Development of Health Promotion Program through IUHPE

- Possibilities of collaboration in East Asia -

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Abstract

This paper considers the possibilities of health promotion from the following perspectives; (1) IUHPE, (2) socio-cultural similarities, (3) action research, and (4) learning from our past.

1. The IUHPE values decentralized activities through regions, and countries such as Japan, Korea, Hong Kong, Taiwan and China belong to NPWP region. Since IUHPE World Conference was held in Japan in 1995, Japan used to occupy more than 60% of NPWP membership. After 2001, membership is increasing rapidly in Chinese speaking sub-region. The transnational collaboration is still in its beginning phase.

2. Confucianism is one of key points. Confucian tradition should not be seen only as obstacles but as advantages to seek a form of health promotion more acceptable in East Asia.

3. Within the new public health framework, people are expected to create and live their health. However, especially in Japan, the tendency of 'lacking of face-to-face explicit interactions' is still common at health-promotion settings as well as academic settings. Therefore, the author tried participatory approaches such as asking WIFY (interactive questions designed for subjects to review their daily life and environment) and as introducing round table interactions. So far, majority of participants welcome new trials.

4. The following social phenomena are comparatively discussed after Japanese invasion and occupation of Korea ended in 1945; ▪ status of oriental medicine, ▪ separation of dispensary services, and ▪ health promotion specialist as a national license. In contrast to Japanese' tendency of maintaining the status quo and postponing of substantial social change, trend toward rapid and dynamic social changes are more commonly observed in Korea.

Although all of above possibilities are still in their beginning stages, they are going to offer interesting directions waiting for further challenges and accompanying researches.

Ⅰ. Introduction

Health promotion is the process of enabling people to increase control over, and to improve, their health. In East Asian countries, such as Japan, Korea, Hong Kong, Taiwan, and Mainland China, health promotion activities are ongoing. However, each of present health promotion activities is mostly restricted within each nation, and transnational collaboration is not yet substantiated. Various barriers exist to prevent the sharing and development of health promotion. However, it is also true that East Asian countries have lots of common characteristics that do not exist in Western countries. The aim of this paper is to consider the possibilities of collaborative health promotion in East Asia from the following points, with special reference to the collaborative learning between Japan and Korea;

- Possibilities opened by the organizational framework of IUHPE and its NPWP region,
- Possibilities opened by socio-cultural similarities,
- Possibilities opened by action research,
- Possibilities opened by learning from our historical past.

Ⅱ. Possibilities opened by IUHPE

To substantiate health promotion transnationally, global network is essential for non-governmental as well as governmental sectors. The IUHPE (International Union of Health Promotion and Education) is the only global organization entirely devoted to advancing public health through health promotion and health education. Since its establishment in 1951, the IUHPE has more than half a century history comparable to World Health Organization (WHO). "The IUHPE is a leading global network working to promote health worldwide and contribute to the achievement of equity in health between and within countries. Members range from government bodies, to universities

and institutes, to NGOs and individuals across all continents" (IUHPE 2003).

The uniqueness of IUHPE lies its decentralized activity through 'Regions', and there are eight of them; Africa, Eastern Mediterranean, Europe, Latin America, North America, Northern Part of the Western Pacific (NPWP), South West Pacific, and South East Asia. The NPWP region now locates its office in Fukuoka, Japan, and the office serves for East Asian countries such as Japan, Korea, Hong Kong, Taiwan and China.

To substantiate our collaboration in transnational framework, NPWP region is expected to function as the basis. In the year 2000, IUHPE comprises 1611 world-wide individual members in total, and 203 (12.6%) belongs to NPWP (IUHPE 2000). As European and North American region comprises 153 (9.5%) and 139 (8.6%) individual members respectively, NPWP is considered to offer more than enough membership contribution. However, the detail of NPWP membership by individual countries shows great imbalance until the year 2001. In March 2001, of all 167 individual members of NPWP, 158 (94.6%) were Japanese, and rests were Korea 2 (1.2%), China 2, Taiwan 2, Hong Kong 2, and others 1 (0.6%). This membership imbalance in NPWP region started to change after 2001. Although still imbalanced, the total 195 individual members in September 2003 are as follows; Japan 130 (66.7%), China 35 (17.9%), Taiwan 17 (8.7%), Hong Kong 8 (4.1%), Korea 3 (1.5%) and others 2 (1.0%). As Hong Kong is going to host the 20th World Conference of IUHPE in 2010, more members are expected to increase in Chinese speaking sub-region.

In contrast to the rapid membership increase in Chinese speaking sub-region, upward trend of membership is only very modestly observed in Korea. Korea's further contribution to IUHPE/ NPWP is very welcomed and highly expected. In the case of Japan, stagnation of membership is noticed. Of all 125 Japanese NPWP individual members in March 2004, 72 (57.6%) got membership in 1995, the year that Japan hosted the 15th World Conference. The still high occupancy rate of NPWP/IUHPE membership by Japan is mostly derived from the membership drive in 1995, and after that, the Japanese contribution to membership is continuously declining.

In conclusion, the realities of NPWP membership shows that the transnational collaboration based on IUHPE/NPWP regional framework is promising, but not yet

substantiated.

Ⅲ. Possibilities opened by regional similarities

In contrast to the rather beginning stage of transnational collaboration in East Asia, there are lots of successful transnational collaborations in Europe. In this part, a European experience is at first referred, and then East Asian situation will be discussed.

Historically, European countries have been active in their initiative of both practice and research regarding health promotion and education. In major worldwide movements of new public health, such as healthy cities (WHO 1995), healthy work places and healthy schools (WHO 2002), European countries always took initiatives. In considering the substantial cooperation within the larger European network, the role of sub-regional network is significant. As a collaborative experience among German-speaking countries, Arnhold (1997) mentioned about a case of Health Promoting Schools Network. In this case, the idea of collaboration resulted from an initial link established in 1992 between Austria and Germany. A series of special transnational conferences followed with representatives of other German-speaking countries. By 1997, the 'sub-regional' transnational network consisted of five countries; Germany, Austria, Switzerland, Luxembourg and Belgium. As the result, Arnhold (1997) concluded the following prerequisites for this successful transnational cooperation; ▪ a common language, ▪ similar health and education frameworks and policies, ▪ comparable economic conditions, ▪ geographical proximity, and ▪ common culture.

Returning to the reality of NPWP region, how these prerequisites apply? These five prerequisites might be full-filled mostly in Chinese speaking 'sub-regions'. However, when whole NPWP region including Korea and Japan is considered, the first prerequisite does not apply. The rest of four prerequisites are expected to be fulfilled only partially. Then, in the case of NPWP region, we need to consider new

prerequisites.

Considering the fact that East Asian countries are often viewed to form a Confucian group, Confucianism is one of key points for consideration. Confucianism is not solely a religion and/or a culture. Confucianism is the way of life propagated by Confucius in the 6th-5th century BC and followed by the Chinese people for more than two millennia. Tu (1985) states that, "Confucianism has traditionally been the substance of learning, the source of values, and the social code of the Chinese. Influence of Confucianism has also extended to other countries, particularly Korea, Japan, and Vietnam. Even today, Confucian values—such as a paternalistic government, an educational system based on competitive examinations, the family with emphasis on loyalty and cooperation, and local organizations informed by consensus—have adapted themselves to the imperatives of modernization."

The Ottawa Charter (WHO 1986) stated that: "Health promotion is the process of enabling people to increase control over, and to improve, their health. Health is, therefore, seen as a resource for everyday life, not the objective of living." This statement clearly shows the importance of 'the way of life'. Then, how the new 'way of life' for health promotion should harmonize with the Confucian 'way of life'? At this moment, this topic is far more than the one that the author is able to discuss fully. Lots of further studies are needed to clarify the meaning of Confucianism in its modern sense in the framework of new public health and health promotion. Confucian tradition itself should not be seen only as obstacles but as advantages to seek a form of health promotion more acceptable in East Asia.

Ⅳ. Possibilities opened by action research

1. A new way of thinking toward health promotion

Within the old public health framework, administrative authorities kept people's health status by varieties of preventive measures such as vaccination, improving sanitation and so on. However, within the new public health framework, people

themselves are expected to create and live their health. It is obvious that the way of thinking regarding health has shifted drastically from an old framework to a new one. Therefore, successful health promotion depends whether all of participants in a given setting are able to accept the new way of thinking or not. In this section, the characteristic of this 'new way of thinking' is referred. Then, based on some action research results in Japan, the possibilities of further disseminating this new way of thinking is discussed.

In comparison to the mechanistic sanitary approach of the old public health, the new public health refocuses on the environmental determinants of health and emphasizes ecological thinking (Ashton 1998). Ottawa Charter served as a catalyst to shift health promotion away from problems and towards environments and settings. This is so called, 'the settings-based approach (Dooris et al. 1998)'. One of the first practical attempts to apply the idea of settings-based-approach was the WHO Healthy Cities project. According to Ashton (1998), "such a way of thinking can be seen as a shift from vertical thinking - whereby individual public health problems remain compartmentalized, to horizontal thinking - whereby links and interactions are made explicit and a synergistic approach is adopted through coordinated action on a range of health determinants."

2. Action research in health promotion settings

The above reference shows the importance of 'horizontal thinking' to substantiate setting-based approach of health promotion. In Japanese reality, even when the principle of health promotion and notion of setting-based approach is officially adopted at various levels such as communities, schools, municipal and central governments, 'horizontal thinking' and related open discussions are not so common. The majority of participants are still used to show hesitation of mentioning about their personal concerns freely in the public (Moriyama 2001). Although, such hesitation was traditionally viewed as a virtue in the old Confucian culture, it is no more a virtue in the modern world. Therefore, during the past several years, the author continued

trials to substantiate a kind of 'horizontal thinking' by the use of WIFY (Moriyama et al. 2001).

WIFY (what is important for you?) is a series of interactive questions originally designed for children to review their daily life and environment. The basic question of WIFY is as follows: "Name five matters of importance in your life that you would miss if you lost them." This basic question is repeated after inviting subjects to reflect their concerns from the following three life-related perspectives; ▪ daily living, ▪ living in the community, and ▪ living in the world.

During the past several years, the author had chances to ask WIFY to various settings regarding health promotion in Japan. By asking WIFY sequentially, participants are supposed to think about health fully reflecting one's life related unique view points (Moriyama 2001). It is interesting that most of participants not only responded to questions frankly but also increased their intention to share the findings with other participants. Actually, spontaneous exchanges between participants occurred and spread. By asking WIFY, participants are encouraged do adopt 'horizontal thinking'.

3. Action research in academic society

The concept of 'setting-based approach' and 'horizontal thinking' is important not only at health-promotion-settings but also at academic conferences. By nature, academic conferences are good chance to learn by interacting directly with other researchers, and straightforward discussions are essential for such learning. In fact, however, the actual chance of interaction is relatively limited. For example, in the annual conference of JSHEP (Japanese Society of Health Education and Promotion), three or four general sessions usually take place at the same time, and participants are able to attend to very limited numbers of presentations. More over, time allowed for each presentation is maximum 12 minutes including discussions. The hidden tradition of culture to avoid conflict and prefer group based conformity sometimes makes the situation worse. As the result, most of participants feel deficiency of discussions.

Intending to increase face-to-face interactions at the conference, the author

implemented the round table discussion on a trial bases at the occasion of JSHEP in 2004. Although round table is one of routine style presentations at various academic conferences in Western society, this is really an innovation in JSHEP. At that time, five round tables were arranged in a large conference room. Each of presenters chose the style of presentation for each table, and one presenter chose to use English as a major communicative language for her table. Since the establishment of JSHEP, this was the first occasion of general presentation conducted in English. One presenter and audiences (five to fifteen members) occupied each table, and spend an hour for presentation and discussions. At the beginning of the session, 13 of all 52 participants reported some sense of tension toward this new trial. However, at the end of session, more than 92% of participants reported satisfaction about this trial. As the result of this trial, the author proposes to add a notion of 'healthy conference' in the list of setting-based approach.

In the coming year of 2005, the author is going to host annual conference of JSHEP in Fukuoka, and its main theme is 'Healthy Conference.' In this coming conference, round table presentation will be the main stream, and some English language tables will be offered in addition to Japanese language tables. The author is also considering the possibility to organize Korean language table upon the request of participants. Overcoming of language barrier will be a prerequisite for Healthy Conference.

V. Possibilities opened by learning from our historical past

In developing health promotion program through IUHPE, learning from transnational framework is essential. From the Japanese point of view, the starting point of learning is Korea. When we learn about the history of health promotion, Constitution of WHO (WHO 1946) will be a starting point. However, when we learn about Korea and Japan, we need to go back for centuries to remind our past. Because of the geographical proximity, there were many historical interactions between Japan and

Korea. Before Edo-era, the most devastating ones were two of Japanese invasions of Korea in the end of 16th century. Despite the mostly equal transnational partnership in East Asian framework during Edo-era, Japan started to overpower Korea from the end of 19th century and finally annexed Korea in 1910. Lee and Lew (2003) mention that "during the period when Korea was under Japanese rule from 1910 to 1945, Koreans were deprived of freedom in all aspects of life." In this period, Japanese forced Koreans to abandon their own socio-cultural systems and to convert to Japanese alternatives, and this situation was also prevalent in the field of medicine, health and welfare. However, after the termination of Japanese occupation, Koreans rapidly recovered their cultural identities, and started to implement their own innovations toward social reformation.

The status of Oriental medicine shows a first example. Up until 1951, Oriental medicine did not have enough legal status in comparison to Western medicine both in Japan and in Korea. The same situation is continuing in Japan. However, in Korea, when Medical Service Act (An 2002) was legislated in 1951 for the first time, Oriental medicine began to have the support of the law system. Presently Oriental medicine has the same legal status as the Western medicine in Korea (An 2002; Nam 2004). The second example is shown in the field of separation of dispensary services from medical practice. In Japan, the separation of dispensary was already included in Isei, the first legislation of Japanese medical system enacted in 1874. However, even when the separation substantially went forward after 1974, the step toward complete separation was very slow. Recently, the rate of separation reached only 48.8% in the year 2002 (Ministry of Health, Labour and Welfare 2004). In Korea, the separation of dispensary advanced very rapidly. The separation officially started from August 2000, driving hospitals and pharmacies into an overall change and accompanied confusions. Because of this sudden change in Korea, both of hospitals and pharmacies reported substantial changes in earnings and/or sales (Nam and Park 2001; The Korea Times 2001). The third example is the newly establishment of health promotion specialist as a Korean national license. At this moment, in Japan, the comparable training of health promotion specialist is ongoing in a very small scale in the private sector, and national license

is still a dream.

Three examples above cited shows unique and dynamic social transition in modern Korea. In contrast to Japanese' tendency of maintaining the status quo and postponing of substantial social change, trend toward rapid and dynamic changes are more commonly observed in Korea. It is needless to say that three examples are only the beginning for Japanese to start learning from Korean way of health and welfare. Considering the fact that health promotion is a kind of social movement and/or social experiment toward more humanistic society, Japanese people should learn Korean people's experimental empiricism and optimism. Starting from the rather similar Confucian background, Korean people have already established highly dynamic and humanistic society. Confucianism is only one of clues to understand Korean dynamism, and other cultural traditions, such as the influence of Christian faith, should be also considered to understand health promotion movements in Korea.

VI. Conclusion

The typical expression of new public health movement is seen in the Ottawa Charter for Health Promotion (WHO 1986); "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love." Movement of health promotion never suggests to forget and/or to lose our diversified identities in East Asia. Considering the unique social and cultural traditions in East Asia, transnational collaboration is essential to find and establish our unique way of health promotion. Therefore, in this paper, the author at first aimed to discuss about development of health promotion programs in East Asia. However, because of the scarcity of recent achievements in East Asian setting, the author changed his mind, and scrutinized possibilities of transnational collaboration from the following perspectives; ▪ through IUHPE, ▪ through socio-cultural similarities, ▪ through action research, and ▪ through learning from our historical past. Although all of these possibilities are still in the beginning stage, each of these possibilities is going to offer interesting

directions waiting for further challenges and accompanying researches. Aiming for the coming 20th World Conference of IUHPE in Hong Kong, we need to accumulate our further collaboration in East Asia.

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국문요약

IUHPE를 통한 건강 증진 프로그램의 발달

- 동아시아권의 공동연구의 가능성 -

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이 논문은 다음 관점들로부터 건강 증진의 가능성들을 고찰해 본다.
(1) IUHPE, (2) 사회문화적 유사성들 (3) 행동 연구, 그리고 (4) 과거로부터의 학습

1. IUHPE는 여러 지역에 걸쳐서 분산된 활약들을 평가하며, 일본, 한국, 홍콩, 대만과 중국은 NPWP 지역에 속한다. IUHPE 세계회의가 1995년에 일본에서 개최된 이래로, NPWP 회원수의 60% 이상을 일본이 차지하곤 했다. 2001년 이후로 중국어권 소구역에서 회원수가 급속히 증가하는 중이다. 다국적 합작(국적을 초월한 공동연구)은 여전히 그 초기 단계에 있다.

2. 유교는 중요한 부분중의 하나다. 유교적 전통은 단지 장애물로써 보여져선 안되며, 동아시아에서 더욱 만족스러운 건강 증진의 형태를 추구하기 위한 이점들로써 보여져야 한다.

3. 새로운 공중보건체제 내에서, 사람들은 그들의 건강을 창조하고 존속시키도록 되어있다. 그러나 특히 일본에서는, 여전히 '직접 대면하는 숨김없는 상호작용의 부족' 추세가 학구적인 환경뿐 아니라 건강증진 환경에서도 흔하게 있다. 그러므로 저자는 WIFY 의뢰(사람들의 매일의 생활과 환경을 재검토하기 위한 주제를 놓고 고안된 상호 작용하는 질문들)나 토론회(원탁 회의 참석자들) 상호작용을 소개하는 것과 같은 참여적 접근들을 시도했다. 지금까지, 참여자 대다수가 새로운 시도들을 기꺼이 받아들이고 있다.

4. 1945년에 일본의 한국침입과 점령이 종결된 이후, 다음의 사회적 현상은 상대적으로 논의된다. -동양 의술의 상태, -공공 의료시설의 분리, 그리고 -국립 면허로써의 건강증진 전문가. 현 상태로 유지를 고집하고 실속 있는 사회 변화를 뒤로 미루는 일본의 경향에 반하여, 한국에서는 빠르고 역동적인 사회적 변화를 향한 추세가 더욱 흔하게 관찰되고 있다.

위의 모든 가능성들이 여전히 그 시작 단계에 있음에도 불구하고, 그들은 한층 더한 도전과 수반하는 연구들을 기다리고 있는 흥미로운 방향들을 제시할 것이다.