THE HEALTHY CITIES MOVEMENT

WORKING PAPER FOR THE LANCET COMMISSION ON HEALTHY CITIES

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1. Introduction

This paper has been prepared for the Commission on Healthy Cities in order to provide a brief overview of the Healthy Cities movement and to offer some questions for the Commission to consider in taking forward its future work. The paper considers the ideas behind the Healthy Cities movement, its origins and development, evaluation and critiques of the movement. It focuses largely on the World Health Organization initiatives, rather than the many other independent and self-declared healthy cities and network. It touches briefly on contextual issues such as health promotion, the so-called new public health and the Commission on Social Determinants of Health, but does not consider these in detail.

The four questions suggested for consideration by the Commission in light of the analysis presented are:

a) Do the ideas and approach of the Healthy Cities movement offer any focus for the Commission's work?

b) Do the recent developments within the Healthy Cities movement suggest a direction for future policy development, and if so, would the Commission wish to align itself with this?

c) Is there a potential role for the Commission in developing the evidence base for the Healthy Cities approach, this being a weak area for the movement thus far?

d) Is there a potential role for the Commission in responding to the critique that a more substantial engagement is needed with social and political theory and a stronger theoretical framework for Healthy Cities?

2. Ideas behind the Healthy Cities movement

In order to explore the ideas behind the Healthy Cities movement, it is useful to consider in turn each aspect of a commonly used definition of a healthy city:

'a healthy city is one that is continually creating and improving those physical and social environments and strengthening those community resources which enable people to mutually support each other in performing all the functions of life and achieving their maximum potential' (Hancock and Duhl, 1986, cited in Hancock, 1993, p.7).

Firstly then, the Healthy Cities movement takes the city as a key site for action on health, providing an opportunity to realize significant health gains for populations and a

'good setting' for action on health (Kenzer, 1999, p.201). While this embraces community action and involvement at all levels, the political commitment of local governments is considered critical (Hancock, 1993) and is often presented against previous achievements in sanitation and public health in Western Europe in the 19th and 20th centuries (*ibid*). These aspects should also be seen in the context of wider trends towards urban governance and decentralization evident in other international programmes and agreements such as Local Agenda 21 and the United Nations Conference on Human Settlements, of which van Naerssen and Barten (2002) provide a helpful overview.

The city itself is seen from an ecological perspective, providing the context (or 'habitat') for health and functioning as a networked system dependent upon the proper functioning of its parts and connections (Ashton *et al*, 1986; Duhl, 1986). Thus the city's ability to 'cope with breakdowns' and 'modify itself and change to meet the always emerging, changing requirements for life' is crucial (Duhl, 1986, p.55). This is linked to a focus on *process* rather than *outcomes* (Hancock, 1993): a healthy city is one which is continually 'creating and improving', rather than achieving specific health outcomes.

Within the Healthy Cities movement, health is conceived as a resource for living, stretching beyond the absence of ill-health in medical terms to include quality of life and general well-being (see, for example, Kickbusch, 2007). Against this approach, 'health is a multi-disciplinary phenomenon: we must being to look at everything that impinges on the human being' (Duhl, 2005, p.358). Thus, the healthy city focuses on the environmental and social determinants of health, and progresses inter-sectoral interventions for health. This can be seen as part of a wider move towards a 'broad new understanding of public health', in which 'the orientation of health promotion began to shift from focusing on the modification of individual risk factors or risk behaviours to addressing the "context and meaning" of health actions and the determinants that keep people healthy' (Kickbusch, 2003, p.383). In Healthy Cities, '*health* development [is placed] as central to urban policy development' (van Naerssen and Barten, 2002, p.10), integrated with other urban policies and programmes.

The Healthy Cities approach includes a strong focus on empowerment and participation, being concerned with individuals' ability and autonomy to live a healthy life (Kenzer, 1999). This approach is seen to benefit health by ensuring expert or professional knowledges are not privileged over community knowledges (thus improving decision making), and empowering individuals (thus improving the context for health through the process itself) (Duhl, 2005). Again, this can be seen against the wider trends towards participatory governance inherent within many international and other programmes (see, for example, van Naerssen and Barten, 2002)

These ideas have been brought together by de Leeuw (2009) in a Healthy Cities 'meta-theory' in a helpful diagrammatic conceptualisation (Figure 1).
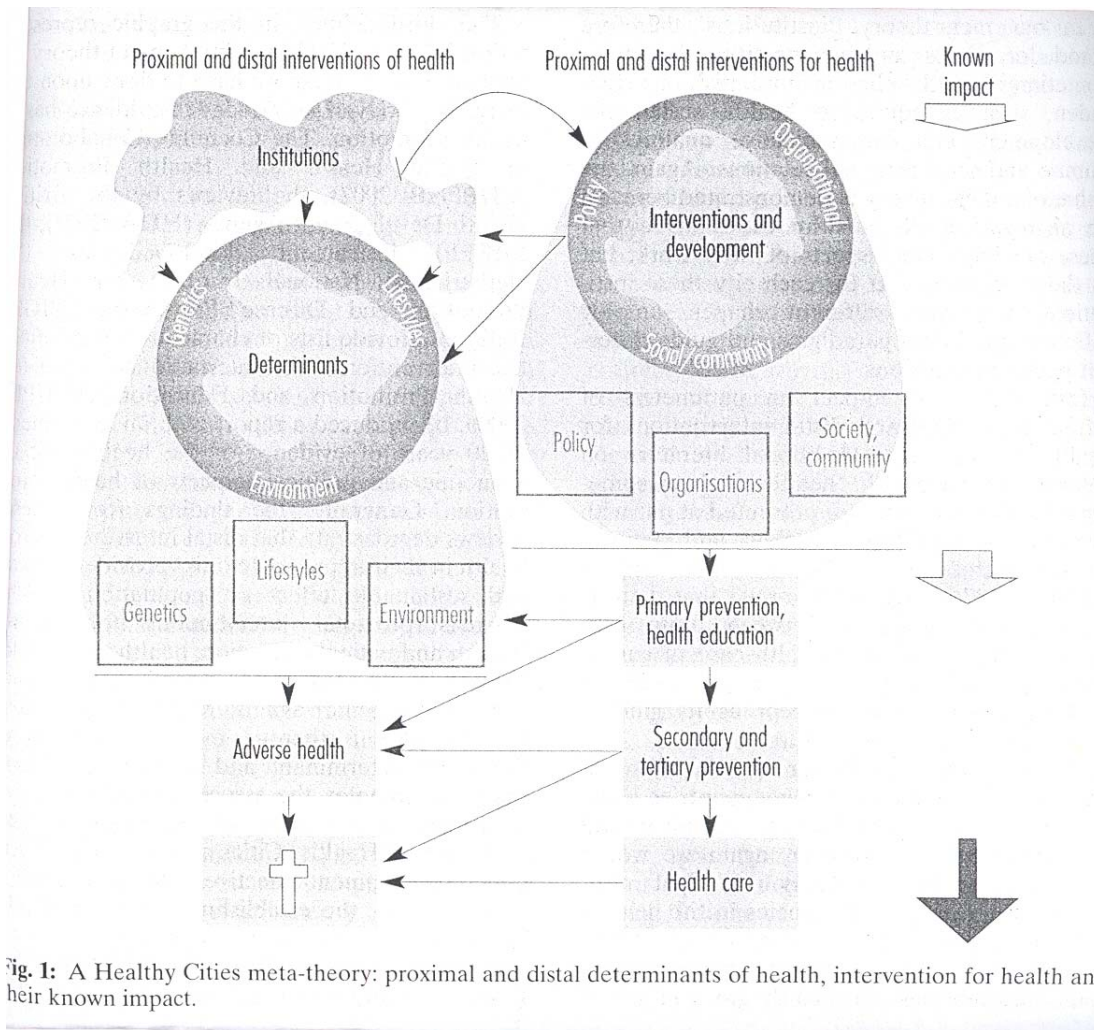
Fig. 1: A Healthy Cities meta-theory: proximal and distal determinants of health, intervention for health and their known impact.

Source: de Leeuw, 2009, p.i23.

The nature of the Healthy Cities movement means that specific policies are not prescribed or advocated – the movement emphasizes process and local context over particular activities (Werna *et al*, 1999). However, project reviews provide case studies which can provide an indication of the sorts of activities underway; a short selection is provided below drawn from a 1994 review of initiatives (WHO Regional Office for Europe, 1994):

- Strategic activities e.g. development of health information systems;
- Targeting specific groups for health equity strategies e.g. development of women's health centres, provision of health information for recently arrived migrants;
- Targeting health in specific settings e.g., health education in schools, campaigns on alcohol in the workplace, healthy food in hospitals; and

- Partnerships and participatory approaches e.g. inter-sectoral approaches to tackling child abuse, involvement of children in city health planning processes, promotion of self-help and autonomy in health.

While these ideas have a history of some 20-30 years (see Section 3), it is worth noting their similarity to those of a recent and influential report from the Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health* (2008). These include, for example:

- A framework which acknowledges the role 'conditions of daily life' - and thus the urban setting - have in determining health outcomes (p.1);
- An emphasis on an inter-sectoral approach to health (p.1), and institutional change (p.22) in order to tackle the urban health problems of today;
- The case for health being placed at the heart of urban governance and planning (p.3);
- The need for health to rise much higher up the political agenda (p.11); and
- The importance of participation and empowerment for action on health (p.18).

3. The origins of the Healthy Cities movement

The Healthy Cities movement originated in Toronto, Canada, in 1984, with the conference entitled *Beyond Health Care*. This was driven by 'the growing awareness of the need for "healthy public policy" initiatives as compared with the tendency toward victim-blaming lifestyle approaches to health promotion' (Ashton *et al*, 1986, p.319) and the realization that new risks posed to health by the urban environment, such as violence and accidents, were not being adequately addressed (Kenzer, 1999). Trevor Hancock and Leonard Duhl were key figures in setting this up. Ilona Kickbusch, the World Health Organization (WHO) European Regional Officer for Health Promotion, attended the Toronto conference, following which she convened a group to discuss a European Healthy Cities project the same year (Hancock, 1993).
Two years later, the Ottawa Charter on Health Promotion was adopted, subtitled *the move towards a new public health* (Kickbusch, 2007), and the WHO held the first Healthy Cities symposium in Lisbon, Portugal to launch the European Healthy Cities Project (Tsouros, 1990). The role of the WHO was to act 'as a catalyst and facilitator in the process of agenda setting, consciousness raising and establishing models of good practice'; the project was seen as a test bed for the theoretical ideas of the new public health movement and a part of efforts to revive public health advocacy (Ashton *et al*, 1986, p.321). The project proved extremely popular, expanding from 11 formally designated cities to some 35 within the first five years of the project (Hancock, 1993).

The WHO European Healthy Cities Project has been run from the start in five-year phases, at the start of which each city is required to make a number of commitments and to make a small financial contribution to the running of the central project by the WHO. From the start, experimentation and variety were expected and encouraged from participating cities (Ashton *et al*, 1986). Phase I focused on 'creating new structures to act as change agents and introducing new ways of working for health in cities' (WHO Regional Office for Europe, 1997, p.4), rather than specifying specific actions or monitoring frameworks (Tsouros, 1990). Instead, annual project conferences and themes provided focus, which included health inequalities, community participation and reorienting health services / public health (*ibid*). In comparison, Phase II (1993 – 1997) 'was more action-oriented, with a strong emphasis on healthy public policy and comprehensive city health planning' (WHO Regional Office for Europe, 1997, p.4).

In addition to running the European Healthy Cities Project, the WHO also supported projects in North America, although many other projects were also initiated independently from it. These cities and networks of cities, supported and encouraged by the WHO, began to form alliances with cities all over the world (Kenzer, 1999). In 1991, WHO selected a small number of cities in the global South to help to spread the initiative more widely, including Accra, Johannesburg and Sao Paolo, followed by a larger second phase in 1995 (van Naerssen and Barten, 2002). By this time, there were over 1000 Healthy Cities established globally, covering every WHO region, although these were still overwhelmingly concentrated in Europe and, to a lesser extent, North America (Flynn, 1996, p.302).

4. The development of the Healthy Cities movement

Phase III of the European Healthy Cities Project (1998 – 2002) brought cities which had been developing healthy cities outside of its scope within it (WHO Regional Office for Europe, 1997), as well as a greater emphasis on cities meeting a fixed set of criteria and delivering a programme of action in line with the project scope. Four conditions had to be met prior to the beginning of the new Phase, including demonstration of political commitment, production of a city health plan and profile, project infrastructure in place and commitment to networking. Particular emphasis was placed on the city health plan and on cities developing a systematic approach to monitoring and evaluation, with action on health to be focused on the three themes of reducing health inequalities, promotion of social development and commitment to sustainable development.

Phase IV (2003 – 2007) continued in the same vein, expanding to 70 cities and with new themes of healthy urban planning, health impact assessment and healthy ageing (WHO Regional Office for Europe, 2003). Emphasis was placed on need for the city health development plan to be based on partnership working and inter-sectoral action, encouraging urban planners to integrate health within their plans and applying health

impact assessment processes to city policies, programmes and projects. The WHO itself focused on strengthening the Network supporting individual cities,

We are currently mid-way through Phase V of the project (2008 – 2012), which makes strong links to the recent report by the Commission on Social Determinants of Health (2008; discussed in Section 2). Thus, the overarching theme for Phase V is 'health and health equity in all local policies', supported by three core themes: caring and supporting environments; healthy living; and healthy urban environments and design (WHO Regional Office for Europe, 2009, p.2). A further expansion to 100 designated cities is planned.

While WHO is active in all world regions, it is clear that the Healthy Cities project remains strongest in Europe. According to a WHO review of 2003, the Healthy Cities projects in the Eastern Mediterranean, Americas and Western Pacific regions are developing fairly strongly, while those in Africa and South East Asia are still struggling or making slow progress (WHO Regional Office for Europe, 2003). In Africa, the Healthy Cities model is seen to have only partly been implemented, due to a lack of formal networks, lack of priority given to issues of environment and health, insufficient resources, expectation of or reliance on foreign support, and other factors. In South East Asia, slow progress has been attributed to a lack of understanding of key concepts and of coordinated urban infrastructure to support the process, although this is now being addressed. In the Americas, strong and often self-declared Healthy Cities and networks exist in Canada and the United States, linked to the projects origins in the region, and a strong *Healthy Municipalities* movement exists in Latin America. In South East Asia, Australia, New Zealand and Japan embarked on projects in the late 1980s, while more recently Malaysia has played a 'pioneering and leadership role' (*ibid*, p.12). In the Eastern Mediterranean region, it seems the Healthy Cities concept has been well received and is spreading throughout the region, despite the challenges of high population growth, associated environmental problems and limited resources and capacities.

Finally, it is worth noting that the theme of World Health Day 2010 is *1000 Cities 1000 Lives*, encouraging cities to open up their streets to healthy activities for people during 7 – 10 April 2010 (see, for example, WHO, 2010).

5. Evaluation of the Healthy Cities movement

WHO's evaluations of the European Healthy Cities Project have focused on the scale and reach of the movement, the extent to which participating cities have delivered on project requirements and assessments of process and institutional change in urban health. The primary purpose of these evaluations has to build and disseminate a knowledge base of use to cities (WHO Regional Office for Europe, 2008). So, for

example, the mid-term review of Phase I identified the project's main successes as its attractiveness to a wide range of groups and interests, the practical knowledge it was developing, the new organizational models and strategies it was trialing and the political declarations of support it had attracted (Tsouros, 1990). At a city level, the factors that appeared to support successful project implementation were identified, and included:

> 'strong political support, effective leadership, broad community control, high visibility, strategic orientation, adequate and appropriate resources, sound project administration, effective committees, strong community participation, cooperation between sectors, and political and managerial accountability' (Tsouros, 1990, cited in Hancock, 1993, p.10).

In a recent assessment of Phase III in relation to health equity and the social determinants of health, Ritsatakis suggests that 'there has been an undeniable shift from rhetoric to action in at least half the cities in the WHO European Healthy Cities Network, bringing the value of equity in health firmly into the planning process' but that 'few cities have shifted from support for vulnerable groups to upstream action to tackle the intermediate determinants of health' (2009, p.i88). So, for example, cities tended to focus on actions such as improved access to care or lifestyle-oriented interventions, rather than tackling poverty, unemployment or housing. The evaluation of Phase IV provides an analysis of the self-assessments of project cities against key project requirements and approaches (WHO Regional Office for Europe, 2008). A brief summary of key findings is set out below.

- 94% of cities have agreed on partnership working and 76% are implementing collaborative plans, projects or programmes, and engagement involves a wider range of sectors than in previous project Phases (p.7).
- Most cities have produced a city health profile and city health development plan (pp.9 - 12), which is considered to be helpful in setting priorities and bringing relevant actors together.
- Nearly all cities have produced a healthy ageing profile (p.19).
- 30% of cities undertook a health impact assessment, and 15% mainstreamed this in their local administration (p.17).
- A range of different strategies for engaging and empowering communities were used by cities (pp.12-13).
- 71% of cities said health is 'very important' for cities, and 19% 'moderately important', with 19% suggesting the Healthy City project had a strategic role in raising health up the political agenda (p.15).

The Phase IV evaluation also examined how successfully cities had been in integrating health and urban planning. More cities have understood the links between health and planning as the project has progressed, such that two thirds of project coordinators now report that they are 'actively involved with urban planners and influential in shaping

planning programmes' (WHO Regional Office for Europe, 2008, p.20). However, not all cities integrated health and planning at all levels: the evaluation suggests that cities new to the project, mainly in Eastern Europe 'still operate at a basic level, concerned with the essential life-support role of settlements: providing shelter, access to food and clean water, fresh air and effective sewerage treatment' (*ibid*). Most cities, on the other hand, have achieved the second level of integration, 'for example, implementing cycling networks, removing physical barriers to walkability and inserting new parks into dense cities, all encouraging health-enhancing physical activity and social cohesion' (*ibid*). It is the third level of integration – 'a holistic approach in which health is fully integrated into the urban planning system', in which, for example, housing and transport etc. are also understood to affect health inequalities – which most cities are still found to struggle with (*ibid*).

There is also a fairly large literature evaluating and assessing individual cities or networks, which can provide a deeper but narrower consideration and a different perspective. Goumans and Springett's analysis of 10 cities in the United Kingdom and the Netherlands in 1993 and 1994 suggested that ' "Healthy Cities" is asking for a radical change and this change is only beginning to happen in a few places' and that 'health, as opposed to health care, still does not have solid place on the political agenda' (1997, p.321). While this does not necessarily pose a major challenge to the WHO's position, as the long-tern nature of the project has been stressed from the start, the suggestion by a few cities that the project had become 'a convenient label' with which to dress old policies as new is perhaps significant (p.319). However, this was not a majority view, and most cities felt the project to have had a facilitative value through bringing a wider range of actors together (*ibid*).

Another study by Boonekamp *et al* examines 13 cities within the Valencian Community Healthy Cities Network, largely through in-depth interviews with project coordinators, and finds a wide variety of practices and situations (1999). The authors highlight some of the difficulties involved in developing a city health plan, including the knowledge and skills required of coordinators and the need to obtain political involvement and support. The key deficiency they highlight is the lack of community participation, and the longer-term implications of this for the sustainability of the projects, in that they are likely to be vulnerable to political changes. Many more case studies could be considered; de Leeuw and Skovgaard (2005) provide a useful review of the evidence in the European context in relation to political commitment and institutional change. They suggest that a reasonable conclusion to draw from this evidence is that 'political considerations *lead to* participation in the Healthy Cities Project, whereas participation in the Project does *not lead to* shifts in political considerations and subsequent policy-making' (p.1336) and that 'implementing these intersectoral policies has proved more difficult than anticipated' (p.1337).

The first evaluation of Healthy Cities projects in the developing world considered four cities within the first group of projects supported by the WHO: Cox's Bazaar

(Bangladesh), Dar es Salaam (Tanzania), Quetta (Pakistan) and Fayoum (Egypt). The authors found that:

> 'political mobilization was weak compared with the vision of the WHO (WHO, 1995), probably because most of the cities did not request the projects. Levels of community participation varied across the projects and reflected resources available for community-based projects and previous experiences of community participation in the different cities. In relation to preparing and implementing the municipal health plan, the lack of needs assessments, other baseline data and the limited capacity of coordinators meant that by and large such plans did not exist' (Harpham *et al*, 2001, p.123).

More positively, however, evidence was found of increased understanding of environment - health links and the importance of community participation and successful inter-sectoral working (p.124). Werna and Harpham (1996) argue that the Healthy Cities project, having been conceived in the context of industrialized cities and transferred to the global South based on their experiences, needed to be adapted to the developing country context. Using a case study of Chittagong, Bangladesh, they identify the key constraints which should be considered as:

- more traditional bureaucratic arrangement of public authorities which are unused to inter-sectoral working and which can be highly constrained by national policy;
- the dynamic of the international aid context, including potentially overlapping and duplicative projects; and
- a lesser organizational capacity amongst community actors and project coordinators.

In an earlier article based on the same case study, the authors argue that the Healthy City project thus has an important role to play in developing the institutional capacities of local public bodies and communities (Werna and Harpham, 1995).

6. Critiques of the Healthy Cities movement

Critiques of the Healthy Cities movement have evolved around the issues of evidence, status and theoretical framework, which will be surmised in turn in this Section. On evidence, a debate has been long-running since the project's conception on the nature and purpose of evidence and indicators of success. The WHO's position has been that Healthy Cities is a long-term project which will take some 10 years between initiation and any significant change in health outcomes in any city (WHO Europe, 2008). Thus, in the early years of a project, it is recommended that evaluations focus on processes, rather than outcomes (see, for example, Werna and Harpham, 1995). Given the

project's focus on institutional change, even in later stages of projects, process indicators are also preferred (*ibid*).

Other actors have called for evaluation of the projects' actual *impact* on health outcomes in the city. Most recently, the Commission on Social Determinants on Health has added its voice to these calls saying, 'It is important that researchers and government evaluate, where possible, the health equity impacts of Healthy Cities/Settings type programmes, formal or otherwise, in order to build evidence for relevant and effective local government actions' (2008, p.63). While the importance of gathering evidence on outcomes has in fact long been acknowledged by key figures in this movement (see, for example, Tsouros, 1990, p.41-2, or Hancock, 1993, p.15), the current focus on this has been considered by de Leeuw to be part of 'an overwhelming urge to produce evidence for the full range of health promotion and public health interventions, including Healthy Cities' (2009, p.i20). There thus is currently an overwhelming sense that the movement must produce evidence of its effect on health and health inequality if it is to remain credible, even in spite of reflections that the Healthy Cities initiative and the Ottawa Charter on Health Promotion which spawned it were ahead of their time in promoting the ideas which are now emerging again in the work of the Commission on Social Determinants of Health (see, for example, Kickbusch, 2007).

The academic literature is insightful in exposing some of the more theoretical and technical debates behind this issue. Firstly, from the start, the project emphasized the importance of local context and prescribed few specific actions, generating a wide variety of responses which, especially combined with little formal monitoring in early stages, posing some challenges to systematic evaluation (de Leeuw, 2009). O'Neill and Simard (2006) unpack the choices lying behind evaluation, such as why to evaluate Healthy Cities, what should be evaluated, for whom, by whom and how, and suggests that these are infact political choices. De Leeuw and Skovgaard (2005) have argued strongly for a 'utility-based' approach to Healthy Cities evaluation, where methods are shaped by the purpose of the evaluation – namely, to assist in decision-making. In a later article, de Leeuw discusses how attempts to increase the monitoring requirements on project cities lead to poor rates of return and poor quality returns, suggesting the process had become onerous and irrelevant for cities (2009). She argues in a piece with Stovgaard that sufficient evidence does exist to suggest that the Healthy Cities approach works, and brings together research which supports different aspects of it, but also acknowledges that 'we have not been able to establish unequivocal proof that would contribute to informed decision-making in urban health' (2005, p.1339). They attribute this to the complexity of the project approach and of the urban context (making randomized controlled trials impossible) and an underdeveloped theoretical framework (which it is suggested 'it is high time for *academia* to deliver' (p.1339)).

This final point can be seen to be connected to a much earlier criticism, most influentially by Petersen (1996), who has argued that the movement has not engaged

sufficiently with social and political theory. He focuses on the use of terms such as community participation, inter-sectoral working and healthy public policy with 'little concerted effort to critically assess the assumptions that underlie such core principles and strategies … or to question established processes for achieving defined health promotion goals' (1996, p.158). On community participation, he questions the assumption that greater local control will lead to greater equity, highlights the existence of non-place based forms of identity such as sexuality and ethnicity and the possibility that 'the community can be a site for exclusion and the suppression of internal differences' (Payne, 1994, cited in Petersen, 1996, p.162), and reminds us of the 'increasing commodification of place' (p.162).

On a separate note, Stevenson and Burk have argued that the debate over evidence and indicators stems from the contradictory nature of the project in being a social movement for community-led action driven largely by an international, expert-led institution (1991). Petersen (1996) makes a similar (but more critical) argument, suggesting that the Healthy Cities movement is a modernist project, not a social movement, driven by the bureaucratic rationalism and technical and expert privilege of the WHO. Other authors have identified this tension; Baum, for example, suggests that as the Healthy Cities movement is attempting to achieve radical institutional change from *within* existing institutions, it might be more effective if it were to be positioned outside of existing institutions, despite the loss of access and resources this would be likely to involve (1993).

7. Suggested issues for the Commission to consider

a) Do the ideas and approach of the Healthy Cities movement offer any suggestions for the Committee's focus?

b) Do the recent developments within the Healthy Cities movement suggest a future policy and is this one which the Committee might want to support?

c) Is there a potential role for the Committee in developing the evidence base for the Healthy Cities approach?

d) Is there a potential role for the Committee in responding to the critique that a more substantial engagement is needed with social and political theory and a stronger theoretical framework for Healthy Cities?

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