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(See back cover for further details)

President, Colm Smyth, Ireland

Cover Photograph:
Brisbane River (Lara Jane Gregson).

Correction
I wrongly attributed the authorship of the article entitled *Chinese New Year Parade – San Francisc,* Volume 9 No. 1, it should have been Mel Seid. Accordingly, I apologise to Mel.
Hon. Editor

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Xavier Bonnefoy
1950 - 2007

For those of us who knew Xavier we will be forever inspired by his sense of urgency, passion and purpose. For those who did not know him your lives too will have been deeply affected by the work that he did in promoting Environmental health policy and practice at the highest international levels. A French Sanitary Engineer by profession and Honorary Member of the CIEH he used his expertise, personality and Gallic charm to great effect in moulding differences of opinion to achieve solutions throughout the world in the promotion of environmental health.

I first met Xavier when the Chartered Institute was forging strong links with WHO in 1991 when he had just arrived in Copenhagen from Paris to drive the information needs supporting the surge in interest in Environmental Health interventions, following the massive political changes that were taking place in Central and Eastern Europe. Xavier subsequently lead an unprecedented programme of survey and report throughout Europe which resulted in a 6 volume series of WHO publications on the recreation and direction for Environmental Health; one of the most extensive exercises ever undertaken in this field and which significantly influenced the outcomes of successive European Ministerial Conferences on Environment and Health. He followed that up with the production of a vast array of technical pamphlets on every element of our subjects aimed at helping local politicians and practitioners put good practice into being.

During his time at WHO he went from technical subject to technical subject with ease (and not an inconsiderable amount of hard work), becoming the expert voice of WHO at conferences throughout the world on so many subjects but particularly noise, housing and health, water quality and drainage. We shared a common interest in rodent control and not surprisingly he was working to the end on a major publication on pest control and health which will be published soon.

One of Xavier's many strengths was his leadership and ability to enthuse and excite others to achieve. He held strong views and was always prepared to voice them. He was at his best when using his vast network of contacts spread throughout the world to secure resources, support and expertise for the many projects he initiated, moulding the process and the people to achieve the desired outcome. He travelled extensively, sharing his knowledge and pushing for improvements in environmental health wherever he went, he knew the right people in the right places to get the job done. Ministers of State, senior civil servants, experts, local and national politicians will be poorer now that he has gone, but he has left a rich legacy in his influence and the papers and publications that he produced.

We also shared a love of long distance running. Xavier came relatively late to the sport but characteristically he embraced it with every part of his being. He competed in several of the key marathons of the world rarely missing a days training even when he was on duty travel. I shall be forever grateful to him for guiding me along a treacherous part of the banks of the Rhine on a late night pitch black run after a busy day at the Bonn office. A guide, a mentor a truly passionate and committed man, a man who cared for others, a friend; he died peacefully in Hospital in Paris on Sunday 18th November 2007 having only relatively recently been diagnosed with Leukaemia. Xavier's wife Odile, his parents, his sons, daughter and grand children and wider family will mourn his passing and so too will the countless numbers of people who had the privilege to know and to work with him.

Au revoir Mon Ami.

Graham Jukes
Chief Executive
Chartered Institute of Environmental Health

While Xavier's family and friends are still in shock at his passing and the focus is on grieving and the arrangements, when they are ready I'm sure they will appreciate the thoughts and views of the so many of us who were touched by Xavier's life. I wanted to mark his unique contribution to our lives by compiling a book of personal remembrance – and I need your help! We all have personal memories of Xavier and if you could share it in a paragraph and forward it on to me by e-mail I will collate them and present them to his family at some point over the coming weeks. To view Xavier's memorial site, the funeral arrangements and Book of Remembrance see link: http://www.cieh.org/about.aspx?id=7486

Environmental Health, Human Rights and Global Governance

By Fred O'Brien,
Honorary Vice President IFEH

Statement discovered on a headteacher's notice board

Dear Teacher,
I am a survivor of a concentration camp. My eyes saw what no man should witness:
Gas chambers built by learned engineers.
Children poisoned by educated physicians.
Women and babies shot and burned by high school and college graduates.
So I am suspicious of education.
My request is:
Help your students become human. Your efforts must never produce learned monsters, skilled psychopaths, educated Eichmanns.
Reading, writing, arithmetic are important only if they serve to make our children more human.

From: **Yes You Do Count: A Teaching Programme on Human Rights** (1995) by Maura Ward, Irish Commission for Justice and Peace,
ISBN 0 905911 20 2

The Charter of the United Nations was signed on June 26, 1945 in San Francisco and came into force on October 24, 1945. It was an attempt to draw up international legal standards for the protection of the fundamental human rights of men and women. Its declared objective is the development of society, improved living conditions, and greater freedom and security for the individual. All UN Human Rights instruments stem from this Charter.

The Universal Declaration of Human Rights was passed by the United Nations General Assembly on December 10, 1948 and affirms that the genuine recognition and observance of all the rights and freedoms contained in the declaration is a goal to be sought by all peoples and all nations. The Declaration is an important recognition of the personal dignity of every human being and outlines the right of every person to circumstances, including environmental conditions that lead to a fully human life.

The constituent organizations of the UN consist of members nominated by the public authority of the various nations and are entrusted with highly important international functions in the economic, social, cultural, educational, health and environmental health fields. The UN Organization encourages and assists friendly relations between nations based on principles of equality, mutual respect, and extensive cooperation in every field of human endeavour.

The Report of The Commission on Global Governance, **Our Global Neighbourhood (1995)**, highlights the necessity for a reassessment of the relationship between the UN and its family of organizations and the growing world-wide array of organized non-state activity in **redressing wrongs that imperil people's security**. The report, additionally, acknowledges that NGO's have provided vital assistance to the UN and "more and

"Climate Change: The Scientific Evidence", moderated by Andrew Revkin of the New York Times, at UN Headquarters in New York. United Nations, New York, September 5, 2007.

more … are helping to set public policy agendas – identifying and defining critical issues, and providing policy makers with advice and assistance." Additionally, it notes the significance for governance of "this movement beyond advocacy and the provision of services towards broader participation in the public policy realm". (cf. pps. 253-255)

Practical Training and Action Required
A purely theoretical outline of the principles underpinning international laws and conventions on human rights and a listing of the social and economic obligations implied for environmental health would be totally inadequate in bringing about improvements. Practical training is needed and a deep sensitivity to cultural values required when environmental health needs are being addressed.

The **Environmental Health in Disasters and Emergencies** (EHiDE) initiative supported by the Federation in June of 2006 and provided with necessary funds as a result of the August 2007 Federation Council meeting in Nairobi, Kenya, Africa, is a flagship on how regions might move forward in this area of major global environmental health need. With the commitment of the Federation to principles of solidarity, subsidiarity and enculturation regional IFEH blocks can provide input to realizing the aims of their regional multinational human rights Charters. The African Charter on Human and Peoples' Rights (1986) (The "Banjul Charter"), for example, is based on the UN 1948 Declaration but with emphasis on specifically African values.

Role of the Federation
The International Federation of Environmental Health, as **the** body, representing in its membership the core competencies of environmental health professionals from around the world, has a responsibility and a right to pursue avenues to promote, through the rule of law, the establishment of mechanisms that more effectively deal with disasters and emergencies. In addition to supporting the EHiDE initiative and like projects, there is a responsibility on IFEH to influence nations, multinational regional blocks (e.g. African and European Unions) and the UN so as to establish mechanisms that provide for the basic environmental health needs of human populations affected by natural disasters, war, or as a consequence of human dislocation events. Such ways and means should include the availability of such services with the consent, if possible, of the Government(s) involved.

LAUNCHING THE AFRICA ACADEMY FOR ENVIRONMENTAL HEALTH – NAIROBI KENYA, ON 29 AUGUST 2007 – A MILESTONE FOR AFRICA

By: Dr Koos Engelbrecht (Elected Chairperson of the Africa Academy for Environmental Health), Head of Department, Environmental Health, Faculty of Science, Tshwane University of Technology, Private Bag X680, PRETORIA 0001. SOUTH AFRICA. Fax: +27 12 3825262, E-mail: engelbrechtjc@tut.ac.za

INTRODUCTION
An historic event for environmental health training in Africa took place when the Academy was officially launched at the 1st All Africa Congress on Environmental Health held in Nairobi Kenya that took place from 27-30 August 2007. The launch took place after more than 10 years of preparatory work that included a consultation process amongst Africa members of the International Federation for Environmental Health (IFEH) that led to the approval of the constitution of the academy as well as approval by the IFEH.

AIM AND OBJECTIVES OF THE ACADEMY
The Academy is a body of academic institutions, organisations representing environmental health professionals and expert practitioners for the advancement of the science and practice of environmental health in Africa, to represent academic institutions and the Africa Group of IFEH and to promote the interest and uphold the status of environmental health training in Africa. The main objectives of the Academy are:

- To advance the discipline of environmental health training in Africa.
- To represent key stakeholders in environmental health training in Africa.
- To strive to improve the standard of environmental health training in Africa
- To promote the national continental and international recognition of environmental health.
- To be a point of reference to professional advice on environmental health training.
- To facilitate contact with other international environmental health training institutions and bodies/associations that share values compatible with the aims of the Academy.
- To promote exchange of environmental health academics and professionals within Africa and abroad.
- To promote sharing of best practices in environmental health within Africa and abroad.

- To promote and facilitate collaborative environmental health research and training.

MEMBERSHIP

Membership shall be confined to any recognized institution responsible for environmental health training in Africa and recognised national environmental health professional bodies/associations in Africa. The Africa Group of IFEH shall approve membership. Individual academics and expert professionals may become associate members by invitation and approval of the Africa Group of IFEH. The most important challenge is to make contact with all environmental health-training institutions in Africa recognised by their respective government (Ministry of Health). Any assistance to ensure that the Academy is inclusive as possible will be highly appreciated by the Executive Committee (EXCO) of the Board of the Academy. Please forward contact details of such training Institutions, to the Chairperson.

SITE LOCATION AND MANAGEMENT STRUCTURE OF THE ACADEMY

At the launch it was decided to locate the site of operations for the Academy at the Tshwane University of Technology, located in Tshwane (Pretoria) South Africa. For the immediate future the EXCO see this as only a virtual site to co-ordinate the functions and activities of the Academy. The meeting in Nairobi also elected the following persons to form the first EXCO of the Academy:

- Chairperson – Dr Koos Engelbrecht (Tshwane University of Technology South Africa) who will be responsible for the communication portfolio
- Dr Tony Grimason (University of Strathclyde, Scotland) responsible for the portfolio of European Links
- Mr Kingsley Lungu (Malawi University, Malawi) responsible for the portfolio of resource mobilisation (including funding)
- Mr Joseph Okweso (Kenyatta University, Kenya) responsible for the academic portfolio
- Mr Dennis Mazali (University of Dar-es-Salaam, Tanzania) responsible for the e-learning portfolio
- Mr William Kitagwa (Moi University, Kenya) responsible for the portfolio of quality assurance of academic programmes

The EXCO was also mandated by the members as the membership grows, to co-opt other members with specific academic skills to the EXCO.

THE WAY FORWARD

At the first meeting of the EXCO of the Academy in Nairobi the committee decided on the following as a way forward:

Web site

The webmaster of the IFEH offered to locate the activities of the Africa Academy on the website of the IFEH. The Chairperson will take responsibility together with the web master of the IFEH to establish a web page for the Academy. As the activity expands the web site will be populated with all relevant information.

Priority tasks

As a matter of high priority the respective portfolio holders will establish an action list of priorities within their portfolios. The actions will be approved by the EXCO of the Academy and target dates and progress will be periodically monitored. The following tasks were listed at the first meeting as tasks to be considered by the portfolio owners:

- Membership database
- Revisit the constitution (as soon as the web page is

The first elected EXCO.
From left to right:
Mr Joseph Okweso,
Dr Koos Engelbrecht
Mr Kingsley Lungu
Dr Tony Grimason
Mr William Kitagwa
Insert: Mr Dennis Mazali

up and running a copy will be posted for information and comments)
- Establishment of a web page
- Academic links outside Africa
- Quality assurance guidelines for academic programmes
- To be a point of entry in Africa for academic information
- Establish an accredited Africa Journal for Environmental Health
- To develop generic training outcomes (syllabus) as minimum requirements for recognition
- To promote exchange of academic staff and students
- To enhance, promote and stimulate environmental health research in Africa
- To promote research skills amongst environmental health academics and practitioners
- To establish a database of environmental health expertise in Africa
- To promote and stimulate e-learning

CONTACT DETAILS

Until such time as the web page is fully operational, the EXCO members can be contacted at the following e-mail addresses:
- Chairperson – Dr Koos Engelbrecht (Tshwane University of Technology South Africa) communication portfolio E-mail: engelbrechtjc@tut.ac.za
- Dr Tony Grimason - (University of Strathclyde, Scotland) European link E-mail: A.M.Grimason@strath.ac.uk
- Mr Kingsley Lungu - (Malawi University, Malawi) resource mobilisation (including funding). E-mail: klungu@poly.ac.mw, Kingsley.lungu@strath.ac.uk or Lunguking1961@yahoo.com
- Mr Joseph Okweso - (Kenyatta University, Kenya) portfolio academic E-mail: joarung@yahoo.com
- Mr Dennis Mazali - (University of Dar-es-Salaam, Tanzania) e-learning E-mail: dmazali@gmail.com
- Mr William Kitagwa – (Moi University, Kenya) quality assurance of academic programmes E-mail: Wilkita2002@yahoo.com

CONCLUSION

The EXCO of the Academy would like to urge all environmental health academics, especially training institutions responsible for environmental health training in Africa to pledge and commit their active support to the aims, objectives and plans of the Academy. At the first meeting of EXCO the members confirmed their commitment to work tirelessly to succeed with the aims and objectives of the Academy.

THE FOLLOWING THREE PROJECT REPORTS FROM THE NATIONAL BOARD OF HEALTH AND WELFARE, SWEDEN, WERE SUBMITTED BY JOHANNA BENGTSSON RYBERG, PhD

INFORMATION BOOKLET – REDUCE NOISE LEVELS IN PRESCHOOLS

Background

The reason for taking action on this issue was that noise levels indoors in preschools are experienced by children and personnel as being too high. Interviews and questionnaires to preschool teachers and other persons involved with children's environments have clearly indicated that the noise levels are a problem. The National Board of Health & Welfare put together a working group with representatives from the Board and three other authorities with a responsibility for these kinds of issues: the National Institute for Working Life, the Swedish Work Environment Authority and the Swedish National Agency for School Improvement. The aim with the working group was to produce an information booklet with concrete ideas on how to lower the noise levels in kindergarten/preschools through pedagogic and strategic work. The work with the information booklet, "Take away the noise – a booklet on healthy sound environments in preschools", started in spring 2005. The booklet was published in August 2006.

Description of action/objectives

The main objectives for the project were to give ideas and inspiration for kindergarten/preschool personnel to work on lowering the noise levels indoors and to make the sound environment better for the children, and for the personnel. The target groups for the booklet are teachers and school administrators, while both children and personnel in kindergarten/ preschools are beneficiaries of the project.

Planning and implementation

We had a good cooperation with a free-lance journalist, a free-lance photographer and preschool teachers in preparing the text of a booklet. Also, all authorities involved wrote relevant text material for the booklet and furthermore, environmental- and health inspectors and headmasters also gave interviews, resulting in short texts in the booklet.
The innovative component of the project is, through good examples to inspire people to take action and to start working with and solve the noise problem in kindergarten/preschools.
The booklet will probably be usable for a number of years. Hopefully, it will be used in the education of pre-school teachers.

To allow professionals to talk to professionals by means of an attractive publication with beautiful photos and well-written and interesting texts and a very competent journalist with long experience from similar projects was an important 'ingredient' in this project.
The main challenge faced during the project was to decide which authority should take the lead on this problem – everybody seemed to think that this is the responsibility of somebody else.
If anyone wants to do something similar, there is a lot of knowledge on how to tackle high sound levels among teachers, so it is advisable to listen to them.
More info:
http://www.socialstyrelsen.se/Publicerat/2006/9252/2006-123-25.htm

PROPOSAL FOR A NATIONAL ACTION PLAN FOR THE PROTECTION OF CHILDREN'S ENVIRONMENT AND HEALTH

Summary
In the appropriations document for 2005, Socialstyrelsen was commissioned to draw up a proposal for a national action plan for the protection of children's environment and health. This commission follows an initiative by the World Health Organisation (WHO), Children's Environmental Health Action Plans for Europe (CEHAPE), which focuses on environmental health and risk factors in children's physical environment. We have interpreted the government commission as a first step towards an action plan for the protection of children's environmental health, meaning that our proposals for measures will need to be further processed.
Work on the proposal for a national action plan began in the spring of 2005, and has been in the form of dialogues between Socialstyrelsen and other authorities and parties, including voluntary organisations, representatives of various professions, and young people.
To avoid making the action plan too extensive, factors such as purely dietary ones, mental ill health, self-inflicted violence, stress and other psychosocial factors have not been included in the proposal. However, some of these issues are dealt with in connection with other issues, and Socialstyrelsen is working actively with some of them in other areas.
In general terms, the state of children's health in Sweden is good. Nevertheless, allergy illnesses (including asthma), diabetes, obesity and mental ill health are considerable problems. Certain health effects can be linked to factors in the physical environment. Despite the fact that the environment has been improved in several cases, and thereby has a less negative effect on our health, many children are still exposed to harmful environmental factors.

The WHO, working together with the member states, has identified four regional priority goals (RPGs) for the national action plans to focus on. These are:

RPG I – Ensure safe water and adequate sanitation

RPG II – Ensure good everyday environments, protection from injuries and adequate physical activity

RPG III – Ensure clean outdoor and indoor air and less respiratory ill health

RPG IV –Reduced chemical and physical environmental risks, and a good work environment.

Socialstyrelsen's proposal for an action plan ties in with those national objectives which are relevant to children's environmental health, primarily the public health policy objectives and the environmental quality objectives.

Clean air, a non-toxic environment, good-quality groundwater, a safe radiation environment and a good built environment are the objectives with the clearest connection to human health. These objectives are central to the proposal for a national action plan for the protection of children's environmental health.

The contents of the proposal
The proposal begins with a section that deals with children's rights. The suggested measures in this section highlight the importance of detailing consequences for children, and consequences for the environment with special regard to children. We also take the participation of children and young people into account, underlining that the implementation of the measures we propose must be subject to collaboration with children and young people, when this is possible and desirable.
Under RPG I, we make proposals aimed at ensuring that all children have access to good quality drinking water. This also applies to children in families whose water comes from a private well.
The proposals under RPG II emphasise children's right to be able to play and move around freely in their everyday environment, so that girls and boys get enough physical exercise to reduce the risk of obesity. This in turn requires a safe environment, which is why proposals for preventing injury and accidents are also included in this section.
RPG III is about reducing allergy, asthma and other respiratory illnesses by ensuring good air quality. The proposals in this section deal with air quality in school and pre-school yards as well as indoor air in the home, in pre-schools, schools, and after-school centres. In order to lower the number of unborn children who are subjected to tobacco smoke, we suggest intensifying tobacco prevention efforts. We also suggest reinforcing the allergy area, beginning with a review of the responsibility issue among the central authorities.

Environmental pollutants, noise, radiation and children's work environment – i.e. schools, pre-schools, and after-school centres – are dealt with under RPG IV. We make several proposals aimed at protecting children from chemicals. Thanks to an active environmental policy, Sweden has progressed relatively far in protecting children from environmental pollutants. In this area, therefore, it is difficult to find examples of concrete measures aimed specifically at protecting children. With respect to radiation, we propose several measures aimed at reducing the risks of cancer later in life. These are either about protecting children from excesses of UV radiation, or about continuing the work to recondition homes, schools and pre-schools with excessive radon levels.
Noise is an environmental factor that bothers many children. In order to provide a good aural environment for children, we suggest that guideline values be set for noise in schools, pre-schools, and after-school centres. Other proposals concerning children's work environment are aimed at improving hygiene in schools and at making supervision more effective by clarifying the roles of the various authorities involved. An outline of the proposed measures, as well as a preliminary estimate of financial needs, can be found in Appendix 1.
More info:
http://www.socialstyrelsen.se/Publicerat/2007/9550/2007-131-28.htm

HIGH SOUND LEVELS FROM MUSIC – A NATIONAL SURVEILLANCE PROJECT

Background
In 2003, the National Board of Health and Welfare, at the request of the government, considered if the regulations on high sound levels were effective and followed. This evaluation showed that many discotheques and fitness centres had sound levels which were too high and that there was a need to review and strengthen the regulations on high sound levels. The evaluation also showed that the municipalities needed guidance for their surveillance work and that there was a need to develop a new method to measure high sound levels.
The overall aim was to reduce sound levels which were above the present guideline values by strengthening (omit of the surveillance) and increasing (omit of the) general knowledge on how to control high sound levels and why this is important. The project also aimed at: streamlining the surveillance between different municipalities; increasing the information on internal quality control to organizers and executives; and receiving data at the national level for future evaluations of the regulation/guidelines in this area.
The National Board of Health and Welfare (NBHW) has financed the project, the local authorities carried out the sound measurements and the County administrative board summarized the local results and sent them to the NBHW.
The key players in the project were the municipalities (Environmental health boards), County administrative boards and the National Board of Health and Welfare.
Work on the project started in 2004. The report was published in March 2006. In May 2007, the Board decided to perform a follow-up study to see what had happened after the national project was completed. The aim was to investigate and evaluate what actions were undertaken by the local authorities when the business operators had exceeded the highest recommended sound pressure levels for music.

Description of action/objectives
One objective was that at least 60 municipalities should participate. This objective was met: 134 municipalities participated, but only 93 carried out measurements. We hope that those which did not manage to perform measurements might improve their surveillance at a later stage.
A one-day course on health effects and measuring methods etc. was carried out at four different locations in Sweden. The target group was environmental health inspectors. We also had meetings with experts in the process of revising the guidelines on high sound levels and on the development of a new measuring method. The new measuring method can be found at the homepage; www.sp.se

Planning and implementation
The National Board of Health and Welfare invited all municipalities to take part in the project. A new method for measuring high sound levels was developed, a revision of the guideline on high sound levels was made, seminars were held, etc. The municipalities then carried out the surveillance. The intention was to reach all municipalities in Sweden (although not all of them participated in the project) and the music industry, music organisations and others arranging music events. The beneficiaries of the project are the Swedish population. Steering group meetings with representatives from the local and regional level were held during the planning phase of the project.
E-mails from the National Board of Health & Welfare were sent on a regular basis to the local authorities to let them follow the project. There were also memory notes from meetings at the central level/planning and a final report from the project, was issued to the media (press seminar).
Revision of the guidelines on high sound levels, the new measuring method, the high number of

municipalities participating and the number of measurements that were made all contributed to an increased awareness of the risks of high sound levels among a vast number of people at all levels, mainly due to a very good press coverage during this project. The final report "High sound levels from music" – a national surveillance project" (in Swedish) attracted quite large interest from media.

Evaluation/Impact

The major innovative component of the project is that the National Board of Health and Welfare has not before tried to coordinate surveillance activities in the environmental health area. With joint efforts it is possible to receive results from a large number of objects with wide geographical distribution. This is also a way to improve surveillance (and reduce environmental risks) in low-activity areas. We are now working on our third project of that kind (on drinking water). At the local level, surveillance of high sound levels should be seen as a regular work within an existing structure, but prior to this project, the level of activity was low. The project will be repeated in approx. 5 years to see if sound-levels are lower.

By helping the local authorities with better guidelines, the work on measuring sound levels and in reducing levels will continue. We have achieved increased knowledge and awareness of risks among surveillance bodies and people arranging musical events. But the actual risk-reduction needs to be evaluated at a later stage.

In order to help the municipalities in the national project, and to ensure that they all worked in a comparable way throughout the project, we:

- Revised the regulations for high sound levels (SOSFS 2005:7)
- Performed a one-day course about high sound levels
- Wrote and distributed two documents about high sound levels from music, that the EHA's can distribute when visiting places with music
- Distributed the new method for measuring high sound levels from music (How to measure high sound levels – a method for measuring high sound levels at discotheques, concerts and other places where there is music. SP INFO 2004:45. In Swedish, for more information: www.sp.se).
- Afterwards, we wrote a final report with the results from the project.

MUNICIPAL PUBLIC HEALTH PLANNING IN QUEENSLAND: ACHIEVEMENTS, BARRIERS AND IMPLEMENTATION SUCCESS FACTORS

By Peter J Davey, Deputy-Director, Centre for Environment and Population Health, Chair-Healthy Cities and Shires Network Queensland Griffith University, Brisbane - Australia

ABSTRACT

Creating healthier and more sustainable cities requires new approaches to planning at the local level. Queensland Health, Local Governments and Griffith University have formed a working partnership to implement Municipal Public Health Planning (MPHP) in local government. Each city has its own culture and diversity, its own political and organisational barriers to planning, and changing health professional capacity. The Queensland Healthy City and Shires Network facilitates partnerships, research, training and learning environments with local government and community agencies that are developing and implementing participatory planning. Healthy cities and shires meet and compare their planning achievements.

Regional and town planning schemes provide consistency for major infrastructure and land development, and local government legislation now requires cities to determine social health needs. MPHP is identified as one of several community public health planning models trialed in this research. A practical 'seven step' MPHP process provides the framework for healthy cities needs-based planning. This paper discusses the importance of a 'platform approach', where government and non-government agencies and community groups form a network and engage in the business of sustainable strategic health planning.

The platform approach has 3 dimensions, *Governance* (long-term vision, layers of planning, industry support and regulation); *a Platform* (mechanism for agency networking, stakeholder forum, advisory committee, terms of reference, project management); *and Implementation* (local strategies and priority action areas, desired outcomes, communication process and evaluation). The research findings highlight the importance of the *'platform approach'*.

An *Implementation Model* has been developed to promote the actioning of strategies in community planning. In the model health strategies *'link-up'* vertically to higher levels of planning, and *'link*

across' horizontally to address gaps in agency planning, community group concerns and resident needs.

The paper will describe the research developed in evaluation of MPHP, including a summary of the qualitative evaluation methodology, results and findings of the study and a 'Platform Approach' to participatory planning and MPHP Implementation Model.

Key Words: healthy cities, municipal public health planning, partnerships, qualitative evaluation and strategic planning, health promotion implementation.

BACKGROUND

Increasingly people are making connections between the urban condition and the eco-crisis confronting the planet. There is an increasing realisation throughout the world of the need to respond to problems that threaten global and local ecosystems. A Healthy City is one where living conditions promote good health and a good quality of life. In order to create a healthier future for cities, communities have to become engaged in and influence city development and be part of the overall reform of governance that puts healthy environments and human development at the centre of concern.

The Healthy Cities Movement was initiated in the eighties by the World Health Organisation to address these concerns and implement the health promotion action areas of the Ottawa Charter in local community settings. At the same time the development of an ecological public health focused on such concepts as the promotion of equity, community participation, and collaborative partnerships, multi-sectoral approaches towards improving the health outcomes of communities. Creating healthier and more sustainable cities requires new approaches to community partnerships and participatory planning at the local level.

Each City's health plan is unique because each City has its own culture and diversity, its own political agendas and organisational capacity to respond to the global and local challenge. Local authorities in Australia are well placed to plan healthy cities as they are democratic organisations, recognised as legitimate facilitators for participatory planning, having political decision-making opportunities, bureaucratic administrations, economic and resource capacity and opportunities, structures for community participation and are the level of government in Australia closest to the people.

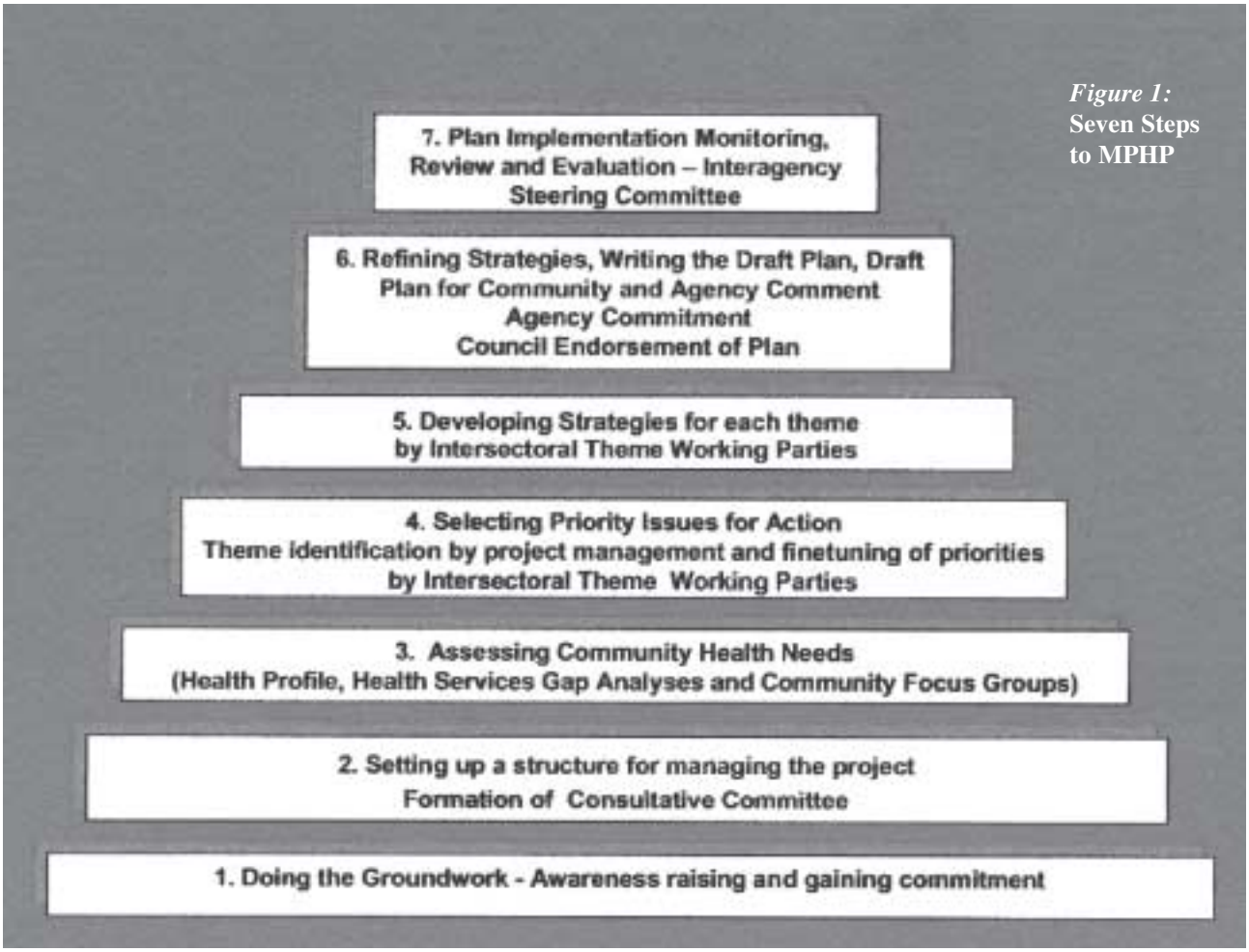

Figure 1: **Seven Steps to MPHP**

In Queensland, a movement in local government to create healthy cities has been gathering momentum since 1997. Eighteen cities and shires in Queensland have developed Municipal Public Health Planning (MPHP) based on the WHO Healthy Cities Philosophy. MPHP can be described as both a product and a process. The product is a dynamic strategic planning document that guides future local health actions, while the process facilitates the development of partnerships and collaborations for change between local government and other stakeholders to identify and seek solutions. Figure 1 highlights the Seven Steps to MPHP.

In Queensland, MPHP is one of several Community Public Health Planning (CPHP) frameworks that have been trialed in communities. MPHP is the model specifically tailored to local government needs and structures, and the model is being improved with each research project experience.

PURPOSE OF RESEARCH

The purpose of this research was to evaluate the degree that partnerships or healthy alliances have contributed to effective health planning, to analyse the extent to which the aims of the MPHP projects have been achieved and investigate the extent to which the MPHP has been implemented. MPHP is a strategic planning process adapted from a business environment for a community setting. Strategic Planning has two stages, namely, an initial plan development stage (1 year), followed by a plan implementation stage (3-5 years).

The literature developed by WHO to promote Healthy Cities and MPHP does not address the fact that many health practitioners and agency staff lack skills and knowledge in strategic planning. The Healthy Cities Movement assumes that local government have the necessary organisational and management skills to develop partnerships and planning outcomes. Planning is complex and demanding. Here lies the weakness in the MPHP process, the issue of lack of skills and knowledge in participatory strategic planning and limited organisational and human resource capacity can threaten the sustainability of planning projects.

Multi-sectorial agencies work in partnership on developing a planning document. The planning process needs organisational capacity and individual support for the critical on-going MPHP implementation. Efforts are directed towards Stage 1 of the Plan itself but more effort is required to implement the plan and action strategies. MPHP project management teams concentrate efforts initially on the planning phase of the process.

There is limited emphasis placed on understanding the success factors needed to support the sustainable implementation of the MPHP. Organisations develop the plan as the main outcome of the project at the expense of continuing efforts to understand the complex issues involved in plan implementation. The old saying that we don't want the plan to be "a dust collector on the shelf" can in fact be the reality of planning if an implementation model is not included in the MPHP from inception.

The wider research questions included:

Do organisations build their capacity and management practices to engage adequately and legitimately in participatory planning?

Do organisations address agency and departmental governance measures to ensure the priority actions in the MPHP are implemented?

Does agency staff have the legitimacy and capacity to implement these actions? How can planning projects be sustained?

The research asked the following specific questions:

Have the aims of the planning process been achieved?;

What are the achievements of MPHP initiatives in local government?;

What are the implementation outputs of the planning?;

Have the MPHPs impacted on the organisations and communities where they have been developed?;

What are strengths and weaknesses of MPHPs compared with other Public Health Planning models and frameworks in Qld?;

What are the barriers that prevent the MPHP from development and implementation?; and

What are the success factors and guiding principals for a sustainable MPHP implementation model?

METHODS - DATA COLLECTION AND ANALYSIS

A qualitative method was used and a Quality Evaluation Framework (see Figure 1) developed which included an 'interviewing tool' adapted from existing Healthy City theory and evaluation frameworks (see Speller, V., and Funnell, R., 1994).

The research also examined the strengths and weaknesses of 7 other planning approaches in Queensland, and compared specifically the achievements, barriers and success factors for sustainable MPHP.

There were three phases of data collection: Initially, a *Preliminary Evaluation with Case Studies*

Figure 1
Quality Evaluation Framework

was conducted in two local government areas in 1999. The reflections from this evaluation provided insight into designing Phase 11 of the study.
Phase 11 was a *Process and Impact Evaluation* and included the conduct of 21 key informants in-depth interviews with stakeholders involved in MPHP from Hervey Bay City, Maryborough City and Gold Coast City in 2002. The key informants were selected from the following domains - political, executive management, management, practitioner, community organisation representative and partner.
In Phase 111 of the data collection, and based on the findings of the first two phases, a *Comparative Study* was conducted in 2003. A comparison of 8 Public Health Planning projects and Legislative Frameworks state-wide included the conduct of 18 in-depth interviews and 3 focus groups with Managers, Practitioners and Partners.

The study examined several other Models that were being implemented in Queensland communities involving local and state government and other Planning Frameworks that have links to health but are driven by other state agencies in Queensland.

These included: -

Community Public Health Planning Models

1. Community Public Health Planning in Rural and Remote Areas Project;
2. The Bowen Project (Bowen);
3. Place Management (Place);
4. Supportive Environments for Active Living (SEAL);
5. Local Agenda 21 (LA21);
6. Municipal Public Health Planning (MPHP);
7. Towards 10 Year Indigenous Partnerships;
8. Community Renewal

Land Use, Development Planning and Legislative Frameworks

9. Integrated Planning Act (IPA);
10. Local Area Planning (LAP); and
11. Regional Framework for Growth Management (RFG).

A full report of these findings can be found in Davey, P., Stewart, D., and Spork, H., (2003) Community Public Health Planning and Implementation Review - Report to the Qld Health Board of Management auspiced by Queensland Centre for Public Health, University of Queensland.

A theme analysts was carried out on the data sets, and the findings of the research described and discussed in light of the literature review.

FINDINGS and DISCUSSION

The MPHP experience has demonstrated varying degrees of achievements, barriers and success. MPHP has its origins in strategic business planning yet little evidence was found of sustainable organisational structures and procedures to support sustainable health planning and implementation. Local Government did provide initial training workshops to up-skill staff in planning techniques however more foundation theory is required.

MPHP barriers and success factors for sustainability included:

- Planning Models must suit community characteristics and needs, no ‘one-best fit’ model;

- Community organisation leaders 'sign-off to the partnership;
- Select '3 Priority Actions' driven by high level partnership Advisory Committee (AC)
- Healthy City Partnership Advisory Committee, agencies work on the other 100 actions simultaneously;
- Need legal support - Advisory Committees endorsed by law - eg Local Government Act;
- Need an Implementation Committee (reports to AC) that meets every three months to drive strategy implementation;
- Agencies report progress on implementation regularly, eg Use web-site;
- Network and partnership building is a priority to improve working relationships and deliverables;
- Committed politicians make a difference - MPHP is a political and bureaucratic intervention;
- Need representatives from the community at all stages of planning;
- Industry is part of the planning and can sponsor the project;
- Build capacity (HRM) of health professionals and agency staff to manage and engage in Healthy City Projects

The research concluded that an outcome of involvement in MPHP was an improvement in people, improvement in organisations and improvement in the planning models. For the planning to be successful partner organisations must address governance measures to ensure their strategic business plans reflect the agreed partnership responsibilities and priority actions in the MPHP and that agencies and staff have the legitimacy and capacity to implement these actions. The main finding of the study was that it would be counter to the principles of 'learning organisations', to nominate a specific model as the most appropriate on a 'one size fits all' philosophy. Community public health planning practitioners, city management, community representatives, and other agencies working in collaboration need to select the approach and instruments that suit the specific planning situation, bearing in mind on one hand the nature of the community and the priority issues, and on the other hand the organisational skills mix and implementation resources available.

However, Figure 2 demonstrates the need for the agreed strategies in the plan to be communicated and progressed 'up' (provides a structure (managed by local vertically) to higher level planning frameworks; 'across' (horizontally) to community agencies and sub-populations of a similar nature; and to all relevant members of identified communities. The improved collaboration of agency staff and local government health and planning professionals would be seen to add value to planning and implementation processes in Queensland.

A 'Platform Approach' has been developed from the study and is currently being tested in local government (Kingaroy Shire and Gold Coast City).

Figure 2: **Integrating Community Public Health Planning in Queensland A 'Platform Approach'**

This approach emphasises the importance of both formal and informal partnership facilitation. The approach government) or a level playing field where government, non-government agencies and community groups can formally agree to network and engage in health action on the same platform.

The approach seeks to improve organisational communication, build organisational and staff capacity and create legitimate collaborations (work on joint programs, grants, and fund raising) and sustainable health planning outcomes. The approach is described in the Figure 3

for communities engaged in the process in Queensland. In the communities evaluated, project participants reported that the aims of the MPHP project were realised, with participants having improved networking opportunities, improved working partnerships - both within departments and across agencies - and more program accountability. There was an increase in community participation in the health agenda and politicians were more focused on delivering health aims. Agencies participating in the MPHP process had gained a clearer understanding of the roles of each agency in health promotion and this was favourable for health outcomes.

Figure 3: **Example of a Sustainable Community Plan Kingaroy Shire – 2005**

The platform approach has 3 dimensions:

Governance (long-term vision, layers of planning, industry support and regulation);

Platform Mechanism (for agency networking, stakeholder forum, advisory committee, enhanced

communication, terms of reference, project management); and

Implementation (priority action areas, partners' responsibility, desired outcomes, benchmarking and evaluation).

The integrated model attempts to understand the health gaps and duplication of services in a community and over time, to improve health outcomes.

CONCLUSION

The research concluded that MPHP is complex and challenging and there have been many achievements

In several communities there was a significant increase in funding for health projects as a direct result of priority action planning and agencies working in partnership. However, more emphasis is required to integrate health strategies into higher levels of planning eg Urban and Regional Planning and into the business plans of the other partner agencies.

MPHP has increased the level of health alliances formed between the agencies that were involved. The collaboration between local government and local agencies has improved significantly during the development and implementation stages of the MPHP. However, MPHP was difficult to sustain for longer than 3 years, this cycle linked closely with the political cycle for elected representatives in local government. Several elected representatives and mayors saw healthy cities as a policy initiative that would increase their electoral support. MPHP needs

political support to be effective; it cannot be only a beaurocratic process. Staff turnover significantly reduced the medium to long-term impact of MPHP. The high turnover of staff in agencies impacted adversely on MPHP outcomes.

The project management skills of the Project Officer managing the MPHP impacted directly on the success of the plan implementation. All members of the Advisory and Project Management Committees need on-going training and capacity building in strategic thinking and business planning, communication, project management and grant writing.

RECOMMENDATIONS

The success factors recommended for future MPHP include building individual and organisational capacity to strengthen strategic planning; improving governance and legitimacy for planning; sustaining structures and processes; formalising collaboration and partnerships; a commitment to investment in implementation; integrating the layers of planning cycles and addressing the on-going challenge that organisational barriers present for sustainable MPHP. In summary, there is no one best-fit community public health planning model. Agencies working in partnership in local communities need to select the planning model and tools that suit the specific planning situation; bearing in mind the nature of the community and the priority issues, and on the other hand the organisational skills mix and implementation resources available. The research established that the MPHP Approach is most suited to local government environments.

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CLIMATE CHANGE – THE EUROPEAN UNION AND POOR COUNTRIES MOST VULNERABLE TO CLIMATE CHANGE

By Ann Goodwin, Chartered Institute of Environmental Health, London

"Climate change is happening. Urgent action is required to limit it to a manageable level. The EU must adopt the necessary domestic measures and take the lead internationally to ensure that global average temperature increases do not exceed pre-industrial levels by more than 2ºC."

This bold but simple statement from the European Commission forms the corner stone of its document "Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions - Limiting Global Climate Change to 2 degrees Celsius. The way ahead for 2020 and beyond" which is a major new policy document in which the European Commission sets out what it thinks are the key objectives for future EU climate change policy. Accompanying the document is a 56-page impact assessment examining the major issues surrounding the climate change debate, including the latest scientific research, the costs of inaction for key sectors like agriculture and health and the benefits of climate action for other policy areas such as air pollution and energy security.

To help achieve the 2ºC goal, the policy document calls on the European Council to propose a greenhouse gas emission reduction target for developed countries of 30 percent by 2020, compared to 1990 levels as part of a new international climate change agreement. In the meantime, the European Union should commit itself to achieving at least a 20 percent reduction in emissions by the same date. Various measures are suggested for doing this, including improvements in energy efficiency, an increase in the use of renewable energy and the adoption of an environmentally safe carbon capture and geological storage policy.

The European Commission, it states, is under no illusions about the European Union's ability to make any significant impact on its own. Attention must also be given to the developing countries and their increasing contribution to global emissions. The European Commission states that this can be achieved without affecting their economic growth and poverty reduction, by taking advantage of the wide range of energy and transport related measures that not only have a major emissions reduction potential, but also bring immediate economic and social benefits in their own right.

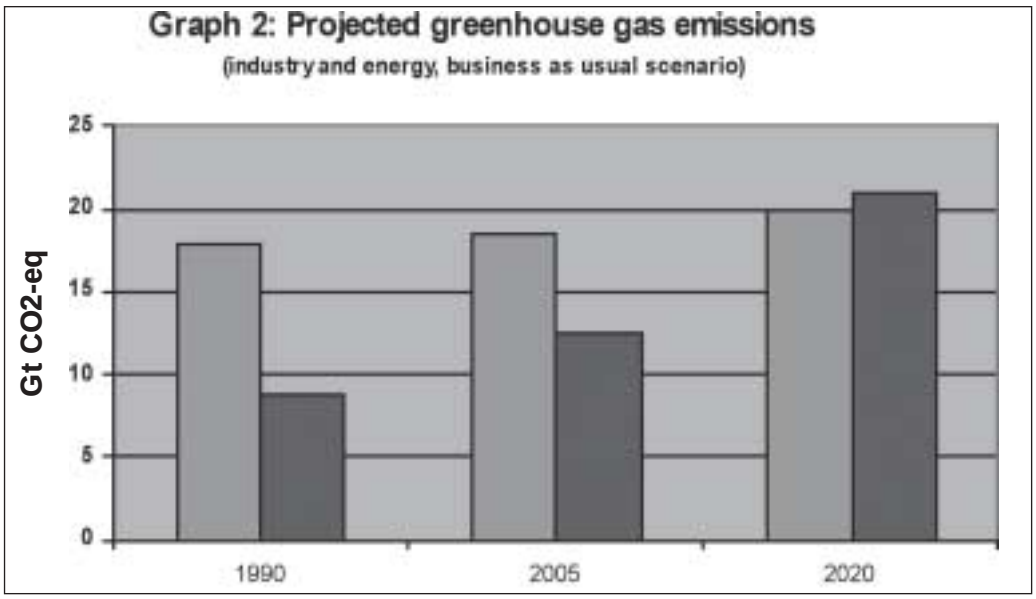
The policy document goes on to state that strong scientific evidence shows that urgent action to tackle climate change is imperative. Recent studies reaffirm the enormous costs of failure to act. These costs are not only economic, but also social and environmental and will especially fall on the poor, in both developing and developed countries. The European Union's objective is to limit global average temperature increase to less than 2ºC compared to pre-industrial levels. This will limit the impacts of climate change and the likelihood of massive and irreversible disruptions of the global eco-system.

The distribution of impacts of climate change is likely to be uneven. For instance, in southern Europe, climate change is likely to decrease crop productivity, increase heat related mortality and have a negative impact on tourism during summer. Action on climate change reduces air pollution thus generating enormous health benefits and addresses more efficient use of oil and gas. The European Commission estimates a decrease of around 20 percent of oil and gas imports by 2030 thus showing that the integration of climate change and energy policies are mutually beneficial.

Similar benefits, it states, will apply in other countries. For example, by 2030, the US, China and India are projected to import at least 70 percent of their oil. This could lead to tensions as resources become scarcer. At the same time, air pollution is increasing in particular in developing countries.

The document also looks at developing countries which it says should take substantive action to reduce their emissions as developing countries' economies and emissions grow in absolute and relative terms. They will, by 2020, account for more than 50 percent of global emissions (see Graph 2).

Further action by the developed countries alone will therefore not suffice to address climate change even if their emissions were to be drastically reduced. It is, therefore, essential that developing countries, in particular the emerging economies, start reducing the growth of their emissions as soon as possible and cut their emissions in absolute terms after 2020. A major effort should also be made to halt emissions resulting from deforestation. The document states that this is feasible without jeopardising economic growth and poverty reduction. Economic growth and tackling greenhouse gas emissions are compatible. The impact assessment estimates that overall GDP of developing countries with a climate policy in 2020 should be a small fraction (one percent) lower than GDP without a climate change policy. The document states that in reality the



difference would be even smaller as it does not take into account the benefits of avoiding climate change damage. However, it also states that it would be more convincing in engaging developing countries to take action, if all major developed country emitters substantially reduced their emissions.
The document goes on to state that many developing countries are already making efforts that result in significant reductions in the growth of their greenhouse gas emissions. There are many policy options for developing countries where benefits outweigh the costs.

Some of these include:

- Addressing low productivity of energy use and hence reduce growing concern about energy costs and security
- Renewable energy policies are often cost effective, including meeting rural electricity needs
- Air quality policies improve people's health
- Methane captured from landfills, coal beds, decomposing organic waste and other sources is a cheap source of energy

The document states that sharing good practice in policy design and planning and technology co-operation can strengthen these types of policies. This would enable developing countries to play a greater part in global reduction efforts. The European Union will continue and increase its co-operation efforts in this area.

One of the options proposed for engaging developing countries to take further action in reducing their greenhouse gas emissions is improved access to finance. The investment in new electricity generation in developing countries, it states, is projected to reach more than 130 billion euros per year in order to support economic growth. The majority of these resources will be generated by the major developing countries themselves. This new equipment will be in place for decades and will determine greenhouse gas emissions beyond 2050. It is therefore stated that it should be 'state of the art' development presenting unique opportunities for reducing emissions in developing countries.
The document states that least developed countries, it is anticipated, will suffer disproportionately from the impacts of climate change. Because of their low-level greenhouse gas emissions, they should not be subject to the obligatory emissions reductions. The European Union is proposing to enhance its co-operation with least developed countries to help them tackle climate change that includes measures to reinforce food security, disaster risk management, and preparedness as well as disaster response.

Measures to assist countries to adapt to the unavoidable consequences of climate change will need to be a part of the future global climate agreement, the document states. It also proposes that the EU should enhance its alliance-building with developing countries in the areas of climate change, adaptation and mitigation.

In September 2007, the EU Commission brought out a communication "Building a global climate change alliance between the European Union and poor developing countries most vulnerable to climate change". This communication explains that the International Panel on Climate Change 4th Assessment Report[1] provides a regional analysis of the impacts that can be expected from climate change. For Africa, the report concludes that it is one of the most vulnerable continents to climate variability. Water stress, food insecurity through droughts and desertification, sea level rise, extreme weather events and migration pressures are just some of the projected impacts. Other parts of the world, including Asia, Latin America and Small Island Developing States (SIDS), face similar challenges. In many least developed countries and SIDS, food security and safe water supply are already challenged due to gradual erosion of natural resources. At the same time, due to their limited economic development, it is the least

developed countries and SIDS that are least responsible for the accumulation of greenhouse gases in the atmosphere and hence climate change.

Enhanced dialogue and co-operation between the EU and developing countries on climate change, through building a Global Climate Change Alliance (GCCA), is called for in the green paper on the options for EU action for adapting to climate change in Europe[2]. The GCCA will provide a platform for dialogue and exchange between the EU and the poor developing countries most vulnerable to climate change, on practical approaches to realising the integration of development strategies and climate change. The GCCA is complementary to, and supportive of, the on-going process within the United Nations Framework Convention on Climate Change (UNFCCC) and the Kyoto Protocol. The EU believes that establishing a forum for the exchange of views and experiences with least developed countries and SIDS will help to advance the implementation of the UNFCCC and related agreements.

Participation in the GCCA is intended for those countries committed to taking measures to respond to climate change. Beyond dialogue, the GCCA will provide technical and financial support for adaptation and mitigation measures and for the integration of climate change into development strategies. Five priority areas are proposed and these will have to be discussed further and refined in the GCCA dialogue.

The five priority areas are:

- To help developing countries improve their knowledge base on the effects of climate change, to develop and implement adaptation strategies.
- To decrease CO_2 emissions from deforestation in developing countries, by creating economic incentives for forest protection, while preserving livelihoods and ecosystems depending on forests.
- To help developing countries to participate in and benefit from the global carbon market, through the Clean Development Mechanism.
- To improve the preparedness of developing countries and societies for climate related natural disasters and to mitigate the risks and limit their impact.
- To assist developing countries in systematically integrating climate change into development strategies and investments, and to systematically integrate climate change into development co-operation.

The European Commission is committed to mobilising substantial resources to implement the GCCA in these priority areas[3]
The European Commission has called on all EU Member States to join forces on the GCCA and to work towards common arrangements for delivery. This collective effort could take the form of a joint GCCA financing mechanism that could be managed by the Commission and governed in such a way as to reflect the participation of the Commission and the Member States.

In its conclusions, the Commission states that the EU is the largest provider of Official Development Assistance in the world and has put forward concrete proposals to reduce greenhouse gas emissions to try and contain temperature increases below 2ºC. Its proposal for the GCCA will support this vision with collective action to match the legitimate demand from least developed countries and SIDS that climate change should not jeopardise their development efforts and their fight against poverty. The GCCA will provide the EU with a unique opportunity to show international leadership and reaffirm the principles of multi-lateralism and global responsibility that underpin its international relations.

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More info:
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PERCEPTIONS OF NURSES AND NURSE-MIDWIVES ABOUT THEIR ROLE AS REGARDS THE HIV/AIDS PANDEMIC

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ABSTRACT

Nurses and nurse-midwives are in close interaction with patients/clients including their families in most health care settings, hence are considered to be better placed to provide and address patients / clients' needs and expectations as regards health needs. They are involved in the decision making process at clinical practice level and occasionally in management; therefore, their role in the advent of the HIV/AIDS pandemic is crucial. This article focuses on perceptions of nurses and nurse-midwives about their role as regards the HIV /AIDS pandemic in Zimbabwe. An exploratory, quantitative study was carried out to explore the perceptions of nurse-midwives as regards the HIV/AIDS pandemic. A sample of convenience was used. Respondents were drawn from nurses and nurse-midwives enrolled in the Bachelor of Nursing Science Degree Programme with the Zimbabwe Open University (ZOU). All these people work in areas where they provide care for people living with HIV/AIDS (PLWHAS). Data was collected through self-administered questionnaires. Results indicate that most respondents had received in-service education on caring for PLWHAS; the majority were at risk of contracting HIV infection at work. The issue of maintaining confidentiality as regards informing people caring for PLWHAS was overlooked and knowledge of support groups was minimal. Review of educational programs is recommended.

Key words: caring, confidentiality, encounter, interaction, pandemic, and perceptions.

INTRODUCTION, BACKGROUND AND RATIONALE

According to UNAIDS, 2006 about 20.1% of the adult population in Zimbabwe are infected by the HIV. Current data on new infections are not available as at 2000, adults living with HIV/AIDS in Zimbabwe, were estimated to be 20% of the population with 2000 new cases reported every week (Zimbabwe Community Home Based Care Policy Document, 2001). Aids is not curable but it is care able (UNAIDS, September 2001). Some of this care is provided by nurses and midwives, while support services are offered by the Social Welfare, Red Cross Society, and support groups for people living with HIV/AIDS (PLWHAS), Community Home Based Care Programmes and Village Health Workers.

The government of Zimbabwe, through the Ministry of Health and Child Welfare, has put in place interventions to reduce the incidence of HIV/AIDS. Some of these interventions include universal screening of blood which was established in 1985, an emergency short term plan (STP) was implemented between 1987 and 1988 to create public awareness about HIV/AIDS and to train health personnel (nurses and midwives included) in different aspects of HIV/AIDS, including prevention and control. During the STP phase, nurses and midwives received in-service training in caring for PLWHAS.

A multi-sectoral medium-term plan (MTP) was initiated between 1994 and 1998.
The medium term plan led to the implementation of the multi-sectoral approach that includes involvement and participation of all stakeholders. In Zimbabwe, the National AIDS Council (NAC), relevant government ministries, non-governmental organisations (involved in HIV/AIDS Programmes) the churches, community based organisations, support groups for PLWHAS, the media and international collaborating partners form part of the stakeholders. The ultimate aim/goal of the multi-sectoral medium term plan is to prevent the spread of HIV and to reduce personal, social and the economic impact of the HIV/AIDS pandemic. In this approach, the nurse/midwife plays a major role as she/he forms a link between the patient or client and all stakeholders including the relevant support groups for people living with HIV/AIDS. The aim of this study was to identify the perceptions of nurses and midwives about the HIV/AIDS pandemic.

RESEARCH QUESTIONS

To focus the study, the researcher stated the following research questions: -

- What training on care of PLWHAS have nurses and midwives received?
- How do nurses and midwives perceive the magnitude of HIV/AIDS in Zimbabwe?
- What do nurses and midwives perceive as factors contributing to the spread of HIV/AIDS and what do they perceive as interventions to curb its spread
- What do nurses and midwives perceive as their role in caring for PLWHAS?
- To which support services do nurses and midwives refer PLWHAS?

METHODOLOGY

To find answers to the research questions, quantitative, descriptive method was found to be the

most appropriate. According to Brink (2003), in simple descriptive surveys the researcher merely searches for accurate information about characteristics of particular subjects, groups, institutions or about frequency of a phenomenon's occurrence. Five lecturers and fifteen students enrolled in the Bachelor of Nursing Science Degree Programme, in the Zimbabwe Open University, critically evaluated the instrument in a pilot study. These students did not participate in the study. Face and content validity were ascertained through experts in the field of HIV/AIDS prevention who critically reviewed the questionnaire and suggested a few improvements that were taken note of.

Convenience sampling was used. One hundred and thirty nine students (139) pursuing the Bachelor of Nursing Science Degree with the Zimbabwe Open University participated in the study. These students are registered general nurses and nurse-midwives working in areas where they care for PLWHAS. Data was collected through self-administered questionnaires. Three out of ten regions participated in the study. The regions were conveniently selected due to their geographical location to the researcher. Data was analysed using descriptive statistics.

RESULTS AND DISCUSSION

The relevant control literature is integrated in the discussion of the relevant results.

Socio-Demographic Characteristics N=139

The majority 73(52.5%) of the respondents were aged between 30-39 years. Those in the age group 20-49 had the possibility of having received input either during training or as in-service education on caring for PLWHAS. This is because HIV/AIDS issues have now been integrated in the regular curriculum for training of nurses and nurse-midwives. Most of the respondents 117 (84.2%) were female. This may be attributed to the fact that females dominate the nursing profession. One hundred and twelve (80.6%) were married.

Professional Profiles N = 139

Professional profiles of the participants were identified. The majority 55(40%) of the respondents worked as both nurses and midwives (Table 1). Most of them 70 (50.8%) worked in provincial hospitals. Provincial Hospitals are located in urban areas. The majority of hospitalised (PLWHAS) are found in provincial hospitals.

The majority 109 (78.4%) of the respondents had nursed PLWHAS and seventy one point nine percent 100(71.9%) had received training on caring for PLWHAS (as highlighted in Table 1), though they cited that training was inadequate to prepare them to function effectively. Areas requiring further training were outlined as HIV/AIDS counselling, bereavement counselling, training relatives on home-based care, mother to child transmission and treatment of HIV/AIDS. In support of this, (Maslin) 2001, in her report on the progress and contribution of Nursing and Midwifery across the Commonwealth pointed out that few nurses and midwives were satisfied with the level of training they had received in relation to HIV/AIDS. Zimbabwe as one of the Commonwealth countries, at that time, which had participated in that particular study, hence the findings are applicable.

Most of the respondents 124(89.2%) were at risk of contracting HIV/AIDS at their work-place, through needle-stick injuries and inadequate resources to minimize the spread of HIV infection as shown in Table 1 (resources included protective clothing and resources to institute infection control measures).

Table 1: Professional Profiles N = 139

Variable	No.	%
Qualifications		
General Nurse	63	45
General Nurse and Midwife	55	40
Mental Health Nurse	4	3
Community Health Nurse	17	12
Nursed People Living with HIV/AIDS		
Yes	109	78.4
No	30	21.6
Received Training on Care of PLWHAS		
Yes	100	71.9
No	39	28.1
Received Sufficient Training in caring for PLWHADS		
Yes	46	33.1
No	93	66.9
Risk of Contracting HIV/AIDS at the workplace		
Yes	124	89.2
No	15	10.8

Accidental needle-stick injuries to health care workers constitute less than 0.01% of global HIV infections (WHO, 1994 p.9). Maslin (2001), in her survey on the progress and contribution of Nursing and Midwifery across the Commonwealth found out that a considerable proportion of nurses and midwives felt themselves to be at risk of contracting HIV/AIDS through their work. Concerns were also raised about the inadequacy of the precautions being adopted.

Magnitude of HIV/AIDS in Zimbabwe

The majority of the respondents 57 (41%) placed the magnitude of HIV/AIDS in Zimbabwe between 25-

50% of the adult population. In Zimbabwe the magnitude of HIV/AIDS is 20.1 % of the adult population (UNAIDS, 2006). This echoes the participants' concerns of the need to update their knowledge on the HIV/AIDS pandemic in Zimbabwe. Maslin (2001) had similar findings where nurses and midwives pointed out that there was need to be kept abreast of ongoing developments on HIV/AIDS. The other issues including orphan hood, care of the affected and the window of hope were not addressed by this study.

Perceptions on Factors Contributing to the Spread of HIV/AIDS

In general, respondents demonstrated accurate knowledge of the likelihood of transmission of HIV/AIDS through sexual behaviours and through some health-related behaviours. Factors cited included having multiple sexual partners 137(98.6%) and sharing injection needles among drug users 124(89.2%) (Table 2) In the USA, AIDS was found to be more common among men who had multiple sexual partners and where drug users were sharing injection needles. HIV was also found to be readily transmitted through infected blood products such as untreated Factor VIII, administered to people with haemophilia (WHO 1994,p.11). Safety of all blood and blood products should be ensured before transfusion (National AIDS Council Strategic Framework for a National Response to HIV/AIDS, 1999 p.38)

Respondents also reported on risk taking behaviours as highlighted in Table 2. Having multiple sexual partners carried the highest risk. According to Boyer and Kegeles (1999), understanding the nature of risk taking behaviours that contribute to the spread of HIV is important in planning health education and prevention programs on HIV/AIDS.

Table 2: Respondents' Perceptions of Factors Contributing to the Spread of HIV/AIDS N = 139

Variable	Respondents		
	Agree	Disagree	Not Sure
Having multiple sexual partners	137(98.6%)	-	**2 (1.4%)**
Sharing needles among drug users	124(89.2%)	1 (0.7%)	14 (10.1%)
Mother to child transmission	120(86.3%)	10 (7.2%)	9 (6.5%)
Use of contaminated blood products	117 (83.5 %)	-	22 (15.8%)
Improper disposal of sharps	116(83.4%)	-	23(16.5 %)
Contact with body secretions	124(89.2%)	-	15 (10.8 %)

Interventions to Reduce the Spread of HIV/AIDS

Knowledge on interventions to reduce HIV/AIDS transmission assists nurses and midwives to give relevant information to PLWHAS on appropriate interventions during educational sessions. Results on appropriate interventions are reflected in Table 3. Boyer and Kegeles (1991) say that interventions to reduce HIV/AIDS transmission should be innovative and not limited to information about the nature and causes of HIV. Peer educators are used extensively in youth programmes with the assumption that young people know how best to communicate with each other and are also trusted by their peers not to have a hidden agenda (WHO, 1994 p.77). Consistent use of condoms and making condoms available were considered as some of the interventions as highlighted in Table 3. In order to limit HIV transmission through sexual intercourse, condoms should be made available, accessible and affordable to all sexually active individuals (National HIV/AIDS Policy of Zimbabwe, 1999 p.9). Making condoms readily accessible to drug users may go a long way in reducing the spread of HIV/AIDS, as they are likely to be used (Jaddock, Hyde and Keller, 1995 p.318).

Table 3: Interventions To Reduce The Spread Of HIV/AIDS N = 139

Variable	Respondents		
	Agree	Disagree	Not Sure
Peer Education	130(93.5%)	-	9 (6.5%)
Mass Campaigns	125(89.9%)	-	14 (10.1%)
Screening Blood Products	121 (87.1%)	7 (5.0%)	11(7.9%)
Prophylaxis following needle –stick injury	107(77%)	11(8%)	2(15.0)
Sticking to one sexual partner	124 (89.2%)	2(7.9%)	13(9.3%)
Distribution of Condoms	106 (76.2%)	13(9.4%)	20 (14.4%)
Easy Access to Condoms by Users	114 (82.0)	7(5%)	18(13%)
Consistent use of Condoms	102(73.3%)	14(10.0%)	23(16.5%)

Sticking to one sexual partner is echoed and reinforced by religious organizations but findings also indicate that respondents were in support of sticking to one sexual partner 124 (89.2%). Faith Based Organisation (FBO) said they wished to promote fidelity and abstinence rather than condoms (Green, 2001 p.9). Green refers to fidelity as sticking to a single partner or sexual abstinence as primary behaviour change.

Most respondents 121 (87%) agreed that screening blood products for the HIV reduces spread of HIV/AIDS. In Zimbabwe, the risk of infection through blood transfusion is virtually non-existent as all blood and blood products are screened for HIV before transfusion (National AIDS Policy Document of Zimbabwe, 1999 p.9).

Support Services for People Living With HIV/AIDS

Support for PLWHAS and their relatives was assessed by two items: whether nurses and midwives refer PLWHAS to support groups in the community and whether they prepare relatives to care for their relatives (PLWHAS) at home. Fifty –four percent of the respondents referred PLWHAS to support groups while 46% did not. When asked to identify support groups to which they referred the clients most of the respondents cited organizations dealing with HIV/AIDS. If nurses refer PLWHAS to support groups, this will go a long way to minimize isolation of PLWHAS in communities. "PLWHAS are just isolated" (WHO, 1994 p.81). Referral of PLWHAS by nurses and midwives to organizations will only delay the referral process, as the person will be further referred to the support groups in her area. Therefore, knowledge of these support groups by nurses and nurse -midwives is essential to minimize the delay in receiving appropriate care and support. Referring PLWHAS to support groups ensures continuity of care. Continuity of care is desirable for health service users.

Perceptions of Nurses and Midwives about Their Role in Caring for PLWHAS

Respondents were presented with a list of five items pertaining to their role: offer pre-test counselling before collecting blood for an HIV test, obtain consent from the patient prior to testing for HIV, offer post-test counselling regardless of outcome of results, offer post test counselling for positive results only, and confidentiality is not necessary if one wants to protect relatives who are caring for PLWHAS. For each item, respondents indicated their role by checking one of the three possible responses: (a) agree (b) disagree and (c), not sure. Results are highlighted in Table 4. An open-ended question was given to capture any other role of respondents about their perceptions not addressed by the close-ended questions.

Table 4: Respondents' Perceptions about their Role in Caring for PLWHAS, N = 139

Variable	Number of Respondents		
	Agree	Disagree	Not Sure
Offer pre-test counselling	17 (84.1%)	10 (7.1%)	22 (15.8%)
Obtain consent from the patient prior to testing for HIV	106 76.3%)	8 (5.7%)	25 (18%)
Offer post- test counselling	90 (65%)	24 (17%)	25 (18%)
Counsel for positive results only	80 (57.5%)	46 (33.1%)	13 (9.4%)
Confidentiality not necessary for protection of relatives	120(86.3%)	19 (13.7%)	-

Other role perceptions were cited as:

- Counsel PLWHAS to live positively
- Improve quality of life for PLWHAS through support, education and play advocacy for both the patients and their relatives
- Training relatives under the Home Based Care Programme.

Pre-test counselling aims to provide information to the individual about the technical aspects of testing and the various implications of being diagnosed as HIV positive or negative. Hence pre-test counselling helps people to make informed choices (ZAPSO leaflet, Questions and Answers about HIV Testing, 2001).

Most of the respondents 80(57.5%) pointed out that post –test counselling was essential for positive results only. "The HIV testing result, whether positive or negative should be discussed including how the person feels about the result. In the case of negative results, then counselling about risk behaviours and methods to avoid infection are vital" (Women's matters on HIV/AIDS, ZAPSO, 2001). When the result is positive the nurse and midwife should tell the person as gently as possible, providing emotional support and discussing how to cope with the results and relevant health support services should be mentioned if there is concern that the person might not return. "Nurses make special contributions in caring for PLWHAS and their families." (Director General of WHO during an address to celebrate ICN's 100 years of unity).

Continued counselling and support to PLWHAS is essential as it helps to improve the quality of life and enhance the ability to cope and make informed decisions about on going care. Advocacy brings together groups and individuals to influence design, execution and change in the policies and behaviour of institutions and communities that have power over them (SAT Programme 2001). Therefore, nurses and midwives have a role to play in influencing policy makers to develop policies that are favourable to PLWHAS.

Most respondents 120(86.3%) felt that the issue of confidentiality can be breached in order to protect relatives, this is contrary to the ethics of medical practice." Privacy over health matters is a basic human right and a fundamental principle of ethics of medical practice. "Shared Confidentiality" may occur with the spouse/partner and caregiver. Legal provisions should be made to enable health professionals to disclose a client's/patient's HIV status to those who have critical reasons to know" (National HIV/AIDS Policy, of Zimbabwe 1999 p.5-6).

RECOMMENDATIONS

The recommendations from this study are made with specific reference to nursing education, nursing management in the clinical area and policy makers.

Nursing Education

An environment conducive to periodic in-service education on HIV/AIDS should be established. This could be achieved through structuring regular in-service education over a certain period. Areas to be addressed should focus on needs analysis. Input on counselling in the nurse-training program should include practical sessions to enhance their skills.

Nursing Management

Nurse managers should facilitate procurement of necessary protective clothing to minimize the risk of spread of infection. Provision of adequate resources also facilitates better performance. The process of lobbying and development of the legal framework to allow for breach of confidentiality to allow for disclosure of one's HIV status to those who have critical reasons to know needs to be hastened by the relevant stakeholders.

CONCLUSION

Most respondents, though they had been trained in caring for PLWHAS, felt that their training was inadequate and they recommended further training and education with regards to HIV/AIDS issues. The issue of inadequate resources for protection was raised and needs to be addressed by the nurse managers and the relevant authorities. The majority of the respondents were aware of their roles in caring for PLWHAS, but required further education and training to enhance their roles and to keep up to date with current information. Confidentiality was an issue overlooked by the majority. Legislation on confidentiality is still in force in Zimbabwe and all health workers are expected not to disclose the HIV status on an individual. These "drawbacks" can however be addressed and rectified through dialogue with policymakers and the other relevant authorities.

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NSF 2007 FOOD SAFETY LEADERSHIP AWARDS

Annual Awards Program Recognizes Foodservice Leaders

NSF International announced the winners of its fourth annual **Food Safety Leadership Awards Program** on May 19, 2007, at the National Restaurant Association (NRA) Restaurant, Hotel-Motel Show in Chicago, Illinois. As part of NSF's ongoing public health and safety commitment, the annual awards program identifies key individuals who have demonstrated outstanding leadership in foodservice safety.

Congratulations to Rasheed Ahmed, M.Ed, CPHI(C), DAAS, FRSH, Environmental Health Supervisor, Royal Commission Jubail, and representative to the IFEH who was a recipient this year.

NSF International: NSF International, an independent, not-for-profit organization, helps protect you by certifying products and writing standards for food, water and consumer goods (www.nsf.org). Founded in 1944, NSF is committed to protecting public health and safety worldwide. NSF is a World Health Organization Collaborating Centre for Food and Water Safety and Indoor Environment. Additional services include safety audits for the food and water industries, management systems registrations delivered through NSF International Strategic Registrations, organic certification provided by Quality Assurance International and education through the NSF Center for Public Health Education.

BOOK REVIEW

"Whither Thou Goest" by David Tonge

Published in 2007 by The Memoir Club; 209 pages; I SBN: 978-1-84104-172-8

Since I retired, I am seldom asked to review a new publication but, when the opportunity arose for me to do so in relation to this book, I agreed with some enthusiasm due to the fact that I know the author and felt that his memoirs would make for an interesting read.

Having read the book, I now know that my instinct was correct and I am sure that the experiences of the author, who spent almost all of his working life in Environmental Health, will strike a chord with others currently operating in the same profession or those who have operated in this field in the past.

David's reminiscences resonate particularly with one who is of a similar vintage to him (I am 6 years younger) and who met the author when he was coming to the end of his career – in the Orkney Isles off the Northern coast of Scotland. I can empathise therefore with the problems with which he dealt in the later years of his working life.

The experiences that he deals with in his book and which cover the years that he spent doing his National Service, also will be of considerable interest to others who served their country in the same way.

I anticipate that Mr Tonge's memoirs will be of value too, in the future, to scholars who wish to carry out research into the work of Environmental Health Professionals (and their predecessors, the Sanitary Inspectors and the Public Health Assistants) in the days of British Colonial rule in various parts of the World.

The author's first posting was at the time of the last days of what had been the British Empire but which was rapidly metamorphosing into the Commonwealth. He therefore experienced, quite uniquely, at first hand, the changes which transformed not only the lives of the indigenous population but also of the administrators and professionals sent from Britain to maintain Public Health and a host of other services many thousands of miles from home – in climates which were so different to those experienced "at home".

"Whither Thou Goest" will also provide a useful source for present-day professionals operating in the countries where David Tonge worked, namely Zambia, Malawi, Saudi Arabia and St Helena.

Michael Halls
November 2007

"Blasts from the Past!"

Top:
Brighton, England, 1991

Left Middle:
Aberdeen. Scotland, 1996

Right Middle:
Brighton, England 1987

Bottom:
Canberra, Australia, 1993

Reach for the skies, up she goes!
With gusto in it, beauty shows.
Stretch the boundaries, barriers break.
Shoot for heaven, shackles shake.
Back flip, pike, somersault,
Hand stand, inward, swallow,
Take the board and shoot aloft,
Faith will bring the morrow.

By Fred O'Brien

THE INTERNATIONAL FEDERATION OF ENVIRONMENTAL HEALTH

10th WORLD CONGRESS ON ENVIRONMENTAL HEALTH

SECOND ANNOUNCEMENT

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