Action for health in cities

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN
1994
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Preface

The Healthy Cities project is a fast growing movement. Capturing the tangible edge of the project and documenting city actions are essential to its development. This document gives a glimpse of the wealth of activities initiated or brought under the project umbrella in cities that were part of the Healthy Cities network during 1987–1992. The 49 case studies presented here show in concrete terms how cities can implement the healthy cities idea in the main areas of the World Health Organization strategy of health for all. It is an exercise that was part of the five-year review of the first phase of the project. In the long term, the goal of the evaluation of individual city initiatives should be to demonstrate positive health gains and the added value of the project. It is equally vital, however, to recognize that cities actively engaged in the project continuously need ideas, legitimacy and inspiration. They need to share experiences as they need to have a dialogue that is based on common interests. Furthermore, I am convinced that this document will be particularly helpful to healthy cities "beginners" who are being introduced to the concepts and theory of the project.

I should like to express my gratitude to Lisa Curtice and Rachel Minay of the Research Unit in Health and Behavioural Change, University of Edinburgh, who researched, compiled and edited this document. Many thanks are due to the Chief Scientist of the Scottish Home and Health Department who provided the funding for Lisa Curtice's time. I deeply appreciate the cooperation and keen interest of the project cities coordinators who generously shared their case studied for this document. Many thanks are also due to Gill Paludan-Müller for her excellent administration of the preparation process.

Agis D. Tsouros, M.D., Ph.D.
Healthy Cities Project Coordinator
Introduction
Positive action for positive health

This booklet is about the action that cities can take to improve health. Many actors can take part, illustrating the huge potential for partnerships to develop the infrastructure for healthy cities. Municipal councillors, housing departments, environmental scientists, urban planners, health departments, social welfare agencies, schools, nongovernmental agencies, self-help groups, neighbourhood associations, children – the combinations of people and organizations that support initiatives to improve the health of cities would fill a booklet by themselves. Women, children, the elderly, and people living in poverty, however, appear in these pages not only in their traditional role as subjects of health and social programmes but also as active participants in health promoting initiatives.

The case studies presented here are examples of accumulating know-how in urban health action. The knowledge they contain was gained from experience:

- how a city-wide health information system was set up;
- how a comprehensive health strategy was planned;
- how local health clinics were made more accessible;
- how children were involved in decision-making about their city;
- how information was given to citizens to help them make healthier choices;
- how citizens were encouraged to change the way they disposed of their household refuse;
- how the inhabitants of a deprived neighbourhood were supported in tackling health issues; and
- how city-to-city collaboration on AIDS, tobacco, alcohol and nutrition was established at an international level.

These experiences represent a human technology: the technology of innovation in urban health management.
Participants in action for healthy cities are engaged in a common enterprise: creating social change. This volume shows the breadth of change embedded in the notion of a healthy city. Changing priorities in strategic planning enables prevention and health promotion to gain importance in decision-making. New alliances encourage organizational change and provide incentives to change practice. Networks accelerate the pace of change through the exchange of experience. Participation helps to develop new skills and may increase the resources available for further community action.

The scope of action for healthy cities is as broad as the vision of what a healthy city could be like. Building a waste treatment plant that provides for recycling and energy recovery is one step towards creating a sustainable ecosystem for a city. Action to protect the rights of minorities, such as black and ethnic communities and travellers, is a route to equitable communities. Powerlessness is not conducive to positive health. Cities have developed many strategies to help people to take more control over decisions affecting their lives, health and wellbeing. These include: providing information about health choices, encouraging city agencies to involve people in decentralized planning and establishing centres to support grass-roots organizations and neighbourhood initiatives. A desire for equity in health inspires schemes to ensure that all the people in a city can meet their basic needs, projects to reduce obstacles to access to health care services, and development work in areas of deprivation. Programmes for tobacco or tuberculosis control have been developed to improve the health of city dwellers.

The cities included in this volume were all members of the international Healthy Cities project of the World Health Organization (WHO) Regional Office for Europe during the project’s first phase: 1987–1992. These cities are distinguished by commitment to a comprehensive approach to the project. At the highest political level, they are prepared to participate in an international network, to exchange information and to work systematically to make their cities healthier. The project cities differed widely in size, political orientation, structure of government, economic status and health problems. It may have seemed too much to hope that common approaches could emerge. Nevertheless, the numerous actions reported here show remarkable coherence. Three themes recur to characterize the innovative nature of action for healthy cities. First, policy-making is based on an enlarged vision of health, expressed in a way that has concrete appeal to municipal politicians and officials. Second, initiatives are invariably implemented through partnerships between groups with a stake in the action. Finally, no matter the task – research, planning city services, opening a new bicycle path – or the health issue, there is a focus on approaches that support and
broaden public participation. This approach is aptly called local healthy public policy.

The last years of the twentieth century are seeing a global explosion of spontaneous, innovative action for health in urban communities. The WHO Healthy Cities project offers five years’ experience with sustaining a process in the city that can weather political storms and maintain a growing momentum for change. The booklet Twenty steps for developing a Healthy Cities project set out the fundamental building blocks for an intermediate agency in the city that can catalyse political support and partnerships and provide a framework for action.

This booklet focuses on the outcomes of Healthy Cities processes, on what cities have actually done to create supportive environments for health and to become healthier. The shape and significance of these actions, however, are closely linked to the framework of organizational development outlined in Twenty steps for developing a Healthy Cities project. The range of action described here reflects the outcomes of political decisions about city priorities and resource allocation. In part, partnerships forged through the intersectoral and technical committees of the Healthy Cities project account for the scope of many of these actions. Healthy Cities project offices were often the silent enablers of the action reported here, as they performed their role of facilitating, mediating and advocating health promoting change in the city.

Whether directly stimulated by the Healthy Cities project or representing the work of city councils and project partners, the action described here fulfils four important functions for healthy public policy in the city. Action for healthy cities:

- uses the principles of the WHO strategy for health for all and the Ottawa Charter for Health Promotion to make cities healthier places in which to live;
- builds support for new approaches to public health;
- contributes to changes in policy by raising awareness and winning support; and
- promotes innovation by providing opportunities for many different groups and communities to take part in new forms of health action.

The combination of vision, political commitment, infrastructure development, the progressive development of action in many areas within a comprehensive framework, and international collaboration distinguishes action for healthy cities. This provides the energy that

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a Twenty steps for developing a Healthy Cities project. Copenhagen, WHO Regional Office for Europe, 1992.
channels the cascade of actions described in this booklet into a powerful stream with a global influence on how people think about and act for health.

Investing in health makes sense. The initiatives in this booklet not only illustrate how this can be done but give examples of many concrete gains accruing to cities that adopt these strategies. Read together, these case studies distill some very important lessons from the experience of the project during its first phase.

Healthy public policy

Healthy Cities projects have discovered that arriving at a comprehensive healthy city plan requires a journey that may take several years. The fundamental building blocks of a comprehensive healthy city plan are:

- political commitment
- contributions from a wide range of municipal departments
- priority-setting based on information about health in the city
- building on the existing capacities and activities of agencies in the city
- active involvement of citizens in planning and taking action.

The examples in Section 1 show how, in different ways, the focus of strategic development adopted by cities can help all citizens to perceive the possibilities for action on health. Planning on the basis of an ecological approach to health has been developed into an approach to action that is characterized by collaboration and participation. The case studies show how a dynamic relationship can be created between information, planning and action.

Equity

Healthy Cities projects have made daring attempts to link work with local communities in areas of deprivation with strategies for organizational and policy development. In Glasgow, the lessons from a pilot project in Drumchapel have been extended to other areas of deprivation, and the city project has a resource unit that helps local communities to find resources to implement their proposals. Cities have learned that action for equity demands the processes of collaboration and
participation called for in the WHO strategy for health for all. Strengthening community action and developing personal skills among people with the least access to resources are vital to the success of urban health strategies. Healthy Cities action at the local level has shown that developing and implementing local healthy public policy with the active participation of the people most affected by it can mobilize hidden resources and contribute to sustainable development in communities.

People can be empowered through health action. In the Healthy Cities approach, people are supported in challenging the structures and processes that reduce their health potential. Section 2 shows that the Healthy Cities approach can tackle a major, complex urban problem. Healthy Cities projects have influenced city policies towards the goal of greater equity, used their positions as enablers, mediators and advocates to encourage agencies to collaborate to make services more available, and developed a range of innovative action to strengthen and empower communities.

Lifestyles and settings

The Healthy Cities project offers huge potential for the implementation of programmes to develop healthier lifestyles and to make the settings of daily life more supportive of health-related change. Cities can use the know-how of project cities to develop and test initiatives and then to make successful models of good practice into resources available city-wide. The partnerships between agencies developed through the project can be used strategically to increase the resources available for health action. High-level political commitment and local involvement can both be used to overcome barriers to professional collaboration. In addition to operational gains, the case studies reported here illustrate how the Healthy Cities approach leads to a broadening of the agendas of lifestyles and settings approaches. Conceived in the context of a healthy city some initiatives develop the connections between health and the environment to take innovative action. In other cases the city's existing framework of support for health promotion activity can be catalysed to ensure the effectiveness and success of pilot projects that attempt to change long-established patterns of service delivery and professional training, as in the example of the Vienna women’s health centre. The Healthy Cities project's emphasis on equity leads particularly to the selection of action that complements and improves existing services.
New forms of action on major urban issues

Healthy Cities ideas lead to innovation in policies, programmes and actions. City projects experiment with new organizational forms such as networks and "one stop" support agencies for citizens. They also promote activities that develop structures and skills for collaboration and exchange. Practical know-how is exchanged at both the local and international levels. Confronting major urban issues – pollution, social deprivation, urban decay – city councils and governments need far-reaching strategies to produce sustainable solutions. An awareness of health impact adds value to strategies for urban renewal and the environment, and the process of public involvement mobilizes greater resources to create effective solutions.

Working towards the vision of the healthy city

Cities follow different routes to achieve their vision of the healthy city, because they not only adopt different strategies but also face different challenges and have different opportunities and constraints. Section 7 shows how cities adapt their strategies to expand or survive. Section 8 recalls the vision of the healthy city and the goals that inform the strategies. The Healthy Cities movement supplies vision, know-how and support to help cities move towards realizing this vision.

This compilation of case studies is the outcome of a process stretching back over several years. The coordinators of city projects, their political representatives and the many people involved in associated community and technical action in the cities have often spoken and written about the activities of their projects. The sources that we, the researchers, used have included conference presentations, project reports and other documents, a specially designed questionnaire and case studies prepared for inclusion in this volume. Many project coordinators commented on the case studies but no doubt many points have escaped our understanding, which is inevitably limited in dealing with the diversity of languages, approaches and situations covered by the project. For our errors of omission and misinterpretations of the position in particular cities we unreservedly apologize.

The case studies are the product of secondary analysis of accounts of local action and are not, with the exception of cities in the United Kingdom and those where meetings have been held, based on direct observation or experience of the activities described. These weaknesses, however, do not affect the validity of the stories recounted, since these
rely strongly on the practitioners' own accounts. Moreover, the interpretative framework that we use to comment on the significance of particular case studies has been developed through our knowledge and experience of the project as a whole over several years, and was strongly influenced by the way in which activists in the Healthy Cities movement have expressed their understanding of the project's development. The case studies included were chosen to provide, as far as possible, a range of examples of actions in different cities, addressing different population groups, settings and urban concerns.

There is an inevitable bias towards city projects that wrote detailed accounts of particular actions and towards fairly well developed activities. We cannot say how this has affected the range of examples described. The range of cities from which examples were drawn and the material included, however, were revised as a result of feedback received at the business meeting of the project held in St Petersburg in 1993. The large amount of material that we saw led us to believe that many of the characteristics of this volume, such as a high proportion of projects concerned with youth, reflect a real emphasis in the project's first phase.

Over the coming years the focus of interest may well change, just as strategies and our understanding of them will increase. The exchange of information about good practice will accelerate out of all recognition with the introduction of an online database. These case studies record some of the learning experiences of the first phase of the project; as we become more confident in these approaches we expect to see more critical evaluation of their effectiveness and bolder interpretations of their significance. We should not be too quick to reject our past, recent or otherwise. Others may learn from these accounts, while it may be several more years before we can determine which of the initiatives that are starting now will survive. Already we have learned that the idea of a model of good practice is misleading. While ideas, strategies and actions will take different forms and be variously applicable in different cities, to different problems at different times, by putting them together we take a further step in explaining those strategies and in demonstrating the value of healthy public policy at the local level.

A box appears at the end of each case study, listing the relevant WHO target for health for all, and giving three keywords describing important points. The following symbols are used:

- ! Concept/issue
- S Strategy/process
- O Outcome/beneficiary
A favourable environment

Developing the strategic framework

A precondition for healthy public policy is the development of a supportive environment for far-reaching change. This involves political commitment, a strategic analysis of health in the city and an action plan for implementation by a wide range of agencies. A healthy city plan is a vehicle to obtain the active involvement of a wide range of municipal departments, citizens and other partners in the city in strategic development and innovative action for health goals. Such strategic frameworks aim to create supportive environments in every aspect of city life that can sustain the physical and social preconditions of health. The case studies in this section show how different cities have identified a process to begin the implementation of healthy public policy.

Case study 1. Developing a local strategy and a city health plan in Seville

In 1987, Spanish city councils were looking for ways to implement their new health remit. The health department in Seville saw the emerging national documents on the new public health and health promotion as providing and validating a framework for action. “Moreover”, they explained when they joined the project in 1989, the Healthy Cities approach “integrated all those different actions which we had to struggle with to get started”. This approach appeared to provide a mechanism to emphasize possible links between different health-related actions and winning political acceptance for these activities. A document – *Local aims on health: perspectives from the municipalities* – was prepared to focus political commitment. By applying health promotion concepts, it explained the potential contribution of the city government to the health function of the local health councils, as set out by the Spanish Health
Law of 1986. The document explained what the idea of a healthy city meant and how it could be applied to Seville. It was presented to the local parliament, and approved by all parties with an absolute majority. Political approval was specifically given for the following actions, which enabled the technical groundwork to proceed:

- a health plan was to be presented every year to the local parliament for approval;
- Seville was to join the WHO Healthy Cities project and the Spanish national network;
- a budget would be provided to support the national network; and
- a technical coordinator would be appointed, and a political figure would take responsibility for the Healthy Cities project in Seville.

The vision of a healthy city was translated into strategic planning in Seville by developing and consolidating the health information system. First, classical objective indicators were used to make reports describing the health status of the people of each of the 10 council districts. Second, exploratory qualitative indicators were used to examine citizens' perceptions of their health and living conditions. Techniques drawn from qualitative research were then used to develop a health plan and define the areas for action.

To develop the health plan, three groups of key informants were given the same set of information and asked to summarize their subjective perception of the city. The chosen groups were the community, technical experts and politicians, who were drawn from both government and opposition parties. Each group was given a document about the Healthy Cities project, the summary of the health status of the city (based on the objective indicators), and a semi-structured questionnaire. They were each required to rate (on a scale from 1 to 6) different dimensions of the city. The results of these discussions were used to formulate the health plan.

The next step was to define action areas. An expert group was established to build consensus; it consisted of a sociologist, a health administration expert, a technician, a community representative and a media expert. They received all the documents mentioned above, the reports of the key informant groups and the Ottawa Charter for Health Promotion. Their task was to use this framework to agree on specifications for action. The Ottawa Charter provided guidelines by which the list of problems in Seville could be made to relate to health promotion objectives. The process can be symbolized as an engine pulling a long train. The Ottawa Charter guidelines (pursue equity, promote healthy environments, encourage self-help, empower
communities) are the four wheels of the engine; community participation is the axle that transmits the power to make the train move; intersectoral collaboration provides the rails that send the train in a particular direction; and the guidelines for action are the windows that enable the passengers to see what is happening. The group produced a document containing seven guidelines, which later became eleven sectors for action, grouped around the Ottawa Charter recommendations.

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<td>Political support</td>
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Case study 2. Copenhagen Healthy City Plan 1994–1997

In Denmark, health promotion planning has been required by law since January 1994 but the city of Copenhagen had been preparing a healthy city plan for some time. The municipal government made a proposal to prepare the plan in May 1992, and an intersectoral steering committee took the work forward. The Copenhagen Healthy City project had a central role in the preparation of the plan, with the project coordinator helping to form the secretariat for the committee.

Healthy public policy emphasizes the responsibilities that many different parts of the community have to improve health for people in the city. The process by which the plan was prepared illustrates the health for all principles of intersectoral collaboration and participation. The plan builds on the work of all the municipal departments to promote positive health. Local information on health in Copenhagen was collected for the development of priorities. Earlier work, such as a report on the health of Copenhagen children, was also used. In the autumn of 1991, a population survey asked citizens about their health. Health profiles were produced for 14 districts. The following year, public meetings were held, with the assistance of community organizations, and citizens were invited to present their own proposals for the plan. The ultimate aim is to make it routine for citizens to make suggestions about health improvements in the city.

In January 1994, the proposal for the City of Copenhagen's Healthy City Plan was published. It shows how such a plan differs from a traditional health care plan. The Healthy City Plan highlights what action agencies can take on health problems in Copenhagen. It sets priorities
and targets for all relevant sectors, and builds on the skills and strengths already present in the city to provide a framework for current and future health promotion initiatives. The Copenhagen Plan selects three aspects of life through which the promotion of health could be improved: social networks, positive health behaviour and improvements in the environment. This choice forms the basis of the approach adopted in the Plan, and this approach is then worked out in key settings and for important health and urban themes (Table 1).

A good example of the developmental approach which permeates the plan is the extension of healthy city shops and health consultants to all districts. The first healthy city shop was set up in 1989. The centre provides health information, offers support to community organizations and acts as a focus for health activity and publicity. This is one example of an innovative activity which is now being promoted with the proposed new strategic framework. New resources and integrated information systems will support the implementation of the plan.

Table 1. Structure of the Copenhagen Healthy City Plan

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<td>Social networks</td>
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<td>Traffic and environment</td>
<td>Inner Vesterbro – ecological urban renewal</td>
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\(^a\) The plan includes action in the health services setting.

Action for Health in Cities, WHO Regional Office for Europe, 1994

| Target 13 | Healthy public policy |
|           | Health promotion/disease prevention |
|           | Public participation |
Case study 3. **Rennes: providing a favourable environment**

The close links between people and their environment constitute the basis of a socioecological approach to health. It is ecological, because the quality of the city's life depends on the management of its natural resources, on water and air quality and on a form of town planning that is adapted to meet the present and future needs of the inhabitants. The approach is social, because the environment is also made up of human contacts leading to the implementation of discussions and the creation of trade and employment. The human aspect also allows ethnic, cultural or religious groups to co-exist, to cooperate and to respect one another's differences. Finally, the approach is socioecological, because the natural and human environments must be seen as intrinsically linked in order to ensure an environment favourable to health for all. Preventive action and the promotion of health cannot be successful without the involvement of the city's population. To take responsibility for their health, people need support from the networks of social contacts available to them and help from the cultural communities to which they belong. Ethnic, religious or cultural groups, sports clubs, professional, arts or consumer associations, neighbourhood committees and informal groups all have a role to play in promoting and extending action in favour of health. In Rennes, these groups have long been acknowledged as a major driving force and the project in Rennes provides a means of building on their strengths.

Many initiatives have been set up in Rennes that are based on the principles of health for all, and stress the importance of collaboration as an approach to health care. These include environmental initiatives, those set up for young people (environmental health classes for schoolchildren, "Health for the City's Adolescents Week"), charters for the elderly and the disabled, and action for other groups. The city realizes the importance of giving not only help to groups or individuals but also the power that enables people to help themselves. The city's project coordinator writes:
Take charge of your own health, assert your independence and participate fully in the life of the town! The City Council is looking to offer everyone the possibility of being responsible for their own health and the health and wellbeing of others; it also wants citizens to develop and express their own potential to the full.

<table>
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**KNOW-HOW POINT**

**HOW TO DEVELOP ACTION AREAS FOR HEALTH**

Healthy Cities projects aim to combine political priorities, an understanding of the processes underlying the creation of health in the city, and public perceptions to define their areas for action.
2

Equity

Equity is the primary goal of the policy of health for all. The case studies in this section show how strategies can be implemented to tackle inequalities, based on the understanding of how disadvantage and ill health are related.

Work for equity

Healthy Cities projects can be vehicles for reorienting city policies towards equity. Differences in health status between population groups are key targets for equity strategies. The Glasgow Healthy Cities project illustrates how a health policy developed by and for women can provide a comprehensive framework within which the obstacles to greater equity can be identified and addressed. People living in poverty and in the most deprived areas often suffer multiple disadvantages: poverty, unemployment, poor housing, stressful and dangerous living conditions, poor social networks, poor access to education, and air and water pollution. Intensive work in neighbourhoods is a characteristic Healthy Cities approach to multiple disadvantages. Participatory approaches to local health action can help to realize the human potential that is wasted by the multiple restrictions on quality of life imposed by environmental hazards, restricted access to services and lack of opportunities. In addition, work for equity includes concern with relative poverty and social exclusion. City councils can take significant action to overcome the marginalization of some groups – the unemployed, single parents, the disabled – and to enable them to fulfil their potential in accordance with their rights as citizens.
Case study 4. Glasgow women's health policy

The main aim of the women's health policy is to improve the health and wellbeing of women in Glasgow ... services will be responsive to the current, often unrecognized needs of all women, lesbians, women with disabilities and women from areas of priority treatment.

In Glasgow it was recognized that women's health needs can often be overlooked; one example is that women are far less likely than men to be referred for or to receive treatment for heart disease. Healthy public policy involves incorporating a broad range of groups into policy development. Glasgow has shown the way in developing healthy public policy by collaborating with interest groups that express the views of those who will be most affected by the policy. The Glasgow Healthy Cities project has supported the development of an initiative for a women's health policy that came from a working group on women's issues, and incorporated the views of women in voluntary groups, such as One Plus and the National Childbirth Trust.

Women have particular health needs, not all of which were being met by existing services:

- mental health problems related to their role in society;
- physical and mental problems related to their biological function;
- physical and mental problems that are not always sympathetically dealt with;
- a risk of domestic and sexual violence.

In addition, women do not have sufficient or appropriate access to: knowledge, information, services, resources or choice.

The Glasgow women's health policy seeks: to address inequality issues, to encompass all of a woman's life-span, to reflect women's role in society, to promote greater participation in decision-making and to recognize women's rights as health consumers. The development of the policy can be traced through a series of steps.

In 1983, 6000 women attended a health conference at which topics such as employment and social roles were discussed. This had never happened before in Glasgow; the health fair demonstrated just how neglected women felt in terms of health. In 1984, the Clydeside Women's Health Campaign was established. The well women services were changed in 1985/1986; this provided the group with further ideas and ammunition to push for a health centre for women. In 1987, a women's
health centre was proposed. The Healthy Cities Women's Health Working Group was formally established in 1990.

The Women's Health Working Group drafted a discussion document on the need for a city-wide women's health policy addressed to all agencies in Glasgow. The Glasgow Healthy Cities project financed the printing of this discussion document and gave it a high-profile launch in the chambers of the local government. This began a comprehensive process of consultation with city agencies which was actively supported by the project. Seminars on women's health were given in the organizations to which the discussion document had been circulated for comment. The comments were compiled to provide the framework for the formal women's health policy that was launched in June 1992. The Women's Health Centre was set to open in new premises in August 1994, and will address all aspects of women's health in a friendly, informal atmosphere.

This development shows how using a city-wide approach can provide a framework within which groups can develop their own policy recommendations, tailored to their needs.

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**Case study 5. Women’s health – targeting the needs of two groups in Milan**

Research carried out in Europe, Canada and Australia has established that good integration in the community, the working environment, the family and relationships with others is closely correlated with a low percentage of suffering caused by illness linked to the menopause and pre-menopause. Only a few epidemiological studies related to the menopause have been carried out on the general population, and none at all in Italy. The Milan Healthy Cities project believes such work should be the basis of a network of services aimed at teaching a lifestyle suitable for the preservation of physical and mental health. To achieve this aim, the project set up a working team at the end of 1991. This team,
which included a psychologist, a gynaecologist, a communication expert, a statistical research worker and an expert on family problems, drew up a questionnaire to test the behaviour of a random sample of 1000 Milanese women aged 45–55 years. The results of this survey represent the first step of an epidemiological study of the psychological and social condition of the middle-aged woman. The research also includes:

- a comparison of a representative sample of the population who use the national health service, particularly the population that uses the advice bureaux that will provide the means to test the prepared instrument and data to compare with the general sample; and
- a longitudinal survey on a subsample of women who are going through the pre-menopause (while the other survey is carried out) to trace the development of the symptoms compared with the women’s original physical and mental condition.

Surveys in Milan have examined the use of social and health services by the city’s population. One significant outcome was that the language barrier faced by the non-European citizens – particularly women – has prevented this group from fully utilizing the city’s services. Consequently, non-European women find it much more difficult to obtain both economic and social integration. The recent dramatic increase in the number of non-European citizens of Milan adds importance to this finding.

The Milan Healthy Cities project office has faced these new problems and needs, by creating the Services’ guide for foreign women. This received support and financing from the Lombardy region as an "important initiative promoting health”. The main issues on which the project office was urged to act, according to the recent modification to a law on citizenship, are:

- family law and new laws on citizenship
- health and social services
- educational and professional training
- work.

The guide gives detailed information about the nature and the features of the private and public services, how to approach them, how citizens can benefit from them, and details of all legal requirements.
It was recognized that there was a significant gap in health care for middle-aged and non-European women in Milan. A women's health centre with a more general approach may have (unintentionally) marginalized middle-aged women, and the language barrier may have prevented the non-European women from discovering or using the service. Further, even if they were aware of the service, both groups may have been unwilling to use it if they considered such a centre would not meet their needs. The creation of these two initiatives in Milan is an attempt to show the importance of trying to reach the entire population.

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<th>Target 8</th>
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<td>Women with specific needs</td>
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Case study 6. Glasgow: the Drumchapel Healthy Cities project – "Drumming up Health"

Drumchapel is a housing estate on the edge of Glasgow with a population of about 23 000, and life expectancy that is 10 years shorter than that in Glasgow’s richest area, neighbouring Bearsden. Drumchapel is also the site of a community health project that uses the health for all principles of participation and collaboration to improve health in an area suffering many types of deprivation. The Glasgow Healthy Cities project was instrumental in establishing and supporting the pilot phase of the project "Drumming Up Health". The project works to coordinate, support and extend work on health issues. It has built on existing community health activity in the area, such as the mental health forum. A working group was formed to bring together workers involved in health issue forums such as the HIV and Addictions Group. The project has established self-help groups, including a group for agoraphobics, and produced and disseminated health information.

Cooperation underpins the project’s empowering role. New resources were kept to a minimum in setting up the project; funding and staff time for the pilot phase were given by the Drumchapel Initiative – a partnership of the Strathclyde Regional Council, the Glasgow District Council, the Glasgow Healthy Cities project and the Greater Glasgow
Health Board. Glasgow University seconded a researcher for one day a week. The management group of the project includes senior staff of the contributing agencies and people from the community.

One of the project's main achievements has been to train a pool of community health volunteers. These are local people who help in the work of the project, for example, in the community health library and self-help groups. The volunteers have received training in such skills as communication, group work and personal development. Some have featured in a videotape called *Local voices, local lives*, which describes their involvement in making a community health profile in the Kendoon area of Drumchapel. Some take part in the management of the project.

Participatory evaluation models have now been pilot-tested. The community health volunteers have reported having increased confidence and skills. The project has been a model for the development of community health initiatives in other areas of Glasgow. The coordinator considers that the Glasgow Healthy Cities project was essential in legitimizing the Drumchapel project’s way of work.

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*Case study 7. Opportunities for the disabled in Rennes*

It is important to recognize the particular physical needs of disabled people in an urban environment, without marginalizing or treating them as an entity separate from the general population. The Glasgow Healthy Cities project states that the disabled:

- face three barriers to equal access to health resources; environmental, structural and attitudinal. Environmental barriers include problems of physical access to buildings and public transport. Structural barriers involve discrimination, which is built into employment policies, for example, and lack of representation in policy-making. Attitudinal barriers, such as discrimination and a lack of awareness, are at the root of all the above.
The Rennes Healthy City project has tried to address these problems on a variety of levels. First, the City of Rennes Easy Access Charter tackled the environmental and structural problems. The Charter resulted from concerted effort by an umbrella organization that draws its membership from among associations for the disabled. It is designed to be used both as a means to an end and a reference framework within which to facilitate social change and encourage a general policy to promote the integration of disabled people. The Charter includes eight measures for improvements, which have already created easier access to the Town Hall, the football stadium, local swimming pools and other public and leisure facilities. This is in direct response to the practical needs of people with disabilities. In addition, the project has developed and improved facilities for people with hearing problems. The City Council has equipped its public reception desks with an electronic directory dialogue service, enabling the deaf or hard-of-hearing to communicate via the telephone network. An interpreting service is available once a week at the Rennes Social and Cultural Office, for those who communicate by sign language.

Second, and equally fundamentally, the Rennes project recognizes the need to cope with attitudinal barriers, to see disabled people as part of a diverse society and not as a satellite group or separate entity. The three projects outlined below – aimed at improving the general health of the people of Rennes – clearly state the desire to include everyone. The implication is that the disabled can share in the same life as other people; they are not committed to some removed, sheltered existence. Rennes' approach to these initiatives illustrates how the project is attacking structural barriers and, by their nature, attitudinal problems.

**Housing for all**
The vitality and economic development of a city often results in rent increases which make home ownership difficult for a great many citizens. To improve coordination between varying local housing policies, and to provide the young, the elderly, people in difficulty, travellers and the disabled with the accommodation that meets their special requirements, the City Council in Rennes has long been committed to a policy of joint action with all the public bodies and associations working to provide low-cost housing.

**Allotments for flat dwellers**
Whether young or old, manually or intellectually inclined, able-bodied or disabled, all flat dwellers can rent their own patches of land from the Rennes City Allotments Association. There are 655 allotments in all, where people can grow flowers or vegetables or simply relax, in five different areas of the city. They give everybody a chance to rediscover or learn about the delights of gardening, without travelling too far from their flats.

*The great outdoors – the way to good health*

The City Council aims to give all Rennes' citizens an opportunity to rediscover the countryside, rivers and forests in and around the town, and to enjoy the rewarding experience of meeting the inhabitants of St Gilles-du-Mene, a village in the Côtes-d'Armor that has been twinned with Rennes for a number of years. This is the main purpose of holidays that are offered especially to people who seldom have the chance for a change of scene, owing to social isolation, low income or disability.

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<th>Target 3. Better opportunities for people with disabilities</th>
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**KNOW-HOW POINT**

**HOW TO DEMONSTRATE THE VALUE OF EQUITY STRATEGIES**

Reducing health inequalities gives significant help towards achieving other social objectives in the city. The experience of city projects shows that the rewards of strategies to promote equity in health can include: reduced social exclusion, increased personal skills and more appropriate and accessible services.
3
Lifestyles

The work of city projects for healthier lifestyles offers well developed alternatives to the risk factor approach to the prevention of disease. The actions included in this section:

- characterize people by their potential rather than by their problems;
- promote benefits for health from lifestyles;
- provide active and structured ways to overcome the restrictions imposed by culture and environment;
- build on the experience of the self-help movement to develop the skills of participants; and
- establish new partnerships to create sustainable health resources.

Uses of information

Citizens are provided with sources of information that are made easily available to them in their daily lives. Citizens have increased awareness of the range of possibilities for healthy choices, but appropriate support is also made available, particularly for those with problems. This support takes account of the barriers that particular groups of people face. Healthy Cities approaches to lifestyle change respect human autonomy and potential. A variety of networks supports large-scale public awareness campaigns to develop personal skills. Information is used to identify and maintain differences and change in the population.

Case study 8. Make healthy choices easy choices: health promotion in Eindhoven
One of the most popular slogans of the Healthy Cities project is "Make healthy choices easy choices". Examples are given below of how Eindhoven has tried to put this slogan into practice.

The project in Eindhoven is based on a well established municipal policy on health promotion. Health promotion in the city is based on the assumption that all individuals are responsible for their own lives, and therefore also for the health choices they make. Executive Project Coordinator Janine Cosijn writes:

We assume that people have an active role in gathering information on health, in the same way as they are shopping in a supermarket.

The health professionals in Eindhoven try to provide reliable and accessible health information so that people can decide what kind of information they need and how they want to use it.

About ten years ago, the Women's Council in Eindhoven complained that general information on health, which was produced at the national level, was difficult for individuals to obtain. The Council suggested that this problem could be solved by setting up a centre – the Gezondheidswijzer – where all kinds of information on health and diseases would be available. The centre opened in 1984; located on the ground floor of the Municipal Public Health Services, it is easily accessible to the citizens of Eindhoven. It provides the addresses of many local, regional and national organizations dealing with health care, patients and self-help. Printed information, such as magazine and newspaper articles, and many leaflets and brochures are available. The information materials selected are those comprehensible to people with no medical background. The Gezondheidswijzer has a so-called weekly special in which all information on a particular topic is offered free of charge for one week. These topics are announced on local radio, cable television and in free papers. The supply of information is the full responsibility of the Municipal Public Health Services, but medical advice or consultation is never given because the centre is run by volunteers recruited from the Women's Council. The Gezondheidswijzer appears to be very successful in meeting needs. In February 1992, request number 25 000 was received. Another argument for the centre's success is that at least 12 other Municipal Public Health Services in the Netherlands have taken up the Eindhoven initiative.

Nevertheless, the information supplied by the Gezondheidswijzer does not reach everyone. Health information
should be available whenever the consumer wants it. An information supply that can be consulted continually, free of charge and in the home therefore offers the best possibility for solving this problem. In Eindhoven, the Municipal Public Health Services bought some "pages" from the cable television teletext services of the local newspaper. With the help of this teletext service, people can now consult health information in the privacy of their homes. About 70% of the households in Eindhoven have a television with teletext facilities. Research has shown that these health pages are frequently consulted.

In addition, health information is brought to neighbourhoods by means of an Info-Bus, a mobile information centre that started as a joint activity of five municipal services to distribute their information. The Municipal Public Health Services is one of the participants in this project.

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<td>Health promotion</td>
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<td>Enabling healthy choices</td>
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<td>Improved access to information</td>
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**Case study 9. Self-help centres for teachers in Vienna**

Health promotion works by developing personal skills in a supportive environment. The Vienna Healthy City project took the initiative to set up a service that would meet an underacknowledged health and social problem: stress in teachers. The project used its neutral position, outside the school system, to set up a support centre that teachers would not be afraid to use. The project was set up through a collaboration between the Vienna Healthy City project, the municipal authorities in Vienna and the Austrian Federal Ministry of Education.

The centre is intended to be a place where teachers with problems with alcohol and drug abuse, mental health, schoolchildren or colleagues, for example, can call in for anonymous help free of charge. They can also attend self-help and therapy sessions. The centre has been widely publicized to legitimize the idea that teachers can have problems for
which they may need to seek help. While the centre is currently unique in Austria, the organizers would like to see a similar centre in each major city of the other eight provinces.

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<th>Target 12</th>
<th>Reducing mental disorders and suicide</th>
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<td>Stress reduction</td>
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The needs of young people

Further, some mental and physical health problems particularly affect the young. Young people are not used to the idea that their feelings may be important, or that their voices will be heard. They may feel alienated from adult society, or that nobody will meet their health needs. It is significant that this was seen as enough of a problem in Milan to form the basis for two initiatives: the "uneasiness project" and the "youth observatory". The former defined uneasiness as a sense of alienation (of lacking meaningful relations, a sense of belonging and feeling important), and an inability to make decisions about one's life. The project aims to develop in young people a sense of belonging, and abilities both to establish their own social network and to be "able to single out the problems they feel urgent and identifying the best solution to undertake".

One of the many health problems that particularly affects the young is the likelihood of coming into contact with drugs. This is an issue not merely of physical health – of the damage to health that experimentation with drugs can cause – but also of mental wellbeing. The Mechelen drug prevention programme attempts to address both sides of this problem by informing young people, strengthening individual choice and freedom (the ability to say no to drugs) and establishing a clinic for drug-dependent people.

Case study 10. Mechelen drug prevention programme

Through a pilot project, Mechelen investigated the theme of drug prevention throughout 1991–1992. The two staff members of the city's drug prevention team designed a questionnaire aimed at the sixth-year students in the secondary schools. The results are concerned with the students' use of drugs – backgrounds, motives,
and the connection with their family, school and leisure environments. A booklet was then compiled for teachers in the schools. As a result of this enquiry three specific projects were set up.

"Keys to Life"
The Lions Quest Association developed the "Keys to Life" programme:

- to influence behaviour
- to strengthen team spirit
- to strengthen individual choice and freedom (learning to say no to drugs).

The project's aim is to familiarize all of Mechelen's schools with this programme, which targets the group aged 12–14 years. The general idea is to teach the students social skills that will enable them to say no to drugs. Skilled training officers give assistance and instruction to a group of 36 teachers, school directors and educational institutions. They later have to put what they have learned into practice. The programme has already led to positive results. In 1994 two more groups of teachers and others will be trained.

A two-week drug prevention campaign
From 27 January to 11 February 1994, the Mechelen Healthy Cities project office ran a campaign with:

- seven performances of the play SMACK, which deals with the problems of drug addiction;
- three films about drugs;
- a cartoon exhibition.

There are programmes for students over 16 years of age, teachers and parents.

Outpatient clinic for drug-dependent people
About 500 people in the Mechelen are addicted to drugs. An outpatient clinic was set up in response to the repeated confirmation of the lack of sufficient reliable care for these people at the regional level. The City of Mechelen created a joint project with the nonprofit organization, the Brothers of Charity, which already had centres in Antwerp, Ghent and Bruges. The aim of the
project is to contribute to the individual and social maintenance of people dependent on drugs, and to try to reintegrate them into society through an appropriate therapeutic approach.

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<th>Tobacco, alcohol and psychoactive drugs</th>
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<td>Young people and drug users</td>
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Case study 11. Health Environment Lifestyle Project (HELP) in Dublin

One of the key issues addressed by the Dublin Healthy Cities project is how to develop community participation in health awareness activities. The Health Environment Lifestyle Project (HELP) comprises community-based health awareness projects in disadvantaged areas. They are designed to develop greater awareness of social, environmental and lifestyle factors that affect the health of the individual, community and city, and to encourage appropriate action. One of the long-term goals is to influence the policies of local authorities and health boards in the project areas. Each project is organized and run by local people with the active support of the Dublin Healthy Cities project, the local authority and the health board.

The overall framework has a number of parts. First, a community health forum is set up, with representatives of community groups, health and council authorities and the city project, to discuss the range and quality of local services offered by statutory and voluntary agencies. This forum supports a ten-week preparatory self-development course for 10–15 people. It covers influences on health and possible courses of action. One of the projects is following up this course with a health survey of the local area. A Healthy Cities week concludes the year’s events. It includes a health fair, talks, displays, environmental projects, and sporting and cultural events.

In addition, the representatives of HELP meet under Healthy Cities auspices as the Community Participation Issue Group to discuss other ways of increasing community influence over
policies that affect the health of the city. A monthly "health focus" is held, which includes talks, exhibitions, and other events which illustrate a particular health, environmental or lifestyle issue. If possible, the focus reflects various campaigns promoted by WHO, such as European Drugs Prevention Week, World AIDS Day, and World No-Tobacco Day.

Four pilot programmes within HELP have already started: two in newly developed areas of larger local authority housing estates, one in a mixed area of high-rise flats and local authority housing, and the last in a more established local authority area. One of the projects is being run in conjunction with a community mothers' programme, and another is being organized through a well established group with a good track record in adult education.

The Dublin Healthy Cities project made a clear choice to begin working at the local level. It trains and employs a local programme worker for each area. One advantage of the process is that the money for the project is spent locally, and the knowledge gained stays in the local area. Evaluation of similar programmes, such as the Greater Blanchardstown Community Mothers' Programme, has shown the potential for this type of project. The Blanchardstown project is based in a new town with poor infrastructure and underdeveloped social networks. The evaluation finds that the project has been successful in developing self-esteem among the women who attended the courses and has encouraged greater community development in the area. In Clondalkin, evaluation of the Healthy Cities week showed that it had reached a considerable number of people in the area, that some new groups had been formed locally and that some groups had consolidated their activities as a result of the week's activities.

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The DRECAN study (Dresden cardiovascular risk and nutrition) was carried out during autumn and winter of 1990/1991 in 15 factories and institutions in the Dresden area. The design included an interview, some clinical check-ups (measurement of blood pressure, weight, height, waist and hip) and a dietary history taken by specialized medical assistants, as well as a detailed analysis of venous blood. A follow-up questionnaire was administered in 1993. Results were obtained on five topics.

Smoking behaviour
The prevalence of smoking was low in Dresden in 1990/1991; 72% of men and 83% of women were nonsmokers. The percentage of smokers decreased by age in both men and women. One quarter of men but only 13% of women under 17 years started to smoke, in contrast to 48% of males and 40% of females between 18 and 22 years. In 1993 the pattern was similar; a few of the previous nonsmokers started to smoke during the two years, but more than 10% of smokers had given up smoking during that time.

Physical activity in leisure time
In 1990/1991, 64% of men and 56% of women performed leisure-time physical exercises at least once a week – gardening, biking, hiking and mountain climbing being the most popular activities. The 1993 results show that 61% of active men maintained their leisure-time behaviour, while 14% had become more active, but 25 and 38%, respectively, had decreased leisure-time physical activity. One quarter of the population was active more than once a week in the garden, and 30% went on a hike once a week or more often. The percentages obtained in women were similar, but they used the sauna more often and more regularly than men. Various reasons were suggested for the change in habits: the increased possibilities for exercise, and professional or "healthy" reasons.

Weight
About 50% of men and 29% of women were overweight in 1990/1991. The results of the follow-up questionnaire in 1993 showed that, over a two-year period, about 75% of women weighed themselves regularly at home. Men showed a great difference between age groups. One quarter of men reduced their
body mass index (BMI) over this period; 9% reached a figure below 25. On the other hand, 33% of overweight men had a higher BMI; the values in women were similar.

Hypertension
In 1990/1991, hypertension was observed in 23% of men and 14% of women. Between 1990/1991 and 1993, only 28% of men and 17% of women had their blood pressure checked periodically, and 20% and 16%, respectively, measured it themselves at home at least monthly. In both sexes, hypertension was more common in the older age groups. On average, blood pressure levels measured in older people were better during the second visit, in 1993, than two years before.

Nutrition
The basic DRECAN investigation included a diet history interview by specialized medical staff. The study asked about the consumption of 121 food components, before and 10 months after the unification of Germany. Absolute daily fat intake did not fall but two thirds of the respondents had replaced butter with margarine; margarine with a low content of oleic acid predominated. The consumption of fruits and vegetables increased as a result of the better supply. Further, there was a pronounced shift in the composition of the fruit basket, towards new or previously rare foods such as kiwi, papaya, orange, aubergine and banana. Fatty pork and beef were replaced by less fatty meats. On the other hand, the consumption of high-fat cheese increased; on the positive side, cereals and wholemeal bread were becoming more popular. In total, there was an increase in food rich in fibre, a decrease in high-cholesterol products, and a change towards a better ratio of polyunsaturated to saturated fats. The daily beer consumption was not influenced by the unification, but remained high.

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Know-how point
how to encourage healthier lifestyles

A Healthy Cities project can show how many city structures and services can be reoriented to offer more opportunities for citizens to make healthier choices. The city has a vast reserve of means of providing information and facilities to support people in changing their lifestyles. Key processes are the development of community networks and resources and activities to develop personal skills.
Supportive environments for health include places (schools, workplaces and localities), resources (organizational structures, networks and skills) and opportunities (for information, training and action). Settings can be a form of supportive environment in which:

- strategies can be developed for people where they are;
- resources can be mobilized; and
- people can be enabled to take health action.

Many Healthy Cities strategies make active use of settings. This section demonstrates the strengths of the settings approach in: developing health education in schools, creating supportive environments, reducing work-induced stress, reorienting hospital services to meet needs and developing local teamwork. These examples show how specific strategies can be elaborated in settings. An important feature of action in settings is the development of organizational networks, which sometimes extend across sectors. Organizational collaboration, underpinned by closer cooperation between professional groups, can result both in better services and in training and support opportunities for the professionals. Addressing a particular setting gives an opportunity for synergy between action at different levels to produce change.
Schools

Case study 13. Health promotion in schools – "Addicted to Health" in Pécs

Young people are the future of every city. Young people therefore need information and education about health and environmental issues in particular. The Pécs Healthy City foundation has been working with the city council to agree that health promotion among young people (school project) should be the focus of local health promotion and health education activities. The school project in Pécs began in 1992/1993; by 1993/1994, the project steering committee had grown, owing to the interest of volunteers from the health authority, the medical university, Pécs University, the local environmental foundation and various city departments.

The project's ideology is based on the idea that health and environment form one entity, so the promotion of better health and environments should be discussed and achieved together. All the city's primary and secondary schools were invited to submit proposals for improving their hygienic, physical and natural environments, and their needs for financial assistance. The project steering committee visited all the schools, to help them prepare their proposals and to make a report for the committee. Each school's report outlined its particular problems. Financial assistance was limited to 200 000 Hungarian forints per school (about US $2000). All the schools that submitted proposals took part in all kinds of activities to improve health and the environment. These included teacher retraining, health and environment education for at least 20 children per school and clean-up activities around the schools and in certain areas of the nearby mountains.

Besides these compulsory programmes, all the schools have the opportunity to take part in various competitions and games all through the school year. The first half of the 1993/1994 school year ended with a New Year's Eve swimming programme, and the end of 1994 will be marked by a health tour of the city and a health and environment fair. Thirty schools are participating, with a minimum of 5000 children taking some role in the health and environment activities of their schools.
Workplaces

Case study 14. Alcohol and the workplace in Copenhagen

The workplace can be seen, not as a risk to health, but as an environment that supports people in leading healthier lives. Model policies, projects and training materials are essential to support these developments. They can convince employers and employees of the benefits of promoting health at the workplace and show how changes within institutions can be introduced and maintained.

Rates of alcohol consumption and deaths from liver cirrhosis and suicide are higher in Copenhagen than in the rest of Denmark. Men drink twice as much as women in all age groups. The Copenhagen Health Council, which is composed of politicians from all sectors, has identified the prevention of alcohol abuse as a priority. The Copenhagen Healthy City project has responded by creating an "Alcohol and the Workplace" programme that has received active political support. The programme aims to develop a particular attitude to alcohol at the workplace and to build support within the workplace to help people who are dependent on alcohol.

The process depends on cooperation between employers and employees in discussing and formulating a written policy on alcohol, and developing a support network. The model has been pilot-tested and now the package of materials is being sold to workplaces; hence the initiative is self-funding. The Healthy City project views this venture as a successful starting point for more general health promoting activity in Copenhagen’s workplaces, and is developing workplace health profiles as a basis for health promotion activities in this setting.
Case study 15. Campaign against musculoskeletal strain in Sandnes

One initiative in Sandnes aims to help people who are unable to work through injury (whether sustained at home or in the workplace) to help themselves. The aim of the campaign against musculoskeletal strain is “to help those placed on sick leave as a result of musculoskeletal strain to prevent and reduce their own suffering”. The main target group for the work comprises the inhabitants of Sandnes between the ages of 30 and 45 years. The project is to be carried out through training and rehabilitation or, alternatively, by pointing out the opportunities open to the sick, such as arenas for exercise and outdoor activities. The aim of the work is to reduce the number of musculoskeletal injuries and the amount of sick leave taken.

Health Services And Hospitals

Case study 16. Vienna Women's Health Centre

Vienna is at the forefront of the movement for health promoting hospitals. The opening of a Women's Health Centre at the Semmelweis Gynaecological Clinic in 1992 was an example of the reorientation of health services to local needs and towards health promotion objectives. The inspiration for the Centre came from the WHO meeting on women, health and urban policies, which was
held in Vienna in 1991, and at which examples of such centres were discussed.

The objective of the Centre is to provide a range of health services for women that will also lead to the development of various professional skills for such services. Three female psychologists and a team of other workers offer counselling to schoolgirls, help women dependent on tranquillizers and offer support for women in middle age. The Centre offers an open, client-oriented package for all, but particularly younger women. Since the services are comprehensive, many opportunities are likely to open for the women who come, even if they initially attend for one specific problem. The Centre has a separate street entrance from the Semmelweis Clinic. It is open to hospital staff and members of the community, and hosts seminars, lectures and courses that health workers can attend.

The Vienna Healthy City project office organized this project as a pilot study, ensured political support and provided funding. It helped to ensure that firm contracts were drawn up between the participating agencies: the Clinic, the organizing research institute, the City of Vienna and WHO. Before the project was introduced, all Clinic staff were asked to give their opinions of the proposal through a referendum; their agreement has been sought at every stage. Research is used to identify the needs of clients and to develop services to respond to them. Three full-time research staff were seconded for the pilot project from the research institute where the Women's Health Centre is based. The project office has organized press conferences to explain the project, and the Centre was launched at a mayor's press conference. Now it is responsible for all the press and public relations work. The Centre is intended to provide a model for other gynaecological and obstetric hospitals and wards throughout the WHO European Region, and to improve the primary and hospital care services for women in Vienna.

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<td>Appropriate health services for women</td>
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Case study 17. Introducing healthy food for children in Munich

In one children’s hospital in Munich, the Parents’ Board for Chronically Ill Children made a proposal about the food needs of the children. Only the medical aspects were being considered, and the hospital cook ignored the topic of healthy food as such. The Parents’ Board established cooperation with all the relevant professional networks to consider healthy and child-focused menus. Nurses, some doctors, the hospital cook, the dietician, the hospital administration, the City Health Department and young patients and their parents worked out improved menus for hospital meals. A university research group assisted in the task. The groups involved have agreed to continue to communicate on this topic. The activity has increased awareness of healthy food options in the hospital, resulted in changes in the menus for adult patients and influenced menus in other hospitals in the city.

Further, a healthy food event was run with different themes each year to improve the provision of healthy food in nurseries and schools. Children were encouraged to examine the problem and create solutions. The work of all participating schools was displayed. Although based on the involvement of children, the initiative had results that included an increased awareness of healthy food options in school staff. Another interesting result was the revival of school herb gardens, a tradition that had all but vanished. The results of the activity have been widely disseminated.

Cities

Case study 18. Healthy Valby: visible local action on health promotion in Copenhagen

Valby is a district of Copenhagen with 44 000 inhabitants. In 1989, a local approach was developed to tackle health issues in a big city. It aimed to include local people in health promotion and to establish ways of working that would encourage better cooperation between agencies and ensure that local authorities would respond to identified issues. The creation of the initiative can be summarized as a series of key steps:
• appointment of a full-time project leader in August 1989 to organize the launch;
• establishment of a working party made up of local professionals and community representatives in October 1989;
• a one-day conference in January 1990 to point out how the working practices of city agencies in the area could be changed to establish a framework for new initiatives;
• establishment of a health committee to coordinate future work; and
• provision of information on the project to city departments.

The priorities for 1990/1991 adopted at the conference were used to launch a series of initiatives that included: health talks by family doctors to middle-aged men, outreach work to alcoholics, weight loss courses, feedback to family doctors on their prescribing habits, an activity centre for families with children, and the use of cafeterias in rest homes by the wider community. The focus on a single area has made it possible to take action on all the different dimensions of health: lifestyles, social networks, physical surroundings and population groups. Greater community involvement and stronger cooperation between service providers has proved feasible at the local level. The Healthy Valby project has strengthened support for the Healthy Cities project as a whole in Copenhagen by providing a practical model for politicians of the meaning of Healthy Cities strategies at the local level. Three lessons have been learned for developing local health promotion:

• resources should be made available to coordinate the work;
• practical activities should be strongly emphasized; and
• outreach strategies are needed to encourage more public participation.

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Case study 19. Health and sports in Düsseldorf

People can be encouraged to take action on their health, and the city's potential health resources identified and made available to more people in many imaginative ways. Health and Sports in Düsseldorf was an initiative to open up a wider range of health-related sports opportunities to the general public. The principal steps taken were:

- producing an inventory of sports facilities;
- publishing a brochure on opportunities for healthy sport in the city;
- coordinating and publicizing the available activities; and
- evaluating the quality of the opportunities on offer.

The initiative was a combined effort by the Ministry of Culture and the Sports Association in Düsseldorf. It shows how city projects can be a focus for cooperation between agencies at different levels. In addition, an activity such as the release of the brochure is a useful way to combine the interests of different agencies in an intersectoral initiative, while raising awareness of options for active living. This initiative raised awareness of how people can take responsibility for their own health by living more active lives.

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**Know-how point**

how to encourage professional collaboration

The fragmentation of support services and sectoral responsibilities is a major barrier to providing more supportive environments for health-related change. By focusing strategies to respond to needs in particular settings, city projects show how resources, networks and personal skills can be mobilized to support the individual.
New styles of action: partnerships and participation

Innovation can be hard to recognize and organizational change, in particular, may take decades. Healthy Cities projects are nonetheless developing distinctive styles of action, backed up by new organizational forms. Three types of organizational arrangement can be identified in Healthy Cities actions that are innovative in their application to the development of projects and programmes. These are:

- partnerships to raise awareness and develop activities;
- networks to exchange information and models of good practice; and
- intermediate support organizations to promote participation and self-help.

The development of different styles and structures to organize the development and implementation of strategies and programmes is closely related to the functions of city projects to act as enablers, advocating change in the city. Partnership characterizes action for healthy cities at all levels. Partnerships deliver the benefits of implementing healthy public policy: more resources, skill sharing and awareness of the possibilities for change. The development of strategic multisectoral action and multidisciplinary professional practice illustrates a fundamental attribute of healthy public policy; it deals with problems and solutions too big to be handled in a single sector. Partnerships can make a real difference to a city's ability to respond to major urban challenges, both social and environmental. International networks are a developing means of exchanging experiences and implementing joint actions. Partnerships accelerate change. The scale of action facilitates public involvement.

Respect for autonomy and community self-help is a recurring theme in action for healthy cities. City projects have used a number of
organizational solutions to support community self-help and participation, including intermediate support agencies and "one-stop shops" for health information and community organizing.

Partnerships

As an international project, Healthy Cities should build on the capacities of cities, encourage technical exchange and create a supportive political environment at the European and global levels.

Case study 20. Collaboration in strategic development in Camden

As activities in a city affect people's health and quality of life, it follows that all agencies have a role to play promoting health. It is therefore important to develop health as a core value in the policies and service plans of these agencies. The Camden Healthy Cities project has attempted to raise the profile of health across the borough in many ways, through project work and the participation of project workers in various forums, by organizing events, such as the open forums held early in the first stages of the project’s life, and by steering group members’ action as advocates in their organizations. Through these means, Healthy Cities principles have been incorporated into several of Camden's strategies, such as those on the environment and on HIV. Work on the Health of the nation targets in the Camden Council has been initiated through the public health committee.

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Case study 21. A new approach to child abuse in Milan

The complexity of the phenomenon of child abuse, and the need to use an interdisciplinary approach to make a correct diagnosis and to take the most adequate measures has led the municipality of Milan to create their Città Sane project. Its aim is to enable the city and its services to recognize child abuse as quickly as possible, to be fully aware of high-risk environments and situations, to prevent abuse, to intervene correctly and to raise awareness and inform the population about the problem.

Owing to the complexity of this problem from an institutional point of view, no single service could provide comprehensive answers. An interdisciplinary approach is therefore needed to utilize and coordinate the existing system of services. The project aims:

• to set up a crisis unit at the Buzzi Paediatric Hospital to deal with emergency cases, rather than referring every case to the territorial services;
• to create a 24-hour telephone service to receive reports and activate social workers;
• to set up a multidisciplinary central team to deal with first interventions;
• to set up an interdisciplinary advice bureau in every local health district to deal with prevention and the cases in the area; and
• to work out a training programme for the social and health workers of the services.

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Case study 22. Noise reduction in Patras, Greifswald and Horsens

The cities of Patras, Greifswald and Horsens chose noise reduction as an issue of common concern in 1992. The implementation of the noise reduction project depends on a wide intersectoral participation within each city. Background material was provided by Horsens in August of the same year.

Baseline data have been collected, but there is a general lack of adequate, up-to-date information on noise pollution. An ambitious city-wide project on traffic (led by the Greek Ministry of Environment and the University of Patras) is under way; it is expected to offer an explicit description of this principal source of noise pollution. The results will be available after one year, and lead to a new urban traffic policy. The EnviroNet Centre will be responsible for making links with decision-makers who favour measures to reduce noise production. Effective intervention on behalf of the municipality of Patras depends on the commitment and availability of additional financial and human resources. Night-time refuse collection has been identified as a serious noise nuisance, and, although the project is still in its initial stages, one early outcome is the acquisition of eight new vehicles for domestic refuse collection in the city, under strict requirements for low noise production.

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Case study 23. The multi-city action plan (MCAP): a vehicle for international collaboration on common problems

MCAPs came about because city projects working on the same issues wanted a forum in which to meet and exchange information. MCAPs develop ideas and models of good practice that will be useful to cities outside the project network.
The first MCAP to meet was on AIDS. Facilitated by WHO, a meeting was held in Düsseldorf in June 1990 on AIDS care and services. As a result, a joint action programme began to develop. Other MCAPs soon followed, on tobacco, women’s health, environmental issues in the Baltic region and the health promoting hospital. Membership was not confined to people working in city projects, or even to WHO project cities. Many cities from national Healthy Cities networks joined, as well as interested institutions. The latter included the Ludwig Boltzmann Institute in Vienna, which obtained funding for a full-time coordinator for work on health promoting hospitals, and the Agricultural University of the Netherlands, which got a research grant from the Dutch prevention fund for work with the MCAP on nutrition.

Much has already been learned about how to sustain effective multilateral cooperation and action between cities. Effective MCAPs develop clear action programmes, and resources for coordination help to sustain the network. The coordinating cities ensure administration and communication. Institutions and cities joining an MCAP advocate relevant action in the city and ensure that commitments are fulfilled. Local city project offices mediate with relevant sectors in the city and help to obtain political commitment and funding. A professional in the WHO Healthy Cities project office has special responsibility for MCAPs, and relevant WHO programmes provide technical input.

**Action**

Three MCAP groups – on alcohol, tobacco and AIDS – are working to apply internationally agreed strategies at the city level. The WHO European Action Plan on Alcohol, for example, calls for municipal action on alcohol, among other things. The MCAP on alcohol is collecting the experiences of its members to produce guidance on municipal action and resource packs that will be useful right across the European Region. The MCAP on tobacco pursues a similar strategy. In contrast, the AIDS MCAP is generating some proposed standards for services for HIV and AIDS prevention, using the WHO global AIDS strategy as a starting point for a wide consultation process within member cities.

MCAPs accelerate change. They are a way to help cities to share practice and to learn from each other, thus avoiding continuously reinventing the wheel. By joining to address common issues, city projects can give each other feedback on their activities and new ones can learn from the more experienced. Expected outcomes include: increased multilateral cooperation between other partners in member cities, beyond the city project offices; a more strategic approach to common problems among cities; and joint action by cities, including the development and
implementation of innovative programmes, policies and declarations and the sharing of know-how. The role of MCAPs within the international project has been recognized by the requirement that membership in an MCAP is mandatory for cities joining the second phase of the project.

| Target 37. | Partners for health |
| S         | Exchange           |
| O         | Multilateral cooperation |
|           | Joint action       |

**Participation**

The Pécs school projects recognized the importance of young people as the future of our projects, services and cities. It is equally necessary to recognize the rights of the child. It is not enough simply to give children existing knowledge; young people must have a chance to air their views, and adults must listen. These ideas are important not only in Pécs but also in a case study in Turku and an innovative project in Munich.

**Case study 24. Children and political decision-making in Munich**

The United Nations Convention on the Rights of the Child establishes the importance of respecting the needs and rights of children as much as those of adults. This principle is directly relevant to the holistic practice of health promotion. The Munich Healthy Cities project made the comprehensive health needs of young people in the city a major focus of its activity. This group was identified as a priority because of the vulnerability of young people, and because it was felt to reflect the health needs of adult society.

The project drew up a comprehensive action plan – ”Healthy Children in a Healthy City” – and set up six workshops on different subjects to implement it. One of these created a variety of methods to develop the political and social participation of children and young people in the city. The members of the workshop organized and evaluated "future laboratories", which aim to inspire creative problem solving. In these laboratories, children worked with young people and adults from the self-help
sector to identify the qualities of a healthy city for children. A city-
wide future congress was held in the city hall, bringing together
young people and concerned adults under the auspices of the city
council.

The Children's Forum is another activity that uses a
participatory learning model. Aimed at the group aged 9–15 years,
the Forum is held four times a year in the council room of the city
hall. Children prepare subjects, problems, criticisms and proposals
with parents, teachers or representatives of relevant organizations,
and present and discuss them in the presence of council officials,
local politicians and the local media. The politicians and
administrators have to respond to the children's presentations, and
prepare solutions, proposals and constructive feedback in time for
the next Children's Forum. The proceedings are modelled on the
meeting and decision-making of the city council. The Forum
received financial support from health insurance funds, the city
and nonprofit organizations, and some people contributed their
time. As a result of the Forum, local politicians now consider the
needs of children when formulating their party platforms. District
forums are now growing up to support the city-wide Forum. Another Bavarian city has taken up the idea, and more have
expressed interest.

In 1992, the last year of Munich's membership of the WHO
Healthy Cities project, the city project held an international expert
meeting on the political participation of young people. The
meeting included the participation of the expert group: children.
One of the most important facts identified was that children are not
successfully involved in political participation through the usual
mechanisms of the adult world, such as regular attendance at the
meetings of a working group. Direct, rapid participation, through
unrestricted access to decision-makers, is much more effective and
acceptable. The significance of this finding is not, of course,
limited to children.

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Case study 25. Blackstaff community health project in Belfast

Excluding people from decisions that directly affect the conditions in which they live adds disempowerment to disadvantage. In Belfast, the community development principles of ownership and empowerment have been applied to make a community health profile of Blackstaff, an electoral ward in the southern part of the city. The objectives were to involve statutory agencies in action on recommendations for change formulated by the local community, and to establish a community health project to support the implementation of the recommendations. Participation was encouraged from the beginning through public meetings, which were held to determine the form and content of the questionnaire. The meetings were well attended, and all the issues suggested by residents were retained in the final version of the questionnaire, thus enabling the community to control the information process. Volunteers from the management committee of the local community centre helped formulate the questionnaire and carry out the interviews. The Belfast Healthy Cities project was important in giving the project wider credibility and financial support. A broad range of agencies was asked to support the project. Resources in one form or another were provided by the Milltown Action Team, Belfast City Council and the Eastern Health and Social Services Board. The mass media gave widespread coverage to the launching of the project report.

The Blackstaff community health project was part of the development of a wider and more relevant approach to health in a community. The results included the following. The research carried out was only the first step in a process that gave the local community an opportunity to comment on services and to develop closer links with service providers. The project has established a mechanism for change, given local people greater control in their community and helped them to develop their confidence and skills. The project has now been established with a project development worker, and other community activity has developed. When the results of the profile were slow to emerge, a local steering group for community action was formed; it obtained resources for the area from the Belfast Action Team. In June 1990, Women Too, Windsor Women's Centre opened as a resource for women in the area, with the involvement of some of the women who had worked on the health profile.

Policy-makers in Northern Ireland have adopted the Blackstaff model as a tool for increasing citizen participation in
decision-making. The regional strategy for the Northern Ireland Health and Personal Social Services requires that, by 1995, each health and social services board should have carried out at least one pilot project to facilitate the participation of citizens in decision-making on their health and social needs:

Boards should also consider providing appropriate administrative support to assist people to draw up local health profiles and should participate with local people in community development which addresses health and social needs issues.

The Belfast project also initiated community participation days, which involve about 100–150 local people in sharing information on health. The days illustrate the pivotal role of the city project as intermediary between the communities and agencies in Belfast. The community participation days are part of a process of giving the public more control over their lives, health and wellbeing, and they provide a valuable meeting point, as the coordinator notes, "bringing people from all over the divided city together to value their contribution to the debate about health".

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Case study 26. Croxteth Health Action Area, Liverpool

The Croxteth Health Action Area (CHAA) provides individuals, families and the community with an alternative role in health service provision to that of consumers exercising choice in the market-place. Participation is defined as an acknowledgement of people's role as primary providers of health care, not as a formal influence on service provision. Health action areas represent the vehicle for the community development strategy of the Liverpool Healthy City project. They are based on a social model of health, following the principles of health for all, and recognize the importance of social factors, such as unemployment, housing and the environment, as influences on a community's health status.

CHAA was set up early in 1990 and encompasses the outer council estates of Croxteth, Gillmoss and Norris Green. In 1983,
the Croxteth area working party made a report on health and service provision in the area. The working party represented the views of voluntary, community and statutory agencies, and recommended improvements in housing and environmental conditions and attention to the poor health of the people in the area. The city council's urban regeneration strategy tackled the poor housing and environment, but health issues were not addressed. In 1988, the partner agencies of the city project prepared a funding application to the Urban Programme for a model health action project in the area. Funding for four years was obtained to establish a neighbourhood health team and set up a community chest, that is, locally managed funds for health-related activities.

Through CHAA, a primary health care strategy is being developed for the area, using community development principles to encourage active partnership between the community and providers of statutory and voluntary services. The main mechanism for change is a neighbourhood health team, which develops responses to health issues through the active involvement of the local community, in partnership with the local government, health authority and all relevant agencies. Such cooperation has led to a number of activities, including a community environmental improvement project, and two groups for people with learning difficulties: a carers’ group and an independent living project. A major survey on the health effects of housing improvements was commissioned for the project, and showed that housing improvements carried out under the city council's urban regeneration strategy had paid a major health dividend.

The neighbourhood health team will provide a forum in which the different agencies can jointly set priorities and plan neighbourhood services. The community can be brought into partnership with the formal service providers by being actively involved at all stages. Pat Thornley, manager of CHAA, writes:

The Croxteth Health Action Area is a Liverpool Healthy City 2000 initiative with roots firmly in the community. Although I am indebted to many professionals for their advice and support it is the commitment and cooperation of ordinary, hard-working and caring community members that have taken the action forward. There are dozens of groups and individuals working locally behind the scenes to make this neighbourhood a healthier place.
Liverpool is about to transfer models of good practice developed in Croxteth to other neighbourhoods.

| Target 28. Primary health care                  |
| ! Community participation                     |
| S Neighbourhood health team                   |
| O Local partnerships                          |

**Case study 27. Children’s views on their local environment in Varissuo, Turku**

Turku is losing population owing to both the falling birth rate and migration. Rapid growth after the Second World War created social problems, particularly in the new residential areas. The Turku Healthy Cities project therefore had a particular interest in the effects on health of people's relationship with their environment. It initiated research to find out what people in Turku think about their living environment, concentrating on two areas with high-priority social needs. Three factors in the Finnish context make the Turku project's emphasis on neighbourhood planning significant:

- a traditional lack of cooperation between the health and welfare sectors;
- a current move to decentralize planning decisions; and
- a certain reservation in Finnish culture about public authorities and public debate.

In the residential area of Varissuo the project worked to discover children's views on their surroundings, and published them in a report to influence the planning department. As a less official agency, the project could publish the views of children in a way that the city council would have been reluctant to do. The project had already carried out a "kid's place" survey in some schools; its aim was not so much to identify needs as to highlight children's views to influence the planning of a new residential area. The area studied had come to be perceived as a problem area. Many problems had resulted from the fact that it was not as spacious as envisaged in the original plans. This exercise actually represented
an evaluation of the previous planning. The participants hoped to influence planners and decision-makers to evaluate new plans at an early stage. A competition to develop a plan for a new area provided the opportunity for showing what could be done.

An architect and office worker from the council’s planning office took part in the action, alongside the city project. Two interviewers, funded by the project, observed the physical features of the area and asked children, parents and teachers about their experiences there. The children stressed the importance of the nearby wood and green space. The public facility they wanted most was an indoor swimming pool. All respondents stressed the importance of safety. The conclusions of the study concerned the need for programmes for young people and ethnic minorities, and the need to include public facilities appropriate to the needs of local people in planning residential areas. As a result of this activity, the city project forged closer links with the town planning department in the council. A small project – in size, time and cost – proved an effective way to contribute to increasing participation in the city planning process.

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**Case study 28. The Servicestelle – to improve and facilitate self-help in Frankfurt**

The health of a city’s inhabitants is strongly related to their living environment—with the aid of health promotion every person should be able to reach their highest possible level of health.

Many cities probably contain significant numbers of people who would like to help influence health through health promoting activity, but who are prevented by a lack of information. The Servicestelle in Frankfurt is a contact institution to support self-help groups in the city. It aims to enable people who are interested in the idea of a healthier Frankfurt to make contact with one another, and to facilitate and improve innovative projects. The
project coordinator writes that "the aim of a healthy Frankfurt is a political matter", incorporating for all citizens:

- social justice and security
- suitable housing
- work and an income
- a healthy working and living environment
- a useful life and the potential of "personal growth in your own direction".

The Servicestelle is a private foundation funded by the Frankfurt city project. The people active in establishing and running it include politicians, members of the public who are interested in health issues, community initiatives and self-help groups. Public participation is very important.

The institution helps interested people or groups to found initiatives within the city. It gives information on the activities of various projects and organizations, and offers advice on possible collaborators for a new initiative. It also offers practical help: meeting rooms, information on training seminars, use of the photocopier, computer and video recorder, postage, a postal address and possible financial assistance. The various groups are assessed by need, and given more or less continual support and advice accordingly. When an initiative wishes to become independent, the Servicestelle assists with this process which includes, for example, looking for new members and other offices. It has contact with politicians, scientists, experts in various fields and the mass media. Self-help groups that the Servicestelle has helped to set up include those for people with problems associated with alcohol abuse, those for the mentally ill, soup kitchens, a car sharing scheme and an HIV/AIDS group. In addition a programme for cheap housing was set up. Many soldiers from the United States live in Frankfurt and an initiative was set up to convert old barracks into housing for the homeless.

Further, the Servicestelle in Hamburg has proved to be a very successful project, with some 70–80 initiatives at present.
Case study 29. The health market-place in Nancy

The health market-place (carrefour santé) is situated in the heart of Nancy. It is an exhibition space, a place to show films and a focal point for information on health. Its aims are to inform, to educate and to involve the public in large health issues, and it adopts a preventive and health promotion perspective.

The centre is a "one-stop shop" for information on self-help groups, community organizations, health, and health services and insurance. Exhibitions, games, conferences and other events are put on to highlight preventive strategies for health problems. The centre’s programme is developed in a participatory way. Self-help groups propose health education topics to be publicized. Voluntary groups cooperate with health and social welfare professionals on a steering committee. The city council, the local branch of health insurance and a social welfare centre jointly lead the initiative.

Access is the key to the health market-place. It is like a city centre shop, located in the midst of cheap and popular shops and next to the city welfare office. Support is offered at several levels by: encouraging self-help groups, putting people in touch with public facilities and counselling, and exhibiting health education materials that emphasize environmental and social issues and cultural perspectives. The centre has had 40 000 visitors and has held 20 exhibitions on health themes. Through this initiative, healthy choices are being made more accessible to all.
Target 2. Health and quality of life

Choice
S Health shop
O Access to information

Know-how point
how to enable and advocate health action

City projects are both formal and informal structures to catalyse action by different partners in the city. Networking approaches complemented the work of strong intersectoral committees. New styles of support agency encourage participation and empowerment offering both public information about health and support for health action by community organizations.
Responses to major urban issues

Healthy Cities approaches are being used to tackle major public health problems in cities. As a result, sustainable solutions are being sought to other urban problems, using ecological thinking and strategies in which awareness of health and of environmental implications works synergistically. In Rotterdam, project work on inequalities was perceived to provide a way to implement the social innovation strategy in districts. This is an example of how Healthy Cities approaches, by providing a health focus, can contribute to the social and environmental objectives of urban renewal. Healthy Cities action tackles inequalities, which makes it relevant to areas of urban decline and regeneration across the European Region. Public health action that develops in a Healthy Cities context shows the possibilities of reorienting health services towards health promotion and disease prevention. Broad ideas, joint health and social care solutions, and integrated services can significantly affect the way that the city tackles major health challenges such as tobacco, tuberculosis or AIDS. Processes that allow public participation add value to major environmental strategies to implement green, waste and clean air policies and the related monitoring.
Urban renewal

Case study 30: Public health strategy and urban renewal in Rotterdam

Rotterdam, a major port with a population of some 600 000, is the second city of the Netherlands. It exemplifies the health and social problems of major urban conurbations, rather than those of the Netherlands as a whole, and demonstrates the need for local health strategies that reach beyond health care. Rotterdam has a high proportion (17%) of the population over the age of 65 years. Other significant features of social conditions include an unemployment rate of 23%, and 18% of the population is composed of members of ethnic minority groups from Turkey, Morocco, Surinam and the Dutch Antilles. Inequalities between population groups and neighbourhoods are the greatest priority for health strategy. Neighbourhoods differ dramatically in health status, and social problems tend to be concentrated in the older parts of the inner city.

In the late 1980s, local discussions quickly expanded the field of urban renewal from economics and town planning to the need for a strategy for social change aimed at reducing inequalities and improving living conditions. In 1988, a Social Innovation Commission was established; it made recommendations to local government a year later. Meanwhile, a political demand had grown for the Rotterdam Health Service to adopt a broader perspective on health, which had led to the first health policy plan in 1988. In 1989, interest in the Healthy Cities approach arose and the memorandum, The new Rotterdam – a healthy city, was issued at the recommendation of the Social Innovation Commission.

When the city government responded to the Commission with a strategy document called Social innovation Rotterdam, the Healthy Cities approach was adopted as a potentially fruitful response to inequalities, a social priority for Rotterdam. Other priorities were job creation in the social sector, comprehensive policies for those on low incomes, a policy for the elderly, child care facilities and neighbourhood development.

The Rotterdam Health Service needed to respond to the problems in neighbourhoods, and many of the problems there demanded action outside the health care sector. The importance given in the Healthy Cities approach to community involvement
and intersectoral collaboration corresponded with the processes selected to achieve the social innovation strategy, which was based on collaboration between local government and other partners. This local situation coincided with a national shift in responsibilities for public health, as the central government attempted to increase local power to implement health and social policy. The law for public health intervention of 1990, gave local government in the Netherlands responsibility for public health promotion and coordination.

The Rotterdam city project has seen the development of neighbourhood work in the local health service, harmonizing with the general decentralization of administrative responsibilities and resources to district level, where social policy issues provided a basis for common work. Through the social innovation strategy framework, local health action was linked to intersectoral policy development.

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**Case study 31. Strategic analysis of the health environment in Rotterdam**

A major argument for the development of urban health policies is that local variations in health problems may necessitate appropriate local strategies. The Healthy Cities concept is particularly appropriate as a basis for drawing together information on the various dimensions of health in the city, to provide an ecological framework for urban health policy.

Information and research formed a solid basis for the analysis of health priorities in Rotterdam. The Epidemiology Department of the Rotterdam Municipal Health Service has developed a local health information system called REBUS (Rotterdam Epidemiologisch Buurtkenmerken System). It combines quantitative and qualitative data.
• to monitor the health situation and related factors at district and local levels; and
• to contribute to the development of a local health policy to reduce the differences found in the health of the population.

The city is divided into 83 small areas or neighbourhoods. Data are collated for each neighbourhood. Data sources include routine health and social data, survey data, documentary information, such as health-related articles from local newspapers, and the results of enquiries with key informants (individual and group interviews and semi-structured postal questionnaires). The information categories include:

• mortality rates;
• health status – individual perceptions of health, health complaints, psychosexual problems, and rates of disease (particularly communicable diseases);
• health care – availability of, access to, use and opinion of both hospital and community services;
• lifestyles – consumption of tobacco, alcohol, certain drugs, eating habits, exercise;
• indicators of the environment – housing quality and quantity, traffic density, pollution, and the availability of local facilities such as shops, schools, transport and public parks; and
• social environment – education, occupation, income, household composition and political participation.

The information gathered is integrated into profiles for each of the neighbourhoods, giving a geographical analysis of health to enable an exploration of health and living conditions and the differences between neighbourhoods. The analysis is repeated every two years, which allows longitudinal monitoring. The REBUS system shows how an information system that can monitor health at the local level can be used to support the development of a local strategy for health for all that specifically aims to reduce health inequalities between districts. The Healthy Cities project highlights the need for integrated urban health information systems to make relevant and timely information available to urban planners and the public.
Case study 32. St Pancras ward health and environmental survey in Camden

Environmental hazards are part of the chain linking disadvantage and poor health. In Camden, priority has been given to enabling community action on the environment and health in a small area. Indices of deprivation show the St Pancras ward to be among the least privileged areas of Camden. A relatively high proportion of people are from ethnic minority groups. Community organizations are strong and include tenants' and residents' associations and pensioners' clubs.

The St Pancras ward health and environmental survey identified the views of local residents, particularly the Bangladeshi community, on problems in the environment that affected their health. The idea originated in 1989 with two members of the intersectoral committee of the Camden Healthy Cities project, the Director of Environmental Services and a community worker. This project depended on a partnership between local residents and relevant agencies and on a commitment from the agencies to act on the problems identified. The survey was organized and coordinated by a steering group that included residents, representatives of community organizations (such as the Bengali Education Centre and the Neighbourhood Advice Centre) tenants' associations, and members of the Camden Healthy Cities steering group, who represented the environmental services in Camden Council and Bloomsbury Health Authority. Community centres played a crucial role in recruiting members of the community for the steering group, and the work was coordinated from a community centre. A sample of one in ten households was surveyed in 1990.

The results showed that most people liked living in the area, but many were concerned about house maintenance, damp, rubbish, vermin, traffic, pavement repair, and the lack of gardens and green space. People from the Bangladeshi community reported
more problems with their housing and cited racial harassment and unemployment as the most important causes of stress; 93% thought that stresses related to living in the area affected their health. The elderly and some ethnic minority groups were underrepresented in the survey, however, and the local residents were not involved in the analysis. A public meeting was held in July 1991, and a health development group formed to act on the reported findings. Funding was obtained from a joint health and social services budget for a full-time development worker in the area.

The partnership approach of the survey shows how Healthy Cities projects can help local people to tackle the barriers that prevent them from influencing the planning and delivery of services in their neighbourhoods, and to challenge local government to listen to their demands and needs. The community worker stresses the importance of the community input to the success of the initiative, and he writes, that the project "provides the authorities with a practical example, opens the door for the community and vice versa for mutual cooperation".

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<td>Community action</td>
<td>Local health and environment survey</td>
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Case study 33. Action on major public health priorities in Kaunas

Public health experts across the European Region are increasingly conscious of the public health priorities in the eastern countries. Environmental quality, tobacco control, youth health education programmes and the reconstruction of health and social services are recurring themes. The city project of Kaunas, Lithuania has developed a series of linked programmes to control smoking, implement ecological monitoring and develop health promotion among young people. The activities developed illustrate what action cities can take, even under difficult conditions, to tackle these seemingly intractable issues.
The Kaunas tobacco programme is a partnership with organizations active in tobacco control, including the Kaunas Society against Cancer, the Health Promotion Centre and the city project itself. Partnerships, including international partnerships, have been used creatively in Kaunas to provide resources and publicity, and public action has been linked to pressure for policy change. The most important achievement to date for tobacco control is the drafting of a law on tobacco products control, in association with the Ministry of Health. Another important event was the quit-and-win competitions held in Kaunas on World No-Tobacco Day in 1992 and 1993. The 1992 competition was the first ever held in Lithuania. Over 380 smokers entered. Of 100 people randomly selected for follow-up, about 60 succeeded in quitting and 10, who had stopped smoking for over two months, received awards. The prize, a trip to Rome, was a gift from Poland and the competition received wide publicity.

Other groups in Kaunas are taking their own action to control tobacco. Action on Smoking is a Lithuanian association of nonsmokers based in Kaunas. The group has been putting pressure on the government to act promptly against tobacco advertising and to prevent unrestricted sales of tobacco products. In 1993, the Kaunas City Council declared the main pedestrian street in Kaunas, along with two squares near the Music Theatre and the Historical Museum, to be no-smoking zones. The Council's policies on tobacco control are visible to all.

As to the environment, the city has taken a lead through environmental health assessment. A municipal ecological monitoring programme was set up in 1993. The municipality now has a computer-assisted geographic information system for environmental and health assessment and management. The system produces seasonal and annual maps showing environmental quality in different areas. These have been used to define emergency zones, where hazards are particularly acute. A smaller programme has been developed to monitor the health of children and other residents in the municipality. Environmental education for young people is another key element of the city's environmental activity. In 1993, the Youth Environment Centre was established to provide environmental training for schoolchildren in Kaunas. Educational programmes have been developed on the environment, health and culture, and new environmental education project has been established. It has five main elements: lectures on geographic information systems and methods of environmental assessment, practical training in the use
of information technology, field work using biological tests, assessment of the urban region with practice in data measurement and computer modelling, and comparing data with the municipal ecological monitoring data.

The area of children's health promotion illustrates how Kaunas has built on its own interests and links to become associated with a number of relevant international initiatives. Three schools in Kaunas are part of the WHO European Network of Health Promoting Schools. About 1000 children will be included in the WHO study of the health behaviour of schoolchildren. Six kindergartens have an action plan for children's health promotion, which has been developed into the “Let’s Grow Healthy” programme.

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<th>Target 18. Policy on environment and health</th>
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Case study 34. Tuberculosis control programme in Barcelona

The incidence of tuberculosis is very high among homeless people in Barcelona, and is a significant issue for work against AIDS and drugs in the city. The tuberculosis control programme is an initiative of the Municipal Department of Health, which works in the framework of the new public health, encouraged by having the Healthy City project within it. The programme shows how feedback from research can be used to sustain cooperation and to demonstrate the benefits of reorienting services towards a social approach to health.

The programme is intended to reduce the incidence of tuberculosis in Barcelona and to improve the effectiveness of treatment. It complements health service provision by addressing the social needs of the target groups – the homeless, prisoners and intravenous drug users. Homeless people, who often failed to complete treatment in the past, are given accommodation for the nine months of treatment, and offered training and help to find employment.
Doctors and nurses in all the major hospitals in Barcelona have cooperated with the programme. Social workers have provided social support, and religious groups have helped the very poor. The programme has resulted in:

- cost-effectiveness, by reducing the need for stays in hospital;
- a significant increase in the proportion of people completing treatment;
- greater awareness among professionals, especially AIDS workers, of tuberculosis in Barcelona;
- new jobs or treatment for alcoholism for some people in the programme; and
- earlier detection and effective treatment of prisoners.

Throughout the programme, regular monitoring has made it possible to provide information feedback to service providers and caregivers to sustain their collaboration. The work has been awarded a research prize by the Spanish Ministry of Health and Consumer Affairs.

Tackling the health problems of marginal groups in cities requires active cooperation from workers in different sectors. The Barcelona city project coordinator, who works in the Department of Public Health, writes:

To obtain the collaboration of people, you have to demonstrate your work is serious and not only talking and talking. This programme is carefully evaluated each year and has clear objectives that can be measured. Changes are suggested according to the results obtained. We propose to encourage this rational approach in all the initiatives carried out in our cities.

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<th>Target 5.</th>
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<td>Prevention programme</td>
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**Case study 35. Creation of an AIDS centre in Milan**

AIDS is an extremely serious problem in Milan, which houses 27.9% of the people in the Lombardy region who have the disease. With 955
diagnosed cases since the epidemic started, it is the most heavily affected city in Italy.

Acting immediately, the City Hall has tried to respond to varying requirements – both by giving correct information to the population and through training the staff in charge of the problem. The City Hall has cooperated with all the associations dealing with the issue, and has tried to integrate all existing resources. The aim has been to create a different culture for support, with a more human approach.

Milan's AIDS Operating Centre (COAM) was established to organize the action of institutions and to rationalize resources and interventions. Its aims are:

- to assess needs and resources, in cooperation with hospitals, the local health services unit, and the private social sector;
- to prepare information and education campaigns, in cooperation with other institutions such as schools and associations;
- to coordinate both the voluntary and the private social sectors;
- to act as a reference point for the coordination of the different public services; and
- to act as secretariat for these activities.

A work team was created within COAM. It designed an integrated project of intervention that takes account of different circumstances and resources, and promotes the coordination of both City Hall initiatives related to AIDS and city services and institutions in general. The aim is to stimulate the creation of integrated interventions at city level that enhance and promote solidarity and alliance building.

Target 27. Health service resources and management

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<td>Coordinated action</td>
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Case study 36. Environmental education in Gothenburg

The case for the cost-effectiveness of tackling environmental problems at the source is as compelling as the case for disease prevention. At a time of recession, however, it is hard to act on long-term priorities without the support of short-term action to
catch the imagination of policy-makers and the public, and to demonstrate what action they can take on seemingly intractable problems. Chemical pollution is a major problem in Gothenburg. Following an investigation in 1987, reports from the Swedish Environmental Protection Agency and the Environment and Health Protection Agency in Gothenburg highlighted the problem and proposed a pollution control programme.

The Environment Project Gothenburg aimed to:

- reduce hazardous emissions into the air and water;
- change the mixture of waste;
- develop products that create less environmental damage; and
- increase citizens’ understanding of environmental issues and change their attitudes.

The programme included an educational policy to harness the commitment of the people of Gothenburg to local environmental work. This part of the programme had three aims:

- to explain to local people what action they could take to reduce environmental hazards;
- to start a dialogue with producers to develop alternative products that would be less harmful to the environment; and
- to persuade retailers to reduce trade in environmentally harmful goods.

To set up the campaign, the Environment and Health Protection Agency worked closely with the Municipal Consumer Office and engaged the services of an information consultant. The first intensive information campaign, called "Practise as You Preach in Gothenburg", took place in 1988–1989. Information strategies included special newsletters and the production of display material for shops. The initial public information campaign broadened into a range of activities that have closely involved producers, shop owners and consumer organizations. All households in the city received an Environmental catalogue published by the city council, which was reissued in 1991. The campaign "Chemical Sweep", which started in 1990, aimed to reduce the use of chemicals in Gothenburg.

The results of these linked activities include not only greater public awareness but also progress in influencing the supply of products. As a result of Environment Project Gothenburg two large detergent manufacturers in Sweden produced new detergents that
were friendlier to the environment. In addition, the city's purchasing policy and practices were influenced. All purchasing agreements made in Gothenburg are now reviewed from an environmental perspective. In March 1990 the city council decided that products bought by the city should pose as little hazard to the environment as possible. Finally, the Project influenced existing environmental problems. Major efforts are being made to reduce discharges from the Hissingen industrial area.

While industrial pollution declines, the city must address the increase in air pollution from traffic and the growing threat of acid rain from abroad. For the city council, the action taken to influence public opinion on environmental products represents a new way of working. Difficulties in influencing producers have represented the biggest obstacle to the initiative, but intersectoral action has helped to put health on the agenda of environmental agencies.

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**Case study 37. Assessment of indoor air quality in Stockholm**

Most people spend about 90% of their time indoors, and more than half of this time at home. Modern, more airtight construction techniques and shortcomings in ventilation systems lead to the emission and retention of many chemicals in dwellings. Changes in the way people live, such as greater use of electrical appliances, also place heavier demands on the design of homes.

The Stockholm city council wanted to investigate the prevalence of symptoms of the sick building syndrome, as increasing numbers of people in Sweden suffer from allergies. Could these be attributed to buildings, construction technique or technical systems, or are they related to psychological factors? If sickness were due to building quality, what could be done about it, and how much would such improvements cost? In 1989, a working group – Buildings and Health in Stockholm – was set up to analyse the effects of inadequate indoor environments on health, and to report on how such environments could be improved. The
The group represents many different city departments, municipal and private property owners and tenants in Stockholm.

Buildings and Health in Stockholm intends to prepare an inventory of all properties in Stockholm whose shortcomings give rise to health risks or problems. As Stockholm comprises some 50,000 properties, a technical survey of each would be too costly. Instead, a survey has been made of a sample of residents of 100,000 dwellings; they are asked to report any health problems that could be attributed to their housing. The study will:

- estimate the proportion of "sick" residential buildings in Stockholm;
- establish baselines for the levels of comfort, air quality, and sound and light conditions that Stockholm residents consider normal;
- identify the most important reasons for problems with heating, air quality and noise; and
- identify patterns of characteristics of the indoor climate, and building performance and maintenance that residents perceive as either good or bad.

The Stockholm Office of Research and Statistics, in cooperation with Swedish Public Utility Housing Enterprises and the Stockholm Residents’ Association and City Environment Department, designed the questionnaire. It covers the tenants' assessment of general features in the dwelling, temperature in different rooms in winter and summer, and air quality and ventilation. Questions about health problems in the preceding three months were derived from a questionnaire developed by the Occupational Medicine Unit in Örebro, Sweden; they ask about symptoms such as itching, irritation of the mucous membranes, hoarseness and coughing, and whether such symptoms seem to be related to the home. Other questions address acoustic and light conditions. To establish what people consider to be the main problems with the indoor environment, respondents are asked to evaluate the importance of a number of possible problems that could occur.

The survey analysis compares single-family houses and flats, and differences between dwellings in the city centre and the suburbs. For each category of building a problem profile is being drawn up to identify the number of occupants who experience problems. This will enable the administrators responsible for
different types of dwelling to see what tenants think about the indoor climate in their homes. The city council can use the baseline information obtained on the indoor environment in Stockholm to establish standards for new buildings.

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<th>Air quality</th>
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**Case study 38. New household waste management system in Nancy**

An aim of the Nancy Healthy Cities project has been to introduce health dimensions into urban services and to promote concrete activities to improve the quality of life of the people living in the city. Many of the project's initiatives are based on partnerships with both public and private agencies. One of the most ambitious schemes is an innovative environmental project that extends beyond the 18 communes in the urban district of Nancy. The objectives of the project are:

- to reduce nuisance, pollution and waste through an innovative system of urban waste management;
- to recycle 60% of the waste produced and to recover its value through energy production; and
- to encourage environmentally friendly behaviour among the inhabitants of Nancy by providing for the separate collection of different types of waste.

By 1994/1995, the Nancy conurbation will be served by an effective and innovative system of waste management that extends from the point of collection to disposal. Key processes include the sorting of the waste before collection, recovery and incineration to produce energy. The first step in the process is selective sorting of the rubbish by a local agency called RIMMA, an enterprise involving the public and private sector. In the last two years, three different approaches have been tried to encourage the population of Nancy (numbering 12 000 people) to sort their rubbish. Disposal
containers were supplied to an area of detached housing. Different types of bag for different types of rubbish were distributed to households in an area containing houses and flats. In an area with an even greater range of housing types, household bins were provided with two compartments, to separate paper, cardboard, glass, plastic and metal from other rubbish. The scheme has been judged a great success; studies of both opinions and behaviour agree that about 90% of people cooperated with the collection, with an average recovery rate of over 20% of the total volume.

The second stage of the system is the new treatment plant, contracted to Nancy Energie, a private firm and an offshoot of a leading company in energy and environmental management. The treatment centre consists of a sorting centre for the green bins and an incineration mill with an energy recovery system. Atmospheric emissions are expected to be 50% below European Union standards. Work on the centre began in 1993 and the plant should be operational in 1995. The centre is south of the city and uses the latest technology. It will have an initial annual capacity of 135 000 tonnes, rising to 180 000 tonnes. There will be excess capacity, so the plant will be able to treat waste from other towns in the south of the département. In addition an extremely effective autonomous system to treat hospital waste is envisaged to cater for the whole Lorraine Région. The energy produced by waste incineration will be enough to heat 4000 homes and produce 24 000 MWh of electricity; that is, it will save each year the equivalent of 500 lorry loads, each carrying 35 tons of fuel. The treatment centre offers tours for adults and schoolchildren. In two years’ time, visitors will have the opportunity to discover that a waste disposal plant can be as beautiful and exciting to visit as a glass or paper factory.

This initiative was the brain-child of the environmental service of the Nancy urban district. The city councillors took it up to develop the environmental aspect of town planning. The intersectoral committee of the Nancy Healthy Cities project has helped to keep the focus on the environmental policy, and has assisted with publicity. Information on waste management policy has been shared between cities in the French national Healthy Cities network.

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**Know-how point**

**how can health actions influence city life?**

The experience of city projects shows that health awareness can contribute to finding solutions to major urban problems. Sectors have more hope of finding solutions when they collaborate and seek public involvement.
City experience

Different challenges, different responses

Losing the stories of individual cities among the multiplicity of actions for health would be wrong. This section gives four accounts that illustrate the different challenges faced by cities, opportunities for action and responses adopted. The example of Horsens shows how projects can adapt their strategy during development and implementation. Experience in Liège and, to a much greater extent, Zagreb shows that Healthy Cities projects are not an option only for cities that are safe and financially secure. Cities in crisis can use them to make reforms and find feasible solutions.

Case study 39. Horsens: building connections in a small city

The Horsens Healthy City project is working to make the small city of Horsens a better place to be for all by acting, not for residents, organizations, municipal systems and others, but with them to make improvements and create models of good practice. The location of the project office in the town hall square has been central to its strategy of involving residents in promoting action for health and increasing public influence on political decisions that affect health. The project has achieved this aim by quickly supporting ideas for action that people bring forward. From the early days, the project’s committee structure and very active communication strategy have encouraged both community participation and intersectoral collaboration. Formal collaboration was secured through a system of direct representation on the health committee that sets priorities for the project. The committee has 22 members, including 9 citizens, 1 trade union representative, 1
representative from the employers’ organization, 2 heads of municipal departments, and 6 city and 2 county politicians.

The city project has involved municipal staff in activities by finding motivated, skilled people and then securing approval from management to involve them in project work. Such suggestions have always met a positive response. Professional staff advise the project on health, strategic and political issues through an intersectoral health advisory board. Its members include: an architect/planner, a cultural worker, a chemist, a dentist, engineers, general practitioners, health visitors, hospital doctors, nurses, a nutritionist, police officers and a social worker. One of its members writes,

If you really want to improve the health of people living in urban areas, you will have to go beyond the involvement of the traditional health system, which almost exclusively deals with the combating of diseases. You will have to establish contact with the professionals who during their work influence the lives of the citizens, and not least their quality of life, through town planning, architecture, housing conditions, choice of building materials, traffic planning, cultural opportunities, social conditions, education, etc.

Political commitment is achieved by involving politicians and community members on the committees of the project, and naming a politician as representative of the health advisory board. Politicians are also invited to local, national and international workshops, seminars and conferences.

Latterly, the Horsens Healthy City project has become an independent nonprofit foundation. This has put the project in a better position to obtain funding from the private sector, as well as to receive municipal grants. The foundation is a nonprofit sector of a share-holding company, the Health and Environment Group, Ltd, which markets consultancy and training and has won signal success in obtaining a large grant from the European Union for an environmental project in Pécs. This financial and operational autonomy has not isolated the project from the city government; some of the project staff continue to work there part-time. The experience of the Horsens Healthy City project has been that a more autonomous organizational base has provided leverage to win human and financial resources to support project activity. Using all of the hidden resources in a city triggers a reaction for change.
**Case study 40. Liège: constraints and opportunities in implementing the health for all agenda**

Liège faces serious economic crisis following long-term industrial decline. Health and social services were cut after the bankruptcy of the city in 1989/1990. Unemployment hits young people without qualifications particularly hard, and many indicators show high levels of stress and insecurity in the population. For example, Liège has the second highest suicide rate in Europe (after Copenhagen) and is a world capital for tranquillizer consumption (112 tablets per inhabitant per year).

Before Liège became a project city, the city government took steps to improve living conditions. This created a supportive environment for the project. Liège nearly withdrew from the Healthy Cities project during the city's financial crisis, but the project was re-established as a partnership between the province, the University of Liège and the city department of environment and quality of life. The project's resources are small but, with strong political commitment from the mayor, it has influenced the approaches used in joint activities with other agencies. These activities emphasize prevention of disease and raising public health awareness of health.

*Breast cancer screening*

A major campaign brought together the province and University of Liège, the local Oeuvre Belge de Cancer and primary health care. It aimed to introduce systematic mammography and thus to reduce mortality and morbidity related to breast cancer in women. It focused on improving the coverage of the service through activities such as mobile mammography units and publicity through voluntary groups. It is hoped to extend the programme to regional and national levels.
Enquiry into health needs
"Health at Stake" was a major enquiry into population health needs and attitudes. It aimed to provide baseline data, raise public awareness and make health services more responsive to the needs of the consumer. The survey was carried out through a written questionnaire and interviews. It included indicators of:

- self-perceived general, mental and physical health
- food, tobacco and alcohol use
- work and leisure activities
- recent major life events
- use of and satisfaction with health services and medicines; and
- views on who is responsible for health in Liège.

City cleanliness campaign
In May 1991, a campaign encouraged people in Liège to be more aware of the action they could take to improve the cleanliness of the city. The project was an initiative of the environment and quality of life department of the city, together with the ministry of the Walloon region, neighbourhood associations in Liège and sponsors in the private sector. In "Green Week", different themes – such as litter and dog excrement – were emphasized each day in the local press. Citizens were encouraged to sign a four-point charter to look after their litter, rubbish bins, the pavement in front of their homes, and the dogs. Skips were made available in public places to help people clear out their attics and cellars and dispose of unwanted possessions. In one neighbourhood, where the population is predominantly Ghanaian, local schoolchildren planted flowers in window boxes to cheer up the grey concrete balconies.

Conclusion
The city project has shown the value of cooperation between agencies and the direct involvement of the people in decisions and activities that affect their health and environment. Locally, concern for health and the environment is a growing part of the culture of public agencies.
Case study 41. Promoting local action strategies in Padua

The city project in Padua is part of the structure of the local council. It is located in the Social Affairs Department and the Culture and Events Department. Traditionally, health policies in Padua focused on the social and environmental aspects of public health while the national health service was responsible for medical services. In recent years, city health policy has increasingly reflected an awareness of the importance of lifestyles to health. City health priorities include:

- the reduction of air and noise pollution;
- drug addiction;
- campaigns against smoking and alcohol;
- the extension of traffic-free zones;
- the reduction of urban traffic through the creation of parking areas on the outskirts of the city; and
- the creation of pedestrian precincts and cycle paths.

Practical actions have been developed in line with these priorities. For example, a system for monitoring noise and air pollution has been set up in some districts for pilot testing. Levels of pollution are regularly printed in the newspapers – on a weekly basis for air pollution and semiannually for noise pollution. An action plan on tobacco has been implemented in cooperation with the national health service, the city hospital (which is a pilot hospital in the WHO health promoting hospitals project) and the school authorities. In addition, two automatic syringe distributors or exchanges have been installed to help reduce syringe-sharing by drug addicts, as part of the campaign against drug addiction and AIDS. In cooperation with the Youth Project, the city project works to contain the spread of the drug ecstasy among young people.
The city project is stimulating events and actions that will help to encourage the development of alternative models for dealing with health practices in the city. For example, training seminars encourage health education, healthier lifestyles and community organization by helping people to organize, find funds for and manage self-help and community groups and activities. Some self-help groups receive a small contribution from council funds.

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<tr>
<th>Target 14.</th>
<th>Settings for health promotion</th>
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<td>!</td>
<td>Lifestyles</td>
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<td>S</td>
<td>Action to raise visibility</td>
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<tr>
<td>O</td>
<td>Health awareness</td>
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**Case study 42. Zagreb as a healthy city in war**

By applying a set of values and strategic objectives, rather than a rigid programme, the Healthy Cities movement has been free to learn from the unexpected. Several project cities have experienced sudden economic problems – many have faced political crises. No city, however, faced problems as fundamental as those of Zagreb in the wake of the dissolution of the former Yugoslavia. Zagreb's experience of the conflict in Croatia was a significant learning experience for the entire Healthy Cities network in the European Region, and resulted not only in the mobilization of practical help but also in an increased realization of the role of city projects and of the meaning of action for health at times of human disaster.

Zagreb was one of the first cities to join the Healthy Cities project. The city project has always displayed a strong interest in sharing experience with the whole network, and it hosted the annual Healthy Cities symposium in 1988. Since the beginning of hostilities in Croatia, the Zagreb Healthy Cities project has exercised leadership by developing solidarity in the network of Croatian cities, documenting the needs of refugees and mobilizing support.

In informing the project cities' network of the destruction in Croatia, Zagreb has highlighted the needs of cities struck by disaster. This illustrates the importance of peace as a precondition for health. In particular, Zagreb has produced videotapes,
information bulletins and photographs to show the nature and extent of the war damage to people and property. The enormity of the statistics is difficult to grasp: 3000 killed, 40% of the economy destroyed, 200 churches lost, etc. It conducted significant action research, documenting the precise needs of the 120,000 displaced persons (out of the total of 700,000 refugees in Croatia) who fled to Zagreb.

The project proposes the creation of an MCAP on cities struck by natural or man-made disasters, so that its own experience can be utilized and the network cities can be prepared to respond quickly and effectively to the special needs of other cities in the future.

Zagreb's experience has led directly to practical expressions of solidarity. Following the visit of a WHO mission to Zagreb (with representatives from Vienna, Milan and the Healthy Cities project office), the WHO Regional Office for Europe appealed to the European project cities for help. As a result, aid worth US $9.5 million was sent to Zagreb. Cities that made outstanding contributions include Horsens, Sandnes, Hamburg, Eindhoven and Mechelen.

Zagreb continues to show what a commitment to reason and human dignity can achieve in the most adverse circumstances. From Zagreb the project as a whole has learned the importance of human solidarity in the European Region.

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<th>Target 37. Partners for health</th>
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<tr>
<td>! War</td>
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<tr>
<td>S Vision, collaboration</td>
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<tr>
<td>O Coping, solidarity</td>
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</table>

**Know-how point**

**how can projects survive?**

The Healthy Cities project provides a flexible framework. Cities can adapt strategies to cope with circumstances ranging from stability to war.
8

Qualities of a healthy city

The targets for health for all are used throughout this booklet to indicate the topics of action for healthy cities. This section illustrates some of the qualities of a healthy city. In a healthy city, basic health needs are met, and there is exchange between generations. In addition a sustainable ecosystem supports the city and everyone has access to high-quality services. In the end, however, project cities have not realized a distant vision, but are striving to achieve these goals for all their citizens.

Health priorities and services

Case study 43. St Petersburg: health priorities amid great change

St Petersburg, with a population of 5 million people, is in the midst of profound political, social and economic change. It was designated a WHO project city in May 1991. A key aspect of the St Petersburg Healthy Cities project is its strong links to the political and executive decision-making structures of the city. WHO is helping to catalyse the local process of change by coordinating international support through the St Petersburg support project, which is led by WHO, the cities of Hamburg, Milan, Rotterdam, Stockholm, Turku, and the Nottingham School of Public Health. A voluntary donation by the Swedish government in 1992 made it possible to organize events to secure international cooperation on the project.

The city project provides a coordinated, continuing and sustainable base for large-scale reforms involving the political leadership, and the executive and professional groups of the city. WHO and the city authorities have identified services and care for
mothers and babies, training for health workers, health promotion, family planning and reforms of public health and primary care services as priorities.

Maternal services are a first priority. The maternal mortality rate for 1991 was 69.4 per 100 000 births; one fifth of these deaths were related to abortion. Maternity care is highly medicalized and contraception unavailable. There are twice as many abortions as births. There is little education in child development, and only 10–20% of babies are breastfed.

Pilot projects to generate change are combined with long-term reform of the values and structures of maternity services. An interdisciplinary consensus conference with external expert support was held in the city in 1992 to set standards of maternity care. Based on the recommendations of that conference, an action plan has been drawn up specifying a set of process priorities, outcome indicators and activities for the next 2–3 years. The pilot projects include: the establishment of a centre for teenage girls with reproductive problems, the implementation of the baby-friendly hospital approach by a maternity hospital, the provision of special support to single and disadvantaged mothers, and the creation of a modern family planning centre.

To strengthen policy-making and the setting of priorities, WHO and the Nottingham School of Public Health are assisting St Petersburg to produce its first health profile.

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<tr>
<th>Target 2.</th>
<th>Health and quality of life</th>
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<tr>
<td>!</td>
<td>Basic health needs</td>
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<tr>
<td>S</td>
<td>Health programmes</td>
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<tr>
<td>O</td>
<td>Improved health status</td>
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Case study 44. The CUPTEL project in Milan

The CUPTEL project demonstrates the ability of Healthy Cities projects to catalyse partnerships between public and private agencies to manage an important health care issue. With CUPTEL (unified telephonic booking system) the Milan Healthy Cities project has developed a model to improve access to health services in large cities by using appropriate information and communication technology. CUPTEL provides an interesting example of improved service delivery at a time of transition in the state provision of health services across the European Region.

Milan, like all the major Italian cities, has a network of clinics that provide specialist medical examinations, non-urgent treatment and diagnostic tests (radiological and laboratory) for the population. These 28 clinics, along with 15 hospital outpatient clinics, are public services run by the Regional Health Service. The public clinics, in conjunction with contracted private health care services, provide an integrated service. Annually these providers deliver 5 million visits, 3 million non-urgent treatments and more than 10 million diagnostic tests.

The public services make 90% of the visits. The booking system for the clinics used to be very bureaucratic; people had to queue for a long time at desks to get an appointment. The city project adopted improved access to these clinics as a priority from 1990; better access for the elderly, the disabled and for working people was a particular target. The CUPTEL project was initiated to fulfil these aims.

CUPTEL has been in operation since mid-1992, and is a real advance on the old system in technology and convenience. It allows people to book appointments by telephone from own homes between 8.30 a.m and 4.30 p.m, Monday through Friday. The schedules of the outpatient clinics of the participating clinics can be read and updated in real time. The system handles some 13 000–15 000 calls per month (about 600–700 a day). When the line is busy for more than 50 seconds, an answering machine is activated.

In addition to booking appointments, callers can ask for information about health problems. Such information is given in about 5% of calls. A support office maintains the system and returns the calls of everyone who leaves a name and telephone number on the answering machine. The project is very popular; people are amazed to have a public service return their calls. In this sense, the project is changing people's experience of Milan's public services.

The Milan Healthy Cities project established the initiative. Local health units participated on a voluntary basis; three of those invited by the project agreed to take part (75/vi, 75/v and 75/ii). In addition Sacco
Hospital and Buzzi Hospital (a part of the WHO health promoting hospitals project) became partners. The hospitals serve a total catchment area with over 700,000 inhabitants. The local health units and hospitals operate as a kind of consortium under the leadership of the city project. The Lombardy region has approved the project, and is willing to extend it throughout Milan. In addition, other cities in Italy are likely to take up the model, as a result of publicity by the national Healthy Cities network. CUPTEL provides an answer to the question as to how public services can be made more responsive and how more efficient and integrated systems can be introduced into big cities, while maintaining local autonomy and decentralization.

<table>
<thead>
<tr>
<th>Target 1.</th>
<th>Equity in health</th>
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<tbody>
<tr>
<td>!</td>
<td>Equity</td>
</tr>
<tr>
<td>S</td>
<td>Improving access to services</td>
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<tr>
<td>O</td>
<td>Effective health care systems</td>
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</tbody>
</table>

**Elderly people**

During the next century, the proportion of elderly people will continue to rise in most populations, which is likely to lead to a greater social problem. Although elderly people may often form a substantial proportion of a city's population, their needs from and contributions to society are often forgotten. The Gothenburg case study tackles the physical and medical needs of the city's elderly, and the Bremen example explores the potential influence of this group on the rest of the urban population.

**Case study 45. Care for the elderly in Gothenburg**

The increasing proportion of elderly people in the European population creates a need for new types of collaboration between health and welfare services. Imaginative solutions are needed to provide for both the active and the frail elderly. Inappropriate housing and a lack of integrated community care are invariably the greatest obstacles to improving the independence and quality of life of elderly people in cities. In Gothenburg, a comprehensive policy and programme for the elderly has resulted in the provision
of more suitable housing and the development of local care plans. The multisectoral programme began as a political initiative at the highest level, and has stimulated wide public debate. In November 1990, local politicians in Gothenburg, acting on the suggestion of the Chair of the Public Health Council, decided to set objectives for the care of the elderly in the 1990s. Their policy aims were published in a 1991 document, *Being old in Gothenburg: orientation and aims for care of the elderly.*

The development of a comprehensive strategy for the care of the elderly in Gothenburg was based on extensive research into the living conditions of elderly people. A study was conducted in 1988 by the Medical Services Board, the social services and the city administrative services, in collaboration with the Chalmers Institute of Technology and the University of Gothenburg. It included 700 home visits, 106 of which were visits with people aged 85 who were still living in their own homes. In addition, 1500 elderly people were contacted through questionnaires delivered through the post. The survey showed that most elderly people wanted to remain in their own homes.

The policy establishes the principle that places in existing institutions should not be lost until new housing has been made available, and sets a target of 2000 new housing places for the elderly in the 1990s. The aims of the policy are to enable people to remain in their own homes if they wish, and to develop good collective housing for those who cannot remain in their own homes, primarily in the form of group housing and old people's homes with 24-hour access to medical care. The aims are:
• to encourage well developed and skilled primary care;
• to make high-quality home help readily available;
• to continue to refine clinical care at geriatric and psychogeriatric clinics; and
• to provide increased scope for non-municipal projects and ventures.

The needs of people over the age of 80 will be met by redistributing resources between the medical services board, the committees for district medical care and the district councils, and by increasing the resources for the care of the elderly. Under the Swedish system, responsibility for the implementation of these objectives now rests with the services at the district level, particularly the 21 local councils and the 5 medical care districts that have to draw up local action plans. Local agencies are jointly accountable for the resources devolved to provide services in that area. The implementation of the elderly policy city-wide will therefore depend on the effective development of joint work at the local level. The initiative also involves other city departments, such as those for premises management, and building and planning. Local pensioners’ consultation groups have been established and involved in the implementation of the policy. As part of the development of community facilities for the elderly, self-help groups have been given support to run activities such as visiting services, walking groups and study circles.

<table>
<thead>
<tr>
<th>Target 30. Community services to meet special needs</th>
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**Case study 46. Knowledge exchange (Wissenborse) in Bremen**

The self-help movement is a powerful force for making better use of human resources, but self-help initiatives need time and resources to develop a common purpose, structures and independence. The city project in Bremen acted as the midwife at the birth of an innovative venture to enhance the confidence of
elderly people. The activity was a response to the needs of the active elderly, and part of an overall action plan for the elderly developed by the project in a city with a solid tradition of self-help groups. The Knowledge Exchange (Wissenbörse) is an opportunity for older people to share their knowledge and experience with each other and with other groups within Bremen: the young, the disabled or newcomers to the city. A newsletter, *Borsenbrief*, provides a forum for the exchange of experience. This draws on two of the qualities of a healthy city:

- access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction and communication; and
- the encouragement in the inhabitants of a sense of connectedness with the past, their cultural and biological heritage, and other groups and individuals.

Elderly people were enabled to transfer their knowledge in a non-exploitative way. Cultural exchange between generations was encouraged, and personal skills in the elderly were developed through an approach that was sensitive to the context of cultural life in the city. The development owes much to the principles and practice of adult education, and was set up through a partnership between the city project office and an adult education institute. They paid for the services of an educational consultant to help develop the Exchange. Acting as an advocate, the city project helped to create the conditions for the successful development of the initiative towards independence. The adult education institute provided access to elderly people, and supplied expertise to organize seminars, run groups and design the newsletter. Other support to establish the Exchange came from a building company (which initially provided a room), the Grey Panthers, and officials in the city administration, who were contact points for applications for funding. In 1991 the Exchange became independent, with its own budget.
Environmental concerns

Case study 47. Stockholm: the environmental plan

The health and wellbeing of the individual depend on his or her total environment. In other words, the condition in the dwelling and at the workplace, the social environment, eating habits, smoking habits, etc. ...

The Stockholm environmental plan provides a comprehensive action programme for 1989–1994. Produced by the environmental and public health committee and approved by the whole city council in June 1989, the plan is intended to create the prerequisites for better health and greater wellbeing for Stockholm residents. It has three main goals:

• to prevent mental or physical ill health caused by air pollution, disturbing noise, unsuitable foods or other environmental hazards;
• to prevent lasting damage to the environment as a result of human activities; and
• to base environmental policy on an ecological and economic approach that makes allowances for what nature can stand.

Traffic is the biggest environmental problem in Stockholm and the subject of six proposals of the plan. First, the total volume of traffic should be reduced, and measures taken to reduce traffic problems in the centre of the city. Second, the city council should promote further improvements to vehicles, including those in its own fleet. Third, investment should continue in more environmentally friendly ways to obtain and use energy and other resources. Fourth, emissions from domestic waste incineration should be reduced and fifth, less wastewater should be emitted into
Lake Malaren. Finally, the plan suggests concrete action such as that in Table 2.

**Table 2. Suggestions for action on the environment in Stockholm**

<table>
<thead>
<tr>
<th>Environmental sector</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>External environment</td>
<td>Renewal of the sewage works, and opening of new bathing beaches</td>
</tr>
<tr>
<td>Soil and vegetation</td>
<td>Stricter requirements for the analysis and use of formerly industrial land</td>
</tr>
<tr>
<td>Food</td>
<td>More information on the design of premises for food production</td>
</tr>
<tr>
<td>Traffic</td>
<td>Increased control of compliance with limits on carbon monoxide emissions during idling of petrol-fuelled engines</td>
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<tr>
<td></td>
<td>Tests of different types of road surfaces to reduce noise</td>
</tr>
<tr>
<td>Industry</td>
<td>Cessation of heavy metal discharges into water</td>
</tr>
<tr>
<td></td>
<td>Reduction of mercury emissions from crematoria</td>
</tr>
<tr>
<td>Energy</td>
<td>Promotion of introduction to natural gas</td>
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<tr>
<td></td>
<td>Renewal of individual boilers in areas where district heating is used</td>
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<tr>
<td>Waste handling</td>
<td>Successive phase-out of household waste incineration</td>
</tr>
<tr>
<td></td>
<td>Tests of alternatives to salt in treating icy roads</td>
</tr>
<tr>
<td>Indoor environment</td>
<td>Stricter supervision of ventilation, mould and damp problems</td>
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<tr>
<td></td>
<td>Concerted efforts to deal with sick buildings</td>
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</table>
The Stockholm environmental plan declares that it is part of the progress for Stockholm to become a healthy city:

How we live – our lifestyles – affects both health and the environment. Lifestyle does not only involve what we eat and drink or whether we smoke or keep fit but also what we buy, how we dispose of our waste, our choice of detergents and cleansers and a great deal else besides ...

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<thead>
<tr>
<th>Target 15.</th>
<th>Policy on environment and health</th>
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<tr>
<td>S</td>
<td>Sustainable ecosystems</td>
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<tr>
<td>O</td>
<td>Environmental policy and programmes</td>
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<tr>
<td>O</td>
<td>Improved urban environment</td>
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**Case study 48. The cycling city of Sandnes**

The city of Sandnes has combined the promotion of active living with environmental concerns in its cycling initiative. As part of the city’s transportation plan, a project of national importance was started with the support of the Ministry of Environment and the Directorate of Public Roads:

Sandnes will be the ‘Bicycle Town’ of Norway. The project will develop cycling in Sandnes as an alternative to motor vehicles. In Sandnes there are many separate pedestrian and cycle paths, but they are not linked together. The main object is to make the existing roads continuous by building new roads and linking them together.

By promoting cycling as opposed to car use, the project is both encouraging people to travel in a more active way and alerting them to the great harm motor vehicles cause the environment. Further, the project means to prepare the city for the change by adapting conditions to meet the requirements of cyclists. In this way it is hoped that Sandnes will become “a more cycle-friendly city with a conscious cycling culture”.

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<th>Target 16.</th>
<th>Healthy living</th>
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<td>Active living</td>
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<td>S</td>
<td>Transport plan</td>
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<td>O</td>
<td>Improved urban environment</td>
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Cultural diversity

A healthy city is a place of cultural diversity where different ethnic groups can peaceably coexist. In Jerusalem, the means to reach this ideal are being developed through a network of decentralized neighbourhood centres that stimulate local democratic action. This development is led by an umbrella group that cooperates closely with the city project, illustrating the fact that the healthy city is built on partnerships – of values, peoples and organizations. This final case study is a reminder that, even in the biggest cities, neighbourhoods form the basis for community action.

Case study 49. Jerusalem Association for Community Councils and Centres

In the past two decades, Jerusalem has undergone a period of startling growth. It has become a cosmopolitan city that has expanded in all directions to accommodate an enormously increased population. The form of government that has developed in Israel is a centralized system responsible for providing a network of services dealing with virtually all aspects of life. With the exception of the mayor, municipal representatives – like their counterparts on the national level – are elected on the basis of party alone and not geographic districts. The municipality of Jerusalem has made a commitment to build a culturally pluralistic city that aims to foster the unique potential of its population. The Jerusalem Association for Community Councils and Centres is working to achieve this aim.

The Association is an umbrella organization of neighbourhood centres throughout Jerusalem. Its purpose is to strengthen Jerusalem's neighbourhoods by encouraging resident participation in improving the quality of life. Thirty centres in both Jewish and Arab neighbourhoods, encompassing over 50% of the city's residents, provide a wide variety of cultural, recreational, and social activities to meet each neighbourhood's needs and concerns.

The Association, which is affiliated with the municipality of Jerusalem and the Israel Community Centres Association, operates as a nonprofit organization. It is chaired by the mayor and includes representatives of the centres, their parent bodies and the Joint Distribution Committee – Israel.
Grass-roots approach to neighbourhood needs
Jerusalem is populated by a kaleidoscopic mix of people. Outward expressions of identity, such as language, mode of dress and mannerisms, reflect radically different lifestyles, values and world views, and deeply rooted religious and cultural traditions. The centralized bureaucracy of a large municipal system like Jerusalem's cannot, try as it might, adequately meet the needs of a growing, highly heterogeneous society.

The emergence of neighbourhood centres administered by local residents gave rise to a policy of municipal decentralization and neighbourhood self-management. This policy, advocated by the Association, has begun to streamline service delivery in Jerusalem and transform the city into a model for democracy that is being emulated. The five major areas of activity are as follows:

- providing neighbourhood centres with consultation in community development and professional training in specialized areas (pre-school children, youth, the elderly and urban planning);
- strengthening local democracy by conducting and supervising neighbourhood council elections and involving residents in the decision-making process;
- lobbying for the decentralization of municipal services where appropriate, through dialogue with the municipality;
- raising funds for neighbourhood programmes and allocating funds in accordance with professional guidelines; and
- serving as a coordinating body between leaders at the grass-roots level and the municipality.

Guidelines for action
The neighbourhood centres are legally autonomous entities, authorized by the municipality to make decisions on behalf of their neighbourhoods. Non-partisan neighbourhood councils are democratically elected according to geographic districts within the neighbourhood. The council representatives are accountable to the residents. The centres operate in full cooperation with the municipal and national authorities to eliminate duplication and waste. The centres work in close cooperation with the Healthy Cities project on various programmes and activities. Both directors of the Association are members respectively of the steering and planning committees of the Healthy Cities project.
Challenges for the future

Even in 1994, some neighbourhoods in Jerusalem still do not have centres. Target neighbourhoods for new centres include former Project Renewal communities, Arab and Orthodox neighbourhoods.

To promote democracy and neighbourhood elections, the Jerusalem Association will hold elections in most neighbourhoods of the city within the next few years. In principle, elections are held once every three years in each neighbourhood.

In conjunction with the Hebrew University, the Jerusalem Association conducts a yearly course on community administration to enhance the skills of neighbourhood leaders and senior professionals.

Jerusalem’s very diversity makes it a model for potential coexistence. The Association has sponsored a variety of programmes to reduce friction and foster coexistence among its different groups.

Tens of thousands of recent immigrants, particularly from the former USSR, have settled in Jerusalem’s neighbourhoods. The Jerusalem Association plays a central role in easing their transition into society by assisting in their economic and social absorption in the community. The Association also supports special projects designed for such population groups as young children, youth at risk, the elderly and women.
Target 2. Health and quality of life

! Integration
S Decentralization
O Public participation/Community action

**Know-how point**

*how to realize the vision of a healthy city*

Healthy cities do not develop overnight, but policies and programmes can be changed through awareness of the opportunities in urban environments to increase choice and to improve quality of life. Practical developments in urban policies, social programmes, health services and self-help initiatives can help to bring about improvements to the physical and social environment of a city.
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