Healthy Settings Coordinator Training

Report of a National Workshop
Yogyakarta, Indonesia, 25–27 February 2009
Healthy Settings Coordinator Training

Report of a National Workshop
Yogyakarta, Indonesia, 25–27 February 2009
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>Inaugural session</td>
<td>2</td>
</tr>
<tr>
<td>Development and growth of Healthy Cities in Indonesia</td>
<td>3</td>
</tr>
<tr>
<td>Basic criteria of HCP in Indonesia</td>
<td>4</td>
</tr>
<tr>
<td>Training sessions</td>
<td>6</td>
</tr>
<tr>
<td>Objectives of training</td>
<td>6</td>
</tr>
<tr>
<td>1. Health in development</td>
<td>7</td>
</tr>
<tr>
<td>2. Healthy settings concepts and practice</td>
<td>10</td>
</tr>
<tr>
<td>3. Health promotion concept relating to healthy settings</td>
<td>14</td>
</tr>
<tr>
<td>4. Health programme planning and management - leadership and team-building</td>
<td>15</td>
</tr>
<tr>
<td>5. Good governance</td>
<td>18</td>
</tr>
<tr>
<td>6. Resource mobilization (in urban settings)</td>
<td>21</td>
</tr>
<tr>
<td>Schedule of Training of Trainers for Healthy Cities Programme</td>
<td>29</td>
</tr>
<tr>
<td>Participants</td>
<td>31</td>
</tr>
</tbody>
</table>
Background

The workshop was a continuation of the work aimed at creating a critical mass of healthy settings (HS) coordinators in the South-East Asia (SEA) Region. Over the past over twelve years, the healthy settings process has been stuttering in countries of the Region.

In a way, this flux is the result of WHO not being able to keep up the momentum of advocacy of this process. Among competing demands of other programmes in WHO and in Member States, this agenda has floundered particularly with the reduction in environmental health programme staff in more than half of country offices in the Region. Where the Regional Office has managed to maintain Environmental Health (EH) staff, these programmes have continued and moved slowly along. Bangladesh, India, Indonesia, Nepal and Thailand are countries where this process is much better ingrained, whereas, in Bhutan, DPR Korea, Maldives and Sri Lanka, the effort is less visible at national level. Sri Lanka had a good beginning with the healthy villages and the healthy towns’ programmes in the late 1990s, but the progress was stalled due to the absence of a WHO facilitator at national level.
Another reason for the flux, and in several cases for the unseen progress, has been the politics involved in the process. In all countries, these efforts have been initiated by city mayors. As political leaders, they were the primary driving force for promoting the healthy settings process. No doubt they were the promising resource for the success of the process because mayors lead the community. But their leadership is inevitably short-lived. Their survival is only as long as they survive the political support of the community. The loss of an election the next time around subjects the process they had begun for healthy settings to a halt. This is particularly so when a mayor has not been able to institutionalize the HS process into the working of the municipal machinery. To date, only Thailand has been able to carry the healthy settings process towards institutionalization at the municipal level and even carry it forward to be integrated into their national development process.

Underlying these issues, however, is the larger concern of sustainability. How can we make the process go on by itself without anyone outside the community nurse-maiding it, is the dominant concern.

So, it was logical that we needed to move away from this ownership model of political leaders, and also away from these programmes to be WHO hand-holding exercises to being an independent and self-reliant process that the community can implement by themselves. This could only be conceived through developing an innate capacity of enlightened citizens within the community to promote such a HS process. It is hoped that such a critical mass of practitioners brought forth by this type of training will energize the programme once again, with the factor of sustainability built into the process this time around.

Inaugural session

At the opening session of the HS coordinators training course, the WR to Indonesia, Dr Salunke was present and provided the lead thoughts for the sessions. He mentioned that processes such as healthy settings were necessary for community development, because of its umbrella nature that helps to pool in many health-related functions. He conveyed greetings from Dr Samlee Plianbangchang, Regional Director and promised support on technical matters at country level.
Dr Wan Al-Gadri, Director-General, Communicable Diseases, Ministry of Health, Indonesia, inaugurated the course. He said that HS was started in October 1998 with pilots undertaken later in six districts. He also talked about the Swastiya Sabha (clean cities) movement and the “Alert Villages” movement of 2004. The first award was given in 2007 for 38 districts. The following criteria were met for awarding the selected villages: local problem-solving on local demand, putting society at the centre of development, starting with a single action, sustainability focus, action implementation carried out at local level, SWAP approaches practiced, programme monitoring by the local forum and local community, and capacity building and empowerment of society at the local level. Simple tests for self-assessment of local ownership were used.

Development and growth of Healthy Cities in Indonesia

The “Healthy City” programme (HCP) was launched on 26 October 1998 launched by the Ministry of Home Affair in six districts as pilot projects. This was followed up by starting the programme in eight tourist areas in Java and outside Java islands in 1999. By December 2006, the Healthy City approach had been developed in 186 districts/municipalities (40.2%) out of 443 districts/municipalities.

Later, the Minister of Health, Indonesia launched the National Movement on Healthy Cities and Healthy Districts in July 2005 in a more formal manner, recognizing the approach as a comprehensive mechanism to promote holistic health at the local level. Subsequently, two relevant ministries formally endorsed, through a joint decree, the healthy settings process. This provided added legitimacy to the programme.
Basic criteria of HCP in Indonesia

The following aspects are used as the criteria that signify the healthy settings process in the Indonesian context.

➢ Programme activities are conducted on priority local- problems and implemented gradually.

➢ Society is a development agent that works through city-level forums and sub-district task forces or other forums as agreed upon.

➢ Potential areas are used as entry points, beginning with simple activities that lead onto greater development of healthy area within that city, province, and the nation by 2010.

➢ Focusing on sustainable processes than just being target oriented and project oriented.

➢ Option of menu, activities, and indicators are decided through discussions between the Healthy Cities (H.C) forum and the local government.

➢ Government programmes which are not selected by the forums, continue to be conducted by related sectors.

➢ The budget comes from the local government and public resources.

➢ Evaluation is conducted by stakeholders.

The types of healthy settings being implemented in the country include: settlement areas, and public facilities (viz. housing, schools); transportation areas; healthy mining areas; healthy Forest areas; healthy industry and healthy office areas; healthy tourist areas; food and nutrition related settings; healthy social life settings; healthy independent communities; healthy cities; and community forests.

Recognition and citation is also a part of the healthy settings process in Indonesia. While the original system of awards of Adipura and the Clean
Friday movement are at a low ebb, the first Healthy City Award, Swasti Saba, was given by the Vice President to 20 districts/municipalities, on 12 November 2002, on the occasion of Indonesia’s National Health Day. The second award was given on National Health Day, 2007. This new Swasti Saba is a trophy given by the President every two years on National Health Day, to the head of the district which has most successfully implemented the Healthy City Programme.

Steps are being taken to begin networking. On the capacity building front, an MoU was signed between Ministry of Health and Griffith University in Australia in April 2005, on promoting Healthy Cities.

A review of implementation reveals that while the Ministry of Home Affairs has primary responsibility for the clean settings movement, coordination between the MoH and Home Affairs is lagging. But bhupatis, mayors and district governors periodically discuss ways of pushing forth the programmes and so the MoH started the Community-Led Total Sanitation (CLTS) interventions recently which have been very popular. Apparently, in three years, sanitation coverage has improved by 15%-20% in these places. The district health office is the lead agency for technical inputs. New activities such as hand-washing and household water treatment are being implemented, and soon food safety will also be included.

In the area of Healthy Settings, there is a national committee as well as local-level forums. The lead role is played by the Ministry of Home Affairs. The latest five-year national development plan mentions healthy settings as an operational modality. An interesting example of how the healthy settings process is making development headway is from the news that in the municipality of Payokumbu in West Sumatra, the mayor has put all the development activities under the healthy setting programme. This type of positive example, if implemented well can attract others to do the same and made this process as a part of a holistic development programme that straddle both economic and social development.
During 2003-2005, healthy settings had a lag period when the approach got less attention politically. In the past there was a good push at the political level when local awards were presented - especially presidential awards. This three-year period witnessed a lag because there were no rewards given by the government. No monitoring of the programme was conducted. But enlightened bhupatis continue to work with local forums that are still functioning. Recently, at the central level, the MoH and Local Affairs had two collaborative national meetings. This indicates the revival of the healthy settings process.

WHO is providing sustained support to the process. The bahasa guideline for healthy settings is being translated into English. The healthy food markets programme now has the support of EU funds. Other regular budget funds, while already spent on CSR team’s surveillance and case management activities, more funds seem to be on the horizon. There is a feeling that the WHO Representative office can better use this umbrella approach of healthy settings process and work as a team. The environmental health staff at the WHO country office is also involved in the healthy markets implementation process.

Training sessions

The primary purpose of this activity is to orient and train healthy settings coordinators in the critical knowledge and skills base required to function effectively. Whatever the type of setting, this combination of modules would help the manager to get the programme off the ground using the local resources available for sustaining the programme.

Objectives of training

A total of about 25 participants largely from various government departments attended. They were from the MoH, the ministries of public works, trade, forestry, agriculture, transportation, education, the national laboratory for communicable diseases, the centre for health empowerment, public health associations, university department of community medicine, post-graduate centre for anthropology, and from the Yogyakarta health office.
Most participants were involved directly or indirectly in promoting healthy city activities.

It was observed during the presentations by the Ministry of Health, that the healthy cities programme is well established in the country. By December 2006 the healthy city/settings approach had been developed and established in 186 districts/municipalities covering nearly 40% of all districts in the country. Presentations, discussions and group work followed based on the six training modules presented by Dr A. Sattar Yoosuf and Dr Surinder Aggarwal over a period of four days.

1. **Health in development**

Health in development was the main focus of Chapter 6 of Agenda 21, which brought to the forefront the idea that health was the centre of sustainable development in its first Principle – “Human health is at the centre of concerns for sustainable development...”. Presenting the definition of sustainable development as “development that meets the needs of the present without compromising the needs of the future generations to meet theirs” and thus the idea of responsible behaviour was clarified.

The Declaration of Alma Ata on Primary Health Care 1978, United Nations Conference on Environment and Development (UNCED), World Summit on Sustainable Development (WSSD) in Johannesburg in 2002, and more recently the MDGs all promote this idea of sustainable development. How the health sector can move the policy agenda of other sectors, through influencing their actions to be more health-promoting needs to be determined.

In this context, sufficient awareness needs to be created on how each sector’s development actions affect human health. Sectors such as
transport, energy, agriculture, tourism, industry, produce effluents as a result of their activities that pollute and degrade the environment. The fumes from vehicles and industries pollute the air, effluents from industry and agriculture pollute our rivers and other water bodies, agricultural ventures kill biodiversity, or fill the soil with chemicals that drain into our aquifers and water bodies, and accumulate in our bodies. The health repercussions would make a long list.

Much of this is preventable but lack of enforcement of legislation, or lack of political will and commitment of national leadership are among several of other causes that hamper clean-up efforts. The resulting degradation of the earth’s biosphere is perhaps reaching an advanced stage of no return. Given that this century has seen an unprecedented plundering of our ecosystem, drastic global efforts are needed to curb the onslaught of impending global warming and climate change, and the resulting drastic and unexpected health consequences.

The recrudescence of malaria, dengue and other vector-borne diseases, diarrhoeal diseases, respiratory infections, and the emergence of exotic species of diseases is the result of habitat change due to warmer temperatures. The change in climatic variability would lead to extreme weather events such as storms and droughts that will affect the production of food and livestock, either because of floods or water stress, and precipitate the mass exodus of human populations across borders. This could cause anxiety, stress and conflict among nations, and pave the way for complex emergencies and inhuman treatment of internally displaced and migrant populations.

This module also highlighted the driving forces of environmental change – modernization, urbanization, globalization, international travel, climate change and information technology. These are the inevitable manmade forces that have changed our environment. The degree of awareness on the consequence of these stresses will determine the mitigation effort we will apply as a global community. Thus, the importance of every sector being aware of these detrimental consequences, must precede rational and sustainable action.

The question of how we address these challenges will need a lot of efforts by the health sector, working with other sectors. We can no longer be comfortable with dealing with the health sector alone. There would be a
need for partnerships and sharing of work on common outputs. These will require a redefinition of work within and among sectors, and the type of leadership and skills that will move the future multi-sectoral and multi-disciplinary agendas of this 21st century.

Group work focused on identifying a development sector and discussing its development activities and the perceived ill-health consequences of their work. Who would be the partners to address these issues? Groups selected four development sectors - **agriculture, transport, forestry, and trade and industry**.

**Transport**. The issues identified were accidents, carrying of vectors, increased poisonings and increased air pollution. Partnerships were needed with the department of environment, health, pesticide bureau, public works, hospitals, and research institutions. Partnership were also needed for reducing stress at the workplace.

**Forestry**. The issues were related to the changed disease pattern, zoonoses, chemical pollution, and water shortage for hygiene, injuries from logging, mental stress related to migration, landslides, and floods, air pollution from burning of forests, climate change and water shortage. Need partnerships with agriculture for locating development programmes, health for disease mitigation, education for advocacy and teaching in schools, local government for ground level assistance and decentralization concerns, laws and regulations, labour, transport and public works, for plans on urbanization and relocation of people to new settlements. Also, NGOs for community-level work on forestry.

**Trade and industries**. The issues related spurious drugs and food in the market, safety, public purchasing power, hazardous materials, poisoning, and occupational heath concerns, pollution from industries into rivers and water bodies, nutritional issues, and an issue of esthetics due to non-environmental friendly activities by industry.
Partners national planning and development board, district level, finance ministry, home affairs trade health, forestry, environment, transportation, NGOs, and civil society.

Agriculture: The issues included food resilience, combining foods for pregnant mothers, students, pesticides in the plantations, backyard poultry AI concerns, under-nutrition, harvest-time waste water, organic waste management, bad storage and food spoilage or chemical poisoning from herbicide and fungicides, occupational health and indoor air pollution. Partnerships with sanitarians and puskesmas, health ministry, trade and industries, local government, Bangkok universities and NGOs.

2. Healthy settings concepts and practice

The module introduced participants to the difference between a healthy settings process and a regular community development type of activity. Defining the setting as “a physical or geographically demarcated location where people live, learn, play and work”, the dynamic nature of the setting was highlighted. More formally, from the early literature of healthy settings, the term is defined in the following way “A healthy setting is defined as one that is continually creating and improving those physical, social and environmental determinants and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential”

This shows the importance of the community providing leadership and resources to promote health and, in the process, deriving a sense of achievement and confidence to do more. Resources that are available can be used to progressively reach higher levels of self-sufficiency and independence. This provides for a sustainable process that would not depend on external donor inputs. This type of demonstration of local capability and commitment would encourage donors to provide funds that they are sure to be used to good advantage and purpose.
Some ask why a settings approach to promote health? The response would be that a setting offers practical opportunities for implementing comprehensive strategies that indicate the holistic nature of health. Health can be achieved through clinical services alone. It is created through supportive environments that control the conditions that cause ill health. The Ottawa Health Promotion Charter of 1986 expounded the concept of “supportive environments” as follows: “Health status of a community is determined more by the conditions of the setting where people live, learn, work or play, than by the number of health care facilities that it provides”. Thus, in a setting, this promotion can be invoked through people taking command of their lives. A setting gives the people living there a sense of identity and purpose (that is why they are called a community) and motivate them to work together for their collective wellbeing and welfare. It is also easier to monitor and track the progress of development within confined and smaller settings than larger ones. Thus, community-level entities such as schools, villages, townships, hospitals, markets, etc. are both manageable and changeable within short time frames. Such progress will help build community confidence to achieve success. And success would beget success.

Settings can be elemental or contextual, depending on the model one wishes to use. A town can be a contextual setting within which elemental settings such as schools, marketplaces, hospitals, etc. are situated. For programmatic and practical purposes, one can develop a process for promoting health at the contextual level or elemental level. Each would be valid as a healthy settings process if it conforms to a very simple...
criteria: these are that the programme undertaken is carried out by first preparing a plan of action that is developed with the participation of the community for which it is conceived, it has a managerial mechanism to implement it, and this is done with the full involvement of the community. This would be in contrast to the ordinary type of periodic efforts of community health development often undertaken when a donor or well wisher gives some funds to carry out a particular task. In this type of situation, when all the money is spent, the programme also often comes to a halt. In the healthy settings type of programmes, there would be an iterative process in operation that ensures an annual review of progress and re-planning to address managerial constraints of the previous year, and include new actions that can be undertaken given the progress of the past year.

In the SEA Region, the healthy settings process has been going on for over a decade. Every country except DPR Korea and Timor-Leste have healthy settings programmes in operation. Perhaps, even these two countries may have related activities that may not be known to WHO or other agencies. The process is actually a return to the past where decentralized action can be made effective through organized and streamlined work processes. Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand have healthy villages, towns, schools, and market places in operation. Indonesia and Thailand have healthy market places in a large measure taken up with the emergence of avian influenza infections and its logical relationships with wet markets where live ducks and poultry are sold. In Maldives, the going label is healthy islands, and Bhutan had begun their “model villages” idea over a decade ago which spread widely within the country.

“Twenty steps to healthy cities”, is one of the first documents WHO prepared during the early part of this campaign. The process it outlines are delineated into three phases.

1. Getting started (which includes building support groups, understanding the ideas behind healthy settings, knowing the city, finding finances, deciding the organization, preparing the proposal, getting approval);

2. Getting organized (includes appointing a committee to oversee and analyze the project environment, define project work, set up the office, plan strategy, establish accountability), and
(3) Taking action (includes increasing awareness, advocating strategic plan, mobilizing inter-sectoral action, encouraging community participation, promoting motivation, securing resources, and securing healthy public policy for action).

The sustaining factors of a healthy settings process are good leadership and vision; well-defined goals; well-developed coordinating mechanisms; and community ownership of the process.

Given the past actions in the South-East Asia Region, several constraints in implementation are noted. Lack of progress is linked to leadership issues and the community not being well aware of the HS concept, weak planning and management, weak coordinating mechanisms, low advocacy focus and motivation, unrealistic time frame for achievement of targets, turnover of government and project staff, as well as the gap between NGOs and the government. Constraints to sustainability include personality dependence, inadequate level of community involvement, and the focus on external resource.

Healthy settings group work

Visualize a healthy setting of your choice. Describe the physical, social, economic and spiritual considerations that you see. Or pick a setting and then characterize the minimum things that must happen in the community for harmonious healthy living and healthy working.

Group work: Each group visualizes a healthy setting of their dreams. What do you see in it - physical, social, economic, political, and spiritual?

What is happening in their settings programmes? This can be a contrasting process.
What successes can they note, or what failures, and why were these successes and failures? What hardships / constraints did they face?

3. **Health promotion concept relating to healthy settings**

A presentation on health promotion was made by Dr Abdul Sattar Yoosuf, Director, Sustainable Development and Healthy Environments, WHO/SEARO.

Prevention is what you do to keep yourself from getting sick. “Healthy cities” was conceived as a health prevention and promotion idea that advocated for the control of environmental causes of disease. While WHO has maintained that prevention is better than cure and WHO’s Constitution defines health as the “complete state of physical and mental wellbeing, and not merely the absence of disease or infirmity”, health services in our countries have followed this precept. The drive towards clinical care continued to dominate national health sector actions until the Declaration of Alma Ata on Primary Health Care. It provided a moment to reflect on the rationality of our actions vis-à-vis availability, accessibility, affordability and acceptability of the health services being offered to the masses. Were these efficient and effective to address the prevailing morbidities? And what must we do to change? The health education concept thus gave way to the preventive and promotive paradigm. A holistic approach to health and the involvement of the community was necessary for health promotion - not just the knowledge that is provided by health educationists.

The Ottawa Charter enunciated this paradigm shift in the form of healthy public policy (change from public health policy) to denote that health really is everybody’s business and not just the health sector’s. The concept of supportive environments and the five strategies for health promotion was also expounded at the Ottawa conference. The five health promotion strategies are:

1. Building healthy public policy (puts health on the agenda of all development sectors),

2. Creating supportive environments (includes social, political, economic and physical environments),
(3) Strengthening community action (setting priorities and making decisions),

(4) Developing personal skills (providing information, education for health and life skills),

(5) Reorienting health services (health services should go beyond curative, towards preventive and promotive services).

Healthy settings is the umbrella process conceived at this meeting to use these five strategies – a local level process that would be close to the people it served, and thus operationally more practical.

4. Health programme planning and management - leadership and team-building

Planning is broadly defined as the process of deciding how the future should be better than the present, what changes are necessary to make these improvements, and how the changes should be implemented, and progress monitored and assessed.

Planning is a part of the managerial process. The elements of the managerial process are: problem analysis, planning, implementing, monitoring, evaluating, and re-planning. The functions of management are: planning, organizing, staffing, directing, coordinating, overseeing, mobilizing resources and budgeting.

We need to plan any complex piece of work that it is done in an organized, systematic, and timely manner. Also, because resources are scarce, once need to solve problems logically or rationally, match work with resources, know where we are going, how we are going to get there, know when we get there, avoid duplication in the process of doing so, and
promote coordination. Thus, health planning is to solve health problems (community health issues), promote equity of health outcomes (to all groups in society), promote efficiency (in the use of money, manpower and other resources), coordinate work and avoid duplication (with other programmes), and use available resources as resourcefully and efficiently as possible.

Implementing a programme requires both managerial and leadership competencies. There is a difference. Leadership is about leading and directing, with the notion of passion. Being a visionary and knowing the horizon, with a view to creating a future and not merely travelling towards an already set future - is the task of the leader. Leadership also has the aspect of innovation and creativity.

In contrast, the manager is one who works to achieve a set of targets set apriori, through a planning process. Thus, the role of management is to achieve those goals and targets with as much resource efficiency and effectiveness as possible. The quality of management is judged by the degree to which set agendas have been achieved.

Leaders’ emotions are contagious. If a leader resonates energy and enthusiasm, an organization thrives, and if a leader spreads negativity and dissonance, it flounders. This means that leaders need to prime good feelings in the people they lead.

Leadership is judged on the basis of how the leader was able to inspire and lead his team to a created future with a shared vision. A future that is better one than would predict without that leadership. The leader’s asset is empathy, meaning the connection he/she makes with the team is invoked from the heart rather than from the head; from feeling rather than thinking, from inspiration, rather than just from raw rationality. Leaders lead by example, communicating well that shared vision, building trust in the team, and supporting the team effort with empathy. Leaders don’t just do different things, they do things differently. They innovate and push the frontier.
Leading is about context. Only those who know the context can be effective leaders but of course, supplemented by the virtues and values of leadership that are - trustworthiness, dedication, empathy, courage, charisma, and awareness.

There are many approaches to leadership: the most prominent ones include command and control, rationalist, transformational, and learning (nurturing non-linear thinking and learn as we go approach). Depending on the context, the styles which leaders adopt within each category can also differ. The styles include the visionary, coaching, affiliative, democratic, pace-setting, and commanding. Often, approaches and styles have a strong correlative relationship. For example, transformational leaders maybe more visionary and democratic, while the rationalist types may use more of coaching and pace-setting. The "command and control" leader is most likely to use the style of commanding. Command and control is not always negative as in the case of an emergency, when we don’t have the luxury of time to make decisions; thus the command and control approach is the most efficient and perhaps most effective also to get the job done.

The learning process leaders go through was also discussed. To excel, leaders must continue to learn, share knowledge, listen to others, engage in dialogue (as contrasted with discussion, instructing or prescribing), having courage, taking risks (calculated) and leaning from failures, and learning the skills of negotiation and alliance building. The virtue of being flexible and accepting should also be practiced.

Group work on the method of Causal Web Analysis. On four issues - diarrhoeal diseases, diabetes, acute respiratory infections, malaria/dengue, the groups brainstormed on the causes behind the causes (web of causes) of each of these, drew the relationships so delineated on the board, forming at times an untidy doodle of spaghetti-like connections (a web of causes). This helped in understanding the wide array of causes that surround the issue under discussion.

The group work for the leadership session began with an exercise in pairs: the question asked was: What was a leadership event that you experienced (about something you did or someone else did) that showed good leadership qualities? What happened? Who was involved? Why did you think those leadership qualities were important? (the groups identified trust, encouragement, fairness, appreciation of others, quick decision-
making, transparency of character and actions, and target-orientation being the prime qualities of leaders they talked about in the stories they related to each other in pairs).

5. Good governance

Dr Surinder Aggarwal presented the module on good governance.

It is well recognized that the urban/rural settings are unhealthy largely due to forces of hyper-urbanization and lack of relevant development initiatives. These produce poverty, slums, environmental degradation, inadequate environmental infrastructure and conditions of social pathology. Most local bodies do not have sufficient resources, both human and financial, to tackle such issues at the community level.

It is realized that supply-driven government/administration approach has not produced desired results as it was too centralized and unaccountable. Under such conditions, it is realized that good governance with its demand-driven approach with community involvement in decision making at all levels can play a crucial and positive role in upgrading the settings and produce quality living and working conditions.

According to a most simple definition, government constitutes, “The complex of political institutions, laws, and customs through which the function of governing is carried out in a specific political unit”. Whereas governance implies and comprises “the mechanism, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences.” It is a process which brings together all the stakeholders who have the pieces of the jigsaw which, once made, will be the picture of that community’s future.

What are communities and what constitutes community governance?
Communities are characterised by collective identity, common interest, and a common vision (about markets, schools, health clinics etc.). They recognize that ownership of “wicked issues” rests with the community as a whole and that for a sustainable future, community governance is a good tool. They also realize that elected governments have the legitimacy to provide a strategic leadership role in establishing community government processes. For effective community governance the key is: facilitation by the local government, networking of communities, mutual dialogue for common interests, participation of civil society groups (women and the poor in particular), decentralization of responsibilities and decision making based on principles of consensus building, subsidiarity and accountability, following the rule of law and principles of social justice.

Some other considerations include minimizing corruption, sharing views of minorities and being responsive to future needs of the community.

Different actors are involved in urban/community governance. The urban elite are largely more organized and take the lead in shaping the community. The urban poor are least organized and empowered and hence have little voice and remain marginalized in decision making. The middle class is found to be uninformed, unorganized and uninterested but have the greatest potential to bring about change. In good community governance the poor and the middle class has to be strengthened, activated and given space to so as to empower them for active participation in the decision-making process.

There are examples of good governance that demonstrate the benefits of this approach in bringing out a sustainable difference towards healthy living and working conditions.

Surat, in India, is a good example to demonstrate how an unhygienic city could be transformed into a healthy entity and become the second most beautiful city in India – with a good governance approach. Effective leadership, accountability, transparency, decentralization, empowerment of the civic staff, networking between different stakeholders, and support of citizens and the media played a key role in the transformation of the city.

Likewise, at a local/community level, the slums in Ahmedabad city are being transformed into liveable and productive settings, through a partnership approach. Many unauthorized slums in the city are now
networked with city sewerage, water supply and power grid with the involvement and partnership of the city administration, a civil society group (SEWA), the local business groups and the community themselves to improve the overall living environment of the slums. This has resulted in more livelihood opportunities for women, a declining school dropout rate, and declining out-of-pocket expenditure on health care.

It is recognized that governance cannot be measured quantitatively. As a process quality indicators are a much better way. Popular indicators of governance are: voice of the people through a free press; accountability of public officials; political stability; absence of violence; government effectiveness; regulatory quality; rule of law; and control of corruption. There is also an urban governance index that is currently used to measure effectiveness. This is based on factors such as effectiveness, equity, participation, and accountability.

There was some discussion as to why slums are situated in Jakarta along the bank of the river. The participants reflected on the plight of the people having to move up and down with the flooding and drought. Also, why do we continue to allow slums, and why we cannot do away with them and their political power.

The group work for this module was local on picking an unhealthy situation we are familiar with, in any given context, and then figure out what the governance issues are, based on the good governance criteria defined in the presentation. In each case, the merits of the administrative and political governance (managing) of this setting had to be decided by linking action with the indicators, and discussing how improvements could be made. A matrix of criteria has to be used to describe/display these merits. The settings selected were:

**School:** the issues here were - weak command for teachers, lack of supervision from parents, seniority dominance syndrome, unfair competition poor enforcement of school regulations, bad management of school budget and income.
Prison: the issues were corruption, nepotism, illegal fees for sex, food services and quality; crime and availability of drugs.

Village: The issues were floods, drainage and waste management, traffic jams - chaotic in public transport, under-capacity of roads, misuse by pedestrians; messy traditional markets - dirty and wet, unsafe, unhealthy; and corruption (pungli) illegal fees.

Hospital: There was no mechanism to express clients dissatisfaction. There was no accountability; no networking, no transparency; lack of coordination, policy changes because ministry changes positions; lack of supervision and follow-up, corruption through collusion with pharmaceuticals and procurements and provider collusion to mark-up prices.

Other group work that could be undertaken

A case study: how did a good governance measure taken by a leader improve the work of a setting, or bad governance measures affect outcomes? Why was this and can we do something about it; what could we do given the political, economic and social concerns that society or community faces at any given moment?

Mapping of stakeholders/actors - both formal and informal; and then think of how to convert them to the new policy.

6. Resource mobilization (in urban settings)

There is growing realization that expenses of most urban local bodies are much higher than the available resources. As a result, many local bodies are heavily indebted and hence depend on external resources (central and state governments and private or corporate donors) to provide basic urban services. Urban settings, in particular inhabited by the poor and in disadvantaged locations are affected most with such income-revenue gaps. This leads to inadequate and ill-maintained environmental infrastructure and other basic services that are meant to promote and facilitate public health. In order to bridge the gap and to provide quality services there is a strong need to mobilize various human, financial and technical resources.
At the municipal level financial resources can be raised by changes in tax structure, reduction in subsidies for various services, raising user charges at an affordable level and with marginal cost principle. Funds can be raised by borrowing from national and international banks and international institutions for good infrastructure projects like water supply, roads, sewerage and health services. Such loans were not available earlier. However, with a sound and scientific proposal and by meeting the requirements of the donor, municipal governments are using this opportunity now in many developing countries. Public-private partnership in selected urban services like solid waste disposal, energy, transport, tourism, and security is possible and cost-effective as well. This encourages public participation, accountability and transparency towards good governance. Financial instruments such as municipal bonds can be introduced to encourage people to become development partners, stakeholders and entrepreneur. The municipalities could encourage new business and service sectors to invest in cities by providing certain tax and other subsidy incentives. More business for the city could generate extra revenue not available earlier. Good governance with elements of efficiency, inter-sectorality, participatory budgeting (fostering public participation in budget-making), devolution of financial powers, reduction of corruption and transparency in decision making/information sharing can increase confidence and inclusiveness of the staff and also increase their efficiency in the delivery of services.

Along with the financial resources of the local bodies, sharing of community resources in kind (labour and skills) and money can be mobilized if they are involved in the decision-making process for upgradation of their own settings. The “Parivartan” programme in Ahmedabad is a good example. Social capital of the communities embedded in their technical and conventional wisdom can be utilized without any financial commitment which else raises the sustainability of development activities.

To raise funds from donors and other agencies, local bodies need training to prepare good proposals. Agencies like WHO, Citynet, UNESCAP...
can help in identifying the donors and also strengthen technical competency in writing the proposals.

Group work: Developing a funding proposal based on the presentation and using the skeleton framework for a proposal. Use five concerns that society faces. Then discuss who might be the potential donors and how we would approach them and present our case.

**Field visit**

A half-day field visit was organized to three different settings-healthy settlement, healthy school and community forestry – near Yogyakarta. The involvement of the communities in sharing their experience and processes followed by them were of immense interest.

After the field visit, the lessons learnt from the three healthy settings were shared. It was felt that all three settings were success stories. The main and common characteristics which made the initiative a success included:

- The healthy city programme gained stakeholders’ participation and political commitment.
- Strong community awareness of healthy city initiative.
- Income generation for sustainability and livelihood support.
- Women are empowered.
- A well thought out plan of action and its implementation.
- Periodic monitoring and evaluation.
- Good leadership
- Good networking with other initiatives

Visited the Kabupatan (district) Guntung Kidul (south mountain) with capital Wonosari (forest flowers).
The Bupati welcomed all the participants and mentioned their healthy communities programme that the said eight out of the 18 sub-districts were covered by this programme, focusing on public facilities, forestry, food supply, food resilience and safety, and promoting community independence.

The community participation process is generated through the local forums that have as members selected stakeholders who are respected in the community including retired government servants and the PKK (community organization) leaders. Three settings were visited in the district of Guntung Kidul.

Healthy housing - village of Jeruksari village

Here, the pathways were well paved, swept and the drains kept very clean. Home gardening is vigorously promoted through local composting methods. The composting is done with a prepared innoculant fluid made of water, pineapple pulp, salt and sugar. When this is used to compost the kitchen and vegetable waste it radically shortens the breakdown time, taking only 20 days whereas the conventional methods would take two or three times longer for the compost to mature. Visit to neighbourhood houses also showed that the cleanliness was pervasive. The village also segregates waste in coloured bins for plastic, vegetable waste, metal and glass. They do monthly cleaning, home gardening, and working together.
The school - Wonosari occupational skills school

This was a vocational training school that teaches small business management, dress design and dress making, and their management. An interesting cultural facet that promotes feeling of sharing and community spirit was in the school’s "honest cafeteria" where there is no cashier and the students just deposit the money into an open box and take the change by themselves.

Sustainable forestry

Sustainable forestry began in this district during the 1960s. This was a government-led effort in reforestation but it did not catch on till the late 1990s. This terrain was always arid and with no water retention in the soil. By 1998, there was about 60 hectares of forest; but by 2008, in a span of ten years, 325 hectares were under sustainable forestry. In the 1960s there was apparently rampant under-nutrition, and all kinds of skin diseases because of bad cultivation, and lack of water to bathe with. The first effort was by the government to plant rubber. That failed and so they turned to mahogany trees. Later in 2000, the farmers began planting teak. There is a community organized process where farmers are given ownership of two hectares to grow by themselves, and there is sharing of saplings and expertise also. There is good ownership of this by the community because they are now more aware that this practice of sharing would be mutually beneficial to farmers and also creates the sense of identity among the residents. Forty years ago, this district was very dry and arid. Water was not available and taking a bath was a luxury. Now, with high rates of re-forestation, the soil water retention has improved and the water table had been revived and the terrain is not dry anymore. Now, there is greenery everywhere in contrast to the dry brown terrain of yester-years. As national recognition, the district was awarded a medal of merit.
Lessons learnt from field visit

(1) Green, successful re-forestations
(2) Cleanliness of surroundings
(3) Environmental-friendly composting/waste management
(4) People enthusiastic about programme
(5) Good participation/partnership
(6) Community empowerment working
(7) Good leadership
(8) Women are empowered
(9) NGO involvement
(10) Friendly people
(11) Resource, local resource

(12) Social punishment/legal sanctions control
(13) Sharing culture
(14) Norm building – values/morality
(15) Nurturing honesty
(16) Income generation livelihood
(17) Top-down, bottom-up process is complementary
(18) Community is the actor not the client
(19) Replication observed in housing/forestry
(20) Change from house-hold help production to other jobs
(21) Hand washing facilities inadequate in school
(22) In water regeneration, the community is collective actor
(23) Sharing saplings in forestry
(24) Networking
(25) Community learning from mistakes (government gave seeds but failed. Later the Bupati engineered and energized the community).

Any plan of action for a healthy setting should be based on three principles of
(1) Plan (health ) is in place and adopted by the community
(2) Process (intersectorality, good governance, leadership, coordination, resource mobilization ) is installed in the setting
(3) People are involved and have developed a sense of ownership and skills of management/governance.

Utility of training

The training provided a common platform to the participants from various sectors of development (viz. health, agriculture, forestry, mining, NGOs, academia) to learn from the presentations and do hands-on group work relevant to the training modules. The dialogues led to various doable actions and policy modifications in related sectors to achieve healthy living and working environments. The training further reinforced the ideas and skills during the field visits.

Next steps

(1) Prepare funding proposal for healthy setting training and seek technical support from WHO/RO to prepare the proposal ( action MoH )
(2) Share details about this training with other partners and initiate similar training on an important theme at the earliest ( action MoH )
(3) Call steering committee meeting for the National Plan of Action within one month ( action MoH )
(4) Establish e-network
Assessment of the quality of the course: This was based on: content quality; delivery quality; interesting discussion; useful group work; useful for daily work; practical application and relevance; duration of training.

The participants scored the course in the upper quartile for every module.
# Schedule of Training of Trainers for Healthy Cities Programme

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activities</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1</strong>&lt;br&gt;February 24&lt;sup&gt;th&lt;/sup&gt;</td>
<td>08.00 - 08.30</td>
<td>Registration&lt;br&gt;Opening Session&lt;br&gt;– Welcoming remarks&lt;br&gt;Head of Health Provincial Office, Jogyakarta</td>
<td>Dr Subash Salunke&lt;br&gt;Dr Wan Alkadri,</td>
</tr>
<tr>
<td></td>
<td>08.30 - 09.15</td>
<td>– Opening remarks&lt;br&gt;WR, WHO, Indonesia&lt;br&gt;Director of EH, MOH</td>
<td>11.00 - 12.00&lt;br&gt;09.15 - 10.15</td>
</tr>
<tr>
<td></td>
<td>09.15 - 10.15</td>
<td>Health in Development (Module I):&lt;br&gt;– Definition of health, its scope and implications&lt;br&gt;– Sustainable development: Health and environment concept and application&lt;br&gt;– Understanding the national health system&lt;br&gt;– Drivers of environment change - globalization; urbanization; climate change</td>
<td>10.15 - 10.30&lt;br&gt;10.30 - 12.30</td>
</tr>
<tr>
<td></td>
<td>10.15 - 10.30</td>
<td>Tea Break</td>
<td>15.00 - 15.30&lt;br&gt;15.30 - 17.00</td>
</tr>
<tr>
<td></td>
<td>10.30 - 12.30</td>
<td>Healthy Settings (Module II)&lt;br&gt;– The healthy settings concept and its development&lt;br&gt;– Steps to developing a healthy setting&lt;br&gt;– Experiences from countries&lt;br&gt;– Assessing progress: Evaluating settings programmes - determinants; approaches</td>
<td>12.30 - 13.30&lt;br&gt;13.30 - 15.00</td>
</tr>
<tr>
<td></td>
<td>12.30 - 13.30</td>
<td>Lunch Break</td>
<td>15.00 - 15.30&lt;br&gt;15.30 - 17.00</td>
</tr>
<tr>
<td></td>
<td>13.30 - 15.00</td>
<td>Health Promotion (Module III)&lt;br&gt;– Concepts and practice - theories, principles and practice&lt;br&gt;– Practical frameworks for the application of health promotion&lt;br&gt;– Linking health promotion with healthy settings</td>
<td>15.00 - 15.30&lt;br&gt;15.30 - 17.00</td>
</tr>
<tr>
<td><strong>Day 2</strong>&lt;br&gt;February 25</td>
<td>08.00 - 10.00</td>
<td>Managerial Process (Module IV)&lt;br&gt;– Role of the manager in programmes management&lt;br&gt;– The managerial process defined and delineated&lt;br&gt;– Leadership approaches&lt;br&gt;– Team building and sustainable programming</td>
<td>WHO SEARO&lt;br&gt;Dr A Sattar Yoosuf</td>
</tr>
<tr>
<td></td>
<td>10.00 - 10.30</td>
<td>Tea Break</td>
<td>10.00 - 10.30&lt;br&gt;10.30 - 12.30</td>
</tr>
<tr>
<td></td>
<td>10.30 - 12.30</td>
<td>Good governance (Module V)&lt;br&gt;– Principles and indicators of good governance&lt;br&gt;– Approaches to promote good governance&lt;br&gt;– Linking good governance with healthy settings programme implementation&lt;br&gt;– Link to environmental sustainable and poverty alleviation</td>
<td>12.30 - 13.30&lt;br&gt;13.30 - 15.00</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Activities</td>
<td>Presenter</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>12.30 - 13.30</td>
<td>Lunch Break</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13.30 - 15.00</td>
<td>Resource Mobilization (Module VI)</td>
<td>WHO SEARO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Principles of resource mobilization</td>
<td>Dr A Sattar Yoosuf</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Who will give? - identifying donors and contributors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Preparing project proposals - components and tying together</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Presenting proposals to donors and contributors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.00 - 15.30</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.30 - 17.00</td>
<td>Group Work (Case exercise)</td>
<td></td>
</tr>
<tr>
<td>Day 3</td>
<td>08.30 - 09.00</td>
<td>Introduction to the field work and objectives</td>
<td></td>
</tr>
<tr>
<td>February 26</td>
<td>09.00 - 12.00</td>
<td>Field visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12.00 - 13.00</td>
<td>Lunch Break</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13.00 - 15.00</td>
<td>Reflection on field visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.00 - 15.30</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.30 - 17.00</td>
<td>Closing Session</td>
<td></td>
</tr>
<tr>
<td>Day 4</td>
<td>08.00 - 11.00</td>
<td>Reflection on field visit, workshop and next steps</td>
<td></td>
</tr>
<tr>
<td>February 27</td>
<td>11.00</td>
<td>All participants check out</td>
<td></td>
</tr>
</tbody>
</table>
Participants

Asri Indiyani, ST  
Sub directorate of Liquid Waste  
Direktorat PLP, Ditjen CK, Dep PU  
Ministry of Public Works

Irv. Chandra Rudyanto, MPH  
Administration Unit Staff  
Centre of Health Promotion  
Ministry of Health Indonesia  
Jl. Rasuna Said. Gedung Depkes Lt. VI  
Kuningan, Jakarta Selatan  
E-mail: chrudy28@hotmail.com  
HP/TELP: 08158862359

Puthut Tri Prasetyo  
Occupational Health Directorate  
Ministry of Health  
Jl. H.R Rasuna Said  
Gedung Depkes Lt. VI R. 612 Blok C  
Kuningan, Jakarta Selatan  
E-mail: puthut_1999@yahoo.com,  
hseput@gmail.com  
HP/TELP: 08161429594

Fredy Hasan Basri  
Ditjen PDN  
Ministry of Trade  
Jl. M. J Ridwan Rais No. 5 Jakarta Pusat  
E-mail: fredyhasanbasri@yahoo.co.id  
HP/TELP: 08129510650

O maj M. Sutisnaputra  
WHO-Indonesia  
Jl. Rasuna Said Kav. 10-11, Jakarta Pusat  
E-mail: sutisnaputrao@who.or.id  
HP/TELP: 08122009225

Syahrul Aminullah  
IAKMI  
Indonesia Public Health Association  
Gd. Moctar Lantai 2  
Jl. Proklamasi No.16 Jakarta  
E-mail: syrl51@yahoo.com  
08557800476

Kriptianti (titi)  
Departement of Social  
Rural Community Empowering Directorate  
Jl. Salemba Raya 28  
(021) 3100373  
HP/TELP: 08128060298

Yophie Septiady  
Postgraduate Centre for Anthropology  
University of Indonesia  
Depok, Jawa Barat  
E-mail: yophie_28@yahoo.com  
HP/TELP: 081908356420

Rektarini  
Ministry of Forestry  
Directorate of Development of Social Forestry  
Gedung Mangala Warnabakti  
Jl. Gatot Subroto Senayan, Jakarta  
E-mail: rektarini@yahoo.com  
HP/TELP: 081519841981

Sri Kuntjoro  
Directorate of BSTP  
DG of Land Transportation  
Ministry of Transportation  
Jl. M. Merdeka Barat No. 8  
Jakarta Pusat  
(021) 350616, (021) 3506150  
HP/TELP: 0817647099

Rachmadi Purwana  
Environmental Health Department  
University of Indonesia  
Kampus UI, Depok  
E-mail: rachmadhi@yahoo.com  
HP/TELP: 0818117040

Slamet Budiyanto  
Pekalongan District  
Healthy City Forum  
Jl. Jawa No. 28. Pekalongan  
E-mail: ibudks@yahoo.com  
HP/TELP: 08156626353
Tri Prasetyo Sasimartoyo  
WHO Indonesia  
Gedung I Bina Mulia  
Jl. HR Rasuna Said Kav 10-11 Kuningan  
Jakarta Selatan  
E-mail: sasimartoyot@who.or.id  
HP/TELP: 08119696220

Elly Wismayanti  
Department of Education  
Pusat Pengembangan Kualitas Jasmani  
Jl. Jenderal Sudirman  
Gd. C. Lt. 19 Senayan, Jakarta 10270  
(021) 5732469  
E-mail: elly18_id@yahoo.com  
HP/TELP: 081311321375

Karyanto  
Technical Laboratory of Environmental  
Health and Communicable Disease  
BBTKL- Yogyakarta  
Jl. Wiyorolor, Baturetno, Bangun Tapan  
Bantul, Yogyakarta  
HP/TELP: 08562889636

Purwadi Ardwojo  
Centre of Health Officer Empowerment  
Taman Pondok Cabe C5/27  
Pondok Labu  
HP/TELP: 08161429594

Sadono Mulyo  
BTKL Jogjakarta  
Bantul, Yogyakarta  
HP/TELP: 08175486360

Maya Safrina S  
Centre of Food Consumption and Food  
Resilience  
Ministry of Agriculture  
Jl. Harsono RM No. 3 Ragunan  
Jakarta Selatan, Gedung E lantai VI  
E-mail: maya_safrina@yahoo.com  
HP/TELP: 08129471654

Riris Nainggolan  
Centre of Research and Development and  
Health Status  
Ministry of Health  
Jl. Percetakan Negara No. 29  
Jakarta Selatan  
E-mail: riris@litbang.depkes.go.id  
HP/TELP: 0811822576

Anung Trihadi  
Yogyakarta Province Health Office  
Jl. Tompengan TR III/201  
Tegalrejo, Yogyakarta  
(0274) 563153  
E-mail: atrihadi2004@yahoo.com  
HP/TELP: 08122774574

Imran Agus Nurali  
Subdit Kesehatan Perkotaan dan Olahraga  
Directorate of Community Health  
Ministry of Health  
Pondok Damai Blok G4/16  
(021) 8231406  
E-mail: ian88ellyas@yahoo.com  
HP/TELP: 081317918913

Sri Endah Suwarni  
(nunik)  
Healthy Setting and Emergency  
Sanitation Sub - Directorate  
Environmental Health - MOH  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
E-mail: pd_nunieq@yahoo.com.au  
HP/TELP: 081319501664

Anita Rentauli Gultom  
Healthy Setting and Emergency  
Sanitation Sub - Directorate  
Environmental Health - MOH  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
E-mail: anitarentauli@yahoo.com  
HP/TELP: 081310442656

Yuni Cahyati  
Healthy Setting and Emergency  
Sanitation Sub - Directorate  
Environmental Health - MOH  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
E-mail: yunicahya@yahoo.com  
HP/TELP: 081314252885
Carolina  
Waste Management Unit  
Environmental Health Directorate  
Ministry of Health  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
E-mail: carolina_akib@yahoo.co.id  
HP/TELP: 081646060020

Dewi Minarni  
Administration Unit  
Environmental Health Directorate  
Ministry of Health  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
HP/TELP: 08128000183

Ir. Sofwan  
Waste Management Unit  
Environmental Health Directorate  
Ministry of Health  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
HP/TELP: 081514514176

Dirman Siswoyo  
Healthy Settings and Emergency Sanitation Sub - Directorate  
Environmental Health - MOH  
Jl. Percetakan Negara No. 29  
Gedung D Lt. 2  
Jakarta Pusat (021) 4245778  
HP/TELP: 08129336399

WHO Secretariat  
Abdul Sattar Yousuf  
Director  
Department of Sustainable Development and Healthy Environments  
WHO-SEARO  
IP Estate  
New Delhi

Surinder Aggarwal  
TIP-SDE  
Professor  
Delhi University  
Delhi
The practice of promoting "healthy settings" in Member States of the WHO South-East Asia Region began over a decade ago as an approach to encourage community-level health development. A range of practices spanning different degrees of success is in place in almost every country in the Region. The hallmark of the "settings" idea is the active engagement of local communities in creating optimum conditions for their health. They do so by improving the quality of their physical and social environment that is often the source of ill-health. Progress is indicated by how fledgling community health efforts generate successes that snowball into confidence for more complex tasks.

Quality local action needs quality local capacity. Recent assessment reveals a lack of this in many localities. This short training package focuses on the importance of local leadership for program success and sustainability. Its six modules provide the basic awareness, management and leadership content needed to understand health as a development concept and to lead a "healthy settings" local team to success. This document is a report of the conduct of this short course in Yogyakarta, Indonesia from 25 to 27 February 2009.