

Religion-based tobacco control interventions: how should WHO proceed?

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Abstract Using religion to improve health is an age-old practice. However, using religion and enlisting religious authorities in public health campaigns, as exemplified by tobacco control interventions and other activities undertaken by WHO's Eastern Mediterranean Regional Office, is a relatively recent phenomenon. Although all possible opportunities within society should be exploited to control tobacco use and promote health, religion-based interventions should not be exempted from the evidence-based scrutiny to which other interventions are subjected before being adopted. In the absence of data and debate on whether this approach works, how it should be applied, and what the potential downsides and alternatives are, international organizations such as WHO should think carefully about using religion-based public health interventions in their regional programmes.

Keywords Tobacco use cessation/methods; Smoking cessation/methods; Religion; Health promotion; Health policy; Evidence-based medicine; World Health Organization; Eastern Mediterranean (*source: MeSH, NLM*).

Mots clés Arrêt tabac/méthodes; Sevrage tabagique/méthodes; Religion; Promotion santé; Politique sanitaire; Médecine factuelle; Organisation mondiale de la Santé; Méditerranée orientale (*source: MeSH, INSERM*).

Palabras clave Cese del uso de tabaco/métodos; Cese del tabaquismo/métodos; Religión; Promoción de la salud; Política de salud; Medicina basada en evidencia; Organización Mundial de la Salud; Mediterráneo Oriental (*fuentes: DeCS, BIREME*).

Arabic

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Introduction

The 12th World Conference on Tobacco or Health in Helsinki, Finland, held in August 2003, ended with a plenary lecture on the role of religion in tobacco control; this stirred much discussion. The rationale for using religion, as well as examples of activities and data on its perceived impact, were presented by WHO's Eastern Mediterranean Regional Office (EMRO) and summarized in a news article (1). While it is commendable that EMRO is using all opportunities to promote tobacco control, it remains unclear whether this is actually affecting tobacco use in the region. The more difficult question is how WHO should approach interventions for which there is no peer-reviewed evidence and which have yet to be subjected to vigorous discussion.

Religion and tobacco

Summarizing the complex association between religion and health is beyond the focus of this article, and it has been covered extensively elsewhere (2). Religion may play a part in health beliefs and behaviours such as tobacco use. However, no sys-

tematic effort has been made to summarize the relationship between tobacco use and religious beliefs and practices, but a few observations can be made. Reports from diverse settings suggest that religiousness in different faiths is associated with less use of tobacco (3–11). Members of the same community, even if they adhere to different faiths, seem to have similar patterns of tobacco use (12). Maziak et al. have shown that where differences are present, it is not clear whether this is due to religion or to broader social differences (of which religion is only one) (13). This and other studies (14–17) raise questions about the importance of religion as an explanatory variable for tobacco use. Indeed, tobacco use by religious professionals is common (18, 19), and patterns of tobacco use worldwide do not correlate with the religiousness of societies or the faiths to which their members adhere.

Religion-based public health interventions: relevance for tobacco control

There are an increasing number of reports from multiple settings, in richer as well as poorer countries, and in areas of different faiths, monotheist and others, on using religion as a public

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health intervention to improve variations of health outcomes. A review on this topic summarized the research and practice challenges (20). The evidence is difficult to synthesize and remains conflicting due to variety in methods, settings, populations, definitions of exposures and outcome measures. Common methodological limitations of many published studies include small sample sizes, inadequate control of confounders and failure to control for multiple comparisons. The increasing interest in the impact of religion (and, more generally, spirituality) on health has led to the introduction of this topic into the curricula of many medical, public health, nursing and theology schools (21). Several large-scale initiatives, involving universities or schools of public health, are devoting important resources to studying the impact of religion on health and to openly promoting the need for considering religion in health care (22).

With regard to tobacco, studies have reported on the use of religious settings, holy times, religious professionals and/or faith-based interventions to reduce tobacco use and other risk behaviours (23–28). There are calls to use more of these approaches to prevent diseases and reduce the use of tobacco (29–32). EMRO has taken several steps towards using religion to promote tobacco control in the Eastern Mediterranean Region. Religious authorities, both Muslim and Christian, were solicited to provide their opinions on tobacco and to advocate against tobacco. Muslim scholars issued religious opinions, or “fatwas,” advising their followers that smoking inflicts bodily harm upon its users and so they should abstain from using tobacco (33, 34). WHO followed this up with a larger meeting of prominent leaders from all religious faiths, and they unanimously agreed that smoking is not sanctioned (35). EMRO has worked with Saudi Arabian authorities to restrict access to tobacco in the holy sites of Mecca and Medina, especially during Ramadan and the annual pilgrimage. These steps build on EMRO’s publications that advocated using a religious perspective and approach to tackle diverse public health issues, such as AIDS, environmental health and health promotion (36).

To involve religion or not: WHO’s dilemma

It is important to have cultural sensitivity, pay attention to local needs and use local opportunities when choosing health interventions. These considerations had a role in creating WHO’s regional offices in the first place. WHO, academic public health institutions and state health institutions, which have traditionally shied away from seriously considering religion, cannot ignore religion as an important component of the social fabric of many societies. The issue then is not whether religion should be considered in public health but how and under what conditions.

In the Eastern Mediterranean Region it is often claimed that widespread religiousness among the public dictates the need to use religion as a pillar of public health interventions (36). This argument alone, however, is not sufficient for using religion as the basis for public health policy for the following reasons:

- communities in this region, and individuals in these communities, are quite diverse in terms of religiousness, thus interventions need to be tailored accordingly to affect members of all communities, including those who are not religious;
- religiousness is not unique to the region, in fact it occurs all over the world and among members of all faiths. Therefore, the rationale for focusing on religion in this region, as compared with other regions, must be more clearly presented;

- there are other social attributes that also need consideration but which are inadequately studied and utilized. These include, for example, the values, beliefs and attitudes of the new cyber-savvy younger generations, especially women.

Furthermore, there are many other problematic issues to address because in religion, as in other fields, the devil is in the detail. What are some of these issues?

Inadequate evidence base

Data are inadequate to support this approach. Process indicators, such as issuing a fatwa against smoking and banning smoking in certain sites and at certain times, are of course welcome. However, it has yet to be demonstrated that the wider application of religion-based interventions will have an impact on high rates of smoking in this region. Country profile data published between 1997 and 2003 do not show any reduction in smoking in the region (37–39). Furthermore, although studies indicate that religion can be a deterrent to smoking in the Eastern Mediterranean Region (11, 13, 34) this cannot be assumed to mean that religion-based interventions will be effective in controlling tobacco use. Indeed, despite a high level of awareness of the fatwa against smoking in Egypt, attempts to quit smoking have not increased (34). Data from EMRO’s campaign remain too preliminary for wide advocacy of this approach. This means that we need to evaluate religion-based interventions in a research context so we can generate evidence from properly designed and conducted studies. Without such evidence, advocating and adopting religion-based interventions would be a departure from evidence-based practice, a potentially significant step for WHO. At the very least, arguments to justify excluding religion-based interventions from the usual process of efficacy evaluation should be presented and debated.

Unintended consequences

Using religion to help control the use of tobacco may have unintended consequences. For example, religious institutions and authorities may come to be seen as the main public health players thus overshadowing already weak public health institutions. Although religious authorities may care about public health, they have no public health expertise and their priorities may come into conflict with other public health initiatives. For example, religious authorities who agree with WHO on tobacco control may have opposing views when it comes to other health issues, such as family planning. When religious authorities take positions on controversial issues that are favourable to public health their considerations tend to be more religious and political rather than health oriented.

Additionally, religion is unavoidably linked to religious institutions and authorities and thus to politics. Therefore, relying on religious authorities in the fight against tobacco, and in other public health areas, may be perceived as promoting religious authorities as key social players. This has the potential to increase their strength in many societies but especially among the more traditional societies in the Eastern Mediterranean Region. This may add more heat to existing contentions between religious and secular groups over social policies.

Selective use of religious authorities

There is no unified interpretation of what all religions dictate in terms of health policy. This is not so much of a problem for tobacco control (which receives wide if not unanimous support

from religious authorities) as it is for other health interventions, such as family planning. Therefore, using religion to promote health requires selective application of religious principles and careful treading of sensitive terrain that is influenced by preferences and strong opinions. But promoting selectivity may backfire. Some policy-makers may choose to use religion selectively to promote policies that do not have public health merit. The current administration of the United States would like to withdraw support from family planning programmes that allow abortion, partly on religious grounds. However, its weak support of the WHO Framework Convention on Tobacco Control does not give it the high moral ground.

Moreover, selectively enlisting one religious faction to promote public health may alienate other factions who see the issue differently. An important lesson was learnt from the United Nations' International Conference on Population and Development held in Cairo in 1994 during which there was an apparent conflict between religious factions of the same faith that held different views, for example Catholics for Free Choice and other Catholic clerics argued over family planning methods. WHO needs to consider whether it can afford to be put in the middle of such conflicts.

Opportunity costs and resources

There are many unexploited or inadequately exploited non-religious public health interventions. In tobacco control there are well tested interventions, including taxation and restriction of access, that deserve wide application. As a public health intervention the use of religion is associated with opportunity costs, and it requires resources. Interventions should be chosen based on opportunities that are informed by evidence. For example, even in a traditional society such as that found in Syria, health consequences were more important deterrents to smoking than religion (17). Focusing on religion in this case may not give the desired outcomes.

Ethical issues

Complex ethical issues need to be considered when religion is used to meet public health needs. Sloan et al. (40) have argued that religion is not in the domain of responsibility and expertise of health professionals, and while there is a need to consider religion as a social factor, its use in health promotion has risks. They have also argued that the use of religion-based interventions may be associated with harm because the public may link poor health outcomes to non-adherence to religious teachings, thus further exacerbating the guilt that many people, especially elderly people, feel about their responsibility for their bad health.

Potential risks specific to WHO

Using religion-based interventions to promote health is not without potential risks for an organization such as WHO. If religion-based programmes are run under its name and logo and are branded as WHO programmes, they must be well designed

and implemented and be able to withstand the scrutiny of sceptics. Furthermore, as an international organization, WHO would need to consider a range of opinions when deciding on a policy issue of this importance. It seems that the rationale for, the need for, the effectiveness of, and alternatives to using religion as a strategy have not been thoroughly considered within WHO.

What needs to be done?

There is no consensus within the public health community about using religion in interventions, even for those that receive unanimous support, such as tobacco control. Because religion remains a divisive issue, well beyond public health circles, the issue of whether to use religion-based interventions must be approached with care. Obviously, religious practices and the faith of the public should be respected. When requested by national governments and regional bodies to work in religious settings and with religious authorities WHO is mandated to respond as positively as it would to requests to work with other bodies. Furthermore, WHO should not shy away from considering and incorporating religion into its policies and programmes as it would other social attributes.

What is controversial is whether it is acceptable to use religion as the basis for health promotion programmes as the Regional Office for the Eastern Mediterranean has done and whether religion-based interventions can be exempted, because of cultural sensitivities, from the evaluation process usually used before public health interventions are adopted. We argue that at the very least a broad dialogue should be started. Such a dialogue should debate the conceptual, philosophical and social implications of using religion-based interventions; review case studies and discuss lessons learnt in the Eastern Mediterranean Region and elsewhere; and develop recommendations and mechanisms for assessing the potential health impact and social impact of using religion-based interventions. This process should be guided by evidence evaluated in the same manner and with the same rigour as evidence used to assess other candidate health interventions.

Another issue for debate is whether using religion in public health can be explored at a country level or regional level or whether it requires organization-level discussions and strategies. The first approach befits the decentralized nature of WHO and encourages national and regional initiatives and creativity. However, sensitive issues may need to be taken up more centrally and involve all countries in order to synthesize evidence from multiple settings and devise a strategy that makes sense to all. This applies not only to the use of religion but also to approaches at the opposite end of the spectrum, for example the use of symbols of consumerist culture, such as beauty queens, to promote tobacco control. While WHO should be involved in debating these issues, broader participation is also important to solicit a range of opinions. ■

Conflicts of interest: none declared.

Résumé

Interventions antitabac s'appuyant sur la religion : comment l'OMS doit-elle s'y prendre ?

Faire appel à la religion pour améliorer la santé est une pratique séculaire. Cependant, l'utilisation de la religion et l'enrôlement des autorités religieuses dans des campagnes de santé publique, comme dans le cas des interventions antitabac et autres activités entreprises par le Bureau régional de l'OMS pour la Méditerranée orientale, représentent un phénomène relativement récent. Bien qu'il convienne d'exploiter toutes les possibilités offertes par la société pour lutter contre le tabagisme et promouvoir la santé, les interventions s'appuyant sur la religion ne doivent pas être

dispensées de l'examen factuel approfondi auquel sont soumises les autres interventions avant d'être adoptées. En l'absence de données et de débats sur l'efficacité de cette approche, sur la façon dont elle doit être appliquée et sur ses inconvénients et ses solutions de remplacement éventuels, les organisations internationales telles que l'OMS devraient engager une réflexion approfondie sur l'utilisation d'interventions de santé publique s'appuyant sur la religion dans leurs programmes régionaux.

Resumen

Intervenciones de control del tabaco basadas en la religión: ¿cómo debe actuar la OMS?

Recurrir a la religión para mejorar la salud es una práctica secular. Sin embargo, el uso de la religión y de las autoridades religiosas en campañas de salud pública, como se ha hecho en algunas intervenciones de control del tabaco y de otro tipo emprendidas por la Oficina Regional de la OMS para el Mediterráneo Oriental, es un fenómeno relativamente reciente. Aunque hay que explotar todas las oportunidades posibles que brinde cada sociedad para combatir el consumo de tabaco y promover la salud, las intervenciones

basadas en la religión no deben quedar exentas de los exámenes basados en la evidencia a que se someten otras intervenciones antes de adoptarlas. A falta de los datos y el debate necesarios para determinar si este enfoque funciona, cómo debe aplicarse y cuáles son sus inconvenientes y las alternativas, las organizaciones internacionales, como la OMS, deben estudiar detenidamente la conveniencia de acometer intervenciones de salud pública basadas en la religión en sus programas regionales.

Arabic

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