



EUROPE

# City leadership for health



Summary evaluation of Phase IV of the  
WHO European Healthy Cities Network





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WHO European Healthy Cities Network

Edited by Geoff Green & Agis Tsouros

## Keywords

CITIES  
URBAN HEALTH  
LOCAL GOVERNMENT  
LEADERSHIP  
PROGRAM DEVELOPMENT  
PROGRAM EVALUATION  
EUROPE

## Abstract

The report is a summary evaluation of Phase IV of the WHO European Healthy Cities Network. It reviews the organization of healthy cities, their enduring values and the core themes of health impact assessment, healthy ageing, healthy urban planning and active living. There are 23 key messages for city decision-makers and the international public health community.

ISBN 978 92 890 4287 1

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web site (<http://www.euro.who.int/pubrequest>).

Text editing: David Breuer

Design: [www.paulpugh.co.uk](http://www.paulpugh.co.uk)

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# Key messages

## 1. Introduction

Healthy cities comprise a true laboratory of cutting-edge public health ideas and concepts. This knowledge and experience are intended to benefit all cities in Europe and beyond.

## 2. Assessing the impact of Healthy Cities

The work of healthy city projects was evaluated using a long-term perspective and cutting-edge methods.

The purpose of the evaluation was to generate a synthesized knowledge base for dissemination to city governments and to the international public health community.

## 3. Partnerships

Healthy city partnerships encompass more sectors than in previous phases, achieving a greater degree of collaborative planning and implementation.

The WHO European Healthy Cities Network is well regarded both as a source of technical expertise and as a powerful force for engaging politicians and organizations from many sectors.

## 4. City health profiles

Over 15 years, city health profiles have evolved as an indispensable tool for informing citizens, policy-makers and politicians about health and as an evidence base for city health planning.

Although most cities understand the concept of a city health profile, effective intervention strategies require systematically analysing the local links between population health and its wider determinants to identify where the problems lie and to monitor progress towards outcomes.

## 5. City health development plans

City health development plans are essential strategic documents in many cities, encompassing the contribution of many sectors and using the skills and commitment of many actors.

Cutting-edge cities are developing city health development plans to optimize resource allocation using health impact assessment and cost-benefit analysis.

## 6. Active participation by and empowerment of communities

Healthy cities are characterized by a strong commitment to community participation and empowerment.

Cities demonstrate inspiring activity across the four quadrants of Davidson's wheel of participation – informing citizens, consulting with local people, enabling participation in decision-making and empowering communities.

## 7. Equity and determinants of health

Healthy cities have raised equity higher on their political agenda, changing emphasis to address the wider determinants of inequality in health.

Although targeting poverty and exclusion removes some forms of inequality, policies for equity in health should also address the full social gradient in health, which runs from the top to the bottom of the socioeconomic spectrum.

## 8. Health impact assessment

In a few years, many healthy cities have developed capacity for planning and performing health impact assessment, encouraging decision-makers in all sectors to improve the health of their citizens by using health impact assessment.

Cities have innovated in health impact assessment methods and practice in Phase IV, and this should be developed further in Phase V to optimize policies and other local government proposals.

## 9. Healthy ageing

Membership of the WHO European Healthy Cities Network has encouraged nearly every city to adopt a healthy ageing approach.

By applying healthy ageing strategies in many sectors, city governments can compress the age of dependence and expand the age of achievement and independence.

## 10. Healthy urban planning in European cities

Healthy cities catalyse intersectoral cooperation between planning departments and health agencies.

Most WHO Network cities have implemented projects and programmes that enhance the health dimension of urban development, but many struggle to fully integrate health into the urban planning system.

## 11. Active living

Healthy cities have moved beyond a traditional focus on dedicated exercise towards active living as a routine part of everyday life.

An integrated model of urban development encourages tougher choices in urban investment to optimize the health benefits of physical activity.

## 12. National Healthy Cities networks in Europe

Of the 25 active national Healthy Cities networks in Europe, most significantly influence public health policy at the city, regional and national levels.

National networks are now better organized than before, with clear strategies and annual plans. More than 70% now have a formal strategy document.

# Introduction

City leadership is a red thread running through 20 years and 4 phases of the WHO European Healthy Cities Network, celebrated at the 2008 International Healthy Cities Conference in Zagreb, Croatia. Courage and vision are required of city mayors whose remit does not extend to formal responsibility for health services. Health is the business of every sector, and mayors have a key role in orchestrating the contribution of many actors.

## Commitment

The challenge is to sustain a long-term commitment to the goal of health for every citizen, with effective interventions supported by stronger evidence and better understanding of the determinants of health and the quality of life. Decision-makers cannot turn their institutions and policies upside down every time an international declaration calls for change, and many calls to adapt to new realities have been made during the past 20 years. Healthy cities provide a compass, promoting health as an enduring core value in city policies and development plans and serving as a beacon of social justice and participatory governance. Cities in the forefront of development today must possess the energy, leadership, skills and expertise to respond to new ways of thinking and doing and to take advantage of new opportunities.

## Evidence

Evidence is critical for successful interventions. Many governments took more than 10 years to develop policies based on the proven link between poverty and health. Cities are taking as long (Chapter 2) to respond systematically to the many determinants of health and

sustainability in the urban environment. The report of the Commission on Social Determinants of Health (1) adds greatly to our knowledge. The evidence base for the work of healthy cities has become much more robust over the past 20 years. Healthy cities comprise a true laboratory of cutting-edge public health ideas and concepts. The diverse socioeconomic and organizational profile of the diverse members provides a vast and unique seeding ground to test new ideas and harvest precious knowledge.

## Evaluation

The evaluation of Phase IV of the WHO European Healthy Cities Network offers insights and lessons from WHO Network cities and national Healthy Cities networks active in 25 European countries. This report summarizes city partnerships (Chapter 3), health profiles (Chapter 4) and city health development plans (Chapter 5) as organizational features of healthy cities. Community participation (Chapter 6) and equity (Chapter 7) are core values. The core themes of Phase IV are health impact assessment (Chapter 8), healthy ageing (Chapter 9), healthy urban planning (Chapter 10) and physical activity and active living (Chapter 11). Finally, Chapter 12 analyses national Healthy Cities networks. The report reflects underlying coherence in the Healthy Cities approach and potential for change and innovation. The Healthy Cities movement has sustained its relevance for city governments and offers a specific basis for local commitment and partnership across Europe.

**Agis D. Tsouros**

*Unit Head, Noncommunicable Diseases and Environment, Division of Health Programmes, WHO Regional Office for Europe*

# Assessing the impact of Healthy Cities

*Geoff Green & Evelyne de Leeuw*

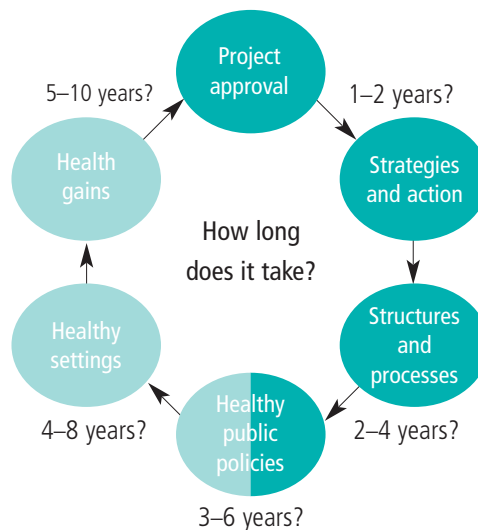
**Key message 1** The work of healthy city projects was evaluated using a long-term perspective and cutting-edge methods.

**Key message 2** The purpose of the evaluation was to generate a synthesized knowledge base for dissemination to city governments and to the international public health community.

The inspirational report of the Commission on Social Determinants of Health (1) does not merely review the evidence on cause and effect. The focus is primarily on action to close the health gap within a generation. Good city governance will significantly contribute to this.

WHO in evaluating impact. Reviewing Phase I (1988–1992), Ron Draper (2) focused on healthy city projects as catalysts for change, presenting a ten-year perspective from inception to significant health gains (Fig. 2.1). His model underpins the current evaluation of Phase IV (2003–2008).

**Fig. 2.1. Ron Draper's ten-year perspective on how healthy city projects affect processes and structures**



## City potential

European cities and partners have formal competence or a guiding hand on the living and working conditions that mediate between the distal structures of society and proximal lifestyle determinants such as exercise and diet. Their capital investment programmes and urban planning regimes may erode, sustain or enhance the health effects of transport, housing, working environments, sanitation, food distribution and education.

## Long-term impact

Over 20 years and 4 phases of the WHO European Healthy Cities Network, member cities have joined

## Methodological considerations

Our cutting-edge approach to generating knowledge goes beyond traditional epidemiological paradigms. First, we build in context. Realist fourth-generation evaluation techniques are appropriate for gauging the performance of healthy city projects. Second, we account for multiple interventions. Practical

city politics means simultaneous investment across many sectors, including those in which effects on health are not the primary concern of the decision-makers. Third, we account for the complex ways health is determined by reviewing different levels of planning, policy and action.

## Rationale

Evaluation of Phase IV focuses on the wealth of knowledge accumulated by the healthy city movement in Europe. The purpose is to generate a knowledge base for dissemination to city governments and to the international public health community. A team of experts has conducted the research, which will be published in the *Journal of Urban Health*. This booklet summarizes the key findings.

## Scope

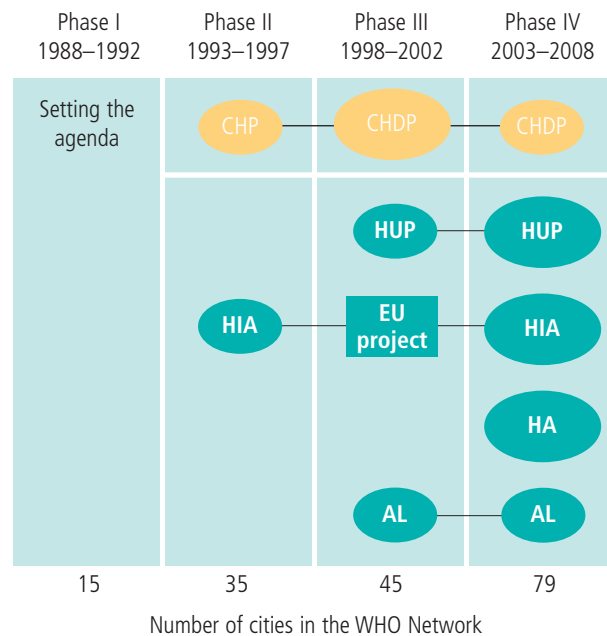
We encompass 2003–2008 and address four main questions.

- How did cities use their membership in the WHO Network to strengthen their public health agenda?
- How did cities work on partnerships for health, participation, equity and the social determinants of health?
- How successful were they in promoting action on the core themes of healthy urban planning, health impact assessment, healthy ageing and active living?
- What evidence is there on the impact and results of healthy city work at the local, national and international levels?

## Methods

The annual reporting template has become a core tool in evaluating recent phases, compiling information on cities' organization and activities. The general evaluation questionnaire evolved from the evaluation of Phase III. These and other instruments were used for evaluating the work of the 79 member cities of the WHO Network and the 25 active national networks.

**Fig. 2.2. Phases and themes of the WHO European Healthy Cities Network, 1988–2008**



CHP: city health plan. CHDP: city health development plan. HUP: healthy urban planning. HIA: health impact assessment. EU: European Union. HA: healthy ageing. AL: active living.

The annual reporting template and general evaluation questionnaire were sent to cities in February 2008; 60 of 79 (77%) responded online. Data were supplemented by reports from the subnetworks on the core themes and from 190 case studies prepared by June 2008 for the 2008 International Healthy Cities Conference in Zagreb. Ten experts were recruited to analyse the data and prepare scientific papers. This report summarizes their findings.

Expert authors used Ron Draper's framework and drew on theoretical perspectives related to their domain. Empirical data came primarily from questionnaire responses marshalled by each healthy city coordinator and approved by a politician or politically responsible officer. Although cities provided information in good faith and with professional integrity, evaluators endeavoured to account for any bias.



# Partnerships

*Alistair Lipp & Tim Winters*

**Key message 1** Healthy city partnerships encompass more sectors than in previous phases, achieving a greater degree of collaborative planning and implementation.

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**Key message 2** The WHO European Healthy Cities Network is well regarded both as a source of technical expertise and as a powerful force for engaging politicians and organizations from many sectors.

## Concept and context

In 1985, *Targets for Health for All (1)* highlighted social determinants of health beyond the scope of traditional health services. The pre-requisites for health enshrined in this policy made health everybody's business. Action to improve population health required the cooperation of all sectors.

From the launch of the WHO European Healthy Cities Network in 1988, cities have implemented this policy at the local level. Cities applying for membership were required to establish an intersectoral committee for health, and this structure has remained a key feature throughout all the phases. Stakeholders must cooperate both politically and technically.

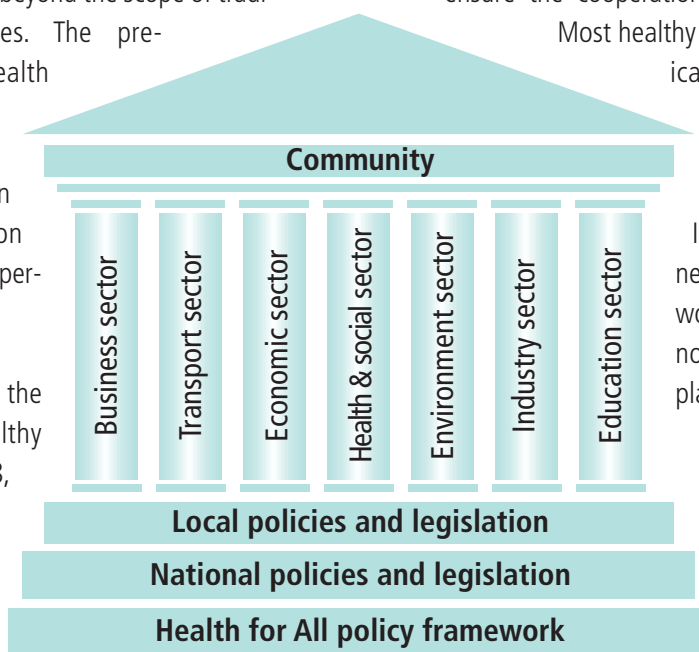
## Partnership structures

The political commitment of city mayors is essential to ensure the cooperation of municipal departments.

Most healthy cities have both formal political structures and informal working relationships with statutory, voluntary, private and public agencies. In Phase IV, 94% of city partnerships have agreed on joint working and only 12% have not yet implemented joint plans.

Technical cooperation is necessary both to undertake collaborative projects and produce the strategic city health (development) plans within Phases II–IV. Fig. 3.1 shows the iconic Parthenon highlighting the key sectors and levels of collaboration (2):

78% of city partnerships plan strategically, with 19% having this as their main focus; 81% supervise collaborative projects, with 22% as their main focus.



**Fig. 3.1. Key sectors for healthy city collaboration**

## Engaging key sectors

Partnerships within the health and social service sectors dominated earlier phases of the WHO Network and account for most collaborative partnerships in Phase IV. At the most engaged level, 76% of city partnerships are implementing collaborative plans, projects or programmes. A further 15% have agreed strategies and plans, and only 9% remain at the basic level of merely agreeing to collaborate.

However, compared with Phase III, more cities in Phase IV are engaging with other sectors: 64% at the highest level with the education sector, 46% with the voluntary sector, 42% with urban planning and 28% with the transport sector. Cities recorded the greatest increase in collaboration with urban planning, reflecting a core theme of Phase IV. Relatively few cities engage with the economic sector; 21% have agreed strategies, but only 15% operate at the highest level.

## Achievement

Partners have agreed to work together in the vast majority of cities (98%), although in a very few cities, predominantly in eastern Europe, partnerships have struggled to achieve the most basic level of partnership work. Fig. 3.2 shows how cities rate their partnership with healthy urban planning on a spectrum ranging from “No contact” through “Implementation of collaborative plans, projects or programmes”. Compared with Phase III, cities have scaled up. Then the largest group (43%) agreed on plans and strategies. Now many (42%) are moving on to implementation.

## Success factors and obstacles

For many cities, political support is critical to success, typically “the enormous and unanimous political drive to make this project succeed” and “endurance, tenacity, leadership and optimism”. Another key factor is a strategically located office and well-organized team with good management and communication skills. One city cited “the importance of negotiating objectives and establishing goals with reasonably high standards”.

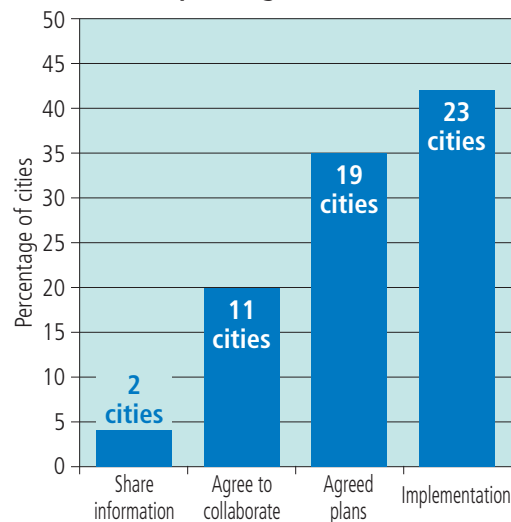
Obstacles to success include organizational and personnel change, for some “a fairly constant change in the health service structures in the city, which has often led to planning blight”.

Others cited lack of time and money: “Funding is allocated according to the sector silos and, given the lack of resources, everyone protects their own piece of the cake”. Although the concept of intersectoral working is central to the Healthy Cities approach, implementing a global strategic focus can be difficult.

## Membership of the WHO Network

The WHO connection is important to most cities. Although 82% said that they would continue without it, many cities said that membership of the WHO Network had persuaded local governments of the benefits of intersectoral collaboration. It provides leverage, confers “significant public status and recognition” and is “important for leadership, inspiration and motivation of politicians and decision-makers”.

**Fig. 3.2. Partnerships with the urban planning sector**



# City health profiles

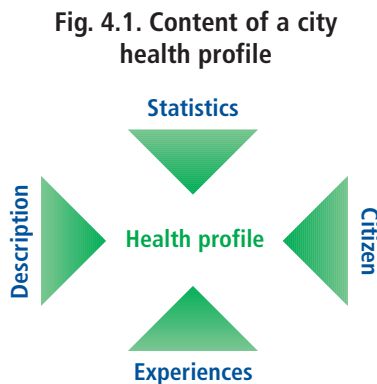
*Premila Webster*

**Key message 1** Over 15 years, city health profiles have evolved as an indispensable tool for informing citizens, policy-makers and politicians about health and as an evidence base for city health planning.

**Key message 2** Although most cities understand the concept of a city health profile, effective intervention strategies require systematically analysing the local links between population health and its wider determinants to identify where the problems lie and to monitor progress towards outcomes.

## Concept and context

City health profiles originated in Phase II to provide an evidence base for health planning. They continued in Phases III and IV as an essential tool for informing citizens, policy-makers and politicians about health and its determinants in cities. WHO defines city health profiles as reports that “identify in writing and graphs, health problems and their solutions in a specific city” (1). City health profiles are the basis of city health development plans, which set out strategies and intervention programmes to improve the health of a city’s population. The best city health profiles are not limited to indicators describing health status and the determinants of health but also incorporate an analysis of how these determinants influence health outcomes. Fig. 4.1 summarizes the content of a city health profile.



## Purpose

The role of city health profiles in influencing health policy is:

- to interest, inform and educate the public, health professionals, politicians and policy-makers and stimulate them to action;
- to act as a source of information about health in the locality;
- to identify health problems, high-risk groups and unmet needs;
- to be a critical component of health planning, indicating health priorities, the preferred resource allocation and direction of service development; and
- to provide a focus for intersectoral action.

## Reviews

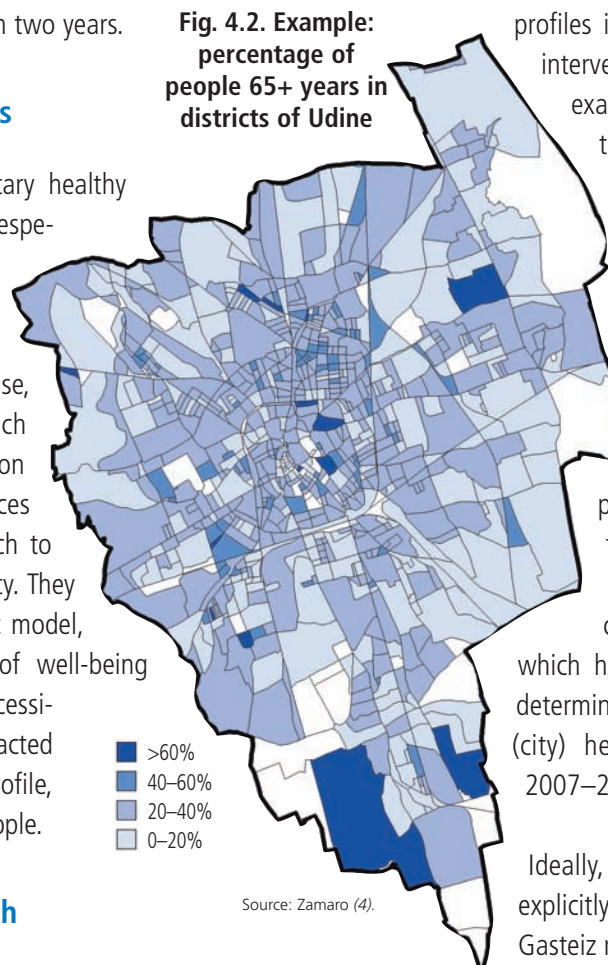
A 1999 review (2) highlighted lifestyles and inequality as the two main areas for development, with the challenge of systematically connecting determinants to health outcomes. A second review in 2005 (3) reported some success in providing an evidence base for health planning, although many cities had difficulty in making recommendations for target-setting.

## The updating cycle

A city health profile is an essential tool in the Healthy Cities toolbox, adapting and evolving since first developed in 1994 to become a sophisticated mechanism for gathering planning-relevant information. Most cities have produced a city health profile and have a three- to five-year cycle for updating them. One third updated it in the past year and, of the remainder, 84% planned to update within two years.

## Health ageing profiles

Cities developed complementary healthy ageing profiles in Phase IV, especially in the Subnetwork on Healthy Ageing. Emphasizing health outcomes rather than indicators of illness and disease, healthy ageing profiles reach beyond a traditional focus on health and social care services towards a life-course approach to maintaining functional capacity. They adopt a positive and dynamic model, identifying wider indicators of well-being such as secure housing and accessible transport. Fig. 4.2, extracted from Udine's city health profile, shows the density of older people.



Source: Zamaro (4).

## Intersectoral approach

Cities report how the production process brings together stakeholders from many influential sectors. For example, Dresden involved urban planners in addition to the Office for Social Affairs, with its traditional responsibility for providing social services. In Cherepovets, the health profile was developed by a

working group including “sociologists, strategists, experts in all city spheres: town planning, education, public health services, transport, culture, social care, physical training, housing and communal services”.

## Intervention

The ultimate aim of city health profiles is to improve the health of the local population. Evidence from profiles is used to inform appropriate interventions to improve health. An example is the systematic collection of mental health indicators in Rijeka to enable mental health care and activities to prevent mental disorders and their effects. City health profiles also contribute to strategic development, providing the evidence for city health development plans. Victoria-Gasteiz, a city that joined the WHO Network in Phase IV, produced its first city health profile in 2007, which helped “set the priorities and determine the goals that constitute the (city) health development plan for 2007–2009”.

Ideally, city health profiles should explicitly be part of a cycle. Victoria-Gasteiz reported that “once the health plan concludes, a new city health profile will be discussed and designed” to measure changes in health status as a result of intervention programmes. Over the years, a city's health profile is expected to become an influential part of public health policy and activity.

# City health development plans

Geoff Green

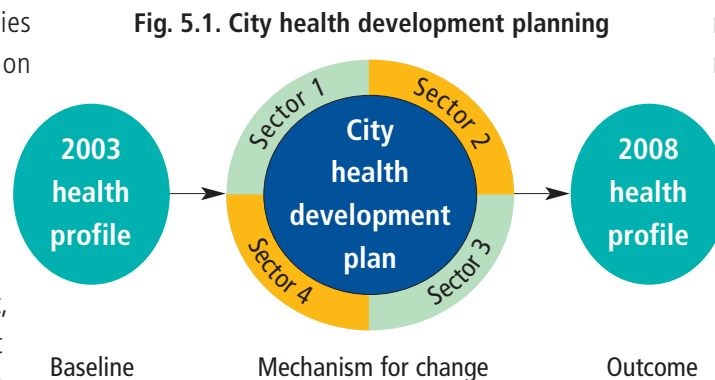
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**Key message 1** City health development plans are essential strategic documents in many cities, encompassing the contribution of many sectors and using the skills and commitment of many actors.

**Key message 2** Cutting-edge cities are developing city health development plans to optimize resource allocation using health impact assessment and cost–benefit analysis.

## Context

City health development planning was initiated at a business meeting of the WHO European Healthy Cities Network in Belfast in 1990. Until then, cities primarily focused on demonstration projects to place the new public health higher on the agenda of municipal councils and their partners. In Belfast, cities agreed that demonstration projects alone were not sufficient to fundamentally alter the direction of city development. Missing but essential was an instrument for strategic city planning for health.



education and disease prevention by the health sector. It was agreed that enhanced city health development plans (1) would be required in Phase III. They would advance city health plans by addressing the wider determinants of health and relating to social, environmental and economic aspects of city life. Relationships between health, economy and environment are reciprocal and mutually reinforcing. City health development plans should harmonize strategic plans at the city level, with health sometimes in focus and sometimes integrated into other plans for the city or sector.

## Concepts

Despite subsequent investment in city health plans during Phase II, a series of WHO Network business meetings concluded that many plans were too limited in scope and strategic direction, often focusing on health

According to Jostein Rovik, former Mayor of Sandnes, city health development plans should “tell us where we are going and how we get there”. They therefore require a vision and a mechanism for change. Health profiles provide a baseline and indicate progress (Fig. 5.1).

## Types of city health development plans

When Phase IV started, three types of city health development plan were identified to reflect the practical politics of each city (2). The classic model (type 1) contains the essential elements of vision, integrative strategy and operational sector plans. In a sectoral approach (type 2), the project team (or steering group) negotiates bilateral agreements with competent agencies to include a health dimension in their plans. An integrated approach (type 3) seeks to embed a strong health dimension into a comprehensive city development plan.

Of the 31 cities initially applying for membership in the WHO Network for Phase IV, 17 had already developed a classical city health development plan, 10 had adopted an integrated strategy and only 4 were pursuing bilateral agreements (Fig. 5.2). Cities now report good progress with reviewing their plans; 19% had updated their plans in the previous year and 57% planned to do so.

## Profile and plans

Udine says that city health profiles are the starting-point in a virtuous circle of reviewing and updating the city health development plan, allowing cities to continually evaluate progress and health status. In Posnan, every action for citizens is only taken after deep analysis of their health needs. Helsingborg has initiated a new monitoring system to reach further into the management levels of the city.

## Process

As Stoke-on-Trent reported at the start of Phase IV, "The plan is not an end in itself but has to have a purpose ... . The process of developing the plan is more important than the actual plan." This is reflected now. Izhevsk says that the process of preparing a city health development plan "is an excellent school for specialists and heads of departments", leading "to their understanding

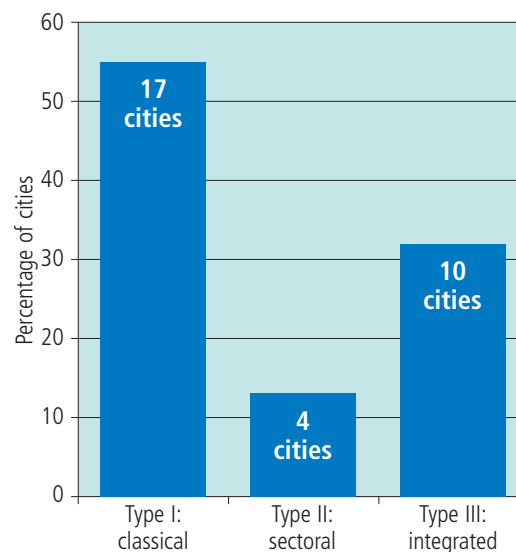
that the health of the population is not a task for the health sector only and that they have an important role in public health". For Athens, "It was the right instrument to bring together experts from different sectors to cooperate, think and plan together."

## Cutting edge

A few cities are developing a harder cutting edge to their city health development plans. Their decision-makers no longer merely require evidence on intersectoral

determinants of health and summarize strategies for improving health. They want to optimize resource allocation. Montijo reports how the integrated city health development plan process overcame "scarce cooperation" that "multiplied interventions and consumed excessive resources". Łódź highlights how their city health development plan ensured "organized action and the rational use of resources". Helsingborg's Department for Sustainable Development provides the knowledge needed to optimize resource allocation in the annual budgeting process. Their ambition is comprehensive economic impact assessment covering health, social and environmental aspects.

**Fig. 5.2. WHO Network cities by type of city health development planning**



# Active participation by and empowerment of communities

*Mark Dooris & Zoë Heritage*

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**Key message 1** Healthy cities are characterized by a strong commitment to community participation and empowerment.

**Key message 2** Cities demonstrate inspiring activity across the four quadrants of Davidson's wheel of participation – informing citizens, consulting with local people, enabling participation in decision-making and empowering communities.

## Context

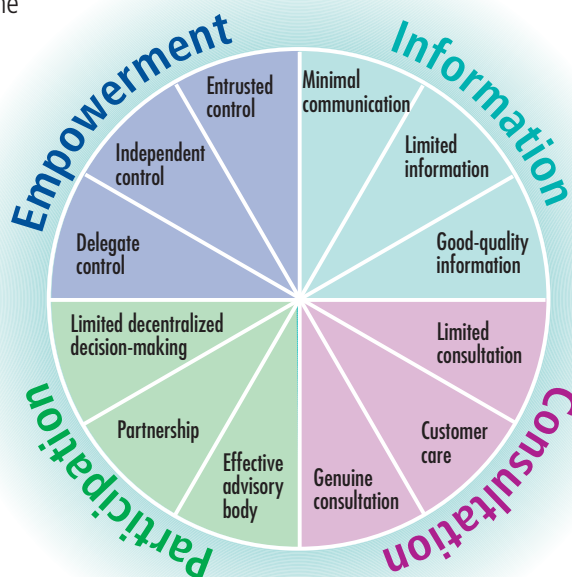
The core principles of community participation and empowerment underpin all phases of the WHO European Healthy Cities Network. A series of international charters and declarations have guided the work of WHO and provide a framework for healthy city development. The Ottawa Charter for Health Promotion (1) declared "At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies."

## Concepts

Although it is generally agreed that participation implies being involved, the concept of empowerment is used in a

variety of ways. However, its core is the notion of power, defined as "the ability to control the factors that determine one's life" (2). In practice, this means that healthy cities should promote "support for community-level action and capacity-building; strengthening of infrastructures and networks; and meaningful organizational development and change" (3).

**Fig. 6.1. Davidson's wheel of participation**



The famous ladder of participation, popularized by Arnstein (4), puts genuine empowerment on the top rung, participation midway and consultation on the lower rungs. However, the WHO European Healthy Cities Network prefers the non-hierarchical model popularized by Davidson's wheel of participation (Fig. 6.1) (5). In reviewing Phase IV, cities have described their action in each quadrant.

## Informing citizens

Every city gives priority to informing their citizens about health issues. Two thirds use the traditional mass media of television, radio or newspaper, with nearly as many using the Internet. For example, Belfast launched its own new web site during Phase IV. Half of cities use specialist newsletters and bulletins.

**"At the strategic level, the City of Kuopio has decided that the Health Kuopio Programme and the WHO European Healthy Cities Network are major brands of the region. We inform our citizens about health in all possible ways: via the Internet, media cooperation, leaflets, posters and events."**  
Kuopio, Finland

## Participation in decisions

One third of cities in the WHO Network involve representatives for nongovernmental organizations on their healthy city steering groups. Another 18% highlight the importance of more general participation in strategic processes and formulating and delivering programmes as an all-purpose municipal venture.

**"A vivid example was the City Health Forum: choosing the city's priorities for health. Authoritative public organizations (pensioners, environmental organizations and children's and youth nongovernmental organizations) were involved."** Izhevsk, Russian Federation

## Consulting local people

Some cities confine consultation to specific projects, and others are committed to consult across the breadth of their work. The most commonly used mechanism is questionnaires (62% of cities) followed by meetings and public events (48%). Rennes has developed large public events to compile residents' desires for the city of tomorrow.

**"We have learned the importance of local accessible venues, providing the basics (transport, child care and interpreting), making it a good experience, giving and receiving feedback and being accountable."** Newcastle, United Kingdom

## Empowering citizens

Cities often regard consultation and participation as steps towards empowerment. Others strongly emphasize the enabling role of funded professionals and active participation, leadership and management by citizens. A priority is to equip citizens with the skills, confidence and capability to participate in the city's decision-making processes.

**"We produced a strategy for involving vulnerable groups in participatory budgeting: a feasible and tested method for local government to produce maps of priorities."**  
Tirana, Albania



# Equity and determinants of health

*Anna Ritsatakis*

**Key message 1** Healthy cities have raised equity higher on their political agenda, changing emphasis to address the wider determinants of inequality in health.

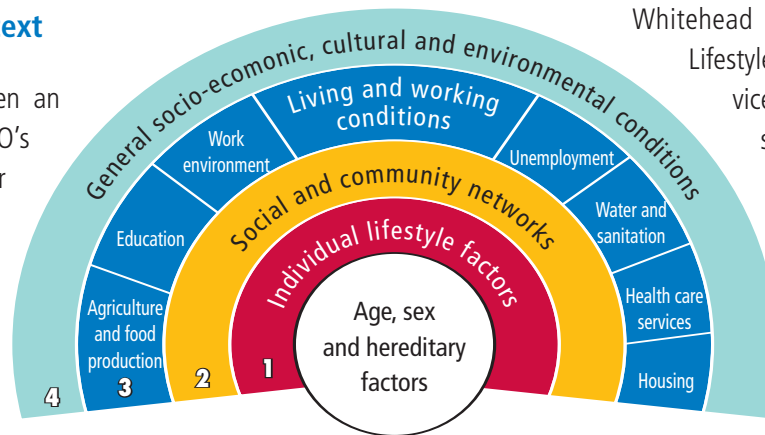
**Key message 2** Although targeting poverty and exclusion removes some forms of inequality, policies for equity in health should also address the full social gradient in health, which runs from the top to the bottom of the socioeconomic spectrum.

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## Concept and context

Equity in health has been an underlying value of WHO's Health for All policy for three decades (1). Defined as unjust and avoidable differences in health status in the early 1990s (2), equity is the core value in *Closing the gap in a generation: health equity through action on the social determinants of health*, the 2008 report of the Commission on Social Determinants of Health (3). Promoting equity is not confined to alleviating poverty. Like HEALTH21 (4), the Health for All policy framework for the WHO European Region, the Commission addresses the full social gradient in health from the top to the bottom of the socioeconomic spectrum.

The goal of equity is intimately linked to action on the social determinants of health – part of the title of the Commission's report. Fig. 7.1 shows the famous social model of health (and inequality in health) developed by



**Fig. 7.1. A social model of health**

Source: adapted from Whitehead & Dahlgren (5).

Whitehead & Dahlgren (5). Lifestyles and health services are important, but so are wider social, economic and environmental determinants of health.

Healthy city governments are well positioned to influence living and working conditions.

In Phase IV, progress has depended on whether:

- equity in health is on their political agenda;
- information is gathered to raise awareness and monitor progress;
- their emphasis has changed from health care to a wider spectrum of determinants; and
- interventions address the social determinants of health.

## Highlighting equity

Although some city partners report difficulty in gaining a common understanding of equity, more than two thirds refer to the broad concept embedded in WHO Health for All policy. Poverty and social exclusion are high on the agenda of the European Union, providing extra impetus to giving equity higher priority on the agenda of the 40 cities in the WHO European Healthy Cities Network within European Union countries. Equity in health is important for the cities, with 71% saying “very important” and 19% “moderately important”.

## Healthy city catalyst

Healthy city project offices significantly influence policies and processes in most cities; 19% highlight their critical strategic role, indicating that equity would not be on the city agenda without their input. Evidence, either from local health profiles or via the wider WHO Network, helps persuade politicians that tackling inequality in health is a priority. The central location and intersectoral approach of healthy city projects also encourages agencies and partners to include equity in formulating their development plans.

## Action

City action to address the determinants of inequality in health has gradually changed (since Phase III) away from downstream (proximal) determinants towards the upstream (distal) determinants shown in the outer rings of Fig. 7.1. However, Fig. 7.2 reveals a fine balance

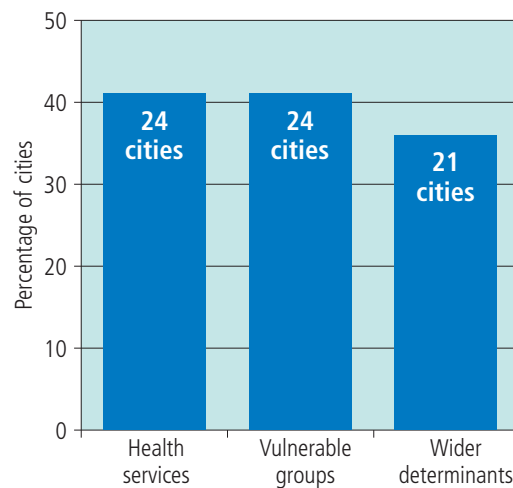
between action within the health sector, targeting vulnerable groups and addressing wider determinants of health.

Traditional health sector interventions include health education, disease prevention and health care. Programmes often target high-risk or vulnerable groups: for example, screening for tuberculosis in disadvantaged areas of Barcelona and providing primary health care for uninsured people and disadvantaged regions in Çankaya.

Cities in Denmark, Finland, Sweden and the United Kingdom strongly address the wider determinants of health, often as part of comprehensive regeneration strategies to improve the environment, social cohesion and job opportunities in disadvantaged neighbourhoods. Twenty-four cities in the WHO Network are acting to enhance the

economy or reduce poverty, often by promoting education and training to gain access to employment.

**Fig. 7.2. City action to promote equity in health**



## Monitoring and checking

To varying degrees, promoting equity in health has entered the policy cycle of: awareness-building → policy formulation → implementation → monitoring and evaluation → reassessment → revision. Compared with earlier phases, more cities are auditing policies, plans and programmes for how they affect equity, are able to compare differences between neighbourhoods and are targeting unhealthy citizens. However, targeting poverty has a downside; the full social gradient in health runs from the top to the bottom of the socioeconomic spectrum.

# Health impact assessment

*Erica Ison*

**Key message 1** In a few years, many healthy cities have developed capacity for planning and performing health impact assessment, encouraging decision-makers in all sectors to improve the health of their citizens by using health impact assessment.

**Key message 2** Cities have innovated in health impact assessment methods and practice in Phase IV, and this should be developed further in Phase V to optimize policies and other local government proposals.

## Concept and context

The Gothenburg consensus paper published in 1999 (1) describes the concept of health impact assessment: a method used to assess the potential effects of a policy, programme or project on the health of a population using a combination of procedures, methods and tools (Fig. 8.1).

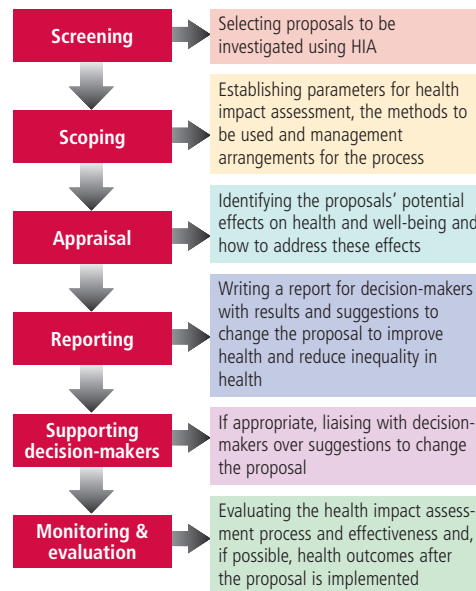
During the past decade, the WHO European Healthy Cities Network has developed health impact assessment as a tool for local decision-makers. Progressive city governments are well placed to assess how their non-health policies affect their citizens' health. With their strong intersectoral approach to influencing the socio-economic and environmental determinants of health, healthy cities have a unique opportunity to use health impact assessment for the integrated development of sustainable communities.

## Implementation

Health impact assessment was a core theme for Phase IV. A subnetwork of 10–15 cities led by Belfast was created to provide training and to encourage cities to assess their own policies and other proposals and had four objectives:

- to raise the awareness of politicians and city administrators of the potential for health impact assessment to enhance policies and plans;
- to provide leadership and to strengthen capacity for health impact assessment at the city level;
- to disseminate the practice of cities, with evidence of how health impact assessment contributes to developing health and the potential for strengthening healthy urban planning and healthy ageing; and
- to help mainstream health impact assessment as a systematic framework for assessing all city policies and projects.

**Fig. 8.1. The six stages of health impact assessment**



## Challenges

There are many challenges to implementing health impact assessment and many barriers to grasping this relatively new and complex method even at the national level. The greatest problem for cities was lack of expertise or experience. Building capacity takes time. Politicians and professionals resisted in some cities. If health impact assessment was given low priority, no resources were allocated to introducing and implementing it.

## Achievements

Cities succeeded best with the first objective (Fig. 8.2), required for meeting the other more demanding objectives. Clarifying the purpose and methods of health impact assessment encourages cities to invest in health impact assessment and gives politicians courage to use the results. Nearly 40% of cities built capacity by training politicians and professionals in health impact assessment.

Nearly 30% of cities undertook one or more health impact assessment studies. Cities lobbied governments at the regional (Italy), federal (Switzerland) and national level (France and Lithuania) to adopt health impact assessment. Only 15% of cities mainstreamed health

impact assessment in their local administration; in some cities this was linked to healthy urban planning or was integrated into other methods of impact assessment.

## Success

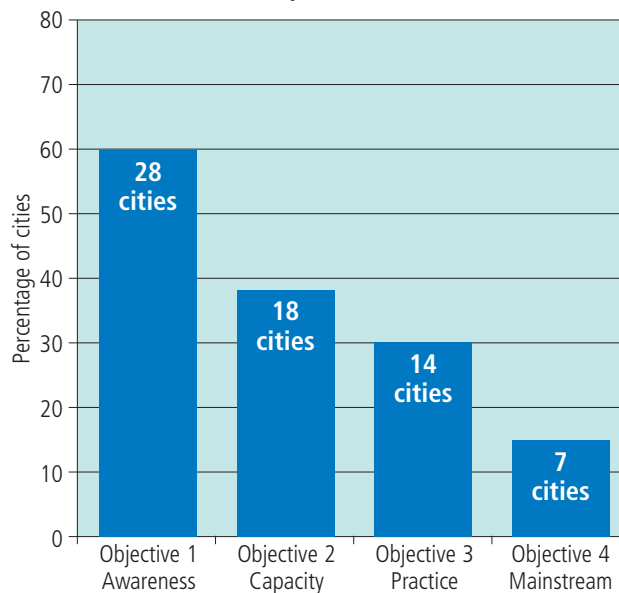
Cities found that the two most important factors facilitating health impact assessment were political support and training, followed by links to an academic or public health institution providing access to expertise. Previous experience is also important. Successful cities more likely operated within a pre-existing culture of intersectoral work. Other factors critical to achieving the objectives were commitment to implementing health impact assessment in successive years, a supportive national policy context and subnetwork membership.

## Innovation

Phase IV has been innovative. Some cities, mainly in Scandinavia and the United Kingdom, have been at the forefront of developing health impact assessment and are exploring ways of redesigning it to make it fit for purpose in a local government setting to optimize policy (2). With the overarching goal of health and equity in health in all

local policies, Phase V of the WHO Network (2009–2013) provides an opportunity to use health impact assessment systematically across all domains of city life.

**Fig. 8.2. Achieving the objectives of health impact assessment**



# Healthy ageing

## Geoff Green

**Key message 1** Membership of the WHO European Healthy Cities Network has encouraged nearly every city to adopt a healthy ageing approach.

**Key message 2** By applying healthy ageing strategies in many sectors, city governments can compress the age of dependence and expand the age of achievement and independence.

### Concept and context

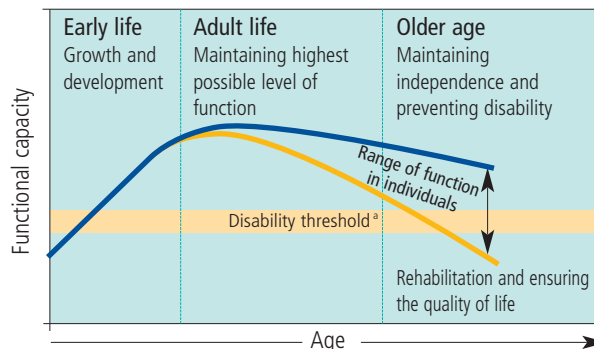
*Active ageing: a policy framework (1)* inspired the core theme of healthy ageing. This challenged orthodox perspectives of global ageing as a “demographic time bomb” likely to adversely affect both sustainable economic development and demand for health and social support services. Central to our alternative concept of active or healthy ageing is a life-course approach maintaining that interventions in the early and middle life-course will reduce levels of disability in later life (Fig. 9.1).

### The third age

Equally important is the concept of a third age of personal achievement and independence after withdrawing from the labour market but before the onset of “dependence and decrepitude” (2). Only in the last 50 years has a significant proportion of older people

survived into the third age in many countries, with major policy implications. Older people are an increasing resource to the economy and society.

**Fig. 9.1. A life-course approach to ageing**



<sup>a</sup> Sources in the environment can lower the disability threshold, thus decreasing the number of disabled people in a given community.

Source: Kalache A, Kickbusch I. A global strategy for healthy ageing. *World Health*, 1997, 50(4):4–5.

### City action

City governments have a key role in promoting independence and empowering older people as a resource. Traditionally responsible for social services and for regulating living and working conditions in most European countries, cities and their partners can also shape a social and physical environment that encourages healthy lifestyles.

### Core theme of the WHO Network

This was the rationale for selecting healthy ageing as one of the core themes of Phase IV of the WHO European Healthy Cities Network. The four objectives were (a) to raise awareness, (b) to empower, (c) to develop supportive environments and (d) to improve access. Nineteen cities were recruited to a Subnetwork on Healthy Ageing to lead the way.

## Raising awareness

Raising awareness of the status and role of older people is a prerequisite to strategies and plans to enhance their lives. The Subnetwork on Healthy Ageing committed to a “positive and dynamic” model for healthy ageing profiles at its first meeting in Stockholm in 2005. Traditional indicators of population health and local health care systems are balanced by those describing the determinants of health and empowerment.

Nearly all Subnetwork cities and many other WHO Network cities have produced healthy ageing profiles (Fig. 9.2). One quarter also refer to policies or strategies that raise awareness. Brno, Posnan and Sandnes have given older people higher priority in updating their overarching city development plans.

## Empowerment

Although literature on health promotion tends to focus on personal empowerment, most city responses refer to collective forms of empowerment by communities representing the interests of older people. These range from small mutual groups, such as the clubs in Athens, Liverpool, Novocheboksarsk and Rennes, to city-wide organizations such the veterans’ organizations in Russian Federation cities or the elders’ councils in Győr and Newcastle. Many receive funding from the city. One third of cities describe how the municipality and its partner agencies hear and act on the voice of older people.

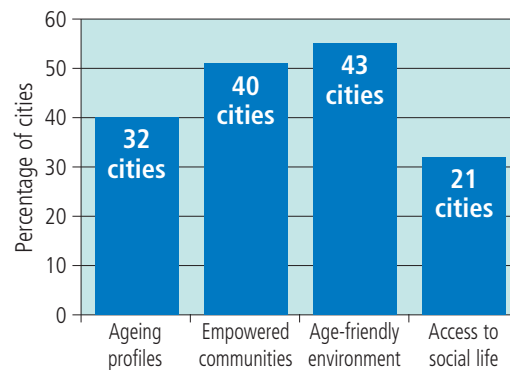
## Supportive environments

The work of the WHO European Healthy Cities Subnetwork on Healthy Urban Planning has positively influenced cities. More than half report specific programmes or projects to enhance their urban environment. Brighton & Hove, Győr and partners have developed a European good practice guide to housing design that promotes independence and quality of life (3). Most cities have removed architectural barriers to walkability in their streets and parks. Others have improved road traffic management systems to help older pedestrians cross roads safely. Udine and Vienna have a comprehensive approach to neighbourhood development emphasizing age-friendly environments to promote socialization and intergenerational solidarity. Thirteen cities take a strategic approach, incorporating age-friendly environments into overarching transport programmes and city development plans.

## Access

Cities do not usually report on the rationing of health and social care services, which disproportionately affects older people. They focus instead on two main types of intervention by service providers. The first type enhances social networks and improves mental health. Many older people receive formal help to accomplish basic activities in their own homes but may feel isolated and lonely. Cities report a variety of innovative projects to integrate them into the wider community, such as the “sympathy houses” in Aydin. The second type is the provision of either cultural or physical activities. Sunderland’s sport and leisure facilities, libraries, arts centres and community venues offer a wide range of activities for the physical and emotional well-being of older residents.

**Fig. 9.2. Healthy ageing achievements in four domains**



# Healthy urban planning in European cities

*Hugh Barton & Marcus Grant*

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**Key message 1** Healthy cities catalyse intersectoral cooperation between planning departments and health agencies.

**Key message 2** Most WHO Network cities have implemented projects and programmes that enhance the health dimension of urban development, but many struggle to fully integrate health into the urban planning system.

## Context

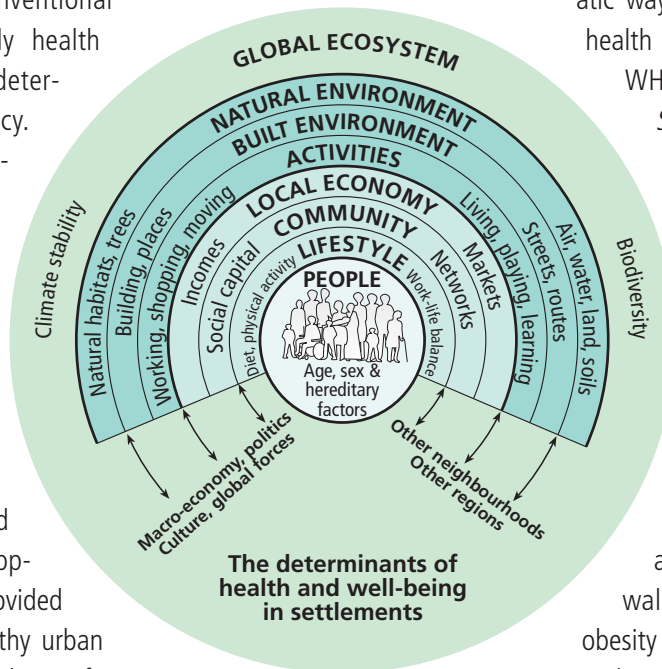
The WHO European Healthy Cities Network has pioneered the concept and practical application of healthy urban planning – challenging the conventional assumption that only health care professionals determine health policy. *Healthy urban planning: a WHO guide to planning for people* (1), published during Phase III, posed a challenging agenda for cities to achieve 12 key objectives for health and sustainable development. These have provided a framework for healthy urban planning as a core theme for Phase IV. We have used them as benchmarks for assessing progress.

## Healthy urban planning influences health

Urban spatial planning is a mechanism of environmental control influencing health in systematic ways. Fig. 10.1 shows a settlement health map originally developed for the WHO-sponsored practice guide *Shaping neighbourhoods for health, sustainability and vitality* (2).

This anthropocentric model puts people at the heart of sustainable development but also recognizes ecological limits to growth. Urban sprawl damages the environment, but health is also a casualty. The decline in regular daily walking is resulting in increased obesity and greater risks of diabetes and cardiovascular diseases (4). The decline in local facilities, the reduction in pedestrian movement and neighbourly street life all reduce opportunities for the supportive local contacts that are so vital for mental well-being (5).

**Fig. 10.1. A settlement health map**



Source: adapted from Barton & Grant (3).

## Healthy city catalyst

Healthy cities catalyse intersectoral cooperation between planning departments and health agencies. Many coordinators understand well the interplay between housing and planning; a diminishing number do not. In Phase II only one quarter reported links. By the end of Phase IV, two thirds of coordinators were actively involved with urban planners and influential in shaping planning programmes. This resulted in an increase in high-intensity healthy urban planning in established cities (Fig. 10.2). The high achievers all have vibrant healthy urban planning programmes, typically an active programme of training and stakeholder meetings and a programme including a large strategic project or many small projects or both. However many cities new to the WHO Network reporting for the first time in 2006 still had much to learn.

## Impact

Integration of health and planning has three distinct levels. Some cities new to the WHO Network, mainly in eastern Europe, still operate at a basic level, concerned with the essential life-support role of settlements: providing shelter, access to food and clean water, fresh air and effective sewerage treatment.

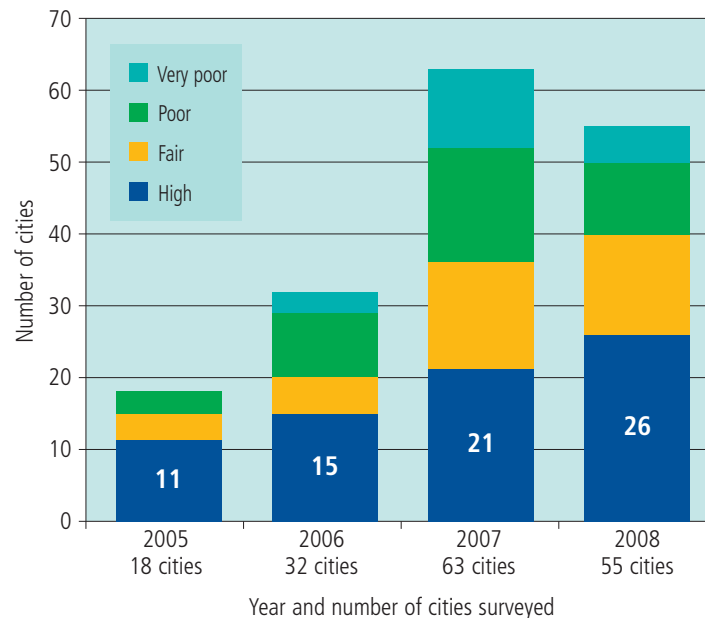
However, most cities have achieved the second enhanced level of supporting projects that enhance the quality of life and thereby health: for example, implementing cycling networks, removing physical barriers to walkability and inserting new parks into dense cities, all encouraging health-enhancing physical activity and social cohesion. Of the three most important healthy urban planning issues, the cluster of green spaces,

recreation and physical activity is the top priority in 17% of cities. The transport and accessibility cluster is a top priority for 12% of cities.

As Phase IV ends, most cities are still struggling to work across disciplinary and professional boundaries to achieve a holistic approach in which health is fully integrated into the urban planning

system. Only a few cities identified housing, transport, accessibility and other policy areas related to the built environment as affecting inequality in health. However, in contrast to earlier years, strategic urban planning issues now have the highest priority in many cities (22%). All the signs point to a progressively deeper and broader understanding of the relationship between health and urban planning, with action following in its wake.

**Fig. 10.2. Healthy urban planning activity in cities**





# Active living

## Johan Faskunger

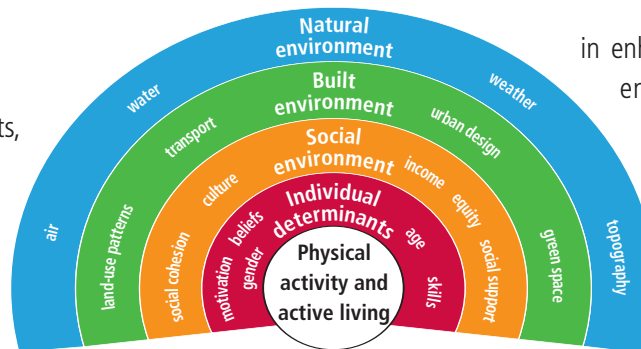
**Key message 1** Healthy cities have moved beyond a traditional focus on dedicated exercise towards active living as a routine part of everyday life.

**Key message 2** An integrated model of urban development encourages tougher choices in urban investment to optimize the health benefits of physical activity.

### Active health

Changes in city environments, less physically demanding working lives and technological innovation have all contributed to sedentary lifestyles, posing a threat to public health. Strong scientific evidence shows that regular physical activity promotes health. Physically active people are not depressed as often, have better cardiovascular and musculoskeletal fitness, a healthier body composition and a biomarker profile more conducive to enhancing bone health and preventing cardiovascular disease and type 2 diabetes (1).

All levels of government are concerned with promoting physical activity and limiting the potential burden of disease. However, individual education and fitness programmes have not succeeded in reversing the sedentary trend. *Promoting physical activity and active living in urban environments: the role of local governments. The solid facts (2)* therefore emphasizes shifting focus towards promoting active living as part of the daily life of a city. City governments have a critical role



**Fig. 11.1. Influences on physical activity in communities**

Source: adapted from: Edwards & Tsouros (2).

in enhancing their social and built environment to encourage active living (Fig. 11.1). In Phase IV, a task group of cities on physical activity and active living led by Turku helped to develop an innovative agenda for the WHO European Healthy Cities Network.

To assess progress in Phase IV, the following questions were asked.

- How do you promote walking, cycling and physical activity when planning your neighbourhoods?
- How does your city's active living programme link to public health concerns, including heart disease and obesity?
- How does your city reach out to sedentary people in your population?
- Is the active living approach incorporated into your city's plan and strategies for urban development?
- How does your city measure and monitor levels of physical activity in the population?

## Activity types and targets

Healthy cities reveal a definite shift away from the traditional focus on callisthenics – dedicated exercise, often in gyms or clubs or classes – towards an active living approach. Although exercise classes are important and team sports may keep people fit, city responses emphasize integrating physical activity into everyday routines – especially cycling and walking for work and leisure. A whole-population approach is required, including older people, children, ethnic minorities, women and disabled people.

## Urban environment

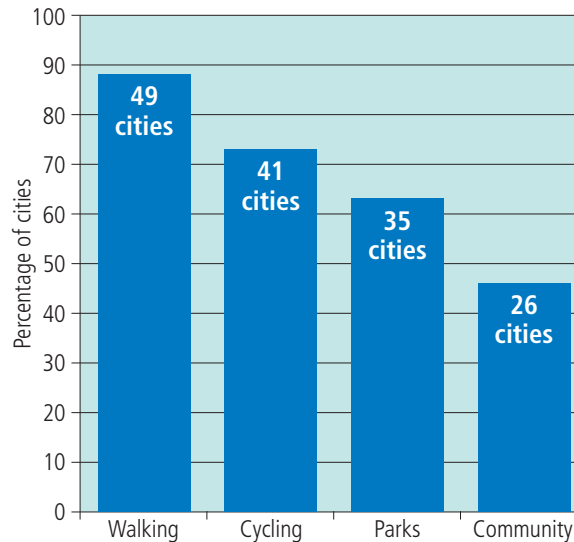
Cities mainly highlight action in the urban environment to encourage everyday activity. The highest investment priority (Fig. 11.2) is improving the infrastructure for walking. Barriers are removed by lowering kerbs on pavements and improving road junctions. Connectivity is enhanced by opening up culs-de-sac. Pedestrian-friendly zones are created in city centres. The second priority is investing in cycling infrastructure, with action to introduce cycle priority lanes, connect suburbs with city centres and make crosswalks safer. The third priority is improving or creating green spaces or parks, to provide facilities and raise people's spirits in dense and often deprived residential areas. People-friendly urban spaces, such as piazzas, are also important.

## Social environment

Cities in the WHO Network are fostering social contacts and cohesion, preventing segregation, promoting

equality and reclaiming the streets to enhance both physical and mental health. Action includes singular events such as cycling and health days. More often, there are sustained community schemes and programmes – such as cycling courses, community clubs, walking groups or buddies – and financial incentives to encourage target groups to become active.

**Fig. 11.2. City investment in active living domains**



## Integrated planning

Mirroring the assessment of healthy urban planning (Chapter 10), relatively few cities report fully integrated urban planning processes to encourage active living. Although 40% refer to city transport plans that include traffic-calming

and reducing motorized road traffic, few cities make systematic links to health or education plans. Only 14% of cities refer to integrated plans for active living. Twice as many have specific programmes to tackle overweight and obesity among adults and children.

## Optimizing design and development

Deploying an ecological model would facilitate better understanding of the interaction between various elements of city development. It would also encourage wise investment via cost–benefit analysis. For example, less than 1% of Sweden's national transport budget is invested in walking and cycling despite evidence that 30% of all trips are by foot or bicycle. One way ahead is to make decision-makers more aware of the health effects of travel choices.

# National Healthy Cities networks in Europe

*Zoë Heritage & Leah Janss Lafond*

**Key message 1** Of the 25 active national Healthy Cities networks in Europe, most significantly influence public health policy at the city, regional and national levels.

**Key message 2** National networks are now better organized than before, with clear strategies and annual plans. More than 70% now have a formal strategy document.

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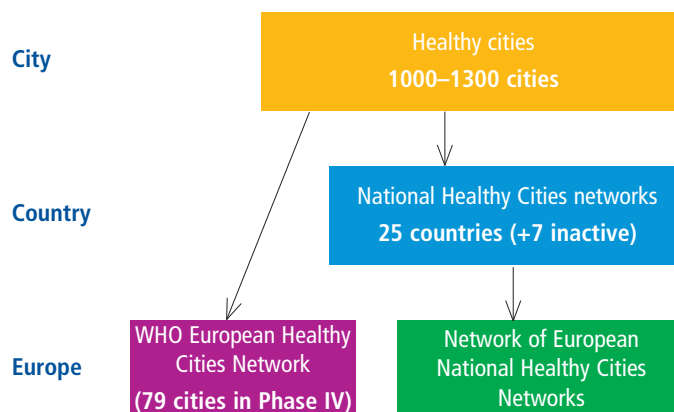
## Context

Interest in the concept and practice of Healthy Cities extended far beyond the 11 pilot cities joining Phase I of the WHO European Healthy Cities Network in 1988. National networks were initiated to encourage wider city participation and, within a year, had linked together 200 cities in 6 European countries. In 2000, WHO and network coordinators agreed on common membership criteria for national networks. By 2003, national networks represented more than 1000 cities in 29 countries (1) under the umbrella of the Network of European National Healthy Cities Networks.

## Purpose

National networks were initiated to help cities exchange information and experience and to create more favourable conditions for implementing healthy city strategies. Common aims include enabling access to

**Fig. 12.2. Number of cities in selected national Healthy Cities networks in Europe, 2003–2008**



new public health evidence, representing cities at the national level and expanding knowledge about the principles of healthy cities.

## Phase IV

At the end of Phase IV, there are 25 active national networks; another 7 are inactive or in the process of reorganizing (Fig. 12.1). They vary greatly. Some are long established; others (Bosnia and Herzegovina and Cyprus) are less than 10 years old. A few have a full-time coordinator (Czech Republic, Norway and Slovenia), but most do not. WHO has accredited 20 national networks that have met the agreed membership criteria.

## Developing capacity

Successful networks develop in three stages: facilitating exchange between city members, concerted action and joint production (2). Every active national network has achieved the first stage, and at least half have reached

the highest level in which cities jointly organize training events and produce common strategies.

These achievements require considerable organization, with formal structures for decision-making by an assembly of network members and a secretariat based in a member city or national institution. Technical and financial resources are critical: two thirds have membership fees, although the most successful networks, such as the Czech Republic's network, have external funding. National networks are becoming better organized, with 70% producing formal strategies and annual plans.

### Impact in cities

A core function is to increase awareness of the social determinants of health among city actors, supporting them to produce integrated health profiles and implement city health development plans. National networks are key vehicles for disseminating new public health evidence, especially around the core themes of Phase IV. They provide training, support health promotion events and guide cities towards more strategic interventions. One marker of achievement is an increase in cities per network (Fig. 12.2).

### Regional effects

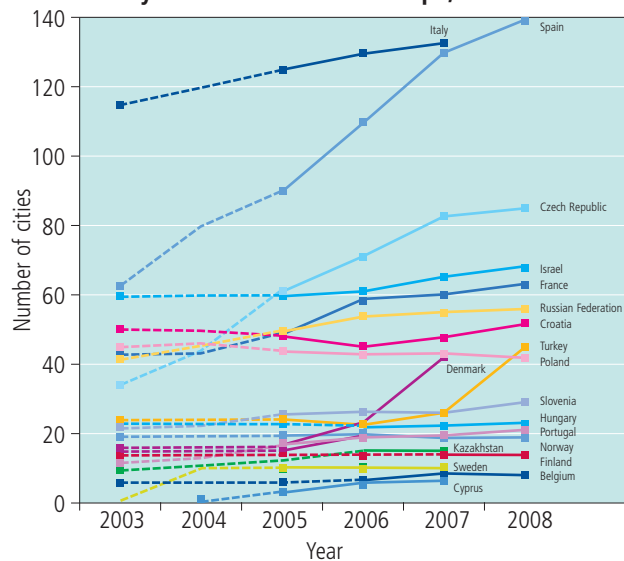
National networks influence decision-making at the regional level. Norway's network injected a public health dimension into a 2007 government report on the

future of the regions. Croatia's network has been responsible for a training programme in 18 (of 20) counties to improve public health capacity.

### National effects

More than two thirds of national networks have established partnerships with the national government and exert powerful influence by disseminating evidence on determinants of health and core themes. Most work with health ministries. Spain's network helped design and implement the Strategy for Nutrition, Physical Activity and Prevention of Obesity. Portugal's network helped draft the National Health Plan 2004–2010, and Slovenia's network programme was adopted as part of the National Public Health Plan (2003–2010).

**Fig. 12.2. Number of cities in selected national Healthy Cities networks in Europe, 2003–2008**



### European level

More national networks report projects or partnerships with international organizations, mainly funded by the European Union on topics such as active living, urban health indicators, profiles, HIV and mental health. HEPRO (focus on health and social well-being in the Baltic Sea region) is the largest collaborative project, involving 32 partners in 8 countries including the national networks of Denmark, Norway and Poland. However, to achieve its full potential, the Network of European National Healthy Cities Networks needs extra support from WHO in training and information sharing.

# References

## Chapter 1. Introduction

1. Commission on Social Determinants of Health. *Closing the gap in a generation. Health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008 ([http://whqlibdoc.who.int/hq/2008/WHO\\_IER\\_CSDH\\_08.1\\_eng.pdf](http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf), accessed 6 October 2008).

## Chapter 2. Assessing the impact of Healthy Cities

1. Commission on Social Determinants of Health. *Closing the gap in a generation. Health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008 ([http://whqlibdoc.who.int/hq/2008/WHO\\_IER\\_CSDH\\_08.1\\_eng.pdf](http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf), accessed 6 October 2008).
2. Draper R et al. *WHO Healthy Cities project: review of the first 5 years (1987–1992). A working tool and a reference framework for evaluating the project*. Copenhagen, WHO Regional Office for Europe, 1993.

## Chapter 3. Partnerships

1. *Targets for Health for All: targets in support of the European regional strategy for health for all*. Copenhagen, WHO Regional Office for Europe, 1985.
2. *City health planning: the framework*. Copenhagen, WHO Regional Office for Europe, 1996.

## Chapter 4. Healthy city profiles

1. *City health profiles – how to report on health in your city*. Copenhagen, WHO Regional Office for Europe, 1995 (<http://www.euro.who.int/document/wa38094ci.pdf>, accessed 6 October 2008).
2. Webster P. Review of the “city health profiles” produced by WHO healthy cities – do they present information on health and its determinants and what are their perceived benefits? *Journal of Epidemiology and Community Health*, 1999, 53:125–127.
3. Webster P, Lipp A. The evolution of the WHO city health profiles: a content review of WHO healthy city profiles. *Health Promotion International* (in press).

4. Zamaro G, ed. *Udine: il profilo di salute della popolazione anziana [Udine: healthy ageing profile]*. Udine, City of Udine, 2008.

## Chapter 5. Healthy city development plans

1. *A working tool on city health development planning: concept, process, structure and content*. Copenhagen, WHO Regional Office for Europe, 2001 ([http://www.euro.who.int/healthy-cities/UHT/20050201\\_1](http://www.euro.who.int/healthy-cities/UHT/20050201_1), accessed 6 October 2008).
2. Green G et al. City health development planning. *Health Promotion International* (in press).

## Chapter 6. Active participation by and empowerment of communities

1. *Ottawa Charter for Health Promotion*. Geneva, World Health Organization, 1986 (<http://www.who.int/healthpromotion/conferences/previous/ottawa/en>, accessed 6 October 2008).
2. Robertson A, Minkler M. New health promotion movement: a critical examination. *Health Education Quarterly*, 1994, 21:295–312.
3. Tsouros A. Healthy cities mean community action. *Health Promotion International*, 1990; 5:177–178.
4. Arnstein S. Eight rungs on the ladder of citizen participation. *Journal of the Institute of American Planners*, 1969, 35:216–224.
5. Davidson S. Spinning the wheel of participation. *Planning*, 1998, 126:14–15.

## Chapter 7. Equity and determinants of health

1. *Global strategy for Health for All by the year 2000*. Geneva, World Health Organization, 1981 (“Health for All” Series, No. 3; <http://whqlibdoc.who.int/publications/9241800038.pdf>, accessed 6 October 2008).
2. Whitehead M. *The concepts and principles of equity and health*. Copenhagen, WHO Regional Office for Europe, 1990 (EUR/ICP/RPD 414).

3. Commission on Social Determinants of Health. *Closing the gap in a generation. Health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008 ([http://whqlibdoc.who.int/hq/2008/WHO\\_IER\\_CSDH\\_08.1\\_eng.pdf](http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf), accessed 6 October 2008).
4. *HEALTH21 – the Health for All policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 ([http://www.euro.who.int/InformationSource/Publications/Catalogue/20010911\\_38](http://www.euro.who.int/InformationSource/Publications/Catalogue/20010911_38), accessed 6 October 2008).
5. Whitehead M, Dahlgren G. What can we do about inequalities in health? *Lancet*, 1991, 338:1059–1063.

### Chapter 8. Health impact assessment

1. *Health impact assessment: main concepts and suggested approach*. Gothenburg consensus paper. Brussels, WHO European Centre for Health Policy, 1999.
2. Bekker M. *The politics of healthy policies. Redesigning health impact assessment to integrate health in public policy*. Delft, Eburon, 2007.

### Chapter 9. Healthy ageing

1. *Active ageing: a policy framework*. Geneva, World Health Organization, 2002 (<http://www.who.int/ageing/publication/active/en/nidex.html>, accessed 6 October 2008).
2. Laslet P. *A fresh map of life: the emergence of a third age*. Cambridge, MA, Harvard University Press, 1989.
3. Emilia-Romagna Territorial Economic Development S.p.A. (ERVET) et al. *Older persons' housing design: a European good practice guide*. Bologna, Wel\_hops Network, 2007 (<http://www.brighton-hove.gov.uk/index.cfm?request=c113815>, accessed 6 October 2008).

### Chapter 10. Healthy urban planning in European cities

1. Barton H, Tsourou C. *Healthy urban planning: a WHO guide to planning for people*. London, Spon Press, 2000.
2. Barton H, Grant M, Guise R. *Shaping neighbourhoods for health, sustainability and vitality*. London, Spon Press, 2003.

3. Barton H, Grant M. A health map for the local human habitat. *Journal of the Royal Society for the Promotion of Health*, 2006, 126:252–253.
4. Franklin T et al. Walkable streets. *New Urban Futures*, 2003, 10 July:5–7.
5. Halpern D. *Mental health and the built environment*. London, Taylor and Francis, 1995.

### Chapter 11. Active living

1. *At least five a week: evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer*. London, Department of Health, 2004.
2. Edwards P, Tsouros A. *Promoting physical activity and active living in urban environments: the role of local governments. The solid facts*. Copenhagen, WHO Regional Office for Europe, 2006 (<http://www.euro.who.int/document/e89498.pdf>).

### Chapter 12. National Healthy Cities networks in Europe

1. Lafond LJ et al. *National Healthy Cities networks: a powerful force for health and sustainable development in Europe*. Copenhagen, WHO Regional Office for Europe, 2003 ([http://www.euro.who.int/InformationSources/Publications/Catalogue/20050118\\_3](http://www.euro.who.int/InformationSources/Publications/Catalogue/20050118_3), accessed 6 October 2008).
2. Broesskamp-Stone U. *Assessing networks for health promotion: frameworks & examples*. Münster, University of Bielefeld, 2004.

## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

### Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czech Republic  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Moldova  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
The former Yugoslav Republic of Macedonia  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

# City leadership for health

## Summary evaluation of Phase IV of the WHO European Healthy Cities Network

The report is a summary evaluation of Phase IV of the WHO European Healthy Cities Network. It reviews the organization of healthy cities, their enduring values and the core themes of health impact assessment, healthy ageing, healthy urban planning and active living. There are 23 key messages for city decision-makers and the international public health community.



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