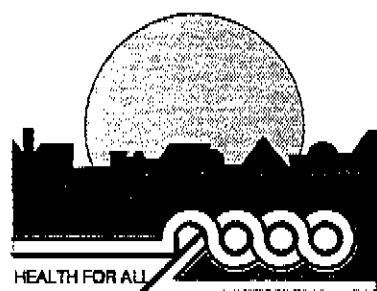




# WHO

REGIONAL OFFICE FOR EUROPE

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Healthy Cities Project Office

## *WHO HEALTHY CITIES PROJECT*

Report on a WHO Business Meeting

Jerusalem, Israel  
26-29 October 1997

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## 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.*

### ABSTRACT

Project coordinators and politicians from 29 WHO project cities and 13 national networks of the Healthy Cities network attended the meeting. The main items on the agenda were phase III of the project, health for all for the twenty-first century, evaluation of phase II of the project and preparation for the conference to be held in Athens in June 1998. Items for debate and exchange of experience included city health planning, sustaining political commitment, addressing inequalities in cities and engaging the business sector. The main outcomes were the overall phase III approval which will be finalized by the end of December 1997, and the unanimous endorsement of a resolution from the meeting on health for all for the twenty-first century. The next meeting of the network will take place in Athens in June 1998 and will herald the start of phase III.

### Keywords

URBAN HEALTH  
HEALTHY CITIES  
PROGRAM EVALUATION  
HFA STRATEGY COORDINATION  
EUROPE

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## 1. Introduction

The final WHO Healthy Cities business meeting of phase II of the project (1993–1997) took place in Jerusalem from 26 to 29 October 1997. The meeting was attended by 70 participants, representing 29 project cities and 13 national networks.

The principle purposes of the business meeting were:

- **Phase III (1998–2002).** To consult with cities on the draft city package for phase III of the WHO Healthy Cities Project (POLC 06 01 04/3); and to explore with cities the other key elements of phase III.
- *Evaluation.* To report on progress with the phase II evaluation and to consult with cities on the draft evaluation framework (tabled – POLC 06.01.04/6).
- *Health for all.* To consult with the cities on the European Regional draft document, *Health for all for the twenty-first century* (EUR/ICP/EXCC 01 01 01 – circulated August 1997) and to produce a collective response for WHO from the healthy cities perspective.
- *Athens.* To report on progress to date for the International Healthy Cities Conference to be held in Athens in June 1998 and to seek involvement from cities in the planning mechanism.
- *Item for information.* To give feedback on the Jakarta Health Promotion conference.
- *Items for debate and exchange of experience.* City health planning/sustaining political commitment; addressing inequalities in cities; engaging the business sector.

More than half the meeting time was spent in small groups and workshops. The agenda (POLC 06 01 04/1) and programme, which had been prepared in consultation with the cities, were adopted by the meeting.

## 2. Official opening – Sunday 26 October 1997

The official opening of the WHO Healthy Cities business meeting took place at the Jerusalem City Hall on Sunday 26 October and was followed by a reception given by the Mayor of Jerusalem, Mr Ehud Olmert, M.K.

**Ms Pnina Herzog, Senior Adviser, Ministry of Health** chaired the formal opening session which began with words of welcome from **Ms Batya Waschitz, Coordinator of the Jerusalem Health Cities Project.** Jerusalem had been a WHO Healthy City since 1988 and was described as a complex city, a “melting pot” of over 560 000 people. Ms Herzog stated her belief that it was less difficult to achieve intersectoral cooperation at the local than at the national level: the local government were closer to, and more involved with, the people.

**The Mayor of Jerusalem, Mr Ehud Olmert, MK** spoke of his long involvement with the project and great pleasure at being a “healthy city” Mayor. He impressed upon delegates the importance of what they did for health. He described the quality of the project coordinator as being key to the success of a project in a city: someone with the ability to inspire everyone to accept this mission as a top priority.

**Dr Agis Tsouros, WHO Healthy Cities Project Coordinator**, thanked the speakers for their words of welcome and said how delighted he was to be in Jerusalem. He echoed Mr Olmert's view on what was needed to bring about change in a city: someone with entrepreneurial skills and the vision and capacity to bring people together was required. He recognized that there were difficulties in bringing together the sectors but stressed that no one technical group could act alone. The added value of this programme was that it linked to things that made a difference to health. Dr Tsouros announced that agreement had now been reached within WHO/EURO to set up an urban health centre, to draw on all sectors and have a greater visibility for urban health. For the next phase, the project needed to develop alliances with national government and to build bridges across Europe. The European countries so far untouched by the movement, would present a great challenge.

### **3. Opening session – Monday 27 October**

**Professor Ariel Cohen, Deputy Mayor of Jerusalem**, in charge of the Jerusalem Department of Environment, chaired the first session of the business meeting which opened on Monday 27 October. He described Jerusalem as a "healthy" city, with the ideal combination of both hours of sunshine and precipitation. It held the world record in the use of solar energy, with more than 60% of families using solar energy to heat water.

The agenda was approved, **Dr Jill Farrington, Consultant, WHO Healthy Cities Project**, was appointed as General Rapporteur and the cities of **Patras** and **Milan** were welcomed to phase II of the network.

**The Israeli Minister of Health, Yehoshua Matza, MK** attended the first session to wish delegates a fruitful meeting for the benefit of all those that would be touched by the project. He told them that they were part of reshaping both local and national health policy, part of the present and the future. Health needed to be more than health care, it needed to tackle the determinants of health. He believed that health was one of the issues that went beyond politics and nationality.

### **4. Report of the WHO Healthy Cities Project Office**

Dr Agis Tsouros presented the report (POLC 06 01 04/5) of the Healthy Cities Project Office (HCPO). He drew attention to the developmental and innovative components of the office's wider work: taking an active part in the health for all renewal process; providing conceptual support to health promoting universities; involvement in the design of the health component of EXPO 2000 to take place in Hanover; and, in partnership with the EU, its work to bond health and sustainable development. Dr Tsouros went on to highlight the main areas in which the office had concentrated its work in the previous six months.

#### *WHO Urban Health Centre*

The HCPO had been successful in its bid to launch a new concept for urban health in WHO, the WHO Urban Health Centre. The aim was to take a strategic role and strengthen healthy cities and urban health in the European Region. This would begin from January 1998 and run on an experimental basis for four years. The unit would draw on the expertise of a number of departments and be headed by the Regional Advisor for Urban Health, Dr Tsouros.

### *Phase III*

The phase III city package for the network of WHO project cities was now in draft form. So far, efforts had concentrated on this component of the third phase but there were others. The national networks had a major role which had not yet been addressed, and for whom a comprehensive strategy for phase III was also needed. Looking at the parts of Europe covered by the national networks, it was also clear that the east represented a major challenge: the newly independent states (NIS), the Asian republics, the Balkans.

### *Evaluation database*

A comprehensive database has now been developed which archives all the materials received from the cities and will be invaluable resource for the evaluation.

### *Athens 1998*

The Regional Director of WHO has designated Athens 98 as a "whole office conference" for WHO which gives it a higher status politically. There will be representation from Ministries of Health from around Europe.

### *Resources*

Charles Price has left and been replaced by Mark MacCarthy who was Director of Public Health in Camden. Sally Fawkes has arrived from Australia to plan the Athens Conference. The many people who had provided resources to the project over the previous six months were thanked: Carol Tannahill, Ray Bateson, the subregional centres and members of the Evaluation Advisory Committee (EAC).

### *Ron Draper*

The meeting was informed of the death in August of Ron Draper, someone who had been an inspiration to the movement. One minute of silence was held in respect for his memory.

## **5. Phase III of the WHO Healthy Cities Project**

**Carol Tannahill, Director of Health Promotion, Greater Glasgow Health Board** and WHO temporary advisor, presented the document on the requirements and designation process for WHO project cities in phase III (POLC 06 01 04/3). She reminded delegates of the development of the document and of the key decisions that had been taken in Gothenburg in April 1997: the need for introduction of new cities ("new blood") to the network; the agreement in principle to an annual contribution to the network; priority being given to the issue of equity; a harder line being taken with cities that appeared to "drift" along; more flexibility over phase III requirements, in recognition of cities' greater maturity.

The draft document proposed that there should be a **two stage recruitment process**. Cities would first need to be assessed for eligibility for designation. There would be no limit to the number of cities that might apply. Cities would need to submit: written evidence of political commitment; the city health plan and profile; an organigram to show the project's structure and position within the city administration; and a statement of current networking activities. Then, the eligible cities could apply for designation as WHO project cities. For this second stage, cities would need to submit for assessment: a detailed proposal on how the city would tackle the phase III requirements; written evidence of political commitment and resources; agreement to participate in the evaluation and monitoring mechanisms. Final decision on designation would rest with WHO and no more than 40 cities would be designated as phase III WHO project cities.

Dr Agis Tsouros explained that since the draft document had been circulated, the HCPO had been informed by WHO headquarters in Geneva (Office of the Legal Counsel) that the proposed contract for phase III between WHO and the WHO project cities was not an option. Some elements of the contract, however, could be retained on an informal basis, if it was wished.

After taking some points of clarification on aspects of the package, the meeting adjourned into parallel working groups, with one group comprised entirely of national network coordinators. The discussions were structured around questions based on the document (POLC 06 01 04/3) and the wider issues relating to phase III as a whole. Feedback from all four workshops took place in the final session of the day. The key points from the day's discussions are as follows:

#### *Overall*

Overall, the document was welcomed and there was general approval of its contents and style. It was agreed that the involvement of national networks in phase III needed to be further developed, possibly in the form of a parallel document.

#### *Presentation*

It was felt that the document was too long to "sell" easily to city politicians and it was agreed that an executive summary be produced to accompany the main document.

#### *Language*

Concern was raised over the issue of language and the emphasis on English. It was explained that, for practical and financial reasons, the working language of the Project was and would remain English. Nevertheless, flexibility was possible for meetings and documents if resources allowed. It was agreed that the final version of this document and its accompanying shorter version should be available in all four official languages of WHO. It was agreed that whereas the applications to phase III would need to be in English, the accompanying documents could be submitted in their original language, with only a summary needing to be provided in English.

#### *Political commitment*

There was debate over who should actually sign the application and statement of commitment on behalf of the city, and whether they could commit the city to a five-year period. There was agreement that only one political decision needed to be made at the highest political level within the city. Barring a few exceptions, the "city" remains the symbolic entity, the primary actor. The partnership is with the city, and this partnership cuts through parties and sectors in the fulfilment of the commitments. The criteria for eligibility encourages the participation of other sectors outside the city administration but, from the city, a letter from the mayor (or political leader) is enough. It was clarified that commitment was to joining the whole five-year life of the phase during which certain things would have to be delivered.

#### *Intersectoral group*

Each city would need an intersectoral group to steer the development of a policy, strategy and plan. Each city should define the composition of this group according to local circumstances so that structure follows purpose.

#### *Financial contributions*

Various formulae were suggested for setting the level of annual financial contributions in order to recognize the differential between rich and poor countries. Finally, it was agreed that the most equitable and simplest solution was likely to be one of an "East/West" split of

US \$3000/US \$5000. Funds generated would be used for the benefit of the network. It was clarified that the funds would be used, firstly, to cover the costs of some of the services or products that WHO currently provided free of charge; and, secondly, to cover additional products and services. Suggestions for this latter category included: evaluation; training for coordinators; travel expenses for an advisory group; developing an electronic network. No definitive list was made but it was accepted in principle that an advisory group of city representatives should be formed to work with WHO on this, although WHO had the final veto.

#### *Completion of phase II requirements*

It was recognized that phase II cities who have not completed their plans and profiles would need support and time in order to do so.

#### *Networking and integration of networks*

The phase III network of project cities would consist of experienced cities from western, central and eastern Europe. WHO would develop a separate network during phase III to suit the needs of inexperienced cities and countries. During phase III, there would be a number of different networks operating on the basis of, for example, theme, competence, geographical area, language, level of development. Networks would build bridges amongst themselves allowing an interaction of networks. Delegates requested feedback on the present Multi-City Action Plans (MCAPs) and for flexibility over the form and type of networking that a city might be involved in, depending on its interests.

#### *City health plans and City health development plans*

The city health plan should be based on the needs of the population (health profile) and provide evidence of health for all based, multisectoral planning (policy, strategic, operational). The plan may be one or several documents. The City Health Development Plan was not a repeat of the phase II plan. Instead, it should build on, and be a natural development of, the city health plan. It should mobilize resources for health, focusing on the people and tackling the determinants of health.

#### *Link between evaluation and phase III*

The overall review and evaluation of phase II would be used to inform phase III. But the results would not be used on an individual level to judge cities when they applied to join phase III.

#### *Eligibility and designation assessment mechanisms*

The full mechanism for eligibility and designation applications was still under discussion. However, assessment of applications be undertaken by people experienced in healthy cities ways of working. The final decision regarding designation would lie with WHO.

#### *Privileges for phase II cities?*

Phase II project cities do not have the automatic right to enter phase III: this point had already been agreed in both the Dublin and Gothenburg business meetings. Phase II cities will need to apply to enter phase III.

#### *Network size and country quotas*

A network of 40 cities was considered to be a manageable size. It was agreed that the entire network should consist of large and small cities and, where possible, would show a geographical spread across Europe. Ten places would be reserved for new cities to the network. A formula for country quota had yet to be devised. In the past, there had been a maximum of four cities per

country and quota size had depended on the size of the population. For historical reasons, there had been a few exceptions, such as Denmark, which had had two members since the very start.

#### *Nature of application*

For those phase II cities who have not completed the requirements for a city health profile and a plan, they would still be considered for designation if they could demonstrate that they were working towards completing them by the time of designation. The application for designation should describe how the requirements of phase III will be met and consist of objectives, processes and timetable describing the commitment and overarching strategies. It was agreed that cities should have feedback if their applications were unsuccessful.

#### *Distribution of document*

WHO will be sending the final version of the document to all coordinators of project cities and national networks by the end of December 1997. National network coordinators should distribute the document to their network members. The package will also be put on the Internet.

#### *Role of national networks*

The national networks made a number of suggestions for which no clear agreement was reached and which require further consideration: inclusion of a national network coordinator amongst those assessing eligibility; the opinion of national network coordinators to be sought on cities applying for phase III; phase III applicants should be members of their national networks; during phase III, national networks should be part of the same evaluation process as project cities. National networks asked that WHO should influence national governments to work with national networks and incorporate healthy city approach in national health plans.

#### *Frequency of business meetings*

It was suggested that the business meetings should take place once a year, with a focus on phase III objectives, for example, equity, healthy urban planning. For the rest of the year, there could be other activities, such as meetings of other networks or workshops on areas of interest.

#### *Schedule*

Cities expressed their concern over the proposed timetable in the draft document. They stressed that they would need to fit in any proposed timescale with their local circumstances and events, such as elections, infrequent committee meetings and so on. These concerns were acknowledged but it was also emphasized that there would be several rounds of designation, and opportunities to apply. The proposed timetable for the first round took into consideration the time of the Athens Conference.

#### *Support needed by cities*

Cities felt that they would need support from WHO to achieve the phase III requirements, particularly in the areas of: training and documentation; influencing politicians; developing skills for encouraging community participation; involving the business sector.

## **6. Items for information**

### ***6.1 Feedback from Health Promotion conference in Jakarta***

**Fran Perkins (Toronto)** reported from the Jakarta Health Promotion conference which had been held in July 1997. This had been the first conference of its kind in the developing world and took place 20 years after Alma Ata and 10 years after the Ottawa Charter. In style, it had been quite a

formal conference with a complex agenda and much time spent in plenary. On the positive side, the background documentation was highly praised and was available via the website. She had participated in the group on "Healthy Cities/Villages/Communities/Islands". The differences between culture and their approaches had been marked, with Healthy Cities seen as both an art and a science. Issues covered had included engagement of the business sector, partnership with literacy, learning skills on how to build partnerships, engagement of volunteers. It was emphasized that Healthy Cities should be an umbrella for all the other settings. They developed their own charter, the Healthy Cities Partnership Declaration. The Jakarta Declaration and supporting materials are available via the world wide web site.

### **6.2 WHO collaborating centre for the built environment, Bristol, United Kingdom**

Hugh Barton, Executive Director of the WHO collaborating centre for the built environment gave a short presentation to introduce the work of the centre in Bristol. The centre brings together the work of different disciplines in an integrated way with the common vision of an attractive, safe, equitable, healthy and sustainable environment. He outlined a list of the current projects in which the centre was involved and how the centre might work with healthy cities in the future. Further information is available directly from him.

## **7. The International Healthy Cities Conference – Athens**

**Agis Tsouros** introduced the Athens Conference as a celebration of ten years of the Project and reiterated his earlier point about this being accorded a high profile by WHO. Anyone wishing to be involved in the planning of the Conference should contact the HCPO, from where Sally Fawkes would be acting as coordinator.

**Dezi Papathanassopoulou**, Project Coordinator for Athens, introduced the city of Athens, the venue for the Conference and the facilities that would be available. The city of Athens presented each delegate with an information pack on Athens and a music CD.

**Ray Bateson** of Dublin had been commissioned by the HCPO to draft a framework for the Conference and this was presented. The basis for the framework had come from comments received during the Gothenburg business meeting. A four day conference was proposed, during which there would be twelve time blocks in which to work. It was suggested that four of these be allotted to "achievements". The schedule would also include site visits. The framework had been designed to be of interest to the various stakeholders involved in healthy cities. Cities would have further opportunity to have input to the programme during the business meeting and as members of a steering group, should they wish.

During the business meeting, a workshop was convened for those cities who wished to discuss the conference further and be involved in its planning. Twelve people attended and the following points were covered:

1. *Fees*. There was concern over the level of the proposed fee, which was felt to be too high, particularly for the eastern European cities.
2. *Mayor's meeting*. There was discussion of the possibility of having a Mayor's meeting during the conference.

3. *Duration.* Four days for the conference was felt to be too long. It was suggested that the time might be split into three days conference, ½ day for a business meeting at the end, ½ day for site visits.
4. *Format.* A range of styles and formats were discussed, from the more conservative to freer style (mix and match, pick and choose). There was agreement over there being a greater emphasis on time spent in workshops rather than formal plenary.
5. *Steering meeting.* A number of cities expressed interest in further involvement in the planning process. It was suggested that politicians might wish to be involved in the programme planning.

## 8. Phase II evaluation

**Jill Farrington (HCPO)** reported on progress with the phase II evaluation. As far as the project led by the European Union/London School of Economics (EU/LSE) was concerned, the EAC had approved the revised selection criteria that the research consortium had presented to their meeting in June. On the basis of this, ten cities had been selected for in-depth visits by the research team. The first visit to Horsens had taken place in the week prior to the business meeting. For those cities who had not been selected, letters were likely to go out shortly from the LSE to explain how they might still participate in this part of the evaluation.

An evaluation database had been developed and during the summer; the HCPO had been checking city information that it held. This work was being led by Leah Rothstein (HCPO). National networks were encouraged to contact her with current lists of their membership. Other components of the evaluation included the survey on project management being carried out by Colin Hastings. The HCPO was pleased to assist its colleagues in the Environmental Centre, Rome with an investigation into healthy transport policy within cities. It was reported that, so far, responses from cities had been positive and useful.

**Carol Tannahill (Glasgow)** outlined the key elements of the evaluation framework (tabled – POLC 06 01 04/6) drawn up by herself and Jane Springett (Liverpool) in collaboration with the EAC. The purpose of this framework was to develop an overall strategic approach for evaluation which would carry through from phase II into phase III. Remarks and comments would be welcomed on the framework, which would be finalized in early 1998.

A workshop was convened to discuss the draft framework in more depth with those cities who were interested. Most of the time was taken up in presentation and clarification of the proposed approach. Those who attended the workshop were very supportive of the proposal, and felt that it would be useful not only for phase II evaluation but also as a framework to be used from the outset for phase III. There were no expressed criticisms or concerns about the approach. There was, however, a strong feeling that a number of other actions needed to happen to support the implementation of the framework.

1. There is a need for training in evaluation, in order to increase the research/evaluation capability in cities. It was suggested that this could start at the Athens Conference.
2. It was felt to be very important that a "how-to" document be developed to support the implementation of the framework.
3. There was also a demand for a parallel framework for evaluating the healthy city approach at a city level.

4. It would be important early in phase III to identify which "indicators of a healthy city" were most useful (and relate to the 11 characteristics of a healthy city). Usefulness needs to reflect a balance between what it is useful for WHO to know and what is useful for cities.
5. The process of collection and use of the indicators should also be carried out in a way that is empowering, participative, etc.
6. The CD-ROM approach had been found to be useful by some cities in relation to health profiles. It may be useful to consider something similar in relation to the evaluation process, for example, a database of cities' evaluation approaches and results.

The workshop felt that the provision of these additional supports would be a very helpful use of some of the fees that will be paid by cities to WHO for phase III.

## 9. Health for all for the twenty-first century

Jill Farrington presented the European draft document *Health for all for the twenty-first century* (EUR/ICP/EXCC 01 01 01). This had been circulated to all members of the network during the summer. Coordinators had been asked to consult on the document locally. These local consultations were to be informal and in addition to the ongoing official consultation process being carried out within each country. The timetable for the health for all renewal process, both global and European, was outlined. Healthy cities had until the end of November in which to make their comments known to WHO in three ways: on an individual level, via their country focal points or collectively as a network through the HCPO. The key points of the document were highlighted.

The meeting then split into four parallel workshops for the purpose of discussing the document in more detail and to consider, in particular, the issues of importance to healthy cities, the local level and urban health. The aim was to form a Healthy Cities network viewpoint on the document. Feedback from the groups took place in plenary and the key points are summarized below.

### *Healthy city involvement in national consultations*

Although not directly being asked to involve healthy cities, Member States had been asked to ensure that consultations on the document were wide-ranging and involved those at national, regional and local levels. Of those attending the meeting, only Padua and the Italian national network cities had been formally approached as part of their national consultation. Three other cities (Liège, Copenhagen, Jerusalem) had taken part in the consultation process but this had occurred either by chance or their own initiative.

### *General comments*

Overall the response to the document was very positive. The document was described as "interesting", "comprehensive", "inspiring", "visionary", "exciting". It was thought to be a good guideline for professionals, a reference book, but less attractive for use, in its present form, with politicians and the public. It was considered too long and, in style, too heavy and analytical.

While the spirit of the original should be retained, the present document needed improvement. Suggestions included: the inclusion of an up-to-date glossary; a more interesting and inviting contents page; an index; an introduction which stresses the importance of the local political perspective in implementation; translations into local languages.

In addition, to this main document, there was thought to be a need for an abridged version which was attractive and easy to read, digestible and clear, which summarized and identified the priorities and contained good examples. There was particular concern that there should be a version that was suitable in length and form for politicians. The suggestion was made that there should be specific summaries for different purposes and different audiences, which pulled out the relevant detail for a particular issue and guided the reader through the document.

#### *Specific comments on targets and target setting*

The reduction from 38 to 26 targets was welcomed. The targets on equity and primary health care (19) in particular were singled out and praised. It was thought possible by some to put together targets 17 and 5. It was suggested that quantitative indicators should be available for all targets and that there should be clear links drawn between the new 26 and the old 38. Many city health plans had been based on the 38 targets and it would be necessary to see the links with the new configuration.

#### *Healthy cities perspective*

Cities felt that the issue of urban health had been mentioned well but the importance of local level health policy development had been less well recognized. Cities perceived that a lot of responsibility had been placed with the local level for implementation of the plan. It was felt that, in their communications with national government, WHO should make explicit reference to healthy cities as a tool for implementation and recommend that national government draw on local expertise. For example, healthy cities were thought to have more possibilities for, and experience of, intersectoral working at a local level than a national government. WHO was seen to have a role in acting as a catalyst to improve communication between local and national levels.

An important point of note was that healthy cities should be recognized as a broad scope setting which acts as an umbrella to the other sectoral or institutional settings, rather than being in the same category.

#### *Conclusion*

The conclusion of the business meeting was that, in addition to the synthesized report of city comments, the three most important issues should be highlighted in the form of a resolution. The following resolution was unanimously endorsed by the meeting.

The WHO Healthy Cities Project network urges WHO to recognize the following in redrafting the *Health for all for the twenty-first century* document:

1. The importance of healthy cities as a vehicle to implement the strategy health for all at the local level.
2. The importance of local level policy development.
3. That healthy cities, as a broad scope setting, which addresses a level of government cannot be in the same category as other sectoral or institutional health promoting settings.

## 10. City health plans

**Agis Tsouros** chaired a panel of cities on the subject of city health plans. The aim of the session was to have an open and honest look at the process and outcomes of city health planning within different cities.

**Vienna (Tina Svoboda)** described how her city had first needed to gain legitimacy for the city health plan before they were able to progress the project. Over the previous five years, they had spent time convincing people and waiting for the right time opportunities to arise. Eventually, they had succeeded in getting the issue formally recognized within a coalition paper, to which all the politicians would become signed up.

**Camden (Ruth Stern)**. The project had used the process of city health planning as a tool to get ownership, to bring health onto agendas and into the mainstream. They had started by carrying out an audit of all sectors, asking all lead officers what they were doing and how it related to health. From this, they had produced the document, *Towards a health plan*, which went through all the committees and gained broad political support. They had used existing structures and strategies, rather than creating new ones. They had prioritized their work into three areas: anti-poverty; transport; and older people. Following this initially promising start, however, their work had gradually become marginalized. Their difficulty had arisen from a change of local political leadership and priorities. However, with the change in national government, health was back on the political agenda. There had been agreement that the health authority should develop a broad based health strategy, which built on the work that had been already done. They had found the Liverpool plan helpful as a model.

**Dublin (Ray Bateson)**. There had been ambivalence within the city over the potential usefulness of a city health plan. For a long time, it had been seen as a burden and, consequently, had featured low down on the list of priorities for their office. The project had used the Copenhagen plan to gain some initial support and, following this, had asked each partner to write their aspect of the plan. This approach had ended up with eight different reports from eight different sectors. So they tried a different approach. Using Liverpool's plan, they had produced a document which contained some key inspirational statements and to which people could sign up. It was publicly launched and they received over 200 public responses. There was still work to do in the coming months in terms of fleshing out the "plan" that they had produced. While they acknowledged the inadequacies of their method, they felt that overall they had progressed, particularly now that they had a public support that was difficult to ignore. They had considered other options: pressurizing people into action would have been unlikely to have produced anything better; writing their own plan from within the health sector/project office would have had difficulties in implementation.

**Gothenburg (Helena Sandelin)**. In Gothenburg, from the political point of view, they had tried to take a strategic approach, which although less ambitious, had taken account of the local situation. Each department already had its own plan. So the project had sent out questionnaires to 300 partners in the city, asking them what they thought of as the priorities strategically. On the basis of the replies, a draft was written which is now being circulated to everyone for feedback.

**Glasgow (Carol Tannahill)**. In Glasgow, the process of producing the city health plan had been detailed and thorough with, for example, around 300 consultative meetings being held. The final product was a very long document: section one was the vision of healthy cities and its objectives;

section two was a department by department listing of what Glasgow would be doing in response, although it was not very integrated. But since the production of the original plan, there had been a local government reorganization and reform of the health services. This meant that the city health plan was no longer relevant in its current format to the situation in Glasgow. In response, they were needing to take a new approach to planning. Over the last year, a new plan had been developed. This had seven key strategic objectives, and they had agreed their values and models underpinning the key actions that needed to be taken for each objective. Implementation would be done on the basis of annual operational plans. Given their experience, they no longer believed that the concept of a detailed operational plan which lasted over five years was realistic. They felt that there was no point in producing a plan that was not deliverable. It was more important to be clear about the strategies and methodologies: the attention should be to what can be delivered rather than to the long-term planning.

Several other cities added their own experience. In **Liverpool**, they had found the process of city health planning to be a continuous one, in which they needed to constantly review the process in response to change. Their original detailed plan was now out-of-date and each year they were developing a different operational priority. In **Padua**, they had developed an information system to produce a yearly profile so that politicians could be provided with ongoing feedback from health on a yearly basis. This proved more popular and, politically, more useful than a plan which was considered to be too rigid. In **Jerusalem**, using both the city administration's plan and the health profile, they had found it useful to determine, first, the needs of the community and, then, to select those areas not covered by the city administration plan. In **Toronto**, they had to produce annual implementation plans. They were taking a priority approach based on the determinants of health.

The meeting then broke into four parallel workshops to discuss the issues of city health planning in more detail. The afternoon session in which they fed back their findings was chaired by **Alex Leventhal, Department of Health Service, Israel**. A summary of the key points is as follows:

#### *The nature and purpose of a city health plan*

The city health plan does not need to be a single document. It could be a collection of documents. The city health plan or its equivalent should show evidence of strategic thinking, connected to action and be policy/strategy/plan all rolled into one. City health plans should: emphasize strategy; clarify objectives; be consultative; mobilize local partners; be integrative. HFA principles should determine the overall planning of the city. The plan should bring a crucial policy and political dimension to issues. There should be an emphasis on equity and the determinants of health. There should be evidence of health being dealt with in an integrated way, outside the traditional context. The city should use the city health plan to decide its local priorities and implementation. It was more important that the city health plan was implemented than that it was "perfect". Cities had found that problems could arise because: agencies were stuck in traditional patterns of working, unwilling to extend their interest because of lack of resource for diversification; and there was a lack of experience/skills with public relations.

#### *The added value of the city health plan*

The added value of the city health plan over any other city plan was considered to be:

- i. the opportunity to deal with determinants of health rather than the status quo;
- ii. the ability to draw partners together and provides a platform for cooperation;
- iii. the opportunity to force conscious decisions between competing priorities;

- iv. the provision of an agreed agenda and shared ownership for all sectors, thereby creating a context within which individual agencies could produce their operational plans.

#### *Selling city health plans*

Particular difficulties were mentioned with *selling* city health plans. The terms involved could be unfamiliar to politicians, more used to working with the municipal plans. Some cities had found that the higher the health of the citizens, the more difficult it was to convince decision-makers of the need for a plan and the lower the political interest. Too much time could be spent explaining what a city health plan was *per se*, instead of selling the concept and conveying the strategy. It is the idea and principle of the plan that should be sold, not the final product. The importance of accessibility in terms of length and language was acknowledged in order to suit the different audiences (community, politicians, etc). The coordinator's role was seen as: to sell the plan to politicians; to show political benefit; to professionally advise politicians; to identify solutions and prepare the decisions for the politicians/councils. The lead politicians' role was seen as: to be involved in the project; to sell the idea to other politicians; to be ambassadors for the project; to provide resources; and to get re-elected!

#### *Sustaining political support*

Political support was essential and needed to be built in from the beginning in such a way that was sustainable. The level of political support could come and go. At times of political change, support could also change, with things becoming easier or more difficult. If a project had the effective involvement of other agencies, and visible public support, then the politicians had more difficulty in ignoring the project. If the political will existed, then structural obstacles were less important and more easily overcome.

#### *Involvement of other sectors*

The intersectoral component is important. Putting each different sector's activities together is not a plan. There needs to be a common vision, a common strategic context in order to deliver key deliverables. It needs an implementation horizon to be built in with achievement dates. In its core and essence, it provides a platform on which to build agenda. Essentially it provides a base for cooperation between different sectors. For planning to be intersectoral, it needs to move out of health promotion. Overall, city experience was that, in practice, decision making was by the municipality and there was not enough involvement of other sectors. Some cities had found that intersectoral working was easier where there were strong, local nongovernmental organizations; others found it more difficult where the city had a collegial organization.

#### *Role of WHO*

Cities valued the role of WHO as catalyst for action and for emphasizing the importance of the planning process. WHO requirements were not always a priority at city level, however, and sometimes the HCP coordinator had a difficult role balancing WHO's demands and the reality and constraints of a public administration. Cities asked that WHO be very flexible in its interpretation of what a plan was. Local experiences were different and plans needed to be understood within their local context. Some cities needed more time to arrive at the same level as other cities and this was not necessarily a negative thing.

#### *The process*

Cities were looking at different approaches to the plan, e.g. adaptation of the profile to draw planning aspects; neighbourhood plans; issue plans. Overall, cities emphasized the value and importance of the process of working towards a city health plan, sometimes above the finished

product. An anonymous survey was carried out during the course of the session to find out cities' opinions on the city health plan and its process which confirmed this impression.

### *City health plans and Agenda 21*

The link with Agenda 21 needs to be developed. Agenda 21 has strong environmental, social and financial focus but can be limited by the environment departments. The healthy cities come in with the social aspect. The Healthy Cities Project should be advocates of Agenda 21, not take it over. In some cities political will exists for Agenda 21 which can create opportunity.

## **11. Technical items**

### **11.1 Addressing inequalities**

Dr Carol Tannahill chaired this workshop which began with presentations from **Ruth Stern (Camden)** and **Willy de Haes (Rotterdam)** about the approaches taken in their cities to tackle inequity.

Ruth described initiatives to assess and address the needs of housebound people, and also the Horn of Africa project in Camden. She also showed how the Camden Health Profile had been used to highlight health inequalities in a very visual manner. The visual representation had helped to communicate the messages.

Willy stated that on embarking on healthy cities work in Rotterdam the overall aim had been to reduce inequity. This was, therefore, the dominant thinking and strongly influenced the targeting of their project's work. He described the approach taken to promoting migrant health, through the education and training of volunteers from within these communities. After about one year these volunteers become employees working within their communities, and with a particular focus on increasing links with primary health care services. A related approach was taken to promoting the health of the elderly. The project was now aware of the need to ensure the provision of support for volunteer care-givers.

There was some discussion about how it could be found out whether the approaches were making a difference. Willy described a "Barometer of Health" being developed in Rotterdam, which measured six key dimensions. In the context of health inequalities, the importance of looking not at absolute levels but at relative levels was highlighted. Again, cities were keen for some help with indicators and research methods.

This was a very large and active workshop, with a lot of discussion and interest from cities. A number of common themes emerged in discussion:

1. The need to be **aware of demographic trends** in our cities, so that it was possible to identify those groups that are currently marginalized or are likely to experience relatively poor health in the future. Cities identified different priority groups. For many cities minority ethnic groups were a priority, and for some elderly people within these ethnic groups were of particular concern. Other cities described their work with "the lost generation" – that cohort of young adults who had not secured employment and mainstream roles in society. The workshop felt that MCAPs (or a similar mechanism) could be used very helpfully to support work across cities with common priority groups. It was also recognized that links between "country of origin" cities and "host cities" could be

invaluable in relation to work with migrant populations. This could be a particular benefit of being part of a network.

2. Some common themes were identified as being crucial in **overcoming the obstacles** to tackling inequity. These included willingness and commitment over a sustained period of time; financial resources; use of networks within communities and the establishment of new networks which integrate different communities; mechanisms to overcome language and cultural differences – and to ensure the active involvement of the community of interest; investment in listening to their concerns and needs; and “use” of people with the community’s characteristics (e.g. age, ethnicity) in the implementation of the programme.
3. There was a discussion about whether there should be a **focus on population groups or on neighbourhoods** in the work to increase equity. Currently a wide diversity of approaches are used by cities. It was agreed that there are benefits of working on a neighbourhood basis, particularly with regard to the opportunities for linking health work with broader regeneration activities. However, the health needs of some population groups would not be adequately addressed by focusing on neighbourhoods. A combination of approaches was therefore seen as being essential.

### **11.2 Engaging the business sector**

Dr Agis Tsouros chaired this small workshop which concentrated on sharing practical experience from cities.

**Antonio de Blasio (Pécs)** presented the approach that was being taken in Pécs in engaging the business sector. They had found that businesses were interested in participation for three reasons: more profit/less tax; creating a better image for themselves; giving a helping hand to social issues. Their experience had been that it was useful to start work with businesses on short term, concrete projects with visible outcomes in order to later build more long term partnerships.

Tina Svoboda (Vienna) agreed. For their Health Promoting School project, they had found support for schools from an insurance company. Initially they had needed a visible project with clear products but now they were able to move on from that to transfer the support to other youth work. They had found it useful to include businesses in the health planning process.

Des McNulty (Glasgow) described a number of examples from Glasgow. For the whole city, they had a long-term strategic partnership with business, the “Partnership for Regeneration”. They also worked closely with a food production company in providing school meals. They were working with them to use school meals as a mechanism to give dietary information, through the packaging and use of colour and logos. This work was not costly but was proving effective.

A number of common issues emerged:

1. *The definition what is meant by the business sector.* Business is not a single group. “Business” is a broad term which encompasses, different sizes, and both public and private sectors, some of which may require very different approaches. For example, small companies might be limited by how much time they were able to devote to alliances for health. Medium-sized businesses might lack time and interest to develop the vision, looking for a role rather than a partnership.

2. *The identification of partners.* The HCP should identify appropriate partners and activities although, within the city, the respective roles of the HCP and the Mayor should be clarified to avoid duplication.
3. *The nature of the relationship.* There was a need to build on short-term projects to develop genuine long-term partnerships with the business sector, with strategic investment in the city and to the mutual benefit of the partners involved. There was a need to create and build awareness with business of their impact on and contribution to the city: this would require a cultural change. Business needs to improve the city in order for them to make more money – attractive city, educated population, etc. Ultimately the business benefits if the city is healthy. It depends on it for workforce and consumers.
4. *The nature of the mechanism for engaging and business interest.* Accreditation/good standards is one mechanism, although it could be complicated. Another is to give advice on how to be a healthy company, e.g. how to improve the health of the workplace setting. Opportunities also arose when large companies contacted the municipality about moving their business to a site in the area. It was important to find the interest of future partners, to provide businesses with what they look for so that there is mutual benefit. As an HCP network, there is a scope for extending and increasing partnerships with business. The issues of Agenda 21 and sustainability could bring good partnerships. Some companies have a wider disregard for social benefit in different countries, although this can vary by political culture.

## 12. Decisions and recommendations

The phase III document was accepted by the meeting. There were a few points of clarification and minor amendment the main items of which are listed below:

### Phase III (overall)

*Integrated networks.* There will be a number of integrated networks. These will include the three core networks: the phase III network of WHO project cities; the network of national networks; a network for cities new to the healthy cities way of working, mainly in the NIS; and other types of overlapping networks including thematic (MCAPs), geographical (subregional), and strategic, e.g. linking metropolitan networks.

*National networks:* A strategy relating to national networks and accreditation needs to developed.

### Phase III (network of WHO project cities)

*Contract.* There will not be a formal legal contract between WHO and members of the phase III network of WHO project cities.

*Size of network.* A network of 40 cities with at least 10 places reserved for new cities.

*Language.* The working language of the network remains English but there is scope for flexibility over the use of other languages within meetings and documents where resources allow. The phase III city package will be produced in all four WHO languages (English, French, German, Russian).

*Presentation.* An executive summary, suitable for politicians, should be prepared to be used in conjunction with the main document.

*Distribution.* The phase III city package for designation and application to join the network will be distributed to all project cities and national network coordinators by the end of December

1997. National network coordinators should distribute the document to all their cities. The document will also be available via the internet.

*Political commitment* to phase III should be made by the highest political level within the city and signed on behalf of the city by the Mayor, leader of council or their equivalent. Partnership with other sectors should be demonstrated.

*Financial contributions.* The annual financial contribution for this phase III network would be set at US \$5000 but this would be reduced to US \$3000 for those cities from the "East". Funds would be used to finance some of the products and services currently provided free of charge by WHO. An advisory group would be formed to advise on additional use of financial contributions to the benefit of the network, although WHO would retain final veto.

*Designation.* There would be a two-stage process for entry to the network: eligibility and designation. The final decision on designation would rest with WHO. Cities who are unsuccessful in their applications will receive feedback.

*MCAPs.* The effectiveness of these needs to be evaluated. Cities would like more feedback on MCAP activities.

#### Evaluation

The framework for the evaluation will be completed in early 1998 and will inform activities during phase III, evaluation products and the planning for the Athens Conference.

#### Athens

A steering group will be set up with representatives from project cities and national networks.

#### Health for all

A resolution from the business meeting was unanimously endorsed and this will be presented to WHO with the general feedback from the network.

### **13. Closure**

Alex Leventhal, Department of Health Service, Israel chaired the closing session. Jill Farrington presented the General Rapporteur's report. Agis Tsouros presented a draft for the resolution on health for all from the business meeting to go to WHO. This resolution received unanimous agreement. Batya Waschitz thanked everyone for coming and for their contributions to such a successful business meeting. Dr Tsouros expressed his gratitude to Batya and to the city of Jerusalem for the excellent local arrangements and the warm hospitality shown.

