WHO European Healthy Cities Network and
Network of European National Healthy Cities Networks

Governance for health at the local level: people, citizens and assets for health

15-18 June 2011
Liège, Belgium

Report on a WHO Business and Technical Conference
Abstract

This is the report of the Third Annual Business and Technical Conference of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks in Phase V (2009–2013): Governance for health at the local level: people, citizens and assets for health, held on 15–18 June 2011 in Liège, Belgium. This event explored the current evidence, significance and relevance and interrelated issues of governance for health at the local level within the global dimension, emphasizing people, community assets, resilience, democracy, human rights and citizenship within the new social and economic landscape of the WHO European Region. The event provided the first opportunity for consultation with local governments on the new health policy for the WHO European Region – Health 2020. Following debate and comment, 322 participants from 30 European countries and 95 cities agreed on the Liège Political Statement at the conclusion of the Business Meeting. The meeting comprised 5 keynote presentations, 29 parallel and 2 subplenary sessions, 15 teach-ins, 2 politicians’ panels, 5 round-table discussions, 4 subnetwork meetings, national network and city briefings, meetings of politicians and coordinators, Health 2020 consultation discussion in 5 groups and 2 business sessions. 80 case studies were presented and discussed during the conference. Several conclusions and recommendations were made, business conducted and decisions agreed to inform the strategic direction of continued Phase V action, future technical guidance and the development of Health 2020.
## Contents

Abstract ................................................................................................................................................ ii

1. Introduction .................................................................................................................................. 5

2. Opening remarks – the context for the Conference ................................................................. 2

3. Governance for health in the 21st century ........................................................................ 2
   3.1 Political debate .......................................................................................................................... 2
   3.2 Health interests and market forces .......................................................................................... 3
   3.3 Key messages ........................................................................................................................... 3
   3.4 Conclusion ................................................................................................................................. 3

4. European Union action on health inequalities and chronic diseases in the context of the Europe 2020 strategy ........................................................................................ 4
   4.1 Europe 2020 strategy ................................................................................................................ 4
   4.2 Directorate-General for Health and Consumers ...................................................................... 4
   4.3 Key messages ........................................................................................................................... 4
   4.4 Conclusion ................................................................................................................................. 5

5. Marking the 25th anniversary of the Ottawa Charter for Health Promotion ...... 5
   5.1 First International Conference on Health Promotion ........................................................... 5
   5.2 WHO Healthy Cities project ..................................................................................................... 5
   5.3 Key messages ........................................................................................................................... 6
   5.4 Conclusion ................................................................................................................................. 6

6. Initial consultation with local government on the new European health policy – Health 2020 .................................................................................................................................... 6
   6.1 Introducing Health 2020 – a new approach to health and well-being in Europe .... 7
   6.2 Why a new policy? .................................................................................................................... 7
   6.3 Development process so far ..................................................................................................... 7
   6.4 Principles for action .................................................................................................................. 7
   6.5 Supporting studies .................................................................................................................... 8

7. Health 2020 – the social determinants of health and the health divide: what cities can do ........................................................................................................................................ 8
   7.1 Challenge ................................................................................................................................. 8
   7.2 Key message 1 .......................................................................................................................... 9
1. Introduction

The Province of Liège hosted the Third 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 15–18 June 2011. Bernard Rentier (Professor and Rector of the University of Liège) opened the meeting, warmly welcomed the participants and chaired the session. Further welcome and speeches were given by Georges Pire (Provincial Deputy in charge of Health, Quality of Life and Environment, Laboratories, Works and Foreign Affairs, Vice President of the Provincial Council of Liège, Province Santé and President of the Belgian French-speaking Network of Healthy Cities), Katty Firquet (Provincial Deputy in charge of Social Affairs, Hospitals and Regional Integration Centres), Christopher Lacroix (Provincial Deputy in charge of Budget, Finance, Non-teaching Staff, Administrative Simplification and Optimization, General Affairs and Sport), Andre Gilles (Provincial Deputy in charge of Protocol Communication and Information, Education, Training, Partnerships and Major Events and President of the Provincial Council of Liège), Valerie Levy Jurin (Chair of the French National Healthy Cities Network and Councillor for Health, Nancy, France) and Agis D. Tsouros (Head, Policy and Cross-Cutting Programmes and Regional Director’s Special Projects, WHO Regional Office for Europe).
2. Opening remarks – the context for the Conference

Agis D. Tsouros, Head, Policy and Cross-Cutting Programmes and Regional Director’s Special Projects

The Conference is taking place in a rapidly changing array of global, regional and national forces such as the economic recession, climate change, urbanization, poverty, ageing population, migration and developments in technology and communication. These are rapidly reshaping health and the social and economic landscapes of our cities and creating new opportunities and challenges in our common pursuit for health and well-being. The Conference content was developed around three main themes:

- governance for health at the local level
- people and citizens
- assets for health.

The plenary sessions were designed to report progress on both the overarching goal of health and health equity in all local policies and on the three Phase V core themes:

- caring and supportive environments
- healthy living
- healthy urban design.

The strategic nature of WHO Healthy Cities conferences and particularly the strong political presence from the participating cities and networks provides a unique opportunity to consult on the new health policy for the WHO European Region – Health 2020. The Conference was held over four days rather than the normal three days to facilitate the consultation discussion. To initiate consultation during the Conference, plenary and group discussion sessions were also organized, and two of the support studies commissioned to support consultation were presented – the European review of social determinants of health and the health divide led by Michael Marmot (1) and a study on governance for health in the 21st century led by Ilona Kickbusch (2).

A total of 332 participants from 30 countries attended, including 143 participants from 72 cities in the WHO European Healthy Cities Network, 64 healthy city coordinators and 73 politicians from both cities and national networks. A total of 65 participants were from national networks, including 20 national network coordinators. Nine observers and 4 applicant cities were present together with 17 WHO expert advisers, a representative from the Directorate General for Health and Consumers (DGSANCO) of the European Commission, a UN-HABITAT representative, 10 WHO staff members, staff of the Belfast Secretariat of the WHO European Healthy Cities Network and 9 participants from 4 WHO collaborating centres.

3. Governance for health in the 21st century

Ilona Kickbusch, Professor, Global Institute for International Studies, Geneva, Switzerland

3.1 Political debate

Ilona Kickbusch stated that health has now moved up the political agenda across the European Region and in high-income welfare states globally. Health has become vital to overall government performance at the national level, and because of this it has again moved out of the technical sphere into the centre of political and ideological debates. Increasingly, analysts cite controlling health care costs as a key purpose for broader economic stability and growth of societies, and the overall costs of certain health conditions are also increasingly discussed, including concerns about the effect on both the economy and productivity.
Examples that are heavily debated on economic or ideological grounds include: the government response to global pandemics; the extent to which governments should regulate products such as tobacco, alcohol or fast food, and government action with regard to major health inequalities (2).

### 3.2 Health interests and market forces

The importance of the debate on the freedom of markets, the responsibility of individuals, the protection of vulnerable groups and the extent of state intervention was outlined. As the chronic disease agenda expands, this conflict between health interests and market forces will increasingly shape public health policy. Six issues in particular need to be addressed, in no particular order of importance; all are occurring simultaneously, and many interface not only with one another but also with many other areas of government responsibility:

- ageing of societies
- well-being of children
- the organization and funding of health systems
- the ongoing threat of global infectious disease pandemics
- global chronic diseases and the challenge of mental health
- increasing health inequalities.

### 3.3 Key messages

Identifying the social determinants is not enough. It is important to consider how the health sector communicates with other sectors and develops health diplomacy skills. There is a need to identify who is the driver and who is the leader on major policy and action, particularly involving health ministries and other key stakeholders and working towards a whole-of-government approach.

Capacity and skills need to be enhanced on inequalities, assets, determinants of health and communication.

The complexity of health needs to be acknowledged. The challenge is to create new approaches to health governance that respond to the challenges at various structural levels and to incorporate a concern with health effects into the policy development process of all sectors and agencies. This presents a historic effort akin to the creation of the public health system and the health care system in the late 19th and early 20th centuries.

### 3.4 Conclusion

For almost three decades, the goal of the Healthy Cities movement has been to move health high on the political agenda, recognizing the importance of intersectoral action, the right to health and citizen participation in decision-making.

Healthy cities have practiced good governance from the outset, developing social and political innovation and putting evidence-informed policy into effective action.

The WHO European Healthy Cities Network is uniquely placed to champion this forward and outward-looking whole-system approach, recognizing the requirement for consistent, continuous evaluation and review, new approaches to citizen participation and using evidence in new ways to support whole-of-government policy and action.
4. European Union action on health inequalities and chronic diseases in the context of the Europe 2020 strategy
Charles Price, Directorate-General for Health and Consumers, European Commission

4.1 Europe 2020 strategy
Europe 2020 follows on from the Lisbon Strategy 2000–2010 (3), which sets out to create “the most competitive and dynamic knowledge-based economy” in the world. It also aims to address some of its predecessor’s shortcomings. In order to meet the headline targets, smart growth, sustainable growth and inclusive growth, the European Commission has proposed a Europe 2020 Agenda (4) consisting of seven flagship initiatives. Implementing these initiatives is a shared priority, and action will be required at all levels: by EU-level organizations, countries and local and regional authorities.

4.2 Directorate-General for Health and Consumers
The Directorate-General for Health and Consumers is responsible for integrating health policy principles and objectives within the overarching policy and has forged a new partnership with WHO to ensure synergy with:

• the EU health strategy 2008–2013 (5);
• Europe 2020 in general, health priorities within the Europe 2020 flagships, the post-2013 cohesion policy (6);
• Health 2020 (7).

4.3 Key messages
At the EU level, healthy life-years are not increasing in line with life expectancy. This burden of ill health is largely due to chronic illness problems in the working population, mainly due to noncommunicable diseases: mental disorders, coronary heart disease and cancer, much of which is preventable. Health is therefore wealth, and the headline targets will not be achieved without specific and renewed action for improving health.

Europe 2020 is an economic strategy but has a strong social dimension incorporating health policy principles.

• Principle 1 — a strategy based on shared values focusing on the recent Commission communication *Solidarity in health: reducing health inequalities in the EU* (8). Developing health system values that recognize the right to health, with meaningful citizen empowerment and patient involvement supported by health literacy action.
• Principle 2 — “health is the greatest wealth”: the economic returns from improving health, in general, are estimated to be very large (9). Whether it is an increase in life expectancy, health during early childhood, health during peak earning years or health in the twilight years, the benefits to individuals and society are strongly positive, and according to some researchers, overshadow the gains from most other types of investment.
• Principle 3 — health in all policies: health is acknowledged as a cross-cutting issue within all Commission policy. Integrated action is required at all levels – EU, national, regional and local – supported by health impact assessment to ensure effective policy and efficient implementation.
4.4 Conclusion

Health in the Europe 2020 strategy will require innovation – undertaking research and innovation on products and systems and developing sustainable financing of different aspects related to healthy ageing. This will include developing new online health services, such as telemedicine and electronic prescriptions that enable patients to manage their own care and monitor their own health (personalized medicine).

A European Innovation Partnership was adopted on 6 October 2010 under the Europe 2020 flagship initiatives. This is a novel concept of the Commission to tackle societal challenges by linking research and innovation and will be crucial to successfully integrating health into the Europe 2020 strategy. The aim of full alignment of cohesion policy to support Europe 2020 objectives in general is welcomed, in particular including specific health objectives to introduce health as a thematic priority for investment. The reduction of health inequalities will be a horizontal priority. A “beyond GDP” indicator (10) will be adopted for the allocation of structural funds with output indicators, reflecting the priorities of the health sector.

The WHO European Healthy Cities Network had a long established record of being an incubator of new ideas. We should renew our efforts and rise to the challenge with strengthened vigour, building on our past achievements.

5. Marking the 25th anniversary of the Ottawa Charter for Health Promotion

_Evelyn de Leeuw, Professor, Deakin University, Australia_

5.1 First International Conference on Health Promotion

The First International Conference on Health Promotion in 1986 (11) was primarily a response to growing expectations for a new public health movement around the world. Discussion focused on the needs in industrialized countries but took into account similar concerns in all other regions. It built on the progress made through the Declaration of Alma-Ata (12), the development of Health for All targets by the WHO Regional Office for Europe (13) and the recent debate at the World Health Assembly on intersectoral action for health.

5.2 WHO Healthy Cities project

The year 1986 also marked the birth of the WHO European Healthy Cities Network.
The WHO Healthy Cities project sought to put health high on the agenda of decision-makers through a process involving political commitment, institutional change, partnership-based city health development planning and innovative action for health.

5.3 Key messages

The values, principles and processes are as relevant today as they were 25 years ago. However, rather than becoming obsolete, the healthy cities movement needs to hold true to the past within the context of the challenging global economic and social context today and strive to be more cutting edge and innovative. We must not forget the principles and, in looking back, recognize that we do not require new road maps but new infrastructure such as governance arrangements. Recent policy approaches have drifted towards a focus on lifestyles as the easier solution to tackling societies’ ill health problems rather than the wicked issues such as how we support children in having positive self-esteem.

From the beginning, the WHO Healthy Cities set out to think globally and act locally. It is essential to now think and act both globally and locally: Although policies are complex at all levels of decision-making, lessons can be learned from tobacco industry tactics and how these tactics (their understanding of markets and consumers) are now being applied to the food industry, which has as much opportunity for adversely affecting health as tobacco has.

The private sector has always been considered an important intersectoral partner. However, we need better engagement with entrepreneurial industries and economic and social enterprises and we require smart thinking: for example, what is the economic incentive to set up enterprises in the poorest areas? How do we empower people to think about economics at the local level?

We have underestimated markets and consumerism while focusing on governance and people’s involvement, and we need to understand better what motivates people and influences their behaviour.

It is necessary to ensure a mix of policies, regulatory action, legislation and partnerships with industry and the involvement of people.

5.4 Conclusion

Developing a new economics of health and well-being is essential. Most of today’s public health challenges, including noncommunicable diseases and inequity in health, cannot be addressed effectively without intersectoral action and action at the global, national and local levels. Health actors need to understand and connect with the perspectives, value systems and agendas of a wide range of national and international actors.

6. Initial consultation with local government on the new European health policy – Health 2020

Agis D. Tsouros introduced the consultation session with the WHO European Healthy Cities Network and the national networks, and Michael Marmot stimulated discussion through a keynote presentation on Health 2020 and the social determinants of health and the health divide: what cities can do.
6.1 Introducing Health 2020 – a new approach to health and well-being in Europe
Agis D. Tsouros, WHO Regional Office for Europe

Our vision is for a WHO European Region in which all people are enabled and supported in achieving their full health potential and well-being and in which countries, individually and jointly, work towards reducing inequalities in health within region and beyond.

Health 2020 is to act as a vehicle for accelerating progress towards achieving the WHO European Region's health potential by 2020 and beyond. It is designed to help reset priorities and encourage coordinated action by policy-makers in all sectors to improve population health.

6.2 Why a new policy?
The time is right for a new policy framework for the European Region. Although health is improving it is not improving as rapidly as it should be, given the knowledge and technological capacity available. Inequalities are increasing, and the growing evidence on the determinants of health is crucial but not sufficient to change how societies meet needs. Health systems are characterized by uncertainty and complexity rather than clearly delineated areas of functional responsibility. Most of today’s major health challenges, including noncommunicable diseases and inequalities in health, cannot be addressed effectively without intersectoral action at all levels.

6.3 Development process so far
A two-year development plan has been established including the development of a policy framework and governance for health approach to fit with the context of the 21st century, and with a 10-year horizon, gathering the best evidence of the causes of ill health and inequalities in health, public concepts and effective solutions. Engaging with countries to strengthen expertise and the capacity for addressing major policy and governance challenges together with consulting a wide range of stakeholders, decision-makers, public health professionals, civil society organizations and international agencies is an important aspect.

6.4 Principles for action
The consultation and discussion so far have affirmed several key principles for action.
- Health 2020 should be the vision and overall agenda within which all other WHO initiatives for the European Region would be framed.
- The process of developing the policy is as important as its output. The process should be participatory and transparent to allow fully shared ownership of Health 2020.
- Health 2020 should call for a whole-of-government approach with messages that speak convincingly to other sectors and address the wider government, including presidents and prime ministers.
- Many Member States are in the process of reviewing national policies, and there are many opportunities for learning from past successes and failures that should not be missed.
- Further learning from the experiences of different countries on intersectoral approaches is required.
• More needs to be invested in disease prevention now. Prevention does not only pay off in the medium and long term. It also pays off in the short term.
• European Region targets, practical and visionary, should be an integral part of Health 2020.

6.5 Supporting studies
Supporting studies have been commissioned to inform Health 2020 and include:
• governance for health in the 21st century;
• a European review of the social determinants of health and the health divide;
• the economics of disease prevention;
• research and analysis of relevant past WHO resolutions and commitments;
• experience in countries in implementing intersectoral approaches; and
• anticipatory analysis of the drivers and trends that influence health.
The first two studies were presented at the Conference and are reported below.

7. Health 2020 – the social determinants of health and the health divide: what cities can do
Michael Marmot, University College London, United Kingdom

The WHO Regional Office for Europe commissioned a review of the health divide and inequality in health in the WHO European Region from July 2010 to 2012 to inform the development of the new Health 2020 policy. The review draws on the best available evidence and will also inform and reinforce the implementation of the Tallinn Charter: Health Systems for Health and Wealth (14), the Millennium Development Goals (15) and the European Commission communication on solidarity in health (8).

7.1 Challenge
Although health has improved for many people, there is significant inequality in health across the Region, notably life expectancy differences of about 20 years for males and 12 years for females between countries with the highest and lowest levels. In countries for which data is available, health outcomes have a clear gradient according to social factors such as income, education, social position and employment—the social determinants of health and well-being. The evidence shows that key determinants in health include early-years experiences, education, employment, the quality of work, the adequacy of social protection and income and the types of places and communities where people live. Evidence also demonstrates that these inequalities in health are mostly avoidable and have significant human and economic cost.
Political empowerment, equity and human rights are also significant in relation to health and efforts to reduce inequity. Local, regional and global forces influence and impact on all these factors. The WHO European Region is diverse in terms of cultures, history and development. This provides varied experiences and contexts and means that universal policy recommendations are difficult. The lack of data in some areas presents a significant challenge in addressing inequality.
7.2 Key message 1

Unless action is taken the gap between and within countries will increase. Having described and quantified the nature and extent of the social gradient and health divide in the region, the task is determining the "right thing to do". To this end, several task groups have been set up to find examples of good practice in the European Region. These will focus on:

- early years, education and the family;
- working conditions, occupation, unemployment and migrant workers;
- disadvantaged, excluded and vulnerable groups, including vulnerable migrant workers and Roma;
- GDP, taxation, income and social welfare;
- sustainability and community;
- preventing and treating ill health;
- gender issues.

Five groups have been set up to tackle cross-cutting, generic issues:

- governance and delivery systems
- measurement and targets
- economic considerations
- equity issues
- global issues.

7.3 Key message 2

What can cities and countries do to support both the development of the final report and the implementation of the recommendations? Several cities, reflecting the diversity of the Region, would be selected from those expressing interest, to work with the review group, sharing experience and practice at the city level to inform recommendations for action. Evidence and findings from the Interim first report on social determinants of the health divide in the WHO European Region (1) demonstrate that building on the healthy cities approach and experience is necessary.

7.4 Key message 3

- Take a life-course view of policy and practice “from the womb to the end of life”, putting fairness at the heart of all policy and delivery.
- Emphasize the whole-of-society approach, reviewing and revising governance arrangements to tackle the barriers to progress towards reducing the social gradient.
- Continue to base all efforts on the founding principles of the WHO Healthy Cities project.
- Tackling the health divide and social gradient is a moral issue and the right thing to do.
- Build resilience in local communities.

7.5 Conclusion

The link between the social determinants of health and the health divide can be broken. The city of Birmingham (United Kingdom) narrowed the gap in three years by focusing on the most disadvantaged areas and population groups with the most important factors determining life expectancy.
Early childhood development is one of the most productive types of investment that is rarely viewed as economic development. Several longitudinal early childhood development studies in the United States that are based on a relatively small number of children at higher risk (risk factors including low family income, violence or neglect in the home, low parent education levels, low birth weight and parent chemical addiction) from low-income families demonstrate that the potential return is extraordinary (16). These findings, however, pose a challenge: although small-scale early childhood development programmes can work, can they be reproduced at a much larger scale? There are reasons to be sceptical, as some recent attempts at scaling up early childhood development have been disappointing. Nevertheless, it is argued that a large-scale programme can succeed if it has the following three features.

- The programme focuses on children at higher risk and encourages direct parent involvement.
- The programme represents a long-term commitment to early childhood development.
- The programme rewards successful outcomes in order to encourage high-quality and innovative practices.

### 7.6 Consultation framework

Three panel discussions comprising two political panels and a panel of experts and city representatives together with five working groups incorporating all participants were organized to consult and gather comments from city delegations.

1. A politicians’ panel to further expand the discussion on how a whole-of-government and whole-of-society approach to intersectoral action can further improve health and well-being: the unique position of and contribution by cities included:
   - Valerie Levin-Jurin, Nancy, France
   - Christine Thomas, Preston, United Kingdom
   - Furio Honsell, Udine, Italy.

2. A politicians’ panel discussion on leadership for health at the local level: putting people first – democracy, participation and community empowerment included:
   - Georges Pire, Province of Liège, Belgium
   - Oleg Kuvshinnikov, Cherepovets, Russian Federation
   - Gratis Truksnis, Jurmala, Latvia
   - Zvonimir Sostar, Zagreb, Croatia
   - Norun Ostraat Koksvik, Sandnes, Norway.

3. A panel of WHO advisers and city representatives discussed implementing a social determinants approach to health inequalities at the local level included:
   - Michael Marmot, University College London, United Kingdom
   - Anna Ritsatakis, independent consultant, Athens, Greece
   - Michael Grady, University College London, United Kingdom
   - Nicola Morrow, Healthy City Coordinator, Sunderland, United Kingdom
   - Anna Balkfors, Commission for a Socially Sustainable Malmö, Sweden

Five group discussions involving all participants in the Conference enlarged the consultation discussion. In addition, opportunities were provided to enable participants to make video or audio interview statements during the meeting. Delegates were encouraged to send additional comments through the web-based questionnaire, blog site and Twitter.
7.7 The Health 2020 approach, vision, values, goals and process – a summary of consultation comments from the panel and group discussions

7.7.1 Politicians Panels: Governance for health

Panel 1: How a whole-of-government and whole-of-society approach to intersectoral action can further improve health and well-being: the unique position of and contribution by cities

Panel 2: Leadership for health at the local level: putting people first – democracy, participation and community empowerment

Key messages

Health 2020 is an important document for local governments. The consultation requires the full involvement of local authorities to enable everyone to have a voice.

Finding common ground and language understood by all partners is essential for effective partnerships. Increasing health literacy is also essential to progress.

Citizen engagement is not enough; we need to move to meaningful empowerment. Partnerships with local people need to be strengthened and renewed based on empowerment and power-sharing, with budgets allocated accordingly. People should be central to all our thinking and action – we ignore them at our peril.

There is a need for more ‘champions for action for equity’ who are positive, enthusiastic and inspirational leaders at all levels to turn strategy into action.

All cities should have an analysis of inequalities and their causes with a clear map of the way forward. Local authorities are key to making it happen.

Public health needs a new language – the emphasis on health and well-being fits closer what local governments are about.

Promote active partnership with local governments, nongovernmental organizations, academia and the business community.

Provide specific tools to promote effective governance for health: health impact assessment, transparency, intersectoral work and accountability.

Strengthen the capacity and expertise of local governments to promote citizen participation and empowerment and the needs of vulnerable groups.

Catalyse research on health effects and sound economic analysis of various models and interventions of national support to local governments related to devolving responsibilities and authority in health and well-being.

7.7.2 Enhancing capacity: partnerships for change

Panel of experts and city representatives on implementing a social determinants approach to health inequalities at the local level
The new policy should build on the firm foundations laid by the WHO Healthy Cities but should also capture today's socio-political context in Europe and be informed by the best available evidence on solutions that work to address the public health challenges of the Region.

Health 2020 should clearly show its added value in the pursuit of health and well-being.

In most countries, disease prevention loses out to health care, and we need to advocate the economics of disease prevention and get smarter at demonstrating the cost–benefit of preventive strategies and interventions. Improving health and health equity is still a challenge even for high-income countries.

As Michael Marmot advocates, a systematic and coherent approach to the life course is needed. This focuses on the trajectories or forecasts of individuals through key life stages and how significant life events and transitions (points of significant change) affect these trajectories from womb to the end of life. At each stage of life, people experience quite dramatic changes, not only in physical appearance but also in the social, emotional aspects of interacting with others. Learning and development, how we live our lives and how we cope with adversity and the particular challenges that each transition brings can affect health and well-being positively or negatively.

Resilience needs to be built in individuals and especially in communities as a protective factor for positive health and well-being.

It is necessary to address well-being more strongly, not only focusing on the social determinants but emphasizing the psychosocial factors that powerfully influence health. Psychosocial and mental well-being is a dynamic state that refers to individuals’ ability to develop potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. There is a need to work innovatively to develop interventions that address these issues.

The European social determinants and health divide review which was launched to inform Health 2020 has a strong focus on strategies and interventions that work and which are appropriate for lower, medium and higher income countries. One important dimension of this work is to engage and learn from the experiences of local governments. A toolkit for scrutiny will be piloted.

7.7.3 Discussion groups framed their response through four key questions on Health 2020 related to contribution, resonance, added value and the commitments of healthy cities

1 Contribution – what do you believe is the unique contribution of local government?

The important interface between citizens and politicians drives policy development. The local level is often responsible for delivering policy recommendations with activities, including early preventive interventions.

Local politicians are democratically elected by local people, have direct contact and are actively involved with the citizens they represent. They also cooperate closely with NGOs.

The long experience of healthy cities working intersectorally at the local level strengthens governance and enables the effective contribution of all partners. Health 2020 should reflect this broad intersectoral responsibility.
Cities have demonstrated over time that they are adaptable and responsive to new challenges. Health 2020 can help with tools for transparency in monitoring and accountability.

The emphasis on increasing investment in health protection and disease prevention is welcomed. However, this will require interministerial and parliamentary resolutions for implementation and legislative powers and freedoms to enable effective action.

Proposals and suggestions for WHO to include in Health 2020

The crucial role of partnerships with local government; emphasize the importance of delivery at the local level.

It would be helpful to identify focal points in ministries to connect to national Healthy Cities networks and other networks in both developing and implementing Health 2020.

A specific recommendation is to commission research on the legislative base in cities, regions and countries within Europe, highlighting the likely implications for the implementation and devolution of Health 2020.

2 Resonance: given your experience in developing and implementing health development plans and working with other sectors, what are your impressions of the Health 2020 process, vision, values and content as described in the presentations and distributed materials?

Health 2020 should be substantially different than Health 21 and other documents. It should be challenging, provide a wake-up call to action and be an altogether more punchy and inspirational document.

It should have a pragmatic vision exploring and defining what type of European Region we want to see in 2020.

Health 2020 should be value driven. This is particularly important in countries in the eastern part of the European Region. It should very clearly focus on equity, social justice, governance and partnerships and have an asset-based approach.

Case studies would enable sharing of the learning and good practice examples to support implementation.

The language should be clear and understandable to everyone: for example, the word accountability is not universally used across Europe. Using words understood by all sectors is important. The text should not be too dense, with good use of visual elements, text boxes and strap lines.

3. Added value – what key elements should Health 2020 include to address the challenges that healthy cities experience in implementing a whole-of-government approach?

Health 2020 should be the cornerstone policy for cities and national networks and all levels of governance, local to global. We need to look back whilst moving forward in the new economic and social context today.
Healthy cities continue to maintain that the process is as important as the product. Experience has developed over the years of intersectoral working, community participation, action on equity, utilizing technical expertise, developing tools and techniques to support implementation, sharing knowledge, being an incubator for new ideas has influenced health development at all levels from the community to globally. We need renewed effort and vigour to continue and enhance these processes through Health 2020.

Health 2020 should promote vigorous awareness of the determinants of health and of intersectoral responsibility at the national level, ensuring support for local-level delivery of appropriate interventions. It should include specific goals on “improving environments with a socioecological approach”.

Partnerships with academia, business and various sectors such as entrepreneurial, education, planning and security should be promoted.

Practical examples of tools and techniques developed through the WHO European Healthy Cities Network such as partnership-based city health development planning, health profiles and health impact assessment should be included.

The strong foundations and experience of healthy cities validate and legitimize working across sectors at the national level – use the healthy cities as test sites for implementation.

7.4 Commitments – In what ways do you see your city engaging in the Health 2020 development process?

National networks and healthy cities are uniquely placed to be advocates and ambassadors for Health 2020.

The WHO European Healthy Cities Network is a powerful movement with a powerful voice. It is important that the knowledge in the Network be published and promoted to assist the transfer of experience and support others to engage in the necessary action to deliver Health 2020.

The strategy provides an important instrument to promote Health 2020 goals with other institutions such as universities.

Health 2020 consultation events provide an important opportunity to inform lead politicians, the scientific world and other potential new partners of past healthy city experience, skills, capacity and knowledge.

The use of local data and case studies will outline past achievements, barriers to success and provide opportunities to encourage future development within the context of local priorities while ensuring synergy with the vision, values and goals of Health 2020.

8. Round tables

Round table discussions were held in plenary and also parallel sessions on the topics of (1) a whole-of-society approach, (2) Roma people and (3) all about people.
8.1 A whole-of-society approach (parallel session)

This round table sought to discuss the rationale for a whole-of-society approach with political insight from experienced Healthy Cities political representatives:

- Franklin Apfel, World Communication Associates, Somerset, United Kingdom; and
- Ilona Kickbusch, Professor, Global Institute for International Studies, Geneva, Switzerland.

Political debates took place with:
- Bulent Tanik, Çankaya, Turkey;
- Ron Gould, Liverpool, United Kingdom; and
- Marianne Klicker, Vienna, Austria.

Speakers outlined the specific challenges each face within their own cities. This included the context commonly found within the member cities of the WHO European Healthy Cities Network of two aspects to cities: populations experiencing poverty and deprivation and populations that are more affluent. A particular concern for some cities is how to provide for those with the greatest need and how health can be improved when much of the population is not covered by health insurance or a welfare system. The problems of conflict are not conducive to effective governance systems.

The process of involving intersectoral partners in city health development planning proved to be very effective. Involving civil society in particular and working together on their concerns enables local people to take control of improving their own neighbourhoods.

The value of political leadership was illustrated through the use of effective communication, and by informing and by listening to the community. This creates ownership and acceptability of outcomes by all sides concerned. At the national level, the determination from one city to seek support for a private members bill to ban smoking in the workplace spread like wildfire across the North West region of the United Kingdom and then nationally to effect a successful change in the law endorsed by the whole of government. Communication is a determinant of health.

Key messages

Communication has changed dramatically in the past decade. Two thirds of people globally own mobile phones. In the United Kingdom, more people vote electronically and by phone on a reality TV programme Big Brother than vote in local and national elections in the United Kingdom.

There is a need to change the way we operate in terms of governance, ensuring two-way communication to understand better how people perceive issues and shift from a paternalistic approach using creative and innovative means of communication. There has been a major shift in WHO underlying a whole-of-society approach, which will enable communication with many different stakeholders.

The whole of society is an unstructured framework. The Healthy Cities project has traditionally been both technical and political, focusing on people. The Healthy Cities project was established on a whole-of-society approach. As health becomes more important politically, politicians will give higher priority to it. Citizen engagement has always been central to the approach. Healthy cities always operate better within the umbrella of supportive national government policies. Local authorities have less ability to act in certain areas On the other hand they can also influence national policy upwards.
We need to learn from the political manoeuvring in the 19th-century sanitary era of public health, which brought such dramatic change to life expectancy, and identify the levers for change such as economic development. Transparency in the whole of society is ever more important. Leadership for healthy cities needs to move from control to inspiration. Citizen engagement has always been central. Does the right to health legitimize the whole-of-society approach? There are many new examples of engaging people at all levels, but where is the learning from the past and why the drift towards lifestyles and emphasis on noncommunicable diseases? We need to push where things are happening, have courage in the face of vested interests and learn from the past.

8.2 Improving Roma health by addressing the social exclusion process at the local level (parallel session)

This round table sought to discuss social exclusion in the Roma population and how it might be tackled to improve health and well-being, with three presentations to facilitate discussion:

- presentation on social exclusion processes at the local level, Jennie Popay, Professor, Lancaster University, United Kingdom;
- presentation on social exclusion and Roma women’s health, Sebihana Skenderovska, Programme Coordinator for Women and Youth, Kumanova, the former Yugoslav Republic of Macedonia; and
- presentation on social exclusion and Roma health in Sweden, Leena Eklund, Senior Lecturer, University West in Sweden, Trollhättan, Sweden.

A complex set of disadvantage face Roma people including racism, poverty, exclusion and oppression. Exclusionary social, cultural and economic processes exacerbate and compound unequal exclusion. One example of a particular barrier illustrated that, although Roma children had been given free bus passes for travel to school, they arrived at the bus muddy and wet and the driver would not allow them to board and they had to return home. Some people inferred that, since they were then at home, their parents did not care about education. All three presentations identified similar issues related to exclusion and that access to education was a significant barrier to social and economic inclusion and also to accessing health and care services. In the former Yugoslav Republic of Macedonia, 51% of Roma women have never been to school, and most live in rural areas or in ghettos; 44% of their children never finish school. The gap in life expectancy between Roma people and the general population is 10 years.

In Sweden, the problem has been analysed, and the findings identify racism, powerlessness and poor health with structural racism in society denying access to social and economic rights. Participatory research methods involved and empowered Roma people to build their own capacity through training and subsequent training future trainers has built capacity in the community.

Key messages
- Effective policies are required to address exclusion, but implementing the policies requires political realism and political will.
- Accurate and disaggregated data is also required to allow benchmarking of progress towards inclusion.
- There is a need to build an infrastructure for inclusion – the example from Sweden could be transferred to any other country.
- All three presentations described systemic problems that require systemic solutions.
8.3 All about people (plenary session)

This round table sought to demonstrate how better health in the European Region can be achieved by ensuring that people are at the centre of all planning and decision-making on issues that affect their everyday lives and that communications are appropriate and inclusive.

There were presentations by:

- Hugh Barton, Professor, WHO Collaborating Centre for Healthy Urban Environments, Institute of Sustainability, Health and Environment, University of the West of England, Bristol, United Kingdom;
- Maged N. Kamel Boulos, Associate Professor in Health Informatics, Faculty of Health, University of Plymouth, United Kingdom;
- Robert Manchin, Chairman and Managing Director, the Gallup Organisation Europe, Brussels, Belgium; and

8.3.1 Spatial planning as if people mattered

Hugh Barton, Professor, WHO Collaborating Centre for Healthy Urban Environments, Institute of Sustainability, Health and Environment, University of the West of England, Bristol, United Kingdom

Two thirds of the population of the European Region lives in towns and cities. Urban areas are often unhealthy places to live, characterized by heavy road traffic, pollution, noise, violence and social isolation for older people and young families. People in towns and cities experience increased rates of noncommunicable diseases, injuries and alcohol and substance abuse, with people with low income typically exposed to the worst environments. However, there are ways to tackle these challenges.

- **The environment and physical activity**

  Accessibility to local goods and services strongly affect the levels of active travel (walking and cycling) and outdoor recreational activity. Access to green, natural environments and to local social networks are factors in mental well-being.

- **Planning**

  The wider subregional pattern of housing, economic development, land use and transport is a determinant of social exclusion and therefore health inequalities. It also affects health-damaging pollution, adaptability in the face of climate change and the level of carbon dioxide emissions.

**Key message**

We have literally been building unhealthy conditions into many towns and cities. But comparisons with the best cities in Europe indicate that the less desirable trends can be reversed. Planners should be seen as “settlement doctors” who diagnose the potential health-damaging effects of place shaping and prescribe remedial solution advice to politicians and policy-makers.

Success depends, however, on more radical policies of local authority control over land and finance than any political party has yet advocated. It also requires collaboration between the full range of powerful public and private organizations that influence the built environment.
8.3.2 How social media and sociable tools are affecting how people interact and make decisions on matters that relate to their health and well-being

Maged N. Kamel Boulos, Associate Professor in Health Informatics, Faculty of Health, University of Plymouth, United Kingdom

New technologies and communication

New technologies such as social media and sociable tools are affecting how people communicate, interact and make decisions. The latest generation of smart phones are increasingly being seen as hand-held computers rather than phones, because of their powerful computing capability, capacious memories, large screens and open operating systems that encourage the development of applications. Health-related applications (apps) in current use target both the public, patients and health professionals related, for example, to health, fitness and lifestyle education, chronic disease management; supported living; continuing professional education tools; and public health surveillance.

Key message

It has been stated in the past that those of us involved in the Healthy Cities should be “healthy virus vectors”, infecting others with our principles and processes for action. New technology uses the term viral marketing, referring to a social web strategy that circulates messages from person to person, and an amusing demonstration of the Nativity on YouTube clearly indicated the potential benefit of this technique.

Young people widely use Twitter and Facebook as their main form of communication. The wisdom of the crowds could be used to circulate health information.

Google Earth has the potential benefit of supporting healthy place shaping for people. Examples currently in use by the National Health Service (NHS) in the United Kingdom:
- self-help support – “patients like me”
- patients can vote and rate their health system – “United Kingdom patient opinions”
- NHS direct offer mobile apps
- NHS armchair project.

Key message – equity and barriers to participation

Cost is a consideration; some technologies are complicated and may not be very user friendly for older age groups. Network accessibility is a further consideration. Using electronic communication requires a moderately high level of functional health literacy; if this is not present, it will be a significant barrier and an equity issue.

8.3.3 Measuring well-being and health perception

Robert Manchin, Chair and Managing Director, Gallup Organization Europe, Brussels, Belgium

The Gallup Organization (www.gallup.com) was set up 75 years ago during the Great Depression, when George Gallup launched the measurement of economy. During the 1960s, the social indicator movement led to the development of quality of life indicators. In 1971, Gallup participated in preparing the Eurobarometer. Also that year, together with friends, Gallup launched a 70-country global poll on “man’s material and psychological well-being”. In 2005, Gallup started an ongoing project of a yearly survey of more than 150 countries and states and shares the data with a group of senior scientists for analysis. In 2010, a not-for-profit Institute of Behavioural studies was set up to expand research into the application of behavioural economics and measures of well-being.
Beyond GDP. Gallup is involved in the debate at the EU level to determine a “beyond GDP” indicator. GDP is seen as a rather crude measure of assessing economic performance at the country, regional and subregional levels. Finding a more appropriate indicator has gained support during this time of economic crisis and uncertainty.

Measuring well-being and the future. There are many dimensions to well-being, emotional, social, physical and mental capital, and the survey instrument is revised regularly as a result of research and development. The Europe 2010 Gallup survey comprised Well-being Index measures including career, social, financial, physical and community aspects. Current debate questions include whether money can buy happiness and whether measures of use of time, quality of life experiences, flow and creativity are to be included in future surveys.

Key message
There is significant diversity across the European Region, with great differences in life evaluation across the Region, especially with respect to life satisfaction and happiness. Self-reported happiness and life satisfaction are higher in Scandinavian countries in particular and in countries in western, central and southern Europe compared with those in the eastern part of the region, which is catching up. Meanwhile France, Greece and Portugal are at the lower end of the distribution across the other areas of the region. The least happy countries are Ukraine and the Russian Federation.

Conclusion
Further consideration will be given to the measures within the survey instrument, particularly country-specific and cultural factors.

8.3.4 Urban development challenges; the perspective of the United Nations Human Settlements Programme

Mohamed Halfani, United Nations Human Settlements Programme

Cities are about people
WHO and the United Nations Human Settlements Programme (UN-HABITAT) published *Hidden cities: unmasking and overcoming health inequalities in urban settings* (17) and launched it in Kobe, Japan on 7 November 2010. This will enable city leaders and urban planners to identify deprived populations and target measures to improve their health. The report shows how ill health is linked to poverty in cities and not just among the poorest urban populations. It calls for policy-makers to take action targeting health inequalities. The report is based on a new analysis that looks beyond city averages and beyond the usual information from cities and towns to identify hidden pockets of ill health and social deprivation.

To better understand the causes of poor health, the report focuses on several factors, including population dynamics, urban governance, the natural and built environment, the social and economic environment and access to services and health emergency management and notes that, unless urgent action is taken to address urban health inequalities, countries will not achieve the health-related Millennium Development Goals.

A key finding of the report is the environmental burden of disease associated with inadequate housing. It provides evidence that inadequate housing has substantial health effects. Improving housing in a way that removes or minimizes the negative effects on health and safety and promotes a healthier living environment is good for the residents and benefits society. Reducing the burden of responding to the demands on the health system attributable
to inadequate housing is an obvious public health priority but also something that makes economic sense.

**Key message**
The findings set out in the full report provide ample justification for the principle that health should be at the centre of housing policy. Making housing healthy, affordable and sustainable should be a prime objective of all professionals and policy-makers involved in any aspect of housing and of health, and people should be at the centre of all systems of governance.

**Conclusion**
The challenges set out in the *Hidden cities* WHO report are relevant to the European Region. By 2020, about 80% of the Region will be urbanized, with increasing needs in an increased diversity in the Region. This poses significant challenges for the urban environment, social and economic conditions, inclusion, food security and food safety and increases the demand on health systems as a result of the burden of ill health related to noncommunicable diseases.

9. **Subplenary sessions**

9.1 **Why the emphasis on well-being and the assets for health approach?**
The purpose of this session was to discuss the benefits of changing the emphasis from a needs-led deficit model of health to a focus on the contribution of the assets of communities, individuals and institutions in creating positive health and well-being.

*Moderator: Franklin Apfel, World Health Communications Associates, Somerset, United Kingdom*

*The debate was led by Ilona Kickbusch, Professor, Global Institute for International Studies, Geneva, Switzerland and Erio Ziglio, WHO European Office for Investment in Health and Development, Venice, Italy*

A health asset can be defined as any factor or resource that enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family, community or institution as protective and promoting factors to buffer against life’s stresses. Understanding the assets available in a community enables a positive approach to strengthening communities, supports community involvement and engages people in their own health through participation and community empowerment processes.

9.2 **Social exclusion, disadvantage, vulnerability and health: the local context**

Discrimination, disadvantage and social exclusion are interrelated causes of significant inequalities. In order to create a socially cohesive society, both individuals and communities need to feel that they can participate fully in society and be treated as equals. Where this does not happen, people may feel alienation, disengagement, discrimination and disadvantage. Sometimes this can lead to generations of people living on the margins of society. The right to health is central to the healthy city approach and community engagement and involvement the means to acknowledge this. Communities have the lived experience of their everyday lives.
**Key message**

It is necessary to shift our thinking from the needs assessment deficit model to an asset-based approach, and to do this, we also need to shift from community engagement and involvement to meaningful community empowerment. Approaches that help communities to work as equal partners (co-production) or that delegate some power to them or enable them to take total control may lead to more positive health outcomes.

**10. Parallel sessions**

The major themes of the Conference, corresponding to the goals of the WHO European Healthy Cities Network in Phase V, were addressed in detail in 29 parallel sessions based on 80 case study presentations and 15 teach-ins. The parallel sessions covered a number of central and interrelated themes, with governance and equity as central and caring and supportive environments, healthy living and healthy urban environment as interrelated themes.

**10.1 Governance for health**

Key messages include the following.

1. Evidence of intersectoral cooperation has led to health improvement, and several sessions identified the need for a focus on outcomes.

2. Successful community engagement involves going to the places where people live their everyday lives and not expecting them to come to the table of governance committees. Peer support is an effective way of engaging population groups, and engaging with children and young people can have a positive influence on adults.

3. Effective communication is essential using a whole variety of media such as Facebook and Twitter, and suitably targeted to different stakeholders at different levels. Understanding organizations outside the health sector and their language facilitates effective communication and creating win-win opportunities. It is also vital to involve and learn from and work with the media as an effective channel of communication.

4. The city health profile is a useful tool to engage all stakeholders in the process of producing the plan and indicators for measuring achievement. The process is as important as the product. Decision-makers need to be involved from the beginning, and being able to demonstrate quick successes is useful.

5. There is a need to systematically analyse policies and actions to ensure that health and inequalities are central to policy which in turn influences future service design.

Key messages from Healthy Cities National Networks include the following.

1. It is essential to develop a sustainable framework with indicators agreed nationally to support the local evaluation of the social determinants designed and targeted to improve the health of vulnerable groups such as young and older people. The potential further strengthening of governance is systematic follow-up as a tool to influence municipalities.
2. The creation of a framework of values and approaches to tackle health equity has the potential to strengthen governance.

The challenge for the future of the examples above is to be able to secure a common understanding and transform new knowledge into new ways to tackle the governance of health and above all health equity.

10.2 Equity

The key issues raised in presentations included the following.

The potential future role for healthy cities to act as the honest broker and neutral voice in confronting entrenched social problems, such as domestic violence, and developing advocacy and catalysing social movements to bring about change is a challenge for the future.

The experience of healthy cities in testing and piloting innovative approaches and subsequently in working to mainstream these models in self-sustaining ways needs to be captured and publicized.

The essence of strengthened governance for equity is shared values among partner organizations and commitment to common goals and mutually beneficial outcomes.

It is essential to use the tools and techniques that support health and health equity in all local policies such as health impact assessment at the beginning of the development process and not just as an add-on.

The role of politicians and other key decision-makers in promoting health equity is enhanced if there is clarity on what they should do and if their capacity and competence is developed to maximize effectiveness.

The importance of enabling social solidarity between different groups in society with a focus on integrating migrant families both from outside the country and outside the city was recognized and the value of training and peer support in addressing key social and cultural problems.

Confronting gender oppression and inequity needs to be highlighted, including finding various ways to gain support and secure the involvement of sectors.

Key messages

The role of healthy cities in working with citizens and across sectors to identify common problems and components of joined-up problems and finding and implementing shared solutions (total problem-solving) is a potential way forward in addressing the complex challenges of 21st-century living.

The importance and legacy of the WHO Healthy Cities project should not be forgotten or underestimated. Implementing the WHO Healthy Cities approach itself is a systematic method of putting health and health equity high on the agenda at the local level.

The potential for strengthening governance to promote equity is to find better ways of sharing the experience of cities and how this might influence policy at the national level. It is important to recognize that a very high level of commitment is required to develop and deliver action on equity with shared vision and goals by all the intersectoral partners. A major concern was how to sustain and maintain commitment over time, particularly at a time when social and economic conditions are not conducive to prioritizing tackling inequalities.
Equity was also integrated within all other parallel session themes.

10.3 Healthy living
Case study presentations mainly focused on the physical benefits of activity and less on the potential positive impact on psychosocial well-being. A range of presentations demonstrated engaging vulnerable and marginalized groups.

Discussion indicated that a focus on specific population groups was essential: for example, young people demonstrating that physical activity is fun has a far greater effect than “health message” type information.

In many countries, the priority of tackling the obesity epidemic has led to an increased focus on healthy living. Engagement with a wide range of partners is essential, including planners, transport agencies, the food industry, supermarkets and local food outlets.

The importance of using a wide range of settings to promote healthy living includes discussion of the workplace and within health care facilities.

Tackling drugs and alcohol concerns is a significant challenge for many cities.

Key message
Involving the broadest and most appropriate partners to address the specific area of concern leads to good governance for health.

10.4 Caring and supportive environments
Creating supportive environments and the importance of the built and green environment were interrelated issues to the presentations on healthy living.

A project providing advice and support to homeless people with their immediate social, health and well-being concerns reduced their overuse of accident and emergency services, thereby saving expensive national health service resources in favour of more appropriate services providing more value for money.

The response to the question “Do older people prefer to live independently?” is not clear, but we need services that evolve and, as the needs change, so must service design if we are to support our ageing population adequately.

The concern over the rising levels of Alzheimer’s disease and dementia had led to the development of an Alzheimer’s Café where people can socialize and be stimulated and where information and support is provided for both people with Alzheimer’s and their caregivers. Participants in this discussion felt that this model is worthy of transfer to other cities. Georges Pire signed a Dementia Friendly Cities Charter during the business meeting on behalf of the Province of Liège.

Key message
Public policy needs to adapt to address the needs of ageing populations. Older people are an asset and not a liability. Older people can learn new skills and make a valuable contribution. Many older people wish to remain in their own homes, and housing policy in particular needs to adapt to meet these expressed requirements. Governance can be strengthened by applying
the development of a programme for a specific population to the whole city: for example, creating a conducive and supportive environment designed for older people is a good environment for everyone.

### 10.5 Healthy urban environment

The studies presented commonly focused on raising awareness and understanding of environmental impact and infrastructure and involving local people. Innovative approaches included the use of pictures to facilitate learning and overcome specialist professional jargon and abstract concepts, addressing the likely effects of climate change and very practical approaches to successfully engage children.

Common issues were compact cities with too much road traffic and the need for a long-term approach requiring regulation, changes to streetscapes and the promotion of the positive benefits of healthy urban design.

A session on regeneration demonstrated how health had become central to urban renewal in several cities through the use of health impact assessment tools, policies and skills and experience developed through participation in the WHO European Healthy Cities Network.

The objective of becoming a walking city can be achieved by implementing pedestrian areas, underground parking, renovating public spaces and renovating just one street using shared space standards. These initiatives can make a great difference in how people use public spaces that become friendlier to pedestrians and bicycles with less car use and lower speed limits.

A five-step process to using health impact assessment on planning development has resulted in a checklist for future use.

**Key message**

The focus on well-being needs to be strengthened, including demonstrating the importance and effects of the green and built environment to feeling good. Investment in green space supports the development of social capital and benefits individual health and well-being. Governance can be strengthened by empowering and involving the people concerned in the proposed development that affects their lives and their environment.

### 10.6 Areas for WHO to take forward

#### 10.6.1 Sharing the learning

- Help is needed to share the learning beyond case studies at annual conferences and technical meetings using other mechanisms. A public facility to share models, tools and resources used by cities would be very useful.

- Consideration should be given to developing a public page on the WHO Regional Office for Europe web site for WHO Healthy Cities case studies.

#### 10.6.2 Publications

- It would be helpful to produce a joint publication for both the cities and national networks demonstrating ways of working and best practice examples of achievement to showcase the benefits of implementing the process and principles of the healthy city approach.
A WHO publication of teaching materials for equity interventions that demonstrate various strengths and weaknesses to use with intersectoral partners to build capacity to tackle inequalities at the city level would be most helpful.

WHO should reinforce the importance of high-quality tools for meaningful community engagement.

The WHO Regional Office for Europe should develop a specific programme for Roma health, employing Roma people in the process of development and running specific campaigns engaging Roma people.

### 10.6.3 Technical support

It was suggested that WHO develop guidance on the following:

- community empowerment and engagement in governance at all levels;
- engaging with migrants and ethnic minority groups;
- demonstrating the costs and benefits of pursuing programmes to improve governance and reduce inequalities within reduced budgets in this current economic climate and maximizing the value of international cooperation on health and well-being;
- sustaining long-term commitment to strengthening governance and equity at the local level; and
- reviewing the evidence base on overcoming the cultural barriers to becoming more physically active and how to link more effectively the food and physical activity concerns with the obesity epidemic.

Guidance publications should include case studies illustrating best practices.

### 10.6.4 Improving links

- WHO should link the Healthy Cities agenda with the WHO Global School Health Initiative.
- Working with industry at the local level should become more widely accepted as a mechanism to promote health, well-being and equity.
- Stronger links at EU level are required to influence the ability to use revenue from taxation on tobacco for health promotion at the national level.
- Promote follow-up with specific projects presented as case studies in 2011 at the next annual conference in 2012 that will provide results, achievements and challenges.

### 10.6.5 Healthy Cities training

The cost of attending training sessions used in previous phases of the WHO European Healthy Cities Project is prohibitive in the current economic climate, particularly with respect to restrictions on travel. There are numerous possibilities through new technology. WHO is using a new web-based videoconferencing system to communicate and hold meetings (similar to Skype) that presents future opportunities for online group meetings and sessions. Translation is difficult, however and this would potentially exclude some cities from taking part. Australia has a long tradition of teaching by radio airwaves, and this could provide a useful framework for using new technology.
11. Teach-ins

Teach-ins were provided on a wide range of topics addressing migrant health at the local level, implementing the equity action framework, health literacy, healthy urban environment and assets for health. Leaders for teach-in sessions requested that these be publicized more widely, as some sessions had no participants. However, the number of parallel sessions presented a wide range of choice, with participants selecting topics of greatest relevance to their needs.

12. Subnetwork meetings

Meetings of the four of the WHO European Healthy Cities Network in Phase V were held: healthy urban environment, health literacy, health equity and healthy ageing. This was the first meeting of the health equity and the healthy ageing subnetworks during Phase V.

The purpose of the meetings was two fold: to review and generic terms of reference for subnetworks and to identify the key issues that subnetworks will develop and take forward during Phase V. The discussions at the subnetwork meetings have informed the final terms of reference for each of the subnetworks.

12.1 Health equity subnetwork: key issues

- Agree on common definitions and language on the terms equity, inequality and inequity.
- Provide training and training materials that can be adapted across cities in the European Region; consider further training in health impact assessment.
- Tools should be developed that will support cities in assessing policies for equity.
- Case studies should focus on “how” and review progress and or success.

12.2 Healthy literacy subnetwork: key issues

- Support cities in developing a minimum understanding of health literacy.
- Identify health literacy priority areas and initiatives with cross-cutting scope across the Phase V goal and core themes.
- Identify and develop materials to support cities in delivering on health literacy.
- Identify the preconditions for success and barriers to change by systemically assessing city progress on implementation.

12.3 Healthy urban environment subnetwork: key issues

The first meeting of the WHO European Healthy Cities subnetwork on healthy urban environment in Phase V was held in May 2011, and the follow-up meeting in Liège proposed the following objectives:

- develop an evidence base of international case studies illustrating how the built environment affects health and health equity;
- present local case studies for critical peer review;
- provide clear guidance to cities on how planning can act to improve health and health equity;
- develop and disseminate tools and publications to support cities; and
- facilitate knowledge exchange and learning on healthy urban environments.
12.4 Healthy ageing subnetwork: key issues

- Disseminate the guide produced in Phase IV on producing healthy ageing profiles.
- Produce a guide on strategic planning for healthy ageing within cities.
- Develop close working relationship with the WHO Headquarters led Age Friendly Cities initiative and the WHO European Healthy Cities networks with the support of the officer responsible for healthy ageing at the WHO Regional Office for Europe.

13. Engaging universities

Two sessions were held to explore closer working relationships between the WHO European Healthy Cities Network and city universities. During the first session, Agis D. Tsouros suggested several initiatives universities could consider developing, and the second session responded to these suggestions.

1. WHO suggestion: get more universities involved in the WHO European Healthy Cities Network

*Proposed responses*

Conclude the University of West of England mapping of the current involvement of universities near cities in the WHO European Healthy Cities Network and produce a final report for WHO.

Assist WHO in drafting invitations to nearby universities to enhance their contribution to case studies and local evaluations.

2. WHO suggestion: consider higher visibility for abstracts and case studies presented at WHO European Healthy Cities conferences in WHO reports, studies and public website and also in peer reviewed journals

*Proposed responses*

Circulate a summary of 17 abstracts from the 2010 Sandnes Conference to local universities involved and elicit and synthesize updates.

Synthesize and evaluate the 80 abstracts from the Liège Conference. Develop criteria for selecting and promoting a shortlist for publication in (1) WHO reports and (2) peer-reviewed journals.

Provide advice to authors of case studies to bring case studies to required standard for submission to scientific journals. Another attractive option is proposals to journals for producing special editions with healthy cities experiences.

3. WHO suggestion: develop a common framework for evaluating Phase V of the WHO European Healthy Cities Network

*Proposed response*

WHO/HAVEN convenes an expert meeting of academics and coordinators to draft a common framework both for (1) evaluating Phase V and (2) local city evaluations.

4. WHO suggestion: contribute to a European local urban health database

*Proposed responses*
Review, synthesize and compare city health profiles of cities in the WHO European Healthy Cities Network using updated WHO guidance.

Combining the *Hidden cities* framework with geographical information systems analysis developed by some cities in the WHO European Healthy Cities Network, review and synthesize inequalities within cities and their dynamics into a report for WHO and the WHO European Network.

5. WHO suggestion: update the annual reporting template

*Proposed response*

The advisory committees with the support of academics (1) reviews the conceptual foundations of the annual reporting template, (2) reviews city responses, (3) identifies weaknesses and strengths and (4) updates the framework and template.

6. Publish more peer-reviewed WHO Healthy Cities articles

*Proposed responses*

Map all published Healthy Cities articles and trace citations and impact.

Develop a publishing strategy.

14. Politicians’ meeting

Georges Pire, Provincial Deputy, chaired the politicians’ meeting and Agis D. Tsouros and Franklin Apfel facilitated. The meeting discussed and finalized a draft Health 2020 Statement that Georges Pire signed as a political statement from the Liège Conference addressed to WHO and shared at the sixty-first session of the WHO Regional Committee for Europe in September 2011. Politicians emphasized the success of delivery at the local level and the importance of the local level and the Healthy Cities experience being included in the new policy and the role of this policy in supporting local-level delivery. Politicians also shared their experiences in the challenges and success of promoting action on inequalities at the local level and discussed the potential development of a network of cities that would deliver rapidly on inequalities. It was agreed that WHO will issue guidance on this and on the terms of reference for establishing the subnetworks on core themes.

15. Coordinators’ meetings

Two coordinators’ meetings were held: one with city coordinators and another meeting with national network coordinators.

15.1 Healthy city coordinators’ meeting

The meeting had two purposes: firstly to review and amend if necessary the annual reporting template with coordinators and secondly to discuss any other issues relevant to the role of coordinators. The facilitator of the meeting reported that cities’ responses to the annual reporting template are limited and in some cases quite poor. The purpose of the annual reporting template was explained: it is a monitoring tool for WHO to monitor continuing local support and engagement in healthy cities as well as progress on Phase V deliverables including on core theme and action on health and health equity in local policies.
It emerged that some new cities or new coordinators in experienced cities are not familiar with the annual reporting template process.

Key comments on the annual reporting template

Different views were reflected across cities regarding the annual reporting template.

- Some cities feel the annual reporting template works – it allows cities to report on progress.
- others indicated they are not clear about the purpose of the annual reporting template.
- for some cities language is an issue in completing the annual reporting template.
- others feel the online version is too long and cumbersome to complete.

Suggestions for amendments to the annual reporting template included:

- WHO to remind cities about the purpose of the annual reporting template;
- feedback on the annual reporting template to individual cities, including cities making limited progress, is essential;
- reporting on outcomes from activities rather than on activities themselves;
- politicians, where possible to be more directly involved in completing the annual reporting template;
- visual evidence on progress to be added, where feasible as an integral part of the annual reporting template;
- case studies on equity and core themes may be a more appropriate way to complement vide monitoring information in the annual reporting template;
- changes to Healthy City Steering Group members and intersectoral working group members to be reported in annual reporting template.

Other items

- Mentoring with new cities – mentoring between new and old cities should be developed and encouraged.
- Equity and capacity-building – training in various formats is required to support cities to implement work on equity within cities. Interactive training should be piloted – it can be a positive way, although language is an important consideration.
- Advisory Committee – explore the Advisory Committee being more proactive and having a supportive role with new coordinators and inviting agenda items from cities for Advisory Committee meetings. The Advisory Committee advises WHO but should also advise cities.
- Length of Conference – the Conference in Liège was too long. It is too costly for some cities to attend

Conference structure:

1. Suggest that all teach-ins should be on one day and case study sessions on another full day only.

2. Consider a marketplace-type event or agora at future conferences where individuals stand and provide details of their project that has been chosen to be presented. This could take one of the 1.5-hour sessions and would allow a large number of cities to present their projects – and could reduce the number of parallel sessions.

Coordinators’ meetings – more time is required to meet with other coordinators to discuss core themes, challenges and experiences.
15.2 Meeting of the Network of European National Healthy Cities Networks

1. Annual reporting template
Annual reporting template reports completed by each national network are available.

2. Action plan of the Advisory Committee of the Network of European National Healthy Cities Networks for 2011–2012: Objectives
a. Enhance cooperation between national networks in the European Region
   - Improve the knowledge and skills of coordinators
   - Increase the number of accredited national healthy cities networks in the European Region

Activities will include:
- continuing to support WHO to prepare the business meetings
- produce a briefing paper or newsletter quarterly
- make a publication with a two-page profile of each national network
- develop a training course for national network coordinators in Dubrovnik on 21–23 March and invite Evelyne de Leeuw and Ilona Kickbusch to participate.

3. Adapting health in all policies at the national level
It was outlined that several models exist.
   1. National networks can provide tested tools and processes at the local level that the national-level ministry can roll out to other cities.
   2. Consider developing joint projects where the ministry has one role and the national network another.

The diversity of cultures makes it difficult to have the same approach for all, but the experience of national network coordinators’ meetings demonstrates that using the four-year city health plan process can be a useful tool for advocating health in all policies on other agendas at the local level. National networks reported on individual opportunities and experiences in implementing health in all policies.

4. Making Health 2020 work
Ensuring that Health 2020 is delivered requires support from other ministries and not just the health ministry. To prepare Agenda 21, several ministries had to work together – this provides a model that WHO can promote in each country with all ministries. Ministries need to commit to make progress on Health 2020, and targets should be monitored every year. National networks supported by WHO could be a technical partner for supporting ministries in implementing Health 2020.

15.3 WHO European Healthy Cities Network and national network sessions
Both networks organized meetings and briefing sessions for newcomers.
The Province of Liège demonstrated their exceptional hospitality by inviting all coordinators to dinner in the beautiful setting of the Château de Jehay.

16. Business sessions I and II
The purpose of the business sessions was to outline and report back on the practical management of the WHO European Healthy Cities Network and to provide news and information relevant to the future direction of the WHO Healthy Cities project. Within these sessions, participants formally adopted the programme and appointed the general rapporteur.

16.1 Report of the WHO Centre for Urban Health

Agis D. Tsouros, Head, Policy and Cross-Cutting Programmes and Regional Director’s Special Projects, WHO Regional Office for Europe

- Zsuzsanna Jakab, WHO Regional Director for Europe, was unable to attend the meeting due to urgent business. A video message expressed her apologies for not being able to attend and her support for Healthy Cities. She also stated that she welcomed and valued the contribution of the WHO European Healthy Cities Network and collaboration with the WHO Regional Office for Europe in producing the new Health 2020 policy.
- Agis D. Tsouros is taking the lead role on behalf of the Regional Director in developing the WHO Health 2020 strategy, integrating it across departments and consulting on it.
- Several healthy city representatives, including politicians, had attended the launch of the WHO/UN-HABITAT report *Hidden cities: unmasking and overcoming health inequities in urban settings (18)* on 7 November 2010, in Kobe, Japan.
- The WHO Healthy Cities project provided a strong input to World Health Day 2011.
- WHO secretariats in Helsingborg and Belfast, supported by Heini Parkkunen in Turku, provide ongoing assessment of city applications for membership in the WHO European Healthy Cities Network. Leah Lafond supports the accreditation of national healthy cities networks. The WHO European Network currently has 110, designated and applicant member cities, and the 30 national healthy cities networks, accredited and applicant include 1400 further cities and towns as members.

16.2 Report from the Advisory Committees and announcement of election to the Advisory Committee of the WHO European Healthy Cities Network

A joint meeting of the Advisory Committees of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks was held in Helsingborg in 2011, chaired by Iwona Iwanicka and Milka Donchin. Three new members were elected to the Advisory Committee of the WHO European Healthy Cities Network, as Colin Cox, Elisabeth Bengtsson and Karen Amlaev stepped down. During the second business session, the successful candidates elected to serve on the Advisory Committee were announced. The membership of the new Advisory Committee includes:

- Iwona Iwanicka, Łódz, Poland (current chair)
- Sule Onur, Kadikoy, Turkey
- Gianna Zamaro, Udine, Italy
- Judy Kurth, Stoke-on-Trent, United Kingdom (new member)
- Nicole Purnôde, Brussels, Belgium (new member)
- Ursula Hübel, Vienna, Austria (new member)
- Maija Perho, Turku, Finland (new member)

Four new members were elected to the Advisory Committee due to an equal number of votes for each member.
16.3 Results of the assessment of training needs of the WHO European Healthy Cities Network in Phase V

On behalf of WHO, the University of West England led the training needs analysis with members of the WHO European Healthy Cities Network and national networks. There are three major audiences for training in cities: politicians, healthy city coordinators and professionals from other sectors. The training needs of cities varied from training related to the Phase V core themes to the broader skills and management training required to support coordinators and key players in maximizing the benefits of being a member of the WHO European Healthy Cities Network.

A survey was sent out on 21 April 2011 to 84 cities and 19 networks. By the deadline of 9 May 2011, 40 responses had been submitted (37 cities and 3 national networks).

The objectives of the exercise were:

- to generate policy and practice expertise, good evidence, knowledge and methods that can be used to promote health in all cities of the WHO European Region; and
- to promote solidarity, cooperation and working links between European cities and networks participating in the Healthy Cities movement.

The survey first asked on which three important issues within the Phase V overarching goal and the three core themes the cities would like to receive training. The most popular response was related to the overarching theme of health and health equity in all policies, with 45 responses. Some of these simply asked for guidance under the heading of health and health equity in all policies, but other requests included identifying inequity, guidance on social determinants, identification of indicators and how to intervene and monitor and evaluate interventions.

The second most popular area for support was caring and supportive environments, with 36 cities expressing a preference for this area, two for the overall theme and others giving priority to health literacy, active citizenship and age-friendly cities.

Healthy living was the least popular area, with 14 cities expressing an interest in training, including 4 for the overall area of the theme and others giving priority to: preventing noncommunicable diseases; well-being and happiness; and alcohol and drugs.

There were 20 requests for support in healthy urban environment and design. The most important was integrating health into planning, housing and regeneration and noise and pollution.

The top three key training skill requirements in cities were leadership, negotiation and strategic influencing. The three most important management training needs were strategic planning, project management and partnerships.

Knowledge training needs included assistance in applying findings from research, assistance in preparing an evidence base and support in producing and evaluating measurable results, developing indicators and measuring health outcomes.

Other training requirements were identified as ways of working, specific themes and good practice and sharing experience.

Course delivery preferences were stated as:

- training programme templates that can be implemented in my own city
- training provided by the national network
• online topics with feedback (1.5 days of learning each)
• training at the annual WHO Healthy Cities conference.

The following training requirements for professionals not from a (public) health background were given priority for:
• planners: urban planners, city planners and strategic planners
• politicians and other political actors
• health care professionals
• environment and environmental protection managers
• architects, housing professionals and transport workers
• the voluntary sector.

Where face-to-face training is delivered, two days was the preferred length. Events should be interactive and include good practical examples. Respondents acknowledged that meetings can be very productive but require commitment.

About one quarter of the respondents said that they had links with other, not-nearby academic institutions, particularly with national centres of excellence for health or public health.

16.4 Liège Statement

The Liège Statement is the product of all political representatives attending the conference. It was introduced to the participants at the closing plenary by Georges Pire (Provincial Deputy in charge of Health, Quality of Life and Environment, Province of Liège, Belgium (see Annex 2). Everyone present endorsed the Liège Statement.

16.5 Healthy Cities communication and video download facility

Steve Turner, WHO Temporary Adviser
Cities and national network representatives were invited to add consultation comments or make statements through both video and audio recordings during the Conference. The general rapporteur’s report included a short compilation of these, as photographs taken by Connie Petersen were screened.

17. Conclusion

The conference focused on governance for health at the local level, people, citizens and assets for health. Case studies were presented and reported achievements on the overarching goal equity and health equity in all local policy and the Phase V themes: caring and supportive environments, healthy living and healthy urban design.

Health 2020 was introduced, and the Liège Conference providing the first opportunity to consult with local government. The interim report of the WHO European review of the social determinants of health and the health divide and the presentation of the study on Governance for Health in the 21st century were particular highlights. The discussion on the need for a whole-of-government and whole-of-society approach, led to the conclusion that capacity for governance for health is for tackling the social determinants of health effectively. The biology of poverty and the effects of psychosocial well-being on health beliefs, attitudes and behaviour are becoming more widely and better understood. Wide-ranging research is demonstrating that the health effects of social relationships and networks are an important
factor. Traditional methods of improving health are being recognized as insufficient, and a renewed and systematic approach to population health and well-being is required across the life course, one that responds to needs and builds on the assets of individuals, families, communities and society as a whole. The context has changed, and we need to adapt and still ensure a supportive, caring and conducive environment that enables everyone to flourish.

18. Thanks

Thanks were expressed to the Province of Liège, which had provided outstanding hospitality including cultural performances together with the technical programme, which demonstrated the cultural diversity, rich resources of the local population and relevance of the expertise of the guest presenters. Participants also took part in a range of site visits and social events held in locations of historical and cultural interest.
References

Annex 1: Parallel Session and Case Studies

**PSB2** Governance: developing networks and engaging citizens to improve health equity

Vienna, AUS: Feeling good in the 15th District
Glasgow, UNK: Evaluation of Glasgow GRAND
Izhevsk, RUS: Ensuring the availability of primary health care for residents
Lyon, FRA: Biomarkers and personalized medicine

**PSB3** Healthy urban environment: equity at the heart of active travel

Belfast, UNK: Health equity in all policies: travel plan framework
Newcastle, UNK: Developing a movement and access plan for Newcastle
Yalova, TUR: Organic transportation

**PSB5** Healthy living: initiating, promoting and mainstreaming physical activity

Zagreb, CRO: Choose sport
Brighton & Hove/UNK: Partnership for active living

**PSB6** Healthy living: tackling drug and alcohol abuse with young people

Udine, ITA: Alcohol prevention campaign in sports clubs
Swansea, UNK: Neighbourhood partnership – tackling substance abuse
Győr, HUN: Networking against drug consumption

**PSB7** Equity: vulnerable groups – addressing the needs of immigrant families and asylum-seekers

Izmir, TUR: Sibling family project
Eskisehir, TUR: First civilian protocol on gender equality
Arezzo, ITA: Reception of immigrants following family reunification

**PSD2** Healthy urban environment: integrating health and well-being into urban renewal programmes

Izmir, TUR: Kadifekale Urban Renewal Project
Izhevsk, RUS: Reconstruction of Izhevsk Pond embankment
Vitoria-Gasteiz, SPA: Health impact assessment of urban regeneration project
Stoke-on-Trent, UNK: Healthy urban planning in Stoke-on-Trent

**PSD3** Governance: national healthy cities networks: vehicles for health governance

Polish Healthy Cities Association/POL: Learning and sharing experience
Czech Healthy Cities and Regions/CZE: Platform for sharing good practice
Russian Healthy Cities Association/RUS: Intersectoral collaboration of member cities

**PSD5** Equity: strengthening well-being and social capital of people over 55 years

Turku/FIN: 55+ Licence to locomotion
Rijeka, CRO: University of the Third Age
Carlisle, UNK: Creating caring and supportive environments

PSD6 Healthy living: tools and activities to promote physical activity with children and Young People

Manchester-Stoke-Brighton, UNK: Doorstep sport
Villanueva de la Canada, SPA: Predicting energy expenditure
Modena, ITA: Sport beyond the crisis

PSD7 Caring and supportive environments: vulnerable groups – developing inclusive and accessible cities

Novosibirsk, RUS: Social adaptation of disabled people
Kadikoy, TUR: Dental care for disabled people

PSF2 Healthy urban environment: creating welcoming streets

Barcelona, SPA: Active, safe and sustainable mobility
Kuopio, FIN: Kuopio – pedestrian-friendly district with 13 000 inhabitants
Brighton & Hove, UNK: Designing streets for different users

PSF3 Equity: structures to address the needs of disadvantaged children

Stavropol/RUS: School health centre – reducing inequity in health among children
Denizli/TUR: Information houses and course centres
Sant Andreu de la Barca, SPA: Participation and social inclusion

PSF5 Healthy living: tools to assess and promote healthy living

Liège, BEL: SAMI Department for Analysis of Indoor Places
Udine, ITA: Health and social services close to citizens
Brighton & Hove, UNK: Using NHS health checks in the workplace

PSF6 Governance: health governance: assessing health equity

Sunderland, UNK: Sunderland Way of Working (SWOW)
Brussels, BEL: Transforming complaints of inhabitants in proposals
Brighton & Hove, UNK: “Is there anybody out there?”

PSF7 Caring and supportive environments: supporting independent living for older people

Ljubljana, SLV: Daily activity centres for older people
Györ, HUN: Elderly friendly city
Sunderland, UNK: Care and supportive environments

PSF8 Healthy living: health promotion for children and young people

Hungarian Association of Healthy Cities, HUN: Tackling childhood obesity
Udine, ITA: Smoke prevention policies at school
Carlisle, UNK: Healthy living
PSF9  Governance: indicators for health

Glasgow, UNK: Creating health and well-being indicators for Glasgow
Belfast, UNK: Good for regeneration, good for health

PSG1  Governance: engaging citizens and children to promote healthy environments

San Fernando de Henares, SPA: Municipal health plan
Belfast, UNK: Shaping healthier neighbourhoods for children
Sandnes, NOR: Young people’s participation in city development

PSG2  Healthy urban environment: integrating health into urban planning

Geneva, SWI: Urbanism, health and public policies
Glasgow, UNK: Evaluating phase I of Equally Well Test Site
Brighton & Hove, UNK: One Brighton & Hove – new way of living

PSG3  Healthy living: structures and actions for healthy living

Aydin, TUR: Walking-running-fitness in city centre
Denizli, TUR: Live active, do exercise, be rewarded by health
Izhevsk, RUS: Actions aimed at healthy living in Izhevsk

PSG5  Equity: strategies and networks to reduce inequities

Stavropol, RUS: How to reduce health inequities at the municipal level
Cardiff, UNK: Development of an integrated partnership strategy
Liège, BEL: Rosalie, local dynamic to address social health inequalities

PSG6  Healthy living: health-promoting guidelines and assessments

Liège, BEL: Economic evaluation of osteoporosis screening strategy
Milan, ITA: Guidelines for choice of vegetation species and urban greening
Denizli, TUR: Waste and recycling

PSH1  Caring and supportive environments: building self-esteem with vulnerable groups

Liège, BEL: Dementia-friendly cities/Alzheimer café
Liverpool, UNK: Asylum seeker mental health group
Liverpool, UNK: Health care worker for homeless people

PSH2  Healthy urban environment: regenerating urban green spaces

Pärnu, EST: Active places in Pärnu
Lódz, POL: Green ring of tradition and culture

PSH3  Equity: tools and guidance for health equity

Swansea, UNK: Local framework for integrated assessment framework
Belfast, UNK: Tackling inequalities – guide for politicians
Cherepovets, RUS: Strategic city plan
**PSH5  Healthy urban environment: building capacity for change**

Helsingborg, SWE: Healthy urban infrastructure and identity  
Eskisehir, TUR: Raising ecological awareness of children  
Belfast, UNK: Climate change and health: guide for professionals

**PSH6  Healthy living: promoting healthier lifestyles**

Leganes, SPA: Working towards a healthier lifestyle  
Udine, ITA: Promoting physical activity and active living  
Turku, FIN: Inspiration from culture pie  
Turku, FIN: Culture and physical activity

Liège statement on the new European policy for health and well-being Health 2020

Initial consultation with local governments on Health 2020 in Liège, with 322 participants from 30 European countries and 85 cities

We, the mayors and senior political representatives of cities in the European Region gathered at the Annual Business and Technical Conference of the WHO European Healthy Cities Network and the Network of National Healthy Cities Networks in Liège, Belgium, 15-18 June 2011:

recognize the complex and rapidly changing array of global, regional and national forces such as the economic recession, climate change, urbanization, poverty, our ageing populations and migration and developments in technology and communication that are rapidly reshaping health and the social, and economic landscapes of our cities and creating new opportunities and challenges in our common pursuit for health and well-being;

welcome the bold and timely initiative of the WHO Regional Office for Europe to catalyse and facilitate the development of a new common European policy for health and well-being - Health 2020 - that can unite, align and strengthen our individual and collective capacity to take action for health and health equity at the European Region, national and local levels; and

applaud the policy’s emphasis on practical problem-solving based on values, evidence and assets; its commitment to whole-of-government and whole-of-society approaches; its strong focus on health as a human right; the right to participation and transparency in decision-making; and its identifying effective and efficient ways to address the health challenges of our cities, including the social determinants of health, inequities across the social gradient, the noncommunicable disease epidemic, mental health and injuries. Setting common targets will provide critically important tools for monitoring and accountability.

Recommendations
Building on local government knowledge and experience of the needs, assets and daily health and well-being challenges of our populations and our extensive inter-sectoral experience in developing and implementing city health plans, we recommend that the Health 2020 process and policy:
• explicitly recognize the key role of local governments and the importance of delivery at the local level and identifying public health issues that can be best addressed locally;
• promote active partnership with local governments, nongovernmental organizations, academia and the business community;
• emphasize the need for cross-party consensus and support for health policies;
• provide specific tools to promote effective governance for health: health impact assessment, transparency, inter-sectoral work and accountability;
• strengthen the capacity and expertise of local governments to promote citizen participation and empowerment and the needs of vulnerable groups;
• provide guidance for promoting a socially responsible business sector;
• catalyse research on health effects and sound economic analysis of various models and interventions of national support to local governments related to devolving responsibilities and authority in health and well-being;
• address issues related to sustainable development, migration, ageing, cultural and ethnic diversity, biodiversity and climate change in urban and rural settings;
• ensure relevance, delivery and adaptability of policy recommendations to all parts of the European Region through continued active consultation with cities across the Region;
• craft Health 2020 in a way that speaks clearly, simply and inspirationally to a broad European audience, including young people; and
• recognize the potential of healthy cities networks to be effective vehicles for delivering the Health 2020 policy.

Commitment
This new common health policy framework creates a fresh, dynamic and exciting platform for enhanced influence and impact of a better coordinated and focused public health community. This is our time. To this end, we commit ourselves to be proactive partners in the development and consultation process; to be a testing ground for new ideas; to be a source of local knowledge and case studies; and to actively advocate for our common health vision and goals.

This document is submitted to WHO on behalf of the political leaders of the participating cities by George Pire, Political Head for Health of the Province of Liège

18 June 2011
Annex 3. Glossary of terms

Governance is about how governments and other social organizations interact, how they relate to people and how decisions are taken in an evermore complex and globalized world.

Governance for health can be defined as the attempts of governments or other organizations to steer communities or even groups of countries to the pursuit of health and well-being as a collective goal.

Health diplomacy – no universally accepted definition exists, but Ilona Kickbusch describes this as “a political change activity that meets the dual goals of improving global health while maintaining and strengthening international relations abroad, particularly in conflict areas and resource-poor environments”.

Assets is a term formerly found in relation to finances and similar to capital. The World Bank uses the term capital. This notion of capital can, however, be applied to a number of asset states including physical, genetic and psychological disposition and:
- economic capital – financial assets or status in economic society;
- human capital – secured through education, skills and health;
- social capital – represented by networks within family and community; and
- mental capital – encompassing both cognitive (understanding) and emotional resources and including people’s cognitive ability, their flexibility and efficiency at learning and their emotional intelligence or social skills and resilience in the face of stress.

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress such as family relationships, serious health problems, financial or workplace stressors.

Wicked issues – a wicked problem or issue is something that is difficult to solve because of complex interdependence; the effort to solve one aspect of a wicked problem may reveal or create other problems, such as how do we give children positive self-esteem?

Accountability is a concept in ethics and governance with several meanings. It is often used for responsibility for particular actions, being answerable or having liability for giving an account (report) for particular decisions and policies.
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization
Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18.
E-mail: infowho@euro.who.int
Web site: http://www.euro.who.int/healthy-cities