Canadian Healthy Communities Project: A Conceptual Model for Winnipeg

Health and the Community No. 1

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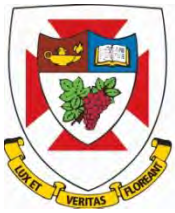
by Barbara J. Lane
1989

The Institute of Urban Studies

INSTITUTE OF URBAN STUDIES
UNIVERSITY OF WINNIPEG



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PREFACE

The Canadian Healthy Communities Project is still in its infancy. This report has been written with the objective of making operational some of the incipient concepts, using Winnipeg as a setting. The study on which it is based was a project carried out during a sabbatical leave granted by the University of Saskatchewan during the 1988-89 academic year, under the auspices of the Institute of Urban Studies (IUS), University of Winnipeg.

I thank the staff of the Institute of Urban Studies and the members of the Healthy Winnipeg Advisory Committee for their useful guidance in preparing the report, although responsibility for the content is entirely my own. In particular, I thank B. Mathur, Chair of the committee for collaborating in devising the process model.

Barbara J. Lane
Institute of Urban Studies

EXECUTIVE SUMMARY

- *While in Canada health care falls in provincial jurisdiction, health itself is everyone's responsibility, and, it may be argued, particularly that of municipal government.* Health, according to the World Health Organization (WHO) is defined as " . . . a state of complete physical, mental and social well-being, and not merely absence of disease or infirmity" (1946, p.1). Viewed as such, health becomes the business of municipal government, as the level of government whose policies and decisions in physical planning and in areas such as water, waste management, transportation and parks, have the most immediate impact on the daily lives of citizens. The Canadian Healthy Communities Project presents an opportunity for municipal governments and people of the community to work together to build and maintain physical and social environments which promote the well-being of all citizens.
- *The WHO Healthy Cities Program arose from a 1984 "Beyond Health Care" conference in Toronto, and quickly developed in Europe, many of whose cities were searching for a vehicle by which to implement the goals and targets of the WHO Health For All by the Year 2000 initiative.* The Canadian project was sponsored initially by the Canadian Public Health Association and the Canadian Institute of Planners, joined in 1987 by the Federation of Canadian Municipalities, at which time the name was change to Healthy Communities, to include and reflect participation of communities regardless of size.
- *Recognizing the need for a model to provide operational definitions and delineate responsibilities for implementing a Healthy Communities project, the Institute of Urban Studies (IUS) at the University of Winnipeg facilitated a study for that purpose, by setting up a Healthy Winnipeg Advisory Committee, chaired by B. Mathur of IUS staff.* Granted sabbatical leave by the University of Saskatchewan for the 1988-89 academic year, the author undertook the study, and assisted by the committee, produced *Canadian Healthy Communities Project: A Conceptual Model for Winnipeg* by June, 1989.
- *Because a municipal government focus on the health of citizens derives from how health is defined, the report begins with a review of the evolution of the concept away from "freedom from disease" and toward a conception of health (consistent with the WHO definition) as a resource, or the total capacity of individuals to achieve goals and carry out socially defined roles.* The introduction links the development of the concept to the WHO Health For All thrust and, more recently, to the Healthy Cities/Healthy Communities movement. The tradition of municipal governments in protection of health is noted, including the impact of water, sewage, waste management, housing regulations, etc., which (in industrialized countries) has led to the eradication of most communicable diseases as a major cause of death.

- *Recently, respiratory and circulatory disease, cancer and accidents have assumed prominence as causes of death, and public health concerns now include such areas as chronic disease and disability, the effects of stress, and services that enable people to cope.* The shift, the changing definition of health and a world-wide trend to urbanization have opened the door to urban-based health promotion programs. In the current situation as in the past, however, municipal government has a pivotal role, albeit with a new focus: the "new public health" implies both inter-sectoral collaboration and public participation, which are achievable through municipal government and around which the Healthy Communities project has been designed.
- *Section 2 of the report presents an overview of Winnipeg on the basis of socio-economic status, education, home ownership, outlay for housing and other variables, and so on, with the data aggregated to the six community areas of Winnipeg.* Illustrative as they are regarding social differences between geographic areas of the city, the groupings present only a general picture: the large area covered by "City Centre/Fort Rouge," for example, masks the extent of differences between neighbourhoods in the area, as is suggested by more detailed analysis using ethnicity, education, etc. A case is made for a Healthy Winnipeg Project on the basis of its potential to improve the situation above and because such an initiative could meet the city's need for pride in the physical and social environments and for "vision" and identity.
- *The framework for a healthy Winnipeg is proposed in Section 3.* The model provides a way to operationalize the principles involved in the Canadian Healthy Communities Project, which calls for community participation and representation in the municipal processes for planning and implementing municipal health strategies. The guidelines adopted for the Canadian Healthy Communities Project call for municipal government to set up " . . .a decision-making entity which includes representatives from all departments, community members and representatives from the private sector."
- *Discussions with municipal government and others in Winnipeg indicate that such an entity "within" municipal government would not be possible in Winnipeg because of the nature and structure of the decision-making processes.* Included in the model, therefore, is an "internal" Interdepartmental Healthy Winnipeg Committee, a body of senior government officials chaired by the Commissioner of Planning and Community Services and reporting to the Committee of Planning and Community Services, a Committee of Council. The model also includes a separate community structure with an inter-sectoral, city-wide Healthy Winnipeg Steering Committee and subcommittees, and geographically-based community committees to manage area-specific concerns. The steering committee, as well as having broad representation from the community, is proposed to have a member from city council and also from the Interdepartmental Healthy Winnipeg Committee.

- *The Winnipeg model is a process framework which assumes the case where municipal participation in the Canadian Healthy Communities Project will likely emerge as a response to public interest in the project, rather than due to municipal government's own leadership.* In contrast to the guidelines from the Co-ordinating Office of the Canadian Healthy Communities Project, the model includes events prior to project declaration by city council. The model's early inclusion of the mobilization of community support is not to suggest that in some municipalities, initiative from council may not lead to public interest, as has been the case in Dartmouth, for example, and could happen in Winnipeg. However, where a project originates from the community, the "predeclaration" phase is important because of the role of public support in capturing council's interest.
- *Section 3 also contains the focus proposed by WHO Europe for each year of the project, and a detailed description of the elements of the framework, including the structure of the committees, tasks, suggested strategies, resources, possible problems, etc.* Project evaluation is discussed and suggestions included regarding the evaluation of the project's "process" and "components."
- *Section 4 advises the setting up of a data base, which has not been the norm in Canadian projects, but which could be useful in determining needs in the city and in ongoing and summative evaluations.* The level of aggregation suggested for analysis is the neighbourhood "characterization area," units designed to reflect neighbourhoods and for which some data, particularly for social variables, now exist. Although the unit is small, there being 228 for the city, analysis at that level is not as likely to blur extremes within the groupings as would larger units. Regarding possible indicators to be used in a data base, the section includes two lists of indicators which may be useful in the context of Winnipeg.
- *The conclusion of the report, Section 5, appeals for a Healthy Winnipeg Project as a way for city council to adopt a Health For All perspective.* The Winnipeg model provides a way for that to happen and for the public to participate fully in the planning, implementation and evaluation of programs that affect community health, without necessitating a restructuring of Winnipeg's decision-making processes.

CANADIAN HEALTHY COMMUNITIES PROJECT: A CONCEPTUAL MODEL FOR WINNIPEG

INTRODUCTION: HEALTH FOR ALL IN THE CONTEXT OF SETTLEMENTS

THE CONCEPT OF HEALTH

In 1946, the constitution of the World Health Organization (WHO) defined health as " . . . a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (p. 1). In recent decades, several perspectives have emerged which have helped to move the concept of health further from the traditionally predominant "freedom from disease" notion. Out of the "ecological school" of the 1960s, for example, came the idea that people are active beings, relating in and with an environment, and possessing various capacities to resist disease (Rogers, 1960). Also in the 1960s, the idea arose that health was the norm and that illness could be defined as deviance from the norm (Goffman, 1963). About the same time, there began widespread use of another contribution from sociology, Parsons' analysis of the rights and obligations associated with the "sick role" (Parsons, 1951). As a result of these developments, learned behaviours and attitudes became prominent as researchers studied expectations associated with health and illness.

Also in the 1960s, Dunn popularized the concept of "wellness," which he defined as " . . . an integrated method of functioning, oriented toward maximizing the potential of which an individual is capable. . . . It requires that the individual maintain a continuum of balance and purposeful direction within the environment within which [s]he is functioning" (Dunn, 1969). Baranowski has also preferred the term wellness, which he defined as the *total*, (not just biological) capacity of the individual to realize goals and perform socially defined role tasks (Baranowski, 1981). Other authors have also used the term wellness; many more, however, have incorporated the ideas of potential and role performance into their conception of health (Lane, 1988).

In Canada, a significant development stemming from a recognition of the weakness of the traditional approach to health was the Lalonde Report, the 1974 Canadian government publication, *A New Perspective for the Health of Canadians* (Lalonde, 1974). The model of health in that document included the environment, individual lifestyle and health care system along with human biology; by those inclusions, the new perspective promoted a re-examination of health policies in Canada and beyond. That a vision of health must move beyond individual biology to include elements like health care programs, social and economic factors and the natural and human-made environments had become clear.

ACHIEVING HEALTH FOR ALL

Two political events were to set the stage for Healthy Cities; both were linked to the World Health Organization's (WHO) Health For All by the year 2000 (HFA/2000). First was the 1978 adoption of Health For All as the main goal of WHO and its member states. The means of attaining the goal, according

to WHO, is the development of "primary health care," defined as " . . . essential health care . . . all the services necessary to prevent disease, maintain and promote health. . . . It includes identification [of health needs], management and referral" (Anderson and McFarlane, 1988). Developing primary health care, according to Ashton and Seymour (1988), depends on two central elements: real community participation, and collaboration between different sectors and agencies.

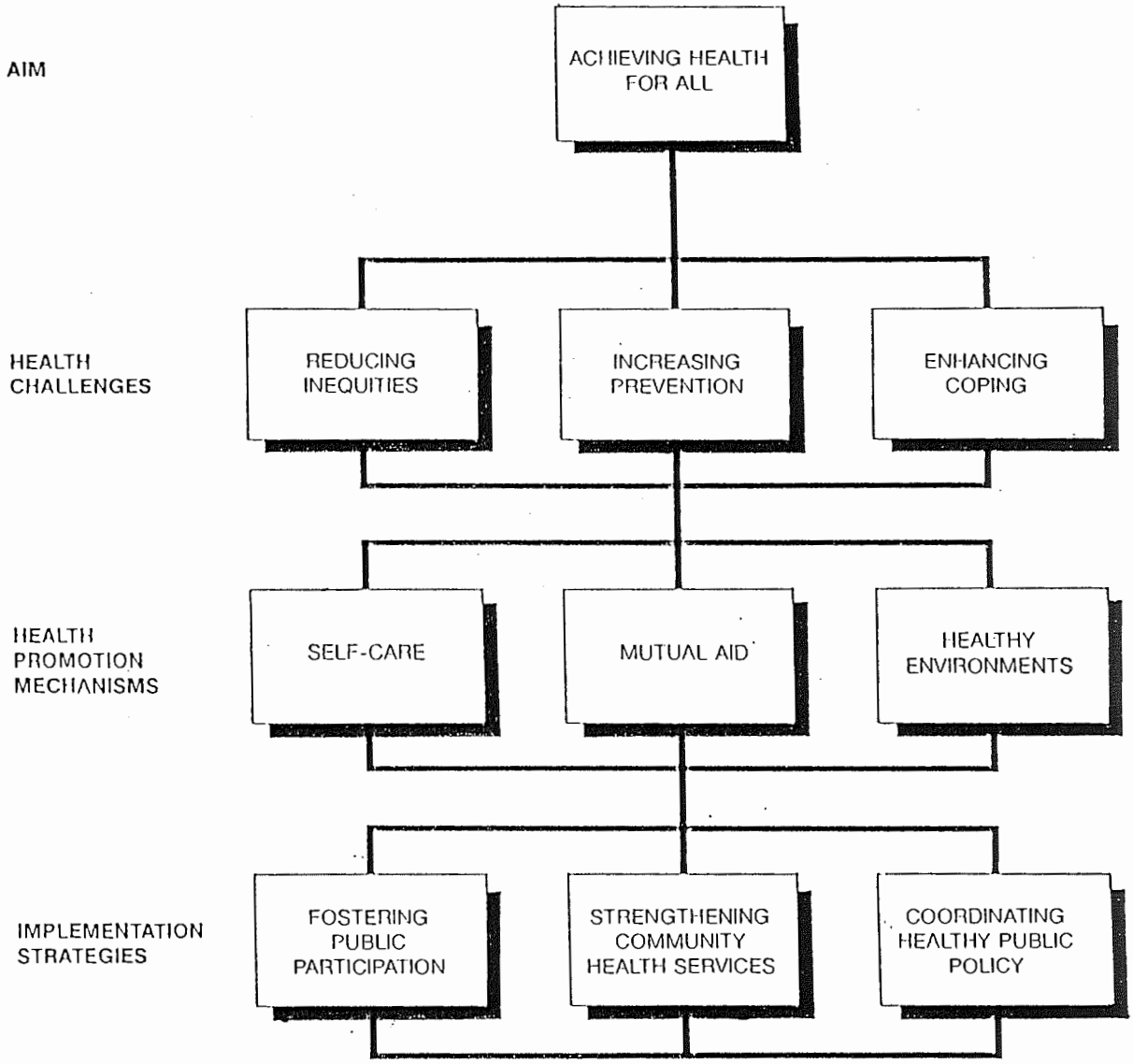
The second major event occurred when WHO Europe and its member governments agreed on 38 specific targets as the steps toward HFA/2000 (WHO, 1984a). Based on the new, broad interpretation of health, the targets require the involvement of public agencies and departments not traditionally focused on health. Extensive publicity has surrounded both these HFA events, and the principles, strategies and targets for HFA have became an inspiration for people with an interest in health promotion. In 1986, when the Healthy Cities project was announced, it was welcomed, particularly in Europe, as the means by which the targets could be reached.

The concept of health promotion was also undergoing change: in the traditional interpretation of health as absence of disease, health promotion could be appropriately interpreted as disease prevention. Conceiving of health as more than the absence of disease, however, calls for a broad, dynamic model of health promotion, one which makes explicit the various elements of the physical and social environments fundamental to health, and which highlights equity, public participation and the role of governments in the process. Perception of that need, influenced by the *Lalonde Report*, WHO's HFA thrust and increasing public concern for health, led to the 1986 production of *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986). The document acknowledged the insufficient attention paid by the current system to areas such as life expectancy, level of health and prevalence of disability within disadvantaged groups; to preventable diseases and injuries; and to chronic conditions and the availability of supports (Epp, 1986).

The framework for health promotion is shown in Figure 1. Using the WHO definition of health promotion as " . . . the process of enabling people to gain control over and improve their health" (p.3), led to identifying three health challenges toward achieving health for all: "reducing inequities, increasing prevention and enhancing coping." Empowering, increasing the ability to control and improve health, implies self care, the actions individuals take in the interest of their own health; mutual aid, those taken to assist others; and healthy environments, settings conducive to health. Finally, because those elements must be accompanied by consistent supports and public policies, fostering public participation, strengthening community health services and co-ordinating healthy public policies were identified as key strategies in implementing the health promotion framework. Realization of the framework, the authors contended,

Figure 1

THE FRAMEWORK FOR HEALTH PROMOTION



Source: *Achieving Health For All: A Framework for Health Promotion.* Ottawa: Health and Welfare Canada (1986).

requires an intersectoral approach, the involvement of government departments other than health, such as employment, social services and housing, and of the private and volunteer sectors.

In 1984, WHO had defined the five principles of health promotion: that it actively involves the population in everyday life, rather than people at risk for specific conditions and in contact with medical services; that it is directed toward action on the causes of ill-health; that it uses many different approaches, including education, community development and organization, health advocacy and legislation; that it depends particularly on public participation; and that health professionals--especially those in Primary Health Care--have an important part to play in nurturing health promotion and enabling it to take place (WHO, 1984b).

At the First International Conference on Health Promotion, held in Ottawa in 1986, the principles were developed into the *Ottawa Charter for Health Promotion.* The four page guide for action to achieve Health For All by the year 2000 focused on the necessity to build public policies which support health, create supportive environments, strengthen community action, develop personal skills and re-orient health services. Meeting the prerequisites for health and supporting the needs of individuals and communities, the document argued, requires the maintenance of open channels between health and other sectors (*Ottawa Charter for Health Promotion,* 1986). Therefore, among other commitments such as tackling inequities in health, conference participants pledged to " . . . re-orient health services and their resources toward the promotion of health, and to share power with other sectors, other disciplines, and most importantly with people themselves" (*Ottawa Charter for Health Promotion,* p. 4).

THE HEALTHY COMMUNITIES PROJECT

Two years before the *Charter,* the concept of Healthy Cities had originated out of a paper presented by Duhl at an October 1984 "Beyond Health Care" conference, held to promote an ecological view of health in human settlements. The meeting was attended by Ilona Kickbusch of WHO Europe; from discussions arising from the conference, she launched "Healthy Cities" in 1986, as a five year joint program of WHO Europe's Health Promotion Program and the Environmental Health Policy Program. The project is designed to finish in 1992. Hancock, a prime mover of the conference and of the project, joined with Duhl to define the Healthy City as:

> . . . one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential (Hancock and Duhl, 1986).

WHO has said the goal of the Healthy Cities Project is " . . . to enhance the health of cities, their environments and their people. The project seeks to mobilize the energy and creativity of local governments

and the community and to harness their efforts toward achieving Health For All. . . . [It] addresses two of the key principles of Health For All/2000, namely multisectoral action and public participation" (WHO, 1988b, p.11).

The dominant themes from all the recent developments in health promotion are represented in the Healthy Cities Project: From HFA/2000, community participation and inter-sectoral collaboration; from *the Ottawa Charter*, those elements and a more explicit focus on reducing inequities; and from Epp's *Framework for Health Promotion*, all of those, along with healthy environments and a focus on healthy public policy. In general, the thrust of the project is twofold: it highlights the role of municipalities in health, including calling for an intersectoral strategy for developing policies, services and projects that are consistent with health, and it fosters the development of "models of good practice," special health promotion initiatives aimed at geographical or cultural communities within the city. According to Flynn, a third characteristic of the European project is its emphasis on the development of a local data base, survey and research connected with the project, a difference in extent if not in kind from the Canadian Healthy Communities Project (Flynn, 1988). Appendix A includes a discussion of the origins of the Healthy Cities Project and a description of five local initiatives, (in the U.K., the U.S. and Canada) whose experience may prove useful for Canadian Healthy Communities Projects. At the second annual Healthy Cities Symposium, held in Dusseldorf in June, 1987, a decision was made to have 20 WHO "Project Cities;" many more cities are participating "outside" WHO, having independently declared their own projects. By 1987, strong national networks were also becoming established throughout Europe (WHO, 1988a).

In Canada, the initiative was originally sponsored by the Canadian Public Health Association (CPHA) and the Canadian Institute of Planners (CIP), joined in 1987 by the Federation of Canadian Municipalities (FCM). At that time, the name of the project in Canada was changed to "Healthy Communities" to reflect and include participation of a wide range of municipalities, regardless of size. Each participating municipality is expected to develop projects, activities and programs consistent with the themes of *Achieving Health for All: A Framework for Health Promotion* and the *Ottawa Charter for Health Promotion*. Like their European counterparts, Canadian projects will be expected to use an intersectoral approach to focus on the enablement of communities to address inequities in health, to foster public participation, and to work toward creating healthy environments and co-ordinating healthy public policy. Like the participating cities of Europe, the Canadian projects are expected to have an evaluative mechanism, so that at the close of the five year initiative, an assessment may be made of its worth.

Differentiating the Canadian Healthy Communities Project from the Canadian Public Health Association initiative, *Strengthening Community Health,* a committee of Health and Welfare Canada, CPHA and the Healthy Communities Co-ordinator (Susan Berlin) described the project this way:

> CHC is municipality focused. It advocates changes in methods of decision making among municipal leaders, planners and policy makers, with the aim of increasing community participation in municipal goal setting, fostering recognition of the health impact of the decisions of all departments and establishing processes for joint interdepartmental and community problem solving concerning otherwise intractable issues (e.g., family violence, unhealthy environments, the situation of seniors). (Canadian Co-ordinating Office, CHC, Fax, Jan. 11, 1989)

Both projects have arisen from Health For All roots, the "strengthening communities" focus deriving from the "strengthening community services" implementation strategy of the Epp framework. Both also involve public participation; "strengthening communities" is more likely to be initiated by health professionals than is a Canadian Healthy Communities project, which may arise from a variety of public or government settings.

Announcing a $650,000 grant for setting up Healthy Communities across Canada and creating a national office to co-ordinate the project, a news release from Health and Welfare Canada stressed the importance of physical and social environments to health: *Achieving Health for All* identified the creation of healthy environments as a principal mechanism for promoting health. Since close to 80 percent of Canadians live in urban areas, "the improvement of social and physical environments of municipalities has great potential for preventing disease and improving health" (June 2, 1988, p. 1). The aims of the Coordinating Office are to assist municipalities to develop, implement and evaluate projects, provide a newsletter, organize conferences and promote links among Canadian projects and with those of other countries. The primary activity of the project is local, however, because, although learnings from others may be applied to some aspects of a project, each one will be unique, shaped by the characteristics and needs of the community as perceived by the local participants. The Canadian Healthy Communities Project has established a guide for local projects:

- a municipality which wants to participate passes a resolution in council indicating its political interest and will;
- it then sets up a decision-making entity which includes representatives from all departments, community members and representatives of the private sector;
- once all these elements are in place, they are mandated to work together to identify a small number of "health" issues (perhaps one or two or three) facing their community which they would like to address through the healthy community process;
- they can use any "screen" they like to select those issues: what is most urgent in their community; what will offer the quickest return; what will be least costly, so that people can see how well the process works before making major financial commitments to it;

- they then design a program to deal with those issues. The program must include an evaluation component so they can come to terms with what works (and what *does not* work) in this approach. (Berlin, 1989)

The model proposed in this report is a process model which includes events leading up to the council declaration of a project as well as after. Where a project has its origins from within the community, as opposed to council or municipal government, the "predeclaration" phase is important because of the role of public support in capturing council's interest. The model presents a special case where the "decision-making entity" set up by municipal government cannot be included *in toto* in municipal government but has a "separate" community structure.

THE MUNICIPAL ROLE AND HEALTH FOR ALL

In a country where powers and responsibilities have been divided by constitution between the national and provincial governments, some Canadians may be inclined to believe that the third or municipal level is at best an expensive and unnecessary addition, an unwarranted luxury in our total government structure (Plunkett, 1968). However, while senior governments play a role in determining how services will be delivered (because they provide funding or because the acts under which municipalities function are provincial) local government, because it *is* local, is of vital importance to the health of Canadians. Most of the services required for people to live well fall among the responsibilities of municipalities. To name a few, garbage must be collected and pure water supplied; transportation, fire protection, safety and health care needs must be met; entertainment, cultural enrichment and recreation must be made accessible; and communities must be planned and maintained in a way that ensures the integrity of the environment.

Traditionally, municipal government has played a major role in health. At the turn of the century, municipalities were instrumental in improving public health by preventing the spread of disease through slum clearance, community planning, water treatment, the provision of health services, and so on. These interventions were based on the traditional view of health as freedom from disease and of disease prevention as the main challenge of municipalities (Mathur, 1989). More recently, with the meeting of many of those basic needs, the nature of medical problems has changed, so that in the developed world infectious diseases have given way to circulatory and respiratory diseases, cancer and accidents as major causes of death. As a result, and along with a new, broad definition of health, the focus has shifted to include quality of life--to disadvantaged groups, chronic disease, disability and stress. For that reason, the *Framework* recognized Reducing Inequities and Enhancing Coping along with Disease Prevention as major challenges to health (Epp, 1986).

In the new definition as in the old one, however, municipal government has a central and appropriate role to play in meeting health challenges. As indicated earlier, Health for All is based on two elements: intersectoral collaboration and public participation. The municipality, as the most immediate level of government, is the one with the "practical mandate" necessary to develop intersectoral approaches to improving quality of life. The BNA Act notwithstanding, in the sense that the business of municipal government has the most impact on the daily lives of its people, health (as in the new public health) is arguably a *municipal* responsibility. Moreover, as Ashton and his colleagues have suggested (1986), because it is a place with which citizens can identify, there are good prospects for public participation harnessed to neighbourhood or civic pride. Given that three fourths of Canadians now reside in cities, and that the trend to urbanization is expected to continue--to reach 93 percent in North America by 2025 (WHO, 1988b)--the need for a renewed municipal focus on health is increasing. The Canadian Healthy Communities Project provides a framework for municipal government initiatives toward achieving health for all. It increases community participation in planning, implementation and evaluation, and also the knowledge and skills of community groups. The project calls for a new perspective from municipal government, one which focuses on the health potential of all municipal policies and services, and requires an interdepartmental and intersectoral approach from municipal government. However, it also promises that making the adjustment will improve the health potential of municipal policies and services and improve the quality of life of all the citizens.

THE HEALTHY COMMUNITIES PROJECT: AN OPPORTUNITY FOR WINNIPEG:

THE NEED FOR A PROJECT

In the previous section, the basis was laid for municipal governments, in the interest of health, to address the physical and social problems that stand in the way of citizens living full and productive lives. The new perspective on health, including as it does all the aspects of carrying out roles, presents a challenge and an opportunity for exploring how a municipality, in this case Winnipeg, can be a healthier place, creating and supporting physical and social environments within which citizens can live to their potentials. A review of the development of Winnipeg from its Hudson Bay post days to the present and some of the city's social characteristics and traditional health indicators are presented as Appendix B; they provide a basis for some conclusions about Winnipeg.

The city of Winnipeg, which now ranks seventh in size among Canadian cities, is expected to continue to grow in the near future, although at a progressively slower rate than in the past. As events stand now, the increases will take place mostly in the suburbs. The central core will continue to decline in population, paradoxically, because that area also experiences high levels of immigration of minority groups, and particularly aboriginals from rural and northern Manitoba. In this city of neighbourhoods, in contrast to those areas that are vibrant, the city centre includes some physical deterioration that has not been erased by attempts at renewal. There is also elegance, usually found in the area's commercial and government buildings, but the overall impression of downtown Winnipeg is one of instability and sporadic deterioration not unlike many present day North American cities, but which is made more striking by the shiny North Portage development. The implications of physical and social decline extend beyond aesthetics and comfort; as Epp observed in 1986, upper socio-economic status males in Canada have a life expectancy exceeding that of lower socio-economic status males by seven years (Epp, 1986). Also, although the connection between equity and health has not been demonstrated for cities in Canada, it has for those in other settings, such as in Liverpool and Sheffield (Liverpool City Planning, 1986; Sheffield Environmental Health Dept., 1985; see Appendix A).

Ethnic diversity is a striking characteristic of the city core; City Centre/Fort Rouge and, to a lesser extent, Lord Selkirk/West Kildonan, have the greatest ethnic range in the city. As discussed in Appendix B, they also have the most unemployment, the lowest average education and income and the greatest proportions of those paying over 25 percent of their household income on housing. The aboriginals of City Centre/Fort Rouge and Lord Selkirk/West Kildonan are particularly poorly off; as discussed more fully in Appendix B, they have the lowest education levels (with 24% of aboriginals in City Centre/Ft Rouge and 27% of aboriginals in Lord Selkirk/West Kildonan having less than a grade 9 education); they have the highest unemployment rates (with 27.5% of aboriginals in City Centre/Ft Rouge and 28.8% in Lord

Selkirk/West Kildonan being unemployed); they have the lowest incomes, at just over $16,000 average annual household income in both districts, they average half the $33,294 figure for Winnipeg as a whole and fall $4,000 short of the average household income for aboriginals in the city. Aboriginals in the central areas are also more likely to be homeless than any other ethnic group in Winnipeg, as discussed in Appendix B. In a city with a poor record of "repair status" of housing, the worst area in that regard is the city centre, where residents are also more likely to rent than to own. Given such conditions, opportunities abound for child neglect, crime, family abuse, violence and other signs of disintegration and (as suggested above) for illness related to social factors, particularly among aboriginal residents.

In 1983, Artibise spoke of the problems of Winnipeg. The most serious fact, he said, was not one of slowing population growth, or unemployment or decline in the city centre, all of which were recognized as serious in the 1981 *Introduction to the Greater Winnipeg Development Plan.* The underlying problem, he said, was shortage of "vision," a sense of itself, also not unlike many other cities, but without which solutions to the other issues could not be reached. A clear goal of where Winnipeg wants to be in the next ten or twenty years, he added, would help councillors, public servants and citizens harness the energy and resources necessary to turn our positive visions into reality (Artibise, 1983). Integrally linked to the physical environment, vision connects both as "cause" and "effect" to conditions for living and thereby to health; where there is vision, there the people are probably healthier, whether measured by mortality and morbidity or by indicators which include elements of role performance and reflect the new public health.

A February 1989 conference sponsored by the Winnipeg Chamber of Commerce expressed a similar concern. Delegates stressed the need for improving educational, employment and housing conditions of Natives, improving the transit system, improving the physical appearance of many areas of the city, creating a wide range of affordable housing options, implementing a more competitive tax structure and improving the existing infrastructure. Recognizing Winnipeg's slowing growth rate, they called for focusing on what exists, for creating an improved self-image for citizens backed up by ". . . an innovative yet realistic Plan, developed on a partnership basis by all sectors of the community" (Carter, 1989, p. 1).

A Healthy Communities Project is a good idea for Winnipeg not only because it is "morally" right to take an affirming stance for equity of access to health, but also because it is appropriate, "theoretically" right that the most immediate level of government should concern itself with improved quality of life for its citizens, and use a mutisectoral and public participation approach to get it. A project is also fitting, "practically" right, because in Winnipeg, as in most places in Canada, a local health department is available as a resource. With the new, broad definition of health, responsibilities for wellbeing extend beyond the boundaries of health departments, which, consistent with the *Ottawa Charter,* are committed to the

intersectoral approach central to the Healthy Communities project. The project is also "politically" right: The "models of good practice," which focus on particular problems in the city, and the intersectoral and public participation aspects of the project are important in themselves, and also as illustrations of positive actions by city council.

The project is also timely because Canada, like the rest of the world, is becoming increasingly urban, and a municipal focus on health is needed so that in the future Winnipeg can solve related problems of poverty, immigration, quality of housing and so on. Now is the time, because this period when Winnipeg is not experiencing rapid growth presents an appropriate pause to take stock of what we have and build a vision for what we want.

In summary, the relationship between equity and health status has been demonstrated, although not in the context of Winnipeg. What has been suggested here is a lack of shared vision and identity, both of which are important to immediate conditions of living and to health. Just as the resolution of physical and economic problems requires leadership, which depends on vision, so also vision develops and remains focused through connectedness, rooting within the physical and social context in which one lives. A Healthy Communities project in Winnipeg could provide the framework for vision, within the citizenship and among the city's current and future leaders. An endeavour which improves health and neighbourhood life in Winnipeg, and at the same time kindles community pride and a sense of mission for the city, is more than, to use a Canadian phrase, "not a bad idea." It is appropriate, needed and timely.

The remainder of this report will suggest a decision structure and framework within which the requirements for a Healthy Communities project in Winnipeg can be accomplished, and address evaluation and the need for a data base to be established as part of the project.

A FRAMEWORK FOR A HEALTHY WINNIPEG

OVERVIEW

Background material for this section has been included as Appendix C to this report. Along with an organizational chart of municipal government, the Appendix includes notes on the growth of the city, the establishment of Unicity and the Community Committees and Resident Advisory Groups (RAGS), and a description of the steps by which an initiative arising from within a city department proceeds through the ranks to discussion by city council.

In 1988-89, not only the Healthy Winnipeg Advisory Committee (HWAC) but also other interested parties in Winnipeg have considered a Healthy Communities Project for the city. Two of these have been groups of students in graduate (Masters) programs at the University of Manitoba. For example, on April 4, 1989, in conjunction with a course project on a Healthy Community project for Winnipeg, the Master of Planning students held a public meeting at which Healthy Community related recommendations were presented to about 40 participants. The conclusion of their report forms part of Appendix D. Four students of the Health Education Masters Program also focused on a Healthy Community project for Winnipeg (Clare et al., 1989). The executive summary of their term project report is also included in Appendix D, as are summary notes from the January 27, March 3 and March 16 meetings of the HWAC; at those meetings, particulars of a possible Winnipeg project were addressed in workshops led by Dr. D. Harvey, University of Manitoba. Output from the reports and meetings were not incompatible; for example, all called for public participation to be included on the basis of local community boundaries. The material in this section relies on all of those sources and, with regard to functions of some of the committees, particularly on the work of Clare et al. (1989).

As proposed, the Healthy Community project for Winnipeg has many players, city hall, the public, and city-wide and community committees, working together to create a Winnipeg that is " . . . continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential" (Hancock and Duhl, 1986). The requirements as set out by the Canadian Co-ordinating Office suggest that a lead role must be taken by city hall. Council may expect to be supported by the community elements of the project, led by the Healthy Winnipeg Steering Committee (HWSC), which will act as a resource regarding the new public health and undertake initiatives which supplement and complement those of municipal government. A detailed description of the functions of these and other project committees is included later in this report.

Figure 2 shows the proposed relationship between the community and municipal government structures of the project. Enclosed in broken lines is the proposed Interdepartmental Healthy Winnipeg

Committee, a committee of senior government officials, chaired by the Commissioner of Planning and Community Services, and reporting to the Committee on Planning and Community Services, a Committee of council. Both committees will have representation on the community based HWSC, facilitating exchanges and collaboration between the community and government structures. The arrangement proposed is designed to maximize public involvement, on indications from municipal government that public representation on the Interdepartmental Committee is not possible in Winnipeg. Although structurally "separate" from municipal government, the community structures of the project are nonetheless important contributors to municipal government initiatives.

Figure 3 shows the proposed structure of the "community" elements of the project. The Healthy Winnipeg Steering Committee (HWSC), to be constituted and orientated by the start-up group, will manage city-wide community aspects of the project, naming subcommittees for some specific tasks: Promotions and Education and Community Volunteers subcommittees, as suggested by Clare et al. (1989), Long Term Planning and Policy, and Data Gathering and Evaluation subcommittees. The HWSC and the subcommittees will have an indirect relationship to the Community Project Committees, supporting them as they become formed and carry out "models of good practice," health promotion initiatives at the local level. Each Community Project Committee will be represented on HWSC, although not necessarily on every subcommittee.

Viewed from another perspective, the Healthy Winnipeg Steering Committee and its subcommittees are intersectoral, representing Winnipeg's public, private and voluntary domains, and are city-wide in scope. The Community Project Committees, on the other hand, are geographically based and deal with area specific concerns. It is to be expected that, over the course of the project, *ad hoc* committees, not included in Figure 3, will be required to meet specific needs as they are identified by HWSC, the subcommittees, the Community Project Committees or by municipal government. Possible focal issues for these "functional" committees may be literacy, industrial pollution, Native health, race relations, the

Figure 2

RELATIONSHIP OF HEALTHY WINNIPEG COMMUNITY STRUCTURES TO MUNICIPAL GOVERNMENT AND EACH OTHER

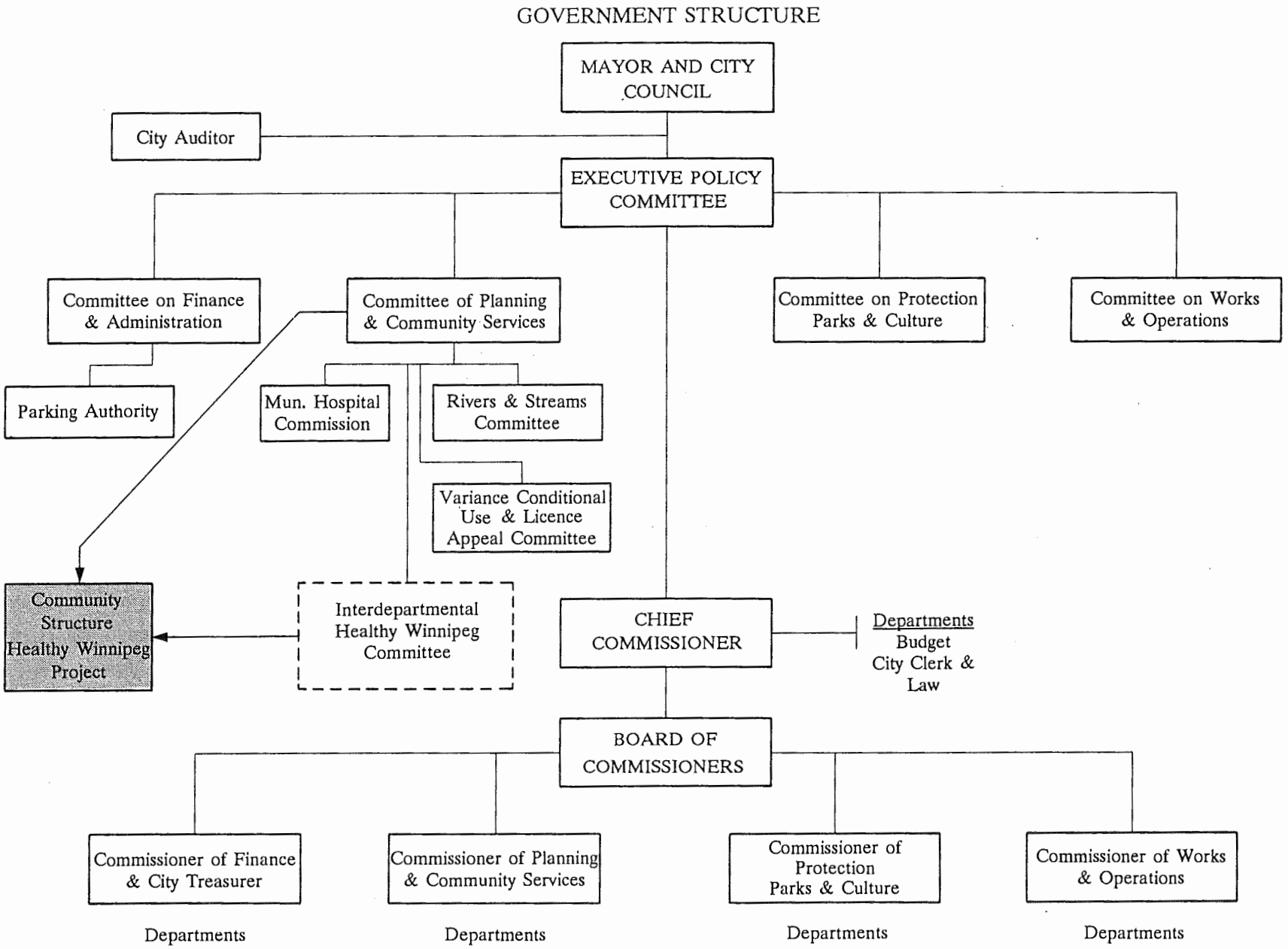
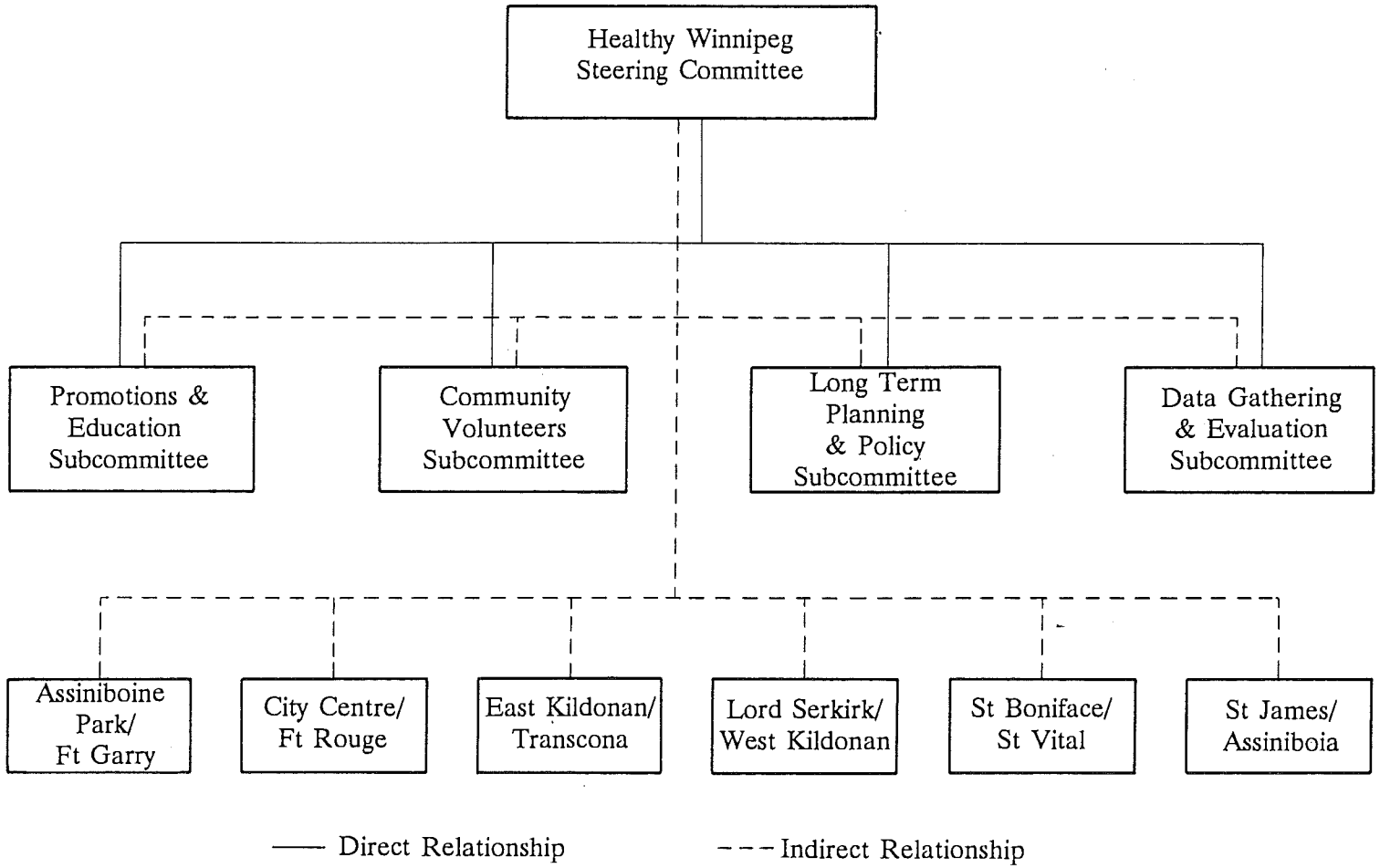


Figure 3

PROPOSED COMMUNITY STRUCTURE, HEALTHY WINNIPEG PROJECT



built environment, housing and the like. They may not extend to the life of the project but be struck and disbanded relative to specific needs.

THE FRAMEWORK

Figure 4 gives a framework of the proposed project showing the process of the project through initiation through to evaluation of project initiatives. The steps are:

Formation of the Start-up Committee

Members of the Healthy Winnipeg Advisory Committee (listed in Appendix G) have agreed to form part or all of the start-up committee. A more detailed description of the tasks of this and the other project committees is included later in this report.

Formation of the Steering Committee (HWSC) and Subcommittees

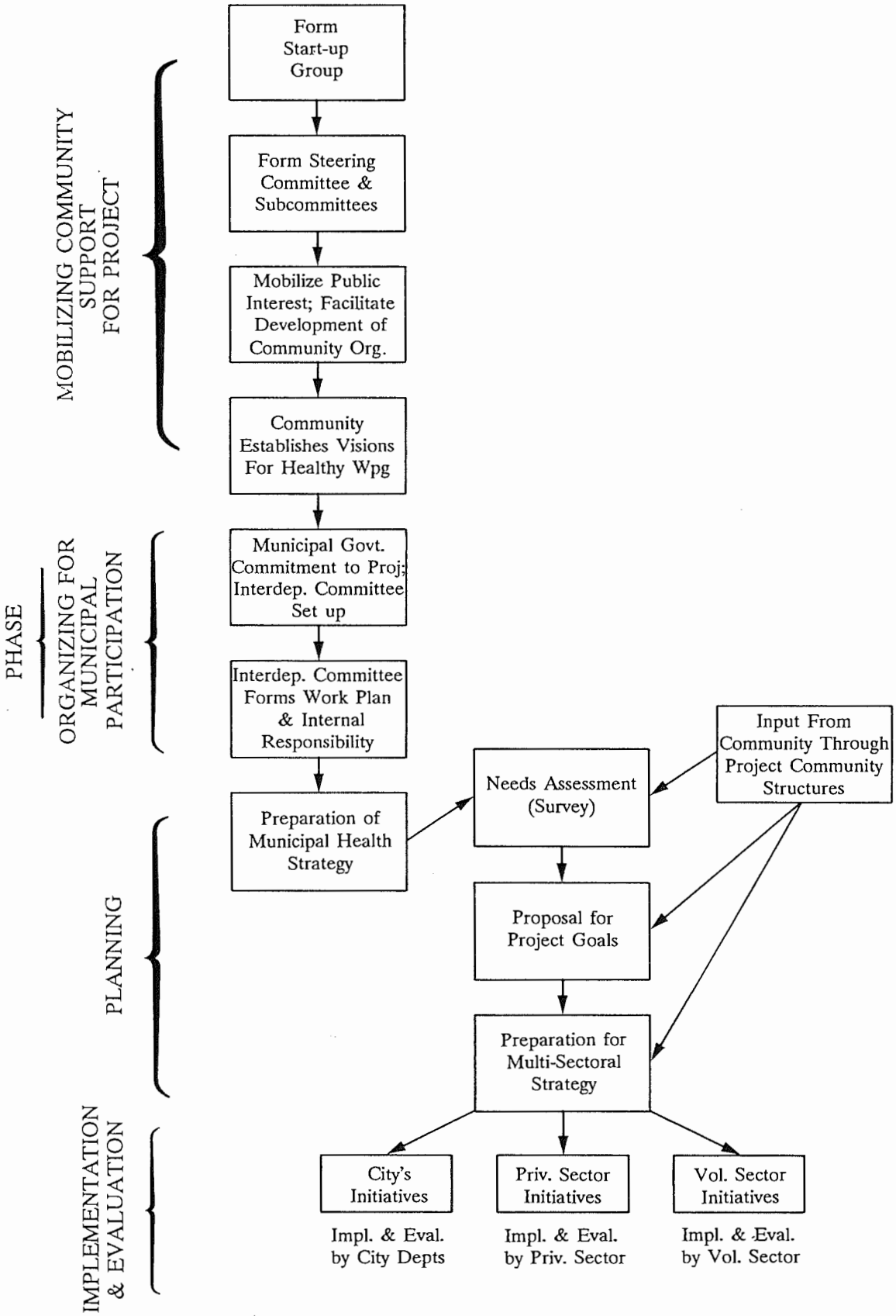
The subcommittees, in fact, may not all need to be established at this stage; some may be set up later, as needed. The start-up committee will have general responsibility for setting up the Healthy Winnipeg Steering Committee (HWSC).

Mobilize Public Interest; Facilitate Development of Community Organizations

The purpose of this stage is inform and interest groups and individuals who may become members of committees, volunteer facilitators, or in some other way support the project. The process may begin early or be extended to run concurrently with the design and implementation of local projects. Training sessions will need to have been held with volunteers from all parts of the city so that an initial nucleus of volunteers is available to manage the meetings in each community. In each of the six communities, the gatherings, whether they are well publicized public meetings or smaller gatherings of existing groups such as service clubs, church groups, Home and School Associations, etc., should inform those present about the project and a potential role for their ideas, gain pictures of participants' current views of their city and communities, and their visions of what they want. The "output" from the process may be utilized at the local community level or "city-wide," with information passed on to HWSC and appropriate subcommittees. Regarding informing the public, some projects, most prominently Rouyn/Noranda (as shown in Appendix A) have effectively used short "questionnaires," perhaps a "tear off, fill out and return" inclusion in the newspaper or neighbourhood news; "mail box dropped" flyers; notices and forms at libraries, supermarkets, pharmacies, post offices, etc. Once completed, the forms were mailed in, dropped in collection boxes at the pick-up point or brought to meetings; media appeal and "phone-in" line for input

Figure 4

FRAMEWORK, HEALTHY WINNIPEG PROJECT



developed by B. Lane & B. Mathur, Institute of Urban Studies, April, 1989.

were also ideas used by other projects; from the events, volunteers for community committees and ideas for local community projects were secured (See Appendix A, Rouyn/Noranda).

Community Establishes "Visions" for Healthy Winnipeg"

Potential tools for this important component include a "guided imagery" exercise, adapted for city workshops by Hancock, and the text for which is included in Appendix E. Output from the sessions should be useful for HWSC, the Community Project Committees and the city of Winnipeg's Planning and other departments, and may motivate volunteers. (See Appendix A, Rouyn/Noranda). Another technique is the "Kids' Place Survey," a method which has proven useful in existing projects. It has been used with school children from Grades 2 to 12, to learn about their reactions to their physical environment and explore ways in which it may be made more "kid friendly." The tool, described in Appendix A, Seattle, can be administered by teachers in the classroom.

Municipal Government Commitment to the Project; The Setting Up of the Interdepartmental Committee

The role of the HWSC and the other community committee structures does not diminish as the Interdepartmental Committee is established, but it does assume another dimension. The HWSC, for example, would act in a support and information role to city council as it prepares for and makes its Healthy Winnipeg declaration and forms the Interdepartmental Committee. Members of the HWSC may also work with municipal government staff in work sessions about the project. The purpose of such meetings would be to inform and interest councillors and public servants about the Healthy Communities Project. Because success of the project requires the acceptance of the goal of equity of access in the municipality, of an inter-departmental collaborative approach to solving problems, and a meaningful public participation process that surpasses mere public information or consultation, participants need to explore these implications of the project for their individual and collective roles. The benefits of such meetings by staff or councillors may include renewed commitment to city and departmental goals. Such a meeting might be a half day work session, carried out within the work environment and repeated as necessary to reach all municipal level individuals to be involved with the project (particularly those to become part of the Interdepartmental Committee). The guided imagery workshops described in Appendix E have been successfully used in Toronto for such sessions. Regarding timing of the event, meetings with public servants could take place after declaration of a Healthy Winnipeg project, but meetings with city councillors must precede their declaration of commitment so they make an informed decision.

Regarding council's declaration, the event provides an opportunity for them to make a positive, public statement of commitment to the Healthy Communities project, declaring council to be held

accountable for the health implications of decisions, services and programs. Although the declaration and the commitment it implies are not sufficient for the project to succeed, they are necessary, considering the actions and changes required are often municipal responsibility. The publicity surrounding the event is useful for arousing public interest. In fact, the earlier declaration can take place and still entail an informed decision on the part of council, the more likely the event can be useful for arousing public interest and participation in the various community structures and actions.

Interdepartmental Committee forms work plan and sets out "internal" responsibilities

The first important task of municipal government's Interdepartmental Committee is to form a work plan and set out responsibilities within the committee. For example, a decision may be made that the task of acting as an ongoing resource for the new public health perspective or for Health For All should fall to the Health Department, and/or that related expertise from the HWSC or elsewhere, such as from the Manitoba Public Health Association, should be utilized.

Preparation of a Municipal Health Strategy

Central among the "characteristics" set out by the National Steering Committee of the Healthy Communities Project, the preparation of a municipal health strategy is a municipal government task in which the Interdepartmental Committee may expect HWSC or other community structures' assistance.

Needs Assessment (Survey)

In this phase of the task, the Interdepartmental Committee would set out a framework for data collection, and in collaboration with the community structures of the project, identify related roles for the community committees.

Input from the Community through Project Community Structures

A suggestion regarding this aspect is that the project could use an "action research" format, a brief description of which follows:

The technique, as described by Vincent, 1972, was used by Institute of Urban Studies (IUS) staff in the early 1970s; he said the model includes three major components. The first is a community survey involving technical experts and trained interviewers, or, alternatively, community self-surveys, with the population being studied providing the interviews and the liaison organization between the community and IUS. The second component includes the pursuit of particular concerns and problems illuminated in the survey; Vincent described one project in which a storefront office for information and referral services

for improved health facilities in an area of Winnipeg. Analysis of the intervention process, the third component, includes an assessment of the community problem being tackled, the level and type of community representation in planning issues, the projects or programs planned by the new citizen-based organizations and the role of the resource (in the case discussed, IUS; see Vincent, 1972; Axworthy, 1972). In a Healthy Winnipeg project, an expectation is that the responsibility for training volunteers for data collection in such "action research" would fall to the Volunteer Subcommittee and the Community Project Committees, although the universities and other resources may be included as well. Municipal government would be expected to process the data, communicating and discussing the findings with the community committees, and in the process discussion of the problems and goal setting would occur.

A proposal for project goals would then be worked out by the Interdepartmental Committee, based on the problems and strategies discussed at the community level.

The Multi-sectoral Strategy that results would have more than one component: municipal government departments would implement actions from their "territory," initiatives such as improvements to water, housing, etc.; the private sector may also implement strategies, as may the volunteer sector, probably through the community structures of the project. Regarding the initiatives, each participant element would be responsible for evaluation, a process discussed later in this report.

WHO FRAMEWORK FOR ACTION

With regard to project initiatives, whether from the public, private or volunteer sectors, WHO's Framework for Action 1988-1992 may provide guidance for local projects, described by Ashton as "models of good practice." The framework discusses the "annual themes" chosen for the European projects, for which supporting material may be available from WHO, and which may suggest useful directions for the Interdepartmental Committee and the various community-based committees. For example, in 1988, the focus was on "inequities in health," a high profile theme from the European targets (Target No. 1), *The Ottawa Charter for Health Promotion* and *Achieving Health for All: A Framework for Health Promotion.* Cities were encouraged to document inequities and develop plans to address them, and a project symposium was held to discuss policies and actions. Listed below are subsequent year themes and related comments:

1989: Strengthening community action and developing personal skills:

> Cities will be encouraged to examine . . . their activities intended to strengthen social support, foster public participation generally to enable people to increase control over health [including] health education (WHO, 1988a, p. 21).

1990: Supportive environments for health:

> Cities will be encouraged to examine . . . their approach to the creation of supportive environments in areas such as urban planning and design, housing, parks, transportation, waste management, pollution control, nature and resource conservation, access for the disabled, the creation of social environments, networks and support systems. This includes promoting healthy municipal policies (WHO, 1988a, p. 22).

The year 1990 is the "International Year of Literacy." Since literacy is one of the personal skills most essential for health, cities are asked to pay particular attention to functional illiteracy.

1991: Reorienting health services and public health:

> Cities will be encouraged to examine . . . efforts to reorient their health services towards more effective adequate, acceptable and accessible health services which are appropriate and sensitive to people's needs and wishes. This involves a greater emphasis on those who are presently underserved and on primary and community health care . . . .Of particular importance is the reorientation of municipal public health from traditional public health to the health promoting programs of the new public health . . . calls for retraining and briefing of key environmental health personnel . . . (WHO, 1988a, p. 24).

1992: Healthy policies for healthy cities:

> Cities will be encouraged to report on their success in developing healthy municipal policies, in establishing multi-sectoral mechanisms to develop and implement Healthy Cities strategies, in educating urban management professionals in multi-sectoral approaches to health and environmental health in the city and related departments. As such, it might lead to a charter for Healthy Cities . . . (WHO, 1988a, p 24).

FUNDING THE COMMUNITY COMPONENT

Prediction of total funding requirements of the process is problematic, as was an exact determination of the U.K. project costs, discussed in Appendix A. Just as some expenses of the Liverpool, Sheffield and Oxford projects were "hidden," borne by the organizations represented on the committees, so the same may occur in Winnipeg. Meeting staff and other resource needs will be facilitated by having those committee members who represent groups, agencies and organizations from senior ranks. Clare et al. have estimated the cost of the city-wide (community) component for the first two years of the project, assuming the hiring of a project co-ordinator for six months of year one and all of year two, and the setting up of a project office. The cost of staffing and operating (including secretarial services, office facilities and supplies, advertising for staff recruitment, volunteer training, public education and promotion, travel, staff training and contingencies) was anticipated to reach $26,544 for six months of year one and $59,588 for year two. The authors suggest that funding support may be secured from Winnipeg sources,

such as the Winnipeg Foundation, or from provincial or federal sources, such as Manitoba Lotteries, the government of Manitoba or Health and Welfare Canada. Hancock and Duhl (1988) suggest public involvement in funding may be accomplished through memberships, subscriptions to the project. Corporate sponsors may be appropriate for "one-time" events, such as health fairs, marathon runs, promotional campaigns, etc.

Tasks, suggested strategies and other aspects of the various committees are described in detail below; the discussion includes the Healthy Winnipeg "Start-Up" committee and the Interdepartmental Committee within city government, which are not included in Figure 3.

COMMITTEES OF THE FRAMEWORK

Healthy Winnipeg Start-Up Committee:

Phase: Early initiation phase, until the first meeting of the Healthy Winnipeg Steering Committee (HWSC).

Participants: Those having expressed an interest in participating; probably some members of the Healthy Winnipeg Advisory Committee, interested members of city council (H. Macdonald and J. Eadie are council representatives to the Federation of Canadian Municipalities).

Tasks: Early organization, formation of the HWSC, balancing broad representation against an overly large, unwieldy committee.

Possible strategies: With regard to formation of the HWSC, word of mouth, one-to-one informing of potential members may be useful, including follow up of those who have already expressed an interest, listed with IUS. The report by Clare et al. suggests groups which could be a source of members of the committee (Council of Women, Winnipeg Labour Council, etc.). For this or other committees, the public could be reached through a media appeal with volunteers asked to submit letters expressing interest, a means by which the city of Saskatoon secures members on city committees. As the project was envisioned at the time of the original proposal, provincial governments were welcomed to become involved, for example through the "establishment of provincial Healthy Communities Projects" (CIP, CPHA, FCM, p. 10). Ensuring provincial as well as federal and local government representation on the HWSC would facilitate that happening.

Key Leader Workshop: A strategy suggested by R. Labonté, Toronto Health Department, was a "key community leader" workshop (personal communication, October 8, 1988). In this event, key leaders from a variety of groups in the community gather to explain their goals, what they do and what they need from the others present to do it fully. According to Labonté, the one day session should not be billed as a "Health" or "Healthy Communities" meeting because of the potential of introducing bias. Any

outlining of the goals of the New Public Health (and make a connection to the community goals of participants) or describing the Healthy Communities Project should only happen late in the session. Similar meetings may be held at the community level as well; an early, city-wide meeting as described should strengthen networking in the city and may produce members for the HWSC.

Orientation of HWSC: With regard to orientation of HWSC, a necessary step would be to use the first HWSC meeting to introduce members to the goals of Health for All, *Achieving Health For All: A Framework for Health Promotion, The Ottawa Charter,* the meaning of health in the new public health and the history and goals of the Healthy Communities Project.

Resources: Organizations represented by members of the start up committee, including the sponsoring groups of the national project (MPH, MACIP and FCM), Health and Welfare Canada, Manitoba Department of Health, City of Winnipeg Health Department, City of Winnipeg Environmental Planning Department, Social Planning Council, Norwest Co-op, Canadian Coordinating Office, Healthy Communities Project (including the "start-up" kit).

Possible Problems, Roadblocks: If members are named to the start-up committee includes members who have not been part of the Healthy Winnipeg Advisory Committee and lack knowledge of health promotion and the new public health perspective, they may lack commitment to the goals and mechanisms of a Healthy Communities Project generally and in Winnipeg specifically.

Healthy Winnipeg Steering Committee (HWSC):

Phase: From formation of HWSC to closure and evaluation of the project.

Participants: As constructed by the Start-Up Committee; probably 15-20 members, including municipal government's Commissioner of Planning and Community Services and Medical Health Officer.

Tasks: To organize and implement community aspects of a Healthy Winnipeg Project; that is, to set goals and develop activities addressing the elements of health promotion outlined in the *Ottawa Charter for Health Promotion* and *Achieving Health for All: A Framework for Health Promotion*:

- To secure commitment of council to a Healthy Community Project;
- To facilitate the work of the municipality in the project, including acting as a resource in the development of a specific municipal policy or strategy for a Healthy Community, facilitating community involvement in needs assessment and so on;
- To secure necessary resources to carry out the project at the city level;
- To promote the adoption of a role of support and facilitation by health professionals, by city, provincial and federal governmental agencies and by nongovernmental agencies;

- To facilitate the development and work of the community committees, directly and through HWSC subcommittees;
- To carry out ongoing and terminal evaluation of community aspects of the project at the city-wide level;
- To develop close working links with other projects and the National Coordinating Office to enable support, collaboration and learning.

Strategies: Members must represent citizens across a range of criteria, including socio-economic status, and government and non-governmental agencies in the city and "grass roots" members. Because members come from diverse backgrounds but must be committed to the goals and mechanisms of the Healthy Communities project, early meetings should focus on achieving a unified sense of purpose about the project and an understanding of the centrality of the "equity" goal and the use of an intersectoral approach and public participation to reach it.

With regard to implementing city-wide community aspects of a Healthy Communities project for Winnipeg, a decision is needed early regarding whether to hire staff and set up office facilities;

With regard to city council commitment, the process and timing of reaching city hall about the project is important, because when they commit, councillors must be aware of the project and the role of the municipality in it. One or more of the following strategies may be useful:

- A special event to inform council, held at city hall including councillors and senior staff;
- Group presentations and "one-on-one" lobbying of councillors, members of Community Committees, Resident Committees and/or Resident Advisory Groups;
- Presentations at municipal election events; letter writing, media attention arising from the community project committees;
- Focus on a publicized issue if possible. For example, the Rouyn/Noranda project effectively used an obvious need, pollution of the city's lake; perhaps "The Forks" or other project may serve as a focus for interest. Linking to existing "Winter Cities" interest may be fruitful;
- Initiate an amendment to *Plan Winnipeg* that includes a definition of health reflective of the "new public health;"
- With regard to working with the municipality on the project, an early decision is needed about "placement" of the committee; some Canadian Healthy Communities projects that have been initiated from within city hall have organized within the municipal structure, ensuring "legitimacy" and ready access to decisions and actions of municipal government. However, the proposed location for the Winnipeg project

is "external" to the municipal structure, with council and senior municipal government participation on HWSC, in order to build a strong public participation role, given that citizen participation on municipal government's Interdepartmental Committee is unlikely to be allowed in Winnipeg;

- With regard to securing resources and to promoting the adoption of a role of support by individuals and agencies, committee members who are representatives of agencies must be sufficiently senior and enthusiastic to bring the commitment of their organizations to the project;
- To facilitate the development and work of both the HWSC and the Community Project Committees and communication with them, all Community Project Committees should have representation on HWSC;
- To facilitate liaison with other projects and the National Organization, responsibility for that task could be delegated to the project co-ordinator (if there is one) or an HWSC member.

Resources: Local organizations of the sponsoring groups of the Canadian Healthy Communities Project (CIP, CPHA and FCM); HWSC members and organizations, including the Departments of Environmental Planning and Health; the Interdepartmental Committee of municipal government; published materials from WHO and others; local interested groups, the Chamber of Commerce, service organizations, the Urban Idea Centre; The Winnipeg Interagency Group, Institute of Urban Studies (IUS), etc. the Co-ordinating Office of the Canadian Healthy Community Project (including the Healthy Communities "start-up" kit).

Promotions and Education Subcommittee

Phase: All phases of the project.

Participants: Some members of HWSC and Community Project Committees and volunteers, chaired by a member of HWSC.

Tasks: Reporting to HWSC.

To create a debate about health within the community, including the development of close working relationships with the media, and exploring ways in which theatres, schools, libraries, etc., can be used to engage the public in debate about health in the community.

To assist in orienting government officials, health professionals and others toward the goals of the new public health, the need for a municipal level intersectoral approach to improving health, and the importance of facilitating public participation.

To facilitate the role of the HWSC and Community Project Committees in the area of promotions and education, through promoting communications between them and acting a resource.

Strategies: The approaching municipal election in Winnipeg may serve a useful purpose in the carrying out of a city-wide promotional campaign, providing a focus on quality of life and municipal government, quality of leadership, etc.

Resources: HWSC members and organizations; organizations and agencies in the community, such as the media, educational institutions, including the University of Manitoba, Health Education.

Community Volunteers Subcommittee:

Phase: All phases of the project.

Participants: Members of HWSC and Community Project Committees and volunteers from throughout Winnipeg, chaired by a member of HWSC.

Tasks: Reporting to HWSC. To facilitate the role of the HWSC and the Community Project Committees by city level promoting of volunteer participation in community projects; by acting in a communications role and as a resource in the setting up of community steering committees and by securing and holding training sessions for volunteers.

Strategies: Volunteers may be secured for city-wide or community level involvement through a wide reaching lively publicity campaign, perhaps in conjunction with city-wide or community level meetings, perhaps organized around a recognized local or city-wide need. The "Guided Imagery" tool designed by T. Hancock and included as Appendix E, may be useful for securing public involvement, especially if used with small groups.

Resources: HWSC members and organizations, including local organizations of the sponsoring groups of the Canadian Project; the active volunteer sector in Winnipeg, service clubs, Resident Committees, etc.

Potential Problems, Roadblocks: There may be difficulty in securing enough volunteers for the task. The community workshops and meetings phase of the project must be accompanied by an effective media campaign about the project and, as Clare et al. suggest, "a well developed training program [which would] enable volunteers to build their skills and which might serve as a suitable motivator to attract [volunteers]" (Clare et al., 1989, p. 37).

Long Term Planning and Policy Committee:

Phase: All phases of the project.

Participants: Chairpersons of subcommittees, other members of HWSC, and of Community Project Committees, and volunteers, chaired by chairperson of HWSC.

Tasks: Reporting to HWSC. To plan community aspects of the project at the city level. To act as a resource to the municipality in the development of a specific municipal policy or strategy for a Healthy Winnipeg. To facilitate the role of the HWSC and the Community Project Committees in the area of planning and policies, through promoting communications between them and acting as a resource, for example, in the area of funding.

Strategies: Work closely with HWSC and representatives from municipal government, and with other subcommittees and the Community Project Committees, to provide input for a plan suitable for implementation and evaluation of the project.

Resources: HWSC members and organizations, including local organizations of the sponsoring groups of the Canadian Healthy Communities Project.

Data Gathering and Evaluations Subcommittee:

Phase: All phases of the project.

Participants: Members of HWSC and Community Project Committees; volunteers; chaired by member of HWSC.

Tasks: Reporting to HWSC. To assist with ongoing and terminal evaluation of a Healthy Winnipeg project. To facilitate the role of the Interdepartmental Committee of municipal government, the HWSC and Community Project Committees in the area of data gathering and evaluations, through promoting communications between them and acting as a resource, particularly in the area of assessing community needs, setting goals and priorities (and perhaps targets), and evaluating community aspects of the project.

Strategies: Investigate financial assistance for the task of developing city-wide characterization area or community level data base of available indicators of health. Develop links with educational institutions and senior levels of government to identify indicators reflective of the New Public Health. Work with the Canadian Coordinating Office of the Healthy Communities Project, to seek, develop, use and promote indicators of health, especially those reflective of the New Public Health.

Resources: HWSC members and organizations, including local organizations of the sponsoring groups of the Canadian Healthy Communities project; Health and Welfare Canada, and government of Manitoba Health Promotion Branch; City of Winnipeg Environmental Planning Department; the University of Manitoba and University of Winnipeg, Departments of Geography, City Planning, Health Education, IUS.

Potential Problems, Roadblocks: Problems of data gathering include the present unavailability of indicators reflective of the new public health; costs of transposing data now at census tract or other level to characterization area or community level for analysis with social indicators.

Healthy Winnipeg Community Project Committees:

Phase: All phases of the project.

Participants: Volunteers from the community, chaired by member of HWSC.

Tasks: To work with HWSC, the Interdepartmental Committee, neighbourhoods, workplaces and volunteer groups in establishing "models of good practice," projects at the community level designed to improve health and quality of life of the people in the community, to promote the *Achieving Health for All* elements of reducing inequities, and to promote public participation and working across sectors.

To organize and carry out local meetings that mobilize community interest, and to summarize and analyze input, for example, from "guided imagery" workshops, "Kids' Place surveys," etc.

To work with other community project committees, HWSC and municipal government on goals, projects and interests broader than the community level.

To carry out ongoing and terminal evaluation of community aspects of the project at the community level.

Strategies: Use existing active groups (volunteer groups, service groups, churches, etc.) as a start, or, where feasible, organize under the Community Committees, Residents' Committees or RAGs. Existing groups should be considered in the light of how fitting they would be for the task now and what the possibilities would be, given the issue of a Winnipeg Healthy Community project. Neighbourhood associations, such as the Wolsely Residents' Association or the North Point Douglas Residents' Association may provide a base for a committee, but would need to be broadened to represent the entire community. With regard to orientation, the guided imagery exercise may be a useful tool to help members focus on the potential of the project (as in Rouyn/Noranda; see Appendix A).

With regard to linking with other Community Project Committees and the city organization, maintain communications informally and through active membership on HWSC. Such communication may be strengthened by delegating related responsibilities to an interested member.

Establish subcommittees as necessary for functions such as summarizing and analyzing public input, securing funds, etc.

Resources: Members of HWSC; HWSC subcommittees; local organizations and key members of the community.

Potential Problems, Roadblocks: A risk exists that not all members of the community may be represented on the community committee, particularly the more transient, "non-joining," lower socio-economic status members. Related to this, a lack of knowledge about the project in the community, transience and a depressed economic level may lead to diminished resources of people, space, funds and time within the community. A realistic fear is that some communities will not form Healthy Winnipeg Community Project Committees.

Interdepartmental Committee of Municipal Government:

Phase: From declaration by council to closure of the project.

Participants: Senior personnel of municipal government, committed to the Project and representing all branches of government (Finance and City Treasurer; Planning and City Services; Protection, Parks and Culture; and Works and Operations), chaired by the Commissioner of Planning and Community Services and reporting to the Committee on Planning and Community Services (see Figure 2).

Tasks: Reporting to the Committee on Planning and Community Services.

To develop and implement a Healthy Community Strategy for Winnipeg, for example, to establish an overview of health related needs in Winnipeg.

To carry out an appraisal of the health impact of current policies, programs and services of municipal government.

To carry out analysis, production of reports and recommendations of cross-sectoral interventions designed to improve health in the city.

To facilitate the work of the HWSC in the project, including acting as a resource as they develop city-wide and community level projects for health promotion; to carry out ongoing and terminal evaluation of municipal government initiatives of the project.

Strategies: Task accomplishment depends on an understanding within government of the new health perspective, and therefore the important role of municipal government in securing health and quality of life for all. Thus, an early activity, in conjunction with HWSC, should be workshops with municipal government staff regarding the importance and potential of municipal government for health.

With regard to assessing needs in the city, "action research," described earlier may be carried out in collaboration with HWSC and the other community structures of the project.

Resources: Members of HWSC, the subcommittees and Community Project Committees; province of Manitoba and Health and Welfare Canada Health Promotions Departments; Faculty of University of Manitoba and University of Winnipeg; IUS; the Health Department of the city of Winnipeg.

Potential Problems, Roadblocks: Lack of commitment because:

- members may not see the achievement of equity as a municipal responsibility, or,
- members may not understand or accept "health" as defined in the new public health, and therefore, may not view municipal government functions as having implications for health or may want to allocate the project to the Health Department only, precluding an intersectoral approach, or,
- members may view a *Healthy* Community project as inappropriate for municipal government, and belonging to the provincial level.

PROJECT EVALUATION

The several purposes of evaluation of the project include to measure the strengths and weaknesses of the Healthy Winnipeg Project, and the progress toward achieving Health For All; to provide a basis for the establishment of new goals, during the project and at its termination, and; to test indicators and process for evaluating in the New Public Health.

Evaluation needs to be carried out at all levels of the project, within municipal government and at the city-wide and community project committee levels. It must be formative, including process evaluation based on tasks undertaken, terms of reference, timeliness and goals, to allow a basis for altering plans as necessary. It must also be summative, at the (five year) termination of the project, based on the "characteristics" defined for projects to be recognized by the Coordinating Office of the Canadian Healthy Communities project and the terms of reference and goals of the various committees. A data base, if one is established for the city and its communities, could prove useful for terminal evaluation.

In *A Guide to Assessing Healthy Cities* (1988), Hancock and Duhl suggest that a complete project evaluation requires the use of a variety of techniques and methods that fall into two complementary groups. The first of these is a picture of the *process* of the project, and Hancock and Duhl suggest a series of questions adapted from a questionnaire presented at the WHO meeting at Dusseldorf in March, 1987. The questions are:

- Who started the process? Who gave key leadership? The Health Department, community committees, city council, etc.?
- How did they start? Meetings with official structure? Surveys or questionnaires to the public? The outgrowth of a "vision" workshop? Community self-study? University projects?

- The city's vision: does your city have a vision of a healthy city? What are the elements of it? Who shares it and how was it arrived at? Has it guided the Healthy city process? Is the vision reflected in the planning of the project?
- Who are the people and organizations involved? Do they represent all the strata of the city--age, gender, economic, political and ethnic status? Are the "non-health" people committed?
- What kind of structure and organization has developed? Is the structure intersectoral? Has it clearly defined roles to deal with all the functions? Does it have formal and informal relationships with other organizations, planning bodies and the private and public sectors?
- Funding and other resources: where do resources come from? Government? Voluntary contributions? Grants? Is there public involvement in funding (e.g., memberships, subscriptions, etc.)? How is "in kind" funding done (e.g., staff secondment, provision of printing, mailing, etc.)? What is its extent and how is it used? Have links been established with the academic community?
- How is communication with the public ensured? Are all the media involved? How? Are all the city's languages used? Are there regular open meetings?
- How is involvement of the public ensured? How do citizens contribute ideas, participate in and evaluate the project? Is it done through organizations, neighbourhood and city-wide groups? Is the project an enabler, a catalyst for more involvement?
- Commitment to action: what other evidence of commitment exists, such as collection of data, participation in the national network?
- Barriers: who are the main critics of the project? What are the major barriers and what strategies were used to push the project forward?

The second element of evaluation outlined by Hancock and Duhl is that of assessing what is happening in each of nine project components (described in detail in *A Guide to Assessing Healthy Cities* (1988). The components are:

- Values;
- An ecological systems approach;
- Personal control over health;
- Inequalities in health and its prerequisites;
- Healthy public policy for urban areas;

- Environments supportive of health;
- Strengthening community action;
- Developing personal skills;
- Reorienting health and other urban services.

Five questions are posed by which each of the elements may be examined:

- What is your impression of *what has worked well* in this component and to what extent is this unique to the city or generalizable to other cities?
- What is your impression of *what has not worked well* in this component, and again, is this unique to the city or is it generalizable?
- Are there *particular problems* in this component that seem to need attention?
- Does the city *have indicators to measure change in this area,* if so what are they and do they use a mixture of both health and non-health measures, process and outcome measures, etc.?
- What is your assessment of the *level of commitment* to action in this component? As a general guide to *assessing the level of commitment,* we suggest you use the following scale:
  - Aware, there is evidence of actual change;
  - Aware, programmes and projects are under way;
  - Aware, policies and planning are in place or under way;
  - Aware, lip service only;
  - Aware, no action being taken;
  - Unaware of the issue, no action being taken (Hancock and Duhl, 1988).

Additional questions suggested by the authors include:

- How does the city see things?
- What has the media response been?
- Are there observers in the community you can involve in the analysis?
- Are there additional resources and skills not now being utilized?
- What are the levels and basis of consensus and dissent about the project?
- Are there lessons learnt that may be useful for others?

Finally, Hancock and Duhl suggest general background material that should be included in the analysis to put the assessment into context. The necessary information includes Geography (Topography, Climate, Natural Resources, Biological Ecosystem, Urban Form or Structure), History, Demography, Political

Structure (Jurisdiction, Governance), Economy, Social Issues, Religion and the Churches, and a "Sense of the City," what it is renowned for, etc.

The evaluation report resulting from the framework should, according to the authors, produce an assessment of what is going on, what is working in the project and what is not, where there may be opportunities or problems and what can be learned.

In March, 1987, a meeting of WHO addressed problems related to Healthy City evaluation. Consensus was reached that indicators are needed for assessing the health status of the city, to monitor progress, to demonstrate results and to enable comparisons between cities (Hancock, 1987). According to Hancock, the main interest of the cities has been in monitoring their own progress internally and making small area comparisons. The conference agreed on criteria for indicators: that they be relatively simple to collect and use, be sensitive to short term change, be capable of analysis at the small area level, be related to health, HFA, health promotion and the Healthy City Project, that they be available now and at reasonable cost and that they carry "social and political punch" (Hancock and Duhl, 1988). A working group was set up to prepare a list for discussion at the June 1989, symposium "Research for Healthy Cities." The conference may uncover indicators which meet the criteria and can be used in Winnipeg.

While the framework above is expected to be useful for evaluation of a Healthy Winnipeg project, some elements, for instance the "inequalities of health and its prerequisites," would be strengthened by a comprehensive data base of the city and its communities. Carried out early in the project, the information would provide a basis for evaluating progress at varying stages, including termination of the project. The following section will discuss establishing a data base in Winnipeg, and suggest indicators.

A DATA BASE FOR A HEALTHY WINNIPEG PROJECT

Many studies have established the general connection between social conditions and measures of health; perhaps the best known is the "Black Report," which related social class to patterns of mortality and morbidity in Britain (Townsend and Davidson, 1982). According to Thunhurst, the report " . . . reawakened the call for a newly invigorated public health movement" (1985, p. 25), and called for municipal governments to review their social, economic and environmental policies and services for their consequences on health. As discussed in Appendix A (Sheffield), local studies were undertaken as part of that review.

Speaking of methodological problems in measuring health/ill health and social circumstances, Thunhurst maintained that indicators such as mortality and morbidity (health indicators) and occupation and housing status (social indicators) are easily measurable but conceptually inadequate for the new public health; on the other hand, measures of health and social circumstances that might be conceptually satisfactory were at present unobservable or difficult to measure (1985). His small area study of Sheffield (1985) used social condition (proportion of lone parents with dependent children in an area, proportion of heads of household in semi-skilled or unskilled work, proportion of houses lacking a bath or toilet). He demonstrated that these social variables accounted for 80 percent of the variation in early mortality rates in Sheffield (1985) As mentioned earlier, a similar connection between mortality and social condition has been concluded for Canada, for example, when Epp reported that lower socio-economic status (SES) men in Canada have a life expectancy seven years lower than upper SES men (1986).

Some important indicators for Healthy Community projects do not lend themselves to small area analysis, but are city-wide; indicators such as traffic statistics, the existence of project-related municipal policies, and so forth. Others are useful for assessing differences between communities and for locating particular events or local initiatives. In few cases have Canadian Healthy Communities projects undertaken small area analysis, in spite of the advantages for determining areas of intervention and for goal setting and evaluation. Part of the reason is the difficulty of obtaining indicators reflective of the new public health. Also, where social and health indicators have been identified, related data may not be available, current, or, reflecting the spatially disparate boundaries and jurisdictions of agencies in the city, they may not be aggregated at comparable "within city" levels.

Analysis of health status and social characteristics within a city requires a common unit for the data, one that has utility from the standpoint of project planning, implementation and evaluation. The unit should be consistent with those already used in the city, so that a health dimension may be added meaningfully to whatever factors are currently considered by municipal government in planning, decision making and evaluation.

Within Winnipeg, if a decision is made to proceed with small area analysis, the level of aggregation that holds the most promise is the city's "neighbourhood characterization areas," 228 divisions in Winnipeg defined in 1984 by the Winnipeg Environment Department, on the basis of land use, transportation routes, etc. The city uses the units, and a city-wide atlas has been developed on that basis for use in public information, research, etc. Social data at that level are recent, deriving from the 1986 Canadian census; most of the social data in the Winnipeg overview of Appendix B are available at the characterization area level, in the case of Appendix B, aggregated by Winnipeg's six communities. It should be noted that a finer level of aggregation, such as the characterization areas, may have revealed greater socio-economic status and other differences based on location in Winnipeg. Moreover, the characterization areas were designed to reflect neighbourhoods and therefore are a unit around which community participation can be facilitated. Potential problems with the choice include that the divisions may be too small for some analysis, there being 228 in the city, and that "translation" to characterization areas of some existing data, notably for health, may be complex, time consuming and expensive.

Following the WHO Barcelona conference on indicators, Hancock devised a list of core indicators potentially useful for Healthy Communities projects, primarily for "within city" analysis. He included a "... variety of indicators, holistic and analytic; subjective and objective; total population and target group; determinants, action and outcome; personal, community and political; old and new--so as to give a broad overall impression" (p. 1). As Hancock stated (p. 2), the perceptual/subjective indicators assume a survey will be conducted by the cities to collect the data. The tentative list is included as Table 1 (pp. 38-43 below), with "level desired," "level available" and "source" of each variable for Winnipeg. Notes explaining each indicator follow, with a list of what it is each one "indicates." There may be other city-wide and area-specific indicators which may be useful for the project; a list of these follows as Table 2 (pp. 44-47), with the level of data desired, availability, and source.

CONCLUSION

The WHO's challenge for Health for All by the Year 2000 has stimulated varied responses from the developed world WHO Europe's *Targets For Health For All* sets the stage for specific goals which were later translated to the city level in the U.K. and other European countries, and which became an integral part of their Healthy City projects. Canada's response did not include targets, but instead led to *Achieving Health for All: A Framework for Health Promotion*, and a revitalization of Canadian public health. The Canadian Healthy Communities project is also part of that response, and it offers a way of making real the concepts of the *Framework*. It is an opportunity for municipal governments to adopt a Health for All perspective, and at the same time it provides a way for increased public participation in planning, implementing and evaluating programs and projects affecting community health. The "Winnipeg Model" is offered as a tool by which that can happen without major changes to the city's existing mechanisms for making decisions.

TABLE 1 HEALTHY CITY INDICATORS
WITH DESIRED LEVEL OF AGGREGATION AND AVAILABILITY OF INFORMATION*

	Indicator	Level Desired	Level Available For Winnipeg	Source of Data
1.	% of homeless families.	c**, comm, ch.ar.	c+	Social Planning Council (SPC) 1986; Bairstow & Assoc. "Reaching Out for Help: Manitoba's Homeless in 1987", (Man. Dept. of Housing).
2.	% of substandard dwellings.	c, comm, ch.ar.	c+	CMHC Survey of Housing Units (1974).
3.	% of unemployment.	c, comm, ch.ar.	c+, comm+, ch.ar.+ census tract	SPC, Institute of Urban Studies (IUS) Statistics Canada.
4.	% of poverty.	c, comm, ch.ar.	as above	As above.
5.	# days/year NO_x/SO_2 levels exceed WHO guidelines	c	c+	Continuous monitoring by National Air Pollution Surveillance (W'peg. Env. Pl. Dept.).
6.	Annoyance index (Max = 15) (noise, cleanliness, no offensive smells).	c, comm, ch.ar.	not avail. now	Survey needed.
7.	% of seniors within 10 mins. walk of park/public open space	as above	as above	As above.
8.	% of people reporting "great difficulty" in physical accessibility to local food shopping.	as above	as above	As above.
9.	% of people reporting "often" or "always" lonely.	as above	as above	As above.
10.	Violent crime rate per 1,000 people.	c	c by (6) police districts	Winnipeg Policy Department, Chief of Police.
11.	% of people who work reporting "fairly" or "very" satisfied with their work.	c	not avail.	Survey needed.
12.	% of people who report they have "fairly great" or "very great" control over the conditions that influence their health and the health of their family (if they have one).	c	as above	As above.
13.	% of people who are daily cigarette smokers.	c	c	Canada Health Survey (1978) Statistics Canada Designed to give regional or provincial estimates over time - data available at best at W'peg level, question & sample permitting (or local survey needed).
14.	% of people who report "fairly high" or "very high" level of self esteem.	c, comm, ch.ar.	not avail. now	Survey needed.
15.	% of traffic accidents involving alcohol.	c	c	Winnipeg Police Department.
16.	% of people who report active self-care activity.	c, comm, ch.ar.	c	"Recent measure to improve health" Health Promotion Survey (HPS) 1986. Data available at best at W'peg level, question & sample permitting (or survey needed).
17.	% of locations where smoking is banned/controlled (max = 5).	c	not avail. now	Survey needed.
18.	Existence of an Interdepartmental Health Community Strategy group.	c	---	-----
19.	Mayor and/or Council have made public commitment to a Health Community strategy or project.	c	---	-----
20.	% of domestic waste recycled.	c	not avail. now	-----
21.	% of people reporting involvement in a health, social justice or environmental group activity.	c	not avail. now	Survey needed.
22.	% of people reporting "fairly good" or "very good" health.	c, comm, ch.ar.	c	HPS as above (or survey needed).

	Indicator	Level Desired	Level Available For Winnipeg	Source of Data
23.	Days of reported restricted activity (unable to do usual work or daily life activities) per person per year.	c, comm, ch.ar.	c	"Number & percentage of persons with at least one limitation in the activities of daily living" Health/ Activity Limitation Survey, Statistics Canada.
24.	% of babies born weighing less than 2,500 gms.	c, comm	postal code prefix within Winnipeg	Manitoba Bureau of Statistics, birth registrations.
25.	% of 7 year olds fully immunized with Diphtheria, Tetanus, Polio.	c, comm	c, postal code prefix, 15 geog areas after Apr. 1, avail. after April 1, 1990	Manitoba Immunization Monitoring System, MHSC as above.
26.	Rate of Salmonella infections reported per 1,000 people per year.	c	c	Manitoba Dept. of Health, Provincial Epidemiologist.
27.	Age standardized mortality rate for cardiovascular disease.	c, comm, ch.ar.	c, postal code prefix (15 geog. areas avail. after April 1, 1990)	MHSC as above.
28.	% of people reporting they feel safe walking at night in their neighbourhood.	c, comm, ch.ar.	not avail. now	Survey needed.
29.	% of people reporting the city is a "fairly good" or "very good" place to live.	c, comm, ch.ar.	not avail. now	As above.
30.	City Council policy on accessibility for the physically disabled.	c	---	-----
31.	% reporting they daily experience anxiety, depression, sadness or extreme tiredness.	c, comm, ch.ar.	c	"% of the population with frequent anxiety or depression", CHS as above (or survey needed).
32.	Potential years of life lost (after age 1, before age 70) per 1,000 residents (standardized).	c, comm, ch.ar.	c, postal code prefix, (15 geog. areas after April 1, 1990)	MHSC as above.
33.	Traffic accident mortality rate (standardized).	c	as above	MHSC as above.

RATING SCALE: 1 = very bad, very difficult, never, very little, very low.
5 = very good, very easy, always, very great, very high.

* Based on Hancock, T., Health City Indicators, March 26 letter to colleagues following Barcelona Conference on Indicators.
** c = city, comm = community committee area (6), ch.ar. = characterization area (228).
\+ Available immediately.

Explanatory Notes for Indicators

1. Homelessness: Housing is a basic prerequisite for health and indicates political commitment to HFA. Very important in the International Year of Shelter for the Homeless. How is this figure calculated in your city?

2. Substandard dwellings: Housing must not only be available, but also health enhancing. Most cities have housing standards. What are they in your city? How is "substandard" defined?

3. Unemployment: Work, and a meaningful role in society, are also basic prerequisites for health. How is this figure calculated? How accurate is it?

4. Poverty: Adequate income is another prerequisite for health. What percentage of people in your city live in poverty? How is that defined? What is the "poverty line" for a family of 2 adults, 2 children?

5. NOxSO2: WHO guidelines form a convenient standard. How are your levels measured?

6. Annoyance index: Rating of level of satisfaction with cleanliness, quiet and absence of offensive smells. Score on a scale of 1 to 5, so that if there is a high level of satisfaction on all three, maximum score is 15; low level of satisfaction, 3. Take average of all responses in group. Can also disaggregate by individual issue, e.g., noise.

7. Proximity to parks/open space: Tries to get at proximity for a relatively less mobile sector of the population. If it is accessible to them, it likely is for all. Not all park/open space is green, but it is open air and a social/recreational activity.

8. Accessibility to shopping: The main interest here is seniors and the disabled. If you have a good index of accessibility for the disabled, let us know! The indicator also shows how generally accessible local services are.

9. Loneliness/support: Loneliness is the consequence of lack of social contact, social support.

10. Violent crime: How is this calculated? What is included in your city under this heading?

11. Work satisfaction: This is not an ideal indicator of quality of work life, but it is important in mental health. It is not enough simply to have work if it is miserable and upsetting.

12. Control over health: This is not a simple issue. (Anatovski's notion of "coherence may fit here, but it is an index based on 27 or so questions. We want to get at enablement and empowerment).

13. Daily smoking: Since this is WHO's No. 1 preventable health problem in the industrialized world, we need to know. Are some subgroups (e.g., 20-34 year old women) more useful?

14. Self-esteem: An important measure of mental well-being.

15. Drinking and driving: Reflects a combination of community acceptance, personal behaviour and public policy for control. How is it measured in your community? How accurately?

16. Self-care: An important component of personal skills and re-oriented health services. But what is the indicator we can use here?

17. Smoking control policy: Do policies exist to control smoking in the following locations (1 point/location): Public places? Restaurants? Public transport? Schools? Workplaces? An important indicator of community and political awareness and commitment.

18 and 19. Political commitment: Is it there, yes or no?

20. Waste recycling: An indication of political commitment to resource and energy conservation and sustainability.

21. Participation in health: Speaks for itself.

22. Perceived health: One of the best indications of health status, a deceptively simple question.

23. Restricted activity: An indicator of general morbidity. How is this measured/interpreted in your city?

24. Low birth weight: Perhaps more sensitive these days than infant mortality weight.

25. Immunization: Indication of political and health system commitment to public health. What is considered "fully immunized" in your city? What is the appropriate age? Should we include pertussis? How about measles, mumps, rubella?

26. Salmonella infection: An indicator of overall food hygiene. How is it reported in your city? How accurate is it? Is the under-reporting at least consistent and systematic?

27. Cardio-vascular disease mortality: The big killer--but who is it killing? And how does your city compare? (Standardize using the same population as Who Europe or Statistics Canada).

28. Feeling safe: Important in mental well-being, and an interesting comparison with item 10.

29. Overall perception: Analogous to the perception of personal health. If people can assess their own health accurately, they can probably assess their city's health too.

30. Policy for disabled: To what extent are the special needs of the physically disabled formally recognized? How does this tally with item 8?

31. Anxiety and depression: Indicators of mental health and well-being.

32. Potential years of life lost: Indicator of the overall prevention status of the city, which takes into account all the actions for prevention. Should be standardized to the same population as WHO Europe or Statistics Canada.

33. Traffic accident mortality: This is affected by a variety of personal, community and policy actions related to road design, public transit, drinking and driving, etc. Use the IDC-9 codes for motor vehicle accidents and standardize to WHO Europe or Statistics Canada.

What is Indicated by the Various Health City Indicators

Indicated	By Indicator . . .
Healthy Public Policy	1, 2, 3, 4, 5, 6, 7, 8, 11, 16, 18, 19, 20, 21, 30
Environments for Health	2, 5, 6, 7, 8, 10, 20
Strengthening Communities	9, 12, 17, 21
Personal Skills	13, 14, 16, 21
Re-orienting Health Services	16, 24, 25
Objective Indicators (18)	1, 2, 3, 4, 5, 10, 15, 17, 18, 19, 20, 24, 25, 26, 27, 30, 32, 33
Survey/Subjective Indicators (15)	6, 7, 8, 9, 11, 12, 13, 14, 16, 21, 22, 23, 28, 29, 31
Mental Health	9, 11, 12, 14, 21, 22, 29, 31
Outcome/Health Status	13, 22, 23, 24, 25, 26, 27, 31, 32, 33

Source: Hancock, 1987.

TABLE 2 OTHER POTENTIAL HEALTHY WINNIPEG INDICATORS
WITH DESIRED LEVEL OF AGGREGATION AND AVAILABILITY OF INFORMATION*

	Indicator	Level Desired	Level Available For Winnipeg	Source of Data
A.	PHYSICAL ENVIRONMENT:			
1.	Biosphere/City Ecosystem			
	Air Pollution/Atmosphere (add "dust" to pollutants listed by Hancock,above).	c**	c+	Winnipeg Environmental Planning Department.
	Water Quality	c	c+	Winnipeg Waterworks (systematic samples from Shoal Lake pipeline; also "grab" samples in Winnipeg).
	Water Waste Management	c	c+	Winnipeg Waterworks Waste Disposal Dept. (Winnipeg rivers sampled daily at 76 locations for micro-organisms over 1/100 mls).
2.	Immediate Physical Environment			
	Radon Gas (level in soil, homes)	c	not avail. now	Survey needed.
B.	HUMAN MADE ENVIRONMENT:			
3.	Recreation Opportunities			
	Recreation facilities	c, comm, ch.ar.	c, comm	Winnipeg Parks and Recreation (cost, availability & accessibility of facilities, proximity to open space).
	Playgrounds	as above	as above	As above.
4.	Transportation			
	Modal split (car, bus, etc), trip time by mode of travel	c, comm	36 "traffic zones" derived from old ward boundaries	Winnipeg Trans. Dept. Research & Devel. Branch, (Travel and Demographic Trends).
5.	Built Environment			
	Highrises.	c, comm		Winnipeg Environmental Planning.
	Local shop access.	c, comm, ch.ar.		As above.
	Home related illness and accidents.	c, comm, ch.ar.	c, by postal code prefix. Since Apr. 1 by geog. areas in Winnipeg (avail. April 1, 1990)	Manitoba Health Services Commission (MHSC).
C.	PSYCHOSOCIAL ENVIRONMENT:			
6.	Civic Pride			
7.	Caring & Sharing Community			
	Use of institutional supports (daycare for children and for elderly, VON, "Meals on Wheels", etc.).	c, comm	c	Utilization information from Agency annual reports.
	Living alone.	c, comm, ch.ar.	c+, comm+, ch.ar.+	Institute of Urban Studies (IUS), Social Planning Council (SPC).

	Indicator	Level Desired	census tract Level Available For Winnipeg	Statistics Canada. Source of Data
	Single parent household.	c, comm, ch.ar.	c^+, $comm^+$, $ch.ar.^+$ census tract	IUS, SPC. Statistics Canada.
8.	Safe & Peaceful Environment			
	Reported crimes of property.	c, comm	c, by (6) police districts	Winnipeg Police Department, Chief of Police.
	Child abuse.	c, comm	as above	As above; also from Child Abuse Unit.
9.	Work as a Source of Health			
	Job related illness or accidents.	c	Manitoba level	Workers' Compensation Board.
10.	Learning Opportunities			
	Education services available, including continuing ed., specialty services available.	c	c	Winnipeg, Manitoba Departments of Education.
	Level of education, population over 15 years.	c, comm, ch.ar.	c^+, $comm^+$, $ch.ar.^+$	IUS, SPC.
	Level of education, by ethnicity.	c, comm, ch.ar.	as above	As above.
	Cultural facilities (library, museums, planetarium, etc.)	c, comm	c	Utilization information from annual reports of facility.
11.	Support of Health Lifestyles			
	Motor vehicle accidents.	c	c^+, street location of accident$^+$	Winnipeg Policy Department (Traffic).
	Smoking in the workplace.	c	not avail. now	Survey needed.
	Smoking during pregnancy.	c	not avail. now	
	Alcohol use.	c	c, 6 research areas in Wpg.	Alcohol Commission of Manitoba (dist'n of pop by age, sex, type of drinker).
	Alcohol use during pregnancy.	c	not avail. now	Data needed.
	Prescription drug use.	c	c	Canada Health Survey (CHS, 1978), Statistics Canada. Designed to give regional & provincial estimates over time - data available at best at Winnipeg level, question and sample permitting (or local survey needed). Health Promotion Survey (HPS, 1987). Data available at best for Winnipeg level, question & sample permitting (or local survey needed).
	Over the counter drug use.	c	c	CHS, HPS as above.
	Illicit drug use.	c	c	As above.
	% of women having regular pap smears.	c, comm	c	As above.
	% of women having regular breast examinations.	c, comm	c	As above.
	% of persons regularly wearing seatbelts.	c	c	CHS, HPS as above.
12.	Wellness Oriented Health Care System			
	Live births by wt., gestation, maternal age.	c, comm	c, by postal code prefix, since Apr.1 by 15 geog. areas in W'peg (avail. April 1, 1990)	MHSC as above.
	Prenatal education for primiparas	c, comm		
	Budget, public health department.	c		Winnipeg Health Dept. (annual report).
	% of people reporting daily use of tranquilizers.	c, comm	c	HPS as above.

	Indicator	Level Desired	Level Available For Winnipeg	Source of Data
13.	Community Support Services			
	Disabled employed	c, comm	c	Society of Manitobans with Disabilities.
	Disabled living independently.	c, comm	c	As above.
	Seniors in institutions	c	c	Canada Census (1981).
	Psych patients deinstitutionalized, living in community.	c, comm	c	Association for Community Living.
	Psych patients in institutions.	c	c, by postal code prefix, since Apr. 1 by 15 geog. areas of W'peg. (avail. after April 1, 1990)	MHSC as above.
	Prenatal classes for primiparas.	c, comm	by street address (not avail. now)	Winnipeg Health Department; Manitoba Health; Lamaze course attendance records.
	Health care resources (range and utilization).	c, comm	c	MHSC as above.
D.	ECONOMIC ENVIRONMENT:			
14.	Housing			
	Housing: type of housing, owner occupied dwellings, tenant occupied dwellings, structural type.	c, comm, ch.ar.	c^+, $comm^+$, $ch.ar.^+$ census tract	IUS, SPC. Statistics Canada.
	Proportion of owners: renters.	as above	as above$^+$	As above.
	Percentage of households making housing payments of 25% or more of household income (owners and renters).	as above	as above$^+$	As above.
	Persons per household.	as above	as above$^+$	As above.
15.	Basic Needs			
	Income, income by ethnicity, income by education.	c, comm, ch.ar.	as above$^+$	As above.
	% of functionally illiterate in Winnipeg	c, comm	c, comm	Statistics Canada, 1981 Census, self reported education level (based on UNESCO's definition of functional illiteracy at less than Gr. 9 education).
	Employment status by age, ethnicity.	c, comm	c, comm, ch.ar.	IUS, SPC.
16.	Health Foods			
	Nutritional status (malnutrition as adm. diagnosis for hospital)	c, comm	c, by postal code prefix, since April 1, 1989 by 15 geog. areas in W'peg. (avail. after Apr.1, 1990)	MHSC as above.
	Breast feeding of infants, by duration	c, comm	not avail. now	Initial record available from hospital records, survey needed for later data.
	% of population regularly consuming milk, whole grains	c, comm	c	Canada Fitness Survey (CFS, 1981). Data available at best at Winnipeg level, question & sample permitting.
	% of population limiting salt, fat from diet.	c, comm	c	As above.

Indicator	Level Desired	Level Available For Winnipeg	Source of Data
E. "HEALTH" STATUS			
Hospital admissions	c, comm	c, by postal code prefix, since Apr.1 1989 by 15 geog. areas in W'peg (avail. after Apr.1, 1990)	MHSC as above.
problems, by age, sex.	c, comm	as above	Morbidity, hospital admissions for specific health As above.
Dental health (decayed, missing, filled teeth for selected ages).	c, comm	City of Winnipeg by schools in Sch. Dis. #1.	Winnipeg Health Department 1978, all Winnipeg school children (K-6).
		Schools outside Sch. Dis. #1.	Manitoba Health.
Cause of death, by age.	c, comm	postal code prefix within Winnipeg	Manitoba Bureau of Statistics, death registrations.

* Generally following the categories defined by City of Toronto Health Department, 1988.
** c = city, comm = community committee area (6), ch.ar. = characterization area (228).
\+ Available immediately.

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APPENDIX A

HEALTHY CITIES IN THE U.K.: IMPLICATIONS FOR CANADIAN HEALTHY COMMUNITIES PROJECTS

INTRODUCTION: HEALTH FOR ALL AND THE HEALTHY CITIES PROJECT

The most significant influences leading to the World Health Organization (WHO) Healthy Cities Project were associated with earlier initiatives of WHO. First, WHO had defined health to mean more than "freedom from disease," and including " . . . complete physical, mental and social well-being" (WHO Constitution, 1946, p.1), thus paving the way for health to be conceived as a resource, or as wellness, "the capacity of individuals to carry out socially defined roles" (Baranowski, 1981, p. 251). Then the 1977 adoption of Health For All by the Year 2000 as the main goal of WHO and its national governments, and the 1984 agreement by WHO Europe and its member states on 38 regional targets as steps toward HFA (WHO, 1984a, 1984b), made the principles, strategies and targets of HFA an inspiration for people in health promotion.

In 1986, WHO co-sponsored the first International Conference on Health Promotion. That meeting produced the *Ottawa Charter For Health Promotion*, which defined health as " . . . a social, personal and physical resource for life," and health promotion as " . . . the process of enabling people to gain control over and improve their health" (p. 2). Toward the goal of health promotion, participants pledged themselves " . . . to reorient health services and their resources toward the promotion of health, and to share power with other sectors, other disciplines and the people themselves" (p. 4). Canada's *Achieving Health For All: A Framework for Health Promotion*, released in the same year, was consistent with the approach; it set out three challenges for Achieving Health For All (Reducing Inequities, Increasing Prevention and Enhancing Coping), three health promotion mechanisms (Self Care, Mutual Aid, and Healthy Environments), and three implementation strategies (Fostering Public Participation, Strengthening Community Health Services and Co-ordinating Healthy Public Policies). The report highlighted inter-sectoral collaboration for health, on the rationale that the factors having an impact on health lie outside the domain of health departments; and also public participation, because the "new" public health implies that people themselves are most knowledgeable about what they need for full and healthy lives. Although *The Framework* did not outline how the processes for "Achieving Health For All" would occur, it and the other events above paved the way for the Healthy Cities/Healthy Communities Project, which would produce such an outline, with a focus on municipal government.

In the past, municipal governments have played an important role in health; programs such as water and waste treatment, housing, slum clearance, etc. have changed the nature of medical problems, so that in the developed world, circulatory and respiratory disease, cancer and accidents have become the major causes of death. Accordingly, public health concern now includes the effects of chronic illness and disability, stress, and services that enable people to cope. As in the past, however, municipal

government has a pivotal role, albeit with a new focus, including collaboration among the various sectors and public participation. The Healthy Cities/Healthy Communities Program offers a way for municipal governments and communities to use these elements for physical and social environments that promote the health of all citizens.

The idea originated at the 1984 "Beyond Health Care" conference in Toronto, from which beginning it was developed as a joint program of the Health Promotion and Environmental Health Policy Programs of WHO Europe, and, in 1985, launched as a five year project of WHO. Focusing generally on equity in health, the thrust of the project is twofold: it highlights the role of municipalities in health, including calling for an inter-sectoral strategy for developing policies, services and projects that are consistent with the new conception of health, and therefore involving departments not traditionally concerned with health, and; it fosters the development of special health promotion initiatives often aimed at geographical or cultural communities within the city. Both aspects imply public participation, the involvement of individuals in decisions that affect community health.

A "Healthy City" has been defined as " . . . one continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential" (Hancock and Duhl, 1986, p. 14). Measures of a healthy city " . . . span from the traditional measures of the quality of the physical environment through measures of mortality and morbidity and the quality of treatment to measures of culture, participation, inter-sectoral collaboration and levels of mutual support" (Ashton, 1988a, p.16). Ashton outlined five major elements as steps toward a Healthy City. They were: the formulation of concepts leading to action-based Healthy City plans; the development of "models of good practice" (special health promotion initiatives emphasizing reducing inequalities); monitoring and research into the effectiveness of models of good practice; dissemination of ideas and experience between collaborating cities and other interested cities; and mutual support, collaboration and learning between the cities of Europe. Among other initiatives, the following are being encouraged: a high level inter-sectoral group (to take a strategic overview of health in the city and to establish effective, cross-sectoral working for health); a parallel technical group (to carry out analysis, produce reports and recommend cross-sectoral interventions for health); a community diagnosis for the city (to identify health inequalities at the ward and neighbourhood level; and development of close working relationships with the media, libraries, art galleries, etc., and exploring ways in which health advocacy can be developed in the city (1988a, p. 20).

The project continues to grow: there now exist ten or twelve national networks and some hundreds of participating towns and cities, not just in Europe but in Canada, Australia and the U.S.A. (Hancock, personal communication, June 4, 1989).

In Canada, the project was initially sponsored by the Canadian Institute of Planners (CIP) and the Canadian Public Health Association (CPHA), joined in 1987 by the Federation of Canadian Municipalities; at that time, the name of the Canadian project was changed to "The Canadian Healthy Communities Project" (CHC) to reflect and invite participation of all communities, regardless of size. Funded by a grant from Health and Welfare Canada, the project has set up a co-ordinating office, located at the offices of CIP in Ottawa, hired Susan Berlin as project co-ordinator and established a steering committee to guide the national project. CHC has been described as:

> . . . municipality focused; it advocates changes in decision-making among municipal leaders, planners and policy makers, with the aim of increasing community participation in municipal goal setting, fostering recognition of the health impact of the decisions of all departments and establishing processes for joint interdepartmental and community problem solving concerning otherwise intractable issues (e.g., family violence, unhealthy environments, the situation of seniors) (CHC, Fax, Jan. 11, 1989).

Health For All had laid the basis for both the Canadian and European initiatives. Just as the project in Europe, especially in the U.K., was welcomed as a vehicle for meeting the targets of HFA/2000, in Canada it was a way to make operational the concepts of *Achieving Health For All.*

THE HEALTHY CITY PROJECT IN THE U.K.

In the U.K., reorganization of health care in 1974 had abolished local boards of health, so that, except for departments of Environmental Health, responsibility for Community Health and most of the responsibility for Health Promotion now fall within the purview of the Central Government. The Healthy City Project has afforded an opportunity for a health promotion focus within local Environmental Health departments and, at least in some cases, a basis for collaboration between those departments and the local and regional Health Authorities and Health Education Authorities, both units of the Central Government.

Other influences have paved the way for the Healthy Cities projects in the U.K. Perhaps most significant, at least for cities in the north, was the "Black Report," a working party study commissioned by the Labour government in 1977 to review differences in health status among the social classes, identify possible causes and draw implications for policy and research (Dept. of Health and Social Security, 1980; Whitehead, 1987). The Black Report concluded that "material deprivation" played a major role in explaining the unfavourable health record of the poor, with biological, cultural and lifestyle factors contributing. The fact that the first of the European targets for HFA/2000 in 1984 dealt with equity in health added

urgency to the discussions generated by the report, in areas of housing, lifestyle, education, regional disparities and so on (Dooris, 1987).

Groups developed an interest, many of them having been inspired by "Health For All." One of these was the newly formed British Public Health Association; others included professional bodies such as the Society of Health Education Officers and the Health Visitors' Association; trades unions, including the National Union of Public Employees; and voluntary groups, some concerned specifically with the future of the National Health Service and others arising from growing consumer concern in areas such as women's health issues, race, and the environment (Ashton, 1988a).

By June, 1987, approximately 50 cities in the U.K. were participating, some of them communicating with the Regional Co-ordinating Centre at WHO Europe Office or with each other informally through the newly formed, loosely knit U.K. Healthy Cities Network, or a bimonthly Healthy Cities newsletter published out of Liverpool, or in April, 1988, at the First United Kingdom Healthy Cities Conference, held in Liverpool. WHO had designated Liverpool and Bloomsbury/Camden as "project cities," to be joined in 1988 by Glasgow and Belfast. However, relatively few cities in the U.K. have aligned themselves with WHO, preferring to declare their own projects without waiting for results from demonstration projects (G.Green, personal communication, Aug. 10, 1988).

As in Canada, there are no identical local projects; they vary according to the skills, interests and biases of the leaders, availability of funding, needs perceived in the community and so on. Some generalizations may be made, however, on the basis of political factors, with the vast majority of participating U.K. cities having Labour controlled councils (T. Hancock, personal communication, June 4, 1989), and regional conditions, with projects in cities of the North likely to reflect a serious economic downturn. Most projects are more or less consistent with the WHO steps referred to earlier. Not all have produced a community diagnosis for the city, although some have done so, creating their own local "Black Reports" to guide policies and decisions. Also, many have used the WHO Europe regional targets, adapting them as necessary to fit local needs.

The context of the Healthy City Project differs from its counterpart in Canada primarily by the absence of an intermediate level of government, which in Canada holds responsibility for matters related to health, and by the fact there are no "public health departments" attached to city governments, as there are in many cities of Canada. The projects in Canada and the U.K. have much in common, however, stemming from their common roots in Health For All and their focus on equity. The U.K. projects are generally more advanced, and Canadian ones, some of them still being conceptualized, may gain from the British experience.

In the summer of 1988, as part of a sabbatical study, the Healthy Cities Projects of Liverpool, Sheffield and Oxford were visited, chosen for their various involvements with Health Cities. In the next section, an overview relating economic conditions to the projects will be given, following which the projects are discussed according to: origins at the municipal level; involvement of the non-health sector; membership and initiatives of the committees; public participation; funding and human resources for implementation, and; evaluation. Implications will be drawn for Canadian Healthy Communities projects.

THE U.K. PROJECTS AND THEIR IMPLICATIONS FOR CANADIAN HEALTHY COMMUNITIES

THE SETTINGS

Liverpool was once a major port in the U.K., but in the twentieth century has experienced population and economic decline in direct relation to the growth of southern, more central, ports. Central government grants to refurbish the waterfront area to accommodate a developing tourist industry have recently improved the city core and provided some assistance for unemployment levels that still rank among the nation's highest (Hayes, 1987). The onset of Sheffield's economic misfortunes has been more recent, within the last 15 years; Sheffield's problems stem from a single industry based economy and the recent availability of cheaper steel from the far east (Sheffield Environmental Health Dept., 1985). An innovative city council has been active in recruiting small businesses and is seeking assistance from Central government. The third city, Oxford, has experienced many layoffs in its automobile industry related to the Rolls Royce decision to use Land Rover parts manufactured in other centres for its Oxford plants. However, the Oxford economy is more buoyant than those of either of the other cities, sustained by a strong tourist industry and the 35 thriving colleges that comprise Oxford University.

Consistent with the above, according to the 1981 census, the percentage of people in the 25-44 year age group in Liverpool and Sheffield is slightly low, at 23.7 percent and 24.3 percent, respectively, compared with 25.9 percent for Oxford and 26.3 for the U.K. generally (Office of Population Census and Surveys, 1981). The figures support a contention that people of that cohort may be leaving those cities for places with better promise of work (Hayes, 1987). There may be a similar phenomenon in Oxford, "masked" by the numbers of students in that city. When the economic/occupation structure of the cities' populations and of the U.K. is examined, all three cities are seen to be over-represented in the "economically inactive" category, Liverpool at 28.4 percent, and Sheffield and Oxford at 25.3 and 25.5 percent respectively, compared with the U.K., at 22.7 percent (Office of Population Census and Surveys, 1981). The same source reveals that Liverpool and Sheffield are under-represented in the better paying occupational categories, at 2.1 and 3.4 percent respectively in the "Professional" category, compared with 7.2 percent for Oxford, and 4.5 percent for the U.K. generally (1981).

The economic/occupation picture is reflected in the education distribution: according to the 1981 census, in Liverpool, only 8.9 percent of males and 10.6 percent of females had education beyond "O level" (Grade 11), and in Sheffield, only 12.5 and 11.6 percent respectively had that education, compared with the U.K. generally, at 13.7 and 12.2 percent, respectively. In Oxford, on the other hand, 20 percent of the males and 23.1 percent of the females had achieved O levels (Office of Population Census and Surveys, 1981).

The pictures translate into differences in the three cities' Healthy City projects. Liverpool and Sheffield have built on the community data bases established for their cities and their most prominent "models of good practice" are aimed at improving the quality of life in economically depressed areas (Flynn, 1988; Sheffield Environmental Health Dept., 1985). In Oxford, a data base was not set up initially, though one is now being established. While one project aim there is to reduce inequalities in health related to race, class, gender or age, and the audit of city policies and programs reflects that fact, the "mini-project" emphasis there is more a general health promotion perspective, aimed at healthy eating, smoking cessation, housing heating improvements, AIDS, pollution, etc., than it is on geographic areas in need (Allen, 1988).

ORIGINS OF THE PROJECTS AT THE MUNICIPAL LEVEL

In all three centres, the projects began through strong leadership by a few individuals in strategic positions in government or academia. For example, John Ashton, of the University of Liverpool, and Howard Seymour and Alex Scott-Samuel, of the Mersey Regional and Liverpool Health Authorities, have been active in the Liverpool Healthy City project, working closely with Peter Flynn, a city planner seconded to the project from the early months. Liverpool city council voted in March 1986 to accept the invitation of the WHO for Liverpool to be a project city (Flynn, 1988). The organizers' first move was to establish an inter-sectoral Healthy Cities Committee, with representation from political, professional and lay communities.

Impetus for the project in Sheffield came from Geoff Green, John Rice and others within the Local Authority, who promoted the project as a vehicle for "Health For All" initiatives; this was important for them partly because local equity studies had revealed serious deficiencies in some areas of the city. Within the Environmental Health Department, city council created a Health and Consumer Affairs Committee, which produced *Good Health for All, The Sheffield Plan* (1987), and in March, 1987, council launched the project and created the Healthy Sheffield Planning Team, chaired by G. Thoms of the Sheffield Health Authority.

Oxford's involvement in HFA/2000 had begun in 1984, when a newly elected city council moved to develop programs in line with HFA/2000. "Healthy Oxford/2000," spearheaded by Peter Allen, Deputy City Environmental Health Officer and others in the Local Authority, was proclaimed by city council and the Oxfordshire Health Authority in November, 1986, and the Healthy City Working Group was set up (Oxford Health Education Authority, 1987). The two national agencies, the Health Authority and Health Education Authority, may be described as having been less central in the Oxford undertaking than have Environmental Health personnel; ironically, in Oxford, the university community has also not been prominent.

The U.K. projects originated locally in a climate of city council support, Health For All and research into poverty and health status having awakened them to the need. In Canada, some projects, such as in Dartmouth, have been initiated through city council; other locations may have to work to convince councils of the appropriateness of Health For All goals at the municipal level of government. One fruitful approach may be to convince councils of the project's potential to fit and expand existing interests, such as the "Winter Cities" approach.

INVOLVEMENT OF THE NON-HEALTH SECTOR

Local Authorities of all three cities, in setting up the Healthy City Committees, invited participation from a range of non-health organizations, such as, in Sheffield, the council for Racial Equality, the council for Voluntary Service, Family and Community Services, the Central Policy Unit of city council, and so on. With regard to willingness to participate, many Canadian projects run a risk that Sheffield and others have been able to avoid because the local Boards of Health there have been abolished, requiring others than health professionals to become involved. In the U.K. cities, which saw the project as a way to regain involvement with health, environment was highlighted because the Environmental Health Department was the only "health" department remaining with the Local Authority. In keeping with the high profile of Environmental Health Departments in the U.K. project is the agenda in the Healthy City projects, such as Oxford's initiatives in housing, home heating and pollution. A Canadian corollary with regard to centralization may be Quebec, where a resulting development of community health networks has fostered the rapid expansion of "Villes et villages en santé" (Lacombe, 1989). Canadian communities with local health departments may have to make a concerted effort to interest non-health professional staff of municipal government in the project, and to establish the connection between the physical environment and health.

Those communities where projects originated from local Health Departments are particularly "at risk" for less than full participation by some, non-health, members. *Achieving Health For All* and the *Ottawa Charter* have paved the way for health professionals to include planners, administrators and others in their perspective; however, convincing non-health professionals to participate will be problematic unless

they realize that their inclusion is valid and essential. Clear discussions about the new public health and about how their roles fit in the perspective are needed. If federal and provincial departments of health are knowledgable and supportive about the projects, municipal politicians and public servants may be less likely to reject the project as not fitting their mandate.

MEMBERSHIP AND INITIATIVES OF COMMITTEES

As suggested above, the Healthy City committees of Liverpool, Sheffield and Oxford have all been constructed with a broad base of representation. Appointees from government agencies are senior staff. This is important because in all three cities, meeting project goals has necessitated studying the health implications of policies in all council departments, and because "borrowing" expertise and work days has required the support of the departments concerned. The committees also all have representation from educational institutions, which facilitates meeting research and education needs and promotes dialogue about health in the city. Sub-committees have been set up to accommodate special issues and the mini-projects, and parallel officer groups to carry out analysis, write reports, etc. The Liverpool and Sheffield projects have hired co-ordinators; by August, 1988, the Oxford committee had no immediate plans to do so, the tasks of the position being carried out by the Healthy City Working Group or by staff in the Environmental Health Department.

As in the U.K., Canadian inter-sectoral committees may function from "within" municipal government, whose interdepartmental decision-making committees of senior personnel include participation by the private and volunteer sectors, the universities, etc. Alternatively, Healthy Communities Committees may function "outside" municipal structure, collaborating with an interdepartmental committee through seating a council or senior public servant on the community committee. In any case, participating public servants must be senior, as in the U.K., to enable them to bring about a review of policies and programs, and to facilitate any necessary moving of money or staff. Health Departments can be useful resources, in particular for interpreting the implications of the new public health. Any community representation on committees must reflect the population of that community.

Regarding project initiatives, by the summer of 1988, the Sheffield and Oxford projects had had Healthy City Strategy statements passed by their city councils, Liverpool and Sheffield had proposed targets, and the Liverpool project had a working committee identifying the environmental and lifestyle changes needed to reach the targets (Flynn, 1988). All committees were studying city policies for their public health implications, and Sheffield and Oxford had also produced several specific policies, on food, smoking, AIDS, and so on. Whatever else Canadian projects include, improving the health potential of the physical and local environments involves the delineation of strategies to get there. A Canadian

example is the *Healthy Toronto 2000: A Strategy for a Healthier City,* produced by the Healthy Toronto 2000 Sub-Committee (1988), and approved by city council in January 1989 (T. Hancock, personal communication, June 4, 1989). Facilitating communication about strategies is an important function of the Coordinating Office of the Canadian Healthy Communities Project.

Whether to establish a local data base for the project was an easy decision for at least two Healthy City committees in the U.K.: both Liverpool and Sheffield had already begun that process when the Healthy Cities Project was launched (Sheffield Environmental Health Dept., 1985; Sheffield Health Authority, 1986; Liverpool City Planning Dept., 1986; Liverpool City Planning Dept., 1988). A community diagnosis is consistent for those centres because the Black Report had paved the way for regional and city studies, and because in Liverpool, the project originated from an academic setting, and in Sheffield from the Central Policy Unit of city council, which wanted a local basis on which to effect change. Even though Oxford did not begin by establishing a data base, it is now doing so.

With regard to a related decision for Canadian projects, neighbourhood level mini-projects are more likely to fit community needs to the extent that solid information exists on which to plan and evaluate initiatives. While such information is not likely to contain as much detail at the ones in Liverpool and Sheffield, some useful data can be obtained from various local, provincial and national government departments, universities, voluntary groups and specific agencies, such as, in Winnipeg, the Social Planning council. Having a picture of different health and social needs of districts within a city or community does not preclude interventions that are city or community wide. However, not having a data base may mean that some needs are missed and some effective initiatives thereby precluded. Also, for projects deciding to work with targets, a socio-economic/health data base could prove useful in setting them. The social and health profile included in *Dimensions of Health in Edmonton*, released this year, should be a useful guide for that city's project.

The "models of good practice," the mini-projects of the three U.K. cities, reflect the projects' focus on the physical and social environment. The first initiative supported in Liverpool was the Mersey Basin campaign, which involved over 50 voluntary organizations in a move to decrease pollution and improve houses and other buildings and the economic, aesthetic and recreational value of an area with severe health and social problems. Another Liverpool initiative, "the Croxteth project," involves housing and other needs determined in part by a door-to-door survey. That project is designed to highlight public participation and is funded with £350,000 from the National government (Flynn, 1988). The physical environment has also featured prominently in Oxford's focus; there, the committee, which may take pride in its collaborative approach, has been successful in working with industries in the region to reduce locally generated air and water pollution (Allen, 1988).

A Sheffield mini-project in a depressed area is the "South Sheffield Community Health Project." It involves workshops, health discussion and support groups and one-to-one interventions by two part-time staff workers to assist women in that depressed core community to define and meet their own health needs. Most of the women are new immigrants, elderly, non-English speaking or otherwise isolated. A joint endeavour, the project is funded by the Sheffield Health Education Authority, Sheffield city council and the Healthy City committee (Sheffield Health and Consumer Affairs Committee, 1987).

Some of the focus on equity is not based on geography and on "mini-Black reports," but on particular groups of people; the "Health and Recreation Project" in Liverpool is an example. A co-operative venture of city council and Regional Health Authorities, the two year project involves improving the use of the city's recreational facilities by women, the disabled, and ethnic minorities. Staff are seconded from the Health Authority to run the project, which entails not only recreation programs and publicity campaigns, but also the making of any structural changes needed in the facilities (Flynn, 1988).

If some of the mini-projects are directed to general health promotion, there are others which are specifically for disease prevention. Liverpool and Sheffield both have such projects, funded by the national Heart Health Campaign, aimed at diet, stress, smoking reduction, etc. (Flynn, 1988; Halliday, 1988). Other successful prevention and education initiatives are Liverpool's "Mr Yuk" campaign, featuring school and community-based dissemination of information to reduce children's accidental deaths due to poisoning, and Oxford's AIDS Sub-committee's project; the first is being evaluated by hospital treatment records, and the second by the fact that in the 18 months after an AIDS Liaison Officer was hired, only one new case of the disease had been found in the city (Allen, 1988). In Sheffield, a "model of good practice" which may soon become a Healthy Sheffield project is the Occupational Health Project, which focuses on teaching workers and lobbying employers and city council to reduce a high incidence of lung disease, injuries and other hazards of being part of the manual work force in Sheffield.

If some of the initiatives of the three U.K. cities are not markedly different from disease prevention thrusts of the "old public health," the same is likely to be true of some elements of Canadian projects where a specific prevention need is recognized, and particularly if outside funding is available to attend to it. Certainly, the city-wide and community-focused "models of good practice" in Liverpool, Sheffield and Oxford illustrate that responses to needs in cities may take a variety of forms, but all require organization skills, enthusiasm and funding, for which the city-wide Healthy Community Committee is the most important resource.

PUBLIC PARTICIPATION

Public involvement is important for its embodiment of the "enablement" component of the new public health (WHO, 1986), and because of its potential to lead to community-relevant projects. In the U.K. projects, public participation involved representatives of voluntary organizations, churches, the Chamber of Commerce, etc., in the "senior" Healthy City committees of the U.K. projects, and also groups of "grassroots" volunteers in the neighbourhood projects, which have been locally publicized for public input. Various tools have been used to involve the community, of which the "highest profile" was in every case council's declaration of the local project. A mechanism for public dialogue on environmental issues, proposed programs and other aspects of the project has been the distribution of flyers or newsletters, such as Oxford's *Healthy Oxford/2000 Health Newsletter* delivered to all households. (Oxford City Council, 1988). The publication includes a tear-out coupon asking for feedback from readers; also, a "Healthy Oxford/2000" telephone list has been included for information and/or further input.

Target setting is an activity in which all three committees have been involved, and for Liverpool and Sheffield, it is the major city-wide element around which public involvement has been sought. For example, Liverpool's 1984 *Health in Mersey: A Review,* produced in collaboration with professional groups, the Local and Regional Health Authorities and others, was circulated widely to the media (Ashton,1984). From that base, a one-day conference of health professionals and key opinion formers established twelve priorities for Liverpool, which were circulated in *Tying Down the Targets and Indicators for Health For All* (Ashton, 1988b). The document, intended to stimulate debate, included subjective and behavioral indicators along with the traditional morbidity and mortality tools. Similarly, in Sheffield, the committee has widely circulated two "drafts" of Health For All targets and a background brochure to a variety of agencies: professional and labour groups, voluntary associations, churches, the Health Authority, educational institutions and so forth. Maddy Halliday, the local project co-ordinator, hopes that the input and revisions will produce targets that validly reflect community needs.

In the Canadian context, a well structured community participation element may be particularly important if community and private sector involvement on the interdepartmental committee of municipal government is precluded. As well, community involvement must start early to be most effective. Participation in the U.K. projects arose only after being actively sought by leaders, and Canadian committees should explore avenues for early involvement of the public. One way is a public invitation, accompanied by concerted efforts to inform the community about the project. Some cities, such as Saskatoon, periodically advertise for volunteers to sit on advisory committees, boards and commissions; this could be useful for a Healthy Community committee, after the public has been well informed by local newsletters, community publications, the media, etc. Council's declaration of the project could provide an important focus for

media attention. Presentations to church and other community groups have proven useful, especially in smaller centres, such as Rouyn-Noranda, Quebec, which provided training sessions for volunteers who undertook a series of "vision" workshops. That community, Edmonton and others have also involved the schools, in a Seattle designed "Kids' Place" survey to obtain input and arouse interest in the quality of the environment. Thereby, not only the children, but also many families became informed. Existing groups, such as service clubs, neighbourhood associations or community-based residents' advisory committees may provide a base from which community participation may be developed.

FUNDING AND HUMAN RESOURCES

Funding of the mini-projects in the three cities has usually been by a combination of grants from national agencies, as with the "Heart Health" projects; secondment of staff and physical resources, as with Liverpool's "Health and Recreation Project;" or by grants from the local committees, such as for local "health fairs," which all three committees support. General project funding has also come from local and national sources, primarily through the Local Authorities and the Central Government's Health Authorities and Health Education Authorities. All three projects have used inputs from existing budgets, including secondment of staff and other resources for various periods of time, making exact determination of costs problematic. For example, the 1986-87 Annual Report for the Mersey Region Health Authority, of which Liverpool is a part, does not include Healthy City expenditures separately, but as part of general Health Promotion costs (Mersey Region Health Authority, 1987). In Sheffield, the project has been given "Joint Teams of Officers" status, and is therefore funded by the Local Authority, the Health Authority and the Family Practitioners' Committee (Sheffield Health and Consumer Affairs Committee, 1987). In Oxford, except for the initial £24,000 publicity grant from the Health Authority and city council, moneys for the project have come mostly from the latter. There, the Healthy City Strategy cost £113,500 in 1986-87, of which less than ten percent came from national agencies (Allen, 1988). In terms of staff and other resources, the participating agencies in Liverpool and Sheffield have also been local and national, while in Oxford, the local Environmental Health Department has been the prime participant.

The U.K. experience suggests that projects need substantial support at the local level. The same may be expected in Canada; as in the U.K., some may be made through existing budgets of participating organizations, including municipal government and others. Canadian projects are fortunate in the interest and commitment of the Department of Health and Welfare, whose grant of over $650,000 set up the National Coordinating Office for the project; the Canadian government may be expected to continue as a resource (in at least an advisory capacity), especially important if the local projects develop a data base, an expensive task which Liverpool and Sheffield had "in place" before their projects began. The

Canadian government and the province of Quebec have financially supported the "Villes en santé" project. A "one-time" event supported by a $20,000 grant from the province was Rouyn-Noranda's "Healthy City Boutique" (Lacombe, 1989).

As in the U.K., there has not yet been extensive private sector involvement in Canadian projects, but Canadian committees may explore that avenue for local or city-wide assistance. Local events may prove useful, as did Liverpool Women's "10 Km. Run," which provided a focus for media coverage and raised over £23,000 for "Heart Health" of the local project (Halliday, 1988).

Concerning the human resources needed for the projects, implementation in the U.K. has required not only senior personnel, but also staff for the mini-projects, often borrowed from city departments. No reliance has been placed on volunteer staffing, even in the mini-projects. In Canada, full time staffing of projects, such as the three person office recently established for the Toronto project, is important; volunteer involvement has also already been useful, especially for particular tasks, such as vision workshops or speaking to community groups.

EVALUATION

Just as the evaluation of the WHO Healthy Cities Project will use the Health For All targets of WHO Europe as the major criteria, so local project evaluation will be facilitated by local targets, derived in Liverpool and Sheffield from the WHO European Region targets, and in Oxford from the strategy document (*Oxford: A Healthy City Strategy*, Oxford Health Education Authority, 1987). Establishing a data base could be useful for Canadian cities as it has been for Liverpool, Sheffield and Oxford, not only for planning and implementing (for example, in setting targets) but also for periodic and terminal evaluations that include more than process elements.

Just as the setting of indicators reflective of the new public health and the collection of related data at the appropriate level have been problematic in Canada, so they have been for the U.K. projects (Ashton, 1987). A beginning for solving some of the methodological difficulties was made as early as 1986, with a tentative list of 12 indicators drawn up at the First Healthy Cities Conference in Lisbon in 1986. Project participants in the U.K. and Canada may be assisted in evaluation by *A Guide to Assessing Healthy Cities* (WHO, 1988); and will also look forward to developments from the Research for Healthy Cities International Conference, at the Hague in June 1989.

CONCLUSION

Discussion about Canada's Healthy Community Project has centred around potential benefits of the project for cities and other communities, and has not focused on the experiences of others. Although

the Canadian Project as a whole has developed along different lines than its European relative, in that it includes small as well as large human settlements, learnings from projects such as those in Liverpool, Sheffield and Oxford, can be applied to individual Canadian projects. Strategies for involving non-health professionals and the public, committee participation, funding and the human resources needed for implementation, and evaluation must be addressed in that light for the implementation of realistic and viable projects.

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ROUYN-NORANDA: VILLE EN SANTÉ

INTRODUCTION

The first Canadian municipality to declare its participation in the Canadian Healthy Cities Project, later to become the Canadian Healthy Communities Project, was Rouyn-Noranda, a city of 26,000, an hour's air time northwest of Montreal. The city had been formed in 1987 by the joining of Rouyn and Noranda, which, according to Statistics Canada, had 1981 populations of 17,319 and 8,870, respectively. (Statistics Canada, 1981). On April 13, 1987, council of the new city voted unanimously to register officially in the Healthy Cities Project. A year later, the newsletter of the Quebec branch of the Canadian Institute of Planners reported that council support was still strong: " . . . the municipality has followed words with action, providing office space, a co-ordinator at city hall and an active public consultation process, with over 35 community groups taking an interest" (Spring, 1988).

Some of Rouyn-Noranda's success with the Healthy Communites project can be attributed to the community's small size and isolation from the larger centres of Quebec, and to a homogeneity that is economic, related to the mining industry (Statistics Canada, 1981), and cultural/linguistic, with 96 percent of the population being unilingual French (Statistics Canada, 1986). Réal Lacombe, consultant to city council on Community Health and now on the Steering Committee of the Canadian Healthy Communities Project, has attributed the success of the Rouyn-Noranda project to nine related factors:

1. A municipal council and a population that had decided to battle for a new city with the amalgamation of Rouyn and Noranda.
2. A health network that was [sufficiently] open and enthusiastic to look at health promotion and the Healthy Communities project.
3. A population that had become more and more preoccupied with questions of physical and social health in their community.
4. Dynamics of the groups of citizens, community organizations and organizations of neighbourhoods such that they could be mobilized in a Healthy Communities project.
5. A favourable economic situation, including initiatives by local businesses.
6. The local community's fundamental values (including a search for a better quality of life) that were consistent with the precepts of the Healthy Communities Project.
7. An elaborate discussion that had been going on for several years about concrete local concerns.
8. The dispensing of abundant information related to health.
9. Outside support from the idea of a Healthy Communities Project in Rouyn-Noranda--at the provincial level from the provincial government, the Public Health

> Association of Quebec and the St. Sacrament of Quebec; and at the national level, from the Canadian Public Health Association (CPHA) and the Canadian Institute of Planners (CIP) and the Federation of Canadian Municipalities (FCM), all of whom promoted the local project's becoming known at the national level and its early participation in the Healthy Community Project of Canada when the National Coordinating Office opened in the summer of 1988. Finally, at the international level, from the World Health Organization and other cities with advanced projects (R. Lacombe, personal communication, October 7, 1988).

The Rouyn-Noranda project is examined in more detail below, according to: origins of the project at the municipal level, membership and initiatives of the committee, public participation, and funding and human resources for implementation.

ORIGINS OF THE PROJECT AT THE MUNICIPAL LEVEL

According to Lacombe, motivation for the April 13 city council declaration of the project arose from several concerns, the foremost of which was a lack of predictability because the local economy was inextricably linked to the vagaries of the stock market (personal communication, October 7, 1988). Moreover, councillors shared with other Northern communities worry about a related exodus of young people to large urban centres. Finally, local industries in the area had produced what Rouyn-Noranda residents believed to be the most polluted environment in the country; for 20 years, the lake at which the community is nestled had been unfit for recreational use (Lavalée, 1989). The formation of the new community in the spring of 1987 provided the energy, and the Healthy Cities project the opportunity, to seek solutions to these problems. Unlike many other projects in Canada, therefore, the Rouyn-Noranda project had political beginnings.

MEMBERSHIP AND INITIATIVES OF THE COMMITTEE

With the official registration of Rouyn-Noranda in the Healthy Cities Project, city council named a committee of ten to promote a project for the new community. Along with Réal Lacombe, the group included two members of city council who had supported the idea from the beginning, the municipal administrator and six others, including a veterinarian, an educator, a college student, a businessperson, the co-ordinator of the water division for the city, and Denise Lavalée, hired as Co-ordinator for the project.

The first objective of the Healthy Community Committee for Rouyn-Noranda was to arouse discussion among the public about the concept of health and about the project and to invite them to participate

in what the committee was convinced was an exciting initiative for the city. As a first move in that direction, a logo was designed for the local project and, with a pamphlet of background information, circulated to all the population. As a follow-up, in the fall of 1987, two tools were put in place to involve the citizens in discussions about the environment. The first of these was a "Kids' Place Survey," a questionnaire adapted and translated into French from the original devised by the "Kids' Place" group in Seattle, Washington. Aimed at primary and secondary school children, the tool used word association for such triggers as "boring," "safe," "dangerous," etc., to elicit the children's impressions of their physical environments. The second tool, used also in Toronto and other cities' projects, were the "vision" workshops, a guided fantasy technique devised by Hancock (1988), to promote ideas and aspirations for the local environment. Following the workshops, participants submitted ideas on their concerns and suggestions for a Healthy Community project in Rouyn-Noranda. The "vision" workshops were used for a variety of targets, such as secondary school students, church and voluntary groups, etc. During the six month "animation" period, the logo was used extensively and was well received.

Other means used to interact with Rouyn-Noranda citizens were "suggestion" cards that could be deposited at the local Caisse Populaire, distribution of environmental questionnaires by the employees of local businesses, and discussions and animation of groups of students from the University of Quebec. By such diverse means, over the six months beginning in the fall of 1987, the Healthy Community Committee of Rouyn-Noranda became convinced that it had reached everyone in the community for her or his opinions about health, the environment and possible projects for Rouyn-Noranda. Analysis of data from the various sources was carried out by students and volunteers from the University of Quebec and the Regional Council of Health and Social Services.

Ashton, of the WHO Co-ordinating Centre for the Healthy Cities Project in Europe, had suggested beginning Healthy Cities Projects with a highly visible initiative with which local citizens could identify (1986). The Rouyn-Noranda Committee did this, taking on early the environmental questions of how and when to rid the centre's lake of pollution. With assistance from the local Lions' Club and other volunteers, the committee organized a lakefront Winter Festival, drawing attention to the condition of the water. The committee believes that the event began a thrust now under way in local industry to clean up the lake.

Another Healthy Communities initiative, the Healthy Communities Boutique/Une Boutique ville en santé, was an undertaking that arose out of committee contention that access to information was the most important, and also the weakest, link in improving the environment. Lacombe explained that citizens need to possess pertinent information to permit them to act directly for environmental improvement; local decision-makers (municipal governments, institutional authorities and businesses) also need information,

partly to influence the central government, and the information must therefore be accessible to everyone. To accommodate this need, the committee set up a Healthy Communities Boutique, to put the citizens and decision-makers in touch with each other and in contact with the expertise, documentation and local resources needed for action. In "the living heart of the community," the central shopping centre, the boutique has become a place for members of the community to interact about their experiences and their action projects. Plans for the future include a focus on crime prevention, using an information table and involving the local radio station (Lavalée, 1988).

PUBLIC PARTICIPATION

Perhaps the strongest element of the Rouyn-Noranda project has been its success in involving the citizens of the small community, especially in defining environmental problems. Enlisting the help of *Trait Union*, the local newspaper, was useful. For example, a weekly column "What Do You Think?" provided a forum for the project, eliciting several suggestions and project ideas from readers. As well, meetings and other Ville en santé events were well covered by the local press. The Healthy Communities Committee also distributed its own printed material. So far, it has delivered four issues of an information bulletin "It Appears That . . . " to about 200 addresses.

Word of mouth communication has also been encouraged, such that each person involved in any way with the project was invited to report back to his or her service group or organization and also to communicate informally with others. The approach is believed by the committee to have changed some groups and individuals from spectators to actors (Lavalée, 1988).

Extensive use of volunteer labour has been made by the Rouyn-Noranda committee, not only for the Winter Festival, as noted above, but also for administering the Healthy Community questionnaires and for leading the "vision" sessions with school children and various community groups. The analysis of the data gathered by those processes is also being carried out by volunteers from the University of Quebec and the Regional Council of Health and Social Services.

Communities exploring ways to promote public involvement should consider the use of volunteer associations, particularly in the "miniprojects," the neighbourhood level projects where citizens may identify strongly with initiatives being planned. As well, Rouyn-Noranda's effective use of local media can be adapted to fit a community of any size.

FUNDING AND HUMAN RESOURCES FOR IMPLEMENTATION

In the beginning, municipal council was the mainstay of the Rouyn-Noranda Healthy Communities project, granting start-up funding of $5000 in 1987 to accompany office space for the co-ordinator, and technical support, secretary, materials and equipment. A further sum of $20,000 was budgeted for 1988.

Enthusiastic support in the community has translated into funds as well, with the Lions' Club supporting the Winter Festival, the Rotary Club paying for publishing and distributing an information flyer, and other service groups undertaking fund drives. Local businesses were supportive too; one of them contributed the costs of printing the logo and Ville en santé slogan on the grocery bags. The National Society of Québécois contributed a theme song. The local Caisse Populaire contributed television coverage, as well as displays at local facilities for the consultation process.

The province of Quebec has also assisted financially in the Rouyn-Noranda project. The Healthy Community Boutique received a "one-time" grant of $20,000, and a $5,000 pilot project award was made by the Ministry of Health and Social Services.

Just as the financial picture of the Ville en santé project seems to be healthy, so the human resources also seem to be sufficient. The project co-ordinator is assisted by a full-time secretary and various volunteers, both of whose participation has been facilitated by an interested and active city council.

By the summer of 1988, when the Canadian Healthy Communities Office was opened and a national co-ordinator appointed, the project in Rouyn-Noranda had moved a long way toward completing the requirements for recognition, particularly in the area of council and public involvement. The remaining outstanding elements are further work on articulating the strategy for a healthy community and evaluation of the project.

CONCLUSION

In part, the enthusiastic response of Rouyn-Noranda to the Healthy Communities Project can be attributed to its being a small, closely-knit community, assisted, according to Lacombe, by religious homogeneity and a supportive clergy. Further factors were that the municipalities in the province of Quebec are smaller than they are in other provinces and the structure of the public system is centralized; municipal government is not directly involved with public health; and local institutions have been developed linking public health with social services. Stimulated by the pride and goals of a new municipal identity, the prime movers of the project, and later the general population, were proud to be the first in Canada to respond to the invitation of the World Health Organization's Healthy Cities Project. Perhaps most important, the *Gemeinschaft* nature of the interactions in Rouyn-Noranda, strengthened by isolation from

Quebec's major centres, allowed the community to coalesce in response to what was to them an obvious need for action to protect the environment.

Besides the factors above and those listed earlier by Lacombe, the success of the movement in Rouyn-Noranda can be attributed to some "right moves" by the Healthy Communities committee. In summary, these are: a concerted public consultation campaign during the initial "animation" phase, including circulation of the logo, the widely distributed questionnaires, a flyer, news items and personal contact by the volunteers conducting "vision" workshops; the effective use of the press, of volunteers (not only for informing church groups, service groups and others about the project, but also for analyzing input data) and of support from local clergy; an early focus on a major, visible environmental health issue with which city residents could identify; the exploitation of a variety of funding sources (the private sector, service groups, the National Association of Québécois, and the governments of Canada and of the province of Quebec); the setting up of a centrally located, publicized "Ville en santé boutique;" and, finally, the holding of a high-profile, fun producing Winter Festival, complete with a theme song to support the project. The settings and natures of other Canadian centres aside, these are learnings from the experience of an enthusiastic, goal-directed community that may assist the city of Winnipeg and others as they design their own projects.

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SEATTLE'S KIDS' PLACE PROJECT: AN IDEA FOR HEALTHY COMMUNITIES

Until 1988, when the U.S. Office of Disease Prevention and Health Promotion announced its support of the Healthy Cities concept, few Healthy City projects were developed in the U.S.A. On the other hand, aspects of health promotion programs of particular cities have been adapted for Canadian Healthy Communities projects. One which has provided a model for Edmonton, Toronto and other Canadian cities is the Kids' Place project of Seattle, Washington.

According to Donna James, special assistant to the mayor of Seattle, interviewed September 17, 1988, the program was developed partly in response to 1980 U.S. Census figures documenting the city's rapidly declining population of children and youth during the 1970s. The overall population dropped seven percent to about two million, but the children and youth population dropped 36 percent. Seattle had had a reputation as a family town, a good place in which to raise kids. But during the late 1960s and 1970s, Seattle's political and cultural climate had come to favour young professionals and the elderly more than families with children. Seattle, like most American cities, became more and more designed for adult use.

Kids' Place was started by individuals, and then groups, outside city government. After the mayor and councillors became convinced that the city needed to attract more families with children and to support and keep those families with children already living in Seattle, the project was jointly funded by the city (which wanted to strengthen its reputation as a family town) the Junior League (which had a tradition of serving children) and the Y.M.C.A. (which had an extensive repertoire of services for kids and few kids to use them). The project moved ahead with the wholehearted endorsement of Seattle Mayor Charles Royer and with funding from the sponsors and from local businesses and foundations.

Among the first steps taken was a 1984 survey of Seattle's children and youth to determine what they thought Seattle would look like if it were to be a good and healthy place for kids (Figure i is a copy of the Kids' Place Survey adapted for use in a Canadian project). What things needed to be changed? How did the children describe commonly known elements in the city? What was the dirtiest place in town? What was the most fun place to go? The 6,700 survey responses have helped city officials determine, for example, that steps were needed around some of the aquarium's exhibits so some of the smaller children could see them, that teenagers could make use of roving Community Service Officers, who could provide such information as where to go for shelter, and that Seattle Parks Department could take a closer look at the design of parks and play equipment. According to Donna James, "We don't see Kids' Place as a project, but as an attitude. When people make policies, we want them to start thinking in terms of how the policy will affect children and families" (1988, p. 5). The survey has been adapted for use in many other cities, the first of which was Edmonton, Alberta.

The results of the 1984 survey and related input on children ad family issues resulted in a planning document "The Kids' Place Action Agenda, 1985-1990," subtitled "Looking at the City with Children in

(1) (2-3) (4-5) (6-7) (8)

"KIDS' PLACE" SURVEY INSTRUMENT
Figure i

F 1 G 2 (9)

GIRL: ☐ BOY: ☐

AGE: _____ Age (10-11)

ADDRESS:: _____ postal code Quartier (12)

SCHOOL NAME : _____ DEGREE: _____ code postal (13-16)

What things or places do these words make you think of? Write your answers.

example

WET When it's rain or LAKE A	*Smells good* B	MYSTERIOUS C
DIRTY D	SAFE E	QUIET F
BEAUTIFUL G	Sad H	Friendly I
FUN J	*Peaceful* K	Unfriendly L
BORING M	CROWDED N	BUSY O
UGLY P	Smells bad Q	HELPFUL R
DANGEROUS S	noisy T	TIRING U

- I think the best place to go in my neighborhood is: _____
- I think the best place to go with my parents is: _____
- My favorite place in the city is: _____
- My parents' favorite place to go <u>with me</u> is: _____
- If I were Mayor, the first thing I would do to make Rouyn-Noranda a better place for kids is: _____

_____

THANK YOU!

|2| (8)

a (9-11) (12-13)
b (14-16) (17-18)
c (19-21) (22-23)
d (24-26) (27-28)
e (29-31) (32-33)
f (34-36) (37-38)
g (39-41) (42-43)
h (44-46) (47-48)
i (49-51) (52-53)
j (54-56) (57-58)
k (59-61) (62-63)
l (64-66) (67-68)
m (69-71) (72-73)

|3| (8)

n (9-11) (12-13)
o (14-16) (17-18)
p (19-21) (22-23)
q (24-26) (27-28)
r (29-31) (32-33)
s (34-36) (37-38)
t (39-41) (42-43)
u (44-46) (47-48)
v (49-51) (52-53)
w (54-56) (57-58)
x (59-61) (62-63)
y (64-66) (67-68)
z (69-71) (72-73)

Mind." More than 300 volunteers, serving on six task forces, developed 30 goals aimed at making Seattle a better place for children and families. Work toward some of these goals--among them creating a kids' bike route network, fighting adult exploitation of children, expanding playground and parks programs, marketing the public school, reducing bus fares for children and youth and expanding multicultural opportunities for kids--is under way. The 30 items, prioritized from an original list of 600, are included because they are "do-able" and achievable within five years. The plan not only describes the action needed, but also describes where the responsibility for action lies.

The survey has also provided impetus for other items. A Kids' Board of 40 teenagers lobbies city hall on issues that run the gamut from fighting against a city-proposed midnight curfew on teenagers to supporting competency tests for local school teachers. An annual Kids' Day promotes positive activities for children by providing free museum admissions, free bus rides and other incentives. On Kids' Day, all Kids' Places--from the zoo to the elevator at the space needle--are free to children 16 and under.

KidFriendly downtown is a new program that has been recently added to the repertoire of Kids' Place. City officials would like downtown Seattle to be viewed as friendly to children. They began a campaign to enlist store owners and shopkeepers on their premises. Stores with the KidFriendly logo in their windows are the ones where children can feel free to go and seek assistance: "I ran out of money," "I need to call my Mom and make sure I get a ride home" or "I need to use the bathroom." These are simple things that help to achieve Kids' Place major goal of fostering a place and an atmosphere in which families would want to live in rather than leave. They would like to stay because it is child friendly--a place where children and families are made to feel welcome.

In addition to these efforts which serve to announce publicly that Seattle welcomes children and families, the mayor has taken several significant administrative steps. The city budget process requires that every department suggests children's initiatives in their annual budget submissions, from which list the mayor chooses those that augment a co-ordinated plan for services to children and families. (A partial list of child and youth services in Seattle is appended). An annual report on the status of children in the city is released as part of the Kids' Day celebration. Another direct result of the initiative has been the city of Seattle Policy Plan for Children and Youth, adopted by city council in May, 1988. Fourteen targets and many related strategic options provide direction in such areas as family development, adolescent pregnancy, homeless, runaway and street youth, etc.

Other Kids' Place action agenda includes: a changing of zoning requirements so that family day care is recognized as an allowable use for dwellings in the city and child care centres can operate on the second floor of a building. Because of a Kids' Place recommendation, the mayor and city council have formed a commission on children and youth to help formulate a city-wide youth policy.

Kids' Place itself is being more formally institutionalized. In the past, it has been co-ordinated by an aide to the mayor; it has now been incorporated as a separate nonprofit entity so that there will be a continuing Kids' Place organization regardless of who is mayor.

Kids' Place is successful already and aims to improve its success. One of the survey responses indicated that the city's parks were its most popular asset. Shortly thereafter, city voters passed a bond issue to renovate them; James suggests that the survey results had a significant impact on passage. She adds that businesses are expected to profit from increased activity when downtown shopping areas are made more attractive to families, and that Mayor Royer is pushing for social programs such as child care, youth employment programs, emergency youth shelters and services to abused children (1987). The 1991 census may suggest that Seattle is again becoming a place for families.

Kids' Place contributes to Canadian Healthy Communities Projects suggestions for child and youth centred projects, and the Kids' Place survey, an easily administered tool for assessing children's reality of their environment. The technique has been adopted in a least three Canadian projects, Edmonton, Toronto, Rouyn-Noranda.

SOME CHILD- AND YOUTH-CENTRED PROGRAMS, SEATTLE, WASHINGTON

POLICE DEPARTMENT

- Downtown, A Safer Place for Children Program.
- Police Explorer Scout Program (fingerprints children, supports youth related activities, such as the March of Dimes Walkathon).
- Alcohol and Substance Abuse Program (prevention/information program for sixth graders).
- Anti-Shoplifting (aimed primarily at seventh graders).
- Bicycle Safety Program (free bicycle inspections, bicycle safety rodeos, aimed at all ages).
- Child Abuse/Neglect (informing children of their rights, how to report situations, etc.).
- Referral/Advocacy for children who are victims of sexual abuse.
- Family/Domestic Violence (information program on history, causes, shelters, etc.)
- Officer Friendly (involves talks by police to young children about safety, etc.).
- School Patrol Program.
- Child Abuse Investigation (increased staff to handle increase of 200% reported incidents, 1983-1987).

TOTAL COST: $1,315,600.

DEPARTMENT OF HUMAN RESOURCES

- Children and Youth Commission (sets broad planning goals and policies; appointments made by the mayor, city council and Kids' Board).
- Child Care Services (day care support program, serving approximately 1,400 children).
- Youth Employment and Education (provides pre-employment training to low income youth).
- Upward Bound Program (assists approximately 85 youths/year to meet college entrance).
- Early Childhood Education (includes comprehensive child development services, including nutritional services).
- Emergency Food and Shelter (a co-ordinator works with non-profit agencies in the area).
- Foster Grandparents (emotionally disturbed or developmentally disabled children are paired with a "grandparent" two hours a week, five days a week, for tender care).
- Child and Family Resource Center (training to child care providers and parents.
- Summer Sack Lunch Program (serving about 800 breakfasts and 4,200 lunches to low income youth at 90 community service sites).
- Daycare Bonus Program (advises the city on the human services and Daycare Bonus program for downtown developers).
- Childcare Voucher Pilot Project (to provide greater flexibility in childcare services and increase program efficiency) .
- Childcare Food Program (nutrition information and food to reimburse child care homes).
- Summer Youth Employment Programs (summer work, life skills training, counselling to 529 low income 14-21 year olds).
- Bridge (career and life planning, work orientation, summer work experience to 50 ninth and tenth graders).
- Tutoring (25 city employees are released for three hours tutoring a week).
- School's Out (a project to raise visibility of need for school age child care. State and city funded).

- Childcare Assistance (14 school-based child care centres, including subsidies to low income families).
- Youth Policy Plan (Human Services Strategic Planning Office will prepare the Youth Policy Plan and work with city departments to implement it, and participate in year end evaluation).

TOTAL COST: $7,199,890.

HEALTH DEPARTMENT

- Refugee Health (health screening, dental care, nutritional counselling, immunizations, family planning to 930 refugees 18 and under, and co-ordinate care to 2200 recent Indochinese refugees).
- Dental Health Program (12,500 screenings and 4,800 dental clinic visits for children 18 and under).
- Women, Infant and Children (nutrition assessment, counselling, food supplements to at risk clients; 28,290 encounters).
- Daycare Screening Program (health care consultation, screening of 2600 children in daycare).
- Pediatric and Teen Health (Complete medical, dental and nutrition care to children, clinic and hospitalization included--does not say how many--for $1,537,025)
- Crippled Children's Services (part of the above).
- School-Based Health Clinic (staffed by a nurse practitioner and mental health counsellor).
- Teen Pregnancy and Parenting Program (childbirth education and parenting skills, development assessments; to include substance abuse).
- Maternity and Infant Care (700 visits to high-risk infants, and 250 to high-risk, low income mothers).
- Communicable Diseases (immunization and investigation of disease outbreaks).
- Family Planning (health education services, clinic services, including pap smears).
- Maternal Care–other (paediatric care, maternal care, maternity care and field nursing).
- Health Education Services (drug, alcohol, curriculum development, AIDS education, medical inservices to school nurses, reproductive health education).

TOTAL COST: $4,926,776.

SEATTLE CENTER

- New Amusement Park Proposal.
- Children and Family Programming (teen movies, winter festival, ethnic events, etc.).
- Pacific Arts Center (Professional artists offer children music, drama, art, dance, etc.).
- Seattle Children's Museum.
- Seattle Center Fun Forest (special programs in the spring and summer months)

TOTAL COST: $421,705.

CHILDREN'S PROGRAMS: COMMUNITY DEVELOPMENT BLOCK GRANT AND HUMAN SERVICES FUNDING POLICIES

- Youth Services Bureau (for 12-18 year olds, offering counselling for sexual abuse, drugs, justice, employment) $484,204.
- Refugee Youth Advocacy $31,000.
- Chinese Youth Leadership (for low income 11-15 year olds) $13,025.
- Seattle Conservation Corps (employment for 18-25 year olds during clean-up) $186,148.
- Project Self-Sufficiency (social services, housing, job training to single parents financed through public funds, United Way) $70,000.
- Emergency Shelter for runaway and homeless youths $32,728.
- Orion Center (multiple services to street culture youths) $55,744.
- YMCA Young Adults in Transition Shelter (Housing, counselling, etc.) $102,808.
- SouthEast Community Development (employs youths in community development) $351,621.
- Dropout Prevention Program (for at-risk youth in four middle school sites) $45,000.
- Minority Street Youth Program $32,550.
- Positive Plus (services and housing for teen mothers) $47,000.

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APPENDIX B

WINNIPEG: AN OVERVIEW

Located at the confluence of the Red and Assiniboine rivers in the Canadian prairie, Winnipeg developed as a trading centre for various groups and became a key link in the Canadian fur trade. From a population of 215 in 1870, the settlement had grown to 1,869 by the time it was incorporated in 1873 (City of Winnipeg, 1986), and to about 625,000 by 1986 (Statistics Canada). The Manual of the city of Winnipeg attributes Winnipeg's success as the North American grain centre and an important midwest financial, commercial, wholesale and manufacturing centre to its geographical placement and excellent railway facilities (1986). The most important elements for growth have been manufacturing (particularly electrical products, metal fabricating and the garment industry) and a service sector supported by a large federal and provincial public administration sector and financial and insurance offices (Kuz, 1974). According to Mason (1985), the city has dominated the economic life of Manitoba, northern Ontario, parts of Saskatchewan, and parts of the northern border states (1985).

The population of Winnipeg has continued to grow, from a 1981 figure of 592,061 (adjusted for boundary changes) to 625,304 in 1986 (Statistics Canada). The rate of growth, however, has been slowing and Winnipeg has slipped to seventh largest among Canadian cities, having been overtaken by Calgary and Edmonton. The decreased rate of growth relative to the Alberta cities must threaten Winnipeg's economic position. As with most North American cities, population increase has occurred primarily in the suburbs (Social Planning Council [SPC], 1987). The trend is expected to continue: using 1981 as a base year, the Department of Environment of the city of Winnipeg projected the population of Winnipeg and its community areas to the year 2001, as shown in Table 1. The total population of the city was expected to increase over the period at a progressively slower rate; in the City Centre/Fort Rouge and St. James/Assiniboia communities, population declines were expected in each of the five year periods to 2001. Assiniboia/Fort Garry, by contrast, was forecast to increase by 26,539, or 18 percent.

The age structure of Winnipeg, consistent with other Western Canadian cities, reflects that people, particularly women, are living longer. The distribution is shown in Table 2, below. The population of Winnipeg is aging, such that, in 1971, 26 percent of the population was under 15 and 9 percent was over 65, but by 1986, only 20 percent was under 15 and 12 percent was over 65. The trend is expected to continue (SPC, 1987).

Very early Winnipeg had a diverse population, comprised of French Canadians, British, Indians, Métis, Americans and within a few years, Icelanders. During the period of heavy immigration from 1895 to 1911, many other groups were added, most notably German, Ukrainian and Jewish. Since 1911, the German and Ukrainian groups have increased relatively, particularly at the expense of the British (Kuz, 1974). The 1986 census responses regarding "mother tongue" support the popular conception of present-

Table 1: Population Projections, Winnipeg Census Metropolitan Area and Community Areas, 1981-2001

	1981	1986	1991	1996	2001
Winnipeg	564,195	594,483	613,929	627,927	636,626
City Centre/ Ft. Rouge	101,520	100,390	99,003	98,103	97,082
St. James/ Assiniboia	70,095	69,922	67,063	65,905	64,594
Lord Selkirk/ W. Kildonan	95,640	102,692	108,482	111,165	113,336
E. Kildonan/ Transcona	105,520	111,621	114,624	116,727	116,684
St. Boniface/ St. Vital	87,140	95,175	103,124	108,763	114,109
Assiniboine Park/ Fort Garry	104,280	114,483	121,633	127,224	130,819

Source: City of Winnipeg Population Projections, Department of Environmental Planning, 1986.

Table 2: Population by Age, Winnipeg Census Metropolitan Area, Manitoba

	Age in Years						
	0 - 4	5 - 15	15 - 24	25 - 44	45 - 64	65 +	Total
Males	22,200	42,425	52,770	98,925	56,255	30,050	302,620
Females	21,020	40,355	53,375	101,420	61,045	45,480	322,860
Total	41,220	82,760	106,145	200,345	117,300	75,530	625,300

Source: *Profiles, Part 1*, Census Canada, 1986.

day Winnipeg as a predominantly English but cosmopolitan settlement: 77 percent of the "single language" responses indicated English as the mother tongue, 4 percent reported French and the rest included

German, Ukrainian, Polish, Filipino, Chinese and others (Statistics Canada, 1986). Recent years have seen an increase in Asian immigrants, 5.2 percent of the population in 1981 (12,410 people, a number which SPC estimates had nearly doubled by 1986). In 1981, 2.5 percent of Winnipeg's population was Native. Both groups, and particularly the Native population, have tended to settle in the City Centre/Fort Rouge community, as indicated by Table 3. In fact, Table 3 shows that, although other individual groups still comprise a much larger proportion of the City Centre/Fort Rouge community, more aboriginal, Portuguese, Indo-Chinese and Asian peoples had settled in the City Centre/Fort Rouge community than in other communities. Problems arising from continual migration of aboriginal peoples from rural and Northern areas to urban centres, especially Winnipeg's inner city, were addressed at a seminar at the Institute of Urban Studies, University of Winnipeg, in April, 1986. The report identified the influx as "... a major issue in terms of older neighbourhood stability, outmigration and renewal. While measures have been undertaken through the Winnipeg Core Area Initiative (CAI) and other mechanisms to address problems of urban Native economic and cultural adjustment, it was suggested that departments in all three levels of government need to more fully address the issues associated with this continued migration" (Lyons and Carter, 1986, p. 5).

SPC's *Environmental Scan* has summarized the labour force trends in Winnipeg, describing a labour force that had increased by 2.1 percent between 1976 and 1986, compared with a growth in the adult population of 1.2 percent. The percentage of males in the labour force had remained constant, at 77 percent, while that of females rose by 10 percent to 59 percent. In terms of share of the workforce, self employed, middle and upper management, semi-professional and professional and technicians increased their share, while supervisors, skilled craftsmen, farmers and farm labourers and unskilled occupations decreased (SPC, 1987). The unemployment rate (highest in manufacturing and construction) steadily dropped from a 1983 peak of 10.6 percent (Statistics Canada, 1983) to 7.9 percent in 1986, although the finding may be a result of outmigration of the unemployed to seek jobs elsewhere. Table 4 shows the unemployment rates of Winnipeg and the community areas for 1986. The highest rates within the city were found in City Centre/Fort Rouge and Lord Selkirk/West Kildonan, especially among the males. When the rates are examined according to ethnic origins, the high rates in those areas can be seen to reflect particularly high unemployment rates among aboriginal residents. Table 4 aggregations do not show how a component group of either of the other categories would fare, although research of the Social Planning Council supports that aboriginals have higher unemployment rates than any other Winnipeg group (1987). The same report suggests unemployment will continue to decrease generally

Table 3: Population by Ethnic Origin, City of Winnipeg and Community Areas, 1986

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk/ W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assin. Pk/Ft Gary
Total: Ethnic Origin	587,415	102,790	68,315	101,750	110,450	92,360	111,745
British & French	21,835	3,605	2,885	2,120	3,320	5,635	4,270
British & Other	72,470	9,830	10,050	10,440	14,800	10,430	16,920
French & Other	11,270	1,710	1,035	1,440	2,160	2,845	2,080
Native Multiples	380	90	20	155	50	25	35
Native & Other	14,245	3,540	1,190	2,825	2,270	2,430	1,995
Multiple Responses	308,540	46,440	42,255	40,670	59,850	40,370	69,960
British	121,820	20,155	21,295	14,165	21,640	18,455	26,115
French	31,310	3,160	2,170	2,380	3,455	16,165	3,970
Dutch	9,510	1,210	1,185	740	3,075	1,430	1,865
German	42,170	6,210	4,245	5,655	13,935	5,085	7,040
Italian	7,740	1,825	800	1,675	745	800	1,890
Portuguese	6,950	4,390	235	1,545	515	140	120
Jewish	131,710	95	6,090	130	155	5,275	
Ukrainian	45,085	5,060	3,325	15,145	12,145	4,705	4,710
Other E. European	20,805	2,915	1,275	7,205	4,470	2,250	2,690
Scand.	7,425	1,410	1,175	810	1,190	985	1,865
Aborig. People	12,855	4,985	545	4,695	1,195	780	660
Arab Origins	285	45	50	15	15	60	90
Pacific Islands/ Filipino	15,665	6,580	355	6,625	870	635	605
Indo-Chin.	2,850	2,090	35	240	315	150	15
Other Asian	15,780	4,535	915	2,440	1,930	1,875	4,070
Carib./ Central American	2,250	755	185	290	325	305	355
Black Origins	3,605	825	290	745	840	270	640
Single Responses	386,550	72,500	41,300	75,400	71,665	58,725	67,235

Source: Census Canada, 1986 Custom Service Products, December, 1988 Institute of Urban Studies. Table 7.

Table 4: Unemployment Rate, Population over 15, by Sex, City of Winnipeg and Community Areas, 1986 (based on 20% sample)

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk/ W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assiniboine Pk./ Ft. Garry
Total Ethnic Groups	8.0	11.3	6.7	9.3	7.5	6.5	6.3
Male	7.7	12.8	5.9	9.4	6.5	6.1	5.6
Female	8.2	9.5	7.6	9.1	8.7	7.1	7.1
Total Aboriginal*	21.6	27.5	12.2	28.8	17.1	12.0	15.6
Male	22.2	30.9	10.3	30.7	15.3	10.3	12.4
Female	20.9	24.0	14.1	26.9	18.9	13.7	18.4
Total Visible Minorities**	8.9	10.1	5.6	8.0	10.2	7.1	9.1
Male	10.0	12.4	7.7	9.2	10.3	7.2	7.9
Female	7.7	8.9	7.6	8.5	8.4	6.9	6.7

Source: Census Canada 1986, Custom Service Products, December 1988 Institute of Urban Studies. Table 31.

*Includes: Those reporting one or more of the following origins: status and non-status Indians, Métis, Inuit, American.

**Includes: One or more of the following origins: Arab, Pacific Islands, Filipino, Chinese, Korean, Japanese,

in the city, largely due to an anticipated growth in services, clerical and sales, which will offset expected continuing decline in manufacturing and the "transportation, communications, utilities" industries.

Education levels in Winnipeg are consistent with the above, such that, according to the 1986 census, and considering all ethnic groups, Lord Selkirk/West Kildonan had 20 percent and City Centre/Fort Rouge had 18 percent of their residents achieving Grade 9 or less education, and Assiniboine Park/Fort Garry, at 6 percent, had the smallest proportion in the city in that category and the highest proportion with a university degree (See Table 5, below). Again, when unemployment is considered in the light of ethnic origins, differences are noted. According to the groupings of Table 5, a higher proportion of Winnipeg residents of aboriginal origins have grade 9 or less education and a smaller proportion have university degrees than do other groups. Among the visible minorities, 14 percent have grade 9 or less education, the same as for Winnipeg as a whole, but a higher proportion have university degrees (16

percent, vs. 11 percent for Winnipeg as a whole). When considering community distribution, however, while almost one third of the Assiniboia/Fort Garry visible minorities residents have completed a university degree, only 10 percent of those in City Centre/Fort Rouge and Lord Selkirk/West Kildonan have; generalizations regarding education levels among visible minority groups in Winnipeg must consider community of residence.

Given the unemployment and education scenarios, a finding that Assiniboine Park/Fort Garry and St. James/Assiniboia had Winnipeg's highest average annual household incomes in 1986, and that City Centre/Fort Rouge and Selkirk/West Kildonan had the lowest comes as no surprise. Within the communities, as shown by Table 6, residents of aboriginal origin fare significantly worse with regard to income than do others, such that in no community do the average earnings of residents of aboriginal origins come very close to the average income for the community. According to the groupings of Table 6, the visible minorities fare on the average as well or better than the average for the community, as does the largest group, "all others."

Table 5:Level of Education, Population over 15 by User Defined Ethnic Origin, City of Winnipeg and Community Areas, 1986

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk/ W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assisiboine Pk./ Ft. Garry
Total all Ethnic Groups	469,885	85,885	56,325	79,170	86,395	73,550	88,550
% with less than Grade 9	14	18	10	20	14	11	6
% with Gr. 9-13 (no secondary school cert.)	31	30	32	35	35	31	25
% with Gr. 9-13 with secondary school cert.	10	9	11	10	11	10	9
% with trades cert./ Other non-univ.	22	20	25	19	24	24	22
% with some univ.	12	12	12	10	9	12	17
% with univ. degree	11	11	10	6	7	12	21
Total Aboriginal*	17,335	5,775	1,150	4,585	1,995	2,100	1,725
% with less than Gr. 9	20	24	14	27	13	13	8
% with Gr. 9-13 (no secondary school cert.)	41	38	39	44	44	41	38
% with Gr. 9-13 with secondary school cert.	6	6	9	6.5	8	8	5
% with trades cert./ Other non-univ.	19.5	19	30	16	22	22	20.5
%with some univ.	19.5	19	30	16	22	22	20.5
% with univ. degree	3.5	3	2	.5	3	6	10

(continued next page)

Table 5:Level of Education, Population over 15 by User-Defined Ethnic Origin, City of Winnipeg and Community Areas, 1986 (continued)

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk/ W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assisiboine Pk./ Ft. Garry
Total Visible Minorities**	34,530	12,645	1,845	8,080	3,575	3,000	5,380
% with less less than Gr. 9	14	19	7	15	12	8	8.5
with Gr. 9-13 (no secondary school cert.)	25	27	26	27	31.5	22.5	17
% with Gr. 9-13 with secondary school cert.	11.5	13	8	14	10.5	8	7
% with trades cert./ Other non-univ.	16	14	19.5	16	19	19	17
% with some univ.	18	17	21	18	15.5	18	19
% with univ. degree	16	10	19	10	11.5	24	32
Total All Others	418,02	567,460	53,325	66,500	80,830	68,450	81,445
% with less than Gr. 9	13	17.5	9.5	21	13	12	6
% with Gr. 9-13 (no secondary school cert.)	31	30	32	35	35	31	25
% with Gr. 9-13 with secondary school cert.	10	8	11	10	11	10	9
% with trades cert./ Other non-univ.	22.5	21	25	20	25	24	22
% with some univ.	12	11	12	9	9	12	16
% with univ. degree	11.5	12	10	6	7	11	21

Source: Census Canada 1986 Custom Service Products, December 1988 Institute of Urban Studies. Table 5.

*Includes: Those reporting one or more of the following origins: status and non-status Indians, Métis, Inuit, American.

**Includes: One or more of the following origins: Arab, Pacific Islands, Filipino, Chinese, Korean, Japanese, South East Asian, Indo-Pakistani, Latin American, Caribbean, Black.

Table 6:Average User Defined Household Income by User Defined Ethnic Origin, City of Winnipeg and Community Areas, 1986 (based on 20% sample)

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assiniboine Pk./ Ft. Garry
All ethnic Origins:							
Number	227,145	47,140	26,005	37,205	40,525	35,375	40,895
Average Household Income ($$)	33,294.7	23,758.4	36,328.2	29,449.3	33,432.1	34,680.2	44,522.6
Aboriginal:*							
Number	7,925	2,985	465	2,100	835	875	660
Average Household Income ($$)	20,399.7	16,377.1	24,907.4	16,276.0	27,309.1	27,486.0	30,408.5
Visible Minorities:**							
Number	15,780	6,595	785	3,375	1,620	1,300	2,100
Average Household Income ($$)	32,672.0	23,590.7	40,212.1	35,408.3	36,377.7	40,788.7	46,091.5
All Others:							
Number	203,440	37,560	24,745	34,730	38,070	33,200	38,135
Average Household Income ($$)	33,845.4	24,374.8	36,420.6	29,688.7	33,441.0	34,630.8	44,680.4

Source: Census Canada, 1986. Custom Service Products, December 1988 Institute of Urban Studies. Table 16.

*Includes: Those reporting one or more of the following origins: status and non-status Indians, Métis, Inuit, American.

**Includes: One or more of the following origins: Arab, Pacific Islands, South East Asian, Indo-Pakistani, Latin American, Caribbean, Black.

In terms of the largest single expenditure, housing, there is little discrepancy within the groups of owners and renters within the city relative to the differences between them. Table 7 shows the percentage of owners and renters in Winnipeg and its community areas who lay out 25 percent or more of their income for accommodation. Across the board, only one fifth or fewer of the owners spent 25 percent or more of their incomes on housing in 1986, while approximately half the renters did. Predictably, among the renters, City Centre/Fort Garry and Lord Selkirk/West Kildonan had the highest percentage of households putting out one quarter or more of their income for housing.

Table 7: Percentage of Households Making Housing Payments of 25 Percent or More of Household Income, Owner Occupied and Rental, City of Winnipeg and Community Areas, 1986 (based on 20% sample)

	Winnipeg Total	City Centre/ Ft. Rouge	St. James/ Assiniboia	Lord Selkirk/ W. Kildonan	E. Kildonan/ Transcona	St. Boniface/ St. Vital	Assiniboine Pk./ Ft. Garry
Owner Occupied Dwellings							
No. of Households	135,230	17,220	16,180	24,305	25,250	22,450	27,755
% of Households with Housing Payments 25% or more of Household Income	18%	19%	15.6%	20%	20%	18%	17%
Rental Dwellings							
No. of Households	91,875	29,865	9,815	12,895	13,265	12,910	13,120
% of Households with Rental Payments 25% or more of Household Income	51%	54%	47%	54%	49%	50%	48%

Source: Census Canada 1986 Custom Service Products, December 1988, Institute of Urban Studies. Table 25.

Considering the availability of housing units in Winnipeg, that number increased during the 1971-1986 period, particularly in the suburbs, with the average number of persons per dwelling steadily declining from 3.2 to 2.6 percent over the period (SPC, 1987). Availability of rental accommodation has been minimal, however, with less that one percent unoccupied in 1986. This may present a particular problem in City Centre/Fort Rouge, the only community where more accommodation was rented than owner-occupied, and at 29,865 rented units compared with 17,220 owner-occupied, that was true by a wide margin (Statistics

Canada, 1988). Lyons and Carter (1986) found that tight private rental markets have contributed to lengthy waiting lists for social housing units.

With regard to quality of housing, studies in the 1970s revealed that Winnipeg had one of the highest proportions of housing in poor condition among Canadian cities. For example, Lyons and Carter report on a 1974 Survey of Housing Units by the Canada Mortgage and Housing Corporation (CMHC) which concluded that, with 13 percent of its housing stock of poor quality, Winnipeg surpassed Regina, which had 11 percent, and all other major Canadian cities, which ranged around five percent (CMHC, 1974). According to the 1981 census, major repairs were required for 11,195 housing units in Winnipeg; most of them had been constructed prior to 1945, and many of them were located in Winnipeg's inner city (Lyons and Carter, 1986). The situation may not have changed appreciably since then. *Plan Winnipeg, An Introduction to the Greater Winnipeg Development Plan Review (1981)* cited problems which the authors said stemmed from the aging neighbourhoods and poor housing conditions: significant long term losses of population, dissatisfaction among neighbourhood residents, higher than average attendance problems among school children and high crime rates. The *Plan* called for a refocus on the growth potential of the downtown and adjacent areas, renewal of older neighbourhoods and a redirection of growth (p. 6). Participants in the Seminar on Housing in 1986, discussing the persistence of housing problems, especially in the core area, concluded that the federal Neighbourhood Improvement Program (NIP) and Residential Rehabilitation Assistance Program (RRAP) and their successors have fallen short of addressing the full problem (Lyons and Carter, 1986).

Winnipeg has some residents who are chronically homeless, although the size of that population is difficult to estimate. SPC (1986) suggested that in the August-November period of 1986, 718 individuals and 87 families were chronically without a regular dwelling (1987). Sayegh has estimated the core population of Winnipeg's "skid row" to be 2,000 people, of whom 75 percent are Natives; he contended that the numbers remain unchanged, although the composition is extremely unstable (1987). It is likely that unemployment contributes to homelessness in a major way, or that housing is not available for the outlay that can be made from sporadic casual work or welfare income; nor is the housing in the right location for those seeking it. Bairstow has suggested that in Winnipeg, loss of housing due to demolitions and conversions is a major factor; he reported that between 1979 and 1987, 300-470 units per year were lost for that reason, and that 1987 demolitions were up 8 percent over 1986 levels, largely due to apartment demolitions. He contended that most of the places that might cater to Winnipeg's presently homeless are reasonably full (1987).

The incidence of crime in the city is no more encouraging than the picture for housing. Between 1981 and 1986, the number of criminal code offenses known to police increased by 28 percent, from

65,400 to 82,856 (SPC, 1987). The fastest rate of increase was among crimes against persons, rising from 3,315 offenses in 1981 to 5578 in 1986, a 68 percent increase, of which the greatest component was non-sexual assault. Among property crimes, theft increased most, 31 percent (SPC, 1987).

With regard to indicators of health, neither the "traditional" mortality and morbidity measures nor those that reflect the new and broader definition of health are available at the community area basis in Winnipeg. The Social Planning Council (1987), however, has drawn some conclusions about traditional indicators of health in Winnipeg and Manitoba; *An Environmental Scan Winnipeg 1971-1991* provides a basis for the following comments.

Considering average lifespan of the population of Winnipeg, *Environmental Scan* reported a steady upward trend in average lifespan. A woman 60 years old in 1965-67 could expect to live another 21.4 years; such a woman in 1980-82 could expect another 23.0 years. A man 60 years old in 1965-67 could anticipate living another 17.5 years; by 1980-82 that had increased to 18.4 years. Consistent with the above, death rates among the 65-69 year population for the province showed a decline from 23.6 in 1978 to 19.8 in 1985. Mortality rates had also decreased among children in their first year of life: from 11.4/100,000 births in 1978 to 6.6/100,000 in 1984. The number and proportion of low birth weight live births had remained constant between 1978 and 1985, around 5.9 percent (523) of live births weighed under 2500 grams (5.5 pounds).

The *Scan* also reported on disabilities, although only at the Manitoba level: in 1985, among children under 15 years of age, 13,000, 5.8 percent, had one or more disabilities that prevented or limited participation at school, play or other activity normal for a child. Mental handicaps in children under 15 years were reported as 0.4 percent of children; learning disabilities, 1.2 percent; heart problems, 0.7 percent and allergies, asthma and bronchitis, 2.8 percent. Among adult Manitobans, 109,000, roughly nine percent, had one or more disabilities. Fifty thousand of them were over 65 years old; accordingly, the most prevalent disability was limited mobility and agility, followed by limited hearing, 31,000, and sight, 14,000.

Considering causes of death in Manitoba, the biggest killer for men has been heart disease, 226.8/100,000 in 1985, having declined from 246.2 in 1980. Cancer was next, 163.6/100,000 vs. 160.6/100,000 in 1980; followed by accidents, 71.8 in 1985 vs. 80.5 in 1980; and respiratory disease, 62.1. Heart disease was also the most common cause of death among women, accounting for 138.3/100,000 in 1985 vs. 161.9 in 1980, followed by cancer, 127.0 in 1985 vs. 120.9 in 1980, cerebrovascular disease 38.7, respiratory diseases 34.2, and accidents 24.7/100,0000.

Morbidity rates increased slightly between 1982 and 1986, from 873/100,000 to 881, with the highest rates among the 65+ population, with diseases of the circulatory system most common, at

535/100,000, followed by nervous system and sense organs, 431/100,000 and musculoskeletal system and connective tissue, 318/100,000. In the under 65 age group, diseases of the respiratory system are the most common, especially in the 0-4 year age group, 496/100,000. Injuries and poisonings feature most among the 15-19 year age group, at 239/100,000. A sharp decline in hospital rates for mental illness may be attributed to psychiatric inpatients being returned to the community. SPC reported one 1987 survey result that 11 percent of the adult Winnipeg population scored high on a psychological depression scale.

Assessment of the extent to which alcoholism exists in Winnipeg is problematic. *Environmental Scan* reported the results of a 1987 survey of Winnipeg residents over 18 years of age: 27 percent indicated one problem-drinking symptom, 13 percent "two or more" symptoms and four percent "three or four" symptoms. An estimate of the smoking population of Winnipeg is not available; the numbers probably do not deviate far from the results of a national Gallup Poll, reporting that 43 percent of respondents over 18 had had a cigarette in the past week, vs. 47 percent in 1975.

The costs of health care in Manitoba were also reported by SPC: the 1985 price tag had increased from $545.2 million in 1975 to $1,730.4, a rise of 22 percent per year over the period. Health care costs, like the picture of social characteristics within Winnipeg's communities, provides a basis for considering seriously the health potentials of promotion and disease prevention interventions.

The Canadian Healthy Communities project differs from its counterparts in the U.S. and in Europe by its inclusion of all municipalities willing to carry out a project, regardless of the size of the settlement. The project shares with the others its roots in *Achieving Health For All*, and consequently a focus on equity of access to health through the creation of health-promoting physical and social environments; that is, through creating environments that enable individuals to fulfil their goals and carry out their socially-defined roles. The review above has described a range of culturally and geographically-based differences in Winnipeg, discrepancies which affirm the need for a project in the city and suggest cultural and geographic communities on which a project could focus.

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APPENDIX C

ORGANIZATION AND DECISION MAKING IN CITY GOVERNMENT, WINNIPEG

GROWTH OF GOVERNMENT

Winnipeg's city government is unique. The early history of its development, however, is much like that of other cities, with geographical expansions taking place through a series of boundary extensions and annexations, as shown in Figure i.

A number of contiguous but autonomous suburban municipalities grew up around Winnipeg as former rural municipalities urbanized and became incorporated. By the late 1950s, the Winnipeg region had twelve autonomous municipalities, whose diverse goals frustrated general, area-wide planning and the provision of a regional infrastructure to service the rapidly growing suburban population (Magnusson and Sancton, 1983). The initial response was a two-tiered metropolitan government, with a twelve-part lower tier and one upper tier. "Metro Winnipeg" was replaced in the late 60s with a single, area-wide council of 50 members. Magnusson and Sancton describe "Unicity" as follows:

> This large council was subdivided into specialized standing committees with responsibility for the environment, finance, works and operations, and later, recreation and social services. Each of these committees reported back to council through . . . the Executive Policy Committee. The standing committee structure was mirrored within the civic administration by a board of commissioners, with each commissioner reporting to a corresponding functioning standing committee (Magnusson and Sancton, 1983, p. 230).

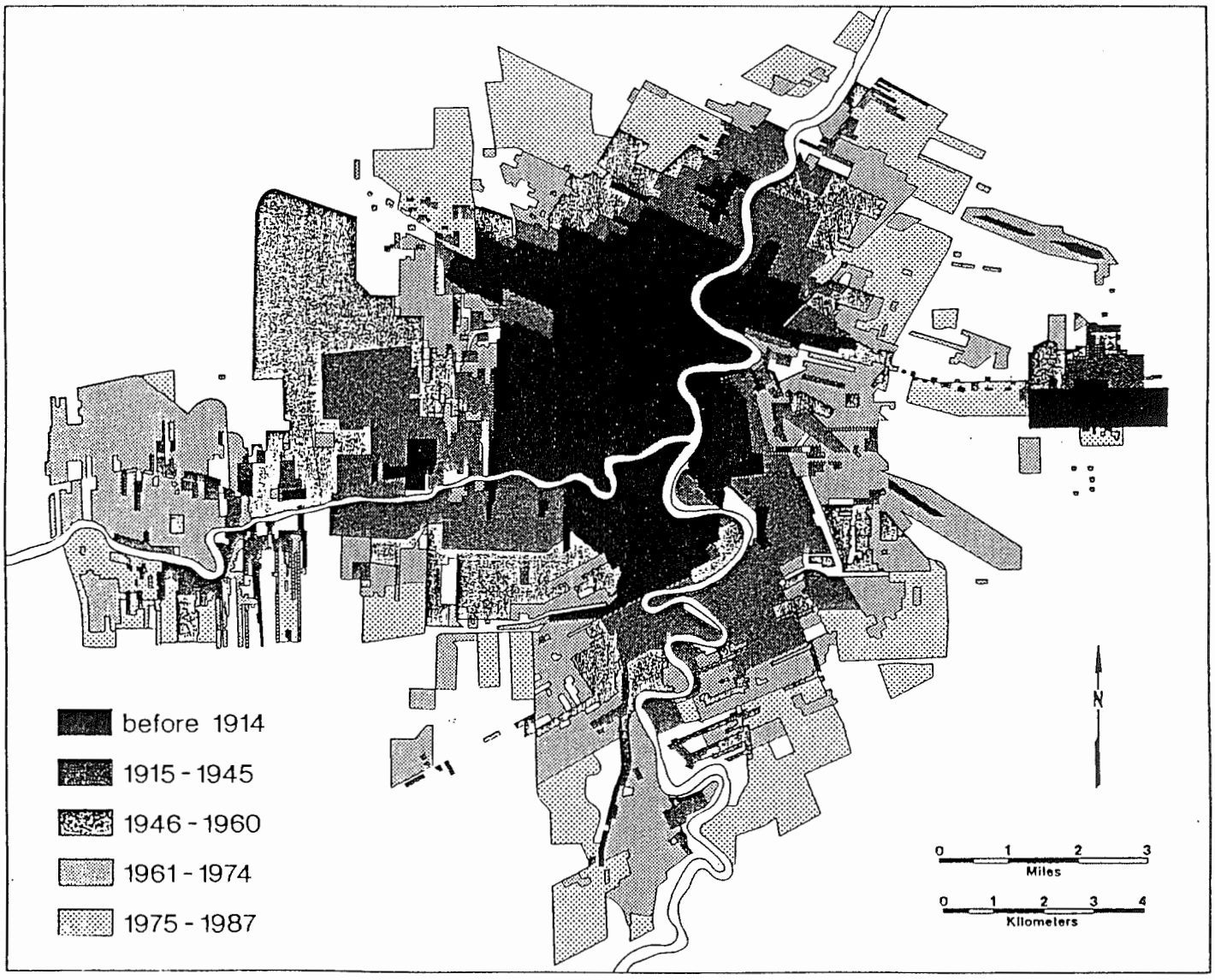
Essential to the reorganization were two elements. One of these was the community committees, sub-regional groupings of councillors from adjacent wards who met regularly to consider and make recommendations on local issues. Winnipeg's Community Committee Areas, which provide the basis for the social data of this report, are shown in Figure ii.

The second element of the reorganization was the Residents' Advisory Groups (RAGs) attached to each community committee and composed of selected interested citizens. According to Magnusson and Sancton, the RAGS are the only municipal groups of organized non-elected participants ever given legal status in Canada (1983). In an evaluation of public involvement in Unicity, Wichern (1984) contended that public involvement in local affairs has been enhanced by Unicity. He wrote " . . . there is evidence

Figure i

EVOLUTION OF THE BUILT - UP AREA OF WINNIPEG

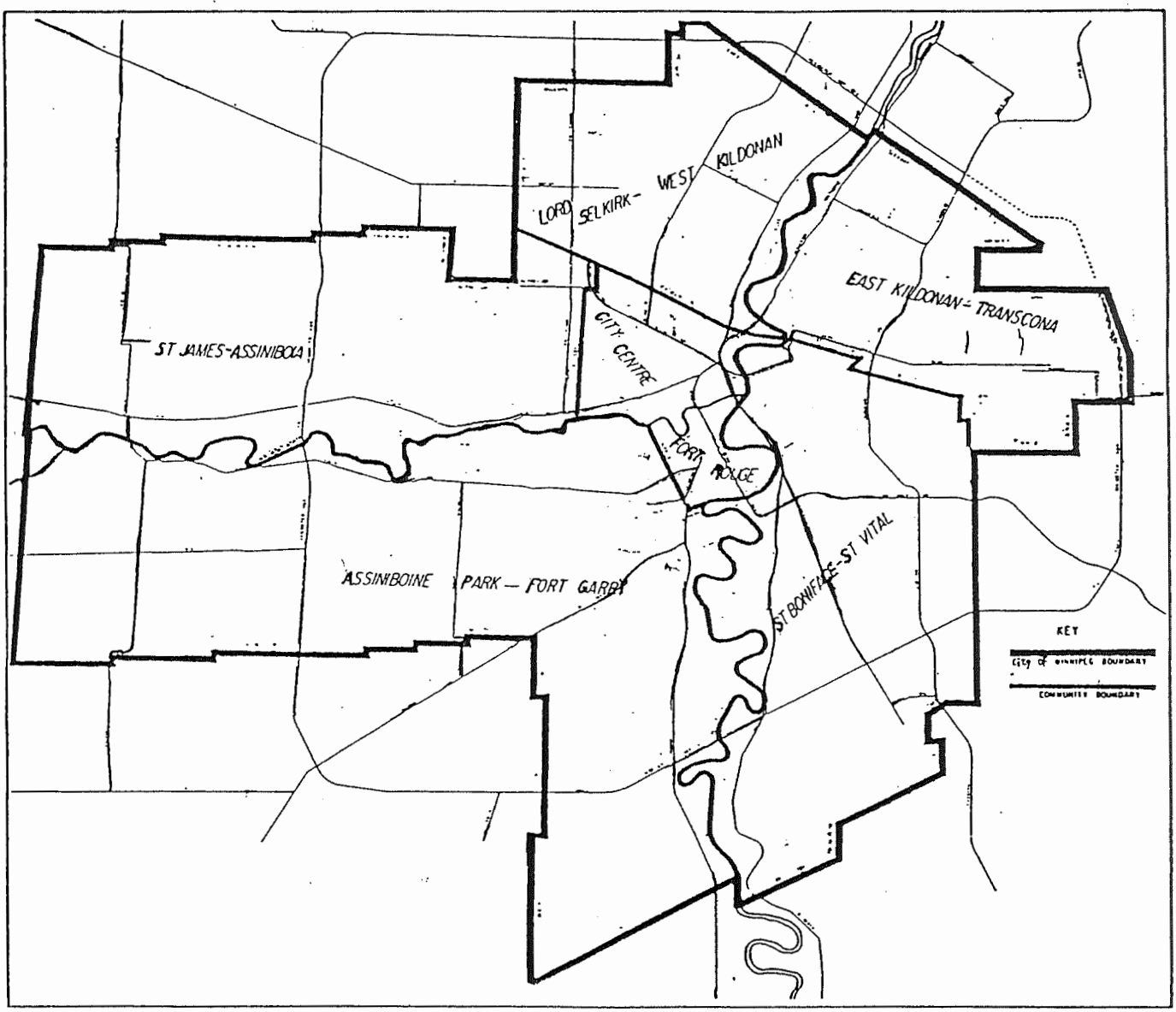
1914 - 1987



Source: I.U.S. files

figure ii

CITY OF WINNIPEG COMMUNITY COMMITTEE AREAS



Source: City of Winnipeg Department of Environmental Planning

of greater public participation under Unicity, despite unfavourable attitudes of public officials and a lack of basic resources, such as adequate information, encouragement and tangible rewards (for Resident Advisors, for example)" (Wichern, 1984, p.51). Carter, however, has called for clarification of the roles, functions and authority of both the Community Committees and the Residents' Advisory Groups to ensure the system adequately informs and consults the public, encourages public participation and provides the proper degree of local control over local matters (Carter, 1989, p. 1).

Each community in Winnipeg has been further subdivided into "characterization areas," neighbourhoods defined in 1984 on the basis of land use, transportation routes, etc. The basic assumption is that neighbourhoods are the basic building blocks from which a city is physically and socially constructed, and therefore data gathered on this basis fits city administration, public information and research (Bell et al., 1984). Bell and Department of Environment planners have produced a *City of Winnipeg Atlas* on the basis of the areas. Also, the city does use the areas in planning, decision making and evaluation, and data are available for a variety of social indicators on that basis.

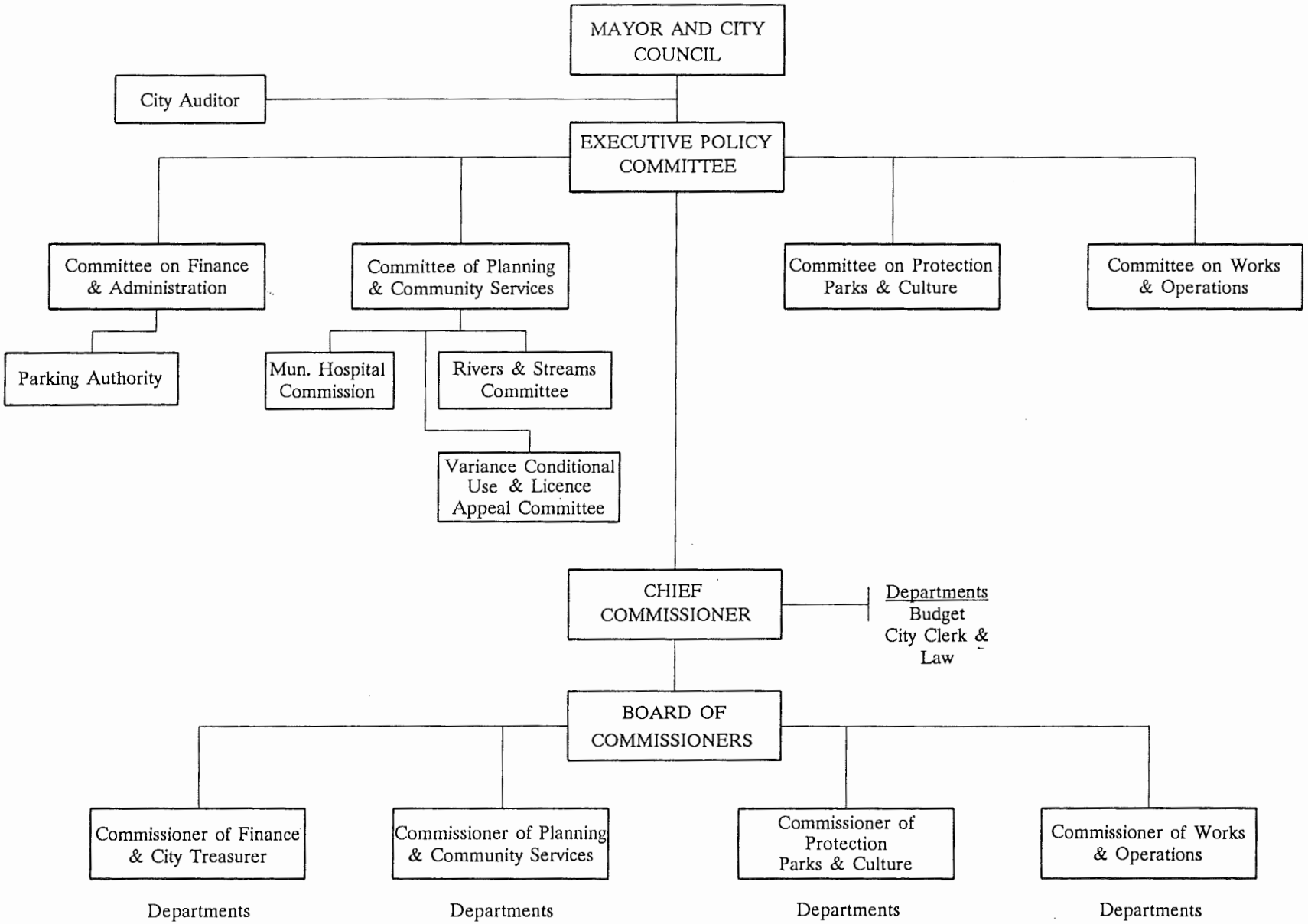
Figure iii shows the structure of municipal government in Winnipeg. Not included in the chart are the departments headed by the various commissioners. They are: under the Commissioner of Finance and City Treasurer: Assessment, Civic Properties, Computer Services, Finance, Land Surveys and Real Estate, Personnel, and Purchasing; under the Commissioner of Planning and Community Services: Environmental Planning, Health, Library, and Social Services; under the Commissioner of Protection, Parks and Culture: Ambulance, Fire, Parks and Recreation, and Police; and under the Commissioner of Works and Operations: Hydro-Electric Operations, Streets and Transportation, Transit, and Waterworks Waste and Disposal.

As to how decisions are made within the structure, an idea originating within a department would go through the hierarchy by a particular route, perhaps taking several weeks to complete the various milestones. At each stage, recommendations are made; the idea may be accepted "as is," required to be revised, or rejected, in which case resubmission is possible. As an example, a report arising from the Health Department would be taken by the Department Head, Dr. D. Gemmill, along with his recommendations, to the Commissioner of Planning and Community Services, Mr. T. Yauk. It would then proceed, with recommendations, to the Board of Commissioners. That body, which meets once a week, is comprised of Mr. Yauk, the other three commissioners, and Chief Commissioner, Mr. R. Frost. The chairperson of Executive Planning Committee, Councillor G. Savoie, is *ex officio* member of this committee; so is Mayor W. Norrie, who is *ex officio* member of all the committees. All being well at that stage, the report and recommendations would proceed to the Standing Committee on Planning and Community Services, which is comprised of six councillors, the Commissioner of Planning and

Community Services, and chairperson, Councillor E. Gilroy. It is not uncommon for Department Heads to speak to the committee on the proposal, perhaps along with other staff members. The media are usually present at the meetings, which take place every three weeks. The penultimate "hurdle" is the Executive Policy Committee, which is comprised of Chairman G. Savoie, the chairpersons of the four standing committees (Planning and Community Services; Finance and Administration; Protection, Parks and Culture; and Works and Operations) and the Mayor. Finally, the Mayor and councillors may discuss the idea and the recommendations of Executive Policy Committee in council. Presentations at this stage may come from councillors or citizens, and have not necessarily had to take the "internal" route to get there; neither does manoeuvring the route guarantee passage through council.

Figure iii

GOVERNMENT STRUCTURE



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APPENDIX D

SUMMARY NOTES, HWAC MEETINGS AND GRADUATE STUDENT PROJECTS

HEALTHY WINNIPEG ADVISORY COMMITTEE WORKSHOPS

JANUARY 27, 1989

1. WHAT IS HEALTH? HOW IS HEALTH DESCRIBED? WHAT IS A FUNCTIONAL CONCEPT OF HEALTH?
   - Health is a resource, a capacity or capability to carry out a complex of life roles to a maximum potential.
   - Health is well-being--physical, spiritual, mental, emotional, social intellectual.
   - Health is subjective and implies a quality of life, satisfaction with one's own state, peace of mind (low stress), high energy, motivation, and a general balance.

2. WHAT ARE THE BARRIERS TO GETTING THE MEANS? WHAT ARE SOME OF THE BARRIERS IN WINNIPEG TO BECOMING A HEALTHY CITY?
   - A narrow, outdated definition of health, supported by:
     - a lack of knowledge of health problems and their relationship to social and other factors
     - the prevalence of jargon within various sectors--health, planning, others; the volume of change that is needed for the new perspective, including education at all levels
   - Unwillingness of individuals, departments and systems to change, supported by:
     - a lack of knowledge of how to effect change, including inequality of access to doing and influencing decisions
     - individual, family and community time management problems
     - system related inertia from the timing of budgets, election related project management and therefore systems are reactive, not proactive
     - professional territoriality and vested interests of professional groups
     - a lack of attention to the relation of health factors and geographic location in the city
   - We need to transfer the new definition to implementation. The system is not geared to measuring health in its new definition. We need to develop effective ways to set priorities and achievable targets and effective evaluation methods of health and health promotion, ones that consider the positive aspects of health, and not merely its deficits; we need people to be made aware of the relationship between health and social factors and the (long term) cost effectiveness of improving equity; and for everyone to accept that "the public is the expert."
   - We need to help individuals, departments and systems accept new values, for example, regarding "ownership," and to develop new habits.

MARCH 3, 1989

1. FROM YOUR PERSONAL AND/OR ORGANIZATIONAL PERSPECTIVE, WHAT DO YOU PERCEIVE TO BE THE HEALTH PROBLEMS IN WINNIPEG? (CONSIDER FACTORS THAT DIRECTLY OR INDIRECTLY ENHANCE OR COMPROMISE HEALTH)

- Rising crime rates, affecting feelings of well-being, safety.
- Lack of support networks for family units, including runaways.
- Climate in Winnipeg--especially winter extremes--affecting mobility, especially for the elderly; recreation, leisure spaces; short daylight hours lead to midwinter depressions; climate "limits" the problem of homelessness here to the extent that people cannot survive here out of doors and may move elsewhere, like some unemployed. Forcing the poor indoors may preclude awareness of poverty in the city.

* Sunny skies.*

- Illiteracy a problem we have inadequate mechanisms to deal with (1991 International Illiteracy Year provides a focus).
- Language (Social Workers, Public Health Nurses, etc. do not have language skills to deal with ethnic problems).
- Homelessness.
- Crisis mentality (with inadequate prevention capabilities). Funding, priorities need review.
- We need new approaches to problems, to assist Natives and non-Natives.
- Many organizations, but territoriality prevents working together

* Lots happening in this city at the community level, large volunteer sector, and many opportunities for exploring talents, self expression. Lots of diversity adds excitement, strength.

* The city is still a manageable size, with accessible city councillors. RAGs could provide mechanism for public participation.

- Changing class structure, the poor may become more neglected as middle class increases.
- No "vision" in the city (a problem that media could help solve?). Leadership lacks vision too.
- Disrepair of streets, houses. Gentrification leads to dislocation, unrest.
- Urban/rural problem of Manitoba creates problems related to funding of services, etc., and jurisdiction problems (need collaboration, an interdisciplinary focus).

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*Assets.

- Instability of income, though the condition of the poor here may be better than other places (little gross malnutrition, etc.).
- Winnipeg is isolated, may be slow to respond.

2. WHAT IS NEEDED TO IMPROVE THESE HEALTH PROBLEMS? (THINK IN TERMS OF STRATEGIES AND VEHICLES NECESSARY TO IMPROVE HEALTH).
   - Community-based program based on a meaningful community education program.
   - Organizations need to decide if they want to participate in such a program.
   - We must empower the people in order to bring about the changes that need to be made.
   - Education systems need refocusing, new strategies, and we need an education process that gets a new, positive definition of health into the community, starting at the community level.
   - Need to have effective demonstration, participation by the public, making it aware of rights and responsibilities; to get redistribution, we must demonstrate success.
   - Eliminate political response to political special interest groups.
   - Educate everyone, especially the young, that all advances come from someone "doing something."
   - Leadership needs vision. As pride grows, people may look at things they would not otherwise.
   - Use the media to educate, construct a vision that emphasizes rights and responsibilities.
   - Resources could be used differently (do not underestimate the effort and time needed to negotiate roles and responsibilities of participants).

3. HOW MIGHT A WINNIPEG HEALTHY COMMUNITY PROJECT CONTRIBUTE TO THE IMPROVEMENT OF HEALTH?
   - If it leads to empowerment (we need a community development process, need to adjust the city's decision processes to foster participation, need changes in policies and services to empower).
   - If we have specific projects that are early and successful and lead to positive attitudes.

4. WHAT WOULD BE AN EFFECTIVE APPROACH TO INITIATING A WINNIPEG HEALTHY COMMUNITY PROJECT?

- Define the players (Who will undertake the project? Who will define the players?) Leadership? Initially, perhaps an individual. Acceptance in city hall may arouse interest there, e.g., with the proclamation event, especially since this is an election year.
- Definition of health is crucial--people must understand the processes in health.
- Initiate an amendment to Plan Winnipeg which includes a definition of health (anyone can do this).
- Because of heavy municipal government involvement in the project (see prerequisites list), need to sell the idea to municipal government and they must assume a central role. Raise awareness of city government. Does the steering committee have to ensure there is public participation? Who defines what public participation will be? Need effective, broadly based advisory committee that has a central concern for public participation (RAGs?) All the initiatives required for the project seem to be municipal--resolution, etc. The problem stems from the fact the project was "borrowed" from Europe, where city governments were looking for a way to implement HFA. In Canada, health is not municipal and the structure does not fit--municipal governments can get away with just declaring a HC project and little else.
- How you educate council in the first place is very important, e.g., on what the resolution entails.
- The steering committee can still work on "the outside," setting agenda, strategies, etc. A potential problem is how does one seek participation at the appropriate city level? Have to talk to the mayor, ensure it does not get slotted into the health department.
- Educating the community and assessing their needs is time consuming (e.g., the vision workshops of Rouyn/Noranda took 6 months) but might work here because of community organization.
- We must not lose sight of all the constituencies out there--groups that are not empowered at the moment need to be empowered at the point of starting off so they will be heard and included. Non-governmental organizations must be considered--we are changing the thinking of whole groups of people and the way we deal with people.

MARCH 16, 1989

THE WHO? WHAT? AND HOW? OF A WINNIPEG PROJECT WERE DISCUSSED.

- WHO? Start-Up members would likely arise from the HWAC, and the "second tier" would be larger and representative. City council "targets" might be S. Timm-Rudolph, D. Mitchelson, C. Lorenz. H. Macdonald and J. Eadie are FCM Council reps to FCM. Decide if the steering

committee is to work "inside" or "outside" municipal structure; likely outside, using staff resources of committee members.

- WHAT? Projects will be defined by community participation, but healthy public policy, public participation and intersectoral approach will be part of it.
- HOW? Could lobby the Community Committees or the Standing Committee (Planning and Community Services). Watch that the project is not labelled a "health issue"

Perhaps have a half-day forum, inviting councillors, department heads and others likely to be involved with the decision. Perhaps an event associated with the completion of the sabbatical report, which could also be used to inform. Perhaps the city-wide RAG meeting. Could start the process asking Department of the Environment to prepare a report. Need an advocate (T.Yauk?). We are involved in creating a small revolution at city hall; tackling inequities has not been seen by city governments as their task, and we are asking them to change that and add public participation and an interdepartmental approach. Need a concerted effort to accomplish this task.

EXECUTIVE SUMMARY, STRATEGIC PLANNING REPORT, THE IMPLEMENTATION OF A HEALTHY WINNIPEG PROGRAM

D. Clare, E. Love, V. Mann and G. Prouten, 1989**

The hypothetical Consulting Group has produced a Strategic Planning Report to be used to organize design, implement and evaluate a Healthy Winnipeg Program.

Health has always been a concern of people in communities. From ancient times until today, leaders have attempted to solve the social problems which affect the health of individuals or groups. The focus of the strategies has changed from socio-cultural solutions to primarily medical solutions, and now to ecological solutions with the individual interacting in his/her environment.

Health is defined in its most global and holistic context, utilizing and integrating the World Health Organization's definition as well as those from other prominent sources. Healthy City was defined using Hancock's (1987) definition. Goals and objectives for the Healthy Winnipeg Project were outlined. Parameters for a Healthy City were also identified.

This report postulates that by enhancing the health of cities and their people, human health and well-being in an industrialized world would be improved. Various definitions for a city were examined. The Consulting Group determined that the best definition for use in this program was that of Community.

Creating a Healthy Winnipeg requires strategies built on sound theories, principles, and models. A variety of theories and models are reviewed. The strategic Planning Report is guided by the Principles delineated by WHO (Hancock and Duhl, 1985) a multisectoral approach and a community participation approach. Both principles are incorporated into the Framework for Health Promotion (Health and Welfare Canada, 1986) and the community-based Health Promotion model (Gelskey ad Harvey, 1987). Community organization coherence, diffusion of organizations, social support and social networks, cognitive theories of beliefs and attitudes relating to behaviours, social learning theory motivations and action structures, mass persuasion and systems approach to evaluation have all been reviewed.

Since WHO's inception of the Healthy Cities Project in 1986, the concept has attracted wide attention. Numerous European and Canadian cities are beginning to plan for action. The approaches reviewed are mainly of a managerial style with indications of intent to seek intersectoral and community collaboration. The process of developing Healthy Cities/Communities will be ongoing.

**A paper prepared by Health Education Masters Students, University of Manitoba, January-April 1989.

The model chosen for the development of this program was Gelskey and Harvey's (1986) Community Based Health Promotion (CBHP) model. Integrated into the CBHP model at the level of "Planning Programs" is the Systems Model for Community Programs (Raeburn, 1979).

A brief vignette of Winnipeg has been included in order to promote a comprehensive intersectoral view of the city. While the CBHP model is a generic process model, the authors have attempted, wherever possible, to use Winnipeg as the case example.

The operationalization of the CBHP model is conceived to be through the formation of a city-wide steering committee (The Winnipeg Healthy Communities Facilitation Committee or WHCFC) and six local community steering committees (LCS committees). The primary role of the WHCFC is one of facilitating the work of the LCS committees so that decision making and control remain at the community level. Membership functions and methods of forming these committees have been described.

Community programming is discussed at the local level using Raeburn and Seymour's (1979) Systems Model in the development of a strategic plan for local programming. Briefly addressed is the city-wide level strategic programming. Specific detailing of the programs is limited by the generic orientation of the community.

The evaluation design chosen for the Healthy Winnipeg Program consists of two levels and two types of evaluation. The types of evaluation are summative and formative. The levels of evaluation are the Healthy Winnipeg Program level and the Local Community Level Program.

The Healthy Winnipeg Program is composed of three developmental phases that occur over a six year time period.

A budget has been developed for the first two years of operation. It includes the core costs associated with the city-wide organizational structure, staffing and programming. It does not include costs associated with the implementation of local community programs, as each LCS committee is responsible for securing the necessary financial resources.

WINNIPEG: A HEALTHY CITY INITIATIVE SUMMARY REPORT (CONCLUSION)***

Winnipeg: A Healthy City Initiative reviews health above and beyond the disease-oriented health care delivery system. This report begins with an overview of health promotion, health promotion indicators and the philosophical roots of planning within the field of health promotion. A multi-disciplinary, multi-faceted and multi-sectoral approach to health promotion, this document reviews many of the root causes

***A study undertaken by Master II students in the Department of City Planning, University of Manitoba, in fulfilling the requirements for a second year course in Land Development, January-April, 1989.

of "ill-being" in the city of Winnipeg. The city's economy, current environmental issues. the built environment and the social environment are examined in as comprehensive a manner as possible.

Prior to an in-depth analysis and synthesis, three goal statements were formulated. Using these goal statements as a measure of attaining a healthy Winnipeg, a number of issue-specific and subgroup-specific recommendations were formulated. It was observed that in order to improve health in Winnipeg, participation is required from both the public and private sectors of society, as well as from all levels of government. While striving to achieve the outlined goals, it became evident that a number of broad-range policies are common to all aspects of health reviewed in this report. These policies are as follows:

- Create a city-supported environmental health committee to pursue the interests of health for all city residents.
- Develop a public forum to facilitate public participation in a civic healthy city movement.
- Promote public awareness of healthy city issues and concerns. This includes developing a wide public education program, possibly including public school, workplaces, a public information department and promotional slogans in government-issued utility bills.
- The city of Winnipeg should conduct a continuing health audit of its services by examining its public policies for their effect on health.
- Representation on the health audit board should be multi-sectoral, including representatives from all council departments, voluntary and institutional health related sectors, and individuals from Winnipeg's six designated communities.
- Winnipeg should undertake a comprehensive assessment of present health conditions in the city. Such a report should incorporate relationship and aspect of health not fully addressed in this report.
- The Master II Study Group offers this document as a foundation for an approach which will achieve a better level of health for citizens of the city of Winnipeg. The starting point for accomplishing this was the implementation of he recommendations listed above.
- We believe this document provides vision for developing our city so as to facilitate maximum health and well-being for residents and for the community as a whole.

APPENDIX E

TEXT FOR HEALTHY CITY GUIDED IMAGERY

T. Hancock (1988)[****]

Now we are going to take a trip to the future, to an ideally healthy Winnipeg (or Fort Rouge, or wherever) about 20 years from now. This is not _____ as it is today, nor is it the place we think it probably will be--this is _____ as we would like it to be if everything worked out well and we truly became a healthy city.[*****] So make yourself comfortable--you may find it useful to close your eyes so that you can more easily "see" the future city in your mind's eye.

Now I want you to imagine that you are hovering over _____, a couple of hundred thousand feet in the air, perhaps in a balloon or a helicopter over an ideally healthy _____ about 20 years hence. Look down at the city beneath you. What does it look like? What colours and shapes do you see? What time of year is it? What would it look like at different times of the year? Look out across the city and look at the shapes of the buildings and structures of the city. Can you see how people and goods move to and fro? What sounds come up to you from _____ and what smells?

Now I want you to descend slowly toward the centre of the city, looking as you come down at the shapes and structures of the buildings and the public spaces. We are going to land in the centre of the area in the morning of a working day. As you get closer to the ground, listen again to the sounds and smell again the scents of the city. Land in the centre of a public space downtown and look around you.

Who is there? What ages? What are they doing? How are they getting around? How do they react to you and to each other? What does this space look like? How safe does it feel? Walk around the downtown area. What activities are going on? Where are people working? What sort of work are they doing? Who is doing it? What else are they doing apart from work?

Walk into a workplace--it could be an office, a store, a school, an industrial setting--and look at who is working there? How do they look, how does this place feel as a place to work? Is it a good place to work? How are the people there interacting with each other? Now go into a different sort of workplace and see what's happening there and how it feels.

Now imagine yourself in a different part of the city, perhaps out in the suburbs, on a working day. How is it different? What activities are going on there? What's happening back in the neighbourhoods

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[****]From T. Hancock, "Healthy Toronto 2000, A Vision of a Healthy City," in J. Ashton and T. Hancock, *Healthy Cities, Concepts and Visions* (Liverpool: University of Liverpool, Department of Community Medicine, 1988). The text should be spoken slowly, taking five to ten minutes, allowing plenty of time for people to "look around" and make an image for themselves.

[*****]Use "community" for "city" where appropriate.

and the community during this working day? Imagine now that it's lunchtime. Where are the people going for their lunch? What sort of food are they eating? How does it look, how does it smell? What else are people doing apart from eating? What sort of stores are there? Walk into a store and look around. What is being sold? How is it being sold? What sorts of goods and products and materials are available? How do they relate to the healthfulness of the city?

As the work day draws to an end, go home with someone from a place of work. How does that person get home? Where is home? How far are they travelling? Walk with people through their neighbourhood. Remember, this is an ideally healthy neighbourhood. How does it look? What sort of buildings are there, what sort of open spaces, what facilities and services. Who lives there? How do they relate to each other? How does the neighbourhood feel? Do you feel safe? What sort of stores and services and facilities are available?

Now walk down the street where this person lives. Who is living there? What ages, what sort of families, what cultural groups? Go with them into their homes. What does it look like, is it a house or is it an apartment? What sort of living arrangements do they have? Who is living there, is it a family, and who is in the family? How does the family and the household feel? What are they doing? How do they earn their living? Are there kids? Where do they go to school, and what are they learning about life and health?

Imagine now it is dinner. What are people eating in this household? How is the food? Who is there to eat it? And after dinner, what does the family do? How do people relax--or do they relax? What do they do with their free time in the evenings or is it free?

Now walk out into the community again, now it is dark. How does it feel to be out on the streets at night? Who is out there? What's going on in the neighbourhood and the community?

Now go downtown. How do you get there in the evening? What's going on downtown, what does it feel like to be downtown at night?

Now imagine that it is a weekend, pick any season of the year you like. Remember, this is your ideally healthy community. What do people do on their weekends? What do they do with their leisure time? What recreational, educational or other activities do they undertake? What is going on in the city and in the neighbourhood? Are people leaving town? If so, how are they leaving and where are they going? Are people working at the weekend? Who is working? What sort of work are they doing? Now imagine it is a different season. What is happening over the weekend in this season? What activities are available to people?

Now, before we leave this ideally healthy city, think back on all you have seen. Think about whether you saw the very young and the very old, the disabled, minority groups, the rich and the poor? Did you find them in the city? How is life for them?

Now I want you to come slowly back to the present time, reflecting on all you have seen, and then write down a dozen or so of the most striking things you saw, heard, smelled or touched. Write down the things that surprised you, the things that pleased you, the things that upset you. What was it that made an impression on you about this ideally healthy city?

APPENDIX F

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