Application of the Modified Method of “Rapid Appraisal to Assess Community Health Needs” for Making Rapid City Health Profiles and City Action Plans for Health
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Aim. To develop a method that Croatian cities could use in the development of the City Health Profile and City Health Plan. The assessment concerned cities that have recently experienced the war and thus the method had to be rapid, cheap, scientifically based, sensitive, participative (involving politicians, experts, and citizens), able to produce immediate action, and to sustain the gained benefits.

Method. A utilization-focused strategy was selected. Through ongoing interactions with intended information users, research questions were focused and the method of Rapid Appraisal to assess community health needs was selected as appropriate. This method was modified to: 1. assess the health of each city and serve as the basis for creating the City Health Profile; 2. select (Healthy City Project) priority areas; 3. establish the working groups on priority areas; and 4. build on the three previous steps to develop the City Action Plan for Health.

Results. During 1996, the Rapid Appraisal was applied in three Croatian cities (Pula, Metkoviæ, Rijeka). The work resulted in the completion of the City Health Profile, selection of the Project Priority Areas, formation of thematic working groups on priority areas, and acceptance of the agreed City Action Plan for Health. The method provided a scientifically based account of health in each of the three cities and identified targets for the future by using health-related measures and citizens’ observations about the community, its problems, and potentials.

Conclusion. The method proved to be credible and sensitive to the social and cultural differences it encompassed.

Key words: community health education; Croatia; health and welfare planning; health campaigns; health care surveys; health planning; health resources; planning techniques

The World Health Organization (WHO) Healthy Cities Project is a long-term international project that aims to place health high on the agenda of decision-makers in the European cities and to establish structures and processes to enhance health in urban environment (1-3). The first phase involved 35 core project cities, the city of Zagreb among them (4). In the first phase, (1988-1992) the emphasis was placed on the development of new organizational structures to act as change agents and the introduction of new ways of working for health in the cities (5,6). The second phase (1993-1998) involved 39 project cities and was action-oriented, with a strong emphasis on public healthy policy and comprehensive city health planning. The key strategic documents that were produced and followed by each project city were the City Health Profile (7) and the City Action Plan for Health (8). They had to be adapted to serve as valuable instruments for addressing the health issues in a comprehensive way, and to provide the informed basis for priority-setting, strategic planning, and accounting for health. The European cities had employed a variety of ways to attain credible and clear City Health Documents (9). This report describes the method used in three Croatian cities, Pula, Metkoviæ, and Rijeka.

Sample and Methods
Andrija Štampar School of Public Health (Zagreb, Croatia), which is hosting the Croatian Healthy Cities Network Support Center, is a methodological center for public health research and training in Croatia, and as such has taken the role of a leading agency acting as a supporter and adviser in the development of the City Health Profiles. It took one year to develop a method that Croatian cities were willing to use and that assisted them in creating the City Health Profile and the City Health Plan (10). It was important, while developing this instrument, to bear in mind post-war abilities of the Croatian cities, and offer a method that was rapid (done in short time), cheap (without much experts’ time and financial resources spent), scientifically based (credible), sensitive (able to reflect local specificities), participative (involving all three major interest parties: politicians, experts, and citizens), able to result
in an immediate action (action research) (11), and able to sustain the gained benefits (e.g., facilitate future collaboration of the interested parties).

**Method**

Several alternative approaches were identified (11-14) but the utilization-focused approach, relying heavily on qualitative research methods, was selected (15,16). The information needed for intended information users (the city project teams and political decision makers) was defined through ongoing interactions and regular network meetings. Relevant research questions were identified and the appropriate research methods, data-analysis techniques, and expected outcomes/products were agreed upon. We opted for a rapid reconnaissance technique because it was important to stay close to the action in the rapidly changing world (11). The method of rapid appraisal described in the Guidelines for Rapid Appraisal to Assess Community Health Needs (16) was chosen as a starting point. The method was modified to help in (a) assessing health in the city (and on the basis of that to create the City Health Profile), (b) selecting (Healthy City Project) priority activities areas, (c) establishing the working groups on priority areas, and (d) developing the City Action Plan for Health.

There were four major phases in this exercise. The preparatory phase included:

1. Selection of a local research coordinator, i.e., a person responsible for conducting the exercise, very familiar with a city that was included in the healthy city project activities, preferably with a background in public health; he/she had to be recommended and appointed by the Healthy City Project team.
2. Formation of a list of panelists – key informants (11) (politicians, experts, and citizens’ representatives) who would be involved in the exercise (Table 1).
3. Written communication to the selected panelists. They were informed in writing about our intentions and asked for cooperation. They received an introductory text and a semi-structured questionnaire with a request to return their essay in two weeks’ time.
4. Review of the existing written documentation and collection of relevant data (Table 2) that could be useful for the City Health Profile.

Table 1: Key for the selection of panelist members for making rapid city health profiles and city action plan for health. [view this table]

Table 2: Useful written data sources. [view this table]

5. Analysis of the essays by a research team, using a free-text processing program (11,17,18).
6. Creation of a photo album of health in the city based on panelists’ observations about what has diminished and what has enhanced the beauty of living in their city.

The second phase included preparation activities for the consensus workshop:

1. Preparation of data for the Consensus Workshop was conducted jointly by the local coordinator and a research team. Three main data sources were combined and used: data available from the existing written documentation, information derived from panelists’ essays, and their observations.
2. Agreement on the most suitable time for a conference and invitation of all panelists whose response (essays) had been received.
3. Technical preparation for the workshop (finding and renting a suitable conference room, equipment, organizing lunch and coffee breaks, etc.) done by the local team, while the backup materials for the conference were prepared by the research team.

The third phase, two-day consensus workshop, included:

1. The first day of the workshop, the participants were introduced to the workshop aims and working method. A list of city problems was generated from the group discussion. First individually and then in small groups (mix of representatives of all three interest parties), the participants had to decide on the priorities by using a priority matrix. At the second plenary session, small groups presented their priorities and a list of five city priority areas (usually those most frequently mentioned by the small groups) were agreed upon.
2. A small “thematic” group was formed around each of these chosen priority areas and the participants were encouraged to join them according to their interest, professional background, and the position they held. By the end of the first day of the workshop, each thematic group presented a description of the problem area they had undertaken (with the explanation of why it was recognized as a problem), defined (measurable) aims and objectives of their work, listed activities that would lead them towards those aims, and recognized partners (institutions and groups) responsible for the program implementation.
3. The starting point of the second day of the work was an input session on health promotion and Healthy Cities. The aim of this session was to introduce participants to the Healthy Cities concept and
to the work of other project cities. Afterwards, the small thematic groups completed their elaboration of an action plan and presented it at the plenary session. After all five priority groups had presented their proposals for action, a plenary session was opened for discussion, which resulted in the acceptance of a draft version of the City Action Plan for Health.

4. The conference ended with an open meeting, where the results were presented to the mayor, members of the city administration, press and other media, and other interested citizens to gain their comments and opinion, as well as their support and personal involvement in the Healthy City Project activities.

The fourth phase, document completion, included:
1. A re-assembly of small thematic groups and a more detailed completion of their action plans.
2. Production of two main documents – The City Health Profile and The City Action Plan (long-term and short-term action plan) jointly created by the local coordinator and a research team.
3. Documents dissemination – when printed, together with the recommendations and invitation for collaboration, the documents were sent to all participants and agencies responsible for making a healthier city.

Sample
The method was strongly recommended to the new cities entering the Project as a tool to start up the healthy cities process in the city. It was also promoted in the cities that had initiated their Healthy City Projects around 1990 as an evaluation instrument that could help them reconsider the priority areas in their projects, gain wider support for activities, and refresh the commitment of their city assemblies. The cities more interested in creating strategic health documents were those more experienced in the Healthy City project. Rapid Appraisal was seen by them as an opportunity for closing down and evaluating the first phase of the project and a chance for reassessment of the priorities. That gave an added value to the whole process. Conducting rapid appraisal also served to summarize and condense all the existing examples of good health promotion practice and create stronger alliances for health inside the city.

The cities (e.g., project teams and city administrations) volunteered to undertake this exercise, so our three pilot cities were self-selected. They differed in the size of the population, geographic location, level of economic development, and Healthy City Project infrastructure. Pula Healthy City Project developed from the County Institute of Public Health, with which (as a key institution) it was closely connected. Metkoviæ Healthy City Project was more of a citizens’ initiative with a loose connection with institutions and city administration. Rijeka Healthy City Project was established within the city Department for Health and Social Welfare, well funded and backed up by the city executives. They had five or more years of experience in the Healthy City project and were not directly struck by the war but to a greater degree by its consequences (displaced persons and refugees, economic transition, deprivation, and unemployment).

Results
The research was conducted during the first six months of 1996 in three Croatian cities: Pula, Metkoviæ, and Rijeka. In Pula, 85 semi-structured questionnaires were mailed to selected persons (politicians, experts, and citizen representatives) and, after several reminders, 47 completed responses in the form of an essay were submitted to the research team, sufficiently representing all three groups of panelists. In Metkoviæ, 115 semi-structured questionnaires were sent out and 53 completed forms returned. In Rijeka, 113 semi-structured questionnaires were posted and 50 essays received. After the analysis by a free-text processing program, those essays became the records on the local community views on health issues in each city.

Local Community Views on Health Issues in Each City
1. What kind of a community is the city?
Heterogeneous (Pula, Metkoviæ, Rijeka):

"Pula has become a community and it is not seen any more as the last resort for the citizens with nostalgic feelings about some far away region or nearby village"

"Metkoviæ is a homogenous community regarding nationality and religion but it is heterogeneous concerning the culture of living"

"Rijeka is a very heterogeneous community, without a strong intellectual and cultural nucleus which could impose and create its identity"

Passive/prosperous (Metkoviæ, Rijeka):

"Inhabitants of Metkoviæ are very communicative by nature but inactive. They know what is wrong but they do not know what to do about it"

"Rijeka has always been a very interesting place for settlers and newcomers, probably because the city has been considered prosperous. Although situated on the coast, which gives it a clear
Mediterranean attribute, the city of Rijeka looks more like a middle-European, inland town. As a typical industrial center, the city gets up early in the morning and falls asleep at 10 p.m. There is a big difference between Rijeka and the tourist resorts which surround it”.

2. How do the people live in the city?
Modestly, difficult (Metkoviæ):
...“In our city, differences are getting bigger and more visible, people live from day to day. They are turning inward to their families”.

The saddest (Pula, Rijeka):
(Pula)... “The saddest are the young disoriented people who do not see any point in the near future (opportunity for employment or income that would allow them to support their families, pay the rent, etc.). The saddest ones are also retired people. They are a marginal group and many of them can hardly survive on their pension allowance”.
(Rijeka)... “It is the same old story, not specifically characteristic for Rijeka – the most unhappy ones are the poor searching for food in garbage containers, or the intellectuals, mostly pauperized but not willing to give up. The people who lost their loved ones during the recent war or were forced to accept Rijeka as a substitute for their hometown are also among the unhappy ones”.

The happiest (Metkoviæ, Rijeka):
(Metkoviæ)... “The youngest, the children in primary and secondary schools are the happiest. They, indeed, have no worries. They always find some money to play and have fun”.
(Rijeka)... “The contented citizens are those between 30 and 50 years of age who are still lucky enough to have a job and a place to live, and who can still make plans for summer holidays or even go skiing”.

3. What has diminished the beauty of living in the city?
(Pula)... “One of the main factors is that the city policy is not at all clear and there is insufficient knowledge in the city administration of the citizens' needs. Citizens do not know or do not understand the arguments and rationale for decisions made by the city administration. Procedures of citizens' influence (participation in decision-making process) are not developed and exercised”.
(Pula)... “Nobody cares about the garbage that can be recycled. There is not enough information on the results of pollution monitoring. The example of this situation is the cement factory and its air pollution almost in the heart of the city”.

(Pula)... “The problem of social institutions for the elderly is an acute one”.
(Metkoviæ)... “The beauty is diminished by the arrogance of the local administration, long administrative procedures and queuing, poor planning and hence no respect for one’s own and other people’s time, unplanned and poorly scheduled (urban) construction works”.
(Rijeka)... “The city lies on the seacoast but the sea is far away and out of reach for its citizens. The coast is occupied by the container terminal, freight trains, and parking lots”.
(Rijeka)... “The green areas are very scarce, and those existing are insufficiently maintained or, worse, destroyed”.
(Rijeka)... “There are waste-disposal problems and a low level of dwelling culture. The same can also be said about traffic, health care, and culture in general”.

4. What has given beauty to the city?
(Pula)... “The beauty has already been here for centuries; it has been given to us by Nature (geographic position, climate, sea, pine trees), Old Romans (Colosseum), and other ancestors”.
(Metkoviæ)... “The geographic location of the city gives beauty to living in Metkoviæ; the Neretva River, woods, and large tangerine orchards planted on fertile soil taken from the surrounding swamp, mild Mediterranean climate, closeness of the sea, and, more than anything, beautiful, friendly people... The youth give beauty to the city and they are the biggest asset of the community. Sports, culture, and entertainment bring stimulation to the monotony of our lives”.

(Rijeka)... “Living in Rijeka is pleasant because of its people, especially the open-minded young ones with new initiatives... People who live here are mostly honest, good-natured, and tolerant. The safety of living is also satisfying... The city’s cultural life becomes richer every day, creating the new image of Rijeka (the traditional city carnival parade, St. Vid’s celebration, etc.) which makes it a remarkable spot on the map of Croatia and worldwide... The amenities of the city and its surroundings are a good reason for pleasant living. The sea, the neighboring islands, the vicinity of the mountains (Uèka, Platak, Risnjak, Hahliè), the forests of Gorski Kotar, the Rjeèina river”.

5. How would you like to see your city in 10 years?
(Pula)... “I would like to see the Old Town arranged with marked monuments, the City Museum, Forum Square, the City Art Gallery, clean streets... streets with bike lanes, bikes on the streets... nice maintained parks... a city with citizens who will be actively involved and able to influence decision-making concerning the city development”
(Metkoviæ) . “I wish to see Metkoviæ as clean as an Austrian town, socially organized by the Scandinavian model and with the soul of a Dalmatian little town... I wish to see more families and neighborhoods, clean river, big city library with activities for children, and people better educated on the use of pesticides”...

(Rijeka) . “In ten years’ time, I would like to see a city connected with Europe and the Croatian hinterland by modern highways and railways, a city with a developed cargo port and a modern shipbuilding industry which, together with private entrepreneurship, should guarantee the development and prosperity of the city’s public health care, public education, and the standard of living in general... I would like to see a city in which the disabled can live a decent life, with no humiliation, particularly among the retired persons, a city with multifunctional public places where various cultural, sports, and other needs of the citizens could be met... I would like to live in the city where all the pavements from Peèine to Preluk are designed for pedestrians, with no cars parked on them and where green areas are clean and properly maintained”...

6. How could you make your vision come true?

(Pula) . “There is a need for more community projects in all segments of life... Public opinion about needs and demands must be frequently investigated... Citizens have to stimulate changes... There are people with initiatives, a lot of young people, and they must have the opportunity to have a say in the matter”...

(Metkoviæ) . “The first step is to establish the facts about the current situation and to define needs and priorities by making realistic plans and programs of activities that would involve inhabitants... People must be motivated through different activities, political parties or other associations”...

(Rijeka) . “A vision can come true only if the citizens have enough freedom in making decisions and the responsibility in choosing the methods of action. Therefore, the development of the local self-management is essential... We have to act locally, in our own neighborhoods. As far as the new infrastructure facilities are concerned, we shall be able to build them only if we develop the economic basis of the city... We could make a vision come true only by putting together the efforts of the city heads working in the City Assembly and City Government and the managing staff of various institutions, firms, and schools. It is very important to have a permanent contact with the citizens and hear their opinions”...

Panelists’ observations about what has diminished and what contributed to the beauty of living in their city served as guidelines in making a photo-album of health in each city.

Information Derived from Written Documentation

The next source of information was the existing written documentation from which we derived 14 indirect indicators as measures of health and factors influencing health. They also provided a basis for the comparison among the cities (Table 3).

Employment. According to the Institute for Accounting and Auditing Data, 57,000 people were employed in Rijeka in 1995 but only 36,012 of those received a salary that month.

Table 3: Indicators derived from the existing written documentation. [view this table]
infections were registered at the neonatal ward of the Pula General Hospital, which were attributed to staff negligence.

Substance misuse. In 1995, according to police information, there were 1,000 registered substance users (all kind of substances) in the city of Pula, out of which 108 were on methadone treatment. At the same time, 20 opiate addicts were on methadone treatment in the city of Rijeka.

Traffic accidents. In 1995, the number of traffic accidents declined in comparison to 1994. The number was still high: 1,391 traffic accidents in the city of Pula, 4,078 in Rijeka, and 351 in Metkoviæ.

Juvenile delinquency. Compared to 1994, in 1995 the number of criminal offenses increased in all three cities, especially burglary committed by juvenile delinquents. According to police information in the city of Rijeka, 37% of juvenile delinquents were less than 14 years of age, 39% from 14 to 16, and 23% from 16 to 18 years of age.

Physical environment. The quality of drinking water was regularly controlled by the County Institutes of Public Health and was found satisfying. Waste disposal was not satisfying in either of those cities (no recycling, potential danger of underground water pollution, etc.). The sewer systems in Pula and Metkoviæ were described as old and insufficient. Traffic congestion, especially during rush hours, was reported in Pula and Rijeka. Unsatisfactory maintenance of green areas, including city gardens, was reported in all three cities. Data on soil pollution were not reported. The quality of sea water on the public beaches was regularly controlled by the County Institutes of Public Health and was satisfactory in Pula, and unsatisfactory at some beaches in Rijeka. Water quality in the Neretva river (Metkoviæ) was not monitored.

Cities’ Priority Areas

Out of the summarized information, the participants at the Consensus Workshops made a list of city problems and decided to proceed with the following five priority areas:

At the Pula Conference, participants decided to work on:

1. Improvement of communication between citizens and city administration;
2. Improvement of the city environmental situation related to waste disposal, sewerage system, traffic, city gardens, and green areas;
3. Support of young people’s health promotion activities, especially those related to quality free-time activities;
4. Improvement of the life quality of the elderly by developing community support programs for the elderly and improving living conditions in homes for the elderly; and
5. Improvement of culture of living by preserving cultural heritage and tradition and providing a better work place for amateur groups (e.g., encourage their activities).

Five priority areas were selected in Metkoviæ:

1. Create new jobs and reduce unemployment, especially among demobilized war veterans;
2. Improve the environmental situation, especially as it relates to waste disposal and sewerage system, to monitor and improve water quality of the Neretva River, to introduce controlled use of pesticides in agriculture;
3. Improve the culture of living by preserving heritage and tradition, by reviving traditional community events, and by nurturing traditional family and moral values;
4. Support young people’s health promotion activities by developing “quality schools” and support young people’s talents and creativity; and
5. Improve quality of life of the elderly through community support programs.

Participants of the Rijeka Conference chose the following five priority areas:

1. Ensure and support sustainable city development by encouraging strategic planning and interdepartmental collaboration at the city level and by introducing the concept of sustainable urban and industrial development;
2. Improve the environmental situation by protecting the city’s water sources, by improving the quality of the sea water in the harbor (introducing sewerage collectors and biorecyclers), by improving quality of air (introducing natural gas as the main energy source), and by protecting the Rjeèina spring;
3. Support young people’s health promotion activities through the improved offerings of good quality free-time activities and by opening a youth center to support children and young people with severe disabilities and their families;
4. Improve the quality of life of the elderly by developing community support programs and by improving their living conditions; and
5. Improve the quality of living for disabled persons and their families (physically and mentally disabled and war victims).

A City Action Plan for Health was built on the proposals given and elaborated by the thematic priority groups. One of the conclusions of the Workshop was that the plan would be revised at regular (one-year) intervals. Such yearly Evaluation Workshop would make it possible to record progress, measure
achievements, and monitor implementations, and would increase awareness of how close each project is to its established targets.

Discussion
Not many traditional public health, epidemiological, and statistical methods are well suited to a post-war environment marked with limited time, financial, and human resources. For this reason, there was great interest in finding suitable alternatives and adapting already known methods to conditions existing in the Croatia (12,14,16). Because of the poor image this method has gained among the members of the scientific community (being seen as “quick and dirty”), strict rules were established and a strong scientific rigor applied through data triangulation (use of a variety of data sources) and investigator triangulation (engagement of three researchers with different academic backgrounds in data processing and analysis and public health) (11). The method was used just to find out what the problems were, and on the basis of these findings it could be decided whether investment in any more complex designs would be likely to be justified (19). It was not a method of comprehensive data collection related to a geographic area or a specific health problem (in contrast to very popular survey methods) (13); therefore, the kinds of data necessary were determined in advance (as a minimum of information needed). This method presented just the first step in the data-collection process, which aimed to elaborate the plan of action; therefore, it was seen as the first step in the process of health intervention planning in the community (16). The selection of panelists was a very delicate, almost crucial part of the rapid appraisal. The more troublesome the city (greater political tension), this part of the Appraisal gained greater importance. For example, the Pula city councilor responsible for health and social welfare was complaining that people invited as panelists were mainly from the opposition parties or citizens’ initiatives (those dissatisfied with the city administration). It proved to be of the utmost importance to rigidly respect the selection criteria (11) and gain the city authorities’ approval for the list in advance. During the preparation of the Rapid Appraisal in Rijeka, two mutually opposite groups were approached and asked to make their own list of panelists using the same criteria matrix. In the final selection, only the panelists mentioned in each list were selected to avoid the kinds of complaints encountered in Pula.

Strengths and advantages of the method were the following: 1. it could be rapidly done (in two months); 2. it was inexpensive (without much experts’ time and financial resources spent) – it took about 120 local coordinator working hours and about 100 hours of two-expert time. The total cost (including human resources, data analysis, consensus conference expenses, and printing of publications) amounted to around US$6,500 per city; 3. it was participative by its nature i.e., totally relying on the community representatives in the assessment of needs and possible solutions (20), able to involve all three major interest parties (e.g., politicians, experts, and citizens), and facilitate their future collaboration in the “taking action” phase; 4. it was sensitive (able to reflect the local conditions and specificities of the local community); 5. it was scientifically based (able to demonstrate credibility); 6. it resulted in the immediate actions but also in long-term plans for action (City Action Plan for Health); and 7. it sustained the gained benefits (e.g., facilitate future collaboration) by establishing priority working groups.

Three Healthy Cities Project teams expected the City Health Profile, selection of the Healthy City Project priority activities areas, formation of the working groups on priority areas, and development of the City Action Plan for Health. The Metkoviæ Healthy City project team also hoped that by applying this method the Project might gain better recognition and support from the city administration. In Rijeka, they hoped for greater project visibility and increased community groups involvement in conducting the Healthy City project activities. The Pula team was willing to review the Project activities and assess whether they were really those needed by the community.

At the Pula Conference, the need for improvement of communication between citizens and the city administration was seen as a main concern. At that time, the city had suffered a lot of political tension and the citizens’ dissatisfaction with the city executives was overwhelming. During the two days of the workshop, working group members, politicians, “experts”, and citizens groups’ representatives agreed to start up with the following activities: open new channels of communication, create better mutual understanding and build partnerships, and improve community participation in the process of decision-making in the matters concerning health and quality of life in the city.
For Metkoviæ inhabitants, creating new jobs and reducing unemployment, especially among demobilized war veterans, was the main issue. Municipal services reports on employment strongly supported their decision, showing that the Metkoviæ situation was worse than in the other two cities, in percentage of unemployed (1 person unemployed to 2.6 persons employed), and in the percent of jobs lost during the past four years (48% less employed compared to 1991).
For the city of Rijeka, ensuring a sustainable city development was recognized as a main issue.
Rijeka inhabitants were keen about the city industrial development and the job prospects city enterprises were offering, but not about the idea that the development should go on their health account. The solutions offered to this problem were to encourage strategic planning at the city level, introduce the concept of sustainable urban and industrial development, and improve interdepartmental collaboration.

Other priorities the three cities had chosen had similar overall titles but addressed diverse aspects of the problem. For example, all three cities stated the need for improvement of the environmental situation through improving waste disposal, which was not found satisfactory (no recycling, potential danger of underground water pollution, etc.); improving the sewerage system, which was described as old and insufficient (especially in Pula and Metkoviæ); revitalizing city parks and green areas, which were found to be unsatisfactorily maintained; and increasing consciousness of the general public in matters concerning environmental health. Enthusiasm for building more biking paths and encouraging citizens to use more public transportation, as a way to solve traffic congestion was specific to Pula. In Metkoviæ, it seemed to be important to monitor and improve the quality of the Neretva river, introduce the controlled use of pesticides in agriculture, and monitor potential soil pollution. In Rijeka, the main issues were the protection of city water sources, improvement of the quality of sea water in the harbor and on public beaches, improvement of the quality of air by introducing natural gas as the main energy source, and protection of the Rjeèina spring.

Pula and Metkoviæ established priority groups for the improvement of culture of living, which aimed to preserve cultural heritage and tradition, stated as “spirit and soul” of the community. In Pula, they thought that this could be accomplished by providing a better working place for amateur groups and by encouraging their activities, while Metkoviæ planned to revive traditional community events and cherish family and moral values through the community volunteer groups.

Most similarity in approaching the problem and offering solutions was shown in the selection of priority groups – youth and elderly. To support young people’s health promotion, the groups thought of conducting research among the youth to define their needs of improving offerings of quality free time activities, supporting young people’s creativity and talents, opening a youth center, developing “quality schools”, and providing support for children and young people with severe disabilities and their families. Although the concept of independent living was advocated, the need for improving living conditions in the existing homes for the elderly was recognized. The groups agreed on conducting research among the elderly, which would enable them better to define their needs.

One priority chosen only by Rijeka was the need for improving the quality of living among disabled persons and their families (e.g., physically and mentally disabled and war victims). That decision was not supported by data in terms of a larger number of disabled persons compared to other cities, but was not surprising since the city of Rijeka has a long history of projects, community-based and institutional, aiming at the improvement of the life of people with special needs (e.g., a public beach especially equipped for accommodating heavy physically disabled persons was opened in Rijeka, as the first of its kind in Croatia).

Three data sources used in this study described the city and the factors affecting health in a way the citizens instantly recognize (21). The citizens contributed to the study with their observations about the community, its problems, and potentials. They selected the priorities and gave proposals for change. This method proved to be sensitive (e.g., able to reflect each city’s specificities). Thematic groups formed around chosen priorities had the enthusiasm and energy to bring about a change. They encouraged members to see the contributions they could make, personally or through the group (organization) they represent. Indeed, the development of healthy alliances across the community could be facilitated and the gained (research) benefits sustained through joint work and collaboration.

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References
3 Šogoriæ S. Što je projekt “Zdravi gradovi”? In: Paunoviæ A, Vanêina F, editors. Grad kao složeni

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