Creating supportive environments for health

Stories from the Third International Conference on Health Promotion, Sundsvall, Sweden

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Foreword

The World Health Organization together with the Nordic countries, and in association with the United Nations Environment Programme (UNEP), organized the Third International Conference on Health Promotion, with the theme of Supportive Environments for Health, at Sundsvall, Sweden, in June 1991. This handbook is one outcome of the Sundsvall Conference, and has been prepared to assist all who are concerned with promoting healthy environments.

The Sundsvall Statement, a forceful consensus among 318 participants from 81 countries, urged the United Nations Conference on Environment and Development (UNCED), held in Brazil in 1992, to foster global action to protect environments that promote health. Further, a WHO Commission on Health and Environment prepared a report for UNCED highlighting health needs related to the environment, spelling out objectives and suggesting activities to achieve them.

The present handbook is intended not only to serve as a means to attain the goals set by the Sundsvall Conference but also to facilitate the activities enumerated in Agenda 21 of UNCED.

The Sundsvall Handbook Committee took advantage of the varying and rich experiences that participants brought to the conference. In a series of workshops, participants discussed practical issues involved in creating supportive environments for health, in the sectors of education, food and nutrition, homes and neighbourhoods, work, transport, and social support and care. They identified approaches and methods for creating supportive environments and provided examples of their application in practice.

Many of these examples are presented in this handbook. Also included are examples contained in the eight "briefing books" that were prepared as background documents for the conference.

The handbook outlines briefly the theory and principles on which practice is based, describing the foundations on which action must be built. Readers are encouraged to choose what is applicable, to adapt what does not fit perfectly and to innovate where necessary.

It is hoped that wide distribution of this handbook will stimulate discussion and promote effective action towards establishing supportive environments for health.

Hiroshi Nakajima
Director-General
World Health Organization
Preface

When the objectives for the Sundsvall conference were outlined, the idea of making a handbook was born. We had no doubt about the need for a book like this, although we consciously avoided looking too hard at the difficulties it might entail and refused to acknowledge that any serious problems might arise. The handbook was, to our minds, an excellent idea.

From that day on a difficult process began, which was to last for several years. Fortunately at the beginning we knew nothing about the problems involved, many of which we had created ourselves by not always choosing the easiest way of getting things done. After all, why base a handbook on people describing their experiences when you can review articles in scientific journals and other literature instead? Why make a handbook international when it is probably simpler to base it on a single country or community? Why ask people from all over the world to travel to Sundsvall, a remote city in the northern hemisphere, to work intensively for one week? These are just a few of the questions one might ask.

Our answer is that we wanted to make something authentic and we wanted to interest committed people in contributing to the development of health promotion by sharing their experiences in a straightforward way. There already exist ways of meeting needs and solving problems. The fact is, however, that these have not been accessible to everyone. By telling other people about these true-life stories we hope we can improve the present situation.

Bodolf Hareide
Chair of the Handbook Editorial Committee
Acknowledgements

It would not have been possible to develop this handbook on the creation of supportive environments for health without the involvement and enthusiasm of a large number of health practitioners around the world. The editors especially wish to thank the following:

• All participants of the 3rd International Conference on Health Promotion who shared their experiences and stories with us.

• The conference handbook committee: Dr Bodolf Hareide, Director General, Institute of Public Health, Oslo, Norway (Chair); Dr Bo J. A. Haglund, Associate Professor, Karolinska Institute, Sundbyberg, Sweden (Co-Secretary); Dr Greg Goldstein, WHO, Geneva, Switzerland (Co-Secretary); Dr Rannevig Nordhagen, Norway; Ms Margareta Nilsson-Giebel, Germany; Dr Lois Philip, WHO, Geneva; Ms Yvette Anne Holder, Trinidad; Ms Rene Loewenson, Zimbabwe.

• The German Federal Centre for Health Education for initiating and funding an international follow-up meeting in Erfurt on 3–7 December 1991 at which the basic structure of the handbook was developed, as well as the following persons who took part in the conference: Professor Christina de Possas, Brazil; Mr Helmut Hildebrandt, Mr Harald Lehmann and Dr Gerhard Christiansen, Germany; Mr John Eastwood, New Zealand; Dr Rudi Slooff, WHO, Geneva; Ms Heather Macdonald, WHO Regional Office for Europe, Copenhagen.

• The resource people and reporters for the handbook committee: Ms Magdalene Abrokwa, Ghana; Mr Tariq Bhatti, Canada; Professor John Cadford, Wales; Dr John Davies, Scotland; Mr John Eastwood, New Zealand; Ms Peggy Edwards, Canada; Dr Anna Egnerova, Czech Republic; Mr Peter Gavelin, Sweden; Ms Nancy Hamilton, Canada; Dr Trevor Hancock, Canada; Mr Arif Hasan, Pakistan; Dr Carlos Alvarez Herrera, Argentina; Ms Lotte Kaba-Schönstein, Germany; Mr Leonard Kafunda, Zambia; Dr Clement Chan Kam, Mauritius; Ms Lenore Kohlmeier, Germany; Dr David Legge, Australia; Ms Pam Leidman, United Kingdom; Ms Karen Mills, Canada; Professor Don Nutbeam, Australia; Professor Gopal Pathak, India; Ms Elisabeth Simwanza, Zambia; Professor Robert Spasoff, Canada; Ms Mabel Chia Yarell, New Zealand; Ms Joyce Yeomanis, Australia.

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Note to readers

The stories in this publication were submitted by delegates to the Third Conference on Health Promotion in Sundsvall, Sweden, who chose them as reflecting successful efforts towards creating supportive environments for health. The choice of these particular stories is that of the Sundsvall delegates and not of the World Health Organization. Although the stories have been edited, they are retold here essentially as they were presented by the Sundsvall delegates and may not always give an entire and complete account of the events described. Individual contributors have vouched for the accuracy of each story. Any viewpoints expressed or implied in the stories are those of the Sundsvall delegates and not necessarily of WHO.

Some of the stories are set in the former socialist countries of eastern Europe. Although major socioeconomic changes have taken place in these countries, the stories have been retained in this book as they are still considered valid models of what may be achieved.
Introduction

The link between health and the physical environment has long been recognized, yet it has been inadequately addressed. Now, however, our old habit of ignoring pollution and waste no longer works. There is no longer any place to throw things away. Increasingly we realize there are social, cultural, economic and political aspects of the way the environment affects our health. If the goal of health for all is to be attained, the total environment must be supportive of health development. Only an enlightened, healthy and involved community can make this happen.

The focus of the Third International Conference on Health Promotion in Sundsvall was on action — long overdue — to improve public health by creating “supportive environments”. The goal of creating supportive environments for health has far-reaching implications for both individuals and institutions. Building alliances — across sectors, disciplines, professions and organizations — is one of the key elements of health promotion and is a central political concern.

Environmental conditions may represent a threat to health, as may behaviour and lifestyle. Medical research provides a basis for identifying health problems. But in order to define strategies for health promotion and learn more about the processes involved, contributions from the social sciences are necessary.

One of the most important challenges is inequality. The contrasts between rich and poor countries, and even between regions within countries, are large. In some cases these contrasts are becoming more marked in terms of resources and health.

By and large, the prerequisites for environmental protection and sustainable development are the same as for health — namely peace, education, food, income, a stable ecosystem, maintainable resources, a supportive social network, social justice and equity. To this list we should like to add participation.

At the same time, the main threats to health and the environment are war and poverty. After these comes depletion of natural resources through exploitation and misuse.

We bear a greater responsibility for the future of our planet and its people than any previous generation. We also know better than any previous generation how to fulfil that responsibility. The population issue relates directly to the link between the environment and public
health. Culturally acceptable family planning programmes and improved access to birth control methods are needed. In many societies, women are grossly disadvantaged and their skills and resources largely untapped. Education of women and girls should be urgently improved.

The world community is sometimes slow to act. People can usually influence their local situation more directly and more swiftly. Empowerment of individuals, local authorities and other groups is crucial. Health is not only — perhaps not even primarily — the concern of doctors and nurses. Health is a question of influence, power and resources.

Change will not come easily. Advocating community participation means starting a process of decentralization. Such a process is a fundamental challenge to the concentration of political and economic power in the hands of small elites. The Sundsvall conference highlighted such community efforts for health. Many are documented in the following pages as examples of how communities the world over have identified health needs and then taken action.

Supportive environments

What does it take for a plant to grow, an egg to hatch, a human being or a community to thrive? Obviously, it takes different things. But whatever those things are, they make up the supportive environment. The plant needs nutrients, water, light and the right air temperature; the egg requires a nest and warmth; a baby must have food, shelter, guidance, care and love. What is being supported in all these cases is nothing less than life itself.

The concept of supportive environments emerged from the First International Conference on Health Promotion in Ottawa, Canada, in 1986, and was examined in more detail at the Sundsvall Conference in 1991. This handbook is a compilation of stories told by the 350 conference participants from 81 countries. The stories offer examples of ways to bring about change for a healthier environment. It is hoped they will enhance communication and above all inspire readers to take innovative action.

A toolbox for change

To use an analogy, this handbook can be seen as a toolbox for creating supportive environments for health. The stories are the tools for bringing about change and creating advocacy for supportive environments at local, national and international levels. Some changes may be slow and come in stages, brought about peacefully through established channels. Other changes may be sudden, requiring painful confrontation and dramatic shifts in values and resources. In every community and every
life there is room for improvement. Some things must be transformed or abandoned in order to build a healthy environment.

The users of this handbook are likely to include health workers at all levels, policy-makers, decision-makers and technical staff in health agencies and in other sectors. Progress depends on improving the training of health and development workers and managers through public and private agencies. The handbook can be used in this training and as a resource for practitioners. Women’s skills and knowledge are particularly important in building bridges between different sectors of society in order to solve practical problems.

More encyclopaedia than novel

This three-part handbook is more of an encyclopaedia than a novel. It can be read from beginning to end, but readers will probably prefer to consult it to obtain specific information.

Part 1, “Strategies that work”, outlines the basic framework of supportive environments and introduces the health promotion strategy analysis model (HELPSAM) with strategies for analysing, describing and understanding problems in the environment. This part will probably be most useful for decision-makers at various levels. Readers who work in an organization or agency may wish, for example, to use the chart to identify weak links in strategies, or areas that need to be strengthened or improved.

Part 2, “Settings, voices and experiences”, contains the stories. Chapter headings reflect the topics used as focal points by the working groups at the Sundsvall conference — education, food, homes and neighbourhoods, work, transport and energy, and social support and care.

Part 3, “Steps for action”, combines and develops elements from Parts 1 and 2. It indicates action to create, by stages, supportive environments for health. Health planners may wish to read this part first.

Three new models

The handbook presents three complementary models that represent improvements on earlier theoretical constructs, specially designed and adapted to the issues at hand. The first model, the “health promotion strategy analysis” model (HELPSAM, page 22) is an instrumental model for analysing health problems and working out solutions.

The second model, the “Sundsvall pyramid of supportive environments”, (page 31) is a conceptual aid, a guide to understanding. It provides a way of contextualizing or relating the six conference topics to each other.

The third model, the “supportive environments action” model
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

(SESAME, page 171), illustrates a logical universal sequence of actions that takes place in many areas of human activity. It is an action-oriented model.

Using the handbook

This book may be used in a variety of settings — at work, in the home, at school, by trade unions, organizations, corporations and political bodies — locally, regionally, nationally and globally. Readers are invited to adapt the ideas in this book to their needs and to write to the authors, using the form on pages 177–182, so that the Sundsvall handbook may become a living forum for health promotion worldwide.

Policy-makers and decision-makers will find that the handbook provides a common understanding of the benefits of implementing action for supportive environments for health.

Practitioners, teachers, health educators, community workers and activists will find that the handbook gives support, supplies ideas for elaboration or adaptation according to need, and provides a structure for analysing efforts.

A major aim of this handbook is to help those involved in health and environmental work to find out what others are doing. It may be seen as a means of continuing education, a chance to update knowledge and sharpen skills.

Action to create supportive environments for health will require changes in social structures, conditions, behaviour, lifestyle and environment. For those who feel strongly about the need for change, this book is for you.
PART 1

Strategies that work
CHAPTER 1

Creating favourable conditions for health

Many elements contribute to building supportive environments for health. Some common conditions will be necessary, such as:

— peace and security in the country or region;
— participative exercise of power, with emphasis on human rights;
— satisfactory living conditions;
— decentralized decision-making involving public participation/empowerment;
— no sectors of the population living in extreme poverty;
— balance between population growth and resources;
— access to clean water, fresh air, wholesome food and energy;
— social/economic equity and justice between and within countries, particularly for the under-represented (e.g. women, children, elderly and disabled people, ethnic minorities);
— equitable access to land and ecologically safe materials and technologies;
— equitable access to health and social services;
— meaningful psychosocial conditions.

Health cannot be seen in a vacuum; it is determined to a great extent by environmental conditions. Environments are not just the visible structures and services surrounding us but have spiritual, social, cultural, economic, political and ideological dimensions as well. Furthermore, all the different facets of life are interwoven and inseparable. Influencing one will bring about changes in others, for better or for worse. Yet if healthy social development is to be maintained (not just promised during an electoral campaign or facilitated by time-limited foreign aid programmes), the environment must be targeted for change. This is what is known as sustainable development, a term introduced in the so-called Brundtland report in 1987.1

CHAPTER 2

Obstacles to achieving supportive environments

Unfortunately, many forces work against improved health. Some are general obstacles such as lack of political awareness and understanding. Others are specific to a particular issue. Participants at the Sundsvall conference listed some of the obstacles to achieving supportive environments for health. They are presented here according to the topic areas dealt with at the conference.

In education the obstacles include:

— a vicious circle of poverty, lack of education and poor health;
— discrimination in educational systems, particularly against women;
— education that is used as a means of control (e.g. through prescriptive political, missionary and medical models);
— slow adaptation to new educational methods;
— inadequate teacher training in health and environmental concerns, plus lack of good teaching/learning materials.

In homes and neighbourhoods the obstacles include:

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

In food and nutrition the obstacles include:

— lack of safe and good quality foods in countries experiencing social, political and economic change;
— socioeconomic differences in food consumption patterns, decreasing standards of living and increasing poverty leading to strong disparities in health both between and within countries;
— inappropriate food handling, food shortages, loss of genetic variety, pesticide use, soil erosion, water and food pollution,
OBSTACLES TO ACHIEVING SUPPORTIVE ENVIRONMENTS

loss of rich farm land, desertification, over-exploitation, and overproduction;
— unhealthy eating and drinking habits promoted by industry and advertising.

Much of the food production in developing countries, particularly in Africa, is dictated by external forces. Land is converted to production of cash crops for export in order to obtain currency to repay debts.

In work the obstacles include:
— discrimination against women and exploitation of women’s labour;
— low wages;
— ignorance of workers’ rights;
— exposure to toxic substances;
— lack of legal controls and support;
— unplanned approach to technological change (environmentally hazardous workplaces, communities subjected to environmental hazards, and lack of alternative employment when jobs are lost due to mechanization or computerization);
— dehumanizing work cultures.

In transport the obstacles include:
— overuse of private as opposed to public transport, leading to greater use of fuel, more congestion, accidents and pollution;
— inefficiencies;
— unavailability of alternative ecological technologies that prevent or reduce pollution;
— resistance of industry to the development of safer fuels and engines;
— transportation systems that are discriminatory against women, the poor, the disabled and the aged;
— unwillingness to introduce and obey safety regulations due to notions of personal freedom.

In social support and care the obstacles include:
— lack of political stability and personal security;
— poor economic growth and development;
— absence of equity and social justice;
— lack of basic resources such as food and shelter, and lack of education and training;
— oppression of women, including excessive societal demands;
— lack of skills for self-care and self-management;
— differences between the priorities of providers and the needs of communities;
— lack of recognition of the family as a primary source of social support;
— lack of skills and an unwillingness to communicate and collaborate between different sectors of society.
CHAPTER 3

Learning from experience

This section contains a selection of stories, arranged under seven headings: policy development, regulation, reorientation of organizations, advocacy, building alliances/creating awareness, enabling, and mobilizing/empowering. These headings represent strategies for change. If, for example, there is a health problem in a community as a result of polluted drinking-water, the necessary action of cleaning up the water or getting people to stop drinking it can be tackled in one or several ways, using different strategies.

In this example, one may wish to develop a "clean water" policy (policy development), take legal action (regulation), transform a wildlife protection society to include human health issues (reorienting organizations), call for change via the authorities, politicians or the media (advocacy), persuade appropriate ministries to cooperate (building alliances), help supply safe drinking-water (enabling), or organize residents to fence off the area, educate the people, or facilitate these and other possible measures (mobilizing/empowering).

In real life, of course, examples of change aimed at creating supportive environments for health typically involve a combination of several strategies. For the sake of clarity each of the following examples is listed under a main strategy heading. The stories have been chosen as illustrations of various strategies. It is hoped they will give the reader ideas for implementing needed change.

The seven types of strategy have not been arbitrarily imposed on the stories but have been derived from these stories and from other real-life examples of working for change. People's experiences have been compiled and distilled, yielding the same strikingly common basic features. The stories are followed, in Chapter 4, by a model for analysing a community health problem and deciding which of the seven strategies to use, and how.

Policy development

Story 1 ■ Food security is making your own food

In Nigeria, a nutrition committee was set up by the Federal Ministry of Science and Technology to find ways of safeguarding access to food,
especially through production. Rather than encouraging the population
to grow wheat, which is not a "common man's food", the Nigerian
committee felt that efforts should be made to increase production of
indigenous crops. The Committee is now working closely with UNICEF,
WHO and the World Bank to compile reliable data on the situation
regarding food and malnutrition and to work out strategies for effective
and sustainable solutions.

Maintaining a basic capability for food production is an important
policy goal, though not equally practicable for all countries. Another
approach to the goal of food security is the development of arrange-
ments for regional cooperation. The importance of maintaining some
breadth of agricultural base for domestic consumption should be recog-
nized as a valid policy goal in industrialized countries as well.

Story 2 ■ Norwegian food policy changes eating habits

In 1976 Norway became the first European country to introduce legisla-
tion on a food and nutrition policy. The policy seeks to encourage a
healthy diet, increase national self-sufficiency in food, strengthen the
rural economy and help to stabilize the world food supply. The two
implementing bodies are the Interministerial Coordinating Committee
and the National Nutrition Council. The strategy includes measures in
eight areas: agriculture and fishery policy, price policy, industrial
processing, trade and food marketing, nutrition education and informa-
tion, legislation, research, and health policy. Since the introduction of
the policy the consumption of cereals, vegetables, fruits, and low-fat
dairy products, cheese and meat has increased. There has been a reduc-
tion in the intake of margarine, butter and standard milk. It is believed
that the nutrition and food policy has contributed to this developmen-
t. An encouraging aspect of the Norwegian food policy is that the powerful
agricultural sector has recognized some of the concerns of the health
sector and an institutional framework now exists to deal with these
concerns.

Story 3 ■ Large public health gains from tobacco tax

In California, USA, almost 30% of the population use tobacco. In 1987
there was pressure to increase the tax on tobacco and use the money for
health promotion but the elected representatives were influenced by
tobacco interests and would not act. Pressure groups were formed by
voluntary health organizations and medical, public health and environ-
mental agencies, which lobbied for a referendum. The referendum
resulted in a 60:40 vote to increase tax on tobacco by as much as 25 cents
on each pack of cigarettes. As of 1990 this increase had amounted to
US$600 million a year. This is money that can be used for medical,
hospital and research purposes. One-fifth of the money — i.e. about US$120 million — is used for tobacco control projects in schools, health departments and community agencies. In California, tobacco use has decreased much faster than in the USA as a whole. Population surveys show that even smokers favour higher tax increases.

**Regulation**

**Story 4** ■ State and business unite behind healthier food laws

Canada has adopted new regulations on nutrition. The aim is to help Canadians make healthy food choices. The recommendations are based on studies involving scientific and community bodies as well as on other work in which all relevant sectors and organizations participated. A major element of the new guidelines is the recommendation to produce and use low-fat products in all sectors. The prospects of implementation are promising since those responsible for production and sales have been involved in negotiations to change products along these lines. This is an example of a multisectoral and multilevel process with a positive outcome.

**Story 5** ■ Hard-hitting anti-smoking campaign shows progress

A survey in Mauritius revealed a high frequency of noncommunicable diseases. This raised concerns about passive smoking and a campaign was launched in 1988 to combat this phenomenon. The aim was to reduce pollution from smoking in buses, homes and public buildings. The aggressive campaign involved educational elements, police checks in buses and legislation that prohibited smoking in indoor environments such as hospital wards, libraries and gymnasiums. Various professional groups were involved, among them public health inspectors, nurses, police and nongovernmental organizations (NGOs). Task forces on smoking were created. A number of approaches were employed, including videos and stickers. Practically all buses are now free of cigarette smoke and smoking has also decreased in homes.

**Story 6** ■ Can workers regain control and improve health?

In Italy after 1945, industrial production increased, but so unfortunately did accidents and occupational diseases. The health-related work of the trade unions was mainly concerned with ensuring that workers had access to medical treatment, and negotiations focused on making sure that workers with risky jobs received extra pay. At the end of the 1960s, the unions and left-wing political parties launched a campaign that involved a national inquiry into health and safety at work. For the first
time, the workers became “judges of their own health”, and subjective opinion was accepted as a valid component of scientific investigation. Popular sentiment, including strikes and demonstrations, brought pressure to bear on industry, government and parliament. The actions involved the employees and their organizations, local and regional administrations, the parliament, students and some parts of the medical profession. The results were dramatic: working conditions in industry improved, and there was a thrust towards innovation, stimulating the development of new technologies. The movement contributed to the creation of a national health service and to increased worker control over the workplace. New rights, such as the right to information, were recognized and the power of the workers was generally strengthened. However, for political reasons, the whole movement encountered difficulties in the late 1970s. The trade unions no longer stood united, and the attitude of the workers changed. In spite of further economic progress, developments in health and safety have been less favourable since 1980 and the number of accidents has begun to rise again.

Reorienting organizations

Story 7 ■ From health care to health promotion

International NGOs are increasingly moving away from top-down aid projects and are aiming more for sustainability, prevention and community participation, often in small-scale projects.

During the 1970s and 1980s, the health care programme of Save The Children in developing countries was geared to supporting the establishment of mother and child health care centres along the lines of similar centres in developed countries. This was thought to be the best way of reducing maternal and infant mortality, and was certainly extremely important for a great many people. But such programmes failed to reach the poorest women and children. When the time came for the host country to take over the activities, costs and quality demands were often too high for the transition to work smoothly. The new approach to health aid builds on people’s participation, and shows much better chances of reaching the poor and dispossessed, and particularly children.

Save The Children recognizes that developing the health care system in developing countries is vital but considers that this is a task for large organizations such as the United Nations and national governments.

Story 8 ■ Future-oriented technology makes sustainable profits

Established in 1989 and based in Switzerland, a global business network, including the heads of 50 international companies, aims to develop
sustainable technology. The business network includes several large enterprises offering advanced solutions for control of pollution and industrial emissions, another providing equipment for metering, regulation and measurement of energy, and one manufacturing cameras, microscopes and equipment for surveying land and assessing deforestation. These enterprises seek to demonstrate to industry that current models of development are impractical from both environmental and economic perspectives. The only viable option is sustainable development which combines growth and environmental protection. In straightforward business terms, this means generating maximum income from a given stock of assets without depleting the capital base.

From a business angle, the fundamental problem lies in the fact that most market prices for energy and raw materials reflect only their direct cost — or even less if they are subsidized. Prices reflect neither the ecological cost in terms of damage to the environment, nor the cost of depletion of natural capital when a non-renewable resource is being used. The business network says, "The real question is not 'Who is going to pay for sustainable development?' That would reflect the old, defensive attitude to environmental protection. The real question is 'How can business fully integrate the value of the environment into its operations and thereby conserve the natural world for future generations?'"

The network of business leaders aims to support industry in adapting to the concept of sustainable development. A prerequisite for action is that governments develop a legal framework which gives financial incentives to sustainable industrial activity. The principal adviser on business and industry to the secretary-general of the Brazil '92 conference on sustainable development says: "Adopting a market-based approach will not be easy. Many companies and some entire sectors will be made redundant by charging the full environmental price of goods and services. But a market-based approach will also ensure that new, innovative companies and industries which meet the criteria can grow. It's our obligation in the richer part of the world to create a new vision of global solidarity."

**Story 9** Equal pay and a say for women in a Swedish garment industry

In the Swedish textile industry, women make up 75% of the workforce. Women are often paid according to what they produce while men are paid standard wages, which are higher. Of the men, 85% worked full-time in 1989 compared with 67% of women. Of the women, 23.7% said they worked part-time because of injuries or fatigue. Dust, noise, chemical substances and working conditions cause considerable health problems. Musculoskeletal injuries are caused by monotonous work and stress, yet women have little say about their working conditions.
The pace of work has increased as well. Today, despite technological advances, a sewing machine operator must sew on 53 collars to earn the same amount of money as she or he did sewing 41 collars 20 years ago.

At a garment factory in south-west Sweden, each of the 17 female machinists sews whole garments (which is unusual in the textile industry) and every employee checks all stages of production. If one woman is absent, another can replace her without any trouble. There are no office personnel or managers. Instead there are three work teams which take care of all the work from order to delivery. The employees also receive a bonus based on the profit. All decisions about production are made by the whole group.

All the sewing machine operators receive exactly the same salary regardless of their age or professional skill. The machinists themselves have fought for that principle through their trade union. Hiring new employees has not been a problem. The staff has almost doubled, no one has left the company and the last time two vacancies were advertised there were 100 applicants.

The machinists have flexible working hours between 06:20 and 16:30. The employees fill out their work record cards themselves. There is no automated clock to record arrivals and departures.

Of course some of the women still suffer from occupational injuries. They are on part-time sick leave, and some go for occupational therapy. But the new working style has not seemed to cause any new injuries. The occupational health services are impressed with the company and have helped organize the new working arrangement.

**Advocacy**

**Story 10** Loans for the poor

In the rural communities of India, economic activity has been traditionally based on established financial institutions. The poor person wanting to borrow money has been at the mercy of the vested interests of the financially powerful. Now banks and insurance companies have been directed by the government to reorient their lending policies to people’s needs. Creditworthiness is to be determined by the needs of the persons requesting loans and their ability to make their activities (e.g. animal husbandry, milk production) profitable. The bank provides capital and even assists in selling products. There is also an educational component involved in getting the loan.

**Story 11** Disaster victims helped by state–volunteer collaboration

In Canada, organizations have been formed to help people in disaster situations, such as when a tornado strikes. The organizations provide
information, help with housing, insurance and emotional support. Multilevel government services and volunteers cooperate under the same roof. Community meetings are held for planning and problem-solving. Emotional counselling is provided for families and one group has been formed to help children.

Building alliances and creating awareness

Story 12  ■ Schoolchildren popularize health

In Indonesia, health education is part of school health services. An important element of this is the "Little Doctor Programme" which has the personal support of the President. The programme uses the students themselves as role models and motivators for change to promote better health in the school, home and community. Children from grades 4 to 6 are selected by teachers to serve as "little doctors" according to their leadership potential, willingness to help others and observance of good personal hygiene.

The little doctors are expected to set a good example by following a healthy lifestyle, observing good personal hygiene and avoiding behaviour that involves health risks. They are expected to participate actively in improving environmental conditions (rubbish disposal, protecting safe water sources and food storage, keeping rooms clean), communicating health messages (on preventing diarrhoea, immunization, mosquito control and so on), monitoring personal hygiene (growth, eyesight, oral health, scar survey/BCG) and illness (such as infections), informing teachers about children in need of attention, providing simple treatment (including first aid) referring cases, maintaining a health log book/diary, writing personal reports, and presenting health facts using graphics. The little doctors are given initial training which includes 20 hours of lessons in which problem-solving and active participation are encouraged. The training is evaluated through tests, essays, skill assessment, role-play and group discussions. The work of the little doctors is monitored and their impact on the school and community is observed.

Ten years after the pilot project, this programme had spread throughout the country. Schools with little doctor programmes show improvements in sanitation, personal hygiene and in the health awareness of parents. Reports from various provinces show that the little doctors have helped get rid of man-made mosquito breeding places in their communities. Similar programmes have been reviewed in more than 70 countries.

Story 13  ■ People solve their own problems

In Conchali, a poor community in Santiago, Chile, health workers started a programme together with local residents. They made a "co-
munity diagnosis” to define the community’s main problems — such as childhood diarrhoea, intestinal and parasitic diseases, socioeconomic problems, disposal of sewage and garbage, and lack of drinking-water in homes. The leaders of eight local communities worked with the authorities, residents and health workers to draw up a list of priority activities and a time frame for carrying them out. During the first year, a transportation system was organized. The next year a local police station was established and youth and women’s organizations were created. Before the fifth year drinking-water was made available to homes in the community. The lesson is that when a community defines its own problems it promotes change in both attitudes and environment.

**Story 14** — Scientific farmers reap bigger harvests

Because of many problems, Uganda has insufficient food and widespread malnutrition. A large proportion of the population is landless, food storage practices are unreliable, and the distribution network is rudimentary. Poor transport and political problems often prevent food reaching the market. Food risks being contaminated at various stages from production to use. Preparation of the food is based on traditional methods that at times are not very hygienic.

The key to solving these problems was a partnership approach, both between government agencies and between the government and the farmers. The interrelated problems had to be addressed in stages. A project was established to improve food production through a “food early warning” system. Members of an interministerial planning group met every 10 days to process field data and disseminate information to farmers, decision-makers and policy-makers. The multidisciplinary working group comprised all departments in the Ministries of Agriculture, Natural Resources and Environment, Information and Broadcasting. Farmers adopted the advice in the bulletins and politicians planned purchasing of food for areas where crops had failed. Daily weather forecasts and warnings were issued to help farmers plan their daily activities. A pilot project is under way to compare yields from farms that are near each other but where one is run in a traditional way and one in a scientific way. Results from studies in other countries indicate that application of scientific information and methods leads to increased quantity and quality of yields. This programme was possible mainly due to donor support. However, a scheme for charging users is expected to be introduced in the future.

**Story 15** — Local skills harnessed to tackle housing and environmental problems

In the city of Glasgow, United Kingdom, insufficient investment in state-subsidized housing was a serious problem. With high unemployment,
there was an opportunity to work with communities to resolve housing and environmental problems. The Glasgow City Council and an NGO formed a voluntary organization called “Heatwise”. Heatwise employed local people to work on energy conservation projects. This initiative was later expanded to create an organization called “Landwise” which tackled the local physical environment. Training modules were developed so that colleges could train local unemployed people to work with their communities on conservation and environmental protection. Funding came from the European Union social fund, the private sector and local government.

Enabling

Story 16 ■ Youth farm project

The aim of this programme in Germany was to give children and young people the opportunity to develop a sense of responsibility. Huchting is a district of the city of Bremen with growing rates of unemployment, single parents and people living on social welfare. Because of the high amount of state-subsidized housing, the area attracts families at the bottom of the social ladder, including many immigrants. The immediate impetus for this project came from repeated violent clashes between neo-Nazis and the children of immigrants. A local conference was set up with the involvement of young people, adult residents of Huchting, churches, politicians, various organizations, teachers, the drug prevention authority, and social welfare departments of the State of Bremen. Intensive discussions led to the establishment of an integrated community-oriented project for children and young people — the city farm of Huchting. A place was created for children and young people to develop their creativity in a natural environment. The young people who were involved in this project had a chance to learn how to look after animals, do gardening, build houses and barns, hold dances and put on music shows. Politicians were, however, difficult to convince that this was a worthwhile investment in the future of children.

Story 17 ■ Music movement empowers marginalized people

In Norway, the father of a mentally handicapped child has developed a method for teaching music in a simple way. He has trained groups of mentally handicapped young people with extraordinarily good results. These groups — or orchestras or choirs — have performed on Norwegian television and at concerts around the country. Similar musical groups have been formed throughout Norway and elsewhere too. This movement illustrates how supportive environments can lead to confidence, self-respect, respect from others and to health and a better life.
Sweden also has a musical group of mentally handicapped people. This initiative has empowered marginalized people and improved their quality of life. The biggest handicap for the disabled is often the fact that the community thinks they are unable to do things. In Sweden, as elsewhere, music, theatre, art, dance and other so-called “expressive art therapies” are successfully used in treating psychiatric disorders and emotional distress.

**Story 18 ▶ Empowerment dispels humiliation**

In a small poor mountain village in Guatemala the children were malnourished. There was a nutrition centre nearby but parents did not use it. The basic problem was found to be that the parents felt humiliated by not being able to take care of their own children. This all changed in connection with the opening of a nursery school. In this project, families became partners in a building project that was to benefit all the children of the village. In this context, parents helped to construct the school and accepted food support for their children in return. Malnutrition decreased and in addition the rate of immunization in the village increased.

**Mobilizing and empowering**

**Story 19 ▶ Community involvement in an aid programme**

A community development programme in Kenya had the aim of empowering the people of a number of villages. The programme was supported by the Swedish International Development Agency (SIDA) and run by the Ministry of Health and Chagonia hospital. The people of the local communities were involved, with young men and women as volunteers. A programme of adult education was intensified, with local dialects being used to ensure better communication. Transportation services were improved with the building of new roads. New eating habits were established as people learned to boil drinking-water and eat a balanced diet. One community started to grow millet for sale to other villages as a source of income. Efforts are needed to keep these positive trends going.

**Story 20 ▶ An injury to one is an injury to all**

In Zimbabwe, many people have no access to adequate housing, transportation and other basics. Zimbabwean workers suffer from a combination of “diseases of poverty” and work-related injury and illness, of which only acute traumatic injury is recognized as being work-related. Because of a lack of effective monitoring of work environments and workers’
health, many problems are not formally detected. Injury reports are made by employers only, resulting in many injuries being attributed to "careless" workers.

Traditionally trade unions have been preoccupied with wage claims and grievances over employment, generally leaving the issue of work-related health to the under-resourced public sector or to individual workers. Awareness of the need for union action on behalf of workers' health has however increased.

According to survey results, most union leaders do not feel that their programmes and collective bargaining agreements adequately protect workers' health. They indicate that workers are not aware of their existing legal rights to healthy working conditions and lack the information and knowledge to extend these rights. There is a new concern for workers' health within the Zimbabwe Congress of Trade Unions (ZCTU). In September 1990 the ZCTU adopted a health policy that endorsed a nine-point programme of rights aimed at improving occupational health.

The development of expertise in the unions enables health issues to be dealt with, from the shopfloor to the national level, as an integral part of broader trade union issues. For example, the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) have been identified as important issues for workers, given that an estimated one in five urban workers in Zimbabwe is infected with HIV and given the potential for discrimination against HIV-infected workers in terms of employment and access to benefits. Other union-based research activities are aimed at identifying more clearly the causes of ill-health in the work environment.

It is still too early to determine the real impact of these developments on workers' health. The most important gain at this stage has been in building knowledge, capacity, collective discussion and shared experience. The first steps have been taken in the process of turning the slogan "An injury to one is an injury to all!" into a programme for action. The trade unions are becoming forceful agents for change in the health of the workforce.
CHAPTER 4

The health promotion strategy analysis model

The health promotion strategy analysis model (HELPSAM) is a summary chart showing the strategic elements of the stories in this book. The chart can be used as a reference guide to the strategies described in the stories in Part 2, and as a tool for analysing problems and for determining how to work towards change.

The model (Fig. 1) lists the seven strategies derived from the Sundsvall stories and other accounts of change — namely policy development, regulation, reorienting organizations, advocacy, building alliances/creating awareness, enabling and mobilizing/empowering. All these strategies can be implemented at international, national, regional or local levels.

The columns in the chart allow information to be recorded on how to achieve changes (approaches), who to involve (actors), for whom the change is intended (target groups), where the changes must take place (levels/arena), which means to use (procedures and tools), and what will be the results (expected outcomes).

Based on the experiences presented by participants at the Sundsvall conference, the health promotion strategy analysis model is a way of analysing strategies for creating supportive environments for health. Its distinguishing feature is that it is based on actual experience. Other approaches to strategies are found in the charter of the First International Conference on Health Promotion in Ottawa in 1986,¹ in the document Call for action: promoting health in developing countries of WHO,² and in the final Sundsvall statement (see Annex 3).

The HELP SAM approach to strategies has certain advantages. Among other things, the HELP SAM approach:

— stimulates intersectoral thinking, which is vital if problems affecting many sectors of society are to be addressed and successfully resolved;

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<th>Implementation Strategies</th>
<th>Approaches</th>
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<th>Target groups</th>
<th>Levels/ area</th>
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*Fig. 1. The health promotion strategy analysis model*

— defines the roles of the actors in specific areas;
— pinpoints weak links in the system, serving as a troubleshooting tool for identifying priorities for remedial action;
— generates new knowledge by examining the strategy from varied perspectives;
— highlights common structural and systemic patterns and weaknesses by transcending sectoral or disciplinary boundaries.

**Seven strategies for creating supportive environments for health**

**Policy development**

Policy development depends on the aims of government or policymakers and is based on specific political and moral values. A concerned social health policy is a means to improve public health and reduce inequities in the health status of individuals and groups that are differentiated by class, economic status, race and other factors. Health-supportive public policies indicate the directions for actions, explain the reasons for such actions, and ensure allocation of resources so that actions can be carried out.

Today it is generally accepted that improvements in living standards have done more to prevent disease and early death than have improve-
ments in treatment and diagnosis. It would be wrong to undervalue the clinical services provided by the health care system, but it is also important to take a larger view of the development of public health and the factors that determine people’s health.

Policy development initiated by people at grass-roots level is not often seen in developing countries. However, small communities have been known to move governments to support actions that meet their needs.

Regulation

Health regulation encompasses laws and norms affecting public health. By establishing standards (such as industrial emission levels) and by protecting the rights of weak groups (such as through sanctions against child abuse), laws can play a normative role in a society. Laws alone cannot bring about wide-ranging and lasting changes in behaviour. However, when combined with health education, and where a large segment of society is ready for change, laws may indeed have a decisive impact.

Reorienting organizations

Initiatives for improving public health often emanate from a few concerned individuals or organizations. Sometimes, the initiatives receive more general support among the population and develop through a range of activities. This may involve reorienting the structure and services provided by the initiating organizations. People may feel a need to institutionalize the activities in order to make them more accessible or affordable to all. In some cases it is appropriate to institutionalize services that have grown out of successful initiatives in response to general needs. The development of maternal and child health care in some countries reflects this trend. In other cases, however, institutionalizing an activity may stifle the energy and dynamics of the initiative.

Advocacy

Change is usually preceded by advocacy for improved health. Advocacy can take many forms. It may be advocacy for policies, both within the field of health and in other sectors, that respond to health needs and encourage positive action for health. Advocacy may also generate public interest in health, encourage allocation of appropriate resources for health and ensure that health is viewed as an economic and political asset. Advocacy may relate to health systems, urging them to be responsive to the needs and aspirations of the population. And advocacy may aim at the creation of supportive environments and facilities that make health choices easier for people. Advocacy may emanate from the grass-
roots level or from the top echelon of an organization. The mass media can also advocate and support health action. Sometimes advocacy has an element of risk, in that it may involve challenging vested interests and existing power structures.

Alliances/awareness

After identifying a health problem or its solution, a crucial next step is to create awareness among the population, through information, education and communication. In almost all societies, it is the authorities who are mainly responsible for disseminating health-related information — on, for instance, substance abuse, traffic safety, food handling and so on. However, it is also crucial to forge alliances with the many other groups involved — such as business, NGOs or the mass media. Large-scale information campaigns are often employed to get a particular message across. However, experienced health educators are sceptical of campaigns for a number of reasons. For instance, complex health messages are hard to simplify in a credible way, the effects are often slight and short-lived, campaigns may cause distrust and animosity by being paternalistic, may not incorporate the most relevant experience and research, and there are often flaws in the coordination of local and central activities. The main drawback is that adequate resources are seldom allotted to carry out and follow up information campaigns. This strategy also involves training of health educators and counselling individuals and groups on health issues.

Enabling

It is difficult to change people’s behaviour if there is no effective alternative to choose. Not only problems but also solutions must be presented in order to help people act. Enabling factors helping people follow health-conducive behaviour include:

— product development (automobile seat-belts, bicycle helmets, healthier foodstuffs, safer machines and tools in the workplace, etc.);
— environmental measures (smoke-free environments, allergy-protected housing, etc.);
— creating resources for innovative solutions to different problems;
— planning and organizing activities that promote health.

Mobilizing/empowering

The strategy of mobilizing/empowering addresses the active involvement and participation of those directly or indirectly affected by public
health problems. Community participation can enhance the quality of life. One form is the self-help methods of the women’s movement, the environmental movement and the consumer movement. Health-related movements include patient groups and groups like Alcoholics Anonymous. The strategy of mobilizing/empowering permeates all the other strategies and ensures the utilization of the important human resource of self-reliance. This resource is often ignored if there is a top-down approach that tells people how to act or does things for them.

Components of implementation in the HELPSAM model

Approaches

Strategies for creating supportive environments for health can involve different approaches, such as:

- welfare policies (e.g. sickness insurance schemes, full employment);
- legislation (e.g. worker and consumer protection laws);
- epidemiological surveillance programmes (e.g. for tracing infectious diseases or monitoring outbreaks of disease);
- screening programmes (e.g. for early diagnosis for cancer);
- product development (e.g. safer medicines, seat-belts, non-flammable materials);
- educational activities (e.g. warnings on cigarettes, skills training for saying no to drugs or unsafe sex);
- counselling (e.g. for pregnant teenage girls, drug abusers, unemployed);
- participatory research (e.g. scientists cooperating with shopfloor workers to improve work conditions).

Actors

Various individuals or groups can be involved, such as:

- political bodies such as parliament or government (e.g. for labour policy measures);
- different public sectors such as the health care system, schools, national authorities (e.g. for health promotion);
- shareholders, employees, trade unions, commerce (e.g. for creating smoke-free workplaces);
- producers and consumers (e.g. for promoting low-fat food products or warning labels on foodstuffs or chemicals);
- communities;
- voluntary organizations and institutions (e.g. fitness groups, patient groups, Weight Watchers, Alcoholics Anonymous);
— professionals (e.g. offering contraception counselling to teenagers).

**Target groups**

Measures are adopted for the benefit of target groups, such as:

— the population as a whole (e.g. taxes on tobacco and alcohol);
— immigrants (e.g. culturally appropriate health information);
— women (e.g. a rape crisis centre, a shelter for battered women, self-help groups, maternal health clinics).

**Levels/arena**

Actions are implemented on various levels, such as:

— internationally (e.g. breast-feeding codes, treaties on environmental health, non-proliferation of nuclear arms);
— regionally (e.g. the WHO Healthy Cities Programme in Europe);
— locally (e.g. starting a district youth centre or tenants' association);
— in groups (e.g. organizing support networks for persons with AIDS or self-help groups of former drug abusers);
— among individuals (e.g. learning techniques for improving relaxation or fitness).

**Procedures and tools**

Procedures and tools used to implement actions can include:

— taxation (e.g. tobacco duties, road tolls);
— pricing (e.g. making healthier products cheaper);
— supervision (e.g. checking that standards and rules are followed by employers, doctors, manufacturers);
— organizational development (e.g. fostering cooperation);
— immunizations;
— education/information/communication (e.g. health promotion);
— negotiations (e.g. to limit emissions of tobacco smoke);
— networking (e.g. by women's groups).

**Expected outcomes**

Expected outcomes of actions might include:

— increased self-reliance and control over health for the individual, civic pride;
— smoke-free environments;
— reduced alcohol consumption;
— improved eating habits;
— improved social environment;
— fewer abortions.
PART 2

Settings, voices and experiences
CHAPTER 5

The Sundsvall pyramid of supportive environments

In Part 2 the stories are presented under the headings of the six topics or settings for action that formed the basis of the Sundsvall conference. These are:

— education,
— food and nutrition,
— homes and neighbourhoods,
— work,
— transport,
— social support and care.

The topic chapters are written by different writers, accounting for some variation in style. On occasion, the reader is referred to other chapters with similar subject matter.

The two settings of education and social support and care are factors that relate the other four areas to each other. Education is an integral institution of society, basically communicating knowledge and skills but also holding society together by transmitting a shared cultural heritage from generation to generation and acting as a catalyst for social change. Social support and care help shape norms, values and relations. These in turn provide security and safety, and foster solidarity.

We can consider the six topics to be related to each other in the form of a pyramid (the Sundsvall pyramid of supportive environments, Fig. 2). Education and social support and care constitute the walls of the pyramid, reinforcing and supporting each other. If the educational system fails in a society, social control is likely to take the form of repressive policies to quell popular movements or unrest. Similarly, if mutual human social support and care are not adequate, a society will tend to develop more centralized, impersonal, institutional structures of caregiving, or there will be an absence of such support, leading to human suffering, waste and tragedy.

The floor of the pyramid contains the topics/settings of food and nutrition, and homes and neighbourhoods — representing the basic needs of all human beings — and work and transport — which are the means for satisfying the basic needs and ensuring the availability and distribution of basic resources.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

Fig. 2. The Sundsvall pyramid of supportive environments
CHAPTER 6

Education

Education is a basic human right and a key element to bring about the political, economic and social changes needed to make health a possibility for all.

(Sundevall statement on supportive environments for health, 1991)

Issues and problems

The traditional role of health education has been to transfer information, knowledge and skills. While educating individuals to make healthy choices is important, it is not the only way in which education supports health.

Education is a key element in bringing about the political, economic and social changes that make health a possibility. For the individual, education supports health by:

— helping people think critically about the issues they face;
— equipping people with the skills they need to participate fully in society;
— involving people in identifying problems that affect them and their communities;
— encouraging people to solve problems together;
— helping people adapt to changing circumstances and conditions;
— enabling people to cultivate individual and collective resources in order to solve problems and take action.

For society as a whole, education supports health by fostering development, production, social integration and political action.

• Development. Education is the means by which one generation transmits its values, norms, beliefs and way of living to the next generation. Thus, it can be a key influence in shifting development efforts towards sustainable action.

CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

- **Production.** Education shapes a society's means of production. It helps determine whether the economy will be agricultural or industrial and equips people with the skills they need to participate in the production process.

- **Social integration.** Education equips people with the skills they need to live and work with others.

- **Political action.** Education empowers people to participate in decisions affecting their future and to develop leadership skills.

Unfortunately, for many, education is unavailable, insufficient or in a form that fails to enable and empower. Millions of people without access to basic schooling have little hope for a better future.

How then can the full potential of education be realized in creating supportive environments for health? This chapter uses practical examples to show the importance of multiple approaches that combine formal and informal education and involve a variety of people (policy-makers, parents, decision-makers, children, community workers, teachers, administrators, employers, employees).

**Education and a healthy society**

**Story 21** ■ Education spearheads development in a Chinese village

When some leaders in the village of Dahu, China, decided to start a primary health care programme that involved the community, they began with a school health programme. They soon realized that a supportive sociopolitical environment was necessary if they were to succeed. The health educator approached the village mayor, who convened a primary health care committee with representatives of all the village organizations. Education became the means of improving collaboration, inspiring advocacy and empowering community members to make decisions about priorities and allocation of resources. Soon the people of the village voted to use communal welfare funds for a primary health care programme with four components — school health, road building, legislative changes and improved training for health workers. There was collaboration between teachers, village leaders, health workers and factory workers. Legislation was introduced concerning latrines, house construction, food handling, smoking in public places, and the separation of industrial and recreation areas.

This story describes how education was used to empower people to take action for sociopolitical change, both in the community and personally, in order to create a supportive environment for health. In many countries, it is natural for health and education systems to cooperate in creating environments that support both health and learning.
Education and health

In many countries, health care and education together account for over half of government spending and up to 80% of public service employment. Both sectors use specialized delivery agencies — hospitals and clinics for one, and schools and universities for the other.

In the search for lower cost and greater value, the health care and education sectors are looking for new approaches. Health care is broadening its action to include disease prevention and health promotion. Similarly, education is widening its focus from formal teaching to a renewed interest in the participatory process of learning, both inside and outside school. The shifts in emphasis from treating illness to promoting health, and from a teacher-centred to a learner-centred approach, are parallel and complementary developments. Both of these movements shift the emphasis from the professional to the individual in the community. Empowerment, local expertise and community participation are integral elements of health promotion and learner-centred education.

Because health promotion and learner-centred education are parallel concepts in parallel sectors, a link between the two serves them both. Cooperation depends on an understanding of each other’s roles and objectives but can benefit individuals, communities and society as a whole by creating a supportive environment for health.

Education and social change

Education is more than what happens inside schools and other formal places of learning. From generation to generation, families have passed down the skills and knowledge that help them to survive and thrive within their society.

There are several definitions of education, but a useful starting point is to think of education as a social institution with two roles:

— to hold society together by transmitting a shared cultural heritage from one generation to the next;
— to be a catalyst for cultural change and a means of responding to change in a way that ensures the survival of society.

For education to be effective, there must be learning. For learning to occur, education must be both meaningful and culturally relevant. While countries may seek to introduce educational change for the sake of development, it must be remembered that education also influences culture. Some educational change brings health benefits, but it may also lead to painful cultural conflict.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

Building a healthy future

Rapid change is the very essence of today's world. Uncontrolled development, overconsumption, the exploitation of natural resources, urbanization, the disruption of family structures, and growing inequities in access to resources are unfortunate by-products of some of that change. The result is a growing threat to both global ecology and individual well-being.

Society's views about what it wants for the future will affect its ideas of what education should accomplish. If people wish for a healthier future, then their commitment to the prerequisites of health — peace, economic and social equity, sustainable environments, and so on — must also be expressed through education. Education can then be an effective catalyst for social change that supports health.

Story 22 ■ Global telecom project for adolescents

KIDLINK is a telecommunications project that encourages adolescents aged 10–15 in more than 30 countries to use their classroom or home computers to share their visions of the future and the steps they can take to create a better world. As a result of KIDLINK, a new global forum called KIDS-ACT has been set up for adolescents involved in activities for social change. Some of the participants have set out to produce an electronic newsletter for global dissemination. The project, which began in 1990 with teachers and students from Canada, Norway, and the United States of America, now extends to Argentina, Australia, Brazil, Poland and several republics of the former Soviet Union. It is run entirely by volunteers and operates in a decentralized manner. The young people have discussed children's rights, the problems of drug abuse, child abuse, war, the environment and other issues.

Opportunities for learning

Learning is a lifelong process that takes place everywhere — in families, at the workplace, through community programmes and within the educational system.

- Formal education is the educational system of schools, from preprimary (kindergarten) to postgraduate studies; it involves the deliberate selection and structuring of learning experiences.
- Informal education includes all the other ways of learning, whether intentional (such as occupational training or literacy programmes) or unintentional (such as children learning from the actions of parents). Informal education that is deliberately planned usually focuses on practical learning to meet individual needs.
Learning in the formal educational system

In most societies, schools are the most widely available institutions for learning. Schools "catch" people when they are young, exerting a considerable influence on the children in a society. The formal school system can be a particularly powerful vehicle for promoting health.

Story 23 ■ Forming youth health action clubs in Kenya

In the rural Nakura district of Kenya, most children between the ages of 7 and 14 go to school. Infections, malnutrition and a lack of access to health information and basic health services were identified as major health problems in the area by schoolchildren, teachers and health workers. To respond to these issues, students were helped to form health action clubs in the district's 33 elementary schools. Student members of these clubs teach their parents about nutrition and hygiene, keep the school environment healthy and refer other children who need medical care to health clinics. Initial resistance by teachers was overcome by involving the Ministry of Education, which made health action part of the school curriculum.

Problem: Many children were suffering from communicable diseases and malnutrition.

Solution: The school became the centre for community health action through the formation of student health action clubs.

Strategies: • Building alliances (between school and community, Ministries of Health and Education).
• Empowering (of children to be leaders in community health improvement).
• Mobilizing resources (teachers, health workers and parents provide the required resources).
• Reorienting organizations (the formal school system reaches out to promote community health).

Learning in the community

Learning in the community is highly sensitive to cultural variations. These variations account for the difference between culturally relevant learning and unassimilated teaching.

Story 24 ■ World Health Day celebrated in Costa Rica

Community leaders in San José, Costa Rica, joined with groups of the elderly, boy scouts, the Red Cross and staff of the Ministries of Health
and Culture in a three-day fair to celebrate World Health Day. Eleven stands, each focusing on one aspect of a healthy lifestyle, were set up in the centre of the city. At the nutrition stand, volunteers weighed visitors and nutritionists gave them dietary suggestions according to their age and health. At the blood pressure stand, visitors could have their blood pressure measured and those with high blood pressure were referred to medical consultants. Ex-smokers staffed the no-smoking stand to talk with people who had questions about giving up smoking. Demonstrating their gymnastic skills, children and elderly people showed that physical exercise has no age limits. Condoms were distributed with educational brochures at the AIDS booth. The fair included videos, music, songs, dances and plays about health topics. The fair was so successful that community groups, health workers and staff from the different institutions are planning similar activities for health promotion in the future.

Problem: The community needed relevant information about the benefits of a healthy lifestyle. The range of information needed was broad, covering all age groups, lifestyles and health topics.

Solution: A health promotion fair in a central, accessible location used a variety of participatory activities covering a variety of topics.

Strategies: • Building alliances (between community groups, and between the community, health workers and national institutions).
• Empowering (community volunteers continued with more health promotion activities).
• Mobilizing resources (many of the “teachers” were ordinary members of the community demonstrating healthy activities by example).
• Reorienting organizations (the streets of the community became the “school” for learning about healthy lifestyles).

Learning and community development
Informal education plays a central role in community development. Everyday experiences are the building blocks of informal education. This approach is based on the belief that learning is a self-generated activity that is enhanced by dialogue between learners and teachers.

The next group of stories demonstrates four principles of community development and informal education as they apply to the creation of environments that support health: (1) activities should respond to locally determined needs and rely on local expertise; (2) activities should
respond to local circumstances; (3) activities should be based on partnership between professionals and community members; and (4) activities should promote political action.

**Story 25** ■ Village health workshops in Sudan

In Sudan, 74% of the population live in rural areas. Knowledge about health is poor, resources are scarce and health services are often not available. Infant and maternal mortality rates are high. To find out what the people considered to be the most pressing problems, a survey was carried out in two villages in Gezira province. The results of the survey showed that people were most interested in learning about pregnancy and childbirth, child health care, home accidents, environmental health and common diseases. A 10-day workshop was held for village volunteers of both sexes and all ages so that they could learn about these problems and teach others. Some 240 villagers were trained by representatives of WHO, the faculty of medicine at Gezira University and the regional Ministry of Health. By the end of the workshop, participants were ready to teach other volunteers.

| Problem: | There were many health problems in rural Sudan and few resources or services to deal with them. |
| Solution: | Issues of local concern were identified by the villagers. Health officials then trained village volunteers to teach others how to deal with these issues. |
| Strategies: | • Empowering (villagers identified issues and volunteered to be part of the solution). |
| | • Mobilizing resources (use of trained community leaders). |

**Story 26** ■ Local food cooperatives set up in Scotland

In the poorer housing areas of Glasgow, Scotland, people have suffered badly during the economic recession. Many people have unhealthy diets because they have little money for food, there is little healthy food available and there is a lack of information about healthy food choices. Local community organizations and the Glasgow Healthy Cities Project set up food cooperatives in vacant houses where the residents could learn about healthy food choices and purchase healthy foods at reasonable prices.
Problem: Underprivileged people in Glasgow had unhealthy diets as a result of economic difficulties and lack of information.

Solution: Local community groups set up food cooperatives in empty houses so that people could buy healthy foods at reasonable prices. Health promoters provided information on healthy eating.

Strategies: • Advocacy (local community organizations).
• Building alliances (community organizations, government, Healthy Cities Project).
• Empowering (the community identified the problem and solved it).
• Mobilizing resources (to set up food cooperatives).

Story 27 ■ Role of traditional healers highlighted in Swaziland

In Swaziland, traditional healers became important partners in designing an intervention to prevent and treat childhood diarrhoeal diseases. The Academy for Educational Development, the Rural Waterborne Disease Control Project and the Ministry of Health have promoted the use of oral rehydration therapy (ORT) in seminars with traditional healers. The programmes acknowledge the existence of traditional beliefs and behaviours to an extent previously unseen in Swaziland. Health education is presented in a familiar form with realistic examples.

Problem: Health education efforts were not taking advantage of traditional healers, who are opinion leaders in matters pertaining to health.

Solution: Traditional healers were invited to be partners in health education: traditional beliefs were respected.

Strategies: • Building alliances (traditional healers treated as equal partners).
• Mobilizing resources (in the community).
• Reorienting organizations (health education builds on, rather than confronts, traditional beliefs and practices).

As people become more knowledgeable about the effect of social conditions on health, they may discover that their community is unhealthy because of an inequitable distribution of resources and political power. Education and community structures can help people develop a critical understanding of the social conditions in which they live and what they can do to change those conditions.
Story 28  ■  In Mexico, women stress social causes of disease

In the Tuxla peasant communities of southern Mexico, most people are very poor. Mujeres para el Diálogo (Women for Dialogue) helps people to become aware of the social causes of disease and to tackle health problems. Community health committees (primarily women) represent the people in calling for change. Preventive health messages are delivered through community organizations. Because diseases are classified according to their social causes (for example, those caused by lack of clean water), people learn about the connection between health, poverty and social justice.

Problem:  Poor peasants had difficulties with health problems caused by social conditions.

Solution:  A mechanism or structure (Mujeres para el Diálogo) enables the community to make its views heard so that community development is not controlled solely by those in authority.

Strategies:  • Advocacy (for improved social conditions).
• Empowering (through involvement in local health committees).
• Reorienting organizations (using a political process to educate people about health problems).

Learning in the family

Research has shown that the level of parental education influences the health of the family. For example, the acceptance of family planning (which affects the spacing of pregnancies and hence the health of both mothers and children) is closely related to the mother's level of education. Achieving universal primary education (especially for women) is clearly an important step in creating a supportive environment for health.

Parents may learn from their children, just as children learn from parents.

Story 29  ■  Children in Indonesia teach parents about diarrhoea

An area of Indonesia with about 100,000 population had a high incidence of diarrhoea. The resulting dehydration brought on many health problems, including a high infant mortality rate. Most of the women in this rural area had a low level of education so reaching them through a media campaign would have been impossible. A programme was initi-
ated by health workers, teachers, the parent-teacher association and the local mayor to educate parents about the importance of water and oral rehydration salts in managing diarrhoea. Posters on the subject were distributed to about 23,000 schoolchildren aged 10–11. The children coloured the posters in school and answered a quiz, then were asked to take the posters home and explain the pictures to their parents. The posters had to be returned with a parent’s signature. An evaluation after six months showed a great increase in parents’ knowledge about the importance of combating dehydration with water and oral rehydration salts.

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**Problem:** Parents who were hard to reach through formal means needed information on how to prevent dehydration.

**Solution:** Children were prompted to teach parents the information about dehydration that they learned in school.

**Strategies:**
- Building alliances (between the school and families).
- Empowering (of children and their parents).
- Mobilizing resources (the children).
- Reorienting organizations (locally relevant information was added to the school’s curriculum and children were prompted to be the “teachers” instead of the learners).

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**Learning in the workplace**

Workplace education strives not only to influence the health choices of workers but also to empower workers to create a healthy workplace.

**Story 30** Swedish study circle changed workplace environment

In Filipstad, Sweden, the Confederation of Swedish Workers set up a study circle to find out about working conditions at a laundry. The study circle included several union representatives and two scientists, all women, plus about 40 laundry employees. Study circles are a traditional form of adult education, participation and mobilization in Sweden. First, a questionnaire was designed by the project leaders and answered by 38 employees. Next the study circle discussed the questionnaire responses which gave a picture of widespread and severe health problems, monotonous work, lack of worker control over the workplace and little confidence in the union or company health services. Finally, an action plan for change was developed based on the employees’ priorities. The action programme included proper measurement of environmental hazards, overhaul of the ventilation and heating systems, and improvement of preventive measures.
Problem: Workers' health was being jeopardized by poor working conditions in the laundry, and the workers had lost confidence in the ability of their union or of their employer to improve conditions.

Solution: A study circle brought the workers together with union representatives and scientists. The means used to measure how working conditions affected employees was credible, and the workers were helped to use the information to develop a programme for change.

Strategies: • Advocacy (for better working conditions).
  • Building alliances (between union representatives, scientists and workers).
  • Empowering (of workers).
  • Mobilizing resources (employers and employees).

Learning through the media

Social marketing (selling ideas) has become an important strategy for promoting health. To maximize the chances of success, a social marketing campaign is usually combined with an educational component.

Story 31 ■ Anti-smoking video targets young women in Canada

In Canada, as in most industrialized countries, adolescent girls and young women are highly influenced by the media. In movies and advertisements, young women see portrayals of attractive and successful women who smoke. To combat this, Health and Welfare Canada has produced a video called Diary of a teenage smoker, which incorporates all the advertising techniques of the tobacco industry but uses them to show smoking as a negative habit. Drama, comedy and “anti-commercials” are combined with the voices and stories of young women in a fast-paced, entertaining video. The video was shown on television at peak viewing times and is now available to schools and community groups, together with a facilitator’s guide.

Problem: Media influence young women to become smokers.

Solution: A social marketing approach was used to put the opposite message across.

Strategies: • Advocacy (video critically examines the tobacco industry’s methods and motives).
• Empowering (young women speak unscripted on film about starting to smoke, continuing to smoke and quitting; the facilitator’s guide has details of activities to promote self-esteem, a positive body image and personal action).
• Mobilizing resources (using the media to discourage smoking).

Tapping education’s potential to create a healthy society

Realizing the potential of education to create a healthy society means facing a number of challenges. There must, for instance, be enhanced cooperation between formal and informal education; there is a need for increased access to education and to continuing education; the educational system itself should be an influence for health; professional training will need reorientation; and there will need to be a political environment that is supportive of health.

Enhancing cooperation between formal and informal education

Tapping education’s potential to create a supportive environment for health may require breaking down barriers to cooperation between formal and informal education and between various sectors and levels of government. Learning outside the school walls is as important as learning within the formal system. A complementary mix of formal and informal education provides people with the greatest opportunity to learn and grow.

Story 32 ■ Non-formal education leads the way in Indonesia

Lack of access to formal education in rural Indonesia is one of the reasons why the Directorate of Non-Formal Education was established in Indonesia’s Ministry of Education. The Directorate stresses learning while working, and offers programmes on literacy, women’s education, family life, health, nutrition, sanitation, vocational skills and community leadership. The Directorate also provides community libraries and income-generating activities. A major part of the informal education programme is the literacy campaign, which uses small learning groups to eliminate illiteracy. Volunteer teachers, tutors and parents cooperate in groups of about 10 learners. Materials for self-learning are also supplied. Peer teaching, in which younger learners are tutored by those more advanced, is common. Currently, the Directorate is focusing on people who were unable to attend primary school or who dropped out. Subsequent programmes will focus on secondary school drop-outs. The Directorate anticipates that 5.5 million people will learn to read and write.
through the programme. Ironically, many of the materials developed by the Directorate are being adopted by the formal primary schools.

Problem: Many rural Indonesians lacked access to formal education. Illiteracy was a major problem.

Solution: The Directorate of Non-Formal Education was established. By stressing learning while working, it has developed an integrated approach to eliminating rural illiteracy.

Strategies: • Building alliances (between the formal system and the community).
• Empowering (of illiterate people).
• Mobilizing resources (production of materials for self-instruction).
• Policy development (establishment of a Directorate of Non-Formal Education).
• Reorienting organizations (use of informal education techniques and lay leaders).

Sometimes schools remain isolated from the community because of barriers to cooperation at other levels. For example, within government there are usually separate departments for health and education at each level. While this is not necessarily bad it can lead to a "top-down" flow of information and resources and poor communication between departments.

**Story 33 ■ Health on the school curriculum in Kenya**

Kenya has introduced a District Development Focus that decentralizes development efforts to the district level and facilitates cooperation between all government ministries at national, provincial and district levels. The Ministry of Health has achieved close collaboration with the Ministry of Education in promoting health education in primary schools, and with the Ministry of Environment and Natural Resources in promoting environmental sanitation. It also collaborates with the Ministry of Information and Broadcasting which uses mass media and community theatre to facilitate health promotion, and with the Ministry of Culture and Social Services by cooperation with social workers.

Although initially there were problems of interministerial collaboration, the establishment of district development committees appears to have overcome these. These committees enabled local people to have a say in national development. Policies have been articulated at all levels,
resulting in the introduction of health education into the science, agriculture, home economics and social ethics curricula. These efforts have been complemented by health promotion projects in primary schools and the production of radio programmes on health issues, including AIDS. Current plans include communicating health information through community theatre and involving local artists and consumers in the development of health promotion materials. It is recognized that materials produced at national level, particularly posters, may not be appropriate to all social settings.

Problem: There was a need for collaboration between ministries and for decentralization of power so that educational content would be more relevant to learners.

Solution: Four ministries collaborated to establish district development committees that provide for local participation in national development.

Strategies: • Building alliances (between ministries, the formal system and the community).
  • Empowering (local participation in programme and policy development).
  • Mobilizing resources (adding the resources of ministries other than health and education).
  • Policy development (policies articulated at local level instead of national level).
  • Reorienting organizations (education restructured to incorporate health promotion into school curricula for science, agriculture, home economics and social ethics).

*Increasing access to education*

According to the Jomtien World Declaration on Education for All:1

— more than 100 million children have no access to primary schooling;
— another 100 million children do not complete basic education;
— more than 960 million adults (two-thirds of whom are women) are functionally illiterate.

Lack of access to education is generally related to demographic patterns.

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Developing countries need ways to provide educational opportunities to large numbers of children (often 50% of the population is under 15 years of age). In poor countries, even basic learning materials may be in short supply and the physical environment of schools may be unhealthy.

Industrialized countries need ways to provide lifelong learning opportunities to an aging population (commonly 20% are over the age of 50).

Reducing inequities
Throughout the world, children of the very poor, rural children, children of ethnic and racial minorities, and girls are least likely to attend school and most likely to leave school early.

Story 34 ■ Rainwear improved school attendance in Chile
In southern Chile, education officials discovered that the main obstacles to regular school attendance by young children were bad weather and inadequate clothing. From the mothers' point of view, getting to school and back made the children ill. The authorities acted quickly to make raincoats and shoes available to all children of school age. The result was a remarkable improvement in school attendance.

Story 35 ■ Tackling inequities through legislation
One of the problems Canada has faced has been the under-representation of native groups, or "First Nations", on decision-making bodies such as school boards. One reason for this, according to an article in Education Canada, was that trustees had to be elected by rate-payers or property owners. The author suggested that a simple change in legislation would enable First Nations to be equitably represented on school boards. Canada has taken steps in a number of areas, including education, to take the views and needs of minority groups and First Nations into consideration.

Story 36 ■ Poor children in the USA get a head start
Head Start is a community action programme for preschool children in low-income families in the USA. In operation for over 25 years, Head Start has three objectives: to prepare economically disadvantaged children for school, to strengthen family support of children and to involve families in community action. Local communities recruit the children and the programme personnel, while the Federal Government provides the funds and overall policy development. Parents (mostly mothers),
who are employed as educational aides, work with professionals from the fields of nutrition and family services. Evaluations have shown that the children in Head Start do better than control groups when they enter school. The programme has also succeeded in creating broad-based political support for an anti-poverty programme.

*Providing universal primary education*

Achieving universal access to primary education, especially in developing countries, will require a major mobilization of resources from both governmental and non-governmental sources.

**Story 37**  ■  Rotary sponsors literacy effort in India

Misra Ranchi is an agricultural area in eastern India where many people lack formal education. In 1989, the Rotary Club chapter at the Birka Institute of Technology began holding classes for the children of support staff and labourers at the Institute. Engineering students act as teachers and the Rotary Club provides all necessary supplies. By 1991, some 400 young boys and girls had learned to read and write.

| Problem: | Children in an agricultural area of India had no access to education. |
| Solution: | The Rotary Club — a nongovernmental organization — provided funding for an education programme. Engineering students volunteered their time as teachers. |
| Strategies: | • Building alliances (Institute of Technology and Rotary Club). |
| | • Empowering (of children and volunteer teachers). |
| | • Mobilizing resources (supplies and teachers). |
| | • Reorienting organizations (staff and students at the institute replace the formal education system). |

**Story 38**  ■  Home schools offer alternatives in Pakistan

In Baldia Town, one of the largest squatter settlements of Karachi, Pakistan, a number of young women had completed secondary education but were not allowed to pursue further education or to move away from home. At the same time, there were many children in the area who had dropped out of school and girls who had not been allowed even to enrol in school. Community leaders and families worked with UNICEF and the University of Karachi to set up "home schools" in the homes of
the educated young women who thus became teachers. UNICEF pro-
vided blackboards and chalk, and the students paid a minimum fee to
the family that hosted the home school. Home schools have since spread
to other squatter settlements. Some 38,000 students have benefited.
A Home Schools Teachers’ Association has been formed and home
schools are now recognized by the Directorate of Education.

Problem: Formal schooling was unavailable to many children, especially
girls.

Solution: Home schools were set up and girls with some education taught
younger students.

Strategies:
• Building alliances (between UNICEF, University of Karachi,
and the community).
• Empowering (of young women teachers and students).
• Policy development (the formal system recognizes home
schools).

Overcoming illiteracy

Research has repeatedly demonstrated the link between poverty and
poor health. Eradicating illiteracy is a key to escaping poverty and,
therefore, to improving health.

Story 39 ■ Innovative literacy project in Canada

To combat illiteracy in the Canadian province of Ontario, the Ontario
Public Health Association and Frontier College (a 100-year-old
nongovernmental organization involved in literacy training at the
workplace) jointly launched a project to explore the link between li-
teracy and health. The project had three aims: to identify major health
issues for people with low literacy skills, to establish a network of organi-
zations and individuals representing the education, health and social
service sectors, and to develop recommendations and strategies for ac-
tion. The first phase culminated in a report on making the world
healthier and safer for people who cannot read. In the second phase, the
project plans to make better use of community networks to facilitate
cooperation among community organizations and to encourage health
professionals to work with people whose literacy skills are limited. The
joint project has proposed more frequent use of non-written forms of
communication, such as pictures, symbols, and audiovisual aids, as well
as exploration of the potential of radio and television.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

Problem: People with low literacy skills suffered the direct effects of illiteracy on their health (e.g. inability to read information on workplace safety or the proper use of medication) as well as the indirect effects (such as increased poverty and less opportunity to make healthy choices).

Solution: Better use of non-written forms of communication. Community networks encouraged health professionals and community groups to work in partnership with people whose literacy skills were limited.

Strategies: • Advocacy (identified and raised issues of illiteracy and health).
• Building alliances (between health professionals, community groups and people with limited literacy skills).
• Empowering.
• Mobilizing resources (of education and public health communities).
• Reorienting organizations (using new strategies to overcome illiteracy).

Supporting continuing education

In past decades, people expected to go to school, complete their education and then enter the workforce. With the present rate of social and technological change, people require periods of learning throughout their lives to help them adapt to changing circumstances and prepare for new roles and responsibilities.

Lifelong learning

Despite stereotypes of older people as limited in their capacity to learn, research has shown that people who stay mentally active maintain their mental capacities into very old age. In retirement, learning helps the elderly cope with change and maintain their independence. It broadens their horizons, quality of life and capacity to give. Health professionals need to understand the potential of older persons.

Story 40 ■ Lifelong learning

Every summer, old people who are members of the Elderhostel programme congregate at universities around the world. They live on campus while attending educational courses, with full access to cultural and
recreational activities. Participants pay a modest fee for lodging and food.

At Glendon College in Toronto, Canada, a group called Third Age Learning Associates provides advice and help to old people on planning and implementing self-managed learning groups. Their newsletter keeps learning groups of elderly persons in touch with each other, offers ideas for educational programmes and informs members about other learning opportunities.

A learning culture at work

Employees tend to acquire new skills more effectively in companies where the corporate culture includes a strong commitment to employee training and on-the-job learning. The development and nurturing of a national learning culture at work will benefit the health and quality of life of all workers.

Story 41 ■ Worker training in Mexico

Two basic legal frameworks cover worker training in Mexico: the Mexican constitution states that all firms are bound to provide their workers with training, and the Federal Labour Law (issued in 1978) spells out how to carry out training in order to increase the workers’ productivity and standard of living. As of August 1990, a total of 416,583 firms were registered as actively training their 7.9 million workers in the areas of agriculture, mining and oil (1%), manufacturing (47%), construction (4%), electricity (4%), services (11%) and other (4%). According to the companies’ training plans, the courses in greatest demand included human relations, motivation, industrial safety, productivity, communications, sales and computer science. Formal education for adults has also become important and the demand for basic reading and writing courses has increased.

Creating healthy education systems

The formal education system has the potential to influence the health of not only students and teachers but also the community as well. If this potential is to be realized, schools, and what happens within them, must be the target of educational change.

A healthy school is one that does more than teach about health. Characteristics of a healthy school include the following:

• A healthy school is clean and safe. It has good lighting, appropriate ventilation and heating, and safety features. The water is clean and there is proper waste disposal.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

• A healthy school is a positive place to be. Teachers, as well as students, have good working conditions and feel empowered and supported in their work.

• A healthy school acknowledges that, in order to learn, people must be healthy. It takes action when students’ basic needs are not being met and provides an appropriate range of health services.

• A healthy school practises what it preaches. It promotes health through positive role models, provides opportunities for physical activity and makes nutritious choices available in school food outlets.

• A healthy school has healthy policies and programmes on smoking, discipline, parent involvement, student initiatives and so on.

• A healthy school respects the right of people to participate in decision-making. It provides opportunities for students, staff and parents to contribute to decisions affecting the school.

• A healthy school involves learners in a participatory learning process that is meaningful and relevant to their situation. It empowers them for future participation in society.

• A healthy school provides opportunities for students to learn about health issues affecting themselves and others. It enables them to make healthy personal choices and to contribute to the health of their families and communities.

• A healthy school is an integral part of a healthy community. In a healthy school, resources are mobilized to meet the learning needs of the community. In turn, the coordinated efforts of children, parents and school personnel support community action that promotes health.

Reforming the system

In most countries, the potential of the formal education system to promote health has not been fully realized and there is a need for educational change in a “health promoting” direction.

Education must equip people for participation in both the society and the economy. A balance between the two sets of goals must be maintained. It is important for health promoters to contribute their views to debate about the purpose of education. This may mean participating in discussions at district, state or national levels.

Story 42 ■ New learning directions in Colombia and Canada

In Colombia, in the 1980s, the government developed the New School Programme which is now implemented in thousands of schools. The programme uses a combination of formal and informal educational techniques to provide locally adapted primary education to poor rural children. The New School Programme features self-instruction manuals
and guides, student-built learning centres, peer teaching (students teaching students), extensive use of community resources, and a change in the role of teacher from communicator of information to resource person. The programme is now being expanded to cover all the rural primary schools in the country. It is also being studied by educators from other countries.

British Columbia, a province in western Canada, has embarked on Year 2000, a new educational policy that is based on a set of 23 principles in four areas — learning and the learner, curriculum, assessment and evaluation, and reporting. Learning goals are identified in three spheres — intellectual, human and social, and career development. Official policy commits the province to the curriculum and describes the implications for the teaching profession and governing structures. The financial requirements ($1400 million) and implementation schedule (10 years) are given, including target dates and detailed descriptions of the responsibilities of the ministry, schools, districts, universities and teachers' unions.

Story 43 ■ The European "Health-Promoting Schools" programme

In the Czech Republic, a blueprint was prepared for “The European Network of Health-Promoting Schools”, a joint project of WHO, the Council of Europe and the Commission of European Communities. The project was designed to promote better standards of physical, mental and social health in the school community. The aim was to develop a model conducive to the health of all those engaged in the school’s daily activities, to develop mutually productive contacts with parents and communities and, most important of all, to disseminate information on these ideas throughout the Czech school community.

A consultative body for the project was established. Consistent information was provided to public, medical and educational institutions. An informative letter was circulated to all schools in the Czech Republic.

Those involved in this project included the National Centre for the Promotion of Health, the Consultative Board of the project, the Ministry of Education, Youth and Physical Education, the Ministry of Health, educational authorities, the Institute of Hygiene and Epidemiology, district hygiene centres, teacher training establishments and educational counselling centres.

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Problem: A school health programme with inadequate standards.

Solution: A comprehensive school health programme involving all concerned parties.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

Strategy: The healthy school concept empowered local people, schools and other institutions, stimulating community initiative and providing appropriate services.

Outcome: Schools were stimulated to participate in the new system.

Making education meaningful and culturally relevant

Learning, not teaching, is the "active ingredient" in education. An environment that supports learning is one in which education is meaningful and culturally relevant to the learner.

Story 44 ■ Aboriginal syllabus introduced in Australia

The school curriculum of New South Wales, Australia, was limited in its presentation of the history and culture of Australia's indigenous people, the Aborigines. After decades of advocacy by Aboriginal organizations, the New South Wales Department of Education set up a committee to develop curricula that were culturally relevant to all students. The committee included Aboriginal and non-Aboriginal teachers, union representatives, other professionals, and members of the community. The committee's first challenge was to break down the barriers of mistrust between its Aboriginal and non-Aboriginal members and between teachers and other professionals. None the less, within several months the committee had produced a new Aboriginal studies syllabus, which was introduced into schools in 1991.

Problem: The curricula of schools reflected the culture of the dominant non-Aboriginal society.

Solution: The school worked with the community to develop culturally relevant education.

Strategies: • Advocacy (by the Aboriginal people). • Building alliances (between school and community and between cultures). • Mobilizing resources. • Reorienting organizations.

Adopting a comprehensive approach to health education

In recent years there has been an increase in the popularity of comprehensive school health programmes. A comprehensive school health pro-
gramme strives for complementary change in three main areas: the school health services, the school health curriculum and the school environment.

In the area of school health services, a comprehensive health programme encourages nurses, dental staff, nutritionists, psychologists, social workers and classroom teachers to work together rather than in isolation.

The school health curriculum has often been developed with little input from health professionals and parents, and has often lacked resources. In a comprehensive school health programme, health becomes an integral part of the curriculum, taught either as a separate subject or combined with other subjects or both. It takes a comprehensive approach to health, rather than treating it as a single issue, and offers learning opportunities throughout the child’s school life.

In the school environment, there may need to be changes to the safety, lighting and cleanliness of the physical surroundings, as well as to the overall social climate of the school. Food services (or lack of them) are an important component since they may often conflict with the health teaching in school.

**Story 45 - Popular school heart and mind health programme**

The Dartmouth Health Promotion Study was a Canadian action research project that aimed to find out whether children’s health and school performance could be improved through a comprehensive school health programme. Parents, voluntary health organizations, the business community, the provincial department of health, the federal government and the local school board were all involved in planning and implementing the project. Based on a needs assessment, the programme targeted heart health and mental health in schoolchildren aged 9–12. The joint efforts of all partners have generated enthusiasm and have led to innovations that complement the curriculum and link it with health services and with the environment. The programme’s influence is felt in the community as well. For example, a local bakery began to make “heart-healthy” muffins. At the end of the study’s pilot year, parents reported that their children were more confident in general, were choosing healthier foods and had increased their levels of physical activity. Ninety-six per cent of the parents said they wanted to be involved in the school health programme.

**Problem:** Educators wanted to provide a comprehensive school health programme and study its effect on schoolchildren and their parents.
Solution: Federal, provincial and local businesses and health organizations collaborated with parents to introduce and evaluate a programme in a local school board area.

Strategies: • Building alliances (among all levels of government, families, teachers and schoolchildren).  
• Empowering (of children and parents).  
• Mobilizing resources (local infrastructure and federal government funding).  
• Reorienting organizations (towards a comprehensive approach).

**Strengthening links between school and community**

To create a supportive environment for health, the educational system must respond to the learning needs of the community. This can mean, for example, reorienting the traditional role of students and teachers (see Story 12, page 17) or strengthening links between school and community.

In many areas of the world, it is often not a parent who looks after younger family members but an older sister or brother. The Child-to-Child Programme described below shows how primary schools can be effective in helping children prepare for this role within the family and the community.

**Story 46 ■ Zambian children recognized as peer educators**

In Zambia, schoolchildren have long been seen as a ready means of conveying information to the community. Because many health problems are preventable, health promotion has always been one of the focal points of child-to-child learning. The Child-to-Child Programme has tried to educate and encourage older children in their efforts to care for those who are younger. The five broad areas in which children can help each other have been identified as eating well, improving health, teaching good habits, monitoring growth and recognizing diseases early, and stimulating younger children by playing with them. To support the older children, activity sheets and simple books on health have been developed.

**Problem:** Older children who care for their younger siblings lack support to fulfill this responsibility.

**Solution:** Support the older children through formal channels and encourage them by praising their efforts and giving them the information and skills they need.
Strategies: • Reorienting organizations (adjusting formal education to respond to community needs).
  • Building alliances (between the school and the community).
  • Empowering (of children to nurture and care for younger siblings).
  • Mobilizing resources (new learning materials developed).

If an educational system is to be a catalyst for “healthy” social change, then it must also embrace the community’s health concerns.

Story 47 ■ Success of a Norwegian child environment club

The Blekkuljf, or octopus, was the brainchild of a Norwegian woman who was concerned about the environment. The blekkuljf appeared on television and in books as an environmental detective who pointed out all the harm that people did to nature. Later, the Norwegian Society of Nature Conservation took over the project and launched the Environmental Detectives’ Club which made children environmental detectives in their homes, schools and communities. Club members began to ask local authorities about the extent of harm to the environment. Local newspapers have published articles by the children and have publicized their ideas for cleaning up the environment. The club is flourishing in Norway and similar clubs are being launched in several other countries.

Problem: Community members were concerned that the formal school system was not involving children sufficiently in advocacy for a clean and healthy environment.

Solution: Informal education of children through a television show, books and local newspapers was used to initiate a club of environmental detectives who advocated for cleaner environments.

Strategies: • Advocacy (by children for cleaner environments).
  • Empowering (children).
  • Mobilizing resources (private citizens, media, children, environmental groups and the school).
  • Policy development (educating children to question policymakers).

Reorienting professional training

The educational preparation of a professional group helps determine how that profession is practised. Education of health professionals
must reflect concern not only for treatment but also for health promotion.

Traditionally, health care specialists such as doctors, nurses and therapists have been educated in relative isolation from each other. The shift of concern to "health" as well as "illness" suggests that health care in the future will be delivered by a team of professionals working together in partnership. Health professionals will need to have a concern for the whole person and a realization that health is closely related to empowerment. Health professionals must be able to use a learner-centred approach in educating people about health.

These changes will only be achieved by altering the content of and approach to the education of health professionals by:

- introducing or increasing exposure to health economics, the determinants of health, health promotion theory and its relation to social justice;
- extending field experience in community settings and in health care teams;
- providing a richer, more balanced educational experience in terms of content, research and community practice.

In addition to shifts in the educational preparation of health care professionals, there is growing interest in:

- reshaping the education of public health workers towards positive health and community development skills;
- examining the educational requirements of health promotion specialists.

Story 48 ■ Multidisciplinary health education in Belgrade, Yugoslavia

The Centre for Multidisciplinary Studies at the University of Belgrade has developed activities in health promotion in three basic directions:

- training postgraduate students in health sciences (to obtain competent personnel for health promotion);
- conducting multidisciplinary research projects (to educate health promotion specialists);
- providing practical multidisciplinary field work in socioeconomic functioning and health in both urban and rural areas.

Story 49 ■ Joint advocacy role of 3000 health organizations in India

The Voluntary Health Association of India (VHAI) came into being in 1974 when leaders of voluntary hospitals and health associations decided to promote community health in order to balance the overemphasis on
expensive hospital-oriented health services. Today, VHAI is a federation of more than 3000 health organizations throughout India and is working to promote social justice in the provision and distribution of health care. Its work spans a wide range of activities, including shaping public policy for health, providing training, involvement in public affairs and communication for health.

The advocacy activities of VHAI are directed at parliament and the press. The concerns of thousands of voluntary organizations in the health field go unnoticed by policy-makers, but the VHAI realized that it was in a position to bring these concerns to their notice and offer recommendations at decision-making and policy-making level in government ministries, the planning commission and parliament. Today, VHAI interacts with the main political parties to impress on them the health realities of the nation, highlighting areas needing immediate attention. Some of VHAI’s ideas and recommendations are now reflected in the manifestos of these political parties.

With the formation of a new government in India in late 1990, VHAI’s persistent efforts led to assurances from the Deputy Prime Minister and the Minister of Health that there would soon be a comprehensive law on smoking with strict sanctions for offenders, a review of drug and agriculture policy, and increased importance given to primary health care.

VHAI has also initiated work in areas such as environmental health and the problems of adolescent girls. A feature film and a booklet on these subjects have been produced with UNICEF support. In its advocacy efforts, VHAI has always been careful to establish close rapport with the media.

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**Problem:** Social injustice in provision and distribution of health care.

**Solution:** A federation of 3000 NGOs was established to shape public policy for health through training, communication and involvement in public affairs.

**Strategies:** • Policy development (policy alternatives offered),
  • Regulation (through new legislation),
  • Building alliances,
  • Advocacy (pressure groups).

**Outcomes:** • Media, parliament and government were made aware of health issues.
  • Political parties’ manifestos reflect health issues and action needed.
  • New legislation has been initiated.
Creating a supportive political environment

A political environment that supports health is one in which politicians and decision-makers make "health promoting" decisions. Here education has three key roles:

- the creation of an informed electorate able to identify problems, find solutions and take action;
- the development of the electorate's ability to influence decision-makers about the health impact of their decisions;
- the preparation of leaders for the political arena.

The stories that follow demonstrate the power of education to break down barriers between people and elected officials.

Story 50 ■ Children as agents of change

The aim of "Voice of the children" is to establish channels of communication between children and decision-makers. It began in Norway after 6000 schoolchildren sent cards or letters stating their concerns about the environment. From these statements, a "Children's appeal" was put together and 10 children from various parts of the country met with six Norwegian leaders to challenge them in a debate on environment and development. The programme has since spread to Argentina, the former Czechoslovakia, Ecuador, Latvia, Malta, Uganda and the United Kingdom.

Problem: Children concerned about the environment and their future.

Solution: "Voice of the children" provided a mechanism for children to contribute to public discussion and debate.

Strategies:
- Advocacy (for children to make their views known).
- Building alliances (between children in different countries; between NGOs and children).
- Empowering (of children).

Coordinated community efforts can effectively influence political decisions.

Story 51 ■ Environmental forums lobby politicians in Norway

Since 1988, over 20 different areas of Norway have organized community forums to discuss local environmental issues and decide how to address them. The outcome of this community education process involved a
combination of political pressure and practical activities to address specific problems. For example, pressure on politicians resulted in a hazardous waste area being moved, as well as in a campaign against phosphates in detergents and against the building of a new highway. Practical actions by the groups included cleaning up neighbourhood beaches and streets. Schools, churches, NGOs, businesses and labour organizations are all involved.

Problem: Numerous NGOs were working on environmental issues in isolation, with little result.

Solution: The community prioritized environmental issues. All those concerned cooperated to solve specific problems through political and practical action.

Strategies: • Advocacy (for political action on environmental issues).
• Building alliances (all parts of the community).
• Empowering (of community to influence the political process).
• Policy development (enlightened political decisions based on community aspirations).

Conclusions

The stories in this chapter demonstrate the potential of education in building a supportive environment for health. The application of action strategies in education can indeed facilitate change. Through education, individuals and communities can make a difference.

Two things are required for education to realize its full potential: access to affordable, appropriate educational opportunities for all and a commitment to lifelong learning that empowers people. The most successful interventions are those that incorporate both formal and informal learning experiences and that create a culture that values and supports lifelong learning.

While the strategies for educational change are universal, they are applied in all kinds of settings (home, school, community, workplace) and at all different levels (local, regional, national). They are used to address problems as diverse as malnutrition, poverty, workers' health, marketing by the tobacco industry, illiteracy, sustainable development, barriers to education in rural and socially disadvantaged areas, and the need for information about healthy lifestyles.

The seven key strategies for the creation of supportive environments for health can be applied to education in the following way:
1. Public policy development — enlightened policy promotes education that is accessible, affordable, learner-centred and relevant to community needs.

2. Regulation — enlightened legislative policy that provides free access to education with health and environmental concerns on the curriculum.

3. Reorienting organizations — finding a balance between formal and informal education, making a commitment to lifelong learning, making education more learner-centred, using community teachers and reorienting the training of health professionals.

4. Advocacy — actions to confront inequities, overcome illiteracy, lobby for political action on environmental issues, create better working conditions, counter marketing initiatives of the tobacco industry, adopt a comprehensive approach to school health and create better living conditions in the community.

5. Building alliances — between education systems and the private sector, education and health infrastructures, governmental and nongovernmental groups, the school and the community, among professionals and community leaders, and among decision-makers at local, regional and national levels.

6. Enabling — a “healthy school” provides teaching that develops personal skills to enable students to make healthy choices and to contribute to the health of their families and communities. The school setting is supportive of healthy choices and is thus enabling for health.

7. Empowering and mobilizing resources — promoting the active involvement of children, adolescents, adults, community leaders and workers in creating learning opportunities that support health. Also, the provision of financial support for primary education for all; complementary financial support for basic education, adult learning and literacy programmes; private sector support for on-the-job training; new leadership roles for students, teachers, parents and community resource people; the training of local experts and the use of the positive potential of technology.
CHAPTER 7

Food and nutrition

The elimination of hunger and malnutrition is a fundamental objective of Healthy Public Policy. Such policy should guarantee universal access to adequate amounts of healthy food in culturally acceptable ways.

(Adelaide Recommendations for Healthy Public Policy, 1988)

Issues and problems

The importance of food for health, well-being, and survival is universally acknowledged. Changes in food supply can play a tremendous role in the course of disease development in a society, in terms of both morbidity and mortality. The strong connection between population growth and food supply demonstrates the need for a multisectoral approach to the problem of food shortage.

Food security is of primary importance to individuals and societies. The need for food rationing and the threat of hunger led in the past to the first government attempts to formulate food and nutrition policies. Most policies are concerned with food security but few address nutritionally related ill-health or disease.

In terms of health, it is the shortage of food which constitutes the main problem in many parts of the world. It is a striking paradox that while millions are unable to obtain the daily minimum subsistence food ration — among them, millions of children suffering from malnutrition — others suffer from obesity and other problems related to overeating.

This chapter deals with the challenges of too much and too little, of limited resources, gaps in the line of responsibility, competing interests, natural disasters such as drought, and what individuals with creative ideas and the ability to realize them have accomplished. It is a tapestry of ideas and activities that have made a difference. Not all the activities

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were successful; some are unfinished, others did not work. But, because failure may teach as much as success, these efforts are also included.

There are three main targets in creating supportive environments for healthy nutrition. They are:

— food security,
— food safety,
— healthy eating.

The importance of each target varies from country to country and there are huge differences between rich and poor nations.

**Food security**

Food security includes safe and continuous access to food in a sufficient quantity and of a quality that meets the need for a healthy nutritional status in the population. It is said that agriculture does not lack resources but lacks policies to ensure that food is produced where it is needed and in a manner that sustains the livelihood of the rural poor. This challenge can be met by building on past achievements and devising new strategies for food security.

Food security depends on global production and the structure of the world food market. Many countries do not produce enough food to feed themselves, and the international community has not succeeded in establishing a sustainable situation for the poor countries. While there are “food mountains” in one part of the globe, people starve in another.

**Food safety**

The world still faces great problems of foodborne diseases associated with contamination of the food supply. WHO estimates that each year there are 1300 million cases of acute diarrhoea in children under five years in the developing world. A substantial number of these are due to microbially contaminated food. It is also clear that much food is lost as a result of spoilage. Other threats to safe food include different chemicals that end up in our food products — pesticides, fertilizers, veterinary drugs, food additives (preservatives, sweeteners, colouring agents) and various pollutants from industrial waste as well as natural toxins. Some of these agents enter the food chain because people are unaware of their dangers.

**Healthy eating**

Healthy eating relates to both the quantity and quality of food consumed. Sometimes food that contains a sufficient variety of macronutrients and micronutrients is simply not available. People may
not know what constitutes healthy food and good nutrition. Traditional food may be forgotten and a change of lifestyle may include eating unhealthy food with too much fat and sugar and too little fibre, as is the case in many industrialized countries. Eating habits are influenced by many forces in society, such as food production and processing, marketing, consumer pressure, and tradition. Similarly, many forces have to be applied to bring about change in eating habits.

Activities and solutions

Many efforts to create a supportive environment for health in the food and nutrition area were reported and discussed in Sundsvall. Some of the stories, without sharp distinctions between different categories, are presented here under the following headings:

- Food policy and intersectoral collaboration
- Food shortage — coping with too little
- Supporting healthy food choices
- Vulnerable groups in nutrition
- Women’s role in food and nutrition matters
- Approaches to better food safety
- Education for better nutrition.

Food policy and intersectoral collaboration

Intersectoral collaboration is crucial to nutrition policy. The health sector, which is responsible for identifying ill-health and its causes, cannot respond adequately without participation by other sectors. Health goals may be set as part of a food and nutrition policy, but intersectoral collaboration is needed to achieve them.

Story 52 ■ Regional WHO conference highlighted food policy needs

In 1984 the WHO Regional Office for Europe began a new programme on nutrition. The new programme officer began by determining who was responsible for nutrition policy in the ministries of health of Member States. The answer was usually no one. Food safety was of national importance and often regulated by health authorities, food security was dealt with by the ministries of agriculture, but there were usually no health-oriented food and nutrition policies. As might be expected when no one was responsible, no goals or targets existed and no surveillance was carried out. Since the situation was not regularly reviewed, plans for improvement were not developed.

The officer decided that the most important goal would be to get the involved parties together for discussions, to try to get nutrition policy on
the agenda of the ministers of health. A regional conference on nutrition policy was planned and ministries of health were invited to send delegations which included representatives from health, agriculture, media, consumer unions and the food industry. The countries were also asked to prepare a report on the status of food and nutrition policy.

The first WHO Regional Conference on Food and Nutrition Policy took place in Budapest, Hungary, in October 1990. Delegations from national governments, as well as representatives of nongovernmental agencies, took part in the conference. With scientific presentations, workshops using case studies and a discussion forum on special topics and the current state of knowledge, an overview of many national programmes was presented and discussed. The most important outcome, however, was the renewal of interest among decision-makers in the health area.

The strategy for a nutrition policy might seem a straightforward technical matter, mapping and defining the health problems related to nutrition in society, setting goals and targets for improvement and finding the ways and means to achieve a healthier future. The problems differ tremendously around the world, from gross deficits in food production, problems of distribution, poor preparation and inadequate composition of food resulting in deficits of vitamins, to excess and highly concentrated sources and overconsumption of nutrients. Consequently each society must create its own policy and change it as necessary according to changes in the health situation.

Norway was one of the first countries to launch an official nutrition policy (see Story 2, page 12). Later, the Netherlands, Iceland and Malta also developed national food policies. The Norwegian policy focused on health goals, and aimed primarily to reduce the amount of fat in food. The adoption of this policy has since resulted in a decrease in coronary heart disease in Norway. Once nutrition is on the health agenda, a continual re-evaluation and refocusing of effort will be needed. One of the most significant contributions to the development of nutrition policies was the FAO/WHO International Conference on Nutrition in Rome, Italy, in 1994.

**Story 53** ■ Policy change in China improved food production

The authorities in China wished to stimulate farmers’ initiative in order to increase agricultural production and improve farmers’ living standards. Previously the state authorities had controlled almost every aspect of agriculture, from production to sales. Farmers were not involved in determining agricultural policy to any great extent and they lacked the initiative to improve production. This resulted in insufficient food supplies. Then the government changed its policy and signed contracts with farmers, giving them the right to make their own decisions about the
land they farmed and encouraging them to diversify their output. The authorities allowed the farmers to run collective businesses and to sell their own farm produce. The farmers showed great initiative in improving their output, and their standard of living improved. Now there is a sufficient supply of food for the market.

Problem: Lack of farmers’ initiative to increase production.
Solution: Contract with farmers to give them right to run their own lands.
Strategy: Policy development (stimulating farmers to increase production).
Outcome: A sufficient supply of food for the market, and an improved standard of living for the farmers.

Story 54 ■ Ethiopian food policy

In Ethiopia, after recurrent famines, all government ministers met with representatives of international bodies (FAO, UNICEF, WHO), marketing institutions, NGOs and various political organizations to discuss priorities in order to make a strategy for disaster prevention and preparedness. The strategy involves conservation measures, food preservation techniques, the introduction of a mixed economy, a proper pricing system, delivery of the minimum per capita calorie requirement and promotion of good eating habits. Pressure to finance relief programmes delayed the implementation of the strategy.

Problem: Recurrent famines.
Solution: Gain recognition of problem, nationally and internationally.
Strategy: Policy development.
Outcome: Uncertain because of delay.

Story 55 ■ Multilevel campaign against heart disease in the United Kingdom

A regional effort was made in Wales, United Kingdom, primarily to fight coronary heart disease by reducing the amount of fat in food. Heartbeat Wales addressed all levels, from food producers to consumers. The producers were persuaded to switch to animal breeds with less carcass fat in order to produce leaner meat. The food processors were asked to manufacture low-fat dairy products and the consumers were addressed
by education and information campaigns in schools and the media. The market responded to consumers’ demands. Institutions and organizations that were big consumers of food, such as hospitals, were also addressed. The butchers were taught how to cut meat so as to present the lean parts, and the supermarkets and delivery services learned to market and advertise low-fat products.

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Problem: Too much fat in food products.

Solution: Reduction of fat in food products.

Strategies: • Advocacy (involving food producers).
• Enabling (healthy consumer choices).

The initiators of Heartbeat Wales understood that to reduce the amount of fat consumed, all the links in the food chain from the producers to the consumers needed to be strengthened. Where a free market policy is operating, this forms a circle. The producers, wholesalers, retailers and food outlets respond to consumer demand, but the consumers will not change their demand until they are convinced of the benefit of such a change and have the options for choice.

This story is from a developed country where overconsumption is the main nutritional problem. Intersectoral cooperation is equally important in other parts of the world where scarcity and hygiene problems are common.

**Story 56** Transportation support saved large crop in Zambia

One year there was a very good harvest of maize in Zambia, one of the country’s staple foods. The good harvest was the result of use of subsidized fertilizers and good rains. The government was concerned that the Ministry of Cooperatives had inadequate transport to collect the maize. Consequently trucks and lorries from all other ministries were mobilized for maize collection for two weeks. The maize was collected in good time and was distributed to all provinces. Farmers were happy and were motivated to grow more maize the following year.

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Problem: Lack of transport facilities for collecting the maize harvest.

Solution: All ministries collaborated in maize collection.

Strategy: Mobilizing (transport resources from all ministries).

Outcome: Maize was collected in good time.
These are different stories of intersectoral cooperation for health. In very different situations, taking the trouble to create cooperation at various levels can yield good results.

**Food shortage — coping with too little**

In some developing countries drought is a life-threatening problem, especially as it affects food production. Drought control is a priority in many countries, particularly in Africa. The great dam on the river Nile is one example of an enormous centralized effort to increase the area available for agriculture, although this has also led to unforeseen side-effects such as a rise in some diseases.

**Story 57 ■ Women struggle against drought in the Gambia**

Rural women in the Gambia were responsible for 90% of rice production and 100% of vegetable gardening. A 20-year drought resulted in most freshwater rice fields drying out. Salt water began draining into the fields. A well-organized and motivated group of village women took up this issue and implemented a land reclamation system devised by the Department of Water Resources and the Soil and Water Management Unit of the Department of Agriculture. The programme was initiated in 1987. Anti-salt dykes were erected to retain fresh water, and water was regulated upstream. Salt water was drained from the entire area. Production and yields have increased. These successes led to aid for further development being provided by international aid organizations.

<table>
<thead>
<tr>
<th>Problem:</th>
<th>Drought and food shortages.</th>
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<tbody>
<tr>
<td>Solution:</td>
<td>Introduction of a system to prevent water run-off and draining of salt water.</td>
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<tr>
<td>Strategies:</td>
<td>• Enabling (using new technology and women's skills).</td>
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<td></td>
<td>• Policy development.</td>
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<tr>
<td>Outcome:</td>
<td>Increase in yield and food production.</td>
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**Story 58 ■ Far-reaching land reform in the United Republic of Tanzania**

After independence the Tanzanian government made it a policy that every Tanzanian should have access to land. The aim was to increase employment through free agriculture and to build the confidence of the people. Traditional land tenure was abolished in areas where it existed. People were reorganized in villages. With these drastic changes, prob-
problems of adjusting to change and adapting to new ways of living and working together developed. Political mobilization and education have helped to solve some of these problems. Land distribution is not a problem in itself. However, some people prefer to live in certain areas rather than others because of transport, water, climate and availability of social services. This therefore causes a shortage of land.

Problem: Lack of employment after independence.
Solution: Increase of employment through free agriculture.
Strategies: • Policy development (free access to land).
• Regulation (traditional land tenure abolished).
Outcome: Development of a new social structure of living and working together.

Story 59 • Resettlement scheme works in Zambia

Zambia faced the challenge of meeting the growing needs of urban retired people. On retirement, many wanted to return to their villages of origin but had no right to land where they could settle and begin farming. After retiring, therefore, they ended up in poor urban accommodation where living standards were low. There was also a high percentage of unemployed young people. Since 1987 the government has been acquiring land under a resettlement scheme. Retirees and unemployed young people are given land portions under the scheme and receive loans at low interest rates. The scheme relies on negotiations with village chiefs. In this way, the formerly unemployed youth and retired people contribute to food production and land use is maximized.

Problem: No right to land for retired persons and young people who wished to start food production.
Solution: Retirees and young people were given land portions in resettlement areas.
Strategies: • Policy development (resettlement schemes).
• Mobilizing (by involving unemployed young people and retired persons).
• Regulation (low-interest loans).
Outcome: Previously unemployed young people and retired persons contribute to food production.
Monocropping or back to basics?

The industrialized world has tended to guide the agricultural practices of developing countries. Agriculture in industrialized countries often relies on modern technology and stable climatic conditions, with a basis of cash crops and trade to obtain a sufficient variety of food. Many developing countries are concentrating on a single cash crop with the hope of competing on international markets and ensuring positive cash flow. When, for whatever reason, these countries do not obtain the expected income, they may no longer have an adequate local supply of staple food of sufficient variety to provide adequate nutrition. For the farmer it may be more profitable, for example, to grow tobacco for export rather than to grow food. Once again, health can be linked with the environment since forests are destroyed to provide wood for fires to dry tobacco leaves.

Story 60 ■ Soya bean gains acceptance in Zambia

A project in Zambia combined the efforts of the Ministries of Agriculture and Social Welfare and Community Development, donor agencies such as the Norwegian Agency for International Development (NORAD) and the Swedish International Development Authority (SIDA), as well as nutrition specialists. Maize farming and the growing of cash crops such as cotton, tobacco and sunflower had received a lot of emphasis. This had not helped reduce childhood malnutrition which was increasing in Zambia. Since 1989, the growing of soya beans has been intensified. The introduction of soya bean products in most Zambian dishes was not well received initially but is gaining acceptance. Communities and especially mothers have now adjusted to adding soya beans when preparing meals for their children and families since they have learned about their nutritional value. The soya beans grow easily without fertilizers.

Problem: Increased farming of cash crops instead of a variety of staple foods was accompanied by an increase in childhood malnutrition.

Solution: Introduction of soya bean products.

Strategies: • Advocacy (education about the value of soya beans).
• Enabling (local cultivation encouraged).

Outcome: Acceptance of the use of soya beans in Zambian dishes.
Story 61 ■ Food changes reduced malnutrition in Bolivia

In an area of Bolivia, community health workers held meetings with the community to find out if people were aware of their children’s malnutrition. The reasons for malnutrition were discussed. An Italian aid organization worked with the community health workers to teach people the nutrition value of foods they usually did not use, such as carrot leaves, mixed beans, some cereals and soya. People started small farms around their houses, cultivating vegetables and fruits. They were taught to avoid diarrhoea and other infectious diseases, and were shown how to prepare food that was both safe and nutritious. This combined effort led to a fall in the prevalence of malnutrition from 45% to 10%. Experience gained in this small community of 2700 inhabitants will be applied to other places in the region.

Problem: Malnutrition among children.

Solution: Increased production of vegetables and fruits, plus preparation of meals with nutritious foods not previously used locally.

Strategies: • Mobilizing (small farms started).
• Enabling (increased local production).
• Advocacy (people educated about nutrition and infectious disease).

Outcome: Great reduction in malnutrition in the community.

Supporting healthy food choices

A common complaint in industrialized countries is that people are “eating themselves sick”. Epidemics of nutrition-related diseases such as coronary heart disease, obesity and diet-related cancers are seen in many countries as they progress from poverty to prosperity. The biggest nutritional problems come from too much food, too much fat, and too little fibre and starch in the food. The least privileged groups — often the least educated and working-class groups — suffer most from unhealthy eating habits. Action to address this problem must therefore incorporate a strong social dimension.

Encouraging new and healthier lifestyles is often a slow and difficult process. A few large-scale community intervention studies have been conducted with the goal of developing a more supportive environment for choosing a healthier lifestyle. In Scandinavia (the North Karelia Project, the Norwegian study, the Stockholm Cancer Prevention Programme), the United States of America (the Five Cities study, the Minnesota Heart study, Pawtucket and others), in the United
Kingdom with Heartbeat Wales and in Germany with the German Cardiovascular Disease Prevention project (GCP), massive well-directed interventions have been undertaken with nutrition as one of the main focal points.

In Germany, the Ministry of Research and Technology, in cooperation with the Ministry of Health, has conducted its largest-ever study on influencing behaviour in communities. Eight intervention centres carried out campaigns against smoking, hypertension and hyperlipidaemia, promoting physical activity and healthy diets among 350,000 people. The GCP used multiple innovative projects to inform and inspire people to make healthier choices.

**Story 62** - "Fitburgers" replace "fatburgers" in Germany

In Berlin-Spandau, health fairs, marathons and other sports events with a focus on health were used to get people together. Many families participated in the "triathlons", in which three family members each took part in separate sports events such as running, swimming and cycling. Spectators were given information about healthy living and were offered "fitburgers" as an alternative to traditional hamburgers. The benefits of low-fat food, such as fresh vegetables (tomatoes, lettuce, cucumbers, red peppers) on a whole grain roll were discussed and the spectators were asked their impressions of this alternative to fatty foods such as burgers or sausages. The health fairs were held on a number of occasions, such as the celebration of the 750th anniversary of Berlin, sponsored by the President of Germany, when guests were present from political, cultural, business, media, administration, sport and church spheres. These visitors were encouraged to spread the message in their areas of influence about healthier food choices.

A similar tactic, using public events such as street festivals, involved people in colourful costumes who carried healthy snacks and were trained to make contact with people, offer them low-fat and low-cholesterol snacks, and record their reactions. An evaluation showed that women were more enthusiastic than men, people over 25 years of age were more interested than younger people, and overweight people and single people were less willing to try the low-fat alternatives than those living in families.

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**Problem:** Unhealthy eating habits.

**Solution:** Campaign for healthy nutrition, combining entertainment, sports activities and education.

**Strategy:** Advocacy (healthy food promoted at fairs and sports events).
Story 63 ■ Contests to stimulate healthier eating

Creative competition is often successful in promoting change. In Wales, United Kingdom, a grading and premium scheme was introduced to reward farmers for producing high quality low-fat lamb. There were also contests for making sausages with the lowest amount of fat.

Story 64 ■ Contest boosted sales of low-fat milk, cut heart disease

The consumption of low-fat milk had been promoted in Norway, but not very successfully. A nutrition consultant came up with the idea of a contest between local schools in one county to see who could build the biggest "house" of low-fat milk cartons? The contest resulted in an immediate rise in the consumption of low-fat milk, which seems to be continuing. The rate of coronary heart disease in the county has been markedly reduced.

Problem: Low consumption of low-fat products, high rate of coronary heart disease.

Solution: Promotion of the use of low-fat milk.

Strategy: Raising awareness (by organizing a school contest).

Outcomes: • Rise in low-fat milk consumption.
  • Fall in coronary heart disease.

Schools and canteens

Schools are also an area of action for better nutrition, not only in terms of the curriculum but also through practical measures.

Story 65 ■ Students run health canteen

The National Nutrition Council in Norway and the WHO Regional Office for Europe have promoted healthy eating habits in schools and have invited schools to come up with ideas for improvement.

At a school in Oslo, Norway, the teachers realized that students had unhealthy eating habits. They ate sweets and cakes while at school and did not eat a proper breakfast. Staff and students set up a canteen at the school, run by the students themselves who also prepared some of the food. The food included whole grain bread with healthy spreads, plus fruit, vegetables and varieties of salad. The prices were only a little above cost and surplus income was used to improve the physical environment.
of the school by painting and decorating. The school received a prize for health promotion from the Directorate of Health.

Problem: Unhealthy eating habits among school students.

Solution: Creation of a student-managed school canteen with healthy food.

Strategies: • Empowering (of students).
              • Building alliances (between teachers and students).
              • Raising awareness (of unhealthy eating habits).

Outcomes: • Improved eating habits.
          • Money to improve the physical environment of the school.

Story 66 ■ Healthier canteen food in the Netherlands

As part of the Netherlands Heart Foundation Project two dietitians visited more than 100 canteens of large companies in order to advise canteen managers on how to achieve a more balanced and healthy variety of food. The advice given was based on the Dutch Nutrition Council’s guidelines for healthy nutrition. These guidelines recommend canteens to introduce more low-fat or less fatty food, with a stronger emphasis on meals that include bread, potatoes, vegetables and fruit. Other recommendations are variety in the assortment offered, smaller portions of cheese and meat and smaller snacks, low prices and attractive presentation of healthier foods. The dietitians have written a manual on providing a more balanced assortment of canteen food which serves as a guide for canteen managers and contains a checklist to assess the variety of food available. The manual includes suggestions for healthier ways of preparing food. This project has now been incorporated in a healthy workplace project which includes concerns such as smoking, fitness and stress management.

Problem: Unhealthy food assortment in company canteens.

Solution: Guidelines for healthier food for canteen managers.

Strategy: Raising awareness (by advising canteen managers on healthy nutrition and a healthy lifestyle).

Outcome: A manual on healthy canteen food.
**Food labelling**

Some countries have regulations on labelling that require the nutrition content of a food product to be listed on the label so as to make choice easier when one is looking for healthy food. Food products need to be labelled in a useful way. Information on nutritional value is often written in small print and means very little to many people. Advertising and marketing at food outlets and in supermarkets are also needed. In many places healthy foods are now displayed according to quality rather than according to brand (such as, for instance, a display of low-fat products).

**Story 67 ▪ Dietitian initiative hastened labelling in the Netherlands**

In the Netherlands a decree on nutrition labelling was approved in 1988. Important aspects were that nutrition labelling of food products was voluntary but that, if it was provided, it was compulsory to indicate energy, fat content, protein and carbohydrates. No uniform format was specified. Dietitians of the Netherlands Heart Foundation were aware that some parts of the food industry were interested in providing nutrition labelling but that objections from management and the lack of a uniform format needed to be overcome. In the Netherlands there is also an organization that provides uniform consumer-friendly nutrition labels (Stichting Beter Voedingswaardering). A dietitian was appointed to the labelling organization by the Netherlands Heart Foundation to encourage manufacturers to provide uniform nutrition labelling of food products. European Community regulations on nutrition labelling were approved in 1990. The uncertain outcome of the European regulations made many Dutch food manufacturers hesitant to introduce nutrition labelling during 1989. However by 1990, nutrition labels for about 1500 food products were issued by 60 food manufacturers.

**Story 68 ▪ A green keyhole means healthy food in Sweden**

In Sweden, a simple symbol — a green keyhole — is printed on the packaging of food that meets certain criteria for healthy food. This is a simple way of labelling which makes a healthy choice easier for consumers. The initiative was first tested in a local cardiovascular prevention programme in Norsjö in the north of Sweden. Local producers and stores started labelling food products in this way and this local activity spread to other counties and municipalities of the country. Eventually food producers, wholesalers and the National Board of Nutrition responded to local pressure and set up a panel that made the green keyhole a national symbol of healthy food choice. The green keyhole on the label has now become a factor in advertising and sales.
Problem: No uniform format for food labelling.

Solution: A local pilot project.

Strategy: Advocacy (by professionals and retailers to introduce labelling on a wider scale).

Outcome: More uniform food labelling nationwide.

Vulnerable groups in nutrition

Not all groups are easily reached by education and information on a healthy diet. Low-income groups constitute a risk group in this regard.

Story 69 — Booklet targets low-income workers

The problem of low-income workers eating an unhealthy diet was taken up in the United Kingdom. This population was difficult to reach but attempts were made through “bed and breakfast” accommodations where people are offered a room and minimal catering facilities while they wait for state-subsidized housing. Families were interviewed about their food preferences, shopping habits, catering needs, facilities in the home, dietary preferences and so on. A booklet was produced containing recipes stressing low fat content and high fibre-rich starch. There is a continuing discussion on how this type of resource material is best distributed to such a diverse and dispersed population.

Problem: Unhealthy eating habits among low-income groups.

Solution: Publication of a special manual on healthy eating.

Strategy: Enabling (booklet on the preparation of healthy food).

In many countries it is still customary for the older men in the household to get the best and biggest portions of food. Data from global surveys indicate that men get priority when family food is distributed. It is imperative not to forget the needs of vulnerable groups and the coming generation, especially pregnant women and small children.

Story 70 — Maternal food supplements improve birth weight in the Gambia

The Gambia Food and Nutrition Association and the Department of Medicine and Health created an aid programme involving several inter-
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

national aid agencies for the purpose of increasing birth weight and decreasing malnutrition of children. Gambian women were offered a dietary supplement during pregnancy and this resulted in a net increase in energy intake of 431 kcal/day. In the rainy season, when the women normally lacked calories because of food shortages but still had a high agricultural workload, the supplementation improved birth weight by an average 224g and reduced the incidence of low-birth-weight babies (<2500g) from 28.2% to 4.7%. This supplementation has now been expanded to 629 villages serving some 44000 women. The success of the programme relies on a dedicated association and international aid.

Problem: Malnutrition among pregnant women, low birth weight of children.

Solution: Food supplementation to pregnant women.

Strategies: • Building alliances (collaboration between national and international organizations to create a national programme).
• Enabling (through dietary supplements for pregnant women).

Outcome: Increase in birth weight of newborn.

Story 71 Networking for improved health of pregnant women in Canada

A project named “Healthy Beginnings” was started in Toronto, Canada. Many disadvantaged women were not eating well and were not gaining enough weight in pregnancy despite counselling programmes. Many smoked and many had poor appetites because of high stress. Many were isolated or abused, lived in poor housing, had only recently arrived in Canada, were unemployed, had no child-care possibilities or were short of food. The Toronto public health department and a food bank worked together to develop a Wednesday morning programme just for pregnant women. Fund-raising is done by the food bank. The women receive a large quantity of healthy foods, and a dietitian and public health nurses attend the programme. Hot food is prepared, usually by one of the women. The atmosphere is warm and friendly, and the women can talk privately with the nurse about any problems they may have. They may be referred to other programmes in the community, such as day-care centres, parenting programmes, shelters or legal aid.

This programme resulted in much more than better nutrition and shows how offering people a meal can support the environment for the unborn in many ways. The programme built up to an attendance of 45 women each week. The women were mostly immigrants to Canada from

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all over the world. From being isolated they quickly formed networks with each other, helped translate for each other and welcomed newcomers. Most of them changed from being shy or passive to participating actively and feeling they belonged.

Problem: Underprivileged women were not gaining enough weight in pregnancy and did not have a healthy lifestyle.

Solution: Creation of a centre where the women received food and were given information and education in health matters and pregnancy.

Strategies: • Advocacy (food bank, health department).
• Enabling (food, social support).
• Empowering (through alliance building, education).

Outcome: Increased gain in weight of pregnant women, increased social contact between women.

Vulnerable groups include newborn children, breast-feeding mothers, persons who are isolated (such as those who are hospitalized or have physical handicaps) old people, immigrants and indigenous people around the world.


Story 72 ■ The Philippines adopts breast-feeding code after women's protest

In 1990, the Innocenti Declaration “On the Protection, Promotion and Support of Breastfeeding” was adopted at a WHO/UNICEF meeting. The declaration states that, as a global goal for optimal maternal and child health and nutrition, “all women should be enabled to practise exclusive breast feeding and all infants should be fed exclusively on breast milk from birth to 4–6 months of age.” One example of inappropriate marketing has been that of breast-milk substitutes in developing countries whereby efforts were made to convince women that the substitutes would give their children better nutrition than breast milk.

In the Philippines action was taken against this practice. A code of ethics was drafted in 1975. In collaboration with WHO and various expert groups, a final draft was agreed in 1983 but adoption of the code by the country’s legislative body was still pending in 1985.

In May 1983 some 500 Filipino women gathered in the town of Makati to breast-feed their children in the streets in protest against the inappropriate and aggressive promotion of bottle-feeding that was resulting in poor health of infants. This demonstration — the first of its
kind to be staged by Filipino women on the issue of breast-feeding — was the culmination of several years of resolute efforts to create nationwide awareness that the mother’s milk is best for the baby. The demonstration was organized by the National Coalition for the Promotion of Breastfeeding and Child Care, a private organization launched in 1983 and affiliated to the National Movement for the Promotion of Breastfeeding. This mass action by the mothers rekindled public interest in the draft code of ethics which was signed by the legislature in 1986.

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<tr>
<th>Problem:</th>
<th>Decline of breast-feeding due to inappropriate marketing of milk substitutes.</th>
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<tr>
<td>Strategies:</td>
<td>• Building alliances (organizations).</td>
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<td></td>
<td>• Mobilizing (of mothers).</td>
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<td>Outcome:</td>
<td>Adoption of the code of ethics in 1986.</td>
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**Story 73** Elderly people become “nutrition neighbours” in Canada

A project in Vancouver, Canada, used peer discussions to increase enjoyment of healthy eating among older people living alone. The project was called Nutrition Neighbours. Discussions with 13 community groups reached approximately 285 old persons. A Nutrition Neighbours manual was produced and a group of old people interested in helping others with their nutrition needs was created. Six active Nutrition Neighbours continue to work in the community and have applied for funding to support new initiatives. Some Nutrition Neighbours became active in food-related projects with other groups and some groups of old persons started eating together regularly. More than 700 copies of the Nutrition Neighbours manual were distributed across Canada and in other countries.

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<thead>
<tr>
<th>Problem:</th>
<th>Concern about malnutrition among old persons, especially those living alone.</th>
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<td>Solution:</td>
<td>A project that encouraged older people to take their meals together.</td>
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<tr>
<td>Strategies:</td>
<td>• Raising awareness (of nutrition problems among older people).</td>
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<td></td>
<td>• Empowering (by arranging self-help groups where old people got together to eat).</td>
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<tr>
<td>Outcomes:</td>
<td>• Several self-help groups have been created.</td>
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<td>• A Nutrition Neighbours manual was published.</td>
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Story 74 ■ Subsidized healthy food by air in Canada

In Canada it was seen that in many indigenous communities, such as the Inuit, the availability and consumption of indigenous food had been declining, particularly among young people. The reasons for this included concern about contamination of the food chain, lack of material resources for hunting and fishing, outside influences such as those in the media, and local pressures on the resource base. Furthermore, many settlements were in remote areas that were not fertile enough to support new types of food production. The alternative of buying imported food was expensive and people often had only meagre incomes. A subsidized air delivery system was introduced to take food to the most remote communities but this failed with great financial loss because it lacked a firm policy. The situation was reviewed in 1990 by an interdepartmental committee. It was realized that without subsidized air delivery of food the nutrition status and health of residents in the north of Canada would be jeopardized. In 1991, after extensive consultations involving 189 communities and several agencies, a policy was agreed on. The federal government decided to restrict the subsidy to nutritious food, give priority to perishable items, stabilize the amount of the subsidy and extend it to all isolated communities on the air delivery network. This action affirms the importance of health in determining food-related policies.

Problem: Declining interest in eating indigenous food in Indian and Inuit communities.

Solution: Change in subsidy policy with emphasis on nutritious food, creation of an air delivery network to all isolated communities

Strategies: • Policy development (change in government policy).
• Building alliances (interdepartmental cooperation).

Outcome: Transportation of nutritious food to remote communities.

Women’s role in food and nutrition matters

Women represent half the world population and one-third of the labour force, yet they receive only one-tenth of total income and own less than 1% of all property. They also account for two-thirds of all working hours.

Women’s role in the food chain is far greater than simply the final phases of cooking and preparation. Women play a part in the food industry as well as in agriculture. After the 1974 World Food Conference, the United Nations adopted a resolution that called on all governments to promote equal rights and responsibilities for men and women in
order that their energies, talents and abilities could be fully utilized in the battle against world hunger.

In North Karelia, Finland, where there is a very high mortality rate from cardiovascular diseases, women played a key role in initiating and implementing social change by influencing the supply of food products in the shops and training housewives to adapt to new food habits.

While heavy responsibilities are often placed on women in this context, the matter of women's rights may be more ambiguous.

**Story 75** Gardening project improves the situation of women in Zambia

A story from Zambia tells about a project in a peasant farming area where the main food produced was maize, which was sold to cooperatives. The income from sale was kept by the men, who either used it for their social needs or put it in the bank. The women and children, who contributed considerably to maize, cotton and sunflower production, benefited very little. An intersectoral approach has encouraged women to grow vegetables for sale and for home consumption. The men have little control over the money raised through gardening. The women are also encouraged to make sunflower oil to increase the energy content in the family diet. Women are now able to make decisions about gardening and a rural banking scheme has been introduced in the project area.

The nutritional status of children has improved and is monitored by the women themselves. Women's clubs have been provided with scales for weighing children. Gardening has ensured a supply of food during the long dry season.

This project was initiated as a result of cooperation between the Ministries of Health, Agriculture and Water Affairs, the Social Development Department, women's clubs and primary health care committees.

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**Problem:** Women lacked control over resources.

**Solution:** Increased vegetable production by women for sale and home consumption; introduction of a rural banking scheme for women.

**Strategies:** • Empowering (women educated, encouraged to use their skills).
                • Building alliances (between women and women's clubs).

**Outcome:** Gardening has ensured a better food supply, especially in the dry season, which has improved the nutritional status of children.
Approaches to better food safety

WHO has developed ten "golden rules" for safe food preparation but, in order for these rules to be followed, education and facilities must be available. The rules are:

1. Choose foods processed for safety.
2. Cook food thoroughly.
3. Eat cooked foods immediately.
4. Store cooked foods carefully.
5. Reheat cooked foods thoroughly.
6. Avoid contact between raw foods and cooked foods.
7. Wash hands repeatedly.
8. Keep all kitchen surfaces meticulously clean.
9. Protect food from insects, rodents and other animals.
10. Use pure water.

WHO has for a long time sought to combat the microbiological contamination of food. The challenge has been met by promoting improvements in sanitary conditions through actions such as improving housing, building latrines and sewerage systems and, perhaps most importantly, introducing systems of control for contaminants in food.

Story 76 ■ Contamination control in the Czech Republic and Slovakia

The Department of Agriculture in former Czechoslovakia set up a national control system for food contaminants in 1985. The aim was to create an information database on the chemical contamination of food in the country. The greatest problem was to set up a network to supply the data. There are now separate control systems in the Czech Republic and Slovakia. In Slovakia the system covers food of animal and plant origin, as well as feed for animals. The items are carefully analysed and approximately 140,000 samples a year are examined for 80 contaminants. The Department of Agriculture of Slovakia is in charge of the programme, utilizing a network of laboratories for examining samples. It took 2–3 years before the system worked satisfactorily but the department now has a good idea of the amount of contamination in the different regions. Areas with most food contamination have been identified. In one region of Slovakia, cattle farming had to be stopped because of a high polychlorinated biphenyl content in milk and fat and alternative types of agriculture were introduced. The trends in types of contamination can be followed to see which are increasing and which are decreasing as a result of the measures taken.
Problem: Lack of information on chemical contamination of food.

Solution: Creation of a monitoring system.

Strategies:
- Raising awareness.
- Regulation (temporarily stopping farming in contaminated areas).

Outcome: Reliable information on contamination of food in different regions.

Pesticides and fertilizers entering the food chain

It has been estimated that 20% of world pesticide production in 1981 was used in developing countries. Use of pesticides overall is doubling every 10 years and the increase is currently more rapid in those countries. Estimates for 1985 show about 1 million cases of accidental acute poisoning by pesticides, mostly in developing countries. Being commonly available, pesticides are also sometimes used in suicide attempts and about one attempt in 10 is fatal.

Although effective in increasing yield in agriculture, pesticides are not without side-effects. One problem is drainage of pesticides into rivers, lakes and oceans, increasing ecological problems and posing a threat to fish.

While most industrialized countries have strict regulations about putting warnings on the labels of pesticides and are carrying out education to teach users of the dangers, this is not the case in many developing countries or in some countries of Eastern Europe.

Story 77 ■ Pesticide laws drafted in Latvia

In Latvia several years ago a young man died on a collective farm after working with a pesticide preparation. There was news of similar accidents in other parts of Latvia. The use of chemical fertilizers and pesticides had increased fourfold during the past 20 years and had reached 307 kg per hectare in 1989. Latvia, which was part of the USSR at the time, had problems with information and education of working people and there was no legislation on the use of such harmful agents. The control system was only a formality. A working group from the parliament was set up after the Ministries of Health and Agriculture, labour organizations, physicians and the Latvian committee of environmental protection had become involved. The working group is preparing a law on the storage, use and transportation of fertilizers and pesticides, including a control system.
Problem: Increase in the use of pesticides and fertilizers, reports of possible poisoning, no control system in operation.

Strategy: Building alliances between different organizations and ministries for a joint approach to the problem.

Outcome: A new law and control system are proposed.

Story 78 ■ When the alarm goes off

In 1986, a strong increase in radioactivity was measured in Sweden, and later in other countries. The cause of this soon became evident — a meltdown at the nuclear power plant in Chernobyl, USSR.

The Chernobyl disaster has had a long-term effect on food safety in the former USSR as well as in Scandinavia. Radioactivity entered the food chain, mostly through animal feed, especially for sheep and reindeer, and forced changes in the eating patterns and lifestyles of native groups. The fear of radioactive food had far-reaching effects on dietary patterns. After the reactor meltdown at Chernobyl, people in the Federal Republic of Germany reduced consumption of milk, fruits and vegetables despite recommendations to the contrary.

The indigenous people of Scandinavia who live from reindeer herding experienced a threat to their subsistence in that reindeer meat could no longer be sold, or only at a very low price.

Education for better nutrition

The problems of providing education and information for better nutrition are multiple. Education and information are needed at every stage of the food chain. Illiteracy in itself is a contributor to ill-health and this may relate to lack of knowledge about possibilities and choices and lack of safe and healthy food.

Apart from direct education on nutrition in the school curriculum, information can be transmitted, through direct contact, written materials, books, brochures and the mass media. Education is a long-term process that requires a lot of effort if it is to have sustainable effects in changing lifestyles and habits.

Story 79 ■ The radio educates families about food

In Tunisia, the National Union of Tunisian Women aided by the National Institute of Nutrition carried out a campaign to create awareness of traditional eating habits. This was done by short radio spots, three or four times a day, aimed at rural families. The broadcasts had the
theme title "our popular wisdom — our doctor". Information was given about the benefits of cereals, of traditional conservation methods and other aspects of traditional nutrition.

Problem: Lack of knowledge about the traditional food culture.
Solution: Broadcasting of radio spots to rural families.
Strategy: Raising awareness of and interest in traditional foods and methods of food conservation.

**Story 80** Gardening exhibitions improve diet in Sweden

In developed countries many children, and adults too, do not know the origin of the food they eat and do not understand its nutritional value. A community in Sweden started an experiment to get young families more involved in gardening and food production for their own use and, at the same time, to improve eating habits. Each summer families were chosen to have their gardens turned into exhibition areas that people could visit to see how fruit and vegetables were grown. During the course of the summer, four meetings were held to discuss different stages of growth. Finally each demonstration garden held a big harvest party. Consultants in agriculture and nutrition participated in the process. The eating habits of the families involved improved. A local gardening association later took over the project. The Swedish Heart Association was encouraged to start similar projects in schools.

Problem: Lack of knowledge about food production in young families.
Solution: Learning by experience — the introduction of a gardening project in the community.
Strategies: • Raising awareness (exhibition gardens, meetings).
• Building alliances (between local gardening groups and the Heart Association).
Outcome: Improved eating habits; similar projects will be started in schools.

**Conclusions**

Not all aspects of creating a supportive environment for health in the area of food and nutrition are covered by the experiences cited in this
chapter. However, the stories reflect some concerns of the participants at the Sundsvall conference and show both differences and similarities in problems and solutions in different parts of the world.

The approaches outlined in the health promotion strategy analysis model (page 22) also apply to the food sector, in both industrialized and developing countries.

- The importance of global and national food and nutrition policies is underlined, with special emphasis on sustainability and re-evaluation and reorientation of the policy when needed.
- Intersectoral cooperation and the building of alliances at all levels are necessary elements in a nutrition policy and affect every link in the food chain from producers to consumers.
- Vulnerable groups should be specially targeted for actions for improved nutrition.
- Education and information are important elements of any nutrition policy.
- Nutrition programmes are vehicles for women's empowerment and should make use of women's skills.

Food and eating have a multifaceted cultural function. They can enhance the quality of life or reduce it. Enough food, safe food and confidence in that safety are primary goals, as are measures guarding against over consumption, with attendant adverse effects for the individual, the family and the society.

There is a tremendous need to apply knowledge about nutrition and health to our diets. Habits are not easily changed, and approaches need to be innovative, inspiring, creative and effective. Everyone has a role to play.