WORLD HEALTH ORGANIZATION
HEALTHY CITIES PROJECT:
A PROJECT BECOMES
A MOVEMENT
REVIEW OF PROGRESS 1987 TO 1990

EDITED BY AGIS D. TSOUROS
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COPENHAGEN

PUBLISHED FOR THE WHO HEALTHY CITIES PROJECT OFFICE
BY SOGESE - MILAN
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Originally published in English by PADI Publishers, Copenhagen.

Permission to reprint this book in English has been given by the World Health Organization Regional Office for Europe.

This report and the WHO Healthy Cities Papers are available from the WHO Regional Office for Europe or from:
SOGESS S.r.l.
Via De Amici, 53
20123 Milan, Italy

Cover design by Dot. Zera
Layout, typesetting and printing by HC Jensen
Offset A/S

Printed in Italy

ISBN 88-85893-01-2
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Foreword

The Healthy Cities project has proven to be an ideal vehicle for bringing the WHO strategy for health for all to the local level. The project has established new professional and political alliances for health and has generated considerable practical knowledge on how to promote health and improve the environment of our cities in Europe. It also takes advantage of the new political realities in most European countries, whereby cities more and more tend independently to undertake concerted action in many areas – including health. Further, the project has caught the imagination of people all around the world, creating a unique platform for the new public health and implementing the European policy for health for all.

I have therefore already extended the support of the Regional Office to the project at least until 1995. WHO is actively exploring alternative ways and opportunities to support this fast growing project, both technically and financially. I am sure that this review of progress will stimulate even more cities to move ahead towards health for all.

[Signature]

J H. ASTRUP
WHO Regional Director for Europe
From a drawing contest in Pecs
for children (aged 6-14 years) on
the theme "Health and my city"
You would not have been believed if you told the people attending the first meeting of the Healthy Cities planning group in January 1986 that the five- to eight-city project they were planning would mushroom in four years to include: a network of 30 project cities with a combined population of more than 18 million people in 18 European countries; 17 national and 3 international networks encompassing hundreds of cities and towns throughout most of the industrialized world; and the beginnings of projects in several other WHO regions.

Even in their wildest dreams, the small group that met at the WHO Regional Office for Europe did not anticipate the interest this project would arouse in the minds of citizens, local politicians and urban professionals across Europe and around the world. Nevertheless, the concerns to be addressed by the project were there, including: the threats to health and wellbeing posed by city life; marked and sometimes increasing inequities in health and its prerequisites in urban areas; the deteriorating quality of the urban environment and its effect on health; and a sense of helplessness, hopelessness and alienation among young people, poor people, immigrants and other disadvantaged populations.

The idea of a healthy city and the means to help bring it about represented a new sense of hope, purpose and direction for many cities in Europe — and they seized the opportunity! The growth of this project has been so startling that, were it a private company, it would be one of the business success stories of the 1980s. The project has been successful not only because it has touched a responsive chord in so many cities and among so many people but, more importantly, because of the energy, enthusiasm and sheer hard work of the thousands of people in the cities and towns that make up the Healthy Cities movement. They inherit an impressive public health history and forerun a renaissance of public health that will bring us closer to achieving health for all the peoples of the world and, in particular, those living in cities.

This report, which is dedicated to the people of the Healthy Cities movement, recounts the development and growth of the project, some of the actions for health underway in the 30 project cities, the growing pains, successes, and challenges that remain, and the hopes, dreams and plans for the project as it approaches the twenty-first century. Given our ability to underestimate the power of the idea and the impact of the project, these hopes, dreams and plans may be an understatement.
From a drawing contest in Fécé for children (aged 6-14 years) on the theme “Health and my city”
I am deeply indebted to everyone who contributed to and helped to prepare this review. In particular, I would like to express my gratitude to Ron Draper, who developed the interview method for the project and provided valuable analytical insight into the progress the cities have made so far. Special thanks are due to Trevor Hancock, who has keenly assisted the project from the beginning and Evelyne de Leeuw, who drafted large parts of the report. Ilona Kiekbusch is due special thanks and appreciation for valuable policy suggestions. I deeply appreciate the research and technical assistance from Judy Luce and Marleen Goumans. I would also like to acknowledge the important contribution made by David McQueen and Lisa Curtice of the Research Unit in Health and Behavioural Change, in Edinburgh, who analysed the annual progress report forms and interview materials of the project. Thanks are also due to Michel O'Neill, who provided a useful structure for these forms.

On behalf of the WHO Healthy Cities team, I express deep appreciation and thanks to all the project cities for cooperating in and contributing to this progress review.

Many thanks to David Breuer, who significantly improved the language and style of this report. He and Helle Møller cooperated in proofreading and technical processing on a short deadline, working around the clock. The project office also expresses its appreciation to SOGESS srl of Milan for financially supporting the printing of this report.

Agis D. Tsouros
Editor
Future Lab 1990, Munich Town Hall. Children discuss environmental problems in the city.
Scope and purpose of the Healthy Cities project

The WHO Healthy Cities project is a long-term development project that seeks to put health on the agenda of decision-makers in the cities of Europe and to build a strong lobby for public health at the local level. Ultimately, the project seeks to enhance the physical, mental, social and environmental wellbeing of the people who live and work in Europe's cities.

The Healthy Cities project contributes to changing how individuals, communities, private and voluntary organizations and local governments throughout Europe think about, understand and make decisions about health.

The Healthy Cities project applies the WHO strategy for health for all by the year 2000, the principles of health promotion outlined in the Ottawa Charter for Health Promotion and the principles of the European Charter on Environment and Health at the local (city) level. The project evolved as a practical, active component of the health promotion programme and the environmental health programme of the WHO Regional Office for Europe.

The Healthy Cities project attempts to strike a balance between placing health high on the strategic political agenda of cities and carrying out applied technical and operational measures. This includes developing and implementing specific plans to improve health in the city and taking the structural, organizational and financial steps to make this possible.

Cities are challenged to reduce inequalities in health status and inequities in access to the prerequisites for health; to develop healthy public policies at the local level, to create physical and social environments that support health, to strengthen community action for health, to help people develop new skills for health compatible with these new approaches; and to reorient health services in accordance with the strategy for health for all and the principles of health promotion.

Project achievements

The project, which was initiated in 1985, has grown to include 50 project cities in Europe and 17 national networks. It has become an international movement involving more than 400 cities in Europe, North America and Australia. The project is now becoming global, as interest grows and the project expands in developing countries.

The major strength of the project is its attractiveness to many different groups and professions and the political and community leadership in many cities.

The project has been very successful in accumulating practical knowledge about the strategies and structures that can help to promote the Healthy Cities idea. It is now possible to prepare a composite picture of the organizational structures and managerial processes that predict success in developing new approaches to public health at the local level.

Health has been put high on the political agenda of cities. About half of the project cities have successfully developed a new organizational model and strategy for addressing health.

The mayors and senior political representatives of the WHO project cities have issued a strong declaration of political support (the Milan Declaration on Healthy Cities), and several cities have already devoted significant resources to the project. The project is based on a spirit of true partnership and has well established mechanisms that
promote information exchange, sharing of experience, mutual support, adjustment of existing plans, development of new strategies and dissemination of ideas and products.

The project is one of WHO's major vehicles for achieving the strategy for health for all. It has provided the testing ground for applying new strategies and methods of operation in cities, which is completely new to the work of WHO. The project has established political, professional and technical alliances for health and fertile ground for change and innovative action. New channels of communication and potential entry points to other active programmes of the Regional Office and other international agencies have been opened up.

The project has laid the basis for a new European public health movement, forged links between WHO and local governments for the first time and has made WHO more visible, credible and relevant to local needs and concerns. There are few other comparable examples in the history of public health in which a relatively small investment has paid off so well.

A taste of success

The Healthy Cities project:

- has put health high on the political agenda of cities;
- has inspired thousands of people in hundreds of cities and towns all over the world;
- is a proven example of how to implement the strategy for health for all by the year 2000 at the local level;
- has laid the basis for a new European public health movement and helped restructure and recreate public health at the city level;
- has created a network of cities working together in a spirit of international cooperation;
- has built a body of experiential knowledge that can be used to develop new practical ideas;
- has created structures for communication between sectors in the cities;
- has raised the issue of supportive environments as a central problem for health;
- has emphasized the importance of equity for health at the local level;
- is visible proof that improving health requires the active participation of many different groups, disciplines and professions and that such collaboration is possible;
- has, for the first time, forged links between WHO and local governments and has made WHO more visible, credible and relevant at the community level;
- has provided good experience for a new generation of potential city administrators; and
- has brought international agencies together under city auspices.

The Healthy Cities project must now find new organizational forms and begin, for example, to establish Europe-wide Healthy Cities resource centres that will provide information, analysis and guidance on strategy in the efforts to establish a new, locally based, international public health movement. National networks and links to the international organizations that will significantly affect Europe's future development will be of great importance in establishing this movement.

The project must address the needs and opportunities for public health action in central and eastern Europe. The globalization of the project, expanding into cities in the developing countries, requires new approaches for healthy cities that are compatible with the health status and the social, cultural, economic and environmental circumstances of these countries. EXPO 1992 in Seville and EXPO 1994 in Vienna and Budapest present major opportunities to increase the visibility of the project and exhibit its achievements.
The Milan Declaration on Healthy Cities

We, the mayors and senior political representatives from the WHO Healthy Cities network, gathered in Milan on 5 and 6 April 1990, affirm our commitment to the principles of the Healthy City project and declare that:

1. Cities' role in promoting health

Health

Health is a positive concept emphasizing social and personal resources as well as physical capacities. Health is created and lived by people in the settings of their everyday lives.

We pledge our political support for healthy public policies and the creation of supportive environments in our cities that develop and sustain the health of all our citizens.

Health for all policy

Cities are key partners in the WHO health for all movement.

We pledge our political support for the health for all policy and the attainment of its targets in our cities. This requires community participation, including, where appropriate, the decentralization of decision-making and resources to the local level.

Sustainability

Health depends on sustaining the world's natural resources, as well as the quality of the natural and built environments.

We pledge our political support for the protection of the health of citizens and the quality of their environment by ensuring that urban development is environmentally sustainable.
In particular, we recognize the adverse effects of traffic on health and the environment, and the need for comprehensive urban transport planning that takes account of these effects.

**Equity**

Harmful effects on people's health arise not only from poverty but also from other kinds of social and educational disadvantage.

We pledge our political support for programmes that promote equity and reduce inequalities in health within our cities.

In particular, in this United Nations International Year of Literacy, we recognize the vital contribution that our city educational systems play in creating and promoting health.

**Intersectorality and accountability**

Health is mainly the result of society's combined action (or lack of action) on the physical and social environment. Improvements in health are due only in part to the advances of medical care systems.

We pledge our political support for the strengthening of intersectoral action on the broader determinants of health and for exploring with our city councils or other city authorities ways to make health and environmental impact assessment part of all urban planning decisions, policies and programmes.

**International dimensions**

Peace is an essential prerequisite for health. In this context, we welcome the new openness in Europe and affirm our belief that cities play an essential role in building bridges of understanding within and between countries of Europe and the world.

We pledge our political support for the WHO Healthy Cities project within the national and international networks and organizations to which we belong, and will encourage the national and international development of the new public health movement.

2. **Action for healthy cities**

We hereby confirm our commitment to the WHO Healthy Cities project, and specifically reaffirm our commitment to take what measures we can to ensure the effective operation of the project in our cities, namely:

- establishing effective intersectoral mechanisms for developing health policies;
- developing a city health plan that identifies the major health challenges and proposes a comprehensive, city-wide intersectoral strategy to address them;
- establishing an adequately staffed Healthy City organization;
- creating mechanisms for public accountability for the effects of decision-making on health;
- ensuring effective community participation in all decisions and actions affecting health.

*Healthy Cities: Facing the Future, the meeting of mayors and senior political representatives of the 30 project cities in April 1995*
To ensure the long-term success of the Healthy Cities movement, we will seek to match the recent commitment of the WHO Regional Office for Europe by continuing our involvement at least until 1995.

In addition, we will explore, with our councils, participation in EXPO 1992 to be held in Seville, and EXPO 1995, to be held in Vienna and Budapest, as part of the Healthy Cities exhibit/programme intended to give high visibility to the successes of the Healthy Cities project.

We hereby pledge that, to promote the health of our cities and citizens, we will explore with our city councils or other city authorities actions that can contribute to recent WHO policy initiatives, including:

- the European Charter on Environment and Health;
- the European Action Plan on Tobacco or Health;
- the WHO air quality guidelines;
- the WHO policy on the prevention of AIDS and the care of people with AIDS.

We recognize the need for additional resources, beyond those that can be provided by our own cities and WHO, to support the further growth and development of the project. Accordingly, we call on WHO:

- to take the lead in the European Region, with other partners, in establishing joint action in urban health that will provide funding and resources with particular emphasis on the cities in Europe with the greatest problems and the fewest resources;
- to explore the establishment of increased financial support to the Healthy Cities project such as a European health fund;
- to explore and facilitate the establishment of a Healthy Cities institute to support the Healthy Cities movement;
- to facilitate the creation of a European Healthy Cities association;
- to broaden the Healthy Cities project to cities in the developing countries.

We will provide political support to WHO in its efforts to expand the resources available to the project.

We undertake to report on our progress in implementing the action
here described in our cities at the next Meeting of Mayors, which will take place at the 1992 Healthy Cities Symposium in Copenhagen.

3. Conclusions

We recognize health and its maintenance as major social investments.

We reiterate our commitment to the concepts and principles of health promotion as defined in the Ottawa Charter for Health Promotion.

We challenge and support the WHO Healthy Cities project in its approach to address the overall ecological issues of our ways of living.

We urge cities throughout Europe and beyond to participate in the Healthy Cities movement and to join us in our commitment to a strong public health alliance.
Achieving health for all: the challenge of healthy cities

Humankind has been concerned about the health of cities and their residents since the earliest times. Early civilizations had a variety of codes, laws and rules intended to protect the health of the residents of cities and to ensure that the cities were as healthy as possible, given the prevailing understanding of health.

Concern about the health of people in cities has changed over the centuries. The rapid urbanization that accompanied industrialization and the health problems that resulted from so many people being crammed into appalling living and working conditions sparked a powerful response – the nineteenth-century public health movement. Based on a concern for health, new techniques were created and laws developed to counter the health hazards of urbanization and industrialization. Sewers were built, water supplies improved, factory laws and housing codes adopted, anti-pollution measures taken, food inspection and control instituted and parks created, while urban planning (an offshoot of public health) grew in importance. These ideas culminated in the late 1800s in utopian visions of ideally healthy cities such as Benjamin Ward Richardson's 

Health for all and health promotion

WHO has pioneered in broadening the idea of health. From its inception it has recognized that health is more than the absence of disease, and this was confirmed when the World Health Assembly, in 1977, adopted the challenge of achieving health for all by the year 2000. Based on an extensive review of health and health problems in Europe, the Member States of the European Region of WHO adopted 38 specific regional targets in 1984 in support of the European strategy for health for all, which had been adopted by the Member States in 1980. These targets provide a framework for action in such areas as equity, preventing disease, lifestyles conducive to health, supportive environments and health care services. Health promotion, the backbone of the new public health, is a key concept in the strategy for health for all. In 1986, the Ottawa Charter for Health Promotion further defined health promotion in terms of policy and strategy.

The Ottawa Charter recognized that policy decisions in areas other than health make a key contribution to health; that supportive physical and social environments are important in establishing the conditions for health and the parameters for health behaviour; that the community can and must play a crucial role in undertaking actions for
health, that a broad range of personal skills for health needs to be developed; and that existing health services need to be reoriented.

The Healthy Cities project was thus launched in the framework of health for all and health promotion, as a testing ground for developing and implementing these new public health approaches at the local level, where the somewhat abstract and global concepts of health promotion and health for all can most easily be concretized. As the lowest level of government, and thus closest to the people, cities can and should play a central role in achieving health, a role they have fulfilled historically but that has been generally neglected in recent years.

**New strategies, new styles**

The Healthy Cities project challenges cities to take seriously the process of developing health - enhancing public policies that create physical and social environments that support health and strengthen community action for health. These new strategies for promoting health are explicitly political, environmental and social in nature, complementing the primarily behavioural and medical strategies employed by public health in the past few decades. Within changed political, environmental and social contexts, people can begin to develop new health promotion skills and support the re-orientation of health services.

The Healthy Cities project advocates not only new strategies, but also the new styles of action described in the Ottawa Charter. Health promotion cannot work if people simply take charge, assume responsibility and direct others. Instead, Healthy Cities projects are challenged by the principles of health promotion to develop new styles of enabling, facilitating, mediating, advocating and building new partnerships and coalitions for health. Projects should:

- enable individual people and communities to increase control over and assume more responsibility for health - without victim-blaming, without dumping problems on them and without abdicating societal responsibility;
- facilitate the political, social and community processes involved in negotiating new ways of doing things;
- mediate between the various and often conflicting interests of the various public, private, voluntary and community sectors involved in creating the conditions for better health;
- advocate with other social forces and on behalf of people who are powerless the changes necessary to promote health (this advocacy must be directed to the public and private sectors at the local, regional, national and international levels that have authority over and the responsibility for actions that protect and promote health); and
- create new partnerships and coalitions for health, sometimes with less powerful people and groups, sometimes with more powerful people and groups, ideally with both (such partnerships need to bring together the public, private, voluntary and community sectors, united in the common purpose of promoting the health of the city's people).

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**Principles for health for all**

- Health for all implies equity. This means that the present inequalities in health between countries and within countries should be reduced as far as possible.
- The aim is to give people a positive sense of health so that they can make full use of their physical, mental and emotional capacities. The main emphasis should therefore be on health promotion and the prevention of disease.
- Health for all will be achieved by people themselves. A well informed, well motivated and actively participating community is a key element for the attainment of the common goal.
- Health for all requires the coordinated action of all sectors concerned. The health authorities can deal only with a part of the problems to be solved, and multidisciplinary cooperation is the only way of effectively ensuring the prerequisites for health, promoting healthy policies and reducing risks in the physical, economic and social environment.
- The focus of the health care system should be on primary health care - meeting the basic health needs of each community through services provided as close as possible to where people live and work, readily accessible and acceptable to all, and based on full community participation.
- Health problems transcend national frontiers. Pollution and trade in health-damaging products are obvious examples of problems whose solution requires international cooperation.
These new approaches mean that cities must be managed differently. The present systems of organization are rooted in nineteenth-century concepts of bureaucracy, hierarchy, paternalistic power, professional authority, disciplinary specialization, win-lose and either-or strategies and sectoral analysis. To address the problems of the twenty-first century, however, the nineteenth-century ways of thinking and working must be abandoned and new, holistic, flexible approaches must be adopted.

Thus, the old system of organization by professional department and by sector has to be complemented by new approaches to such health issues as equity, sustainability, safety and mobility. These issues cut across the old departmental lines and indeed across the different sectors - public, private, voluntary and community. None can be addressed by one department of government alone, nor indeed by city government alone. The whole community has to be mobilized and the efforts of all sectors and departments have to be combined and focused.

In this new approach, power has to be wielded by influence more than authority and health advocates have to learn to share power with people rather than wield power over people; this means giving fewer directives and participating more in negotiations. It also means that, although a structure to facilitate the process is important, the process needs more attention and the structure less. The structures that are implemented should be more collegial and less hierarchical. These structures and processes should enhance collaboration rather than competition, analyze issues holistically rather than sectorially, and use both/and rather than either/or approaches.

These are profound changes from the way things have been done in the past. As much as anything, the Healthy Cities project intends to change the organizational culture of city governments and some basic social values. They do not change overnight; indeed, some of these changes have already been underway for 20 years or more already. The expectations of the Healthy Cities project should be realistic and tempered with a sense of the history of change, the nature of the process of change and the nature of change itself.

Thus, from the start it was recognized that this would be no ordinary project,
given the tremendous changes in strategies, styles and values implicit in health promotion. These challenges were compounded by how little was known about the practical application of health promotion concepts; how little experience there was in working collaboratively with many people from non-health sectors to enhance health; how small the resources for health were at the local versus the national level; how little experience health and other professionals had in working with the community; how little health was placed on the agenda of local politicians; how little was known about health status and health inequity at the city and district levels; and how little these new understandings about health and its sociocultural determinants had penetrated even the public health community, never mind the non-health communities.

From the outset, therefore, the project was conceived as a learning project and, more, whose lessons would need to be learned and applied over the long term. It was also recognized that most of the knowledge and experience would reside and accumulate in the participating cities themselves. WHO had no simple programme or package to give to the cities, no manual of do’s and don’ts, no databases or indicators; fundamentally, the project did not belong to WHO but to the cities. This required WHO to assume a new role as an enabler, facilitator, mediator and advocate of change.

What is a healthy city?

A city is a living, breathing, growing, changing complex organism that has too often been considered as only an economic entity. Cities are players in promoting and maintaining health and have a unique capacity to implement ecological health plans.

In the first Healthy Cities Paper, Hancock & Duhl define a healthy city as one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

The definition and qualities of a healthy city have generally been well accepted and confirmed by experience. One way these qualities have been verified has been through workshops, which take place through a process in which people imagine themselves in their city or community at some point in the future when it is ideally healthy. Their impressions are then captured in writing or drawings. People’s understanding of the qualities of a healthy city are remarkably consistent with those initially proposed by the project.

Thus, there is a generally well accepted vision and definition of a healthy city, as well as an ideal set of qualities that have been verified empirically to some extent.

The qualities of a healthy city

A city should strive to provide:

1. A clean, safe physical environment of high quality (including housing quality);
2. An ecosystem that is stable and sustainable in the long term;
3. A strong, mutually supportive and non-exploitative community;
4. A high degree of participation and control by the public over the decisions affecting their lives, health and wellbeing;
5. The meeting of basic needs (food, water, shelter, income, safety and work) for all the city’s people;
6. Access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction and communication;
7. A diverse, vital and innovative city economy;
8. The encouragement of connectedness with the past, with the cultural and biological heritage of city dwellers and with other groups and individuals;
9. A form that is compatible with and enhances the preceding characteristics;
10. An optimum level of appropriate public health and sick care services accessible to all; and
11. High health status (high levels of positive health and low levels of disease).

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Hancock, T. & Duhl, I. Promoting health in the urban context. Copenhagen, IMD Publishers, 1988 (WHO Healthy Cities Papers, No. 1).
Thinking globally: the WHO Healthy Cities project

The WHO Healthy Cities project was developed because it was recognized that it is both necessary and possible to apply the ideas of health for all and health promotion at the local level, and it has thus become a high priority for the Regional Office for Europe. It is particularly effective in involving a much wider public in the process of achieving health for all and providing a high level of public visibility for WHO. It has proven to be politically appealing, relevant to the community and attractive to local governments, members of the community and the mass media, and it provides clear and specific examples of how to develop and apply health for all. Cities, towns and communities in other WHO regions have also begun to develop Healthy Cities projects, often with the support of national governments. The project has the potential to achieve considerable global significance.

The Healthy Cities project evolved as a practical, active component of the health promotion programme and the environmental health programme at the Regional Office for Europe. The major elements of the Ottawa Charter for Health Promotion are being used as a long-term framework for the project from 1988 to 1992. Developing multi-sectoral healthy public policy, creating physical and social environments that support health, strengthening community action, developing personal skills and reorienting health services are all active strategies that can be applied successfully at the community or local level.

The project has passed through several stages as it has grown. Ultimately, WHO anticipates a Healthy Cities movement consisting of national and international networks linking large numbers of cities and towns not only in Europe and other industrialized regions, but worldwide.

Mission and objectives

The strategy for health for all by the year 2000 is WHO's overall strategy to achieve a level of health that enables every person to lead a socially and economically productive life. Health promotion is a key strategy to achieve this objective, contributing to achieving health for all in Europe by building a new public health movement based on the principles of the Ottawa Charter for Health Promotion.

The ultimate goal of the Healthy Cities project is to improve the health of the people in the cities of Europe. Within this, the mission is to build a new public health movement in the cities of Europe and to make health the business of everyone at the city level.

The project strives to realize the vision of a healthy city through a process of political commitment, visibility for health, institutional change and innovative action for health and the environment:

- Political commitment and leadership can provide the necessary legitimation, direction and resources for the project.
Visibility for health is necessary to promote wide appreciation and recognition of the major health issues in the city and the economic, social and physical factors that influence health.

Institutional change is a fundamental prerequisite for change in cities. The process must be intersectoral in nature, given that the prerequisites for health depend on many different sectors; community involvement should be promoted to support and direct the political leadership and to ensure community ownership of this process.

Innovative action for health initiatives and supports activities that aim to promote equity, sustainability, supportive environments, community action and healthy municipal policies.

The project's process and style, both at WHO and in each individual city, reflect modern management ideas; successful organizations must experiment, learn, adapt and seek change.

There are no simple solutions or recipes for such a process. Strategies at the local level must be compatible with the cultural, social and organizational traditions of a city. The project needs a coherent vision and an overall long-term goal and direction. At the same time, it must be flexible, adaptive and creative, tailor itself to emerging needs and priorities and take advantage of local circumstances.

The WHO project office pursues these project objectives and the broader objectives of health promotion and health for all in five ways:

- Innovation - using an international network of cities to generate and test innovation and to build political support for the new public health in cities;
- Dissemination - using national networks to promote and disseminate applied innovation and to build national and international coalitions for the new public health;
- Developing leadership - facilitating the development of skilled and knowledgeable decision makers who are committed to the ideas of Healthy Cities and the new public health;
- Influencing international organizations - introducing health considerations into the urban programmes of other international organizations, and developing and coordinating resources - establishing effective managerial and support systems for the project.

Four broad challenges have emerged for the project cities:

- to generate visibility at the local level for health issues and the strategy for health for all;
- to move health high on the social and political agenda of the city and contribute to the development of healthy municipal public policies;
- to facilitate organizational and institutional changes that encourage cooperation between departments and key city sectors and promote community participation; and
- to create innovative action for health that emphasizes the interaction between people, environments, lifestyles and health.

Later in this report (pp. 43-64) the extent to which the cities have been able to meet these challenges, the problems they have encountered, and some ways to overcome these problems are described.

### Table 1
The project cities were designated based on a commitment to:

- formulate and implement intersectoral health promotion plans with a strong environmental health component, based on WHO policies and strategies and with active community involvement;
- secure the necessary resources to pursue and implement the plan;
- report back regularly on progress achieved and share information and experience from practice with the other project partners;
- support the development of national networks of Healthy Cities;
- establish an intersectoral political committee to act as a focus for and to steer the project;
- establish a project office with full-time staff and resources and a technical committee that brings together professionals from different disciplines and departments to develop and implement health plans;
- establish mechanisms for public participation and strengthen health advocacy at city level by stimulating visibility for and debate on public health issues and by working with the media;
- carry out population health surveys and, in particular, assess and address the needs of the most vulnerable and underserved social groups;
- involve and encourage local research institutions to support the activities of the project; and
- develop active working links with the other project cities, fostering technical and cultural exchange and hosting Healthy Cities meetings and events.

### Overview of the strategy

The WHO Healthy Cities project began, with a developmental phase (phase I: 1986-1987) and is now half-way through an implementation phase (phase II: 1988-1992). In 1985 the idea of a Healthy Cities project was first put forward within WHO by the then Regional Officer for Health Promotion.

In phase I the initial idea was operationalized by a WHO advisory group and further discussed and developed in meetings and symposia with delegations from European cities. By the end of this phase the project could develop a realistic action plan and WHO had designated 11 cities (first round of selection, September 1987) that were committed to work in the Healthy Cities network.

Phase II started with the designation of another 14 project cities (second round of selection, February 1988), the
official endorsement by all the parties involved of a five-year planning framework (1988-1992), and the establishment of a project office at the WHO Regional Office for Europe to coordinate the project and a method for joint work with the designated cities. From 1988 to 1990 the project also developed and endorsed an information exchange and consultation strategy and a multicentric action plan (described later). The project was expanded (third round of selection, November 1989 and March 1990) with the designation of six project cities (one dropped out after it was designated because of lack of political support). Thus, the WHO Healthy Cities network now consists of 30 project cities.

**Operation of the project**

The project involves a network of European cities who have endorsed the principles and policy directives of the WHO strategy for health for all by the year 2000, and who are politically committed to the five-year planning framework and to developing jointly and implementing action strategies for health. Table 1 shows the criteria for the selection of project cities.

The project is based on a spirit of true partnership and has well established mechanisms that promote information exchange, sharing of experience, mutual support, adjustment of existing plans, development of new strategies and dissemination of ideas and products (Fig. 1).

In two annual business meetings (spring and autumn), project city coordinators, city politicians responsible for the project and the staff of the WHO Healthy Cities project office present progress reports and discuss ongoing and determine new strategies and tactics based on experience and emerging needs. The project is relevant to local concerns and responsive to international developments. The experience of implementing the project provides a solid basis for the agendas of these business meetings.

The annual Healthy Cities symposia (which were only open to project cities after 1988) are integral to project strategy and development. They have three main functions:

- providing the basis for sharing experience, learning and mutual support;
- providing a focus for making progress visible, maintaining commitment and planning for the future; and
- providing an ideal forum to present and discuss models of good practice and case studies in the action areas of the project. The emphasis is on translating the ideas of the Ottawa Charter into practical policies and concrete activities.

The Healthy Cities symposia bring together project city politicians, administrators, town planners, architects, public health and health services professionals, environmental officers, community activists, researchers and others.

The project also organizes specialized technical workshops, on such issues as indicators, the needs of different social groups and environmental issues and training and briefing courses. Open Healthy Cities symposia and conferences are organized with different international partners to enable wider audiences and other cities to learn about the project and to engage in stimulating debate and discussion in specific areas such as research on urban health. Project cities also initiate and organize similar events for local audiences or on local themes of interest and concern.

The project involves visibility for health, political commitment, institutional change and innovative action for health. Fig. 2 shows how this process develops from policy to operation. For example, getting political commitment for the project is a strategy to ensure that city politicians are actively involved. This decision (choice of strategy) can then be further elaborated into a number of strategies for action, such as preparing and enacting a declaration stating that inequalities in health will be reduced in the city. The process of arriving at this desired outcome needs to be further defined and needs specific action to be put into operation.
The WHO Healthy Cities project

Commitment to a future direction:
to strengthen the role of cities in achieving health for all by the year 2000

Mission and purpose statement: to build a new public health movement in the cities of Europe and to make health everyone's business at the city level

Policy level

Objective 1: Visibility for Health
Objective 2: Political Commitment
Objective 3: Institutional Change
Objective 4: Innovative action for Health

Strategy 1.1
Strategy 2.1
Strategy 3.1
Strategy 4.1

Strategic level

Objective 1.1

Strategy 1.1.1
Strategy 1.1.2
Strategy 1.1.3
Strategy 1.1.4

Operational level

Project objective 1.1.1.1

Detailed project strategies and plans

Fig. 2
The action areas of the Ottawa Charter are linked to the process of the project (Fig. 3). Cities are expected to initiate activities for each of these areas. For example, action on equity requires: that the inequalities in health in the city be documented, exposed, and understood (visibility); that decision-makers recognize the inequalities and allocate resources to reduce them (political commitment); that strategies and structures be developed that promote collaboration between different disciplines and agencies and promote strong community involvement (institutional change); and that projects be initiated that address the specific needs of different vulnerable groups such as homeless or elderly people (innovative action for health).

Fig. 2 and 3 reflect the way the projects are conducted after three years of practice. They illustrate the range of changes that the Healthy Cities project is striving to make and can be adapted to each city's needs.

The five-year planning framework

The project applies the strategy for health for all and the principles of the Ottawa Charter and the European Charter on Environment and Health at the local level. The activities that define the joint work of the project cities and the WHO project office are described in documents that were developed and adopted by the partners involved: the Five-year planning framework (adopted at the 1988 spring business meeting in Bremen), the Information exchange and consultation strategy (adopted at the 1989 autumn business meeting in Pécs), and the Multi-city action plan (adopted at the 1990 spring business meeting in Belfast) (Fig. 4).

The Five-year planning framework describes the goal and aims of the project, the roles and tasks of the main actors, the roles, functions, and responsibilities of the project office, a framework for action from 1988 to 1992 and the required support systems and resources.

The framework for action integrates the five key elements of the Ottawa Charter with the regional targets for health for all to provide annual themes for the project.

The annual theme provides a focus for the project cities in their activities, data collection and reporting: for the project office, in organizing workshops and conferences and in its communication activities; and for other cities, national networks and partner organizations in their activities.

The themes are:

- 1988: Inequities in health
- 1989: Strengthening community action and developing personal skills
- 1990: Supportive and community health services
- 1991: Reorienting health services and public health
- 1992: Healthy policies for healthy cities

These themes and their relationship to the European regional targets for health for all are outlined briefly below (and more fully in the Five-year planning framework).

---

1988: Inequities in health. The Ottawa Charter identifies a set of prerequisites for health, as does the European strategy for health for all. These prerequisites include freedom from the fear of war, equal opportunity for all and satisfaction of such basic needs as food, shelter, basic education, water and sanitation, secure work and a useful role in the society, ecological stability and resource sustainability.

Targets for health for all stresses that health for all implies equity. The first of the 38 regional targets aims to reduce the differences in health status between countries and between groups within countries: "This target could be achieved if the basic prerequisites for health were provided for all ...".

Accordingly, the focus chosen for 1988 was inequalities in health status.
within cities and inequalities in access to the prerequisites for health. The Third Annual Healthy Cities Symposium (Zagreb, 1988) focused on the means to achieve equity in cities, including policies and actions to change the physical and social environment, enable healthy lifestyles and make services accessible to all (Fig. 5).

Cities are strongly encouraged to document inequalities in health to raise the profile of this major health issue, to develop long-term plans to address it and to provide concrete examples of city policies and projects intended or shown to affect inequalities in health and its prerequisites.

1989: Strengthening community action and developing personal skills. Strengthening community action particularly attempts to strengthen social support systems (target 14), public participation, community control over the health care system (target 30) and mutual aid and self-help. These latter categories also address developing personal skills for health (targets 15-17), and developing personal skills for taking control over health and participating in decisions affecting health. Target 18 also strives for community participation in environmental matters.

The objectives of the Fourth Annual Healthy Cities Symposium (Pecs, 1989) were: to broaden appreciation of the spectrum of issues and activities involved in community action; to increase the commitment of project cities to community action; and to illustrate strategic and operational ways to enable cities to promote community action at both the statutory level and in the community. Fig. 6 shows the focus of the Symposium.

1990: Supportive environments for health. Supportive environments include both physical and social environments, but particularly emphasize the

prerequisites of ecological stability and resource sustainability identified in the Ottawa Charter and the issues identified in the European Charter on Environment and Health.

Cities attending the Fifth Annual Healthy Cities Symposium in Stockholm in 1990 will be encouraged to examine and report on their approach to creating supportive physical environments, in such areas as urban planning and design, housing, the work environment, traffic, waste management and pollution control, and supportive social environments, especially for children, young people and disabled people.

A special effort will be made to link with: the Third International Conference on Health Promotion – Supportive Environments for Health (Sundsvall, Sweden, 1991), WHO’s support for sustainable development and the 1992 United Nations Conference on Sustainable Economic Development.

Creating supportive physical environments addresses European regional targets 11 and 18-25 and creating supportive social environments applies to targets 2, 3, 12, 14 and 30.

1991: Reorienting health services and public health. At the Sixth Annual Healthy Cities Symposium in Barcelona, cities will be encouraged to report on action strategies and models of practice to reorient their health and public health services in accordance with the strategy for health for all by the year 2000 and the Ottawa Charter.

The Symposium will address:

- providing effective, adequate, acceptable and accessible services that are appropriate and sensitive to people’s needs and wishes;
- enhancing the role of traditional health service systems in promoting health;
- building infrastructures for the new public health;
- building interdisciplinary alliances;
- developing new ways to plan and assess services and fully involve the users;
- strengthening lay care, self-care and self-help; and
- developing appropriate information and monitoring systems for health and ecology.

The care needs of vulnerable and underserved people and community-level health care will be especially emphas-
Addressing Inequalities in Health: Links for Action

Vulnerable Social Groups

People with Chronic Health Problems

Making Services Accessible to All

Changing the Physical and Social Environment

Enabling Healthy Lifestyles

The information exchange and consultation strategy

The information exchange and consultation strategy can support the project partners in implementing the project and assessing their efforts. The strategy is a joint effort between the project cities and WHO, based on shared responsibility and shared benefits. The original document, which was endorsed in 1989, is now being expanded to include the plan and method for the next evaluation of the project, to be completed by 1992 and presented at the Seventh Annual Healthy Cities Symposium.

The strategy consists of seven elements; each element is described in terms of tools, activities, resources, output and schedules.

Assessing the process: project progress and evaluation. A general framework to assess the project was first described in A guide to assessing healthy cities. The two main evaluation tools so far are annual progress report forms and in-depth interviews of city project staff and partners. Both tools were developed to formats that are structured and adaptable to the project's stage of development and the focus of evaluation. The results are analysed by independent researchers and other specialists. The evaluation of project progress from 1988 to 1990 provided the basis for Healthy Cities project. analysing of project progress, individualised city consultation reports and the review in this report. The project encourages research institutions in the project cities to participate in in-depth research on the policy and process of the project.

Assessing components of the project. Tools are being developed and used to assess such components of the project as information and activities on health inequalities and strengthening community action. Nine such components are described. The tools and activities include developing project theme indicators (a group of project cities is currently working on this) and completing and analysing a questionnaire on project city action on the annual theme.

Providing models of good practice. Tools and activities are being developed to create practical means of documenting, storing and accessing information about ongoing and new projects, contact people in various fields in project cities and bibliographies in different languages. A computerized Healthy Cities database is being considered.

Consultation. There are two different types of city visits: formal visits focusing on policy and technical visits focusing on programme and development.
Project cities are usually consulted during city interviews.

Information exchange between cities. Cities exchange information, consult and make bilateral agreements. An electronic wide area network linking the cities, training seminars and other ways to share experience, resources and learning are being developed. A first draft of a communication strategy will be presented at the 1990 autumn business meeting.

Developing indicators of a healthy city. The development and use of indicators in the project has not yet been satisfactorily resolved in terms of process or semantic content. The Healthy Cities workshop on indicators in 1987 agreed on the necessity of and the requirements for indicators but not on what the specific indicators should be. The indicators should be relatively few and should identify changes in both process and outcome that are useful to each city and to the project as a whole. One of the major questions is whether a single set of indicators can meet the unique needs of diverse project cities.

In addition to the work being done by project cities, the WHO project office has negotiated the active involvement of specialist research institutions. In May 1990 a French-speaking working group on indicators for a healthy city met in Nancy and agreed on a set of health, environmental and social indicators for healthy cities. The WHO project cities will consider the proposed indicators at a forthcoming business meeting.

Population health surveys. This refers to developing and using health surveys on such areas as subjective health, perceptions of health and knowledge about health, access to and use of services and social support systems, health inequalities, environmental assessment, social deprivation and vulnerability as well as more traditional aspects such as morbidity and lifestyles.

Evaluating the project (1990-1992). The information and analysis resulting from the evaluation for 1990-1992 will generate the material needed to prepare eight distinct products or resources. Outside institutions will have to support or perform the necessary analytical and editorial work. The material that could be produced includes:

- a consultation report for each city, describing the key information obtained in each interview, analysing its significance and recommending future action;
- training materials to be used by project cities, national networks and academic and professional institutions on such areas as Healthy Cities management and developing the new public health at the local level;
- a Healthy Cities handbook based on examples of action at the city level that would identify the main issues that arise in creating new structures and processes, gaining visibility for health and introducing new policies and programmes;
- a computerized file giving examples of new policies and programmes at the city level and approaches taken to solving the various problems that arise in creating Healthy Cities projects;
- a computerized file identifying personnel in the Healthy Cities network who can be used to advise and consult on project development;
- an assessment guide for national networks in carrying out interviews and consultation similar to that being done for project cities;
- a monograph identifying the research and data that are needed to develop Healthy Cities based on the experience of network cities; and
- an assessment of the significant developments in the WHO network from 1987 to 1991, including political issues, changes in structures and processes and new policies and programmes for health for all initiated through the project.
The multi-city action plan involves groups of cities working together to address common concerns. The initial projects include equity, traffic, housing, young people, elderly people, tobacco, AIDS care, nutrition, mental health and the health-promoting hospital. The plan will enable smaller groups of cities to work together on issues of high priority to them and will expand the number of partners and the resources made available both in the cities and from WHO. The goal of this plan is to develop jointly, implement and disseminate innovative models of good practice at the local level. The plan involves a business partnership of project cities committed to work together on one of the action areas for at least two years, and open market events, which are open to other cities and provide the forum to present models of good practice, exchange information and monitor the progress of the plan.

The multi-city action programmes bring in new social forces who contribute their time and energy to the project. For example, programmes on housing and health should involve the city's housing, town planning and environmental health departments; the social services department responsible for caring for groups with special needs such as people with disabilities, elderly people and homeless people; local housing cooperatives and neighbourhood associations; and public and private construction firms. At the international level, WHO can provide experience and expertise and, together with the cities, can also bring in resources and expertise from national and international organizations (such as the European Foundation for the Improvement of Living and Working Conditions, the European Commission, the Council of Europe and the Organization for Economic Co-operation and Development) that are concerned with housing and urban environmental health.

The key to the success of these multi-city action programmes, some of which will be the topic of meetings for the first time at the Fifth Annual Healthy Cities Symposium, is to ensure that their activities are consistent with the concept and principles of health promotion that are the basis of the Healthy Cities project. For example, the action programme on tobacco, based on the WHO Action Plan on Tobacco, seeks healthy public policy changes in the cities (such as non-smoking by-laws or banning tobacco vending machines) that encourage the creation of social environments that support non-smokers, and mobilize community action to support the rights of non-smokers, not merely undertake educational campaigns focused on personal behaviour and lifestyle choices.

Involving other WHO programmes in achieving health for all at the local level

The project is one of WHO's major vehicles for achieving the strategy for health for all. It has provided the testing ground for applying new strategies and methods of operation in cities, which is completely new to the work of WHO. The project has established political, professional and technical alliances for health and fertile ground for change and innovative action. New channels of communication and potential entry points to other active programmes of the Regional Office for Europe and other international agencies have been opened up.

Fig. 7 illustrates how the project provides opportunities for collaborative work within and outside WHO.

The project is a joint enterprise of the health promotion programme and environmental health programme of the Regional Office. The possibilities for joint work with other programmes include: technical support for preparing project events such as symposia and workshops; participation in the multi-city action plan; technical support and consultation with cities requesting help in various areas; promotion of action packages prepared by different programmes, from nutrition guidelines for local caterers to housing standards and aspects of primary and hospital care; and networking with different local professional groups and institutions and establishing contacts with local
people with relevant experience and expertise. To accomplish this, the Regional Office needs to address the resources needed to enable and facilitate this collaboration.

The potential of this project to build alliances and joint work with other Regional Offices and national and international organizations is described later.

Key events in the project, 1986-1987

The project planning group met for the first time in Copenhagen in January 1986. The First Annual Healthy Cities Symposium took place in Lisbon in April 1986; 21 cities attended. A workshop was held in Gothenburg on strategies in October 1986 and in Barcelona (on indicators) and Rennes (on environment) in March 1987. The Second Annual Healthy Cities Symposium in Düsseldorf in June 1987 was attended by 210 people representing 54 cities from Europe, Canada, the United States and Australia.

So great was the enthusiasm and interest in the project that the initial plans for working with 5-8 project cities had to be revised. Eleven project cities were selected by the end of 1986, and it was announced at the Second Annual Healthy Cities Symposium that this number would be increased further. Within Europe, many other cities expressed keen interest, and several national networks began to develop. Meanwhile, national Healthy Cities initiatives were developing within and beyond Europe, Canada and Australia, in particular, moved ahead rapidly.

Key events in the project, 1988-1990

From 1988 to the present, the project has grown further but, more importantly, it has been consolidated substantially, as both the cities and the project office gained experience in implementing Healthy Cities strategies.

1988

The key events in 1988 were the first major conference co-sponsored with another international organization, the first meeting of the national network coordinators and the Second International Conference on Health Promotion: Healthy Public Policy in Adelaide, Australia.

<table>
<thead>
<tr>
<th>The growth of the Healthy Cities movement</th>
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<tbody>
<tr>
<td><strong>1985</strong></td>
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<tr>
<td>WHO conducts feasibility study for project</td>
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<td><strong>1986</strong></td>
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<tr>
<td>January: First planning group meeting</td>
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<tr>
<td><strong>1987</strong></td>
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<tr>
<td>April: First Annual Healthy Cities Symposium, Lisbon</td>
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<tr>
<td>56 participants</td>
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<tr>
<td>21 cities</td>
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<tr>
<td>17 countries</td>
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<tr>
<td>October: 11 cities selected in first round</td>
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<tr>
<td><strong>1988</strong></td>
</tr>
<tr>
<td>June: Second Annual Healthy Cities Symposium, Düsseldorf</td>
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<tr>
<td>210 participants</td>
</tr>
<tr>
<td>54 cities (7 from outside Europe)</td>
</tr>
<tr>
<td>23 countries (4 from outside Europe)</td>
</tr>
<tr>
<td>January: 14 cities selected in second round, expanding project to 25 cities</td>
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<tr>
<td>May: International Conference on Health in Towns, Vienna, co-sponsored with the Council of Europe's Standing Conference of Local and Regional Authorities of Europe and the City of Vienna</td>
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<tr>
<td>400 participants</td>
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<tr>
<td>111 cities</td>
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<tr>
<td>24 countries</td>
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<tr>
<td><strong>1989</strong></td>
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<tr>
<td>August: First national network meeting, Helsinki</td>
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<tr>
<td>10 national networks</td>
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<tr>
<td>155 cities identified as active in networks</td>
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<tr>
<td>September: Third Annual Healthy Cities Symposium, Zagreb</td>
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<tr>
<td>155 participants</td>
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<tr>
<td>26 cities (2 outside Europe)</td>
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<tr>
<td>18 countries (2 outside Europe)</td>
</tr>
<tr>
<td><strong>1990</strong></td>
</tr>
<tr>
<td>August: Second national network meeting, Eindhoven</td>
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<tr>
<td>23 participants</td>
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<tr>
<td>There were:</td>
</tr>
<tr>
<td>15 national networks (2 outside Europe)</td>
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<tr>
<td>5 subnational networks</td>
</tr>
<tr>
<td>2 international networks</td>
</tr>
<tr>
<td>over 350 cities active (over 100 outside Europe)</td>
</tr>
<tr>
<td>September: Fourth Annual Healthy Cities Symposium, Pécs</td>
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<tr>
<td>207 participants</td>
</tr>
<tr>
<td>26 project cities</td>
</tr>
<tr>
<td>25 countries (6 outside Europe)</td>
</tr>
<tr>
<td>November: 5 cities selected in third round – expanding project to 50 cities (1 later dropped out)</td>
</tr>
<tr>
<td><strong>1991</strong></td>
</tr>
<tr>
<td>March: 1 additional city selected as part of the third round</td>
</tr>
<tr>
<td>May: Third national network meeting, Horsens</td>
</tr>
<tr>
<td>48 participants</td>
</tr>
<tr>
<td>There are now:</td>
</tr>
<tr>
<td>17 national networks (5 outside Europe)</td>
</tr>
<tr>
<td>5 subnational networks</td>
</tr>
<tr>
<td>2 international networks</td>
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<tr>
<td>about 400 cities active</td>
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</table>
The International Conference on Health in Towns – New Public Health Strategies for Local Authorities was sponsored by the Council of Europe’s Standing Conference of Local and Regional Authorities of Europe, the WHO Regional Office for Europe and the City of Vienna, and attracted over 400 participants from 33 cities and towns in 29 countries. The first meeting of national network coordinators in Helsinki revealed that 155 cities were active in one way or another in ten national networks, including two (Canada and Australia) outside Europe.

The Adelaide Conference featured a large number of case studies on local healthy public policy. Many of these were subsequently published.³

Other important events in 1988 included a workshop on ecological models for planning in Liverpool and a seminar on old age, urban living and health promotion in Turku. The Third Annual Healthy Cities Symposium, held in Zagreb, established the principle that the symposia are for the project cities only. It focused on equity and health and attracted 135 participants from 26 cities and 18 countries. The spring business meeting for project cities was held in Bremen and approved the five-year planning framework for the project.

1989

In 1989 the project expanded further to involve 30 cities. Major events included the International Conference on Research for Healthy Cities, held in The Hague, co-hosted with the Netherlands Society of Public Health and Science, workshops on sports and the healthy city (Barcelona), healthy housing (Lisbon), urban ecology (Ursia) and We Are the Future, a workshop for children and teachers (Horsens). The spring business meeting was held in Milan and the Fourth Annual Healthy Cities Symposium, on the topic of community participation, took place in Pécs, attracting 207 participants from 26 cities in 25 countries. The process of gathering information and providing consultation was formalized and approved at the autumn business meeting in Pécs. Representatives of 15 national and several subnational and international Healthy Cities networks met in Eindhoven.

Another major event in 1989 was a series of one-hour television programmes on Healthy Cities (Cities Fit to Live In) produced by Channel 4 in the United Kingdom and aired in seven countries that featured five of the project cities (Liverpool, Turku, Barcelona, Dublin and Pécs), as well as Toronto.

1990

The project is now well into its stride. The spring business meeting was held in Belfast and endorsed the multi-city action plan. At the end of the business meeting, city project coordinators attended a management workshop on effective project leadership. The workshop clarified the leadership role of city project offices and specified the action areas in which each local project will increase its chances of success. Fig. 8 shows the areas of project leadership identified. Forty-eight representatives from 16 national Healthy Cities networks and several subnational or international networks met in Horsens, where it was learned that about 400 cities are now active in the Healthy Cities movement worldwide, and the Fifth Annual Healthy Cities Symposium (on supportive environments) is slated for Stockholm. Workshops were held or planned on an ecological, integrated database for planning (Padua) and community care for people with AIDS (Düsseldorf). Several groups of project cities that will be engaged in different multi-city actions have held initial planning meetings. In addition, the WHO Healthy Cities project and the European Association of Social Pediatrics are co-sponsoring the European Congress.
Within three years of the beginning of the project, the number of national networks operating was larger than the number of cities selected in the first round. As of mid-1990, there are 17 national Healthy Cities networks and an international French-language Healthy Cities network (Fig. 9). The Regional Office provided crucial support in establishing several networks. Subnational Healthy Cities networks have also been developed in 6 countries: France, the Federal Republic of Germany, Spain, the United Kingdom, Canada and the United States. In addition, WHO Regional Offices in the Americas, the Eastern Mediterranean and Africa are also in the process of starting and developing Healthy Cities (or Healthy Communities in the Americas) projects. Healthy Cities has become an international movement (Fig. 10).

**European national networks**

When the Healthy Cities project was initially conceived, and during its first year, national networks were only a small part of the agenda, because the popularity of the project had not been foreseen. Nevertheless, the selection criteria for project cities finalized in October 1986 included a commitment to developing working with a national network. The five-year planning framework identified a specific role for national networks to communicate with cities not part of the WHO project. The WHO project office intended to provide these cities with the full range of materials available to project cities and to invite them to the annual symposia and co-sponsored meetings.

The interest in national networks was so great and they grew so quickly that the first meeting of national network coordinators was held in Helsinki in 1988, this has become an annual event. The role and function of national networks was discussed at the 1989 meeting in Eindhoven, at which it was agreed that the principal role of a national network is to serve and support the needs of its participating cities and to expand the Healthy Cities movement. Nine national networks reported having a support centre and coordinator. At this meeting, it was also agreed to establish a European network of national Healthy Cities networks (EURO-NET) and to develop a system to exchange information.

Sixteen national networks in Europe and in other regions attended the third meeting of national networks (May...
The focus was also on information exchange and the need for training at all levels. The national networks noted the value of a partnership with their national associations of municipalities and expressed interest in linking with relevant international organizations. An advisory group was established to catalyse and support training activity, especially emphasizing the educational needs of trainers.

National network activities at present include: translating the background and strategy documents of the project into other languages, producing newsletters and project information packages and organizing business meetings, conferences, technical workshops and training courses.

Subnational networks have been established in six countries; they function similarly to national networks, but on a smaller scale. France has seven regional networks; Spain has two established networks and one is being developed. The United States has two: one in California and the other in Indiana. The Quebec network in Canada (called Villes et Villages en santé) involves over 30 cities and is the largest formal subnational network outside Europe.

A major challenge for the project is to respond to the emerging needs and opportunities in eastern Europe. Healthy Cities is part of the WHO European strategy for the countries in central and eastern Europe and has the following objectives: to reach a wide range of professional, political and community audiences with products and action plans that are practical and relevant to present problems; to facilitate the process of creating political commitment and alliances for the new public health at the local level; to organise consultation at city level and courses for different groups; and to support actively the creation and operation of national Healthy Cities networks.

**Austria.** At the Healthy Cities symposium for German-language countries in Wels, Austria, in 1989, the City of Linz, supported by the Interuniversitäres Forschungsinstitut für Fernstudien (IFF), took the first initiative to establish a national network in Austria. Since then there have been several meetings to establish a national network. In 1989 the City of Linz organized two seminars on  Together in a Healthy City to initiate cooperation between city administrators and citizens. To support the development of the national network, the IFF is establishing (in collaboration...
with WHO) a German-language Healthy Cities course on health promotion in communities. The national network coordinator has an office in the building of the city council of Linz. Participation criteria are informal.

**Denmark.** There is no established national network yet, but Hernens and Copenhagen (both project cities) have taken the initiative to create one. The City of Hernens has presented the project to the Association of Local Authorities in Denmark and so interested cities and organizations. Hernens hosted the third meeting of national network coordinators in May 1990. In September 1990 interested cities will meet to discuss what has to be done to establish a national network and to become part of the national health plan.

**Finland.** The first meetings between interested cities and organizations started in June 1986. In 1988 the network was officially established by a network constitution. There is no support centre, but the Office for Health Education of the Department of Health Promotion of the National Board of Health acts as a contact point. The goal of the network is to emphasize that cities have an independent responsibility for developing their own health and to shift from internal project development to publicity and political action. Four cities are involved in the network. Each participating city has to have a city coordinator, is responsible for developing activities and an action plan and has to pay for activities, coordination, and administrative work. Helsinki hosted the first meeting of national network coordinators.

**France.** After attending the Second Annual Healthy Cities Symposium in Düsseldorf in 1987, the Mayor of Rennes promoted the establishment of a national network, in particular, by establishing regional networks. In December 1989 the French national network was formally established, and a steering committee was selected. The steering committee acts as an organizing body. Eleven cities are involved. Participation criteria include the criteria for the WHO project cities, a city council resolution, paying an annual fee and a population over 50,000. The national government, universities, and the National School of Public Health support the network. Seven subnational networks have been established. France also participates in an international
French-language Healthy Cities network.

Poland. The national network was formally established in January 1991. Approximately 18 cities are taking part. The network coordination centre is based in Warsaw and is supported by the Ministries of Health and Social Welfare, Environmental Protection, Urban Planning and Constructions, several scientific societies and institutes on the field of prevention and environment and by the Association of Polish Municipalities. The participating cities have already started the process of establishing local project intersectoral committees and have identified some of their major priorities for action. Water, air and noise pollution, waste disposal and prevention of disease programmes represent common concerns of Polish cities. Special emphasis is also given to programmes of collaboration and technical assistance with cities and networks in western Europe.

Federal Republic of Germany. The national network was formally established in June 1989. The network adopted a seven-point action plan at its founding meeting. Official city commitment to this plan is a major criterion for participating in the project. About 17 cities have joined so far the network.

The support centre has been established at the Department of Health of the City of Hamburg, which financially supports the centre. A committee administers the network and advocates the Healthy Cities movement.

The Ministry of Youth, Women, Family Affairs and Health financially supports the annual symposium of the national network.

Several workshops, symposia and meetings have been organized to promote different aspects of the Healthy Cities project and to exchange information.

With the recent reunification of Germany it is expected that former GDR cities will join and significantly increase the number of cities in the German network. The network is in close contact with other German-language countries.

Hungary. The national network was formally established in October 1988 at a meeting of representatives of the participating cities. The support centre, located at the Health Department of the Municipal Council of Pécs, was established in November 1989. A national Healthy Cities fund, run by representatives of cities in the network, has also been established. Seven cities are involved in the network. Participation criteria include political commitment by the local government (formal letter), commitment to the principles of health for all, a city coordinator, establishing a multidisciplinary committee and annual cities. The main objective is to encourage all the cities (and also laypeople and organizations) in Hungary to join the project so that health becomes the most important question on the agenda of local governments and that decisions that affect health are made with active citizen participation. The network meets annually.

Israel. After Jerusalem was selected as a project city, the first initiatives were taken to develop a national network. Because the political situation in each municipality is unique, the involvement of the Israeli Union of Local Authorities was required. In 1989, World Health Day was used to promote the Healthy Cities project. By means of health fairs (established in interested towns) and a multilevel approach, the principles of the Healthy Cities project were introduced to towns and newly elected mayors (because municipal elections had just taken place). In March 1990 the first workshop on Healthy Cities was held and a national network was officially established. Four cities are involved in the network. Participation criteria are formal. The main objective of the network is to develop the network further and recruit more cities.

Italy. In July 1990 a Healthy Cities Association was established in Milan. The objectives of the Association include: promoting the idea that health is a precondition of global wellbeing of the individual; studying and proposing solutions and actions to improve mental, physical and social wellbeing, particularly for city dwellers; encouraging community activities and community participation to improve the environment and the quality of life in cities; promoting, developing and coordinating a national Healthy Cities network that has the same principles and objectives as the WHO Healthy Cities project, and promoting relationships between Healthy Cities networks in Italy, Europe and world-wide. The members of the Association include local public administrations, other interested associations acting in areas or having objectives similar to those of the
Association, private, public, national and international bodies, professional associations, and any person interested in the problems addressed by the Association.

Netherlands. The national network was established in 1987. The selection criterion is commitment to the principles of health for all. About 20 cities have joined the network. A support centre is based in Eindhoven. The network has an open, horizontal structure that enables, mediates and advocates the Healthy Cities values. A basic principle is that structure follows strategy. Although it is horizontally organized, the network is steered by a key group representing participating cities that initiates and promotes ideas. The network is supported by the national government, municipalities and non-governmental organizations. The network closely cooperates with all the existing political structures. In January 1990 the Association of Dutch Municipalities established a Healthy Cities forum. Eindhoven hosted the second meeting of national network coordinators.

Portugal. There is no formally established network yet, but the municipalities intend to build a Healthy Cities network that completely covers the country. The National School of Public Health is the support centre at the national level, and the health centres located in the participating cities support the network at district level. There are 22 participating cities (the district capitals).

Spain. The national government, the City of Barcelona and the Spanish Federation of Municipalities founded a Healthy Cities network in March 1988. The support centre is located at the Federation of Municipalities in Madrid. Ten cities have joined the project. Participation criteria for the network are formal (an official municipal commitment to the Healthy Cities movement, a project coordinator in each city and a minimum fee for each city). The coordinating office has approved a five-year action plan similar to that of the WHO Healthy Cities project. The main objective is to spread the network. Two regional networks are functioning.

Sweden. The network has no official name and has not been officially established. The tasks of the network are integrated in the Division of Health Edu-
ocation within the National Board of Health and Welfare, which has reported on the project on different occasions and distributed information to county councils and some municipal councils. Five cities are involved, and participation criteria are being discussed.

Yugoslavia. In 1987 the Permanent Conference of Yugoslavian Cities (which includes almost all Yugoslavian cities) was informed about the Healthy Cities idea. In 1988 interested cities and representatives of the Conference expressed willingness to join the national network. The national network was officially established during a Healthy Cities training course in June 1990 in Dubrovnik. The support centre is located in Zagreb, where the Healthy Cities movement is becoming more and more popular. There are special boards and expert committees for a range of issues. The mass media are also involved in the movement, registering activities and events. The result is that the whole country is being informed about the project.

United Kingdom. The Local Authority Health Network set up a national Healthy Cities network in 1987. The network grew very quickly and became independent of the parent organization. The inaugural meeting was held in December 1987. In 1988 the network was extended from England and Wales to the entire United Kingdom. Since the beginning of 1990 an official national network office and a full-time organizer have been based in Liverpool, funded by a grant from the Health Education Authority. More than 70 cities, 80 local authorities, 50 health authorities and various community groups and other organizations are involved in the network. The main objective is to establish close liaison with organizations involved in areas related to those of interest to the national network. The national network has a strategic role: assisting members to develop, implement and monitor approaches to health for all. In 1990 decisions need to be made about the future of the network, its priorities, organization, membership, name, direction and constitution.

Networks outside Europe

As originally conceived and developed, Healthy Cities focused on cities in industrialized countries: specifically, Europe. Cities, however, are not the only form of local administrative unit. Thus, as the Healthy Cities idea has spread around the world, it has seen various adaptations.

One of the first adaptations of the idea, and one still hotly debated, was that a Healthy Communities project was initiated in Canada. Any size municipality can join. In addition, there was interest in working with native communities, who suffer the greatest health inequalities and thus have the greatest health needs; they do not live in cities but often in small, isolated communities. The only selection criterion for the project is a municipal council resolution. The national project is co-sponsored by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities, funded by the federal health ministry, and the office is located at the Institute of Planners.

Canada's largest cities (Toronto and Montreal) participate, and the smallest participant is a village of 3000 people in Quebec. It is clear, in accordance with the experience in Europe, that the Healthy Communities project is easier to initiate and develop in smaller municipalities.

The Quebec project is a unique and distinct project within Canada, as Quebec is a unique and distinct society. The project's title, Villes et Villages en sante, reflects the project's focus on both large and small municipalities. The provincially funded project office (the only one in Canada) has been very active, both within Quebec and internationally, through its links to the international French-language Healthy Cities network.

This network is the first international network to reach out beyond Europe and, indeed, beyond the industrialized world. It involves cities from Quebec, France and Belgium, and is developing further by establishing relationships with North Africa, South America, Portugal, Spain and Italy. The network was officially established in 1988. Its first biannual conference was held in Bennes in 1988, the second is taking place in Montpellier in 1990 and the third is scheduled for Sherbrooke, Quebec, in 1992.

A Healthy Communities project has been established in the United States...
through the cooperation of the National Civic League and the United States Public Health Service. The goal of the project is to link the business community, government agencies, citizen groups and nonprofit organizations to improve the way local communities assess their health needs and improve them. A major goal of the Healthy Communities project is convincing people that social change is possible through grassroots effort. A healthy community works to improve its health and quality of life by incorporating the views and resources of all community members in carrying out solutions to locally defined problems.

Two examples of local Healthy Communities projects are the California Healthy Cities project and Healthy Cities Indiana. The California Healthy Cities project was established in April 1988 and involves seven pilot cities. The statewide project is managed by the Western Consortium for Public Health, a nonprofit training, education and research organization sponsored by the Schools of Public Health at the University of California at Los Angeles and Berkeley, San Diego State University is an affiliate member.

Healthy Cities Indiana began in 1988 with a grant from the W.K. Kellogg Foundation and focuses on a public-private partnership for community health promotion. This collaborative project involves the Indiana University School of Nursing, the Indiana Public Health Association and six cities in Indiana. In each of the cities a Healthy Cities committee is developing long-range strategies for city health promotion, but short-term committee projects have also been undertaken. The project has a resource centre that conducts research and disseminates information that is valuable to cities interested in community health promotion.

In May 1987 the Federal Department of Community Services and Health under the National Health Promotion Programme started an Australian national Healthy Cities network. In February 1990 a national network staff was funded for two years. The aim is to develop and demonstrate policy and action strategies that advance health promotion in terms of the new public health in three pilot cities, and to promote the project. The pilot project provided funds for a project officer in each city. Each pilot city has developed an intersectoral collaborative structure to manage the project and has undertaken action on a variety of locally iden-
Taking stock: an assessment of the project

The project is evolving within a long time frame. Its ultimate objective is to enhance the overall health and wellbeing of the people that live in cities in Europe and to develop a new locally based public health movement throughout Europe, and not simply to reduce mortality and morbidity rates (although this is important and should not be dismissed lightly). Thus, the project tries to change how individuals, communities, private and voluntary organizations and local governments throughout Europe think about, understand, and make decisions about health.

These changes take time: if the history of public health and other profound social change is any guide, 20-30 years or more. Moreover, public health in Europe rarely deals with communicable diseases that have a short incubation period or an impact early in life, where an action taken today (such as removing the handle of the Broad Street pump) can produce results in a few weeks or months. The (comparatively) easy changes that reap big rewards in terms of life expectancy and mortality rates were made long ago. Today's health problems are more complex, have longer latency periods, occur later in life and are chronic; they are related to the reduced quality of life and mental and social wellbeing more than to physical disease. The European strategy for health for all thus aims to add life to years, add health to life and add years to life.

The project intends to assess progress by the changes in the way people and city governments think about and address health. In the first few years of this project, such change is one of the key outcomes. If the appropriate structures and processes can be put in place and health becomes and remains a key social objective of a city, and if political will can be mobilized, social partnerships created and community energy harnessed, then health

Students at a technical job training centre in Munich develop ideas for healthier food for other students of the same age. Here they are discussing the do's and don'ts of school snack food (photograph: Delapress)
will improve. Assessing progress in this manner is policy analysis of a rapidly moving target.

Healthy Cities project: analysis of project progress, a 1990 report by the Research Unit in Health and Behavioural Change in Edinburgh* points out that:

In social-science research there is a widely held appreciation that research and evaluation of projects in the "real world" seldom meet the criteria of traditional "scientific" evaluation strategies. Exciting ideas and innovations rarely develop in a logical, coherent manner. Rather, new ideas often carry forward with a momentum of their own. The WHO Healthy Cities project is in its very nature an exploratory venture and therefore standard research paradigms for evaluation may be inappropriate. As with many innovative projects, it was not able to set about an overall evaluation from the beginning.

The evaluation of progress made by project cities from 1988 to 1990 was geared towards investigating and analysing how and to what extent the cities had fulfilled the criteria for joining the project, the structures and processes that were introduced and the types of activities for health that were initiated or linked to the project. The main sources of information for the analysis were the annual progress reports from each city and interviews with city representatives. The evaluation covers the 25 project cities selected in the first and second rounds (Annex 1).

Conclusions and achievements

The major strength of the project is that it is attractive to many different groups and professions and the political and community leadership in many different cities and towns and has thus quickly been disseminated widely. The number of project cities has grown from 11 in 1987 to 30 in 1990, with further expansion anticipated. Seventeen national networks have been developed and more than 400 cities are involved in healthy cities projects worldwide.

The project has been very successful in accumulating practical knowledge about the strategies and structures that can help to promote the Healthy Cities idea. It is now possible to prepare a composite picture of the organizational structures and the managerial processes that predict success in developing new approaches to public health at the local level.

About half of the project cities have successfully developed a new organizational model and strategy for addressing health. This knowledge can be enriched by further annual review processes, developing case studies and wider exploration of organizational theory. Since there was previously no contemporary body of practical knowledge in the new public health, this is a very significant achievement.

The mayors and senior political representatives of the WHO project cities have issued a strong declaration of political support (the Milan Declaration on Healthy Cities), and several project cities have already devoted significant resources to the project.

Business meetings, annual symposia and technical workshops have been regularly established and are well attended. Project cities compete to host these meetings and make considerable resources available for this purpose.

The project is a proven example of how to achieve health for all at the local level. It has laid the basis for a new European public health movement and forged links between WHO and local governments for the first time. It makes WHO more visible, credible and relevant to local needs and concerns. The project city expectations from WHO for leadership, legitimacy and guidance and technical support represent a major challenge for the future.

The success of a local Healthy Cities project depends on the social, economic and organizational features of a city, the extent of political commitment to develop and implement the project and the availability of practical knowledge from international experience. The legitimacy that is achieved by being a part of a growing world-wide movement is a key factor. The practical experience that has been accumulated from the first courageous cities that were involved with the project is now becoming a source of inspiration, guidance and legitimacy for other cities in the movement. Assessing and documenting progress and producing handbooks of practical strategies is crucial to support and fulfill the hopes and

*Available from the WHO Healthy Cities project office.

Tobacco-free Göteborg 2000 project: the Göteborg Health Council gives high priority to working against snuff and tobacco. One special campaign is directed towards young women nurses, since many smoke.
expectations of hundreds of cities. There are few other comparable examples in the history of public health in which a relatively small investment has paid off so well.

Implications for future strategies

This review of project progress has led to several clear directions for future development. The project is experiencing rapid growth and is accumulating practical knowledge, and the world-wide pool of cities that want to be part of this is growing. It has therefore become necessary to decentralize project activities to resource centres outside WHO. For example, the needs and opportunities for public health work in central and eastern Europe need to be addressed. Cities are now seriously taking on a new role in promoting public health. The challenge is to respond to the demand for practical knowledge and guidance and to support the process for political commitment and organizational change for health. Further, the globalization of the project, expanding into cities in the developing countries, requires approaches for healthy cities that are compatible with the health status and social, cultural, economic and environmental circumstances of these countries.

Three major areas have been identified as crucial for future strategies: the need to expand and consolidate the project base of knowledge, a process to support project cities, and the need to further develop the project beyond 1992. The implications for the resources required by these activities are briefly discussed at the end of this section.

Expanding the base of knowledge

The evaluation and documentation of strategies, structures and processes begun in this review needs to continue.

Given the international dimensions of the Healthy Cities project, it is imperative that materials based on the accumulating practical experience be produced. These materials (described on page 28) include handbooks on how to start up and run a viable Healthy Cities project, resource packs that include examples and case studies of activities and projects in the cities, and training manuals.

The focus for 1990 to 1992 should shift increasingly to evaluating the effects of the city projects in the five action areas that are the basis for the project. Have the mechanisms and processes examined in this review actu-
ally developed healthy public policy and community action for health at the local level. The evaluation process will increasingly focus on city actions to develop healthy public policies, create supportive environments for health, strengthen community action for health, develop personal skills and reorient health services. These will form the basis of the final review of this phase of the project, to be presented at the Seventh Annual Healthy Cities Symposium in Copenhagen in 1992. The review process and production of materials will require considerable work with analysts and consultants and with the cities to develop ways to identify and assess such actions and their effects.

Supporting project cities and other cities with special needs

Although many project cities have succeeded in initiating significant structural change, several have still not succeeded in making such changes or in establishing appropriate structures and processes. All cities in the network must therefore be assisted in achieving the level of performance of the best functioning cities, whose performance should also be improved.

Some areas of project development and management are particularly complex and difficult, including adopting long-term perspectives in project plans and developing mechanisms for managerial and political accountability. The WHO project office needs to lead by establishing mechanisms and working groups to develop methods and information in these areas. This will form part of a broader training process that should be made available to the project cities; a training strategy is being developed. Pilot training courses are being held in Vienna, Pécs, Unna and Dubrovnik. Creating European Healthy Cities resource centres with funding from other sources is also a priority of the project.

Beyond 1992

WHO is committed to supporting Healthy Cities as a successful vehicle for achieving health for all. The Regional Director for Europe has therefore announced that the project will receive WHO support until at least 1995.

Given the WHO commitment and given that the project cities have made a parallel political commitment in the Milan Declaration on Healthy Cities, a new five-year plan will be needed for the next phase of the project. Consideration also has to be given to: the role of the project cities whose initial commitment to the project has elapsed, the selection process for future project cities and the development of new criteria for cities entering the project, drawing on the lessons learned in this phase.

EXPO 1992 (Seville) and EXPO 1995 (Vienna and Budapest) provide major opportunities to increase the visibility of the project and exhibit its achievements.

Additional resources and personnel

Given the project’s priorities, opportunities and commitments, additional full-time personnel and resources are clearly needed to collect, analyse and disseminate information. Compiling handbooks and manuals, setting up an electronic bulletin board and database for project cities and national networks and publishing a Healthy Cities newsletter are costly and resource-intensive. At present the WHO Regional Office for Europe invests approximately US $500 000 per year in the Healthy Cities project, including staffing and operations.

Additional resources are needed to develop and provide training programmes for project cities, to support less wealthy cities, so that they can participate fully in the project, and also to support cities in central and eastern Europe; to enable cities to exchange experience with other cities, and to fund direct communication and city visits by WHO staff and consultants. The WHO Regional Office for Europe is currently exploring various ways the project can be supported. The alternatives include Healthy Cities resource centres, which can provide information, analysis and guidance on strategy, a potential European Healthy Cities fund and private sponsorship.

Healthier food project and nutrition contest for schools and kindergarten, one of the first and most successful initiatives of the Healthy Cities project in Munich
Understanding the process: a review of progress in the cities

As the project, in its early stages, focused on the process of making cities more healthy and on the need to put health on each city’s agenda, a preliminary assessment examined the management structures and processes the cities have put in place so far. The project must change the way cities understand and deal with health if it is to have a long-term impact, and this requires new structures, styles and processes. This section of the report reviews and analyses the structural and managerial characteristics and activities of the WHO project cities for the first time. It is the result of a process of interviews of city representatives and visits carried out during and after the Fourth Annual Healthy Cities Symposium in Pécs in 1989, as well as an analysis of the annual progress reports from each city.

What is a local Healthy Cities project?

One of the most interesting qualities of the WHO Healthy Cities network is that it contains a variety of approaches to organizational structure and processes. An essential feature of the WHO project is that it can accommodate this structural variety while moving policy in a consistent direction. Despite these differences, the information available indicates that most projects possess a common set of ten characteristics. Taken together, they provide a composite picture of a local Healthy Cities project:

- Concepts and principles that express the Healthy Cities philosophy are developed. They relate to promoting health and preventing disease, improving the quality of life in cities, balancing the focus on lifestyles and environmental concerns and developing a commitment to reducing inequalities in health status. Intersectoral action and community participation are fundamental strategies of the project. These principles provide the basis for Healthy Cities policy.

- Political decisions are made to build structures and to adopt policies and programmes that comprehensively address health issues within the city. These decisions are expressed as declarations or resolutions of city councils and other partners involved in the project.

- Committee structures are established that direct policy for the project and create a forum that discusses the interests and contributions of various project partners and makes decisions about plans and priorities.

- A small organizational unit known as a local Healthy Cities project office follows up and implements the decisions made by the committees.

- Plans for operations and strategy are prepared that express the intentions of the Healthy Cities projects and, in some cases, outline how all sectors of the city administration will contribute to improving the health of the urban population.

- Administrative arrangements are used to build the knowledge base the project needs, to facilitate cooperation between the various sectors in the city and to encourage community participation in health planning and action.

- Policies and programmes are changed and innovative projects are
developed as a result of Healthy Cities work. Some initiatives are carried out within the city administration but many others involve the work of other statutory agencies, community groups and businesses.

- Activities are undertaken to increase the awareness of health issues, to promote the strategy for health for all and to gain visibility for the Healthy Cities project and its achievements.
- Mechanisms are developed to ensure that the Healthy Cities project is accountable to the political system and to the wider community and similar mechanisms develop political accountability for the implications for health of all decisions made within the city administration and, ultimately, other sectors of the city economy.
- National and international collaborative links within and outside the WHO project are set up to exchange information and experience and to advocate the Healthy Cities philosophy.

Factors influencing development

The WHO Healthy Cities project cities reach from Turku, Finland in the north to Patras, Greece in the south and from Dublin, Ireland, in the west to Jerusalem, Israel in the east. Within this geographic expanse, the WHO network includes cities with diverse social and cultural histories, different political systems and varying degrees of economic development. These factors strongly influence how cities organize their projects and develop other associated processes.

City size

The varying size of the cities in the WHO project (Fig. 11) profoundly influences their strategies and structures. The smallest city is Horsens (population 55,000) and the largest is Barcelona (population 1.8 million).

Information obtained from questionnaires and interviews illustrates the influence of city size in a number of areas:

- It is more difficult to achieve project visibility in large cities and a more deliberate and costly strategy is required. Horsens is a small city in an essentially rural environment and this enables more immediate and direct contact with radio and newspapers, as fewer issues compete for attention. At the other extreme, the Borough of Camden in London is part of an urban environment of 8 million people; the project must compete with many other issues and work with mass media geared to the needs of the whole city.

- City size influences project strategy and ultimately determines the financial resources and personnel required. Most projects located in larger cities now concentrate on one of the districts or focus on groups representing only a small proportion of the population. This is all that can be achieved with the resources available. Ultimately, such cities need to develop ways to extend their coverage and transfer results from one area to another, but this problem has not been given much attention yet.
City size influences the meaning and practice of community participation. In small cities, citizen groups can be more directly involved in project decision-making and can expect more immediate support from the project office. Representation, when it occurs, is likely to take place through some kind of coordinating body. Alternatively, a very large conference or community assembly may be used to represent the interests of many groups. Several city administrations (such as Barcelona, Gothenburg and Milan) are decentralizing decision-making to the district level, which provides a basis for renewing community participation.

City size influences whether and how project activities must be structured or formalized. In smaller cities more can often be achieved through direct personal contact with key people in various parts of the city administration. In larger cities, smaller areas are needed to spread information and ideas and to negotiate intersectoral action. This has implications for the structure of project committees, the functions of and resources for project offices and the administrative systems that are introduced.

Economic differences

The economic situation of project cities varies tremendously. Some cities (such as Liverpool, Bremen, Zagreb and Liege) have suffered prolonged periods of economic depression and industrial decline, which has affected the health status of their populations. High unemployment, low income per capita, pollution and substandard housing influence the potential for improving health status. Municipal revenue is limited in such cities, which is reflected in the quality and quantity of municipal services available and the potential for changing them.

Some cities, such as those in the Nordic countries and the Netherlands, have stronger and more stable economic bases. This is reflected in better health status, higher labour force participation, higher incomes, and relatively good housing. In such situations, health and municipal services are far more comprehensive and easily accessible.

Economic differences influence project strategies and priorities. They affect the resources available and may influence the capacity to change city services. Larger cities need broadly based equity programmes that address such environmental factors as housing, unemployment and limited access to services. Community development projects are important in such cities. In more affluent cities, lifestyle issues such as alcohol, smoking and nutrition may receive greater attention along with initiatives that attempt to improve the quality of life.

Some projects in wealthier cities have taken more time to define their unique role, as the city administration already provides highly developed services. Major health promotion initiatives have been underway in Gothenburg for some time. Turku provides easy access to a broad range of health and social services. Projects in such cities may ultimately decide to try to meet the needs of specific social groups or promote...
Social and political culture

Cities in the WHO project are part of different cultures with diverse social and cultural histories and different political systems. The political changes that have occurred in central and eastern Europe in 1989 and 1990 provide new problems and opportunities for projects.

Differences in political and organizational culture clearly influence project strategy. Finland, Denmark and Sweden have a long tradition of urban planning and the idea of developing city health plans is more readily accepted. The tradition of urban planning in the United Kingdom also influences project development. Cities in southern Europe (such as Barcelona, Milan and Padua) say that they have less of a tradition of long-term planning in the public sector and that this produces resistance to planning for health. Milan also reports that a limited tradition of cooperation between city departments makes it difficult to promote intersectoral action, and Zagreb has indicated that planning is viewed with some suspicion as a product of the bureaucracy.

The cities also seem to differ on the degree to which a strongly based political consensus can be achieved. This consensus appears to be readily achievable in some cities. In others, conflict between political parties limits the level of support that can be mobilized for a local project.

The degree to which direct citizen involvement in local affairs is expected and accepted differs in the cities. Belfast, Glasgow, Liverpool, Camden and Munich have active voluntary and self-help groups. They expect to be consulted on lifestyle and environmental matters and their active participation is readily accepted by the city councils. The Borough of Camden and the City of Munich have long-standing programmes of financial support for community groups.

In Stockholm, on the other hand, the county and city councils are believed to be sufficiently sensitive to local needs to represent citizen interests adequately: this is reflected in the political and official membership of steering and planning committees. Jerusalem and Zagreb have large citizen councils at the city and district levels associated with their projects, reflecting a tradition of community participation. Prague is experiencing a period of transition resulting from national political changes. The project there is developing the skill of dealing with many political parties and is beginning the process of approaching citizen groups for whom direct participation in city activities is a new experience.

Jurisdiction and organization

The Healthy Cities project, implemented in its simplest form, involves a project established within municipal departments with local responsibility for health and for the social and environmental services. This simple model applies to several cities, but many have much more complex juris-

In May 1990, Elnadon organized a teachers' workshop: A Healthy School in a Healthy Community.
dictional arrangements. The responsibility for services that contribute to health may be divided between national, regional and local authorities. Within the boundaries of the city itself, the responsibilities of the statutory health agencies may overlap. These complexities influence the structure and membership of steering committees and the negotiating process leading to the planning and implementation of a project.

The most important influences include historical and political assumptions about jurisdiction over health matters. The Healthy Cities assumption is that the city administration is responsible for health. Historically, this has implied responsibility for public health and for health care. This situation exists in many cities, such as Vienna, Munich, Bremen and Copenhagen; a political context is established within which the idea of intersectoral responsibility can be developed.

This situation does not apply to several cities. The national government is responsible for health services in Patras and in Jerusalem. In Padua and Milan, regional authorities that operate under the direction of the national government are responsible for health in all of these cities, an important step in the development process is convincing the city council and the city administration that they can contribute to improving public health by using their authority over environmental and urban planning.

Barcelona gives high priority to promoting physical activity.

In special workshops, children are encouraged to say what Barcelona should look like.
In May 1989, WHO signed agreement with the organizers of the 1992 Olympics in Barcelona that will make the Olympics non-smoking.

In the United Kingdom, district health authorities that are part of the national health service are responsible for several public health functions and health care services. The situation in three of the network cities in the United Kingdom has become more complex, as the role and responsibilities of regional and district health authorities are now being redefined because of a recent government report. The Borough of Camden offers a successful example of the process by which a district health authority has provided leadership in establishing a Healthy Cities project for which the borough council now accepts primary responsibility. The Bloomsbury Health Authority has been committed to health for all since 1985, using the 38 European regional targets for health for all as a basis for its planning. In 1987 it joined the WHO project and provided a coordinator for the project. Since then, a transition has taken place to the point where the borough council now accepts responsibility for the project and an independent project office is being established.

Glasgow and Stockholm provide examples of effective cooperation between regional and local authorities in the interest of Healthy Cities. The Stockholm project is the joint responsibility of the Stockholm County Council, which is responsible for health services, and the City of Stockholm, which manages environmental and social services. The steering committee for the project includes councillors from both the county and the city. Stockholm reports that a prolonged period of political negotiation was needed to reach agreement on the project. In Glasgow, the project is the responsibility of the city, with support from the Strathclyde Regional Authority, which also sits on the steering committee.

The project has been successful in accumulating practical knowledge of strategies and structures that provide the foundation for promoting the Healthy Cities idea. This practical knowledge is noteworthy given the context in which Healthy Cities operate. Since the traditional public health culture is so dominant, anything achieved to change it is impressive. Throughout the network, examples of innovative structures, processes, strategies and practices have developed that are significant because they lay the foundation for the critical mass necessary to effect major policy and practice shifts. The Healthy Cities network itself provides the vehicle for facilitating the examples, replicating them and legitimating them.

The questionnaires from interviews with and with files on the cities selected in the first and second round reveal patterns of structure, process and activities that will be very useful in determining what needs to be done until 1992 in the cities and by the WHO project office.

- The cities need to assess realistically how many resources are required to implement the Healthy Cities idea in terms of staffing, funding, facilities and an information base.
- Several cities have been successful in mobilizing a high degree of political support, but more experience is needed to establish the structures and approaches that generate broad community control over the project.
- Political support can be reinforced in many ways, and good examples of this can be found throughout the network, but most projects are not using enough of them.
- There is good practical knowledge of how to develop local statements of purpose, but the process needs to be more widely understood.
- Knowledge is growing about the ways to define the role and functions of the project offices in relation to their goals, but this is not being generalized throughout the network.
- There is considerable experience in establishing a committee structure to facilitate intersectoral action and to raise consciousness among partners, but no knowledge base yet on following through to implementation.
- Cities that locate the project outside of the health department make more rapid progress in generating community participation and intersectoral planning and action.
- Some cities are generating initiatives that will have long-term significance and impact, but many projects are focusing most of their energy on short-term ad hoc activities.
- Several cities have defined their role as contributing to the establishment of new ways of generating knowledge (such as community health profiles, maps of health equity and neighbourhood and environmental studies), but most have relied on existing data systems and the traditional research community to provide knowledge.
- Several cities have actively and courageously undertaken to legitimize projects and ideas that were previously viewed as marginal, but many
have focused activities in areas that had gained acceptance as part of the traditional approach to health education.

- The general lack of public, political and managerial accountability prevailing in the health field is reflected in the Healthy Cities projects, but mechanisms in many cities could be integrated into an accountability system.

- Some projects are beginning to make long-term plans, but links with the traditional health sector, complexities in the planning process, lack of resources and skills and resistance to intersectoral cooperation limit progress in comprehensive city health planning. At least three cities are seriously engaged in this process and will be a valuable resource in the network.

- Collectively the cities have a comprehensive set of structures, mechanisms and practices related to community participation, but very few cities have an overall strategy for community participation based on the internal structures of the project itself.

- Cities have a scattered variety of visibility activities but no comprehensive, long-term strategies. Some cities have conflicts about how visible the project should be. There is no experience in marketing either the ideas or the project.

- In some projects, individuals and organizations use lateral negotiating styles, but many projects are having difficulty in achieving new ways of relating and working together because hierarchical and vertical functioning is dominant within the present structures of cities and health departments.

- Several cities have experienced conflict and recognized the inevitability of such conflict when the kind of radical agenda implicit in the Healthy Cities philosophy and strategy is pursued. At least two cities have begun to develop methods to diffuse the conflict.

**Building towards success**

The Healthy Cities project assumes that achieving better health for people in cities requires substantial changes in the organization of city administration and the processes used to develop and implement policy.

Achieving this goal requires the acceptance of a broader view of health that takes into account its social dimensions and recognizes all the factors that contribute to health. It also requires that all sectors of economic, social and political life in the city share the responsibility for developing the prerequisites for health. The role of the local Healthy Cities projects is to advocate this viewpoint and to provide a focal point to bring about the institutional and structural changes needed to promote health in the city.

This review clearly suggests that projects need to have a specific set of qualities or characteristics to perform their role effectively. These qualities are present to varying degrees in the projects that have achieved significant success so far:

- strong political support
- effective leadership
- broad community control
- high visibility
- strategic orientation
- adequate and appropriate resources
- sound project administration
- effective committees
- strong community participation
- cooperation between sectors
- political and managerial accountability.

The organizational structures adopted and the managerial practices used by projects provide the foundation for developing these positive qualities. This section offers a definition of each of these qualities and illustrates the problems encountered in achieving them, based on interviews with the cities. Solutions to these problems are suggested, drawing on the experience of project cities.
A striking conclusion that emerges is the interrelated nature of the positive qualities and, correspondingly, of the means to achieve them: the means or methods that contribute to achieving one quality also contribute to others. For example, the planning necessary to achieve a strategic orientation also supports sound project administration, intersectoral collaboration and provides part of the basis for accountability. Similarly, good accountability practices, which are essential for maintaining political support, involve community participation and high visibility. City projects can thus embark on a cohesive set of initiatives to improve strategies and structures, knowing that they will lead to the qualities that are essential for effective performance.

**Maintaining strong political support**

**Definition.** Political support means that political leaders understand and accept the basic principles and functions of the project and are willing to be easily accessible to the project. It also involves their willingness to provide the project with visibility and legitimacy, to negotiate adequate resources for it and to provide leadership and direction in achieving intersectoral collaboration, especially within the city administration. Furthermore, it implies that the community is actively encouraged to participate in the affairs of the city and that political leaders are willing to deal with controversial issues as they arise.

**Problems.** Healthy Cities projects typically begin with strong political support. This support has continued and grown in some cities, but project staff in other cities report that they receive less support now than they did in the beginning. This is reflected in less active political involvement, reluctance to provide adequate resources and undertake significant long-term initiatives and concern about conflict and controversy.

Several cities offered explanations for this trend in the interviews. The performance of the project itself and factors associated with the general political environment in the city were two explanations offered. Some projects were caught in partisan conflicts or became election platforms for individual politicians. Political leaders were sometimes hesitant to commit to long-term initiatives when the main preocupation was winning the next election. In such situations, support was expected to improve after the election, and this has occurred in some cities. These problems are an intrinsic part of working in a political environment.

Nevertheless, several factors linked to the structure and strategy of projects also appear to have contributed to the loss of political support. Some projects are not organizationally located in the city administration hierarchy in a way that supports easy and continual access to senior politicians. Some do not have effective steering and planning or executive committees that reinforce political interest, broaden the base of control of the project and promote intersectoral collaboration. Others are not visibly active and do not have priorities that are obviously relevant to the critical and immediate political concerns of the city. Sometimes politicians think that the project is too vague or that project offices are not doing anything and therefore do not need many resources.

**Pathways to success.** The projects themselves cannot solve all of the problems in their political environment. The experience of WHO project cities, however, indicates several ways to increase the possibility of maintaining strong political support.
• Encourage widespread recognition of the links between maintaining health and the activities of various sectors of city life, especially those that directly concern the city administration. This task can be one of the elements included in the visibility activities of the project. The Borough of Camden has audited the activities in each of its departments that contribute to maintaining health and has converted it into a display that graphically shows the link between city activities and health.

• Broaden the community control over the project so that a wide range of groups and organizations will support it. This can be achieved by encouraging community groups and organizations to become active members of the steering and planning committees and working groups. Several cities include a wide variety of municipal departments, professional associations and community groups on their steering bodies, including Belfast, Copenhagen, Glasgow, Honsens, Jerusalem and Montpellier.

• Generate positive visibility among the public that increases their interest and generates support from political authorities. The publicity activities of the project perform this function. The Copenhagen project undertook a high-visibility programme involving newspapers and television.

• Support initiatives in the community that are recognized as being relevant to current political concerns. Milan and Sofia have been associated with initiatives to control air pollution and Padua has attempted to improve environmental living conditions in economically and environmentally depressed areas of the city.

• Associate the project with initiatives that are clearly oriented towards action and have a good chance of success. These initiatives should achieve visible progress or results in a relatively short period of time. The Barcelona project has supported a community garden project, the Padua project was involved in developing bicycle paths in the city, and the Belfast project produced a policy on access to public premises for the disabled.

• Define the project in terms of its role and the activities it performs so that politicians and the general public can easily understand it. A project should identify the unique role that it plays in the city administration so that it does not appear to compete or overlap with other structures. Glasgow has published a position statement for its Healthy Cities project that describes the purposes and activities of the project.

• Establish organizational links within the city that support easy access to politicians and avoid any special identification with the health care system. The Milan project is associated with the Office of the Mayor and in other cities it is linked with departments that have a central administrative function, such as the Office of the City Clerk in Glasgow.

• Exchange information frequently with political leaders on the plan, progress and achievements of the project. In many cities, project offices regularly present reports to their steering committees describing the progress being achieved.

Developing effective leadership

Definition. Three kinds of leadership are essential for effective Healthy Cities development. Projects need political leadership that is supported by the political system. This is demonstrated by the kind of resources made available to the project office: budget, personnel and facilitating links to other sectors of the city administration. Political leaders should be actively involved in steering and planning committees and be willing to examine and change city policies and practices. This leadership is absolutely essential to a Healthy Cities project.

Projects need community leadership, which is provided by the active involve-
ment of members of professional organizations, educational institutions, the business community and representatives of community groups in the ongoing activities of the project, including planning and implementing strategy. This kind of leadership is a prerequisite for visibility, legitimacy and support.

Projects also need managerial leadership to generate structural and policy innovation within and outside the project, to develop the project as an effective advocate of health interests in all aspects of urban life, and to mediate the interests that arise when projects tackle equity, environmental and lifestyle issues and institutional and structural change.

Leadership must be creative, strong and visible in all three areas.

Problems. Some projects report having been constrained by an absence of political and community leadership. In other cities the lack of continuity in political leadership and the narrowness of political support has seriously hampered the development of the project.

Some projects lack the structures that would make it possible for representatives from various city departments and other sectors in the community to play leadership roles. In a significant number of projects, the lack of full-time coordinators, who would advocate for and manage the project, was a key factor in the inability to gain and maintain political and community support. In other cities the quality of project leadership compromises project advocacy and does not inspire the confidence of the political authorities, thereby diminishing support.

Pathways to success. A number of steps can be taken to develop organizational structures that provide the basis for effective leadership.

- Adopt committee structures that support effective political and community leadership. This can be achieved by developing close links between committees and the political system, including community representation in steering committees and dividing chairing functions between political and community leaders. Political membership of steering committees is common in the project cities, usually including councillors who are responsible for departments that are critical to achieving project aims. The Mayor of Padua acts as chair of the steering committee, in Glasgow the chair is a prominent citizen from the community, and in Belfast the chair alternates between representatives of statutory and non-statutory organizations.

- Develop profiles of the knowledge and skills needed to provide project leadership.

- Ensure that sufficient financial resources are available to support the leadership function. This includes providing for full-time project coordinators and for sufficient project personnel to perform the support functions needed by political and community leaders. About two-thirds of the cities have employed full-time coordinators. In Horsham, the project office acts as the support needed for the health committee that directs the project, with the coordinator functioning as chair of the committee.

- Develop selection processes for project coordinators that guarantee the selection of personnel with appropriate leadership skills.

- Develop the appropriate support systems for political and community leaders, including access to the information they need to perform their functions. Padua has a comprehensive information system that can provide the data needed to support leaders in interpreting the areas on which the project needs to focus. When Padua entered the WHO network it prepared a comprehensive report outlining the city issues the project should address. The health audit performed by Camden similarly provides the information to generate political leadership in intersectoral collaboration.

- Create opportunities to develop leadership through training, local seminars and exchanging information, expertise and facilities between projects. The workshop on the functions of Healthy Cities project officers held in conjunction with the 1990 spring Healthy Cities business meeting in Belfast is an example of this kind of activity.

Broadening community control

Definition. WHO tries to have health for all accepted as a total social enterprise. This means that all sectors of a community should be involved and think of the project as theirs, including the city council and the municipal administration, professional bodies, community groups as well as business and industry. Community control means that the community identifies the Healthy Cities project as representing their interests. In addition, the project provides opportunities for various sectors and groups to influence its direction. It is viewed as something that deserves people's active involvement.

Projects in the WHO network appear to be located along a continuum. Some are closely identified with the city administration and have steering and planning committees made up of city politicians and senior officials. Others have a
more mixed control and use planning and steering groups in which the community as well as the city administration are represented. A few projects occupy a position that is more closely identified with the broader community, reporting to an independent board of directors that comprises city councillors and community representatives.

**Problems.** Several problems have emerged that interfere with broadening the community control of some projects in the WHO network:

- The project is not highly visible to the public; it is not perceived as being accessible to individuals and to people in other organizations who may be interested in participating in activities associated with it. The physical location of the project sometimes contributes to this feeling.

- Close identification with traditional health care interests sometimes appears to be an obstacle to a broad sense of control. Other bodies who might wish to work with the project consider it to be part of an organization or system that they have traditionally regarded as competitive or narrowly focused.

- The relevance of the work done by other organizations is not clearly identified in terms of its implications for health.

- The project itself, particularly its committee structure, may not have effective arrangements by which representatives from other sectors can state their interest and participate actively in decision-making.

**Pathways to success.** Finding a solution involves broadening the base of those responsible for the project and involved in defining its issues, setting its priorities and making its plans. Possible options include:

- Define problems and solutions in terms that recognize the responsibility and potential contribution of various sectors of the city administration.
and the community. The initiative taken to include Healthy Cities concerns in urban plans in Horsens and Belfast is a step towards defining health as a broad concern of urban environmental planning. The Croxteth project in Liverpool and the Drumchapel project in Glasgow exemplify selecting particular areas of a city and adopting a broadly oriented approach to defining health issues and how to address them.

- Broaden the base of community participation in defining problems and selecting solutions. This can be achieved by convening community conferences to which different groups are invited and share their concerns and by using working groups with broad representation who undertake problem-solving tasks on behalf of the project. Belfast convened a Community Participation Day to discuss health issues in the city and Glasgow convened a community conference on health issues organized by the project office. In Zagreb, a city health assembly of representatives from each district is convened to hold city-wide discussions of current health issues.

- Adopt a committee structure for the project that represents different interests in the community and contributes to balancing these interests. For example, Belfast, Glasgow, Horsens and Montpellier all have a committee structure that accommodates a variety of interests from the community.

- Adopt a project strategy that includes action priorities to engage effort from different sectors of the community. This can include initiatives from business and industry.

- Second personnel from various organizations in the community to perform particular functions or to work with the project for specific periods of time. Four different organizations in Zagreb provide personnel to the project office.

- Secure funding from several sources and develop a fundraising strategy to include business and other non-governmental sources. The Liverpool and Belfast projects receive funds from a number of statutory organizations, and the Horsens project solicits funds from businesses to supplement the grant it receives from the city.

- Adopt an organizational form for the project that enlists strong support from the city council but also involves other sectors. The Horsens project is carried out by an independent organization with its own charter and board of directors.

- Secure high visibility for the activities and achievements of the project.

Becoming highly visible

**Definition.** High visibility is widespread awareness and understanding of the aims and achievements of Healthy Cities projects among the general public and potential organizational partners in the city. The potential partners that need to be taken into account include departments within the city administration, businesses, professional associations and community groups. Awareness and understanding associated with the project needs to include an appreciation of the major health issues in the city and the economic, social and physical factors that influence health. The principles of the strategy for health for all should be emphasized, including the concern for equity and the commitment to intersectoral action and community participation. Strong visibility contributes significantly to the political effectiveness of the project and its capacity to perform its role.

**Problems.** Achieving visibility was one of the most problematic areas identified in this review. The most significant problems identified were:

- Project offices are physically and organizationally remote and inaccessible to other sectors and the community.

- Publicity efforts lack continuity. Although there are many examples of outstanding informative activities or events, they have not been designed to leave a lasting impression on the people targeted.

- There have been no long-term strategies to maintain visibility that defined who the project wanted to reach, the means that would be used and the resources required.

- Projects generally hesitate to market Healthy Cities activities. Many seem to consider this inappropriate in an area of political change and in the health and human service sector.

- Many projects had inadequate access to the resources necessary to develop visibility activities, including financing and technical skills.

- Several projects reported difficulty in building effective working relations with the mass media, who did not understand the project or consider it worth covering.
Pathways to success. A number of steps can be taken to raise and maintain the visibility of projects. The approach taken depends on the size of the city and the approach to publicity that is considered appropriate within the city environment, including effective ways to relate to the mass media. Possible approaches include:

- Locate the project office in a visible and physically and organizationally accessible place. Copenhagen and Horsens have established accessible Healthy Cities shops that provide information to the public and can be used as meeting places for community groups.
- Develop an understanding and consensus within the Healthy Cities project on the appropriate role of information and publicity in developing a project and achieving its agenda for policy change.
- Develop a long-term strategy that sets visibility goals, identifies the means of action to be used, allocates responsibilities and identifies the resources needed and available.
- Acquire the resources needed to raise the visibility of Healthy Cities, partly by using the skills, experience and public relations capability of the business sector. Copenhagen has secured a substantial budget for publicity and Horsens distributed a Healthy Cities newsletter to all households in the city. The Belfast project secured the assistance of the British Broadcasting Corporation in preparing a television programme on Healthy Cities and used a grant programme ("Making Belfast work") to prepare a brochure that was distributed to all households.
- Adopt an open style in relations with the community and the media, which includes providing access to committee meetings for interested parties and distributing agendas and reports in advance. The Jerusalem project uses large community meetings to spread awareness of and build support for Healthy Cities, and the Horsens project has adopted an open style that includes inviting the press to all project business meetings.
- Develop project initiatives in a way that helps to identify and report the progress and results achieved.
- Organize information from research in a way that is interesting to and understandable for the mass media and the public. The Horsens project conducted a health survey and issued a number of press releases based on the information obtained from the survey.

Achieving a strategic orientation

Definition. The fundamental goal of Healthy Cities is to change the economic, social and physical environments of cities to support health more effectively. Changes of the kind that are contemplated can only be achieved in the long term and often imply signific-

The Minister for the Environment, Mr Patraig Flynn TD, with Dublin schoolchildren, launching Seaside Sam on 31 May 1996.
ant innovation and different priorities. This requires a strategic orientation that addresses the major factors that influence health, sets long-term goals and short-term objectives and adopts priorities that are converted into plans of action. Such plans need to take into account the environmental influences on health in the city and to appraise realistically the various interests that have to be mediated and negotiated.

Problems. The project cities have adopted different approaches to developing strategy. There is now enough experience in the network to identify the major problems that have to be confronted and some ways to deal with them. The major problems that have arisen are:

- Some projects have become preoccupied with initiatives that do not address the major environmental influences on health in the city and therefore risk becoming irrelevant. Resources tend to be used exclusively to respond to short-term crises and pressure to act quickly.
- Consequently, there are not enough examples of innovative approaches towards substantial change in policies and programmes. Some projects tend to fall back on traditional medically oriented information and methods of health education.
- Several projects have made no attempt to develop long-term strategic plans, and such planning processes are relatively new in the WHO project network.
- The network has relatively little experience or skill in long-term planning. In some cases, projects could benefit from the experience in strategic planning of other local project initiatives involving urban planning or environmental protection agencies.
- The absence of structures that are closely linked to the political system in the city and have a broad base of community control weakens a project’s capacity to address major strategic problems.

Pathways to success. Several steps can contribute to developing a strategic orientation within a project and among the other groups and organizations in the city with which it is working:

- Develop an environmental analysis that highlights the major factors in the city that influence health. Such an analysis should describe the problems in qualitative and quantitative terms, indicate the agencies in the city that can be involved in solv-
ing them, and analyse the economic, political and other forces that can influence the search for solutions. In the report prepared for its entry to the WHO project, Padua provides an outstanding overview of health issues in the city and the factors contributing to current health status. In Belfast, similar analysis has been used to provide a basis for reflecting Healthy Cities concepts in the urban and environmental plans for the city and in the policies of the housing executive.

- Prepare means to share this analysis openly with the community to obtain their views on its significance and validity and the priorities that should be set in addressing these problems. Community conferences can be used for this purpose; Glasgow took this approach.

- Engage steering committee members and city councils in discussing the most important issues that are recognized by the community, to develop a consensus on the approaches to be taken. Many cities actively discuss policy issues that arise from an overview of health status questions and feedback from the community.

- This process can develop a strategic plan for the project. Within such a plan, the issues projects typically address include:
  - selecting issues that are politically relevant, supported by the community and practical;
  - striking the balance between immediate action and long-term planning and influence;
  - balancing top-down approaches that address the issues affecting the whole city and bottom-up approaches that respond to and build on the immediate and local initiatives of community groups; and
  - balancing responsiveness and flexibility with the need for a consistent, meaningful, long-term course of action.

Glasgow has developed a strategic plan for its project and a similar process was underway in other cities at the time of this review.

- Initiate the process of preparing a city health plan that addresses access to the prerequisites for health, equity and improving environments. Copenhagen has prepared a health plan mainly concerned with re-orienting health services, and urban plans in other cities were adjusted to take into account Healthy Cities concerns.

- Take the steps necessary to strengthen the strategic planning capacity of the project by using the resources available to project partners.
Securing adequate and appropriate resources

Definition. The aims and concepts of the Healthy Cities project represent an extremely ambitious agenda of policy and programme change and new working arrangements at the city level. City projects need to have access to resources that are consistent with this agenda. This includes enough personnel to provide leadership, maintain visibility, follow up on opportunities for intersectoral action and facilitate community participation. It also requires a budget large enough to administer the project and provide accommodation and facilities that are consistent with the need to maintain visibility and be accessible to the public and community groups. Projects also need access to information to support their goals of promoting equity and access to the pre-requisites for health, improving environments, changing lifestyles and re-orienting health services.

Problems. During the period covered by this review, the resource base for project cities did not, in general, reflect this ambitious agenda. This appears to reflect the need for better information to decision-makers and the public for the long-term implications of the Healthy Cities idea. The resources available to projects vary widely in terms of the kind and amount. The specific resource problems encountered are:

- Most projects lack clearly defined statements of purpose and functions and operational and strategic financing, which provide the basis for estimating the required personnel and financing.
- Projects lack full-time coordinators to lead and manage the project, professional staff to work with community groups and maintain visibility of the project.
- Projects must engage in cooperative initiatives and develop support functions in administration, publicity and data analysis. Associated with this was the need to develop clearer policies and systems for negotiating accommodations and other access to personnel among committees and in cooperating agencies.
- Projects have very limited budgets and, in some cases, no separate budget immediately accessible to the project. In some cases, the rationale for funding projects appears to be uncertain. Should the projects, in addition to their own administration, have resources to facilitate and support action and other organizations, especially community groups with limited funds?
- Several projects worked with a limited information base that did not provide data on questions of equity, access to the pre-requisites for health and environmental quality. To provide a strong basis for negotiating with research facilities in the community, most projects need to give more attention to information needs and priorities. There were also gaps in the steps being taken to convert information and research data into a format useful for strategic planning, publicity and building political support.

Pathways to success. All these problems can be addressed by a three-step managerial process as an essential prerequisite for negotiating the long-term development of project resources:

- A statement of purpose and functions should be prepared to provide a rationale for project activities. The time of this review, this process was underway in a number of cities, and Glasgow has completed and published one.
- Many projects were located in accommodation that was not visible and accessible to the public, which did not enable them to play their informational role and to provide a focal point for community participation.
- This can be converted into short and long-term plans with an assessment of the implications for personnel and financing. Although planning processes were underway in a number of cities, this review did not explore the methods by which planned activities were assessed in terms of personnel and financing.
• Specific policies and plans can be developed for personnel, financing, accommodation, facilities and information requirements. This kind of budgetary framework offers a basis for negotiating resources with the city administration and raising contributions from other sources. A research strategy was being developed in Liverpool at the time of this review and cities such as Padova had the information facilities to support a comprehensive assessment of information needs. In general, however, there were few examples of systematically developed resource policies.

In developing proposals for accommodation and facilities, projects need to determine kind of visibility they wish to achieve in the community and the access and support they intend to provide for community groups. In defining their information and data requirements, they also need to clarify the issues they plan to treat as priorities in equity, environmental protection, mechanisms to support healthy lifestyles and reorienting health services.

Achieving sound project administration

Definition. Sound project management meets the expectations of the steering committee, can follow up on opportunities for intersectoral action, can effectively use personnel and resources, and has a good strategic orientation. It is the foundation of an effective project.

Problems. Low morale, poor communication within the project and with partners, lack of organization, lack of clarity about role and function, excessive workload, low visibility and difficulty in interpreting the project to the community were found in varying degrees in many cities. These all indicate basic management problems.

The managerial problems projects encounter appear to arise from inexact understanding of the purpose of the project, what it intends to achieve and how it intends to do it. The solutions to the problems of project management are therefore the same as those involved in achieving a strategic orientation and securing adequate resources:

• preparing operational and strategic plans that cover a period of 3-5 years;

• developing personnel, financing and information policies for the project;

In addition to these initiatives, two other strategies appear to be essential:

• project staff and project committees need to negotiate a set of principles and systems to administer the project. These can include decision-making within the project, relationships with mass media and working arrangements with committees, city departments and community groups;

• the project needs to negotiate with partners the arrangements for reporting results or achievements and the role of project offices in this.

Pathways to success. The following steps can contribute to sound project management:

• Limit project activities to those that are appropriate to the purpose of the project.

• Secure the time and skills needed for effective planning.

• Match the activities of the project with the resources available.

• Build teamwork among project personnel and the partners involved in the project.

• Maintain effective working relationships with municipal departments and groups in the community.

• Interpret the work and achievements of the project.

• Deal effectively with personnel, financial and other administrative restraints imposed on projects by municipalities.
Administrative practices are clearly an important issue in projects but were not systematically explored during this review.

**Achieving effective committees**

*Definition.* The committee structure is central to the development of Healthy Cities. It provides political links and direction, the forum in which commitment to intersectoral action is developed and mechanisms for maintaining links with the community. It is a valuable resource in project planning and implementation, and a source of skills, knowledge, ideas and energy. Committees represent a personnel resource and often work actively on the project.

*Problems.* The value and function of a carefully planned committee structure have not been equally appreciated in project cities. The major problems that have arisen are:

- Projects have not created a functional committee structure specifically linked to the principles and priorities of Healthy Cities. Several cities have not adopted any specialized committee structure.
- The interest of committee members has declined, probably because committee members lack clearly established roles and expectations that require them to be engaged actively.
- The organizations represented on the committees have an uncertain commitment to Healthy Cities.
- Committees have no clearly defined decision-making processes.
- The relationship between committees and project staff is misunderstood, and the functions of project staff in supporting committee work are unclear.

*Pathways to success.* A number of steps can provide structures and processes that make committees work more effectively:

- Develop a clear structure and system for committee work, including:
  - defining the terms of reference for committees and the relationships between them;
  - identifying the functions and what is expected of committee members and the organizations they represent;
- identifying the criteria for being a member or chair;
- clarifying the supportive role of the project office; and
- adopting simple committee procedures.

The patterns of development described previously provide an overview of the work being done by cities in developing committee structures:

- Adopt an action orientation towards committee work that sets clear expectations for individual members and gives them clear decision-making and follow-up tasks. In Horsens, each committee member is assigned an area of responsibility in which to keep informed and take subsequent action on behalf of the committee.
- Provide for regular reporting of project achievements to the committees.
Promoting community participation

Definition. Community participation is a fundamental principle and goal of the strategy for health for all. It is one of the important means of action identified in the Ottawa Charter and is central to the development of Healthy Cities.

Community participation means affirming the right of the community to define its own health problems and to participate in formulating and implementing solutions, including the process of setting priorities. It requires access to information and participation in decision-making processes. The knowledge and experience of community groups are essential and valuable in developing healthy public policy.

Problems. Community participation remains one of the most problematic areas in the development of local Healthy Cities projects. The problems associated with community participation appear to be related to:

- a lack of understanding of what community participation is and the variety of means that can be used to achieve it;
- resistance by politicians and professional and managerial groups to accept the views and knowledge of community representatives;
- mistrust of city administration and the projects themselves, frequently based on the relationship between government and the community in the past;
- a research orientation that underemphasizes community knowledge and does not consult the community in developing research projects; and
- a lack of resources that adequately support and encourage community initiatives.

Pathways to success. To promote community participation, the project must take a very sensitive and responsive approach. This involves clarifying the role of the project in relation to community groups and developing appropriate mechanisms for reaching a widely representative proportion of the community. Achieving credibility and meeting reasonable expectations are important prerequisites for success.

The experience of various project cities provides a composite strategy for developing an effective system of community participation:

- Information on health issues in the city should be shared and the concepts and principles of Healthy Cities action should be promoted. Montpellier has developed an information system for exchanging data between about 600 groups in the city; distribution of information is a priority for the project coordinator in Vienna.
- Actively involve community groups in defining health issues and selecting priorities. The projects in Belfast and Glasgow have supported community groups in carrying out local surveys of health needs based on questionnaires designed to reflect the concerns of people in the community.
- Provide community groups with access to the decision-making processes associated with the project and other city health initiatives. Several cities include community representatives on their steering committees. In Horsens, these representatives are selected from among interested citizens; in other cities, they represent particular groups or community voluntary agencies.
- Use pilot projects to initiate community action. The Liverpool project has initiated the Croxteth Health Action Area using staff from the project office and has established a community advisory board for the health action team.
- Facilitate and support the work of community groups through information, building contacts and securing financial support. A priority of the project in Barcelona is to assist community groups in locating financial support; the Einchoven project has provided immediate support in kind. The Horsens project provides meeting space for such groups.
- Use decentralized systems of decision-making to strengthen community input. Decision-making in such areas as health, social services, education and cultural affairs is being decentralized to neighbourhood or
district committees in several cities, including Barcelona, Gothenburg, Zagreb and Jerusalem. In these cities the project office works with such committees on health issues.

- Publicize the results of effective community activity.

Improving cooperation between sectors

Definition. Intersectoral action is a result of cooperation between sectors and is a fundamental goal of the strategy for health for all and the Healthy Cities project. It provides the basis for healthy public policy and is essential to achieve the prerequisites for health and improve equity. Intersectoral action for health involves planning and implementing initiatives in the interest of health that coordinate and use the resources and functions of different organizations. For example, an intersectoral programme to improve the health status of disadvantaged children could involve several departments in the city administration, including health, social welfare, education, housing, and parks and recreation.

Problems: Significant progress has been made in establishing a framework within which intersectoral action can be developed. The most frequently identified problems in relation to intersectoral action were:

- gaining political acceptance of the links between health status and such prerequisites for health as housing and the environment;
- overcoming the traditional vertical boundaries between the different sections of the city administration, such as environment and health;
- overcoming concerns that the project or the health department may control the activities of other departments;
- securing the involvement of the business community in Healthy Cities activities; and
- finding new resources for or reallocating old resources to intersectoral action.

Pathways to success. Similar to community participation, the experience of projects in developing intersectoral action provides a composite picture of potential means to develop such approaches:
Problems. The most fundamental problems of accountability are:

- People do not understand what accountability means in practical terms and the methods used to achieve accountability.
- Political and administrative leaders resist the idea that decision-makers in other sectors should be accountable for how their decisions affect health.
- There are no criteria or recognized methods to measure the effect of policies and programmes on health.
- The authority and responsibility associated with overlapping jurisdictional boundaries is unclear. (For example, it is difficult to develop an accountability system in a region where authority is divided among several administrations.)

Pathways to success. Developing an approach to accountability appears to require two elements: addressing the accountability of the project itself and focusing on the wider issue of accountability within the city administration. Accountability systems for projects can involve:

- Developing statements of purpose and functions that define the relationship between the project office and project committees;
- Developing plans that include goals, activities, assignment of responsibility, resources and schedules;
- Developing a system to report achievements; and
- Developing a system to act on feedback received from committees and the community.

Developing political accountability systems at the city level is a much more ambitious undertaking. The approach taken can vary widely and be different for different sectors. Some important steps include:

- Gain acceptance of the knowledge of links between the health sector and other sectors.
- Develop the art and science of doing studies of health effects, perhaps drawing on experience from the environmental sector. It may be appropriate to begin by developing such studies for new initiatives such as the HealthLink study being done in Stockholm.
- Prepare comprehensive city health plans that include the work of different sectors or ensure that health concerns are addressed in urban plans (accomplished in Belfast and Horsens).
- Develop approaches to comprehensive city health reports and relate them to small-enough areas in the city so that they will have immediate meaning. The trend towards decentralization in such cities as Gothenburg, Milan and Barcelona and the neighbourhood environmental audits undertaken in Camden will provide useful experiences.
• Establish strong multisectoral representation on steering committees and planning groups. As indicated previously, several cities use multisectoral committees as the basis for initiating cooperative action. They usually include city departments that can specifically contribute to improving the environment and providing access to the prerequisites for health.

• Promote the concepts and principles of Healthy Cities action and illustrate what can be done to achieve better health through intersectoral cooperation.

• Adopt an organizational framework for the Healthy Cities project that offers an independent approach to intersectoral action.

• Highlight the results of projects that involve such an approach.

• Conduct health audits to illustrate how the activities of various departments contribute to better health; give the audits visibility.

• Introduce studies of health effects to forecast the effect on health of major changes in the policies and programmes of the city administration.

Achieving managerial and political accountability

Definition. Accountability means that people and organizations are responsible to the appropriate authorities and to the community for the quality of their performance in carrying out planned activities and for the effect of plans and activities on the health status of the community.

Healthy Cities projects raise two issues of accountability: managerial accountability for the project itself and political accountability for the wider activities of the city administration. Managerial accountability means that the project, through the steering group or other body that provides it with direction, is responsible for the work of the project and its achievements in generating new policies and programmes. Political accountability means that the municipal authorities are responsible for planning and implementing policies and programmes and for how they affect the health of people in the city.

Accountability requires a specific set of mechanisms or processes to make it effective.

Styles of the project cities

According to Healthy Cities project: analysis of project progress, cities have taken different approaches to the Healthy Cities project, which can be characterized using three axes:

• a focus axis, ranging from a focus of action limited to working with bureaucrats and politicians within the city government to working completely outside city government with community groups;

• a focus axis, ranging from a focus on policy development to a focus on action projects; and

• a planning axis, ranging from a fully rational strategic planning process to an entirely reactive and incremental form of planning.

In practice, of course, few cities actually are characterized as being entirely at one end of the spectrum of the other, although their emphases differ, depending on local, cultural, political and personal values and experience. Nevertheless, since the Healthy Cities project seeks to combine change in strategic policy within city government and immediate action in the community, project cities need to understand the merits and importance of both ends of the focus, locus and planning axes and to combine both approaches, depending on the particular issue under consideration.

Style of operation of Healthy Cities projects

![Image of a diagram showing different styles of operation for Healthy Cities projects]

Rational planning

Work "inside" with planners

Locus

Work on policy

FOCUS

Work "outside" with the community

Incremental planning

Work on projects

PLANNING
Acting locally: cities take action for health

Unhealthy living

WHAT a dreadful statistic. Heart disease and cancer accounted for more than half of all deaths in the UK last year. Of these, 25,000 deaths, 24 per cent, were due to all types of cancer. Heart disease caused 24 per cent.

These are the sort of statistics which should make us all think about needing our unhealthy ways. Cutting out cigarettes, eating less on alcohol, taking more exercise and eating more sensibly.

It makes common health campaigns a priority if Scots are to be encouraged to change and improve their lifestyles.

Once again the Government statistical report brings home the great divide in health and lifestyles. Two of Glasgow's poorest areas - the East End and the North Side of the city - have the highest death rates from all causes, reflecting the stresses and strains of poverty, bad diet and poor housing.

Just a few miles away, Bearwood and Mingary are the healthiest places anywhere in Scotland. They have the lowest death rates in the whole country.

One other worrying trend is the country's steady population drift. At 5.1 million, it's 9000 down on the previous year. Many of these leaving are bright, ambitious young people whose skills are highly important to Scotland's development.

Only better job prospects will stop that trend.

Overview

All over the world, people are looking for innovative models to deal with the growing complexities and intricacies of life, including health and wellbeing.

In industrialized countries, laypeople and professionals have become increasingly discontent with the methods and results of a professionalized, traditional health services sector. Self-help groups, consumer forums, ecological groups, women's health organizations and other groups have been formed, which exemplifies the movement towards the new public health.

In addition, demographic epidemiological and sociological data show beyond any doubt that health services alone cannot cope with the environmental, lifestyle and social determinants of health. Growing inequalities in health between countries and within countries, and even more so within cities, at the neighbourhood level, have forced public health workers to reconsider their activities. WHO therefore responded to these developments with the Healthy Cities project.

This section describes some of the activities of the Healthy Cities project in Europe. Some of them are a legacy of an era before Healthy Cities, when some cities were already applying principles in accordance with the strategy for health for all, the concept and principles of health promotion, and the Ottawa Charter for Health Promotion. Other actions have been initiated because a city joined the project. Some are older activities that have been redefined in the Healthy Cities framework. Whatever the status of these actions, Healthy Cities coordinators emphasize these programmes and activities as being exemplary and unique for their project; the actions focus on entirely different matters from project to project.
Action for equity

Equity is crucial to the strategy for health for all in Europe, and thus to the Healthy Cities movement. The Third Annual Healthy Cities Symposium in Zagreb (September 1988) was devoted to equity. The Zagreb Symposium statement says that:

Health for all implies equity, and the challenging task for politicians and decision-makers is to reduce the social differences in health and to ensure that all people have an equal opportunity to develop and maintain their health to the full.

The patterns of inequalities and inequities in many of the participating countries and cities are changing. Parallel to traditional types of social and health inequality, new types of structurally determined inequality are emerging, involving groups such as the elderly, the disabled, the unemployed and ethnic minorities. Inequities are caused not only by economic structures but also by value systems, the skills that people have to take advantage of life opportunities and the behaviour of various social institutions such as government bodies, medical care systems and welfare organizations.

Inequities in access to a healthy physical environment are as important as socioeconomic inequities. They are reinforced by standard town planning regulations or through the absence of policies focusing on equal access to city amenities.

The role of cities in achieving equity in health is unique because of their control over primary health care, environmental protection, town planning and housing.

The Healthy Cities project has a critical role to play in promoting equity and health by identifying issues and experimenting with new solutions.

Ron Draper describes inequity:

If you live longer than I do, or if you suffer from less sickness and disability, our health status is unequal. There is inequality between us, but not necessarily inequity. The difference may not result from our living conditions, which may be essentially the same, but from accidents, genetics, or lifestyle choices.

If, however, the differences in our health status result from different living conditions, mine being less satisfactory than yours, a question of inequity arises. I may have less access to nutritious foods, difficulty in finding decent housing, or high quality health care sensitive to my particular needs. My income may be lower, and my work stressful and demoralizing, punctuated by frequent periods of prolonged unemployment. In this case, inequities in health status are the result of inequalities in life.

Equity is thus an overarching concern of the Healthy Cities movement. A large majority of the activities undertaken by project cities attempt to promote equity. The following is a short account of ten activities in ten different cities in which the projects used equity as the leading rationale for action.

Social action

Years before Liverpool entered the Healthy Cities project, it was notable for actions taken to promote equity. Liverpool is one of the European cities that has been hardest hit by economic recession, and many new ways of dealing with health risks such as socioeconomic inequities (including unemployment and racial tension) were tried out in the city on the Mersey. One of these is the Croxteth Health Action Area. A health team consisting of social workers, community representatives and some health professionals is working in this extremely disadvantaged Liverpool district to broaden people’s consciousness about the determinants of health.

With an annual budget of about US $560,000, a wide range of integrated activities are undertaken that affect the environmental and social and health services components of the prerequisites for health of the district population.

Milan has also taken a position on equity. In this large industrial metropolis in northern Italy, it was found that women and foreigners had substantially less access to a broad range of health and social services. Milan is now tackling the problem by conducting information campaigns targeting specific groups and by functionally improving the accessibility of services. The industrial city of Dusseldorf found similar problems, and addresses the issue through intersectoral action commit-
tecs that link activities for the socially disadvantaged and improving the environmental determinants of health.

The environmental approach

The old Italian town of Padua has taken another angle to address equity problems. After thoughtfully analysing social and health inequities in two pilot districts of the project (Arcella and San Carlo), the authorities found that the main determinants of the problem were environmental. The Città Sane project therefore focused on a wide approach to address a range of environmental issues: mapping noise, tackling the district traffic problems, dealing with solid waste disposal and analysing the chemical environment (mostly focusing on air pollution) with a sophisticated research system. In addition, the mobility of the population was addressed by a project to develop bicycling and walking paths through town, involving an investment of US $1 760 000.

In Pécs (southern Hungary), the local Egészséges városok project found a similar rationale for improving the health and living conditions of the suburban population.

Disadvantaged people

Many cities have found that groups in their population need specific and continuous attention. The Zagreb Healthy Cities office was compelled to do so when, after heavy floods, some ghettos that were extremely unhealthy places and had previously been ignored could no longer be ignored. Now, in the framework of action for equity, these bidonvilles are included in the regular activities of the Zagreb project.

Similarly, in Seville the project found large inequities in inner-city housing. To resolve the problem, the first step taken was asking young and elderly people in these neighborhoods what their favorite areas were and what they should look like.

Community equity

The Healthy Cities projects in Camden, Glasgow and Belfast are notable for their strong community emphasis and involvement in equity, even before Healthy Cities. All three cities have flourishing community activist groups. The local Healthy Cities offices and these community groups found that emphasizing equity further legitimated their activities. The Drumchapel initiative in Glasgow is a well developed health promotion action area. The project encompasses all the ideas and prerequisites of the Ottawa Charter. It is thus intersectoral and participatory, and has a wide range of intervention formats using enabling, mandating and advocating techniques to involve as many groups and organizations as possible. Similarly, one of the focuses of the Belfast project is the maxim “doing without owning”; in promoting health at the local level, the Belfast project carries out every action (including equity actions) with the community and not just for it. Finally, in Camden/Bloomsbury inequities are created because the daily influx of business people, lawyers, university people, and tourists into the borough raises the prices of services and goods, making them less and less accessible to the native population. This problem is being tackled through community action and the development of policy measures.

Action for supportive environments and sustainability

Supportive environments

The environments in which people live determine their quality of life, health and wellbeing. Environments can include nature, the structures of services, housing and facilities, and the social environment people create and live in. Providing information on human environments helps people to know how these environments work and how
people and the environments can best coexist sustainably. Nevertheless, changing environments to support the prerequisites for health would be even better.

Some Healthy Cities projects try to inform people about their environments, and some explicitly try to transform and improve the environments. The following presents examples of action for supportive environments.

Seville, Vienna and Barcelona are taking a broad perspective towards supportive environments. These cities will host major global events in the near future. The Healthy Cities project will link with EXPO 1992 in Seville, the 1992 Olympic Games in Barcelona and EXPO 1995 (Vienna and Budapest). Healthy Cities will thus become a theme in these global enterprises, and the organizers of the events are being encouraged to make the spectacles healthful undertakings. For instance, there is an agreement between the WHO Regional Office for Europe, the International Olympic Committee and the City of Barcelona to make the 1992 Olympics nonsmoking. The Olympics have created additional opportunities for Barcelona to promote innovative action up to 1992, such as programmes to encourage physical activity in the community.

One good example of supportive environments is the Horsemans initiative to build a new block of houses in Toxteth West to promote integrated living. The new living area will site houses and flats for people with disabilities next to housing for people without disabilities, and old people will live together with young people.

There are other notable initiatives in housing. Vienna and Belfast have neighborhood offices for urban renewal where citizens can consult with social workers, architects and health professionals on housing conditions, building renovation and neighborhood renewal. In Belfast these offices are called open design clinics.

Yet another approach to supportive environments is to provide the resources or means that people need to enhance their health. Healthy Cities projects may facilitate the creation of citizens support networks or provide wide-ranging information facilities.

The latter is the case in Rennes, Turku and Eindhoven. In Rennes, the Healthy Cities project linked with a French telematics (telecommunication and information science) initiative called Mintel using ordinary telephone lines. The system provides an extremely wide variety of information and services through small terminals in every household, ranging from travel services and aeroplane reservations to classified advertisements, government information, purchase of products and telematic dating. Health information and health education programmes and materials are fed into the system in addition to listings of activities related to Healthy Cities, even on a world-wide scale.

In Turku, a special media group was established. The group prepares regular news releases on health issues, and has declared Tuesday the information day. In Eindhoven, a gezondheidswijzer was established in the Municipal Health Service. The centre facilitates the exchange of information on self-help groups (now linking over 100 initiatives) and health education materials.

Some cities have recognized the inextricable link between the local economy and health. The Belfast project successfully supports the economic regeneration of the city. Gothenburg has an initiative to provide accessible and less expensive health services through facilities similar to health maintenance organizations.

In a paper prepared for the Fifth Annual Healthy Cities Symposium in Stockholm, Sweden, in 1990, Trevor Hancock clarified the notion of sustainable development.

The phrase "sustainable development" has become a buzz word for the 1990s. But what does it mean? First of all, it has to be understood as a shortened version of what should be the correct phrase - environmentally sustainable economic development. There is now a widespread recognition that our current form of economic development is not indefinitely environmentally sustainable. Hence the call by the World Commission on Environment and Development for sustainable development - a form of development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

Global problems such as the disappearing ozone layer, the greenhouse effect, and the final depletion of resources directly affect local affairs. "Think globally, act locally" certainly applies to sustainable development. Sewage treatment plants, solid waste disposal in landfills, polluted rivers that require high-technology measures to get safe drinking water, lead-polluted soil, and dense traffic in inner cities are specifically local problems that determine the state of health in cities. No wonder that the participants in the Healthy Cities project devote a lot of time, money and energy to environmental problems. The following describes examples of action for sustainable development in the cities, ranging from community action to clean up city streets to city traffic policies and sophisticated environmental monitoring systems.
Greening the city

A city with parks, trees, flowers and meadows is a place to relax, be physically active, and feel comfortable. In addition, green areas can be the lungs of a city. Several projects have undertaken action to green the city.

A major project in Barcelona involves communities and specifically schoolchildren in changing derelict areas into lush inner-city gardens. The children are asked to recreate blocks of demolished flats into places they like, using geographically appropriate plants. Professionals from the Parks Department support this by advising on how to take care of these green play areas. Similarly, in Camden/Bloomsbury a Greening Forum was established in which community groups decide on greening activities in the borough. The local Healthy Cities office helps and mediates the planned actions.

Planning ecologically

Ecological planning consciously shapes the living environment in accordance with the requirements of the ecological system. At least four cities have employed ecological planning to varying degrees, depending on the existing infrastructures and environments.

In Horsens, the Torsked West area is to become a new town district. In developing this neighbourhood, all the known ecological requirements are taken into account, including enough green spaces and the blending of houses with the natural environment.

In Pécs, recreational areas were enlarged as a Healthy Cities activity because of the levels of pollution in certain places, thus attempting to restore the ecological balance. In Turku, children are directly involved in landscaping their own environment, together with the Urban Planning Department. This involves school yards, sports facilities and other areas.

In Glasgow, housing improvement is firmly linked with unemployment action, enabling residents to recreate their own environments to meet their actual needs and to learn job skills.

Traffic

Traffic is a major problem in most urbanized areas. Millions of vehicles run in and out of old city centres that were not designed to take that load, causing massive congestion, noise and air pollution and a high degree of discomfort, especially to pedestrians and cyclists. Several cities have taken action to tackle this problem.

In Sofia, air pollution is a severe problem. The Healthy Cities project helped in obtaining a decision taken in June 1989 to replace the old diesel-powered public transport by trolleybuses and electric trams. In Padua, the inner-city mobility situation will be improved by the development of a network of bicycling and walking paths. Stockholm is undertaking major research (to be followed by health action) on a large north-south artery running through the middle of town: the Health Link project is studying the options for anti-pollution measures.

Air pollution

Traffic is not the only source of air pollution. Industry also produces substantial air pollution. Again, several cities have found it appropriate that their Healthy Cities offices address the problem.

In Milan, the project office played an important mediating role during a long period of toxic levels of air pollution caused by inversion, when no traffic was allowed to enter town. In Sofia, the office plays a role in closing plants that pollute substantially. The Health Link project in Stockholm is working on the air pollution problem. Air pollution has been environmentally mapped in Padua, which will lead to policy measures. In Jerusalem, environmental issues are high on the health agenda: air pollution is a top priority. A weekly Healthy Cities column in a newspaper calls for attention to this issue, and ecology days are organized with the industries in the Jerusalem area.

Water pollution

Pollution of surface water and drinking-water is an obvious threat to public health. Often, however, this type of pollution cannot be properly dealt with within the boundaries of one municipality.

Although many cities are experiencing problems in sewage treatment, few Healthy Cities activities focus on water pollution. Only the city of Pulas reported that investigations had shown high levels of pollution in the harbour and in beach areas, but no subsequent steps have been taken.
Solid waste

Households and industry produce millions of tons of solid waste in most cities. In most cases, this solid waste is deposited at landfills or incinerated outside the cities. Many cities are experiencing problems in this area, and would like to introduce new, more ecological methods of disposal (a technical Healthy Cities workshop in 1991 will discuss practical ways to solve this problem). The Jerusalem project is monitoring solid waste disposal, and consults with various interest groups.

Cleaning your city

Sustainable development can generate substantial community involvement. Economic development means the production and consumption of goods and services; in the end, we are all individual consumers, privately contributing to sustainable or nonsustainable environments. The Liège Healthy Cities office therefore decided to take action to involve people in direct environmental action.

Liège, once the jewel in the crown of the Walloon Industrial community, has suffered considerable socioeconomic setbacks in recent years. The city administration has nearly gone bankrupt several times, and not all municipal services could be maintained as effectively and adequately as the citizens would want. A vicious circle was created: as the municipal services could not fully clean up the city, the Liège population no longer saw any point in helping keep the streets clean. The Healthy Cities project decided that community groups needed a bit of encouragement. Meetings in neighbourhood centres were organized, a media campaign was started, and people were supplied with brooms, garbage cans and other cleaning materials. The project seems to have contributed significantly to cleaning Liège.

Healthy workplaces

Most people spend a large proportion of their time in the workplace: a factory, office or other environment. Workplace health promotion has recently received more and more attention, and several cities have linked with this development. In a healthy working environment, the organizational policies promote positive attitudes and creative, effective solutions to work problems. A healthy organization is willing to change traditional workplace relationships and attitudes that are unhealthy and unproductive, support and if necessary retain employees to meet changing demands, help staff cope with stress and offer flexible ways for employees to balance work and family responsibility.

Workplace health includes such issues as: workplace-specific health and safety issues; policies and working conditions (such as work-related stress, the physical environment and use of equipment, employee needs for child care and employee involvement in decisions); lifestyles (such as nutrition, physical activity and fitness, harmful habits and social interaction) and access to health-promoting services and support facilities.

Dr Jo Asvall, WHO Regional Director for Europe, said recently at a meeting of the Society for Occupational Medicine, in London:

It is not enough to treat the individual worker with stress as a problem case. Increasingly we must see disease as expressions of the policies or working conditions of the company itself. This will require a courageous change in attitudes between workers and management, and with more willingness to enter into a real dialogue and more truly share the responsibility for finding solutions that are acceptable both to workers and management.

In Barcelona, the project office is carrying out a continuous analysis of work-related risks and a major international conference is being prepared for 1991 on health at the workplace. Camden has a similar Occupational Health and Safety Project that develops workplace intervention after carefully analysing workplace health risks.

Action for community involvement

Community involvement is one of the most crucial components of Healthy Cities projects. If people actively participate in determining actions for health, they will be more satisfied and appropriate services and activities will be stimulated. Glasgow and Belfast have taken fundamental steps towards wide community participation. Both cities have organized a community conference at which the possibilities for action were explored with the community.

Community analysis and community development are linked with community involvement. In many project cities, people have been asked to participate in determining and resolving problems.

In Padua, the city of two districts (Arcella and San Carlo) has responded extraordinarily to the Healthy Cities project. Citizens, district politicians, architects, public health professionals and others spontaneously formed an association with a name similar to that of the project, to ensure...
that the municipal authorities fulfill their commitment to implement, on a schedule agreed by the city council, project plans to remove architectural barriers in these districts and establish a system of integrated care services; respect the principles of the project and apply them to all new municipal policies; and strengthen and encourage community involvement in the decision-making processes of the project. In April 1990, approximately 900 local citizens, professionals, and academics signed a petition asking the municipal authorities to implement project plans faster and to organize a community conference to discuss and agree how the project can best meet community needs and wishes.

Decentralization

Decentralization of decision-making and services is basic to community involvement. Several cities have moved to decentralize one or the other. In Belfast, the Belfast area action teams play an important role in various intersectoral activities. They work on a decentralized basis, and are involved with the Healthy Cities project.

From an administrative perspective, another way to decentralize is to bring services closer to the public. Several cities, including Copenhagen and Horsens, have opened storefront shops or offices in an easily accessible part of town. The shops provide information and community groups can meet there. In other cities, the actual responsibility for policy-making and neighborhood management is delegated to the community. In Jerusalem, for instance, a neighborhood self-management council is being developed.

Involving children

Until recently, children received little attention in cities. Children have their own world of living, playing and learning, which sets the stage for their future life. In recent years, however, many project cities have followed a programme initially developed in Seattle, United States, by an organization called Kid’s Place. In this programme, children are asked to draw, paint or write about their neighborhood, and about how they would like it to be. Similar projects have been carried out in Pecs, Eindhoven, Munich, Copenhagen, Barcelona and Horsens, and they will now be followed up by specific measures with and for the children.

Action for reorienting health services

Health services are also a concern of cities. Many cities are therefore making a major effort to reorient health services to meet the needs of the population. This is not always an easy task, however. In some countries health services are a regional or national responsibility, and city administrations cannot interfere with the quality and quantity of health services. Nevertheless, Camden/Bloomsbury, Milan, Sofia, Stockholm, Gothenburg, Horsens and Liège have initiated innovative projects to improve health services in urban areas.

The Bloomsbury health Authority, which is responsible for providing health services in Camden, has a longstanding commitment to the strategy for health for all. This commitment was translated into a wide range of actions that have influenced the authority’s policies and approaches to planning, the provision of services to vulnerable and underserved social groups, training and sensitization of care professionals, establishment of public health accountability mechanisms and collaboration with other local agencies, in particular, the Borough of Camden. In Milan, the accessibility of health services to such underprivileged groups as women and immigrants has been determined. Informational booklets have been written and referral systems have been set up, and a research effort has been coordinated. In Sofia, actions have been undertaken to renovate primary health care facilities for children with chronic diseases. In Stockholm, a community programme to prevent cancer was established, using experiences from health promotion and community-wide integrated intervention schemes. Gothenburg is strengthening its primary health care system, and Horsens and Copenhagen have initiated major programmes to inform people about how to dispose of unused medicine. Liège has the highest per capita tranquilizer consumption of any city in Europe, and a new educational programme to reduce the use of these drugs was therefore developed.

Mothers and children

Cities have traditionally been involved in maternal and child health. Thus, several maternal and child health programmes have been incorporated in Healthy Cities projects. In Montpellier, a city-wide breast cancer screening project was set up; Seville has undertaken targeted vaccination programmes for the children of Gypsies and transients, who have traditionally been underserved. In Sofia, adequate primary health care and counselling for children is especially emphasized. Barcelona combines these approaches in one project in which disadvantaged mothers and children in poor neighbourhoods receive intensified attention; Jerusalem has taken a similar path to improving health and wellbeing in this area, in accordance with the European regional targets for health for all.
Elderly people

Elderly people are an important group at risk in urban environments. The number of elderly people in cities is increasing, and problems in their health status grow accordingly. Elderly people may become isolated, may suffer from multiple diseases, disabilities and discomforts, and can be confronted with inadequate support facilities. The Pécs and Bremen projects specifically target elderly people. In Pécs, a swimming programme was set up, encouraging regular light exercise in addition to the fun and social contacts the swim would bring about. Bremen has developed a nine-point action plan for elderly people with an intersectoral and integrated policy to improve the accessibility of services, provide support systems and facilitate self-help groups.

Food and nutrition

Nutritional state is one of the most powerful determinants of health. In cities, food is purchased and consumed in neighbourhood shops, homes, restaurants, catering enterprises and the workplace.

Two cities have acted to stimulate healthy purchasing and consumption of foods, taking into consideration that a more structural approach to food and nutrition issues is appropriate. In Copenhagen, an educational programme to reduce fat intake during lunch was combined with meetings, seminars and other activities with workplace caterers to improve the labelling, preparation and presentation of healthier foods. A similar programme was established in Munich, where hospital cooks were offered advice on purchasing and preparing nutritious products.

Immigrants and ethnic minorities

Immigrants and ethnic minorities have previously been mentioned as a target group of interventions in accessibility issues and maternal and child health programmes. Some cities take the group of immigrants as a whole into consideration. In Vienna, various specific health promotion campaigns are aimed at different populations, most notably immigrants.

Action for healthy public policy

Healthy public policy is a cornerstone of health promotion; this also applies to urban settings. The Second International Conference on Health Promotion (held in Adelaide, Australia in 1988) was devoted to healthy public policy. The report of the Conference states:

Healthy public policy is holistic and ecological, recognizing that health in its broader sense depends on an integrated view of people's physical, mental and social dimensions, as well as on the fact that people react to and in turn shape their environment.

Healthy public policy encourages politicians and policy-makers at all levels to become more aware of the effects their decisions have on people's health.

This applies whether they are building a new road in a city, planning a new school in the city or setting up a pension system; it is the same whether they are acting at the local, national or international level.

Traditionally, actions and policies for improving health have focused on state intervention; in many countries, national health services and insurance schemes have been considered to be exclusively responsible for people's health. In an increasingly complex world, this vision is now changing. Communities want to take responsibility for their own health, and their (elected) representatives more often than ever want to respond to this need. That is why Kickbusch, Draper & O'Neill say:

"The local level is where the practice of healthy public policy is developing most rapidly and where its effects are most visible. There are clear reasons for this: many of the problems that have environmental or social dimensions are more obvious at the local level. So are the changes needed. Politicians at this level are more closely in touch with their electors and local people, while politicians at the local level can more easily be influenced by local people and can find ways to coordinate their planning and action more readily than at the national level."

So, what is happening in healthy public policy in the Healthy Cities movement? Several cities have acted to place health on the wider urban political agenda, including Montpellier, Rennes, Seville, Vienna, Zagreb, Belfast, Camden and Copenhagen.

In Montpellier, an initiative links more than 600 different organizations with an interest in health, to explore the possibilities for further intersectoral decision-making and policy development. In Rennes, the Healthy Cities project developed a city-wide Charter for the Disabled, establishing principles for policy on accessibility and services for people with disabilities. In Seville, policies are being developed that target risk groups more broadly than health services alone. The process of determining urban renewal policies in Vienna is structured through neighbourhood offices where the community may participate in the decision-making process. The same is happening in Belfast, but in addition, the city strives for more fundamental intersectoral policies, linking various city departments and urban organizations. Further, Belfast has organized a community conference to explore people's needs and demands for healthy public policy. This approach is also taken by Camden, where the project office is also exploring the possibilities for a London-wide programme to develop healthy public policy. The plans for a single market in the European Community by 1992 is of major concern to the borough, and strategic planning is undertaken to see how this will affect health promotion in the inner city.

Zagreb has undertaken a project to label specific factories as being healthy workplaces and is expanding this policy. Copenhagen is using its Healthy Cities shop as its major vehicle to further develop local healthy public policies in close collaboration with the public.
### Annex 1

**Selection of project cities**

<table>
<thead>
<tr>
<th>First round</th>
<th>September 1987</th>
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<tbody>
<tr>
<td>Barcelona</td>
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<td>Bloomsbury/Camden</td>
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<td>Turku</td>
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<table>
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<td>Zagreb</td>
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<table>
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<th>Third round</th>
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<tbody>
<tr>
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<tr>
<td>Kaukas</td>
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<tr>
<td>Seville</td>
<td></td>
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<tr>
<td>Zurich</td>
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</tr>
</tbody>
</table>

### Annex 2

**Annual themes and their relationship to the European regional targets for health for all**

Cities are requested to report to WHO on a biannual basis on progress towards achieving the 38 regional targets. Some cities have already done such baseline reporting in their applications to WHO. Some have also set city-based health goals based on targets.

#### 1988 Inequalities in health and its prerequisites
- Reducing the differences
- Developing health potential
- Better opportunities for the disabled
- Human settlements and housing

#### 1989 Strengthening community action and developing personal skills
- Social support systems
- Coordination of community resources
- Knowledge and motivation for healthy behaviour
- Positive health behaviour
- Health-damaging behaviour
- Multisectoral policies

#### 1990 Supportive environments for health
- Accidents
- Monitoring and control mechanisms
- Control of water pollution
- Control of air pollution
- Food safety
- Control of hazardous wastes
- Human settlements and housing
- Better opportunities for the disabled
- Suicide
- Social support systems
- Working environment
- Coordination of community resources

#### 1991 Reorienting health services and public health
- A system based on primary health care
- Rational and preferential distribution of resources
- Content of primary health care
- Providers of primary health care
- Coordination of community resources
- Ensuring quality of care
- Planning, education and use of health personnel
- Appropriate health technology

#### 1992 Healthy policies for healthy cities
- Developing health potential
- Healthy public policy
- Multisectoral policies
- Policies for health for all

#### Support targets (of relevance throughout the project)
- Research strategies
- Planning and resource allocation
- Health information system
- Education of personnel in other sectors

#### Mortality and morbidity targets (to be used by cities at their discretion)
- Reducing disease and disability
- Elimination of specific diseases
- Life expectancy at birth
- Maternal mortality
- Diseases of the circulation
- Cancer
Annex 3
The Ottawa Charter for Health Promotion

Charter

The first International Conference on Health Promotion, meeting in Ottawa on 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but look into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma Ata, the World Health Organization’s Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

HEALTH PROMOTION
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.

PREREQUISITES FOR HEALTH
The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

ADVOCATE
Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

ENABLE
Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

MEDIATE
The prerequisites and prospects for health cannot be assured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and other media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individuals and regions to take into account differing social, cultural and economic systems.

HEALTH PROMOTION ACTION MEANS:

BUILD HEALTHY PUBLIC POLICY
Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity, joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

CREATE SUPPORTIVE ENVIRONMENTS
Our societies are complex and interdependent. Health cannot be separated from other goods. The interrelated links between people and their environment constitute the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance — to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.
Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way we organize work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment—particularly changes in technology, work, energy production and urbanization—must be followed by action to ensure positive benefit to the health of the people. The protection of the natural and built environment and the conservation of natural resources must be addressed in any health promotion strategy.

STRENGTHEN COMMUNITY ACTION

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own development and decision-making.

Community development drives the existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

DEVELOP PERSONAL SKILLS

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By doing so, it increases the options available to people to exercise more control over their own health and over their environment, and to make choices conducive to health.

Existing people to learn throughout life, to prepare themselves for all life stages and to cope with chronic illness and injury is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within institutions themselves.

REORGANIZE HEALTH SERVICES

The responsibility for health promotion in health services is shared among individuals, communities, groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. The mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorganizing health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

MOVING INTO THE FUTURE

Health is created and lived by people within the settings of their everyday life: where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, trust and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

COMMITMENT TO HEALTH PROMOTION

The participants in this conference pledge:
- to move into the area of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures toward harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition, and to focus attention on public health issues such as pollution, occupational hazards, housing and sanitation;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to envision healthy services and their resources towards the promotion of health, and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance and its social investment and challenge, and to address the overall ecological issue of our ways of living.

The conference urges all concerned to join them in their commitment to a strong public health alliance.

CALL FOR INTERNATIONAL ACTION

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion. The Conference firmly believes that if people in all walks of life, governments and voluntary organizations, the World Health Organization and other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.
Annex 4

Key background material (1978-1990)

Books and articles


Hancock, T. & Duhl, L. Promoting health in the urban context. Copenhagen, PADI, 1988 (WHO Healthy Cities Papers, No. 1).

Five-year planning framework. Copenhagen, PADI, 1988 (WHO Healthy Cities Papers, No. 2).

A guide to assessing healthy cities. Copenhagen, PADI, 1988 (WHO Healthy Cities Papers, No. 3).


Kickbusch, I. Good places are hard to find. Copenhagen, PADI, 1989 (WHO Healthy Cities Papers, No. 5).


Symposium proceedings


Unpublished case studies

Case studies from the 1988 Zagreb Symposium (books 1-3).

Case studies from the 1989 Pécs Symposium (books 1-3).

Declarations and statements from meetings


Milan Declaration on Healthy Cities, April 1990.
Annex 5

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Michel O’Neill
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The Healthy Cities project office has also been assisted by coordinators of city projects (Jaume Costa, Knud Madsen and Hannes Schmidt) and an intern (Marleen Goumans).

The WHO Healthy Cities project started in 1980 as an activity of the Health Promotion Unit of the WHO Regional Office for Europe. In 1987 the Healthy Cities project office was established within the same unit and was supported by long-term consultants under the supervision of the Regional Officer for Health Promotion. At the same time, the Health Promotion Unit and the Environmental Health Unit of the Regional Office began to cooperate officially in managing the project. In 1989, a project officer post and an administrative assistant post were created for the project, which thus became independent. When Ilona Kickbusch was promoted from Regional Officer for Health Promotion to Director, Lifestyles and Health on 1 January 1990, the project became a separate unit and began to fulfil its role as a major vehicle for achieving health for all. The Director, Lifestyles and Health has the overall responsibility for the unit and programmes related to lifestyles and health, including Healthy Cities, and she is an active team member.
Здравч Градове
Sunde Byer
Gezonde Steden
Healthy Cities
Terveet Kaupungit
Villes santé
Gesunde Städte
Υγιείς Πόλεις
 italiana
Egészséges városok
Cittá Sane
Города Здоровья
Ciudades saludables
Ciutats Saludables
Friska Städer
Zdravi Grad