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# TECHNICAL PAPER

# PROMOTION OF HEALTHY LIFESTYLES IN THE EASTERN MEDITERRANEAN REGION

CONTENTS

## EXECUTIVE SUMMARY

Lifestyles are ways of living based on identifiable patterns of behaviour which are determined by interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions. The health and well-being of a community are affected by the social milieu within which people live, thus shifting the focus of our interventions from individuals to the community as a whole. Life conditions, whether social, economic, environmental or biological (genetic), dictate health status, as well as the magnitude and patterns of disability, morbidity and mortality. An epidemiological shift is being witnessed recently due to changes in life conditions, creating a double burden of communicable and noncommunicable diseases in many countries of the WHO Eastern Mediterranean Region. Risk factors related to poor nutrition, use of tobacco, alcohol and other drugs, risky sexual behaviour, stress and other mental disorders, violence, injuries, environmental hazards and physical inactivity are highly prevalent in the Region. These risk factors contribute to the reported increase of noncommunicable diseases.

Changes in culture and technology in some countries have caused rapid changes in the popular lifestyles, which has led to an increasing incidence of chronic noncommunicable diseases. The burden of behaviour-related diseases is expected to be even greater in the future. Urbanization, aging populations and poverty, for example, aggravate the burden of such diseases in the Region.

Healthy lifestyles promotion is a continuous process of enabling people and institutions to increase control over and improve their health. Healthy lifestyles promotion is a people-based approach to health for all in which the health of the people is the ultimate responsibility of several stakeholders, including nongovernmental organizations. In a people-centred approach it is essential to clarify needs, wishes, goals, resources, cultural appropriateness, spirituality and management and evaluation processes.

To achieve better health gains and quality of life, the countries of the Region should invest in strategic thinking, planning and programming to address the determinants of health in the long term and the risk reduction objectives contributing to reduction of the burden of diseases and mortality in the short and intermediate terms. The origins of health lie deep in society; however, in most societies it still awaits the organization and resources to achieve its full potential. Countries must develop, implement and evaluate comprehensive approaches to health that involve health and non-health stakeholders at the community and local levels by focusing initially on determinants of health and health gains. Health services need to move increasingly in a health promotion direction, beyond responsibility for providing clinical and curative services, which requires a change of attitude and organization of health services that refocuses on the total needs of the individual as a whole. A "new epidemiology" is needed in the Region to address social, environmental and causative factors such as inequality, discrimination, social cohesion, social capital, social class gradients, social integration, social networks and social support and their relationships to risk factors and risk conditions. The low profile of health promotion bodies represents an incongruity in light of the fact that most causes of mortality and disability are behaviour-related. Model projects are needed to

spearhead national and regional healthy lifestyles programmes, as well as integration of healthy lifestyles initiatives into the success stories of the Region such as the healthy villages and basic development needs programmes.

## 1. INTRODUCTION

Life conditions, whether social, economic, environmental or biological (genetic), dictate health status, as well as the magnitude and patterns of disability, morbidity and mortality. An epidemiological shift is being witnessed recently due to changes in life conditions, creating a double burden of communicable and noncommunicable diseases in many countries of the WHO Eastern Mediterranean Region. Changes in culture and technology in some countries have caused rapid changes in popular lifestyles, which has led to an increasing incidence of chronic noncommunicable diseases. The burden of behaviour-related diseases is expected to be even greater in the future. Urbanization, ageing populations and poverty, for example, aggravate the burden of such diseases in the Region. The special health needs of the poor, marginalized and elderly are receiving increased attention in most countries of the Region, yet more vigorous efforts in this respect are needed.

Unfortunately, medical care to prevent this shift in the patterns of disease is minimal. Investment with which to create a conducive environment for healthier behaviour is crucial to bring about the desired improvements in health of nations. Recent advances in behavioural sciences have demonstrated that *positive* changes in lifestyle contribute extensively to the betterment of physical and psychological well-being as well as to the prevention of most risk factors which cause disability and diseases. Investment in health promotion should thus focus on generating health conditions which in turn determine the healthy lifestyles we want to promote and achieve.

## 2. EVOLUTION OF HEALTHY LIFESTYLES PROMOTION

The term "lifestyle" has evolved throughout history and ideological debate. This catchy term is now used to cover a wide range of meaning. For example if one surfs the internet, one may find the term "lifestyle" applied on the one hand to haute couture, and on the other, sexual orientation. The term assumed its public health avatar when Marc Lalonde, then Minister of National Health and Welfare of Canada, produced his famous report *A new perspective on the health of Canadians* in 1974. Simply put, the report argued with convincing statistics that in spite of the fact that Canada was then spending 7.1% of its gross national product on health, and that this figure was growing, Canadians' health was not improving. The report stated that any further investment in medical services in Canada was not going to produce the desired gains in health due to the simple fact that most of the causes of the burden of disease and mortality in the country were the outcome of determinants which were outside the heath system. The report identified lifestyles as one of four components together with human biology, environment and health care organization. These four components are known as the health field concept. The report proposed that resources be diverted to be invested in health promotion. The Canadian government in 1978 set up a new health promotion directorate in the Federal Department of Health and Welfare, with about a hundred staff—the first such venture in the world. Of the four components of the health field concept, lifestyle was singled out and focused on. And in the following decades, lifestyle became a major preoccupation of health promotion worldwide, as evidenced by discussions in several global conferences on heath promotion held in ensuing years, such as those in Ottawa, Jakarta and Adelaide. However, academics, sociologists and others saw that the lifestyle

approach fell short of meeting their aspiration of better health through radical social reform. But the fact remains that it was the trigger and the reference point for a new paradigm.

## 3. A SHIFTING PARADIGM: FROM RISK GROUPS TO RISK CONDITIONS

The lifestyle concept evolved into a more radical concept which calls for treating the root causes of ill health, such as poverty, low social status and discrimination, as highlighted in Box 1. This new argument is based on the notion that promotion of healthy lifestyles is a move away from a disease-specific default in most health systems. There remains the issue of whether we are talking about "risk groups" or "risk conditions". This argument by Ronald Labonte helps make this case clearer.

> In the UK, as elsewhere, cancer and heart diseases are routinely identified as the leading causes of death and disease, with smoking the single greatest preventable risk factor. But Canadian data find that if the poorest 20 per cent of the population had the same health status as the richest 40 per cent, they would enjoy 15 more disability-free years of life. If all disease and death from cancer and heart disease were eliminated in this poor cohort, their disability-free years of life would extend by only 3 and 5 years respectively. Rather than cancer and heart disease, we could define the slope of social inequalities as the leading cause of death, for which different diseases are partial expression, and lifestyle risk factors partial vectors. This challenges health promotion to shift its thinking from risk groups to risk conditions.
>
> Consider that African-Americans are often defined as "high risk groups" for heart disease, based on studies finding significant differences in disease rates between blacks and whites. But when such studies are controlled for the effects of income or racist attitudes and discrimination, the black/white difference disappears. African-Americans are not high-risk groups. Poverty and racism are high-risk conditions. As long as the defining practice paradigm focuses on individuals or groups, rather than conditions or contexts, the intervention will be defined as aspects of those individuals or groups. It will ineluctably slip back to individual behaviours.[1]

Promotion of healthy lifestyles is a far-reaching movement for empowering institutions, civic groups, families and individuals. It is not limited to what people can do for themselves through self-restraint and more disciplined health-related behaviour. It also entails a wide spectrum of solidarity, trust and support in attaining the legitimate aspirations of healthy and responsive social structures and institutions, of which the health system is but one. It can start by simple and practical steps as long as there is a vision of empowerment of people to take control of and improve their health. The following is stated in *Health 21*, a document on

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[1] Labonte R. Health promotion in the near future: remembrance of activism past. *Health education journal*. 58:365–77 (1999).

health-for-all policies for the 21st century presented to the Forty-sixth Session of the Regional Committee for the Eastern Mediterranean.

> By 2020, all countries will have introduced, and be actively managing and monitoring strategies that *strengthen health-enhancing lifestyles* and *discourage health-damaging ones*, through a combination of regulatory, economic, educational, organizational and community-based programmes.

The following main directions form the main agenda of work of any healthy lifestyles promotion initiative and the above-stated goal.

- Direction 1: investing in factors that will address social and economic determinants of health and achieve the best health gains for the community.

- Direction 2: creating positive, health enhancing and supportive living, and working conditions and physical environment for a better quality of life.

- Direction 3: developing and maintaining the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.

- Direction 4: reorienting health systems in order to provide equitable and appropriate quality services for all people.

**Box 1. What are the major socioenvironmental risk conditions determining lifestyles (determinants of health)?**

- Poverty (absolute and relative).
- Low social status (occupation, education).
- Work structure (high demand/low control, security and remuneration, exposure to toxins).
- Lack of work (unemployment/underemployment)
- Discrimination (sexism, racism, ageism, ableism).
- Overpopulated communities.
- Inadequate housing and homelessness.
- Natural resource depletion (e.g. food stocks).
- Equitable and effective health care systems.

## 4. THE IMPORTANCE OF PROMOTION OF HEALTHY LIFESTYLES

### 4.1 Magnitude of the problem of unhealthy lifestyles

Risk factors related to poor nutrition, use of tobacco, alcohol and other drugs, risky sexual behaviour, stress and other mental disorders, violence, injuries, environmental hazards and physical inactivity are highly prevalent in the Eastern Mediterranean Region. These risk factors contribute to the reported increase in incidence of noncommunicable diseases. For example, reported prevalence rates of diabetes (though widely under-reported in the Region) among adults aged above 40 years ranges between 13% and 15% in some countries of the Region. Obesity and high cholesterolaemia are rampant in the Region. Cardiovascular disease and stroke are becoming the major cause of illness and death. Hypertension as a major risk factor for cardiovascular diseases affects 26% of the adult population in the Region. Smoking as the most important single risk factor of cancer and cardiopulmonary disease is devastating the Region with soaring rates, which in some countries have reached as much as 50% of the adult population. Cancer, which generally speaking is witnessing a decline in many parts of the world (except lung cancer in women and lymphoma) is unfortunately projected to increase in the Eastern Mediterranean Region due to unhealthy lifestyles. At present death from cancer in the Region is estimated by the Global Programme on Evidence for Health Policy to be 8% of all deaths. Job-related stress becomes a major health concern and source of unhappiness, especially if we know that only 5%–10% of workers in developing countries have access to adequate occupational health services. Risk conditions at work expose 30%–50% of workers to hazardous physical, chemical or biological environments. An emerging risk behaviour which has recently shown an alarming increase is drug addiction.

The heavy burden of such shifting epidemiology severely strains the health systems of low- and middle-income countries which have the double burden of communicable and noncommunicable diseases.

### 4.2 The shifting trend of burden of diseases

The world has changed and so has the Eastern Mediterranean Region; developments have taken place which affect primary health care and health for all and which highlight the importance of health promotion, especially with the increase in overall life expectancy and a shift in epidemiological patterns, with more and more chronic diseases that require long-term interventions.

As shown from data collated by WHO (Table 1), we are witnessing an increasing trend in diseases which are related to unhealthy behaviour. The trend of such diseases will be on the increase in the decades to come. Diseases brought about through unhealthy lifestyles are moving to the top of the list of leading causes of burden of diseases and death in the Region. It is important to start considering strategic approaches which will address the risk factors responsible for the increasing magnitude of these diseases.

**Table 1. Leading causes of burden of diseases and death in countries of the Eastern Mediterranean Region in 1998 (both sexes, all ages)**

| Rank | Burden of disease | Death |
|---|---|---|
| 1. | Perinatal conditions | Ischaemic heart disease |
| 2. | Acute lower respiratory infections | Acute lower respiratory infections |
| 3. | Diarrhoeal diseases | Diarrhoeal diseases |
| 4. | War injuries | Perinatal conditions |
| 5. | Ischaemic heart disease | Cerebrovascular diseases |
| 6. | Unipolar major depression | War injuries |
| 7. | HIV/AIDS | Tuberculosis |
| 8. | Measles | Measles |
| 9. | Tuberculosis | Road traffic injuries |
| 10. | Congenital abnormalities | Chronic obstructive pulmonary disease |
| 11. | Road traffic injuries | Inflammatory cardiac disease |
| 12. | Cerebrovascular diseases | Congenital abnormalities |
| 13. | Protein–energy malnutrition | Interpersonal violence |
| 14. | Anaemias | Malaria |
| 15. | Pertussis | Tetanus |

## 5. MAIN CHALLENGES FACING HEALTHY LIFESTYLES PROMOTION IN THE EASTERN MEDITERRANEAN REGION

### 5.1 Administrative problems related to the organizational aspects of promotion of healthy lifestyles at country level

The nature of promotion of healthy lifestyles is complex and challenging. The wide spectrum of the concept of lifestyles requires a cumbersome organizational structure. The low profile of health promotion bodies represents a dichotomy in view of the fact that most causes of mortality and disability are behaviour-related. Also presently there is a blurring of the dimensions and directions of national health systems due to the confusion of what is the expected role of the national health authorities. The unsettled issue of provision of care versus financing of care is still a major concern for many national health authorities and planners. Adding to the confusion and complicating things further is how to draw a clear and strict line between national and global health care responsibilities. Strengthening the steering role of the national health authority is a requirement which would allow for drastic decisions in favour of promoting healthier lifestyles, as was the case of the Lalonde Report in Canada in 1974. Global solidarity is also needed.

### 5.2 A community in transition

The WHO Eastern Mediterranean Region is witnessing changing and challenging social, demographic, technological, epidemiological and economic circumstances. These

circumstances vary among the countries of the Region, five of which are categorized as Least Developed Countries by the United Nations. Most countries of the Region are also undergoing a demographic transitional phase with both high fertility (higher birth rate) and low mortality rates (longer life expectancy). In addition to the demographic and the epidemiological shifts, the Region comprises diverse and complex cultures which carry a legacy of thousands of years of beliefs, values, concerns and history. Thus the communities in the Region are in transition and are overwhelmed with historical, social and cultural value systems that constitute a multifaceted social fabric. A new wave of modernization which brings different lifestyle patterns is creating unprecedented behavioural challenges. With the transition the rules set by the state are being challenged. The transition is not seen only in the epidemiological, economic and social arenas, it is also happening in governance and in the decision-making processes.

### 5.3 Vested interests

Giant multinational enterprises may monopolize commonly used commodities and manipulate governments to agree to their terms of trading and economical relations. With the increase in international free trade the Eastern Mediterranean Region is a potentially lucrative market. Imports of food products (fast foods, soft drinks, alcohol) and tobacco are increasing. The advocacy machinery of such companies is both influential and widespread, and a lot of resources are spent on propaganda and deals.

### 5.4 Lack of models and tools

The origins of health lie deep in society; however in most societies it still awaits the organization and resources to achieve its full potential. There is a need for tools to respond to issues such as the following.

- Where are healthy lifestyles promoted and maintained in a given population?
- Which investment and strategies produce the largest population health gains?
- Which investment and strategies help reduce health inequities and are in line with human rights?
- Which investments contribute to economic and social development in an equitable and sustainable manner and result in high health returns for the overall population?

Such tools, which aim at developing models of how best to invest for health, are essential to move beyond rhetoric and take into consideration interests of all parties responsible for development, showing at the same time how healthier lifestyles are assets rather than a burden on development.

Instruments of power/political mapping as well as new epidemiological tools to focus on social etiology topics such as social capital, social integration and discrimination and how they relate to health and well-being. So far there is not enough experience or practice with such tools in the Region.

### 5.5 Social gap

Promoting health conditions needs not only government support, but community commitment. It requires active citizens, including women, and community associations, with experience in all kinds of community activities, to promote various social, economic or environmental agendas in support of healthy living. Unfortunately, such community groups are either lacking or are very few in number in the Region. This has led to an almost total dependence on government efforts and especially those of the health sector, which can never be enough.

The challenges facing the realization of a new paradigm should not be underestimated, taking into consideration the following constraints:

- limited intersectoral cooperation for health development
- poor community involvement—the firm conviction that the state is responsible for providing the totality of health services is the main obstacle to active community involvement
- weaknesses of national health systems, in respect to policy analysis and formulation, coordination and regulation
- inequitable and insufficient resource allocation, with limited resources for promotive and preventive activities and programmes.

## 6. MAIN AGENDA OF HEALTHY LIFESTYLES PROMOTION IN THE EASTERN MEDITERRANEAN REGION DURING THE NEXT DECADE

Governments and voluntary and nongovernmental organizations should promote health by encouraging positive lifestyles, particularly through capacity-building strategies, and should design effective programme interventions based on health promotion principles and techniques. The following are the main strategies that are proposed to be adopted in the Eastern Mediterranean Region.

### 6.1 Active health literacy

All human beings are in possession of a certain health potential, which they must develop in order to enjoy complete well-being and ward off disease. The lifestyles followed by human beings have a major impact on their health and well-being. The ideal lifestyle embraces numerous positive patterns promoting health and rejects any behaviour that is deleterious to health. This strategy aims to support advocacy locally, nationally and regionally to raise the profile of "healthy living" for all age groups and in all locations. Thus a national comprehensive framework must be created to address factors influencing health, ranging from social, economic and environmental determinants to individual behaviour patterns. The strategy will advocate health-promoting action, such as exercise, balanced diet and abstention from alcohol, drug abuse and tobacco use. This advocacy of healthy lifestyles is made through means appropriate to the circumstances of each country. All government-controlled media at least should be banned from promotion of unhealthy lifestyles and practices. Creating

awareness of this new way of public health development requires a lot of effort, patience and persistence.

### 6.2 Action-oriented school health curriculum

The school is an important opportunity to promote active health literacy. The curricula of health, educational, instructional and public information institutions are reoriented in a manner that promotes health and encourages healthy lifestyles. Curricula for schoolchildren should include action-oriented health behaviour in all subjects. Life skills are the focus of such an approach, which is now used in several countries of the Region. Schoolchildren are taught how to advocate better and healthier lifestyles at home, in the community and at school through, for example, campaigns against tobacco, poor diet, violence and drugs. Bahrain, Lebanon, Pakistan and Syrian Arab Republic have used the action-oriented school health curriculum approach to good effect. The interface between the health system and the community through the school has the dual advantage of both involving the new generation and fostering long-term commitment from it. The widespread distribution of schools and their accessibility to all families are opportunities for them to mobilize and involve the community and inculcate life skills which will enable the schoolchildren to take correct health decisions and thus lead healthier lives.

### 6.3 Formulation of public health policy

In order to build capacity of nationals in order to develop national policies, programmes and plans of actions in support of healthy lifestyles initiatives, countries must develop, implement and evaluate comprehensive approaches to health that involve health and non-health stakeholders at the community and local levels by focusing initially on determinants of health and health gains. In this way multisectoral responsibility for health is implemented through different settings, especially in schools, cities and other communities, workplaces and health care systems. Governments need to formulate policies to encourage health clubs, sports competitions, antismoking campaigns and health education campaigns on healthy living. Certain legislative and fiscal measures have been initiated in the Region especially with respect to tobacco control, such as increasing taxation on cigarettes and banning smoking in public offices, and road traffic safety. WHO presently is actively developing the framework convention on tobacco control, which is intended to serve as an international treaty to curb the tobacco pandemic.

### 6.4 Risk-reduction approach

The risk-reduction approach is considered as the initial step for any healthy lifestyle programme under the leadership of the heath sector. It should pave the way for the more ambitious healthy nations approach. The proposed list of programmes in Box 2 is being considered by some countries of the Region, such as Egypt. Kuwait and the Syrian Arab Republic. It is hoped that after starting with this approach, a more comprehensive framework will be established in time addressing risk conditions as well. The coming decade is the time to institutionalize these approaches.

**Box 2. Risk-reduction objectives: an interim response/framework to achieve healthy people by 2010**

- Physical activity and fitness risk-reduction objectives.
- Nutrition risk-reduction objectives.
- Tobacco risk-reduction objectives.
- Alcohol and other drugs risk-reduction objectives.
- Mental health and mental disorders risk-reduction objectives.
- Violent and abusive behaviour risk-reduction objectives.
- Unintentional injuries risk-reduction objectives.
- Occupational safety and health risk-reduction objectives.
- Environmental health risk-reduction objectives.
- Food and drug safety risk-reduction objectives.
- Heart diseases and stroke risk-reduction objectives.
- Cancer risk-reduction objectives.
- Diabetes and chronic disabling conditions risk-reduction objectives
- HIV infection risk-reduction objectives.
- Sexually transmitted diseases risk-reduction objectives
- Immunization and infectious diseases risk-reduction objectives
- Clinical and preventive services risk-reduction objective (high fertility rates).

### 6.5 Healthy nations approach

It is now more evident than ever before that improving health status starts in domains that lie largely outside the hierarchical set-up of the health services. Improvement in public health is affected by many partners, but especially by the community. There is a need to move from addressing only risk factors to addressing both socioeconomic risk conditions and risk factors. A promising experience was launched in Egypt in 2000 promoting the idea of developing a health promotion vision document. The document is strategic and was jointly prepared with the Ministry of Health and Population and representatives from related sectors. This initiative has enabled the Ministry of Health and Population to develop the "Healthy Egyptian" strategic risk-reduction objectives in four major areas, namely injuries, tobacco control, pollution, and mother and child health, all to be attained by 2010. Other countries such as Oman and the Syrian Arab Republic have shown interest in doing similar exercises.

### 6.6 Exploiting social capital

The health and well-being of a community are affected by the social milieu within which people live, thus the focus of health promotion interventions should shift from the individuals to people. We in the Eastern Mediterranean Region have the potential to invest in our culture, religions and heritage in order to enhance health promotion activities and bridge the gap between health services and communities. Substantial efforts are thus needed to use social capital to resolve the economical, behavioural, and organizational challenges facing health systems.

### 6.7 Tapping our spiritual and religious heritage

The health and well-being of a community are affected by the religious and spiritual teachings in the social milieu within which people live. Islamic and Christian teachings favour solidarity, tolerance, benevolence, cleanliness, healthy bodies and minds, avoidance of harming oneself or others and love. Caring for others, especially the weak, the poor and the needy is a must in religious teachings. There are so many examples which we can learn from which, if followed, will sustain a healthier lifestyle. However making use of such teachings leaves much to be desired. Apparently there is an important role of the religious institutions, leaders, sectors and organizations to play in educating the individual and community. Joint efforts should be made with related sectors such as education and social welfare. The Regional Office has produced series of monographs, *The right path to health; health education through religion*, on Islamic and Christian perspectives regarding healthier living. The series covers topics such as sanitation, HIV/AIDS, ethics, environment, smoking, female genital mutilation, animal slaughter and general aspects of health. WHO and ISESCO have signed a three-year agreement which is also in support of healthier living conditions. The Amman Declaration on Health Promotion through Islamic Lifestyles in 1989 was a joint declaration with ISESCO and other Islamic bodies. There is a need to gain more partners and develop models and tools for changing attitudes and behaviour based on religious teachings.

## 7. ENHANCING COMMUNITY ACTION

Encouragement of the comprehensive development of local communities and support for them in attaining their basic needs through self-reliance are practical approaches for the introduction of healthy lifestyles. The basic development needs and community health worker approaches are two entry points to community empowerment in the Eastern Mediterranean Region.

### 7.1 Basic development needs and similar developmental approaches

The basic development needs (BDN) approach, which has been adopted by 12 countries of different social and economic circumstances in the Region so far, aims at improving quality of life for communities and individuals through a comprehensive development process planned and managed by the community itself. BDN also accommodates concepts such as poverty alleviation and "healthy villages" and enriches them with a community methodology which puts harmony and balance into social and economic development. Thus BDN addresses the determinants of healthy lifestyles.

### 7.2 Community health workers

The term "community health worker" covers a long list of local terms used for community-based health care providers in the Region. The range of activities carried out by these workers depends on the social and cultural circumstances of the community and the links between the community and the health system. Examples of community health workers are traditional health workers (in Pakistan and many countries), "friends of health centres"

(Saudi Arabia), volunteers (Islamic Republic of Iran) and community support groups (Oman). These and other similar community health workers form a base from which to initiate health promotion through community partnership.

### 7.3 Activating civic action: involvement of nongovernmental organizations and other sectors in selective preventive activities

Healthy lifestyles promotion is a people-based approach to health for all in which the health of the people is the ultimate responsibility of several stakeholders, including nongovernmental organizations. In brief it is about enabling people to increase control over and to improve their health, emphasizing positive, life-enhancing matters, not just the removal of negativities such as symptoms or social problems. The focus is on developing people's strengths, skills, knowledge and resources. The focus is on strengths rather than weaknesses or problems. It is essential to be clear about needs, wishes, goals, resources, cultural appropriateness, spirituality and the management and evaluation processes. It is also important to be clear that our concern is with health, as distinct from other worthwhile endeavours. Basically our efforts are geared to those outcomes which can be readily be accepted as having primarily a health dimension, in particular physical health and mental health.

Nongovernmental organizations are well equipped to work in close contact with communities, and they are numerous in the Region. Nongovernmental organizations usually have strong relations with women's unions, youth federations, etc. Their widespread presence at the grass roots level, their experience and their commitment allow them to play an important role in community partnership for promoting healthier lifestyles.

## 8. REORIENTATION OF HEALTH SERVICES

Individuals, communities, health professionals, health services and governments have a shared responsibility for health. Health services need to move increasingly in a health promotional direction, beyond mere responsibility for providing clinical and curative services, and this requires a change of attitude and organization of health services that refocuses on the total needs of the individual as a whole person, reorienting educational institutions in the health field in such a way as to give a human dimension to the health professions. The role of health workers in promoting healthy lifestyles can be augmented by continuing education programmes directed at informing all health workers about approaches to and methodologies of health education of the public.

### 8.1 Involving health professionals in health promotion

Capacity of national ministry of health personnel should be increased to play a leadership role in healthy lifestyles promotion and implementation has been launched in 2000 by conducting a training course in the promotion of healthy lifestyles in the Eastern Mediterranean Region in collaboration with Leeds Metropolitan University (LMU). This 2 week course was a successful effort to develop capacities of nationals on the new thinking in

health promotion and at the same time agree on assignments to be carried out after the training course. Seven countries started this reorientation which will be followed by others.

### 8.2 Critical structures and resources

In order to effect the required changes in support of healthy lifestyles promotion all countries should revisit the structural and organizational aspects of health promotion. The necessary national structure/policy, advocacy, support, planning, monitoring and steering must be developed and functional.

*Information systems*

A comprehensive information system should be established and developed at country and regional levels for monitoring risk behaviour and surveillance, sharing information, advocacy, prioritization, policy-making and planning, including development of a database for promoting good health. This system will ensure documentation and dissemination of success stories.

*Legislation*

Review of current legislation must be undertaken, including regulations on healthy lifestyles and safety standards, which must be enforced or updated (such as tobacco regulations, consumer product safety and traffic design).

### 8.3 Research

Research on healthy lifestyles must be encouraged, with special reference to women, schoolchildren and youth, and development of demonstration programmes The research would be used to provide the evidence needed for policy advocacy. Model projects would be established and later replicated, and used to spearhead national and regional healthy lifestyle promotion programmes.

### 8.4 Partnerships and collaboration

Linkages must be activated between national, regional and international groups involved in promoting healthy lifestyles creating a wide regional network of people and organizations that are engaged in promotion of and actions for healthier lifestyles, especially in developing guidelines, protocols, data profiles and information to promote, implement and monitor healthy lifestyles throughout life.

### 8.5 Integration of healthy lifestyles initiatives

Healthy lifestyles initiatives must be integrated into the success stories of the Region, such as healthy villages and basic development needs programmes and district team problem-solving techniques. Integrating health into development policies and practices at all levels should aim to reduce poverty and promote sustainable human development.

## 9. DEVELOPMENT OF HEALTHY LIFESTYLES TOOLS: SOCIAL POSITIONING OF HEALTH

Health and well-being of a community are affected by the social milieu within which people live, thus shifting the focus of our interventions from only the individuals to the community as a whole. A new tool is needed to position health socially and economically. A "new epidemiology" is taking ground which addresses the social environment and causative factors such as inequality, discrimination, social cohesion, social capital, social class gradients, social integration, social network and social support and their relation to risk factors and risk conditions. There is a move from focus just on sick people to positive health. This tool is about how society and different forms of social organization influence health and well-being. The tools address the social context of health-promoting and health-damaging behaviours and how behavioural interventions might benefit from deeper integration of the social organization into behavioural interventions. We need such tools to help us move beyond traditional medicine to understand the impact of social organization, social structure, and the policies that shape them on the health of the public. Information on health determinants, needs and risk conditions of special groups such as school-age children, the poor and the elderly needs to be obtained, disseminated and used for formulation of policies and monitoring their implementation.

## 10. CONCLUSIONS AND RECOMMENDATIONS

Lifestyles are ways of living based on identifiable patterns of behaviour which are determined by interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions.

Healthy lifestyles promotion is a continuous process of enabling people and institutions to increase control over and improve their health.

To achieve better health gains and quality of life, the countries of the Region should invest in strategic thinking, planning and programming, addressing the determinants of health in the long term and the risk-reduction objectives contributing to reduction of the burden of diseases and mortality in the short and medium terms. The challenges are formidable but the potential is there, especially now that steps in the right direction have taken place. The following recommendations should empower the Eastern Mediterranean Region to promote healthier lifestyles.

### 10.1 To the WHO Regional Office for the Eastern Mediterranean

1. Continue efforts in countries of the Region to enhance healthier lifestyles through expanding and strengthening the basic development needs approach, healthy cities and villages and the prototype action-oriented school health curriculum.

2. Prepare specific guidelines for health personnel, schools and civic groups on how to promote healthy lifestyles among target groups.

3. Advocate the healthy nations and risk-reduction approaches with other countries of the Region and provide technical assistance to ministries of health and related sectors in developing such approaches based on actual studies of unhealthy lifestyles in each country.

4. Report periodically on progress of countries' experience in launching healthy lifestyle promotion programmes to the Regional Consultative Committee, as well as sharing this information widely.

5. Support countries of the Region to tap their religious and cultural heritage in order to enhance healthier lifestyles.

6. Support countries to link healthier lifestyles with other ongoing activities such as tobacco control and noncommunicable disease control.

7. Continue efforts with other United Nations organizations in order to enhance all contributing initiative towards healthier lifestyles.

**10.2 To Member States**

8. Review the structures/bodies to be entrusted with healthy lifestyles promotion and develop a secretariat with representation from all related sectors.

9. Encourage universities and institutions to study the relationships between social topics, such as inequity and healthy living.

10. Conduct orientation workshops on healthy lifestyles as they pertain to their social and economic situation—to all stakeholders and partners in the healthy lifestyles promotion programmes.

11. Encourage studies on their lifestyle patterns (healthy and unhealthy) and develop a database and monitoring system for risk factors of communicable and noncommunicable diseases.

12. Plan for reducing the risk factors in the medium and long terms through a strategic plan which should be aimed at the government, international organizations and community organizations. This plan should specify the roles of national partners and should have specific targets in a defined time frame.

13. Ministries of health should specify the role of health care in promoting healthier lifestyles through reviewing terms of reference of health facilities and updating job descriptions of health staff.

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