CHAPTER 8

Home and neighbourhood

In dealing with the needs and problems of the human habitat, community involvement at all levels should support the processes of self-help, help between neighbours, and communal cooperative activities.


Issues and problems

Good homes and community environments are essential for health. The most important factors in terms of creating supportive environments for health are the availability, distribution, accessibility and ownership of dwellings as well as the absence of hazards both in the home and in the immediate neighbourhood. There are some 100 million homeless people around the world. It is important to note that many modern and renovated dwellings can threaten people’s health as well as older, run-down houses.

Uncontrolled population growth in many developing countries poses a problem in terms of lack of adequate housing. It becomes increasingly difficult to provide shelter for the growing number of people. The rural–urban migration of people in search of employment and a better way of life is an ever-increasing reality in a number of countries. This movement of populations leads to the creation of slums. In some places there is the added burden of refugees coming in from neighbouring countries to escape conflict or discrimination.

While the physical standard of homes affects people’s health, the environment outside the home also plays a role in terms of injury, noise, and pollution. The social, cultural and architectural environments are important but often neglected aspects of the community.

A crucial element in creating health-supportive housing is to supply homes for people with special needs. Planning and design for those with special needs are usually beneficial to others too.

Urban health problems occur throughout the world but are most severe in developing countries. Urban populations — particularly those living in poverty — are growing fast. Environmental changes have produced a pattern of health problems that includes both the diseases
typical of underdevelopment and the diseases typical of developed communities. Resources for response are relatively meagre, maldistributed and misplaced and inadequacies in government structures and policies may inhibit effective response.

Urban development is associated with the risk of spreading communicable diseases. In urban and rural slums in Latin America, 100 million people are exposed to the risk of Chagas disease, which was once considered a rural disease. Leishmaniasis is now a risk in urban areas of the eastern Mediterranean and south-east Asia, and rabies in dogs remains a threat to 2800 million people.

Urban hazards also lead to accidents and unintentional injury. Road traffic is a major killer in all countries. In developing countries pedestrians and cyclists are especially vulnerable. The impact of traffic hazards and pollution illustrates the inter-relation between human health and the environment.

Many communities in both developed and developing countries require social support services. Support for safe neighbourhoods and healthy houses from governmental and nongovernmental agencies, as well as from informal community groups, contributes to the health of families and communities.

Urban planning is an important public health strategy. Barriers to the development of safe and healthy community environments include lack of overall planning, lack of intersectoral cooperation, and the fact that sectors do not always take responsibility for the effect of their policies on health. Planning must not only take into consideration all health principles of housing but also take care not to create new problems.

The concentration of resources — economic, technological and human — in cities can provide a stronger basis for action than is found in more dispersed rural settlements.

Activities and solutions

What actions and solutions are possible to make homes supportive of health and to minimize health-related hazards?

There are many persons whose work affects the physical and social aspects of housing and their health consequences. These include not only planners and housing officers but also builders, community leaders and the home-owners themselves. All these people should recognize the health implications of their activities.

The stories in this section have been grouped under the following headings:

• People's initiatives
• Healthy cities

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• Improving housing facilities
• The immediate surroundings
• Services in the community.

People's initiatives

Story 81 ■ Indigenous communities bring about clean-up of toxic waste dumps

The Good Earth programme was established in 1989 in several remote Alaskan villages. The objective was to help native Alaskans deal with the problem of hazardous materials and protect their own health and that of their animals and the land.

Alaskan residents have concerns about potential contamination of food and pollution of land, but village authorities lack the money and technical staff to address these concerns. Across the state there are at least 450 abandoned military sites, many contaminated by toxic chemicals. Diesel-generated electric power creates waste lubricating oil but there is no proper local means of disposal. Solid hazardous household waste threatens the environment because of inadequate disposal facilities and systems.

Workshops were organized to raise awareness about hazardous materials. Two publications were produced to give guidance on establishing a local committee concerned with disposal of hazardous materials, to carry out a village inventory of how these materials are used and stored, and to identify pollution and waste sites. Technical assistance was provided to tackle the problems of pollution, waste and handling of materials. This included training of a local village coordinator. A free counselling hotline for telephone assistance was established and advertised.

One of the problems faced was the prominence of other health issues that at times overshadowed the importance of hazardous materials. There was a lack of drinking-water and sewerage systems, as well as high rates of suicide and substance abuse. Interested community members were asked to deal with these problems. It was also possible to tackle some of the problems together, such as the need to reduce use of toxic products in the household in order to reduce abuse of inhalants among teenagers.

The people of one village decided to urge the federal government to do a better job of cleaning up an abandoned military site. They faced resistance from the army to providing information and to setting up a public participation programme. By persistently writing letters on the matter, villagers succeeded in improving the clean-up plans, leading to some of the waste being transported out of the area instead of being dumped on tribal lands.
The funding for this programme came from the Charles Stewart Mott Foundation and was provided to the Alaska Native Health Board. The Alaska Health Project was contracted to provide the technical expertise. Village coordinators included members of the city council, village council and village corporation board.

The programme has provided assistance and workshops in five of the 12 Alaska native regions. The clean-up of abandoned military sites, which are often in or near villages, will continue through the 1990s so that there is a need to provide independent technical assistance to village residents. The Alaska Native Health Board is seeking funding to continue the programme in more regions and to provide continuing assistance to villages already visited.

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**Problem:** Fear of contamination of tribal lands by toxic waste dumps, together with many other health problems among native Alaskans.

**Solution:** Establishing a committee on hazardous materials, documenting how they were used and stored, and identifying pollution and waste sites.

**Strategies:**
- Raising awareness (workshops and publications, training and counselling).
- Enabling (through funding).

**Outcomes:**
- Assistance and workshops in five regions.
- Pressure from village groups for removal of waste.
- Continued clean-ups of military sites.

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**Story 82** — Shantytown dwellers in Latin America improve their homes

Rio de Janeiro's *Favela do Gato*, or "Shantytown of the Cat", provides an example of a peripheral urban community that has successfully organized and advocated for the improvement of its housing conditions. *Favela do Gato*, like many other urban areas in developing countries, grew up on Rio's periphery as rural residents left their homes in search of a better life in the city. These men, women and children scavenged for wood, metal, cardboard or whatever materials they could find with which to build their homes.

With the support of the University Federal Fluminense Group for Community Projects, the slum dwellers negotiated a deal with the national housing authority. This resulted in the building of 71 houses and a community centre, and the granting of individual financing, with
the public authorities paying the cost of the land and infrastructure. Each family chose the site of the house and its position on the plot of land — an unusual opportunity for a low-income housing scheme. The layout of a section of the favela was planned on the basis of residents' wishes.

While Argentina's former military government was in power, many of the urban poor left Buenos Aires when bulldozers destroyed the city's shantytowns in the late 1970s. However, many other residents remained close to the sources of income and the services found in the city. Since adequate housing is expensive and scarce, large numbers of those who stayed took up residence in the decaying buildings near the heart of the city.

Efforts are being made by various groups to improve living conditions and provide better housing for the residents. Tenants' groups in Buenos Aires have devised two strategies for helping poor urban tenants to renovate their homes. One plan provides for technical assistance from university engineering students through the auspices of a group called Grupo Habitat. The other involves a labour pool of tenants with construction skills who are available to make home improvements. The group is also pressing for legislation to make it easier to rent property and to reduce down-payments for long-term apartments.

Problem: Unhealthy, unsafe shantytown dwellings.

Solution: Building model houses and a community centre, and providing voluntary technical assistance.

Strategies: • Enabling (through financing and public payment of land), • Empowering (building alliances by forming pressure groups).

Outcomes: • Improved community services and housing standards. • More reasonable loans encouraged.

**Story 83** ■ Bangkok slum dwellers pioneer a land-sharing plan

The people of the Sengki neighbourhood of Bangkok faced eviction when property developers sought the land on which they lived. After a fire swept through the neighbourhood, owners cancelled leases, turning residents into squatters.

The situation of the Sengki residents was not unique for Bangkok — of more than 1000 slum communities in the city, over 200 were threatened with eviction in 1988. Rehousing residents in new areas is costly for the government and developers and is often not acceptable to residents. Rather than move from their neighbourhood, residents of Sengki have
developed an arrangement called “land-sharing”. This system divides the slum into two parts — one part for the landowner to develop as he or she wishes, and the other part leased or sold to residents who organize themselves into a cooperative to build new homes. Landowners thus have an immediate financial gain and avoid long and costly confrontations with tenants, while tenants gain small but secure plots of land for their homes.

In the Sengki neighbourhood, a commercial loan was obtained by the neighbourhood housing cooperatives for a down-payment on part of the land. This land was then sold to residents at less than half its market value. Owners were able to build new homes on their plots, choosing from various models proposed to them or building whatever type of home they wished. Residents' involvement in their neighbourhood is encouraged through an election process, and eventually much of the administration will be handed over to the community itself. Support for the project came from the United Nations Development Programme and the United Nations Centre for Human Settlements (Habitat). Both of these organizations see land-sharing as a model for future slum clearance. Five other land-sharing projects in Bangkok are in various stages.

Problem: Eviction threat to slum dwellers in Bangkok.

Solution: A “land-sharing” plan offering cheap land to residents.

Strategies: • Enabling (through financing),
• Alliances (residents organized their own cooperatives).

Outcome: United Nations supported project to offer poor slum dwellers cheap land for building.

Story 84 ■ Squatters in South Africa set up cooperative to build homes

In a squatter area of South Africa, activists from different professional backgrounds organized community meetings. When people came together they discovered they had many skills between them. There were electricians, plumbers, builders, persons who could draw plans, and so on. With financial support from some NGOs and with some community resources, mainly in the form of local labour, the community set up a cooperative to build homes and roads. Community empowerment was the basic strategy with community-based resource people playing a key role. Professionals were available when needed, but were not brought in from outside the community. The people of the area experienced a shift from dependence to independence and from individualism to collective
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empowerment, leading to a strengthening of cooperative spirit and local resources.

Problem: A squatter community without decent housing.

Solution: Activists organized meetings leading to common action.

Strategy: • Empowering (by mobilizing local resources in terms of electricians, plumbers, builders and draughtsmen).

Outcome: Improved local control and better self-reliance.

Healthy cities

The WHO Healthy Cities project involves a network of European cities that are seeking new ways of promoting health and improving the environment. The goal of the project is to turn the vision of a healthy city into reality through political commitment, dissemination of ideas and experiences, innovative action and institutional change.

The participating cities have been selected to achieve a geographically balanced coverage of Europe, with a mix of size, health status and socioeconomic conditions. Cities taking part in the project must be committed to the principles and targets of the Global Strategy for Health for All by the Year 2000, must demonstrate the political commitment and resources to make health promotion plans a reality and share their experiences with other cities in the network.

The cities involved in the project recognize that health is both a social and individual resource and a social and political responsibility, as well as a matter of individual choice.

Each city in the network attempts the following:

— to generate visibility at local level for health issues and the health-for-all strategy;
— to place health high on the social and political agenda and contribute to the development of healthy municipal policies;
— to create innovative action for health that emphasizes the interaction between people, environment, lifestyles and health;
— to facilitate organizational changes that encourage cooperation between key city departments, and promote community participation.

The key areas for action in the Healthy Cities project are those defined in the Ottawa Charter for Health Promotion: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.
The project cities are engaged in strengthening the project's infrastructure, developing health plans, making alliances with local partners, implementing a wide range of projects with special emphasis on the needs of vulnerable groups and supporting the establishment of national Healthy Cities networks.

**Story 85 ■ Integrating ecology, health and public participation**

Torsted West covers 55 hectares of land in south-western Horsens, an old provincial town of about 43,000 residents on the east coast of Jutland in Denmark. During the period 1996–2001 the building of a community of 800–900 dwellings, common facilities, services and institutions, small businesses and large green areas will be completed.

The Torsted West project is based on four elements: a healthy city, community participation, local control of future housing and construction, and an ecological perspective. The project emphasizes specific results and the process by which these results are realized, including preliminary planning, implementation and the future use of the district.

The organization of the project was initially hierarchical, under the overall control of the Horsens City Council. Today there is a horizontal structure that includes citizens, city councillors, developers and civil servants as equal partners.

Community participation, discussion and decision-making are flourishing. Between 30 and 60 residents actively and regularly participate in planning, supervising, evaluating and implementing proposals. Participating developers have shown great interest and given helpful advice. An executive committee coordinates all project activities and negotiates with developers. The project is expected to contribute to future developments in housing, community environments, and participative planning.

Another project in Horsens was the Gasvey project, designed to allow people living in a residential district to plan their own district, develop their own activities and use their existing resources better. The intention was to enable the people to improve their living conditions and quality of life.

In 1987, the idea for the project was approved by the municipal council. Fifteen residents of the district and municipal leaders were interviewed. In 1988, the plan was completed and fund-raising began. Many people and institutions became involved — the local school and other institutions, stores, municipal employees, the local media, parents of young children, and others. In 1989, a renovated shop became the centre of the project. Working groups on traffic, conservation, cafés, youth, information, and the post office were established. Each group was assisted by a consultant project worker from the municipality. Most importantly, a residents' association was formed with the aim of setting
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up a community house and continuing the project beyond the projected schedule.

Municipal collaboration gave residents opportunities to achieve the greatest possible control over their district. An important guideline for decentralization is the local definition of local needs and representation of local interests at district level. The project showed that partners must develop mutual trust by broad distribution of information, openness and flexibility in methods and attitudes. The project also demonstrated the importance of having a forum — a group in the district that can gradually take over activities and continue them.

| Problem: | Lack of integration of environmental and health issues, and in the Gasvey case lack of local participation in residential planning. |
| Solution: | A project in which citizens, planners, developers and politicians were equal partners. In Gasvey a residents' association, involving citizens' groups, was also formed. |
| Strategy: | Building alliances (between various institutions and groups). |
| Outcome: | A broad base was created for planning the future of the district, and is expected to contribute to future planning of housing and the community environment. In the Gasvey project a group was formed to carry on activities in the long term. |

**Story 86** “Healthy City Halle” — community initiative in the former German Democratic Republic

In 1990–91 the breakdown of the governmental and health structures in the former German Democratic Republic led to the closure of out-patient clinics and other health facilities in the city of Halle. Unemployment rose, many houses were in a state of decay and there was a shortage of accommodation. The elderly, the handicapped and single-parent families experienced increasing social instability and insecurity.

In the Halle neighbourhood of Trottha, some 30 citizens started a community initiative called “Healthy Trottha”. Their aim was to promote a healthy environment in the neighbourhood and at the same time develop a model for community health promotion for the city as a whole.

The community initiative included young and old, professionals and manual workers, housewives and unemployed people. New structures and social support were created for coping with the problems of social change. The citizens’ initiative encouraged community participation
and facilitated exchange of views about how to promote a more healthy environment. Citizens’ meetings and opinion polls were organized.

Members of the initiative participated in round-table discussions on problems such as traffic, drugs and violence. They visited and helped the elderly and initiated health promotion activities in schools.

Problems were defined and solutions were discussed in working groups. The members of the community initiative had detailed talks with city administrators and elected representatives. In early 1992, the “Healthy Trotha” group decided to campaign for Halle to join the German Healthy Cities Network.

They informed the public, lobbied the authorities, built alliances and later achieved their goal.

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Problems: Sudden breakdown of former governmental and health structures in the German Democratic Republic, rapid social change, massive socioeconomic problems.

Solution: A community initiative mobilized citizens of all ages and social groups, offering the possibility to participate in creating new and effective structures for health promotion and supportive environments in the city.

Strategy: Policy development (through community mobilization).

Outcomes: Awareness of health concerns was raised and new structures were created for health promotion and supportive environments. Political commitment led to decisions to address issues and solve problems (city of Halle has joined the German Healthy Cities Network). Successful mobilization and participation of citizens at a time of radical social change gave orientation and raised self-esteem and confidence.

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Story 87 ■ Grass-roots resistance to upgrading process

In 1989, in a part of Hamburg, Germany, the community was mobilized to prevent the upgrading by wealthy groups of low-income housing in a working-class area. A new shopping centre was planned and the expected rise in prices for dwellings would make them unaffordable for the present inhabitants. Protest groups were formed by community organizations and an information campaign was launched, which used public meetings and posters to warn people of future developments. A “street party” was organized in protest against the new shopping centre. Streets were occupied to stop the traffic in a symbolic protest against the increasing traffic the new development would bring to the area.
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Problem: Upgrading of housing by wealthy groups, threatening to force lower-income dwellers out.

Solutions: Forming a protest group, organizing a street party. Protest should express concern and commitment while striving to avoid conflict.

Strategies: • Mobilization (community initiative).
• Building alliances (forming protest groups).

Outcome: Uncertain, but protests probably moderated some negative consequences of the development, such as the increase in traffic in that part of the city.

Story 88 ■ Public opposition to demolition in former Czechoslovakia

In 1988, in the Raca suburb of Bratislava, the capital of Slovakia which at that time was part of Czechoslovakia, planners decided to demolish some 600 houses to make space for high-rise prefabricated apartment blocks. The centre of the old town of Raca was also to be demolished. Almost all residents of Raca became involved in local action to resist the demolition plans. Even in the centrally planned economy of the time, the city authorities were pressed to change their mind. The houses were not demolished and the traditional town centre was preserved.

Problem: Threat of demolition of houses to make space for high-rise apartments.

Solution: United public opposition.

Strategy: Mobilization (residents of Raca).

Outcome: The old town centre was saved.

Improving housing facilities

Story 89 ■ Self-help in Sarawak

Sarawak is a vast area in the north of the island of Borneo, Malaysia. The coastal areas are populated but the interior mainly consists of dense forests and mountains. Water is rarely in short supply but the problem is to supply it to the areas where people live.

In the 1960s, the Sarawak Rural Health Improvement Scheme was set up to educate kampong (longhouse settlement) dwellers to improve
their personal hygiene, build toilets, clean their compounds and fence in their animals. The response was poor and, in 1967, a new strategy was adopted which included educating and motivating people to help themselves, while providing technical support and incentives. Rural health supervisors, selected from the community and trained in advocacy, provided the thrust in mobilizing communities for action.

Piped water in homes was an incentive that called for community effort based on longstanding or self-help. The initiative for a house water connection had to come from the householder. The householder undertook to contribute money and labour towards building and maintaining the water supply to the community, constructing a sanitary toilet, cleaning surroundings by digging drainage ditches and fencing in pigs. As a result, the communities in Kampong Skiat received a piped water supply from a spring on a mountain a mile away. In Kampong Suba-Bau people received water from a catchment basin with the help of a hydraulic dam that brought the water to storage tanks. People in Kampong Renum and Lebor cleaned the dam that was the source of their water supply on the Renum river. Other longhouse communities in remote areas collected pipes that were airlifted into the area, hauled them to higher ground and built a dam further up-river to avoid pollution.

The government, WHO and UNICEF provided equipment, supplies and services to support people’s contributions and free labour.

By 1977, out of 2800 kampons in the project, 771 kampons with a total of about 200000 people had piped water in their homes, sanitary toilets and cleaner living conditions. By 1980, 1400 kampons had water connected. The project area has since been extended and more than 5000 longhouses have been covered by the scheme.

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**Problem:** Lack of water and hygienic toilets.

**Solutions:** The government, assisted by an NGO, supported improvement of the neighbourhood environment in a project to improve water and sanitation.

**Strategies:** Advocacy and appropriate support moved communities to action, thereby changing the environment for longhouse dwellers. Local people were trained, developed skills and were empowered to help in construction work and other parts of the project.

**Outcome:** Over 5000 longhouses have been provided with piped water, sanitary toilets and cleaner living conditions.
Story 90 ■ Women's building forum in Sweden

In Sweden, a national association called the "Women's Building Forum" has been set up to involve women in the planning of houses. The association has made an impact at the country's annual housing exhibitions, in collaboration with a local university. The aim of the association is to find new ways to meet women's needs in house design. Three women formed a company to build a family house for the 1992 Swedish housing exhibition in the town of Örebro. The result was a block of 30-34 apartments built "on women's conditions". This entailed well-designed foundations, drainage, ground planning, construction, technical systems, choice of special materials and rules for building (such as no smoking on the construction site). The apartments were allergy-proof, adapted to people with physical disabilities and ecologically sound without costing more than other houses at the exhibition.

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Problem: Women seldom have the chance to influence planning and construction of houses.

Solution: A national women's association was started.

Strategy: Building alliances (collaboration with universities, "Women's Building Forum").

Outcome: A special house designed by women was built and exhibited at a housing exhibition in 1992.

Story 91 ■ Norwegian activities to improve indoor environment

In general, people in industrialized countries spend more than 90% of their time indoors. Some materials used in construction may be contributing factors for allergies, asthma, respiratory infections and lung cancer. In Norway, several activities have been undertaken to reduce health problems related to the indoor environment. Firstly, regulatory guidelines for indoor air quality have been developed. Secondly, an action plan for children with hypersensitivity, asthma and other chronic respiratory diseases has been formulated. Thirdly, an intersectoral action plan for a good indoor environment has been published. This plan focuses on exposure reduction, regulatory activities and increased awareness. It is believed that these preventive measures will result in improvements in the indoor environment.
Problem: Health problems related to indoor environment.

Solution: Development of action plans and indoor air quality guidelines.

Strategies: • Policy development.
• Advocacy (through intersectoral collaboration).

Outcome: Reports published as a basis for action.

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**Story 92** ■ Making homes safer in New Zealand

In New Zealand, unintentional injuries account for a major proportion of deaths, hospital admissions and disability. Accidents most commonly take place in the home. Concern about accidents and the need to provide easier access for disabled persons led to Safe Home seminars and even the building of Safe Home showhouses. During the period 1986–1990, a new Safe Home standard was developed and new building legislation was implemented. The new standard includes improved access for the disabled and the goal of home safety through design and construction.

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Problem: The home is the scene of most accidents in New Zealand.

Solutions: Seminars were held and showhouses built.

Strategy: Policy development (standards set and legislation passed).

Outcome: New legislation to improve the safety of homes.

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**Story 93** ■ Maintenance of homes by a housing association

The aim of this project in the Netherlands city of Eindhoven was to maintain the existing social network. The neighbourhood of Woensew west is situated in a so-called "problem cumulation area". The pre-war houses were in poor condition, many people were unemployed, the level of education was low and there were many immigrants. However, social networks among the population were strong. The people did not wish to have their homes demolished or to move to another part of the town, and insisted on the renovation of their homes. With the help of a community worker, a tenants' association was created. After long discussions with the municipal authority, which owned the houses, the housing association (comprising people from the neighbourhood) was given
responsibility for the maintenance of the renovated houses and thus for their own environment. For a small membership fee the housing association makes minor repairs to the houses. These activities have led to active involvement by the housing association in all major municipal decisions regarding the neighborhood. The residents are also responsible for maintaining the green areas in the neighborhood. This gives young unemployed people from the neighborhood an opportunity for paid work and has reduced vandalism in the district. A healthy nutrition campaign has also begun.

Problem: Houses in poor condition were to be demolished in a "problem area" with many unemployed people, a low level of education, and many immigrants.

Solution: A tenants' association was created with support from the planning and housing authorities, urging renovation rather than demolition.

Strategies: • Mobilizing (neighbourhoods and tenants).
• Building alliances (housing association, local municipality).

Outcome: The housing association is now actively involved in all major municipal decisions about the neighbourhood.

The immediate surroundings

Story 94 ■ A housing experiment to prevent crime in Finland

The neighbourhood of Sibeliusparken in Helsinki, Finland, is a non-profit housing project with 169 apartments of various sizes, 22 accommodation units for young people and 36 additional rooms.

The objective of the housing experiment was to create a secure neighbourhood that would promote cooperation and spontaneous contact. The intention was that people should feel responsible for their neighbourhood and be willing to protect it. It was anticipated that this would help prevent crime and violence. The project was supported by the National Council for Crime Prevention.

The design of Sibeliusparken uses existing knowledge of what creates a feeling of security in a neighbourhood and what helps to prevent vandalism and violence. The design is intended to strengthen the sense of identification by means of colour, pattern and materials. The project uses a lot of glass. Glass-covered balconies represent an extension of the apartments and function as a buffer zone between private and public spaces.
Almost half (48%) of the tenants reported that the glass rooms played a substantial or fairly large role in communication and the social life of the neighbourhood.

It has not been possible to assess the effectiveness of this design in terms of preventing crime, but tenants report feeling both secure and responsible. Those involved in planning Sibeliusparken conclude that good design and layout are paramount in supporting people’s well-being.

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<tr>
<th>Problem:</th>
<th>Rising crime rates, insecurity in communities.</th>
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<tbody>
<tr>
<td>Solutions:</td>
<td>Housing remodelled to allow more contact, communication and trust-building.</td>
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<td>Strategy:</td>
<td>Enabling (through adequate planning and design of housing and intersectoral collaboration).</td>
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<td>Outcome:</td>
<td>Tenants feel more secure and responsible for their environment.</td>
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**Story 95** Building an ecological neighbourhood in the Netherlands

In 1991, in the city Alphen aan den Rijn in the Netherlands, a project called “Ecolonia” was started by a local municipality supported by the Ministry of Environment and an NGO, the Association for Energy and Environment. The aim of the project was to find a model of good practice for the Netherlands by planning new neighbourhoods according to the wishes of the future inhabitants — in terms of buildings, green areas, safety for the elderly and children, and workplaces near homes. Building according to ecological principles includes taking into account the urban setting, using only materials that can be easily disposed of and not using tropical wood. People were free to indicate how they wished their neighbourhoods to be. This was an unfamiliar freedom to people more used to being asked by architects and planners to approve of, or only slightly modify, existing plans.

<table>
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<th>Problem:</th>
<th>Lack of communities built on ecological principles.</th>
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<tr>
<td>Solution:</td>
<td>Initiative in 1991 to set up such a community.</td>
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<tr>
<td>Strategy:</td>
<td>Enabling (through participation in planning with regard to ecological principles).</td>
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<td>Outcome:</td>
<td>The first steps towards building an alternative ecological community have been taken.</td>
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Story 96 ■ Safety issues in Castlemilk, Scotland
In 1988, a local group was set up to look at safety issues in Castlemilk, Scotland, in the United Kingdom. Following a joint community forum, nine broad safety issues were identified: play, roads and streets, home, fear of crime, health risks, crime, fire, water and work. A health and safety programme was set up to work with local people and agencies. The programme has been financed by rechannelling funds from existing local government budgets. There is a close link with crime prevention. Since the Castlemilk programme began, the regional council has established a similar regional programme that the Scottish Home and Health Department has funded through its crime prevention programme “Safe Cities”.

Problem: Fear of crime and health risks in Castlemilk, Scotland.

Solutions: Forming a local safety group, pinpointing safety issues.

Strategies:
• Building alliances (local groups and agencies).
• Reorienting organizations (regional programme established).

Outcome: A safety project was established.

Services in the community
Story 97 ■ Home for the elderly becomes focal point of a healthy village
In 1989, a residential home for elderly people was built in the middle of the village of Stenberga in Vetlanda municipality, Sweden. Before this, elderly people often had to leave their home village and move to the city where there were facilities for them. The residential home has now even become the meeting point of the village. Young people meet there in the evenings to play table tennis, while adults can have lunch or buy food in the new centre’s shop. All the people in the village form a “village group” responsible for keeping the centre clean. They are entitled to use the facilities without cost. The residential home and village centre came about as a result of collaboration between the municipality of Vetlanda, a construction firm and the local “village group”. The shop is run by the municipality and the local people.

Problem: The elderly had to leave their familiar home environment because of lack of local services.

Solution: Building a local home for the elderly.
Strategies: • Building alliances (between a local village group and local businesses).
• Enabling (building the centre).

Outcome: The village centre contributed to a more supportive environment.

**Story 98** Networking at home in Sweden

In 1987, a house with apartments for integrated living for the elderly, disabled and families with children was built in Jönköping, Sweden. By making some rooms meeting points for everyone in the house, the need for external facilities was lowered. However, it took the construction company 10 years to implement the idea of a house designed for social networking.

This was a joint project of the local municipality, the construction company and the county of Jönköping.

Problem: Lack of opportunity for social contacts.

Solution: Building a low-cost house to permit social contact between young, old and disabled people.

Strategies: • Building alliances (between local government, business and tenants).
• Enabling (meeting rooms).

Outcomes: Social relationships for tenants were improved. This model was implemented on a large scale.

**Story 99** Local sorting of waste

In Denmark as elsewhere the amount of garbage is increasing and the areas for waste disposal are growing increasingly scarce. Local people voiced complaints about having mountains of waste near recreational areas. Between 1980 and 1990 local non-political groups started experiments with sorting waste at home and reusing it (glass bottles, paper, organic waste). These local movements pressed politicians to introduce new laws implementing systems for reuse of glass and paper. Now there is also a national law regulating the use of cans for beer and soft drinks.
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Problem: Increasing amounts of waste, resistance to waste dumps.

Solution: Local sorting of waste.

Strategies: • Policy development.
            • Mobilizing (local people help recycle waste).

Outcome: New laws on waste passed and new systems established for recycling.

Story 100 ■ Empowerment strategy for sanitation and waste control in Togo

In the cities of Dapaong and Tchamba, Togo, the authorities were unable to provide basic sanitation services for the inhabitants. There were no latrines and no system for the disposal of domestic waste. People were not aware of the link between immediate environmental pollution and disease. In 1988, a comprehensive effort was made to educate the inhabitants about waste disposal and health. The programme included training of trainers, preparation of educational material for the inhabitants, and special efforts to train workers to construct ventilated pit latrines. In 1990 follow-up actions took place involving continued training and information for the city inhabitants. People were encouraged to participate financially in the construction of their own pit latrines. Problems faced by the project, which is still continuing, include language and literacy problems. Those involved were the local inhabitants of the two cities, the Ministry of Health, the Ministry of Social Welfare, the Nutrition Department, the Technical Sanitation Service, a German consulting engineering service and a German development bank.

Problem: Lack of basic sanitation services for disposal of human and domestic waste, and lack of awareness that this could cause disease.

Solution: A training and construction programme.

Strategies: • Empowering (skill development).
            • Enabling (people take responsibility for basic sanitation).

Outcomes: Training programmes, construction of latrines and waste disposal facilities.
Story 101 ■ Exchange of waste for food in Brazil

In Petropolis, Brazil, there were piles of uncollected garbage in the alleys and on vacant lots. At the beginning of 1991 the community agreed to collect the garbage and to take it to collection trucks in exchange for food. Every 30 kg of waste entitled the collector to 1 kg of rice, beans or sugar. The experiment is being evaluated in economic terms.

Problem: Health risks from large amounts of uncollected garbage in slum areas.

Solution: Devising and implementing a food-for-waste scheme.

Strategies: • Mobilizing (through incentives).
           • Policy development.

Outcome: A healthier environment and food supplements.

Conclusions

Many factors in the home and neighbourhood are related to health. Major problems and possible solutions that have an effect on health are listed here.

Lack of access to land and housing

Solutions:

• Legislation to ensure that land is available for public needs.

• Public policies, including public building plans, to ensure sufficient, adequate and affordable housing; availability of financing to make it easier for people to buy or repair houses; and training of communities in planning and building their own houses with the use of appropriate technology.

• Community participation, involving empowerment of people to plan and build their own houses.

An unhealthy environment

Solutions:

• Legislation to ensure environmental balance by basing urban planning on ecological principles that respect environmental concerns and the need for balance between population and resources. Urban
development should have community approval and should define measurable health standards.

- Public policies such as investment in water supply, and wastewater and refuse disposal systems. Housing based on sustainable development, designed to save energy and use renewable energies, built from local materials and conserving traditional styles. Services and facilities in the neighbourhood, including telephone, transport, shops and schools.

- Community participation in public urban planning and in the management of environmental infrastructure.

**Housing hygiene**

Solutions:

- Legislation to ensure indoor hygiene by, for instance, making certain physical standards compulsory. Such standards could apply to the structure of the home, issues of space and overcrowding, building materials, safety, ventilation, lighting, heating and insulation, water and sanitation, kitchen and food storage, biomass fuel for heating and cooking and lighting, venting of stoves, and dampness. Also legislation to ensure outdoor hygiene, by regulating the immediate neighbourhood surroundings of the home in terms of space, children’s play facilities, gardens, trees and attractiveness of buildings.

- Public policies such as promoting healthy housing by encouraging the use of safe building materials.

- Community participation, with each family accepting responsibility for maintaining its house in a healthy condition.
CHAPTER 9

Work

Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society.

(Ottawa Charter for Health Promotion, 1986)

Issues and problems

Working conditions and employment have major implications for health, and it is important to create working conditions and work environments that are supportive of health. To do this one must look not only at the work activity itself but also at how it is organized, what relationships are involved and how production is distributed.

Work satisfies the need to make a living in order to survive, to fulfill oneself as a creative and productive human being, and to contribute to the good of society. It also provides potential for human development and for improved quality of life. Underemployment is increasingly a risk to health that hits women and young people the hardest.

However resolutely people affirm the positive role of work and the importance of human activity, problems of motivation and work organization remain.

Work activities fall into three related sectors: the household, the private and the public. Historically, the household sector has dominated in peasant societies. In early industrial society, the private sector grew in most countries. The public sector covers areas such as education and health care, including child care and care of the elderly.

The household or neighbourhood sector consists of conventional forms of home-based contract work such as self-employment and conventional forms of unpaid work like housework. It also includes a growing range of activities aimed at providing goods and services directly for oneself, one's family and one's neighbours, such as growing food, home improvement, servicing and repair of vehicles and equipment, and many forms of entertainment and care.

Small-scale agriculture is based on the principles of the household

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1 See footnote, page 22.
sector: food is produced for one’s own needs, while surplus produce can be sold at the market.

Industrialized countries provide many examples both of the benefits of industrialization and energy and of the harm that they can cause to the environment and to human health. The negative effects of industrialization are glaringly obvious in places where potentially hazardous industries have been sited too near population centres, or where there is large-scale use of poor fuels such as soft coal, lack of control equipment, unrealistic legislation or inadequate surveillance of workers. Such situations are the legacy of a disregard for predictable environmental damage and, at least initially, ignorance of its long-term effects on human health.

Preoccupation with the problems arising from these conditions should not lead us to lose sight of the need for improvements in the household. Availability of electricity and gas supplies — still a dream in most developing areas — will reduce indoor air pollution and bring down the prevalence of respiratory diseases. At the same time, the growth of cottage industries will increasingly contribute to economic development yet may present environmental and health problems of the same nature as those produced by large-scale industries. Regulating cottage industries may be more difficult because of the number and variety of them, with activities ranging from electroplating to tanning to weaving to dry-cleaning. Workers, including children, may be exposed to unsanitary work environments and exploitation. It is necessary to ensure that the environmental and health dangers associated with cottage industry are minimized.

Air pollution is the most obvious environmental change resulting from industrial activity and energy production. It affects human health both directly and through the damage it causes to buildings, vegetation and fresh water. Thoughtfully selected siting of industry, use of pollution control equipment, rational disposal of waste, strict compliance with good operational practice and continued adherence to measures to protect workers should ensure that environmental and health problems are reduced to a minimum. The major difficulty is to set up the infrastructure that makes planning, operation, surveillance and quality control effective and routine, and to avoid technological "shortcuts" that may appear economic in the short term but will be paid for later in environmental and health damage and in high costs for clean-up and restoration. Training of responsible personnel at all levels to be aware of the environmental hazards their work may cause is an expensive but essential component of any large-scale expansion of industrial and energy-producing activities.

Industrial accidents may involve large numbers of people when they happen in large plants that produce or use hazardous materials, or when
whole valleys are flooded if a dam bursts. Industrial accidents have occurred in developed and developing countries alike. Developing countries have only a small part of the world’s industrial and energy-producing plants but the frequency of serious accidents there is unacceptably high. Weakness of the regulatory system and laxity in its enforcement, as well as obsolescence of equipment, are likely to be the principal causes of accidents. Sometimes the adoption of new and locally untried technologies, or the hasty adaptation of technologies to local conditions, make accidents more likely if workers and their supervisors lack experience in risk prevention. Often local medical and hospital facilities may lack the means and experience to handle a sudden influx of victims with unfamiliar symptoms. Prevention of accidents through discipline and vigilance must be a constant preoccupation of all countries, but especially of newly industrialized countries.

The following list of issues concerning work and health is the outcome of group discussions during the Sundsvall conference. The list reflects participants’ views of the most important issues for work as a supportive environment for health. The issues relate to individuals, families, the workplace and the social context of work.

**Issues for action in work and health**

Participants in the Sundsvall conference stressed the need to make the workplace a health-supportive environment by:

— looking on health and human development as basic for all individuals and as a resource for economic development at all levels;
— highlighting the impact of work on the individual’s psychological state (e.g. self-esteem) and on family function;
— viewing work environments as multiple backgrounds (physical, social, economic, political, ideological, cultural) for physical, mental and social health;
— relating work to social justice, human rights, cultural values and the right to adequate pay;
— identifying potential conflicts between the need for income and the need for health (examining why people take dangerous jobs);
— referring more explicitly to the need for salaries to be adequate to live on in a national context;
— acknowledging that unregulated piecework remuneration may push people into overworking;
— addressing the needs of workers for information and participation in decisions about their workplaces;
— viewing work in a social context;
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- affirming the role of health and social services in influencing health;
- establishing that work includes paid and unpaid work at home, in gardens and farms, in workplaces, and in the informal economy, even though working conditions may be uncontrolled and lack social security (as is often the case for immigrants, women and children);
- recognizing changing types of work (e.g. the growth of service industries) and changing distribution of work (e.g. increase of women in the workforce);
- emphasizing that supportive environments for healthy work require the application of science and technology with intersectoral action and positive environmental policies;
- declaring that work environments are subject to global influences and need global interaction to ensure they are supportive of health; achieving global accountability for work and health;
- referring to the fact that the actions of one nation may either support or damage the environment in other countries (e.g. by exporting dangerous products).

The above issues for action can be summarized as follows:

- the workplace should be viewed as extending into (or at least influencing) the immediate environment;
- interventions should promote equity;
- the role of women as a vulnerable group and as important shapers of health should be stressed;
- workers cannot be expected to show concern for many occupational hazards unless they have achieved a certain basic standard of living;
- financial rewards cannot compensate for increased hazards to health;
- aid programmes must benefit people, not just industries, must be flexible and adaptive, must recognize the increasing importance of NGOs and must also address problems rooted in the informal economy.

Activities and solutions

The interventions are presented under four headings: global issues such as health-supportive legislation and regulation; the social role of work (including examples of combating unemployment and providing work for disabled persons); ways of creating healthy workplaces; and the issues of empowerment and organizational change.

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**Global issues**

The global issues include protection from occupational hazards, the right to know about occupational hazards, and provision of occupational health and safety services.

**Legislation**

While legislation on these matters is highly developed in many countries, it is almost totally lacking in many others. Legislation has its limitations: in some places laws may be passed and enforced only if they do not threaten the priorities of powerful elements in society. There is a need for effective research and action by workers themselves. The following measures are recommended:

- advocacy/actions for legislation (including the right to information, the right to act, the provision of health and environmental monitoring, and rights to collective bargaining, collective action and collective determination);
- establishment and enforcement of work and general environmental standards and practices both nationally and globally;
- establishment of health rights by legislation;
- legislation for affirmative action in the employment of those suffering discrimination;
- establishment of legal requirements for the assessment of the health and environmental impact of economic projects;
- enhancement of the role and capacity of the state to administer and enforce supportive laws and to impose penalties and incentives related to health and work.

**Economic strategies**

Economic strategies for health-supportive workplaces include:

- identification of and information on the health costs of different patterns and forms of economic production;
- identification of and information on the economic costs of ill-health and the economic benefits of improved health;
- broadening of the concept of the economy to include paid and unpaid work and production, including work done in the home, unpaid work done by the women, and so on;
- advocacy and motivation for economic policies and programmes that promote equity, increase people’s control over resources for health, and increase investment in essential needs and services (health care, education, housing, transport, affordable food, etc.);
- a more positive approach by national and international economic
planning agencies towards those who create supportive environments for health and development;
— transfer of resources from military to human development.

**Story 102**

In Sweden, a small town won the fight to keep jobs at home.

Many small towns in Sweden are dominated by one major business enterprise that employs most of the people. If the enterprise cuts back or closes for whatever reason, this can rapidly change prospects for the worse.

In 1982, a paper production plant closed down in Hörenefors in northern Sweden. Overnight, 450 jobs disappeared.

The unexpected news came as a shock to the inhabitants who realized this could be a death blow to their community. Over 1000 people — about a third of the inhabitants — took part in demonstrations to influence decision-makers.

The atmosphere of crisis that followed the decision to close down the plant also resulted in a positive force. The trade union helped to organize a worker support network. Former colleagues were kept informed of developments and support was given to those most seriously affected by the closure. People gradually decided that they were not going to let their community be depopulated. The number of persons who commute from Höornefors to work elsewhere has indeed increased, but there has been no decrease in population. On the contrary, the population of Höornefors has increased by about 100 compared with 10 years ago. Some say that people care about each other more than before and that class distinctions have diminished.

Few people in the community are dependent on unemployment benefits. The old factory premises have been refurbished and now accommodate more than 100 people working in various small businesses.

None of the shops in Höornefors has closed down and no houses or apartments have been left empty. On the contrary, a new children’s store, a shoe store and a clothes store have opened and the hardware store has expanded.

Two factors are considered to have been particularly important in facilitating the changes. Firstly, the economic climate improved and, secondly, Höornefors is within an area that receives extra subsidies. What first seemed like the death knell for this small Swedish community turned out to be a positive and defiant call to action.

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**Problem:** Unemployment.

**Solution:** People cooperated and helped each other to create new job opportunities.
Strategies: • Empowering (through community organization).
    • Building alliances.

Outcome: Employment was created.

Story 103 ■ Community mobilization in hazardous waste control

A hazardous waste management company proposed setting up a storage site on native American reservation lands. The tribal council informed voters about the possibility of other economic development projects, the potential health hazards of the waste storage, and the legal responsibility and liability of the tribe if there should be a claim of injury from leakage from the storage site. An organization called Native Americans for a Clean Environment helped in the education process and the outcome was that the community voted against the contract.

Problem: Proposal to store hazardous waste on reservation lands.

Solution: Seeking legal advice and other information.

Strategies: • Policy development.
    • Enabling.
    • Empowering.

Outcome: Waste storage project was rejected after community involvement.

Social role of work

People's identities are often defined by their work (as viewed both by themselves and by others). Work has an important social role for the individual in offering an avenue to self-fulfilment, a forum for social interaction and a sense of community.

Unemployment has economic, psychological and social effects on workers and their families. Attempts must be made to ensure adequate opportunities for work.

Story 104 ■ European self-help projects against unemployment

Unemployment is one of the single most important factors influencing the quality of living conditions. In 1987 there were 16 million unemployed people in the European Community, with 8 million having been unemployed for more than one year. These included young and old, male and female, and persons of different ethnic backgrounds. Unemployment may result in a vicious circle of economic, social, psychological
and health problems. The European Foundation for the Improvement of Living and Working Conditions began a research study in 1985 to look at how local communities can promote self-help among the disadvantaged and unemployed. Twenty local projects in Belgium, Germany, Ireland, Italy and the United Kingdom were examined.

Community activists, often together with public agencies, trade unions, churches and professionals, developed local projects funded in different ways. This assistance was intended to help unemployed people re-integrate socially and economically into their communities.

The research process involved project organizers and participants, representatives of governments, trade unions, employers, European Community officials, as well as an international research team. A follow-up workshop to debate the findings and agree on recommendations for policy, practice and future research was held in 1988. The work provided a higher profile and understanding of community actions on unemployment. In 1989, the European Community started a large-scale programme (ERGO) to stimulate further action and to evaluate many of these projects. ERGO has reported on the findings and made recommendations.

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**Problem:** Widespread unemployment.

**Solution:** Local self-help projects.

**Strategies:** Empowerment and increased dignity for the unemployed (the initiation of long-term processes of individual and community development, as well as education, training and information).

**Outcome:** Economic and psychosocial support for the unemployed.

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**Story 105**

**Solidarity boosts self-esteem and combats unemployment among young women**

The Swedish town of Eskilstuna is a typical industrial town of 90,000 inhabitants. Women and girls have been badly affected by unemployment. In 1987 the municipality of Eskilstuna started the Amanda project to support young women entering the labour market, especially those with special needs. The goal of the project was to strengthen self-esteem and help women obtain work, start studying or otherwise take a more active part in society.

The project is housed in a 6-room apartment in downtown Eskilstuna. Amanda is for women aged 16–24 years who either contact the project of their own accord or are sent by the employment office or welfare office. Efforts are made to make the most of each woman’s
talents. The Amanda project helps the women plan for the future, and organizes study visits, artistic and creative activities, personal discussions, vocational training and on-the-job training under supervision. With the supervisors, the young women formulate their goals, perhaps to manage living alone, to stop taking drugs, or to get a job. Finally the women are discharged to stand on their own feet. The young women may discontinue their participation in the project at any time, and the amount of time they spend there varies. They cannot be expelled for bad behaviour, though if they stop attending sessions they are immediately contacted by the supervisors and given the chance to return when they feel ready to try again. The friendly atmosphere is intended to help build up as good a relationship with the women as possible. The employment department of the municipality of Eskilstuna was the major force behind this project.

By working and studying, the young women develop their ability to assess situations, make rational decisions, and share a feeling of togetherness. The supervisors base their approach on participation.

After three years, some 30 young women have left the Amanda project, although they still keep in touch with each other. The project cost about US$130,000 in 1989, of which three-quarters went on staff salaries. The annual cost of the project for each woman helped is slightly higher than for a secondary school student.

Problem: Unemployment, drug use and other social problems among vulnerable young women.

Solution: The women were given the chance for personal development through study and work.

Strategies: • Enabling.
• Building alliances (through shared experiences).

Outcome: Many women are able to integrate socially again.

Healthy workplaces
Prevention of occupational diseases and injuries is of paramount importance globally. One important measure is to provide appropriate services to promote health and reduce accidents at work.

Story 106 ■ Community self-diagnosis revealed chemical dangers
There are various approaches to controlling the use of poisonous substances in the workplace. These include stopping the use of the sub-
stance altogether, reducing the numbers of people exposed, reducing
levels of exposure, and providing personal protective equipment.

In the early 1970s, studies in Finland and Sweden found that people
exposed to organic solvents suffered from headaches, forgetfulness,
insomnia, fatigue and personality changes.

In Skaraborg, a Swedish county with just over 250,000 inhabitants, a
multidisciplinary investigation in 1977 revealed an excess of psychiatric
illness in two communities dominated by the wood-processing industry.
A so-called community self-diagnosis survey, carried out together
with the trade unions, showed that some 3000 people were exposed
to solvents in quantities that might constitute a serious risk of
neuropsychiatric illness.

An educational programme was started for the employees of the
industry, a care programme was set up for affected persons, a demonstra-
tion factory was built, and doctors, nurses and psychologists were
trained. Companies and labour representatives joined in an intervention
programme to encourage those involved in the varnish process not to
leave their jobs for fear of the risks. Educational material was designed
and tested both locally and nationally.

All persons exposed to the solvents were asked to answer a question-
aire. The medical survey covered 285 persons, of whom 56 (20%) were
referred to an occupational medicine specialist for further investigation.
In most cases, reported symptoms could be related to work with known
high exposure and could be remedied by fairly commonplace measures
such as ventilation or a change of equipment design.

It turned out that it was easier to improve the workplace environment
if proposals were backed by evidence of how much material and energy
could be saved or how much productivity could be expected to rise. A
new type of face-mask was introduced, increasing employee well-being
without a heavy investment by the company.

The employees who were most exposed to the solvents were able to
take part in company-supported study circles on the risks of organic
solvents.

A demonstration plant for personnel training was created with the
aid of a grant from the national Working Environment Fund.

Problem: Ill-health resulting from chemical hazards.
Solution: Education of employees coupled with environmental changes.

Strategies: • Building alliances.
            • Enabling (through product development).

Outcome: Working conditions were changed and exposure to health-
damaging chemicals was reduced.
Story 107 ■ Organizing electronics workers on health hazards

The Santa Clara Center for Occupational Safety and Health was formed in 1977 in San José, California, USA. The area is the heart of the United States electronics industry but there was little trade union involvement.

The Santa Clara Center came about as a result of a meeting of the local Commission on the Status of Women, at which many women workers publicly complained about the chemical hazards of working in the industry. Community representatives in the Santa Clara Center included the Commission on the Status of Women, the United Electrical Workers Organizing Committee and the American Friends Service Committee. The organizers hoped that the focus on health and safety hazards would help identify workers who had doubts about company practices and who could help organize unions in the industry.

The core group created a non-profit front organization called Project Health and Safety in Electronics which was legally entitled to receive government grants and educate workers about the possible hazards in electronics through public meetings, telephone information and pamphlets. As this group received government money, it was prohibited by law from lobbying to influence legislation. Nevertheless, the Santa Clara Center itself, which received no government money, was free to continue its open advocacy on behalf of workers. A telephone hotline was set up, mainly to answer workers’ questions about the substances they worked with.

| Problem: | Health hazards in electronics industry. |
| Solutions: | Funding, and organization of non-unionized workers. |
| Strategies: | • Advocacy. |
| | • Mobilizing. |
| Outcomes: | • Organization: championed the cause of electronics workers. |
| | • A telephone hotline answered health queries. |

Story 108 ■ Women won fight for new chemical standards in the USA

In 1977 three women who worked at an electronics firm in California realized that the headaches, blisters and metallic taste they were each experiencing might be caused by assembling electronic components. Later a male manager began to exhibit similar allergic reactions. The company rebuilt the ventilation system in the place where the women worked. However, even the new ventilation system was inadequate
to protect the women who continued to suffer toxic reactions and were instructed to spend their days sitting in the company cafeteria. Occasionally the women were called on to sniff the air in a particular department; if they experienced an allergic reaction the air was judged to be contaminated.

In 1979, together with a lawyer and the Santa Clara Center for Occupational Safety and Health, the women called for a health hazard evaluation. Physicians of the National Institute for Occupational Safety and Health determined that the women’s job had made them ill and recommended that the company renew the entire ventilation system in the plant. A university physician determined that the women were “super-sensitive” to industrial chemicals. Soon afterwards the three women were fired, but their case led both to a re-examination of the issues of health and safety within the industry and to a call for a much lower exposure standard for trichloroethylene (TCE), a solvent widely used in the electronics industry.

The women encouraged other non-unionized workers to protest about conditions in the electronics industry and call for government investigation of conditions. Injured Workers United, which focuses on the problems of disabled workers, was formed as part of the Santa Clara Center.

Problem: Health hazards in electronics industry.
Solution: Empowering and encouraging workers to protest.
Strategy: Advocacy (lobbying for investigations).
Outcome: New standards for emission of toxic chemicals, example of successful mobilization.

Story 109 ■ Organic production of bananas in the Philippines

In 1980 an employee of a banana plantation in the Philippines visited Japan to raise the issue of use of pesticides on Philippine banana plantations owned by Japanese multinational organizations. Pesticides not permitted in Japan were reportedly used in countries that exported food to Japan. Documents obtained by Japanese consumer groups in the early 1980s showed that the Philippines bananas contained measurable levels of four pesticides. Consumers were concerned about health risks from long-term exposure to dangerous chemicals.

A campaign to stop use of dangerous pesticides on Philippine banana plantations was started in 1986. A field survey showed that 26 types of pesticides were used.
Despite setbacks, the campaign continues. Consumer and citizens' groups have published documents on the issue. In 1989 the Congress of Consumers condemned the multinational corporations and is in contact with lawyers to evaluate the possibility of regulating their activities.

Another campaign has resulted in the organic production of bananas in the Philippines. The acceptance of chemical-free bananas in spite of the high costs is a victory. Cooperative relations are being established between the two campaigns. Demands continue for an end to the use of hazardous pesticides, for the provision of protective clothing, for education on safety, and for the companies to pay the medical expenses of those affected by the pesticides.

| Problem: | Pesticide use in banana plantations in the Philippines, owned by Japanese companies. |
| Solution: | Campaign against pesticides, education, legal action. |
| Strategies: | • Mobilizing consumers (networking with citizens' groups), |
| | • Reorienting production. |
| Outcomes: | • Continuing attempts to regulate multinational corporations, |
| | • Organic production of bananas. |

**Story 110** Building an occupational health centre in an industrial zone of Sudan

In Khartoum, Sudan, there is a large industrial zone with industries of various sizes. There was no local hospital and sick workers had to be sent to the distant district hospital.

In 1975 a campaign group was formed to advocate the philosophy of health for all, including workers' health. It started by making itself known to everyone including high-level government officials, employees and the strong trade union movement. The group managed to secure an allocation of land in the centre of the industrial zone to establish an occupational health centre. Well-organized fund-raising by government, employers and labour groups meant that the centre could be built in only nine months. Doctors and health supervisors became involved in the project and an occupational health department was also set up.

| Problem: | Inadequate occupational health services for workers. |
| Solution: | Forming a campaign group to influence workers' health. |
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Strategy: Advocacy.

Outcome: Establishment of an occupational health centre and an occupational health department near the places of work.

Story 111 ■ Supporting primary health care in the workplace in Sudan

Since about 1960 the number of work-related accidents in Sudan has been rising sharply. In the 1970s an occupational health department was established with the help of WHO. At the same time some labour and health laws were updated and new ones were passed. Problems of occupational safety started receiving more attention and more people started demanding compensation for work-related accidents.

An active public health advocacy group, the Sudanese Society of Preventive and Social Medicine, in collaboration with the Canadian Public Health Association, the Sudanese Workers' Union and the Employers' Federation, formulated a three-year project to support primary health care at the workplace. Some 120 health care workers were trained for nine months as occupational health and safety supervisors. These supervisors teach workers about safety and health in the workplace and at home. Health education sessions aimed at health promotion were held. Although trends in disease and accident rates have not been assessed, the overall attitude to health has changed as a result of the project.

Problem: Increase in work-related accidents in Sudan.

Solution: Support primary health care in the workplace.

Strategies: • Advocacy,
           • Building alliances (international training).

Outcome: Improved awareness of occupational health hazards.

Story 112 ■ Health insurance schemes develop health promotion in the workplace

Since 1989 German health insurance schemes have been obliged to support health promotion. In order to achieve a comprehensive long-term health promotion programme within a company, appropriate infrastructures and instruments are needed. A number of these have been established. Workplace health committees consist of representatives of employer and employees as well as company health specialists. Together
they analyse the situation, set targets, initiate health programmes and evaluate their results. Company health reports present data on health and sickness of employees in order to identify major health problems in the company. Company health fora provide the opportunity for employee participation in the company health promotion process. Such bodies are useful when the data in the company health reports are too abstract or when there are psychosocial problems to be assessed and dealt with. It is reported that employees are able not only to identify precisely stressful work demands but also to make specific proposals for overcoming these.

The federal agency that deals with company health insurance schemes supports research and development of concepts and models of company health promotion. It also organizes seminars and produces literature in support of this goal. In cooperation with the WHO Regional Office for Europe, the agency has set up a database of some 100 models of workplace health promotion, mainly from large German companies, and described according to standardized categories. As of the end of 1992, this information has been available in English on request free of charge.

Problem: No mandatory health promotion by the German health insurance schemes.

Solution: In 1989 all health insurance schemes were obliged to establish long-term health promotion programmes.

Strategy: Reorienting organizations.

Outcome: • Health promotion in German firms.
• European database on health promotion in the workplace.

**Story 113** First WHO "healthy hospital" established in Vienna

Hospitals are attractive environments for health promotion for several reasons. They contain a great deal of expert knowledge on health and ill-health, they employ many people and have a large number of patients and visitors passing through. Hospitals have multiple contacts with other health and social institutions in the region, are important consumers in different markets and are at the forefront of modern medicine in terms of health care, research and education. Consequently hospitals tend to enjoy a position of prestige and influence.

The Vienna "healthy hospital" project was set up in 1989 at the Rudolfstiftung hospital in the Austrian capital. The project is sponsored by the WHO Regional Office for Europe and the city of Vienna. Volun-
tary participation is a strategic principle of the project and hospital staff voted in favour of carrying it out. One of the subprojects concerns health in the workplace and includes study of hazardous working materials, the organization of the hygiene infrastructure and the development of communication and social relationships. Other subprojects concern the reorganization of outpatient and neurology departments, training for diabetic patients, hospital catering and nursing care.

The projects have been successful in developing strategies, structures and procedures for the implementation of the concept of a health-promoting hospital.

Problem: The potential for health promotion in hospitals was not adequately realized.

Solution: Establishment of a project to develop the concept of the health-promoting hospital and implement appropriate strategies, structures and procedures according to the Ottawa Charter of Health Promotion.

Strategies: • Reorienting organizations (providing appropriate and essential services).  
• Policy development (by applying innovative approaches and mediating).

Outcomes: Expected gains are in higher quality of medical, nursing and social services, with higher job satisfaction among staff. The hospital’s reputation was improved with better integration of the hospital into its regional environment. Through reorganization of services, more attention can be given to the well-being of patients and relatives, working practices, functions and space.

Work can make you healthy

Promoting health through work is currently a high priority in more developed countries. One way of doing this is by developing management styles that make efficient use of human resources through workplace design, time management and staff development.

In one case, employees of a German publishing house were not consulted about the design of their new office building. Their frustration was manifested in the form of complaints about air quality. Complaints were reduced after consultation. A Dutch company found that alcohol problems among employees were linked to frequent organizational changes. Training in coping skills reduced time lost due to sickness, to the benefit of both the employer and the employees.
Trade unions act for health

In Sweden during the 1980s growing differences in health between poor and affluent groups were noted. In 1987 the Swedish Confederation of Trade Unions started a nationwide project, assisted by central authorities, to change this situation.

Traditional health education has often argued for changes in lifestyle without consideration of working conditions. That approach has had some success among white-collar workers but has often failed to arouse much interest among blue-collar workers. Many people simply take the attitude that they should be left to live the way they want to.

In 1983 a new Health and Medical Care Services Act took effect in Sweden. An introductory statute in the law states that the goal of the health care system is good health and that health services should be available to everyone in the population on equal terms.

During this period, the WHO health-for-all targets for the Member States in the European Region were also elaborated. Sweden supported these targets at a European regional meeting in 1984. The greatest resource in this project was the Swedish Confederation of Trade Unions by virtue of its size and structure (more than 2 million members, including 90% of all blue-collar workers in the country). The government allocated 700 000 Swedish crowns (about US$140 000) annually.

In collaboration with the confederation’s 17 regional districts, the county council departments of social medicine and locally based health planners, the project now uses around 7 million Swedish crowns annually.

A basic feature of the project design has been to put responsibility for the goals, methods and priorities at the local level. The central resources have been used not to direct local activities but to relate health issues to work and to various environmental conditions.

Accounts of local projects indicate a dominance of lifestyle-oriented activities. There are also examples of measures that give prominence to issues of work organization. The strong active participation of the members is a notable feature of the project.

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Problem: Persistent class-related health differences in Sweden.

Solution: Large-scale public health project.

Strategies: • Mobilizing,
      • Reorienting organizations.

Outcome: Provision of appropriate occupational health services.
**Empowerment issues and organizational change**

Workers may lack knowledge of factors affecting health, or may fail to act on their knowledge because of tradition or culture, or because of environmental disincentives.

**Story 115** Reorganization of automobile production cuts occupational injuries

The mass production of automobiles depends on assembly lines. Few people view assembly line production as a supportive environment for health. During the 1960s and 1970s there were reports that automobile workers were suffering from exhaustion due to stress, monotony and repetitive tasks on assembly lines in production plants. In the Swedish automobile industry there were high levels of absenteeism due to illness, high staff turnover, a reduction in quality of output, and protests by employees.

Researchers demonstrated that the assembly line was not as efficient a means of production as originally thought. A Swedish company found it was able to cut back on staff who did the actual assembling but had to hire more people to check the products. As factories specialized in specific aspects of automobile production and the number of product variations increased, time was lost in transporting parts and making adjustments.

The company decided to re-examine its approach. When a new automobile assembly plant was built in 1974, attempts were made to allow employees to have a say in planning for a better working environment.

This new approach was taken even further in a new automobile plant that was opened in 1989. Each car produced at the plant is assembled by one production team. The factory has 40 production teams, each of 8–10 men and women. There are no managers in the traditional sense. Team representatives are responsible for quality, cost, maintenance and so on. The goal is to rotate these tasks every month. The teams also take part in recruitment and training. The new plant has the highest quality output of the company’s three Swedish factories and productivity is increasing.

This new way of organizing automobile manufacture may be more profitable than the assembly line because team production is more flexible and more responsive to change, such as when a new model is introduced.

**Problem:** High staff turnover and occupational stress in Swedish automobile factory.

**Solution:** Reorganization of work, job rotation, sharing responsibilities.
Strategies: • Advocacy.
  • Enabling (through production line changes).

Outcome: More worker satisfaction, fewer occupational injuries.

Story 116  ■ Forestry workers fight for a life after 50

Half of Sweden is woodland. The forest has played a significant role in the development of modern Swedish society. Next to iron ore, timber has been the country’s most important natural resource. It is Sweden’s leading export industry, bringing in the largest amount of foreign currency. One in every 16 employed Swedes lives off the forest in some way.

Up until the end of the 1940s, all felling of trees was done manually. Today, the wood-cutting industry is highly mechanized.

Felling timber was extremely hard work. For the wood-cutters of northern Sweden, it also entailed walking in deep snow in the bitter cold. By the time they were 40, workers were often worn out, with chronic back problems; this explains some of the impetus behind the demands of trade union members in northern Sweden in the 1960s for a fixed monthly wage. Most of them felt that piecework, by which they were paid according to the amount of timber produced, contributed to damaging their health and causing injuries. Forestry workers also face other dangers, such as exposure to chemicals used in some processes, exhaust fumes and oils used to lubricate machinery.

At the beginning of the 1970s, 85% of Swedish forestry workers were paid mainly according to the piecework system.

Great efforts had been made to reduce accidents, particularly while felling trees. Felling a tree according to the safe method took on average 14 minutes, though with fewer safety procedures a tree could be felled in four minutes. By using the faster method, forestry workers made more money.

In 1975, there was a strike of 7000 forestry workers in northern Sweden. They called for a fixed monthly wage and higher daily allowances in an attempt to minimize risk of accidents and prevent ill-health among older workers. “A life after 50” was one of their slogans.

The strike resulted in two different wage agreements: a monthly wage, mainly for workers in northern Sweden, and a salary based 85% on time and 15% on productivity for other workers.

Accidents fell by almost 30% after the new wage system was implemented and forestry workers had fewer days of sick leave. Productivity in the timber industry decreased in the first five years after the new rate was agreed on, but this decline had been foreseen.

Today a fixed salary remains the guiding principle for forestry work. Workers can now choose between a set monthly wage and two piecework alternatives accounting for 40% of the salary.
Problem: Piecework among Swedish forestry workers contributed to a high number of accidents and serious injuries.

Solution: Strikes and agreement about a fixed monthly wage.

Strategies: Mobilizing and empowering.

Outcome: When the forestry workers went on strike, their demands for a monthly wage were met. This in turn reduced the number of occupational accidents.

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**Story 117** ■ Pesticides and the international cocoa workers' network

Threatened by corporate takeovers throughout the 1980s, including layoffs and plant closures, workers in the cocoa and chocolate industries began in 1986 to form an international network to gain more control over developments affecting their lives and livelihood. Workers from countries as diverse as Ghana, Hungary, Malaysia, and the United Kingdom shared experiences and visited each other to learn what others were doing in campaigns for employees' rights.

The workers took up the issue of working conditions and the number of health problems attributable to pesticide use. A long working day and hazardous work were part of the problem. Small farmers were unable to use costly chemicals and some fell deep into debt.

Cocoa workers from around the world share information through the network. A core group travels to different countries and helps defend the rights of workers and trade unions. Several companies have responded to requests from the network to reveal the amounts of chemical residues in chocolates.

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Problem: Health problems in the cocoa industry.

Solution: Forming an international network of cocoa workers.

Strategies: • Empowering workers (through exchange, training).
• Advocacy (about deleterious conditions).

Outcome: Concessions from the industry.

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**Story 118** ■ Supplying information as a tool of empowerment in Brazil

In the 1970s policy-makers in Brazil recognized that many cases of accidental poisoning were not registered. Many people working in rural
areas and exposed to pesticides reported headaches, abnormal fatigue, insomnia and other problems related to the nervous system. In the State of Parana, in the south of Brazil, several deaths were reported.

Other health problems related to excessive drug consumption, high exposure to chemicals in industry, and high levels of air and water pollution in urban areas were also identified.

In 1980, the National System for Toxicological and Pharmacological Information was created to increase access to information about the toxic effects of drugs and other products. The main users of this system were policy-makers, health professionals and other citizens.

This system has been transformed into a national programme called PRONITOX which links 14 Centres for Toxicological Information, where health professionals provide information by telephone, and five Centres for Toxicological Control, which provide hospital care with clinical follow-up of patients. This system is coordinated by a public health and biomedical research institute linked to the Ministry of Health.

Problem: Very high levels of accidental poisoning in Brazil.

Solution: Extending access to information.

Strategy: Raising awareness (creating a National Information System on Toxicology and Pharmacology in several states, providing access to information and hospital care).

Outcome: Activities increased awareness of the problem and aided prevention.

Story 119 ■ Promoting better pesticide use in tobacco growing

Farmers in a rural community in Perugia, Italy, started to notice in 1988 that certain kinds of birds were no longer seen in their fields. The farmers thought this must have something to do with the chemicals they were using. They asked local health services to study the problem and to investigate the health status of people living nearby, whether they worked on the fields or not.

A study was carried out to measure the amounts and the strengths of the pesticides used. Farm workers were asked how they used the different products and video recordings were made of their use. Farmers’ meetings discussed problems of pesticide use, such as toxicity, hazards, damage and improper use. A clinical survey was done to determine the health of the population.

Many interested parties were involved in the project — the local
health services, the local administrative authorities, social organizations, the Department of Hygiene and the Institute of Occupational Medicine of the University of Perugia.

As a result of the pesticide project, farmers decided to use fewer chemicals and to use those that were less toxic. However, they refused to stop growing tobacco.

Problem: Pesticides were observed to have poisonous effects on wildlife.

Solution: A survey of pesticide use was initiated and information meetings were organized.

Strategies: • Mobilizing (farmers).
• Building alliances (between workers, administrators and scientists).

Outcome: Less use of chemical pesticides, change to safer brands.

**Story 120** Centre for women’s occupational health opened in the United Kingdom

Traditionally, women were under-represented in trade unions in the United Kingdom. At the same time there was an over-representation of women in the informal sector. Consequently, little attention was being paid to the hazards of women’s work.

A non-profit organization, the Women’s Work Hazard Centre, was established in the mid-1970s in London, to support women’s initiatives in researching and developing solutions to hazards associated with women’s work, both paid and unpaid. The initiative was taken by women concerned about the social causes of women’s ill-health and the neglect of the problem by male-dominated health and safety organizations.

As a result of the initiative, consciousness-raising and alliance-building were carried out in collaboration with other women’s organizations. A conference was organized on the social causes of women’s ill-health. The Women’s Work Hazard Centre gained representation in the Management Group of Women’s Health and in the Reproductive Rights Information Centre. Publications were disseminated on the health hazards of women’s work.

Problem: Neglect of women’s occupational health hazards.

Solution: Women’s organizations established a centre for information dissemination, advice, research and networking among women’s groups.
Strategy: Building alliances (networking, organizing conferences, establishing a new organization).

Outcome: More attention paid to the problems of women's occupational ill-health through contacts with other organizations, dissemination of information and conferences.

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**Story 121** ■ Dealing with substance abuse in workplaces

Some 25 years ago in Norway, retailers, manufacturers, other employers and the state jointly formed the organization called Workplace Committees against Alcoholism and Drug Addiction. The aim was to reduce alcohol and drug problems in the workplace and to avoid having to dismiss employees because of their substance abuse.

The social structure of the work environment is deliberately used to identify and assist high-risk individuals and to disseminate information. “Clients” choose their own contact persons who are instructed and supervised by occupational health officials. This has led to fewer cases of absenteeism and dismissal due to alcohol abuse.

Problem: Employees with substance abuse problems.

Solution: Workplace committees established to help people at risk.

Strategies: • Building alliances (trade unions, employers' organizations and the state, and forming committees at central and local levels). • Enabling.

Outcome: Less substance abuse at work, less absenteeism and dismissal due to substance abuse.

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**Story 122** ■ Taking steps towards better occupational health in Brazil

Brazil has one of the highest rates of occupational injury in the world. The trade unions have grown in strength and new strategies have been defined for improving working conditions, for giving employees information about risks in the workplace and for using new technologies in accident and disease prevention. There has also been improvement in social security benefits in cases of accident and occupational disease.

Important milestones in this development were the use of internal commissions for accident prevention, the creation of the Intertrade Department for Studies in Labour Health in 1981 which improved trade union strategies in health issues, and the actions of the Brazilian Centre
for Studies in Health and the Brazilian Association for Graduate Courses in Collective Health. The Centre for Studies in Workers' Health and Human Ecology is a central reference institution for work and health issues.

Local programmes linking occupational health and public health started in 1982 and made a crucial contribution to a national discussion that culminated in the Eighth National Health Conference in 1986 with the participation of 5000 delegates. The same year the First National Conference on Workers' Health was held. In terms of policy development, the National Commission on Sanitary Reform linked seven different technical groups and paved the way for a new health concept in Brazil's new constitution of 1988. According to the constitution, businesses have to pay a fine if they are proved responsible for an accident in the workplace. The role of the health systems in occupational health has been defined, as have actions for epidemiological surveillance. For the first time a ministry is entitled to take action to protect workers' health and to prevent occupational hazards.

Problem: High rates of occupational injury in Brazil.

Solution: New strategies and technology, access to information.

Strategies: • Policy development (national).
• Empowering (trade unions, strengthening legal frameworks for workers' health, sanctions against industry, mediating through conferences).

Outcome: Redefined focus on occupational health.

**Story 123** Company health promotion workshop in Germany

In 1990, a workshop on health promotion by companies was arranged in Hamburg, Germany, for about 60 managers and other employees of 30 companies. The workshop was arranged by several institutions and organizations concerned with health and employment, including church bodies. Discussions were held about special schemes for improving health promotion within companies, integrated health policies and what the business community could do to support health promotion throughout Hamburg.

The background to the workshop was a multitude of health problems but few health promotion activities in Hamburg companies. A prerequisite for these activities was an increase in interest in health promotion within the business community. There was also a need to support a Healthy Cities policy.
Interest in the business community was generated by the fact that the church agreed to help organize and sponsor the workshop. Health insurance schemes and a network of managers were used as information channels. Models of good practice were demonstrated in the form of reports by representatives of health insurance schemes and health promotion projects.

After the workshop, the organizers set up an exhibition and held follow-up workshops. They also published a report. Negotiations between a health insurance scheme and a chemical company resulted in the establishment of a health promotion project. Several model projects are now being negotiated. The trade unions have also taken up the subject and are scheduled to organize a workshop of their own.

| Problem: | Health problems and few health promotion activities in Hamburg companies. |
| Solution: | A health promotion workshop with the support of business, labour and the church. |
| Strategies: | • Building alliances (business community and religious organizations).  
• Enabling (through health insurance schemes). |
| Outcome: | Dissemination of workplace health promotion. Trade unions involved. |

**Story 124** Training health and safety delegates in Italy

In 1990, the national Italian transport trade union decided to create a network of workers who would promote knowledge and action for supportive environments and healthy working conditions in the workplace. Workers in different sectors (water, air transport, roads and railways) were trained as regional health and safety delegates. The working conditions in parts of the transportation system, especially roads and water, were sometimes difficult.

Health professionals from the National Health Service, as well as experts in hygiene, occupational health, medicine and law, took part in the training courses. During the training activities it was realized that there was a need to change the National Work Contract, defining more precisely the rules regulating the employer–employee relationship, and improving the work environment and other conditions. These changes are now in effect.
Problem: Difficult work conditions in the Italian transport sector.

Solution: Training of regional health and safety delegates.

Strategies: • Raising awareness (training of delegates).
• Policy development.

Outcome: Working conditions and work organization have improved, a National Work Contract has been redefined.

Story 125 ■ A Swedish–Nicaraguan project to improve miners’ health

In 1983, the Department of Social and Preventive Medicine of the University of León, Nicaragua, asked the Kronan Health Centre of the Karolinska Institute in Stockholm, Sweden, to collaborate in a project called Abdon Vega at a gold mining site in Nicaragua.

The project was carried out in two stages. The first phase involved assessing the major work-related health problems of the miners, such as lung disorders and hearing problems. The second stage sought to assess the general living conditions and related health problems of miners’ families and other community members. Another aim was to study the feasibility of establishing a health promotion programme in the community.

The problems were defined by those directly involved. Interviews were conducted with mining executives, union representatives, the staff of the health centre, representatives of popular organizations and the miners themselves. A series of study visits to the mines was undertaken. Screening of miners began to establish the prevalence and types of occupational disease and a technical investigation identified environmental hazards in the mine.

In the second phase involving miners’ relatives and other community members, local popular movements provided a description of local health risks, forming the basis for long-term programmes.

Union representatives participated actively throughout the project period and played a key role in communicating information to workers. The union organized its members to construct a building in their leisure time to house the project’s administration.

Problem: Health problems among miners and their families in a Nicaraguan mining community.

Solution: Community involvement in defining problems and solutions in a joint Swedish–Nicaraguan research project.
Strategies: • Mobilizing (community involvement).
• Building alliances (involving local community, Kronan Health Centre and the Department of Social and Preventive Medicine in León).

Outcome: Results from assessments of the health conditions of the miners and their families formed the basis for long-term health programmes. A local literacy campaign was started, and the construction of houses, latrines and drinking-water projects was speeded up. Garbage disposal improved.

Conclusions
The whole of society has an interest in contributing to supportive environments for health in working life. Company owners, managers, government, politicians, decision-makers, trade unions and workers all have a major role to play.

Improvements in the health of the labour force benefit the whole of society through improved quality of life and less expenditure on social welfare. This support can also help businesses increase their cost-effectiveness.

When considered in terms of the seven strategies in the HELPSAM model described in Part 1, the experiences recounted by participants at the Sundsvall conference and the stories in this chapter demonstrate a number of important factors.

• Government support of policies concerning the health of workers is very important. Policy goals should include the right to work, equity between women and men, and a commitment to fight against unemployment.

• Regulations and laws should protect against occupational hazards. The right to information about occupational hazards is important, as are the provision of occupational health and safety services, the regulation of working hours, legislation against discrimination and abuse of the labour force (particularly children and pregnant women), and the ability to organize and negotiate on working conditions.

• Industry can benefit health by increasing efforts to move towards production methods that do not harm the environment. In the workplace, as workers have increased control of their working environment, they have made health concerns a priority. Trade unions, occupational health services and insurance companies have important roles in supporting workers' health. In addition to traditional tasks such as improving salaries and working conditions, for instance, workers' movements have also shown themselves successful in improving health promotion in the workplace.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

- Groups such as trade unions, women’s associations, occupational health and safety authorities, health promoters and environmentalists play an important role as advocates for health.

- Alliances between the workforce and health promotion bodies, consumer associations and researchers have great potential for the improvement of working life.

- Key enabling factors include education, training, access to information and technologies, and democratization.

- Strategies for mobilization are based on the relation between work, supportive environments and people’s health. Empowerment has both organizational and individual dimensions. The organizational dimension includes the distribution of power and negotiating skills and opportunities for achieving these aims. The individual dimension encourages personal development by supporting self-reliance, self-confidence and self-esteem. These dimensions show the potential for promoting health by creating supportive environments in the workplace.
CHAPTER 10

Transport

The development of environmentally appropriate technologies is closely related to questions of risk management. Such systems as nuclear reactors, electric and other utility distribution networks, communication systems, and mass transportation are vulnerable if stressed beyond a certain point.


Issues and problems

Transportation is an essential part of the daily life of human beings. Without transport, only a low-level subsistence agricultural economy is possible. Cities and rural areas have to be linked because of the need to transport necessities such as food, raw materials, fuel and drinking-water, and for the distribution of products and the disposal of waste. Good planning can facilitate access to employment and services, and efficient transport systems can strengthen the economy through efficient exchange of raw materials and finished products.

Lack of transport results in social isolation, lack of employment opportunities and inadequate access to education, goods and services. Transportation is also needed to ensure safety (fire service), security (police) and quick access to medical care and life-saving services (such as emergency care for people injured in accidents or taken ill).

At the same time, transport today is a major threat to global life-support systems. Transport systems consume oil, an important non-renewable resource. Sustainability of renewable resources is affected by emissions of nitrogen and sulfur oxides that lead to acid rain, degradation of vegetation and damage to crops and forests. Air pollution, particularly high concentrations of carbon monoxide, nitrogen oxides and lead, is a major problem in urban areas throughout the world. Health problems associated with air pollution include chronic bronchitis and asthma. However, the greatest immediate health impact of transport is


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that of motor vehicle accidents, which are a leading cause of death and injury in developed countries and are fast becoming a major health issue in many developing countries as well.

The significant adverse effects of transport on society have received insufficient attention from planners. Construction or widening of roads and increasing traffic disrupt neighbourhoods and communities, making life more unsafe for pedestrians, particularly children. Large areas of urban and suburban land are occupied by parked cars, and buildings of historic value may be destroyed. Car owners often do not pay an appropriate fee for the use of the parking space, nor do they compensate non-car users for urban traffic congestion and smog. In this and other ways, private car transport is inappropriately subsidized in most cities. Where planners assume that most people have access to motorized transport, those without cars are marginalized and excluded from easy access to goods and services.

Existing transport systems and technologies are backed by effective lobbies on behalf of car manufacturers, drivers and petrochemical interests. The justified worries about the dangers of traffic have led to a situation in which young children can rarely be allowed out on their own or play in the street in urban and suburban areas of developed countries.

Substantial benefits to people’s health and well-being can be gained from town planning and transport policy that promote local activity, community interaction and environmentally sound design, thereby leading to a reduction in stress, discomfort and ill-health. There should be public participation in designing a transport environment that is supportive of health.

- Transport policy should pay more attention to safety. For instance, it should be regarded as totally unacceptable that transport accidents are a leading cause of death and disability for children and young adults.

- Transport policy should place priority on ensuring access to facilities and services, especially for low-income groups, women with young children and the elderly. Comfortable, rapid and frequent transportation is essential if people are to be persuaded to choose collective means of transport rather than private cars.

- Transport policy should acknowledge the damage that excessive reliance on the private car has caused in many cities throughout the world, as well as in rural settlements. Environmental and health impact should be important criteria in formulation of policy.

- Transport policy should seek to strengthen interaction between communities rather than discourage it.
Activities and solutions

The stories in this section have been grouped under the following headings:

• Policy development
• Meeting transport needs
• Road safety
• Congestion, pollution and loss of amenities and land.

Policy development

Story 126 ■ The Los Angeles clean air programme

The poor quality of the air in the Los Angeles area was already known in the early 1940s. In 1946, the Los Angeles County Board of Supervisors formed the first air control district in the USA to deal with the problem of industrial emissions. In the 1970s both federal and state authorities realized that local programmes were inadequate to address the problems, most of which were of a regional nature. Accordingly, in 1977, a regional body, the South Coast Air Quality Management District, was established with the primary aim of bringing emissions into line with federal and state limits. In 1989 alone, the federal limit for ozone was exceeded on 127 days.

In order to meet federal requirements for the year 2010, emissions must be reduced throughout the whole of society. As an example, even if all the industry and all the cars were removed from the area, Los Angeles air would still not comply with the limit for ozone. Planned control measures have to be far-reaching, encompassing both stationary and mobile sources of pollution, as well as consumer products. Indirect measures are also needed, including reduction of driving by introducing, for instance, a four-day working week or flexible working hours, building offices adjacent to housing and working from home via computer networks. Efforts are being made to get people to share car rides.

Attempts to limit the population and economic growth of the region are considered undesirable and unrealistic. Nor is it regarded as politically opportune to try to curb the consumption of petrol by raising taxes. The authorities estimate that measures to improve air quality will result in annual savings of US$254 per household by the year 2010. However, critics say that costs will exceed benefits by around US$1600 per household each year.

Problem: Polluted air.

Solution: Reduce car-driving, e.g. by working from home via computer networks.

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Strategy: Policy development (a regional body was established in order to meet federal emission requirements by 2010).

Outcome: Expectations of improved air quality and possible, though disputed, economic savings.

Story 127 ■ Referendum for making Amsterdam a car-less city

In March 1992, the inhabitants of Amsterdam, Netherlands, voted in a referendum to make their city the first capital city in the world to prohibit cars in the city centre. Barely half of the population took part in the referendum, and the decision was taken by a narrow margin with 53% in favour of the car ban and 46% against. The vote was not decisive but only advisory. Nevertheless, a majority of the city council backed the decision. There are 180,000 car owners in Amsterdam, and another 130,000 motorists visit the city each day to work or do shopping. Congestion has reached a level where cyclists, pedestrians with baby carriages and disabled people can hardly move around the city. Now the city’s 140 canals will again become the preferred means of transportation, just as in the past. Boat services are to be extended, while pedestrians and cyclists reclaim the streets from the automobiles. Car parks are to be built outside the city centre. This process is planned to be carried out step-by-step and will take several years to complete.

Problem: Considerable traffic congestion.

Solution: Referendum to prohibit cars in city centre.

Strategy: Policy development.

Outcomes: • Expected reductions in traffic.  
• Alternative transport systems given priority.

Meeting transport needs

In illustrating different approaches to meeting transport needs, the next three stories demonstrate how enabling can bring about change.

Story 128 ■ Complementing transport facilities in Sweden

In the city of Sundsvall, Sweden, community leaders noted that the public transport system was not meeting the needs of the elderly, the handicapped and parents with small children. Special buses adapted to transport people in wheelchairs were purchased by the municipality and used on routes passing housing areas, the city centre and health care
facilities. Drivers were expected to help people and to allow extra time for getting on and off the bus.

**Story 129** Village "playbus" for children in England

In England voluntary agencies identified the special needs of isolated women with young children living in rural villages. A local authority responded by providing a "playbus" to visit isolated villages once a week to collect the women and young children. Supervised play facilities were provided in the bus which took the women to a shopping area.

**Story 130** Supermarket bus for the elderly in Canada

In Toronto, Canada, in the 1970s the provincial government planned a series of highways connecting the centre of the city to the suburbs. In response, several community groups formed to prevent the planned highways from dividing local communities and neighbourhoods. Local residents had meetings, lobbied politicians and even planned to physically block the building of the highways. The community groups were also concerned that the elderly were isolated in apartment buildings as they were unable to walk to public transport. A coalition of representatives of the elderly, community nurses, politicians, housing agencies, public transport and supermarkets was formed. They devised a scheme whereby buses would collect elderly people every Friday and take them to supermarkets. The scheme has now operated successfully for 15 years.

**Road safety**

Road safety is an issue for all countries. In India the majority of deaths and injuries involve vulnerable road users — pedestrians, cyclists and users of motorized two-wheeled vehicles. The number of road accident deaths in India increased from 4500 in 1960 to more than 50000 in 1990. For every death another 10 people suffer serious injury and many of these experience permanent disability.

*The value of alliance building*

A useful strategy to promote greater road safety is to bring together multisectoral groups with a common interest in road safety. The next stories are two of the many examples from all over the world illustrating how this approach has proved successful.

**Story 131** Safety barriers prevent accidents in New Zealand

In New Zealand the Accident Compensation Authority and government agencies for health, sports and recreation joined with local authorities,
the disabled people's assembly, commerce and consumer affairs groups
to share information and plan common projects. One successful project
was the construction of curved barriers more than a metre high between
opposite lanes on highways to prevent serious head-on crashes at high
speed.

**Story 132 ■ Campaigning together in Trinidad and Tobago**

A coalition of interested groups played an essential role in a road safety
campaign in Trinidad and Tobago in 1991. An advertising agency
helped promote the campaign's messages and found sponsors such as
insurance companies, owners of car fleets, driving instructors and sup-
pliers of automobile parts. The medical association helped give the
campaign media attention and the government traffic management
agency followed up with transport activities. Private practitioners and
public health nurses displayed posters and advised parents and parents-
to-be on safety issues while educators developed educational materials
for primary schools. There was a weekly media supplement for adults
and children, and local authorities also backed the campaign. An im-
portant element of the campaign was the formation of an intersectoral
committee with representatives of motor vehicle insurance agencies,
drivers' associations, health bodies, police, and NGOs. A major advance
was the restructuring of the police accident reporting form so that
collision data could be linked with a motor vehicle registration database
and insurance claim data.

**Story 133 ■ Visibility and safety**

An example from India shows the importance of involving all concerned
parties in decision-making on road safety. The three-wheeled scooter
taxi in cities such as Delhi were painted black and the fact that it was
difficult to see them at night was thought to be a contributing cause of
their high accident rate. Academics at the Indian Institute of Technol-
ogy suggested that the simple procedure of painting the taxis yellow
might reduce the accident rate. The issue was referred to a committee
that was planning for the forthcoming Asian Games. The committee felt
that visitors to the games would appreciate the newly painted taxis, so a
decree was issued that all the scooter taxis be painted yellow within one
month. As a result the drivers (who were to be responsible for the
painting) staged a two-day strike. After negotiations a compromise was
reached and the drivers agreed to paint the top half of their taxis yellow.

Problem: High accident rates of scooter taxis.

Solution: Scooters made more visible.
Strategy: Enabling.

Outcome: Taxis more visible to reduce accidents.

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**Story 134** ■ Child car seat law passed in Israel

In Israel an organization of women volunteers realized that because children under five years were not routinely strapped in child safety seats during car travel there were high rates of child mortality, disability and morbidity as a result of car accidents. Groups of women volunteers throughout the country provided information on the problem and promoted the use of child safety seats. They lobbied for a change in the law to make the use of the seats compulsory. In 1991 the appropriate law was passed.

Drinking and driving

Alcohol-related accidents and diseases account for a tremendous amount of premature mortality. From automobile accidents alone, hundreds of thousands of persons die each year.

**Story 135** ■ Mothers lobbied successfully against drinking and driving in the USA

In the USA, a woman whose teenage daughter was killed by a driver who had been drinking founded Mothers Against Drunk Driving and put pressure on the courts for more severe sentencing of drink-drivers. Within three years the movement had developed so much momentum that its effects were seen in a number of states. Private funding was raised and used for campaigns against drinking and driving. A change in attitudes to drinking and driving was widely seen and hosts began to realize their responsibility for intoxicated guests who wished to drive home.

**Story 136** ■ Breweries offer alternative in Ireland

In Ireland there is a growing realization of the problem of excess alcohol consumption. There used to be few non-alcoholic or low-alcohol drinks on the market. After some consumer pressure and an attempt to create consumer demand, the breweries started to produce a wide variety of non-alcoholic drinks which were accepted and welcomed in different social settings.

Problem: High consumption of alcohol at social events, with insufficient availability of non-alcoholic or low-alcohol drinks.
Solution: Better assortment of non-alcoholic and low-alcohol drinks on the market.

Strategies: • Enabling (alternatives offered).
• Advocacy.

Outcome: Producers now manufacture a variety of non-alcoholic and low-alcohol drinks.

**Story 137 ■ Don’t drink and drive in Sweden**

Sweden was one of the first countries to introduce legislation on drink-driving, when in 1941 a legal limit of 0.8g/1 (0.08%) blood alcohol concentration was introduced for drivers. In 1957 the limit was lowered to 0.5g/1. It has been calculated that a blood alcohol concentration of 0.5g/1 increases the risk of an accident fourfold and a blood alcohol concentration of 1.5g/1 increases the risk 40-fold.

For a long time, widespread propaganda led people to believe that two beers were enough to get close to the 0.5g/1 limit. However, a demonstration to Members of Parliament, the Ministries of Justice and Transport and other decision-makers showed that a person could have a drink before dinner, half a bottle of wine with the meal and a brandy afterwards without exceeding the limit. Persons taking part in this demonstration clearly felt the effects of the alcohol when tested in a sophisticated driving simulator after dinner. The fact that one could drive legally after such consumption of alcohol was unacceptable to most people. News media willingly reported the facts and kept the debate going. Polls indicated that most drivers supported a reduction of the blood alcohol concentration limit, and even a zero limit "in principle" (meaning a limit which, with a generous margin, would allow the consumption of low-alcohol beer with a meal). The final vote in parliament in 1990 resulted in a blood alcohol concentration limit of 0.2g/1 for driving a motor vehicle in Sweden.

In 1990, a total of 440 motor vehicle drivers were killed in Sweden. Among these at least 25–30% had been drinking. Still, Sweden is considered to be relatively successful in preventing drink-driving, probably because of the following:

• Legislation is strict and there are rather harsh punishments for drunken driving. This has been the case for more than 50 years, which means that several generations of drivers have accepted the norm of alcohol or driving.
• Restrictions on availability limit the sale of alcohol to the state retail monopoly and licensed bars and restaurants,
• Prices are kept high by heavy taxation, levied according to the alcohol concentration of the drink.
• It has become usual for a driver to ask for — or be offered — non-alcoholic beverages at a party.
• Public attitudes to drink-driving are negative and many people consider drunken driving to be a very serious crime.
• Enforcement of drink-driving laws is strict. The Swedish police, prosecutors and the courts consider drunken driving to be a very serious road safety problem and consequently there is no reluctance to enforce the legislation.

Problem: Accidents and injuries caused by drivers with legal blood alcohol concentration.

Solution: A demonstration to show decision-makers the effects of legal alcohol consumption.

Strategy: Regulation (based on research findings).

Outcomes: • Parliament lowered the blood alcohol concentration limit
• Greater public awareness and support, less drink-driving.

Story 138 ■ Common keys to creating a safe community in Thailand and Sweden

A story from the village of Wang Khoi in Thailand and the town of Lidköping in Sweden demonstrates that there are common keys to creating a safe community. Yet there are also important differences between developing and developed countries in terms of both the problems and the applied solutions.

Wang Khoi is a small village in the central part of northern Thailand. In late 1985 the Nakon Sawan Research and Development Project encouraged the establishment of a village committee to mobilize local resources. An investigation into the main health problems of Wang Khoi found both communicable and noncommunicable diseases. But when problems were listed by priority, accidents ranked the highest.

An extensive accident prevention programme was started. The next step was to look at the traffic problem in view of the fact that a new road had been built through the village, which meant that vehicles travelled faster. Village health volunteers collected information on all village accidents and reported to the health centre. The village committee used the information as a basis for planning and decided to start a campaign regarding traffic safety. This began with a slogan campaign on impaired
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driving and also included a reflector stickers campaign to encourage owners to fit reflectors to their vehicles. The committee also devoted much effort to a pedestrian safety campaign.

The Wang Khoi project is not designed to be a basis for documentation or for evaluation of results. It is possible, however, to follow the rate of injury through statistics from the health centre. The total number of injuries is showing a steady decrease.

Lidköping is a town of about 35,000 inhabitants and has been named as a “safe community” in Sweden. This was because it was part of an accident prevention programme, which led to a substantial reduction in injuries. An overall decline of 28% for home, work and traffic accidents was achieved within two years. The accident prevention methods applied in Lidköping related to four areas — information, training, surveys and environmental change. An information campaign on use of cycle helmets attracted a lot of attention.

The municipality’s home help service employees provided safety training to elderly people. A modern accident surveillance system is now in place. Environmental changes have been made in playgrounds, gravel pits and cycling roads to schools.

The programmes in Wang Khoi and Lidköping seem to be governed more by local conditions than by the original intentions of the accident preventers. Successful development of programmes depends on finding the right people and organizations and making the local population enthusiastic rather than on external economic and other resources.

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Problem: Accidents a major health problem.

Solution: Accident prevention programmes started.

Strategies: • Enabling (local committee established).
• Advocacy.

Outcomes: • Decrease in injuries.
• Accident prevention programmes established.

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**Congestion, pollution and loss of amenities and land**

Local government subsidies of public transport were introduced in several cities in the United Kingdom with the purpose of reducing the use of private cars and the congestion and accidents they cause. The result was a decrease in the price of public transport by 50%. However, the number of cars and accidents did not decrease. What happened was that many more vulnerable people (the elderly, mothers with young children, the unemployed) used the public transport system. It was con-
cluded that the approach was worth while, but that additional measures (such as making drivers pay the full cost of parking places in the city) would be needed to reduce car use, traffic congestion and accidents.

Stories 139, 140 and 141 show how enabling can be strategic in reducing traffic problems. Creating awareness is the main strategy for change in stories 142, 143 and 144, while building alliances is the main strategy in stories 145 and 146.

**Story 139**  ■ Taxing drivers in Singapore

Singapore successfully implemented policies to reduce traffic problems by:

- making drivers of cars with fewer than four passengers pay a hefty fee to enter the central business district before 10:00;
- allowing car owners who use their cars only on weekends to pay a much reduced motor vehicle licence fee and road tax;
- constructing an underground rapid mass transport system.

Similar measures have also been implemented in cities in Australia, Japan and Sweden. Often cars and trucks are completely banned from part of the city, creating a pleasant and safe "island" — free of noise, hazards and pollution — for the enjoyment of pedestrians.

**Story 140**  ■ Rewarding bus use in Canada

When the Quebec provincial government cut subsidies for public transport in 1991, local authorities and environmental groups pressed for similar cuts in subsidies for the cost of parking for civil servants’ cars. As an extra incentive for government employees to leave their cars at home, a free bus pass was provided for a limited period. The pass was called "the green passport" and was intended to give a positive image to public transport as contributing to pollution reduction.

**Story 141**  ■ Recycling waste to make fuel in New Zealand

In 1980, a Christian community at Springbank in New Zealand established a biogas plant for producing vehicle fuel and fertilizer for the community's own use. Since then, it has been producing 164 litres of methane gas as vehicle fuel per day — enough to drive a fleet of 15 vehicles, including two converted diesel tractors. Some vehicles have travelled more than 100,000km on biogas methane. The methane digester is fuelled by animal waste and poultry manure.

Running on methane, tractors develop 10% more power and 20% more torque than they do on diesel, which means they can plough faster. The most noticeable difference between an engine running on methane
and its petrol equivalent, however, is that the oil in the methane engine will remain clean-looking almost indefinitely. It takes about 10000 hens to produce enough waste to drive a methane digester, which means that many commercial dairy and pig farmers could produce fuel in this way.

**Story 142** ■ Changing attitudes to cars in the Netherlands

Nearly every country suffers traffic delays. In the Netherlands their cost was estimated at US$2.8 thousand million a year and, with a predicted 70% growth in car use over the next 20 years, the problem can only get worse. One impediment to the necessary investment in public transport to counter traffic chaos is the unquestioned devotion to cars as the preferred method of transport. To change attitudes a US$1 million advertising campaign, a “campaign against love for the car”, was launched that urged people to “break their bond with cars”. Techniques of humour and exaggeration were used to raise awareness and change attitudes.

**Story 143** ■ Epidemiology for change in South Africa

Prior to 1986, South Africa had a high level of lead in petrol (0.836g/l), associated with high lead levels in the air of urban areas. A university department of community medicine carried out a study to document the impact of exposure to petrol-derived aerosols on the blood lead levels of schoolchildren. It found that children at schools in areas where traffic was dense had significantly higher blood lead levels than other children. After the issue received media attention, it was addressed at the highest level of government, and the lead content of petrol was reduced to 0.4g/l.

**Story 144** ■ “Balance sheet” on pollution in Sundsvall

One approach to the issue of pollution from transport is the use of an annual environmental audit or “balance sheet” to raise public awareness and to spur decision-makers both to consider the consequences of transport decisions on the environment and to seek environmentally sound solutions. In Sundsvall, Sweden, the annual environmental audit includes measurement of noise, air pollution, accidents and other adverse environmental consequences of transport. The environmental audit is publicized each year.

**Story 145** ■ Keeping heavy traffic out of residential areas

in New Zealand

In New Zealand local community groups established a successful partnership with traffic authorities to tackle the problem of heavy traffic and
speeding cars in a residential housing zone. Traffic passing through the area was encouraged to stay on the main road by ensuring that traffic lights changed in sequence. Cars in the residential zone encountered longer waits at traffic lights, as well as speed-restraining devices such as traffic islands.

**Story 146** In Italy and Turkey, communities mobilize against highways

In hilly and mountainous areas the cost of highway construction is high because of the need to build bridges and tunnels. The cheapest option may be to build the highway through good agricultural land in the valleys. In both Italy and Turkey, numerous citizens' associations, environmentalist groups and farmers' associations have joined in opposition to the loss of agricultural land through highway construction.

**Conclusions**

Transport is a vital component of a supportive environment for health, and various effective strategies and tools are identified in the above stories. A number of steps for action are suggested:

- to develop visionary policies and to lobby for strong political commitment;
- to identify issues based on both a technical and professional perspective and on citizens' concerns and requirements;
- to initiate and take advantage of technology and product development (safety belts, road construction, helmets, alternative fuels, etc.) as major components of "passive" prevention;
- to build agreement on priorities;
- to use legislation and regulation as appropriate;
- to establish a local point or office that can monitor effectiveness and efficiency of the transport system in terms of access, equity, environmental and health impacts, and social impacts;
- to build alliances with many groups and organizations to promote action;
- to formulate and carry out an action plan, and to evaluate progress.

Attention must be given to the development, design and use of new and alternative technologies, to make buses, cars and trains quieter, safer, less polluting and less demanding of non-renewable resources. Economic incentives can encourage the use of these alternative technologies. Some priorities for transport policy have been identified. These are relevant in many countries and can be taken up immediately by local or national networks and alliances. Such transport priorities
include the protection of pedestrians and cyclists by provision of adequate paths and cycle-ways, with concomitant restrictions on motorized vehicles in urban areas, and provision of better local public transport.
CHAPTER 11

Social support and care

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

(“Ottawa Charter for Health Promotion, 1986”)

Issues and problems

Individual and community actions are influenced by social institutions and norms such as are related to religion, culture, politics and economics. Such influences have implications for health and must be understood and used by health educators as entry points for influencing health behaviour in a positive direction.

It is increasingly recognized that supportive environments — which include physical, social and psychological dimensions — provide conditions conducive to healthy lifestyles. Knowledge and attitudes about healthy living are often not sufficient to lead individuals and communities to practise healthy behaviours.

Public health practice in earlier times focused on providing services and educating people about health. The need for equal emphasis on social support is more recent and adds a vital element to ensuring individual and community action for health.

Stories from around the world illustrate that social support is being provided to meet health and related needs of groups everywhere. Though these examples refer to small and specific groups, they provide sufficient insight for replication and wider application.

Whether it is the Aging Society in Muang Phon village in Thailand, which raised self-esteem and cared for children, the impromptu banding together of women in a tribal community in India to persuade the government to deal with alcohol dependence among their men, the

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1 See footnote, page 22.
“small house” experiment to help Finnish alcohol abusers rehabilitate themselves, self-help groups for sexually abused women in Sweden, improvement of sanitation by Kenyan women, or persuading reluctant Guatemalan mothers living on rubbish dumps to use the health centre for themselves and their children — these stories open many windows for others to see what is happening around the world to promote health by strengthening supportive environments. The stories describe the target groups to whom support was directed, the needs that were addressed, the ways and means by which support was provided and the outcomes that resulted. They also draw attention to options for action, to ways of solving problems and addressing pressing issues, often in situations where choice seems limited. The lessons that can be learned from these stories about providing support to communities are identified and discussed.

The concept of social support as a component of health promotion was highlighted in the 1970s to describe positive social relations between individuals, groups and communities. Social support for health involves interaction through which people give and receive mental, emotional, informational, material and operational support that leads to better health.

Social support aims to help people gain control of factors that promote health and reduce factors that cause social strain and disparities. Some social networks exist naturally — like families. Others are informal networks formed at the initiative of individuals or groups with a common commitment — like voluntary organizations. Yet others are formal networks instituted by the state as part of national policy.

Common issues faced by communities the world over include:

- social inequity in access to basic socioeconomic needs;
- economic injustice perpetuating poverty;
- lack of access to information;
- discrimination on the basis of minority status, ethnic origin or sex;
- exclusion of people from decision-making and participation;
- inadequate care of chronically ill or disabled people;
- insufficient care and support for vulnerable population groups such as children, the elderly, and those who are unemployed, poor or disadvantaged.

These issues need to be addressed. People cannot live in isolation; there is a need for social networks that function well and for a society that is both sensitive to people’s needs and willing to meet those needs. The focus must be on taking sustained steps to make the environment supportive rather than simply responding in a piecemeal fashion to emergencies.

Social support can be viewed as being provided at primary, secondary
and tertiary levels. The primary level support structure includes a person’s family and close friends; the secondary support structure includes friends, relatives, neighbours and those with whom one works; while the tertiary support structure includes personnel from government, the private sector and voluntary agencies.

Primary level support is most important and must be strengthened where urbanization and other social changes are eroding it. The immediate circle of family and friends can give the emotional, mental and operational support needed, in particular to growing children, the sick and the elderly. The right quality and timing of social support are vital for successful care, especially when a person’s own capacity to cope has been reduced. One must, however, avoid excessive support or support given at the wrong time.

Secondary and tertiary level support structures are established and developed according to the beliefs, cultural norms and ideologies prevalent in a community. Concern for others is the key to providing social support. Advocacy for political commitment to social support by the state is also an important step towards strengthening tertiary support in a country.

Activities and solutions

The stories in this section are grouped under the following headings:

- Community initiatives
- Vulnerable groups
- Women and self-help groups
- Empowering
- Political commitment, advocacy, alliances.

Community initiatives

Story 147 Local groups promote health in Norway

In Norway, national NGOs with local structures offer education on health promotion to members of health associations in their area. This came about after seminars were held to train volunteers from these organizations who wanted to educate others. Trainers interviewed representatives of the NGOs to get a picture of the organizations and their budgets. The project encouraged the involvement of local groups, volunteers and members of health associations. The community groups raised money through lotteries, donations and fund-raising activities such as fairs and dinners. Many organizations concerned with disease are now recognizing the need for prevention and health promotion. The Tuberculosis Association, for instance, focuses on health promotion in addition to early detection and prevention. A lot of money was initially
raised for the treatment of tuberculosis but now the organization is taking a wider view and deals with heart disease and disease prevention. This is an example of how some health institutions are widening their focus to include the creation of environments that are supportive of health.

Problem: Volunteers in NGOs and health associations at local level lacked knowledge and skills in health education. A cure-oriented approach to disease prevailed.

Solutions: Involvement of local groups, volunteers and members of health associations. Training of volunteers.

Strategies: • Empowering (volunteers learn health education skills).
• Enabling (resources mobilized).
• Building alliances.
• Reorienting organizations.

Outcomes: • Involvement and empowering of local groups, volunteers and members of health associations in health promotion.
• Reorientation of health organizations from cure to prevention, promotion and health-supportive environments.
• Mobilization of funds.

Story 148 ■ Sri Lanka’s Sarvodaya Shramadana Movement

The Sarvodaya Shramadana Movement is a nationwide nonpolitical voluntary organization that draws on the philosophy and religion of rural Sri Lanka. The movement had its beginnings nearly 40 years ago when a group of teachers and students worked together on community development projects in economically depressed and remote villages. Villagers and trained helpers identified the most urgent needs of the village that could be met with local labour and resources, such as building of an access road, repair of a water tank or creation of an irrigation scheme. The movement first focused on village awakening, then national awakening and now hopes for world awakening.

Various training courses for village people teach skills in agriculture, carpentry, metalwork, bamboo and rattan work, batik-making, printing, photography and running preschool care centres, village kitchens and creches. Children’s libraries and small industries are also run by the movement. Cooperative farms around the country are used for youth training courses, youth settlement schemes and marketing. The creches, preschool and community kitchen projects have a positive impact on children’s health and are supported and run by local families.
Sarvodaya means welfare of all and shramadana means sharing one's time, thoughts and energy for the benefit of all. Though the philosophy of sarvodaya was inspired by Buddhism, it has been adapted and adopted by other cultures. Sarvodaya groups have been established in Belgium, Canada, the Netherlands and the Philippines. The work of the Sarvodaya Shramadana Movement supports the programme activities of the government at community level. It is recognized as a valued voluntary agency and has attracted external funds.

Problem: Economically depressed and isolated villages.

Solution: A nationwide, nonpolitical NGO focused on traditional values.

Strategies: A nationwide approach to mobilize human and other resources to support government development activities. Training of different forms to prepare adults and children to undertake community service. Commitment to service is the crux of this movement.

Outcomes: • Village awakening
          • Social barriers broken down
          • Village development activities undertaken through self-help.

Vulnerable groups

Story 149 ■ Runaway House for young people in Finland

Particularly in large towns there are children and adolescents whose family ties have been broken and who have not developed lasting ties with anyone else. For these young people, getting a safe place to live may be a decisive step in handling a critical situation. For this reason the Finnish Red Cross launched the Runaway House project which offers accommodation to young people in a crisis. The project is supported by the Finnish Siot Machine Association.

The Runaway House is intended for young people under 18 who need temporary accommodation. The house accommodates eight people and is usually open overnight from 17:00 to 10:00. The residents are given a meal in the morning and evening. Alcohol and drugs are prohibited on the premises and residents are not allowed to bring guests to the house. Parents are given support and guidance. The telephone service works 24 hours a day.

During its short period of operation the Runaway House in Helsinki has demonstrated that it can perform an important function. In helping young people solve their problems, cooperation with various authorities has proved vital. Runaway House tries to ensure continuity of care by
finding the type of service appropriate to each teenager. A group of experts has been formed to evaluate the project, and a follow-up study is planned in collaboration with the National Board of Social Welfare. If assessment indicates positive results, the scheme may be introduced in other large towns as well.

**Story 150**  
**Reaching out to street children in Brazil**

For 7 million children, the streets of Brazil’s cities and towns are their home and workplace. The youngsters are everywhere — shining shoes, washing taxis, guarding parked cars, sorting through garbage for plastic bottles. Many people, however, prefer not to acknowledge the children’s existence, and some authorities treat them only as delinquents or misfits. Street children have even been systematically killed by death squads.

Throughout Brazil, many community-based organizations sponsor programmes to help street children find ways of earning a living and, at the same time, maturing intellectually, socially and emotionally. In 1981, UNICEF, the Government of Brazil, and the National Child Welfare Foundation began the Brazil Street Children Project to pool the knowledge gained by these diverse bodies. They hoped to increase public awareness of the children by broadening community involvement and by making government response more effective.

The 70 programmes directly involved in the joint project have different philosophies, objectives and activities, but they share several features: each seeks to gain the child’s confidence and build a solid bond between child and programme, providing meals, income-generating activities, health care and discussion groups. Some programmes also offer formal training or employment. From their inception, the educational methods being used have placed primary emphasis on the child as decision-maker.

A 1986 evaluation of the Brazil Street Children Project, using such indicators as social skills, career skills, personal growth and moral values, found that the most successful programmes responded to the children’s own needs, the first of which is income. The Salão do Encontro in the city of Betim, Minas Gerais, for example, produces home furnishings and employs more than 350 young people. The production process is labour-intensive and emphasizes the use of local resources. Besides manufacturing the products, young people actually manage the enterprise. The Salão do Encontro tries to build self-esteem among the children on the basis that confidence creates a secure foundation for personal growth and development.

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**Problem:** Critical situation of children and adolescents in large cities, without family ties and community support.
Solution: Projects to help the young people find accommodation and earn a living.

Strategy: Building alliances (different agencies provide joint approach in giving social support to young people in need).

Outcomes: • Shelter and emotional support for young people
• Self-esteem creates foundation for growth and development.

**Story 151** ■ Active parenting programme in Canada

In Canada, the Native Infant Programme on Active Parenting (NIP) is an example of local participation and community control. In 1981, concerned with high drop-out rates from child care clinics, Canadian indigenous groups in five reserves on Vancouver Island, British Columbia, initiated NIP to improve early childhood development. The programme incorporates indigenous child-rearing practices and traditions, and emphasizes the training and employment of local indigenous personnel as infant development workers. NIP relies on mothers, whose active participation in the teaching and early stimulation of the child is considered to be the key element for the success of the programme. Various agencies (such as government and university) collaborate in the programme but the community controls all aspects of it, including training. A salient feature of the programme is that its workers have greater and more frequent access to families and may have more influence on certain families than other professionals.


Solution: A programme by local authorities to promote active parenting.
Training of local persons as infant workers.

Strategies: • Enabling (mothers take an active role in the welfare of their children).
• Raising awareness (of appropriate and essential resources).
• Mobilizing (resources).

Outcome: Community control of a successful programme.

**Story 152** ■ Voluntary home care for long-term patients in Finland

In Finland, the proportion of old people and chronically ill patients has increased. Today, 12% of Finland’s population is over 65 years of age. Moreover, many younger people have been forced to retire on a disabil-
ity pension because of mental health problems. In 1984 a project was started to train voluntary helpers to support long-term patients and their family members. The project aimed to foster an atmosphere favourable to home care by organizing courses and evening meetings for family members, by establishing cooperation with the authorities and the Finnish Red Cross and by building functional relationships for continuing activities.

The staff of health care centres, mental health clinics and social welfare offices trained volunteers in an 18-hour basic course.

The project was initiated by the North Savo District branch of the Finnish Red Cross. Social and health care workers, parishes and the local Red Cross organizations of the towns of Kuopio, Isalmi, Varkaus, Karttula, Kiuruvesi, Nisiiä and Tuusniemi were involved.

As part of the project, 154 volunteers took part in "friendship activities", regularly visiting long-term patients or elderly people. During the evenings 53 people participated as family caretakers. In addition, 80 family members attended regular evening sessions. The project officially ended in 1988, but some of the volunteers have, of their own accord, continued looking after long-term patients and elderly people at home. Care-givers felt the teamwork was both refreshing and necessary.

Problem: An increasing number of long-term patients at home.

Solution: Voluntary helpers trained to provide home care.

Strategies: • Enabling (volunteers help in the home care of long-term patients).
  • Mobilizing (local human resources).
  • Building alliances.

Outcome: Cooperation was established between family members, authorities and an NGO, and continued after the project had ended.

Story 153 ■ Thai Aging Society moves bodies and minds

Elderly people in certain Thai villages felt that their life had become monotonous. A programme called the Aging Society was introduced in Muang Phon village and included regular group physical exercise for old people. Two forms of exercise were used: Singaporean aerobics and Chinese Tai Chi. The Aging Society grew rapidly to several hundred members. The society gave its members a social support mechanism that promoted personal and community health and, most importantly, social solidarity. There were three major forms of psychosocial support: emotional support, esteem support through which members, individually
and collectively, could perceive themselves as valued, and network support which helped members see themselves as having a clear role in a system of relationships. The society soon generated other activities such as getting involved in child care, eating together once a month, going on study tours together, and working as volunteers in local hospitals. Later the Aging Society also started to disseminate these ideas to other communities. Other village groups joined in similar efforts.

The Aging Society had several important features. The movement developed out of a common personal need among members of one community group but had a subsidiary impact on the community at large. The society utilized a “learning by example” strategy taught by peers; it instilled feelings of confidence, social solidarity and achievement; and it incorporated certain social, cultural and religious values.

Problem:  Monotonous life for the elderly in Muang Phon village

Solutions: Establishment of a society for the elderly, focusing on physical exercise. Later members were involved in child care, eating together, going on tours and working as hospital volunteers.

Strategies: • Empowering (through networking with elderly people, families and organizations).
• Mobilizing (local human resources).

Outcomes: • Feelings of confidence, solidarity and achievement in the elderly.
• Actions incorporated religious, social and cultural values.
• Increased self-esteem and worth.
• Community needs of child care and patient care served.

Women and self-help groups

Story 154  ■ Kenyan women improved village sanitation

In Mabati village in Kenya, women’s self-help groups were formed in 1986 to tackle water shortage, poor housing and poor sanitation, with the aim of reducing diarrhoeal diseases. The women raised money to improve housing and latrines and to build water tanks. Women contributed money and carried out some of the work. Those involved were community leaders, community members and environmental health staff. The result was that better houses were built, and water tanks and pit latrines were constructed. For 60% of the year villagers now have clean water near their homes. Every month the group voted on which families should benefit next from the self-help programme.
Problem: Poor housing and sanitation, lack of water, diarrhoeal disease.

Solution: Creation of women’s self-help groups.

Strategies: • Mobilizing (women’s skills and other resources).
• Empowering.


Story 155 ■ Consciousness training for battered women in Sweden

Sexual violence against women is a growing problem around the world. A network of emergency shelters for battered women in Sweden initiated consciousness training groups in 110 towns. Each group comprised 8-10 women who had been physically or sexually abused. A thematically structured programme aimed to enable the women to share experiences, give each other emotional support, acquire more knowledge and act to change circumstances. The programme helps women change their situation.

Problem: Increasing numbers of physically and sexually battered women.

Solution: NGO organized consciousness training groups for battered women.

Strategy: Empowering (through building alliances and gaining awareness).

Outcome: Improved availability of support and options when faced with domestic violence.

Story 156 ■ Sex workers as educators in Norway

Two female sex workers were paid by the health directorate in Oslo to educate their colleagues about safe sex and the use of condoms. This approach started at state level and was later taken up at local levels as well. The women involved were paid and became health educators.

Problem:Unsafe sex among sex workers.

Solution: Peer education by colleagues.

Strategy: Peer skills have been developed and used to educate sex workers about safe sex.

Outcome: Opportunities provided for risk reduction.
Story 157 ■ Indian women get together to combat alcohol problems

In a tribal community in central India, where alcohol consumption among men was high and associated problems evident, an NGO raised the awareness of the community and encouraged action to deal with the problem. Women in the community banded together to prevent the easy availability of alcohol. They persuaded the district authorities to ban alcohol in some places and reduce its sale at other outlets. Those who drank too much were fined. However, alcohol is still sold and the problem has not yet gained the attention of the state legislature.

Problem: High alcohol consumption among men.
Solution: An NGO raised awareness and encouraged action.
Strategies: • Raising awareness (in the community).
• Policy development.
Outcome: Reduced availability of alcohol.

Story 158 ■ Danish self-help groups for people in crisis

In Denmark local self-help groups have been organized over the past five years. They aim to help people facing crisis — due to the loss of a child, illness, divorce and so on. Knowing that family networks have been weakened over the years, individuals have privately established groups that can help. Various problems are discussed in these groups and help is provided to members. Some groups are funded by the government or by organizations such as the Cancer Society.

Solution: Self-help groups at the local level to assist people in crisis.
Strategy: Building alliances (between local self-help groups).
Outcome: Creation of new social networks providing social support in vulnerable situations.

Story 159 ■ New self-help movement for alcohol abusers in Finland

In the “small house” experiment in Sirkkulanpuisto, Finland, isolated people are given a rented apartment and support from peers. Assistance
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from the authorities is as discreet as possible. Material resources of the
society that runs the experiment include an old wooden house in the
centre of town and a leisure activity centre by a lake in the suburbs, plus
a small bus and a truck. The house in the town centre provides tem-
porary shelter, a sauna, shower, laundry, kitchen and companionship. The
only requirement for entry is that the person is neither violent nor
drunk. Those in need of support are mainly people who are retired, have
problems with intoxicants, have a criminal record, or are mentally ill,
homeless or unemployed. Support groups consist of people from a
range of occupations and backgrounds. With the help of the housing
authorities and with loans from the town of Kuopio, 10 one-room apart-
ments have been built at the community’s lakeside site. The residents’
health and progress are monitored by the University of Kuopio.

The Sirkkulanpuisto self-help project started in 1983 and offers sev-
eral examples of the positive effects of friendship, help and collabora-
tion. The project’s participants are typically lonely, unemployed and
homeless. They are advised to use social and health services and directed
to religious and self-help groups for assistance.

About 80% of the participants reported in an interview that the
society had given them the support they needed — such as an apart-
ment, interests, and help with drinking and family problems. The
project has also been able to provide long-term unemployed persons
with temporary jobs.

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Problem: Alcohol dependence, homelessness.

Solutions: Preventive and curative work by government, with help from
NGOs and churches. A new kind of rehabilitation providing
shelter and leisure facilities with group support.

Strategy: Enabling (facilities provided for support groups).

Outcome: About 80% of participants acknowledge the society’s help in
their rehabilitation.

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Empowering

Story 160 ■ Comprehensive health education methods

Innovations to promote learning for health include the use of radio,
television, films, audio and video cassettes, community theatre and local
entrepreneurial initiatives. The promotion of learning for health can be
a complex, multisectoral network of activities that complement health
education in formal and informal educational environments and also act
independently to disseminate health information.
One such programme has been organized by the Zimbabwe Association for Community Theatre (ZACT) which undertakes health promotion, particularly an AIDS campaign, through drama. ZACT also works in schools, putting on performances with health promotion messages. ZACT’s method of working is to find out what issues a community faces, analyse those issues and write them into a script, perform the plays in villages and hold discussions after each performance. Discussion is provoked by questions about the play itself, and about the problems and solutions presented in it.

In Kenya, Theatre for Development is a new primary school project for the communication of health messages. Those involved include the Kenya Institute of Education, the Kenya Broadcasting Corporation (KBC) and the Ministries of Education, Information and Health. In some instances “folk media” are used, including traditional dance. Radio programmes have been produced in several Kenyan languages, such as Luo and Luhiya. These are discussed in schools by “radio listening clubs” which also use audio cassettes of the programmes. Many of the radio programmes were evaluated by UNICEF in 1989. KBC has also provided video cassettes of television programmes on health to polytechnics and teacher training colleges. Other videos have been prepared to train trainers. However, the main thrust has been through radio programmes and audio cassettes because they are cheaper to produce and distribute.

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**Problem:** The lack of relevant health information.

**Solution:** Health education complemented through formal and informal support.

**Strategy:** Building alliances (between official and unofficial bodies).

**Outcome:** Improved relevance of health knowledge.

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**Political commitment, advocacy, alliances**

**Story 161** | Consumer group action against pollution in the Republic of Korea

In the Republic of Korea, a consumer organization protested against a giant industrial company which was polluting a river with phenol. Public campaigns were organized, including a boycott of the company’s products. The company made a public apology and changed its manufacturing process. The consumer group has taken similar action on a number of issues, such as the use of plastic bags.

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Problem: A powerful industrial company was polluting a river.

Solution: A consumer movement organized public campaigns and boycotted the company's products.

Strategy: Mobilizing (the general public).

Outcomes: • The company apologized for pollution and stopped polluting the river with phenol.
• Success encouraged consumer movement to tackle other problems.

---

Story 162 ■ Anti-tobacco coalition in 18 countries

The Fundación Salud Public (FSP) is an anti-tobacco coalition that began in Argentina and has spread as a network to 18 countries of Latin America and the Caribbean.

The FSP seeks to confront the efforts of the tobacco industry to find new markets in the developing world. Before the FSP took coordinated action, the anti-tobacco lobby had little influence in Argentina. But then medical, social and community organizations created a coalition structured to promote community action, lobby against the tobacco industry and host the Eighth World Conference on Smoking and Health. Later, the Latin American Coordinating Committee Against Smoking (LACCAS) was formed. Representatives of the 18 countries meet annually, share planning and programme goals, publish a quarterly newsletter and apply joint political pressure to restrict the tobacco industry from increasing sales and advertising in Latin America.

---

Problem: Individual countries and NGOs in Latin America and the Caribbean were ill-prepared to take on the tobacco industry.

Solution: 18 countries developed a collaborative, pro-active response to counter the influence of the tobacco lobby.

Strategies: • Advocacy (for legislation against the marketing and sale of tobacco products).
• Building alliances (among NGOs within and between various countries).
• Empowering (of NGOs to confront a major industry).
• Mobilizing resources (through networking).
• Policy development (for example, LACCAS successfully influenced the Thai government to oppose tobacco industry pressure to begin cigar advertising).
Conclusions

This section describes some important approaches to social support and care.

• Awareness building involves drawing attention to existing problems, providing facts and figures as a basis for action and involving people in finding solutions.

• Encouraging self-help means stimulating people to determine their own future and raising their self-esteem.

• Community mobilization requires people’s active participation in diagnosing, planning, mobilizing and evaluating. Local resources are used, and there is a free flow of help, support, advice and information.

• Building alliances and networking can take place on many levels: among individuals (self-help), within the community, in informal groups, between communities, between national groups and authorities, and with international agencies that have common interests.

• Empowering and enabling individuals involve providing education, imparting information, giving training in skills, providing resources, allowing people to make decisions and respecting their contributions.

• Political commitment implies advocating, creating political will, taking decisions to address issues, solve problems and allocate the required resources.

• Mobilizing support may refer to material, financial, emotional or legal help for solving problems.
PART 3

Steps for action
CHAPTER 12

From analysis to action

As the Sundswall Statement (Annex 3) notes, supportive environments include the places where people live, work and play. Supportive environments include the framework that determines access to resources for living and opportunities for empowerment. Thus actions to create supportive environments have physical, social, spiritual, economic and political dimensions, all of them interlinked.

Part 1 presented some stories about efforts to create supportive environments. From the experiences in these stories were derived seven main public health action strategies which were summarized in the health promotion strategy analysis model (HELPSAM) (see page 22).

HELPSAM provides a structure for analysing experiences in creating supportive environments. It is an analytical tool for clarifying which strategies or other elements are essential for action. It provides an overview of combinations of different strategies. In Part 1, HELPSAM was used mainly for analysis; however, it can also function as a checklist in health planning. For every strategy option HELPSAM invites the activist, administrator or health planner to answer the questions “how?” (approaches, procedures and tools), “who?” (actors), “for whom?” (target groups), “where?” (levels/arena) and “to what end?” (expected outcomes).

Obstacles to be overcome

Part 1 discussed obstacles to the creation of supportive environments for health. There may be, for instance, a gap between people’s needs and available resources. Or there may be institutional weaknesses and financial constraints. Other obstacles may be psychological, social, economic or technical.

- Psychological obstacles can be overcome by commitment, belief in ideals, motivation and participation. Self-confidence and self-reliance are added forces that break down psychological barriers.
- Social obstacles can be overcome by an organization that is cohesive and draws strength from a strong commitment to social justice and equity.
- Economic obstacles can be overcome by identifying local resources
and mobilizing them effectively. Savings, lobbying for funds and adopting strategies and technologies that reduce costs are other ways of making economic gains.

- Technical obstacles can be overcome by seeking expert advice, undergoing training, using locally appropriate technology and conducting research to make technology compatible with local needs and resources.

At local level, organized groups of people can to a great extent overcome these obstacles, provided the political and social climate allows.

**We can do it!**

The stories in this book were selected from among over 1000 stories contributed by participants at the Sundswall conference. They can give us some insights into how supportive environments are built.

If we take a look at what lies behind the stories, several common factors emerge. Successful projects need a balance between formal knowledge and insight gained from experience. Other important elements are the need to keep people well informed, the need for innovation, the leadership that dedicated individuals can give, the integration of actions into everyday situations, and training that emphasizes practical skills. This does not represent a definitive guide to conducting successful health promotion. But since these factors are revealed in stories from all over the world, they should contain some hints that are worth considering in new projects.

The stories demonstrate that one has to work in a planned strategic way using a wide range of different approaches. Social and political processes are important to improvement of health in the community. Physicians and other health care staff have strongly advocated these strategies for a long time.

The main message of this book cannot be over-emphasized. The single most encouraging insight to be derived from the stories is that if something has already been done once it can be done again. Human beings have managed to make environments more supportive of health. This has been demonstrated again and again by experiences down through the ages and from across the globe. There is hope for human beings who long for better conditions. Evidence teaches us that there is an enormous — and largely untapped — potential in the accumulated experience of empowered human beings, not least on the local level where people can most easily become actively involved.

The conclusions drawn from the stories are strikingly similar. They can serve as directions for action. The similarities between developing and developed countries are generally found in the approaches that can be used. The stories also tell us that the differences between low-income
countries and industrialized countries are huge in terms of the kind and extent of problems encountered.

The material in this handbook thus supports the new public health approach — people-based, multisectoral, aimed at preventing disease and promoting health — and establishes its methods as the accepted norm of practice.

The supportive environments action model

Many processes involve identifying a problem, reflecting on strategies and acting to solve the problem. For health promotion this sequence has been described in terms of several different models. Here some of these models are synthesized as the supportive environments action model (SESAME). Whereas HELPSAM is used for describing, analysing and explaining a situation, SESAME (Fig. 3) facilitates action. HELPSAM and SESAME are complementary, not mutually exclusive or inter-changeable. In fact, each of the eight steps of SESAME could theoretically be followed in implementing each of the strategies in HELPSAM.

![Diagram of the supportive environments action model]

Fig. 3. The supportive environments action model
SESAME can be seen as a spiral model based on an orderly progression of steps in a time sequence. The model is open-ended so that the outcome can be assessed for future relevance. Some steps (such as setting targets, developing strategy and planning evaluation) have been combined in one item rather than separated because they should be carried out at about the same time. SESAME is based on participation by communities and individuals from the very first step.

In order to make the model easier to understand, the different steps are first described in general terms and then exemplified by following a hypothetical project through the various stages of the SESAME model.

1. Identify needs and problems

This is usually done on the basis of information obtained from epidemiological data, though it can also be based on a political agenda or general experience in the community.

Example

Tobacco is the main crop in a developing country that suffers from extreme food shortages. Arable land is used to grow tobacco instead of food. Furthermore, scarce trees are felled for firewood to dry the tobacco, leading to soil erosion, further shortages of firewood and environmental degradation. A programme is set up to combat the problem.

2. Build alliances

This means identifying and contacting potential partners, developing a shared agenda and clarifying the division of roles and labour among those involved.

Example

Alliances can be built by identifying potential partners, defining a mutual agreement or forming a network to develop a shared agenda for improving the food situation. Network partners might be found, for instance, within the education system, local government, transportation system and trade unions, or among farmers, crop developers, wholesalers and retailers in the food chain, and consumer groups.

3. Set targets, develop strategies, plan evaluation

Although targets are often set at an earlier stage, the SESAME model tries to take advantage of the experience of all participants and involve them in initial target-setting. Many of the stories confirm that this
approach facilitates implementation and can even strengthen the commitment of participants to fulfilling the goals. The targets may vary and may focus on overall effect, direction, the process itself, or on structural change. The task of developing strategies cannot be separated from that of formulating targets. At this stage, monitoring and evaluation activities should be planned and sufficient resources allocated for them. Planning the evaluation might involve designing a pilot project to assess the impact of the activities in a limited geographical area. The evaluation plan should be designed to take into account both the process and how best to obtain data. Evaluation can be internal, external or a combination of both.

Example

Targets might be to increase the variety of crops or to improve access to food, especially among disadvantaged groups in the community, with the purpose of improving nutritional status. Strategies might include approaching local farmers and finding incentives to induce them to grow crops other than tobacco. Evaluation of the plan should address how to secure data on the actual number of farmers engaged in tobacco production, as well as an assessment of present tobacco acreage.

4. Design implementation and mobilize resources

This involves planning activities, finding partners and mobilizing financial and other resources to carry out the programme, project or other planned activity. As organizations and people become interested and involved in the activity, it is likely to attract funding and other resources. By pooling these resources, implementation can be made more effective. This in turn gives added credibility which can make this a strategic time to give the programme more visibility.

Example

Designing implementation might involve initiating a pilot project. This could assess the environmental impact of the proposed activities in a limited geographical area as well as the implications for agriculture. The experience of the pilot project could in turn be beneficial in changing regulations, adapting the transport system to multicropping or gaining support for policy changes.

5. Implement activities

At this stage it is important to take advantage of resources that have been mobilized and start initiating desired change. External awareness and
visibility are encouraged, which means taking prompt action without losing momentum.

Example

Implementation could entail enlisting the help of people who are prepared to change and perhaps have proved themselves in the past. Realistic goals are needed for training, planting and setting up farmers’ cooperatives. There is a need to be flexible and open for reorientation.

6. Create maintenance structures

This is a transitional stage during which external support is slowly withdrawn and local ownership is encouraged. As such it is usually a vulnerable period. Developing a support system to maintain activities is of vital importance for long-term sustainability. This can involve the reorienting of existing organizations, setting up new structures, training, shaping opinion via media coverage, or producing newsletters or other materials. External professional support should still be readily available but on a consultancy basis.

Example

Before external support can be withdrawn, the aims of the partners who are involved, as well as existing organizations and structures, should be redefined as necessary in the light of changing needs. This might include reforming long-term policy objectives in line with new directions in farming. It could also entail the provision of assistance to a local farming cooperative to help it create its own structure. There might be the need for education of farmers and others to explain the rationale for change and how to bring it about. Simple manuals could be developed and demand created for them. A newsletter or other source of continuous updated information about activities ensures information exchange and builds a sense of purpose, loyalty and satisfaction. The project team should be available to give assistance as consultants if necessary.

7. Monitor and evaluate

In many programmes, a mechanism for continuous assessment of progress is built into the activities. It is crucial that this is done in a systematic way. Often the demands for evaluation from different parties may be unrealistic. It is therefore important to distinguish between evaluation of research and development programmes, and evaluation of health action programmes without a research component. Demands on research and development programmes are higher in pilot projects. For
other projects, much less costly evaluation models can be used. Advance agreements about requirements and areas of responsibility can facilitate this process.

Example

The evaluation can be based on the targets described in stage 3. Was crop variety increased? Did access to food improve, in particular for disadvantaged groups? Are there any signs of change in the nutritional status of the people? Has policy changed? How were different obstacles dealt with?

8. Renew, reinforce, reorient

Assessment and evaluation should be the basis for development and improvement of future activities. This can involve renewing, reinforcing and even reorienting an action programme. This is a dynamic and potentially repeatable process in all types of programmes. It is a characteristic of health promotion in particular.

Example

Here the task might be to increase pressure on policy-makers to decrease tobacco cultivation, to reorient the programme because planting certain alternative crops did not work, or to offer continued training to improve knowledge and overcome obstacles.

Involving men and women

Traditionally men make most planning decisions involving health promotion, including allocating resources and determining who should benefit from activities. However, it is often women who carry out the health promotion activities. There is a need to recognize and use women’s skills and knowledge in all sectors, including policy-making and the economy, to develop a more positive infrastructure for supportive environments. Women should have a much stronger voice in the development of health promotion policies and structures. A checklist can be useful for project planning. Questions to ask include:

- What are the roles of men and women?
- What is the division of labour between men and women?
- In their different roles, do men and women have equitable access to land, labour, savings/credit, skills and technology?
CHAPTER 13

Make your own handbook

This handbook has tried to show that people can make a difference in creating favourable conditions for health. But change cannot be brought about without active commitment. Each community has its own cultural norms and its own way of defining problems. The lessons of this book have to be adapted to local settings. People in different countries can compile national versions of this handbook based on specific local conditions and needs. Annex 4 contains advice on how to set up a national resource database for supportive environments.

If this handbook is a toolbox, the stories are the tools. They can help counteract ignorance, intolerance, fear and hopelessness. They can spark courage, cooperation, faith and joy. The stories may help readers to think about their community’s problems in a new way. Or they may show readers that others have the same problems and that solutions are possible.

Similarly, a reader may help to inspire others by recounting stories from his or her community. In the process of developing handbooks and creating supportive environments for health, the resource centre of the Sundsvall conference is available as an international clearing-house for collecting and exchanging experiences worldwide.

You are invited to share your experiences with others. Use the form on pages 177–182 when sending in stories. It is particularly important to highlight the main strategies used, because strategies can be adapted to a wide variety of settings. Each of us — policy-makers, administrators, school personnel, parents, students and community leaders — has an important role to play in creating supportive environments for health. The time to begin is now.
Share your experiences

Please type or use block letters

A. Title of project/experience/activity

[Space for text]

... Separate project
... The project is part of a larger programme/activity, namely

[Space for text]

Planned project ... Project in progress ... Completed project

B. This information is provided by (name)

Organization
Address
Postal or zip code ... City, Country
Tel. (including country and area code)
Telefax (including country and area code)

C. Project leader (if different from the above)

Organization
Address
Postal or zip code ... City, Country
Tel. (including country and area code)
Telefax (including country and area code)

D. Contact person (if different from either of the above)

Organization
Address
Postal or zip code ... City, Country
Tel. (including country and area code)
Telefax (including country and area code)

E. Collaborative partner(s) (Note: If there are several, continue on a separate piece of paper)

Organization
Address
Postal or zip code ... City, Country
Tel. (including country and area code)
Telefax (including country and area code)
Twenty questions about projects on creating supportive environments for health

1. Abstract
   Briefly (maximum 15 lines) describe the project. (Cover key information on questions 2 to 20, i.e. aim/objective, how the project was carried out [method of implementation], where and by whom, results and experiences, conclusion and recommendations for the future.)

2. Start
   Project started (year, month)?

3. End
   (Scheduled) time of completion? (year, month)

4. Locality and setting(s)
   Where (i.e. county, municipality or part thereof) and in which settings (school(s), workplace(s) etc.) was the project carried out?

5. Aims
   Main purpose (problems/needs) of the project?

6. Goals and objectives
   What goals and objectives did the project have in terms of its approach, and in terms of its effects?
7. Target groups
   Which groups were targeted by the project:
   (a) Directly approached (e.g. agents, teachers):
   ......................................................................................................................
   (b) Indirectly approached (e.g. students via teachers or agents):
   ......................................................................................................................

8. Equity focus
   (a) Was the project explicitly directed towards increasing equity in health?  □ YES  □ NO
   (b) If yes, was it in terms of:
       groups (social, ethnic)?  □ YES  □ NO
       geographical areas?  □ YES  □ NO
       sex (men and women)?  □ YES  □ NO
   Comments:
   ......................................................................................................................

9. Initiative
   Who/which organizations initiated the project/activity?
   ......................................................................................................................

10. Funding
    (a) What basic financing was available for the project? From where?
        ......................................................................................................................
        ......................................................................................................................
        ......................................................................................................................
    (b) What further financial resources have become available? From where?
        ......................................................................................................................
        ......................................................................................................................

11. Strategies
    Which strategies were chosen to carry out the project and realize the goals?
    (Several strategies may be specified.)
    □ Developing/strengthening public policy (e.g. a ban on smoking in the state) by:
    ......................................................................................................................
    ......................................................................................................................
Creating Supportive Environments for Health

- Developing new laws and regulations (e.g., rules banning smoking in the workplace) by:
- Reorienting organizations (e.g., by creating a local public health council) by:
- Advocating and channelling health interests (e.g., by participating in welfare planning and community development) by:
- Collaborating and building new alliances (e.g., bringing together various interested parties) by:
- Enabling people to change (e.g., changing menu in the lunch canteen, offering exercise during working hours) by:
- Mobilizing/empowering (e.g., advocating increased direct local influence by people in the area) by:

12. Implementation — means and methods
What are the main means used to carry out the project?
(Several means may be specified.)
- Education/training
- Community work
- Information
- Direct lobbying of decision-makers and other key persons
- Other (specify)

13. Monitoring
What type of continuous monitoring is being done/was done during the project implementation period?

14. Evaluation
(a) Completed projects: Has the whole project (or parts of it) been evaluated?
- YES  NO
(b) Project in progress: Has the whole project (or parts of it) been evaluated?
☐ YES  ☐ NO

(c) Planned projects: Is any evaluation planned?
☐ YES  ☐ NO

(d) If yes, briefly describe how the evaluation has been done/is planned and specify any evaluation documentation.

15. Impact
(a) What were the short-term results? (for terminated projects)
(b) What impact has the project had so far? (for projects in progress)

16. Outcome
What has been the main long-term outcome?

17. Obstacles and solutions
(a) What were the major obstacles/constraints?
(b) Have they been overcome and, if so, how?
(c) If problems remain, what are they?

18. Maintenance
What has been done since the project was implemented to ensure that the activities will continue in the future?
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

19. Conclusions for the future
What are the most important conclusions in terms of learning for the future regarding how to renew, reinforce, or reorient the activities?

..........................................................................................
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20. Documentation
Please list reports, memos, and other documentation of the project/activities (including media coverage, newspaper articles, videos, etc.).

..........................................................................................
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If you have any other comments or information, please write them below:

..........................................................................................
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..........................................................................................

Thank you for your contribution.

This questionnaire should be sent to:
WHO Collaborating Centre
Karolinska Centre on Supportive Environments for Health
Department of International Health and Social Medicine
Unit of Social Medicine
S-172 83 SUNDYBERG
Sweden
Fax: ++46 8 28 95 00
Suggested further reading


Kickbusch I. Good planets are hard to find. Copenhagen, FADL, 1989 (WHO Healthy Cities Papers, No. 5).

CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH


ANNEX 1

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If you would like to have more information on any of the stories in this handbook, a complete list of references may be obtained by writing to the address on page 182.
KEY CONCEPTS IN COMMUNITY ACTION FOR HEALTH

COMMUNITY DEVELOPMENT

The process of involving a community in the identification and reinforcement of those aspects of everyday life, culture and political activity that are conducive to health. This may include support for political action to modify the total environment and strengthen resources for healthy living, as well as reinforcement of social networks and social support within a community and development of the material resources available to the community.

ECONOMIC ENVIRONMENT

Economic factors beyond the immediate control of individuals that affect health and healthy lifestyles.

PHYSICAL ENVIRONMENT

The physical, chemical and biological factors within home, neighbourhood and workplace that affect health and that are beyond the immediate control of the individual. Among the most important factors are air and water quality, noise, management of waste (domestic, industrial, hazardous, toxic), other sources of harmful substances (such as heavy metals and persistent chemicals), radiation, housing and other buildings, open spaces, natural or wild areas and global factors (such as the ozone layer and carbon cycle).

POLITICAL ENVIRONMENT

Whether a society is open or closed politically, participative or authoritarian, secular or religious, democratic or undemocratic, at peace or at war, the political environment significantly affects the possibilities for health promotion. Issues such as human rights, constitutional structures, the nature of political parties and other representative institutions, and freedom of or access to information all have a bearing on health and health promotion.
Resource environment

The amount and availability of resources to individuals and communities are clearly key determinants of the extent to which health can be achieved. Among the resources needed to create a supportive environment for health are: financial resources, which may be available from public, commercial or personal sources; infrastructure resources, which range from the physical infrastructure (roads, sewerage systems, etc.) to the legislative, regulatory and administrative infrastructure (authority, laws, inspectors, etc.); information resources, both formally and informally transmitted; and personal resources, or the individual’s own skills and capabilities.

Social environment

The social environment consists of the norms, values, customs, fashions, habits (which might include work), prejudices and beliefs of a society. These factors vary enormously from society to society but in each society their profile will be more or less supportive of health. They are modulated through the mass media, thus emphasizing the role played by the means of communication in creating supportive environments for health. The elements of the social environment are institutionalized in the family, the community (which may be defined ethnically as well as geographically) and the country.

Total environment

All identifiable factors of the economic, physical, political, resource and social environments that may determine and influence the health of individuals or groups.

Health

In the context of health promotion, health is seen as the ability of an individual to achieve his or her potential and to respond positively to the challenges of the environment. It is a resource for everyday life and not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capabilities.

The basic resources for health are income, shelter and food. Health requires a solid foundation in these, but improvement in health will not happen unless other elements are present too, such as: information and basic skills; a supportive environment that provides opportunities for making health choices among goods, services and facilities; and economic, social and physical conditions that enhance health.

This fundamental link between people and their environment is the basis for a socio-ecological concept of health that is central to health
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

promotion. Such a view emphasizes the interaction between individuals and their environment and the need to achieve some form of dynamic balance between the two.

Health literacy
Health literacy is a vital life skill. It is the ability to make informed decisions about one’s health on the basis of an understanding of all the issues involved and the ability to act in accordance with these decisions. As such, it is the foundation for individual and community health development and self-sufficiency. Health literacy requires oral and written communication and the ability to solve scientific and social problems related to health and disease.

Health policy
A formal statement or procedure within institutions (including government) that gives priority to health or that recognizes health goals. Health policy involves health services and other sectors — such as agriculture, energy, transport, industry, trade, aid, social welfare, environment, education and science — that may influence health.

Living conditions
The standard of housing and material resources in the physical environment in which an individual lives. Differences in living conditions usually reflect a wide range of inequalities between different socioeconomic groups within societies. The overall impact of living conditions on health is sometimes difficult to untangle from the combined influence of individual lifestyles and social and cultural norms.

New public health
Professional and public concern with the effect of the total environment on health. The term builds on the old (especially 19th century) concept of public health which struggled to tackle health hazards in the physical environment (e.g. by building sewers). New public health includes concern for the socioeconomic environment (e.g. high employment).

Positive health
A state of health beyond an asymptomatic state. Positive health usually includes the concepts of quality of life and human potential. Notions of positive health may include self-fulfilment, vitality for living and cre-
activity. Positive health is concerned with thriving rather than merely coping.

**Quality of life**

The perception of individuals or groups that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfilment.

**Self-empowerment**

The achievement of personal autonomy through the development and use of life skills.

**Social inequality**

The existence of unequal opportunities and rewards for different social positions or statuses within a group or society. In relation to health, this term often refers to the unequal influence on health of the different social positions or statuses. The fundamental aim of Health for All is to reduce inequalities in health both between countries and within countries.

**Social movement (popular movement)**

Various forms of collective action by a group of individuals aimed at social reorganization. In general, social movements are not institutionalized but arise from spontaneous social action directed at specific or widespread grievances.

**Sustainable development**

A process of change in which the exploitation of resources, the direction of investments, the orientation of technological development, and institutional change are all in harmony and enhance both current and future potential to meet human needs and aspirations.
Annex 3

The Sundsvall statement on supportive environments for health

The Third International Conference on Health Promotion: Supportive Environments for Health — the Sundsvall Conference — fits into a sequence of events which began with the commitment of WHO to the goal of Health For All (1977). This was followed by the UNICEF/WHO International Conference on Primary Health Care, in Alma-Ata (1978), and the First International Conference on Health Promotion in Industrialized Countries, in Ottawa (1986). Subsequent meetings on Healthy Public Policy, in Adelaide (1988) and a Call for Action: Health Promotion in Developing Countries, in Geneva (1989) have further clarified the relevance and meaning of health promotion. In parallel with these developments in the health arena, public concern over threats to the global environment has grown dramatically. This was clearly expressed by the World Commission on Environment and Development in its report Our Common Future, which provided a new understanding of the imperative of sustainable development.

The Third International Conference on Health Promotion: Supportive Environments for Health — the first global conference on health promotion, with participants from 81 countries — calls upon people in all parts of the world to engage actively in making environments more supportive to health. Examining today’s health and environmental issues together, the Conference pointed out that millions of people are living in extreme poverty and deprivation in an increasingly degraded environment that threatens their health, making the goal of Health For All by the Year 2000 extremely hard to achieve. The way forward lies in making the environment — the physical environment, the social and economic environment, and the political environment — supportive to health rather than damaging to it.

The Sundsvall Conference identified many examples and approaches for creating supportive environments that can be used by policy-makers, decision-makers and community activists in the health and environment

1 See footnote, page 33.
sectors. The Conference recognized that everyone has a role in creating supportive environments for health.

A call for action

This call for action is directed towards policy-makers and decision-makers in all relevant sectors and at all levels. Advocates and activists for health, environment and social justice are urged to form a broad alliance towards the common goal of health for all. We Conference participants have pledged to take this message back to our communities, countries and governments to initiate action. We also call upon the organizations of the United Nations system to strengthen their cooperation and to challenge each other to be truly committed to sustainable development and equity.

A supportive environment is of paramount importance for health. The two are interdependent and inseparable. We urge that the achievement of both be made central objectives in the setting of priorities for development, and be given precedence in resolving competing interests in the everyday management of government policies.

Inequities are reflected in a widening gap in health both within our nations and between rich and poor countries. This is unacceptable. Action to achieve social justice in health is urgently needed. Millions of people are living in extreme poverty and deprivation in an increasingly degraded environment in both urban and rural areas. An unforeseen and alarming number of people suffer from the tragic consequences of armed conflicts for health and welfare. Rapid population growth is a major threat to sustainable development. People must survive without clean water or adequate food, shelter and sanitation.

Poverty frustrates people's ambitions and their dreams of building a better future, while limited access to political structures undermines the basis for self-determination. For many, education is unavailable or insufficient, or, in its present forms, fails to enable and empower. Millions of children lack access to basic education and have little hope of a better future. Women, the majority of the world's population, are still oppressed. They are sexually exploited and suffer from discrimination in the labour market and many other areas which prevents them from playing a full role in creating supportive environments.

More than a billion people worldwide have inadequate access to essential health care. Health care systems undoubtedly need to be strengthened. The solution to these massive problems lies in social action for health and the resources and creativity of individuals and their communities. Releasing this potential requires a fundamental change in the way we view our health and our environment and a clear, strong political commitment to sustainable health and environmental policies. The solutions lie beyond the traditional health system.
CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

Initiatives have to come from all sectors that can contribute to the creation of supportive environments for health, and must be acted on by people in local communities, nationally by government and nongovernmental organizations, and globally through international organizations. Action will involve predominantly such sectors as education, transport, housing and urban development, industrial production and agriculture.

Dimensions of action on supportive environments for health

In a health context the term supportive environments refers to both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction. Action must be coordinated at local, regional, national and global levels to achieve solutions that are truly sustainable.

The conference highlighted four aspects of supportive environments:

1. The social dimension, which includes the ways in which norms, customs and social processes affect health. In many societies traditional social relationships are changing in ways that threaten health, for example, by increasing social isolation, by depriving life of a meaningful coherence and purpose, or by challenging traditional values and cultural heritage.

2. The political dimension, which requires governments to guarantee democratic participation in decision-making and the decentralization of responsibilities and resources. It also requires a commitment to human rights, peace, and a shifting of resources from the arms race.

3. The economic dimension, which requires a re-channeling of resources for the achievement of health for all and sustainable development, including the transfer of safe and reliable technology.

4. The need to recognize and use women’s skills and knowledge in all sectors, including policy-making, and the economy, in order to develop a more positive infrastructure for supportive environments. The burden of the workload of women should be recognized and shared between men and women. Women’s community-based organizations must have a stronger voice in the development of health promotion policies and structures.
Proposals for action

The Sundsvall Conference believes that proposals to implement the health for all strategies must reflect two basic principles:

1. Equity must be a basic priority in creating supportive environments for health, releasing energy and creative power by including all human beings in this unique endeavour. All policies that aim at sustainable development must be subjected to new types of accountability procedures in order to achieve an equitable distribution of responsibilities and resources. All action and resource allocation must be based on a clear priority and commitment to the very poorest, alleviating the extra hardship borne by the marginalized, minority groups, and people with disabilities. The industrialized world needs to pay the environmental and human debt that has accumulated through exploitation of the developing world.

2. Public action for supportive environments for health must recognize the interdependence of all living beings, and must manage all natural resources taking into account the needs of coming generations. Indigenous peoples have a unique spiritual and cultural relationship with the physical environment that can provide valuable lessons for the rest of the world. It is essential therefore that indigenous peoples be involved in sustainable development activities and negotiations be conducted about their rights to land and cultural heritage.

It can be done: strengthening social action

A call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control. Examples from all parts of the world were presented at the Conference in relation to education, food, housing, social support and care, work and transport. They clearly showed that supportive environments enable people to expand their capabilities and develop self-reliance. Further details of these practical proposals are available in the Conference report and handbook.

Using the examples presented, the Conference identified four key public health action strategies to promote the creation of supportive environments at community level.

1. Strengthening advocacy through community action, particularly through groups organized by women.

2. Enabling communities and individuals to take control over their health and environment through education and empowerment.
3. Building alliances for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies.

4. Mediating between conflicting interests in society in order to ensure equitable access to supportive environments for health.

In summary, empowerment of people and community participation were seen as essential factors in a democratic health promotion approach and the driving force for self-reliance and development.

Participants in the Conference recognized in particular that 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. Education should be accessible throughout life and be built on the principle of equity, particularly with respect to culture, social class and gender.

The global perspective

Humankind forms an integral part of the earth's ecosystem. People's health is fundamentally interlinked with the total environment. All available information indicates that it will not be possible to sustain the quality of life, for human beings and all living species, without drastic changes in attitudes and behaviour at all levels with regard to the management and preservation of the environment.

Concerted action to achieve a sustainable, supportive environment for health is the challenge of our times.

At the international level, large differences in per capita income lead to inequalities not only in access to health but also in the capacity of societies to improve their situation and sustain a decent quality of life for future generations. Migration from rural to urban areas drastically increases the number of people living in slums, with accompanying problems including a lack of clean water and sanitation.

Political decision-making and industrial development are too often based on short-term planning and economic gains, which do not take into account the true costs to our health and the environment. International debt is seriously draining the scarce resources of the poor countries. Military expenditure is increasing, and war, in addition to causing deaths and disability, is now introducing new forms of ecological vandalism.

Exploitation of the labour force, the exportation and dumping of hazardous waste and substances, particularly in the weaker and poorer nations, and the wasteful consumption of world resources all demonstrate that the present approach to development is in crisis. There is an urgent need to advance towards new ethics and global agreement based
on peaceful coexistence to allow for a more equitable distribution and utilization of the earth's limited resources.

**Achieving global accountability**

The Sundsvall Conference calls upon the international community to establish new mechanisms of health and ecological accountability that build on the principles of sustainable health development. In practice this requires health and environmental impact statements for major policy and programme initiatives. WHO and UNEP are urged to strengthen their efforts to develop codes of conduct on the trade and marketing of substances and products harmful to health and the environment.

WHO and UNEP are urged to develop guidelines based on the principle of sustainable development for use by Member States. All multilateral and bilateral donor and funding agencies such as the World Bank and International Monetary Fund are urged to use such guidelines in planning, developing and assessing development projects. Urgent action needs to be taken to support developing countries in developing their own solutions. Close collaboration with nongovernmental organizations should be ensured throughout the process.

The Sundsvall Conference has again demonstrated that the issues of health, environment and human development cannot be separated. Development must imply improvement in the quality of life and health while preserving the sustainability of the environment.

The Conference participants therefore urge the United Nations Conference on Environment and Development (UNCED), to be held in Rio Janeiro in 1992, to take the Sundsvall Statement into account in its deliberations on the Earth Charter and Agenda 21, which is to be an action plan leading into the 21st century. Health goals must figure prominently in both. Only worldwide action based on global partnership will ensure the future of our planet.
ANNEX 4

How to establish a national or local database

Why a national/local database?
It is good to report what activities are happening. People learn from experiences when reflecting on them and reporting them. Others can share in them and discuss them. Networks can be created of people dealing with the same issues, and this can help them solve problems together.

The stories presented in this handbook came from participants at the Sundsvall conference and from some international agencies. Through a "call for experiences" a Sundsvall resource centre was built up, with not only published books and articles but also flip-charts, demonstration kits and other materials.

What equipment is needed?
A computer and a database program are necessary. Look for shareware programs.

Steps for organizing a local database
1. Create a thesaurus. All materials should be indexed according to a series of key-words. To develop a thesaurus, use available local samples and add key-words that are useful for different sectors, not just health.
2. Find a librarian who is interested in health issues and identify a library or documentation centre.
3. Use the form on pages 177-182 for reporting your experiences. Adapt the form as appropriate to suit your own situation.
4. Collect input. Start on a small scale. Ask for reports from people you know. Widen the circuit by telling others and by simple newsletters. Use presentations at conferences and training courses. Review conference proceedings and magazines to find out who is running interesting projects and programmes.
5. Index material by use of key-words, such as housing, community action, financing, setting, venue and so on.
6. Define accessibility of the material. Is it available by electronic mail, on computer diskettes or in simple printed documents?

7. Make use of experiences. The database should be easy to reach and use. Publish lists of material available and demonstrate the database at conferences and training courses.