. Sucakli, Ozer, Celik, Kahraman & Ekerbicer (2011) showed that opinion is divided among religious authorities in Turkey. Of 406 religious officials who participated in their survey, 43.6% thought that smoking was *haram* and 56.2% considered it to be *mukrooh.* This is no dry theological debate. A recent study by Petticrew, Lee, Ali & Nakkash (2015) analysed internal tobacco industry documents on strategy to deal with rising concerns about tobacco use within Islamic countries. Their research identified the strategy adopted. The industry attempted various interventions to frame anti-smoking views as fanatical and fundamentalist and it recruited Islamic consultants to develop theological arguments in favour of a non-proscriptive attitude to smoking. The tobacco industry conceives the influence of Islam, therefore, as an actual and potential threat to their sales.

**Education or coercion**

Clearly there is a dichotomy between a religious educational approach and a coercive approach associated with prohibition of tobacco use for religious reasons. As an example, the EMRO supported the Saudi Arabian Tobacco-Free Mecca and Medina initiative. The EMRO nominated these cities for the global Tobacco-Free Cities Project, launched in 2002, after the Saudi Arabian authorities had taken measures to restrict the use of tobacco in the vicinity of the two Holy Mosques. [El Awa, 2004]. These measures are described in detail in the EMRO publication *Tobacco-Free Mecca and Medina*. (WHO, EMRO, 2007). They include a range of compulsory measures against tobacco use, such as prohibiting the sale or use of tobacco within the Holy Cities. In Medina, cafes in which *shisha* was smoked were moved to the outskirts of the city. In Mecca, all forms of tobacco advertising were banned.

This paper argues that a religiously-inspired policy approach to tobacco use has two aspects. The education aspect is related to the responsibility of the individual for their own personal well-being within Islamic teaching. Professor Qidwai (2004) concludes that the coercion aspect is not primarily related to personal ‘fear of God’ – only 4 of the 100 patients interviewed cited this as a reason for quitting during Ramadan. The coercion aspect is, in our view, related both to the periods of *Hajj* and Ramadan specifically, and to laws to restrict tobacco sales and use generally. An increase in tobacco taxation, for example, might be expected to be widely unpopular among smokers. When the voices of religious authorities are added to those of health advisers, however, opposition to such control measures might be more muted. If there is general public acceptance on religious grounds that measures to restrict and to discourage smoking are both just and justified, enforcement will be easier and evasion (and the black market for tobacco sales) will be widely eliminated. This suggests a link of socio-religious acceptability between the role of Islam as educator and enforcer, an approach endorsed by the WHO in its literature on Mecca and Medina as smoke-free cities (WHO, 2007, 2011).

The article will now consider faith-based educational and coercive approaches at two consecutive periods of heightened religious significance – *Hajj* and Ramadan. This discussion is based on research conducted to date, on psychological insights offered in terms of orientation, and on the relationship between motivation and nicotine dependence, which is shown to limit the influence of religion in individual smoking cessation to its effect on motivation. In conclusion, a possible ‘softening of approach’ by the WHO EMRO is discussed, and supported by the authors until more definitive research is carried out.

**Motivation to quit - *Hajj***

In Saudi Arabia, it is not true to claim that Mecca and Medina are ‘tobacco-free’ – as an extablished fact. This remains a vision for the future. The combined population of the two cities is approximately 3 million, but numbers double during *Hajj* and Ramadan. The prevalence of smoking amongst residents is 21% for males and 1.3% for females (WHO, 2010). The attitude of Islam towards smoking determines that un-Islamic acts are not permitted near the most sacred places of worship, the Holy Mosques, associated historically with the prophet Mohammed. In 2002, the Custodian of the Two Holy Mosques, King Abdullah, declared the two holy cities of Mecca and Medina to be tobacco-free and there have been concerted efforts to enforce this decree among the two million pilgrims who visit these cities each year during Hajj. Dr Al-Munif, Director of the Tobacco Control Programme in Saudi Arabia, reported on the distribution of 1.5 million leaflets during Hajj:

*Billboards and posters with anti-smoking messages, information regarding anti-smoking clinics and fatwas on the subject are on display in the two cities. Buses carrying pilgrims also have anti-smoking posters on them* (Arab News, 2009).

Clearly, in this case, religious educational messages and religious proscriptions have become inseparably mixed. The WHO’s own sources confirm this, as shown in Tables 1 and 2.

It is evident, therefore, that the elements of a ‘religiously-inspired approach’ to tobacco use need to be defined and clarified. This is not only the case in relation to the Holy Cities in Saudi Arabia and *Hajj*. During Ramadan the coercive element of proscription dominates.

**Motivation to quit – Ramadan**

Some public health bodies have used the beginning of Ramadan as a spur to encourage smokers to quit (Mahroof et al, 2007; Singapore Health Promotion Board, 2011). This has also been the case among sizeable Muslim communities in some cities in the UK, such as Bradford or Birmingham. In Bradford, the 2009 Ramadan campaign targeted taxi bases in the city, following this up with the formation of stop smoking groups and drop-in sessions for taxi drivers – many of whom are from the Muslim community (Bradford District Council, 2009). Birmingham City Council (2014) issued a press release outlining the visits that would be made to mosques by members of the Stop Smoking Services team, giving advice and providing information about the support services available to help smokers to quit.

The Prime theory posits that all behaviour is ‘reactive’ in the moment to internal and external stimuli (West, 2008) and beliefs about what is good or bad influence behaviour through wants and needs. This theory was developed within the specific context of tobacco use to find answers to how better to motivate and assist smokers to stop. It is particularly pertinent to the question of Islamic beliefs, which might be considered internal and heightened on occasions such as Ramadan or *Hajj,* during which internal beliefs are strengthened by external stimuli. Specifically, these occasions potentially may provide the ‘triggers’ which turn the resulting increased motivational tension – based on Islamic teachings – into attempts to stop. Of course, this is not to claim that Islamic beliefs are the unique tension and these occasions the unique triggers in Muslim countries. The relative importance of these religious tensions and triggers alongside strictly secular health messages and measures are what this article seeks to question.

There has been some recent research carried out on smoking cessation during Ramadan. Khan, Watson and Chen (2013) conducted a study among 29 smoking and 46 non-smoking Pakistani men during Ramadan to attempt to assess how much of a challenge smoking presented to Muslim beliefs and practices. A detailed account of the methodology and data analysis methods is provided and the results obtained provide a useful basis for discussion. The small sample size is clearly a limitation of the study and the criteria used for differentiating between the smoker and non-smoker groups in the sample were, in the opinion of the authors themselves, insensitive.

The authors posited that – particularly during Ramadan – smoking challenges Muslim beliefs and practices. They consider that smoking correlates negatively with intrinsic-personal orientation, whether regarded as *haram* or *mukrooh.* This orientation refers to a sincere form of faith which serves as the ultimate motivation in the life of the believer. They suggest that smoking also correlates negatively with extrinsic-personal orientation. In this orientation, religion is the means of achieving the goal of personal well-being. Less certain, however, is whether smoking correlates negatively with extrinsic-social orientation, which reflects the use of religion towards the achievement of social objectives. The relevance of smoking to “setting a good example” suggests that smokers might have lower levels of this orientation. The ‘extensive campaigns’ in the Holy Cities on the hazards of smoking linked with the promotion of ‘right behaviour’, suggest that targeting extrinsic-personal orientation with extrinsic-social orientation has been implemented as a dual strategy within this religiously-inspired approach to tobacco use.

This mental health perspective would place a religious educational approach, based on the teachings of Islam, primarily within an extrinsic-personal orientation. This is important, since it clarifies the religious basis on which motivation to quit or to cut down on tobacco use primarily rests. The dual message – religious and secular – of the health benefits for the individual of smoking cessation or reduction can be regarded as mutually reinforcing. However, this does not answer the question of what resources should be devoted to promoting the religious message. It may be the case that the secular message of the physical health benefits of smoking cessation is the area where the motivation to quit could be developed most strongly for the majority of smokers, independently of a religious message to strengthen it. This has yet to be determined.

Khan and colleagues do not claim to have produced conclusive findings from their research. However, there are some important indications that emerge from their study. Participants were aware that smoking interfered with their spiritual commitments as Muslims and – specifically – with ‘right behaviour’ during Ramadan. That spiritual commitment is at a high point during Ramadan [and *Hajj*] and this may work on two levels: genuine individual spiritual awareness – intrinsic-personal orientation – and a desire to present oneself in the community as a devout Muslim – extrinsic-social orientation. However, the study opens for discussion the possibility that smoking may indicate a lack of religious commitment, and that those who do quit during these periods therefore have no problems resuming their habit once the heightened focus has passed. A cessation policy based on strengthening Muslim commitments may therefore be targeting a group – smokers – in which a significant proportion will be indifferent to a religious call to quit. For this reason, perhaps, Khan and colleagues suggest combining this with other interventions. This returns us once more to the point – secular health messages to quit are possibly the area in which to concentrate resources, expand propaganda, and to heighten motivation to quit among smokers. From this perspective, religious messages would best be concentrated on Ramadan and *Hajj.*

The most comprehensive study on smoking cessation in the Middle Eastern region during Ramadan was conducted by Qidwai (2004). The aim was to investigate barriers to smoking cessation among patients attending the Family Practice Centre at Aga Khan University Hospital in Karachi. This was a qualitative study based on interviews with 100 patients, of whom 96 were men, and all were current smokers. A questionnaire was developed as the basis for the interviews to collect data on the demographic profile of the patient, attempts to quit smoking, quitting during Ramadan and perceived barriers to smoking cessation. As 91% of respondents reported that they had stopped smoking during Ramadan, the question posed by Qidwai was why they had then resumed their habit.

In the discussion of the findings, Qidwai referred to the ‘strong spiritual drive’ which encourages an individual to quit during Ramadan, only to start again once this spiritual drive has gone. His findings suggest that, among this study group, the coercive aspect of religious teaching was not a major factor in quitting during Ramadan. Only 4% of respondents cited ‘fear of God’ during Ramadan as a factor in why they stopped smoking during that month. It certainly appears that a religious element played a minor part in the decision of these patients to quit smoking during Ramadan, but that this element was not predominantly of a proscriptive or coercive nature. When patients were asked about the advantages of smoking cessation in general, health concerns were overwhelmingly given and, of the factors that can convince a smoker to stop smoking, health concerns were also cited by respondents above all other factors. The religious benefits of quitting or the value of Islam in convincing a smoker to quit are completely absent from both sets of responses. This would not seem to justify a link between quitting smoking during Ramadan and the presence of a strong spiritual drive, yet the fact that 9 out of 10 respondents did quit during Islam can only be explained in those terms which Qidwai suggests.

The respondents were then asked to identify the barriers to smoking cessation, as they perceived them. Three factors were cited most frequently: craving for smoking, the habit of smoking and enjoyment from smoking. All of these indicate some form of dependence, whether physical or cultural, to account for why these patients resumed smoking after Ramadan. Qidwai argued that some barriers to smoking cessation are culturally related and it is therefore necessary to identify these in order for smoking cessation programmes to be more effective. It is necessary, for example, to assess the impact of the measures in the Holy Cities to ban waterpipe smoking in cafes and restaurants.

While a religiously-inspired approach to tobacco use may influence motivation to quit – and research is needed to substantiate this view - it does not influence dependence, which must be considered in its relationship with motivation.

**Islam, motivation to quit and dependence**

Although Khan and colleagues asked about this in their study, it is unclear from Qidwai’s paper if the respondents quit smoking completely during Ramadan or only, in accordance with Islamic ruling, during the hours of daylight. Aveyard, Begh, Sheikh and Amos (2011) claim that with continued smoking during the hours of darkness, withdrawal will not subside unless there is complete abstinence. This must surely be a factor to consider in Qidwai’s findings. It is possible, of course, that the prohibition of smoking during the day, and the absence of others smoking, might assist those who decide to make a sustained attempt to quit or cut down tobacco use during Ramadan. This is an interesting aspect which Aveyard and colleagues have raised, involving both religious coercive and social pressures. These are the same influences which are at work in the Holy Cities during *Hajj.* Again, the absence of an evidence-base for this possibility means that it is impossible to assess the impact of the religious message on smoking cessation.

Aveyard and colleagues then make a very important point. Most supported smoking cessation attempts involve medication. However, during Ramadan, it is claimed in their article that many Muslims are unclear whether taking oral medication during daylight is prohibited. If this is the case, oral NRT treatment and also the use of varenicline or bupropion cannot be used. If this claim can be substantiated, then it is surely beyond dispute that religious education programmes have to clarify the situation. ‘Emirates 24/7’ (2013) reported that the use of nicotine patches is permitted and does not break the fast, according to the General Authority of Islamic Affairs and Endowments in Abu Dhabi. A study is again needed to determine how widely this ruling is known among Muslim populations in different Middle Eastern countries.

The provision of advice to smokers by health professionals or through religious messages is, of course, inseparably linked with the question of motivation. However, motivation in turn is linked with the problem of dependence. Smoking cessation and reduction is not only in the mind, it is linked with nicotine dependence and the problems of addiction. These are the exclusive field of the health professional. Only the health professional is in a position to advise on pharmacological treatment for dependence.

Professor West (2004) outlines the relationship between dependence and motivation to stop smoking. Whatever the contributory factors, the combination of a high motivation to quit and low dependence on nicotine will mean that the smoker is most likely to quit. In smokers with low motivation to quit, the role of health or religious educational messages is to increase motivation. Without a high level of motivation ‘treatments’ to assist with smoking cessation, such as nicotine replacement therapy, are likely to be ineffective. In this article, West suggests a simple test to determine motivation to quit. This could be administered in all PHCCs and by health professionals in all settings, including hospitals, doctors’ and dentists’ surgeries as well, of course, as smoking cessation clinics. The drawback is, of course, that the results have to be interpreted with caution, as what smokers claim about their wish to quit – especially in a clinical setting – may not accurately reflect their real feelings. For this reason, the suggested additional questions are strictly factual and independent of the expression of personal opinions. It would act, therefore, as a basis on which to offer [or not offer] help to quit or cut down on tobacco use. Further discussion with the patient would reveal more about their real level of motivation.

Linking this with a religiously-inspired approach to tobacco use, this simple test could be extended. The three questions proposed by West all require only Yes/No responses:

1. Do you want to stop smoking permanently?
2. Are you interested in making a serious attempt to stop in the near future?
3. Are you interested in receiving help with your quit attempt?

Two further questions could be added to this:

1. Do you stop smoking during Ramadan?
2. Do you smoke during the hours of darkness during Ramadan?

While these additional questions would add nothing to our knowledge of the level of motivation to quit of the patient, they would give some rudimentary indication of the sources of that motivation. This would be true whether the answer to each question was Yes or No. The two additional questions would not seek personal opinions, they are simply requests for statements of fact.

Smokers who quit during the period of Ramadan and resumed afterwards can reasonably be assumed to have been motivated by religion for this temporary cessation – especially if they continued to smoke during hours of darkness. This temporary behaviour could hardly be attributed to personal health concerns. It is not a random quit attempt, but a cessation which clearly has some relation to Islamic beliefs. This would, in turn, provide some basis on which to allocate the resources of national tobacco control programs in the Middle Eastern Region, where most countries are signatories of the WHO Framework Convention on Tobacco Control. It would, I argue, be preferable to the present situation of an inadequate evidence base for policy strategy. In other words, a *‘religiously-inspired approach to tobacco use’* must have some justification in research.

**Summary**

The aim of this paper has been to clarify what a religiously-inspired approach to control tobacco use actually means in terms of education and coercion measures, and to discuss how Islam can intervene to promote smoking cessation, individually and collectively. The paper argues that it is possible to determine faith-based motivation to quit by a quantitative study of smoking behaviour during Ramadan. The need for such an evidence-base has been argued. The role of religion in influencing motivation to quit smoking has been discussed independently of the problem of dealing with nicotine dependence for smokers who **are** motivated to quit.

There appears, in our view, to be a recent shift of emphasis towards a more cautious approach in references to religion and tobacco use by the WHO EMRO. Faith-based tobacco control strategies should, according to a recent Fact Sheet (2014) published by the EMRO, be viewed as *‘one part of a comprehensive overall approach to tobacco control’.* The elements of both education and coercion remain present in the objectives of such faith-based strategies, specifically stated as:

▸ raising public awareness of religious views and rulings regarding tobacco use

▸ engaging religious leaders in dialogue and partnerships on tobacco control

▸ mobilizing faith-based organizations to support tobacco control initiatives, including smoke-free policies, tobacco cessation and healthy lifestyles education.

The first of these objectives would involve some allocation of health service resources, since any educational campaign to raise public awareness cannot be conducted without some cost element. Even if the approach of the WHO may have been softened, an evidence-base for using religion to discourage tobacco use in the Middle East region is still a necessity, as a basis on which to build effective strategy. Meanwhile, building on the work already carried out, at this stage a cautious partnership approach to the role of Islam appears to be sensible on the broader question of increasing individual motivation to quit smoking.

REFERENCES

Al-Haddad, N.S., Al-Habeeb, T.A., Abdelgadir, M.H., Al-Ghamdy, Y.S. & Qureshi, N.A.

 ‘Smoking patterns among primary health care attendees, Al-Qassim region, Saudi

 Arabia’. Eastern Mediterranean Health Journal,2003, volume 9(5/6): 911-922.

Arab News (2009) ‘Govt strives to make Haj tobacco free’. Arab News. 3 November 2009.

 <http://archive.arabnews.com/services> Accessed 16 October 2010.

Aveyard, P., Begh, R., Sheikh, A. & Amos, A. ‘Promoting smoking cessation through

 smoking reduction during Ramadan’. Addiction(editorial) 2011, volume 106: 1379-1380.

Batran, A.A. Tobacco Smoking Under Islamic Law: Controversy Over ItsIntroduction.

 Beltsville, Maryland: Amana Publications, 2003.

Birmingham City Council (2014) Helping Smokers Quit during Ramadan.

 <http://birminghamnewsroom.com/helping-smokers-quit-during-ramadan/> Accessed 04

 May 2015.

Bradford District Council (2009)

[http://www.bradford.gov.uk/NR/rdonlyres/310B4FEB-](http://www.bradford.gov.uk/NR/rdonlyres/310B4FEB-%20%20%20%20%20%20%202310-4121-BB14-244FB41DF866/0/PublicPart4DeliveringtheBigPlan.pdf)

 [2310-4121-BB14-244FB41DF866/0/PublicPart4DeliveringtheBigPlan.pdf](http://www.bradford.gov.uk/NR/rdonlyres/310B4FEB-%20%20%20%20%20%20%202310-4121-BB14-244FB41DF866/0/PublicPart4DeliveringtheBigPlan.pdf) Accessed 04

 May 2015.

Dien, M.I. Islamic Law: from historical foundations to contemporary practice. Notre Dame,

 Indiana: University of Notre Dame Press, 2004.

El Awa, F. Bulletin of the World Health Organization,volume 82, number 12, December

 2004: 894 (editorial).

Emirates 24/7, August 05, 2013.

[http://www.emirates247.com/news/emirates/ramadan-](http://www.emirates247.com/news/emirates/ramadan-%20%20%20%20%20%20%20%20%20%20%20question-medication-not-orally-taken-breaks-the-fast-2013-08-05-1.513663)

 [question-medication-not-orally-taken-breaks-the-fast-2013-08-05-1.513663](http://www.emirates247.com/news/emirates/ramadan-%20%20%20%20%20%20%20%20%20%20%20question-medication-not-orally-taken-breaks-the-fast-2013-08-05-1.513663), Accessed 24

 March 2015.

Ghouri, N., Atcha, M. & Sheikh, A. ‘Influence of Islam on smoking among Muslims’.

 British Medical Journal, 2006, volume 332: 291-294.

Hameed, A., Jalil, A., Noreen, R., Mughal, I. & Rauf, S. ‘The Role of Islam in the Prevention

 of Smoking’. Journal of Ayub Medical College,2002, 14(1): 23-25.

Islam, S.M. & Johnson, C.A. ‘Correlates of Smoking Behavior among Muslim Arab-

 American Adolescents’. Ethnicity and Health,2003, 8(4): 319-337.

Jabbour, S & Fouad M.F. ‘Religion-based tobacco control preventions: how should WHO

 proceed?’ Bulletin of the World Health Organization, volume 82, number 12, December

 2004: 923-7.

Khan, Z.H., Watson, P.J. & Chen, Z. (2013) ‘Smoking, Muslim religious commitments, and

 the experience and behaviour of Ramadan in Pakistani men’. Mental Health, Religion and

 Culture,2013. 16:7, 663-670.

Mahroof R., Syed R., El-Sharkawy A., Hasan T., Ahmed S., Hussain F.  Ramadan Health

 Guide. London: The Stationery Office, 2007.

Maziak, W. ‘Religion-based interventions must be supported by evidence’. Bulletin of the

 World Health Organization, volume 82, number 12, December 2004.

 <http://www.who.int/bulletin/bulletin_board/82/elawa1/en/> Accessed 10 November 2014.

Petticrew, M., Lee, K., Ali, H. & Nakkash, R. ‘Fighting a Hurricane: Tobacco Industry

 Efforts to Counter the Perceived Threat of Islam’. American Journal ofPublic Health,

 June 2015. volume 105, number 6: 1086-1093.

Qidwai, W. ‘Barriers to Smoking Cessation: Results of a Survey Among Family Practice

 Patients’. *Middle East Journal of Family Medicine,* 2004, volume 5(5).

 [http://www.mejfm.com/journal/MEJFM%20May202004/Smoking.pdf Accessed 18](http://www.mejfm.com/journal/MEJFM%20May202004/Smoking.pdf%20Accessed%2018)

 November, 2014.

Radwan, G.N., Israel, E., El-Setouhy, M., Abdel-Aziz, F., Mikhail, N. & Mohamed, M.K.

 ‘Impact of religious rulings (Fatwa) on smoking’. Journal of the EgyptianSociety of

 Parasitology*,* 2003, volume 33, Supplement 3: S1087-1101.

Singapore Health Promotion Board (2010) ‘Ramadan Smoking Cessation Program 2010’.

 <http://www.hpb.gov.sg/HOPPortal/health-article/7876> Accessed 12 August 2010.

Sucakli, M.H., Ozer, A., Celik, M., Kahraman, H. & Ekerbicer, H.C. ‘Religious Officials’

 knowledge, attitude and behaviour towards smoking and the new tobacco law in

 Kahramanmaras, Turkey’. BMC Public Health, 2011, volume 11: 602.

West, R. ‘Assessment of dependence and motivation to stop smoking’. BritishMedical

 Journal,2004, volume 328: 338-339.

West, R. ‘Finding better ways of motivating and assisting smokers to stop: Research at the

 CRUK Health Behaviour Research Centre’. The European Health Psychologist, 2008,

 volume 10: 54-58.

World Health Organization (WHO, 1999) Tobacco Free Initiative Meeting on Tobacco and

 Religion, Geneva, Switzerland, 3 May 1999. Report. WHO document

 WHO/NCD/TFI/99.12.

World Health Organization (WHO) Centre for Health Development (2010) *‘*Royal

 declaration to make Mecca and Medina smoke-free’*.*

 <http://www.who.or.jp/SFC_Makkah.html> Accessed 6 January, 2014.

World Health Organization (WHO), EMRO (2007) ‘Tobacco-Free Mecca andMedina’.

 WHO-EM/TFI/029/E . <http://applications.emro.who.int/dsaf/dsa767.pdf> Accessed 12

 November 2014.

World Health Organization (WHO), EMRO (2014) ‘Religion and Tobacco’.

 <http://www.emro.who.int/tfi/emroleads.htm> [accessed 12 November 2014]

World Health Organization (WHO), EMRO (2014) ‘Tobacco Use and Religion’*.* WHO –

 EM/TFI/119/E.

 <http://applications.emro.who.int/docs/Fact_Sheet_TFI_2014_EN_15322.pdf?ua=1>

 Accessed 06 May 2015.

World Health Organization (WHO,1984) Thirty-seventh World Health Assembly, Resolution

 WHA37.13. Geneva: WHO document WHA37/1984/REC/1:6.

World Health Organization (WHO, 2011) ‘Tobacco-free cities for smoke-free air: a case

study in Mecca and Medina’. <http://www.who.int/kobe_centre/interventions/smoke_free/mecca_medina_web_final.pdf?ua=1> Accessed 02 May 2015.

**Table 1**

|  |
| --- |
| **Key measures in Mecca and Medina** |
| Banning tobacco smoking around the two Holy Mosques. |
| Banning tobacco sales within city limits and beyond city limits, prohibiting sales in all food stores and in the neighbourhood of mosques and schools. |
| Prohibiting waterpipe smoking in cafes and restaurants within residential areas and near mosques, schools and wedding halls. |
| Extensive campaigns to raise awareness about the hazards of smoking and the tobacco control policy in the cities amongst the public and city visitors. |

**Table 2**

|  |
| --- |
| **The impact of the measures** |
| Within the smoke-free areas of the cities surrounding the Mosques, there is very little smoking now and most of the visitors know that it is a smoke-free city and they should not smoke around the Mosques. |
| In other public spaces, such as restaurants, smoking has continued, though limiting tobacco sales combined with an increased awareness that smoking within the holy cities does not constitute ‘good behaviour’ means that it has reduced. |
| In Mecca, in 2008, an assessment of the policy found that 75% of stores had complied with the requirement not to sell tobacco. Fines were issued to the remainder of the shops. |
| Squeezing the availability of tobacco from retail outlets has stimulated a black market and pushed up the price of tobacco. |

Source: WHO (2010)

**CONTACT DETAILS: AUTHORS**

Khaled Alturki

Medical Services Department (MSD)

PO Box 395839

Riyadh Zip code: 11375

Saudi Arabia

Dr Ahmed Hamza,

Associate Professor of Psychology

PO Box 844228

Princess Nora Bint Abdul Rahman University

Riyadh Zip Code: 11671

Saudi Arabia

e-mail: dr.hamza677@gmail.com

Corresponding [lead] author: Khaled Alturki kdalturki@hotmail.co.uk

KA conceived of the study and was responsible for reviewing the literature and drafting the manuscript. AH made substantial contributions to the design and to critical revision. Both authors read and approved the final manuscript.

**Biographical information**

KA is employed by the Medical Services Department in Riyadh, Saudi Arabia. In 2014 he completed an M.Phil at the University of Huddersfiled on the performance of the Tobacco Control Program in Saudi Arabia. Dr Ahmed Hamza is Associate Professor of Psychology at Princess Nora Bint Abdul Rahman University in Riyadh.