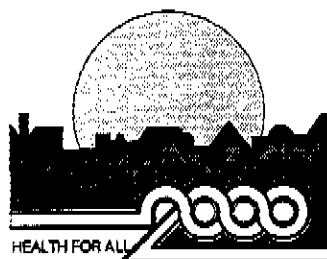




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HEALTHY CITIES PROJECT

Report on a WHO Business Meeting

Glasgow
20-22 January 1994



1994

EUR/HFA target 14

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.

Keywords

URBAN HEALTH
HEALTH PROMOTION
CONSUMER PARTICIPATION
SMOKING – prevent/control
ALCOHOLISM – prevent/control
TUBERCULOSIS – prevent/control
(4) OECD
EUROPE
CCEE

WHO HEALTHY CITIES PROJECT
BUSINESS MEETING

Glasgow, UK, 20-22 January 1994

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WHO HEALTHY CITIES PROJECT BUSINESS MEETING

Glasgow, UK, 20-22 January 1994

Seventy-three people from 28 cities participated in the business meeting. There were three Mayors, four Deputy Mayors, six other politicians, 28 Project Coordinators and seven other city officers. The WHO project Co-ordinator, ten other WHO staff and advisors, representatives from OECD, EURONET and the European Foundation for the Improvement of Living and Working Conditions and 11 observers attended.

1. INTRODUCTION

a) Status

The meeting was hosted by Glasgow and was the first formal business meeting of the second phase of the project.

b) Agenda

The agenda was prepared by the WHO Healthy City Project office in consultation with project cities. The introductory speeches and project report were followed by nine main sessions.

Topic	Presenter
a) the five year plan for the second phase.	Agis Tsouros and several city representatives
b) implementing the WHO alcohol and tobacco action plans	Peter Anderson, Tapani Piha
c) Collaboration with OECD ecological city project environmental priorities	Josef Konvitz, Xavier Bonnefoy
d) Healthy Cities Indicators	Xavier Bonnefoy

- | | |
|---|--|
| e) City Health Profiles and City Health Plans | Ann Marie Connolly,
Jens Egsgaard |
| f) MCAP guidelines | Charles Price |
| g) CCEE mentorship | Charles Price |
| h) Tuberculosis | Ann Marie Connolly |
| i) Community Participation | Robert Anderson,
Sue Laughlin, Aine Kennedy |

There were workshops on implementing the WHO tobacco and alcohol action plans. The city political representatives held two separate meetings. Visits were arranged to local project partners and health projects including Drumchapel Community Health Project and Glasgow 2000.

The general rapporteur of the meeting was Rona Cruickshank and co-rapporteurs were Lisa Curtice and Geoff Green.

2. OPENING SPEECHES

Baillie Sinclair representing the City Council, opened the meeting, welcoming participants to Glasgow. She was especially happy to welcome the new partners to the project from Central and Eastern Europe. Glasgow has been part of the WHO Healthy Cities Project since 1988, it is committed to the project and the goals of HFA 2000. The city has many health problems and obvious inequalities but is determined to work on these. She highlighted the opportunity provided by the meeting to share experiences and learn from other cities.

Councillor Perry, Deputy Convenor of Strathclyde Regional Council and Chair of the project steering committee added his welcome. This meeting was the first of the second phase of the project and was an opportunity for debate, discussion and agreement on a joint vision.

Mr McMillan, Deputy Director of Greater Glasgow Health Board, described the increasing commitment of the Health Board to the project over the last five years which is now bearing fruit in the form of action in many areas.

Agis Tsouros, WHO Healthy Cities Project Coordinator, thanked the hosts for their welcome. He cited the Glasgow project as a good example of wholehearted participation in the project and encouraged others to be as involved. He mentioned the importance of both a strategic vision for projects and for good community participation, the need for leadership as well as pragmatism. The project has been going for five years, it has grown hugely. The project has a local base but has also started to inform national policy. It is active in linking with other international organisations such as OECD, EC and Council Of Europe. He also underlined the role of European healthy cities developments in the global healthy cities movement.

3. REPORT FROM THE WHO HEALTHY CITIES PROJECT OFFICE

June 1993-January 1994

Several key issues from the report were highlighted:

- 1) Designation - this has formed a significant part of the WHO project office workload. A total of 29 cities have now been officially designated participants in the project and it is expected another 20 will ultimately join.
- 2) The Healthy Cities Project presentation at the WHO/EURO Regional Committee - member states showed their support for the project.
- 3) Communications and Publications - a number of booklets such as "Healthy cities political choices: local level responsibilities for public health" and "Action for health in cities: Case study examples from the WHO healthy cities project in Europe" are in the pipeline. "Twenty steps for developing a healthy cities project" has now been translated into 19 languages.
- 4) Baseline indicators - 45 cities returned questionnaires and a database of the information contained in them is being compiled.
- 5) OECD - the project has established formal links with the Ecological City Project of the OECD.

With regard to resources for the project office at WHO, an additional staff member will be recruited for the project, but the budget will not be increased. Special emphasis is put on engaging, formally, technical units to work with MCAPs.

4. THE FIVE YEAR PLAN AND CITY EXPECTATIONS FROM THE SECOND PHASE

Discussion of the plan started during the Copenhagen Symposium and continued in the St Petersburg Business meeting. Agis Tsouros gave an overview of the ground covered and presented a list of outstanding issues requiring clarification or finalization. These included clarification of decision making process at business meetings, the strengthening of the role of politicians in the project, the review of MCAP arrangements, the frequency and themes of open symposia, the frequency and themes of technical meetings, the establishment of technical groups for key areas of project work, the cooperation with the EURONET Association and priority activities for the years 1994 and 1995. Most of these issues were addressed under the relevant agenda items and in ad hoc meetings. In addition, a number of cities gave presentations on their strategic approach to and expectations from the second phase and beyond.

Rotterdam

The local government structure in the Rotterdam conurbation area is changing, and also more power is being devolved locally. The challenge is to maintain and integrate the HCP philosophy into the new structures. The way these changes could be used to increase community involvement was described. Concrete projects mentioned were, courses for the over 55yrs to be trained as health educators and information centres for the local population.

Kosice

The project has decided to use the baseline indicators as a starting point. The project will attempt to impact on 12 programme areas and review their impact using the same indicators in 1998.

Horsens

The aims of their project were summarized as:

- 1) Getting Health on the agenda.

- 2) Keeping it there.
- 3) Getting people to work together.

In two years all the Healthy Cities activities in the city will be reviewed and only the successful ones continued.

Rennes

During the second phase of the project, health has to become a more integral part of the decision-making process. Rennes is focusing on local communities and is establishing a network of local initiatives. They are also committed to making new partnerships, with rural towns, and with cities in CCEE.

Glasgow

The Glasgow project has four main areas

- 1) Policy development, eg City Health Plan, women's policy, working with other organisations to encourage the creation of health policies.
- 2) Local action programme - the aim is to establish a project in every deprived area in the city, the challenge is to ensure the local projects have an impact.
- 3) Information and training - all project staff are involved in training. There are regular conferences and the project has produced 20 publications so far.
- 4) National and international liaison - establishing a Scottish HFA network, feeding into national policy, such as on food and health, working with OECD and the EC.

Poznan

The project had developed a mission statement to drive the project

"Playing a leadership role we strive to use all available resources
in making our city as healthy as possible"

The project has a strategy for the next four years with clear priorities. Some of the targets for 1997 are: reduce lifestyle related health risks, improving health care for the elderly, improve conditions on the main streets for disabled people, facilitate NGOs working together and reform primary health care.

There followed a more general discussion with cities highlighting some of the problems, challenges and opportunities for the city project over the next four years. Torun posed the problem of how to decentralize health services, especially with limited financial resources in a time of political instability? Liverpool said it has allied much of its work to the UK national Health of the Nation strategy.

The danger of too many committees and partners if these do not relate and communicate with each other was mentioned. Camden described a "spider's web" structure of inter-related committees. Vienna described how other organisations were adopting a health brief and questioned how the Healthy Cities Project could respond to this.

The discussion then moved to more specific outstanding issues for the next four years of the project. It was agreed that the next business meeting would be held in September 1994 in Poznan. The meeting would focus on City Health Plans and City Health Profiles. Two new technical groups would be established work on these topics and also to organise the Poznan meeting and prepare background papers. Terms of reference for these groups were agreed. It was agreed that the next major open Symposium would be held in March 1995 in Madrid, this would be held in collaboration with OECD. A steering committee would be established to prepare for the symposium (WHO, OECD, the city of Madrid, Euronet Association, Project cities. A number of possible themes were suggested for the symposium: local capacity building, finding funding, exploring the possible conflict between the ecological city and the healthy city, poverty, equity, examining project outcomes and providing examples of good practice. It was finally decided that the symposium will address three themes: sustainability/ecology - health in cities - equity and poverty, and the dynamic relationship between them. The symposium will have a global dimension: Europe, OECD countries and Latin American countries.

Finally, it was agreed to establish a steering group for the evaluation of Phase Two of the project, and a technical group to steer the further development of indicators. The revised version of the 5-year plan will be sent to project cities for a final consultation before the Poznan business meeting.

5. IMPLEMENTING THE WHO TOBACCO AND ALCOHOL PLANS

This is one of the requirements for all project cities participating in the 1993-1997 phase.

The WHO Alcohol Action Plan

This has nine strategic objectives, three each on policy, community action and action in public services. These are:

- 1) To strengthen policies in member states that prevent the harm done by alcohol use.
- 2) To build consensus with intergovernmental organisations on joint action in the prevention of the harm done by alcohol use.
- 3) To strengthen practices in the alcohol and hospitality industries that support the prevention of the harm done by alcohol use.
- 4) To create and sustain health-promotive settings that strengthen individual motivation and capacity to avoid the harm done by alcohol use.
- 5) To support community action on preventing and managing the harm done by alcohol use.
- 6) To strengthen the public support for safer alcohol drinking practices through educational programmes.
- 7) To strengthen the contribution of health care systems, and particularly primary health care, to preventing and managing the harm done by alcohol use.
- 8) To strengthen the contribution of the social welfare system to preventing the harm done by alcohol use.
- 9) To strengthen the contribution of the criminal justice system to preventing the harm done by alcohol use.

The current main packages of activity at the WHO/EURO office are: consultation on alcohol policy, the alcohol MCAP and work in the primary care setting.

The WHO Tobacco Action Plan.

The basic health education message is: "tobacco is bad for your health", but there are many ways of transmitting this message and a variety of vehicles and themes can be used to convey it.

The tobacco MCAP is being coordinated by Dublin and has already produced a document.

There are five action opportunities for cities

- 1) Policies on tobacco
- 2) Smoke-free public places and workplaces
- 3) Tobacco-free health service
- 4) Nonsmoking generations
- 5) Adults in the community

The economic benefit of stopping smoking was demonstrated by using employment in Glasgow as an example. If Glaswegians stopped smoking, it was suggested between two and four thousand jobs would be generated.

Representatives from cities then examined the issues in workshops. For both alcohol and tobacco delegates were asked to consider three questions:

- 1) What are you prepared to sign up for?
- 2) What do you expect of an MCAP city?
- 3) What do you expect from WHO regarding tobacco and alcohol?

Feedback from alcohol workshops

Question 1

Cities have different starting points. Three options were suggested

- a) Examine what is happening currently in the city and proceed from there.
- b) Use the nine point plan as the starting point and attempt to implement as much of it as possible.
- c) Coordinate with national programme.

Question 2

Develop models of good (and bad) practice. Collect data from cities ie what has been done so far and what did it achieve.

Question 3

Influence national policy. Provide scientific information, organise conferences and seminars. Finally provide a consultation service to cities

Feedback from tobacco workshops

Question 1

Tobacco is a major health issue and should be high on cities' agenda. A suggestion was that project cities should be required to commit themselves to action in certain areas eg smoke free areas. It was proposed that cities get their own house in order and act, within the limited of local legislation, to promote a smoke free environment, refusing tobacco advertising and sponsorship, taxing tobacco products and ensuring smoking cessation services are available. A priority was health promotion for all children and restricting access for children to tobacco products.

Suggested approaches were, building new alliances, using surveys to raise the profile of the issue, using humour and avoiding single issue health promotion.

Question 2

Develop models of good practice, provide good quality information and develop methods of evaluation. It was suggested MCAP cities should have a greater influence on the HCP movement.

Question 3

Recognition of good work. Provide resources, either financial or technical. Facilitate training.

The feedback was brought together and synthesized to give the following:

Suggestions for WHO Project Cities action on alcohol and tobacco.

The basic building blocks of the Healthy Cities approach on alcohol and tobacco

-the basic policy documents are

European Alcohol Action Plan

Action Plan for a Tobacco -free Europe

-MCAPs have produced and are in the process of producing guidelines and practical implementation packages

The role of MCAPs

- produce implementation packages
- prepare a survey questionnaire on alcohol and tobacco
- give support to all cities for implementation

Project Cities

- establish a working group on alcohol and tobacco
 1. answer the survey questionnaire
 2. write a plan identifying how the city will implement the action plans with special reference to the requirements listed below
 3. identify resources for implementation
- the Healthy Cities teams should recognize their responsibilities towards the objectives .

Implementation Plan for the Action Plan on Tobacco

- an effective smoke-free policy including at least the following components
 1. no-smoking at own meetings
 2. smoke-free workplace policy
 3. smoke-free public places and transport
 4. smoke-free health services
- tobacco prevention figures in health promotion for children (health promotion at school)
- working with women's groups on smoking prevention and alcohol use
- working with disadvantaged groups on smoking prevention and alcohol use
- take part in World No-Tobacco Day activities

Implementation of European Alcohol Action Plan

- comprehensive alcohol policy for municipal staff
- develop and implement appropriate training for primary health care on lifestyles, including alcohol and tobacco
- collect and publicise data on broad health and social issues

Monitoring activities

- repeat baseline survey in three years
- annual routine reporting on alcohol and tobacco activities to HCP
- alcohol and tobacco as technical themes in symposium

Responsibilities of WHO

- provide technical information
- support national and international networks to reward activities
- identify expertise for missions and consultations

6. COLLABORATION WITH OECD ECOLOGICAL CITY PROJECT AND PROJECT ENVIRONMENTAL PRIORITIES

Josef Konvitz, representing the OECD spoke of the organisation's Ecological City Project. The organisation is intergovernmental and principally works at national level. The Ecological City Project however is based at city level and is looking to develop case studies from cities experiences on action on environmental issues. The organisation is keen to work in partnership with Healthy Cities both with the case studies, the Madrid Symposium and beyond.

The aim of the Ecological Cities Project is to generate better operational guidelines for the environment. The project is process rather than issues orientated, trying to develop integration across policies. It wishes to take an intersectoral approach and is keen to explore areas such as the possible conflict between health, economic development and environmental health.

Cities welcomed the partnership with OECD and the Ecological Cities Project.

Xavier Bonnefoy spoke of the forthcoming WHO ministerial conference in Helsinki which will endorse an action plan for Environmental Health for Europe. There are several aspects of how this could be translated into action at the local level. Cities can respond to global, national and local issues, such as the greenhouse effect and national use of land and energy. Locally, equity is a principal issue. Members of the project can participate in specific action such as: transport, accidents, housing, waste disposal, greening the city and air pollution. They can act as examples to other cities showing the effects of positive action and by raising the profile of environmental health on the local agenda. An important way in which cities can respond is by creating local environmental plans using HFA principles and demonstrating the links between health and the environment.

WHO project cities and national network cities also have an important part to play in the many environmental networks now emerging in Europe. Healthy Cities have extensive and strong established networks and have much to contribute and gain through sharing experiences with other networks and agencies and establishing a common vision. The environmental dimension of the project will be fully explored at the Madrid symposium.

7. HEALTHY CITIES INDICATORS

The baseline Healthy Cities indicators questionnaire asked about health and health services, the environment, socio-economic factors and a variety of general questions about the city. Forty-five questionnaires have been returned. The quality of responses varied and some indicators were found to be more useful than others. More work will be done on validating the data but the potential of the indicators was illustrated showing comparisons between cities on variables such as unemployment and low birth weight. The South East Thames Institute of Public Health in UK is undertaking the analysis of the data and the preparation of a report that will be published in mid-1994. The work is done by an inter-disciplinary group.

Cities will also receive indicators on diskette. A technical group will be set up to update and revise the baseline indicators but also to develop and introduce indicators that will reflect the project's main action areas such as equity, sustainability and inter-sectoral action.

The importance of cities having suitable computer hardware and software in order to access the information was raised.

8. CITY HEALTH PROFILES AND CITY HEALTH PLANS

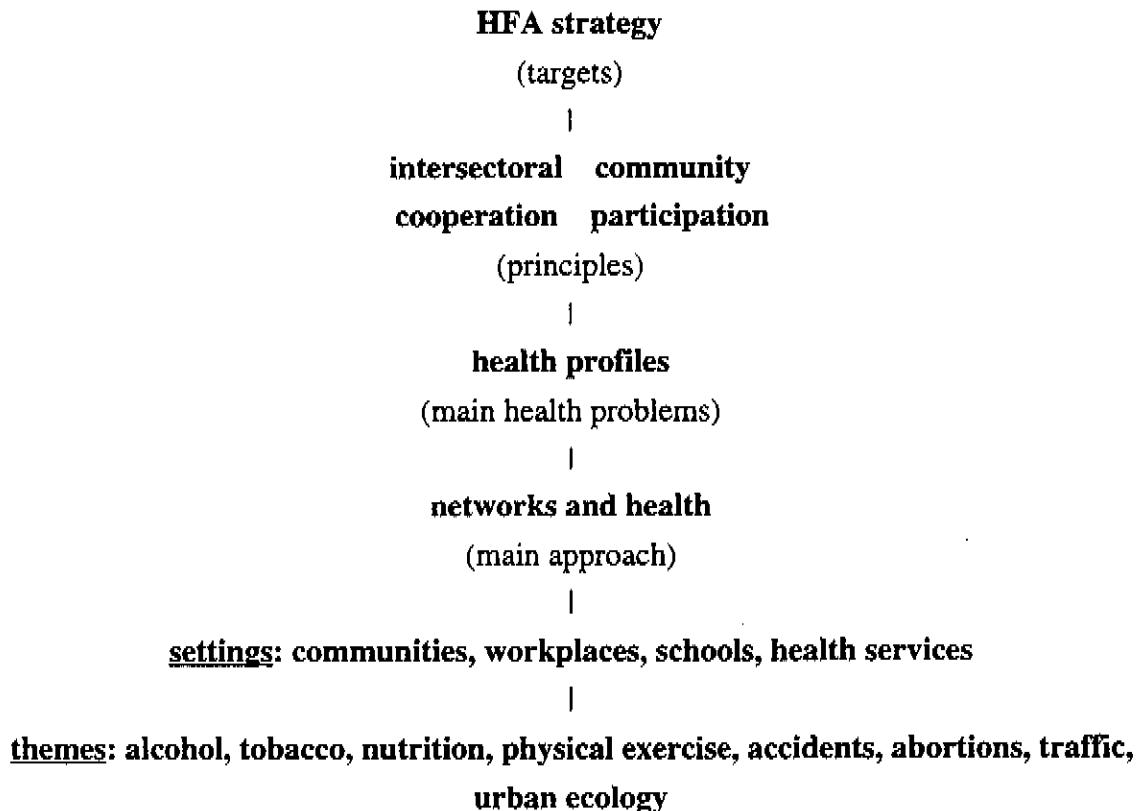
A city health profile is a report on the health of the city and its people. It evaluates both the major health determinants and the actual health status of the city. It addresses demography, mortality and morbidity, the environment, lifestyles and social and

economic circumstances.

There is considerable scope for variety in the content of profiles. Cities used differing presentational styles, including maps, graphics, case studies and humour to convey information about health and its determinants in interesting and convincing ways.

It is important to consult widely about the report and disseminate it to both decision-makers and the public in order to stimulate action and change. The profile can highlight information deficiencies and stimulate research. It feeds into the city health plan. It is also a unique tool for strengthening and ensuring accountability for health.

Jens Egsgaard gave a presentation on the Copenhagen City Health Plan and gave some guidance on how to generate plans. These must be local products but can use the HFA principles and targets as a guiding framework. The Copenhagen plan is the health promotion plan for the municipality, and does not simply relate to the project. The reasons for creating a plan were outlined as: giving common guidelines and priorities for political action, a clear foundation for intersectoral cooperation and the opportunity to shift from short to longer term planning. Copenhagen had a clear framework for the plan which outlined their approach:



It is vital to gain commitment for the plan within the city council, the plan is currently in the process of being adopted by the council. It is important within the plan, to use a clear process to generate priorities and to involve the community. The importance of social support networks was emphasised. Finally proposals on implementing and reviewing the plan were outlined.

It was agreed that the next business meeting would focus on city health plans and profiles. A working group would be set up to prepare for the meeting and the previously circulated terms of reference for it were agreed.

EC presidency

Aris Sissouras, President of the health group to the EU Presidency, described the health priorities for the period of the Greek presidency of the EU. These are cancer, AIDS, tobacco, cardiovascular diseases and communicable disease in migrant populations. Two new priorities will be to produce a framework for action in Public Health (Maastricht treaty article 129) and health promotion and information.

9. POLITICIANS' MEETINGS

There were two meetings of the political representatives from cities. Discussion at these was mainly on defining the role of politicians in the project and how to develop the political input into the HC movement.

It was agreed that political commitment and input in the project was vital, at the local, national and international level. Now that the second phase was starting it was important that the political contribution was systematised.

There was acknowledgment that political action should be within the existing project framework. There was discussion about business meetings, often some of the technical discussions were not relevant to politicians and there was a suggestion that politicians attend for only part of the meeting or perhaps meet separately from coordinators.

Politicians were keen to contribute to the agenda and actual business of project meetings. Politicians should be encouraged to attend the business meetings.

The difficulty of initiating change with limited resources was raised - "health is secondary to survival".

It was agreed to establish an ad hoc working group of politicians, although the membership of this was not finalised. Mechelen offered to host the first meeting of this group in April 1994. The Mayor of Mechelen offered to prepare for the meeting and bring together documents discussed or agreed at previous politician's meetings. Those attending agreed to assist in this by contributing written comments on the political aspect of their local project, the challenges of establishing and running the project and on the following:

1. role of politicians
2. role of politicians regarding the specific goals of the project.
3. proposals for items for the September Business Meeting and the 1995 Madrid Symposium.

The working group will further discuss these issues and report to the next business meeting in September.

10. Multi City Action Plans

MCAPs are groups of cities working with WHO on issues of common interest. They work to an agreed plan. Their aim is to develop and disseminate models of good practice.

Factors common to successful MCAPs were, clear objectives, good technical input, the enthusiasm of participants, sufficient funding, help from relevant institutions and administrative support. Charles Price introduced the guidelines for MCAPs document for discussion. This defines the organisation, scope and purpose of MCAPs.

There was considerable debate about the guidelines. There was some concern that they took a top down approach, were too prescriptive and were biased to encouraging participation from "rich" cities. The cost to cities of participating in MCAPs was raised

and the need for them to justify their cost by their outcomes. The question of how MCAPs differed from other forms of intercity work was raised. It was noted that these MCAPs would necessarily be limited by the range of units at WHO. It was clarified that the MCAPs were only one form of intercity collaboration and that other forms of technical and working groups were encouraged.

The clear contractual form of the MCAPs would allow WHO to plan in advance the commitment of its technical expertise. The advantages of having clear guidance for future MCAPs was mentioned. It would be useful to analyze the impact of MCAPs.

The guidelines were accepted.

11. MENTORING FOR CITIES IN CCEE

The purpose of mentoring is to encourage cities that were in the first phase of the project to be twinned with new cities in order to share experiences and give help and advice. WHO is keen to facilitate mentoring. A suggested method for setting up twinning arrangements was an initial exchange of letters followed by exchange visits and joint events. Cities were asked to inform the WHO HCP office of mentoring arrangements and WHO will report progress in three months.

The framework for mentoring was agreed.

12. TUBERCULOSIS

City representatives had been asked at the beginning of the meeting to give information on the rate and trend of tuberculosis infections in their city. The rate ranged widely, from 4 - 76/100,000, and trend was rising and falling in an equal number of cities. The groups at risk of contracting tuberculosis were outlined as: migrant populations, homeless people, alcoholics, welfare recipients, intra-venous drug users, the socially deprived, unemployed and the elderly. Action for cities to prevent and control tuberculosis were outlined such as monitoring trends and having a control programme. The importance of

responding to the needs of the vulnerable groups identified mentioned previously was also identified in the control of tuberculosis.

Several cities responded to the presentation, commenting on the re-emergence of tuberculosis and other communicable diseases as a major issue. It is strongly linked to equity. Rotterdam indicated that it was already committed to working on this issue. Rotterdam agreed to participate in developing a Healthy Cities approach to tackling TB, and the HCP/EURO would approach a third agency, possibly the communicable Disease Surveillance Centre (London) or the EURO Communicable Diseases Unit to cooperate also in this new work.

13. COMMUNITY PARTICIPATION

Robert Anderson from the European Foundation began this session. He quoted the recent EC framework on action in public:

"it is not sufficient to act unilaterally on health problems nor to limit efforts to people at high risk. Rather the whole community has to be involved in a joint effort that gives a sense of collaboration and participation to everybody and leads to long term improvement of general living conditions".

Community action needs to be developed systematically. Local communities suffer from lack of recognition and power but still contribute to solving a range of social and economic issues quite independent of the public sector.

He described what local action can do and its limitations. Local action can: mobilise voluntary action, protect existing facilities, pressure for new facilities, organise self help schemes and monitor the delivery of public services. It is not good at reaching all the people in an area, providing a standardised service, directly alleviating poverty or involving the homeless or homebound.

Andrew Lyon, coordinator of the Glasgow HCP, introduced two presentations about aspects of community participation in the city.

The Women's Health Working Group

The ten year history of the development of the city's women's health policy was described. Glasgow women have poor health status relative to the rest of Scotland, which itself has a poor record compared with the rest of Europe. The WHO women's health year in 1982 led to a local campaign on women's health in the early eighties. The issue grew, with increasing interest from local communities and collaboration with the HCP. The working group was established and a women's health policy created in 1992 and launched across the sectors last year. This project demonstrates how the combination of community participation and organisational development can stimulating action.

The Drumchapel Project

This project was described with reference to the "Green Tree" as a model for its development. Drumchapel is a poor area, with a declining population, poor housing and high unemployment. A number of local groups existed before 1988 when the project came together. The HFA principles and the Glasgow HCP helped to give the initiative legitimacy. Local health volunteers have been trained and the project undertook a survey to produce a community health profile. The project has established clear strategic health objectives. It works across both the formal and informal sectors and attempts to have high profile and keep itself high on the main agenda.

Cities commented on the potential power of community action and on the use of exchanging information about local projects between cities.

14. OTHER BUSINESS

HCP electronic products

The WHO HCP Office has prepared a package of electronic products for cities that consists of a database of case studies from project cities, the HFA indicators database, the project city profiles database, the EPI/INFO software and information on the Healthy Cities wide area network in Europe with electronic mail and bulletin board facilities. Cities also agreed to contribute to the development of an ongoing project initiatives database that will enable exchange of information and contacts between cities.

Ilona Kickbusch, Director of Lifestyles and Health, in her closing remarks, looked to the

future. By 2025 60% of the world population will be urban. What should the public health approach be to the challenges resulting from this? There is a plethora of issues affecting cities, some complementary, others competing. The evolution of cities in the next 25yrs will require new approaches to government and changes in city infrastructure. The Healthy Cities Project has to continue to keep to the main agenda.

15. RECOMMENDATIONS

Summary of main agreements

1. For the project office to produce a finalized version of the five year plan which will include decisions made at the business meeting.
2. To organise a technical meeting in conjunction with the Autumn business meeting in September 1994. The meeting will focus on City Health Profiles and City Health Plans. A working group will be set up to prepare for the meeting and the terms of reference for this were agreed. Cities will work towards producing City Health Profiles by the end of 1995.
3. To organise, in collaboration with EURONET and OECD, an open symposium in Madrid in March 1995. The symposium will have a global scope, with input from OECD countries outside Europe. In addition to the ecological/sustainable theme, the symposium will focus on a number of issues. This will include, poverty, equity and the dynamic relationship and possible conflicts between the ecological and healthy cities approaches.
4. Participants welcomed a close partnership with the OECD ecological cities project. OECD suggested that a number of cities could belong to both projects and added that they are still open to offers from cities from six countries that have project cities, Holland, Germany, Denmark, France, the UK and Austria.
5. Participants responded positively to and endorsed the summing-up for action on tobacco and alcohol presented by the WHO advisors.

6. Participants appreciated the feedback from WHO on the first analysis of the indicators and development of an indicators database. WHO will clean up the data and prepare a short report/booklet on the findings and will make the formatted data available to all cities on diskette.

7. The politicians agreed to form an ad hoc working group. This will work to strengthen the political process in implementing the project. Encouraging the exchange of experiences will be a key focus. This group will meet in Mechelen in April 1994 and will report to the September business meeting.

8. The revised guidelines for MCAPs involving a close partnership with specialised WHO technical units were endorsed. The project will also continue to encourage the development of a range of technical groups and other types of joint working amongst cities.

9. Cities agreed to confirm their provisional agreements to act as mentors, based on the framework document "Mentoring in the Healthy Cities Project". WHO will report progress in three months. A number of cities have offered to assist WHO to develop the Healthy Cities Project in countries with no project cities at present.