Healthy Settings

Report and Documentation of the Technical Discussions
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Part I - Proceedings*

* Originally issued as Recommendations Arising out of the Technical Discussions on Healthy Settings (document SEA/RC53/19 dated 3 September 2000)
1. **INTRODUCTION**

The Technical Discussions on Healthy Settings were held on 31 August 2000 under the chairmanship of Dr B.D. Chataut, Director-General, Department of Health Services, Ministry of Health, Nepal. Mr Ibrahim Shaheem, Director, Disease Control and Prevention, Department of Public Health, Ministry of Health, Maldives, was elected Rapporteur. The agenda and annotated agenda (SEA/PDM/Meet.37/TD/2.1 and SEA/PDM/Meet.37/TD/2.2 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.37/TD/2.3) formed the basis for the discussions. A set of six discussion questions was also circulated which facilitated the discussions.

1.1 **Introductory Remarks by the Chairman**

While welcoming the participants, representatives of the nongovernmental organizations (NGOs) and all others present, Dr B.D. Chataut, Chairman, highlighted the importance of the subject in today’s context. He said that health is not limited to one sector only; it encompasses environment, education, sanitation and hygiene, advocacy and public awareness programmes etc. He recognized the “healthy settings” viewpoint as a more inclusive way of looking at the present WHO-assisted community development programmes being promoted in different countries.

1.2 **Presentation by Dr A. Sattar Yoosuf, Director, Sustainable Development and Healthy Environment (SDE), WHO/SEARO**

Dr A. Sattar Yoosuf (SDE), presented the working paper and introduced the subject. He highlighted the importance of the subject, especially to developing countries in the Region. He hoped that the topic would be discussed extensively and recommendations made in the light of the prevalent situation in the countries of the Region.
Dr Sattar explained the meaning of ‘setting’ as a physical or geographically-demarcated location, where people live and work. Healthy settings could be conceptualized as an approach or a process. A healthy setting is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential. He mentioned that “Healthy setting” as emphasized in this technical discussion, is merely a generic term that takes into consideration the many types of community development actions being undertaken in society at large; which in effect are actions being carried out in community settings. It was further stated that the health status of any setting is determined more by the quality of the environmental conditions and risk factors than by the health care facilities that are provided. He also clarified the hierarchical nature of settings; each being a subset of the other. These may be called contextual and elemental settings respectively.

Betterment of health and well-being of the community thus become one of the goals of community development. Community development action could either be issue-based or target population-based, and could take the form of campaigns, donor-initiated development projects, government programmes, NGO community efforts or a combination of one or more of these. The target population-based community action can be viewed in the form of a community development programme, such as taking up of a slum area, mother and child health, disadvantageous groups etc. The action will depend upon the needs of the country and on the way the policy-makers view the problem.

The South-East Asia Region has undertaken various community development programmes in the form of (a) metropolitan environment improvement programmes; (b) Sarvodaya in Sri Lanka; (c) Adipura in Indonesia; (d) model village in Bhutan; (e) basic minimum needs action in Thailand; (f) cooperative group housing; (g) Grameen bank and micro-credit banking in Bangladesh; (h) Gonashasthya Kendra in Bangladesh, and (i) Sulabh in India, etc. The concept of healthy settings is of concern to WHO due to its relevance to public health, urban health and managerial factors for enhancing partnership.
A Healthy Settings is achievable through the practical application of the principles of health promotion. Health promotion constitutes a preponderance on public health rather than on individual health; focus on causes of ill-health; use of a multitude of approaches; active participation of public, and ensuring the critical role of PHC staff. The success of the programme will largely depend upon good strategic planning and issue prioritization; effective managerial mechanisms, and involved community participation.

Regional experiences indicate certain constraints in the implementation of healthy settings. They include lack of awareness of the concept, weak planning and management, weak coordination and team-work, low advocacy focus, unrealistic time-frames, turnover of government staff and NGO-Government distance. Constraints to sustainability included non-involvement of the community, too much focus on external resources, over-dependence on specific individuals, and project-based nature of work. The challenges beyond the technical aspects related to the lack of political commitment, partnerships and decentralization.

The application of the Healthy Setting process at the district level was perceived as particularly desirable. Thus, the added utility of a “healthy district” approach for the WHO collaborative effort would constitute strengthening the county capacity for integrated management, promotion of health systems research and demonstration of the effect of technical inputs being used.

2. DISCUSSIONS

(1) It was agreed by the participants that a resolution on the Healthy Settings approach to health promotion should be proposed for adoption by the fifty-third Session of the Regional Committee meeting.

(2) Participants considered that although the term “Healthy Settings” was new, the concept and practice of the elemental components of healthy settings had already been demonstrated in numerous health promotion projects in countries of the South-East Asia Region, such as healthy cities projects, healthy schools projects, healthy islands, healthy marketplaces, healthy workplaces etc. Therefore, the concept is already well known and widely accepted at the country level.
Healthy Settings

(3) It was stated that a district is the lowest politically-demarcated geographical entity with its distinct administrative infrastructure and decentralized government, where peripheral development sectors are present. A district will encompass various smaller settings, such as villages, markets, schools, hospitals, health centres and offices. Therefore, a healthy district could be an umbrella for various healthy settings.

(4) It was agreed that political commitment, partnerships between governmental and nongovernmental organizations, and community participation are necessary for the success of healthy settings-type projects.

(5) There should be a proper coordination mechanism between the different stakeholders in healthy settings projects and programmes. Sanitary engineers, scientists, the media, architects, the community at large, politicians and religious leaders, etc. should therefore meet regularly for achieving the planned goals.

(6) It was agreed, however, that the goals of healthy settings projects and programmes cannot usually be achieved within a short time-frame. Sustained effort over a prolonged period of time is required.

(7) Participants discussed that in many countries, decentralization facilitates local collaboration in healthy settings projects. Model village or model basti projects have been successfully implemented in a number of countries. Integrated management and coordination of large-scale projects, such as healthy cities projects, are more complex and require greater effort.

(8) Participants were aware of the various difficulties in adopting the healthy cities concept as it is practised in the European Region. European cities generally enjoy a more developed physical infrastructure and a more stable population base. It is easier to achieve a healthy supportive physical environment since this is largely a matter of single-sector infrastructure development. Building supportive social environments requires multi-sectoral collaboration.
(9) Some of the common challenges that have been noted in healthy settings-type projects in SEAR countries include high turnover of government personnel, a culture of verticalism and weak coordination, insufficient community participation, poverty and ignorance.

(10) Countries will require external support in order to strengthen and expand the healthy settings approach to health promotion. Such support should be primarily technical.

(11) While initial seed money from donors may be useful in initiating projects, other fund-raising mechanisms should be sought for sustaining projects. Dependency on donor-financing compromises the sustainability of projects. Sometimes, fee for services, charity and donations, private sector support, self-help approach, cross-subsidies, establishment of cooperatives and micro-enterprises, micro-credit, and volunteerism should also be considered.

(12) Although many healthy settings-type projects have been implemented and are ongoing in SEAR countries, the aim now should be to institutionalize the concept as a national programme in all countries.

(13) Participants agreed that basic water supply and sanitation are priority issues in virtually any setting in SEAR countries. A diagnosis of needs in most healthy settings projects and programmes will inevitably give emphasis to these areas.

(14) Participants also agreed on the vital importance of air pollution issues in creating healthy settings, not only with respect to urban air quality but even more so on indoor air quality in rural settings. Other health issues considered by the participants to be important for achieving healthy settings in SEAR countries included food safety; vector control; solid and hospital waste management; malnutrition; diarrhoeal diseases; illicit drug use; alcohol and tobacco use; HIV, and TB. These have to be addressed on a priority basis.
3. **RECOMMENDATIONS**

(1) Member Countries should each identify a pilot district where a Healthy District project may be undertaken using the Healthy Settings concept, and should establish the necessary infrastructure to manage such projects by the end of 2001.

(2) Member Countries should give priority to strengthening human resources capabilities for managing Healthy Settings projects, and should advocate intersectoral action for health towards strengthening future application of the primary health care approach at the district level.

(3) Member Countries should strengthen the capacity and active involvement of communities, NGOs, and the private sector towards healthy settings approach, particularly in the areas of priority settings, monitoring and evaluation of projects.

(4) Member Countries should build an existing mechanism of local intersectoral management approach such as municipal councils, district and community development committees, for the planning, implementation, monitoring and evaluation of healthy district projects.

(5) WHO should provide technical support to Member Countries while advocating healthy districts using the healthy settings approach at the national level. Strategic advocacy will generate collaborative support starting from the national level down to the implementation at the district level.

(6) WHO should provide necessary technical support to Healthy District projects in countries of the Region, particularly in the areas of project planning, capacity-building, monitoring and evaluation. To extract and learn from lessons regarding the current healthy settings-type projects, in terms of both successes and failures, should be a priority.

(7) WHO should support the development of healthy settings management information systems and assist with networking among the various Healthy District programmes in Member Countries.
Part II - Resolution, Agenda and Working Paper
Resolution*

The Regional Committee,

Recalling the World Health Assembly resolutions WHA51.12 and WHA51.28 relating to health promotion and environmental health, and its own resolutions SEA/RC40/R5 and SEA/RC41/R8 relating to development of comprehensive district health systems,

Recognizing the need for intersectoral action for sustainable health development and its relevance in the “healthy settings” approach,

Emphasizing that the healthy settings can be initiated within the various national health promotion and health development programmes, such as healthy cities and islands, health promoting schools, healthy workplaces, and healthy districts, and

Having considered the report and recommendations of the Technical Discussions on “Healthy Settings” (SEA/RC53/19),

1. **ENDORSES** the recommendations contained in the report;

2. **URGES** Member States:

   (a) to identify by the end of 2001, at least one district to pilot a “healthy setting” programme, with active involvement of local communities, other sectors and NGOs, and

   (b) to evaluate the existing technical and managerial capabilities for promoting various “healthy settings” programmes, and enhance these where necessary, and

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* SEA/RC53/R4
3. REQUESTS the Regional Director:

(a) to provide necessary technical support, including guidelines and indicators to Member States for formulating plans to establish “Healthy District” projects, and

(b) to promote exchange of experiences among Member States and WHO on various “healthy settings” approaches and strengthen networking among countries.
Agenda*

1. Introduction
2. Regional Experiences on Various Healthy Settings Approach
   2.1 Healthy cities
   2.2 Health-promoting schools
   2.3 Health-promoting hospitals
   2.4 Other community-based and thematic healthy settings
3. Policy Challenges
   3.1 Political commitment
   3.2 Partnership
   3.3 Decentralization
   3.4 Healthy district as an umbrella for various healthy settings
   3.5 Some highlights on working mechanism
      - Information systems
      - Monitoring, supervision and evaluation system
      - Networking
      - Capacity building
      - Resource mobilization
      - Social marketing
4. Conclusion

* Originally issued as document SEA/PDM/Meet.37/TD/2.1 dated 23 August 2000
Annotated Agenda

1. INTRODUCTION

What is the healthy setting approach? What are the “regional experiences” on different healthy settings (geographical, community-based and thematic-driven healthy settings)?

2. REGIONAL EXPERIENCES ON VARIOUS HEALTHY SETTINGS APPROACH

2.1 Healthy cities: regional experience on healthy city initiatives.

2.2 Health-promoting schools: country experiences on health-promoting schools.

2.3 Health-promoting hospitals: different country initiatives on health-promoting hospitals and baby friendly hospitals.

2.4 Other community-based and thematic healthy settings: healthy villages; healthy islands; no smoking villages/islands; no alcohol villages; drug-free areas/villages.

3. POLICY CHALLENGES

3.1 Political commitment

3.2 Partnership

3.3 Decentralization

* Originally issued as document SEA/PDM/Meet.37/TD/2.2 dated 23 August 2000
3.4 Healthy district as an umbrella for various healthy settings

3.5 Some highlights on working mechanisms
   - Information systems
   - Monitoring, supervision and evaluation system
   - Networking
   - Capacity building
   - Resource mobilization
   - Social marketing

4. **CONCLUSION**
1. INTRODUCTION

Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature. A healthy and productive life is influenced by health determinants and risk factors within the control of individuals themselves such as health behaviour. There are other determinants outside the control of individuals such as social, economic and physical environmental conditions and the provision of health care services.

Health is created and lived by people within the settings of their everyday life: where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. The International Conference on Health Promotion in Sundsvall, in 1991, declared that countries should support in implementing healthy settings. The Conference called for the creation of supportive environments (refers to both the physical and the social aspects of our surroundings), which is a practical proposal for public health action at the local level, with the focus on settings for health that allow for broad community involvement and control, enable people to expand their capabilities and develop self-reliance.

A few years later, at the International Conference on Health Promotion held in Jakarta in 1997 the participants stressed the need to strengthen infrastructure and partnership mechanisms for implementation of different healthy settings. They declared that particular settings of health and its related

* Originally issued as document SEA/PDM/Meet.37/TD/2.3 dated 23 August 2000
The environment offered practical opportunities for the implementation of comprehensive strategies for development. These included healthy mega cities, islands, healthy cities and municipalities, local communities, markets, schools, workplaces, and health care facilities. The Jakarta Conference confirmed that settings for health represented the organizational base of the infrastructure required for health promotion and that new and diverse networks could be created to achieve intersectoral collaboration. Such networks could provide mutual assistance within and among countries and facilitate exchange of information on strategies, which proved effective in particular settings.

For more than a decade, the concept of healthy settings has been well accepted and adopted by Member Countries of the Region, as evidenced by the mushrooming “healthy settings” as integral parts of various health development programmes. These include healthy cities, healthy villages, healthy islands, and healthy workplaces, health-promoting hospitals, health-promoting schools and healthy districts.

The experiences of these “healthy settings” programmes are worth exploring, sharing and developing. This working paper, thus, reviews the practical experiences of these “healthy settings”, covering specific priority areas such as health promoting hospitals, health promoting schools, healthy cities and healthy districts. The manifestation of the 1990 World Health Day Slogan “Our Planet, Our Health: Think Globally, Act Locally” reflects the values and principles of the healthy settings approach.

2. REGIONAL EXPERIENCES ON HEALTHY SETTINGS APPROACH

2.1 Healthy cities

Healthy City initiatives were launched in all Member Countries of the South-East Asia Region more than a decade ago. The policy and strategic guidance from the Technical Discussions at the World Health Assembly held in May 1991 on the strategies for health for all in the face of urbanization, as well as from the intercountry consultation on health policies and strategies for urban slums held in WHO/SEARO in August 1992, paved the way to expand healthy city initiatives in the Region. A comprehensive review on healthy city initiatives in selected Member Countries was conducted in 1998 and a
regional consultation on the same issue was organized by WHO/SEARO in April 1999. The reviews indicated that many lessons could be learnt from the rich experiences of Member Countries for the development of a viable healthy city programme. In general, all healthy city projects/programmes mainly dealt with interventions aimed at improving the access to essential health care and solving the physical environmental problems. Healthy market places and healthy schools have been used as a unifying theme in many healthy city development programmes. All Member Countries have given importance to healthy market places including food inspection and analytical services.

In Bangladesh, the healthy city programme was initiated in 1993 in Chittagong City. Later, other urban areas were added, such as Cox’s Bazar in 1995, Rajshahi in 1996, and Sylhet in 1997. In all these cities, school health programmes were getting higher priority, followed by improvements related to the physical environment of the cities, which depended heavily on partnership between municipalities and the community. The orientation and training of various stakeholders were important in ensuring the broadest possible commitment and participation. The healthy city approach has led to the initiation of other healthy settings, such as in primary schools, market places, government offices, public restaurants and beaches. Strong linkages among political leaders and between sectors were also critical for the success of the healthy city project.

In Bhutan, the Healthy City concept was introduced in May 1999. The four major towns of Thimphu, Phuntsholing, Gelephu and Sjongkhar were proposed as project areas. However, healthy city-like initiatives under the label of Model Villages have been in existence for over a decade now.

In India, many initiatives for healthy urban settings were carried out under different ministries as well as local administrations. Urban health development projects were initiated at various places. These include the Calcutta Slums Health Improvement Project funded by the World Bank, Solid Waste Management in Calcutta, Healthy Drainage in Chennai, Healthy Bus Terminal in Hyderabad, Community Participation in Bangalore and Healthy Hospital in Kottayam Municipality in Kerala. A number of sub-national healthy settings were initiated mostly by the community, such as healthy street children programme, healthy school project and upgrading of health services.
In Indonesia, the healthy city movement started in the early eighties. It was generated through a yearly healthy city competition in each province, based on central government instructions to beautify and clean the cities all over the country. National committees identify the best cities capable of obtaining awards from the national government. The healthy city competition runs concurrently with the best village competition, which is conducted first within each sub-district, and then moved to the provinces. Then, the best village in the province is selected. Finally, the national committee selects the best village for the national award. The winner is invited to attend the National Independence Day celebration and the President personally distributes the, “ADIPURA Award” to the best city in all provinces.

WHO has supported healthy city projects in Balik Papan, East Jakarta, Lampung, Malang and Pekalongan, technically and financially. While the government is more closely involved in Balik Papan and Lampung, other stakeholders outside the government and community are involved in Malang and East Jakarta. Cianjur and Sukabumi have also joined the healthy city movement, with new paradigms, “empowering the community and encouraging government’s role as a facilitator of efficient development”.

In Myanmar, keeping in view the environmental health concerns in big urban areas, a healthy city programme was launched in the early 1990s in Yangon as a part of Yangon City Development. This was followed by another healthy city programme in Mandalay, the second largest city in Myanmar, launched as part of the World Health Day celebrations in 1996. The Mandalay healthy city setting was developed with the thematic drive on mass sanitation campaigns, intensive health education at schools, and twice-a-week special clean-up movements.

In Nepal, the WHO Healthy City Concept was introduced in the early 1990s in Kathmandu Municipality through a “Healthy City Demonstration Project” at Kuleshwor area in collaboration with a local NGO, Kuleshwor Club, the community and other development agencies. Later, the Banepa Municipality was proposed to be the first municipality to launch the healthy city programme in Nepal.

In Sri Lanka, the Healthy City Programme (HCP) was adopted in 1995 in Badulla. The programme was extended to Matale in 1996 and to Colombo in 1998. At the same time, the healthy village concept and experiment was also
introduced in Gampahailluapitiya in 1995, and in Moratuwa Kaikawala in 1996. At Badulla, a top-down approach was used in the implementation of HCP. In Matale, although private citizens initiated it, the healthy city concept was later adopted widely and provided a good example for other places.

In Thailand, the first healthy city initiative was undertaken in Bangkok in the early 1990s. Later in 1996, the World Health Day campaign for “Healthy Cities for Better Life” triggered the movement in other cities, like Korat, Payao, Yala and Panustritorn. In 1996, the healthy district programme was initiated in three districts (Yannawa, Sathorn and Bangkholae).

2.2 Health-promoting schools

A health-promoting school is a school constantly strengthening its capacity to implement a comprehensive school health programme and serve as a healthy setting for living, learning, sharing and working. The development of health-promoting schools varies in countries of the Region. In general, all countries are developing health-promoting schools comprehensively, based on their own capacities and resources. Many health-promoting schools are concentrated at the primary education level. Most schools have health education activities incorporated into the general school curriculum. Besides addressing traditional health promotion activities such as personal hygiene, prevention and treatment of skin diseases, control of diarrhoea, eye infections, communicable diseases and promotion of safe food and nutrition, some countries deal with emerging health issues such as HIV/AIDS, reproductive health, drug abuse and tobacco use. Sanitary facilities have been installed in many schools. Unfortunately, some primary schools in remote villages still have no access to adequate and safe sanitary facilities. All countries provide primary health care services for schoolchildren, including dental care. In most countries, the education and health sectors are working together on the school health programmes.

In Bangladesh, a pilot project on school health supported by the World Bank began in 1996 with the focus on preventive, promotive and curative health care of schoolchildren. Health education training to school teachers formed an important component of this project, as well as equipping students to educate their peers, their families and their communities on health. In
Bhutan, with support from WHO, a school health programme was launched in 1980. Health and physical education was separately taught as part of the general school curriculum. The “Health for Growth” books for Grades 4 and 5 of primary schools were used intensively. Meanwhile, a new approach to primary education, initiated in 1985, attempted to integrate health by incorporating it into every subject. After a review, the Division of Health and Education of Bhutan launched a comprehensive school health programme in 1998 with a focus on all primary schools. The new comprehensive school health programme included several activities for improving the health promotion component of the school curriculum, including development of lifeskills education on reproductive health and substance abuse.

In India, after decades of development of school health programmes several strategies have been adopted to improve school health. These include, among others, integrating health education into the school curricula, training teachers in health education and implementing a nation-wide special school health check-up scheme for all primary schools in the country. There have been various lifeskills education initiatives to address HIV/AIDS and drug problems in several states. These experiences could be shared to establish national strategies on lifeskills education in schools. In Indonesia, the “Little Doctor Scheme” or health promoting schools through schoolchildren has been implemented in all provinces since 1980s. The scheme aims to amplify learning on various aspects of health by giving responsibility to children to take care of their own health through active participation as little doctors. They supervise daily health matters at schools such as cleanliness of the school environment, latrines, beautification of schools, personal hygiene including examination of clothing and dental hygiene and providing first-aid services for accidents at schools. The little doctors also convey health messages to their parents at home. In view of the serious concerns on the new and emerging health issues, HIV/AIDS has become a priority school health programme implemented in all educational institutions, from the primary to university levels. Anti-narcotic and anti-smoking campaigns have been strengthened. In 1997, the Ministry of Education and Culture declared all public schools to be “smoke-free zones”. Lifeskills education for primary schools addressing various health problems had also been implemented nationally. Meanwhile, the module for secondary schools was prepared for trial in several schools.
Another Indonesian innovation to promote school health was through the Posyandu* programme, especially in the Maluku and East Kalimantan Provinces. Schoolchildren from the fourth and fifth grades were trained to carry health messages home to convince their mothers to attend Posyandu on a regular basis. The local health authorities developed this initiative jointly with an NGO, Project Concern International (PCI). A four-month training course for students covering key MCH areas such as growth monitoring, maternal and child nutrition, immunization, diarrhoeal disease management, dehydration, acute respiratory illness and family planning, was conducted in Maluku. In East Kalimantan, the training was extended by three weeks to cover tuberculosis and other principal communicable diseases. In order to ensure that the students shared this information at home, a workbook for homework was designed and provided to each student. The PCI also encouraged each student to locate two children under three years of age and follow them up to ensure that they completed their immunization schedules. Based on the encouraging results of the evaluation, the project was expanded to cover Maluku province. In 1996, the Ministry of Health in East Kalimantan considered using the school Posyandu programme approach to detect and treat tuberculosis in village communities using the DOTS (Directly Observed Treatment Short-course) strategy. Currently, Indonesia is conducting Rapid Assessment and Action Planning (RAAPP). This looks at national capacity for health promoting schools that brings action planning at national as well as regional and local levels in the development of health-promoting schools in the country.

In Maldives, in order to strengthen the collaboration between the health and education sectors, a School Health Coordinating Committee was established in 1995, comprising high-level officials and professionals from the Ministries of Health and Education, headed by the Deputy Minister of Education. Recently, Maldives conducted a series of training courses for health workers and teachers responsible for school health. At least two schools in Malé and two schools in other islands were selected for the health-promoting schools programme.

* Posyandu is a scheme of organized community-based integrated health services covering mothers and children under five. Health workers and trained village volunteers in the community jointly provide the services on a monthly basis.
In Myanmar, a central-level school health coordinating committee is in place and regular meetings are held. The latest initiative is to establish health-promoting schools in all townships by 2001. The School-based Healthy Living and HIV/AIDS Prevention Education (SHAPE) project was launched in 1993. Lifeskills education has been piggy-backed on SHAPE since 1997. Sixty townships were implementing lifeskills education in lower and upper secondary schools. In Nepal, the Basic and Primary Education Project (BPEP) with support from the World Bank, DANIDA, UNICEF, JICA and ADB has just completed its first phase. The project is aimed at expanding the access to education through: construction and repair of school buildings, non-formal education for out-of-school children, improving quality of education through curricular reform, teacher training, and provision of textbooks and strengthening education management. The second phase of the project was planned to give priority to further enhancing the quality of education and children’s learning. There was a growing consciousness that for quality education, effective school health was essential. The project is now being expanded to cover especially-at-risk children, including those with nutritional and health risks and community participation on educational issues.

In Sri Lanka, the National Institute of Education, Ministry of Education, is responsible for health curriculum development and teaching as well as for monitoring the school health programme. Adolescent health, reproductive health and HIV/AIDS are some of the new subjects introduced in the curriculum. A special unit in the Ministry handles problems like alcoholism, drug abuse, sex-related and mental health problems of schoolchildren. School health clubs have been established where members (schoolchildren) promote health through maintaining a healthy school environment and influencing parents and communities on healthy practices. The syllabus and modules on lifeskills education for Grade 9 was developed in 1999, and was being implemented in all schools. In Thailand, in response to the rapid social changes taking place in the Thai society and the epidemiological transition from communicable to noncommunicable diseases, the need to inculcate the principles of healthy behaviour and practice in young persons and lifestyles related to emerging diseases led to the development of a research project in 1997, aimed at developing an appropriate model of a health-promoting school. The school health programme in Thailand is one of the critical components of the healthy city programme in some cities, enjoying the
support of the municipal government. HIV/AIDS information has been incorporated into the school curriculum since 1992, and a project on “Human Development in AIDS prevention for Teenagers” was developed in 1993. Nation-wide expansion of lifeskills education on AIDS and drug dependence was started in 1998.

2.3 Health-promoting hospitals

A significant development in countries of the Region has taken place recently with respect to hospitals. Even though they do not carry the label, “health-promoting hospitals”, all hospitals have several key elements for promoting health. Most countries have initiated health promotion activities within the hospital premises as a part of hospital services, such as providing health education to patients and family members, creating a good hospital environment, providing good sanitary and waste management facilities and other amenities. Most countries conduct in-service training for hospital staff on health education. Several countries use audio and video tape recordings and video-based education programmes for their hospitals. Some countries have even developed a community-based programme where the community is involved in hospital services. All countries have even undertaken Baby Friendly Hospital Initiatives (BFHI). Since its launch in 1991, BFHI has now the support of politicians and health professionals alike. A majority of hospitals are currently registered as “baby friendly”.

In response to the increasing burden and challenges on health services, most Member Countries have improved the management of their hospitals through the appointment of qualified directors with a degree in hospital management. Many countries have conducted leadership and management training workshops for their managerial staff. Some countries have even developed an accreditation system for hospitals as a tool for improving the quality of hospital services. Bangladesh, Bhutan, Maldives, Myanmar and Nepal are attempting to address issues in care in hospitals including management, quality assurance of medical services, referral systems, infection control and waste management. The expected outputs of the initiatives include the development of strategic planning capacity, improved information systems in relation to finances, personnel and clinical care, effective quality
assurance programmes and effective referral systems. In Bhutan, the welfare of staff, including housing facilities, is included in the programme.

In India, all hospitals with over 250 beds are required to have infection control committees. The delivery of outreach community clinic services is another important feature of the health care system. For example, all specialists working in teaching hospitals are required to conduct regular health camps in the community using mobile vans. Another area of concern in India is related to the welfare and health of hospital staff. Those working in high-risk areas are given immunization where appropriate. Increasingly, hospitals are covering staff with group health insurance. Community participation in hospital management committees is encouraged; eminent citizens are included in advisory committees.

Indonesia is embarking on major reforms in health systems development. An important aspect of the broad strategy is termed the “proactive hospital approach”. This is based on the principle that individual and community action, and not just government action, has to be at the forefront of efforts to reduce health risks and promote health. In addition to providing treatment to patients, hospitals will be supporting efforts by those people who are already healthy, to remain so and by those who are ill or disabled to optimize their quality of life. A “Swadana Hospital” (Hospital Corporatization Scheme) has been tried out in line with the decentralization process initiated in the country.

Currently, Sri Lanka has special units in hospitals for health education, infection control and baby-friendly activities. However, in major hospitals, these will be transformed shortly into hospital-based public health units, led by a community health physician. The project partners include donors and groups sharing responsibility for health promotion such as schools, Lions Clubs, the Buddhist Students’ Federation and businesses. Some hospitals have identified areas where the health of the local community was being threatened and have taken action to promote public health solutions. An example is eye injury caused by threshing machines. In this instance, hospital staff went to the fields to talk to operators about the necessity of wearing protective spectacles and conducted health education campaigns on this issue.
In an effort to shift its hospital system from a mainly curative service focus to one that incorporates promotion and prevention, the Ministry of Public Health in Thailand developed a master plan for health-promoting hospitals in 1998. This change helped to contain treatment costs and make health services more responsive to community needs. The first phase of the Master Plan is now under way with 24 pilot (or “learning”) hospitals already participating. The second phase, which is scheduled to commence in 2000, envisages the expansion of the approach into all hospitals operated by the Ministry of Public Health, with participation being voluntary. The system of hospital accreditation in Thailand came into operation in 1996, with 35 hospitals participating. The interest of hospitals in participating has been a major feature and the project will shortly be expanded to include a total of 100 hospitals. The system is based on a Total Quality Management approach with the emphasis on the hospital as a learning organization rather than relying on externally imposed sanctions and controls to meet required standards. The potential for this type of accreditation process as a vehicle for improving all aspects of hospital performance was recognized at an intercountry meeting in the South-East Asia Region in 1998. Recommendations included mobilizing support within countries for hospital accreditation for improving quality of care. Both within Thailand and the Region, this development was perceived as being directly relevant to maximizing the potential of hospitals to become health promoting hospitals.

2.4 Other community-based and thematic settings

In Bhutan, as an entry point to intensify PHC activities, a Model Village Concept was introduced in 1993, following the success of promoting sanitation and hygiene practices through community participation at the block level. Basically, a healthy village should adopt the following: each household should have a simple hygienic latrine, safe drinking water, proper waste disposal, domestic animals segregated from the residence, smoke and soot-free environment, all children and women fully immunized; and all children enrolled in school. In Indonesia, the healthy workplace has been piloted in several industries and offices. Thematic healthy settings, prohibiting smoking in various environmental settings, have not only been tried at school settings addressing the schoolchildren, teachers and the staff, but also in other places, such as Smoking-Free Office Zones to cover workers. This was started in the
premises of the Ministry of Health and at all health-related offices and services in the country. Other agencies are now adopting the Smoking-Free Office Zones scheme. ‘Healthy village’ has been a model concept for village development in the country. It includes health education activities at the village level, mobilization of village health volunteers, setting up of village health posts, cleaning the village every Friday or on alternate days, etc. Competitions between villages was introduced as a government mechanism to stimulate healthy villages.

In Maldives, the Healthy Islands Programme developed a thematic healthy setting ‘Tobacco Free Island’. One island won a WHO Award, which was presented in Bangkok by the WHO Director-General on 31 May 2000. In Nepal, a locally-organized Mothers' Group at Chainpur village of Dhading district has banned smoking cigarettes, chewing tobacco and selling alcohol in their community. Within two years, 150 women voluntarily quit their smoking and chewing habits. In this district, women are the key players and can influence the health status of their families - they contribute significantly to improve the health status of the community. The Village Development Committee of Dhading district is vigorously practising people-centered development approaches and has made significant progress in becoming a model village development committee.

3. POLICY CHALLENGES

The most challenging task for the Region is to improve and expand the healthy settings Programme. Based on the positive, effective and efficient experiences of the strategic implementation of healthy settings in the Region, as well as from the failures and inefficiencies, the following challenges need to be addressed:

3.1 Political commitment

In a few countries, it is found that although the central government is committed to implement healthy settings initiatives, at local levels the commitment is low. It was reflected in poor intersectoral collaboration and integrated planning at local levels due to lack of leadership. It was also reported in a review that intersectoral collaboration in the healthy cities programme was the least successful and most difficult to realize.
Any initiatives need strong political commitment, both at the national and local levels, which, in turn would bring about strong leadership and an integrated framework on planning and implementation of the healthy cities programme.

3.2 Partnerships

Building of partnerships is essential for the proper implementation of healthy setting initiatives. The involvement of nongovernmental organizations, agencies, and community leaders was lacking. Most local governments lack resources – some of the resource problems can only be solved through partnership. An integrated framework cannot be accomplished without close partnerships between and among various governmental development sectors and nongovernmental organizations, universities, research institutions, donor agencies and local communities.

3.3 Decentralization

In several countries, decentralization facilitated local collaboration. However, due to different interest groups, some misunderstandings developed between the national and local levels, which was a major constraint in taking action for dealing with national and local priorities. This challenge could be solved through frequent exchange of views and dialogues and by balancing local and national priorities.

3.4 Healthy districts as an umbrella for various healthy settings

Under the healthy settings approach there are two activity components: community-based activities that are target-oriented and thematic-driven activities that are health-issue oriented. Both are manifestations of strategic needs in the implementation of the healthy settings approach. Unfortunately, it was found that those initiatives lacked linkages and were far from efficient due to lack of a united leadership of the programmes at the local level. Therefore, it is important to adopt a comprehensive health system at the local level. For practical purposes, a district (a “setting” within a specified
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geographical boundary) could be viewed as a comprehensive and cohesive unit of local-level administration that is bound to a manageable geopolitical environment. The comprehensive health development of a district health system is conducive to organizing various healthy settings. Thus, within each setting, several health activities can be developed to address prevalent health concerns. These could take the form of addressing target population groups needing intervention such as babies, children under-three or under-five, schoolchildren, adolescents, mothers, the elderly, slum communities, street children, or workers. Also, within each setting, health activities could be generated to deal with certain thematic health issues, such as nutrition, blood safety, HIV/AIDS, reproductive health, drug dependence or substance-abuse control, alcohol abuse control, tobacco control, healthy lifestyle, lifeskills education, malaria control, polio immunization, leprosy control and safe sex, etc.

A healthy district, in most Member Countries, is the smallest politically demarcated geographical entity with its distinct administrative infrastructure and decentralized government, where the most peripheral development sectors are present. Consequently, a district will cover various smaller settings such as villages, markets, schools, hospitals, health centres and offices, etc. Therefore, a “healthy district” could be an umbrella for various healthy settings located within the district. Through this approach, a more effective, inclusive and comprehensive district health system could emerge.

3.5 Highlights on working mechanisms

(1) Strategic planning: This is needed to match priority and community resources and clarify objectives and the role of the various players in the cooperative Healthy Settings programme.

(2) Information systems: Evidence-based decisions are to be adapted at all levels. Therefore, the database should be up-dated in each country and at different levels of administration.

(3) Monitoring, supervision and evaluation system: Although monitoring, supervision and evaluation have been part of the programme, these elements need to be intensified. Some countries have developed a short-cut mechanism through competitions to ensure
implementation and guarantee close supervision, monitoring and evaluation. Rewards to the winners are a positive mechanism, especially to generate community action. Health impact assessment is also crucial to evaluate the efforts being made. The result of assessments will consequently stimulate efforts as well as guide the remedial actions.

(4) Networking: In many countries, experiences have been shared to stimulate both initiation and acceleration of healthy settings implementation. Visits by government officials, local or community leaders inspire them to replicate the programme in their own settings. Networking among related settings such as through twin-cities partnerships could generate the development of healthy cities projects. Networking could be enhanced through the use of electronic media and computers. This networking and sharing of experiences could also be initiated between countries as well, to enrich the development of healthy settings implementation in the future.

(5) Capacity-building: Various training activities and other mechanisms are critical aspects of healthy settings development and expansion. Government officials and staff as well as NGOs, community leaders and volunteers need to be updated with knowledge and skills to make them more effective and efficient in their respective tasks.

(6) Resources: Most local initiatives have meagre resources to fund the activities. All kinds of resources could be generated from outside the settings, but it is imperative that resources within the settings should be maximally identified and cultivated. Any action that exceeds the capacity would usually abuse the efforts and frustrate the people involved. Therefore, planning should be reasonable and based on available resources, while continuing efforts to obtain more resources. Resources should not be limited to finances. They could be in terms of skills and contributions in kind as well.

(7) Social Marketing: Any healthy setting initiative needs to be adopted by the target community. At the same time, it is to be supported by all stakeholders. Therefore, marketing of the health issues for adoption as well as for support is an important aspect of the
initiative. Although various face-to-face methods are more effective in expressing ideas and changing human behaviour, the role of the mass media is important to create awareness on health issues and to encourage positive actions.

4. **CONCLUSION**

All Member Countries in the South-East Asia Region are implementing the healthy settings approach in one way or another. Although the “settings approach” was enunciated in the Ottawa Declaration in 1986, Member Countries had already implemented the concept of healthy villages, healthy health centres, etc. long before. After the World Health Assembly Technical Discussions on “healthy cities”, the concept of healthy settings in urban areas has been replicated in the Region, and is now being implemented in all Member Countries. Health-promoting schools and health-promoting hospitals are also at various stages of development. Thematic-based healthy hospitals such as baby-friendly hospitals and smoke-free-zone schools have been implemented in all countries.

Based on the reviews and consultative meetings on various healthy settings, several challenges have been explored. The experiences gained from the implementation of the healthy settings approach could be extensively shared among Member Countries to enrich the future development of healthy settings.

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