A short guide to implementing the healthy city programme

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Preface

The healthy city programme expresses a commitment on the part of an urban community to improve its members' health through sustainable development. This requires including health equity for everyone in all health and development policies. This initiative has been established in all six WHO regions and was put into practice in the Eastern Mediterranean Region in 1990 with its implementation in the Islamic Republic of Iran and its later expansion into Afghanistan, Bahrain, Iraq, Oman, Pakistan, Saudi Arabia and Sudan.

As yet, no universal systematic approach for the implementation of the healthy city programme has been established, so countries are implementing the programme according to their own understanding of it and their interests. In 2007 a training manual for use by trainers and members of healthy city coordinating committees was developed in order to provide clear guidance for city planners and community members through a training course on the healthy city programme. The outcome of World Health Day 2010 (held on 7 April 2010) and the excellent responses of mayors, governors and city planners from 209 cities in the Region encouraged the Regional Office to develop a clear, concise, simple and practical guide to help countries standardize their methods, mechanisms and processes of implementation.

World Health Day 2010 provided the opportunity to push forward the urbanization and health agenda by securing the political commitment of more than 200 cities in the Region. It also encouraged community participation and intersectoral collaboration on actions for health. The cities' dedication to actively support the urbanization and health agenda must be sustained through membership in the regional healthy city network. Entrance into this network is contingent upon meeting certain criteria that qualify a city as a "healthy city".

The purpose of this guide is to provide members of healthy city coordinating committees, healthy city programme trainers, local partners, nongovernmental organizations, stakeholders, and key health and social service workers with practical ways and procedures to implement the programme effectively. The Regional Office seeks to build on past experiences to unify all implementation processes of the programme and so improve the health equity and quality of life of urban communities.

1. Developing healthy cities

1.1 Introduction

The healthy city programme has emerged as an effective tool for improving health equity in urban areas, particularly in low-income and underprivileged neighbourhoods. It is playing a role in the formation of political, professional and technical alliances to achieve health improvement goals and it helps create a supportive environment in which innovative action for local development can take place following a holistic and integrated approach. The healthy city approach involves comprehensive and systematic efforts to address health inequalities, focusing on urban poverty and the needs of vulnerable groups. It addresses the social, economic and environmental root causes of ill-health and places health at the centre of the economic regeneration and urban development agenda. To qualify as a healthy city, a city must complete three steps.

1. **Join the regional movement on health and urbanization:** The 209 cities from the Region that registered for the 1000 cities – 1000 lives global movement on the occasion of World Health Day 2010 completed this step by committing themselves to improving health in urban settings and implementing health awareness activities.
2. **Join the regional healthy city network:** The 209 registered cities must sign a letter of collaboration to commit to the healthy city programme and join the network. The cities must agree on a set of activities that will improve the health and social status of their residents and promote health equity, particularly in urban slums.
3. **Request assessment to qualify as one of the global healthy cities and receive a certificate from the Regional Office:** The cities must introduce activities and meet the criteria that will assist them to gain recognition as a healthy city. They must ensure that all monitoring indicators (the 80 points that are highlighted in these guidelines) are in place and ready to be assessed by the joint regional and country evaluation team.

1.2 Joining the regional healthy city network

Any city – regardless of its current health and social status – can request to join the regional healthy city network and be counted among the global healthy cities. The most important consideration is whether or not the city has the political will and commitment to improve the health and social status of its residents and is willing to redirect its resources and adopt the policies, organizational structures and processes required for achieving healthy city status. In light of observed global and regional experiences, the Regional Office has established the following list of tasks and criteria for cities wishing to implement the healthy city programme.

- **Sign the letter of collaboration:** The mayor or governor and the WHO representative must sign the letter of collaboration (see Annex 1) to commit to improving the health and social status of their cities via participation in the healthy city programme.
- **Brief and orient city planners:** Organize a meeting where national level authorities, experts, or the training team can brief and orient city planners on the healthy city programme.
- **Select an implementation site:** The city authorities must identify a part of the city as a healthy city programme implementation site. This should be based on the willingness and enthusiasm of the community and on the community's

prior active involvement in social welfare activities. Poor access to social services (including health, education, transportation, water, and sanitation) is one of the important factors that city planners should consider when selecting the site.

- **Establish a healthy city coordinating committee:** Establish an effective, influential, and enthusiastic healthy city coordinating committee capable of taking an active role in urban needs assessment, planning, implementation, monitoring and expansion of successful interventions and programmes. The committee should be chaired by the governor or mayor and should draw its membership from all development sectors, interested nongovernmental organizations, academics and community leaders.
- **Establish community development committees:** Facilitate community organization and mobilization by establishing community development committees and training health and social volunteers at the local level.
- **Select and train volunteers:** Suitable individuals with relevant backgrounds and an interest in public health should be trained following the healthy city programme guidelines.
- **Redirect available resources to programme needs:** Prioritize health and the environment in city development plans and devote resources to activities aimed at mobilizing many different sectors.
- **Open a healthy city office and hire a healthy city coordinator:** Open a healthy city office and appoint a healthy city coordinator to run it. Provide the office with an adequate number of staff, resources, and electronic connectivity.
- **Assess needs and develop long- and short-term plans to fill gaps:** Conduct a needs assessment survey, paying special attention to social determinants of health. Then develop long- and short-term plans to fill the gaps identified in the assessment.
- **Implement planned activities, monitor and document achievements and share data:** Monitor and document activities and achievements. Be willing to share information about the initial analysis of the situation, progress of work, implementation process, and lessons learnt with partners and with other cities in the healthy city network, both in and outside the Region.

A sample list of criteria for qualifying as a healthy city is given in Annex 2. This can be used by the community and members of the healthy city coordinating committee to assess the situation and ensure that all the criteria have been met. A city must meet at least 80% of these criteria in order to qualify as a healthy city.

1.3 Implementing the programme

To establish the healthy city programme in any given country or city it is important to tailor the programme to meet specific local needs. There is no standard formula to be followed; however, it is recommended that the programme be implemented in a methodical manner. The framework for implementation consists of three stages:

1. Getting started
2. Getting organized
3. Taking action

1.4 Stage 1: Getting started

The initial stage of implementation begins with establishing a core support group and orienting all relevant parties on the healthy city approach. This stage ends with the approval of the project proposal and the generation of funds. Stage 1 entails the following steps.

Build a core support group

When introducing the programme in a given city, a national level technical support committee or core support group comprising public health experts and master trainers should be formed. This group serves to mobilize government support at the national and local levels and it provides all necessary technical assistance for: briefing policy-makers, conducting needs assessment, planning, prioritization, implementation, monitoring, evaluation, documentation and expansion.

Orient concerned parties

The core support group orients city authorities, politicians, the media, partners and communities on the approach and explains the healthy city programme philosophy, principles, strategies, methodology, and implementation processes in simple, straightforward language. The objective is to gain consensus on the main strategies and areas of work, in addition to exploring avenues to generate the national and local resources required to implement the programme. The healthy city training manual published by the Regional Office in 2007 can be used as a reference for conducting training and orientation sessions. The orientation sessions should simply and directly address the city's most important health, environmental, social and economic problems and should encourage the city's government, community and nongovernmental organizations to work together to confront local health, environment and social problems with local solutions and available resources.

Get to know the city

When initiating the programme, it is essential to have a good understanding of the city in question. This stage does not require gathering in-depth information about the city, but an overview of the demographic, health, environmental, social and economic data should be sketched out and offered to the core support group, so its members can gain an understanding of the city's various problem areas.

Choose a location for model area development

This decision should never be made on political grounds; the best and most suitable geographic area should be chosen to ensure success and present opportunities for expansion. The most important criteria to consider are:

- readiness of the local community to participate and its social dynamics;
- poor access to social services such as health, education, transportation, water and sanitation;
- presence of active and interested nongovernmental organizations and community groups ready to participate in creating the model development area on a voluntary basis;
- approval of the local city authorities.

Plan a quick needs assessment

The core support group should propose a strategy for performing a quick situation analysis using existing data, as well as by collecting key information through focus group discussions with managers, health-care providers, members of the media and the community and nongovernmental organizations. Some data may need to be collected via a questionnaire and a rapid needs assessment survey may be needed to complement the available information. This process should be time limited. The following indicators may be considered in a quick needs assessment:

- access to safe drinking-water and sanitation (e.g. percentage of houses with piped water supply; percentage of houses with access to a sewage system; existence of an adequate solid waste management system; percentage of solid waste recycled; percentage of treated wastewater; amount of ambient and indoor air pollution; rate of green areas per 1000 population; rate of sports facilities per 1000 population; quality of roads and pavement, etc.);
- local public transportation and health care facilities within a 30-minute walk;
- satisfaction of citizens with municipal and health services;
- community participation in local elections and history of financial contributions to social services;
- number of schools; net school enrolment rate; and adult illiteracy rate by gender;
- mortality rate due to accidents and injuries; mortality rate for children under 5 years; major causes of child mortality; and availability of city disaster preparedness and response plans;
- low birth weight; obesity; malnutrition; and exclusive breastfeeding;
- early pregnancy and access to skilled birth attendants;
- immunization coverage;
- access to sports facilities and green areas and utilization rate of these facilities.

If possible, all data should be recorded according to gender.

A sample baseline household survey can be found in Annex 3.

Analyse data collected

Analyse information on the local situation to determine a set of baseline data, from which appropriate and feasible strategies to modify health policies and launch new initiatives can grow.

Prepare a project proposal

The project proposal should be prepared with technical assistance from the core support group and must follow the healthy city approach and comply with all its main strategies and procedures. It should reflect health and development priorities and propose innovative approaches to solving problems. It is essential that the proposal's objectives be feasible and measurable. The following projects may be considered after analysing the baseline survey:

- developing healthy lifestyles by actively involving women and youth and increasing access to sports facilities, green areas, etc.;
- establishing a sustainable mechanism for increasing poor people's access to primary health care and creating healthy settings such as: healthy environments, green areas, nutrition, restaurants, markets, hospitals, schools and workplaces;
- fostering active community participation and intersectoral action on social determinants of health based on the needs of the community;
- providing public health-care services to all through training and involving local volunteers to: follow up on loan defaulters, collect vital statistics and conduct continuous needs assessment of households;
- launching interventions to open channels of communication with the media on health equity and to build community awareness;
- improving school health services in the healthy city model development area;
- building communication and support networks linking people and agencies concerned with urban health development.

See Annex 4 for sample project proposals.

Obtain approval from the city council

When the healthy city coordinating committee approves a proposal, it provides official recognition of the healthy city programme as an integral component of the national system. It also indicates formal political commitment and ownership. The approved proposal represents an important tool for developing local partnerships and mobilizing resources at the local level. Following its approval, the programme gains official status as part of local development and public health policy and future actions can be planned accordingly.

Mobilize funds for programme implementation

Funds can originate from many sources, including city budgets, government support, partners, departmental allocations, joint United Nations allocations and community resources. Business groups and local industries interested in city development are another potential source of funds.

Organizations unable to provide financial resources can support programme activities through the provision of human resources and technical services. Fundraising activities (e.g. exhibitions, variety shows and cultural events) can be an effective way of generating resources to support project costs. A *zakat* (Islamic charitable giving) fund may be used after obtaining permission from religious leaders. Different project proposals may be prepared using the project proposal format available in the annex and shared with interested donors and partners. Proposal preparation and presentation demand special skills and a deep understanding of the project itself. These skills must be taught to all city managers and planners. It should be noted that when a community succeeds in bringing about even a small change in its situation using local resources, this provides a platform to which other donors can add their resources.

1.5 Stage 2: Getting organized

Stage 2 begins with the formation of organizational structures and administrative

mechanisms to provide leadership, encourage intersectoral coordination and ensure community participation in programme activities.

Organize committees

The core support group and national focal point facilitate the process of organizing the healthy city coordinating committee, which is composed of representatives of health and other sectors and community representatives. This committee is responsible for formulating strategies, planning, decision-making and monitoring the implementation of programme activities. Other subcommittees, task forces and working groups can be created to address more specific tasks and activities. The selection of healthy city programme coordinators at the national and city levels is also an essential prerequisite.

Set up a programme office

This office will act as the focal point for the programme coordinator and the coordinating committee and subcommittees and facilitate effective community participation in programme activities. Past experiences indicate that municipalities are often interested in providing physical space for the programme office. The office should also serve as a link between partners and act as a liaison between the healthy city networks at the city level. All correspondence with the media, government officials, the community, United Nations agencies and donors should be channelled through this office. The healthy city programme coordinator must report regularly to the city coordinating committee (chaired by the governor or mayor). In some countries the programme office is located in the governor's office.

Build capacity

Capacity-building is the shared responsibility of the healthy city core support group, national focal point, coordinating committee and coordinator. They should jointly plan training activities to build the capacity of all sectors and individuals involved (including community members), orient stakeholders and develop human resources to carry out programme activities. WHO can play a key role in this area and can offer technical assistance in organizing the training sessions.

Organize and mobilize the community

The organizational and developmental process through which the healthy city programme and other community-based initiatives enable poor communities to improve their health and quality of life is illustrated in Figure 1. Community organization and women's development are

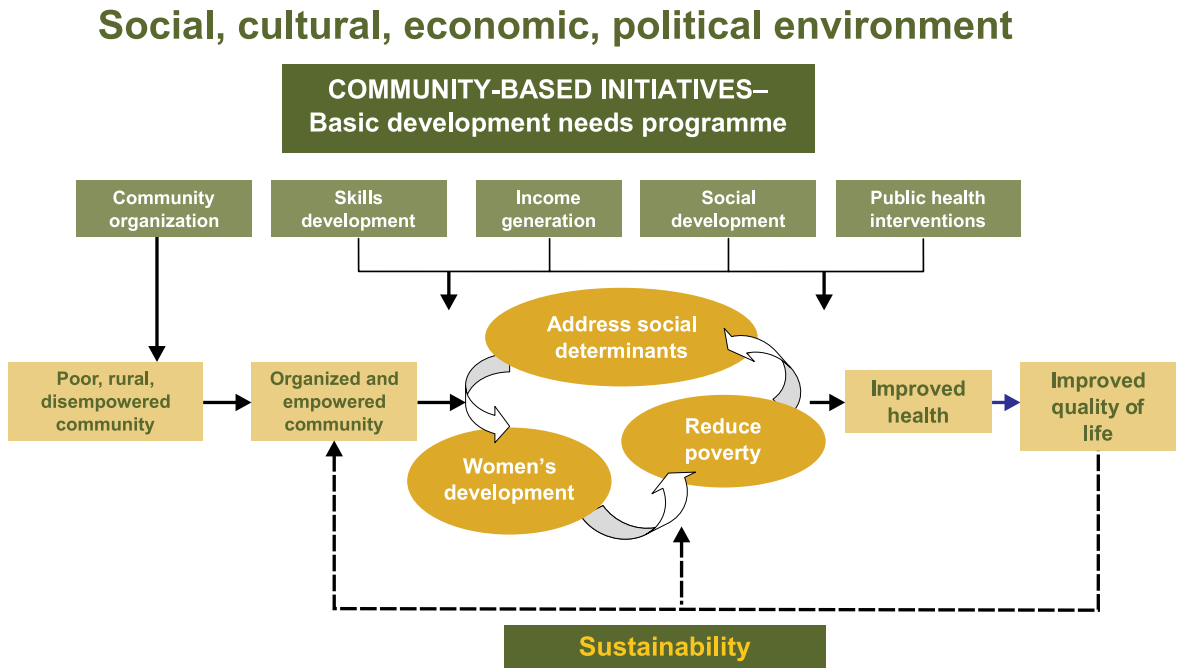

Figure 1. Community-based initiatives – basic development needs programme: tackling the social determinants of health through community-based initiatives

central to reducing poverty, improving health outcomes, empowering women and improving access to basic physical and social needs (e.g. health services, nutrition, safe drinking-water, sanitation, and shelter). The basic components that make up the platform for launching the healthy city programme are:

- **Community organization** – awareness and empowerment through community development committees, health volunteers, women, youth, other special committees and community health workers
- **Community needs assessment** – baseline survey of residents, setting development and health priorities and developing a city profile
- **Community-based capacity-building and planning** – development of social and income-generating projects, skills development, self-employment and community involvement in primary health care, water, sanitation and education
- **Community-based management and ownership** – efficient use of available resources and active community involvement in implementing, monitoring, supervising and expanding the programme
- **Community resource mobilization and partnership** – connecting with donors and civil society to generate resources and establishing local civil society organizations to increase sustainability
- **Institutionalization** – integration of the healthy city programme into the national health and development strategy, policies and programmes.

Guidance on the selection and responsibilities of volunteers and community development committees are given in Annex 5.

The community-based initiative self-monitoring tool, found at http://www.emro.who.int/cbi/publications_cbi_checklist.htm, should be used as a checklist to ensure that healthy city programme standards are in place (after some minor modifications based on local needs).

Define work priorities

The healthy city coordinating committee should prepare a clear list of priorities and present it to the healthy city coordinating committee for approval. The list should offer recommendations for actions to be taken. It should also define plans for the formulation and implementation of community-oriented interventions to improve residents' health and quality of life. Special attention must be paid to the needs of vulnerable groups and those living in urban slum areas with less access to health and social services.

Plan long-term strategies

Planning a healthy city requires building partnerships and drawing a road map that lays out the strategies that will be pursued to create a healthier environment. Long-term planning is necessary to encourage politicians and decision-makers to adopt healthy public policies. An essential element in strategic planning is striking a balance between highly ambitious aspirations and limited resources, while also addressing priority areas.

Establish accountability mechanisms

Accountability is a critical part of the programme. There must be a clear strategy to ensure accountability and build capacity. The reporting system needs to give a clear account of decisions, activities and results on a regular basis. Furthermore, regular health impact assessments must be undertaken and an annual health status report must be written.

1.6 Stage 3: Taking action

Taking action can begin when the healthy city programme has selected capable leaders and has built organizational capacity. It is essential to emphasize the importance of partnerships in the programme and the need for the partners' sincerity and commitment. Increasing health awareness and strongly advocating for public health policies and strategies are also significant components of this phase.

Increase health awareness

The programme promotes a holistic approach to health that addresses its physical, mental and social determinants. Socioeconomic equity and access to quality health care are crucial to improving health status. Health awareness is an important driving force for change because it generates public demand for sound public health policies, which, in

turn, compels various municipal departments to take appropriate actions.

A health awareness-building subcommittee can be formed with the participation of local media, schoolteachers, education authorities, nongovernmental organizations, health-care providers and managers, community members, and representatives from youth and women's groups. Specific tasks with clear responsibilities should be delineated. A comprehensive annual plan on health awareness building addressing the community's needs and major health and social problems should be formulated.

Advocate strategic planning

Strategic plans that set goals to be achieved over a period of 3–5 years should be formulated. The plans should provide directions for long-term activities, allow flexibility to respond to changing circumstances and address emerging situations.

Mobilize partnerships and intersectoral actions

An essential responsibility of the programme is to create organizational structures and administrative systems that mobilize intersectoral actions and assist the relevant sectors with the technical and material support necessary to implement projects. Partnership-building should be a continuous process and all available opportunities for cooperation should be explored. This serves to reduce duplication of services and programmes. Each project should be assigned a principal investigator who regularly reports to the healthy city coordinating committee on technical and financial issues. The principal investigator can be selected from within the community.

Encourage community participation

Community members should make direct contributions to improving health and living conditions as members of committees involved in strategy formulation, planning, decision-making, and implementation. The healthy city programme is committed to strengthening community participation at every level, including in its organizational structures, its administrative systems, the prioritization of projects and monitoring and evaluation processes.

Promote change and innovation

Strategies for promoting health through multisectoral collaboration must be continually developed and expanded. The achievements of the programme and the development of healthy public policy are contingent on the ability to design innovative projects that provide solutions to the communities' problems. Achieving success through innovation depends on creating a supportive environment for transformation and change.

Ensure healthy public policy

Local healthy public policy is perhaps the most important outcome of the successful implementation of the programme. Healthy public policy uses the leadership and resources of the city to create healthier settings for daily life at home, in schools, in workplaces, in health care facilities, and throughout the urban environment. The programme's ultimate objective is to ensure that local public policies effectively contribute to the development of an urban environment that promotes a high quality of life and good health for its residents.

2. Healthy city organization

The success of any programme depends on its organizational structure and on the abilities and dedication of those involved. In order to ensure that the programme's objectives are met, its organizational structure should be compatible with the government infrastructure and the country's sociopolitical norms. To maintain uniformity, the establishment of the following structures is highly recommended.

At the national level:

- Core support group
- National focal point

At the city level:

- Healthy city coordinator
- Healthy city coordinating committee
- Subcommittees/task forces/working groups
- Community development committee

A more detailed description of the responsibilities of the various staff, volunteers and committees and the criteria for selection is given in Annex 5.

2.1 National level

Core support group

The healthy city core support group is initially formed at the national level, but its membership is later extended to include local experts, authorities and influential residents. It may become known as a core group or a healthy city team. The national level core support group consists of staff from WHO and related United Nations agencies, staff from the Ministry of Health and representatives from various sectors and other relevant organizations. After making initial contact at the national level, an official agreement on the initiation of the programme is reached and collaboration begins between the main partners: WHO, the Ministry of Health and other government authorities. Support is then extended to the city to include municipal authorities, politicians, decision-makers, and representatives of different sectors of the city. This process ensures ownership and the involvement of all stakeholders. The members' dedication to the programme and their capabilities are critical. The core support group orients, motivates and mobilizes the national authorities and assists in selecting a suitable location for the model development area.

Other main functions of this group include: advocacy, building broad support, research and analysis, preparation of project funding proposals, establishing ways to implement work plans and offering technical support for programme implementation.

National focal point

The national focal point should be nominated by the government – preferably in consultation with partners – to guarantee his/her qualifications and capacity to provide leadership to the programme and effectively coordinate relevant activities in the country. He/she must either hold a senior post, preferably in a central sector (e.g. health), or be a government official able to efficiently and effectively to carry out the duties of the position, who has easy access to national authorities and decision-makers. The national coordinator for community-based initiatives may be given the same responsibilities as the national focal point. The main functions of the national focal point include:

- facilitating collaboration between the government, municipal authorities and WHO
- preparing project proposals and generating resources
- taking the necessary steps to implement the programme
- ensuring the effective operation of activities in areas where the healthy city programme has been implemented

- providing technical and administrative leadership and support to programme areas
- monitoring progress and managing all relevant information
- creating a healthy city network at the national level
- exchanging information and experiences with other countries.

2.2 City level

Healthy city coordinator

Each city implementing the programme should have a healthy city coordinator. He/she should preferably be from the local offices of a central department (e.g. health, municipality, or the governor's office), have a strong background and understanding of the programme approach and be capable of implementing programme activities. He/she should have a strong interest in public health, social welfare activities, the environment, urban development and strategic thinking. The most important requirements include: strong communication and negotiation skills; past experience and high performance at the city level; a respectful and tolerant outlook; solid understanding of socioeconomic and political issues; impartiality; flexibly; and the capacity to plan strategically and build widespread support.

The healthy city coordinator has the following main responsibilities:

- implementing the programme in accordance with regional and national approaches and strategies;
- providing leadership to the healthy city team and workers and supervising day-to-day operations;
- liaising with the national focal point and healthy city coordinating committee;
- providing support to the subcommittees, community and other working groups;
- coordinating multisectoral activities and development projects;
- mediating, facilitating and enabling local partnerships;
- generating support and financial resources;
- identifying, designing and implementing innovative solutions to underlying problems;
- joining the national and regional healthy city networks and exchanging information with the national, regional and global networks;
- managing the healthy city programme office;
- supervising the baseline survey;
- documenting, recording and reporting all information related to the programme;
- monitoring the implementation of strategies and plans;
- exploring opportunities and creating links with relevant agencies, departments and ministries;
- monitoring progress, reporting to the healthy city coordinating committee and making sincere efforts to keep the programme on track;
- acting as a driving force in the improvement of residents' quality of life and playing an important role in bringing about sustainable change in the healthy city implementation site.

Healthy city coordinating committee

The core support group also facilitates the process of organizing a healthy city coordinating committee at the local level. It is chaired by the governor or mayor and is assisted by the healthy city coordinator. Coordinating committees vary in size and composition but usually have a limited membership made up of key players from the fields of health and development. Members are selected based on their past activities and interest in public health issues as well as their ability to mobilize support. Potential candidates for coordinating committee membership are:

- the governor or mayor (as chairperson);
- the healthy city coordinator (as secretary);
- key officials responsible for city operations from the departments of health, social services, education, the environment, traffic, police, housing and urban planning;
- representatives of community groups;
- representatives from the private sector and related professional bodies;

- representatives from women's and youth groups;
- representatives from the electronic and print media;

The coordinating committee performs tasks including:

- leading and managing programme activities;
- liaising with individuals, partners and stakeholders and coordinating joint activities;
- encouraging the participation of community groups and nongovernmental organizations;
- facilitating collection and analysis of relevant information and preparation of the city's health profile;
- preparing the city health plan, individual workplans and proposals for development interventions;
- obtaining the city council's approval of the project document, strategic plans and proposals for interventions;
- providing technical support and assistance in accomplishing programme activities;
- ensuring intersectoral support and mobilizing resources;
- managing and controlling financial and other resources for the programme;
- monitoring and reviewing programme progress and achievement of its objectives;
- undertaking health risk and impact assessments;
- making day-to-day decisions on programme operations and tasks of the subcommittees and programme office.

A sample of criteria for recognition of a city as a healthy city is given in Annex 2. This can be used by the community and members of healthy city coordinating committee to assess the situation and ensure all the criteria have been met. A city must meet at least 80% of the points in this annex in order to be recognized as a healthy city.

Subcommittees

In order to operate efficiently, the healthy city coordinating committee usually nominates a core group of people from among its members to act as an executive committee. They meet more frequently and have direct involvement in planning programme activities and in day-to-day decision-making. Subcommittees gather information on relevant issues, design solutions to problems, identify people who can be of assistance to the programme and prepare recommendations for the healthy city coordinating committee. Some subcommittees are formed to implement projects or interventions and to monitor progress. Members of the subcommittees may come from the steering committee or from related departments or organizations.

Healthy city programme office

An efficient healthy city programme office in the project location is required to manage the programme. The office needs to be able to provide initiative, continuity and follow-up of programme activities and be of assistance in translating decisions and plans into practical interventions. The office should assign clear responsibilities in an organized manner, be staffed with adequate personnel, have appropriate facilities and be easily accessible.

Location

The programme office should be conveniently located, preferably near city administrative offices such as the municipality, governor's office, or health department. Visibility and access are key factors in choosing the location; the office should be located in a place that is easily accessible to key decision-makers, government officials and community members.

Facilities

A model programme office offers pertinent information on the work of the programme, healthy lifestyles, the environment and health care. It should be comfortably furnished and adequately equipped. It should also be accessible to the community. The office must contain a suitable conference room and a resource centre or library that are good venues for conveying health messages to community members.

Personnel

The programme office requires a full-time administrative and support staff. The need for

other personnel depends on the local situation, the extent of the programme activities, and other specific requirements (e.g. the demands of community development work and the need for information management, research, advocacy and communication).

Administration

An efficient programme office has simple and clear administrative procedures well suited to its functions and to local practices. The office should have convenient working hours that meet the needs of both the management and the general public.

Responsibilities

The healthy city programme office is the link between the different parts of the healthy city network and it extends programme activities by developing a wide range of contacts throughout the city. Its specific responsibilities and functions include:

- providing professional and administrative support to the coordinating committee and its subcommittees;
- assisting in planning, implementation, follow-up, supervision and monitoring of projects;
- convincing relevant stakeholders to implement decisions made by the coordinating committee;
- providing technical support and advice;
- documenting all activities, measuring progresses and keeping records;
- collecting information, conducting analysis and presenting results of analysis;
- helping the community to organize development committees and train them according to their needs;
- communicating with community members, partners and stakeholders;
- maintaining the healthy city network and sharing information and experiences;
- advocating programme strategies and action plans;
- acting as a resource centre for public health and human development issues;
- negotiating with potential partners and coordinating intersectoral activities;
- facilitating and supporting the active participation of community groups;
- undertaking health risk and impact assessments of programme policies and initiatives;
- providing information when required by the national focal point, the Ministry of Health, WHO and other stakeholders.

Annex 1. Letter of collaboration

Letter of Collaboration*

between

Governors/Mayors of .....

and

Country Representatives of the World Health Organization

on the healthy city programme

**This is only a sample letter of collaboration proposed by the World Health Organization Regional Office for the Eastern Mediterranean.*

City planners are requested to plan activities related to the healthy city programme, which aims to attain urban health equity and socioeconomic well-being. The focus should be placed on social determinants of health and the approach should be based on community ownership and sustainable intersectoral collaboration.

Cities registered in the 1000 cities – 1000 lives global movement are requested to write the letter of collaboration in their local language and to send copies of the signed letter to the Ministry of Interior and the Ministry of Health, as well as to other partner organizations.

Letter of Collaboration

This letter of collaboration, signed on _____ (date) between the Governor/Mayor of_____ (name of the city) and the World Health Organization (WHO) Representative, introduces the healthy city programme, which is part of the urbanization and health campaign launched on World Health Day 2010 .

The healthy city programme, which uses a participatory and partnership-based approach, focuses on addressing health challenges that arise from rapid urbanization. Currently, many cities in the WHO Eastern Mediterranean Region are facing rapid growth, which has an adverse impact on health due to environmental hazards, unhealthy diets, unhealthy lifestyles, the existence of slum areas, inadequate schools, heavy traffic and congestion, life stressors, an increase in noncommunicable diseases, road traffic accidents, other injuries, and health-related social issues. In summary, to safeguard the health and well-being of city dwellers, the lack of equitable preventive and curative health care services and the adverse effects of social determinants of health must be addressed.

Recognizing that the national and municipal authorities have prioritized improving the health of city dwellers in _____ (name of country), the signatories give approval for _____ (name of the city) to join the regional healthy city network and qualify as one of the Region's "healthy cities". As a healthy city, the signatories commit to:

- facilitating a briefing and orientation session about the healthy city programme that will be organized by national level authorities, experts or training teams;
- forming an effective, influential and enthusiastic healthy city coordinating committee (which is chaired by the governor or mayor and draws its membership from all development sectors, interested and reputable nongovernmental organizations, academics, and community leaders) capable of taking active part in urban needs assessment, planning, implementation, monitoring, and expansion of successful interventions and programmes;
- training volunteers at the local level;
- putting health at the top of the city management and development priorities and allocating the necessary resources to initiating activities to mobilize different sectors and actors;
- establishing a healthy city office with adequate staff, resources and electronic connectivity and appointing a healthy city coordinator;
- assessing residents' health and social needs and developing long- and short-term plans to fill identified gaps, paying special attention to economic and social determinants of health;
- monitoring and documenting achievements and sharing information about the initial situation analysis, progress of work, implementation process and lessons learnt with partners and other cities in the healthy city network in and outside the Region.

Governor/Mayor

Date _____

WHO Representative

Date _____

Annex 2. Criteria for qualifying as a healthy city

A) Community organization and mobilization for health and development		
Result	**Evidence available +**	**Evidence not available -**
1. Cluster representatives/volunteers are selected and trained on needs assessment, prioritization, data analysis, project preparation, monitoring, recording and reporting mechanisms.		
2. The healthy city coordinating committee has been formed, registered with local authorities as a community-based organization or nongovernmental organization, and members have been oriented on their tasks and responsibilities.		
3. Cluster representatives/volunteers are active partners in local health and social planning and procedures. They can also ensure that health care and other social services are used in their clusters.		
4. The healthy city coordinating committee monitors and supervises socioeconomic projects, records achievements and constraints and identifies local solutions for local problems.		
5. The healthy city coordinating committee looks for resources and builds relationships with potential partners for further development in their local areas.		
6. A community centre has been established or planned for different uses according to the community's needs (e.g. to hold community meetings, conduct vocational training, serve as a community information centre, or hold local cultural, national, and religious events, etc.).		
7. Women's and youth groups have been established and registered and are contributing to local development interventions.		

B) Intersectoral collaboration, partnership, and advocacy		
Result	**Evidence available +**	**Evidence not available -**
8. Members of the healthy city coordinating committee are nominated officially by different sectors .		
9. The healthy city coordinating committee is formed under the leadership of the mayor or governor, drawing its members from the representatives of all relevant sectors. Minutes of all meetings are recorded and reported.		
10. An official coordinator for the healthy city programme is appointed and provided with sufficient staff, physical space and facilities.		

11. Members of the intersectoral team meet with healthy city coordinating committee and provide technical advice and support for the community.		
12. Potential partners are located and contacted and at least one joint project with partners is being conducted in the healthy city implementing site.		
13. Financial issues related to joint activities are recorded, reported and shared with the community for the sake of transparency.		
14. Success stories are documented, published and used for advocacy. A comprehensive strategy and tools for advocacy taking into consideration local culture have been created and are being implemented by the local community development committee.		

C) Community-based information centre

Result	Evidence available +	Evidence not available -
15. A community-based information centre has been established and cluster representatives/volunteers and members of the intersectoral team are trained to collect key information, analyse it and use it for local development planning.		
16. Key information is displayed in the community-based information centre or local healthy city programme office and shared with the community and other relevant sectors/partners.		
17. Key information is used for advocacy and monitoring purposes by the local community development committee and other stakeholders.		
18. Baseline survey forms, its results, and information on current projects are well documented, up to date, and available from the local community development committee and the healthy city focal point.		
19. A city profile is created, regularly updated and used for planning and monitoring purposes.		

D) Water, sanitation, food safety, and air pollution

Result	Evidence available +	Evidence not available -
20. The programme implementation site is clean and has enough green areas.		
21. An effective community-based solid waste management system is set up in the programme implementation site.		
22. Water sources are mapped and protected. A water treatment plan has been established and the healthy city coordinating committee is aware of it.		

23. All families have sustainable access to safe drinking-water and basic sanitation. They are aware of the dangers associated with unsafe water and know how to purify water using what is locally available.		
24. Cluster representatives/volunteers are trained in maintaining healthy environments/healthy settings and related interventions accessible to the public such as healthy market places, healthy hospitals, healthy schools, etc.		
25. The community is involved in food safety and all healthy food shops/markets are monitored by the national food safety departments .		
26. Healthy food markets are easily accessible selling essential products such as iodized salt.		
27. Smoking is prohibited in closed areas and public places and a plan for creating a smoke-free city has been developed, approved and put in place.		
28. A community-based air quality management centre is established in the healthy city programme implementation site (involving the municipality) to ensure that air pollution is monitored regularly. The community is aware of the dangers of air pollution.		
29. City planners are implementing interventions that prevent air pollution.		
30. Urban zoning and housing schemes conduct air pollution impact assessment before being approved. Such housing schemes ensure, for example, households' access to clean fuel, ventilation, improved kitchen stoves and heating appliances.		

E) Health development

Result	Evidence available +	Evidence not available -
31. Cluster representatives and health volunteers are trained on priority health issues and health-related programmes. They are active in health promotion and education and they follow up on procedures through regular contact with local health-care providers.		
32. Cluster representatives and health volunteers register and report births, deaths and other vital statistics.		
33. The healthy city coordinating committee, in collaboration with health-care providers, have established sustainable referral systems.		
34. The community is trained and actively involved in community participatory research projects.		
35. A subcommittee of the healthy city coordinating committee has been formed to manage and supervise local health care services.		

36. All essential medicines, vaccines and medical instruments (according to the local health system's needs) are available at urban health facilities.		
37. The quality of health care services, clients' satisfaction with the services, health care staff's level of training, and interactions between health-care providers and the community are assessed and actions are taken accordingly.		
38. All pregnant women receive timely antenatal care (including tetanus toxoid vaccinations). A safe delivery plan for all pregnant women in their third trimester has been prepared and all women have access to a safe and clean delivery setting, where they are assisted by skilled birth attendants.		
39. All mothers receive postnatal care for at least 40 days after delivery.		
40. All children have been fully immunized against vaccine preventable diseases by the age of 1 year.		
41. All newborn babies are registered by cluster representatives and health volunteers and are vaccinated at birth and during the first year of life as per the national Expanded Programme on Immunization (EPI) schedule.		
42. The healthy city coordinating committee, cluster representatives and health volunteers are actively involved in polio campaigns (if any are being conducted).		
43. All children under age 5 have access to and are receiving regular health care services (including growth-monitoring) and a functioning follow-up system is in place.		
44. Malnourished children and mothers suffering from vitamin A deficiency and iron deficiency anaemia are identified and receive treatment and follow-up care.		
45. The tuberculosis DOTS strategy is being implemented using trained cluster representatives or volunteers as treatment partners.		
46. The malaria control programme (if needed) is being implemented with the active involvement of cluster representatives or volunteers and the leadership of local community development committees.		
47. Cluster representatives and health volunteers report all suspected cases of tuberculosis, malaria, HIV and other communicable diseases to the nearest health facility and carry out follow-up activities according to the training they have received from health facility staff and ensure family members are taking part in weekly healthy physical activities.		
48. Communities are informed about modes of transmission and preventive measures for HIV/AIDS. All diagnosed cases of HIV/AIDS are supported by cluster representatives and health volunteers.		
49. All chronically-ill patients (e.g. with diabetes, hypertension, cardiovascular diseases, cancer, kidney disorders, etc.) are identified, mapped, and a follow-up plan has been put in place by cluster representatives and health volunteers, who ensure that all individuals receive timely medical examinations and medication.		

50. All cases of mental disorders and substance abuse are identified and receive community support and assistance. Educational activities are carried out in the community to reduce stigma.		
51. All people with physical disabilities are mapped and receive community support to ensure their ability to earn a livelihood.		
52. Dangerous areas in programme sites are identified and appropriate actions/measures are taken to reduce death, injury and disability caused by accidents.		
53. The programme implementation area is free from crime, violence, and discrimination against women, men and ethnic groups.		
54. The community is adopting and promoting early childhood development and child-friendly homes and communities.		
55. The healthy school initiative is in place in all schools in programme implementation sites.		
56. Occupational health and safety procedures (especially accident prevention) are in place in all workplaces and workers have easy and quick access to first aid equipment and services.		

F) Emergency preparedness and response

Result	Evidence available +	Evidence not available -
57. Common emergencies that have occurred in the past 20 years have been identified and the number of victims and local infrastructure that was damaged or destroyed have been documented.		
58. A subcommittee for emergency preparedness and response has been established, oriented and tasks are assigned to members.		
59. A city profile has been developed and a copy of this profile is kept outside of the programme implementation area.		
60. Cluster representatives and health volunteers are trained on emergency preparedness plans, how to deal with emergencies and the provision of first aid when and where it is required.		
61. A contingency plan has been prepared and shared with competent local authorities for resource mobilization and required action. The community knows about the contingency plan, what to do, whom to report to and who will do what during an emergency situation.		
62. Vulnerable groups (e.g. pregnant women, people with physical disabilities, chronically-ill patients, malnourished people, elderly people, people with mental disorders, etc.) are mapped and this information is shared with the competent authorities in advance of an emergency.		

G) Education and literacy

Result	Evidence available +	Evidence not available -
63. All eligible children (girls and boys) are enrolled in school and no pupils have dropped out.		
64. School headmasters hold regular meetings with local community development committees, parents, and other stakeholders to assess the quality of education, school environments, the children's health status, and relationships between parents, children and teachers in order to overcome existing shortcomings or problems.		
65. Standards for the quality of education are in place in schools located in programme sites.		
66. A subcommittee for education has been formed under the community development committee and schools are regularly monitored. The subcommittee coordinates with the district education department.		
67. Youth and women's groups are encouraged to be active members of the literacy campaign on a voluntary basis.		

H) Skills development, vocational training, and capacity-building

Result	Evidence available +	Evidence not available -
68. Local skills, interests and appropriate technologies are assessed and promoted.		
69. Skills training centres that are linked to the local market have been established for males and females and are supported by intersectoral teams.		
70. The healthy city coordinating committee gives priority to the provision of microcredit loans to students of vocational training centres.		
71. Vocational training centres are self-financed and self-managed by the community or local nongovernmental organizations.		
72. Computer training centres, language classes, sport facilities, etc. have been established and are self-managed and self-financed by the community or local nongovernmental organizations.		
73. Innovative people have been identified, supported and promoted.		

I) Microcredit activities

Result	Evidence available +	Evidence not available -
74. Poor and needy members of the community are identified according to specific criteria (agreed upon by the city coordination team) and priority is given to them in the provision of income-generating loans.		
75. Linkages are made between local skills and vocational training centres and microcredit activities, ensuring that the area is moving towards self-sufficiency.		
76. All financial issues are recorded, registered, and followed up on by the finance secretary of the healthy city coordinating committee.		
77. Loans are repaid on a regular basis and a follow-up mechanism established by the healthy city coordinating committee or local banking system is in place.		
78. A bank account has been opened for the healthy city coordinating committee or programme office and all financial interactions related to microcredit schemes go through the relevant bank. The programme coordinator and the community are well aware of it.		
79. A 5%–10% service charge is taken from each income-generating loan and is collected in a separate account to be used for social development activities (i.e. social development funds).		
80. Cluster representatives ensure the timely deposit of monthly repayments from beneficiaries within their respective clusters and keep the repaid money in a revolving fund for future activities.		

Annex 3. Baseline household survey

A baseline survey is an absolute prerequisite for the initiation of healthy city programme interventions in any location. The salient features of the baseline survey are as follows.

- The baseline survey should be conducted on a house-to-house basis.
- All necessary information should be collected according to the questionnaire.
- Cluster representatives and health volunteers should be trained by the healthy city coordinating committee on the survey process and tabulation of collected data.
- At the time of the survey, each family in the locality should be allocated a number that will be helpful in programme management and the planning and implementation of projects.
- The surveyors should visit each house and collect the information required from the family members or through personal observation, depending on the nature of the question or survey item.
- The healthy city coordinator and members of the healthy city coordinating committee should supervise the survey process and ensure the quality and validity of the information collected.
- The surveyors should submit the completed questionnaires to their supervisors (nominated by the healthy city coordinator), who will cross-check the information collected.
- The surveyors and supervisors should jointly compile the data, first on a cluster basis and then at the locality level.
- In addition to the household survey, general information about the locality (e.g. health and education facilities, civic amenities, sports facilities, green spaces, and social organizations) should be collected according to the questionnaire.
- Respondents should be members of the healthy city coordinating committee, cluster representatives, prominent community figures and leaders, government employees, or other people knowledgeable about the overall situation.
- The information collected will be of great value, particularly when it comes to setting priorities and preparing the city development profile.
- The information collected will also be helpful when monitoring the programme's progress and evaluating the results of programme interventions.

Setting priorities

To prioritize the problems identified in the survey, the following actions should be taken.

- list identified (recognized and unrecognized) needs
- assess the scope and magnitude of the problem
- analyse the risks involved
- explore available and potential resources related to the problem
- estimate future requirements
- give each need and problem a priority number
- classify the proposed solutions and set the order and schedule for future actions.

Criteria for prioritization of needs include:

- magnitude of the problem (i.e. the extent of the problem in terms of the number of people affected)
- effects of the problem on the community and families' health (e.g. spread of disease due to flies)
- sociocultural effects (i.e. adverse effects of problems such as substance abuse on social and cultural practices, dynamics, and values)

- economic and financial effects of the problem (e.g. reduction in purchasing power).

The community and intersectoral technical team may discuss a problem and if they are able to come up with a way to solve it using existing resources, that problem should be given priority.

Baseline household survey

City:
Cluster number:
Survey date:
Family number:

Province/state:
Name of cluster representative/health volunteer:
Surveyor:
Name of family head:

Q. No.		Answer	Additional information	Explanation
1.	**Demographic data**			
1.1	Family members	Total	Male... Female...	
1.2	Children (<1)	Total	Male... Female...	
1.3	Children (1–4)	Total	Male... Female...	
1.4	Children (5–14) (school aged)	Total	Male... Female...	
1.5	Adult (15–44)	Total	Male... Female...	
1.6	Adult (45–64)	Total	Male... Female...	
1.7	Adult (65+)	Total	Male... Female...	
1.8	Married couples in household	Total		
2.	**Education and literacy**			
2.1	No. of children attending school in the family	Total	Male... Female...	Children 5–14 years of age
2.2	No. of people who can read and write in the household	Total	Male... Female...	
3.	**Training and skills**			
3.1	No. of skilled individuals among family members	Total	Male... Female...	Type of skill must be mentioned for each member.
4.	**Drinking-water**			
4.1	Does the family have access to safe drinking-water throughout the year?	Yes .... No		Access means water is available within a 15-minute walk.

Q. No.		Answer	Additional information	Explanation
5.	**Access to sanitary latrine and proper sanitation**			
5.1	Does the family have a sanitary latrine inside the house?	Yes …. No ….		
5.2	Does the family have a shower in the house?	Yes …. No ….		
5.3	Is there a proper garbage collection system or garbage container in the household?	Yes …. No ….		
6.	**Means of livelihood**			
6.1	Type of livelihood	Select all that apply	Agriculture Small trade Technical work Labour Employment Other	
6.2	Does the family earn less than US$ 1 per person per day?	Yes …. No ….		Consider all sources of income.
7.	**Food and nutrition**			
7.1	Does the family eat meat, fish, eggs, milk, fruit, and vegetables at least twice per week?	Yes …. No ….		
7.2	Does the family have physical/financial access to healthy markets/shops	Yes …. No ….		
7.3	Is there a child of 2 years of age in the house?	Yes …. No ….	If yes, for how long was he/she breast-fed? • Not at all • Less than 6 months • 6 months to 1 year • 1-2 years • More than 2 years	
7.4	No. of children above 6 months old in the household that were exclusively breastfed	Total …..	Boys… Girls…	

Q. No.		Answer	Additional information	Explanation
8.	Health			
8.1	Any live births in the household during last 12 months?	Yes …. No ….	Boys… Girls…	
8.2	If yes, who helped the mother during delivery?	Trained personnel: Untrained personnel:	Boys… Girls…	
8.3	No. of neonates weighing less than 2500 g in the family	Total …..	Boys… Girls…	
8.4	Have all children in the family been immunized against vaccine preventable diseases by the age of 1 year?	Yes …. No ….		According to national EPI schedule.
8.5	Any deaths in children under 1 year during last 12 months in the household?	Yes …. No ….	Boys… Girls…	Specify causes of death.
8.6	Any deaths in 1–5 year-old children during last 12 months in the household?	Yes …. No ….	Boys… Girls…	Specify causes of death.
8.7	Any pregnant women living in the household at present?	Yes …. No ….	Number…	
8.8	If so, is the pregnant woman vaccinated against tetanus?	Yes …. No ….		
8.9	Has the pregnant woman been visited by a skilled birth attendant?	Yes …. No ….		
8.10	Has a pregnant woman died during the last 12 months in the household?	Yes …. No ….	Number…	Specify causes of death.
8.11	Are there any married females aged 15–49 years in the family?	Yes …. No ….	If yes, how many?	If yes, please specify.
8.12	How many of these women are using a modern contraceptive method?	Total …..		Modern methods are: pills, IUCDs, condoms, ampoules, caps, surgical methods.
8.13	How many members of the household smoke?			
8.14	Has any member of the household been diagnosed with the following diseases: heart, renal, liver, diabetes, hypertension, cancer, etc?	Yes …. No ….	Please specify.	

Q. No.		Answer	Additional information	Explanation
8.15	Are any members of the household disabled?	Yes …. No ….	Please specify.	
8.16	Has there been a death in the family due to the following reasons: heart, renal, liver, diabetes, hypertension, cancer, accidents?	Yes …. No ….	Please specify.	
9.	**Access to and provision of social services**			
9.1	Does the household have access to health facilities within a 30-minute walk?	Yes …. No ….		
9.2	Is the family satisfied with the health services provided by the nearest health facility?	Yes …. No ….	If no, please specify.	
9.3	Does the household have access to sports facilities?	Yes …. No ….	If no, please specify.	
9.4	Do household members participate in weekly healthy physical activities?	Yes …. No ….	If yes, please specify how often per week	
9.5	Does the household have access to green areas?	Yes….. No……	If no, please specify	
9.6	Are household members satisfied with roads, housing, infrastructure, water, sanitation, and other services provided by the municipality?	Yes …. No ….	If no, please specify.	
9.7	Does the family have access to local transport within a 30-minute walk?	Yes …. No ….	If no, please specify.	
9.8	Have any members of the household contributed financially to social services during the last year?	Yes …. No ….		

Note: This form can be modified according to local needs.

Annex 4. Healthy city project proposals

Project proposal preparation requires technical knowledge and a great degree of responsibility. The healthy city coordinator at the city level as well as representatives of relevant sectors and the community should be well-trained in the preparation of development projects that aim at improving health equity and social well-being. The project's feasibility, responsibilities, tasks, expected outcomes, timeline, budget, monitoring indicators and partners' role in its implementation should be addressed in the project proposal. Countries can modify and translate the attached tools in accordance with local needs. Approval of the project proposal requires that the community and related partners were included in the process of development of the proposal.

Proposals for social projects

The healthy city coordinator and coordinating committee at the local level (where the projects will be introduced) should take a leading role in designing project proposals, which should be based on the results of the baseline survey and on community needs and requirements. Representatives of other sectors should support and assist with formulating proposals. The format prescribed for social projects should include a feasibility report and a summary of the implementation plan.

The proposal should demonstrate that the social project:

- has a needs-oriented approach;
- is compatible with the community's social and cultural norms;
- increases social services and enhances quality of life and health equity in urban areas;
- can expect certain outcomes in terms of improvement of social and health indicators;
- raises awareness and the literacy rate and develops technical skills;
- promotes sustainable social development;
- encourages self-reliance, self-sufficiency and a sense of ownership;
- has a positive effect on the city's cleanliness and on residents' health, social well-being, happiness and satisfaction;
- is feasible and manageable by the community and healthy city programme authorities;
- can guarantee the contribution of local resources;
- has technical support available at the intersectoral team level of the healthy city coordinating committee.

Application for a social project

Instructions for use

Project title

The project title should clearly indicate the nature of the project and the area or locality where it will be carried out.

Introduction

The proposal should include background information on: the most pressing needs of the community, previous interventions and their outcomes and reasons for proposing this project.

Objectives

The objectives should be related to the urbanization and social and health issues of the community. The objectives should be specific, measurable, achievable, relevant and time bound (SMART) with not more than three or four clear objectives.

Expected outcomes

The proposal should present a very clear picture of the expected outcomes. The objectives and targets should be the basis for assessing outcomes.

Time frame

The schedule for the project activities should be appropriate for the targets and proposed activities. It should indicate the time required for all of the activities.

Requirements

There may be financial, logistic or other requirements to be met before the project can be implemented and these should all be noted. Intersectoral collaboration and active community involvement are a must in all projects designed for the healthy city programme.

Cost

The cost of the project should be calculated in terms of capital and recurrent costs and the proposal should note the cost of the various components of the project. Potential sources of financing and expectations for each partner should be indicated.

Signatories

The proposal should be sent to the chairperson of the healthy city coordinating committee for discussion and approval at a city coordinating committee meeting. The approved proposal should be signed and submitted by the healthy city coordinator and community representatives or the chairperson of the healthy city coordinating committee.

Application format for a social project

Title of project
Brief introduction (existing situation related to the project; why this project is needed)
Objectives (SMART) • • •
Measurable expected outcomes • • •
Time-frame: Start date …… End date ……
Costing

Components	Government	UN agencies	Other partners	Community
Capital cost				
Equipment and machinery				
Furniture and fixtures				
Loan for project				
Other				
Total capital cost (1)				
Recurring cost				
Salary of staff				
Project allowance				
Stationery and printing				
Other supplies				
Operational expenditures				
Other				
Total recurring cost (2)				
Grand total (Total 1+2)				

Names and signatories

_____

Chairperson, Healthy City Coordinating Committee

Date _____

_____

Healthy City Coordinator

Date _____

Proposals for income-generation projects

The community (as individuals or cooperative groups) may be given the chance to apply for income-generation projects if city planners agree and funds are available through bank loans, etc. The healthy city coordinating committee and coordinator should analyse the project requirements in light of overall programme requirements.

Considerations for income-generation project proposals:

- social preparation and demand
- positive participatory attitude of the community
- respect for, and capitalizing on, the specific traditions, culture and capabilities of the local community
- impact on individual and community needs
- existing traditional or inherited skills
- availability of raw materials and resources locally
- feasibility
- job creation
- availability of marketing opportunities
- availability of proficient technical guidance
- promotion of individual, community and environmental health.

Applications for income-generation projects submitted by the beneficiaries should be in the format shown on page 41. Project decisions should be based on the needs assessment survey, the recommendations of volunteers at the local level and approval of the community development committee.

The healthy city coordinator should screen applications and help community members prepare proposals following the given format. The proposal should be supported by a feasibility study providing details of the project requirements. Approval of the application should be at the district level.

All loan disbursements should be made through a contractual agreement between the healthy city coordinating committee as guarantor and the beneficiaries following the format provided.

Beneficiaries, under the supervision of the healthy city coordinating committee, should implement the project with the support of the committee. The implementation process should only be initiated after completion of the necessary documentation.

Application for an income-generation project

Instructions for use

Beneficiaries should apply using a standard application form, which volunteers should forward to the healthy city coordinating committee and coordinator. The application should contain basic information about the applicants' families.

Particulars

The particulars should include the beneficiary's name (as well as the father's or husband's name), age, sex, occupation, address, national identity card number (if any), and the number of family members dependent upon him/her.

Project type

The beneficiary should describe the type of proposed project, providing a clear picture of the project and the location.

Expected loan

The beneficiary should state the approximate amount of the loan required to implement the project.

Commitment of the beneficiary

The beneficiary should confirm his/her commitment in writing to abide by the healthy city programme and community-based initiatives rules, guaranteeing the timely return of the loan, and commitment to contribute to the socioeconomic development of his/her family and community.

Verification and recommendation

Screening and verification of the application by the relevant volunteers, the healthy city coordinating committee, and the healthy city coordinator will be considered an informal guarantee of the proposal's viability. These parties should determine whether or not the applicant meets the healthy city programme criteria and verify the reliability and capacity of the family to successfully implement the project and return the loan on time.

The healthy city coordinating committee and healthy city coordinator should also screen and verify the information provided in the application before the preparation of the project proposal.

Application format for an income-generation project

Particulars

Name of applicant	Age	Sex	Father's/ husband's name	Profession	National identity card number	Address	Family size

Project type	
Expected loan in local currency	

I/we solemnly declare that:

- I/we shall abide by the rules and regulations, as well as the terms and conditions of the project, and shall return the loan according to the agreed-upon schedule.
- I/we agree to pay a penalty in the event of unauthorized delay or default as identified by the healthy city programme authorities.
- I/we shall make all possible efforts to improve the health, educational and socioeconomic status of my/our family.
- I/we shall contribute to social mobilization and support other community members in their efforts to improve their quality of life and address health-related problems in urban areas.

Verification and recommendation

I/we agree to guarantee the return of the loan on the specified date by the applicant. In case of any delay or default, I/we shall be responsible for arranging the repayment of the loan.

Volunteer	Chairperson, Community Development Committee	Healthy City Focal Point
Name, signature and date	Name, signature and date	Name, signature and date

Income-generation project proposal

The project proposal is to be prepared by the healthy city coordinating committee with the support of technical intersectoral support team members from the relevant sectors and in consultation with the healthy city programme coordinator. The project proposal should be prepared according to the format on page 43, which can be adapted according to local and individual project needs.

Instructions for use

Note: The beneficiary's application will be part of this project document.

Project

The project title should describe the type and nature of the project.

Introduction

This should provide background information that reflects the community's need for the project. If similar projects were previously conducted, relevant experiences and outcomes should be mentioned.

Objectives

The objectives should relate to health and urbanization and to improving the socioeconomic status of families and the community. The objectives should be specific, measurable, achievable, relevant, and time bound (SMART). Ideally, there should not be more than three or four clear objectives.

Expected outcomes

The outcomes can be predicted based on the project's goals and objectives. They should not be unrealistic or hypothetical.

General characteristics

This section should provide information about the project schedule, lag period, loan source, loan amount and repayment schedule.

Budgetary requirements

The preparation of the budget requires special skills and knowledge of the market. The cost of each component should be realistic and match the needs of the project. The unit cost of different items quoted in this statement should be comparable with market prices. It is advisable that the beneficiary and team member from the relevant sector explore the market first and get price quotes for the required items. The total cost will be shared by the community member, who will contribute at least one quarter of the total cost. The remaining amount will be the covered by the proposed loan. The amount of the loan will not exceed a fixed limit.

Interest and user charges

If the healthy city coordinating committee impose any interest or user charges on the loan, this will be calculated in the proposal, the rate mentioned and the monthly instalment fixed. The healthy city programme seeks to move towards self-funding, so charging a 5%–10% service charge on each income-generating project, which can then be spent on healthy programme office expenditures, is advised.

Signatories

The signatures of the chairperson of the healthy city coordinating committee and the healthy city programme focal point should be affixed to the application before it is forwarded to the loan authorities.

Proposal format for an income-generation project

Project title	
Beneficiary	
Introduction (situation analysis and why this project is needed)	
Objectives • • •	
Expected outcomes • • •	
General information	
Project period	
Lag period	
Loan source	
Expected loan	
Repayment scheme	

Budgetary requirements

Component	Qantity	Unit cost	Period	Total cost	Beneficiary share	Loan
Establishment						
Machinery and equipment						
Materials						
Operational expenditure						
Follow-up materials						
Labour						
Other						
TOTAL						

Calculation of interest/user charges (if any)

Category	Rate	Total	Instalment amount
Service charge			
User charges			
Other			
TOTAL			

Names and signatories

_____

Chairperson, Healthy City Coordinating Committee

Date _____

_____

Healthy City Coordinator

Date _____

Contractual agreement

Instructions for use

In signing the contractual agreement the beneficiary is morally and legally bound to repay the loan. The agreement can be adapted according to country procedures and specific situations. Preferably, it should be registered with the legislative authorities of the country. The application and the project proposal should also be enclosed with this document.

Names of partners

The full names of the loan issuing authority and the beneficiary should be provided.

Project

The name of the project as written in the project proposal should be provided.

Location

The place where the proposed project is to be implemented should be provided.

Loan amount

This should be written in figures and words in the local currency.

Loan repayment schedule

The instalment amounts and the target dates should be provided.

User charges

If there are any user charges or interest amounts, they should be part of the project agreement.

Commitment by the beneficiary

The beneficiary should provide a commitment in writing for the timely return of the loan and for other terms and conditions as fixed by the country.

Signatories

The signatures of the partners entering into the agreement – along with those of the guarantor, the chairperson of the healthy city coordinating committee, and the healthy city focal point, as collateral partners – will be affixed. The programme manager will affix his/her signature on behalf of the loan issuing authority; however, the loan issuing authority may later sign it in person.

Format for contractual agreement between:

1- Loan issuing authority _____	
2- Loan receiving beneficiary _____	
Project	
Location	
Loan amount	
Loan repayment schedule	
User charges	

With reference to the beneficiary's project proposal and enclosed application, initiated and recommended by the healthy city coordinating committee on his/her request,

1. The beneficiary agrees to undertake the aforementioned project in accordance with the enclosed project document and stipulated financial and administrative arrangements.
2. The healthy city programme authorities agree to provide the loan to the community in the aforementioned amount, which will be reimbursed according to the agreed schedule and the terms of reference in the project document.
3. The beneficiary will pay user charges if required by the healthy city programme.
4. The beneficiary will abide by all the terms and conditions outlined in the project proposal and strive to meet the goals and objectives of the project.
5. The beneficiary will not leave, transfer to others, or sell the project and he/she will not change its location without informing the healthy city coordinating committee and receiving permission from the healthy city programme loan issuing authority.
6. The beneficiary will allow the healthy city coordinator and his/her team to collect data on this project and to visit the project site, as and when required.
7. The contract will come into effect upon disbursement of the funds, which will enable the execution of the project.

Signatories

All clauses of the agreement and enclosed project proposal, feasibility and budgetary proposition, have been read out to us and we agree with their compliance. The healthy city coordinating committee and the guarantor agree to pay back the loan user charges if the beneficiary defaults or delays the instalments.

Beneficiary	Guarantor	Chairperson, Healthy City Coordinating Committee	Healthy City Focal Point
Name, signature and date	Name, signature and date	Name, signature and date	Name, signature and date

Annex 5. Volunteers and committee members: selection and responsibilities

Selection of volunteers

- Volunteers who are able to read and write may be elected by the community to cover a cluster of 40–50 households.
- Volunteers will be involved in social welfare and health-related activities and interventions as required, and will seek the assistance of the healthy city programme coordinator and other members of the intersectoral team at the city level. Volunteers will be trained to assess community needs, develop priority projects, ensure that all households can access and use social services (e.g. health, education, roads, water, sanitation, transport, parks and libraries). Volunteers can also be used to follow up on loan defaulters who are in need of continuous health-related services (e.g. pregnant women, children under-5 years of age, and patients suffering from chronic diseases such as diabetes, hypertension, mental disorders, etc.).
- Volunteers should be trained on health-related issues using the regional training manual for cluster representatives and health volunteers, published in 2010.
- Volunteers will be in continuous contact with the healthy city coordinating committee in their area to consult on key problems, identify gaps and find solutions using available local resources and to help generate additional resources when needed.
- Some volunteers can also be members of the healthy city coordinating committee.
- One of the volunteers may be nominated as the cluster representative in charge of that particular area.
- All activities are on a volunteer basis and no salaries should be paid to the volunteers.
- Good performance will be the criteria for continued service as a volunteer.
- The volunteers must be aware of the health status, living standards and socioeconomic conditions of the households in their cluster.
- Volunteers should be selected by the households in their cluster from among the most reliable people within that cluster.
- It is preferable that volunteers be permanent residents of the cluster area.

Terms of reference

- Creating sustainable linkages between families, the healthy city coordinating committee, and the healthy city programme team and transmitting information to and from the community.
- Conducting household surveys (if needed) and assisting with needs assessment and priority setting.
- Identifying, recommending and processing applications for social and income-generating projects.
- Working on social activities (particularly community health awareness raising and health promotion activities) in close collaboration with the community, the healthy city coordinator, and other relevant sectors.
- Assisting in planning, implementation and monitoring of projects, loan recovery and resource mobilization.
- Participating in other community development activities in collaboration

with the healthy city coordinating committee and healthy city programme team.

Selection of the healthy city coordinating committee

- The Chairperson, Vice Chairperson, General Secretary, Finance Secretary (if needed), and Communication Secretary should be the core members of the healthy city coordinating committee.
- The volunteers may elect the chairperson and members of the healthy city coordinating committee in a democratic manner through secret ballot, a show of hands or vocal support.
- The healthy city coordinating committee may be registered with district authorities or the social welfare department as a community-based organization or a nongovernmental organization. This may be adapted according to the government's organizational set-up.
- The healthy city coordinating committee members may be selected from among the volunteers, and senior, respected, resourceful, tolerant and influential members of the community.
- The healthy city coordinating committee members should preferably be permanent residents of the local area, acceptable in the eyes of the community, educated, dedicated and willing to work on a strictly voluntary basis.

Terms of reference

- Help the volunteers to carry out their tasks and responsibilities.
- Identify community problems, prioritize needs and plan projects that are feasible, sustainable and cost effective.
- Coordinate with the healthy city programme team to mobilize resources and with potential partners to secure financial, technical and material input.
- Process and recommend social and income-generating projects. Maintain active involvement in managing, supervising and monitoring projects, recovering loans, operating the revolving funds, collecting the community development fund and planning for its use and overall accounting and financial record-keeping.
- Monitor performance of the volunteers and various city level committees.
- Establish contacts with community leaders and elected members of the community to expand the healthy city programme.
- Liaise with the district administration, district line departments and healthy city coordinating committee to seek their technical assistance.
- Assist and facilitate training and visits of different groups (in and outside of the district) to the healthy city programme implementing sites.
- Conduct monthly meetings to follow up on agreements and other necessary interventions.

Useful reading

Community-based initiatives self-monitoring tool: 100-point checklist. WHO Regional Office for the Eastern Mediterranean, 2009 (WHO-EM/CBI/063/E).

Healthy cities guidelines for the development for healthy cities projects and activities. WHO Regional Office for the Eastern Mediterranean, 1997 (WHO-EM/PEH/501/E/L).

Training manual for community-based initiatives: a practical tool for trainers and trainees. Cairo, WHO Regional Office for the Eastern Mediterranean, 2006 (Community-based Initiatives Series, No. 1).

Training manual for the healthy city programme. Cairo, WHO Regional Office for the Eastern Mediterranean, 2007 (WHO-EM/CBI/058/E).

Urbanization and health: heath equity and vulnerable populations. Case studies fom the Eastern Mediterranean Region. Cairo, WHO Regional Office for the Eastern Mediterranean, 2010.

Healthy city programmes have been implemented in countries of the WHO Eastern Mediterranean Region for 20 years. However, no universal systematic approach for the implementation of the healthy city programme has been established. World Health Day 2010 provided the opportunity to push forward the urbanization and health agenda by securing the political commitment of more than 200 cities in the Region. Entrance into the regional healthy city network is contingent upon meeting certain criteria that qualify a city as a "healthy city". This concise, simple and practical guide is intended to help countries standardize their methods, mechanisms and processes of implementation of the healthy city programme and is particularly targeted at members of healthy city coordinating committees and programme trainers, as well as partners.

For further information contact:

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