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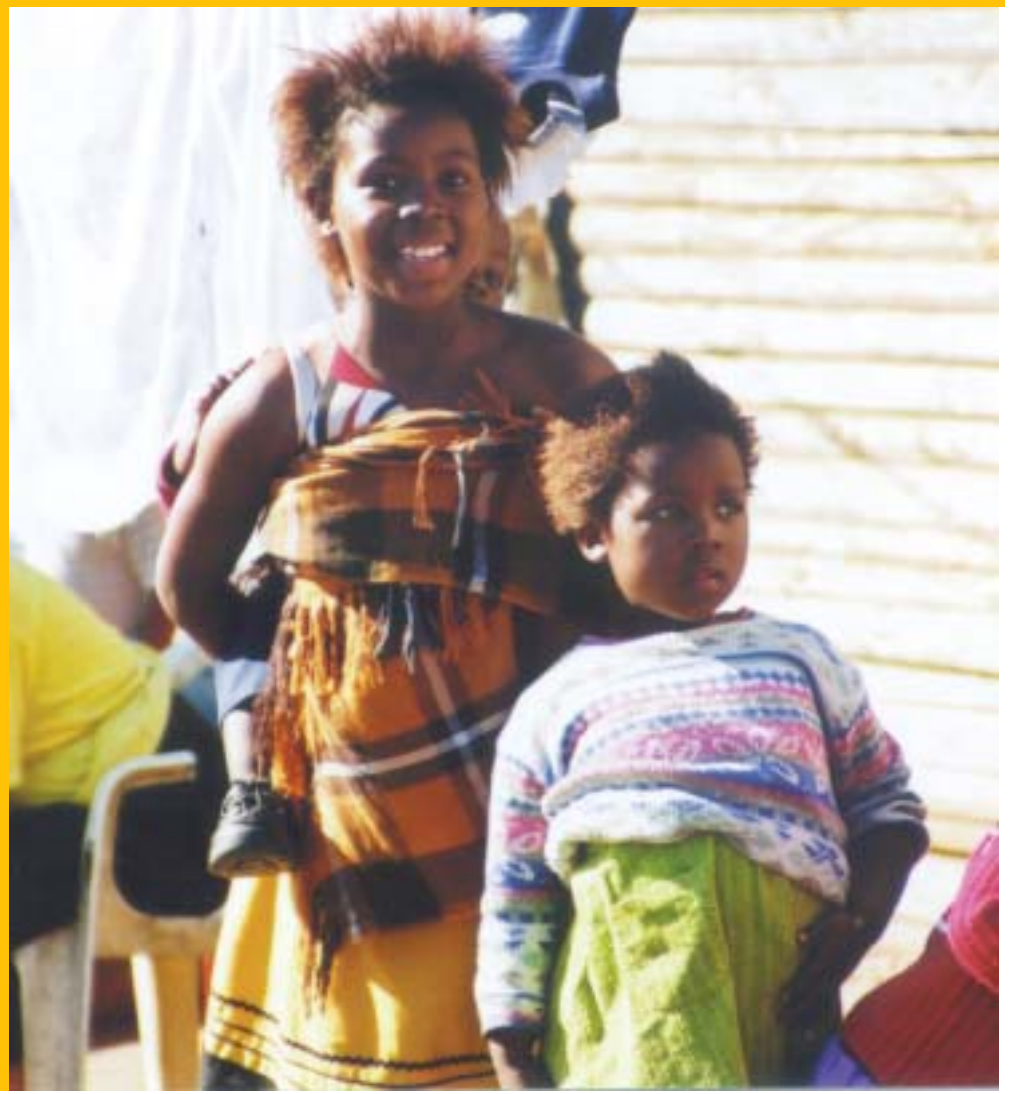
Healthy Cities Initiative:

APPROACHES AND EXPERIENCE IN THE AFRICAN REGION

World Health Organization
Regional Office for Africa
BRAZZAVILLE



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Preface

The Healthy Cities concept provides a tool to address health and environment issues in cities and urban centres. The concept, first developed by the World Health Organization (WHO) Regional Office for Europe, has taken different paths in different regions, with regional guidelines, implementation plans and frameworks prepared and being applied.

To facilitate the initiation and development of the Healthy Cities approach in the African Region, the WHO Regional Office for Africa felt the need to prepare an implementation manual, which will help countries and provide guidance on how to start and to establish Healthy Cities Programmes (HCPs). The first Regional Healthy Cities Workshop held in 1999 also identified such a need. This manual on approaches and experiences for implementing Healthy Cities Programmes in Africa is divided into five chapters:

- the first chapter gives the general background of the Healthy Cities movement;
- chapter two provides an overview of the WHO Global Programme on Healthy Cities;
- chapter three describes the principles and approaches for establishing Healthy Cities;
- chapter four elaborates the key steps for implementing an HCP; and
- tools for the implementation of and techniques for monitoring the HCP are outlined in the fifth and final chapter.

Several case studies from the Region are presented in the manual in order to give examples of the way HCPs have been set up in Africa.

The manual forms part of a series of documents produced on the subject for use in Africa and other developing countries. The principles of implementation of HCPs outlined in this book are of a general nature, but have been tailored in order to meet the specific circumstances in African cities. The aim is to provide sufficient details for national and civic authorities to set up their own programmes without having to rely too heavily on external agencies.

There is no one 'formula' which can guarantee success of an HCP since, by its very nature, each project has to be tailored to meet the specific needs of a particular city. However, if tackled correctly, there are ways that one can help to ensure a successful Programme.

The steps and procedures described in this manual are descriptions, not prescriptions, and creativity and innovation are encouraged.

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Foreword

The population shift from rural to urban areas is a global phenomenon, and Africa is no exception. People in rural areas look for better economic opportunities, which they hope to find in cities. This has meant a near explosion of population in most cities in Africa.

National governments and civic authorities, already much constrained to provide basic civic amenities, have to cope with an ever-increasing influx of people. Unable to find or afford suitable shelter, migrant populations tend to put up in shantytowns and slums, creating serious health problems for themselves as well as for others. They become the most vulnerable groups, suffering diseases of poverty such as diarrhoeal diseases, parasitic infections, tuberculosis, malaria and sexually transmitted diseases.

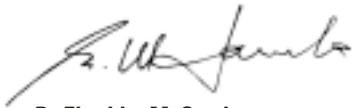
Africa already faces a plethora of health challenges, and unhygienic and unsanitary conditions in cities and urban centres are adding enormously to the health problems. Overcrowding, as is happening in cities, gives rise to social and behavioural changes, family disintegration, homelessness and crime. Woman and child abuse, violence and drugs follow in their wake. Addressing these challenges requires a sound approach that would take into account the environmental and socio-economic determinants of health in the context of Agenda 21.

The Healthy Cities concept, which is based on the principles and strategies of Health for All, is central to Agenda 21. It has emerged as an important and effective tool for improving health in cities and urban centres. It provides national governments and local bodies with an effective means of dealing with health-related issues such as poverty, pollution, lifestyle changes, urban planning, transport and the special needs of marginalized and vulnerable groups.

The International Conference on Health and Environment in Africa, held in Pretoria, South Africa, in 1997, emphasized that approaches that had a demonstrated effectiveness in addressing health and environment issues should be adopted. The Healthy Cities/ Villages approach was specifically cited, and intersectoral action using this approach as an umbrella concept at local level, was urged for priority action. The World Health Organization Regional Office for Africa was particularly requested to accelerate its implementation.

It is in this context that the World Health Organization has taken the initiative to develop this manual for the initiation and implementation of the Healthy Cities Programme. We will continue to assist member states to introduce and implement the Healthy Cities concept in the African context by preparing further documentation and providing training and opportunities for exchange of information and experience among countries.

The World Health Organization will continue to provide leadership in promoting better approaches to address urban health issues as well as taking a leading role in stimulating networking among countries and cities.



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We would also like to thank Ruth Stern for her permission to reproduce some of her material used to summarize the Healthy Cities concept and Elizabeth Morfaw, then of the WHO Regional Office for Africa, for her valuable comments on the earlier drafts.

Glossary of terms

Action Plan – the product of an initial brainstorming exercise intended to outline the vision for the development of a Healthy Cities Project or Programme.

City – there is no universally agreed definition of a 'city'. Urban centres usually refer to a concentration of people; buildings or economic activities which a government *chooses* to call 'an urban centre'.[1] The commonly accepted notion of a city is a large settlement in which most inhabitants are engaged in commerce, industry, services or some other non-agricultural occupation. Absolute size of a city is less important that its complexity or relative importance in a given region or country.

City Health Profile – the present health status of the city, including the processes which currently determine or impact upon health.

City/Municipal Health Plan – a detailed plan of action for achieving a Healthy/Healthier City developed jointly by city government and civil society.

Empowerment – the means and opportunity for people to lead healthy, active and productive lives through access to education, employment, improved financial security, health and social services, etc. Empowerment is concerned with enabling people to participate in decisions that affect their lives and is fundamental to human development and quality of life.

Health development – improving and maintaining health status and quality of life, and ensuring that health concerns are taken into account in policy and planning in all sectors and settings.

Healthy City – a Healthy City is not necessarily one that has achieved a particular level of health, it is one that is conscious of health and is striving to *improve* it.

Health indicator – a quantitative or qualitative measure of the magnitude or nature of a health determinant or risk factor.

Informal/unplanned settlement – a settlement in which the housing does not conform to local building and/or planning guidelines.

Slum – in much of Africa it is often used synonymously with both 'informal' and 'squatter' settlements, but in developed countries is used to describe formal housing which no longer conforms to satisfactory standards from health or structural aspects. Some formal inner-city housing in Africa falls into this latter category.

Squatter settlement – settlement which is illegal, usually being on land over which the residents have no right of tenure. Houses usually do not conform to local building and/or planning guidelines.

Stakeholders – *primary stakeholders* are the direct beneficiaries of a (Healthy City) project; *secondary stakeholders* are those who are affected by the project, but not necessarily directly.

CHAPTER ONE

Background to the Healthy Cities Programme

The Healthy Cities movement has its origins in the recognition that health is determined much less by health services than by social, environmental and economic factors, as originally pointed out by McKeown.[2] Observations of this kind gave rise to the now well-established concepts of Health Promotion and Primary Health Care and policies such as WHO's Health for All. Despite these ideas having been promoted for more than 20 years, responsibility for health matters in most city governments falls within a single department, which in most instances finds itself having to devote the greater part of its budget to curative medical care.

The Healthy Cities Programme (HCP) aims to improve recognition by city governments of the holistic nature of health, and to mobilise resources from a wide range of sectors in order to address health problems in an integrated manner. The initiative also builds on concepts that are central to Local Agenda 21,[a] which arose after the Earth Summit held in Rio de Janeiro in 1992.

Two of the key aspects recognized at the Earth Summit were the important role to be played by local governments in promoting sustainable development, and the importance of involving local communities in decision-making. This approach is mutually beneficial for all sectors in that partnerships are promoted between city management and the people around an issue, namely health, which is almost universally accepted as beneficial to development.

The HCP aims to bring about a partnership between public, private, and voluntary or community agencies to focus on urban health and related issues. The Programme has been one of WHO's main vehicles for giving effect to the strategy of 'Health for All', and has been implemented in more than 1000 cities and towns around the world. It has forged political, professional and technical alliances for health and uncovered a fertile ground for innovative action at local level, thus significantly strengthening WHO's potential for bringing about change. Since their inception, HCPs have emerged as the most effective, appropriate and sustainable tool for improving health in cities and urban centres, particularly in low-income and underprivileged neighbourhoods.

THE HEALTHY CITIES APPROACH IS BASED ON A PHILOSOPHY WHICH ASSUMES THAT:

- ***Enhancements in health will come about principally through improvements in certain social, cultural and economic conditions coupled with positive changes in human attitude;***
- ***people should be encouraged to take the initiative to improve their own health and their own environment; and***
- ***health should be seen as an essential part of overall development within the community.***

[a]The primary objective of the Local Agenda 21 initiative is to advance the techniques and professional standards for integrated environmental planning or sustainable development planning.

The programme rests on the assumption that any city can be seen as an appropriate candidate for participation in the Healthy Cities movement. The current health status of a city's population is not the key issue in deciding on participation. The most important consideration is whether the city is *politically* committed to *improving* the health of its residents and is willing to create *policies, organizational structures* and *collaborative processes* through which to do so. The Healthy Cities concept is about a process, not just outcomes. A Healthy City is not necessarily one that has achieved a particular level of health - it is one that is conscious of health and is striving to *improve* it.

Based on the success of the European experience, the WHO Global Management Development Committee (MDC) encouraged WHO to endorse an inter-regional programme on Healthy Cities in 1995. This programme laid down an inter-regional work plan under which networks of Healthy Cities in each region would be supported and promoted. These networks offer an opportunity for sharing experience and can be a useful resource for countries which wish to initiate HCPs.

1.1 The importance of healthy cities in Africa

Some may question whether *urban* health is a priority in Africa, since it is a continent with a low level of urbanisation (37.3% projected for 2000[3]). It is for this very reason that urbanization and health are so important in Africa. Low levels of urbanization, combined with development which is concentrated in urban areas creates an enormous potential for urban growth. Urban growth rates in many African countries already exceed 4% per year, whereas in developed countries urban growth is static or even negative.

In most developing countries urban growth results from both rural to urban migration and high natural growth rates of existing urban populations. Therefore, even if decentralization and regional development initiatives reduce migration, rapid growth of existing urban populations will exacerbate already poor health conditions in cities. On top of this is the tendency for impoverished rural communities to abandon marginal agricultural land in favour of life in the cities, and the stream of displaced persons resulting from the many wars which still trouble this continent.

When moving into cities, it is the poor who face the worst environmental health challenges, although the rich are not immune to factors such as widespread pollution or epidemic diseases.

1.2 The health-environment link

Another reason for giving urban health high priority in this Region is the particularly high burden of disease, which is associated with environmental factors on the continent. Analyses carried out by Smith *et al.*[4] indicate that not only is the burden of disease in sub-Saharan Africa much higher than in other regions (measured in disability-adjusted life years or DALYs), but at least 40% of this burden is environmentally determined (Figure 1).

Owing to the intricate interrelationships that exist between health and environmental quality, development planners today entertain the time-honoured view that health can be tremendously improved by modifying living conditions. Living conditions are greatly affected by local action, by the work of local governments and by community groups and

organisations through their development activities.

Urban development activities such as commerce, housing, agriculture, infrastructure and industrial development can produce unhealthy living conditions when health leadership lags behind. Conversely, they can produce the 'supportive environments' which modern health promotion theory requires for health improvements.

Many of these determinants of health extend beyond the direct control of the health sec-

When sanitation is poor, diseases spread and health expenditure increases. Diseases resulting from poor sanitation impoverish households and nations.
Photo WHO/ AFRO.

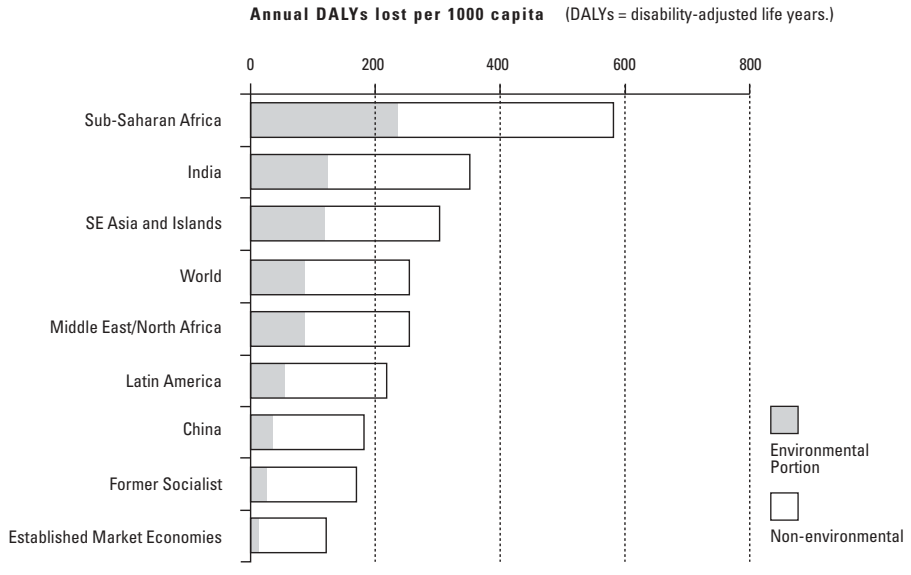


Figure 1. Environmental portion of disease in the major world regions.
Source: Smith, Corvalán, Kjellström 1999.

tor, and the environmental component is probably the most important. The health sector has an important role to play in identifying and quantifying health risks, but it is just one of the contributors to the promotion and protection of health.

The multiplicity of factors which impact on health demand interdisciplinary and intersectoral co-operation. City governments have to manage to do much more than merely set up health services if they are ultimately to achieve health for all. They must also manage issues such as migration, urbanization, industrialization and changing value systems.

This confirms the need for programmes which address health, environment and development in a holistic way: the *World Health Organization, Global Programme on Healthy Cities* is such a programme.

CHAPTER TWO

The World Health Organization Global Programme on Healthy Cities

Since its launch in 11 cities in Europe in 1986, the Healthy Cities Programme (HCP) has grown to involve hundreds of cities and towns in both the industrialized and the developing world. The development of HCPs has taken different paths in different regions, with local guidelines and implementation frameworks already developed and under application in most of the WHO regions. Initially the focus was on large cities, but the Programme has also been successfully adapted for use in smaller areas such as villages and islands.

2.1 The European Region

In Europe, where the WHO Regional Office originally developed the concept, a well-developed framework has been put in place. Success stories of the experience in Europe have been adequately documented.[5] There are now more than 600 HCPs under implementation in the European Region alone.

2.2 The Western Pacific Region

In the Western Pacific Region, Healthy Cities initiatives began in 1991. The regional policy framework, *New Horizons in Health*, endorsed in 1994 by the WHO Western Pacific Regional Committee, has been the regional implementation strategy document for Healthy Cities. In 1997 the WHO designated the Department of Public Health and Environmental Science of Tokyo Medical and Dental University as the WHO Collaborating Centre for Healthy Cities and Urban Policy to strengthen the Healthy Cities work in the Region. Currently approximately 170 cities are implementing Healthy Cities activities in the Western Pacific Region.

2.3 The American Region

In the American Region the approach has been applied for over 15 years using municipal secretariats. The total number of cities taking part in HCPs in this region is estimated to be more than 300. A network of Healthy Cities exists in the USA and in Quebec, Canada. The WHO Collaborating Centre on Healthy Cities in Quebec supports Healthy Cities activities in other countries, including some French-speaking countries of the WHO African Region.

2.4 The Eastern Mediterranean Region

In this region Healthy Cities activities started in 1988, with a regional strategy formulated in 1990. Many countries have since established national Healthy Cities networks and the Regional Office has developed guidelines for the development of Healthy Cities as well as a regional network programme. Healthy Village Programmes are now very popular in the region and the Regional Office prepared a document on Healthy Village initiatives here in 1997.

2.5 The South-East Asia Region

Ongoing Healthy Cities Programmes exist in all Member States, and some have more

than three HCPs. A regional consultation on Healthy Cities was held in New Delhi, India, in April 1999 to measure progress and evaluate experiences. The regional Healthy Cities implementation framework was endorsed at this conference.

2.6 The African Region

The Healthy Cities movement is a relatively new initiative in Africa. As can be seen from the scale of activities in other regions, it is a versatile programme with enormous potential. Africa has much to offer the programme in that there is a strong tradition of community-based health programmes in the region. This tradition, combined with the excess burden of disease associated with human environmental factors makes Africa especially suitable for HCPs.

Extensive awareness-raising has been carried out and a number of cities have begun Healthy Cities activities. However, the establishment of a formal, Africa-wide, Healthy Cities network co-ordinated by WHO Regional Office only began in 1999. Some cities have established their own networks using resources both within and beyond the WHO African Region. For example, Rufisque in Senegal has developed an HCP without the aid of a local network by using support from its twin city, Nantes, in France. Other cities have developed substantial HCPs with support from the United Nations and bilateral funding agencies (e.g. Dar es Salaam) or using local resources (e.g. Cape Town).

Many other cities have elements of the HCP in place but in the absence of formal networks, the Healthy Cities model has often been only partially implemented rather than forming a central component of government or city health plans. With the establishment of an African Healthy Cities Network it is to be hoped that there will soon be a long list of cities in Anglophone, Francophone and Lusophone Africa with active HCPs.

CHAPTER THREE

Establishing Healthy Cities Programmes in the WHO African Region

The WHO African Region (WHO/AFRO) subscribes to the views of the WHO Global Management Development Committee, but recognises that HCPs have to be implemented somewhat differently in the African setting. It sees HCPs not as ends in themselves but as *processes involving specific sets of actions* that any city can undertake in order to make progress towards achieving Health for All.

3.1 Principal characteristics of the HCP

A Healthy City is characterized in terms of a 'process' which contributes to positive changes in health in urban centres. It is about commitment by both government and civil society to building those physical and social environments that enable people to support each other in order to develop their maximum potential.[6] HCPs are integrated local environmental health programmes that strive to focus on actions at local level, to use local leadership, effective community mobilisation and participation, as well as intersectoral collaborative mechanisms that involve all stakeholders in programme planning and implementation.

HCPs provide a framework for action based on Health for All and the Ottawa Charter on Health Promotion[7] (healthy public policy, supportive environments, community action, personal skills, reorientation of the health services) and involving both 'top down' and 'bottom up' approaches. In other words, the programme requires buy-in at the 'top' from city managers and politicians while at the same time recognising that there needs to be a partnership that spans sectors and involves communities.

The Programme involves a series of projects which will need specific strategies and policies for a particular city. However, despite the need to tailor the initiative to each city, HCPs benefit greatly from the sharing of experience. The project has been described as "old wine in new bottles," or a new way of doing old things (Ruth Stern, personal communication).

Another element of the HCP is that it is a specific tool for the implementation of Agenda 21.[8] The health objectives of Agenda 21 include "protecting and promoting human health", which entails:

HEALTHY CITIES HAVE THE FOLLOWING CHARACTERISTICS:

- ***They are based upon a commitment to health***
- ***They require political decision-making for public health***
- ***They generate intersectoral action***
- ***They emphasise community participation***
- ***They work through processes of innovation***
- ***Their outcome is healthy public policy***

- promoting primary health care;
- addressing communicable diseases;
- protecting vulnerable groups; and
- addressing urban health and environmental hazards.

The HCP is an ideal tool for intersectoral action in support of health and environment in urban areas.

3.2 Moving into action: The City Health Profile and City Health Plans

The characteristics of a Healthy City given above call for a sophisticated assessment of many factors determining the 'city's health'. An important starting point, therefore, is to develop a **City Health Profile** (Intersectoral Health Promotion Plan) which determines not only the present health status of the city but the processes which currently determine or impact upon health. These processes will include many of the elements of development indicated in chapter 1, 'The health-environment link' (1.2).

Data are collected for selected core indicators (see 'Healthy City indicators', p. 36) and analysed to provide an overview both of how the city functions and its health status. A good City Health Profile identifies problem areas and gives the policy makers directives as to where to employ resources to improve the status of health in the city.

The city health profile is an important precursor to the development of a **City Health Plan** (see section 4.2, 'Plan strategy and develop a City Health Plan', p. 25), which is a strategic planning document developed in consultation with the wide range of stakeholders who are concerned with health matters. These stakeholders will cover the whole range from city managers, secondary stakeholders or indirect beneficiaries, to the poorest of the poor, who are usually primary stakeholders or direct beneficiaries.

3.3 The settings approach

Identifying the forces that influence a city's health is important, but it is also essential to understand the places where these forces act, i.e. the '*settings*' in which people live, learn, work and play. The settings approach is one of the major attributes distinguishing HCPs from other health programmes.

Municipalities need to work with communities to establish appropriate measures to protect consumers against the risk of contamination resulting from unhygienic practices of cattle slaughter, meat transport and storage. Photo WHO/ AFRO.

The determinants of health and what impacts on it are not only often outside the control of the health sector, they are also contextual. Accordingly, the decisions needed to bring about health improvements should also be taken within a particular context or *setting*. The *settings approach* has been shown to be an effective strategy in the promotion of health in many localities. *Settings* are major social structures that provide channels and mechanisms of influence for reaching defined populations,[9] and include:

- cities, towns, districts, villages, neighbourhoods and islands;
- workplaces, homes, households and families;
- health facilities (hospitals, dispensaries and clinics);
- schools, colleges, universities;
- markets, especially food markets; and
- sport and leisure facilities (parks, recreational facilities, hotels, tourist resorts).

The following are characteristics, opportunities and qualities offered by the *settings* approach that facilitate the promotion of health and sustainable development programmes:

- Each *setting* has a unique set of authorities, rulers, members and participating organisations.
- Each *setting* involves frequent and sustained sets of social interactions.
- Each *setting* is usually organized for more deeply socially and binding purposes than just one single mission of health promotion.
- Each *setting* is characterised by patterns of formal and informal membership and communication.

Integrated approaches based on these *settings*, involving people, the local community, local governments and organizations, can help to put programmes needed for better health into operation. These new approaches to health-environment problems perceive health as an essential component of sustainable development. They are the approaches that are embraced by the *Agenda 21 Declaration*[8] on measures that will produce the healthy and hence supportive environments necessary to achieve sustainable human development.

The Healthy Cities concept draws heavily from this line of thought. The approach creates efficiencies in time and resources for health promotion programming and offers more access and greater potential for social influence.

3.4 The participatory approach to more effective city governance

In order to gain access to all the various *settings*, partnerships need to be forged between government and civil society. The ease with which this can be achieved will depend on the history of any given city. Managers with little experience of participatory approaches may be reluctant to promote such methods if this is seen as a potential loss of control over outcomes for which they may be held accountable. Communities, on the other hand, may be reluctant to participate if they feel they have no power to influence decisions or feel ill-equipped to participate in decision-making.

Healthy Cities Networks provide access to a wealth of experience that can provide both case studies of what has been achieved elsewhere and people who will be able to assist with capacity building. There may be initial difficulties when adopting new ways of

Municipalities can increase their capacity to address the environmental and health problems of urban areas by using the participatory approach.
Photo WHO/ AFRO.

working but experience has shown that participatory approaches invariably arrive at better solutions, since they are more closely attuned to real needs and, owing to a wider support base, are more sustainable.

Community participation is such a central issue within the HCP that it is worth considering its definition. 'Community participation' is defined as a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs.[10] However, it is important to recognize that community participation goes far beyond a simple interaction between the service providers and communities since it is in part determined by the democratic and cultural history of the state. The willingness or even the ability of communities to engage in health programmes cannot be taken for granted.

Involving community representatives from the beginning of an HCP is vital. The process requires time and resources because effective inclusion of community interests is a developmental process. Community involvement can happen at all stages of an HCP including the needs assessment, preparation of a local action plan, establishment of a vision for the community, specific activities and task groups, and management of and advice to the overall HCPs.

Even when good community support has been obtained it is important not to merely consult the communities at the start and then report on progress some time later. Active involvement of the community all along the way will help ensure that the Programme stays in touch with real needs.

Empirical evidence for the benefits of community participation was collected at one of the preparatory conferences for Habitat II, which identified 'best practices' for sustainable development.[11] A clear conclusion from this exercise was that when initiatives are anchored with public support for change and based on self-interest as well as public interest, they stand a better chance of success.

HCPs help local people re-examine the community in which they live and involve them in addressing community health problems. People participate in health through their lifestyle choices, their use of health services, their views on health issues and their work in

When communities are involved in, and actually own, sanitation programmes, they are more willing to intensify their efforts to ensure the success of these programmes. Photo WHO/ AFRO.

community groups. HCPs promote more active roles for people in all of these areas. They provide means by which people have a direct influence on Programme decisions and, through the Programme, on the activities of city departments and other organisations.

While it is essential for people to be able to identify with the Programme, involvement can often be seen as merely getting people to assist in the implementation of plans that have already been made. However, a Programme can hardly be considered to include community participation unless there is a real sharing of decisions with the community from the start.

When this is done properly new projects can make use of local resources and should not put any additional burdens on the national or local economy. With community participation some of the advantages are that more will be accomplished, services will be provided more cheaply, work will be a catalyst for further development and, most importantly, it uses valuable indigenous knowledge and makes people more conscious of their problems, helping them to take control of them.

3.5 The role of local governments

The relevance of local government in Healthy Cities work cannot be over-emphasised. Municipal governments have the most direct impact on the environmental health qualities of cities since they:

- control and operate the economic, social and environmental infrastructures such as schools, fire protection, police, roads, waste collection, potable water supply and sanitation;
- affect and effect the development and implementation of local, regional and national policies;
- oversee municipal planning processes; and
- control land use patterns, zoning regulations, building codes, industrial location and permits.

Lessons on basic hygiene may have little effect if schoolchildren buy their lunch from street vendors selling food off the ground. A simple participatory intervention, such as tables and protection from flies, involving the teachers, traders, parents and scholars, can turn an everyday event into a lesson for life.
Photo WHO/ AFRO.

In short, little can be executed in the city without the approval of the local or municipal governments. If HCPs are placed high on the development agenda of cities, they will help municipal governments of Member States of WHO/ AFRO to:

- give health services a new focus and shift them from reactive and curative services to preventive and community-based ones;
- apply development policies that focus on health;
- build local capacities in order to help local communities to manage their own environmental health problems;
- mobilise all available resources needed for sustainable human development; and
- develop services and programmes that are need-based, given the local *setting*.

Experiences from the ongoing programme in cities have demonstrated that strong political support is essential to the implementation and sustainability of an HCP. Without this, Programmes have little chance of achieving the organisational change, co-operation across sectors and reallocation of resources that are essential to bring about differences in the ways health and environmental issues are tackled in cities.

HEALTHY CITIES PROGRAMMES ARE ABOUT:

- ***a framework - based on Health for All principles;***
- ***an approach - a way of working that involves 'top down' and 'bottom up' approaches;***
- ***a partnership - that spans sectors and involves communities;***
- ***a series of projects;***
- ***in a group of settings;***
- ***a series of strategies and policies;***
- ***'old wine in new bottles' or a new way of doing old things.***

Strong political support for Healthy Cities will mean that the political leadership offers

direct support for the initiative and recognises the importance of community participation and intersectoral action.

3.6 Role of the health sector

At the Earth Summit in Rio de Janeiro in 1992 it was observed that there was a significant absence of health leadership in development planning. Development was primarily focused on economic issues and not on the consequences of these to health.[12] To bridge this gap, *Local Agenda 21* called on the entire health sector to assume leadership roles in environmental health service delivery, and for local governments to enter into dialogue with their citizens in order to incorporate health issues into local development projects.[9] HCPs are local initiatives promoted by the health sector.

The health sector therefore has been challenged to play a leadership role so as to ensure that health concerns are appropriately represented at all stages and at all levels of development. This role includes guidance, advocacy, promotion, co-ordination and evaluation, setting of goals and standards and, above all, becoming an influential voice on behalf of environmental health issues. This function is crucial and may be the health sector's most powerful contribution to sustainable development.

The role of the health sector in gaining and sustaining community participation is to assist in identification of problems and solutions; assist in the solution of health sector-related issues and to facilitate contacts with other sectors, organizations and institutions.[13]

CHAPTER ONE

A framework for implementing the Healthy Cities Programme

An important departure point in setting up any HCP is to recognize that, by its very nature, it has to be tailored to the specific city in which it operates - and within that city to the various settings in which its people (and projects) exist. Thus, there is no standard formula for what will be done, but there is consensus that there are common *processes* which, when carried out correctly, contribute to the success of HCPs.

The material that follows draws extensively on the principles outlined by the WHO[14,15] and Werna *et al.*[16] in books on HCP implementation, with specific reference to developing countries. The WHO Regional Office for Europe in Copenhagen has also published extensively on aspects of HCP implementation[17-19] primarily in Europe, and much of this material can be adapted for use in developing countries.

Much of what follows is based on what is known as 'the twenty steps for implementing Healthy City projects'.[17] However, many HCPs have chosen to combine several of these steps or have found that their order has to be modified to local circumstances. We have also elected to combine some and re-order the steps into what seems to be a logical sequence. Figure 2 summarizes the three phases in establishing an HCP:

- 'Getting started',
- 'Getting organized,' and
- 'Taking action',

plus the various stages that have been identified as essential components of the process. Carefully thinking through what each stage entails and achieves will help to ensure that the programme proceeds smoothly. An example of an 'indicator' or question to ask to gauge progress (usually one of many which can be used) is given at the end of each stage. See also 'Healthy City indicators', p. 36, for a more detailed discussion of indicators.

4.1 PHASE 1: Getting started

Build the support group - *Who do you need in your core team?*

Most HCPs have started off with a group of like-minded individuals who are concerned about health and believe that health promotion has the potential to change population health in a way that conventional health services cannot.

Usually this group has been found among health professionals, although Werna *et al.*[16] argue that owing to the intersectoral nature of the Programme, this core team should have representation beyond health alone. It helps greatly if a charismatic leader with citywide influence, preferably from local government but possibly from a non-governmental organization or the private sector, can be brought on board at the earliest opportunity.

A useful product at this very early stage is an

Action Plan, which is derived by 'brainstorming' the Healthy Cities concept with a few informed and enthusiastic people. Action Plans need not be detailed work plans (see 'Prepare a work plan', on p. 19), but help to chart the way forward and identify some short-term goals.

Action Plans should, ideally, include activities to initiate community participation since activities carried out in the community, on the basis of a common perception of the priority health issues, make an HCP sustainable. Women are often key actors in the community, especially in areas such as housing, water, sanitation, and health services, so the Action Plan should allow for the participation of women in decision-making.

- ***Is the support group representative of the different sectors that will need to be involved?***

Understand the ideas behind the HCP - *how does the HCP differ from the usual health programmes?*

The notion of intersectoral responsibility for health is often regarded as a novel and perhaps even radical notion in many cities. Therefore the initial participants have to go through a phase in which they learn more about the interactions between health and environment and learn the language of people operating in different sectors.

It is one thing for a public health specialist to realise that town planning, housing designs and transport systems have a large influence over the health of a city's population, but quite another for him/her to be able to explain these concerns to an engineer or planner in a way that leads to joint action. Likewise, the constraints under which the engineer is working may be difficult for the health specialist to understand.

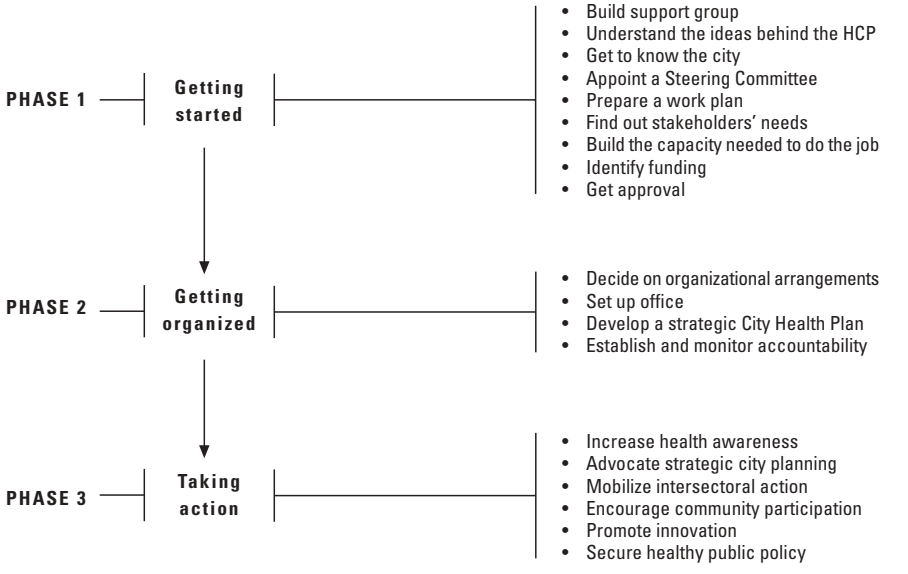


Figure 2. A framework for implementing HCP.
Adapted from Harpham and Werna, 1996.[12]

The WHO has produced many documents describing Healthy Cities initiatives in different countries, and these provide a valuable resource for programmes during their start-up phase. The cumulative experience of hundreds of Healthy Cities practitioners is contained in this documentation, and although it may not necessarily apply directly to the new venture it gives excellent background information. Much of this literature is now available on the Internet, which is becoming increasingly available in many developing countries. It is no longer necessary to wait weeks for a report to arrive - it can often be accessed within minutes via the WHO websites in Geneva (http://www.who.ch) or Copenhagen (http://www.who.dk).

- ***Does the programme have access to WHO documents on HCPs?***

Get to know the city - *what is our city like in terms of health and the way it functions, and who has the most influence over decisions?*

Collect baseline health information

Information is generally regarded as a critical ingredient for effective planning but the type of information collected must be carefully considered. In HCPs the point of departure is usually to collect data on some basic health indicators. The major causes of mortality and morbidity are usually recorded in most cities, but it is important to be aware of the limitations of routinely collected data. For example, if the data are derived from health services, they may provide information useful for planning the management of existing case loads but may also be unrepresentative of the health problems experienced by the city population as a whole.

In general, the most vulnerable parts of a city's population, such as the poor or those living on the fringe of the city, have much lower access to health services and consequently facility-based data may severely under-represent their health problems. However, routine data are usually suitable for general planning and priority setting if the information is interpreted with care.

Other information about the city

Although the conventional health statistics are obviously important, there are many other factors which need to be understood if a successful HCP is to be undertaken. The requirement is for an integrated health pro-

Box 1. Ten questions around which information can be organized

1. What are the important health problems in the city?
2. How do economic and social conditions affect health?
3. Whose support is essential for health?
4. How do city politics work?
5. How does the administration function?
6. What are the concerns of the health care system?
7. What part do citizen groups play in city life?
8. How will national and regional programmes affect the programme?
9. Will business, industry and labour support the programme?
10. Where can information for project development be found?

Source: Werna, Harpham, Blue and Goldstein, 1998.[16]

file that captures both health status and the factors that determine health. Werna *et al.*[16] provide a list of ten questions around which information can be organized. It is evident from the list that this phase is as much about strategic planning as it is about mere information gathering. Typically, this information gathering will need to be a combination of using routinely available data, key informant interviews and *limited* new surveys.

Stakeholder analysis

Understanding who will participate in or influence the Programme is a critical step. Stakeholder analysis is the process used to identify people with an interest in the Programme and to assess the ways in which these interests affect risks and viability.[20] Stakeholders can be categorised as:

- primary (those who are ultimately affected either positively [beneficiaries] or negatively) or
- secondary (the intermediaries engaged in the delivery of services).

This definition of stakeholders includes both 'winners' and 'losers', and those included or excluded from the decision-making process. Burton[21] applied this process in the evaluation of two HCPs and demonstrated the importance of conducting a stakeholder analysis to understand the context in which the programme operates (Table I overleaf).

- ***Has a detailed profile of the city been developed?***

The first activity in stakeholder analysis is the identification and categorisation of groups into primary or secondary stakeholders. Secondary stakeholders are defined as a broader group including but not limited to implementers, managers, collaborators and so on. Most programmes identify stakeholders by document review and key informant interviews but an open forum such as a workshop can be used. Once stakeholders have been listed representatives from different stakeholder groups are asked to identify their interests and involvement in the programme.

Stakeholder analysis is not a one-off exercise. It is critically important at the beginning, when the programme team is trying to find out who will help and who will hinder. Later it is a useful analytical tool which shows who is involved and who is not, and what they have done. The stakeholder analysis helps to establish lines of accountability, which are essential if a programme is to move from mere plans to actual products (see also 'Establish accountability' on p. 27).

- ***Are the stakeholders in agreement on the main health and environment problems in the city?***

Appoint a Steering Committee - *who are the people with the know-how and the skills needed to make things happen?*

Setting up a Steering Committee to guide the programme is the next step. Because of the intersectoral nature of the HCP, the Steering Committee should ideally have representatives from as wide a range of stakeholders as possible.

The structure shown in Figure 3, proposed in some of the early documentation on HCPs,[22] provides useful examples of the types of people likely to be involved at two levels, namely the Steering Committee and the Technical Committees or Working Groups.

Table I. Examples of stakeholders and their interests/expectations (adapted from Burton, 1999[21]).

STAKEHOLDERS	INTERESTS/EXPECTATIONS
Primary	
Residents of informal settlements	Improved opportunity for income generation; safe environment; development in informal settlements; clean streets and city; good roads
Unemployed	Improved job opportunities; safe environment; education for children; clean environment
Migrants/homeless	Housing; land
Hawkers	Better standard of living; increased employment; health awareness; education for children; increased services (e.g. sanitary latrines and tube wells); clean environment
Tenants	Clean environment; safe neighbourhood
Youth	Improved quality of education; clean environment; health services; improved planning of city activities
Schools	Improved facilities such as sanitary latrines; status as a 'Healthy School'
Secondary	
Local political leaders	Ownership of programme; control over resources; public support
Municipality staff	Job opportunities; opportunities for travel; making contacts; access to funds; more effective service delivery
Programme staff	Control over funds; status; doing a good job
Health ministry	Achieving common objectives; a means of getting intersectoral support
Environmental Affairs	Achieving common objectives; a means of getting intersectoral support
Medical staff	Increased awareness of public health (preventive as opposed to curative approaches); additional health facilities in priority areas
Traditional healers/birth attendants	Role in health promotion; possible decrease (or increase) in income
International agencies (WHO, UNICEF, etc.)	Achieving common objectives (e.g. 'Health for All'); effective use of resources
Regional government/administration	Increased services to people and slums outside the municipality
Local government (municipality, city council)	Opportunities for promoting better city planning; greater sensitivity to community needs; mechanism for popular involvement in service delivery
Water and sanitation	Complementary process to mere engineering solutions thereby making service delivery more effective
Planning	Opportunities for promoting better city planning
Education	Improved learning environment
Law enforcement	Safer communities; community policing
Traffic and Transportation	Addressing air and noise pollution; reducing road traffic accidents
Non-governmental organizations	Achieving common objectives; making contacts/networking; collaboration with government
Community-based organizations	Their role in a development project; religious and social influence
Private sector	Increased income; improving businesses; attracting tourists; corporate social investment - positive publicity
Trade unions /Labour associations	Improved work opportunities; healthier workforce with better quality of life
Home owners	Higher rents; safe clean city; healthy environment
The media	Role in dissemination of health messages, 'newsworthy' events

The specific members will vary according to the city's management structure and particular tasks. Members of the Steering Committee need to be influential in city decision-making, so it is important to have high-level political support for the committee. Ideally, the Mayor or Chief Executive will chair the committee, although this function is often delegated to an official. The Steering Committee has responsibility for the overall management and co-ordination of the programme. The Technical Committees or Working Groups can have members from many different sectors and are set up to address specific projects. One important stakeholder which is not specifically shown in this example is the private sector, which should be included whenever there are opportunities for mutually beneficial alliances relating to corporate social investment.

- ***Is the steering Committee representative of all the sectors and local stakeholder groups?***

Prepare a work plan - *can we describe our plans in a way that is accessible and attractive to all the stakeholders?*

Having decided on the proposed strategy for starting the HCP, it becomes necessary to put the ideas on paper in a form that can be easily understood by the wide variety of stakeholders who will need to be involved. The **work plan** needs to be concise, clear, convincing and realistic. It must outline the organizational structure, the specific goals of the Programme and the methods it intends to employ (see Box 2 overleaf). While it is necessary to make the Programme exciting enough to attract prospective supporters, the proposal should be careful to indicate realistic objectives and measurable targets.

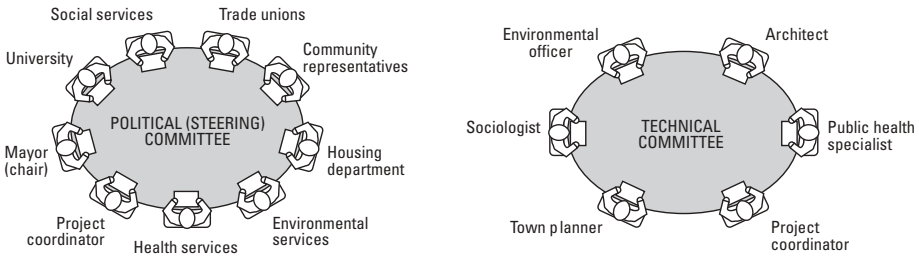


Figure 3. Examples of the multisectoral Steering Committee (left) and one of the Technical Committees or Working Groups (right). The Technical Committee shown would be typical of a healthy housing project.
Source: WHO, 1991.

Box 2. Guidelines for a Healthy City Work Plan

Work plans should describe:

1. The principles on which the Programme is based (Health for All)
2. The aims of the Programme
3. The unique role it will perform
4. The major strategies it will use
5. Its organizational structure
6. Its key supporters
7. Its estimated cost and potential sources of funds

It helps to remember that the City Council will want to know:

1. How the Programme will help with critical problems in the city
2. What is new about it
3. How it will fit within the present city administration
4. What visible results it will show
5. How different groups in the community will react

Source: WHO, 1995.[17]

- ***Is there a proposal with clearly defined objectives?***

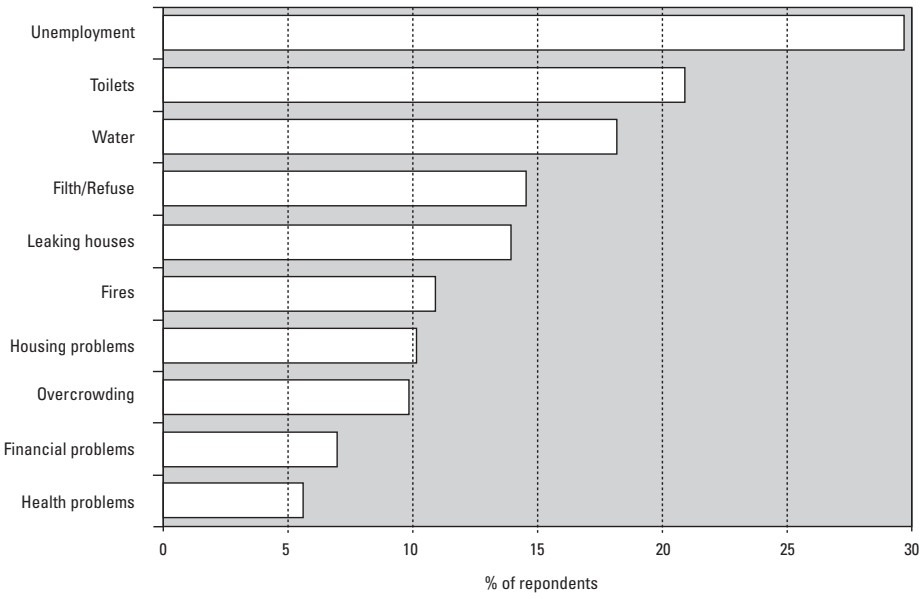
Find out stakeholders' needs (define Programme) - *what do the stakeholders want done?*

The various technical committees or sectoral task forces have a major role to play in identifying the needs - and therefore the priorities - of the various sectors. The intersectoral partnerships and community involvement will lead to priority lists which may differ substantially from conventional health planning models. This is a good sign since it indicates that the Programme is beginning to address real perceived needs of the city's residents.

The decisive test for participatory development is the extent to which the conventional planning processes are able to take cognizance of *and respond to* community-expressed needs. For example, a needs assessment conducted by health professionals in a typical low-income community is likely to show that the foremost priority is jobs, followed by infrastructure such as sanitation and housing, with health matters appearing well down the list (Figure 4). While the standard response of health professionals might be to conclude that they are unable to address the perceived priorities of the community, the more appropriate response is to develop a holistic health intervention which addresses the perceived needs of the community *and* improves health at the same time (see Box 3).

How one arrives at appropriate priorities is beyond the scope of this manual, but these priorities are usually subjective and will be influenced as much by political and financial considerations as by hard facts. Werna *et al.*[16] suggest that final decisions regarding the projects to be undertaken should rest with the Steering Committee. Since financial resources will always be a limiting factor, a good rule of thumb is to tackle those issues which contribute the most to reducing the disease burden at the least cost, especially

Figure 4. Perceived priorities of a typical developing community.



Adapted from Mathews, van der Walt, Hewitson, et al., 1991.[23]

where there are opportunities for capitalising on resources such as poorly utilised infrastructure and human capital.

- ***What processes are used for reviewing and revising priorities?***

Box 3. Jobs are needed before health improves. The Philani Nutrition Project, Cape Town, demonstrates an appropriate response to the primary need of mothers of undernourished children.

Each Philani Centre (meaning 'to get well') comprises a nutrition centre, an educare programme for pre-school children, a woman's clinic and a skills training and employment centre. Malnourished children between 2 and 6 are referred to the Centre by local clinics, community health workers, social workers and from a house-to-house visiting programme.

Mothers receive training in child care, nutrition and general health matters. In addition, the mothers are offered 3 months' training in weaving and the use of the Philani looms for producing carpets to generate an income for themselves. The weaver receives 67% of the income from the carpets with 33% being returned to the Philani Centre.

Philani hopes to be perceived as a place where women can share and analyse their problems as well as become empowered through skills training while their malnourished children are being rehabilitated.

Source: Matolengwe, 2000.[24]

Build capacity - *who do we need to train for the work that needs to be done?*

Having placed all the ideas on the table, it is now necessary to identify the resources that will be needed. Media campaigns and workshops will be necessary precursors to action, especially in cities where the population has not been used to participatory governance. This stage deserves careful attention, and although capacity building can be a slow process it will pay large dividends in the long term.

Training in basic matters such as how to run meetings and achieve consensus through debate may be required before citizens can participate in workshops, and courses explaining the interactions between the environment and public health may also be necessary. In populations with low literacy levels training material available in the form of videos and slide shows is preferable. Videos can be particularly effective in transmitting the enthusiasm from successful projects elsewhere to new cities (examples can be obtained from WHO).

- ***What opportunities for training has the Programme provided?***

Finances - *how will the Programme be funded? Do we need to look for donors or can we make a start with existing funds?*

Any HCP stands or falls by the ability of its programme leaders to budget effectively and identify sources of funding. While it is possible to run an HCP on a small budget within existing structures, some additional funding usually needs to be raised or reallocated from within existing budgets in order to publicise the Programme and support its basic infrastructure. Financing of the longer-term objectives is such a crucial component that it warrants a member of the Steering Committee dedicated to the task. Much of this task relates to following up on needs identified during stakeholder analysis in the 'getting started' phase.

HCPs in developed countries tend to have the advantage that the cities in which they were established had considerable resources. In the developing world cities may be severely under-resourced and often lack the capacity for complex programmes of this kind. In the latter case it is important to recognise the advantages of starting with small demonstration projects which, when successfully executed, can subsequently be used to mobilise resources for larger ones.

However, even small projects require funding, but if the needs of the city have been sufficiently well investigated in step three, it should be possible to prepare proposals that specifically address some of the existing concerns of local government. In this way existing funds may be made available for the new initiative if the proposal is sufficiently convincing and indicates that an issue on the current political or service agenda will be addressed.

One of the attractions of the HCP is that it can pool resources from a number of sectors and thereby bring both additional resources to bear and improve efficiency of existing initiatives. There will often be tangible advantages in implementing new development initiatives when there is direct community involvement at an early stage. It is for these reasons that proposal writing needs to be taken very seriously and should make use of both technical and marketing expertise.

An important consideration with regard to finances is that HCPs are rarely beneficiaries of major donor funding, since the Programme is specifically designed to be self-sustaining. There are exceptions, especially when there is a need for training or other capacity development initiatives, but the HCP should not be seen as a donor-driven programme. If external funding is sought it should be for specific, well motivated priority issues, and donor agencies are more likely to view such requests favourably if there is already evidence of optimal utilization of local funds and organization of resources. Werna *et al.*[16] point out that there is insufficient donor funding to solve the many problems facing the cities of the developing world, so self-help initiatives have to be regarded as the only sustainable approach.

- ***What efforts are being made to mobilize the resources needed for the Programme?***

Get approval - *can we obtain high-level political commitment?*

Clearly, once the proposal is written approval must be sought for its implementation. This approval should ideally be obtained at the highest level possible. Thus, if the objective is to have the proposal adopted as part of the city's management strategy, it needs to work its way up from, say, the health department for approval and support by the full Council or Executive body.

Many HCPs have been championed by Mayors, although the relatively rapid turnover of political appointees may be a problem in long-term ventures such as these. Ideally, health is an uncontentious issue which should receive support from any administration. However, there are many examples of Programmes started by one administration which were not supported by the next. One way around this problem is to ensure that the Programme becomes 'entrenched' in the city's management systems so that it cannot easily be uprooted or ignored. Alternatively, support for the initiative from civil society is likely to ensure that there will be popular demand for its continuation.

The strategy for obtaining approval will depend very much on the political climate in the particular city. In a progressive, democratic environment in which the local authority gives public health high priority, the standard models will apply. In a less progressive or even hostile environment the task is harder and popular pressure under the banner of human rights may be the appropriate response.

- ***Have the politicians identified and accepted their roles in the HCP?***

4.2 PHASE 2: Getting organized

Decide on organizational arrangements - *where will the Programme find a 'home'*?

The affiliation of the HCP to city management structures is a critical component of success. Considering that the long-term goal is for the Programme to be integrated into city management policies, it makes good sense for the Programme co-ordinator to be located within the city administration. However, experience has shown that when the task of co-ordination forms part of the many duties of an existing official, it tends to be neglected. The ideal is for the co-ordinator to be a

dedicated full-time position. In some cases agencies such as non-governmental organizations (NGOs), research organizations or the private sector have seconded a person to the local authority or help to set up an (initially) independent Programme office.

- ***What factors influenced the choice of the Programme co-ordinator?***

THE HEALTHY CITIES PROGRAMME CO-ORDINATOR HAS TO:

- ***mediate, facilitate, enable;***
- ***co-ordinate;***
- ***innovate;***
- ***network;***
- ***support;***
- ***manage staff, strategies and plans;***
- ***spot opportunities and make links;***
- ***keep an eye on the city as a whole - the 'helicopter' effect;***
- ***be a change agent and catalyst.***

Set up office - ***where will we set up a visible presence as the central contact point for the Programme?***

In the model proposed by the WHO,[17] setting up the Healthy Cities Office only takes place after extensive preparatory work. It can take a year or two of extensive consultation to reach this stage. Two main types of Healthy Cities Offices have been established in the past:

- one tends to be tucked away in the administrative offices of the local government;
- the other has a high profile position on a main street.

Clearly these two offices tend to have different functions: the first is well placed to influence city decision-making, whereas the other gives the Programme a public profile from which it can engage with the city's population.

Providing public access to Programme resources is an important aspect of HCPs. Ideally there should be a resource centre open to all health-related initiatives which provides services, including information (literature, posters), expertise (health advisors, proposal writers) and access to funding (either directly from the HCP itself or by linking communities with appropriate sources of funding). In under-resourced developing country cities it may be easier to find a spare office in the local municipality than to open a new one elsewhere. If this is the case, publicity must be achieved via active promotional campaigns, community outreach initiatives, and so on.

Once the office has been identified, a Programme co-ordinator must be appointed who has a sufficiently broad health, environment or development background to allow him/her to facilitate intersectoral collaboration around health. It helps if this individual has good local knowledge and contacts with both local government and community organizations. Strong communication and motivational skills and the ability to maintain complicated networks are also important. The Steering Committee should be directly involved in the appointment process even though the post may be on the establishment of the local government or NGO.

- ***Does the Programme have a visible presence and who uses it?***

Plan strategy and develop a City Health Plan - *can we get agreement on what needs to be done?*

By this stage general priority health and development issues should already have been identified and a suitable co-ordinator appointed. The next step is the drawing up of a **City Health Plan** (Intersectoral Health Promotion Plan) which aims to *operationalize* the Programme. This plan is an example of a *participatory* process and outcome towards which the whole city is working. The WHO has developed an outline for a City Health Plan for building a Healthy City, and this plan is a key component for ensuring that municipal governments move towards healthier public policies. The Plan consists of two main components: the one to gauge community perceptions of health problems in the city, and the other a technical assessment of the relationships between environmental and social conditions and health. It is critical for **community participation** to be part of the process for drawing up the Plan. The Plan must also make allowance for the limitations any city government faces in that many policies are directly or indirectly determined at provincial or national level.

A well thought out City Health Plan becomes a valuable tool for guiding the Programme as it progresses, but it must be flexible enough to be adapted to changing circumstances along the way. (See Box 4, overleaf.)

Box 4. The City 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 multisectoral team of community representatives and organizations, Ministry of Health (MoH) staff, NGOs, university representatives, representatives of the Mayor's office, representatives of hospitals and the media. The Plan is consistent with any national urban health plan/planning guidelines of the Ministry of Health or the Ministry of Urban Development, 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 Ministry of Health, or NGO or municipal office; and
- public hearings 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 United Nations, bilateral agencies and NGOs that can potentially contribute to solutions to health problems;
- identify potential mechanisms for partners to work in a more co-ordinated manner in addressing problems; and
- identify and rank the priority actions and programmes, including setting of targets, and evaluation plans.

Ensure action
- Obtain commitment of community leaders;
- train municipal staff and community participants;
- publish stories and reports in local media;
- monitor, evaluate and publish annual health status and activity data.

Source: Werna *et al.*[16], 1998.

The City Health Plan differs from conventional health plans in that it generates awareness of health issues among City authorities, non-governmental organizations and communities *simultaneously*.

The processes leading up to the development of a City Health Plan build on the initial City Health Profile (see 'Get to Know the City', on p. 16), which helped to identify priority areas for action. The participatory process allows those stakeholders who are in a position to contribute to health improvements to contribute their knowledge, skills and services from the outset. This is so much more effective than approaching stakeholders with a question such as: "We have a great plan, wouldn't you like to join us?". The alternative resulting from a participatory City Health Plan is: "This is *our* plan [i.e. developed jointly by representatives of all the stakeholders] and we are going to take it forward together".

Publicising the *City Health Plan* contributes to raising awareness about the health and environmental situation in the city. The media has a crucial role to play in promoting the Plan and raising awareness about the Healthy Cities Programme. Other important strategies are workshops aimed at the transfer of technical skills and community meetings.

- ***To what extent have the community's views been incorporated in the City Health Plan?***

Establish accountability - *who is going to do what?*

Getting agreement on the principles of Healthy Cities may be relatively easy, but carrying this agreement through to action is somewhat harder to achieve. From the outset it is important to assign responsibility to individuals, departments and communities, and to put in place mechanisms for evaluation of progress. At community level, it can be useful to develop 'social contracts' in which communities 'sign up' to formally acknowledge their support for a given project. Regular reporting, both written and verbal, helps to track accountability and to monitor progress.

- ***Do agreements exist at all levels?***
- ***Is there provision for follow-up to ensure that agreements lead to action?***

4.3 PHASE 3: Taking action

Increase Health Awareness - *how will we take the vision to the people?*

Once the nature of the problems is understood and the systems are in place for managing the Programme, the time comes to translate knowledge into action. The key stakeholders will have already been made aware of the Programme, but now it is necessary to take the vision to the broader community. A popular word for the required process is 'empowerment', which means providing people with the information (power) to make better decisions regarding their lifestyles, environment and health.

Active promotion activities are necessary to get the Programme accepted as a part of the everyday life of the city's population. Coverage must be provided in all forms of media and through local action. Projects often increase health awareness through relatively inexpensive activities such as clean-up campaigns and competitions for

school children, which provide a platform for broader health and environment issues. Africa has a rich tradition of popular theatre, song and dance that is a very effective medium for health promotion.

- ***What activities have been implemented in order to increase public awareness of health issues?***

Advocate strategic planning - ***are there opportunities which we can grasp as they arise?***

Moving beyond the broad information campaigns in the previous step, the Programme needs to set about strategic planning. These plans need to set goals for the next 3-5 years and identify the opportunities within the city and its management processes for achieving them.

Strategic opportunities for changing policy need to be recognized well in advance and built upon as policy development proceeds. For example, if the city transport system is in disarray (a common feature of many rapidly growing cities) it is likely that, sooner or later, a revised transport policy will have to be developed. This event can be grasped as a strategic opportunity for advocating healthier transport options such as less polluting vehicles, restrictions on the use of single-driver private vehicles, improved efficiency of public transport, etc.

- ***Is the Programme engaging in strategic partnerships with city management and planning processes?***

Mobilise intersectoral action - ***how will we promote the city as a single economic and health development unit?***

The next requirement is to develop strategic partnerships among departments and the stakeholders in the city. There will be many people in a city who subscribe to the basic ideals of the HCP but remain detached and cannot see an obvious role for themselves. Health impact assessments can serve a useful purpose in demonstrating not only the health impacts of, for example, development and industrialisation, but also by providing incentives for healthier approaches in the form of financial benefits.

Alternative ways of doing things are often thought to be too expensive, but a thorough cost analysis can highlight the high consequential costs of poor health and motivate for change. However, while departments operate independently it can be difficult to get executives to accept responsibility for impacts in other sectors. This has been cited as one of the reasons for the failure of intersectoral collaboration in the past.

Recognition of the city as a single economic unit in which all sectors have to succeed (or fail) is a critical step on the way to effective intersectoral action.

- ***Are representatives from each major sector involved in the Programme?***

Encourage community participation - ***how will we ensure that the ultimate beneficiaries have 'ownership' of the Programme?***

An essential component of the Healthy Cities movement is that it needs to be 'owned' by the people of the city and is not merely a 'top down' process. Buy-in from local govern-

ment is important but the ordinary citizens must be involved for the Programme to work. The key question which needs to be asked is "Who is involved and why?"

Community participation is regarded as such a key element for successful implementation of the Healthy Cities Programme that tools for promoting community mobilization are discussed in detail in chapter 5.

- ***What measures are being taken to ensure that all strata of society are included?***

Promote innovation - ***how will we share ideas with others, and publicise the 'best practices'?***

Many of the concepts involved in the HCP are innovative and will require new approaches for them to be successfully implemented. For innovation to be accepted, the Programme needs to promote a climate that supports change. On the one hand this may require challenging the existing way of doing things, and on the other, finding good examples of innovative approaches which have had a beneficial impact.

One way of promoting innovation and change is to facilitate exchange of ideas between cities. The WHO supports Healthy Cities **networks, workshops, conferences** and **seminars** that are appropriate for ensuring that 'best practices' are identified, shared and implemented elsewhere.

- ***Is the Programme learning from and contributing new ideas to other programmes?***

Secure healthy public policy - ***can we entrench the ideas in policy for the achievement of longer-term goals?***

The ultimate objective of the Healthy City movement is to ensure that local public policies contribute to the development of an urban environment that promotes health. Health awareness is a driving force for change since it generates demand from the population for a healthy public policy. This, in turn, should lead to a response from city departments to take action.

Strategic planning helps to promote the idea of taking a longer-term view and a willingness to implement programmes and plans that may take many years to achieve results. Such initiatives may be less popular with politicians, whose term of office is relatively short, but are more likely to produce a lasting legacy than are minor adjustments to short-term initiatives.

Intersectoral action potentially releases resources for health not otherwise optimally utilized. Community participation also brings people's needs into the policy development process and contributes directly to improved quality of life by engendering a sense of 'control' over the living environment.

Finally, innovation and the processes of trial and evaluation contribute to incremental improvements in public policies. Understanding the full health impact of current policies and sharing experiences of alternative approaches allows new policies to be developed with greatly reduced risk of failure.[16]

- ***What mechanisms exist for integrating successful activities into city policies?***

CHAPTER FIVE

Tools for implementating the Healthy Cities Programme -

how should the work be done, what will be achieved, and how will we measure it?

5.1 Mobilizing the community

In many African countries a major constraint upon community participation is lack of experience of engaging with the policy-making and development process. Programme initiators may interpret this as a lack of interest on the part of the public, but with appropriate facilitation and capacity building great enthusiasm can often be aroused.

Skills which need to be shared with communities include communication, marketing, management, leadership and, often most important, assertiveness in communities which feel that they have never had a voice and therefore do not expect to be allowed to participate. It is also necessary to be aware that participation must have tangible benefits. The unemployed and people living in poverty-stricken environments may appear to have plenty of free time, but this may not be the case. An enormous amount of time is devoted to obtaining the necessities of water and food for mere survival.

Individual and community perceptions about health and the likely benefits of participating in particular health activities are also crucial determinants of community participation. Many communities in both the developed and developing world have limited understanding of the determinants of health. It is therefore important to work within peoples' frame of reference. **Workshops** are required to educate the community regarding involvement in health, environment and nutrition projects. One useful approach is to hold '**Vision Workshops**' which encourage people to develop a positive health vision for their city and to move from accustomed thinking to alternative solutions.

Before engaging with a community it is necessary to establish the **community profile**, usually by conducting a small survey. Rapid Appraisal (RA) methodology has been advocated for this purpose and is based on the premise that relevant and necessary information may be gained from available local knowledge using community representatives. Community characteristics of interest include geographic, demographic, social, cultural, economic and political environments, within a historical setting. Understanding community structure and organization is also important in predicting how a community will react to new ideas.

Boxes 5-7 (pp. 31-33) contain case studies which demonstrate the importance of adapting the approach to community mobilization dependent upon the specific circumstances of the city or setting.

Box 5. Different communities within the same city require different approaches: Examples from Ibadan, Nigeria

In the early 1980s Ibadan consisted of a **traditional core,** a **transitional zone** and a **suburban periphery.** Groups existed which had differing orientations ranging from traditional family councils to modern landlord associations. There was a resentment of the new modern landlords by the old traditional councils owing to a scarcity of land. The suburban area was characterized by modern low-density residential estates, institutions of higher learning and some small villages upon which the city had encroached as it expanded. The suburban periphery had little community identity and interaction was restricted to a range of competing religious and landlord groups, many of which included absentee landlords.

In the **traditional core**, waste removal was identified as a priority but land was so highly prized for economic, historical and spiritual reasons that making space available for refuse dumps and/or access roads was deemed impossible by the **traditional family** councils.

In the **transitional zone**, initial Healthy Cities activities focused on interventions at ward level but the wards contained too many neighbourhoods or communities for joint actions to be effective. Subsequently, a Community Health and Development Council was elected to attend to the identified problems. All members were **immigrant landlords** with strong links to city and state agencies. The project focused on improved drainage at primary schools, minor road repairs, pedestrian crossings and road safety education.

Observing the successes of the immigrants motivated the **traditional family councils** to form their own health committee and start similar projects. Successful projects included a market clean-up campaign, regular collection and burning of refuse in areas inaccessible to refuse trucks and minor road repairs that the people could undertake for themselves.

In the **suburban periphery**, the lack of community identity made it difficult to find an entry point. Landlord associations proved inappropriate owing to most of the landlords not living in the neighbourhood, so a **primary school** was selected as it offered an opportunity for engagement via the parent-teacher association and scholars. The first project identified by scholars was to collect concrete blocks left over from other building projects and to use these to build an incinerator at the school to process the waste indiscriminately dumped on the school grounds. Despite the intervention being designed with full participation of *local* stakeholders (scholars and parents), it could be criticised for failing to address the real problem, which was the dumping of waste on the school grounds. If the waste from outside could have been controlled, a simple pit or trench could have dealt with the school's own waste requirements. However, this example shows how one project can lead to another and deal with problems in stages.

Source: Brieger and Adniyi, 1982.[25]

Box 6. Building partnerships: Buguruni Healthy Market, Dar es Salaam

At Buguruni Healthy Market a partnership was formed for the provision of technical and financial support. This partnership included market vendors, the Buguruni Market Co-operative Union (a community-based organization), the City Council (Health Department and Trade and Planning Department), the Ministry of Health, the National Food Control Commission, Plan International (an NGO), and the WHO. These partners were involved in planning and implementing activities to improve the environmental conditions and food safety at the market.

The roles of various groups and agencies were as follows:

- The multisectoral task team assessed problems and needs and drew up an action plan and provided technical assistance and advice for the initiative.
- The community, through the vendors' co-operative association, identified their priorities, proposed solutions and designed mechanisms for mobilizing resources and community management.
- Local and Municipal officials played an essential role in facilitating a survey and providing technical and financial assistance and basic data necessary for planning. They also provided approval for the public latrine, water supply and regular supervisory visits.
- Plan International and the United Nations Development Programme, Local Initiative Facility for Urban Environment (UNDP/LIFE) Programme participated in planning meetings and provided financial and technical support for the improvement of the public latrine and water supply at the market.
- WHO Headquarters and country office Tanzania provided overall technical and financial support. Part of this support included food safety training.
- The vendors' co-operative was instrumental in following up implementation of agreed activities.

The process was not without its difficulties. After long negotiations with the City Commission the vendors entered into a contract with the municipal authority to run the latrine and water supply on a 'user pays' basis. The association took responsibility for cleaning and maintenance. The facility was recently reported by a WHO Healthy Market-Places mission to be one of the best managed public latrines visited.

Source: Hawa Senkoro, ex-Healthy City Project Co-ordinator, Dar es Salaam, Tanzania.

Box 7. Initiating community participation is not always easy: Ocean View, Cape Town

The Ocean View Healthy Cities initiative in Cape Town began with a presentation to the local council, which secured political buy-in to the Healthy Cities concept. The municipality then held a workshop for its staff to extend the understanding of the Healthy Cities philosophy and to obtain their buy-in to the project. At this stage there was confidence in the proposed ideas and a site was selected for a demonstration project.

Ocean View was selected owing to its geographic location (convenient and a clearly circumscribed area), a very poor tuberculosis (TB) cure rate (as low as 38% in 1996/97) and poor waste management practices, these characteristics being issues that the local authority felt it could realistically address.

A workshop was then held to present the Healthy Cities Initiative to the Ocean View community. The workshop included presentations on Healthy Cities, TB and waste management and also sought information on issues the community regarded as priorities. Unfortunately, the workshop was not very well attended nor was it representative of the community, but those present appeared to accept the priorities identified. An Integrated (intersectoral) Working Group (IWG) was formed comprising 4 elected councillors and officials from various departments within the council; it was co-ordinated by the Health Directorate. However, a second workshop was so poorly attended that a 'boycott' was suspected: clearly something had 'gone wrong' and it appeared to be more than merely poor advertising of the meeting. Longstanding political differences within the area meant that there were suspicions about the motives of the local council, and some members of the community were apparently unhappy with the process which had been followed. There was existing information on community needs that was not utilized.

Here we have an example of a well-intentioned project being vetoed by a community that did not feel sufficiently involved in the process and suspected a hidden political agenda. When one looks at the overall course of the events in Ocean View, some of the obstacles could have been avoided had the proponents of the Healthy Cities Initiative spent more time on the *community profile*, especially its political dynamics. Furthermore, it would probably have been of more value to the process had the community identified their own needs, as opposed to being told by the organizers of the workshop of how 'they' saw the priorities. This would probably have ensured a greater commitment by the community to the Healthy Cities Initiative and have contributed to its sustainability.

Despite the initial setbacks, successes to date include numerous clean-up campaigns involving scholars and students; an indirect contribution to the TB cure rate increasing from 38% to 87% (probably relating to a general improvement in community awareness of health matters), and a community survey on perceptions of health, waste and sanitation in order to identify further priorities. The remaining challenges facing the Ocean View Initiative include the ability of the municipality to meet concerns raised in the community health survey despite limited financial resources, and sustaining commitment from all role-players.

Based on interviews with Ian Gildenhuys, South Peninsula Municipality, Cape Town, and Trevor Edwards, Ocean View Development Trust.

In addition to the community profile, it is important to conduct a **community needs assessment**, as felt needs exert considerable influence over the process of community participation. Very often communities reject the best intentions of community development agencies since they themselves have different priorities (see Box 7). Health care is often perceived as curative rather than preventive or promotive, and this perception may inhibit community participation in health activities. The following statement typically sums up this concept: "I am not sick, so why should I be concerned with health matters?" The nature of communities' perceived needs may also serve to remind developers to consider intersectoral approaches since the typical needs of a community will not be limited to skills available, e.g. within the Health Department or Housing Department alone (**see Figure 4, p. 21**).

In some situations the community can be mobilized around popular issues such as housing or sewerage before undertaking more direct health interventions. Success in one area - especially if it addresses a strong community need - is likely to create greater commitment to longer-term objectives. However, care must be taken to ensure that the participatory process is not exploited as a means to an end or merely achieving the preconceived plan. True participatory planning must allow stakeholders to review and, if necessary, to *reject*, the original proposal.

Media coverage can influence both policy development and community participation. People are more likely to get involved in a project or programme which is receiving publicity than one that, although possibly doing good work, remains unknown to those outside its immediate influence. Publicity is also attractive to politicians and the private sector. Politicians need to secure popular support, and they can do this better if they are seen to be 'getting involved'. Likewise, the private sector may be attracted by opportunities for positive publicity related to corporate social investment. In successful HCPs, local newspapers and radio, and occasionally national newspapers and television have covered key events. In the absence of formal media local events were often broadcast to the community through the use of mobile loudspeakers, leaflets and posters.

Advocacy and **lobbying** are also important tools for Healthy Cities practitioners. In addition to the relatively passive publicity arising from the media, there is no substitute for one-on-one meetings with influential people. A good Healthy City co-ordinator will never miss an opportunity to talk to the press, officials, politicians or community leaders about the exciting opportunities contained within his or her HCP.

Cultural sensitivity requires attention to the natural workings and structure of the community. A new HCP should review relevant existing initiatives within the city and, whenever possible, integrate them into the Programme or integrate Healthy Cities activities into them. The ability of Healthy City practitioners to recognize the merits within existing structures is an important ingredient for success. No matter how small these existing initiatives, recognition of their worth (albeit with adjustments) can give the Programme's facilitators much greater credibility. Any appearance of coming in with 'all the answers' and 'foreign' or 'new' ideas without giving due credit to the resources already in place will quickly alienate the people from the Programme.

In the African urban neighbourhood one might find traditional councils of elders or elected representation to modern decision-making bodies or both. Restrictions on leadership and decision-making are based on age, sex, and inherited status. There is often limited participation for women and younger men. Open conflict is often suppressed. **Identity** is an emotional bond that holds a neighbourhood together, giving a sense of belonging. It often has an ethnic or historical base. Identity in urban African neighbourhoods manifests itself in numerous ways. One may find cores of traditional indigenous residents or clusters of ethnically homogenous immigrant populations. Women and children, who generally spend a greater part of their time in their local neighbourhood, are more likely to respond to its social pressures and identity.

A question which frequently arises is how does one identify appropriate local leaders and how is the concept of representation to be understood? In general, it seems that if competent leadership already represents a community's needs, it is best to accept this leadership. It is unwise to impose your own concept of proper representation. Community-wide committees may seem appealing but may cause difficulties, especially in the case of a politically polarised community. When working with communities it is important for Healthy City practitioners to serve as its consultants and not to take on the role of director.[21]

5.2 Techniques for monitoring progress

As part of the monitoring of HCPs it is necessary to be able to quantify progress and make information accessible to all levels of society. A variety of methods are desirable, ranging from simple graphic images such as cartoons, through to charts and tables. Different types of presentation will be required for various potential audiences.

Sophisticated analysis will be required to assess the longer-term benefits of the Programme and address issues such as cost-benefit analyses. These analyses must be carefully designed to measure progress along the way, usually captured by 'process indicators', in order to avoid the pitfalls of

SOME PRACTICAL GUIDELINES FOR COMMUNITY DEVELOPMENT INTERVENTIONS

- ***Work within the boundaries of the community as identified by residents themselves.***
- ***Work through local interaction mechanisms such as recognized leaders and organizations.***
- ***Allow for interaction problems such as factionalism and work for greater community harmony.***
- ***Recognize, respect and respond to existing orientations, values and motivations.***
- ***Do not force foreign norms and ideas on people.***
- ***Utilise internal resources where possible.***
- ***Foster external linkages in a way that will help the community to form its own future links.***
- ***Seek external resources that are compatible with the community's economic and cultural patterns.***

abandoning a Programme prematurely because of a perceived lack of tangible outcomes. Just as importantly, realistic monitoring programmes are necessary to avoid continuing with a project for which there is no evidence of real benefit.

Healthy City indicators

Gathering information to monitor progress can be costly both financially and in terms of effort. For this reason **indicators**, which summarize a range of processes and/or outcomes, are often the method of choice. There may be a great deal of information already available within the city, but this needs to be carefully screened regarding its usefulness for monitoring the particular programme. Quantitative data are appealing but routine data are often incomplete or suffer from various selection biases (see 'Collect baseline health information', p. 16). Since our interest is to understand not just health status but also the overall determinants of that status, qualitative data are also required.

General criteria for the selection of sound and practical indicators include:

- sensitivity to change and difference;
- comparability, preferably both within and between cities;
- clarity in terms of clear meaning and significance;
- interpretability in that they can be analysed; and
- ethics with regard to such issues as privacy, personal autonomy and collection methods.

The principal criteria used in selecting specific indicators for a given study should be:

- relevance to the objectives of the programme;
- validity regarding determinants of health;
- measurability (both quantitative and qualitative); and
- availability at reasonable cost and at the required level of desegregation, i.e. so that the information obtained is useful at the local level.

The issue of indicators which can be collected at reasonable cost and which are useful at the local level cannot be over-emphasized since data quality is in part determined by its perceived usefulness to those who collect the data. Limitations with regard to the quality of routine data need to be recognised and improved if possible, but intensive evaluation procedures tend to be expensive and difficult to sustain. There is merit in conducting a full evaluation every 5 years or so and, indeed, some funding agencies insist upon this, but relatively simple indicators should be selected for routine use.

It is also important, however, to guard against selecting simplistic indicators for the evaluation of HCPs. Evaluation should not only focus on outcome indicators such as improved health status, but also give considerable emphasis to process indicators such as the way in which decisions are taken with regard to matters which impact upon health. Nutbeam[26] recently discussed this issue and emphasized the need to distinguish short-term impacts from longer-term health outcomes in the evaluation of effectiveness in health promotion initiatives. 'Hard' outcomes such as changing disease patterns may take decades to achieve, whereas there may be outcomes such as changing attitudes and policies, which promote health and are detectable in the short term. These changes may be intermediate outcomes for better long-term health.

An environment that meets adequate norms of hygiene and cleanliness will help preserve the physical, mental and social health of the individual, the family and the community. Photo WHO/ AFRO.

There is considerable debate as to whether locally designed or internationally comparable indicators should be used to evaluate Healthy Cities Programmes (see Werna *et al.*,[16] pp. 86-103). It has been said that given the reluctance of new 'converts' to the ideals of HCPs to expose themselves to evaluation, a minimalist approach should be considered. This approach consists primarily of looking for evidence of policy shifts and changes in process, and establishing how these changes were effected.

While this approach may be appropriate in cities with very limited resources, the major advantage of rigorous evaluation is that it allows the Programme to collect hard data - which is much more effective in responding to critics.

The choice of which of the many possible indicators to use is beyond the scope of this manual hence the reader is referred to the companion volume in this series, *Healthy Cities Initiative in the African Region: Evaluation Manual* produced by WHO.[27]

Maps

Mapping techniques, often referred to as 'geographical information systems' or GIS, are a method for presenting data in a way which allows different geographical areas to be easily compared. This technique collates data on the city and links this to geographical co-ordinates. Indicators can be mapped in colour or shading to indicate various levels of particular indicators. The technique is particularly useful for highlighting problem areas within a city and to show intra-urban differentials.

In some cities the technique has been successful in making ward councillors aware not only of conditions in their own area but also helped them to see at a glance how their area compares with other parts of the city. This can create a healthy competitiveness between wards, which in turn can be an effective way of mobilizing communities.

The example in Figure 5 shows the variations in wealth status (measured using ownership of consumer durables as a proxy for wealth)

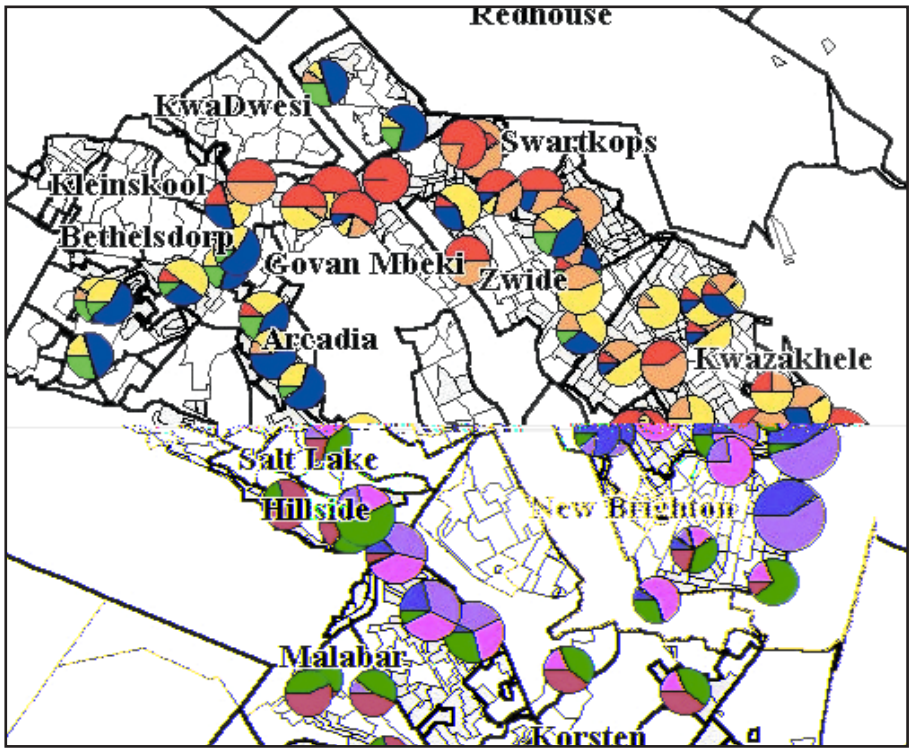


Figure 5. Variations in wealth status of households in a South African city.
Source: Seager *et al.*[28]

in households in a city in South Africa. These data were useful for showing that appearances can be misleading. The area covered by the map has predominantly low-quality housing and the population living there was assumed to be 'poor', but the map shows that within this area there were many wealthier households (indicated by the blue and green shading). Therefore uniform policies applied to geographic areas, such as subsidies for housing, water and electricity, may not be appropriate in this instance.

Radar plots

A technique which is useful for plotting changes in indicators over time relative to pre-defined targets, or for comparing cities or areas, is the 'radar plot' (Figure 6). This technique is particularly suitable for showing changes in a large number of indicators within a single graphic.

There are various ways of presenting the data in a radar plot. The example shown compares the two values by expressing the smaller value as a fraction of the larger one. The method is particularly suitable for indicators with widely differing units.

The method can readily be adapted for monitoring progress towards targets within a city. If, for example, the target for sanitation is 100% coverage, then the current value can be read off as a percentage of the target. In the example, current sanitation coverage scores about 0.45 or 45% of the future level or target. In the case of infectious diseases or demographic factors, targets may be

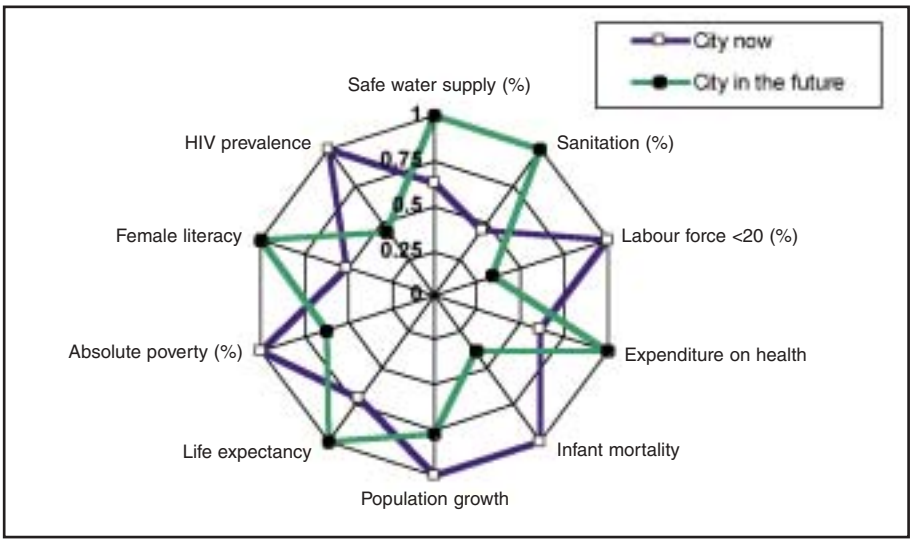


Figure 6. Example of a 'radar plot' showing levels of multiple health and development indicators at two points in time (hypothetical data).

harder to set, in which case levels in other, 'healthier' cities may offer some guidance.

5.3 Ensuring the sustainability of the HCP

The Healthy Cities concept emphasizes a number of characteristics that can contribute to sustainable urban health, namely a broad definition of health, an intersectoral approach and the involvement of a wide range of actors. An additional important characteristic is that the WHO provides limited external funding and places emphasis on mobilizing local resources. Factors which have been shown to contribute to sustainability include strong political support, community ownership and the demonstration of positive outcomes.

A well-implemented HCP is sustainable because of its broad-based **participatory approach** to city development and its focus on creating supportive environments in different settings. Placing the emphasis on mobilizing local resources instead of depending on external funding results in greater development of local capacity to manage resources. Community participation also leads to 'ownership' of the Programme, or at least of its ideals, and thereby grants it sustainability.

Political support is usually essential for sustainability since the Programme must be able to influence and become part of policy development. In the absence of political stability, the HCP co-ordinator must be prepared to spend considerable time and energy on ensuring the commitment from new city leaders. Werna *et al.*[16] suggest that community participation can be an effective mechanism for achieving political commitment. This effect was demonstrated in Campinas, Brazil, where a change in mayor lead to reduced political support for the Healthy City Programme, but the community was already so mobilized that the HCP activities were maintained. Ultimately, it makes good sense for politicians to support an issue that has substantial support from the electorate.

Clearly defined mechanisms to maintain political commitment, intersectoral collaboration, community participation, finance, human resources, information sharing, awareness building, and national and international networking assure sustainability.

Continuing **training** programmes and opportunities to develop personal skills of the Programme staff are essential. Regular seminars and plenary meetings at which stakeholders review their experiences and propose new ideas also contribute to Programme sustainability.

In addition to political and community support within the city, it is important to establish **city-to-city networks.** Exchanging and sharing experiences between cities can lead to the building of capacity in the cities and hence to the sustainability of the HCP. Since an HCP is a complex set of activities, it may not be appropriate to apply the concept of sustainability to every single activity. Activities will come and go during the life of the Programme. What is important is that the sum (or net effect) of the activities within a specific area is sustainable.[1] An approach to sustainable urban development which is able to connect such a wide range of issues may constitute a solid basis for achieving sustainable health and, by comparison, a unisectoral approach to sustainable urban development is bound to have notable constraints. Sustainability depends on keeping the values, vision and concept of Healthy Cities alive. Special events, international visits and celebrations are important for achieving the sustainability of a Programme. Making friends with the media is an important part of this process, and the best HCPs develop a healthy media liaison relationship, which provides good stories to the media at regular intervals.

Annexure I: Case studies of Healthy Cities Programmes in Africa

Healthy Cities Programmes take many forms and should always be developed by local stakeholders in the context or *settings* in which they operate. Many African cities are already undertaking activities which conform to aspects of the Healthy Cities model, although they may not have formally recognised this as their central approach. One of the essential elements of the HCP is its recognition by political leadership of intersectoral, participatory approaches. It is hoped that the establishment of a Healthy Cities network in Africa will both strengthen existing initiatives and contribute to healthier urban development throughout the continent.

Since the existing ones vary considerably, it is difficult to present case studies of 'typical' HCPs, but the examples that follow are intended to give an idea of some of the variations which occur. The two examples of Healthy Cities Projects from South Africa illustrate different approaches and stages in HCP developments:

- **Johannesburg** is the largest city in South Africa, with the population in the greater Johannesburg metropolitan area now approaching 5 million. It is therefore appropriate that this was the first South African city to establish an HCP.

- **Cape Town** (population approaching 2.5 million) began its HCP a few years after Johannesburg and has the advantage of hindsight from the Johannesburg Programme.

Dar es Salaam in Tanzania is a city of 2.5 - 3 million people with an estimated growth rate of 8% per annum. In 1995 the city was selected as one of the cities to receive Netherlands support (through the United Nations Development Programme/Local Initiative Facility for Urban Environment) to initiate and support the development of an HCP.

Bangui, Central African Republic, began its Healthy Cities Programme after presenting a well-prepared national plan of action to the WHO Regional Office-organized Mayors Meeting in November 2000.

Kampala, Uganda, with a population of around 1.2, million has made good progress in establishing its HCP. One of the first steps in the Kampala project was to develop a comprehensive 'City Health Profile', which assessed a wide range of standard indicators against which progress can subsequently be measured.

One of the most recent programmes to get under way is the Swaziland Healthy Cities initiative in **Mbabane**. This project, along with the many others in various stages of development within the WHO African Region, offers great opportunities for networking and exchanges of ideas and experience. It is to be hoped that during the next

decade the African Healthy Cities Network will become a major force for environmental health improvements in the Region.

As a result of awareness created during the 1996 World Health Day, celebrated under the theme Healthy Cities for Better Life, **Libreville**, Gabon, with a population of 500 000, initiated Healthy City activities in 1997. A workplan has been prepared with involvement of all line ministries and key stakeholders.

Nouakchott Healthy City in Mauritania is another very recently established Programme (following the WHO Regional Office awareness-raising workshop in1999). Good progress is being recorded in forging partnerships and initiating pilot activities

Two HCPs have recently (2001) been initiated in **Mozambique**, one at Municipality of Matola, Maputo Province and another at municipality of Mocimba da Paria, Cabo Delgado.

Box 8. The Johannesburg Healthy City Programme

Getting started
This phase of the Johannesburg HCP began in 1993 with the formation of an intersectoral activating committee. This committee included various council departments, namely environmental health, community health, urbanization, planning, and housing, plus outside bodies such as the local medical school, the Medical Research Council and some non-governmental organizations. The local council provided a supportive environment for the project, having already moved towards intersectoral management by merging several departments under one head called 'Health, Housing and Urbanization' and the council's Management Committee also took on the role of the project Steering Committee.

Getting organized
The next stage consisted of a series of workshops and seminars both on the general concept of Healthy Cities and on specific settings, including homes, schools, markets and environments. Despite the high-level commitment of the council to the project, it did not fund the post of Co-ordinator and this was initially obtained by having a research assistant seconded from the MRC. This arrangement worked moderately well for the first few years of the project but the lack of permanence in the post led to a higher turnover of staff than was desirable. Eventually the tasks of the Co-ordinator were integrated into the functions of officials in the environmental health directorates. This degree of integration of the HC philosophy into local government may be regarded as the 'ideal', but it can lead to the role becoming increasingly marginalized among the heavy workload of these officials. A more positive development, however, was the co-ordination of several smaller local authorities under a metropolitan authority. This presented the opportunity for more integrated approaches for health and environment planning across the city.

Taking action
Some of the positive outcomes of the Johannesburg initiative included:
- Several small but successful demonstration projects in settings such as schools, homes, markets and workplaces;
- Environmental policy guidelines for the new metropolitan government;
- A draft environmental management strategy to form a context for future initiatives;
- A participatory planning framework for improved environmental management;
- The linking of the Metropolitan Council to the MRC and the University of the Witwatersrand in a partnership which forms the WHO Collaborating Centre for Urban Health.

Challenges and constraints
Without doubt the biggest challenge for the Johannesburg HCP has been the restructuring of local government, which has been almost continuous throughout the life of the project. Uncertainties and job insecurity have led to both attrition and rapid turnover of staff. Vacant posts have often been 'frozen' which led to increased workloads. In these circumstances officials struggle to maintain existing services and innovative ideas tend to be stifled. Despite these problems many of the principles of the HCP have been incorporated into the current city management structures and an enthusiastic core group maintains a watchful eye for opportunities to expand Healthy Cities activities in the future.

Box 9. The Cape Town Healthy City Programme

Getting started
The Cape Town HCP began in 1996 with an extensive consultative process via public seminars and workshops. A Steering Committee was formed from those organizations which nominated members: this resulted in a predominance of local government officials plus a few CBOs, NGOs and academic institutions. The committee which has been formed is continuously engaging with new stakeholders in the city and has co-opted new members as the project proceeds.

Getting organized
A positive development in the Cape Town Programme was that the Metropolitan Council created a full-time post for the Healthy City Co-ordinator. Initially this was a contract appointment but as more people became convinced of the potential benefits in the long term, the Steering Committee was successful in convincing the Council to make the Healthy City Co-ordinator's post part of their permanent establishment. This in itself bodes well for the programme in that the Metropolitan Council has already committed itself to the project for the long term. Another feature of the programme has been the setting up of Integrated Working Groups in each of the local government sub-structures. These bring the various sectors together and offer a forum through which healthier public policy can be promoted.

Taking action
The approach taken to date in the Cape Town HCP has been to work towards developing programme structures within the metropolitan government and identifying suitable projects and partnerships. The programme has looked at opportunities within both existing Healthy City type projects and under Local Agenda 21, which is also active in the city.

The Cape Town HCP has agreed to support and enhance existing and new projects which emanate from the Integrated Working Groups. These projects tend to have relevance at the local level and are therefore more likely to receive support. In addition, a few metro-wide, or at least multi-centred projects, have been promoted which will serve as models of good practice.

Challenges and constraints
Despite wide-scale acceptance of the principles of HCPs, the true democratic process required to obtain nominations for the Steering Committee proved to be very difficult to achieve. Calling meetings of 300 or more delegates who represented the wide range of NGOs, CBOs, local government and academic institutions, led to lively discussions but it was difficult to keep the momentum going from meeting to meeting in order for decisions to be taken. Despite considerable information having been presented, many NGOs and CBOs remained unwilling to commit themselves or nominate members for the Steering Committee. People need information in order to give their basic support to the concept but they will often require evidence of success, and preferably in their own setting, before they will commit time or other resources. Finding the appropriate balance between following optimal processes and actually moving ahead is a constant challenge within programmes of this kind. Bold steps were sometimes needed to get things moving.

Box 10. The Dar es Salaam Healthy City Programme

Getting started
The HCP was proposed and introduced to the government by the WHO in 1995 and was officially inaugurated in 1996 on World Health Day with the theme 'Healthy Cities for Better Living'. Various activities to raise awareness about the project were organized. Among these activities were sensitization of the population through the media, theatre and a painting contest and exhibition portraying various health issues as perceived and experienced by the city residents.

Awareness raising and building public and political support are ongoing activities in all phases of the project. This involves direct contact, discussion and consultation with the community, different agencies, NGOs and individuals active in environmental and health issues.

Getting organized
This phase involved gaining approval from the City Authority, forming the Activating Committee and preparation of the City Health Plan. Once pilot projects such as healthy food markets and schools were successful, the big 'City Consultation' and the formation of the Steering Committee could proceed. This step involved holding a broad city consultative meeting to initiate the development of the City Health Plan and to introduce the Healthy Cities concept and method to the broader community. To ensure a multisectoral approach participants were drawn from central and local government, Ministry of Health, Ministry of Education, NGOs, Universities, Embassies, departments of the City Commission, hospital representatives, CBOs and the media.

Taking action
This phase involved further development of the City Health Plan and its implementation. A number of pilot projects based on the settings approach were initiated including:
- food markets and street vendors (e.g. improved water and sanitation, the training of vendors in food hygiene and safety);
- healthy primary schools (e.g. sanitation improvement and screening of students for obvious health problems);
- health promotion in unplanned and high-density settlements (e.g. advocacy for sanitation and hygiene behaviour, latrine improvement in areas with a high water table).

Challenges and constraints
- Identification of the right people to work on the ground, who are in a position to take the necessary decisions;
- Ensuring that the city dwellers and partners in the programme are accurately informed about its concept and objectives;
- Being prepared for the uncertainties associated with restructuring of the city administration;
- Identification and acceptance of roles and responsibilities by all partners;
- Dependence on donor funding for activities;
- Sustaining momentum of the various committees and task forces.

Box 11. The Bangui Healthy City Programme

Getting started
Following the initial Healthy Cities workshops, organised by Regional Office in 1999, the Central African Republic prepared a national plan of action. This plan was presented at the Mayor's Meeting held in Lomé in November 2000 and was among those receiving very positive comments from the World Bank and the Regional Office.

Getting organized
In the start-up phase the Special Head of Delegation of Bangui City confirmed government commitment to the HCP and a Co-ordination Unit was formed by the Regional Office. Some initial funding was provided to support priority activities to operationalize the programme, undertake capacity building and institutional strengthening, and to inform external partners specializing in urban development. National experts, including various ministries, were directly involved in the development of proposals and encouraged to develop 'bankable' projects.

The Mayor of Bangui chaired a meeting of all municipal counsellors and representatives to promote the concept of Healthy Cities at local level and for the programme to be implemented in urban districts through communities and NGOs.

Taking action
The municipality took advantage of the programme '*Porte Ouverte sur la Mairie de Bangui* - Open Door for the Mayor of Bangui', to launch the priority activities of the HCP. These announcements were attended by Central African Republic dignitaries, which indicated the high level of political support for the programme.

Achievements
The following activities have taken place so far: the Co-ordination Unit has been established; an initial plan of action has been prepared; meetings with NGOs and communities have taken place; a documentary film has been made on the Healthy Cities activities in Bangui; equipment has been provided to improve environmental health protection; and posters have been made.

Challenges and constraints
Like many such initiatives, the HCP suffers from resource constraints and is dependent on the support of local leaders. There is a need for more advocacy and the Mayors have more work to do in sensitizing local partners to the aims of the Programme.

Box 12. Kampala Healthy City Programme

Getting started
The Kampala HCP began with the premise that the most appropriate response to demand does not necessarily mean accepting that demand in the form that it is expressed. The project determined to enter into dialogue in order to deepen understanding and to arrive at a shared view of the way forward. The process of problem resolution included assessing demand, creating demand and responding to informed demand. The concept of Healthy Cities in Kampala City takes into consideration these three approaches through the use of a participatory methodology. However, it has gone further by using these approaches for various settings in the city. The insight from the various settings utilizing this approach is the basis for the development of the Kampala Healthy Cities 5-year Strategic Macro Workplan that has been developed.

Getting organized
A Steering Committee was established using a multisectoral team with representation from the various sectors, which were seen as key to implementation. The Committee was constituted and convened by His Worship the Mayor of Kampala and chaired by the City's Deputy Mayor. The membership is composed of representatives from: the District political leadership; the private sector (representing business interests); the religious community; the City Public Health Department; the District Civil Administrative leadership; Central Government (Ministries of Health and Finance); key parastatals (National Water and Sewerage Cooperation and National Environment Management Authority) and development partners in health (WHO, and United Nations Children's Fund).

Task forces are being initiated based at the City's divisional level. So far, 50 participatory problem analysis/community resource mobilization meetings have been carried out by task teams in all the 5 Divisions. These have included settings such as the urban poor, institutions, schools, markets and industries, among others. Community problems have been raised, possible solutions sought, and responsibilities apportioned for key actions to be undertaken.

It is proposed that task forces will keep evolving to become more inclusive of all stakeholders and that their composition would reflect that of the steering committee of the city, thereby making them in essence sub-committees of the City Committee.

Kampala City Council envisions that private sector partnerships are critical to achievement of the objectives of the Healthy Cities approach and therefore emphasis is channelled to measures that will enhance sustainable partnerships as a way forward.

Constraints
There is a need to further harmonize the role of the task forces to make them more complementary to the existing structures, since some of the stipulated activities they are to undertake were a mandate of the Parish Development Committees.

Box 13. Mbabane Healthy City Programme

Getting started
The Swaziland HCP was initiated at a workshop held in November 2001. Representatives from the four main streets in the capital city of Mbabane, other towns and cities and staff from the Ministries of Health and Social Welfare, and Housing and Urban Development were invited. The workshop aimed to introduce the concept of Healthy Cities and the 'settings' approach; to draw up action plans for the city's streets; to elect interim steering committees and tasks forces and to identify ways in which participants could mobilize resources for the settings. The focus of the initial activities was on environmental problems and to encourage self-monitoring of good environmental practices by shop owners.

The participants identified a number of concerns within the cities: street children; the mentally disabled; inadequate public toilets; street vendors (leading to overcrowding of streets, poor hygiene due to lack of access to clean water and inadequate refuse facilities); restaurants with inadequate food safety; inadequate street lighting; open culverts and manholes; overgrown plots and vacant houses (fertile grounds for crime); improper zoning and unplanned development; and illegal keeping of livestock within the town. A variety of solutions were also proposed for these problems.

Getting organized
An Interim Steering Committee was elected pending a larger meeting at which a truly multisectoral committee could be elected. During 2002 the Interim Steering Committee will draw up Terms of Reference for the Steering Committee; elections will be held for further Street Environmental Health Committees and project proposals will be called for. Once the full Steering Committee is elected, task forces or technical committees will be established. The focus of the proposed task forces will be on:

a) Lifestyles (smoking, alcohol, misuse of drugs, exercise, diet)
b) Housing (aesthetics, homelessness, density of occupation and physical characteristics of housing)
c) Socio-economics (education, employment, income, crime and violence, cultural participation)
d) Physical environment (air quality-related, water supply-related, waste disposal, energy-related).

Box 14. Libreville Healthy City Programme - Gabon

Getting started
This project started in 1997 after awareness-raising activities organized during the 1996 World Health Day, celebrated under the theme healthy Cities for better life.

Getting organized
A plan of action has been developed. A consultative meeting that was broad-based was organized to review and adopt a plan of action. All line Ministries were involved. The meeting was chaired by the Prime minister - an indication of the high level of political support for the HCP. Various community actions are being initiated based on what was identified as of priority in the City Action Plan. Key are training of 15 trainers in Participatory Hygiene and Sanitation Transformation and organisation of three big rat eradication campaigns.

Major challenge
Sustaining the momentum and enthusiasm on the programme, and establishing and sustaining an effective institutional set-up for effective project implementation.

Box 15. Nouakchott Healthy City Programme

Getting started
The programme was initiated in 2000 after the first Regional Healthy City Awareness Raising workshop in 1999. Various meetings were organized to introduce the concept and the principles of Healthy Cities to the authorities and the broad community.

Getting organized
A Programme Committee has been established. This has been responsible for overseeing preparation of the City action plan, which was presented at the WHO Regional Mayors Workshop in 2000. The work plan that was developed using guidelines from the WHO mainly focuses on environmental sanitation improvement, hygiene promotion and setting approach. Pilot activities aimed at sanitation improvement and hygiene promotion are being initiated. Notable is a campaign for removal of a waste disposal site that was near people's homes and its ultimate transfer to a site where it does not pose a health threat to the people. Partnerships are being established with the community, national hygiene centre, national human rights commission and other development agencies.

Box 16. Healthy City Programmes in Mozambique

Getting started

In Mozambique the Healthy Cities concept was introduced in the municipalities of Motala City and Mocimba da Praia in Cabo Delgado by organizing a National Workshop in 2001. Given the multisectoral nature of the Healthy Cities concept, participants were drawn from central and provisional level and included staff working in the area of environmental health and education in the municipalities of Maputo, Matola, Quelimane, Nampula and Mocimba da Praia. International organizations and some key NGOs also attended the workshop. In this seminar the Healthy Cities concept was adopted and steps to be followed for the elaboration of the plan for implementation of the HCP in cities of Mozambique were outlined. Two municipalities, Matola, Maputo Province and Mocimboa da Praia were selected as initial cities where pilot activities can be initiated.

Getting organized

Municipality of Matola: A working group to advocate for the initiative at the municipality assembly and co-ordinate project activities has been set up. Key environmental health problems in the municipality have been identified in community meetings. These are: waste management, erosion, sanitation, lack of water and lack of public sanitary facilities. Four localities were selected for some pilot community-based activities. In these localities it was proposed to rehabilitate infrastructure in food markets, primary schools, and construction of public toilets. Various meetings and workshops have been held to develop implementation strategies for activities identified, including defining responsibilities of all stakeholders.

Municipality of Mocimbo da Praia, Cabo Delgado: Major environmental health problems were identified as: unhygienic practices, inadequate waste management, lack of water, and lack of public sanitary facilities. After identification and analysis of major environmental health and living condition problems, community meetings prioritized construction of public sanitary facilities at the beach, markets, gardens and school as key areas for urgent action. The municipal plan of action was thus elaborated with full community participation to respond to the identified priorities and finally approved by Municipal assembly. Resources are being mobilized for implementation of pilot projects jointly with United Nations Children's Fund, Ministry of Education and other local partners of the municipalities.

Annexure II: Contacts for further information on Healthy Cities

WHO Regional Office for Africa

The WHO African Region Healthy Cities network is co-ordinated by the Division of Healthy Environments and Sustainable Development at the WHO Regional Office for Africa in Brazzaville, Congo. Further information on the Healthy Cities Programme in Africa is available from:

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Congo.
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WHO Collaborating Centre for Urban Health

The WHO Collaborating Centre for Urban Health is a partnership involving a research organisation, the South African Medical Research Council, training institutions, the University of the Witwatersrand, Technikon Witwatersrand and Rand Afrikaans University and a service provider, the City of Johannesburg. The Centre's work is seen as contributing to a better understanding of the urban environment and establishing options for healthier, sustainable development. The Centre promotes urban health programmes, such as Healthy Cities, as evolving models for intersectoral collaboration and health advocacy.

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