THE HEALTHY CITIES, VILLAGES, AND NEIGHBOURHOODS CONCEPT

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Introduction

Health is promoted, protected, maintained, and restored, or in the event of an incurable condition, controlled and palliated by the individual and by the coordinated actions of medical professionals and workers, citizens and institutions among which local administrations feature prominently.

The healthy cities concept, which I prefer to call the healthy cities, villages, and neighbourhood (HCVN) concept, is an innovative approach to an integrated and comprehensive health programme. Community participation, multisector cooperation, and accountability are key features. The concept grew out of theoretical considerations at the World Health Organisation (WHO) and from the experience of Liverpool according to the British or research in Toronto according to the Canadians.

The concept is an extension of the Declaration of Alma-Ata[1] which states inter alia:

> Economic and social development ... is of basic importance to the fullest attainment of health
>
> Primary health care includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child care, ...
>
> Primary health care involves in addition to the health sector all related sectors and aspects of ... development ... and demands the coordinated efforts of all those sectors
>
> All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors

The HCVN concept also incorporates targets from WHO's Regional Committee for Europe document, Health for all by the Year 2000[2] which state:

Target 13:

> [N]ational policies in all member states should ensure that legislative, administrative, and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making

Target 18:

> [M]ember states should have multisectoral policies that effectively protect the human environment from health hazards, ensure community awareness and involvement

Target 30:

> [A]ll member states should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level

Another component of the healthy cities or the HCVN concept is reflected in their names: their operational base is a decentralised local body or authority whether a city, a town, a village, or even a neighbourhood. As these decentralised bodies often have, or can be delegated, legislative power and administrative infrastructures to implement multisectoral policies and community-based projects, they could, should, and have, in fact become the targets for implementation.

The healthy cities concept was first introduced during an international conference in Toronto in 1984. It spread to Europe by 1986. A network involving over a hundred cities emerged in Canada, in Australia, and in nearly all European countries. In Britain, Glasgow, Belfast, Harlow, Oxford, and Liverpool had by 1988 started healthy cities projects. Next year or the year thereafter will be WHO's healthy cities year. We should aim to be there with a South African city, town, village, or neighbourhood!

A conference on healthy cities was held in Liverpool in March 1988. It published a declaration which borrowed from William Morris who wrote:

> At least I know this, that if a person is overworked in any degree, they cannot enjoy the sort of health I am speaking of; nor if they are continually chained to one dull round of mechanical work with no hope at the other end of it; nor if they live in continual sordid anxiety for their livelihood; nor if they are ill-housed; nor if they are deprived of all enjoyment of the natural beauty of the

world; nor if they have no amusement to quicken the flow of their spirits from time to time; all these things, which touch more or less directly on their bodily condition, are born of the claim I make to live in good health."

The Liverpool Declaration[3] made 8 points:

1. the right to health

   In recognising every citizen's right to health, we accept the responsibility carried by all agencies throughout our society to take account of the public health costs of all their activities

2. equity in health – the reduction of inequality

   We reject all forms of discrimination that reduces people's chances of good health and accept the challenge of substantially reducing current health inequalities

3. community participation

   We acknowledge the necessity for meaningful public participation in all processes and activities that affect people's health

4. intersectoral collaboration

   We will work with all agencies and groups whose activities are relevant to the promotion of the public health

5. health promotion

   We acknowledge our collective responsibility to promote and create healthy physical and social environments and to facilitate people's choices of healthy lives

6. primary health care
7. international cooperation
8. research, data-based planning and evaluation

The HCVN concept also parallels in part the thinking as set out in the 1988 Acheson Report[4] – a revival of the old Victorian public health programme. The Public Health Act of 1848 and the Housing Acts of the late 19th century were all concerned with disease control and used housing intervention to promote public health. The Acheson Report was however criticised for under-acknowledging the role of local

authorities and the voluntary sector in providing public services. This inadequate recognition probably reflects the current medical paradigm, prevalent among doctors and patients, and one which could also undermine the HCVN initiative.

The word "health" should be used correctly and preventive and curative medical intervention should not be called "health care". It is therefore also useful to add to the WHO definition of health as “a state of complete physical, mental, and social well-being” that of Illich[5]:

> Health ... is simply an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions. ... [H]ealthy is an adjective that qualifies ethical and political actions ... which condition the milieu and create those circumstances that favour self-reliance, autonomy, and dignity ...

Because action is decentralised to a local authority, bureaucracy is minimised. Within the HCVN definition power and responsibility is even devolved to grassroots level where appropriate. The HCVN concept also presupposes the operation of two important processes which it seems everybody supports: participation and accountability. Accountability of the functionaries to the community of which they are a very obvious and immediate part is enabled by the check that members of the community can exercise on their (hopefully elected) representatives on the local authority or the voluntary group/s involved in the project/s.

Examples of HCVN projects

I am basing much of this presentation on the experience in Quebec.[6] The first place in Canada to become officially involved in 1987 in a healthy cities project was Rouyn-Noranda, a mining town of 27,000 inhabitants. It borrowed the idea from California and the technique of strategic visions workshops from Trevor Hancock.[7]

The healthy cities concept spread rapidly within Quebec. By 1988 more than 35 places were interested and 13 of these – large and small, urban and rural – had committed themselves to healthy cities projects. Ideas were exchanged by the municipalities associated with the Quebec Network of Healthy Cities and Villages. Despite their diversity (and this diversity is part of its appeal and strength) healthy cities projects have much in common:

- a global vision of health and the community
- an official commitment by the municipal governments to participate as partners and facilitators of multisector health-related actions
- encouragement of municipalities to give proper consideration to health matters while reaching decisions within their jurisdictions

- encouragement to foster health promotion actions when contributions from all sectors of the community are required
- a determination to undertake concrete actions
- creativity and cooperation among several sectors of the community
- the active participation of citizens
- self-reliance.

Several reasons for the speed of the spread of the healthy cities movement in Quebec are noted:

1. self-reliance (of special importance in small municipalities)

2. assistance (information dissemination, documentation, and advice) from a special healthy cities information and promotion centre established by the Association for Public Health in Quebec and a committee of the Saint-Sacrament Hospital. The centre concentrates its support on municipalities that are truly committed and it publicises the achievements in order to encourage and motivate others

3. the time was right/favourable:

    - there was public interest in the "quality of life"
    - municipalities were interested in general welfare
    - citizens were sensitive to the health impact of decisions taken by local and central government
    - the size, complexity, and rigidity of centralised public administration made it difficult to adapt interventions to regional and local realities
    - opportunities for citizens to participate in decisions taken centrally, were limited
    - citizens realised that they could not rely solely on the state to meet their needs

4. the existence and use of networks in health and other sectors, both within the state and among voluntary organisations. These facilitated formal and efficient contacts with all kinds of people.

Scope of the HCVN concept

The HCVN concept emphasises disease prevention and to a lesser extent health protection and promotion relegating medical care to a complementary role. The concept stresses those environmental determinants of health and disease that are amenable to action at a local level by civic groups in partnership with administrative bodies, non-governmental organisations, and private enterprise. The HCVN concept

implies that people act in control of their own health independently, but not to the exclusion, of medical service providers.

We should look at the major causes of distress, disease, disability, and death (4Ds), outline their direct and indirect determinants and/or risk factors and plan strategies within the HCVN framework to address these. It is possible to say and for all to agree that the major causes of the 4Ds in South Africa today include:

> gastro-enteritis, under-nutrition, over-nutrition, and wrong nutrition (malnutrition), measles, pulmonary tuberculosis (PTB), acute and other respiratory infections, other respiratory diseases (many due to tobacco smoke and other micro- and macro-environmental pollutants), hypertension, related cardio-vascular diseases, diabetes, other diseases collectively referred to as the metabolic syndrome, cancers, mental ill-health, musculo-skeletal distress syndromes (MSDS), dental caries, sexually transmitted diseases (STDs), physical injury, …

It is also possible to draw up a list of risk factors for these conditions such as:

> poverty (unemployment, cheap labour), poor housing, homelessness, disrupted family and social life, migrant labour, rootlessness, mean and polluted physical environment, unsafe and unhealthy working conditions, food insecurity, inadequate access to clean water and safe and affordable fuel, transport, and healthy food, compounded by the scourges of evictions and forced removals, effective tools of ideologically motivated social engineering and ethnic cleansing, ... almost in a word: APARTHEID.

According to Durning from Worldwatch Institute[8]

> Apartheid has been as disastrous for South Africa's environment as for its people. Institutionalised racism has polluted the air and water, pillaged the bedrock and ripped away the earth ... [It] has turned the homelands ... into ecological wastelands. Pretoria has allowed mines to ignore common safety and pollution precautions ... and has developed an energy policy that makes it among the most polluting nations. [I]ts wars against neighbours have devastated endangered plant and animal species.

From this list factors that can be ameliorated or eliminated locally can be identified as sites of action within dedicated customised HCVN projects. I quote what has been said by others on some of the more important of these factors in the hope that perhaps you will more readily accept what others say, rather than what I say.

Tony Davis in his 1976 Medical Officer of Health Report for Salisbury (Harare) identified what he called “three massive and overriding problems”:

1. the continued inability of this city to house employed men and their families adequately. The concern of the City Health Department is based firmly on the well-documented evidence of the intimate connection between adequate housing and ... health

2. the tendency to entrench commuting ... as a feature of the workman's life. There is good evidence that the failure to preserve the proximity of employment and residence is destructive not only of nuclear family life but also of the identity and cohesion of communities within the city

3. the universal adoption of free-flow as the basis of traffic engineering [to accommodate] the increasing use of private motor vehicles. ... [I]n ensuring the free-flow and uninterrupted access of traffic to and from cities, we are destroying the cities themselves

The WHO[9] stressed the need to reduce the "cruel toll of death and disease directly attributable to the appalling living conditions of one quarter of the world's population".

Stella Lowry in a series of articles on Housing and Health[10] in the British Medical Journal highlighted aspects of housing relevant to health:

> Sanitation has had, and continues to have, more impact on health than any advance in medical science.
>
> Access to ... basic amenities of a kitchen sink, wash hand basin, shower or bath, and indoor toilet ... is important in determining health: studies of people rehoused from slums have shown that standards of hygiene rise when clean water is freely available, even without specific educational programmes.
>
> Homelessness is bad for health. The consequences of life on the streets are all too obvious but hostel dwellers are often little better off. Living in bed and breakfast accommodation is also damaging to health, yet some of our [UK] most vulnerable groups are increasingly being placed in these conditions

She also noted that "[h]ouses should not be designed just to prevent harm to their occupants but also to promote health". This echoes what Tony Davies implicitly warned against in his 1973 Medical Officer of Health Report for Salisbury:

> [E]ngineering in concrete, asphalt and steel has in most instances taken precedence over the principles established by the behavioural sciences and modern sociological research findings.

Don Pinnock elaborated on the role of community and family structures – the social environment – when he wrote[11] that:

> [T]he extended family maintained the vital relationships needed in the struggle for survival in ... District Six [a slum area in Cape Town] and other similar areas. They provided accommodation, limited capital, and labour for small-scale production and services, as well as maps of meaning for migrants from the countryside. But they also provided more than this: they acted as networks of social control.

Social and cultural alienation and alcohol abuse impact negatively on health as Dr de Miranda from the South African National Council on Alcohol implied when he referred[12] to social and community interventions on alcohol abuse in Canada:

> The "forced imposition of foreign strange values" on the Amerindians in Canada was associated with a "massive increase in suicides." Alcoholism affected whole villages. A 100% prevalence of "severe alcohol abuse is reported resulting in the literal decimation ... of all age groups". Intervention programmes included action on education, health, land ownership and the assertion of minority rights. These were run by the people themselves.

He also noted the results of a youth forum in Canada on preventive strategies against alcohol and drug dependency. I list some relevant points:

- extend drug-free activities
- say NO is a waste of time
- re-establish cultural values
- more involvement of private enterprise
- use young people in programmes

The role of personal medical care and its providers

Prof Davis in his 1977 Medical Officer of Health Report for Salisbury remarked on the limited role of medical services:

> Society and individuals have an essential and key role in the maintenance of health. There is an urgent need for much wider and more active cooperation from individuals ... Professionally managed health services with the best will in the world cannot provide more than the mechanics of health care, and then only in certain fields.

Mc Kweown[13] was more critical. He wrote:

> [T]he recognition of the limited impact of medical procedures was a key which would unlock many doors. Misinterpretation of the major influences, particularly personal medical care, on past and future improvements in health has led to misuse of resources and distortion of the role of medicine.
>
> Past improvement [in health] has been due mainly to modification of behaviour and changes in environment, and it is to these same influences that we must look particularly for further advance.

Stella Lowry in the BMJ series on housing and health[14] wrote that:

> There has been a change of emphasis in public health in the 1970s and 1980s. Health issues have become individualised – people should stop smoking, eat less fat, use condoms, not share needles, have regular cervical smears. Even the campaigns to prevent hypothermia have degenerated into an obsession with individual behaviour: stay in one room, wear several layers of clothes, and knit yourself a woolly hat. [W]e have become so obsessed with individual responsibility [and personal medical care] that we have stopped looking at how more widespread intervention might help.

But hopefully:

> The complacency of the 70s and early 80s is fading, and housing is emerging as a major public health issue again.
>
> Modern medicine is as much about prevention as cure, and doctors have a role in campaigning for better housing conditions. Providing more and better housing is a cost effective way of improving people's health.
>
> Doctors still have a role in ... campaigning for an end to ... overcrowded, unsanitary conditions.

She also quotes from a British Medical Association's report[15] which summed up the doctors' role thus:

> Doctors are responsible for promoting health as well as treating illness, and doctors share with other disciplines a responsibility to suggest social policies which might prevent avoidable illness.

Illich[4] while criticising the medical service sector nevertheless recognised its important supplementary role in an autonomous people-centred society:

> The destructive power of medical over-expansion does not of course mean that sanitation, inoculation and vector control, well-distributed health education, healthy architecture and safe machinery, general competence in first aid, equally distributed access to dental and primary medical care, as well as judiciously selected complex services, could not all fit into a truly modern culture that fostered self-care and autonomy.

What is to be done?

With this albeit simplistic analysis in mind, the medical and allied professions (MAP) industry should rephrase its priorities. I propose that they adopt the HCVN movement. I recognise that the MAP industry could feel very threatened by this option but hope that most members of the industry could find a new and meaningful role (but with adjusted/deflated egos) within the HCVN movement.

As Dr Halfdan Mahler said in 1975 when Director General of the WHO:

> [T]here is some middle ground between those [doctors or the MAP industry] either frightened of any change or confidently proud of present achievements, and the grim and embarrassing rationalists wanting to make a new start because they consider that the present system is an adapted historical accident, unjustifiable on any grounds, and following its own professional path divorced from people's needs ....

John Ashton, the guru of HCVN, from the Department of Community Medicine, University of Liverpool put is bluntly, challenging the doctors among us to re-examine our attitudes and role. He wrote[16]:

> The main threat to innovation comes from dogs in a manger; they become really dangerous when they [state] that it is people who are not doing what they should … but are damned if they let anybody else do it.
>
> When you try to innovate ... you will be told that you cannot do it. When you ask why not, you'll be told that it won't work. When you ask if it has been tried, they will say no. When you explain that it has been tried elsewhere and that it works, you will be told that it won't work here. When you ask why, you will be told it is all to do with social history.

But he ends with a plea to try. He says that “[t]he way to break into this cycle of inertia is through [good] local demonstration models ...”

The HCVN concept embodies the antithesis of two important negative processes: fragmentation and bureaucracy. Multisectoral action implies coordination, integration

and cooperation. There need be no fragmentation or duplication. In addition no sector need lose its autonomy. No body is in charge over any other. Hierarchy and hegemony are not infringed nor threatened. We all contribute within our area/s of expertise and work within our own structure/s on a joint venture. How nice!

I am not unaware of the possible hiccoughs in this rosy picture, the most glaring of which is the present unrepresentative nature of the councils in the black townships. But the vision is theoretically possible; we can make it practical. Already the government is making the right noises. In Port Elizabeth the President FW de Klerk, speaking at the Cape Province Municipal Association's congress said[17]:

> The government is committed to the greatest possible devolution of authority to the lowest effective decision-making level, a system which would give the necessary flexibility to a system which had to accommodate divergent regional and community needs. … [D]evolution of authority was only meaningful if it was accompanied by devolution of sufficient fiscal resources and authority [never mind his hidden agenda].

In the current political climate in this country, changes in local government possibly aided by a HCVN initiative can advance constitutional deliberations nationally. Jan Steyn speaking at the same congress, when referring to the provision of housing warned that "[a] political settlement ... could be seriously undermined by the crisis in urban areas". He pleaded for the poor to be given a better deal.

> Don't let us perpetuate the injustices ... by the continued destruction of our urban infrastructure – both human and physical. The time has come to build together. Let us begin by developing productive and constructive approaches towards the challenges and opportunities offered by our cities.

The gambles in the HCVN movement are considerable but the issues raised have universal relevance. I quote again from the article on Quebec. The issues include:

- changing priorities and practices in municipal government and their local partners
- sharing of responsibilities and resources between local and central governments and between governments and NGOs
- development of effective cooperation among the actors at the different levels
- mobilisation of citizens and groups and their real participation
- viability of projects
- equity within and among communities, groups, etc

Some other issues may, could, or have become constraints:

- resistance to change
- fear of dumping responsibility onto cities
- anxiety about new demands

In this country its strange history adds further gambles and/or constraints:

- the lack of credibility of the non-white urban councils (however called)
- the suspicion/mistrust of the labour union hierarchy
- the entrenched nature of the MAP establishment, their insecurity, arrogance, and their overwhelming need for a spurious and illegitimate freedom
- the isolation of South African social scientists (including the much-maligned MAP) from WHO and international thinking

THE SOUTH AFRICAN SCENE –

I asked for this meeting because I wanted to challenge you to review your thinking on health in the light of international WHO thinking, in particular their healthy cities initiative, the new public health approach in the UK as in the 1988 Acheson report, the local crisis in medical care provision and general service delivery, international and local ecological concern, the state's proposals to devolve power, deregulation and privatisation and the promise of a new South Africa in a period of rapid urbanisation with its associated problems of unemployment, urban overcrowding homelessness, alcohol and drug abuse, rural depopulation as the country gropes towards a new image and a new life.

Reasons for recommending the HCVN concept locally

There would/could be:

- closer association of conventional medical care programmes and environmental health programmes
- inter-sectoral collaboration of formal health structures with other statutory bodies (roads, industry and commerce, housing, education, recreation) and public agencies and NGOs such as green/environmental groups, child welfare, mental health, care for the aged, SANCA, ...
- community and trade unions participation in health-related matters
- health promotion and disease prevention programmes
- accountability and accessibility of services
- rational and integrated local budgeting so that the programmes can be afforded and paid for locally

Existing state thinking dovetails into some of the concepts inherent in the HCVN initiative. According to the State National Health Facilities Plan (SNHFP) the local authority is involved in:

Level 1 Satisfaction of basic needs –

- safe drinking water
- sufficient food for human existence
- sewage and refuse disposal
- reasonable housing

Level 2 Health education –

- minimum level of [basic] education and training
- health education

Level 3 Primary health care –

- self-care and community responsibility
- community health nursing
- community health centre/clinic

Level 4, 5, 6 Hospitalisation –

- only indirectly in public hospitals – bed need being affected by intervention at the preceding three levels
- private hospital regulation

According to the Browne Commission report[18] the local authority has environmental health functions and some personal health service responsibility. These extend only to health promotion, disease prevention, maternity services, infectious diseases, some ambulatory medical services, and to rehabilitation. The provincial and national departments of health are responsible for services rendered at public hospitals other than those served at local level. There have been no changes since the publication of the report in the late 1980s.

Health and disease are on a continuum and facilities and attendant personnel should not be arbitrarily segregated into separate tiers of administration – local, provincial, and national. These considerations also apply to the determinants of health and disease and to the levels of services. There is also a continuum or convergence between patients and medical personnel: patients are partner-managers in their own health and when medical personnel are sick, they are patients. The HCVN concept facilitates an easy flow along these continuums/continua (?) through integrated and

coordinated action on health and disease between civil society, public and private service providers, government, industry and commerce, the lot/us all.

I look briefly at sectors where the HCVN concept could be applied

Considerations of interest to residential areas

1. housing, water, and energy (fuel and light),
   refuse removal, storm-water drainage –

These issues are critical to health and to any HCVN programme. The local authority is responsible for providing and/or controlling these functions. It is therefore appropriate and encouraging to see both the Urban Foundation and local authority environmental control personnel (the health inspectors) at this work-shop[19].

But housing is not merely a matter of building physical structures. The implications for health must also be considered. It is necessary to:

- create an organic integrated community and not just houses (or shacks) on stands (site and service) in nice neat rows (streets)
- make provision for communal facilities for laundering and bathing, preparing food, learning, recreation, working (home industries), eating, drinking alcohol, communing, child-minding (0 - 21 years), caring for the disabled and the elderly, first-aid, and shopping – oops, I nearly forgot – for clinics
- ensure safe and uninterrupted access to potable and other-use water
- supply energy preferably from environment-friendly sources and provide for the local recycling of water and waste.

The electrification of residential areas can fundamentally alter for the better the pattern of disease, disability, and death in whole areas/neighbourhoods. The use of a non-polluting source of energy needs consideration.

2. roads, bicycle tracks, and pedestrian paths,
   safe, affordable, and accessible public transport –

Road accidents need to be prevented and physical exercise (walking, cycling, jogging) encouraged. The location of roads and the lead content of petrol are legitimate concerns for local authorities and the people in their constituency. The departments of transport, health, roads, side-walks, pavements and sports (facilities for joggers, fun-runs) etc. should be integrated as part of a HCVN programme.

In most non-white townships the condition of the roads are very bad. Public transport is dangerous. There are no facilities for cyclists and pedestrians.

3. open spaces, recreational facilities –

The need for open spaces, recreation facilities, and public amenities such as eating houses, legalised and controlled drinking gardens/pubs/shebeens, public baths, play grounds, sports fields, swimming pools, adult education and literacy programmes, libraries, reading rooms, etc., is particularly great for the poor and for those without adequate housing, and who suffer/ed from structural deprivation. These facilities could redress some existing inequality and prevent anti-social behaviour and substance abuse (including alcohol and tobacco). They would promote health and enhance the quality of life. They are essential elements in the HCVN concept.

4. environmental pollution within the residential area and from neighbouring industrial sites, waste disposal facilities, wasteland, hazardous effluents, … –

But perhaps the most important consideration in urban development is the need to ensure the proximity of places of employment and residence, with its positive spin-off in reducing the hazards, the monetary cost to society and to the individual, the inconvenience and the social disruption inherent in commuting.

Considerations of interest to trade unions

Employment per se is also critical for the health of individuals and communities, and for the success of a HCVN programme. Relevant considerations for health include:

working conditions, work-place hazards, occupational and environmental air and noise pollution, working hours, eating and ablution facilities, child-minding, first-aid and health-care provisions, transport to and from work, ...

1. occupational health and safety –

Local authority health inspectors have the training and can obtain the legal right under the Mines and Occupational Safety Act to inspect and act on conditions in the workplace.

2. primary occupational health care –

Occupational health nurses and occupational health doctors can play a vital role in promoting and protecting workers' health. They can also provide curative, control, and rehabilitative services. The law however does not demand their deployment in small industries (fewer than 50 workers) and in commercial concerns. The local authority can be paid to provide trained nursing and medical staff to meet the needs of both big and small industrial and commercial enterprises – and on site.

3. coordinated and integrated total health care –

All categories of health professionals can be employed by the local authority. Data (records) on work conditions, worker distress, disease, disability, and death, and the physical and social environment outside the workplace can be linked. Coordinated action can be planned and evaluated.

4. trade union funding and control –

The trade unions can motivate for and support the deployment of local authority inspectors, occupational hygienists, occupational health nurses, and occupational health doctors inside the place of work. The trade unions can fund a part or the whole of the service through medical benefit societies and should insist on proper access to all findings, reports, and investigations on health-related matters.

Medical Aid (fee for service) rules do not allow sufficient flexibility or the essential opportunity to exercise control. This system also does not enable a coordinated, comprehensive, and integrated approach to workers' health. Funding the service (instead of demanding/expecting free service) enables worker control, ensures that the employer contributes towards worker health (a free service from a public body is paid for out of public funds), and assists local authority budgeting.

5. open spaces, recreation facilities, canteens, public baths, and centres for nursing mothers, crèches, nursery schools … –

These can be established and maintained by the local authority. Trade unions can motivate that they be sited near places of work so that the workers can use them before, during (tea and meal breaks), and after work. Their use could enhance female emancipation, improve worker and child health, and increase production. They should be viewed as integral to a programme for worker health and safety. Commerce and industry should be encouraged to contribute towards these facilities.

6. the impact on the environment –

People, animals and plants who live near an industrial or commercial area have the right and the need to breathe clean air, to be protected from acid rain and other pollutants, and to be watered by unpolluted rivers or streams.

It is the local authority's responsibility to ensure a clean, non-polluted environment. If the local authority can control effluent disposal at source, its ability to protect the environment is facilitated. Trade unions are aware of man's responsibility towards

the balance of nature. Together with the local authority trade unions can contribute towards healthy living in a healthy city, village or neighbourhood.

7. the unemployed and those with special needs –

It is also necessary to consider the special needs of occupationally marginalised persons such as very pregnant and lactating mothers, disabled and handicapped persons, the elderly, and in our traumatised society, the long-term unemployed, those without specific skills, the illiterate, ...

Considerations of interest to the business community

1. business could participate in structured locally-controlled projects –

2. an avenue for action could address their concern for the environment –

3. business could profit financially because of:

    - more control on money spent on workers' health
    - reduced medical aid and WCA contribution, as prevention is more cost-effective than often magnificent and occasionally chillingly disastrous, high technology medicine and/or attempted disease cure or control
    - an increase in productivity from healthy workers

The need for an area-based local infrastructure was recognised as important for the efficient and productive operation of industry. This was implied in a study commissioned by the Tongaat-Hulette group[20] which investigated the problems and the possible future of the Durban Functional Region. The chairman of Tongaat-Hulette when introducing the first report of the study said that the region "must be fully integrated politically, socially and economically if it is to progress with peace and prosperity into the 21st century." Social integration implies healthy people living in a healthy environment.

In the course of this enquiry into the HCVN concept I also met with the Small Business Development Corporation (SBDC). There is a confluence of interests between the HCVN concept and the objectives of the SBDC. The SBDC could participate in the development of the concept and could incorporate health promotion and protection into its objectives. This might promote changes in aspects of their programme that have elicited criticism (deregulation and low wages – a job at any price). It believes that:

- small business development is essential for generating wealth and spreading prosperity, and for encouraging grassroots development

- community involvement is essential for an effective business development programme.

Recommendations

It is proposed that a preliminary inquiry be mounted into the objectives, structures, processes, and feasibility of a pilot HCVN project in greater Sandton (ie including Alexandra township and Marlboro).

Greater Sandton area is considered a suitable site for a pilot project because the project should be:

- based within an area defined in geographic and economic but not racial terms
- piloted by a relatively small local authority with adequate private financial resources
- sited in a community that is concerned about the environment
- developed with the support of local authorities and civic bodies with credibility in the area

Places like Witbank as discussed with the National Department of Health[21] where the need for the development of a HCVN initiative is great, are unsuitable because of the political conservatism of the white local authority.

The practical arrangements for the deployment of a HCVN programme can be neat, simple, straight-forward, rational, sensible, easy, accommodating ... just fine!

Such an inquiry should have 2 components:

1. systematic research into the concept and
2. canvassing the opinions of potential actors and funders

It is useful at this stage to look at what was done in Toronto in the pre-healthy cities era. A city council committee was appointed in 1976 to examine the role and function of public health. The committee conducted a staff survey and a community outreach process and also commissioned a study from the University of Toronto. The report[22] published in 1978 proposed that the department of public health:

- decentralise
- adopt a team management approach
- encourage more community involvement
- place more emphasis on education, promotion, and social and political advocacy and on
- data collection, research, and data-based planning.

It is even more useful to look at what was done in Rouyn-Noranda[5]:

- The municipal council became officially involved. It created a promotional committee, giving it the financial means and administrative support necessary for the launching of the project
- The committee was made up of citizens from different sectors as well as political and administrative representatives of the city ...
- The committee first undertook consultation with the community ...
- A multisector community forum with more than 150 participants, individuals, and representatives of 49 public and private organisations in the community reviewed the ideas gathered during the consultation process and translated them into action plans ...
- The activities were undertaken principally with voluntary contributions or as part of the normal functions of the people and organisations involved.

I suggest something similar. The members of the inquiry should report back to the local authorities, the civic bodies, the persons and bodies that were consulted, and to current and potential funders. A multisector community forum should then be convened to present the project to the community who should commission persons and organisations to prepare a draft programme with funds guaranteed by the forum and instruct the drafters to report back to the forum within a specified period.

The people to be invited to the forum could include local municipal councillors and officials of local authority health and other departments, the Alex Civic Organisation, the Alexandra Health Centre and University Clinic, the Sandton Foundation, the Urban Foundation, the Development Bank, local relevant NGOs, other local community welfare and pressure/activist groups, local commerce and industry, other possible funders, trade unions, doctors, nurses, and other medical professionals and workers, teachers and university academics, interested individuals, ...

If Sandton Council organises the forum, the political and perhaps even the financial implications for other local authorities and civic bodies could become irrelevant and community participation could be ensured from the outset, with contentious issues such as who represents Alexandra township, roads, squatters, open spaces, pollution, possibly becoming depoliticised.

Doreen Atkinson from Natal University is reported[23] to have pleaded at the City Futures conference of the Wits Graduate School of Business Administration for local government officials and councillors to be brought into the process of designing local authority structures. She said that “the ideals of many of these councillors resembled those of the ANC and other similar organisations. Differences were not of principle

but of strategy". Perhaps cooperation within the HCVN framework would facilitate the resolution of similar differences within greater Sandton.

Parameters that could/should be investigated include in no particular order:

1. demographic structure
2. environmental health hazards
3. infrastructure – especially aspects with problems
4. human and physical resources including medical facilities
5. expressed and observed needs
6. population health status
7. finance – cost and funding

Examples of objectives and achievements in HCVN projects in other communities could help to site our investigations in reality.

1. In Rouyn-Noranda where it was decided to:

   - promote the reduction ... of emissions of sulphurous anhydride from the local smelter
   - develop a botanical garden around a small lake
   - develop activities for young people aged 12 - 17
   - create neighbourhood committees dedicated to the promotion of a better quality of life for citizens
   - complete a project for recycling solid waste
   - develop a new all-seasons recreation park.

2. Liverpool

   Liverpool is an economically depressed area. One third of the city's population is unemployed, sick, or retired. Its mortality rate is higher than the national figure. People are dumped on the outskirts of the city, in areas described as "homelands" where there are almost no public services, people hardly go out, vandalism is common, and the environment has deteriorated.

   The following projects were embarked on.

   - The city is being rebuilt and renewed. Self-help programmes are promoting self-confidence and self-sufficiency.

   - The city council is employing people in service industries and in programmes of construction. Retraining, education, leisure, and community activities are being organised.

- A local street community association is redesigning and rebuilding old homes and building new homes so that people who lived together for generations can remain neighbours.

- A new local community market garden is providing training as well as jobs. The polluted river mouth is being changed into an economic and recreational resource.

3. Glasgow

   In Glasgow an innovative program to improve city housing stock initiated by an active tenants' association obtained a grant from the Glasgow Council as part of the city's contribution to the healthy cities initiative. The history of this campaign is instructive.

   A group set up in 1984 by an active citizens association commissioned an investigation into the causes of damp and heat loss in rented and other houses. The findings were presented to the Glasgow council in 1985 which agreed that something should be done but said that there was no money. After many unproductive meetings with the council, residents used collected material for poster exhibitions and in 1987, they in association with technical agencies and the Glasgow district council, organised a Heathfest. Architects, surveyors, engineers, housing managers, and tenant representatives from all over Britain attended three days of seminars and workshops, culminating in a competition for the best solution to the problems of the houses in the area. The winning package was offered a European Community grant to cover 40% of the costs and in 1990 Glasgow Council agreed to provide the balance. The scheme will be monitored by the local School of Architecture and the residents will monitor the health of the people in the demonstration houses.

On the basis of the findings objectives and priorities should be identified and their feasibility and cost-effectiveness investigated and ranked. The findings and the proposals should be submitted to the forum for consideration and agreed projects should be taken further – implemented – by the bodies, organisations and groups represented at the forum including the local authorities, and co-opted others. All should be involved and committed to the extent of their own areas of jurisdiction, competency, and concern and should operate within new or modified integrated structures within the HCVN framework.

A good data base should be established and maintained, the projects should be monitored and evaluated, and the public should be kept on board with regular report-back meetings and with transparent and (hopefully) successful implementation.

Funding

Funding will be critical and much will depend on the separation of the three tiers of government so that all executive functions are located at the local level. Sources of funds for the initial inquiry, the investigation, and the pilot programme could include:

1. local authority special contribution and usual budget
2. state refunds on delegated functions
3. industry and commerce
4. fee for some services
5. local authority penalties (macro-pollution, tobacco smoking in restricted areas, speed fines, littering, …)
6. donations to parks, libraries ...
7. fund-raising events
8. special contributions from state and parastatal bodies
9. integrated budgeting:

   If a prevention programme results in less money having to be spent on curative or rehabilitative programmes, the money so saved should not be available to the latter services, but to the former

10. the establishment of a health management organisation (HMO) for the area

    Initially the HMO would buy selected services from hospitals and members of the MAP industry, paying per diagnostic category, and financed through medical aid contributions or a national health insurance scheme if and when it comes on stream. As it expands the HMO would provide more services. The HMO would compete with private establishments for work.

    Such a HMO service could enhance decentralisation, accountability, coordination, and integration, with minimal duplication. It could be cost-effective. Monitoring, review/audit/evaluation and data-based planning should be built-in. The service should be financially viable (hopefully make a profit) and be integrated into the HCVN local authority budget.

The challenges of the healthy cities initiative as outlined in Quebec apply here too:

1. The new vision of the health of communities calls for transformation of roles, of responsibilities, of priorities, and of practices
2. healthy cities address the attitudes of all actors ... and their relations must evolve to meet this challenge

3. [A] new partnership must be created based on flexible multisector cooperation and making room for real citizen participation
4. All results obtained become bases for more complex projects of longer-term impact.

THANK YOU

Postscript: September 2011:

- I left to work in KwaZulu within days and was away for 1 year.
- There was no follow-up on anything; also not on the recommendation that the presentation should be prepared for publication in a sociology journal
- The 2003 National Health Act retained the overlap of responsibility between the three tiers of government
- The document on the National Environmental Health Policy[24] published in August 2011 also divides responsibilities across the three tiers of government. This is likely to exacerbate existing service delivery problems experienced in other sectors relevant to health such as water[25] and roads
- The analysis and recommendations are still relevant and will form the basis for my comments on the document on Environmental Health policy
- Evidence on the ground is accumulating on the importance of integrated service delivery as evidenced by the recently documented experience in Alaska[26]:

  Our experience with the social and ecological dimensions of Hg contamination of fish and game in Alaska … offers three considerations regarding the potential benefits available through place-based approaches: (1) they can contribute to the accuracy and systematic characterization of risks and their relationship to multiple direct and indirect health outcomes; (2) they are more likely to inform actual changes in behavior; and (3) they afford greater transparency to the risk management process and therefore facilitate environmental justice. …

  [T]he management of environmental health at the regional and local level requires an approach that is cognisant of local circumstances and needs, and addresses health in a systemic and integrative fashion capable of incorporating qualitative social, cultural, and economic drivers and determinants.

REPORTS OF MEETINGS AND COMMENTS
ON THE PROPOSED HEALTHY CITIES/LOCAL AUTHORITY PROJECT

1. CHP - Wits University

Report of an exploratory meeting with the
Centre for the Study of Health Policy (CHP) 13 November 1989

PRESENT: Mr Cedric de Beer and Dr Effie Schultz

Cedric tentatively raised possible difficulties:

- business already pays rates and regional service levies, and may object "justifiably".
- Alex clinic functions in the area and "will need to be accommodated

Other issues discussed:

1 the local authority can subcontract to provide a clinic paid for by medical benefit scheme.

2 concern on environmental pollution may motivate local authority to act/take responsibility on industrial hygiene

3 the local authority can and does work with organisations active in health (Alex Clinic, Four-ways Clinic thru Civic Foundation, Heart Foundation, Hospice, Child Welfare, etc)

4 by example the local authority can establish its own medical benefit society

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2 Department of Environmental Health – Sandton

Report of a meeting with the Department of
Environmental Health at Sandton 12 December 1989

PRESENT: Mr J du Bruyn (Senior Health Inspector),
Mr I P Ferreira, Mr J de Jong (Health Inspectors) and Dr Effie Schultz

The following concepts were endorsed:

1 closer association of conventional medical care programmes and environmental health programmes

2 intersectoral collaboration of formal health structures with other statutory bodies (roads, industry and commerce, housing, education, recreation) and public agencies and groups (such as ecological/green/environmental groups)

3 community participation in health matters (including trade unions at the workplace)

4 health promotion and disease prevention

5 the level for an integrated, comprehensive and coordinated health programme should be the local authority with the programme adapted to local needs (and with local accountability).

The following feelings were expressed:

1 the Sandton council is likely to cooperate with a programme as suggested
2 funding can/may/should be obtained from the state
3 the staff in the local environmental health unit are willing and able to act as industrial hygienists and health educators

The following problems were outlined:

1 unwillingness of the Departments of Manpower, Health and Education to provide legal access to the local authority environmental health unit for community programmes. Mention was made of the project planned for 1990 to investigate industrial pollution with access to factories blocked by the Department of Manpower

2 time, effort and money wasted due to fragmentation

It was suggested that:

The town clerk be approached to approve participation of members of the department in further discussions.

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3. NCOH and Transvaal Provincial Council

Notes for a meeting with the director of the National Centre
of Occupational Health (NCOH) and a member of the Democratic
Party caucus on the Transvaal Provincial Council 20 December 1989

PRESENT: Prof Tony Davis, Mr Rupert Lorimer, Dr Effie Schultz.

1 the concept

- decentralisation
- healthy cities
- integration of 2 health departments
- expanded role of the health departments
- environmental pollution/ecological concern
- PHC: local authority's role and in industry
- facilitation of life-style modification for health
- health promotion/disease prevention (local authority function) relevant to all sections of the community – not only the poor

2 the new forces: an idea whose time has come

industrial pollution
community concern re environmental issues
concern re housing and quality of life
community participation/involvement in local issues (Alex, western bypass)
deregulation; privatisation
enabling legislation: MOSA, no constraints in the Health Act
Browne Commission submissions
innovative use of Medical Aid Schemes legislation
medical care cash and concept crisis
trade union clout and growing concern with health

3 what's to be done

preliminary meetings with key persons from:

Sandton and Randburg 2 departments of health
other local authority health departments, local city councillors
trade unions
environmental action groups
parliamentary parties
Alex Civic, MASA, NAMDA, SAHWCO

public meetings/seminars
commission of enquiry/formal enquiry into feasibility
pilot project

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3. NCOH and Transvaal Provincial Council

Report on the meeting with the director of the National Centre of Occupational Health (NCOH) and a member of the Democratic Party caucus on the Transvaal Provincial Council 20 December 1989

PRESENT: Prof Tony Davis, Mr Rupert Lorimer, Dr Effie Schultz.

There was general agreement that the project as outlined in the notes for the exploratory meeting, was important and relevant.

The interest and commitment of the Sandton local authority department of environmental health was appreciated. An opportunity to meet with them would be welcomed. Mr Lorimer undertook to facilitate such a meeting.

It was felt that legislation relevant to health enable and empower the local authority to undertake decentralised executive functions. Sandton as a progressive and rich local authority could be a good place for the project to be piloted.

It would be useful to inform the Democratic Party (health and environmental affairs portfolio and groups as well as its parliamentary group and its local authority members) of the project to encourage further contact, thinking, research, insight, action.

The following areas of note were stressed:

1 healthy cities
2 environmental pollution and ecological balance
3 community concern re environmental issues
4 deregulation: opportunity for community action and the danger of laisser faire leading to chaos
5 trade unions: growing interest in occupational health and their increasing power

What's to be done:

1 lobby Sandton councillors
2 contact the democratic party informally
3 contact the Alexandra Civic Association
4 contact NUMSA or COSATU (Mr M Mayekiso is a senior member of the Alexandra Civic Association (ACO), NUMSA and COSATU)
5 Organise a working seminar on "Healthy Cities in S A" open to the public and with participation from the state, local authorities, academia, party politicians, extra-parliamentary activists, private individuals, community groups, industry, trade unions .....

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4 Alexandra Health Centre and University Clinic

Report of an exploratory meeting with the medical director
Alexandra Health Centre and University Clinic 10 January 1990

PRESENT: Dr Tim Wilson and Dr Effie Schultz

Dr Wilson showed interest and wished to be kept informed.

The clinic may cooperate in the occupational health component of the project after consideration of detailed proposals.

Dr Wilson stressed the need for realism; there was a danger that a planning and feasibility study could be too time-consuming (15 years!).

Sandton and Alexandra Township could be considered as a single unit from the perspective of the healthy city project.

The Alexandra Township Council does not enjoy the confidence of the inhabitants of the area, but administers the local environmental health portfolio and the other health-related local authority departments. The Alexandra Civic Organisation (ACO) on the other hand enjoys the confidence of the inhabitants but has no standing in law at a local authority level. It will be necessary to obtain the cooperation of both these bodies without alienating either - a tricky exercise.

It will be useful to discuss the project with the trade unions active among the workers who stay and/or work in the Sandton/Alex area. These include NUMSA and CAWUSA. Although Dr Wilson knew Mr M Mayekiso (NUMSA and ACO) he was not keen to introduce Dr Schultz or the project to Mr Mayekiso.

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5 MRC - CERSA

Report on a telephonic conversation with the director (as from 1 February 1990) of CERSA (Centre for Epidemiological Research in South Africa) a division of the MRC 17 January 1990

BETWEEN: Dr Malcolm Steinberg and Dr Effie Schultz

Dr Steinberg was interested in the project and indicated that CERSA may be willing to fund and supervise the planning and feasibility study as proposed, as well as a subsequent pilot study.

Dr Schultz felt that the project should be under the auspices of Sandton/Alexandra and was very pleased with the possible offer of support from CERSA.

Dr Schultz indicated that her present brief would end with the presentation of a memorandum to the Sandton town council. She would be available for appointment to an enquiry into the objectives, structures, processes and feasibility of the project, but that such an appointment was a technicality to be considered after the acceptance of the memorandum and the decision to set up an enquiry.

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6 NUMSA and ACO

Report of an exploratory meeting with an executive member of both the National Union of Metal Workers (NUMSA) and Alex Civic Association (ACO) February 1990

PRESENT: Mr Moses Mayekiso and and Dr Effie Schultz.

General

1 The greater Sandton (including Alex and the industrial areas around Alex) healthy city proposal as outlined was noted with interest.

2 There is a need for the residents of Alex and the workers in greater Sandton to become involved now with Sandton Council in planning for the future of the whole area.

Mr Oertel (Sandton Council Management Committee) is setting up a meeting on the healthy city project. NUMSA and ACO need to participate in this project from the beginning.

3 The healthy cities concept has been proposed and developed by the World Health Organisation. Success is reported from the UK and Canada.

4 The need for decentralised programmes is generally recognised politically and administratively.

5 Dr T Wilson of the Alexandra Health Centre and University Clinic sees a role for the Clinic within a greater Sandton healthy city programme.

Considerations of interest to NUMSA

1 environmental pollution and other health hazards in work

Local authority health inspectors have the training and can obtain the right (Mines and Occupational Safety Act) to inspect and act on conditions in the workplace.

2 primary occupational health care

Occupational health nurses and occupational health doctors can play a vital role in promoting and protecting workers' health. They can also provide curative, control, and rehabilitative services. The law however does not demand their deployment in small industries (fewer than 50 workers) and in commercial concerns. The local authority can be paid to fill this gap by providing trained nursing and medical staff to meet the needs of both big and small industrial and commercial enterprises.

3 coordinated and integrated total health care

All categories of health professionals can be employed by the local authority. Data (records) on work conditions, worker distress, disease, disability and death, and the physical and social environment outside the workplace can be linked. Coordinated action can be planned and evaluated.

4 trade union funding and control

The trade unions can motivate for and support the deployment of local authority inspectors, occupational hygienists, occupational health nurses and occupational health doctors inside the place of work. The trade unions can fund a part or the whole of the service through medical benefit societies and should insist on proper access to all findings.

Medical Aid (fee for service) rules do not allow sufficient flexibility nor the essential opportunity to exercise control. This system also does not enable a coordinated, comprehensive, and integrated worker health approach.

Funding the service (instead of demanding/expecting the local authority to provide the service free) enables worker control, ensures that the employer contributes towards worker health (a free service from a public body is paid for out of public funds) and assists local authority budgeting.

5 open spaces, recreation facilities, canteens, public baths, centres for nursing mothers, crèches , nursery schools *

These are/can be established and maintained by the local authority. Trade unions can motivate that they be sited near places of work so that the workers can use them before, during (tea and meal breaks) and after work. Their use could enhance female emancipation*, improve worker and child health and increase production and should be viewed as integral to a programme for worker health and safety. Commerce and industry should be encouraged to contribute towards these facilities*.

6 the impact on the environment

People, animals and plants who live near an industrial or commercial area have the right and the need to breathe clean air, to be protected from acid rain and to be watered by unpolluted rivers or streams*. It is the local authority's responsibility to ensure a clean, non-polluted environment. If the local authority can control effluent disposal at source, its ability to protect the environment is facilitated. Trade unions are aware of man's responsibility towards nature*. Together with the local authority trade unions can contribute towards healthy living in healthy cities*.

Considerations of interest to ACO

The Alex Council has no credibility with the residents of Alex, while ACO is considered to be representative of their interests. The designation, local authority, does not refer to a specific local authority, but to the concept of one.

1 housing, water and energy, refuse removal, storm-water drainage

These issues are critical to health and to the concept of healthy cities. The local authority is responsible for providing and/or controlling these functions.

2 roads, bicycle tracks and pedestrian paths;
safe, affordable and accessible public transport*

In Alex the condition of the roads are very bad. Public transport is dangerous. There are no facilities for cyclists and pedestrians.

Road accidents need to be prevented and physical exercise (walking, cycling) encouraged. The location of roads and the lead-ding of petrol are legitimate concerns for the local authority and local residents*. The departments of transport, and health should be integrated as part of a healthy city programme*.

3 quality of life, open spaces, recreational facilities,

The need for open spaces, recreation facilities and public amenities such as eating houses, legalised and controlled drinking gardens/pubs/shebeens, public baths, play grounds, sports fields, swimming pools, adult education and literacy programmes *, libraries, reading rooms, etc., is particularly great for the poor and for those without adequate housing, and who suffer/ed from structural deprivation. These facilities could redress some existing inequality* and prevent anti-social behaviour and substance abuse (including alcohol and tobacco)*. They would promote health and enhance the quality of life. They are essential elements in the healthy city concept.

The Sandton Council is preparing a plan for open spaces and recreation facilities in Sandton (SOS). The scrapping of the Group Areas Act presupposes …

4 community participation/involvement in local issues*

The electrification of Alexandra township for example can fundamentally alter for the better the pattern of disease, disability and death in Alex and its neighbouring areas. The use of a non-polluting and cheap source of energy needs consideration; see Sandton's experimental use of solar energy to provide light in its parks*.

Without community participation a healthy city programme cannot be successful. Its initiation, development and maintenance depend on community concern and enthusiastic public involvement. Such a commitment can only be obtained if the programme is seen to be relevant and seen to be coordinated by trusted leaders*.

* ES after-thought

7 BARLOW RAND

Notes for a meeting with the medical director of Barlow Rand
(directed at the specific needs of industry) 5 March 1990

PRESENT: Dr Des Whittaker and Dr Effie Schultz.

1 workers' health:

occupational health and safety -

accidents (non-occupational variables)
Mines and Occupational Safety Act (local authority health inspectors)
hazardous substances and situations

prevention and cure/control of common diseases

small enterprises (no nursing and medical staff)
herd immunity
linked data (1 data base per workplace and area)
control of medical care
integrated, coordinated health programme
area-based corporate health promotion
medical aid drain (cure/control oriented),
lack of control, disjointed, confrontational

2 corporate image

contribution to the community
concern for the environment
participation in structured locally controlled projects

3 environmental impact (pollution and accidents)

coordination and participation: industry, residents

We stay where we work; it’s for our own good
Lets make Sandton clean, healthy and good to live in.

4 financial implications

more control on money spent
medical aid expensive and problems
prevention is more cost-effective
healthy, satisfied workers are more productive

7 BARLOW RAND

Report of a meeting with the medical director of Barlow Rand 5 March 1990

PRESENT: Dr Des Whittaker and Dr Effie Schultz.

Barlow Rand ran a health service which was internally coordinated. Regional health directors reported to the central director (Dr Whittaker) and coordinated and directed the work of the local part-time and full-time doctors, and the occupational health nurses. The duties of staff were clearly defined; there appeared to be little local autonomy and few opportunities for personal initiatives. The local medical staff was often expected to act on behalf of management in policing the actions and decisions of the workers' personal medical attendant/s.

The lower paid workers were medically covered on site, while the others were covered by medical aid schemes. It was intended to expand the medical aid scheme to cover all employees and their families. Emergency and interim medical care was provided to all workers.

Barlow Rand believed in industrial democracy (whatever that meant) and believed that workers with medical aid scheme participation should be free to choose their own doctor and service. Barlow Rand (allegedly) had its own occupational hygienists and did not need local authority assistance. No health-promotive nor disease-preventive programmes operate.

Barlow Rand was concerned about the environment and about social issues and quietly (unlike the Anglo-American Corporation) contributed considerable sums to upliftment programmes. Dr Whittaker seemed suspicious of trade unions, reflecting I suppose management's feelings.

Dr Whittaker did not see any role for Barlow Rand in the healthy cities concept, but agreed that it could be helpful for small enterprises without health and safety units. Generally he was very smug and was unable or unwilling to see or think beyond the facilities and activities of Barlow Rand.

The report (The Star, January 1990) of Tongaat-Hulette's study that investigated the problems and the possible future of the Durban Functional Region and sentiment expressed by the chairman when introducing the first report of the study group that the region "must be fully integrated politically, socially and economically if it is to progress with peace and prosperity into the 21st century." was noted.

Dr Schultz thought that the contribution by corporate industry in any study of the future of a region in which it operates is important. Barlow Rand could and should be similarly associated with the local authority and the people in greater Sandton.

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8 CHP

Report of another meeting at the
Centre for the Study of Health Policy 13 March 1990

PRESENT: Dr Jonathan Bloomberg and Dr Effie Schultz

The report of the meeting with Mr Mayekiso was tabled, as well as a comment from the Lancet (Vol 1, page 57, 1989) on the UK Health Education Authority's report entitled *Health at Work?* Relevant items from the Lancet comment included:

1 alcohol, stress and nutrition programmes now outnumber those in the traditional areas of safety, noise, and dusts

2 few programmes have been properly evaluated.

3 the report does not address how prepared companies were to alter conditions at work that lead to physical and psychological ill-health when change would cost money.

4 surveys by factory inspectors showed that the majority of accidents can be prevented and

5 the economic benefits from adopting better health promotion are known

6 it is generally forgotten that the costs of poor safety and health standards are more often borne by the community at large than by the employers

7 the majority of employers are unlikely to improve health and safety practices or to expand health promotion programmes unless legally obliged to do so.

The following comments are noted:

1 Management should pay for occupational health programmes, as workers consider it wrong/unfair that they should have to contribute towards workplace health and safety.

2 Funding of local authority community health programmes should not come from joint management/worker sources, such as medical aid schemes or medical benefit funds. Workers employed in greater Sandton without staying there, would then be contributing towards programmes for the families of other workers. An appropriate accounting system could however possibly accommodate this problem.

3 If Sandton called together interested parties to discuss a feasibility study into a healthy cities project, the unions would/could participate.

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9 Urban Foundation

Report on two exploratory meetings
(directed at housing) 20 March and 18 April 1990

PRESENT: Mr Jeff Mc Carthy and Dr Effie Schultz.

At the first meeting the concept of the Healthy Cities project was outlined. Memoranda and papers as well as the responses at previous meetings were tabled.

The centrality to health of housing was stressed. It was thought that a paid coordinator for a pilot project in the greater Sandton-Alex area should be deployed. It was suggested that funds might be obtained from the Urban Foundation and/or the McLean Trust.

At the second meeting when material submitted had been studied and consultations within Urban Foundation held, it was noted that:

1 the Urban Foundation considered it important that the project was sited without reference to racial borders

2 cooperation on housing was already developing between Sandton-Midrand-Tembisa-Alex at a formal level

3 housing and female literacy were more important than formal medical intervention in promoting and maintaining health and preventing disease

4 the Urban Foundation needs to incorporate considerations on the implications for health into planning and policy:

communal facilities for washing, preparing food, learning, recreation, working (eg home industries), eating, drinking alcohol, smoking tobacco and/or grass, child-minding (0 - 21 years), caring (for the disabled and the elderly, first-aid, shopping (spaza shops), … *

the creation of an organic integrated community and not just houses (or shacks) on stands (site and service) in nice neat rows (streets)

the supply of energy from environment-friendly sources*

local recycling of water and waste (gardens)*

4 the Urban Foundation's division for community structures/resources also contributes towards the development of healthy people in a healthy environment

* ES after-thought

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10 SBDC

Report on an exploratory meeting with a consultant at
Small Business Development Corporation
(directed at employment) 18 April 1990

PRESENT: Mr Sidney Schultz and Dr Effie Schultz.

Employment is critical for the health of individuals and communities, and for the success of a Healthy Cities programme.

Relevant considerations for health include:

> working conditions, work-place hazards, occupational and environmental air and noise pollution, working hours, eating and ablution facilites, child-minding, first aid and healthcare provisions, transport to and from work, ….

It is also necessary to consider the special needs of occupationally marginalised persons such as:

> Lactating mothers, disabled persons, the elderly; and in our traumatised society those employed for very long without specific skills, the illiterate, ….

It is noted that the SBDC believes that small business development is essential for:

> generating wealth and spreading prosperity
> encouraging grassroots development
> community involvement.

It is further noted that the SBDC:

1 provides suitably located premises in attractive and secure business environments ... for convenient shopping and as pleasant gathering places

2 develops business infrastructures

3 assists emergent enterprises through its Business Promotion Units

5 mobilises members of local communities to promote small businesses through its Local Entrepreneurs Taskgroup Scheme

6 Development priorities are determined in consultation with local communities".

There is a confluence of interests between the Healthy Cities concept and the objectives and activities of the SBDC. The hope was expressed by Dr Schultz that the SBDC would incorporate health promotion and protection into its objectives and develop a community outreach policy directed specifically at the disadvantaged.

11 NHPD (National Health and Population Development)

Report on an exploratory meeting with a senior staff member of the Directorate of Environmental Health in the department of National Health and Population Development 23 April 1990

PRESENT: Dr Oberholzer (NHPD), Mr Jeff Mc Carthy (Urban Foundation), and Dr Effie Schultz

APOLOGIES: Dr Johan Kotze (Director of Planning in the Department of National Health and Population Development)

The concept of Healthy Cities and Villages was outlined. Dr Oberholzer was interested and indicated that the department would support any initiative in this regard.

It was considered that the project should be:

1 based within a area defined in geographic and economic but not racial terms

2 piloted by a relatively small local authority with adequate private financial resources

3 sited in a community that is concerned with the environment

4 developed with the support of local authorities and civic and community bodies with credibility in the area

It was pointed out by Dr Oberholzer and by Dr Kotze that the threat of and the need to control environmental pollution was receiving urgent and serious state attention

It was felt that while there were areas such as Witbank where the need for the development of a healthy cities initiative was great, the political conservatism of the local white authority mitigated against an integrated non-racial geographically-based pilot study. Greater Sandton area (including Alexandra township and Marlboro) was thought to be a suitable site.

Dr Oberholzer suggested that Mr Hamilton at the Southern Transvaal Region Environmental Health division of the Department of National Health and Population Development in Johannesburg should be contacted for discussions on relevant legislation.

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12 THE STAR (local daily newspaper)

Report on an exploratory meeting with the
lead columnist on the environment at THE STAR 9 May 1990

PRESENT: Mr James Clarke and Dr Effie Schultz

Documents were tabled (some copies were made and others were sent later the same day) and the concept was outlined with particular emphasis on community participation and the role of environment in health.

Mr Clarke was interested in and supportive of the healthy cities and villages concept as outlined by Dr Schultz. He indicated a willingness to promote public awareness through his press column. He was willing to this end to arrange that reports of discussions, meetings, seminars, etc where the issues were raised be published. He planned to write an article on the subject.

He suggested that Andre Spier who has retired to Mac Gregor and Heinz Hachler a town planner in Krugersdorp should be consulted. Andre Spier had in the early 1980s prepared an integrated health maintenance organisation (HMO) and had developed a masterplan for Alexandra township and Heinz Hachler is an enlightened town-planner who does not plan towns in nice straight rows, but as integrated, organic, functional units clustered culturally and economically to promote health/life. He referred also to Kathryn Mc Camant and Charles Durrett book entitled *CoHousing – a contemporary approach to housing ourselves*.

A quote from William Morris used in Liverpool at the Healthy Cities Conference in 1987 to epitomise the concept was considered relevant:

> “At least I know this, that if a person is overworked in any degree they cannot enjoy the sort of health I am speaking of; nor if they are continually chained to one dull round of mechanical work, with no hope at the other end of it; nor if they live in continual sordid anxiety for their livelihood; nor if they are ill-housed; nor if they are deprived of all enjoyment oqnf the natural beauty of the world; nor if they have no amusement to quicken the flow of their spirits from time to time; all these things, which touch more or less directly on their bodily condition, are born of the claim I make to live in good health."

The question of AIDS was (inevitably) raised. It was suggested that the control of AIDS could also be approached within the framework of a Healthy Cities concept, siting a preventive programme within the context of a changed life-style with a stable home-life in a supportive and pleasant physical micro (house and work-place) and macro (street, village, countryside) environment, with secure employment, less (or no) alcoholism, substance abuse and medicinal misuse, less infective disease, …

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13 Department of Environmental Health - Sandton

Report of another meeting with
Sandton Department of Environmental Health 4 June 1990

PRESENT: Mr C F du Plessis (Head: Environmental Control),
Mr J du Bruyn (Senior Health Inspector),
Mr I P Ferreira (Health Inspector) and Dr Effie Schultz

Consensus was reached on the following:

1 The greater Sandton area (including Marlboro and Alexandra Township) is suitable for a Healthy Cities pilot project. The Sandton Council is progressive and non-racist, formal contact exists with the other local authorities and an an informal working relationship exists with the Alexandra Civic Organisation. The question of housing and squatting is addressed through consultation.

2 The state supports the integration of local authorities without reference to race and for the devolution of responsibility and power to local authorities.

3 Cooperation within each local authority (between different departments), between local authorities and between different levels of state functioning (eg manpower, health, education) is undermined by:

overlapping legislation with different departments within local authorities and/or state structures responsible for the same or similar area or within the same law

power struggles, need for autonomy and hegemony.

It is therefore necessary to motivate for the rationalisation of legislation and the promulgation of enabling legislation so that inter alia executive functions are devolved to the local authority. It appears that the state is looking at this.

The healthy cities concept however enables cooperation on agreed agendas without challenging the autonomy or hegemony of the participants, predating the expected legislative changes and serving as an experiment.

4 If funding could be obtained from an outside source, the department was willing, keen, and ready to implement the pilot study.

Assuming the support of the Council and the completion of preliminary local research the next step would be to convene a public meeting to enlist public cooperation and participation and to obtain a mandate for a study of objectives, structures, process and feasibility of a pilot study.

5 Data-based planning is essential.

MOTIVATION FOR A COMPREHENSIVE PILOT HEALTHY CITIES INITIATIVE GREATER SANDTON AREA

NOTES FOR AN EXPLORATORY MEETING

EFFIE SCHULTZ 30 JANUARY 1990

Introduction

In South African today the local authority is well placed to play a pivotal role in health.

The Health Act of 1977 does not circumscribe the functions of the local authority. It merely assigns certain responsibilities to it. The Machinery and Occupational Safety Act (MOSA) of 1983 enables local authority inspectors to act as industrial site inspectors. Other Acts similarly instruct and empower local authorities.

Health inspectors functioning within the jurisdiction of the local authority are responsible for safe sewage and refuse disposal, the control of public eating places, the cleanliness of public premises, hospitals and schools, sterilisation and infective material control (medical premises, barber shops), the sale of foodstuff, the control of noise, industrial effluent, vehicular discharges and other sources of environmental pollution, the provision of potable water, pest control, clean pavements and other environmental determinants of health.

Through the departments of roads and traffic the local authority has direct and responsible access to a very common cause of morbidity and mortality, motor vehicle accidents. The local authority also plays an important role in housing, another critical determinant of health. Other areas where the local authority is either directly involved or can act on behalf of the state and with relevance to health include parks and recreation, squatters, radiation protection, ….

Sandton's burgeoning industry and the development of a social and communication infrastructure can create personal and environmental health problems. It is necessary to take steps not only to circumvent these, but also to promote an orderly and healthy process of settlement and industrialisation.

The WHO in addressing global health issues almost a decade after launching its primary health care project, has embarked on a programme directed at cities and by extension towns, villages and neighbourhoods. The components of the programme were set out in the Liverpool declaration and comprised:

1 the right to health
2 equity in health - the reduction of inequality
3 community participation
4 intersectoral collaboration
5 health promotion
6 primary health care which includes at least

- education concerning prevailing health problems and the methods of preventing and controlling them
- life-style modification for health
- promotion of food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health, including family planning
- immunisation against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs.

7 international cooperation
8 research

It is within this conceptual framework and taking cognisance of current legislation, the state's encouragement of deregulation and privatisation and justified local and global concern about the environment, that this motivation is sited. Sandton is a new town and prides itself on its sensitivity, its community concern and its modern, scientific and progressive presence.

It is therefore proposed that the Sandton Council enquire into the objectives and feasibility of a pilot intervention project as a preliminary to the establishment of an integrated, comprehensive and coordinated health programme to meet the needs of its greater constituency (ie including Alexandra township and Marlboro) and as part of Sandton's contribution to the WHO objective of Health for All by the year 2000.

IN GREATER SANDTON

Areas of concern and application

1 the concept

decentralisation
integration of 2 health departments
expanded role of the health departments
environmental pollution/ecological concern
PHC: local authority's role
PHC in industry
facilitation of life-style modification for health
health promotion and advocacy -
health protection and disease prevention -
a local decentralised function
for all sections of the community - not only the poor

2 the new forces: an idea whose time has come

industrial pollution
community concern re environmental issues
concern re housing and quality of life
community participation/involvement in local issues (Alex, western bypass)
deregulation
privatisation
enabling legislation: MOS Act, no constraints in the Health Act
Browne Commission submissions
innovative use of Medical Aid Schemes legislation
medical care cash and concept crisis
trade union clout and growing concern with health

3 what's to be done

preliminary meetings with key persons from:

Sandton's 2 departments of health
Alex Civic Organisation (ACO)
local trade unions
other local authority health departments
local city councillors
environmental action groups
welfare organisations
extra-parliamentary pressure groups
parliamentary parties
health-related groups, bodies and associations
academic institutions, study commissions and information groups, etc.

commission of enquiry/formal enquiry into feasibility
public meetings/seminars
pilot project

Proposed interventions on environmental health and medical services

1 health promotion and advocacy

environment control (industrial and domestic)
housing, transport, recreation,
water, refuse disposal, lighting
employment (placement, preparation, lack of)
education (adult, literacy, pre-school, extra-mural)

2 disease prevention and health protection

- immunisation, GOBI FFS, child health
- mental health
- motor vehicle accidents
- chronic disease prevention: (nutrition, exercise, tobacco, alcohol)
- drug abuse (tobacco, alcohol and substance)
- STD (including AIDS)
- occupational health: legislation (MOSA) enables local authority health inspectors to act as occupational inspectors and hygienists (biological monitoring, hazards control)

3 medical service provision

The National Health Act does not prevent local authorities from treating patients, so set up local authority clinics or use existing ones to diagnose and treat as well:

in the community, at the work-place
with mobile or fixed units/teams

4 chronic disease control and the prevention of complications – dedicated wellness centres for the support of people suffering from chronic diseases

5 rehabilitation programmes - as Johannesburg does

6 palliative medicine - hospice function and TLC (tender loving care)

Everything depends on support from the council and its support is contingent on lobbying and getting finance. The local authority can levy fees on its rate-payers. It should do so specifically to finance the health programme. With deregulation and privatisation the state will not only allow such financing but may also encourage it (even possibly with grants).

1 employers should finance the inspectors. A good case can be made out for the establishment of a cost-effective occupational health service.

2 concern on environmental pollution may motivate local authority to act/take responsibility on industrial hygiene

3 the local authority can work with other bodies active in health

4 by example the local authority can establish its own medical benefit society for all its employees, and run this on a comprehensive basis.

Outcome: The chairman of the Sandton Management Committee did not support the project because he saw it as an attempt to introduce socialist medicine to which he is opposed: he favours private medicine!

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[16] John Ashton. Health for all by the year 2000 News.

[17] Reported in *The Star* 8 May 1990.

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[19] Among those present were staff members from the Department of Community Health and the Centre for Health Policy Studies at Wits, Tony Davies from NCOH, Irene Menell from Democratic Party, health inspectors from Sandton local authority, and representatives from Johannesburg City Health department

[20] Reported in *The Star* January 1990

[21] See appendix

[22] Canadian Journal Public Health. 77: 180-189. 1986

[23] Reported in *The Star* 8 June 1990

[24] National Department of Health Invitation for public comments on the National Environmental Health Policy. Notice 517 of 2011. Government Gazette. 3 August 2011. No.34499 3

[25] Edna Molewa Minister of Water and Environmental Affairs referred to the problem linking the bulk infrastructure provided by the department to infrastructure provided by local government water services authorities. Engineering News online. 13 September 2011

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