BEST PRACTICE STORIES IN LIFESTYLE MEDICINE

A Global Compendium

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Foreword

As we noted in the previously published World Lifestyle Medicine Organisation (WLMO) Compendium of Origin Stories (2025), our stories are a powerful way to capture people's attention, hardwire information into their memories, while forging close, personal bonds. Through our stories we can weave together the tapestry of our efforts and illuminate the innovative paths ahead for all our existing and future members.

And as with the Compendium of Original Stories (2025), these Best Practice stories speak to the solidarity of intention of a growing movement of people and organisations acting and advocating for a more equitable, sustainable, ethical and enjoyable way of doing health using Lifestyle Medicine.

This compendium brings together Best Practice stories from Lifestyle Medicine organisations across many countries. The stories reflect the diversity, innovation, and impact of Lifestyle Medicine as it is practised around the world, from primary care clinics and hospital-based services to remote community programmes, student parliaments, and workplace wellness initiatives.

Each story has been reformatted for consistency to enable comparison and learning across contexts, and in doing so the editors objective in shaping this compendium for Global consumption, is that we have not lost the meaning and emphasis intended by the authors. The World Lifestyle Medicine Organisation acknowledges with gratitude all contributing authors and organisations for sharing their work. We hope these stories inspire further innovation and collaboration in the global Lifestyle Medicine community.

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Equipping Family Physicians as Frontline Leaders in Obesity Care: A National Training Initiative from Israel

This story comes from Israel. It was contributed by Dr Lilach Malatskey, MD, MHA, President of the Israeli Society of Lifestyle Medicine and a leader in the Israeli Association of Family Physicians (AFPI). This story describes a landmark national initiative to train family physicians in evidence-based obesity management, embedding lifestyle medicine principles into the heart of primary care.

Background

Obesity is among the most urgent public health challenges of our time. Driven by modifiable lifestyle factors, including poor dietary habits, physical inactivity, inadequate sleep, chronic stress, and harmful substance use, obesity substantially increases the risk of non-communicable diseases (NCDs), which remain the leading cause of morbidity and mortality across the Western world.

In Israel, nearly half of all adults presenting to primary care are living with overweight or obesity. Yet despite considerable public awareness, most patients struggle to translate knowledge into sustained behavioural change. In practice, treatment has often defaulted to pharmacotherapy alone, without meaningfully addressing the underlying lifestyle determinants of the condition.

Recognising this critical gap between knowledge and action, the AFPI, through its Lifestyle Medicine Society, identified primary care as the most strategic lever for system-wide change. Family physicians, who maintain long-term, longitudinal relationships with patients, are uniquely positioned to lead the shift towards sustainable, behaviour-based obesity care.

The Initiative

The National Obesity Training Project was established with three interconnected objectives. First, to develop and publish a national expert position paper, endorsed by the Israeli Medical Association, articulating best-practice standards for obesity assessment and management in primary care. Second, to build workforce capacity by equipping family physicians with the clinical knowledge, motivational skills, and behavioural competencies required to treat overweight and obesity effectively. Third, to create a sustainable, multi-level training infrastructure capable of providing consistent educational support across every region of the country.

The initiative reflects a broader vision: to shift the paradigm of primary care so that lifestyle-based obesity management becomes embedded in routine clinical practice, with family physicians serving not simply as prescribers but as catalysts for lasting health behaviour change across the population.

Implementation

The initiative was delivered through a multi-phase, multi-modal model. The first phase centred on the publication of the position paper, a foundational clinical document that defines the approach expected of primary care physicians when assessing and managing obesity. This document underpins all subsequent training activity and provides the professional and scientific basis for the programme.

The second phase involved the development and delivery of a National Master Trainer Course, held across May to July 2025. This course was designed to build a network of approximately 30 expert physician-trainers capable of leading educational activities across the country. Delivered in hybrid format, the course combined online modules, in-person instruction, and simulated patient sessions with professional actors. Content areas encompassed the pathophysiology of obesity, behavioural and motivational interviewing techniques, pharmacotherapy options, bariatric pathways, and adult learning design.

A complementary self-paced online learning platform was developed to ensure broad accessibility, serving both as pre-learning material for regional workshops and as a standalone resource for physicians unable to attend in person. Looking ahead, regional Obesity Training Schools, led by the newly trained Master Trainers, are planned for launch in the year ahead. These regional schools will deliver contextualised, clinically focused training tailored to the needs of physician communities in each area.

Outcomes and Impact

While formal outcome data from the regional training schools remains forthcoming, as the programme was underway at the time of this report, early indicators speak to the initiative's momentum. The successful training of approximately 30 Master Trainers represents the creation of a self-sustaining educational infrastructure capable of reaching thousands of family physicians. The position paper, endorsed by the Israeli Medical Association, has provided the profession with a shared standard and a legitimate mandate to practise obesity care within a lifestyle medicine framework.

Participating physicians reported that the training expanded their clinical toolkit, particularly in the domain of motivational interviewing and behaviour change counselling, skills historically absent from medical curricula. The hybrid delivery model enabled participation from physicians in diverse geographic settings, supporting equitable access to training across urban and rural regions.

Broader national impact is anticipated as the regional school model activates. The initiative positions Israel as a leader in primary care-based lifestyle medicine and offers an adaptable framework for nations seeking to strengthen their own frontline response to the obesity epidemic.

Lessons Learned and Future Directions

This initiative demonstrates that meaningful change in clinical practice requires investment in both content and capacity, it is not enough to publish standards without simultaneously building the workforce able to implement them. The combination of a strong evidence base (the position paper), skilled educators (the Master Trainers), accessible learning platforms, and locally delivered regional schools creates a system capable of genuine, sustained impact.

Key lessons include the value of professional endorsement in driving physician uptake, the importance of experiential learning, particularly simulated patient encounters, in developing communication skills, and the need for flexible delivery formats to ensure broad reach. Future directions include the launch of regional training schools, formal outcome evaluation, and ongoing development of the online platform. Israel's model offers an instructive and replicable blueprint for integrating lifestyle medicine into national primary care systems.

Building Evidence Literacy and Critical Appraisal Skills: The Japanese Society of Lifestyle Medicine Journal Club

This story comes from Japan. It was contributed by Dr Naho Ruiz Yokota, MD, PhD, and Dr Tamami Shirai, MS, PhD, of the Japanese Society of Lifestyle Medicine (JSLM). This story describes an innovative, member-led Journal Club that has fostered critical thinking, international dialogue, and contextually grounded application of lifestyle medicine evidence among Japanese healthcare professionals.

Background

Lifestyle medicine is a rapidly expanding global discipline, yet the translation of international research evidence into local clinical practice is rarely straightforward. Findings generated in Western populations may not apply directly to Japanese patients, whose genetic predispositions, dietary traditions, cultural norms, and healthcare contexts differ considerably from those in which much of the evidence base was produced.

Within Japan, healthcare professionals interested in lifestyle medicine have historically had limited opportunities to engage in structured, critical discussion of the evolving research literature. Many practitioners prepared for international board certification using materials developed primarily in the United States, with limited scaffolding to contextualise that evidence for a Japanese clinical setting. There was a clear need for a forum that combined rigorous critical appraisal with culturally informed, locally relevant application of lifestyle medicine principles.

The Initiative

In 2020, the JSLM established a member-led Journal Club (JC) as a voluntary study group. Originally formed to support members preparing for International Board of Lifestyle Medicine (IBLM) certification, the JC has since evolved into a dynamic, wide-ranging forum for discussing current evidence-based research and its practical implications for clinical practice in Japan.

The JC meets four to six times per year, having begun with twice-monthly sessions. Discussions deliberately span a broad range of topics and research methodologies, including studies on the Mediterranean diet, the DASH diet, randomised controlled trials, epidemiological investigations, and digital health interventions. This diversity of content reflects the JC's commitment to developing members who can critically evaluate different types of evidence, appreciate the limitations of various study designs, and identify what is genuinely translatable to their practice.

Implementation

Each JC session is highly interactive, with discussions occasionally extending beyond two hours. Participants scrutinise study design, statistical analyses, and real-world applicability, engaging in lively debate and collectively refining their critical appraisal skills. Discussions on dietary patterns have been particularly vigorous, debates around veganism and vegetarianism, for example, have prompted careful examination of both the global evidence and its relevance within Japan's distinct nutritional context, including consideration of balanced dietary approaches aligned with Japanese traditions.

Members examine Japanese epidemiological studies, such as the Hisayama Study, alongside international research, intentionally selecting papers that are not typically covered in mainstream lifestyle medicine programmes. This deliberate broadening of scope ensures that important nuances and

underexplored dimensions of the field are not overlooked as lifestyle medicine expands internationally. Discussions have extended to policy implications, the standard of evidence that should guide practice, and questions of transparency within lifestyle medicine organisations.

A distinctive and enriching feature of the JSLM is the growing participation of Japanese healthcare professionals living and practising abroad. These members contribute an international perspective that highlights the limitations of applying Western data to Japanese populations, enriching discussions and encouraging members to weigh contextual factors carefully when interpreting research findings.

Outcomes and Impact

The Journal Club has become a valued and sustaining feature of JSLM membership. Its greatest impact lies not in the transmission of factual content but in the cultivation of professional confidence and clinical discernment. Members report that participation has sharpened their ability to evaluate research claims critically, helped them to distinguish findings that can be meaningfully applied to their patients from those that require contextual adaptation, and deepened their appreciation for the complexity of lifestyle medicine as a discipline.

The cross-specialty, cross-experience composition of the group, with practitioners ranging from newly qualified physicians to senior clinicians — creates an environment where questioning is welcomed and diverse perspectives are valued. The inclusion of members based overseas has enriched discussions by introducing comparative insights from healthcare systems in Europe, North America, and Australia, strengthening members' capacity to locate Japanese practice within a broader global context.

Lessons Learned and Future Directions

The JSLM Journal Club demonstrates that professional learning communities, even when small and voluntary, can generate significant impact when they are structured around genuine intellectual engagement rather than passive content delivery. Critical appraisal is not a technical skill acquired in isolation, it is developed through sustained, collegial dialogue.

A key lesson is the importance of deliberate content curation: selecting papers that challenge assumptions, represent underexplored perspectives, and invite debate produces deeper learning than reviewing only consensus findings. The international membership dimension has proven particularly generative and is a model worthy of replication in other national societies. Future directions include expanding the breadth of topics covered, strengthening links between JC discussions and clinical practice guidelines relevant to Japan, and potentially publishing insights arising from the group's deliberations.

Integrating Lifestyle Medicine into NHS Long-COVID Care: The Persistent Conditions Assessment and Support Service

This story comes from the United Kingdom. It was contributed by Dr Caroline Gibson of the County Durham and Darlington NHS Foundation Trust. This story describes the development of the Persistent Conditions Assessment and Support Service (PCASS), an NHS-embedded, multidisciplinary service that draws on lifestyle medicine principles to support people living with Long COVID, post-viral fatigue, and ME/CFS.

Background

When COVID-19 arrived, it brought not only an immediate acute crisis but a sustained and complex long-term challenge: thousands of people left living with persistent, multi-system symptoms that conventional clinical pathways were poorly equipped to address. People presented with breathlessness, overwhelming fatigue, cognitive difficulties, sleep disruption, anxiety, pain, and a significantly reduced capacity to function in their daily lives. Their symptoms crossed biomedical boundaries; their experiences encompassed physical, psychological, and social dimensions simultaneously; and their recovery required a coordinated, compassionate, person-centred approach.

In County Durham and Darlington, many affected individuals struggled to access joined-up care. Patients frequently reported feeling dismissed or passed between specialties, without anyone holding a coherent picture of their condition. It was clear that a new model was needed, one grounded in the whole person rather than isolated organ systems, and capable of supporting recovery across multiple interconnected dimensions of health.

The Initiative

In late 2020, a holistic service was developed in response, grounded in lifestyle medicine principles and the framework of personalised care. Launched in January 2021 as the Post-COVID Service (PCS), the programme was designed to provide a person-centred approach for patients experiencing ongoing symptoms of Long COVID, delivered by a multidisciplinary team via a cross-system biopsychosocial model.

What began as a pilot for Long COVID evolved significantly over subsequent years. In 2024, the service was redesigned and relaunched as PCASS, the Persistent Conditions Assessment and Support Service, bringing together expertise in Long COVID, post-viral fatigue, and ME/CFS into a unified pathway for complex, overlapping conditions. The six pillars of lifestyle medicine, nutrition, physical activity, restorative sleep, stress management, social connection, and risk behaviour reduction, formed the implicit framework underpinning assessment and recovery planning throughout.

Implementation

The service was built around a simple but powerful commitment: compassionate, person-centred care. Each person received a comprehensive assessment followed by an individualised support plan, which could include one-to-one or group-based interventions encompassing physical rehabilitation, psychological support, and behaviour-change approaches addressing energy management, sleep, movement, nutrition, stress, and social connection. Medical investigations and conventional treatments were integrated where clinically indicated.

The multidisciplinary team brought together GPs, physiotherapists, occupational therapists, psychologists, respiratory and psychiatry consultants, and community colleagues. Supervision and reflective practice were embedded within the team structure to sustain both service quality and staff wellbeing. Alongside individual care, a structured group programme provided education, pacing strategies, mindfulness, movement rehabilitation, and peer support.

The service also forged active partnerships with community programmes, including Wellbeing for Life and the Community Resilience Team, providing social prescribing pathways and step-down support that extended the reach of care beyond the clinical setting. Delivery was offered in hybrid formats, combining in-person and remote options to maximise accessibility.

Outcomes and Impact

Since January 2021, PCASS received over 2,800 referrals, completed more than 1,500 initial assessments, and delivered over 7,600 follow-up appointments. Independent evaluation by Durham University demonstrated significant improvements across all major outcome domains. Quality of life scores, measured using the EQ-5D-5L, showed meaningful gains, particularly in the domains of pain, anxiety and depression, and usual activities ($p < 0.01$).

Fatigue levels, measured using the Modified Fatigue Impact Scale (MFIS), improved substantially, with mean scores reducing by 32%, a result that was both clinically and statistically significant ($p < 0.000001$). Mental health outcomes also improved markedly: PHQ-9 depression scores fell from 13.5 to 10.3 ($p < 0.000001$), and GAD-7 anxiety scores decreased from 10.1 to 8.3 ($p < 0.01$). Patients consistently reported feeling heard, informed, and empowered. One participant reflected: "Having everything joined together, the group sessions, physio, doctor and psychology, has been instrumental in my recovery. I never thought I'd get back to work, but with this support I have."

Lessons Learned and Future Directions

A complementary evaluation by Northumbria University identified key enablers of success: multidisciplinary co-location, flexible hybrid delivery, structured clinical supervision, and strong community partnerships. Challenges encountered included IT integration, workforce capacity, and the sustained capture of outcome data, lessons that are now actively shaping future service design.

Observations relevant to lifestyle medicine practice include: persistent symptoms are rarely isolated phenomena, with 80% of patients presenting with significant comorbidities; recovery requires sustained attention to lifestyle factors, pacing, self-efficacy, and relational continuity; and community partnerships substantially strengthen outcomes, particularly for individuals facing social, economic, or psychological barriers. PCASS demonstrates that lifestyle medicine principles can not only survive but thrive within a publicly funded health system, offering a replicable blueprint for managing persistent and long-term conditions.

Tackling Health Inequalities through Co-Designed Lifestyle Medicine: The Lifestyle Medicine Accelerator in North Lewisham

This story also comes from the United Kingdom. It was contributed by Dr Camille Hirons, a General Practitioner with North Lewisham Primary Care Network (PCN), South East London. This story describes the development and scaling of the Lifestyle Medicine Accelerator (LMA), a co-designed, community-rooted model that demonstrates lifestyle medicine can be both inclusive and transformative in areas of significant deprivation.

Background

North Lewisham Primary Care Network serves a population of approximately 90,000 people in South East London. Around 65% of this population falls within the NHS Core20PLUS framework a recognised indicator of significant health inequality. Half of North Lewisham's residents do not speak English as their first language, and there is a nine-year gap in life expectancy between the most and least deprived communities in the area.

Existing health inequalities work led by Dr Aaminah Verity, informed by the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR), had already illuminated the depth and complexity of these disparities. Against this backdrop, North Lewisham PCN recognised that addressing the underlying drivers of poor health would require approaches that were not only clinically sound but genuinely equitable, accessible, and shaped by the communities they aimed to serve.

The Initiative

Dr Camille Hirons introduced the concept of lifestyle medicine to the North Lewisham Community Forum, proposing it as a framework for addressing the social and behavioural determinants of health in a community context. The response was enthusiastic: a co-design working group was formed, bringing together residents, health professionals, and community representatives to shape a service from the ground up.

The co-design process generated clear, community-led priorities: the service should be run by non-clinicians; appointments should be longer and more holistic than conventional consultations; cultural relevance and accessibility for underserved groups should be central; and the service should be open to all adults, positioning prevention, not just treatment, as the primary aim. These principles became the foundation of what would become the Lifestyle Medicine Accelerator.

Implementation

The resulting service is delivered entirely by Health and Wellbeing Coaches , some of whom also hold qualifications as nutritionists, funded through the NHS Additional Roles Reimbursement Scheme (ARRS). Each coach provides personalised one-to-one sessions, working with patients to set and pursue their own lifestyle goals, as well as facilitating group coaching workshops that explore all six pillars of lifestyle medicine: nutrition, physical activity, restorative sleep, stress management, social connection, and reduction in risky behaviours.

The programme runs for approximately twelve weeks, during which patients also benefit from multidisciplinary team input through the PCN. Appointments are deliberately longer than standard general practice consultations, enabling the kind of relational, exploratory conversations that support

genuine behaviour change. Cultural humility and accessibility are embedded throughout — materials, coaching approaches, and group dynamics are adapted to reflect the diversity of the communities served.

To reach underserved populations proactively, the service has partnered with community organisations and leveraged existing community networks. Of the first 133 patients enrolled, 75% came from the Core20PLUS cohort, and 79% identified as non-white ethnicity, figures that challenge the common misconception that lifestyle medicine is exclusively for the wealthy or the worried well.

Outcomes and Impact

Evaluation demonstrated significant improvements across all subjective outcome measures over the twelve-week programme compared to baseline. Improvements in self-reported outcomes included quality and duration of sleep, sense of social connectedness, mental wellbeing, perceived control over health, weekly levels of physical activity, and daily portions of fruit and vegetables consumed (all $p < 0.001$).

Among 65 patients living with prediabetes or diabetes, results were particularly striking. Those with prediabetes achieved an average reduction in HbA1c of 4 mmol/mol at three months, sustained at six months. Those living with diabetes showed an average reduction of 22 mmol/mol at three months, increasing to 35 mmol/mol at six months. Overall, 91% of participants reported that they had achieved what they had hoped from the service, a remarkable result in any clinical or community programme.

The Lifestyle Medicine Accelerator (LMA) was subsequently formed to scale the model. Working with Lewisham Borough, LMA expanded the service to all seven PCNs within the Integrated Neighbourhood Team model, with each PCN employing dual-trained nutritionists and health and wellbeing coaches. The model has since been adopted in Stoke-on-Trent, supporting patients prescribed Tirzepatide, and in Bromley, where it operates from a local shopping centre with walk-in access.

Lessons Learned and Future Directions

The North Lewisham experience offers powerful evidence that lifestyle medicine, when co-designed with communities and delivered through trusted non-clinical roles, can reach and benefit the people who need it most. Co-design is not merely a consultation exercise, it is the mechanism through which the service becomes genuinely fit for purpose.

Key lessons include the importance of longer appointments in enabling meaningful engagement, the power of peer learning in group settings, and the critical role of cultural competence in building trust with diverse communities. Funding lifestyle medicine through existing NHS mechanisms, specifically the ARRS, demonstrates a viable pathway for sustainability and scale. Future directions include formal health economic evaluation, broader adoption across NHS systems, and development of training pathways for coaches in culturally responsive lifestyle medicine practice.

Lifestyle Medicine in Action: Four Stories of Transformation and Practice from South Africa

This story comes from South Africa. It was contributed by Dr Dave Glass, MBChB, FCOG(SA), DipIBLM, Chairperson of the South African Lifestyle Medicine Association (SALMA). Through four interconnected stories, a patient encounter spanning continents, and the practices of three South African clinicians, this story illustrates the breadth and adaptability of lifestyle medicine in diverse real-world contexts.

Background

South Africa carries one of the world's highest burdens of non-communicable disease, shaped by a complex interplay of socioeconomic inequality, urbanisation, and rapidly shifting dietary and activity patterns. Within this landscape, lifestyle medicine offers a compelling, evidence-based response, one that addresses the root causes of chronic illness rather than managing its downstream consequences.

Despite this promise, the integration of lifestyle medicine into mainstream South African healthcare remains uneven. Many patients spend years cycling through conventional consultations without any meaningful discussion of the lifestyle factors driving their conditions. The stories shared by Dr Glass illuminate both the profound impact that lifestyle medicine can achieve and the varied, creative ways in which dedicated practitioners are bringing it to life, in private consulting rooms, community halls, church gatherings, and across digital borders.

A Patient Across Oceans

In 2020, Dr Glass was writing a weekly column for the Port Shepstone South Coast Herald on the theme of Lifestyle Medicine: Turning the Tide. Among his readers was a gentleman living in a small coastal town in Scotland, who had spent part of his early life surfing on the Durban coast. Now managing diabetes, hypertension, and hyperlipidaemia, he was struck by the suggestion that these conditions could be meaningfully controlled, and potentially reversed, through lifestyle interventions.

An online clinical conversation began, and over the following months the patient began implementing change: increased daily exercise, improved sleep, the elimination of harmful habits, a shift towards a whole-food dietary pattern, and greater social connection. His blood pressure and cholesterol fell significantly; his need for diabetes medication diminished; his weight reduced; and his sense of wellbeing improved markedly.

His greatest frustration, he confided, was that in all the years he had attended his local NHS clinic, no one had ever spoken with him about the underlying causes of his conditions. The exchange demonstrated something important: that lifestyle medicine principles can generate positive, lasting change for individuals even when contact is entirely virtual, and that the gap between what patients need and what conventional care provides remains painfully wide.

Jen's Story: Bridging Surgery and Prevention

Jen is a middle-aged GP who discovered lifestyle medicine in her search for an approach that addressed the causes, rather than just the consequences, of chronic disease. She had previously explored functional medicine but found lifestyle medicine more firmly grounded in evidence and more financially accessible for her patients.

Jen works part-time assisting a cardiothoracic surgeon, actively participating in coronary bypass procedures, and devotes the remainder of her clinical week to a dedicated lifestyle medicine practice.

This juxtaposition of acute surgical intervention and preventive care is, she notes, a powerful daily reminder of what becomes possible when lifestyle change is not prioritised early enough.

In her lifestyle medicine consultations, Jen conducts detailed histories and examinations, assesses each patient's readiness for change, and then immerses them in lifestyle principles. She introduces clients to whole foods, takes them on a walking consultation, a "walk with the doc", and discusses stress management and the other pillars of lifestyle medicine through motivational interviewing. Each session lasts a full hour, with repeat visits as needed. These sessions are funded privately, which Jen acknowledges as a significant barrier to access. Her greatest ongoing challenge is sustainability, designing a practice model that is financially viable without compromising on the time and depth that meaningful lifestyle medicine requires.

Lydia's Story: Community-Based Lifestyle Medicine

Lydia's path to lifestyle medicine was circuitous but purposeful. Shortly after completing her internship, she recognised that the relentless clinical demand of managing non-communicable diseases was taking a significant emotional toll. She transitioned to microbiology, then, after missing patient contact, moved into infectious disease research, eventually leading a research facility focused on sexually transmitted diseases. Further study in stress management and coaching led her to discover lifestyle medicine.

At the time of writing, Lydia is living in Australia, where her husband is working on a fixed-term contract. When COVID-19 prompted local councils to fund community health programmes, she connected with a like-minded dietitian and exercise coach, and together they began delivering community lifestyle seminars that incorporate culinary medicine. The seminars are partially funded by council grants and partially supported through ticket sales. They are consistently fully subscribed and warmly received by participants, demonstrating that community appetite for practical, accessible lifestyle medicine education is genuine and strong.

Amanda's Story: From Physiotherapy to Lifestyle Medicine Research

Amanda is an experienced physiotherapist whose engagement with lifestyle medicine began when she and her GP husband attended the first CHIP (Complete Health Improvement Programme) training programme in South Africa. She has delivered weekend lifestyle medicine seminars for communities and church groups ever since, weaving lifestyle medicine principles into her physiotherapy practice and extending their reach far beyond the clinical encounter.

Amanda subsequently completed an undergraduate Diploma in Lifestyle Medicine from Avondale University, followed by a Master of Science in Lifestyle Medicine. Her MSc research examined the implementation of LIFT Project principles in the management of patients with depression and anxiety — contributing to the growing body of evidence supporting lifestyle medicine in mental health care. She is now completing her PhD in Lifestyle Medicine. Her journey illustrates the transformative potential of lifestyle medicine not only for patients but for clinicians themselves, who find in it a professionally revitalising and intellectually rich framework for practice.

Lessons Learned and Future Directions

These four stories collectively demonstrate that lifestyle medicine can be practised in many forms and setting, from a transatlantic digital exchange to a community hall, from a busy surgical suite to an academic research programme. What unites them is a shared conviction: that addressing the root causes

of chronic disease through compassionate, evidence-based lifestyle change is both possible and profoundly worthwhile.

Key lessons include the importance of flexibility in delivery, the value of community and peer-based models, and the need for sustainable funding mechanisms to ensure equitable access. SALMA continues to grow the community of practice within South Africa, supporting practitioners across disciplines to integrate lifestyle medicine into their work and to build the evidence base that will secure its place within the national health system.

A Journey Rooted in Connection: Lifestyle Medicine in Central Australian Aboriginal Community Health

This story comes from Australia, specifically from the remote communities of Central Australia. It was contributed by Dr Monica Theron, a General Practitioner working with the Central Australian Aboriginal Congress Corporation, an Aboriginal Community Controlled Health Organisation (ACCHO). Dr Theron is a Fellow of the Australasian Society of Lifestyle Medicine (FASLM) and was named ASLM GP of the Year in 2025. This story describes how lifestyle medicine principles come alive in one of the world's most distinctive and culturally rich healthcare settings.

Background

Remote Aboriginal communities in Central Australia face some of the most significant health disparities in the country. The burden of chronic disease, including type 2 diabetes, cardiovascular disease, renal disease, and mental health conditions, is disproportionately high, shaped by a complex intersection of historical trauma, social disadvantage, geographic isolation, and the disruption of traditional ways of living that, for millennia, were inherently health-promoting.

These communities live at what might be called the frontier of the lifestyle medicine challenge: the conditions that lifestyle medicine seeks to address are most acute here, yet the conventional Western clinical model, built around individual, time-limited consultations in clinical environments, is often a poor fit. Effective healthcare in this context demands something different: a model that is relational rather than transactional, that privileges connection over efficiency, and that recognises culture as central to health rather than peripheral to it.

Aboriginal Community Controlled Health Organisations (ACCHOs) such as the Central Australian Aboriginal Congress represent a deliberate, community-led response to this challenge. They exist to deliver healthcare that is not merely accessible but genuinely responsive, care that reflects the values, priorities, and knowledge systems of the communities they serve. It is within this setting that Dr Theron found her deepest engagement with the principles of lifestyle medicine.

The Initiative

Dr Theron's journey with lifestyle medicine began long before she encountered the term. As a clinician working within an ACCHO, she found that the formal pillars of lifestyle medicine, nutrition, physical activity, restorative sleep, stress management, social connection, and avoidance of harmful substances, were already embedded, in various forms, within Aboriginal community life and cultural practice. Her work has been to honour and amplify those foundations, rather than to import an external framework wholesale.

Central to her approach has been a commitment to cultural safety, the creation of clinical and community environments in which Aboriginal patients feel respected, heard, and free from discrimination. Cultural safety is not an add-on to good clinical practice; in this setting, it is a prerequisite for it. Without safety and trust, engagement in any health programme, however well designed, is unlikely to occur.

Implementation

Healthcare delivery in remote Aboriginal communities looks strikingly different from the consulting-room model familiar to most clinicians. Health teams travel to outstations, homes, and community centres, spaces alive with culture, family, and community. Consultations often take place under open skies, with red sand underfoot and ancient ranges as a backdrop. This physical context is not incidental; it reflects a foundational recognition that health is inseparable from Country, from land, place, and belonging.

One of the most transformative modalities Dr Theron has experienced is the shared medical appointment (SMA), a group-based consultation model in which a clinician meets with multiple patients simultaneously, facilitated by a skilled health worker or community facilitator. In the SMA setting, the traditional doctor-patient hierarchy dissolves. As a doctor, Dr Theron is outnumbered, she joins the group as one participant in a broader conversation, rather than holding the central authoritative position. Led by a skilled facilitator, these sessions encourage relaxation, banter, and collaborative problem-solving in a manner that feels natural and deeply human.

Within SMAs, the pillars of lifestyle medicine emerge organically. Movement, nutrition, sleep, and the management of chronic conditions are discussed in practical, contextually relevant terms. Patients share knowledge with each other, and with the clinical team, creating a two-way learning environment in which the clinician is as much a student as a teacher. This dynamic is 'humbling and instructive in equal measure'. It is also, as evidence increasingly suggests, more effective for behaviour change than the conventional one-to-one, physician-led consultation.

Multidisciplinary collaboration is integral to care in this context. Aboriginal health workers, nurses, allied health professionals, and community members work alongside doctors, each contributing knowledge and perspective that the others cannot. The health team is invited into the community, not the other way around, and this inversion of the conventional clinical dynamic carries profound significance for trust and engagement.

Outcomes and Impact

The outcomes of lifestyle medicine in this context are not easily captured in clinical metrics alone — though improvements in chronic disease management, medication review, and health literacy are observed through sustained engagement with patients over time. The most meaningful outcomes are often relational: the gradual building of trust between health services and communities that have historical and justified reasons for wariness; the growing confidence of community members to engage with and advocate for their own health; and the quiet but profound recognition, on the part of clinical staff, that health knowledge is not the exclusive domain of the Western biomedical tradition.

Dr Theron observes that Aboriginal communities have long practised what we now formally call lifestyle medicine, embedded in traditions of movement, communal eating, connection to Country, storytelling, ceremony, and spiritual practice. These are not vestiges of the past; they are living dimensions of health and wellbeing that modern lifestyle medicine would do well to recognise, learn from, and collaborate with.

Lessons Learned and Future Directions

Working in Central Australia has shaped Dr Theron's understanding of lifestyle medicine in fundamental ways. It has reinforced that lifestyle medicine is not simply a set of evidence-based interventions, it is a

way of being in relationship with patients and communities. Humility, curiosity, and respect are not optional professional attributes; they are the foundation on which effective care is built.

The shared medical appointment model holds particular promise in community health settings and deserves wider adoption and evaluation. Cultural safety, the genuine, ongoing work of creating environments free from racism and discrimination, is a prerequisite for any effective health programme delivered with First Nations communities. Future directions include expanding the shared medical appointment model across more communities, strengthening partnerships with Aboriginal health workers and community Elders, and contributing to the growing body of evidence supporting culturally responsive lifestyle medicine practice in Indigenous health contexts.

Preventive Care as Primary Purpose: The Oracle Healthcare Model in Sydney, Australia

This story also comes from Australia. It was contributed by Dr Lena Attebo, MBBS, GradCertMed (Metabolic Health), General Practitioner, Medical Director, and Founder of Oracle Healthcare in Sydney. Dr Attebo is a member of the Australasian Society of Lifestyle Medicine (ASLM). This story describes the development of a pioneering interdisciplinary clinic that positions preventive, lifestyle-focused healthcare as its central purpose rather than an adjunct to conventional treatment.

Background

Preventive healthcare occupies an awkward position within many health systems: universally endorsed in principle, yet persistently underfunded and structurally marginalised in practice. In Australia, as in most high-income countries, general practice operates under significant time pressure, with standard consultation lengths ill-suited to the kind of exploratory, lifestyle-focused conversations that prevention requires. Fragmented care pathways mean that patients often encounter different practitioners with different priorities, without anyone holding an integrative picture of their overall health trajectory.

Medicare funding structures, while comprehensive in many respects, provide limited support for preventive health assessments and lifestyle medicine consultations, creating a financial disincentive for practitioners wishing to prioritise this work. Against this structural backdrop, many clinicians interested in lifestyle medicine find themselves practising it in the margins, fitting brief lifestyle conversations into consultations primarily designed for diagnosis and prescription. Dr Lena Attebo, drawing on fifteen years of experience in corporate and private health assessments, set out to build something different.

The Initiative

Oracle Healthcare opened its doors in March 2022, founded on the conviction that preventive health and lifestyle medicine deserve a purpose-built clinical home, not a supplement to conventional care, but its own centre of excellence. Following the completion of a Graduate Certificate in Medicine (Metabolic Health), Dr Attebo was inspired to create a clinic that could realise the full potential of an interdisciplinary, prevention-first approach in a model designed from the ground up for that purpose.

Oracle Healthcare brings together general practitioners, cardiologists, exercise physiologists, dietitians, and melanographers within a single integrated facility. Its founding philosophy is clear: by identifying and addressing the foundational elements of health, diet, physical activity, metabolic function, stress, and sleep, the clinic empowers individuals to maintain their wellbeing and prevent chronic diseases before they take hold.

Implementation

Oracle Healthcare's model centres on comprehensive health assessments that address every relevant aspect of a patient's health, identifying common medical conditions and risk factors early, before they have progressed to symptomatic disease. These assessments combine the expertise of in-house clinicians across multiple specialties with cutting-edge diagnostic technology, offering a genuinely integrated picture of health that no single-specialty consultation can provide.

The clinic is deliberately situated within a major hospital precinct, a location that is both practically strategic, enabling warm referral pathways to acute care when needed, and symbolically significant,

representing the bridging of the gap between preventive and acute medicine. This positioning embodies Oracle Healthcare's vision of a more integrated health system in which proactive care and acute care exist in relationship rather than in parallel.

Care plans are built around realistic, achievable lifestyle changes, thoughtfully tailored to each client's individual circumstances, goals, and values. Recognising that sustainable behaviour change is the core mechanism of lifestyle medicine, follow-up care is built into every service package rather than being offered as an optional add-on. The majority of Oracle Healthcare's clinicians hold additional training as Accredited Health Coaches, enabling them to provide a level of personalised, motivationally informed support that extends well beyond conventional clinical advice. This coaching integration equips clients not merely with information but with the skills, strategies, and ongoing support to enact lasting change.

Outcomes and Impact

Since opening in 2022, Oracle Healthcare has established itself as a distinctive model within the Australian preventive health landscape. The clinic has developed a reputation for thoroughness, interdisciplinary integration, and genuinely personalised care, attracting clients who are motivated to take a proactive role in their health but who have found that the conventional health system does not provide the space or structure to support this.

The clinic's positioning, accessible and premium, without being exclusionary, has enabled it to serve a clientele that includes both individuals managing early-stage chronic conditions and those seeking to optimise health in the absence of diagnosed disease. The integrated model reduces duplication and ensures that lifestyle recommendations from different disciplines are coherent and mutually reinforcing, rather than fragmented across separate consultations.

Feedback from clients consistently highlights the value of having access to multiple specialists in a single setting, the quality of time spent in consultation, and the sense of being genuinely supported, rather than simply advised, in their health journey. The coaching-informed approach has proven particularly valued by clients who have previously received lifestyle advice in conventional consultations but lacked the ongoing support to implement it effectively.

Lessons Learned and Future Directions

Oracle Healthcare's experience underscores a fundamental insight: the quality of lifestyle medicine depends not only on the content of clinical advice but on the structural conditions that support its delivery. Time, integration, and continuity of care are not luxuries; they are prerequisites for effective preventive practice.

Key lessons include the critical importance of coaching competencies in enabling behaviour change, the value of interdisciplinary co-location in producing coherent care, and the need for funding models that recognise and reward prevention. Challenges include navigating the financial sustainability of a premium preventive model in a system geared towards acute care, and reaching populations who would benefit most from preventive health investment but face the greatest access barriers. Future directions include advocacy for better Medicare support for lifestyle medicine, partnerships with corporate health programmes, and exploration of lower-cost delivery pathways to extend the benefits of the Oracle model more broadly.

Re-imagining Medical Education: The ISLM Student Parliament as a Catalyst for Future Clinicians in India

This story comes from India. It was contributed by Dr Michelle Shah, a member of the Board of Directors of the Indian Society of Lifestyle Medicine (ISLM), with responsibility for clinical practice. This story describes the inaugural ISLM Student Parliament, held at the 6th Annual International Conference on Lifestyle Medicine in Ahmedabad, and its potential to reshape how lifestyle medicine is taught and understood in Indian medical education.

Background

India faces an accelerating non-communicable disease (NCD) crisis. Rates of type 2 diabetes, cardiovascular disease, hypertension, and mental health conditions have risen sharply over recent decades, driven by rapid urbanisation, dietary transition, increasingly sedentary lifestyles, and chronic psychosocial stress. Physical inactivity is pervasive, and the gap between the scientific evidence for lifestyle-based prevention and the realities of clinical practice remains wide.

Within this context, the medical education system carries a particular responsibility, and a particular opportunity. The doctors trained today will shape the clinical culture of tomorrow. Yet conventional medical curricula, focused primarily on the identification and treatment of established disease, often provide limited exposure to lifestyle medicine as a coherent, evidence-based discipline. Many undergraduate medical students in India encounter lifestyle medicine only as a passing reference, if at all, without grasping its potential as a foundational framework for clinical thinking and patient care.

The Initiative

The ISLM Student Parliament was conceived as a response to this educational gap. Hosted at the 6th Annual International Conference on Lifestyle Medicine in Ahmedabad, the Parliament was designed exclusively for undergraduate MBBS students. Its purpose was clear: to allow young future doctors to debate, design, and deliver real solutions to pressing health challenges using the principles of lifestyle medicine, not as passive recipients of knowledge, but as active participants in clinical and public health problem-solving.

The Parliament brought together students from diverse regions and years of training, many of whom had never previously encountered lifestyle medicine in any depth. Faculty members and lifestyle medicine leaders provided guidance and framing, but the substantive work, the debate, the deliberation, the proposed solutions, belonged to the students themselves.

Implementation

The day began with case briefs rooted in India's most urgent health concerns: the rising burden of non-communicable diseases and alarmingly low rates of physical activity across the population. Rather than asking students to diagnose and treat, the Parliament challenged them to think upstream. How do you modify micro-habits at the population level? How do you design environments and incentives that support healthy behaviour? How do you influence the cultural and social determinants of lifestyle?

The Parliament's power lay in its immersive, democratic structure. Students were assigned to committees representing the various stakeholders they would encounter in a real legislative setting, clinicians, policymakers, public health advocates, community representatives, and educators, and tasked

with developing solutions that reflected each stakeholder's perspective and interests. This structure required students to practise systems thinking, coalition-building, and evidence-based argumentation simultaneously.

The committee debates produced proposals of genuine creative and clinical merit. One team proposed integrating garba, a traditional folk dance of Gujarat, into physical activity programmes, both as a culturally resonant vehicle for movement and as a means of strengthening community bonds. Another group recommended training grassroots-level health workers in safe movement practices during pregnancy and the postpartum period. A third committee proposed incentive schemes to encourage children from rural communities to participate in sporting activities, linking physical activity to social recognition and community pride.

Participating students were also invited to join ISLM's membership body, with the longer-term objective of establishing a formal student wing to sustain engagement and expand the community of emerging lifestyle medicine advocates across India.

Outcomes and Impact

The Student Parliament produced outcomes that were both immediate and potentially far-reaching. In the immediate term, students shifted from a passive, fact-memorisation mode of engagement to one characterised by active inquiry, creative problem-solving, and collaborative deliberation. By the time each committee presented its proposals, participants spoke with confidence, clarity, and scientific grounding. Their final resolutions, in the assessment of faculty observers, read like genuine blueprints for the future of Indian medical education.

More profoundly, the Parliament appeared to change how students understood the discipline itself. Many entered the day perceiving lifestyle medicine as a specialist add-on, a peripheral interest for nutrition enthusiasts. They left recognising it as a foundational clinical framework that integrates sleep science, nutrition, physical activity, emotional regulation, social connection, and substance avoidance into a single coherent toolkit. Several students described the experience as the first time they had understood medicine as a discipline concerned with the science of health, not only the science of disease.

Lessons Learned and Future Directions

The ISLM Student Parliament demonstrates that immersive, collaborative educational formats can achieve what conventional didactic teaching cannot: the transformation of students from passive learners to active co-creators of knowledge and policy. The parliamentary model is particularly well-suited to lifestyle medicine, whose strength lies precisely in its integrative, systems-oriented approach.

Key lessons include the importance of contextual relevance, anchoring the Parliament in India's specific health challenges and cultural resources produced solutions that were both more creative and more practical than generic exercises might have yielded. The experience also highlighted the appetite among medical students for a different kind of clinical education: one that asks them not only what is wrong and how to fix it, but what kind of doctors they want to be. Future directions include formalising the ISLM student wing, replicating the Parliament model at medical colleges across India, and tracking the long-term influence of participants on institutional and clinical culture.

Embedding Preventive Health in the Workplace: The Riphah CHANGE Model of Employee Wellbeing in Pakistan

This story comes from Pakistan. It was contributed by Dr Samia Khalid, under the supervision of Dr Shagufta Feroz, Director of the Riphah Institute of Lifestyle Medicine (RILM) and Founder of the Pakistan Association of Lifestyle Medicine (PALM), at Riphah International University, Gulberg Campus, Lahore. This story describes the CHANGE Model, an innovative, behaviour-focused workplace wellbeing programme that brings lifestyle medicine principles into the lives of non-clinical university staff.

Background

Non-communicable diseases represent a growing and largely preventable public health burden across Pakistan. Within workplace settings, the health of non-clinical and administrative staff, those who perform the essential but often physically and emotionally demanding operational work of institutions, is frequently overlooked in health improvement agendas that focus primarily on clinical or academic personnel.

At Riphah International University, Gulberg Campus, a sizeable proportion of Category C staff, attendants, sweepers, and security guards, presented with common health concerns including low energy, poor sleep, digestive difficulties, mood dysregulation, chronic fatigue, and musculoskeletal discomfort. Many of these conditions are directly amenable to lifestyle intervention, yet this workforce had limited access to structured health education or preventive support. Recognising this gap, the Riphah Institute of Lifestyle Medicine identified the workplace as a strategic and accessible setting for preventive lifestyle medicine delivery.

The Initiative

The Riphah CHANGE Model of Employee Wellbeing was designed as a preventive, behaviour-focused workplace wellness initiative targeting Category C staff. The programme name reflects its six-stage implementation framework: Create Awareness, Harness Willingness, Activate Change, Nurture with Follow-Up, Gauge Outcomes, and Empower Ambassadors. This structured sequence ensures that the programme moves participants from initial awareness through to sustained behaviour change and peer influence, a pathway grounded in established behaviour change theory.

The initiative was launched with an inaugural session on 1 May 2025, led by Dr Samia Khalid under the supervision of Dr Shagufta Feroz. It reflects the shared vision of RILM and PALM to extend lifestyle medicine beyond clinical and academic settings into real-world organisational environments, demonstrating that preventive health interventions can be meaningful, accessible, and impactful across diverse workforce populations.

Implementation

Monthly sessions are delivered in accessible, non-clinical formats designed to engage participants who may have limited formal health education. Content focuses on practical, low-cost, and sustainable lifestyle behaviours: establishing early and nutritious breakfast routines, maintaining adequate daily hydration, adopting safe dietary practices, seasonal self-care strategies, and personalised guidance based on the specific needs and concerns raised by employees in each session.

The programme adopts a deliberately inclusive and non-stigmatising approach. Sessions are interactive and participatory, designed to build trust gradually and to meet participants where they are, without presupposing health literacy or prior engagement with wellness concepts. Follow-up sessions each month allow for continuity, the reinforcement of previous learning, and the tailoring of guidance to individual progress and changing circumstances.

Monitoring and evaluation are built into the programme structure from the outset. The programme utilises pre- and post-session feedback, self-reported wellness indicators, and validated tools such as the WHO-5 Well-Being Index to assess changes in wellbeing over time. This commitment to structured evaluation reflects RILM's broader institutional emphasis on evidence-based practice and accountability.

From May to December 2025, the programme engaged 38 unique staff members from a total workforce of 81 employees at the campus. Participation varied across months in response to job demands and duty schedules, a pattern acknowledged as a practical challenge in workplace programme design.

Outcomes and Impact

Preliminary outcomes indicate meaningful and encouraging change among programme participants. Staff reported improved hydration habits, better energy levels, reduced body aches, more positive mood regulation, and greater attentiveness to daily health routines. These self-reported improvements point to genuine shifts in health awareness and preventive behaviour, even within a relatively short programme period.

One of the most notable qualitative outcomes has been the extension of lifestyle guidance beyond the workplace itself. Participants have increasingly sought consultations for family members, bringing the knowledge and skills acquired in programme sessions into their home environments. This ripple effect, the reach of the programme extending into families and communities through the participants themselves, is a powerful indicator of trust, perceived benefit, and cultural resonance. It also speaks to the programme's potential to generate broader social impact beyond its immediate institutional setting.

Lessons Learned and Future Directions

The Riphah CHANGE Model demonstrates that workplace settings offer a uniquely accessible and high-impact entry point for lifestyle medicine, reaching people who may not engage with health services voluntarily but who benefit significantly from structured, supportive health education in a familiar environment.

Key strengths of the model include its continuity, its personalised and culturally relevant approach, and its cost-effectiveness, making it viable for institutions that lack large dedicated wellness budgets. Challenges include limited administrative support and scheduling constraints, which have made consistent programme organisation difficult. Strengthening institutional facilitation, integrating the programme into formal HR wellness policies, and expanding the use of validated assessment tools will be critical to scaling the model and establishing a robust evidence base. Future directions include broader rollout across Riphah campuses, training peer health ambassadors from within the participating workforce, and formal publication of outcomes to contribute to the growing evidence base for workplace lifestyle medicine in low- and middle-income country settings.

Vanguards of Self-Care: A Student-Led Lifestyle Medicine and Wellbeing Initiative across Pakistan

This story comes from Pakistan and presents *Vanguards of Self-Care*, a structured, student-led wellbeing and leadership initiative grounded in lifestyle medicine and positive psychology. The programme is cultivating a new generation of health advocates across university campuses by promoting preventive health, self-awareness, and peer-led engagement.

Background

University students represent a population that is simultaneously vulnerable and strategic. The transition to higher education. with its associated academic pressures, social disruptions, new independence, and often poor sleep and dietary habits, places students at elevated risk of burnout, emotional distress, and the entrenchment of unhealthy lifestyle patterns that may persist long into adult life. The mental health challenges facing Pakistani university students have become increasingly visible, yet the response has often been reactive: focused on managing crisis rather than building the foundational capacities for sustained wellbeing.

Recognising these limitations, the Riphah Institute of Lifestyle Medicine, under the guidance of Dr Shagufta Feroz, identified an opportunity to move upstream, to design a preventive, capacity-building programme that would equip students not only with information about healthy living, but with the self-awareness, leadership skills, and peer-support structures to practise and promote it actively. The result was Vanguards of Self-Care.

The Initiative

The initiative represents a collaborative effort between the Pakistan Association of Lifestyle Medicine (PALM) and the Riphah Institute of Lifestyle Medicine (RILM), Riphah International University. It operates under the overall supervision of Dr. Shagufta Feroz, a leading advocate of lifestyle medicine in Pakistan.

Leadership of the programme is distributed across regions to ensure effective implementation and contextual relevance. Dr. Samia Khalid, Manager of the Riphah Institute of Lifestyle Medicine (Lahore Chapter), leads the initiative across Lahore campuses. Dr. Abeera Zainab leads programme implementation across Rawalpindi and Islamabad campuses. This distributed leadership model strengthens coordination, ownership, and scalability of the initiative across multiple sites

The initiative's conceptual framework draws on the Biopsychosocial-Spiritual Model of Health, a comprehensive model that views wellbeing as a dynamic interaction between biological, psychological, social, and spiritual dimensions of a person's life. This integrative framing aligns naturally with lifestyle medicine's multi-pillar approach and provides students with a sophisticated, non-reductive vocabulary for understanding their own health and that of their communities.

Implementation

Students participate through regular group meetings and reflective sessions that create a safe space for sharing experiences, challenges, and progress. Awareness campaigns and student-led advocacy initiatives extend the programme's reach beyond core participants to the broader campus community. Students undergo pre- and post-intervention assessments to evaluate changes in happiness, self-care practices, and overall wellbeing, providing a quantitative foundation for ongoing programme development.

The programme operates across multiple Riphah campuses in Islamabad, Rawalpindi, and Lahore. The Lahore Chapter, which initiated structured engagement in 2025, has conducted regular monthly online sessions supplemented by in-person meetings, a hybrid approach that has proven particularly effective in maintaining participation across geographic distances and academic scheduling pressures.

Student ownership is a defining feature of the initiative. Participants are not passive recipients of health education; they are empowered to design and lead activities, mentor peers, and advocate for healthy lifestyles within their academic institutions and wider communities. This peer-leadership model draws on established evidence that health behaviour change is often most effectively promoted by trusted individuals within a person's own social network.

Vanguards of Self-Care students have also played a central role in celebrating Lifestyle Medicine Week across all participating campuses, organising events aligned with global lifestyle medicine themes and helping to build awareness of lifestyle medicine as a discipline among their broader student peer groups.

Outcomes and Impact

Over the reporting period, Vanguards of Self-Care maintained an active presence across multiple Riphah campuses, with overall student membership exceeding 400 participants. In the Lahore Chapter, pre- and post-intervention analysis revealed encouraging improvements across key wellbeing indicators. The Self-Care Score improved from a baseline of 62 to 67, an 8% improvement. The Happiness Score improved more substantially, from 58 to 71, a 22% improvement. While these figures represent early-stage data from a single campus chapter, they point to meaningful positive impact on student wellbeing.

Broader qualitative outcomes across all campuses include enhanced leadership qualities, including initiative-taking, peer mentoring, and advocacy for healthy lifestyles; improved knowledge and understanding of lifestyle medicine principles; greater self-awareness, clarity of purpose, and intrinsic motivation; improvements in planning and organisational skills; and strengthened communication skills and confidence in self-expression. These outcomes extend well beyond the health domain, suggesting that engagement with lifestyle medicine in this format is generative of broader human capacities.

Lessons Learned and Future Directions

Vanguards of Self-Care demonstrates that the university setting offers a compelling and largely untapped platform for lifestyle medicine. When students are treated as agents of their own wellbeing, and as potential advocates and educators for their peers, the programme becomes more than a health intervention; it becomes a leadership development opportunity.

Key strengths include strong institutional leadership from RILM and the SSD Department, high levels of student ownership and engagement, and the coherent grounding of the programme in an evidence-based lifestyle medicine framework. Challenges include limited resources, the competing demands of academic life on student time, and the early stage of comprehensive quantitative data collection across all campuses. Moving forward, the programme aims to expand structured assessments across all campuses, strengthen research outputs, train a new cohort of student ambassadors, and explore pathways to formal academic recognition of student participation. The initiative offers a replicable model for universities across Pakistan and the broader region seeking to cultivate the next generation of health-literate, wellbeing-oriented citizens.

Evidence, Advocacy, and Government Partnership: The Turkish Society of Lifestyle Medicine's Rapid Rise to National Impact

This story comes from Turkey (Türkiye). It was contributed by Dr Hande Nalam Turyilmaz of the Turkish Society of Lifestyle Medicine (YTTD: *Yaşam Tarzı Tıbbı Derneği*). The story describes how a newly established national society, founded on the unwavering principle of evidence-based practice, has rapidly built a professional community, earned public recognition, and forged a landmark partnership with the Ministry of Health to integrate lifestyle medicine into national primary healthcare strategy.

Background

Turkey faces a significant and growing burden of chronic non-communicable disease, driven by shifting dietary patterns, declining physical activity, and the pressures of modern urban life. Lifestyle medicine, as a prevention-focused, evidence-based discipline, offers a compelling framework for addressing these challenges, yet its formal establishment as a recognised professional field in Turkey is recent, and the work of building an informed practitioner community, public awareness, and institutional legitimacy has had to be accomplished in a compressed timeframe.

The YTTD was founded on the principle that this work must be grounded at every stage in the best available evidence. From its inception, the society has sought not merely to promote lifestyle medicine as a philosophy but to build a credible, scientifically rigorous professional community that could engage meaningfully with government, the healthcare system, and the public. Speed and rigour, rather than being in tension, have been held simultaneously as defining values.

The Initiative

The YTTD's strategy unfolded in two parallel streams: professional development and public advocacy. Recognising that a qualified, confident workforce is the foundation on which all other progress depends, the society's initial priority was to rapidly build practitioner capacity through accessible, high-quality education. Simultaneously, the society sought to create public demand for a more preventive, holistic approach to health, generating the community engagement and visibility needed to demonstrate to policymakers that lifestyle medicine had genuine and widespread support.

Both streams were designed from the outset to build towards a larger goal: the establishment of lifestyle medicine as a recognised and formally integrated component of Turkey's national health strategy. This vision, ambitious at inception, was realised with remarkable speed.

Implementation

The professional development stream centred on an extensive free webinar series targeting healthcare professionals. These webinars covered the core competencies of lifestyle medicine, nutrition, physical activity, sleep, stress management, social connection, and the avoidance of harmful substances, as well as the scientific evidence underpinning each domain. The free-access model was deliberate: removing financial barriers to participation ensured that the programme could build a broad, geographically diverse professional community, not merely reach those with institutional resources to fund continuing education.

The public advocacy stream encompassed a range of community events designed to raise awareness of lifestyle medicine and to position prevention as a meaningful, accessible personal health strategy. These

events built a public profile for the YTTD and generated community demand for the kind of preventive, whole-person care that lifestyle medicine offers.

The culmination of these parallel efforts was the First YTTD Symposium, held in May 2024. The event achieved an exceptionally high participation rate, validating the professional and public engagement the society had cultivated. It also served as the catalyst for the society's most significant achievement to date: a formal partnership with the Turkish Ministry of Health.

Following the symposium, the YTTD and the Ministry of Health established a national training programme for the physicians responsible for the country's network of Healthy Life Centres — primary care and prevention facilities distributed across Turkey. This partnership directly integrates lifestyle medicine principles into the nation's primary healthcare strategy, placing the YTTD's evidence-based framework at the centre of preventive care delivery nationwide.

Outcomes and Impact

The YTTD's impact has been both rapid and substantial. Within a few years of its establishment, the society has built a strong foundational community of practitioners committed to lifestyle medicine, achieved public recognition through its advocacy activities, hosted a successful national symposium, and secured a landmark partnership with the Ministry of Health, one of the most significant formal recognitions any lifestyle medicine society can achieve.

The national training programme for Healthy Life Centre physicians represents a particularly meaningful outcome: it moves lifestyle medicine from the professional periphery to the structural core of primary healthcare in Turkey. By educating the physicians who staff the country's prevention infrastructure, the YTTD is shaping the health experiences of millions of Turkish citizens. Looking further ahead, in February 2026 the YTTD will host the Lifestyle Medicine Leadership Forum in Turkey, combined with its next symposium, an event at which the Minister of Health will be in attendance, signifying the highest level of governmental support for the field.

Lessons Learned and Future Directions

The Turkish experience offers an instructive model for lifestyle medicine societies in countries where the discipline is newly established. The combination of free, accessible professional education and visible public engagement creates the dual legitimacy, with practitioners and with the public, that is ultimately needed to influence policy. Neither stream alone is sufficient; their interaction is what generates momentum.

Key lessons include the strategic value of the first symposium as a catalytic event, the power of demonstrating community demand to policymakers, and the importance of positioning lifestyle medicine not as an alternative to conventional medicine but as its evidence-based preventive complement. Future directions include immediately launching more comprehensive and structured education series, developing clinical research projects to build the local evidence base for lifestyle medicine application in the Turkish context, and leveraging the 2026 Lifestyle Medicine Leadership Forum as a platform for international collaboration and knowledge exchange.

Conclusion: Common Themes and a Shared Vision

The eleven stories gathered in this compendium span five continents, and an extraordinary range of settings, from an inner-city London primary care network tackling deep health inequalities, to a remote Aboriginal health service in the deserts of Central Australia; from a student parliament held in Ahmedabad, to a national government training programme in Türkiye. Read together, they offer something more than a collection of case studies. They offer a portrait of a global movement.

Shared Principles Across Diverse Contexts

Despite the considerable differences in geography, culture, health system structure, and resource environment, several themes recur with striking consistency across these stories. First, the centrality of relationship. Whether in the shared medical appointments of Central Australia, the one-to-one coaching relationships of Oracle Healthcare in Sydney, or the peer support built into the Vanguards of Self-Care programme in Pakistan, every story affirms that sustainable health behaviour change is fundamentally relational. It is not achieved through information alone, but through connection, trust, and continuity.

Second, the importance of meeting people where they are, literally and figuratively. The North Lewisham Lifestyle Medicine Accelerator co-designed its service with the very communities it sought to serve, ensuring cultural relevance from the outset. The Riphah CHANGE Model reached university staff who had rarely been the focus of workplace wellness initiatives. The JSLM Journal Club recognised that international evidence cannot simply be transplanted into a Japanese clinical context without critical appraisal. Contextualisation is not an optional refinement, it is a prerequisite for impact.

Third, the power of education as a lever for systemic change. Israel's national training programme for family physicians, Türkiye's free professional webinar series, the ISLM Student Parliament in India, and Japan's Journal Club all demonstrate that investing in workforce capability, and the next generation of practitioners, is among the highest-return activities available to lifestyle medicine organisations. The clinicians and students who encounter lifestyle medicine deeply, rather than superficially, become its most effective advocates.

The Case for Integration

A fourth and particularly significant theme is the move towards integration, of lifestyle medicine into mainstream health systems, rather than its practice at the margins. PCASS in County Durham demonstrates that lifestyle medicine principles can be embedded within a publicly funded NHS service, achieving clinically significant outcomes at scale. The Lifestyle Medicine Accelerator has secured commissioning from public health bodies and expanded across an entire London borough. The YTTD has partnered with the Turkish Ministry of Health to train physicians working in the national network of Healthy Life Centres. These are not peripheral programmes, they are beginning to reshape how health systems are organised and how prevention is resourced.

Looking Forward

What these stories collectively demonstrate is that the global Lifestyle Medicine movement is maturing. It is moving beyond proof of concept, beyond showing that addressing diet, movement, sleep, stress, relationships, and harmful substance use improves health outcomes, towards questions of how to embed these principles at scale, equitably, and sustainably within diverse health and social systems.

The World Lifestyle Medicine Organisation is proud to publish this compendium as a contribution to that conversation. The challenges ahead are significant: funding models that reward prevention rather than treatment, health systems that prioritise acute care over sustained support, and persistent inequities in access to the conditions that make healthy living possible. But the stories gathered here are evidence of

what becomes achievable when skilled, committed practitioners apply the principles of Lifestyle Medicine with creativity, compassion, and rigour. They are an invitation to others, practitioners, policymakers, educators, and organisations, to build on this foundation and to accelerate the global transition to a healthcare system that is genuinely oriented towards health.