

Community Participation and Empowerment in Healthy Cities Initiative: Experience from the Eastern Mediterranean Region

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ABSTRACT

Background: The concept of Healthy City has been widely accepted globally and has been established in all six World Health Organization (WHO) regions. Community involvement, empowerment, and leadership are embedded core principles in the Healthy Cities initiative and pillars to achieve the health and health-related sustainable development goals. This article aimed to present the findings of the recent evaluation of eleven healthy cities in the WHO Eastern Mediterranean Region (EMR).

Methods: The evaluation was based on the 80 indicators of a WHO/EMRO Healthy City. It included eleven cities (Al-Dariyah, Jalajil, Al-Jamoum, Unaiza, Riyadh Alkhubra, Sharoura, Al-Madina, Al-Taif, and Al-Munraq in Kingdom of Saudi Arabia; Al-Yarmouk in Kuwait, and Manama in Bahrain).

Results: The findings revealed that eleven cities were peculiar in demonstrating community involvement, empowerment, and leadership in real terms. All had proper mechanisms for their communities to voice themselves and participate in decision-making, assessing the needs, setting priorities, planning better for their cities, and monitoring. Their community engagement was based on voluntarism with a high sense of loyalty. This feature has been well demonstrated in their community organizations, such as women and youth groups, health volunteers, community-based organizations, etc.

Conclusion: Although community participation and empowerment remain at the heart of the healthy cities initiative, to be more meaningful, the government-related sectors must foresee this as an integral part of long-term strategic development. Moreover, a paradigm shift towards a more integrated approach to promote health and well-being would accelerate the achievement of health-related sustainable development goals and reduce health inequities in urban settings which would require multi-stakeholder collaboration, including public, private, and community civil societies.

Keywords: Healthy Cities, Community Participation, Empowerment, Eastern Mediterranean Region



Introduction

The Healthy Cities initiative (which incorporates towns, municipalities, districts, neighborhoods, cities, megacities, and islands) is a dynamic movement and a multisectoral platform to facilitate commitment at the highest political level of the city or municipality. It aims to mobilize city governments' power and influence to promote city dwellers' health and well-being through the collaborative efforts of the public, private, voluntary, and community sectors (WHO PAHO, 2000; Price & Tsouros, 1996; WHO, 1995). It thrives on improving equity, social justice, participatory governance, inter-sectoral collaboration, and comprehensive local strategies to address and improve the physical and socio-economic environments affecting health through multisectoral potential.

The concept of Healthy Cities originated in 1842 when the British government held a "Health of Towns" conference (Department of Health Hong Kong, 2007; Morley, 2007; LSHTM, 2004). In 1977, the 30th World Health Assembly issued the Alma Ata Declaration when countries committed themselves to achieve a level of health that will empower the people and communities to lead socially and economically productive lives (WHO, 1988).

In 1980, European countries adopted the "Health for All" principles, while the WHO European Healthy Cities Network was formally launched in 1987–88 as the strategic vehicle for bringing the WHO strategy for Health for All to the local level (WHO EURO, 1999). It was based on recognition of three issues, namely the importance of local action in all aspects of developing health, the specificity, and importance of urban settings for health and well-being, and the key role of local governments in creating conditions and supportive environments for healthy living for all (Tsouros, 2017; Tsouros, 2009).

The creation of the European Healthy Cities Network was inspired and influenced by several international and local developments, including

Health for All principles and strategies of the Ottawa Charter through local action in urban settings (Tsouros, 2015).

The healthy city concept has been widely accepted globally and has been established in all six WHO regions. The WHO Eastern Mediterranean Region (EMR) adopted the concept in 1990 (Khosh-Chashm, 1995). Iran was the first country in EMR to implement a healthy city program in 1991. It has then been introduced in most member states (namely Afghanistan, Bahrain, Egypt, Jordan, Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Tunisia, and United Arab Emirates). The WHO Eastern Mediterranean Region Office (EMRO) provided technical support to different countries of the region.

The urban health challenges are becoming more acute and complex due to unplanned urban growth and mushrooming of urban slums that put populations at increased risk of poor quality of life, poor health coverage, poor infrastructure and sanitation, unsafe drinking water, higher vulnerability to disasters. Hence, it will lead to a higher risk of communicable and non-communicable diseases, injury, and mortality (Galea & Vlahov, 2005). As a result of uncontrolled urban development, green areas have been eroded, leaving behind inhospitable environments. Swelling urban populations has also created congestion, air pollution, water contamination, inadequate sewage disposal and the unmanageable disposal of solid waste, lack of human services, deficient energy resources, and insufficient communication means. Additionally, rapid urbanization has affected traditional social bonds and cultural affinities (Galea & Vlahov, 2005).

Such conditions call for more equity and social justice in accessing basic services, which have become the guiding principles for development activities. The Member States emphasized the importance of health equity in the Rio Political Declaration on social determinants of health



(WHO, 2011) and subsequently by the World Health Assembly in May 2012 in resolution WHA 65.8 (WHO, 2012).

Several policy documents from the World Health Organization and other bodies suggested introducing new approaches toward managing cities, enhancing healthy urbanization, and addressing major health challenges, focusing more on understanding causes and prevention than medical intervention and treatment (Tsouros, 2009).

The 2030 Agenda for Sustainable Development places renewed emphasis on just how interconnected our social, economic, and environmental ambitions are. Health promotion efforts grounded in a healthy city approach can help achieve the Sustainable Development Goals (SDGs), including SDG 11: Make cities and human settlements inclusive, safe, resilient, and sustainable (WHO, 2017).

In translating the mission and qualities of healthy cities to a 21st-century context, the primary goals can be summarized as follows: promoting health and equity in all local policies (health in all policies) and fully aligning with the sustainable development goals (SDGs) agenda; addressing inequalities in health through social determinants of health (SDH) approach; creating environments that support healthy lifestyles, providing universal health coverage; investing in health promotion and health literacy; providing support to disadvantaged groups; supporting community empowerment, participation, and resilience, and strengthening the city's capacity to respond to public health emergencies (Tsouros, 2017).

Any city can be a healthy city regardless of its current health status, since this has never been defined as an outcome but a process. What is required is a commitment to health and a structure and process to target and solve local problems and engage people from various community parts in the Healthy City process (Tsouros, 1995; de Leeuw, 2009). For instance, cities wishing to join the WHO European Healthy Cities Network have

had to fulfill a set of 'requirements of the engagement.' They include political commitment, evidence-based policies, city health profiles, administrative infrastructure, prioritized action, city health plans, partnership, capacity-building, participation in networking activities, attending WHO European healthy cities network meetings, and monitoring and evaluating mechanisms (de Leeuw et al., 2015). Furthermore, eleven qualities were determined for a healthy city related to the environment, housing, public participation, access to health and high health status, innovative economy, and cultural heritage (de Leeuw et al., 2015)

Periodic monitoring and evaluations of the healthy cities initiative are an embedded process to record and document the achievements and challenges of how effective actions were in real life. The European Healthy Cities and Networks, led by the World Health Organization Regional Office for Europe (WHO EURO), have adopted a five-year periodic process to evaluate the healthy cities. Every five years (a phase), the evaluation focuses on different priority themes determined by the network (de Leeuw et al., 2015). Drawing on Phase IV evaluation data and concerning the four quadrants of Davidson's Wheel of Participation (information, consultation, participation in decision making, and empowerment), the large majority of European Healthy Cities have mechanisms in place to provide information for and to consult with local people (Dooris & Heritage, 2013).

The WHO/EMRO has established 80 indicators that contain a list of tasks and criteria for cities wishing to implement a healthy city program (WHO EMRO, 2007). A city must sign a letter of collaboration to commit to the healthy city program and join the regional healthy city network, agree on a set of activities that will improve the health and social status of their residents and promote health equity, and ensure that all monitoring indicators (the 80 indicators) are in place to be assessed by the joint regional and country evaluation team to be qualified as a



healthy city (WHO EMRO, 2007). A city must meet at least 80% of these criteria to qualify as a healthy city.

Regardless of its current health and social status, any city 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 improving its residents' health and social status and is willing to redirect its resources and adopt the policies, organizational structures, and processes required for achieving healthy city status (WHO EMRO, 2007). The WHO/EMRO has established a list of tasks for cities wishing to implement a healthy city program (WHO EMRO, 2007; WHO EMRO, 2010). The tasks include signing the letter of collaboration, brief and orient city planners, selecting an implementation site, establishing a healthy city coordinating committee, establishing community development committees, selecting and train volunteers, redirecting available resources to programme needs, opening a healthy city office and hire a healthy city coordinator, assessing needs and developing long- and short-term plans to fill gaps, implementing the planned activities, monitoring and documenting achievements and sharing data (WHO EMRO, 2010).

Besides, WHO/EMRO launched the Regional Healthy City Network (RHCN) Website in 2012, an interactive website that enables interested mayors and governors to join the RHCN. Registered cities will be located on the regional interactive map with a three-color code according to city status. Orange indicates registered cities in RHCN; blue is for cities that applied to be recognized as a healthy city based on specific criteria to be evaluated, while green awards "healthy city" status by WHO after the city meets the 80 indicators based on the results of the evaluation (WHO EMRO, 2010). Currently, 67 cities from 14 countries (Afghanistan, Bahrain, Egypt, Jordan, Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Sudan,

and United Arab Emirates) have been registered in the RHCN with different levels of implementing HCP related activities.

The commitment to community participation and empowerment received due attention in the WHO/EMRO healthy city endeavors reflecting its origins in the Declaration of Alma-Ata and the Ottawa Charter for health promotion (WHO, 1988; Tsouros, 2015). The latter includes 'strengthening community action' as one of its five action areas. It states that health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of this process are communities' empowerment, ownership, and control of their endeavors and destinies (Tsouros, 2015; Bracht & Tsouros, 1990; Heritage & Dooris, 2009).

Despite the healthy cities' commitment to community participation, the conditions for effective community participation, and what role the community plays or should play in building healthy cities are often unclear (Claveir et al., 2017). This paper aimed at presenting the findings from the recent evaluation of nine healthy cities in the Eastern Mediterranean Region carried in 2018, 2019, and 2020 with the main focus on community participation and empowerment.

Methods

This is a descriptive comparative study, whereby WHO/EMRO has assigned experts to evaluate eleven healthy cities, namely Al-Dariyah, Jalajil, Al-Jamoum, Unaiza, Riyadh Alkhubra, Sharoura, Al-Madina, Al-Taif, and Al-Mundaq in Kingdom of Saudi Arabia; Al-Yarmouk in Kuwait, and Manama in Bahrain in 2018, 2019, and 2020. The eleven cities went through the WHO/EMRO process, i.e., they registered in RHCN, undergone the self-assessment, and applied to be recognized as a healthy city based on the 80 indicators.

The evaluation was based on the WHO 80 indicators clustered around nine domains, namely



community organization and mobilization for health and development; intersectoral collaboration, partnership, and advocacy, community-based information center, water, sanitation, food safety, and air pollution, health development, emergency preparedness and response, education and literacy, skill development, vocational training, capacity-building, and microcredit activities. The evaluation methods comprised a review of supplementary documents (including the self-assessment reports) that verify the achievement and fulfillment of the indicators, key informant interviews, and field visits to implantation sites. The key informants were carried purposively. That identified the potential respondents who can contribute valuable information. The selection included those involved (currently or previously) in decision-making for the healthy city, the heads of the sub-committees, government officials from related sectors, and selected volunteers. This evaluation approach depends on synthesizing and verifying evidence from many sources and involves the policymakers, city leaders, government-related and private sectors, and the community in the process. Despite this approach's limitations, all information was utilized to triangulate the interventions with the target groups' achievements. Table 1 shows the nine domains, the number of indicators, and the assessment methods for each domain.

The selected healthy cities

The nine cities in KSA

The Healthy Cities Program (HCP) in KSA started in 1998 in two cities and expanded in phases till the total number reached 27 healthy cities by 2017 (with 19 registered on the Regional Healthy City Network website). The expansion was based on realizing that urbanization had been snowballing, as nearly 80% of the population lives in cities and towns and the acute and complex nature of the urban health challenges. Recently, the Ministry of Health scaled up HCP by putting the program under the supervision and direct reporting to Deputy Minister for Public

Health to place health issues at the top of the decision-makers' agenda. Accordingly, a situation analysis to assess the progress of HCP implementation in different cities of the Kingdom and many planning and capacity building workshops have been conducted to systematize the implementation of HCP in different cities as per WHO guidelines and criteria (9 domains and 80 indicators). Nine cities were evaluated (after completing the self-assessment and applied to be recognized as a healthy city), namely Al-Dariyah, Jalajil, Al-Jamoum, Unaiza, Riyadh Alkhubra, Sharoura, Al-Madina, Al-Taif, and Al-Mundaq.

The total population varies in the nine cities ranging from 5,000 in Jalajil city to nearly one million in Al-Madina. The municipalities coordinate and supervise the HC initiative in close collaboration with the Ministry of Health. The nine cities' HCP works through different sub-committees (executive arms) with clear tasks and diverse representation, including social, educational, environmental, health, and emergency preparedness. There is also a women subcommittee that consists exclusively of women and bears the main responsibility for women's and child issues.

Al-Yarmouk city in Kuwait

The Healthy Cities Program implementation started in 2000 in Kuwait and reactivated in 2014 by establishing the Healthy Cities Office at the Occupational Health Department, Ministry of Health. Al-Yarmouk was the first city in Kuwait to register in the healthy cities' regional network early in 2014. Currently, Kuwait has nine cities registered in the regional network representing the six governorates of Kuwait, of which Al-Yarmouk is the first to be evaluated.

Al-Yarmouk is located in the capital governorate of the State of Kuwait, and it is divided into four areas. It covers a population of around 24,000. The HCP in Al-Yarmouk is led by Yarmouk Mayor named "Mukhtar" who is a community leader appointed by the government. He performs his leadership and coordination role

in close collaboration and technical guidance of the Healthy Cities Office in the Ministry of Health. Al-Yarmouk HC has an office hosted in Yarmouk health center "Abdullah Abdelhady Center." Mukhtar has appointed the HCP coordination committee. The HCP coordination committee has established six sub-committees with clear tasks and diverse representation, including social, educational, environment, health, information and media, and emergency preparedness. All the members of the coordination committee and the sub-committees work voluntarily.

Manama City in Bahrain

Manama is the capital of Bahrain. The HCP was introduced in 2018 by establishing a higher coordinating committee chaired by H.E., the governor of the capital (Manama) and membered by directors of different sectors and the private and civil society sectors. An HCP coordinating committee is hosted in the governor's office. Subcommittees have been formulated and membered by different sectors with identified roles and tasks.

Data collection and quality assurance

The whole data collection process was guided by the WHO/EMRO checklist, which classifies and organizes data according to the domains and indicators. The qualitative data were obtained and recorded with the participants' consent. Data collection continued until saturation is reached, and the final decision on the accomplishment of the indicator is based on evaluators' consensus.

Participants' consent was taken in advance before performing the interview.

Results

Forty-five indicators are related directly or indirectly to community participation and empowerment, which constitutes 56% of the 80 indicators, as shown in table 2.

Table 3 shows the achievement of indicators related to community participation and empowerment by the 11 cities. According to the

WHO guideline, nine cities achieved 89% of the indicators as they fulfilled each indicator's criteria, while two cities reached 87%. Less achievement was in the indicators related to the health development domain. Some indicators were under the full responsibility of the ministries of health (e.g., birth and death registrations).

There are established offices responsible for HCP in the 11 cities, either located in the health centers, municipality, or governor offices. The offices are also serving as health city information centers. There is an active HCP coordination committee either headed by the governor in Al-Dariyah, Al-Taif, Unaiza, Riyadh Alkhubra, and Manama; the head of the municipality of Jalajil, Al-Jamoum, Al-Munraq, and Sharoura, vice chancellor of university in Al-Madina, or the Mukhtar in Al-Yarmouk. The committees are meeting on a regular basis in the 11 cities. The healthy city coordinating committee in Al-Yarmouk has been registered in the Ministry of Social Affairs as a voluntary-based community organization. The governors in all the cities were aware of the HCP and showing their commitment through their close follow-up of the HCP activities.

Among the key salient features that were noticed in HCP interventions are the high political commitment at ministerial, governmental, and community level, well-planned coordination mechanism, community involvement, motivated and trained volunteers, well-equipped facilities, efficient information systems, continuous monitoring, and supportive supervision from all parties and stakeholders.

The coordination committees and sub-committees in the 11 cities have developed multisectoral action plans based on the nine domains to guide the interventions towards achieving the 80 indicators. The plans were based on the "Health in All Policies" concept, which has provided a useful strategic framework to guide the actions.

There is an active engagement of voluntary organizations, benevolence societies, and the private



sector in HCP activities (crisis management, health campaigns, solid waste management, school initiatives, building walking tracks for physical activity, skills development). In Jalajil, Unaiza, Riyadh Alkhubra, and Al-Madina healthy cities, most of the projects and activities are covered by benevolence societies and rich people who showed a high level of commitment to the HCP through giving their donations and contributions on an annual basis. In Al-Madina, mobile clinics (including mammograms) and mobile blood banks are donated and run by voluntary groups.

The health centers in the 11 cities perform active screening for early detection and management of non-communicable diseases and raise public awareness about the risk factors. Obesity as a risk factor for non-communicable diseases was recognized as the major concerns by the local communities, and actions were taken to tackle this problem, e.g., building walking tracks for physical activity, establishing fitness centers, regular measurement of the body mass index, advocating healthy diets in the schools and restaurants, and organizing campaigns to reduce obesity in public places regularly. In Al-Yarmouk, a joint initiative in collaboration with the National Food & Nutrition Authority has been implemented to reduce obesity among students, and impressive results have been achieved. Besides, many endeavors initiated by the communities towards creating smoke-free cities are ongoing under the umbrella of a healthy city program. In Jalajil city, 20 obese adults were selected to undergo a special dietary and exercise program (on a completion basis) in collaboration with the sports club. Manama has adopted healthy working places and advocates the concept in public and private settings and social clubs in collaboration with the community.

Under the guidance of the HCP health sub-committee, Al-Yarmouk health center has implemented many evidence based innovative approaches in response to community needs (through conducted opinion surveys on regular basis) such as reducing the waiting time by

implementing the "fast track clinic" and taking appointments online (using mobile applications donated by one of the private companies) that have reduced the waiting time into two minutes. The center respects the patients' rights and assesses the level of clients' satisfaction in each visit and establishes a complaint box (donated by the community) that is checked regularly, and actions are taken accordingly.

The schools have many innovative initiatives covering many health promotion and preventive aspects. Parents and students are involved in health-promoting school activities. Most of the schools in the 11 cities introduced innovative initiatives to promote leadership among students. In some cities, school clinics are run by students trained to provide first aid under the teachers' supervision, the Red Crescent Societies, and the Ministry of Health. Students also monitor food hygiene and safety through the student food inspector initiative. In most cities, the schools adopted skills development programs such as formulating natural compost and cultivating plants and vegetables through teachers, parents, and student partnerships.

Different innovative interventions to improve the health and well-being of vulnerable populations such as the elderly, disabled, and people with special needs were part of the city action plans in the 11 cities.

A special community initiative, "Breaths", started in Al-Yarmouk intending to convert all public parks into healthy lifestyle-promoting areas. Two parks have been constructed and equipped with needed instruments for physical activities. The HC committee established collaboration with a private company (Omniya) for plastic recycling. A park has been constructed and accessible to the community architecturally using the recycled materials to promote waste management and recycling among the public.

The social welfare centers are multi-purpose in functions and access to the communities. The welfare centers include skill and handcraft training, literacy classes, rehabilitation for people

with special needs, playgrounds, swimming pools, theaters, conference and exhibition rooms.

The vocational and skills training programs have been conducted in the context of HCP to support microcredit projects in coordination with the Center for Social and Community Development in the case of Al-Yarmouk and Manama; the Social Affairs Society, the University of Knowledge, and the Saudi Institute of Electronics in Al-Dariyah; the benevolence societies in Jalajil, Al-Madina, Al-Jamoum, Al-Taif, Unaiza, Riyadh Al-Khubra, Sharoura, and Al-Mundaq.

The women and youth play a prominent role in HCP and voluntarily participate in different aspects of the HCP activities. As volunteers, they showed lots of enthusiasm and pride attached to the participation in the HCP sub-committees and the activities.

The use of information by the community was evident in all 11 cities. In Jalajil, the city map was marked with the locations where traffic accidents occurred, and actions had been taken to avoid them. Table 4 summarizes the achievements of selected indicators in the 11 cities.

Table 1. The number of indicators and methods of assessment for each domain

Domain	No. of indicators	Methods of assessment
Community organization and mobilization for health and development	7	Interview
Intersectoral collaboration, partnership, and advocacy	7	Reports/ actions
Community-based information center	5	Field visit
Water, sanitation, food safety, and air pollution	11	Reports/ Interviews/ Field visit
Health development	26	Reports/ Interviews/ Field visit
Emergency preparedness and response	6	Reports/ Interviews
Education and literacy	5	Reports/ Interviews/ Field visit
Skills development, vocational training, and capacity-building	6	Reports/ Interviews/ Field visit
Microcredit activities	7	Reports/ Interviews/ Field visit

Table 2. The number and percent of indicators related to community participation and empowerment

Domain	Number of indicators	Indicators related to community participation and empowerment
Community organization and mobilization for health and development	7	7
Intersectoral collaboration, partnership, and advocacy	7	4
Community-based information center	5	5
Water, sanitation, food safety, and air pollution	11	3
Health development	26	14
Emergency preparedness and response	6	3
Education and literacy	5	2
Skills development, vocational training, and capacity-building	6	4
Microcredit activities	7	3
Total	80	45 (56%)



Table 3. The number and percentage of achieved indicators related to community participation and empowerment in the 11 cities

Domain	Indicators related to community participation and empowerment	No. and % of indicators achieved by the cities										
		Dariyah	Jalajil	Jamoum	Unaiza	Riyadh Alkhubra	Sharoura	Madina	Taif	Munadq	Yarmouk	Manama
Community organization and mobilization for health and development	7	7	7	7	7	7	7	7	7	7	7	7
Intersectoral collaboration, partnership, and advocacy	4	4	4	4	4	4	4	4	4	4	4	4
Community-based information center	5	5	5	5	5	5	5	5	5	5	5	5
Water, sanitation, food safety, and air pollution	3	3	3	3	3	3	3	3	3	3	3	3
Health development	14	10	9	10	10	10	9	10	10	10	10	10
Emergency preparedness and response	3	3	3	3	3	3	3	3	3	3	3	3
Education and literacy	2	2	2	2	2	2	2	2	2	2	2	2
Skills development, vocational training, and capacity-building	4	4	4	4	4	4	4	4	4	4	4	4
Microcredit activities	3	2	2	2	2	2	2	2	2	2	2	2
Total	45	40 (89%)	39 (87%)	40 (89%)	40 (89%)	40 (89%)	39 (87%)	40 (89%)	40 (89%)	40 (89%)	40 (89%)	40 (89%)

**Table 4.** The achievement of selected indicators related to community participation and empowerment in the 11 cities

Activity	11 cities
Health city committees are trained on needs assessment, prioritization, data analysis, project preparation, monitoring, recording, and reporting mechanisms.	✓
The healthy city coordinating committee has been formed, and members have been oriented on their tasks and responsibilities.	✓
Volunteers are active partners in local health and social planning and procedures.	✓
The healthy city coordinating committee monitors and supervises health and socio-economic projects, record achievements and constraints, and identifies local solutions for local problems.	✓
The healthy city coordinating committee looks for resources and builds relationships with potential partners to develop their local areas further.	✓
A health city office was established and utilized for different activities (e.g., community meetings, training, and information center).	✓
Women's and youth groups have been established and are contributing to local development interventions.	✓
Sub-committees are trained to collect key information, analyze it, and use it for local development planning.	✓
Key information is displayed in the community-based information center or local healthy city program office and shared with the community and other relevant sectors/partners.	✓
Key information is used for advocacy and monitoring purposes by the local community development committee and other stakeholders.	✓
A city profile is created, regularly updated, and used for planning and monitoring purposes.	✓

Discussion

The Healthy Cities movement has been in process in the WHO Eastern Mediterranean Region for more than 25 years, and the criteria and indicators needed to transform a city into a healthy one have been deeply understood and become embedded in the ministries of strategic health plans. Recently, thousands of cities worldwide are part of the Healthy Cities Network in all WHO regions. The movement is becoming increasingly important, gaining more momentum, and been actualized as an important platform for achieving health and health-related sustainable development goals. Furthermore, the movement addresses the social determinants of health and materializes the concept of health in all policies. The healthy cities approach capitalized on the political and community leadership and catalyzed their participation and involvement to place health on the city's top agenda.

Achieving community participation has become a statutory obligation for many national and local governments, building optimism about the possible benefits to partnerships. However, there have been substantial critiques of the limited gains made in increasing community participation levels and outcomes (Stern & Green, 2008).

The evaluation revealed that the communities' participation and empowerment were vivid in the 11 cities but differed in scale and modalities. The HCP assisted the communities to vice themselves through frequent consultations, better use of information for planning, decision making, advocacy, and resource mobilization, creating different innovative platforms for participation for individuals and communities, which increased the sense of loyalty, championship, and competition with other cities. Healthy city initiatives are a little different from other urban development strategies. Despite their focus on health, well-being, and social justice, they are subject to the game's urban governance rules (Clavier & O'Neill, 2017). Communities may ally with public and private actors and work together to define the healthy city (Clavier & O'Neill, 2017).

The evaluation of Phase III of the European Healthy Cities Network highlighted the continuing high priority given to community participation (Heritage & Dooris, 2009). Nearly 90% of the cities proactively informed citizens about their initiatives and other public health priorities (Heritage & Dooris, 2009). At the same time, Phase IV evaluation showed that many European healthy cities have mechanisms in place to provide



information for and consult with local people. Most of the cities demonstrated a commitment to enabling community participation in decision-making and empowering citizens (Dooris & Heritage, 2013).

Community leaders, sub-committees, and volunteers in the 11 cities used different communication means to keep local people informed and foster community members to get engaged in the HCP activities. Social media, websites, brochures, and local mass media were among the most frequently used channels. In Al-Yarmouk, the Mukhtar and coordination committee uses the "Diwaniya" to advocate for the healthy city, gather community opinions, and encourage participation. The Diwaniya is the reception hall where the house owner received his relatives, business colleagues, and guests. It serves as an important gathering by facilitating quick communication and consensus-building, among other things. The Diwanias are considered the core of Kuwait's social, business and political life, the places where topics of interest are discussed, associates introduced, election campaigns held, alliances formed, and similar networking activities undertaken. Formal Diwanias may be convened to discuss particular topics, sometimes with guest speakers.

The beneficial evaluation of the healthy city construction in China revealed that people's ability to engage in self-care has improved. Also, there were excellent institutions and networks for health education, personnel, and funding (Wang et al., 2017).

Additionally, the healthy cities' vision, values, and concepts allowed the local communities to pay more attention to health, well-being, health-related determinants, and addressing inequities through novel approaches. The communities in the 11 cities, through their executive arms (the sub-committees), played an active role in creating better social and economic environments for healthy living, extending the boundaries of collaboration and partnership within their neighborhoods, developing innovative ideas, and

being early adopters in addressing and tackling the socio-economic determinants of health.

Conclusion

The healthy city evaluation in the 11 cities demonstrated the added value of the HCP vision, values, concept, and approaches in empowering the communities through different innovative mechanisms and modalities. Unfortunately, the existing literature on community participation in healthy cities is mainly from Europe and other high-income countries. There is a need to generate more evidence in low-income and middle-income countries.

The concept of community participation and empowerment in HCP has generally moved from specific ad-hoc or occasional events to an inbuilt and integrated strategic component that plays a significant role in the city development's success and sustainability.

The evaluation also revealed the significant technical inputs and guidance of the healthy city offices and coordinators and the government-related sectors and private establishments to support and empower the communities to be at the forefront of the movement, taking an active role in spearheading efforts to improve their urban life.

Conflict of interest

No conflict of interest was declared.

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Authors' Contribution

Conceptualization, N.M. and I.E.Z.; Methodology, N.M.; Investigation, N.M.; Formal analysis, S.E. and M.Kh.; Data Curation, A.A.Sh. and S.I. and A.A.; Writing – Original Draft, B.A.; Writing – Review & Editing, N.M. and S.E.

All authors read and approved the final manuscript and are responsible for any questions related to the article.



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