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Article

The whole and inclusive university: a critical review of health promoting universities from Aotearoa New Zealand

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Summary

As well as serving as a critic and conscience for societies, universities are elite sites of privilege which, at a surface level, are unlikely locations for health promotion interventions. This paper provides a critical review of the existing health promoting universities (HPU) approaches which is informed by health promotion values. It explores the silence in the global literature around issues of structural discrimination such as the sexism, homophobia and institutional racism that can thrive within university settings. The existing literature also reveals a very limited engagement about positive mental health or indigeneity. In response, this paper brings together these three factors—structural discrimination, mental health, and indigeneity—all of which the authors consider are criterial to health and its promotion. The authors introduce the New Zealand university landscape, in which there are eight Western universities and three whare wānanga (Māori universities), and, drawing on a survey of their Charters and other official statements, offer a moemoeā (vision or dream) of an HPU that addresses structural discrimination, is based on holistic conceptions of health, and is centred on indigenous worldviews and concerns.

Key words: health promotion, universities, indigenous

INTRODUCTION

Every day across the planet health promotion is being taught within universities. The curriculum is likely to showcase health promotion values of human rights, social justice, and equity from the *Ottawa Charter* (World Health Organization, 1986). Students will be learning about planning, evaluation, advocacy, public policy, and how to support communities to take control over the determinants of their health. Meantime at the grass roots those same students may be juggling study with paid and volunteer work, and family commitments, while attempting to maintain their fitness, social networks and mental wellbeing. On the other side of the desk, classroom or lecture theatre, the academics supporting them are balancing a different set of responsibilities, driven by the university's imperatives to recruit and retain students and to produce quality-assured research outputs. The demands on both parties can threaten our health and quality of life (Alkhati, 2015). The requirements of neo-liberal university life make it challenging to walk the talk of health promotion.

This paper provides a critical conceptual review of the World Health Organization's (WHO) health promoting universities (HPUs) programme (Tsouros *et al.*, 1998), and seeks to bridge a gap in the teaching of health promotion between its theory and practice,

especially when it takes a predominantly behaviourial approach, and students' lived experience of health. Our engagement in this critical review is supported by the definition of the role of the university, as defined in the New Zealand *Education Amendment Act 1990* (4), which outlines the characteristics of universities, including that 'They accept a role as critic and conscience of society' (4(v)). Our critique draws on critical public health traditions, including the view that health promotion is political (Mackenbach, 2014; Kickbusch, 2015) as well as understandings of health promotion shaped in the unique environment of Aotearoa.

SETTINGS-BASED HEALTH PROMOTION

The origins of settings-based health promotion lie within the *Ottawa Charter* (World Health Organization, 1986) and its global call to re-orientate from a deficit model of disease prevention to focus on the settings where people 'learn, work, play and love' (p. 3). Settings reflect a holistic, ecological model and are informed by systems thinking and organizational theory. They focus on reorienting an entire system rather than targeting behavioural/healthy lifestyle interventions that historically have emphasized personal responsibility over structural barriers to health. Over the last two decades a multiplicity of health promoting settings approaches have emerged, including, more recently: health promoting islands (Galea *et al.*, 2000), villages (Howard, 2002), marketplaces (World Health Organization, 2004), hospitals (Groene and Grarcia-Barbero, 2005), schools (Lee, 2009) and prisons (Woodall *et al.*, 2014). Settings approaches have been widely embraced within the health promotion community with health promoting schools and workplaces programmes widely regarded as being the most successful (Dooris, 2013). In Aotearoa, the health promoting schools approach has gained particular traction and is funded by the Ministry of Health as a core public health programme (Cognition, 2011).

The process of settings-based health promotion is similar to action research whereby you form a change team, undertake a needs/wish assessment, devise a plan, implement it, then reflect/evaluate it, and then start again in continuous cycle of learning and refinement. Settings work requires an intersectoral approach that involves brokering political and practical support from a spectrum of policy makers and decision-makers in a variable political climate.

Dooris (2005) asserted that settings-based approaches are underpinned by principles of equity, community participation and sustainability. Lang and Rayner (2012) argued that, at best, settings approaches take account of biological, social and cultural dimensions of health, and address human health within the context of a wider ecosystem, while Kickbusch (cited in Dooris, 2013) maintained that theoretically at least settings approaches can also address the wider determinants of health.

Kickbusch (2003) also conceded that settings work does 'not fit easily into an epidemiological framework of "evidence" but needs to be analysed in terms of social and political processes' (p. 386). This can make it difficult to showcase effectiveness to stakeholders' familiar with more linear 30 evaluation measures. In a review of settings-based approaches Dooris (2013) highlighted gaps between theory, policy and practice and the lack of robust evidence to support settings approaches.

HEALTH PROMOTING UNIVERSITIES

Universities are significant employers, teach—and generally have a duty of care for—thousands of students, frequently provide clinical health services, and generate knowledge that contributes to civil society and health promotion in a globalized world. As a workplace, as a learning institution and as source of knowledge, they are in a unique position to be champions of health promotion: in practice, in process and in theory, respectively. The HPUs initiative was first launched in the mid-1990s as part of the wider settings approach, championed by the European office of the WHO (Tsouros *et al.*, 1998). Being a relative new settings-based approach, Whitehead (2004) argued that the HPUs initiative has been a beneficiary of learning from other settings, particularly health promoting schools (Weare, 2000).

In Europe, the University of Central Lancaster (UCL) was one of the first HPUs. Reporting on this, Dooris (2001) explained that their initial pilot project was led by a dedicated co-ordinator who established a steering group which then developed a conceptual framework that captured the distinctive culture and ethos of their university. This was then refined into an agenda for action and sub-groups were set up to advance projects. Rather than undertake a comprehensive needs assessment they opted to get visible successes in key wellbeing areas during the pilot period to secure organizational commitment and a foundation for future work. Initial project work focused on sexual health, mental wellbeing, building design and drug use. Following their formal designation as an HPU, UCL utilized their in-house expertise and influence to embrace the role of advocate; calling for healthy public policy and championed health impact assessment.

Beattie (1995) has argued that early HPU work followed a strategy of 'purposeful opportunism' in that, rather than adopting a system change approach, in reality it often comprised a series of projects within a particular setting. This view is reinforced by Dooris' (2001) experiences which found a tendency to rely heavily on the HPU co-ordinator to initiate and drive work from the centre rather than more organic leadership from multiple locations across the university. He recounted pressures from critics to ensure the HPU work did not 'rock the boat' and the widespread prevalence of the neo-liberal mantra that students need to take personal (i.e. individual) responsibility for their health.

In 2005, *the Edmonton Charter* was developed as a global living statement to define and promote HPUs. In 2015, the follow-up *Okanagan Charter* was launched to generate dialogue and mobilize action for the integration of health in all aspects of campus culture and all policies and practices, e.g. providing healthy alternatives in vending machines; more opportunities for students to receive mental health support; 'lunch and learn' panels with health professionals; and fitness classes in public spaces. All of these are environmental and life-style contributions to health but do not address the substantive drivers of health and wellbeing in universities. This *Charter* 16 also the affirmed the global agenda developed by the World Health Organization and the United 17 Nations; but, whilst it affirmed the unique opportunity presented by the tertiary education sector to provide.

LIMITATIONS OF THE EXISTING APPROACH

Within New Zealand traditions, as elsewhere, tertiary education has, historically, been seen as a public service to be funded by the nation-state. Since the 1990s universities have often been channelled by neo-liberal governments into a competitive global marketplace where performance is tightly measured against quality assured research outputs and student completions (Zabrodska *et al.*, 2011). This has resulted in conflicts between universities over resource allocation, and a decrease in co-operation. Within this environment, universities are expected to balance their unique role of being a critic and conscience of society, while also forming partnerships with corporations to make up for shortfalls in funding. Regarding this complex ethical quagmire, Bansel and Davies (2010) argued that critique and dissent have become dangerous: a perceived threat to the security of university funding. At the same time, a university that aspires to be an HPU needs alignment between its institutional values and health promotion values. Given this fraught operating environment, the authors query how a complex entity such as a university can authentically embrace core health promotion values.

Based on our review of the literature and our extensive practice-based knowledge we discuss three areas in and with which we see neo-liberal universities in general, and the behavioural approach to health promotion within universities in particular, struggle that is, in addressing structural inequalities, mental health and indigeneity. We consider these areas important as they reflect people's context as well as their personal and cultural identity, all of which affect their place in the world and sense of wellbeing or health.

Structural inequalities

Historically, universities have been elite institutions which, as Larner and Le Heron (2005) asserted, have made false claims of universal access for women, indigenous people and working class students. In the 1970s students in New Zealand were given a living allowance by the state and tuition fees were nominal. By the 2000s the user-pays regime had transformed the face of tertiary education and full-time students were expected to invest thousands of dollars in fees each year, juggle paid work with study or, alternatively, take out life-altering student loans. This profound change in orientation has financially locked out many New Zealanders from the university (Healey and Gunby, 2012). However, as education is a critical determinant of health for indigenous people, the priority should be to enable to enrol and find work at universities and for these institutions to be healthy and health promoting. This approach is consistent with ethical health promotion as defined by the New Zealand Health Promotion Forum (2011).

Structural inequalities are literally black and white issues. For instance, a report published in 2013 noted Oxford University's institutional bias against Black and minority ethnic students in its offers to applicants: 25.7% of white applicants compared to 17.2% of ethnic minority students with the same grades; in medicine white applicants were twice as likely as ethnic minority applicants to get a place (Parel and Ball, 2013).

In their landmark text *Transforming the Ivory Tower: Challenging Racism, Sexism and Homophobia in the Academy*, Stockdill and Danico (2012) identified what they called the 'ivory tower paradox' (p. 12). By this they were referring to that fact that, while universities can be a sites of resistance to injustice, they can also perpetuate inequities. In their study of racial climate on campus, Nadal *et al.* (2014) identified that Black,

Hispanic and indigenous students frequently experience macroaggressions and putdowns. From a gender perspective, Ramsay *et al.* (2014) argued that there are significant issues around pay parity and the underrepresentation of women in senior leadership roles within universities. Studies by Fine (2011) and Tetreault *et al.* (2013) confirmed that, as part of 'ordinary' campus life, sexual minority students actively have to navigate homophobia and heterosexism both inside and outside the classroom.

The New Zealand Tertiary Education Strategy (Ministry of Education and Ministry of Business Innovation and Employment, 2014) identified a plethora of unresolved equity issues in relation to student access and completions that The New Zealand *Tertiary Education Strategy* (Ministry of Education and Ministry of Business Innovation and Employment, 2014) need addressing. Whilst the prevalence and intensity of racism, sexism and homophobia is difficult to quantify, health researchers in New Zealand (Harris *et al.*, 2012), Australia (Paradies, 2006) and the United States (Williams and Mohammed, 2013) have nevertheless isolated how racism impacts on physical and mental health. Similar research is also being advanced around the health effects of sexism (Moss, 2002; Townsend *et al.*, 2011) and homophobia (Choi *et al.*, 2013; Shilo and Mor, 2014). Not unexpectedly, this body of research demonstrates that being the target of discrimination is damaging to your health.

The authors' review of HPU literature (as referenced throughout) suggests that systemic discrimination has yet to substantively make it onto the agenda. Within a complex HPU setting it may be problematic to advance such politically sensitive issues but, from an ethical health promotion standpoint, freedom from discrimination is a basic and achievable human right.

The mentally unhealthy university

While most practitioners and researchers would agree that health is a holistic concept, given the influence of dualism, at least in Western thinking, and the dominance of the biomedical model, 'health' is still viewed as more concerned with the physical sphere of the body than anything else. In this context, we are interested to emphasize the mental aspect of health for, as the World Health Organization (2014) has stated: 'Mental health is an integral part of health . . . there is no health without mental health.' Drawing on the work of Tudor (1996), Raeburn (2001) and others, we consider mental health as a criterial to a more general and holistic appreciation of health and approaches to health promotion. Unfortunately, as the term 'mental health' is often conflated with and used as a substitute for 'mental illness'. Even the WHO's annual Mental Health Day (held on 10 October) is usually about some aspect of mental illness, for instance, citizen advocacy (2008), primary care (2009), integrated care (2010), depression (2012) and schizophrenia (2014). Clearly, the mental illness of students and staff in a university setting is important and requires a response; however, it is not the focus of what we are referring to as (positive) mental health or well-being. By contrast, the Okanagan Charter (2015) made reference to an inclusive concept of health 'mental well-being' (p. 6).

In the WHO's publication on HPU (Tsouros *et al.*, 1998), there is one reference to mental health by Peterken (1998) who reported on work at the University of Portsmouth. This included action on mental health comprising, for staff, staff training on managing change and stress management sessions; and, for students, a Mental Health Fair which included techniques for peer education programme. Whilst this is a reasonable start, we think it is interesting and significant coping with revision and examination stress; positive messages about mental health and illness; and a that the approaches to the two different populations was so different: with staff, more managerial; and with students, more facilitative. We would take this further and argue that the graduate profile of a mentally healthy university would include emotional literacy (Steiner, 1984), alongside such attributes as critical thinking and reflective practice.

White-brick universities

The term 'white-brick' offers a critical reflection on what are referred to as 'redbrick' and older universities founded in the Western intellectual tradition (such as Oxbridge in the United Kingdom and the Ivy League in the United States of America) that do not account for ethnic and especially indigenous populations, and, as such, in effect provide a structural and a very observable example of 'white skin privilege' (McIntosh, 1990). In Aotearoa, where the indigenous Māori population is

> 14.9% of the population (Statistics New Zealand, 2013), only one of the Western universities, the University of Waikato, had enrolments higher than that (at 18.6%). The rest varied from 10.2% (Victoria University of Wellington) and 10% (Auckland University of Technology) down to 7.0%
>
> (University of Auckland).

The figures for Pacific peoples, who form 7.4% of the population of the country and 14.6% of the population of Auckland (Statistics New Zealand, 2013) are

13% (Auckland University of Technology), and 7.9% (University of Auckland), to 5% (Victoria University of Wellington), and 1.3% (Lincoln University). Australia's indigenous population is also under-represented in the university system. According to the Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People (Universities Australia, 2014), while indigenous people comprises some 2.2% of the overall population, they form only 1.4% of student enrolments Australian universities (2010 statistics) — and only 0.8% of all full-time equivalent academic staff. Some of the reasons for this include the structural inequalities referred to above, which, with regard to indigenous populations, rest on deprivation as a result of colonization. Marsden (2003) summarized this well when he wrote about 'pattern[s] of domination and methods of socio-political control' (p. 34), namely: pacification, appropriation, cultural genocide, and processes of assimilation past and present. How we see this operating especially in the Western universities in Aotearoa New Zealand is (i) through the assumption of the Western intellectual tradition, rather than an indigenous or Southern one; (ii) a lack of knowledge and acknowledgement on the part of staff of indigenous wisdom and knowledge (see below), including holistic conceptions of health and education; (iii) a lack of attention from staff and students given to indigenous customs, rituals and protocols; and (iv) a low take up on the part of staff and students of opportunities to learn and to engagement with indigenous people, ideas and events.

A NEW ZEALAND PERSPECTIVE

Aotearoa has eight Western universities and three whare wānanga (indigenous universities) (see Table 1), many of which teach curricula related to hauora (health), and seven of which specifically teach health promotion. However, a review in 2014 of the websites of all these institutions found no evidence that any of them has formally engaged with the WHO's HPUs programme. Given the nature of health promotion, whether it is approached in a behavioural way (as in the traditional health education) or in a more integrative way, we do find it surprising that none of the New Zealand universities or whare wānanga appear to be walking their talk with regard to the health of the institution itself.

The authors argue that the concept of HPU and its application in New Zealand is worthy of an informed debate. For those of us teaching health promotion, our non-engagement with HPU could be perceived as a significant incongruence between theory and practice. Engaging with the HPU initiative is an opportunity to demonstrate to students, colleagues and the wider community the university's commitment to the values and practices of health promotion, i.e. human rights, social justice, equity and inclusion. Becoming an HPU is also a chance to harness the resources of the academy to strengthen (health) policy and practice.

Te whare wānanga

The original places of higher learning in New Zealand were traditional whare wānanga. Students were selected to participate based on their ancestry and were taught a repertoire of traditional Māori knowledge (mātauranga). Kāretu (2008) maintained that knowledge was divided into three kete (baskets): te kete tuarui held the knowledge of peace and love, while te kete tuatea contained knowledge of warfare and agriculture, and te kete aronui contained knowledge related to the preservation of physical, spiritual and mental welfare. Curricula related to these kete of knowledge as well as practical skills such as weaving, astronomy, bird-snaring, and fishing were taught. Students were instructed away from the village by kaumātua (elders) and tohunga (healers). Royal (2012) argued that the process of learning and research entailed rote and experimental learning, whakatiki (fasting) and nohopuku (meditation). Traditional wānanga practices are believed to have stopped in the 1850s.

In the 1980s on the back of the kōhanga reo movement, which is an early childhood te reo Māori language nest. The first modern wānanga, Te Wānanga o Raukawa, was established in Otaki as part of a wider tribal plan to revitalise te reo Māori (the Māori language). In 1985, Te Wānanga o Aotearoa was established, initially in Te Awamutu, an initiative which has since grown to become one of the biggest tertiary education providers in the country, with 25 centres in both North and South Islands. In 1992 Te Whare Wānanga o Awanuiārangi was established in Whakatāne, and subsequently has been accredited to teach courses to PhD level, a world first for an indigenous tertiary institute.

A review of wānanga websites, shows modern wānanga operate from holistic kaupapa Māori philosophies, principles and approaches. The wānanga demonstrate a commitment to tikanga (Māori protocols), as well as a focus on delivering quality educational outcomes and the pursuit of tino rangatiratanga (sovereignty). Zepke (2009) argued that wānanga emphasize the revitalization of traditional cultural practice and a commitment to Māori economic development. These goals are closely aligned to Durie's (1998b, 1999) articulation of the determinants of Māori health. The mission

Table 1: Health promotion in the curriculum of universities in Aotearoa New Zealand

Established	University/Wānanga	Health promotion in the curriculum
1869	University of Otago, Dunedin	Two papers within the Postgraduate Certificate and Diploma in Public Health. (The university has a Health Promotion and Policy Unit, the only one in the country.)
1873	University of Canterbury, Christchurch	One course.
1878	Lincoln University, Lincoln	None.
1883	University of Auckland	Two Undergraduate Health Promotion papers, and two postgraduate papers, the latter of which can be taken as part of the Masters in Public Health, in Health Promotion, comprising five courses specifically on health promotion.
1897	Victoria University of Wellington	None.
1927	Massey University, Palmerston North	Some teaching on health promotion on the Diploma, Bachelor and Postgraduate Diploma in Health Science.
1964	University of Waikato, Hamilton	None.
1984	Te Wānanga o Raukawa, Ōtaki	Heke Kawa Oranga | Diploma of Health Promotion, Sport and Exercise, and Poutuarongo Kawa Oranga | Bachelor of Health Promotion, Sport and Exercise.
1985	Te Wānanga o Aotearoa	None.
1991	Te Whare Wānanga o Awanuiārangi, Whakatāne	In Te Ōhanga Mataora Paetahi, Bachelor of Health Sciences Māori Health one course includes some teaching on health promotion.
2000	Auckland University of Technology	A major, comprising eight papers, within the Bachelor of Health Science.

statements of the wānanga variously highlight aroha (love), empowerment, self-determination and kotahitanga (unity): all values aligned to health promotion paradigms. Since the re-emergence of the wānanga, Māori tertiary enrolments have improved considerably thereby helping alleviate unequal access to education as a determinant of health (Statistics New Zealand, 2013). Given the holistic philosophy of wānanga, a systems-based HPU approach seems well aligned. However, if hauora were to be more formally integrated, it would seem more likely that an indigenous framework such as whānau ora would be chosen over a Western framework. Whānau ora is currently the central Māori health strategy in Aotearoa New Zealand, championed by the Whānau Ora Taskforce (2010) and Te Puni Kōkiri (2014). Whānau ora is a holistic approach to empowering whānau (extended family) to build on its strengths and capabilities. It is a supported Māori process of identifying whānau aspirations and working collectively towards those goals being achieved.

Western-style universities

As there is nothing specific within the *Education Act 1989* that defines universities as health promoting, we undertook research into the key documents of the eight New Zealand Universities and the three whare wānanga. The survey firstly identified these documents by means of a search of the websites of the respective universities and whare wānanga, and, where necessary, correspondence. The authors then conducted a word search of these documents using the terms 'health' and 'wellbeing'. Supplementary Table S2 summarizes the references to health and wellbeing in these documents, which 11 are or were available on the universities' websites. Under the *Education Act 1989* it was a requirement that all universities had a charter; however, under the *Education (Tertiary Reforms) Amendment Act 2008* this requirement was repealed, as a result of which, most universities no longer have a current charter, and, significantly, Lincoln University has replaced its charter with an 'Investment Plan'.

The moemoeā | vision: an HPU informed by indigenous wisdom

So what might a Western HPU look like in the context of New Zealand? As a starting point the authors propose that a New Zealand based HPU would (i) engage with te Tiriti o Waitangi and indigenous realities, (ii) challenge structural inequities within the university and (iii) be mental health promoting.

As te Tiriti o Waitangi is the founding document of the colonial state of New Zealand, and a core ethical imperative of health promotion practice (Health Promotion Forum, 2002, 2011), it follows therefore that an HPU would engage with te Tiriti. Te Tiriti was signed between the British Crown and rangatira (chiefs) in 1840 to establish the terms and conditions of British settlement and

reaffirmed Māori sovereignty. So what might a health promoting, treaty-based university look like? As all land in New Zealand was once Māori land universities are built on Māori land. Some of this land was secured legitimately through private sales; other land was confiscated by the Crown, or gifted to universities by Māori through the process of tuku whenua (Healy, 2009). In terms of restoring mana (authority), for instance, by applying Durie's (1998a) vision of self-determination, a Treaty-based HPU would have ongoing formal relationships with Māori, who would, thereby have meaningful input at a governance level into decision-making. Māori aspirations would be reflected in the design of the university in terms of the built environment, the culture of the university, the curriculum and influence the agenda of the research being undertaken. Māori paradigms would sit comfortably as ordinary alongside western knowledge and institutional racism would not be present.

As noted earlier the presence of sexism, racism and homophobia within a university is an anathema of a health promoting institution. The authors dream of an HPU where both students and staff feel safe on campus and are free from micro, meso and macro violence and coercion. We dream of an HPU where there is zero tolerance to workplace bullying and harassment (Worksafe New Zealand, 2014), where pay equity is a reality, where there is equity in leadership roles and promotional opportunities. Through their programme of study students are taught from curricula and by staff that reflects their diversity. This freedom from personal-mediated, cultural and structural discrimination, is a basic human right (United Nations, 1948), which would be prioritized alongside more conventional healthy promotion initiatives. This prioritising would reflect health promotion ethical values about working with the most vulnerable and open up human potential on campus to tackle/enhance other parts of the university system.

Finally, we dream of mentally healthy university, based on a holistic concept of health that encompasses its behavioural, emotional, mental, physical, psychological and spiritual aspects of wellbeing. The built environment would not only be accessible but positively healthy and facilitative of learning. Factors that impact on and compromise the educational process, such as homelessness, poverty, poor housing, violence, abuse, the illness of family members, etc., for both students and staff can be acknowledged and discussed.

CONCLUSION

Establishing an HPU in the neo-liberal age is a significant challenge, and as New Zealand has been at the forefront of the global neo-liberal agenda, it is not surprising that none of its Western universities or the three whare wānanga have formally engaged with HPU. There are vested economic, social and political interests in maintaining the status quo; Western universities in Aotearoa New Zealand and other countries are well-established in their ways, have generally served the elite and have thereby maintained their status. Also, as large institutions, universities are difficult and slow to change, re-orientate and re-configure. Moreover, given our critical perspective, we could argue that as a relatively privileged institution, the university is not a top priority for the investment of scare health promotion resources. Nevertheless, we advance a broader argument that health promotion is important wherever people work, live and play. In this context, the authors' vision for an inclusive, egalitarian and mental HPU in Aotearoa New Zealand—and elsewhere—is also broader and more fundamental than ad hoc discrete projects co-ordinated from the corporate centre and hierarchy of an institution. We envisage an intersectoral, systems-based approach to change, grounded in a commitment to end sexism, homophobia and racism on campuses. Critical to our vision is alignment between core health promotion values and universities' charters, constitutions and/or mission statements. Our health promotion agenda is centred on equity, social justice, holism, inclusion and the possibilities of transformational relationships with local communities and, in our country, indigenous partners. To return to the original question in these challenging times, should we be prioritising co-creating HPUs? The authors are undecided but it seems worthy of a korero (conversation) with our indigenous partners to see how it aligns to their aspirations.

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SUPPLEMENTARY MATERIAL

Supplementary material is available at *Health Promotion International* online.

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