IMPLEMENTING A HEALTHY ISLANDS APPROACH IN THE PACIFIC: FIVE CASE STUDIES

August 2000
The WHO programme "Healthy Cities – Healthy Islands" for the Western Pacific Region has been developed in response to the need of Member States to integrate efforts of various stakeholders in improving the health of people living in urban areas and islands. It is implemented following the concepts and approach outlined in "New horizons in health", a WHO initiative for the Western Pacific Region which was adopted by the WHO Western Pacific Regional Committee in 1994. The objectives are:

1. to minimize health hazards in urban areas/islands through the integration of health and environmental protection measures in the physical and economic planning process;
2. to enhance the quality of the physical and social environment supportive of health in urban and island settings;
3. to increase public awareness towards healthier behaviour, lifestyle and habits;
4. to improve the provision of health services through developing appropriate health care systems in urban areas and islands; and
5. to upgrade country capabilities and develop policies to improve health in urban areas and islands through better intersectoral coordination and public participation.

This document was prepared by the Environmental Health Unit of the WHO Regional Office for the Western Pacific in collaboration with an editorial team consisting of Dr Michael Sparts, Dr Jan Ritchie, and Dr Arie Rotem from the School of Medical Education, University of New South Wales, Sydney, Australia, who compiled this report incorporating five case studies. The contribution of the authors of the case study reports are acknowledged: Dr Simione Bikai from Fiji Islands; Dr Taumalua Jackson from Niue; Dr Kaoga Galowa from Papua New Guinea; Dr Palanitina Toelupe from Samoa; and Dr Dennie Iniakwala from Solomon Islands.

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Introduction

During 1999, the World Health Organization (WHO) Regional Office for the Western Pacific commissioned a review of Healthy Islands initiatives through documenting five case studies from the Fiji Islands, Niue, Papua New Guinea, Samoa and Solomon Islands.

Reports of these case studies were originally presented in Suva, Fiji at a WHO Workshop on Healthy Islands in February 1999. The text of the original case study reports has been retained in this document.

Given the variety of approaches taken in writing up the case study reports, each of the authors was further interviewed to obtain consistent categories of information from which conclusions could be drawn. The questions were divided into the four general areas of overview, initiation, process, and outcome.

The responses assisted the review of the Healthy Islands initiatives and enhanced the opportunity to learn from the case studies. The results of the interviews are presented immediately following each case study. It is recommended that the original case study report and this supplementary information be read together to develop a more detailed view of the activities undertaken.

The final section of this document synthesises some of the conclusions drawn and provides an opportunity for both reflection and identification of emerging issues.

Attached as Annex 1 is the document: Case Studies – Lessons Learnt, as identified by participants at the Suva Workshop.

The term “Healthy Islands” in this document is defined by Pacific peoples themselves as articulated at Yanuca and Rarotonga.

The Yanuca Island Declaration on Health in the Pacific in the 21st Century, stated: “Healthy Islands should be places where:

• Children are nurtured in body and mind;
• Environments invite learning and leisure;
• People work and age with dignity; and
• Ecological balance is a source of pride.

The Rarotonga Agreement, Towards Healthy Islands, stated:

“The Healthy Islands concept involves continuously identifying and resolving priority issues related to health, development and well being by advocating, facilitating and enabling these issues to be addressed in partnerships among communities, organisations and agencies at the local, nation and regional levels. Implementation of the concept includes consideration of [a broad range of] core elements in identified settings.”

It is hoped that the analysis of these case studies, the lessons learnt and the conclusions drawn will assist in developing regional guidelines for Healthy Islands activities.

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World Health Organization, Regional Office for the Western Pacific, 1995

World Health Organization, Regional Office for the Western Pacific, 1997
The Makoi Peri-Urban Health Promoting Community" Suva, Fiji: A Case Study Report
Author: Mr Simione Bikai, Environmental Health Officer, Ministry of Health, Fiji

1.1 Introduction

The Yanuca Island Declaration was adopted at a Conference of Ministers of Health of the Pacific Island countries on 10th March 1995. The Declaration adopted the concept of "Healthy Islands" as the unifying theme for health promotion and health protection in the island nations of the Pacific for the twenty-first century. The Conference also reached consensus on the course of action to place the health and well-being of Pacific Islanders at the centre of national development plans.

The Conference of Ministers of Health was again held in Rarotonga on 6th and 7th August 1997, and there was again a reaffirmation of the importance of partnerships among communities, government departments and other sectors in resolving priority health issues. The process of defining priority health issues should emphasise community involvement and reflect the local cultural context.

Progress in Fiji in relation to the Yanuca Island Declaration and the Rarotonga Agreement has been considerable, particularly in the field of environmental health. Recognising the need to develop innovative approaches to the management of environmental health, the Ministry of Health embarked on a Healthy Islands initiative in Kadavu in 1995. The Kadavu Rural Health Project explored the potential for the development of community-based management of environmental health in rural village settings. The success of the project has resulted in its extension to several other rural and urban settings in other districts. This Case Study Report presents in detail the development and progress of the Makoi Peri-Urban Health Promoting Community outside Suva.

1.2 Project Development

1.2.1 Project facilitators

In early 1997, a team of Environmental Health Officers from the Suva Rural Local Authority and Department of Environmental Health at the Fiji School of Medicine, being mindful of the need to intensity the process of defining and solving priority health issues through better co-ordinated community involvement, undertook the initiative to embark on a community health project, based on the Healthy Islands Concept. The team’s principal roles would primarily be restricted to being project facilitators, to allow for maximum community involvement.

The proposal was intended as a follow-up to the recently completed Kadavu Rural Health Project, in which the team members had been actively involved. However, it was decided that a peri-urban setting be identified for the project, whereby the applicability of some of the principles employed in the Kadavu Project would be assessed in a totally different setting.

There were no comprehensive selection criteria used to identify potential project areas; however, consideration was based on issues such as:

- the area’s peri-urban location with high population density;
- the population’s multi-racial distribution;
• the general living standard of the population;
• the availability of facilities, e.g. schools, shops, markets, etc, which contribute to the general development of the area;
• existing health services; and
• potential industrial and other environmental health problems.

1.2.2 Selection of project area

While several possible project areas were identified, the Makoi peri-urban community was finally selected as a pilot project area, having fulfilled most of the informal selection criteria. The final decision, however, was to be made only after confirmation was received from the members of the Makoi community that they have agreed to participate in the project.

The Makoi peri-urban community is located approximately 18 kilometres north of Central Suva. It has a multi-racial and multi-religious population of over 5000. The community comprises of a housing subdivision, 2 primary schools, a shopping centre with temporary marketplace, and 2 industrial subdivisions. The existing infrastructure consists of bitumen roads, electricity, government treated water supply, sewerage system, and garbage collection and disposal service.

1.2.3 Gaining entry into the community

Having selected the project area, it was necessary to identify an already-existing and active group or organisation to serve as an initial contact point that will enable the facilitators to gain entry into the community. A Methodist Church Group, among a number of other existing organisations and committees, was identified to be the most active, with a well-established administrative structure, and a reasonably wide coverage in terms of area, as well as membership. The Makoi Methodist Church Group was found to be the best possible option for gaining entry and establish initial contact with the community.

1.3 Consultation Process

1.3.1 Learning about the community

The Resident Methodist Church Minister, who has overall responsibility of the Methodist Church congregation, and holds an influential position in the community became the initial contact person. Traditional introductory protocol and informal discussions were held, as the project facilitators acquainted themselves with their new team players. Meanwhile, a brief outline of the current aims and objectives of the Ministry of Health in regard to community-based health projects was presented.

Informal discussions and information-sharing exercises were held over a two week period as the facilitators continue to build up a closer interactive relationship with the church members. It was also an opportunity for the facilitators to slowly build up their understanding of the community's views and perceptions regarding community participation in any health project. The familiarisation period also allowed the facilitators to conduct an informal needs assessment with a selected church group, who were requested to express their own personal views and experience, regarding the potential needs and problems that may exist within the community.

1.3.2 Introducing the Healthy Islands concept

A strong interactive relationship with the community is an essential element in the successful implementation of Healthy Islands concept in any setting.
The community, being the most prominent stakeholder will need to be thoroughly briefed of the concept, the aims and objectives, and they must display adequate initiative to take active participation in the project.

Makoi’s Methodist church minister, had been thoroughly briefed of the whole concept, and was very enthusiastic and highly supportive of the project. After a thorough briefing, members of the community unanimously agreed to take active participation in the development of the project. The community was also advised that the sustainability of the project will entirely depend on their involvement, especially in being part of the decision-making process at the outset. Hence, the “Healthy Makoi Peri-Urban Community Project” was born.

1.4 Planning the Project Activities

1.4.1 Needs assessment

The planning of project activities commenced with the identification of some basic needs of the community through a needs assessment jointly conducted by the facilitators and the community. The needs were then analysed and prioritised. Some of the needs identified may require their full involvement in order to be able to address them, while others may require the assistance of other organisations and government departments. Some needs were identified as short term, and may be addressed within a short time span, while others may require a substantial period of time before full results are realised.

The focus on the planning and implementation of project activities were directed primarily towards achieving the health needs of the community. This report presents a few of the activities that were planned and implemented as a result of the needs assessment.

1.4.2 Health and environment promotion centre

An urgent request expressed by the community was the need to establish a Health Centre at Makoi to cater for the ever increasing population in the area. It was crystal clear that the proposal will no doubt require substantial financial provisions as well as ministerial approval.

During a joint discussion, two important factors were taken into serious consideration relating to their request; one was the possible high cost of the proposal, being mindful of the fact that the Government was facing severe financial constraints; and two was the close proximity of the Valelevu Health Centre, which is approximately 4 kilometres away, where members of the community can easily commute to seek medical treatment.

However, it was agreed that there may be a need to set up a Health Centre with a difference, at a comparatively less cost than a standard Government Health Centre. Preferably a simple health and environment promotion centre, where the local community can gain immediate access to health promoting information, and also undergo health screening procedures. The proposal would strictly exclude any curative medical care whatsoever, but would rather be a centre for the dissemination of health promoting information, and environmental health activities. The centre would conveniently accommodate essential health screening facilities, which, ultimately will provide important indicators as to the health status of the community, and thus form the basis for community education on disease prevention and control.

The Fiji School of Medicine’s Department of Environmental Health provided invaluable assistance towards the proposal by arranging for the provision of funds from WHO and other sources to establish the centre.

By mid-1998, the Makoi Health & Environment Promotion Centre was formally opened, and is now being manned full time by an Environmental Health Officer. The facility is also being utilised by Public Health Nursing Staff to conduct MCH (Maternal Child Health) services.
for nursing mothers in the area. It is also anticipated that Final Year Medical Students from the Fiji School of Medicine will soon be conducting health screenings at the Centre in the evenings at 7pm to 8pm as a form of community service.

1.4.3 Formation of sector health committees

The project started off with a central committee elected by the community to oversee all the activities that would be carried out. However, the committee faced some difficulties in organising themselves and was not able to fully satisfy the needs of all the 500 plus households in the community. An immediate review had to be carried out, and it was decided that the community be divided up into small manageable sectors, utilising the 10 existing sectors of the Methodist Church's organisational structure, which virtually covers the whole of the Makoi community.

Sector committees were then formed by the existing members of each sector, and these committees immediately swung into action and commenced identifying the health needs of those who reside within their designated sectors. The committees were also responsible for spreading the Healthy Islands gospel to other racial and religious groups within their sector boundaries.

Following the review, the central committee was re-organised and its members finally comprised of representatives from all the 10 sector committees, and their primary role is to deal with issues that can not be addressed at sector level.

1.4.4 Community health workers

Requests were received from several sectors that there were needs to train some volunteer community health workers to assist the community in basic health-care activities.

A formal request was then forwarded to the Ministry of Health for the training of the health workers. Unfortunately there was some disagreement in the training arrangements by the Nursing Division, who were responsible for conducting the training. They argued that they had been by-passed by the facilitators, who did not follow the normal procedural channel and directly approached the Ministry of Health Headquarters. Admittedly, there had been some misunderstanding, which was clearly noted down as an important lesson learned during the course of the project. In the end, 5 community health workers from 5 sectors finally underwent a 6-week training program. The five volunteer community health workers have now become a very useful tool, and are assisting the public health nurses who conduct maternal child health-care services weekly at the Health & Environment Promotion Centre at Makoi.

It is anticipated that 5 more community health workers from the 5 remaining sectors will be trained. Meanwhile, every effort is being made to acquire some basic health screening equipment for the health workers to use, in order to enable them to put into practice what they have learned during the 6-week training program.

1.4.5 Litter prevention and vector control

Community participation is a very important component of health promotion, and the sustainability of a program may depend on the active involvement of the community. It is also important to realise that in some action areas, there may be a need for legislative provision to support the program in order to be able to address some difficult issues.

This alternative possibility was highlighted when the community raised the need to address the problems of indiscriminate littering and mosquito breeding in the area.

The proposal was taken up with the sector committees, seeking their views and consensus in the legal appointment of volunteer community litter prevention and mosquito control officers under the jurisdiction of the Suva Rural Local Authority, to help address the problems of littering and mosquito breeding.
The sector committees fully supported the proposal, and arrangements were made with the Suva Rural Local Authority for the appointment of volunteer litter prevention and mosquito control officers. Each sector committee was required to select its own volunteers, who would be given the powers to administer the Litter Decree and the Public Health Act in relation to litter prevention and control of mosquito breeding.

1.5 National Government Support

As mentioned at the beginning of this report, the development of the project was initiated by Environmental Health Officers from the Suva Rural Local Authority and Fiji School of Medicine, with a modest financial support from WHO. The Institute of Environmental Health, which was established in 1996 to promote further growth and development of the profession, also played a very prominent role in the development of the Makoi project, since the project facilitators are active members of the Institute.

Government commitment to the project was mainly towards the provision of human resources, in the form of facilitators, who were all Ministry of Health employees. In terms of direct financial assistance to support the program, the government is yet to be fully committed. To ensure sustainability, the Healthy Islands Program in Fiji needs a much stronger commitment at national level, and if possible a separate budget should be allocated specifically for the program. It is also of utmost importance that an individual should be appointed as National Healthy Islands Coordinator. The Makoi experience has indicated that community-based projects would not necessarily require substantial budgets to be successfully implemented. The utilisation of existing resources makes these type of projects more cost-effective.

1.6 Successful and Unsuccessful Aspects and/or Elements

1.6.1 Successful elements

A. Improvement in health-care services

The establishment of the Makoi Health and Environment Promotion Centre was a new concept in health-care service. Even though very little public attention was focused on the establishment of the Centre, it was in fact a milestone in the delivery of health services in Fiji. The Makoi Health and Environment Promotion Centre, is the first of its kind to be established in Fiji, and its usefulness is now being realised by the increasing number of nursing mothers attending the MCH clinic.

Prior to the establishment of the Makoi Centre, the total number of MCH clinic attendance conducted by Public Health Nurses in the Makoi area recorded an average of 200 to 300 annually. In the first 4 months since the establishment of the Centre, attendance rose to 1300 plus.

There were a number of reasons identified as the causes of the increase in clinic attendance that can be directly attributed to the establishment of the Centre:

1) In previous years, the clinic defaulters who live within the Makoi area, were normally the ones who were finding it difficult, due to financial constraints, to travel to Valelevu Health Centre for MCH clinic. Most of these defaulters are now attending clinics at the Makoi Health and Environment Promotion Centre, because it is within walking distance of their homes.

2) Due to the non-availability of a proper place to conduct MCH clinics, a private residence was usually arranged, which may dissuade some nursing mothers to attend clinic due to social and cultural reasons. The new Makoi Centre, being a public institution, does not create any barrier to anyone who may wish to attend, irrespective of social or cultural orientation.
3) Previously, the nurses had difficulties in drawing up an advance timetable for MCH clinics in the Makoi area due to unavailability of a permanent venue, which eventually caused some mothers to default. At the new Centre, the nurses are now able to draw up their programs of clinics several weeks or months in advance, thus enabling the mothers to take note of the exact dates of future MCH clinics.

B. Improvement in networking and community/facilitators relationship

The presence of a full time Environmental Health Officer at the Centre proved very valuable. It has definitely improved the efficiency and effectiveness of the Department in dealing with the community's health needs and problems through better networking with the community. There has been a remarkable increase in the number of community meetings attended by the facilitators. The officer at the Centre has now developed a very close relationship with the community and also maintains regular contact almost on a daily basis.

C. Legal empowerment helps the community to protect their own health and environment

The legal appointment and empowerment of Volunteer Litter Prevention and Mosquito Control Officers selected from within the community has helped to develop a sense of responsibility and watchfulness. People are now becoming more careful in disposing of their litter, knowing that among them, there are members of their own community, who have been legally empowered to monitor and enforce legislation relating to litter prevention. However, the Volunteer Litter Prevention Officers have been strongly advised that community education towards a healthy way of life must always take priority, and enforcing the law remains to be a last resort, and only when education fails to change people's behaviour.

The facilitators have now observed a strong sense of health consciousness within the community. This was indicated when the community, through their own initiative, conducted two anti-dengue clean-up campaigns recently.

D. The successful use of an existing social structure to accommodate an external program

The existing Methodist Church Organisational Structure, was almost tailor-made to accommodate the development of the project. With a little bit of changes here and there, and being mindful not to disturb the organisation of the church, a transformation took place within the existing structure, allowing the project to develop. Interestingly, the church and all its programs were uninterrupted and functioned as usual, even when its structure was being utilised to accommodate members of other religious and ethnic groups who were an integral part of the Healthy Makoi Project.

The successful development of the project within the existing structure is highly exceptional, especially in a peri-urban community which comprise of several religious and ethnic groups, who have totally diverse interests. Experience has shown that it has always been very difficult to bring such members of a multi-racial and multi-religious community together to agree on a common point of interest.

1.6.2 Unsuccessful elements

A. Response from Indo-Fijian members of the Community

Initially, the facilitators had difficulties in mustering reasonable support from the Indo-Fijian members of the community. This was to be expected, as they are more inclined to an individualistic way of life, and in addition, racial interaction in everyday life hardly exists. Total community support is highly necessary to enable the project to develop and become sustainable. The facilitators then conducted a community awareness program, through house to house visits, distribution of flyers, and even the use of loudspeakers at street corners, to emphasise the development of the project. The campaign messages had some impact and wooed in several members of the Indo-Fijian community. Hopefully, as the project develops, more and more members will eventually show interest and take active participation.
1.7 Summary of Lessons Learned

(1) The development of a community-based project in an urban community may require a totally different approach from that of a rural village setting. Due to the absence of a recognised social structure, urban communities are highly sensitive and therefore need to be approached in the most diplomatic manner. And because of the diversity in ethnic origins, culture, religion, and educational standards, it is important to devise a mobilisation program that is acceptable to all or a majority of the population.

(2) The achievement of an acceptable standard of economic development, through the provision of all the necessary utilities and infrastructure, such as treated water supply, sewerage system, electricity, bitumen roads, and garbage collection service does not guarantee a complete state of good health. Urban communities have a much more complex health-related issues, and therefore require complex answers. Some health issues may even require scientific and technical studies to be adequately addressed.

(3) Project facilitators in urban and peri-urban settings need to possess the highest degree of tolerance, commitment, selflessness, and have a heart for the community. He/She must be willing to spend quality time with the community, sometimes after working hours, and even Sundays and Public Holidays. Compared to rural village settings, urban and peri-urban project facilitators will require more quality time with the community.

(4) Project facilitators cannot do it alone, they will need to mobilise the support of other government departments, NGOs, and members of other health discipline, and most importantly, the full involvement of the community. These are important stakeholders, who must be included in the decision-making process right from the outset.
MAKOI METHODIST CHURCH STRUCTURE

- RESIDENT CHURCH MINISTER
- CHURCH DEACON
- CHURCH STEWARD
- CHURCH MINISTER
- CHURCH DEACON
- CHURCH STEWARD
- CHURCH ELDERS

MAKOI METHODIST CHURCH CONGREGATION

- SUNDAY SCHOOL
- YOUTH FELLOWSHIP
- WOMEN'S FELLOWSHIP
- MEN'S FELLOWSHIP

SECTOR 1 LEADER
SECTOR 2 LEADER
SECTOR 3 LEADER
SECTOR 4 LEADER
SECTOR 5 LEADER
SECTOR 6 LEADER
SECTOR 7 LEADER
SECTOR 8 LEADER
SECTOR 9 LEADER
SECTOR 10 LEADER
MAKOI COMMUNITY MOBILIZATION MODEL

ADVISORS & FACILITATORS
- RESIDENT MINISTER
- CHAIRMAN CENTRAL COMMITTEE
- ENVIRONMENTAL HEALTH OFFICERS
- PUBLIC HEALTH NURSES
- CHURCH DEACON & STEWARD

CENTRAL COMMITTEE
THE MEMBERS ARE SECTOR REPRESENTATIVES

THE MAKOI COMMUNITY
METHODIST CONGREGATION
MULTI-RACIAL GROUPS
OTHER CHRISTIAN DENOMINATIONS
OTHER RELIGIOUS GROUPS
TENANTS ASSOCIATION
YOUTH GROUPS

SECTOR 1 COMMITTEE
SECTOR 2 COMMITTEE
SECTOR 3 COMMITTEE
SECTOR 4 COMMITTEE
SECTOR 5 COMMITTEE
SECTOR 6 COMMITTEE
SECTOR 7 COMMITTEE
SECTOR 8 COMMITTEE
SECTOR 9 COMMITTEE
SECTOR 10 COMMITTEE
2.0 Supplementary Information on the Fiji Healthy Islands Case Study

2.1 Overview

In Fiji Healthy Islands activities are co-ordinated by the National Centre for Health Promotion, a part of the Ministry of Health. There is no formal Healthy Islands Plan of Action in place. Political support for the Healthy Islands approach is provided at a ministerial level though no specific budget has been allocated for Healthy Islands activities. Though the activities undertaken as part of the Healthy Islands program do not require great amounts of funding, there needs to be some funding allocated to develop greater program awareness in communities and across other agencies and ministries. Dedicated funding would also assist in expanding Healthy Islands activities to other settings and in teaching more health care workers about the approach.

2.2 Initiation

The impetus for this particular Healthy Islands activity came from the Environmental Health Officers of the Ministry of Health. In an applied way, the project was initiated through selection of a specific site, gaining entry to the community through a Methodist Church group and meeting with the community to learn about its needs, introduce the Healthy Islands concept and conduct a needs assessment.

2.2.1 The political context

As the activities of the Healthy Islands approach were undertaken as part of the environmental health, there was no political difficulty. The political support that has been provided at the ministerial level is implicit in the work of the environmental health officers.

2.2.2 The social context

The social structure of the village was used in this Healthy Islands activity and it was evident to the program officers that the same approach would not have been successful in an urban setting. The multi-racial and multi-religious composition of the village was also something that had to be taken into consideration when developing strategies to implement the activities.

2.2.3 The physical environment

Infrastructure such as roads, electricity, water supply, sewerage and garbage collection was well established in this community. Members of the community identified the physical aspects of the community that they felt were a priority and a litter prevention and vector control program was developed to address these issues.

2.2.4 The setting as a whole

The selection of this particular peri-urban setting was deliberate. Environmental Health Officers analysed a number of sites prior to deciding on this community. The community’s multi-racial and multi-religious population, its established infrastructure and its classification as neither urban nor rural all had an impact on the activities that were undertaken and the manner in which the Healthy Islands approach was applied.

This activity was more a demonstration of the Health Department’s commitment to the Healthy Islands approach than a demonstration of political will. The approach is not particularly politically driven in Fiji. The community role was vital in identifying issues and developing priorities once the Healthy Islands approach was explained. Members of the village were quite willing to participate but it would be inappropriate to say that the activity came about in reaction to a groundswell of community concern.
Leadership for the project was provided by the Environmental Health Officers in the Department of Health. It was strongly felt that the activity, though successful, demonstrated an ongoing need for a Healthy Islands budget to be allocated. Though the financial allocation for the project would not be large, due to the fact that much of the work is carried out by the community, there is a need for a paid Healthy Islands coordinator to be appointed.

The activities on Fiji very strongly emphasised community involvement and were applied in a range of settings. The activities were developed in response to stated needs of the community. The community was involved through the use of an existing community participation structure that was adapted to the use of Healthy Islands activities. Where possible, the community participated in carrying out the work of these activities. In particular, the community was involved as volunteer community health workers, community litter prevention committee members and mosquito control officers.

A partnership approach was taken with the main partners being the Environmental Health Officers of the Ministry of Health, the Makoi Methodist Church, The Fiji School of Medicine's Department of Environmental Health, and the Suva Rural Local Authority. The Makoi Community Mobilisation Model structure included formal methods for input from a broad range of advisors and community members (see model).

The Healthy Islands activities undertaken on Fiji were action oriented and had clearly defined outcomes and indicators of success. Priority issues in the community were determined through a consultative needs assessment process. The results of the needs assessment were then used to set specific goals and targets.

In Fiji, the community was consulted in the very early stages of the project. The community was selected by a team of Environmental Health Officers from the Suva Rural Local Authority and the Department of Environmental Health at the Fiji School of Medicine. The team approached the community to see if they were willing to participate. Once the idea was accepted in the community, entry was gained through an existing Methodist Church group. The input model already in place at the church was modified and expanded for the purposes of the Healthy Islands activities.

In terms of community participation, there were members of church groups, mult-racial groups, the Tenants' Association, youth groups, Environmental Health Officers, and Public Health Nurses. The sectors that were mobilised were the health care sector, environmental health, religion, community and youth.

Arrangements were negotiated among parties through the Community Mobilisation Model structure which set up a central committee with membership from each of the sectors and who were advised by a special group of experts. Open discussion was the style of the meeting with ideas being exchanged freely and decisions made, where necessary, by a vote of the committee. Given the representative nature of the committee it was important to leave enough time for members to consult with their constituencies and report back to the committee.

Though there was not an identifiable catalyst that influenced the outcome of the Fiji Healthy Islands activities, credit must be given to the original team who clearly explained the principles and how they might be put into practice. Once the community had a clear idea of the purpose of the activities and knew that they would be responsible for working to achieve their goals, the project really took flight.

Members of the Makoi community were empowered in several ways through the project activities. They felt that their ideas and concerns were given legitimacy when the Government approved their top priority idea, the Makoi Health and Environment Promotion Centre. They were further empowered through the development of stronger networks for the communication of ideas, problems and solutions. Those who volunteered to be litter prevention, mosquito
control and health care workers were empowered with training, and people in the former two categories were legally empowered to monitor and enforce relevant legislation relating to litter.

2.4 Outcomes

Policy outcomes included changes to rubbish disposal policies and mosquito control policies. The establishment of the Makoi Health and Environment Promotion Centre signalled a policy shift on the part of the Ministry of Health. The training of health care workers, litter prevention officers and mosquito control officers in the community represents a change in the Ministry’s policy toward community participation and empowerment.

Planning and co-ordinating lessons learned from the activities include:

• The need to use communication and participation structures appropriate to the community;
• Project facilitators need to possess the highest degree of tolerance, commitment, selflessness, and community concern;
• When a representative structure is used members must be given sufficient time between receiving information and making a decision to consult with their constituencies; and
• If people are empowered to determine their own problems and priorities, they will work harder to achieve them than they will if priorities are imposed externally.

Standard practice has changed in many ways since the project. Now that the community has a local health and environment promotion centre, it is being used more effectively. There are more people attending the clinics, fewer defaulters and a broader range of community members are utilising the centre than previously utilised mobile services. Volunteer health workers, mosquito control officers and litter prevention officers have resulted in a higher standard of health care and community cleanliness. The continuation of the community mobilisation model has meant that community ideas and problems are regularly discussed. The networks established as part of the activities are also still used, which contributes to a strong sense of health consciousness in the community and a sense of empowerment to redress problems. The people of Makoi are doing more decision making on environmental and lifestyle issues.

The problem solving abilities of partners have been strengthened because they now have a structure for discussing and acting on problems that arise in the community. Training for volunteers has helped address other community problems. People are more forthcoming with suggestions to solve problems since they see they are taken seriously and respected when they participate.

Supportive environments created as a result of the Fiji activities include the supportive environment created by training volunteers to help with both health and environmental issues. The new community-based health and environment promotion centre supports people to make healthier choices. The adapted communication and participation structure supports greater community input into the identification, prioritisation and solution of area concerns. The networks established as part of the activities continue to provide a means for inter-sectoral collaboration.

Lifestyle changes that were a result of the project include greater attendance at clinic, greater awareness of the importance of environmental issues such as litter and mosquitoes, a greater sense of health consciousness among community members and many more are now participating in an obesity audit being carried out by the Secretariat for the Pacific Community.

The main examples of reorientation of health services is the establishment of the Makoi Health and Environment Promotion Centre and the change in attitude toward training community workers for roles as health care and environment workers. Prior to the project these
services were not located in the community and did not involve community members in the delivery of their services. The shift marks a greater empowerment of the Makoi community and supports the recommendations of the Ottawa Charter for Health Promotion.

There was no formal evaluation of the activities during the life span of the project. It is hoped that a better profile of information will be possible after a review of the health of the community which is being done as a result of the Healthy Islands initiatives.

Enabling conditions that exist for sustaining the work of the Healthy Islands approach beyond the initial project phase include the networks that were established, the ongoing existence of the Centre in the community, the ongoing community discussion of issues through the Makoi Community Mobilisation Structure, and the sense of empowerment developed among members of the community.

The most important gain from this case study is that of empowerment. This is also an ongoing impact in the Makoi community. When time is taken to explain the principles and objectives of the Healthy Islands approach in a clear way, the community will respond. Using the community gatekeepers, in this case church leaders, was a highly successful strategy. It is useful to note that the Chair of the Community Committee is now a frequent visitor of the Ministry of Health and regularly engages in conversation about community concerns. The people developed a sense of ownership of both the problems and the solutions because they participated in the identification of both and did the work for themselves. The project initiators learned that they need to identify themselves with the community, do things on the terms of the community and in their time. The key to success is developing a genuine partnership with the community.

Since the completion of the project activities there has been interest in the approach from other areas. People across Fiji are beginning to discuss the process in other communities and in other settings. This may lead to self-initiated projects and the application of Healthy Island principles in other peri-urban communities.
II. NIUE CASE STUDY REPORT

Case Study Report Niue
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1.1 Country Profile

Niue is a small isolated island nation situated approximately 480 kilometres east of Tonga, 660 kilometres south east of Samoa, 930 kilometres west of Rarotonga. It is the largest and highest coral atoll in the world with a land mass of 259 square kilometres. There are fourteen villages situated around the island, eight of which are coastal villages on the western side while six are found further inland on the eastern side.

The 1997 census counted the total population at 2082. The 1996 census of New Zealand counted 18,000 Niueans living there. It is estimated that some hundreds or more Niueans reside in Australia and elsewhere. The population in the villages ranges from twenty eight to ninety five in the four small villages to over one hundred in the bigger villages with the main town having seven hundred and two.

It may seem that the people move to town but it is not so. The main town is the seat of government, the centre of commercial activities, has the airport and seaport, and most of the expatriates live there. After their posts are localised, these flats are occupied by young married Niuean public servants who pay rent and at the same time save for their own homes. Niueans move all the way to New Zealand and thereafter, for a very few, to Australia. Niue people have free access there.

1.2 Background

The Yanuca Declaration on Health in the Pacific towards the 21st Century led to the Healthy Islands concept which embodied the themes of health education, health promotion and health protection in the island nations. Niue is one of the island nations privileged to be included in the Australia – South Pacific Healthy Islands Health Promotion Project.

With the Minister of Health’s assistance and advice an inter sectoral committee was formed. It was recognised that having sectors of interest working co-operatively to enhance the health of the people was the most effective way to approach the health concerns of Niue.

The composition of the working committee therefore was derived from: Health Department (which included the Director, the Dental, the Maternal Child Health, and the Environment Public Health division); Education Department represented by one teacher each from the two national schools; Agriculture, Forestry and Fisheries Department; Community Affairs Department which also represents the churches, villages, councils and cultural organisations. The non-government organisation is represented by the Chamber of Commerce, the National Council of Women, the Youth Council and the Sports Association, and a legal officer.

The coordinator was appointed from the preventative services division of the health department since the focal point is that department.

In order to gain the people’s confidence and co-operation, a local name to reflect the spirit of the project was given – Moui Olaola and to date it is a household word.

The project was formally launched on 31st May 1996, World No Smoking Day. This was done to highlight an area of concern the committee felt would create a good beginning.
This was also done because most of the policy and legal decision-makers, those who should set examples and standards for the nation to follow, were smokers.

It may be viewed that given the smallness of size and the population of Niue, the island should be relatively free of health concerns and problems. The committee have identified that complacency and satisfied attitude should not be encouraged and condoned.

Exposure to the outside world through technology and frequency of travel, changes of cultural values and attitudes are key players in health concerns. Therefore they perceive it as their duty to the people to upgrade and deliver post haste health education, health promotion and health protection programs.

The committee is structured in two folds – departmental collaboration. The involvement of government departments in the utilisation of the expertise found in their personnel is the collaboration of departments required for the delivery of programs. The participation and co-operation of the committee is the involvement of the non-government organisation in the dissemination of information and knowledge and feed back to the rest of the communities. Evaluation and concerns from them would be deliberated on and actioned by the committee.

As the co-ordination of all non-government organisations is under the Community Affairs Department, the facilitating of all activities to and from the communities are well organised and easily accessible.

![Community Affairs Department Organisation Chart]

The process in the delivery of health programs is accessible to everyone as highlighted by the above diagram. In every village there are women’s groups as are youths and sports groups which are affiliated to national councils.

As with the neighbouring islands, Niue experiences the same health concerns and related problems, all needing attention and solutions. Prioritising these problems is a problem in itself. What the professional knows and perceives, the layman regards as nuisances because they only feel unwell infrequently. The non-communicable diseases of diabetes, hypertension and cancers are diseases the layman do not see and understand because of the cause, and the effects are long term. To compound this not seeing, treatment is easily available and what’s more it is free. Domesticated animals problems in the form of pigs, dogs, cats and chickens are every day
occurrences which the layman sees and therefore will co-operate only if he himself is not personally involved.

Health concerns also impacts socially, economically and environmentally on the people of Niue, therefore the committee endeavours through its functions and objectives to address these concerns to attain a healthier Niue.

1.3 Moui Olaola Action Priorities For Health Promotion 1997-1998

1.3.1 Goals

The goals of the committee reflect the Yanuca Declaration which states – Healthy Islands are places where:

- Children are nurtured in body and mind
- Environments invite learning and leisure
- People work and age with dignity
- Ecological balance is a source of pride.

Moui Olaola seeks to promote the health of the people of Niue by:

- **Enhancement of living conditions**
  Priorities - litter reduction
  containment of domestic animals
  development of vegetable and flower gardens
  policy and legislation issues.

- **Enhancement of lifestyles**
  Priorities - no smoking
  reduction of alcohol consumption
  good quality nutrition
  freedom from STDs, HIV-AIDS
  oral health
  reduction of non communicable diseases

- **Enhancement of settings in which people live, work and play**
  Priorities - health promoting schools
  healthy hospitals
  healthy villages

1.3.2 Functions of the committee

- Develop a plan of action for Moui Olaola
- Facilitate, implement and disseminate health promotion strategies
- Assist the individual/departments/community and organisational efforts in the health promotion strategies
- Assist the development and implementation of health promotion policies
- Participate in health promotion activities
- Assist in the skills development and training of selected community people
• Be responsible, accountable and committed to the cause of Healthy Islands
• Ensure proper management of the project.

1.3.3 Objectives

• To create an inter sectoral action for health with support from the national government
• To establish a harmonious working relationship between sectors to address health concerns identified
• To develop a plan of action which provides clear directions for each sector to address on a collaborative level
• To source sustainable funds to assist the project once project funding expires
• To assess analytical data and indicators which measure progress of project
• To lobby for the passing of appropriate legislation which supports healthy lifestyles.

1.3.4 Visions of the Moui Olaola Committee

By the turn of the century:

• Niuean people will be making correct, informed health choices concerning their lifestyles, behaviours and attitudes leading to reduced and controlled lifestyle diseases
• Less Niueans smoke and public meeting places declared smoke free zones
• People will be well informed and well educating taking more responsibility for their own lives
• Niue an Environmental, Friendly, Happy, Healthy and Wealthy Nation.

Some of the achievements so far reached with the assistance of the Minister of Health.

• Smoking which was originally targeted has made promising progress and the outcomes favourable resulting in –
  a) Cabinet meetings declared SMOKE FREE ZONE.
  b) Meeting of the Niue Legislative Assembly declared SMOKE FREE ZONE.
  c) All government departments' work places SMOKE FREE ZONES as of August 1997 except the Niue High School Staff room.

Having a political leader committed to the cause and paving the way for others of equal importance lends credibility to the project.

1.4 Development and Implementation

Strategic approaches to the NO SMOKING ZONE program of awareness started three months before the formal launching of the project on World No Tobacco Day, 31 May 1996 and continued during and after the event.
• Radio anti-smoking information aired weekly

• Articles of smoking hazards targeting the general population were inserted weekly in the NIUE STAR

• Students and pupils of the two national schools were given the information for the essay competition

• Poster competitions on health food/healthy body for the two national schools

• Winners of competitions invited to the launching; the overall winner to read the winning essay

• Theme songs composed by the minister for the project, sung by family members

• World No Smoking Day banners fly from the Fale Fono and the High School

• Anti-smoking Billboard erected at the entrance of the National High School

• Leaflets and brochures were displayed for the taking and everyone encouraged to help themselves

• Interviews of smokers, non-smokers and the former smokers to compare reasons

• Policies formulated and departments approached and encouraged to enforce

• Sports association hold fun games, fun runs, power walking with banners in support

• Health department and/or the Moui Olaola committee challenges friendly games with another sector represented in the committee

• T-shirts printed and sold or given as prizes

• Traders requested and encouraged to cease selling tobacco for the day

• No Smoking signs nailed up at the main entrances of government departments

• Questions on smoking habits included in the census questionnaire

• Publish of available data from the health department’s cancer register and number of cases and deaths attributed to smoking

• Parents who smoke who have children suffering from respiratory infections regularly are cautioned and encouraged to either quit or smoke outside the homes

• Churches included in all activities by requests for prayers on the Sunday nearest to the day of a particular health event

• Churches are included to open health promotion events with prayers and short sermon

• The Women’s Christian fellowship included Moui Olaola themes in their international day of the women events.
1.5 Resources

Material and funding resources made available from VicHealth, SPC, WHO and other United Nations agencies have made it possible and has assisted in the island wide campaign against smoking. Aspects of success have already been mentioned. As to whether it is enforced can be observed and seen when one visits these premises with their NO SMOKING ZONES. The air is clean, no smoking odour present, no ashtrays and no ashes. Smokers are sometimes seen under trees outside not in groups but individuals having a quick smoke. Analysis of why the campaign is successful is due to political commitment, departmental collaboration, community participation and co-operation, and the Moui Olaola committee's dedication to the project.

The one aspect of failure experienced has been the refusal of the high school teachers who smoke to consider declaring their staff room a No Smoking Zone. Efforts in encouraging the teachers to support the policy will continue until it is enforced.

Legislation to ban children under a certain age from buying tobacco products has been discussed but not yet actioned. Having all meeting places, restaurants and social gatherings declared No Smoking Zones has also been discussed but is yet to be actioned as well.

1.6 Lessons Learned

1. Sustainable resources must be available for continued success.
2. Decision and policy makers, law makers and all leaders must set standards.
3. Political commitment must be evident.
4. Other sectors besides the health and education must collaborate more.
5. Communities must be informed.
6. Communities to participate from start to end in order to co-operate.
7. Committee members must be committed to the cause.
8. Continuity of the program should be encouraged and reinforced regularly.
9. Free supply of drugs for treatment is not conducive to healthy living.
10. Incentives are required for participation.
11. More assertive measures to be taken to encourage smokers to quit.
12. Former smokers have more credibility in health promotion than non-smokers.
13. Some smokers refuse to be convinced because there have been smokers who smoked and lived long lives.
15. Donors are helpful if project is to their liking.
16. Calling meetings of the Moui Olaola Committee is difficult as most of these members are already involved elsewhere.
17. Niue must own the project for the people to appreciate more fully the funding element of the project.
(18) The sectors involved in health promotion must include in their budget funding for activities.

(19) Niue has already attempted their healthy islands approach in their public health preventative activities, for example health villages through village inspections.

(20) Formal evaluation mechanism is yet to be in place for the project.

1.7 Conclusion

The WHO initiative of the Healthy Islands has been a welcomed incentive for Niue. It has given an opportunity for the refocusing of its fragmented efforts in its health education, health promotion and health protection activities under the umbrella of the Moui Olaola Project. The generous sponsorship of AusAid funding through the Victorian Health Foundation in collaboration with the University of New South Wales has made it all possible.

Niue is now focusing its efforts towards the turn of the century with its health promotion strategies consistent with that of WHO theme for Health. It is apparent that assistance is needed for the initiative given the economic climate it experiences. Nevertheless with concentrated efforts from all sectors, lessons learned from mistakes and people to literally take their own lives into their own hands, Niue will be a happy, healthier and wealthy place to live.

To all those people who gave tirelessly and willingly to the cause, appreciation is extended from the project.

2.0 FAKAAUE LAHI MAHAKI: Supplementary Information on the Niue Healthy Islands Case Study

2.1 Overview

In Niue the National Healthy Islands co-ordinating mechanism is called Moui Olaola. The Moui Olaola committee is composed of representative from the Health Department, the Education department, Agriculture, Forestry and Fisheries, Community Affairs, village councils, cultural organisations and NGOs. A Healthy Islands Plan of Action has been developed and endorsed by the committee.

There is a mixed sense of political support for the Healthy Islands approach in Niue as the Minister of Health and other members of government are very positive about Moui Olaola but it has yet to be discussed in Parliament. The support for Moui Olaola is evident in the multi-sectoral representation on the committee and the release of government staff to work on activities.

2.2 Initiation

2.2.1 The political context

Political will is perhaps the greatest initiating force for Moui Olaola. The Minister and the project coordinator discussed who would be the most appropriate partners then invited them to a meeting to form the committee and chart the direction. The Minister personally chaired the meeting.

2.2.2 The social context

At first there was a bit of confusion about ownership of the healthy settings approach. Health promotion staff of the Department of Health thought they were the rightful ‘owners’ of Healthy Islands but so did some Department of Education staff. Because it covered issues of nutrition, there was also a gambit claim from Agriculture. The project had to start, right from the beginning, talking about health being everybody’s business and explaining the concepts of the Ottawa Charter. Other sectors were reluctant to relinquish their ownership but eventually
did co-operate. There was a ‘what’s in it for me?’ attitude that was conquered in the end through repetition of the idea that it is ‘our’ health and ‘our’ responsibility; the Health Department will only take care of you when you are sick – staying healthy is your responsibility.

2.2.3 The physical environment

There existed in Niue the idea that beauty and health were linked. This was demonstrated through the beautification of homes and the creation of gardens. A link existed between rubbish and the tourism industry; tourists came in greater numbers if there was less rubbish around. When there were more tourists, there were better economic conditions. In the community there was a connection made between containers that could hold stagnant water and mosquito breeding and a similar connection between rubbish and rat breeding. There was not, however, a connection between piles of old scrap metal and disused cars and environmental health prior to Moui Olaola.

2.2.4 The setting as a whole

The smallness of the setting is a significant factor in relation to the application of a settings approach. There is a small population, easy access to people, and existing structures with which to work. The task was a matter of engaging these structures and beginning the work.

As previously mentioned, the Niue case study clearly represents a demonstration of political will. The activities were more pro-active than reactive to the expressed desires of the community. The community didn’t know anything about the concept of Healthy Islands before the project activities started. They had to be drawn in by the positive nature of Moui Olaola. They previously would wait till just before a village inspection to clean up the village. They needed to be taught to take on the responsibility for health for themselves.

2.3 Process

Leadership for the approach was provided by the Minister for Health who chaired the meetings of the committee. This gave clout to the proceedings and the presence of other heads of departments or their deputies added to it. The project coordinator had to set up the processes and ‘drive’ them to get projects initiated. She led the principles of the approach.

The feeling of the Moui Olaola coordinator is that they had to involve the community and use a settings approach or the whole project would have failed. The Department of Health had to get away from the idea that they would always go to the community and foster a responsibility among the community to come to the Department for assistance. This was reinforced through radio spots and newspaper articles. The settings used are villages, schools, hospitals and indirectly, churches.

A partnership approach was involved with representative from a broad range of sectors, NGOs and community groups (see previous paragraphs).

The project was not so strictly action oriented with clearly defined outcomes and indicators of success. It was more concerned with broader issues of improving the environment and improving health.

The community was involved through representation on the committee from the first meeting. Village counsellors were invited then community activity was co-ordinated through the Director of Community Affairs.

Efforts to mobilise people across government sectors were an integral part of the initial organisation of the committee. A broad representation of government sectors was invited to be on the committee from the start. At the community level, village counsellors increased
community awareness and involvement in project activities. Money has since been increased to run projects in communities through the village counsellors.

Matters were negotiated between the parties through open discussion of ideas. An example of successful work from the committee is that of problems with domestic animals. There were laws regulating the containment of pigs, so the problem was initially dealt with through the Police. This did not work very well. After discussion in the committee, it was decided that the Department of Agriculture should address the problem as well. They did so through a series of workshops for villagers and setting traps to catch errant pigs. This has led to far more success with the containment of domestic animals and makes it much easier for the police to enforce the relevant laws. This represented a direct benefit of multi-sector committee membership and open exchange of ideas.

The catalysts that were employed for the project activities were the use of World Health day to carry out some activities and the use of World No Tobacco Day to launch Moui Olaola and the anti-smoking campaign activities. World AIDS Day was also used to heighten awareness of some project activities.

Empowerment was achieved through attendance at workshops where community members learned how to take better care of and have more control over their environments. Radio sessions also provided information and knowledge of issues related to non-communicable diseases.

2.4 Outcomes

No smoking policies were taken up by government departments in their offices.

A great lesson in planning and co-ordination was learned early on in the process. The number of people on the committee that turned up was less than expected or hoped for. The Minister wanted to then limit the number to a core of people. The coordinator wanted broader representation, however slowly they turned up. She theorised that they were late or absent because they were very busy. Moui Olaola learned that they must consider other people’s commitments when planning meetings. They must also prioritise and develop realistic expectations of meeting outcomes.

There is real evidence that smoking had decreased in Niue as a result of project activities. There are still unacceptably high numbers of smokers on the island and Moui Olaola acknowledges that it is an uphill battle, but they are encouraged by their early results.

Empowerment happened in a number of ways. Sectors were empowered to participate in activities that had previously been considered to be outside their portfolio. People were empowered with skills and knowledge through workshops and information sessions. Networks were established that empowered members to identify and solve problems for themselves.

An interesting reorientation of a service happened as a result of the project. The Moui Olaola coordinator asked the Census bureau to include questions on smoking in the census. Without resistance they agreed and a reliable source of information about one of the main health concerns of Niue suddenly came into being.

There was no formal evaluation method in place but a recent New Zealand ODA special health project have reviewed health services in Niue and have recommended the Healthy Islands approach be continued.

Though the idea of health being everybody’s responsibility took months of preaching again and again, it finally sank it. Moui Olaola is still being discussed and is becoming entrenched in the culture. Young people are leading the charge and it seems that the concepts are both appreciated and utilised now.
The most important gain from Moui Olaola is that people in Niue are more aware of their responsibility to care for themselves and prevent themselves from getting sick.

Since the end of the project there has been a noticeable level of curiosity about what is happening with Moui Olaola. People want it to start up in earnest again. Exercise and fitness concepts have really taken off and people are much more physically active and fitness conscious. Obesity is a major problem so this is great news. An example of the impact of the project is the independent continuation of a fun fitness program for people over 35 that was developed by the Amateur Sports Association through the aegis of Moui Olaola. It was not originally envisaged that the activities would continue without funding but the members have changed aspects of their lifestyle and embraced a healthier way of having fun and they don’t want to give it up. This is a minor testament to the effectiveness of the Moui Olaola project.
1.1 Introduction

The people of Yalu village have shown remarkable initiative by constructing their own water supply. They now have ventilated and improved pit toilets. They also have rubbish pits for disposal of household waste. Individual families units have started to put in electricity in their homes. Lawn grass has been planted in areas that were previously bare dirt.

Other improvements made in the village include:

- Pig fencing;
- Proper drainage;
- Mosquito bed netting;
- Law enforcement; and
- Strengthened village structures.

1.2 History of Yalu Healthy Village Project

In 1995 World Health Organization (WHO) Fellowships were granted to four environmental health officers to study malaria for 4 months. The idea of introducing ventilated improved pit latrines (VIP) was discussed. Morobe Province was selected as a site for implementation.

In 1996 the WHO Regional Advisor on environmental health, Dr Ali Basaran visited Papua New Guinea (PNG) as part of the Water and Sanitation Monitoring Systems (WASAMS) project. By then, a village outside of Lae was selected. Together with the Advisor, a visit was made to the village to meet with the community. The community was willing to try something that would be of benefit to their lives. Positive thinking about doing something for themselves was mainly due to experiences such as:

- There had been hardly any government services to the village since PNG became independent in 1975.
- There were significant numbers of people with communicable diseases and the closest health care centre was far away in the city.
- The collection of clean water in containers which is used for cooking and drinking required a four (4) hour round trip daily to a site uphill from the village.

1.3 Selection of the village

The selection of the village around Lae was discussed among the officers involved. Certain criteria were developed:

- Easy access to the village;
- Community willingness to try something new to improve their lives;
• Political support;
• Access and availability of technical support; and
• Availability of resources within the community.

1.4 Implementation

Certain activities were carried out prior to the implementation of the Healthy Village Project.

1.4.1 Community leaders workshop

• With the assistance of WHO/NDOH and Provincial Health Division this workshop was conducted over a period of one week.

1.4.2 Objectives

• To build positive behaviours to develop trust to solve their own health problems;
• To identify essential information to understand health conditions and goals in the community;
• To stimulate members of the community for action development in the village; and
• To develop community action plans in accord with the goals and priorities of the community.

1.4.3 Participants

Participation included:
- village committees
- youth/women leaders
- traditional village leaders
- church leaders/ and councillors

1.5 Plan of Action

A plan of action was developed towards the end of the workshop. Water supply was identified as the first priority. The whole village as committed to bring in potable water to the village.

1.5.1 Resources

• Already trained technical artisans were members of the community.
• Local councillors contacted the local politician for political support in terms of initial funding - K10,000 was allocated.
• Technical support was sought from the PNG University of Technology for surveying, selection of pipe, design and costing.
• Local resources were already available:
  - free labour in the community;
  - sand/gravel/timber.
- housing and food;
- local tool with the community; and
- local transportation.

- Additional technical support was provided by the local Health Division, WHO and the National Department of Health.

The water supply (reticulated) has 8 standpipes, soak pits, and shower recesses.

1.5.2 Sustainability

For maintenance, improvement and extensions to households, the community have:

- Opened a bank account. A fee of K1.00 is collected each month from each family; and
- A water committee has been formed to run the system.

1.5.3 Other priorities

Programs that have been initiated by the community include:

(1) Construction of VIP latrines before accepting the type of latrines, the villager was exposed to information and certain types of methods of excreta disposal;

(2) Demonstrations of type of latrines were made possible per local health division in Lae. This ranged from straight pit toilet, pedestals, WCs and VIP.

(3) The village went for the pit toilet ventilated improved with local materials such as bamboo as pipes and coconut shells as caps over the vent pipes. Those who can afford went for PVC pipes and concrete slabs. Each household has a VIP latrine.

1.5.4 Rubbish hold

Each household has dug out pits for disposal of household waste.

1.5.5 Electricity

As the village is situated along the main highway where there is electricity lines, the people have decided that electricity should be brought in. Already family households have stated to bring in the power lines from the main. Again local resources from the village in terms of technical know how exist in the village – with official assistance from PNG Electricity Commission in Lae.

1.5.6 New programs

- Pig fencing
- Grass planting

1.6 Results

People are generally happy. Their lifestyles have change. Health has improved.
2.0 **Supplementary Information on the Papua New Guinea Healthy Islands Case Study**

2.1 **Overview**

Healthy Islands activities in PNG are directed by a working group which is chaired by the Director of Health Promotion. This working group is a sub-group of the National committee task force. Though this committee functions like a ministerial committee it has yet to be formalised as such. A Healthy Islands Plan of Action is in the draft stage and will be submitted to Government after it is finalised by the working group. The terms of reference for the group are to develop the Plan of Action, to determine settings, to develop advocacy, to build mechanisms for partnerships, and then to implement the plan through Cabinet.

After the signing of the Rarotonga Agreement, there was political support from the Minister. Cabinet endorsed the Rarotonga Agreement then directed the Department of Health to form the working group. The then minister was very supportive of the Healthy Islands approach. Recently there has been a change in government and the new Prime Minister is also the Minister of Health. Political support is still evident and the new minister has asked that the Healthy Islands approach be broadly applied in PNG.

2.2 **Initiation**

The initiating forces for the PNG Healthy Islands activities were staff of the Department of Health. They had been thinking broadly about the application of Healthy Islands principles to PNG before there was a formal decision to undertake specific activities. Villagers, however, were more reluctant to act. A community development workshop was held in the village selected for the activity. The community came up with their own plans in the course of the workshop. The community found that the workshop motivated them and gave them a starting point for action.

2.2.1 **The political context**

The Healthy Islands activities in Yalu village were not politically motivated. Political support at a Ministerial level was demonstrated through the allocation of K10,000 but the committee had to mobilise the community for greater political support at the local level.

2.2.2 **The social context**

The people of the village, after the community development workshop, were genuinely enthusiastic about participating in the Healthy Islands activities. They wanted to set their own goals and were committed to achieving them.

2.2.3 **The physical environment**

The physical environment had a lot to do with the nature of the activities undertaken. The issues that were of greatest concern to the community were related to the physical environment. The lack of a local water supply was the chief concern of the people, followed by human waste disposal issues and rubbish disposal issues. The physical environment had an impact on the way that each of these priority issues was resolved.

2.2.4 **The setting as a whole**

The village setting had both positive and negative influences on the activities. The reluctance of the villagers reflects some of the barriers that may have to be overcome when conducting Healthy Islands activities in areas where community members have little experience with community development projects. The close-knit nature of the village, however, acted to facilitate greater ownership and community participation once the villagers were on side. The distance of the setting from a reliable supply of potable water was another factor that influenced the direction taken by the villagers. The staff of the Health Department were quite pleased with...
the setting in the end as they felt it set a good example for other villages and it represented a ‘typical’ village.

The Yalu village activities represented a combination of political will and community concern. The initial influence came from the Department of Health and was motivated by political commitments made by the minister and the ongoing concerns of Health Department staff members. The beginning of the activities represented government staff dominance but eventually this shifted to the community. The people were told of the political support that existed but were urged to act for themselves. The enthusiasm and action, however, was provided by the community members themselves once they had a good understanding of Healthy Islands principles and had determined priority action areas for themselves. The community identified the problems, proposed their own solutions, then carried them out.

2.3 Process

Leadership for the Healthy Islands approach in PNG has been provided by the Department of Health and has been supported by provincial health organisations and the University of Technology. The activities emphasised community involvement and used the settings approach to achieve results. A partnership approach was taken and partners included the Department of Health (both Health Promotion and Environmental Health staff), the World Health Organization, provincial health, the University of Technology, the village and local government.

The project was clearly action oriented and had clearly defined outcomes. This was ensured as the identification of desired outcomes and the processes for achieving them were included as part of the community development workshop undertaken in the village. The plans were revised along the way but the revision process was still a community driven one. An ongoing effect has been achieved through this activity as the community has continued to meet to discuss action and how to achieve it even though the funding for the project activities has ceased.

The community was consulted in this project at the initial stages. Once the target village had been determined by the Department of Health, the people were consulted. The community development workshop was the entry point into the community and acted as an empowering force for the villagers. Once the villagers had determined their priorities and developed ways that they thought they might achieve the desired results, they brainstormed to develop a list of potential partners and began calling upon other organisations and sectors for assistance. The question that dominated their considerations was, where can we get free help? This included getting the local village chiefs to provide additional financial support for their ideas, getting experienced artisans in the village to donate time and effort to do the work required, writing to the University of Technology seeking technical assistance for the engineering of the new water supply, and seeking additional technical support from the local health division, the World Health Organization and the Department of Health’s Environmental Officers.

The arrangements were negotiated among partners through community meetings. The Department of Health did not intervene in these meetings and only participated when asked to do so. The villagers made the final decisions on all aspects of the project. The Health Promotion staff of the Department of Health initiated the project, but the villagers took total control very soon thereafter. Department of Health staff continued to support the villagers with technical advice.

The catalyst for the success of the activities in Yalu village was the initial community development workshop. Without it, the project activities may never have come to fruition. The workshop empowered the villagers and developed interest as well as ownership.
2.4 Outcomes

The policy changes that came about as a result of the activities were all at village level. Several village laws were changed by the village magistrate. These laws generally related to environmental and social issues such as law and order, rubbish disposal, pig fencing, and an ongoing financial contribution of K1 from each family to maintain the changes to the water supply.

In terms of planning and co-ordination, the villagers learned that they could plan for themselves and co-ordinate the activities of people across sectors to achieve their objectives. This was a great lesson for the people of Yalu and regular planning meetings have continued in the community even after the formal end of the project activities.

Another lesson learned was, that even with the community eager for something to happen, there must be some impetus, some starting point for a project to get off the ground. Though there was political will and community concern, nothing would have happened had it not been for the initiating activities of the Health Promotion unit of the Department of Health.

Standard practice changed as a result of the work done in this project. A manual has been produced to show how to stimulate community action and participation. This will provide a format for resolving problems within communities. There is also a greater awareness since the project of where to go, or at least where to start action to resolve community problems. The activities fostered the idea that members of the village could actually do something about their problems themselves.

The most obvious demonstration of a supportive environment created by the project activities is the water supply itself. It is now safer, more reliable and more accessible than ever before. Prior to the creation of the new water supply it was pointless to preach, 'wash your hand, wash your hands' and promote good hygiene because they didn't have water with which to wash. Now even the village children have shown their appreciation for the water supply and hygiene is much easier to maintain in the village.

The greatest lifestyle changes relate to the use of the new water supply and the use of rubbish and human waste disposal systems. People now bathe more frequently, have a better self-image, are more motivated to work for change when they have a community problem, and have a systematic way in which to resolve priority issues.

The services that have been reoriented in this project are not particularly health services. The most notable service change was that of electricity. As a result of the activities a permit was granted to give the village permission to have electricity. Now many of the homes have electric lighting and power. Members of the village are now considering telephone services and how they might be introduced in the village.

The activities undertaken were not formally evaluated when they were done. An instrument is being devised now to attempt to measure the impact of the Healthy Islands initiatives in the village. Observation has been the chief means of evaluation to date though community participation levels were measured at various times in the project.

Enabling conditions for sustaining the work beyond its initial project funding include the use of the village as an example to others. This results in regular visits from other districts and these visits keep the community motivated. Moral support is still provided by the Health Promotion officers in the Department of Health who always stop by the village to check on how things are going when they are in the area. The structures that the village set up for themselves and the manual that is being developed also contribute to the sustainability of the work.

The greatest lesson learned was that there needs to be a catalyst or at least a strong impetus to begin such activities. All the political will and community concern in the world...
won't result in action is someone doesn't say "go!". With a good kick start, the people were quite capable of identifying and working to resolve problems. It is considered that the impetus for further action in other communities may best come from health care workers at the provincial level.

Since the completion of the initial project phase, the Yalu village work has served as a model and an inspiration to others. There are now new shops in the village, people are cleaner and they seem to have a prouder community image. The village is clean, more flowers and grass have been planted and children are even beginning to go to school more regularly. Incidence of malaria in the village is down as well. A small aid post is now being considered for the village and the villagers are beginning to 'think big' about their future.
IV. SAMOA CASE STUDY REPORT

Samoa Case Study Report on the Australia-South Pacific Islands Healthy Islands Health Promotion Project 1995 – 1998
Author: Ms Palanitina M. Toelupe

1.1 Introduction

Samoa is a country in transition and that transition is not uniform. It varies with age and sex of the population and their geographical location. Samoans living in urban areas are not necessarily facing the same challenges and social problems as those living in rural areas. Similarly, the context upon which family and village life is practised is not the same any more.

Samoa’s attempt to translate the Yanuca Island Health Islands Declaration 1995 was facilitated strongly by the assistance of the Australia: South Pacific Islands Health Islands Health Promotion Project 1995 – 1998. It was also responsible for the facilitative mechanisms that provided the strong local drive to learn, understand and apply the Rarotonga Agreement 1997. All these were assisted through a capacity building development for the staff of the Department of Health, Health Education and Health Promotion Services (HEAPS) who in turn advocate the vision at all levels.

1.2 The Australia-South Pacific Islands

1.2.1 Healthy Islands Health Promotion Project (HIHPP)

This project derived from an Australian Government response to a growing concern amongst Pacific Island Countries Health Ministers and officials about the increasing prevalence of non-communicable diseases. Five Island countries namely Samoa, Cook Islands, Niue, Tuvalu and Kiribati were selected to work in partnership with VicHealth in Melbourne and the School of Medical Education, University of New South Wales (UNSW) in Sydney; to develop and implement an integrated regional health promotion program.

The project aimed at assisting the implementation of the recently adopted Yanuca Islands “Healthy Islands” Declaration, in which it is recognised that health issues must be understood in holistic terms and that health promotion interventions must be integrated across sectors for successful outcomes.

The projects founding principal is to promote the concept while providing sustainability of effort through the building of health promotion capacity at the institutional level and at an individual level.

1.2.2 Project objectives

- To assist the development, integration and implementation of the health promotion concepts outlined in the Yanuca Island Healthy Islands Declaration

- To build capacity for integrated health promotion strategies by working with a range of people in localised settings
  - Initiating local consideration of existing VicHealth conceptual and practical health promotion models
  - Developing conceptual understanding of health promotion models
  - Building the capacity to develop local health promotion models
- Trialing on a restricted scale practical integrated programs based on locally developed health promotion models

- Facilitating transfer from local models to full-scale healthy island programs.

- To build capacity in participating NGO's to seek advise funding for future health promotion work from government and private aid donors.

1.2.3 The components

- Formalisation of collaborative relationship and level of support at institutional and community level

- Education and training of "gatekeepers" within three settings - sports, churches and schools

- Development of setting - specific initiatives

- Evaluation and dissemination of the program

1.3 A Samoan Perspective

Samoa's participation started off as a passive partner of the consultative communications from Australia in April 1995. A former teacher of the writer made initial contact from the School of Medical Education at the UNSW. Support was sought for a joint proposal submitted between the UNSW and VicHealth in Melbourne to the Australian Agency for International Development (AusAID). A regional project on "Healthy Islands Health Promotion" was in the making.

The Department of Health's (DOH) support was successfully facilitated. The Director General of Health (DGOH) agreed that Samoa would benefit long term. Between the DGOH and the writer as Chief Health Educator, a strong commitment was made to strengthen the health education and health promotion services (HEAPS) in Samoa through whatever assistance that would come our way. Building on that commitment was the willing assistance of the Australia-South Pacific Islands HHPP staff. Official word from the VicHealth Project Manager was received on 9 August 1995 to convey the start of the chain of events. However, Samoa did not get to benefit from the cash flow until 1997.

A team of four Australian experts arrived on December 1995 to conduct a field analysis in the five selected islands. Their documented perception of the health education and health promotion situation in Samoa angered us. There were both misconceptions and mistakes in their written report about key players, the local situation and our potential for the future of which the project had to address. As a result, Samoa decided to undertake the project activities according to our preferred framework, focus and direction.

The framework we use is Samoa's Model of Learning. This model depicts the essence of culture that emanates from dialogue, openness, timeliness, participation and many other values that are Samoan in nature. It reiterates the strength of our reciprocal culture "faasomao", our identity, language and family values. The structure of our Samoan "fale" is symbolic of many things. Like in any traditional society the traditional components make and break any well-meaning developments. So culture needs to be an integral aspect of the project.

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The roof represents Samoan culture and its key role to protect. The upper house with its interwoven composition reflects society itself and its complexities. The folded blinds represent silent beliefs in the unseen gods and their spiritual presence. The open structure with posts linking the upper fale to the foundation represent the transparent nature of Samoan dialogue; that has no time limits so as to allow each family member the benefit of the doubt. The posts also reflect the connections and linkages in different contexts. The circular shape allows for collective participation, whilst the solid foundation represents the strength of community solidarity. Samoan knowledge, language, and identity through genealogy plus family connections are openly discussed in our open fales.

This was our framework. We decided to give it justice. We refused to conform to the VicHealth Model. We were willing to learn from it but we were not adopting it in totality.

At this point in time, the DOH's HEAPS was already working on the promotion of the Healthy School Setting. The WHO in its preaching, was adamant that Pacific Island Countries (PICs) in the Western Pacific Region should try to translate the key themes in the New Horizons in Health 1995, which are the “preparation for life” and “protection of life”. Preparation for life identifies Health Promoting Schools (HPS) as one of the principle strategies in attaining good health.

When the Australia-South Pacific Islands HIHPP started, it was therefore most appropriate to link the two, as the two concepts identified “health promotion” as the principle focus. Hence, Samoa's decision to use HPS as its entry point for this particular partnership was reaffirmed.

1.4 How Project Activities Were Developed

Before the Australia-South Pacific Islands HIHPP began, the country's health education and health promotion activities were mostly funded by WHO, Hanns Seidel Foundation (a German agency) and the South Pacific Commission as it was called then.

The project activities were obviously developed to happen at different levels. There were the Australian based activities like the initial negotiations, organisation and administrative
tasks. Likewise the consultancy work by the Australian based partners around the region were significant developments.

Again for Samoa, the project activities started off on a slow and passive nature. Communications from Australia on April 1995 introduced the idea. Then there was the field analysis undertaking by the Australian team. Samoa was then asked to nominate a Country Coordinator who was the writer (thanks to the DGOH for the vote of confidence). A Partnership Forum for all Country Co-ordinators a year later on the 15-19 April 1996 facilitated the development of country specific plans of action. Samoa then re-emphasised Health Promoting School as its entry point for the project.

Samoa's intention was clear. The project would help resource a lot of existing activities. There was no plan to expand or attempt any new activities, as the decision was to have the project improve, strengthen and enhance already existing activities. Assertion was made about the professional ability of the HEAPS staff, who could comfortably continue the project's identified direction. This professional claim was both loud and quite stubborn. The importance of traditional learning tools was also advocated as the preferred methodology to use. The Australian partners willingly supported Samoa, in attaining its project objectives on that understanding.

Most of the project activities were very much locally driven. They permeated from the linkages that were already made between HEAPS and other local partners. Some of the activities were initiatives of sports leaders, church youth group workers and other community field staff.

Capacity building and health promotion advocacy were HEAPS' staff priority tasks. Through this, we were able to provide the supportive mechanism and direction to our local partners. The objective was to make the linkages between the different health initiatives that the many different sectors were doing. We shared ideas, resources and power on a sub contracting approach.

1.5 Activity Implementation

Activity implementations were guided by the five action based components of the Ottawa Charter on Health Promotion, 1986. There was a real attempt to facilitate the development of public health policies that will empower the general public to sustain good health practices. For example, the DOH worked hard on its Food and Nutrition Policy, which was finally endorsed in 1996. Efforts on the Tobacco Legislation facilitated an increase in excise duty and tax although the legislation is not yet passed. Creating supportive environments was encouraged. The smoke-free advocacy dwelled on positive settings. Communities were also encouraged and assisted to strengthen their already existing actions. The DOH HEAPS staff lobbied hard for the department to accept the principle of sub contracting activities, associated costs and responsibilities. Capacity building to enhance personal skills was a major aspect of activity implementation. There was a bold and strong push to have "health promotion" included as one of the principle values of the Health Sector Strategic Plan 1998/2003; so as to reorient health service focus from the disease centred approach to a positive health model.

With the growing number of enthusiastic local partners, the DOH was able to effectively play a co-ordinating and facilitative role at all levels. Youth to youth outreach activities were implemented in close collaboration with pastors of the different congregations in the rural villages. The village pastors organise the mobilisation of people to gather at selected venues, whilst the HEAPS staff provide transport, food and capacity building for the youth to conduct outreach activities.

The sub contracting approach involved lots of negotiations, budgetary preparations, debates, arguments and most importantly the development of Memorandum of Understanding.
(MOU), between the DOH and local partners. These were jointly developed, signed and actioned.

Government and non-government organisations (NGOs) were encouraged to organise, promote, implement and evaluate their own activities. The MOU took care of the roles and responsibility that the respective sectors undertake.

The Australia-South Pacific Islands HIHPP gave Samoa an annual budget of A$20,000. It funded the activities, which marked the local transition from school health education to HPS. It also enabled the department to undertake a wide range of activities, implement its subcontracting approach, conduct capacity building training processes, strengthen linkages with local partners, pursue some successful health promotion campaigns using social marketing, initiate youth to youth health social community outreach, build the DOH public profile, resource sporting bodies which join the smoke-free advocacy and of course pay the writer's allowance as Country Coordinator. The project also enabled local staff to undertake capacity building training overseas. A most significant capacity building costing was the one provided to allow young DOH staff who work as kitchen hands, groundsmen and casual workers to go to Vanuatu and Fiji to learn professional drama production and puppeteer work. These young unskilled casual workers make up the DOH's youth to youth group, and would never get an opportunity for training in their area of service.

1.6 People and Sectors Involved

There were so many people involved. It all started with the HEAPS staff and the project partners in Australia. Their combined energy, enthusiasm and knowledge did the DOH well (and proud). They facilitated the committed involvement of the political leaders. The Minister of Health had no hesitation in becoming the most influential health promotion change agent. His eloquent advocacy filtered through to his ministerial colleagues and strong opponents.

The DGOH himself became a faithful convert from his natural disease-centred orientation to health promotion. There was clear political support from this level. However, this was not enough. Most of the management leaders within the DOH do not really understand and or support health promotion in its true sense. With the exception of the Director of Nursing and perhaps one other, there is definitely a need to undertake a thorough re-orientation of health services for the rest of the staff.

By the end of the project, the DOH had established committed partners within its own structures and with other government sectors and NGO. The HEAPS staff facilitated the strong participation of the Nursing Division, the Dental Health Division, the Clinical Health Services and more importantly its own division colleagues from the Nutrition Centre, the Environment Health Section and others.

The partners from government sectors included: the Department of Education, the Accident and Compensation Board, the Ministry of Women Affairs, the Treasury Department, the Public Service Commission, the Department of Lands, Survey and Environment, the Ministry of Youth, Sports and Culture, the Department of Agriculture, the Ministry of Transport, the Fire Brigade, the Police, the Department of Broadcasting Services and the powerful Televise Samoa Corporation.

Partnership with the noted NGO like the Samoa Rugby Football Union, the Samoa Red Cross, the YMCA, the Family Health Association, the Prevention of Alcohol Abuse Society, the Religious Youth Group Organisations from different congregations, the Family HAVEN Association on Violence Against Women, the Women’s Committees Development Association, Old Student’s Associations, Sporting Federation and various sporting bodies.

The Department of Health community outreach was not only enriched but also strengthened through the project resources.
1.7 Support from National Government

The Samoan Government Stated Economic Strategy (SES) 1998/1999 in its vision stated that:

"Samoa [is] to lead the region in structural and public sector reform, good governance and increasing per-capital incomes, growth in employment and improved health and education standards while incorporating social and cultural values and environment sustainability".

This government SES is of significant importance as it reaffirms the government's commitment to intensify health promotion and disease prevention. Government increased excise duty and tax on cigarettes and alcohol in response to the health promotion advocacy. It recognised the pro-active nature of health promotion initiatives and made special reference to the DOH's Healthy Islands initiatives towards the next millennium.

On the department level, the DOH had for years referred to the Primary Health Care (PHC) principles as the guiding basis of health care delivery. The writer with the HEAPS staff challenged the DOH to revisit their traditional PHC basis in the context of the new public health movement. The idea was not accepted immediately. It encountered much reluctance as management staff in the DOH felt that the concept was already included.

In the end "health promotion" was not only included in the context we advocated but it also became one of the two key principle values: in addition to PHC for the HSSP 1998/2003. This was indeed a reflection of forward-looking vision and we in HEAPS perceived it as a guarantee for sustainability.

Further government support was reflected in the local budget, where the DOH HEAPS sub output provisions included costs for some of the HPS and Healthy Sports activities. There was also an increase of the HEAPS overall budget from the midget figures of previous years. The progressive growth and developments of HEAPS staff during this period was another clear reflection of government and department support.

1.8 Resource Requirement

This is the difficult part. Resource requirement is endless for long term initiatives. At this stage, the writer feels that the most needed resources for Samoa's Healthy Islands efforts to be maintained is Human Resource within the DOH. Practically all of the trained and qualified staff in HEAPS who had both understood and advocated the practical translation of the concepts, have left. The DOH will need to quickly replace these staff in order to sustain the coordination work that has been established. It is important to continue working with local partners in the healthy sub settings identified.

There is also a need for the DOH to continue the sub contracting approach it started within the conditions of the MOU signed. Those MOU obligated the different partners to continue the health promotion work on their own costs. A lot of innovative activities were initiated. These need to be sustained by government through staff, provision of necessary resources and technical assistance.

1.9 Success Stories

(1) The work undertaken in the HIHPP are good examples of the way in which the established local initiatives in HPS can be strengthened and further developed? The project triggered significant awareness of the healthy settings concept in a broader sense.

(2) The proven ability of local staff in translating and applying the Healthy Islands vision within the context of the health promotion concept. It assured maintenance of cultural sensitivity, which is fundamental to both health promotion and societies involved.
(3) Ability to work with diverse groups of government sectors, NGO and community groups in the implementation of the project and department objectives. There was a strong determination on local integration and collaboration.

(4) Much inter sectoral work and strategies were achieved, thus increasing community participation. This took away the didactic approach that is typical of health care delivery.

(5) The inclusion of "health promotion" in the HSSP 1998/2003 has ensured ongoing capacity building, better understanding of the concepts and sustainability. The quest for a Healthy Samoan Island further values the health promotion principles and philosophy.

(6) The project advocated more awareness and application of the "Health Model" as opposed to the 'disease centred" orientation, which equated lifestyle to health promotion.

(7) The successful facilitation of the other sector’s participation in the Healthy Islands quest resulting in them taking over responsibility for the various sub settings. Health has become everyone’s business and everyone’s responsibility. It was once everyone’s business but the Department of Health’s headache.

(8) The establishment of the Samoa National Council on Health Promoting School (NCHPS) which the DOH and Department of Education had jointly developed. HPS in Samoa is now the prime responsibility of the NCHPS, which comprises of 30 government and NGO. The council has developed its policy document and plan of activities. In addition to that the Foreign Affairs Department informed the council this month (12 Feb. 1999) that AusAID is funding the HPS developments for the next two years.

(9) The establishment of the Healthy Homes and Healthy Villages Working committee with the Ministry of Women Affairs as the focal point for this sub setting. There is hope of making the working committee a national council like the HPS in the future. Protocols and terms of references are yet to be developed.

(10) Capacity building for DOH staff on the development of health promotion indicators had fulfilled an evaluation recommendation on this matter. Questionnaires were then developed to translate the identified indicators for evaluation purposes. This was done to evaluate HPS, Healthy Homes and Healthy Villages sub settings. Results have been fed back to the participating schools and villages.

(11) It provided forward looking benefits and opportunities for other sectors, which by tradition do no get recognised for the health services they provide. For example, the sub setting approach brought to attention other related issues with significant social importance.

(12) The HIHPP finally recognised the capacity of country partners to provide technical assistance to other neighbouring PICs. This was the climax of partnership.

1.10 Why Success was Successful

   It is strongly believed that the success permeated from the commitment of the key staff to create health and partners in health. The high public profile which the DOH enjoyed attracted interest among some influential local partners with similar agendas. It is also important to acknowledge the empowerment of local staff by government, DOH leaders and more specifically the contribution of International Agencies like WHO, AusAID, SPC and others. The capacity building make the organisation and individual performances more credible, relevant and successful. This empowerment of local staff filtered through to local partners who in turn passed it on beyond the initial visions.

   Likewise the success road was further enhanced by the ability of the key players in the DOH to let go. Sharing ideas, resources and power made a major contribution to the success
achieved. Without that the DOH would not have succeeded in facilitating support in the sub setting approach.

1.11 The Downside

(1) There was always the tendency of resorting back to the disease-centred perception as the way of providing health services.

(2) There was a significant time lapse from when the project was introduced and when the cash flow started arriving in country.

(3) The conceptual shifts confused some and it affected application. It was not easy trying to explain to people that HPS and Healthy Islands strive for the same outcome although the other is the Big Picture whilst the other is the sub picture.

(4) The Healthy Islands vision was not well explained to local staff after the PIC leaders agreed on it. It did not get integrated well enough in the basic planning by donors.

(5) The issue of sustainability is not guaranteed due to loss of key staff from the DOH HEAPS. The withdrawal of resources and technical assistance at a time when the impetus of Healthy Islands and health promotion is just beginning to impact and gain momentum nationally.

(6) There is frustration at donor's capriciousness. Their "stop start" and "start stop" approach is quite demeaning at times. Increasingly, Samoa as a small country is tired of getting switched on and off at the donor's peril; after all beggars can have a choice.

1.12 Lessons Learned

(1) The DOH can never advocate and or undertake health services on their own.

(2) Good sincere partnership involves sharing ideas; resources and most importantly POWER.

(3) Good technical assistance is a positive capacity building process with long term benefits.

(4) PIC as partners can call the terms for help. It is no longer enough to just stay back and complain. It is both a misconception and a cop out to claim that PIC is just following donor conditions.

(5) Country Co-ordinators for any Healthy Islands program should be able to link up most if not all of the incoming assistance from the different agencies. We were able to do that in Samoa to enhance our own efforts, direction and perspectives. One of its benefits is the ability to bring International Agencies to jointly contribute to something that they are all doing under different packages. More importantly is the fact that no one agency can claim the merits of success as solely their own.

(6) The test of all good innovation is the ability to sustain it. The eventual take over of governments is very much dependent on the skills and ability of key local players to facilitate awareness and action.

(7) Traditional learning methods are enhanced in their effect by the modern social marketing strategies and vice versa.

(8) One of the great lessons learnt is the ability to make the most of technical assistance so as to learn. To top off that learning is the ability to practically apply it all.
1.13 Activity Evaluation

Although evaluation was an integral component of the project activities; it was apparently not good enough for the team of Australian evaluators who conducted an end of project evaluation on December 1998. There were the clear statements directed at the difficulty to assess activity impact, level of effective application of skills and information learnt by people trained under the project. It was felt that some limited impact evaluation of aspects of the activities implemented should have taken place. We believed that impact evaluation was already reflected in the success of the processes undertaken and by the number of local parties participating in the movement. Still this was an area, which we were found to have lapsed in, as we did not clearly document our evaluation attempts.

The project was responsible for the assistance given by Dr Jan Ritchie of the UNSW to help local staff develop health promotion indicators for evaluation purposes. The outcome of this process resulted in two undertakings, which involved the evaluation of our HPS developments and Healthy Homes plus Healthy Villages settings.

AusAID conducted a major evaluation of the project on December 1998. The result was a recommendation to end it.

1.14 What of the Rarotonga Agreement, 1997

Samoa has not established a National Healthy Islands Co-ordinating Committee. It has attempted it through the settings approach with a national body responsible for each sub setting. This approach is working for us and it is our way of achieving the Healthy Islands dream. We have developed many partnerships through this way.

1.15 Conclusion

The Australia: South Pacific Islands HIHPP did much to create significant actions in Samoa to translate the Healthy Islands vision through health promotion. However, the decision by AusAID to end a project that was impacting positively in Samoa was perceived as a penalty for doing it well.

The HIHPP success was an extension of the work by many other donors with the WHO as a leader. It is therefore appropriate to conclude this case study report by naming the noted contributors to Samoa’s efforts to date. Our “Health Promotion towards a Health Samoan Island” friends are listed below not in any order of importance:

Barbara Spalding – HIHPP Team Leader, VicHealth Melbourne
Dr Rosemarie Erben – Former Regional Adviser on Health Promotion, WHO
Dr Jan Ritchie – Senior Lecturer, School of Medical Education, UNSW Sydney
Josephine Gagliardi – Health Promotion Specialist SPC
Heather McDonald – AusAID
Prof. Arie Rotem – Director of the School of Medical Education, UNSW Sydney
Prof. Paul Zimmet – Executive Director International Diabetes Institute, Melbourne
Prof. Don Nutbeam – Director of the School of Public Health, University of Sydney
Judith Perrin – Former Team Leader HIHPP, VicHealth Melbourne
Rhonda Gallaby – Former Executive Director of VicHealth Melbourne
Isabelle Henry – Team Leader Pacific Islands Diabetes Project

Dr Harley Stanton – Director of Health, SDA New South Wales Tobacco Project

WHO Staff WR Office Apia, Samoa plus all our PIC friends whose names we need not mention

Finally it is strongly believed that Samoa’s sub setting approach will take the Health Islands vision to the next millennium.  SOIFUA!!!

1.16 List of References


HEAPS Strategic Plan 1997/2000

WHO:  New Horizons in Health 1995

The Yanuca Island Declaration, 1995

The Rarotonga Agreement, 1997


Samoa:  National Council on Health Promotion in the South Pacific

SPC:  Health Education and Health Promotion in the South Pacific Islands – The Noumea Declaration, Feb 1997

Health Promotion for Healthy Islands, 1998


Samoa’s National Plan for the Translation of the Yanuca Island Declaration and Rarotonga Agreement
2.0 Supplementary Information on the Samoa Healthy Islands Case Study

2.1 Overview

There is no formal National Healthy Islands co-ordinating mechanism within Samoa. There is a national settings mechanism for Healthy Schools and there is also a working group for Healthy Homes and Healthy Villages. These could evolve into a national council for Healthy Islands. There is also a working group for Healthy Hospitals and a small committee composed of the Department of Health and the Accidents Compensation Board working on Healthy Marketplaces.

There is a Healthy Islands Plan of Action for Samoa which has been submitted to the World Health Organization.

Political support for the Healthy Islands approach is clearly evident in Samoa. The Healthy Islands commitments were officially launched by the Department of Health and the principles of the Healthy Islands approach were clarified regarding the role of health promotion officers. All stakeholders with a health promotion mandate were invited to participate in a one week process sponsored through AusAID and VicHealth. A Ministerial award system has also been started to recognise good health promotion work in Samoa. The Minister contributes trophies and money to recognise pioneers in health promotion within the Healthy Islands framework.

2.2 Initiation

The initiating forces for the Healthy Islands activities in Samoa were really the partners in Australia who had been involved in the process. Samoa didn’t know till it was informed that it was selected to be a ‘Healthy Island’. This particular case study was initiated at the request of the World Health Organization. In retrospect, it is felt that a better job could have been done in promoting the principles of the Healthy Islands approach in Samoa. What was lacking were leaders who were pro-active and who could have advised appropriate staff of the need for action.

The process of applying the Healthy Islands principles in Samoa is one of evolution. Samoa was not prepared to adopt what was seen as an inappropriate model developed in a different culture so they developed their own distinctive approach that roughly conformed to the parameters set down in the VicHealth model.

2.2.1 The Political Context

The political context at the beginning was very much one of the Department of Health acting in isolation, with the Minister of Health making the broad agreement and the Director General of Health enforcing it within the Department. All the activities were initially confined to the Department of Health. The Health Education and Promotion Service (HEAPS) gave permission to make it multi-sectoral. This was achieved through a Smoke-Free Sports Tournament in co-operation with the Education Department and the Samoa Rugby Football Union headquarters.

2.2.2 The Social Context

Within the community, Healthy Islands had no meaning in the beginning. It was only when the Healthy Village setting was translated that it began to be understood. Realisation slowly dawned on them that quality of life activities could be a part of the Healthy Islands approach. Then came a process of labelling what the community had already been doing to look after the local environment as Healthy Islands activities. A great deal of new work was facilitated through the approach. Within government departments there developed a long-term, inter-departmental vision of reinforcing the ongoing activities and linking them to the Healthy Villages approach.
In Samoa, the responsibility for kitchens, toilets, shelters etc is with women. The Ministry of Women's Affairs is the current 'home' of the Healthy Islands approach as it is ideally placed to deal with women and issues of wellness. The Department of Health continues to have more of a disease focus. There is ongoing debate over who should be doing health promotion. Lately everyone wants to be doing it but not everyone understands the concepts. The Ministry of Women's Affairs may be a champion of the Healthy Islands approach instead of just another partner. The HI approach is not completely embedded in the culture. The Department of Health still feels that it has rightful ownership over Healthy Islands concepts and approaches.

2.2.3 The physical environment

Particularly in schools with a Health Promoting Schools concept there is a great deal of emphasis on physical environment as one of the major components of the concept. Teachers have realised that they can control the environment and work on it for the benefit of the students and themselves. For the Healthy Marketplaces activities the Accident Compensation Board, as owners, chose to first give a face lift to the marketplaces. They re-did all the basic amenities where produce and handicrafts are sold. They cleaned up the places that shoppers eat and the places where they buy food. The marketplaces were fully renovated in 1997 with new tables, carpet, new hygienic standards, regular daily inspections, and food handling and preparation standards.

Within the Healthy Villages and Healthy Families activities the central focus is on the physical environment.

2.2.4 The setting as a whole

The World Health Organization's idea of a Healthy Islands Council couldn't be complied with immediately due to the fact that so many other 'Healthy' settings structures were already in place. It was determined that the Healthy Islands approach would be applied across the existing councils. It is hard for the coordinator of the project to imagine a single nation coordinating body because each of the settings has its own focus and its own committee. They now work together and complement each other rather than competing with each other.

The Healthy Islands activities in Samoa could only be classified as a demonstration of political will if one can call the Department of Health's commitment such a demonstration. The signature of the Minister on the Rarotonga Agreement had no impact in Samoa. Departmental staff were unaware that the agreement had even been signed for some time after the signing. It was almost as if the document was signed and then forgotten. If it were not for the other settings approaches already in place it could well have been forgotten. However, when the Government realised that the Healthy Islands approach could be applied across existing programs, they supported it.

The attitude of community members was initially one of reactive response to the project proposal rather than proactive. It gradually shifted to a more community centred approach.

2.3 Process

Leadership for the project activities was initially provided by Health Education and Health Promotion Services (HEAPS) in the Department of Health. On a personal level, leadership was provided by the project coordinator.

Community involvement was a key feature of many of the activities undertaken under the Healthy Islands banner. It is useful to keep in mind, however, that the Healthy Islands approach and its associated funding would help resource a number of activities that already existed under other contexts including other healthy settings. Much of the community involvement was through existing organisational structures such as religious organisations, women's organisations, youth organisations and sporting clubs.
Partnership approaches were used in all of the activities and inter-sectoral collaboration was encouraged. Included among the partners were the community groups listed above, NGOs such as the Samoa Red Cross, the YMCA, the Family Health Association, the Prevention of Alcohol Abuse Society, the Religious Youth Group Organisations from different congregations, the family HAVEN Association on Violence against Women, the Women's Committees Development Association, Old Student's Associations, Sporting Federation and various sporting bodies.

The activities of the project were supposed to be action oriented with clearly defined outcomes and indicators of success but they didn't always turn out to be. The activities were implemented with very general outcomes initially. As the program developed the activities became more outcome oriented. The activities evolved into a much more indicator-oriented process in the end. Evaluative aspects of the Healthy Islands approach have provided useful lessons for other settings.

In Samoa the community was not involved until a fair way into the project. In the early days the agreement was signed at a high political level, but nothing really happened. After a while, HEAPS staff became aware of the need for activities following international pressure for project work. The community consultations took place roughly one third of the way into the process through the development of Healthy Schools, Marketplaces, Villages, Homes and Families initiatives. Again, a valuable lesson was learned from this and now it is considered essential that communities be consulted very early on when planning a healthy settings activity.

Sectors that participated include Government, NGOs, Community organisations, sporting organizations, and religious organisations. As HEAPS developed and promoted activities under the Healthy Islands banner, people wanted to come on board. An example is the School Boys Rugby Union coming to HEAPS staff and asking if they could participate in the Healthy Schools activities. A memorandum of understanding was signed with partners and funding was subcontracted to organisations for leading and managing specific tasks and activities. This helped to ensure sustainability as the agreement stipulated that the organisations would receive funding for two years, then would be expected to fund the work themselves. The School Boys' Rugby Union continue to participate in the Healthy Schools activities but are no longer receiving any funding.

Arrangements were negotiated between partners and departmental staff. Because the range of activities undertaken was so broad and the partners so diverse, there was not a central decision making mechanism that brought them all together. Representatives of various sectors and partners took place in committee meetings as required.

The only catalyst that had much impact was really the personal commitment of the coordinator and HEAPS staff. Once the financial capital was invested there was visibility for the project and that helped generate interest and enthusiasm.

Examples of empowerment come from NGOs as partners as they grew more confident about doing health promoting activities. Most had never done these kinds of activities before and were empowered by their success.

### Outcomes

Policy outcomes that resulted from the Healthy Islands activities includes changes to the Department of Health's Food and Nutrition Policy and efforts to change Tobacco Legislation (as yet unsuccessfully). Smoke-free advocacy has also resulted in greater numbers of people choosing to implement smoke free workplace policies.

Lessons learned about planning include that it has to be a lot more open and truly involve the stakeholders. Prior to this project, planning was undertaken within the Department of Health. It has now been broadly acknowledged that for plans to be effectively realised, they must be developed inter-sectorally and through broad consultation. Co-ordination of the
activities is enhanced by better networks and a commitment to communicating the highs and lows of project activities to all partners. Justice must be done to co-ordination or the activity is doomed to fail. All partners must be willing to share information and resources. Though it was a tough lesson to learn, it was found that there were great rewards in letting go of some of the power and of some of the funding.

Standard practices that were changed include decreased levels of smoking, increased development of partnerships to deal with health issues, broader adoption of healthy settings approaches across Samoa and better networks for mobilising responses to health issues. By providing people with an opportunity to participate and an improved network, the Healthy Islands project assisted all the partners by giving them the means to solve problems more creatively and collaboratively.

Supportive environments were created particularly in the case of the Smoke Free campaign. There are now more smoke-free environments and there is more support in the community for non-smokers. Schools are providing shade, planting trees and beautifying their local environments. The sea wall was also improved with a footpath for walkers being developed. It is difficult to isolate and identify other supportive environments as the activities carried out were so broad and the supportive environments are more an accumulation of small supportive elements rather than dramatic transformations.

Lifestyle changes brought about by the activities include increased walking for exercise, a decrease in the number of smokers, and improved eating practices. An example of the latter is that paw paw and coconuts are no longer perceived as inferior foods. The project took on these conceptions in the community and people are now re-adopting the use of these traditional foods. More fruit is being served and other healthy foods are being served instead of unhealthy high-fat and high-salt foods. The project attempted to facilitate a better approach to vegetable gardening and statistics show far more families growing their own vegetables since the project. This influences the lifestyle of the families through their dietary practices. Schools have implemented policies whereby high-sugar products such as ice blocks are no longer sold at the school canteens and locally grown food is more readily available there.

Health Promoting Schools training reoriented teachers to take on the school nursing role and provide more health services in schools. There has also been a move by nurses to utilise previously unused health centres for multiple purposes; translating a clinic to a community based centre. This gets exercise going across a broad sector of the population. It also represents a shift toward health promotion and away from a curative medical focus.

Formal evaluation is taking place in the Healthy Schools setting and in the Healthy Villages and Healthy Homes settings. Base line data is being used for evaluation. The outcomes are being revisited though the indicators and evaluations. The process of developing indicators was a major development for many working in the Healthy Islands approach. Developing settings-based indicators was very useful.

WHO has taken over the costing of expanding the activities to homes and villages. This represents a major enabling condition for sustaining the work beyond its initial phases. This funding also allows for the expansion of numbers, situational analysis, and community based capacity building for women.

The project resulted in a great deal of learning and capacity building for key staff as they practically translated the principles to multiple contexts and spread the work further. There was a greater and more comprehensive understanding of health promotion and an improved ability to translate it across all settings and sectors, not just in 'health' contexts. There was also a gain in that this activity provided an opportunity for the Samoan context to be explained to donors and for clarity of direction to be determined as a result.
Since the project has finished there are more people talking about healthy settings approaches. The impact has been delayed but it is still quite strong. More transition time could have led to greater rewards. Samoa felt that the approach was an imposition initially as it appeared that the activities would be donor-driven from start to finish. The conclusion could have been seen through longer for greater results and improved sustainability.
Towards A Healthy City - Malaria Control Program In Honiara
Author: Dr Dennie Iniakwala

1.1 Background

Malaria remains a very significant public health problem in Solomon Islands despite three decades of control effort. A National Malaria Conference held in November 1991 marked the commencement of a new era in malaria control in the Solomon Islands. Following the conference malaria operations were decentralised and a new national malaria control policy was drafted. This Policy was subsequently approved by the Government in July 1993 and based on that a National Anti-Malaria Plan of Operation for 1994-1998 was prepared and approved. The declaration of Malaria Action Year – 1994 further demonstrated the firm commitment by the Government for the control of this disease.

In 1995, on the basis that one third of all reported cases come from Honiara, an intensified campaign to reduce malaria was launched there. It made use of a variety of control measures including residual spraying, ultra low volume spraying, mass blood examination and treatment, mass drug administration, insecticide treated mosquito nets, environmental modification, larval control, and surveillance.

Implementation of the national five-year plan has progressed as anticipated with most of the objectives already achieved. For five consecutive years there has been a reduction in cases of malaria and a workable and sustainable program for malaria control has been established.

The dramatic reduction in malaria during the last five years of the national plan of action could not have been achieved without the support of the many local and international partners who have collaborated and contributed to the anti-malaria program.

1.2 Overall Objectives

1.2.1 To reduce clinical malaria and prevent mortality by providing early diagnosis and effective treatment of all suspected or confirmed cases; and

1.2.2 To reduce malaria morbidity, hence the incidence of cases, through feasible and appropriate vector control interventions which are effective and sustainable.

1.3 Honiara Town

<table>
<thead>
<tr>
<th>SUMMARY: CONTROL INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Incidence Rate: 264/1000 population</td>
</tr>
<tr>
<td>Percentage of P.falciparum: 46%</td>
</tr>
<tr>
<td>Slide Positivity Rate: 15%</td>
</tr>
</tbody>
</table>

Honiara, the capital of Solomon Islands, on the island of Guadalcanal, has a multi-ethnic population of 66,507 in 1997 living in approximately 8,000 households. The town is made up of 88 localities within a total land area of 22 square kilometres and is densely populated with over 3,000 persons per square kilometre (as compared to 180/sq km for the country). The population is highly mobile with large numbers of people constantly moving between the capital and their original home islands for employment or in search of better life. About 60%
of the people in Honiara are temporary residents as most of them maintain strong ties to their home village and clans. Malaria continues to be the main health problem in this town.

Emphasis has been given to establishing a sustainable malaria control programme. In collaboration with the Ministry of Health and Medical Services and the Honiara Town Council, an intensified malaria control programme has been supported by the World Health Organization since July 1995. The annual incidence rate of malaria has declined by 75% since 1992 through this intensified control initiative (Fig 2).

![Figure 2: Annual Incidence Rate of Malaria in Honiara](image)

1.4 Objectives

(1) To reduce malaria incidence in Honiara to less than 150 cases per 1000 by the end of 1997.

(2) To apply effective vector control measures.

(3) To establish an effective and sustainable malaria surveillance system that includes intensified case finding, treatment and follow-up.

1.5 Epidemiology

Figure 3 highlights the remarkable reduction achieved in the monthly incidence rate of malaria since the launch of the Intensified Malaria Control programme in July 1995. No seasonal peak was observed in the incidence rate unlike the previous years. A 45% reduction in the overall annual incidence rate was achieved in 1996 and a further 20% reduction was recorded in 1997 (Fig 2). The predominant parasite – Plasmodium falciparum has also recorded a significant decline from 65% to 46% during the same period. P. vivax on the other hand has not declined significantly which may be due to increased level of resistance to chloroquine and the failure of the drug to kill hypnozoites, the relapse stage of the parasite.
1.6 **Account of Control Activities**

1.6.1 **Case detection**

All the clinics and the National Referral Hospital in Honiara had microscopists to detect and confirm all the cases. A total of 102,252 slides were taken and only 17,569 (SPR 15%) were positive.

1.6.2 **Drug resistance studies**

A total of 25 *in-vivo* Chloroquine resistance studies were completed to assess the levels of resistance in *P. falciparum*. 5 cases (20%) were Late Treatment Failures while the rest were classified as Adequate Clinical Response.

1.6.3 **Quality control of slide diagnosis**

A sample of slides were collected from all the eight microscopists in town and these slides were cross checked by supervisors. Only 5.3% of the 208 slides cross checked were found to be wrong. Microscopists were then called for refresher courses during the year to correct their mistakes.

1.6.4 **Mass blood surveys /treatment**

Mass blood survey was carried out in the first quarter of the year. The programme targeted the population living in all the valleys and squatter settlements. The results are given in the table below:

<table>
<thead>
<tr>
<th>Total slides taken</th>
<th>Total slides positive</th>
<th>Slide positivity rate (SPR)</th>
<th>% <em>P. falciparum</em></th>
<th>% <em>P. vivax</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>18,922</td>
<td>2,118</td>
<td>11.2</td>
<td>49</td>
<td>51</td>
</tr>
</tbody>
</table>

1.6.5 **Surveillance activities**

Active surveillance activities started in January 97 after training twenty workers to cover all households in Honiara. They were assigned the task of taking blood films from all fever cases, visitors and those people who volunteer to have their blood tested. All the positive cases are subsequently treated and followed up for a period of one month. A detailed case investigation was also carried out to differentiate indigenous cases from imported ones. They are also encouraged to promote the usage of nets by distributing treated nets in the community.
Cases recorded in the clinics are also given to these workers for follow up. The total number of slides taken by the surveillance workers and their results are given in the table below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Slides Taken</th>
<th>Slides Positive</th>
<th>Slide Positivity Rate</th>
<th>Percentage of P. falciparum cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>438</td>
<td>81</td>
<td>18</td>
<td>40</td>
</tr>
<tr>
<td>February</td>
<td>3,110</td>
<td>584</td>
<td>19</td>
<td>57</td>
</tr>
<tr>
<td>March</td>
<td>2,662</td>
<td>300</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>April</td>
<td>3,690</td>
<td>314</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td>May</td>
<td>2,481</td>
<td>202</td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>June</td>
<td>3,351</td>
<td>243</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>July</td>
<td>2,781</td>
<td>213</td>
<td>8</td>
<td>46</td>
</tr>
<tr>
<td>August</td>
<td>2,454</td>
<td>197</td>
<td>8</td>
<td>39</td>
</tr>
<tr>
<td>September</td>
<td>2,631</td>
<td>208</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td>October</td>
<td>3,236</td>
<td>208</td>
<td>8</td>
<td>54</td>
</tr>
<tr>
<td>November</td>
<td>3,078</td>
<td>269</td>
<td>9</td>
<td>46</td>
</tr>
<tr>
<td>December</td>
<td>1,942</td>
<td>186</td>
<td>9</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>31,854</td>
<td>3,005</td>
<td>9</td>
<td>48</td>
</tr>
</tbody>
</table>

1,286 investigations were completed and the results showed that 24% of the cases were imported from areas outside Honiara.

1.6.7 Environmental management

The Mataniko River flows through the centre of Honiara, and villages to the east and west of this river have high incidences of malaria. During the dry season, flow in the river is severely restricted because of the build up of a sand bar at the mouth. This increases breeding of mosquitoes along the banks of the river associated with the extensive growth of weeds. A pipeline was constructed to control the breeding. The pipe allows the flow of freshwater from the river (and adjacent land drainage) to discharge readily to the ocean on the ebb tide and the following high tide brings in salt water and hence the salinity of the water in the mouth of the river increases to about 15 to 25 parts per thousand (the salinity of sea water is 35 parts per thousand). This tidal rise and fall and the two-way discharge of water through the pipe into river creates local currents and mixing, reducing the freshwater/saltwater stratification. This brackish water environment was less conducive to mosquito breeding with significant reduction in freshwater plants along the shoreline. Mosquito breeding was absent up to a distance of 2 kms upstream after the installation of the pipeline in April 1996.

1.6.8 River/Stream clean up and larviciding

The vegetation and solid waste clog the small streams, creating local micro-environment conditions conducive to mosquito breeding. These were regularly cleaned and on the main
river a flat-bottomed boat helped the operation. Over 60 breeding sites were mapped and monitored every week for mosquito breeding. 65,000 metres of drains were also monitored and sprayed with larvicides regularly.

1.6.9 **Ultra low volume fogging**

Three rounds of ULV fogging using Aqua Resigen was completed in April 97. Each round covered an average of 1,270 houses and consumed 14 litres of the chemical. Field trials using caged mosquitoes showed that this measure had a knockdown effect that significantly reduced mosquito-biting densities for a period of 4 days.

1.6.10 **Residual spraying of houses**

An annual round of indoor residual spraying of houses was done in April to May 97. The overall coverage has dropped to 78% from 88% in 1996. This decline in the level of acceptance was expected since the earlier round of spraying was done in October-November 1996. The overall date is given below:

<table>
<thead>
<tr>
<th>Population covered</th>
<th>26,870</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of houses</td>
<td>4,566</td>
</tr>
<tr>
<td>Total number of houses sprayed</td>
<td>3,353</td>
</tr>
<tr>
<td>Number of houses which refused the spraying operation</td>
<td>287</td>
</tr>
<tr>
<td>Number of houses found locked</td>
<td>508</td>
</tr>
<tr>
<td>Number of houses partially sprayed</td>
<td>160</td>
</tr>
<tr>
<td>Amount of Icon 10 WP used</td>
<td>280 kgs</td>
</tr>
</tbody>
</table>

1.6.11 **Distribution/retreatment of insecticide treating mosquito nets**

Several localities of Honiara were covered with ITMN during the first half of the year. A total of over 25,000 nets have been distributed since 1992. The retreatment rates were very poor in Honiara, ranging from 10% to 30%. The people preferred to purchase new nets rather than washing and treating the old ones. Several of these nets were taken to their respective villages in the provinces.

A cluster survey was conducted in early December to measure the coverage and usage of nets in Honiara. The nets were individually checked for number, size, colour, age, condition and the frequency of treatment. 210 households with a total population of 1,823 were covered by the survey. 13% of the population covered were less than 5 years of age. Major findings of this survey were:

- 55 houses (26%) had no nets;
- 409 nets were found meaning there were 1.9 nets per household and 4.6 people per net;
- 6% of the nets had never been used, 64% were in good condition and 30% were torn;
- 42% of the nets were less than a year old, 48% were between 1-2 years old and 10% were over 2 years old;
• Only 9 out of the 409 were retreated (2.2%);
• Of children less than 5 years old 57% slept inside nets while only 36% of the other age groups used the nets regularly.

The findings clearly indicated the need to improve the coverage of nets and the poor retreatment rates. It was encouraging to find greater use of nets by children.

1.7 Programme Management

The operations committee met every week to assess the progress of all control activities in town. Technical and other management matters were discussed and decisions taken to improve the implementation of these activities. The staff of the malaria programme regularly supervised field activities and additional casual workers were hired as and when necessary.

1.8 Partnership

The intensified malaria control programme in Honiara is an ideal example for joint collaboration between the Malaria staff of the National programme, town council and the World Health Organization. Other divisions within the Ministry of Health and Medical Services join the programme on specific assignments.

1.9 Conclusion

1997 ended with an impressive 20% decrease in malaria incidence over 1996. All indicators have shown a positive trend but more importantly there is a genuine feeling in the community that malaria is becoming less and less of a problem. The bednet survey has clearly highlighted the need to saturate Honiara with more nets. The retreatment technique and other social aspects inhibiting the re-dipping process will have to be assessed in the future.
2.0 Supplementary Information on the Solomon Islands Healthy Islands Case Study

2.1 Overview

There is not a specific National Healthy Islands co-ordinating mechanism in the Solomon Islands at present. Healthy Islands work is co-ordinated through the National Health Plan and linked to the National Health Education and Promotion Department within the Ministry of Health and Medical Services. Healthy Islands plans are incorporated into the National Health Plan rather than being separated as a distinct plan. Political support for the Healthy Islands approach is evident in that the government has made a commitment in Yanuca which the cabinet endorsed in 1995. This constitutes a demonstration of top-level endorsement. Health Promotion has been targeted as a priority and resources have begun to shift to this direction to some degree. An ongoing commitment to redirect resources, however, has not yet been demonstrated.

2.2 Initiation

One of the powerful initiating forces for this particular activity was the political need to introduce the concept of a Healthy Islands approach to the Ministry of Health and Medical Services and to the people. It was determined within the Ministry that the focus of this activity and the entry point for Healthy Islands would be through a malaria control activity.

In terms of the initiation of the activity in an applied way, the Ministry of Health and Medical Services (MOH) set the priority and emphasised the public health problems that arise from malaria. The activity was officially started on World Health Day with mass campaigns in the media. These campaigns introduced the Healthy Islands theme, specifically targeted malaria and helped to create a sense of urgency about this public health problem. Radio talk back shows were also used to increase awareness and create a forum for discussion of malaria.

2.2.1 The political context

The impetus for the approach and for the specific activity were both politically based as they came from the MOH. There was clearly support from the political players. This support was demonstrated through resource allocations to the activity (both human resources and financial ones).

2.2.2 The social context

Initially there was not much influence from the social context but this changed as the activity developed. Immediately following the media campaigns and radio talk back shows there was a heightened sense of awareness of the problem of malaria and mosquitoes. This awareness later translated into a willingness of people to participate in community clean up campaigns, mosquito net use and maintenance, and other parts of the activity.

2.2.3 The physical environment

As much of the problem with malaria relates to environments in which mosquitoes breed and prosper, the physical environment was crucial to this activity. Prior to the activity there was not a strong awareness of the connection between the physical environment and malaria. Through the activity it was possible to change both environmental factors that contributed to malaria, and the knowledge of the people about the relationship between the environment and malaria.

2.2.4 The setting as a whole

The activity was based in Honiara City and that setting as a whole was seen to be a complex one in which to attempt to alter the incidence of malaria. Compared to other village based settings the choice of Honiara City had more key players and stakeholders. This required a greater level of partnership building, consultation and participation across a broader range of
groups. It also meant that a broader range of participants were exposed to Healthy Islands concepts.

This case study clearly represents a demonstration of political will as it was largely politically motivated and was supported by political forces throughout. The Ministry of Health and Medical Services determined the problem, developed an awareness-raising initiative and drove the process of consultation and partnership building. An interesting aspect of the political will behind the activity is the absence of a single figure championing the Healthy Islands approach.

It can not be said that there was a strong community driven demand for the activity in Honiara prior to the selection of malaria control as a priority by the MOH.

2.3 Process

The Ministry of Health and Medical Services provided leadership for the activity. Within the ministry there is not an individual who could easily be identified as a champion or change agent for Healthy Islands. In spite of this, there was genuine commitment from the staff of the Ministry.

The activity was a very good example of community involvement. Included among those who participated were youth groups involved in clean ups of drains and bushes; women’s groups who sewed and treated bed nets; and local community members who were involved with the clean up of the environment.

A partnership approach was taken in this activity. Youth groups, women’s groups, local communities, private sector business organisations (engineers), local government, the Ministry of Health and Medical Services (members of the National malaria staff and other divisions) and the WHO were all enlisted as partners.

The activity was action oriented. Types of action included community based education and awareness campaigns, cleaning activities (environmental modification and larval control) and net making and treating. Other methods included residual spraying, ultra low volume spraying, mass blood examination and treatment, mass drug administration, and surveillance. A pipeline to provide an ocean draining point for the fresh water from the Mataniko river was also constructed as part of this activity. Outcomes and indicators of success were clearly set out in the National Anti-Malaria Plan of Operation.

Community involvement began formally with the foundation of the operations committee for the activity. This committee consisted of representatives from the MOH, a range of communities within Honiara, private sector and non-government organisations.

Within the MOH staff from different divisions were utilised for specific assignments in the activity (for example, epidemiologists used in surveillance, medical service staff used in blood screening and National malaria staff used for operational aspects of the activity.) Within communities, organised women’s and youth groups were mobilised and other members of the broader community were involved in clean up activities and surveys. Greater levels of participation among community members were achieved due to inclusion of community representatives in the operations committee.

All parties had representation on the operations committee. At meetings of this committee input was sought from all members. Issues were openly discussed and responses were sought to difficulties that arose.

The one event that could be referred to as a catalyst in terms of community awareness and commitment was the mass campaign on World Health Day. This led to discussion of malaria-related issues in communities and on talk-back radio. A sense of urgency and a need
for action was created by this campaign, making it easier to enlist community members for the work of the activity.

This particular healthy islands activity empowered members of the community as it raised awareness of risk factors of malaria and developed skills among community members to combat these factors. It further empowered community members and other partners both by providing a means for input into the process of addressing a health issue and by involving the members in a partnership approach that may be applied to mutual benefit in future activities. Donor partners were also well co-ordinated.

2.4 Outcome

Policy outcomes from this activity included changes in policy at a national and local level. Nationally a new malaria control policy that included an inter-sectoral and integrated approach was adopted where previously there had been a very top-down approach to malaria control that did not involve community members. The new policy creates links between local communities, local government and national organisations. It crosses health promotion, environmental health, and rural water supply and sanitation boundaries. The model has been considered a success and allows the development of further policies governing other vector-borne diseases. The model may also be applied in future to other policy areas including youth issues, drugs and substance abuse, STDs, tobacco use, and adolescent sexual and reproductive health.

The operations committee met every two weeks to assess the progress of all control activities in the town. Technical and other management matters were discussed and decisions taken to improve the implementation of these activities. The staff of the malaria program regularly supervised field activities and additional casual workers were hired as and when necessary. It was felt that this multi-sectoral committee was a very successful way of inviting input into the development of activities and dealing with any difficulties as they arose.

Standard practice changed in a number of ways as a result of this activity. Within the community there was a greater use of mosquito nets and higher acceptance of insecticide spraying of dwellings. The re-engineering of drainage from the river represents a major change in standard practice. The local council has taken responsibility for maintaining the drainage pipeline. Malaria case management has also changed. There is now a greater emphasis placed on access at the community level. Diagnostics take place in the community with analysis still being centralised. The results are provided to community-based malaria technicians who provide a more personal service. The co-operative inter-sectoral model with community participation has now become standard practice for dealing with health problems in the community.

The major impact on the problem solving abilities of the participating partners was the creation of a forum in which problems could be solved with input from all sectors. Increased knowledge and awareness of malaria breeding sites, transmission, and prevention provided individuals with more of the basic information they needed to solve problems around their homes and in their local environments. Government participants also benefited from the multi-sectoral approach as a broader base of expertise was represented in program activities.

Supportive environments that were developed as a result of this activity included the physical environment of many parts of the community as well as a social environment that encourages participation in a partnership approach to solving community health problems.

Community members also changed various aspects of their lifestyles. Many were initially resistant to the idea of sleeping under mosquito nets as this represented a major change to their lifestyle. Health educators acted to reinforce the need to sleep in mosquito nets. Community members started to accept the benefit of using the nets when mosquitoes were more abundant and when reports of incidence of malaria increased. Maintenance of net use in all seasons is an ongoing difficulty.
Another change that was important to address related to the re-treatment of the nets with insecticide. Many members of the community were reluctant to bring their nets into a public place to have them re-treated. The resistance to this was raised in the operations committee and an alternate strategy developed. The new approach involved the development of at-home treatment kits for families. This approach was far more readily accepted by the community.

Health services were reoriented to provide a more community-based face for malaria testing and counselling. The location of malaria technicians in communities was a change from previous practice. The success of the partnership approach and its subsequent broader application to other health problems also represents a shift in attitude on the part of the MOH and its staff. This shift is much more in line with the objectives of the Ottawa Charter than was previous practice.

There was no formal process evaluation of this activity. The results of the activity were reported in the Annual Report of the MOH with an outcome focus. However, malaria incidence is monitored on a monthly basis.

This activity acknowledged community involvement and helped to create a sense of responsibility amongst all stakeholders. Annual donor partners meeting assists in fostering this process. More specifically, people in the community see connections between sanitation and water supply now. This creates awareness and a sense of control for the benefit of the community.

The most important gain from this activity has been the creation of an environment where various groups in a community are brought together to address an issue. The results are not isolated to one group or area, they are disseminated broadly in the community. Activities are better co-ordinated and more people know what is going on and the sectors in which things are happening. Resources are used more efficiently. The activity has created a real sense of partnership in the process. There is greater commitment from Government to respond to community needs and there is a corresponding sense of ownership in the community and across the sectors that were involved.

Presentation of the results of this activity have aided in gaining commitment for other Healthy Islands activities across sectors. Honiara is now working toward becoming a Healthy City. Lessons learned from this approach in controlling malaria in Honiara will be used to address other health issues there.

It is of interest to note that malaria incidence is still dropping. In fact, it is at a record low since malaria data has been properly analysed. It is thought that this result may be due to the healthy islands approach in the program, especially in Honiara. A graph illustrating the decrease in incidence of malaria is provided on the following page.
MONTHLY MALARIA INCIDENCE IN HONIARA (1992-99)

- Reorientation of the Malaria control program
- Major Malaria public awareness Campaigns in Honiara
- Malaria control program in Honiara using Healthy Islands concepts
- Cabinet endorses the healthy islands concepts

Graph showing the monthly malaria incidence in Honiara from 1992 to 1999.
Case studies are concrete instances where specific activities or explicit approaches occur, with particular influence from, and interaction with, the local context. The term implies that the case or situation will be studied for what can be learned from the single event. In this report, five case studies are documented, each defined by the specific needs and opportunities existing in each situation at the time, and each similarly bounded by its local limitations. However, there is value in synthesising the messages exposed in each instance, drawing them together to search for commonalities and differences. This section of the report will attempt to draw on the five cases to expose what can be learned collectively, for the purpose of coming to some understanding of what constitutes working within a Healthy Islands framework.

1.1 Diverse Nature

At the time these five activities were planned and implemented, the Healthy Islands concept was at the stage of being a unifying theme, and no directions for action were as yet spelt out. Hence, the diversity of the approaches and the consequent variety of entry points was to be expected. The nature of the project activities, the specific starting point and the development of partnerships was different in each case. Each island country conducted the activities according to its internal pressures, structures and needs, reflecting its own unique culture and environment. However, the fact that these cases were viewed as instances where some success was achieved highlights the value of maintaining the freedom for diversity under the Healthy Islands banner.

It was interesting that three of the cases were initiated as environmental health projects and their starting points were focused on preventing communicable disease, whether human to human, or through vectors. Indicators of effective outcomes could be easily developed, such as tracing trends in the incidence and prevalence of these diseases. (Of course, these measures would not be proof that the project itself was the sole cause of the improvement; as with all use of indicators of this nature, factors other than these project interventions could have been contributing to the positive improvements). On the other hand, the remaining two cases were part of a donor-funded regional health promotion project which had as its overall aim the building of local capacity to create and maintain the health of the people. Starting points for these latter two projects were not focused on diseases as such, but more on creating local mechanisms for addressing health issues. Indicators of success in these two cases would therefore be more to do with demonstrable instances of effective process. In the smaller country, Niue, this process was island-wide with the development of a culturally acceptable, all-embracing, health-promoting committee. In the larger island country, Samoa, the process was explored within the more-defined, more manageable setting of schools rather than the whole country.

1.2 Strong Leadership

A common feature of the successes of each of the initiatives was a strong, powerful or influential individual who was willing to begin the project, introduce Healthy Islands concepts, mobilise support and get the activities going. A very clear message from the case study reports and from the co-ordinators was the need for ongoing financial and political support for a Healthy Islands coordinator with whom rests the ongoing responsibility for future activities and sustainability of both past and present projects.

If such support can be garnered, it is also important that the Healthy Islands coordinator receive appropriate training in Healthy Islands concepts and approaches so that they may train other key partners. The coordinator will need to be well networked with fellow Healthy Islands project officers and others with expertise in settings approaches as well as maintaining contact with the regional office of WHO. As evidenced in the case studies, an activities coordinator or
a committee chairperson with experience in health promotion or environmental health was a
definite benefit to Healthy Islands activities.

Funding for the role of the coordinator, and indeed the placement of the coordinator
within the country (Ministry/Department of Health/Womens Affairs/Education/
Environmental Health) may be dictated by the needs or availability of personnel on the
specific island. Some islands may even wish to consider creative funding arrangements
whereby the position is funded from a range of partners but physically located in one agency.
Several of the case study report authors commented on the very real possibility that chances for
ongoing sustainability of the activities will be severely limited or impossible without a funded
Healthy Islands coordinator.

1.3 Community Participation and Empowerment

Although community development principles indicate that the impetus for change should
ideally start with the community, this was not evident in any of these initial case studies. In
each instance the Healthy Islands approach was introduced to the community, and only then did
local ownership evolve. This was strengthened by political will, capacity building activities,
inter-sectoral collaboration and increased involvement from a broad range of community
members.

A related observation was the necessity of a ‘kick start’ to initiate Healthy Islands
activities. In each case study, co-ordinators had to find a way of introducing the concept of
Healthy Islands to their community. It appears that the choice of entry point was little
importance, whereas the engagement of community members was critical. Once the concepts
have been introduced, the community should then determine the specific activities it wishes to
undertake.

A common theme from the five case studies, particularly those in which the community
was involved from the onset, was that of empowerment. Each of the studies indicated that
Healthy Islands principles were taken up best when communities were actively involved in
determining what their problems were, the level of priority that should be given to resolving the
problems, and the strategies for addressing the problems.

1.4 Political Support

Political support for the Healthy Islands approach was evident in each of the five case
studies but the manner in which it was demonstrated varied. Ministerial support for the Yanuca
Island Declaration was universally evident but sometimes this political support did not result in
what was seen as sufficient financial support. In some instances the Ministerial support was
seen as lip service to an international agreement with little substantive demonstration on the
ground.

The mobilisation of political support at a regional and/or local level proved beneficial in
all the cases where it was attempted. Surprising levels of support - financial, moral and human
resources - were provided once local political support was gained. Participation in the direction
setting and implementation of project activities was the standard method of involving local
political bodies.

1.5 Role of Donors

Owing to the poor economic base of most Pacific Island countries, donors play a key role
in developments such as Healthy Islands. This role is valuable and can provide much-needed
assistance. However, donors must acknowledge that this is a paradigm shift for most
communities. If they provide opportunities for training a coordinator and appropriately fund
initial activities, they must also trust and support the coordinator and the community to follow
Healthy Islands principles. Attempting to direct the activities to meet some externally
determined agenda poses a serious threat to the future of Healthy Islands initiatives. The case studies demonstrated how, in the eyes of the recipients, donors almost ruined the local ownership in some cases. This aspect was made worse by the funding coming from a regional project where the donor had unrealistic expectations that the same objectives could be sought and attained in each participating country. Shared goal setting must in future become an integral part of any externally-funded Healthy Islands projects.

1.6 Evaluative Measures

One area in which there seems to be a direct need for guidance is that of developing methods to appropriately evaluate Healthy Islands activities. In some cases, epidemiological data or base line data were used, in others, more qualitative measures were put in place. Some cases had no formal evaluative measures and relied on subsequent reviews of community health or health services, post-activity impact assessments, or recording of observations by participants/co-ordinators. Recommendations on the development of evaluative measures should include process as well as outcome.

1.7 Sustainability

An interesting point to note from all five case studies is the ongoing interest in Healthy Islands principles beyond the life of the funded activities. With this interest, however come issues of sustainability. The communities are now motivated and the outcomes evident, with other sectors recognising their role in promoting health. While some project co-ordinators fear that without funding the impetus and support for Healthy Islands activities will eventually wither, others indicate that community interest is still strong.

In Fiji, the adaptation of an existing social structure, the church, to address community concerns has resulted in what appears to be an easily sustainable change for that community. With the development of the National Health Promotion Council as a co-ordinating mechanism for Healthy Islands throughout the country, political will has been strengthened and policies supporting initiatives of this nature are evolving.

The project coordinator in Niue feels that Moui Olaola is becoming entrenched in the culture. As a result of recommendations resulting from the recent health services review by the New Zealand Overseas Development Agency in Niue, the activities of the Moui Olaola Committee are to be an integral part of recurrent health funding. The position of coordinator will be covered by this funding, thus ensuring sustainability.

In Papua New Guinea the village in which the Healthy Islands activities took place has become a model for other communities and other activities. Community pride in the work that was achieved is also evident there.

In Samoa capacity has been built among key staff and a drive to develop indicators for the purpose of evaluating healthy settings approaches is now occurring. Inter-sectoral collaboration for health is apparent across government sectors and increasingly occurring with non-government organisations.

In Solomon Islands the creation of a useful partnership has led to greater commitment from Government to respond to community needs and a corresponding sense of ownership in the community and across sectors.

These case studies provide a useful insight into a limited range of small-scale and discrete activities. A question arises, however, in discerning how to translate these insights into a broader, country-wide approach. What is learned from these activities can inform the wider picture but an impetus is needed for the next step to be taken. For success at a national level, these cases demonstrate that there is a minimum requirement of a combination of well-trained personnel, enthusiastic communities and appropriate resources. In order to take the step to scale up to a country-wide line of attack, it might be that a shared vision of one’s own Healthy Island could be the additional factor which is really motivating for both policy makers and the community alike. This vision could act as the overarching umbrella under which the whole
country might set their goals for health and quality of life, with concrete developments on the
ground meeting their own particular aims and objectives, yet always reflecting the overall
goals.
CASE STUDIES – LESSONS LEARNT

The five case studies reviewed at the workshop all demonstrated the value in using the "healthy island" approach. The activities undertaken in the case studies demonstrated many elements that could be incorporated in to future activities. However the activities also encountered problems which countries need to consider and act on in the future. In total the case studies have significantly contributed to our learning and summarised below are the major lessons that can be drawn from the experiences. These lessons need to be considered and read in context and should be read in concert with the full case study reports. They are grouped together around the themes of “Conceptual Development”, “Capacity Building” “Collaboration” “Continuity” and “Commitment” all of which have emerged as key focal areas for attention. The case studies provide valuable “tips” for those of us who continue the journey towards fulfilling the healthy islands vision.

1. Conceptual Development
   - Paradigm shifts need to be supported to avoid frustration and conflict in the field.
   - There is a tension between the need to develop clear concepts and the frustration sometimes expressed by the imposition of models and project outcomes.

2. Capacity Building
   - There is a need to encourage communities to mobilise their own resources and for government staff to not impose ideas and actions.
   - The community should actively participate in the prioritisation, planning, implementation, monitoring and revision of projects.
   - The community should seek technical and other support for projects at local, district and national levels.
   - Community leaders often need training in project planning and management.
   - Some government officers will need support to orient them away from control to facilitation.
   - Donors need to be flexible in reprogramming project funds in order to obtain the broad objective.
   - Provision of support services (financial, technical and advisory) as well as incentives to communities is important.
   - In many cases it is better to use existing community organisations rather than develop new ones.
   - Equitable access to facilities and different levels of services by communities is important.
   - Support needs to be drawn from inside and outside Departments and Ministries of Health.
   - The provision of technical assistance provides the opportunity to learn and the practically apply that learning.
   - Traditional learning methods are enhanced in their effect by modern social marketing strategies and vice versa.
3. **Collaboration and Partnership**

- Community leaders need to establish a strong bond with their government workers and work with them as full partners.
- Ensure there is effective communication and understanding within and between Ministries and Departments and private sector stakeholders.
- Project facilitators need to elicit the support and collaboration of many community and government organisations.
- All stakeholders should be included in the project from its very inception and participate in an ongoing manner.
- Incentives may be required to achieve participation from some groups.
- Departments and Ministries of Health need to be flexible and assist others to contribute.
- There needs to be effective delegation of decision making and support to community level staff. The arrangements for sharing control between agencies may need to change.
- Good sincere partnership involves sharing ideas, resources and most importantly power.
- There is a need for information sharing and alliance building and improved co-ordination between donors.
- Project facilitators need to possess the highest degree of tolerance, commitment, selflessness and have a heart for the community.
- Methods used to gain community participation may vary depending on a variety of factors including whether the activities are located in urban, rural and peri-urban settings.
- Acknowledgement (credit due) should be facilitated by, with or for the community for whatever role it plays in implementing healthy islands.

4. **Commitment**

- Communities need to own the projects.
- Good projects do not always require extra money but commitment, and occasionally extra funds and other resources are helpful.
- Political will and bipartisan support at all levels is needed.
- Governments need to “put their money where their mouth is” in the realisation of the Healthy Islands vision.
- There is a need for leaders in all sectors to champion the healthy island concept.

5. **Continuity**

- It is essential to develop rigorous methods for the monitoring and surveillance of projects.
- Governments need to be assertive in expressing clearly their needs to donors.
- The resource cycle of donor projects need to be carefully harmonised with countries implementation requirements and include a transition phase when projects near completion.
- Evaluation may prove difficult given the complex and dynamic nature of island communities, national governments, donors and the evolving definition of “healthy islands”.
- There is a need for more guidance on the development of national indicators
- There is a need to be sensitive to the traditional values and local context of PICs in project design and implementation.
- There needs to be access to a sustainable source of resources for continued success.