

The role of religion in tobacco control interventions

Fatimah El Awa¹

The systematic study of the relevance of religion and spirituality to health is urgently needed. Public health advocates must join with other sectors to advance knowledge in this field and improve its use in support of health for all. This does not mean, however, that religion-related health campaigns should cease until such studies are completed: both should advance in parallel to change the social acceptance of harmful behaviours such as tobacco use.

In connection with the paper in this issue by Samer Jabbour & Fouad Mohammad Fouad (pp. 923–927), the following points need to be made concerning WHO's part in religion-based tobacco interventions. The origin can be found in the resolution passed by the Thirty-seventh World Health Assembly, in 1984, which called upon WHO Member States to include a spiritual dimension in their health strategies based on their social and cultural patterns (1).

The link between religion and tobacco was not initiated by the WHO Regional Office for the Eastern Mediterranean (EMRO). It began as early as 1602, when a fatwa was issued in Morocco completely prohibiting the use of tobacco; 19 similar edicts followed (2).

At the present time there is no doubt about the negative health consequences of tobacco use. All religions, with the well-being of humans at heart, are in a position to show disfavour with tobacco use, if not to prohibit it totally (3).

EMRO supports its Member States in this field, when requested. A prime example is the Saudi Arabian Tobacco-Free Mecca and Medina initiative: EMRO nominated the two cities for the global Tobacco-Free Cities project, launched in 2002, after the Saudi Arabian authorities took steps towards restricting the use of tobacco in the area of the two holy mosques.

A similar situation occurred with the mass distribution of the fatwa in Egypt, at the Ministry of Health and

Population's request. EMRO published *Islamic ruling on smoking*, in 1988, which included the views of Islamic scholars, and the Christian view of tobacco use.

The WHO Regional Office for the Western Pacific (WPRO) has also supported religion-related events. The first was the International Seminar and Exhibition on Tobacco or Health, held in Brunei Darussalam in July 2002, whose main focus was to discuss the Islamic perspective on tobacco use. The second, held in Cambodia, was on Buddhism and tobacco (4).

It is clear from documents of the tobacco industry that religion-based tobacco control activities are seen as a threat. Such activities should therefore be considered by public health advocates as a promising component of tobacco control (5).

Behaviour, especially addiction-associated behaviour, cannot be changed in the span of a few years: it requires dedicated action and time. In the Eastern Mediterranean regional plan of action for tobacco control 1999, it was considered advisable to use religion-based approaches in a wider context with other measures that are well known for being effective in controlling tobacco use. What to implement and what to exclude is a national choice (6).

The unintended consequences mentioned by Jabbour & Fouad are unlikely to arise.

Religious leaders are key social players. On many occasions and in many countries they have played a key role in promoting healthy lifestyles. A clear example is the role of Iranian scholars in promoting family planning, which has led to notable success (7). In the philosophy and strategy of health for all it is stated that all sectors of society should be involved in health promotional activities; in some countries this is not possible without the involvement of religious leaders (8).

Consensus is not always essential in order to conduct various activities. In the area of tobacco control, for example, the

lack of consensus on the use of health education campaigns does not mean that they should stop. In WHO Member States, however, there is considerable agreement on the use of religion in support of public health, confirmed by the many activities and literature concerning not only tobacco control but also other areas, such as the recently adopted strategic plan 2002–2005 for HIV/AIDS (9) which states that "protective cultural and religious values are key determinants in the development of an effective response to HIV/AIDS/STD".

It should be noted that if national authorities tend to use religion-based campaigns in addition to other measures, it is because they are less costly and there are no complications at the level of authority. Earmarking or taxation-related policies take much longer to adopt and implement, and involve so many parties that conflicts of interest often arise.

In conclusion, and as suggested by Jabbour & Fouad, it is believed that religion-based initiatives should be evaluated and developed in light of the evaluation, in order to ensure evidence-based activities. Withdrawing from the use of religion-based activities, however, would be a setback for public health. ■

References

Web version only, available at: <http://www.who.int/bulletin>

¹ Regional Adviser, Tobacco-Free Initiative; Regional Focal Point, Health and Human Rights, World Health Organization Regional Office for the Eastern Mediterranean, WHO Post Office, Abdul Razzak Al Sanhoury Street, Naser City, Cairo 11371, Egypt (email: alawaf@emro.who.int).
Ref. No. 04-018382

1. *Thirty-seventh World Health Assembly, Resolution WHA37.13*. Geneva: World Health Organization; 1984. WHO document WHA37/1984/REC/1:6.
2. Hajji M. Le tabac et l'éléphant [Tobacco and the elephant]. In: Esskalili L, editor. *Le mémorial du Maroc [The memorial of Morocco]*. Rabat: Mord Organisation; 1985. Volume 3:231-3.
3. *Tobacco Free Initiative Meeting on Tobacco and Religion, Geneva, Switzerland, 3 May 1999. Report*. Geneva: World Health Organization; 1999. WHO document WHO/NCD/TFI/99.12.
4. *International Workshop on Buddhism and Tobacco Control, Cambodia, 7–9 May 2002*. Geneva: World Health Organization; 2000. Available from: http://www.who.int/tobacco/national_capacity/religion/en/
5. Hammond R, White C. *Voice of truth*. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2002. WHO/EMRO document WHO-EM/TFI/001/E/L/07.02/500.
6. *Plan of action for tobacco control in the Eastern Mediterranean Region*. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 1999. Available from: <http://www.emro.who.int/tfi/TFI%20Plan%20of%20action-June99.pdf>
7. Larsen J. *Iran, model for family planning*. Washington (DC): The Earth Policy Institute; 2002. Available from: <http://www.earth-policy.org/Indicators/indicator1.htm>
8. *Formulating strategies for health for all by the year 2000*. Geneva: World Health Organization; 1979. Health-for-All Series, No. 2.
9. *Improving health sector response to HIV/AIDS and sexually transmitted diseases in the countries of the Eastern Mediterranean Region of WHO: Regional strategic plan 2002–2005*. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2000. WHO/EMRO document WHO-EM/STD/029/E/G/2000.