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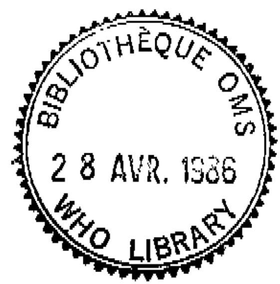


# INTERVENTION STUDIES RELATED TO LIFESTYLES CONDUCIVE TO HEALTH

Report on a WHO meeting

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## 1. The Workshop in the context of WHO activities

The promotion of lifestyles conducive to health is one of the three programme areas defined as a focus for action in the Regional Office's strategy for attaining health for all by the year 2000 (1). The selection of lifestyles as a focal point for health and health promotion reflects the growing acceptance of the complex multifactorial nature of health and its determinants. In developing its own programme and targets for action for HFA2000 (2), the Health Education unit of the Regional Office has recognized the central role of lifestyles in health and this Workshop was an intermediary stage in the process of identifying, planning and implementing appropriate action for promoting lifestyles conducive to health throughout the European Region.

## 2. Outline of the programme

The Workshop was held at the Regional Office for Europe from 9 to 11 March 1983. Participants were welcomed by Dr O. Petersson, Director of Comprehensive Health Services, who stressed the importance of taking into account the particular social, political, economic and cultural climate of a country when planning the implementation of lifestyle interventions. In particular he mentioned the difficulties involved in implementing interventions in unstable conditions, e.g. situations of high unemployment. The opening session was addressed by Dr Ilona Kickbusch, Regional Officer for Health Education, who gave a summary of events leading up to the Workshop, together with a framework for discussion. Following this, the participants decided to spend time considering a number of areas including the problem of information and knowledge deficiency, available and possible research methodologies, research appropriate to lifestyle data required to inform action, ethical issues involved and intervention priorities. During the course of discussion it became clear that clarification was required in relation to the concept of lifestyle and this was seen as an area for priority work. The participants then felt that sharing their own work would help to develop a common understanding of the problems involved and some time was spent in so doing. By the end of the second day it became obvious that there were four major spheres of concern which required further comment and recommendation. These were:

(a) concepts informing research and interventions
(b) issues requiring further research
(c) knowledge-based interventions
(d) ethical issues in research and intervention action.

The last day was spent in collating information, knowledge and ideas in these four areas and in making recommendations for action.

Some of the participants in the Workshop had already submitted background papers which formed a useful basis for shared understanding of the problems identified during the course of discussion.

## 3. Scope and purpose

Although there is a well established knowledge base and a substantial literature implicating lifestyles as the major determinant of health status, there remain serious information deficiencies that have so far impeded the implementation of effective health education and health promotion policies for encouraging healthy lifestyles. In addition, the recognition of the close relationship of lifestyles and health transposes the field of action from the confines of medically oriented endeavour into the sociopolitical arena, a domain fraught with pitfalls and difficulties. Health as a sociopolitical issue expands the boundaries of health promotion into every dimension of human life and encompasses all aspects of human action. In the context of lifestyles, it becomes obvious that health is a problem of profound complexity, to which there is no simple or single solution. In dealing with lifestyles and health there are a number of mysteries yet to be elucidated and a variety of confusions to be disentangled before effective action can be implemented. Some of these must take priority as the keys to solving the remainder. Thus, before decisions can be made regarding the nature of effective interventions and their implementation, the data and information banks informing intervention action must be amplified and augmented in order to adequately reflect the intricacies of the field.

The purpose of this particular meeting was to establish an agenda for priority research on lifestyle factors, as well as priorities for community intervention strategies with appropriate outcome measures. It was also expected that the report of the meeting would contribute to the Regional Office's planning for pilot projects in health education and health promotion programmes 1984-1989 with particular reference to indicators of health.

## 4. A concept of lifestyle

An essential prerequisite for progress in the implementation of action to promote health lifestyles is to develop a clear conception of the term "lifestyle", since without this, communication will be seriously impeded. At present definitions and concepts vary according to origin, but in essence lifestyles represent the way in which individuals and social groups come to terms with their immediate and wider environment. There are a number of behaviour pattern options available to individuals and groups, the choice depending on the particular living conditions available to them. The political, economic, cultural and social climate in which individuals live out their lives will determine their choice of behaviour pattern. The behaviour patterns available also depend on personality, values, beliefs, traditions and aspirations of each individual and his or her particular social group. In simple terms, lifestyle can be described as "the way in which people live their lives" (3), but in sociological terms lifestyles are regarded as mediating structures, an expression of the way "in which the broader values of society are transmitted down to the individual" (4). Individual behaviour choices can be limited or expanded by environmental factors and also by the extent to which the individual feels in charge of his or her own life. The crux of this approach is the reciprocal nature of the relationship between the individual and the environment. The way in which an individual lives his or her life may produce behaviour patterns which are either health promoting or detrimental to health. To affect health, action is required to change both the individual and environmental components of the equation. The Workshop based its deliberations on the above concept of lifestyle.

## 5. Discussion

The nature of the experience of the participants, together with the complexity of the subject matter, created wide-ranging discussions, which eventually focused on four main areas. These were:

(a) concepts informing research and interventions
(b) issues for research
(c) knowledge-based interventions
(d) ethical issues in research and intervention.

### 5.1 Concepts informing research and intervention

There were a number of concepts that were felt to be essential as a basis for research and intervention and that were of common concern. It was felt that unless these concepts were understood and accepted there was little chance of success in promoting healthy lifestyles.

#### 5.1.1 Individual behaviours

It was felt to be no longer appropriate to consider individual behaviours as the main cause of health and illness. Although there is much evidence to support a wider approach, the belief persists that concentration on the individual as the main source of his health status will produce effective change, as epitomized by much of present health education practice. Individual behaviours are embedded in lifestyles and although a given behaviour pattern is intimately related to other patterns which are dependent on and influenced by both the cognitive and emotional structure of the individual, this behaviour takes place in the situational context provided by past experience, stresses, social networks and knowledge within the framework of the cultural, political and economic environment that characterizes a particular society. Many factors cannot be affected by the individual even though he may be aware of their deleterious effect on health. Therefore it is inappropriate and ineffective to concentrate on individual responsibility for health without taking all these factors into account. An effective programme of health promotion must be founded on a clear understanding of the role of different personal and environmental aspects in the development and maintenance of particular lifestyles including work, leisure, social and family life.

#### 5.1.2 Lifestyles as a paradigm shift

The transition from emphasis on the individual as the main cause of his health status to health as a social and political concept constitutes a paradigm shift (3). Inherent in this concept is the fact that great resistance will be experienced to the acceptance of lifestyles as the major determinant of health and health as a positive notion. Paradigm shifts occur over time and require fundamental reorientation of beliefs and attitudes. Different societies are at different stages of readiness in terms of accepting the lifestyles approach to health and the implications inherent in the paradigm shift framework must be incorporated into any policies and strategies for action in relation to lifestyle research and intervention. The important practical aspect is to expect and accept the resistance while at the same time working to overcome it.

5.1.3 Lifestyles and risk behaviour

Lifestyles are seen to encompass behaviour patterns and to include traditions, culture, beliefs, values, work, leisure, housing and family life. The behaviour patterns of an individual are determined by the way in which he lives out his life. In essence, behaviours of an individual are based on beliefs, values and attitudes tempered by culture, the political system, economic conditions and the wider social life. In industrial society it is accepted that most lifestyles are hazardous to health, which is not due in the main to the willingness of people to risk their health. Sometimes the chosen way is the only way that people can continue to function or to cope with the requirements of the social system. In this sense health risk behaviour becomes functional. It may be perceived as being compensatory: the only way in which people can express their need to make choices.

Industrialized society is a highly structured one which influences life in all its aspects from the management of time to food choice. In such a system responsibility is removed from people who come to feel powerless. Powerlessness is known to be a major factor in increasing levels of health hazard and risk behaviour (5). For many people it is the only way in which they can express their individual needs and frustration. It is also a way of regaining physical and psychological ability to confront the conflicts that they experience within their social structure. The use and abuse of alcohol and other health-damaging drugs may give individuals the only means for escape from insoluble conflict.

The participants discussed risk behaviour at some length and were in agreement regarding the functional nature of much observed risk behaviour. The evidence corroborating this makes it all the more important to place any change strategies within the context of the total life situation rather than at the level of individual behaviour. Health risks must be seen as a desperate action to deal with problems outside the control of the individual who does not feel that there are any other options open to him. This makes it important to see the promotion of lifestyles conducive to health as essentially providing a wide choice of options for behaviour choices.

5.1.4 Lifestyles as a mediating concept

Mediating structures are "those institutions standing between individuals in their private lives and the large institutions of public life" (6). They are the "elements within the social system that transmit broader behaviours reconciling the requirements and functions of the social system and that of the individuals" (4). These mediating structures include the family, school, religious organizations, work, etc. Lifestyles are a mediating concept in the sense that they represent the result of the effect of socialization through the variety of mediating structures to which each individual is exposed. This socialization process determines the norms, values, attitudes, beliefs and behaviour patterns that an individual adopts in order to conform to the demands of the society within which he lives out his life. The participants in the Workshop accepted this concept and were quick to realize that the promotion of changes in lifestyle in order to improve health might also produce effects that could conceivably work against the interests of the more inflexible components of a society.

5.1.5 Lifestyles and personal choice

It is vital for people to make choices about the way in which they want to live their lives. Being in control of one's own destiny and taking responsibility for so doing is an inherently healthy action. In the promotion of healthy lifestyles, the essence of action should be to provide a wider choice of options and to fully include all those whose lives are to be affected in the decision-making process. Health promotion then becomes a facilitative process, enabling people to make decisions about their own lives. Thus social control is in the hands of those who are affected by social change.

This is fundamentally different from the medical model of health in which health activities would be imposed upon people as being "good for them". This would inevitably lead to the medicalization of social life, an inherently unhealthy development. There is no one right way to health and no one right health status. The healthy way is to allow people to choose for themselves within the context of an accurate information and knowledge base together with the acquisition of the skills to empower them to change their environment to one which encourages healthy behaviour.

5.1.6 Lifestyles, social support and social networks

It was accepted by the group that good social support and social networks are fundamental to health. Without such support people are much more likely to succumb to ill health and disease. The evidence for this is well documented (5,7). Lifestyles in a stable society are much more likely to incorporate a satisfactory social support system than those developed in unstable political, economic and social conditions, e.g. high unemployment, large rehousing schemes. Rapid moderization processes can lead to severe social disruption with consequent isolation and alienation. In these conditions it is essential to reweave the social fabric and to re-establish both formal and informal social networks. Otherwise, lifestyle patterns may be developed which will be hazardous to health.

Work in this area was noted by the participants and comment was made that in developing social networks, it might be more profitable to seek out those already existing and to strengthen them rather than to try and create them de novo.

5.2 Issues for research

There was consensus within the group that although much was already known about lifestyle factors and health that could inform intervention strategies, there still remained a number of areas requiring clarification and development. Evidence was already abundant regarding the relationship of social and work stress with health. Social isolation and loneliness are major contributory factors in the creation of poor health as is acute and chronic stress in family life and in work. Other established relationships between lifestyle and health include the effect of traumatic life events such as bereavement, life transitions, e.g. from puberty to adulthood, and the perception of powerlessness, low self-concept and low self-esteem that some individuals develop in the face of their social situation. However, even in these areas where much work had already been done, it was felt that there were gaps in knowledge which were needed both to support further what was already known and to break new ground. Furthermore, there were a number of areas where little, if any, information was available to enable the development of a cogent and rational intervention strategy.

5.2.1 Research methodology

The use of quantitative medically-oriented research methods in eliciting lifestyle data was seen to have severe limitations since much of the data to be gathered was of a qualitative nature. To meet this need the boundaries and perspectives of methodology required expansion both to incorporate those methods already available within disciplines used to dealing with qualitative data, e.g. sociology, organization development, education, and also to create new methods to meet the need. A number of ideas were captured including the use of scenarios, case studies, health diaries, role play, tape and video recording. Stress was given to the adoption of a creative approach to data collection in what is essentially a virgin field of action. Overall it was agreed that urgent priority be given to the whole area of methodology in lifestyle research, as without it progress would be seriously impeded.

5.2.2 Coordination of available knowledge

It became obvious from the discussions that a great deal of research was already in progress and that knowledge was available in different parts of the Region and beyond. However, an immediate problem was one of collating and coordinating what was already known and potentially available, and that immediate attention and resources be allocated to establishing a communication network and a collection centre for the dissemination of information and knowledge on lifestyles. This would avoid unnecessary duplication of effort and also accelerate the growth of knowledge to inform effective interventon strategy.

5.2.3 Subjects for further research

It was agreed that more knowledge was required in the following areas:

(a) the development of appropriate indicators of positive health and of suitable outcome measures - although a great deal of work was already available (8), there were many aspects still to be clarified;

(b) factors affecting the equity of access to health care systems both professional and lay;

(c) the role of the family and health;

(d) the effect of employment and unemployment on health and wellbeing;

(e) knowledge of lay care systems, including self-help and mutual aid groups;

(f) factors potentiating risk behaviour;

(g) the development and maintenance of health beliefs;

(h) the cause and control of social isolation and alienation;

(i) clarification of the concept and principles of health promotion;

(j) factors influencing the ability of the individual to change his lifestyle to one more conducive to health;

(k) humanization of professional care;

(l) the contribution of education to health and in particular the utilization of educational approaches, techniques and methods to reduce dependence and to enhance empowerment and self-control;

(m) the development and control of "healthism" and health paternalism;

(n) factors maintaining and improving health, e.g. "why is it that some people stay healthy despite their existence in an established health damaging environment?"

(o) housing and health;

(p) the effect of life and social skills training on health;

(q) transportation and health;

(r) nutrition, diet and health;

(s) knowledge about health-promoting behaviour in the community, i.e. finding out what is already in operation;

(t) factors encouraging the development and maintenance of different lifestyle options.

The problem of a pragmatic approach concerned the group and the importance of the development of a comprehensive theoretical base for action was stressed.

### 5.3 Knowledge-based interventions

During the Workshop a number of intervention areas were identified that were considered to be feasible in the light of present knowledge. The recommendations were based on both research findings, and also a variety of interventions already in progress within and outside the Region.

#### 5.3.1 Coordination

There are interventions already in progress in a variety of communities in different countries, but knowledge of these is haphazard. Participants in the Workshop themselves were unaware of many of these activities and it was felt to be essential to document all known intervention projects as soon as possible. This knowledge could then be made widely available, prevent duplication of effort and inform new projects. The utilization of existing experience is of prime importance in accelerating the implementation of interventions into lifestyles conducive to better health.

#### 5.3.2 Choice of intervention

It was stressed that lifestyle interventions must never be imposed on people since this was antipathetic to the whole concept of health promotion. Success could only be assured if there was enthusiasm, cooperation and full participation of individuals and groups concerned. Essentially

there should be minimal interference by the professions and full ownership of the activity by those for whom the project is to be of benefit. Lifestyle interventions that were professionally dominated would merely perpetuate the existing paradigm and would not be health promoting in the new sense.

5.3.3 Family-based interventions

It was already well known that family life can have both positive and negative effects on health. Families can provide a stable social support base, a nurturing and protective environment and a growth climate (9). However, families can also be a source of chronic strain due to inadequate financial resources, lack of knowledge and skills in relationship building and child rearing, etc. (5). Marriage, parenthood and child-rearing are considered to be natural abilities and as a consequence little attention has been paid to the need for any formal training in any of these areas. Evidence indicates that although some people do have natural abilities in these areas of human activity, most are ignorant of what is required. With what is already known, it is obvious that interventions can be developed which could have a major impact on family health. Such interventions will include life and social skills training for established families (10), the development of educational programmes for incorporation into school curricula and adult education activities, and the training of health professionals in knowledge and skills to facilitate the development of more effective families.

5.3.4 Social networks, self-help and mutual aid groups

It is known that strengthening social networks and improving social support in both work and wider social life has a health-promoting effect. Based on this, it was agreed that much more effort should be put into the development of social networks, particularly where it was obvious that major social disruptions were in operation. Lay helper networks were already in existence in many communities which could be enhanced by identificaton and skills training for the individuals concerned. It has been shown that barmen, pharmacists, hairdressers, etc., are important sources of advice and help, and other networks should be sought out. Furthermore, the development of self-help and mutual aid groups has already been shown to be extremely important in providing social support and these should be encouraged and developed throughout the Region with minimal professional interference.

5.3.5 Work

The relationship between work, work organization and stress is well documented and the provision of healthier work environments, both psychological and physical, have been the focus of a number of intervention projects in both public and commercial organizations. In general, these projects utilize the knowledge, techniques and methods of the field of applied behavioural science known as organization development, and such projects should be encouraged on a wide basis as a means of promoting healthier work lifestyles.

5.3.6 Intervention at the macro-level

Knowing the effect of nutrition, housing, transportation and poverty on individual and community health, and appreciating that these areas cannot be effected by individuals themselves, action is required at local government and at national government levels for change to be implemented. Such interventions can only be effected by individuals as a collective, and only if individuals have the capacity to take responsibility for their environment. This demands a knowledge and skill level that does not exist for most people and interventions to empower people to take this responsibility are required for social change at a macro-level.

5.3.7 Retraining of health care professionals

It is already established that the curricula for medical and paramedical training are largely inadequate in the context of health as a social and political issue. High technology medicine still has an important place in health care, but a specialized one at one end of the total health care spectrum. Undergraduate medical education clings firmly to its hospital-oriented training programme and doctors are not equipped for working in a positive health, health promotion mode, with the possible exception of those who specialize in community medicine. Changes should be encouraged and implemented in the curricula for medical, nursing and other health-related programmes to enable health professionals to make effective intervention from a health promotion perspective at community level.

5.3.8 Knowledge, information and action

One of the reasons that people do little about their own health is that they are not aware of health as an issue for them, or they do not possess knowledge that will allow them to take appropriate action. Interventions at the level of consciousness-raising and information provision are essential. However, careful thought must be given to the best ways of ensuring the effectiveness of such interventions, and experimentation with the use of the media was stressed during discussions on this issue, e.g. television, radio, newspapers, special handouts, etc.

5.3.9 Health handbook

The group recommended the production of a health promotion handbook which would include the following:

(a) the paradigm of health
(b) theories, methods and results
(c) new professional roles and institutions
(d) interventions/health promotion projects
(e) health movements
(f) health politics/conflicts.

5.4 Ethical issues

A number of ethical issues were raised in relation to both research intervention into lifestyles which the participants felt must be taken into consideration by all those involved in the development and implementation of projects.

5.4.1 Privacy

Lifestyle research and interventions encroach upon the private world of the individual, which of itself may be health damaging. It is absolutely vital to ensure that individuals are fully involved in the decision-making processes regarding both research and intervention strategies from the beginning so that they understand what is being asked of them and that they are prepared for the possible consequences. The imposition of professional activities upon people must be avoided and individuals and communities must only be involved from a position of knowledge and information-based choice.

5.4.2 Anxiety

Consciousness-raising activity may raise anxiety levels which can be health damaging. When people discover that the habits and behaviour integral to their way of life and which they enjoy, constitute serious health risks, the anxiety and worry that may be created in them may be high enough to be health damaging in themselves. Furthermore the efforts required to change the behaviour may be too great and they are left with the health risks and the associated anxiety. It is no use identifying health risks without concomitant intervention strategies that allow people to change reasonably easily.

5.4.3 Confidentiality

There is a problem of confidentiality and the acquisition of lifestyle data and information. People must feel confident that their private lives are not further exposed if interventions are to be successful.

5.4.4 Choices

The essence of the health promotion paradigm is choice and the broadening of options for how people live their lives. If, in the process of promoting lifestyles conducive to health, one tyranny is substituted for another, i.e. healthism, then the whole process will have failed. People must have the freedom to choose how they want to live and this must be a prime requisite for all intervention strategies.

## 6. Recommendations

The group made the following recommendations for priority research:

(a) the development of a clear, conceptual framework to inform intervention strategies;

(b) knowledge in relation to factors affecting lifestyle choices;

(c) the effect of stress on health in relation to work and family life;

(d) knowledge in relation to the effect of social isolation, alienation and social disruption on health and the implications of the development of self-help groups, mutual aid groups and the strengthening of social networks;

(e) knowledge about the effect of life and social skills training in relation to the enhancement of personal power, self-concept and the development of a more effective social support network;

(f) knowledge about healthy people, i.e. why do some people remain healthy in the face of health-damaging influences;

(g) knowledge about health beliefs and concepts of health in relation to lifestyle choices;

(h) the development of indicators of health and useful outcome measures.

It was strongly felt that little progress would be made in promoting lifestyles conducive to health if we awaited comprehensive research results before developing intervention strategies, and that there was much that was already known to a sufficient degree to inform immediate planning for action. Furthermore, the importance of taking creative approaches was also thought to be of great importance. The field of lifestyle intervention is one which is relatively unexplored and it is necessary to take steps into the unknown if we are to discover more about this new territory. To this end the group made recommendations for intervention priorities, as follows:

(a) the development of a strong network of people involved in research and intervention studies in lifestyles throughout the Region;

(b) the production of a health handbook;

(c) the promotion of change in the training curricula for medical and health-related disciplines;

(d) the use of a variety of methods for disseminating information and changing attitudes, beliefs and values in relation to health and health promotion;

(e) the development of self-help groups, mutual aid groups and lay helper networks with minimal professional intervention;

(f) interventions in the work situation using an organization development approach;

(g) the encouragement of model projects in different countries for promoting lifestyles conducive to health at the individual, family and community levels;

(h) the development of family-based life skills training programmes;

(i) the development of a centre for the coordination, collation and dissemination of knowledge and information regarding research and interventions for lifestyles conducive to health.

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Annex 1

## LIST OF PARTICIPANTS

### TEMPORARY ADVISERS

Professor B. Badura
Fachbereich Soziologie, University of Oldenburg, Federal Republic of Germany

Dr K. Dean
Institute of Social Medicine, University of Copenhagen, Denmark

Professor D. Deliege-Rott
School of Public Health, University of Louvain, Brussels, Belgium

Dr F. Eskin
Department of Community Medicine, University of Manchester, United Kingdom (Rapporteur)

Dr P. Franzkowiak
Research Group "Youth and Health", Heidelberg, Federal Republic of Germany

Dr U.R. Laaser
Deutsches Institut zur Bekämpfung des hohen Blutdruckes, Heidelberg, Federal Republic of Germany

Dr S. Panico
Semeiotica Medica, University of Naples, Italy

Professor T. Theorell
Director, Department for Health Care Research, National Institute for Psychosocial Factors and Health, Stockholm, Sweden

### WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr I. Kickbusch
Regional Officer for Health Education (Secretary)

Professor L. Levin
Consultant for Health Education

Dr P.G. Svensson
Scientist, Health Research