Proceedings of the WHO Meeting on Health Protection and Health Promotion

Harmonizing our responses to the challenges of the 21st Century

Manila, Philippines, 16 - 20 August 1999

World Health Organization, Western Pacific Regional Office
Proceedings of the WHO Meeting on Health Protection and Health Promotion

Harmonizing our responses to the challenges of the 21st Century
Manila, Philippines, 16 - 20 August 1999

WHO/WPRO LIBRARY
MANILA, PHILIPPINES

12 NOV 2004

World Health Organization, Western Pacific Regional Office
Proceedings on the WHO Meeting on Health Protection and Health Promotion—*Harmonizing our Responses to the Challenges of the 21st Century*
16-20 August 1999, Manila, Philippines
This document was edited by Professor Elma B. Torres of the University of the Philippines Manila under a contractual service agreement with the WHO Western Pacific Regional Office. The document is published informally by the WHO Western Regional Office. The findings, interpretations and conclusions contained in the papers are entirely those of the authors.
# TABLE OF CONTENTS

## INTRODUCTION

1

## REGIONAL OVERVIEW ON HEALTHY SETTINGS:

3

- Health Protection and Health Promotion: Harmonizing Our Responses to the Challenges of the 21st Century—*Vivian Lin* 4

- Prevention of Cigarette Smoking Among Junior High School Students: A Case Study of Promoting Health in Schools — Experiences in Health Promoting Schools—*K.C. Tang* 27

- A Pilot Project on HIV/STD Prevention as an Entry Point for the Development of Health Promoting Schools in Beijing, China—*Jiangping SUN* 39

- Health Promoting Schools: FSM Case Study Report—*William Eperiam* 48

- WHO-Shanghai Pilot Project on Work-Site Health Promotion—*Liu Min & Gu Xueqi* 52

- Health Promotion at Workplaces in Small and Medium-Scale Enterprises In Ngo Quyen District, Haiphong City and in Hue City, Vietnam—*Nguyen Thi Hong Tu* 62

- Kuching City’s Experience in Resettlement of Food-Hawkers and Wet Markets—*Andrew Kiyu* 72

- Experiences in Healthy Market Place in Vientiane, Lao People’s Democratic Republic—*Rattiphone Oula* 82

INTEGRATING HEALTHY SETTINGS IN HEALTHY CITIES AND
HEALTHY ISLANDS:

Review of experiences in Integrating Settings in Healthy Cities and
Healthy Islands—Wai-On Phoon 91

Integration Viewpoints and “Doing Research Together” Activity—
Takehito Takano 92

Of Plans, Practice and Place: Integrating Settings into National
Environmental Health Planning in Fiji—B.J. Powis 103

Experiences in Integrating Healthy Settings in Healthy Cities, Malaysia—
Rozlan bin Ishak 108

Healthy City Hai Phong Project, Vietnam—Van Vy 120

The Use of Settings in the Australia-South Pacific: Healthy Islands
Healthy Promotion Project—Barbara Spalding 136

Health Promoting Keiyasi Health Centre: A Health Promoting Primary
Health Care Facility—Margaret Cornelius 143

A Case Study Report on Healthy Village Initiative—Lindsay Piliwas 153

LIST OF PARTICIPANTS, TEMPORARY ADVISERS, CONSULTANTS,
OBSERVERS, REPRESENTATIVES AND SECRETARIAT 156
INTRODUCTION

In the Western Pacific Region, the approach employed in the development of Healthy Cities, Healthy Islands and elemental healthy settings, such as schools, workplaces, marketplaces and hospitals, has served as a practical framework to integrate and implement health protection and health promotion activities for specific communities or populations. The further development and application of this “healthy settings” approach was one of the main recommendations in the Jakarta Declaration, the outcome of the Fourth International Conference on Health Promotion, held in July 1997 in Jakarta, Indonesia. Since the Jakarta Conference, WHO for the Western Pacific Region has pursued to implement this recommendation, and a number of “healthy settings” initiatives have been developed throughout the Region.

As a follow-up activity of the Jakarta Conference, the WHO Western Pacific Regional Office convened the Meeting on Health Protection and Health Promotion: Harmonizing our Responses to the Challenges of the 21st Century, in Manila, Philippines from 16 to 20 August 1999. The overall aim of the meeting was to exchange, among participants, experiences gained in “healthy settings” initiatives developed in the Region and to harmonise future responses of those who would implement healthy settings activities. Specifically, the objectives of the meeting were to:

1. Share experiences in relation to the development and implementation of health protection and health promotion initiatives in elemental community-based settings such as schools, workplaces, marketplaces and hospitals;

2. Discuss ways of bringing together these experiences and follow-up actions in the larger contextual settings of communities, cities, islands and nations, and in relation to local and national planning and economic development frameworks;

3. Discuss successes and lessons learned from these experiences with a view towards identifying new partnerships among communities, countries and organisations in the development of resources, collaboration and networks for health protection and health promotion; and

4. Develop a framework and plan of action for building a regional health protection and health promotion alliance in such areas as research and human resource development, which enables Member States and the people they serve to advance health priorities in the development decision-making process.

The meeting brought together a total of 58 participants (including temporary advisers and observers) from 22 countries, including Australia, Cambodia, China, Cook Islands, Fiji, Japan, Kiribati, the Lao People's Democratic Republic, Malaysia, the Federated States of Micronesia, Mongolia, Nauru, New Zealand, Niue, Papua New Guinea, the Philippines, the
Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga and Vietnam. Three WHO consultants and seven staff members also attended.

The meeting arrived at the following main conclusions:

1. The concept of "healthy settings" has firmly taken root in most countries in the Region in recent years and is attracting increasing awareness and more widespread support;

2. There is now a considerable reservoir of resources in expertise, experience and materials for developing and implementing programmes and activities of "healthy settings"; and

3. Challenges which lie ahead include the development of improved methodologies for evaluation, the need for increased political commitment, the ensuring of sustainability, the strengthening of human resources and more effective deployment of existing funds and the identification of new sources of funding.

The meeting also drew up a regional action plan for further promotion of "healthy settings". The report of the meeting, describing presentations, discussions, conclusions and the regional action plan, is available from the WHO Western Pacific Regional Office, Manila Philippines upon request.

This publication is a compilation of the papers prepared for and presented at the meeting by participants, temporary advisers and consultants. Its purpose is to make available to wider audience the experiences gained in developing and implementing "healthy settings" initiatives in the Western Pacific Region.
REGIONAL OVERVIEW ON HEALTHY SETTINGS
HEALTH PROTECTION AND HEALTH PROMOTION:
HARMONIZING OUR RESPONSES TO THE
CHALLENGES OF THE 21ST CENTURY

Vivian Lin
Executive Officer, National Public Health Partnership, Department of Human Services
Melbourne, Australia

Abstract

The healthy settings concepts has become well established in the Western Pacific Region as an integrated approach to health protection and health promotion. Pilot projects in elemental settings (of schools, workplaces, hospitals, etc) and in contextual settings (of cities and islands) have been linked and mutually reinforcing. Generic processes have been identified for developing and implementing projects, and key elements are being encapsulated in regional guidelines. In the immediate future, the healthy settings approach needs to become further entrenched through additional regional technical guidelines and training materials as well as the development of evaluation framework and monitoring indicators. The further development of projects can also benefit from inter-country collaboration on some cross-cutting health priorities, including operational studies. As settings enable a coordinated approach to tackling a myriad of health risks, the approach can address both immediate threats to health as well as assist in enhancing community capacity to address future health issues. A challenge for the future is to ensure that the healthy settings approach becomes mainstreamed in decision-making and policy processes. This will require further commitments to institutional strengthening and human resources development of health protection and promotion. Country strategies for integrated health protection and promotion may be useful in refining the contribution to be made by WHO as well as basis for resource mobilization and coordination.

Introduction

The 1990s have seen considerable developments in “healthy settings” as a framework for health protection and health promotion. At the global and regional level, the concepts and related tools have been developed. In many countries, the concept has been translated into policy frameworks and pilot projects. The concrete experiences in communities and social institutions have led to further international learning about effective processes and
methods for the implementation of "healthy settings" as an integrated approach to health protection and promotion.

Overtime, the "healthy settings" idea and approach have been applied to cities, islands, schools, workplaces, hospitals, marketplaces. There are potentially many more settings which can be locale for health promotion and protection interventions. The rapid extension of the concept and projects across countries suggests a ready acceptance of a holistic approach to health, placing health within the broader context of work, family, culture, economy and society. At the same time, questions are raised about the achievement of tangible health outcomes and the evidence base. Concerns are also voiced about the relationship between the various "healthy settings" programmes and other targeted health programmes, in particularly whether they are competing programmes or not.

As the new millennium approaches, it is timely to take stock of "healthy settings" as a framework for integrated approaches to health protection and promotion. This paper will briefly review regional developments in the 1990s and the issues raised by these experiences. The paper will also consider briefly the challenges of the 21st century and suggest some directions for future attention. A tentative agenda for the near term is also proposed.

Why "healthy settings"

The importance of the physical environment for health was recognized by Hippocrates around 300 BC. The Romans contribution to health was through the provision of systems for water supply, sewage, and roads. The English Sanitary Reform movement of the 19th century gave further emphasis to the interaction between environment, society, and economy. Their efforts then was focused on the problems associated with urbanization and industrialization, but many of the concerns and debates still have currency.

While the specific health issues may change over time and vary across locations, the major health problems faced by societies have been concerned with community life, with the living and environmental conditions that are responsible for health. While the particular activities undertaken to protect and promote health have varied, the major objectives have remained constant, and community action has been one of the key strategies. The key ideas emerging from the Sanitary Movement can be summarized as (Ashton 1992):

- importance of working locally
- appropriate research and inquiry
- need for special skills and qualifications
- populism and health advocacy
- resourcefulness and pragmatism coupled with humanitarianism
- value of producing reports on health of the population
- public health as responsibility of a democratically accountable body
The “healthy settings” idea has strong links back to the early history of public health, with local action and advocacy based on evidence as continuing themes. The idea, however, has also had an evolutionary path, with differing interpretations and different practices.

The notion of “settings” has been with health educators for a long time. Cast as “major social structures that provide channels and mechanisms of influence for reaching defined populations” (Goldstein and von Schirnding, “Environmental Health Indicators in Evaluation of Healthy Cities Programmes”, Working Paper for 4ICHP, 1997), the “setting” has long been as a way of reaching a captive audience. As such, “settings” provided entry points and access to specific populations as well as channels for delivering health promotion programmes. Health promotion in schools and workplaces often began with this utilitarian perspective.

Since the advent of the Ottawa Charter of 1986, “settings” have also taken on a new meaning. One of the action areas of the Ottawa Charter was to “create supportive environments”. This recognition of socio-environmental influences on health led to the exhortation that part of the health promotion objective was to “make healthy choices easy choices”. This notion of “settings” recognized that relationships existed between participants, authorities, and organizations, and access to gatekeepers was important in order to facilitate diffusion of information and reinforce desired behaviour. Health promotion programmes based in various settings thus took on such issues as the physical environment, the organizational culture, policies or rules in schools/workplaces, supply of healthy and/or safe products, etc.

More recent studies on community-health and community-based interventions suggest yet another element of the “settings” concept as important, that is, a setting is a context - and a complex set of relationships and structures - within which people live/work/trade/socialize (Hawe, 1998). Settings represent social systems which are deeply binding, involve frequent and sustained interactions, and are characterized by multiple forms of membership and communication. There are unique traditions, practices, identities, and context for the individuals, authorities, organizations within each setting. Settings, as a context for relationships, may also exert direct and indirect effects on health, and acting on community-level influences may need to parallel interventions with individuals (Kawachi et al 1997, Birch 1998, Kaplan 1996).

The Fourth International Conference on Health Promotion, held in Jakarta in 1997 affirmed the “settings” approach as an effective strategy for health promotion. The Jakarta Declaration also recognized that a multiplicity of interventions was most effective. There is, however, no uniform approach to the application of the “settings” approach. Diverse health realities, along with diverse social, economic, and political realities, demand that health protection and promotion efforts take into account the contexts for intervention as well as the evidence base for effective interventions.
Overview of recent developments in the Region

The Western Pacific Region of WHO has some of the fastest growing economies in the world. The Region also has both the most populous country and many small island nations. While there is enormous diversity across the Region, rapid socio-cultural changes are apparent in all countries.

While Healthy Cities projects were being developed a decade ago in the industrialized nations, WHO-WPRO began a series of consultations on urban health issues with a view to considering an approach to meet the formidable challenges presented to the developing nations in the Region by rapid urbanization and economic development. In 1992, the Regional Committee endorsed the Healthy Urban Environment initiative. This was followed in 1993 by the endorsement of a Regional Strategy on Environmental Health and the Regional Health Promotion Programme, which included a focus on settings. In 1994, when the Regional Committee endorsed New Horizons in Health, health protection and promotion became accepted as key strategies for meeting the challenges of the 21st century. The Yanuca Island Declaration of 1995 adopted the concept of Healthy Islands as the unifying theme for health protection and promotion in the Pacific islands.

Since 1994-95, health protection and promotion activities have been undertaken across the Region in such diverse settings as homes, schools, workplaces, villages, marketplaces, hospitals, cities, and islands. In support of various initiatives within countries, there have been several regional workshops and national workshops on health promoting schools and on urban health developed. Regional guidelines have been issued for healthy schools and drafted for healthy workplaces, and some generic lessons across settings (such as the approach to planning and implementation) appear to be possible and desirable. Consideration of how to integrate health promotion into medical education has begun as well. The issue of tobacco has had some particular prominence across the Region.

At the regional level, a pattern of development is now identifiable as the key steps for WPRO in progressing work in each of the settings. These are:

1. support pilot projects in selected countries to develop models
2. share project experiences and plan diffusion through regional workshops
3. document projects as case studies and use project sites as study tour venues
4. develop regional guidelines based on pilot projects
5. support development of national programmes
6. review progress and evaluate experiences

In the case of Healthy Islands, AusAID has been a partner with WHO in supporting pilot projects in five Pacific Islands. Resource mobilization and coordination with other international, multilateral and bilateral agencies have been a feature of healthy settings developments in the Region.
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

On the basis of experiences at the country level to date, a number of key strategic elements can be identified as necessary for implementing integrated health protection and promotion activities in settings. These are:

- high level policy support for the concept or approach
- policy and institutional framework to support activities
- technical guidelines to assist with programme design
- training and human resources development
- pilot projects to develop appropriate prototypes
- evaluation, monitoring, and support for operational studies
- information, networking, and diffusion of experience
- mobilization and coordination of resources

While these elements require leadership within countries, WHO also plays a significant role in policy advocacy, technical support, and regional networking.

Developments in Healthy Schools

The recognition that behaviour and lifestyle patterns established early in life can have a strong influence throughout life has led to schools being identified as a priority setting across the Region. In 1994, the first regional workshop on school health promotion identified the key areas for intervention as: school health education, school health services, and school health environment. Cross-cutting health issues identified were: nutrition, hygiene, human sexuality/family planning, HIV/AIDS, communicable diseases, alcohol/tobacco, and non communicable diseases. Since then, health promoting schools have been initiated in nearly all countries in the Region, with these developments linked into Healthy Cities in China, Malaysia, Vietnam, Laos, and Mongolia and as a central feature of Healthy Islands initiatives in the Pacific. Physical infrastructure improvement projects have been undertaken to improve water and sanitation in schools. Schools have provided as the entry points for such issues as helminth reduction, leprosy education, and smoking control. While health promoting schools remains at the pilot phase in some countries (such as China, Vietnam, and Mongolia), they are moving towards becoming a national policy framework in other countries, especially in the Pacific. In some countries (e.g. Singapore, Marshall Islands), the concept of healthy schools have been integrated in to an existing school health programme, rather than started as a separate initiative.

Policy support and resource mobilization have been recognized as integral to the development of healthy schools. At the country level, collaboration between the health and education authorities has been critical to programme implementation. In a number of countries (such as Micronesia, Vanuatu, Kiribati, Singapore and Malaysia), national coordinators have been appointed in the Ministry/Dept of Education, with a counterpart in the Ministry/Dept of Health. National Coordinating Committees are also being developed in a number of countries, including PNG, Samoa, Cambodia and Lao.
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

Arising from the experiences of the pilot projects, the regional guidelines (1996) propose six key elements, each with a number of components. These guidelines provide both a definitional framework as well as reference points for programme development and review. In summary, a health promoting school consists of the following dimensions:

<table>
<thead>
<tr>
<th>School Health Policies</th>
<th>Physical Environment</th>
<th>Social Environment</th>
<th>Community Relationships</th>
<th>Personal Health Skills</th>
<th>Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>healthy food</td>
<td>safety</td>
<td>supportive</td>
<td>family and community</td>
<td>holistic curriculum</td>
<td>basic health services</td>
</tr>
<tr>
<td>substance use</td>
<td>water and sanitation</td>
<td>care and trust</td>
<td>involvement</td>
<td>problem-solving skills</td>
<td>available links with local health services</td>
</tr>
<tr>
<td>gender equity</td>
<td>sustainable environment</td>
<td>assistance for disadvantaged</td>
<td>proactive link with community</td>
<td>teacher preparation</td>
<td>health service</td>
</tr>
<tr>
<td>medication distribution</td>
<td>care and maintenance of physical conditions</td>
<td>inclusivity</td>
<td></td>
<td>training for stakeholders</td>
<td>contribute to training</td>
</tr>
<tr>
<td>first aid</td>
<td></td>
<td>parenting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>control of parasites</td>
<td></td>
<td>education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sun protection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>emergency closure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>natural disasters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Developments in Healthy Workplaces

Health at work and healthy work environments are important assets for individuals, communities, and countries. A healthy work environment ensures not only the health of workers but also contribute positively to productivity, work motivation, morale, job satisfaction, and overall quality of life. Thus, a healthy workplace is beneficial for families, communities, and society at large, as well as for individual workers. The development of health promoting workplaces, however, is not without its challenges. The rapid pace of economic development, within a context of globalisation, has resulted in a complex set of issues in the workplace. These include: changing nature of technology and work organization, regulations pertaining to environment and occupational health and safety, information and knowledge about health issues related to the workplace, capacity of workers and managers to identify and resolve health issues, etc. The 4th International Conference on Health Promotion in Jakarta pointed to the importance of complementary principles which underlie healthy workplaces: health promotion, occupational health and safety, human resources management, and sustainable social and environmental development.

The first healthy workplace demonstration projects in the Western Pacific Region were implemented in Shanghai, in large state-owned enterprises. These projects addressed such issues as: management practices, clean and safe work environment, housing provision, recreational facilities, and workers' morale. The experience suggests that it is possible and
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

Appropriate to direct activities at both protection from harm caused by the work environment as well as at promotion of work and lifestyles conducive to health. Healthy workplace projects are also currently taking place in Malaysia, Mongolia, Philippines, and Vietnam, with most of these projects linked to Healthy Cities projects in those countries. Vietnam's projects, working with small and medium enterprises, are likely to provide additional lessons for the Region.

Regional guidelines for healthy workplaces are now in final draft form (WHO 1999). Drawing from the experience with the school setting, the Guidelines suggest that policy mobilization and institutional framework are important to ensure success. As such, it is recommended that programme initiation should involve all key sectors, such as health, labour and environment, and appropriate coordination mechanisms be established at all levels.

While the specific interventions in a workplace will depend on the assessed needs and defined priorities, the draft Guidelines suggest a number of key elements and components for a healthy workplace. As with the regional guidelines for healthy schools, the proposed framework for healthy workplace helps to define what constitutes a healthy workplace as well as to offer points of reference for programme design. The key features are summarized below.

<table>
<thead>
<tr>
<th>Workplace Policies</th>
<th>Organizational Environment</th>
<th>Physical Environment</th>
<th>Personal Health Skills</th>
<th>Health Services</th>
<th>Impact On External Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>policy commitment</td>
<td>supportive workstyles</td>
<td>safe and healthy</td>
<td>programmes reflect</td>
<td>basic health</td>
<td>environmental management</td>
</tr>
<tr>
<td>committee mechanism</td>
<td>reasonable shift work</td>
<td>environment</td>
<td>need support</td>
<td>services</td>
<td>strategy</td>
</tr>
<tr>
<td>performance indicators</td>
<td>job transition</td>
<td>exposures minimized</td>
<td>skills development</td>
<td>available</td>
<td>access to safe transport</td>
</tr>
<tr>
<td>training</td>
<td>arrangements</td>
<td>procedures for safe work</td>
<td>and behavior</td>
<td>available</td>
<td>contribute to local health services</td>
</tr>
<tr>
<td>human resources management</td>
<td>special needs addressed</td>
<td>practices</td>
<td>change</td>
<td>links with</td>
<td>local community life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clear accountability</td>
<td></td>
<td>family and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>hygiene and</td>
<td></td>
<td>community links</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>sanitation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Developments in other elemental healthy settings

While schools and workplaces have been the main settings for integrated approach to health protection and promotion, there have been initiatives in other elemental settings as well. By elemental, it is suggested that these settings have three characteristics (Galea, Powis, and Tamplin, 1998):

- small enough for members to self-identify as belonging to that setting and to engender a sense of one entity;
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

- has distinguishing social, cultural, economic, and psychological peculiarities; and,
- has recognizable formal or informal administrative structures to sponsor/support health protection and promotion activities.

Some of the elemental settings where health projects have been implemented in the Region include: homes, sports, arts, marketplaces, and hospitals.

The marketplace has been of interest as a healthy setting as it is often one of the defining characteristics of a community, reflecting the local culture and traditions of the people, particularly in developing countries. Marketplaces serve as the channel for food distribution from producers to consumers and retailers, and accessible and affordable food are also offered by vendors. Marketplaces also serve a social role as a place of congregation, for exchange of information and ideas, and are promoted as tourist attractions. The development of marketplaces as healthy settings, however, require a number of health issues to be addressed. Key among these are basic infrastructure of water, sanitation, and solid waste disposal, and safe food handling practices. In addition, there is the opportunity for promoting knowledge about nutritional status and health.

The international experience on healthy marketplace is still limited, and some efforts are underway in Malaysia and Lao, as part of Healthy Cities, and in Samoa, as part of Healthy Islands. The experience of Healthy Marketplace project in Dar Es Salaam, Tanzania, suggests that it is important to integrate the following sub-systems and behaviours (Moy 1999): market administration (including food inspection), water and sanitation, waste management and nuisance control, training of producers and food handlers, and education of consumers. These elements are deemed to be critical in assuring safe and wholesome food in the marketplace. For healthy marketplaces to further their roles as social centres, additional considerations are likely to be necessary.

The hospital is another setting of interest because many communities view hospitals as the cornerstone of the health system for advice and services. The Ottawa Charter has called for "re-orienting health services", which includes such notions as increasing the preventive content of health services, promotion of primary health care, and building links between the hospital and the local community to address unmet needs. Given the need for hospitals to maintain a focus on its core business, i.e. acute care in an inpatient setting, the challenge for health protection and promotion is identifying the suitable entry points and developing a partnership.

The first healthy hospital project supported by WHO is in Cambodia and the focus was on the critical issues of water supply and sanitation. Under the Health VII (Health Promotion) Project in China, prevention and control of NCDs and STDs have served as the entry points and hospitals in pilot sites are engaged in such activities as: systematic blood pressure screening, patient education (including use of behavioural prescriptions), quit smoking campaigns among health workers, recruitment of no-smoking families via antenatal education classes, anonymous treatment of STD patients, provision of free condoms, and
community education classes. The Technical Review of Healthy Islands, conducted in late 1998, suggests that Clinical Services Task Force should be charged with setting up protocols for integrating prevention and control of diabetes, cardiovascular disease, and cancer into the primary health care system and coordinating this with secondary and tertiary care provision. It also suggests that adherence to these protocols be monitored, including as an indicator of quality of service. In the Philippines, efforts are underway to effect a partnership between the Department of Health, a major hospital, and a non-government organization to develop support services for children with such chronic illnesses as HIV and TB as a model of hospital-community partnership to address priority public health needs.

From the above overview, it can be seen that while developments within the Region has progressed rapidly with the school setting and, to a lesser extent, the workplace, other elemental settings are still in initial stages development. The following table is a broad summary of the status of implementation for each of the key elemental settings in relation to strategic elements for implementation. It is evident that further development is still required in some settings, although the generic tools and lessons can be transferred across settings.

<table>
<thead>
<tr>
<th>HEALTHY SCHOOLS</th>
<th>HEALTHY WORKPLACES</th>
<th>HEALTHY MARKETPLACES</th>
<th>HEALTHY HOSPITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONCEPTUAL AND POLICY SUPPORT</td>
<td>In place in most countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POLICY AND INSTITUTIONAL FRAMEWORK DEVELOPMENT</td>
<td>Approach developed and accepted</td>
<td>Regional guidelines in draft form</td>
<td></td>
</tr>
<tr>
<td>TECHNICAL GUIDELINES</td>
<td>Regional guidelines completed and translated</td>
<td>Regional guidelines in draft form</td>
<td></td>
</tr>
<tr>
<td>PILOT PROJECTS</td>
<td>Progressing in most countries and expanding</td>
<td>In China, Vietnam, Malaysia, Mongolia</td>
<td>Limited - Lao, Malaysia, Samoa</td>
</tr>
<tr>
<td>INFORMATION, NETWORKING AND DIFFUSION</td>
<td>Network meetings held</td>
<td>Video of Shanghai complete</td>
<td></td>
</tr>
<tr>
<td>EVALUATION, MONITORING AND OPERATIONAL STUDIES</td>
<td>? evaluation framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOBILISATION AND COORDINATION OF RESOURCES</td>
<td>With AusAID as part of Healthy Islands</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Developments in Healthy Cities and Healthy Islands

The concepts of Healthy Cities and Healthy Islands parallel those of other healthy settings. The WHO Healthy City Programme builds on "the time-honoured idea that living and environmental conditions are responsible for health" (Werna, Harpham, Blue and Goldstein 1998). Cities are places where health and illness are produced by people living and working in close proximity; at the same time, they are also governance structures which play a key role in protecting and promoting health of the population.

Within the Western Pacific Region, pilot projects were also developed simultaneously in the mid-1990s. These projects aim to address local health priorities, incorporate health considerations into urban/island development and management decision-making, mobilize community participation for better health, and coordinate the efforts of stakeholders within and outside the health sector. It is estimated that there are approximately 170 healthy city projects in the Western Pacific Region, of which WHO support has been provided to 18. Healthy Urban China and Healthy Urban Malaysia projects were the first, followed by Healthy Cities projects in Vietnam, Laos, Mongolia, Philippines, and Korea.

The Healthy Islands vision was initially expressed through the Yanuca Island Declaration of 1995 and subsequently supported by the strategic directions given in the Rarotonga Agreement of 1997. While health promotion and health protection are key strategies, as in Healthy Cities, the Health Islands concept applies more to the national level of operation. In that sense, they imply a comprehensive national approach, or plan of action, for health improvement, including health sector development.

The specific health issues addressed through these projects have been varied. Fiji adopted a comprehensive approach to redevelop its approach to environmental health, including the development of village environmental health workers, strategic management models for delivery of environmental health services, and protocols for management of urban and rural environmental health issues. For the Solomon Islands, an intensified effort in malaria control was the initial priority (and the action provided a basis for mobilizing resources from other donors). Local integrated programmes to address non-communicable diseases were the focus for islands participating in the AusAID-supported Healthy Islands Health Promotion Project.

For the Healthy Cities projects, the health issues addressed were similarly diverse. They ranged from waste management and tree planting in Shanghai, to road accidents and dengue fever in Vientiane, to food safety, air pollution reduction, and water and waste management in Haiphong. In the case of Kuching, a comprehensive action plan was drawn up to address the economic, social and physical dimensions of living in the city. These issues included: worker health and safety, employment opportunities, electricity supply and usage, school health, crime, rodents, fire safety, food safety, squatters, literacy, parks and open space, sewerage system, traffic congestion, etc.
In most of the Healthy Cities and Islands, there have been efforts to develop projects in elemental health settings. Healthy schools can be found in all locations and most Healthy Cities are attempting to develop healthy workplaces. In this way, the contextual settings of cities and islands and the elemental settings (of schools, workplaces, hospitals, marketplaces, etc.) can be mutually reinforcing. By locating and linking projects focused on elemental health settings with the contextual settings of cities and islands, there is also assurance of an integrated effort, rather than the appearance of new vertical programmes.

Despite these experiences with pilot projects, the meeting of Pacific health ministers in Rarotonga in 1997 noted that the general concept suffers from some ambiguity and should be clarified in relation to the specifics of its content the processes involved. At their meeting in Palau in 1999, while recognizing the need for long-term perspective and support, the Pacific health ministers re-affirmed the need to set short-term targets in order to sustain momentum and attain tangible outcomes.

In terms of the process issues, some generic steps have emerged from the pilot projects and these can be modified to suit local conditions. These are:

1. establish intersectoral mechanism at appropriate levels and appoint coordinator;
2. develop profile of current and future health and environment profiles;
3. develop a vision for the city/island through a consensus process;
4. delineate priority health issues and development activities and search for measures to address these problems;
5. prepare action plan to implement the proposed measures;
6. implement and monitor progress and impact; and,
7. review and revise action plan.

As with implementation of elemental health settings, there are also strategic elements for implementing healthy cities and islands as contextual settings. The following table provides a broad summary of the status in the Region for implementation, according to the strategic elements and by the contextual setting.

<table>
<thead>
<tr>
<th>HEALTHY CITIES</th>
<th>HEALTHY ISLANDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONCEPTUAL AND POLICY SUPPORT</td>
<td>At national level - in Malaysia</td>
</tr>
<tr>
<td>POLICY AND INSTITUTIONAL FRAMEWORK DEVELOPMENT</td>
<td>Associated with pilot projects</td>
</tr>
<tr>
<td>TECHNICAL GUIDELINES</td>
<td>Under preparation</td>
</tr>
<tr>
<td>TRAINING AND HUMAN RESOURCE DEVELOPMENT</td>
<td>INTAN/JICA/WHO course on urban healthy environment; UWS course on environmental management for health; Flinders course on healthy cities and communities</td>
</tr>
</tbody>
</table>

14
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

<table>
<thead>
<tr>
<th>PILOT PROJECTS</th>
<th>HEALTHY CITIES</th>
<th>HEALTHY ISLANDS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In China, Vietnam, Malaysia, Laos, Mongolia; Cambodia, Korea, starting in Philippines</td>
<td>In many countries</td>
</tr>
<tr>
<td>INFORMATION, NETWORKING AND DIFFUSION</td>
<td>6 case studies published; 5 in preparation; inventory on website</td>
<td>Ministerial meetings held; 5 case studies under preparation</td>
</tr>
<tr>
<td>EVALUATION, MONITORING AND OPERATIONAL STUDIES</td>
<td>LICA support for training; regional workshop with UNDP/UNCHS</td>
<td>Links with AusAID in 5 countries; NZODA support thru SPC; donor coordination in Solomon Islands</td>
</tr>
<tr>
<td>MOBILISATION AND COORDINATION OF RESOURCES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In relation to Healthy Islands, Pacific health ministers, at their 1999 meeting in Palau, recommended increased information and resource sharing through regional networks; increased collaboration across international/multilateral/bilateral agencies; increased distribution of research protocols, instruments and results; and collaboration across common health problems. These recommendations address some of the major gaps in the above table. The need for evaluation and monitoring indicators was also underscored at the meeting of the Western Pacific Advisory Committee on Health Research in 1998 (WHO, 1998).

The issue of common content has been a matter of debate. It has been argued that if the intent of the settings approach is to allow for local determination and local solution to health priorities, then specified content runs contrary to local ownership and control of issues. On the other hand, as the Pacific health ministers have indicated, there are many common health problems, such as vector-borne diseases, non-communicable diseases, emerging and re-emerging diseases, tobacco and alcohol consumption and other substance abuse. A collaborative approach and a common framework, if not entry points, may be an invaluable form of providing policy advocacy and technical support.

Lessons, issues, constraints and opportunities

The foregoing overview of developments in the Region suggests that considerable progress has been achieved over the past five years, and there remains a substantial agenda to be tackled. Most immediately, there are lessons about how to implement healthy settings projects. There are also some clear gaps in relation to policy advocacy and technical support that need to be addressed in order to further activities in particular settings. Furthermore, there are new challenges which need to be addressed at the next phase of development, and these relate in particular to evaluation, translation of pilot projects into mainstream policy, institutional strengthening and human resources development, and resource mobilization and coordination.
In terms of positive lessons, the pilot projects have demonstrated that it is possible to develop an integrated approach to health protection and promotion in both the elemental and contextual settings. They also demonstrate some generic processes that can be applied across settings. These relate to developing policy support, involving communities, creating institutional framework for coordination and implementation, assessment of health priorities, and agreement on plans of action. The pilots also suggest some critical ingredients for success. These appear to include: high level support or champion, meaningful entry points and action-orientation, appropriate organizational locus for coordination and implementation, specific authority and resourcing, and integration of activities into ongoing management decision-making.

There are also some lessons to be derived from the less successful efforts. The key issues which impinge on the effective implementation of healthy settings appear to include: limited resources, lack of ownership at appropriate levels, over-reliance on small number of people, lack of action orientation or insufficient results achieved, insufficient management capabilities among public health professionals, and insufficient engagement with other health programmes and with other sectors. The above list of issues would suggest that strategic timing and engagement with the appropriate people is a key issue. As such, the translation of the concept and vision of healthy settings into tangible and meaningful models for action is a prerequisite for adoption and diffusion.

Clarity of institutional framework for coordination and implementation may be useful for stakeholders to identify points of engagement. The Technical Review of Healthy Islands proposes the following model, which can be adapted for projects across all settings and can also be considered as an approach for longer term institutional development (Galea 1998):

<table>
<thead>
<tr>
<th>COORDINATING BODY</th>
<th>responsible for planning, policy, evaluation, R&amp;D, training</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL TASK FORCE</td>
<td>responsible for improved preventive services and integrating public health and clinical care</td>
</tr>
<tr>
<td>BEHAVIOR/LIFESTYLE TASK FORCE</td>
<td>responsible for social marketing and personal skills development</td>
</tr>
<tr>
<td>ENVIRONMENT TASK FORCE</td>
<td>responsible for physical, social and economic environment</td>
</tr>
</tbody>
</table>

Most of these process issues can be reflected in regional guidelines and training materials, for adaptation at country and lower levels. Such materials still need to be developed for some of the elemental settings (such as marketplaces and hospitals) and the contextual settings. The existing materials for schools and workplaces provide good models for new guidelines.

The early diffusion of the healthy settings approach reflected, in part, its appeal as a vision and an integrated approach to health protection and promotion. The continued expansion and uptake of healthy settings is likely to require greater evidence of its benefits, although many projects are still in relatively early stages of development. Nonetheless, a system for monitoring and evaluating the achievements in all settings is now a matter of some urgency.
Traditional approaches to health program evaluation has focused on well-defined disease states, yet healthy settings projects may be addressing individual and setting level issues simultaneously, and possible objectives of projects may include: reduction of ill-health; changes in attitudes and behavior; management of determinants of health; creation of social welfare (or social capital); development of social institutions, etc. Thus, while some will wish to measure all health outcomes within a setting and other will resist outcome measurement, it is important that an evaluation framework is developed which is able to strike a balance between:

- process and impact indicators
- quantitative and qualitative methods
- measurement of health status and risks and measurement of community capacity building
- evaluating specific components vs. evaluating approach as a whole

Defining and measuring community capacity will be a particular challenge and development of new tools and methods may be required as a first step.

The evaluation framework should be informed by programme theory (or the logical framework) which inform the identification of inputs, activities, outputs, outcomes and impacts, although capturing the unanticipated outcomes and impacts (at both the individual and setting levels) should also be addressed. Economic evaluation (most likely to be cost-effective and cost-utility analyses) will need to be built in, with some particular attention to how indirect benefits (at individual, setting and societal levels) might be assessed. Evaluability assessment should also an integral part of the framework, so that the appropriate measures and methods are adopted at the right stage in a project's life cycle, and no premature evaluation is conducted. While there will be temptation to develop a global approach to evaluation, in order to have comparative data, an action-research model of evaluation may be more useful at the country level. These two approaches, of course, need not be mutually exclusive.

Well-evaluated projects, however, do not guarantee sustainability or diffusion. In their purest forms, the healthy settings approach is concerned with changing the way business is done - be it in schools, workplaces, cities, or villages. Sustainability is ultimately dependent on the project no longer being a project but a way of managing and decision-making. Diffusion of the experience can be ad hoc and rely on good documentation and communication which captures the imagination of others and identifies a way for their needs to be met. Diffusion can be made more systematic through formal networks or associations and collaborative projects. Diffusion can become systemic when projects become the basis for national policy and programmes. The above review of current developments suggest that more effort in documentation and diffusion (with within country and across countries) would be valuable.

How to secure healthy settings approach as a feature of national policy remains a challenge in many countries, especially at a time when national health policies have been concerned with reforming the financing and organization of health services delivery, including the
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

adoption of market based approaches. In order to drive policy development and implementation, there needs to be strong institutional mechanism and leadership within health authorities for health protection and promotion. This capacity also needs to be developed to lower levels in the system, alongside strong and competent advocacy from non-government organizations. The institutional strengthening and human resources development agendas will need to go beyond pilot projects and be infused through the health sector.

For the healthy settings approach to become mainstreamed, the benefits of an integrated approach to health protection and promotion must be demonstrated. At the most practical and immediate level, this is seen in a coordinated approach to health investment, whereby funds from different programmes and for various infrastructure requirements can be channeled or sequenced in an appropriate manner. Resource mobilization and coordination across health programmes should be the initial aim, such that school teachers are not bombarded with various health programmes wanting to conduct training, or resources can be pooled from a range of programmes to address common underlying determinants of health. Mechanisms established for coordination with other sectors should similarly promote joint programming and budgeting, such that urban infrastructure development can be accompanied by appropriate human services. At the country level, where healthy settings becomes a framework for national health development, such as Healthy Islands, then the national plan of action can become the basis for resource mobilization and coordination across international/multilateral/bilateral agencies.

In summary, the review of current development in the Region suggests the following as key areas for further work:

- technical guidelines and training materials related to the various settings
- evaluation framework and monitoring indicators across settings
- documentation and mechanisms for diffusion with a view to policy uptake
- institutional strengthening and human resources development
- framework for resource mobilization and coordination

Preparing for new challenges of the 21st century

Healthy settings has been seen as a means for integrating health protection and promotion activities. The experiences of pilot projects confirms this aim as realistic. The review of progress in the Region suggests there are clear identifiable areas of work which is needed to support further developments within countries. With the arrival of the new millennium, it is also desirable to take a longer term view and ask whether healthy settings will continue to serve countries well to meet new challenges of the 21st century and what actions are necessary to ensure preparedness for the new challenges, especially as the World Health Report 1999 expressed the concern that more than one billion people would enter the 21st century without having participated in the “health revolution”.

18
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

The major causes of mortality are well known but mortality statistics only reveal one aspect of the challenge for health protection and promotion. The Global Burden of Disease study documents the simultaneous existence of persistent problems of infectious diseases and maternal and child disability and mortality with the emerging epidemics of noncommunicable diseases and injuries. The distribution across countries, however, is not uniform. For countries in the Western Pacific Region, the relative burden (DALYs) for countries by income level, for 1998, is shown in the following table (World Health Report 1999).

<table>
<thead>
<tr>
<th>Category</th>
<th>High Income</th>
<th>China</th>
<th>Other Low And Middle Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable diseases, maternal and perinatal conditions, nutritional deficiencies</td>
<td>2,109</td>
<td>27,779</td>
<td>17,512</td>
</tr>
<tr>
<td>Noncommunicable diseases</td>
<td>15,738</td>
<td>134,185</td>
<td>18,030</td>
</tr>
<tr>
<td>Injuries</td>
<td>2,151</td>
<td>35,740</td>
<td>6,921</td>
</tr>
</tbody>
</table>

The ranking of leading causes of Disability-adjusted life years (DALYS) is also different. For the Western Pacific, the ranking for countries by income level, for 1998, is shown in the following table (World Health Report 1999). Clearly, there will be differences by country and by regions within countries.

<table>
<thead>
<tr>
<th>Rank Order</th>
<th>High Income</th>
<th>China</th>
<th>Other Low And Middle Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ischaemic heart disease</td>
<td>Chronic obstructive pulmonary disease</td>
<td>Acute lower respiratory infections</td>
</tr>
<tr>
<td>2</td>
<td>Unipolar major depression</td>
<td>Unipolar major depression</td>
<td>Diarrhoeal diseases</td>
</tr>
<tr>
<td>3</td>
<td>Cerebrovascular disease</td>
<td>Cerebrovascular diseases</td>
<td>Perinatal conditions</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol dependence</td>
<td>Other unintentional injuries</td>
<td>Other unintentional injuries</td>
</tr>
<tr>
<td>5</td>
<td>Road traffic accidents</td>
<td>Self-inflicted injuries</td>
<td>Unipolar major depression</td>
</tr>
<tr>
<td>6</td>
<td>Perinatal conditions</td>
<td>Acute lower respiratory infections</td>
<td>Other cardiac diseases</td>
</tr>
<tr>
<td>7</td>
<td>Other cardiac diseases</td>
<td>Perinatal conditions</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>8</td>
<td>Osteoarthritis</td>
<td>Anaemias</td>
<td>Childhood diseases</td>
</tr>
<tr>
<td>9</td>
<td>Alzheimer and other dementias</td>
<td>Ischaemic heart disease</td>
<td>Road traffic accidents</td>
</tr>
<tr>
<td>10</td>
<td>Diabetes mellitus</td>
<td>Road traffic accidents</td>
<td>Other digestive diseases</td>
</tr>
</tbody>
</table>

DALYS, of course, only represents a starting point for analysis and action. A cursory examination of the rank order highlights the fact that a great deal of the burden is avoidable and the need to enhanced efforts in health protection and promotion. From the viewpoint of action, a closer analysis would be required of the key determinants which are amenable to intervention. Nonetheless, it is clear that, given the complex web of causation, the key issues include: access to and quality of health care, factors in the social and physical environment, and personal healthy skills, with socioeconomic status as a critical underlying factor. The main challenge is to develop a refined understanding of how these factors intersect in particular localities and population groups and the most effective mix and means for intervention in those settings.
Looking into the future, the Global Burden of Disease study predicts some major changes, particularly in the rise of neuropsychiatric conditions and conditions related to violence and war. What the figures do not reveal is the rapid rate at which some epidemics are moving to the Region - particularly HIV/AIDS and tobacco use. These are problems which some countries have adopted effective containment strategies but remain major challenges for other countries. The problem of newly emerging diseases (be it drug-resistant diseases or new forms of zoonosis) is not yet a quantifiable entity but is likely to test existing paradigms about disease prevention and control.

More expansive approaches to future-gazing have been adopted by others. The following table summarizes some of the key issues for the future raised by different forums or authors. While necessarily reflecting the differing contexts for debate, there are some remarkable points of agreement.

<table>
<thead>
<tr>
<th>Issue</th>
<th>NPHP/ Australia*</th>
<th>Potter/ Canada**</th>
<th>WHO Habitat paper***</th>
<th>Pacific Island#</th>
<th>Calman/ UK##</th>
<th>Beaglehole &amp; Bonita/NZ###</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population growth and ageing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious diseases</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emerging and re-emerging diseases</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Noncommunicable diseases risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Violence and injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health inequalities and vulnerable population groups</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban environment and infrastructure</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climate change and environmental degradation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Information technology and communications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cost and demand for medical care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetics and new medical knowledge and technology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

** Plenary Speech by Ian Potter, Health Canada, at 4ICHP, Jakarta, 1997
# Derived from meetings of Pacific Health Ministers in Rarotonga and Palau, 1997 and 1999
### Robert Beaglehole and Ruth Bonita, in Public Health at the Crossroads, 1997
Given these observations, it is possible to suggest some agendas for health protection and promotion which are shared across nations. These include:

- the need to reduce greatly the health burden suffered by the poor and vulnerable populations;
- the need to counter proactively the potential threats to health resulting from unhealthy environment, social and economic change, and risky behaviour;
- the importance of strengthening family and community capacity for public health action to address the above; and,
- the need to mobilize leadership and investment across diverse sectors in order to achieve the above.

Such an agenda confirms the value of an integrated approach to health protection and promotion, continuing to work simultaneously at the policy level and within local settings. It also points to the importance of strong links within the health sector, to incorporate targeted health programmes within settings, and to work with other sectors, to ensure broader determinants of health are addressed through coordinated investments. It is within settings that a coordinated effort is possible to address the range of health concerns and risks (both immediate and underlying) within each community of interest.

There are some obvious preventable problems that require immediate attention, with sound evidence about effective interventions, such as smoking; childhood illnesses; control of vector-, water- and food-borne diseases; and other infectious diseases. From the viewpoint of preparedness for the future, given the context of globalisation, the additional priorities for strategic investments are likely to be related to the physical and social environment, as these represent the key underlying determinants of health.

The history of public health demonstrates that improvement of the physical environment is one of the most significant contributors to improved population health and safety, be it in the urban environment or the workplace (Calman 1998). Modifications in the environment is an immediate measure for controlling health hazards. Investment in environmental improvements remains critically important in all settings and can be expected to have beneficial impact for the entire community of interest and across a range of health outcomes.

Given the rapid pace of socioeconomic development in the Region and persistence of health inequalities, it is necessary to consider the international evidence on the socioeconomic gradient across health problems and the emerging knowledge that the gradient may be explained by lack of social support, poor education, nature of work organization, access to economic opportunities, sense of control, etc. (Blane, Brunner and Wilkinson 1996; Wilkinson & Marmot 1998, Berkman & Syme 1979; Evans et al 1994). Child health and early childhood development could be given particular focus for integration of social and environmental interventions (Ehir & Prowse 1999). In line with the Barker hypothesis (1992) and new findings in chronic disease epidemiology (Kuh & Ben-Shlomo 1997, Marmot & Wadsworth 1997), new emphasis may be required to take a life course approach, with a particular focus on competence, resilience, and coping skills, as well as healthy
Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

behaviour. In addition, attention will need to be directed to family and community capacity to address key determinants of mental health - including economic participation, social connectedness, and freedom from discrimination and violence. The settings approach is the most suitable framework for tackling these underlying social issues.

There are some cross-cutting health issues which could be the basis for collaborative work across countries. Some of these are common problems and sharing of possible solutions would be beneficial for countries. Others span borders and require joint action. Some have well-defined, cost-effective interventions and simply require the mobilization of organizational and political will for action. Others require collaboration to achieve better understanding of the nature of the problem along with development of cost-effective interventions. As such, they may be the priorities for operational studies. An initial list of these cross-cutting health issues, which cover immediate as well emerging challenges, include:

- tobacco (and other substance abuse)
- child health
- environmental health and safety
- mental health and well-being
- emerging and re-emerging diseases

These issues are relevant to all settings. Actions specifically designed to address these issues will have spin-off effects on other health issues. For instance, addressing environmental health and safety and substance use may lead to reduction in injury rates. Similarly, efforts in tobacco control, mental health and child health will contribute to prevention of noncommunicable diseases. Through these targeted efforts, the capacity of individuals and communities to exercise greater control over their own health destiny should be enhanced.

Some concluding propositions

With New Horizons in Health, health protection and health promotion became accepted in the Western Pacific Region as principal strategies for improving health. This review of developments in the Region has highlighted the considerable achievements across countries in testing an integrated approach to health protection and promotion in elemental settings and contextual settings. In the immediate future, there is further technical guidance and training materials to be done for healthy cities, healthy islands, healthy marketplaces, and healthy hospitals. Further pilots in workplaces, marketplaces, and hospitals would be valuable to add to the Regional experience, and these should be linked to healthy cities/islands activities.

The summation and further development of the healthy setting approach in the Region would be enhanced by an evaluation framework across settings, including appropriate monitoring indicators and economic evaluation methodologies. It will be important that the evaluation framework is informed by clear programme logic, deploys a range of quantitative and qualitative tools, and addresses both health risks and community capacity. Specific
Operational studies can be undertaken on a collaborative basis across countries in order to examine specific experiences in greater depth.

Given the experiences to date and the shared health issues across countries, it may be desirable to adopt some cross-cutting health issues as shared priorities across settings and countries, without ignoring priorities which are particular to each local setting. These should be a mix of immediate and emerging problems, and emphasis should be on both measurable behavioural and environmental change as well enhancing individual and community capacity to manage local health issues.

The most significant challenge ahead is to mainstream healthy settings into management decision processes of each setting and to secure the approach as a central plank of health policy. Action plans for health, in various settings and at different levels, should become the basis for resource mobilization and coordination. To achieve these objectives will require systematic approach to documentation, diffusion, and policy advocacy, as well as strengthened institutional and human resources capacity in government agencies and non-government organizations.

Effective health protection and promotion is needed to address the challenges of the 21st century. The World Development Report on investing in health (World Bank 1993) suggests that for low-income countries, the most critical government policy objectives are to foster an enabling environment for households to improve health and to improve government investments in health. This latter objective remains the priority for middle-income countries. Healthy settings is an approach for coordinating investments in health, harnessing resources for health action, and ensuring local capacity and preparedness for meeting new challenges.

WHO has an important role to play in terms of technical support and policy advocacy, to ensure that the financing, planning and management of public health services are adopting contemporary approaches and meeting the health needs of the population. The WHO reform process should lead to enhanced capacity to fulfil these roles. Building on the Healthy Islands precedent, country strategies for integrated health protection and promotion may be a useful step in refining the contribution WHO can make for each country. Such strategies become both a process of auditing and organizing current investment in health as well as a basis for mobilizing and coordinating resources for further investments in health.

REFERENCES


### Health Protection And Health Promotion: Harmonizing Our Responses To The Challenges Of The 21st Century

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Publisher</th>
</tr>
</thead>
</table>


Introduction

Smoking prevention remains an adolescent health priority. Although school-based intervention programs have been found to have moderate and consistent effect in the United States (US Dept of Health and Human Service, 1994; Arkin et al, 1981; Aaro et al, 1982), there has been a tendency to broaden and extend the impact of these programs by adding parent support and supply reduction strategies because of the greater impact of using comprehensive and multi-strategies than the use of only school-based education (Perry et al, 1992; Nutbeam et al, 1993; Tang et al, 1997b). Although comprehensive and multi-strategies have increasingly been used for organising smoking prevention projects among adolescents, their effectiveness, more often than not, remains unclear (Nutbeam, et al 1993; Tang et al, 1997b). For these comprehensive projects to succeed, two challenges must be overcome. First, schools need to recognise the importance for schools to achieve good health for their students in addition to their academic development and, thus, are committed to the achievement of both academic and health goals. Second, they must have the capacity to achieve the academic and health goals.

This manuscript will examine these two challenges and propose solutions by using the health promoting school framework. The discussion will be illustrated with a case study.

The case study

To delay the onset of smoking among adolescents, the Kickbutts smoking prevention project was developed by the Southern Sydney Health Promotion Unit in 1993. The project was jointly funded by the Health Promotion Unit and the Drug and Alcohol Directorate of the New South Wales Department of Health, two hospitals in southern Sydney and the local Health Promotion and Drug and Alcohol Units in 1994.

The project consisted of three components: school-based education, parental support and community-based supply reduction. Its target population was Years 7 and 8 students in schools in southern Sydney.
Design of the case study

All schools in a local government area of southern Sydney were invited to participate in a smoking prevention project. Schools from other Sydney local government areas with similar demography were invited to participate as a comparison group. Intervention schools fully implemented the New South Wales Department of Schools Education's "Why Smoke?" package for students in years 7 & 8, distributed information to all parents of participating students and supported a community-based reduction in the sale of cigarettes to minors. Comparison group schools implemented usual smoking prevention interventions. Data were collected from students between February and March 1994 and again 12 months later, and also from parents in the intervention groups schools. The details of how the intervention project was developed, implemented and evaluated as published elsewhere (Tang & Rissel, 1997; Tang et al, 1997a and b; Tang et al, 1998; Tang et al, 1999) are described in the attachment of this manuscript.

Results of the case study

Of the 20 schools invited, 13 agreed to participate and were included in the intervention group. Fourteen schools were recruited and assigned to the comparison group. Students in the matched study cohort represent 67.2 per cent of baseline students. Table 1 shows that the intervention group students in the study cohort were generally similar to the unmatched sample at baseline and follow-up.

Table 1- Characteristics of study cohort at baseline and follow-up by intervention group status, compared with unmatched samples at baseline and follow-up by intervention group status.

<table>
<thead>
<tr>
<th></th>
<th>Baseline (n-4567)</th>
<th>Follow-up (n-5270)</th>
<th>Cohort (n-3070) (pre-intervention)</th>
<th>Cohort (N-3070) *post intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IG*</td>
<td>CG#</td>
<td>IG</td>
<td>CG</td>
</tr>
<tr>
<td>% Male</td>
<td>53.5</td>
<td>56.1</td>
<td>53.4</td>
<td>56.1</td>
</tr>
<tr>
<td>% LOTE@</td>
<td>6.0</td>
<td>16.9</td>
<td>6.7</td>
<td>13.6</td>
</tr>
<tr>
<td>% father smok'g</td>
<td>23.8</td>
<td>25.8</td>
<td>24.9</td>
<td>26.4</td>
</tr>
<tr>
<td>% mother smok'g</td>
<td>19.2</td>
<td>21.7</td>
<td>21.0</td>
<td>22.2</td>
</tr>
<tr>
<td>% brother smok'g</td>
<td>10.0</td>
<td>11.5</td>
<td>13.8</td>
<td>16.6</td>
</tr>
<tr>
<td>% sister smok'g</td>
<td>8.0</td>
<td>9.2</td>
<td>11.9</td>
<td>13.0</td>
</tr>
<tr>
<td>% peer smok'g</td>
<td>36.0</td>
<td>43.0</td>
<td>49.6</td>
<td>53.8</td>
</tr>
</tbody>
</table>

*IG - Intervention Group; #CG - Comparison Group; LOTE - Language Other Than English
Table 2 shows that there were no significant differences in post-intervention smoking behaviour or attitudes toward smoking between students in the intervention and comparison group schools after adjustment for potential confounders.

### Table 2 - Baseline and follow-up values of dependent variables in the study cohort

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IG</td>
<td>CG</td>
</tr>
<tr>
<td></td>
<td>IG</td>
<td>CG</td>
</tr>
<tr>
<td>% smokers</td>
<td>4.6</td>
<td>9.6</td>
</tr>
<tr>
<td>% strongly agree or agreeing</td>
<td>8.8</td>
<td>8.4</td>
</tr>
<tr>
<td>Smokers are more mature</td>
<td>4.9</td>
<td>6.6</td>
</tr>
<tr>
<td>Smokers look better</td>
<td>29.3</td>
<td>40.7</td>
</tr>
<tr>
<td>Smokers are more popular</td>
<td>33.8</td>
<td>39.3</td>
</tr>
<tr>
<td>Smoking mild cigarettes is OK</td>
<td>21.2</td>
<td>15.1</td>
</tr>
<tr>
<td>Smokers can stop easily</td>
<td>14.4</td>
<td>15.2</td>
</tr>
<tr>
<td>Smokers are thinner</td>
<td>13.4</td>
<td>13.1</td>
</tr>
<tr>
<td>Perceived benefits</td>
<td>14.6</td>
<td>20.8</td>
</tr>
<tr>
<td>OK for someone to smoke at my age</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Analysis of aspects/elements that were successful**

Although the results of the intervention were disappointing, they also give a much better understanding of the importance of promoting adolescents’ health through schools and of the factors that lead to adolescents smoking.

It is important to note that access to a large number of young people en masse was only possible through schools. More importantly, many schools did recognise, to some extent, their need to meet the academic, social and health goals of adolescents, as was found in this study. Support from parents and the community was also available through the schools to prevent cigarette smoking among adolescents.

The cultural background of students as well as that of their parents need to be taken into account when intervention is developed, implemented and evaluated.

The findings of this intervention indicated that the impact of the project appeared to be effective in the delay of the onset of smoking in a few classes in a few schools. However, as a whole, the results were disappointing. To achieve population health among adolescents, attention should be given to promoting students’ health of the school sector as a whole rather than students in a single school. Strategies need to correspond to mass scale interventions.
Through this intervention, a number of factors that lead adolescents to smoking have also been found and these factors will be of great use in the development and implementation of smoking prevention interventions among adolescents, in particular, in southern Sydney.

As revealed by the findings of this study, adolescents' smoking prevalence was high, particularly, the drastic onset of smoking among adolescents. In other words, tobacco control is still a major issue of concern that affects the health of junior high school students. The findings also revealed that adolescents were greatly influenced by their older siblings and close friends.

It is important to note that mothers who were worried about their child smoking were more likely to have discussed smoking with their child and to have enforced non-smoking rules. It is also revealed that parents in general either did not feel that their children were likely to become smokers or that the degree of danger was not a high priority for them, as reported, "if all that their children did were to smoke, then they really did not have much to worry about".

The involvement of parents and other family members, particularly elder siblings is important was found to be effective in delaying the onset of smoking among adolescents. It is also necessary for parents and elder siblings to understand the harmful effects of smoking; be role models, discuss smoking with the adolescent family members and enforce strict non-smoking rules at home. Yet it is important to note that strict enforcement of non-smoking rules by itself may delay onset but not prevent adolescents from smoking and thus a combination of discussion and strict enforcement of non-smoking rules is needed to provide a greater impact on the prevention of cigarette smoking among adolescents.

In addition to asking smoking parents to quit themselves, it is also important to inform smoking parents what to do to prevent their adolescent children from taking up smoking. For example, smoking parents should avoid asking their children to buy or to light their cigarettes or to refrain from giving cigarettes as gifts to their smoking friends.

Perceived ease of access to tobacco by minors is likely to contribute to adolescents trying tobacco. Reducing access to cigarettes by minors is a major tobacco control strategy. However, direct associations between access or perceptions of access and smoking status have rarely been documented in Australia. In this study, it was found that perceptions of ease of access to cigarettes was a predictor of smoking behaviour (Tang and Rissel,1997). The odds of being a current smoker were almost 50% greater for students who reported that access to cigarettes was easy or very easy compared with students who were no longer smoking, after adjusting for other social environmental factors.
Analysis of aspects/elements that were not successful

The overall impact of the project was disappointing. There was neither a reduction of smoking onset nor positive changes in knowledge and attitudes toward smoking. One possible explanation is that there was little difference in the extent of exposure to the intervention components in the comparison and intervention group schools. The parental involvement component was found to be relatively weak and seems not to have engaged the parents. Also unknown to the intervention project staff, a relatively comprehensive project aimed at reducing sales of cigarettes to minors was implemented during the closing stage of the study in northern Sydney where many of the comparison group schools were located. The considerable media coverage of that project in northern Sydney was comparable to the publicity generated in the local government area where the intervention schools were located.

Another explanation may be that the "Why Smoke?" package, even under relatively favourable conditions, may not be effective in preventing smoking onset or even leading to knowledge and attitude change. This raises the question of whether it is reasonable to expect significant changes in smoking after only a five to eight week program and whether or not there is a need for a new package, in particular, for students speaking a language other than English.

In fact, evidence is available that argues that for school-based cigarette smoking prevention programs to be effective, the intervention may need to be sustained for several years (US, 1994; Glynn, 1989).

Maintaining teacher enthusiasm in the intervention group schools was difficult. Despite the availability of teaching guidelines and materials and the strong support from some schools, some teachers found it hard to thoroughly implement the "Why Smoke?" package given the competing demands on their time. It was possible that the school-based education component could have been better implemented. It was only due to the extremely positive attitudes on the part of school that project staff were able to enlist the support of teachers to be involved in the teaching of sequential smoking prevention sessions with reference to the guidelines given. The only way to gain more involvement from the teachers would be to provide them relief from teaching so that the package is implemented in a more rigorous manner through training and close liaison with project staff.

Above all, concepts in promoting health and preventing disease must be incorporated into the school curriculum to meet a wide range of health promotion needs of school students.

The school must develop policies and procedures to support behavioural changes in order to ensure that any attempt to prevent cigarette smoking among junior high school students in a school setting is effective and efficient.
The difficulties in obtaining active participation from parents in the project weakened the impact of this component. As was found in the findings of the mothers survey, the messages that should have been given to mothers included the need for mothers to take action to reinforce non-smoking behaviour in their children regardless of their own smoking status and the use of a combination of discussions and strict enforcement of non-smoking rules (Tang et al, 1999). Moreover, older siblings need to get involved in preventing their younger siblings to smoke.

The contribution of the retailer education strategy is not clear. Without publicised prosecutions of retailers, the cigarette-selling behaviour of retailers is unlikely to improve over the medium term.

Summary of lessons learned from the implementation of the project

There are a number of lessons learned from this case study.

First, the commitment of schools to their responsibility for preventing cigarette smoking among adolescents varies. There is a debate about whether or not schools should also be responsible for the achievement of good health among their students given that they have limited curriculum time and resources.

There is, however, a limit to what schools can do to solve the health and social problems of the wider community, if there is no additional input to the schools. Many schools cannot meet the demand, by public health and health promotion practitioners, to address a wide range of health issues among their students for a number of reasons, for example, lack of expertise, finance and teaching materials. If schools are required to take up a major role, additional funding must be provided. Training must also be given to teachers so that any intervention can be implemented effectively and efficiently.

Education is not only about the academic development of the students but also their physical, social, mental and moral development. Moreover, there is a considerable coincidence of determinants to the achievement of the best academic, social and health outcomes for adolescents (St Leger and Nutbeam 1999). After all, given the high prevalence and early onset of cigarette smoking among adolescents, the well-established evils of cigarette smoking and the widespread coverage of adolescents by schools, schools must be responsible for and, therefore, committed to preventing young people, particularly, adolescents to smoke cigarettes. It is important to emphasise that asking schools to be responsible for preventing cigarette smoking among adolescents does not mean exclusive responsibility. Schools, families and the wider community must work in partnership through a school-home-community approach. It is a shared responsibility among the three sectors. Family members, particularly, parents and elder sibling as well as the wider community, particularly, the tobacco retailers must also be responsible for their part. In fact, the schools can show
leadership by initiating strategies to work with family members and key stakeholders in the community. It is time for schools to play a leading role in the community and advocate for the achievement of social and health goals of young people.

Second, the approach that is being used in schools to the organisation of cigarette smoking prevention project has not yet been well thought through and the capacity of the schools in undertaking these projects is also limited.

The identification of predictors that lead to the onset of smoking of a particular population group is also important. More often than not, interventions for cigarette prevention are developed and implemented based on theoretical expectations and assumptions. As predictors of adolescent smoking onset are in abundance and findings in this area are quite often conflicting, the predictors leading to cigarette smoking onset may be different from one adolescent group to another. For example, while fathers' smoking behaviour was a key predictor of some other adolescent groups, it was not a predictor in this case study. Whereas elder siblings' smoking behaviour which might not be a predictor of some groups was a key one in the present study (Tang et al, 1997a; Tang et al, 1998). Mothers should have also been encouraged to use a combination of discussions and strict enforcement of non-smoking rules to prevent the onset of cigarette smoking among their adolescent children. A rigorous examination of the key predictors of smoking of a group under study is thus recommended to be undertaken prior to the development of population-based behavioural outcome interventions for that group. It may be more cost-effective to target the key predictors identified through such an examination than to solely target those that are simply consistent with theoretical expectations. The impact of interventions for cigarette smoking prevention for a particular population sub-group can be more effectively developed if the various predictors of smoking of this sub-group are known in advance.

The need for rigorous field testing of the various component of any interventions appears to be another important task. In the case study, with regards to the effectiveness of the three intervention components, parental support and supply reduction have not yet been proven directly linked with reduced smoking prevalence. Nutbeam and colleagues (1993) argue that field testing of interventions, particularly population-based behavioural outcome interventions, is important before actual implementation.

Effort must also be made to avoid the comparison group being exposed to similar smoking prevention messages that are used for the intervention group if a comparison group is to be used. Otherwise, single group repeated posttest design can be used.

It is a fact that school-based health education programs alone seldom work in preventing cigarette smoking among junior high school students and the effect of any intervention will likely be more positive if it is operated within the school-home-community framework.
To date, however, although the essential elements of school-based prevention strategy have been developed, the same elements of parental support and supply reduction strategies have not yet been identified. By using the findings of this case study, a model of good practice in preventing cigarette smoking among junior high school students must possess a number of essential elements in the school, home and community settings. These essential elements are listed as below:

A model of good practice

- Essential elements of school smoking prevention programs, as reported by Glynn (1989)

<table>
<thead>
<tr>
<th>Time allocation</th>
<th>minimum of five 40 minute lessons per year for a few years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing:</td>
<td>right at the beginning of year 7, if not at the beginning of year 6</td>
</tr>
<tr>
<td>Content:</td>
<td>two programs are required, with one targeting years 7 &amp; 8 students and the other for years 9 &amp; 10 students. As a rule of thumb, the core programs should emphasise on peer influence, refusal skills, media influence, the role of the tobacco industry in encouraging young people to smoke and short-term consequences. However, the identification of predictors that lead to smoking onset of a particular population group under-study is crucial. Specialised programs needs to be given to special needs students such as smokers and students speaking a LOTE</td>
</tr>
<tr>
<td>Mode of delivery:</td>
<td>integrated with existing school curriculum and extra-curriculum activities</td>
</tr>
<tr>
<td>Method:</td>
<td>role modeling, prevention oriented, student-led and involvement of parents as well as elder siblings</td>
</tr>
<tr>
<td>Education and training:</td>
<td>required for teachers and school as a whole through capacity building</td>
</tr>
</tbody>
</table>
Prevention Of Cigarette Smoking Among Junior High School Students: A Case Study Of Promoting Health In Schools - Experiences In Health Promoting Schools - Australia

- Essential elements of family involvement as reported by Tang and colleagues (1999)

<table>
<thead>
<tr>
<th>Time allocation</th>
<th>on a regular basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing:</td>
<td>transition period between primary and high schools</td>
</tr>
<tr>
<td>Content:</td>
<td>smoking behaviour, negative attitudes toward smoking such as harmful effects and short term consequences of cigarette smoking, appropriate parent/child interaction such as discussions and strict enforcement of non-smoking rules</td>
</tr>
<tr>
<td>Mode of delivery:</td>
<td>through the parents and citizens or friends committees and social marketing</td>
</tr>
<tr>
<td>Method:</td>
<td>role modeling and use of social group work</td>
</tr>
<tr>
<td>Education and training:</td>
<td>required for parents and elder siblings through empowerment</td>
</tr>
</tbody>
</table>

- Essential elements of community involvement

<table>
<thead>
<tr>
<th>Time allocation</th>
<th>on-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing:</td>
<td>on-going</td>
</tr>
<tr>
<td>Content:</td>
<td>enactment of legislation to limit access by elimination of advertising, sponsorship and illegal sales, increased price and reduced exposure to smoking behaviour and retailer education</td>
</tr>
<tr>
<td>Mode of delivery:</td>
<td>community-wide and community-based programs</td>
</tr>
<tr>
<td>Method:</td>
<td>community development and policy analysis (eg lobbying for policy changes)</td>
</tr>
<tr>
<td>Education and training:</td>
<td>required for key stakeholders such as tobacco retailers, politicians, senior government officials as well as the wider community through media advocacy and empowerment</td>
</tr>
</tbody>
</table>
With regards to capacity building, there must be effort in building the capacity of individual teachers as well as the school as a whole. In addition to their capacity in achieving the academic goals, there is also need for the school to examine its curriculum and content, organisational behaviour and its connections to the community to achieve its academic, social and health goals. As regards the capacity of teachers, they must be taught at universities why it is important to achieve academic, social and health goals and how to achieve all of these goals. On the job training given by working together with public health and health promotion practitioners is necessary but not sufficient to provide the teachers with adequate knowledge of and skills in these two areas.

The capacity of a school as a whole to promote health has to be developed as well. It is important for the school to make policy and organisational changes that support the achievement of both academic and health goals, for example, the collection of social and health data of students, the development of school policies, structure and climate that sustain the impact of its academic and health education on student health and well-being, the creation of a healthy physical environment, the provision of education to teachers and the involvement of active participation of students and the creative use of the school curriculum in achieving both the academic and health goals.

To build its capacity, the school, with assistance from public health and health promotion practitioners, can use the organisation of a particular health project such as prevention of cigarette smoking as a means and incorporate in the organisational process capacity building opportunities, as an end.

Conclusion

To ensure that interventions which aim to prevent cigarette smoking among junior high schools students are effective, these interventions must be planned and implemented using a school-home-community approach in a health promoting school framework. The schools, families and the public health sectors must work in partnership and comprehensive intervention strategies have to be used. The different intervention strategies must also be well planned, thoroughly implemented and rigorously evaluated. For these intervention strategies to succeed, schools have to assume a major and leadership role and the capacity of individual teachers as well as the schools as a whole needs to be built so as to achieve both the academic and health goals.

References

Prevention Of Cigarette Smoking Among Junior High School Students: A Case Study Of Promoting Health In Schools - Experiences In Health Promoting Schools - Australia


US Department of Health and Human Services (1994) Preventing tobacco use among young people: A report of the surgeon general. Atlanta, Georgia, US Department of Health and Human Services, Public Health Services, Centres for Disease Control and Prevention, national Centre for Chronic Disease prevention and Health Promotion, Office on Smoking and Health.
A PILOT PROJECT ON HIV/STD PREVENTION AS AN ENTRY POINT FOR THE DEVELOPMENT OF HEALTH PROMOTING SCHOOLS IN BEIJING, CHINA

Jiangping SUN
Institute of Child and Adolescent Health
Beijing Medical University, Beijing China

Introduction

Currently there are still no cure or vaccines for HIV/AIDS, therefore health education is very important for AIDS prevention. In China, children and adolescents comprise one-third of the total population, and therefore, it is more important for China to promote health education on AIDS prevention among students in schools and universities.

Young people in China are not believed to initiate sexual activities as early as young people in the Americas, Europe and Africa. Many teachers, parents and health/education officials are concerned and reluctant to introduce education about sex and HIV in China's schools. Strategies are needed to develop prevention programmes that can build on existing and accepted efforts to promote health and address topics related to sexuality in China.

Health promoting schools is a global program on school health advocated by WHO. The Chinese government pays much attention to it, and focuses on the theme of strengthening and enlarging school health work and exploring the feasibility of developing health promoting schools in China.

In such situation, the Project on HIV/AIDS/STDs Prevention as an Entry Point for the Development of Health Promoting Schools in China was introduced and initiated in 1997 with the support of WHO/HQ, UNAIDS, CDC of USA and UNDP.

As a pilot study, the project was expected to achieve some objectives such as setting up a surveillance system to monitor knowledge, attitudes and practices associated with HIV infection, developing a training program for teachers, and implementing education programme among students to prevent HIV infection. Ideas and experiences from the pilot study could be shared and would be useful for many schools in other cities.

The project was implemented by the Institute of Child and Adolescent Health of Beijing Medical University during 1998-1999. Methods of the project were delineated to explain the purpose of the survey to parents, students, teachers and other school personnel, to obtain approval to conduct the survey, to ensure the anonymity of participating students/schools, to administer the questionnaire, to process and analyse the data, to implement the intervention, to evaluate the outcomes and to report and share the experiences. This report discusses the five aspects of the project as follows.
A Pilot Project On HIV/STD Prevention As An Entry Point For The Development Of Health Promoting Schools in Beijing, China

Surveillance System Development

For the collection of base-line information, a questionnaire adopted from the CDC's Youth Risk Behaviour Survey Questionnaires was developed to survey risk behaviours among middle school students. The survey was approved by the Ministry of Education and the Ministry of Health of China. Prior to the conduct of the survey, the questionnaire has been pre-tested and revised accordingly.

The survey was conducted in 44 pilot schools from Beijing (10), Shenzhen (10), Yunnan (10), Liaoning (10) and Tianjin (4), and over 12,000 students in Grades 8 and 11 were selected as respondents. The answer-sheets of the survey were completed and collected at the field, and the set of data was scanned and analyzed by the Institute. The main results show the following:

- The proportion of students who have basic knowledge on AIDS varied from 22.0 percent to 75.1 percent, increasing along with grade levels. Thirty two percent of the students have been taught about AIDS or HIV infection in school. 31.9 percent of them have talked about HIV/AIDS with their family members, while 49.2 percent talked with their friends;

- Generally, the students do not have enough knowledge to protect themselves from HIV/AIDS infection. Only 37.7 percent of the students thought that they knew how to avoid HIV infection. The fear to HIV/AIDS infection and discrimination against AIDS patients and HIV infected persons were very common among students and only 10.1 percent of them indicated that they could seat with HIV infected classmates;

- The students have many health risk behaviours such as smoking cigarettes, drinking alcohol and drug abuse. On the issue of cigarette smoking, 37.7 percent of students have tried cigarette smoking, and among them, during the past 30 days, 26 percent smoked cigarettes for more than 20 days, 7.6 percent smoked 5 cigarettes per day. With regards to drinking alcohol, 45.2 percent of students have taken alcoholic drinks, among them 48.4 percent had their first drink of alcoholic beverages at an age younger than 13 years old. Regarding drug abuse, only 30.4 percent of students knew that some hypnotic and anti-anxiety medicines possess addiction to people, and 68.4 percent understood that illicit drugs possess addiction and the physical and mental dependencies on drugs are hard to get rid of.
A Pilot Project On HIV/STD Prevention As An Entry Point For The Development Of Health Promoting Schools in Beijing, China

Development of Intervention

The main measures of intervention were to initiate and to develop formal/informal curricula and school activities that will help young people maintain behaviour that protects them from HIV and STD infection and to prevent infection in the future.

A series of WHO documents on Health-Promoting Schools have been translated into Chinese and distributed to these pilot schools at the beginning of the project to improve quality of intervention.

Educational needs of students have been identified from the first survey. Based on these needs, educational materials about HIV/STDs prevention have been developed for teachers and students using reference materials from international and national education agencies. The materials focus on the issues of HIV/STDs prevention and other risk behaviour reduction, as well as other health issues.

A set of textbooks for students has been developed and published in the second half of 1998. These books contain chapters on HIV/STDs prevention, on drug abuse, and on reduction of other risk behaviours. In details, the contents of the textbooks include on what human biology and the reproductive system are, on how HIV/STDs is transmitted, on how HIV/STDs is not transmitted, on why we do not need to fear people with HIV infection or AIDS, and on how to say "no" to smoking, drugs and sex, and the like.

A teacher's handbook and a four-hour teaching module have also been developed by the Institute. It includes knowledge on HIV/STDs prevention, transmission, signs, treatments, principles of health education, national policies/strategies of HIV/STDs prevention and control, and everything that students and teachers should know, with more depth.

The teaching module contains also methods for acquiring skills on two-way communications, usage of teaching facilities, and skills on encouraging students to deal with difficult situations and to care for HIV infections, etc. Workshops to train teachers on how to use the materials have been held during the period October-December of 1998. The intervention activities for students in pilot schools were implemented from Dec. 1998 to May 1999 to adjust with the schools' academic calendar.

Orientation and Training

In China, about 10 percent of teachers in primary schools, 30 percent in junior middle schools and 45 percent in senior middle schools, have not met the qualification standards set by the Ministry of Education in 1997. However, they have been teaching in some schools for many years considering that these schools are badly in need of teachers. Those teachers are
not capable to take on full responsibility in the implementation of school health program and of health education in their schools, even though they show interest in doing so. Thus, the training of teachers is another decisive step taken to build up the capacity of teachers in implementing initiatives on health promoting schools. Meetings and training workshops were convened by the Institute of Child and Adolescent Health, in collaboration with the Ministry of Health, the Ministry of Education, WHO, UNAIDS, and UNDP with the primary aim to inform and train the officials and schools’ staff in target areas. Specifically, the workshops aimed to:

- identify questions that might be asked anonymously in schools in determining the prevalence of sexual and other important risk behaviours among students; and,
- obtain information that would be useful in planning education programmes that would help students acquire the knowledge, attitudes, values and skills needed to avoid HIV infection.

In the training workshops, participants discussed and improved the teacher’s handbook and the student’s book, practised by role playing the teaching module, and shared their experiences on health education.

School and Other Local Activities

During this project, schools implemented activities which enable students and school staff recognise ways in preventing HIV/STDs infection.

The Regional Guidelines on Development of Health-promoting Schools - *A Framework for Action* and *New horizons in health* published by the WHO-WPRO were translated into Chinese, and distributed to the pilot areas as well as in other areas, so as to increase awareness on the development of health promoting schools in China.

Posters, pamphlets and brochures about HIV/AIDS prevention and other schools activities were published by other agencies and distributed to the selected schools. These materials include contents about knowledge, attitudes, beliefs and values relevant to the prevention of HIV/STD infection that students, teachers, headmasters and parents need to have.

Information about telephone hotlines has been delivered to students in case they need help in an anonymous way.

A painting activity for anti-HIV/AIDS was launched in Beijing middle schools by the Institute in 1998. About 30 middle schools including those pilot schools in Beijing participated in the activity. This activity was highly praised by the Ministry of Education, the Ministry of Health, and by students and professionals.
A Pilot Project On HIV/STD Prevention As An Entry Point For The Development Of Health Promoting Schools in Beijing, China

Some pilot schools integrated HIV/AIDS education into the formal and informal health education curricula; some revised/adjusted their school health policies; some organized small anti-AIDS activities within or outside of schools; and some invited experts to deliver lectures to students and teachers on HIV/AIDS/STD control.

Some schools provided training programmes for teachers, even to those who teach other classes, so that they can teach about new health topics or improve the quality of their teaching methods.

Some schools developed guidelines for school health education, based on WHO guidelines, which call for coordinating interventions to address a variety of health-related issues and skills, including the prevention of HIV infection.

Some schools have taken actions to create a healthy physical and social environment. Environmental programmes can teach children that they have considerable control over risks in their environment. For example, they can be taught to avoid and report used needles and syringes found on the ground, request medical clinics to use new or properly cleaned needles when receiving an injection, or choose professional dentists rather than informal dentists whose equipment may not be properly sanitised.

Some schools have news bulletins that keep all students informed about activities and issues of interest to students. A school newspaper provides a means by which all students can receive information and ask questions about HIV/STD. It also provides a means by which students can become involved in educating their peers about HIV/STD.

Sharing of Experiences

One significance of the pilot study is the ability to share experiences and lessons that can be drawn and could guide the implementation of further studies. To be a part of, and to coordinate the national activities of health-promoting schools in China, we like to share the experiences of this project with other countries whenever it is appropriate.

- Identify what students and teachers need

Baseline data collection is essential to provide information for implementation of a project. It can explore what needs should be met for students and teachers, orient what objectives should be achieved, what measures of implementation should be adopted, and what evaluations should be provided.

Baseline information can convince teachers and principals about the need for HIV/STD education so that they will develop school policies and provide resources to support the project or efforts to help teachers implement health education.
Baseline information can help project planners to determine the entry point which schools can use to develop health promoting schools appropriately. There are many concerns which decision makers are interested in, for example: helminth reduction and control, myopia prevention, anaemia prevention, oral hygiene, mental health risk behaviours, and malnutrition, including obesity and so on. Choosing the appropriate entry point based on local situations is a crucial step for project success.

At present, about 270 primary and middle schools are involved and are being developed into health-promoting schools in China. Activities undertaken in these schools included deforming campaign, conduct of health education, prevention of HIV/STDs, campaigns against smoking, improvement of environmental sanitation and the like.

- **Encourage parents to take part in school activities**

  In China, one of the greatest fears among parents is that their child will become ill or die. Thus, some parents pay close attention to the advice from schools, such as through special programmes like "parent schools", and vice versa, a child's voice is powerful usually in his family, and health information is often communicated to the parent through the child. In this way, school health education programmes enable parents and children to take messages to each other and to use their influential positions in the family in addressing important risk behaviors, such as smoking and drinking.

  It is necessary to educate parents about the risks of HIV/STD infection, especially among young people. Parents need education about how to talk with their children about sex and HIV/STD infection and about the importance of educating students about HIV/STD infection. It is insufficient for parents to encourage teenagers to listen at the bedroom walls of newly wedded couples to learn about sex, as is done in rural areas of China.

  Because many schools have school health education programmes that reach students and parents, education about HIV/STD can be added to such programmes to influence both groups.

- **Strengthen training of responsible people and build up their knowledge**

  The sexual content of such education is very sensitive in China and some persons want to avoid this issue. Concrete steps are needed to help responsible persons make the decisions about what is to be given, when and by whom on this issue.

  Usually education and health officials, school headers/teachers are in the position to determine the most appropriate and effective ways to educate students at various
A Pilot Project On HIV/STD Prevention As An Entry Point For The Development Of Health Promoting Schools in Beijing, China

grade levels about sex knowledge and HIV/STD infection, including the extent of details to be provided. The education of responsible people therefore is essential to build up their knowledge and to ensure that students are given accurate information and are not confused by teachers or staff persons who may not be well informed. Parents, teachers and principals also need opportunities to meet and discuss ways of determining the most appropriate ways to educate students about the risk and prevention of HIV/STD infection.

• Create a policy environment that supports HIV prevention in schools

Policies are most necessary to create a healthy environment. School health policies demonstrate that people can collectively act through policies and legislation and address health problems, such as controlling drug use and caring students with HIV/STDs.

During the project, some schools have established policies to prevent smoking and encourage students to undertake activities against smoking. These enabled students to realise that their own actions can help create a healthy school environment. However, there are no school policies that facilitate prevention of HIV/STDs infection within schools. Schools should be encouraged to develop policies related to school health education and HIV prevention. Policies are also needed to ensure that students and staff who are infected with HIV, or relatives and friends of persons with AIDS are not socially rejected or barred from participating in school.

• Enhance multi-sectoral co-operation

During the preparation of the survey, the Ministry of Education of China sent out a formal request letter for support to education departments of the target areas for the project. Therefore, investigators easily got support from local education departments and school principals and teachers, and this made the smooth implementation of the project.

In China, schools are getting advice, suggestions and requests for action from many different sources. These include the education department and health department, but there seems to be a lack of coordinated approach to enable schools to know which direction to follow. This sometimes has led to problems in some health-related programmes.

A close multisectoral co-ordination at all levels is needed for successful implementation of a project. Establishing a working group consisting of health and education sectors is a considerable way to guarantee that programs are carried out smoothly and effectively.
The co-operation between health and education departments is the crucial measure for the completion of school health programmes. In China, multi-sectoral co-operation is organised and advocated by government/public when national school health program is initiated. It has been shown that when there is strong co-operation among the stakeholders, more progress is achieved from the program.

- **Integrate multi school health programs into one**

Another constraint that usually limit initiatives of health promoting schools is lack of financial resources. Schools do not generally allocate funds aside from the limited resource for extra project expenses. Resources to plan and implement education programme about HIV/STD should be allocated with consideration to the resources available in the community. Poor areas will need more resources than affluent ones. Resources should be allocated for a variety of actions, not just for a one time or one class approach.

The funding obstacle may be turned into a motivation for strengthening the links between schools and sponsors outside the education system. With the rising of social awareness on the concept of health promoting schools, funding from local communities or companies may flow into schools for promoting student’s health, improving school environment and school facilities. In addition, to integrate multi school health programs into a comprehensive one will allow the more efficient use of resources.

- **Technical and financial support from the International Community**

During the development of the project, crucial supports were received from international organisations as mentioned above. To value and accept the outcome of the project by international criteria, more international technical support is also needed.

China has a tradition of learning from the experiences of other countries, thus the review of existing HIV-related health education guidelines and curricula from other countries is very useful in considering what to do in China.

International co-operation provides an impetus to China's efforts to enhance school health activities. It does not only provide opportunities for exchanging ideas and experience between China and other countries but also gives moral support and inspiration as well.

The international co-ordination is also necessary for China to keep pace with other countries and share experiences that certainly favours programs on school health.
A Pilot Project On HIV/STD Prevention As An Entry Point For The Development Of Health Promoting Schools in Beijing, China

Acknowledgements

Many thanks are given to Mr. Jack Jones of WHO/HQ, Dr. Nancy Fee of UNAIDS and Dr. Wick Warren of CDC of USA for their efforts to initiate and implement this study. Without their contributions it is impossible to make this project go on successfully.
Introduction

The Federated States of Micronesia (FSM) is an independent, constitutional, democratic Federation which consists of four island states: Pohnpei, the capital state, Chuuk (formerly Truk), Kosrae (formerly Kusaie), and Yap. The FSM is situated in the central northern Pacific. It was once part of a conglomeration of island countries in the Pacific formerly known as the Trust Territory of the Pacific Islands administered by the United States of America under a United Nations (UN) Trusteeship Agreement since 1947. The FSM became an independent country in 1986, and thereafter became a full member of the UN on September 17, 1991. Under an international treaty known as the Compact of Free Association between the USA and FSM which became effective in 1986, the USA was delegated the responsibility for defense of the FSM. The US, however, does not have any military installation in the FSM.

The total land area of the FSM is 271.3 square miles consisting of 607 small islands, both volcanic and coral islands. The four main island states include Pohnpei with 133.4 square miles, Chuuk with 49.2 square miles, Yap with 45.9 square miles and Kosrae with 42.8 square miles. The FSM island states are dispersed across the northern Pacific covering an area of approximately 2.5 million square miles.

The average year-round temperature throughout the FSM ranges from 80 to 85 degrees Fahrenheit. Annual rainfall averages between 100 and 200 inches, although the interiors of Pohnpei and Kosrae are estimated to average over 300 inches annually.

Based on the 1994 FSM Census, the population of FSM was 105,506 with an estimated annual growth rate of 1.9%. State population as of 1994 are as follows: Chuuk—533,319; Pohnpei—33,694; Yap—11,176; and Kosrae—7,317. Ethnic groups and languages in the FSM are as follows: Micronesian 98%, Polynesian 2%. There are eight officially recognized indigenous languages spoken in the FSM: Yapese, Ulithian, Pohnpeian, Nukouran, Kapingamarangese, Chuukese, and Kosraean. The English Language is the common language for the FSM and it is our second language.

The health system is comprised of four state departments of health and a national department of health, education and social affairs. The FSM constitution give “concurrent” powers to state and national governments for the provision of educational and health services. In general, the locus of educational and health policies is at the state level. The stage governments administer, regulate, and fund almost all line educational and health services.
The national government, on the other hand, is principally assigned support and coordination services, such as training, reviewing, updating, and developing policies and regulations, as well as planning and setting minimum education and health standards. This really creates a major difficulty for education and health program in the FSM.

Health Promoting Schools Program

The World Health Organization (WHO) invited the Federated States of Micronesia (FSM) to join the Health Promoting Schools (HPS) program in July of 1995. FSM responded by selecting a National Coordinator and an Assistant Coordinator immediately. The designated National Coordinator came from the Department of Health Services while the Assistant Coordinator was from the Department of Education. The two coordinators attended the workshop for national coordinators of health promoting schools in the Pacific, from 2-6 October 1995 at the University of the South Pacific in Suva, Fiji. Immediately following the workshop, the National Coordinator informed all FSM citizens of the existence of HPS in the country through a press release.

The Coordinator and the Assistant Coordinator then visited all the four states in FSM, to explain the HPS concept to the Directors of Education and Health, and to solicit appointment of state contact persons from the two departments. The Directors were enthusiastic about the HPS concept and thus appointed contact persons. However, the appointed contact persons resisted the new responsibility, initially, because of the extra workload.

The State Directors of Education and Health also agreed to a proposed student health survey that was to be conducted in April – July of 1997 with the assistance of the University of Sydney in Australia. However, said survey has not been conducted. The concern expressed by the contact persons regarding “work load” was eased when the Regional Guidelines for HPS came out. When instructed on how to use the guidelines for implementation, monitoring, and evaluation purposes, they realized that it was not as cumbersome as they thought. At the outset, only education and health sectors were involved in the implementation process, and the National Government provided support in an advisory capacity and in providing human resources.

The geographical demography of FSM called for travel in the HPS implementation process. In November of 1995, WHO gave FSM $4,465 dollars and the money was used to support travel of the HPS National Coordinator and Assistant Coordinator to the FSM states to meet with the Education and Health Department Directors. Subsequently, the coordinators have been holding meetings and demonstrating the application of the Regional HPS guidelines to complement existing school health activities or health curricula.

FSM experienced some setbacks in 1997 to early part of 1999, due to restructuring of State Governments and changes in administration. In Chuuk State, the contact person in the Department of Health moved to the College of Micronesia, Chuuk Campus. In Yap, the contact person in the Department of Education was detailed to do other duties. The situation in Chuuk has been rectified by the appointment of a new contact person, but the Yap
situation has not been solved. The new Director of Education and Health in Chuuk, Kosrae, and Pohnpei had to be reoriented. Encouragingly, they have been and are all very supportive of the HPS concept and its implementation. The spirit of support and enthusiasm was enhanced in Pohnpei by the visit of the HPS Regional Network Coordinator, on March 16-18, 1999 when she met with the Secretary and the Assistant Secretary of Health, Education and Social Affairs (DOHESA), the National Coordinator and Assistant Coordinator, the Pohnpei contact person in the Department of Education and the Directors of Education and Health. She also visited the two designated pilot schools and held meetings with the teachers on the concept and implementation of HPS program. Also, in April of this year, in a health education workshop for elementary school teachers, the National Coordinator gave a presentation on HPS.

In early part of June 1999, FSM received the generous assistance of WHO, through the WHO Office in Suva, Fiji in preparing for three HPS workshops that were held last month in the States of Chuuk, Kosrae, and Pohnpei. After the workshops one elementary school teacher in one of the Pilot Schools in Pohnpei, a heavy smoker, quit smoking and is still not smoking. In a telephone conversation with the Principal of Sokehs Pah Pilot School, also in Pohnpei, the HPS Coordinator learned that materials to build a fence around the school premises have been provided through the National Senator from that election precinct. The Coordinator has yet to make contact with other states.

WHO also provided substantial assistance in preparing for another workshop on Promotion of Health Education for young people through audio, video and printed materials, which was conducted in Pohnpei last July. While it was meant to be a national workshop, participants from Chuuk, Kosrae, and Yap were not able to travel in time to make it to the workshop due to time constraint.

Lessons Learned

We learned from our implementation experiences that:

1. HPS program needs close monitoring for continuity and sustainability;

2. well-established and well-maintained dialogue between the National Coordinators, the State Directors of Health and Education and State Contact persons including a reporting system must be in place;

3. well-established and well-maintained dialogue between National Coordinators and WHO must exist;

4. there must be a direct interaction between the National Coordinators and WHO Consultants;

5. workshops to facilitate public awareness and advocacy should be implemented;
6. financial resources for supplies, equipment and travel should be available, and above all;

7. there must be total commitment to achieve quality outcomes and to overcome hardships; and,

8. It should be noted that a parallel health promotion program exists in FSM: the Teacher Child Parent Community (TCPC) program. The program was promoted by UNICEF, coordinated by FSM National Nutritionist and executed by the FSM States. TCP and HPS share a common purpose in that they both aim to promote health starting with the student population. TCPC puts emphasis on dietary issues and values. HPS takes one step further in that it is action oriented and utilizes a holistic approach. That is, it takes into consideration the inter-relationship between the physical, mental, social, and environmental aspects of health. In terms of coordinated efforts, the TCPC coordinators in Pohnpei and Chuuk States are also HPS contact persons in the Department of Education. However, there is evidence that there is need for further clarification of the roles the programs play and how they complement each other. At one point the coordinator of efforts. A reporting system between states and National Government and between National Government and WHO needs to be established.

In conclusion, I would like to state that like TCPC in its early years of implementation, HPS is experiencing some difficulties but we know that HPS program will grow in the FSM. We know it will grow because we started from point zero, and now we are at a point where we have local advocacy and the support of our education and health leaders. We know it will grow because we need it. We know it will grow because we have the support of our sister countries in the South Pacific Region. We know it will grow because we have the support and guiding hands of WHO and other agencies and organizations such as the Secretariat of the Pacific Community (SPC), University the South Pacific (USP) and Vic Health in Australia. Above all we know it will grow because we are determined to make it grow and to sustain its existence on the FSM.
WHO-SHANGHAI PILOT PROJECT ON WORK-SITE
HEALTH PROMOTION

Liu Min; Gu Xueqi
WHO Collaborating Center for Health Education and Health Promotion
Shanghai, China

Introduction

Located in the middle of the eastern coastline, Shanghai is the largest industrial city and economic center in China. It is one of the four cities directly under the jurisdiction of the central government. Covering a total area of 6,400 square kilometers, Shanghai has a total population of over 16.4 billion, of which over 4.2 million work in industries.

Since the early 1990s when the economy began to develop rapidly, non-communicable diseases have become the main health problem in Shanghai along with the traditional communicable diseases. In addition, occupation-related risks still endangered the population in workplaces.

There was a good network of primary health care in the industrial system in Shanghai, that delivered health education programmes. However, similar to other health education activities in the workplace at that time, these activities had some deficiencies namely: (1) focusing on specialized or single issue; (2) ignoring the creation of supportive environment; (3) lacking well-designed planning, implementation and evaluation.

In view of this situation, WHO/WPRO entrusted the Shanghai Health Education Institute which is also the WHO-Shanghai Collaborating Center for Health Education and Health Promotion with a pilot project to explore an effective model for workplace health promotion that could also be replicated in other countries of the Region.

Beginning January 1993 and applying a comprehensive approach, the three-year project aimed to create healthy work environments, encourage healthy lifestyles and reduce the risk factors and incidence of occupational diseases and accidents.

This report will describe the methodology and findings of the project and lessons learned.

Methodology

Sampling

Cluster sampling was used based on four criteria: (1) management interest and support; (2) good health education infrastructure; (3) the potential for positive
economic returns; (4) Variety of industry. Four factories were selected using the above criteria: Hudong Shipyard (12,300 staff), Wujing Chemical Complex (6,590 staff), No. 34 Cotton Mill (2,227 staff) and Baoshan Iron and Steel Company (36,478 staff). In view of the large number of workers in Baoshan Iron and Steel Company, only two factories of it were selected to participate in the project— the Power Plant and Steel Tube Plant (total of 1,200 staff). The project was carried out among all the staff in the selected factories.

Cluster sampling method was also used for KABP surveys that were conducted at the beginning, midterm and end of project. The primary sampling unit was the working group in the factories. The smoking rate was used to calculate the sample size.

Data Collection

Data were collected through two methods: (1) document review, including the disease reporting records, and monitoring reports on occupational risks. These records were available in the pertinent departments of the factories, and (2) KABP surveys. The uniform sampling strategy and questionnaire were used in the baseline, midterm and final surveys by face-to-face interview. The questionnaire covered such areas as demographic status, KABP about the risks targeted by the project (like smoking, eating habit, and labor protection, etc.). Information obtained from the questionnaires were treated with utmost confidentiality.

Data Analysis

Logistic regression was used to find the correlation between risk-related KABP and demographic status. \( \chi^2 \) was used to compare the differences between baseline and final data.

Project Management

A network was established to guarantee the implementation of the project:
The Lead Group consisted of decision-makers from the Shanghai Municipal Health Bureau and Shanghai Health Education Institute which provided political support to the project. The members of the Steering Committee are experts from four organizations (Shanghai Medical University, Shanghai Hygiene and Anti-epidemic Center, Shanghai Occupational Health Institute, and the Shanghai No.6 Hospital), and the committee provided technical support to the project. The Executive Group members are health professionals from the Shanghai Health Education Institute and is responsible for the general planning, monitoring and evaluation of the project and organizing project-related activities. In each factory, there was a Health Promotion Committee consisting of the general manager and managers of all related departments such as the general office, labor union, youth league, safety and environment protection, health, education, communication, finance, equipment and logistic, etc. It enabled the project to be a part of the business in the factory. Also in each factory, there was a Working Group the members of which consisted of professionals from health department as well as from other departments (e.g. equipment and logistic, etc.) in the factory. The group was responsible for the planning and implementation of subprojects in its own factory.

Intervention Strategy

The development of intervention strategy aimed to create a supportive environment through behavioral changes taking place both in the organizations and among individuals.

The strategies for organizational change were: (1) establishment of a health promotion committee; (2) development of policies on the control of risks (e.g. smoking, labor protection and diet, etc.); (3) creation of a better physical and work environment (e.g. improved toilet facilities and waste disposal, expanded green areas, renewed equipment and reorganized work processes etc.); (4) provision of healthy food in the canteens; and (5) reorientation of health services (e.g. hypertension management, and involvement of health professionals in labor protection).

The objective of the strategy which target on personal behavioral change was to enlighten the workers and enable them to recognize the risks and know how to control them. Different methods were used to achieve this objective: (1) media, such as "Health Education Textbook", pamphlet, blackboard, broadcast, cabled TV and video, etc.; (2) inter-personal communication, such as quit-smoking club, self-help group, training course, knowledge contest, consultation, etc.; (3) skills provision which made healthy behavior possible; and (4) encouragement by awarding honorable titles to model workers.

Process Evaluation

Four working systems were established to guarantee the quality of the project. (1) Instruction system. Starting from the planning stage, the Steering Committee was involved in the whole process of project development. In addition, temporary consultants assigned by WHO/WPRO held workshops and made field visits to give advice; (2) Monitoring system. Regularly
(usually once a month), the Executive Group staff visited the factories to monitor the progress of the project; (3) Inspection system. Quarterly meetings were held in the factories rotationally. Participants were from the Steering Committee, Executive Group and Working Group. Not only does the Working Group staff of the host factory report on the implementation in the last three months, but also the participants from other three factories had to make reports. Problems emerged, especially those in the host factory, and recommendations to solve the problems are raised. At the same time, good experiences were shared among the participants. (4) Match system. As the members of the Steering Committee came from four organizations and university in Shanghai, matches were made between factories and organizations in accordance with the interests of both sides. More frequent and focused technical support was given within each match.

Impact evaluation

Data from sampling surveys and documents were used to evaluate the changes at the time when project was finished. Indicators were set regarding the following areas:

1. Prevalence of risk-related factors and KAP, such as smoking, self-care, eating habit, labor protection and first-aid, and physical exercise, etc.

2. Control of diseases
   - Incidence of gastro-intestinal infectious diseases (reported hepatitis A and bacterial dysentery);
   - Prevalence of target diseases

   Two diseases were targeted in each factory to be controlled. One was hypertension, of which the management rate (as indicator for health service delivery) was used. Another was the most common disease in each factory, of which the prevalence was used. The most common diseases were pharyngitis and laryngitis in Wujing Chemical Complex, cervical erosion in No. 34 Cotton Mill, and gastric ulcer in the other two factories.

   - Absence rate resulting from the target diseases

3. Health-related policy and service
   - number of health policies developed for required issues and whether special staff was assigned to oversee the execution of the policies.
   - management rate of hypertensives (e.g. filing and follow-up), frequency of physical examinations provided and the amount of table salt used for lunch in the canteens
4. Control of occupational risks

- use of personal protective devices (earplug and dust-mask)
- proportion of monitoring spots that complied to national standards

Two major occupational risk factors in each factory were monitored: Coal dust and noise in Baoshan Steel Company, silica dust and noise in Hudong Shipyard, CO and NH₃ in Wujing Chemical Complex, and cotton dust and noise in No.34 Cotton Mill.

- incidence of occupational accidents

5. Environmental management

- proportion of "three-waste disposal" that was up to national standards
- coverage of greenery in the available open areas
- proportion of hygiene toilets
- proportion of managed garbage disposal

Resources

The resources (totaling RMB 880,000 yuan) came from three sources: resources from WHO/WPRO and Shanghai Municipal Health Bureau were used for project management, while the resource input by the project factories (accounting for 80% of the total) was used mainly for all the activities implemented in the factories.

Project Results and Lessons Learned

1. The general results of the project are the following:

- Reduced male smoking rate and increased rate of physical exercises (Table 1);
- Decreased incidence of gastro-intestinal infectious diseases and prevalence of target diseases as well as absence rate resulting from target diseases (Table 2, Figures 1, 2, & 3);
- Development and execution of policies and improved health service, such as reduced salt content for lunch in canteen food (on the average, reduction from 6-7g per capita to 4g), increased management rate of hypertensives (with the lowest increasing from 71.4% to 95.0%), and regularly delivered physical examinations involving more workers.
- Improved labor protection, such as increased proportion of monitoring spots that were up to the national standard, increased use of protective devices, and decreased occupational accidents (Figures 4, 5, 6, & 7);
- Cleaner and greener environment
2. Four elements that were successful in the creation of a supportive environment are:

- **Comprehensive issues**

  The problems that might exist in the workplaces were considered. Most of them were closely related. Therefore, the project focused on comprehensive issues instead of one single issue that could gain satisfactory impact by dealing with all these concerns.

- **Integrated approach**

  The integration of the project into the workplace business plan made it alive. Both health sectors and other sectors worked together. Moreover, the families of the workers were also involved.

- **Systematic management**

  The working system of the project enabled both top-down and bottom-up procedures that helped find effective solutions to problems and made the sectors and people participate willingly.

- **Multi-faceted intervention**

  By targeting different groups and issues, different intervention strategies (a combined administrative and behavioral method) functioned well.

3. One unsuccessful element was the inadequate assessment of needs. Originally, the project plan included a large number of issues to be controlled. After one-year of implementation, a problem appeared that the efforts gained little impact on some issues because the staff of the working groups could not deal with all the issues in one period. Thus, under the instruction of WHO/WPRO consultant and Steering Committee, needs assessments were done and priorities were given to some issues. After that, all the efforts were put on these issues. The other unsuccessful element was the incomplete data recording. Especially in the Cotton Mill, some data were not available before and for 1993. After defining the problem, the working group in the factory was required to record all the related data.

4. Aside from the above unsuccessful elements, another lesson learned so far was the issue of sustainability. Although sustainability was considered in the project planning, after the project, some of the efforts in some factories discontinued that the improved status could not be maintained. There might be two reasons for that: one is that the project was independent from the local health education centers that are responsible for overseeing the daily health education activities.
and providing guidance in these factories; another is the poorer economic return due to industrial restructuring.

### Table 1. Male smoking rate and percentage of involvement in physical exercises in baseline (1) and final (2) surveys (%)

<table>
<thead>
<tr>
<th></th>
<th>Baoshan</th>
<th>Hudong</th>
<th>Wujiang</th>
<th>No.34</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>smoking</td>
<td>58.7</td>
<td>48.6*</td>
<td>55.7</td>
<td>46.7*</td>
</tr>
<tr>
<td>exercises</td>
<td>30.6</td>
<td>45.9</td>
<td>33.0</td>
<td>45.0</td>
</tr>
</tbody>
</table>

P<0.01, * P<0.05

### Table 2. Absence rate resulting from target diseases in 1992 and 1995 (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Laryngitis &amp; pharyngitis</td>
<td>1.18</td>
<td>0.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.71</td>
<td>0.46</td>
<td>0.19</td>
<td>0.07</td>
<td>1.0</td>
<td>0.5</td>
<td>0.59</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Ulcer</td>
<td>0.19</td>
<td>0.09</td>
<td>0.19</td>
<td>0.09</td>
<td>0.19</td>
<td>0.09</td>
<td>0.74</td>
<td>0.51</td>
<td></td>
</tr>
</tbody>
</table>

### Figure 1. Prevalence of Laryngitis and Pharyngitis in Wujing Chemical Complex (1992-1995)
Figure 2. Prevalence of Gastric Ulcer in Two Factories (1992-1995)

Figure 3. Prevalence of Cervical Erosion in No.34 Cotton Mill (1992-1995)
WHO - Shanghai Pilot Project on Work-Site Health Promotion - China

Figure 4. Prevalence of Earplug Use in Three Factories (1992-1995)

- Hudong
- No.34
- Baoshan

Figure 5. Prevalence of Mask Use in the Four Factories (1992-1995)

- 1992
- 1993
- 1994
- 1995

factories
Figure 6. Proportion of the Noise Monitoring Spots that Were up to National Standard (1992-1995)

Figure 7. Incidence of Occupational Accidents in the Four Factories (1992-1995)
HEALTH PROMOTION AT WORKPLACES IN SMALL AND MEDIUM-SCALE ENTERPRISES IN NGO QUYEN DISTRICT, HAI PHONG CITY AND IN HUE CITY - VIETNAM

Nguyen Thi Hong Tu
Deputy-Director, Department of Preventive Medicine, Ministry of Health, Socialist Republic of Vietnam

Background

Nowadays, small and medium-scale enterprises have contributed importantly to the socio-economic development of Vietnam. The number of these enterprises has been increasing rapidly comprising up to 80-90% of the total number of registered enterprises with diversified jobs. The number of workers in small and medium-scale enterprises has also constituted a great part of the total industrial workforce. Majority of small and medium-scale enterprises belong to the non-state enterprises, however, the policies and regulations related to taking care of workers' health mainly focus on the state enterprises. The management of many of these small- and medium-scale enterprises has limited knowledge of the occupational health and safety laws and regulations thereby compliance is still very weak. On the other hand, some employees of these enterprises view work as a vital source of livelihood regardless of the adverse effects of their working conditions to their health. Policies such as compulsory social insurance are not implemented and many employees do not have access to the health insurance system.

According to some occupational health and safety studies in these enterprises, employees laboured in working environment which did not meet health standards, for example high noise intensity, high dust concentration, exposure to many toxic chemicals, hazardous production processes, inappropriate machines to Vietnamese anthropometry, etc. Taking care of workers' health in these enterprises was particularly poor. One of the reasons is the employers lack of basic knowledge on occupational health and safety, thereby they do not invest enough support into the improvement of working conditions and health promotion for the employees.

Development of small and medium-scale enterprises is an important policy of our government in diversifying the economic compositions thereby contributing to the national economy. This would also create many job opportunities and shifts one part of rural economy into industrial development. Our Party orientations have been to achieve the objectives for development of small and medium scale enterprises by the years 2000 and 2010. Consequently, it is expected to increase the gross domestic product from 24% to 25% by the year 2000 and to 28% by the year 2010; and the proportion of production from small and medium scale enterprises will increase from 31% to 32% by the year 2000 and to 34% by the year 2010.

With the policy of our Party and our Government: "Health for all, and equity in health care for all", the Ministry of Health is greatly concerned with the workforce in small and medium scale and those in non-state enterprises for them to have the appropriate health protection. In that circumstance, we are making great efforts in occupational health activities toward improving labourer's health. These activities mainly focus on prevention and control of work-related hazards as well as management of occupational diseases.

In Vietnam, health promotion for the working population is a new issue and has just been carried out in some aspects whereas the role of the health promotion in the workplace is very
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

crucial. Health promotion is not only the duty of health sector but also of the society in general. Health promotion is the bridge between risk prevention and treatment in order to achieve perfect health. Strategic activities of health promotion are the development of public health policy, environmental protection, strengthening communication activities, and changing health services to improve labour's health.

Among the duties of the health staff in the health promotion programme are as follows:

- To protect worker’s health by controlling risks and applying ergonomics at workplace;
- To advise employees and employers about health-promoting activities and how to improve working conditions.
- To assist in the control of working environment and promote worker’s health through early identification of health risks as well as in the assessment of the effectiveness of health protection & promotion programme.

Health promotion is new issue in Vietnam but there have been some initiatives done concerning to this issue such as prevention of smoking, alcohol, controlling blood pressure. However, such activities have not been summarised and evaluated thus these have not been included in the training plan.

The Labour Law introduced in 1994 has a chapter on occupational health and safety. In 1995, the Prime Minister approved a Decree which gave more details on OHS in existing law. In 1996, under that Decree, the Ministry of Health approved the regulations on occupational health management in all enterprises. The new regulations helped us in developing occupational health and safety programmes in small- and medium-scale enterprises.

In 1997, the Department of Preventive Medicine, Ministry of Health conducted a survey about the potential working relationship between district health units & small- and medium- scale enterprises. The survey is entitled “Higher productivity & better working conditions and health”. The survey results have shown that it is very necessary to implement health promoting-workplaces projects in small- and medium-scale enterprises in order to create healthy, supportive and safety working conditions for the workers. The programme will not only improve workers' health but also increase productivity. In the conference on “Development of health-promoting small- and medium-scale enterprises held in Thuong Hai, last December 1997, it was agreed upon that Vietnam will continue doing the pilot project for 1998-1999 with technical support from WHO support.

Objectives

The project aims to implement health promotion activities at workplaces in small- and medium-scale enterprises in two pilot healthy cities: Hai Phong and Hue.

Activities for 1998-1999:

1. Conduct of a National workshop to introduce the concept and the role of health-promoting workplaces among different government agencies and non-governmental institutions
2. Conduct of a survey to collect data on worker’s health, environmental hazards and assess the needs and interests of the workforce in small- and medium-scale enterprises in the two pilot cities

3. Organisation of a training course at Haiphong and Hue city for enterprises on the development of plan of action.

4. Implementation and follow-up in two health districts with the topic: “Healthy city, healthy workplace

5. Evaluation workshop. The pilot projects will be evaluated in order to draw experience before deploying the program to other workplaces

Characteristics Of Ngo Quyen District, Haiphong City And Hue City

Ngo Quyen district, Haiphong city: The population of Ngo Quyen district is 171,213 with 14 quarters. There are 91 small- and medium-scale enterprises with a total of 1,347 labourers, of whom 569 persons are female (42.24%). However, it has been reported that there are only 73 enterprises currently operating, but through out the actual survey only one-third of the total enterprises (48 enterprises) are operational while the rest have been closed or temporarily ceased. Of the 48 enterprises surveyed, 46 are small-scale enterprises (95.8%), of which there are 6 co-operatives, 9 working groups, 31 companies & private companies. There is no state & joint venture enterprise. There are two medium-scale enterprises (4.1%) of which there are 1 co-operative & 1 private company. The main occupation, which have the highest number of workers involved are in mechanical, chemical, food processing, construction material and garment enterprises. The District Commercial and Industrial Office is the responsible authority in the registration of these enterprises.

In the district there are:

➢ A district health centre with 243 staff;
➢ A hygiene & epidemiology team with 23 staff;
➢ 9 polyclinics with 163 staff & 3 special clinics on metal, dermatology and occupational health with 63 staff.
➢ 14 health stations with 57 staff; and
➢ 76 other health units registered.

Hue city: Hue city has 02 resident areas, which are urban & suburban areas. In the urban area, there are 5 sub-areas (about 6-7 resident groups/area). Their major jobs and occupations are in business, agriculture, industry, and services and in administrative offices. There is one group working in traditional casting. There are 284 small- and medium-scale enterprises with 4593 workers, of whom there are 1,625 female (35.38%). At present, however, there are only 278 enterprises, which account for 8%, that are operating. There are 198 small-scale enterprises (83.54%), of which there are 14 co-operatives, 23 working groups, 161 companies & private enterprises, and there is no state-owned enterprise or joint venture. There are 39 medium-scale enterprises with 4 co-operatives, 3 working groups, 23 companies & private
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

enterprises, 4 state-owned enterprises & 5 joint ventures. Food processing enterprises take a large part with 82 small-scale enterprises with 403 workers and 6 medium-scale enterprises with 546 workers (equivalent to 45% and 27.27%, respectively); Casting enterprises have 60 small-scale enterprises with 200 workers (32.96%) and 3 textile enterprises with 398 workers.

Casting village: Established in 1983, the casting village is divided into 3 areas with 2 hamlets and located in Thuy Xuan commune. There are 1,660 households with 10,400 workers. This is a traditional casting village with a long history of more than 400 years, which moved from Bac Ninh province. In the village, there is a casting co-operative with 27 workers compared with more than 100 persons in the past. In addition, there used to be 32 casting households and the number now has decreased to 27. Their jobs are to mould copper, lead (fishing net). Now their main products are fine art work such as bas-relief, bell, and buddhism statue. Income per person in the co-operative is about VND300,000 - 450,000 per month (equivalent to USD20-30/month).

During the casting process, copper is heated up, melted, and poured into a mound by hand, without proper personal protection equipment. In addition, there is no method to protect labourers' health. This production process in the village, moreover, also affects residents living around the production. Raw materials mainly used are mud, rice husk, wasted copper. In the past, they used rubber as fuel until its use is prohibited & wood is used instead.

The Commercial Service is the responsible authority in registration.

In Hue City there are:

- A health centre with 171 staff;
- A hygiene & epidemiology team with 11 staff;
- 3 polyclinics with 41 staff, there isn’t any special clinic;
- 25 health stations with 86 staff;
- Other health units of textile branch, railway branch, and cement producing branch: 7 health units with 31 staff

Implemented Activities of the Project.

1. Establishment of the Steering Committee at all levels

Before setting up the action programme on health promotion at small and medium scale enterprises, the Steering Committee at all levels had been established:

- At National level - National Steering Committee includes staff of Dept. of Preventive Medicine-MOH, experts from National Institute of Occupational and Environmental Health and experts from local Institutes.

- At Provincial level:
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

- In Haiphong city: the steering committee includes staff of local Health Service, experts from local Centre of Preventive Medicine and experts from other organisations.

- In Hue city: the steering committee includes Director of Health Service-Chairman, 13 staff from Health Service, local Centre of Preventive Medicine, Confederation of Labour, Group of Hygiene and Epidemiology and People Committee of Foundry District.

- At Enterprises level: in each enterprise there is one person responsible for OHS.

2. Organisation of the National workshop

A National workshop on Health promotion was organised in December 1998 with the participation of the WHO consultant. The objective of the workshop was to introduce the role and importance of Health Promotion at Workplaces to different organisations including governmental organisations and non-governmental organisations. The workshop content included the definition of a Healthy Workplace, the Jakarta Declaration, and reports of several sub-projects of Healthy City project (Healthy school, healthy hospital, healthy market, etc.).

3. Survey on the need assessment of Health Promotion at Workplaces

The Steering Committee conducted a survey on the assessment of Health Promotion at small and medium scale enterprises in Hai phong city and Hue city. The results of the survey are as follows:

- Most of the workers were male, and young aged 21-40 years old (68.5% in Hue city and 76.6% in Haiphong city). Only 1.4 % workers in Hue city and 0.3% workers in Haiphong city were children and elderly working at foundry families and other production families. Almost all workers graduated from primary and secondary schools. The living standard of workers was mainly at medium level, about 12% of workers have many economic difficulties in their lives.

- Health status of 4-10% workers did not meet the health standards

- Workers themselves evaluated their working conditions: they were not satisfied with:
  - Inconvenient workplaces (50%); hot (50%); high noise level (15-17%); high dust concentration (11-18%); toxic gases (10%); bad health services (65%); no pre-employment and periodic medical examinations and no occupational disease examinations at any of the enterprises.

- Some of the enterprises improved the working conditions but only in a few area and most of them did not have occupational health and safety (OHS) files and records.

- The number of smoking workers was still high (Hue city: 46%; Haiphong city: 30%). However, when they were asked to give up smoking, all of them expressed that they would like to give up smoking and to participate in smoking cessation programmes.
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

➢ 90% of workers wanted to participate in the Health Promotion Programme. All of them thought that the program should be organised before or after working hours and it should last for about 30 minutes.

➢ Most of the workers were willing to pay 3,000-5,000 VND (20-30 cent) per month for organising the program.

➢ Almost all of the workers needed some activities covering subjects such as exercise, nutrition and proper diet, occupational diseases, AIDS prevention, low back pain prevention etc.

4. Development of a detailed action plan

Based on the information collected from the needs assessment survey, the Steering Committee defined priorities and developed an action plan which includes the following:

➢ organisation of training courses regarding regulations on OHS, the law of health care for workers, general information on OHS for enterprise employers and the key staff of the related organisations in 2 cities (Haiphong and Hue).

➢ discussions with enterprise employers on the criteria of setting up health promoting workplaces and finally decided on 5 criteria:
   - 1 person responsible for OHS at enterprises.
   - Implementation of the environmental program (green, clean, beautiful) at enterprises.
   - 80% of workers are trained and with increased awareness on OHS.
   - In each year of implementation, at least two improvements in working conditions are in place.
   - Monitoring work environment and management of health care for employees.

➢ Signing of Commitment of Implementing the Program on “Health Promotion at Workplaces” between the employers of enterprises and the Chairperson of the Steering Committee: 15 enterprises of each city signed the Commitment.

➢ Establishment of a Health Corner in the medical room or on the wall of enterprises. In health corner there should be: first aid bag, supplies and materials for disease prevention and control of hazards at the workplaces.

5. Training and improved awareness on OHS:

➢ compilation of reference materials such as books, leaflets and propaganda materials by the National Steering Committee on relevant topics such as: What is Health Promotion at Workplaces, Foundry Hazards and Prevention, Exercise and Nutrition at Workplaces, Back pain Prevention, Handbook on First Aid at Workplaces, Dust and Prevention, Solvents, What is Noise-induced Deafness,
Occupational Skin Diseases, Prevention of Smoking, AIDS and Prevention, among others

- compilation by the National and Provincial Steering committees 10 questions on OHS and about the 5 aforementioned criteria
- design and implementation of a training programme with the title “Higher productivity, better health and working conditions”
  - One course was organised for the district health personnel and other relevant offices such as the department of industry and district people’s Committee, women’s group, and trade union. Training utilised materials on OHS like the Handbook of Occupational health, which is mainly on the labour law, Decree on Occupational safety and health, regulations on OHS by the Ministry of Health, inspection regulations and first aid needs. Duration of this course was one day.
  - In order to improve working conditions, one course was organised for the owners, the cadres in charge of hygiene and safety at the enterprises and representatives of the workers. The training was based on “Practice Handbook - Working condition improvement at small scale enterprises (WISE)” by ILO and “Safety - Health and working conditions. Duration of this course was two days

6. Monitoring the project

After providing the criteria of a healthy workplace, the Steering Committee compiled and gave employers of the enterprises the monthly report form, the 6-month report and evaluation checklist for implementing healthy workplaces. Once every month and once every 6 months, employers of enterprises return the above forms to the Steering committee for analysis and synthesis. For example: In Haiphong, the Provincial Steering Committee is divided in three groups in order to follow up and monitor activities of the project. In Hue city: there are 2-3 staff in each group and they are responsible for guiding the employers of enterprises on implementing healthy workplaces and in the training of workers.

A person from each enterprise fills up all the forms, submits records of the meeting of OSH at the enterprise and reports to the District Steering committee.

7. Summary evaluation

Six months after the implementation of the project “Health Promotion at Workplaces” The evaluation of the improvement of project was performed and a 3-day meeting with all the enterprises in the two pilot cities was organised in July 1999. The objective of the meeting was to feedback the evaluation results to the key stakeholders. The evaluation results are summarised as follows:

- 100 % of the enterprises had a person responsible for OHS with monthly reports and notebook for OHS in place. All of the enterprises are determined to follow the schedule of inspection on OHS. Each enterprise has established a health corner in the workplace.
Almost all of the enterprises supply sufficient water for workers: 93-100% of enterprises. Clean toilet and wash room at enterprises: 73.3% - 100%; Clean mess hall and kitchen, have approved cleaning schedule and adequate garbage disposal: 60%-80%.

Education and training on Health Promotion at Workplaces, Training in OHS law and regulations, first aid.

16-85% of the workers of Hue enterprises gave up smoking.

The improvements of working conditions include: heat insulation, good ventilation, control measures for dust and toxic gas, and noise, improved lighting (natural and artificial), improved lifting equipment to reduce physical effort and to assure safety, etc. The cost of investment for improvements ranges from 300,000 VND to 20 million VND.

All enterprises measured factors of the working environment, 10%-30% of samples of the hazardous factors exceeded the permissible limits.

Prevalence rates of diseases: in Hue: gynaecological diseases: 9.7%; skin disease: 2.9% ear and eye diseases: 2.3%. In Haiphong: eye diseases: 6.2%, ear disease: 1.4%, cardiovascular diseases: 2.7%, skin disease: 1.7% and others: 14.4%.

The number of sick workers was 8 in Hue city (2.3%) and 4 in Haiphong city (0.6%).

Sectors involved in the process

The project has involved many sectors such as:

- In Haiphong city: Provincial and District People Committee, Health Service, Centre of Preventive Medicine, District health centre, Confederation of Labour, Commercial and Industry Office, District Preventive medicine team.

- In Hue city: Health Service, Centre of Preventive Medicine, Confederation of Labour, District Preventive medicine team and People Committee of Foundry District.

Support from national government

Besides this project, the Ministry of Health provided for a small project entitled "Develop OSH in District level for Small and Medium-scale enterprises". The objective was to integrate concerned sectors in District level on OSH and to install new regulation on OSH in Small and Medium-scale enterprises. This project was also participated upon by the Department of Preventive Medicine and 10 provinces.

6. Resources required for the activities.
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

a. Budget:

<table>
<thead>
<tr>
<th>Content</th>
<th>Time</th>
<th>Budget (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National Workshop to introduce health promotion in the workplace</td>
<td>12/1998</td>
<td>5,000</td>
</tr>
<tr>
<td>2. Survey on needs assessment in 2 cities</td>
<td>1998</td>
<td>4,000</td>
</tr>
<tr>
<td>3. 2 training course on action plan in 2 cities (Hai phong and Hue cities)</td>
<td>2/1999</td>
<td>5,000</td>
</tr>
<tr>
<td>4. Support to 2 cities at enterprises levels</td>
<td>1998-1999</td>
<td>13,500</td>
</tr>
<tr>
<td>- Collection of data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Measurement in working environment and health examination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Set up the healthy corner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Technical and administrative support (basic, simple equipment for district health centre, education materials, guidelines, leaflets)</td>
<td>1998-1999</td>
<td>9,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>41,500</td>
</tr>
</tbody>
</table>

b. Equipment: for training and education (video, transparency, overhead projector, slide), examination, and measurements at the work environment.

c. Manpower: personnel for monitoring, health examination, and environmental measurement.

Aspects that were successful

At city:

- Increasing the responsibility of the local government in small and medium-scale enterprises
- Increasing collaboration between agencies.
- Creating trade union in small- and medium-scale enterprises.
- Improving the skill (management and technical) at District level.
- Integrating OSH into primary health care in commune health station.
- Installing the training package based on workers needs resulting to the enterprises being interested in the programme.
Health Promotion at Workplaces in Small and Medium-Scale Enterprises - Vietnam

At enterprises:

- Working conditions are improved.
- Housekeeping is better.
- Improved awareness of workers.
- Acceptance of increased responsibility by the managers.
- The participation of the workers in first aid training.

Aspects that were not successful

Training program for worker is weak because of limited time for the workers and project members. To solve the problem, the members of the steering committee have to discuss with the enterprise to find the appropriate time for the conduct of training.

Improvements desired from promotion program on smoking and exercises are quite slow because of weak participation by the workers.

The training programme for workers and competition among the enterprises will be organised to rectify above problems.

Summary of the lessons learned from the implementation of the project

- Identification of key agencies concerned with the registration of small-scale enterprises and their involvement in project monitoring and evaluation.
- Establishment of the Steering Committee at all levels.
- The action plan should be clear at all levels.
- Supervision is very important during the implementation process.
- The participation of both manager and workers in the programme is important.
- Training materials should cover the type of industries so that enterprises are interested and motivated to participate in the programme.
- All directors of enterprises should be encouraged to participate during meetings and evaluation.
KUCHING CITY’S EXPERIENCE IN RESETTLEMENT OF FOOD-HAWKERS AND WET MARKETS

Andrew Kiyu*
Deputy Director, State Health Department Sarawak, Malaysia

Introduction

Kuching City started resetting its food-hawkers and wet markets since 1985. This case shows how the resettlement of food-hawkers and petty traders from an old market at Padungan in Kuching South was carried out. That resettlement solved not just the hawker problem *per se*, but also other related problems such as solid waste management, traffic obstruction, vehicle parking, surface water pollution and so on. Similar resettlement had been successfully carried out by other agencies in the City as well as in other towns of the State. Even though a single agency can do the resettlement, our experience with the healthy city concept has convinced us that this multi-agency approach is a better way to identify problems and possible solutions for the city.

Kuching City is the capital of the state of Sarawak, which is one of the thirteen states in the Federation of Malaysia. Kuching was officially proclaimed a city on 1st August 1988. It is divided into two municipalities: Kuching North and Kuching South. It has a population of about 300,000 people.

Kuching North has an area of 369 square kilometers and is managed by Kuching North City, while Kuching South, with an area of jurisdiction of 61.5 square kilometers is managed by the council of Kuching South. This case study is mainly concerned with Kuching South.

Identifying and Prioritizing Urban Issues

Among the environmental issues faced by Kuching were: (a) solid waste management; (b) sewerage system; (c) squatters; (d) food hawkers; (e) small-scale industries being carried out in residential areas; and, (f) water pollution. While these problems are not as bad in bigger cities, they have to be reduced or contained, so as not get worse. When Kuching was just a small trading centre in the 19840s and later a town, the problems were minimal. With the rapid growth of the town from the 1970s the problems also grew.

Among the many problems discussed, those associated with hawkers were within the capacity of the city council to solve, at reasonable cost and within a reasonable time frame. This is in contrast to such problems as squatters, central sewerage systems, and so on, which need many agencies to work together and needing a huge investment in terms of financial resources and technical expertise to solve. Thus hawker-associated problems were tackled early on by the city council.

*With Jamilah Hashim, Healthy City-Kuching and Daniel Voon of the City Council Kuching South, Sarawak, Malaysia*
Petty trading and hawking started in the old days with a bamboo stick across the shoulders and a basket hanging from each end of the stick. Those eventually gave way to hawking with bicycles, tricycles, pushcarts and stationary stalls. Apart from being a source of income for the hawkers themselves, hawking also provided social services in the form of cheap, tasty food that were readily available.

However, even in the early days it was realised that food-hawkers posed certain problems with regard to hygiene and obstruction of public ways. This led to the building of markets and hawker centres such as the Central Market at Gambier road in the 1930s and the Open Air Market in the early 1950s in Kuching.

In the 1980s, as the town grew, the problems associated with hawkers became more acute. They included environmental hazards in the form of improper rubbish disposal, and indiscriminate disposal of sullage water.

Hawking also contributed to traffic hazards by blocking traffic as they were usually located at the roadsides and customers stopped their cars anywhere to buy and eat the foods at the roadside stalls. Some of the hawkers who operated in the housing areas contributed to nuisances in the form of noise from the business and traffic from the customers, and the smoke and odour from the stalls.

They were also public health hazards, as they were more often than not, unhygienic. They did not have proper: (a) water supply to prepare the food and to wash the plates; (b) place for storage of cooked food and uncooked food; (c) place to store ice; (d) techniques for handling food; and, (e) impervious table tops as stipulated in the ordinances.

In some places, the hawkers were located close to wet markets where vegetable and meat were sold. The close proximity of hawkers to wet markets arose because in Kuching, as in many other Asian cities, people still did (and still do) their marketing daily. They believed in buying fresh as opposed to frozen foods. After they finished their marketing, the customers would take their own breakfast and then buy back breakfast for the children and family members at home.

One such wet market/hawker stall area was the old Padungan market, which was built before the Second World War. All the environmental problems mentioned above were present at that market. Due to the age of the market, the facilities there were out of date. Further, as the demand increase there was no place for the market to expand.

With the development of the tourism industry in Sarawak, there is a more urgent need to make the hawkers hygienic and aesthetically pleasant while maintaining the easy availability of really affordable, great tasting food.
The Actors and Stakeholders

Those who played important roles and had interests in the hawkers and wet markets could be arbitrary divided into four: (a) the government and local authorities; (b) the hawkers themselves; (c) the public; and, (d) the mass media.

The Federal Government’s interest in hawkers stemmed from the fact that they: (a) were important sectors of the economy; (b) provided service for the public; and, (c) were possible sources of communicable diseases if they are unhygienic. Thus the Federal Government enacted the Food Act 1985 which was very comprehensive and covered the whole food industry in the country, hawkers included. The Ministry of Health also issues guidelines and directives relating to food and hawkers as and when necessary.

The State Government’s interest in hawkers was similar to that of the central government but was more intense by virtue of it being closer to the people in the State. The State government also set general development policy, including town planning and development, in the State. Thus it had impact on the resettlement of hawkers. In addition, it provided funds for the construction of markets and hawker centres.

The local authorities had been given the mandate to administer the markets, hawkers and petty traders in their areas of jurisdiction. Administratively, they are under the state Ministry of Environment and Public Health. Within the local authorities, several technical divisions namely Engineering, Building and Landscaping, Public Cleansing, Enforcement, Valuation, Parking and Treasury Divisions had roles to play.

Hawkers and petty traders had direct interest in the resettlement, as it would affect their livelihood. They had some degree of influence in the resettlement process, as they would give their inputs in the planning process. Apart from that, once the decision had been made to move, they would have to comply or else they would lose their trading licenses.

The public had an informal influence in the process. If they were unhappy with any aspect of hawkers or markets, they could channel their views verbally or in writing to the Local Authorities, or to any Councilor. They could also exercise their influence through the mass media. Once issues were raised through any of the channels, the hawkers would be investigated and dealt with following established procedures.

The mass media’s roles were related to their: (a) acting as channels for the members of the public to complain and air their views, (b) function to report on any matter of public interest. Government agencies scanned the newspaper for issues that may affect their respective offices.
Formulating Strategies

Having decided to resettle the hawkers, the Local Council asked its standing Committee on Markets and Petty traders to work out how to solve the problem. This part of the study and developing strategies took approximately six months.

After the study it was recommended that the hawkers and wet markets traders be resettled together. As part of the strategy development a study of the benefits and drawbacks of resettling the hawkers was done (see Annex I).

Of benefit to everybody was that the relocation of hawkers to a centre equipped with proper facilities will be the: (a) clearing away of traffic obstruction at the old site as well as in the housing areas where hawkers ply their trade; (b) provision of convenient parking spaces to customers and traders at the new site; (c) reduction of surface pollution from the wet markets and hawker stalls; (d) reduction of smell and fly nuisance; (e) reduction of solid waste piling up, and, (f) creation of a beautiful new market. The old sites can be converted into gardens with paved sidewalks and trees to provide shade for pedestrians.

The plan to resettle hawkers was agreed to by the Council’s Standing Committee on Hawkers and Petty traders. The plan was presented to the full Council where it was approved. The next step was to get the plan translated into action.

Preparation and Implementation

A survey of the hawkers and market traders was done to determine the number who needed to be resettled. The survey also identified who the traders were, where they came from, what they sold and who and where the customers came from.

A suitable piece of land was identified that was relatively nearby (less than a kilometre from the old site) and which belonged to the Council. That was good news, as the needed land area need not be purchased for the project. That meant reduction in cost, because land in urban areas is expensive and takes a long time to acquire.

The market was designed to cater for: (a) increased trading space; (b) the provision of basic amenities such as water supply, electricity, and lighting; (c) pollution reduction measures such as disposal of waste water and solid waste generated from the markets, and fume extraction system for the cooking areas; and, (d) customer conveniences and comfort such as parking spaces, landscaping, public toilets, and so on.

Access to the new market was also considered. Even though most of the customers were known to use their own cars to go to the market, there were others who would need public transport. Hence, the private bus company that serve the area was asked to provide service to the new market, which they did.
The concept, design and drawing plans were carried out by the Council’s architects and engineers. This part of the process took six months.

A project proposal was prepared and presented to the State Government for funding. The proposal was accepted and funding provided. The construction was tendered out to private contractors under the supervision of the Council’s technical staff. The market cost approximately five million Ringgit. It took about 18 months to construct.

Some of the special features of the food-hawkers section of the new market included: impervious table tops provided as part of the market, the installation of hood and flue over the cooking areas, and the provision of ceiling fans. To reduce the discharge of food wastes and vegetable matter into the drains and waterways, sieves and strainers were provided to screen out the coarse materials. These would be removed by the maintenance team and kept in solid-waste bins for further disposal. Water leaving the strainer was discharged into the river without further treatment.

There were some initial resistance, from the food-hawkers and traders from the old market, to moving from the old site to the new centre. When it become clear to the traders and hawkers that the trading licence of those who refused to move will not be renewed, then they all moved to the new site.

The rentals to be paid by the hawkers at the new site were the same as at the old market because the rates were governed by Kuching Municipal Council (Licensing of Miscellaneous Occupations) (Amendment) By-laws, 1964. The cost of rentals depended on the types of items sold. The cost of trading licence also depended on whether the space rented was just a table to sell cakes or a stall to cook and sell.

Electricity for lighting to common areas was borne by the Council. However, if stalls needed electricity to run their freezers and refrigerators then individual meters were provided and the stall owner would pay for the electricity to the Sarawak Electricity Supply Corporation at the standard rates.

For water, the Council charged a flat rate for those who only rented tabletops. Higher rates were charged from those who rented lock-up stalls and bigger food stalls.

Council provided washing, collecting solid waste maintenance of the building, sweeping. The washing and flushing of the floor is done once a day at the end of trading while sweeping of the floor is done all the time.

The vegetable and meat markets operate in the daylight hours based purely on demand. Most of the food stalls operate from early morning till the night, some of the stall operators start their business in the evening till the early hours of the morning.

During the first few months after the shift to the new market, the number of people who came to patronise the place was less than in the old market. Part of the reason as the distance and
the fact that there was only one road leading to the market. The Council after having done some study of the factors involved, concluded that another road was needed to further shorten the distance from the town centre to the market. This road involved the construction of a bridge across the Padungan River and it was constructed by the Public Works Department at a cost of about one million Ringgit. Probably because of this road and the fact that after a while people get used to the new centre, the number of people who came to the market has increased to the extent that on most mornings, the car parks are full and it is difficult to find empty parking space there.

Soon after the market has shifted to the new location, the old market and hawker place was converted to a public garden.

Institutionalizing the Process

With his experience, the concept of having the wet market and food stalls together in a central location has been extended to other towns. Most districts in the State now have this type of markets.

In Kuching City itself, this concept is extended to other locations in the city. Some of the projects have been taken up by other government agencies. For instance, the Land Custody and development Authority and Sarawak Economic Development Corporation each built a multi-storey car park with food courts on the top floor (see Annex 2). These are beautifully designed and attractively painted. In those instances, the projects succeeded in not just resettling the hawkers but also provide much-needed parking spaces. It is to be noted here that parking fees are levied during office hours in the city.

The design of the newer markets has also been improved. For instance, to improve air circulation at the top level where the food stalls are, wind-driven ventilators are installed in the roofs of newer markets. And instead of providing just hood and flue over the cooking areas, fume extraction system was installed in the newer markets such as the Kenyalang Park Market.

The treatment of wastewater from the markets still needs improvement. At the moment only the big debris are removed. The quality of water that goes into the river from the market is still not satisfactory.

The success of this concept does not mean that there is no place for other forms of resettlement of hawkers. For instance, there are food markets with proper facilities that are confined only to selling food and they are located at ground level.

Also, in tourist areas such as the Kuching Water front: The People’s Place, there is still a role for individual food and drink stalls. However, these stalls are non-polluting and they do not generate much waste. Further, only limited number of stalls is licensed to operate there.
Prior to Kuching City joining the Health Cities Project of the World Health Organisation, most of the planning that has been done for the city has been done mainly by just one or at most a few relevant Department. After joining the Healthy Cities movement in July 1994, identification of problems, needs and solution for the city involve many departments. Currently more than 30 government agencies are members of the Healthy City Committee. The committee had carried out a situational analysis of the city's current and future problems, and needs. It had also prepared a Healthy City-Kuching Plan covering the next five-year old period. One of the results of the analysis and planning was the identification of areas in the city that still needed wet markets and food markets. Another result is that in view of the high ambient temperature food may spoil faster. In order to improve the situation, it was proposed that in future the meat and fish sections of the wet markets be air-conditioned. However, this has to be studied further in terms of acceptance by the traders and customers, as well as the running and maintenance costs of such conditioning systems. The Healthy Cities concept of planning for the City has been recommended by the State Government for the other towns in the State.

Lessons to be learned

Based on the experience of Kuching South, the prerequisite for success in solving the problems posed by hawkers are: (a) the Council must recognise that hawkers and food hygiene are high on its priority list; (b) availability of land; (c) availability of funding; and, (d) political stability.

The experience of Kuching South have also shown that in solving one problem, other related problems have to be identified. The intervention to be adopted must be able to solve or mitigate as many of the problems as possible.

Local cynics say that the reason hawker food taste so good is that they are served in unhygienic place. The new food-markets and hawker-centers have shown that we can have tasty, cheap and many varieties of food in hygienic and pleasant places that are friendly both to the vendor, customer as well the environment.

The experience of the city and other towns in Sarawak has shown that this method of solving the problem is replicable not just in other areas of the city but also in the smaller towns as long as the government gave support and funding.

One of the underlying reasons for resettling the hawkers is to have more hygienic food preparation and service. This will reduce the number of food-borne diseases in the city. However, existing statistics show that the food-borne diseases are not so common among Kuching City dwellers. This may be due to the local population getting used to the micro-organisms in the city. The other reason is that even when they were plying their trade all over the place, most of the hawkers was not that filthy dirty and most of the food that they sell was freshly prepared and piping hot. That killed the germs and did not give chance for organisms to grow and multiply in the food.
Nonetheless there are reasons to continue surveillance of such foods. The Councils, and the State Health Department as part of the central government's Food Quality Control Programme, do this on a routine basis. Specified number of ready-to-eat-food samples, for instance, must be taken every month for bacteriological examination. The results are monitored at City, district, State as well as at national levels.

In addition, the Agriculture Department and the Health Department are monitoring the levels of pesticide residues in the vegetable sold in the markets.
Annex 1
Benefits and drawbacks of resettling food-hawkers

TO THE COUNCIL

BENEFITS
Resettlement will enable the Council to properly control the hawkers by providing basic facilities such as water supply, clean places for preparing and serving food, electricity for refrigerators for proper storage of cooked and uncooked food.

To ease and reduce obstruction of traffic and unsightly illegal structures erected by the roadside hawkers.

Enable proper control and disposal of food waste and waste generated by hawking activities during preparation, cooking, washing, etc.

DRAWBACKS
The Council will have to request for funds to build the centre.

The Council need to provide funds, engage management staff, and labourers for cleaning and maintaining the centres.

The amount of money needed to maintain the markets would increase.

TO HAWKERS

BENEFITS
By paying a minimum fee, the resettled hawkers can enjoy a high standard of sanitary facilities provided by the new centre. This will definitely attract new customers.

Well-designed stall spaces enable the hawkers to keep their utensils, equipment and refrigerators for proper safekeeping of food.

DRAWBACKS
Centralisation means that the hawkers in a centre may have to compete with each other. This is especially so for those in the same trade or selling similar items. Such competition may lead to quarrels and fights among the hawkers.

A resettlement centre may be out of the way as land available for the purpose may be far away from their homes or housing areas. This may lead to reduction of customers patronising the centre resulting in poor business and less income.

The ymey may also have to pay more in terms of licenses and facilities.
Kuching City’s Experience in Resettlement of Food-Hawkers and Wet Markets - Malaysia

**TO HAWKERS**

**BENEFITS**

Providing more comfortable, hygienic and clean place for eating. For instance: there will be no odour problem; the tables and chairs will be of good quality; the ground will not be wet.

Basic hand washing facilities will be provided for the use of customers.

Public toilets will also be provided at the Centres.

The combination of the wet vegetable and meat markets with the food-hawkers stalls at one place will allow customers doing their daily morning marketing to have their breakfast at the top-level of the market.

Hawkers who had hitherto been scattered around will be grouped together. Thus customers have more varieties of food to choose from at one location. This is convenient to the public.

**DRAWBACKS**

Customers have to go the extra distance to do their marketing and get hawker food.

**ANNEX 2**

Locations of new combined markets in Kuching City.

<table>
<thead>
<tr>
<th>Location</th>
<th>Year of Completion</th>
<th>No. of Food Hawkers There</th>
<th>No. of Wet Markets Traders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petanak</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pending Sea-Food Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenyalang Park</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hui Sing Garden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bintawa Market and Hawker Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top Spot Multi-Storey Car Park and Hawker Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Song Kheng Hai</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saujana Multi-Storey Car Park and Hawker Centre</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper Foochow</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXPERIENCES IN HEALTHY MARKET PLACE IN VIENTIANE, LAO PEOPLE'S DEMOCRATIC REPUBLIC

Rattiphone Oula
Chief of Primary Health Care and Team Member of Healthy City Project,
Department of Public Health
Vientiane, Lao People's Democratic Republic

Introduction

Vientiane is the capital city of Lao People's Democratic Republic, and covers an area of 3,920 square kilometers.

The urban areas comprises 5 districts while in the rural areas, 4 districts. The total population of Vientiane is 528,109. Workforce consists of farmers, government officers, market vendors, businessmen, and daily wage workers.

In terms of infrastructure, the following is the profile:

Drinking water supply

Access to potable water
Access to potable water
81.2% (urban)
32.6% (rural)

Housing

Private houses
Rental houses
State-owned houses
Living with relatives/friends
82.5%
6.7%
6.5%
4.2%

Solid waste management

Solid waste generation
Collected
Self disposed
Recycled
138 tons/day
13.8 tons/day
91 tons/day
21.8 tons/day (food)

Health services

7 central hospitals
1 provincial hospital
9 district hospitals
35 health centres
Healthy city workshop in Vientiane 1996
Healthy market place in 1997
Healthy market place will be established to address issues such as:

- Infrastructure (water, toilets, physical layout)
- Health conditions of stall-holder and food handlers
- Practices for storage and handling of raw and semi-processed foodstuffs (meat, vegetable)
- Safety of street-vended food
- Solid and liquid waste management
- Consumer education
- Role of government authorities

Activities of the project

- Training: Health staff, staff of commercial department, market manager and security guard in the market.
- Development of education and training materials
- Organisation of a clean-up campaign
- Provision of model garbage containers in model market
- Exchange visits to healthy markets within the country
- Regular supervision from health staff at district hospital (2 times/week)
- Waste disposal
- Sewage system
- Advice on proper food storage practices (i.e. covering cooked food, proper temperature for storage of raw food, etc)

Sectors involved in the process:

- Department of Public Health, Vientiane
- Health staff at district hospital
- District governor
- Market manager
- Village leader
- Financial support
- Local community
Experiences in Healthy Market Place in Vientiane, Lao People’s Democratic Republic

- Private sector
- Self market
- District government
- Department of Public Health
- NGO
- WHO: training

Resources required for the activities:
- Experts who have experience
- Training staff
- Training materials
- Equipment for food inspection

Aspects that were successful:
- Introduction of healthy city concept to policy maker during the healthy city workshop in 1996.
- Good support and encouragement from district governors
- The activities of healthy market place in the yearly plan of the district.
- Regular supervision and monitoring by the district level.

Aspects that were not successful:
- The movement of food sellers
- Lack of training materials
- Lack of local experience to implement
- Inadequate training of staff
- Lack of communication between health section and market constructor during design and planning.
- Lack of resource persons
Experiences in Healthy Market Place in Vientiane, Lao People's Democratic Republic

Lessons learned from the implementation of the project

- The integration of different departments is very important to manage and monitor the project.
- The training of the staff is necessary for planning and implementing the project.
- The provision of basic information and concept of healthy market place to all citizens as well as district governors, market manager are essential for getting support.
- Involving mass media to promote community involvement in building up healthy market place is a key approach.
- Collaboration with NGOs, communities, private sector and other international organization is a key to obtain financial support.
- Regular meeting, supervision and monitoring are necessary to assess the progress of project.
- Production of information materials appropriate to local conditions, writing report, and setting up meetings to feedback progress of work are other means in getting community participation.

Plans for the year 1999

- Classification of market places in Vientiane
- Identification of evaluation indicators in such markets
- Setting up criteria for building model healthy marketplaces such as primary and secondary level of model healthy market places
- Training of market authorities
- Monthly meeting with market authorities
- Production of posters, pamphlets and cassette tapes for promoting cleanliness among passengers in bus station near the market
- Repair canal to drain wastewater from the market
- Build model latrine in the market
- Monitoring and supervision of markets in Vientiane
- Declare model healthy marketplaces
HEALTHY HOSPITALS IN THE PHILIPPINES:
The Hospitals as Centers of Wellness Program 1992-1999

Susan P. Mercado
Undersecretary and Chief of Staff, Department of Health, Philippines

Introduction

The "Hospitals as Centers of Wellness Program" is presented as a case study for a national initiative to promote health in government hospital settings. The program was part of 23 preventive and promotive programs for the Department of Health of the Republic of the Philippines under the leadership of the Health Secretary Juan M. Flavier. The case study shows how the hospital must be seen not just as a setting where health services are delivered, but as a place of work and a setting for health promotion and health education.

How Did We Start?

During the 1970's and the 1980's, under a highly centralized government, huge massive specialty centers were constructed in Manila under the national government. These facilities were known for their highly sophisticated and expensive equipment and technology, but were focused on the curative aspects of health care.

With changes in government in the mid-80s and the subsequent decentralization of government, including health care services, these hospitals along with 46 other regional medical centers and tertiary facilities remained with the national government.

In 1992, under the leadership of Health Secretary Juan M. Flavier, health promotion and prevention of disease were prioritized over curative medical care. Apart from mobilizing communities and civil society for national campaigns for immunization, micronutrient supplementation and family planning, the Department of Health felt that part of the strategy to propel the principles of prevention into the national consciousness would be to convert hospitals from "disease palaces" to "centers of wellness" through a nationally-initiated program.

The "Hospitals as Centers of Wellness Program" (HCWP) was guided by three basic principles: a) primary health care; b) health promoting; and, c) disease prevention.

Policies governing the program included:

a) Integration of prevention, promotion and primary care into curative and rehabilitative care settings.
Healthy Hospitals in the Philippines: The Hospitals as Centers of Wellness program 1992-1999

b) Establishment of support groups with participation of the community, NGOs and volunteers.
c) Ensuring the well-being of the staff.
d) Providing opportunities for professional growth and technical assistance.

The vision of the program was encapsulated into the acronym, “the six C’s” namely:

- Comprehensive health care
- Competent, well-managed hospital
- Caring, compassionate, and communicating staff
- Community-oriented
- Culture-friendly
- Clean and green

In order to facilitate implementation at a national level, a Ten Step Checklist was developed to guide hospital directors on how to convert their hospital into a “center of wellness”. This checklist included the following:

1. Development of hospital policies
2. Implementation of hospital-wide orientation
3. Creation of a program committee
4. Establishment of health education and information area
5. Implementation of a training program for personnel
6. Provision of psychosocial support
7. Participation of patients, families and volunteers
8. Enhancement of hospital personnel welfare and job satisfaction
9. Strengthening of two way referral system
10. Incorporation of local customs and traditions

The core strategies used to start-up the programs were characteristic of strategies used to propel other public health programs. These strategies included:

a) Strong personal support from the Secretary of Health
b) Development of a guide to implementation (Ten Step Checklist)
c) Simple vision statement
d) Decentralization of operations
e) Maintenance of an environment that is conducive to innovation
f) Recognition of best practices
g) Resources from the national budget

Who Were Involved?

While the ideas were organized at the national level, the program was implemented by all chiefs of government hospitals that remained with the Department of Health following the
devolution of health services. Participatory and consultative workshops were organized with the hospital chiefs and experts in Philippine architecture, Philippine art and culture and public health specialists, to evolve a shared vision for the program.

**What Was The Role Of The National Government?**

The national government initiated the program as part of the Department of Health's thrust to emphasize prevention and promotion as a priority. To initiate the program, the Ten Step Checklist was developed with administrative issuances to support implementation. Resources were allocated for the program through the national budget process. Best practices were recognized and given incentives and awards.

**What Resources Were Needed?**

Initially, each hospital was asked to generate its own funds to organize their activities. Subsequently, each hospital was given the amount of $25,000 - $50,000 to support start up activities under the program. Eventually, hospitals allocated their own resources through innovative mechanisms which involved the community. As of 1999, national government still provides support for the program through the national budget.

**What Were The Success?**

Hospitals as Centers of Wellness became a major program of national government hospitals from 1993 to 1995. The flexibility of the guidelines allowed hospital directors to innovate and develop programs with the community that were responsive to local needs and contexts. Clinicians become interested in prevention and health promotion. Hospital chiefs were challenged to exercise their leadership in a different way.

One of the successes of the program was the opportunity it created to develop patient support and education groups with the community. Once a hospital had gained experience in organizing support groups, the principles for organization were applied to other groups of patients.

**What Were The Limitations?**

Support for the program has fluctuated depending on the interest of the Secretary of Health. In some hospitals, the HCWP became isolated and was seen as an "add-on" program instead of one that would cut-across the entire spectrum of services delivered at the hospitals. When national support dwindled, some hospitals did not sustain the program and provided limited support to hospital personnel who were involved with the program.
Healthy Hospitals in the Philippines: The Hospitals as Centers of Wellness program 1992-1999

What Did We Learn?

1. Given a policy and management environment to shift the paradigm of a national health agency from curative care to prevention and promotion, hospitals can become settings for health promotion. Because a paradigm shift is involved, the vision and personal commitment of hospital directors and their staff is an important factor in initiating the transformation of a hospital from being a “disease palace” to becoming a “center of wellness”. However, over a longer period of time, institutional reforms (such as creation of positions for nurse educators, incorporation of wellness programs as a requirement for renewal of licenses, inclusion of OPD care as part of social insurance) are necessary to sustain the process and ensure that hospitals will not backslide.

2. Heavy investments in capital outlay and training are not necessary to start the program.

3. The key role of the nurse-educator in development of wellness programs cannot be underemphasized. In most settings, the nursing staff “championed” the principles when compared to the medical staff.

4. Support and leadership of the nurses from the medical center chief or hospital director is a critical factor in sustaining wellness programs.

Where Are We Going?

1) For 1999-2000 under the leadership of Secretary Alberto Romualdez Jr., a major quality assurance initiative called SENTRONG SIGLA (Centers of Vitality) will strengthen programs started under the HCWP and expand the guidelines, policies and principles to devolved hospitals at the provincial and district level.

2) Through the HEALTH SECTOR REFORM AGENDA, the existing Centers of Wellness will be designated as COLLABORATING CENTERS for DISEASE PREVENTION AND HEALTH PROMOTION through grants, subsidies, technical assistance and partnership programs with the national government.

3) In 1998, the Nurse Educators Network was organized to ensure plantilla positions for nurse educators and to provide a forum for continuing professional growth and sharing of experiences on development of materials for patient education and support groups in different communities.
Conclusions:

1. To ensure that principles of primary health care, disease prevention and health promotion are a part of the entire health care delivery system, tertiary and secondary hospitals must be converted into health promoting settings.

2. Prevention and promotion must be integrated in all clinical disciplines and not treated as a separate vertical program in the hospital.

3. Clear guidelines and strategies must be communicated to the staff and the community.

4. Nurse educators must be given full-support.

5. Political will and commitment to quality of care is essential to sustaining the program.
INTEGRATING HEALTHY SETTINGS IN HEALTHY CITIES AND HEALTHY ISLANDS
REVIEW OF EXPERIENCES IN INTEGRATING SETTINGS IN HEALTHY CITIES AND HEALTHY ISLANDS

Wai-On Phoon,
Professor of Occupational Health,
University of Sydney, Australia

Summary

A brief account is given of how the concepts of “Healthy Cities and Healthy Islands” evolved. The need largely arose because of the sometimes fragmentation of public health programmes and relative disregard of the health impact in traditional developmental schemes. It was increasingly felt that the safeguarding of the quality of life and health of human habitats, both in cities, the rural sector and on islands, require the full cooperation of many kinds of experts and the entire community. At the same time, it is increasingly realized that mechanisms for integration of the “healthy” settings activities are vital for their continued success.

“Health professionals will naturally see various needs that the community may have. Some of these needs are felt by the community, while others may remain unfelt. Programmes designed for unfelt needs are often destined for failure as they often remain unsupported and unaccepted by the community.” Paul Chen

Introduction

To appreciate the need for integration of the Health Settings in Health Cities and Health Islands projects, it is first necessary to take the historical approach and review briefly why and how these projects come into being. It can be seen that, right from their very inception, integration has been a key element of their activities.

The traditional approach taken by WHO was to set up discrete programmes, such as that in Environmental Health in Rural and Urban Development and Housing. The new approach promoting environmental quality through urban planning now focuses on intersectoral coordination. The change is to ensure political support for this process, especially with sectors whose activities have health implications but whose primary role is not related to health.
Review of Experiences in Integrating Settings in Healthy Cities and Healthy Islands

It was felt that one of the main problems with attempting to promote and improve urban health in general was that both environmental and health concerns were usually peripheral to policy-making and planning processes in many sectors, such as housing, agriculture, transportation, industrial developments, economic development, water supply and sewerage and solid waste management, affected urban environmental health, but health matters were not usually a primary concern. Although planning procedures in principle should include such concerns, the continuing urban environmental problems even in developed countries in the Region indicated a serious gap between theory and practice. Political sectors at the highest level and their respective bureaucracies need to agree to a common set of health targets or goals to direct the planning in all public and private sectors to guide multi-sectoral coordination and intersectoral collaboration.

Hiatus Between Development Policies And Health Effects

The evaluation of development policies did not pay enough attention to their impact on health. Health research tended not to examine development policies as immediate and underlying causes of ill-health. Improvement of health conditions was often hindered by an enormous number of problems involved in the implementation of these policies.

Many factors contributed to the large gaps which exist in the understanding of the relationship between development policies and health conditions. So broad and pervasive were those policies that the causal chain from policy to health aspects is often far from clear, and certainty about quantitative relationships was hard to achieve. Nevertheless, there existed a number of research methodologies which are suitable for assessing short and long-term health effects of development policies. These include: risk measurements and assessment; analysis of social and environmental impact; cost-benefit analysis and cost-effectiveness studies; analysis of institutional policies and planning systems; controlled intervention studies; sociological and anthropological studies; large-project evaluation; and techniques for the assessment of macroeconomic policies. To carry out such research, it is obvious that many kinds of skills needed to be organized and that integration of activities is essential.

However, more research is still required to assess how interdisciplinary work can be carried out, and how problem areas can be identified. The fundamental question that researchers must help policy-makers to answer is: Are the health hazards so great as to make the policy unreasonable to pursue at all, or are there ways to proceed while preventing or ameliorating the adverse effects on health? Even better, is there a modified policy which will at the same time promote development and improve health?
Review of Experiences in Integrating Settings in Healthy Cities and Healthy Islands

Some Early Experiences Of Holistic Attempts To Improve Health Of Communities In The Western Pacific Region

Some of the earliest projects on improving neighbourhoods or communities in the Western Pacific Region on an inter-disciplinary or inter-sectoral basis included the following:

- Sarawak Rural Health Improvement Scheme in the 1960s. Long house settlement developments were educated to improve their personal hygiene, build toilets, clean their compounds and their animals. The governments, WHO and UNICEF provided equipment, supplies and services.

- Safer homes project in New Zealand in the 1980s. Home accidents were reduced with the help of Safe Home seminars, building of safe Home Show Houses, and eventually a new safe home standard and new building legislation.

Identified Obstacles To Achieving Supportive Environments For Health

The Third International Conference on Health Promotion held at Sundsvall, Sweden, in 1991, identified obstacles to achieving supportive environments for health. In homes and neighbourhoods, the obstacles were said to include:

- segregation of socioeconomic and ethnic groups
- lack of intersectoral cooperation
- lack of planning for humans settlements
- lack of land ownership
- poverty and indebtedness
- uncritical imitation by developing countries of methods from industrialized countries
- unwillingness to clear slums and provide better accommodation

The Declaration from the 1996 United Nations Conference on Human Settlements concluded that “Our cities must be places where human beings lead fulfilling lives in dignity, good healthy, safety, happiness and hope.”

Genesis Of Healthy City Projects

When the Health City projects in European and other industrialized countries were first developed, they called for action “beyond health care”.

The commencement of Healthy Cities activities in developing countries began in early 1990s. The issues emphasized were somewhat different from these in Europe and North America. Issues associated with basic sanitation and environmental health received more emphasis.
Review of Experiences in Integrating Settings in Healthy Cities and Healthy Islands

Health City projects play a leading role in integrating the various services and programmes within the health sector and for coordinating with other sectors in tackling health problems and enhancing health and quality of life. Strategically, Healthy City projects integrates the efforts of health and other sectors by focusing on certain population groups e.g. children and adolescents and elderly.

Historically the Healthy Cities concept is a public health approach that builds upon the work of Professor T. McKeown. He found that, contrary to popular belief, the major factor in the nineteenth and twentieth centuries in the United Kingdom and other developed countries was not advances in medical care and technology, but certain social, environmental and economic changes:

- Limitation of family size
- Increase in food supplies
- A healthier physical environment
- Specific preventive and therapeutic measures

WHO, from its beginning in 1946, recognized the interactions of physical, mental and social factors in determining health and the need for integrated actions to control such factors. In 1978, WHO launched a major public health movement called “Health for All” at Alma Ata, based on six principles that reflect McKeown’s concerns:

- Reduced inequalities in health
- Emphasis on the prevention of disease
- Intersectoral cooperation including reducing environmental risks
- Community participation
- Emphasis on primary health care in health care systems
- International cooperation

In 1985-1986, the European Office of WHO proposed health promotion projects to be known as the Health Cities project. The intention was to devise ways to apply the principles and strategies of Health for All through local action in cities. The project originated in a workshop held by the City of Toronto, Ontario, Canada, in October 1984 called Healthy Toronto 2000. The strategy involved bringing together a partnership of the public, private and voluntary agencies, institutions and organizations to focus on urban health and do tackle health-related problems in a broad way. The speed of the growth of this project was remarkable, not only in developed countries, but also in developing ones.

Aims Of The Healthy City Programme

The programme aims to improve environment and health conditions by raising awareness, and by mobilizing community participation through partnership with local (municipal) agencies and institutions, thereby helping them to deliver effective environmental and health services. A priority objective is to develop the role of local government in public health and to encourage them to implement Health for All policy at city level.
Through various urban development activities (housing, industry, infrastructure, etc.) can bring health hazards if they lack health and environmental safeguards, they also offer health opportunities. They can enhance the health status of the population if health promotion and protection measures are undertaken in implementing the development. For example, basic environmental services and primary health measures should be implemented with community participation.

The concept of a Healthy Cities project was that it could be a stand-alone project in a given city, or it could be a health component in a larger development effort involving infrastructure, land management, municipal finance and industrial development. Key development projects addressed by healthy city programme (HCP) are:

- Poor health in urban dwellers, especially those in high-density, low income settlements
- Deficient basic services, poor housing and environmental pollution
- Inability of many local governments to cope with their public health and environmental responsibilities.

HCP recognizes that, while the initiatives and ingenuity of the poor in self-provision of basic needs and survival strategies are impressive, this "do-it-yourself" provision has serious limitations, particularly in urban areas where crowded conditions expose people to various pollutants and create risks of disease epidemics. In addressing these urban problems, a HCP does not seek to take over the management of these functions from the competent authorities and agencies. Rather, it adds the health dimension to them by measurement of the health burden such problems create (in terms of death, disability, etc.) so that health issues are made relevant and understandable to the work of local government and non-government agencies.

Thus a HCP supports city health authorities and/or local government in undertaking what may be new roles:

Information and analysis - monitoring of health impacts, measuring of health status and estimation of the contribution that various environmental factors are making to health problems, analysis of health requirements and opportunities in various development sectors that are significant for health.

Policy and advocacy - specific health policies for each sector are formulated (for water, sanitation, local government, education, industry, labour, (e.g., workplace health, etc.). The advocacy by policy-makers is the work of competent agencies.

In the process of consultation with the community and many different agencies and groups, there has to be also an effort to develop a "vision" of the future direction of the city and to understand its current (and past) strengths and qualities. An appreciation of the cultural heritage and cultivation of "a sense of place" that celebrates the unique characteristics and history of each city have proven important elements in mobilizing people to improve living
conditions and address health and environment problems on a comprehensive and integrated basis.⁶

**Current Definitions**

A Health City on Healthy Island Project is a process of achieving better health and quality of life and healthier physical and social environments in the urban area or island of concern.⁷

"A health city is one which is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."⁸

**Current Concepts of Key Action Areas in Health Cities Project**

The key areas for action in the WHO Healthy Cities project were defined in the Ottawa Charter for Health Promotion. They include:

- building healthy public policy
- creating supportive environments
- strengthening community actions
- developing personal skills
- reorienting health services

The project cities were also to do the following:

- developing health plans
- making alliances with local partners
- implementing a wide range of projects with special emphasis on the needs of vulnerable groups
- supporting the establishment of national Health Cities networks

**Twofold Areas Of Governance**

The Health Cities programme supports two aspects of governance at the local level:

- Technical aspects, involving local level resource mobilization, plan formulation, technology application and resource allocations

- Representational and participatory aspects, including participation, channels for popular representation and increased transparency and accountability in the workings of local authorities. Thus the analysis of needs and the priority setting process in a Health Cities project involves both of the views of the communities involved in terms of their needs or priorities, that expresses fully the local perception of the problems and issues
Review of Experiences in Integrating Settings in Healthy Cities and Healthy Islands

- A technical assessment based on available health statistics and epidemiological linkages between health status and environmental and social conditions.  

**Yanuca Island Declaration On Healthy Islands**

The Yanuca Island Declaration on Health in the Pacific in the 21st Century was issued at the Conference of Ministers of Health of the Pacific Islands in March 1995. "Inter-Alia", that Declaration 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
- ecological balance is a source of pride

This was followed by the Rarotonga Agreement towards Health Islands in 1997. The Conference of Ministers of Health of the Pacific Islands recommended, "inter alia" that Pacific island governments should address the following aspects:

- adequate water supply and sanitation facilities
- nutrition, food safety and food security
- waste management
- housing
- human resources development
- communicable and non-communicable disease prevention and control
- lifestyle and quality of life issues
- reproductive and family health
- promotion of primary health care
- social and emotional well-being
- population issues
- ecological sustainability
- information management
- tobacco or health
- alcohol and substance abuse
- environmental and occupational health

It was further recommended that Pacific island governments should establish a national Healthy Islands coordinating mechanisms, and that education and training should be reoriented towards the priority requirements emerging from the Health Islands approach.

**Ongoing Need For Integration Of Healthy Cities And Health Island Activities**

In recent years, there have been several examples of successful integration of such activities in the Western Pacific Region. Some of these examples will be presented by participants. Nevertheless, the need for continuing and improving integration remains.
The word "integration" has rather different meanings and for our purpose we could use the meaning of "making whole or complete by adding or bringing together parts", in this particular context of bringing together all the activities of Health City or Health Islands projects. The positive purpose would be to pull together human, financial and other resources and to use them more effectively. The negative purpose would be to avoid reduplication of activities or even working at cross purposes.

There is often a need for integration at different levels and between different sectors of activity.

Integration is required at the following and sectors levels:

- Between governments, especially those either in adjacent geographical areas or in groupings with common political interests, e.g. Ministers of Health in Pacific Island Countries, Association of South-east Asian Nations, or Asian Pacific Economic Cooperation.
- Between different government ministries or agencies of the same country, e.g. Ministries of Health, Environment, Development, Industry, Manpower, Education, Agriculture, Energy, etc.
- Between national, provincial and local (city or rural) councils.
- Between government agencies and non-governmental organizations (NGOs), e.g. consumer associations, national safety councils, (inter-) professional and uniprofessional bodies, civic or religious organizations.
- Between employer groups and trade union or other employee representatives, at national, provincial, community and enterprise levels.
- Between sending and receiving countries and enterprises in technology transfer, or between donors and recipients of local or international aid.

As a first step, agencies and individuals who are active in health development should be identified and their cooperation should be sought to achieve common goals. They should be involved in training, their services should be used and they should receive technical and material support. They should be involved in planning, implementation and evaluation of programmes.¹

Mechanisms To Promote Such Integration

Formal mechanisms should be developed following informal collaboration.

It is not possible to provide details of either existing or possible mechanisms to promote integration of Healthy City or Healthy Islands projects in a short paper like the present one.
Such mechanisms have to be formulated according to the particular set of socio-economic or cultural milieu of particular situation, be implemented only after full consultations with all the interested parties concerned, and be modified according to changing circumstances or needs. It is one thing to establish a mechanism, but could be another to make it function or continue to make it function. Unfortunately, history abounds with magnificent plans or organizational structures which have solely or mainly existed on paper or which have become dormant or extinct after only a brief span of existence. Moreover, mechanisms should be put in place which are realistic in terms of time and personnel resources and would survive the warm inter-personal relationships which might happen to bond key personnel of organizations on agencies at a particular time.

Communications between the various participating agencies or organizations sometimes pose a formidable challenge. Of greatest importance is the need to encourage both formal and informal communications. Formal methods of communications can take the forms of regular meetings and briefings, written and electronic memoranda, and reference information services, etc. Informal networking is often just as important, so that the specialized knowledge and experience that individuals may have is made as available as possible to all who need it.

In addition, mechanisms which support public participation in policy development need to be created. A network of libraries and documentation centres and a complement of fully trained staff of engineers, health professionals, scientists and information/communication experts are required for effective programme development and implementation.

Last but not least, mechanisms for integration of the different “healthy settings” have to be firmly established. In the final analysis, healthy market places, schools, hospitals, workplaces, etc. could be regarded as sub sets of Healthy Cities, Islands or Healthy Rural Communities within the Western Pacific Region. Several examples exist of how “single setting” Healthy Programmes have led to the development of Healthy City or Healthy Island programmes later on. On the other hand, these holistic programmes have also spawned “single setting” healthy programmes after particular needs in individual sectors had been identified.

Conclusions

Great strides have been made in health promotion and in the WHO “Healthy Settings” activities throughout the world, not least in the Western Pacific Region. It is fair to say that decision makers at all levels have now a greater awareness of the need to factor in health aspects in all aspects of planning and implementation of developmental activities in both developed or less developed countries. Many successful projects have been achieved in elemental “healthy settings” activities, as well as in the more “global” activities of “Healthy Cities” or “Healthy Islands”. Nonetheless, there remains a need to ensure adequate and continued integration of all these activities to minimize reduplication of effort and to maximize broad-based support and deployment of all kinds of inter-disciplinary expertise in planning and implementing such activities in the next millennium.
Integration indeed should be factored in right from the conceptual or planning stage of a Healthy Cities or Healthy Islands programme. Mechanisms should be established as early as possible to facilitate the integrative process.

In training or educational activities for personnel to be involved, adequate emphasis on the philosophy for the need for integration and the methods for doing should be made.

Moreover, the evaluation of the efficiency or effectiveness of all Healthy Cities or Healthy Islands programmes should pay due regard to the efficiency or effectiveness of integrative endeavours in such programmes. In this manner, successes or failures of integrative efforts could be documented and experiences could be shared with other Health setting programmes in the same country, regionally or internationally.

I end with another quote, “Now that Asia appears to be emerging from the financial crises, aggressive moves are essential to address environmental problems. Any intervention, however, must balance social and economic considerations...this must occur alongside genuine political and bureaucratic efforts within these countries to implement environmental reforms. Otherwise, a second crisis - this time centred on environmental collapse - could well be on the horizon”.14 I believe that the interventions alluded to require multi-disciplinary and multi-sectoral cooperation on an integrated basis.

References

Review of Experiences in Integrating Settings in Healthy Cities and Healthy Islands


INTEGRATION VIEWPOINTS AND "DOING RESEARCH TOGETHER" ACTIVITY

Takehito Takano
Professor and Chairman, Department of Public Health and Environmental Science
Tokyo Medical and Dental University, Japan

Integration-Oriented Viewpoint in the Healthy Cities Approach

The integration-oriented viewpoint in the Healthy Cities approach may be one strategy that surprises those who are familiar with using a specific technique to solve a specific problem. This may cause some people to feel the program is overly vague.

However, recent research has further progressed to clearly show that the health level of city dwellers is largely dependent upon their living conditions and life styles, and is affected not only by single health determinant but also by combinations of health determinants. The combination of these health determinants creates different living conditions that impact on health.

It is necessary to understand a causal web-like relationship of various factors affecting health in the urban environment for the effective implementation of Healthy City concept.

The involvement of multiple factors is common in the case of urban health issues and the factors which influence health are interactive. Therefore, if we consider the wider range of health determinants most of which may not be dealt with in the health sector, we can obtain the more explanatory model about health status. A number of studies have shown that the actual health status of the urban population is determined by a wide range of factors in our daily lives.

It is recommended that integration be considered in several aspects including effectiveness and efficiency achieved by integration of existing activities for goals, maximized impact with optimum cost benefit ratio expected from integration of individual policies for city health development, and synergy and substantial benefits realized by integration of resources for visible progress in the Healthy Cities program.

Evaluation with People in the Community — "Doing Research Together"

Community participation for collection of baseline data is a very important process for creating awareness, and also a good opportunity for encouraging involvement of the people. This is the same viewpoint as when making the health profile of the city.
Integration Viewpoints and “Doing Research Together” Activity

It is worthwhile to involve professionals who have the ability to work with community people and to carry out appropriate and understandable general research together for the development of the program. It is necessary for the Healthy Cities planners to acquire the ability to analyze the relationship among various factors in both physical and social environments in the context of health status in order to demonstrate visible outcomes from the Healthy Cities project/programme.

One of the roles of the Planning and Research Committee of the Tokyo Citizens' Council for Health Promotion towards Healthy City Tokyo is to carry out research. And the research performed by the Citizens' Council is different from the rigorous scientific research, but very important from the viewpoint of developing the Healthy Cities program.

The research has been carried out under the principle of "doing research together", that means, the research is carried out not just by people in academia but by members from different sectors composing the four committees of the Council. The main research topics of these several years were: community group activities, family health, healthy aging, and healthy cities initiatives.

There are many possibilities in the "doing research together" activity. Evaluation might be a good example. Visualization of health and environmental conditions by applying Geographic Information System (GIS) is convenient, because it provides combined-information of statistics and location and makes data base easily understandable. This method for analytic purposes is able to clearly demonstrate a distribution of health, distribution of resources necessary for a city's development, and a diversity of environmental conditions in cities, which influence the health of the residents.

GIS enables us to further advanced analysis of information for planning and policy making. And there are some sophisticated applications as well. However, it is not necessary to use a computer when the main principle of this technique is applied. All we need is a handwritten map and colored pencil. This is a very important point of this technique particularly when applied in the community.

When considering counting and compiling of health and environment indicators of areas in the city for GIS application, community based assessment and evaluation activities are necessary.

The outcome of these research activities is persuasive to the public as well as to administrators, private sectors, and other people. Using substantial and objective data is an important point to involve other sectors and to obtain strong political support to Healthy Cities projects.

The analysis on the basis of evidential data is essential to formulate the most effective plan for the Healthy Cities program, to involve various sectors in the Healthy Cities program, and to obtain the visible outcomes of the Healthy Cities program.
Integration Viewpoints and "Doing Research Together" Activity

In addition, it helps the members of the Healthy Cities team recognize the validity of what they are doing. The members who have done these research activities become more convinced that the healthy cities approach is valuable and effective.

Usage of Information Technology

Opportunities to share experiences with other cities are invaluable to carry out health development with an integrated approach.

Networking is an important approach in sharing information related to Healthy Cities. Information sharing by using information technology increases transparency of the process of intersectoral collaboration, community participation, and evidence-based planning and evaluation.

Some important aspects in the Tokyo Message which was adopted in the International Forum on Health Promotion in 1996 in Tokyo mentioned networking as a significant means to foster Healthy Cities.

This message proposed (a) preparing an information network by using media, information processing, communication technologies, and other approaches so that everyone can have access, at anytime and from anywhere, to valid and useful information regarding health promotion, (b) developing a collaborative network among citizens who play key roles in health promotion and among health-focused citizens groups of diverse types and sizes, so as to strengthen community action, and (c) formalizing a link to advance city-to-city networking for exchanging and sharing information to meet global health challenges.

Linkage between Healthy Cities and Development Benefits

A well-planned combination of several control measures against major diseases in the community will bring an effective and efficient cost-benefit ratio into community development planning and its implementation. An integrated plan containing several major targets, several core activities, and several strategies to realize the plan is an important part of the Healthy Cities program. That is why the Healthy Cities plan is usually incorporated into the total city plan.

In addition, the plan and its implementation will be far more successful if they are linked to economic development with priority on the health and environmental conditions of the community. Investment for health based on knowledge of health determinants will ensure the effectiveness and efficiency of the investment and may lead to healthy and sustainable development in cities.

Urban development usually brings us some kinds of benefits: public projects, improved infrastructure, increased land value, capital gains, better quality of housing, more activity in
the local economy, increased convenience of living and so on. These benefits are called development benefits. It is worth while to discuss how these benefits can be used effectively as a resource to implement the Healthy Cities programs.

Although actual contributions of health determinants are different from city to city, and from country to country, the health status of city dwellers is influenced by several health determinants. These factors, on the other hand, are influenced by urbanization of the cities. Because urban development changes these health determinants, sometimes for the better but sometimes for the worse, Healthy Cities programme should be treated as a part of a long-term total city plan in order to lead city development and to improve health determinants.

For sustainable development of Healthy Cities, a mechanism consisting of integrated planning and implementation by using the benefits of city development would be essential.

References


This paper will briefly describe how “healthy settings” were incorporated into the development of Fiji’s National Environmental Health Action Plan (NEHAP). In doing so, I will seek to draw from the experiences of the practitioners to develop a broader framework for the future integration of settings into the planning and practice of “Healthy Islands” and “Healthy Cities”.

Healthy Islands and Environmental Health

An early development in operationalising “New Horizons in Health” was made as a result of the conference of the Ministers of Health of the Pacific Island countries in Fiji in March 1995. The Yanuca Island Declaration on Health in the Pacific in the 21st Century adopted the concept of “Healthy Islands” as a unifying theme. The Declaration reflected the desire to seek Pacific solutions to Pacific problems and achieve this through broad based participation. The wording of the declaration reflects these desires and states that:

“Healthy islands should be 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”

The Conference of Ministers agreed to begin the work of attaining the vision of Healthy Islands by focusing on three interrelated areas: Health Workforce Development, Management of Pharmaceutical’s, Medical Equipment and Essential Drugs, and Environmental Health.

In relation to environmental health the Declaration called for a range of environmental health initiatives, all of which require health promotion and health protection as means to achieve necessary outcomes.
These included:

- "to encourage governments to designate a focal point to design with an appropriate mandate and sufficient authority to design and implement the activities which follow from this agreement;
- to participate in designing a common protocol for developing national action plans and delineating these activities;
- to develop national action plans which align with the unique health and environmental needs of each country;
- to jointly identify factors which adversely influence environmental health;
- to share information concerning effective policies, legislation intersectorial actions and other enabling strategies to promote health and protect the environment.
- to identify innovative approaches, such as the healthy islands concept, and promote their application;
- to collaborate in building capacity at all levels to develop and manage environmental health programmes and activities;
- to grant new status to environmental health professionals in government services; and,
- to formulate performance indicators
- to measure outcomes, and monitor and evaluate environmental health initiatives, including training". (WHO 1995, p9)

The development of a National Environmental Health Action Plan (NEHAP) for Fiji was initiated by the practitioners themselves through the Fiji Institute of Environmental Health, its own formation a direct response to the Yanuca Declaration. However, there was no sense either within the Yanuca Declaration or by the Institute at what the plan might look like. At the time no Pacific nation had commenced development of any such plan (WHO 1997) and the only example internationally was the Draft National Environmental Health Plan completed in the UK and subject to considerable criticism at the time by the practitioners themselves (Chartered Institute of Environmental Health 1995). The U.K. Institute criticised the use of a prescribed planning approach and format claiming that the opportunity was lost to develop strategy which reflects individual systems and cultures. Other concerns included the:

- lack a visionary perspective
lack of specific detail on “what, how and when”

- failure to engage people at the local level to inform national policy development.

Indeed these concerns are reflective of a more general tendency in “planning” to produce top down “blueprint” style policies where policy is poorly connected to implementation and practice.

The challenge for the Fiji Ministry of Health and the Institute at this time was how to develop an action plan that reflected Fiji's unique cultural character and not follow the apparent shortfalls evident in the Draft UK Plan. In addition there was a desire by the practitioners themselves to break down many continuing colonial models of practice and build capacity at all levels to develop and improve the management of environmental health programmes and activities. The “Healthy Islands” concept provided an entry point to begin to explore how change might begin.

The opportunity to explore change came in 1995 with an AUSAID funded health development project on the island of Kadavu, which involved the construction of a hospital and health facilities and included a community development and community training component (Roberts 1997). What followed included a comprehensive island wide training wide program for all chiefs, turaga ni koros and health workers (Roberts 1997) in what was described by at a subsequent Healthy Cities conference as developing a “new cadre of health workers called Environmental Health Workers” (Litidamu 1996). The approach adopted in the training program included not only providing village leaders with new knowledge about environment health issues but also introduced them to the strategic management tool “ABCD”. The aim of the three week programs was to equip the communities to be responsible for their own decision making processes and to develop and implement new village policies related to environmental health (Litidamu 1996).

I took the opportunity to walk around one of the villages during one training program to interview village chiefs and turaga ni koros regarding the program. The responses were all positive, in that they felt that they had all learnt much about environmental issues and in particular the concept of developing an action plan using the ABCD planning tool. Typical responses included:

“yeah we had a good time. We all hope that when we go back after the course we are laying the base for a five years plan. I think our progress, five years we have to look at different....we have got to try and deal with projects like water supply and kitchens”

“Oh it's very good. It gives us some ideas of how to solve problems in the village....We should be laying out a program of all these development things and then you can put it inot a weekly program”
"It was quite easy because we used that model there, the ABCD model and we do a lot of problems, that's why it was easy to do that assignment. We just have to prioritise, to make one really important".

The AUSAID funded project on the island of Kadavu neared completion in June 1996, having established a new framework for the concept of a "healthy village" and the role of environmental health practitioners. However there were growing concerns amongst practitioners about sustainability of the process and the ability to transfer the concept to other settings.

By June 1996, the formation and proactive involvement of the Institute of Environmental Health and the implementation of the "Healthy Village" concept in Kadavu by the Ministry of Health had established an important platform for the further development of more national approaches. The Institute together with the Ministry of Health commenced in June 1996 to explore organisational issues. Particular attention was given to work culture and management systems that needed to change in order to sustain and transfer the emerging "Healthy Island" principles. This began at first at the local level in one district with the development of a "Local Environmental Health Action Plan". The first six months of this process highlighted that transformation of policies and practice was indeed possible but would take considerable time and that action was needed at both the local and national levels. Following these early advances, WHO and UNDP provided support to further develop these initiatives at a national level. Table 1 shows the projects goal, objectives and outcomes and Figure 1 the framework for the overall process.
Table 1. Goals and Objectives of National Plan (Fiji Government 1998)

<table>
<thead>
<tr>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The goal of this project is to enhance the country’s capacity for integrating health and environment issues in the formulation of plans for sustainable development and to harmonise the various activities related to health, environment and sustainable development. The project will be carried out at both local and national levels. More specifically the objectives are:</td>
</tr>
</tbody>
</table>

**Objective 1**

To demonstrate the feasibility of integrating the management of health and environment into local community decision making systems.

**Objective 2**

To collaborate with the government to develop strategic management approaches to the development and implementation of environmental health policy at the local level.

**Objective 3**

To collaborate with the government in the formulation of a National Strategy for strengthening consideration of health and environment issues in sustainable development planning.

**Expected Outputs**

1. Development of community based strategies for the management of environmental health issues in rural and urban areas.


3. A National Environmental Health Action Plan (NEHAP) which will harmonise the various activities related to health, environment and sustainable development and propose new environmental health policy initiatives.
Action Research and Learning in Settings

The process of transformation commenced with the emergence of a new vision for the Pacific developed at Yanuca. The transformation of this vision to new policy and practice began with activities of the Institute and the development of new approaches to environmental health practice at the district level. Practitioners had already embarked on an experiential learning path. With the formal adoption by the government of the development of a national plan this learning was now more structural and utilised an action research approach by practitioners within a range of “healthy settings”.

The concept of action research includes a cyclical process involving the four major phases of planning, acting, observing and reflecting (Zuber-Skerritt 1991). These authors point out that the now widely varied definitions of action research found in the literature all share four
common themes: empowerment of participants, collaboration through participation, acquisition of knowledge and social change. Reason (1994) describes action research as a form of inquiry into practice which is concerned with the development of effective action that may contribute to transformations of organisations and communities. This involves systematic evaluation and feedback of collective and individual performance.

As recently reviewed by Schon (1999) there are a variety of forms of participatory research. Schon points out that the participatory research movement was originally designed to:

"resist the intellectual colonialism of western social research into the third world development process, participatory research developed a methodology for involving disenfranchised people as researchers in pursuit of answers to the questions of their daily struggle and survival" (Schon, p1).

The adoption of such an approach is widely considered to be one way to connect practitioners to policy development in ways that connect strongly to the place or setting involved. The development of the national plan further unfolded with a commitment from senior environmental health officers within the Ministry to undertake the plan as a participatory action research process.

Focus on Communities and Settings

The “healthy village” framework developed on Kadavu was subsequently used by the “research group” to adapt and apply to urban environments. The overall process of the “Plan” development incorporated four national workshops where environmental health officers from throughout Fiji progressively developed a vision for environmental health and identified opportunities to establish healthy settings in their own districts and learn from the experiences of others.

Throughout the following two and half year period a large number of settings were explored. Four settings in particular were actively managed and flourished as “healthy settings”; “Healthy Makoi”, a suburb of Suva, “Healthy Squatter Settlement”, “Healthy School”, and Healthy Korovu, a small town. Each provided unique challenges to the practitioners both in terms of challenging the concept of their role and in the engagement of communities in social change. “Healthy Makoi” serves to illustrate the process.

“Healthy Makoi”

The second National Conference of practitioners held in July 1997 provided an opportunity for the research group to report on the development of the “Makoi Model”. The group presented the model to the workshop which described the process they had undertaken (Figure 2).
The team reported:

"Initial contact was made with the Makoi Methodist Circuit Minister, who summoned a few church elders for a traditional Fijian introductory ceremony and informal discussions with environmental health officers on the objectives of the Ministry of Health in regard to community based projects" (Institute of Environmental Health Minutes, 1997).

The Makoi process included a ‘needs’ assessment, formation of community committees and development of action plans by the community. The report highlighted that the practitioners played a facilitating role with decisions about implementation being made by the community.
The team celebrated successes in attempting to deal with unemployed youth and litter reduction in one innovative program that saw the community win a contract with the Public Works Department for roadside cleaning. In one initiative, the community both gained control over street cleanliness and employed its out of work youth to carry out the tasks.

The “Makoi” project had gained a lot of momentum within both the community and by the team with community newsletters distributed throughout Makoi now regularly announcing progress and future events. The first of these newsletters described the approach as;

"The Healthy Islands concept encourages the members of any community to examine their own situation and letting them decide for themselves what they need to do to improve their health and quality of life”. In doing so, Makoi becomes one of the first peri-urban areas in Fiji where the concept is being tried. The exercise will have the benefit in that what we learn together and will be a useful model to be tried in other peri-urban communities around Fiji”. (Makoi Community Newsletter, 1997)

In presenting these findings to the national workshop the environment health officers also reflected on their own experiences. They began to appreciate that the Environmental Health practitioner may need to deal with issues that are not considered the traditional business of environmental health in order to develop programs that are community oriented (Institute of Environmental Health Minutes, 1997).

One of the workshop participants reflected his learning from Makoi;

"This is new ground that we are going into. Again the definition of environmental health is to manage people. One thing that we have come up with is that we can’t restrict ourselves only now to traditional areas of environmental health, there has to be more than that now”.

A major innovation to emerge over the first year was the concept of building a “environment and health centre” whereby the practitioner could facilitate improved service and access to and by the community. By June 1997 the concept had been adopted by the community and funding and land donation was being sought. The centre is now constructed and operating with community and government officers working in partnership. The role of the centre and the partnership continues to evolve.

An Environmental Health Model for Healthy Islands

By mid 1997 the team of practitioners working on the Plan began to articulate a broader model which began to link settings within a broader canvas of programs and policy. The model (Figure 3) formed the basis of much discussion both within the group and subsequently at the Rarotonga Meeting held in August 1997.
Settings and Process

Each of the settings provided a broad range of experiences for Environmental Health practitioners upon which explicit models were continuously refined. The models enabled practitioners to develop connections and design guiding principles upon which new environmental health policy and practice could be built. The action research approach to the development of the NEHAP in general ensured that the plan was an ongoing process and "emergent" in nature.

In each of the settings, management "tools" and methods of practice were trialed including the ABCD strategic management system, building models of systems and facilitation techniques. Importantly in relation to these, "tools" changes were made to adapt to the needs of both the practitioners and the community. In other instances Environmental Health Officers and the District management had to radically address the environmental health management system including issues such as reporting, work times and style of interaction.
with the community and work culture. There was increasing awareness within the practitioner team of the impact of past colonial administrative approaches and structures and the need to develop systems more in keeping with the cultural features of Fiji.

The connections between all of these elements and the settings experiences may be captured under the overarching framework of “Learning Organisations”. As described by Senge et al., (1996) the “architecture” of such organisations supports the learning process and includes its guiding principles, infrastructure and tools/methods (Figure 4). In Fiji, the development of the NEHAP has involved working at the local level in a range of settings to begin to articulate new guiding principles that will ultimately provide the framework for new public health legislation.

At the same time new problem solving tools have been trialed and important issues regarding organisational culture and systems addressed. This has been driven by a process for plan development that has focused on learning and participation.

Figure 4. Integration of Settings into the Learning Organisation of Healthy Islands
The process continues to be one which is emergent in nature and continuous. One that is more a bottom-up approach to policy development in which the practitioners are providing important leadership and ownership of the healthy island process.

Reference


EXPERIENCES IN INTEGRATING HEALTHY SETTINGS 
IN HEALTHY CITIES, MALAYSIA

Rozlan bin Ishak
Assistant Director of Health
Disease Control Division, Public Health Department
Ministry of Health, Malaysia

Summary

The Healthy Cities Project was started in Malaysia in 1994. The two cities, which were chosen for this project, were Johor Bahru and Kuching. This project has managed to create an impact at the local and even at international levels.

Several healthy cities conferences and workshops have been organised at the local level and four at the national level. These conferences, workshops and meetings were organised to strengthen the intra-sectoral and inter-sectoral collaboration between the program managers at the national level and the Healthy City Technical Working Group (TWG) at the states and cities level. Several ideas and innovative projects, which were identified, managed and implemented by the City’s Healthy City TWG, were discussed. At the national level, financial and technical support were provided to the two initial cities and other cities and towns which are now part of this project. After strengthening the City’s Healthy City TWG, the Ministry of Health is now ready to focus on the implementation of healthy setting initiatives at the cities level. Areas of concern are (a) communities, (b) workplaces, (c) hospitals and clinics, (d) industrial areas, (e) schools, (f) marketplaces, (g) islands and travel-health, and (i) tourist spots.

Target for the implementation of healthy cities in urban areas has been set until year 2005. It is expected that about 35 towns and cities will be involved in this project. Within these cities and towns, healthy settings will be incorporated as the city’s projects with the city’s Healthy City TWG providing the organisational framework and support for the implementation of these initiatives.

Healthy Cities Indicators will be used to evaluate the cities performances towards achieving a better quality of life for its citizens. Various activities that have been identified by the National Healthy City Technical Working Group will be forwarded to the respective city’s Healthy City TWG for consideration. The evaluation results may be used as a basis to develop further and expand the project. In the future, it is envisaged that this project will become part of all developmental programmes in the cities of Malaysia.
Introduction

Malaysian cities and town are rapidly undergoing expansion in size and population. The urban population has increased from 50.6% in 1991 census to about 60.0% by the year 2000. It is expected that the urban-rural ratio will increase to 73%: 27% by the year 2020. The urban centres have increased from 67 in 1980 to 129 in 1991. The fast rate of urbanisation and continued concentration have resulted in various problems of traffic congestion, overcrowding, shortage of affordable housing, environmental degradation, flash flood, waste disposal, stress-related diseases and increase in demand for more and better urban services. The rapid and unplanned urban expansion will create an urban environment, which is not conducive for the upbringing of children and adolescence in the cities. Health and social problems especially among children and adolescence are associated with the inadequate provision of basic facilities and amenities that will support the promotion of good health and quality of urban living for these groups of the urban population.

The demand for land to build on houses, industries, recreational facilities, schools, clinics, public areas, community halls and others amenities in urban areas will be affected as the cost of land increases. The green areas and parks will be sacrificed in the name of development. Similarly, rapid urbanisation will result in poor planning of basic infrastructure such as roads, drainage systems, solid waste disposal, urban green parks (urban forest), water supply, electricity and telephones for the cities.

Healthy Cities Project in Malaysia

Malaysia's Healthy Cities Project has been a challenging one and the achievement so far has been encouraging. Since the initiation of this project in the two cities of Kuching and Johor Bahru in 1994, this project had managed to attract the attention of key people from other cities and towns in the country. The interest shown by them needed to be fully capitalised upon so that more cities in Malaysia will take up this idea thereby creating a better overall impact for the country. The Ministry of Health, which is the driving force behind this project, has been actively promoting and disseminating information to those who are interested in the project.

The Healthy Cities Project in Kuching and Johor Bahru would not have been as successful if not for the support of the respective city councils. They encouraged the implementation of the project and this ultimately gained support from other government departments and agencies. The respective Mayors of the cities further provided the momentum by being fully committed to the activities related to the project.
Kuching’s Healthy Cities Project has rapidly gained recognition in this part of the world through the World Health Organisation. The achievement of Kuching’s Healthy Cities Committee in promoting the healthy cities concept among the top government officials was remarkable. Since the implementation of this project, the State Government had, through its support of the ideas and approaches of the Ministry of Health, obtained the co-operation and commitment of the various government departments and agencies. Much encouragement was given to the participation of public and private bodies in the project. Within 5 years (1994 - 1999), five conferences were organised to discuss and identify issues and problems relating to Kuching city as well as earmark resources and technical expertise available so that a concerted effort may be taken. These efforts included the pooling of resources and minimising wastage of money, manpower and equipment.

The Safety, Health and Environment Committee (SHECOM) which was formed from the Healthy Cities initiatives, has received recognition from the State Government. Sarawak’s State Government had contributed RM 10,000 (US $ 4,000) for the committee to develop strategies and activities to minimise the undesirable occupational and environmental health effects arising from the rapid development and industrialisation going on in the state.

Similarly, a ‘Policing the Community’ programme was developed by the community with co-operation from the local police department. This has been a source of great pride to the people in being able to reduce the crime rate in Kuching City. Joint efforts between the committee and the police have managed to curb the increase in criminal activities in many areas.

The 3rd Inter-agency Conference organised in Sibu, Sarawak on the 5th - 10th August, 1996 was to evaluate the project. It also provided an avenue for other agencies to understand the concept of working together for the betterment of the health, welfare and social environment of the Kuching community.

The City of Johor Bahru, which is situated in the south of Peninsular Malaysia, bordering the island Republic of Singapore, is rapidly expanding. As a gateway to Malaysia, this has provided opportunities for Johor Bahru to expand especially in the tourism industry. Johor Bahru’s Healthy Cities Project included the organisation of conferences and workshops to disseminate information and to better understand the issues and problems, which are occurring in the city. The plan of action has been compiled and several activities have already been started.
The urban forest within Johor Bahru City is one of the major achievements by Johor Bahru's Healthy Cities Committee. It is located in the centre of the city and has been gazetted as the green lung for the city. The project has provided the urban population with a place for recreational activities and relaxation. The land area for the project is about 20 hectare and it was formerly used for anti-malarial drainage to control malaria. As malaria is not a problem anymore in Johor Bahru City today, the Johor Bahru City Council has converted this area to an urban forest.

Besides the urban forest, the Johor Bahru Healthy Cities Committee has developed strategies to provide comprehensive health care services to the urban community through the Well Men Clinic, Community Dengue Control Programme and Safe and Hygienic Food Hawkers Programme. These projects planned for the citizens of Johor Bahru will be regularly assessed and measured by specific parameters such as prevalence of diabetes mellitus and hypertension among the healthy adult population and incidence of dengue fever and food poisoning in Johor Bahru.

In 1997, under the budgetary "new policy" process, the Healthy Cities Project (HCP) has been allocated RM500,000 (US $ 200,000) to undertake the expansion of the project. This fund will be used to strengthen further the activities organised at the national and local levels and to include more cities in the country to HCP. With this fund, healthy cities co-ordinators will be given training by attending courses, workshops, conferences and seminars organised in the country.

The Second National Healthy Cities (Urban) Conference with the objective of sharing ideas and innovations developed at the local level has been implemented. This conference was jointly organised as previously by the Ministry of Health, Ministry of Housing and Local Government, Economic Planning Unit and World Health Organisation for the Western Pacific Region. About 150 participants from various organisations attended the conference with 17 papers presented.

Meetings for the City Mayors with government departments and agencies will be conducted in co-operation with INTAN. The aim of the meeting is to explain and derive consensus on the appropriate approaches in developing HCP in the cities and towns of Malaysia. This meeting will also be an opportunity for various departments and agencies to market their activities and products to other participating cities.

To support the project, allocations will be provided for promotional activities such as preparing posters, collateral, pamphlets and leaflets to give the HCP a better coverage other than through the newspapers. Coverage by the newspapers was provided quite extensively during the World Health Celebration with the theme "Healthy Cities for Better Life" on 7 April 1997. About 10,000 leaflets and posters have been produced to promote healthy city project to all parts of Malaysia. Besides that, exhibitions have been organised to propagate the ideas to all Malaysians.
Experiences in Integrating Healthy Settings in Healthy Cities, Malaysia

It is envisaged that by the year 2005, the Healthy Cities Project will be implemented in 35 cities and towns. Workshops and seminars would be organised to perpetuate the idea so that major towns and cities would adopt the healthy city concept. It is important for the towns and cities to have an organisational framework or structure to support health and health related issues because with the rapid development and urbanisation that are being experienced by Malaysia, economic issues were always given a higher priority and the health issues are seldom discussed. Such developments have already created health-related problems such as malnutrition, mental illness, chronic respiratory diseases, and social ills. The increase of social, mental and physical illnesses in the cities if left unchecked will soon create major problems for the city dwellers. By then, urban planning would need major funding to rectify problems rather than more beneficially to develop new areas of progress.

Macroplanning

Macroplanning for the HCP has been developed where funds and manpower have been identified to support the programme. This fund will be used to support the local healthy City TWG in establishing the organisation framework and identify projects and issues that are pertinent for the health of the communities in the city. This were done through conducting training, workshops and conferences at the local levels so that ideas and technical know-how will be disseminated and further strengthened. At this juncture, we were able to sit-down and evaluate the progress made thus far (1994-1998) and to assess whether we are proceeding in the right direction. Is the outcome what we had predicted or what we had wanted?

We had organised our thoughts, visualised our vision for the country and believed that this programme will clearly benefit the towns and cities concerned. We had continuously evaluated our strategies and approaches, and we need to re-focus our activities towards integrating specific settings into the cities. The settings identified were: homes and communities, hospital and clinics, marketplaces, workplaces and industrial areas, tourist spots and parks, islands and travel health, and schools. These pilot projects will be implemented by stages by various cities, which are involved in the healthy city project.

For the Ministry of Health, health issues are the main concern and the need to create supportive environments towards improving the health and quality of life are the main goals. At the local level, they may focus on issues related with their need, either on economic, social or environmental issues. The Healthy Cities Project in Malaysia is about supporting the city and municipal authorities in promoting the health of the community. Since many of the health care programmes are managed by the Ministry of Health through primary care services, the main task of the National Healthy City TWG is to identify the needs for the local authorities to provide basic needs of the people such as adequate and affordable housing, food hygiene and safety, safe drinking water,
creation of jobs and employment, affordable education etc. The local Healthy Cities TWG will work with the local authorities and other government agencies and departments to plan and organise joint activities with non-governmental organisations (NGO's), community organisations and other groups in the city.

The Ministry of Health through local health offices headed by the Medical Officers of Health takes actions on the health effects of environmental changes occurring in the cities such as outbreak of infectious diseases, rise in infant and maternal mortality rates, increased prevalence of non-communicable diseases, etc. The Medical Officers of Health also organise and manage preventive and promotional activities such as those under the dengue control programme, AIDS awareness programme, awareness on food and water borne diseases and immunisation programme with other government agencies and departments, NGO's, and the communities.

As most of the existing public health programmes involved multi-sectoral and multidisciplinary co-operation, thus this project will provide a platform that will generate solutions and ideas to solve, reduce or prevent problems associated with rapid urbanisation in the country.

Project Focus

The Healthy Cities Project focuses on sharing of the ideals and ideas, which are quite pertinent for the improvement of community health. The two main approaches taken are:

- providing technical expertise on social, health, economic and infrastructure development at the local level. This is achieved by involving and mobilising resources and expertise available at the local level, formulating plans, promoting use of sound technology and allocating funds;

- organising interagency and interdepartmental meetings and discussions with the private sector, NGO's, the community and certain interested parties. This forum will give them the opportunity to express their views and perception of their problems, needs and to suggest solutions.

Based on available health statistics and knowledge of epidemiology, the linkage of existing health, social, economic and environmental problems can be determined and therefore a comprehensive healthy city plan of actions have to be developed.
Experiences in Integrating Healthy Settings in Healthy Cities, Malaysia

Some of the activities planned (with a few already implemented) for Malaysia's Healthy Cities Projects are directed at:

- specific settings e.g. schools, markets, homes, communities, hospitals, workplace, industrial places, islands, tourist spots and parks.

- specific issues related to socio-economic and health problems within the cities such as homelessness and squatters, unemployment, poverty, smoking, drug addiction, accidents and injuries, alcoholism, cardiovascular diseases, hypertension, diabetes, infectious diseases such as tuberculosis, HIV/AIDS, food and water borne diseases, vector borne diseases, etc.

The local healthy city technical working group needs to prioritise the issues and the settings in the city.

Monitoring of Healthy Settings activities

A monitoring mechanism will be established to ensure the process of integrating the settings into healthy city project. This will be followed-up closely by the National, State and Local Healthy City TWG. The common issues that will be monitored are:

Cleanliness and Safety : The physical environment where the healthy setting will be implemented needs to comply with the requirements for a safe and clean physical environment. Safety in terms of free from diseases, accidents and injuries and crimes.

Layout plan : The physical layout of the particular setting needs to be reviewed so that it is friendly to all categories of the population i.e. the young, elderly, handicapped, women etc. Also to improve the landscape planning of the particular setting.

Environment supportive of stable ecosystems. : The waste disposal and sewerage and drainage systems must be within the set standards and regulation.

Basic needs for the inhabitants : The setting must be able to provide basic needs for the occupants or visitors to the said settings. The basic needs are food safety and hygiene, adequate water supply, electricity, telephone, employment and job security, safety at the worksite.
Experiences in Integrating Healthy Settings in Healthy Cities, Malaysia

Cultural and biological heritage: These settings will promote and preserve the cultural and biological heritage of the occupants or their surroundings. Also to provide venue for research and cultural exchanges between the local people and others.

Vibrant economy: The setting promotes the occupants to participate actively in the city through providing training and encouragement on entrepreneurship and skills development among the young, students, adolescents.

Community participation: Allowed community to be involved in the improvement of the setting.

Public participation: Provide venue for the public to voice their opinions and suggestions towards improving the setting.

Health care services: Provide basic health care services to the residents of the said setting. Also encourage the promotion, prevention and rehabilitation of chronic diseases.

Sharing of experiences and resources: Allowed the residents/occupants to exchange experiences and share of resources, which are available towards promoting a better place to live-in. Also to promote the utilisation of information technology and the multimedia among the occupants and their surroundings.

Conclusion

The Healthy Cities Project is very challenging and the ability to understand the relationship between health and health-related problems with environmental changes in the urban setting is very inspiring. With rapid urbanisation and aggregation of people in the urban areas, the disease trend changes accordingly from injury, food and water-borne diseases, dengue, food poisoning and measles to a chronic and behavioural type of diseases such as diabetes mellitus, obesity and social ills. Changing the settings in which the people work and live will eventually solve, reduce or prevent the occurrence of certain physical, social, mental and spiritual illness that have been experienced in those particular places.
With the recent changes in the national economics i.e. the recent economic downturn that is occurring in the Asian region, it is believed that there will be an increase in environmentally-related diseases such as stress at homes and workplaces, cardiovascular diseases, diabetes and hypertension, cancers, chronic respiratory diseases and skin diseases especially in urban areas. Some examples of environment-related problems which might aggravate the urban stress are: traffic jams, floods and work-related pressure which may reduce the quality of life. Environmental and urban health activities to provide the necessary information for solving, reducing and preventing urban related stress need to be further strengthened.

The Ministry of Health has a role to play in ensuring that the health of the people is promoted and protected especially among the urban poor. The Government needs to develop and strengthen settings approaches because these are more manageable by the local community. The local healthy city TWG still has to deal the city as a whole. The whole issues of urbanisation need to re-focus towards the overall benefits of the city. The urban communities still need to be given opportunities to voice and express their problems, needs and priorities at suitable forum. This forum is one of many initiatives that may help to further strengthen the Healthy Cities Project.

The success of integrating healthy settings in Healthy Cities Project will depend on how well the various agencies and the Ministry of Health work together to derive maximum benefit from all the programmes planned and implemented.

References:

Draft Conclusion of Western Pacific Regional Consultation on Healthy Cities, October 1996, Beijing, and China.

Healthy City progress report for Malaysia, 1997/98.

Healthy Cities Indicators: Analysis of Data from Cities Across Europe, WHO, Regional Office For Europe, Copenhagen 1996.


Experiences in Integrating Healthy Settings in Healthy Cities, Malaysia


WHO, Healthy Cities Conference in China, October 1996.

Introduction

Urbanization is occurring rapidly, especially in most developing countries. There are many problems associated with urbanization that have a negative impact on the health of communities. These problems include changes to the traditional ways of living; social problems such as drug abuse, alcoholism, prostitution and AIDS; traffic accidents; crime; scarcity of housing; poor public hygiene; and environmental pollution among others.

To prevent and mitigate these problems the World Health Organization (WHO) promotes the healthy city concept with the primary aim of providing "health for all".

Vietnam is a developing country with a high urban growth rate (an increase of 4% to 6% per year). Vietnamese cities are poor cities. We altogether know that in the course of social and economic development, problems related to urbanization will also crop up. Urban policy in Vietnamese cities is therefore oriented towards the healthy city approach as recommended by WHO. The goal of the Vietnamese government and its people is to have healthy cities.

Hai Phong City is the third largest city in Vietnam with a population of approximately 600,000. It is located in Hai Phong at the north coastal region of Vietnam with an area of about 1200 square kilometers and with a total urban and rural population of approximately 1.7 million.

The annual gross domestic product (GDP) growth rate has been 13 percent for the last five years. Hai Phong City is faced with many problems as a consequence of this economic and urban growth. Among these are:

- industrial pollution
- inadequate, old and overloaded infrastructure which needs to be improved (for example, road networks, water supply and sewerage systems, solid waste management).
- social problems (for example, substance abuse, prostitution)
- food safety

Health City Project

In October 1994, with the assistance of WHO and the Ministry of Health, Hai Phong City was introduced to the healthy cities approach. From that time until the present day our city has accepted and expanded the Hai Phong Healthy City pilot project.
The goal of the project is for Hai Phong City to become a healthy and sustainable developed city.

Phase 1 of the project was conducted from October 1994 to June 1995. The objective of Phase 1 was to:

- Establish the health and environmental conditions of Hai Phong City and determine the priority issues for action and for inclusion in the Hai Phong Healthy City Action Plan.

The five priority issues identified were as follows:

- Need to increase community awareness on environmental health issues, with a particular focus on promoting the point that “community health is closely connected with community responsibility”;
- Food safety;
- Water supply and sewage;
- Air pollution; and
- Solid waste disposal.

In order to address these priority issues, simultaneously Phase 2 of the Healthy City Hai Phong Project was initiated. The Hai Phong Peoples Committee decided to establish the Healthy City Steering Committee on 22 January 1997 led by Mrs Bui Thi Sinh, Vice Chairwoman of Hai Phong Peoples Committee. There are two deputy leaders of this steering committee; those are the Director of Department of Science, Technology and Environment (DOSTE) and the Director of Health Service (HS).

The Healthy City Steering Committee decided to establish the Health Environment Office with a Coordinator to work full time and a total of 6 project officers, drawn from the Health Service and DOSTE, to work only half time. Specific work guidelines were written for the Health Environment Office and work commenced in March 1997.

The Vision of Hai Phong City is summarized by the poem:

*Hai Phong is the place we love*
*Where people will live in peace in good health*
*Hai Phong is the cradle feeding its people*
*Its clean environment is a fairyland*
*It is green, civilized, rich and beautiful*
*This is the famous third city in Vietnam*
Project Results

The results achieved over the last two years include:

1. Hai Phong Peoples Committee decided to close the cement factory. The cement factory causes significant air pollution that impacts negatively on community health. The closure is occurring in stages that are simultaneous with the building of new cement factory 20km from Hai Phong City.

2. Hai Phong Peoples Committee closed the old dumpsite that caused ambient pollution and built a new dumpsite that is 12km from the city center and in a less populated location. The new dumpsite was opened for use in January 1998. Currently 75% of solid waste in Hai Phong City is collected daily and then treated at the dumpsite. Testimony from tourists who have revisited Hai Phong is that “Hai Phong City is cleaner now than in the past”.

3. With the assistance from the Finland Water Supply and Environmental Hygiene Project, Hai Phong City has:
   - eliminated bucket latrines in 20 Quarters;
   - increased the number of people who use tap water from 22,500 to 225,000;
   - reduced the average water loss rate in the city from 70% to 50%. In the Quarters where the water supply system was rebuilt, water loss has been reduced to 20%; and
   - recorded profit in 1997 for the Hai Phong Water Supply Company after suffering losses for many years.

4. Hai Phong City invested 1 billion VND (US $72,000) to improve the Quan Ngua Lake and its ambient areas that were polluted. The establishment of a Youth Cultural Centre in this area is now planned. Hai Phong City has also invested resources to improve Tam Bac Lake that is near the city centre so that the lake will be green, clean and beautiful.

5. The Healthy City Steering Committee chose Ngo Quyen District to pilot a Healthy District Project because Ngo Quyen District is the largest in Hai Phong City with an area of 12 square kilometers and with fourteen Communes of a population of approximately 170,000. There are a number of projects being piloted in Ngo Quyen District such as:
   - Healthy Market Project in the Ga Market.
   - Health Promoting Workplaces Project in 15 small enterprises.
   - Healthy Commune Project in Lach Chay Commune.
Healthy City Hai Phong Project, Vietnam

6. Hai Phong City built four air-monitoring stations that use high volume PM$_{10}$ sampling equipment supplied by WHO.

7. The Health Environment Office, the MOH and the WHO jointly organized nineteen workshops and training courses about healthy cities, healthy districts, air pollution monitoring, healthy markets, health promoting schools and health promoting workplaces. Between 50 and 100 people attended each of these workshops.

8. Projects are expanding, for example:

- from the one initial Healthy Commune there are now two additional Communes registered as Healthy Communes. These are the Lac Vien and Le Loi Communes in Ngo Quyen District;
- the participation of a second school, Nguyen Khuyen Primary School, in the Health Promoting Schools Project;
- a second market, An Duong Market, registered to build a Healthy Market.

9. Communities in the target settings have been increasingly willing to participate actively as volunteers to improve the projects as their knowledge on the projects improved. They were also increasingly willing to give financial contributions to implement the projects. Support from the Hai Phong City Peoples Committee and Ngo Quyen District Peoples Committee has also increased. Examples of this increased participation and support from the communities and Peoples Committees include:

- In the Healthy Market Project the sellers agreed to pay 75 million VND ($7000 USD) to repair the infrastructure of the market and the Hai Phong City and Ngo Quyen Districts contributed about 500 million VND ($50,000 USD);

- In the Health Promoting Schools Project one of the schools together with the Parents Association invested about 30 million VND ($2,000 USD) to buy equipment for a health room, healthy canteen and kitchen for pupils. The City and District spent about 500 million VND ($50,000 USD) to rebuild classrooms and a pupils’ club;

- Organization of a Festival of Knowledge about health promotion for pupils in the Nguyen Dinh Chieu School. The evaluation of this festival showed that the strategy was very effective for both pupils and teachers;

- In the Health Promoting Workplace Project all fifteen managers agreed to invest between 20 million to 70 million VND into their workplaces in order to improve working conditions, to purchase safety equipment and to improve the bathroom and toilet facilities for workers.
• In the Healthy Commune Project the local community contributed more than 100 million VND ($10,000 USD) to repair the playground for youngsters and teenagers; to build a 350 meter sewerage system; to pave 450 meters of road lanes; and to rebuild 16 public toilets. The Commune also signed an agreement to organize and undertake the cleaning of the local environment for better health.

• Training of media people to improve their knowledge about health and environmental issues in the community.

• Creation of many posters and billboards about food safety, environmental hygiene and “health for all” for display in key public places.

• Production of many video tapes about Hai Phong Healthy City, Healthy District, Healthy Market and Health Promoting Schools.

• Production of many cassette tapes about the prevention of disease and protection of environment health. These are broadcast over the radio to the communities in the market and in the schools.

• Distributed 2,500 leaflets titled “Golden Rules of Food Safety”.

10. Good cooperation and collaboration between the Health Service, DOSTE, Department of Training and Education, Veterinary Sector, Department of Culture and Communication, Department of Trade, Department of Transport and Public Works, Women’s Union, and the Red Cross.

Lessons from the Project

1. There is significant support and commitment from the MOH and Peoples Committees at all levels (for example financial support and policy commitments).

2. The priority issues and objectives of this project have been identified and the community has been consulted about the current problems in Hai Phong City which need to be solved as well as the proposed goals, objectives and strategies of the action plan.

3. Communities have agreed to be involved and contribute funds for the projects.

4. There is the core group of project officers in Hai Phong especially from the Health Service and Department of Preventive Medicine who are sharing their skills with the project communities and staff from other departments by giving technical guidance particularly at the implementation level.
5. There is good cooperation between government departments, the People Committees and different sectors.

6. There is an effective supply of resources, support and direction from MOH, WHO and other international organizations.

7. The strategy of media is working effectively to improve the knowledge of the community.

8. The Steering Committees are working very well at all levels.

9. The Hai Phong Healthy City Project has mobilized significant funding and resources from the:
   - National Government;
   - City Government;
   - WHO;
   - International Organizations;
   - Districts; and
   - Community.

In summary these results represent a significant step towards the goal of Hai Phong in becoming a healthy and sustainable developed city. We still have many more steps to take in order to achieve this goal. However, with the continued support of all of the stakeholders and especially the assistance of WHO and other international organizations we feel hopeful that we will continue to be successful.
THE USE OF SETTINGS IN THE AUSTRALIA-SOUTH PACIFIC: HEALTHY ISLANDS HEALTH PROMOTION PROJECT

Barbara Spalding
Associate, Victorian Health Education Foundation, Victoria, Australia

Summary

The broad topic under which this paper is being considered is the experience of integrating healthy settings into healthy islands. This paper describes the prominent role of settings in the design and development of the Australia-South Pacific: Healthy Islands Health Promotion Project and the various ways in which project activities were developed in settings. However the issue of the integration of settings into healthy islands is not so straightforward, mainly because the concept of “healthy islands” was relatively undeveloped at the time the project commenced in 1995. For the project integration meant greater prominence being given to health promotion in national health policy, plans and structures. This is discussed in more detail below.

The comments in this paper are limited to issues associated with settings and there is no attempt to provide an overview of the project as a whole.

Background to the Project

The Australia-South Pacific - Healthy Island Health Promotion project was developed at the time of the Yanuca Island Declaration. This Declaration, which arose out of the 1995 conference of Health Ministers of Pacific island countries, specifically stated that the meeting 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 Declaration included an invitation to relevant regional and donor bodies to continue to provide technical and financial support to Pacific island nations in formulating and implementing their proposed strategies and options for each of the three main areas targeted as development priorities. One of these was health promotion and health protection.

The purpose of the project was to support the efforts of the partner countries to strengthen their existing capacity in health promotion. The Pacific island countries with whom the project entered into partnership were Samoa, Kiribati, the Cook Islands and Niue. Tuvalu was one of the original partner countries but did not proceed beyond the second year due to local factors.
The project was conducted by the Victorian Health Promotion Foundation (VicHealth) and the School of Medical Education at the University of New South Wales. AusAID provided the funds and VicHealth acted as project manager. It was designed to have a three year existence, commencing in July 1995, but it took nearly a year before the establishment stage was completed. Consequently the action stage of the project in most of the participating countries did not commence until the latter part of 1996. Even though the timelines were extended to March 1999, this still meant effectively that there were less than two and half years of actual operation. Given what has been learned from experience about the time required to achieve and consolidate organizational change, it can be said in retrospect that these timelines were, at best, optimistic.

The Project Design

The project was designed in three broad stages:

Stage 1. Establishment

This stage included the situational analyses, negotiating the memoranda of understanding with each of the partner countries, the establishment by each of the partner countries of an administrative and structural base, including a cross-sectoral coordinating committee, and the appointment of a project coordinator. Working in conjunction with the coordinator, the committee in each country would have overall responsibility for planning, implementing and steering the project.

Stage 2. Implementation

The coordinator and the committee would identify local priorities relating to health promotion and prepare and implement an action plan based on a program of local projects which would address those priorities. This was seen as a “learning by doing” stage with technical support offered as needed. The design outline proposed that the project should include local settings “such as schools, churches and sports groups”.

Stage 3. Consolidation

In this phase the experience gained in the local projects would be considered at the broader national level and lead to incorporation into the appropriate national structures and planning processes (e.g. by setting up a formal health promotion council). This was described in the design as the transfer to “full-scale healthy islands programs”, meaning the adoption of a national health promotion strategy.

It can be seen that the design was similar in many respects to the model applied to Healthy Cities projects.
The key elements in this case were that it was a health promotion project, that its main function was capacity building, that healthy settings were seen as an important base for health action and that enhanced institutional support for health promotion in the participating countries was an intended outcome.

**Resources Provided**

The project provided an amount of AUD$20,000 per country per year for costs associated with implementing the action plans undertaken in Stage 2. Funds were also provided towards the overhead costs incurred by the sponsoring Ministry and for support activities such as network meetings of coordinators, attendance of coordinators at regional meetings and professional development.

**Why Settings?**

Settings were seen as a useful basis for introducing or extending health promotion concepts and providing experience with models of practice. First the development, planning and implementation work is done in conjunction with the people affected, those whose interests are most at stake. Second there is the potential for a holistic approach to determining priorities and selecting strategies which bring into consideration environmental health issues, economic issues and social and cultural issues. This has sometimes been termed the ecological approach. Third, within settings the links between various discrete vertical health related programme issues can be strengthened, such as nutrition and oral health or household waste disposal and dengue fever control.

A further consideration was that at the time the project was designed the term health promotion was commonplace but was often used inappropriately, particularly to describe single issue traditional health education practice based on information, education and communication (IEC). The focus on settings was useful in shifting both the conceptual understanding and the practice of health promotion from this more limited model.

**Evaluation as an element in the project design**

The initial design had two phases of evaluation built in. The first was a mid-term evaluation which was undertaken by an AusAID team at the end of 1997. This was an assessment of the project against the formal objectives which were related to the goals of capacity building and consolidation. A second stage internal evaluation to take place at the end of the project was included in the initial design but, on the advice of the AusAID review team, this did not proceed as it was considered likely to duplicate the work done by the team.

In each country documentation was maintained on project developments. Monthly monitoring and data collection was attempted, using a questionnaire format designed by
The Use of Settings in the Australia-South Pacific: Healthy Islands Health Promotion Project

VicHealth. However only one coordinator maintained this throughout and for a number of practical reasons it proved not to be an appropriate method of recording or reporting. In three of the four countries end-of-project reports have been prepared or are now being prepared by the local project personnel. These will also provide a record for other countries interested in learning from the experiences of the Pacific island project partners.

Developing evaluation skills in project participants

Apart from issues relating to the evaluation of the overall project there was the issue of the evaluation skills requirements of the relevant personnel in each country. Evaluation methodology and skills were topics which were built into the program of technical support, with a particular focus on the development and use of indicators.

Taking account of the dynamic environment

This project did not happen in isolation. Developments in the region during the course of the project were influential. For example both the WHO regional office and the SPC organized meetings relating to health promotion and “healthy islands”. The Pacific island Health Ministers’ meetings in Rarotonga in 1997 and Palau in 1999 helped keep up interest in what came to be called the “healthy islands approach.

The four countries involved started from very different positions and had to contend with very different internal conditions during the course of the project. These factors present a continuing challenge in terms of evaluation methodology.

Integrating healthy settings into “healthy islands”

Integration in this context could be indicated in a variety of ways. Indicators included:

- setting up a new formally constituted ongoing cross-sectoral health promotion planning and coordinating committee
- changing the structures within the health ministry to consolidate health promotion within the local bureaucracy and give more influence to the relevant personnel
- increasing the emphasis on health promotion in the national health plan
- getting political commitment for health promotion initiatives, especially from portfolios other than health, along with formal support for cross-sectoral initiatives
- giving increased priority to health promotion initiatives in terms of budget allocation or use of donor funds
- preparing and implementing forward health promotion program plans extending beyond the end of the project
In each participating country there was some evidence at the end of the project of one or more of these developments. However, the point must be made again that the project would not and could not claim to be the main instigating factor. At most it is likely to have been one influence amongst many. Nor is it possible at this short distance to measure whether the changes will be sustained. However it is possible that the project helped trigger other initiatives which will build on it, just as it was able to build on what was already happening in the respective countries and in the region generally.

Definitions and Clarifying of Concepts

Caution needs to be exercised in extrapolating too directly from a Healthy Cities conceptual model to healthy islands. Healthy Cities, while including a wide variety of settings within their boundaries, are nevertheless themselves part of larger units, that is the nation. As cities they do not necessarily have their own health policy, health planning, health management or health financing framework. Healthy islands however need to be defined. They may coincide with national boundaries or they may not. Different considerations may apply in either case.

The experience of using settings in the Healthy Islands Health Promotion Project

Each of the countries in the project had its own way of utilising the opportunities presented by the project, reflecting their own circumstances and priorities. Three of the four combined the use of settings with other approaches involving population subgroups and risk factors. One committee chose not to use settings at all at the outset, but to develop a multi-faceted strategy based on the responsible use of alcohol on the main island, as this was its highest health promotion priority. In this instance the country’s strategy included a particular focus on licensed clubs associated with the major sports codes, but as a strategic location for specific interventions such as host responsibility training, rather than as a focus for more comprehensive organizational change as implied by the use of settings. Two countries made health promoting schools the major initial focus. Of these one adopted a universal approach at the outset, involving all primary schools in the country. The other adopted a pilot scheme, trailing initially with three schools on the main island, then all schools on the main island and now moving systematically to a whole-country programme.

In general the project appeared to make the greatest impact in those countries which incorporated it into their own agendas and blurred the boundaries between the project as a set of introduced interventions and the country’s own plans and priorities. For example in Niue, the project was given a local name, Moui Olaola, and the structures set up for the project were used to coordinate and integrate a range of initiatives which took on this identity, including many which were initially not directly linked to the project. Niue and Samoa in particular developed a broad multi-faceted health promotion agenda which brought together initiatives and resources from many sources, combing settings with other strategies. They were proactive in making the project work for them rather than the reverse.
The action plans were an important planning mechanism, essential for working out priorities, allocating the budget and setting provisional timelines. However these plans did not take on a static once-only form but were reviewed and adapted at least annually to reflect the growth in understanding and experience that was occurring. New settings such as homes, villages, market places, workplaces and hospitals were added in different countries at different points in time.

These developments may not have occurred as they did without the resources and the technical support provided by the project, but at no point did the project stand alone as the identifiable sole intervention. Part of its apparent usefulness was that it could be merged with the countries' own agendas while at the same time expanding their scope and focus.

Lessons learned

- Flexibility

There is a need for flexibility in project design, including with respect to timelines. This is particularly true of projects involving several countries. Rigid procedural requirements are inappropriate. Broad design parameters are important to have. However they are not necessarily the only way to achieve the objectives. A particular country may have other ways of achieving the desired outcomes. There must be scope for local adaptations.

- Respecting local priorities

There is a need to ensure that the priorities of the health planners and experts are not imposed on the people in particular settings where they are not consistent with local priorities. In such a situation there needs to be careful discussion and negotiation and in particular the provision of all relevant information.

- The value of other approaches

Population sub-groups with particular social, cultural and health needs, may not always be accommodated in a settings approach and special planning may be needed for them. Different strategies may also be needed if the country in question considers its first commitment is to deal with a particular health related issue on a national basis rather than through using elemental settings.

- The development of conceptual and practical skills

Support needs to be provided so that any project based on settings result in opportunities being provided for participants to enhance their skills. This includes evaluation skills which should not be seen as the preserve of the experts. There is a
The Use of Settings in the Australia-South Pacific: Healthy Islands Health Promotion Project

clear presumption in settings that participants will be involved in defining issues, planning action and assessing progress and will therefore need to be supported to obtain the necessary concepts and skills.

- **Adequate timelines**

Adequate time is needed to allow changes to be incorporated and sustained. Short term interventions are not likely to have long term results and serve only to divert the precious resources of busy people in the particular countries.

- **The sharing of experience amongst Pacific island countries**

The experience of countries in the Pacific in the use of settings can be shared through the use of Pacific island consultants and through exchange visits as well as through regional meetings.

- **Action plans**

"Healthy islands" action plans do not have to be comprehensive, all or nothing exercises. They can be incremental, subject to regular review and reassessment and should merge ultimately into national health plans and strategies. Some aspects might be incorporated into the normal planning process of other portfolios where there is cross sectoral action. It is legitimate and sensible to start small and learn by experience.

References:


HEALTH PROMOTING KEIYASI HEALTH CENTRE
A Health Promoting Primary Health Care Facility

Margaret Cornelius
Assistant Director Primary & Preventive Health Services
responsible for Non-Communicable Diseases and Health Promotion, Ministry of Health Fiji.

Introduction

The Health Promoting Communities (HPC) Project, developed by the (Fiji) National Centre for Health Promotion with the support of the Trilateral Health Promotion Project, aims to improve the conditions for health by working district by district (tikina). Within each tikina; schools, villages, settlements and primary health care facilities are encouraged to develop and implement action plans to improve the conditions affecting health. These action plans are discussed with the existing Tikina, Provincial and Advisory Councils, on whose support it will become an important component of the local government’s development plans.

The Keiyasi district is situated within the province of Nadrogra-Navosa in the Western division of the main island (Viti Levu). It was chosen as a pilot site for developing HPC activities because of the active involvement of a non-governmental organization in community development activity, its relatively depressed economic status and inaccessibility and upon the recommendation of the Western Divisional Medical Office.

Background

Keiyasi Health Centre (KHC) is situated about 60 kilometers inland from the main shopping centre and the Sigatoka subdivisional hospital. It provides health services to more than 6000 people living in 24 villages and 43 settlements.

The KHC was built 30 years ago and is currently staffed by one medical officer, two midwives and two zone (registered) nurses. The non-health worker is a laborer/handyman. The Centre also provides support and is a back-up for three Nursing Stations in the Keiyasi District. There are ten schools in the area as well. Currently, Keiyasi Health Centre does not have electricity or telephone, its water supply is unreliable and public transport is not easily available.

Health Promoting Keiyasi Health Centre

Since the launching of the Health Promoting Communities Project, the Western Divisional, Sigatoka Subdivisional and Keiyasi District management teams decided to start the project from the primary health care facility. The teams were trained by the staff of the National Centre for Health Promotion to profile the Centre, identify the major problems and needs and
develop a plan of Action using the six action areas and five steps of health promotion. The six action areas are:

- physical environment
- social concerns
- strengthening community action
- developing personal skills
- reorientating health services
- building healthy public policies

The 5 steps involved are:

- mobilizing support
- establishing and training health communities
- health and development profile
- developing plan of action
- implementation and evaluation

The profile of the Keiyasi Medical area revealed that there were five major community health problems that need to be addressed. These were skin diseases, respiratory problems, gastro-intestinal infections, soft tissue injuries and untreated (river) water supply. Other pressing issues were lack of a private place for counseling of clients on family planning and absence of resource materials for family planning education.

The profile also revealed that some improvements could be done in the Centre itself in most of the priority action areas.

**Initiatives/Action Plan**

The action plan for the Centre was developed after reviewing the profile and gathering information from key informants (mainly regular clients of the Centre).

The plan of action defined the nature of the activity, stated who was responsible for this activity, gave a timeline and put in place an indicator, for example, when this activity is expected to be completed. (See appendix 1.)

People and sectors involved in the process included primary health care workers (doctor, nurses, dietitian and environmental health officer), Board of Visitors (a community group nominated by the Minister for Health for the welfare of the Centre), Non-Governmental Organisation and some clients (key informants).
Support from the National Government was in the form of material (a large generator to provide electricity for longer hours), repair and renovations of physical infrastructure, funding and human resource allocation for training of health committees. Resources required for the activities were varied. For some action areas like renovations, paint and human resources were needed, a small amount of funding was needed to provide for a locked cupboard for prohibited dangerous drugs.

The reasons for the success of the Programme are:

- the primary health care staff are motivated and take active part in progressing the action plan;
- the sub-divisional management team is supportive;
- the community is responsive and the NGO is active.

Some Constraints

This programme is ongoing and the action plan is for three years. Some problems encountered are:

- difficulty in accessibility of the Centre;
- difficulty in communication;
- frequent changes in primary health care workers;
- leadership and ownership issues;
- diversity of people.

Summary/Lessons learned so far:

- that the programme is supported by the people;
- that stronger links with other partners in health need to be established right from the start of the programme;
- leadership issues need to be addressed in the early phase and;
- that the community needs regular feedback for continued support.
## Appendix 1

### ACTION AREA 1: PHYSICAL ENVIRONMENT

**Objective 1.1 To Create a Pleasant, Safe and Health Promoting Environment at The Keiyasi Health Centre**

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Fencing of the health centre.</td>
<td>Board of Visitors</td>
<td>1999</td>
<td>Fence installed.</td>
</tr>
<tr>
<td>1.1.3 Secure storage of drugs.</td>
<td>Sub-Divisional Management Team</td>
<td>1999</td>
<td>Locked drug cupboard provided</td>
</tr>
<tr>
<td>1.1.4 Providing full time electricity at the facility.</td>
<td>Fiji Trilateral Health Promotion Project</td>
<td>1999</td>
<td>Bigger Generator provided. Electricity available full time in the health centre and staff quarters.</td>
</tr>
<tr>
<td>1.1.5 Cleaning and painting of the Centre. Providing new curtains and linen.</td>
<td>Sub-Divisional Management Team</td>
<td>1999</td>
<td>The Health Centre is cleaned and painted. New curtains and linen are available.</td>
</tr>
<tr>
<td>1.1.6 Upgrading the general equipment of the Centre.</td>
<td>Sub-Divisional Management Team</td>
<td>1998</td>
<td>The Health Centre has all necessary equipment</td>
</tr>
<tr>
<td>1.1.7 Painting of the waiting burr.</td>
<td>Sub-Divisional Management Team</td>
<td>1999</td>
<td>Waiting burr painted.</td>
</tr>
<tr>
<td>1.1.8 Renovating and painting of the toilets</td>
<td>Sub-Divisional Management Team</td>
<td>1999</td>
<td>Toilets repaired and painted. Proper signage for males and females provided</td>
</tr>
</tbody>
</table>
### Health Promoting Keiyashi Health Centre, Fiji

<table>
<thead>
<tr>
<th>ACTION AREA 2: SOCIAL ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 2.1:</strong> To Improve Communication for Keiyashi Health Centre</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Negotiate the extension of telephone lines to Keiyashi Health Centre. Fax machine to be provided at the Health Centre.</td>
<td>Sub-Divisional Management Team Divisional Management Team Board of Visitors</td>
<td>1999</td>
<td>The health centre has access to telephone and a fax machine</td>
</tr>
</tbody>
</table>

**Objective 2.2:** To Develop a Policy to Allow for Time off for Staff for Banking and Shopping

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Hold meetings with SDMO and DMO to establish a policy to allow time off for Staff to travel to Sigatoka for business purposes.</td>
<td>Divisional Management Team</td>
<td>1999</td>
<td>Policy in place to allow the staff to take turns for a half day off for shopping and banking.</td>
</tr>
</tbody>
</table>

### ACTION AREA 3: COMMUNITY RELATIONSHIPS

<table>
<thead>
<tr>
<th>ACTION AREA 3: COMMUNITY RELATIONSHIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 3.1:</strong> To Improve the Availability of Support Materials for Community Education</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Develop IEC materials on skin diseases and family planning.</td>
<td>National Centre for Health Promotion Sub-Divisional Management Team</td>
<td>1999</td>
<td>1) NCHP has run focus groups in Keiyashi 2) Appropriate IEC materials on family planning and skin diseases are available at Keiyashi in all languages</td>
</tr>
</tbody>
</table>
3.1.2 Establish a process for requesting IEC materials from the Centre

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.3 Ensure that display and teaching equipment is available at the Centre</td>
<td>Board of Visitors Ministry of Health Fiji Trilateral Health Promotion Project</td>
<td>1998 1999</td>
<td>The Health Centre has a mobile whiteboard, notice board, pamphlet display board, overhead projector and portable TV.</td>
</tr>
<tr>
<td>3.1.4 Ensure that appropriate storage, display and filing equipment is available for IEC Materials.</td>
<td>Board of Visitors Fiji Trilateral Health Promotion Project</td>
<td>1998 1999</td>
<td>Locked cupboard, pamphlet display board and filing cabinets available.</td>
</tr>
<tr>
<td>3.1.5 Ensure that an efficient system is in place at Sub-Divisional level to ensure distribution of IEC materials to the Health Centre and other Primary Health Care Facilities in the Sub-Division.</td>
<td>Sub-Divisional Management Team Divisional Management Team</td>
<td>1998 1999</td>
<td>NCHP distributed resource materials available in all the facilities in the Sub-Division. An Officer at Sub-Divisional level handles and keeps records of all distributions, does cataloguing where necessary and provides feedback to NCHP on what is needed.</td>
</tr>
</tbody>
</table>

Objective 3.2: To Improve Relationships Between the Community and the Health Centre in Order to Empower the Community to take Greater Control over their Health

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1 Hold Regular Meetings with The Board of Visitors</td>
<td>Keiyasi Health Centre Sub-Divisional Management Team</td>
<td>1999</td>
<td>1) Regular meetings held 2) Minutes of the meetings available to all villages, settlements and schools' health committees.</td>
</tr>
</tbody>
</table>
Objective 3.2: To Improve Relationships Between the Community and the Health Centre in Order to Empower the Community to take Greater Control over their Health

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1 Hold Regular Meetings with The Board of Visitors</td>
<td>Keiyasi Health Centre Sub-Divisional Management Team</td>
<td>1999</td>
<td>3) Regular meetings held 4) Minutes of the meetings available to all villages, settlements and schools health committees.</td>
</tr>
<tr>
<td>3.2.2 Establish ongoing relationship with leading churches, NGOs and social organisations</td>
<td>Keiyasi Health Centre with Support of the Board of Visitors Sub-Divisional Management Team</td>
<td>1999</td>
<td>Regular consultations undertaken with Women's Groups, Youth Groups, Religious Organisations etc. and the Health Centre.</td>
</tr>
<tr>
<td>3.2.3 Training Programs and Support given to Health Committees in villages, settlements and schools</td>
<td>Keiyasi Health Centre with Support of the Sub-Divisional Management Team Board of Visitors National Centre for Health Promotion</td>
<td>1999 2000 2001</td>
<td>All villages, settlements and schools have Health Committees with Profiles and Action Plans which they are implementing Evaluation and Reorienting Action Plans</td>
</tr>
<tr>
<td>3.2.4 Working relationship established with Tikina, Provincial and Advisory Councils</td>
<td>Keiyasi Health Centre with Support of the Sub-Divisional Management Team Board of Visitors National Centre for Health Promotion</td>
<td>1999</td>
<td>Local government bodies support HPC Project. They are informed of progress e.g. have copies of all Action Plans from the Pilot Area</td>
</tr>
<tr>
<td>3.2.5 Ensure that Village Health Worker training materials are revised and available</td>
<td>Keiyasi Health Centre with Support of the Sub-Divisional Management Team Divisional Management Team National Centre for Health Promotion</td>
<td>1999</td>
<td>NCHP has consulted widely on revision of Kadavu, FSM and the Peace Corps training manuals for Village Health Workers Revised materials available in all languages.</td>
</tr>
<tr>
<td>ACTIONS</td>
<td>RESPONSIBILITIES</td>
<td>TIME</td>
<td>INDICATORS</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>3.2.6 Conduct Training Programs for Village Health Workers</td>
<td>Keiyasi Health Centre with Support of the Sub-Divisional Management Team</td>
<td>1999</td>
<td>All villages and settlements have active trained Village Health Workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td>3.2.7 Improve Community Awareness of Keiyasi health problems through use of Community Theatre</td>
<td>Keiyasi Health Centre working with Foundation for the People of the South Pacific (FSP) National Centre for Health Promotion Fiji Trilateral Health Promotion Project (FTHPP)</td>
<td>1998</td>
<td>FTHPP funding provided to FSP to develop a Keiyasi Youth Theatre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>3.2.8 The Rest House to be converted into a Community Health Promotion (HP) Centre</td>
<td>Board of visitors Sub-Divisional Management Team Divisional Management Team</td>
<td>March 1999</td>
<td>1) A plan is available to convert the Rest House into a Community Health Promotion (HP) Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>December 1999</td>
<td>2) Rest House becomes a Community HP Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000</td>
<td>3) Community HP Centre used for training, theatre, video shows, workshops etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td>3.2.9 Community Made Aware of the Community Health Promotion Centre</td>
<td>Keiyasi Health Centre</td>
<td>1999</td>
<td>Community using HP Centre for theatre, talks, video shows, conferences, workshops, training etc.</td>
</tr>
</tbody>
</table>
### ACTION AREA 4: PERSONAL KNOWLEDGE AND SKILLS

**Objective 4.1:** To Improve the Professional Development of Kei�asi Health Workers

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1 <strong>Hold meetings with Fiji School of Nursing staff and discuss the possibility of further training opportunities in areas of sterile techniques and other clinical skills.</strong></td>
<td>Sub-Divisional Management Team Divisional Management Team</td>
<td>1999</td>
<td>Training programs developed in the areas identified.</td>
</tr>
<tr>
<td>4.1.2 <strong>Hold meetings with NCHP to provide training on Participatory Skills for community involvement and community Evaluation Methods</strong></td>
<td>Sub-Divisional Management Team Divisional Management Team approach NCHP</td>
<td>1999</td>
<td>NCHP with WHO support provides training in Participatory Methods for Community Mobilisation and Evaluation</td>
</tr>
<tr>
<td>4.1.3 <strong>Try to establish a regular Update Newsletter/Bulletin on Professional Matters</strong></td>
<td>Sub-Divisional Management Team Divisional Management Team to approach Fiji School of Medicine Fiji School of Nursing</td>
<td>1999</td>
<td>Written materials available on a regular basis</td>
</tr>
<tr>
<td>4.1.4 <strong>Ministry of Health to regularly update Health Workers Manuals</strong></td>
<td>Sub-Divisional Management Team Divisional Management Team to approach Ministry of Health</td>
<td>1999</td>
<td>Regular Update of Health Workers Manuals</td>
</tr>
</tbody>
</table>

### ACTION AREA 5: REORIENT HEALTH SERVICES

**Objective 5.1:** To Reorient the Health Centre to give Greater Emphasis to Disease Prevention and Health Promotion
**Health Promoting Keiyashi Health Centre, Fiji**

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1 Establish a Health Promotion Charter for The Health Centre</td>
<td>National Centre for Health Promotion</td>
<td>1998</td>
<td>Health Promotion Charter displayed</td>
</tr>
</tbody>
</table>

See 3.2.1, 3.2.2, 3.2.3, 3.2.4, 3.2.7, 3.2.9 etc.

---

**ACTION AREA 6: POLICY**

Objective 6.1: To Develop Policies which Assist in Making the Health Centre more Health Promoting for Staff and the Community

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>RESPONSIBILITIES</th>
<th>TIME</th>
<th>INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.1 Develop a Policy to ensure Privacy for patient Counselling and Treatment</td>
<td><strong>Keiyashi Health Centre with Support of The Sub-Divisional Management Team</strong> Divisional Management Team</td>
<td>1999</td>
<td>A Written Policy in place for Privacy on Counselling and Treatment</td>
</tr>
<tr>
<td>6.1.2 Develop a Policy on the use of The Health Promotion Centre</td>
<td><strong>Keiyashi Health Centre with Support of The Sub-Divisional Management Team</strong> Divisional Management Team</td>
<td>1999</td>
<td>A Written Policy in place on the use of the HP Centre</td>
</tr>
<tr>
<td>6.1.3 Develop a Policy on How Requests to NCHP for IEC materials are to be made and coordinated</td>
<td><strong>Keiyashi Health Centre with Support of The Sub-Divisional Management Team</strong> Divisional Management Team</td>
<td>1999</td>
<td>A Written Policy in place on how Requests to NCHP for IEC materials are to be done</td>
</tr>
</tbody>
</table>
A CASE STUDY REPORT ON HEALTHY VILLAGE INITIATIVE

Lindsay Piliwas
Director, Health Promotion, Department of Health, Port Moresby, Papua New Guinea

Introduction

This report is about a village named Yalu in Morobe Province of Papua New Guinea. The village has a population of approximately five hundred and is situated about fifteen kilometers from the city of Lae and about a kilometer away from the main highway.

Yalu village is a healthy village as defined under the healthy island framework. The village has a water supply system, ventilated improved pit toilets, rubbish pits for disposal of household waste, individual family units with electricity connected to their homes, and an improved environment. Additional things people had provided include pig fencing, proper drainage, mosquito bed netting, law enforcement and strengthening of the village structure.

Project Development

The healthy village initiative started with the introduction of ventilated improved toilets, an experience, which the officers who had visited an overseas country had brought back with them to experiment what they have seen. Yalu village was chosen for implementation because of its accessibility and the willingness of the people.

In addition to this, a visit by the WHO Regional Adviser on Environmental Health re-enforced the desire to do something. A meeting with the community and the adviser has confirmed the willingness and desire of the people to do something different.

Implementation

Certain activities were carried out prior to the implementation of the healthy village initiative.

First, a workshop among community leaders with the assistance of WHO and the National Health Department was conducted. The objectives of the workshop were to:

- understand positive behaviors in order to develop trust among the people in solving their own health problems;
- identify essential information to understand health conditions and goals in the community;
- motivate members of the community for action development in the village; and,
- develop community action plans according to goals and priorities of the community.
Second, a plan of action was developed towards the end of the workshop. Water supply was identified a first priority. The whole village was committed to bring in potable water to the village.

People/sectors involved in the process

- village committee, youth/women leaders, traditional village leaders, church leaders and councilors.
- politicians
- technical officers from the Health Department
- WHO technical support

Support from national government

The government provided technical support. Materials such as pedestal toilets etc, which are not available in the province were provided by the Department of Health.

Resources required for the activities

- people/community
- money
- labor
- technical advise
- materials
- transport

Aspects/elements that were successful

There are number of successful aspects of the initiative. Community involvement was present. This has resulted from adequate consultation and the interest shown by the technical officers. The community was highly motivated due to support received from others including the politicians, and technical advice from the Department of Health and WHO. Another aspect was the public awareness. On hearing about the improvements in Yalu village, the neighboring villages and others from outside of the provinces were interested to learn about how to have a healthy environment. For example, a village in the central province of Manana is currently undergoing through the process of developing a healthy village.

Aspects/elements that were not successful

The sustainability of the initiative may be a problem. This is due to lack of full participation by the community from the beginning. It is obvious that the project is considered a family one by the general community because of its location. Usually in such situation, as soon as the project is completed, a ban for the use of facilities by the general community is enforced causing discontentment and vandalism. Encouragement from and leadership by the village leader should help to build confidence and acceptance of one another.
Summary

The concept is good as it allows people to be responsible for what they need. Education or awareness of the community plays important role in bringing communities together. Actually the success of the project depends on leadership, the commitment of the people, and availability of resources (finance, materials, etc)

Lessons learned:

- bottom-up planning works out well when people are involved from the beginning to the end. That is from initial discussions, planning, decision making and actual implementation.
- leadership is a key to successful development.
- support from outside of the community including politicians, technical personnel, and materials.
- community participation is an answer to sustainability.
LIST OF PARTICIPANTS, TEMPORARY ADVISERS, CONSULTANTS, OBSERVERS, REPRESENTATIVES AND SECRETARIAT

1. PARTICIPANTS

CAMBODIA

Dr LIM Pich
Health Training Officer/Chief of Health-Promoting School
National Centre for Health Promotion, Ministry of Health
Building # 168, Preah Sihanouk Boulevard
Phnom Penh
Tel. no.: 855-23-213609
Fax no.: 855-23-213608; 855-23-426841

Dr Leng POTHIKA
Deputy Chief of Environmental Health Unit
Ministry of Health, Phnom Penh
National Centre for Health Promotion
Building # 168, Preah Sihanouk Boulevard
Phnom Penh
Tel. no.: (855) 23-213609
Fax no.: (855) 23-380374; (855) 23-426841

CHINA

Dr FAN Fangzhao
Office Head
Dalian Patriotic Health Campaign Committee
No. 1, Renmin Square
Dalian
Tel. no.: +86-411-3633704
Fax no.: 86-411 3633704

Mrs KONG Lingzhi
Director
Division of Non-Communicable Diseases Control
Ministry of Health
Xizhimen Wai Nan Lu
Beijing 100044
Tel. no.: 86-10-68792368
Fax no.: 86-10-68792514

Dr LIU Min
Doctor-in-charge
Shanghai Health Education Institute
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

122 Shanxi Road (south)
Shanghai 200040
Tel. no.: 86-21-54032047
Fax no.: 86-21-54030084
E-mail: lm98@hotmail.com

Mrs LIU Xiao
Translator
Haikou Healthy City Work Committee Office
Room B10, Haikou Municipal Government
Haikou
Tel. no.: 08-98-6716441
Fax no.: 08-98-6716441

Dr SUN Jiangping
Deputy Director
The National Education Resources Center
for HIV/AIDS/STD Control
Associate Professor, Beijing Medical University
Institute of Child and Adolescent Health
38 Xueyuan Road
Beijing 100083
Tel. no.: +86-10-62091524
Fax no.: +86-10-62091178
E-mail: jpsun@public3.bta.net.cn

COOK ISLANDS

Dr Teariki Ta'amaria
Secretary of Health
Ministry of Health
PO Box 109, Rarotonga
Tel. no.: (682) 29664
Fax no.: (682) 23109

Ms Edwina Tangaroa
Acting Health Educator
Ministry of Health
PO Box 109, Rarotonga
Tel. no.: (682) 29110
Fax no.: (682) 29100

FIJI

Mr Manasa Niubalerua
Senior Environmental Health Officer
Ministry of Health
PO Box 2223, Government Buildings
Suva
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

Tel. no.: (679) 306177-434
Fax no.: (679) 306163

Mrs Ilisapeci Movono
Senior Health Promotion Officer
National Centre for Health Promotion
Ministry of Health
PO Box 2223, Government Buildings
Suva
Tel. no.: (679) 320844
Fax no.: (679) 320746

JAPAN

Mr Toshimo Kaminishi
Deputy Manager
Planning Division, Planning Department
Miyakonojo City, Miyazaki Prefecture
6-21 Himegi-cho, Miyakonojo city
Miyazaki Prefecture
Tel. no.: 81-986-23-2112
Fax no.: 81 986-21-5098

Dr Kazuo Nishioka
Chairman of the Board, Fukuoka Health Promotion Foundation
AIREF, 2-5-1, Maizuru, Cyuo-ku
Fukuoka City 81-00073
Tel. no.: 092-751-4507
Fax no.: 092-751-2572

KIRIBATI

Dr Takeieta B. Kienene
Permanent Secretary for Health
Ministry of Health
Bikenibeu
Tarawa
Tel. no.: 686 28100
Fax no.: 686 28152
E-mail: mhfp@tskl.net.ki

Mr Kotii Torite
Senior Health Education Officer
PO Box 268, Ministry of Health
Bikenibeu
Tarawa
Tel. no.: 686 28100
Fax no.: 686 28152
E-mail: mhfp@tskl.net.ki
LAO PEOPLE'S DEMOCRATIC REPUBLIC

Mr Kham Phiane Vanhmany
Head, Environmental Health and Water Supply Section
Department of Public Health
Vientiane
Tel. no.: (856) 21 212440
Fax no.: (856) 21-412660

Dr Viriya Duangvilaykeo
Chief of Healthy City Unit
Luangprabang Health Department
Ministry of Public Health
Luangprabang
Fax no.: (856) 21-413432

Dr/Mrs Rattiphone OuJa
Chief of Primary Health Care/Team Member of
Healthy City Project, Department of Public Health
Vientiane Municipality
PO Box 1634, Vientiane
Tel. no.: (856) 21 217827
E-mail: chanpomma@moh.gov.la

MALAYSIA

Dr Jamilah Bt Hashim
Medical Officer of Health (Urban Health)
Healthy City Kuching,
Sarawak Health Department
Jalan Tun Abang Hj. Openg
93590 Kuching, Sarawak
Tel. no.: (082) 256566
Fax no.: (082) 424959
E-mail: jamilah.hashim@sarawak.health.gov.my

Dr Rozlan bin Ishak
Assistant Director, Public Health Department
Ministry of Health
National Coordinator for the Healthy Cities Programme
Diseases Control Division
Level 2, Block E, Komplek Pejabat-pejabat
Jalan Dungun Bukit Damansara
50490 Kuala Lumpur
Tel. no.: (603) 2540088
Fax no.: (603) 2543366/ (603) 2561566
E-mail: rozlan@dph.gov.my

Dr Daud bin Abdul Rahim
Senior Medical Officer of Health
Healthy City Johor Bahru
Pejabat Kesihatan, Jalan Abdul Samad
80100 Johor Bahru, Johor
Tel. no.: (607) 2224711
Fax no.: (607) 2236549
E-mail: pkjb@tm.net.my

Mr Jeff Benjamin
Assistant Secretary
Department of Health, Education and Social Affairs
FSM National Government
PO Box PS-70
Palikir
Pohnpei
Tel. no.: (691) 320 2619
Fax no.: (691) 320 5263
E-mail: jeffb@elele.peacesat.hawaii.edu/jeffben@mail.fm

Dr Gombodorj Tsetsegdary
Senior Officer for Health Promotion
Strategic Management and Planning Department
Ministry of Health and Social Welfare
Building 8, Olympic Street-2
Ulaanbaatar-11
Tel. no.: 976-327874
Fax no.: 976-1-327872

Mr Bataa Battulga
Project Manager, Darkhan City “Healthy City” project
Head of Chancellery, Governor’s Office
Darkhan-Uul province, Post Office 195
Darkhan
Tel. no.: 976-37-37323
Fax no.: 976-37-37121

Dr Nagnii Saijaa
Project Manager, Ulaanbaatar City “Healthy city”
Director, Governmental Agency for Hygiene and Epidemiology
Control, Ministry of Health and Social Welfare
Olympic Street-2
Ulaanbaatar-48
Tel. no.: 976-1-323047
Fax no.: 976-1-323047

NAURU
Dr Godfrey Waidubu
Director of Public Health and Medical Services
Health Department, Republic of Nauru
Tel. no.: (674) 444 3882
Fax no.: (674) 444 3881; (674) 444-3106

NEW ZEALAND
Ms Molly Pardoe
Programme Coordinator
Community Injury Prevention Programme
22 Lowe St., PO Box 847
Gisborne NL
Tel. no.: 06 867 8974
Fax no.: 06 868 7796
E-mail: cipp@xtra.co.nz

Mr Peter Burton
Senior Locality Manager, Public Health
Health Funding Authority
229 Moray Place, PO Box 5849
Dunedin
Tel. no.: 64 3 477 4222
Fax no.: 64 3 474 0080
E-mail: peter.burton@hfa.govt.nz

NIUE
Mr Holo Tafea
Chief Public Health Officer
Health Department
PO Box 33
Alofi
Tel. no.: (683) 4100/4200
Fax no.: (683) 4265/4206
E-mail: health@mail.gov.nu
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

PAPUA NEW GUINEA

Mr Lindsay Piliwas
Director
Health Promotion
Department of Health
PO Box 807, Waigani
Port Moresby
Tel. no.: (675) 301 3692
Fax no.: (675) 301 3769

Mr Pepa Koka
A/Principal Advisor MMD, Health Promotion
Ministry of Health
PO Box 807
Waigani, NCD
Tel. no.: (675) 301 3826; 301 3745
Fax no.: (675) 301 3769; 301 3604

PHILIPPINES

Dr Susan Pineda-Mercado
Undersecretary of Health and Chief of Staff
Department of Health
Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz
Manila
Tel. no.: (63-2) 711-6061; (63-2) 743-8301, loc. 1101, 1102, 1108
Fax no.: (63-2) 711-6061
E-mail: susy@doh.gov.ph

Dr Maria Rosarita T. Quijano
Program Manager - Healthy Cities Initiatives
Medical Officer V, Office of the Chief of Staff
Department of Health
Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz
Manila
Tel. no.: (63-2) 743-8301 loc. 1108, 2801;
Direct line: (63-2) 338-3310
Fax no.: (63-2) 711-6061; 711-6305
E-mail: rtq@doh.gov.ph; smiley@hotbitscafe.com

REPUBLIC OF KOREA

Dr Jooheon Lee
Delegate of Kwachon Healthy City Project
Kwachon Health Centre
Kwachon, Kyunggi Province
Tel. no.: (82-2) 3677-2556
Fax no.: (82-2) 3677 2788
E-mail: makrigy@kornet.lo.kr
## List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

<table>
<thead>
<tr>
<th>Country</th>
<th>Name</th>
<th>Position</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAMOA</strong></td>
<td>Dr Nu’ualofa Tuuau-Potoi</td>
<td>Director of Preventive Health Services</td>
<td>Health Department, Private Bag</td>
<td>Apia, Samoa</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tel. no.: (685) 23 330/21212</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fax no.: (685) 26 553/21440</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E-mail: <a href="mailto:Potoimedics@Samoa.net">Potoimedics@Samoa.net</a>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nuualofa <a href="mailto:Potoi@Samoa.net">Potoi@Samoa.net</a></td>
</tr>
<tr>
<td></td>
<td>Mr Richard Chin Bee Lim</td>
<td>Deputy Director</td>
<td>National Health Education Department</td>
<td>Singapore 2nd Hospital Avenue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ministry of Health</td>
<td>Tel. no.: (65) 435 3538</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fax no.: (65) 536 6247</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E-mail: Richard <a href="mailto:LIM@MOH.gov.sg">LIM@MOH.gov.sg</a></td>
</tr>
<tr>
<td><strong>SOLOMON ISLANDS</strong></td>
<td>Dr Dennie Iniakwala</td>
<td>Undersecretary, Health Improvement</td>
<td>Ministry of Health and Medical Services</td>
<td>Honiara</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tel. no.: (677) 23402; 23404</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fax no.: (677) 20085</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E-mail: <a href="mailto:SMMHMS@Welkam.Solomon.sb">SMMHMS@Welkam.Solomon.sb</a></td>
</tr>
<tr>
<td></td>
<td>Mr Joe Denty</td>
<td>Chairman, Honiara Healthy City Coordinating Committee</td>
<td>Health and Medical Division, Honiara Town Council</td>
<td>Honiara</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Principal Health Education and Promotion Officer</td>
<td>Tel. no.: (677) 20432</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ministry of Health and Medical Services</td>
<td>Fax no.: (677) 20085</td>
</tr>
<tr>
<td><strong>TONGA</strong></td>
<td>Dr Maika Kinahoi</td>
<td>Chief Medical Officer, Public Health</td>
<td>Ministry of Health</td>
<td>Nuku’alofa</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tel. no.: (676) 23-200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fax no.: (676) 24-291</td>
</tr>
</tbody>
</table>
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

VIET NAM, SOCIALIST REPUBLIC OF

Dr/Mrs Nguyen Thi Hong Tu
Deputy Director, Department of Preventive Medicine
Ministry of Health
138A Giang Vo Street
Hanoi
Tel. no.: (844) 8460347
Fax no.: (844) 846 0507

Mr Pham Van Hoan
Vice Chairman, People’s Committee of
Ngo Quyen District, Haiphong City
No. 19, Da Nang Street
Ngo Quyen
Haiphong
Tel. no.: 031 625032
E-mail: vpskmt-hp@hn.vnn.vn (c/o Dr Minh)

Mr Nguyen Nhien
Foreign Affairs
11 Ngo Quyen Street
Hue City
Tel. no.: 82 09 14
Fax no.: 83 29 69
E-mail: Huyngha@netnam.org.vn

Dr Nguyen Huy Nga
Deputy Director of Department of Preventive Medicine
Ministry of Health
138A Giang Vo Street
Hanoi
Tel. no.: 844 8461325
Fax no.: 844 8460507

2. TEMPORARY ADVISERS

Dr Margaret Cornelius
Head, National Centre for Health Promotion
Ministry of Health and Social Welfare
Dinem House, PO Box 2223
Suva, Fiji
Tel. no.: (679) 320844
Fax no.: (679) 321746
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

E-mail: cornelius@suva.is.com.fj (H) / nchp@health.gov.fj (W)

Dr Andrew Kiyu
Deputy Director of Health (Public Health)
Jalan Tun Abang Haji Openg
93590 Kuching
Sarawak, Malaysia
Tel. no.: 082-256-566
Fax no.: 082-246-470; 082-424-959
E-mail: andrew.kiyu@sarawak.health.gov.my

Mr Brent Powis
Head, WHO Collaborating Centre in Environmental Health
School of Applied and Environmental Sciences
University of Western Sydney-Hawkesbury
Bourke Street, Richmond, NSW 2753, Australia
Tel/fax no.: (612) 02-45-701479
E-mail: b.powis@uws.edu.au

Mrs Barbara Spalding
Associate
Victorian Health Education Foundation
c/- 29 St Vincent Place South
Albert Park 3206
Victoria, Australia
Tel. no.: 61-3 9699 6106
Fax no.: same
E-mail: spalding@melbpc.org.au

Dr Takehito Takano
Head, WHO Collaborating Centre for Healthy Cities and Urban Policy Research; Professor, Department of Public Health and Environmental Science, Tokyo Medical and Dental University
Yushima 1-5-45, Bunkyo-ku
Tokyo 113-8519, Japan
Tel. no.: +81 3 5803 5188-5190
Fax no.: +81 3 3818 7176
E-mail: takano.hlth@med.tmd.ac.jp

Professor K.C. Tang
Director, International Development
Australian Centre for Health Promotion;
List of Participants, Temporary Advisers, Consultants, Observers, Representatives and Secretariat

Senior Lecturer, Department of Public Health and Community Medicine
Edward Ford Building (A27), University of Sydney, NSW
2006
Sydney, Australia
Tel. no.: 61-2-9351 7601
Fax no.: 61-2-9351 5205
E-mail: kctang@pub.health.usyd.edu.au

Professor Elma Torres
Department of Environmental and Occupational Health
University of the Philippines (Manila)
625 Pedro Gil St., Ermita
Manila, Philippines
Tel. no.: (63-2) 526-5966; (63-2) 524-7102
Fax no.: (63-2) 521-1394
E-mail: ebtorres@starnet.net.ph

3. CONSULTANTS

Dr Vivian Lin
Executive Officer, National Public Health Partnership
Department of Human Services
120 Spencer Street, Melbourne, Victoria 3000, Australia
Tel. no.: (61-3) 9637 5436
Fax no.: (61-3) 9637 5510
E-mail: Vivian.lin@health.gov.au

Professor Wai-On Phoon
Head, Department of Occupational Health
University of Sydney
Pymble Medical Consultants P/L
PO Box 818, Pymble
Sydney, NSW 2073, Australia
Tel. no.: (612) 9440 8965; 9440-8961
Fax no.: (612) 9449 5062

Ms Merri Weinger
58 Rue de Vermont, 1202
Geneva 27, Switzerland
Tel. no.: (4122) 791 4344
Fax no.: (4122) 791 4123
E-mail: merriweinger@hotmail.com
4. OBSERVERS

Ms Lorraine Anderson
Executive Director, Precious Jewels Ministry
P.O. Box 3356
Metro Manila 1099
Philippines
Tel./Fax no.: 921-8076
E-mail: pjewels@pacific.net.ph

Hon. Connie S. Angeles (represented by her staff)
City Vice Mayor, Quezon City
2/F Legislative Wing, Quezon City Hall
Quezon City
Philippines
Tel. no.: (63-2) 922-2358
Fax no.: (63-2) 912-4169

Mr Ray Barge
Director of the Health Group
Australian Agency for International Development (AusAID)
GPO Box 887
Canberra, A.C.T. 2601
Australia
Tel. no.: (02) 6296 4001
Fax no.: (06) 206 4880; 02 6206 4876
E-mail: Raymond_Barge@ausaid.gov.au

Dr Rosmarie Erben
Director, Regional Office for the Southwest Pacific
International Union for Health Promotion and Education
c/o School of Public Health, Griffith University
Meadowbrook, Queensland 4131, Australia
Tel. no.: +61-7-3341 0743
Fax no.: +61-7-3382 1034
E-mail: rosmarie@mail.bigpond.com

Dr Keiko Nakamura
Associate Professor
Department of Public Health and Environmental Science
Tokyo Medical and Dental University
Yushima 1-5-45, Bunkyo-ku
Tokyo 113-8519, Japan
Tel. no.: +81 3 5803 5188-5190
Fax no.: +81 3 3818 7176
E-mail: nakamura.hlth@med.tmd.ac.jp

Dr Jan Ritchie  
Director of Academic Programs  
School of Medical Education  
The University of New South Wales  
Sydney 2052, Australia  
Tel. no: +61 (2) 9385 2500  
Fax no.: +61 (2) 9385 1526  
E-mail: J.Ritchie@unsw.edu.au

Dr Takako Yasukawa  
Health Specialist  
Asian Development Bank  
6 ADB Avenue  
Mandaluyong, 0401  
Metro Manila, Philippines (P.O. Box 789, Manila, Philippines)  
Tel. no.: (632) 632-5766  
Fax no.: (632) 636-2404  
E-mail: tyasukawa@mail.asiandevbank.org

4. SECRETARIAT

Dr Linda Milan (Responsible Officer)  
Director, Health Protection and Promotion  
World Health Organization  
Regional Office for the Western Pacific  
1000 Manila, Philippines  
Tel. no.: (632) 528-9981  
Fax no.: (632) 521-1036; 526-0362; 526-0279  
E-mail: milanl@who.org.ph

Dr Hisashi Ogawa (Co-responsible Officer)  
Regional Adviser in Environmental Health;  
Acting Regional Adviser in Health Promotion and Mental Health  
World Health Organization  
Regional Office for the Western Pacific  
1000 Manila, Philippines  
Tel. no.: (632) 528-9908  
Fax no.: (632) 521-1036; 526-0362; 526-0279  
E-mail: ogawah@who.org.ph
Mr Stephen Tamplin (Co-responsible Officer)
Regional Adviser in Environmental Health
World Health Organization
Regional Office for the Western Pacific
1000 Manila, Philippines
Tel. no.: (632) 528-9943
Fax no.: (632) 521-1036; 526-0362; 526-0279
E-mail: tamplins@who.org.ph

Dr Gauden Galea
Medical Officer, Noncommunicable Diseases
Office of the WHO Representative in the South Pacific
3rd Floor YWCA Building, Sukuna Park
Suva, Fiji
Tel. no.: (679) 30-4600
Fax no.: (679) 300462
E-mail: galeag@who.org.fj; who@who.org.fj

Mr Steve Iddings
Environmental Engineer
P.O. Box 1217
Phnom Penh, Cambodia
Tel. no.: (855) 23-216610; (855) 23-216942
Fax no.: (855) 23-216211
E-mail: iddingss@who.org.kh

Dr Genandrialine Peralta
Environmental Engineer
Office of the WHO Representative in Papua New Guinea
AOPI Centre, Waigani Drive, PO Box 5896
Boroko NCD, Papua New Guinea
Tel. no.: (675) 301 3754; (675) 301 7827
Fax no.: (675) 325 0568
E-mail: peraltag@who.org.pg; gperalta@datec.com.pg

Ms Reiko Muto
Associate Professional Officer
Communicable Diseases, ICP/EMC/901
Office of the WHO Representative in the South Pacific
3rd Floor YWCA Building, Sukuna Park
P.O. Box 113
Suva, Fiji
Tel. no.: (679) 30-4600
Fax no.: (679) 30-0462
E-mail: mutor@who.org.fj