

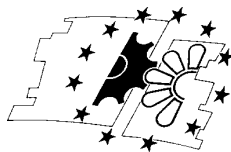
City planning for health and sustainable development



European Sustainable Development and Health Series: 2



European Sustainable
Cities & Towns Campaign



European Commission
DG XI



WHO Regional Office
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Healthy Cities Network

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Target 14: settings for health promotion

By the year 2000, all settings of social life and activity, such as the city, school, workplace, neighbourhood and home, should provide greater opportunities for promoting health.

ABSTRACT

City planning for health and sustainable development is the second document in the European Sustainable Development and Health Series produced by the WHO Healthy Cities project within the European Sustainable Cities & Towns Campaign. It describes how health and sustainable development are closely related. City health plans form an important model for local Agenda 21 plans, using local health profiles and promoting community participation to achieve change at the municipal level. Examples of practice are drawn from Belfast, Bologna, Glasgow and Liverpool. The text includes 47 references and further sources of information.

Keywords

URBAN HEALTH
HEALTHY CITIES
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Public health action has always focused on the relationships between the environment and health, and these relationships now have a global perspective. Frameworks for action on socially and environmentally sustainable development are necessary because uncoordinated economic and social development is having increasing adverse effects on people and the planet. The 1992 United Nations Conference on Environment and Development recognized the role of urban communities in shaping healthy and sustainable development in Agenda 21, the United Nations programme of action on sustainable development.

This is the second document in the series on European sustainable development and health produced by the WHO Healthy Cities project within the framework of the European Sustainable Cities & Towns Campaign. It sets the background for local Agenda 21 and healthy cities, exploring the challenges underpinning these movements and describing the similarities between them. In particular, this document explores how the work on health challenges developed within healthy city projects

can support the fulfilment of the recommendations related to health found in Agenda 21. This document draws on the experience of a wide range of work taking place around the world to indicate directions for the long journey towards sustainable wellbeing.

The key recommendations on health in Agenda 21 relate to developing municipal health plans, using local health profiles and strengthening city networks for health. The work of healthy city projects in Europe since 1987 provides many specific methods of tackling these challenges at a municipal level. They include the development of structures that ensure the participation of the community as well as service organizations, the development of health profiles for cities and towns and the process of developing and sustaining city health planning.

Creating healthier and more sustainable cities and towns requires new approaches to planning. This document aims to support people in urban settings who are attempting to develop collaborative work and integrated action on the challenges that affect health and sustainability. Action needs to be developed at the local,

national and international levels to move towards a healthier and more sustainable world. The development and sharing of new approaches at the local level is of key importance in this challenge.

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Introduction

The world is becoming increasingly urbanized. The projected number of people living in cities is expected to more than double between 1990 and 2025, growing from 2.4 billion to 5.5 billion. This trend is accelerating in developing countries; their share of the total urban population will rise from 63% in 1990 to 80% in 2025. The huge increase in urban population linked to the economic development of cities and towns has given rise to concern about the sustainability of these trends.

The growth of the world population and the development of consumption patterns that cannot be sustained ecologically and socially are severely stressing the life-supporting capacity of

the planet and the ability of many countries to prosper and support the wellbeing of their inhabitants.

The United Nations Conference on Environment and Development, held in Rio de Janeiro in 1992, attempted to address a huge range of environmental and social problems related to economic and population growth. The Conference stated that the world has reached a defining moment in its history. A choice has to be made: either to maintain development policies that will continue to destroy ecosystems and further deepen the economic divisions within and between countries or to change course. The Conference argued that the thrust of development within the world must move towards being sustainable,

not just for now but for the future.

To support a move towards meaningful policies in urban sustainable development, the Conference presented Agenda 21 (1), the United Nations programme of action on sustainable development, as an agenda for the twenty-first century. Agenda 21 places environmental concerns within a social and economic framework, starting from the needs of people (1):

Human beings are at the centre of concern for sustainable development. They are entitled to a healthy and productive life in harmony with nature.

Agenda 21 highlights the role of cities and towns in developing sustainable practices. Local government is identified as a main partner in implementing the Conference's recommendations by developing local Agenda 21 action plans.

Agenda 21 sees human health as fundamental to sustainable development. Health is understood as being an outcome of all the factors that affect human beings. Sustainable development requires paying attention to the determinants that shape health

outcomes.

Agenda 21 refers to health more than 200 times. One section of Agenda 21 devoted explicitly to health highlights that (1):

...the primary health needs of the world's population are integral to the achievement of the goals of sustainable development.

Agenda 21 views health as the outcome of environmental, economic and social factors that also affect sustainable development. WHO has also developed work that sets health outcomes in a similar framework (2). Since 1978, WHO's strategy for health for all by the year 2000 has developed a range of projects within both industrialized countries and developing countries.

Agenda 21 and the health for all programme have many common principles and complementary processes. They are both international programmes adopted by countries but operating at the national, regional and local levels. Both have a core concern for human health and wellbeing in the present and future. Social, environmental and economic challenges are addressed holistically, and both programmes are based on the

“The message has come through that – on a global scale – the future of mankind will be shaped largely by urban conditions. Whether or not governments find ways of coping with accelerating urban growth, whether or not local authorities find ways of coping with pollution, limiting automobile traffic, securing basic health and social needs – this will determine the quality of life for the generations to come and with it the chance to solve conflict within nations and between them.”

Source: Topfer (3)

principles of equity, sustainability, community involvement and intersectoral action.

WHO has established the Healthy Cities project to explore the opportunities and mechanisms for developing collaborative action in cities to achieve health for all. Many cities involved directly in the project and others working within this model have developed practical experience that can be used to fulfil the health requirements set out for local governments in Agenda 21. Especially useful models have been developed in collaborative and intersectoral work on urban health challenges and in municipal and city health plans.

Trying to make positive changes within cities requires establishing the rationale and the action required. Both Agenda 21 and health for all address core human aspirations. In the form of local Agenda 21 and healthy city projects, both programmes provide important tools for enabling change at the local level. Both programmes have inspired a range of ideas, information, projects and publications.

This document is a practical guide to taking forward the health component

of local Agenda 21. It brings together the main thinking about local Agenda 21 work and healthy city projects and explores the challenges underpinning the two movements. It discusses the links between them and examines the extent to which practice developed within healthy city projects can help to fulfil the recommendations relating to health of Agenda 21.

Although this book should be read as part of the series, it also summarizes some of the important concepts of both health for all and Agenda 21 and introduces some of the challenges.

This document is designed to assist the people responsible for the environment, health and overall planning in cities in supporting the development of the health dimension of planning for sustainable development. Many people are familiar with one or more of the challenges; this document can promote linkage between different disciplines and sectors. It can be especially useful for planners and developers responsible for or involved in local Agenda 21 work.

Note

The term “city” in this document means the full range of centres of population and settlement, such as towns and boroughs.



Life in cities

Urban settlements have developed over the last four thousand years of the approximately two million years that humans have existed on Earth. Over the past century, the balance of the population has tilted away from the countryside, the pace quickening with industrialization, and now nearly half the world's population lives in cities. This trend is slowing in industrialized countries but increasing in developing countries. War, plague and other diseases, medical advances, trade, technology, religion and perspectives on urban growth have all played a part in creating and sustaining cities, although there is considerable debate about the relative importance of each.

Cities are complex and dynamic places of contradiction that have been compared to living organisms. They contain opportunities for developing the potential and enriching the lives of many of their inhabitants. Nevertheless, life in cities can reduce the wellbeing of some people. In many ways cities represent the reality of political, economic and social decisions made nationally and globally. On the other hand, past and present struggles for local autonomy have created the identity of each city. They have also counteracted some of the effects of national decisions that might otherwise have had a more negative impact. The state of cities is the outcome of patterns of development that have yielded

differing forms and location of infrastructure and organization of public buildings and public spaces, residential areas and recreational and cultural facilities.

Much of the current worldwide debate around cities focuses on the problems associated with size and function. The tenor of this debate is one of crisis. For example, the most recent United Nations Conference on Human Settlements (Habitat II, the City Summit) was held in Istanbul in 1996. The main themes around which progress is needed are:

- governance and opportunities for citizens to participate in local decision-making;
- housing needs;
- urban economy, poverty reduction and job creation;
- awareness that women and men use and experience cities differently;
- environmental management; and
- disaster mitigation, relief and reconstruction.

In Europe, the objectives that emerge from the debates about the urban agenda for policy and planning may be less oriented towards crisis, emphasizing a more holistic approach

to city development, which can provide a focus for solving wider national problems (4). The objectives in Europe include :

- improving the overall urban environment driven by heightened environmental awareness;
- making cities more sustainable;
- strengthening the city economy and entrepreneurship;
- creating employment by developing healthy and environmentally sound activities;
- improving the health and wellbeing of city residents;
- improving public transport, emphasizing accessibility rather than mobility;
- creating livable home environments and neighbourhoods, especially in the anonymous periphery of cities;
- creating viable political, social and environmental relationships between cities and their surrounding counties and regions; and
- integrating all urban policies to achieve these objectives.

Despite the vast scale of the problems in cities, too little energy and space are devoted to describing and celebrating the benefits of cities. These also need to

be explored to construct a vision for the future both for smaller cities as whole units or smaller parts, such as boroughs or districts that significantly control the factors affecting the daily lives of the population, and for the much larger megacities.

Much has been written on cities: their history, their design, their role, their culture and their meaning for residents and visitors in all facets of their lives. This brief introduction to life in cities cannot completely distil this body of thought, analysis and theory. The aim is to identify some of the aspects of the ongoing debate and to consider reasons for the current challenges that any city planning for health and sustainability needs to consider.

The benefits of living in cities

The city has been regarded as humanity's single most impressive and visible achievement. Lewis Mumford, an influential early writer on urban life, has described it, at least in its social aspect, as (5)

...a special framework directed toward the creation of differentiated opportunities for a common life and a significant collective drama.

Living in large settlements provides a focus for the development of a supportive, humanistic structure for human fulfilment. Cities can and should provide excitement and variation and opportunities for extending experiences, breaking out of traditional moulds or meeting new people. They are also centres of learning, invention and innovation that benefit from cultural diversity.

Aggregations of people bring together a range of skills and new ideas and ensure that the accumulated wealth, services, education and cultural opportunities can potentially be provided efficiently and effectively. Similarly, concentrations of people can use the limited land available more productively, allowing agricultural areas to be protected from urban encroachment.

The size of cities and how they are planned are important. Although cities have increased in population and population density as they have developed, this growth has not necessarily benefited city residents. Large cities are difficult to live in, but limits to city size have been rare because this has been seen as holding back progress. Research on urbanization (6) indicates that the size

of a city must reflect its ability to fulfil the social relations that are important to people and to maximize the strengths of community living. The question as to whether cities as a whole or individual cities have an optimum size needs to be debated more rigorously.

The evolution of cities and the development of suburban life

Cities have evolved and will continue to do so as the factors that affect their size and form change. Urbanization is specifically connected with economic development and the technological developments that flow from it. In much of Europe, industrialization and the capitalist economy have been the motor for rapid change over the past two centuries by triggering massive migration from rural to urban areas.

Before industrialization, people lived where they worked, but industrial processes moved the work and forced people to move into larger centres of population. Poor housing and nutrition and limited natural resources such as clean water made many people unhealthy and made them die young. As the health and life expectancy of the population improved, brought about in part by public health initiatives, the population began to grow and became

more differentiated into social classes.

A growing middle class and improved transport promoted clearer zoning of different functions. This led to the development of the suburbs and, more recently, the flight to the countryside by those who can afford it. Population and some employment has been decentralized from core areas to suburbs since the 1950s. Industrial decline and a growing service sector since the 1970s has reinforced this pattern and has created inner-city decay. This spatial reorganization and the polarization between different population groups has created a new geography of centres and margins, and many divided or dual cities have evolved.

The increasing population and suburban expansion have had many effects. The effect on the environment is especially notable and problematic. Large cities demand huge quantities of water, energy and other resources, which affects the environment severely. The effects are exacerbated by the inefficient use of resources and poor waste management. The geographical separation of the functions of city life has created an excessive demand for transport.

The car has become an addictive

form of transport for suburban residents. The increasing numbers of cars have also led to rapidly flowing traffic and/or congestion, resulting in safety problems, declining amenities in city centres, noise and pollution. Indeed, transport and consumption generate more air pollution than does manufacturing. The challenge for cities is therefore how to achieve accessibility to city centres and renew the environment while maintaining the viability of surrounding areas.

Differences in how city life is experienced

To meet the challenges of urban development, cities need to harness the full complement of human energy and skills available. Thus, the attributes and potential contributions of all residents need to be recognized. This also requires recognizing that different groups of people experience the city in different ways.

All cities have a diverse population; people differ in gender, age, ethnicity, religion, income, wealth and ability. Many cities are becoming more diverse. In some cases, this reflects ethnic or religious differences. In others, immigration is substantial and the consequent relations between existing

residents and newcomers are important. The ways cities have been planned or developed, both historically and currently, fail to take into account the needs of many of these diverse groups because the groups lack the influence to bring their interests to prominence and therefore to affect policy and planning decisions.

Gender has an especially profound impact. The experience of women and men in the city and the way they use it reflects their roles and responsibilities in the division of labour according to gender. Differences in tasks, differential access to and control over resources and the different value accorded to the activities of women and men influence the spatial and

The city has been regarded as humanity's single most impressive and visible achievement.

Gender can be defined as the socially constructed and culturally determined characteristics associated with women and men, the assumptions made about the skills and abilities of women and men based on these characteristics, the conditions in which women and men work, the relations that exist between women and men and how these are represented, communicated, transmitted and maintained.

Source: Itzin (7)

organizational aspects of the city. The heart of cities usually reflects men's interests, whereas suburbs are more the domain of women, thus reinforcing gender roles.

The gradual changes in women's lives, especially the increasing participation in the labour market and changes in the form of the family and the household, are making the limitations of traditional urban planning and housing policy more apparent. The implications of the challenges women face are such that gender can no longer be ignored either in planning practice or city governance.

Threats to public spaces

Public spaces include public squares, parks, municipal buildings, cultural sites, sporting arenas, leisure facilities, shopping areas and markets, roads and pavements. They have been described variously as fortresses of freedom, spaces for action and islands of humanity. They are viewed as the connective tissue of cities and have functional, environmental, cultural and aesthetic roles. They have both historical and contemporary characteristics, and ensuring the balance between the two is a constant challenge.

Public spaces are central to many urban challenges, especially for cities or districts in which road building has limited these areas, in which shopping centres or malls have become the dominant public space or in which public safety is of concern, especially for women, children or elderly people.

The desire for security in cities is becoming a major impetus for policy and planning as well as for individual behaviour. This desire is leading to fewer public spaces, as some people seek to protect themselves from real or perceived fears by restricting the use of public space. This can be further exacerbated by decisions about new architecture, public transport and street lighting, which may be made without considering collective safety.

The effect of economic changes

Economic development has been a major driving force for city development. Until recently, manufacturing was the dominant source of wealth creation, but its recent decline in industrialized countries in favour of service industries and new technologies has brought about many changes that affect city life.

Unemployment, which is a

permanent feature of market economies, has increased throughout Europe since the 1980s, leading to increased poverty. It has affected people living in public and private housing, thus affecting both the inner city and the suburbs. The form of the available work has changed, and this has been accompanied by shifts in the composition of the workforce.

Unemployment generally impoverishes the inner city and reduces the quality of the housing stock, although not as consistently as many would argue. Inner-city neighbourhoods can attract new residents because of their cultural and symbolic interest, and the location of service industries has also helped to generate a sense of renewal.

In some parts of Europe, notably the Mediterranean countries, both core areas and the suburbs have continued to grow simultaneously. Other countries have attempted to improve the lives of people in inner-city slums by moving them to specially created areas or townships. Paradoxically, this has also generated problems of poor living conditions, unemployment and poverty, which have been worsened by the changes in the economy.

Technological developments are

changing the nature of work, making it easier to work at home or on the move using new forms of communication. The nature of the marketplace is also changing as home shopping becomes a possibility. These effects raise questions about the nature and use of public spaces, building developments and existing buildings and their need for transport and support services.

Poverty and inequality and their effects on city life

Poverty is a major challenge for cities throughout the world. Poor people in cities usually have no secure employment, savings or saleable assets and are vulnerable to changes in the demands of the labour market, the prices of basic goods, land costs and use and housing policies. The effect on city life of increasing urban poverty has led in part to the introduction of economic reforms, but these very reforms often create new poverty. These measures include shifting towards privatization and limiting the ability of local government to sustain previous levels of services. In addition, welfare provision has shifted away from redistribution towards targeted safety-net programmes. A combination of these factors has made many people

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homeless or confined them to shanty towns, and both are now widespread in a number of European cities.

Poverty profoundly affects health and wellbeing. It contributes significantly to the inequalities in health within many European cities and across Europe. Inequalities in health parallel inequalities in environmental quality, which are similarly associated with poverty, each contributing to and exacerbating the other.

Gender is especially key in poverty, as women are disproportionately represented among the urban poor. The reasons for this include women's situation in the labour market, general inequalities in access to society's resources and inequities in the distribution of resources and decision-making power in the household.

Even where women have taken over job categories that have traditionally been dominated by men and unemployment among men has increased, most women have lower pay and less job security than most men. In countries where changes in family patterns have increased the number of households with single mothers, this has affected women and children by increasing poverty.

High levels of poverty in a city are as significant for affluent people as they are for poor people.

High levels of poverty in a city are as significant for affluent people as they are for poor people. The existence of areas of decline and the emergence of derelict spaces affects people's perceptions of the city as a whole. The polarization between places with fewer resources and more affluent areas creates disharmony and contributes to increasing crime and vandalism. Most significantly, large numbers of poor people can further weaken a struggling economy, as they do not have the resources to consume goods and services or to participate fully in all aspects of city life.

Overcoming the challenges

The challenges facing European cities and their residents may make it difficult to imagine how these challenges can be overcome and the potential benefits of city life maximized. Whatever the outcome, a new stage in the history of cities is probably emerging as the human community evolves. Some even argue that the form and function of cities will change profoundly, with suburban areas becoming more dominant and old city centres or cores becoming obsolete.

Many challenged cities desire new

forms of participation in the decisions related to urban policy and planning and want these decisions to lead to action that further enhances participation by, for example, improving safety and access.

Current approaches alienate the public from design professionals, public administrators, politicians, property owners and investors, as the desires, lifestyles and values of the public are often ignored. The limitations of this undemocratic approach are slowly being realized as social wellbeing erodes more despite the apparent wealth and financial power in many cities.

Improved forms of representation and an acknowledgement of the importance of community action can enhance social justice. Nevertheless, those who have power are very reluctant to share it and often wage a considerable struggle to maintain it.

Part of the desire for renaissance in cities is greater understanding of the benefits of social diversity in the city population instead of viewing it as a non-issue or as a problem. Recognizing that most cities have a multicultural past and present gives

choices and options for the future instead of just seeing ethnic or cultural differences as a source of problems. Non-sexist or gender-conscious urban planning has been explored but has not yet been realized despite the increased involvement of women in urban planning and policy debates and the policy-making process. A non-sexist city would involve action that reflects an understanding of gender inequalities in society and ensures that the built environment and use of space meets the needs of women as well as men of all ages (8,9).

In addition, cities in Europe have begun to reclaim a health agenda away from the confines of medicine and are becoming laboratories of ecological innovation. The significance of these related developments is that the wellbeing of people and the environment are challenging the dictates of spatial and economic planning.

These themes of health and wellbeing and the environment are explored in more detail throughout this document together with the implications for practical action.

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Understanding health

There are many different accounts of health and what influences it. One of the most common and useful descriptions is the definition of health from the WHO Constitution (10):

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief or economic and social conditions.

This description prompts questions:

what is complete social wellbeing?

How can it be measured?

Nevertheless, the WHO definition of health does have important strengths that should not be overlooked.

Health is a complex concept. It is not just the absence of disease but a state of being that has a number of components, such as where people live, whether they are employed or not, the services and support available and the state of their environment. All these factors in an economic and social context produce a range of states of health. In addition, WHO maintains that health is a fundamental right of every human being regardless of race, sex, politics or economic circumstances.

Perspectives on health

The medical profession has largely dominated policy planning and services for health. The early public health movement succeeded mainly through work in environmental action and social policy, including clean water supply, effective drainage and sewerage and housing reform. Nevertheless, in the last century the medical profession has mainly focused on developing specific interventions to counteract disease in individuals instead of addressing the needs of the population as a whole.

The medical model underpinning disease-focused interventions views the body as a machine and considers health the polar opposite of illness. Increasingly sophisticated medical procedures and interventions are used to treat disease. Preventive techniques such as immunization and screening are deemed to be of prime importance in making and keeping individuals healthy.

This view makes health care services responsible for improving and maintaining health. Most national health care resources are allocated to cure and repair, with only a small percentage for promoting health. For example, the United Kingdom spends

only about 2–3% of the National Health Service budget on health promotion, and most of this is spent on health information.

A social model of health is a contrasting approach. This model considers health as an outcome of the effects of all the factors affecting the lives of individuals, families and communities in different ways and through different pathways.

Whitehead & Dahlgren (11) (Fig. 1, page 18) describe this in terms of layers of influence. Individuals are at the centre with a set of fixed genes. Surrounding them are influences on health that can be modified.

The first layer is personal behaviour and ways of living that can promote or damage health. Individuals are affected by friendship patterns and the norms of their community.

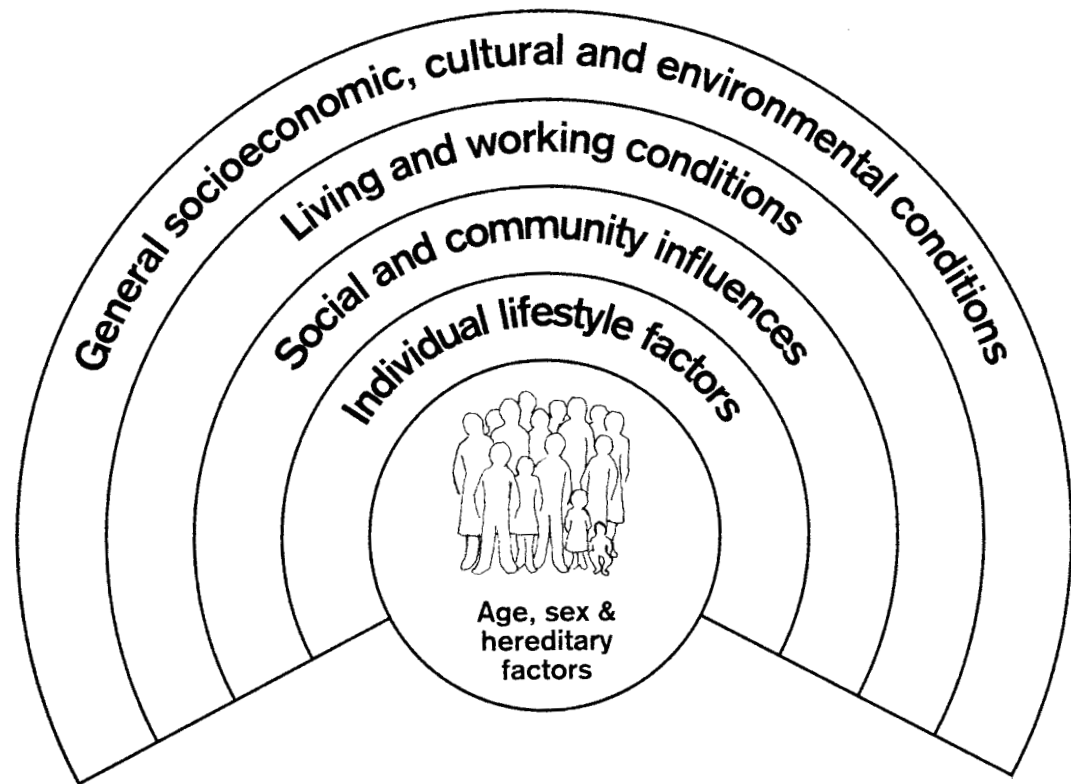
The next layer is social and community influences, which provide mutual support for members of the community in unfavourable conditions. But they can also provide no support or have a negative effect.

The third layer includes structural factors: housing, working conditions, access to services and provision of essential facilities.

In 1986 the first International Conference on Health Promotion held in Ottawa, Canada declared that: “The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvements in health require a secure foundation in these basic prerequisites.”

Source: Ottawa Charter for Health Promotion (12)

Fig. 1. The main determinants of health

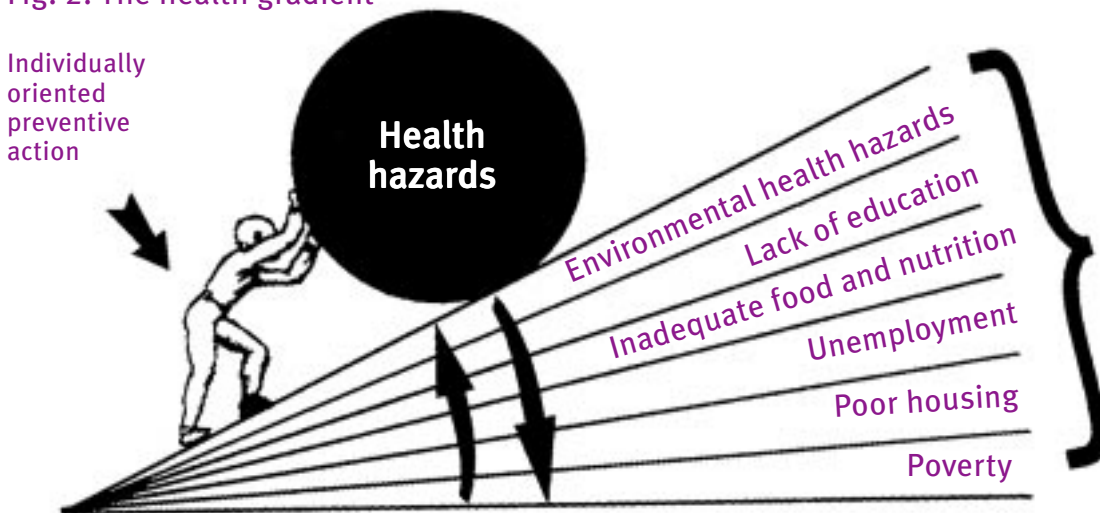


Source: Whitehead & Dahlgren (11)

Overarching all of these are the factors that can affect whole societies: socioeconomic, cultural and environmental conditions. The economic and labour market conditions in each country influence all the factors that affect health, but so do the prevalent cultural beliefs in a society. For example, views about the

role of women or the status accorded ethnic minorities can shape their ability to live well. Over the past decade it has become more and more apparent that the sustainability of the Earth's ecosystem is a crucial factor for maintaining health. The factors found in this rainbow are interrelated and influence and shape each other.

Fig. 2. The health gradient



Source: adapted from *Making partners: intersectoral action for health* (13)

Any systematic attempt to improve health has to embrace action at all levels.

Another way of representing the effects of the range of health factors in society is the health gradient (Fig. 2).

The health gradient depicts the effects of a range of factors that can powerfully affect an individual's ability to achieve health, especially acting in combination. The steepness of this gradient is different for different sectors of society. The traditional model of health promotion that only encourages individuals to change their behaviour does not ease the load for poor people struggling against a whole range of structural factors. The

agencies responsible for these factors must act in a focused way to improve the health of the groups in society that have an increased load.

Research from across Europe (14) has identified a substantial social class gradient in influences on health, with an uneven population distribution of health hazards and risk factors. Groups with lower status have poorer health.

One response to these inequities has been to ascribe them to differences in personal behaviour rather than to societal inequities. Fig. 2 shows that reducing the gradient of health inequalities requires action on factors mainly outside the control of individuals.

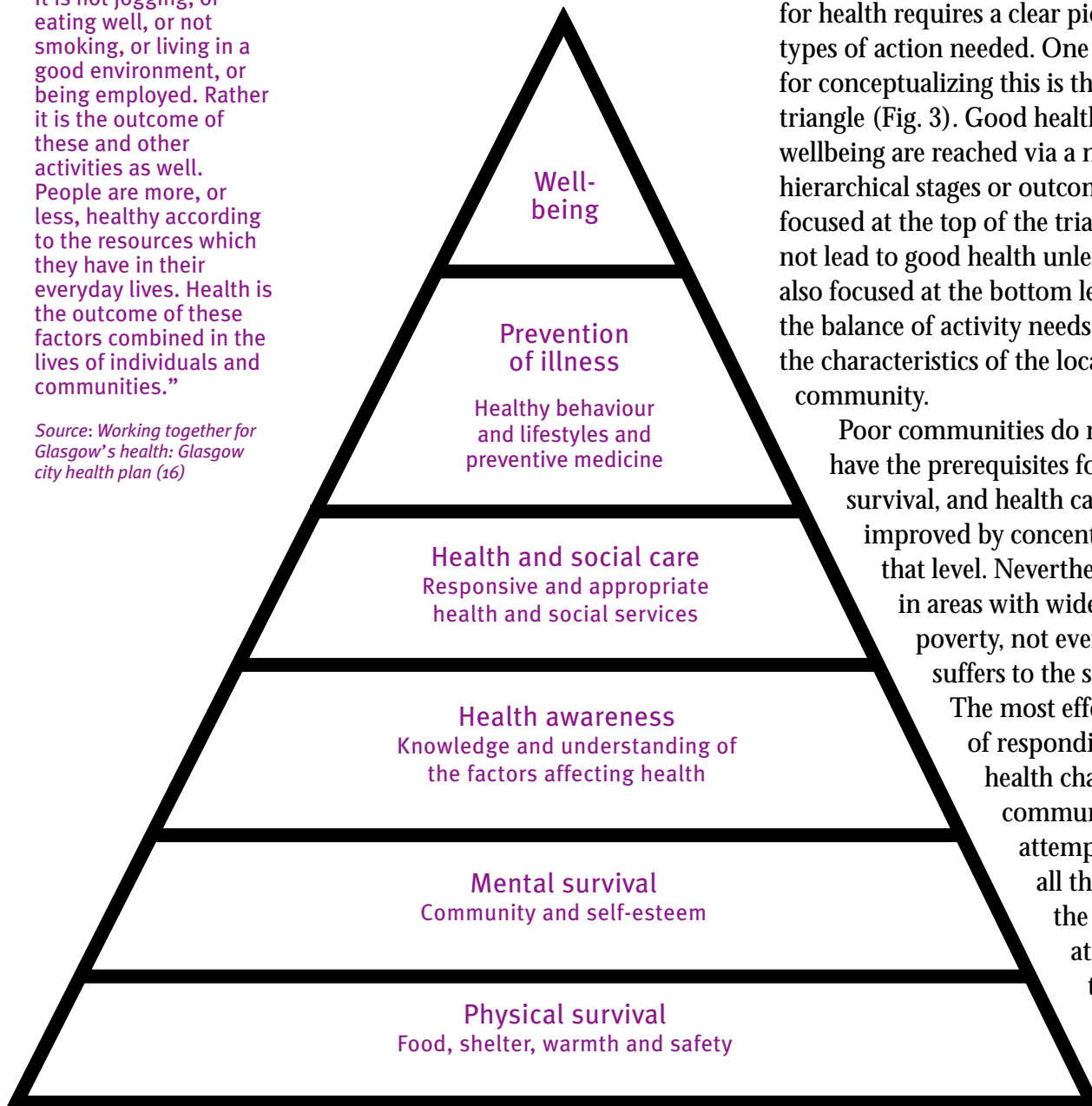
“That political, economic and social inequalities should manifest themselves in health differences should surprise no one. What is surprising is that such inequities should be attributed to differences in behaviour, when evidence for this view is grossly inadequate compared to the wealth of data which links them to social conditions.”

Source: Research Unit in Health and Behavioural Change (15)

“Health is not an activity. It is not jogging, or eating well, or not smoking, or living in a good environment, or being employed. Rather it is the outcome of these and other activities as well. People are more, or less, healthy according to the resources which they have in their everyday lives. Health is the outcome of these factors combined in the lives of individuals and communities.”

Source: Working together for Glasgow’s health: Glasgow city health plan (16)

Fig. 3. The health triangle



Source: adapted from Laughlin & Black (17)

Making meaningful local action plans for health requires a clear picture of the types of action needed. One framework for conceptualizing this is the health triangle (Fig. 3). Good health and wellbeing are reached via a number of hierarchical stages or outcomes. Activity focused at the top of the triangle does not lead to good health unless activity is also focused at the bottom levels, and the balance of activity needs to reflect the characteristics of the local community.

Poor communities do not always have the prerequisites for physical survival, and health can only be improved by concentrating on that level. Nevertheless, even in areas with widespread poverty, not everyone suffers to the same extent. The most effective way of responding to health challenges in a community is to attempt to cover all the levels of the hierarchy at the same time.

A new coalition for health in society

The complex interrelationships between the factors that affect health and the inability of a purely medical approach to deal with them are being increasingly understood. The concept of health for all was adopted by the thirtieth World Health Assembly at Alma-Ata in 1977.

This was to be achieved by work incorporating the principles of health for all (see page 23), which include statements about equity and also that:

...health is created in the setting of everyday life and is influenced by actions and decisions of most sectors.

The partnerships for the promotion of health that arose from the principles of health for all are still important now.

The Ottawa Charter for Health Promotion (12) further developed this thinking, advocating that action to promote health means building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (box).

Ottawa Charter for Health Promotion

Build healthy public policy

- Put health on the agenda of policy-makers in all sectors and at all levels.
- Combine diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, social and income policies that foster greater equity.
- Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

Create supportive environments

- Societies are complex and interrelated. Health cannot be separated from other goals. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance: to take care of each other, our communities and our natural environment.

Strengthen community action and develop personal skills

- Support the empowerment of communities. This enhances self-help and social support and allows for the development of flexible systems for strengthening public participation and direction of health matters.
- Enable people to learn throughout life.

Reorient health services

- Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life and open channels between the health sector and broader social, political, economic and physical environmental components.

The Healthy Cities project is one of WHO's main vehicles for giving effect to the strategy of health for all. It has forged political, professional and technical alliances for health and uncovered a fertile ground for action at local level.

Source: adapted from Tsouros (18)

The principles of health for all were used to develop a common European strategy for attaining health for all. The Member States of the European Region adopted a health policy for Europe in 1984 that includes 38 regional targets for health for all. This health policy requires fundamental changes in approaches to health development. It focuses on four areas of concern: lifestyles and health, risk factors affecting health and the environment, reorienting the health care system and mobilizing political, managerial and technological support to bring about these changes. Health for all had a good deal of success in developing countries, but implementation was slow in European countries.

Healthy cities

The idea of the healthy city was raised at the Beyond Health Care conference in Toronto in 1984. This was based on the notion that the city is the level of governance closest to the population and therefore can best influence the factors affecting health.

Substantial interest in the idea was generated over the next two years, and WHO supported a pilot project (originally limited to 1987 to 1992) for

European cities to develop models of good practice in promoting health and positive health policy. The idea was one whose time had come. After beginning to work with 11 cities in a pilot project, WHO found that it had unleashed a movement. In the first five years 35 project cities were participating in Europe. National networks developed in 20 countries, and 12 groups of cities based on specific topics or interests were set up as multi-city action plans.

The pilot project cities were not project cities because they had reached some particular level of health. They were part of this work because they understood the processes necessary to make cities healthier.

They have demonstrated this by action in specific areas:

- making a political commitment to work for health in the city;
- giving visibility to health issues in their city;
- making institutional changes to support intersectoral work and involve the community; and
- taking innovative steps to improve health and the environment.

The first phase of the project between 1987 and 1992 emphasized developing structures and processes within cities to allow collaborative work between organizations, departments and communities. The cities taking part have developed initiatives showing how a range of groups can successfully participate in developing health for all at the city level. Many cities developed a truly integrated approach to incorporating health in the local planning process for the first time.

In its second phase between 1993 and 1998, the project is focusing on formulating and implementing city policies targeting health for all and on developing comprehensive city health plans with explicit targets addressing such issues as equity and sustainable development. About 60 project cities have been designated, and more than 550 cities are part of national networks in Europe.

The Healthy Cities project is useful for tackling the complex problems that shape health in cities. The cities have developed new models of collaborative working within organizations and between organizations and communities.

Health for all principles related to city health planning

Equity in health means that all people have the right and the opportunity to realize their full potential.

Health promotion: A city health plan should aim to promote health using the principles outlined in the Ottawa Charter for Health Promotion.

Intersectoral action: Health is created in the setting of everyday life and is influenced by the actions and decisions of most sectors.

Community participation: Informed, motivated and actively participating communities are key partners in setting priorities and making and implementing decisions.

Supportive environments: A city health plan should address the creation of supportive physical and social environments. This includes issues of ecology and sustainability as well as such aspects as social networks, transport, housing and other environmental concerns.

Accountability: Health is created through the interaction of all aspects of the environment and living conditions with the individual. Decisions of politicians, senior executives and managers in all sectors affect the conditions that influence health. Responsibility for decisions that affect health creating conditions should be made explicit in a clear and understandable manner in a form that can be measured and assessed after time.

The right to peace: Peace is a fundamental prerequisite for health, and the attainment of peace is a justifiable aim for those who are seeking to achieve the maximum state of health for their community and citizens.

Source: adapted from City health planning: the framework (19)

The Healthy Cities project requires cities to have to a project office, staff and budget. These organizational foundations allow project staff to build

and develop the range of projects and collaborative exercises that enable the development of truly collaborative city-wide health promotion.

Main requirements for participation in the second phase of the WHO Healthy Cities project

- All project cities should establish a widely representative intersectoral policy committee with strong links to the political decision-making system, to act as a focus for and to steer the project.
- All cities should appoint a person to be politically responsible for the project.
- All project cities should establish a visible project office that is accessible to the public, with a coordinator, full-time staff and an operating budget for administration and management.
- All project cities should develop a health for all policy based on the European health for all targets and prepare and implement a city health plan that addresses equity, environmental, social and health issues, within two years after entering the second phase for old project cities and within four years for new cities. Cities should secure the necessary resources to implement the policy.
- All project cities should establish mechanisms for ensuring accountability, including presentation to the city council of short annual city health reports that address health for all priorities.
- All project cities should take active steps to take on the strategic action priorities of the WHO Regional Office for Europe and, in particular, to implement the European Tobacco Action Plan and the European Alcohol Action Plan.
- All project cities should establish mechanisms for public participation and strengthen health advocacy at city level by stimulating the visibility of and debate on public health issues and by working with the media.
- All project cities should carry out population health surveys and impact analyses and, in particular, assess and address the needs of the most vulnerable and disadvantaged social groups.

Source: adapted from Tsouros (18)

The players in healthy city projects are:

Local authorities
Health authorities
Academic institutions
Community groups
Tenants' groups
Businesses
Politicians
Health issue groups
Environmental action groups
Elderly groups
Transport groups



Sustainable development and health

Concern about the effect of unrestrained economic development on the environment has been growing over the last decade. In recent years a number of factors have led to acceptance of the need to devise strategies to move towards sustainable economic, environmental and social development.

It is argued (20) that the move towards the notion of sustainable development arises from a meta-crisis facing the world. This meta-crisis comprises a set of three core crises of development, environment and security.

The crises of development focus on the inability of the affluent countries to facilitate meaningful development in the poor countries. Since the Second World War, the proportion of people in the world who are desperately poor has remained constant at about one fifth. Since the 1980s, the terms of trade have deteriorated for developing countries, intensifying poverty among these countries. The impact of financial restructuring following growing debts by developing countries has caused these governments to cut back social programmes, further depriving the poor.

The root of the environmental crises is the limited capacity of the planet to support humanity. This has two aspects.

The seemingly inexorable rise in world population of about 100 million per year is increasing consumption of the Earth's resources, including the finite stock of mineral resources and farming land. Resource consumption is unequal: 20% of the population consume 80% of the resources, mainly in countries located in the Northern Hemisphere.

In addition, resources are being degraded. Air, water and soil are being polluted, including acid rain, ozone depletion, pollution of water stocks, desertification and poor city air quality, and biodiversity is declining.

Since the end of the Second World War, a whole range of wars have continued to destroy people, environments, livelihoods and even the hope of sustainable development. Huge sums of money have been directed away from investment in positive development towards armies and ever more powerful weaponry.

These three crises are not separate, but interwoven and mutually supportive. Moving towards sustainable development means

tackling a web of disparate interests. Regardless of how this is attempted, either gradual incremental change or major structural change, a paradigm shift is required for the global economic, political and social systems.

Defining sustainable development

Sustainable development as it is now understood can be traced from *Our common future* (21). This report of the World Commission on Environment and Development (the Bruntland report) examined the relationships between economic development and environmental sustainability, defining sustainable development as “...development that meets the needs of the present without compromising the ability of future generations to meet their own needs”.

The Commission was concerned about poor people and the huge imbalance in resources between the industrialized and developing countries and therefore believed that economic development is required to meet the needs of poor people. However, this development should not be achieved at the expense of the planetary ecosystem.

Our common future focused on economics and environment and did

not explicitly refer to health or to social sustainability. Sustainable development has since grown to include the idea of sustainable societies. Later definitions embrace a broader notion of sustainable development. For example, Rees (22) defines sustainable development as:

...positive socioeconomic change which does not undermine the ecological and social systems upon which communities and societies are dependent. Its successful implementation requires integrated policy, planning and social learning processes; its political viability depends on the full support of the people it affects through their governments, their social institutions and their private activities.

The Canadian Public Health Association produced a more concise definition in 1991 (23):

Human development and achieving human potential require economic activity that is socially and environmentally sustainable in this and future generations.

By including the concept of social

sustainability, these definitions move from reducing the environmental effects of economic development as an inherent objective to working towards human development being served by environmentally supportive and equitable economic development.

Developing a framework for action: Agenda 21

The United Nations Conference on Environment and Development in 1992 (the Earth Summit in Rio de Janeiro) moved the debate on sustainable development further. The major outcomes were the Rio Declaration on Environment and Development, a statement on the principles of forest management and Agenda 21.

More than 178 governments adopted these declarations at the Conference. Following the Conference, the United Nations Commission on Sustainable Development was formed to oversee progress in implementing Agenda 21.

Agenda 21, the United Nations programme of action for sustainable development, explicitly addresses the relationships between social and economic development, the need to conserve and manage resources, the strengthening of the roles of major

social groups and how these are to be achieved. Agenda 21 has a concern for human health and wellbeing at the core of all its work.

The Agenda 21 process in cities and localities has developed rapidly in its first five years. Agenda 21 has four main areas: social and economic development, resource management, strengthening the participation of major groups and means of implementation.

Social and economic development covers such challenges as international cooperation, poverty, sustainable consumption, population, health, settlements and integrating environment and development.

Resource management includes atmosphere, land resource planning, deforestation, fragile ecosystems, rural development, biodiversity, biotechnologies, oceans, fresh water and waste management.

Strengthening the participation of major groups includes such previously marginalized groups as women, children, indigenous peoples and nongovernmental organizations.

Means of implementation include finance, institutions, technology transfer, sciences, education, capacity-building, international

institutions, law and information for decision-making.

Underpinning all this is a set of practices and processes that Agenda 21 (1) states are essential for achieving sustainable development:

- reducing the use of energy and raw materials and the production of pollution and waste;
- protecting fragile ecosystems; and
- the sharing of wealth, opportunities and responsibility more equitably between North and South, between countries and between social groups within countries.

Agenda 21 (1) argues that sustainable development can only be reached through a process that is democratic, cooperative and planned. Sustainable development will not be achieved by accident, but must be planned and worked for consciously at all levels, from international to local. All people, including poor and disadvantaged groups, must have a say in decisions about the environment and development. All social groups and interests, including business, education and voluntary and

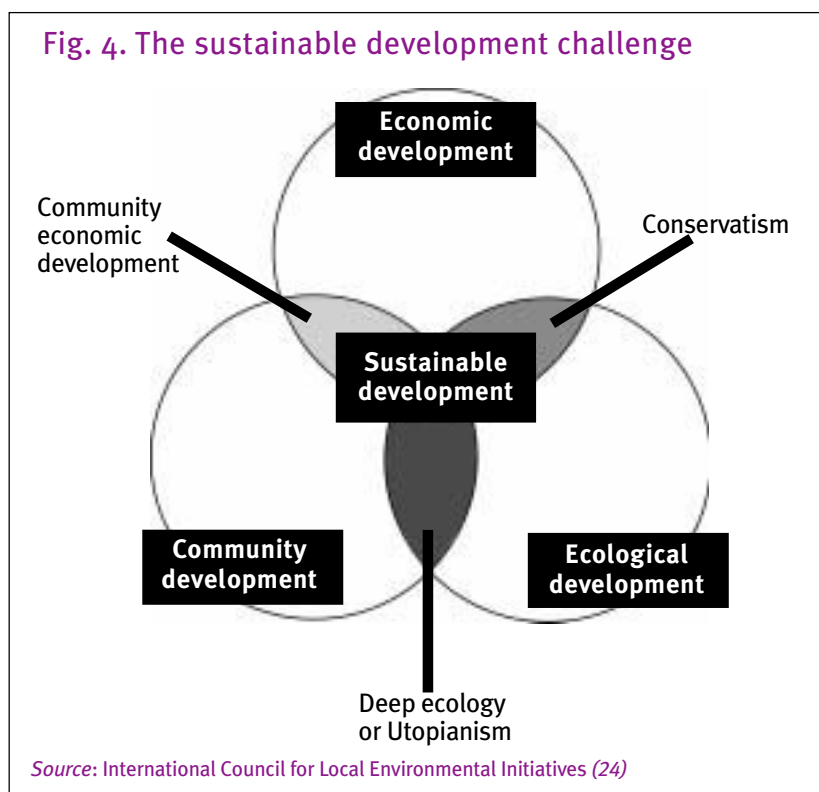
community groups as well as governments at all levels need to work in partnership.

The International Council for Local Environmental Initiatives covers sustainable development planning comprehensively (24) and gives a succinct picture of the challenging processes underway at the local level (Fig. 4). The Council points out that the imperatives of economic, community and ecological development often contradict and that local (and global) sustainable development is the process of bringing the three development processes into balance. Implementing a strategy for sustainable development requires negotiation among the stakeholders and developing an agreed plan. This type of multi-agency work is often new to some organizational participants but is central to the work.

The growing awareness of and willingness to act on the challenges of environmental, social and economic sustainability

should not obscure the real difficulty facing the process of achieving such outcomes.

The transition to sustainable development depends on the ability of governments, intergovernmental organizations, transnational capital and nongovernmental organizations to manage the transition arising from the development of new sets of winners and losers in the global economy.



The transition to sustainable development needs to be planned, managed and administered, but it needs a sense of purpose, a vision, a goal towards which societies can strive.

Pearce (25) attempts to map the possibilities for this transition: “Any shift towards sustainability will inevitably be slow, taking generations, not years. Full sustainable development involves a cultural shift, not just economic and political tinkering.”

The early periods of transition are the most difficult, when vision is dim and resistance is strong. The transition

to sustainable development needs to be planned, managed and administered, but it needs a sense of purpose, a vision, a goal towards which societies can strive. Pearce (25) charts various stages of the move towards sustainability and what this would mean in terms of policy, economy, society and discourse (Table 1).

Table 1. Stages in the move to sustainability

	Policy	Economy	Society	Discourse
STAGE 1 Ultra-weak sustainability	Lip service to policy integration	Minor tinkering with economic adjustment	Dim awareness and little media coverage	Corporatist discussion groups; consultation exercises
STAGE 2 Weak sustainability	Formal policy integration and deliverable targets	Substantial restructuring of micro-economic incentives	Wider public education for future vision	Round tables; stakeholder groups; parliamentary surveillance
STAGE 3 Strong sustainability	Binding policy integration and strong international agreements	Full economic valuation; green accounts at business and national level; green taxes offset	Curriculum integration; local initiatives as part of community growth	Community involvement; twinning of initiatives in the developing and the developed world

Source: Pearce (25)

Implementing Agenda 21 at the local level

Agenda 21 sees local authorities as being a main partner in implementation. Their full participation is crucial to the success of Agenda 21. Local authorities are involved in many key components of sustainable development in cities and communities (1).

Action for local Agenda 21

Local authorities are called upon to actively participate in the Agenda 21 process in their area by collaboratively developing a local version. It is hoped that this will build strategies in local areas that have the principles of Agenda 21 as their foundation (1):

By 1996, most local authorities in each country should have undertaken a consultative process with their population and achieved a consensus on a “Local Agenda 21” for the community.

Local Agenda 21 in Europe

The local Agenda 21 process has substantial support throughout Europe. In 1994 in Aalborg, Denmark, 80 cities signed the Charter of European Cities and Towns towards

Sustainability (the Aalborg Charter) (26).

The Aalborg conference provided the starting point for the European Sustainable Cities & Towns Campaign, which is supported by the International Council for Local Environmental Initiatives, the WHO Healthy Cities Network, Eurocities (European Association of Metropolitan Cities), United Towns Organization and the Council of European Municipalities and Regions.

The signatories to the Aalborg Charter reaffirmed their commitment made at the United Nations Conference on Environment and Development in Rio de Janeiro to have developed a local Agenda 21 plan by the end of 1996. The Aalborg Declaration (26) reaffirmed the role of sustainable local communities in helping the world to move towards overall sustainability and laid down 14 prerequisites for European cities and towns:

- the role of European cities and towns in achieving sustainability;
- the notion and principles of sustainability;
- local strategies towards sustainability;
- sustainability as a creative, local,

- balance-seeking process;
- resolving problems by negotiating outwards;
- urban economy towards sustainability;
- social equity for urban sustainability;
- sustainable land-use patterns;
- sustainable urban mobility patterns;
- responsibility for the global climate;
- preventing ecosystems from being poisoned;
- local self-governance as a precondition;
- citizens as key actors and the involvement of the community; and
- instruments and tools for urban management towards sustainability.

The initial two-year phase of the European Sustainable Cities & Towns Campaign was primarily devoted to disseminating information about local sustainability by promoting the Aalborg Charter, urging additional local authorities to sign the Charter and to join the Campaign and providing guidance on the local Agenda 21 process.

Local Agenda 21: the second phase

The next phase was launched at the Second European Conference on

Sustainable Cities & Towns in Lisbon in October 1996. This phase focuses on implementing the principles set out in the Aalborg Charter, starting and undertaking the local Agenda 21 process and implementing the local sustainability plan. By engaging in this work, European local authorities will contribute to implementing not only Agenda 21 but also the Habitat Agenda from the Second United Nations Conference on Human Settlements.

The participants in the Lisbon Conference endorsed the Lisbon Action Plan (see box) (27). It was based on local experiences as reported and discussed at the 26 workshops at the Conference and takes into consideration the principles and recommendations laid down in a number of documents: the Aalborg Charter (26), a guide from the United Kingdom Local Authority Association and Local Government International Bureau (28), the *Sustainable cities report* from the European Commission's Expert Group on the Urban Environment (29) and the *Local Agenda 21 planning guide* from the International Council for Local Environmental Initiatives (24).

Headings from *The Lisbon Action Plan: from Charter to action*

- We believe that the adoption of the Charter of European Cities & Towns towards Sustainability (Aalborg Charter) is one of the best starting points for a Local Agenda 21 process.
- We believe that the local authority should be the main facilitator of the Local Agenda 21 process.
- We believe that the Local Agenda 21 process requires the involvement of the entire local authority – whether city, town or rural community.
- We shall enter into consultation and partnerships with the various sectors of our community to create synergy through cooperation.
- We shall seek to get our own house in order by implementing the principle of negotiating outward.
- We shall carry out systematic action planning to move from analysis to action.
- We shall integrate environmental with social and economic development to improve health and quality of life for our citizens.
- We shall use advanced tools for sustainability management.
- We shall establish programmes to raise awareness among our citizens, interest groups, as well as politicians and local government officers of sustainable development issues.
- We shall gain strength through inter-authority alliances: associations, networks and campaigns.
- We shall build North-South and West-East alliances for sustainable development.
- We shall go ahead in concert with the European Sustainable Cities & Towns Campaign.

Source: The Lisbon Action Plan: from Charter to action (27)

Environmental factors and health

The links between environmental factors and health outcomes have been recognized and acted on since the early days of the public health movement. All European cities have examples of regulation for clean water and control of housing and industrial hazards dating from the early 1900s. This is now commonly described as environmental health regulation and is enforced by environmental health departments.

The range of environmental problems has grown both in scale and in type over the years. Environmental health problems caused by economic activity have not only local but national and international effects. Examples include water supplies polluted by nitrates and pesticides from farming; acid rain caused by industry and power stations; and foods contaminated with pesticides used in agriculture.

There is also a further range of new problems that early public health pioneers could not have imagined, such as the role of transport policy and its effect on health. Transport has local effects on individual health (such as accidents, the barrier effect and lack of encouragement of health-promoting

activities such as cycling and walking) and wider effects on air quality, and using and manufacturing automobiles affects the global environment.

The destruction of the global ecosystem has received much national and international concern. Table 2 shows some of the possible effects of these changes on health.

Cities in industrialized countries are major consumers of nonrenewable resources. The cities of Europe are collectively responsible for a large proportion of the emissions contributing to global climate change: together with the cities in other industrialized countries, they provide 80% of carbon dioxide emissions, for example.

Many European cities are becoming the site of large-scale environmental, economic and social challenges. Poverty and growing inequality are increasing hand in hand with problems of pollution, decaying infrastructure, poor air and water quality, loss of green space and reduction in housing standards. These factors are compounded in some countries by the blind promotion of economic development at the expense of large groups of marginalized people. The relationships in cities between

Table 2. Possible adverse effects on health due to possible global environmental change

Environmental damage Manifestation Type (direct, indirect) and timing (early, late) of adverse effects

		Direct early	Direct late	Indirect early	Indirect late
Enhanced greenhouse effect	Global warming and climatic change	Heat wave–related death and illness		Altered distribution of vector-borne infectious diseases	Reduced viability of edible fish in warmed oceans
		Natural disasters: cyclones, floods, landslides, fires		Food shortages due to altered agricultural productivity	
	Sea level rise	Increased risk of flash floods and surges	Inundation, social dislocation, sanitation breakdown, farm loss	Consequences of damage to foreshore facilities, roads etc.	Destruction of wetlands, decline in fish stocks
Stratospheric ozone depletion	Increased ultraviolet B radiation flux at Earth's surface	Sunburn, photo-kerat-conjunctivitis, suppression of immune system, increased risk of infection, cancer	Skin cancer, ocular effects; cataracts, pterygium		Impaired growth of food crops and marine microorganisms (base of aquatic food web)
Acid aerosols (from combustion of sulfurous fossil fuels)	Acid rain (and other precipitation)	Possible effects on respiratory system		Killing of aquatic life, reduced food, impaired crop growth	Impairment of forest growth, reduced ecosystem productivity
Land degradation, over-intensive agriculture and excessive grazing	Erosion, sterility, nutrient loss, salinity, chemicalization, desertification	Decline in agricultural productivity	Rural depression, migration to shanty towns (see also final entry)	Exposure to higher levels of pesticides and fertilizers may also lead to toxic algal bloom in waterways	Consequences of silting up of dams and rivers
	Depletion of underground aquifers	Lack of well water for drinking and hygiene	Decline in agricultural productivity		
Depletion of plants and animals, loss of biodiversity	Destruction of habitat	Deforestation, disruption of local culture and health	Shortage of edible species		Deforestation, enhancement of greenhouse effect
	Loss of genetic diversity (species and strains), weakening of ecosystems			Loss of medicinal chemicals and other health-supporting materials	Greater vulnerability of plants and livestock, decline in vitality of ecosystem
Other effects of overpopulation, particularly in poor countries	Proliferation of crowded urban slums and shanty towns (due to migration and high fertility)	Infectious diseases, malnutrition, antisocial behaviour	Effects of breakdown of social organization		Various consequences of overload of local ecosystem

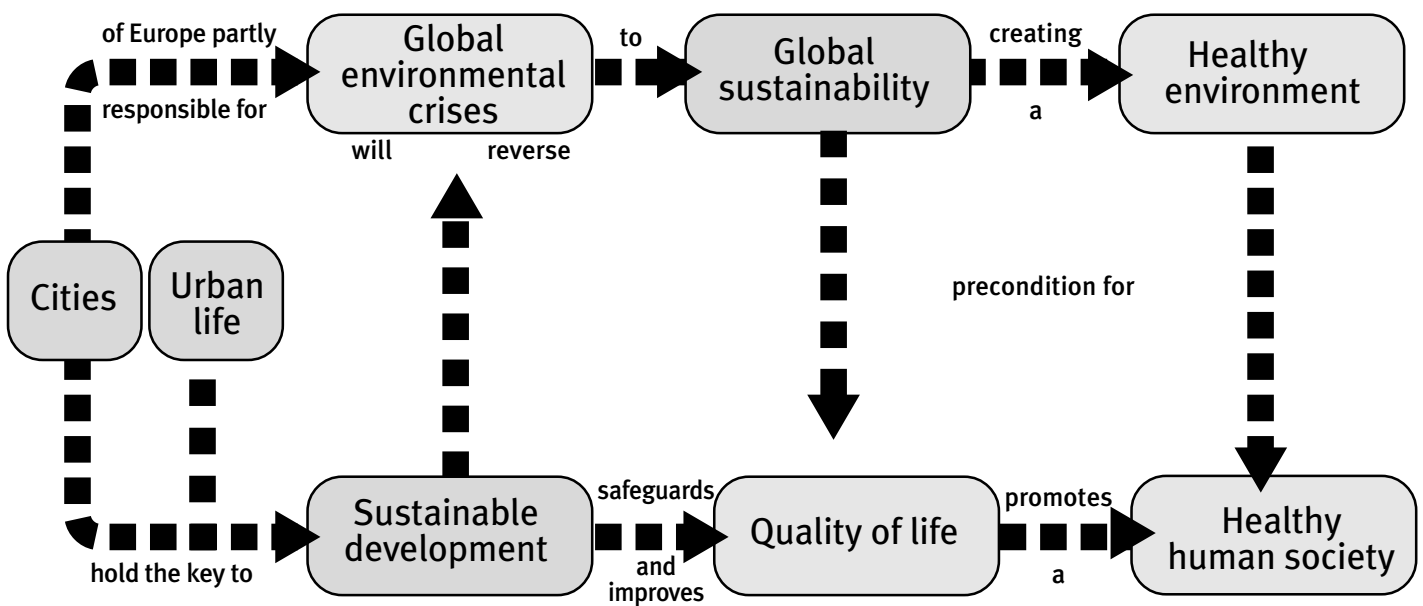
Source: adapted from Tansey & Worsley (30)

social wellbeing and health, economic development, the quality of the community environment and the health of the global ecosystem have been in focus during the past decade. There is movement towards a new model of the interrelationships between all the activities taking

place in cities.

The report on European sustainable cities (29) tried to conceptualize all the challenges pictorially (Fig. 5): the relationship between cities, sustainable development, global environmental crises and the outcome of a healthy society in a healthy environment.

Fig. 5. Concepts of key concern in health and sustainable development



Source: adapted from European Commission Expert Group on the Urban Environment (29)

Health outcomes at all levels

Human health can be identified within the sustainable development agenda as part of the global ecosystem, as a focus for development, as an outcome of initiatives to promote environmental sustainability and as a sector that affects the environment and other sectors.

Human health as part of the global ecosystem

Human health is sustained by the global ecosystem. Unsustainable development and consequent damage to the ecosystem directly and negatively affect human health throughout the world. The cities of the industrialized world are responsible for a large proportion of global environmental disruption and damage.

Health as a focus for development

The first principle of the Rio Declaration on Environment and Development is that human health is the centre of concern for sustainable development. Improving health therefore goes hand in hand with sustainable development. Improving health can be necessary to improve other aspects of life.

Health as an outcome of initiatives to promote environmental sustainability

Most initiatives taken principally for environmental reasons improve human health, although this may not always be explicit. Examples include fewer accidents and improved physical fitness caused by transport policies that shift emphasis from cars to public transport, cycling and walking.

Impact of the health care sector on the environment and other sectors

The health care sector employs many people and is a substantial user of natural resources. It therefore has a key role in ensuring environmental and other benefits by managing its activities better. An example is reducing energy use in hospitals. The health care sector also has a role in other aspects of Agenda 21, including attention to human rights and the role of women.

Specific recommendations in Agenda 21

Agenda 21 has many specific recommendations about health. Some refer to well defined health challenges, but the most significant recommendations deal with health in the context of overall development.

Most initiatives taken principally for environmental reasons improve human health, although this may not always be explicit.

Key recommendations relate to the development of municipal health plans, the use of health profiles and the strengthening of city networks for health.

Principles and methods

Agenda 21 recognizes that many of the challenges it covers, including health, need to be elaborated further. The health for all strategy and the role of WHO in this are mentioned explicitly. The main principles of Agenda 21 and of the WHO strategy for health for all are essentially the same, especially when they are applied to the main strategies for implementing action plans at the local level (see Table 3, page 41).

New ways of thinking about human development

Trevor Hancock (31) describes a new conceptual model of human development. This model (Fig. 6) has three main areas: community, environment and economy. The outcome of the interrelationship of these areas can be conceptualized as health or, more broadly, as human development.

The model suggests that good health and sustainable human development

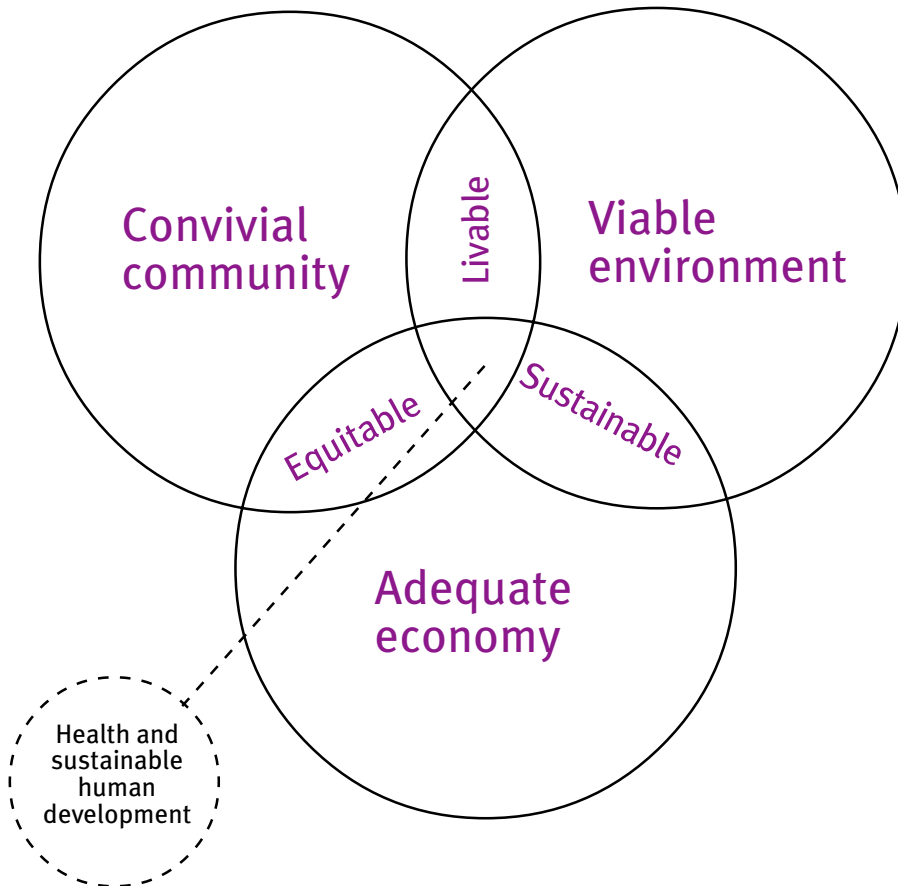
will only be achieved if the relationships between the areas are equitable, sustainable and livable. Community conviviality, environmental viability and economic adequacy need to be balanced. Community conviviality is related to the web of social relations, civic community and social solidarity. Environmental viability refers to the quality of the local ecosystem, including air, water, soil and the food chain. Economic adequacy means having a level of economic activity that can meet basic needs.

In this model a healthy community has an integrated approach to developing all its components and tries to be equitable, livable, sustainable and cohesive, to achieve high environmental standards and to be adequately prosperous.

This model of integrated action has underpinned some of the work within the Canadian Healthy Community Projects and in some Canadian provinces as well as in some of the European Healthy Cities projects.

Attempts like this to find conceptual models and styles of working that adequately incorporate social sustainability are part of the structure of Agenda 21 and WHO's Healthy Cities project.

Fig. 6. Conceptual model and planning tool



The model indicates that in order to ensure social cohesion and a civic community, the benefits of economic activity must be distributed in a way that is **socially equitable**... In addition to being socially equitable, economic activity must be **indefinitely ecologically sustainable**; the community must not so deplete natural resources or so pollute the environment... as to irreparably harm future generations or distant populations. Finally, the community requires a **livable built environment**; this refers to the quality and nature of the built environment, including housing, roads..., urban infrastructure...and land use.

Source: adapted from Hancock (31)

Health for all and Agenda 21

The concerns of Agenda 21 and the European health for all movement are very similar. Both are concerned about the health of people within a framework that tries to make development equitable and sustainable. They also have a similar focus on cities and the growth of urban areas. The principles underpinning the movements are almost identical.

Both Agenda 21 and health for all:

- are visionary approaches to global problems;
- suggest new paradigms;
- address ecological, economic and human health challenges; and
- are concerned for human wellbeing now and in the future.

The methods they suggest for change are similar:

- both advocate a planned approach;
- both advocate change in the way organizations work, moving them towards a more open and

collaborative style;

- both stress the need to support community capacity; and
- both suggest intersectoral approaches.

The programmes also have differences. Health for all:

- has existed longer;
- has developed experience in collaborative community and organizational work;
- has developed community-based work that is more than just consultation; and
- has accumulated experience of new ways of developing policy and strategy.

Agenda 21:

- is more explicitly inclusive in its philosophy;
- has a much broader organizational base; and
- appears to have more support from government.

Table 3. Comparison of principles and processes for planning for health and sustainable urban development from health for all and Agenda 21

Principles	Health for all	Agenda 21
Equity	yes	yes
Sustainability	implicit	yes
Health promotion	yes	(health)
Intersectoral action	yes	yes
Community involvement	yes	yes
Supportive environments	yes	yes
International action	yes	yes

Processes	Health for all	Agenda 21
Consider existing planning frameworks	yes	yes
Analysis of health, environment and social conditions	yes	yes
Public consultation on priorities	yes	yes
Structures for intersectoral involvement	yes	implicit
Vision	yes	yes
Long-term action plan with targets	yes	yes
Monitoring and evaluation	yes	yes

“...Health and development are intimately connected. Lack of development adversely affects the health of many people, but development can damage the environment in ways that also reduce health.”

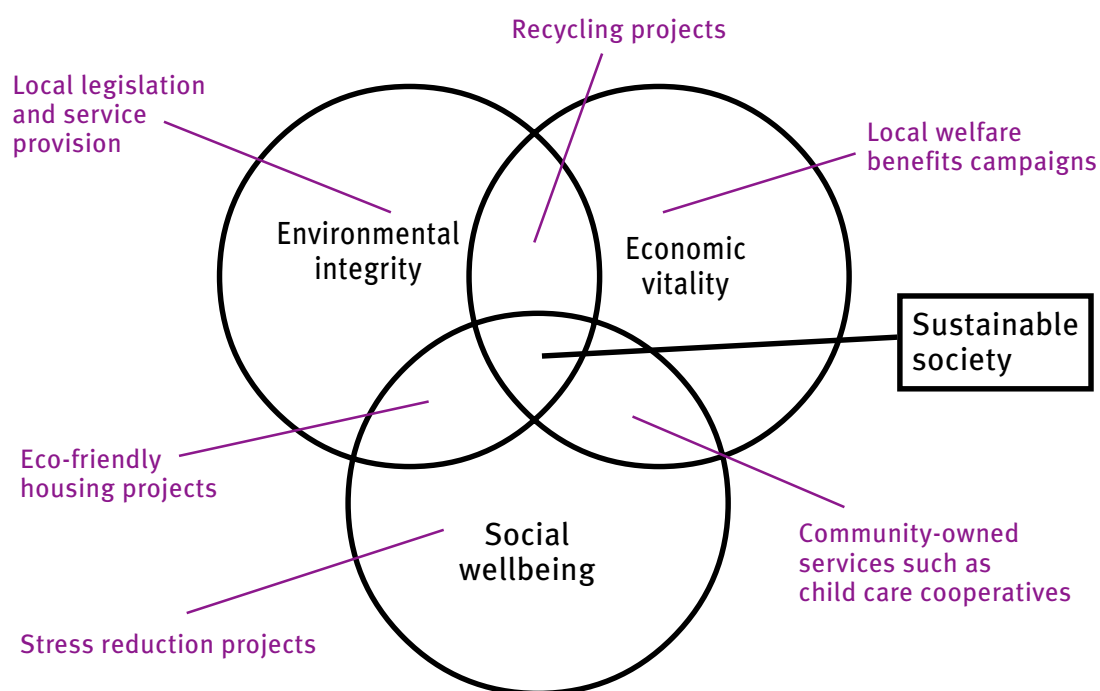
Source: United Nations [Agenda 21] (1)

As yet there are few examples of local projects and services mapping their activities against a framework for sustainable development (Fig. 7).

Both environmental and social sustainability issues are receiving substantial attention at the global level, but practical examples of collaborative work at the local level are more difficult to find. In many areas markedly different organizations fund environmental projects and health and wellbeing projects. This makes the development of joint work between them difficult.

What Agenda 21 and health for all offer through local Agenda 21 and the Healthy Cities movement are new opportunities for local workers and communities to draw together with service providers to explore new ways of working. Some of this innovative development is already happening within the movements for community health, community transport or sustainable communities.

Fig. 7. Mapping local action towards a sustainable society



Source: adapted from *Working together for Glasgow's health: Glasgow city health plan (16)*



Local Agenda 21 plans

A local Agenda 21 plan is a comprehensive plan for an area. It should be the key overall development plan for that community, and wide involvement and participation are required to prepare such a plan. These plans need to develop environmental, economic and social sustainability and therefore have a range of objectives.

The Aalborg Charter (26) broke down the process of developing local Agenda 21 plans into a number of areas:

- recognition of the existing planning and financial frameworks as well as other plans and programmes;

- the systematic identification, by means of extensive public consultation, of problems and their causes;
- the prioritization of tasks to address identified problems;
- the creation of a vision for a sustainable community through a participatory process involving all sectors of the community;
- the consideration and assessment of alternative strategic options;
- the establishment of a long term local action plan towards sustainability which includes measurable targets;
- the programming of the implementation of the plan

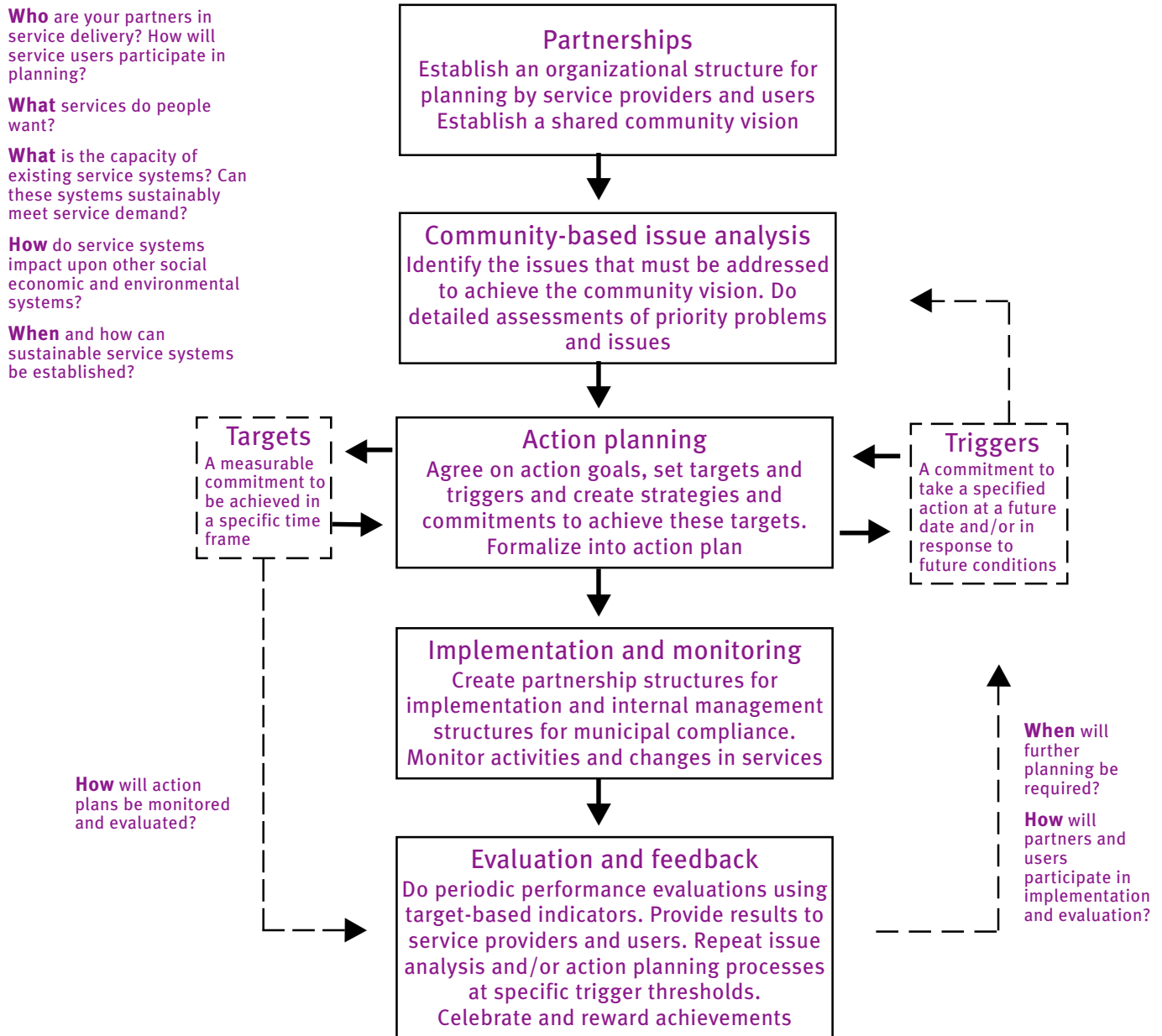
Agenda 21 states that: “Each Local Authority should enter into a dialogue with its citizens, local organizations and private enterprises and adopt a local Agenda 21.”

Source: United Nations [Agenda 21] (1)

“Local Authorities... should be encouraged to... (a) develop and implement municipal and local health plans, (b) survey, where necessary the existing health, social and environmental conditions in cities, including documentation of intra-urban differences.”

Source: United Nations [Agenda 21] (1)

Fig. 8. The elements of sustainable development planning



Source: *The local Agenda 21 planning guide: an introduction to sustainable development planning (24)*

including the preparation of a timetable and statement of allocation of responsibility among the partners;

- the establishment of systems and procedures for monitoring and reporting on the implementation of the plan.

This has been further expanded by a number of key agencies. The International Council for Local Environmental Initiatives (24) describes sustainable development (local Agenda 21) planning as integrating three planning traditions:

- strategic planning, which has been used within the private sector to provide long-term vision and goals;
- community-based planning, which has been used extensively within development to engage local residents and service users in participatory development of local projects and programmes; and
- environmental planning, which was developed in the 1970s to ensure that development projects take environmental issues into consideration and that such projects take measures to mitigate the environmental impact of their activities.

Methods and tools in local Agenda 21 planning

These approaches provide a wide range of planning methods and tools for use in the local Agenda 21 planning process. The common elements are: partnerships, community-based issue analysis, action planning, implementation and monitoring and evaluation and feedback. Fig. 8 shows the relationship of these elements in the overall process.

The description of the local Agenda 21 process developed by the United Kingdom Local Government Management Board also evokes similar themes, defining local Agenda 21 as (32):

...a continuing process rather than a single event. There is no standard “tick list” of things you must do for Local Agenda 21. The process can involve a range of activities and tools from which a local authority and its partners can choose according to local priorities and circumstances.

The United Kingdom Local Government Management Board identifies six key features of the local Agenda 21 process in the United Kingdom divided into action in the

Fig. 9. Steps in the local Agenda 21 process



Source: adapted from *Local Agenda 21: principles and process. A step by step guide (32)*

local authority and in the wider community.

The two features related to the local authority are:

- managing and improving the local authorities own environmental performance; and
- integrating sustainable development aims into the local authorities policies and activities.

The four features of the process in the wider community are:

- awareness-raising and education;
- consulting and involving the general public;
- partnerships; and
- measuring, monitoring and reporting on progress towards sustainability.

Fig. 9 describes these features more thoroughly, teasing out the aspects of developing environmental, economic, health and social strategies that have to be integrated into the planning process for sustainable development.

Intersectoral and community-based work through awareness-raising, consultation and partnerships is also needed, as is concern for monitoring

and evaluation.

In Fig. 10, health strategies are featured in the development of local policies and are also part of the integration of policy across sectors. Health impact assessment and local health profiles need to be part of the evaluation planned in considering specific action to promote sustainable development.

The Lisbon Action Plan (27) states that “We shall carry out systematic action planning to move from analysis to action.” and that “We shall integrate environmental with social and economic development to improve the health and quality of life for our citizens.”

The Lisbon Action Plan also clearly indicates the key values underpinning the local Agenda 21 planning process:

- the local authority should be the key facilitator and show leadership but not domination;
- the process should involve the entire local authority, politicians, elected officials and all departments and levels of responsibility;
- consultation and partnership with the various sectors of the community are needed to make the action plan robust enough that it has a chance of

The players in local Agenda 21 projects are: planning departments, environmental health departments, local authorities, health authorities, academic institutions, community groups, tenants’ groups, environmental action groups and transport groups.

- being implemented;
- the community should not export its problems;
 - planning should be systematic and participatory in its move from analysis to action;
 - planning should be integrated across environmental, social and economic sectors to improve health and quality of life for all citizens; and
 - planning should use a wide range of methods and tools for environmental, economic, social and health management.

The role of health in the local Agenda 21 process

The approaches to local Agenda 21 planning require a commitment to partnerships and intersectoral working. Communities and organizations need to be involved actively in creating a local Agenda 21. Health is a fundamental dimension of Agenda 21 and has a high profile within communities and organizations. The active inclusion of specific work on health and the consideration of impacts on health and the outcomes of

Shape of a local Agenda 21 document

A local Agenda 21 should:

- be a short, clear and accessible published document;
- identify the main sustainability issues and aims for the areas;
- contain explicit objectives for both the state of the environment and for the quality of life in the area;
- say which organizations or sectors will take which actions (and by when) to work towards these objectives – and how performance and achievements will be assessed; and
- set out a review process for the whole programme

Source: adapted from *Local Agenda 21: principles and process. A step by step guide* (32)

development is both part of Agenda 21 and ensures wide community participation in the development of local Agenda 21 plans.

Local Agenda 21 plans are general documents: broad frameworks for change. Detailed action on any one area of the local Agenda 21 plan requires specific plans for that area. Agenda 21 advocates that municipal and city health plans and associated health profiles be established. These plans need to address the challenges affecting health and also support the objectives of Agenda 21.

In developing the health aspect of Agenda 21 work, local authorities can benefit from the experience of cities and projects working on the health for

all agenda. Many of these cities have experience in carrying out local health profiles at the city and community levels. They also have experience in organizing and carrying out city health plans together with experience in developing processes for community participation and intersectoral action, which are both key factors within local Agenda 21 work.

The work developed by Healthy Cities projects shows some of the best models for how the health component of local Agenda 21 should be pursued. The next section outlines the processes, context and steps developed within Healthy Cities projects to carry out city health plans.



● City health planning

This section describes the development of city health plans for cities that wish to promote a health agenda systematically in conjunction with local Agenda 21. It is based on the experience of healthy city projects.

Formulating a city health plan is an important process for a city because the plan:

- places the challenges related to health and the quality of life on the agenda of policy-makers within local government, health authorities and other organizations;
- links health gains to environmental issues;

- rationalizes scarce resources, including people's time and energy;
- establishes a basis for monitoring the progress of initiatives and evaluating success;
- develops a basis for budgeting for the development of appropriate services and programmes for health;
- demonstrates the commitment of city organizations to greater community participation in local decision-making; and
- can improve the experience of living in cities, neighbouring areas and communities over time.

Effective planning is complex and demanding. Crucially, it involves

developing a climate with the political will for planning for health, which means that the strategies must accommodate the unique political context of cities and their organizations.

This can be time-consuming and difficult, as there are no quick technical fixes. It may also involve new ways of working for bureaucracies and communities. Some challenges may be common to all countries and others specific to each country.

This section highlights:

- the nature and value of city health plans;
- the likely challenges;
- the processes and structures of support that provide the foundation for a city health plan and therefore make it viable; and
- the steps needed to produce a city health plan.

What is a city health plan?

The WHO Healthy Cities project (19) describes a city health plan as:

...a key activity for the implementation of Agenda 21 [that needs] to be developed in the context of overall sustainable urban development.

The end product is a document that city organizations and communities are involved in producing and for which wide consultation has been implemented. A city health plan:

- describes the current health status of the city population in all its diversity;
- outlines the key factors that promote and limit the health of the population;
- describes the aspects of health that need to be improved and goals that need to be reached;
- determines the key priorities;
- details an overall framework for change;
- explains the operational plans for an agreed time scale;
- provides examples of good practice; and
- presents a process for monitoring and evaluating achievements.

Benefits

The cities that have developed city health plans have found that the task has facilitated creating a vision for a healthy and sustainable community and identifying the strategies needed to bring it about. It has helped to move health planning beyond the realm of health care services or environmental

A city health plan is a key tool for health development. It is also an important aspect of the general development of a city... [City health plans] link the health for all strategy with a local analysis of health priorities and set out the commitments by local authorities and other agencies to improve health at the local level. City health plans are also a key activity for the implementation of Agenda 21 and need to be developed in the context of overall sustainable urban development.

Source: adapted from City health planning: the framework (19)

City health plans are not health care plans as such but they are part of a process to “develop a collaborative vision of a healthy and sustainable community as well as offering concrete means to reach that vision”.

Source: Municipal public health planning: a resource guide (33)

health departments, where it has traditionally been located and influenced.

Cities also acknowledge that the process of preparing a city health plan:

- enables local government to examine its role in relation to the health of the public;
- aids communication between organizations and promotes partnership;
- raises awareness of the factors that affect health and the implications for policy and practice;
- provides the opportunity to counteract inequalities in health;
- improves professional development and planning skills;
- facilitates closer links with communities and users of services; and
- creates the basis for services that are more flexible and responsive to needs.

Challenges

Introducing the change required to create and implement an effective city health plan brings with it a series of challenges and threats of which planners must be aware. One of these arises with people and organizations

who are comfortable working in well established ways even if they know that this poses problems. This can lead to resistance to change. Another challenge results if the social model of health and the links between health and local Agenda 21 are not universally accepted, and as a result these are neglected. Yet another challenge is political or organizational cultures that expect immediate results, making it difficult to accept the time scale involved in producing a comprehensive plan, implementing it and identifying measurable outcomes.

Finally, power is an issue. Power is a controversial but undisputed part of city and organizational life, and it is necessary to determine who has it, where it comes from and how it can be harnessed to plans for change. Power is the potential or capacity of a person or a group to influence other people or groups, and power can be used positively or negatively. It is therefore necessary to be aware of the positive and negative uses of power and the impact that each can have (box).

The relationship of city health plans to other city planning

Some cities have no overall development plan for the future that

incorporates all aspects of city life because of the complexity of functions and services, the population needs they have to meet and political challenges. In this case, city health plans and other aspects of local Agenda 21 planning should acknowledge and react to other plans and be integrated into them, informing the operations of individual agencies and organizations. Each community, centred around either a geographical area or an issue, also needs to develop its own plans, ideally in conjunction with the city health plan.

Cities that have a detailed master plan covering all sectors should give health a high profile in the policy and social agenda of this plan. A detailed description of other actions aimed at improving health and the environment should form separate but linked documents comparable to a city health plan.

Foundations of the process of city health planning

Two important processes are required to successfully produce and implement a city health plan:

- intersectoral collaboration; and
- community participation and development.

Sources of power in organizations

Position or authority

This is the power that an individual or group holds by virtue of their role or position within the organization. Their position gives them the power to do certain things, organize work, allocate resources and instruct others. This type of power is determined by the rules, regulations and resources of the organization and limited by your job title.

Control of resources

Control over resources, such as money, personnel, materials or technology can be an important source of power, particularly if these resources are scarce. You may have power if you are the only person in the department who is permitted to access the information databases or if you have control of people and how they are deployed.

Social networks

The ability to gather information and mobilize resources and support gives power. This may be acquired through your networks or by building on the influence and power that others have. Social power depends on the range of connections you have inside and outside your organization – a case of “it’s not what you know, but who you know”.

Expert power

You have expert power if you have a reputation for giving good advice or for managing things well. This type of power is especially valued among professional groups but can also be seen in workers whose experience, expertise or knowledge of the “system” gives them influence. An administration worker who knows the grant-making procedures of the European Union inside out will have considerable expert power, as does the person who understands the temperamental photocopier.

Control of information

Information and its communication flow is critical to organizations. It shapes our knowledge of the world we work in and the issues we are tackling. People who can open or close channels of communication, analyse, filter, summarize or access accurate and reliable information will have considerable power to shape knowledge in their organization.

Personal power

Personal power comes from qualities such as charm, intellect, self-confidence, self-esteem etc. People with these qualities are often said to have charisma although it is debatable how much of this is innate and how much of this is developed. For example, self-confidence is also associated with gender, race, disability, class and other factors where social barriers and oppression can affect opportunities to develop self-esteem.

Source: adapted from Action for women’s health: making changes through organizations (34)

Intersectoral collaboration

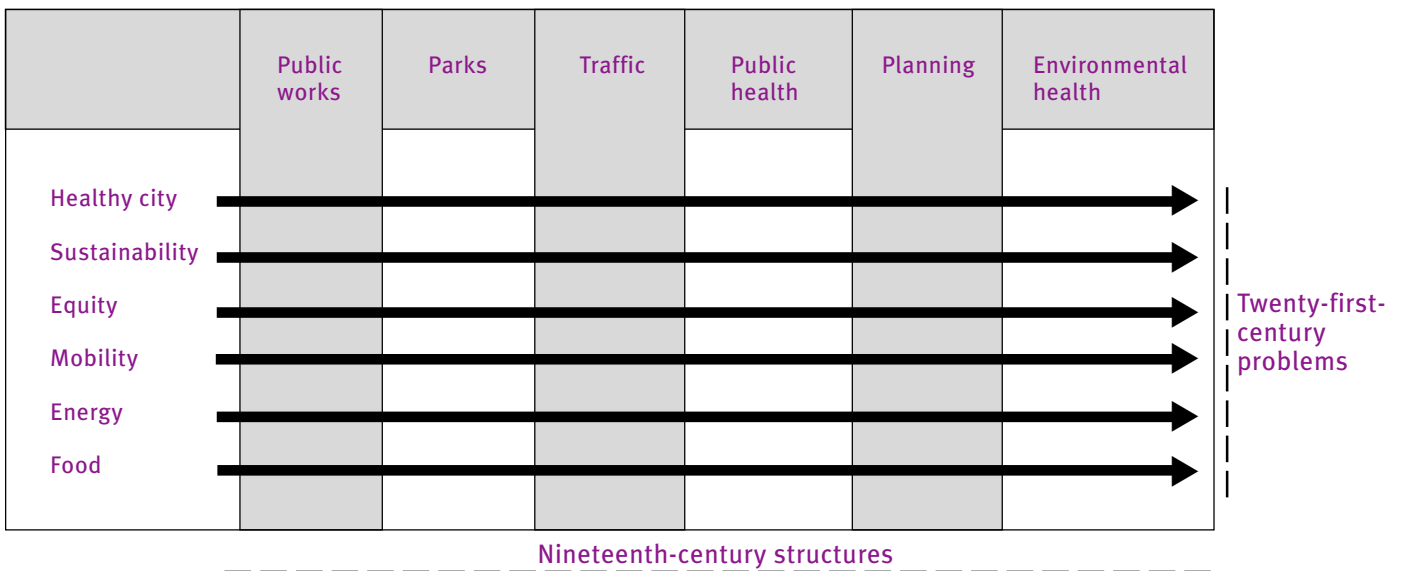
There are many stakeholders in city health plans, such as politicians, municipal organizations, voluntary organizations and communities. All have their own discrete focus on the factors affecting health and their own set of skills. City health planning demands a new vision of health in cities that recognizes a social model of health and involves all stakeholders. There is often little collaboration, and even when organizations have started to develop mechanisms for partnership the local population does not recognize this.

In exploring public beliefs about health, the Province of Ontario (Canada) found that many residents pictured the government structures that provide them with services thus (35):

...In many cases governments have become a collection of vertical solitudes with walls, narrow mandates and incentives to pass the buck. It has created a multiplicity of programmes at the community level that rarely work in a collaborative fashion.

Hancock (31) describes this as nineteenth-century governance: the

Fig. 10. Twenty-first-century problems and nineteenth-century structures



Source: adapted from Hancock (31)

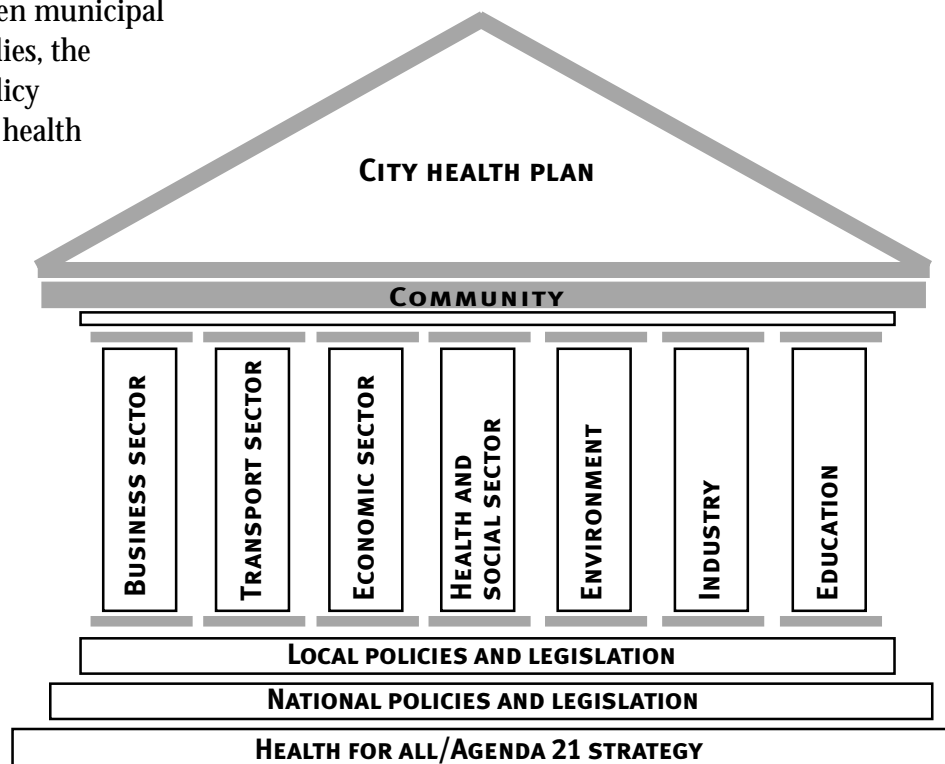
early municipal departments originated from the development of separate strong disciplines. He points out that most of the problems faced in the twenty-first century cut across these neat boundaries (Fig. 10). Responding to these challenges requires new structures that are democratic and collaborative.

In exploring new responses to the health problems found in cities, the WHO Healthy Cities project represents the relationships between municipal departments, other bodies, the community and the policy framework as pillars of health (16) (Fig. 11). This highlights the need for cities to extend or develop existing collaboration, both horizontally within the city and vertically with other levels of government and the wider community.

Intersectoral collaboration often develops naturally between grassroots workers in localities in

which the benefits to the workers and communities are clear. Collaboration between departments within corporate structures such as a city council or between corporate structures, however, can be problematic.

Fig. 11. The pillars of health



Source: adapted from *City health planning: the framework* (19)

Some of the influences that shape the level of collaborative working within local government corporate structures are:

Management and organizational structures

Blocks to new forms of working are often created by departmentalism and protectionism. Success is more likely where management systems are flexible and corporately led.

Political support

Successful integration requires a political lead with positive member support and organization.

Finance and resource consideration

There will almost certainly be a lack of resources for coordination or “new” forms of work. Competition with service activity can often be a barrier to funding collaborative work.

Strategy competition

In most local governments there will be in place, or developing, a range of different strategies, e.g., anti-poverty, community development, economic development, housing, equal opportunity.

External factors

Paradoxically, some of the special financing initiatives at European and state/city level sometimes force collaboration and partnership onto usually competing departments and agencies.

Source: adapted from a personal communication from the Healthy and Sustainable Preston Steering Group

Mechanisms to support intersectoral collaboration

An intersectoral steering committee is a key support for the intersectoral work within organizations of healthy city projects. Such a committee very clearly indicates to the city organizations and community groups that joint work is being taken seriously.

Commitment to intersectoral approaches is also underpinned by developing collaborative pilot projects for specific communities and organizations. Examples include funding of local projects in both Belfast and Horsens and the development of a city-wide policy on women’s health in Glasgow.

Healthy and Sustainable Preston

The Healthy and Sustainable Preston Steering Group developed its work on a sustainable society plan, examining how it could achieve the strategic integration necessary to achieve its goals. This was done by modelling how the local council had restructured. The council restructuring brought together key policy areas into single departments with a strategic management core, thereby creating synergy within a flexible and corporately led system.

The Healthy and Sustainable Preston Steering Group recognized that achieving successful external networking and true intersectoral collaboration requires adopting a similar structure (Fig. 12) to minimize the compartmentalizing effect of organization boundaries, especially at the strategic management core.

Many of the problems affecting collaboration and integration for sustainability arise from the rigid boundaries that organizations and service departments build around themselves, and the Steering Group suggests two complementary approaches to tackle this.

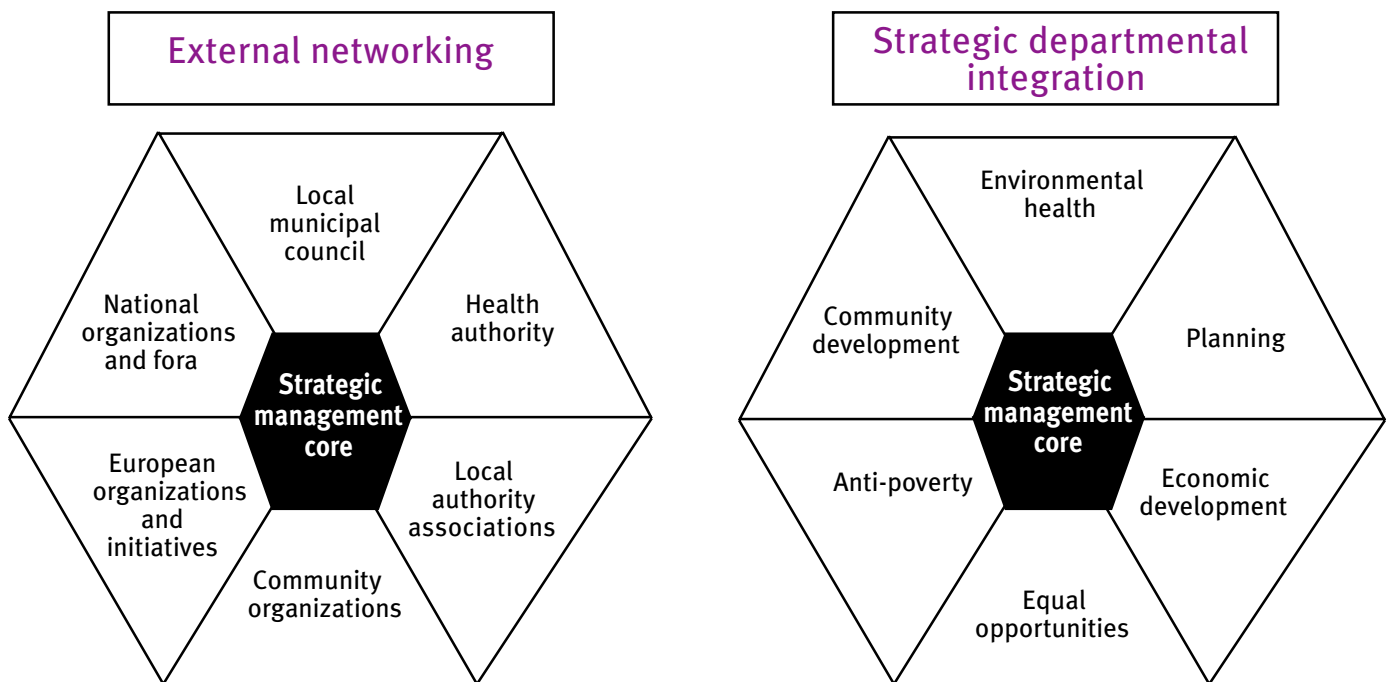
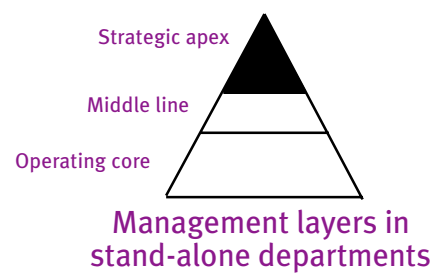
Specific positive actions and examples of good practice should be developed. These are more likely to succeed if community participation is supported and two or more policy areas are linked. Such examples could include:

- fuel and energy efficiency;
- access to green spaces;
- affordable warmth;
- reducing air pollution and preventing respiratory illness; and
- preventing crime and promoting community safety.

The Preston Steering Group suggests that the most successful actions embrace one or more of the following:

- involving the community to achieve participation and empowerment;
- developing structures to ensure local delivery;
- pilot projects that can be mobilized quickly and become “early winners”;
- small-scale, incremental but strategic development;

Fig. 12. Model for intersectoral collaboration



Source: adapted from a personal communication from the Healthy and Sustainable Preston Steering Group

Stakeholders in the planning process differ for each city and country, but common categories could be: politicians, policy developers and planners; public sector service providers; health, education, environment, transport, housing and welfare etc., voluntary organizations, interest groups and community groups. Groups may need to be convened to address specific elements of the plan as it develops.

- targeting different strategies to address the concerns of different communities; and
- practical examples of integration that politicians support and that have wide appeal.

The second approach ensures that the city or local agencies are all working towards a common agenda and have a common understanding of the need to develop integrated policies. The Preston Steering Group points out that, in many places, sustainability is

seen only as an environmental concept and that more work needs to be done to ensure that the understandings from the United Nations Conference on Environment and Development inform developments in all policy areas, including environment, economy, community and health. The critical factor for integration is to lead politicians and decision makers within authorities to develop a clear vision for the future that embraces the concept of the sustainable society.

Six basic steps in the establishment of partnerships for planning

Step 1

Determine the scope of the planning exercise and define goals and objectives. This should be done by the initiating organization (such as the municipality) in consultation with stakeholders. It should include preliminary educational campaigns to generate public interest and support.

Step 2

Create or designate a stakeholder group to coordinate and guide the overall planning effort and to integrate the results of discussions, research and planning into an action plan or plans.

Step 3

Establish distinct working group structures under the supervision of the stakeholder group. Working

groups are given responsibility for each of the unique planning tasks. They may also be established to focus on distinct issues such as housing, poverty etc.

Step 4

Identify appropriate partners to participate in the stakeholder group and its working groups.

Step 5

Establish terms of reference for the activities of each group.

Step 6

Develop a common community vision to guide the entire planning process.

Source: adapted from The local Agenda 21 planning guide: an introduction to sustainable development planning (24)

Involvement of communities in city health planning

The development of wide ranging community participation is a key factor for the success of collaborative approaches to health planning in the city. Representatives of city communities should be involved in the process of developing, carrying out and evaluating a city health plan. Community participation in the planning process has to be structured clearly. It should be built into the framework for the plan rather than being added as an afterthought.

Community participation

Community participation covers different levels of activity and participation:

- communities merely legitimizing decisions already taken;
- offering limited opportunities to comment on plans that have already been established;
- enabling people to question and change proposed ideas; and
- in-depth consultation with all options open.

These different levels of participation are considered in Table 4.

Community development

Healthy city and local Agenda 21 initiatives need to shift the balance away from token involvement to full public consultation and participation.

Achieving meaningful participation means changing organizations and supporting the communities involved. Community development is an important tool in realizing this, especially for disadvantaged communities, which have the poorest access to decision-making processes in the city.

Community development has been defined as a set of processes (36):

...directed in particular at people who feel excluded from society. It consists of a set of methods which can broaden vision and capacity for social change, and approaches, including consultation advocacy and relationships with local groups. It is a way of working which is informed by certain principles which seek to encourage communities – people who live in the same area or who have something else in common – to tackle for themselves the problems they face and identify to be important, and which aim to empower them to change things by developing their

own skills, knowledge and experience and also by working in partnership with other groups and with statutory agencies. The way in which such change is achieved is crucial and so both the task and the process [are] important.

Community development can be used in different ways. One strand focuses on locality and advocates strengthening community networks, building self-help activities and developing local leadership. It brings in such ideas as enablement, support and empowerment. In this view, organizations such as local government and health authorities are essentially benign organizations that should respond sympathetically and effectively to make resources available for local activity and new local services and can be challenged to do so. It does, however, leave intact the essential functioning of the organization.

Community workers often feel more comfortable with this view than do the communities they serve.

Another strand advocates campaigning and struggling for social change against the policies and organizations that create or support disadvantage.

Thus, people have different approaches to community development work that have both strengths and weaknesses.

Community development and health

There are many ways of responding to the challenge of producing health, and much of that work has been based within communities. Only a few of the challenges relating to health can be totally solved from within these communities.

Community development in the context of health has received great impetus in recent years from the commitment of health for all to community participation and empowerment. As community development and health have grown, the community and social services use these methods increasingly, and this way of working has gradually been adopted by mainstream health education and promotion and community nursing.

Healthy city projects are in a good position to define a strategic perspective for the work to influence the broader factors and circumstances that influence local communities.

Principles for social action

The principles of the Centre for Social Action effectively summarize a set of values that should form the basis for work with communities:

- All people have skills and understanding on which they can draw to tackle the problems they face. Professionals should not attach labels to service users.
- All people have rights, including the right to be heard, the right to define issues facing them and the right to take action on their own behalf.
- People acting collectively can be powerful. People who lack power and influence can gain it through working together in groups. Practice should reflect this understanding.
- Individuals in difficulty are often confronted by complex issues rooted in social policy, the environment and the economy. Responses to this should reflect this understanding.
- Action should strive through its work to challenge inequality and discrimination in relation to race, gender, age, class, disability or any other form of social differentiation.

Source: adapted from Principles and values (38)

This often involves:

- assessing community health needs;
- developing a response that takes account of all levels of action necessary to achieve a healthy city;
- developing policy;
- promoting collaborative work between communities and agencies and organizations;
- supporting organizational development to make community involvement easier;
- influencing the purchasing decisions of health and local authorities;
- influencing the decisions of local authorities; and
- campaigning for national solutions to problems affecting health.

Local Agenda 21 initiatives therefore need to engage with healthy city projects and health for all initiatives in their cities so that they can utilize this expertise.

Communities and city health planning

Representatives of communities in a city must be involved in the process of developing, producing and evaluating a city health plan. This is easier to achieve if collaborative community work is already established.

The healthy city projects that have carried out city health planning exercises had spent a number of years developing collaborative work within communities. This means that requests for community involvement in the process of developing a city health plan are seen as a continuation of joint work and not as a tokenist exercise.

The Australian National Local Government Environmental Resource Network (NLGERN) has developed a useful process for forging partnership between local government and the community called CONSULTT. The process is described in the box.

The CONSULTT process

Clarifying the existing situation by: interviewing key players, distributing a simple survey, reviewing literature and using this information to prepare a discussion paper for circulation.

Opening up the issues to allcomers: by circulating the discussion paper, attending community meetings, holding workshops for special interest groups and presenting all ideas to a public forum.

Negotiating agreements on direction with the community stakeholders before any commitments are made (credibility vanishes if people believe they are only there to rubber stamp other's decisions).

Synthesizing contributions into a common strategy to achieve the negotiated agreement.

Undertaking a test of the strategy in practice, either as a feasibility study or as a trial run of the real thing, before the process is cast in metal and citizens can no longer influence the process.

Learning from the practical implementation and reporting back to the community and those whose task it will be to implement the strategy.

En**T**renching the management solution in community and council structures and then:

Taking it around again: repeating the whole process at stated intervals, so that the system remains responsive and flexible.

Source: Towards local sustainable development: a toolkit of strategies (39)

Steps in producing a city health plan

If the mechanisms for developing the foundations for collaborative work and community participation have been established within a city, producing a city health plan requires progression through a series of stages. Passage through these stages may not be linear because of prevailing conditions and

attitudes, and movement backwards and forwards between them should be expected. City health plans have a developmental, qualitative and visionary perspective on the health of a city and are not simple routes and markers, as demonstrated by the rationale and definition for a city health plan of the WHO Healthy Cities project (box).

WHO Healthy Cities project: rationale for and definition of a city health plan

Rationale

- A city health plan is a key tool for health development. It is also an important aspect of the general development of a city. The production of a city health plan sets out a city's vision of health and the steps it intends to take to achieve it.

Definition

- The city health plan adapts the WHO health for all strategy to the local situation...It integrates all health and health-related activities and links health to all relevant sectors that affect it.
- The plan should have explicit and broad support within the city. This includes not only the usual decision-making structures of the city council and administration but also the support of the public.
- Where possible the plan should include targets. It should also include mechanisms for evaluation and a process for incorporating the evaluation results into subsequent planning processes.
- The city health plan is a point in a process and not an end in itself. It is important to speak of planning as well as the final plan and to recognize that planning is a dynamic process.
- The city health plan should be informed by the current health situation in the city as assessed by a city health profile.
- The city health plan is not just a collection of policies and activities influencing or relating to health. It is more than the sum of its parts. It provides the basis and a means to create a vision of health and integrated policies and strategies by which to achieve it.

Source: adapted from City health planning: the framework (19)

The steps to a plan

A city health plan is much more than a fixed description or inventory of problems, resources and solutions. It is an opportunity to re-discover the fact that many people have a role to play in making cities healthier and more sustainable and that planning should be a dynamic process involving many partners.

The development of a city health plan can be an educational process for organizations and communities. It can link together organizations and communities, developing larger projects and collaborations from the successes of smaller ones, and from these build confidence in the ability of collaborative work to provide useful new policy directions and models.

As the relationships in any city are complex, the process of the city health plan must be decided pragmatically. Depending on the existing relationships in a city, it may be better to develop a comprehensive city-wide consultation on health in the city and develop the plan from there. It may be more appropriate to develop a plan for service provision and a separate community approach and fuse them later (see the examples of Glasgow and Bologna, pages 86 and 88). Either way,

several steps are essential (Fig. 13).

A vision

A vision involves raising awareness and gaining commitment to the development of the plan and to the vision and the benefits expected to politics, services and communities.

Managing the project

The management structure for the project is clarified as well as the composition of the project team and the roles and responsibilities of both.

Collecting data

Data are collected about health in the city and the factors affecting it using a combination of approaches.

Determining priorities

The data collected are then analysed to agree on priorities.

Developing strategies

The next step is to formulate goals, objectives, strategies and measurable targets to address the priorities identified in the previous step.

Drafting the city health plan

When the plan is drafted, it can then be fed back into the process to make sure

Fig. 13. A seven-step model for city health planning



Source: adapted from *Municipal public health planning: a resource guide* (33)

that it meets people's needs and expectations.

Implementation, monitoring and evaluation

Progress is monitored, achievements are reviewed and feedback is given in an ongoing process to ensure that the strategies are implemented.

One of the problems of describing developmental work by steps is the fact that work needs to be seen to have a beginning. The beginning can be difficult to pin-point precisely. The foundation work described earlier (pages 54–63) includes how to support organizations in working together, the development of structures to allow communities to participate actively in making decisions and the development of a vision and support for new work. This foundation work has to be developed and supported by a group.

New and innovative approaches to problems in the city are usually developed locally in the interfaces between organizations and professions.

Concern about health in a city often brings together like-minded people

across agencies and communities in health for all and healthy city projects. They then brainstorm for ideas and examples of work that seem to address problems similar to those in their city. This group of innovators and enablers supports much of the early developmental work. These groups need to include senior actors in city services, as they have access to politicians and management and key figures from community organizations.

The foundation and early steps of city health planning work need support (Fig. 14). This is especially important in the early days of projects and plans, when they are vulnerable to pressure from service departments that perceive threats to their territory or from communities that are trying to shape the project policy.

Guiding the development of this area of work is difficult, as the participants in the process vary. Communication with members of healthy city projects (contact the WHO Healthy Cities project for details of projects in your area) can indicate the problems and successes of this work.

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A vision

Developing political commitment

City health plans attempt to develop a type of major organizational change that is generally difficult to achieve. Organizations and departments are competitive entities that like to dominate their territory, to delineate their boundaries and to allow people in only on their terms. The support of local politicians can circumvent some of these problems, as the politicians can often mediate in internal rivalries.

Local political support and involvement have been crucial in setting up healthy city projects, as they provide an entry gate into decision-making in the city. Strong political commitment to the development of intersectoral work on health is essential. This is also true for work on sustainable development.

The management or steering groups of healthy city projects operate at the highest levels within the city administrative and political structures, and senior politicians usually participate in these groups. Membership of such a group gives them access to senior people in other organizations such as universities, health authorities and regional authorities and also reinforces the fact that the issues being dealt with are serious and substantial.

If healthy city projects also support and/or fund community-level work, this is beneficial. Local politicians can see the work in progress and involve themselves with a successful project, thereby gaining respect in their local area.

One of the problems with this type of work is the long lead time for outcome. A strategy for informing local politicians of the time scale for outcome is essential to prevent loss of commitment over time.

Partnerships for city health planning

The work of the healthy city projects in all their different settings has been successful because broad partnerships have been formed at city level to support and develop their work.

The vision of working together for a healthy city and holding a common aim seems to provide a neutral playing field for the work of organizations and communities. This also appears to be true for the challenges related to sustainability. Nevertheless, developing such intersectoral groups is never easy, regardless of their level of organizational support. When a project brings together core organizations at the city level, very clear aims and

objectives for the partnership are required.

The fact that the WHO Healthy Cities project requires participatory and collaborative project structures eases the problem of supporting the development of the vision for a city health plan within the services and community. A healthy city project team usually carries out or coordinates this work.

Developing the vision

Explaining the vision, aims and benefits of a city health plan within organizations requires a development group with access to senior management. Members need to have a sound background in the concepts, models and processes of health for all and a keen understanding of local organizational dynamics.

The development of the city health plan must have professional support from the start. The team needs to have expertise in strategy and policy development across city service provision (health, environment, economics, education, etc.) and the ability to organize awareness-raising events in both service and community settings. The composition and support of this team can be crucial to success.

The following approaches can be used in developing a vision for the city health plan:

- consultation documents to be circulated to service organizations and community groups;
- briefing seminars for management;
- public seminars to explore new visions for the city's health;
- community-based vision workshops for both community members and service providers;
- discussion of city health in local mass media;
- developmental workshops across service agencies to explore the benefits of collaborative work;
- seminars synthesising the ongoing work in the city that already supports this approach.

No city is a desert in this sense, and there is an opportunity for creative licence in putting together community action and new service development to show what can be achieved. The aims of this work are to raise awareness of the opportunities that could arise from the plan, to gain support from the city services and the community for the idea of a plan and to raise awareness of the potential benefits to the city.

“The vision is for a future in which economic prosperity, social justice and protection of the natural environment are pursued simultaneously to secure good health and enhance well-being for all people, now and for generations to come.”

Source: Liverpool city health plan (40)



Managing the project Management structure

As everyone living and working in the city is responsible for creating sustainable and healthy cities, the management of the city health planning process needs to reflect this. The management structure differs by country and city, but the management must reflect the values of participation and cooperation.

Preparing a city health plan requires a steering group and a project team.

Steering group

The steering group needs to have clear terms of reference for the relationship with its funding partners and the other stakeholders. The steering group oversees the work of the project and provides its links into and between the participating agencies and the community. The organizations and groups whose work affect public health should be represented. Members need to be in senior positions in their organizations to enable the project to obtain funding and support.

The members should represent the community, services, politics and academe and include experts in planning, public health, strategy development and health promotion.

The box on page 71 shows the membership of a typical project.

Time and effort has to be spent in supporting, educating and developing this group. It is imperative that they understand well the aims, processes and benefits of the plan. The development of clear committee rules is also important in such a diverse group as this. Steering committee members from agencies have to have the mandate to commit their agency to tackling the challenges that arise as part of the planning process. One model is shown in Fig. 14.

Project team

A skilled organization is needed to develop collaborative projects; this is not a part-time task for an overworked civil servant. A team is required whose members understand the intricacies of the relationships between the partners, not just the organizational stakeholders but also community, academic and voluntary stakeholders.

This is not a convenient place to put excess staff waiting for retirement. Project coordinators and development workers need to be intelligent and think clearly, educated at least to degree level and have a practical understanding of the social and

political model of health and experience with collaborative work within an organization. They need to be allowed to develop work both within and outside the funding organizations.

If the health plan team is based within an organization, the team needs to be positioned within the strategy development section or the chief executive's department. If the team is based in the local authority, the team needs to form strong links with the public health function within the city. It should not be thought of as an extension of a health promotion or environmental health department. The city health plan team will have a set of specific tasks to develop and support the plan. These could include:

- serving the steering group;
- taking responsibility for developing the planning process and the plan;
- organizing the development of the range of consultations and vision workshops;
- coordinating the consultation process within the organizations and community;
- organizing a communication and public relations strategy for the plan and carrying it out; and

- educating participants about the aims and goals of the plan.

Space and financing

A separate office space is required of a standard that reflects the importance and the values of this work. The office should be easily accessible for members of the public as well as staff from the partner organizations.

Membership of the steering group of a typical collaborative health project

- Chair of the health authority
- Chair of the regional authority
- Senior politicians from the regional and local authorities
- Director of public health
- Academic professor of public health
- Director of environmental health
- Director of health promotion
- Director of planning
- Representatives of the local voluntary associations
- Representatives of the local tenants' associations
- Representative of the community health councils
- Representatives of the local health-based nongovernmental organizations
- Representatives of the healthy city working groups (such as women, environment and poverty)
- Representative of local community health projects
- Representative of the strategic planning department of the local authority

Fig. 14. A management structure for a city health planning project

Making and keeping partners

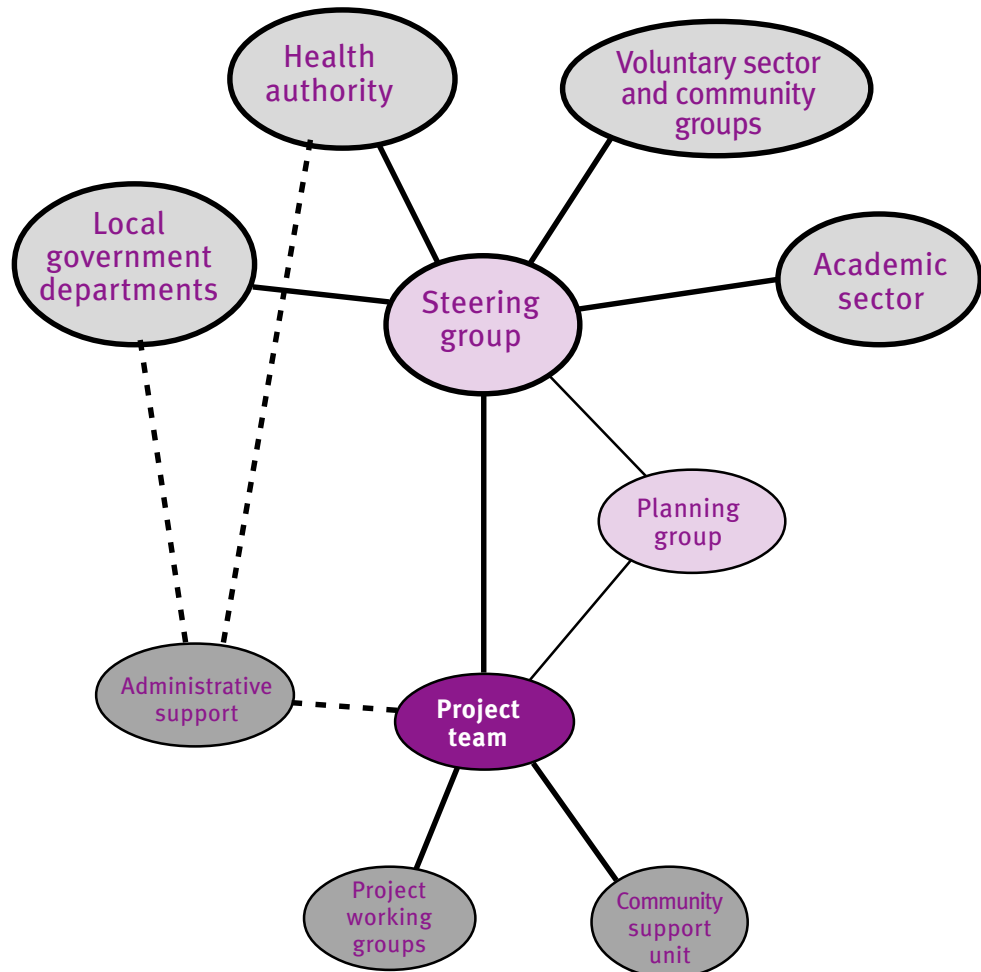
If the process of developing interest and support has been positive, the city will have a city health plan project with an intersectoral steering group. Several developmental stages in the formation are required to get this far.

1. The group has an agreed aim or vision. This is based on research into the health indicators and the factors that affect health in the city.

2. The group has agreed objectives and key issues to be taken forward and has started to draft plans to achieve them.

3. Membership criteria for the steering group are agreed.

4. The group has agreed on the roles, responsibilities and reporting mechanisms of the partners in the steering group.



The project has to have a reasonable level of funding that is protected for the life of the project. It should have access to short-term development money from statutory agencies and other sources, but the partners need to jointly fund the project and view it as part of their core services. This is important in working with the agencies. The plan must be seen as a central part of the process of developing strategy in the city. This cannot be achieved if the project is perceived to be short term with transient staff.

The project team also has to be sure that they work collaboratively to optimize development. One way of doing this is to make sure that the project has enough money for salaries and seed projects (especially community ones) but not for large joint projects. To fund these, the project has to build intersectoral alliances, thereby reinforcing the philosophy, values and utility of the project's work.

Time scale

The state of health of a city cannot be changed overnight; there is no quick fix in this type of work, and a sensible time scale and targets have to reflect

this. Helping to facilitate change in organizations takes years and not months; making a healthy city takes decades and not years.

This type of project must have time and support to develop. Credibility needs to be built for collaborative work both within the partner organizations and at the grassroots level. A range of successful collaborative activities around health is required to gain credibility in developing a city health plan.

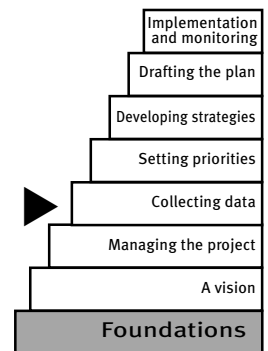
Collecting data

Developing a plan for the health of a city requires being aware of the current state of health in the city. This necessitates a city health profile, which should provide a broad picture of health by examining all the factors that affect health outcomes in the city.

In most cities the health authorities produce a range of figures related to health. These are usually illness and death statistics that indicate the state of health in the city. Producing a city health profile requires this information but also the range of other routinely collected data in the city to provide a broad overview of the state of health.

Data should be included on poverty; housing conditions; access to transport and food; provision of health and

The state of health of a city cannot be changed overnight; there is no quick fix in this type of work, and a sensible time scale and targets have to reflect this.



Sample data from a city health profile

Demographic data

Population density
Population change
Age groups
Gender
Ethnicity

Socioeconomic data

Education levels
Income distribution
Occupations
Benefit recipients
Employment

Health data

Mortality by cause
Morbidity by cause
Notifiable diseases
Mental health
Immunization rates
Accident figures
Health behaviour

Environmental data

Environmental quality indicators
Environmental monitoring
Risk assessment data
Pollution data

Service provision

Transport services
Health and social services
Education and leisure
Community support and networks

social services; employment figures and economic statistics; and statistics traditionally related to health. The data should be presented according to class, gender and geographical area.

Examples of broad descriptions of the factors that affect health in cities can be found in healthy city projects as city health profiles for specific areas (41,42). The WHO Healthy Cities Project Office has also produced a guidance document on health profiling (43).

Such collaborative productions highlight the social, environmental and economic basis of health in cities. They are very useful overviews, but other pictures of health in the city are needed to develop the city health plan. Community health profiles and needs assessment exercises provide information about people's perception of the health issues in their local areas.

Community-based assessment of health needs

In addition to the quantitative material provided by the large-scale data that are collected routinely, a picture of how communities perceive their health and the factors that affect it is required. This can be accessed by carrying out community-based assessment of health

needs and health-profiling exercises. These give a rich picture of health and health needs in communities.

A wide range of methods are used, including local implementation of validated health assessment forms (44) and the use by communities of focus groups and rapid assessment methods. Examples of these types of work can be found throughout the Healthy Cities and health for all networks.

Developing and supporting this type of work demands skills that may need to be brought in to the project team. Attention needs to be paid to the scale of this work.

- Is an assessment needed in all communities in your city?
- If not, who chooses the representative communities?
- Time scales have to reflect the need to develop support in the community.
- Volunteers may need to be trained.
- The community should have a voice in the choice of methods, and this may mean a period of education and discussion.

Community assessment is important because it can encourage support for joint work at a local level. The

assessment usually involves local workers and communities with the support of academics or external consultants. Most community profiling uses residents as interviewers or enablers. This strengthens the commitment of communities to the process and the outcome. The materials produced are good examples of the strength of community development approaches (45).

Producing reports

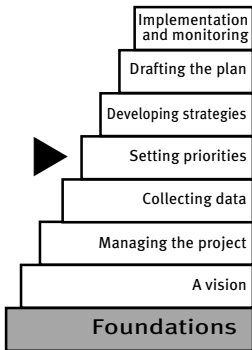
Just as how the research is carried out is important, the way such reports are produced, disseminated and acted upon is also important. The knowledge and experience of local communities on the factors that promote or restrict their ability to achieve good health should be respected. Communities should understand how the results of the research will be used.

Reports should be designed and printed to a reasonable standard. The

launching of the results of the research as a publication, video, play or a comic book should be used to generate further interest in the topic.

Once the data about the city and communities have been collected, the results should be fed back to the agencies and communities that have been involved as part of the ongoing openness in developing the plan.

The data collection provides the health plan steering group with a wide range of information about the city's health and the factors that shape it. Levels of disease and illness, poverty, the broader environment and service provision and their interrelationship should be explored in the city health profile. Differences in health status and its relationship to socioeconomic status and geographical and environmental factors should also be teased out; all of this should be grounded by information on citizens' views about the factors affecting their health.



Setting priorities

The city and community health profiling and needs assessment produce a wide range of information. This material needs to be collated and categorized and then the priority challenges for the plan need to be determined.

Simplifying the data

Organizing the data into general themes can aid in setting priorities. This is best carried out by a group comprising the project team and some members of the steering group and community researchers. This process can take a while, so a day should be set aside for this.

The project team should produce an overview of the data and draw up some provisional categories to be discussed with the group. Possible categories could be:

- the physical environment
- the social and cultural environment
- community safety
- women's health
- children's health
- accidents
- specific diseases (such as cancer)
- health education.

The health issues and data should then be placed in these categories.

Setting priorities is very difficult as many forces are always competing for increased budgets and time. A combination of techniques should be used to reach a list of priorities that can be taken forward by the city and its agencies.

Use of experts

Many data collected regularly by the city agencies will be compared with national and regional figures. Localities in the city may also be compared. This means that differences between the city and other areas can be highlighted and used to help in setting priorities. Service departments may already have statutory responsibilities and fixed national priorities such as reducing deaths from heart disease or improving water quality. Specialist help from agencies and universities may be used to discern trends in local data and to conduct comparative assessments of data, but this should not be the only approach.

After the city health profile is published and the data are simplified, a series of public consultations should be organized for a number of reasons:

- to allow public dialogue on the findings of the profile and to validate the findings from the community surveys;
- to allow the public to identify their priority issues; and
- to keep the public aware of the process of producing the city health plan.

The consultations should take a variety of forms, such as large public meetings, small local focus groups, meetings with community leaders, meetings with department heads and discussion groups with staff teams and inter-agency groups.

When this process is completed, all the stakeholders in the city health planning process should be consulted to formalize the priorities for the plan. This process has three stages. Small group meetings are held with service providers and communities separately to explore their priority issues. Then these findings are compiled for the steering group so that the priorities for the plan can be categorized and ranked. Finally, a public forum should feed the priorities back and reach a consensus on them.

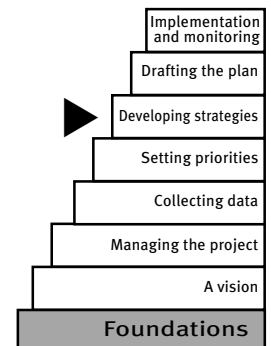
Developing strategies

When the priority themes and issues have been determined, they should be converted into strategic targets the health plan can address systematically.

The health plan has to address problems organizationally and systemically with a long-term perspective. It has to work across organizations and groups, acting synergistically and integrating efforts by different stakeholders to achieve common aims. This means that it has to be linked to local formal planning processes and be consistent with them.

The broad intersectoral group developed for setting priorities should be involved in the continuing development of the plan. Representatives from the service departments should not be the only ones shaping the strategies. The wider the group developing the strategies, the better the chance that new and innovative collaborative work will develop. In addition, this enhances the commitment from the community and all the stakeholders.

This document describes the stages of the development of strategic plans using aims, objectives, strategies, targets and programmes.



Aims

Aims are general statements about a theme that outline an outcome. Aims should be broad and compatible with the vision and philosophy of the planning process.

For example, one of the key themes to develop from the priority-setting may have been food security. The aim for the health plan for this theme could be:

To ensure through services and programmes that people have both physical and economic access to the food they need for a healthy life.

The priority issues for this theme could be:

- food and poverty
- food safety

Guidelines for developing strategies

The following issues should be considered in order to develop effective strategies:

- The issue should be thoroughly understood. It may be that some extra time is needed to explore the context surrounding the issue such as current policies, attitudes of key players and social factors.
- There should be a clear understanding of the characteristics of the target groups for the strategic interventions, including issues of age, gender, culture and their attitudes and beliefs about the issue.
- Research should be conducted into current strategies (to avoid duplication) and those that have been previously successful.
- The strategies should be achievable but not at the expense of discarding challenging strategies for the sake of easily achievable ones.
- Strategies should provide “early wins” (short-term achievements) so that both the local government and the community can see the efficacy of the time spent in planning.
- Strategies may include formalizing an already existing process and giving it direction.

Source: adapted from The local Agenda 21 planning guide: an introduction to sustainable development planning (24)

- nutritional awareness
- access to shops
- food quality
- heart disease
- obesity
- community gardens
- local food partnerships.

These priority issues would provide the platform from which to develop the objectives for the plan.

Objectives

Objectives are commitments to produce a specific outcome by a specific time. All the actions necessary to produce the outcome are shown in a strategy in clear, manageable steps. Objectives need to be achievable for the stakeholders involved.

For example, one of the priority areas under the theme of food security was local food partnerships. An objective for that area could be:

To nurture local food partnerships that influence where, when and at what price people can buy their food.

Objectives also need to be developed for the other priority issues as well as strategies by which the objectives will be reached.

Strategies

Strategies are the plans for achieving the objectives. The strategies are an opportunity to build on the strengths of the intersectoral group managing the plan. The proposals should not just be rooted within the departmental services but should give options for the development of new working relationships across local government, the voluntary sector and community stakeholders.

A strategy framework

The five action areas of the Ottawa Charter provide a useful framework for conceptualizing overall strategy:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.

Table 5 provides examples of possible strategies for realizing the objective of nurturing local food partnerships that could be mapped onto this framework.

Targets

Strategies need to identify measurable targets as part of their development. Setting targets is a difficult and complex

process; they need to:

- be achievable
- be specific and measurable
- have a timetable
- have the support of the stakeholders.

A wide range of types of targets can be

specified to address health in a city using a social model. For example, targets can be:

- technical: for example, air quality, reducing sulfur dioxide concentrations in the air by 10% over the next 12 years;

Table 5. The Ottawa Charter for Health Promotion (12) as a framework for strategy development using the example of food partnerships

Healthy public policy	Supportive environments	Community action	Personal skills	Reorienting health services
Develop a retail planning policy that supports local-scale shopping	Municipal and health authorities make available land for community market gardens	Development of local bulk-buy and food cooperative schemes	“Get Cooking” training schemes	Health centres to have gardens and vegetable plots
Provide planning support for community market gardens	Local food audits carried out by municipality and community	Using waste land as allotments and market gardens	Good eats on a low-budget courses	Health promotion departments to fund fruit and vegetable initiatives aimed at children and disadvantaged communities
Local purchasing policy for fresh fruit and vegetables	Agencies to support local food forum	Skill-sharing schemes, youth and elderly people working together	Market gardening, management and marketing courses through community education	Hospitals to support local market gardens by purchasing locally
Lobby retail sector to consider the needs of the poor	Food growing and cooking as part of school curriculum Community transport schemes	Development of local economy trading schemes		

- behavioural: reducing the percentage of 18-year-old girls who smoke by 10% within 10 years; and
- process: increasing the level of collaborative work between the local authority and the health authority by 15% over the next 8 years.

Targets are important in ensuring that the aims and objectives of the plan are achieved and should be set for all strategies. Hand in hand with the strategies and targets go the development of programmes to allocate the tasks.

Programmes

Programmes are the work plans for the targets. They are not usually included in the actual health plan but are separate publications from the agency or team responsible for achieving the strategic targets. The programmes need to outline:

- the parameters of the task;
- the actions to be taken;
- who will be implementing the actions;
- the resources that are necessary;
- an appropriate time frame; and
- criteria for monitoring and evaluation.

Drafting the city health plan

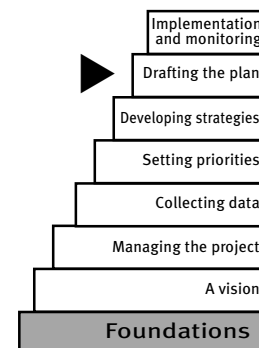
The next stage is drafting the plan. The plan is a document that is the visible result of the long and complex work of the project team and intersectoral steering group. The draft plan is the first result of this work many people see, and high-quality writing and production are important.

The plan should be written and edited for a general nontechnical audience and should be presented clearly with distinct sections. A city health plan should be written in the active voice: “we will do it” rather than “it will be done by this department”. Illustrations and diagrams improve the impact of the plan. It should be designed by a graphic designer and not just typed and should be tested on its potential readership.

Content of a city health plan

The WHO Healthy Cities Project Office (19) suggests that a city health plan contain the following information:

- the political status of the plan;
- the process of developing the plan;
- the principles on which the plan is based;
- the findings of the health assessment based on the health profile;



- the background of and relationships with previous policy and legislation;
- priorities chosen, and the reasons, methods and criteria used;
- the strategic aims, including targets;
- the plans and action to be carried out by each sector and level of government; and
- follow-up and the process for monitoring, evaluation and review.

The links between the health plan and other city plans should be shown.

Consultation and feedback on the draft plan

Comments and amendments to a draft plan are an important part of the intersectoral and developmental approach to this work. A strategy for distributing, reviewing and commenting on the draft plan should target a number of sectors, including:

- members of the service departments in all the city agencies (management and all levels of staff should have the opportunity to discuss and comment on the plan);
- local politicians as individuals and local political structures, such as the

- committees on policy and resources and on joint planning;
- boards of other organizations, the health authority, local business forums and large local employers;
- community health workers and public health departments;
- community groups and agencies;
- local mass media, to generate public interest and debate; and
- the general public, including making the plan easily accessible at public libraries and community centres.

Summary documents should be produced in different forms and languages. The project team should also develop and support a range of organizational and community-based fora and seminars from which to collect feedback. The plan needs to go through a number of versions before it can be presented to the statutory agencies for adoption as policy.

Adoption by the agencies, partners and stakeholders is not the end of the planning process but the beginning of the next phase of planning for a healthier city. The lessons learned from the process and from the monitoring and evaluation of the policy should be fed into the next version of the plan.

Implementation, monitoring and evaluation

Implementation

A health plan is only as good as its implementation. The first step in getting the plan implemented in municipal organizations is to get it accepted as policy. This means that an identified person or section in the administration has to take responsibility for overall coordination and monitoring.

The project team should develop a framework that ensures the coordination among the group of officers and workers who are responsible for implementing and monitoring all the programmes included in the city health plan.

The steering committee for the plan should then become the coordinating body for the health plan. This helps to ensure that the stakeholders continue to own the plan and that the plan is not hijacked by one agency or group.

The coordinating body should receive regular reports from the person or section that has overall responsibility for the plan and from the group of programme coordinators. The coordinating body can then ensure progress for programmes.

Monitoring

Structures to record and report the action taken to implement the health plan are needed, and mechanisms to allow reporting within and between stakeholders should be developed.

A regular accounting system should be set up for reporting performance and progress. This could be built around the regular meetings of the coordinating group and should also be collected and published as part of an annual review.

This review should be carried out by a subgroup of the coordinating body and should:

- assess progress towards the vision and aims of the plan;
- describe the state of local health in relation to national figures;
- determine whether targets have been met and strategies implemented;
- discuss successes and failures; and
- examine whether plan targets should be reassessed.

The monitoring strategy should include the development of structures for regular feedback to and from the community. This can take the form of community conferences, local focus



An excellent action plan provides no guarantee that problems will be solved, that needs will be met, or that the life of a community will become more sustainable. Indeed, one of the major hurdles that local government may encounter in establishing a local Agenda 21 planning process is the scepticism its residents and service users may feel towards more planning and more plans.

Source: adapted from The local Agenda 21 planning guide: an introduction to sustainable development planning (24)

groups and input into community groups of many types. A similar structure should be developed for service departments and key figures in the organizations, such as politicians and managers.

Regular information-sharing reinforces interest and commitment to the plan and its processes. As part of that, a public relations strategy needs to be developed to support and not supplant the more time-consuming but rewarding feedback and consultation structures.

Evaluation

The progress towards achieving the strategic targets should be evaluated at the end of the designated time frame to assess the effectiveness of the plan. This is more comprehensive than regular monitoring and comes at the end of the planning cycle. The indicators

chosen should be measurable, valid and easy to collect and should show whether the action has had the expected result.

They should also be useful in exploring how well the planning and strategic development process worked, the impact of the strategy within the community and the agency in both the short and longer term and the outcome: the change in the wellbeing of the community.

Evaluation is necessary for a number of reasons. The value of this approach to health development can be assessed. Evaluation can point to successes and failures, allowing successes to be replicated and failures to be modified. Evaluation also provides sources of funding and other resources with information that supports their continuing involvement and creates the basis for further development and change.



Examples of city health planning

This section provides examples of city health planning processes. The steps and processes described have been used in developing city health planning around Europe. They are intended as a guide to be adapted to suit the needs of each city. The examples have similar sets of steps but in slightly differing orders, reflecting the needs of their cities.

City health planning within healthy city projects has a flying start on the model presented in this document, as the foundations and early steps (a

vision and managing the project) are usually assured by the city's commitment to the principles of health for all. Structures to promote collaboration and appropriate management are therefore already in place. This section explores the experiences of four European healthy city projects that have carried out city health planning exercises. The detailed descriptions of the processes can make it easier to understand the work involved and the potential outcomes.

The process of developing the plan within the agencies took about three years from start to launch, but it was only possible because of the strong collaborative structure and high-level commitment the project has worked to achieve and develop over its lifetime.

Glasgow: starting with a service-based plan

The city of Glasgow, Scotland (population 750 000) started the development of its city health plan with a model to be used as a plan for the agencies in the city. This was to be used to gain more support for collaborative work and to establish a firm foundation from which to develop a community perspective on planning for health in the city.

The process of developing the plan (Fig. 15) can be viewed as circular, beginning within and feeding back into the most powerful decision-making committees of the city.

The process started by obtaining commitment from the most important decision-making fora in the city. High-level commitment to the idea was necessary to provide access to senior management in the service agencies.

The planning team conducted a series of meetings to develop an overview of the work of the agencies.

The City of Glasgow already collected an extensive range of health and social statistics, and these were fed into the process. The agencies

themselves provided overviews of their work and how it relates to a broad picture of health. A draft city document was produced over a year based on these and personal interviews.

After extensive consultation the Healthy City Project steering group, the local authority and health authority approved the draft.

The draft was again circulated for updating and comment by all the service agencies.

This process of developing the plan within the agencies took about three years from start to launch, but it was only possible because of the strong collaborative structure and high-level commitment the project has worked to achieve and develop over its lifetime.

The launch of the document was not the end of the process but the beginning of the task of building wider community participation and development for the plan.

After the plan was adopted and launched, a strategy for monitoring, review and development was put in place to monitor strategic targets and take forward the collaborative work.

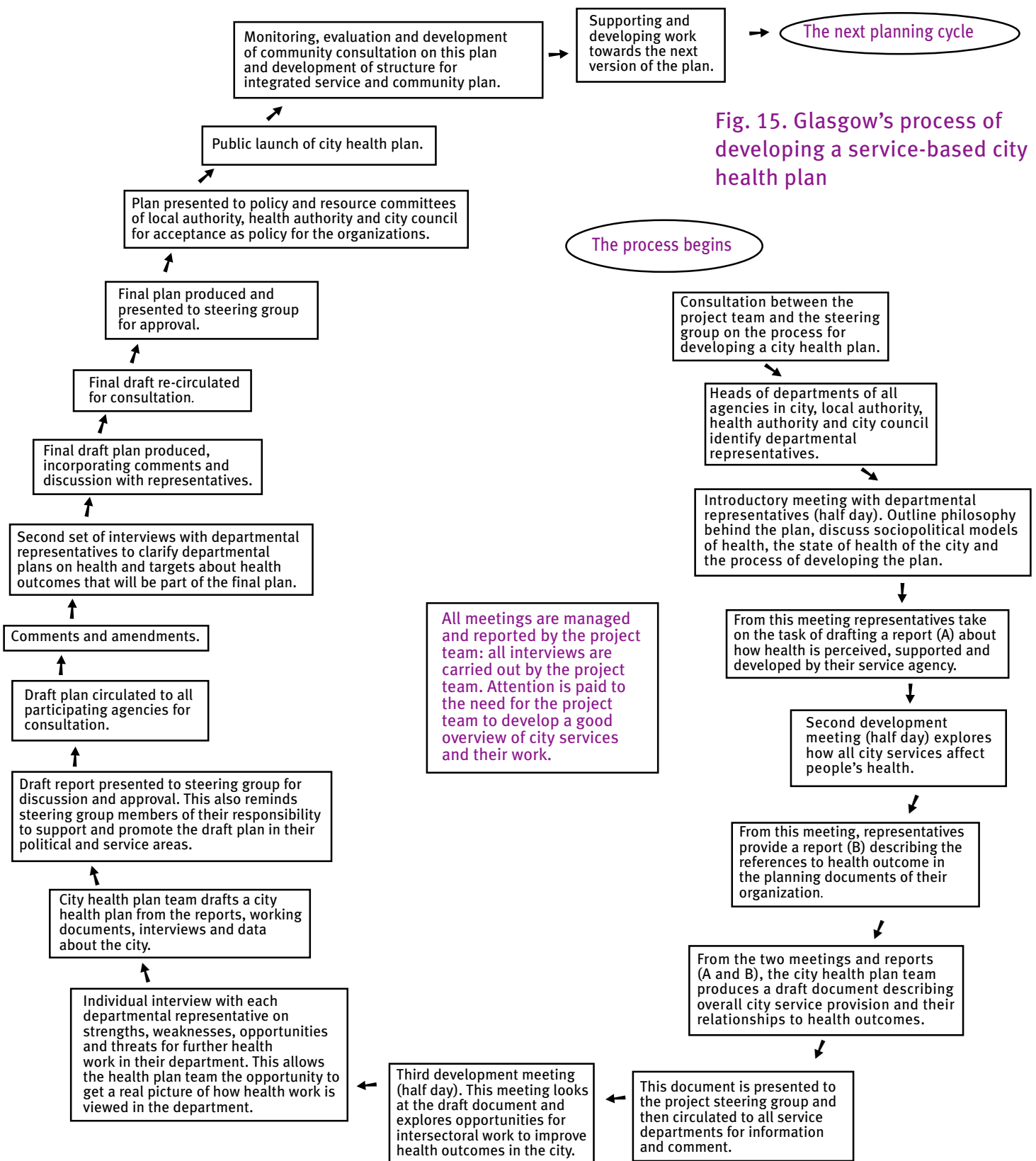


Fig. 15. Glasgow's process of developing a service-based city health plan

Bologna's health and environmental plan

Bologna joined the WHO Healthy Cities project in 1994, building on work taking place in the city since 1991. This work had developed the community capacity for health action, which led to the development of a self-protection health project and the opening of a health shop. This work involved the local community actively in gathering and producing information on health.

This collaboration at the local level is reflected in the activities and developments at the municipal level. The Municipality of Bologna has signed the Aalborg Charter, joined the European Sustainable Cities & Towns Campaign and the WHO Healthy Cities project and initiated a local Agenda 21 process in 1996.

The Environmental Department is responsible for local Agenda 21, coordinating collaboration both within the municipal board and at the local level. The commitment towards local Agenda 21 and the Bologna Healthy City Project are clearly shown in the political plan for the city for the years 1995 to 1999, in which the main goal is the development of long-term action plans towards sustainability.

The objectives for the healthy city process include building strategic links with other sectors and organizations that substantially influence health and strengthening national alliances and support systems. The goal is to achieve a comprehensive city health profile and to plan to tackle such challenges as equity and sustainable development.

Because the principles and practice of health for all and local Agenda 21 overlap substantially, the Municipality intends to integrate environmental issues and health in developing a comprehensive municipal health and environmental plan. The local Agenda 21 team and the Healthy City Project Office are analysing the environmental factors in the city and preparing a city health profile.

Environmental indicators

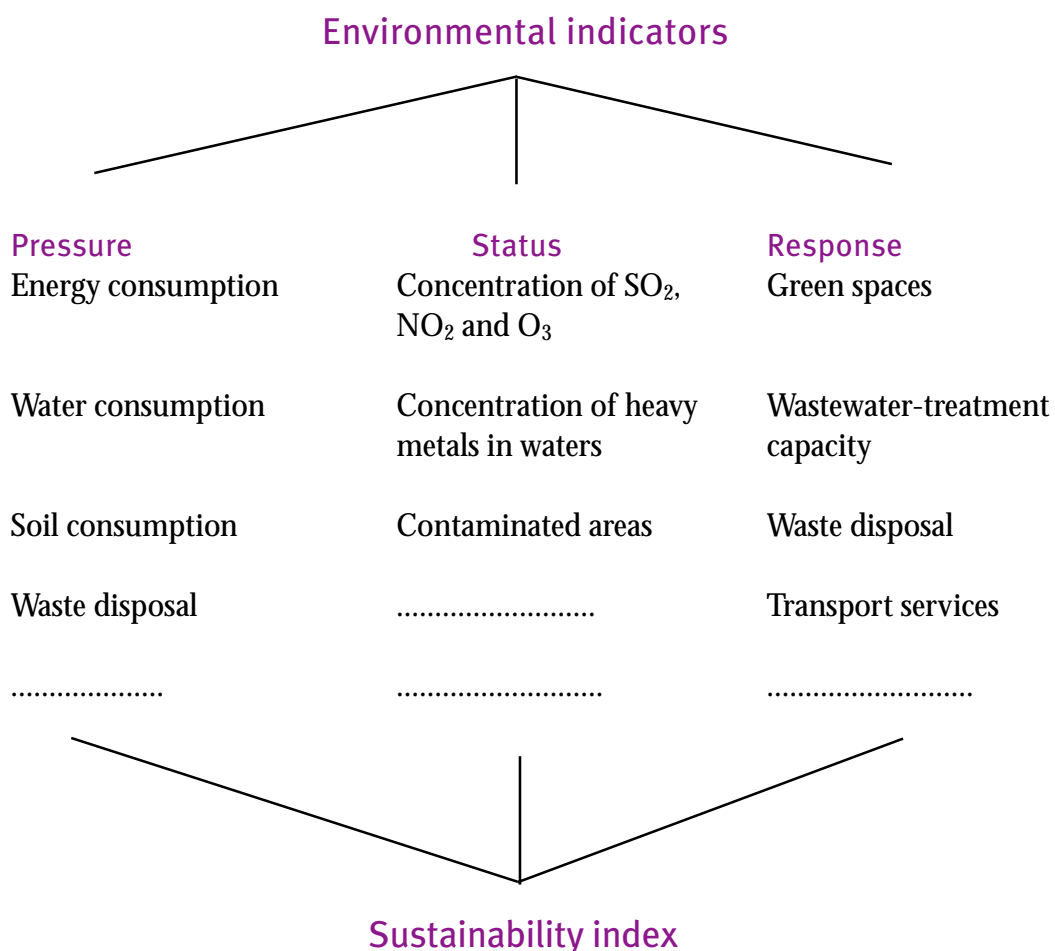
The Agenda 21 team has already developed a set of 80 environmental indicators divided into three categories: status, pressure and response (Fig. 16). The challenges identified are air and noise pollution, water resources, use of energy, waste disposal, transport, industrial activities, urban water planning and misuse of resources. This set of indicators will constitute a permanent database that will be

updated regularly. From this, a sustainability index based on 12 indicators will be developed.

As the indicators were being developed, a series of public

consultations and seminars were held in Bologna to develop a citizens' forum for local Agenda 21. This forum, which has representatives from environmental groups, trade unions, the Artisans'

Fig. 16. Bologna's environmental indicators

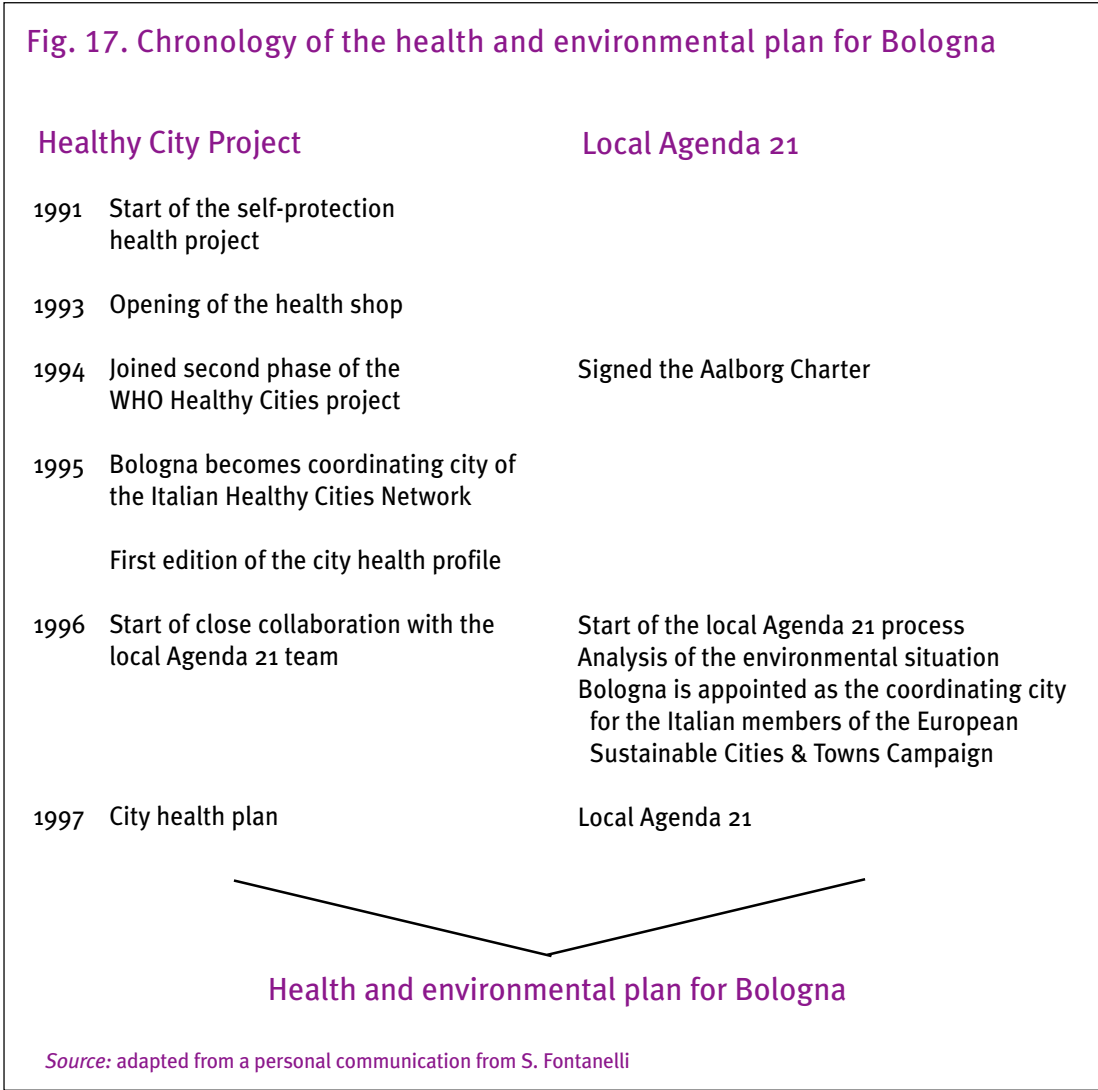


Source: adapted from a personal communication from S. Fontanelli

Confederation, the Industrialists' Confederation, the professional associations, the Consumers' Association and other voluntary groups, will be involved in all

significant stages of the preparation of the local Agenda 21 plan. The citizens' forum will be involved with the local Agenda 21 team in developing and determining the 12 environmental

Fig. 17. Chronology of the health and environmental plan for Bologna



indicators for the sustainability index. The tasks and priorities for the actual local Agenda 21 plan will be discussed with the citizens' forum, and their suggestions and priorities will be taken into account. The final document will represent a collaborative effort between the community and the agencies and will provide a good base for working together in implementing the plans.

A city health profile and social equity indicators

Bologna's Healthy City Project completed the first city health profile in 1995 and is now working on selecting a set of indicators of social equity. This is seen as an important step in developing coordination of intersectoral action for health. The development of a set of indicators will help in the future definition of an index of social sustainability and capacity. This objective is still much more difficult to achieve for health and

social challenges than it has been for environmental challenges. The Healthy City Project team is developing methods and initiating discussions with the community about what challenges they perceive to be the most important.

It is hoped that the health shop can be used as an important tool in finding and integrating the social and environmental factors affecting health in communities. A health network is being developed that will be decentralized in the nine districts of the city, enabling these communities to be reached in a new and more direct way. This network will have the health shop as a focal point.

The health and environmental plan

The health and environmental plan (Fig. 17) will be based on the findings from the city health profile and the environmental reports and will serve as a guide for the priorities for action to be developed.

Aims of the health shop

Identify and integrate the environmental and social aspects that could affect health.

Reach out to the population in the various areas of the town in a new and more direct way, encouraging healthier lifestyles and behaviour.

Create health networks as well as a database by means of information technology.

Liverpool: developing a collaborative plan

The City of Liverpool felt strongly that developing health plans should not be seen as a one-off exercise that will set in motion all the work needed to solve a city's health and environmental problems at once. Instead a health plan should be viewed as a process of consultation, data-gathering and analysis, mobilizing the resources required to make key improvements and open new channels of communication between different sectors and communities in the city that can learn to work together on a continuing basis.

In Liverpool, the consultation with the service organizations and the community has been tightly coordinated with the planning process. The health plan is a five-year strategy to improve the quality of life and health in the city. The plan has long-term and short-term targets and aims to get everyone moving in the same direction to take action on the underlying causes of ill health in Liverpool and to achieve the levels of health described in the document on health strategy for England (46).

Liverpool became one of the first cities to participate in the WHO

Healthy Cities project in 1988.

During the first phase of funding, the Liverpool Healthy City Project was devoted to getting organized and to establishing commitment among all agencies to the philosophy, strategy and principles of health for all. During the second phase of funding, the Project became involved in developing its own city health plan.

In 1993, new arrangements and structures were put in place for public health in the city, thereby bringing public health within the mainstream planning processes of the key authorities (Fig. 18). The Healthy City Project was revised with a brief to set up task groups on priority health challenges in the city. These task groups were made accountable to a newly formed Joint Public Health Team and to the Joint Consultative Committee.

The role of the task groups was to develop strategic and operational plans towards the development of an overall city health plan. Task group topic areas included the national health promotion policy key topic areas of cancer, heart health, sexual health and accidents. A fifth task group was set up on housing for health to address the underpinning factors of ill health such as poverty. Housing was considered to be an

The vision is for a future in which economic prosperity, social justice and protection of the natural environment are pursued simultaneously to secure good health and enhance well-being for all people, now and for generations to come.

extremely good indicator of poverty.

Members of the task groups included representatives from the health authority, the Liverpool City Council, the voluntary sector, the Trades Council, the City Health Promotion Department, community health councils, universities, the Chamber of Commerce and the communities of the city themselves. About 150 people were involved in developing the city health plan.

The draft city health plan was launched for consultation in January 1995. The plan was produced in a number of versions and used in a number of settings with facilitators to ensure accessibility for all groups. A video was also made to aid group discussion. Responses were elicited by questionnaires and letters.

The analysis of the consultation revealed that people widely supported the plan. City residents understood the links between the underlying causes of ill health and the main causes of premature death and illness and agreed that tackling these would have the greatest impact on health. The environment was ranked as the first of the top ten concerns expressed by local people. This included the environment – in general and specifically in relation

to air pollution and the desire for a clean, green city. This was followed by poverty and unemployment, mental health, housing, access to health services, education and training, young people having more influence in the city, diet and nutrition, accidents and transport.

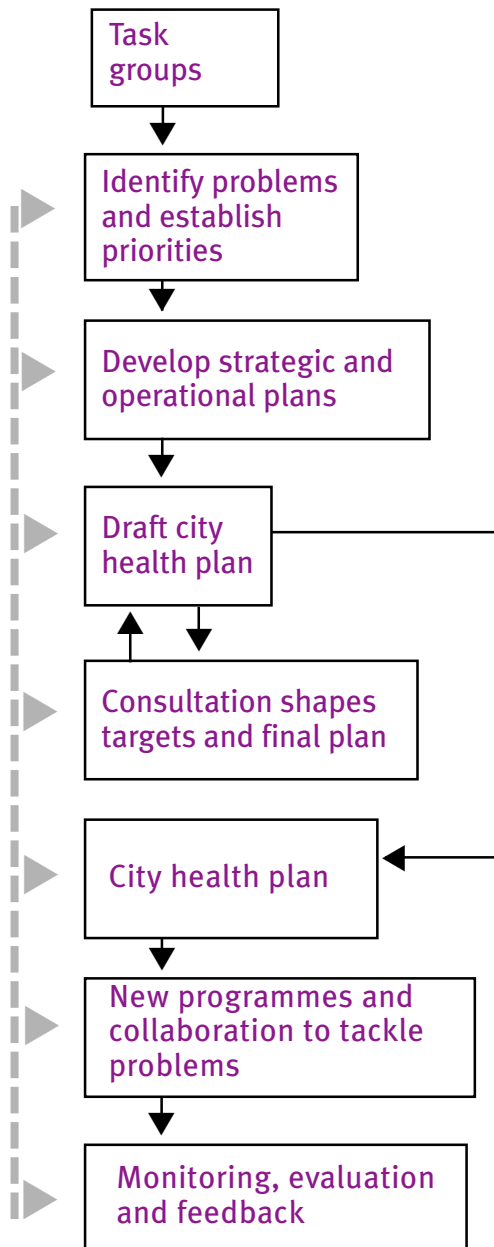
Comments from the consultation were then included in the revised city health plan, and the final version of the plan (40) was launched on 7 April 1996 to coincide with World Health Day, which focused on healthy cities in 1996.

The city health plan reflects the need to address the wider socioeconomic, environmental, political and discriminatory determinants of ill health. Action is being taken, for example, to tackle the problem of widespread poverty in the city. This action includes using new money such as European Union Objective 1 funding to target areas of the city with the intention of creating new work. Existing resources are being redirected towards city regeneration and investment in the economy, and the city is working towards balanced targets for environmental sustainability.

The plan is already influencing mainstream activity in the Liverpool

The plan was made available in full draft format, as a summary guide, as translated versions of the summary guide in seven different languages, on audio-tape in different languages, in Braille, in large print, in articles in newspapers, in discussions on radio and in free newsheets to every home in the city.

Fig. 18. The health planning process



City Council and Liverpool Health Authority. Some action has already been incorporated, and consequently the city is working and thinking differently. Gone are the old ways of thinking only about the present, short-term crisis management, exclusive ways of working and centralization of planning.

The new ways of thinking and acting revolve around long-term neighbourhood planning, partnerships between agencies and local people, local action and cooperation, output that can be measured, concern for future generations and an increased understanding of health challenges and the impact on health of various policies and actions.

The impact of the plan on health will be measured. Indicators will be developed for measuring progress over the next five years of the plan, and a review of progress will be published annually.

Intersectoral planning for health in Belfast

Belfast started its process of developing a health plan (Fig. 19) with a very clear rationale and structure (47):

Since many different factors contribute to health, responsibility for its production rests with a wide range of individuals and agencies, each having a role to play individually and collectively in the production of good health in our city. Government has a strong role to play through its economic and social policies. Employers, large and small, have a role to play through their impact on the environment, the products they supply, the jobs they provide and the conditions under which their employees work.

Planning for health in the city therefore becomes the responsibility of all relevant sectors within the city, which impact upon it, environmental, social, education, housing and health care sectors.

An aim and objectives for the city health plan were developed from this philosophy.

Aim

The aim of the city health plan is to create a vision for the health of the people of the city across all sectors and to develop integrated policies and strategies by which to achieve it.

Objectives

The objectives of the plan are:

- to develop a city health profile, including qualitative and quantitative data that will describe the health of the people of the city and the conditions in which they live;
- to make visible the challenges relating to health: for example, the current planned health activities and policies of statutory sectors and the facilitation of new integrated approaches to and coordination of all health and health-related activities within the city;
- to enable communities in the city to participate and influence decision-making processes about health and the provision of health-related public services;
- to provide a rational basis for decision-making, geared towards investing in health and reducing inequalities in health; and

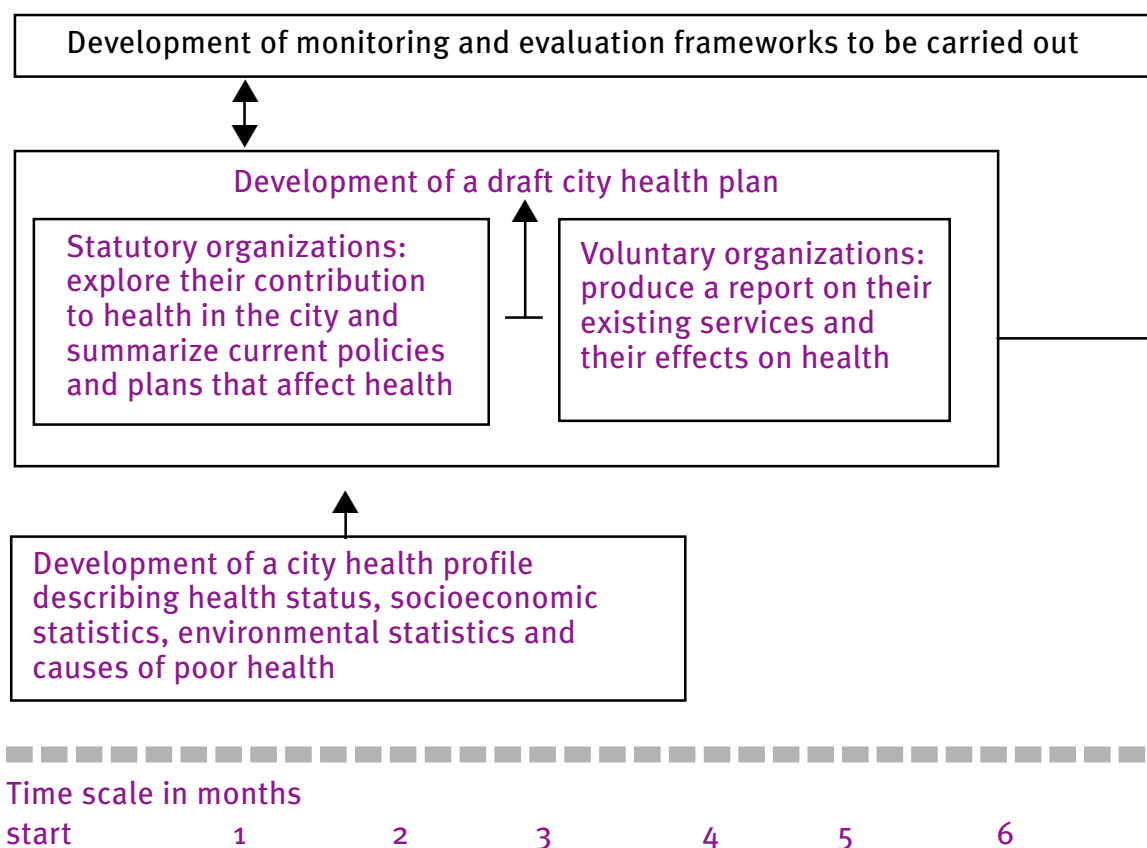
- to develop a monitoring and evaluation framework that will indicate the progress of strategies for action and measure the outcomes.

planning process. Overall and specific outcomes for the plan are also outlined. The overall outcomes desired by the city health plan are:

Process measures, outcome and time scales are provided for each stage of the

- a common direction towards health in the city for all agencies; and

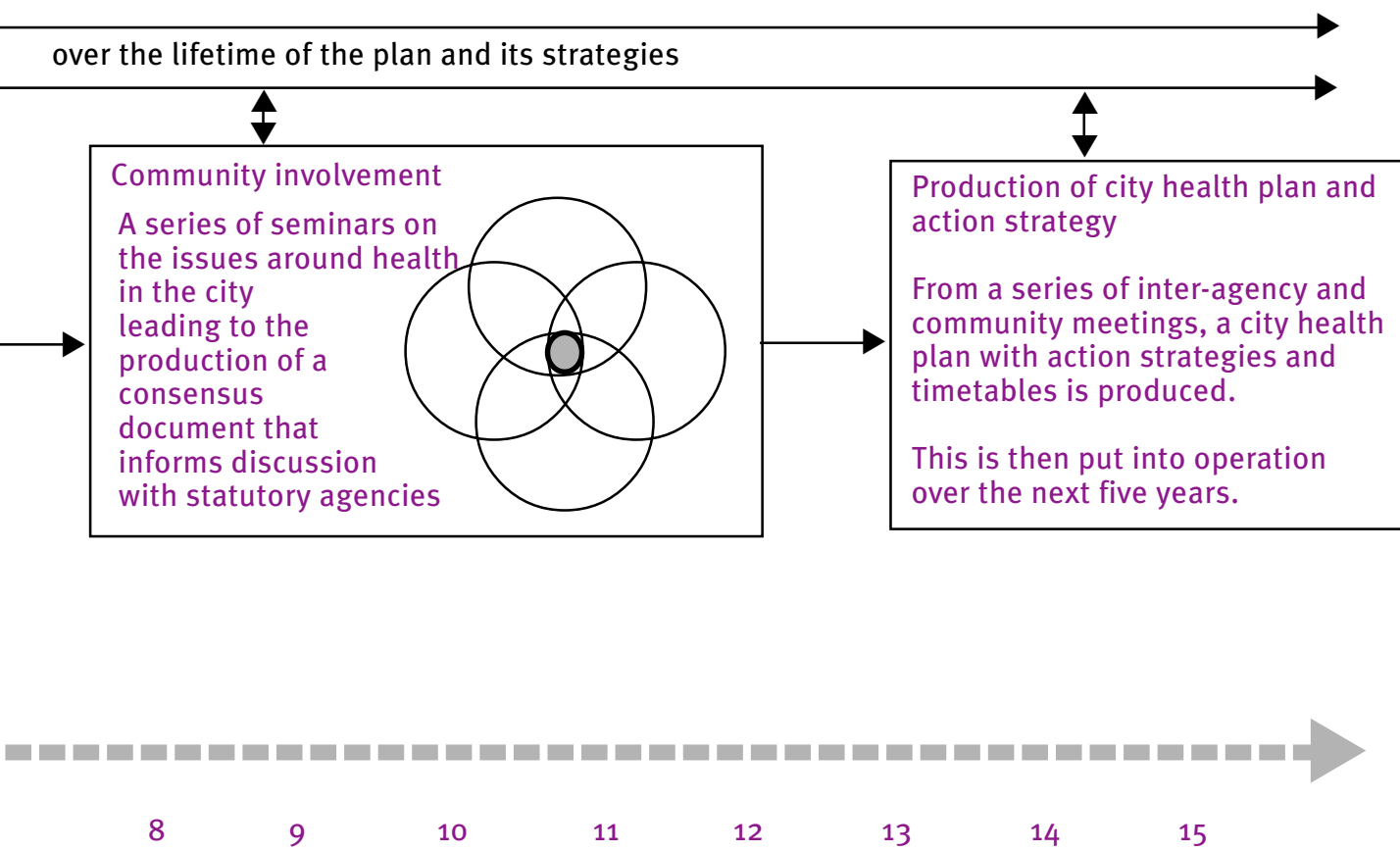
Fig. 19. Process for developing the Belfast city health plan



- improved coordination and synergy resulting from the process will enhance individual programmes.

- integrated policies evident in the future planning cycles of statutory organizations;
- increased coordination between sectors on appropriate service delivery to meet community needs;

The specific outcomes desired by the city health plan are:



- evidence of change in the policy of statutory organizations that invest in good health;
- action strategies with time scales and indicators that will lead to improvement in people's quality of life in such areas as environment and health, poverty and health, social networks for health and appropriate services;
- community involvement in future planning and development of policy and service in local areas;
- strengthened community participation in statutory organizations;
- ethnic minority communities being involved in assessing needs and developing action plans;
- an increased understanding of the wider dimensions of community needs and of the range of skills and resources within communities;
- new partnerships formed with the statutory, voluntary, community and private sectors at the community, city, country and European levels to sustain long-term action;
- the development of locality health plans;
- community needs being evident, both in policy changes and strategies for action;
- the development of support structures for negotiation;
- increased satisfaction from communities on delivery of services;
- evidence of collaboration between government departments that supports the long-term viability of communities;
- evidence that socially excluded groups are being involved in planning policy and programmes;
- evidence that organizations are developing and building sustainable policies and programmes in partnership with communities; and
- evidence of capacity-building within communities.

Similar to all the city health plans developed within healthy city projects, the fundamental work of gaining commitment and having support and staff to carry out this work is part of the project.

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<http://www.who.dk/tech/hcp/index.htm>

“The prerequisites and prospects for health cannot be ensured by the health sector alone.”

Source: Ottawa Charter for Health Promotion (12)

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