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Building Civic Health

The health care system has less impact on public health than do patients' lifestyle choices at home, work, and in the broader community. Ample research has shown that people live longer and healthier lives if they eat well, live in decent housing, work at a job, enjoy safety from violence, avoid illegal drugs and excessive alcohol use, have access to basic medicines, and can turn to friends and family. This is the basic tenet underlying the "Healthy Cities" movement, a worldwide initiative that promotes quality-of-life factors that can help a community of any size improve its social, physical, and cultural environment. Public health advocates say that this improvement can, in turn, lead to a healthier population.

The international Healthy Cities movement was first conceived during a 1984 meeting to explore the concept of public health policy, when Trevor Hancock, a physician and member of the City of Toronto Public Health Department, and Len Duhl, a psychiatrist teaching urban development and public health at the University of California, Berkeley, proposed a model of a “healthy community.”

Healthy Cities reflects a paradigm shift in the field of health and urban studies. “Medicine only deals with the ill,” Duhl recalls saying at the conference. “But health really involves schools, employment, environment, and everything else.” Thus, he says, the active participation of all sectors of a community, as well as its residents, is essential. “Unless people participate in the solution, it won’t work,” says Duhl, who now heads the Berkeley-based International Healthy Cities Foundation, which links people, organizations, and networks that advance Healthy Cities goals. Most important, he says, is that communities have tremendous assets that are unused; money is secondary to social and community skills.

Healthy Cities aims to place health concerns uppermost on the agendas of decision makers, build strong local lobbies for public health, and encourage holistic public sector approaches to dealing with health issues. Although the movement is fairly new, the concepts behind it are based on traditional social services of community development and helping the poor. In a nutshell, the movement is about helping people take charge of their own health and build connections within their own communities—improving the health of urban dwellers through improved living conditions and better health services.

Spreading across the Globe

The 1984 Toronto conference inspired the World Health Organization (WHO) Regional Office for Europe to initiate the Healthy Cities Project in 1986. The WHO European office, which initially aimed for full-scale Healthy Cities efforts in 25 European cities, now has 49 municipalities under the banner of the official European WHO Healthy Cities Network. These 49 urban centers serve as the core of Healthy Cities networks comprising approximately 1,500 municipalities throughout Europe.

But the Healthy Cities movement has moved far beyond the official European network. Indeed, most of the Healthy

Cities programs worldwide are outside the WHO program’s purview. Since the late 1980s, the WHO global office, the International Healthy Cities Foundation, individuals, cities, and other organizations have disseminated the movement’s principles around the world. In seminars and workshops, hundreds of communities beyond Europe are learning how to begin the process.

In recent years, several networks in Latin America have received technical support from the Pan American Health Organization. The movement is now growing most rapidly in Latin America, where the Pan American Health Organization is still serving as a stimulant to countries setting up programs.

“It’s spread like wildfire to every continent except Antarctica,” says Duhl. By the year 2000, researchers had counted more than 4,000 communities that had joined in; that figure is now up to 8,000, says Duhl.

The smallest Healthy City is Saint-Antoine de l’Isle-aux-Grues (population 200) in the St. Lawrence River of Canada, and the largest is Shanghai (population 15 million). Large or small, each community generally follows the same process: “You get everybody around the table and have active participation,” says Duhl. A group of local organizers, aided by an outside facilitator, chooses representatives from all segments of the community: business, government, the media, the voluntary sector, faith groups, labor unions, residents, environmental organizations, and others.

The community group then holds “vision workshops” in which the representatives discuss questions such as “What kind of city do you really want?” and “What would make this a healthier place?” The discussion might center on problems in housing, the environment, jobs, or transportation. The goal, says Duhl, is to establish points of commonality and build on those. The organizers help facilitate discussion of what people can do to improve the local situation.

Just the act of getting involved and being organized confers health benefits upon a community’s residents, says Hancock, who is now a private consultant in developing core programs in public health; research shows that people who feel connected to others tend to have healthier lives. He says, “We have found that, in general, when members of a community engage in fixing the area’s problems—let’s say hunger or pollution or substandard housing—it is good for their health.”

How It Works

In most of the European region, the WHO facilitates Healthy Cities programs through municipal governments. Participants in the official WHO Healthy Cities program must meet rigorous entry requirements. For example, cities must demonstrate that they have municipal political support for the Healthy Cities principles, a city health plan, and the basic structures to deliver the project—a full-time project coordinator, administrative and technical support, and a steering group for the project. Cities must also provide a statement of current networking activities, along with an outline of how they would like to contribute to national and European networks.

Official Healthy Cities also must become members of their respective national networks. Every WHO Healthy City and every national network has a formal linkage to the WHO Regional Office for Europe in Copenhagen. For example, Copenhagen itself is a WHO-designated Healthy City as well as a member of the Danish Healthy Cities National Network. Each WHO-designated Healthy City provides information and leadership to its national network. Many European programs exist outside of the WHO structure, although they use the same general principles. They interact and learn in an informal manner through meetings worldwide.

The WHO program works in five-year phases of implementation. The first three phases focused on establishing an urban health profile for each participating city, creating comprehensive and integrated city health plans, and developing internal and external monitoring procedures. The WHO is pausing before initiating the fourth phase; it must renegotiate with the cities what are called “terms of reference”—the visions, goals, and objectives—for the next phase. Plus, the coordinating team within the WHO is very small, and they want to make sure they can provide cities with the necessary support before a next phase is announced. Poverty and good urban governance have emerged as priority issues for the next phase.

Some cities focus across each phase on establishing policy, such as fine-tuning health plans and strategies across various city departments. Other cities use a bottom-up approach, working more directly with disadvantaged groups.

For each five-year project phase, one WHO Healthy City might report a few hundred separate activities undertaken with disadvantaged groups, says

Evelyn de Leeuw, a professor of public health at the University of Southern Denmark, former director of the now-discontinued WHO Collaborating Centre for Research on Healthy Cities in Maastricht, the Netherlands, and a consultant to the WHO. Meanwhile, another city might report only a half-dozen activities, though the latter community might “work more strategically,” she says, “trying to include health considerations into the work of other city departments.”

Communities in the United States have also adopted Healthy Cities principles in an initiative known as Healthy Cities and Communities. The fundamental principles of the U.S. movement “were in great part inspired by the WHO Healthy Cities,” says Tyler Norris, president and CEO of Community Initiatives, a consulting service for communities and health care organizations based in Boulder, Colorado. Norris is also a former program director of the Denver, Colorado-based National Civic League, an advocacy organization that promotes citizen involvement in local governance.

In 1989, the U.S. Department of Health and Human Services asked the National Civic League to help launch a nationwide Healthy Cities effort in the United States, not just as a medical or public health program alone, but also as an urban improvement program. Both the Centers for Disease Control and Prevention and the W.K. Kellogg Foundation have supported various projects within this effort. The WHO does not evaluate state, local, or national networks of Healthy Cities and Communities in the United States.

In the United States, the movement does not follow the WHO Healthy Cities municipal government model. Instead, much of the U.S. Healthy Cities and Communities initiative was developed outside of city governments, as part of local or statewide programs. And the addition of the words *and Communities* was important. “At that point, we recognized that a city, per se, was not the only unit of problem solving that made the most sense,” says Norris. “We also realized that government plays a different [less centralized] role in U.S. society than it does in European communities.” Therefore, U.S. programs were driven by multisector cooperation among hospitals, state health departments, and various nongovernmental organizations such as charities and chambers of commerce, says Norris.

Healthy Cities at Work

The city of Gothenburg, Sweden, has been among the most active of the European Healthy Cities in directly reaching the disadvantaged, says de Leeuw. Gothenburg focuses on courses for citizens in smoking cessation, eating a healthy diet, and alcoholism prevention. The city also provides courses for professionals, particularly teachers, in preventing alcohol abuse in children and teenagers, curbing child accidents, and alleviating asthma and allergy problems among children.

In Glasgow, Scotland, one facet of the city’s Healthy City Partnership focuses on health challenges at the very beginning of life. The program’s Starting Well Health Demonstration Project teams, serving more than 1,000 Glasgow families, provide an intensive home visiting service to all families with newborns in two target areas of socioeconomic deprivation, according to Valerie Millar, development officer of the project. This project uses the Positive Parenting Program (<http://www.triplep.net/>) developed at the University of Queensland, Australia, to boost parents’ self-esteem, with the aim of preventing emotional and developmental problems in their children. Members of the teams include specialists in health support and child care, as well as bilingual workers when needed. Together, the families and home visitors commit to goals defined by the family members, and create meaningful activities that will help the family reach its goals.

In the United States, the Healthy Cities and Communities model is adapted differently in various places. A group of nurses, for example, started a Healthy Cities program at Indiana University. Later, it developed into the first—and only—U.S. WHO collaborating research center. The Indiana center serves as a resource to promote the Healthy Cities movement by encouraging, developing, and conducting interdisciplinary research on community health issues and collaborating with communities in identifying solutions to their health concerns. Becoming a WHO collaborating research center requires a lengthy application process and site visits from the WHO.

The Indiana center works with local communities to build leadership skills, says Sharon S. Farley, executive associate dean for academic affairs of the Indiana University School of Nursing (Indianapolis campus) and interim head of the Indiana Healthy Cities program. The center brings residents together to identify issues that affect their health and to

plan interventions to improve their quality of life. “Citizens have a great capacity for solving their own problems,” says Farley. After concerns are identified and specific interventions begin, the center helps community members evaluate the effectiveness of their own actions.

According to Farley, health priorities often differ, depending upon the size or type of community. For instance, in a larger city such as Indianapolis, health concerns focus on crime, school issues, sewage, and other problems, she says. In contrast, smaller communities may target economic development or housing as the main factor affecting community health.

Other state programs have little contact with the WHO. In California, the Center for Civic Partnerships in the state public health institute facilitates the program there. The program, which began in 1988 as the California Healthy Cities Project, initially chose 10 demonstration cities. Over the next several years, 33 additional cities participated. In 1998, 20 more communities joined, including neighborhoods, unincorporated areas, and multijurisdictional regions. With this expansion, the project changed its name to California Healthy Cities and Communities.

Writing in the May/June 2000 issue of *Public Health Reports*, Joan M. Twiss, director of the Center for Civic Partnerships, and colleagues point out that the California program initiated a formal partnership in 1990 with the League of California Cities and Americans for Nonsmokers’ Rights to educate and support municipal officials regarding tobacco control. Before 1990, only one California city had an ordinance banning smoking in restaurants. By 1994, more than 100 cities had banned smoking in restaurants, and almost 90 cities had banned smoking in workplaces. In 1995, state legislation was passed requiring smoke-free workplaces and allowing local governments to establish stronger policies.

Regardless of where they are found and who sponsors them, the fundamental principles behind Healthy Cities around the globe are largely the same. “Ninety percent of what we need in order to generate good health is found outside the health care system,” says Norris. “If you want to improve public health status, it’s not just about improving public health policy—it’s about healthier public policy”—creating policy that eliminates public health threats before they come into being.

John Tibbetts