Health Promotion Policies†

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I am doubly honoured to speak about health promotion in the country that initiated, in the early seventies, one of the largest and most comprehensive community projects in health promotion that the world has ever seen. The North Karelin project to reduce the prevalence of cardiovascular diseases has become a classic example of total mobilisation life styles. I look forward to hear about the progress of the project, now that almost two decades have passed and therefore results will have firm meanings and indications to all of us.

When the World Health Organization broadened the definition of health to mean the condition of physical, mental and social well-being and not simply the absence of diseases, it recognised several well known medical principles. Included was that health reflects the human's close relatedness *to* the physical, psychological and social environment, that man is the product of interaction between his inner world and external environment, and that there is a need to integrate body, mind and spirit.

This holistic approach to the concept of health was firstly a revision of the traditional doctor-patient relationship, which historically relied on the practice of healing and which was becoming more strained by the phenomenon and depersonalisation that has resulted from over-specialisation of doctors, excessive use of technology and skyrocketing costs. It was secondly a recognition of the limitation of the classic view of disease that had been based primarily on organismic conception of disease which emphasised its temporary and discontinuous nature and which lead to the unjustified preoccupation of the medical profession and the public with the glamorous feats and achievements of curing chronic diseases. It was thirdly a response to the medical research findings that the process of disease had a multifactorial nature and that the search for specific pathogenic agents for many chronic diseases was proving to be futile. It was finally, an acknowledgement of the emerging behavioural medicine that integrated biomedical and behavioural sciences.

It was logical for the above broadened definition and concept of health to result in the introduction of the concept of health promotion which simply meant intervention that aims at developing the biopsycho-social model of well-being. To achieve that aim, health promotion required a reasonable understanding of risks in the environment and of behaviour that determine the life style of the individual and community, as well as specifying the needed intervention measures.

It was soon realised that efforts must be simultaneously directed at the twin concepts of the well established disease prevention and the newly introduced health promotion.

I believe that in order to truly promote health a government must be truly promoting justice. Can we even remotely imagine a successful health promotion in a society plagued by a grossly imbalanced distribution of wealth? Similarly, inaccessibility of all citizens to essential social services, especially education, housing, employment and active leisure, will have a serious negative effect on health promotion policies.

In fact, policies and practices that may affect health of the individual and the community can be in education, employment, social welfare, population, defence, sport, religion, culture, women, leisure, youth, commerce, agriculture, industry

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† This article is based on a speech given by His Excellency, the Minister of Education, Dr Ali Fakhro at the joint meeting of the International Union for Health Education and the Finnish Council for Health Education held in Helsenki, Republic of Finland, during June 16-21, 1991.

and technology. In other words, health stands in the centre of man's existence and activities.

It is this close association of health promotion to all that goes on in society and, therefore, to the ideals of justice, that turns its practice into a constant battling with narrow interests of influential segments of the society, be it economic, commercial, political or traditional. We need not go far in the past to remind ourselves of some of our battles with tobacco growers and cigarette companies; with promoters of powder milk for infants; with alcohol distillers; with environment polluters; with opposers to birth control; with producers of pesticides. In fact, with powerful lobbies of all kinds.

The argument that was repeatedly thrown in our face during those battles was the powerful superseding argument of economics. Who among us dares to argue against the importance of competitiveness in the world market or the nightmare that governments may face if GNP was lowered? But we must admit that part of our helplessness in front of this powerful economic argument can be attributed to our failure to convince ourselves and others that health factors must be fully accounted for as part of GNP.

This difficult and complex picture is not presented to discourage ourselves, by making our tasks seem impossible to fulfil. Rather, it is simply meant to put the whole issue in its proper moral frame and complex reality. It is to remind ourselves that the concept of health promotion can become real only through political action of the highest and purest form. Otherwise, our achievements in the field of health will be incremental, sporadic and at times even temporary, reflecting policies that are not more than ad hoc responses instead of policies that are turned into comprehensive anticipatory evolving actions.

To avoid those serious defects I believe that public policies of health promotion should aim at strategies and action having the following characteristics: they should be intersectional, diverse, determined by epidemiological and risk studies, specific for various phases of life, aimed at the majority of population especially the underprivileged, continuous and evolving, as comprehensive as possible for both the individual and community, and depend heavily on primary prevention without neglecting secondary and tertiary prevention.

While action will be the responsibility of all sectors of the society, coordination, monitoring, evaluation and development should be carried out by the health delivery system, especially that of primary health care.

Health promotion has been developed and practised in some developed countries. You will discuss during this conference some of those experiences. However, in the developing countries health promotion concepts are yet to be accepted and applied. An example is that of the Arabian Gulf region countries. These countries made, during the last three decades, substantial strides in the field of traditional public health. Communicable diseases have become virtually under control, sanitation of the environment has been remarkably improved, vaccination coverage has reached very high percentage (for example more than 95% in Bahrain) and maternal and infant mortality have been drastically reduced. In fact, in some countries of the Region, it is less than the rate recorded in some developed countries.

But, as a result of improved economic conditions of those countries, and the rapid social change that adversely affected the individual, the family and the community, chronic, degenerative and occupational diseases are dominating the medical scene. Traffic, work and home accidents are becoming a major public health problem. Mental and psychosocial aberrations are increasing by leaps.

Risk factors such as smoking, narcotics, alcoholism, risk-carrying sexual practices, obesity and unnecessary use of drugs are becoming realities and formidable threats.

Industrial complexes of gigantic oil refiners, petrochemicals, electricity, water desalination, and millions of cars and leisure boats, and tens of oil tankers sailing in the Gulf waters are creating the usual problems of air and sea pollution.

Today, there is hardly a difference between the medical practice of a doctor in Europe and the practice of a doctor in any of the countries in the Gulf region.

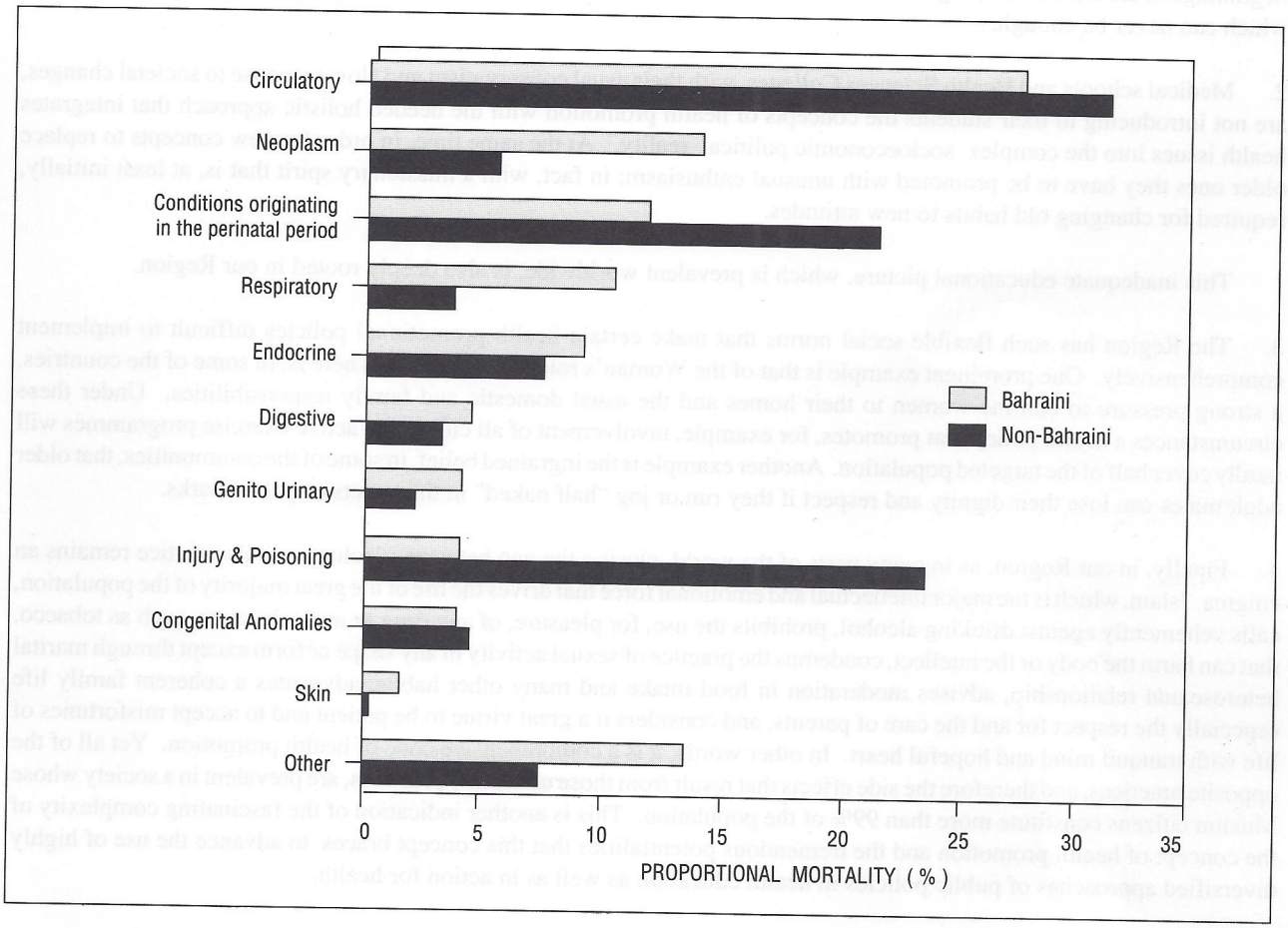
The case of Bahrain illustrates the spectacular shift in the map of diseases and health that has taken place. Forty years ago the morbidity and mortality rates were highly dominated by infectious and parasitic diseases while cardiovascular diseases and neoplasms occupied a small corner of the picture. Today, the picture is not different from that of many developed countries. Table 1 shows the reported deaths by international classification of Causes of Death among the indigenous population of Bahrain in 1989.

Table 1
Reported deaths by international classification of cause of death, nationality and sex, Bahrain 1989

Cause of Death	*Bahraini*			
	% of total	*No*	*Female*	*Male*
Infectious and parasitic diseases	0.9	12	3	9
Neoplasms	12.8	168	64	104
Endocrine, nutritional and metabolic and immunity disorders	7.5	98	50	48
Diseases of the blood and blood-forming organs	1.0	13	4	9
Mental disorder	0.2	3	1	2
Diseases of the nervous system and sense organs	0.8	10	6	4
Diseases of the circulatory system	27.4	359	169	190
Diseases of the respiratory system	8.9	117	46	71
Diseases of the digestive system	4.7	61	22	39
Diseases of the genitourinary system	4.4	57	25	32
Complications of pregnancy, child-birth and the puerperium	0.2	2	2	—
Diseases of the skin and subcutaneous tissue	1.1	15	5	10
Diseases of the musculoskeletal system & connective tissues	—	—	—	—
Congenital anomalies	4.2	55	29	26
Certain conditions originating in the perinatal period	10.5	138	57	81
Symptoms, signs and ill-defined conditions	10.0	143	77	66
Injury and poisoning	4.4	58	14	44
Total	100.0	1309	574	735

Figure 1 shows the proportional mortality from different diseases by ICD classification, among Bahrainis and non-Bahrainis.

Fig 1
Proportional mortality from different diseases by ICD classification Bahrain 1989



However, the new health picture has not been met with new approaches, such as that of comprehensive policy and action of health promotion. There is too much emphasis on disease treatment, and in the field of prevention the emphasis is mostly on secondary and tertiary prevention. An exception to this are the measures and policies that the countries of the Region adopted vigorously against the habit of smoking. These countries were the first in the world to insist, in the mid seventies, on a specific warning statement to be printed on cigarette packages and advertisements of newspapers and magazines. It mentioned boldly that smoking was associated with cancer of the lung and cardiovascular diseases. The move was strongly opposed by cigarette dealers and promoters, but the Ministries of Health did not yield. The result has been a substantial reduction in smoking, especially among the young.

However, other similar programmes did not appear and await a radical change in the outlook of the Region to the concept of health.

One may ask about the reasons for this lagging behind of health promotion policies in the countries of the Region. The answer, I believe, can be found in one or more of the following points:

1. Health promotion needs a societal commitment in addition to the usual governmental efforts. Many classic preventive measures of diseases, such as availability of safe drinking water or provision of sewage system or even vaccination, could be executed by health authorities even in the face of a passive noninterested public.

Health promotion on the other hand requires an interested and active public, who is usually a by-product of training and experience via years of membership and activity in all kinds of societal institutions, such as professional associations, political parties, movements for various socioeconomic issues, etc....

Unfortunately such institutions are either absent in some of the countries of the Region or are at their ineffective beginnings in the other remaining countries. This, of course, has lead to almost total dependence on governmental efforts, which can never be enough.

2. Medical schools and Health Sciences Colleges, with their usual conservatism and slow response to societal changes, are not introducing to their students the concepts of health promotion with the needed holistic approach that integrates health issues into the complex socioeconomic political reality. At the same time, in order for new concepts to replace older ones they have to be promoted with unusual enthusiasm; in fact, with a missionary spirit that is, at least initially, required for changing old habits to new attitudes.

This inadequate educational picture, which is prevalent worldwide, is also deeply rooted in our Region.

3. The Region has such flexible social norms that make certain health promotional policies difficult to implement comprehensively. One prominent example is that of the Woman's role in the society. There is, in some of the countries, a strong pressure to confine women to their homes and the usual domestic and family responsibilities. Under these circumstances a health policy that promotes, for example, involvement of all citizens in active exercise programmes will hardly cover half of the targeted population. Another example is the ingrained belief, in some of the communities, that older adult males can lose their dignity and respect if they run or jog "half naked" in the streets or public parks.

4. Finally, in our Region, as in many parts of the world, closing the gap between ideology and its practice remains an enigma. Islam, which is the major intellectual and emotional force that drives the life of the great majority of the population, calls vehemently against drinking alcohol, prohibits the use, for pleasure, of any drug or any substance, such as tobacco, that can harm the body or the intellect, condemns the practice of sexual activity in any shape or form except through marital heterosexual relationship, advises moderation in food intake and many other habits, advocates a coherent family life especially the respect for and the care of parents, and considers it a great virtue to be patient and to accept misfortunes of life with tranquil mind and hopeful heart. In other words, it is a comprehensive code of health promotion. Yet all of the opposite practices, and therefore the side effects that result from those unhealthy practices, are prevalent in a society whose Muslim citizens constitute more than 99% of the population. This is another indication of the fascinating complexity of the concept of health promotion and the tremendous potentialities that this concept braces to advance the use of highly diversified approaches of public policies in health education as well as in action for health.