Technical Discussions

HEALTHY LIFESTYLES
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1. INTRODUCTION

The term "lifestyle" is used to give explicit recognition to the fact that health and illness are greatly influenced by the ways people live. Recognizable patterns of habitual behaviours and attitudes make people's preferences in areas such as nutrition, recreation, drug use, sleeping, employment and sports predictable in a given social and physical environment. The extent to which these habits and mental attitudes are recognized as determinants of health outcomes reveals the importance of approaching health and disease from a psychosocial and behavioural sciences perspective, in advance of the traditional biomedical processes of diagnosis and treatment.

2. SCOPE AND ORGANIZATION OF THE PAPER

This paper briefly reviews the concepts of health and lifestyle. It examines the relationship of human behaviour to health and disease and how the modification of some aspects of human behaviour can help in the prevention of disease and promotion of health.

The paper further discusses the implications of a psychosocial and behavioural approach to promoting healthy lifestyles and to identifying some of the difficulties and opportunities inherent in adopting such an approach, the utility of which will be considered in the context of the problems, opportunities and constraints currently prevailing in the Eastern Mediterranean Region (EMR). This is followed by a set of recommendations for consideration by the Regional Committee.

3. A BRIEF REVIEW OF THE CONCEPTS OF HEALTH AND LIFESTYLE

3.1. Definitions of health

WHO's definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" represents an ideal concept of health as a sublime state of existence. It has sometimes been criticized as utopian and absolute. Commentators have pointed out that allowance could be made for the fact that being healthy could be a matter of degree, relative to an individual's or group's need for health to achieve other purposes.

Health has also been considered as a capacity, potential or ability to achieve goals or perform functions. It has been seen as an ever-changing dynamic phenomenon or process which may be cumulative, in terms of accumulated learning and development, or cyclical, in phases of creation and destruction. These concepts emphasize health as a means to an end rather than as an end in itself.

However, in practice, the negative concept of health as the absence of disease has tended to determine decision-making, planning, expenditure and the organization of "health" services in both industrialized and developing countries. In actual fact, services for sickness are named "health services", reinforcing the custom of defining health by what it is not.

3.2. Definitions of lifestyle

The term "lifestyle" has become popular in the medical literature in recent years. It generally refers to personal habits or patterns of
individual behaviour which have become persistent over a long period of time. In the field of health, for example, such personal habits or lifestyles would include the patterns of behaviour related to eating, drinking, sleeping, exercise, personal hygiene, sexual behaviour, etc.

One working definition of lifestyle that attempts to cover the multitude of background factors reads as follows:

"Lifestyles are patterns of behavioural choices made from the alternatives that are available to people according to their socio-economic circumstances and to the ease with which they are able to choose certain ones over others."

3.3. The place of healthy lifestyles in modern concepts of health

Progress in medical science and technology over the last 100 years has been spectacular in many ways. An immense body of knowledge has been produced that enables us to understand many diseases in ever greater detail and use many forms of interventions to prevent and treat them in a large number of cases. However, the vast organizational complexes called "health care systems" that exist in many countries have become a source of growing and serious concern, despite their unquestionable contribution to the cure of disease and the care of the sick.

Most of the concerns about modern health care systems are already well-known. Firstly, the growing cost of medical technology is becoming unbearable, particularly in the context of Third World countries. Secondly, the benefits of modern medicine are disproportionately distributed: i.e. the economically better-off sections of society get more out of health services than the poorer sections, in both urban and rural communities. Many of the chronic and degenerative diseases such as cardiovascular diseases, cancer, mental and neurological disorders, accidents, alcohol- and drug-dependence, appear to be increasing, while the existing services can provide very limited help in such situations. Lastly, too much dependence on machines and technology is slowly dehumanizing medical care.

There is growing awareness that the currently popular biomedical paradigm of health provides only a limited view of health and disease. It tends to look at the disease phenomenon in a mechanistic way and considers the human being like a machine, the disease being a breakdown of the machine and the doctor's task being to repair it.

3.3.1. Newer concepts of health

An alternative way of looking at health is through the sociomedical paradigm, which has gained great prominence in recent years. According to this concept, there is a clear link between the prevalence of health and ill health in any given population and the socio-economic and sociocultural factors involved. It is interesting to note that before the recent prominence of the biomedical paradigm, many earlier civilizations had looked upon health and disease in a somewhat different light. For example, in both Arabic Islamic medicine and the Indian medical system of Ayurveda, health was conceptualized as a "balance" between various natural forces and bodily forces (the humoral theory). Disease was a sign of imbalance in this interaction. Healthy living, following the natural laws, was thus considered essential for health. Even in Europe of the seventeenth and eighteenth centuries, with the rapid industrialization and urbanization that were taking
place then, poverty and the adverse living and working conditions of the lower classes were seen to account for their poor health and high rate of premature death. Insufficient nutrition, poor housing, inadequate hygiene, extremely long working hours and lack of recreation were all identified as the most deleterious influences on health and well-being.

The sociomedical paradigm is well illustrated in the well-known Lalonde Report from Canada (1974) in which health is perceived, not as something which is confined to the individual but as a "field of health". According to this report there are four important components of this "health field". These are: (1) human biology (2) environments (3) lifestyles and (4) health care organizations. It is obvious that, during the last hundred years of the progress of medicine, the fourth component, health care organizations (particularly hospitals), has received disproportionately greater attention and has absorbed the greater part of financial and manpower resources. Environmental factors have received much less attention than they deserve while the field of lifestyles, i.e. personal habits and personal choices related to health, has been largely neglected.

3.3.2. Health promotion

At this stage it may also be important to clarify the term "health promotion". It may be noted that this is a relatively new term. The meaning of health promotion overlaps to some extent with the meaning of prevention. The main difference between the concepts of disease prevention and health promotion seems to be one of focus rather than one of overall perspective. Whereas prevention is a disease-related concept, health promotion is a health-related one. Sometimes the term "health protection" is also used along with "health promotion". Together they refer to the balance of health. While health promotion refers to efforts to strengthen the health potential, health protection refers to prevention of any imbalance of health equilibrium.

Some authors have visualized health as a balance between health resources and health risks. According to Noack, this balance can operate at four levels, i.e.: (1) the person, (2) health-related behaviour, (3) the sociocultural system, and (4) physical biological environments. This is illustrated in Table 1.

As already pointed out, health promotion is still an evolving concept. Some of its components which are commonly agreed upon are:

- fostering healthy lifestyles and enabling people to cope with their health problems;
- fostering social, economic and environmental conditions conducive to health;
- attaining these two by raising awareness about health matters in individuals and communities.
### TABLE 1. SUMMARY OF HEALTH RESOURCES AND HEALTH RISKS

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<thead>
<tr>
<th>System</th>
<th>Health resources</th>
<th>Health risks</th>
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<tr>
<td><strong>Person</strong></td>
<td></td>
<td></td>
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<tr>
<td>Biological system</td>
<td>Good nutrition status, immunity</td>
<td>Malnutrition, susceptibility to infections</td>
</tr>
<tr>
<td>Cognitive system</td>
<td>Ego identity, positive health attitude, adequate health knowledge</td>
<td>Inappropriate health attitudes and misinformation</td>
</tr>
<tr>
<td>Whole person</td>
<td>Emotional stability, physical fitness</td>
<td>General vulnerability</td>
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<tr>
<td><strong>Health-related behaviour</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habits</td>
<td>Healthy personal habits</td>
<td>Smoking, excessive drinking, overeating, lack of exercise</td>
</tr>
<tr>
<td>Work</td>
<td>Fulfilling and unstressful work</td>
<td>Overwork, stressful and/or dangerous work</td>
</tr>
<tr>
<td>Recreation</td>
<td>Sufficient sleep and recreation</td>
<td>Insufficient recreation and sleep</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sociocultural system</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health culture and practices</td>
<td>Positive health-related values, norms, lifestyle, religion</td>
<td>Unstable health-related values and beliefs; unhealthy lifestyle</td>
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<tr>
<td>Social network</td>
<td>Social integration, social ties</td>
<td>Social isolation, lack of social support</td>
</tr>
<tr>
<td>Work organization and job system</td>
<td>Availability of work, positive work climate, job satisfaction</td>
<td>Unemployment, work stress, job dissatisfaction</td>
</tr>
<tr>
<td>Health services, schools</td>
<td>Adequate and accessible health care and social services, health education</td>
<td>Lack or inaccessibility of health and social services or health education</td>
</tr>
<tr>
<td>Socio-economic structure</td>
<td>Adequate material resources, income, social security</td>
<td>Lack and uneven distribution of resources</td>
</tr>
<tr>
<td><strong>Physical-biological environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical resources</td>
<td>Adequate food supply, safe consumer goods</td>
<td>Insufficient and unhealthy food; easy access to cigarettes, alcohol, drugs</td>
</tr>
<tr>
<td>Micro-environment</td>
<td>Adequate housing and communications, safe water and transportation, proper waste disposal</td>
<td>Inadequate housing, crowding, dangerous traffic conditions</td>
</tr>
<tr>
<td>Macro-environment</td>
<td>Healthy climate, preservation of nature</td>
<td>Inadequate waste disposal Environmental pollution, exploitation of nature</td>
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3.3.3. Lifestyle-related illnesses

The heaviest burden of illness on developed countries today is related to individual behaviour. Epidemiological studies show that in such countries about half the mortality from the ten leading causes of death can be traced to health-damaging behaviour, including heavy smoking, high alcohol intake, over-eating, inactivity, and reckless driving.

Lifestyle factors identified as significant in developed countries are also important in developing ones. Smoking, for example, a major cause of cardiovascular disease and cancer, is on the rise in developing countries, as is the use of alcohol. The problem of nutrition is, of course, directly related to the availability of food, but even when food is available it may not be used in ways needed to prevent malnutrition. Breast-milk is an important resource, for nutritional, immunological and fertility reasons, yet breast-feeding poses difficult behavioural problems in the modern world.

The most effective interventions against diarrhoeal diseases are those that interrupt the transmission of infectious agents in the home. Well-documented findings show the importance of faecal contamination of food and water, and the effectiveness of simple actions such as hand-washing in preventing infection. Unfortunately, field demonstrations of effective household hygiene are rare in poor countries. Hygienic measures are essential in the fight against diarrhoeal diseases, the major killer of the young in developing nations, and behavioural research has a role to play in gaining their adoption.

3.3.4. Responsibilities and choices in lifestyles

Individual choice and responsibility play key roles in maintaining health. Research in industrialized countries has shown that only 15 to 20% of all sickness is cured by treatment in hospitals or other health facilities; the remainder is managed by individuals. This fact often goes unrecognized, because people tend to view modern medicine as a system of crisis management rather than of prevention through steady self-care. People's own instincts, wisdom, and customs are being ignored.

One way to counteract this is by adopting a lifestyle that promotes health and prevents disease. Such action depends on two factors: (1) personal choices and (2) national policies and health strategies. Lifestyles are intimately bound up with the values, priorities and practical opportunities of specific social and economic situations. A person's particular way of life is shaped by personal behaviour, social learning, and social environment. Thus lifestyles, shaped by experience and environmental factors, are not simply individual decisions to avoid or accept certain health risks. There are limits to the choices open to individuals - limits imposed by their physical, social and cultural environment and by their financial means.

A great deal of knowledge is needed to understand the relationships between health and the components of particular lifestyles. Many lifestyles enhance health, develop physical and mental well-being, and protect the individual from the effects of stress. Other lifestyles include behaviour that may damage health. Harmful practices, such as smoking or alcohol consumption, are sometimes ascribed to personal stress, but they often become routine habits. They can also symbolize certain stages in human development, such as growing up. Cultural patterns of social interaction, symbolic
behaviour and tension reduction are learned in childhood and reinforced throughout life. Thus they reflect ways in which members of a given society or group organize their daily lives.

Lifestyle practices are increasingly influenced by public and corporate policies that control the production of goods and promote products that may damage health. Opportunities and incentives to select healthy lifestyles thus depend heavily upon policies that shape the economic and social conditions under which people live. There are ethical issues to be considered when lifestyle policies and programmes are being devised. This means that a delicate balance must be achieved between respect for individual rights of free choice and the duty of society to promote the health of the population.

One of the major factors shaping individual lifestyles is inequality between countries and within countries. Socially and economically privileged people have a wider range of options in seeking a healthy lifestyle, while the disadvantaged are still grappling with the basic problems of existence. Ill health and poverty are closely related to each other and to lifestyles. Programmes for enhancing health through changes in lifestyle must not only widen personal choice, but also be supported by a resolve on the part of society to improve the status and standard of living of the poor. Other factors, such as rapid urban and industrial development, can also negatively influence health by uprooting large numbers of people and destroying cultural patterns and social ties.

People may not have the necessary knowledge to make an informed choice of lifestyle, or they may be inhibited by traditional attitudes. However, even when knowledge and motivation are present, they are not always sufficient to induce change once a type of behaviour has become part and parcel of daily life. Every opportunity should therefore be taken to provide incentives that make health-enhancing behaviour easier to choose and maintain, in the awareness that people's behaviour is largely determined by the necessities of everyday life and by what they perceive as pleasant and rewarding.

It is important to recognize that in some parts of the world change of lifestyle may be more closely linked with social groups and social organizations as opposed to individual responsibility. For example, in many EMR countries an individual is more likely to follow either correct or faulty behaviour because of group pressure as opposed to individual choice. Hence, efforts for alteration of lifestyles in such geographical areas should be directed more toward the group and its organizing leadership than to individuals as such. Conditions that foster dirt, poverty and overcrowding are regarded more as the responsibility of the group than of the individual.

4. ROLE OF BEHAVIOUR IN HEALTH AND DISEASE

4.1. Some examples of health-damaging behaviour

4.1.1. Behaviour related to nutrition

In the field of nutrition, health-damaging problems include insufficient nutrition, unbalanced nutrition, overnutrition and self-imposed under-nutrition. The problem of insufficient nutrition is related to social equity and sufficient basic resources. Unbalanced nutrition may be due to lack of knowledge; it is closely related to food advertising, packaging, etc. as well
as to the choice of menus in fast-food outlets, cafeterias and restaurants. The development of food-processing technology has influenced the availability, distribution and consumption of foods more than any conscious nutrition education campaign. There is commonly too little fibre, too much fat and too much sugar in diets in many affluent countries, and there may be deficiencies in important micronutrients. Overeating of energy-rich foods leads to obesity - an important problem in many countries - which in turn is linked with cardiovascular diseases, diabetes, etc.

Lessons in nutrition are not only for poor countries. Too many people in rich countries have not learned how to enjoy life without over-eating; the over-fed person does not necessarily eat well. "Malnutrition of the affluent" is a new reality. A cursory look at world nutrition tables is most revealing. Rich countries seem to be well at the top of the "fat list": 30% of what the average European eats consists of fat. In the United States, over 30% of men and 40% of women between the ages of 40 and 50 are obese. Similar patterns are now emerging in a number of affluent EMR countries. All this adds up to a disease-promoting recipe.

While obesity is mostly a problem for people in affluent countries, millions of poor children elsewhere suffer from malnutrition due less to the absence of food than to the presence of infection and disease. Their diseased bodies' ability to use efficiently the nutrients available from foods is impaired; and when insufficient calories are consumed, protein ordinarily used for growth and repair must instead be burned for fuel - thereby increasing the body's vulnerability to new bouts of illness.

4.1.2. Smoking, alcohol- and drug abuse

(a) Smoking

Smoking is the form of risk behaviour related to health that has been most studied. Smoking-related diseases include lung cancer and some other cancers, ischaemic heart disease, chronic bronchitis, emphysema and certain chronic arterial diseases of the leg. Furthermore, the effects on the foetus of smoking by pregnant women are causing increasing concern.

About a quarter of all cigarette-smokers are killed before their time by tobacco. Most would have lived another 5 to 30 years, the average being an extra 10 to 15 years. Government policies can facilitate individual choice and inhibit the popularization of smoking. Restrictions on both cigarette-advertising and promotion of cigarettes reduce the incentive to smoke; raising the cost of cigarettes lowers consumption; and health education promotes a way of life free from smoking. All this is especially necessary in developing countries, where present controls on the promotion and sale of cigarettes are generally minimal, and where the countries involved can ill afford the enormous burden that tobacco-related illness places upon already overstretched health resources. Losses in cigarette-tax revenue and tobacco-related jobs in farming and industry are a minor price to pay compared with the other consequences - expensive, long-term medical care; incapacitation; human suffering; and premature death.
FIG.1. Health problems with possible nutritional links

Note:
- Individual susceptibility to the prevailing diet is important in both nutritional deficiency and excess.
- The nutritional components have only been tentatively linked to many of the conditions shown.

(b) Alcohol abuse

Industrialized nations are witnessing major alcohol-related strains on their health services. In some European countries every third hospital bed is occupied by a patient with an alcohol-related disease. In most industrialized countries, drinking in company is a reflex action. Alcohol is part of social communications; it is both accepted and expected. But few people reflect on its damaging effects. Virtually all the body's vital organs are damaged by excessive drinking. Alcohol raises the blood pressure, causes psychiatric disorders, and has many other serious repercussions. Families suffer, violence flares, and serious accidents become more frequent, both at work and on the road.

The countries of the Eastern Mediterranean Region are fortunate that, due to Islamic traditions, they have some of the lowest rates of alcohol-related problems in the world. This is a clear indication of how lifestyles can influence the health of communities.

(c) Use of illicit drugs

Patterns of drug use in EMR countries are linked to social phenomena, such as changing living conditions, alienation and lack of cultural identity, especially among young people. The insecurity and conflicts arising from such social conditions are exploited by unscrupulous persons who promote drugs for profit, including very dangerous addictive drugs such as heroin and cocaine. This situation is exacerbated by several factors, including ineffectiveness of national drug control policies; insufficient coordination of drug control programmes, both nationally and internationally; ineffectiveness of programmes for prevention and treatment; and ineffectiveness of rehabilitation health services. It is sufficient that, in recent years, some EMR countries have successfully collaborated with religious leaders in the campaign against drug abuse.

Problems related to the use of psychoactive substances are not confined to illicit drugs, as there is substantial misuse and abuse of pharmaceutical products. It has, unfortunately, become a common practice to choose drugs to deal with social and psychological problems. The overprescribing of psychoactive drugs is a serious component of this problem.

4.1.3. Other risk-taking behaviours

There are many other examples of unhealthy behaviours which are linked with disease.

(a) Risk-taking sexual behaviour

In recent years, the rapid spread of AIDS has strongly focused attention on sexual behaviour. It is obvious that sexual promiscuity, multiple partners, and certain sexual practices greatly increase the risk of AIDS as well as that of some other sexually transmitted diseases. Since at present there is no known cure for AIDS, prevention through behaviour change is absolutely essential.

(b) Dangerous driving

Abuse of alcohol and other mood-altering drugs not only has direct effects but is also heavily related to the death and disability that result
from dangerous driving. In traffic accidents, driving behaviour is responsible for extensive death and disability, especially among adolescent males. In this respect, it should also be remembered that some societies have fostered a dependence on the motor car, which places people at an unavoidable risk. In many EMR countries, the number of cars is rapidly increasing. Many factors are involved in road traffic accidents, but not using seat belts, careless driving (especially under the influence of alcohol and drugs) and speeding are very significant. The protective effect of helmets for motorcyclists is also high; a non-helmeted rider is about five times as likely to suffer severe or critical injury and twice as likely to suffer a minor head injury as a helmeted one.

(c) Violence

Violent social behaviour also may result from drug- and alcohol abuse. This is perhaps the area where interaction of health-damaging forms of behaviour and their complex relationship with life's situations are most obvious. Child abuse, wife-beating, street violence, and rape are forms of violent social behaviour that are currently subjects of growing concern in many countries. Violence is associated with high levels of situational stress and/or inability to resolve conflict.

4.1.4. Mental stress

There is strong evidence that stressful events can be risk factors for both physical and mental disorders. Studies have shown that natural disasters produce both emotional and physical consequences. More common events, such as death of a loved one, divorce or loss of a job, are also associated with adverse health changes. Such life events have been identified as risk factors for a variety of physical disorders, e.g. peptic ulcer and myocardial infarction. A particularly well-documented risk factor for coronary heart disease is the type A behaviour pattern. This type of behaviour includes being highly competitive, aggressive, driven to achievement, hurried and impatient.

Modern research has identified many neurophysiological and immunological correlates of stress. It must also be understood that there is considerable individual variation in reaction to stress. A growing body of research evidence demonstrates the consequences of stress-producing situations on both physical and mental health. Coping behaviour, then, has both direct effects (the frequency of stress reactions in the body) and indirect effects (the tendency to use health-damaging forms of behaviour in attempts to feel better) on the preservation of health. Balanced physical activity, relaxation and social interaction, all of which promote health, are important components of effective coping. Unfortunately, the lives of many people do not allow the balanced lifestyle most conducive to health.

Health promotion programmes should not only provide information regarding health-enhancing behaviour but should also help individuals to obtain active support in their endeavours to lead a healthier life. Health professionals must develop an interest in health promotion and be ready to study the effectiveness of new approaches, e.g. in stress management. It is not enough to help people to overcome health-damaging ways of responding to stress. Active health-enhancing methods of stress management must be devised and promoted, including methods of problem-solving, keeping a proper balance between work and leisure and being able to relax in stressful situations.
4.2. Some examples of health-promoting behaviour

4.2.1. Exercise and fitness

Men and women in many affluent countries have gradually adopted an easy-going sedentary lifestyle which is not by any means healthy. In the countries of the Third World, physical work and plenty of walking give many an edge on fitness. The danger there is being unable to ensure an adequate diet, particularly for growing children; and when the diet is poor, too much exercise may reduce stamina and increase the risk of infection and disease. Exercise helps to maintain a steady body temperature and to regulate appetite, and it may provide protection against heart disease, asthma and hypertension as well as muscular and rheumatic diseases. A personal plan of fitness can also help to counteract work-related stress and other daily pressures of life.

By following a moderate exercise plan, the elderly may reduce the likelihood of immobility and so retain their independence. The disabled also have techniques well suited to them. Rich and poor alike can enjoy the benefits of exercise. The last decade has witnessed the great popularity of "jogging"; "work-outs" and other physical exercises, particularly in North America and Europe. The desire for exercise and fitness is also a psychological weapon against the use of tobacco and alcohol. Exercise produces a mental "high"; its psychological benefits have physical results, confirming the age-old statement about "a healthy mind in a healthy body".

Sports and physical activity programmes should be promoted and made more accessible to people in all social and age groups. Physical activities combined with recreation that strengthen social and family ties should be enjoyable and inexpensive. This requires town planning that protects nature areas and parks for walking, relaxing and socializing and provides opportunities for swimming, cycling, etc. Imaginative health promotion campaigns can stimulate interest and awareness in activities that combine social involvement with physical activity.

4.2.2. Positive mental health

Health cannot be accepted in purely physical terms. Mental health is an essential component of health. In positive terms, mental health means a potential to face the inevitable stresses of life and a potential for growth and self-actualization. Conceived in this way, it is not so important that there be total elimination of disease and infirmity but it is more important that the healthy part of the personality and healthy mental attitudes be preserved and maintained, in spite of infirmity. As is well known, there are some individuals who are incapacitated by a minor infirmity while, on the other hand, there are others who go on carrying the burden of life smilingly, in spite of very serious infirmity or even life-threatening illness. Such attitudes are of course strengthened by a degree of faith. Here again the cultural and religious traditions of a society are of immense help. A note of caution may also be added about what has been sometimes referred to as "healthism". Undue or over-involvement in health matters, such as repeated visits to doctors for health check-ups or constant concern about one's weight or blood pressure or levels of cholesterol, do not necessarily lead to good health. Concern for health should not reach such a level that it hinders one's enjoyment of life.
There is a growing realization that health and a well-functioning mind are precious properties that must be protected. New techniques for relieving stress and tension are gaining popularity as people adopt a more healthy attitude towards the crises of everyday life. Regular physical exercise, which can be practised at any age, whether it be walking, swimming, jogging or aerobics, is becoming popular everywhere in developing and developed countries alike. Communication with others, either talking or listening, can often release much of the stress we feel and help us re-evaluate situations, and is being recognized as an important part of health care. Past generations often relied on the family doctor as someone who would listen to their fears and anxieties. One of the drawbacks of modern medicine and highly sophisticated technology is that doctors are not able to spend the time needed to listen and pinpoint the real factors that are affecting the health of their patients. Moreover, specialization has often meant that patients are not continuously seen by the same physician. Over-reliance on technology (such as laboratory examinations) has contributed to a growing dissatisfaction with health care and a desire to pay increased attention to psychosocial aspects of medicine.

Whilst personal behaviour and attitudes can determine the health status of individuals, there is a need for human support and interaction with other members of the community. Since the Declaration of Alma-Ata, the focus has been on primary health care and action at the community level. Since the first contact with the health system is often the primary health care worker, it is essential that he or she should be able not only to recognize the symptoms of mental disorder, but also to incorporate the promotion of mental health into the daily round. Self-help groups, teachers, parents, religious leaders, traditional healers – all have a role to play in the promotion of mental and spiritual health and well-being.

WHO recognizes the elderly as another important resource in the community, a resource which is often not utilized in the more developed countries but seen rather as a burden. In developing countries, the elderly are revered and respected as valuable members of the community. Their knowledge of life and their wisdom, acquired over the years, is passed on to the younger generations and they often represent a stabilizing force within the community. The very old and the very young have an uncanny way of communicating with and understanding each other. There is less need for old people's homes or orphanages in developing countries. People around the world are gradually beginning to understand the importance of traditional solidarity as a means of resisting and coping with the stresses of life. If people learn to live in harmonious equilibrium with their environment and with those around them, if they assume responsibility for their own health and well-being and for the conditions in which they live, then perhaps the noxious crutches of alcohol, drugs and tobacco will no longer be needed. As our expectancy of life increases, so too should our expectancy of quality of life, to ensure that health for all – in all its three dimensions, the mental, physical and social – will not be merely a slogan but a heritage which we can offer to coming generations.

In the current health services and health education programmes in EMR, mental health has been greatly neglected. For success in health promotion, mental health must receive an important place. This can only be possible if both the individual and society grant a higher place to mental health in their value system than that which it is currently accorded.
4.3. A list of desirable behaviour changes for health

Over the last few years, many behavioural scientists have tried to compile lists of desirable behaviours which can prevent disease or promote health. Of course, there can be no final or universal prescription of such behaviour for all countries for all times. Each country has to select what is relevant and desirable for its population. Table 2 gives one such list of 17 social and behavioural changes which, according to Jenkin, can prevent most cases of major diseases and traumatic disability. As will be noticed, some of these items are already part of the WHO programme in the countries of our Region.

5. SOME SPECIAL FEATURES OF THE EASTERN MEDITERRANEAN REGION WHICH INFLUENCE LIFESTYLES

5.1. Religion and health

The cultural and religious heritage of the EMR is deeply rooted in the traditions of Islam, the dominant faith of the Region, and Christianity, as well as in their interactions with original local cultures. In many parts of the world there is at present a resurgence of man's interest in religion. For this reason, it is proposed to discuss in this section the influence on healthy lifestyles exerted by religion in general, and Islam in particular.

While religion may prescribe, and proscribe, certain behaviours that are seemingly health-related, the results are not necessarily uniform, because human behaviour is influenced by many other biosociocultural factors. Nonetheless, religion is a force with great positive potential. This positive aspect can further be reinforced by balancing it with other aspects of the human psyche (e.g. rationality, scepticism, tolerance of ambiguity, etc.).

5.2. The nature of individual versus group consciousness

In Islam, the responsibility for individual behaviour lies first with the individual himself/herself. However, social groups also play a very significant role in Islamic tradition.

In Islamic societies an individual's allegiance remains veering between the family or the local community and the idea of a universal "Umma", or Islamic nation. In the Islamic Umma there is no difference between individuals except on the basis of the degree of piety and good deeds. According to the well-known historian Arnold Toynbee, of the two major contributions made by Islamic culture to human civilization, the first is the overcoming of racial discrimination, (the other being the overcoming of alcoholism). The individual in Islamic culture paradoxically combines a constricted sense of family (or small local group) allegiance and a wider sense of universalism. In both cases the emphasis on the individual as an agent of change remains secondary to that of the group. Indeed a Quranic pronouncement about change is that God will not change a people (rather than individuals) until they change themselves*.

* The Holy Quran: Sura XIII, Verse 12: "Allah will not change the condition of a people until they first change themselves."
TABLE 2. SOCIAL AND BEHAVIOURAL CHANGES WHICH COULD PREVENT MOST CASES OF
MAJOR DISEASES AND TRAUMATIC DISABILITY

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<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>Prevent cigarette-smoking</td>
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<tr>
<td>2.</td>
<td>Develop healthy eating habits</td>
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<tr>
<td>3.</td>
<td>Foster regular habits of moderate exercise</td>
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<td>4.</td>
<td>Prevent alcohol abuse</td>
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<td>5.</td>
<td>Prevent chemical dependency on legal or illegal substances</td>
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<td>6.</td>
<td>Develop consistently safe driving habits</td>
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<td>7.</td>
<td>Provide pure water and food</td>
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<tr>
<td>8.</td>
<td>Dispose of toxic or infectious waste safely</td>
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<tr>
<td>9.</td>
<td>Foster preventive health habits (e.g. using seat belts and protective equipment; obtaining immunizations; removing home hazards; improving personal hygiene)</td>
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<tr>
<td>10.</td>
<td>Improve adherence to effective medication regimens</td>
</tr>
<tr>
<td>11.</td>
<td>Reduce unhealthy behaviour patterns, such as type A behaviour, sensation-seeking, risk-taking, and promiscuity</td>
</tr>
<tr>
<td>12.</td>
<td>Ameliorate chronic anxiety, depression or exhaustion</td>
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<tr>
<td>13.</td>
<td>Ameliorate chronic sleep disturbance</td>
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<tr>
<td>14.</td>
<td>Reduce the distress of life crises (especially losses or events from which recovery is slow)</td>
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<tr>
<td>15.</td>
<td>Use stress-reduction methods to reduce autonomic hyper-reactivity</td>
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<tr>
<td>16.</td>
<td>Reduce social isolation and increase social support (especially during periods of crisis)</td>
</tr>
<tr>
<td>17.</td>
<td>Make appropriate health services available and acceptable (especially for screening, early response to danger signals, adherence to medical instructions)</td>
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</table>

Hence what is regarded mistakenly by Western thinkers as fatalism in Islamic culture is really a renunciation of individualism in favour of group consciousness. The individual tends to comply with the group rather than deviate from it or attempt to divert it from its traditional course. Therefore, in addressing alteration of lifestyles, it is important to take into account the group organization and its leadership along with the call to individuals to change.

This also leads to the requirement that culture must be taken well into account while calling for change. While Islamic culture may be seen as having certain well-defined sacred concepts and written words, the idea of thinking and reinterpretting, as part of "ijtihad", provides possibilities for adaptation to changing times and conditions, and hence to modernization and development. Thus change is possible but only on the basis of certain basic traditions and beliefs. In other words, change must come from within Islamic thought rather than be implanted from without.

5.3. National boundaries and equity

Islamic culture recognizes no national boundaries and regards the Umma as the universal nation of Islam, open to all who accept the Oneness of Allah and that Mohammed is His last (but not the only) Prophet. Resources that are regarded as basic needs for survival (such as water) are not treated as private property and are not even subject to restrictions on trespassing.
Nevertheless, the Islamic world to-day is going through a schismatic process such as it has rarely witnessed throughout its long history.

As a result there are now neighbouring nations in Islam that vary widely in socio-economic development. While some are extremely rich, with some of the highest per capita incomes in the world, their immediate neighbours may have some of the lowest. Furthermore, even among poor nations, there is a rich élite with access to the greater proportion of wealth, power and prestige, pitted against a vast majority with scant access to the same assets.

This gives rise to a difficulty in proposing recommendations for the pursuit of a given healthy lifestyle, whether for all the nations in the Region or for all people within a given country. For example, élites generally tend to have smaller families, more leisure and luxury, as well as easier access to health care (especially technologically advanced interventions), and more facilities for cleanliness, food, drugs, sports, etc. They also tend to pursue more risky lifestyles. What would constitute relevant recommendations for a healthy lifestyle for them might not be applicable for other sectors of the same country's population. This applies to nations also. What may be considered feasible for a rich country may not be so for an LDC. This difficulty is also partly covered by Islamic teachings. Zakat*, one of the five basic tenets of Islam, explains some remarkably altruistic behaviours between and within these countries, (e.g. some of the greatest "donors" in the world financial loaning system come from among such nations). In addition to zakat there are other Islamic concepts which are particularly positive reinforcers. For example, the emphasis on spending rather than hoarding; on investing and providing labour rather than usury; on labour and preservation of the earth, rather than exploiting the earth - all these can positively modify social attitudes.

In view of the fact that Islam regards health as a state of complete physical, mental, social and spiritual well-being, and considers this to be a necessary component of faith and the Islamic way of life, WHO EMRO, in collaboration with the Islamic Organization for Medical Sciences and the Jordanian Royal Academy for Islamic Civilization Research (Al-Beit Foundation), convened a Consultation on Islamic Lifestyles and their Impact on Health Development and Human Development in General. The aim was to contribute to the presentation of this valuable cultural legacy, for the benefit of all humanity.

The Consultation was held in Amman, Jordan, from 23 to 26 June 1989. A panel of health professionals, scientists, jurisprudents, religious scholars, educationalists, thinkers, economists, sociologists, writers, journalists and representatives of the organizing bodies participated in this Consultation. It identified Islamic lifestyles in different areas and verified their relevance to Islam by means of evidence from the Holy Quran and the Hadith, or sayings of the Prophet (peace be upon him). It then studied their impact on health and human development and discussed various ways and approaches for their implementation in today's society.

The Consultation ended by issuing a document called "The Amman Declaration on Health Promotion" (see Annex to this paper) which is designed

* Zakat = Obligatory contribution to the Islamic social security system. It is levied at the rate of 2.5% on the growing (or potentially growing) capital (animal, monetary and/or commercial properties) and at the rate of 2.5-10% on the revenue of fixed assets (real estate, farm land, etc.)
to help in the execution of the identified lifestyles, and recommended that WHO EMRO should undertake the task of coordinating the follow-up process with regard to the implementation of this Declaration.

5.4. Migration and labour

As mentioned before, in theory the universal nation or *Umma* of Islam acknowledges no national boundaries. Yet the existence of such boundaries is a reality. Then, differences in wealth and population density between nations forces a further exaggeration of them. Hence immigration and naturalization laws have become in some cases very strict, so that it is now very difficult for nationals of some countries to immigrate and settle in others. This was not the case, for example, in the times of the Ottoman hegemony.

Because of demographic and economic differences, migration of labour without settlement has increased. This has had its repercussions on the family, and on social cohesion, in both donor and recipient countries, especially in situations where the breadwinner in the family migrates for labour, and sends back home money for his dependents. This increases inflation, despite apparent initial affluence. The recipient country loses productive power to the benefit of consumerism. This is accompanied by the situation of having consumers without control exercised by the producer.

The implications for family values and health cannot be overlooked. On the positive side, consumers may gain in education, culture, self-confidence and increased emancipation of women and children; on the negative side, they may turn to licentiousness, pleasure-seeking, and loss of a controlling parent figure upon whom to model their behaviour. This latter situation may in turn lead to such health and social problems as drug abuse, sexually transmitted diseases, rape, and other forms of violence, not to mention scholastic failure.

5.5. Population density

Although population density has been referred to in the previous section, it merits a separate re-emphasis. It is generally the poorer nations and classes who suffer from health problems related to family size as well as overcrowding, especially in cities. There is nothing in Islamic teachings which goes against family planning. On the contrary, Islam favours all measures taken to protect the health of mothers and to ensure the healthy development of children. Often the problem is social. For example, for the poor family, the child who moves into the labour market is a source of income rather than an economic burden. Moreover, the child represents potential social security, caring for his/her parents in illness and old age when the State is unable to provide adequate services in these areas. Such populations are caught in a paradoxical situation where short-term socio-economic and health interests are not conducive to family planning, while long-term influences, though not as pressing or as clearly conceived, may have the reverse effect.

In tackling the problem of family planning, the Islamic teaching of group responsibility arising from group consciousness is very useful. It is in the interest of élites, whether within each nation or among nations, to upgrade the socio-economic and environmental conditions for the masses, if they are expected to conform to what is preached in terms of healthy family size and spacious living conditions.
5.6. Age distribution

Improved health care in recent years has resulted in more live births, less infant mortality, and greater life expectancy. As a result, the population ratio between children and adults has greatly changed. In many countries of the Region, between 45-50% of the population is now below the age of 20 years.

In spite of traditional respect for the paternalistic structure of the family and society, the growing demands of youth in the face of scarcity of opportunities in education, work, housing and marriage, are giving rise to an unrest which could destabilize social systems. Parents are coming under increasing pressure to yield to their children's needs; and ruling elites are increasingly catering to the wishes of the young which are often contrary to formerly prevailing social traditions.

Unless healthy lifestyles are made possible for children and youth, their demands and unrest may result in more repression and deprivation rather than in liberalization and satisfaction. This could in turn influence children and youth in the counter-direction of more explosiveness, violence or defiance. Crimes, violence and drug abuse are becoming major health problems in this growing segment of the population and may pose a threat to traditional social structures.

On the positive side, traditional respect for the paternalistic structure can provide parents and social elites with an immense opportunity for positive change in terms of healthy living for children and youth. Good leadership can harness such energy from the young populations in a positive direction. Child and youth power is a potential force that has been discovered in the developing world (examples are the Sarvodaya movement in Sri Lanka and the current Palestinian "intifada"). Such power may be directed towards healthy living. Adults aware of such power will eventually adopt healthy lifestyles themselves as a way of maintaining their leadership over such potential forces.

6. STRATEGIES FOR PROMOTING HEALTHY LIFESTYLES

WHO's goal of Health for All means the attainment of a level of health that will permit the world's people to lead a socially and economically productive life. Promotion of healthy lifestyles is one important approach toward this goal. The direction of this approach is to increase health-promoting behaviour and reduce health-damaging behaviour. There are many strategies to achieve these twin aims. The European Regional Office of WHO has recently outlined a number of them*. The following discussion is based on some of the proposed strategies.

6.1. Healthy public policy

The ways in which public policies influence choices are manifold. Only a few examples will be given here. In many countries, some industries are subsidized, even though their products are harmful to health, and harmful products are freely advertised. National economies may finance health

promotion programmes and at the same time depend heavily on revenues from taxing unhealthy goods. Health-damaging products are exported to and promoted in developing countries, thus compounding their already serious health problems. Gross inequality in income distribution may give rise to poverty groups with such limited financial means that choosing a healthy lifestyle is precluded.

If communities, and governments, are to become aware of the influence of environmental conditions on the adoption and maintenance of lifestyles, the general public must be involved in policy and programme development. People will be both less able and less inclined to choose health-promoting types of behaviour if they have no influence on decisions made by both the private and the public sector that affect their own lives.

As declared in Alma-Ata in 1978, the key to health for all is primary health care, with active public participation. In most EMR countries, however, there is still gross imbalance between the influence on health policy of powerful lobbies (such as the tobacco or food industry and professional groups) and that of the public at large. Many Member States have not yet established ways to ensure public involvement in policy development.

6.1.1. Some proposed strategies

In every country, a scrutiny of policies and programmes that may affect health should be made an obligatory step in the public planning process and a systematic review of major areas of existing policy should be carried out in order to:

- determine their influence on health choices, e.g. the effects of tax policies on the consumption of harmful substances;
- recast existing policies so as to reduce health inequalities;
- eliminate subsidies to industries that manufacture harmful products and subsidize those that are good for health;
- restrict or preferably ban the advertising of harmful products;
- intensify cultural and educational activities so that people can be more easily involved in worthwhile leisure pursuits.

The participation of the public will vary according to national and local political, administrative and cultural patterns. However, representative community participation should be the rule in all official bodies (local, regional and national health councils, socio-economic planning councils, etc.) that deal with developmental issues which may have implications for lifestyles and health.

6.2. Social support systems

The skills that enable people to control and direct their lives are most easily learned in childhood and youth. It is more difficult to change to a healthy lifestyle later in life once unhealthy habits have become deeply ingrained.

The early socialization and learning that take place in the family are major determinants of decision-making and coping skills. The patterns of problem-solving and conflict-resolution in which small children participate as their personalities are in the process of developing will influence both the health practices they adopt and their readiness and ability to modify or
change their behaviour. Recent research has shown, for example, that a sense of personal worth and self-esteem growing out of acceptance and encouragement during development is associated with more effective patterns of coping and more frequent preventive health practices.

Family is important not only for learning but also for support and caring functions. In recent times, both the structure and the function of family units have been changing. The composition of a household in this Region ranges from multiple generations of relatives living together to individuals living alone. If endeavours to provide opportunities and strengthen capacities for choosing healthy lifestyles are to be effective, they must take account of the varying context and composition of social groups and environments and their changes over time.

As children grow older, peer groups have a progressively more important influence on their behaviour, until in adolescence peer influence becomes dominant. Therefore, the school and friendship group experiences of children help to shape and maintain forms of behaviour that may have either a positive or a negative influence on health. Potentially health-damaging practices that may become imprinted on lifestyles during adolescence include smoking, the use of habit-forming drugs, eating disorders and unsafe driving behaviour. Not enough attention has been given to the reinforcement of positive health behaviour through peer groups.

6.2.1. Some proposed strategies

Policies and programmes that enhance the problem-solving, supportive and care-giving capacities of families and extended social networks perhaps offer the greatest potential for health promotion and for facilitating health-enhancing lifestyles in the Eastern Mediterranean Region.

There should be support services in the community to help families according to their situations. Sometimes families may need help with patterns of conflict resolution or to bridge the generation gap. Other family situations may require community services for child care or to complement the family care of an ill or disabled member.

Special attention should be given to programmes in kindergartens, nurseries, play groups, schools and youth groups. School health education should guide and encourage children to look after their own health, to evaluate symptoms and to decide whether they can deal with them themselves or should seek professional help. Programmes designed for workplaces, educational institutions and health facilities or disseminated by the media should contain elements of problem-solving in difficult situations and decision-making in health care settings. Research should be encouraged to develop new and more effective approaches to, for example, preschool and school education.

6.3. Enhancing knowledge and motivation for healthy behaviour

People may do things that damage their health because they know nothing of the risks involved or of healthier alternatives, or because their values do not give them sufficient motivation to change their behaviour in response to what they do know.
Provision of information regarding the health implications of particular forms of behaviour, however, is not enough. Smokers, for instance, often know very well that smoking is bad for their health; this is true of children and teenagers, but many of them still start smoking. Complex factors shape potentially damaging practices. Many people need help to change habits that have become matters of routine.

Being bombarded with advertising or with indirect sales promotion, which associate potentially harmful practices such as drinking alcohol and smoking with attractive and desirable lifestyles, may increase or reinforce unhealthy behaviour. In many countries of the Region, many people are captivated by campaigns presenting "junk" food and smoking as symbols of modernity and wealth. An especially insidious influence on the behaviour of young people is the sponsorship of sporting events by companies that produce health-damaging products. It is therefore important that people be provided with information through a wide range of effective educational methods of presentation to counteract these health-damaging messages.

Most EMR Member States have not yet set up an adequate organizational structure for health education and health promotion, although there is already some coordination in preparing health education messages between government agencies and non-governmental groups and organizations. There is urgent need to produce and effectively distribute much more health education material, relevant for the local cultural contexts, in Arabic and other Regional languages.

6.3.1. Some proposed strategies

Successful health education programmes must be based on local social and cultural patterns and be intimately linked with the formation of individuals' value systems. Consequently, they must start very early in life and be reinforced at those periods in life when changes in value systems are most likely to occur.

Health education efforts must cover a very wide range of activities: teaching children in kindergartens and primary schools about the role and function of their bodies and how behaviour affects health; incorporating mental health information in all health education programmes; and providing easy and free access to the most up-to-date knowledge about health through major social institutions such as schools, the workplace and the media. Non-governmental organizations have a major role to play in developing such health education programmes.

The powerful influence exerted by peer groups and the wider social pressures that today so often strongly encourage unhealthy behaviour can be diverted to enhance lifestyles. Celebrities and prominent personalities can popularize healthy behaviour. Similarly, self-help groups, such as those set up for people wishing to stop smoking or to control their weight, can provide an effective means of combining information and support for persons working to change their potentially damaging habits.

Finally, there must be planned, systematic monitoring and evaluation of public acceptability and relative success of health education programmes to provide feedback in order to increase their relevance and effectiveness. Accordingly, health education must also be adequately integrated into academic structures.
6.4. Promoting healthy behaviour and reducing health-damaging behaviour

(a) Healthy behaviour

Positive health behaviour constitutes a conscious effort by individuals to actively maintain their health and that of others. Research indicates that practices such as eating a balanced diet, taking regular physical exercise, ensuring rest and relaxation and engaging in rewarding social and personal relationships help to increase an individual's sense of well-being and act as buffers against illness.

Most research hitherto has focused on health-damaging rather than health-enhancing forms of behaviour, but interest in developing positive health indicators is growing. In some countries, a new interest in health is manifest among the general public. Physical activity, sports and non-smoking are gaining more and more public attention.

Positive health behaviour is by far the most challenging field for a health-promotion policy. It opens up important fields of research, since more knowledge is needed of what constitutes positive health behaviour and how individuals can be induced to take more responsibility for their own health and for that of others. Some of the areas where positive health behaviour is especially important, such as balanced diet, non-smoking and/or drinking, physical activity, stress management, positive mental health, etc. have already been dealt with in Section 4 of this paper.

One can sum up by saying that, ideally, healthy behaviour patterns, learned in childhood and supported by social conditions, opportunities and resources for maintaining them, offer the most certain long-term strategy for promoting health in the population. However, it is important to note that group approaches, e.g. within adult education, have yielded promising results and opened up prospects for adult behaviour to change in a positive direction.

(b) Health-damaging behaviour

There is no doubt that the way many people live, in both developing and developed societies, is hazardous to their health. This is not necessarily due to the willingness of people to risk their health, since many are, in fact, not always able to choose a healthier lifestyle. Health-damaging practices should not be thought of as discrete forms of behaviour, but rather as aspects of cultural life, often one of several interacting problems.

Risk-taking behaviour can be a way in which people try to resolve conflicts within themselves and between themselves and society. In such situations risks, if calculated at all, may be calculated more in terms of immediate benefit and social acceptability than in relation to their health consequences. Unfortunately, risk-taking behaviour is self-reinforcing; it may not only allow people to cope with a current conflict, but give them a sense of strength to face the same or similar conflicts again.

Feelings of powerlessness may also contribute to risk-taking behaviour. Furthermore, many people feel or associate pleasure or a sense of control with forms of behaviour that may damage their health. These feelings will be felt more intensely when the behaviour is reinforced by peer-group pressure and has become part and parcel of daily life. Such motivating forces are particularly strong during adolescence, when they interact with a great deal of experimentation, and uncertainty.
Important examples of risk-taking behaviour are use of illicit drugs, dangerous driving, promiscuous sexual behaviour, violence, etc. Some of these have already been dealt with in Section 4 above.

7. CONTRIBUTORS TO THE PROMOTION OF HEALTHY LIFESTYLES

For the promotion of healthy lifestyles, the strategies outlined in the preceding section can be implemented at various levels. Jenkins* has proposed various levels of interventions for health promotion work in both developing and developed countries. The following discussion is based on the identification of those levels of intervention suitable for countries of the Eastern Mediterranean Region. Of course, it is expected that, in many country programmes, actions will be taken simultaneously at various levels.

These levels are outlined hereunder:

7.1. The individual

The individual's behaviour which can prevent illness and promote health is always an important starting point. There are many other levels of intervention, but certainly, in every culture, personal lifestyles are responsible for a large share of avoidable disease. People are constantly making decisions regarding what foods to eat, how much to eat, whether to engage in physical activity, whether to use tobacco or alcohol, whether to seek excitement and take risks or to "play it safe".

At less frequent intervals, but perhaps of greater importance, are decisions regarding how to react to signs and symptoms of ill health, whether to seek health services and, if so, where and what kind. People are also involved with regard to community decisions for such measures as sanitation, waste disposal, regulation of air and water pollution, etc.

7.2. The family

Many decisions are made at family level, especially in developing countries, where family ties are still very strong. In addition, the behaviour of one individual has an impact upon others in his or her family. The decision of a parent to smoke cigarettes affects not only the air inhaled by the children but also the values and norms which are absorbed by them. Parents act as role models and make decisions regarding what foods are "good for you" or "fun to eat" as well as concerning health care and protection from danger. Reciprocally, children also bring home from neighbours and from school information about health and attitudes to healthful living which can influence parents.

7.3. The health professionals

The entire array of health professionals constantly make decisions regarding their own behaviours, which serve as examples to clients and patients, as well as making decisions regarding both the therapeutic and the preventive interventions they perform. They also choose what to emphasize in

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transmitting information or when urging courses of action with regard to health behaviours. They help to set standards of practice for their own profession and are regarded as a source of expert opinion by community leaders and groups, as well as by the general public.

7.4. The health institutions

In this category we include clinics, hospitals, health maintenance organizations, public health departments, ministries of health, insurance companies and universities training health professionals. All these institutions have great influence, not only on therapeutic services, but also with regard to preventive services and health promotion efforts at the community as well as institutional levels. In many instances, steps toward reform of the system can only take place if policies and practices at institutional levels are changed. This process begins with changing key people. A university's or medical centre's decision to restrict smoking to limited areas and not to allow sale of tobacco products on its premises has a profound effect not only on behaviour of employees, students, patients and visitors, but also makes a clear statement of values to the entire community.

7.5. The schools

Schools provide not only formal learning opportunities but also informal learning through social contact and shared environment. Many health habits and lifestyle decisions are made by children and youth in the school setting. Schools therefore provide an excellent opportunity for making information available, developing motivation, organizing value systems, and providing models of appropriate health behaviours as well as opportunities for practising new ones. Schools can also be an organized setting for delivery of health services, such as immunizations, screening programmes and other elements of primary health care.

7.6. The workplace

Most of the employed spend the greater part of their waking hours at their place of employment. The workplace can provide an effective setting for health promotion, health protection and primary preventive services. Labour organizations can also have a great influence on personal health practices of workers, as well as monitoring the adequacy of health protection provided by employers. Employers can, in their turn, also make a major contribution to the health of employees and their families through the kind of health promotion programmes they offer and through selection of health insurance benefit packages which emphasize preventive services and reward persons having healthful lifestyles, for example with reduced health insurance or health services costs.

7.7. The communities

The community level is the one at which many public health programmes are delivered. In addition to mobilizing the political structure of a community to provide adequate protection for health and adequate preventive health services, the effective community programme will also involve networks of voluntary agencies, civic groups and sources of public information. Working together, all of these resources can provide a more complete spectrum of health services and foster a climate of support for better health.
7.8. Religion and culture

A significant part of community intervention in the Eastern Mediterranean Region can be effected through religious leaders and institutions. As already mentioned in Section 5, Islam is the dominant religion in most of the countries of the Region. Perhaps no other religion has dealt with the question of individual and social codes of behaviour in such precise detail as has Islam. As has been brought out earlier, also in Section 5, many Islamic injunctions are very similar to modern health teachings, e.g. avoidance of alcohol and other toxic agents, disciplined life, personal hygiene, sexual moral code, etc. Thus religious institutions present a great possibility for utilization in health promotion endeavours in the countries of this Region.

7.9. The Government

Government agencies, at both regional and national levels, have extremely important policy and legislative functions to perform with regard to the promotion of health. Following the WHO recommendations for intersectoral cooperation, it is important for comprehensive health actions that bodies such as ministries of agriculture, public works, labour, education, and social welfare, recognize the impact of their activities on the health of their populations, and that they also realize that improved health will benefit the specific functions which they as agencies provide for their populations. Health and economic development, for example, are intricately interrelated.

WHO's Global Strategy of "Health for All" recognizes "the fundamental truth ... that health contributes to social and economic development in much the same way as development itself enhances health. The two must go hand-in-hand". Another fundamental principle underlying the global strategy of WHO is that "any action for health should be socially relevant. In this world of gross inequalities in the health status of people in developed and developing countries, as well as within countries, social equity is a concept with great political and social power, and constitutes a major force in widespread acceptance of health for all".

Thus any comprehensive strategy for social and behavioural change to achieve the goal of Health for All must consider in the planning process all nine of the possible levels, outlined above, for interventive action. Further study is needed to determine which health problems would be most effectively addressed through which combinations of these nine levels, and which techniques for intervention would be most effective, given the state of industrial development and the specific culture of the geographical area in which a health programme is to be undertaken.

8. EXISTING WHO PROGRAMMES IN THE EASTERN MEDITERRANEAN REGION RELATED TO PROMOTION OF HEALTHY LIFESTYLES

Prevention of disease and promotion of health has been a central theme of WHO programmes from the very beginning. The Alma-Ata Declaration states that "people have the right and duty to participate in the process for the improvement and maintenance of their health". Health education has always been an essential element of primary health care but the modern concept of health promotion has made this a matter not merely of the passive receiving of health knowledge but also active involvement and participation of the individual and the communities in health matters. Most current WHO programmes,
such as those of maternal and child health, nutrition, occupational health, and disease control, to mention only a few, have a significant component of health education.

The MCH programme, for example, educates mothers about breast-feeding, child growth, immunization and many other areas of health promotion. The nutrition programme advocates healthy and balanced diet, for both the poor and the affluent. In the programme for workers' health, a number of activities are related to educating workers about safety habits and healthy lifestyles. The programme on AIDS has a major component about education, healthy living and counselling. Throughout the Region there are also special programmes on the control of smoking, alcohol and drug abuse, prevention of accidents, etc.

The WHO mental health programme has the following three components: (1) psychosocial and behavioural factors in health and human development; (2) control of alcohol- and drug-related problems, and (3) prevention and treatment of mental, neurological and psychosocial disorders. Thus all the three sub-programmes are closely related to the subject of healthy lifestyles. Under this programme in this Region, a number of activities have been undertaken by the countries through developing national policies and programmes of mental health. Activities include provision of essential mental health services within primary health care, behavioural psychosocial training for health workers, school mental health programmes, and involvement of community and religious leaders particularly for the control of drug abuse.

Another major initiative in EMR has been the joint WHO/UNICEF-sponsored Action-Oriented School Health Curriculum for Primary Schools. This prototype curriculum consists of a Teachers' Guide, a Teachers' Resource Book, and a set of National Guidelines. The Teachers' Resource Book has units specially devoted to social and mental health as well as healthy lifestyles. In other units there is discussion on health promotion related to other matters. The teaching methodology proposed by this curriculum promotes group work, action-orientation, positive attitudes, healthy lifestyles, etc., among school-children. This prototype curriculum has already proved very popular and a number of countries, namely Bahrain, Egypt, Jordan, Morocco and Sudan, have undertaken trials to introduce it in their schools. (It has also been very positively accepted beyond the Region, in China, Latin America and Sierra Leone).

WHO EMRO is now finalizing a Family Health Directory to promote self-health-care. Furthermore, integrated social development to meet basic minimum needs and thus promote quality of life is now considered as part of the accepted Regional strategy for attainment of HFA/2000, while EMRO leadership development programmes help to identify potential leaders and prepare them to support the HFA movement through health promotion and health protection efforts.

Particularly significant among WHO EMRO activities related to lifestyles was the Conference (referred to in Section 5 above) on Islamic Lifestyles and their Impact on Health Development and Human Development in General, held in June 1989 in Amman and organized by WHO EMRO in collaboration with the Islamic Organization for Medical Sciences and the Jordanian Royal Academy for Islamic Civilization Research. An important outcome of this meeting was the Amman Declaration on Health Promotion (See Annex).
9. CONCLUSIONS AND RECOMMENDATIONS

1. Recent work strongly indicates that healthy lifestyles constitute a vital link in the health chain, without which optimum health cannot be attained. However, lifestyles are not entirely dependent on the individual; they are intimately bound up with the values, priorities, practical opportunities and constraints of specific socio-economic and cultural situations. In order to achieve success in the promotion of healthy lifestyles, equal attention must be paid to physical and social environments. There are limits to the choices open to the individual, imposed by the physical, social and cultural environment and by the availability of economic resources.

2. Health promotion should be an integral part of national health policy in every country. It is recommended that a high-level multisectoral team be assembled in each Member State to (a) examine national health and related sectors' policies and programmes, (b) report on the extent to which health promotion, including promotion of healthy lifestyles, is reflected in these programmes, (c) make recommendations for policy change and (d) develop national strategies to promote healthy lifestyles.

3. Each Member State is urged to gather country-specific information on the aetiology and prevalence of health problems of significant concern to them which have lifestyle and social environmental correlates. The information should attempt to identify significant health-promoting and health-damaging behaviours and conditions. This may be used in health-promotion endeavours.

4. Religion is a significant factor in the lifestyles of people of the Eastern Mediterranean Region. Attention may be drawn to appropriate religious teachings to propagate the concept of healthy lifestyles.

5. Health education units in ministries of health should be assigned clear responsibility for health-promotion advocacy. In order to carry out this broad role, the health education/promotion departments would need to be suitably staffed, financed and supported by the health ministries. WHO may assist countries by advising on the implementation of the programmes related to healthy lifestyles.

6. A healthy body and a healthy mind go together. Positive mental health should be an integral part of all health-promotion programmes. Knowledge and skills of psychosocial and behavioural sciences should be included in the training curricula of all health personnel.

7. It is recommended that each country identify some health programme or projects which have clear lifestyle implications to demonstrate the effectiveness and importance of health-promotion approaches. Such demonstration programmes should provide the feedback for further expansion at the national level.

8. It is recommended that a concerted effort be made, both nationally and on an intercountry basis, to conduct research on particular health problems such as obesity, smoking, drug-dependence, occupational stress, etc. This research should study not only developmental patterns of such problems, but practical strategies to change unhealthy behaviours and environments. WHO may assemble an expert working group to formulate a series of protocols to solicit and guide such research on the links between lifestyles and health.
9. Children today are the decision-makers of tomorrow. Hence the teaching of healthy lifestyles must begin early in school years. It is recommended that EMR countries ensure that material on healthy lifestyles is included in the curricula of all schools and sufficient time is devoted for its teaching.

10. It is essential for the development of healthy lifestyles that individuals, families, social groups and communities become involved. Leaders are needed in this field. Therefore, the health ministries should seek to identify and recruit national leaders to promote, articulate and advocate for health, healthy living and healthy environments. It is equally desirable to have collaboration between health personnel and religious leaders so as to obtain the support of the latter for the promotion of healthy lifestyles in the community.

11. Each Member State should review its health legislation and, where required, introduce legislation to restrict advertising of unhealthy and harmful products. Steps may also be taken (a) to eliminate state subsidies to those industries that manufacture harmful products and (b) to subsidize those that are good for health.
Annex

THE AMMAN DECLARATION ON HEALTH PROMOTION

The Consultation on Islamic Lifestyles and their Impact on Health Development and Human Development in General, held in Amman, Jordan, on 19 to 22 Thul Qa'da, 1409 A.H, (corresponding to 23-26 June 1989) with a view to achieving Health for All by the Year 2000, hereby issues the following Declaration on Health Promotion:

Whereas the consultation was convened in response to the urgent need in the Eastern Mediterranean Region for the formulation of health messages to its populations, in language that they can understand and respond to, and for the initiation of health promotion activities, making use of the devotional spirit that characterizes them, and that makes of the religion the authority to which they turn and the stimulus for their survival;

Therefore, and based on the deep-rooted health heritage with which the people of the Region have contributed to human civilization, on the goal of WHO aiming at achieving Health for All, on the Alma-Ata Declaration on primary health care, and on the resolution by the World Health Assembly regarding the spiritual dimension; the Consultation declares the following:

First: Health is a grace of God, which is abused by so many people, according to the Prophet (peace be upon him).

Second: Health is but one element of life, which cannot be complete without the availability of other major elements, such as: freedom, security, justice, education, work, self-sufficiency, food, water, clothing, housing, marriage and environmental health.

Third: Man can preserve his health as enjoined in the Holy Quran by maintaining the health balance in a state of dynamic equilibrium, without exceeding the bounds, nor falling short in that balance.

Fourth: Each human being is in possession of a certain health potential, and it is imperative that he/she should develop it, so that he/she can enjoy full well-being and store enough health to draw on during disease, as stated by the Prophet (peace be upon him).

Fifth: The lifestyle followed by a human being has a major impact on his/her health and well being.

Sixth: Islamic lifestyles embrace numerous positive patterns promoting health and reject any behaviour which is contradictory to health.

Seventh: Islam, as defined in the Holy Quran, is the nature in which God has created mankind. Hence, adhering to Islamic lifestyles is, in itself, a realization of the true nature of the human being, and ensures harmony with the laws of God in body and soul, in the individual, the family and the community, and between the human being and his environment.

Eighth: The document to be annexed to this Declaration comprises a list of the Islamic lifestyles derived from the Holy Quran and the Sunna (tradition reported of the Prophet), and affecting health development and human development in general. It comprises an integral part of this Declaration.
Ninth: The Consultation calls upon all international organizations, governments, voluntary and non-governmental organizations, to promote health through encouraging positive lifestyles, particularly through:

1. Introducing the health-promoting Islamic lifestyles, and advocating them through proper channels, as befits the circumstances of each country.

2. Providing suitable conditions for the promotion of health and healthy lifestyles; and refraining from: advertising unhealthy lifestyles, supporting the production of material harmful to health, or promoting unhealthy behaviour.

3. Encouraging the comprehensive development of local communities, and supporting them to meet their basic needs by means of self-reliance, as this is a practical introduction to the implementation of healthy lifestyles.

4. Reorientation of health, educational, instructional and public information institutions, in such a manner that promotes health and encourages healthy lifestyles, especially those mentioned in the document to be annexed to this Declaration.

5. Reorientation of health education institutions, so as to humanize health professions, and to make each of these professions a vocation rather than a mere occupation.

6. Declaring a Decade dedicated to the strengthening of efforts aiming at the implementation of a plan, developed by the authorities concerned, for adoption and application of Islamic lifestyles.
1. Promotion of healthy lifestyles should be an essential part of a national health policy in every country.

2. Knowledge and skills related to psychosocial and behavioural factors should likewise be an essential part of training of all health personnel. It is recommended that the current training of health personnel in all Member States be reviewed to incorporate psychosocial and behavioural aspects of health as an essential part of their training.

3. WHO should help Member States to produce suitable material for promotion of healthy lifestyles in national languages for the use of health personnel, and also for that of the media.

4. Appropriate research on lifestyles and behavioural factors should be undertaken at Regional and country level, especially focused on behaviour-related health problems of the Region.

5. Collaboration with other sectors and with key figures such as cultural leaders in developing community strategies to combat unhealthy lifestyles, should be encouraged.

6. Adoption of the Amman Declaration on Health Promotion is recommended.
Recent work strongly indicates that healthy lifestyle is a vital link in the health chain between the individual and the environments. The present paper briefly reviews the concept of health and life-style. It examines the relationship of human behaviour to health and disease and how the modification of some aspects of human behaviour can help in the prevention of disease and promotion of health. The paper further discusses the implication of psychosocial and behavioural approaches to promote healthy life-styles and to identify some of the difficulties and opportunities inherent in adopting such approaches, particularly in the context of conditions prevailing in EM Region. The paper examines in detail the role of religion in the promotion of healthy life-styles and highlights the recommendations at the recently held meeting in Amman on Islamic Life-styles. The paper is followed by a set of recommendations.
Dr Khayat, Director Division of Health Protection and Promotion, presented the paper. He briefly reviewed the current definitions of health and lifestyle. He pointed out that the concept of health has undergone a significant shift in the twentieth century. Whereas, in the last century health was generally viewed in a mechanistic way with main emphasis on diseases and its treatment in the individual, the emphasis has now shifted to the role of environments and prevention of the disease processes. Recent work strongly indicates that healthy life styles are vital links between the individual and his environments, both physical and psychosocial. The human behaviour seems to be a crucial factor which determines the balance between health and diseases.

The influence of a number of health damaging behaviours is by now well recognized and documented. These include excessive and imbalanced consumption of food, use of tobacco, alcohol and many other psychoactive substances, risk-taking behaviour, like dangerous driving, promiscuous sexual behaviour, excessive mental stress, etc. On the other hand, the positive effect of exercise, maintaining of optimal weight, relaxation on health are well recognized. However, it must be accepted that there are limits to the choices open to an individual; lifestyles are intimately bound up with the values, priorities, practical opportunities and constraints of a given socio-economic and cultural situation. For the success in the promotion of healthy life styles, equal attention must be paid to physical and social environments.
Among these socio-cultural factors, perhaps religion plays a crucial role in guiding human behaviour. Most of the countries of EM Region have a common heritage of Islam, which lays a great stress on healthy lifestyle. In his presentation, Dr Khayat referred to a recent meeting on Islamic Life Style held in Amman, which has made important recommendations in this regard. It has come out with a special Amman Declaration highlighting Islamic Principles which form the basis of healthy lifestyle.
DRAFT RESOLUTION

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

Thirty-sixth Session

Agenda item 18

HEALTHY LIFESTYLES

The Regional Committee,

Convinced that lifestyles are of crucial importance for the promotion of health as well as for the prevention and treatment of disease;

Aware that psychosocial and behavioural factors have not been sufficiently well recognized as determinants for health by health care authorities and those responsible for the training of health workers;

Concerned that effective methods to change behaviour have not been used to a sufficient degree in the promotion of health;

Impressed by the potential for promoting health and redressing health damaging practices and behaviour by teachings contained in the religions of the region:

1. URGES Member States to incorporate within existing development and health programmes, policies and strategies to promote healthy lifestyles in their countries;

2. ADOPTS the Amman Declaration on Health Promotion as an entry point to promote the development of healthy lifestyles;
3. REQUESTS the Regional Director to:

(i) carry out a review of current training of health workers in behaviour and psychosocial factors to make recommendations about improved training in this field;

(ii) stimulate and support operational research on healthy lifestyle and behavioural factors at regional and country levels;

(iii) help the member states to produce materials in national languages that can be used in the training of health personnel and by media in promoting healthy lifestyles;

(iv) collaborate with other sectors including cultural leaders in developing community strategies to combat unhealthy life styles;

(v) report to Regional Committee in 1992 about the progress of programmes to promote healthy life styles.
HEALTHY LIFESTYLES

SUMMARY OF RECOMMENDATIONS

1. Promotion of healthy lifestyles should be an essential part of a national health policy in every country.

2. Knowledge and skills related to psychosocial and behavioural factors should likewise be an essential part of training of all health personnel. It is recommended that the current training of health personnel in all Member States be reviewed to incorporate psychosocial and behavioural aspects of health as an essential part of their training.

3. WHO should help Member States to produce suitable material for promotion of healthy lifestyles in national languages for the use of health personnel, and also for that of the media.

4. Appropriate research on lifestyles and behavioural factors should be undertaken at Regional and country level, especially focused on behaviour-related health problems of the Region.

5. Collaboration with other sectors and with key figures such as cultural leaders in developing community strategies to combat unhealthy lifestyles, should be encouraged.

6. Adoption of the Amman Declaration on Health Promotion is recommended.