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## SUMMARY REPORT

# Second Interregional Healthy Cities Conference (French language)

Montpellier  
8-11 October 1990



1991

EUR/HFA targets 14 and 24

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## TARGET 14

### Social support systems

By 1990, all Member States should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.

## TARGET 24

### Healthy homes

By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment.

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## Introduction

Two hundred and twenty-three participants (politicians, local government officers, physicians, public health professionals, welfare association leaders and technical staff responsible for environmental matters) representing 81 cities from 17 countries and territories in 4 WHO regions (Africa: 6, the Americas: 2, Eastern Mediterranean: 2, Europe: 7) met in Montpellier from 8 to 11 October 1990 to exchange experience of their Healthy Cities projects, both in terms of the process of setting them up and with regard to the content and implementation of the health, social and environmental actions planned in each city's programmes.

## Summary of discussions

From the discussions, it was clear that the most "advanced" Healthy Cities are those associated with the Province of Quebec's network. They presented the best papers on the process of setting up Healthy Cities projects.

The participants were pleased to see that, in addition to the networks already built up in Quebec and France, a Belgian bilingual national network and a Portuguese network were being established, a Maghreb network had been constituted at the Tunis meeting in May 1990 and a sub-Saharan network would soon be established.

The participants recognized that action plans based on WHO's 38 European targets for public health were not applicable outside European and North American countries. They suggested that cities in developing countries should draw up their plans of action on the basis of the eight components of primary health care laid down at the World Conference in Alma-Ata.

So far as the quality of the urban environment was concerned, the participants acknowledged the importance of a good transport system, as well as the need to reduce the environmental damage done by cars. Papers presented by local officials and field visits enabled participants to learn about the achievements of the host city.

## Conclusions

The Montpellier meeting demonstrated the considerable advantages of using the French language, not only to convey WHO's message to a larger number of countries but also to forge links for cooperation between regions.

The meeting offered an opportunity to strengthen the national Healthy Cities networks being established in Belgium, Portugal, the Maghreb and sub-Saharan Africa. It also gave international visibility to the Healthy Cities projects being set up in Geneva, Monaco, the Caribbean and the Indian Ocean.

It gave prominence to the model of good practice constituted by the Quebec network, with regard both to the process of setting up a Healthy Cities project and to mechanisms for the exchange of information between cities.

Despite the unfortunate absence of Romanian observers, the meeting illustrated the possibilities for cooperation by the participating cities in the seven countries of south-eastern Europe with the new Healthy Cities in central and eastern Europe.

For the first time, it was possible to tackle the question of adapting the Healthy Cities concept to cities in developing countries with high rates of population growth.

Lastly, the meeting offered an opportunity for Healthy Cities to harmonize their views both on strategies and indicators and on the creation of a physical and social environment favourable to health for all and, in particular, to the health of disadvantaged groups.

### Recommendations

1. It is recommended that participation in this project should be open to all cities and villages who wish to join, provided they meet the following minimum requirements:

(a) official commitment by the city council to implement a health for all policy as defined by WHO;

(b) involvement of these cities and villages in a health, social and environmental action programme based on principles advocated by WHO (equity, community participation and multisectorality), resulting in an optimal situation for developing people's aptitudes to lead a healthy life. The frame of reference for such a programme will be either the 38 European health for all targets or the eight basic components of primary health care as defined at Alma-Ata.

2. Given the disparities between cities and villages in rich and developing countries, it is recommended that all types of exchanges between rich and poor cities should be reviewed and supported within the project. This recommendation could take the form of twinning arrangements focused on the exchange of information, techniques and, possibly, material assistance.

3. It is recommended that the necessary conditions should be created for developing national or regional networks within the context of this Healthy Cities project.

In particular, it is hoped that the WHO Regional Offices for Europe, Africa, the Eastern Mediterranean and the Americas will support the establishment of networks in their respective regions.

- The presence of very active and highly competent participants from the sub-Saharan region of Africa, Dakar, N'djamena, Kumba (Cameroon) and Brazzaville is the basis for such a move in the African Region of WHO.
- The presence of representatives of Fez, Algiers, Tunis and Bardou offers a basis for a possible Maghreb network as outlined by the important Tunis Conference (July 1990), which brought together representatives of cities in five Maghreb countries.

- The presence of representatives of Saint-Pierre (Reunion) and Fort-de-France (Martinique) offers an opportunity that should not be missed with regard to the areas of the Indian Ocean and the Caribbean.
- The presence of participants from Coïmbra, Lisbon, Barcelona, Valencia and Milan will heighten the Regional Office for Europe's interest in developing this French-language project in countries with Latin-based languages.

4. It is recommended to consider holding a third meeting from 27 September to 2 October 1992 in Sherbrooke and Montreal (Canada). In view of the rapid development of this project, this third meeting will be open to cities which have already officially joined WHO's Healthy Cities programme and initiated one or more social, health and environmental activities related to the programme. However, a limited number of observers from cities which wish to join the Healthy Cities movement will also be admitted.

A fourth meeting might be held in 1984. Three sites are proposed:

- Geneva (Switzerland)
- Dakar (Senegal)
- Fort-de-France (Martinique).

5. Given the vigorous growth of the Healthy Cities programme, it would seem advisable to let the national networks develop in a flexible way before envisaging an institutional framework on an interregional basis. It is recommended that these networks should continue to be structures adapted to multinodal contacts between equal partners; they should not adopt a pyramidal and pro-active structure.

It is recommended that the WHO Regional Office for Europe should make preparations to publish all the documents produced for this second Healthy Cities meeting in Montpellier, referring to the proceedings of the first meeting held in Rennes in 1938, published in cooperation with the French National School of Public Health.

In addition, the group of French-speaking Healthy Cities might consider publishing, either in Rennes or in Quebec, a book highlighting the progress made by the Healthy Cities, along the lines of the publication "Healthy cities, a project becomes a movement", written in English by Dr A. Tsouros and concerning the pilot group of 30 Healthy Cities in WHO's European Region.