In this issue

World Health Day 1996
Healthy cities for better life
Hiroshi Nakajima

Healthy cities
for better life
3

A healthy city is a better city
Greg Goldstein & Ilona Kickbusch

A nine-year investment
Agi D. Tsounis

Calls the right priorities
Rodrigo Guerrero

Innovations in West and North Africa
Eric R.J. Giroult

Around the Baltic Sea
Mori Hakkala

Teheran: success in a suburb
Hassan Salameh

Towards a healthier Managua
Française Barès & Ángel Sanchez

A concept that bodes well for the Maghreb
Slaheddine Chenili

The Quebec Network
Agnès Dupriez

Healthy cities
Glasgow: working together to make a healthier city
David Black

The Chittagong Healthy City Project
Edmundo Werna & Trudy Harpham

Giving the public their say
Jamilah Hashim, Andrew Nyas, & Stalin Hardin

Venezuela: the community spirit
Herman Melago

Three cities of Jordan
Eric R. J. Giroult

Measles in the cities
John Clements

Mental health matters
Iłona Blue & Trudy Harpham

Reducing urban violence
Joan Twiss

Health in housing
Harold L. Cohen

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Editorial

World Health Day 1996
Healthy cities for better life

Dr Hiroshi Nakajima, Director-General of WHO.

The proportion of people in the world living in cities is escalating. Many of the world’s cities are expanding far beyond their mid-20th-century frontiers. The result? Hundreds of millions of people — the world’s urbanites as they are called — are now living in conditions that are detrimental to their health and even endangering their lives. “Healthy Cities”, the theme chosen by WHO for World Health Day 1996, addresses this crisis.

In 1990 already, the health of at least 600 million people living in cities in developing countries was being threatened by lack of food, clean water and shelter. Overcrowding, inadequate waste disposal, hazardous working conditions, polluted air, and street violence were contributing to what have now become intolerable, risks of city life. Since 1990, on the whole, the situation has not been getting any better. By the end of the century, more than half of the developing world’s population will be living in urban areas and thus exposed to major health hazards.

Against this alarming backdrop was born WHO’s Healthy Cities Programme. The aim of the Programme is to call on local governments and community associations to form coalitions for improving urban health and solving environmental problems.

To date, the Healthy Cities Programme has been extremely successful. It has been adopted as a model for promoting urban health — particularly in low-income population groups — in over 1000 cities around the world. Many city councils are using the “Healthy Cities” slogan to publicize health and environmental issues. And in some places, the concept has been broadened to include other sectors of society, such as “Healthy Islands”, “Healthy Villages”, and even “Healthy Schools”.

Cities committed to improving the health of their populations through concerted, participatory and multisectoral approaches are linking their efforts and sharing their experiences through national and regional networks that exploit the many existing channels for the exchange of goods, services, technology and information.

Most encouragingly, a global network now seems to be emerging. International efforts to improve urban living conditions are being undertaken by WHO together with other United Nations agencies, in particular the UN Centre for Human Settlements (UNCHS), UNDP, ILO and the World Bank. In June 1996, representatives from these agencies will gather in Istanbul for “Habitat II”, the second UN Conference on Human Settlements, at which WHO’s Healthy Cities Programme will be of pivotal interest.

The health of urban populations deserves our urgent attention. If we continue to let our cities grow without proper planning, local government authorities will be overwhelmed and unable to provide even the most basic conditions for health such as housing, employment, and safe environment. At a time of explosive urban growth, the health of city populations is a challenge for all concerned with human development — from municipal and national authorities to international health and development organizations.

Through its Healthy Cities Programme, WHO has taken up the challenge.

WHAT WORLD HEALTH DAY MEANS

World Health Day, 7 April 1996, offers all participating cities around the world the opportunity to demonstrate the significance of what is being achieved with the Healthy Cities approach. WHO has been encouraged by the many city leaders, professionals and citizens who have taken up this challenge. For WHO, World Health Day offers valuable links with an active and vibrant network of Healthy Cities in every region of the world, thus opening up and developing the dimension of city-level work in international public health. On the basis of experience in some 1000 cities, Healthy Cities will be presented to the “Habitat II” Human Settlements Summit in June 1996 as an example of “best practice” in urban management.
A healthy city is a better city

Greg Goldstein & Ilona Kickbusch

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

The world is being urbanized at a furious pace. Within 15 years, between 20 and 30 cities will have populations of over 20 million. As national government resources become more limited and the global trend towards political and administrative decentralization gathers pace, city governments are emerging as stronger forces. Many of the most pressing urban management problems are associated with rapid urban growth, including such environmental health issues as water supply, housing, pollution and solid-waste management, and the social health issues of marginalization and violence. By 1990, at least 600 million people in the urban areas of developing countries were already living in life-threatening and health-threatening conditions.

People in cities – particularly the poor and the newly arrived – experience stresses and exposures that result in a wide range of health problems, including communicable diseases, malnutrition, mental illnesses and chronic respiratory diseases. Unhealthy conditions include poverty, inadequate food and shelter, insecure tenure, physical crowding, poor waste disposal, unsafe working conditions, inadequate local government services, overuse of harmful substances and environmental pollution. Around the world, the cities attract young people from the countryside, lured by freedom from traditional bonds and ways of life, and the promise of increased wealth and opportunity. Instead, many of them find only a new type of poverty.

Poor people in cities often have to shoulder total responsibility for their basic needs in health, welfare and employment creation. Of particular concern to women are issues of social behaviour associated with the breakdown of the extended family and of the two-parent nuclear family; more women are working away from home, and more heads of
household are single mothers. In the era of the AIDS epidemic, urban life often involves more transient relationships, especially for migrant workers, with early sexual activity among adolescents, high levels of prostitution, and a reduction in traditional methods of birth control.

With all these problems, environmental considerations in urban planning and management require far greater attention. The price of neglecting them, apart from the negative health and social impacts, may be to impair urban productivity and restrict future development options, because of unsustainable use or damage to natural resources.

**Health through local action**

The Healthy Cities Programme builds on WHO’s definition of health as a state of complete physical, mental and social well-being, and has its roots in the public health culture of many parts of the world; indeed, many of the public health innovations in the past and present have sprung from the local level. In 1985, WHO proposed a health promotion scheme to be known as the Healthy Cities Project. The intention was to devise ways of applying the principles and strategies of health for all through local action in cities and putting them firmly on the agenda of local government.

The value of this programme to cities has been demonstrated by its unexpectedly rapid expansion to hundreds of cities and towns, not only in the industrialized world but increasingly in the developing world.

In Healthy Cities work, attention is given to the principle that health can be improved by modifying the physical environment and the social and economic determinants of health. Although various urban development activities (housing, industry, infrastructure, etc.) can cause health hazards if they lack health and environmental safeguards, more importantly they offer health opportunities. They can enhance the health status of the population, provided they are accompanied by health promotion and protection measures.

In addressing urban problems, a Healthy Cities project does not seek to take over the management of such functions from the competent authorities and agencies. Rather, it seeks to make health issues understandable and relevant to the work of local government and other agencies. It supports city health authorities and local government in two activities that are often new to them: monitoring environmental factors and their impact on health; and putting forward specific health policy recommendations for relevant departments such as water and sanitation, industry, and education. In the process of consultation with the community and many different agencies and groups, an effort is made to develop a “vision” of the future direction of the city, and to understand its current (and past) strengths and qualities.

**Generating awareness**

Drawing up a Municipal Health Plan serves to generate awareness of health and environmental problems among municipal authorities, nongovernmental agencies and commu-

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**HEALTH FOR ALL implies**

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

**SETTINGS THAT SUPPORT HEALTH**

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

- Home, Village, Neighbourhood.
- School.
- Workplace.
- Food Markets.
- City and District.
- Sport and Leisure.
nities, and to mobilize resources to deal with the problems. The plan should not be considered a “one-off” exercise that will generate all the necessary actions to solve the city’s health problems once and for all; rather it should be seen as a process of consultation, data-gathering and analysis that continually opens new channels of communication. The plan may include programmes or projects for specific settings, such as schools, workplaces, the marketplace and health care locations.

A key issue is how national programmes may influence the project. In some countries, it has been helpful to establish a “national Healthy Cities commission” or network. A clear commitment by such a body to local government policies that reduce marginalization or the exclusion of poor communities from social and economic life and services can greatly assist local efforts.

Comprehensive health development approaches in a Healthy City project include “healthy villages”, “health-promoting schools”, “health-promoting workplaces” and “health-promoting hospitals”. In addition, partnerships aimed at tackling local issues may form between women’s organizations, health-oriented nongovernmental organizations, the ministry of health, and municipal health agencies responsible for providing health services, running health centres or managing hospitals. Such issues might include making maternal and child health services more accessible for underserved areas, strengthening family planning, improving health education, or introducing better, more appropriate and more readily available drug therapies for common diseases.

Healthy Cities may be a “stand-alone” project in a given city, or may be the health component of a larger development effort that involves such areas as urban infrastructure, land management, municipal finance and industrial development.

Examples of such links include the joint Healthy Cities and Sustainable Cities Programme in Ibadan, Nigeria (where a city health plan is integrated into the development plan for the city), and the joint effort on Healthy Cities and urban infrastructure development now being introduced in Bangladesh by WHO and the Asian Development Bank.

WHO is actively promoting the Healthy Cities approach worldwide, not least by organizing intercountry meetings in all regions, on a regular basis, to review the progress of the participating cities and to facilitate the exchange of health and environmental technologies as well as experiences with successful projects. The project coordinators of participating cities are entered into an international database, and newsletters and technical reports are regularly circulated to the interested parties.

In cities, all aspects of the environment are interlinked and impinge on the citizens’ health.

**CHARACTERISTICS OF A HEALTHY CITY**

- Clean, safe physical environment.
- Basic needs met for all people.
- Strong, mutually supportive, integrated and non-exploitative community.
- High degree of public participation in local and city government.
- Access to wide variety of experiences, interaction and communication.
- Promotion and celebration of historical and cultural heritage.

**CHALLENGES FOR HEALTHY CITIES**

- GENERATE visibility at the local level for health issues and the health-for-all strategy.
- MOVE health high on the social and political agenda, and contribute to the development of healthy municipal policies.
- CREATE innovative action for health that emphasizes the interaction between people, environment, lifestyles and health.
- FACILITATE organizational and institutional changes that encourage cooperation between various departments and sectors, and that promote community participation.
Healthy Cities is about changing the ways in which individuals, communities, private and voluntary organizations and local governments think about, understand and make decisions about health. Firstly, it calls for recognition that a city can play a key role in promoting and maintaining the health of its citizens and, secondly, that it has a unique capacity to mobilize action for sustainable development. Ultimately, it is about enhancing the physical, mental, social and environmental well-being of the people who live and work in the cities.

Over the past nine years, WHO's Healthy Cities Project has developed into a major public health movement at local level, involving networks of over 550 cities throughout Europe. World Health Day, 7 April 1996, will mark the culmination of nine years of major innovative endeavours for public health at city level in Europe. The WHO Regional Office for Europe (EURO) has played a pioneering role and has made a considerable investment in promoting the Healthy Cities approach throughout Europe. To do this, it created an interdepartmental project (a partnership between departments responsible for lifestyles, health and environmental health) designed to involve city administrations and commit them to actively developing and putting into effect Healthy Cities policies and programmes. The project thus became one of EURO's main vehicles for giving effect to the strategy for Health for All.

The project strives to realize the vision of a healthy city by:
- securing political commitment (to provide the necessary legitimation, direction and resources for the project);
- giving visibility to health (to...
promote wide appreciation and recognition of the major health issues and the factors influencing them;  
- making institutional changes (to encourage and establish intersectoral collaboration, modernize public health structures and processes, and promote the active involvement of the community);  
- and taking innovative steps to improve health and the environment (to promote equity, ecological management, sustainable development and healthy municipal policies).

The project has four main operational elements: the WHO project cities network; national and subnational Healthy Cities networks; multi-city action plans; and special (model) projects in cities of central and eastern Europe.

**WHO project cities**

Up to October 1995, 34 cities had been designated to the WHO project cities network: Amadora, Athens, Bialystok, Bologna, the London Borough of Camden, Copenhagen, Dresden, Dublin, Eindhoven, Frankfurt, Geneva, Glasgow, Gothenburg, Győr, Horsens, Jerusalem, Kaunas, Kosice, Liège, Liverpool, Lodz, Maribor, Mechelen, Nancy, Padua, Pécs, Poznan, Rennes, Rotterdam, Sadnes, Sumperk, Torun, Turku and Vienna. All these cities are committed to the establishment of project infrastructures and processes, the development of healthy public policies and city health plans, systematic monitoring, evaluation and analysis of experience, and the dissemination of good practices. Project cities are "field laboratories" for testing and developing health-for-all initiatives at local level.

The first phase, from 1987 to 1992, emphasized advocacy and, by tackling the political and institutional barriers to change, laid the foundations for successful work towards Health for All.

The strategic objectives for the second phase (1993-98) include speeding up the adoption of policy at city level, strengthening national and subnational support systems, and building strategic links with other sectors and organizations that have a major influence on urban development. Comprehensive city health plans are setting explicit targets and tackling issues such as equity and sustainable development while establishing mechanisms to promote accountability for health. The 1995 “Healthy and Ecological Cities” Conference in Madrid (organized by WHO and the Organization for Economic Cooperation and Development) produced an impressive number of reports on local initiatives - from insulating tower blocks in Sheffield (UK) to restoring a deprived area of Barcelona (Spain), from transforming Krakow’s environment (Poland, with its legacy of pollution from the communist era) to working towards "child-friendly" cities in Italy.

**Networking**

National networks started to develop spontaneously as a result of the widespread interest among cities throughout Europe in being actively involved in the Healthy Cities Programme. National networks have been established in many countries, and there are several subnational networks involving smaller cities and towns. The countries of central and eastern Europe are receiving special attention in this context.

**Multi-city action**

The Multi-City Action Plans bring together groups of cities to work on issues of common concern. There are now 13 such plans, focusing on accidents, AIDS, alcohol, environmental issues in Baltic cities, diabetes, drugs, people with disabilities, health-promoting hospitals, nutrition, sports, tobacco-free cities, urban primary health care, and women’s health.

**Special projects**

In central and eastern Europe, special projects include initiatives in the fields of health, environmental reform, democratic processes and resource mobilization; they are based on intercity cooperation and a spirit of solidarity with cities most in need. One example of this is the St Petersburg special project, which focuses on care services for mothers and babies. The project has built up a body of know-how and practical knowledge that can be used to develop health-for-all policies and programmes, based on intersectoral cooperation and community action.
Sharing information

EURO has produced a highly successful series of publications on the theory, practice and evaluation of the Healthy Cities project in Europe. These include two overall reviews of project developments; the booklet, *20 steps for developing a healthy cities project*, which has been translated into 22 languages; a comparative analysis of health, environmental and social indicators from 47 cities across Europe; and guidelines for producing city health profiles and health plans.

“What’s in it for you?”

Healthy Cities has had a profound impact on EURO’s approach to innovation, project development and networking, and has brought Health for All to the cities and streets of Europe through a non-health-services door. Making health every sector’s business is probably the most significant achievement of this project.

When WHO project cities were asked “What’s in the project for you?” their answers included the following.

- The Healthy Cities Project has given us a voice in Europe and legitimation and courage to carry on.
- It has given us contacts and access to information and to a wealth of experiences.
- It has created a basis on which to build solidarity with other cities.
- It has made us think less provincially and more about what is really important.
- It has given us the WHO label of quality, which has helped to mobilize local support for initiatives that had been at the periphery of our policy focus, such as dealing with inequalities.

Our experience has let us to arrive at the following six conclusions.

- Projects are an important means of achieving change, serving as vehicles for strategic growth, and powerful tools to deal with change, uncertainty and the building of alliances.
- No single recipe can be drawn up for every city.
- Project ownership is crucial; health is not a party political issue, nor can the project be the exclusive territory of one party or city department.
- The project needs a sustainable commitment to a long-term process which can truly bring health considerations and healthy public policy into the mainstream of municipal decision-making.
- Health should be regarded as an investment and not as an expenditure.
- The project was not implemented in a closed system, but was shaped locally through the commitment, persistence and creativity of cities; its diversity gives it strength.

As we approach the dawn of “the urban millennium”, when for the first time the majority of the human species will live in towns and cities, we have a desperate global need for the innovation and the networking that are characteristic of the Healthy Cities network.

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Cali: the right priorities

Rodrigo Guerrero

"This is all very fine, but what are you going to do for the health of Cali?". "Aren't you a doctor - then, what are your specific programmes for health?" Challenging questions like these were frequently put to me while I was Mayor of Cali, Colombia's second largest city with around two million inhabitants.

For me, the main programme issues for Cali were: extension of public services (water, sewerage and electricity) to all the city, creation of 40 000 new low-income housing projects, support to the self-employed through a small enterprises development programme, achievement of universal coverage with primary education and the introduction of a comprehensive programme to deal with the extremely important problem of interpersonal violence.

In my view, these efforts were aimed at promoting health in the best sense of the word, yet many Cali citizens were asking what I was going to do for the health services of the city. They thought, as many people do, that in order to improve health one has to develop hospitals or health centres. Better housing for low-income populations is a first step towards improving their health status.

A mother and her children in a poor urban area of Colombia. Better housing for low-income populations is a first step towards improving their health status.

were being flooded with injuries resulting from accidents and interpersonal violence. But more important things had to be done in order to improve the health of the citizens and maintain Cali as a healthy city.

An illegal land development that took place during the 1980s in Aguablanca District still lacked running water and sewage facilities for most of its 300 000 residents; there was a shortage of 60 000 housing units for the poorer families already living in Cali; and crowding in expensive but often insanitary conditions was causing considerable illness.

With strong participation from the private sector and the active support of the Catholic church, an integral primary health care movement was started to help the people of Aguablanca to help themselves. Among many other activities, voluntary health workers helped to distribute oral rehydration salts. Infant mortality rates dropped from 70 per 1000 in 1983 to 26.2 in 1994.

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Innovations in West and North Africa

Eric R.J. Giroult

Two intercountry Healthy City networks have been built up in French-speaking Africa: a sub-Saharan African network created with Canadian assistance, whose coordinating office is in Dakar; and a Maghreb network created through a Tunisian initiative, whose coordinating office is in Tunis and whose official language is Arabic.

The sub-Saharan African network includes eight cities located in six different countries, while the Maghreb network comprises 20 cities located in Algeria, Morocco, and Tunisia. In all these cities, the first objective is to achieve full coverage of the population with the eight components of primary health care, and the second objective is to strengthen secondary medical care through the development or improvement of district hospitals.

Rufisque in Senegal is a city of 300,000 inhabitants on the coast 20 miles east of Dakar. Once an important harbour for the export of peanuts, it lost its harbour function due to changes in merchant marine practices and is now an industrial satellite city of Dakar.

Rufisque has developed a successful Healthy City project with the help of its twin city of Nantes, in France. The two main components of its action plan are environmental improvements and the rehabilitation of district hospitals. High priority is being given to cleaning and repairing drainage channels and sewers, and improving the city’s waste management operations.

Of the city’s two district hospitals, an old one built in colonial times needs repairs and extension, while the second – built recently – has serious construction defects due to the failure of the contractor, but it is proposed to make good the defects and reopen the hospital.

Mohamedia in Morocco is a coastal city about 20 miles north of Casablanca. It is both a tourist centre and an industrial harbour which handles most of the country’s imports. Besides the usual efforts to improve environmental and basic health services, the Mohamedia project is notable for the excellent collaboration between the public health services run by the city and those run by the Ministry of Health. The project has also fostered town-planning and cultural activities that have made the city a more attractive place to live in.

Nabeul in Tunisia lies on the coast 80 miles south of Tunis. It has a very active ceramics industry and attracts international tourism. Two innovative achievements have stemmed from the Healthy Cities project. The first is the programme undertaken to control emissions of toxic chemicals and to abate air pollution from the ceramic industry. Success was achieved through relocating some workshops, changing the technologies used and improving management of liquid and solid waste. Air pollution was reduced through the use of cleaner fuel and improvement in the traditional ovens.

The second noteworthy action relates to the management of medical wastes. The city has organized the collection of infectious wastes from a variety of scattered sources, including the retrieval of discarded syringes from tourist hotels.

In Nabeul, as in other Tunisian Healthy Cities, great efforts have been made to improve sewerage, drainage and waste disposal, and to protect recreational water quality.
The creation of a network of cities under the umbrella of WHO’s Healthy Cities Programme in 1991 coincided with significant political changes in the Baltic Sea region. The network came to be called Baltic Cities, Environment and Health Multi-City Action Plan (MCAP). Initially, strong emphasis was placed on environmental issues but today other health issues are coming to the fore.

The city of Turku in Finland has acted as coordinator for the network, which includes the cities of Stockholm (Sweden), Copenhagen (Denmark), Greifswald and Rostock (Germany), Kaunas (Lithuania), Riga (Latvia), Tallinn (Estonia) and St Petersburg (Russian Federation). The Baltic MCAP usually meets once a year but individual cities also arrange meetings on specific bilateral agreements. Representatives of Gdansk in Poland and Gothenburg in Sweden have attended some meetings as observers.

Kaunas, Copenhagen and Vilnius have had discussions on air pollution, for instance, while Gothenburg, with Turku and Stockholm, has had contacts with Tallinn on the subject of waste management: a symposium was held, with related booklets aimed especially at elected members in the city’s decision-making bodies. The idea of arranging a seminar and preparing written material beforehand to be delivered during the seminar to the participants came from the Ecological Health Planning Unit at the WHO Regional Office for Europe in Copenhagen, which also provided a focal point for the Baltic MCAP.

One of the main features of the Baltic MCAP is direct collaboration between cities, like that between Turku and St Petersburg. They have been twin cities for more than 40 years, so it was natural for them to welcome the new framework of connections.

Many and varied needs

At first, it was no easy matter to introduce the methods central to the Healthy Cities Programme, namely health promotion by creating healthy public policies, improving the environment, initiating and sustaining intersectoral work, and involving the community. The circumstances were not altogether favourable for a radical change of old patterns in cities of several million inhabitants with many and varied needs. Even a city with a population of only 160 000, like Turku, felt a certain anxiety in confronting the immense challenges.

With support from the WHO Regional Office in Copenhagen, St Petersburg organized a big Consensus Conference for people involved with the care of mothers and babies, reproductive health and family planning. The city published a specific programme to introduce new concepts of maternal care. This provided a good opportunity for
Turku to share its expertise, since it boasts the lowest infant mortality rates in Finland and indeed in the whole world. Another happy coincidence was that Turku had a nursing manager who could speak Russian and who was in a position to participate in an exchange of experts for some weeks with the Maternity Hospital No. 11 in St Petersburg.

Maternity Hospital No. 11, with its 125 beds, is not a big institution. With the full support of the hospital’s Chief Doctor, it looked as if change was possible. The visiting nursing manager from Turku provided a questionnaire to the staff, and the replies showed that the majority of informants had been working in this hospital for five years or more. Almost all the informants (94%) considered their work stressful and physically strenuous, though most of them thought it was on the whole satisfactory, and they were prepared to review and develop their work methods.

Within a very short time, between 1993 and 1995, Hospital No. 11 adopted the principles of a Baby-Friendly Hospital, and a visitor to this institution cannot help being impressed with the changes. Only three years ago, the Russian tradition was that fathers were not allowed inside the building; the mothers had to talk with the rest of the family by leaning out of second-floor windows. The babies spent all the time between feeds in baby-rooms and there were perhaps six or more mothers in the big rooms. Now there are family rooms where families can visit, and – contrary to old beliefs – nobody is the worse for it. The atmosphere is one of cheerfulness, or even elation.

The report written after the exchange suggested that it was a good principle to start where the action is, where the work is being done; at the same time, changes need to obtain support from the city government, and a specific health policy needs to be established if permanent structural change is the aim. Moreover, the value of support from the worldwide organizations cannot be underestimated.

Recently an agreement was drawn up between Turku and Tallinn, whereby Turku committed itself to making its experience and expertise available to the Tallinn Healthy Cities Project in Estonia. So far, experiences have been exchanged on alarm systems and crisis centres. Turku has been involved in evaluating Tallinn’s waste management plan and continues to have frequent contacts on environmental issues. Interaction with Tallinn is made easier for the Finns by the fact that the Estonian and Finnish languages belong to the same family. This contributes to a feeling of familiarity which facilitates all kinds of communication.

At a time of structural and economic change, a network based on geographical and historical links seems to be an effective means of finding new ways of steering towards a better future. Languages may differ but the language of those with responsibilities at city level has very many common traits – including smiles, approving nods, flashes of intuition and inspiration – whenever common ground is touched.
It was in November 1991 that Teheran's 20th municipal district, Kooy-e-Sizdah-e-Aban, was formally selected as an experimental area for a major Healthy City project. This followed discussions between the Minister of Health and Medical Education, representatives of the Teheran Municipality, mayors of the Islamic Republic of Iran's main cities, and the WHO Representative. The Healthy City Centre was officially inaugurated and went into operation at once.

Besides forging close links between all the relevant authorities of the district and the city, a public awareness campaign began to inspire the general populace with enthusiasm for improving their own health. The essential objective was to increase health standards and improve services so as to fulfil the basic needs of all the citizens.

The Mayor of Teheran was enthusiastic about the project and actually donated a building situated in the pilot area to serve as the Healthy City Centre, with all the necessary facilities. Lying to the south of the city, the district has a population of 30,000. A Healthy City High Council was chosen to serve as a steering committee and lead the project. Its members are drawn from the ministries of Health and Medical Education, Education, Labour, Energy, and the Interior, as well as the Social Welfare Organization.

A pilot project in a suburb of Teheran is inspiring the general populace with enthusiasm for improving their own health. The essential objective is to increase health standards and improve services so as to fulfil the basic needs of all the citizens.

The first step was to prepare a questionnaire aimed at different groups of the population. Its purpose was to determine the priorities, needs and expectations of the residents in respect of the project. Secondly, specialized committees were formed to pursue specific objectives of the Healthy City project. Working under the High Council, these committees covered the subjects of public relations and community participation, research and investigation, education, public health, employment and income generation, and urban services improvement. Each was given specific tasks but was also required to coordinate its efforts as much as possible with those of the others, so as to preserve the symmetry of the project.

The committees are chaired mainly by people from the relevant authority, while the members consist of representatives from different city organizations and the community in general. Proposals suggested by the High Council are sent to the appropriate committee for technical study and then redirected for final approval; other proposals are put forward by the specialized committees.

Public relations

Active community participation is a prerequisite for the project's success, so no efforts are spared to bring the basic principles and the progress that is being made to the attention of all residents. The committee concerned with public relations and community participation seeks to create direct relationships with different strata of society, explaining the slogans of the project and focusing on particular areas for action.

One of the important activities undertaken is the Women Health Volunteers Project, which has already scored notable successes. The District Health Network was primarily responsible for mobilizing
women from target groups among the urban community. This resulted in a decisive step being taken towards boosting the role of local health centres, which subsequently became known as Community Health Centres. These became a base for providing community-oriented medical education, including scope for medical students to carry out health systems research.

Each woman volunteer is responsible for 50 households and communicates regularly with the health centre. The volunteers’ main tasks are to provide health education to women in their area, encourage all family members to receive family health services, and report every month on all the vital events occurring in their area. They also attend weekly training sessions at their respective health centres.

The research committee gathers information on the area and acquaints itself with special needs. It also assembles data aimed at understanding and classifying the shortcomings actually experienced by local residents.

### Schoolchildren as health workers

The educational committee is responsible for an important project called the Healthy School or Community School Establishment. Two schools (one for boys and one for girls) were chosen from among six primary schools in the pilot project area. The aim was to train the pupils to take care not only of their school but also of the neighbourhood environment, extending even to street cleanliness and hygiene at home. The pupils have regular classes on health education for this purpose, where they learn to understand and classifying the shortcomings actually experienced by local residents.

They too receive health education and learn to accept responsibility for specific health-related activities. At the same time, efforts are made to step up the active delivery of health care services to the schoolchildren themselves.

The educational committee introduces Healthy City concepts to head teachers and other school executives as well as to people involved with the environment, food hygiene and medical services. A magazine called Healthy Message helps to propagate innovative ideas with the cooperation of all relevant educational staff. Some 5000 students benefit from a Postal Library which sends books by post to their homes; this activity was devised in cooperation between the Healthy City Centre and the Institute for the Intellectual Development of Children and Adults.

### Solving city problems

The public health committee is seeking to expand the primary health care network and to ensure the active delivery of health care services. When an urban health centre in the pilot area is upgraded to a community health centre, its aim is to cover not only health issues but a host of other interrelated problems.

The employment and income-generating committee faces serious unemployment in the area. Several vocational and art training courses have been started with the cooperation of the Ministry of Labour, the Social Welfare Organization and the Teheran Municipality. Men and women volunteers can receive training in such skills as cloth printing, tailoring, embroidery, car repairs, painting, carpet weaving and pottery.

The urban development committee is studying the city’s environmental problems to determine a set of priorities for improvement. Its activities include ensuring suitable access for disabled persons, maintaining and improving parks, building a swimming pool, making better use of green spaces and creating safe cycle tracks.

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Towards a healthier Managua

Françoise Barten & Angel Sanchez

At present, Nicaragua is one of the poorest countries in Latin America. The dislocation caused by the low-intensity war during the last decade led to massive migration from the countryside, and the population of the capital, Managua, more than doubled in three years. Today, roughly one-third of the country’s population live in Managua. This rapid and uncontrolled growth of the city, combined with a lack of urban planning and increased demand on urban services, has contributed to a crisis situation, with increasing social inequalities and the political polarization of society.

Between 1987 and 1994, poverty in Managua increased from 30% to 72.5% and extreme poverty from 15% to 50% – mainly among female-headed households. Unemployment stands at a staggering 62% and malnutrition in children at 68%, while domestic violence and drug abuse among school-aged youth are rapidly rising. The 270 squatter settlements constitute the most unhealthy environments of the city, and more than 300 polluting industries are located in low-income areas. Waste is dumped at 310 illegal tips throughout the city, causing serious health hazards.

On the positive side, although the public health budget was reduced by 50% during recent years, the authorities have developed innovative strategies to meet health needs. The Movimiento Comunal (Communal Movement) in Managua at present has more than 3000 “brigadistas de salud” (health promoters), and owns 60 health posts and some 600 “casas bases” (community health houses); it promotes self-reliance and active participation of the community in the improvement of living conditions.

In July 1995, Managua decided to launch a Healthy Cities project because of the increasing inequity in social and physical living environments; the need to base urban health sector reform on innovative strategies developed by civil society; and the lack of intra- and intersectoral collaboration. The possibility of attaining greater social democracy through health helped to raise interest in a “Managua, Municipio Saludable” Project. The beginning of the project coincided with the unification by the Ministry of Health of the capital’s three district health systems into one municipal district health system. Recognition of the central role played by local government in health was spurred by the limited capacity of the health sector to control serious epidemics of malaria and dengue.

More than 30 different organizations participated in a workshop convened to identify current contributions to urban health development upon which a Healthy City project could be based, and to explain the concept and the approach of the WHO Healthy Cities Project. It soon became clear that many different institutions, municipal agencies, community bodies and nongovernmental organizations were making various separate efforts, often in the same barrios of Managua. Community-based organizations with a long history of participation in local development were recognized as crucial resources.

It was decided that the School of Public Health would act as the national counterpart of WHO and UNDP and would be the focal point for action during the first phases of the project. In collaboration with WHO, a field study is being conducted in order to identify the city’s main environmental health problems through direct consultations with the public. The information provided will help to set the agenda for building a Healthy Managua for all its inhabitants.
A concept that bodes well for the Maghreb

Slaheddine Cheniti

Tunisia shares with many other countries the problems of rapid urban growth and a consequent increase in health risks in the mushrooming cities. The Healthy Cities concept therefore quickly won the support and the necessary commitment of leading politicians. The Ministry of Public Health was appointed as the national and Maghreb coordinator and was thus able to develop the project not only in Tunisia but in the region of north-west Africa as a whole, which includes Algeria, the Libyan Arab Jamahiriya and Morocco.

In June 1990, the first Maghreb symposium on the Healthy Cities Project brought together representatives from the four neighbouring countries, who agreed to set up a network. Since then, the network has steadily expanded and in each country there is involvement by the ministries of the interior, housing, environment and land-use planning, social affairs, youth and children, education, and science. Special efforts are made to raise public awareness of the project through television, radio and the press.

Within Tunisia itself, each city has its own network of "neighbourhood committees" which contribute to local development and support municipal activities. Funded by the residents themselves, each committee encourages positive community participation in all matters relating to the environment and health, and seeks improvements in community-based hygiene, particularly in poorer parts of the city.

To support these activities, the committee sponsors school competitions, festivals and clean-up campaigns, and also tries to improve the physical appearance of the city by planting trees and safeguarding green areas. Today there are over 5000 neighbourhood committees in the country, whose membership totals 35,900. Of these, 2646 are women.

Already, the activities undertaken within the scope of the Healthy Cities Project have made tangible improvements in Tunisian cities, and the experience has made the neighbourhood committees increasingly self-confident. All urban areas now have safe drinking-water, with household connection rates to mains water supply standing at 73%. All development projects include a health component and there is very real coordination between the different sectors concerned with health and the environment.

As social conditions are improved, the most common communicable diseases are showing a steady decline. A prize offered to "the most healthy public establishment" encourages managers at all levels to "think health." Municipal technicians are being trained in vector control, general sanitation in the cities is being improved, and primary health care services are everywhere being strengthened. Most schools have formed their own health clubs, so that the younger generation is receiving the right messages about good hygiene and sensible lifestyles. And apart from the improved physical appearance of clean cities with well-cared-for trees and green open spaces, there is special emphasis on the control of coastal water quality, since Tunisia offers a great many attractions for international tourism.

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The Quebec Network

Agnès Dupriez

The Quebec Network of Healthy Towns and Villages has proved so successful that links are now being forged with different countries — including Brazil, Colombia, Mexico and Senegal — which recognize its achievement as a model for their own projects.

On 26 May 1989, high officials from some 100 towns of Quebec Province in Canada braved torrential rain to plant a tree on the banks of the River Magog. Two weeks earlier, the Mayor of Montreal had been invited to plant his own tree in front of a school in the Mercier-Est suburb, where pupils had told him of their concerns about the environment and the quality of life.

These two activities figured among the health promotion projects that the towns of Sherbrooke and Montreal have been undertaking for more than seven years, in close collaboration with officials of the Quebec health network and other partners from the economics, education and environment sectors, as well as ordinary citizens.

The Healthy Towns and Villages movement was launched in Quebec in April 1987, when Rouyn-Noranda became one of the earliest Healthy Cities in the Americas. The town of Sherbrooke and the Mercier-Est suburb of Montreal followed hard on its heels.

Rouyn-Noranda

Rouyn-Noranda had long been notorious as "the most polluted town in Quebec". Like many single-industry towns, it faced the difficult choice between a polluted environment with jobs for all or a healthy environment with large-scale unemployment. This is no doubt why the Healthy City concept appealed to the municipal council. Initially, Rouyn-Noranda chose projects that would not provoke lawsuits and were backed by the citizens, such as creating a botanical garden and organizing a Winter Feast, projects which the local copper-refining plant could readily support.

Three years later, when a serious risk arose of children living close to the factory being exposed to lead pollution, a new way of thinking ensured that the factory was obliged to put the matter right. This followed a short process of consultation involving concerned citizens, the plant management, the workers’ union, municipal authorities, representatives of the local group for environmental protection and members of the local public health network. Rouyn-Noranda is now
tackling such problems as poverty and the family, and violence and urban security, always through dialogue with the bodies concerned.

**Sherbrooke**

The Healthy City of Sherbrooke has staked all on a community participation process to ensure a varied range of activities which impinge on all facets of daily life. Thus the Young People's Square offers a meeting place for 14–17-year-olds, and provides leisure activities which suit them because they participate in the planning. Until recently, dangerous domestic rubbish was collected only once a year by more than 120 volunteers; now it is easily disposed of at a nearby site specially designed for it.

From the start, intersectoral action has been an essential ingredient of the project's success. Sherbrooke is now tackling more complex problems, such as those aimed at reducing poverty, and it relies on motivating the citizens themselves to get things done at the local level.

**Montreal**

With more than a million inhabitants, the city of Montreal includes areas with wide social and economic disparities. Becoming a Healthy City implied its commitment to making all its different sections healthy. The first step towards this commitment was taken in the Mercier-Est suburb in 1988 by citizens supported by their local centre for community health and Montreal's municipal housing office. Thanks to the success of the project in Mercier-Est, the city officially committed itself in 1990 to promoting the health of all its citizens, and joined forces with the Quebec Network of Healthy Towns and Villages.

Today, Montreal has ten Healthy Suburbs (out of a total of 22), each spearheaded by its own citizen's group backed by the municipal services and local institutions. Each one can take pride in activities of a social nature, such as setting up communal kitchens, campaigning against drug-taking and its consequences, helping to overcome the isolation of down-and-outs, arranging "welcome days" for newcomers to the city, and running community centres. These Healthy Suburbs can be equally proud of their environmental and educational activities, which include the management of green spaces, clean city and crime reduction campaigns, and the planting of trees and flowers.

**A well-run network**

Hundreds of such projects are being carried out in the Healthy Towns and Villages of Quebec; the Quebec Network now includes more than 100 municipalities and covers more than 45% of the Province’s population. Created in 1990 out of the municipalities' clearly felt health needs, the Network is a non-profit-making body which has its own information centre, financed by the Quebec Ministry of Health and Social Services. It offers its members a platform for lively discussion and mutual aid. The seventh annual meeting of the Network was held in October 1995 with the theme of "Closing the inequality gap: a responsibility to be shared."

The concrete results achieved have ensured that the network continues to expand. The local projects of each town or village may vary but they all have in common a global vision of health in the community, a willingness to take practical action at short notice, great ingenuity, cooperation between the many concerned bodies, actively participating citizens and a remarkable zest for inspiring solidarity.

The vigour of these projects is due, among other things, to the richness of the exchanges of information and ideas between the different municipalities at provincial, national and international level. Throughout Canada more than 125 Healthy Community projects have been developed. As regards the international scene, in December 1991 the Quebec Network agreed to support an initiative of the Commune of Dakar in Senegal to create a Healthy Towns and Villages Network for Francophone Africa.

The Canadian International Development Agency (CIDA) and the Canadian Federation of Municipalities have given the initiative their backing. New links are constantly being forged with various countries in Latin America, including Brazil, Colombia and Mexico – links through which Quebec's successes can serve as a model for developing their own projects.

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INTERESTED IN HEALTHY CITIES?

Learn all about Healthy Cities. Here are some of the major documents obtainable from WHO:

**Twenty steps for developing a Healthy Cities project.** World Health Organization Regional Office for Europe, Copenhagen, Second Edition 1995, (English and French versions available).


Join a Healthy City network and receive the network newsletter, by contacting your Healthy City Coordinator at your nearest WHO Regional Office:

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**WHO Regional Office for the Eastern Mediterranean**
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**WHO Regional Office for Europe**
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**WHO Regional Office for South-East Asia**
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**WHO Regional Office for the Western Pacific**
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Fax: (632) 521 1036/526 0279.

Eleven European cities started working together in 1986 to create new approaches to public health that were grounded in the principle of Health for All. Stemming from this beginning, the global Healthy Cities movement has flourished and prospered under the leadership of WHO. More and more cities are joining in the drive to promote the health and improve the quality of the life of their citizens. This page offers practical suggestions on how a city can create its own project, with a view to becoming a Healthy City.

Managua Healthy Municipality Project in Nicaragua: the first workshop.

Johannesburg: motivated by the local authorities, slum dwellers in Soweto join forces to improve their environment.
TWENTY STEPS TO DEVELOP A HEALTHY CITY PROJECT

Taking Action

1. Increase health awareness
2. Advocate strategic planning
3. Mobilize intersectoral action
4. Encourage community participation
5. Promote innovation
6. Secure healthy public policy

Getting Organized

7. Appoint a committee
8. Link health status to living conditions
9. Define project work
10. Set up an office
11. Plan strategy and develop a city health plan
12. Build capacity
13. Establish accountability

Getting Started

14. Build a support group
15. Understand ideas and health – environment links
16. Know the city
17. Identify potential project partners
18. Decide on the organization
19. Prepare a proposal
20. Get approval
Glasgow: working together to make a healthier city

David Black

The largest city in Scotland with some 700,000 inhabitants, Glasgow is a city of change and contrasts. A city of change in that it has moved from being seen as a grim industrial area to being named as one of Europe’s Cities of Culture; a city of contrasts in that there are still significant inequalities in health between the richest and poorest areas.

Glasgow has an unenviable health record. The very poor health of a substantial number of its citizens has been recognized by the major agencies in the city for a number of years, and they have been developing collaborative ways of tackling this problem. One of the major successes in this work has resulted from its membership of WHO’s European Healthy Cities Project. It accepted WHO’s invitation to become a member in 1988 because the partner agencies realized that to tackle the city’s inequalities meant working together. Health had to be put back on the agenda for action at city level.

At the heart of the Glasgow Project lies the belief that Glaswegians are more healthy or less healthy according to the ingredients of their everyday lives. Health is the outcome of such factors as personal behaviour, access to services, warm homes, affordable fuel, reasonable employment and good social and physical environments. Clearly therefore, a purely medical approach to changing the health of the city would be inappropriate, so the project has developed a number of partnerships to work on the key issues.

The Scottish city of Glasgow has an unenviable health record. Now ways of tackling this problem have been worked out, thanks to the city’s membership — since 1988 — of the European Healthy Cities project.

Examples of good practice

In its seven years of existence, the project has had a major impact on how the city views and tackles health matters. It has supported developments at both the community and the policy levels which exemplify a new way of working on health; these have been recognized within the city, in Europe and further afield as examples of good practice.

The project is committed to supporting the development of local action projects which attempt to put health-for-all principles into practice, and has already provided splendid examples of the strengths of collaborative work at a community level. Much of the activity has been based on the concept of community health workers. These volunteers are local people who have been trained and given the necessary support. This approach ensures that the work reflects locally defined needs and interests and can therefore win support and be developed.

In Drumchapel, a local council housing estate in the north-west of the city, the Drumming up Health Project has been running for six years. It is based in the local health centre and is funded through a mixture of Government Urban Programme funding and secondment from the health authority. The community health volunteer scheme and the community health library have provided fertile ground from which a number of innovative and exciting projects have grown. These cover areas as diverse as the women’s health network, a breastfeeding support group, an asthma support group, One to One (a counselling and complementary therapy project), a men’s health group, Food Action Drumchapel and a community health newspaper.

In all these activities the local volunteers are key players, having in most cases been the originators of the idea as well as supporting its development. The real collaboration between the local paid workers and the volunteers has been a feature of this exciting and successful project.
Policy development

Viewing health as an outcome of all the activities which take place in a city means that health must have a place in the policies of all the city's agencies. The project has sought to do this in two main ways: by working with the service agencies themselves to develop a broad-based City Health Plan, and by supporting the preparation of policy initiatives from outside the statutory agencies.

The project supports a number of working groups to explore important areas of health work and bring them to the attention of the city. The project's Women's Health Working Group has developed a Women's Health Policy for the city which has been accepted by all the statutory agencies and is being implemented. The aim of the policy is to improve the health and well-being of women in Glasgow, and it sets out recommendations to be followed whenever issues of women's health arise in these agencies.

The project launched its city health plan document in March 1995. This document is seen as the first step for the city as a whole to work towards better health for all its citizens. The plan is a collaborative document, since bringing about change of the size and complexity needed to make any city healthy is only possible through joint work. It provides an overview of all the work that is taking place to advance health. A model for the development of joint work is set out, and the plans and proposals of the agencies for further work are described. The plan has been accepted as policy by all the agencies, and a monitoring and development group has been set up.

Over its six years of existence the project has seen the development of collaboration by project partners on a wide range of innovative policies, programmes and projects aimed at the root causes of poor health in Glasgow. A substantial amount of new health work involves upwards of 200 staff all working towards making the city one in which all its citizens are able to reach their maximum potential unhindered by the burden of ill-health.

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The Chittagong Healthy City Project

Edmundo Werno & Trudy Harpham

The Healthy Cities Project in the second city of Bangladesh is encouraging local people to use existing resources to the maximum and to mobilize themselves to seek complementary resources. This makes all their endeavours far more sustainable and more likely to have a real effect than if the populace were “spoon-fed” with top-down projects.

The ancient city of Chittagong remained small until about 1960. Then in a few decades its area soared from just over ten square kilometres to 183 square kilometres, and its population from 300 000 to between 1.5 and 2.5 million. Today the city is the second largest in Bangladesh, the country’s main seaport and its main industrial centre.

This rapid growth has been accompanied by increasing urban problems. Poverty abounds, and it is estimated that there are 110 slum areas where about one million people live. The provision of most urban services has been inadequate, and the fabric of buildings shows significant signs of decay. The city-dwellers face numerous health problems including diarrhoea, acute respiratory infections, injuries resulting from accidents, diseases derived from malnutrition such as anaemia, and skin diseases such as scabies. This situation stems from a combination of urban hazards including contaminated water, lack of sanitary facilities, overcrowding, constant flooding, unsafe roads, unemployment and under-employment, and poor housing. The net result is that the health conditions of the population of Chittagong will only be substantially improved through comprehensive action aimed at tackling these urban problems.

It was in an attempt to address this situation that the Chittagong Healthy City Project was launched. It started with a series of meetings and workshops held in late 1993 and coordinated by WHO.

The organizational framework of the project has followed the general structure suggested by WHO. It consists of: (i) a steering committee, responsible for major decisions concerning the project (chaired by the mayor and formed by representatives from all sectors of society and all types of organizations involved with the development of Chittagong); (ii) a project office to coordinate all activities, headed by a staff member of the city corporation (and physically based in that authority); (iii) zonal task forces, responsible for specific plans and actions in the different geographical areas of the city; and (iv) sectoral task forces, responsible for specific plans and actions in the different sectors of activity in the city (for instance, housing, water and sanitation).

City health plan

By integrating the plans of the zonal task forces with those of the sectoral task forces, the overall City Health Plan was formulated. The guidelines for the Chittagong Plan were drawn up during the workshops held in October and November 1993. From that point onwards, the organizational structure of the Chittagong Project was set in motion, and WHO has taken up the roles of enabling and monitoring progress.

A seminar organized in 1993 to finalize the Chittagong Healthy City Plan in Bangladesh.
The take-off phase of the Chittagong Project was anything but a smooth process, mainly due to the traditional way in which local institutions have worked and the lack of integration between different people and different sectors. The Healthy Cities concept entails strong popular participation and a partnership between the various institutions working in different sectors of urban development.

Yet it is the very existence of these problems that has enhanced the importance of the Healthy Cities Project in Chittagong. By working with the local people and through the urban institutions, the project has helped to build local capacity and strengthen participation at various levels. Major features of the Chittagong Project have included reinforcing the coordinating role of the local government authority (which had previously lacked the necessary support to liaise with other agencies) and stepping up support for the participation of the poorer inhabitants — hitherto traditionally left out of major urban development decisions. Support for the poor has even resulted in the establishment of a Slum Dwellers’ Forum.

The Chittagong Project is now in its second year, and it is still too early to witness tangible improvements in the health profile of the population. Nevertheless, the ground is being prepared; local institutions have gradually absorbed the project’s concept, and the degree of participation and integration of activities is much greater today. The task forces have been working hard to identify and define the most pressing needs of the city, thus leading to the drawing up of a list of priorities for action. Such priorities include a few city-wide projects, among them the construction of eight new maternal and child health centres. In addition, one of the 41 wards of Chittagong was chosen as a pilot Healthy Ward to concentrate action and to set the pattern for other wards to follow.

Although the initial “take-off” friction is now past and gone, it is true to say that the Chittagong Project still faces serious problems, such as a shortage of funds to implement activities and ongoing conflicts in the decision-making process between local participants. However, it goes without saying that a shortage of funds has always been a chronic problem for developing countries. Under such circumstances, the Healthy Cities Project makes a significant contribution by encouraging local people to use existing resources to the maximum and to mobilize themselves to seek complementary resources. This makes all their endeavours far more sustainable and more likely to have a real effect than if the populace were “spoon-fed” with top-down projects. Furthermore, conflict in decision-making is in no way a unique feature of Chittagong, and has always existed throughout the world. Healthy Cities did not suddenly create new tensions in Chittagong out of the blue. Rather, it provided a forum for hitherto repressed conflicts to surface — and only through this process will it become possible for such conflicts to be overcome.

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Giving the public their say

Jamilah Hashim, Andrew Kiyu, & Stalin Hardin

By the year 2000, a majority of the world’s population will be living in cities. The Healthy Cities Project is increasingly being recognized as a means of grappling with the human-induced crises which today, more than ever before, affect city dwellers. The challenge facing the project is to find ways of achieving a better quality of urban life.

Kuching City is the capital of the state of Sarawak, one of the thirteen States that make up the Federation of Malaysia. The city is divided into two municipalities, Kuching North and Kuching South, each administered by its own mayor. It has a total land area of 430.5 square kilometres, and its multi-ethnic and multi-religious population of 252,000 live together in harmony. Rapid industrialization is taking place but despite economic prosperity and a strong Western influence, the residents still preserve and observe their rich Eastern social and cultural values.

In July 1994, WHO invited Kuching City to join other cities worldwide in the Healthy Cities Project. The State Government accepted the invitation, and the Healthy City – Kuching Project was officially launched by the Chief Minister of Sarawak.

The specific aim of the project is to make steady improvements in the quality of life of the citizens. Health is viewed holistically, that is to say, there is a general awareness that it will be directly affected by the economic, social and physical environment. Consequently, improvements in health become the responsibility of all those agencies whose activities impinge on the environment.
What the public want

It is widely accepted that the views of ordinary people are essential and must be taken into account when plans are being drawn up that will affect their lives. Nevertheless, those views are rarely canvassed because it is not an easy task. Furthermore, policy-makers and planners often think that they know best what people want and what measures are good for them. So they usually formulate plans without first getting the opinions of the people who will be affected.

During the development of the Healthy City Plan for Kuching, a Technical Committee was formed in which the two City Councils played the leading role. Its members were made up of officers from relevant government agencies in the city. The first draft that was drawn up was based on the views of government officers and was considered inadequate because it lacked the input of views and ideas from ordinary citizens. The committee needed to know what ordinary people loved and hated about their own city.

To find out, they devised a simple, interviewer-based questionnaire for people who live in the city and people from outside who frequently visit and use the various facilities. They were asked to list five things that they (a) hated most, (b) liked most about their city, and (c) wished for most for it. The findings of this survey were then used to complement the ideas of the official policy-makers and planners.

This anonymous, non-threatening survey managed to gather valuable information. On balance, Kuching citizens had many things that they liked about the city and relatively few things that they hated. This is probably a reflection of the economic prosperity and peace that they enjoy. Nonetheless, it is very important to deal adequately with those things that the citizens “hate most” in order to ensure a continuous improvement in the quality of life for the citizens.

Hates and likes

The responses were arbitrarily categorized into economic, social and physical dimensions. Generally, a majority of the “hate most” items were in the physical dimension, and especially concerned public transport, where the number of “hates” heavily outweighed the “likes”. This is an area that definitely needed to be looked into. What citizens liked most about the city were its landscaped gardens, with plenty of open areas and parks that are available for relaxation and recreation, as well as the many shops and night markets. There is an apparent need to provide more of such facilities, and to improve as well as maintain existing ones.

Some of the findings of this survey were unexpected. For instance, it had not occurred to the policy-makers and planners that public transport was one of the main concerns of the people, or that they actively hated the present public transport system. Simple though it was, the survey was able to provide useful inputs to the policy-makers and planners in assessing and diagnosing the needs of the community. Such inputs are essential for drawing up proper plans which will contribute to meeting the needs of the public and ensuring the acceptability of those plans. The quality and the variability of responses are dependent on the background and diversity of the people interviewed. Therefore, getting a good cross-section of the people is essential to the success of such a survey.

Thanks to its usefulness and simplicity, the survey was extended to other urban areas of the State, with an additional question: “What do you feel you can do to make your town a better place to live in?” The findings of this broader survey will be used as plans are developed for the other urban areas. Thus the Healthy City - Kuching Project will benefit not just those who live in the city; planning concepts that emerge from it will benefit all the urban dwellers of Sarawak.

A letter from the Malaysian Ministry of Health declaring Kuching the cleanest and most beautiful city in Malaysia.
Venezuela: the community spirit

Hernán Málaga

Important changes have taken place in the health field in Venezuela in recent years. Even though there is still a tendency to think of hospitals as the key element of the system, the enormous importance of preventive medicine and of the strategy of primary health care is being recognized again. In January 1994, the Healthy Cities Project was launched in Venezuela at Zamora Municipality, Falcón State. The project has made it possible to establish a communication channel between the civil population, the health team and local politicians. The PAHO Office in Venezuela has played an important role in the process, and by September 1995 no less than 13 municipalities were incorporated in the programme.

In each case the strategy involves action aimed at promoting healthy public policies, favourable environments, community action, the development of personal skills, changes in lifestyles, and the reorientation of health services.

Once a municipality or impoverished area has been selected, the mayor and the local health authority agree on a strategy based on a proposal by PAHO. Later, meetings are held to sensitize the community groups involved, problems are identified and the health situation is analysed. Specific projects can then be designed for subsequent presentation to potential donors and to the rest of the community.

Zamora Municipality of Falcón State is in north-western Venezuela, and has 30,000 inhabitants. It is in a region of beautiful landscapes and coastlines, impressive highlands and many rivers and streams. One of the main characteristics of Zamora is its high level of community participation and social solidarity. These have contributed to important achievements, such as the building of an aqueduct, and the enforcement of health protection measures against a cement factory which operated in the neighbourhood. Political support within the municipality finally led to the declaration of Zamora as a City Towards Health.

After many meetings convened by the mayorress, attended by representations from several sectors of the population and with a carefully designed methodology, it proved possible to draw up projects that reflected the real needs and priorities of the community. These were formally made public in September 1994,
at an event attended by the whole community, the Governor of the State, and representatives from the European Union, UNDP and other national and international cooperation agencies. The projects covered a wide range of needs, including family orchards, solid waste disposal, recreational activities, teachers’ development, classes in reading and writing for preschool children, early pregnancy, care of senior citizens, and preventive care.

The enthusiasm shown by the municipality and the community led to the constitution of a Healthy Cities Network in May 1995, linking Falcón with the rest of the country; the inauguration of a “Neighbours’ House” as a centre for community work and follow-up activities to the programme; and the publication of a periodical on health promotion. A Permanent Technical Council was also created to oversee the carrying out of the projects. The Governor, the Dean of the University, and the Mayoress of Zamora and all the mayors who attended the original meeting were signatories to agreements putting these projects into effect.

**Improving a city’s slums**

Maturin is the capital of Monagas State in north-eastern Venezuela, one of the most promising areas for tourism and industrial development. Traditionally, this State was devoted to agriculture and cattle, but it also has a great potential due to its vast oil reserves. Half of the State’s population live in Maturin, which has about half a million inhabitants. Although a prosperous city with thriving businesses, it is surrounded by slums where people live in extreme poverty. These slum areas were chosen to join the “Cities Towards Health” Programme.

After a long series of meetings convened by the mayor of Maturin, the chosen set of projects were formally made public in May 1995. This event was attended by 85 participants from different sectors, including the Minister of Health and Social Welfare, the Mayor of Maturin and the PAHO Representative.

The projects were prepared with a logical methodology and represented a response to the most urgent and important needs identified by the community. These included housing, sewrage systems, drainage of rain water, reservoirs for drinking-water, street and sidewalk repairs, solid waste disposal, aqueducts, adolescent lifestyles, communal drugstores, family orchards, and police precincts.

By September, work had already begun on several of these projects. The municipality and the community are still seeking sponsors to finance their projects at the local, regional, national and international level. Of particular significance is the interest shown by the community itself and its willingness to participate in this initiative and to take a positive and open attitude towards health promotion.

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**Healthy Islands**

**The Yanuca Island Declaration on Health in the Pacific in the 21st century**

The Healthy City concept and approach, far from being limited in its application to urban areas, can always be modified to suit local needs. In March 1995 on Yanuca Island, Fiji, the Conference of Ministers of Health of the Pacific Islands adopted the concept of “Healthy Islands” as their unifying theme for health promotion and health protection. The Healthy Island approach can best meet the challenge of improving the health system, ensuring that health care processes become more integrated and holistic, creating stronger links through networking between the island nations, and paying greater attention to health promotion and protection, to environmental health and to intersectoral health initiatives. Furthermore, Healthy Islands can build on the health resources that are available, including training institutions and programmes for the health professions. Among these are the medical, nursing and allied health schools in American Samoa, Cook Islands, Fiji, Guam, Kiribati, Northern Mariana Islands, Marshall Islands, Federated States of Micronesia, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga and Vanuatu.

The Yanuca Island Declaration endorsed agreements made in the areas of health at work, environmental health, and pharmaceuticals and medical equipment. National action plans will be drawn up to meet the unique health and environmental needs of each country, and to identify environmental factors which adversely affect health. Healthy Islands is seen as an innovative concept that can help to mobilize people and resources to solve health and environmental problems, and that can give impetus to intersectoral action, policy development, health promotion, preparation of legislation and capacity-building at all levels. The Declaration emphasized that all countries must work together by sharing information, technology and expertise aimed at improving the environment and raising the general status of health.
Three cities of Jordan

Eric R.J. Giroult

The wide variety of social, environmental and health problems that face the urban areas of Jordan are being systematically targeted through Healthy Cities projects in three very different cities.

The only harbour

Aqaba is the country's fastest growing city and its only harbour. The harbour activity has grown tremendously owing to increasing exports of minerals and fertilizers. Part of this fertilizer industry is located in Aqaba and is the source of significant air pollution. There has been a huge increase in transit traffic across Jordan, through the port, towards the countries of the Arab Gulf and especially Iraq. In addition, Aqaba is now attracting international tourism, so the 27 kilometres-long seashore is the scene of both industrial and tourist developments.

The waters of the Gulf of Aqaba do not yield large quantities of fish or seafood, but there are remarkable coral reefs where rare species of sea creatures live. Since freshwater resources are so limited, underground water from central Jordan is supplied to the city through long-distance aqueducts, but increasing demand for water has triggered studies into the possibility of building a sea-water desalination plant. Using tankers to import fresh water is another possibility but has not yet been seriously considered. Despite the scarcity of water resources 97% of the population has access to safe drinking-water, although the per capita consumption is limited to 70 litres per day through a rationing system.

Aqaba does not yet have an adequate sewage disposal system. Even if the sewer network is extended but no treatment plant is built, the quality of seawater may soon become incompatible with tourist development and the survival of coral reefs. To overcome this problem it is planned to design the future...
A Palestinian refugee in Jordan. Efforts are made to change refugee camps into ordinary neighbourhoods.

Refugee camps

Irbid is a middle-sized city in northern Jordan, and shares the same environmental, social and epidemiological problems as the country’s other urban areas. These include the impact of refugee camps, which for many have become a long-term home. It is therefore necessary to change the refugee camps into regular urban neighbourhoods. Jordan’s housing authority has drawn up three main criteria for assessing slum conditions; the first is based on overcrowding, the second on the availability of piped water and hygienic latrines, and the third on the quality of roofing – whether it keeps out rainwater and provides enough thermal insulation. When those criteria were applied in a national survey, they showed that 80% of Jordan’s slums are located in refugee camps.

Irbid’s Healthy City action plan therefore includes the rehabilitation of refugee camps, but also total coverage of the population with the eight components of primary health care, and intensification of health education and health promotion activities aimed at women and schoolchildren.

Toxic emissions

Zarqa is a relatively remote part of the Amman metropolitan area, where several hazardous industries are located, as well as a gigantic sewage treatment plant serving the 2 million metropolitan residents. As a result of toxic chemicals emitted from industrial sources, there have been several cases of human poisoning, and there is an urgent public health need to abate industrial emissions.

The Zarqa River drains most of the metropolitan area and, after receiving the effluent from the huge sewage treatment plant, carries it to the King Talal reservoir, which feeds agricultural irrigation schemes in the Jordan valley. If the present phytotoxic content of the river increases, the reservoir’s water quality may become incompatible with agricultural needs. This is yet another reason for controlling toxic chemical emissions, even though industrial development is vital to provide jobs for the increasing population.

Zarqa’s Healthy City action plan gives top priority to limiting the impact of toxic chemicals on health and the environment. This entails strengthening the occupational health services, monitoring industrial liquid or gaseous emissions, and also encouraging the industries responsible for pollution to invest in abatement devices. Other activities are planned to achieve full coverage by primary health care services, to step up health education and to ensure that women, schoolchildren and industrial workers benefit from health promotion activities.
Measles in the cities

John Clements

Measles immunization is one of the most cost-effective public health tools; it makes good sense to concentrate measles control in the cities, where case fatality rates are highest and the disease causes greatest damage.

Bringing immunization to underserved areas in the cities is a vital – and potentially difficult – part of the Expanded Programme on Immunization (EPI). Special activities are called for to achieve high vaccine coverage and target specific diseases for control. Focusing on urban measles control helps programme managers to increase coverage for the other EPI diseases at the same time.

Using World Health Day 1996 to promote measles immunization among the urban poor is an opportunity that must not be missed. Even though global coverage of 78% for measles vaccine has been achieved, over a million children still die from measles each year and another 43 million contract the disease, many of whom will suffer severe complications. Measles immunization has been called one of the most cost-effective public health tools ever invented, so to concentrate measles control on the cities – where case fatality rates are highest and the disease does the most damage – makes good sense. The additional resources required are well justified in both economic and humanitarian terms.

Routine immunization services may not be enough by themselves to control the EPI target diseases. Floods and other natural disasters sometimes hamper the work, urban slums are often underserved, and their inhabitants tend not to use existing services.

High risk

Measles, poliomyelitis and neonatal tetanus cases do not occur at random throughout the population, but can be seen to cluster in certain geographical areas (high-risk areas) and in certain population groups (high-risk groups). For measles, high-risk areas are those with a high population density, high mobility, and low immunization coverage.

Most high-risk groups are found in such areas, where children may also be malnourished and vitamin A-deficient. They include mobile populations, ethnic minorities and refugees, all of whom tend to gravitate towards the poor areas of cities.

Because these groups are often hard to reach with immunization services, countries may have to adopt new strategies to ensure that the vaccine reaches those not at present served by fixed centres; they also need to target an expanded age range of at least 9 to 36 months.

The strategy of using urban mass campaigns to immunize high-risk groups has been endorsed by WHO, UNICEF and the Children’s Vaccine Initiative. If it is to succeed, measles control in urban areas will require enthusiasm from donors and national programmes. Efforts to raise measles vaccine coverage needs to be accelerated through national or subnational immunization days to
reduce measles in these areas. Measles campaigns should be implemented rapidly in every high-risk situation as an additional strategy to control this disease.

Five aspects of the epidemiology of measles are particularly important for control activities:

- the virus circulates easily in densely packed communities where children are under-immunized;
- the phenomenon of "seeding" occurs, whereby urban measles is seeded or exported to nearby villages and towns which might otherwise be free of the disease (or at any rate have a much lower incidence);
- studies in a number of cities show that measles continues to circulate in the urban environment despite reasonable immunization coverage, so even if routine coverage exceeds 80%, the disease may not be eliminated from the densely populated areas through routine immunization services;
- measles case fatality rates are highest in very young children who contract the disease, and cases in cities tend to occur at younger ages;
- measles in the cities frequently loses its tendency to fluctuate with the seasons, and continues like a smouldering fire which never goes out.

**Multi-disease campaigns**

Health authorities will need to decide whether measles control is a top priority for them, and whether they can afford to provide other vaccines at the same time. Many urban high-risk districts for measles will also be at high risk for neonatal tetanus and polio. It may be possible to run multi-disease campaigns simultaneously for measles and oral polio vaccines as well as tetanus toxoid for women of childbearing age. Vitamin A should also be considered as a low-cost effective intervention at the same time.

The cost of a campaign in the urban slums will not be great. Partners such as UNICEF and various nongovernmental organizations will find it an attractive venture because it reaches top priority groups and will have a big impact on the target diseases. Experience in the Americas suggests that the full cost of a measles mass campaign ranges from US$ 0.50 to 0.75 per child; if administered during a polio mass campaign, the cost additional to that of polio is about $0.30 per child. Funds will be needed to purchase vaccine, syringes and needles. WHO and UNICEF recommend the autodestruct syringe for campaigns such as this.

Areas and populations which in the past are likely to have resisted invitations to come forward for immunization need to be specifically targeted and new ways must be sought to reach them or attract them to fixed centres. World Health Day 1996 offers a particularly good opportunity for introducing such new approaches.

Bangladesh has set a good example with its 1995 immunization campaign for tetanus toxoid and measles vaccine. All high-risk districts for measles are in poor urban areas. Today, overall coverage for all antigens has increased to around 75% but is lower in high-risk areas. Manila in the Philippines and Lagos in Nigeria are also undertaking lively urban immunization programmes.
Mental health matters
Ilona Blue & Trudy Harpham

As cities in developing countries grow and face a multitude of problems related to the provision of basic services, it seems well worth while to consider the mental health of city dwellers — who represent an increasing proportion of the population in developing countries.

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HO's definition of health stresses the importance of mental, physical and social well-being as opposed to the mere absence of disease. The inclusion of mental well-being in the overall definition of health, no less significant in past decades than it is today, has not led to any major improvement in the status of mental health in international public health work. In the last few years, however, there have been some indications that mental health issues are finally gaining ground and becoming accepted as an important part of the public health agenda. One manifestation of this was the recent publication of World mental health: problems and priorities in low-income countries (by Robert Desjarlais, Oxford University Press, 1995), which prompted the UN Secretary-General to declare: “Priorities must change. Mental Health must be recognized as a foremost challenge ... an international campaign is needed. It is time for mental health problems to be seen by the international community as what they are: a threat to individual well-being, and a threat to peace and development worldwide”.

The notion that cities are inherently bad for both physical and mental health has a long history, but early research on mental health problems in urban areas focused exclusively on developed countries. This was mainly because it was assumed that the health problems of developing countries were limited to the so-called “traditional” problems of malnutrition and infectious and parasitic diseases. However, research into the “epidemiological transition” in developing countries has demonstrated that “newer” diseases such as heart disease, cancer and mental disorders are prevalent in developing countries. Whether or not mental disorders are more prevalent in urban as opposed to rural areas remains unclear. As cities in developing countries grow and face a multitude of problems related to the provision of basic services, it seems well worth while to consider the mental health of city dwellers — who represent an increasing proportion of the population in developing countries.

The common mental disorders have a debilitating effect on the sufferer and their families, and also result in a significant burden being placed both on primary health services (research has shown that around 20% of primary care attenders have a common mental disorder) and on society as a whole. There is clearly ample justification,
from both an economic and humane standpoint, for advocating that increased resources should be directed towards issues pertaining to mental ill-health.

**Risk factors in the cities**

It has been established that there are strong links between social and environmental factors and mental well-being. In particular, urban environment has been considered as having a particular effect on the onset of mental disorders. Possible risk factors include those related to long-term stresses due to the physical environment (e.g. overcrowding), the social environment (e.g. social disintegration), low availability of positive social support, and negative life events (e.g. loss of employment). It is in urban areas that many of the above factors occur in profusion.

To give some idea of the various problems faced by people who live in urban areas of developing countries, the following quotations are taken from focus-group interviews held with women in one of the poorer districts of São Paulo, Brazil. They indicate some of the daily worries of women in the area, particularly related to the place in which they live:

"I don't like where I live, there are lots of shacks. The roads aren't paved, we made the drains ourselves. There are people who live right on top of sewage. There's flooding ... there's a place near where I live where water runs down the road; I don't want my son to get ill."

"There is a lack of safety at night. We listen to gunshots, there's violence. The traffic is violent, cars don't stop at traffic lights. They don't look out for children going to school."

"Violence goes on everywhere, but especially in schools. Men abduct girls. I fear for my son even when he is studying during the day ... It's completely open, anyone can get in. There is a piece of waste ground in the school; a dead child was found there."

"Where I live there are gunshots, even during the day. If we are outside when it happens, we run in because we're frightened. This happens anytime, not just at night. People grab their kids and run away."

**Beyond individual control**

These quotations demonstrate a variety of factors operating at a level beyond an individual's control that are likely to influence people's stress levels, well-being and therefore mental health.

Various types of interventions for improving mental health have been identified. These may be: 1) training of staff to improve detection and management of a range of disorders at primary, district and village health worker level; 2) community-based interventions such as self-help groups, training of child care staff, and better policing; or 3) related to the macro-level, promotion of women's education and access to the legal system, advocacy of employment programmes and so forth.

To date, much of the effort to make cities healthier has focused on physical aspects of health. This is not surprising, given the overall emphasis on physical health in much of the international health literature. However, mental health problems abound in urban settings, and it is increasingly being recognized that tackling such problems is a vital step to take if the health of communities is to be improved.

WHO's Healthy Cities Projects offer a unique opportunity for improving health city-wide. Mental health poses a considerable challenge to health professionals everywhere in the world. But it is possible that these projects, through their emphasis on multisectoral interventions and by insisting that tackling health issues should not be confined to the health sector alone, can bring about a real improvement in the mental well-being of large numbers of city dwellers.

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Reducing urban violence
Joan Twiss

Graffiti and marginalized people — increasingly common features of the world’s large cities.

Healthy Cities all over California are rising to the challenge of preventing violence, using approaches that seek to reflect a comprehensive view of community health.

In recent years, the problem of violence in California has demanded the attention and resources of municipal leaders throughout the state. Community residents have grave concerns about their safety. The escalating incidents of violence increasingly involve young people. Today, nine of California’s 23 participating cities have violence issues on their Healthy Cities agenda. Their efforts are categorized under four headings: neighbourhood focus; community-wide initiatives involving youth; school-based efforts; and getting at the underlying causes.

Neighbourhood focus
Berkeley is transforming the Telegraph Avenue/South Campus area into a safe and economically vital neighbourhood. Lying south of the University of California campus, this area has been characterized by above-average prevalence of assault, drug-related and other violent crime, and high numbers of mentally ill and homeless individuals.

In August 1993, Berkeley launched a programme which united the city, residents, merchants, students, property owners, churches, the University and others in this effort. Activities include monthly “Cops and Shops” forums to promote public safety and maintain communication with Telegraph Avenue merchants; community meetings to develop common standards on alcohol sales; treatment and aftercare of adults with drug and mental health problems; and community celebrations which have attracted thousands to the area. Since the project started, arrests for assaults have fallen by 36% and arrests for violent crime by 47%.

Oceanside is conducting a community-wide effort to improve the appearance and safety of a demonstration neighbourhood through positive community-based projects. To curb graffiti, the city developed the slogan “Community begins with me!”, sponsored a Community Awareness Day attended by 100 people and made a video for elementary schools called “You have no right to tag”. Later, surveys carried out in Spanish and English among more than 200 neighbourhood residents found that there had been a 55% reduction in graffiti. Residents also reported greater participation in neighbourhood watch and clean-up programmes.

Community-wide initiatives involving youth
Ideas for Cathedral City’s initiative arose from its Gang-Related Activity Suppression Programme (GRASP), originally formed to fight gang violence, drug dealing and drive-by shootings. In carrying out GRASP, police officials learned that youth in trouble share one common characteristic — low self-esteem. By increasing self-esteem, Cathedral City’s goal is to reduce incidents of graffiti vandalism, drug-related crimes and violence in schools.

The programme kicked off with “I Like Me! Week” in cooperation with the Palm Springs Unified School District, in which 7500 students received lessons in problem-solving, conflict resolution and other interpersonal skills. Over 200 teachers and administrators later
gave a positive evaluation. Although this has been a Healthy City for only six months, it has already initiated many other activities, including leadership training for 18 young people; creation of a “warm line” for troubled youth needing support not available at home; “Club PM”, which hosted 62 youngsters at its grand opening; and “Top Ten” groups, in which at-risk youth discuss personal responsibility, conflict and other relevant topics in their lives.

The town of Vista is expanding its youth mentoring programme “Club Challenge”, using the premise that increasing self-esteem and a sense of belonging to the community will deter young people from gang involvement, substance abuse and other antisocial behaviour. A unique aspect of the programme is a signed contract in which each participant agrees to increase school attendance by 20%, decrease detentions and suspensions by 50% and participate in 18 productive community activities during the year. Community activities may include feeding the homeless, cleaning parks and streams, attending a City Council meeting or “shadowing” a mentor for a day.

Coachella’s Bicycle Conversion Program provides at-risk youngsters with refurbished bicycles, which otherwise would be auctioned, in exchange for ten hours of community service in litter removal, graffiti abatement, assisting senior residents and other activities. The Coachella Police Employee’s Association provided basic training in bicycle repair, so that repairs could begin on 12 bicycles. The City’s goal is to have 100 young folk participating, ultimately enabling the City to reduce youth arrests, establish positive youth activities, and decrease graffiti and litter throughout the city.

Chino Hills established an initiative in partnership with the San Bernardino County Probation Department. The Chino Hills Advisory and Mentoring Program (CHAMP) pairs first-time juvenile offenders with adult mentors to link them with counselling, training, employment and recreation opportunities. Twenty-five volunteers have completed training, allowing work to begin with ten juvenile offenders. CHAMP was publicized through numerous community presentations, press releases, news articles, public service announcements and a press conference.

School-based efforts

Chico began “Healthy Chico Kids 2000” with a ten-month media campaign, posting billboards in strategic locations to reach a cross-section of the population, and completing conflict management workshops in four out of six targeted schools. Pre- and post-campaign tests will assess the success of these efforts.

To decrease the number of adolescents who fight and carry weapons in Pittsburg schools, 300 at-risk youngsters received education and outreach services to prevent gang-related activities. Another 300 participants – young people, adults and professionals – discussed how to develop a violence-reducing curriculum at a “Violence Prevention Summit”. The city continues discus-

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**Getting at the underlying causes**

Escondido is undertaking an innovative strategy for reducing crime and violence by developing a “community prevention planning database” to identify indicators for alcohol-related crime and trauma in the context of community-wide planning. Escondido produced maps and graphics depicting alcohol-licensed establishments and their distribution in high-crime areas for use by community meetings. Ultimately, the database will allow the city to monitor and evaluate crime-prevention policies and strategies.

By working in partnership with other public agencies, the private sector and community residents, Healthy Cities all over California are rising to the challenge of preventing violence, using approaches that seek to reflect a comprehensive view of community health.
Health in housing

Harold L. Cohen

In every community, talented individuals have learnt by experience how to solve problems. It is these competent people who form the critical core for the programmes of the US-based Health in Housing initiative.

HIH works with professionals and community workers to help those involved to find and use the services and resources available. Local HIH teams cooperate with regional government agencies responsible for areas such as health, housing, social services, education, water and sanitation in designing programmes that strengthen existing services or meet specific community needs.

Most of the projects are initiated in poor neighbourhoods and newly settled barrios where basic services are not being provided. HIH's Healthy Cities approach is based on helping these families to learn how to improve their health while upgrading their housing and physical environment. Efforts to provide services to a community often fail because they treat all communities in the same way, they don't involve the people concerned in the process of recognizing problems and designing solutions, and they don't enlist the support of the local leaders. In the past, agencies have examined and treated such complex problems as housing, water and medicine through separately funded projects, each with its own focus. This segmented approach to a compound problem rarely succeeds.

Too little time

Complex social and often life-threatening problems cannot be solved or even understood in the short funding period usually assigned to community programmes. In our experience, just getting people to work together and to identify the problems takes from two months to a year, and initiating a project takes between two and five years. Community people have too little spare time to participate actively, but having outsiders to do most of the organizing, designing and setting of goals and tasks means that people are not taught how to help themselves. Each community works at its own pace, and is made up of diverse people with different skills, different schedules and usually with very little experience of collaborating with national or outside agencies.

Too often, agencies have little interest in administering small programmes, and treat people as ignorant children who need the agency's fatherly help. HIH is opposed to large-scale, indiscriminate funding for programmes which the community has not asked for and is unable to sustain after the initial funding grant is stopped. Instead, HIH offers support to those who ask for it. However, they must work with us, learning how to operate the programmes themselves.

Courses in primary health care

Where doctors and hospitals use the medical model to treat sickness, the HIH teams teach families—particularly mothers and children—how to prevent illness and how to avoid the spread of infectious diseases. Each
A father with his newborn baby. Whether people have a standard academic education or not, they can learn how to create a better lifestyle for their family.

The project offers primary health care courses and self-help programmes within the community—teaching them to be responsible for their own health. The participants are helped to build, maintain and repair their own shelters, and to develop community plans for cleaning up environmental health hazards.

HIH auxiliary centres are located within the country’s universities and collaborate with the regional government agencies to carry out multifaceted programmes in the communities. Every effort is made to integrate this approach into the curricula of professional schools teaching medicine, nursing, social and preventive medicine, architecture, planning, community development, sanitary engineering and other relevant subjects. The auxiliary centres also develop short courses and seminars as extra curricula. In this way, HIH enters into a partnership with all the sectors involved in creating healthy cities.

In every community, talented individuals have learnt by experience how to solve problems. These people have survival skills that come out of their history: building houses, making stoves, growing vegetables, resolving social issues. It is these competent people who form the critical core for any HIH programme. Of course, different approaches are applied to inaugurating programmes and developing facilities in different countries—whether in a barrio in Tegucigalpa, Honduras, a lowly suburb of Caracas, Venezuela, or two city public schools in poor neighbourhoods of Buffalo, New York State.

Many people without an academic education have learnt not only how to survive in brutal environments but also how to create a good lifestyle for themselves and their extended families. Governments and nongovernmental organizations often ignore these accomplishments, creating the illusion that they alone know how to solve their problems. The result has been to make dependency a way of life that rodes an individual’s self-respect and destroys all community initiative.

If we really wish to create healthy cities, we must break out of this system and start supporting local people and accepting them as partners. We must make sure that governments and international agencies learn how to work together with their clients to make strong families, healthy cities, and strong democratic nations.

In the next issue

Our culture is a powerful determinant of our health, and culture is in turn deeply entrenched in our behaviour. It is all the more important, therefore, to take cultural factors into account when providing health care. The March-April 1996 issue of World Health will study this delicate interrelationship as a contribution to UNESCO’s World Decade for Cultural Development (1988-1997), which has as its 1996 theme: Culture and Health.

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Corrigendum

The article on Tobacco on page 16 of the July-August 1995 issue of World Health on Substance Abuse Prevention contains an incorrect figure. The statement that “about 6000 million million cigarettes are smoked every year”, should have read “about 6 million million cigarettes are smoked every year.”
7 April 1996

World Health Day

Healthy Cities

For Better Life

World Health Organization