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Evelyne de Leeuw

University of New South Wales

Anna Stevenson

University of New South Wales

Gwyn Jolley

University of New South Wales

Sandra K. McCarthy

University of Wollongong, University of New South Wales, sandramc@uow.edu.au

Erik Martin

University of New South Wales

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Healthy cities, urbanisation, and healthy islands: Oceania

Abstract

Oceania is described as a vast and diverse region in which some of the world's greatest and biggest cities are found, but also ones that may not feature on the urbanist radar (e.g. the densely populated capitals of many Pacific Island nations). After an introduction to the ecological, demographic and cultural diversity of this part of the world this chapter proceeds with case descriptions of Christchurch (New Zealand), Onkaparinga and Kiama (Australia), and the Healthy Island initiative. Christchurch, and early adopter of the Healthy Cities idea, benefited from its flexible and value-based character when it was facing post-earthquake recovery challenges. Both Onkaparinga and Kiama found new ways of organising local health development efforts outside and beyond the government and health apparatus. Small Island Developing States (SIDS) have benefited from the Yanuca Healthy Island Declaration that connects heritage, ocean ecosystems, economic development and well-being just like Healthy Cities do-and some of the settlements on such SIDS Healthy Islands in fact are among the most urbanised in the world.

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Chapter 12

Healthy Cities, Urbanisation, and Healthy Islands: Oceania

Evelyn de Leeuw, Anna Stevenson, Gwyn Jolley, Sandra McCarthy, and Erik Martin

For the purpose of this book, we see the region of Oceania as consisting of Australasia (New Zealand, Australia and its overseas territories such as Christmas Island, the Cocos Islands and Norfolk Island), Melanesia (with the exception of Indonesian territories in Papua as they are part of the Southeast Asian region of WHO), Micronesia and Polynesia (with the exception of Hawaii as it is part of the Americas region of WHO). The region is highly diverse in many respects, in terms of ecosystems, development levels and demographics. It comprises some of the most sparsely populated countries in the world (such as Australia with a population density of 2.7 people per km²) and oddly—because of their relative isolation in the expanse of the Pacific Ocean—some of the most densely populated ones (such as Tuvalu—428.7/km²—and the Marshall Islands—406.8/km²; the full global range of population densities is between Macau at 21,190/km² and Greenland at 0.03/km²). Most countries have been colonised over the last three centuries, and indigenous populations suffer disproportionately in terms of health equity.

Five of the countries in this region (Tonga, Fiji, Palau, New Zealand and Australia) rank above the world average of the Human Development Index (UNDP 2014) although the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) puts another seven Pacific sovereign territories in this category.

The region enthusiastically embraced the Ottawa Charter for Health Promotion following its adoption in 1986, and healthy settings projects and programmes quickly emerged. Some of the first Healthy Cities in the southern

E. de Leeuw (✉)

Centre for Health Equity Training, Research & Evaluation (CHETRE),
University of New South Wales, South Western Sydney Local Health District,
Ingham Institute, Locked Bag 7103, Liverpool, BC NSW 1871, Australia
e-mail: e.deleeuw@unsw.edu.au

A. Stevenson • G. Jolley • S. McCarthy • E. Martin
University of New South Wales, Sydney, NSW, Australia

hemisphere were Noarlunga and the Illawarra region of Australia (Baum and Brown 1989). The Australian Federal Government embraced Healthy Cities enthusiastically and supported the establishment of pilot projects towards the end of the 1980s and early 1990s. Canberra, Australia's capital, for a while was designated a Healthy City. The fact that Healthy Cities appeared so visibly on the government agenda was certainly a sign of the times: many states and territories adopted local legislation mandating that local governments develop broad determinants of health-based health policy (see Chap. 16). New Zealand/Aotearoa followed suit, and the notion of Healthy Cities and Healthy Communities was embraced from the late 1980s, for instance in Aotearoa's North Shore (Abbema 1997). The settings idea in the region extended to schools, villages and marketplaces, and other initiatives in the smaller Pacific nations (Ritchie et al. 1998; Tagivakatini and Waqanivalu 2012).

The diversity of Oceania has had an impact on Healthy City development. Some of the smallest nations in this part of the world have the highest rates of urbanisation, although it may sound odd to speak of a 'highly urbanised' nation when we talk, for instance, of Kiribati, one of the most sparsely populated countries on earth (with vast expanses of ocean) but with one of the most densely populated capitals, South Tarawa.

After the initial success of Healthy Cities in this part of the world, the regional office for the Western Pacific Region of WHO decided to take a unique approach to Healthy Urbanisation (WHO 2011), embracing a mix of Healthy City-specific values with particular challenges found in this part of the world (Fig. 12.1). 'Healthy Urbanisation' as a concept casts the net beyond a model that views a Healthy City as the ultimate outcome of a local approach to health development, and embraces a dynamic perspective that has the potential to extend beyond the boundaries of the traditional city to the thriving network of Healthy Islands in the region.

For the future of Healthy Cities in the region, a series of consultations led to recommendations that WHO should not adopt a 'top-down approach' (possibly code for 'the WHO European Region process of designating and accrediting Healthy Cities and Healthy Cities National networks') but should support national and local governments to

- Strengthen institutional arrangements to promote healthy urbanisation
- Build capacity for action towards healthy urbanisation
- Strengthen the evidence base for governance, policies and actions, and value of investment for healthy urbanisation
- Advance national policies and action on healthy urbanisation
- Support city-to-city learning and networking within and across countries

The case studies in this section attest to the vibrancy of the settings approach in the region. Nearly two dozen Australian local governments and universities are members of the Alliance for Healthy Cities based in Japan which originally focused on the Western Pacific Region of WHO, and several states and territories in the country have statutory requirements to develop local health plans inspired by 'The New Public Health', as De Leeuw and Lin demonstrate. That same inspiration has extended to the smaller island states in the Pacific that have come together in a Healthy Islands programme.

Fig. 12.1 Eight key domains for Healthy Cities in the Western Pacific Region of WHO (2011)

Christchurch: A Healthy Cities Case Study¹

The City of Christchurch was built by British settlers in the 1840s and officially named in 1856; it is the oldest colonial city in New Zealand. It lies about one-third of the way down the eastern border of the South Island and is the main port and airport for the South Island. The area was known as Otatauhi by local Maori, who had been present in the area for several centuries prior to the arrival of European settlers. Christchurch has a population of approximately 360,000; currently it is New Zealand's third largest city. Compared with the rest of New Zealand it has an ageing population, with a median age of 37 years. The proportion of Maori is low, at just under 8%.

An advisory group led by the Public Health Unit² and the city council was formed in 2001 to inaugurate Healthy Christchurch. This was a second attempt to create a

¹Anna Stevenson.

²New Zealand has a comprehensive, publicly funded public health system. In 2001 regional public health units delivered services funded by the Ministry of Health. More recently, public health units have been located within 20 district health boards, which deliver and fund the full range of health services.

Healthy Cities interagency project locally; the failure of the first had been evaluated as resulting from the dual failure to engage at either a grass-roots or a chief executive level. In 2002 the Healthy Christchurch Charter³ was developed, a formal document in which principles and protocols were agreed. The charter was the result of a wide-ranging engagement process to ensure that both high-level champions and grass-roots organisations were involved. By signing the charter, parties confirmed that they were committed to the values, principles and goals of Healthy Christchurch, and to working together to 'promote, protect and improve the health and wellbeing of the people of Christchurch' (in the process, becoming committed 'Signatories'). The incorporation of the Ottawa Charter for Health Promotion and Te Tiriti o Waitangi⁴ (The Treaty of Waitangi, the founding document of New Zealand/Aotearoa) in the charter marked the intention of diverse signatories, from national government agencies to small NGOS, to work collaboratively to address the wider determinants of health.

By 2003, 88 signatories were actively working on nine projects together. These ranged from breast-feeding promotion to employment opportunities for Maori. In 2005 Healthy Christchurch made a submission to the local council, recommending that health impact assessments (HIAs) be utilised in the council policy cycle. Later that year the council and health board collaborated on a high-level policy HIA in the Greater Canterbury Urban Development Strategy.⁵

Capacity and relationship building were the focus when, in April 2008, Healthy Christchurch hosted an inaugural Healthy Cities short course. It was held over 4 days, with 30 people attending. The course focused on the importance and practicalities of embedding health and well-being in town planning, and included speakers from the fields of architecture, geography, policy, public health and health impact assessment. The guide for planners, *Health Promotion and Sustainability Through Environmental Design* (HPSTED),⁶ was a joint production of the local council and the district health board, and was released just prior to the course.

In 2009 Healthy Christchurch focused on developing the Christchurch City Health and Wellbeing Profile,⁷ using a combination of available health data, the signatories' views and widespread community consultation. The development process was based on an indigenous health promotion model known as Te Pae Mahutonga (Southern Cross Star Constellation)⁸ (Fig. 12.2). Two questions were asked under each of the six headings: What is working well for you in this area? What do you need more of to make living a healthy life easier for you? Graphics (Fig. 12.2) were developed for each of the areas and these graphics have since been used to brand Healthy Christchurch activities, including its website. Consultation was completed in the week of the devastating September 2010 earthquakes, and the release of the final document was delayed until the following year (Fig. 12.3).

³<http://www.healthychristchurch.org.nz/about/charter.aspx>, accessed March 2016.

⁴<http://www.treaty2u.govt.nz/the-treaty-up-close/treaty-of-waitangi/>, accessed March 2016.

⁵<http://www.greaterchristchurch.org.nz/background/related>, accessed April 2016.

⁶<http://resources.ccc.govt.nz/files/HPSTED.pdf>, accessed March 2016.

⁷<http://www.healthychristchurch.org.nz/city-health-profile.aspx>, accessed March 2016.

⁸<http://www.healthychristchurch.org.nz/media/9291/tepaamahutongatxtvers.pdf>, accessed March 2016.

Fig. 12.2 Te Pae Mahutonga (the Southern Cross Star Constellation)—an indigenous model of health promotion developed by Prof. Sir Mason Durie Rangitane, Ngāti Kauwhata (Healthy Christchurch—http://www.healthychristchurch.org.nz/media/22388/te_pae_mahutonga.pdf)

A number of large and destructive earthquakes devastated Christchurch and the wider Canterbury region in 2010 and 2011, and more than 14,000 aftershocks led to ongoing community anxiety and difficult living conditions. Many Healthy Christchurch projects have focused on addressing the impacts of the earthquakes. At a community level these have included the River of Flowers,⁹ a yearly event to commemorate those who died in the 2011 earthquakes; the Wellbeing Game,¹⁰ a community project designed to support mental well-being in workplaces; and the world-leading social marketing campaign ‘All Right?’ which was designed to support population-level mental well-being.¹¹

The planning guide referred to earlier (HPSTED) was reformatted and renamed the *Integrated Recovery Planning Guide*,¹² and training in how to use the guide and implement a broad range of actions on health determinants as an approach to planning and earthquake recovery was provided to many different groups.

The earthquakes exacerbated pre-existing issues in the region such as poor housing, low incomes, social and economic inequality, and accessibility to schools and employment opportunities. As with the rest of New Zealand, Canterbury faces rising rates of obesity and insufficient exercise levels and, linked to these risk factors, alarming levels of type two diabetes, cardiovascular disease and mental illness. The ongoing reduction in smoking rates in New Zealand (14.4% in Canterbury) is a

⁹<http://www.healthychristchurch.org.nz/priority-areas/wellbeing-and-community-resilience/river-of-flowers.aspx>, accessed March 2016.

¹⁰<http://www.healthychristchurch.org.nz/priority-areas/wellbeing-and-community-resilience/the-wellbeing-game.aspx>, accessed March 2016.

¹¹<http://www.healthychristchurch.org.nz/priority-areas/wellbeing-and-community-resilience/all-right-wellbeing-campaign.aspx>, accessed March 2016.

¹²<http://www.cph.co.nz/Files/IntegratedRecoveryGuideV2-Jun11.pdf>, accessed March 2016.

The four stars of the Southern Cross

represent the four key tasks of health promotion: Mauriara (access to a secure cultural identity), Waiora (environmental protection), Toiora (healthy lifestyles) and Te Oranga (participation in society).

The two 'pointer' stars

in the constellation represent the two key requirements for achieving these health promotion goals: Ngā Manukura (leadership) and Te Mana Whakahaere (autonomy).

Mauriara

Among indigenous peoples cultural identity is considered to be a critical prerequisite for good health. For Māori a secure cultural identity requires meaningful contact with Māori language, customs and inheritance. This requires endorsement of and cultural expression within the wider society's institutions. It is important that Māori cultural, social and economic resources are shared among all Māori. Using this model has enabled other cultures to reflect on the importance of this issue for their own wellbeing.

Waiora

The human condition is intimately connected with the domains of Rangi and Papa. Protection of the environment is critical for human health.

Ngā Manukura

Leadership for health promotion will be more effective if there is recognition that no single group or individual can encompass all the skills and linkages necessary for effecting change. Institutions should not work in isolation. Health promotion leaders should understand the value of working closely with a range of community and professional leaders. The importance of 'language' to convey messages across cultural and socioeconomic barriers must be understood and addressed.

Toiora

Individual health outcomes are often strongly linked to personal behaviour choices and healthy lifestyles. Some choices (such as smoking) have well known and largely preventable outcomes. Not everyone has the same degree of choice to avoid risks – there is strong evidence linking risky lifestyles to poverty. Whole of society solutions to poverty traps are likely to be more successful than individual targeted solutions.

Te Oranga

Good health and wellbeing is also about services (e.g. schools, good health services, recreational opportunities) and the level of decision making and ownership that they can have in relation to those services. Increasing the extent of Māori participation in society is critical to increasing health and wellbeing. This is also true for other groups in society who are excluded from societal goods such as education and employment.

Te Mana Whakahaere

No matter how excellent a health promotion program is, if it is undertaken in a legislative or policy environment that is not supportive of good health, or it is imposed without community engagement, it will make little headway. Autonomy reflects how communities' unique aspirations are supported and the control people have over the programmes undertaken in their communities.

Fig. 12.3 A summary of Te Pae Mahutonga. From p.23 Christchurch City Health Profile http://www.healthychristchurch.org.nz/media/44655/chch_city_health_profile_2012.pdf

huge public health success and can be attributed in large part to a strong lead from central government. Post-earthquake Canterbury is experiencing challenges in dealing with the harmful use of alcohol, and Healthy Christchurch has supported the creation of a new position coordinating alcohol harm reduction activities.¹³

¹³<http://www.healthychristchurch.org.nz/priority-areas/alcohol.aspx>, accessed March 2016.

The public faces of Healthy Christchurch are ‘champions’ who give high visibility to its activities and work within their own organisations to support the Healthy Christchurch vision. They agree on specific priorities that they can champion within their own organisations while lending a voice to wider efforts. Champions are not individuals but representatives of organisations: the mayor of Christchurch is a champion, as is the CEO of the local health board and the kaiwhakahaere (chairperson) of the local tribe, Ngai Tahu. The champions have focused on alcohol harm minimisation for several years. They have contributed to central government alcohol policy, written editorial comments for local newspapers and advocated the safe use of alcohol within their organisations. They are supported by an advisory group that meets regularly to review the progress of Healthy Christchurch against its strategic plan.

Healthy Christchurch is currently serviced by the equivalent of 2.6 full-time staff, based at the local public health division of the district health board. This small team collates and distributes newsletters, maintains a Facebook page, arranges regular signatory meetings on topics of interest, maintains the Healthy Christchurch website and supports community projects as required.

The Canterbury Health in all Policies Partnership¹⁴ is a subcommittee of Healthy Christchurch and has led a number of health impact assessments, joint organisational work plans and many other capacity-building projects that support a social determinants approach in sectors beyond the purview of the health board.

In 2014 there were well over 200 signatories to the Healthy Christchurch charter. A strategic plan is in place and, despite the challenges of the post-earthquake environment, the group is in good heart and making significant progress.

Onkaparinga: A Healthy Cities Case Study¹⁵

History and Context

Healthy Cities Noarlunga (HCN) was originally set up as one of the three Australian pilot Healthy Cities projects in 1987. Funded by the federal government for 3 years, the pilot project was modelled on WHO European Healthy Cities but adapted to the Australian context (Baum et al. 1990). Two evaluations of the first 3 years were conducted (Worsley 1990; Whelan et al. 1992), and found that the project had been successful in taking concrete action based on abstract principles, including the concepts of community participation and intersectoral collaboration.

Noarlunga is an outer suburb of Adelaide, the capital city of the state of South Australia. The population at the time was about 77,000. In 1997 the City of Onkaparinga was formed through the amalgamation of Noarlunga and two neighbouring areas. The population today is 165,000, with a higher proportion of children and youth than the average in Adelaide.

¹⁴ <http://www.healthychristchurch.org.nz/priority-areas/chiapp.aspx>, accessed March 2016.

¹⁵ Gwyn Jolley.

The early years of HCN built on a previous needs assessment and community visioning workshops. HCN was based in the then new primary health care service and community hospital, Noarlunga Health Services. In-kind support was received from the health service, the local council and other agencies. Following the loss of federal funding in 1991, local community activists reviewed the management of the project and decided to incorporate HCN as a non-government organisation. HCN changed its name to Healthy Cities Onkaparinga (HCO) in 2008 to reflect the new local government area.

Values

HCN was community driven from the start, with local community members and agency representatives joining to form the initial governance structures and to advocate incorporation. This community focus has continued, with community members having a majority of seats on the management committee. Community members are valued by being supported to attend training courses, forums and conferences relevant to Healthy Cities.

The importance attached to community participation demonstrates an equity approach that encourages all voices to be heard. Over the years, HCO has hosted many forums and planning sessions where members of the wider community have had an opportunity to discuss and vote on issues to be tackled. For example, increasing public transport and improving access to it has been a major area of action, culminating in an extension of rail links to newer suburbs.

A major achievement of HCO has been in fostering intersector activity. Various sectors, including health, local government, housing, education, policing, welfare agencies and small businesses, have contributed to HCO goals by providing small grants, in-kind support and representation on the target committee. This intersectoral approach has become a way of working in the region, as exemplified by a number of 'round tables' and collaborations that have evolved from HCO and that work across silos to improve services and support community well-being.

Political commitment to HCO has varied. Despite a generally positive evaluation, the pilot project was not extended beyond some 3-year 'networking' funding. Over the years South Australian state governments have occasionally shown interest in expanding the Healthy Cities approach, but this has not amounted to actual investment. HCO has striven to remain bipartisan in its relationships with changing governments. The local government (City of Onkaparinga) has been supportive throughout and has given in-kind support such as hosting events, providing a representative to the management committee, and giving access to competitive grants.

HCO has been sustained for over 25 years. This is a remarkable achievement given changes globally, nationally and locally in that time. The factors contributing to this sustainability have ensured the long-term nature of HCO and its evolution from a project to an approach: here for the long haul.

Triggers

The major contributor to the ongoing achievement of HCO can be linked to the passion and commitment of early champions. Fran Baum of Flinders University, Richard Hicks of Noarlunga Health Service and founding community members all fought hard to win the original pilot funding and establish Healthy Cities, and these early champions continue to support HCO today. Another long-standing supporter was Mr. Ray Gilbert, mayor in the 1980s and early 1990s.

The WHO Healthy Cities project has provided resources, guidance and networking opportunities. International awards from WHO have greatly increased the recognition of HCO in South Australia and nationally, and have given legitimacy to its approach. Baum and Hicks have both been formally recognised for their achievements in health promotion.

The ongoing connection with Flinders University has a two-way benefit, strengthening the academic focus within HCO and providing an opportunity for students and scholars to see a Healthy Cities initiative in action. Flinders University has run a Healthy Cities short course that attracted enrolments from home and overseas; it included a field trip to meet HCO members and see some of the practical outcomes the project had achieved.

Problems and Interventions

The main activity focus of HCO has been in advocacy for healthy public policy and bringing together community and other sectors to influence the social determinants of health. Examples of specific projects include the Onkaparinga Estuary Water Quality Group, community safety (e.g. eye safety in small business, body art), community action on drugs and public transport advocacy.

The Onkaparinga estuary is an important native bird and vegetation habitat and is a significant site for Aboriginal people dating from before white colonisation. From the mid-1800s to mid-1900s, vegetation was cleared and weirs and reservoirs were constructed to meet the growing demand for water from metropolitan Adelaide. In 1970 sludge drying ponds were constructed as part of the local waste water treatment plant. In 1989, following growing community and local government concern about high levels of pollution and health impacts from recreational use of the river, HCO was able to bring together the many agencies with responsibility for water quality, and organised public meetings to discuss pollution issues. From these the Onkaparinga Estuary Water Quality Group (OEWQG) was established (Baum 2002). Intense advocacy resulted in resources being made available by the state and federal governments, and regeneration began. In 1992 the first wetlands were constructed, and in 2013 the sludge ponds were rehabilitated and the Noarlunga Downs wetlands opened. The area now supports a diverse range of native fauna, and regenerating flora improve the visual amenity and extend the treatment time of storm water before it enters the estuary. The wetlands project was implemented with strong community engagement throughout. HCO and the OEWQG were influential in getting the water quality issue onto the government agenda, and active in arguing for resources that would provide a solution.

The OEWQG was supported by HCO from the beginning, demonstrating the way that issues could be addressed by drawing on community participation and intersectoral action. HCO was able to bring together partners, work with government, and provide access to the government and governance system and key people (Cooke 1995). The approach was to support a resident-driven project and enhance community empowerment. Many members of the OEWQG are still actively participating in environmental or other projects, so their advocacy effort has extended beyond the original project.

Conclusions and Lessons for the Future

In some ways HCO has done its work. Working collaboratively with community, business and government agencies has become the default: local government hosts intersectoral round tables and embraces the role of urban planning for health and well-being (Baum et al. 2006). But the impact of the global financial crisis and the dominance of a market-driven user-pays ideology mean that inequities continue, presenting ongoing challenges for the Healthy Cities approach.

HCO is at a turning point. In South Australia in the 2010s, government resources and support for health promotion are low (Government of South Australia 2013). There is an increased focus on clinical services and hospital demand management. Evidence-based medicine spills over to health promotion and demands ‘hard’ evidence that health promotion contributes to reduced hospital admissions. However, there are also opportunities in that the state government appears to be shifting some health promotion resources to local governments to support implementation of a new public health act which, for the first time, requires local governments to ‘promote health’ (South Australian Public Health Act 2011).

HCO is unique in having an incorporated structure rather than being based in local government. This brings both benefits, in terms of autonomy and independence, and challenges, in terms of being outside the system and facing uncertain funding; but as long as community members and agencies are committed to support HCO, it will continue to evolve to face the new challenges ahead.

Kiama Municipal Health Planning: Providing a Safe, Strong and Sustainable Community¹⁶

Introduction

The Kiama Local Government area is on the South Coast of New South Wales (NSW), Australia, approximately 120 km south of Sydney. It has an area of 256 km² and is essentially a rural community surrounded by beaches, rainforest and

¹⁶ Sandra McCarthy.

farmland. Kiama Municipal Council has had a long-standing multidisciplinary commitment to the health of its community, through its operation of the Illawarra Home Nursing Service, which won a National Award of Excellence in Local Government and Blue Haven Aged Care Facility (nursing home, hostel, retirement facilities including a specialised Dementia Unit). It also provides a range of public health and health promotion services—the only Council in NSW to offer this quality of aged care.

The role, and subsequently the boundaries of responsibility, of local government is increasingly expanding and includes a focus on providing services for the health and well-being not only of the individual within a municipality but also of the community and environment. To address this role Kiama Municipal Council has embraced WHO's definition of health in recognition of the interaction between the health of the community and the wider environment. This socioecological definition of health is embodied in the development of local government initiatives which offer a holistic, collaborative approach to solving local issues.

Kiama was one of the first councils in NSW to develop and implement a municipal health plan. The plan came about by a chance opportunity: the Kiama District Health Watch was required to undertake community consultation using vision processes to identify priority health issues, and at the same time Healthy Cities Illawarra and Kiama Council were examining a proposal to develop a health plan. The development and implementation of the plan relied on the establishment of strong partnerships, particularly between Healthy Cities Illawarra, Kiama Council and the local health district, and with the support of the community and local organisations.

The Kiama Municipal Health Plan documents its holistic planning approach and outlines strategies to address the interaction between human and environmental health. It includes health, environment, social, strategic and land-use planning, and economic development. It is a whole-of-government approach which incorporates the principles of ecological sustainable development (ESD) and Agenda 21, and links international, commonwealth, state, regional and local issues, goals and programmes. Ultimately it attempts to encourage every citizen to become responsible for improving their own health and to preserve, protect and improve the local environment, and to provide opportunities to accomplish this.

The aims of the plan are:

- To improve the health, well-being and quality of life for all residents and visitors to the Kiama Municipality
- To improve, protect and enhance the environment for the benefit of present and future generations
- To promote ecological sustainable development that minimises hazards and maintains the local environment to a degree that human health and safety are not impaired and yet encourage development to proceed

The Process

The first Kiama municipal health plan of 2001–2004 had a strong focus on vision workshops to identify health issues within the areas of environment, community and economy. Participants were asked what their vision was for an ideal healthy municipality in 20 or 25 years' time. Groups participating included farmers, businesspeople, youth and tourists. Their visions included clean air and no pollution, land viable for food production, open spaces, a village atmosphere and a feeling of belonging and a sense of community. These workshops were supplemented with a community and tourist survey, a health needs assessment, research into and review of existing policies, goals and strategies being conducted by other agencies, and the construction of demographic and epidemiological profiles. The information from all of these was analysed to identify priorities in 12 theme areas: health, safety and injury, tourism, employment, transport, social and cultural, food and nutrition, leisure and recreation, pollution control, education and training, built and physical environment. Strategy workshops were then conducted with residents, community groups and government and non-government organisations.

Achievements of the Municipal Health Plan

The implementation of the Municipal Health Plan has led to significant programmes:

- A Safe Communities project.
- Kiamasphere, a sustainable living program: The objective of Kiamasphere projects is 'to manage, improve and protect the total environment to attain a sustainable and high quality lifestyle for present and future generations'. The logo incorporates the council's colours and represents the holistic approach required to achieve sustainable living.
- A Sustainable Living Expo, conducted annually to showcase the activities of the council and community groups and to introduce commercial products that promote a sustainable living environment.
- Sustainable Living grants which provide funding to community groups and schools to implement health and environmental strategies to create a more sustainable community. Grants have included the funding of tree planting, establishment of indigenous gardens, sun protection activities, building of a school chicken coop and development of community information resources.
- The development of a comprehensive physical activity programme including the provision of marked walking paths (the Heart Care Walks) to encourage regular physical activity and the development of a 12-km coastal walking track between Kiama Heights and Warri Beach.
- The establishment of the Kiama produce market, which came about through two significant issues: the lack of access to fruits and vegetables except through one large-chain grocery store which was very expensive, and the need for local

farmers to find uses for their land other than dairy farming after the deregulation of the dairy industry.

- The establishment of a community garden at Blue Haven Retirement Village, which is maintained by a wide range of community groups.

There are numerous other successful outcomes of the first plan, demonstrating how local government can lead and partner the community and local organisations to build a strong, healthy and safe community.

The Second Municipal Health Plan

Development of the second Kiama Municipal Health Plan 2005–2008 has involved widespread community participation through focus groups, interviews and surveys. Research and review of literature including local, state and national goals and programmes were conducted to identify key priorities for council; demographic, environment and epidemiological profiles were also prepared to assist in priority identification. The priorities identified through these processes were the following:

- Strengthening community by building partnerships and networks and community connections: The council undertook many public infrastructure projects, involving the community in planning and construction, to ensure the ongoing use of facilities and improved health outcomes. The projects included the Pavilion (town hall, community meeting place and home of agricultural show), redevelopment of the library to include the community college and a bridge club constructed on the AFL field so that senior citizens and young footballers share and socialise in a common public space.
- Providing supportive social environments for health, particularly through healthy lifestyle strategies, safety and injury prevention and high-quality health services.
- Protecting and enhancing the health of the environment, specifically through addressing issues related to the natural and built environments, waste and transport.

Kiama Healthy and Sustainable Cities Plan (2011–2017)

In the evaluation and review of the plan Kiama Council engaged with community focus groups to obtain vital feedback and recommendations. Overall there was broad consensus about the priorities identified by the council, and in turn the community delivered rich discussion and opinions which were incorporated in council decisions. A theme emerged: ‘building partnerships, networks and community connections’, acknowledging that positive relationships, social contact and a strong sense of belonging to and connection to the community in which one lives can greatly enhance health.

The priorities identified were the following:

- Building stronger partnerships with government and non-government organisations and community groups
- Addressing social isolation, particularly for new residents, young families and the aged
- Researching how residents in Kiama interact and how individuals become connected creating a harmonious and generous society
- Providing sustainable population and health equity programmes
- Bringing the community together with the celebration of food as a cultural experience
- Developing a new Resident's Kit to welcome new residents to the municipality, with the aim of empowering residents to form social connections and actively participate in the community

Triggers and Values

Kiama Council was a founding member of Healthy Cities Illawarra and still plays an active role in the organisation. In 2004 Sandra McCarthy, mayor of Kiama Council and president of Healthy Cities Illawarra, attended the inaugural meeting of the International Healthy Cities Alliance in Kuching. The meeting formed the beginning of strong, collaborative partnerships and friendships with global scholars, mayors and health and local government professionals. The key message of the conference was that if the Healthy Cities model were to be sustained, it had to be embedded in local governments, which were seen as the foundation stone or key component for community strategic planning, able to bring about behavioural change in policy and council organisation. On return from the conference, the mayor and council were active in working for the Kiama municipality to be recognised as Healthy City; this was achieved in 2008. That same year Kiama hosted the inaugural national forum of the Australian chapters of the Healthy Cities Alliance. International and local collaborations have continued to foster the exchange of information and experiences, from Taiwan, Singapore, Hangzhou in China and Muju City in South Korea, as well as all Australian members.

Long-term, sustainable community ownership of the plan was achieved due to the political commitment of the council. Significant contributions were made by the executive council officer and members of the health and sustainability committee.

Conclusion

Kiama's Health Plan has received international recognition from WHO. It is an evolving document which is regularly reviewed to ensure that it remains responsive to the local needs of a growing community. Encouraging the public to participate in

the development, implementation and evaluation of the Health Plan is seen as essential to its continued success. The future in Kiama is positive: through the community's engagement in the Health Plan, it can look forward to better health and well-being, and to a safer, sustainable environment which ensures greater quality of life, empowerment, harmony and equity.

Healthy Islandsy¹⁷

One rather particular environment in which local government initiatives meet national interests is that of the small island state. Island nations face particular challenges. This was recognised as early as 1994 when the UN-sponsored Global Conference on the Sustainable Development of Small Island Developing States determined that sustainable development was the only option for the development of such nations. The conference subsequently adopted the Barbados Programme of Action for the Sustainable Development of Small Island Developing States (SIDS). Where the Barbados Programme of Action continues to work towards sustainable economic and ecological development (see sidsnet.org), the Yanuca Island Declaration (1995) squarely connects development with health. It adopts a settings-based health promotion agenda, recognising that (Healthy Pacific) islands are places where children are nurtured in body and mind, environments invite learning and leisure, people work with age and dignity, ecological balance is a source of pride and the ocean which sustains the people is protected. As a key action programme, the Yanuca Island Declaration advocates a strengthening of health care and the health care workforce, collaborative efforts between SIDS and the further development of expertise and technology to address the unique challenges faced by this group of countries.

The formal WHO Healthy Islands programme (Nutbeam 1996) governed by the Yanuca Declaration extends to nations and territories in the Pacific Ocean (American Samoa, Cook Islands, Fiji, French Polynesia, Guam, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, New Caledonia, Niue, the Commonwealth of the Northern Mariana Islands, Palau, the Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna). There is considerable diversity among these islands, in terms of demography (most have Melanesian/Micronesian/Polynesian core populations, but there have been considerable European and Chinese influences), geography (some nations like Vanuatu are highly volcanic, others like Kiribati consist of numerous coral reefs and atolls and a few like Pitcairn or Nauru are singular rocky outcrops) and 'development' (Palau ranks 52nd on the Human Development Index—above Russia—and the Solomon Islands is 143rd) (Malik 2013).

All of these islands find themselves in the vastness of the Pacific Ocean, and those that occupy territorial areas of several million square kilometres (like Kiribati or the Cook Islands) suffer from an 'internal tyranny of distance' as much as the

¹⁷ Evelyne de Leeuw and Erik Martin.

smaller ones do with their most direct neighbours. To travel from the outer islands to the administrative centre may well take weeks, and acute health issues are often hard to address promptly. This challenge, of course, is exacerbated by low population sizes and the smattering of expertly trained professionals, including public health and health promotion specialists.

Numbers alone may deceive, though. Pacific islanders have a rich cultural history, and they established systems of navigating the high seas through ‘wayfaring’ long before Chinese and European technologies enabled the colonisation of the area (Pyrek 2011).

The most serious threat to health and the very existence of these islands, however, is climate change. The International Panel on Climate Change forecasts that some of these ‘may face serious threat of permanent inundation from sea-level rise. Among the most vulnerable of these island states are the Marshall Islands, Kiribati, Tuvalu, Tonga, the Federated States of Micronesia, and the Cook Islands’ (Smith et al. 2001, p. 935). This effectively means the annihilation of human existence on those islands (Nunn 2013), and although some island governments have pre-empted this future, for instance by Kiribati purchasing land in Fiji for possible relocation of its residents (Office of the President 2014), there will still be profound impacts on the health of these nations.

Some of the more traditional health challenges in Pacific SIDS are summarised in Table 12.1. This material shows that some Pacific islands are surprisingly urbanised, and would merit a Healthy City rather than a Healthy Island programme on their own—for instance, as Suva on Fiji has declared, although there is very little documentation for ‘Healthy Suva’ (Fig. 12.4). Regardless, islands, and in particular SIDS, seem proverbial ‘settings for health’, although as Dooris (2004) has written, the range of settings (healthy marketplaces, health-promoting schools, healthy villages, health-promoting health services) could benefit from consistency in value systems across the board, given the extent to which they are places where people ‘live, love, work and play’ (WHO 1986) and create health. The Yanuca Island Declaration (WHO 1995) builds on a heritage of global conferences concerning health, sustainability and development in the later half of the twentieth century, and sees Pacific islands as 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
- The ocean which sustains the people is protected

In 1997 health ministers of Pacific Islands confirmed their commitment to Healthy Islands (Galea et al. 2000), and stated in their Rarotonga Agreement, ‘The Healthy Islands concept involves continuously identifying and resolving priority issues related to health, development and well-being by advocating, facilitating and enabling these issues to be addressed in partnerships among communities, organizations and agencies at local, national and regional levels’. The following priority areas and concerns are listed in the agreement:

Table 12.1 Pacific island nation/territory demographic information and health expenditure (WHO/WPRO, 2012 — WHO Multi-Country, Cooperation Strategy for the Pacific 2013–2017)

Country or territory	Population			Per capita GDP		Health Expenditure		General government expenditure on health (% of total government expenditure)	
	Year	Population (in '000s)	Urban population (%)	Year	US\$	Year	Per capita US\$	As % of GDP	
<i>Melanesia</i>									
Fiji	2010 ^e	854.0	51.9	2009	2978.95	2009 ^p	130.40	3.60	9.30
New Caledonia	2009 ^p	245.6	57.4	2008	36,758.00	2008	3420.76	9.5	–
Solomon Islands	2009	515.9	18.6	2008	1014.00	2009 ^p	71.84	5.30	16.80
Vanuatu	2009	234.0	25.6	2009	2685.10	2009	104.00	3.90	13.60
Papua New Guinea	2011 ⁱ	677.4	12.5	2011	1767.24	2011 ⁱ	75.98	4.28	12.75
<i>Micronesia</i>									
Federated States of Micronesia	2010 ^p	102.6	22.7	2008	2223.00	2009 ^p	333.33	13.80	20.60
Guam	2010 ^e	180.7	93.2	2005	22,661.00	–	–	–	8.71
Kiribati	2010	103.5	48.3	2010	1307.40	2009 ^p	204.80	12.20	8.70
Marshall Islands	2012	54.4	71.8	2007	2851.00	2009 ^p	419.35	16.50	20.10
Nauru	2010 ^e	10.0	100.0	2006–2007	2071.00	2009 ^p	625.00	10.85	18.50
Northern Mariana Islands	2010 ^e	63.1	91.3	2005	12,638.00	2007	–	–	25.40
Palau	2010 ^e	20.5	83.4	2007	8423.00	2009 ^p	1000.00	11.20	16.70

(continued)

Table 12.1 (continued)

Country or territory	Population			Per capita GDP		Health Expenditure		General government expenditure on health (% of total government expenditure)	
	Year	Population (in '000s)	Urban population (%)	Year	US\$	Year	Per capita US\$	As % of GDP	
<i>Polynesia</i>									
American Samoa	2010 ^e	65.9	93.0	2005	9041.00	2003	500.00	–	14.00
Cook Islands	2010 ^e	23.3	75.3	2009	10,298.00	2009 ^p	503.60	4.50	10.60
French Polynesia	2010 ^e	268.8	51.4	2006	16,803.36	2008	3361.57	13.09	29.00
Niue	2010 ^e	1.5	37.5	2006	8208.20	2009 ^p	1866.55	16.94	15.81
Pitcairn Islands	2009	.05	n	–	–	–	–	–	–
Samoa	2010 ^e	184.0	20.2	2009–10	2908.02	2009 ^p	161.04	5.30	14.50
Tokelau	2006	1.5	0.0	2003	612.50	2001–09	3705.64	–	10.46
Tonga	2010 ^e	103.4	23.4	2008–09	2988.00	2009 ^p	161.04	5.30	14.50
Tuvalu	2010 ^e	11.2	50.4	2002	1139.32	2009 ^p	312.50	10.50	11.00
Wallis and Futuna	2010 ^e	13.3	0.0	2004	3800.00	2008	–	–	24.00

e estimated, *p* provisional, *i* <http://hiip.wpro.who.int/portal/countryprofiles/PapuaNewGuinea.aspx>, *GDP* gross domestic product. Source: WHO Country Health Information Profiles (CHIPS) 2011

Fig. 12.4 Suva—a Healthy Fijian City

- Adequate water supply and sanitation facilities
- Nutrition, food safety and food security
- Waste management
- Housing
- Human resources development
- Communicable and non-communicable disease prevention and control
- Lifestyle and quality-of-life issues
- Reproductive and family health
- Promotion of primary health care
- Social and emotional well-being
- Population issues
- Ecological sustainability
- Information management
- Tobacco use
- Alcohol and substance abuse
- Environmental and occupational health.

These key remits were confirmed at a forum on Healthy Islands at WHO Headquarters in 2010, and a programme of recognition of successful and worthy projects in Healthy Islands was initiated.

The WHO Pacific division of the Healthy Island Recognition Programme explicitly connects with the visionary ideas emanating from the Ottawa Charter on Health Promotion and the work that was initiated by the Yanuca Declaration (Fig. 12.5).

Fig. 12.5 Ottawa Charter, Yanuca Declaration and Healthy Islands: complementary values

The WHO Healthy Island recognition programme was called for at the 2009 meeting of the Pacific Ministers of Health as part of the call for revitalisation of Healthy Islands. Since the conception of Healthy Islands, WHO has worked with its member countries and organisations to provide support for project and programme planning, implementation and evaluation, for the improvement of health and quality of life of Pacific Islanders. These initiatives fell on fertile ground, and a diversity of Healthy Island initiatives have been developed and maintained.

To encourage further development and building on this momentum, WHO member states decided that the sterling pioneering work needed formal recognition. With the main purpose of encouraging communities and countries to continue to innovate and demonstrate effective and efficient ways of promoting and protecting the health of their populations, a formal programme to recognise and award outstanding work in defined areas was developed. It focused on good practices or proposals for Healthy Islands, based on community actions or efforts, engaging across different sectors and with strong governmental support. Entries were open to all Pacific Island countries and organisations, and applications were to be submitted in the form of a report, either on work in progress or a completed project, for the Best Practice award. The Best Proposal category required the submission of a detailed proposal for intended work not yet initiated; the award monies could be used to start the proposed action.

Of the 19 applications received for assessment, 8 were for Best Practice and 11 for Best Proposal. Submissions came from the Federated States of Micronesia, Tonga, Solomon Islands, Samoa, Niue, Cook Islands, Tuvalu, Vanuatu, Papua New Guinea and Kiribati. The applications were of varying quality; some were quite exceptional in content and presentation, others needed extra work for presentation and a few did not align with the criteria. The broad range of quality and substance is not surprising, as some Pacific Islands have a proud record in health promotion: for instance, the Tonga Health Promotion Foundation has been recognised since its establishment in 2007 as a regional powerhouse of health innovation (Fotu et al. 2011) and others are still facing huge health and resource challenges.

A shortlist was made of the top five in each category. The committee engaged in detailed assessments against preset criteria based on Fig. 12.5, and scores on a number of categories were assigned. In discussion with representatives of Pacific Islands and WHO experts recommendations for awards were made to the Regional Director:

- Best Practice Community-based Effort (CBE): NCD Elimination in Aniwa and Aneityum (Vanuatu)
- Best Practice Government Sector: Healthy Workplace (Palau)
- Best proposal: Five Circles for Healthy Pacific Islands (NGO)
- Best Proposal: Adopt a Healthy Community (Chuk)

At the ninth Pacific Ministers of Health Meeting in 2011, the regional director of Western Pacific presented a recognition plaque and further monetary support for Best Practice projects, and monetary support only for Best Proposal, with the view to assess progress in ensuing years. Applications that did not get an award were referred to appropriate departments in WHO for further technical support. Everyone benefited.

A formal review of the process revealed that the countries applauded the recognition programme as a great measure of recognition of Healthy Island practices, which resulted in more and better quality proposals and reports being received for the second round which were awarded at the tenth Pacific Ministers of Health meeting in Apia, Samoa. The programme continues, with work towards the recognition at the 20th anniversary of Healthy Islands in 2015, to be held in Fiji where the first Pacific Ministers of Health Meeting was held in 1995.

Wrap-Up: Oceanic Values for Health Development

In this chapter we have highlighted the enormous diversity in approaches and governance models for Healthy Cities in Oceania. The Australian case studies show that—although local government is an important partner in these endeavours—Healthy Cities are essentially community-driven operations where NGOs (or, in the case of Onkaparinga—formerly Noarlunga—just *one* NGO) keep the momentum and sustain enthusiasm and vision. This is also the case in many Healthy Islands, as demonstrated by the initiatives that received WHO recognition across the Pacific.

It is not surprising that this emphasis on community presents itself so strongly in this region. Crawford et al. (2010) recognise and embrace the importance of diversity for healthy urban planning. Baum et al. (1990, 2006) consistently show evidence that community-based diversity in urban health (equity) planning approaches is a critical ingredient for success and sustainability.

The case study from Aotearoa (New Zealand) shows an inspirational perspective on how an indigenous vision of health promotion and Healthy Cities creates a powerful and appealing, as well as culturally safe and responsive, planning and development paradigm for urban health development. This is reaffirmed, more broadly, by Ryks et al. (2014) in their analysis of an inclusive urban health planning agenda in Aotearoa that builds on traditional patterns of settlement. It appears that embracing a value system for community living that is hundreds of years (and in the case of Indigenous Australia, tens of thousands of years) old in adaptation to ‘modern’ urban settlement could be an important way forward in dealing with equity matters in a culturally diverse Healthy City environment.

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