

Case Study: Metropolitan District of Quito, Ecuador



Key features:

This case study reports work of the municipality and communities in the Metropolitan District of Quito (DMQ) and the Municipality of Quito Health Department in the project: *Healthy Neighbourhoods - closing the gap in health inequality*. The project promotes community led initiatives to integrate health in urban planning, local investment decisions and the creation of local public policy. Quito residents in community meetings and community health teams use information on health and its local determinants to set local priorities and plans, to promote healthy physical, economic, and social environments through citizen participation in action on community health and its determinants. DMQ has facilitated a community –led certification of “healthy spaces” (such as in fresh food markets and schools) within the municipality.

The local socio-political and health system context for this work needs to be considered in any discussion of their adaptation in other settings. However, the steps and processes in Quito for information gathering, analysis and priority setting in the community, for encouraging co-ordination across sectors and for ensuring that the gathering and analysis of information supports both community and cross sectoral roles in problem-solving could be shared with other settings. They are already being exchanged with other municipalities in Latin American countries.

Introduction to the site and its practices:

This case study reports work of the municipality and communities in the Metropolitan District of Quito and the 1298 neighbourhoods that have emerged over time as the city has grown and changed. The residents of Quito have a sense of belonging to their neighbourhood and organize to make community-led decisions and implement actions at this geographic level. The Health Department of the Municipality of Quito leads the efforts to promote health and prevent disease. A key component of these efforts is the implementation of a project called *Healthy Neighbourhoods - closing the gap in health inequality*. The case study describes how this project is working to improve the health and well-being of Quito inhabitants, through integrating health in urban planning, local investment decisions and the creation of local public policy, by promoting community-led initiatives and sharing them with other cities.

As one element the programme is adapting the Urban Heart methodology to the Quito context. It uses indicators selected in a participatory manner by an inclusive work team including members from the community and other sectors in DMQ. It has set up an observatory and ‘situation room’ in neighbourhood health and designed and is implementing a range of programme activities, viz:

- Setting up community health teams
- Implementing local health diagnoses used with other evidence to set up a Neighbourhood Health Improvement Plan with evidence-based high impact actions.
- Training citizens in non-communicable diseases, mental health, sexual health and reproductive health, determinants of health and social participation in health, and
- Implementing healthy school and healthy market projects.

To support this the team is carrying out face-to-face and/or virtual workshops to share knowledge and support cooperation on local good practices in health across municipalities in Ecuador and the Americas.

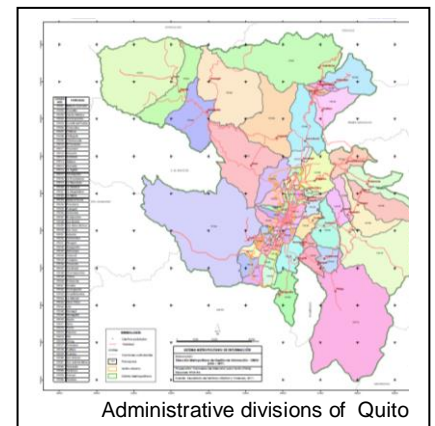
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Context:

The Metropolitan District of Quito (DMQ) is the second most populated city in Ecuador. It has experienced rapid growth in recent decades. It has a 2010 population of 2.2mn in 65 districts called *parroquias*, 32 of which are considered urban and 33 rural. These *parroquias* are further sub-divided into 1298 neighbourhoods. The residents of Quito are mainly mestiza-type (83%), although some areas have higher shares of indigenous, Afro-descendent and montubia people (DMQ 2016). Residents have a sense of belonging to their neighbourhood and organize to make community-led decisions and implement actions at the neighbourhood level. At the same time there are numerous social differentials in the district: In terms of education, 28% of the population have primary education, 25% secondary education and 25% tertiary and higher education. The illiteracy rate in DMQ is 2.7%, higher in poor and rural households and those with afro-descendant and indigenous women (DMQ 2016).



The urban population is mainly involved in retail trade, manufacturing and construction. More rural parts of the district practice agriculture, livestock, forestry and fisheries. Unemployment levels are low (4.9%), but nearly half of the population have no formal social security scheme. Poverty levels have decreased post 2007 (Yanez 2013). Poverty in Quito in December 2016 was at 10.27% of the population, lower than the national average of 22.9%, but with geographical and residence differentials in its distribution (INEC 2016). Differentials in education and other areas may affect how different residents benefit from the rapid increase in scientific and technological innovation in DMQ's economy, with approximately 25% of the national high-tech employment concentrated in the district, particularly in IT and telecommunications. Quito has 13.8m² / inhabitant of green spaces, 138.08 hectares of outdoor recreation spaces and public access for every 100,000 inhabitants, as recommended by the Ministry of Public Health. It has approved standards for air quality (Empresa Metropolitana de Movilidad y Obras Públicas del MDMQ, 2016; Secretaría de Ambiente del MDMQ, 2016). Urban expansion and the growth of infrastructure has increased the pressure on and degradation of natural resources in Quito, however, and increased pollution of air and water resources has been observed. The districts that are more vulnerable to climate change and ecosystem damage are reported to be those with lower coverage of drinking water, an aging population, lower education levels of women and those with high rainfall, (> 2000mm per year), mainly outside urban Quito.



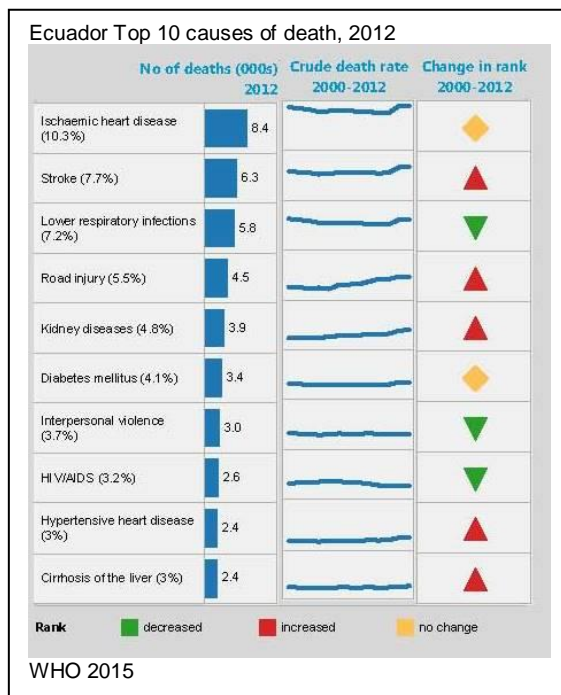
Ecuador's 2008 Constitution, National Plan of Good Living, Organic Code of Territorial Ordering, Autonomies and Decentralization; Organic Health Law; and Metropolitan Ordinance 0494 all set an enabling legal framework for a more holistic rights-based approach to and for social participation in health. The Constitution provides in Art. 32 for health as a right whose implementation is linked to the exercise of rights to water, food, education, physical culture, social security, healthy environments and other areas that sustain good living (Asamblea Nacional del Ecuador 2008). The *buen vivir* model in the Constitution conceives that personal well-being is reached when human's basic needs are satisfied in harmony with the community and the environment (Yanez 2013). The Ecuador National Plan for Good Living 2013-2017 locates health within *buen vivir* (wellbeing) in a holistic inter-sectoral perspective, that encompasses life habits, food culture, promotion of physical activity, health services, sexual, reproductive and intercultural health and a healthy environment within a social and solidarity economy. This is located within the right to the city and its democratic management (GoEcuador 2013).

The DMQ is an autonomous local government according to the Ecuadorian Constitution. It has decentralised powers to plan and exercise control over various aspects of urban development to implement rights to these different dimensions of wellbeing, such as to allocate land, and to plan, build and / or regulate, road and public transport systems, public services for drinking water, sewerage, wastewater treatment, solid waste management and sanitation, physical infrastructures, health promotion and prevention and education services and spaces for social, cultural and sports development, in ways that preserve the architectural, cultural and natural heritage of the city. The *Organic health law* identifies the role of schools, communities, municipalities as key spaces for delivering on health through inter-institutional and inter-sectoral approaches with participation and oversight of the community (GoEcuador 2012). The *Organic Code of Territorial Ordering, Autonomies and Decentralization* provides for these needs to be met in ways that involve citizen participation, oversight and accountability (GoEcuador 2010). The *Metropolitan Ordinance 0494* 2014 requires that

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municipalities promote a culture of civic coexistence based on respect, recognition and appreciation of diversity, gender equality, generational and inter-cultural diversity, with special protection for priority groups, and citizen participation in health actions.

DMQ Administrative data indicate that some of these social determinants of health (SDH) have better levels than others. Urban households have good access to sewerage, public drinking water and garbage collection. However a DMQ health secretariat comprehensive health diagnosis (*Diagnóstico de Salud*) for the city in 2016 (available as [a separate document](#)) highlights that the city faces a high burden of chronic non-communicable diseases, particularly due to cerebrovascular and ischemic heart diseases, hypertension, diabetes, overweight / obesity and transport accidents (DMQ 2016). This is also a concern in Ecuador nationally (see adjacent figure). Data from the 2012 National Health and Nutrition Survey (MSP, INERC 2012) indicate that overweight and obesity in 19 to 59 year olds is at 63.5% in DMQ, and in 12 to 19 year olds at 22%. While a lower level of 4.5% of DMQ's adult population of DMQ consumes tobacco or tobacco products, 41% consume alcohol on a monthly basis, and 34% of 10 to 18 year olds and 64% of 18 to 60 year olds are inactive (MSP, 2015).



DMQ's health profile is attributed to changes in eating habits and physical activity, itself attributed to an urbanization that is not adequately addressing health, and to migration, mobility, pollution, violence and traffic accidents (MSP, 2015; DMQ 2016). There are also gender and reproductive health determinants: Pregnancy and its complications are a major cause of hospitalisation amongst adolescents, although at lower levels in DMQ than for the country as a whole. Teenage pregnancies have been attributed to low family planning coverage, inequity in access to reproductive health resources, lack of education and sexual violence (DMQ 2016). Women are particularly vulnerable to gender violence (domestic violence and sexual abuse). Adolescent suicide is reported to increase in July associated with the end of the school year and family pressure over academic performance, and harmful drug use is observed to be starting at earlier ages (12 years) with alcohol, tobacco, drugs, marijuana and cocaine base paste the drugs most consumed in Quito (DMQ 2016). Elderly people and people with disabilities are also identified as vulnerable by the city, with poor coverage of pensions, limiting access to health services and exposing them to informal employment and begging to survive (DMQ 2016).

Delivering on the constitutional obligation to provide access to high quality services at no cost to all in the country has faced various challenges before 2008: limited growth over decades, a fragmented system and a large share of privatised services. Public services were seen to be key to address these challenges. The government divides the country in zones, made up of 3-4 provinces and the administrative offices of the health ministry in each zone and province coordinate with other de-concentrated offices of the national government, local government and non-state and civil society organisations to provide health services. The Ministry of Coordination of the Social Sector (*Ministerio Coordinador del Desarrollo Social*) supports collaboration between national government sectors. It proposes sectoral and inter-sectoral policies that respond to priority needs in the social sectors. It coordinates the policies and actions of different institutions to implement these policies and the cooperation resources to underpin them. It develops and updates an information system of social indicators to monitor programmes and a social registry of beneficiaries of social programmes.

Curative services are the responsibility of the national government and health promotion and disease prevention is a shared responsibility with municipal governments. DMQs Health Department is responsible for prevention and promotion services through Municipal Health Units (UMS), medical services of municipal educational establishments, education centres, mobile units and dispensaries linked to health units. The Ecuador Constitution in Article 366 provides for public health financing to be timely, regular and sufficient, from permanent sources of the general state budget and distributed based on population criteria and health needs. In accordance with Transitional Provision 22, the health budget should increase each year by not less than 0.5% of the Gross Domestic Product, until reaching at least 4% GDP. Article 300 requires that the tax regime be governed by principles of generality,

progressiveness, efficiency, administrative simplicity, non-retroactivity, equity, transparency and sufficiency of tax collection, with a priority for direct and progressive taxes (Rep Ecuador Asamblea Nacional 2015).

After 2007 there was an increase in national investment in public sector health services. The annual health budget rose from US\$606 million in 2007 to US\$1.6 billion in 2012 (Yanez 2013). These funds were mainly invested in health facilities, acquisition of medicines and vaccines, state led health programs and prevention campaigns. This was reported to lead to significant improvements in access to services (Yanez 2013). However two key challenges are noted: Firstly, while the public sector is the largest provider of health services generally with outpatient and primary care facilities mostly public in DMQ (94%), as for Ecuador generally DMQ has a high and increasing level of private-for-profit services at hospital level (DMQ 2016). Private services raise fee and other access barriers for poorer households. Secondly, there is concern that achieving the health goals and rights set in policy calls for the prior reactive biomedical model to be replaced by a stronger proactive community-based and population health approach (Rasch and Bywater 2014). Within municipal financing, a portion of funds are invested locally to facilitate and support collective processes in the neighbourhoods that involve the community and that re for improvement of their conditions and public spaces. The activities that use these resources are discussed in and guided by Assemblies that represent the communities (described later).

The Constitution recognises the right to the full participation of the citizenry in health services. Within the repositioning of Primary Health Care (PHC) as a key strategy, *Comités Locales de Salud (CLS)*, set up by the national government, are set in policy to facilitate public input to health services, “to generate democratic deliberative and associative spaces of citizen power” (MSP 2012: 45). The national government took over responsibility for the committees in 2007 from local government. Local community and social organization representatives are elected by the community to form the CLS. Each CLS reaches a consensus on its structure, decision making and other procedures, and elects its coordinator and secretary and appoints relevant thematic sub-committees. The CLS participates in the creation of a Health Situation Diagnosis. It coordinates with the health personnel within their jurisdiction, and participates in health promotion activities in the community. The CLS is charged with strengthening or supporting the development of youth, elderly and other local health organizations. Representatives of the CLS participate in citizen participation forums such as the *parroquia* (district) Level Assembly or Municipal Level Assembly and the CLS participates in development of the health agenda in the Municipal Plan (*Plan de Desarrollo y Ordenamiento Territorial*) (MSP 2012). The CLS exist in Quito but the municipality sees the need to support their efforts, specifically in relation to the Health Situation Diagnosis. The municipality is building on an existing culture that has existed in Ecuador and Quito of collective work within the community to address practical needs. People have a culture of working together on areas where there is wider community benefit, such as in food preparation, in building housing and in improving public spaces and schools. This has acted as an important basis for the work in Quito, and made embedding an understanding the health implications of these existing local processes and decisions a key aspect of the work, described further in the next section.

The participatory practices:

While the legal and policy environment promotes social participation in health, and while important information on health and its determinants are available, key informants observed that the information is not organised for local decision making and was not in the past shared or discussed with relevant civil society actors or with organized neighbourhood groups. Citizens were thus not empowered about their health and had no access to mechanisms to influence local public policy. The DMQ Health Department is thus implementing a *Healthy Neighbourhoods - closing the gap in health inequality* project. The programme was initiated in 2015, when DMQ realized that it was investing most efforts in health education and health prevention, with very little action in the other areas of health promotion, such as social participation in health, promotion of healthy spaces and promoting healthy local policies. With the support of the Secretary of Health, a *coordinador de determinantes de salud y acción territorial* was hired and the participatory interventions integrated within the Healthy Neighbourhoods project. It was given a small seed budget for 2017 (US\$114 000) that will be increased based on demonstrated value of the work.

The DMQ Healthy Neighbourhoods project aims to improve the health and well-being of the inhabitants of Quito through integrating health in urban planning, local investment decisions and the creation of local public policy, by promoting community-led initiatives and sharing them with other cities. It identifies the means to achieving this change through three intermediate pathways:

1. Increased local public policies generated and implemented with the participation of Quito residents taking desegregated health data and SDH into account.
2. Increased use of healthy environments (physical, economic, and social) created with citizen participation in action on community health and its determinants.
3. Increased access to knowledge and best practices in urban health for local governments in the region.

The first districts where the participatory work is being implemented are Ponceano, Centro Histórico, and Chimbacalle, with 17, 13, and 6 neighbourhoods respectively and with populations of 54 438, 36 610, and 38 533, respectively. In addition to the general health profile raised above, these areas have higher health needs. They have double the death rates and levels of tuberculosis mortality compared to the DMQ average, and area specific problems, such as respiratory diseases in the Historical Centre. The specific neighbourhoods / districts included are those where the administration has capacities to support implementation and where there are municipal schools, markets, and health services, as well as elected representatives the community.

An **inclusive institutional mechanism, a steering committee**, was defined by the DMQ Health Department to be a flexible mechanism to resolve issues that come up at the local level and keep communities informed on the work. The DMQ asked each organisation for a delegate to the committee and the first meeting was scheduled in February 2017. The Ministry of Health Direction of Promotion, Prevention and Surveillance and Direction of Policies and Health Planning; the DMQ health department and about 20 divisions of DMQ and local ministry departments responsible for SDH are involved in a Technical Health Committee. **Community health work teams** at the city and neighbourhood level are being formed and trained by DMQ to bring voice of the local community to the processes: Work teams are being established made up of members of the neighbourhood (or geographic area selected) with representatives of DMQ Health Department and the *Secretaría de Coordinación Territorial y Participación Ciudadana*. The work teams aims to promote participatory work on healthy physical, economic, and social environments.

The community team represents the following five sectors of each neighbourhood (or geographical area) and includes community representatives from:

1. The community: addressing SDH used by the entire community, such as access to natural foods, access to walkable or cycling spaces, smoke-free spaces, or personal safety.
2. Community institutions or organizations: including those that provide social services such as day care centres, churches, senior centres, community centres, and universities.
3. Local health care, including all places where people come to receive preventive care or treatment or health emergency services such as hospitals, clinics, doctors' offices.
4. Primary and secondary education, including private and public schools.
5. Workplaces, including private and public workplaces.



Community identifies the main health and determinants of health issues in the Parroquia Centro Histórico of Quito. © LJ Cárdenas 2016

Other sectors include opinion leaders of their sector (education, health, etc.) within the parroquia. The selection process for interested candidates for the community teams is being led by the Secretaría de Salud and is currently underway.

These mechanisms are being set up within the context of Municipal Ordinance 102, that outlines the various mechanisms of citizen participation. The leaders of the parroquia (district/neighbourhood) level assembly define the process for electing the representatives and the voice and capacity they have in the neighbourhood and district level assemblies. The establishment of these assemblies was facilitated in Quito by the *Secretaría de Coordinación Territorial y Participación Ciudadana*. There are 65 parroquias (district) level assemblies that are required by municipal ordinance to meet three times per year.

To generate and implement policies and programmes that address health equity in a holistic manner and with participation of the residents, the city is producing, gathering and processing information on health and SDH to communicate with residents and hear their priorities on the state of the health in the different neighbourhoods. Through inter-sectoral coordination, the existing databases of various DMQ departments are being reviewed. Surveys are then designed and implemented to collect missing information. The findings are then organised as accessible visual charts to show their importance for population health. The work has used the WHO Urban Health Equity Assessment and Response Tool

(Urban HEART) from the United States Centres for Disease Control Healthy Communities programme and from the Ecuadorean Ministry of Public Health (MSP) National Program for Healthy Municipalities (See *Appendix A1* and the programme guide). DMQ staff are trained on the methods and on initiatives that impact on health. DMQ is developing in 2017 a virtual platform to display updated and accurate health data and health determinants disaggregated by district of Quito to make the information publicly accessible, including for slum neighbourhoods.

Residents are involved in and build ownership of the process through their own awareness raising and local 'priority setting' workshops that DMQ holds in local neighbourhoods with residents. These workshops use the evidence gathered by DMQ but also the issues perceived by the communities. In 2017 DMQ will engage further with civil society organisations and explore further methods for participatory mapping and needs assessment by communities. The workshops with civil society from selected neighbourhoods review the health evidence from DMQ, add or collect additional information of interest to residents, prioritize health problems of each locality and develop a road map with activities for the neighbourhood and city level. The responses are organized in an intervention proposal that is presented to the mayor for approval and implementation.



MDMQ steering committee meeting, Quito LJ Lurado 2016

DMQ supports the capacity of residents to generate these intervention plans, or Community Health Plans within their health teams (described earlier). The interventions chosen are those that are seen to have high impact, or that draw on examples of promising practices from the region and from national and international evidence, such as from the Ecuadorean Association of Municipalities, the Resilient Cities initiative and from PAHO. DMQ is providing incentive funds of between \$2 000 and \$5 000 on a competitive basis to promote community involvement in the development and implementation of plans and initiatives for health. It holds events to provide wider community sensitisation on the findings on the local health situation, and to launch the contest and award. The local health teams and wider community set their local plans for improvement of health in their neighbourhood, as proposed by key community stakeholders in the neighbourhood sports association, collective neighbours and neighbourhood committees. They then submit these to the competition. The submissions are evaluated and those succeeding obtain the incentive funds. The district health teams develop the criteria for the receiving the seed funds based on the preliminary analysis of the health issues in their parish, and determine the winner of the seed funds. These funds support initiatives from the community to improve the health situation and raise awareness, and that benefit the wider community, rather than a small group of individuals. The scheme is being piloted in areas of the city where there is institutional capacity to pilot the model and show results, but with an intention to target the funds towards and stimulate participation in those with higher health need and that need the support to be participate in health.

Along with the process of setting and implementing the participatory plans DMQ is increasing the two-way communication between the municipality and residents. One way of doing this is through establishing and strengthening the community health teams, described earlier.

Another element of the work is that of facilitating a community –led certification of “healthy spaces” (such as in fresh food markets and schools) within the municipality. Those that meet certain criteria are certified. The criteria for certification in the case of schools are developed by the DMQ Health Department in collaboration with the Ministry of Education, the Ministry of Health and PAHO. In the longer term it is intended that responsibility for certification of these healthy spaces will be delegated to the Community Health Teams. For food markets, DMQ discusses the standards for health promotion and food safety, and the evidence they have on this. Teams from the community such as the users of the market from the community, the administrative staff, the workers and municipality assess the markets and develop workplans for health improvements on prioritised gaps in the standards. Similar work is done in schools, and for healthy public spaces selected by community teams such as equipped parks or streets in residential neighbourhoods. In all cases the participatory action plans are implemented in coordination with relevant actors, with participatory review of how well they worked. The certification process aims to support the administrators and users of spaces like markets and schools to prioritize how to best invest limited resources to address those issues that are important to preserve and promote health and to address any gaps identified. It is expected that the initial effort around receiving a certification will forge a working relationship between the relevant actors in the improvement of these spaces which will continue after the space meets the criteria for certification.

These processes being facilitated by DMQ are designed to empower and guide the different community sectors (education, health, community institutions) to act within their area of influence, so that they have the power to implement these changes. Out of this work DMQ expect to identify tasks for the municipal government. These tasks will become the agenda of the Secretary of the Health Department, who will negotiate with the mayor, other secretaries and the council on behalf of the community. For the communities, these approaches resonate well with collective approaches customarily used for improvements that have wider social benefit, as discussed earlier, For health sector personnel, engaging communities and strengthening their understanding of the health implications of the decisions, activities and choices being made on priorities and resources is clarifying the health impact of people's decisions and embedding health within their thinking and priorities. DMQs key role in promoting population health is accepted by Ministry of Health and making the link between health and its determinants is strengthening health promotion and population health improvements within the community.

DMQ plans to hold meetings to share knowledge and local best practices that improve health with other cities. This exchange is identified as important to strengthen and support local capacities and build networks for urban health. While the immediate beneficiaries are the 129 581 inhabitants of the districts of Ponciano, Centro Histórico and Chimbacalle, these dissemination and outreach processes mean that the work will be shared with and reach all neighbourhoods in DMQ and their 2 781 641 inhabitants by 2020 and other communities and services through exchanges other cities in the Americas.

Factors and inputs affecting the participatory practices:

The practices do face various challenges and risks, according to personnel from DMQ. There is a risk that the mechanisms used do not adequately represent specific groups like youth, women or children. In some areas the culture of participation is weaker than others. To address this, the programme is setting up specific efforts to incorporate these groups into the participatory mechanisms, and ensuring that people elect their representatives. DMQ is also aware of the need to ensure that private actors like companies are included for them to play their role and that all actors get the necessary capacity support to play their role. The process raises expectations from community members, and these need to be managed, especially as building the capacities and shared understanding take time, and given the limited resources DMQ have to address the expectations.



Students explaining perceived health problems in their neighbourhoods. Quito © LJ Cárdenas 2016

The co-ordination across sectors is also challenging. Sectors have historically had separate administrative procedures and resources and historical siloes have to be broken to generate the shared planning, shared indicators of success and shared results for inter-sectoral action in a way that does not compromise the individual goals of each sector. The resources for health exist at three different levels, in the local health sector resources, in those applied across sectors for inter-sectoral work and in those that are mobilised locally by residents and private actors. To direct these individual resources towards shared goals, all sectors and the community involved need to know their roles, to be part of the identification of problems, priorities, needs and interventions, in processes that are effectively and professionally facilitated. Key informants from DMQ perceive that this needs time and to progress step by step. The evidence being gathered intends to build confidence of the sectors and communities involved and of others in the links between health and key social determinants and the outcomes from the work. As important are the relationships being built, and the focus on priorities identified by the community.

DMQ negotiates on behalf of the health of the residents of Quito with key actors at a global, regional, national and local level to support implementation of their plans, including by sharing good practices from other cities. In addition to the local sector representatives and institutions noted earlier, including community institutions like schools and markets, and state institutions like the Ministry of Health, the *Ministerio Coordinador del Desarrollo Social* and the *Secretaría de Coordinación Territorial y Participación Ciudadana*, the DMQ also engages with the Ecuador PAHO office and with local universities. PAHO have supported the work through both international specialists and local teams, providing technical support and skilled facilitators for the work with the community. DMQ has negotiated internships in the Unidades Metropolitanas de Salud, and graduate students have led workshops in physical activity. PAHO is also supporting efforts to exchange best practices with other cities in the region. DMQ has held workshops to exchange knowledge to support institutional learning to better serve the residents. In October 2016 a meeting was held with several cities on *Urban Health and Chronic Non-*

Communicable Diseases to share experiences with other cities in Ecuador and with Mexico City. In 2017 further such workshops are planned to share experience in other areas.

Perceived or measured outcomes:

The city has identified the programme and health equity outcomes it hopes to achieve and has set up an interactive electronic system to store, update and give public access to the health information included.

As outputs for the two year program it sets:

- 20 Participatory health diagnoses in selected neighbourhoods
- 4 technical reports on the environment and health of the MDMQ published.
- 3 awards to implement initiatives that improve the environment for the health granted.
- 15 face-to-face or virtual workshops on knowledge sharing and inter-municipal cooperation in local good practices against health challenges and health determinants with municipalities in Ecuador and the Americas region.
- 8 training/knowledge transfer workshops on processes and projects with a high impact on health.
- 10 exchange workshops with provincial capital cities in the country and the region.

As outcomes, the work aims to achieve:

- A DMQ representative health work team that has been formed, sensitized and that is carrying out high impact actions in health policies and environments.
- 3 community health work teams representing selected geographic areas in DMQ, formed, sensitized, and performing high impact actions in health policies and environments.
- 100MDMQ staff trained in tools and techniques for advocacy on health determinants.
- 20Neighbourhood Health Action Plans, elaborated in a participative way with implementation and a financing schedule that involves dependencies of the Municipality of DMQ, among others responsible for influencing environmental and socio-economic determinants of health.
- 3300 people, including the district's leadership, sensitized to health determinants.
- 14 schools implementing health promotion activities.
- 15 markets taking health promotion and food safety into consideration.

There have not yet been measured social, health, health system outcomes or changes identified to date. While the investments in the processes and information needed to support assessment of these outcomes have been described earlier, it is still too early to see changes in outcomes.

Areas for shared learning:

Key informants in DMQ note that the conditions for the practices are important in any discussion of their adaptation or adoption. The approaches being applied in Quito depend on a recognised role for, orientation and competencies of the municipality in population health, and for the prevention, promotion and public health activities for this. This is critical for engaging other sectors and for the participatory processes. The practices aimed at involving the community in solving their problems draw, as noted earlier, on a culture of collective work for common goals, and a legal and policy framework that support this.

At the same time, there are practices that could be adapted elsewhere: The steps and processes in Quito for the information gathering, analysis and priority setting in the community, for encouraging co-ordination across sectors and for ensuring that the information gathering and analysis supports both community and cross sectoral roles in solving problems can be shared with other settings.

There is already exchange of these participatory approaches for health promotion underway with other municipalities in Latin American countries. (See *Appendix A4* for further links to news and videos in the work of the Secretaría de Salud, Quito).

For those in Quito this is a work in progress. There is thus interest to know how other cities and settings are managing their processes. How are they organising information, resources, with what media and mechanisms to support community priority setting, decision making and action? How have others transformed and communicated the information on health and its social determinants in a way that is meaningful for the concrete realities in the communities and for community processes? How have others disaggregated information to show and integrate the diversity of settings and groups, both in decision making and in assessing progress on outcomes?

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Appendices:

A1: Urban Health Equity Assessment and Response Tool (Urban HEART) and the Programa de Municipios Saludables Program Guide

Urban HEART is a user-friendly guide for local and national officials to identify health inequities and plan actions to reduce them. The tool enables local communities, programme managers, and municipal and national authorities to:

- better understand the unequal health determinants, unequal health risks and unequal health outcomes faced by people belonging to different socioeconomic groups within a city;
- use evidence when advocating and planning health equity interventions;
- participate in inter-sectoral collaborative action for health equity;
- apply a health equity lens in policy-making and resource allocation decisions.

Using evidence from WHO's Commission on Social Determinants of Health, Urban HEART encourages policy-makers to develop a holistic approach in tackling health equity. Since the launch of the pilot programme in 2008, Urban HEART has been pilot-tested and used in numerous cities globally. There are four main principles on which Urban HEART was developed:

1. Easy to use: The results generated by Urban HEART should facilitate a more intuitive understanding of health equity and its determinants for all stakeholders.
2. Comprehensive and inclusive: Urban HEART adopts an approach that addresses the concerns of multiple sectors and is inclusive to generate buy-in, participation and facilitate effective dialogue between stakeholders.
3. Operationally feasible and sustainable: Urban HEART should be implemented through existing institutional mechanisms where possible. As much as possible, data should be collected from existing information systems and regular reports.
4. Evidence linked to actions: Evidence generated by Urban HEART should clearly link to feasible strategies and actions to reduce health inequities.

Urban HEART can be implemented in six simple steps. The steps are designed to be followed in order. Some steps may need to be revisited and repeated as Urban HEART is intended to be a cyclical process:

STEP 1: Build an inclusive team

STEP 2: Define your local health equity indicator set and benchmarks and targets for evaluating performance

STEP 3: Assemble relevant and valid data relying as much as possible on use of available datasets.

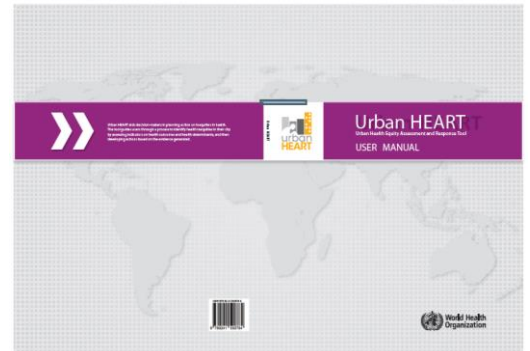
STEP 4: Generate evidence in easy-to-read charts (the MATRIX and the MONITOR) to illustrate health inequities in your city.

STEP 5: Assess and prioritize health equity gaps and gradients through participatory careful and deliberative discussion with all stakeholders that integrate their perceptions and concerns, including on the causes and consequences of inequities.

STEP 6: Identify the best response, taking into account the relative strengths of potential interventions, their potential impacts on equity, community preferences, available resources and alignment with existing government priorities and finalize a response plan.

A user manual (in diverse languages) supports users to implement the steps.

See also the Ecuadorean Ministry of Health Programa de Municipios Saludables Program Guide a local tool used in the training and programme.



Secretary of Health - José Ruales giving a training to the Steering Committee © LJurado 2017

A2: CDC's Healthy Communities Program: Community Health Assessment and Group Evaluation (CHANGE). Building a Foundation of Knowledge to Prioritize Community Needs

The CHANGE tool helps community teams (such as coalitions) develop their community action plan. This tool walks community team members through the assessment process and helps define and prioritize possible areas of improvement. Having this information as a guide, community team members can create sustainable, community-based improvements that address the root causes of chronic diseases and related risk factors. It can be used annually to assess current policy, systems, and environmental change strategies and offer new priorities for future efforts.

The CHANGE Tool aims to

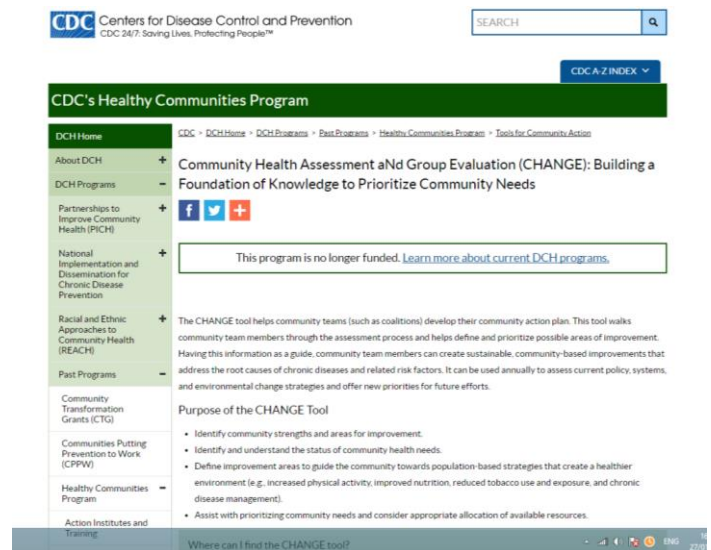
- Identify community strengths and areas for improvement.
 - Identify and understand the status of community health needs.
 - Define improvement areas to guide the community towards population-based strategies that create a healthier environment (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management).
 - Assist with prioritizing community needs and consider appropriate allocation of available resources.
- It allows local stakeholders to work together in a collaborative process to survey their community; offers suggestions and examples of policy, systems, and environmental change strategies and provides feedback to communities as they institute local-level change for healthy living.

The CHANGE tool is located within the Building a Foundation of Knowledge to Prioritize Community Needs Action Guide, which walks you through a step-by-step process for completing the tool. In addition, this Action Guide provides resources for team building along with worksheets, templates and Excel Files to support the data collection and review processes.

For each sector, this tool includes specific questions to be answered in the areas of demographics, physical activity, nutrition, tobacco, chronic disease management, and leadership. In addition, the school sector includes questions related to the school district and after-school program.

- Community-At-Large Sector includes communitywide efforts that impact the social and built environments, such as improving food access, walkability or bikeability, tobacco use and exposure, or personal safety.
- Community Institution/Organization Sector includes entities within the community that provide a broad range of human services and access to facilities, such as childcare settings, faith-based organizations, senior centers, boys and girls clubs, YMCAs, and colleges or universities.
- Health Care Sector includes places where people go to receive preventive care or treatment, or emergency health care services, such as hospitals, private doctors' offices, and community clinics.
- School Sector includes all primary and secondary learning institutions (e.g., elementary, middle, and high schools, whether private, public, or parochial).
- Work Site Sector includes places of employment, such as private offices, restaurants, retail establishments, and government offices.

CHANGE is a data-collection tool that allows community team members to track progress across a five-point scale, so incremental changes can be noted. As problem areas are identified, health-related policies are implemented, and systems and environmental change strategies are put in place, team members can document the community-level changes.



A3: Programa de municipios saludables del Ministerio de Salud Pública del Ecuador.

The Healthy Municipalities Program guides municipalities through a three step process to improving social determinants of health, culminating in a certification as a “Healthy Municipality”. The Ecuadorean Ministry of Health created the program to help municipalities address the health and well-being of the population and to make the connection between health and their determinants. The program has four objectives. To promote the certification of healthy municipalities, to provide technical assistance and support to participating municipalities, to leverage national technical and financial resources from various ministries to support the work of participating municipalities and finally to promote citizen participation in health.



1. The first step is a public declaration from the mayor and council of the city that they will prioritize high impact actions on health where the mayor signs a letter of intent.
2. The second step is a participatory analysis of information for the health situation room of the Ministry of Health.
3. Lastly, the municipality is evaluated based on their performance on a scorecard that includes indicators of the municipality’s provision of basic services, healthy spaces, the promotion of healthy practices, promotion of active transport, and participatory and inclusive planning.

The score card uses a stop light system that helps a municipality to self-evaluate for each indicator, when the municipality has 85% of the indicators in green, or optimal, the municipality can receive the certification as Healthy Municipality.

Estructura del Modelo de Certificación



PARTE DESCRIPTIVA				PARTE EVALUATIVA		
EJE DE TRABAJO	CATEGORÍA	INDICADOR	UNIDAD DE MEDIDA	ROJO	AMARILLO	VERDE
Saneamiento	Cobertura de acceso a alcantarillado	Hogares en área urbana con conexión domiciliar al sistema de alcantarillado.	porcentaje	< 86,4	92,2-86,4	>92,2
		Hogares en el área rural con conexión domiciliar al sistema de alcantarillado.	porcentaje	< 18,3	27,5-18,3	>27,5

A4: Links to information materials about the work of the Secretaría de Salud, Quito

News from the Secretaría de Salud MDMQ:

http://www.noticiasquito.gob.ec/index.php?module=Noticias&func=news_user_category&category=10159&umt=Salud

News related to “Barrio Saludable” and Health Change:

http://www.noticiasquito.gob.ec/index.php?module=Noticias&func=news_user_view&id=22662&umt=Municipio%20de%20Quito%20promueve%20el%20programa%20Barrios%20Saludables

http://www.noticiasquito.gob.ec/index.php?module=Noticias&func=news_user_view&id=23531&umt=Quito%20participa%20en%20iniciativa%20global%20en%20salud

Youtube Channel of the Secretaría de Salud - Municipio Metropolitano de Quito
<https://www.youtube.com/channel/UCB7jXEtZtdFKBCUzpDzED5w>

Cotocollao Community Health Team. <http://bit.ly/2tEXmCY>