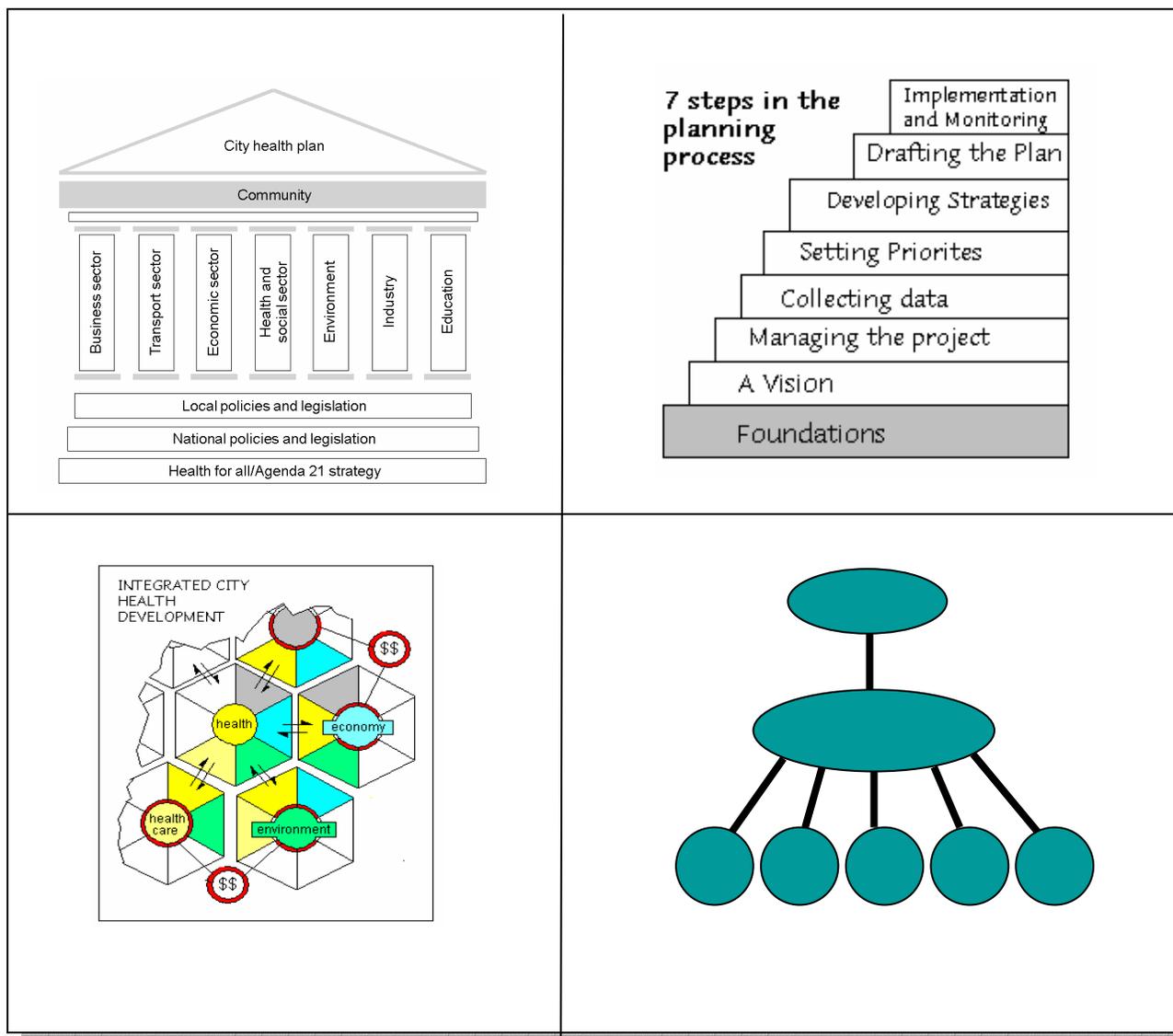


A working tool on

City health development planning

Concept, process, structure, and content



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Introduction

City health development plans are central to phase III of the WHO Healthy Cities project in Europe. Their primary role is to provide cities with a means to build and maintain strategic partnerships for health, and to develop a platform to encourage all sectors to focus their work on health and quality of life. The city health development planning process is therefore the key tool of the healthy city project in working towards the goals and aspirations of phase III.

The purpose of this document is to clarify the concept of the plan, and to provide clear and succinct information on the planning process. It gives guidance on the structure and content of the plan document, and provides case studies describing the approach taken in a number of cities. It includes an annex containing a checklist intended to assist cities during the preparation of their plan documents.

This document draws on a range of materials relevant to the city health development planning process. Selected points of these documents are highlighted, but the reader is referred to the original documents for further details. (Of particular relevance are two key documents published to assist in the production of city health plans in Phase II (1993–1997). These are *City health planning: the framework (1)* and *City planning for health and sustainable development (2)*.) The processes described in these documents remain the basis for integrated health planning at the local level. They address the technical process of local health planning in cities, and give emphasis to issues such as community participation and the relationship to Local Agenda 21 planning. This document builds on these, and emphasizes the aspects that make city health development plans different from their predecessors, city health plans. It is therefore important to read this guidance in conjunction with the previous documents.

This document was presented as a draft working document at a business meeting of the phase-III network of Healthy Cities (1998–2002) in Horsens, Denmark in June 2000. The discussions and comments of participants at that meeting have provided the material for the finalization of this guidance.

City health development plans: answers to key questions

HEALTH21(3) is WHO's strategy for health for all in the twenty-first century in the European region. Its three basic values are:

- health as a fundamental human right;
- equity in health and solidarity in action between and within all countries and their inhabitants; and
- participation and accountability of individuals, groups, institutions and communities for continued health development.

Health development is fundamental to HEALTH21, and the policies and strategies for health for all in the twenty-first century fully reflect this concept. Health development is enshrined in the Jakarta Declaration on Leading Health Promotion into the 21st Century (4). This builds on the Ottawa Charter for Health Promotion (5) by taking health promotion a step further. It recommends a more comprehensive and strategic approach to intersectoral health promotion.

A city health development plan (CHDP) is a HEALTH21-based strategy document that contains a comprehensive picture of a city's concrete and systematic efforts for health development. It contains a city's vision and values, and a strategy to achieve that vision.

Its political purpose is to demonstrate that health is a core value for the city administration, and, further, to demonstrate that the vision, values and strategy are translated into action through operational planning.

A CHDP draws on the contribution of the many different statutory and nonstatutory sectors and agencies, whose policies and activities have an influence on health. It gives expression to a city's partnership for health by emphasizing the role that these actors will take in working to improve health and quality of life in the city, but it is not merely a catalogue of activities. It provides a process and a framework for creating partnerships for health and for healthy public policy-making, and its added value is therefore more than the sum of the contribution of individual partners.

Although the CHDP has evolved from the city health plan (CHP), there are certain important differences. These differences relate to both scope and operational implications. CHPs deal mainly with the control of risk factors and the promotion of healthy lifestyles, while CHDPs put increased emphasis on the determinants of health. There is no clear-cut line between the two types of plans. In theory, an advanced CHP could be indistinguishable from a CHDP. Nevertheless, it is important to stress that the evidence on the determinants of health is much clearer today than it was five or ten years ago, and therefore an increasingly wider range of sectors and actors can be expected to be involved.

In practice, health promotion in its broadest sense is very close to action for health development. This is often a source of confusion, but the latter has a wider scope. In the business sector, health promotion activities might concentrate on a settings-based approach, encouraging companies to promote health in the workplace. Health development goes much further. It means making health a central consideration of economic development strategies, or acting to minimize the negative and maximize the positive health effects of business activities across the city.

The Athens Declaration for Healthy Cities (6) represents a commitment by mayors and senior politicians across Europe to the principles of equity, sustainability, intersectoral cooperation and solidarity to improve health and quality of life. Health development brings the issues of human

development, sustainability and equity much more into focus, and involves recognizing the importance of the social determinants of health (7). Health development is in that sense much more upstream than health promotion. CHDPs are therefore much more upstream than CHPs. This in turn means a wider mobilization of society and the involvement of the economic and social as well as environmental sectors. Health and human development can also deal more naturally with the issue of inequalities, access and opportunities for fulfilling one’s aspirations.

A CHDP is therefore broader in scope than a CHP, reflecting the broader partnership base needed successfully to address all the determinants of health. A CHDP should also be more centrally positioned in the universe of city decision-making and policies. This depends on both the location of the healthy city project in the city administration, and the extent of its partnership base. The ultimate goal is for the Healthy Cities office to be centrally located, and for the Healthy Cities approach to become the mainstream in terms of city policy-making and activity.

Progress with the Healthy Cities project can be broadly described as a series of five developmental stages. Table 1 illustrates those stages and the different position of CHPs and CHDPs within them.

Table 1. Stages of progress for WHO Healthy Cities

	Stage				
	1	2	3	4	5
Focus	Health education and disease prevention mainly within the health sector	Increased volume of disease prevention and some health promotion activities. New actors involved	Intersectoral health promotion and disease prevention programmes	The policy jump: health on policy agenda. Addressing inequalities. City health plans based on limited intersectoral input	The development of integrated CHPs with the input of all health related key city sectors
Approach	Traditional	Traditional	Application of health for all, Ottawa Charter and Agenda 21 principles	Increasing emphasis on policy, health determinants, the needs of vulnerable groups and building alliances for health	Health and sustainability become core values in city visions and policies. Emphasis is on accountability for health and on addressing inequalities, determinants and positive aspects of health

Source: adapted from Tsouros (8).

CHDPs: the process

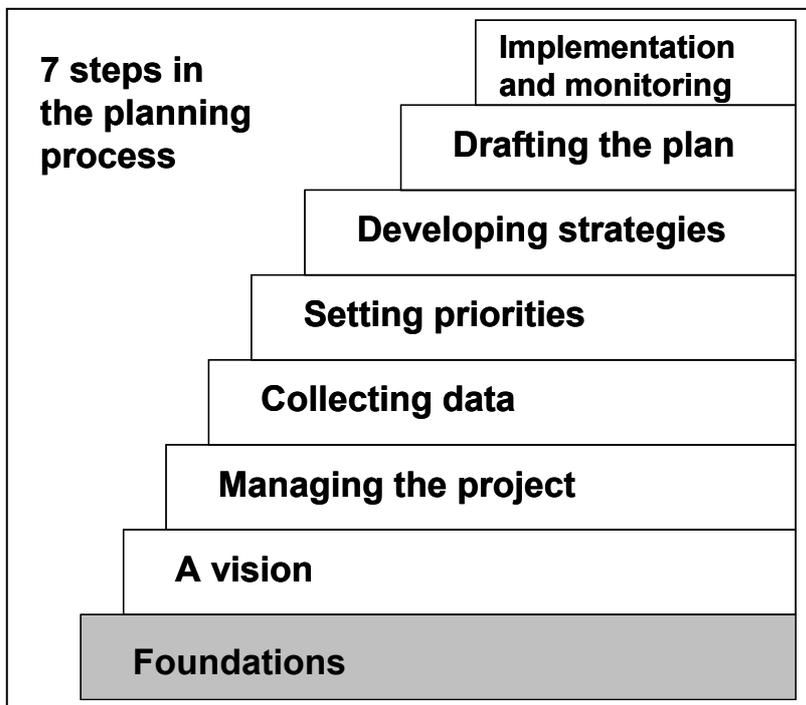
Policy development and strategic planning are continuous, cyclical processes. The CHDP process should be continuous and used as a means to increase the focus on health of each relevant sector in the city and to build strategic alliances for health development. Its long-term goal is to enable cities to reinforce these partnerships over time, and to implement specific programmes, policies and actions to improve health and the quality of life throughout the city and its neighbourhoods. The benefits of local intersectoral health planning are derived as much from the process of working together for health as from the production of a document.

A technical group initiated by the healthy city project, and supported by key politicians, will normally lead the CHDP process. Municipal departments and relevant agencies, nongovernmental organizations (NGOs), community groups, citizens and many other groups will be involved in setting priorities and developing the document.

A seven-step process

City planning for health and sustainable development (2) describes in detail a seven-step process, which can be followed to develop a local health plan, and this model (shown in Fig. 1) also provides the broad framework for city health development planning. The seven steps described in that document are summarized below.

Fig. 1. A seven-step model for city health planning



Step 1. Vision

The need for a strong political base and a commitment to working in partnership are important in developing the vision. A number of approaches are suggested for forming a vision for the city. The process can be a means of raising awareness about the plan throughout the city, using the mass media; among politicians, professionals of different sectors and agencies, voluntary groups and NGOs; and within community settings.

Step 2. Managing the project

Project management issues such as the composition of the steering group, and project team and their roles and responsibilities, are reviewed, along with financing and time-scale. *Twenty steps for developing a Healthy Cities project (9)* provides valuable information in this area.

Step 3. Collecting data

The need to collect data about health in the city and the factors affecting it, using a combination of approaches, is emphasized. Health profiling can be the source of valuable data on health and its determinants in the city. A number of documents provide guidance on this task (7,10–13). The need for a community-based assessment of health needs is emphasized. This provides qualitative data showing how the community perceives its health.

Step 4. Setting priorities

This section gives advice on analysing the information generated in step 3 and on agreeing priorities for the plan. Community groups and other stakeholders should be involved in the process of setting priorities, and this should link to the work and priorities of specific service providers.

Step 5. Developing strategies

Tips are given on the need for the plan to include goals, objectives, strategies, measurable targets and programmes. These should be formulated to address the priorities identified in the previous step. It is important that the strategy links with and provides consistency with other formal planning processes, and that synergies are created through integration between different sectors.

Step 6. Drafting the plan

This section gives tips on the drafting process, the content, and the presentation of the document. Emphasis is given to the need for consultation and feedback on the draft plan from all stakeholders and a wide range of sectors.

Step 7. Implementation, monitoring and evaluation

The rationale and need for an implementation framework with a coordinating body is outlined. This should evolve from the steering committee, and be broad based. The aim is to maintain the ownership of the plan by all stakeholders during the implementation process. A comprehensive approach to monitoring and evaluation, with suitable structures and mechanisms, is recommended. This includes an annual review process, as well as a framework for reporting back to communities, politicians, professionals and other stakeholders. Evaluation at the end of each planning cycle is an important way to measure successes and failures.

While this framework is still relevant, city health development planning places greater emphasis on creating strategic partnerships and giving priority to organizational structures and strategies for integrated planning. The plan should be compatible and in synergy with other planning frameworks in the city, and should be carried out within a manageable time-scale

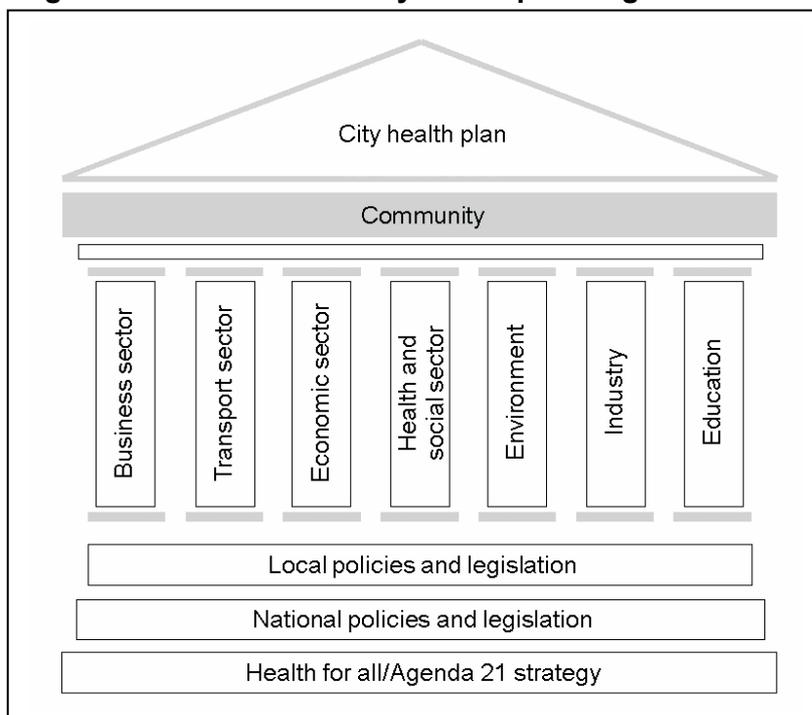
Key challenges and opportunities in the CHDP process

Every city has its own particular culture, institutions and frameworks, but a number of challenges and opportunities in city health development planning are common to many cities. Some of these are examined here.

Intersectoral planning

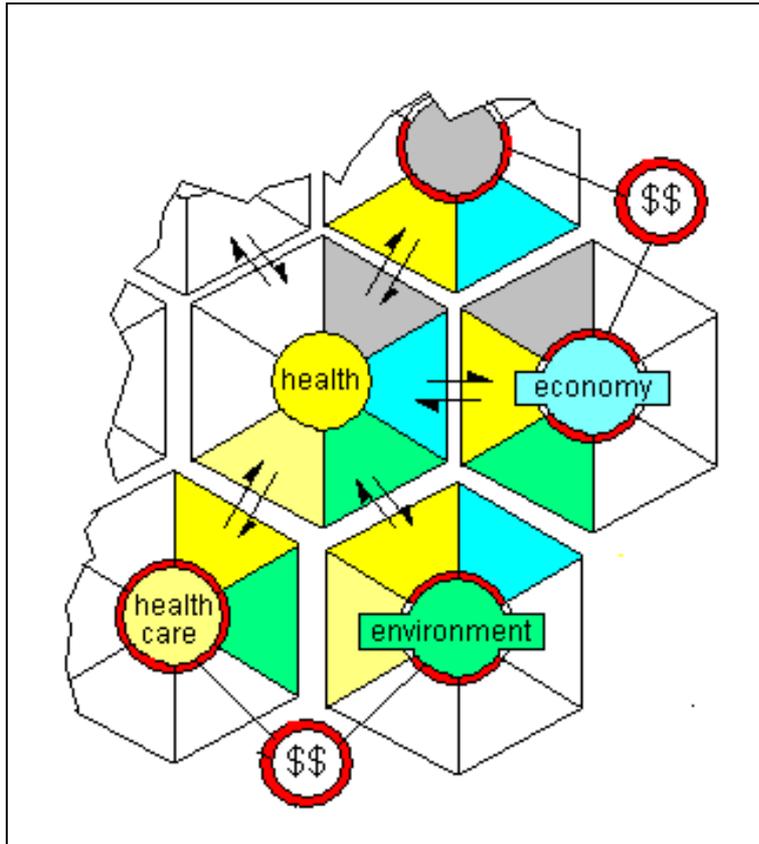
Modern city planning should be integrated; consistent; coherent; firmly based on core values such as equity, sustainability, health and social development; and involving the contribution of several sectors and an active community. *City health planning – the framework (1)* introduced the model of the Parthenon, with different sectors as pillars supporting the CHP (Fig. 2). This model, and the guidance on intersectoral planning associated with it, are still important, as they illustrate the idea that a range of sectors have an impact on health and that all these should therefore be involved in health planning in the city.

Fig. 2. The Parthenon of city health planning



City health development planning takes this concept one step further by emphasizing the linkages between the health plan and the plans of other sectors in the city. It also means integrating the work of the health partnership with other partnership structures in the city, including Local Agenda 21. City administrations perform best when all sectors share a common vision. Then departmental goals are more likely to be consistent and strategies will harmonize with each other. In such circumstances the CHDP can be fully integrated with other sector plans. Fig. 3 represents an ideal model of how the plans produced by a number of departments and agencies relate to each other.

Fig. 3. Integrated planning for health in cities



In this model, each city plan has a different central focus – properly reflecting the purpose and responsibilities of each agency – but each acknowledges and interlocks with the contribution of other sectors. From the Healthy Cities perspective, the CHDP is the centre of attention and the other plans are ranged around it. It should be noted that the healthy city project office, although having an overview, does not have executive responsibility for implementing every element of the plan. In this model, however, this is not a weakness. Commitments in the CHDP may also be reflected in other plans in the city, for example, in sectoral plans where there are accountable executive officers backed up by financial resources.

Integration is sometimes wrongly understood as something that is done after the various plans have been completed. This approach is not uncommon, however, and some people confuse cross-referencing with integration. Integration should start from the moment planning processes in the city begin to use the principles of HEALTH21 and Agenda 21 (14). In practice, integration also means being aware of and taking into account the interdependence of the effects of sectoral policies and actions. It means recognizing and promoting the positive synergistic effect of actions for health with a view to achieving maximum impact.

Integration is an active process. Cross-referencing is a passive one. The latter is useful but not enough. Given the importance of health, one should expect to find in one document what the city does to promote and develop health. Where there is no common planning platform, mutual representation in parallel planning processes may go some way to supporting integration, but a document that is the product of strategic and integrated planning for health is to a mere catalogue of assorted sectoral contributions is as a diamond to zircon.

Time-scale

A city health development plan should be at the core of systematic efforts to improve the health of a city's population. Such a key document requires time and effort to produce. At the very beginning of the process, cities will wish to make a realistic assessment of the resources required. It may take six months to a year to produce the document. Building the intersectoral partnerships that provide the foundation for the document is likely to take much longer. This is a continuous process that supports not only the CHDP, but also the entire work of the healthy city project and the process of health development in the city.

It is important to find a balance. The planning process itself is an excellent opportunity to bring new sectors, agencies and the community on board, promoting the Healthy Cities approach and the concept of health development in the city. This means investing time in the CHDP process. A lengthy and over-complex planning process, however, can become unmanageable, consume too many resources and, by the time it is completed, quickly become out of date, especially when it includes specific activities to be carried out by different sectors and agencies.

Although intersectoral planning is an important element of the CHDP process, it is also one of the biggest challenges. Getting enough time and commitment from departments whose primary focus is not health can be hard to achieve. To keep new sectors engaged, it is helpful to have a clear production timetable and a clear understanding of the key components and implications of the plan within the city.

Community participation

Ensuring meaningful and long-term community participation in any planning process is difficult to achieve. Further, finding the right balance between the top-down and the bottom-up approaches and meeting the need for a manageable and focused process add to these difficulties. *Community participation in local health and sustainable development (13)* addresses the challenge of community participation in detail. This document explores the need for a strategic approach in community participation, linking it to the city health development planning process. It examines the role of community participation in planning processes, and describes a number of techniques, illustrated by case studies, which can be used at different stages of the planning cycle.

CHDPs: structure and content

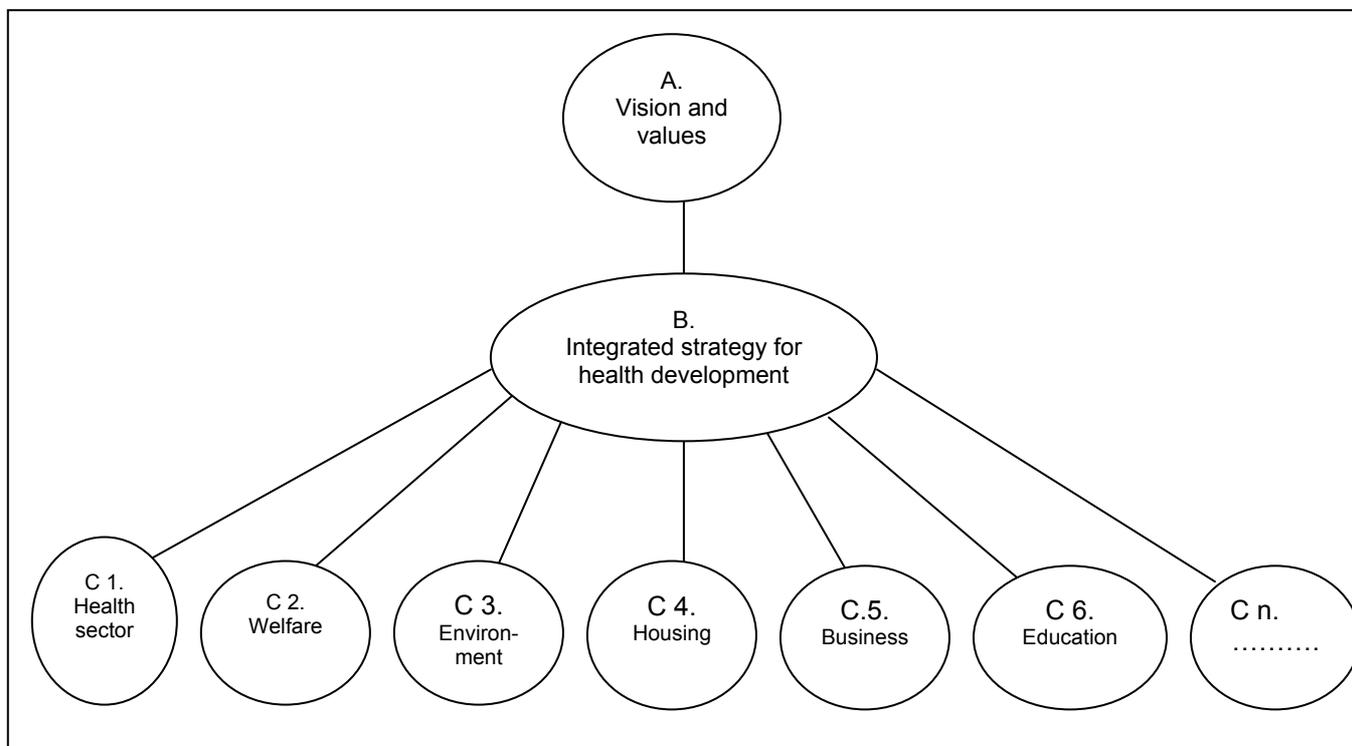
This section describes the broad format for a CHDP. The document itself provides a reflection of the extent and nature of the health partnership in a city, and the vision, strategy and activities that are an integral part of that partnership. The document will normally be about 50–100 pages long, and should be presented in a readable and marketable format to appeal to a range of audiences.

The CHDP should be limited to a specified period. This provides focus and direction for both the strategy and the operational activities. Maintaining the commitment of politicians and decision-makers over the long term and during periods of change can be a challenge. An intersectoral group should follow up the implementation of the plan (2). A clear framework for monitoring and evaluation should be linked to this. Both implementation and monitoring frameworks should be outlined in the CHDP, the latter specifying linkages to the systematic monitoring and evaluation process in the city. The plan document should be reviewed at regular intervals (for example, every 4–5 years) so that health is kept firmly on the agenda of decision-makers in every area of the city administration

The shape of a chandelier can schematically represent the city health development plan (Fig. 4). The model includes three main elements:

- a city's vision and values for health;
- an integrated strategy for health development based on the broadest possible intersectoral partnerships; and
- a series of sectoral health development plans addressing the health, social, economic and environmental determinants of health.

Fig. 4. The chandelier: components of a CHDP



Note: The size of the sphere at the C level is not significant in this drawing.

Vision and values for health

Political commitment to the principles and goals of Healthy Cities should be evident in the city's vision of the future. Health, sustainable development and equity should be visible, bold values in policy documents addressing the future of the city. Thus the city's overall vision and values should directly support and guide the health development planning process.

The CHDP should therefore start with a clear statement on the city's position towards health, which should be endorsed at the highest possible level and by the broadest possible intersectoral partnership. Politicians and high-level decision-makers in each sector should understand and subscribe to the vision. This can be demonstrated by the inclusion of a council resolution, and letters from the senior decision-makers of key partners in developing the CHDP.

Integrated strategy for health development

An integrated strategy for health development, based on the broadest possible intersectoral partnerships, sets priorities based on the common vision. It outlines the strategic objectives of the plan, and should identify broad mechanisms for change. It draws on profiling exercises and the consensus developed by the partners. It identifies broad linkages between health and the different sectors in the city and illustrates how the CHDP is integrated with other planning processes. The strategy forms the strategic glue of the CHDP. It provides a coherent and consistent framework for the development and integration of operational plans and action for health in each sector. A challenging aspect of integrated planning is reconciling the different levels and remits of local stakeholders, some of whom may be controlled by central or regional governments.

Series of sectoral health development plans

The sectoral health development plans, addressing the health, social, economic and environmental determinants of health, are operational plans that can take many forms. Contributions towards them should not be limited to certain groups or sectors. Any sector, agency or city department that has an impact on health can legitimately contribute to the CHDP. If true integration is taking place, health objectives will be reflected in these sectoral plans.

Operational plans will describe programmes and policies in specific theme areas and how these policies will be implemented. They may also include specific lists of activities, with financial and investment information. Operational plans should mirror the CHDP as a whole in that they will incorporate systems for monitoring and evaluating the activities that they plan to carry out. Plans that are funded by different actors and agencies can create some difficulties in management, implementation and accountability. It is important to be aware of these issues from the beginning so that they can be addressed in a strategic way throughout the process.

The operational elements of the plans for different partner sectors in a city may be developed in a number of ways, reflecting the different situations and realities of each sector.

- In some cases the plans of individual sectors may be so well integrated with health objectives that they are actually included within the CHDP document in full or summary form.
- Other sectors, for many different reasons, may produce their own separate plans, but fully integrate them with the CHDP. These would not be a part of the CHDP document, but would form part of the main package, and act as supplements to the CHDP.
- In other cases, planning cycles or other constraints may prevent a sector from contributing an operational element to the CHDP. If so, the sector can still be a partner in developing the

strategy, but may decide to bring the operational element into the CHDP framework at a later date.

The nature and time-scale of the operational plan will depend on the sector or agency to which it relates, but the proposed activities should fall broadly within the time-scale of the whole plan. If the time frame of the CHDP is five years, and a particular sector usually plans in one- or two-year cycles, it could include short- and long-term activities. The CHDP steering group in any particular city should decide on the approach and the method of linking the planning cycles of the different plans in the city.

Building the CHDP

The ideal CHDP would combine in one document all concerted city efforts towards health. This means including the vision, strategy and the sectoral plans together in one document (see Fig. 4). The basis of health development is the broadest active partnership for health in the city. It is therefore essential to invest time and energy to develop a common vision and a strategic framework for health in the city. The CHDP chandelier will collapse without a solid strategic frame. Many urban health issues call for intersectoral and interdisciplinary approaches. Delivering a plan that is based on the contribution of, for example, the health and the welfare sector at operational level, without a strategic framework is not enough. Many CHPs in phase II were of this type.

A strategy alone, however, will not suffice. A city needs to take the strategy and, on this basis, design specific short- and long-term actions relating to the different elements (policies, programmes, services or projects) that form operational plans. The more sectors and agencies that jointly take part in this exercise, the more successful the CHDP.

Many different planning processes are being carried out in the different sectors and agencies in a city at any one time. Flexibility is needed to find the best way to integrate these with the CHDP, so operational plans for different sectors will have different relationships to it. The key for health development is to integrate these plans with the CHDP at the strategic level, as this provides the chandelier framework. A CHDP could include the strategy, plus, for example, the health sector and the education sector in one document. The remaining operational elements would exist, but they would not be contained in the same document, but in the health contributions in other sectoral city documents. If health is being integrated into other city plans, then health as a concept, the health implications of the sectoral activities and the CHDP itself will be mentioned in other city plans, and their links in activities will be evident.

An annex to this document contains a checklist based on the model for CHDPs outlined above. This checklist highlights the most important elements of a CHDP, and is intended as a guide to help cities assess their progress in developing a fully integrated and strategic approach to local health planning.

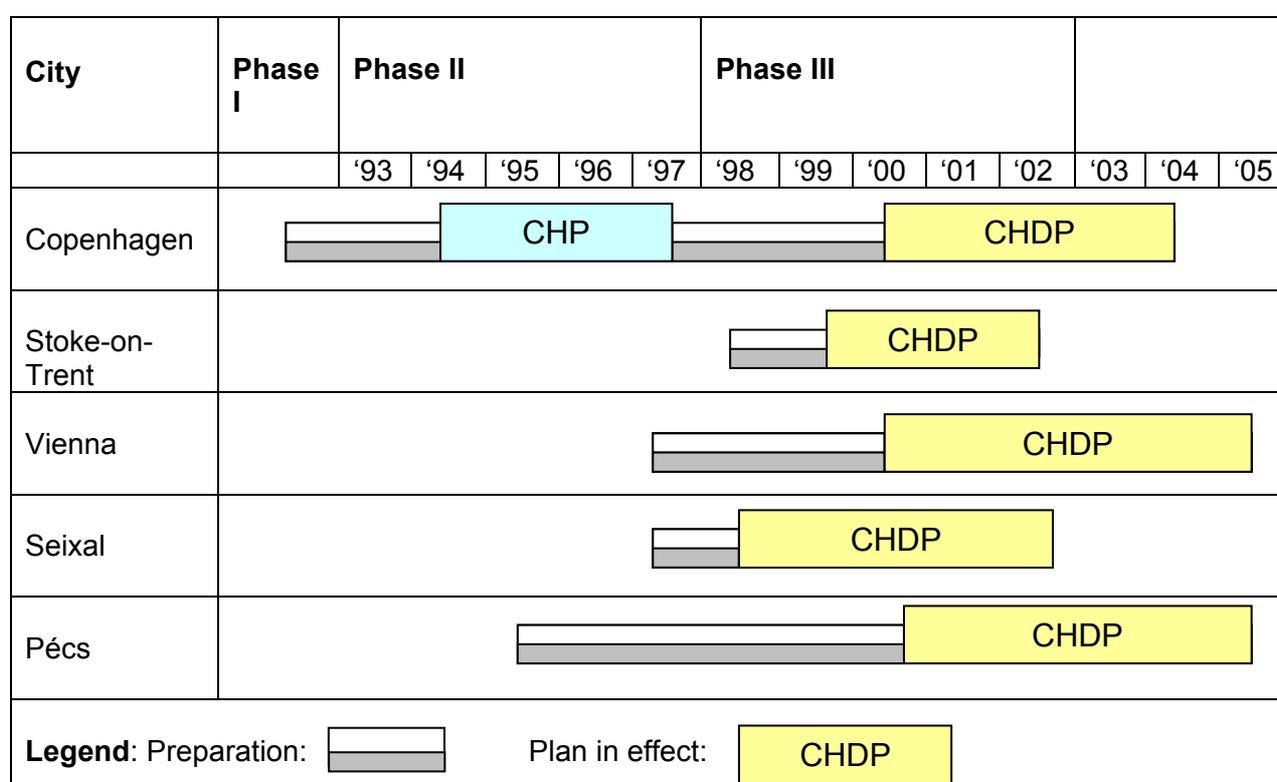
Case studies in WHO Healthy Cities

The following case studies provide examples of approaches to city health development planning in five different cities. They were chosen to reflect a geographical spread of healthy city projects across Europe and to balance more established cities with new cities joining phase III.

Copenhagen (Denmark), Vienna (Austria) and Pécs (Hungary) joined the WHO Healthy Cities project during phase I (1987–1992); Seixal (Portugal) and Stoke on Trent (United Kingdom) joined in phase III (1998–2002).

Fig. 5 compares the preparation and development of the five CHDPs. The years 1997 to 2000 can be considered as a transition period when cities evaluated earlier attempts at CHPs and considered the new designation requirements for phase III.

Fig. 5. Development and duration of CHDPs in five project cities



All five cities were designated into phase III between 20 October 1998 and 15 January 1999. All had shown evidence of substantial progress with preparing CHDPs. CHDPs now operate in the new project cities of Stoke and Seixal, and in Copenhagen, Vienna and Pécs, the process is almost complete.

Copenhagen

Context

The city of Copenhagen has a powerful role in health development. It is Denmark's largest municipality with responsibilities across many sectors influencing health. Exceptionally, it also has the status of a county, which brings direct responsibility for health services. City administration was reformed in 1998 with much executive power devolved to seven committees, each headed by an elected mayor. The Healthy City Project is located within the health administration as part of the Department of Planning and Public Health.

Process

Copenhagen pioneered one of the first CHPs during phase II of the WHO Healthy Cities project (1993–1997). It was adopted after intensive public consultation in 1993 for implementation in the four years until 1997. A number of sectors and agencies were involved. As this implementation period drew to a close, an evaluation was commissioned by the intersectoral committee responsible for coordinating health promotion in the city. This healthy city steering group is called the Healthy City Council and is responsible for developing the new CHDP. It is composed exclusively of administrative staff with authority to make binding decisions. They represent departments from all seven of the city council's committees.

Early in 1998 the Healthy City Council took the decision to proceed with a CHDP. It was a commitment endorsed at the highest level. Indeed, in Copenhagen's application for designation the chief executives of all seven committees signed a statement saying that they believed health to be a matter of concern for all the administrations of the City of Copenhagen as the prevention of sickness, and that the promotion of health must be solved by concrete activities in broad cooperation among all sectors of the municipality.

Such commitment facilitates a degree of integration with other city plans, and the Healthy City secretariat is represented on the Agenda 21 steering committee, whose membership is again drawn from all municipal departments. This intersectoral approach is endorsed by the new national public health plan.

The new CHDP was drafted during 1999, building on the previous CHP and the latest health profile of the city. The draft CHDP was subject to comprehensive consultation later in 1999, giving citizens, organizations and the private sector opportunity to influence objectives, strategies and activities. A proposal was then presented to the Health and Care Committee in early spring 2000.

Structure and content

The proposal covers the years 2000–2004. It is 250 pages long and broadly follows the chandelier structure outlined in Fig. 4.

The **vision** is of a city with much greater equity in health, a better quality of life, an increase in life expectancy and more accountable and accessible public services.

There are two summary chapters on citizens' health and lifestyles and their attitudes and values, establishing a baseline for action. The **strategic approach** is to move beyond disease prevention to a wider approach to health in society. Social cohesion and environmental sustainability are strategic objectives. It is considered important to integrate demonstration projects into mainstream programmes.

The **operational part** of the proposal develops the previous CHP with a matrix of levels (individual, community, environment) and themes (such as tobacco and exercise) and settings (such as communities and schools). The strongest operational elements – such as action on alcohol, nutrition and tobacco – are to some extent within the executive competence of the health administration. The proposal includes programme summaries on urban renewal and environmental protection that are elaborated in other operational plans such as the city traffic and environment plan.

A final chapter covers evaluation, describing how each agency has a responsibility to measure outcomes. The overall CHDP is subject to biannual review.

Implementation

The proposal is being discussed in the Health and Care Committee. Ratification requires action by the City Council.

Pécs

Context

Pécs is an industrial city in Hungary that has undergone great political and economic transformation over the past decade. The municipality has gained increasing autonomy and responsibility for a wide range of infrastructure and social services. Because it has the status of a county, it is also responsible for primary and secondary health services. The Healthy City Project has been managed since 1992 by the Healthy City Foundation of Pécs, which is run by a board of trustees and chaired by the city mayor.

Process

The board of trustees represents a broad multisectoral approach to health development. In 1995 it decided to develop a CHP, collaborating with the Fact Foundation of Pécs. The first step was to commission a health profile and this was accomplished in 1996. The results were widely disseminated by the local press and considered by the health and education committees of the municipality. The next step in the process was to hold consensus-building meetings around six key thematic areas. Technical experts met in 1997 to discuss the challenges of and potential for home care, tobacco control, health education, mental health programmes, etc. Where agreement was reached, certain recommendations were adopted for inclusion in the CHP.

The next step leading to the development of the CHP was a public opinion poll of a representative sample of 1000 residents of the city, undertaken in 1998. Respondents were asked to rank a number of health related problems. Most thought poor condition of the built environment/pollution of the natural environment was the most serious problem for their neighbourhood and low efficiency of social care most serious for Pécs as a whole.

All these initiatives helped build support for the CHP. Late in 1998 they were incorporated into a preparatory planning document which included an outline health plan for Pécs and a draft charter on quality of life. This accompanied the application for designation to phase III of the WHO Healthy Cities network. Since then, further discussion of CHDPs has led to a review of this outline and a new broader framework for health development. Further, in 1999 the City Council decided that the Healthy City Foundation should coordinate environmental, environmental health and health planning in the city. A three stage planning process has been agreed to finalize a broader-based CHDP.

Structure and content

The Pécs CHDP for 2001–2005 will be submitted to the City Council for approval early in 2001. Its structure and content are not fully resolved, but are likely to build up the preparatory planning document to include:

- **vision;**
- **five strategic goals:** improvement/protection of the built and natural environment, improvement of public safety, strengthening of the role of health education, development of mental health services and improvements in traffic conditions;

- **integration** with local environment and health action plans (LEHAPs) as a key element of this strategy, which will be informed by a summary of the health profile of Pécs and the results of the opinion poll; and
- **operational action plans** in certain key thematic areas.

A series of task groups undertook the preparatory work and was assisting with drafting the CHDP towards the end of the year 2000.

Seixal

Context

Seixal is part of the Lisbon Metropolitan Area in Portugal and includes approximately 150 000 inhabitants. Over the past two decades its social and economic life has been transformed and the population has quadrupled. Seixal is an independent municipality with responsibilities in the social and environmental fields. It has an overview of the health of its population, though the central government is responsible for the delivery of most health services, administered through district authorities. The Healthy City Project is located at the heart of the municipality within the jurisdiction of the mayor.

Process

Seixal is one of the new-blood cities. In 1997 the prospect of joining phase III of the WHO network had revitalized the local healthy city project. A directive committee was established to oversee the project. A small coordination committee began the preparatory work for designation, including the development of a CHDP. Its eight members were drawn from key sectors both within and outside the municipality, including social care, health services, social security and education.

Work on the CHDP started in November 1997. An inquest was held into the key determinants of health. Over 100 representatives from key agencies gave an opinion. The process concluded, on balance, that lifestyles are most important in shaping the health of individuals; poverty and housing conditions strongly influence family health; environment and health services are important for community health. Then a health profile was produced. This included not only health status, but also the status of health determinants. This information was fed into deliberations on the CHDP.

The coordination committee was given responsibility for developing a strategic direction for the CHDP and was greatly influenced by the values, principles and strategies for health for all in HEALTH21 (3). They took account of the health strategies of the ministry of health. They could also build upon a vast and pioneering experience of municipal planning. One significant advantage arising out of the consultation meetings with municipal decision-makers was a degree of integration with existing plans. Early in 1998, there was also widespread consultation and debate on the draft CHDP with other private and public organizations within and outside the municipality. The universities were also asked to give a technical assessment. The CHDP was finally approved by the city council in April 1998.

Structure and content

The health development plan of the municipality of Seixal covers the period 1998–2002. It is 90 pages long and follows the chandelier' structure.

The document begins with a summary of its **political status** within the context of municipal and regional planning in general. Then it describes how the plan was elaborated – through partnership and citizens’ participation.

The **vision** of a healthier Seixal is based explicitly on HEALTH21 (3). Equality of access to health and positive citizen involvement in health is part of the vision.

There are two summary sections on the **health profile** of Seixal: a starting point and the results of the inquest into major health determinants. The **strategic approach** is to focus on key determinants of health identified by the inquest. These require intervention by a number of sectors. Strategic objectives are to improve social and economic circumstances, improve the quality of urban life, improve housing conditions, promote healthy lifestyles and provide better health care services.

Most of the document is devoted to **operational plans** designed to meet these strategic objectives. Each section identifies the problems in a sector and sets out proposed action. Typically each section lists 5–10 actions, some with a target and time-scale. A method of monitoring progress is listed against each action point. The local universities are asked to evaluate the execution of the CHDP.

Implementation

The project office and steering group have devoted time and energy to mobilizing and maintaining support for the CHDP. Four work groups have been established to take forward the programmes on: social, employment and professional training; health; education, sports and leisure; and environment and city planning. Specialists in each group have developed a number of projects that link to the mainstream plans. Objective data were being collected and progress with the CHDP was to be evaluated at the second health forum in November 2000.

Stoke-on-Trent

Context

Stoke-on-Trent is a significant industrial city in the middle of England. The population of 250 000 has experienced relatively high levels of poverty and poor health. The municipality acquired many new responsibilities for health-related services when it became a new unitary authority in 1997. Nevertheless, the central government is responsible for the delivery of most health care services, administered through special district authorities. The healthy city project is located in the municipal Department of Housing and Consumer Protection.

Process

The Stoke-on-Trent Healthy City Project was re-established at the inception of the unitary authority in 1997 as an integral part of the City Council’s work to develop a holistic strategy for improved quality of life for all sectors of the community. An intersectoral strategy board was created with the City Council as one of seven partner institutions. Within two years, Stoke was accepted as one of the new-blood cities in phase III of WHO Healthy Cities project.

The year following reorganization of local government was a period of great planning opportunities. Most of the key partner agencies were establishing new relationships, and seeking to coordinate their planning processes. This created a good opportunity to develop a CHDP. By mid-1997 strong links were established with the Agenda 21 planning process. By November that

year, the board agreed a declaration of health and a model of health to be found in HEALTH21 (3). These were to be incorporated into the vision and strategy of the CHDP.

Preparatory work started in the spring of 1998 prior to designation. Terms of reference and a specification for producing the CHDP were agreed in April; a working group was established in May, and an audit of relevant strategies and plans was undertaken over the following six months to ensure a degree of integration. A new health profile was commissioned and community health priorities were confirmed by a population survey undertaken by a local university. A CHDP was drafted, and in the new year there was extensive consultation to secure agreement and commitment to relevant recommendations. An action plan was then drafted in consultation with the relevant agencies and incorporated into the final CHDP. It was approved by the board and published in August 1999.

Structure and content.

Sharpening the Focus on Health: A City Health Development Plan for Stoke-on-Trent covers the period 1999–2002. The document is 46 pages long: the shortest of those treated here. It follows the chandelier structure.

The document begins with a summary of its **political status** and the endorsement of board members representing the key partners. This leads into the purpose and structure of the plan.

The next section describes a **vision** for Stoke-on-Trent: communities are thriving; health inequalities are being reduced and different sectors are working together. This vision is based on principles contained in the earlier declaration of health and eight **values** including the right to health and promoting social justice and equity through health.

Then follows a summary of the **health profile** of the city, including health determinants. This and the survey of community priorities inform the priorities for action which the city needs to address in order to improve health locally.

Three **strategic objectives** are linked to each vision statement. They influence the strategic programmes to tackle the determinants of ill health that form the main body of the report. Determinants range across a number of key sectors: lifestyle, economic development, education, poverty, environment, crime and transport.

The CHDP addresses each issue, how it will be tackled, linkages with other plans and the action to be taken. This section could be classified as a set of **operational plans**. In the appendix, these short term plans are combined into the Stoke-on-Trent CHDP with strategic objectives, actions, milestones, key outputs and resources.

At the end there is a short section on **monitoring and evaluation**. There is a commitment to an annual report. The health profile will be updated regularly. There will be audits and a detailed system of monitoring and evaluation will be established.

Implementation

The board held a review session in November 1999 to challenge members of the healthy city partnership to determine how best they can provide the drive to pursue the objectives set out in the CHDP. The main result of the review is greater integration with mainstream central government policies to reform health care services. The healthy city board now includes representatives from primary health care groups that have been created locally in response to a central government directive to promote community health. The CHDP will evolve into separate

local community plans, giving a lead in equity in health. The CHDP was reviewed in June 2000 to assess progress in each of the areas and to develop operational plans for 2001/2002.

Vienna

Context

The city of Vienna has a powerful role in health development. It is Austria's largest municipality, with a competence for health care services and responsibilities across many other sectors influencing health. As capital city it also has the status of a region, which brings many coordinating responsibilities for the metropolitan area. The healthy city project is located within the Health Planning Division of the Health Department.

Process

The Vienna Declaration on Health Promotion, signed by all political parties in 1989, remains the basis of the city council's commitment to health for all and to the healthy city project. Intersectoral cooperation is important for implementing the strategy. In 1996, representation on the project steering group was broadened to include council departments covering schools and psychosocial services, as well as agencies outside the city council. These include the Austrian Medical Association, Vienna Hospital Association, the Austrian Broadcasting Company, the Chamber of Commerce, the Chamber of Labour and the Sickness and Social Insurance Fund of Vienna.

Before proceeding with a Vienna CHDP, the steering group commissioned an expert evaluation of CHPs developed elsewhere in the world. The assessment, published in 1997, was broadly favourable and the steering group decided to proceed with a CHDP.

A technical group was established, with expert members from municipal departments, central government ministries and research institutes. It used existing WHO guidance on city health planning to develop a systematic programme of preparatory work. The group was responsible for developing a vision and strategy, updating the Vienna Declaration with ideas drawn from a draft of HEALTH21 (3). A draft strategy for Vienna was discussed in workshops with renowned experts in health promotion. The group also considered evidence of current health status (for example, a health profile of Vienna and a lifestyle survey) and reviewed existing structures and measures to improve health in the city.

These components of the CHDP were drafted in 1998, submitted as part of the WHO designation process and published in 1999. It was envisaged that ten action programmes would follow. The final action component of the CHDP, approved by the city council in 2000, focused on three specific action programmes.

Structure and content

The CHDP covers the years 2000–2005 and is called Wien Vital (the Vienna Health Plan). It is published in two books. The first is 470 pages long and covers vision, strategy, health status and current intersectoral measures to improve health. The second book is 80 pages long and mainly covers operational plans within the competence of the Health Department. Taken together the two books reflect the chandelier structure.

The first book begins with a **vision** for the city. Vienna in the twenty-first century is a city enabling its citizens to live with maximum health, ranking as one of the best in the world. This

proceeds from a healthy environment and social solidarity supported by an excellent public health system and economic stability.

A section on **strategy** follows with five objectives: to allocate responsibilities between individuals and institutions, to develop know-how, to create communication networks, to improve programme quality and to secure transparent and well grounded resource allocation.

Most of the first book is devoted to analysing the current health system in its broadest sense: the health status of the population, the most vulnerable groups of people and determinants of health, especially lifestyle influences. The CHDP describes the current responsibilities of seven sectors that could make a significant contribution to health.

The second book contains **operational plans**. It begins with basic principles and strategies, but the main focus is three action plans: to reduce back pain, to fight cardiovascular disease and to create healthy eating habits.

Implementation

The operational component of the plan was approved in April 2000. Most of the interventions included in the strategy require interventions from other sectors. The CHDP stresses common planning in processes. Negotiations are underway for a health dimension to be included in the plans of these other sectors.

Conclusions on case studies

CHDPs have been developed in four of the five cities reviewed; in Pécs, the CHDP is scheduled for completion early in 2001. In all cases, the CHDPs broadly reflect the process and structure outlined in this document.

The five cities follow a remarkably similar process of developing CHDPs. In general, the Healthy City Project steering group starts and then oversees the process. A relatively small technical group elaborates the vision and strategy. This group commissions a health profile and a health needs assessment or opinion survey. This is fed into a draft strategic plan, which is discussed on a common planning platform with key partners from a variety of sectors. Then follow negotiations with these partners to agree on operational plans. The population is involved and finally the CHDP is approved by the city council and other key agencies.

The case studies also reveal important differences in both process and content between the two new-blood cities and the three that joined the WHO Healthy Cities project in phase I. The key difference in process is the much faster development and completion of CHDPs by the two new-blood cities compared.

There are two key differences in content. The CHDPs of the new-blood cities are shorter (48 pages for Stoke and 90 pages) and tend to summarize and synthesize all the existing health-related plans in the municipality. In contrast the completed CHDPs in Copenhagen and Vienna (250 and 550 pages, respectively) are longer and tend to elaborate the science of health development. The second difference is the wider range of operational plans summarized in the CHDPs of the new-blood cities compared with the CHDPs of Vienna and Copenhagen. Because the latter have a responsibility for health services, their CHDPs give greater emphasis to detailed operational plans for health promotion, which are the responsibility of the health department.

It is too soon to generalize about the implementation and impact of CHDPs, but two benefits are already evident from the earliest plans completed in Seixal and Stoke. First, the strategic framework provided by a CHDP gives direction to projects and programmes initiated by the healthy city project office. Second, the CHDP document is used as a negotiating tool to influence and modify the direction of mainstream municipal programmes and those of other agencies. A CHDP gives emphasis to the potential for health development of all other city plans, programmes and budgets.

Conclusions

The city health development planning process is an opportunity to put health firmly on the agenda of other decision-makers, so that they make health, wellbeing and quality of life central considerations in their work. This can only be achieved successfully when done strategically and followed up in the policies, programmes and initiatives of different sectors citywide. The foundation for successful health development is a broad and committed partnership for health across the city, and both the process and the resulting CHDP can be used as a tool to develop this partnership.

Some sectors in the city may already have health as a key component in their work. Others may have issues of wellbeing and quality of life as an implicit rationale for their existence, but this may have been forgotten. The CHDP and partnership process can be an excellent way to reawaken awareness of the ultimate goals of their work. Still other sectors will need to be convinced of the benefits to them of focusing on health objectives in their work. These objectives may be social and/or economic, but they will ultimately be linked to issues of human development in cities, for which health is a key element.

A cosmetic planning process, carried out merely to satisfy the requirements of phase III of the WHO Healthy Cities project, will achieve little in a city. A document put together without real commitment from a broad health partnership will have little merit other than to catalogue action and policy for health. This is not really a CHDP. It is important to use the CHDP to raise the profile of health and the Healthy Cities approach in the city. The process should not be a burden, but a tool to bring the approach into the mainstream of city decision-making, thus promoting health, wellbeing and quality of life throughout the city.

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Annex. The city health development plan – A checklist

The purpose of this checklist is to assist cities during the preparation of their city health development plan. It includes the three key elements of a CHDP – vision, strategy and operational plans – and provides a series of questions intended as a way for a city to assess the broad content of its CHDP document. Answer each of the questions below. The answer will be “yes” if the plan document reflects that element .

Your city’s vision and values for health

1. Is health clearly identified as a core value in your city’s political statements about the future? Are these statements contained within the plan? Are these statements duplicated in other city planning processes?
2. Has a common vision been developed by a broad partnership for health?
3. What policy or strategic documents inform this vision, and are these referenced in the text of the plan? This includes documents produced at international, national, regional and local level.
4. Have key decision-makers and politicians in the city endorsed the vision, and will this be reflected or contained in the CHDP document?

An integrated strategy for health development

1. Has an integrated strategy for health development, based on the broadest possible intersectoral partnerships, been developed, based on the common vision for health and with clear priorities and objectives?
2. Does the strategy show evidence of the broad partnership in the city – is it truly intersectoral?
3. Does the strategy provide the framework for or inform the operational plans of the sectors involved in the partnership? Does the content of the strategy and the strategic priorities feed into the operational plans?

Operational plans

1. Have operational plans which form part of the CHDP been produced by all relevant agencies and departments whose work affects health or the determinants of health? For example, does this include health, social, economic and environmental sectors)
2. Are the operational elements of your CHDP included within the main document, either in full or summary form? Is this true for all sectors or just those most involved in the health partnership?
3. For those partner sectors and agencies that do not have an operational element within the main document, do their own operational documents seek to implement the strategy of the

partnership for health, and are they well integrated with the CHDP? Were these documents developed with health as one of their key aims?

4. Are there any partner sectors or agencies involved in developing the strategy, whose operational plans do **not** relate to the city health development strategy? If not then how will this problem be addressed in the city?