Healthy city projects in developing countries: the first evaluation

TRUDY HARPHAM, SALMA BURTON and ILONA BLUE

Faculty of Built Environment, South Bank University, London SW8 2JZ, UK

SUMMARY

The 'healthy city' concept has only recently been adopted in developing countries. From 1995 to 1999, the World Health Organization (WHO), Geneva, supported healthy city projects (HCPs) in Cox's Bazar (Bangladesh), Dar es Salaam (Tanzania), Fayoum (Egypt), Managua (Nicaragua) and Quetta (Pakistan). The authors evaluated four of these projects, representing the first major evaluation of HCPs in developing countries. Methods used were stakeholder analysis, workshops, document analysis and interviews with 102 managers/implementers and 103 intended beneficiaries. Municipal health plan development (one of the main components of the healthy city strategy) in these cities was limited, which is a similar finding to evaluations of HCPs in Europe. The main activities selected by the projects were awareness raising and environmental improvements, particularly solid waste disposal. Two of the cities effectively used the 'settings' approach of the healthy city concept, whereby places such as markets and schools are targeted. The evaluation found that stakeholder involvement varied in relation to: (i) the level of knowledge of the project; (ii) the project office location; (iii) the project management structure; and (iv) type of activities (ranging from low stakeholder involvement in capital-intensive infrastructure projects, to high in some settings-type activities). There was evidence to suggest that understanding of environment–health links was increased across stakeholders. There was limited political commitment to the healthy city projects, perhaps due to the fact that most of the municipalities had not requested the projects. Consequently, the projects had little influence on written/expressed municipal policies. Some of the projects mobilized considerable resources, and most projects achieved effective intersectoral collaboration. WHO support enabled the project coordinators to network at national and international levels, and the capacity of these individuals (although not necessarily their institutions) was increased by the project. The average annual running cost of the projects was approximately US$132 000 per city, which is close to the costs of the only other HCP for which a cost analysis has been undertaken, Bangkok (US$115 000 per year) Recommendations for these and other HCPs are provided.*

Key words: developing countries; evaluation; healthy cities; urban

INTRODUCTION

The healthy city project (HCP) strategy advocates an intersectoral approach to health development that focuses on the environmental, social and economic determinants of health, and aims to put health issues onto urban agendas. HCPs, which were initiated by cities in developed countries, have spread to developing country cities. In 1995, the World Health Organization (WHO), with assistance from the Local Initiative Facility for Urban Environment (LIFE)/United Nations Development Programme (UNDP) and the Dutch bilateral aid agency, collaborated with five developing country cities (Cox's Bazar, Bangladesh; Dar es Salaam, Tanzania; Fayoum, Egypt; Managua, Nicaragua; and Quetta, Pakistan) in establishing HCPs.

Except for Managua, the cities were selected because they were already part of the UNDP/LIFE initiative and it was anticipated by the funding organizations that synergy between

UNDP/LIFE (which also receives Dutch funding) and HCPs would be achieved.

The HCPs' objectives are (WHO, 1995) as follows.

- Political mobilization and community participation in preparing and implementing a municipal health plan.
- Increased awareness of health issues in urban development efforts by municipal and national authorities, including non-health ministries and agencies.
- Creation of increased capacity of municipal government to manage urban problems, and formation of partnerships with communities and community-based organizations (CBOs) in improving living conditions in poor communities.
- Creation of a network of cities that provides information exchange and technology transfers.

The authors evaluated four of these projects in 1999 using methods agreed by funders and project coordinators. Managua is only included in the evaluation of costs. Results are presented by evaluation themes, rather than by city, in order to make comparisons more readily. Full details of all the evaluations can be found in Burton *et al.* (Burton *et al.*, 2000).

METHODS

Evaluations usually assess progress against the original objectives of the intervention. However, over-attention to objectives has been criticized by Cronbach *et al.* because it can give too much power to the evaluator to determine what activities become primary in a project (Cronbach *et al.*, 1980). Scriven argued further for goal-free, needs-based evaluation in order to avoid the risk of missing unanticipated outcomes as a result of a narrow focus on stated project objectives (Scriven, 1972). Therefore, this evaluation, in addition to measuring progress against objectives, asked additional questions.

The importance of identifying evaluation questions has been stressed by Rossi *et al.* (Rossi *et al.*, 1999). Evaluations of HCPs, namely by Baum (Baum, 1995), Goldstein (Goldstein, 1998), De Leeuw (De Leeuw, 1998) and Werna and Harpham (Werna and Harpham, 1995) were considered and the following evaluation questions were agreed.

Degree of involvement

- Who are the key stakeholders, what are their perceptions of the project and to what extent have they been involved in the project?
- To what extent have women been involved?
- To what extent has the project targeted and reached the poorest?
- To what extent has the city leadership been involved?

Municipal change

- Has there been any policy changes as a result of the healthy city project? Have there been any changes in the way local public service workers approach their work?
- What financial and human resources have been mobilized?

Linkages

- What collaboration between sectors has occurred?
- What networking with other similar projects and other cities have occurred?

Capacity building and sustainability

- Has technical and institutional capacity been strengthened as a result of the HCP?
- To what extent is the project sustainable?
- What are the project costs?

Results of the evaluation are reported by addressing these questions in the corresponding sections below.

Patton, Weiss and Wholey have criticized traditional evaluation results for under-use (Weiss, 1972; Wholey, 1994; Patton, 1997). 'Utilization-focused evaluation' begins with the premise that evaluations should be judged by their utility and actual use (Patton, 1997). Improving use was addressed in this evaluation by involving stakeholders (defined as persons, groups or institutions with interests in the project). The concept of stakeholder involvement emerged in the 1970s and was first proposed in the evaluation field by Cronbach *et al.* (Cronbach *et al.*, 1980). Efforts to involve stakeholders in evaluation have resulted in processes ranging from consultations to a high degree of participation based on 'fourth generation evaluation', where stakeholders are actively engaged in the evaluation and are both objects and subjects for it (Guba and Lincoln, 1989).

Stakeholder analysis (ODA, 1995) is a process used to identify a project's key stakeholders, and

to assess their interest and the ways in which these interests affect project risks and viability. Stakeholders can be categorized as primary [those who are ultimately affected either positively (beneficiaries) or negatively] or secondary (the intermediaries engaged in the delivery of services). Burton applied this process in the evaluation of two HCPs and demonstrated the importance of conducting a stakeholder analysis to understand the context of the project and to involve the stakeholders in evaluation (Burton, 1999). Thus, stakeholder analysis was used here.

In HCPs across the world, evaluations have been carried out using process and outcome indicators in varying proportions (Burton, 1998; Werna *et al.*, 1998). HCP literature states that when such long-term development projects are evaluated during the first few years, the focus should be on process rather than outcome indicators (Werna and Harpham, 1995; Nutbeam, 1998). This is because most outcome indicators (improvements in health status) are only likely to change in the longer term. The HCPs involved in this evaluation began 3–4 years before the evaluation. Some outcomes were expected, but it was decided that the evaluation's focus should be on processes. In this sense, the evaluation amounts to a detailed 'mid-term' review. The evaluation could not consider the ultimate objective of HCPs, which is to enhance the overall well-being of people that live in cities.

Methods used in the evaluation were stakeholder analysis, evaluation workshops, document analysis and interviews. Stakeholders (205 in total: 69 females and 136 males; 102 managers/ implementers and 103 intended beneficiaries) were interviewed in all four cities. The managers/implementers (secondary stakeholders) were interviewed directly by the evaluators. Intended beneficiaries (primary stakeholders) were randomly selected from each stakeholder group and interviewed by local volunteers. Typically, non-government organization (NGO) members, communicating in the local language, used a questionnaire that covered the respondents' knowledge of HCPs, their perceptions, interest, participation, their views on progress of HCP activities and suggestions for improvement of the project.

The demographic, socio-economic and environmental characteristics of the cities covered by the evaluation are provided in Burton *et al.* (Burton *et al.*, 2000).They range from a town of 70 000 inhabitants (Cox's Bazar) to a city of 3 million

(Dar es Salaam). All have rapid population growth (e.g. 8% per annum in Dar es Salaam) and all have a large low-income population (e.g. 45% defined as living below the poverty line in Cox's Bazar). The main health problems are malaria, diarrhoea, skin disease and acute respiratory infections. Water supply varies (e.g. 89% of households in Quetta were reported as having indoor taps, but only 20% in Cox's Bazar), while sanitation is poor across the cities (e.g. only 20% of Fayoum was linked to the sewerage system).

WHO has identified the municipal health plan as one of the key steps in HCP implementation (WHO, 1995). The plan should be the 'map and compass' of the HCP and contextualizes the HCP in that it has locally set priorities. The concept originated from European HCPs during their first phase, and became a requirement by WHO for the designation of cities in the second phase. However, in the evaluation of the second phase [(De Leeuw, 1998), pp. 25–27], there were 'radically different positions in the ten cities' that were evaluated. Only two cities had plans (one of them existed before the HCP started), five cities reported that they were in the process of production, two had initiated development of plans, and one did not foresee any development. Note that the evaluation took place 10 years after the initiation of the European projects.

Development of municipal health plans 'is a lengthy process that involves negotiation and debate' [(De Leeuw 1998), p. 36], and as noted by the European evaluation, 'project offices should take ample time to allow for this debate' [(De Leeuw, 1998), p. 36]. A full municipal health plan involves linking health status to environmental conditions, gathering information, priority setting and action (Werna *et al.*, 1998). Most of the cities included in this evaluation did not develop a full plan, although all identified priorities that were reflected in their activities and action plans. The reasons for this varied between cities and included the following.

- A limited capacity to undertake a health needs assessment (owing mainly to discontinuity in coordinators plus a lack of training in basic epidemiology and social survey methods).
- Inability to gather views rapidly from a wide range of stakeholders and to feedback a resulting plan of action. Achieving this degree of participation has been difficult in other HCPs. 'Unfortunately, the elaboration of a city health

plan is no easy task, and not all the cities achieve their aims. Obviously, this is one of the weak points which needs to be worked on by reinforcing the role, knowledge and abilities of the project coordinators to enable them to facilitate, negotiate and market the process' [(Boonekamp *et al.*, 1999), p. 108].

- Inability of the project coordinator to take a lead role in policy formulation at a municipal level. This is a particular problem where provincial or district health departments are located in the same city.
- Reluctance on the part of non-health municipal departments to have their key initiatives subsumed under the HCP. This is related to the fact that many organizations involved in HCPs are not accountable for health outcomes (Goumans, 1998).

Initial efforts towards developing a municipal health plan took different forms in different cities. In Cox's Bazar and Fayoum, extensive meetings were held amongst members of the task forces, while in Quetta there were smaller scale workshops, and in Dar es Salaam it was a major consultation attended by 77 representatives of HCP-related sectors, NGOs, communities, the WHO and other related organizations. The results of these efforts were a healthy city action plan in Cox's Bazar (developed in 1995 and revised in 1999), annual action plans in Fayoum and annual work plans in Quetta. The report of the city consultation in Dar es Salaam was the closest to meeting the guidelines provided by the WHO for the form of a municipal health plan. The report identified seven priority areas: housing, food safety, school health, water and sanitation, work place health and mental health. However, it remained in draft form and was never used. Instead, Dar es Salaam implemented plans developed by 'settings'-based task forces for healthy markets, healthy schools and unplanned settlements.

All four cities identified priority areas for city-wide action, with specific focus on settings-based projects. Advocacy, awareness raising of the concept of HCPs and of health issues, and environmental health were the key activities in all four cities. Cox's Bazar, Dar es Salaam and Fayoum, but not Quetta, also implemented healthy schools, healthy markets, income generation and training activities. These activities enabled a wide range of intersectoral stakeholders and communities to be involved in implementing the projects. Stakeholder awareness of HCP was very high in Cox's Bazar and Fayoum, with >90% of beneficiary stakeholders in each of the cities being aware of the HCP activities and being in some way involved in them. In Dar es Salaam, community awareness was more localized in the settings where activities were being implemented, while in Quetta, awareness was much lower because very few activities were being implemented by the project.

There was a high turnover of project coordinators. Boonekamp *et al.* emphasized the importance of the coordinator, suggesting that they are crucial in influencing local health policies (Boonekamp *et al.*, 1999). It is notable that the city with the most discontinuity, Quetta (which had three different coordinators), is the city that appears to have made least progress.

In terms of activities within the HCPs, full details can be found in Burton *et al.* (Burton *et al.*, 2000). Each city undertook awareness raising activities. The healthy schools settings approach was used in Cox's Bazar, Dar es Salaam and Fayoum. Cox's Bazar and Fayoum had predominantly environment-related activities, although in Cox's Bazar the emphasis was at the community level, while Fayoum chose larger scale public works. Compared with the guidelines given by the WHO that envisage activities in schools, workplaces, market places and health services (WHO, 1995), there was little focus on health services.

The evaluation questions are addressed below.

DEGREE OF INVOLVEMENT

Stakeholder involvement

The HCPs varied in the range and type of primary stakeholders (from slum dwellers, hawkers and school children to parents, teachers and community development society members). This was partly related to the degree to which the settings approach had been adopted. For example, in Dar es Salaam most of the primary stakeholders were limited to the healthy schools and market places initiative. Secondary stakeholders ranged from political leaders, HCP task force members, university staff, municipal staff, religious leaders, NGO and CBO members to UNDP/LIFE and WHO regional and headquarter staff. Primary stakeholder involvement was associated with four factors: (i) degree of

knowledge of the project; (ii) *project office location*; (iii) *project management structure*; and (iv) *type of activities*.

Knowledge of the HCP amongst primary stakeholders was highest in Cox's Bazar and lowest in Quetta. In Cox's Bazar, >90% of stakeholders interviewed knew of the HCP and had at some time been involved in an HCP activity. In Quetta, primary stakeholders were aware that health–environment initiatives were being discussed within their communities, but they were unfamiliar with the HCP phrase or concept. In Dar es Salaam and Fayoum, knowledge of HCP was largely limited to a single, specific activity that the stakeholder had been involved in.

In all cities, the *project office location* played a major part in stakeholder awareness and the opportunity for creation of partnerships. Cox's Bazar had the highest level of awareness among all stakeholders and had the widest range of stakeholder involvement in HCP activities. The HCP office was the largest space in the municipal building, was air conditioned and had a meeting room. This facility, its open plan and direct access from the street made the HCP office a focal point for discussions among the stakeholders. Other municipal organizations also used the room to hold their meetings, enabling the coordinator to participate in other city-wide discussions and develop further partnerships.

The HCP offices in Quetta and Fayoum were less accessible to primary stakeholders. While there were no restrictions as to who could visit and meet the coordinator, the lack of any sign (e.g. healthy city logo or board) to identify or define the functions of the office made these offices appear to be no different to any other office in the municipality. The elected councillors of Quetta described the HCP coordinator's office as a place to go to discuss health and environment problems, while in Fayoum many municipal officials who knew of the coordinator (as a senior official of the municipality) were not aware of the HCP or its functions.

Many primary stakeholders in Fayoum defined the HCP as whatever particular activity was being implemented in their community. For example, defining HCP as a garbage disposal and tree planting project. In Dar es Salaam, location of the HCP office in the WHO office, which is located some distance from low-income communities in which the HCP worked, prevented access by primary stakeholders. Here too, beneficiaries defined HCP as the particular activity that was being implemented in their locality (e.g. 'HCP is a project funded by WHO to train market food vendors'). In contrast, secondary stakeholders [e.g. the International Labour Organization (ILO), UNDP, the German Agency for Technical Assistance (GTZ), Health Ministry and City Commission] had developed partnerships with the HCP and were fully aware of the concept of healthy cities.

Project management structure also determined stakeholder involvement. The Cox's Bazar HCP was planned and managed by five task forces, each consisting of representatives from government and municipal departments, political leaders, NGOs and CBOs. The municipal and government institutions that were represented on the task forces had been involved in defining policy, planning HCP activities and participating in awareness raising activities, such as street and beach cleaning. The number of stakeholders involved in Dar es Salaam was also high, but more focused on beneficiaries within settings. Primary stakeholders such as market vendors and customers, students and teachers had been involved in identifying priority problems, proposing solutions, defining strategic and action plans, and implementing activities. Training in participatory methods facilitated this.

The *type of activities* also determined stakeholder involvement. Activities in Cox's Bazar, for instance, emphasized advocacy and awareness (e.g. rallies, workshops, community meetings, posters and banners), while activities in Fayoum were more infrastructure-oriented (e.g. water tanks), which can be carried out without involving stakeholders. With respect to healthy market activities, no stakeholder involvement was considered necessary in Fayoum, while Dar es Salaam involved all stakeholders from initiation through planning, fund raising and implementation. Thus adoption of a common goal (healthy markets) can generate different patterns of involvement.

Lessons learned

Achieving a high level of involvement by both secondary and primary stakeholders at the same time was a difficult task. There was an initial focus on secondary stakeholder involvement, followed by a shift to primary stakeholder involvement.

Secondary stakeholder involvement can be increased by managing the project through

formalized sectoral task force structures such as in Cox's Bazar. Formal decisions made in such committees, in the presence of colleagues, can be followed up by the coordinator. However, management through complex task force structures such as in Cox's Bazar can also take up a major part of the time of the coordinator, limiting the amount of time available to work with primary stakeholders.

Primary stakeholder involvement can be increased by the following.

- Advocacy and raising awareness of the HCP concept among communities.
- Using the settings approach, whereby the concept of healthy cities is applied to settings where people live and work. Focusing on settings also enables seed funds to be used effectively.
- Ensuring the office and its functions are visible to local communities.

Involvement of women

The HCP guidelines (WHO, 1995) stressed the importance of women's involvement:

[HCPs should] ensure participation of women in decision-making in relation to project activities, and especially in key areas such as housing, water and sanitation, and health services [(WHO, 1995), p. 13].

In general, the levels of women's involvement in urban development initiatives are likely to reflect levels of women's involvement in other aspects of city life (e.g. employment or freedom to leave the home). However, as one of the objectives of an HCP is to involve women, attempts should be made to include them in project activities, even where this goes against the cultural norm. The four HCPs considered in this report achieved varying degrees of female participation (of both primary and secondary stakeholders) through representation on HCP committees and participation in project events and activities.

In Cox's Bazar, Dar es Salaam and Fayoum there was evidence of female primary stakeholders' involvement. Several project activities targeted women specifically. For example, in Dar es Salaam 'mamanthilias' (women street and market food vendors) were invited to participate in a health awareness training course organized by the HCP. A majority of the small grants established in Fayoum focused, at least in part, on providing revolving loans to women for implementing income generating activities. Women who received the loans had invested in small scale animal husbandry, poultry farming, tailoring and retail of fruit, vegetables and other goods. The women were regularly paying back the loans and were investing their additional income to 'improve their children's education and nutritional status'. Demand for the revolving loans was high and there were many women on the waiting list.

The level of participation of female secondary stakeholders varied between the four cities. For example, in Cox's Bazar, Fayoum and Quetta, relatively few women were members of the committees. In contrast, the situation in Dar es Salaam revealed high levels of female participation: a reflection of the relatively large proportion of women employed in government institutions and the private sector. The project coordinator was female and >50% of the evaluation workshop participants were female.

Lessons learned

Ensuring that women become members of HCP committees is not enough to ensure their participation in decision-making. Efforts have to be made to encourage women to state their views, perhaps by using innovative techniques for involving people of different backgrounds and status.

Reaching the poor

People in cities—particularly the poor and newly arrived—experience stresses and exposures that result in health problems, ranging from communicable diseases and malnutrition to mental health and chronic respiratory diseases [(WHO, 1995), p. 3].

HCPs aim to reduce inequalities in health in cities by focusing on improving health and environment conditions in which poor people live.

In Cox's Bazar and Dar es Salaam, the poor have been targeted either by implementing activities in locations where the poor live or by focusing on services that affect the health of the poor. The Cox's Bazar HCP targeted ward one, the poorest in the municipality with the largest number of slum residents The HCP also extended the work beyond the municipal boundary to the district urban area where the poorest population lived. In Dar es Salaam, geographic

targeting of the poor was achieved through the selection of key settings (e.g. markets that serve the poor, deprived schools and unplanned settlements). In Fayoum, targeting of the poor was less distinct. In Quetta, the focus has been on two low-income areas, but these areas were not housing the 'poorest of the poor' according to the HCP coordinator and provincial WHO operations officer.

Lessons learned

As the HCP aims to improve the health of low-income urban dwellers, the design of projects needs to incorporate findings of recent literature on poverty reduction efforts. These debate the value of: (i) targeting the poorest of the poor as opposed to broader targeting of low-income groups (Vandemoortele, 1999); and (ii) targeting low-income groups without consideration of the wider urban system that includes middle- and high-income dwellers (Stephens, 1996). In the absence of consideration of these issues, the projects have used different foci for targeting, with some projects emphasizing the entire city and others targeting discrete low-income areas.

Political commitment

Boonekamp *et al.* (Boonekamp *et al.*, 1999) and Werna *et al.* (Werna *et al.*, 1998) described the need for high-level political commitment to the HCP to enhance the likelihood of project success. The WHO HCP guidelines (1995) emphasized the importance of building public support and of gaining the approval of the municipal government [(WHO, 1995), p. 15].

A clear-cut approval and commitment of the government to the project sends an important signal to all municipal government staff and agencies that public health issues are now 'on the agenda' and worthy of greater consideration, and provides a framework for greater cooperation by relevant municipal agencies in undertaking public health work.

Political commitment is taken to mean commitment from actors with political influence in the city, for example the head of the municipality, senior civil servants, and district and provincial politicians. In different cities, the influence of appointed or elected politicians versus high level civil servants can vary. For example, in Fayoum it is the appointed local government officials who hold the most political power, while in Quetta

the appointed administrator of the Municipal Corporation is supported by senior civil servants and members of the Provincial Government who are highly influential in the city. In addition, the levels of responsibility of local versus central government institutions can vary between cities, and the relations between municipal, district, provincial and central governments may not always be harmonious.

There are a number of ways in which the city leadership can demonstrate their commitment to a HCP: mobilization of resources; representation of city leadership on HCP committees; and participation of city leadership in HCP events.

By collecting the minutes of HCP meetings and interviewing members of the various committees, it was possible to draw conclusions about the representation of the city leadership in the HCPs. In Fayoum, Quetta and Cox's Bazar, the city leadership (although not always at the highest level) is represented on the steering committees and task forces (Fayoum) or technical committee (Quetta). A further indication of the commitment of political leaders to the projects was the secondment of local government officials to the post of HCP coordinator in Quetta and Fayoum.

Evidence of the participation of city leadership in HCP events was drawn from media reports, interviews with HCP coordinators and representatives from the local government. It was apparent that in many instances, high level politicians had been involved in HCP events and activities. In Cox's Bazar, in the absence of the Chairman of the municipality (who is rarely in town), one of his three deputies, the Commissioner of ward one, had been heavily involved in facilitating community-based HCP activities. In Quetta, the administrator of the Municipal Corporation was present at the inauguration of the HCP in 1996 and he participated in World Health Day 1996, which had healthy cities as its theme.

The guidelines for HCPs [(WHO, 1995), p. 15] state that: 'Municipal government approval has in practice almost never been difficult to achieve, especially when government staff and officials have been consulted and involved in the start-up phase [of the HCP]'. It is, however, worth noting that in the four HCPs considered in this report, certain problems in obtaining political commitment were encountered.

In Quetta, the biggest obstacle to obtaining consistent, strong support from the city leadership was the frequent changes in members of public agencies. For example, from 1996 to 1999

there were six Secretaries of Health in the Government of Balochistan, and from 1998 to 1999 there were five Administrators of the Quetta Metropolitan Corporation.

In Cox's Bazar, the city leadership objected to the proposed location of several project activities (the installation of toilets and a tube well) outside the municipal boundaries, which served non-constituents. These proposals were put forward by members of the task force who were from district agencies that covered a wider area than the municipality. Thus there was a dispute between representatives of district and municipal agencies, with the municipal actors refusing to take part in activities that took place beyond their boundary. Such disputes could have been avoided if the geographical focus of the HCP had been stated clearly at the outset.

In all four cities, an important determinant of the level of political commitment was the ability of the coordinator to access and influence high-level political leaders. In Quetta and Fayoum access was relatively easy to achieve due to the links the coordinators had with the local government. In Cox's Bazar and Dar es Salaam access was limited due to the absence of municipal leadership in Cox's Bazar and the location of the Dar es Salaam project. However, in all four cases, the ability of the coordinators to influence high-level politicians depended on their understanding of the project, their propensity to 'sell' the project, the status of the project and the current political climate. The first two factors (understanding and 'selling') revolve around the experience and motivation of the coordinators, their levels of commitment to the project and the level of support they have received from the WHO. The third factor (status) relates to many factors, but particularly to the support the project receives from the WHO structure (i.e. provincial, national, regional or international levels). The final factor is largely beyond the control of the project and constitutes one of the supra-urban factors described by Harpham and Werna that can impact upon project sustainability (Harpham and Werna, 1996).

De Leeuw (1998) described how different reasons for initiating HCPs can impact on later levels of political commitment. It is therefore likely that the method of selection used for Fayoum, Quetta, Cox's Bazar and Dar es Salaam has resulted in weaker political commitment than in the cases where HCPs are established at the request of local leaders.

Lessons learned

In the absence of political stability, the HCP coordinator must be prepared to spend considerable time and energy in ensuring commitment from new city leaders. As outlined by Werna *et al.* a mechanism for achieving political commitment to the project in the absence of political stability is through high levels of community participation in the project (Werna *et al.*, 1998). The impact that community participation can have on project sustainability was demonstrated in Campinas, Brazil, where a change in mayor lead to reduced political support for the HCP. However, the community was so mobilized that the HCP activities were maintained regardless of the lack of input from politicians [see (Werna *et al.*, 1998)].

The role of the coordinator in achieving political commitment is key. They can enhance such commitment through facilitating community participation, creating a high-profile project and convincing political leaders of the importance of the project. Thus capacity building of coordinators is vital. HCPs that are set up for external reasons (i.e. not at the behest of local leaders) require additional efforts to ensure strong political commitment.

MUNICIPAL CHANGE

Influence on policy

Although the word policy is often taken to mean different things (Walt, 1994), in this instance, due to the aims of HCPs, the term will be equated with municipal policy. It is not just commitment from political leaders that is required, but also their willingness to make policy changes that reflect the aims of the HCP. The mechanisms through which policy can be changed include the ability of the HCP actors to influence key political actors. In addition, popular pressure and media coverage can impact upon policy (Walt, 1994).

There was little concrete evidence to suggest that there had been any municipal policy changes as a result of the HCPs. This is similar to results of evaluations of HCPs in Europe (Goumans and Springett, 1997). In fact in Fayoum, it appeared that the HCP had been adapted to the prevailing view of development held by municipal officials (the need for high technology and infrastructure improvements) rather than the HCP impacting upon the views of such officials. Despite this, some secondary stakeholders reported that compared with the situation prior to the start of the

HCP, the municipal systems were planned better and there was greater recognition of the relationships between the environment and health.

In Dar es Salaam, the municipality had attempted to apply the healthy city model to other areas of their work. For example, following the success of market improvements, the municipality re-built another market using a loan from an international NGO. Similarly, school health had become a priority issue within the municipality following the apparent success of the healthy schools activities initiated by the HCP.

Although the main interest is in municipal policy change, there was some evidence to suggest that certain institutional and government department policy changes could be linked to the HCP. In Cox's Bazar, for example, priorities set during task force meetings were often adopted by government departments. During one such meeting, the problem of congestion and accidents in the town centre was identified and linked to the location of the bus terminal. A priority action was therefore set as the relocation of the bus terminal. This task was subsequently undertaken by the Transport Department.

Lessons learned

As was the case with political commitment, there are many factors that affect the HCPs' ability to influence policy: the distribution of responsibility and cooperation between central, provincial, district and municipal governments; the ability of the HCP coordinator to influence politicians; the status and profile of the HCP; and existing policy. Achieving municipal policy change will probably take at least 3–4 years to achieve, particularly in places where there is political instability, highly centralized government and frequent changes in HCP coordinator.

Resource mobilization

In the concept of healthy cities, the municipal health plan is partly seen as a 'process of consultation, data gathering analysis and resource mobilization' (WHO, 1995). Resources can be analysed according to type and source. According to De Leeuw [adapted from (De Leeuw, 1998), box 3, p. 24], the types of resources important for an HCP are as follows.

People:

- paid staff
- secondments by public bodies
- secondments by NGOs
- volunteers
- non-project staff time

Money:

- operational budget to run the office
- resources to be used as seed money

Hardware:

- office space
- equipment
- communication materials

Intangible resources:

- the WHO label
- know-how and expertise
- mutual support from other cities
- networking capacities
- status

In terms of staff, the project coordinators were funded by the WHO and were sometimes 'seconded' (for example in Quetta, the coordinator and his assistant were seconded from the municipality). Community members volunteered their time to participate in numerous activities, but no detailed information exists on person-days made available. The operational budget was expected to be provided by the municipalities (e.g. phone bills). With regards to the hardware for the projects there were several problems, e.g. in Quetta the lack of a computer was considered by the coordinator to be a substantial drawback and in Cox's Bazar the non-repair of a photocopier was a constraint.

The intangible resources are, by their nature, difficult to assess. The desirability of extended use of the 'WHO label' is debatable, but can be useful in the early stages of the project. In these projects it varied from a minimum in Quetta and Fayoum to a maximum in Cox's Bazar, where the coordinator needed to identify her status in the absence of strong municipal commitment. In summary, the different types of resources regarded as important were available to the projects but there were some problems regarding hardware and operational budgets.

Considering sources, resources can be mobilized from community members, CBOs, NGOs, municipal government, central government ministries, the private sector and donor organizations. In Fayoum, Quetta and Cox's Bazar, the HCP offices were located within governorate/municipal buildings and were supplied with accommodation of variable quality. In Dar es Salaam,

the City Commission have expressed a desire to re-locate the HCP office from WHO buildings to their site. Other ways in which the city leadership have contributed resources is through time spent participating in committee meetings and other HCP events, and through the provision of facilities (e.g. in Cox's Bazar, the municipality had provided office space and paid the electricity expenses of the HCP).

The most common pattern of the current projects was for the respective departments in the municipality to use their own departmental resources. For example, in Cox's Bazar this included the construction of the bus terminal outside the city, tree planting schemes to prevent erosion, and construction of drains. The Cox's Bazar project also generated NGO resources, for medical supplies and rickshaw vans for garbage disposal.

The Fayoum governorate directed significant resources to HCP priority activities and sites. The environmental improvements, which involved significant capital expenditure, cost US$7 million. US$127 500 were provided by the WHO (1.6%). Respondents in Fayoum regarded the limited HCP funds as necessary seed money. They perceived that without these external funds, HCP 'priority status' would be lost. For example, many secondary stakeholders stated that in 1998, when there was a gap in HCP funding, the HCP sites lost their priority funding status and no funds were committed by the governorate during this phase. While the project enabled activities to converge in priority areas and to target priority populations, the large-scale infrastructure projects such as public water supply and sanitation were not always perceived by the public to be connected with the HCP. Note that in the absence of the HCP the $7 million might have been spent elsewhere in the country, and possibly not on sanitation. This mobilization of resources is attributed to the HCP because the activities implemented using these resources were specified in the HCP plans, prior to resource mobilization.

Lessons learned

The types of resources available to the projects were generally appropriately allocated between staff, expenses and hardware, but in some cases there was insufficient operational budget. Future projects need to ensure that an appropriately allocated (between hardware and software)

budget is available. In terms of raising monies from different sources, the experience across the projects varied. In countries where government-lead projects predominate, and there is traditionally a weaker NGO sector (e.g. Egypt), HCPs will have to rely largely on government departments. However, the fact that HCPs can be presented both as a municipal strengthening activity and as a community development-oriented project means that projects can be agile in obtaining both government and NGO funding, as happened, for example, in Cox's Bazar.

LINKAGES

Intersectoral collaboration

Intersectoral collaboration is a key strategy that should be used in HCPs (Tsouros, 1995; WHO, 1995). It can be implemented in different ways and can range from simply establishing a network of relevant organizations to implementing a particular action and joint working (Costings and Springett, 1997). From a comparison of HCPs in the UK and The Netherlands, Goumans found that intersectoral collaboration tended to equate with interpersonal rather than inter-organizational collaboration (Goumans, 1998). Goumans outlined various factors that can determine the extent of intersectoral collaboration. These include local and national policies, the structure for collaboration (provided by HCPs) and knowledge of how different sectors can affect health.

In the projects evaluated, intersectoral collaboration had been achieved to different degrees in planning and implementation. In planning, collaboration had been achieved through workshops held for the purpose of situation analysis and developing action plans. Task forces, particularly those based on settings, were an effective way of facilitating intersectoral collaboration in implementation.

The Cox's Bazar action plan was implemented through six task forces, namely land development and infrastructure, environment, poverty alleviation, education, health and tourism. Each task force consisted of 20–30 members. Many sectors were represented in more than one task force, making it possible for lateral coordination between task forces.

In Fayoum, the HCP developed early linkages with other government institutions (e.g. education, agriculture, transport, sanitation, production and

social departments). The activities carried out later required greater associations with local planning units, community development societies and the communities themselves.

In Cox's Bazar and Fayoum, where task forces and intersectoral groups had identified priority activities, these were often activities already included in the plans of different sectors. This encouraged task forces to coordinate activities implemented by the different sectors and to prioritize previously planned activities to match the healthy city action plan. However, inclusion of some of the sectoral activities in the action plans constrained evaluation efforts in that it was difficult to determine the difference between healthy city achievements and those of other sectors. Examples of such activities were the construction of drains in Cox's Bazar and the US$1.6 million waste recycling plant in Fayoum. The greater the collaboration between sectors, the more difficult it was to attribute municipal health and environment activities to the HCP alone.

Collaboration in implementation was most distinct in Dar es Salaam, where sectors had come together at different settings such as markets and schools. Werna *et al.* pointed out that 'the use of settings facilitates people's participation and cooperation' [(Werna *et al.*, 1998), p. 16]. In Dar es Salaam, a consultation was held over 3 days in 1997 and was attended by 77 people. To ensure an intersectoral approach and wider participation, the participants were drawn from central and local government sectors, including all departments of the City Commission and relevant ministries, NGOs, CBOs, the WHO and other partner agencies. During the consultation, thematic papers on the following topics were presented by key representatives of the city:

- development context;
- environment profile;
- housing and health;
- food safety;
- school health;
- water, sanitation and health;
- health profile;
- who is doing what in the area of health; and
- hospital health, urban life and mental health.

The participants then identified the key problems encountered by the city, proposed possible solutions, set priorities for action and defined activities that should be carried out in order to address the problems. While this exercise has sometimes been considered to be a consultation, the resulting document is considered a form of city health plan.

As an example of a multi-sectoral activity, improvement of water and sanitation facilities in Buguruni market involved bringing together various government institutions, NGOs, CBOs and the community. The overall coordination of activities was implemented by the HCP task force on healthy markets. As an initial step, the task force together with the Buguruni Market Association carried out a situation analysis of the market. This was followed by the development of an overall plan to develop different facilities in the market. Once this was done it was clearer for the different organizations that were involved and/or those who would like to be involved to understand where their inputs would be most useful. The plan also reduced overlaps.

At the time of development of the plan, there was no system for regular collection and disposal of waste created in the market. The sanitation system was inadequate and water supply to the market was irregular. The markets were identified as the origin of epidemics such as cholera. Since the development of the Buguruni market sanitation improvement plan, several organizations have been involved in the implementation of this plan through research, contributing resources, financing various projects and raising awareness.

Lessons learned

Intersectoral collaboration has been a key strategy in all the HCPs evaluated. It was found that when collaboration was stronger at the secondary stakeholder level (e.g. between government departments), it emerged as coordination of previously planned activities, whereas collaboration at the primary stakeholder level or in settings tended to involve not just coordination, but resource generation and joint working as well. Thus, coordinators and future HCPs should be aware that: (i) there are different types of intersectoral collaboration; (ii) it takes time to achieve; and (iii) a range of factors can inhibit or facilitate it.

Networking

As emphasized in the Healthy City Practitioners' Guide [(WHO, 1995), p. 29], networking is regarded as an important output of any HCP:

… networking and contact with other healthy cities both within the region and elsewhere will provide a

source of stimulation, exchange of technical knowledge, mobilization of resources, and a standard for comparison for achievement in addressing health and environment problems. Senior officers should have taken part in one or more international healthy cities events.

International networking was achieved in the current projects, as all the HCP coordinators attended a meeting in The Netherlands in 1998, where progress was reported and evaluation planned. In addition, some project coordinators undertook effective local networking and had the opportunity to influence both regional and international discussions (e.g. the Cox's Bazar coordinator attended a south-east Asia WHO regional meeting and the Dar es Salaam coordinator gave a presentation at the international meeting on HCPs in Athens in 1998).

While there is no evidence that international networking has mobilized additional resources, it appears to have strengthened capacity in that city coordinators are now practised in presenting their project achievements. It should be noted, however, that due to the prestige associated with international travel, overseas visits occasionally caused tension between project colleagues. It is difficult to foresee how such networking will be sustained without further external funding. This leads into the issues of capacity building and sustainability, which are considered in the next section.

Lessons learned

National, regional and international networking can increase the capacity of project coordinators (although this capacity building can then be limited if the coordinator leaves his/her post). As HCPs are relatively new in developing countries, networking is particularly important for knowledge sharing, but needs sensitive planning.

CAPACITY BUILDING AND SUSTAINABILITY

Capacity building

Capacity building needs to be considered in terms of both institutional and individual capacities. While there is evidence of individual (coordinator) capacity being strengthened, there is little evidence of institutional capacity building. This reflects the fact that the main inputs for

capacity building were directed at the coordinator [e.g. exposure to national and international meetings, technical advice from consultants (averaging 1 week per annum per coordinator over the 5 years) and special training events]. The scope of this evaluation did not permit an assessment of any change in capacity at the community level.

While some cities spent a large proportion of project costs on training (figures not available), other cities (e.g. Fayoum) gave less attention to training. On the face of it, there appears to be a correlation between the amount of training received and the amount of 'software'-type projects as opposed to capital, infrastructure projects. For example, in Fayoum, ~98% of funds have been assigned to building works (infrastructure).

Lessons learned

Focusing capacity on the coordinator alone is risky, particularly since there is often a high turnover rate of coordinators. Only one of the projects, Dar es Salaam, invested in training persons other than the coordinator and this appears to have had a 'trickle down' effect, particularly as it took a 'training of trainers' approach. Projects might need additional technical assistance to develop training programmes.

Sustainability

Capacity building is linked to sustainability in that strengthened capacity will be maintained whether or not additional financial support is received for particular activities. Werna *et al.* identified three key factors of HCPs likely to enhance sustainability: a broad definition of health, an intersectoral approach and a wide range of stakeholders (Werna *et al.*, 1998). The fact that HCPs receive limited external funding makes them reliant on mobilizing local resources.

Sustainability needs to be considered at the municipal level (both leadership and management), at the level of NGOs and CBOs, and individual households. Strong political leadership in support of HCPs has not emerged. However, in some of the current cities there has emerged an active level of senior management that enhances prospects of sustainability. In Cox's Bazar, for example, the individual task forces should be able to continue their work without any strong central leadership, as the latter has not been present for the last 5 years. As in many other development projects, it is the activities that

involve the least expenditure that are likely to be most sustainable.

A major threat to the sustainability of healthy city activities is the loss of the coordinators. In these projects, the salaries of coordinators have been paid by the WHO with support from UNDP/LIFE. However, at the time of writing, UNDP/LIFE funds have ceased. While the concept of healthy cities is that eventually the urban local government (municipality) will assign the role of coordinator to one of its establishment staff, there was no indication (at the time of evaluation) that this will happen in any of the four cities under consideration. As for continuing the employment of existing coordinators, this depended on the ability of the municipality to pay the same salary as that provided by the project. This problem is not specific to this group of HCPs and is highlighted in Werna *et al.* (Werna *et al.*, 1998).

Lessons learned

Without absorption of the coordinator into the municipality's establishment budget, any HCP has limited sustainability. It is unrealistic to expect the healthy city concept to be engendered at municipal and community levels without the 'driving force' of an individual dedicated to HCP objectives. The limited political will for the current projects jeopardizes their sustainability, and future projects should be supported only if there is strong senior political interest and support at the outset, or preferably in initiating the project.

Costs

Reviews of evaluations of healthy city projects in developing countries have often criticized the fact that the evaluations do not consider costs (Werna and Harpham, 1995; Werna *et al.*, 1998). The only cost analysis of an HCP in developing countries is that by Puntularp and Patarasuk (1998), who analysed Bangkok. They estimated the true economic cost (financial cost plus opportunity and time costs) and found that the approximate cost per year of the Bangkok HCP was US$115 000. Ninety-six per cent of this annual expenditure was on projects in the communities and the remaining 4% was on the management of the project. Recurrent costs were much higher than capital costs, and it is interesting to note that expenditure on equipment and

training was relatively low. It is useful to compare this with the annual costs of the current projects as presented below (note the analysis includes Managua).

In terms of the WHO's contribution to the HCPs, there was a total of 116 professional person months and 19 administrative person months over a 4 year period. The cost of this input is $1 734 200, i.e. $86 710 per city per year. In addition, direct expenditure (including coordinator costs) was $45 429 per city per year. When these costs are added to the WHO input it makes a total of $132 139 per city per year (note that this does not include additional resources mobilized, as such information was only available for Fayoum). Thus, we have an expenditure that is very close to the running cost of the Bangkok HCP. To the authors' knowledge there is no equivalent costing of any of the HCPs in the north ('developed' countries). Costs have been averaged across the five cities, as no city specific costs were available from WHO Geneva.

Lessons learned

Without deliberate planning, the costs of the HCPs appear to be 'reasonable' when compared with the only bench mark available (although extra resources mobilized cannot be analysed). Future HCPs need to ensure good financial records are maintained and a cost analysis is undertaken to provide more comparative data and to ensure that cost-effectiveness can be assessed.

CONCLUSIONS

It was 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. However, a certain level of political mobilization was achieved and preceded community participation in 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 to facilitate the design of such a plan meant that by and large such plans did not exist.

There was evidence to suggest that among secondary stakeholders, understanding of environment–health linkages and the need for community involvement in the projects had been enhanced by the HCPs. Similarly, among primary stakeholders in certain HCPs, there was evidence of increased awareness of the link between their own health and the urban environment (particularly sanitation).

There was successful intersectoral collaboration through joint planning and resource mobilization. Where the settings approach was used, there was increased evidence of intersectoral collaboration. Through the deployment of UNDP/LIFE small grants, partnerships with CBOs and NGOs were created. There was some evidence of increased capacity of coordinators, but this was not reflected in increased capacity in institutions.

Key recommendations drawn from the lessons learned are that:

- coordinators should be flexible in creating project management structures;
- the settings approach should be used whenever possible;
- community development projects initiated by the HCP should receive seed resources from the HCP (as in UNDP/LIFE small grants);
- practices to enhance female participation in HCPs should be adopted;
- HCPs should take into consideration recent literature on effectiveness of poverty reduction efforts;
- future HCPs should be initiated only at the behest of local partners;
- coordinators should receive continuous guidance and support in managing HCPs;
- the objective of achieving policy change should not be evaluated during the first 5 years of an HCP;
- HCPs should have an appropriately allocated budget, in particular a reasonable operational budget;
- HCPs should be presented as both a municipal strengthening activity and a community development project;
- coordinators should be aware of the factors that can enhance intersectoral collaboration;
- resources should be allocated for networking both within and between HCPs;
- international networking should be sensitively planned;
- capacity building should not focus on the co-ordinator alone and should have appropriate technical assistance;
- HCPs should ensure financial reporting is undertaken; and
- cost-effectiveness of HCPs should be assessed.

When these projects began, there was no information available on the experience of HCPs in developing countries. Comparisons with other northern HCP evaluation findings have been made above. Thus this evaluation, by adding to the small but growing literature on HCPs in developing countries, will hopefully make a valuable contribution.

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Address for correspondence:
Trudy Harpham
South Bank University
London SW8 2JZ
UK
E-mail: T.Harpham@sbu.ac.uk

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