

**HEALTHY LIFESTYLE:
STRENGTHENING THE EFFECTIVENESS OF LIFESTYLE
APPROACHES TO IMPROVE HEALTH**

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Document Preparation Process

Two meetings of the Lifestyles Working Group were held at Health Canada: one meeting in December, 1999, to draft the objectives of the project, followed by a two day meeting in February that included several members of the Consortium and Health Canada. Many drafts of this paper were prepared by the Atlantic Health Promotion Research Centre, Dalhousie University, and two were circulated to members of the Group for feedback. Two teleconference calls were held as well as email communication as the paper evolved.

Author's Preamble

It takes time for ideas to evolve, as well as evidence to be discovered, synthesized and examined for its relevance to policy and action. This paper was conceived mainly by volunteer effort in the midst of hectic schedules. Due to the limited time available to prepare this paper, we acknowledge

the omission of useful human and print resources from our discussions and from this document. Moreover, the concepts and approaches suggested in this paper are in the “incubation” stages.

The issue of healthy lifestyles is an important one. As health budgets are squeezed, increased pressure is placed on individuals to live healthier lives. Policy makers have an opportunity to thoughtfully consider their leadership on this issue. Reducing tension among roles of personal responsibility (what I do), social responsibility (what we do, what I do for those around me), and the state (healthy environments, healthy public policy, reduction in social inequities) must play a key role. Clear goals and synchrony of effort toward these goals will result in more effective outcomes.

Executive Summary

A healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life. However, convincing Canadians that health is a good investment, and providing guidance and incentives to create a culture that fosters health, are complex processes. How do we direct efforts to engage people in becoming and staying healthy?

The purpose of this paper is to redefine the construct “healthy lifestyle” so that the term can be more usefully applied in health promotion and population health, and in the implementation of health-related interventions. The authors present a reconstructed perspective of “healthy lifestyle”, evidence for the effectiveness of lifestyle interventions, and promising approaches to foster healthy lifestyles. We suggest that barriers to implementing healthy lifestyles include how the concept has been defined and promoted, and how people, especially those with lower socio-economic status, are enabled to live healthy lives.

This paper has been prepared by an inter-sectoral "Lifestyles" Working Group comprised of members of the Canadian Consortium of Health Promotion Research Centres and Health Canada. It addresses the questions: Is “healthy lifestyle” a useful concept? What are the determinants of lifestyle choice? What approaches have been used to foster healthy lifestyles and have they been effective? How can social and community processes foster healthy lifestyles?

The authors conclude that a healthy lifestyle is an adaptation to one's social environment. Unless lifestyle is constructed (as a category of intervention) in concert with the way that lifestyle is experienced by target group(s), interventions are unlikely to succeed. The strategies for action set out in the Ottawa Charter are relevant to interventions aimed at the interdependence of individuals and communities, with most emphasis placed on strengthening communities, environments, and public policy arenas. Social environments are complex. Therefore, we must approach health issues and problems that recognize this complexity and that are targeted at a number of determinants, and at more than one level simultaneously.

Introduction

A healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, for recovery, for coping with life stressors, and for improving quality of life. However, convincing Canadians that health is a good investment, and providing guidance and incentives to create a culture that fosters health, are complex processes. How do we direct efforts to engage people in becoming and staying healthy?

Illness is costly. It takes considerable family and state resources to cope with and to ameliorate health problems. The increasing prevalence of chronic illness and disabling conditions, along with greater life expectancy and the rising average age of the population, are substantive contributors to the rising burden of illness. Conditions such as heart disease, cancer, diabetes, joint disease, and mental illness are responsible for the vast majority of death and disability. Currently, we rely almost exclusively on the provision of clinical care by highly trained health professionals as our major strategy to deal with these conditions (MacLean, 2000). However, the aging of Canada's population suggests that problems in the provision of health care will likely worsen unless action is taken now to promote health and prevent illness. Action must include the development of more efficacious alternatives to the present reliance on health care services as the response to illness.

Many health problems can be prevented or at least their occurrence postponed (U.S. Dept. Of Health & Human Services, 1999; IUHPE, 1999; Stroebe & Stroebe, 1995). We have known for the last 20 years that a sizable proportion of the 10 leading causes of death is due to potentially modifiable social and lifestyle factors (US Dept. of Health & Human Services, 1999). Some health issues are addressed with relative ease (e.g., wearing seatbelts). Many others such as exercise, nutrition, smoking, and substance abuse are integrally linked to culture and to socio-economic status (Kawachi et al., 1996; Labonte, 1998; Lupton, 1994; Marmot et al., 1997; Stewart et al, 1996), and are much

more difficult to address. Evidence has shown that many of these health-related personal and social factors are subject to modification, but only through comprehensive, intersectoral, long-term strategies that employ a variety of health promotion and disease prevention approaches (FPT Advisory Committee on Population Health, 1994; Frolich & Potvin, 1999; Hobfoll, 1998; Hyndman, 1998; Lomas, 1998). Many of the behaviours that contribute to health conditions, whether good health or ill health, are clearly related to the **interdependence** between people's lifestyle and their social environment (Bhatti, 1999; Frankish & Bishop, 1999). We are just beginning to understand the concepts of social integration, social support, and interdependence at the same time that health promotion strategies focused purely at individual health behaviors are yielding limited success (Coyne & Fiske, 1992; Frohlich & Potvin, 1999; Glouberman, 1999)

Purpose and Structure of this Paper

The purpose of this paper is to examine and re-construct the concept of "healthy lifestyle" so that the term can be more usefully applied in our approaches to health promotion and population health. As our society evolves, so too do the concepts we use to understand and act on the world around us. The concepts of "lifestyle" and "healthy lifestyle" have changed and are changing. Painting a picture of these terms for the year 2000 and developing strategies to improve the health of Canadians through healthier lifestyles must align with our knowledge base about health and its determinants, and the evidence we have accumulated about the effectiveness of strategies to improve health.

This paper is structured around the following questions. Is "healthy lifestyle" a useful concept? What are the determinants of lifestyle choice? What approaches have been used to promote healthy lifestyles and have they been effective? How can social and community processes foster healthy lifestyles? The authors present a reconstructed perspective of "healthy lifestyle". Evidence for the effectiveness of lifestyle interventions, and promising approaches to cultivate healthy lifestyles are presented. It is posited that the difficulty in changing the lifestyles of Canadians to improve their health

may be largely due to the way that lifestyle has been defined and promoted, and the ways that people, especially those of lower socio-economic status, are enabled to live healthy lifestyles. The approach to health presented in this paper emphasizes the interdependence between individuals and their community or communities. The bulk of research and intervention has focused on the lifestyles of individuals. Therefore we devote time in this paper to explicate the social and community aspects of healthy lifestyles. At the end of each section, we include a Key Points section to summarize the major points examined.

This paper is based on the following perspectives:

- 1) People's lifestyles are significant contributors to their physical health, psycho-social (emotional, psychological, spiritual) health and well-being.
- 2) Lifestyle, particularly when related to "risk" behaviours such as smoking and physical inactivity, is typically conceptualized as a function of individual choice.
- 3) The concept of "lifestyle" has considerable value in the analysis of the health of Canadians, but not as it is currently conceptualized.
- 4) Expanding lifestyle beyond an individualistic notion is a key to fostering healthy people and healthy communities.
- 5) Understanding the relationship between individuals and their social context will lead to the development of more effective methods to improve the health of Canadians.
- 6) Opportunities to engage in and change the social context foster health. Engagement at these various levels means that the culture does not simply act on the individual to influence his or her lifestyle. Individuals and groups of individuals must act to appraise and change aspects of the social context to enable healthy lifestyles (theirs and those of the people around them). Macro level policies and practices have a substantial impact on the lifestyle of individuals, their relationship to their communities, and the capacity of communities to foster the health of individuals.
- 7) Partners in health promotion and population health have an important role to play in developing and supporting a new "community-oriented" conceptualization of lifestyle, marketing the idea, and providing a supportive environment to enable it to happen.

Is “Healthy Lifestyle” a Useful Concept?

What is “lifestyle”? What is a “healthy lifestyle”? How have understandings concerning lifestyle and its role in health evolved in Canada?

The concept of “lifestyle” is based on the idea that people generally exhibit a recognizable pattern of behavior in their everyday lives. (e.g., regular routines of work, leisure, and social life). A popular 1970's television show, “Lifestyles of the Rich and Famous”, was based on the notion that celebrity and wealth constituted key resources for an interesting and desirable lifestyle. The term "healthy lifestyle" evolved from the idea that people's daily pattern of activities can be judged as healthy or unhealthy. A healthy lifestyle is generally characterized as a “balanced life” in which one makes “wise choices”. However, the array of choices is influenced by many factors.

In real life, lifestyle is a product of some combination of choice, chance, and resources. Rutten (1995) offers important distinctions among a number of lifestyle-related concepts: life conditions (resources), life conduct (pattern of behaviors), lifestyle (collective patterns of life conduct), and life chances (structural-based probability of correspondence of lifestyle and life situation). One's socio-cultural environment is a very powerful determinant of lifestyle. In fact, Shields (1992) and other sociologists have suggested that lifestyles are essentially artifacts or reflections of culture, individual choice being a less important factor than societal determinants. *Lifestyles are viewed as groupings of commodity consumption involving shared symbolic codes of stylized behavior, adornment, and taste* (Shields, 1992, p.14).

The concept of lifestyle assumed new importance for Canadian health policy with the 1974 publication *A New Perspective on the Health of Canadians* (Lalonde, 1974). This landmark document was among the first to identify lifestyle as a determinant of health and illness, and influenced thinking about health around the world. Lalonde defined lifestyle as:

"The aggregation of decisions by individuals which affect their health, and over which they more or less have control. ... Personal decisions and habits that are bad, from a health point of view, create self-imposed risks. When those risks result in illness or death, the victim's lifestyle can be said to have contributed to, or caused, his own illness or death." (p. 32)

Early discussions of lifestyle centered primarily on nutrition, exercise, smoking, and alcohol use. Programs to improve lifestyle were founded on a belief that information and education would change lifestyles. While revolutionary in its day, our understanding of lifestyle and its relationship to health has evolved substantially since that time. Research and experience in health promotion have changed the way we think about lifestyle and how we work to improve health.

Over twenty years later, the WHO definition (WHO 1998a) of lifestyle provided a broader understanding of the determinants of a healthy lifestyle. It stated that lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions.

The WHO definition suggested that patterns of behaviour are continually adjusted in response to changing social and environmental conditions. It also suggested that efforts to improve health by enabling people to change their lifestyles must be directed not only at the individual, but also at the

social and living conditions which contribute to the behaviour or lifestyle. The WHO definition further stated that there is no one "optimal" lifestyle, and that many factors determine which way of living is appropriate for each individual.

A reconstructed definition of lifestyle must incorporate components beyond diet, exercise and alcohol use in order to account for social conditions and processes such as socio-economic status and social relations. Perspectives on lifestyle must move beyond the individual.

What Constitutes a Healthy Lifestyle?

Recent perspectives on the determinants of population health have broadened our understanding of the **elements that constitute a healthy lifestyle**, for example:

- < Effective coping is now widely recognized as an important determinant of health. Coping behaviours help people deal with the challenges and stresses of life without recourse to risk behaviours.
- < Lifelong learning is part of a healthy lifestyle.
- < Safety and security precautions in the home, school, and workplace are part of healthy lifestyles.
- < Social activity and volunteering are now considered important components of healthy lifestyles, in recognition of the influence of social relationships on health.
- < Sense of purpose and meaning, spirituality, and hope are key elements in lifestyle. These concepts involve efforts to make sense of and find one's place in the world (Ansbacher, 1959; Bhatti, 1999).

Two other factors which have been taken into account when defining a healthy lifestyle are life stage and perception of risk. Research on human development throughout the life cycle suggests that individual perceptions of a healthy lifestyle may change with life stage. For example, research in gerontology has shown that healthy aging is associated with lifestyles that include social interaction, multiple roles, leisure activities, and an internal locus of control (Rowe & Kahn, 1997). For parents of young families, parenting, managing stress, and maintaining a balance between work, family, and community may be more important components of healthy lifestyle than for older adults.

Perception of risk is associated with life stage. Lifestyle education aimed at young people often conveys the message that risk-taking is unhealthy. However, understanding the importance of risk in the learning process, and of risk-taking in adults, has led to recent questioning of the lifestyle messages directed at youth. There is no one healthy lifestyle but there are components (attitudes, knowledge, skills, and actions) which clearly enhance health. It is also clear that lifestyle messages aimed at any one life stage need to be clearly targeted. (For a fuller examination of risk and health promotion, see Peterson, 1996).

Reconstructing “Healthy Lifestyle”: Individuals in Relation to Their Communities

According to McLeroy et al. (1988), health-related behaviours are determined by five categories of factors: **intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy**. As four of the five factors are in the external environment, the importance of targeting interventions at the environment rather than the individual becomes apparent. There is a vast body of strong and compelling evidence about the impacts of the social determinants of health (WHO 1998b). To avoid the perspectives that lifestyle is an

individual attribute and that individual behavior is the primary lever of change, Frohlich and Potvin (1999) propose that we consider re-framing lifestyle as a collective lifestyle heuristic. These authors suggest that this heuristic will help to understand more fully the interaction between social conditions and behavior in shaping health. They also suggest that the current conceptualization of lifestyle has swayed far from its origins (see also Lupton, 1994), which are based on Max Weber's idea that lifestyle is mostly defined by status and distinction among groups, and is reinforced by patterns of consumption. Life chances are not a merely matter of chance, but are opportunities people have based on their life situations.

A reconstruction of the concept of “healthy lifestyle” which takes the social context into account is similar to the reconceptualizing that occurred in the area of stress and coping (Coyne & Fiske, 1992; Eckenrode, 1991; Lyons et al., 1998). Recently, there has been a move away from viewing stress and coping as solely individualistic notions (how I alone deal with stress) to seeing them as social processes (how we deal with stress and how others influence stress appraisal and coping). A central theme of this change in thinking is interdependence and increasing evidence of the influence of interdependence on coping and on adopting healthy lifestyles. **Interdependence is the connectedness of individuals with their social environment** (Kelley, 1979). A person’s identity, choices, and lifestyle are defined to a very large degree by the nature of one’s interdependence. If conceived on the basis of interdependence, a “healthy lifestyle” is understood less as acquiring strictly personal health skills, and more as acquiring competencies and an orientation to creating a mutually supportive environment for healthy living.

The population health framework is based on strong evidence of the need for attention to the broader social level. Somewhere on a continuum between the individual and society as a whole is the **community**. A community is a collective of people identified by common values and mutual concerns for the development and well-being of their group or geographical area (Green & Kreuter, 1999). The community is the locus of interaction between people as well as the locus of many health determinants external to individuals (e.g. environment and income).

The impact of the community on health is not uni-directional (i.e. my community affects my health). The relationship is bi-directional (i.e., individuals strengthen or weaken a community and influence the well-being of others) and inter-connected (i.e., the community and its members are inseparable).

By focusing on specific lifestyle issues such as eating and exercising only from an individualistic perspective, we may be reinforcing the notion that lifestyle as a component of health is only about “what I do for me”. However, if we talk about lifestyle as one's relation to community as part of defining healthy lifestyle, we need to understand that relationship. What elements of the “individual in the context of community” should comprise our definition of healthy lifestyle? The following is a list of four components that may be as important to healthy lifestyle as individual health behaviors:

A) My health impacts the lifestyle of others

One's own health has an impact on the lifestyle of others (e.g. illness burden and care giving).

B) My actions influence the lifestyle of other people

“Don't worry that children never listen to you; worry that they are always watching you” (Fulghum, 1986). Actions that influence the lifestyle of others include: social support for health behaviors; volunteer "rescue" services; "role models" for children, families, or neighbours; constructing the physical environment for healthy living; introducing health practices to others by inviting their participation; offering people opportunities to engage in positive health behaviours (health related gifts, transportation to events, organizing neighbourhood events).

C) I influence the conditions in my community that contribute to healthy lifestyles

Individuals contribute to the health of their community. They use their expertise and energy in the planning, design, and development of healthy community level initiatives and to support the reduction of the factors that work against health (e.g., unsafe physical environments).

D) We (acting together) influence the health of others

People in communities cooperate to assist individuals who, as a result of an individual level circumstance or a group stressor (e.g., flood or plant closure), have fallen on hard times or who need extra resources to cope effectively. People may cooperate to create infrastructural supports in communities (e.g., build a playground or lobby to reduce pollutants). Community support may also be activated by events that appear to happen to individuals, but which have significant impacts on social networks (e.g., illness).

In pre-industrial societies, people needed the collective to survive. With industrialization and the associated social changes, social norms and values favoured "independence" and individual accumulation of resources. Now, many people do not belong to a supportive community. In urban and suburban centres, people often live far from family and friends. A fast-paced culture leaves little time for building new relationships and creating a sense of community. Reliance on family and neighbours is replaced by institutions such as organizations, governments and businesses, leading to impersonality and disconnection. Community is often "the workplace". Our market-driven, individualistic society encourages people to purchase services that were once provided through personal relationships and communities, thus reducing the incentive to invest in relationship-building, and undermining community development. Perhaps the next iteration in fostering "interdependence" is a new form of community in our lives that is valued as a place of dynamic interdependence, where people feel they are part of a community that fosters health, and are part of the growth and existence of this community.

“Healthy Lifestyle” Reconstructed

Is the concept of “lifestyle” still useful? “The short answer is ‘yes’, but with the important condition that our understanding of it is expanded. When the term ‘lifestyle’ is used it should include components that acknowledge the interdependence between the individual and her/his relevant social and physical environments. Most importantly, the term should not be used as shorthand for those aspects of behaviour, such as eating or exercise, which affect health, but which are seen as personally ‘modifiable’ health behaviors.

If we are to promote the idea of a healthy lifestyle, what do we promote? A healthy lifestyle can be thought of as a generalized description of people’s behaviour, in three inter-related dimensions: individuals; their social environments (family, peers, community, workplace); and, the relation between individuals and their social environments.

Key Points:

Components of a Healthy Lifestyle

& Early definitions of lifestyle emphasized nutrition, exercise, smoking, and alcohol use.

& More recent definitions of lifestyle have begun to consider the influence of social, economic, and environmental factors on lifestyle.

& Definitions of "healthy lifestyle" in Canada may vary considerably by gender, life stage, geography, culture, and resources.

& There is no one optimal healthy lifestyle. Healthy lifestyles include a wide range of behaviours, such as effective coping, lifelong learning, safety precautions, social interaction, volunteering, parenting, spirituality, balancing work and family, as well as good nutrition, physical activity, safe sex, and avoiding tobacco and substance abuse.

& A reconstructed notion of "healthy lifestyle" includes individual, community, and "interdependence between individual and community" dimensions.

& A healthy lifestyle is about striving to obtain a reasonable balance between enhancing one's personal health, the health and well-being of others, and the health of the community.

What are the Determinants of Lifestyle Choice?

Perspectives on Lifestyle Choice

1. Opportunities and limitations for choice vary considerably. While most people do make choices, the choices for many are limited. The range of choices available is a function of education, relationships, socialization, personality, physical and mental ability, situational factors and goals, and financial and other material resources. People make choices in the context of community norms and broader social and economic conditions. For people with higher incomes and education, the degree of choice is much greater; however, this enhanced capacity does not mean that those who possess knowledge and resources always choose healthier behaviour. Consider Kuwait as an example. High rates of smoking, obesity, physical inactivity and cardio-vascular disease suggest a culture that does not support healthy living, despite abundant economic resources. When health is viewed as more than individual choice, clear links between lifestyle choice and life circumstances emerge. The need for considering the interdependence between individual practices and socio-economic context becomes clearer.

2. Health for most people is not an end in itself. The WHO definition of health points out that health is a means to an end, a resource for everyday living. Further, health choices and lifestyles are embedded within daily activities (work, learning, parenting, relationships) such that they may not be identified specifically as “health” choices.

....health maintaining practices do not stand alone and above other practices of everyday life, but are incorporated seamlessly into the life-world of the individual, often in ways that submerge any overt health associations under other meanings deemed more important to the individual's identity

....health promotion activities, values and discourses themselves should be evaluated for the part they play in the rich culture of everyday life
(Lupton, 1994, p.117).

Often people make choices that satisfy multiple and competing personal and family needs. Choices are infrequently made for purely personal health reasons. For example, Cape Breton coal miners are acutely aware of the serious health risks of their occupation, but may choose (because of limited education and few available occupational alternatives) to work underground to provide for their families. Is this a healthy lifestyle choice? People with substance addictions often choose to smoke (another substance addiction) as a way of coping with the stress of withdrawal. Given limited resources, smoking may be the only coping mechanism available to them. Is this a healthy choice? **People maintain lifestyles which they know are unhealthy because they meet certain immediate needs.** In order to address “unhealthy” lifestyle choices (those that have been scientifically proven to be harmful to one’s health), factors in the broader context of people’s lives must be understood and changed to permit healthier choices.

The University of Toronto’s Centre for Health Promotion model of “Quality of Life” includes the concepts of being, becoming and belonging. This model suggests that people define quality of life as a goal, and health has to make sense for one's efforts toward this goal (Raeburn & Rootman, 1998; Renwick et al., 1996).

3. There are Important Linkages Between Lifestyle Choice, Determinants, and Health.

The causes of health and disease are a complex interplay between individuals, social structural factors (i.e., SES, educational attainment and occupation), cultural factors (eg., health beliefs of various ethnic communities and peer subcultures) and exposures to particular risk and protective factors. Overlaying these factors are persuasive pressures from the consumer marketplace and information from diverse sources that may impinge on perceptions of health and risk.

If exposures to microbes (bacteria and viruses), to products (eg., cigarettes and tobacco smoke), or to chemical contaminants in the air, water, or food are thought of as causal agents affecting health, then health determinants (e.g., SES, education, gender, genetic endowment, etc.) can be thought of as individual and social conditioning factors that affect the probability and extent of the causal exposures. In turn, the interaction between these exposures and underlying genetic and social resilience factors result in varying states of health and disease as experienced by individuals and defined populations. 'Healthy lifestyle' in this wider context is defined by the interaction between choices and habits of individuals with different social locations, susceptibilities, and exposure risks. Time spent indoors or outdoors, and the sort of neighborhood one lives in, are factors related to lifestyle, as much as habits of diet, exercise, and alcohol or drug consumption.

Smoking provides a good example of this complexity. Addiction to tobacco is often said to be the largest single cause of ill-health and premature death in Canada. Between 85% and 90% of lung cancers are attributed to smoking. The chances of being a smoker are not evenly distributed throughout society: Canadians from all social and educational backgrounds are still counted among smokers (who comprise about one quarter of Canada's population), but the prevalence of daily smoking is highest among Canadians with relatively low levels of education, low income, low rates of exercise, and high rates of obesity. The significance of thinking about health and risks to health in terms of health determinants, lifestyles and resultant patterns of exposure to (multiple) risks and adverse outcomes is that we gain a better understanding of how health is maintained or illness produced. Based on this fuller understanding, it may prove feasible to develop more effective, comprehensive programs of multi-level intervention, combining information, tax policies, social marketing, regulation and community action - all of which, acting in concert, may positively influence population health status over time.

Determinants of Lifestyle Choice

Frohlich and Potvin (1999) suggest that lifestyle choices are not random behaviors unrelated to

structure and context, but are choices influenced by life chances. Five important determinants of lifestyle choice include personal skills, stress, culture, social relationships, and a sense of control. Although these concepts should be considered elements of lifestyle, they are not always included in lifestyle heuristics or constructs.

1. Personal life skills: It is now widely recognized in Canada that enhancing personal life skills is an important element of health promotion, including skills beyond those connected to specific health practices. **Life skills are abilities for adaptive and positive behaviours that enable people to deal effectively with the demands of everyday life.** They consist of personal, interpersonal, cognitive, and physical skills that enable people to control and direct their lives. Personal life skills include literacy and numeracy, decision making and problem solving, creative and critical thinking, empathy, mutual support, self-help and advocacy, communication, and coping (IUHPE, 1999).

2. Stress: The choices people make are also strongly influenced by stress. A recent study by Decima Research for the Heart and Stroke Foundation found that nearly half of Canadian adults are overwhelmed by either their jobs, families or finances, and time pressure appears to be a prime contributing factor. Almost three-quarters of respondents said they were likely to watch excessive amounts of television, eat comfort foods, smoke cigarettes, or resort to alcohol to help control stress. More than half of Canadians said that they do not have adequate time for family, friends, and partners. Respondents suggested that time stress makes "health enhancing" activities such as exercise even more stressful. People reported cutting out things that were important to them, such as hobbies, sports or other recreational activities, in order to meet the increasing demands of careers and families (Heart and Stroke Foundation, 2000).

3. The Influence of Norms and Culture on Lifestyle Choice: All human behaviours (including acts of resistance to the dominant culture) reflect, to some extent, the culture and values of a given society.

...meals and other eating habits are statements about society and the things considered important in culture such as social class, family relationships,

life-cycle issues, and aesthetics... When one consumes a hamburger from McDonalds' family restaurants, one is also consuming American culture. ...Chocolate, in particular, has great symbolic meaning in western society. It symbolizes luxury, decadence, indulgence, reward, sensuousness, femininity and is an icon (along with satin sheets, champagne and red roses) of passionate romance, all of which are powerful and desirable meanings (Lupton, 1994, pp. 112-114).

Community norms and standards of behaviour also limit personal choice. Smoking may be a widely accepted means of coping with stress in low-income and immigrant communities, but far less acceptable behaviour in middle and upper income communities. Complying with community norms represents security and acceptance; defying them is much more difficult.

The relative level of affluence in a neighbourhood has an important influence on risk factors for cardiovascular disease, which goes beyond educational attainment. Sundquist et al. (1999) found, for example, that people living in the most deprived neighbourhoods had an increased risk for being a daily smoker, not engaging in physical activity, and being obese when adjusted for SES.

4. Control and coherence: A sense of life control and coherence are other important components of lifestyle choice. Recent Whitehall studies on morbidity and mortality of British civil servants suggest that lack of control over work contributes significantly to ill health and to heart disease in this population (Marmot et al., 1997). High levels of stress reflect a lack of control over long periods of time, leading to anxiety and insecurity. The stress response causes a wide range of physiological changes, including depression, susceptibility to infection, diabetes, high blood pressure, and increased risk of heart attack and stroke (Bruner, 1997). Lomas (1998) argues that social support and social cohesion are much stronger influences on cardiovascular disease than individual medical care.

Wallerstein (1992) documented the role of powerlessness as a risk factor for disease and conversely the role of empowerment as a health promoting strategy. She reviewed the literature from the fields of social epidemiology, occupational health, stress research, social psychology, community psychology, social support and networks, community competence, and community organizing. From this diverse literature, Wallerstein concludes that:

...control over one's destiny, or lack thereof, emerges as a disease risk factor...A working hypothesis is that lack of control over destiny promotes susceptibility to ill health for people who live in high demand or chronically marginalized situations and who lack adequate resources, supports, or abilities to exert control in their lives (p.202).

5. Belonging: A healthy social environment gives people a sense of belonging and of being valued. It reduces stress, increases control, and reduces social isolation. Supportive environments can be created in homes, local communities, schools, places of employment, and places of recreation. An individual response to the health effects of stress might be to control them with drugs or through "stress management". Tackling the causes of stress at the collective level, by creating supportive environments in homes, schools, businesses, and other institutions is a more promising approach (WHO, 1998b).

Social relations and support from family, friends, and communities are important contributors to health and reduce premature deaths (Bruner, 1997; Hanson, 1986; Stewart, in press). Social support is now recognized as an important determinant of health. Social relationships may have as great or even greater influence on health as do the more established lifestyle and risk factors. Social support provides a buffer against adverse life events and living conditions, and an emotional and practical resource for coping and for enhancing quality of life. Belonging to a social group makes people feel cared for, loved, and valued. It provides social status and a sense of control, two elements that have powerful protective effects on health (WHO, 1998b; FPT Advisory Committee on Population Health, 1994; Lyons et al., 1998).

People who receive less social support are more likely to experience depression and mental illness, pregnancy risk, and chronic disability (Kaplan et al., 1988; Kawachi et al., 1996; Oxman et al., 1992). Good social relations can reduce adverse response to stress. Social support interventions improve medical outcomes in a variety of high risk populations (WHO, 1998b).

It is important, however, not to idealize the community as a locus of effort without substantive challenges. A community focus includes power issues (ingroups vs. outgroups), enmeshment in one another's lives, and control/constraints upon personal freedoms. Maintaining community can be difficult. As we noted earlier, one of the biggest challenges to humankind is the dialectical tension between the individual and the community and the need to strike a reasonable balance between individual and community level effort (Hobfoll, 1998; Lyons et al., 1998). Community may be a major resource in health, but it also can be a major challenge.

6. Pleasure vs. “Healthy” Choices: Choice is further influenced by human physiology. The human body finds sweet and fatty foods tasty, becomes easily addicted to certain chemicals, and seeks opportunities to rest. These biological characteristics cannot easily be overcome. Tiger (1992) suggests that humans are motivated to seek pleasure and avoid pain. Many healthy behaviours appear to require giving up pleasure.

People who live in conditions of poverty and/or insecurity are more likely to engage in risk behaviour, such as smoking and unhealthy food choices (Stewart, 1996). The pleasure provided by these activities often serves as a distraction and respite from difficult life situations.

7. Personality traits may influence lifestyle change. Personality traits such as optimism and self-efficiency contribute to healthy living. For example, research has shown that people who are optimists live longer (Mayo Clinic, 1999). If individuals do not think well of themselves, or do not feel that their efforts will make a difference, why engage in a healthy lifestyle? The concept of learned helplessness demonstrates this linkage. “Learned helplessness” suggests that people can be socialized to believe that their efforts will not pay off; that they cannot have any measure of control over their environment

(Bandura, 1986; Seligman, 1975). If people believe they cannot exercise control over various aspects of their lives, they are unlikely to attempt changes to control their health, or the health of their family or community.

8. The Overabundance of Choice in Canadian Society: Today's society provides us with an overwhelming array of choices, and conflicting information about what are the "right" choices. People are not well equipped to sort through the many conflicting messages from the media and other sources. They can be drawn to the appeal of immediate pleasure by engaging in behaviours that may carry long term negative consequences.

Key Points:

Determinants of Lifestyle Choice

- & Opportunities and limitations for lifestyle choice vary considerably.
- & Health behaviors are not usually an end in themselves, but rather a means to an end.
- & Lifestyle choice is linked to social and environmental determinants of health.
- & Lifestyle choice is influenced by human physiology (e.g., the desire for pleasure).
- & The issue of lifestyle choice is a growing societal challenge; there is a broad range of choices/commodities and broad access to immediately pleasurable activities with potentially long term negative outcomes for health (e.g., rich food, drugs, unsafe sex).
- & Support or lack of support from the social context for healthy behavior is an important determinant of health.

What Approaches Have Been Used to Foster Healthy Lifestyles And Are They Effective?

What approaches have been used to positively influence lifestyle? What works and what doesn't work? Approaches for influencing lifestyle can potentially be directed toward changing individual behaviour, changing some aspect(s) of the community, or changing the relationship between the individual and the community.

The recent history of health promotion has offered evidence that both individual behaviour and aspects of the social environment are potentially modifiable. Moreover, there is a dynamic linkage between the two levels of intervention. The social movement to reduce tobacco use and to restrict opportunities for smoking is a case in point. One-quarter of Canadians smoke, and rates of smoking uptake among youth continue to be a cause for concern. The spread of smoking restrictions, higher tobacco taxes and regulations on cigarette marketing have arguably changed the once seemingly unchangeable environment for smoking in ways that may at the least help consolidate gains made to date.

It is important to distinguish among two concepts, “health-related behavior” and “health-directed behavior”. The former is behavior that is undertaken for the sake of health; the latter is behavior undertaken for other reasons but which has health consequences (known or unknown to the individual). Health promotion efforts are sometimes directed to increase health-related behavior; other times toward health-directed behavior.

To date, most of the strategies for changing or enhancing lifestyle have been aimed at the individual. Strategies have included media campaigns/social marketing, incentives and punitive

measures (legislation, taxes, fines, insurance, safety standards), training/education, health communications (mass and interpersonal), health promotion/prevention services through public health, community clinics, and health promoting activities in specific settings such as the workplace, school, home, or doctor's office.

Which Strategies are Effective in Fostering Healthy Lifestyles?

A review of evidence does not provide a clear indication as to which strategies are most effective. We seem to have more information about what health behaviours need to be changed and what is not effective, than a clear picture for how groups should invest efforts. Examples of analyses of evidence are work by Hyndman (1998), the IUHPE (1999), Stroebe and Stroebe (1995), and the U.S. Dept. of Health & Human Services (1999).

Stroebe and Stroebe (1995) is one of the more comprehensive analyses of efforts to promote healthy lifestyles. This text examines models of health behavior and strategies that have been employed to modify health behaviors. Each model is explained together with its implications for interventions. The authors suggest that the predictive success of health models have not been more powerful than general models of motivation such as the theory of planned behavior. They also suggest that scare tactics generally are not effective, in and of themselves, to change behavior. Cognitive models of lifestyle that have the most predictive value tend to include components such as beliefs about the outcome of the behavior, normative and other evaluations of outcomes, the costs and benefits of engaging in a certain behavior, motivation, and perceived control.

On the one hand, the evidence suggests that there is considerable differentiation in effectiveness and preferred strategies according to the target group (e.g., at risk youth), and the behavior (e.g., tobacco legislation). On the other hand, the literature suggests some general trends for potentially successful strategies as we try to address issues beyond specific health behaviors that are quite easily modifiable through legislation. Limited effects can usually be gained from any one intervention. General findings from research on health promotion and modifying health behaviors suggest the following:

A) Local Commitment is Important

Short term impacts without local involvement ("buy in") are unlikely to change cultural norms and to be sustained. Cultural norms often need an injection of resources to stimulate change. The reasons for success in the North Karelia project (a long-term community-based project in Finland to decrease cardiovascular risk factors) were that the leadership originated within the community; it was a long term project with involvement throughout the community; and the community was involved in setting goals, planning strategies, etc.. Two other key elements of success include mounting small instead of large-scale projects and developing focused objectives (see Pransky, 1991 for a review).

B) Sustainability is a Key Factor

Often the "gold standard" intervention that may result in the most impressive outcomes is not sustainable over time or is too costly to implement beyond the pilot stage (Hawe et al., 1997). Interventions must parallel the resources available to sustain them.

C) Target Populations are a Key Factor in Success

Another key factor in decision-making is whether or not the intervention is influencing the identified target group. Generally, those with the least resources for a healthy lifestyle require the greatest investment.

The difficulty encountered when trying to change lifestyle (heart disease prevention) in individuals from a low socio-economic neighbourhood is illustrated in a Montreal study (O'Loughlin et al., 1999). This 4-year, community-based cardiovascular disease prevention program was aimed at adults aged 18 to 65 years living in St-Henri, a low-income, inner-city neighborhood. Over 40 interventions were implemented (i.e., smoking cessation workshops, contests, heart health cooking classes and recipe contests, nutrition education workshops, direct mail and ad campaigns...). The authors address the substantial challenges of working in a community in which social and economic

problems were a greater priority than heart health. Although they carefully adapted each intervention to local needs, the results were dismal. Awareness of the program reached 37.4%, but participation was low (2%-3%). There were no significant decreases in smoking or high-fat diet, and physical inactivity increased. In the longitudinal cohort sample, there was a small, statistically significant increase favoring St-Henri in frequency of cholesterol checkups. The authors attribute their findings to a general lack of participation in the program, and the lack of commitment by community groups to sustain the activities. For example, the responsibility to continue a morning walking group could not be devolved to community groups. The authors state:

... "unless or until basic living needs are ensured, persons living in low-income circumstances will be unlikely or unable to view CVD [cardio-vascular disease] prevention as a priority. Second, while local community groups and agencies can be mobilized to participate in and take leadership for selected interventions, it is difficult for these groups to maintain a sustained commitment, since these activities are often simply added onto existing agendas with few additional resources. They have difficulty sustaining long term commitment...because national and local health priorities change over time (O'Loughlin et al., 1999, pp.1824-1825).

D) Information Should be Used in Conjunction with Policy Change

Some people assume that providing information about health-related risks and benefits through education and/or the mass media will contribute to behaviour change. Although information can increase knowledge, such interventions rarely have a strong impact on behaviour. Information competes against a barrage of real life experiences that promote conflicting messages. Efforts to provide information should be accompanied by public policies and services that alter people's experiences (Anderson 1999; Montonen, 1996; Reid, 1996; Stokols 1996).

A Note on Social Marketing

Effectiveness and impact have been given considerable attention in health-related, social marketing research. The purpose of social marketing is to change attitudes, behavior, and cultural norms with specific messages (e.g., smoking is bad for you; physical activity is good for you). Social marketing is a popular method that governments use to attempt to change lifestyles. It is now widely recognized that social marketing campaigns to influence lifestyle have been most successful in changing behaviour among people with higher levels of education and income, who also have more control over their lives. While these campaigns were at first marginally successful, they have been least effective for the most disadvantaged populations, and have had the unintended effect of increasing health inequality between socioeconomic levels (Labonte 1998). Health messages communicated through mass media are quite limited on their own for a variety of reasons:

- 1) They appeal to people who already have a pre-existing desire to change.
- 2) People have become resistant to media messages. *“Advertising is propaganda and everyone knows it”* (Schudson, 1984, p. 4).
- 3) Proportionately less money is spent by the private sector in advertising than on developing images based on intensive qualitative research with consumers (Mellencamp, 1992, p.21).
- 4) Individuals are rarely responsive to coercion to change behavior. Coercion, in fact, may lead to resistance.
- 5) Commercial promotions create an image of the consumer as authoritative, having the power to choose, which is not always the case.
- 6) Unpleasant, boring, or unduly paternalistic messages are ineffective compared with attention to dominant images and commodities used by sub-groups to construct identity (Lupton, 1994).

A Note on Behavior Change Models

Have we oversimplified our understanding of lifestyle and the strategies to improve it? Attempts to modify an individual's behaviour toward a healthy lifestyle are typically rooted in the medical model, view the individual as the key determinant of health, and rely on human psychology that highlights personal traits. Interventions aimed at the individual may be direct, for example through counseling and

small groups, or indirect, as in health communication. They are based on a wide range of models linking knowledge, attitudes, and behaviours. Much of the research on behavioural change has focused on modifying diet, exercise, smoking, addictions, sexual practices, drinking and driving, and the use of seat belts (see Stroebe & Stroebe, 1995).

The strengths of behaviour change approaches are that they can be tailored to individuals or specific target populations. The limitations are well known. Specifically, they have had only modest results; require individual or small group counseling and so entail high cost; require voluntary, sustained, and often intense effort on the part of the individual; and, have limited impact on overall health because they usually focus on only one aspect of health. Nevertheless, behavioural approaches are still in widespread use.

More recent research on behaviour change suggests that change unfolds through a series of stages, and that supportive relationships and environments facilitate movement through these stages. The Transtheoretical Model of Behavior Change developed by Prochaska et al. (1994) has been used extensively to promote behaviour change in areas such as smoking, diet, alcohol and substance abuse, and eating disorders. The model recognizes that behaviour change unfolds through a series of stages from recognizing the need to change, contemplating a change, making a change, and finally sustaining the new behaviour. Prochaska's model highlights the need to tailor the message to the individual's actual stage of change, and that messages promoting change will be ineffective for people who are only just beginning to contemplate change.

Approaches Used to Change the Environment

Approaches to modify the environment are based on the belief that the environment (both social and physical) is the strongest determinant of health. The environment is emphasized in public health, health promotion, and the current focus on population health and inequalities (Glouberman, 1999). Such approaches see the environment as either an enabler of, or an obstacle to, healthy behaviour.

Environmental enhancements include smoke-free workplaces, bikeways, playgrounds, and green spaces, as well as legislative measures such as taxation and healthy public policy.

The strengths of environmental approaches are that they have the potential to affect everyone, and they require no sustained effort on the part of individuals. The limitations of environmental approaches are that they frequently neglect individual and group differences in response to the measure. It may be useful to design lifestyle-related social marketing campaigns that are focused on creating a supportive environment for healthy living and conceptualized as a community effort.

A Note on Exacerbating the Social Gradient

Some programs, by their very success, widen the health status gap due to differences in the population. In one smoking cessation initiative (Osler et al., 2000), it was found that the prevalence of smoking decreased mainly in adults with high education, increasing existing social differences. The increasing SES difference in cardiovascular mortality during the 1980's was accompanied by a growing social difference in the prevalence of smoking.

Beyond some point, qualitatively different approaches and mixes of policies/programs must be mounted to address the SES/health disparity, the 'gradient'. These approaches may include more precise targeting, but also more attention to community-based dimensions of 'interdependence' between individual behaviours, SES, and community/institutional resources. Although there is still a role for focused social marketing to prop up the background message, it seems unlikely that social marketing would form a very significant component of effective approaches in relation to those whose health status remains relatively untouched by health promotion efforts.

Key Points:
Fostering Healthy Lifestyles

- & Knowledge alone does not usually lead to behaviour change.

- & Many short term strategies used to improve health have limited impact on their own.

- & Social marketing on its own may increase/steepen the gradient between people with high and low socio-economic levels. Campaigns to influence lifestyle are more successful in changing behaviour among people with higher education and incomes, who have the most control over their lives, and the most options available to them.

- & Lifestyle messages must be associated with health as a resource to achieving ends of relevance to the listener.

- & Long-term strategies that create supportive environments can be a valuable investment.

- & Specifically focused initiatives that target symptoms or specific negative health behaviors have limited success if the intervention does not attend to "the larger picture" of lifestyle and its determinants.

- & Combinations of health promotion strategies (e.g., supportive environments, social marketing, community level initiatives, building healthy public policy) with community "buy in" have the greatest possibility for success.

How Can Social and Community Processes Foster Healthy Lifestyles?

The limited success of earlier attempts to improve health through lifestyle education has shifted the focus for intervention from the individual toward more comprehensive approaches that address health as a social or community (shared) issue, and act on the social processes that influence personal behaviour. Placing the entire responsibility for change on the individual is now understood to be an insufficient response that blames the victim rather than addressing the social circumstances that lead to harmful behaviour. Indeed, social or community responses can add resources to an individual's repertoire of strategies to cope with change and foster health (Lyons et al., 1998).

However, the community context can increase the likelihood that individual problems may occur. For example, as noted by Holder (1998):

“Alcohol-involved problems are not simply the results of actions of a set of definable high-risk individuals; rather, they are the accumulative result of the structure and interactions of complex, social, cultural, and economic factors within the community system.”

This observation led Holder to develop a community systems approach to the prevention of alcohol problems which challenges the current individual level models of problem prevention in favour of an approach which sees communities as complex, dynamic and adaptive systems which can be modified to decrease the chances of individuals developing alcohol-related problems.

Community Level Interventions

The authors of this paper are not arguing for elimination of the notion of individual lifestyle, but for striking a balance between individual and social orientations toward this concept. Community level interventions modify the entire community through organization and activation, as distinct from interventions that are community based, but aimed at modifying the behaviour of individuals (Lomas, 1998). There is now widespread recognition of the importance of community level action to promote health by **building social networks and creating social capital** (Kawachi et al., 1997; Kawachi & Kennedy, 1997). Social capital is created from the everyday interactions between people in structures such as civic and religious groups, family membership, informal community networks, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a community will co-operate for mutual benefit. In this way, social capital influences health, and may enhance the benefits of investments for health (WHO, 1998a).

In the Healthy Community movement, communities have successfully created healthy "community lifestyles" by increasing green spaces and play areas, removing cars from downtown streets, improving public transportation, and building community centres, walking trails, and bikeways. The Healthy Toronto initiative involves city support for neighbourhood initiatives, including a self-help project for homeless people, an urban food project, a street safety initiative, and a clean air project that combines public education and action to reduce air pollution (Healthy City Toronto, 1993). A study by Weinehall et al.(1999) on a community intervention in Sweden for the prevention of cardiovascular disease concluded that combining individual and community/population approaches can also be effective in a rural setting.

Community initiatives aimed at modifying the relationship between the individual and the environment hold great promise. These **social ecological approaches** have been shown to have a positive effect on health (Anderson, 1999; Glouberman, 1999; Stokols, 1996). Social ecological approaches view health as a product of the relationship between the individual and the environment, and focus on enhancing people's capacity to engage in and create their social environment. They are multi-disciplinary, with a strong citizen participation component. These approaches integrate individual

and environment-focused interventions, and are embodied in initiatives such as the Healthy Communities movement, the Community Action Program for Children (CAP-C), John McKnight's asset-based community development (Kretzmann & McKnight, 1993), participatory action research, and many other community health promotion programs. Over the past decade, the Health Promotion and Programs Branch of Health Canada has supported hundreds of community based projects aimed at enhancing the capacity of individuals to engage in and shape their social environments.

Enhancing the scope for interdependence involves individuals interacting within their community as they address particular types of issues, and assist others in their community. As the scope of the problem being addressed becomes more complex, the level of action becomes more complex because people need more resources (chronic illness, for example). Therefore, knowing the level of collective action needed to effectively address an issue is an important coping skill. In fact, a healthy lifestyle might involve the acquisition of coping skills, the accumulation of coping resources, and the development of coping strategies from an interdependence perspective (See Lyons et al., 1998, for a fuller discussion of these concepts; also Israel et al, 1994, for a model of empowerment from the individual and community perspective).

Creating supportive environments for health requires action at many levels, and may include political efforts to develop and implement supportive policies and regulations, sustainable community economic development, and social action.

Research has demonstrated that the involvement of "communities" in health promotion and disease prevention programs is critical. Communities and their members need to acquire the capacity for stronger health promotion and disease prevention roles. Capacity is the development of "community" infrastructure for health promotion and disease prevention and the commitment to use it for these ends. The process is multi-directional: a strong community culture that supports health increases the health of individuals; the commitment of individuals to foster health from a community perspective increases the well-being of all; and the interaction between the individual and community creates the

ingredients for social capital, social cohesion, and resilience. Health becomes both an individual and a collective resource. Furthermore, the health of individuals and of communities improves the health of the nation (U.S. Dept. of Health and Human Services, 2000).

Clearly, building this capacity for health promotion and disease prevention at the community level should be an essential component of Canadian health services focused on "lifestyle". Community mobilization can bring together varied social units prepared to work collectively to achieve a greater measure of health for all citizens.

Key Points:

Social and Community Processes to Foster Healthy Lifestyles

- & Learning effective team skills should be an important feature of "lifestyle" training; e.g., leadership, cooperation, communication, social support strategies, collective coping and problem-solving strategies.

- & Healthy lifestyles will be encouraged by providing opportunities to develop coping strategies and fostering resilience (individual and community).

- & A healthy lifestyle incorporates a balance between individual autonomy and contributions to community.

- & Community processes include providing training in skills that will help to build social capital.

- & Social ecological approaches focus on building community capacity and citizen empowerment.

- & A goal of healthy lifestyles is to enhance the scope for interdependence: freedom and opportunity within community.

- & Resource optimization is important. Enhancing the scope for interdependence includes identifying the level of collective action needed to effectively address an identified issue.

Summary and Conclusions

This paper has examined the notion of “healthy lifestyle” from four perspectives: what it means and its value in improving health; the factors that influence lifestyle choices; the approaches that have been used to enhance health behaviors; and new approaches that include the relationship between the individual and the community as a key aspect of a healthy lifestyle. In each section of the paper, we have provided a list of key points.

As stated earlier in the paper, some health issues are addressed with relative ease (e.g. using seatbelts to protect drivers and passengers). However, many other health concerns such as exercise, nutrition, smoking, and alcoholism are integrally linked to culture and to SES (Kawachi et al., 1996; Labonte, 1998; Lupton, 1994; Marmot et al, 1997; Stewart et al., 1996), and are much more difficult to address. Evidence shows that many of these health-related personal and social factors are subject to modification, but only through comprehensive, inter-sectoral, long term strategies that employ a variety of health promotion and disease prevention approaches (FPT Advisory Committee on Population Health, 1994; Frohlich & Potvin, 1999; Hobfoll, 1998; Hyndman, 1998; Lomas, 1998).

Fostering healthy lifestyles is about modifying the content of and relationship between lifestyles, life skills, and life circumstances. Therefore, we must approach the conceptualization of “healthy lifestyle” and strategies to promote it very thoughtfully. More complex approaches will require more time to conceptualize, implement, and evaluate.

A Determinants Approach to “Healthy Lifestyle”

“Lifestyle” is an adaptation to one's social environment. Unless lifestyle is constructed (as a category of intervention) in concert with the way that lifestyle is experienced by target group(s), interventions are unlikely to succeed. The strategies for action set out in the Ottawa Charter are relevant

to interventions aimed at the interdependence of individuals and communities, with most emphasis placed on strengthening communities, environments, and public policy arenas.

By addressing the determinants of health in a systematic manner, it has been demonstrated that individuals can live longer and healthier lives. To achieve these goals, individuals need personal knowledge and skills plus a facilitative social environment where these skills can be put to effective use. This latter point recognizes the need to institute measures that will address health and healthy lifestyles from a "systems" or "community" perspective, if health gains are to be achieved and sustained.

What Needs to be Done?

In order to effectively use a "reconstructed" concept of healthy lifestyle in the formulation of health policies and programs, some changes are required in the following:

(1) reframing "healthy lifestyle"; (2) the approaches used to foster healthy lifestyles; (3) research; and (4) policy.

1. Reframing "Healthy Lifestyle"

É **A healthy lifestyle is a resource** for quality of life and coping. Health is an investment whose benefits grow over time. By learning the art of being healthy, building resources for making healthy decisions, and building social capacity, a healthy lifestyle becomes a long term investment.

É Develop health promotion interventions considering the social context, with "helping others to be their best" in mind.

É Do not increase the gradient between those who are healthy and those who are unhealthy.

É Promote the creation of physical and social environments that support and strengthen healthy lifestyles.

É Provide “rescue” services for people who are at high risk for unhealthy behavior.

É Change the role of the community vis a vis health. Healthy communities provide a legacy of health for our children.

É Consider age and life stage, short and long term consequences, and the role of social relationships in health.

É The best investments toward healthy lifestyles are **to improve basic living conditions** and to **strengthen communities**.

É Use slogans in social marketing campaigns that promote “individual in the context of community” orientations, such as:

My health is up to me - but not me alone.

Health - We're in it together.

Let's create a supportive environment for health.

Take a risk - don't follow an unhealthy trend.

2.1 General Approaches to Foster Healthy Lifestyles

É Develop support interventions that reward positive health behaviors (acknowledgment, money, forums to exchange ideas, documents that share strategies, awards for people and communities, health “heroes”, model communities to visit).

É Link the initiatives governments are already undertaking to the notions of lifestyle (e.g., CAP-C).

É Do not invest in social marketing with the traditional lifestyle messages, as this tends to increase the social gradient. Instead, distribute information about a new model of healthy living so that attitudes shift to recognize that health is individual, environmental, and social.

É Portray a “culture” that supports healthy people in healthy communities.

2.2 Community Approaches to Foster Healthy Lifestyles

É Support quality projects that strengthen community-level strategies to foster health. Provide opportunities to profile and share the findings of such projects (e.g., healthy communities, healthy schools, healthy workplaces).

É Support community initiatives that modify the relationship between individuals and environment (using a socio-ecological approach).

É Provide insight into how to increase the level of participation of people in the health of their community and its members, and how communities can mobilize internal and external human resources (e.g., from universities) to work together collaboratively to foster healthy living. Support the creation of community infrastructure such as community-based organizations, citizen's groups, tenants groups, community centres, community events.

É Support community outreach programs and other strategies that reduce isolation of individuals and social groups. Support local recreational programs that include persons at high risk for social isolation: youth, persons with disabilities, and the elderly.

É Support community meeting and recreation places that permit people to coalesce around issues and actions that foster health.

É Support dialogue to clarify roles for supporting healthy lifestyles in communities.

É Facilitate action at the community level by encouraging civic participation and contributing resources to community level initiatives that promote thinking about the connection between individual health and community health.

É Discuss current health problems in the context of community rather than blaming the victim.

É Create a fund that supports communities to development healthy lifestyles across Canada.

É Support skills training on technologies of participation (how to be inclusive, group process, group decision-making, conflict resolution, team-building, leadership that builds participation).

3. Research

É Evaluate and synthesize lifestyle and health promotion strategies that work.

É Commission a systematic review of the effectiveness of lifestyle/health promotion interventions.

É Create new indicators and measures (contributions to others, community capacity, health culture of communities, individuals who change) that support the community as a unit of analysis for health and social aspects of lifestyle.

4. Public Policy to Support Healthy Lifestyles

É Apply a “healthy lifestyles lens” to policies that affect the health and well-being of citizens.

É Ensure that policies decrease the challenges of daily living, particularly for the most vulnerable populations (e.g., persons with disabilities, children, people on welfare, single parents, new immigrants, seniors).

É Involve policy-makers “on the ground” in community-level interventions to broaden mutual understanding about healthy lifestyles.

The Last Word

As indicated at the beginning of this paper, it takes time for ideas to evolve, as well as evidence to be discovered, synthesized, and examined for its relevance to policy and action. The concepts and approaches suggested in this paper are in their "incubation" stages. The issue of healthy lifestyles and how we approach this topic are critical. As health budgets are squeezed and increased pressure is placed on individuals to live healthier lives, it is incumbent upon policy makers to thoughtfully consider their leadership on this issue.

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