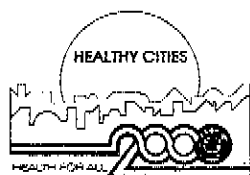


City Action for Health

Review of the first phase of the
Healthy Cities project



WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

TARGET 14

SETTINGS FOR HEALTH PROMOTION

By the year 2000, all settings of social life and activity, such as the city, school, workplace, neighbourhood and home, should provide greater opportunities for promoting health.

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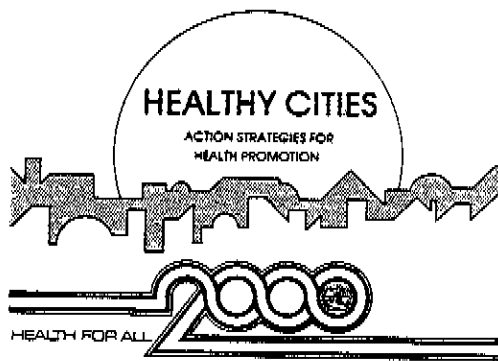
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City Action for Health

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Report on the Seventh Healthy Cities Symposium

Copenhagen
9-12 June 1992



1993

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ABSTRACT

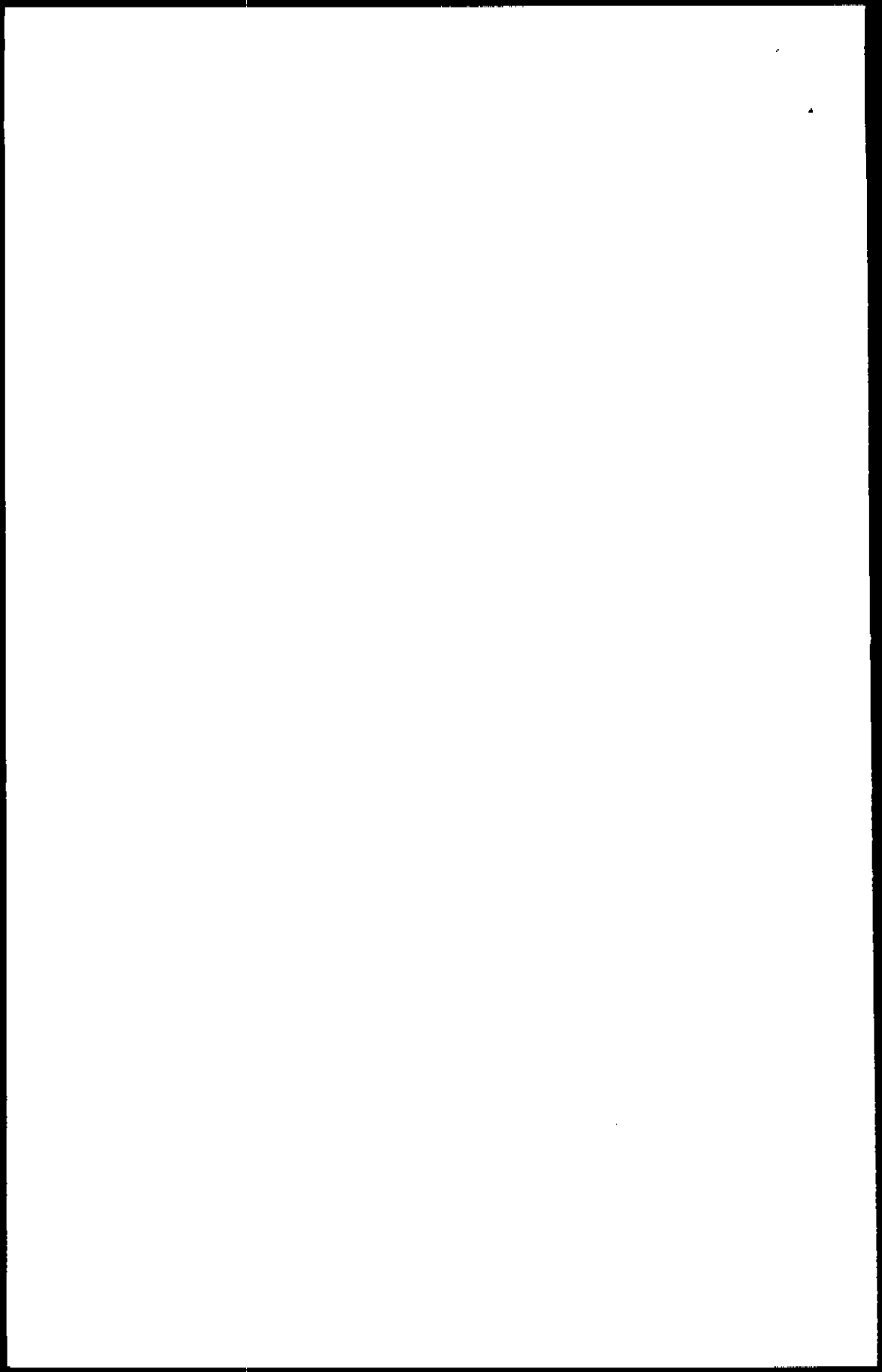
At the end of the first five-year phase of the WHO Healthy Cities project, the WHO Regional Office for Europe and the Copenhagen Healthy Cities Project Office organized the Seventh Annual Healthy Cities Symposium. Nearly 500 participants from a wide variety of disciplines and sectors – a measure of the project's size and success – met to evaluate the first phase and to launch the next five-year phase of the project, using the unifying theme of healthy public policy. The participants discussed factors in the success of the work done by project cities and national Healthy Cities networks, and the development and implementation of healthy public policies, which create safer and more supportive environments and services in cities. Some 40 case studies described cities' practical achievements, including four particularly successful multi-city action plans, and workshops addressed important common issues. The Symposium participants concluded their work by agreeing on strategies for the second phase of the Healthy Cities project and on the initiatives to be taken by all partners at the international, national and city levels.

Keywords

URBAN HEALTH
HOUSING
HEALTH PROMOTION
CONSUMER PARTICIPATION
PUBLIC POLICY
HEALTH FOR ALL
PROGRAM EVALUATION
INTERSECTORIAL PLANNING
CONGRESSES
ENVIRONMENTAL HEALTH

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INTRODUCTION

The Seventh Annual Healthy Cities Symposium, held in Copenhagen from 9 to 12 June 1992, was organized jointly by the WHO Regional Office for Europe and the Copenhagen Healthy Cities Project Office and supported by the Council of Europe and the Commission of the European Communities. The Symposium, which marked the end of the the first five years of the WHO Healthy Cities project, focused on the theme of healthy public policy as a means of reviewing and tying together the variety of work done by the WHO project cities.

The Symposium was attended by 465 participants from 87 cities and 31 countries, mainly from the European Region, but also from the WHO regions of the Americas, the Eastern Mediterranean and Africa. A special effort was made, with support from the City of Copenhagen and the Danish Government, to secure participation of some 100 participants from countries in the central and eastern parts of the European Region. In addition to representatives from 32 WHO project cities, there were representatives of 17 national networks and a number of national and international organizations. The participants came from a wide range of disciplines and included mayors and senior politicians, city staff and other professionals, community members and academics. A list of the participants comprises Annex 2.

Chairpersons of the plenary sessions were: Ms Julie Fitzgerald, London; Professor Lowell S. Levin, New Haven; Dr Claus Lundstedt, Copenhagen; and Ms Margarethe Nimsch, Frankfurt. The opening and closing ceremonies were chaired by the Lord Mayor of Copenhagen, Mr Jens Kramer Mikkelsen. Dr Trevor Hancock was the Rapporteur.

It was the largest Healthy Cities Symposium yet; in addition to 3 plenary sessions, 14 sessions of smaller groups, 9 workshops (featuring some 80 presentations), 7 teaching sessions and 14 site visits, the Symposium encompassed the second Healthy Cities mayors' meeting, an impressive exhibition on the project and the generous hospitality of the City of Copenhagen and the Danish Ministry of Health. In addition, meetings were held for participants representing the national networks, the multi-city action plans, and international organizations and agencies with an interest in urban health. Moreover,

the City of Copenhagen marked the Symposium by organizing a "Healthy City Week" throughout the city, with activities organized by advocates in districts. This was accompanied by a gathering of some 1000 senior citizens from project cities across the European Region and by a lunch table of record-breaking length, running from end to end of the pedestrian shopping street (*Strøget*), at which tens of thousands of Copenhageners ate a healthy meal.

The Symposium marked the end of the first five years of the WHO Healthy Cities project and the beginning of the next five-year phase. The main objectives of the Symposium were:

- to evaluate the first five years of the project;
- to review achievements and problems in creating healthy public policies;
- to describe examples of action taken in particular areas – including the work done through multi-city action plans; and
- to outline future strategies and challenges, launching the next phase of the project in a changing European setting.

DISCUSSION

Reflections on progress

The WHO Healthy Cities project has grown from 11 cities in 1987 to 35 cities in 1992. It is also linked to national networks of cities in 18 countries in Europe and to other health initiatives in cities, towns, municipalities and communities in all WHO regions. The project not only helps to achieve health for all at the local level but, in doing so, creates the basis for a new approach to public health.

The Healthy Cities project was never conceived as a laboratory experiment or a plan operating in a closed system. It has always been a long-term effort to bring about social and political changes that will benefit health. At the same time, however, projects in cities must demonstrate their value to communities. People need to know that such principles as intersectoral collaboration and community participation actually work. In difficult times, the project must demonstrate

its worth by its adherence to the principles of health promotion and by speaking up for the people in most need.

A five-year review of the project will be published in 1993. It will be used to plan the second phase of the project (1993-1997), and will analyse and illustrate the progress made by the project cities and national networks in Europe in creating settings and conditions that promote health. The review will look at progress in terms of input (what has to be done), output (what has been done) and impact (what the effect has been) at the local, subnational, national and international levels. It is important to realize, however, that such work takes time: perhaps 2-4 years to change structures and processes, 3-6 years to develop healthy public policies, 4-8 years to create healthier settings and 5-10 years to see these reflected in health gains. This time is needed to overcome political concern, the traditions of bureaucrats, the scepticism of the community, the resistance of professionals and the scarcity of resources.

As an example of what is needed, participants from Copenhagen reported on the decision to establish a Healthy Cities plan and common, concrete goals. District health profiles have already been prepared and are available on diskette, so that communities can better understand their health conditions. In addition, representatives of a number of cities and national and regional networks reported on their progress to date. Examples from Glasgow, Toronto and Sheffield highlighted the momentum achieved through the project in translating local aspirations into action to change particular determinants of health in the community. An indication of the range of partnerships needed to apply project goals to a variety of areas of public concern was given by participants from Rennes. Further, as shown in Horsens and other cities, the project is increasingly encouraging partners from the private sector to invest in the health of the community.

The experience gained in national networks suggests that technical support, annual meetings and proximity to the project office are factors favouring success of projects, as is the size of the city. Larger cities seem to find intersectoral collaboration and community participation more difficult than smaller ones.

Other points raised in the sessions included the value and importance of partnerships between project cities in different countries and

the important role cities can play in providing support to their partners, particularly in times of crisis. This includes the obvious and material benefit in the case of the aid (worth US \$7 million) given by Horsens to Zagreb, but more generally applies to links between cities in central and eastern Europe and those in other parts of the European Region.

Healthy public policy and cities

The theme for the 1992 Symposium was healthy public policy. In practical terms, this means measures taken at the city level to create and influence safer and more supportive environments and services in the community, with an explicit emphasis on promoting wellbeing.

This theme needs to be understood in the context of the development of health promotion and healthy public policy as fundamental approaches to the achievement of health for all. Reference was made several times to the common origin of healthy public policy and the Healthy Cities project in a conference in Toronto, Canada in 1984. The Ottawa Charter for Health Promotion, adopted in 1986, placed healthy public policy at the top of a list of five means to implement health promotion. The importance of healthy public policy was explained in 1988 at the Second International Conference on Health Promotion in Adelaide, Australia. The results of the conference included a book of case studies on the development of healthy public policy at the local level. The Third International Conference on Health Promotion, held in Sundsvall, Sweden in 1991, focused on the second key approach to health promotion identified in the Ottawa Charter, namely, the creation of supportive environments for health.

The importance of cities as a focus for healthy public policy received extra emphasis at the United Nations Conference on Environment and Development, which was held at the same time as the Healthy Cities Symposium. The project cities have a great interest in the creation of health promoting built environments and in sustaining their natural environments and resources. Thus, the mayors of the WHO project cities not only made a statement on the Healthy Cities movement (Annex 1) during their meeting but also sent a telegram to the Conference expressing their commitment to environmental health

and sustainable development, to addressing health inequalities and particularly the needs of the urban poor and disadvantaged, to solidarity with cities in central and eastern Europe and to international cooperation. The Healthy Cities movement is a fine example of thinking globally and acting locally; it is a reminder that the vast majority of people in the industrialized world lives in cities, and soon the majority of the world population will do so. WHO is therefore paying increasing attention to the health challenges of cities, as witnessed by the 1992 technical discussions on the topic at the World Health Assembly. As a result, the Healthy Cities project or movement is beginning to spread into the countries of the developing world, which find it a useful approach to the health challenges that their cities face.

Healthy public policy has a new style, approach and content, and part of its strength is that it cannot be limited to only one sector. Its key elements include:

- a focus on the determinants of health and on the question of where health is created;
- an interest in discovering which investment produces the largest health gains (for example, investment in primary education versus investment in health care services);
- a commitment to equity and determining which strategies will narrow the gap in health status; and
- the wish to see public resources allocated on the basis of these considerations.

Such policy needs more relevant epidemiological research and indicators, and a capacity for health impact assessment. Healthy public policy is compatible with the new politics – which focus on particular issues – because it is flexible, transcends traditional political boundaries and requires new approaches to policy-making. It is also relevant to two key issues: human wellbeing and environmental sustainability. Healthy public policy can be thought of as a form of organizational development for health.

The Symposium covered several aspects of developing and implementing healthy public policy in areas ranging from environmental protection, housing and traffic through the needs of refugees,

immigrants and other disadvantaged groups to senior citizens, children and schools, new approaches to urban planning, and vigorous and innovative health promotion programmes.

Examples of achievement

Some 40 case studies presented in 10 sessions gave an insight into the many practical achievements within the Healthy Cities project. They showed the many facets of the project and the variety of dimensions of urban life that are influenced when people in a community decide to combine forces to address issues affecting their living and working conditions. The case studies illustrated two requirements for successful action within the Healthy Cities project:

- the processes involved, such as planning, gaining political commitment, building alliances and inviting public participation; and
- the need to make the ideas behind the project clearly visible through concrete projects and experiments.

The role that the project can play in bringing a community's serious social problems to the surface was shown in a number of projects to support disenfranchised groups, such as displaced people in Zagreb, gypsies and abused children in Milan and women from immigrant groups in Rotterdam. In addition, the willingness to re-direct and redefine community resources to meet the needs of groups at risk was indicated in the sessions on care for elderly people. Examples from Stockholm, Copenhagen, Gothenburg and Hamburg concerned steps to exchange a standardized approach for more tailor-made consideration of individual needs in providing services, and to pay attention to social and environmental conditions that could help the elderly to stay within their neighbourhoods.

The presentations showed that environmental issues are increasingly becoming a major item on the city agenda. A model for dealing with hazardous materials, developed for cities in the European Community, was presented by participants from Copenhagen; it emphasized the benefits of sorting waste materials before disposal and included attention to illegal ways of waste disposal. In Pécs, new

lines of communication between the city government and the community, as well as new administrative infrastructures, were being established as awareness grew of the consequences of problems such as hazardous waste, pollution and inadequate sewerage.

The particular vulnerability of children to air pollution raised the concern of both citizens and industry in Copenhagen, leading to joint action to restrict pollution. In Eindhoven, a project focused on ways to encourage children and adolescents to take an active and responsible role in improving their environment. Further, the potential of the school as a setting for investment in the health of the community was described in a case study from Copenhagen on a policy for the health promoting school.

The role of urban planners in the strategic development of the healthy city of the future was stressed in a case study from Vancouver. In Bremen, the Healthy Cities project has concentrated on experiments to involve senior citizens and city authorities in creating safer traffic conditions. Traffic conditions, particularly for pedestrians, were also the main concern in a project in Belfast that forged an alliance between transport planners and a residents' group for safer environments. The complexity of the relationship between city planning and health was demonstrated in a case study from Liverpool, where renovated housing had resulted in improved perceptions of health, but had also shifted social problems to other areas.

Four multi-city action plans (MCAPs) were evaluated. The success of the MCAPs on AIDS, tobacco-free Healthy Cities, health promoting hospitals and the environment and health in Baltic cities was ascribed to several factors, including the input of the coordinating city of each MCAP, close links with related programmes at the WHO Regional Office for Europe and the interest and participation of member cities. The project cities clearly need to work together on concrete issues with high visibility, as shown in Eindhoven by the successful cooperation of agencies and the community on physical activity. The case study on this work signalled the start of a new MCAP on active living. Other presentations covered particular lifestyle topics, such as:

- the AIDS campaign in Copenhagen, using public transport vehicles as billboards;

- a tobacco control action as part of the health self-protection project in Bologna;
- the work of a centre in Padua against cigarette smoking, which includes the use of municipal ordinances to ban smoking; and
- a project in Copenhagen in which employers and employees have joined forces to find cultural and social answers to drinking at work.

Presentations on either the overall development or particular elements of the Healthy Cities project struck a more general note.

A team from Liverpool demonstrated the many dimensions of the Healthy Cities strategy, stressing the "bottom-up" approach. Participants from Turku described how the project had become closely tied to the city's health promotion unit, thus benefiting from an established organization in the Finnish statutory framework, and contributing to it an international dimension and the Healthy Cities principles. In the Nancy area, the project has forged a broad alliance between the scientific, environmental, cultural and leisure communities and public health institutions. In addition, the project in Camden relies on a survey approach and communication to achieve and maintain community participation.

The essential role of information and communication was stressed repeatedly. For example, the national network in the Netherlands emphasizes the need for a strong organizational framework to enable its members to communicate, and Australian cities depend on a national network to foster the ideas of the Healthy Cities project. One type of answer to this need has been found in Denmark, where the Danish Public Health Fund has concentrated on backing about 100 local health initiatives through its information system.

Workshop reports

The participants in six workshops reported their conclusions.

Health in small towns

Big cities can learn from the experience of small cities involved in the Healthy Cities project, which holds the key to public participation.

Big cities should employ more decentralized versions of the project. They should perhaps use the concept of working at the community, neighbourhood or village level. In addition, small cities have problems in organizing because of a lack of resources. They need access to central resources or support through the national networks.

National networks

Each national Healthy Cities network exists for its members, with mutual training and learning as a key activity. The national networks need some organizational structure, but this must not impede the information flow or the network's flexibility.

Support centres are needed, particularly to support smaller cities and towns, to facilitate networking, to provide advice and support, to disseminate information and to develop training programmes. Further, it was suggested that national networks need to diversify their funding and not to rely on only one sponsor.

Developing countries

Key criteria for attempting Healthy Cities projects in developing countries are that: the cities or communities have some kind of public health structure, city leaders be interested in public health and a degree of democracy exist to allow community participation.

In the cities of developing countries, the health and social problems of the poor, the middle class and the affluent differ greatly. The health problems of affluent people are more like those of developed countries, while the problems of the poor are more typical of developing countries. Local government in these countries may be weak, and experience has shown that this necessitates working with community groups, and sometimes focusing on a specific area and not trying to operate city-wide.

Strategies and problems in project cities

Project cities differ widely in that strategic approaches tend to be in different stages of development. Some cities are in the initial process

of establishing a basis for the project, while others have expanded the project into a city-wide movement. Although the project can be developed from very different starting points, and even from existing risk reduction programmes, a feeling of ownership by the community is the very first requirement, closely followed by coordinated planning. To gain the confidence of the community the project has to be visible, include public consultation and be subject to a procedure to ensure accountability.

Pitfalls in project strategy range from a dependence on just a few key people to the appropriation of the project by a single political party.

Health profiles

The participants considered health profiles as a basis for setting priorities and planning work in the Healthy Cities context. Such profiles must be based on both qualitative and quantitative data.

Quantitative data often are already available, for example, from census materials, although they are not always arranged to review the various determinants of health in the city (such as the economy, the environment, housing, transport and education) or broken down to the district level. To attract the interest of the public and politicians, health profiles need to include subjective views and perceptions of what constitutes a healthy or "livable" city. These may be gathered by interviews with residents or questionnaires aimed at particular groups, or by using "environmental scans" made by interest groups.

Community participation

Community participation is solicited in many ways in cities, either for the implementation of particular projects or on a more permanent basis. The examples presented at the workshop indicated the need for members of the community to recognize problems and issues as their own if they are to take a truly active role. This may be one of the main reasons why projects originating in the grassroots or lay care, which are intended to empower people, tend to generate community support more easily than institution-based approaches, no matter how well

intended. A possible combination was offered in the case of a local information centre. Although based on the idea that people should shop for health as for any other product and therefore need a place to get consumer advice, the centre also acted as a community thermometer, alerting institution-based services to local health needs.

When community participation involves direct contact with city administrations, experience suggests that the differences in aims and expectations, as well as inequalities in resources, put a heavy mortgage on long-term cooperation. Other examples, however, suggest that the investment by city politicians of faith (and funds) in community health initiatives encourages responsibility in citizens. In conclusion, it was suggested that every project city be asked for one model of good practice in community participation, to encourage further exchange and that the subject receive special attention during future symposia or meetings on the Healthy Cities project.

FUTURE STRATEGIES

The second phase of the Healthy Cities project will begin in 1993. The project will retain its commitment to the principles of health for all and to health promotion strategies. This will mean continued concern for equity, sustainable development, the creation of settings for healthy living and health care reform. The overriding challenge for the second phase will be to sustain the consensus and commitment that have been built to initiate direct action on particular health problems. This will be reflected in the widespread adoption and implementation of healthy public policies in cities that are part of the Healthy Cities movement.

Objectives and initiatives

The present challenge suggests four strategic objectives for the next five years:

- accelerating the adoption and implementation by cities of healthy public policy based on intersectoral cooperation and community participation;

- strengthening national and subnational support systems and spreading their development throughout the European Region;
- building strategic links with other sectors and organizations that have an important influence on urban development; and
- strengthening the international system of support for the Healthy Cities movement.

Major initiatives in phase two should reflect the achievements of the past and the challenges of the future. While work accomplished in the first phase will continue in the second, new approaches and priorities will be needed. Committed effort will be required for the major initiatives chosen for the international, national and local levels.

At the local level, the WHO project cities represent demonstration sites and focal points for the dissemination of ideas. These cities have seriously and explicitly committed themselves to the goal of health for all. They are willing to test new ideas and, through a monitoring and evaluation process, to build a body of applied knowledge to share with other cities and the Healthy Cities movement as a whole.

The progress achieved in local Healthy Cities projects suggests a new set of priorities for the next five years. Local initiatives will vary according to the cities' length of participation in WHO or other networks and the progress achieved. In general, the new priorities reflect a change in emphasis from creating new structures and processes to facilitating direct action on health problems.

International initiatives

1. A new network of cities in the WHO Healthy Cities project will be created.
2. The national networks have formed a network called EURONET; a EURONET association will be established.
3. Cities in central and eastern Europe will receive special support. This will mean the designation of new WHO project cities, the development of national networks and the provision of special support for consultation, training and the preparation of resource materials.

4. Strategic links will be made with international bodies that have a major influence on urban development. Efforts will be made to develop shared agendas with such organizations and to undertake joint activities. Priority will be given to forming links with such organizations as the Council of Europe, the European Community, the Organisation for Economic Co-operation and Development (OECD), the International Union of Local Authorities (IULA), and the International Council for Local Environment Initiatives (ICLEI).

National initiatives

5. Each country should strengthen its existing national and sub-national Healthy Cities networks.
6. National and subnational networks will be promoted in countries where they do not yet exist. Special attention will be given to new Member States in the European Region that currently lack focal points to encourage Healthy Cities development.

WHO project city initiatives

7. The formulation and implementation of healthy public policy will become the most important concern for WHO project cities.
8. The cities will act on WHO strategies such as the action plans on tobacco and alcohol.
9. Project cities will adopt policies based on the WHO regional targets for health for all and make plans for their implementation.
10. The cities will establish mechanisms to support accountability for health throughout city administrations.
11. Project cities will emphasize strengthening the performance of their projects. This will involve securing the people, money and information necessary to act as effective advocates and to support multisectoral action and community participation.

Approaches

The methods developed in the first phase of the Healthy Cities project will continue to be applicable. Some adjustments in approach, however, will be made to reflect new priorities, the current state of development and the existing support networks.

1. The WHO project office will pursue a highly focused mission and set of priorities, with a special focus on policy development, advocacy, strategic planning, project development, liaison with international bodies and the coordination of the activities of the WHO project city network. The project office will also work to foster the development of support centres throughout the Region and to strengthen the role of national and subnational Healthy Cities networks.
2. A reapplication process will be used to reaffirm the political commitment of the project cities. The criteria for participation have been clarified and confirmed and will be followed closely as a condition for continued participation. A five-year plan will be negotiated to affirm the project cities' commitment to sharing information and experience.
4. Business meetings of the WHO Healthy Cities project will continue to be held twice each year. Because politicians will play a more active role in the development of and international advocacy for the project, each project city participating in business meetings will be asked to send a delegation that includes the politician responsible for the project, the project coordinator and another senior official from the city administration.
5. Healthy Cities symposia will be convened on a biennial basis. The participating cities, national networks and EURONET will be urged to assume responsibility for organizing and sponsoring the symposia. New themes for the symposia such as intersectoral action, accountability for health, sustainable development and city health plans, will be considered.
6. Technical workshops will be convened as frequently as needed. They will cover areas of special interest to representatives from various

sectors involved in Healthy Cities work. Participating cities, national networks, collaborating centres and academic institutions will be invited to organize such workshops.

7. The development of multi-city action plans will continue, and participation will be extended to cities in national and subnational networks.

*Annex 1***STATEMENT FROM THE
MAYORS' MEETING IN COPENHAGEN**

On 9 June 1992 mayors and senior politicians from the cities in the WHO Healthy Cities project met in Copenhagen during the Seventh Annual Healthy Cities Symposium. The meeting resulted in a mayors' statement that highlights the challenges for the coming years and confirms the will to strengthen efforts to develop a new model of cities. This statement will serve as a political basis and agenda for the Healthy Cities project during its next five-year phase:

We – the mayors and senior politicians of the WHO project cities, on the occasion of the 1992 Copenhagen Symposium – reconfirm our strong commitment to the Healthy Cities movement.

We commend the World Health Organization on the foresight and innovation it has shown in embarking on a Europe-wide project to put health on the political agenda of cities.

The WHO Healthy Cities project was one of the first initiatives to link European cities through an international organization. It has since been followed by a range of city projects launched by other organizations, thus underlining the increasing role cities will play in shaping the Europe of the future.

The WHO project has widened our understanding of health and its determinants at the local level. Our involvement in the WHO project has strengthened our capacity to implement healthy public policies that create physical, social and mental wellbeing. It has highlighted the need to overcome sectoral separation in order to respond to new health challenges. In particular, the project has confirmed to us the need to involve partners throughout the city in health, above all the citizens themselves.

The WHO project has led to a myriad of concrete innovative actions on the ground and has initiated a shift in city priorities towards

health promotion. It has most definitely strengthened our ability to respond to new developments.

This is due in particular to the unique strategy of intercity cooperation within the project and building on each other's experiences.

The relevance and success of the project is mirrored in its rapid growth; it now includes 35 cities, while the movement as a whole encompasses national networks with 400 cities in Europe alone, as well as many networks and initiatives in other parts of the world. At this stage, the project has become a truly global movement that we call on WHO, other agencies and cities throughout the world to strengthen and develop even further. This is all the more relevant in view of the issues raised at the Earth Summit (the United Nations Conference on Environment and Development) in Rio de Janeiro, meeting at the same time as this Symposium.

The challenges of the next five years are enormous. Europe is changing at an unprecedented rate and much of this change will affect – and is already affecting – the lives of our citizens. We see the need for the Healthy Cities movement to take up in particular the following challenges:

- making a political commitment to sustainable development and supportive environments through responsible and consistent pollution and traffic policies;
- demonstrating solidarity with the cities of central and eastern Europe in helping them develop the infrastructures and skills they need to tackle their problems;
- showing a willingness to answer, with committed policies, the growing health inequalities in cities, such as the increasing number of the urban poor and homeless, migrants and isolated citizens.

The Healthy Cities movement has established a unique network throughout Europe. We call on other intergovernmental organizations and agencies actively to use this network and to show foresight in linking the various city-based networks and projects to support each other.

We welcome the proposal to create a Healthy Cities association with the aim of becoming a strong public health voice in Europe –

where cities will play an increasing role in maintaining and developing the quality of life.

Our commitment to Health for All has been strengthened through our experience, and we call on cities throughout the world to join us in this effort to develop a new model of cities of the future.

*Annex 2***PARTICIPANTS****Project Cities**

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Gothenburg, Sweden
Horsens, Denmark
Kannas, Lithuania
Liège, Belgium
Liverpool, United Kingdom
Mechelen, Belgium
Milan, Italy
Munich, Germany
Nancy, France
Padua, Italy
Patras, Greece
Pécs, Hungary
Rennes, France
Rotterdam, Netherlands
Sandnes, Norway
Sofia, Bulgaria
St Petersburg, Russian Federation
Stockholm, Sweden
Turku, Finland
Vienna, Austria
Zagreb, Croatia

Countries^a

Australia
Austria
Belgium
Canada
Czechoslovakia
Denmark
Egypt
Estonia
Finland
France
Germany
Greece
Hungary
Iran
Israel
Italy
Japan
Morocco
Netherlands
Norway
Papua New Guinea
Poland
Portugal
Saudi Arabia
South Africa
Spain
Sweden
Switzerland
United Kingdom
United States of America

^a Participants from these countries either represented national Healthy Cities networks or were linked to the project in some other way.

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