

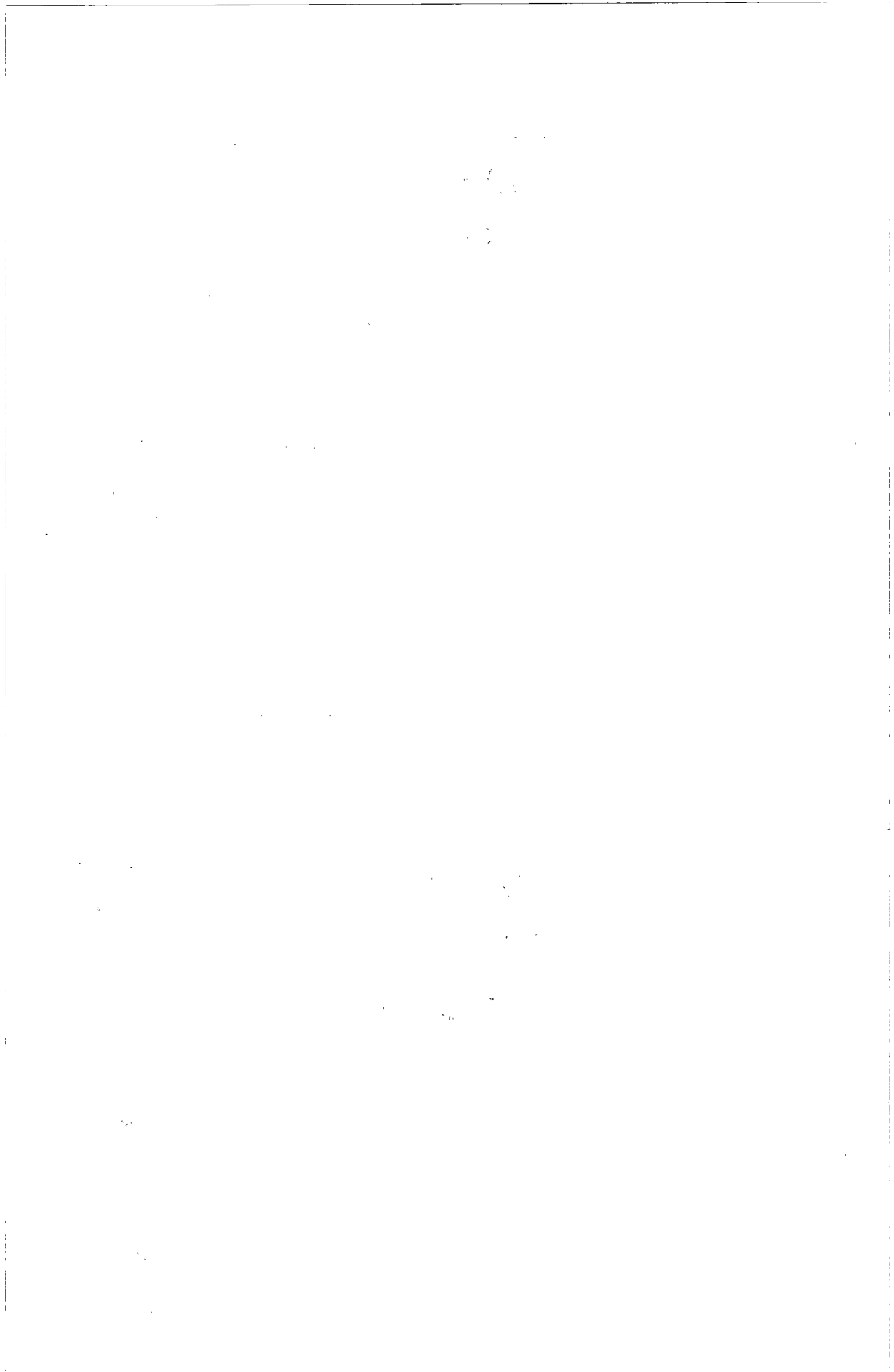


# **BUILDING A HEALTHY CITY: A PRACTITIONERS GUIDE**

A STEP-BY-STEP APPROACH  
TO IMPLEMENTING HEALTHY CITY PROJECTS  
IN LOW-INCOME COUNTRIES



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## **BUILDING A HEALTHY CITY: A PRACTITIONERS' GUIDE**

A Step-by-Step Approach to Implementing Healthy City Projects  
in Low-income Countries

A manual prepared by the Unit of Urban Environmental Health  
Division of Operational Support in Environmental Health



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## **DEFINITION**

A Healthy City is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

## **HOW TO USE THIS MANUAL**

The manual is designed for those considering or actually implementing a Healthy City Project (HCP) in their city. They may be project coordinators or people prepared to assist with projects, who may work in a non-governmental organization (NGO), a municipal agency, or a university or a health department. Readers familiar with the HCP concept may wish to turn straight to Chapter 3, where every activity required for implementation is outlined step by step. Others may wish to read first the preceding chapters on the problems of urbanization and how the HCP project addresses these. A more extensive description of the project concepts, scope and elements has been included in Chapter 4, in an effort to anticipate many questions that may arise in implementation.

A key aspect of Healthy Cities is networking, and potential project coordinators and supporters are encouraged to contact and seek support from the global, regional or, in some cases, national networks of Healthy Cities. While this manual can guide and explain, it is no substitute for the exchange of experiences and support that contact with other Project cities can offer.

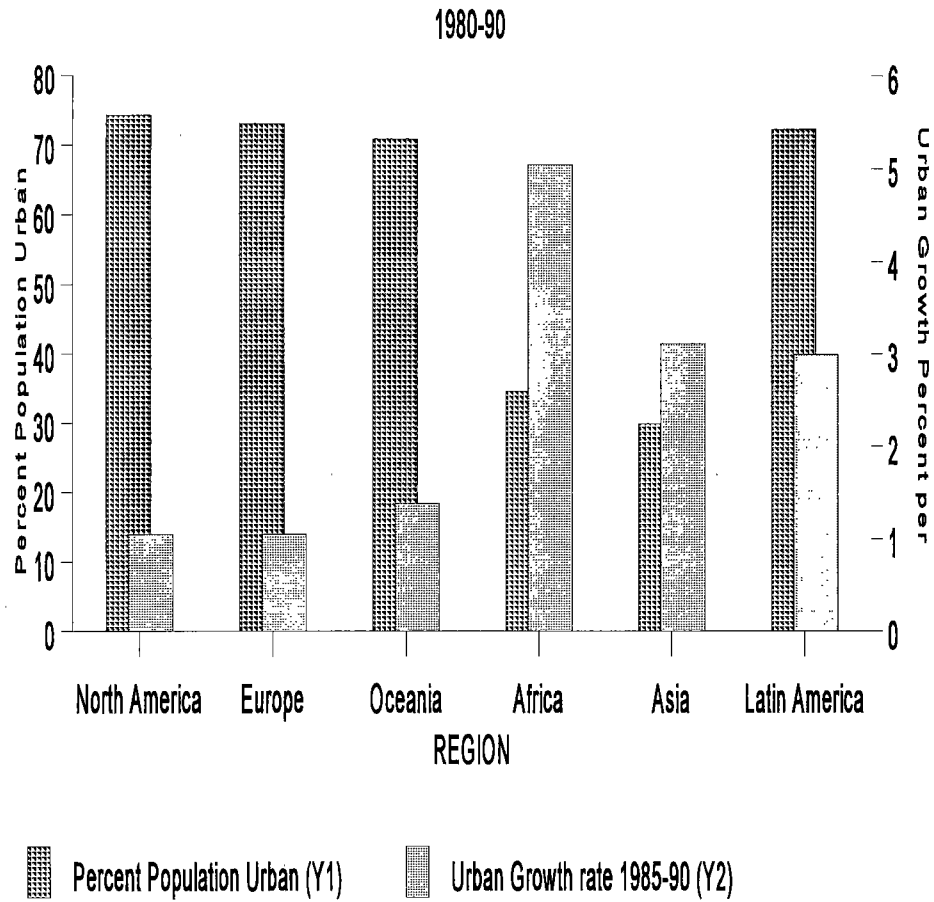
## CHAPTER 1. URBANIZATION AND HEALTH

The world is being urbanised rapidly. Within 15 years, 20-30 cities will have over 20 million people. More importantly, human-made environments will account for the living space of most of the world's population. By 1990, at least 600 million people in the urban areas of developing countries were living under life- and health-threatening conditions. City governments are emerging as stronger forces, as national government resources become more limited and the global trend towards political and administrative decentralization develops pace. Many of the most pressing urban management problems are associated with rapid urban growth, particularly environmental health issues such as water supply, housing, pollution and solid-waste management.

Figure 1 shows that the level of urbanization (the proportion of the population that is urban) is high in 4 regions (North America, Europe, Oceania and Latin America) 3 of which have low rates of urban growth. The two regions with a low level of urbanization (Africa and Asia) have high urban growth rates that lead to severe urban health and environment problems.

Health problems in cities are aggravated by growth and development that is largely unplanned, uncontrolled, and underfinanced. Rapid urban growth is overwhelming the capacity of municipal authorities to provide basic environmental services, housing, employment and other minimum prerequisites for a healthy population. This generates severe — in some cases, explosive — social, financial, political, and health problems.

## URBANIZATION AND URBAN GROWTH



*Legend Figure 1: Regions with the lowest level of urbanization, that is the proportion of the population that is urban, (Africa and Asia) are experiencing very high annual growth rates in the urban population.*

*Source: United Nations, World Population Prospects 1988. Population Studies No. 106. ST/ESA/SER.A/106. (New York, 1989)*



People in cities — particularly the poor and newly arrived — experience stresses and exposures that result in health problems, ranging from communicable diseases and malnutrition to mental illnesses and chronic respiratory diseases. These unhealthy conditions include poverty, inadequate food and shelter, insecure tenure, physical crowding, poor wastes disposal, unsafe working conditions, inadequate local government services, overuse of harmful substances and environmental pollution.

Under these conditions, collective welfare provisions are little more than a pipe-dream, and poor people in cities often shoulder total responsibility for their basic needs in health, welfare and employment creation.

Neglect of environmental considerations in urban planning and management, also has negative health and social impacts, restricting future options because of unsustainable use or damage to natural resources. This impairs urban productivity.

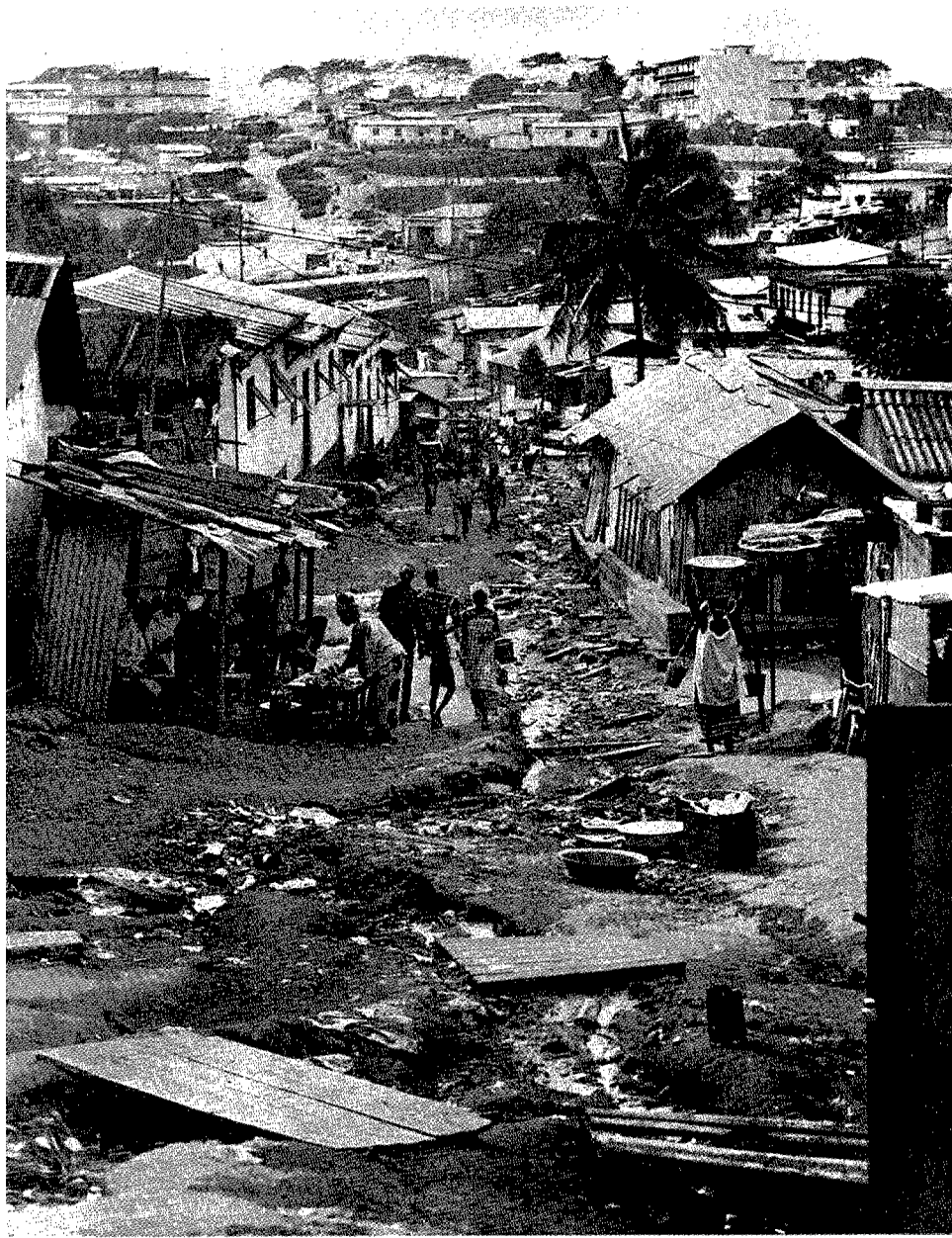
Various issues relating to social behaviour also affect health. These include:

- Integration (or in many cases the exclusion and marginalisation) of migrants to the city;
- Diversity of cities in terms of class, religion and ethnicity;
- Changing concepts of neighbourhood, whereby social networks associated with say, occupations or sports, extend beyond the immediate neighbourhood to various parts of the city; and
- Issues of particular concern to women, including more women working away from home, increased numbers of female-headed households, more transient relationships especially for migrant workers, early sexual activity of adolescents, high levels of prostitution and reduction in traditional methods of birth control.

Information about how urban development affects health is a vital tool in Healthy Cities work. In most countries, responsibility for health statistics and epidemiological work belongs wholly or partially to the Ministry of Health, with important contributions often coming from universities. Such work includes

- monitoring health status in relation to environmental conditions and indicators,
- making an analysis of the impact of urban development activities of all relevant sectors on health status, and
- developing health policies and participating in health-related measures and health promotion in urban management and development planning.

Unfortunately, sufficient capability to fulfil these functions is all too often absent, but this is a gap that Healthy Cities can help to fill.



*Crowded, makeshift housing and inadequate water and sanitation are associated with serious elevations in the mortality and morbidity of communicable diseases, especially gastro-intestinal and respiratory diseases. Infant mortality for example may be 3-5 times higher than in other parts of the city. Street scene, Abidjan.*

## CHAPTER 2. BASIC CONCEPTS OF HEALTHY CITIES

Healthy Cities is a public health approach that builds upon the work of Professor T McKeown.<sup>1</sup> He found that — contrary to popular belief — the major factor in the improvement in health in the UK and other developed countries in the nineteenth and twentieth centuries was not advances in medical care and technology, but certain social, environmental and economic changes:

- Limitation of family size;
- Increase in food supplies;
- A healthier physical environment; and
- Specific preventive and therapeutic measures.

WHO, from its beginning in 1946, has recognized the interaction of physical, mental and social factors in determining health. In 1978, WHO launched a major public health movement called “Health for All” at Alma Ata, based on six principles that reflect McKeown’s concerns (Panel 1).

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### PANEL 1

#### **Principles of Health for All**

- Reduced inequalities in health.
- Emphasis on prevention of diseases.
- Intersectoral cooperation including reducing environmental risks.
- Community participation.
- Emphasis on primary health care in health care systems.
- International cooperation.

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In 1985/86, the European office of WHO proposed a health promotion project to be known as the Healthy Cities Project. The intention was to devise ways to apply the principles and strategies of Health for All through local action in cities. The project originated in a workshop held by the City of Toronto in October 1984 called Healthy Toronto 2000.<sup>2</sup> The strategy involved bringing together a partnership of the public, private and voluntary agencies, institutions and organizations to focus on urban health and to tackle health-related problems in a broad way.

The value of this project to cities has been demonstrated by its startling and (initially) unexpected growth to involve hundreds of cities and towns, not only in the industrialised world, but increasingly in the developing world. A list of cities in low-income countries involved in projects appears in the accompanying panel.

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**PANEL 2 Healthy City participants in developing countries**

**Africa**

Nigeria: Ibadan  
Ghana: Accra  
Senegal: Dakar  
Tanzania: Dar es Salaam

Côte d'Ivoire: Abidjan and Toumodi  
Niger: Dosso and Niamey  
Cameroun: Garoua and Yaounde  
Congo: Brazzaville

**Latin America.**

Argentina (Posadas, Buenos Aires)  
Bolivia (La Paz).  
Brazil ( Curitiba, Rio de Janeiro  
Sao Paulo, and others)  
Chile (Santiago)  
Colombia (Bogota, Cali)  
Costa Rica (San José)  
Cuba

Dominican Republic  
Ecuador (Quito)  
Lima (Peru)  
Martinique (Le Lamantin)  
Mexico  
Nicaragua (Managua)  
Venezuela

**Eastern Mediterranean**

Pakistan: Lahore, Bahawalpur,  
Karachi, Rawalpindi, Quetta and  
Abbottabad  
Iran: Teheran and a number of  
provincial capital cities  
Egypt: Fayoum  
United Arab Emirates: Dubai

Morocco  
Tunisia, Tunis (national network of  
cities)  
Cyprus  
Kuwait

**South-East Asia**

Bangladesh: Chittagong and  
Coxes' Bazaar  
Nepal: Kathmandu and Lalitpur

Bangkok, Thailand.

**Western Pacific**

Japan (many towns)  
Australia  
New Zealand

Vietnam  
China  
Malaysia (Kuching & Johore Bahru)

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A recent publication by WHO's European Office, entitled *Twenty Steps for Developing a Healthy Cities Project* <sup>3</sup>, has described the implementation of a project in a developed country. Demand for practical advice relevant to low-income countries has led to this guidebook. It is based on documented activities in Chittagong <sup>4,7,8</sup>, Ibadan <sup>5</sup> and Accra <sup>6</sup>, as well as experience from other cities such as Lahore, Rio de Janeiro and Teheran.

### **Aims of the Healthy City Programme**

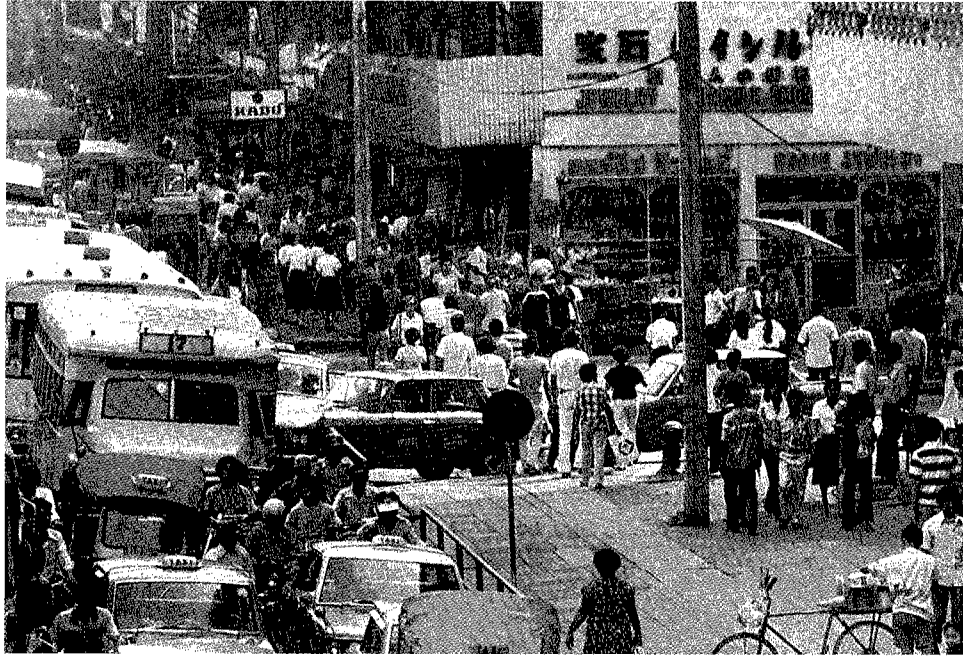
The Healthy City Programme (HCP) aims to improve environment and health conditions by raising awareness, and by mobilizing community participation through partnerships with local (municipal) agencies and institutions, thereby helping them to deliver effective environmental and health services. A priority objective is to develop the role of local governments in public health and to encourage them to implement a Health for All policy at city level.

Though various urban development activities (housing, industry, infrastructure etc) can bring health hazards if they lack health and environmental safeguards, more importantly they offer health opportunities. They can enhance the health status of the population if health promotion and protection measures are undertaken in implementing the development. For example, in industrial development, occupational safety considerations, worker training and pollution control should be integral; or in housing development, basic environmental services and primary health care measures should be implemented with community participation.

A Healthy Cities Project may be a stand-alone project in a given city, or it may be a health component in a larger development effort involving infrastructure, land management, municipal finance and industrial development. Key development problems addressed by HCP are:

- Poor health in urban dwellers, especially those in high-density low-income settlements.
- Deficient basic services, poor housing, and environmental pollution.
- Inability of many local governments to cope with their public health and environmental responsibilities.

HCP recognizes that, while the initiatives and ingenuity of the poor in self-provision of basic needs and survival strategies are impressive, this "do-it-yourself" provision has serious limitations, particularly in urban areas where crowded conditions expose people to various pollutants and create risks of disease epidemics. In addressing these urban problems, a



*Reaching the limits? Heavy traffic clogs a street in Bangkok, Thailand.*

Healthy Cities Project does not seek to take over the management of these functions from the competent authorities and agencies. Rather, it adds the health dimension to them by measurement of the health burden such problems create (in terms of death, disability etc), so that health issues are made relevant and understandable to the work of local government agencies and non-government agencies.



*Young people in cities may have increased opportunities for personal development, but are also vulnerable to problems such as juvenile delinquency, demoralization and despair, alienation, drug abuse, and suicide.*

A Healthy City Project supports city health authorities and/or local government in undertaking what may be two new roles:

Information and analysis — health impacts are monitored, involving measurement of health status and estimation of the contribution that various environmental factors are making to health problem. This is then followed by analysis of health requirements and opportunities in various development sectors that are significant for health;

Policy and advocacy — specific health policies for each sector are formulated (for water, sanitation, local government, education, industry, labour (eg workplace health) etc., and are advocated by policy-makers in the work of competent agencies.

In the process of consultation with the community and many different agencies and groups, there is an effort made to develop a “vision” of the future direction of the city, and to understand its current (and past) strengths and qualities. There may be a “Vision Workshop” especially for this purpose, that can start with the question, “why is this city a fine place to live”?. In all parts of the world an appreciation of the cultural heritage, and cultivation of a “sense of place” that celebrates the unique characteristics and history of each city are proving important elements in mobilising people to improve living conditions and address health and environment problems.

### **Role of WHO**

Healthy Cities is essentially a facilitating programme aimed at health promotion and institutional development both at the municipal level and the “grass-roots” level. The WHO team involved in implementation includes professional staff in WHO HQ and 6 Regional Offices, with technical support from a wide range of WHO programmes. In many countries, WHO country offices are also strongly involved.

The WHO European Office has facilitated contacts between established HCP in cities in Europe and interested cities in other regions. Regional Offices provide a focus and assist networking in each region, and support many of the activities detailed in this publication. The WHO Collaborating Centre for Healthy Cities at University of Indiana, USA, maintains a database with names and addresses of some 850 Healthy City Coordinators, who receive and exchange information, newsletters and other material dealing with Healthy Cities work. Other Collaborating Centres for Healthy Cities in various countries undertake research and provide technical support to cities.

WHO is not the only UN agency active in urban development. Many UN agencies are deeply involved in efforts to improve the capacity of municipal governments to manage the urban environment and improve living conditions.



## CHAPTER 3. PROJECT IMPLEMENTATION

### Basic considerations

A Healthy Cities Project seeks to create neighbourhoods and other urban settings (markets, schools, workplaces etc) that are safe and promote good health. City or district-wide systems are required in urban areas, for water supply, sanitation, health care (including a referral system for hospital care), education, and housing and land-use planning. To create these systems the project establishes partnerships among community groups, community based organizations, NGOs, local institutions and municipal agencies.

Health depends not only on good health services or individual lifestyles (important as these are) but on a supportive physical and social environment. "Supportive environment" refers to the physical, economic and social aspects of the surroundings, the settings where people live and work.

Within each city, the objectives of the project are determined by the project participants, and may be modified and refined as the project develops. However the following objective and sub-objectives have emerged as a starting point that may be suitable for any new project:

#### HCP objective

To improve the health of urban dwellers, and especially low income urban dwellers, through improved living conditions and better health services.

#### Sub-objectives

Increased awareness of health issues in urban development efforts.

Political mobilization and community participation to prepare and implement a municipal (city-wide or local) health plan.

Increased capacity of municipal government to manage urban problems using participatory approach.

## Action Plan

The following action plan can be adapted to any city situation. It has three phases: Start-up, Organization and Implementation. Total duration is stated as 3 years, but some cities will require 4-5 years to complete all three phases. The time frames are only approximate.

Activities in each phase may overlap; for example awareness-raising and developing a support group (to support project activities) are activities that last the life of the project.



*Job-seekers in urban areas are increasing faster than municipal economies. Is this employment? Repairmen offering their services by the roadside, Mexico City*

Some advice applies to all phases:

- Focus activities on the city and community rather than on regional and global activities and concerns;
- Focus on activities to improve specific settings within the city (neighbourhood, schools, workplaces, etc), rather than “single issue” projects (for example, improvements to water supply will be made concurrently with activities to improve sanitation and food safety).
- Emphasise stimulating partnerships between municipal agencies and the community (increasing the responsiveness of local government to community needs);
- Emphasise community participation in local government, with a view to increasing the influence of the community in decision-making;
- Ensure the poor will benefit from project activities;
- Ensure participation of women in decision-making in relation to project activities, and especially in key areas such as housing, water and sanitation, and health services.

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### PANEL 3

#### **Management of a Healthy City Project**

**Local Task Force:** a nucleus of several key individuals in the city with leadership capabilities to initiate the project and all the individuals who are prepared to support the project.

**Partnership Task Force:** provides the leadership and legitimacy needed for health advocacy and mobilization of people and resources for health improvements. It formulates and implements the Municipal Health Plan.

**Project Steering Committee:** Overseeing group to which the Partnership Task Force is accountable. This may be a national or local body.

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## **Phase 1 — Start-Up (3-6 months)**

### **Develop Local Task Force (LTF).**

#### **Build public support.**

#### **Raise awareness.**

A Local Task Force (LTF) is established, acting with or without support from NGOs or an external agency. The LTF starts with a nucleus of several key individuals in the city who have leadership capabilities, the desire to improve the health conditions in the city and the ability to stimulate the participation of key actors such as NGOs, community groups, municipal agencies, university and training institutions. They may be municipal government staff, health workers or community activists. The LTF may be accountable to some form of project steering committee that can be established locally within the city, or nationally (see panel). It will be incorporated into the Partnership Task Force established in Phase 2.

The LTF invites individuals from the key organisations mentioned above as well as private companies, international organizations and others to join the LTF, which becomes widely based; individuals can be selected and recruited on the basis of proven interest and activity in community development and public health.

The LTF then facilitates contact and discussion between different municipal and government agencies and identifies which organisations should be invited to participate in the assessment of health problems in the city. The LTF's job is to gather and analyse information; to make contact with key individuals needed to address priority issues and assist in preparation of a municipal health plan; to convince potential supporters; and eventually to assist in preparation of the municipal health plan and project proposals.

The LTF has an important role in contacting many groups and individuals who may be interested in improving city conditions, but fail to see a role for themselves. Many people living, for example, in poor environmental conditions in low-income high-density housing recognise the need for change, but feel there is nothing they can do. Other people may be already involved in community development activities, for example in an NGO, but may not recognise that working in a "broad spectrum" project that addresses many development issues such as an HCP may be an effective way to gain political support and resources to implement their programme.

WHO offices are an important source of information about Healthy Cities, and may assist in holding workshops or seminars that can attract the interest of local media and generate increased interest and awareness of a project.

## **Phase 2 — Organisation (4-6 months)**

**Gaining approval of the municipal government.**  
**Appointment of a Partnership Task Force (PTF).**  
**Setting up a project office and appointing coordinators.**  
**Preparation of a Municipal Health Plan (MHP).**  
**Raising awareness of the MHP.**  
**Mobilization of resources.**

Municipal government approval has in practice almost never been difficult to achieve, especially when government staff and officials have been consulted and involved in the start-up phase. A clear-cut approval and commitment of the government to the project sends an important signal to all municipal government staff and agencies that public health issues are now “on the agenda” and worthy of greater consideration, and provides a framework for greater cooperation by relevant municipal agencies in undertaking public health work.

The Partnership Task Force (PTF) is appointed based on the recommendations of the LTF. It provides the leadership and legitimacy needed for health advocacy and mobilization of people and resources for health improvements.

The PTF’s functions are:

- Formulating the Municipal Health Plan (MHP);
- Persuading the city council to accept the MHP;
- Consulting all groups represented on the LTF and the Steering Committee (if there is one);
- Fund-raising and seeking project participants;
- Encouraging community groups to become involved in health issues; and
- Making decisions on the operation of sub-committees and the project office.

Potential members of the PTF come from:

- City councillors responsible for social services, water and sanitation, environmental sanitation, city markets, education, housing, traffic, industry or urban planning;
- Senior managers of the primary health care system or network of health centres for the city;

- Representatives of community groups;
- The mayor and city councillors with health responsibilities;
- University departments with research interested in public health or social policy;
- Representatives from business, industry, labour and professional bodies; and
- Other non-government agencies, religious leaders etc.

The PTF may decide to establish a number of committees to address particular issues, for examples to study health conditions in markets, or sanitation in low-income neighbourhoods, and advise on possible options for improvements. Members are often people with direct knowledge and considerable experience of the issue under consideration.

The PTF, with the support of the city, NGOs and other partners, appoints one or two HCP coordinators, who will receive several weeks of intensive training in Healthy Cities implementation by an experienced consultant. The coordinators become or are members of the PTF and their salaries are met by the city itself, perhaps with financial support from other agencies. It is essential to have at least one full-time coordinator, to provide continuity, visibility and credibility throughout the life of the project.

Coordinators should have:

- Multiple, varied work experiences;
- Strong interests in public health, urban development and social development;
- A strong local knowledge of the city;
- Good contacts with government and community organizations; and
- Powerful skills in communicating, negotiating and planning.

A visible and accessible office makes a valuable contribution to the project. Several cities have set up Healthy Cities shops at street level, that encourage visitors to drop in, and provide information on lifestyles, environment and health care.

The preparation of a Municipal Health Plan (MHP) (see panel) serves to generate awareness of health and environmental problems by municipal authorities, non-government agencies and communities, and mobilize resources to deal with the problems. The plan should not be considered a "one-off" exercise that will generate all the necessary actions to solve the city's health problems once and for all; rather it should be seen as a process of consultation, data gathering and analysis, and resource mobilization to undertake some priority improvements, and to open new channels of communication that can facilitate ongoing cooperative work by community groups, municipal agencies, universities and colleges and the private sector.

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## PANEL 4

### **Outline of a Municipal Health Plan**

This outline is based on the development of Municipal Health Plans in the cities of Rio de Janeiro, Accra and Lahore during 1991-1992.

#### *Who formulates the plan?*

A multi-sectoral team of community representatives and organizations, MOH staff, NGOs, university, representative of Mayor's office, representatives of hospitals, and media. The plan is consistent with any national urban health/planning guidelines of the MOH or the Ministry of Urban Developments, and is endorsed by the Mayor.

#### *Goals of the plan*

- To get health education and the other health-related activities incorporated into the community level activities of municipal staff working in water, sanitation, solid waste, housing, education, social support and other areas; and
- To improve the performance of the municipality both in provision of services, and in supporting local community initiatives in activities that promote health.

#### *Prerequisites*

- Community organization and representation in formulation of the plan;
- Health leadership which may be found in MOH, or NGO, or in municipal office; and
- Public hearing to allow broad public discussion.

#### *Content*

- Identify and review all studies and reports that are available that describe and quantify the social, economic and environmental health problems, and environmental conditions in the city;
- Attempt to rank the contribution that problems make to the burden of ill-health;
- Identify the existing municipal agencies and the organizations including UN, bilateral agencies and NGO's that can potentially contribute to solutions to health problems;
- Identify potential mechanisms for partners to work in a more coordinated manner in addressing problems; and
- Identify and rank the priority actions and programmes, including setting of targets, and evaluation plans.

#### *Ensure Action*

- Commitment of community leaders;
  - Training of municipal staff and community participants;
  - Publish stories and reports in local media;
  - Public campaigns on population issues eg vaccination or street cleaning;
  - Monitor and evaluate and publish annual health status and activity data.
  - International/Bilateral agencies and NGOs role.
-

The MHP may have programmes or projects for specific settings, such as schools, workplaces, the market-place, and health care settings.

In preparing the plan, the PTF must keep in mind that there may be some government functions (policy-making, services etc) that are outside the responsibility of the city government and are controlled by national ministries. Identification of these functions will be critical, as will information about which city and national politicians and officials are sympathetic to health issues, or to the involvement of citizen groups in local government, and therefore may be prepared to support the project.

A key issue is how national programmes may influence the project. In some countries, it has been helpful to establish a "national Healthy Cities commission", and the project city may serve as a model for other cities. A clear commitment by such a body to local government policies that reduce marginalisation or exclusion of poor communities from socio-economic life and services can greatly assist local efforts.

Strengthening of municipal government capabilities as part of a Healthy Cities project may further a national policy of decentralization of various urban development activities. In cities where all significant decisions must be referred to national authorities for review, or where powers to retain locally generated revenues are very limited, the issue of decentralization of certain responsibilities is likely to become an important one for the Project. Finally, in some countries there are national institutions of municipal bodies, that are dedicated to improved municipal management and government (eg IBAM in Brazil), who can be involved in the project city and can subsequently inform cities throughout the country about the Healthy Cities approach.

The MHP is collated and analysed by the PTF, and distributed to government agencies, NGOs and the public in one or more municipal HCP meetings. The plan is not so much a blueprint but a tool to promote discussion and raise awareness that there are possibilities of changing living conditions in the city for the better, through cooperative efforts and partnerships. These meetings are funded by the city, and help to develop a list of priority environmental and health problems to be addressed.

Interviews and meetings as part of the assessment process are used for awareness raising, and to solicit participation in solutions to various problems. Once priority problems emerge, the HCP committee will mobilize resources (people's participation, technologies, funding) from the community, the municipal government, and other sources to deal with them.



### **Phase 3 — Implementation (24 months)**

#### **Further development and implementation of a MHP.**

**Assessment and adjustment of municipal policies and programmes.**

**Distribution of WHO guidelines.**

**International technology exchange.**

Following the municipal HCP meeting, the PTF will further develop the MHP to address priorities identified in the meeting. Some aspects of the plan involve projects that will require external funding by donors, while other projects may be undertaken using resources mobilized from the city itself. The advice of the partnership committee is critical at this point. WHO's role is often to provide information and to assist in project formulation and matching of donors with project proposals. For developing the plan, representatives from other HCP cities may be invited (by the local or international teams) to meetings to discuss successful approaches that have been identified elsewhere. All municipal agencies with potential to assist are encouraged by the PTF to participate in the improvement project. Participation in implementing the plan is also sought from NGOs and community members.

Municipal government staff in relevant departments are encouraged by the PTF to re-orient their activities in accord with the MHP, and to support health goals expressed by the Mayor. The WHO and PTF are responsible for distributing relevant WHO guidelines and technical materials on urban health subjects to relevant agencies and institutions in each city. An HCP Newsletter is also circulated.

WHO organizes inter-country meetings on a regular basis to review the progress of the participating cities, and for exchange of health and environmental technologies, and experiences with successful projects. It provides the meeting with Healthy City evaluation reports and information about successful projects in all countries, and emphasis is on exchange of technologies between low-income country cities. Successful projects from developed countries may also be discussed, adapted as appropriate and exchanged in the course of the meeting. Participating cities have their project coordinator entered into an international database, and newsletters and technical reports are regularly circulated.

Evaluation procedures and criteria have been developed for Healthy Cities, and members are encouraged to undertake frequent evaluations for presentation at inter-country meetings.

The first Healthy City in a country should, through the PTF, maintain contact with other interested towns and cities, and when several cities are ready to initiate Healthy City projects, should organise a national HCP meeting, taking over the support role which in its own case was provided by WHO and other agencies.

## CHAPTER 4. Partnerships and Settings

This chapter provides additional explanation of the key concepts of Healthy Cities: the partnerships, the “settings approach”, and the MHP. It also details some of the project outputs.

### Agency/community partnerships

In the partnerships between community and municipal agencies, local people participate in decision-making about municipal services and planning. They may commit their resources to assist implementation of the solutions to the above basic needs issues, with solutions tailored to the level of resources that can be mobilised, to the cultural and social context, and the requirements of health and environmental protection. The participation of community groups may be formalized by “community contracts” with the municipality, whereby the municipality supports and assists community groups in recognition of the work they undertake in improving local environments and health conditions.

### The “settings” approach

In making the environment “supportive for health”, health authorities and NGOs must do more than merely look for the hazards and risk factors that damage health. Rather the emphasis of the HCP is on improvements and support for the “settings” where health is maintained, promoted and indeed created (see panel)

The idea of a supportive environment and the “settings” approach has turned out to be a powerful and valuable one for the promotion of health in many countries (Figure 2, BOX 1). The home, the school, the village, the workplace, the city are the places where people live and work. The health status is determined more by the conditions in these settings than by the health care facilities that we can provide. These are settings where health may be maintained and indeed

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#### BOX 1

#### SETTINGS THAT SUPPORT HEALTH

Improved health requires making these “settings” more supportive of health

H O M E ,            V I L L A G E ,  
N E I G H B O U R H O O D

S C H O O L

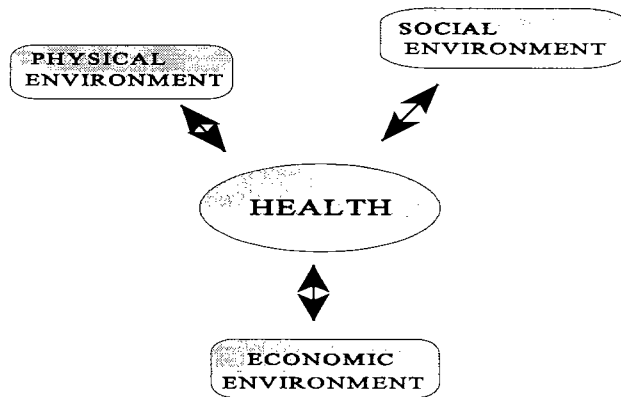
W O R K P L A C E

F O O D M A R K E T S

C I T Y A N D D I S T R I C T

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created, by engaging all participants and authorities that operate in the settings, in activities to create a supportive environment for health.



In relation to the settings of neighbourhoods and cities, the local/municipal government may examine the health implications of its work and develop a municipal health plan, with participation of community organizations, local institutions etc. In relation to the school setting, the parents, school principal, and education authorities must

## SUPPORTIVE ENVIRONMENTS

together develop a plan to install in the school adequate water and sanitation facilities, and a good safe playground, and perhaps allow the children to participate in these activities. WHO now has examples of these comprehensive health development approaches (which usually have titles like "healthy villages", "healthy schools", "healthy workplaces etc"), with the following characteristics:

### *Schools*

Schools in the city may participate in a "Healthy Schools" project that addresses:

- Environment and health education with grade-appropriate curricula;
- Parental and teacher involvement, and child participation in relevant school management and decision-making, and in projects to improve water facilities, toilets, school playgrounds and classrooms; and
- A school medical service that emphasises prevention.

## *Workplaces*

A “Healthy and Safe Workplace” programme would necessarily operate on two levels:

- The “traditional” occupational health service that emphasises factory level work by health inspectors; and
- The newer challenge of the small-scale and cottage industry (SSI) which demands community-based and participatory approaches.

Important issues may include:

- Education of workers (for example about assessing risks, safe procedures etc);
- Support and training of NGOs to undertake worker education in SSIs;
- Worker participation and representation in industry management, and industry/trade associations;



*Cottage industry is a major employer in many cities, especially for new-comers or people without access to the formal employment sector, but it is often associated with long hours, poor pay, and inadequate or non-existent occupational safety provisions. Women winding silk thread in Thailand.*

- Mass media role in education;
- Health services for workers;
- Attention to the needs of women workers and a support role for women's associations;
- Establishing channels of communication between managers, workers and authorities responsible for environmental protection;
- Proper management of solid and liquid wastes; and
- Siting industries in locations to reduce pollution and environmental damage.

#### *Market-Places*

A “Healthy Market-Places” programme would establish partnerships between all concerned to address issues such as:

- The health conditions of stall-holders and food handlers (water, toilets, availability of health services);
- Practices for storage and handling of foodstuffs;
- How to minimize any adverse impacts of markets on surrounding residential areas;
- Solid waste management of the market area;
- Methods of inspection by government authorities(eg, how food inspectors can play a more educational rather than a punitive role); and
- The role of the market-place in health education.

#### *Health services*

Important areas for consideration in a “Health Services Upgrade” are:

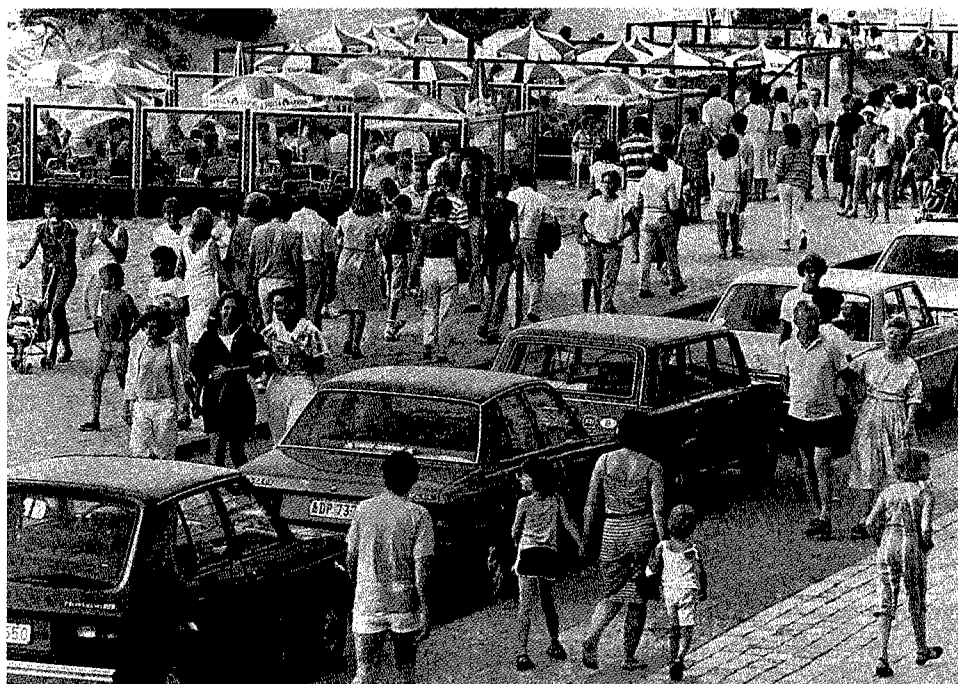
- Development of inputs from the user community to the decision-making processes and management of the health services;
- Development and promotion of preventive services alongside curative services; and
- Equity in provision.

Partnerships may form between women's organizations, health-oriented NGOs, and Ministry of Health and municipal health agencies responsible for provision of health services/running health centres/managing hospitals to address local priority issues, for examples: how to make maternal-child health services more accessible for under-served areas; improved family planning; improved health education; better and more appropriate and readily available drug therapies for common diseases etc.

Settings-based projects force all participants to work cooperatively and synergistically, and make intersectoral cooperation an operational rather than a theoretical concept.

## National and local policies

The Healthy Cities Project involves commitment by official government agencies, supported by the private and voluntary sector, to improve the total city. Central to this approach is the improvement of environmental health (including water supply, control of toxic wastes, sewage, housing, transportation, air quality and communication), health promotion, improved health services, and commitment to “sustainable” ecologically sound urban development.



*Enjoying city life. A place to stroll, to relax, to meet, to enjoy a drink with friends.*

In many capital cities, national ministries may play an important role in day-to-day decisions and policy-making, and cities may have a problem with the weakness of municipal governments in carrying out their health and environment responsibilities.

A focus of the HCP is the development of public policies that attach importance to health as a development goal. All agencies concerned with energy, food, agriculture, macroeconomic planning, industry, education, housing, land-use, transport and other areas, must examine the health implications of their policies and programmes, and adjust them to promote health and a healthy environment better. Governments at all levels should formulate urban environmental policies and plans, and integrate environmental considerations into all urban development planning efforts.

Mayors/municipalities should commit themselves to a Healthy City process with broad-based community participation that will involve:

- Assessing current city health status;
- Formulating and adopting an MHP;
- Developing solutions to problems on a community-wide basis;
- Participating in and/or hosting meetings of network cities;
- Reporting back on health-related data and indicators of city health (see below).

Reduction in inequity is a goal of a Healthy City, as expressed in reduced “intra-urban differences” between different neighbourhoods in the same city, in the above indicators. Data must be collected and analysed in as disaggregated a form as possible to allow measurement of intra-urban differences. Greater equity in access to health services is an important goal.

## CHAPTER 5. EXPECTED OUTPUTS

The outputs of Healthy City Projects can vary in different cities according to the local requirements; however typical outputs are improved health and environmental conditions in participating cities with:

### **Physically upgraded settlement infrastructure**

using local materials and labour-based appropriate technologies, including:

- Street drainage, tree planting, repaired/improved public spaces and sporting facilities;
- Improved market places and slaughterhouses;
- Sanitation, with a strategy of community-based labour-intensive construction of sewerage and stabilization ponds;
- Household water connections installed, quality monitoring upgraded, and drinking water and washing stations designed, constructed and used with improved taps;
- Upgrading of houses by individual households with support from community development associations, local NGOs and municipal agencies, using local materials and labour-based technologies; training of municipal staff in health principles of housing; and
- Solid waste management, with low-technology solid waste collection systems designed and tested; community-based management of waste collection established and ongoing; improved management of landfill sites established on non-agricultural land.

### **Better school health**

This will include:

- Improved tuition in basic health and hygiene for pupils;
- Participation of children in discussions of how the school can be made healthy;
- School medical service;
- Participation of children in activities to improve the school environment, eg the playground;
- Participation of parents and community organizations in provision of an adequate water and sanitation facility in every school.

It is increasingly understood that participation of a child in an activity to improve the school facilities is a more effective method of health education than a teacher working at a blackboard in front of a class.



## Upgrading of health centres

with a focus on their capacity to undertake health and hygiene education, to raise the level of vaccination coverage, and to provide effective primary care services; health centres to serve as entry point to the health referral system.



*A challenge for urban planners. All the discussion and activities described in this manual have the common theme, to place health and well-being at the centre of all urban development and management initiatives*

### **Greater awareness**

of health and environment, and participation of people in the operation of local councils and community development associations; and a greater readiness of municipal staff dealing with local services to consult with community organizations such as the community development association or NGO's in efforts to upgrade these services.

Health and hygiene education programmes are needed, adapted for semi-literate and illiterate target population, to cover the following subjects:

- water and sanitation;
- solid waste disposal;
- rodent and insect control;
- food safety;
- fertilizer and pesticides use, handling and storage;
- health in housing, and household maintenance;
- school health;
- occupational health, including safe operation of machinery, handling of chemicals, use of protective clothing etc; and
- priority social issues, eg teenage pregnancy, neighbourhood safety.

### **Networking**

with other Healthy Cities (see below, under 'strengthened institutional capacity').

### **Occupational safety**

includes safe workplace programmes in the formal sector, and community-based approaches to occupational safety and pollution control for the informal sector and cottage industries.

### **Employment**

Temporary improvement in the income of a number of households of temporary workers who will have participated in the water, sanitation, solid waste or other upgrading works, or permanent employment for some operatives in charge of the physical improvements.

### **Strengthened institutional capacity**

- Further consolidation of the process of decentralization of administration to local levels, and demonstration of the effectiveness of strengthened municipal institutions in water, sanitation and housing and environment improvements with community participation;

- Identification through the MHP of the health issues and linkages to be considered in the work of each local government agency, the mechanisms for coordination, the goals and objectives in relation to baseline health and environment data, and a workplan;
- Improved functioning of environmental/environmental health monitoring agencies, including the water and wastewater quality monitoring laboratory; introduction of environmental health impact assessment procedures for urban development projects;
- Community-based health monitoring and management units established and active in ongoing activities;
- Improved performance of staff, both in technical areas and in liaison activities with community organizations; for example improved capacity of municipal staff to support house upgrading, through provision of low cost loans, bulk buying of building materials, ability to show and guide house occupiers how to upgrade, and improved communication with community development organizations;
- Networking and contact with other Healthy Cities both in the region and elsewhere will provide a source of stimulation, exchange of technical knowledge, mobilization of resources, and a standard for comparison for achievement in addressing health and environment problems. Senior officers should have taken part in one or more international Healthy Cities events;
- Demonstration of the costs, technologies, community inputs and external assistance inputs needed to provide urban areas with comprehensive and integrated programmes to support health and environment.

#### **Upgrading of health sector information management system**

- Socio-economic and environmental health data on the project area recorded;
- Project studies, designs, technical specifications and all construction documentation of the various works recorded.

## CHAPTER 6. EVALUATION

Not many cities really meet the definition of a Healthy City given at the front of this book — it is not exactly a practical or operational definition. But its idea of a supportive environment and the settings approach has turned out to be a powerful and valuable one for the promotion of health in many countries.

Evaluation is an ongoing process integral to all phases. The emphasis will be on the “process type” indicators as measures of project implementation and effect, and it is acknowledged that the “outcome type” indicators listed below may be difficult to relate to the project. Nonetheless, they are valuable in guiding the work of the PTF and project activities, and are encouraged in all projects.

Evaluations will be based around the development of MHPs and projects to implement aspects of the plan.

### **“Process type” indicators**

These relate to the formation of partnerships between community groups, CBOs, NGOs, local institutions and municipal agencies dealing with water supply, sanitation, health care, housing and land-use planning, etc.

The application of a completion date to each task (see Chapter 3) creates a checkpoint to be used for evaluation, and these will be established for the completion of each task.

An assessment should be made of the actual work undertaken by partnerships and task forces, in terms of meetings held, participation in meetings, outcome of meetings, and activities to improve health and environmental conditions. For example, the school health task force organized meetings of school staff and parents in 10 schools, and in 7 of these schools there have been improvements in the class-rooms and playgrounds (details of these improvements and the methods to be provided).

Measurement of indicators related to mobilization, participation, awareness, and partnerships require process evaluation techniques such as participant observation and interviews with key informants.

### **“Outcome type” indicators**

These may be longer term in nature, but some could be expected to change within the life of a project. Even if measured only once, the indicator could be a stimulus (or guide to

priority setting) for the PTF to undertake an intervention. A short list of indicators used in evaluation will be agreed upon in relation to each city. A minimal list might include:

- Percentage of population with access to sufficient quantity of safe drinking water
- Percentage of population with access to hygienic excreta disposal
- School enrolment for boys 7-12 years
- School enrolment for girls 7-12 years
- Percentage of babies weighing less than 2.5 Kg at birth
- Immunization coverage
- Prevalence of malaria
- Number of people to be served by each primary medical care facility, average for city
- Number of people to be served by district hospital bed, average for the city (or number of people without access).
- Percentage of people served by public garbage removal service
- Average level of lead in blood from children 10-15 years
- Percent of population equipped with impregnated mosquito nets
- Incidence of acute enteric infections
- Prevalence of intestinal helminths among children (2-15)
- Maternal death rate
- Expectancy of life at birth
- Infant mortality

In each city, indicators will be sought from the following possibilities:

- Health status indicators;
- Inequalities in health status (ie, intra-urban differences);
- Environment supportive to health;
- Indicators of community participation in health and environmental services, and municipal planning and management;
- “Healthy public policies” by municipal and national governments;
- Values, eg importance of health goals for various sectors;
- Reorientation of health services, from a "curative" approach to a preventive approach;
- Reorientation of non-health urban services and agencies to incorporate health goals and assist improved health;
- Public education for health (in schools, workplace, mass media etc); and
- Concern for “sustainable”, ecologically sound urban development.

An international advisory body may be established to oversee implementation of the project.

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PANEL 6

**Suggested indicators for Healthy Cities**

*Health indicators*

Life expectancy at birth.  
Infant mortality.  
Levels of nutrition.  
Vaccination coverage.  
Ranking of diseases by morbidity/mortality index.

*Socioeconomic indicators*

Mean years of schooling for girls and boys.  
Adult literacy.  
Employment.

*Environmental indicators*

Percentage of population living in poor housing conditions/slums.  
Drinking-water supply coverage.  
Adequate basic sanitation coverage.  
Parasitic diseases prevalence (urban malaria, filariasis, intestinal helminths).

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