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Evaluation of Healthy Cities Projects: A Case Study of 13th Aban Street

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Abstract

In 1985-86, the European office of World Health Organization (WHO) proposed the health promotion program under the theme "Healthy Cities Projects". With the aim of securing individual and collective welfare, the staffs of healthy city in Tehran also began their official activities at 13th Aban Street at Rey (Tehran's 20th municipal district) along with community participation and intersectoral coordination.

Since, the "Healthy Cities Projects", emphasised on intersectoral coordination, self-awareness and community participation; the issue of the current research is whether or not there is any specific difference of opinion among people and officials regarding this project? For this purpose, people's viewpoints on the activities was conducted through 424 samples from 13th Aban Street coincidentally with 46 officials of the "Healthy Cities Projects" and thus analytical study was carried out keeping in view level of differences between people and officials of "Healthy Cities Projects" and their viewpoints regarding community participation in the physical and mental health, individual security, environment and utmost to sports and training.

The results indicate that with reference to the satisfaction level on "Healthy Cities Projects", there isn't a significant difference between people's and officials viewpoints.

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But, with respect to their viewpoints about the level of community participation, there exists significant differences between people's and officials viewpoints in the fields of "Healthy Cities Projects" physical and mental health, individual and social safety, environment and utmost sportive and educational activities. The obtained results from officials, therefore, are more than those obtained from people.

Keywords: Physical and Mental Health, Healthy Cities, Community Participation, Health Promotion, Intersectoral Coordination.

Introduction

Speedy growth of urbanization has undesirable effects on the health of the citizens. With dispensation to these effects, the World Health Organization[1] executed "Healthy Cities Projects[2]" in 1986, based on actual intersectoral coordination and community participation. Strategically, this project had been to amass the cooperation of governmental, non-governmental and voluntary organizations, with the purpose to attract them towards city's hygiene and health and to minimize health related problems on wider scale. [1, p. 4]. The first symposium on healthy city was organized in Lisbon, Portugal in 1986 and participated by 22 European countries, where 11 countries declared their readiness to experimentally execute the project. So far, more than two thousand cities around the word have been active in executing the healthy city project. In Islamic Republic of Iran, the introductory execution of this project, as an experiment, was carried out at 13th Aban Street in Rey city (south of Tehran) in 1991 and officially this began in Rey city on October 30, 1992. Under the guideline of this project, the staffs of healthy city are busy in cultural, sport, construction and health fields etc. while their various committees with specific target are busy in performing different activities in the fields of health, social hygiene, planning, urban welfare and environmental conservation on the basis of cooperation among different sectors. Regarding the urban pathological problems, the above staffs presented the implementations to different related divisions of the city (like municipalities, ministry of housing, ministry of power and wellbeing organization etc.) under the guideline of WHO. In 1995, thus, WHO selected 13th Aban Street of the city of Rey as a model healthy city on limited basis, declared the plan as "successful in executing experimental healthy cities project and search towards access to healthy environment for life". Apart from that, the cities like Gochang in Malaysia for 'making the plan of healthy city', Glasgow in England for 'attraction to public participation' Sherbrooke in Canada for "economic and social participations'

1. WHO
2. HCP

and Johannesburg in South Africa for 'wide public coordination' were selected in the same year as other sample healthy cities [2, pp.34-35].

With the ratification of amendment in 1996, group of government official and coordination council of the project were formed with the inclusion of ten ministers and five directors of the organization for increases of intersectional cooperation. Up till now, this project has been executed in 16 provinces in the country with the initiation of care and training workshops.

The actual aim of the HCP is to elevate the level of social health in accordance with the WHO motto ' Health for All[1]', which will be possible only with the active cooperation among various sectors and exposition of community participation [3, p.4]. The present research attempts to summarize briefly the functioning of healthy city project at 13th Aban Street, through studying the differences of opinion of intersectoral cooperators (officials) and people with regard to their satisfaction to the project and level of community participation in the health, environment, safety and utmost training and exercise.

Explanation and Actual Research Hypotheses

Up to 1990s, about 600 million people from the marginal cities of the developing countries have lived in undesirable and unsanitary conditions. Environmental problems such as inaccessibility to safe drinking water, housing problem, pollution and defense management are some of the important issues, which have extensively pressurized the city managements due to unexpected urban growth. Health problems in the cities usually arise out of unplanned, uncontrolled expansion and growth, without suitable budget and care to the potentialities of the people. The speedy urbanization increasingly make the capacity and strength of the city weak in providing essential environmental services, housing facilities, employment and other minimum need for one healthy society [1, pp.1-2].

With the speedy urbanization, the problems increased in the fields of housing, employment, income and especially increased the problems of physical and mental health and social safety. So, the increasing amplitude of social abnormalities made the healthy living space of the cities more congested for the human being and necessitating exhaustive effort for rescuing the city and making it healthy and safety, more than ever. A healthy city is considered as one of the important necessities to reach the sustainable urban development, and therefore enough emphasis must be paid on health in the city planning. Shakoei (1998) explains that the issues which emphasized in the social city planning are progressive human resources such as social welfare and support of the families, conservation of environment, education and training, health care and treatment, community participation in

1. HFA

different fields, support of poor and low income groups and effort to promote their living standards [4, p.35]. Because, for a successful HCP, a city should have qualities such as strong political support, effective leadership, broad community control and participation, and cooperation between sectors [5, p.8]. It is important that all sectors understand that they have an important role in attaining better health status it is not entirely up to the medical community to play that role [5, p.8, quoted from Gesler & Gordon, 1998].

The axis of the correct execution of the healthy city are the identification of the strength and manifold capacities of people and possibilities of governmental and non-governmental structures of every region and their coordination with the aim of fulfilling healthy city in the various domain. The execution of HCP tries to bring the viewpoints of the officials and people close to each other so that solution and suitable methods emerge to overpower problems and issues. As long as these two groups have close understanding, there is more possibility for the success of project. Main emphasis of the present research is to study the diverse opinion of people and officials in the 13th Aban's HCP activities. In this process, two hypotheses have emerged in our mind, which are:

First Hypothesis: There is a significant difference between the viewpoints of people and officials with regard to the satisfaction level in the 13th Aban's HCP.

Second Hypothesis: There is a significant difference between the viewpoints of people and officials with regard to the level of community participation in fields of physical and mental health, environmental, individual and social safety, and educational and sportive activities in the 13th Aban's HCP?

Theoretical Bases of Research

The constitution of WHO (1948) has defined the health as the complete physical, mental and social wellbeing and not merely the absence of disease or infirmity [6, p.19]. Also the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition [7, p.7 , quoted from WHO]. Garcia and McCarty are of the opinion that positive health has three linked dimensions – Social, Psychological and Physical – which should all be included when measuring health [8, p.2]. Hancock considers concepts of health from three aspects: the first is that health is a positive concept, not merely the absence of disease; the second is that the model of health is holistic or ecological, taking into account all the many different factors that determine health and the third is a particular concern with inequalities in health [9, p.15].

The project is rooted in a concept of what a **city** is and a vision of what a **healthy city** can become. A city is viewed as a complex organism that is living, growing, and constantly changing. A healthy city is the one that improves its environments and expands its resources so that people can support each other in achieving their highest potential [10, p.7].

The healthy city project does not only attempt to reach all the cities to the equal and ideal level of health, rather it aims to nourish abilities and strength in order to improve present condition to the possible limit.

Doyle & Brunning (1997) have the opinion that a healthy city is not the one that has achieved a particular level of health; it is one that is conscious of health and is striving to improve it. Thus, any city can be part of the healthy city movement regardless of its current health statues; what is required is a commitment to health and a structure and process to achieve it [11, p. 10]. Davies & Kelly (1993) emphasize on healthy cities and its accompanying ideas of health for all, health promotion and the new public health constitute a major shift in the conceptualization of health. In healthy cities and the new public health, health is expanded out of the biophysical realm into the socio-political domain [12, pp. 6-7]. Health promotion is the process of enabling people to increase control over, and to improve, their health [13]. Perhaps, we can say that the best and the most complete definition of healthy city is presented by Hancock and Duhl. In their opinion, the healthy city is the one that is continually creating and improving those physical and social environments and strengthening those community resources, which enable people to mutually support each other on performing all the functions of life and achieving their maximum potential [14].

Hancock & Duhl (1986) propose the elements - environment with high quality, sustainable ecosystem, strong community, participation and control by the public, meeting of basic needs, access to experiences and resources, innovative city economy, encouragement of connectedness with the past, compatible form with preceding, optimum level of appropriate public health, and high health status- as key parameters for healthy cities, communities and towns [7, pp.23-24, quoted from Hancock & Duhl]. Tsouros (1997) says too that a city should strive to provide all of the above fields [10, p.9]. According to him, the HCP have six characteristics in common:

1. They are based upon a commitment to health;
2. They require political decision-making for public health;
3. They generate intersectoral action;
4. They emphasize community participation;
5. They work through processes of innovation;
6. Their outcome is healthy public policy [10, pp.13-14].

Twenty steps are essential for project development. They divide the development process into three phases – getting started, getting organized and taking action. The three phases of project development are illustrated in Figure1. Projects don't evolve in a continuous, systematic way. They are experimental and grow by trial and error. Sometimes they develop rapidly and at other times they grow slowly because conditions are complex and contradictory. Each healthy cities project must find its way through the maze of changing circumstances in which it works [10, pp. 16-17].

Figure 1 The three phases of project development (extracted from Agis D. Tsouros 1997)

Getting started	Getting organized	Taking action
1. Build a local support group	8. Appointing a project steering committee	15. Increasing health awareness
2. Understand healthy cities ideas	9. Analyze the project environment	16. Advocating strategic planning
3. Get to now your city	10. Define project work	17. Mobilizing intersectoral action
4. Find financial support	11. Set up a project office	18. Encouraging community participation
5. Decide organizational location	12. Plan long-term strategy	19. Promoting innovation
6. Prepare a project proposal	13. Build project capacity	20. Securing healthy public policy
7. Obtain project approval	14. Establish accountability mechanisms	

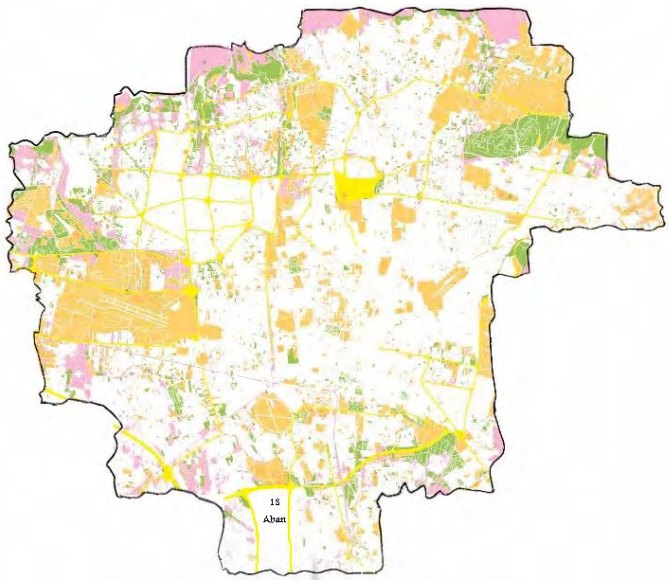
Since community participation is being focussed in this paper, we proceed to it.

Community participation in the city affairs is not the new phenomena and to be bought forth for discussion in geographical studies cannot be imagined an innovative topic. Shakoei (1999) explains that during the last years of 1960s, issues like social welfare, intense inequality, poverty, disease outbreak, racism, nationalism, crime and offences, life expectation, women genuineness and hovel dwelling have hastily entered in the geographical domain. It means, sound of the losers of the society echoed for the first time in the science of geography [15, p.141]. They desired adjudication of their rights, acquisition of power, participation and more share in the social and economic systems.

Hosseini (2003) has quoted from Nagel in his PhD thesis that defines the community participation as decision-making through the target groups, people, interested groups and those who utilize the democratic process and progress in the direction of public benefits [16]. People participate in health through their lifestyle choices and their use of health care. In broader terms, they also participate by expressing opinions that influence political and managerial decisions, working through voluntary organizations, self-help groups or neighborhood associations. HCP are committed to strengthening community participation in all of its forms. The organizational structure, administrative systems, work style and priorities of the project should encourage and support community participation. Several means can be used for this, such as: easy access to the project office for community groups and attention to community groups' proposals from project personnel, enabling community participation and encouraging communication between groups as important functions of steering committee memberships, presenting healthy information in order to help groups to improve their understanding of help problems and learn about new approaches in their areas of interest, practical support to community groups in the field of writing project proposals, searching for funds, preparing publicity and setting up simple administrative systems, helping communities to assess their needs and preferences, community development initiatives with concentration of a "subproject" and concentration of efforts to remedy it [10, pp. 49-51].

Targeted Area of Study

From the geographical point of view, 13th Aban Street is situated in the southwest of Tehran, and is counted as the 3rd of seven wards of city of Rey (20th municipal district of Tehran). Having an area of about 158 hectare [17, p. 7], this ward is surrounded from three sides by expressways, railway and metro lines while at one side by factories and agricultural land, making it a kind of island (Map 1). High underground water level especially at the margin of this ward has been counted among various problems usually dealt by the inhabitants. According to the research conducted by Naeini et al (2001) indicates that the rate of intestinal parasitic pollution is very high in this area and have forwarded suggestions for the necessary steps from the health committee as well as staff of the healthy city for the cure and prevention from the diffusion of the pollution to the other family members through necessary training. [18].



Map 1 Location of 13th Aban Street in Tehran

From the Historical point of view, 13th Aban Street Ward initially was an arable land, which was purchased by Housing Organization in 1965 and constructed 3398 residential units, each with 80 square meters, with the aim to settle the hovel dwellers from different regions of Tehran [17, p.5]. Recently, the increase of congested building structure with two or three stories and construction at the part of residential complexes have increased the number of residential units as well as number of families and population. The speedy growth of families and population in those units at 13th Aban Street are the result of various factors, one can be named as 'migration'. Meanwhile, the factors like cultural and economic problems can also be other factors in this growth. From its texture, majority of the population of this ward is formed by migrants from Pashtkooh of Yazd, Nahavand, Touyserkan, Azerbaijan and Arak, who settled there due to the low prices of the houses. Most of the early inhabitants, whit desirable economic condition, sold their houses to new migrants and have settled at other suitable places. [16, pp. 14-15].

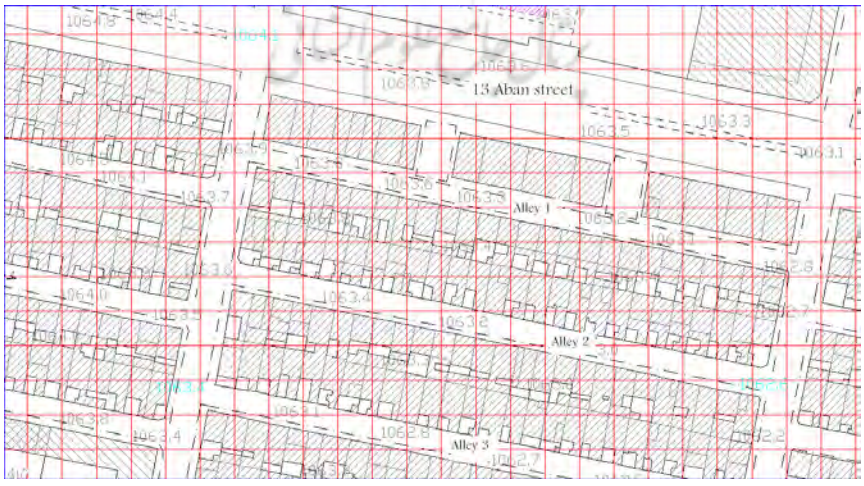
Research Method and Test of Hypotheses

During the initial stage of this research, available contextual theories and texts have been studied and reviewed. To study the present condition and their comparison with the earlier situation in the healthy city project, descriptive method was applied through using observation and interviews with officials, library consultations and study of documents and materials. The method of the questionnaire was used to study the functioning of project as well as their priorities from the point of views of people and officials. There was no need

of sampling in distributing questionnaire among officials whose numbers were limited and were reachable (though not so easily). For this purpose, the present and ex-officials of coordination council of the "healthy cities and healthy villages projects" and the officials who were related directly or indirectly to the execution of the project at 13th Aban Street were selected. A total 46 questionnaires were collected from this group. On the other hand, however, sampling was needed for distributing questionnaires among people. With due attention to 7115 families in the area under present study [19], about 365 samples were needed, which was accumulated using Kochran method.

Coincidental sampling method on the gridded map was applied in order to complete the coincidental samplings. For this, the map of the area was gridded with equal cells and then with the selection of coincidental numbers, characters Xi and Yi cells were fixed [20, p.182] and by distinguishing the established houses in these cells, utmost 424 questionnaires (59 more than needed) were distributed among the selected samples (Map 2).

To test the hypothesis, first the acquired information from the questions were evaluated on the basis of Likert Spectrum, and questions on satisfaction of the project, physical and mental health, environment, safety, educational and sportive activities were grouped separately and then total acquired points in every field were calculated. To compare the mean of data, One-Sample T-Test was carried out. Afterwards, the responses of the two groups were classified where the total acquired points of each group was evaluated on the basis of a distance scale. At the end SPSS was applied to resort the statistical analysis with the use of Independent-Sample T Test to compare the mean of two constant societies with unequal samples and statistics.



Map 2 A section of gridded map for coincidental sampling

Test of the First Hypothesis

To test this hypothesis, firstly, opinion of people and officials about the satisfaction level of the project, which was carried out through the questions related to identification of 13th Aban Street as a healthy city, activities, method of implementation and information, were collected on the basis of Likert Spectrum with ordinal scale. Then the descriptive statistics from the accumulated information based on questionnaires came by applying SPSS software whose result can be seen in Table 1a, 1b, and 1c. As such, number 1 shows minimum acquired points while number 5 shows maximum of each question (Table 1a). Among the total four presented questions, number 4 shows minimum, an average is in the amplitude of 4-20 and number 20 shows maximum acquired points in distance scale with regard to the special subject i.e. satisfaction level of healthy cities project (Table 1b). Among the total 470 samples of people and officials, 426 cases (90.6%) i.e. 386 people and 40 officials responded all of the four questions with general mean of 11.7958. In this way, the response from the people and officials found with an average 11.7306 and 12.4250, respectively (Tables 1-b & 1-c).

Table 1-a Distribution statistics of answers related with satisfaction level about HCP

Satisfaction issue		**Recognition of 13th Aban as a healthy city**		**Acquaintance With performed activities**		**Methods of performance**		**Informing**	
scale	**Grade**	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very little	1	34	7.2	11	2.3	12	2.6	31	6.6
little	2	110	23.4	112	23.8	84	17.9	164	34.9
To some extent	3	242	51.5	203	43.2	210	44.7	165	35.1
much	4	51	10.9	102	21.7	107	22.8	76	16.2
Very much	5	23	4.9	35	7.4	24	5.1	16	3.4
total	15	460	97.9	463	98.5	437	93.0	452	96.2
Missing	-	10	2.1	7	1.5	33	7.0	18	3.8
sum		1299		1427		1358		1238	
Mean		2.82		3.08		3.11		2.74	
Std. Deviation		0.904		0.925		0.870		0.938	

Table 1-b Distribution statistics of answers related with satisfaction level about HCP

Total scores	Frequency	Percent
6	3	.6
7	9	1.9
8	27	5.7
9	34	7.2
10	54	11.5
11	78	16.6
12	76	16.2
13	55	11.7
14	32	6.8
15	26	5.5
16	10	2.1
17	11	2.3
18	4	.9
20	7	1.5
Valid	426	90.6
Missing	44	9.4
Sum	470	100.0
Median	12	
Mode	11	
Mean	11.7958	
Std. Deviation	2.56273	

Table 1-c Group Statistics of satisfaction level about HCP

GROUP Statistics	N	Mean	Std. Deviation	Std. Error Mean
People	386	11.7306	2.59769	.13222
Officials	40	12.4250	2.12298	.33567

For the statistical analysis, firstly, total average of data was tested to One-Sample T Test for community average. In the process of the test because P.value quantity that found i.e. 0.101 was upper than α=0.05, and thus hypothesis H_0 was not rejected showing that data mean was near to

12. With attention to the accumulated average (11.7958) and P.value quantity (0.101), it can be ascertained that satisfaction level of project was significantly near to average (Table 1-d). In the later stage, mean data of people and officials were placed for comparative analysis. In the Independent Samples test result, the quantity of P.value has found for equality of variances i.e. 0.196 was upper than α=0.05 and thus hypothesis *Ho* based on equality of variances was not rejected and since the P.value for equality of mean i.e. 0.103 was upper than α=0.05, therefore hypothesis H_0 based on equality of mean was not rejected. By this way, first hypothesis of this research was rejected, i.e. there isn't a significant difference of opinion between people and officials with regard to the satisfaction level in the healthy cities project at 13th Aban Street (Table 1-e).

Table 1-d One-Sample Test of satisfaction level about HCP

Total of question about satisfaction level of HCP	Test Value = 12					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
	-1.645	425	.101	-0.20423	-0.4483	0.0398

Table 1-e Independent Samples Test of satisfaction level about HCP

Independent Samples Test	Levene's Test for Equality of Variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal variances assumed	1.679	.196	-1.635	424	.103	-.69443	.42485	-1.52950	.14064

Test of the second Hypothesis

Second hypothesis itself is divided into four sub-hypotheses. To test this hypothesis, firstly, opinions of people and officials were collected about the level of community participation in fields of physical and mental health activities, environment

activities, safety activities and educational and sportive activities in the project, on the basis of Likert Spectrum with ordinal scale. Then, the descriptive statistics from the accumulated information based on questionnaires came by applying SPSS software. As such, number 1 shows minimum accumulated points while number 5 shows maximum of each question (Table 2-a).

Table 2-a Descriptive statistics of answers related with community participation level in activities of HCP

	Questions	Scale	Very little	Little	To some extent	Much	Very much	Total	Missing	sum	Mean	Std. Deviation
		grade	1	2	3	4	5	15	-			
Physical and mental health activities	Prevention of community injury and addiction	frequency	19	14	142	87	79	341	129	1216	3.57	1.062
		percent	4.0	3.0	30.2	18.5	16.8	72.6	27.4			
	Mental health consultation base	frequency	1	30	153	118	67	369	101	1327	3.60	.886
		percent	.2	6.4	32.6	25.1	14.3	78.5	21.5			
	Family health activity	frequency	9	13	116	160	76	374	96	1403	3.75	.900
		percent	1.9	2.8	24.7	34.0	16.2	79.6	20.4			
	Healthy connectors	frequency	4	7	87	157	88	343	127	1347	3.93	.833
		percent	.9	1.5	18.5	33.4	18.7	73.0	27.0			
	Sanitize of stores	frequency	48	8	101	168	67	392	78	1374	3.51	1.171
		percent	10.2	1.7	21.5	35.7	14.3	83.4	16.6			
Environmental activities	Promotion of environmental situation	frequency	8	11	62	171	115	367	103	1475	4.02	.895
		percent	1.7	2.3	13.2	36.4	24.5	78.1	21.9			
	Protect of local gardens	frequency	53	27	109	100	112	401	69	1394	3.48	1.319
		percent	11.3	5.7	23.2	21.3	23.8	85.3	14.7			
	Time of garbage excreting	frequency	5	1	7	87	357	457	13	2161	4.73	.611
		percent	1.1	.2	1.5	18.5	76.0	97.2	2.8			

	Recycling	frequency	5	16	23	151	196	391	79	1690	4.32	.858
		percent	1.1	3.4	4.9	32.1	41.7	83.2	16.8			
	Improving environment	frequency	7	7	81	205	104	404	66	1604	3.97	.827
		percent	1.5	1.5	17.2	43.6	22.1	86.0	14.0			
Safety activities	Local police	frequency	31	63	101	104	71	370	100	1231	3.33	1.205
		percent	6.6	13.4	21.5	22.1	15.1	78.7	21.3			
	Being self police	frequency	11	12	28	162	208	421	49	1807	4.29	.909
		percent	2.3	2.6	6.0	34.5	44.3	89.6	10.4			
	Safety against natural hazards	frequency	9	27	28	200	101	365	105	1452	3.98	.934
		percent	1.9	5.7	6.0	42.6	21.5	77.7	22.3			
	Work safety-health	frequency	6	7	59	149	137	358	112	1478	4.13	.873
		percent	1.3	1.5	12.6	31.7	29.1	76.2	23.8			
Educational and sportive activities	Ladies matins exercises	frequency	12	16	30	268	77	403	67	1591	3.95	.831
		percent	2.6	3.4	6.4	57.0	16.4	85.7	14.3			
	Local sports teams	frequency	12	8	35	228	99	382	88	1540	4.03	.847
		percent	2.6	1.7	7.4	48.5	21.1	81.3	18.7			
	Local library	frequency	6	9	100	171	121	407	63	1613	3.96	.874
		percent	1.3	1.9	21.3	36.4	25.7	86.6	13.4			
	Preschool training	frequency	21	34	90	172	80	397	73	1447	3.64	1.060
		percent	4.5	7.2	19.1	36.6	17.0	84.5	15.5			
	Meetings for questioning and answering	frequency	2	14	128	141	79	364	106	1373	3.77	.850
		percent	.4	3.0	27.2	30.0	16.8	77.4	22.6			

Among the total five presented questions in fields of physical and mental health, environment, and educational and sportive activities, number 5 shows minimum, an average is in the amplitude of 5-25 and number 25 shows maximum acquired points in distance scale. But, in field of safety activities, among the total four presented questions, number 4 shows minimum, an average is in the amplitude of 4-20 and number 20 shows maximum acquired points in distance scale (Table 2-b).

Table 2-b Distribution statistics of answers related with community participation level in activities of HCP

Physical and mental health activities			**Environmental activities**		**Safety activities**		**Educational and sportive activities**	
Total scores	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
6	-	-	-	-	1	.2	-	-
7	2	.4	-	-	2	.4	-	-
8	-	-	-	-	2	.4	-	-
9	-	-	-	-	3	.6	1	.2
10	2	.4	-	-	3	.6	-	-
11	4	.9	1	.2	5	1.1	2	.4
12	3	.6	1	.2	19	4.0	5	1.1
13	9	1.9	1	.2	24	5.1	1	.2
14	5	1.1	4	.9	20	4.3	12	2.6
15	29	6.2	2	.4	47	10.0	7	1.5
16	23	4.9	10	2.1	59	12.6	16	3.4
17	38	8.1	18	3.8	38	8.1	38	8.1
18	23	4.9	33	7.0	29	6.2	34	7.2
19	21	4.5	38	8.1	16	3.4	37	7.9
20	23	4.9	33	7.0	33	7.0	63	13.4
21	24	5.1	48	10.2	-	-	24	5.1
22	13	2.8	43	9.1	-	-	12	2.6
23	15	3.2	29	6.2	-	-	15	3.2
24	9	1.9	21	4.5	-	-	7	1.5
25	30	6.4	34	7.2	-	-	35	7.4
Valid			316	67.2	301	64.0	309	65.7
Missing	273	58.1	154	32.8	169	36.0	161	34.3
Sum	197	41.9	6539	100	4749	100	6010	100
Median	5124	100	21		16		20	
Mode	18		21		16		20	
Mean	17		20.6930		15.7774		19.4498	
Std. Deviation	18.7692		2.75751		2.72524		3.18808	

Among the total 470 samples of people and officials, in fields of physical and mental health activities 273 cases (58.1%) i.e. 235 people and 38 officials responded all of the five questions with general mean of 18.7692 (in the amplitude of 5-25). In this way, the response from the people and officials found with an average 18.0170 and 23.4211, respectively. In the field of environmental activities, 316 cases (67.2%) i.e. 277 people and 39 officials have responded all of the five questions with general mean of 20.6930 (in the amplitude of 5-25). In this way, the response from the people and officials found with mean 20.3538 and 23.1026 respectively. In field of safety activities, 301 cases (64.00%) i.e. 263 people and 38 officials have responded all of the four questions with general mean of 15.7774 (in the amplitude of 4-20). In this way, the response from the people and officials found with mean 15.4373 and 18.1316 respectively. In field of educational and sportive activities, 309 cases (65.70%) i.e. 269 people and 40 officials have responded all of the five questions with general mean of 19.4498 (in the amplitude of 5-25). In this way, the response from the people and officials found with mean 18.8922 and 23.2000, respectively (Tables 2-b & 2-c).

Table 2-c Group Statistics of community participation level in activities of HCP

Issues	GROUP	N	Mean	Std. Deviation	Std. Error Mean
Physical and mental health	People	235	18.0170	3.46159	.22581
	Officials	38	23.4211	2.04849	.33231
Environmental activities	People	277	20.3538	2.63294	.15820
	Officials	39	23.1026	2.42568	.38842
Safety activities	People	263	15.4373	2.51159	.15487
	Officials	38	18.1316	3.00604	.48764
Educational and sportive	People	269	18.8922	2.87025	.17500
	Officials	40	23.2000	2.66218	.42093

For the statistical analysis, firstly, total average of data in the fields of physical and mental health, environmental, safety, educational and sportive activities was tested to One-Sample T-Test for community mean. In the process of all of four above fields tests, since P.value quantity was found i.e. 0.000 was less than α=0.05, thus hypothesis H_0 was rejected showing that mean data was not equal to the acquired averages. It can be ascertained that successes rates of project in community participation about all of four above

fields were significantly higher than averages (Table 2-d).

In the later stage, mean data of people and officials were placed for comparative analysis with the Independent Samples test. In the result of physical and mental health activities test, the quantity of P.value found for equality of variances i.e. 0.002 was less than α=0.05 and thus hypothesis *Ho* based on equality of variances was rejected and since the P.value for equality of mean i.e. 0.000 was less than α=0.05, therefore hypothesis H_0 based on equality of mean was rejected and against hypothesis i.e. H_1 (the second-a hypothesis of this research) was accepted. By this way, there is a significant difference of opinion between people and officials with regard to the level of community participation in physical and mental health activities in the 13th Aban's HCP (Table 2-e).

In the result of environmental activities test, the quantity of P.value found for equality of variances i.e. 0.574 was higher than α=0.05 and thus hypothesis *Ho* based on equality of variances was not rejected and since the P.value for equality of mean i.e. 0.000 was less than α=0.05, therefore, hypothesis H_0 based on equality of mean was rejected and against hypothesis i.e. H_1 (the second-b hypothesis of this research) was accepted, i.e. there is a significant difference of opinion between people and officials with regard to the level of community participation in environmental activities in the 13th Aban's HCP (Table 2-e).

In the result of safety activities test, the quantity of P.value found for equality of variances i.e. 0.274 was higher than α=0.05 and thus hypothesis *Ho* based on equality of variances was not rejected and since the P.value for equality of mean i.e. 0.000 was less than α=0.05, therefore hypothesis H_0 based on equality of mean was rejected and against hypothesis i.e. H_1 (the second-c hypothesis of this research) was accepted, i.e. there is a significant difference of opinion between people and officials with regard to the level of community participation in safety activities in the 13th Aban's HCP (Table 2-e).

In the result of educational and sportive activities test, the quantity of P.value found for equality of variances i.e. 0.930 was higher than α=0.05 and thus hypothesis *Ho* based on equality of variances was not rejected and since the P.value for equality of mean i.e. 0.000 was less than α=0.05, therefore hypothesis H_0 based on equality of mean was rejected and against hypothesis i.e. H_1 (the second-c hypothesis of this research) was accepted, i.e. there is a significant difference of opinion between people and officials with regard to the level of educational and sportive activities in the 13th Aban's HCP (Table 2-e).

Thus, the Second hypothesis of this research was accepted, i.e. there is a significant difference of opinion between people and officials with regard to activities in the 13th Aban's HCP (Table 2-e).

Table 2-d One-Sample Test of community participation level in activities of HCP

Issues	Test Value	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Physical and mental health	15	16.417	272	.000	3.76923	3.3172	4.2212
Environmental activities	15	36.700	315	.000	5.69304	5.3878	5.9982
Safety activities	12	24.0408	300	.000	3.77741	3.4683	4.0865
Educational and sportive	15	24.535	308	.000	4.44984	4.0930	4.8067

Table 2-e Independent Samples Test of community participation level in activities of HCP

Issues		Levene's Test for Equality of Variances		T-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Physical and mental	Equal variances assumed	9.527	.002	-9.353	271	.000	-5.40403	.57777	-6.54153	-4.26654
	Equal variances not assumed			-13.451	76.479	.000	-5.40403	.40177	-6.20414	-4.60392
Environmental	Equal variances assumed	.317	.574	-6.161	314	.000	-2.74877	.44617	-3.62663	-1.87091
	Equal variances not assumed			-6.554	51.458	.000	-2.74877	.41940	-3.59057	-1.90697
Safety activities	Equal variances assumed	1.199	.274	-6.022	299	.000	-2.69432	.44739	-3.57474	-1.81389
	Equal variances not assumed			-5.266	44.776	.000	-2.69432	.51165	-3.72497	-1.66367
Educational and sportive	Equal variances assumed	.008	.930	-8.936	307	.000	-4.30781	.48206	-5.25637	-3.35924
	Equal variances not assumed			-9.450	53.415	.000	-4.30781	.45586	-5.22197	-3.39364

Conclusion

In 1995, WHO had identified 13th Aban Street as the first rate pattern of healthy city in the world. With the limited choice, WHO declared the plan as "success in executing experimental healthy cities project and search towards access to healthy environment for life". In the cases during this research, the testing of first hypothesis confirmed that there isn't a significant positive difference between the opinions of people and officials in relation to satisfaction level about project and the mean data in field of satisfaction level about project was near to average level; which can hesitate selection of WHO in the area under study. But, the test of second hypothesis that was about different activities in the project, the significant differences of opinion between people and officials were observed in relation to community participation in all of mental and physical health, environmental, safety, education and sporting activities. The mean data in different fields of community participation in the project, was significantly upper than the average level; which can confirm the success of the healthy city project in different fields of community participation. Though in all the cases, the result was hopeful and more than average, but the result found from the officials was more optimistic than from people. Are the officials satisfied from community participation more than the people? Whether activities have really been approved with the peoples' viewpoints and their participation? What factors have influenced to community participation levels? What are the causes of differences of opinions between people and officials? Have we observed these differences in other related researches? Whether 20 steps program has successfully been passed for the reaching out to healthy city? How can be minimized the differences between peoples' and officials viewpoints? If this activity is shaped for the people why can not the views of people be secured more than the officials or at least to their limit? May these reasons are hesitate selection of WHO in the area under study? These are some of the important questions or other questions of the same magnitude that could be formulated during the course of other researches in this field.

Such projects must pay attention to following objects:

- Participation ability of people from all age and sex groups and with all levels of literacy, jobs and marriages and all fields of their interest, especially related to groups that have records of participatory work;
- Using propaganda, information, training and increasing peoples' awareness about HCP;
- Continuing other phases of HCP in 13th Aban street;
- Comprehensive and thorough evaluation of community participation from all aspects and all stages;
- Invigorate the role of Social Determinations of Health (SDH) in community welfare.

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ارزیابی پروژه شهر سالم (مطالعه موردی: کوی سیزده‌آبان)

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در سال ۸٦-۱۹۸۵ دفتر اروپایی سازمان جهانی بهداشت برنامه ارتقاء سطح سلامت را تحت عنوان "پروژه شهر سالم" پیشنهاد نمود. ستاد شهر سالم تهران نیز با هدف تأمین رفاه فردی و اجتماعی بر پایه مشارکت عمومی و هماهنگی بین بخشی به‌منظور ایجاد شهری سالم در هشتم اسفند ماه ۱۳۷۱ فعالیت خود را به‌طور رسمی در کوی سیزده‌آبان شهر ری آغاز نمود.

از آنجا که در پروژه شهر سالم، بر بهره‌گیری از همکاری بین بخشی و جلب خودیاری و مشارکت اجتماعی تأکید شده‌است، مسأله اصلی تحقیق حاضر این است که بین نظرات مردم و مسؤولان در مورد برنامه‌های پروژه شهر سالم تفاوت معنی‌داری وجود دارد یا نه؟ بدین منظور، نظریات مردم در بین ٤۲٤ نمونه تصادفی در کوی سیزده‌آبان با نظریات ٤٦ تن از مسئولان مرتبط با پروژه شهر سالم در مورد فعالیت‌های انجام گرفته در زمینه تفاوت سطح رضایت‌مندی مردم و مسؤولان از پروژه شهر سالم و تفاوت دیدگاه‌های آن‌ها از سطح مشارکت اجتماعی در زمینه‌های بهداشت جسمی و روانی، امنیت فردی و اجتماعی، محیط زیست و نهایتاً ورزش و آموزش مورد بررسی و مقایسه قرار گرفته‌است.

نتایج پژوهش نشان می‌دهد که در رابطه با سطح رضایت از پروژه شهر سالم بین نظریات مردم و مسؤولان تفاوت معنی‌داری وجود ندارد ولی در مورد تفاوت دیدگاه‌های آن‌ها از سطح مشارکت اجتماعی در زمینه‌های بهداشت جسمی و روانی، امنیت فردی و اجتماعی، محیط زیست و ورزش و آموزش بین نظرات مردم و مسئولان تفاوتهای معنی‌داری وجود دارد. به‌طوری که در تمام زمینه‌های فوق نتایج حاصل از کارشناسان و مسئولان در سطحی بالاتر از مردم قرار داشته است.

واژگان کلیدی: بهداشت جسمی و روانی، شهر سالم، مشارکت اجتماعی، ارتقای سلامت، هماهنگی بین بخشی.

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