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Cities Network and Network
of European National
Healthy Cities Networks

**Fifth Annual Business Meeting and
Technical Conference of the WHO
European Healthy Cities Network
and the Network of European
National Healthy Cities Networks
in Phase V (2009–2013)**

Izmir, Turkey, 20–22 September 2013



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1. Introduction

The City of Izmir, Turkey, hosted the Fifth Annual Business Meeting and Technical Conference of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks in Phase V (2009–2013) on 20–22 September 2013.

The overarching theme of the Conference was innovation through leadership and shared governance for health and well-being. This theme was explored through three main strands in the main plenary sessions: health in all local policies; building resilient communities; and considering the implications of new compelling evidence on the economics of public health.

The Conference emphasized innovation and leadership by drawing on the most recent evidence and experience from across the WHO European Region and beyond. It focused on Europe's new health policy framework, Health 2020. Healthy Cities helped to shape this key document, which will guide Healthy Cities through its new phase of action. The Conference also drew on the outcomes and conclusions of the 8th Global Conference on Health Promotion – Health in All Policies, which was held in Helsinki, Finland on 10–14 June 2013.

The objectives of the Conference were:

- to share and learn from the best available evidence together with innovative and practical approaches on shared and smart governance for health, equity and well-being at the local and regional levels;
- to broaden understanding of the consequences of austerity – vulnerability and health and opportunities for strengthening public health and investing in resilient communities;
- to explore mechanisms for establishing dialogue with the private sector; and
- to start the process of evaluating Phase V and to launch and explain the content and goals of Phase VI.

The Conference gave priority to the Phase V evaluation process and the official launch of the Phase VI package.

The above objectives and priorities were explored through an expansive programme, which included 5 plenary sessions, 5 strategic workshops, 6 evaluation circles, 4 sessions for politicians, 3 sessions for coordinators, 15 case study sessions and 5 teach-ins.

The conference was attended by a total of 270 participants from 27 countries. This figure included representatives of 53 WHO designated cities, 16 national healthy cities networks, 5 ministries of health, 3 collaborating centres and representatives of 3 new countries interested in developing healthy cities.

The Conference had a rich programme of 28 parallel sessions, 8 teach-ins and 5 strategic workshops. Other sessions were held in parallel, including 4 sessions for politicians, 4 evaluation circles and 2 sessions for coordinators. The results of these sessions have been incorporated into other sections of this report.

Agis D. Tsouros, Director, Division of Policy and Governance for Health and Well-being and Head, Centre for Urban Health, WHO Regional Office for Europe, thanked the city of Izmir on behalf of WHO for their outstanding commitment to hosting the event following the unfortunate cancellation of the event in June 2013. The City of Izmir showed participants outstanding hospitality throughout the Conference, giving participants an appreciation of the city's 8500-year heritage and its modern-day public health approaches.

2. Opening session

The City of Izmir provided a colourful opening ceremony of traditional dance, sharing the country's rich cultural history. This was followed by a series of speeches to welcome participants and set the context of the Conference.

Aziz Kocaoglu, Mayor of Izmir, opened the meeting and welcomed participants. Aziz Kocaoglu indicated that urbanization and migration have become global priorities and that cities play an important role in improving the health of urban populations. He cited examples from Izmir, which follows the goals and principles of Healthy Cities. He highlighted the need for synergy with the sustainable development agenda.

Recep Altepe, President of the Turkish Healthy Cities Association, gave a brief history and an overview of the role of the Association. The Association has grown from 10 member municipalities from its establishment in 2005 to 48 municipalities. Health profiles, in the form of health maps, have been used to identify problems and served as an important tool for decision-makers. Recep Altepe referred to the wide action the national network takes to raise awareness of determinants of health, share good practices, involve experts, publish results and inspire cities to take action.

Oleg Kuvshinnikov, Chair of the Russian Association of Healthy Cities, Districts and Settlements, shared the Russian experience of healthy cities. The Association has already taken action to implement Health 2020. The Association, through a government commission, has received presidential endorsement for implementing healthy cities in the Russian Federation. Oleg Kuvshinnikov shared the mission and trends of the Association, which relate to governance models, methodological experience, the development of case studies, gaining practical experience and problem-solving.

Zsuzsanna Jakab, WHO Regional Director for Europe, presented the development of the Health 2020 policy framework¹ and called on healthy cities for their continued support, leadership and inspiration in the process of its implementation. She stated that, for more than 20 years, the WHO European Healthy Cities Network has articulated models that help us all to better understand and address the complexity of social determinants. She reviewed the challenges of the urban landscape, which include:

- demographic changes, with falling fertility and ageing populations;
- the political, social and economic effects of globalization;
- powerful new technologies that are changing health and health care; and

¹ Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013.

- the demands and expectations of citizens to be well informed and involved in decision-making.

She recognized that identifying ways to address these challenges through intersectoral action has been the consistent aim of the Healthy Cities movement and that this experience has helped to shape the vision, process and action programmes of Health 2020.

Zsuzsanna Jakab further presented Health 2020 strategic objectives and the four common policy priorities, and in officially launching Phase VI (2014–2018) of the WHO European Healthy Cities Network, was pleased that the Phase has been aligned to this framework. Zsuzsanna Jakab further reported on the work WHO has undertaken to promote the framework to national governments. This includes developing an implementation package for both national and local governments. Member States adopted several health targets and indicators at the annual meeting of WHO's governing body in Europe, the WHO Regional Committee for Europe.

Zsuzsanna Jakab referred to the launch of the publication, *Review of social determinants of health and the health divide in the WHO European Region*,² which was commissioned to support the development of Health 2020. It has policy recommendations to ensure that progress to reduce health inequities and the health divide can be made across all countries, including low- and middle-income countries. New evidence revealed in this publication makes a strong economic case for action. Importantly, it concluded that the current economic difficulties in countries present a call for action on social determinants of health.

Zsuzsanna Jakab concluded by calling upon Healthy Cities to show leadership and to take action, referring to Healthy Cities as “the place where the wheel meets the road”.

Agis D. Tsouros, thanked the City of Izmir for their graciousness around postponing the conference following an unavoidable cancellation in June 2013. He thanked cities for their continued commitment. Healthy cities played an important role in informing the Health 2020 process with practical information on responsive actions for health and well-being. He noted that Health 2020, an evidence-informed document supported by all countries, brings added legitimacy to the WHO European Healthy Cities Network. The WHO European Healthy Cities Network in Phase VI will focus on building capacity for leadership for health. Health 2020 offers a framework for healthy cities to measure their current progress and set priorities future action. With decades of experience, Healthy Cities has a strategic opportunity to provide leadership.

3. Leadership and innovation for health at the subnational level: evidence that can make a big difference

This plenary session focused on the role of evidence as a trigger for action. Three experts presented evidence for local action based on economic arguments, the need for settings-based approaches and the social determinants of health.

² Marmot M et al. Review of social determinants of health and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2013.

3.1. The economic case for health promotion

David McDaid, Senior Research Fellow in Health Economics, London School of Economics and Political Science, United Kingdom

This presentation put forward the argument that cities could win support for investment in health promotion by demonstrating the economic costs and consequences of inaction on the broader society. Health action not only improves public health but also improves other sectors. For example, cycling initiatives produce gains in health, but such measures have other benefits such as calming traffic and increasing tourism. Since many sectors affect health, promoting health requires whole-of-government and whole-of-society approaches.

Noncommunicable diseases, such as diabetes and cardiovascular diseases, have enormous costs for countries across the WHO European Region. Local governments are well placed to take action on noncommunicable diseases, regardless of their income level, through a wide range of evidence-informed actions that local governments can implement.

Schools offer an opportunity to reach the wider population at a vital, early life stage. With preschool taken into consideration, schools offer a point for early interventions that provide powerful economic returns. Action includes protecting the mental and emotional well-being of children, healthy eating and support for parents to bond with children.

Three examples of evidence and interventions in Canada, New Zealand and the United States of America demonstrate that children with behavioural problems and/or a disadvantaged start to life were more likely: not to gain qualifications; to have lower incomes; to be unemployed or reliant on welfare benefits; to be drug users; or to be taken into the prison system, with obvious costs to society. Improving the health of children will result in savings in the education system in the short term, with additional long-term savings in other sectors. Local governments have a critical role to play in coordinating actions targeted at children.

Healthy living was presented as another key area for local government action. An Australian example of a local community campaign designed to get people to eat more fruit and vegetables showed that a €5 investment to reach every community member would produce an estimated €12 return through, for example, a reduced need for health care spending and a reduction in work absenteeism.

A third area for action was on environmental hazards. There were economic returns on introducing interventions such as congestion charging. In London, United Kingdom, congestion charging has reduced environmental pollution from cars and, as a result, the number of bronchial disorders has also fallen.

Active travel is a fourth area for intervention. A study published in *The Lancet*³ estimated that, over 20 years, £17 billion of benefits could be gained through increases in walking and cycling by reducing diseases associated with physical activity. Reducing pollution and traffic in cities also produces other economic benefits. Urban road safety measures are another area for local government action. Interventions include preventing crashes by reducing road speeds.

³ Jarrett J et al. Effect of increasing active travel in urban England and Wales on costs to the National Health Service. *Lancet*. 2012;379:2198–205.

Simple health interventions could be delivered through community health programmes, whereby local governments facilitate opportunities for people to come together. Bringing people together also helps to tackle problems such as isolation and falls among older people by engaging in social activities and gentle exercise programmes such as tai chi.

Workplace health promotion, specifically focused on mental health, is another area that shows significant return on investment.

Taken together, the above actions could have a significant economic benefit for society, and identifying these costs could help strengthen the case for local investment in health promotion. However, care must be taken to ensure that interventions are equitable and reach the people who are most in need; otherwise there will be a risk of widening the health divide. Interventions should be tailored to reach key population groups.

Healthy Cities should emphasize the benefits of interventions beyond expected health improvements. Local governments are key players in the delivery, coordination and funding for innovation, and this work needs to be carefully evaluated going forward.

3.2. The epidemic of noncommunicable diseases

Gauden Galea, Director, Noncommunicable Diseases and Life-course, WHO Regional Office for Europe

This presentation focused on the settings in which health professionals should take action to improve the health and well-being of society. It was emphasized that healthy choices need to be made the easy, natural and even fun choices. This depends on how cities design and organize their cities and services.

Green spaces in cities are important for facilitating increased physical activity. They affect family mental health, the uptake of exercise, reductions in noise pollution and overall increases in the quality of life. The importance of introducing such environments is emphasized by the fact that, the poorer someone is, the less likely they are to have such spaces to enjoy in their own neighbourhood. Providing green spaces contributes to equity.

The mass media are another area for cost-effective interventions. Governments often do not use the media effectively or use the right kinds of messages. For example, physical activity tends to be promoted as “exercise”, with images of expensive gyms that require a separate time commitment. Instead, there should be messages about opportunistic physical activity (such as using the stairs or getting off a bus a few stops early). This is still quite rare in Europe.

Schools have been proven to be an effective setting for getting across health messages, but there is still not a wide enough uptake of health promotion in school. Despite 30 years of work in this area, health-promoting schools are still not the norm in Europe.

Workplaces are a good setting for intervention, as every municipality is likely to be a large employer. For example, simple measures include providing healthy food choices in canteens and smoking-cessation services with outreach to families.

Religious institutions provide another setting for reaching people with health messages, but care should be taken to keep health messages separate from the ideology of religion itself.

Alcohol is a serious problem in Europe, as it is culturally acceptable, part of celebrations and woven into business relationships and sponsorship. Overall, alcohol consumption adversely affects health, even if people stay at the recommended limits. Action is needed to control the pricing, marketing and the availability of alcohol.

It was suggested that health professionals make better use of untraditional data, such as search engine trends and social media, to gain insight into health. For example, people's data trails from mobile phones could give insight into creating opportunities for physical activity. Purchases at supermarkets could give insight into health diets, and data on value-added taxes could be a source of knowledge on alcohol and tobacco consumption.

3.3. Recommendations of the European review of social determinants of health and the health divide – perspectives for local leaders

Peter Goldblatt, Deputy Director, Institute of Health Equity, University College London, United Kingdom

This presentation provided an overview of the findings of the review of social determinants of health and the health divide in the WHO European Region and highlighted key points for local government action.⁴ This review was one of the major studies that informed the new WHO European policy framework for health and well-being, Health 2020.

The main social determinants of health analysed by the review are related to income, child poverty, pre-primary school attendance, education, unemployment and patterns of alcohol and tobacco consumption. The review documented variation between and within countries on these determinants, which affect people over the life-course. The review provided new evidence on the magnitude and patterns of persistent inequalities in the 53 countries of the European Region of WHO.

Principles for action were spelled out in the European review.⁴ These principles are also important to give guidance on how local governments can create the conditions for citizens to take control over their lives, promote health and reduce health inequalities. The review identified four broad themes for action:

- the life-course: factors that influence health and accumulate through life, with action needed at each stage;
- the factors within the wider society;
- the systems that are in place within society, such as health, welfare and education systems; and
- the macro-level context – the economic and global context.

In identifying recommendations for action, the review specifically focused on::

- human rights;
- community resilience and empowerment;

⁴. Review of social determinants of health and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office for Europe; 2013.

- action across all stages of the life course;
- protecting future generations against the perpetuation of inequalities were handed down from parent to child;
- ensuring intergenerational equity, such as economic and environmental sustainability; and
- the need for joined-up action.

The concept of proportionate universalism is a priority. This means that action at each part of the health gradient needs to be proportionate, whereby the health of the people who are worst off is improved proportionately more and at a faster rate to reduce the health divide in society.

Local governments have responsibilities affecting most social determinants of health, and they are best placed to identify and to respond to social needs. However, local governments are also limited by the wider legislative and political contexts that shape their ability to act. Local policies need to be aligned with those of the upper levels of government. For this purpose, the review stressed the importance of policy consistency for tackling health inequities at all levels of policy-making.

Strategic focus needs to be placed on upstream determinants of health over the whole of the life-course, with an asset-based approach. This relies on forming local partnerships engaging communities. Local governments should place great focus on social determinants within strategic health, equity and environmental impact assessments.

Several areas of policy failure were identified:

- failure to conceptualize causal pathways of health inequities: for example, a child who does not attend preschool may have lower education outcomes and in turn less employment and health outcomes and opportunities throughout life;
- a delivery-chain failure: for example, a government lacks the political commitment or infrastructure to act on multiple determinants;
- failure to implement accountability mechanisms that monitor health inequities; and
- failure in public health systems, whereby the competencies needed to act on social determinants of health are not developed.

The coherence that is needed at all levels underlines a need for continued intersectoral approaches. Action must be evidence-informed, and every policy and action should undergo appropriate monitoring and evaluation. The process of evaluation should involve stakeholders in a process that fosters common understanding, sustains commitment to deliver shared results over time and builds evidence.

3.4. Panel discussion

Erio Ziglio, Head, WHO European Office for Investment for Health and Development, moderated a panel discussion that included the previously named presenters and **Johanna Reiman, Executive Director, Baltic Region Healthy Cities Association and WHO Collaborating Centre for Healthy Cities and Urban Health in the Baltic Region, Turku,**

Finland and Gabriel Scally, Director, WHO Collaborating Centre for Healthy Urban Environments, Bristol, United Kingdom.

Johanna Reiman pointed out that, when local governments engage communities, they must be consulted on their needs, but local governments must also be able to identify and provide services for needs they can articulate. She agreed that an aspect of fun should be included in programmes that promote physical activity, and participating in these activities should be made easy.

Gabriel Scally agreed that cities are at the centre of what needs to be done to improve health and noted that local governments often neglect economic analysis. He pointed out, however, that the economic issues that arise at the local level often do not get attention on the national stage. With regard to local economics, he referred to the local supply of food (such as local sourcing) and cycling lanes (such as the use of local labour and materials). With respect to noncommunicable diseases, he agreed that the burden is enormous and that cities have to respond to the causes within society and not rely solely on clinical services. He stated that we need mayors to show leadership and act as health heroes.

Erio Ziglio reflected that evidence at times triggers action, but he also noted that there are plenty of examples of inaction despite a wealth of evidence. He asked panellists what they think would help to facilitate action.

David McDaid stated that capacity-building is needed for leadership and innovation. Leaders need the awareness and skills for making economic arguments for health. These arguments should be built into any process of rolling out pilot schemes so the positive effects on the broader society are understood in addition to specific health gains. Sharing this information with other comparable cities will lead to further innovation. Although access to international information might drive innovation, accumulating local or country-specific information with demonstrable costs and benefits is essential and more valuable to local-level actors. The process could be made simpler by integrating effective approaches into the day-to-day practice of local government decision-making.

Gauden Galea stated that clinical services still have an important role to play in noncommunicable diseases. Strong evidence indicates that improving health services has also reduced noncommunicable diseases. However, health services should be seen as one setting of many settings, and clinical and population-based approaches should work together. Although considerable evidence supports the need for new policy approaches, there is not enough evidence on policies that work. This latter field of study has not entered strongly enough into the public health arena compared with epidemiological studies focusing on risk, exposure and outcome. He felt that a large body of evidence on policy implementation is available for noncommunicable diseases that is simply unwritten.

Peter Goldblatt stated that a key issue is the process of priority-setting in addressing health and health inequity. It relies on bringing national and international evidence to the local level, which cities can apply to the social and health problems in their localities. This evidence should be combined with processes of community involvement to ensure that strategies reflect local concerns and will gain local support. Combining these two types of evidence would result in sustainable, effective strategies.

Agis D. Tsouros stated that one of the greatest challenges is communication, and he asked the audience to consider how we might need to change or adapt the narrative of healthy cities. Communication will be an important part of Phase VI.

4. Business session 1

This session covered business issues of the partner networks of the WHO European Healthy Cities Network. The technical programme for the Business and Technical Conference and the general rapporteur were adopted. Reports were provided by the WHO Regional Office for Europe, the WHO European Healthy Cities Secretariat (Belfast) and the Chairs of the Advisory Committees of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks. The results of annual reporting for cities and national networks were presented, and further presentations were made on evaluation and Phase VI.

The process for electing two members to the Advisory Committee of the Network of European National Healthy Cities Networks was outlined.

Agis D. Tsouros, chaired this session.

4.1. Report from the WHO Centre for Urban Health

Agis D. Tsouros, Director, Division of Policy and Governance for Health and Well-being and Head, Centre for Urban Health, WHO Regional Office for Europe

Important developments had taken place in the WHO European Region since the last Business and Technical Conference of the WHO European Healthy Cities Network in St Petersburg, Russian Federation in 2012. Most notably, all 53 Member States of the European Region adopted the Health 2020 policy and strategy and the European Action Plan for Strengthening Public Health Services and Capacity.

In the past year, there have been consultations with the Advisory Committee of the WHO European Healthy Cities Network and the Advisory Committee of the Network of European National Healthy Cities Networks on developing the evaluation approach for Phase V and prepared the Phase VI package.

WebEx conference calls took place with city and national network coordinators to consult on Phase V evaluation and on the Phase VI package.

The postponement of the Annual Business and Technical Conference entailed considerable additional organizational and administrative work for the WHO European Healthy Cities secretariats in Copenhagen and Belfast.

4.2. Report from the WHO European Healthy Cities Secretariat

Joan Devlin, WHO European Healthy Cities Secretariat, Belfast

The networks comprise 99 members of the WHO European Healthy Cities Network (of which 3 had been designated the previous year) and 20 accredited national healthy cities networks. There are also unaccredited national healthy cities networks in 11 other European countries.

In the previous year, three subnetwork meetings were held on the topics of health equity, health literacy and healthy ageing.

Annual reports were received and analysed as described in the sections below.

A web-based facility has been developed and is available to all coordinators. It contains all the case studies presented by cities and national networks at conferences during Phase V. They can be accessed by conference, city or network or theme.

4.3. Report from the Advisory Committee of the WHO European Healthy Cities Network

Iwona Iwanicka, Healthy City Coordinator, City of Łódź, Poland

The role of the Advisory Committee is to facilitate and represent the views of coordinators in WHO Healthy Cities activities. During Phase V, the Committee advised and assisted WHO on developing and implementing Phase V goals, preparing annual business and technical conferences and using financial contributions. Activities during the previous year included a meeting in November 2012, the assessment of abstracts and consultation on documents for the Izmir Conference. Advisory Committee members also participated in WebEx meetings on the topics of Health 2020, Phase V evaluation, the annual reporting template for cities, subnetworking and the process and content of Phase VI, including the role of national networks.

4.4. Report from the Advisory Committee of the Network of European National Healthy Cities Networks

Yulia Abrosimova, Coordinator, Russian Healthy Cities Association

The Network of European National Healthy Cities Networks has a mission to support cities and towns across the WHO European Region in achieving the core goals of the Healthy Cities programme and to raise the standards of member cities. National networks will be key vehicles in delivering Health 2020 by providing direct leadership to cities through training, developing methods and tools and facilitating networking and exchange.

There were three key events during the year. These included an annual meeting and training event for coordinators in March 2013 in Copenhagen, Denmark. This meeting involved participants from 16 countries. Topics of discussion by participants at this meeting were Phase VI and Health 2020, including issues surrounding the application and membership by cities to the national healthy cities networks; the terms of reference for national network accreditation by WHO; the developmental needs of national networks; and their delivery role. Experts on community resilience and gender rights provided training to coordinators.

Participants of the meeting proposed preparing a revised WHO booklet on national healthy cities networks. The booklet will provide national networks with an opportunity to present their goals, working methods, future directions and their most outstanding achievements. The booklet will help coordinators to share information on their networks and demonstrate the value of international exchange with their partners.

National networks are in the process of collecting examples of how to promote Health 2020, and in some countries this work has already been implemented. Such actions include national launch events, training and workshops, publications and translations.

4.5. Results from the annual reporting template: WHO European Healthy Cities Network

Premila Webster, School of Public Health, Oxford University

Premila Webster provided a brief overview of the results of the annual reporting templates submitted by member cities of the WHO European Healthy Cities Network.

The response rate to the annual reporting template was 72%. In 85% of the responding cities, the lead politician had seen the completed annual reporting template, and the steering group had seen the completed annual reporting template in 61% of cities.

Political commitment is robust, reported as being either enthusiastic or adequate by all cities. This commitment is demonstrated through council decisions and participation in events. Seventy per cent or more of cities have at least five meetings per year with their leading politician. As in previous years, local political changes are mainly related to the appointment of a new mayor or a change in the ruling party because of elections. National changes are mainly related to changes following elections.

Facilitative factors for healthy cities include good partnership working within the city and an effective and cohesive healthy city team. Strong political commitment is a key facilitative factor. Several cities reported limited financial resources as an obstacle, but cities seek funding through their partners and the private sector through the concept of corporate social responsibility. The lack of proficiency in English is an obstacle for some cities.

Intersectoral committees in most cities meet four or more times annually. Partnership work is based principally on planning and supervising collaborative projects and long-term strategic planning. Cities have used their city health profiles marginally more to inform local politicians, identify inequalities and inform new projects.

Seventy-two per cent of cities said they had initiated local actions as a direct result of being a member of the WHO European Healthy Cities Network in Phase V. This included integrating health in local strategies, holding conferences, obtaining grants for projects and working collaboratively with other cities in the WHO European Network. The Health Equity Subnetwork appeared to be the most popular among the thematic subnetworks, but cities said that the Healthy Ageing Subnetwork had done the most to facilitate implementation.

In terms of evaluation, 82% of cities reported that they had plans to evaluate and monitor their work and 55% of cities reported that they produced an annual report. Most evaluation in cities related to project evaluation, but some cities had carried out comprehensive reviews.

The analysis showed successful and comprehensive engagement between cities and a wide range of organizations and stakeholders, which results in the healthy city principles and concepts being better understood and integrated in policies and strategies within cities.

The visibility of health equity principles in local policy documents has increased substantially related to education and in economic development, planning and housing documents. The concept of equity appears to be better understood and integrated within cities both in measuring inequalities and in planning measures to reduce inequalities. Cities also appear to have had an impact within the overall local government on raising the issue of inequalities and ensuring visible delivery, or implementation of action, on equity at the local level.

In summary, the annual reporting templates demonstrate that the WHO European Healthy Cities Network is making progress in a range of areas. There is more sophisticated understanding of health concepts and their determinants and more robust evidence-informed planning. The WHO European Network is active and enthusiastic and able to influence local governments. The concept of equity underpins strategies and policies specifically in these difficult times when inequality is even more in evidence.

4.6. Results from the annual reporting template: national healthy cities networks

Leah Janss Lafond, WHO Temporary Adviser

Leah Janss Lafond provided a brief overview of the results of annual reporting templates submitted by national healthy cities networks, which was available as a working document.

This annual reporting template was sent to 20 national healthy cities networks, and 17 responded. These 17 respondents answered all the questions on the annual reporting templates.

The national networks are stable in terms of political and member support. Member support is demonstrated by high levels of participation at events and in activities of the networks and through the local dedication of resources toward the national network and local initiatives. Membership figures also remain stable.

National networks place great importance on responding to member needs, including in response to the difficult economic situation in many countries. National networks have waived or suspended participation fees and introduced relevant programmes to alleviate social and health problems (such as related to unemployment and social exclusion). Despite economic cutbacks in many countries, all but three networks reported being financially secure.

Most national networks are largely volunteer-led. Six national networks have a full-time coordinator, and four networks have part-time paid coordinators.

National networks have well-established national-level partnerships. Sixteen of 17 national networks have partnerships with their health ministries. Twelve networks have partnerships with ministries outside the health sector and 13 have partnerships with nongovernmental organizations. Partnerships are defined in terms of the exchange of expertise and joint work, including partner-funded projects. Thirteen national networks have also reported that they have influenced the policies of a partner organization. There has been an incremental increase of networks reporting partnerships with European organizations.

Many networks commented positively on the impact of their own operations and strategies. A few networks emphasized enforcing or strengthening their national network criteria and even limited membership as a means of raising the standard of work. Networks, and their members,

placed high value on conferences and other events that offered opportunities for the exchange of experience and training. Evaluation remained largely informal due to the time and expense of its undertaking.

Facilitative factors for national networks remain consistent with the responses from previous years. These factors include local commitment to the networks, national partnerships and recognition and efficient organizational structures and working methods. Obstacles include human and financial resources.

In the future, national networks will place priority on their organizational development (including strategies, fundraising, partnership agreements and communication plans), thematic work and conferences, training and other events.

4.7. Evaluation of Phase V of the WHO European Healthy Cities Network

Evelyne de Leeuw, Glocal Health Consultants, Australia

Agis D. Tsouros introduced the evaluation of Phase V. The WHO European Healthy Cities Network is evaluated every 5 years. It is an essential obligation of membership that gives the movement credibility. WHO is also obligated to provide cities and national networks with feedback and useful deliverables that demonstrate achievements, lessons learned and advice for areas in which difficulties are experienced. It is crucial to approach evaluation with rigour and depth.

Evelyne de Leeuw presented the evaluation framework.

The evaluation aims to demonstrate city commitment to healthy cities, to demonstrate success and to provide feedback and essential guidance to cities. The evaluation is expected to yield practical information that will support cities in better managing their day-to-day operations, to build on their past and to prepare for the future.

The method is based on pyramid logic, which allows cities to tell their stories based on the key attributes to which healthy cities are committed. These attributes related to governance, equity, partnership, leadership, participation and policy-making. The evaluation aims to answer the question of whether it makes a difference to adopt these attributes through four broad research questions on strategic work, operational work, health outcomes and the extent and intensity of action on the social determinants of health. The case study approach has been developed in recognition of the overlapping nature of the above attributes.

The evaluation instrument, or pyramid, will take into account and build on existing information, including the annual reporting templates, a Phase V questionnaire as well as three types of case studies:

- proudest achievements on Phase V themes;
- case studies on core strategic attributes of the healthy cities approach; and
- case studies with a thematic approach.

Some outputs of the evaluation will address academic and practice-based areas. However, publications in scientific and peer-reviewed journals will only be one aspect. Other outputs will

include local and national advocacy packs, tools and manuals. Advocacy packs will enable coordinators to more easily approach partners inside and outside government and to demonstrate the added value of healthy cities. The evaluation team will generate concrete, step-based tools and manuals.

Cities will receive support from the evaluation team, including telephone interviews and follow-up questions. The evaluation will also take into account the outcomes of politicians' sessions at the Conference, which aimed to understand what was needed for successful local leadership for health.

A series of evaluation workshops was planned and held at the Izmir Conference to prepare cities to provide case studies based on the evaluation framework.

4.8. Phase VI of the WHO European Healthy Cities Network

Agis D. Tsouros, Director, Division of Policy and Governance for Health and Well-being and Head, Centre for Urban Health, WHO Regional Office for Europe

Health 2020 will provide the context for Phase VI. The WHO Regional Office for Europe has decided that Healthy Cities will be the strategic vehicle for delivering Health 2020 at the local level. In the transition to Phase VI, many of the issues from Phase V, such as health in all policies, will be carried over and further reinforced.

The overarching goals of Phase VI are to improve health for all and to reduce inequalities by improving leadership and participatory governance. The core priority areas are:

- investing in health through a life-course approach and empowering people;
- tackling major health challenges (infectious and noncommunicable diseases);
- strengthening people-centred systems, public health capacity and emergency preparedness, surveillance and response; and
- creating resilient communities and supportive environments.

A wide range of subthemes have been identified under each major priority.

The goals and requirements for Phase VI have been developed and framed on the two Health 2020 strategic objectives and the four priorities for policy action.⁵ Cities will receive guidance on how to carry out the Health 2020 analysis, a requirement of the Phase VI application process. Cities that participated in Phase V will be on a fast track for Phase VI membership.

5. Leadership for health – what makes the difference?

Health 2020, the policy framework for the European Region adopted in 2012, reinforced the key principles and values that have underpinned the WHO European Healthy Cities Network from its beginnings. Strong leadership and commitment, a special emphasis on working across sectors and engaging civil society has been at the core of every phase of the WHO European Healthy

⁵ Phase VI (2014–2018) of the WHO European Healthy Cities Network: goals and requirements. Copenhagen: WHO Regional Office for Europe; 2013.

Cities Network. As the WHO European Healthy Cities Network enters Phase VI, Health 2020 has significantly strengthened this agenda.

This session explored the key attributes of effective leadership for whole-of-government and whole-of-society approaches, taking into account successes and barriers to innovation and change at the local level.

5.1. What constitutes 21st-century leadership for health applied to the local level?

Ilona Kickbusch, Director, Global Health Programme, Graduate Institute, Geneva, Switzerland

This presentation challenged city leaders to review their leadership role and to reconsider what healthy cities is all about.

The implementation of healthy cities requires political choices and strong political leadership. There are contested visions of what a good society should look like wherever people acted politically. If cities undertake a process of defining the common good, the importance of values and ethics within local leadership will grow.

Acting for the common good requires involving multiple actors and coalitions. With this broad involvement, there will be a need to resolve conflict and handle negotiations over the distribution of power and resources. Politics creates the institutions that embody a society's laws and regulations, and they are critical for ensuring the common good. The negotiation of those institutions creates conflicts, and the process of negotiating such conflicts has to be well understood. Moving forward the current public health agenda requires revisiting public health laws in countries and determining whether they reflect our new vision of public health leadership.

With urban economic activity driving the gross national product of most countries, cities have become critical for national development. Despite this wealth, there have been increases in urban inequalities, especially within lower-income cities, and there is an ideological divide regarding the responses to this gap.

Healthy cities view health and well-being as a collective good. However, well-being has become increasingly difficult to ensure in the face of globalization, individualization, economic constraint and the commercialization of the environment. Healthy cities are challenged to better articulate the holistic view of a city and to work collaboratively with all actors that affect the determinants of health. Cities are presented with a four-fold leadership challenge to make cities more:

- equitable
- inclusive
- resilient
- responsive.

Leaders should strive for better cities and not only better health. How cities frame health issues is one of the most important issues for leading collaborative processes. To convince others of the healthy cities agenda, the language used should be inclusive. Leaders need to create a consensus

on how life in cities should be lived. Collaborative processes should be in place to enable the common good to be continually reassessed and redefined.

Cities need to be astute in their understanding of political processes to put health and well-being firmly on the agenda. These processes transcend political parties, elections and governments and require wide multistakeholder involvement. Three major leadership skills are needed:

- systems thinking – the collaborative, inclusive approach inherent to healthy cities;
- redrawing the map – a reflection of how health and well-being issues are framed so that they are understandable to other actors; and
- bridge building – linking to other processes and agenda.

Healthy cities leadership involves defining the mission, highlighting values of equity and access to health, aligning many different sectors and actors and empowering people.

There has been a tendency to define any shortcomings of governance in terms of a lack of technical capacity rather than in terms of the power and constraints imposed by vested political interests.

Leaders in healthy cities need to understand which actors, inside and outside local government, have the power to affect institutions and drive change. The political determinants of health comprise values, drivers and social determinants. Public goods need to be defined and clarified in contrast to market values. Power and resources are drivers with both political and commercial determinants. Cities need to identify how they can empower people and create better environments in which to live.

Healthy cities have understood the tension between technical and political actors, but their interaction needs to be better understood. Their actions are mutually dependent. Resolving political problems always requires technical help, and technical solutions require political support.

As healthy cities have been so reliant on collective action, cities should think in terms of health diplomacy. This diplomacy is based on an understanding of how to build, maintain and drive coalitions forward.

Leaders in the 21st century must act transparently and with accountability. Measures for joint accountability need to be established alongside collaborative actions. The full range of benefits to other sectors, which arise from health-driven actions, should be made clear. Healthy city indicators need to reflect this collaborative approach and the quality of life in cities.

Indicators that could be used relate to:

- the quality of family life: happiness, personal fulfilment, balancing work and family commitments and nurturing children;
- the quality of neighbourhood life: sustainability, safety, relationships, transport and public and private amenities for all city residents;
- a stronger analytical focus on outcomes;
- more attention to big-picture outcomes, such as jobs with living wages, reducing poverty and promoting overall well-being; and

- health literacy.

Measures of success have to be integrated into city planning, and leadership messages have to reflect these outcomes. Measures must also reflect defined values and approaches, with the consequence that a city could only be described as successful if it was socially equitable, economically viable, politically participatory, ecologically sustainable, culturally transferable and has multiplier effects.

The key task for political leadership is to ensure that democratic institutions value health and address equity. Cities have to invest in the health literacy of parliamentarians and the citizens who elect them.

5.2. Implementing health in all policies in countries: outcomes of the 8th Global Conference on Health Promotion

Taru Koivisto, Director, Ministry of Social Affairs and Health, Finland

The 8th Global Conference on Health Promotion took place on 10–14 June 2013 in Helsinki, Finland.

It was jointly organized by the Ministry of Social Affairs and Health of Finland and WHO on the theme of health in all policies. Eight hundred participants from 120 countries attended the conference. The Conference gave health in all policies the following definition (<http://www.healthpromotion2013.org/health-promotion>):

Health in all policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.

Health in all policies has been built on the outcomes of previous international global health conferences, from the Alma-Ata Declaration on primary health care in 1978 and the Ottawa Charter for Health Promotion in 1986 to the present. Health in all policies is expected to feature as a working practice within the United Nations Millennium Development Goals.

The Conference focused on implementation, with concrete guidance and practical examples of how to collaborate with other sectors systematically. The Conference yielded a framework for country action on health in all policies and technical papers (all available at <http://www.healthpromotion2013.org>). A new book, *Health in all policies: seizing opportunities, implementing policies*, has been published and made publicly available at <http://www.hiap2013.com>.

The Conference endorsed the Helsinki Statement on Health in All Policies on 14 June 2013. It made several recommendations to governments, but the contents of the statement apply to all levels of government. These recommendations included the following:

- commit to health and health equity as a political priority;
- ensure effective structures, processes and resources;
- strengthen the capacity of health ministries to engage other sectors of government;
- build institutional capacity and skills;

- adopt transparent audit and accountability mechanisms;
- establish conflict-of-interest measures; and
- include communities, social movements and civil society.

The health in all policies framework, which gave guidance on implementation, was still a draft to be finalized (as of November 2013).

6. Leadership for health – politicians' discussions

The Conference aimed to harvest the extensive experience cities have gained dealing with the politics of health and sustainable development and engaging stakeholders and communities. A politicians' panel was held during Plenary 3, which was themed as "Leadership for health – what makes the difference?" This was followed up by three parallel sessions to facilitate further dialogue.

6.1. Panel discussion

The session was moderated by **Franklin Apfel, World Health Communication Associates**, and **Ilona Kickbusch, Director, Global Health Programme, Graduate Institute, Geneva, Switzerland**.

Christina Iniesta Blasco, Health Delegate, Barcelona, Spain stated that local governments have three priorities: (1) to ensure people's well-being; (2) to promote economic and social progress; and (3) to improve hope and trust (as a consequence of the economic crisis). The city has developed a four-year action plan on health policy, focused on people, public health, health in all policies and research and innovation. The policy takes into account the perceived needs of citizens, through district-level consultation, with the involvement of politicians from all sectors. Careful thought has been given on how best to communicate with sectors and the public to improve the health literacy of the population.

Birgitta Södertun, Deputy Governor, Skåne Region, Sweden said that Skåne is one of 21 counties in Sweden. The Region comprises 33 municipalities that share a common public health strategy. Health 2020 will be an important foundation to the new public health strategy, with a view to raising the profile of health in all governments in the Region. The strategy will focus on the particular problems Skåne faces – smoking and cancer. Citizens in the Region have the highest incidence of cancer in Sweden. The strategy makes social investment, with a focus on children and youth. The government needs to play a role in reducing the effects of poor lifestyles, with a focus on better environments for healthy choices. The Region will introduce measures to promote strong families and policies to increase employment and strengthen communities.

Oleg Kuvshinnikov, Governor, Vologda Region, Russian Federation stated that Health 2020 is a priority for the Russian Federation, and that it will be impossible to implement without the involvement of municipalities. The Russian Association of Healthy Cities, Districts and Settlements has developed an implementation model and has presented it within a government commission chaired by the Prime Minister. This model, based on healthy cities' intersectoral approaches, was approved for implementation across the Russian Federation. The responsibility

for implementation will be given to the governors of the country's 83 federal administrative regions, which will work with their constituent municipalities. Municipalities are perceived as "health-saving spaces".

Aziz Kocaoglu, Mayor, Izmir, Turkey stated that there is nothing more important than health and that local authorities play a key role through their responsibilities for education and the environment. Izmir is proud to be a leader in health and environmental services. It provides a wide range of preventive and health care services, which are accessible to all and extended to provincial areas. The city has been recognized with international awards for its work on the environment, which ranges from purifying seawater to establishing a national park. The city has set up mental health programmes and promoted educational opportunities for students from lower-income backgrounds.

Furio Honsell, Mayor, Udine, Italy stated that health and sustainability are two faces of the same coin and they are already on the political agenda in Udine. He said that health is on his checklist whenever he makes a decision. In his view, investing in health promotes job creation and is high on people's list of concerns. The public is aware of the need for health measures. The city can provide examples of experience related to accessibility, including the Roma population, active living, urban gardens and responding to dementia. The issue of Roma inclusion provided a good example of how healthy cities could help leaders make decisions on difficult topics by framing issues in terms of equity. Taking part in transnational projects has also been an asset in taking on new approaches. He felt that many policies are fragmented and that the health in all policies approach will make policies more efficient. He also saw a division between elected politicians and administrators, whereby the politicians indicated the policy direction and professional staff took responsibility for implementation. He appreciated healthy cities and the Health 2020 framework as good mechanisms to bridge this gap.

Marianne Klicka, President of the Vienna Provincial Parliament, Austria stated that the population of Vienna is at 1.8 million, having increases by 10% in the previous 10 years. The city benefits from a modern public health system with services accessible to all. Vienna emphasizes creating good environments, access to recreation and culture, social services, housing, employment opportunities and access to nursery schools. The city provides affordable public transport and has been building more cycle lanes. The city is working with 12 health targets that are in accordance with Health 2020 and health in all policies. Considerable work is being done to integrate people into the labour market.

6.2. Politicians' dialogue sessions

During parallel sessions, mayors and other local politicians addressed issues of leadership for health, as outlined in the presentation by Ilona Kickbusch (see section 4.1).

The discussions clearly showed that healthy city politicians have a strong value base and that the individual politicians are personally committed to healthy cities. They feel that healthy cities as a concept is understandable, valuable and useful as a vehicle for gaining broad local support for intersectoral collaboration. Politicians cited concrete examples of how healthy cities contribute to work on social care, developing public-private partnerships and redirecting larger shares of the municipal budget to public health.

The politicians discussed the challenges of the European economic downturn. In this context, cities have a more important role to act as health champions and to inform the public. Participants warned that “hazard merchants”, such as the tobacco industry, are more active in such a period. City leadership is needed to address many social conditions arising from increased unemployment and poverty, including the rise in suicide rates. One city, Udine, saw promoting healthy city and public health initiatives as a means of creating jobs. Other cities said that healthy cities offer an approach enabling cities to set priorities and pool resources, thereby optimizing the use of limited resources.

It was acknowledged that there are multiple levels of negotiation and that healthy cities require more than one local champion. Politicians want more space for exchange between themselves at healthy city events to strengthen their leadership skills. Politicians want to see the development of practical tools for their professional and technical staff.

7. Innovative approaches to building resilient communities

Adnan Akyarli, Councillor, Municipality of Izmir chaired this session on community resilience. This session defined community resilience and shed light on how to work with this concept at the community and individual levels. Subsequent presentations focused on reducing inequalities in health at the city level and creating mechanisms at the country level to enable local healthy city action.

7.1. Innovative approaches to building resilience

Nina Mguni, Senior Associate, Young Foundation, United Kingdom

The aspiration behind community resilience is to understand how the links between resilience and well-being could sharpen the focus on the protective factors that help communities cope in the face of adversity. The challenge is to understand resilience in a meaningful way. This means asking what the terms community, resilience and community resilience mean and what the main challenges are to innovation.

Community resilience should be understood in terms of the everyday challenges society faces, such as unemployment and ageing, rather than in terms of one-off high-profile events. The speaker defined a resilient community as “one that has a collectively held belief in their ability to adapt and thrive despite adversity.”

One must understand the cultural, political, financial and resources within the community. Rather than look at communities in terms of what they lack, one must also assess their assets. Resilience must be thought of as more than survival. It is recognized that tightly knit communities may be exclusive rather than inclusive, reinforcing negative social norms. Therefore, one should promote adaptive resilience, which is the ability of a community to reach out and create bridges to draw in resources.

The Young Foundation has developed a tool called the well-being resilience measure, which has helped to identify areas of high and low resilience in cities. For example, the tool has demonstrated that some areas have high levels of well-being but low levels of resilience. This suggested that these communities were vulnerable to shocks. Similarly, areas with low levels of

well-being but high levels of resilience indicated assets that could be mobilized within the community.

Emotional resilience interventions are those that raise the resilience of individuals. These interventions are positive activities that give individuals mental coping strategies and build social networks and capital. Emotional resilience is something that can be taught. Teachers, volunteers and frontline staff were involved in such interventions to strengthen the capacity of society to help individuals, for example, within job centres and health services.

An example of an intervention targeting older, unemployed men was described. It was recognized that being unemployed led to mental health problems. The goal was to improve these men's social networks and increase their access to services and involvement in local activities. The intervention was designed to be responsive to the services they were comfortable with and likely to use.

The challenge of increasing resilience in the community was multifold:

- making soft information credible;
- developing new ways of understanding what is happening in communities (identifying community assets and not only deficits or liabilities);
- developing a framework or structure to support communities, to enable local community leaders to respond to change and to help them adapt according to a set of agreed terms of engagement;
- identifying organic and immediate responses with local leaders and to ensure that networks and practices are sustainable; and
- understanding where best practice lies, how to pilot interventions and how to broaden their scope.

7.2. Addressing social determinants of health in Malmö

Marianne Dock, Architect, City Planning Office, City of Malmö and Head of the Swedish Subgroup on Healthy Urban Environment and Design

The City of Malmö has identified problems in terms of a widening income gap and variable levels of health and mortality across the city. It has a large immigrant community speaking 174 languages. Compared with the national average, Malmö has high levels of child poverty. There are increasing gaps within the city on education, poverty, employment and life expectancy.

The City established the Malmö Commission, which was inspired by the WHO Commission on Social Determinants of Health. The goal of this Commission was to collect and analyse evidence to inform strategies to reduce health inequalities. The Commission involved 2000 people for 2 years from the City and university in 32 scientific reports, seminars and workshops.

The final report was produced in March 2013 and included 24 goals and 72 measures. The report was expected to be implemented in November, but the process of producing the report had already made a big impact locally through awareness-raising and partnership-building. For example, there had already been cooperation on issues such as long-term social effects and how to finance them, community resilience and urban safety. The report's action areas included the living conditions of children and young people, the living environment and urban planning,

education, income and employment, health services, changes in social processes and sustainable development.

The report has two overarching recommendations: to establish a social investment perspective to policies and, following Health 2020, to change processes through governance and shared knowledge. Focus areas are the conditions under which children grow up, democracy and influence in society and economic and social conditions. Changes in local processes include building alliances with scientific institutions, creating holistic instruments for governance, new directions for leadership and creating an infrastructure for knowledge.

Changes had already taken place before the report was formally adopted. The City had investigated new ways to measure sustainability and models for different departments to measure socioeconomic change.

Resources will be made available on the Swedish Healthy Cities website in English (<http://healthycities.se/in-english>).

7.3. Healthy cities in the Russian Federation – a major road to public health

Tatyana Shestakova, Cherepovets, Russian Federation & Russian Association of Healthy Cities, Districts and Settlements

The Russian Association of Healthy Cities, Districts and Settlements already has a 17-year history in the country. It has been recently founded as a legal body with the support of leading Russian politicians. The Association has received direct support from the Minister of Health, who proposed that the healthy cities model be disseminated nationally as an effective mechanism for implementing health policy. The Association will serve as a platform for implementing new strategies based on a social model of health through integrated regional policies. With regard to the implementation of Health 2020, the Association will accumulate methodological experience, develop case studies and a library of best practices and provide a governance model and a system for monitoring health changes.

The healthy cities model, through its intersectoral approaches, is expected to bring efficiency between levels of government and help to overcome municipal financial constraints. Healthy cities will serve as a platform for engaging a wide range of partners regionally. In this context, municipalities will be better supported by the regional level and gain from international recommendations, policy models as well as the national and local expertise of nongovernmental organizations, government commissions and the scientific community. The model allows each municipality to identify its most important areas for action.

8. Discussions on Phase VI: coordinators' meetings and panel debate

Joint and separate meetings were held for coordinators of member cities of the WHO European Healthy Cities Network and national healthy cities networks accredited by WHO. The key outcomes of these meetings were reported in plenary, followed by a panel debate.

8.1. City coordinators' meetings

Iwona Iwanicka, Healthy City Coordinator, Łódź, Poland, provided feedback from the city coordinators' meeting, which discussed the Phase VI content and application process and other key issues.

8.1.1. Phase VI application

Cities identified several areas for clarification and support on the Phase VI application process.

- Cities need guidance on how to carry out the Health 2020 analysis, a requirement of the application process.
- The deadline for the letters expressing interest is too early for some cities.
- The cities want to know the criteria by which WHO will decide whether a city will be admitted to the WHO European Healthy Cities Network in Phase VI.
- It is unclear when the financial contribution has to be paid within the application process.
- Country quotas pose a problem, especially in smaller countries, which have many keen cities.
- Cities want clarification on the assessment process, including who will carry it out and the time frame for final decisions.

8.1.2. Sustaining and re-energizing the WHO European Healthy Cities Network

Phase VI will offer new goals and aims and require cities to achieve higher standards. The cities thought that there should be more communication with experts, stronger involvement of communities and nongovernmental organizations, more thematic cooperation and a more visible contribution from WHO.

8.1.3. Key strengths cities will take from Phase V to Phase VI

Cities will take their existing knowledge into Phase VI. Subnetworking was important for generating knowledge in Phase V, as well as regional cooperation. Local steering committees and partnerships were assets and provided stability. Existing strategic approaches and supportive policy frameworks and documentation promoted further action.

8.1.4. What do cities need from politicians?

Cities need more financial resources along with stronger political commitment. Support is still needed for fundamental aspects of healthy cities, such as intersectoral cooperation. Politicians should influence their peers to support and promote the implementation of healthy cities. They should trust and give freedom to coordinators and show openness to new ideas, tools and working methods. They should develop a stronger identification with healthy cities.

8.1.5. What do you expect to be different in Phase VI?

Cities expect deeper involvement from politicians and better intersectoral cooperation. They expect to further develop their capacity for health diplomacy.

Cities suggest that leadership training is needed for both coordinators and politicians.

At the European level, better cooperation is needed between the Healthy Cities networks and other networks working in similar thematic areas.

Coordinators want future meetings to offer better possibilities for communication and discussion between coordinators. The type of hall or room in which discussions are held, as well as the group size, influence the level and quality of exchange.

8.2. National network coordinators' meeting

Kerstin Månsson, Coordinator, Swedish Healthy Cities Network

National network coordinators feel that Healthy Cities will experience its “moment of truth”. The networks feel that there has never been such a good framework to roll out actions, with Health 2020 and the Phase VI framework driving cities forward. These documents will allow networks to align themselves with the national level in a new way. National networks are planning many activities to maintain and raise the quality of dialogue in the national arena.

Future roles for national networks might include looking for gaps between the Phase VI framework and national-level activities. National networks have the opportunity to connect the national, regional and local levels, with the local level as the entry point for action in which the broad determinants of health can be best influenced.

National networks should be more analytical and produce guidance on governance and strategic settings. National networks could support cities in carrying out the Health 2020 analysis. Networks could deliver case studies and guidance to support city work in areas in which knowledge gaps existed.

National networks have expressed a desire to be more fully involved in evaluating Phase V. Their country-level knowledge of issues facing cities will add richness to the overall evaluation, and better understanding their influence on policy development and their advocacy and lobbying roles will be useful. They advised that some of their cities should be invited to submit case studies.

National networks want WHO to review their role in the WHO process of selecting members for Phase VI in terms of how national networks could facilitate and support cities in this process.

8.3. Panel debate

Agis D. Tsouros and **Joan Devlin** moderated a discussion on the strategic and operational aspects of Phase VI of the WHO European Healthy Cities Network.

The panellists included **Karen Amlaev, Stavropol, Russian Federation; Nalan Fidan, Turkish Healthy Cities Association; Iwona Iwanicka, Łódź, Poland and Polish Healthy Cities Association; Kerstin Månsson, Swedish Healthy Cities Network; and Nina Williams, Swansea, United Kingdom.**

Phase VI will offer the opportunity to broaden and deepen the work of the WHO European Healthy Cities Network, with more evidence to support its goals than ever before. The goal of

putting health high on the policy and social agenda in cities remains a constant challenge, especially given changes in governments and political roles. Leadership training for coordinators is an important issue.

Coordinators of cities and national networks are asked to comment on various issues related to Phase VI.

Nina Williams, Healthy City Coordinator, Swansea, United Kingdom was asked as a relative newcomer to healthy cities to comment on the preparations they had made on Phase VI and on the challenges they perceive going forward. Nina Williams felt that the learning from Phase V gives a clearer focus into Phase VI. She felt that health inequity means different things to different people and that people have to be educated on the health gradient. Collaborative work is still not the norm, although it is there in rhetoric. The strategic objective should be to make healthy cities the core of work; healthy cities should not be on the outside. She felt that greater emphasis should be placed on the early years of life to reduce noncommunicable diseases over the long term. Local data are needed to change opinions and to show improvements.

Nalan Fidan, Healthy City Coordinator, Bursa and Coordinator, Turkish National Healthy Cities Association, as a representative of a more experienced city, was asked to comment on her experience of collaborative work and how she will prepare for it in Phase VI.

Nalan Fidan, with reference to work in the Turkish National Healthy Cities Association, stated that local leadership and participatory governance is very important, but more cooperation will be needed with the Ministry of Health in the new phase. This is because the municipalities are integrated into a national health plan for the first time, which gives municipalities a greater role. Mayors, in this context, need to take on a greater leadership role. Coordinators also need to take on a greater leadership role; they tend to remain constant in their positions, while political positions change frequently.

She commented that 40% of Turkey's population is covered by healthy cities. She felt that strategies must be long-term and invest in analysing the effects.

Karen Amlaev, Healthy City Coordinator, Stavropol, Russian Federation was asked to comment on leadership and the impact of Phase V. His country's 17-year history in the healthy cities movement has given cities optimism. Within the past 8 years, there have been several local parliamentary changes and 8 mayors. It has to be kept in mind that politicians do not simply want to hear problems described but to be offered solutions. Interventions have to include some short-term goals. He sees the role of healthy cities as helping communities to very clearly articulate their needs to politicians. Having good media strategies is also essential.

Iwona Iwanicka, Healthy City Coordinator, Łódź, Poland and the Polish Healthy Cities Association commented that the quality of work and commitment differs greatly between cities in the WHO European Healthy Cities Network and cities in national networks. National network cities have lost some enthusiasm. They must be challenged with higher standards to stay in the movement.

Based on the perspective in the WHO European Healthy Cities Network, she felt that the Ministry of Health needs to give more support and recognition to local healthy cities work. She hopes that ministerial involvement in Health 2020 will encourage the ministry to use the

experience of and collaborate with cities in the WHO European Healthy Cities Network and the national network.

Kerstin Månsson, Swedish Healthy Cities Network, felt the most important aspect going forward is participatory governance. The skills coordinators need to provide leadership during Phase VI should be identified and training should be organized. Coordinators need to be strategic, possess passion for change and have the capacity to deal with diverging opinions. Finally, a coordinator must embrace the fact that success requires leaving power in the hands of other people, including citizens.

8.4. Comments and feedback by WHO

Agis D. Tsouros, Director, Division of Policy and Governance for Health and Well-being and Head, Centre for Urban Health, WHO Regional Office for Europe

Making healthy cities appealing, relevant and resonant with local-level aspirations is a great communication challenge. It is important to explain that there is a legacy of continuing work on the major issues of equity, solidarity and community empowerment. The goal of putting health high on the agenda remains as important as ever. Health is far more visible and widely perceived as a common good than in the past, but this needs to be reinforced. The WHO European Healthy Cities Network needs to reframe its dialogue and do justice to its experience. Leadership training for coordinators is an important recommendation. Coordinators need to have the confidence and understanding to navigate through the Health 2020 and healthy cities concepts when reaching out to various stakeholders aiming to build bridges for change.

Agis D. Tsouros agreed that something needs to be changed to create something fresh and new for national network cities.

Agis D. Tsouros responded to issues on the Phase VI application process (sections 6.1 and 6.2). He stated that the WHO Regional Office for Europe will issue guidance on the Health 2020 analysis, which was not meant to be a detailed exercise. He said that the Health 2020 analysis will involve applying a Health 2020 lens to local work. It involves applying the two strategic objectives and the four goals of the Phase VI framework to current city practices.

It was decided that the deadline for the letters expressing interest in Phase VI will be extended to the end of March but that the other deadlines in the process will not be shifted. WHO will invite cities to formally apply after receiving their letter. This will allow WHO to invite cities to apply based on the limitations of country quotas, with the advice of national networks.

When the demand from a country exceeds its quota, WHO will look at the overall subregion. If, for example, some countries from southern Europe did not fill their country quota, the quota of other countries in the same region could be increased. This will maintain balance throughout the European Region.

One quarter of the cities in the WHO European Healthy Cities Network in Phase VI should ideally be “new” cities.

Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden will be the focal point for assessing Phase VI applications, and the WHO European Healthy Cities Secretariat in Belfast and experts in specific areas will support Elisabeth Bengtsson. The assessment process is

expected to take 2–3 months. Cities that participated in Phase V will benefit from a fast-track process, since the transition from Phase V to Phase VI will not be complicated.

Upon being invited to formally apply, cities will be asked to pay the participation fee.

9. Business session 2

This session summarized the final business matters arising from the meeting related to the Phase V evaluation and the Phase VI designation process and programme of work.

Agis D. Tsouros chaired and moderated this session. Agis D. Tsouros raised and presented all topics unless otherwise indicated.

9.1. Expanding the WHO European Healthy Cities Network and national healthy cities networks in Phase VI

Agis D. Tsouros said that priority during Phase VI will be placed on expanding the healthy cities movement to non-participating countries within the WHO European Region, comprising 53 Member States. Such a priority was greatly supported by the Health 2020 process, whereby local governments across the Region will be encouraged to take on the Health 2020 challenge. Representatives from Belarus, the Republic of Moldova and Romania attended the Conference and have confirmed that cities in their countries want to submit applications for Phase VI. There was also support to introduce healthy cities in the central Asian republics. Expanding healthy cities also involves developing new national networks. Agis D. Tsouros called on the support of experienced cities and national networks to mentor and support newcomers to healthy cities.

9.2. Feedback from evaluation circles

Seven evaluation circle sessions were held throughout the Conference, with high attendance. **Evelyne de Leeuw, Glocal Health Consultants, Australia** provided feedback.

The sessions enabled the Phase V evaluation instrument to be validated. Cities provided feedback on the logic and approach of this instrument. Following some minor revisions to the instrument and the instruction manual, it will be redistributed to city coordinators and made available online.

It was agreed that the submission deadline would be 29 November 2013. The evaluators expect to receive a minimum of 198 case studies from cities in the WHO European Healthy Cities Network.

The national networks are greatly committed to being part of the evaluation exercise and to contributing batches of local case studies. Evelyne de Leeuw stated that seeing the results of cities in national networks that committed themselves to Phase V goals would be very useful.

9.3. WHO publications released

Conference participants received hard copies of new WHO publications:

- *Health literacy – the solid facts* (<http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health/publications/2013/health-literacy.-the-solid-facts>);
- a special supplement of the WHO European Healthy Cities Network published by the *Journal of Urban Health*, which was also freely available online for wide dissemination by cities in the WHO European Healthy Cities Network and national networks (<http://link.springer.com/journal/11524/90/1/suppl/page/1>);
- *Implementing a Health 2020 vision: governance for health in the 21st century. Making it happen* (http://www.euro.who.int/data/assets/pdf_file/0018/215820/Implementing-a-Health-2020-Vision-Governance-for-Health-in-the-21st-Century-Eng.pdf);
- *Health 2020: a European policy framework supporting action across government and society for health and well-being* (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being> (E/R/F/D));
- *Health 2020: a European policy framework and strategy for the 21st century* (<http://www.euro.who.int/en/publications/policy-documents/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century> (E/R/F/D));
- *Review of social determinants and the health divide in the WHO European Region: executive summary* (<http://www.euro.who.int/en/publications/abstracts/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-executive-summary> (E/R)); and
- *Review of social determinants and the health divide in the WHO European Region: final report.*

9.4. Report of the general rapporteur

Leah Janss Lafond summarized the main themes, outcomes and decisions of the Conference, which are included within this report.

9.5. Advisory Committees

The constellation of both Advisory Committees are as follows:

Network of European National Healthy Cities Networks

1. Denmark – Christina Krog – nominated and re-elected to the Committee:
email: crk@kl.dk
2. Greece – Dasy Papathanassopoulou – Chairperson (new): email: dasy_pap@hotmail.com
3. Italy – Daniele Biagioni: email: daniele.biagioni@comune.modena.it
4. Russian Federation – Yulia Abrosimova: email: yulia.abrosimova@gmail.com
5. United Kingdom – Stephen Woods – nominated and re-elected to the Committee:
email: smwoods2@uclan.ac.uk

France – Zöe Heritage, outgoing member.

WHO European Healthy Cities Network

1. Brussels – Nicole Purnode: email: ville.sante@oms.irisnet.be
2. Lodz – Iwona Iwanicka: Chairperson: email: i.iwanicka@uml.lodz.pl
3. Maija Perho, Turku: email: maija.perho@elisanet.fi
4. Karen Amleav – Stavropol: email: kum672002@mail.ru
5. Judy Kurth – Stoke-on-Trent: email: Judy.kurth@stoke.gov.uk
6. Ursula Huebel – Vienna: email: ursula.huebel@wig.or.at

9.6. Organization of the 2014 open Healthy Cities conference

The 2014 Healthy Cities conference will be an open event. It will create a platform for European healthy cities to inspire new cities, disseminate outcomes from Phase V and engage a global audience. Cities are invited to use the criteria and terms of reference for organizing an annual event, which are already available online, to submit a dossier with proposals for organizing this event. The conference will take place over four days in September or October 2014 for about 800–1000 participants. Additional information is available from the WHO Regional Office for Europe and the WHO European Healthy Cities Secretariat in Belfast. Cities are encouraged to contact the organizers of the previous open conferences (Belfast in 2003 and Zagreb in 2008) for advice.

9.7. A Healthy Cities summit

As a result of discussions in Izmir, it was decided that the time has come to organize an event for mayors. This Healthy Cities summit will take place at the start of Phase VI and offer an in-depth engagement of politicians on the goals of Phase VI and Health 2020.

10. Parallel sessions: case study sessions, strategic workshops and teach-ins

Participants of case study sessions, strategic workshops and teach-ins were requested to report on the key issues raised in the sessions, the key issues related to the conference theme, Innovation through Leadership and Shared Governance, and on areas WHO should take forward.

The summary of the key issues identified by session rapporteurs is reported below. The reports reflected strategic and project management issues more than the content of any individual presentation. The reports varied greatly in their detail and quality. Since they focus on leadership issues, the reports contained many overlapping issues, but this demonstrated that the healthy cities working methods and leadership skills set are transferable across sectors and disciplines. The case studies demonstrated that cities take value-based, multidisciplinary approaches in health policies and programmes.

10.1. Healthy living

Five case study sessions were held on the broad theme of healthy living, covering a wide range of issues including children, physical activity and active living, ageing and food. Within each session and looking between sessions, there were many overlapping themes related to governance, project management, the use of tools and the role and impact of international experience.

For several of the cities that gave presentations in the sessions, participation in the healthy cities networks and access to international tools and experience have been important for achieving local outcomes. For example, the Israeli Healthy Cities Network relied on a WHO publication to produce planning guidelines aimed at increasing physical activity in cities. Participation of the City of Izhevsk in the WHO European Healthy Cities Network has been a factor that has led the city to take on active living, and the city has become a leader within the Russian Federation on this theme. Participation in WHO subnetworks and support from WHO collaborating centres were facilitating factors.

10.1.1. Ageing

Discussions on ageing covered several topics. Older people need to keep active and living at home as long as possible, with opportunities to socialize and to take part in health-giving day activities outside the home. Older people who remain at home tend to maintain more active lifestyles and stay healthier longer. Cities offer a range of services to promote active lifestyles. Such activities are also linked to neighbourhood-level initiatives designed to monitor the changing vulnerability of older people by creating social spaces that reduce social isolation and offer greater social protection. Cities also offer a mix of services, from cultural and social to home support. However, there is a need to recognize the limitations of family-based care and to be prepared to provide external care. Issues related to physical activity are reported below.

10.1.2. Physical activity

Case studies on physical activity have some overlap with ageing, as physical activity is so essential for preserving health to enable older people to live independently.

Physical activity is not synonymous with organized sports or gym-based recreation, and the concept of active living must be extended to families and all generations. Physical activity interventions should be varied, age-appropriate and offer gentle options for older people. The concept of active living should be integrated into city planning to enable increases in physical activity and make them a good option in the routine of daily life. Linking physical activity to culture is identified as an area for further development.

Nevertheless, gyms have their place in active living interventions. For example, in Modena, a network of gyms serves as an interface for contact between institutions and health care providers. Family doctors prescribe physical activity to patients who can undertake it safely. The City of Denizli (Turkey) makes sporting facilities freely available to the public and it has subsidized sporting equipment with health outcomes such as decreases in diabetes, reductions in muscle ache complaints and improvements related to social interaction.

10.1.3. Healthy food environments

Case studies on this topic were varied, in that they involved working across a range of settings including schools, neighbourhoods and rural and urban spaces. Interventions influence food awareness and physical health but also positively affect social cohesion and inequalities, the state of the environment, sustainability in broad terms, culture and economic poverty. Interventions include school canteen programmes, mapping exercises, active community participation and community needs assessments, supporting the modernization of local agricultural production, training for women farmers and developing urban vegetable gardens.

It is important to consider the role of surrounding rural areas and the impact of rural isolation. It is also necessary to engage with economic actors to support actions that promote access to healthier food. Ultimately, people's access to high-quality healthy food and green urban spaces greatly affects their overall health and quality of life.

10.1.4. Key issues

All sessions identified the need for effective leadership and local infrastructures, which optimize intersectoral collaboration and partnership working. Participants deemed this as being essential. All the initiatives presented in the sessions were undertaken at the strategic level, and it was noted that integrated actions require a strong sense of ownership by executive and senior-level managers. Attention should be given to continually improving these working methods. It is of key importance to be absolutely clear with key players on the aims, objectives and actions of projects from the outset. Cities think that focusing on values is a very important part of planning processes and building trust across sectors. Having continual feedback of data and progress leads to continual improvements and helps to influence decision-makers. Creating mechanisms for accountability and equity, including ways to measure good governance, is very important.

Raising public awareness by using campaigns, publicity and community events is important for many initiatives. Community participation is essential.

Investment in training for health professionals, frontline workers as well as community members is an important success factor.

The economic downturn experienced in many countries has devastating effects on the lower strata of society – especially older people and the families who support them. There is a need to understand how cities can maximize resources through intersectoral work, making resources stretch further.

10.1.5. Areas for WHO to take forward

- Advice is needed on how projects can become institutionalized in the working practices of cities to ensure their long-term sustainability.
- Concerning physical activity and active living, raising the importance of culture on that agenda would be useful to increase uptake.
- Thematic tools and guidance are welcomed across issue areas, including step-by-step guidelines.
- Fact sheets should be developed on good practice for intersectoral work.
- Organized study visits can bring together a range of professionals with the aim of developing skills and sharing knowledge.
- Guidance is needed on gaining true cooperation with the private sector.
- More should be done to cooperate with European-level organizations to harvest international best practices and expertise.

10.2. Healthy urban environments

Three case study sessions and one strategic workshop on healthy urban environments explored issues of linking action areas such as local heritage, creating accessibility for all and creating walkable environments. The concept of heritage includes the built and cultural heritage. Diverse methods for implementing healthy urban planning are being explored. Cities reviewed actions needed to support the four objectives of Health 2020 (reducing inequalities, life-course approaches, active citizenship and innovative leadership) through spatial planning.

Participants in the teach-in identified a need to think about the shape, form and function of our future cities, shaping the places for health and how people navigated between them. This requires a common vision on how to address the complexities of urban density, demography, diversity and democracy.

The case examples made use of local and European data and best practices to identify areas for intervention and the types of interventions as well as to win the support of stakeholders and decision-makers. There are examples of a broad mix of actions from education in schools to changes to the physical environment that improve safety and promote walking. This includes constructing paths and measures to improve security. Cities give priority to identifying socially excluded and inactive groups within society. Inactive groups are often living in socioeconomically deprived neighbourhoods. Some groups, in particular children, are targeted in interventions aimed at reducing accidents through a wide range of measures involving schools, education and awareness-raising and changing the physical environment. The involvement of

citizens and target groups helps cities to better understand what promotes walking and the uptake of physical activity.

10.2.1. Key issues

Healthy urban planning requires a shared vision across the city, with community involvement, because of the complexity of urban changes and issues surrounding land ownership. Low-cost interventions could make a difference and build momentum, leading to increased awareness and political support for further interventions. Designing cities for less able-bodied people could improve access to the wider population. Healthy urban planning as a tool is important for achieving health outcomes.

10.2.2. Areas for WHO to take forward

- Healthy urban planning in some cities is managed on a project-by-project basis, and cities needed support to put it back into the strategic level within the concept of good governance and leadership.
- Cities need guidance on strategic approaches for re-engineering spaces across cities.
- Healthy city coordinators, as well as politicians, need leadership training in healthy urban planning.
- Walking as a form of physical activity needs to be given greater prominence in healthy city debates and priorities.
- The role of the private sector in designing and delivering city development and its impact on health need to be better understood and managed.

10.3. Caring and supportive environments

Caring and supportive environments is a priority area within Health 2020. The WHO European Healthy Cities Network has extensive experience in community involvement, settings approaches as well as the working methods needed to assess health effects and presenting coherent solutions. Two parallel sessions focused on this theme. These addressed children and creative caring and implementing health in all policies. A teach-in on healthy urban environments, which had community resilience as a key focus, is included in this section. Unfortunately, other session reports on community resilience were unavailable.

10.3.1. Children and creative caring

Case studies on this topic focused on maternal and child health, children's mental health and factors leading to youth unemployment. A common theme in all the case studies was focusing on prevention. For example, research carried out in Swansea (Wales, United Kingdom) identified children at risk of not being in employment, education or training at the age of 16 years old. The goal was to intervene early with career advice so that all school-leavers have status and a known destination. The issue of the life cycle is very important in terms identifying crucial moments for health development early in life. The health interventions give importance to education and training but also to giving young people and parents essential life skills.

10.3.2. Community resilience

Participants of the teach-in concluded that municipalities have to identify the different types of participation that are needed to facilitate community action. More information is needed on how to engage vulnerable groups and monitor the long-term results of community involvement. A detailed case study from Rotterdam reveals how the city has taken different approaches to community participation to achieve different goals.

10.3.3. Key issues and areas for WHO to take forward

- In engaging the political level, it is important to offer interventions that show quick wins and well as long-term results.
- Time and resources need to be allocated to community involvement, with a view to testing and developing innovative approaches.
- An agenda and a set of actions for engaging communities in the ownership of healthy cities should be developed.

10.4. Health promotion and health literacy

Four case study sessions were grouped under the theme of health promotion. These sessions covered gender and human rights, improving health through local leadership, creating innovative and inclusive programmes and inequalities. This section also covers the outcomes of a strategic workshop and a teach-in on health literacy.

10.4.1. Gender and human rights

Presentations in this session covered the rights of sex service providers in Klaipeda, Lithuania and the social inclusion of the Roma population in Udine, Italy. Gaining support for the former involved a whole-of-society approach in which the direct focus was taken off sex service providers and put on the need to protect the society as a whole by preventing the spread of disease. The city gave sex service providers anonymous access to a wide range of services to remove the fear of stigma and increase uptake.

The City of Udine, Italy overcame local pressure to forcefully move a Roma settlement by setting up a local support group that engaged with the Roma community and overcame the problems that perpetuated their exclusion from society (such as not having legal status or nationality). The City developed areas for their inclusion around housing, health, work, education, legal status and training, with achievements related to child vaccination, voluntarily rehousing families within the community and enrolling children in schools.

10.4.2. Improving health leadership

Heath 2020 identifies political leadership and local intersectoral work as key elements to successfully promoting and advancing action on health and addressing inequalities. Győr, Hungary presented the initiation and process of a city health development planning involving a survey of citizens that that has developed new ideas and initiatives with intersectoral and political engagement. Kuopio, Finland presented the project Well-Being Kiosk, which aimed to provide low-threshold services focused on the needs of the citizen.

10.4.3. Inclusive programmes

Cities have developed innovative structured projects to meet the needs of local communities and vulnerable groups. The Vila Real, Portugal presentation involved several small projects with a range of partners that supported independent living for older people. Novi Sad, Serbia, presented the work of projects by nongovernmental organizations and others that were successful in applying for funding to provide health promotion to the most vulnerable groups. Most of these projects, which were based on the health needs identified in the city's policies and strategies, aimed to strengthen the health education of citizens. Çankaya, Turkey presented the Çankaya Wooden Toy Workshop project, which aimed to integrate people with disabilities into society and improve their quality of life.

10.4.4. Addressing inequalities and fostering well-being

City presentations in the case study session related to inequalities and well-being focused on reaching disadvantaged communities, making services widely accessible at the population level and reducing smoking and alcohol consumption within deprived communities. These projects undertaken in Vienna (Austria), Izmir (Turkey), Glasgow (United Kingdom) and Galway (Ireland) were underpinned by the goal to reduce inequalities by acting on social determinants of health. Schools and communities need to be involved in a whole-family approach. Discussions highlighted the importance of political involvement. Cities have benefited from the experience of adopting new working methods.

10.4.5. Health literacy

Two sessions were held on the topic of health literacy. A teach-in on the topic covered European-level research findings and approaches to health literacy, the importance of various interventions for different settings and the strengths and weakness of the current evidence base. These were covered in the new WHO publication: *Health literacy – the solid facts*. Activities of the WHO European Healthy Cities Subnetwork on Health Literacy as well as European-level projects on health literacy and ageing were reviewed.

The strategic workshop likewise covered research findings. This group emphasized the importance of stakeholder involvement in developing the information that informs health and lifestyle choices. This participation also enhances readability. The active involvement of individuals raises awareness and enhances social determinants. Health literacy interventions should be measured for their multiplier effects and outcomes. Health literacy should be a part of city health planning and linked to indicators.

10.4.6. Key issues

Local action groups and the involvement of communities on difficult issues must be managed with an incremental approach. It is important to access target groups without judgement and instead focus on the instruments needed to solve problems. All sessions emphasized that using or collecting evidence is key for winning support for initiatives, planning and involving communities. Similarly, evaluation and demonstrable results are essential. The experience of intersectoral cooperation brings benefits.

Participants involved in the health literacy sessions highlighted that health literacy is an important determinant of health, with a social gradient. Health literacy, resilience and social capital are linked.

10.4.7. Areas for WHO to move forward

- The concepts of equality and the use of a whole-of-society approach could be further explored as a tool for resolving conflict around including groups that experience exclusion and stigmatization.
- Emphasis should be placed on local evaluation and developing and using evidence.
- The WHO European Healthy Cities Subnetwork on Health Literacy should be strengthened.
- The WHO European Healthy Cities Network should consider adapting the European Health Literacy Survey measurement tool to the local level.
- Practical support should be given to cities to carry out research on health literacy.
- Health literacy should be part of the Phase V evaluation to capture learning and knowledge gaps and create a baseline for action in Phase VI.
- Training on health literacy should be developed for national policy-makers, politicians and health professionals.

10.5. Shared governance

Four case study sessions were specifically grouped under the theme of shared governance, although issues surrounding this topic were discussed widely in all sessions. The concept of shared governance is inherent and explicit in the healthy cities approach. As described in earlier sectors of this report, shared governance requires a whole-of-government and whole-of-society approach. From its outset, healthy cities has focused on such concepts with processes that have required intersectoral approaches, broad political engagement and wide community engagement. National networks enable this approach to be extended to other levels of governments and to national and, increasingly, European actors.

Topics related to this theme at this Conference focused on ageing, health in all policies, city planning and data and information tools.

10.5.1. Ageing

A teach-in and a strategic workshop on ageing were held with a focus on shared governance and leadership. Participants took stock of the variety of healthy ageing policies and interventions that exist at country and city levels. The roles and responsibilities of different levels of government and the voluntary sector were discussed. The strategic workshop reflected on WHO's joint project with the European Commission on Age-Friendly Environment in Europe and on the European healthy ageing strategy and action plan. Outcomes of the Age-Friendly Environment in Europe project will include a city guide, an evaluation and indicator package and a city toolkit with an action plan and policy advice for creating age-friendly cities. International recommendations need to be made coherent.

10.5.2. Data and information tools for equity in health

Participants in this session discussed the importance of using data and developing indicators. Data could be used to “paint the picture” by graphically presenting issues and themes of concern

locally. Participants felt that methods for collecting and using data should be reviewed, including identifying any overlapping indicators. It is essential to consider the complexities of data collection (influencing factors) for the best possible accuracy and to present data in ways that are understandable to everyone. Policy solutions should be evidence-informed, and the use of data has an important role to play in change management.

10.5.3. Health in all policies

This session included a city example from Belfast, Northern Ireland, United Kingdom and four examples of how national healthy cities networks promote health in all policies. The examples indicated the importance of using and developing evidence, training on cross-sectoral working methods for both professionals and politicians and the need to create coherence between national programmes and local responsibilities. Belfast has developed a series of case studies to support the engagement of non-health departments and other partners. The Norwegian Healthy Cities Network has run a teaching programme targeting politicians. The Finnish Healthy Cities Network has developed intersectoral working methods and good practices for cities in support of local responsibility to produce health and welfare reports. The Danish Healthy Cities Network, in support of Denmark's national agenda for health promotion, has worked to strengthen cross-sectoral work through a teaching programme and an evidence-informed tool for decision-makers. The Swedish Healthy Cities Network has developed socioeconomic models aiming to identify the costs of unemployment for the individual and for urban areas.

Participants in this session highlighted that the processes through which stakeholders are involved are very important. The earlier in the process they are involved, the more commitment they show. It is also important to gain commitment from local staff. Participants in this session noted that legislation is sometimes necessary to facilitate local action.

10.5.4. Strategic city planning

Three cities presented their city planning experiences. Denizli, Turkey, presented a process based on a range of studies that formed the basis of the Denizli Municipal Plan. This plan brought together a range of actors in the city to form a common vision and develop new solutions to common problems. Łódź, Poland presented a comprehensive approach to the Integrated Development Strategy for Łódź 2020+ based on three pillars that incorporated policies and implementation plans on key determinants of health to improve the health of city residents. Cherepovets, Russian Federation, presented the learning and results from the 10-year healthy city policy experience and the principles and approach in developing the 2022 city development strategy intended to contribute to a range of determinants of health and well-being.

Even with long-term involvement in healthy cities, real intersectoral cooperation remains a challenge.

10.5.5. Key issues

With regard to ageing, there are fragmentation and knowledge gaps in the policy advice that is promoted at the international level to cities. There is also still a lack of city guidance on what policies work. Cities need guidance on how to integrate the local work of different actors on ageing into a single framework. Some existing guidance on ageing might have lost its relevance, since the responsibilities related to healthy ageing have shifted in many countries. Country profiles should focus on organization and allocating responsibilities at different levels of government. Such profiles reveal facilitating factors and barriers to policy implementation and

promote more useful exchange between cities. Evaluation is deemed critical in future to resolve knowledge gaps, identify successful policy approaches and constantly improve the available evidence base.

As mentioned in other parts of this report, using evidence to identify the costs of inequities is essential. Establishing well-being indicators is important. Data have an essential role in influencing and supporting leaders in their decision-making. To this end, care should be given to timing the release of politically sensitive data.

The key issue with regard to planning concerned the role of the mayor, who has a vital role in determining the level of intersectoral collaboration that could be achieved.

10.5.6. Areas for WHO to take forward

- More support is needed on evaluation and indicators for work on ageing.
- Policy tools should take into account the differences in responsibilities at the local, regional and national levels in countries.
- Demonstrating the costs of not taking a health in all policies approach would be useful.
- Cities would like to have online presentations and case studies on health in all policies as a means of generating local discussions.
- Cities want WHO to support them by influencing the national level.
- Advice is needed to manage the social effects of economic austerity: for example, by mobilizing the social sector to manage the effects on the most vulnerable in society.
- WHO should provide leadership and develop a framework to integrate existing projects on ageing to enable coherent local action. This should include a clear vision and definitions of healthy ageing and how to work with the concepts of life-course, empowerment and equity.
- Indicators, linked to economic effects, should be emphasized more strongly during Phase VI. The existing healthy city indicators should be reviewed and disseminated.
- Cities need support in gaining mayoral support for intersectoral collaboration, methods for participatory governance and healthy urban planning.
- Health impact assessment screening tools should be revisited.

11. Closing session

Agis D. Tsouros chaired this session.

S. Sirri Aydogan, Vice Mayor of Izmir, Turkey, gave the Conference his reactions and closing remarks on the Conference.

He remarked that the new policy processes of Health 2020 give responsibility to the local level but noted that local governments do not always possess devolved authority to act on health policy. He stated, however, that local responsibilities provide great opportunities for cities to

influence the social and environmental determinants of health. He emphasized the importance of forming partnerships with nongovernmental organizations and civil society.

He thanked participants for their dedication to work on healthy cities and for having come to Izmir to share their experience.

Agis D. Tsouros further remarked on how deeply the cities in the WHO European Healthy Cities Network understand the determinants of health today. Although the WHO European Healthy Cities Network continues to work on a number of core issues as it did 20 years ago, the context, evidence, social landscape, partners and decision-making context differ today. The WHO European Healthy Cities Network has a high level of engagement at the city level and external national and international partners, which form the basis for Phase VI.

Agis D. Tsouros thanked the city of Izmir for their dedication and flexibility in postponing the conference. He further thanked city coordinators for their attendance.

12. Conclusions

The WHO European Healthy Cities Network and national healthy cities networks are embarking towards a new phase with the most extensive call for action and leadership ever. International experts have spelled out compelling evidence, which not only legitimizes local action but also identifies it as essential. Zsuzsanna Jakab, in her discussion of Health 2020, described Healthy Cities as “the place where the wheel hits the road”. WHO is committed to working with national governments to enable the local level.

Cities are responsible for most social determinants of health and they are best placed to identify and respond to social needs. Although cities are important economic actors that influence national development, their actions are often limited or restricted by other levels of government. Presentations at the Conference gave high priority to settings-based approaches and community involvement and called for whole-of-government approaches. National healthy cities networks are well placed to support cities by mobilizing different levels of government in support of local action.

The participation of cities in healthy cities networks and international projects helps them to gain support for new initiatives and to take on new challenges and ideas. Many cities have benefited from using international and national evidence in this and other contexts. However, local evidence needs to be produced. Using and generating data were strongly emphasized throughout the Conference. The availability of local evidence enables health champions to win support for equity-inspired interventions on the determinants of health. The processes through which evidence is collected support and help to sustain collaborative working methods and create mechanisms for joint accountability. A parallel session on the topic of data advised that the city health profiles and indicators used by healthy cities should be reviewed and updated.

Evaluation in healthy cities was more focused on project evaluation than on comprehensive evaluation at the local level. Collectively, the WHO European Healthy Cities Network possesses a rich body of experience on the priority action areas spelled out by Health 2020 and, indeed, that experience helped to develop Health 2020. However, although the international community now has the evidence that creates a strong case to take action on social determinants of health and inequalities, little written evidence exists on what constitutes successful policy

implementation. Participants in many parallel sessions called for more guidance on policy implementation and what works.

The evaluation of Phase V will seek to redress this issue. Regular annual reports have shown that healthy cities and national networks have developed a sophisticated understanding of health concepts and determinants of health. Taking a case study approach, cities will have the opportunity to describe their complex policy outcomes and initiatives. National healthy cities networks will add to this richness by demonstrating how international learning can be adapted and effectively disseminated downwards and how new initiatives can be piloted and disseminated to all levels. The evaluation of Phase V will produce the knowledge and instruments to take healthy cities into Phase VI and reinforce healthy cities' leadership on the local implementation of Health 2020.

Leadership is expected to be a defining factor in Phase VI. This echoed through plenary and parallel sessions on all topics. Expert presenters, politicians and coordinators agreed that capacity and innovation in leadership need to be built. Capacity-building is needed across all aspects of healthy cities leadership: from understanding the wider political processes that define common values and economic interests to leading multisectoral processes and engaging citizens. A balance must also be struck between technical and political leadership. Capacity needs to be built to effectively frame and communicate issues for the wide range of stakeholders healthy cities brings together as well as the public. Strongly linked to leadership, communication is a vital skill for healthy city leaders in Phase VI.

Cities have continued to enjoy strong political commitment through the WHO European Healthy Cities Network and the national healthy cities networks. Sustaining this support is a priority. The choice of interventions is important for winning political support. Successful low-cost projects with short-term, visible gains that demonstrated the value of intersectoral working methods could bring support for strategic, long-term and more resource-intensive policies and programmes. In some areas, however, such as healthy urban planning, participants said that there is too much focus on project work. Cities called for guidance in several parallel sessions on how to make effective healthy cities practices routine in the life of local government.

There was universal agreement that intersectoral collaboration and community involvement are factors for success in any healthy city initiative. Both coordinators and city politicians highly value intersectoral collaboration. To manage this collaboration well, initiatives have to be driven by the elements of good governance, which include transparency, joint accountability and community involvement. Capacity needs to be built to develop indicators and evidence that demonstrate joint responsibility for health outcomes and the causes of health inequalities. Community involvement makes interventions relevant and effective and enables local governments to identify and strengthen community assets. Local leaders and professionals need training to manage processes that resolve conflict, build trust and develop and strengthen shared values.

Politicians in particular noted that a benefit of healthy cities' intersectoral methods has been their ability to maximize resources in economically tough times. Experts at the Conference presented international evidence demonstrating that economic austerity created a call for action on health inequalities. Inaction on health inequalities has been proven to lead to high costs to society through, for example, special educational needs, substance abuse, unemployment and an increased need for health services. Capacity needs to be built to enable leaders to make economic arguments for action on social determinants of health and to be able to spell out the benefits for the whole of society.

As healthy cities move forward, they are urged to strive to build better cities and not only healthier cities. Leaders have to pull together their experience to better frame issues, build coalitions and negotiate change. They have to articulate a holistic, shared vision for the future in which people are empowered and enabled to address the major challenges of their time.