REPORT

WORKING GROUP ON HEALTH PROMOTION PLANNING

Singapore, 22-24 March 1993

Manila, Philippines
August 1993
REPORT

WORKING GROUP ON HEALTH PROMOTION PLANNING

Convened by the
REGIONAL OFFICE FOR THE WESTERN PACIFIC

WORLD HEALTH ORGANIZATION

Singapore, 22-24 March 1993

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Health promotion / Life style / Singapore
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SUMMARY

The Working Group on Health Promotion Planning was convened by the World Health Organization, Regional Office for the Western Pacific and hosted by the Ministry of Health in Singapore. It took place at the Ministry of Health, College of Medicine from 22 to 24 March 1993.

The objectives of the meeting were:

1. to review the regional health promotion programme outline;
2. to make recommendations on what individuals can do for their own health;
3. to make recommendations on what countries should do in the area of health promotion; and
4. to specify how WHO should support activities and mobilize intersectoral action.

The working group was attended by nine participants from four Member States and three secretariat members from the Western Pacific Regional Office. Dr Kwa Soon Bee and Dr Lam Sian Lian, both from Singapore, were elected chairperson and co-chairperson respectively. Dr Vijaya Karruppih, Singapore and Dr Don Nutbeam, Australia were nominated as rapporteurs for the working group.

The working group was opened by Dr Kwa Soon Bee. He introduced the participants to Singapore's comprehensive ten-year programme to promote healthy lifestyles. He congratulated the World Health Organization, Regional Office for the Western Pacific in adopting health promotion as a priority for the Region in response to the challenge of reducing lifestyle-related diseases.

Dr Liu Xirong presented the opening speech of the Regional Director of the World Health Organization, Dr S. T. Han, thanking Dr Kwa Soon Bee for hosting the meeting at short notice and expressing the conviction that the experiences of Singapore in the promotion of health would provide an excellent starting point for the tasks in front of the working group.

The working group was first provided with a variety of background information with regard to Singapore's orientation towards health promotion, and introduced to various programmes, for example the "Trim and Fit" scheme in schools and the "Live for Life" programme in workplaces. These all form part of the national healthy lifestyle programme, carried out by different sectors under their own responsibility and guided by the Healthy Lifestyle Coordinating Committee, which is supported by the Prime Minister.

Participants analysed the elements of these programmes from the perspective of their own experience. They introduced programmes from their respective institutions. Discussion also took place with examples from Singapore and Australia, on the advantages of defining targets for improved health status and using them to monitor health programmes.
The working group then concentrated on an examination of the draft health promotion outline, prepared by the Regional Office to guide health promotion activities for the remainder of the period 1993-1995. Participants identified health issues in the different stages of the life cycle and constructed a matrix to answer key questions posed in the objectives for the meeting. (The matrix is presented in Annex 1.) They stressed the need for a balance between individual, community and government action to promote health and achieve well-being. In going through this process, it became clear that the mechanisms through which health promotion can be organized, include schools, workplaces, health facilities and mass media, with regard to community action, and legislation, regulations, standards and policies with regard to government action.

It was recognized that national policies in all Member States have to be set up with regard to health promotion, which would have to reflect their social and economic development, geography and culture.

The Working Group concluded, that health promotion is directed towards enabling individuals to take action to promote health and towards the factors in peoples' environments that would be supportive of such actions.

The recommendations made to WHO included:

(1) WHO should continue to emphasize individual responsibility for health and suggest simple actions that can be taken by individuals and their families to promote and protect health.

(2) WHO should continue to use the life cycle as a frame of reference for the identification of priority health promotion issues and the most appropriate response to these issues, and should refer to four stages in the life cycle: childhood, adolescence, adulthood, and older age.

(3) WHO should take account of the major differences in economic development and resulting health issues between countries in the Region.

(4) WHO should advocate that individual health promotion action should be balanced by a strong emphasis on community and government action.

(5) WHO should encourage governments in the Region to recognize their role in health promotion. This role includes the development of consistent policies across government sectors to promote and protect the health of the population.

(6) WHO should recognize that programmes to promote health need to be tailored to the needs of different groups and utilize existing mechanisms and institutions for programme development and implementation, for example, schools, worksites and local government organizations.

During the closing ceremony, Dr Kwa Soon Bee suggested that WHO should consider tabling health promotion on the agenda for the next session of the Regional Committee, to allow Member States to discuss the programme and to consider their plan of action in line with the recommendations made.
1. INTRODUCTION

Health promotion is a priority area for the work of WHO in the Western Pacific Region. Between 1993 and 1995, the health promotion programme will concentrate on empowering people with the knowledge, attitudes and skills they need in order to take responsibility for their own health. The underlying concept highlights health as a potential to be fulfilled, and as an essential element of the quality of life, both personal and social, which can be promoted at every stage of life.

The objective of the health promotion programme is to strengthen the ability and willingness of individuals, in the course of each stage in their life cycle, to take action in support of their health and that of their families and communities in settings such as the home, the workplace and the school, and during recreation. The targets that have been set in order to achieve this objective include the formulation of national health policies and the development of health promotion programmes in most countries and areas in the Western Pacific Region. In addition, support for health goals will be enlisted from ministries responsible for other aspects of life, such as education, environment, agriculture and economic development.

Activities have been proposed for different age groups which aim at informing people about health and enabling them to do simple things that would contribute to the realization of their fullest health potential and healthy aging.

The proposed activities need to be further specified and the most effective means of implementation identified.

1.1 Objectives

The objectives of the Working Group were:

(1) to review the regional health promotion programme outline;

(2) to make recommendations on what individuals can do for their own health;

(3) to make recommendations on what countries should do in the area of health promotion; and

(4) to specify how WHO should support activities and mobilize intersectoral action.

1.2 Participants

The seven members of the working group came from Australia, China, Japan and Singapore. Two observers from Japan and three secretariat members from the Western Pacific Regional Office participated. A full list of participants is attached as Annex 2.

Dr Kwa Soon Bee was elected as chairperson of the meeting, with Dr Lam Sian Lian as co-chairperson. Dr Vijaya Karuppliah and Dr Don Nutbeam were nominated as rapporteurs for the meeting.
1.3 Organization

The Working Group met at the Ministry of Health Headquarters, College of Medicine Building, 16 College Road, Singapore, from 22 to 24 March 1993. The Agenda is attached as Annex 3.

During the first one and a half days, Singapore's experience with health campaigns and the national healthy lifestyle programme were introduced and formed the basis for the discussion. Papers were presented also by non-Working Group members, who attended only their respective sessions. The Programme of Work is attached as Annex 4.

1.4 Opening Ceremony

The meeting was opened by Dr Kwa Soon Bee, Permanent Secretary of Health/Director of Medical Services, Ministry of Health, Singapore who welcomed the participants. Dr Kwa informed the participants of changing patterns of health and disease in Singapore, emphasizing that noncommunicable diseases such as cancer and cardiovascular diseases were now the major health problems in Singapore and most of the countries in the Western Pacific Region. He congratulated the World Health Organization Regional Office for the Western Pacific in adopting health promotion as a priority for the Region as a part of its response to the challenge of reducing the impact of noncommunicable diseases in the Region.

Dr Kwa explained that Singapore has been very active in public health education for more than a decade. He introduced participants to the National Healthy Lifestyle Programme which was launched in Singapore in April 1992 as a comprehensive ten-year programme to promote healthy lifestyles. Although proud of Singapore's achievements to date, Dr Kwa emphasized that there was no simple solution to the complex problem of influencing people's lifestyles. He emphasized the importance of each country in the Region finding a socially and culturally appropriate way to organize health promotion.

The full text of Dr Kwa's speech is attached as Annex 5.

Dr Liu Xirong welcomed participants on behalf of the Regional Director of the World Health Organization, Dr S.T. Han, and gave a prepared speech on behalf of Dr Han.

Dr Han complimented the Government of Singapore on its effective health promotion programmes and explained this as the motivation to hold the meeting in Singapore.

Dr Han stressed that he hoped that the meeting would identify simple actions that individuals can take to improve their health, and would identify what countries can do to support and protect the health of their populations. From this, Dr Han hoped that the special role of WHO in health promotion in mobilizing intersectoral action could be clarified.

In considering these issues Dr Han emphasized the importance of taking account of the great diversity in the countries of the Western Pacific Region in terms of the social and economic development, geography and culture. Effective health promotion would be based upon creative responses to the characteristics of the different societies in the Region.

The full text of Dr Han's speech is presented in Annex 6.
2. PROCEEDINGS

2.1 Introduction

The proceedings opened with the adoption of the agenda (Annex 3) and the Programme of Work (Annex 4) and an introduction by the chairperson to the working format for the meeting.

2.2 Health of Singaporeans

Dr Shanta C. Emmanuel, Assistant Director of Medical Services, Evaluation and Planning Division, Ministry of Health, Singapore provided an overview of the health status of Singaporeans drawing upon the 1992 national health survey to illustrate improvements in the health status of Singaporeans over the past 20 years. Dr Emmanuel provided an overview of the leading causes of deaths and highlighted the major gender and ethnic differences in health status.

The national health survey was designed to meet three major objectives, namely:

- To evaluate past efforts to promote healthy lifestyle in Singapore.
- To provide baseline information to assist in the evaluation of the new National Healthy Lifestyle Programme.
- To provide the basis for planning future health programmes in Singapore.

The study results indicated progress in reducing blood pressure and cholesterol levels among Singaporeans, but also emphasized important outstanding challenges to reduce smoking and obesity, and to increase participation in physical activities.

Dr Emmanuel then went on to provide an overview of the national health policies for the 1990's in Singapore. She highlighted five major priority programmes for the next decade including:

- Improving the health of the elderly
- Strengthening the prevention and management of leading causes of ill health
- Enhancing child health
- Improving mental health, and
- Improving health education as the basic strategy common to most health programmes.

Dr Emmanuel summarized the important characteristics of health care provision in Singapore including the health financing policy and the current attention being given to maximizing efficiency and quality in health care services.

Dr Emmanuel's presentation was followed by a short discussion and clarification of the main findings from the national health survey. Special attention was drawn to the challenge of the high prevalence of diabetes in Singapore.
A copy of the two papers from Dr Emmanuel are attached in Annex 7, papers 1 and 2, respectively.

2.3 National healthy lifestyle programme

Dr Lam presented an overview of the Singapore National Healthy Lifestyle Programme. She identified the links between lifestyles and the major noncommunicable diseases in Singapore and indicated that campaigns to combat diseases due to harmful lifestyles have been conducted in Singapore since 1979.

These early campaigns were supported by a national health campaign committee comprising 29 organizations which have assisted in the educational efforts. These organizations included government ministries, nongovernmental organizations, professional and educational associations, employers' associations and their unions.

Since the first campaign in 1979, the Health Ministry has continued its educational programmes on healthy lifestyles. In 1986, the "Healthy Heart, Healthy Life" programme was launched. This consisted of a wide range of activities, including a thirteen part television series and the first national health fair held in 1989.

Dr Lam also described the considerable achievements of Singapore in the field of smoking control and she highlighted the combined approach of education and legislation in achieving the low smoking prevalence now enjoyed in Singapore.

Dr Lam then described Singapore's new approach to health promotion. Using a multidisciplinary and multisectoral approach, the National Healthy Lifestyle Programme was launched in April 1992. A Healthy Lifestyle Coordinating Committee was established with high level representatives from key ministries, statutory boards, employers federations, the unions and health professional bodies to monitor the progress of the national programme. Under the National Healthy Lifestyle Programme, the various ministries and organizations are in charge of developing and implementing their own programmes.

The National Healthy Lifestyle Programme will encourage Singaporeans to adopt healthy lifestyles, by supporting the development of persons and their skills, and by creating supportive environments to help them to do so.

Dr Lam also emphasized the importance of political support for the National Healthy Lifestyle Programme at the highest level. The national programme in Singapore was launched by the Prime Minister, Dr Goh Chok Tong, and continues to enjoy his support.

A paper providing further information on health promotion in Singapore and on the National Healthy Lifestyle Programme is attached as Annex 7, paper 3.

This presentation was followed by discussion of a range of issues raised during the morning's session. Particular emphasis was placed on finding the right balance between individual responsibility and action for health, and the leadership role of the government in protecting and promoting the health of the population. Delegates identified a range of factors which would influence this balance in the different countries of the Region.

Discussion also took place on the advantages of defining targets for improved health status and using these targets to plan and monitor health programmes in a country. Examples from Singapore and Australia were considered.
2.4 Nutrition promotion activities in Singapore

Mrs Tan Wei Leng, Deputy Director, Food and Nutrition Department, Ministry of Health, Singapore provided an overview of nutrition promotion activities in Singapore since 1960. She highlighted how these activities began by providing support for undernourished children. Today, nutrition promotion in Singapore consists of a far more complex range of activities related to the effects of overeating, and of specific dietary factors in the development of noncommunicable diseases such as heart disease, cancer and diabetes.

Mrs Tan described the overall structure of the work of the food and nutrition department. This included a major educational effort to promote healthy dietary practices among the general public, and among specific target groups including pre-school and school aged children, and workers in their workplaces. She also described the activities of the department in attempting to influence food supply and menu choices. Activities included developing guidelines for catering, improved nutritional labelling, and new product development and marketing.

A paper providing further information on the presentation is attached as Annex 7, paper 4.

Discussion followed the presentation highlighting the complex nature of nutrition education when compared to other issues such as smoking. The experience of promoting nutritional health in Singapore drew attention to the importance of combining public education with efforts to influence the supply of food and its marketing. The emphasis was to promote wise food choices whilst at the same time ensuring that wise food choices are easier to make.

2.5 Trim and fit (TAF) scheme in schools

Mr Goh Ek Piang, Senior Specialist Inspector, Ministry of Education, provided an overview of the TAF Scheme. The TAF scheme, launched in January 1992, is part of the National Healthy Lifestyle Programme. It aims to improve the physical fitness of school children and decrease the obesity rate among school children. It includes counselling students on proper nutrition and exercise as well as taking them through additional weekly exercise lasting one to two hours held after school or on weekends. Students are guided on the selection of healthy and nutritious food in the school canteens. Measures taken include

(i) the "green" labelling of low-fat, low-calorie and nutritious food items;

(ii) implementation of the approved "Drink List" where drinks containing 10 Brix or less are allowed to be sold in school canteens (10 Brix is 10% of sugar by weight. Sweetened drinks previously sold in school canteens contained 6% to 14% of sugar); and

(iii) monitoring the sale of foods in the school canteens.

The Ministry of Education has set aside a sum of S$30.11 million for the implementation of the TAF scheme. This amount will be spent on health and fitness equipment and facilities to help schools carry out their TAF programmes effectively.

At the end of 1992, the TAF scheme was evaluated based on the obesity and physical fitness level of pupils and fitness index of schools. The fitness index is the average of the percentage of pupils within the normal weight and the percentage of pupils who pass the National Physical Fitness Award (NAPFA) test. These findings formed the baseline data
for monitoring the progress of the TAF scheme. Details of the TAF scheme are attached as Annex 7, paper 5.

During discussion, Dr Goh said that part of the motivation for parents to allow their obese children to participate in the TAF scheme, was a known link between obesity and academic performance. Studies have shown that while there was a higher proportion of pupils with acceptable weight range among the high achievers, there was a higher proportion of overweight pupils among the low performers. Top management support by principals was made possible by organizing health management seminars. Through these seminars, principals are equipped with the skills to better plan and implement TAF programmes in their schools.

Mr Goh also indicated that more teachers are being trained in physical education to conduct classes more creatively and to make exercise "fun-like".

2.6. Strategy for workplace health promotion

Dr Koh Yang Huang, Head, Workplace Health Education Unit of the Training and Health Education Department of the Ministry of Health outlined the strategies for the Workplace Health Promotion Programme of the Ministry of Health, Singapore. She outlined three main strategies to meet the needs of the 1.6 million strong Singapore workforce. These are:

(i) activities that enhance awareness about lifestyle and health
(ii) activities that encourage healthy behaviour, and
(iii) activities that create supportive environments for health.

In view of increasing health care costs per employee per year and the link between productivity and healthy workers, the demand for workplace health promotion programmes have grown. She highlighted the major challenges, namely:

(i) training of workplace facilitators - to meet this increased demand for workplace health promotion programmes;
(ii) multiple dimensions of health - to ensure that the workplace health promotion programme incorporates the five dimensions of health, namely the physical, intellectual, social, emotional and spiritual health;
(iii) behaviour change programmes - to provide workers with the opportunity to learn and practise new skills; and
(iv) to organize more health promotion programmes in small companies - as they are slow to organize these programmes.

The details of Dr Koh's presentation are attached as Annex 7, paper 6.

During discussion, Dr Koh shared her experiences in dealing with situations where top management was not supportive of workplace health promotion programmes. For example, in a situation where the Chief Executive Officer is a heavy smoker and is not supportive of a smoking cessation programme, she advised that it was best first to introduce programmes that the top management supports, followed slowly by other programmes that the company actually requires.
2.7 Public sector workplace healthy lifestyle programme

Mr Lau Kim Yang of the Public Service Division, Ministry of Finance, discussed the Public Sector Workplace Healthy Lifestyle Programme. This programme was launched on 5 December 1992. Since then all seven public sector organizations under the pilot programme (four ministries and three statutory boards) have embarked on Stage 1 of the "Live for Life Programme". To date, more than 7000 employees from the public sector have taken part in the health profiling. An average of 89% of employees at each site participated in the health profiling. Despite their different demographic make-up, the corporate health profiles identified similar key problem areas for all the pilot sites. These were a lack of exercise, high cholesterol levels and high body fat composition. These problems will be addressed by the intervention programmes in the Stage 2 of the "Live for Life Programme".

Details of Mr Lau's paper are given in Annex 7, paper 7.

During discussion, Mr Lau noted that employees participated in the choice of intervention programmes to be implemented. This was important for the success of these programmes.

Members also discussed the point that the work sites should not be solely used as a convenient place to get workers to learn about healthy living. Instead, the work environment should also be improved to enhance the health of workers. Work Improvement Teams (WITS) were already in place in Singapore workplaces to improve the work environment in terms of structure and work process. What remains now is to combine WITS with Workplace Health Promotion Programmes to achieve a holistic approach to promote the health of workers at the workplace.

2.8 National smoking control programme

Dr B. Vaithinathan, Medical Director, Training & Health Education Department, presented the National Smoking Control Programme. The smoking control programme began as early as 1970, when legislative measures to prohibit smoking in certain places and prohibition of advertisements for cigarettes, were passed. Health education on harmful effects of smoking began in 1979. In 1986, a comprehensive long-term programme for smoking control spearheaded by the Ministry of Health was launched. The theme of the programme was "Towards a Nation of Non-Smokers". It aims to reduce smoking rates through education and publicity, establishment of no-smoking areas and services for smoking cessation, taxation and legislative measures. It is targeted at all sectors of society, but has a special emphasis on youth.

A national smoking control coordinating committee was set up comprising representatives from eight ministries, the trade unions, and private sector employers.

Details of the public education programme undertaken from 1979 to 1992, legislative measures from 1970-1993 and tax measures are contained in Dr Vaithinathan detailed report included as Annex 7, paper 8.

During discussion, members noted that Singapore was able to successfully demonstrate the different levels of health education required to effectively control a public health problem, such as smoking. Singapore also demonstrated how strong governmental support was needed for effective health promotion programmes. For example, the banning of advertisements encouraging smoking was instituted despite great economic loss to state-owned television/radio stations.
There was also discussion on the importance of role models such as teachers, doctors and parents who could influence young people and other members of the public to either take up or give up smoking. These role models are an important group to reach in any smoking control programme.

2.9 Health Promotion in Japan

Professor Yasushi Fukuwatari presented information about health promotion activities in Japan. The Japanese government supports twenty cities in their efforts to develop into healthy cities. One example, the position paper from Kyoto City "The Road Towards a Healthy Environment" is presented in Annex 8, paper 1. Special attention is given to health issues in Japan's school curricula. The content of health instruction in elementary, lower secondary and upper secondary schools, which includes such themes as life-long health, and environment and health, is presented in Annex 8, paper 2.

A total plan for health promotion has been developed by the Japanese Institute of Labour and is implemented by all workplaces as part of industrial safety and health. The plan includes health guidance, nutritional guidance and physical exercise guidance for the employees. At the same time, regulations exist which obligate the employer to create comfortable working environments. Information is given in Annex 8 in papers 3, 4 and 5.

2.10 Visit to a work site

Participants visited the Central Environment Health Centre, one of the offices of the Ministry of Environment. Participants were able to see on-site the health profiling of employees which is Stage 1 of the Public Sector Workplace Healthy Lifestyle Programme. The health profile was conducted on-site by a team of nurses and paramedical staff. The health profile measured height, weight, blood pressure, body fat composition and total cholesterol of the employees. The employees also answered a self-administered questionnaire on their lifestyle practices. Based on these data, an individual report was generated by a computer. The employees were then given individual counselling based on their health profile results.

2.11 Review of WHO draft health promotion programme

The meeting was then devoted to an examination of the draft health promotion programme outline, prepared by the Regional Office to guide health promotion activities for the remainder of the period 1993-1995 (Annex 9). The programme was examined according to the objectives for the meeting stated above. Participants recognized the advantages of building the programme according to stages in the life cycle, and after discussion recommended that WHO should use the four stages of childhood, adolescence, adulthood and older age as the basis for the programme.

Participants then constructed a matrix to answer the key questions posed in the objectives for the meeting. After some discussion, it was agreed that for each stage of the life cycle, the following would be considered:

1. What are the priority health promotion issues?
2. What actions can individuals take in relation to these priority health promotion issues?
3. What actions can occur in communities to support individual action?
(4) What actions should government take to support health promotion in communities and by individuals?

(5) What role does WHO have in supporting this range of actions?

This extended matrix was discussed in detail. Participants at the meeting emphasized the important role of individuals in taking actions to promote and protect their health, but also recognized that the ability to take effective action to promote health can be greatly enhanced (or constrained) by living and working conditions. To this end, the participants highlighted the importance of achieving a balance between individual action, community support and government action to create supportive environments for health. Participants recognized that the balance between individual, community and government action would vary from country to country, and from issue to issue. In summary, delegates strongly emphasized that health promotion as a strategy is both more complex and comprehensive than individual action alone.

Participants then went on to consider in detail the major health promotion issues relevant to the different stages in the life cycle, and to nominate a full range of specific actions which could be undertaken by individuals, in communities and by government. This detailed analysis is provided in Annex 1.

Participants were concerned to emphasize that the issues and actions highlighted in this detailed analysis were not intended to be prescriptive for WHO or for individual countries. Rather they are intended to illustrate the process of analysing what action could be taken at various levels to tackle the priority health promotion issues which had been identified by participants.

In going through this process, it became clear to participants that the mechanisms through which health promotion can be organized and delivered needed to be more clearly explained. In the community, such mechanisms include schools, health facilities, work sites, neighbourhood organizations and the mass media. Through government, such mechanisms include legislation, regulation and standards, and national systems of health and education. Participants referred in this context to the major conclusions presented in the summary report from the 1992 Shanghai International Symposium on Health Education which is included as Annex 10.

Participants also recognized that some priority health issues remained throughout each stage of the life cycle, albeit that the emphasis changed with age. For example, healthy nutrition might include breastfeeding for infants, achieving a balanced diet among adolescents and adults, and specific nutritional supplementation among older people.

The content and discussion from this part of the meeting formed the basis for the conclusions and recommendations given below.

2.12 Closing ceremony

Dr Kwa brought the working group meeting to a close by complimenting participants on their contributions and active participation. He suggested that WHO should consider tabling the recommendations of the working group at the next session of Regional Committee to allow Member States to consider their next plans of action. Dr Kwa suggested that there should be a follow-up meeting after two years to review the progress of the recommendations. Dr Liu in his closing remarks also thanked all participants for participating actively in the working group and especially the Singapore hosts for their kind hospitality.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

The working group concluded that health promotion is directed towards enabling individuals to take actions to promote their health, especially by improving health behaviours and lifestyles. Participants recognized that the health promotion issues varied according to different stages in the life cycle and proposed childhood, adolescence, adulthood and older age as stages to be used to identify priority health promotion issues and possible responses to them.

It was made clear during the discussions that the health issues identified in an individual's life cycle require more complex and comprehensive responses than individual action alone.

Health promotion in this sense was considered as consisting of a balance between individual, community and government action to promote lifestyles and living conditions conducive to health.

3.2 Recommendations

On the basis of these general conclusions, the working group made the following recommendations:

(1) WHO should continue to emphasize individual responsibility for health and should suggest simple actions that can be taken by individuals and their families to promote and protect health.

(2) WHO should continue to use the life cycle as a frame of reference for the identification of priority health promotion issues and the most appropriate response to these issues, and should refer to four stages in the life cycle: childhood, adolescence, adulthood, and older age. Some issues will remain important through the entire life span, such as nutrition, physical activity and family support.

(3) WHO should take account of the major differences in economic development and resulting health issues between countries in the Region.

(4) WHO should advocate that individual health promotion action should be balanced by a strong emphasis on community and government action.

(5) WHO should encourage governments in the Region to recognize their role in health promotion. This role includes the development of consistent policies across government sectors to promote and protect the health of the population.

(6) WHO should recognize that programmes to promote health need to be tailored to the needs of different groups and utilize existing mechanisms and institutions for programme development and implementation, for example, schools, worksites and local government organizations.

(7) WHO should facilitate and coordinate the exchange of practical experience and expertise, including exchange of educational materials; provide technical advice on different aspects of health promotion; and sponsor specific health promotion activities according to opportunities in countries of the Region.
(8) WHO should facilitate applied research and quality evaluation of health promotion, support model demonstration projects and widely disseminate findings.

(9) WHO should support training in health promotion.
Table 1: EXAMPLES OF MULTISECTORAL APPROACHES TO HEALTH PROMOTION ISSUES

This table was developed by participants at the WHO Working Group on Health Promotion Planning, Singapore, March 1993, to illustrate the way in which major health promotion issues will vary according to different stages in the life cycle. It also provides an example of the way in which these issues, once identified, can be translated into practical actions by individuals, in communities, and by government. It should be emphasized that the content of the table has been assembled for illustrative purposes only, and is not intended as a prescription for action for health promotion in the Western Pacific Region.

<table>
<thead>
<tr>
<th>Stages of life cycle</th>
<th>Major health promotion issues</th>
<th>Actions by individuals</th>
<th>Actions by communities</th>
<th>Actions by government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood</td>
<td>Planned and safe pregnancy and childbirth</td>
<td>Practise family planning Attend pre-natal clinics</td>
<td>Promote pre-natal women's groups Provide well-trained personnel in health centres/clinics</td>
<td>Provide family planning and maternal care programmes</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding</td>
<td>Mothers to breast-feed their babies exclusively for the first four to six months</td>
<td>Ensure hospitals oriented towards breast-feeding Ensure maternity homes, midwives and workplaces facilitate breast-feeding</td>
<td>Adapt and implement the International Code of Marketing of Breast-milk Substitutes</td>
</tr>
<tr>
<td>Balanced nutrition</td>
<td>Take and provide balanced nutrition (eating green, local vegetables, less meat, whole grain bread, less sugar)</td>
<td>To ensure availability and safety of nutritious food</td>
<td>Establish food safety policies as well as price policies Ensure comprehensive school health programmes</td>
<td></td>
</tr>
<tr>
<td>Growth, development and illness</td>
<td>Learn about child development and what to do in case of illness Provide a health supportive environment</td>
<td>Provide parenting classes Provide well-baby clinics Initiate/support parents' self-help groups Integrate handicapped children</td>
<td>Establish policies for comprehensive child care Promote immunization programmes Establish policies in support of families</td>
<td></td>
</tr>
<tr>
<td>Child abuse</td>
<td>Develop responsible parenting behaviour Talk about aggression with others and learn to control it Join Alcohol Anonymous or other groups</td>
<td>Provide family counselling and services centres Control child labour Provide (skill) training for street children</td>
<td>Create public awareness of child abuse and violence in families Ensure counselling for disturbed families Establish regulations to protect abused children Implement policies regarding child labour</td>
<td></td>
</tr>
<tr>
<td>Safety/injury prevention</td>
<td>Create safe home environments Parents to demonstrate safety behaviour Child to learn about and apply home safety and traffic rules</td>
<td>Provide neighbourhood child minder groups Provide neighbourhood playgrounds</td>
<td>Ensure safe roads and conformity with traffic regulations</td>
<td></td>
</tr>
<tr>
<td>Personal hygiene and self-care</td>
<td>Teach children good personal hygiene and self-care Child to learn and practice hygienic behaviour and to take care of itself and others</td>
<td>Provide clean neighbourhoods, schools, etc., with appropriate water and sanitation facilities</td>
<td>Ensure adequate housing, water and sanitation facilities, and waste disposal Ensure comprehensive school hygiene education</td>
<td></td>
</tr>
<tr>
<td>Stages of life cycle</td>
<td>Major health promotion issues</td>
<td>Action by individuals</td>
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</tr>
<tr>
<td>Adolescence</td>
<td>Smoking</td>
<td>Resist peer pressure to take up smoking</td>
<td>Provide attractive smoke-free meeting places for youth</td>
<td>Table legislation concerning tobacco advertising, non-smoking in public places and vending machines</td>
</tr>
<tr>
<td></td>
<td>Abuse of alcohol and other drugs</td>
<td>Order non-alcoholic drinks Avoid drugs</td>
<td>Sell non-alcoholic drinks cheaper than beer in pubs and restaurants</td>
<td>Provide education and employment. Set age limits for alcohol purchase</td>
</tr>
<tr>
<td></td>
<td>Safe sexuality</td>
<td>Practice responsible sexual behaviour</td>
<td>Sex education in schools to provide information about HIV/AIDS and STDs</td>
<td>Establish policies that allow for sex and AIDS/STD education in schools and offer counselling services (for example youth health clinics)</td>
</tr>
<tr>
<td></td>
<td>Physical exercise</td>
<td>Exercise regularly</td>
<td>Encourage physical exercise, support teacher training, provide sports facilities</td>
<td>Provide budgets for building sport/leisure time facilities</td>
</tr>
<tr>
<td></td>
<td>Personal and social development</td>
<td>Participate in communal activities and youth councils; be responsive to the needs of others</td>
<td>Involve youth in communal activities and culture events</td>
<td>Provide families with adequate housing and facilitate formal and non-formal education</td>
</tr>
<tr>
<td></td>
<td>Injury prevention</td>
<td>Avoid alcohol when driving</td>
<td>Make roads safe and educate for responsible driving</td>
<td>Establish seat belt and helmet laws</td>
</tr>
<tr>
<td></td>
<td>Balanced nutrition</td>
<td>Eat regularly and avoid fast-food</td>
<td>Provide variety of food at affordable prices</td>
<td>Establish food safety and food price policies</td>
</tr>
<tr>
<td>Stages of life cycle</td>
<td>Major health promotion issues</td>
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</tr>
<tr>
<td>Adulthood</td>
<td>Smoking</td>
<td>Stop smoking</td>
<td>Provide smoking cessation courses and smoke-free environments</td>
<td>Table legislation concerning tobacco advertising, non-smoking in public places, etc.</td>
</tr>
<tr>
<td></td>
<td>Abuse of alcohol and other drugs</td>
<td>Drink moderately Use medicines appropriately</td>
<td>Work with the mass-media to provide information Support self-help groups</td>
<td>Table legislation on alcohol limits for drivers and drug prescription</td>
</tr>
<tr>
<td></td>
<td>Responsible sexual behaviour</td>
<td>Practice safe sex and family planning</td>
<td>Stimulate public discussions on healthy sexuality and on issues of power and control in sexual relationships</td>
<td>Screen donated blood and blood products for HIV/STDs</td>
</tr>
<tr>
<td></td>
<td>Physical activity</td>
<td>Exercise regularly</td>
<td>Provide safe exercise grounds and public parks</td>
<td>Take measures to reduce air pollution</td>
</tr>
<tr>
<td></td>
<td>Balanced nutrition</td>
<td>Eat low fat and low sugar meals</td>
<td>Provide information through consumer organizations</td>
<td>Control food labelling</td>
</tr>
<tr>
<td></td>
<td>Good mental health</td>
<td>Discuss and shape problems with others</td>
<td>Promote social support groups for lonely people</td>
<td>Encourage a social climate that favours public participation and minimizes stigmatization</td>
</tr>
<tr>
<td></td>
<td>Supportive family environment</td>
<td>Take time to listen to problems of family members and try to find a solution together</td>
<td>Create awareness about psychosocial factors in the family through media</td>
<td>Build policies that allow families to stay together</td>
</tr>
<tr>
<td></td>
<td>Protecting the environment</td>
<td>Separate garbage Dispose of water thoughtfully</td>
<td>Discriminate between different types of garbage in public garbage collection</td>
<td>Guarantee waste-specific disposal Take measures to reduce air pollution</td>
</tr>
<tr>
<td></td>
<td>Safe and healthy work environment</td>
<td>Follow workplace safety regulations Contribute to better work organizations</td>
<td>Provide a safe work environment through filters and other protective devices Allow for participation of employees in work organization</td>
<td>Implement and monitor work safety and emission standards Take measures to reduce air pollution</td>
</tr>
<tr>
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<tr>
<td>Elderly Old age</td>
<td>Balanced nutrition</td>
<td>Eat fibre-rich foods</td>
<td>Organize meal services offering balanced food (meals on wheels)</td>
<td>Subsidize meal services for elderly people</td>
</tr>
<tr>
<td></td>
<td>Physical activity</td>
<td>Walk regularly or do other exercises</td>
<td>Offer sportgrounds and facilitators</td>
<td>Include parks and recreation places in town planning and make them accessible for handicapped elderly</td>
</tr>
<tr>
<td></td>
<td>Mental health</td>
<td>Join a club for the elderly</td>
<td>Organize clubs for elderly</td>
<td>Encourage employment and volunteer services for elderly</td>
</tr>
<tr>
<td></td>
<td>Management of chronic illness</td>
<td>Participate in self-help mutual support groups</td>
<td>Facilitate self-help and mental support Organize classes on care during chronic illness</td>
<td>Provide home-care facilities and adequate health services (including mental health services)</td>
</tr>
<tr>
<td></td>
<td>Family and social support</td>
<td>Enjoy active social life</td>
<td>Provide support for those who take care of elderly family members Provide respite care for carers of the aged who are sick</td>
<td>Provide homes for the elderly</td>
</tr>
</tbody>
</table>
LIST OF MEMBERS, OBSERVERS, AND SECRETARIAT

1. MEMBERS

Professor Yasushi Fukuwatari
Director
Health Promotion Research Centre
School of Medicine
Juntendo University
Hongo 2-1-1, Bunkyo-ku
Tokyo 133
Japan

Dr Vijaya Karuppiah
Director, Healthy Lifestyle Unit
Primary Health Division
Ministry of Health
College of Medicine Building
16 College Road
Singapore 0316
Republic of Singapore

Dr Kwa Soon Bee
Permanent Secretary (Health)
Director of Medical Services
Ministry of Health
College of Medicine Building
16 College Road
Singapore 0316
Republic of Singapore

Dr Sian Lian Lam
Deputy Director of Medical Services
Ministry of Health
College of Medicine Building
16 College Road
Singapore 0316
Republic of Singapore
Annex 2

Dr Don Nutbeam
Professor of Public Health
Department of Public Health, A27
University of Sydney
NSW 2006
Australia

Dr Bhakarathi Vaithinathan
Medical Director
Training & Health Education Department
Ministry of Health
College of Medicine Building
16 College Road
Singapore 0316
Republic of Singapore

Mr Zheng Baoyi
Associate Director
Department of Health Behaviour
(Tobacco & AIDS)
National Health Education Institute
Building 12, District 1
Andingmenwai Anhuaxili
Beijing 100011
People's Republic of China

2. OBSERVERS

Professor Bruce Allen
Department of Public Health
Juntendo University School of Medicine
2-1-1 Hongo, Bunkyo-ku
Tokyo, Japan

Professor Takashi Muto
Department of Public Health
Juntendo University School of Medicine
2-1-1 Hongo, Bunkyo-ku
Tokyo, Japan
3. SECRETARIAT

Dr Liu Xirong  
Director, Programme Management  
World Health Organization  
Regional Office for the Western Pacific  
United Nations Avenue  
Manila, Philippines

Dr Rosmarie Erben  
Regional Adviser in Health Promotion  
World Health Organization  
Regional Office for the Western Pacific  
United Nations Avenue  
Manila, Philippines

Mr Francisco J. Dy  
Programme Officer  
World Health Organization  
Fitzpatrick Building  
50200 Kuala Lumpur  
Malaysia
AGENDA

1. Welcome/Introduction
2. Health of Singaporeans
3. National healthy lifestyle programme
4. Nutrition promotion activities in Singapore
5. Examples of programmes for specific target groups
6. National smoking control programme
7. Visit to a worksite - health profiling of employees
8. Discussion and formulation of recommendations on what people can do for their own health
9. Discussion and formulation of recommendations on what countries should do in health promotion
10. Discussion and formulation of recommendations on how WHO should support activities and mobilize intersectoral action
11. Recommendations for implementation of the WHO health promotion programme
12. Drafting of summary report
13. Closing ceremony
# PROGRAMME

Ministry of Health Headquarters  
Lecture Room 2, College of Medicine Building, Singapore  
22-24 March 1993

<table>
<thead>
<tr>
<th>Day/Date</th>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>Monday 22 Mar 1993</td>
<td>0900</td>
<td>1. Welcome/Introduction</td>
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<tr>
<td></td>
<td>0915</td>
<td>2. Health of Singaporeans</td>
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<td></td>
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<td>(1) Status of Health of Singaporeans</td>
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<td></td>
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<td>(2) National Health Policies for 1990s</td>
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<td></td>
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<td>(3) Discussion</td>
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<td></td>
<td>1015</td>
<td>Coffee Break</td>
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<td></td>
<td>1030</td>
<td>3. National Healthy Lifestyle Programme</td>
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<tr>
<td></td>
<td></td>
<td>(1) Brief review of Health Promotion Programme in Singapore in the last 10 years</td>
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<tr>
<td></td>
<td></td>
<td>(2) Brief overview of National Healthy Lifestyle Programme</td>
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<td>(3) Implementation</td>
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## Provisional Programme

**Monday (cont'd.)**

<table>
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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>1145</td>
<td>4. Nutrition Promotion Activities in Singapore</td>
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<tr>
<td></td>
<td>(1) Public Nutrition Education Programmes</td>
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<td>(2) Development of Dietary Guidelines for Specific Groups</td>
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<td>(3) Discussion</td>
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<tr>
<td>1300</td>
<td>Lunch</td>
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<tr>
<td>1400 - 1630</td>
<td>5. Examples of programmes for specific target groups</td>
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<td>(1) Trim &amp; Fit (TAF) Scheme for Schoolchildren</td>
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<td>(2) Health at Work</td>
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<td></td>
<td>- Strategies for a Workplace Health Promotion Programme</td>
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<td>- Public Sector Workplace Healthy Lifestyle Programme</td>
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<td>(3) Discussion</td>
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<tr>
<td>1930</td>
<td>Dinner hosted by Permanent Secretary (Health)/Director of Medical Services</td>
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**Tuesday**

<table>
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<th>Date</th>
<th>Time</th>
<th>Provisional Programme</th>
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<tbody>
<tr>
<td></td>
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<td>(1) Trends in Smoking</td>
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<td>(2) Smoking Control Programmes</td>
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<td></td>
<td>- The Singapore Experience</td>
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<td></td>
<td></td>
<td>(3) Discussion</td>
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<tr>
<td>1015</td>
<td>Coffee Break</td>
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<tr>
<td>1030</td>
<td>7. Visit to a worksite</td>
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<td></td>
<td>- Health Profiling of Employees</td>
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<td>1200</td>
<td>Lunch</td>
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<tr>
<td>Day/Date</td>
<td>Time</td>
<td>Provisional Programme</td>
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<td>Tuesday (cont'd.)</td>
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<tr>
<td></td>
<td>1300</td>
<td>(1) Introduction of WHO Health Promotion Programme Outline 1993-1995</td>
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<tr>
<td></td>
<td>1400</td>
<td>(2) Discussion</td>
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<tr>
<td></td>
<td>1530 - 1630</td>
<td>8. Discussion and formulation of recommendations on what people can do for their own health</td>
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<td></td>
<td></td>
<td>9. Discussion and formulation of recommendations on what countries should do in health promotion</td>
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<tr>
<td>Wednesday</td>
<td>0900</td>
<td>10. Discussion and formulation of recommendations on how WHO should support activities and mobilize intersectoral action</td>
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<tr>
<td>24 Mar 1993</td>
<td>1015</td>
<td>Coffee Break</td>
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<td>1030</td>
<td>11. Recommendations for the implementation of the WHO Health Promotion Programme</td>
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<tr>
<td></td>
<td>1130</td>
<td>12. Summary report</td>
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<tr>
<td></td>
<td>1245</td>
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</table>
OPENING CEREMONY

Monday, 22 March 1993

0800

Welcome Address by Dr Kwa Soon Bee,
Permanent Secretary (Health)/Director of
Health Services
Ministry of Health, Singapore

Opening Remarks of the Regional Director
of WHO, Regional Office for the Western
Pacific by Dr Liu Xirong, Director
Programme Management, WHO, Regional
Office for the Western Pacific

Self Introduction of Participants

Election of Officers
- Chairperson
- Co-Chairperson
- Rapporteurs

Administrative Announcement

Moderator: Dr Rosmarie Erben
Regional Adviser in Health
Promotion, WHO, Regional
Office for the Western Pacific
## TENTATIVE TIMETABLE

<table>
<thead>
<tr>
<th>TIME</th>
<th>22 March, Monday</th>
<th>TIME</th>
<th>23 March, Tuesday</th>
<th>TIME</th>
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</tr>
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<tbody>
<tr>
<td>0830</td>
<td>Registration</td>
<td>0900</td>
<td>6. National Smoking Control Programme</td>
<td>0900</td>
<td>10. Discussion and formulation of recommendations on how WHO should support activities and mobilize intersectoral action</td>
</tr>
<tr>
<td>0900</td>
<td>Welcome/Introduction</td>
<td>1015</td>
<td>COFFEE BREAK</td>
<td>1015</td>
<td>COFFEE BREAK</td>
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<tr>
<td>1015</td>
<td>COFFEE BREAK</td>
<td>1030</td>
<td>7. Visit to a worksite</td>
<td>1030</td>
<td>11. Recommendations for the implementation of the WHO Health Promotion Programme</td>
</tr>
<tr>
<td></td>
<td>(1) Brief review of Health Promotion Programme in Singapore in the last 10 years</td>
<td></td>
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<td>1245</td>
<td>13. Closing ceremony</td>
</tr>
<tr>
<td></td>
<td>(2) Brief overview of National Healthy Lifestyle Programme</td>
<td></td>
<td></td>
<td>1300</td>
<td>End of programme</td>
</tr>
<tr>
<td></td>
<td>(3) Implementation</td>
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<td></td>
<td>(4) Discussion</td>
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<td>1145</td>
<td>4. Nutrition Promotion Activities in Singapore</td>
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<td></td>
<td>(1) Public Nutrition Education Programmes</td>
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<td>(2) Development of Dietary Guidelines for Specific Groups</td>
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<td>(3) Discussion</td>
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<td>1400</td>
<td>5. Examples of programmes for specific target groups</td>
<td>1300</td>
<td>(1) Introduction of WHO Health Promotion Programme Outline 1993-1995</td>
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<tr>
<td>1630</td>
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<td>(2) Health at Work</td>
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<tr>
<td></td>
<td>- Strategies for a Workplace Health Promotion Programme</td>
<td>1530</td>
<td>9. Discussion and formulation of recommendations on what countries should do in health promotion</td>
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<td></td>
<td>- Public Sector Workplace Healthy Lifestyle Programme</td>
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<td></td>
<td>(3) Discussion</td>
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</tbody>
</table>
Distinguished Members of the Working Group,

Ladies and Gentlemen

I extend a very warm welcome to all our distinguished participants to this Meeting on Health Promotion Planning. We are very happy to be asked to host this Meeting, albeit at very short notice. I would also like to thank Dr S T Han, Regional Director of the Western Pacific Region for this privilege and honour and for his confidence in our ability to organise the Meeting at such short notice.

2. The incidence of non-communicable diseases related to lifestyles is rapidly increasing in the Western Pacific Region. In 26 of the 35 countries, 3 of the 5 leading causes of mortality are due to non-communicable diseases. Singapore is no exception. In 1990, heart disease, cancer and strokes contributed to 60% of the total deaths, equivalent to deaths of almost 8,000 Singaporeans a year. It is therefore timely that WHO in the Western Pacific Region has decided
to make health promotion one of its priority areas for future development. We need to develop a comprehensive health promotion programme that can be implemented by all countries in the Western Pacific Region:

3 Singapore has been actively implementing health promotion programmes for more than 10 years. My Ministry has been conducting regular health promotion and public education programmes and campaigns on proper nutrition, the need to exercise regularly, and not smoking and stress management. We have, I believe, a very comprehensive public education programme and health policy which enjoys the highest level of political support.

4 To further assist individuals to adopt healthy lifestyles, we have launched a 10 year National Healthy Lifestyle Programme in April last year. The National Healthy Lifestyle Programme is a multisectoral and community based programme. It involves the participation of government ministries, statutory boards, employers and employees unions, community and voluntary organisations and professional bodies to work together to provide the information, skills,
training and supportive environment for the people to practice healthy living. The activities of the ministries will be ongoing throughout the year. However, each year a month-long National Healthy Lifestyle Campaign will be organised to focus attention on Healthy Lifestyles.

5 This year, we will be dedicating one day, the launch of the Campaign, as the Healthy Lifestyle Day to commit Singaporeans and the Nation to the concept of a healthy lifestyle living. It will involve the public and private sectors, politicians and MPs at the highest level, grassroots and community leaders and professional organisations such as the medical and educational bodies, sports and community organisations.

6 Many countries in the Western Pacific Region have also made much progress in the field of health promotion. I am certain that through the discussions and contributions from members of the Working Group, who are renowned public health specialists in their own right, our Singapore participants will further enhance their expertise in these areas. We are happy to share with you our experiences although I believe that ultimately each country must
determine its own areas of priority and its own strategies and programmes to fit the stage of its development. We must not simply adopt programmes which have been found effective in developed countries or for that matter the Singapore programme. Whilst suitable in the Singapore context, it may not be so for some other countries because of its size, population distribution or infrastructural development.

7 To the foreign participants, I wish you a pleasant stay in Singapore. I hope you will find time to visit some of the places of interest in our beautiful island Republic.

8 On that note, I wish all of you a successful Meeting.
OPENING REMARKS BY THE REGIONAL DIRECTOR OF THE WESTERN PACIFIC REGION AT THE WORKING GROUP ON HEALTH PROMOTION PLANNING

Singapore, 22 - 24 March 1993

DEAR DR KWA SOON BEE, PERMANENT SECRETARY OF HEALTH, Distinguished Members, Colleagues,

Perhaps more than any other programme area, effective health promotion depends on a successful combination of many points of view. Both as a concept and as a strategy, it has to respond creatively to the special characteristics of each society in which it is carried out.

Some important work has already been done to outline approaches that take into account the diversity of the Region in terms of culture, geography, levels of socioeconomic development and health status. At this point in the process we have agreed within the organization on a programme outline to guide our work for the next three years. It emphasizes simple things that individuals can do for their own health and that of their families and communities in each stage of their life cycle. We now need to be more specific about what we expect people to do, what countries should do, and how WHO should support activities and mobilize intersectoral action. This working group has been brought together to provide some answers to these questions.

You have been invited to join it because of your professional experience in health promotion. You bring with you very valuable knowledge from your own countries, which are among the leaders in this field and I am sure you will have highly practical suggestions about how to develop our health promotion programme.

I am very grateful to the Ministry of Health of Singapore for agreeing to host this working group and share with us some of their experiences in developing and implementing its own excellent health promotion programme. The Permanent Secretary, Dr Kwa Soon Bee, together with his colleagues, has without hesitation given us his full support and I warmly thank him for his involvement.

I am confident that with Singapore’s experience as a starting point and with the valuable input that each of you can provide, this working group will come up with the necessary concrete proposals for implementing our health promotion programme in the Region.
Annex 6

The outcome of this crucial meeting will be recommendations. Let me make it very clear: we are not looking for better concepts or general strategies. What we need is sound advice on a very practical level. I am interested in simple things that people can do for their health, as I feel strongly that change has to come from the people themselves. Enabling people to "take responsibility for their own health" is a bit of a catch-phrase in this context, but I would like to see it filled with meaning, and I know you can help to do this.

When working towards this goal we should not only look at people who consider themselves to be healthy but also at those who live with a chronic condition. The idea of the health potential that can be fulfilled at every stage of a life cycle should guide our work, for both humanitarian and economic reasons.

I realize that in a second step the human environment has to be considered and the policies that contribute to living conditions conducive to health. But our first concern should be the lifestyles of individuals and groups and what they can do to develop healthy lifestyles, thus contributing to healthy aging.

I am sure you will find the environment in Singapore with its healthy lifestyles campaign very stimulating for your work, and I wish you every success.
INTRODUCTION

The state of health in Singapore is good. With rapidly rising standards in living, better education, good housing, water and sanitation, improved medical services and an active promotion of preventive health, internationally recognised indicators of health have reached favourable levels in Singapore.

Indicators of Health

The Infant Mortality Rate declined from 80 per 1000 live births in the early 1950s to 5.2 in 1992. The Expectation of Life at birth for an average Singaporean today is 76.0 years, 73.7 years for males and 76.1 years for females.

Leading Causes of Death

These levels of health have, in a large measure, been due to the control of the major infectious diseases such as tuberculosis, pneumonia and gastrointestinal diseases which were the leading causes of death in the immediate postwar period. This pattern of ill-health in Singapore has changed to one dominated by chronic degenerative diseases which are lifestyle-related. These are Cardiovascular Diseases (Coronary Heart Disease, Hypertension and Stroke), Cancers, Diabetes and Injuries, all of which share common risk factors associated with
affluent living such as smoking, sedentary lifestyles, obesity, and unhealthy diets.

The Singapore population is a multi-ethnic one, comprising 77% Chinese, 15% Malays and 8% Indians. There are interesting inter-ethnic variations in the patterns of diseases among the 3 ethnic groups, with Cancers being responsible for the main morbidity among Chinese and heart disease among Indians and, to a lesser extent, the Malays.

National Health Survey 1992

The latest assessment of the state of health of Singaporeans, measured through a national epidemiology health survey, was carried out between September to November 1992 using state-of-the-art methods to determine the current levels of the diseases of importance eg. heart disease, stroke, high blood pressure, diabetes and their risk factors eg. smoking, obesity, physical inactivity and alcohol consumption in the Singapore population. This Survey covered 3,600 Singaporeans (2% of the population) aged between 18 to 69 years, who were randomly selected from the 1990 Singapore Census Sampling Frame.

The National Health Survey 1992 was designed to meet the following objectives:
To evaluate the efforts taken so far on healthy living in Singapore and to give feedback to Singaporeans about their current state of health. For the past decade, intensified programmes on healthy living have been implemented by the Ministry of Health.

To provide baseline information for the National Healthy Lifestyle Programme in Singapore. This is a broad-based, multi-disciplinary and multi-sectoral programme involving the participation of most ministries and statutory bodies, the private sector, professional bodies, non-governmental and community organisations in the country. The Programme was launched in 1992.

To provide the basis for future directions for health programmes in Singapore to improve the health of Singaporeans.

The last comparable epidemiological survey was carried out on 2,100 Singaporeans in 1984, by the National University of Singapore.

Survey Findings

The National Health Survey demonstrated that some risk factor levels have declined among Singaporeans, showing
Annex 7

Paper 1

the results of the Ministry of Health's efforts to promote healthy living over the past decade.

(i) High Blood Pressure

High Blood Pressure levels fell from 15.7% in 1984 to 13.6% in 1992. One quarter of those found to have high blood pressure during the Survey, did not know that they had it. Hypertension levels among males were highest in Chinese and among females in Malays. Hypertension levels were higher among the obese and those who consumed alcohol frequently.

(ii) Obesity

One-quarter of Singaporeans aged between 18 to 69 years are overweight or obese. This is made up of 5% obese and 21% overweight persons. Obesity levels (BMI of =>30) in the Singapore population has however declined from 5.9% to 5.1% between 1984 and 1992.

Obesity was highest for males among Indians (10%) and for females among Malays (16.7%). Obesity levels averaged 4.5% for males of all age groups but rose steadily with age for females. This is probably because of compulsory National Service for males in Singapore.

(iii) Cholesterol Levels

The total cholesterol levels among Singaporeans is now 207 mg/dl (5.3 mmols), down from 226 mg/dl (5.8 mmols) in 1984. The decline has been seen in both sexes of all 3
ethnic groups. This is the result of the changes Singaporeans have been making over recent years in their eating, towards healthier choices.

The proportion of Singaporeans with high Total Cholesterol (24 mg/dl or >=6.2 mmol/l) also fell from 27% in 1984 to 19% in 1992.

Mean HDL Cholesterol was 1.3 mmol in 1992, up from 0.9 mmol in 1984.

The National Health Survey 1992 has therefore shown a significant decline in the levels of important risk factors to the diseases of importance. This should have beneficial long-term effects on the load of diseases in the country.

(iv) Physical Activity

Almost one-third of Singaporeans take part in some form of exercise, at least once a week. However, those who exercise regularly to reap the beneficial cardio-protective effects of exercise was low at 14%. Men had twice the rate of regular exercise as women (19% vs 8%),

Exercise was very much related to age, being highest among the younger and older age groups of Singaporeans.
Annex 7
Paper 1

The preferred exercises were swimming, jogging, Badminton and brisk walking and Taichi among older Singaporeans.

(v) Alcohol Consumption

The 1992 Survey showed that 35% of Singaporeans consume alcohol. However, only 7% of the population drink regularly. Regular alcohol intake is higher among males (7% vs 2% among females). Similarly, frequent alcohol consumption is practised by 4.6% males and 0.7% females. Binge drinking or having more than 5 drinks on any one occasion is practised by 9.8% of males and 0.8% of females.

(vi) Cigarette Smoking

Smoking levels in Singapore rose from 17% in 1991 to 18% in 1992. The rates now is 33% for males and 3% for females.

The main rise has been among the young, among whom the rates have risen from 12% in 1991 to 15% in 1992 among the 18 to 19 year olds and 16 to 19% among the 20 to 39 year olds. Smoking rates among older Singaporeans have been declining with increasing proportions of ex-smokers over the years.

The average number of cigarettes smoked by Singaporeans is 15 per day.

Smoking rates are highest among Malays.
(vii) Diabetes

Diabetes levels have risen significantly in Singapore. The level now is 8.6% compared to 4.7% in 1984. Indians continue to have the highest prevalence of diabetes (12.8%) followed by Malays (9.3%) and Chinese (8.0%). Diabetes levels among Chinese have doubled (8% vs 4%) in the past 8 years while that among Indians rose by 44% (12.8% vs 8.9%) and Malays by 22% (9.3% vs 7.6%).

Diabetes in Singapore was seen more among the obese, the less active, and those with higher cholesterol, illustrating the risk factors to this disease.

DISEASE REGISTERS

In addition to health surveys, 2 population based Diseases Registers are run to provide valuable information on Cancers and Heart Attacks, the two leading causes of illness in the Singapore population.

(i) Singapore Cancer Registry

The Singapore Cancer Registry was established in 1969. Data from the Cancer Registry shows the leading cancers to be cancer of the lung, breast and colorectal cancer.

(ii) Singapore Myocardial Infarct Registry

In 1987, the Singapore Myocardial Infarct Registry was established along the specification of the WHO MONICA
Registries. Data for the Infarct Registry shows that the incidence of Myocardial Infarcts is declining from 7.6 per 1000 of our population aged 20 to 64 in 1987 to 7.1 in 1991.

DR SHANTA C EMMANUEL
ASSISTANT DIRECTOR OF MEDICAL SERVICES
EVALUATION & PLANNING DIVISION
MINISTRY OF HEALTH HQ

16 March 1993
INTRODUCTION

The main thrust of Singapore's health care policy in relation to the current disease profile, is to build a healthy population through a vigorous preventive health care programme. Since the past decade, the Ministry of Health has strengthened its national health education programme. This encourages people to be responsible for their own good health. The public are informed about the adverse consequences of certain harmful lifestyles and habits, such as sedentary living, obesity, smoking and unhealthy dietary habits, and persuades them to change such harmful habits. In 1992, a National Healthy Lifestyle Programme was launched, which is a broad-based, multi-disciplinary and multi-sectoral programme involving the participation of most Ministries and Statutory bodies, the private sector professional bodies, NCROs. The Programme is aimed at encouraging Singaporeans to live healthily in all aspects of their daily living, and provides the supportive environment for it.

We also have a strong immunisation programme against the important childhood diseases, over and above WHO's expanded immunisation programme recommendation. The childhood immunisation programme covers tuberculosis, polio, diphtheria, whooping cough, measles, tetanus, mumps, rubella and recently Hepatitis B. For the adult population, we have
stepped up screening programmes for the early detection of the common causes of ill health in the country today, such as cancers, heart diseases, hypertension and diabetes especially in the high-risk groups, identified from national epidemiological surveys, Disease Registers and other forms of disease surveillance.

We recognise, however, that it is inevitable that people will fall ill. A high standard of basic medical care is provided through a comprehensive range of public sector medical services, complemented by expanding expertise and facilities in the private sector, have been developed over the years.

PRIORITY AREAS IN HEALTH CARE

For the channelling of resources in health in the 1990s, 5 major health programmes have been prioritised by the Ministry of Health. They are:

- Improving the health of the elderly, in view of their rapidly expanding numbers;

- Strengthening the prevention and management of the current leading causes of ill-health among Singaporeans (namely heart disease, stroke, cancer, diabetes and injuries);
- 47 -

• Enhancing child health so as to give Singaporeans the best start in life;

• Improving mental health; and

• Improving health education as it is the basic strategy common to most of our health programmes.

HEALTH CARE PROVISION

The majority provision of health care by the government has served to regulate and control health care costs through the central planning for health manpower and bed provision to prevent oversupply, serving as a benchmark for charges and professional standards for the private sector and regulating the introduction and the use of expensive technology in the public sector.

There will be continuing emphasis on improved primary health care and ambulatory treatment so as to reduce hospitalisation and to keep healthcare costs in control.

PROVISION OF HOSPITAL CARE

Heavily subsidised services are provided in public sector hospitals for those in the lower income group who cannot afford to pay the full cost of medical treatment. These services are basic and without frills, but without compromising on medical standards. Patients in the subsidised wards receive subsidies of between 70 to 80% ie
they pay only 20 to 30% of the real costs of the service. The government will continue to provide subsidised hospital services and ensure that these services continue to remain affordable to the lower income groups.

Currently subsidised beds comprise 60% of acute hospital beds.

Those who prefer a more personalised service and a higher level of comfort and luxury, can choose such services from either the private or public sectors. They will not however have the benefit of any subsidies. The wider choice of private health facilities in the country available will promote greater competition, leading to improvements in service and efficiency. The public sector today provides 26% of all Class A beds whose service is comparable to care in the private sector. This level of provision will not be increased but only serves to provide a benchmark for charges and professional standards in the private sector.

For the future, the recommendation is that although the government can continue to be the majority provider of healthcare, its share of the market can be gradually reduced. The private sector will be encouraged to expand in the provision of inpatient care up to 30%. This is to offer the people a wider choice in the type of hospitals offered. Voluntary not-for-profit organisations
will be encouraged to manage some public sector hospitals. The government will continue to provide subvention for the care of subsidised patients.

HEALTH FINANCING POLICY

Recognising the deficiencies of the health delivery and financing system of many developed countries, a major decision was taken in 1983 to avoid recognised pitfalls by:

(i) actively moving away from a system funded purely by general taxes and enforcing greater cost-sharing by the patients to curtail unnecessary demands for health service. This is achieved through the Medisave Scheme.

(ii) restructuring the management of government hospitals to attain greater efficiency and to facilitate more effective cost control.

The Medisave Scheme

The Medisave Scheme is a savings scheme in which every employee is required by law to put aside 6% of his monthly income up to a maximum of S$360 into his personal Medisave Account to meet future hospitalisation expenses for himself and his immediate family. 3% of this is from the employee and 3% from his employer. The Scheme was first implemented in 1984.
Today, Medisave may be used to pay for the hospitalisation charges incurred in government and private hospitals and for outpatient and day surgical/medical procedures; radiotherapy and cancer chemotherapy treatment; Hepatitis B vaccination; and expensive procedures like renal dialysis and in-vitro fertilisation.

Medisave cannot be used to pay for outpatient primary health care which is relatively cheap and affordable. Those who find it difficult to afford private general practitioner would make use of the government primary health services which are subsidised to 50% of the cost.

Limits are imposed on how much can be withdrawn to pay for hospital bills. This is to ensure that some co-payment is involved to reduce the likelihood of overuse or abuse of the system even though Medisave consists of the patient's own money.

Today about 80% of all patients admitted to hospitals make use of Medisave to pay for their hospital bills. The remaining 20% pay their bills through employers' medical benefits or by cash. The Scheme has provided patients with savings to pay for their hospitalisation.

The Medisave Scheme has eased the burden of paying for hospital bills, and has made it possible for many to
choose freely between public and private, and between subsidised and non-subsidised government hospital services.

However, there is an urgent and recurrent need for continuing patient education on the prudent use of Medisave which has been designed to meet the life-time hospitalisation needs of the account holder and that of his family. The public has to be constantly reminded that Medisave is their money and that it should be used wisely and not for stay in classes of wards beyond their means. Monitoring of short-stay patients in both public and private hospitals shows that the introduction of Medisave has not led to a significant rise in this group of patients, which would reflect unnecessary hospitalisation so as to enable Medisave to be used.

While Medisave is adequate for the hospitalisation needs of the average Singaporean, it will not be adequate for any major or catastrophic illnesses.

The Medisave Scheme, its operation and utilisation are regularly monitored and enhancements introduced as and when the need is shown. For the 1990s, this includes requiring the self-employed to become part of the Scheme, reviewing the contribution rates to Medisave and reviewing the application of Medisave for ambulatory care of the important chronic conditions which require longterm management which will be expensive.
Medishield

To supplement Medisave, a Catastrophic Illness Insurance Scheme or Medishield was implemented in July 1990, to pay for prolonged and major illnesses. To avoid the problems associated with a pre-paid insurance scheme, there is a system of first quantum payment and copayment. Medishield is funded from premiums paid from the Medisave accounts. It is operated on an opting-out basis.

These include requiring the self-employed to subscribe to the Scheme, reviewing the contributions and the application of Medisave for ambulatory care for chronic conditions. The use of Medisave is regularly monitored and enhancements incorporated as and when the need is shown.

Medishield has 1.7 million members. A total of 32,000 claims have been processed under the Medishield Scheme as at December 1992.

Medifund

The Medifund Scheme is a proposed health endowment to ensure that all Singaporeans enjoy access to health care. This applies particularly to the poor, the chronically sick and the old who need assistance to pay for their medical care.

An Advisory Committee is being set up to draw up guidelines on the use of Medifund. The processing of
applications from each hospital will be decentralised to each Hospital's Medifund Committee.

**MAXIMISING EFFICIENCY/EFFECTIVENESS**

The government undertook a restructuring programme for many of its hospitals to maximise the efficiency and effectiveness of running hospitals. Each restructured hospital is managed through its own Board of Directors and management team thus releasing it from the constraints of the rules and regulations of the civil service. These hospitals will have full autonomy in their daily operations and will be expected to be more responsive to the needs of the patients. With greater management flexibility and financial accountability, we expect the restructured hospitals to deliver health care services more cost-effectively and efficiently.

They will compete with each other and with the private sector by rationalising and streamlining procedures, by providing a high standard of service to their patients, by striving for medical excellence, and through higher productivity achieve economy. Their objective must be to provide quality medical services at prices that are affordable. Their ability to contain costs will ultimately benefit all patients.

To date, 7 out of the 10 acute hospitals in the public sector are restructured.
The restructuring of the government hospitals will not effect the commitment of the government towards the poor as these hospitals are wholly government-owned. The government will continue to provide the restructured hospitals with an annual subsidy for operating the subsidised wards.

MEDICAL AUDIT AND QUALITY ASSURANCE IN HEALTHCARE

The most significant recent change implemented in the area of health care in Singapore is the implementation of the Private Hospitals and Medical Clinics Regulations (1991) which took effect on the first week of 1992. Under the Regulations, all private medical establishments in Singapore must apply for licences to operate. Once licensed, the medical establishments must comply with the minimum standards for medical services and facilities laid down in the regulations. The aim is to safeguard the interests of patients and ensure a minimum standard of quality care. With this new medical ruling, the government hopes to enforce stricter control over the quality of practice and the conduct of health care personnel in order to ensure that medical services in Singapore are of a high standard.

The most notable ruling affecting hospitals under the Regulations is perhaps the legislation that requires all patients to be informed before admission to the hospital of the estimated total hospital charges that they are likely to
have to pay. In this way, patients can make an informed choice and decide which hospital they would like to be admitted to.

DR SHANTA C EMMANUEL
ASSISTANT DIRECTOR OF MEDICAL SERVICES
EVALUATION & PLANNING DIVISION
MINISTRY OF HEALTH HQ

16 March 1993

:health
INTRODUCTION

Countries experience different health problems at different stages of socio-economic development. In Singapore, in the 1950s, the leading causes of death were due to infections such as tuberculosis, pneumonia and diarrhoea. The priorities then were the promotion of child health, immunisation, personal hygiene and prevention of infectious diseases.

2 Two decades later, as standards of living improved with better education and better paid jobs, improved housing, environmental sanitation and medical services, the pattern of morbidity and mortality has changed. Non-communicable diseases such as cancer, heart disease and stroke have become the leading causes of death.

3 Coronary heart disease mortality rates in Singapore have been rising although there has been a declining trend in Australia and New Zealand since the late '60s. Coronary heart disease death rates have risen from 25 per 100,000 population in 1960 to 40 in 1970 and 82 in 1980 (Figure 1). Mortality rates for cancer and stroke follow the same trend.

Figure 1. Deaths from Cancer, Coronary Heart Disease and Stroke, 1960 - 1980

Prepared by R&E Dept. MOH
Data Source: Registry of Births and Deaths
CAMPAIGN AGAINST DISEASES DUE TO HARMFUL LIFESTYLES

4 Studies have demonstrated the link between lifestyle and diseases, and the risk factors of lifestyle related diseases such as cardiovascular disease and cancers have been identified. These include smoking, eating unhealthy diet, lack of exercise and stress. It became evident that morbidity and mortality from these diseases could be largely prevented through reduction of the risk factors.

5 In 1979, the Health Ministry in Singapore conducted a month-long nation-wide educational programme called the "Campaign against Diseases due to Harmful Lifestyles" to educate the public on the risk factors and motivate them to adopt preventive measures. The 5 disease conditions highlighted were ischaemic heart disease, hypertension, lung cancer, diabetes mellitus and mental illness.

6 The objectives of the Campaign were:

(i) to reduce the prevalence of the diseases by:
   (a) educating the public on the risk factors and preventive measures,
   (b) motivating them to adopt preventive measures;

(ii) to promote early detection and regular treatment by:
   (a) educating the public on the signs and symptoms of the diseases,
   (b) motivating them to seek early and proper treatment,
   (c) motivating them to follow regular treatment regimes; and

(iii) to promote better understanding of the diseases and in particular, to remove the social stigma against mental illness by:
(a) educating the public on the causes and nature of the diseases,

(b) educating the public on the role of the patient in aiding his own recovery,

(c) educating the public on the role of the family/relatives in helping the patient to recover.

7 A National Health Campaign Committee comprising 29 organisations was formed to assist in the educational effort. These organisations included government ministries, quasi-government organisations, institutions of higher learning, professional medical associations, employers' associations and the unions.

8 The main target groups were the youths who were reached through the schools, tertiary institutions and national service camps, and the general population who were reached through the government ministries, the workplaces and community centres. The educational activities utilised both interpersonal as well as mass media communication methods. The message was "Don't Smoke, Eat Wisely, Exercise Regularly and Relax". The highlight of the Campaign was a large-scale 9-day health exhibition.

9 Since the first Campaign in 1979, the Health Ministry has continued to educate the public on healthy lifestyles. In hospitals and clinics, doctors and nurses also provide health advice to their patients. Preventive services such as health screening were introduced and expanded.

10 In 1986, the "Healthy Heart, Healthy Life" programme was launched with the "Hearty" mascot which was featured on all health education materials. A locally produced 13-part series called "In the Pink" was telecast over television. It highlighted the risk factors of cardiovascular diseases and gave tips on specific health practices to reduce those risks. In 1989, the first National Health Fair was held over a 2-week period with the slogan "Your Health in Your Hands". The call was for Singaporeans to take greater responsibility for their own health. It attracted 400,000 visitors. In the same year, a Nutrition Week was held in conjunction with World Health Day to educate the public on healthier choices of food and good dietary practices.
11 The educational programme for the general public relied very heavily on mass media, particularly television, radio and the press. For specific target groups such as school children, employees, uniformed groups and patients, face-to-face communication activities were used as well. Facilitators of health education for these groups, eg teachers, union leaders and nurses were given training to enable them to conduct the health education.

12 Health education was built into the curricula of both primary and secondary schools. In primary schools, health education textbooks and workbooks were used whereas in secondary schools, health education topics were included in subjects such as science and physical education.

SMOKING CONTROL

13 Smoking is a major risk factor of lifestyle diseases. Singapore has adopted a comprehensive approach to controlling tobacco and smoking through public education, legislation, tax increases and the provision of smoking cessation programmes.

14 The initiatives taken to discourage smoking were:

. In 1970, legislation was passed banning advertising of cigarettes and tobacco on television, radio and printed materials. In 1989, the ban was extended to all forms of tobacco promotion including sponsorship of sporting events.

. In 1970, a ban on smoking in cinemas, theatres and buses was introduced. Over the years, the ban was extended to cover elevators, hospitals and medical facilities, airconditioned restaurants, departmental stores and supermarkets. Smoking in all public buildings has been prohibited since 1987.
In 1980, the health warning "Cigarette can damage your health" on cigarette containers became mandatory. In 1989, 4 different health warnings to be rotated on cigarette packets were implemented and the limit on levels of nicotine and tar to 1.3 mg nicotine and 15 mg tar per cigarette was set.

Since 1983, as part of the economic measures against smoking, the tax on imported and locally produced cigarettes has been regularly increased.

In 1986, a National Smoking Control Programme called "Towards a Nation of Non-Smokers" was launched to reduce smoking rates. The outreach was to all population groups, with emphasis on youths. A National Smoking Control Coordinating Committee was set up with representatives from government ministries, the trade unions and employers.

The control of smoking involves several government ministries and departments namely Health, Environment, Trade & Industry, and Revenue. This is an example of multi-sectoral involvement in policy formulation and programme implementation.

NEW APPROACHES

In 1991, a Review Committee on National Health Policies was set up chaired by the Minister of State for Health. The Committee felt that although the health status of Singaporeans was good (Infant Mortality Rate was 6.7 per 1,000 livebirths and life expectancy at birth was 74 years) Singapore was still experiencing high prevalence rates of cancer, heart disease and stroke which affected life span and quality of life. It was therefore necessary to focus on the preventable lifestyle diseases and seek new strategies to deal more effectively with them. In their Report titled "Healthy Family Healthy Nation", the Review Committee recommended the adoption of a health promotion and disease prevention approach to reduce morbidity and mortality from lifestyle diseases.
The Committee set targets for the reduction of the risk factors for the major diseases to be achieved by the year 2000. These are obesity, inadequate physical activity, smoking, high blood cholesterol, high blood pressure and unhealthy diets. Figure 2 shows the targets for the year 2000.

**Figure 2. Targets for the Year 2000**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Baseline</th>
<th>Target 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. School children</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>. Adult population</td>
<td>4.3%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Exercise</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Population doing</td>
<td>19%</td>
<td>40%</td>
</tr>
<tr>
<td>regular exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Population rate</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>High Blood Pressure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Population rate</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Blood Cholesterol</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Mean cholesterol level</td>
<td>5.8 mmol/L</td>
<td>5.2 mmol/L</td>
</tr>
<tr>
<td>. % population with</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>over 240 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6.2 mmol/L)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Daily calorie intake</td>
<td>NA</td>
<td>3,000 Cal (Male)</td>
</tr>
<tr>
<td>. % energy intake as fat</td>
<td>NA</td>
<td>20 - 30%</td>
</tr>
<tr>
<td>. Daily salt intake</td>
<td>NA</td>
<td>&lt;5 gm</td>
</tr>
<tr>
<td>. Daily fibre intake</td>
<td>NA</td>
<td>25 - 30 gm</td>
</tr>
<tr>
<td><strong>Dental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. DMF (T) of 12 year olds</td>
<td>1.39</td>
<td>1.20</td>
</tr>
</tbody>
</table>
The strategies recommended by the Review Committee to promote health and prevent disease are:

- Supplement the Ministry of Health's efforts by involving other government departments, the private sector, employers and unions, community and voluntary organisations and professional bodies, ie adopt a multi-disciplinary and multi-sectoral approach.

- Emphasise the role of the individual in being responsible for his/her own health.

- Create a supportive environment to assist individual to adopt a healthy lifestyle. Two urgent areas identified were availability of healthy foods and the provision of exercise facilities.

- Provide health education to enable individuals to make informed choices and learn the skills necessary for healthy living.

- Strengthen the existing preventive health services by expanding medical check facilities and encouraging the public to go for regular health checks.

- Ensure that public policies do not have conflicting objectives and are well coordinated, and that they all work towards a common goal.

- Implement special programmes for specific target groups such as school children, national servicemen, working adults and the elderly.

NATIONAL HEALTHY LIFESTYLE PROGRAMME

In response to the recommendations of the Review Committee on National Health Policies, the National Healthy Lifestyle Programme was launched by the Prime Minister in April 1992. A Healthy Lifestyle Coordinating Committee was established with high level representation from key...
ministries, statutory boards, employers' federation, the unions and health professional bodies to monitor the progress of the national programme.

20 There are several key programmes in the National Healthy Lifestyle Programme. The first is the annual month-long health campaign which is organised on a nationwide basis. The campaign provides a focus of intensive health education reaching out to the community to provide health information and teach the skills for healthy living. The Campaign theme is Healthy Family, Healthy Nation. Each year, the Campaign emphasises a risk factor of lifestyle disease or a component of healthy living. In 1992, the emphasis was on obesity. In 1993, the emphasis is on physical activity.

21 The second key programme is the Trim and Fit Scheme (TAF Scheme) implemented in the schools to promote healthy living and control obesity among school children. The main components of the scheme are nutrition and physical activity to enable students who are physically fit and have acceptable body weight to maintain or enhance their status and those who are physically unfit, underweight or overweight to improve their condition through appropriate remediation.

22 The third is the Workplace Health Promotion Programme. The public sector is taking the lead by implementing a pilot Workplace Wellness Programme. The private sector is encouraged to also implement workplace health promotion programmes and some organisations have responded to the call.

23 There are numerous other programmes targeted at specific groups, eg national servicemen, the elderly, housewives or the general population, all with the aim of promoting healthy living.

24 The emphasis of the National Healthy Lifestyle Programme is very much on healthy living rather than on diseases. Programmes and activities are aimed at creating awareness of the need to lead a healthy lifestyle, teaching the skills to do so and stressing on individual responsibility for one's own health.
MONITORING AND EVALUATION

25 The impact of the various measures taken to control smoking is demonstrated by the smoking rates of the population aged 15 to 64 years, which fell from 23% in 1977 to 13% in 1987. However, the smoking rate rose to 16% in 1991.

26 The measures taken to combat lifestyle diseases and improvement in treatment have resulted in the plateauing of mortality rates of coronary heart disease, cancer and stroke (Figure 3).

Figure 3. Deaths from Cancer, Coronary Heart Disease and Stroke, 1960 - 1990

Rate per 100,000 population

Prepared by R&E Dept, MOH
Data Source: Registry of Births and Deaths
The findings of two national health surveys done in 1984 and 1992 have shown that there is a reduction in the levels of some of the risk factors of non-communicable diseases (Figure 4).

**Figure 4. Level of Selected Risk Factors of Non-Communicable Diseases, 1984 and 1992**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>1984</th>
<th>1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension@</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Population with hypertension</td>
<td>15.3%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean total cholesterol</td>
<td>5.8 mmol/L</td>
<td>5.3 mmol/L</td>
</tr>
<tr>
<td>% Population with</td>
<td>27%</td>
<td>19%</td>
</tr>
<tr>
<td>≥ 6.2 mmol/L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Population obese</td>
<td>4.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Population exercising</td>
<td>-</td>
<td>13.6%</td>
</tr>
<tr>
<td>≥ 3 times a week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

@ Blood Pressure: Systolic ≥ 160 mmHg and/or Diastolic ≥ 95 mmHg
# Body Mass Index ≥ 30

The National Healthy Lifestyle Programme is being monitored to ensure that the targets for the year 2000 are achieved. Health indicators such as morbidity and mortality statistics are readily available as they form part of the national health data systems. However, special studies/surveys will need to be carried out to provide comprehensive evaluation of the major programmes.
In the early 1960's and 1970's, as a result of surveys and assessments indicating special needs among young children and low-income population groups, the Government of Singapore expanded its public health programme to include direct delivery of food and nutrition services.

A small scale food assistance programme was implemented to meet the immediate needs of undernourished young school children. The programme included the School Feeding Scheme in which a Wheat-Soy-Blend-drink was served free to each underweight primary school child on every school day, and the Tuberculosis Food Ration Scheme in which a two-week ration of food was distributed to parents of deserving children to supplement the meals served at home.

A register was kept of undernourished pre-school children for follow-up in the Maternal and Child Health Clinics. The severely undernourished were followed-up at home with regular home visits. Weekly talks and demonstrations on preparation of weaning diets and on young child feeding, initiated in the early 1970's, are still being conducted in the Maternal and Child Health and School Health Clinics, though somewhat modified to address today's health concerns and adapted to today's eating patterns.

Nutrition services began to extend beyond the Maternal and Child Health and School Health during the mid 1970's to the whole population. The "Better Food for Better Health" campaign was conducted in 1975. The emphasis was on messages targeted at low-income families, messages such as low cost protein sources, the cheaper locally available vitamin C containing fruits and ways to increase the energy content of meals. The campaign also dealt with food hygiene and proper food handling practices.

Towards the latter half of the 1970's, obesity among school children began to emerge as a public health concern. The major focus of attention in nutrition then began to shift away from protein energy malnutrition and growth retardation due to undernutrition, to the effects of overeating and leading a sedentary lifestyle, and of specific nutrients and dietary factors, on the long, slow development of chronic degenerative diseases. A weight management programme for overweight school children was started in 1977. It has been revamped several times, the latest just two years ago, to cope with the rising trend of obesity among children 6-18 years old. An obesity management and prevention programme for preschool children was also started recently.

Numerous national health campaigns and major health education and promotion programmes in the past twenty years had nutrition education as a component. In the 1970's the focus was on undernutrition and deficiency diseases. But in 1979, "Combat Diseases due to Harmful Lifestyle" National Health Campaign, obesity and poor eating habits were featured as major health risk factors. The 1986 "Healthy Heart, Healthy Life" education programme cited nutrition in several of its thirteen part series in which "HEARTY" went on mass media using the television, radio and local newspapers to promote heart health. HEARTY even went to the "Bird Park", bringing the heart health message to school children in a fun way. The "Eat Healthy, Choose Wisely" theme of the Nutrition Week in 1989 was imaged by smiling "HEARTY" armed with a fork and spoon. The programme placed
nutrition in the forefront of disease prevention and health promotion. Interest was generated well ahead of the 'Week' with seven-part weekly TV quiz series entitled 'You've got the choice' involving pre-university students. HEARTY had a busy time then. He was in the supermarkets, at hospital beds, and even at the 1989 National Day celebration.

In 1989, after ten years of heart health promotion, the Ministry of Health organised a gigantic National Health Fair with the theme "Your Health in Your Hands". The two-week Fair drew an estimated 390,000 visitors. The nutrition sector at the Fair was a massive crowd puller and was judged the best area. Many had hands on experience at the participatory exhibits whilst others queued to measure their body fat level. HEARTY'S CAFE was well-patronised by all, old and young. It not only served healthy meals and snacks, but also had computers to give the nutritional value of the food sold. The more recent Cancer Education Programme in 1990 featured diet in its "CHECK EARLY, CHECK CANCER" list of suggested activities to reduce cancer risk.

In 1992, at the launch of the ten-year National Healthy Lifestyle Programme, nutrition was featured prominently at its Health Fair - the "Healthland" as well as in its mass media programme. The numerous supporting activities included public forums, weight management workshops, a nutrition hotline and a three-months mass media follow up programme over TV, radio and newspapers.

This year, the "Healthy Meals, Healthy Family" message will be publicised to the non-working homemakers and retirees at community centres. Activities will include organised supermarket tours, cooking demonstrations and counselling sessions, exhibitions and quizzes.

To ensure an enlarged pool of nutrition educators to serve the population, the then Nutrition Unit of the Ministry of Health started extensively and intensively the training of nurses in the public health sector. This was in the early 1970's. Similar training was extended to home economics teachers in the second half of the 1970's to prepare them to teach the revised nutrition component of the home economics syllabus which was made compulsory for all lower secondary school girls in the early 1980's. Since then, nutrition has been built into the training curriculum of both basic and post-basic nurses, home-economics, health education and human and social biology teachers, doctors and pharmacists. From 1994, home economics in schools will be taught to lower secondary boys as well.

The 1950's and 1960's saw a drastic decline of the prevalence of breastfeeding among both the lower and higher socio-economic groups in Singapore. An education programme was put into action to reverse the declining trend. A committee was later formed to oversee the marketing practices of the infant milk industry. The Sale of Infant Foods Ethics Committee, Singapore, SIFECS in short, finally formulated the Code of Ethics on the Sale of Infant Formula Products in Singapore. Implemented since 1979, adherence to the Code is obligatory on the entire Infant Food Industry operating in Singapore.

Dietary recommendations on eating wisely have been publicised since the early 1970's. The early guidelines advised the public to "Choose some foods from the three basic food groups - GO, GROW, and GLOW". Later, as more foods became available, in the marketplace, the principle of variety was introduced, still within the confines of the three food groups.

In the 1980's however, the focus of nutrition objectives expanded to encompass the role of over-consumption of fat, cholesterol, salt and sugar, and dietary factors associated with chronic diseases. The words, variety, moderation and balance began.
to appear in nutrition messages. Initially, guidelines were qualitative or directional, suggesting that people eat more of and less of certain foods. In response to public demand as the people became more health conscious, efforts have now been made to quantify the guidelines, naming individual nutrients, food components and certain foods, and to recommend average daily intakes. Also, dietary guidelines have been designed increasingly to translate the RDA's into terms usable by consumers, as in the DAILY FOOD GUIDE.

Dietary adequacy today includes consideration of the most reasonable proportion of dietary factors for prevention of chronic disease, as well as for the promotion of health and well-being. This new prospective was reflected in "Guidelines for a Healthy Diet", recommended by the National Advisory Committee on Food and Nutrition in 1988, for all healthy Singaporeans over the age of two years. The Committee established quantitative targets for consumption of total fat, saturated, monounsaturated and polyunsaturated fats, cholesterol, complex carbohydrates, refined and processed sugar, salt and alcohol, and for breastfeeding. The guidelines were reviewed recently following feedback from health professionals.

The first guideline emphasizes the need to consume a variety of foods from the three basic food groups to provide essential nutrients. It proposes the number of servings of each food group for various population groups, and provides examples of serving sizes. On food energy, the guidelines emphasize that it is important for individuals to maintain body weight and if overweight, to gradually reduce to achieve desirable weight. The recommendation is to follow a long term plan involving sensible eating habits and a programme of increased physical activity. For determining healthy weight, the Body Mass Index (BMI) has been recommended for adults.

Specific recommendation about desirable level of fat in the diet is made in the guidelines. It suggests 20-30% of total energy intake from fat as a target. Besides the avoidance of too much fat, the nutritional guidelines recommend modification of the composition of the fat in the diet. It is to consist of equal portions of polyunsaturated, monounsaturated and saturated fat. Dietary recommendations for the general public include a reduction of dietary cholesterol to less than 300 mg a day.

The guidelines recommend an adequate amount of starch and dietary fibre in the form of complex carbohydrates. This can be achieved through increased consumption of foods like fruit, vegetables, legumes and breads and cereals especially wholegrain types so that these supply about 50% of daily dietary energy. This supports other objectives related to increasing the intake of nutrients like vitamins A and C, and avoiding too much fat and sugar.

On salt intake, moderation is recommended for the general population. The aim is to suggest diets at the 'safe and adequate' level of about 5 grams a day for adults. Nutritional recommendations include reducing the intake of salt cured, preserved and smoked foods. Particular emphasis is placed on reducing commonly eaten local food products like barbecued meat, smoked fish and fish roe, cured meat and pickled food.

Like salt, moderation of refined and processed sugar is also recommended for the whole population. A goal of less than 10% of total energy intake from these sugars is proposed. For those who drink alcoholic beverages, the principle of moderation that is no more than two drinks a day is again applied. The nutritional guidelines for Singaporeans conclude with a special recommendation on breast feeding. It encourages breast feeding of infants until at least 6 months of age.
Strategies for promoting the adoption of the dietary guidelines include increasing the awareness of the people of the relationship between diet and health; publicising the guidelines to those responsible for health and nutrition education; including the guidelines in the curriculum of related health professionals and teachers; and providing simple, relevant and consistent nutrition information to the general public at talks and exhibitions, and in print and audio-visual materials.

To facilitate the adoption of a diet in line with the nutritional goals and recommendations, the Ministry of Health has started consultation with the food industry and caterers to increase the availability of healthier food choices in the marketplace and at eating outlets. Food service personnel and caterers in hospitals and other health care institutions, school and college canteens, child care centres, workplace canteens, fast food outlets and hawker centres are encouraged to modify food preparation and catering practices and to offer a wider range of healthier food choices. For example, the Ministry completed a six-month pilot project in selected schools in 1991. The objective was to promote healthier food choices in school tuckshops as part of the school's effort in encouraging good eating habits among school children. The project took a four-prong approach, involving principals and teachers, food stall holders, students and their parents. The experience culminated in the development of a handbook entitled "Towards a Healthy School Tuckshop". Similar handbooks will be developed for the other areas of mass catering.

Effort is also being directed at encouraging energy and nutrient labelling of food, and at responsible advertising and product claims to enable consumers make informed decisions in food selection and purchase. Progress in this area will be slow as food composition and dietary consumption data are very much lacking and will take time to collect.

The Ministry of Health, in its National Health Policy for the 1990's has prioritised "Enhancing health promotion through health education and better nutrition" as one of its five major national programmes to significantly improve the level of health of Singaporeans. With this national directive and nation-wide cooperation among health and nutrition professionals, the food industry and the government, Singaporeans can look forward to having a 'healthier' nation. There are on-going plans for a more coherent programme of extensive nutrition education for the general public and specific population groups as well as for the establishment of closer liaison with the food industries and caterers to ensure the increased availability of a healthy food supply.

References: Annual reports - Ministry of Health, Singapore

Food and Nutrition Department
15 Mar 93
WHY TAF?

1 Over the years, as a result of automation, growing affluence and a rising standard of living, Singaporeans are adopting a more sedentary lifestyle. In addition to increasing physical inactivity, our eating habits have also changed. In the past, meals were often simple and plain, freshly prepared and vegetable-based. Today, because of factors such as increased income, changing tastes and more working mothers, we and our children have more meals at hawker centres, fast-food outlets or restaurants. These places usually serve food of a high fat content, often deep-fried and high in sodium and other additives. Such food, consumed frequently and in large quantities over a period of time, poses a risk to our health.

2 Among school children, the incidence of obesity has been increasing from 5.4% in 1980 to 13.2% in 1990. Physical fitness tests in schools show a declining average pass rate of 63.4% in 1987 to 57.2% in 1990 in the secondary schools.

3 These figures point to a need to foster a greater consciousness of the importance of leading an active and healthy lifestyle for our young.

WHAT IS TAF?

4 The Trim and Fit (TAF) Scheme is a ten-year school programme in support of the National Healthy Lifestyle programme. It concentrates on two major areas: Nutrition and Physical Activity. The TAF Scheme is a motivational framework to encourage schools to develop strategies to reduce obesity and improve physical fitness of the pupil population and to provide incentives for pupils to keep physically fit.

5 Schools will be categorised into 4 bands, ranging from Band A to Band D according to the level of performance based on the Fitness Index, the overweight percentage and the percentage of pupils who pass the physical fitness test. The Fitness Index is derived from the average of the percentage of pupils within the acceptable weight range according to the Weight for Height Table and the percentage of pupils who pass the annual National Physical Fitness Award (NAPFA) test. Schools in Band A will receive a Gold award, schools in Band B a Silver award while those in Bands C and D will be assisted to develop remediation programmes to improve. Pupils who pass their physical fitness test will be given certificates.
HOW IS TAF IMPLEMENTED?

6 The scheme is implemented at two levels - the individual school level and the national schools level.

7 Individual School Level

Each school draws up its own programme of activities. These include taking pupils' weight and height, conducting the annual NAPFA tests, organising talks, quizzes and exhibitions on healthy lifestyle, counselling overweight and/or physically less fit pupils and their parents on management of diet and nutrition and the need for regular physical activities as well as conducting meaningful physical activities. These physical activities include walking, jogging, fitness conditioning workouts, aerobic exercise to music, swimming, adventure-type activities like hiking and camping as well as modified sports and games. The severely obese pupils are referred to the School Health Service for counselling and treatment by the doctors. Schools constantly guide pupils in the selection of healthy and nutritious food in the school canteen. Measures taken include labelling of "Green Food Items", implementing the approved "Drinks List" and monitoring the sale of food in the canteen.

8 National Schools Level

The programme at the national level involves all schools. The activities include forums, symposiums, seminars and courses for principals, vice-principals, teachers and tuckshop vendors. There are also mass events like the Schools Mass Jog. These activities are aimed at equipping school principals and teachers with the necessary knowledge and skills in nutrition, health and fitness and physical activities necessary for the successful implementation of the TAF Scheme. They also help to provide a conducive environment for pupils to develop good eating habits and an active and healthy lifestyle.

National Schools Programme

a) Forum for Principals, January 1992

The official launching of the TAF scheme in January 1992 was followed by a forum for all principals and sports secretaries on healthy lifestyle.

The programme included a panel presentation by professionals and consultants from the various disciplines in Medicine, Sports and Nutrition.

b) Symposiums for Key Personnel, February 1992

The symposium for VPs and HODs (PE) of primary schools was preceded by the official launching of the National Physical Fitness Award (NAPFA) Scheme for primary schools. The main objective of the symposiums was to ensure that key personnel in schools had a good understanding of the TAF Scheme. The symposiums also provided practical approaches to implementing the TAF programmes.
c) Exhibition of the TAF Scheme, April 1992

To support the National Campaign on Healthy Lifestyle and to complement the implementation of the TAF scheme, MOE participated in the National Health Fair by setting up a booth to display to the public MOE's programmes in relation to healthy lifestyle promotion. The exhibition covered programmes and activities organised in schools and tertiary institutions.


The School Mass Jog was carried out as an event of the Singapore Youth Festival organised by the Singapore Schools' Sports Council. About 50,000 secondary and pre-university pupils participated in the event.

e) NAPFA Testers' Course for Teachers

To date, approximately 3115 teachers have attended the course. The theory section of the course was conducted by the sports medicine doctors from the Singapore Sports Council and the practical session by teacher-instructors. By helping teachers understand concepts of physical fitness and exercise, they are better able to conduct the NAPFA test more effectively.

f) Health Education Course for Teachers

This course was conducted by the Training and Health Education Branch of the Ministry of Health in June 1992 for secondary and pre-university PE teachers. The course content covered disease prevention and risk reduction, exercise, nutrition and weight control, chemical dependence, mental health and stress management. Teachers were also instructed on the use of skinfold callipers to measure body fat. This course will be conducted again in 1993 for TAF scheme coordinators in the primary schools.

g) 3-Day Health Management Seminar for Principals and Vice-Principals

The Health Management Seminars are conducted to equip principals and vice-principals with the necessary knowledge and skills to better plan and implement the Trim and Fit (TAF) programmes in their schools. The seminar programme includes a personal health assessment to enable principals to know their own health status and a broad range of topics related to health like nutrition, exercise, weight control, lifestyle related diseases, stress management and family life.

h) Secondment of Physical Training Instructors (PTIs)

In January 1992, 30 PTIs from the Ministry of Defence were posted to 22 secondary schools as a pilot project to help schools improve the physical fitness of their pupils. Feedback from principals and PTIs on the scheme has been positive. This year, 58 PTIs have been posted to 58 schools to assist in their PE and TAF Club programmes.
"Promoting A Healthy School Tuckshop" - Workshop for Primary School Tuckshop Vendors - February-May 1993

The objectives of the workshop are to provide vendors with a better awareness of the effects of poor nutrition on health. To know the importance of their role in providing healthier food choices for pupils in the school. A teacher serving on the canteen committee has been included in the workshop to assist the school in the evaluation and monitoring of food items sold more effectively. These workshops are conducted in Chinese, Malay, Tamil & English. The programme which will reach out to approximately 1200 vendors includes an illustrated talk, demonstration and tasting reinforced by exhibition panels.


ON-GOING PROGRAMMES

Remediation Programme

a) It is necessary for schools to identify obese and unfit pupils for remediation. The TAF programmes for obese pupils in schools include counselling pupils on proper nutrition and exercise as well as taking them through exercise.

b) Some of the common physical activities of the TAF programmes are jogging, modified games, hiking, orienteering, aerobic exercise to music, and camping. Common activities related to health education are health talks on nutrition and exercise, counselling obese pupils, visiting health fair and health quizzes. Pupils are encouraged to keep a record of their anthropometric data and this is reviewed periodically. Some junior colleges also record their students' body fat percentage.

Health Talks and Exhibitions

c) Individual schools organised talks and exhibitions on healthy lifestyle. Specialist Inspectors from the Home Economics and Physical Education Units and officers from the Ministry of Health provided the assistance.

Nutrition in School Canteens

d) Schools are constantly guiding pupils in the selection of healthy and nutritious food in the school canteen. Measures taken include labelling of "Green Food Items", implementing the approved "Drinks List" and monitoring the sale of food in the school canteen.

FINANCE

9 The Ministry of Education has set aside a sum of $30.11 million for the implementation of the TAF Scheme. This amount will be spent on health and fitness equipment and facilities to help schools carry out their TAF programmes effectively.
EQUIPMENT

10 The following equipment would be supplied to schools/junior colleges and centralised institutes to encourage pupils to drink more plain water and to help schools conduct the NAPFA tests more efficiently as well as to plan and conduct more effective and varied physical fitness programmes.

- Water Coolers
- Electronic Weighing Scale
- Electronic Timer with printer
- NAPFA testing equipment
- Outdoor Fitness Stations
- Indoor Fitness Gymnasium

PRINTED MATERIALS

11 The following printed materials were prepared and issued to schools/junior colleges and centralised institutes to assist them in the implementation of the TAF Scheme.

- Handbook for Schools on Trim and Fit Scheme
- Charts on exercises to improve physical fitness
- Charts on nutrition
- Charts on Weight for Height
- Posters on Physical Fitness Award Scheme
- Pamphlets and self-monitoring booklets on nutrition and physical activities
- List of "Green Food" items
- List of approved drinks for sale in school canteens

TAF INDICATORS

12 All schools, junior colleges and centralised institutes conduct the National Physical Fitness Award (NAPFA) tests and take the weight and height measurements for their pupils annually in the month of August. All NAPFA tests results and the percentage of overweight pupils are analysed. The analyses will then be fed back to schools, junior colleges and centralised institutes for follow-up action.

MONITORING AND EVALUATION

13 The implementation of the TAF Scheme is being monitored closely through school visits by specialist inspectors. A questionnaire has also been designed to gather periodic feedback on the status of the TAF Scheme, with the objective of providing appropriate and timely assistance to schools.
TARGETS

14 Based on the targets set for year 2000, that is an overweight percentage of 9% and a 10 - 20% improvement in physical fitness test, intermediate targets have been set for the different levels. These intermediate targets are derived from the NAPFA test and height/weight measurements taken in 1992. The table for these targets is given in Annex 3.

CONCLUSION

15 It is hoped that through the TAF Scheme in schools, pupils will develop good eating habits and lead an active and healthy lifestyle for life.

Physical Education Unit
Curriculum Planning Division
Ministry of Education

17 March 1993
## TRIM AND FIT (TAF) SCHEME PROGRAMMES IN 1992

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Name of Activity</th>
<th>Status</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Start</td>
<td>End</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>January</td>
<td>11.1.92 11.1.92 Official Launching of the Trim &amp; Fit (TAF) Scheme by SMS</td>
<td>Completed</td>
<td>All schools</td>
</tr>
<tr>
<td></td>
<td>11.1.92</td>
<td>11.1.92 Forum for all Principals</td>
<td>Completed</td>
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</tr>
<tr>
<td>Jan-Dec</td>
<td>28.1.92</td>
<td>27.3.92 NAPFA Testers’ Course</td>
<td>Completed</td>
<td>1615 teachers</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>January</td>
<td>December</td>
<td>Completed</td>
<td>22 schools</td>
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<td></td>
<td>22.2.92</td>
<td>22.2.92 Symposium for VPs and HODs/PE (Secondary &amp; Pre-U levels)</td>
<td>Completed</td>
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<tr>
<td></td>
<td>29.2.92</td>
<td>29.2.92 Symposium for VPs and HODs/PE (Primary level)</td>
<td>Completed</td>
<td>All schools</td>
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<td></td>
<td>29.2.92</td>
<td>29.2.92 Official launching of the NAPFA Scheme (Primary) by MOS (Mr Sidek)</td>
<td>Completed</td>
<td>All schools</td>
</tr>
<tr>
<td>Apr/May</td>
<td>19.4.92</td>
<td>4.5.92 Exhibitions of TAF Scheme materials and exercise demonstrations by students at the National Health Fair</td>
<td>Completed</td>
<td></td>
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<tr>
<td>June</td>
<td>1.6.92</td>
<td>26.6.92 Conduct health education courses for secondary and post secondary PE teachers.</td>
<td>Completed</td>
<td>276 teachers</td>
</tr>
<tr>
<td>July</td>
<td>12.7.92</td>
<td>12.7.92 National Schools Mass Jog</td>
<td>Completed</td>
<td>50,000 students</td>
</tr>
<tr>
<td>May 92</td>
<td>May 92</td>
<td>Aug 92 Conduct physical fitness test and take height and weight measurements for all students</td>
<td>Completed</td>
<td>All schools</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>-</td>
<td>- Counsel students in the Trim and Fit Club on nutrition and exercise. Take students through exercise programme</td>
<td>On-going</td>
<td>All schools</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>-</td>
<td>- Health talks and exhibitions organised at individual school level</td>
<td>On-going</td>
<td>All schools</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>-</td>
<td>- Monitor and evaluate the implementation of the TAF scheme in schools</td>
<td>On-going</td>
<td>All schools</td>
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# TRIM AND FIT (TAF) SCHEME PROGRAMMES FOR 1993

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Name of Activity</th>
<th>Description of Activity</th>
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<tbody>
<tr>
<td>Jan</td>
<td>9.1.93</td>
<td>Award Presentation Ceremony</td>
<td>Presentation of TAF Scheme Awards to schools in bands A and B</td>
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<tr>
<td>Jan</td>
<td>Jan</td>
<td>MOE PTI Scheme</td>
<td>Induction course for PTIs - Swimming, games, fitness conditioning, safety, pupil-management</td>
</tr>
<tr>
<td>Feb-Apr</td>
<td>Feb</td>
<td>NAPFA Testers’ Course</td>
<td>NAPFA Testers’ Course for 1500 teachers in all schools</td>
</tr>
<tr>
<td>Feb</td>
<td>Feb</td>
<td>MOE/PTI Scheme</td>
<td>Secondment of 58 PTIs to 58 secondary schools</td>
</tr>
<tr>
<td>Feb-Jun</td>
<td>Feb</td>
<td>Workshops</td>
<td>Workshops to Promote A Healthy School Canteen (Primary) for Tuckshop Vendors</td>
</tr>
<tr>
<td>Mar-Nov</td>
<td>Mar</td>
<td>Health Management Seminar</td>
<td>Health Management Seminar for Principals</td>
</tr>
<tr>
<td>Jun-Nov</td>
<td>Jun</td>
<td>Health Education Workshop</td>
<td>Health Education Workshops for TAF Scheme Coordinators in all Primary schools</td>
</tr>
<tr>
<td>May-Aug</td>
<td>May</td>
<td>NAPFA Test</td>
<td>NAPFA Test for all pupils from P4 upwards. Height and weight measurement for all pupils from PI to PU3</td>
</tr>
<tr>
<td>Oct</td>
<td>Oct</td>
<td>Health Check</td>
<td>Health Check-up for MOE Staff (To be organised by MERC, staff to pay for the full cost of the check-up)</td>
</tr>
<tr>
<td>Oct</td>
<td>Oct</td>
<td>Games</td>
<td>Inter-division games for MOE staff</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>Jan</td>
<td>Remediation Programme</td>
<td>Conduct remediation programme activities like jogging, sports &amp; games, hiking, etc. for TAF Club Members</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>Jan</td>
<td>Health Talks and Exhibitions</td>
<td>Organise Health Talks, Exhibitions, Quizzes etc. by individual school</td>
</tr>
<tr>
<td>Jan-Dec</td>
<td>Jan</td>
<td>Nutrition in School Canteen</td>
<td>Monitor green food labelling, sale of approved drinks, fruit stall, sale of deep-fried food</td>
</tr>
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Intermediate targets for obesity levels are pegged at 0.5% decline per year from 1992 baseline.

<table>
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<th>Year</th>
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<th>JC &amp; CI</th>
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<tr>
<td>1992</td>
<td>14.29%</td>
<td>14.09%</td>
<td>10.80%</td>
</tr>
<tr>
<td>1996</td>
<td>12.29%</td>
<td>12.09%</td>
<td>8.80%</td>
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<tr>
<td>2000</td>
<td>10.29%</td>
<td>10.09%</td>
<td>6.80%</td>
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Intermediate targets for physical fitness test results are pegged at 2.0% improvement per year from the 1992 baseline.

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<th>Year</th>
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<th>Secondary</th>
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<td>62.34%</td>
<td>52.60%</td>
<td>65.43%</td>
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<td>1996</td>
<td>70.34%</td>
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<tr>
<td>2000</td>
<td>78.34%</td>
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HEALTH AT WORK : STRATEGIES FOR WORKPLACE HEALTH PROMOTION
WORKING GROUP ON HEALTH PROMOTION PLANNING

by Dr Koh Yang Huang
Head, Workplace Health Education Unit
Training & Health Education Department

1. INTRODUCTION

The Workplace Health Education Unit (WHEU) was created with the aim to increase the level of health knowledge of all workers, instil in them positive attitudes towards health, help them acquire the skills necessary to enhance their health and create workplace environment that are conducive for healthy living.

The Unit was formally known as the Employee Health Education Unit when it was first set up in 1984. Prior to this, although health education activities were implemented at the workplace, there was no formal unit as such. The name was later amended in 1990 to Workplace Health Education Unit to reflect more accurately the scope and focus of our work.

2. TARGET POPULATION

Activities are directed at four main target groups:
- Staff of Ministries or Government Organisations which include uniformed personnel
- Staff of Statutory or Semi-Government Organisations
- Staff of Private Organisations
- Staff of Trade Unions

WHEU target population includes the estimated 1.7 million workforce of 13 Ministries, 28 Statutory Organisations, 1,172 Private Organisations which include Hotels, Banks, Factories and Companies.

2. EVOLUTION OF WHEU PROGRAMME

Over the years as the quality of programmes has improved and the number increased, we have also seen an evolution in the scope and focus of workplace health promotion programme in Singapore.

The initial step in this evolution was to persuade the public of the concept of health. Initially programmes that were requested covered disease control, and health was characterized by just the absence of disease. Now people are able to see health more and more as the presence of well-being and that through health promotion, they can move towards a condition of optimal health.
The second step in the evolution of workplace health promotion was greater involvement of the 'consumer' in the planning, implementation and evaluation of the programme. While WHEU continues to play key role in organising projects for the workplace, the emphasis is increasingly shifted to programmes that are implemented by workplace facilitators, with our staff providing consultation and resource support. These facilitators include company doctors, company nurses, prison and drug rehabilitation officers, safety officers, wellness managers, human resource managers, recreation managers and union leaders. Regular training seminars and workshops are organised to help the facilitators function more effectively in their roles as change agents for their workplace.

We realise that if we are to reach our goal of helping people move toward optimal health, we need to recognize that workplace health promotion programmes which limits their strategy to an awareness or behaviour change focus will have limited impact. Utilization of multiple strategies therefore represents the third step in our programme evolution.

3. STRATEGIES

We have realised that to be most effective, we need to utilize three levels of strategies:

3.1 Activities that enhance awareness.
3.2 Activities that encourage behaviour change.
3.3 Activities that create supportive environment.

3.1 AWARENESS PROGRAMMES

Many of our health promotion programmes focus on providing information about the dangers of various health habits. We achieve this through the following activities:

- Distribute educational print materials such as pamphlets, booklets, kits and brochures.
- Display posters.
- Display exhibitions which can be easily set up and dismantled in workplace.
- Organise health fairs.
- Organise health screenings.
- Conduct health talks.
- Organise seminars and forums.
- Screen videos.
- Stage drama and sketches on health-related themes.
- Organise mobile bus exhibition, such as the Smoke-Buster and Smoke-Choker buses.
- Conduct quizzes, contests and computer interactive games.
- Distribute newsletters, such as the Health Education and Health Connection and provides articles on current health issues for inclusion in company newsletters.
The greatest limitation of awareness programmes grows from the fact that changes in knowledge do not necessarily lead to changes in the attitudes and health behaviours.

3.2 BEHAVIOUR CHANGE PROGRAMMES

Recognising the limited impact of awareness programmes, we begin to develop and implement more behaviour change programmes such as:

- **Lifestyle change courses**, e.g. smoking cessation clinics. The first workplace smoking cessation clinic was conducted in 1987.
- **Demonstrations**, e.g. Breast Self-Examination, Nutrition Demonstration, Exercise classes.
- **'In Healthy Company' programme** jointly organised with the National Productivity Board. This is a self-learning package which uses a combination of interactive classroom sessions, home assignments, videos and audiocassettes to provide employees with the skills of how to practise healthy lifestyles. Since it was first marketed early last year, more than 8,000 employees have signed up for the programme.

In addition to teaching specific skills, such programmes provide an opportunity to practice new skills, receive feedback, have access to a subject matter expert, and develop group support.

Unfortunately they have often been shown to be effective in producing short-term behaviour changes, but relapse to previous health behaviours is common. When the course ends, participants leave the supportive environment of the group and return to the 'hostile' environment that helped them form their negative health habits and continued to reinforce them for years. It is difficult to maintain behaviour change without changing the environment too.

3.3 SUPPORTIVE ENVIRONMENT PROGRAMMES

In recognition of the limitations of behaviour change programmes, the WHEU has begun to persuade and work together with workplace management to create workplace environments that encourage and support healthy lifestyles. We achieve this through the following:

- Implementing and enforcing organisational policies that support healthy lifestyles, e.g. smoking restriction policy at workplace, 'Put Smoking To The Vote' project for private organisations.
- Improving physical environments, e.g. water coolers, absence of ashtrays, sales of healthy food alternatives in office cafeteria, lockers and shower facilities.
 Organisation structure. A few workplaces have incorporated health promotion into its organisation structure. The presence of a health promotion department is a clear indication of the organisation's long-term commitment to health promotion.

Programme ownership. Working groups are encouraged and employees' interest and needs surveys are done to encourage employee involvement. This is important because if employees feel that the programmes are forced on them and are not meeting their needs, they will not participate.

Organisation culture. We conduct talks and meetings to encourage positive health role models, especially among top managers. E.g., the seminar organised for CEOs of private companies last year 'Smoking At The Workplace - Appropriate Action', the Cancer Awareness Forum for Women Leaders, Seminars for Union Leaders. We also liaise closely with the National Trade Union Congress and the Singapore National Employers' Federation.

3.4 HEALTH AT WORK PROGRAMME

We realise that to be most effective, an organization needs to create programmes utilizing all three levels of strategies. Awareness programmes stimulate readiness for change. Behaviour change programmes provide the tools to change. Supportive environment programmes create a predisposition to change and reinforce newly acquired health behaviours. Together these three levels of strategies should produce a synergistic effect.

The Health At Work programme combines these three levels of strategies to produce a synergistic effect. It is a workplace health promotion programme package designed to be easily implemented at all workplace at an affordable cost. A working manual is developed to offer a step-by-step guide to how a company can start its own health promotion programme with our support.

4. CHALLENGES

Some of the challenges faced by WHEU are as follows:

4.1 TRAINING OF WORKPLACE FACILITATORS

With more workplaces conducting health education and promotion programmes, we have an even greater need to achieve more with our limited resources. Hence a pool of key workplace health facilitators need to be trained to enable them to plan, implement and evaluate workplace health education programmes. Furthermore, trained facilitators are in a better position not only to assess the needs of their organisations but also to be able to convince and relate to their own management on the need
for a more structured, integrated and long-term workplace health education and promotion programme. We are currently working with the WHO on a training programme for workplace health facilitators.

4.2 MULTIPLE DIMENSIONS OF HEALTH

We would like to see more of our workplace health promotion programmes incorporating the five dimensions of health, namely the physical, intellectual, social, emotional and spiritual health. It is important to note that employees' health is impacted by many dimensions of their lives. For example, an employee who does not smoke, eats a healthy diet and exercises regularly, can have insufficient social support, be depressed and be highly susceptible to a nervous breakdown.

What we hope to achieve is not for employees to strive for excellence in just one dimension, but improvement and balance among all the dimensions.

4.3 BEHAVIOUR CHANGE PROGRAMMES

We will like to develop and reinforce our current behaviour change programmes. As our objective of making people more aware of the importance of having a healthy lifestyle is achieved, we need to provide them with programmes that will give them the opportunity to learn and practise new skills. Specifically such programmes will include:

- Smoking Cessation Programme
- Weight Management Programme
- Nutrition Programme
- Stress Management Programme
- Others - Diabetes Education Programme
- Cancer Prevention Programme

4.4 HEALTH PROMOTION IN SMALL COMPANIES

It has been our experience that most small companies are slow to start health promotion programmes for their staff, when they actually have the most to gain. We will therefore like to see more health promotion programmes organised for such companies. The 'Health At Work' manual has been developed with this in mind. It is a do-it-yourself guide to a company's own worksite health promotion programme. Small companies will also find the 'Health At Work' concept practical as it encourages them to utilise existing community facilities which they otherwise will not be able to afford.
IMPLEMENTATION OF THE PUBLIC SECTOR WORKPLACE HEALTHY LIFESTYLE PROGRAMME

INTRODUCTION

The Public Sector Workplace Healthy Lifestyle Programme was launched on 5 Sep 92 by the Minister for Finance & National Development, Dr Richard Hu. This Programme involves 4 Government Ministries and 3 Statutory Boards in its pilot phase, covering some 38,000 employees. It comprises 2 stages:

Stage 1: Health profiling exercise;
Stage 2: Health improvement programmes.

The National Productivity Board (NPB) and a U.S. company Johnson & Johnson Health Management Incorporated (JJHMI) have teamed up to form the JJ-NPB Company Wellness Centre (CWC) which provides the services to the 7 public sector organisations for the 2 stages under its LIVE FOR LIFE programme.

On 7 Sep 92, the first public sector organisation, Ministry of Finance, commenced the health profiling of its employees at the Treasury Building site as part of Stage 1 of the LIVE FOR LIFE programme. Since then, all 7 public sector organisations under the pilot programme, viz. the Ministries of the Environment, Home Affairs and Health, Port of Singapore Authority (PSA), Public Utilities Board (PUB) and Jurong Town Corporation (JTC) have embarked on Stage 1 of the LIVE FOR LIFE programme. The Public Service Division (PSD) under Ministry of Finance and the PUB have also just gone on to Stage 2, offering health improvement programmes to their employees. To date, more than 7,000 employees from the public sector have taken part in the health profiling exercise. The health profiling of the remaining employees in the 7 pilot organisations should be completed within this year.

This paper outlines the implementation of the Workplace Healthy Lifestyle Programme in the public sector.
ORGANISATION

5 The Workplace Healthy Lifestyle Programme is overseen by a Steering Committee chaired by the Deputy Secretary of the Public Service Division (PSD), Ministry of Finance and comprising key officials from the 7 pilot organisations. Representatives from the Company Wellness Centre and the Singapore General Hospital are also on the Committee. The Steering Committee met 4 times last year. It sets directions for the pilot programme and decides on policy issues. The Secretariat is provided by PSD.

6 Each pilot organisation has formed their own Healthy Lifestyle Committees to work out the specific programmes for employees in their own organisation based on the recommendations put up by CWC. Each organisation has also nominated one or more Management Representatives who are charged with the implementation of the Programme and liaising between the top management of the organisation and the CWC which provides the services.

7 The pilot organisations are divided into geographical sites for the implementation of the Programme. Each site has a Worksite Committee which typically comprises the staff representatives at various levels. The Worksite Committee also includes the union representative at the site, if the workforce is unionised. The Worksite Committee’s roles include collection of data, gathering feedback from employees, promoting the programmes at the site, providing inputs for improvement of programmes, etc.

STAGE 1 ACTIVITIES

8 Stage 1 of the Programme involves conducting a health profile for the employees. The health profile provides employees with a snapshot of their personal health status and is the first crucial step in the Programme, especially in reaching out to employees who hitherto have not been concerned with the impact of their lifestyles on their own health. The health profiling exercise is fully funded by the employer and is held during office hours. The publicity meetings and actual health profiling is conducted on site as far as possible to make it convenient for the employees to take part. As top management support and aggressive publicity are crucial to ensuring high participation rates, these were given priority among the activities of Stage 1. The activities in Stage 1 are summarised below:
Management Representative Training

9 Prior to the start of the Programme, each pilot organisation appointed one or more Management Representatives who are charged with the responsibility of implementing the healthy lifestyle programme in their organisation and liaising between Management and the CWC. In view of their important role, Stage 1 of the LIVE FOR LIFE programme started with training of the Management Representatives. The training was conducted by a Johnson & Johnson consultant on for representatives from all 7 pilot organisations, with the aim of helping them to understand clearly their role and what is required of them.

Planning Process

10 The Accounts Manager from the CWC responsible for the programme in each organisation generally initiated the planning process one to two months before the scheduled date of health profiling. The officers from the pilot organisations are then systematically guided through the planning process. Target dates were also set for specific actions to be taken. Data is also collected to enable the CWC to understand the peculiar characteristics and special needs, if any, of the population at each site.

Publicity

11 In consultation with the CWC, letters were issued by the heads of the organisations to show management's support and to inform employees that the LIVE FOR LIFE programme will be offered to them. The letters explained the programme and encouraged participation in the Information Meetings and Health Profile. Publicity materials such as posters supplied by CWC were put up in visible, high-traffic areas in the offices. These posters gave information on the location, time and dates for the health profile. As further publicity, an "Apple Day" or "Fruit Day" was conducted whereby the Accounts Managers and helpers from each department distributed fruits and leaflets to employees to inform them of the Information Meetings.

Information Meetings

12 Information Meetings were held to explain the health profiling process and address some issues which employees might be concerned about, such as confidentiality. These were conducted during office hours and all employees were encouraged to attend. The turn-out for the Information Meetings was generally very good. As an incentive to attend the Information Meeting, lucky draws were conducted with prizes like pens and LIVE FOR LIFE watches.
Health Profile

13 The health profile was conducted on site by a team of 6 nurses at each site. The health profile measured the total cholesterol, blood pressure, height, weight and body fat composition of the participants. The participants also answered a questionnaire on their lifestyle practices. Based on these data, an individual report was generated. The participants were then given individual counselling based on their health profile results. These results were also aggregated and presented to the Management of each organisation together with recommendations on what health improvement programme should be undertaken in the next stage to improve the employees' health.

EMPLOYEE CHARACTERISTICS

14 The employee population at the first 10 sites profiled was quite diverse in demographic profile. In terms of age, most sites have more than 60% of employees above 35 years of age, with some sites (eg. PUB Building) having as high as 74% of their employees above 35 years of age. The male-female ratio varied greatly between Ministries such as Finance and Health where more than 70% are female to those such as Ministry of Home Affairs where the population is predominantly male. In terms of the jobs they hold, there was a high percentage of managerial/professional and clerical officers in a few sites such as the headquarters of Ministries and Statutory Boards, but some other sites were made up largely of uniformed and technical personnel, who tend to spend a large part of their working hours in the field. There was also a significant number of daily-rated employees from the Ministry of the Environment who were offered the programme.

15 The participation rates at 10 pilot sites ranged from 70% to 98%, with an average of about 89% of employees at each site participating in the health profile.

HEALTH PROFILE GROUP RESULT

16 Despite their different demographic make-ups, the group health profile identified the same key problem areas for all the pilot sites. At every site, the main problem areas were found to be lack of exercise, high cholesterol level and high body fat composition, although the degree varied between sites. Smoking and alcohol abuse were generally not serious problems in most of the sites. These results may be a reflection of the sedentary lifestyle of most of the workers, compounded by poor dietary habits. A summary of the main findings is given below:
Total Blood Cholesterol

17 The percentage of participants at each site with higher than recommended total cholesterol (>200 mg/dl) ranged from 42 to 70, with the majority of sites below 50%. Therefore, this is a significant problem which will be addressed by health improvement programmes during Stage 2.

Body Weight and Body Fat

18 In terms of body weight, more than half of the participants at almost all the sites are within the recommended weight range, with between 18 and 28% overweight and roughly the same proportion underweight. Obesity occurs only in 3 to 4 percent of the participants. However, there was a much higher percentage of participants who were above the recommended range for body fat. This prevalence of high body fat could be attributed to a number of factors, particularly the lack of exercise.

Blood Pressure

19 In general, high blood pressure was not a serious problem at the 10 sites profiled. The percentage of participants who are hypertensive ranged from 9 to 17%.

Aerobic Exercise

20 It was found that about one third of the participants in most sites do not exercise at all, between 48 to 63% exercise once or twice a week and generally less than 20% of participants exercise at least 3 times a week.

Nutrition

21 Based on the answers to the questionnaire, about 40% of participants need to reduce their intake of fat and cholesterol and more than 60% need to increase their intake of fibre.

Smoking and Alcohol Use

22 The percentage of smokers is generally quite low. Alcohol use is also reported to be low.
Level of Stress

23 Between 6 to 8% of participants reported "a lot" or "overwhelming" amounts of stress at home. The figures for work-related stress were higher, ranging from 13 to 26%.

FEEDBACK FROM EMPLOYEES

24 The feedback was generally positive. The promotional activities were well-received, especially the "Fruit Day" which was a novelty for the employees. These activities achieved the aim of publicising the Information Meetings and encouraging people to attend them. The colourful posters and leaflets were also effective in raising awareness of the events.

25 Most employees found the health profile useful as it heightened awareness of their personal health. Even before the start of Stage 2, some employees are already starting to make efforts to change their dietary habits and exercise more as a result of the health profile. In terms of increasing awareness among employees of the importance of healthy lifestyle, the health profile has certainly achieved its aim.

26 Another area was that some of the employees felt that the health profile should include a breakdown of the HDL/LDL ratio. This and other feedback have been conveyed to the CWC for the purpose of making improvements to the process.

STAGE 2 PROGRAMMES

27 The organisations which have received their group health profile and management report are currently studying the recommendations of the CWC before proceeding on to Stage 2 of the LIVE FOR LIFE programme. According to the health profile results, the main problems faced by most organisations are lack of exercise, high cholesterol, excess body fat, and a diet rich in fat and cholesterol but low in fibre. These form the priority areas that will be tackled in Stage 2 of the Programme.
28. The programmes in Stage 2 follow a 3-tier strategy of awareness, motivational and behavioural change programmes:

(a) **Awareness Programmes** - aimed at raising employees’ awareness about areas of health need and potential steps for change. They are targeted at a broader employee base to create initial interest in making those changes.

(b) **Motivational Programmes** - action-oriented, enjoyable and non-threatening health improvement activities that generate enthusiasm for taking more concrete steps toward lifestyle change.

(c) **Behavioural Change Programmes** - encompass awareness and motivational activities that involve skill development, assessment and practice vital to successful and long-term lifestyle change.

29. Typical health improvement programmes include exercise, stress management, weight management, nutrition programmes, etc. These will be conducted at the workplace. However, employees are also encouraged to attend programmes provided by the community service-providers such as community centres, People’s Association, etc. They are also encouraged to exercise on their own or with colleagues. The health improvement programmes at the workplace will be supported by promotional events, environmental supports, as well as integration of existing sports/recreation activities and enhancement of in-house facilities, where feasible.

30. Most of the health improvement programmes are held during lunchtime or outside office hours. To encourage employee participation in certain activities, the employer could consider giving time-off for attendance at these activities. Employees could also be given a certain amount of flexibility to alter their working hours to make it more convenient to attend such activities but they have to make up for it at another time so that the total number of working hours are not reduced. In this way, the employer shows his commitment to the programme but the employee is also required to put in his own time and effort. This drives home the message that the individual is also responsible for his own health and well-being.

**INCENTIVE SCHEME**

31. An incentive scheme has been established to support the Workplace Healthy Lifestyle Programme. The aim is to increase and sustain participation in healthy lifestyle activities. A common point system will be adopted by all 7 pilot organisations whereby employees will earn points for taking part in health
improvement programmes organised under Stage 2 of the Programme or if they exercise on their own. The points are awarded based on the level of effort put in or commitment required to complete a series of activities.

32 Each employee will be given a card at the onset of Stage 2 in which he can record the programmes or activities he has participated in. The card also enables them to record some of their body measurements, such as weight, height, waist/hip ratio and blood pressure. These are chosen as they are easily measurable indicators that individuals can use to track their own progress.

33 With the points collected, employees can take part in periodic lucky draws and win prizes which are related to healthy lifestyle, such as exercise equipment, sports wear, health-check equipment, etc. The very active ones are also recognised with awards of incentive items to encourage them to continue their healthy lifestyle and be role models for the others.

CONCLUSION

34 The implementation of the Public Sector Workplace Healthy Lifestyle Programme has been proceeding smoothly so far. In the next few months, the main activity, besides completing the health profiling of the employees in the remaining sites, will be the launch of Stage 2 for those sites which have completed Stage 1. The Programme will be reviewed one year into the implementation of Stage 2.

Prepared by: Lau Kim Yang
Dy Director (Personnel Development)
Public Service Division

Approved by: Tan Boon Huat
Deputy Secretary
Public Service Division
NATIONAL SMOKING CONTROL PROGRAMME (1979 - 1992)

The first laws to control smoking were enacted in 1972. In 1979 smoking education started in conjunction with a National Campaign on Diseases Due to Harmful Lifestyles. Following this a series of talks and exhibitions were held in schools, as part of an ongoing 'Smoking and Disease' programme.

In 1983, a "Superman Against Nick O'Teen programme was launched for school children. 50,000 children aged 10-12 years wrote in to help Superman.

From 1985 to 1987, the problem of passive smoking was included in public education programmes. The Programme to establish hospitals and clinics as smoke-free areas began in 1985. The media was used together with videos in "health corners" in waiting areas in government clinics.

In 1986 a comprehensive long-term programme for smoking control spearheaded by the Ministry of Health was launched. The theme of the programme is "Towards a Nation of Non-smokers". It aims to reduce smoking rates through education, publicity, the establishment of no-smoking areas and services for smoking cessation, taxation and legislative measures. All sectors of society would be reached, with emphasis on the youth.

A National Smoking Control Coordinating Committee was set up, comprising representatives from 8 ministries, the trade unions and private sector employers. There are 34 other main participating organizations in the Programme. In 1990 the total number of participating organizations was increased to 50.

Public education and information

The Programme was launched on 1 Dec '86 with a 3 month publicity and education campaign which included more than 500 television commercials, 2,500 radio spots, 100 newspapers advertisements, and 100 newspaper articles. 400 buses, 1,000 exhibition panels and banners and well over 1,000,000 pamphlets and posters carried the campaign messages. A local football star, a television actor and a pop singer, all popular with youths, appeared on poster subadvocates against smoking. Exhibitions and other programmes were held at community centres, schools, youth clubs, armed forces camps and workplaces.
A Smoke-Free Week was held from 11-17 Jan '87, starting with a walk and concluding with a public concert in the Botanic gardens. Materials encouraging smokers to give up smoking was distributed through workplaces, at shopping centres and pedestrian malls. From June - Sept 87, a programme targetted at youth was carried out.

In 1988, the focus was to encourage the public to ask for no-smoking sections when eating out. In addition, the less obvious yet important consequences of smoking were publicized. In conjunction with Smoke-Free Week 88, (7 - 13 April '89,) a smoking death toll clock was erected to display the deaths in Singapore attributable to smoking. Patient education programmes and seminars were held to encourage doctors and teachers to participate in smoking control efforts.

In 1990, the campaign had the theme 'Growing up without Tobacco'. The month-long campaign combined mass-media advertising and community events. Nine competitions including song and rap composition, poster design and science projects were open to those under 30. The media campaign portrayed non-smoking as glamorous, trendy and healthy. A 5-day smoking cessation programme was telecast in English on prime time and reinforced daily by a full page of supportive articles in the main newspaper. Pop concerts and dramas with the no-smoking theme were held in shopping centres.

Workshops were held for doctors and teachers to involve them in smoking education activities. A programme was held in 55 workplaces to encourage employees to vote for a smoke-free workplace.

Singapore's third Smoke-Free Week was launched with a Youth Rally where well-known personalities shared their views on a smoke-free lifestyle with 1000 youths.

For 6 months following the Campaign, two buses converted into mobile exhibitions toured community centres, shopping centres and army camps.

In 1991, a month-long campaign with the theme "We have the right to Smoke-Free Air" was launched on 4 May 91 with a seminar for youth leaders. Guest speakers Mr. David Simpson, Action on Smoking and Health (UK) and Dr. Arthur Chesterfield-Evans of Non-Smokers Movement (Australia) also participated in other seminars organised for principals, teachers, parents, doctors and nurses. The mass-media campaign focused on youth with the slogan "Get Smart- Don't Smoke using a rap as a TV commercial. The campaign achieved 93% awareness.
Several workplace programmes were held. Private and government hospitals and clinics conducted education programmes for staff and patients. All babies born during Smoke-Free Week were given T-shirts with slogans promoting a smoke-free environment.

During Smoke-Free Week 91, a Smoke-free party was held on the main shopping street of the city which was closed to traffic. Fitness demonstrations, a concert, competitions, guest appearances by local stars and lucky draws attracted about 60,000 people.

In 1992 the emphasis was on passive smoking. The campaign was launched on Smoke-Free Week with an exhibition and pop-concert at a shopping centre. Guest speaker Dr Judith Mackay participated in seminars organised for students and employers. The Singapore Cancer Society held a youth rally and a walk-a-jog to commemorate World-No-Tobacco Day. Leading retail and departmental stores again supported the programme by not selling tobacco products on 31 May 92.

The media campaign after the Week had the slogan "Smokers Put Us All At Risk". Press, TV and print materials were used to inform on the harmful effects of passive smoking.

Legislation

The existing legislation was reviewed and revised to strengthen smoking control efforts.

On 1 July 88, the Prohibition of Smoking in Certain Places Notification was extended to include hospitals, clinics, maternity homes, nursing homes, fast food restaurants, indoor skating rinks and roller discotheques. This was further extended on 1 Nov 89 to cover public libraries, libraries in institutions of higher learning, public museums, art galleries, any air-conditioned multi-purpose hall or room used for public functions, air-conditioned supermarkets, mini-supermarkets, indoor sports arenas (stadium, bowling alleys, billiard saloons, gymnasiums, aerobic and fitness centres, air-conditioned restaurants and 31 departmental stores.

On 2 Oct 89, amendments to the Poisons Act were passed to restrict the sale of cigarettes in Singapore to those containing less than 15 mg tar and 1.3 mg nicotine. Amendments to the Consumer Protection (Labelling of Tobacco Products
Containers) Regulations were made to require tobacco companies to equally rotate within one year, four clearly displayed health warnings on packages of tobacco products sold in Singapore. These warnings are:

- Smoking causes heart disease - Government warning
- Smoking causes cancer - Government warning
- Smoking damages your lungs - Government warning
- Smoking harms those around us - Government warning

The tar and nicotine content of cigarettes must also be displayed on the package.

On 1 Jan 90, the Smoking (Prohibition on Advertisements) Act was amended to remove exemptions allowed in the 1970 Act.

Advertisements on notices containing tobacco product brand names, names of tobacco manufacturers or distributors or any symbol or picture associated with these will not be allowed. Such notices will no more be allowed at tobacco retail outlets, and on vehicles, souvenirs or gifts. Tobacco products cannot be offered as prizes or free gifts alone or with another product or vice versa. The Minister for Health will approve any application for use of any tobacco brand or manufacturer's name as a sponsor of an event or in a congratulatory message. These notices should not promote smoking.

On 1 Jan 91, the removal of duty-free privileges for cigarettes for all inbound travellers was implemented.

In 1992, the amendment to the 'Prohibition of Smoking in Certain Places Notification' extended prohibition of smoking in banking halls, air-conditioned barber shops and hair dressing salons, private buses, school buses and taxis, court buildings.

The management of places (restaurants, billiard clubs) where smoking was banned were made liable for a fine if they did not enforce the law.

In February 93 the different legislations on smoking under the purview of the Ministry of Health were placed under the Smoking (Control of Advertisements and Sale of Tobacco Act) 1992. Three new laws were included to prohibit the supply to persons below age of 18 years, smoking and possession of tobacco products in public by persons below 18 years and sale by vending machines.
No smoking areas

In 1987, a survey revealed that 82% of adults supported prohibition of smoking at work and public places. 15,000 copies of a booklet encouraging the setting up of no smoking areas were sent to workplaces. By the end of the campaign in early 1987, civil service offices had become smoke-free and sale of cigarettes was disallowed in their office canteens. Many private sector workplaces had set up smoke-free areas. Fastfood restaurants voluntarily declared their outlets smoke-free for the campaign period.

Legislation to make more public places smoke-free was passed in 1990 and the Put it to the Vote programme was introduced to private workplaces to help extend the smoke-free work workplace concept. The booklet 'A Healthier Workplace - Clearing the Air' was updated and distributed again in 1992.

Smoking cessation

In 1986 two "quit kits", one for smokers and another for "helpers" were developed and advertised. There were 10,000 requests for the smoker’s kits and 12,000 for the helper’s kits from members of the public. A new programme for doctors to routinely educate their patients about smoking was introduced to private practitioners as well as government doctors. The Ministry of Health started group counselling services for smoking cessation.

The Singapore Cancer Society and the Youngberg Adventist hospital conduct regular cessation clinics. Some schools have set up clubs to help smokers stop their habit and remain smoke-free.

Taxation

As part of the economic measures against smoking the tax on imported and locally produced cigarettes has been increased gradually from 1987.
Monitoring and evaluation

The Smoking Control Programme in Singapore is constantly monitored to evaluate its effects and to plan new strategies.

There has been a decline in total cigarette consumption, per capita consumption and population smoking rates since the launch of the National Smoking Control Programme. But in 1992 survey results showed a slight increase in the rates. This was again noted in a survey done in 1992.
## Cigarette Consumption and Smoking Rates
### (Selected Years, 1970-1991)

<table>
<thead>
<tr>
<th>Year</th>
<th>Cigarette consumption (million kg)</th>
<th>Per capita* consumption (kg)</th>
<th>Population smoking rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>3.146</td>
<td>2.48</td>
<td></td>
</tr>
<tr>
<td>1974</td>
<td>3.610</td>
<td>2.46</td>
<td></td>
</tr>
<tr>
<td>1977</td>
<td>3.783</td>
<td>2.34</td>
<td>23% (1977)</td>
</tr>
<tr>
<td>1978</td>
<td>3.828</td>
<td>2.39</td>
<td></td>
</tr>
<tr>
<td>1982</td>
<td>4.351</td>
<td>2.37</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td>4.198</td>
<td>2.20</td>
<td>19% (1984)</td>
</tr>
<tr>
<td>1986</td>
<td>4.059</td>
<td>2.06</td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>3.351</td>
<td>1.87</td>
<td>13.6%</td>
</tr>
<tr>
<td>1988</td>
<td>3.639</td>
<td>1.79</td>
<td>13.5%</td>
</tr>
<tr>
<td>1989</td>
<td>3.543</td>
<td>1.72</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>3.210</td>
<td>1.55</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>3.380</td>
<td>1.59</td>
<td>15.7%</td>
</tr>
<tr>
<td>1992</td>
<td>3.511</td>
<td></td>
<td>18%**</td>
</tr>
</tbody>
</table>

* based on population 15 years and above

** based on population 18 to 64 years
# MEASURES UNDERTAKEN TO DISCOURAGE SMOKING IN SINGAPORE

## (A) LEGISLATIVE MEASURES

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>Prohibition on Smoking in Certain Places Act: prohibition of smoking in cinemas, theatres, and other specified buildings, and buses.</td>
</tr>
<tr>
<td></td>
<td>Prohibition on Advertisements Relating to Smoking Act: prohibition of any advertisement which encourages the use of cigarettes or any form of tobacco in printed materials, TV or radio EXCEPT (a) souvenirs, mementos given free of charge or as gifts (b) vehicles of tobacco retailers and distributors (c) notices at premises where tobacco is sold</td>
</tr>
<tr>
<td>1980</td>
<td>Consumer protection (Warning Against Danger of Smoking) Regulations: statutory requirement for cigarette containers to carry Government Warning &quot;Smoking Can Damage Your Health&quot;.</td>
</tr>
<tr>
<td>1983</td>
<td>Prohibition on Smoking in Certain Places Notification: prohibition of smoking extended further to cover amusement centres.</td>
</tr>
<tr>
<td>1985</td>
<td>Administrative prohibition on smoking in Government hospitals and clinics.</td>
</tr>
<tr>
<td>1987</td>
<td>Administrative prohibition on smoking in all public buildings.</td>
</tr>
<tr>
<td>1988</td>
<td>The Smoking (Prohibition in Certain Places) Notification: prohibition of smoking extended further to cover hospitals, maternity homes, medical clinics and nursing homes, fast-food restaurants, indoor skating rinks and roller discotheques.</td>
</tr>
</tbody>
</table>
(A) LEGISLATIVE MEASURES (Contd)

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
</tr>
</thead>
</table>
| 1989 | The Consumer Protection (Labelling of Tobacco Product Containers) Regulations: statutory requirement that every container of tobacco products must conspicuously print on the package -  
(a) in rotation one of the following Government Warnings:  
i Smoking Causes Heart Disease  
ii Smoking Causes Cancer  
iii Smoking Damages Your Lungs  
iv Smoking Harms Those Around Us  
and  
(b) additionally, in case of cigarettes, the tar and nicotine content.  

The Poisons (Amendment) (No 2) Rules: any cigarette containing 1.3 mg of nicotine and/or 15 mg of tar would be classified as poison under the Poisons Act. This would restrict the sale of cigarettes in Singapore to those containing below the permissible levels of nicotine and tar.  

The Smoking (Prohibition in Certain Places) Notification: prohibition of smoking extended further to cover air-conditioned restaurants, departmental stores, supermarkets, mini-supermarkets, indoor stadiums, bowling alleys, billiard saloons, gymnasiums, aerobic and fitness centres, convention halls and multi-purpose halls used as meeting places.  

The Smoking (Prohibition on Advertisements) (Amendment) Bill: removes exemptions in the 1970 Act and prohibits all forms of tobacco advertisements and sales promotion.  

1991 Removal of duty-free privileges for cigarettes for all inbound travellers.  

1992 The Smoking (Prohibition in Certain Places) Notification was amended to extend prohibition of smoking in private buses, school buses and taxis. It also made it the duty of the management or operators of specified places and vehicles to inform any smokers to stop. Failure to do so, makes the management liable to a fine.
1993  The Smoking (Control of Advertisements and Sale of Tobacco) Act 1992 This Act combined all the various laws on smoking under the purview of the Ministry of Health. Several new sections were included:
i) Prohibition of sale or supply of tobacco products to persons below 18 years of age.
 ii) Prohibition of smoking, chewing or possession of tobacco products by young persons below age 18 years.
 iii) Prohibition of sale of tobacco products by vending machines.
 iv) Prohibition of sale of imitation tobacco products.
 v) The power to license tobacco retailers.

(B) HEALTH EDUCATION MEASURES

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>National Campaign on &quot;Diseases Due to Harmful Lifestyles&quot;, with special emphasis on smoking, launched.</td>
</tr>
<tr>
<td>1980-83</td>
<td>Educational programmes on anti-smoking targeted at school children and national servicemen conducted.</td>
</tr>
<tr>
<td>1983</td>
<td>&quot;Help Superman Fight Nick O' Teen&quot; programme conducted in primary schools.</td>
</tr>
<tr>
<td>1984</td>
<td>- Education on harmful effects of smoking included in primary school health education syllabus.</td>
</tr>
<tr>
<td></td>
<td>- Publicity on harmful effects of passive smoking given in the mass media.</td>
</tr>
<tr>
<td>1986</td>
<td>- &quot;Healthy Heart Healthy Life&quot; programme, emphasizing smoking as one of the main risk factors of heart disease, launched.</td>
</tr>
<tr>
<td></td>
<td>- National Smoking Control Programme &quot;Towards A Nation of Non-Smokers&quot; launched, followed by a 3-month publicity and education campaign.</td>
</tr>
<tr>
<td>1987</td>
<td>- Singapore's First Smoke-Free Week: launched with a walk from Orchard Road, ended in the Botanic Gardens with a public concert.</td>
</tr>
</tbody>
</table>
A mass media education programme focused on youth was carried out.

- Smoking cessation clinics set up.

- Medical Advisory Committee on Smoking Control set up.

1988

- Conduct of mass media programme focusing on non-smoking areas in restaurants and the harmful effects of smoking to smoker and family.

- Singapore's second Smoke-Free Week: erection of the Smoking Death Toll Clock for 1988 and 1989. The Smoking Death Toll Clock was first erected during Smoke-Free Week 1988. It displayed the number of deaths in Singapore statistically attributable to smoking. The clock was first placed in a junction of Orchard Road (the main commercial street of Singapore) for 6 months, then moved to another part of the city. It was dismantled in 1989 as it was not a permanent structure.

- Intensive publicity over mass media.

- Public exhibition on harmful effects of smoking.

- Departmental stores requested not to sell tobacco products during the Smoke-Free Week.

1989

- Heart Health Package which included smoking education introduced in primary schools.

- National Health Fair: an exhibition in a 5524 sq metre hall which drew 390,000 visitors. Smoking was one of the lifestyles focused.

1990

- Conduct of mass media advertising and education programme focusing on youth, portraying not smoking as glamorous, trendy and healthy.

- Private workplaces were asked to vote for a smoke-free working environment in the 'Put It To The Vote' programme.

- 'Stop Smoking Kit' workshops for general practitioners, Smoke-free workshop for childcare personnel and kindergarten teachers/supervisors; and in hospitals, polyclinics, schools exhibitions and talks were conducted.
Singapore’s third Smoke-Free Week 
(25-31 May)

- launched with a Youth Rally
- a smoking cessation programme were conducted on 
television supported by a series in the main focal English 
newspaper.

- Mobile exhibitions on two buses toured the whole island for six 
months, visiting schools, army camps, workplaces and public 
areas.

- Concerts and plays on non-smoking were held in shopping 
centres.

1991

- A month-long campaign launched (4-31 May).

- Seminar "Smoking and Youth - Confronting the Issues" (4 May). 
  Guest speakers Mr David Simpson and Dr Arthur Chesterfield.

- Seminar "Tobacco and Out Youth" for principals, parents and 
teachers (5 May)

- Seminar "Smoking Why You Ought to Care" for doctors and 
nurses (6 May).

- Month-long media advertisement focused on youth "You Want to 
  Get Smart - Don't Smoke. A local rap on TV.

- Put It To The Vote programme in workplaces.

- Educational programmes and activities in hospitals and clinics.

- Smoke-Free Party (26 May) in Orchard Road with a live concert, 
  fitness displays, celebrity testimonials and endorsements of a 
  smoke-free lifestyle and 'Aladdin Exchange' of items with tobacco 
  brand names for hampers and lucky draw prizes.

1992

- A month-long media education programme 
  (23 May to 21 June).

- Launch of week-long public exhibition at Marina Centre shopping 
mall.

- Seminar for medical students.
- Seminar for management staff of private sector.

- Pop concert at Marina Centre with NTUC Radio Heart (23 May).

- Pop concert with SBC 98.7 and 95.8, also aired live (31 May).

(C) TAX MEASURES

<table>
<thead>
<tr>
<th>Year</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>Tax measures used for the first time in 1972 to support the Government Campaign against smoking. Duty on cigarettes and other tobacco products were revised upwards in line with this official policy to discourage smoking.</td>
</tr>
<tr>
<td>1974</td>
<td>Duty on cigarettes and other tobacco products were further raised during each of these years 1977</td>
</tr>
<tr>
<td>1975</td>
<td>partly to add impetus to the national effort</td>
</tr>
<tr>
<td>1980</td>
<td>to discourage smoking. Between 1972 to 1989,</td>
</tr>
<tr>
<td>1983</td>
<td>the duty on locally manufactured cigarettes</td>
</tr>
<tr>
<td>1984</td>
<td>had risen by 13-fold from $3 to $40 per kg</td>
</tr>
<tr>
<td>1987</td>
<td>and imported cigarettes by nearly 3-fold from</td>
</tr>
<tr>
<td>1988</td>
<td>$31 to $85 per kg.</td>
</tr>
<tr>
<td>1989</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>Tax increase: local $50 per kg and imported to (April) $100 per kg.</td>
</tr>
<tr>
<td>1993</td>
<td>Tax increase: Local $60 per kg and imported $115 per kg.</td>
</tr>
</tbody>
</table>
KYOTO CITY — THE ROAD TOWARDS A HEALTHY ENVIRONMENT

November, 1991

Kyoto City
1. THE CITIZENS PLAY A MAJOR ROLE IN KYOTO

Japan is taking up the challenge of a new theme: "The realization of affluence" where benefits resulting from economic and technological progress are given back to the people.

A great many advantages have been gained thanks to economic growth and technological breakthroughs. However, looking at conditions in our city there are still many things lacking or even lost such as mental fulfillment, strong ties between people and between man and nature, etc. Some people do not even have the benefits that others are enjoying.

The "realization of affluence" therefore involves city development to improve the quality of life and provide a suitable stage where people can dwell, work, learn, play and relax. The challenges for a city today, are to accomplish goals and regain the qualities that have been lost.

Kyoto is not only an energetic megalopolis, but also a city of charm, unique because of its long history and culture. Also our city has many traditions fostered by the people themselves. With all its beauty and 1,200-year history of tradition, Kyoto should be a leading city in the development of facilities to ensure an affluent life for its people.

2. "HEALTH" IS THE KEY TO CITY DEVELOPMENT

As a result of improved standards of life and medical and technological progress, many diseases have been overcome and life expectancy has risen to 80 years of age. Efforts are now being expanded from overcoming illness and disability to encouraging its prevention by maintaining good mental and physical health. Today, in this aging society, the major problem confronting us is how to enjoy full, long lives. A healthy life style reflected in our dwelling, working place, learning
environment and place for amusement and relaxation is very important.

"Health" is one of the most significant factors in our lives. "Kyoto City — The Road Towards a Healthy Environment" is the guideline and evidence of the commitment to develop our city. Kyoto is also a "World City Open to Cultural Exchange" and by showing the desire to play a greater part in the world this demonstrates how the relationship should be between an urban city and the people that come into contact with it.

The good "health" of a city is improved by the participation of its citizens and we hope our guideline will encourage individuals to be healthy.
II. PROFILE OF A HEALTHY CITY — KYOTO

1. The Goal of a "Healthy City"

The "health" for which we are searching is to lead a life worth living with high standards for dwelling, working, learning, enjoying and relaxing environments and a healthy city should supply these facilities.

**Health of the People**

Each individual must have their own sense of worth in order to have a happier, more productive life. Nowadays, adult diseases caused by over-indulgence account for 70% of deaths. It should be our common goal to improve and maintain our fitness level whether we are ill or not and thus attain self-fulfillment and enjoyment.

A "Healthy City" should provide each one of us with equal opportunities to better our health and encourage us all to improve the quality of our life in accordance with our own sense of values.

**Health of the Community and Society**

Good health is enhanced by close human relationships. Therefore the community and society should firmly support one another, respect the dignity of life and uphold human rights.

**Health of the City and Nature**

Cities should provide necessary facilities and services to support us in our endeavors towards good health and the environment should be beautiful as well as safe, at one with nature.

A "healthy city" can be defined as a city where human dignity and rights are highly valued and where everyone is assured of an equal opportunity to maintain good health in an environment enhancing healthy human relationships.
2. Profile of a “Healthy City — Kyoto”

Kyoto is an attractive city surrounded by nature and rich in history and culture, where its citizens enjoy full lives in the beauty of the changing seasons. Kyoto is also an economic hub boasting many different industries which have prospered through the hard work and activities of the local people. These features are much admired by visitors from all over the world.

Using all of its resources to create a “Healthy City — Kyoto” enabling its inhabitants to live a full life in a city environment, the Kyoto City Government has conceived 10 objectives in cooperation with citizens, groups and the business sector.

The main goal is to create a city: where there is a healthy exchange of friendship between young and old and where all the visitors can actually experience good health for themselves.

Health of the people — To create a city where a higher quality of life is achieved

(1) By providing improved medical, health and social welfare services for a gradually aging society.
   - Encourage an active network for health maintenance, preventive treatment, thorough medical examination, earlier treatment, emergency medical care, relief for disabilities, and rehabilitation.
   - Make available the required information to decide applicable services necessary according to age and physical fitness level of the individual.
   - Ensure that both elderly and handicapped people alike have more opportunities to work and participate in society and thus lead happy lives.

(2) By providing public facilities in natural surroundings where citizens can enhance their physical fitness.
   - Increase facilities and public spaces near the home and work place, and also make information available to citizens on the best use of mountain, river and farming areas surrounding the city to enhance physical fitness.
(3) By encouraging productive change within the city while preserving its history and culture.
- Supply abundant opportunities for lifelong education through courses providing exchanges with a variety of people in various fields such as religion or the arts.
- Create an enjoyable atmosphere at shopping centers, parks and public squares by promoting seasonal events.

Health of the community and society—To create a city where its citizens live in harmony with one another

(4) By recognizing the importance of human rights and applying this practice to everyday living.
- Provide numerous occasions for people to see and experience other ways of living, therefore cultivating a generous and unbiased way of thinking towards different values and customs.
- Promote human rights and the dignity of life.

(5) By developing ties between people through their participation in a variety of activities.
- Develop a network of talented people by supplying them with information on available organizations, agencies and the assistance of experts.
- Promote the formation of different groups involved in a common enjoyment.

(6) By creating a community where young and old alike can live in harmony together.
- Create a comfortable living environment for the different types of family units: aged families, families with young children, and three generation families.
- Encourage exchange between different generations at local events, festivals and in everyday life thus making it possible for knowledge and culture to be passed down.
Health of the city and nature—To create a city that encourages a healthy environment

(7) By installing pride and happiness in its citizens to live in such a beautiful place at one with nature and history.
  - Develop a new modern city with land utilization specifications protecting nature and Kyoto's historical landscape.
  - Maintain a clean and beautiful environment by cooperation between government and citizens.
  - Preserve many cultural, historical and academic assets to attract visitors from all over the world and further expand international friendship.

(8) By making it a place conducive to work, learning, amusement and relaxation with one's family and friends.
  - Promote the merits of living and working in Kyoto, while further developing a change of industrial method from traditional to high-technology.

(9) By improving facilities and increasing public space for safe and convenient use.
  - Make available much needed well-run facilities and improve city areas so that they are safe for everyone including the elderly and handicapped.
  - Develop measures for protection in case of disaster to ensure a safer living environment.

(10) By acknowledging the necessity of a harmonious co-existence between man and nature and the need for protection of the blue sky and atmosphere; rivers and water; mountains and greenery.
  - Change our habit of throw-away consumption to one of resource-saving and recycling to help the world maintain sustainable growth.
  - Achieve a fulfilling life style in harmony with nature.
III. STEPS TOWARDS A HEALTHY CITY — KYOTO

Kyoto City government has formulated comprehensive policies in line with the ten objectives shown in Chapter II, "Profile of a Healthy City — Kyoto". These policies will be carried out in 1992 as part of a new Kyoto City project for city development, in cooperation with citizens, local groups and businesses. The Kyoto city government is therefore presenting 5 Key Policies to be accomplished by both the administration and local citizens. These policies are in response to problems revealed by the Advisory Committee of "Kyoto — the Road Towards a Healthy Environment" and "One Hundred Citizens on Healthy City Kyoto" and will be initiated as soon as possible.
1. Key Policies

① A long life in good health
(Improving medicine, health and social welfare in preparation for a aged society)

In today's aging society adult diseases caused by over-indulgent life styles account for 70% of the deaths of our citizens. The number of these diseases as well illnesses causing elderly patients to be bedridden and and senile dementia need to be reduced.

<table>
<thead>
<tr>
<th>To Improve life styles</th>
<th>Supply information as a guide to improving life styles.</th>
<th>Place promotional material at fitness centers for citizens such as information on non-smoking areas in public places.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve local sporting facilities to increase fitness levels.</td>
<td>Construct public sports centers, improve local gymnasium facilities and provide hiking tracks.</td>
<td></td>
</tr>
<tr>
<td>Expand home services.</td>
<td>Improve home welfare services including home help assistance, short stay and day service projects and home-visit rehabilitation. Introduce home-visit medical care, and enhance counseling support for families with a dementia patient or seriously handicapped family member.</td>
<td></td>
</tr>
<tr>
<td>Improve facilities.</td>
<td>Improve special nursing homes, day care centers, public health centers, facilities for the physically or mentally handicapped.</td>
<td></td>
</tr>
<tr>
<td>Provide more staff.</td>
<td>Educate staff engaged in health and medical welfare. Initiate a comprehensive volunteer program.</td>
<td></td>
</tr>
<tr>
<td>Improve the emergency medical system.</td>
<td>Provide access to first-aid medical information for citizens. Increase the number of emergency-aid rescue staff and strengthen the tie-in with doctors.</td>
<td></td>
</tr>
</tbody>
</table>

Requirements for all citizens and companies in the business sector
- To enhance physical fitness by leading a healthy life style.
- To create a community support network to help the elderly and disabled.
- To make available company sporting facilities to the general public.
- To monitor health within companies.

Targeted projects

| To Establish a Research Fund for Good Health | Establish a Research Fund for Good Health in cooperation with local citizens and the business sectors. This fund aims to sponsor research carried out by appropriate individuals and research institutes on how to improve health in an aging society. The results of the research are fed back to the citizens and the people throughout the world. |
| To establish measures on overcoming adult diseases | Establish counter-measures against adult diseases in an effort to dramatically decrease the occurrence of the bedridden elderly and the death rate from these illnesses. An effective course of action should be planned on the best way to improve citizens' life styles and public health centers developed to meet the needs of an aging society. |
② Goodwill among all (realization of spiritual affluence)

Kyoto City upholds all human rights and encourages the development of relationships thereby creating a spiritual affluence. With prolonged life expectancy and more leisure time, quality of life has become a most important issue.

<table>
<thead>
<tr>
<th>To provide acceptance and support of others by creating a human communication network</th>
<th>Enhance consciousness of human rights</th>
<th>Promote further understanding of human rights by the establishment of a &quot;Human Rights Research Center&quot; (name to be finalized) thereby encouraging spiritual education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organize volunteer network.</td>
<td>Promote training of volunteers and establish a group of youth leaders.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To encourage life-long education within the local community</th>
<th>Provide facilities for life-long education.</th>
<th>Encourage open school classrooms for the general public, improve library facilities and establish &quot;Women's Information Center&quot; (name to be finalized).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form systems to organize life-long education system.</td>
<td>Establish a network of educational courses and introduce a Festival encouraging life-long education.</td>
<td></td>
</tr>
<tr>
<td>Preserve customs and culture.</td>
<td>Collect and exhibit more historical and craft items, re-introduce festivals and promote these activities among all generations.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To become more nature-oriented</th>
<th>Preserve natural surroundings.</th>
<th>Preserve greenery, river and mountain environments as well as historical background. Encourage active farming and forestry policies and prevent littering or illegal garbage dumping by save-our-environment education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide opportunities for local citizens to mix together.</td>
<td>Projects for the reforestation and improvement of farming villages and parks. Construction of parks in Omi and Umekoji. Organize a National City Greenery Fair.</td>
<td></td>
</tr>
</tbody>
</table>

Requirements for all citizens and companies in the business sector

- To promote human rights education within the family, community and workplace.
- To follow a spiritually affluent lifestyle.
- To promote community exchange among different generations.
- To encourage fair practices in business management respecting human rights.
- To shorten company working hours and introduce day-off system for volunteer activities.
- To encourage business sector sponsorship of community cultural activities.

Targeted projects

<table>
<thead>
<tr>
<th>To Establish a &quot;Creative Activities Center&quot;</th>
<th>A Creative Activities Center would provide various educational courses for citizens and an information network for volunteer opportunities to enrich their lives. Classrooms and a research library would enable work on various projects and the education of those who wish to contribute even more to society on the basis of knowledge acquired here. Teachers for the courses would be Kyoto citizens qualified in different fields.</th>
</tr>
</thead>
</table>
## A comfortable life encouraging city dwelling

Kyoto City wishes to provide a healthy, spiritually affluent environment for family living. The population of Kyoto city has declined recently due to the loss of couples with young children re-locating outside the city environs. This trend is particularly evident in the city center. Our goal is to make Kyoto a more attractive city appealing to all generations with the convenience of work place, cultural facilities and leisure activities located nearby.

<table>
<thead>
<tr>
<th>To provide city condominium housing</th>
<th>Provide houses for senior citizens.</th>
<th>Provision of housing with supervised care.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide new deluxe apartments.</td>
<td>Provide new housing for rent while promoting the restoration of older buildings.</td>
</tr>
<tr>
<td></td>
<td>Restore traditional houses and districts.</td>
<td>Restore houses and condominiums. Make re-location scheme attractive.</td>
</tr>
<tr>
<td></td>
<td>Promote city dwelling.</td>
<td>Legislate housing registration.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To improve living environment</th>
<th>Encourage active citizen participation on city development.</th>
<th>Organize support for city redevelopment policies. Decide on district planning and construction regulations.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improve local public facilities.</td>
<td>Give a facelift to residential area public parks, children’s playing areas and community roads.</td>
</tr>
<tr>
<td></td>
<td>Encourage the local market place.</td>
<td>Provide assistance to improve community shopping facilities and attract certain businesses.</td>
</tr>
<tr>
<td></td>
<td>Promote disaster prevention measures.</td>
<td>Form volunteer fire brigades to strengthen protection against fire and flood.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To provide support for families with young children</th>
<th>Enhance child care support system.</th>
<th>Improve children’s home-nurse visit program to meet newly emerging social needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide a more relaxed-atmosphere style of education.</td>
<td>Help the education system to nurture individualism and encourage affinity with nature.</td>
</tr>
<tr>
<td></td>
<td>Improve children’s environment.</td>
<td>Update park facilities.</td>
</tr>
</tbody>
</table>

### Requirements for all citizens and companies in the business sector

- To initiate community activities.
- To re-examine the female/male roles within the home.
- To become more actively involved in the community.
- To introduce greater flexibility in working conditions such as time-off for child raising.

### Targeted projects

<table>
<thead>
<tr>
<th>Launching a multi-generation re-location scheme.</th>
<th>Initiate a project improving community facilities to enable comfortable dwelling for senior citizens and young couples alike. With the support of local citizens certain representative areas will be selected where housing, a better living environment and support for families with young children will be provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Children’s Playgrounds</td>
<td>Update playground facilities particularly the Takaragaike Pond Park area. Also develop a new site.</td>
</tr>
</tbody>
</table>
A city where everyone can walk safely (a people-oriented city)

Kyoto City plans on providing supervised public facilities and proper sidewalks particularly for the handicapped, elderly, expectant mothers and children to develop a people-oriented city area based on the “normalization” concept. Today the traffic accident rate in Kyoto is one the highest among the large cities. Our existing policies placing top priority on economic efficiency should therefore be reviewed in the light of the car-dependent society we have become.

| To allow people to enjoy their city | Provide more sidewalks for the elderly, handicapped and expectant mothers. | Improve and increase sidewalks, roadside greenery and construct public roads, etc. |
|-----------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------
|                                   | Create a beautiful city landscape.                              | Check the possibility of city space, availability to renovate buildings with the cooperation of local citizens. |
|                                   | Utilize a special government fund to better city landscape.       | Improve school hedges and gardens and recommend the installation of underground electric cables. |

<table>
<thead>
<tr>
<th>To provide a safe public transport system for everyone to use.</th>
<th>Improve railway system.</th>
<th>Extend railway lines, provide elevators and escalators in stations and build new JR stations to service more areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improve bus system</td>
<td>Provide more bus stops for convenience and introduce a special lift for handicapped passengers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To counteract the disadvantages of a car-dependent society.</th>
<th>Intensify measures encouraging cars and bicycles to be left in parking areas.</th>
<th>Improve parking areas for cars and bicycles. Develop public campaign encouraging usage of these special areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intensify measures against car pollution.</td>
<td>Promote the sale of electric cars and introduce low-pollution buses.</td>
</tr>
</tbody>
</table>

Requirements for all citizens and companies in the business sector

- To treat others with benevolence.
- To cooperate with others to create a city of well-being.

Targeted projects

<table>
<thead>
<tr>
<th>To improve the facilities of one representative road.</th>
<th>Improve Oike Street demonstrating the theme “Healthy City — Kyoto” to be enjoyed by the public. This project will be carried out in cooperation with stores and businesses in the shopping area to create a lively, safe public space. Place trees and statues along the street to make a new landscape around the Kamo and Takase rivers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>To legislate a plan for city development which considers the people</td>
<td>Legislate standards to improve roads and facilities. Decisions should be endorsed by the citizens before implementation.</td>
</tr>
</tbody>
</table>
Annex 8
Paper 1

5. An Environment-oriented City (emphasizing resource saving and recycling)

Kyoto City promotes recycling and efficient use of resources thereby controlling the amount of trash. Wasteful use of energy and resources by individuals and companies must be stopped so that our environment can be kept beautiful for future generations.

<table>
<thead>
<tr>
<th>To control garbage generation</th>
<th>Discourage mass consumption and the throw-away concept.</th>
<th>Educate citizens and businesses on reduced use of wrapping paper and recycling methods.</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve resource recycling system</td>
<td>Formulate a recycling system of collection production, distribution.</td>
<td>Encourage the participation of local citizens, communities, consumer groups and companies.</td>
</tr>
<tr>
<td></td>
<td>Promote group collection.</td>
<td>Rally citizen groups and organizations to provide support to recycling businesses and start up their own family composts.</td>
</tr>
<tr>
<td></td>
<td>Intensify efforts for separate collection system for different items.</td>
<td>Concentrate particularly on the recycling of used cans separately from other trash and study better methods for collection.</td>
</tr>
<tr>
<td></td>
<td>Promote efficient use of energy and resources at public facilities</td>
<td>Promote recycling of energy at garbage collection and sewerage plant. Encourage the usage of natural energy sources such as solar energy.</td>
</tr>
</tbody>
</table>

Requirements for all citizens and companies in the business sector

- To change the habits of a throw-away lifestyle.
- To prompt recycling and the end-products.
- To reduce the use of wrapping paper.

Targeted projects

| To legislate a project to control the amount of trash and encourage recycling | Carry out a study on how trash can be decreased. Announce specific roles of the administration, citizens and business sectors in controlling trash and recycling. |
2. Promoting a healthy city

(1) Promotion by communication, creative ideas and citizen participation

Towards the goal of making a "Healthy City — Kyoto", the government will establish organizations to put forward constructive proposals in view of municipal policy and local citizens' activities.

In the planning, deciding and carrying out of such policies the following points need to be taken into consideration.

- Are these policies well planned from the position of all citizens?
- Are public facilities well organized to enable communication between different institutions?
- Are these policies practical, creative and flexible?
- Do these policies take the best advantage of community features?
- Are these policies multi-functional?
- Will these policies promote the growth of Kyoto's distinctive and traditional features?
- Do these policies emphasize the value of beauty and enjoyment?
- Are citizens participating in the decision-making?

(2) Promotion by a wide range of groups

Kyoto has many individuals and organization actively involved in the creation of an energetic community in cooperation with Kyoto City government.

Kyoto City provides the backing for many events and information exchanges organized by citizens and local groups, and encourages them to assist in improving the health of the individual, community, city and society.
Shifting Life Styles Bring about New Problems

Over the past half a century many changes have taken place in our lives. Although the quality of life has improved materialistically, healthwise, many aspects have not been realized and some even lost. Some of these changes and the resulting problems are discussed here under four headings.

• Improved Material Affluence

Thanks to rapid and technological progress daily living has become very convenient and standards of life have risen dramatically. However more recently, not only material wealth but also sufficient leisure time and mental well-being are becoming even more important considerations.

Emerging Problems

- How can we best use our time and material wealth to live full lives by enriching our mental and physical well-being?
- What facilities and services should be supplied by public and private sectors?
- How can everyone be given the same opportunities to enjoy these benefits?
- What can the government, private companies and community do to eliminate discrimination?

• The Dawn of an Aging Society

Thanks to rapid technological advancement in medical and health fields, life expectancy has now increased to over 80 years of age. On the other hand, the number of children is on the decline due to a decreasing birth rate. It is feared that this trend will weaken the power of a future society.
Emerging Problems

- How should public and private sectors improve the public welfare system to enable all to enjoy long, full lives.
- Nowadays major health issues include stress management and how to overcome various adult diseases such as cancer and circulatory disease. In response to these problems, how should the government organize a preventive and medical support network? Also, how should each citizen improve their own lifestyle?
- Financial burden to support an increasingly aging society grows with the demand for better services and facilities. What kind of role should citizens, families, communities, public and private sectors play, to maintain a network enabling optimum medical care and social welfare for the aged and a better environment to encourage birth and child raising?

Diversified Family Groups within the Community

The typical family unit structure has changed and nuclear families, households with only an elderly couple or elderly person living alone are increasing while the number of children is decreasing. The role and function of the family, too, are changing due to the growing number of working women and the resulting independent life styles of each family member.

The role of the community has been weakened and diversified by the continual change of its members. However, new relationships are being formed with the development of internationalization and our advanced information network.

Emerging Problems

- How can we continue to enhance the family and community roles of passing down knowledge, codes of behavior and providing a mutual-aid system.
- The important function carried out by the community as a support for family living is drawing attention once again. In what way can we support the groups and organizations assisting the community? What roles do the government and
each citizen have to play?
- What type of innovative steps should citizens, public and private sectors take to interact and form ties with a variety of different people.

The Advancement of Urbanization

Urbanization has brought about convenient changes to our society. At the same time, however, it has caused isolation from familiar surroundings and the loss of friendships so necessary to our spiritual well-being.

Economic effectiveness has been emphasized to a large degree, ignoring facilities for the handicapped and elderly, children and expectant mothers.

Urbanization has also caused environmental degradation on both a local and global basis resulting in the overuse of resources and increase of waste materials.

Emerging Problems

- How can citizens, public and private sectors maintain a safe, comfortable and convenient city life style?
- How can urban space be visually improved to provide a pleasant, enjoyable encounter in the hustle and bustle of the city?
- How can we protect the environment in the light of new city development?
  What roles should citizens, communities and private sectors play?
Definitions of Health

Since WHO (The World Health Organization) first defined health various other concepts have been presented to expand this definition.

**Definition of health by WHO**

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

**Comprehensive view of health**

Good and poor health, or health, disease and death are not far apart. They involve a comprehensive change in physical condition to which proper treatment is required. (First prevention: enhancing physical fitness and preventing disease. Second prevention: early diagnosis and early treatment. Third prevention: improving disability and rehabilitation)

**Initial prevention**

This concept should be carried out prior to first prevention (enhancing physical fitness and preventing disease). It involves the family, community and citizens working towards improvements in living and social environments thereby creating a safe and comfortable city enabling an increase in the level of fitness.

**Well-being**

Well-being is defined as a total improvement in the quality of life which includes not only improving the physical condition of an individual but also providing the opportunity for life-long education and community service and volunteer activities.
Normalization

This concept holds that in a normal society we have to accept many individuals' different values and life styles including the disabled and normal, elderly and young, men and women. Everyone should have an equal opportunity to participate in society and provide support for one another within the family, community, school or work place.

Health for all

The word health does not exclude mentally or physically disabled people or those who are socially disadvantaged. Its true meaning is a warm integration of health-minded people thus enhancing their mental and physical well-being.

Revival of "Play"

Culture, sports and recreation are one of the elements of "play". "Play" is essential in our lives. In this modern age where health is taking on a new meaning, "play", which has been treated as a luxury or supplement since the advent of our modern industrial society, must be reviewed and revived.

The important goal of serving others

Health is closely related to the way we spend our leisure time. European people are said to be good at using their free time and serving others is one of their most important pursuits. These volunteer activities seem to be lacking in Japanese society.
In a "Healthy City", the following three elements are linked together.

1. Citizens make up the city and family structure and form the basis for a common sense of values.

2. Society bonded together by the community, school and working place.

3. City and nature in harmony to promote a healthy life for the citizens.
Advisory Committee of
"Kyoto—The Road Towards a Healthy Environment"

Members of Advisory Committee

Andre Brunet, Professor, Ritsumeikan University
Eiji Kitabayashi, Director, Kyoto Branch of National Labor Union
Eitaro Nakamura, Professor, Kyoto University. (Sub-committee member)
Fumie Matsumoto, Director, Kyoto Branch of Women’s Medical Association
Hayao Kawai, Professor, International Research Center of Japanese Culture
Hideko Kanai, Professor, Kyoto University of Education
Hirohisa Hachisuka, Dean, Kyoto University of Education.
    (Advisory Committee Assistant Chief and Sub-committee chief)
Hironobu Yoshida, Associate Professor, Kyoto University
Hiroshi Mimura, Professor, Kyoto University. (Sub-committee Assistant Chief)
Hiroyuki Yamada, Professor, Kyoto University
James P. Griffith, Lecturer, Kyoto Industrial University
Jiro Onishi, Director, Volunteers’ Committee, Ukyo Ward Municipal Administration
    (from Sept. 13, 1991)
Keiichi Kawai, Professor, Kyoto Prefectural University of Medicine. (Sub-committee member)
Kenzo Matsunaga, Manager, Dept. of Policy and Economy, The Kyoto Shinbun Ltd.
Kuichiro Obata, Leader of Directorial Volunteers’ Committee, Minami Ward Municipal Administration (July 9, 1990 - Sept. 12, 1991)
Machiko Inoguchi, Nurse, Ijinkai Takeda Sogo Hospital
Masao Horiba, Chairman, Horiba Ltd.
Michitaka Nakura, Professor, Ryukoku University
Morihiro Komoda, Deputy Mayor, Kyoto City
Noriko Nishikoji, Architect
Seiko Hirata, Director, Zen Culture Research Center
Shosuke Naka, Manager, YMCA Wellness Center
Shotaro Nishi, Deputy Director, Medical Association of Kyoto Prefecture
Tatsuo Otsuka, Professor, Doshisha University
Tatsuzo Sato, Deputy Mayor, Kyoto City (from Sept. 13, 1991)
Takeo Yamamoto, Emeritus Professor, Kyoto University
Tomoya Takaishi, Folk singer
Toshinao Yoneyama, Professor, Kyoto University
Yutaka Sano, Emeritus Professor, Kyoto Prefectural University of Medicine.
(Advisory Committee Chief)

<Members of the Advisory Study Group>

Akane Higashi, Assistant, Kyoto Prefectural University of Medicine
Michiko Noguchi, Technical Official of Education, Kyoto University
Prefectural Center for the Handicapped
Rim Bon, Assistant, Kyoto University
Toshio Moritani, Associate Professor, Kyoto University
Yayoi Ariga, Visiting Doctor, Dept. of Neurology, Rehabilitation Hospital of Kyoto
Yoshiyuki Watanabe, Lecturer, Kyoto Prefectural University of Medicine
### CONTENTS OF HEALTH INSTRUCTION IN JAPAN

#### Elementary Schools
- grades 5-6
  1. growth of body and development of mind
  2. prevention of injury
  3. prevention of disease
  4. healthy life

#### Lower Secondary Schools
- grades 1-3
  1. development of the function of mind and body, and mental health
  2. health and environment
  3. prevention of injury
  4. prevention of disease
  5. health and life

#### Upper Secondary Schools
- grades 1-2
  1. contemporary society and health
  2. environment and health
  3. life-long health
  4. group health

Organization Chart for Safety and Health Management

Plant manager

Deputy plant manager (Acting general safety and health supervisor)

Department manager

Section chief

Chief of safety and health division

Head of the clinic

Industrial physician

Health nurse

Safety and health committee

Labour union

Safety and health management meeting

Division-level safety and health meeting

Foreman

General employees

Source: Industrial Safety and Health, 1988
(The Japan Institute of Labour)
Staff and Role of Total Health Promotion Plan (THP)

<table>
<thead>
<tr>
<th>(Title)</th>
<th>(Duties)</th>
<th>(Details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial physician</td>
<td>Evaluation of health</td>
<td>Evaluation of health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Interview by doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medical examination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Examinations (blood tests, heart and lung tests)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Preparation of written material for physical exercise guidance</td>
</tr>
<tr>
<td>Health care trainer</td>
<td>Physical exercise guidance</td>
<td>Physical exercise guidance</td>
</tr>
<tr>
<td>Health care leader</td>
<td>Guidance and assistance for physical exercises</td>
<td>Guidance and assistance for performing physical exercises</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistance in performing physical exercises</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- In house physiotherapist</td>
</tr>
<tr>
<td>Psychological consultant</td>
<td>Mental health care</td>
<td>Mental health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistance in reducing stress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Guidance for relaxation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counseling</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>Nutritional guidance</td>
<td>Nutritional guidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Evaluation and guidance for diet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>Health guidance</td>
<td>Health guidance</td>
</tr>
<tr>
<td>Health supervisor</td>
<td>Health supervision and guidance</td>
<td>Health supervision and guidance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Guidance about private life (sleeping, smoking, drinking, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coordination of health guidance</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Promotion of setting up of a health assurance program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assistance during working hours</td>
</tr>
</tbody>
</table>

Source: Industrial Safety and Health, 1988
(The Japan Institute of Labour)
Creating Comfortable Working Environments

The changing patterns of job formats accompanying technological innovations and other factors have led to the new problem of "techno-stress" and other problems. At the same time, moreover, there are still many production sites with poor working environments and conditions that impose a major burden on workers. Because this situation has caused many workers to report fatigue and stress from their work, efforts to improve the working environment have become an important task. These amendments of the law are aimed at improving working environments and promoting the creation of comfortable workplaces.

Under the Industrial Safety and Health Law, a comfortable working environment is one that meets the following conditions.

1. The proper maintenance of the ambient environment in the workplace, including appropriate control of temperature, humidity, etc.

2. Properly managing and improving work that imposes substantial mental and physical burdens on workers, and giving consideration to eased working conditions.

3. The installation and proper maintenance of facilities and equipment to help workers recover from mental and physical fatigue, such as resting areas, lounges, etc.

4. The proper maintenance of facilities necessary to meet basic worktime needs, such as lavatories, toilets, etc.

The development of comfortable working environments and eased working conditions still assumes that all necessary measures are taken for industrial accident prevention. While the Industrial Safety and Health law obligates employers to meet the minimum requirement of industrial accident prevention and face penalties, the law, on the other hand, strives to encourage employers to take self-implementations to create comfortable working environments.

Accordingly, the law states that employers must first meet their legally mandated obligations, then strive to realize a working environment that satisfies the above conditions on a continual and systematic basis. In order to assist employers in efficiently carrying out these efforts, the Labour Minister is empowered to formulate guidelines on target objectives related to comfortable working environments, and to outline the contents of employer measures to realize these goals. These guidelines were issued by the ministry on July 1. As a further measure to promote employer efforts towards realizing comfortable working environments, JISIA and other related associations are providing consultation and guidance and conducting education activities.

Source: Safety and Health in Japan, No.6 November 1992
(Japan Industrial Safety and Health Association)
Health promotion is a priority area for the work of WHO in the Western Pacific Region. A comprehensive health promotion programme will be developed for the Ninth General Programme of Work. Up to the end of 1995, this document on health promotion provides the framework for a systematic and focused approach and modifies the medium-term programme, which was the basis for programme 6: Public Information and Education for Health under the Eighth General Programme of Work. It will be the basis for the transitional period.

The main thrust of the Programme on Health Promotion is to cooperate with Member States in stimulating and supporting individual action contributing to better health in the different stages of a life cycle and thus contributing to healthy ageing.

**CONTENTS**

1. INTRODUCTION AND POLICY BASIS
2. OBJECTIVE AND TARGETS
3. APPROACHES
4. ACTIVITIES
5. PROGRAMME MANAGEMENT AND RESOURCES
1. INTRODUCTION AND POLICY BASIS

Health promotion is a priority area for the work of WHO in the Western Pacific Region.

The Western Pacific Region contains a tremendous diversity of countries in terms of population size, socioeconomic status, political systems and cultures. Development in some parts of the Region is occurring at a great pace while underdevelopment and rural poverty still remain in others. The explosive growth of cities has not been accompanied by adequate improvement in standards of living. In developing countries, urban poverty and environmental degradation are added to the continued existence of traditional health problems. Lifestyles and living conditions undergoing changes through industrialization, urbanization and modernization have produced health problems of major concern for WHO and its Member States.

Noncommunicable diseases related to lifestyles are increasing in the Western Pacific Region: in 26 of its 35 countries and areas, 3 of the 5 leading causes of mortality are noncommunicable diseases. Especially cardiovascular diseases are seen as major causes of mortality, and it is expected that they will double in the next 20 years. Injuries will also increase owing to growth in the numbers of vehicles in use for public and private transport. HIV infection and AIDS pose a major problem for future health planning. At the same time, a steady growth in the elderly population is occurring as the result of increased longevity and lower birth rates. New approaches are needed in order to reach health-for-all goals.

The choice of health promotion as a strategy to address these issues reflects the necessity to locate and combine resources differently and to be more systematic in approach.
A comprehensive health promotion programme will be developed for the Ninth General Programme of Work. Up to the end of 1995, this document on health promotion modifies the Medium-term Programme, which was the basis for Programme 6: Public Information and Education for Health under the Eighth General Programme of Work and will be the basis for the transitional period. It also aims at strengthening the health promotion elements in WHO’s programmes and providing a framework for systematic and focused project development and implementation.

The main thrust of the Programme on Health Promotion is to cooperate with Member States in stimulating and supporting individual action contributing to better health in the different stages of a life cycle and thus to contribute to healthy aging.

This will include the development of health-supportive public policies, the aim of which, is to create environments that make it possible for people to lead healthy lives.

The underlying concept for this process is to empower people to increase control over their health and to improve it. It stresses the importance of individuals and groups being able to identify and fulfil their aspirations, to satisfy their needs and to change or cope with the environment. This concept highlights health as an essential element of the quality of life, both personal and social, which can be promoted at every stage of life.

Health promotion, therefore, is concerned with enabling people to realize their health potential as fully as possible, whether they are considered healthy or as living with a chronic condition. It is a continuing process of creating awareness concerning the health potential of individuals and social groups and finding ways and means to overcome health threats. It is also concerned with creating environments which support people’s health and their efforts to maintain it.
2. OBJECTIVES AND TARGETS

The objective of the programme is to strengthen the ability and willingness of individuals in the course of each stage in their life cycle to take action in support of their health and that of their families and communities in settings such as the home, the workplace, and the school, and during recreation.

To achieve this objective, the following targets have been set for 1995:

(1) Most countries and areas will have formulated national health policies and developed programmes that focus on the promotion of health and the prevention of disease, and build up a corresponding infrastructure.

(2) Most countries and areas will have enlisted support for health goals from ministries responsible for other aspects of life, such as education, environment, agriculture and economic development, and will have developed a mechanism for intersectoral collaboration that includes nongovernmental organizations and the private sector.

3. APPROACHES

While recognizing the broad concept of health promotion, simple and practical health promotion activities will be identified and linked to an overall health promotion plan for the interim period. Through innovative and action-oriented approaches, health should be recognized as a goal to which each individual can contribute.

With a view to promoting favourable changes in lifestyles, WHO will support Member States in the development and implementation of health promotion policies and practices, and in the planning and execution of public information and communication strategies. While emphasizing individual action for health, attention will be paid to health as a sound social investment. WHO will create awareness that health-supportive public
policies in the short term will lead to long-term economic benefits, thus helping to establish a political commitment of countries to health promotion.

Strengthening the health promotion component of the different health programmes will be a continued feature of the programme.

At the country level, a balanced combination between mass media and personal communication will be used to keep the public informed about health matters and to motivate individuals to take action. Particular attention will be given to the links between health, environment and lifestyles.

To establish an effective communication process that will result in creative interaction, community participation will be ensured in the planning, design and implementation of projects. Attention will be given to behavioural research, the development of programme indicators and coordination with other regional and interregional organizations.

At the intercountry level, the involvement of WHO collaborating centres and regional networks of health promotion professionals, and mass communication institutions will be emphasized; this should facilitate information exchange and studies on lifestyles and health.

4. ACTIVITIES

Activities have been chosen which represent one of the main areas of action in health promotion, which is to enable people, through their attitudes, knowledge and skills, to act wisely and effectively in solving both personal and collective health problems. They have been arranged according to five stages in the life cycle, i.e., childhood, adolescence, adulthood, middle age and old age.
The following overview of approaches for 1993-1995 with the related activities is structured according to stages of life; it indicates programme and activity code numbers as they are available.

The overview includes health promotion activities of different programmes and presents a basis for progress reports concerning the status of the regional priority area "Strengthening of support to programmes related to health promotion and changing lifestyles."

The relevant country-level activities for 1994-1995 will be added during the course of 1993.
<table>
<thead>
<tr>
<th>APPROACHES</th>
<th>ACTIVITIES</th>
<th>COUNTRIES 1993</th>
<th>COUNTRIES 1994</th>
<th>COUNTRIES 1995</th>
<th>PROGRAMME &amp; ACTIVITY CODE</th>
<th>LINKAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Childhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Funds to be requested from UNFPA</td>
<td>UNFPA</td>
</tr>
<tr>
<td></td>
<td>To promote planned pregnancy and safe delivery</td>
<td></td>
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<tr>
<td></td>
<td>- Brochure/IEC materials</td>
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<td>UNICEF</td>
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<td>02.020.STC.01 - 2 months STC for implementation and review of breastfeeding activities in 2 countries, and 02.030.LC - 2 national workshops on breastfeeding</td>
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<tr>
<td></td>
<td>- Brochure</td>
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<td>ICP/CDD/001/VC.92.2</td>
<td>CDD/HQ</td>
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<td></td>
<td></td>
<td>(22.832.LC.24 - workshop to be held in April 1993; request for release of funds received January 1993)</td>
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<tr>
<td></td>
<td>- Training course on breast-feeding counselling</td>
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<td>ICP/CDD/001</td>
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<td>EB source expected</td>
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<td></td>
<td>- Preparation of breast-feeding plan</td>
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<tr>
<td></td>
<td>- Support in the adaptation of the</td>
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<td>International Code on Breast Milk Substitutes</td>
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<tr>
<td>To provide information about growth and development of children and what to do in case of illness</td>
<td>- Information kit with child development cards</td>
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<td>X</td>
<td>X</td>
<td></td>
<td>Funds to be requested from UNFPA</td>
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<td></td>
<td>- Production of face-to-face communication materials</td>
<td>CHN</td>
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<td>ICP/ARI/001</td>
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<td>$20,000 from HQ</td>
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<td>VAN</td>
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<td></td>
<td></td>
<td>FIJI</td>
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<td></td>
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<td>5,000 from HQ (proposals sent to HQ; approval awaited)</td>
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<td></td>
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<td>X</td>
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<td>2A.010.SE.01 $3,000</td>
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<tr>
<td>To create a health supportive psychosocial environment in the family (e.g., to promote child-adult relationship, to increase social competence, to learn how to preserve one's own health, to prevent the formation of habits hazardous to health)</td>
<td>- Campaign: Health Promotion through the Family</td>
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<td>X</td>
<td>X</td>
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<td>&quot;The family - all for one and one for all&quot;</td>
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<td>01.030.SE ($30,000 provision)</td>
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<td></td>
<td>- Workshop on family mental health</td>
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<tr>
<td>To promote balanced nutrition (i.e., eating green local veg., less meat, whole-grain bread, less sugar)</td>
<td>Projects for schoolchildren with teacher, child, parent approach (curriculum development, school vegetable garden, etc.)</td>
<td>LAO</td>
<td>HQ funds expected ICP/IEH/001/RB/92 01.030.LC.01 $5000</td>
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<td>LAO</td>
<td>ICP/HPR/001/RB/94 01.040.LC.01 ($60,000 provision)</td>
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<td>ICP/NUT/001/RB/92 02.010.STC.02, 1 mo. STC</td>
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<td>VTN</td>
<td>ICP/NUT/001/RB/94 03.020.LC ($10,000 provision)</td>
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<td></td>
<td></td>
<td>Selected</td>
<td>2 national workshops to strengthen or establish national food and nutrition policy</td>
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<tr>
<td>- Training of health professionals</td>
<td>Selected</td>
<td>Pacific Islands</td>
<td>FIJ/NCD/001/RB/92 01.010.LC.01 $20,000</td>
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<tr>
<td>To promote personal hygiene of children (e.g., washing hands and brushing teeth regularly)</td>
<td>Development of school curricula, modules and training aids</td>
<td>LAO</td>
<td>HQ funds expected ICP/IEH/001/RB/92 01.030.LC.01 $5000</td>
<td>UNESCO</td>
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<td></td>
<td></td>
<td>LAO</td>
<td>ICP/HPR/001/RB/94 01.040.LC ($60,000 provision)</td>
<td>UNICEF</td>
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<td>VTN</td>
<td>ICP/CWS/001/RB/94 01.030.SE ($10,000 provision for training project)</td>
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<td>ICP/RUD/001</td>
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<td></td>
<td>Studies on hygiene education through projects on child-to-child learning and learning through playing</td>
<td>X</td>
<td>ICP/CWS/001/RB/94 01.060.RSG ($60,000 provision for applied studies)</td>
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<td>COUNTRIES</td>
<td>PROGRAMME &amp; ACTIVITY CODE</td>
<td>LINKAGES</td>
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<tr>
<td></td>
<td>- Project in Khong Island on school hygiene education and provision of safe drinking water and basic sanitation</td>
<td>LAO X</td>
<td>To be proposed for funding</td>
<td>UNDP</td>
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<tr>
<td>To promote physical activities</td>
<td>- Collection of expert advice for preparation of school curricula</td>
<td>JPN</td>
<td>ICP/CVD/001/RB/92 (02.010.STC.01) $6500</td>
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<tr>
<td>To prevent childhood accidents</td>
<td>- Research</td>
<td>X X</td>
<td>ICP/APR/001/RB/92 03.010.RSG.01 $5000 available for research project on multicentre study of childhood accidents in WPR in 1993</td>
<td>UNICEF</td>
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</table>
### APPROACHES

To promote healthy behaviour among schoolchildren

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Review of existing curricula</td>
<td>X</td>
<td>To be proposed for funding</td>
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<tr>
<td>Regional workshop on health promotion among schoolchildren</td>
<td>X</td>
<td>To be proposed for funding (Additional funds expected from HQ)</td>
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### 2. Adolescence

To promote non-smoking

<table>
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<tr>
<th>ACTIVITIES</th>
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</thead>
<tbody>
<tr>
<td>Distribution of &quot;Tobacco Alert&quot; No. 1/93</td>
<td>X</td>
<td>HQ</td>
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<tr>
<td>Materials for World No-Tobacco Day, including film</td>
<td>X</td>
<td>HQ</td>
</tr>
<tr>
<td>Support to Third APACT Meeting, Japan</td>
<td>X</td>
<td>ICP/TOH/001/RB/92 Several activities under this project not yet implemented</td>
</tr>
<tr>
<td>Distribution of IEC materials</td>
<td>PHL</td>
<td>PHL/IEH/001/RB/92 03.060.SE.01</td>
</tr>
</tbody>
</table>

$64 275 balance: (LC $30 000) (STC $21 000) (RSG $10 000)

- No action with $64 275 balance:
- $3200 for reproduction of anti-smoking IEC materials; and
- $16 500 for purchase of video camera and photocopying machine

### LINKAGES

- HQ
- UNESCO
- UNICEF
<table>
<thead>
<tr>
<th>APPROACHES</th>
<th>ACTIVITIES</th>
<th>COUNTRIES</th>
<th>PROGRAMME &amp; ACTIVITY CODE</th>
<th>LINKAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote female non-smoking</td>
<td>Advertising campaign</td>
<td>X X</td>
<td>To be proposed for funding</td>
<td></td>
</tr>
<tr>
<td>To prevent drug and alcohol abuse</td>
<td>Training of health workers</td>
<td>X X X</td>
<td>ICP/ADA/002 CHN/ADA/003/RB/92 01.030.STC.01 $7500 1 month and 01.040.LC.01 $3000</td>
<td>KIR/IEH/001/RB/92 02.010.LC.01 $3000 workshop on alcohol and drug abuse</td>
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<td></td>
<td>Workshop for health personnel and community leaders</td>
<td>KIR</td>
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<td>3. To promote sexual health/responsible sexual behaviour</td>
<td>GPA/IEC Activities through IEC subcommittees of National AIDS committees</td>
<td>X X X</td>
<td>Country/GPA/220 projects</td>
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<td></td>
<td>Development of school curricula</td>
<td>PHL, KOR, X</td>
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<td>LAO, VTN, X</td>
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<td>CAM, X</td>
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<td></td>
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<td>CHN X</td>
<td></td>
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<tr>
<td></td>
<td>Youth workshop</td>
<td>Palau</td>
<td>BLA/ADH/001 (CST/Suva Arrangement)</td>
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<td></td>
<td></td>
<td>SMA</td>
<td>SMA/MCH/001 under BL 33.04 for 1993 $4800</td>
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<tr>
<td>To promote self-care (e.g., to promote self-massage techniques)</td>
<td>Development of youth workshop models for health</td>
<td>X X</td>
<td>ICP/HPR/001/RB/94 01.040.LC ($60,000 provision)</td>
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Annex 9
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<th>COUNTRIES</th>
<th>PROGRAMME &amp; ACTIVITY CODE</th>
<th>LINKAGES</th>
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<tbody>
<tr>
<td>To promote physical activities</td>
<td>Workshop</td>
<td>X</td>
<td>ICP/CVD/001/RB/92 01.020.LC.01 $10 000</td>
<td>WHO CC's</td>
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<tr>
<td>To promote things anyone can do to keep healthy</td>
<td>Working Group on Health Promotion Planning</td>
<td>X</td>
<td>ICP/IEH/001/RB/92 01.040.MTG.01 $12 000 Provision</td>
<td>WHO CC's</td>
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<td></td>
<td>Small expert meeting (Informal Meeting of WHO Collaborating Centres)</td>
<td>X</td>
<td>ICP/IEH/001/RB/92 01.040.MTG.01 $13 500 available</td>
<td>WHO CC's</td>
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<td>Brochure “Things anyone can do to keep healthy”</td>
<td>X</td>
<td>ICP/IEH/001/RB/92 01.010.STC.01 $13 000 01.020.SE $8800 available</td>
<td>WHO CC's</td>
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<tr>
<td></td>
<td>Workshop for “Healthy Islands”</td>
<td>X</td>
<td>ICP/NCD/001/ST/92/JSIF $24 697 (would need UNICEF reprogramming) WP/ICP/CVD/001/VD/92A 02A.010.STC.01 FOR STC ICP/ADA/001/RB/94 01.020.LC (workshop - $20 000 provision) ICP/APR/001/RB/94 01.020.LC (4 workshops - $20 000 provision) ICP/TOH/001/RB/94 03.010.MTG) ($45 000 provision) ICP/PSF/002/RB/94 01.020.LC ($20 000 provision)</td>
<td>UNICEF</td>
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<td>Evaluation of Brochure “Things Anyone Can Do To Keep Healthy”</td>
<td>X</td>
<td>ICP/HPR/001/RB/94 01.030.SE ($30 000 provision)</td>
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### APPROACHES

#### To promote non-smoking
- Workshops and material production
- Distribution of IEC materials

#### To prevent alcohol and drug abuse
- National workshops to develop plan of action

#### To promote family planning
- Mass media

### ACTIVITIES

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<td>1993 1994 1995</td>
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<tr>
<td>TON</td>
<td>TON/IEH/001/RB/92 01.010.SE.01 ($8000 available)</td>
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<td>PHL</td>
<td>PHL/IEH/001/RB/92 03.060.SE.01 $3200</td>
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<td>SMA/IEH/001/RB/92 03.010.LC.05</td>
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<td>KIR</td>
<td>KIR/MCH/002/FP/92 BL36.01 $2652 UNFPA</td>
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<td>MIC</td>
<td>MIC/MCH/001 BL36.02 $2000 BL36.03 $2184</td>
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<td>MSI</td>
<td>MSI/MCH/001 BL36.02 $2000 BL36.03 $2184</td>
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### LINKAGES

- UNFPA

### Annex

- 9
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<th>LINKAGES</th>
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<tbody>
<tr>
<td>To promote environmental awareness and community involvement in urban health activities</td>
<td>- Bi-regional Meeting on Urban Health Development</td>
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<td>ICP/IEH/001/RB/92</td>
<td>HQ</td>
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<td>01.040.MTG.01</td>
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<td>$32 000 provision</td>
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<td></td>
<td>- Urban health campaign tailored to specific urban populations</td>
<td>X X</td>
<td>ICP/RUD/002/RB/94</td>
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<td>APW $30 000</td>
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<td>- National workshops (5) on environmental health support for disaster preparedness</td>
<td>X</td>
<td>ICP/RUD/001/RB/94</td>
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<td>02.040.LC $25 000 for 5 workshops</td>
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<td>- Collection, documentation, and analysis of innovative community projects and production of brochure with examples of good practice</td>
<td>X X</td>
<td>To be proposed for funding</td>
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<td></td>
<td>- Study of community involvement on media support on examples of private initiatives (for example cleaning up a river)</td>
<td>X</td>
<td>To be proposed for funding</td>
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<td>- Study of organizational resources in communities as agents for change (for example women's groups)</td>
<td>X</td>
<td>To be proposed for funding</td>
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<td>To promote awareness among decision-makers on health issues related to development projects</td>
<td>- Regional workshop for development decision-makers</td>
<td>X</td>
<td>ICP/RUD/001 (PTT)</td>
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<td></td>
<td>- Series of articles on the impacts of water pollution addressed at politicians and industrialists</td>
<td>X</td>
<td>ICP/RUD/001/1/RB/94 01.1801.001 ($38 000 provision)</td>
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<td>- Study on health advocacy and policy development of five agencies in Manila</td>
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<td>To be proposed for funding under ICP/RPD/001</td>
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<td>- Information kit on health supportive public policies for political decision-makers</td>
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<td>To be proposed for funding</td>
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<td>To promote active participation of fathers in family life</td>
<td>- Three-day meeting for men</td>
<td>SMA</td>
<td>SMA/MCH/001 BL33.03 for 1993 $1200</td>
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<td></td>
<td>- Campaign: Health promotion through the family</td>
<td>X</td>
<td>ICP/HPR/001/1/RB/94 01.0301.001 ($30 000 provision)</td>
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<td>To promote physical exercise</td>
<td>- Information kit: How to organize &quot;Fun Runs&quot;</td>
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<td>To promote self care through traditional knowledge of health</td>
<td>Preparation of manuscript with indigenous health advice</td>
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<td>Production/distribution of brochure</td>
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<td>Workshop on promoting health through indigenous knowledge</td>
<td>KIR</td>
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<tr>
<td>To promote responsible sexual behaviour</td>
<td>GPA/IEC activities</td>
<td>X</td>
<td>X</td>
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<tr>
<td>To promote balanced, nutritious and safe food intake</td>
<td>Production of information/learning material</td>
<td>FIJI</td>
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<td>Regional training course for street food safety</td>
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<tr>
<td>To prevent road traffic accidents</td>
<td>Workshops</td>
<td>X</td>
<td>X</td>
<td>ICP/APR/001/RB/92 01.010.STC.01 to 03 (STC for VTN impl) 01.020.LC.04</td>
</tr>
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<td></td>
<td>Consultant services</td>
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<tr>
<td>To strengthen existing health potentials and identify risk-taking behaviours</td>
<td>Studies on lifestyles and perceived health</td>
<td>X</td>
<td>X</td>
<td>To be proposed for funding WHO - CC's</td>
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<tr>
<td></td>
<td>Travelling exhibition (bus) with equipment for self-testing</td>
<td>X</td>
<td></td>
<td>To be proposed for funding</td>
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<tr>
<td></td>
<td>Study on lifestyles of mothers of streetchildren</td>
<td>X</td>
<td></td>
<td>To be proposed for funding</td>
</tr>
<tr>
<td>4. Middle age</td>
<td>To promote physical exercise</td>
<td>X</td>
<td></td>
<td>ICP/NCD/001 - STC ($27 000 provision) &amp; LC ($15 000 provision) for prog. rev. &amp; national workshop on NCD, part. diabetes mellitus in South Pacific countries</td>
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<tr>
<td></td>
<td>To promote &quot;Heart Groups&quot; for employees</td>
<td></td>
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<tr>
<td></td>
<td>Development of community exercise programmes</td>
<td>X</td>
<td></td>
<td>ICP/CVD/001/RB/94 04.010.RSG ($10 000 provision)</td>
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<td>APPROACHES</td>
<td>ACTIVITIES</td>
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<tr>
<td>To promote balanced nutrition</td>
<td>Mass media</td>
<td></td>
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<td>To be proposed for funding</td>
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<tr>
<td>To promote cleanliness, stress reduction-techniques, smoking cessation,</td>
<td>Support to training course for project staff and management</td>
<td>CHNV CHN KOR KOR</td>
<td>ICP/IEH/001/RB/92 01.030.LC 2 x $3000 01.020.SE $ 8800 available ICP/HPR/001/RB/94 01.040.LC ($60 000 provision)</td>
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<tr>
<td>non-smoking, physical exercise, balanced nutrition and safe behaviour among industrial workers</td>
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<td></td>
<td>Provision of technical advisory service and equipment for the production</td>
<td>CHNV CHN</td>
<td>ICP/OCH/001/RB/92 01.010.STC.01 $6500 01.020.LC.01 $4900 Funds under allocation for national training on occupational diseases, as per RO's remarks may be used for HPR activities ICP/OCH/001/RB/94 01.010.STC ($18 000 provision) 01.010.LC ($15 000 provision)</td>
<td>To be proposed for funding</td>
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<tr>
<td></td>
<td>of educational materials and the monitoring and evaluation of health</td>
<td></td>
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<td>promotion among industrial workers</td>
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<td></td>
<td>One-day meeting with managers on &quot;Health and Corporate Identity: Wellness</td>
<td>PHL</td>
<td>ICP/IEH/001/RB/92 01.030.LC.01 ($27 000 available)</td>
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<td></td>
<td>Support to (3 weeks) training course for worksite health education</td>
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<tr>
<td>To promote stress reduction techniques</td>
<td>Training for health workers</td>
<td>X CHN PHL KOR SMA SOUTH PACIFIC</td>
<td>ICP/PSF/002/RB/94 01.020.LC $20 000 provision for 4 workshops</td>
<td>Annex 9</td>
</tr>
<tr>
<td></td>
<td>Workshop to formulate guidelines on smoking cessation counselling.</td>
<td>PHL</td>
<td>PHL/IEH/001/RB/92 03.010.LC.01 ($2600 available) 03.020.LC.01 ($1200 available)</td>
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<tr>
<td>To promote smoking cessation</td>
<td>Workshop to formulate guidelines on smoking cessation counselling.</td>
<td>PHL</td>
<td>PHL/IEH/001/RB/92 03.010.LC.01 ($2600 available) 03.020.LC.01 ($1200 available)</td>
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<tr>
<td></td>
<td>Development of self-help groups to support those living with cancer</td>
<td>X</td>
<td>ICP/CAN/001/RB 02.010.LC.01 $10 000</td>
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<tr>
<td></td>
<td>Development of materials to be used by self-help groups</td>
<td>X</td>
<td>ICP/CAN/001/RB (To be reprogrammed from 04.010.RSG.02 to 04.010.CSA.01) $5000</td>
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<tr>
<td></td>
<td>Development of pain relief self-help/support groups through facilitator and seminars</td>
<td>MAA</td>
<td>MAA/CAN/001/RB/92 01.010.STC.001 $15 000 and 01.020.LC.01 $10 000</td>
<td></td>
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<tr>
<td></td>
<td>Regional meeting on health promotion in chronically ill</td>
<td>X</td>
<td>To be proposed for funding</td>
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<tr>
<td>APPROACHES</td>
<td>ACTIVITIES</td>
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<tr>
<td>5. Elderly</td>
<td>To promote self-help activities</td>
<td>KOR</td>
<td>WP/ICP/HEE/001</td>
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<tr>
<td></td>
<td>- Workshop to identify health promotion needs for the elderly</td>
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<td>STC/92 JSIF</td>
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<td>2A.020.LC.01</td>
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<td></td>
<td>To promote physical exercise</td>
<td>CHN</td>
<td>ICP/CVD/001/RB/92</td>
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<tr>
<td></td>
<td>- Research</td>
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<td>(01.010.RSG.01)</td>
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<td></td>
<td></td>
<td></td>
<td>$5000</td>
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<td></td>
<td>- Expert meeting to develop action plan</td>
<td>X</td>
<td>To be proposed for funding</td>
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<td></td>
<td>To promote mental health</td>
<td>CHN</td>
<td>ICP/MND/002/VP/92 JAPAN</td>
<td></td>
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<tr>
<td></td>
<td>- Research</td>
<td>X</td>
<td>($7000 available under RSG component)</td>
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<td></td>
<td>HOK KOR JPN</td>
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<td></td>
<td>To promote initiatives to form clubs for the elderly</td>
<td></td>
<td>To be proposed for funding</td>
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<tr>
<td></td>
<td>- Video</td>
<td>X</td>
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</tbody>
</table>

**Note:** The table details various approaches to promote self-help activities, physical exercise, mental health, and initiatives for forming clubs for the elderly in different countries. The programme and linkages are specified for funding proposals.
<table>
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<tr>
<th>APPROACHES</th>
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<th>COUNTRIES</th>
<th>PROGRAMME &amp; ACTIVITY CODE</th>
<th>LINKAGES</th>
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<tbody>
<tr>
<td>To promote self-care and traditional practices</td>
<td>- International workshop</td>
<td>X</td>
<td>To be proposed for funding</td>
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<tr>
<td></td>
<td>- Workshop on promoting health of elderly through traditional knowledge and exercise</td>
<td>VTN</td>
<td>ICP/IEH/001/RB/92 01.030.LC $5000</td>
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</tbody>
</table>
5. PROGRAMME MANAGEMENT AND RESOURCES

5.1 Management and technical support

The programme will be managed by the Regional Adviser in Health Promotion. Support will be given by a Health Promotion Task Force. Mutual support from and to Regional Advisers of related programme areas is a special feature of health promotion, as it cuts across programme structures. Special projects require collaborative working relations in task forces of which HPR is a part. Expert advice from HQ (HED and HPP) will support activities.

The following resources for programme support and guidance will be used:

- Subcommittee on Health Promotion of the Western Pacific Advisory Committee on Health Research

- Network of Collaborating Centres for Health Education, Health Promotion, and Behavioural Research and related institutions

- National Centres for Health Education and Health Promotion

- Various NGOs such as the International Union for Health Education

- Regional networks of persons involved in health promotion projects at different levels

- Consultants, advisory groups, communities for national projects, and

- Workshops and training seminars

Special mechanisms have to be developed for influencing policies in other sectors than health in Member States, and for working with the private sector.
5.2 Financial resources

Regular budget is provided for country and intercountry activities under Programme 6: Public information and education for health and under other health programmes as indicated. Joint activities are jointly funded.

Resources for this new programme will also depend to a large extent on extrabudgetary funds.

At the national level, the possibility for the provision of funds for joint projects from cities and industries exists. Health promotion projects for schoolchildren could attract joint funding from UNICEF and UNESCO. In addition, WHO Collaborating Centres for Health Education, Health Promotion, and Behavioural Research are expected to identify funds in their respective countries for joint activities/research with WHO.

The main effort will be to channel existing resources and develop an attractive programme which could draw support from more funding agencies.

6. MONITORING, EVALUATION AND INDICATORS

Progress will be monitored using programme targets as indicators, while programme effectiveness will be assessed in relation to the achievement of the programme objectives. The impact of the programme will be assessed by the identification of programme contributions to global indicators.

Specific indicators for the evaluation of progress and for the measurement of impact need to be studied on a solid methodological base.
7. LINKAGES

The health promotion programme will have linkages with many other WHO programme areas. A coordinated effort is required since a major strategy is to strengthen the health promotion component in other programmes.

Crucial aspects of health lie outside the health sector. Health promotion is consumer-oriented and implies horizontal, multisectoral and multidisciplinary approaches. It has, therefore, consequences for day-to-day operations which will require WPRO to cope with new working situations, particularly with regard to the support programmes.

Close relationships will be developed with WHO Collaborating Centres for Health Education, and Health Promotion. Their work is expected to contribute actively to achieving the objectives of the programmes.

Linkages will be maintained with United Nations and its Specialized Agencies such as UNDP, UNFPA, ILO, UNESCO, and UNICEF. Collaboration at national, regional, and global level will be developed with international and national nongovernmental organizations and bilateral agencies.
SUMMARY REPORT

Background

More than 100 specialists in health education and health promotion from nine different countries met in Shanghai, People's Republic of China during October 1992. The meeting was organised by the Shanghai Health Education Institute, in collaboration with the National Health Education Association and the World Health Organization. The participants met to exchange experience and to discuss common opportunities and problems in promoting better health in their respective countries. This report provides an overview of the symposium and a summary of key conclusions concerning future action.

The meeting was opened by Dr Wang Daomin, Director, Shanghai Municipal Health Bureau and Chairman of the Conference Organizing Committee. Dr S.T. Han, Director of the WHO Regional Office for the Western Pacific welcomed delegates on behalf of WHO and brought greetings from the Director General Dr Hiroshi Nakajima. Dr Han presented the vision of WHO for health education and health promotion in the Western Pacific Region and set the scene for the conference.

Other important contributions to the conference came from Mr H.S. Dhillon, Director of the Division of Health Education in WHO Headquarters, Geneva. Mr Matti Rajala, President of the International Union for Health Education, and Dr. Rosmarie Erben, Regional Advisor for Health Promotion WHO Western Pacific Region. In total, 26 papers were presented during the four days of the symposium. Participants also worked in groups to consider the key messages from the Symposium and to agree on the main conclusions included in this report.

This Symposium was organised at a time of significant change in the Western Pacific Region. Rapid economic growth and industrialisation, together with related social change and urbanisation are presenting many new challenges to promote and protect the health of populations in the Region. These challenges arise from the impact of change on the lifestyles and living conditions of many people.

Such challenges are further increased by population growth and a changing population structure. The increase in proportion of young people, and of older people in many countries in the Region is a sign that past efforts to protect and improve the health of populations have been successful. However, such successes bring with them the challenge of maintaining good health among all people to enable them to lead socially and economically productive lives.

It has not been possible to include a detailed description of all contributions to the Symposium, and a separate list of papers presented at the symposium is included as an appendix to this report. A number of key themes emerged from the conference papers and discussion, and these are summarised below.
1. Improving Lifestyles and Living Conditions for Health

On many occasions during the symposium, participants were reminded that achieving better health for individuals and communities is not simply a matter of helping people to change their behaviour - to stop smoking, eat a healthy diet - recognition also has to be given to the ways in which living conditions influence health choices and decisions.

For example, eating a healthy diet is not only dependent upon knowing what foods to eat, but also on regular access to healthy food at affordable prices. The control of infectious diseases is not only dependent upon good personal hygiene and immunisation, but also on clean water, adequate waste disposal, and appropriate housing. Reducing injury and occupational disease not only requires safe working practices (such as wearing protective equipment), but also a safe working environment and safe equipment. These examples illustrate some of the ways in which the environment where people live and work can directly affect health, and greatly influence the possibility of making a healthy choice.

Addressing such issues will require some form of social action. Again, several important general conclusions concerning such a process were reached at the symposium.

i) the success of health education will be dependent upon supportive living and working environments.

ii) creating supportive environments for health will require direct action by communities, as well as government action on behalf of the people.

iii) support for direct action by communities to improve their environment should draw upon existing social networks and organisations where this is possible.

iv) government actions need to be based on well developed policy, and need to be backed by appropriate legislation, financial incentives or controls, and effective surveillance.

v) government actions need to be across different sectors, involving not only health ministries, but also education, agriculture, transportation, industry and other relevant sectors.

vi) government action will also need to include the provision of adequate resources for health education. This must include support for an effective infrastructure for communication, and where possible, special support for school health education.

vii) there is a need to recognise that lifestyles and living conditions are closely related to economic conditions, urban/rural differences and cultural differences. Programs to change living conditions should focus on the specific needs of local communities.

In achieving more supportive environments for health, due consideration must be given to the principles of individual and community participation which are described below.

2. Participation through Empowerment

Symposium participant emphasised the importance of active participation by both individuals and communities in the decisions and actions taken to improve their health. This includes participation in the assessment of health needs and in selecting priorities for action, participation in action to achieve change, and participation in the assessment of the success of those actions. Above all the Symposium emphasised the importance of listening to communities and acting upon their views.
Again, several important conclusions were reached concerning the basis for effective participation, these included:

i) individuals need to be well informed about how their lifestyles and living conditions influence their health. This will require access to information and opportunities to develop skills to improve their health. In turn, this will require effective health education for all people - particularly through schools, local communities and the mass media.

ii) individuals and communities must have meaningful opportunities to participate in decision-making. This will require opportunities to develop personal skills which enable effective participation. It also requires a genuine partnership in decision-making between health experts and policy makers on the one hand, and the communities they serve on the other.

iii) communities must have real opportunities to bring about change. In other words, they must have the necessary political support from government. This requires that opportunities exist for participation in the political process, and for advocacy for government policies which ensure that the promotion and protection of health is a clear priority in all policy decisions.

Different countries with different social and cultural traditions, and different political organisation will need to interpret these general conclusions in ways which are appropriate to their circumstances.

3. Improving the Effectiveness of Health Education

Participants at the conference were given the opportunity to share experiences in health education and health promotion from around the world. In all cases there were positive lessons to be learned from these experiences, and in some cases, mistakes to be avoided. Although the case studies came from countries with different social and cultural traditions, and countries at different stages in economic development, some common messages concerning best practice in health education emerged from the symposium:

i) To be effective, health education requires systematic planning and appropriate evaluation. This requires:

- an assessment of needs and opportunities
- a clear definition of the objectives of a program
- a well defined program of action, and
- appropriate surveillance and monitoring

ii) To be effective, health education will require a co-ordinated approach which draws upon different disciplines and skills and uses different media for delivery. This will require an infrastructure for co-ordination and adequate resources.

iii) To be effective, health education requires a skilled workforce. Such skills include those of management, advocacy and facilitation. Training programs for health and education professionals are essential to improving the quality of health education. They will require resources to support appropriate training institutions.
iv) To be effective, health education requires living conditions conducive to health and supportive government policies at all levels - local, regional and national. This will involve action across traditional sector boundaries. It is necessary to have an impact beyond the health sector and to influence decision-making in other sectors. This will require effective advocacy for health which is a special responsibility of the health sector. Effective advocacy involves identifying common goals between health and other sectors and engaging the interest and commitment of community leaders. Such a comprehensive approach, intended to influence lifestyles and living conditions, is referred to as health promotion.

v) To be effective, much can be gained by learning from existing model programs. However, such programs need to be carefully adapted to local conditions rather than simply copied from one place to the next. This means that adequate time and resources need to be available for field testing and development.

vi) To be effective, health education requires continued action to reinforce and maintain improvements in health. This requires a long-term commitment to funding.

4. Supporting International Co-operation

Finally, the symposium participants recognised that promoting the health of all people benefits from international co-operation. Sharing new ideas, experiences, successes and failures is an essential part of improving the effectiveness of health education and health promotion. By providing the opportunity to discuss common problems and find appropriate solutions the first Shanghai International Symposium on Health Education has made an important contribution to making HEALTH FOR ALL less of a slogan and more of a reality for the people of the world.

5. Concluding Remarks

The meeting was closed by Dr Chen Min Zhang, Minister, Ministry of Public Health, People's Republic of China. The Minister emphasised the commitment of China to strengthen and extend co-operation with other countries and international organisations. He recognised that this Symposium served as a good example of this spirit of openness and co-operation. The Minister pointed out to participants that health education was one of the designated strategic priorities in China as a part of the current 10 Year Health Plan. He emphasised that support for the existing health education institutions, such as those in Shanghai and Beijing, were an important part of a wider commitment to promote health in China, and that the work of these Institutions was well-integrated with the development of primary health care in China, and the existing Patriotic Health Campaign. Finally, the Minister emphasised the important need to deepen theory and research towards the goal of improved practice in health education. He acknowledged that the Symposium had made an important contribution to this end, and looked forward to continued collaboration with other countries in the promotion of better health in China.

In the final address of the conference, the Vice-Mayor of Shanghai Municipal People's Government, Mrs Xie Liguan, identified the challenge posed by health promotion - that of combining education with environmental regulation and control. She observed that Shanghai was going through a period of unprecedented change and development which posed the challenge to balance economic development with the need to protect and promote the health of the people. She thanked participants of the Symposium, and invited all to return to see progress - in health and economic terms - in Shanghai in the future.
LIST OF PAPERS PRESENTED

Building up Health Education with Chinese Characteristics
Bi Xiaozeng, Chief, Division of Health Education, Office of National Patriotic Health Campaign Committee, Shanghai, China.

Multi-sectoral Social Alliance in Health Education
Yuan Zhongjian, Deputy Director, Office of Shanghai Patriotic Health Campaign Committee, Shanghai, China.

International Union for Health Education: Global Development
Matti Rajala, President, IUHE, Paris, France.

Planning for Health for All
Don Nutbeam, Professor, Department of Public Health, University of Sydney, Sydney, Australia.

A Multi-sectoral Approach to PHC in Fujian Province
Guan Jihui, Deputy Director, Fujian Health Education Institute, Fuzhuo, China.

The Net-work Construction of Shanghai Health Education
Hu Jinhua, Director, Shanghai Health Education Institute, Shanghai, China.

An Analysis of One Year Hot Line Counselling on Psychological Health
Tian Yongbo, Head, Section of Community Mobilization, Shanghai Health Education Institute, Shanghai, China.

Computer Assisted Learning under the Status of Health Education in Japan
Yasunori Yamashita, Professor, University of Chiba, Chiba, Japan.

Community Action Programmes in Health Promotion
Sally Redman, Lecturer, University of Newcastle, Newcastle, Australia.

Research on Model of Health Education of Rural Areas of Shanxi
Wei Maoquan, Chief, Division of Health Education, Department of Health of Shanxi Province, Taiyuan, China.

Behavioral Change
Stoy E. Proctor, Director, Breathe-Free Plan to Stop Smoking, Silver Spring, USA.

Health Education and Role of Children and Adolescents in National Development
Ian M. Newman, Professor, University of Nebraska-Lincoln, Lincoln, USA.

Light Entertainment Television and Health Education: A Report on a Joint Health Education Authority/BBC "Health Show" Which Used Light Entertainment Techniques to Provoke an Unprecedented Audience Response
David Bedford, Director of Public Communications, Health Education Authority, London, U.K.
Appendix 1

Study on the Methodology and Effect Evaluation for the Popularization of Health Education Textbook in Shanghai
Zhang Wanqing, Information and Materials Research Section, Shanghai Health Education Institute, Shanghai, China.

Discussion on the Position and Effect of Social Union in the Implementation of Health Education
Lui Ruilan, Director, Liaoning Health Education Institute, Shenyang, China.

Education to Avoid Western Lifestyle Diseases
Terry Butler, Director, Quit Now! National Program, Gordon, Australia.

School Health Education and Primary Prevention of Essential Hypertension
Wang Wenying, Associate Professor, Shanghai Medical University, Shanghai, China.

Health Education for the School Age Child
Colin Yarham, Member of the Board of Trustees, IUHE, Roseville, Australia.

Study on Intervention of Farmers Smoking in Shanxi
Zheng Baoyi, Chief, Division of Disease Control, National Health Education Institute, Beijing, China.

Influence of Health Education on Breakout of Hepatitis A in Shanghai in 1988
Shi Rong, Shanghai No. 2 Medical University, Shanghai, China.

Evaluation of Anti-smoking Education of Kindergarten Children
Wang Ling, Associate Professor, Shanghai Medical University, Shanghai, China.

Evaluation of Breast-feeding --- A Health Education Program
Huang Jingheng, Professor, Shanghai Medical University, Shanghai, China.

Strategy and Impact Evaluation of Health Education in Flooded Areas in Anhui Province
Zu Guanghuai, Director, Anhui Health Education Institute, Hefei, China.

The Health Education Intervention to the 205 Patients with Hypertension in the Ruijin and Songshan Street of Luwan District of Shanghai
Chen Xiangchun, Shanghai Medical University, Shanghai, China.
INFORMAL MEETING OF WHO COLLABORATING CENTRES FOR HEALTH EDUCATION AND HEALTH PROMOTION WITH OTHER RELATED INSTITUTES

20 October 1992, Qian He Hotel, Shanghai, China

Introduction

Dr Wang Daomin, Director of the Shanghai Municipal Health Bureau, welcomed participants to the Informal Meeting of Collaborating Centres on behalf of the hosts. The Shanghai Health Education Institute was represented at the meeting by the Director, Mr Hu Jin Hua, and by the Deputy Director, Mr Gan Xing Fa.

WHO Regional Office for the Western Pacific

Dr Rosmarie Erben welcomed participants on behalf of the WHO Regional Office for the Western Pacific, and brought greetings of the Regional Director, Dr S T Han. Dr Erben outlined recent developments in WPRO regarding arrangements for health promotion. In particular she drew attention to the current change in status of the Public Information and Education for Health program to a new program for health promotion in the Regional Office. She highlighted current planning for a new health promotion program for the years 1995-2000 and emphasised the important need to develop a strong network of collaborating centres in health education and health promotion in the Western Pacific Region to support the implementation of the program.

She then invited each of the Centres represented at the meeting to provide a brief overview of activity.

Shanghai, China

Mr Gan Xing Fa spoke on behalf of the Shanghai Institute for Health Education, WHO Collaborating Centre for Health Education. The Institute was established in 1958 and has been a WHO Collaborating Centre since 1985. The Institute is involved in a full range of health education activities including development of educational materials and other work with the mass media, and health education research. Priority is given to "health city" activities. It has a special interest in worksite health promotion and would be collaborating with WHO and four worksites in Shanghai on a new worksite health promotion demonstration project.

Newcastle, Australia

Dr Sally Redman spoke on behalf of the WHO Collaborating Centre for Health Behaviour Research at the University of Newcastle, Australia. She highlighted the creation of the Hunter Centre for Health Advancement which integrated University and Health Services activity. She outlined the full range of education, training and research activities of the Centre, placing special emphasis on the multidisciplinary approaches to research and project development in the work of the Centre.
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