Healthy Tourism in a Fijian context

A WHO initiative for island tourism

Russell Staiff and Robyn Bushell

Abstract

This paper describes research undertaken to assist in the institutionalisation of the ethic of sustainability into tourism planning and operation. It involves developing a conceptual framework for Healthy Tourism in island microstates in the Western Pacific Region. Such a quest, to be achieved in a way that is sensitive to local geography and under the auspices of an international body such as the World Health Organization, is complex. This paper explores issues prompted by such a project. A case study of Fiji before the 2000 constitutional crisis is presented. The paper investigates attempts by the WHO to bring together tourism and the health of destination communities. It describes the theoretical contexts of tourism and health, along with the issues arising from a series of workshops conducted in Suva in March 2000. Together, these highlight implications for planning a healthy tourism concept that focuses on the health and well-being of locals as well as the safety of tourists.

The reality, however, is that tourism is a cultural process as much as it is a form of economic development, and the destination of the tourist and the inhabited landscape of local culture are now inseparable to a greater degree. (Ringer 1998: 1)

Health is a process engaging social, mental, spiritual and physical well-being. It bases its actions on the knowledge that health is a fundamental resource to the individual, the community and to society as a whole and must be supported through sound investments into the conditions of living that create, maintain and protect health. (Kickbusch 1989: 17)

Ethnicity is what makes people what they are. Everyone has a certain identity aligned to their history and traditions. Issues of ethnicity are part of the colonial history of many countries. I am a Fijian first. That is what gives meaning to my life. (Berenado Vunibobo, quoted by T. Parkinson and B. Lagan in the *Sydney Morning Herald*, 27 May 2000: 40)

Background

Sustainable tourism is a popular contemporary research topic, described and defined in various ways in tourism literature. Attempts to translate the theory and rhetoric into practice are more limited, partly because the tourism industry is primarily concerned with attracting more visitors, meeting their expectations and maintaining profits (Honey 1999: 18–21). This limited focus will not lead to sustainable development, a concept that is highly contested, as is that of sustainable tourism (Harrison 1996: 72). While the debate is clearly important, it is necessary to move beyond semantics to the more practical agenda of reducing various negative impacts of tourism development. This requires much broader goals for tourism planning than the ones currently in place: institutionalising the ethic of sustainability into the many businesses and organisations involved in tourism, and integrating tourism development and activity into mainstream government and community spheres of influence. Hopefully, this will ensure that benefits extend beyond the visitor and the investor/business operator and create positive (or at least neutral) impacts for the natural and social resources on which tourism depends. The extension of non-economic benefits to local communities in tourism destination areas is always important. It is especially crucial in island

settings, where limited natural resources have led to increasing economic dependence on tourism, often at considerable cost to the natural and cultural heritages that together form the basis of the tourism 'product' (Butler 1996: 15; deAlbuquerque & McElroy 1992: 619–32; deAlbuquerque & McElroy 1995: 24–6; Harrison 1996: 74). Improvements to community health, well-being and quality of life are possible if tourism planning is informed by local needs, and if community health is considered a priority. This would mean that efforts required to market destination areas are matched in ensuring that tourism enterprises and developments are compatible and conducive to a healthy local community. Equally, those responsible for health promotion must be attuned to the needs of tourism and become active stakeholders in tourism planning processes.

In 1999, the World Health Organization (WHO) in the Western Pacific Region initiated a project to develop a conceptual framework for healthy tourism, initially in island states but with a long-term global agenda. This was an aspect of an existing WHO project focusing on travel health that, in turn, was partly in response to a cultural shift within WHO.[1] While the primary mission of WHO is the treatment and prevention of disease, it is also taking a more holistic view of health and well-being and, consequently, addressing a much wider constituency. Hence tourism is seen as a valid area of interest. Such a shift in emphasis means that the technical language of health and medicine is being replaced with a language more appropriate to business, governments and local communities (Bushell 2000a: 2–3). Arguably, any attempt to develop a healthy tourism concept will founder if it reduces the enormously complex dynamics of health and tourism to a simple set of guidelines akin to the traditional water or sanitation guidelines. Similarly, if the approach targets only visitor health and safety, it will focus only on tourism planning for *visitor* needs. Further, an approach such as that proposed in this paper will be valid only if the process is grounded in the local context of destination communities (Ringer 1998: 1–10) where the tourism/health/community nexus, as a lived experience, is taken into account and where community processes are seen as central to the approach.

This research is in the initial stages, and the concept will not evolve until suitable indicators of the process, impacts and outcomes can be established and evaluated. This is the next phase of the work to be undertaken. WHO requested a framework as a first stage in the process, but within an existing

programme of Healthy Islands that involved articulating the broader issues as well as 'testing' these within the specific context(s) of an island community.

Case study work was undertaken in Fiji, a Pacific island destination in which tourism is well established. However, Fiji has (again) become embroiled in a racially-inscribed political crisis. In May 2000, thirteen years after the first coup d'état, constitutional political institutions were again literally held to ransom by forces seeking a 'solution' to questions of race and power within this multiracial state. The 'resolution' of the immediate crisis, the subsequent appointment of a provisional government, and the elections in 2001 did not seem to alter the underlying political dynamics of Fiji. For many, what seems to be at stake is the very survival of Indigenous Fijian culture and the future of that culture (Lal 1990: 1–10; Thomas 1990: 131–46; Lal 1993: 275–98). This crucial issue, and the socio-political convulsions it sometimes produces, affect tourism in a number of ways, not only in its impact on present and future investment in Fiji resorts (Hall 1997: 229–33), but also on tourism's role as an acknowledged 'player' in a vast array of community issues. These include land ownership and tenure, rural community development, environmental integrity and environmental health, community health, education, cultural and heritage conservation, or community economic sustenance (Tourism Council of the South Pacific 1997: 6).

It is because of tourism's integration into local community life (Picard & Wood 1997: vii–x and 1–24) that WHO has become more proactive in matters touristic. This recognition has generated a project investigating the idea of 'healthy tourism' and aiming to develop procedures for a healthy tourism praxis. The notion of 'healthy tourism', as used here, is not an extension of health resort tourism, a niche market undergoing resurgence, but is a response to the growing and increasingly ubiquitous nature of tourism in island microstates like Fiji.

Our starting point was a set of assumptions that can be considered basic to sustainable tourism. First, the idea that tourism can contribute to healthy lives has been premised on the requirement that there is a balance across the ecological, social and economic needs of the host community, the visitor and the tourism industry. Secondly, it was considered important that members of communities felt that they 'belonged', had a role to play, and could make contributions that were valued by themselves and others. Tourism is often

alleged to exacerbate community tensions if, as it develops, communities in destination areas feel a loss of control and ownership of place (Doxey 1976: 26) and believe their needs are considered of less importance than those of visitors (Bushell 2000b: 6–10; *Daily Telegraph*, 2001: 10–11). Thirdly, it is assumed that tourism has an important role to play, for the community and the individual, in maintaining a sense of place and a pride and belief in heritage (no matter how it is defined). This sense of place has tangible elements that pertain to the contribution made by material culture and landscapes to a place's identity and to the identity of the individual in places. Equally, the identity/place dynamic has to do with such non-tangible elements as history, sentiment, memory and familiarity. A 'sense of place', it is assumed, comes from knowledge of and commitment to 'our' place (Bushell 2001: 46) but it may also be in crisis, driven by dysfunctional or fractured communities, where community formations are not necessarily place-specific (for example, 'communities' defined by sexuality) (see the case-studies in McDowell 1997). The role of tourism in any sense of place formation is, therefore, highly complex and while sustainable tourism is premised on a positive, nurturing role, this cannot be guaranteed (see, for example, the case-studies in Picard & Wood 1997).

From the outset of the research, it was necessary to examine the characteristics and implications of a healthy tourism approach in the natural and sociocultural environments of Oceanic tourism. In this regard, we did not seek a precise definition of what constitutes 'healthy tourism' but rather, sought to identify key issues implied by this *idea* for the local community in specific locations.

The conceptual framework requested by WHO involved first, a need to convey to stakeholders the changes in the agendas of both tourism and health. In other words, there was a need to highlight to health professionals that tourism, as an industry, had become concerned about broader issues of sustainability; and to the tourism industry, that health was much more than just medical science. The outcome of such recognition was that a meaningful relationship between the tourism 'industry' and health professionals was possible. This is what we termed a health–tourism partnership. Secondly, it was necessary to identify a coalition of government, non-government, industry and community players within the tourism and health sectors who could contribute to a conceptual framework for healthy tourism. Because WHO had already chosen Fiji as the site for developing this

conceptual stage, and the Healthy Islands initiative was already well under way, we sought a tourism context that was compatible with Healthy Islands and that formed part of a public discourse. Village-based ecotourism was a most appropriate context; it had an emerging profile in the local media, and as a result of village-based tourism, the links between tourism and health were already in the public domain. The third imperative was to bring together this 'coalition' in a workshop where the notion of healthy tourism could be explored from a variety of perspectives, leading fourthly, to a conceptual framework.

The contexts of a health–tourism partnership

The following section situates the central concern of this paper: how to achieve a more sustainable tourism practice through the health benefits of tourism.

Tourism: a contested entity

In the last decade or so, there has been constant debate over the nature of 'tourism', especially in the sociology and anthropology of tourism, where postmodern critiques derived from wider disciplinary contexts have been applied (Rojek & Urry 1997). A consequence has been an expansion of the range of phenomena considered worthy of investigation, and it has become clear that 'tourism' is no longer (if it ever was) a discrete entity, but a global phenomenon that permeates society and culture (see, for example, Picard & Wood 1997; Mowforth & Munt 1998). Indeed, the fact that so many research papers continue to revisit definitions is perhaps the best illustration of the extent to which 'tourism' is a contested term (see, for example, Ross & Wall 1999:123–32).

Despite the somewhat academic nature of this debate, it is an important setting for the WHO project, which brings together the apparently divergent fields of tourism, health and community development. Two features of this research landscape are particularly pertinent to any consideration of healthy tourism. First, over the last two decades, tourism research has been massively extended into virtually every other academic discipline, as well as into applied social and cultural studies (McIntosh, Goeldner & Ritchie 1995: 19). Secondly, and as a corollary of this, agencies whose core business is not defined, in the first instance, as tourism have nevertheless taken an

interest in tourism as a sociocultural phenomenon, for example in matters of rural community development (Mowforth & Munt 1998: 17). As MacCannell argued more than twenty years ago, such a burgeoning interest in tourism occurred because it had become a defining activity of postmodern culture (MacCannell 1976) and *also* a defining economic activity for many countries across the world. The movement of people is a key characteristic of this particular 'global moment' in history (Rojek & Urry 1997: 1–19).

These various developments within tourism—in research, in increased community awareness of the role of tourism, and in the nature of the 'industry' itself—contextualise the WHO Healthy Tourism research project in the Pacific Region, a project focusing initially on a case-study of tourism in Fiji. In fact, despite its apparently local focus, the WHO project reflects a much wider, multi- and inter-disciplinary research agenda, in which 'tourism' no longer refers simply to the crossing of national boundaries, and 'health' is not considered to be only about preventing and curing disease.

Health as process

The emergence of teleonics—or process-based systems (as opposed to analysing the structures of systems)—has recently been applied to health (Dostal, Jaros & Baker 2000: 193–211). Underpinning teleonics is the notion that 'life' can be conceptualised as a complex web of processes and activities called the 'biomatrix'. When these processes are (spatially and temporally) convergent and relatively stable, they appear to the observer as structures. As the name 'teleonics' suggests, these processes are teleological; that is they are goal-oriented and governed by biophysical processes. In teleonic thinking, processes produce structures, and both the processes and the structures are dynamic and constantly changing. Applying this approach specifically to health, Dostal, Jaros and Baker (2000) argue that health care teleons should not be dealing with disease or defensive medicine. They divide health teleons into three main groups: healthy living conditions teleons (for example, nutrition, recreation, physical exercise, environmental management etc.); healthy environment teleons (for example, water management, sanitation, hygiene, housing etc.); and healthy working conditions teleons (for example, work environment management, working hours, recreation at work).

This conception of health enables specific goals to be identified within the groups, and facilitates description of the particular processes, structures and governances that pertain to the teleons. In decision making, it is argued, stakeholders concerned with particular teleonic convergences should participate in the design of that teleon and with an eye towards the biomatrix—that complex web of nature-made and human-made processes. The teleonic literature articulates ways forward for health research and management in a context where dynamic processes are regarded as central in any conception of health. The emergence of health teleonics provides a conceptual basis for understanding the possible relationships between an activity like tourism (when it has attached to it health outcomes) and health (when it has attached to it community-based tourism). Health teleonics 'speaks' the same language as our assumptions about tourism contributing to healthy lives, as discussed above.

Healthy Islands as a concept

Over the last four decades environmental issues have gained increasing recognition. At the 1972 Stockholm Conference on Human Environments, the world's governments acknowledged threats to the natural environment and the concept of ecologically sustainable development emerged. Rapid globalisation throughout the 1980s led national governments to look increasingly to international agreements on environment and health.

In 1983, the UN General Assembly established the World Commission on Environment and Development (WCED) to produce long-term strategies for global problems. WHO then adopted the Ottawa Charter and this provided a strategic framework for the promotion and protection of health as well as acknowledging the interconnectedness of human health and environment (Powis 1999: 2). The WCED report, *Our Common Future* (1987), incorporated the guiding principles of inter- and intra-generational equity and asserted the need for global ecosystem integrity, further linking 'environment' and 'health' and in doing so, considering both in much broader terms. WHO, whose executive director, Gro Brundtland, also chaired the WCED, linked ideas from the Ottawa Charter and *Our Common Future* by promoting the concept of Healthy Settings—including workplaces, homes, schools and cities. These strategies aimed to prevent illness and differed from the previous approaches, which had focused more narrowly on *treating* illness (Powis 1999: 3).

The integration of health and environment was also a theme of the 1992 UN 'Rio Earth Summit'. In particular, *Agenda 21* of the Conference reflected the need for the consideration in planning processes of inter-sectoral health and environmental issues (UN 1993). The Earth Summit and subsequent meetings have paid particular attention to the health and environmental problems of small island states (UN 1994; Powis 1999). Tourism, among other forms of human activity, has been singled out because of its economic importance to many island states, and its reliance upon and potential negative impact on natural resources.

These various strategic approaches have prompted many local initiatives. For example, in the Western Pacific the need for more effective management of the region's complex health problems was recognised, and in 1995 a WHO meeting of Health Ministers at Yanuca, Fiji, formulated the Healthy Islands concept. It reflected a desire to seek Pacific solutions to Pacific problems and create healthy islands where 'children are nurtured in body and mind; environments invite learning and leisure; people work and age with dignity; and ecological balance is a source of pride' (WHO 1995: 5). The Healthy Islands approach involves continuously identifying priority issues related to health, development and well-being. It advocates these issues be addressed collaboratively among communities, organisations, and local, national and regional agencies (Powis 1999: 6). The need for more sustainable tourism practices was considered a priority issue and this led to the Healthy Tourism initiative.

The discursive landscape

The WHO project on healthy tourism is necessarily embedded in documents already in circulation in Fiji (and elsewhere), some of which were discussed in the previous section. We say 'necessarily' because a project like this is both framed and contextualised by existing policy initiatives and 'on-the-ground' practices. However, bringing together tourism and health considerably broadened the pool of relevant policy documents. In order to define a 'discursive context' for research, and provide an epistemological and methodological framework for its activities, the research team needed a definable commonality between the two vast policy areas. Could a distinctive 'discursive landscape' (one shared by both health and tourism) be identified?

Existing WHO policy documents also introduced two major restraints on the researchers. First, they foreshadowed possible conclusions by moulding the research process in a certain direction, a direction already ordained as highly desirable by sections of WHO itself. Secondly, they incorporated perceptions of the role of health guidelines and measurable outcomes (that were considered scientifically verifiable) by one part of the organisation, and a focus on community health and health promotion by other WHO representatives. While they were not necessarily contradictory, both positions had to be accommodated in any conception of healthy tourism.

The formulation of a discursive landscape thus needed to take into account the contested nature of health and tourism, the vastness of both industries, and the constraints arising from the way the project had initially been defined. It was necessary to develop a conceptual framework that would identify and enable all stakeholders in tourism and health to 'speak' to one another and that could be applied in diverse geographical locations. What, then, would such a discourse look like and how would the main elements of this discourse be defined?

In viewing tourism as a tool for community development rather than an end in itself, the research team used *Agenda 21 for the Travel and Tourism Industry* (WTO 1995) as a way of articulating the notion of possible inter-relationships between health, environment, conservation, sustainable tourism, community participation and the identity/culture of indigenous peoples (Mowforth & Munt 1998: 113). The joint declaration of the Earth Council, the World Tourism Organisation and the World Travel and Tourism Council envisaged an industry that would:

· help people live healthy and productive lives in harmony with nature;
· contribute to the conservation, protection and rehabilitation of ecosystems;
· have protection of the environment as an integral component of tourism development;
· be planned at the local level and allow for the participation of the citizens;
· recognise and support the identity, culture and interests of indigenous peoples; and
· respect international agreements to protect the environment (WTO 1995: 34).

This set of relationships contrasts starkly with an economic development model of tourism, where international investment opportunities, profit maximisation and increased GNP are key elements. It also sets itself up against models of tourism defined by interconnections within the service industries, particularly those clustered around transport, accommodation, food and beverages. This is not to claim that economic viability or service sector inter-relationships are irrelevant when considering ESD (Ecologically Sustainable Development), but such a discourse is characterised by its contrast with unsustainable capitalist development. To this extent, the WHO project is ideologically charged. More importantly, though, *Agenda 21 for the Travel and Tourism Industry* had the hallmarks of some recent WHO policy settings (discussed below). Commonality could be identified.

For a conceptual framework to make sense to all those involved (especially when coming from very different professional contexts) and to have both validity and authority, it must perpetuate earlier discursive forms—like that of *Agenda 21 for the Travel and Tourism Industry* or the WHO's Healthy Islands strategy—and it must, albeit temporarily, regard the structural elements of policy as an uncontested and stable given. For there to be a common language and a 'community' of interests among stakeholders, conceptual stability is a fundamental requirement. However, we recognised that such a 'shared agreement' was highly provisional because, as participants in the research project acknowledged, terms such as 'health', 'environment', 'conservation', 'sustainable development', 'community' and the 'identity/culture' doublet are highly contested entities that are always provisional and culturally inscribed. This paradox indicates why the discursive framework is more than a rhetorically inclined articulation of ideas. A discourse can work to bring together, and sustain, a certain coalition of interests and stakeholders, and can define both a shared language and a set of ideological assumptions. It provides an arena for negotiation but, crucially, a negotiation between those who *already* share a broadly similar praxis.

Understanding and working with this 'coalition' became an early and vital part of developing a conceptual framework for WHO. Indeed, the project's 'success' would be defined in outcomes that would satisfy the client, WHO, and tourism policies that would bring clear and observable benefits. But who would constitute this 'discursive community'?

In the light of this question, the terms of the project are of interest because they intentionally locate the project within the sociopolitical

environment of the instrumentalities involved (and by 'instrumentality' we refer to the organisations and their policies and practices) and because the terms of the project reach out to quite a precise 'audience'. This project for WHO was defined by a methodology aimed at:

- · identifying key issues that the healthy tourism concept must address;
- · identifying existing practice in the various tourism planning, development and operations processes;
- · identifying existing policy that may either enhance or hinder the ultimate acceptance and usefulness of a healthy tourism approach; and
- · determining the focus areas for various aspects of the guidelines— for non-tourism government departments, tourism departments, non-government organisations and community groups, tourism industry bodies, tourism developers, tourism operators and tourism educators.

In turn, we argue that the conceptual framework should: address the health-related issues of current practice; meet the multi-sectoral needs of the local community, government, industry and private business; consider the shortcomings in current legislation, procedures and skills to ensure positive change; and meet the needs of different nations within the Pacific Region.

Defined in this way, the project was responding not only to *Agenda 21 for the Travel and Tourism Industry,* but also to WHO's Healthy Island concept. Indeed, in the intersection between these two policy frameworks, a clearer notion of 'healthy tourism' begins to emerge. The emphasis is on: community participation in decision-making and action; collaboration and partnerships across different sociopolitical sectors; holistic thinking and education; environmental integrity; sustainable development; spiritual, cultural and physical well-being as an integrated and integrating objective; and a health praxis spatially focused on place and at the same time culturally and socially sensitive as well as proactive (Powis 1998: 2; Powis 1999: 6). There is a distinct discursive landscape evolving here: certain key ideas are circulated in a number of contexts, but each (re)statement reinforces the earlier formulation. The structural elements—the taxonomy of entities—are (provisionally) unchallenged while the process-oriented descriptors are given full play. 'Holism', 'well-being', 'integrity', 'praxis' and 'spatiality'

(potentially) refer to non-teleological formulations, and are obviously quite crucial here, but they also counter such *provisionally* fixed terms as 'environment', 'community', 'culture' and 'health'. This tension in the discourse can act like a beacon: it can identify and attract the like-minded who have a framework for 'speaking' to one another and for action that is rooted in a shared (if negotiated) language.

For WHO's 'healthy tourism' project to make progress, the identification of sympathetic stakeholders able to operate within this particular discursive/ policy landscape was central. The Healthy Islands initiative helped define the particular Fijian health network, but what about the tourism side of the equation, and other interested parties with a stake in a community-based tourism agenda? The aspect of Fijian tourism most closely linked to the aspirations associated with the Healthy Islands program was village-based ecotourism. At the time of the workshops (see below) this type of tourism was receiving considerable attention in the local media. As a consequence, analysis of the rhetoric of village-based ecotourism was considered a logical way to begin identifying first, those within tourism who might have been sensitive to a particular WHO-inspired discourse and secondly, other parties who saw positive outcomes arising from village-based ecotourism.

An examination of village-based ecotourism and its associated rhetoric revealed a coalition of interests that not only use and work within a discourse very similar to WHO's, but also are interconnected with the WHO Healthy Islands programme. At both village and policy levels, the two overlap. However, before examining the overlap, it was important to establish where village-based ecotourism was positioned in Fijian public discourse. We used three inter-related and decidedly non-academic data sources to define the characteristics of this emerging public discourse: a widely available guidebook, an airline in-flight magazine and a recent newspaper article on the topic.

The 1997 Lonely Planet guide book to Fiji reports that one of the 'highlights' of a visit to the island of Ovalau is a hike to the village of Lovoni, located near the centre of the island and 'uphill though rainforest and into the crater of an extinct volcano'. The guidebook writers capture the experience in an evocative description: 'There you can visit the village, have a Fijian lunch and swim in the river pools. Guides will tell you about local customs, the history of the Lovoni people and about the cultural, medicinal and traditional uses of plants' (Jones & Pinheiro 1997: 235). Tours to rural

villages like Lovoni, described in ecotourism terminology, have become a central plank in recent Fijian tourism policy development and, as such, provide a type of local counter to resort tourism (although, in reality, ecotourism and resort tourism are linked in a number of ways). Visiting rural villages has, of course, always been part of the Fijian tourism story: it has a history that reaches back to the 19th century (Stephen 1993; Thomas 1994; Stephenson 1997), and it continues to be a powerful marketing image for, and lure to, foreign tourists (*Fiji Magic* 2000). But the development of rural village tourism under the aegis of ecotourism and with strong government-driven endorsement (Harrison 1999: 4) represents a further step in the alliances between traditional landowners, villages, cultural and community development agendas and environmental concerns. Consequently, the repackaging of rural village tourism in this way can be regarded as furthering the (political) interests of this alliance. At least, this is what was revealed within popular/public discourse.

One way to measure the intensity of this development was to examine media attention to ecotourism and the discursive strategies employed. Both the first issue for 2000 of *Islands*, the in-flight magazine of Air Pacific, and the magazine section of the *Fiji Sun* (Wilson 2000: 19–26) carried substantial articles on the subject. Keith-Reid's article in *Islands* presents a report about Hector Ceballos-Lascuráin's first 'mission' to the Pacific Islands. Ceballos-Lascuráin, often referred to as the 'father of ecotourism', is quoted thus: 'I am tremendously impressed by the South Pacific's ecotourism potential. You have very good forests, endangered birds, and lots of cultural alternatives. It is very important for the South Pacific to encourage this new type of tourism'. The article further quotes Ceballos-Lascuráin on what ecotourism is not: 'It's not casino tourism, it's not riding around at 70 kph on a jet ski in a mangrove swamp. It's not downhill skiing with lots of facilities'. The man who believes he first coined the term is then quoted as proffering a definition of ecotourism as:

> [e]nvironmentally responsible travel and visitation to relatively undisturbed natural areas in order to enjoy, study and appreciate nature and any accompanying cultural features that promote conservation, has a low negative visitation impact and provides for substantial beneficial active socio-economic involvement of local populations. (Keith-Reid 2000)

The taxonomy of terms echoes, understandably, the rhetoric of *Agenda 21* and in the replication, grounds the conceptual into a foundational discourse. The article goes on to list what it calls the 'commandments from Hector's ecotourism bible'.

· Governments should allocate funds for environmental education at national, state and municipal levels.
· Private industry, like hotels and tour operators, needs to work with local communities. Get them round a table for joint decisions.
· For any ecotourism area you need a physical master plan and a zoning scheme to specify areas for agriculture, mining, fishing and different categories of tourism. Some zones may be off limits to tourists.
· Very intensive training is needed for government officials, tour operators, local people and hotel owners. If you don't have local people involved it just won't happen.
· Ecotourism must involve government, the private sector, local communities, non-government organisations, journalists, development agencies and ecotourists. Ecotourists want to know what kind of experiences to expect so an inventory of eco-attractions is needed.
· Nature trails are important, and information posts; sometimes just a post with a number and details explained in a pamphlet.
· Local guides are vital, some with a western scientific perspective and others expert on local culture. It is a good idea to have both.
· Handicrafts are very important; a tourist goes direct to the site where they are made; no 80–90 per cent mark-up middle people. And sell local food and drink.
· Training. 'We need a lot of training of people in this new and complicated business.'
(based on Keith-Reid, 2000: 29–30.)

The article ends with advice from Ceballos-Lascuráin to potential ecotourism supporters and developers within the Pacific Islands: 'Ecotourism is just a new niche . . . It's also a tool for conservation, an instrument for sustainable development and it is good business. Ecotourism is not a panacea. People live in rural areas and continue to do their usual activities. It is just additional income for them plus additional pride' (quoted by Keith-Reid 2000: 30).

When this discourse is compared with that of the WHO Healthy Islands project, a shared discursive landscape linking some health and tourism interests can be discerned. A coalition of interests in what WHO terms 'healthy tourism'—which involves a shared discourse and a shared political programme—is also revealed. This is highlighted in an extended interview with Manoa Malani, senior ecotourism officer with the Ministry of Tourism and Transport in Suva, which provided a government perspective on 'what ecotourism is all about' (Wilson 2000: 20). The account begins with a definition of ecotourism from a Ministry document, the 'Policy and Strategy for Eco- and Village based Tourism':

> Eco-tourism is nature based, involving responsible travel to relatively undeveloped areas, fostering an appreciation of nature and local culture while conserving the physical and social environment, respecting the aspirations and traditions of those who are visited, and improving the welfare of local communities.

Malani, then quoted at length, provides an historical background to ecotourism and the reasons for the government's commitment. His opening words frame the rest of his response:

> Eco-tourism is (more) environmentally and culturally concerned than other tourism projects, that is what it is all about and that is what it is. It is a great income alternative for local people because it only involves the environment and doesn't require as much capital investment as other tourism projects. (Wilson 2000: 20)

According to this view, ecotourism is village-based, small-scale, locally owned and operated, and (unlike large-scale resort tourism) not prone to 'leakages' from the Fijian economy. It is a perception situated within a discursive environment that, for several reasons, should dramatically shape the WHO Healthy Tourism project. The discourse helps identify possible areas of commonality between health and tourism, and identifies how local issues are articulated. At the same time, it identifies those who are sympathetic and receptive to frameworks bringing together health, the environment, tourism, community development, process-oriented praxis, local ownership and local decision-making, and also helps identify the 'community of interests' to be consulted in developing the framework WHO is seeking.

One consequence of this discursive framework and its attendant epistemology is the global/local problematic that arises from the way the WHO project is conceptualised. For example, WHO, a global institution, works in intimately local circumstances where global strategies are translated into the local and vice versa. Similarly, the doctrine of ecotourism resonates at the global level in its relationship to *Agenda 21* and is translated into the local within Fiji. This conceptualisation of the global/local dynamic (a constant process of local translations) is instructive; it informed both the conceptual stage and the implementation stage of the WHO project. Another factor to consider is the presence of Australian-trained academics in a postcolonial sociopolitical context that is itself heavily mediated by British imperial history and its aftermath.

These examples raise fundamental issues about the inherent instability in the term 'tourism' (having significant local meanings and contexts), the shifting conceptions around 'culture' and 'nature' (both significantly mediated by the local), the reworking of the global/local doublet under the sign of the postcolonial and the sign of postmodernism, and the role of the researcher not as (dispassionate) observer but as active participant. The particulars of the local context are, therefore, absolutely crucial (as was reinforced during the May 2000 putsch in Fiji). They must be central in any attempt to arrive at mechanisms making 'the local' a central player in the WHO's Healthy Tourism strategy, no matter how this relationship is eventually defined and acted upon.

Fiji workshops

Community coalitions speak

WHO's aim of developing a conceptual framework for a Healthy Tourism approach (within the Healthy Islands concept) and using Fiji as a case-study meant that the discursive landscape incorporating Fijian tourism and Fijian health became a key feature of the initial consultation process. As part of the brief to produce this framework for WHO it was thought necessary to articulate the health–tourism relationship from a variety of local perspectives, both inside and outside the health and tourism sectors. The authors conducted workshops in Suva on 21 and 23 March 2000 (two months before the May 2000 coup attempt and the constitutional crisis it engendered). The first workshop brought together representatives of groups from

Table 1 Summary of issues identified at the non-tourism workshop

Environmental Management	Community Well-being	Appropriate Legislation and Procedures	Heritage Management
environmental integrity	•community health–extending,improving and empowering •mobilisation of communities and community participation (including consultation in planning) •social integrity, especially the socio-cultural impacts of tourism on village and family life	•land ownership monitoring and enforcing existing relevant legislation and ensuring that legislation has teeth •integration of policy and practice across sectors (government, NGO and the tourism industry)	•cultural integrity •education and training about culture, heritage and tourism and for the tourism industry •heritage (natural and man-made) conservation

Issues that relate equally to environmental management, community well-being, appropriate legislation and heritage management

- issues arising from rapid change, like the impacts of modernity, cultural authenticity, gender, ethnicity, nutrition, sexually transmitted diseases and the physical environment
- ecotourism as a vehicle for cultural heritage development and for the conservation of culture, of heritage and of the natural environment
- tourist behaviour and attitudes

government departments, non-government organisations and community groups working in natural resource management, environmental health, planning and development, community health, culture and education. While all of these have significant briefs that relate to tourism, it is not part of their core business. By contrast, the second workshop focused on tourism: operators, government departments, professional associations and tourism education. Each workshop required the participants to identify, *inter alia*, the key issues facing tourism in Fiji; the intersections between tourism and those organisations represented; and the connections between tourism and the concept of Healthy Islands. The process consisted of group-based, task-

oriented discussions, with a report-back mechanism, leading to discussion, both within small groups and within several plenary sessions, of key priorities. All the groups (micro and macro) recorded their discussions. These were then collated and written up as a draft report of the workshops and sent back to participants, who could then add to the written record or comment on it, or both. (The final part of the process was severely interrupted by the attempted coup).

When asked about the key issues facing Fiji's tourism, participants in the 'non-tourism' workshop highlighted a number of overlapping concerns that can be broadly related to environmental management, community well-being, appropriate legislation and procedures, and heritage management, as indicated in table 1.

Issues identified at the tourism and non-tourism workshops

Participants at the tourism workshop, consisting of tourism associations, government departments, operators and educators, produced a similar set of responses to those from the non-tourism workshop. Indeed, in their identification of key issues, the two groups were distinguishable only by the language they used, a semantic distinction that reflected the different professional orientations of those who attended. However, the groups differed in their approach to the various types of tourism. Whereas the 'non-tourism' group viewed ecotourism as quite distinct from resort tourism, and considered it a means of integrating tourism into other sociocultural agendas that would strengthen indigenous Fijian culture and society, participants at the tourism workshop saw the issues as applicable to all types of tourism. The representatives of the tourism 'industry' regarded all nature-based tourism as ecotourism, and as integral to Fiji's tourism industry, be it a village visit, diving, trekking, cruising or sunbathing on the beach at a resort.

The responses from the workshops are relevant to wider strategic considerations because tourism issues were constantly subsumed under other concerns. Reference was often made, for example, to environmental impact assessment, social impact assessment, cultural impact assessment and gender impact assessment. This indicates that tourism was seen as an inseparable element of wider and pressing community concerns. Simultaneously, a range of quite different strategies was also strongly articulated, including community consultation and empowerment, culture

and conservation, cultural authenticity, holistic praxis and the dynamics of change. A discourse alliance, as described above, is undoubtedly operating here. Several of those attending the workshops—especially the 'non-tourism' workshop—were engaged in a collaborative project with WHO personnel in Fiji (the Healthy Islands programme) and so the conceptual language already had currency. Consequently, the strategies articulated by those at the workshop were ones heavily promoted by WHO and then transferred, by the participants, to a tourism context. The importance of a shared discourse between health and tourism was therefore illustrated, and the need to graft the Healthy Tourism initiative on to existing WHO programmes made apparent.

Another significant outcome of the workshops was the suggestion that measurable indicators (environmental impact assessment, social impact assessment, cultural impact assessment and gender impact assessment) should be integrated into community processes. While indicators of this kind are highly problematical in both their definition and their measurement, the crucial point being articulated was the recognition that such indicators need to be negotiated by the concerned communities and at the community level.

The consequences for any conceptual formulation of Healthy Tourism are as follows: the importance of a shared language for those bringing health, tourism and community development together as a praxis; the centrality of the local in both the geographic sense and the sociocultural–historical context of WHO's initiative, and the need to integrate a healthy tourism praxis with measurable outcomes and 'scientific' validation by making all of these subject to a community consultation process.

Towards a conceptual framework

The workshops made it clear that for the participants, any guidelines that link health and tourism must be process-oriented, as well as outcome-driven, and must be grounded in local community. It is noteworthy that it was the *processes*—of tourism, of community, of environment, of culture, of identity, of health—that were so prominent in the discussions and, equally, that the relationships (both institutional and personal) that linked these processes could be understood only in the light of their local context. Just as instructive was the call by the participants for integration. All the processes, the workshop members observed, need to be integrated and the

definition of stakeholders should always be open-ended. By the end of the workshops, many participants recognised that stakeholders in both tourism and health (in the widest possible senses) were drawn from a wide range of community members, including personnel from museums or women's centres, heritage groups or hotel owners, resort managers or conservation groups, or community health groups and natural resource managers. This followed an initial perception by those in the 'non-tourism' workshop (and expressed in the first set of round-table discussions) that tourism was not central to their 'core business'. By the end of the day, the records of the discussions reveal that tourism had become 'everybody's business' (see table 1).

The discursive landscape of *Agenda 21*, of the WHO's Healthy Islands concept and of rural village ecotourism in Fiji all point to a possible framework for Healthy Tourism guidelines because all three 'speak' a similar conceptual language. This conceptual language has quite distinct characteristics and strongly suggests that guidelines need to be 'holistic'; community-centred; locally 'owned'; empowering; consultative; culturally, environmentally, historically and gender sensitive; and 'scientifically' endorsable.

Political events in Fiji over the last three years demonstrate that concepts of 'Fiji' and being 'Fijian' continue to be strongly, even brutally, contested. In such circumstances, it is a moot point how far guidelines developed in that context can be generalised by WHO, a global organisation, across a wide range of other island micro-nations, which may *also* be subjected to their own stresses and strains. Clearly, national 'stability' cannot be assumed. However, the emphasis in the literature (particularly Dostal, Jaros & Baker 2000) and the workshops, and the shifting inter-relational strategies that are perpetually negotiated in the community, suggest that process, as a tool, must *always* be embedded in any guidelines. In other words, any guidelines or new approaches promulgated by an *international* agency like WHO need to be subject to a process-oriented *local* strategy of ownership, planning, implementation and assessment. Hitherto, WHO guidelines have tended to be rigorously scientific and 'one size fits all' (or 'what is sauce for the goose is sauce for the gander'), allowing no difference in standards of acceptability (for example with regard to water quality, sanitation, air quality, food safety and so forth). Above all, they have been not negotiable. Surely, though, the

idea of community-based processes of planning, implementation and assessment would seem not only germane to Healthy Tourism approaches at the local level, but also to the principles and policies for more generic and globally applied sustainable tourism development.

A further implication is that healthy tourism outcomes and the use of indicators in their measurement have a symbiotic relationship with the community consultation processes. Indicators of Healthy Tourism in Fiji, for instance, should carry and reflect distinctly local characteristics, rather than represent measures arrived at through the use of externally devised and allegedly universally-agreed criteria. Herein lies a considerable challenge for an agency like WHO, steeped as it is in a significant history of scientific verification. 'Healthy Tourism' puts together two (contested) entities, and when wellness, well-being and quality of life are added as desired outcomes for destination societies, imprecision is even more pronounced. The challenge for WHO is accordingly just as pronounced. Our work thus far points to some of the problems of defining a framework for 'health' and 'tourism' but, equally, points to some of the avenues available to make it possible to proceed, even when the path is slippery! This path requires commitment to a negotiated framework subject to wide community consultation—beyond that normally regarded as the professional or industrial spheres of 'health' and 'tourism'. It requires those involved in this process of community action to 'speak' the same conceptual language, and expects the integration of healthy tourism into existing community-based programmes. It means that all the relevant stakeholders involved in a healthy tourism initiative must agree on what are the indicators of measurable achievement, and that integration must be both horizontal (across diverse community groups) and vertical (across levels of government). Above all, the path requires that the very concepts of 'health' and 'tourism' be negotiated within the socio-cultural and political spaces of the local.

In 1991 at the Third Global Congress of Heritage Interpretation International, Konai Helu-Thaman gave one Pacific Islander's perspective on tourism development. She stated that tourism to Pacific Island microstates should be understood as a 'neocolonial relationship between island nations and metropolitan countries', where islands like Fiji become the providers of leisure, recreation, entertainment and 'exotic alternatives to their own alienation' (Helu-Thaman 1993: 108–9). The question for Helu-Thaman was

how such nations should respond to the modernist development explicit in tourism. In an interview she said:

> Models of development, whether in tourism or education or health, are inappropriate in our contexts because they make incorrect assumptions about indigenous peoples and their cultures . . . most if not all models of development I have seen . . . treat culture as a variable in the development process; yet traditionally, culture is perceived not as a variable but as a framework and basis for our development. (Helu-Thaman 1993: 109; compare with Hitchcock, King & Parnwell 1993: 1–31 and Wood 1993: 48–70)

Here is a generalised appeal with specific applicability. It aptly represents, for instance, Fijian feelings about what they signify by the word *vanua*, an integrating framework that synthesises land, culture, history and spirituality. Whole landscapes are valued and nurtured in such a way that communal sharing and mutual assistance are given prominence over national governance, by emphasising the future and the past in the present as the basis for community stability and well-being (Batibasaqa, Overton & Horsley 1999: 100–06).

A framework for Healthy Tourism, it seems to us, must necessarily be enmeshed in a Fijian way of thinking and being (however it is locally defined and/or negotiated). And when applied elsewhere, geographically, such an approach must be similarly enmeshed in, and responsive to, the spaces where local cultures interact with health and tourism. This is the challenge for developing a conceptual framework of Healthy Tourism guidelines for WHO, or, indeed, sustainable tourism indicators for the World Tourism Organisation, or for any international body. It is especially the case when the interests and welfare of destination communities are given equal weighting with the health and well-being of travellers.

Note

1 The existing WHO literature on tourism defines tourism and travel almost exclusively in terms of the physical health of the traveller. More recent WHO research has regarded tourism as predominantly an issue of the movement of people and the exposure of the traveller to health risks.

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Health tourism actually helps counter average seasonality in tourism as a whole. The share of health tourists arriving from outside the EU amounts to an estimated 6%. Scientific and public sources point to a stable development of EU health tourism, whereas market reports indicate medium to strong growth in medical, wellness, and spa tourism. In a scenario where health policies prioritise improving health, there is a role for the tourism and hospitality sector to cooperate with the health sector by exchanging experiences and requirements for accommodation, transport, services, employee competences, etc. that help to facilitate accommodation and mobility for less-abled visitors or visitors requiring special treatments. Healthy Tourism in a Fijian context A WHO initiative for island tourism. Russell Staiff. Robyn Bushell. This paper describes research undertaken to assist in the institutionalisation of the ethic of sustainability into tourism planning and operation. A case study of Fiji before the 2000 constitutional crisis is presented. The paper investigates attempts by the WHO to bring together tourism and the health of destination communities. It describes the theoretical contexts of tourism and health, along with the issues arising from a series of workshops conducted in Suva in March 2000. Together, these highlight implications for planning a healthy tourism concept that focuses on the health and well-being of locals as well as the safety of tourists. Read more. Discover more. Health tourism includes medical tourism aesthetical/plastic tourism thermal tourism and thalassotherapy tourism. â€ Medical Tourism. Health and wellness brand destination becomes more important to promote the image of high-quality healthcare in a location (city region country). Seeking to attract international patients from around the world partners and stakeholders should work together to develop network synergies health and wellness clusters.