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Tobacco-free Mecca and Medina

World Health Organization

Regional Office for the Eastern Mediterranean

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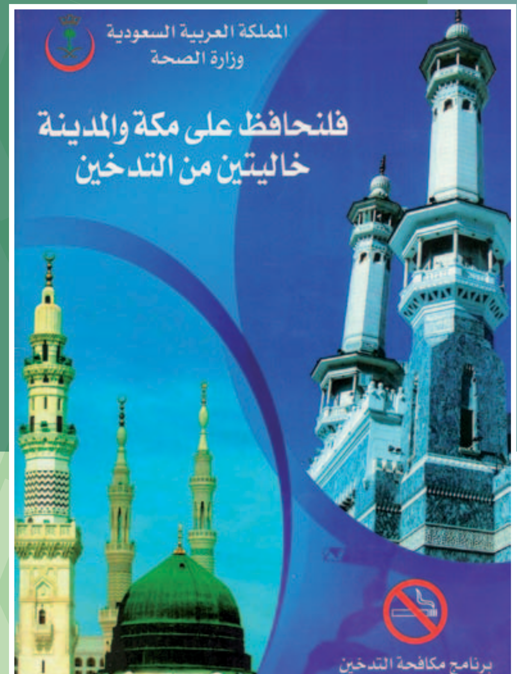
Tobacco-free Mecca and Medina

Introduction

Political, economic, social, cultural, environmental and other factors can all favour health or be harmful to 'good health'. The aim of health advocates is to modify these factors to promote health [1]. Religion too provides opportunities to improve health [2]. It can offer motivation, encouragement and support for healthy lifestyles and behavioural choices.

The tobacco industry views religion-based tobacco control activities as a real threat. As far back as 1987, the industry had recognized the need "to develop a system by which Philip Morris can measure trends on the issue of Smoking and Islam" [3]. Their plan was to identify "Islamic religious leaders who oppose interpretations of the Qur'an which would ban the use of tobacco and encourage support for these leaders."

In 2002, the Ministry of Health of Saudi Arabia adopted a new and radical policy approach to strengthening tobacco control through religion. It launched an initiative to make the two holiest cities in Islam, Mecca and Medina, not just smoke-free but literally tobacco-free. The rationale and experiences of the Saudi government in regulating tobacco use in Mecca and Medina are examined in this report.



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Tobacco use in Muslim countries

A fifth (1.2 billion) of the world's population is Muslim and this proportion is expected to rise to 30% by 2025. This would then make Islam the world's largest faith. The Organization of the Islamic Conference (OIC), an inter-governmental organization of countries with large Muslim populations, has 57 members [4]. Of these 46 have signed and 36 have ratified the WHO Framework Convention on Tobacco Control.

In many OIC member countries attitudes to tobacco use are ambiguous. It is socially acceptable for men to smoke but not for women. The prevalence of tobacco use among men in these countries is generally high, with smoking rates ranging from 69% in Indonesia, 51% in Turkey, 48% in Bangladesh and 40% in Egypt, to 15% in Nigeria. The smoking prevalence among women is generally much lower, from 2% to 11% [5].

The main commercial products that are smoked are cigarettes, *kreteks*, *bidis*, and waterpipes. The association of the waterpipe with Arab culture has seen its ready acceptance in many non-Arab Muslim countries. A variety of smokeless tobacco products are consumed including *gutkha*, snuff and chewing tobacco [5].

Tobacco control legislation in most Muslim countries is still at a rudimentary stage, with limited restrictions on smoking in public places and advertising being the most common [6]. A survey by the WHO Regional Office for the Eastern Mediterranean found that most countries in the Region (70%–85% of respondents) have banned smoking in health care facilities, educational institutions and public transport, and require health warnings on tobacco packaging [7].

Islamic views on tobacco

The basic purpose of Islamic laws is to protect religious beliefs, life, intellect, children and property. In general, Islam is a permissive religion, allowing everything except that which is specifically prohibited. Islamic law is derived from the Qur'an and the recorded practices of the Prophet Mohammed ﷺ. Muslim jurists (*ulama*) draw on these sources to guide the community in deciding the merits of new developments. Since tobacco was introduced to the Muslim world in 1598, about 900 years after the Qur'an was revealed [8], scholars have had differing views on tobacco use. Some early scholars viewed smoking as useful and permissible, others as harmful and *haram* (prohibited), and others as lawful but to be discouraged. This ambiguity persisted until the late 20th century.

In recent years, with the availability of scientific evidence on the harms of tobacco the rulings have inevitably changed. In 1996, the WHO Regional Office for the Eastern Mediterranean asked scholars at the respected Al-Azhar University in Egypt for their opinions [8]. They declared tobacco to be *haram*. The *muftis* of Oman and Egypt, and the Permanent Committee of Academic Research and Fatwa, Saudi Arabia, concurred with this opinion. Pakistan's highest religious body, the Islamic Ideology Council, have also proposed a ban on smoking, declaring it a habit that violates Islam.

The basis for this ruling is the general prohibition in Islam on actions that cause harm. The Qur'an states: *Do not, with your own hands, expose yourself to destruction* (2:195), which may almost specifically refer to the act of smoking. Islam requires people to look after their health, avoid harms and practise good hygiene. Some verses of the Qur'an may also be interpreted as barring smoking by parents while a woman is pregnant and after birth, as well as against harming nonsmokers through passive smoking. The Qur'an states: *Let no mother cause harm to her child, nor a father of a newborn cause harm to his child* (2:233). The Prophet Mohammed ﷺ also said: "There shall be no infliction of harm on oneself or others".

The declaration of a product as *haram* forbids Muslims not only from using the product but also from trading in it. The Prophet ﷺ said: "When Allah prohibits something, He prohibits eating its price." So, Islam forbids not only the drinking of alcohol but the brewing, selling, transport and serving of alcohol. Likewise, once it is considered that tobacco is *haram*, no Muslim may manufacture, buy, sell, trade or promote tobacco. These actions represent 'aiding someone in committing a sin'.

Currently, although the consensus is that smoking is *haram*, in many countries Muslim jurists have not issued rulings on the matter and so smoking remains lawful.

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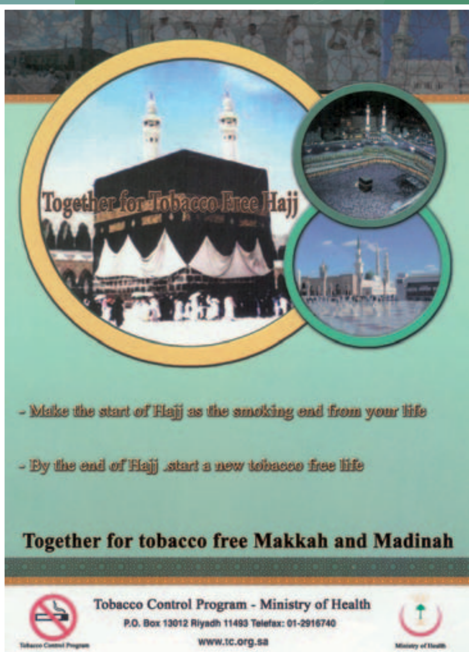

The potential benefits of making these cities tobacco-free are many.

Making Mecca and Medina Tobacco-free

The Holy Mosque in Mecca and the Mosque of the Prophet in Medina are the two holiest places in Islam. It is obligatory for all adult Muslims, who can afford it and are in good health, to make the pilgrimage (*hajj*) to Mecca once in their lifetime. Each year over 3 million pilgrims make the journey to Mecca for the 5 days of *hajj*. In addition, millions more visit the two cities outside the *hajj* season, for the lesser pilgrimage of *umra*.

The potential benefits of making these cities tobacco-free are many. Since the *hajj* represents for pilgrims a spiritual rebirth and forgiveness of sins, informing pilgrims that tobacco use is a sin in Islam would persuade many to quit, often immediately. Further, pilgrims come from every corner of the globe and they would carry the anti-tobacco message back to their communities. This would put the two holy cities at the forefront of a global campaign to combat tobacco.

In 2002, Mecca and Medina were declared tobacco-free by royal assent. The health ministry and nongovernmental organizations were charged with implementing the declaration. The aim was not simply to restrict smoking in the two cities but to prohibit all commercial activities involving tobacco. No one may buy, sell or use tobacco within the boundaries of the two cities. Tobacco is not completely prohibited as the trade may continue outside the city boundaries and personal possession of tobacco products is allowed.

In Medina the support of the Governor, was invaluable. An overall strategy was jointly agreed between the governor's office and a tobacco control civic

organization. The city and its districts were divided into three concentric circles with the Holy Mosque of the Prophet at the centre. The inner, middle and outer circles had a radius of 1, 5 and 15 kilometres, respectively.

Initially the Governor and City Council banned the sale of all tobacco products within the inner circle and a few months later the ban was extended to cover the middle circle. Thereafter, an order was issued banning the renewal of all licences to sell tobacco within the third circle. Agencies with a licence to sell tobacco were also barred from delivering tobacco products to any commercial facility in Medina.

As part of an information campaign about 500 000 brochures and pamphlets were distributed, as well as 5000 posters and 5000 cassette tapes. Twenty restaurants, cafés, and similar establishments were closed to prevent them from selling *shisha* (waterpipes) and their operations moved to the outskirts of the city. In addition, 200 retailers stopped selling tobacco products.

In Mecca, smoking and the sale of tobacco were prohibited within a prescribed radius of the holy mosque, as well as near schools. Billboards carrying anti-smoking messages were posted all around the city but especially around the Holy Mosque. Posters, brochures, pamphlets and stickers were handed out to 3 million pilgrims, in six different languages. Further, no form of tobacco advertising is now permitted around these holy zones.

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A visit to the two cities reveals that they are free of tobacco advertising and that cigarettes are not visibly on sale.

Civil society activities

The Ministry of Health and two civil society groups, the Charitable Organizations to Combat Smoking in Mecca and Medina, spearhead tobacco control activities within the cities of Mecca and Medina. These organizations make policy recommendations to the authorities, run educational programmes in schools and for adults, monitor the implementation of policies, run smoking cessation clinics and follow international initiatives in tobacco control. On World No Tobacco Day anti-smoking advertisements are broadcast on television. The organizations have also developed cartoons, comic books, rhymes and songs for younger children explaining the harms of active and passive smoking.

Smoking cessation clinics

The Saudi health ministry took the additional step of establishing specialized smoking cessation clinics for smokers. These are available at no cost to both locals and pilgrims from abroad. These clinics offer information about the health effects of tobacco and on addiction. Smokers are also helped to make informed choices of treatment methods. On average, each clinic treats about 4000 people a year. The main treatment method offered at these clinics is electrical stimulation of acupuncture points, the aim of which is to reduce the withdrawal symptoms associated with quitting smoking.

Effectiveness of the policy measures

A visit to the two cities reveals that they are free of tobacco advertising and that cigarettes are not visibly on sale.

Enquiries at several retail stores generally produced the same response: they do not sell cigarettes, because the authorities have clamped down on such sales. However, this does not mean cigarettes cannot be bought within the two cities. An underground trade has developed, with street cleaners readily selling tobacco to pilgrims.

One benefit of the prohibition of sales is that there are no retail displays or promotions of tobacco products. The usual promotional techniques which increase the visibility and reinforce the imagery of cigarette brands at retail are absent. So the tobacco companies are not able to offer retailers rebates, free products, display cases or special value added offers, that encourage retailers to create tobacco friendly environments with enticing displays, competitive prices, and visible point-of-sale advertising. Point-of-purchase advertising and displays have been found to increase average tobacco sales by 12% [9,10].

The most obvious reminder of tobacco in the two cities is visible smoking outside international hotels and on the streets. Because princes and other members of the royal family themselves smoke, it appears that the control of such smoking may be politically sensitive. In the absence of proper enforcement the no-smoking rules will remain ineffective and the hoped for effect on pilgrims diluted.

Some attempt has been made to remedy the situation. In the immediate vicinity of the holy mosques, young religious scholars politely remind pilgrims of the no-smoking rule. The airport authorities have also been given responsibility to ensure that the airports are smoke-free. The lack of strict enforcement of the no-smoking rules in public places is a major drawback. More positively, surveys of schoolchildren indicate that the educational efforts have resulted in an increase in anti-smoking attitudes and a reported reduction in smoking among younger children.

With regard to the use of acupuncture in the smoking cessation clinics, although the therapists report high levels of subjective patient satisfaction with the treatments, acupuncture is not generally considered an effective treatment. A Cochrane review looked at 24 trials comparing active acupuncture with sham acupuncture (using needles at points that are supposedly 'incorrect' for the condition) or other control conditions [11]. The review did not find consistent evidence that active acupuncture or related techniques increased cessation success rates. However, there was not enough evidence to dismiss the possibility that acupuncture might have an effect greater than placebo. There is an urgent need for the clinics to evaluate the effectiveness of their cessation clinics, through randomized, controlled trials of acupuncture. The Saudi clinics are in an excellent position to conduct such a trial as they have been using the technique for several years and have the facilities to recruit and treat sufficient patients for meaningful analyses.

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Sheikh Al-Ghazali advised that the way forward is to give people time to find a solution to their predicament, while clearly informing them they commit an offense.

Solving the adherence conundrum

A universal ruling that smoking is *haram* creates a major dilemma for Muslim communities. Overnight, millions of smokers will have their addiction declared a sin. This would include many religious teachers and scholars themselves, as well as political and social leaders.

Recognizing the problem, Sheikh Muhammad Al-Ghazali, a highly respected 20th century scholar, advised that the way forward is to give people time to find a solution to their predicament, while clearly informing them they commit an offence. He advocated a "gentle, gradual approach". He cited the measured approach that Islam adopted to prohibiting alcohol. First, Muslims were warned that although there were benefits in alcohol, the harms exceeded the benefits. Some people got the message and started to abstain, but the majority continued to drink. Next, Muslims were not allowed to pray while under the influence of alcohol. So those who prayed five times daily had to stay sober throughout the day and until well after nightfall. Finally, alcohol was totally prohibited, but only once people were psychologically prepared for the prohibition.

A similar strategy with regard to tobacco may be to declare that tobacco is *haram* and that it is the responsibility of Muslims to abstain from its use. Smokers must therefore make good faith attempts to quit. Those unable to do so should be advised to use less harmful substitutes, while continuing to seek ways of quitting.

Conclusions

The availability, affordability and social acceptability of any drug are key determinants of the level of use of that drug in society. When cigarettes are inexpensive, easily available and their use encouraged by society, then consumption will be high. The Saudi authorities have attempted to moderate two of these factors (availability and acceptability) in Mecca and Medina to reduce tobacco consumption. They have innovatively appealed to pilgrims' religious beliefs to change the social acceptability of tobacco use.

There is a clear rationale for appealing to religion in these two cities. Pilgrims at a time of spiritual renewal and seeking forgiveness for their past sins may be particularly receptive to messages to quit smoking not only for their health but as a religious responsibility. Moreover, people from across the world will receive this message at a 'teachable moment'.

The use of religion in health promotion is questioned by some who argue that it treats believers as passive recipients of religious doctrine. There is also the fear of clashes with religious authorities on more controversial issues, such as family planning or organ donation. The first considerations of clerics will be religious and political, and not health orientated [12]. However, given the importance of religion as a social factor it would be unwise to ignore religion in promoting health when it is appropriate to do so. The added value of religion- based appeals to quit smoking in Mecca and Medina cannot be denied.

How much the campaign has influenced pilgrims is not known. Nor is it known how the pilgrims perceive the campaign and if it has changed their attitudes and behaviour. It is important to evaluate the effectiveness and impact of the intervention and to determine to what extent programme goals were met. There are several areas that need to be studied both among the local inhabitants and international visitors:

The Saudi authorities have innovatively appealed to pilgrims' religious beliefs to change the social acceptability of tobacco use.

1. What level of awareness is there of the campaign and what opinions do they hold about it?
2. Has awareness of the religious injunction against smoking increased among both smokers and nonsmokers? Have knowledge and attitudes towards tobacco use changed?
3. Has the law reduced the availability of tobacco and public smoking?
4. Has reduced accessibility of tobacco reduced use among children and adults? In this regard children are less mobile than adults and cannot easily travel to the city limits to buy cigarettes. Did the prohibition of sales lead to less smoking among minors compared to adults in the local population?
5. Has the absence of point-of-sale advertising reduced children's awareness of tobacco brands?
6. How effective are the smoking cessation clinics and the methods used?

In addition to reducing availability and accessibility, the affordability of tobacco also needs to be reduced. Increasing the price of tobacco, through tax increases, is the single most important short-term determinant of levels of tobacco use. There is still scope for increasing tobacco taxes in Saudi Arabia. Comprehensive tobacco control activities are more effective than isolated strategies. Best practice also requires that the current traditional social stigma against women's smoking be replaced with health, religious and information-based motivations.

Making Mecca and Medina truly tobacco-free can send a resounding message to the world's 1.2 billion Muslims. Reducing tobacco use in these communities can, in turn, make a very significant contribution to reducing the global health impact of the tobacco epidemic.

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