Healthy Islands: from concept to practice

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The Healthy Islands initiative is an innovative approach to promoting the health of island peoples. This paper seeks to clarify the concepts underpinning this approach and to consider issues evolving in its early implementation.

The impetus for integrating health promotion efforts in a defined setting arose in Europe in 1987 with the birth of the Healthy Cities movement. This approach was founded on the premise that health is primarily a social rather than a medical concept and that human habitats could provide an ideal context for the promotion of health.[1] The Healthy Cities movement has evolved within the World Health Organization as a collaborative effort between the health promotion and the environmental health sections and has focused particularly on improving living conditions and environments in order to enhance lifestyles and patterns of living. From this beginning has arisen a family of similar settings-based approaches. Among these are Healthy Communities, Healthy Localities, Healthy Villages, Health Promoting Schools, Healthy Homes, Health Promoting Hospitals, Healthy Workplaces, Healthy Marketplaces and others. Recently, Healthy Islands has joined the family. It is interesting that the concept of Healthy Islands reflects that of Healthy Cities more than the other, more defined, smaller settings in that the use of the Healthy Island term can have a dual meaning. It can refer to both to the island setting in its own right, as well as to an umbrella concept spanning the promotion of health across a collection of what could best be called 'sub-settings', such as healthy schools, villages, etc. The adoption and articulation of this initiative by the Pacific Health Ministers' meeting in March 1995 has made it an imperative for the Pacific island countries (PICs).

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The Pacific situation

During the last decade, much has been documented regarding the importance of promoting health in the Pacific. Health programs have developed in these countries strongly influenced by the economic and political situations existing in the region. At the end of World War II, a majority of the countries were under the control of colonial powers, but slowly these PICs have gained independence or self-government. Political independence, however, has not been matched by economic independence, and most of the PICs have continued to depend on the support of massive foreign aid for their prosperity. According to the South Pacific Commission, *"Per capita, the region is still one of the most heavily aid-assisted in the world, but economic growth has been marginal".*[2]

Useful as this support may have been, it has also raised difficulties for the promotion of the health of islanders. A major problem voiced by many small PICs is the presence in their countries of a plethora of health programs and projects, each supported by different donor agencies and each seeking to address objectives specific to their own program, thus resulting in a collection of fragmented activities and segregated expertise. The objectives of these programs have been formulated sometimes in response to actual in-country needs, sometimes to donor preference and at other times to the country being the recipient of multilateral or regional

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initiatives. The latter on occasion have brought pre-determined broad aims which have sometimes been considered to be of questionable value for each particular country. Each program is likely to operate on separate funding with separate structures and personnel. A further problem is that project funding is finite and there is the ever-constant risk that individual programs will peter out as soon as specific funding dries up.

Although the history of the South Pacific Commission shows that the broad concept of the 'healthy village' was already conceived in the 1950s [3], most of the funding has been narrowly disease-focused. Health promotion has been primarily considered as one component of a total approach to the prevention, control and management of those health problems that beset the PICs. WHO has exerted a strong influence on health promotion programs since the Alma-Ata Declaration of 1978, which exhorted all member states to reduce focus on efforts in tertiary, acute, hospital and clinical care and instead, offer a more balanced approach to health care through a greater emphasis on the public health facets of protection, promotion and prevention. In 1994, the WHO Regional Office of the Western Pacific drafted a policy document, 'New Horizons in Health', encouraging all member states, including those in the Pacific, to take a comprehensive lifespan approach to the promotion of health, and this policy was formally adopted in 1995.[4] A momentous occasion in March 1995 heralded a real strengthening of interest in these approaches. The Pacific Health Ministers' Meeting of that date issued the Yanuca Islands Declaration on Health in the Pacific in the 21st Century. Its now frequently quoted key statement reads as follows:

> Healthy Islands should be places where:
> - children are nurtured in body and mind
> - environments invite learning and leisure
> - people work and age with dignity
> - ecological balance is a source of pride.[5]

This Declaration reflected the principles and aims documented in 'New Horizons' and brought the Pacific Island countries into line with other innovative approaches to the promotion of health that were being developed around the world. More specifically, the Ministers' meeting adopted the concept of Healthy Islands as *"the unifying theme for health promotion and protection in the island nations of the Pacific for the twenty-first century"*.[5] Through this wording, the Pacific health ministers emphasised one of the concepts integral to the settings approach - that is, that good health promotion practice is all-embracing and consists of integrating strategies, in place of the previous, fragmenting approach where diverse, separate programs co-existed in an unrelated way.

Two years later, at the 1997 Conference of the Pacific Islands Ministers of Health at Rarotonga, this concept was further refined, and strategies for implementing it were developed. The Rarotonga Agreement stipulated that *"The Healthy Islands concept involves continuously identifying and resolving priority issues ... in partnerships among communities, organisations and agencies ... Implementation of the concept includes consideration of ... core elements in identified settings"*.[6] In summary, the key features expressed in this most recent agreement are a continued emphasis on a settings approach as the way to proceed, and a focus on collaboration and coordination through partnerships for action.

As already noted, health programs of the Region have up to the present tended to be directed towards a *health issue*, such as reduction of non-communicable diseases, prevention of HIV/AIDS or control of diarrhoeal disease. The 'New Horizons' approach has given legitimacy to focusing more on *populations*, for example, on maternal and child health, health of the elderly and so forth, thus offering a more comprehensive coverage of all health problems experienced by the designated population. With the Yanuca Island Declaration, and the subsequent Rarotonga Agreement, opportunity has arisen, with high level political support, to develop a *settings approach* as an appropriate focus - in this case, an island. The settings approach is not an alternative to the health issue or the population approach but in essence embraces them both.

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What are the characteristics of a 'settings approach'?

In a recently published paper on this topic, Wenzel suggests that a 'setting' refers to:

- a socially and culturally defined *geographical and physical area* of factual social interaction, and
- a socially and culturally defined *set of patterns* of interaction to be performed while in the setting [our emphases].[7]

In other words, the context is integral to the approach and the influences on health that arise from the physical, structural and organisational environment are addressed within the approach. Both the natural and the built environment are considered. Social relationships are recognised, cultural patterns harnessed and the collective energy of the community is utilised. The changing nature of the patterns of interaction are reflected through the dynamics of the health

promotion process. The wide focus of the settings approach embraces those who might otherwise fall through the net when only specific focus approaches are used.

Wenzel makes the point that this approach does not necessarily overcome the disadvantages present with other health promotion approaches. Risks can be identified, as follows:

- victim-blaming can still occur - individuals may still be expected to assume unrealistic responsibility for their own health;
- healthism is another risk. The term refers to the tendency to subsume a multitude of quality of life factors inappropriately under the rubric of health;
- paternalism is another where authorities may 'play God' in acting on behalf of communities, questionably in their interest;
- social control is also identified by Wenzel as a hazard since a focus on policy and ensuing regulations could go too far.

An additional major concern, identified by Wenzel, occurs when a so-called settings approach is characterised by a lack of connection between its context and the lifestyle patterns of the people in the setting. If patterns are isolated from their social context, this is no longer a settings approach but an individual, behavioural one, despite its designation referring to the place where this behaviour occurs. Similarly, some health issue approaches have been disguised as a settings approach just because they occur in a geographical locality. It appears that this risk derives from the fact that 'environment' has always been a factor in the traditional epidemiological model, where intervention to prevent a nominated disease is recommended at any one of the three points: host, agent or environment. However, the difference in the epidemiological model approach is that the environment is included in the formula as an entry point for prevention of a *specific* disease.

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The following examples may clarify the above. Entry points for intervention through manipulating the environment by removing containers around habitation where mosquitoes might breed reduces the presence of the agent in dengue fever prevention. Similarly, use of a condom in sexual activity provides a barrier between the agent and the host in the prevention of HIV/AIDS. This specificity is a characteristic of particular disease prevention. On the other hand, the creation of a supportive environment for health is concerned with the determinants of health in general, and attention to the environment in this instance refers to enhancing the natural and built environments generally and additionally, attending to the social climate. If these examples of disease prevention strategies can be integrated into the creation of a supportive environment for health, they would be incorporated into the local context. In these instances, the community in partnership with the authorities might decide that habitat surroundings should be improved, and therefore, that containers should removed from these areas for aesthetic reasons, for clean water security, for better waste management and also for prevention of vector borne disease. Barrier methods of sexually transmitted disease such as condom use could be considered as an integral part of community concern over optimum birth spacing, enhancement of social relationships as well as prevention of HIV/AIDS. Note the subtle difference between the problem focused, disease prevention specificity as opposed to the optimum-health focused, health promotion generality of the settings approach.

Wenzel's concerns are reflected by Baum, who suggests that there are three major obstacles to satisfactorily establishing a settings approach, all of which have strong influences in the health sciences.[8] She suggests that economic rationalism acts as a barrier to addressing the determinants of health in that a concern with balancing the books through market forces gains precedence over any action to balance social reform in an equitable manner. User-pay principles are valued more highly than efforts to attain greater social good. Kickbusch declares that ecological sustainability is an integral aspect of a health promoting setting[9], but this is viewed as long term luxury from an economic rationalist perspective, and is more than likely to be sacrificed for short term gain. It is noticeable that the conventional epidemiological focus on specific disease prevention fits more comfortably with this economic rationalist perspective.

Another obstacle identified by Baum is individualism. Although the settings approach calls for a collective involvement of community members, there is a real risk that the community may be regarded as just an aggregation of individuals. Mass media campaigns may fall into this category in the instances where they target individual behaviour even if they are community-wide in their reach.[10] Baum's concern here, like that of Wenzel[7], is around the potential for the individual approach to foster victim-blaming.

The third obstacle identified by Baum is professionalism. It is difficult for professionally trained personnel to regard members of the community as their peers and to work with them in partnership. Professional knowledge gives power and it can be seen as too risky to relinquish that power. Hence, the ethos of the settings approach where the commu-

nity is enabled to identify health problems and make decisions over appropriate strategies is of questionable acceptance to many health professionals.

Baum's suggestion is that to reduce these three hazards, they need to be put on the agenda explicitly and addressed overtly so that their potency can be reduced.

What then characterises an 'island setting'?

Islands have particular contextual characteristics quite different from other settings which must be considered if the promotion of health of their people is a goal.[2] In most instances islands start with incredible natural beauty. They tend to be small land masses in vast oceans, with fragile, transparent ecosystems. Although they are insulated from the rest of the world, inhabited islands have a history of self-supporting subsistence and opportunities for unique cultural evolution. Many are vulnerable to climatic disturbances such as cyclones, and suffer volcanic upheavals and seismic activity.

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Island nations are also affected by political, economic and cultural factors. Most islanders are staunchly patriotic, respecting and valuing their cultural heritage, and this value system is usually reflected in their political structures. Boundaries placed on PICs tend more to reflect the influence of previous colonial powers rather than racial or cultural lines of demarkation, thus complicating this patriotism. The usually limited land availability of island nations supports relatively small national populations, but there is the potential for local over-population, due mainly to their geographical isolation and the concentration of employment, education and service resources in one locality. A similar potential exists for fragmentation of components of the nation over wide areas of the ocean. Island nations usually have limited natural resources which leads to difficulties in establishing market economies, made even harder by difficulties in transport and communication. The strong indigenous cultural heritages described above are, in most PICs, being slowly but surely eroded by Western influences. Out-migration of young adults seeking employment accentuates the small human resource pool from which to draw people with key responsibilities. Islands are frequently threatened from environmental degradation both from within and without their own national boundaries.

What then makes up current Healthy Island initiatives?

With the Yanuca and Rarotonga documents declaring political support for this concept in the Pacific, consideration has moved to what might be best entry points for implementation of these concepts. Just as Wenzel gave two major characteristics of a setting[7], so these two facets currently form alternate entry points under the Healthy Islands banner.

These entry points can be through:

- The socially and culturally defined environment, or
- The socially and culturally defined set of patterns between groups of people[7].

In other words, the entry points established in existing projects under the Healthy Islands banner in the Pacific are either through an initial focus on managing island environments for health or through an initial focus on community development and organisational development for health. Environmental health initiated programs are of the former kind (see, for example, case studies in Chu and Simpson[11]), health promotion initiated programs of the latter (see, for example, Roberts[12]). Although neither approach is mutually exclusive, the basic rationale for each of the two entries is different. The first suggests that the reciprocity between the health of people and the health of the environment is so great that careful management of the environment is intrinsic to the promotion of health. The second builds on the assumption that social, cultural and organisational structures have already evolved to support living conditions and lifestyles within each island country. Strengthening these structures in ways that island peoples feel are valuable, in order to promote health, seems a culturally appropriate option as a starting point.

The key issue in both cases is the extent to which each approach eventually expands to take in both components of a setting so that the projects are holistic and all-embracing. The real risk in the first approach is the risk of becoming paternalistic and not involving the community to the extent that they can gain a feeling of ownership over the project.

The real risk of the second approach is that existing health issue approaches may come under the umbrella of a Healthy Islands project but still maintain their narrow disease prevention focus. The second approach depends strongly on intersectoral collaboration. Cultural, economic and political divisions that are a mark of the social organisation of these island nations are required to come together to consider the contribution of each one's sector on the health of the islanders.

The significance of the peoples of the Pacific working in, what they call, 'the Pacific way' cannot be underestimated. Characteristics of this 'way' as seen by an outsider include respect for others to the extent that consensus is an antici-

pated outcome of any negotiation, and a precedence given to interpersonal relationships over time frames and deadlines. The Pacific way includes a requirement to share, and a firm belief that negotiations must be conducted in an atmosphere of warmth often accompanied by music and feasting. The backdrop to all this is a feeling of unity with their island home.

To summarise then, existing Healthy Island approaches are characterised by a recognition of the integration of health and environment, by an involvement of communities in the decision-making process and by collaboration across sectors for the social good. In this regard, the approach is recognised as reinforcing the health-focused rather than disease-focused aspects that have evolved since the Alma-Ata Declaration. As such, a Healthy Islands approach does not so much bring unique and innovative ideas but rather consolidates these aspects of health care, framing them in a form which appears to be politically attractive, socially acceptable and eminently achievable.

How to evaluate these projects?

The literature informs us that there are three ways of considering evaluating a project of this nature.

The first is to regard the evaluation process as a form of applied research within the conventional paradigm, where the randomised controlled trial still holds the gold standard, and at the very least, quasi-experimental designs are attempted. Comparative studies are valued and rigorous attempts to attain the highest internal validity are undertaken. This approach to evaluation seeks causality - that is, to find out whether the program actually produced the results that occurred. This approach in a natural setting is fraught with enormous difficulties. The lack of fixed objectives, the fluidity of the interacting variables and the vague time frames of community-directed approaches for the promotion of health all contribute to a degree of confusion that is not compatible with the tightly structured nature of experimental or quasi-experimental evaluation designs.[13]

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Recognising these obstacles, the case study approach has found currency as a means of evaluating Healthy Island projects. This form of evaluation is not as concerned with causality, but rather it attempts to indicate that associated with the project are some preferred outcomes. Relevant health issues are nominated by those who are stakeholders in the activity, and suitable indicators are chosen to demonstrate whether there is a move in the preferred direction. Indicators can be either qualitative or quantitative or a mix, with the rationale for the choice depending on it being the best way that the trend towards the preferred outcome can be demonstrated.

Learning from the Healthy Cities' literature we can gain three understandings:

- First, that choosing indicators with input from stakeholders should be a part of the Healthy Island process;
- Second, that a range of stakeholders leads inevitably to a range of different perspectives, that these perspectives can be conflicting, but that this is acceptable; and
- Third, that, as O'Neill states categorically: *"the primary and probably most important lesson is the fact that there is no magic list of indicators that can be universally utilized".*[14]

The remaining, more radical approach, is to work within the alternative paradigm as some of the influential Canadian literature is suggesting.[15] The use of a participatory action research methodology provides opportunity for the integration of investigation with action and learning.[16] If a critical social science perspective is taken, then power and politics are acknowledged, especially in relation to those who are disadvantaged. The greatest advantages of this evaluation approach is that issues are defined by the community itself, that variables to be measured are not stripped from their context, that power and politics are considered as real influences on health rather than as contaminating confounders and that the strategies undertaken within any Healthy Island project are recognised as dynamic and as part of an interconnected system rather than as separate strands that can be teased out for measurement. In McKinley's words, this evaluation approach is seeking *"substantive significance rather than statistical significance".*[17]

An example of application of a Healthy Islands approach

Niue, the smallest self-governing country in the world, has embraced a Healthy Island approach. In response to an enthusiastic request for support from the Minister of Health following her presence at the Yanuca Island meeting, the Australian Government invited Niue to be one of five countries offered the opportunity to take part in an AusAID funded regional project - the *Australia-South Pacific Healthy Islands Health Promotion Project.* The authors of this paper are part of the Australian team involved in implementing this Project. The Minister's presentation of a Country Paper at Rarotonga describing the response of her country to the Yanuca Declaration summarised much that had been achieved within the

Project in the two years between meetings. In that period, Niue had first appointed a dedicated Country Coordinator and a Project Committee, the latter spanning various relevant government sectors and non-government organisations and representing key community groups.

The Committee have given the Project a local name - *Moui Olaola*, designed a logo, developed a mission statement from an early visioning exercise and achieved a resulting high-level community presence. Intensive efforts have been made by the Project Committee members themselves to be able to build their own capacity to promote health in a meaningful way. They have recognised from the beginning that this entails working across sectors in a spirit of collaboration. They have sought to negotiate priorities with strong political support which can lead to real action.

A serious investment in capacity building has been recognised as the most important ingredient for health promotion personnel so that they are able to mobilise, to advocate, to create policy and to form partnerships to achieve their health promoting aims.

At a workshop during the second year facilitated by Australian consultants, a framework for implementation evolved through working with Committee members. The framework statement reads as follows:

Moui Olaola seeks to promote the health of the people of Niue by:

enhancement of living conditions

priorities litter reduction
containment of domestic animals
development of vegetable and flower gardens
policy and legislation issues

enhancement of lifestyles

priorities no smoking
reduction of alcohol consumption
good quality nutrition
freedom from HIV/AIDS and STDs
oral health

enhancement of settings in which people live, work and play

priorities health promoting schools
healthy hospital.[18]

Various relevant initiatives were undertaken by the Project and the Committee has sought assistance in attaining skills in mediating, advocating and in policy formulation. The Committee has played a strong role in setting health promotion priorities and in integrating existing activities. For instance, a successful litter reduction project implemented under *"enhancement of living conditions"* commenced in the main town of Alofi. Use of the Healthy Island litter bins has now spread to other villages in response to community action. An oral health policy has been framed by the Moui Olaola Committee to address the need voiced in the Ministry of Health of enhancement of this aspect of lifestyle. Both the primary and secondary schools have set up health promoting schools committees, and plans for a new hospital are being drawn up with the Committee being invited to provide input on the potential of this new institution to be a health promoting hospital. Discriminatory use of the small budget arising from the Project has enabled the Committee to strengthen various components of these activities.

The Country Paper goes on to conclude:

"The [Healthy islands] initiative by WHO has been a welcome incentive for Niue. It has given us the opportunity to gather and refocus a somewhat fragmented segment of Niue's own health promotion, health protection and health education efforts under one umbrella, namely the Moui Olaola Project".[18]

Niue has asked for this degree of assistance to be continued until the year 2000, at which time the Committee have indicated that they will have a within-country mechanism for the development of a funding base so that the project can be really sustainable.

Some lessons learned

The above example, even though presented as a very short overview, demonstrates how one PIC has been able to build on the Healthy Islands initiative, exhibit real political support, undertake various effective components within the project and set up a method that will seek sustainability after donor funding is exhausted. The specific context of this one PIC is not generalisable but there are some lessons that can be learnt and applied elsewhere.

The major message gained from this country's efforts is that this approach is not just an ideology in an abstract form. The concepts are indeed able to be put into practice. A serious investment in capacity building has been recognised as the most important ingredient for health promotion personnel so that they are able to mobilise, to advocate, to create policy and to form partnerships to achieve their health promoting aims. These skills are not natural skills of case workers and therefore warrant high priority.

Health workers who gain these broader understandings can then cope with political forces and territorialities that would otherwise undermine their efforts. This enlarged role for health workers will allow recognition that there are many

problems out there with which the health sector alone cannot cope. Taking a lead role among a wide range of key stakeholder representatives in a Healthy Islands approach may hold the most promise of achieving results.

A factor in Niue's favour may be the smallness of the setting. A nation living only on one island with a very small population is most likely to allow a higher level of involvement of all citizens and to permit issues to be addressed in a more manageable way than in a larger, more populated country. This may have implications for considering the most effective way to disseminate the benefits of this approach across the Pacific. It may be important for larger PICs to implement this approach island by island rather than as a country wide endeavour. Even more effective may be efforts to break settings into sub-settings so that the components of the Healthy Islands program could be healthy villages or healthy schools or healthy marketplaces which similarly appear so much more manageable. A true Healthy Islands approach then could have a Healthy Islands Council at a central level and a series of working groups feeding into this Council from each of the sub-settings. The core areas nominated in the Rarotonga Agreement, such as nutrition or waste management or human resource development,[6] can then be addressed across all these sub-settings.

Conclusion

This paper has traced the origins of the Healthy Island concept and described early attempts at converting this concept into practice. Those of us working in the area feel enthusiastic that this movement has developed so positively and attracted such a high degree of political goodwill and cultural acceptance. We have no doubt that these developments are taking the PICs forward in their continuing quest for Health for All.

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