



World Health
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REGIONAL OFFICE FOR Europe

HEALTHY CITIES

Promoting health and equity – evidence
for local policy and practice



Summary evaluation of Phase V of the
WHO European Healthy Cities Network





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WHO European Healthy Cities Network**

Edited by: Evelyne de Leeuw, Agis D. Tsouros, Mariana Dyakova and Geoff Green

Abstract

This publication summarizes the evaluation of Phase V (2009–2013) of the WHO European Healthy Cities Network. The evaluation process was designed in collaboration with city representatives, academic institutions and public health experts. It adopted a realist synthesis approach, being responsive to the unique social, cultural, political, health and epidemiological circumstances in the 99 cities in the WHO European Healthy Cities Network and 20 accredited national networks. The evaluation findings are rooted in the enduring healthy city values such as equity, governance, partnership, participation and sustainability. Considering also the core Phase V themes, this publication focuses on policy and governance, healthy urban environments and design, caring and supportive environments, healthy and active living, national network performance and effects on health and equity. The evaluation finds good progress among cities and networks but differing in scale and quality. The healthy cities movement adds value and allows local governments to invest in health and well-being and address inequities through novel approaches to developing health.

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Evelyne de Leeuw, Agis D. Tsouros, Mariana Dyakova & Geoff Green

Foreword

This publication is a very brief summary of the recent evaluation endeavours of 99 cities in the WHO European Healthy Cities Network and of the Network of European National Healthy Cities Networks. It covers Phase V (2009–2013). Although the commitment to the values of equity and sustainability endures, the socioeconomic and environmental landscape of Europe has changed fundamentally since I assumed responsibility for the programme 23 years ago.

The WHO Regional Office for Europe has responded with a strategy for Health 2020, supported by our 53 Member States. I was asked by the Regional Director to take responsibility for its development and drew on my WHO Healthy Cities experience to emphasize both the wider socioeconomic determinants of health and the role of local governments and their partners in controlling, regulating or influencing these determinants. In turn, Health 2020 provides a framework and incentive for Phase VI of our networks, spanning the period 2014–2019.

This next phase will draw on results of the ambitious evaluation of Phase V, led by Evelyne de Leeuw, supported by a team of 15 academic experts and advised by our healthy city coordinators and critical friends. They have used an innovative realist synthesis method to marshal the evidence revealed by six research instruments, centred around 159 case studies provided by 79 cities. The second and final chapters of this publication summarize some of the opportunities but also the contested limitations of this method.

This publication is launched at the Annual Business Meeting and International Healthy Cities Conference, which concludes Phase V and heralds Phase VI. I hope it will assist this gathering of policy-makers, decision-makers and academics to critically debate, confront and find common ground in assessing the value and impact of our networks and the work of member cities. It is only the first in a series of robust but accessible publications arising from the evaluation, including a review of 25 years of Healthy Cities in Europe and a special supplement of Health Promotion International. I welcome your experience, insights and priorities, in Athens and beyond.

Agis D. Tsouros

**Director, Division of Policy and Governance for Health and Well-being
WHO Regional Office for Europe**

Summary

1. Phase V prerequisites and designation

The WHO European Healthy Cities Network shares vision, values and an explicit commitment to good governance for health by local councils and their executive arms.

Phase V has three core themes set within a durable framework of four overarching priorities and six strategic goals.

2. Methodology

A realist synthesis methodology was negotiated over two years with key stakeholders, leading to high response rates across the WHO European Healthy Cities Network.

Within the framework of the Phase V programme logic, a team of evaluators deployed a multi-method approach to secure good-quality data from member cities.

3. Enduring values

Innovation and resilience ensure that European healthy cities contribute to values-based urban health development.

Health equity is the fundamental value guiding healthy cities' policies and programmes, even during a period of economic and social crises.

4. Policy and governance

The WHO European Healthy Cities programme pioneered and sustained good local governance, with health on the agenda of intersectoral partnerships.

Health in all policies has provided a strategic framework for strategies and action programmes.

5. Healthy urban environment and design

Health impact assessment gives a sharper focus to the inputs and multiple benefits of healthy urban planning and design.

Innovative neighbourhood planning should grow organically, adopting then adapting citywide frameworks for social and physical regeneration.

6. Caring and supportive environments

Many elements of caring and supportive city environments interact dynamically to increase social inclusion and promote greater equity in health.

Innovative interventions to improve the health and well-being of vulnerable populations are nested within a whole-of-city approach.

7. Healthy and active living

Healthy cities have an innovative role in creating social and economic environments for healthy living – pushing boundaries, developing ideas, being early adopters, creating new partnerships and tackling social determinants of health.

The focus of interventions to promote active living has generally moved from specific events and projects to integrated policies and programmes based on intersectoral collaboration.

8. National healthy cities networks in Europe

National healthy cities networks in 31 countries of the WHO European Region promote the strategic healthy cities priorities of health equity, partnership and health in all policies.

National healthy cities networks are an effective intermediary between local and national governments, communities, academe, industry, the WHO Regional Office for Europe and the European Union.

9. Health and equity

Members of the WHO European Healthy Cities Network remain committed to more equitable urban health but have difficulty in measuring progress.

Cities have developed policy and programme frameworks to guide action on health and equity, gained better understanding of concepts and positively changed local and national agendas.

10. Towards Phase VI

Cities assume a critical role in the governance arrangements underpinning health development in Europe.

Confounding factors pose difficulty in attributing effects to certain healthy city interventions.

1. Phase V prerequisites and designation

Agis D. Tsouros, Evelyne de Leeuw, Geoff Green,
Mariana Dyakova, Nicola Palmer & Lucy Spanswick

Summary

1. The WHO European Healthy Cities Network shares vision, values and an explicit commitment to good governance for health by local councils and their executive arms.
2. Phase V has three core themes set within a durable framework of four overarching priorities and six strategic goals.

Commitment

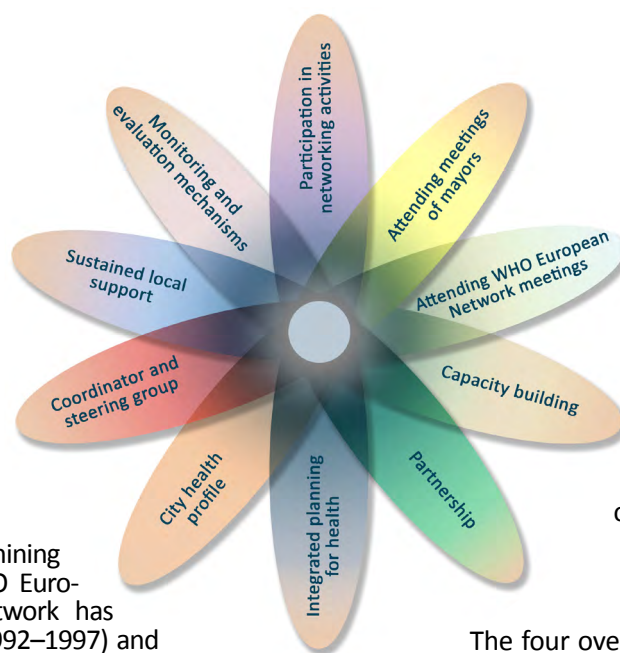
Distinguishing features of the WHO European Healthy Cities Network are shared vision and values and an explicit commitment to good governance by local councils and their executive arms. City mayors have an important leadership role and convening power to engage many sectors influencing city life and health (1).

Membership

The process for determining membership of the WHO European Healthy Cities Network has evolved since Phase II (1992–1997) and was formalized in a goals and requirements contract for Phase V (2009–2013) (2). Designation applies to cities and accreditation to national networks (see Annex 1). Fig. 1.1 summarizes 10 designation requirements. Designation means that cities establish direct relations with the WHO Regional Office for Europe.

Cities have an opportunity to apply for membership of the WHO European Healthy Cities Network throughout a phase without any deadline (Fig. 1.2).

Fig. 1.1. Ten key requirements for membership of the WHO European Healthy Cities Network



This allows for continual development and support, with cities consulting with national and international networks and WHO. Attendance at relevant meetings enables mayors and other representative to consider their programmes and fine-tune them towards membership. However, for evaluation purposes, this continuity may create difficulty, since baselines vary over time from city to city, compounding the methodological limitations referred to at the end of the next chapter.

Overarching priorities

The four overarching priorities over 25 years have been:

- to address the determinants of health, equity in health and the principles of health for all;
- to integrate and promote European and global public health priorities;
- to put health on the social and political agenda of cities; and
- to promote good governance and integrated planning for health.

Strategic goals

The six strategic goals are:

- to promote policies and action for health and sustainable development at the local level and across the WHO European Region, emphasizing the determinants of health, people living in poverty and the needs of vulnerable groups;
- to strengthen the national standing of healthy cities in the context of policies for health development, public health and urban regeneration, emphasizing national-local cooperation;
- to generate policy and practice expertise, good evidence, knowledge and methods that can be used to promote health in all cities in the Region;
- to promote solidarity, cooperation and working links between European cities and networks and with cities and networks participating in the healthy cities movement;
- to play an active role in advocating for health at the European and global levels through partnerships with other agencies concerned with urban issues and networks of local authorities; and
- to increase the accessibility of the WHO European Healthy Cities Network to all Member States in the European Region.

Three core themes in Phase V

The overarching theme for Phase V (2009–2013) was health and health equity in all local policies. Within this, designated cities committed to pursue investments, actions and changes in three core themes.

Core theme 1. Caring and supportive environments

A healthy city should be above all a city for all its citizens, inclusive, supportive, sensitive and responsive to their diverse needs and expectations.

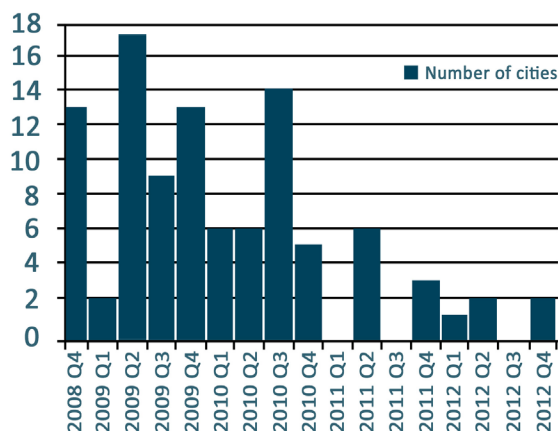
Core theme 2. Healthy living

A healthy city provides conditions and opportunities that support healthy lifestyles.

Core theme 3. Healthy urban environment and design

A healthy city offers a physical and built environment that supports health, recreation and well-being, safety, social interaction, easy mobility, a sense of pride and cultural identity and is accessible to the needs of all its citizens.

Fig. 1.2. Designation of members: a continuous process (number of cities designated in Phase V, by quarter)



National networks

National healthy cities networks are the engine for motivating and supporting European cities to join the movement, to help them to exchange information and experience, and to create more favourable political, social, economic and administrative conditions and capacity for developing and implementing healthy city strategies and plans. National networks act at the interface between their members (members of the WHO European Network and others) and the WHO Regional Office for Europe. National networks are accredited by formally committing to European standards (3).

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2. Methodology

Evelyne de Leeuw, Geoff Green, Mariana Dyakova,
Nicola Palmer & Lucy Spanswick

Summary

1. A realist synthesis methodology was negotiated over two years with key stakeholders, leading to high response rates across the WHO European Healthy Cities Network.
2. Within the framework of the Phase V programme logic, a team of evaluators deployed a multi-method approach to secure good quality data from member cities.

Cutting-edge research

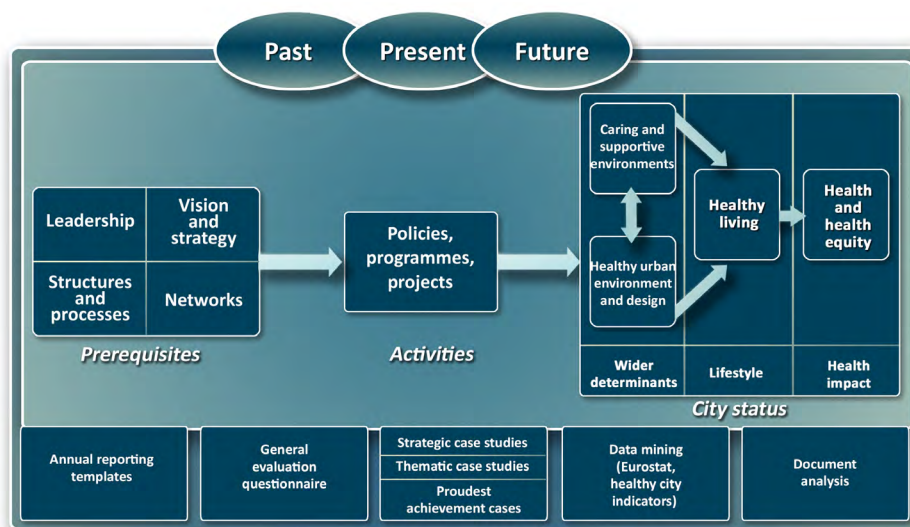
Monitoring and evaluation have been integral to the WHO European Healthy Cities Network since its inception. Research evidence records progress towards important objectives: assessing accountability and improvement; informing management and policy decisions at the community, city, and international levels; gauging responsiveness to emerging issues; and assessing how effective actions are in the real-life urban health laboratory of the WHO European Healthy Cities Network.

The methods deployed for healthy city research are now more sophisticated. They recognize that (urban) health development deals with highly complex and dynamic issues and reflects more refined membership requirements for members of the WHO European Healthy Cities Network. Research partners also adopt approaches to data collection and analysis that acknowledge the evaluation requirements of diverse communities, health professions and local governments (1,2).

A comprehensive model

The programme logic of the WHO European Healthy Cities Network highlights a dynamic relationship between essential prerequisites, activities and changes to city health status (Fig. 2.1).

Fig. 2.1. Realist synthesis programme logic of the WHO European Healthy Cities Network and the accompanying research



The evaluation team synthesized a broad range of data and insights within a realist framework. This is an important premise of fourth-generation evaluation (3), making research more relevant to the policy community. In several iterations over two years, this proposition was discussed and validated with the stakeholders in the WHO European Healthy Cities Network: city representatives, WHO and the research community.

Data collection and analysis

This synthesis brings together a range of methods. Data from 99 cities in the WHO European Healthy Cities Network and 31 national networks of healthy cities were collected on all elements of the programme logic by means of five instruments: the responses of cities throughout Phase V to the annual reporting template; a general evaluation questionnaire administered online; three types of case studies (thematic – on core themes of city status; strategic – on core attributes of healthy city activity; and proudest achievements); quantitative indicators mined from Eurostat and national data bases; and document analysis.

Table 2.1 shows the overall city response rates to the three key data collection tools. Analysis of nonrespondents does not reveal over- or underrepresentation of any particular type of city in the WHO European Healthy Cities Network. This means that the findings are probably typical of all members of the WHO European Healthy Cities Network. Data were entered in standard software packages for quantitative (SPSS) and qualitative (NVivo) analysis. The material was made available to research partners for further investigation.

Creating health, programme logic and good research

The membership criteria for the WHO European Healthy Cities Network are firmly rooted in current understanding of determinants of health. These not only address the proximal healthy living causes

of health, but also the causes of the causes – the social, political and economic determinants of the health choices open to individuals, groups, communities and their institutions. Fourth-generation evaluation recognizes that this field is highly complex, and many factors influence many others over both shorter and longer time frames, with many feedback loops and conditional circumstances (4).

This dynamic complexity is evident in the prerequisites and core themes of Phase V and reflected in our research programme logic. Consequently, drawing simple linear conclusions on health effects from the data is difficult (such as: “Cities that actively engage in initiatives to improve governance

for health increase public participation in health, which demonstrably leads to a reduction in non-communicable disease.”).

The elegance of realist synthesis is that it triangulates primary data from our enquiry with both evidence and conceptual models of causality generated elsewhere in Europe and beyond. We may claim, with some confidence, for instance, that “Cities more active than others in enhancing governance for health, develop more active and more sustainable public participation in health decisions. Such participation should lead to improvements in health.”

Table 2.1. Response rate (%) to three data collection tools

Annual reporting template		General evaluation questionnaire	Case studies	
2010	87	72	Thematic	67
2011	79		Strategic	69
2012	67			
2013	72			

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3. Enduring values

Evelyn de Leeuw, Geoff Green, Agis D. Tsouros,
Mariana Dyakova, Nicola Palmer & Lucy Spanswick

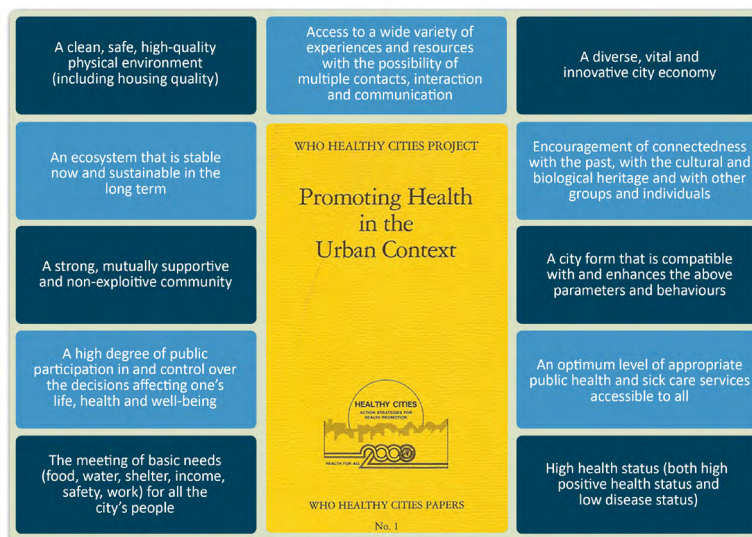
Summary

1. Innovation and resilience ensure that European healthy cities contribute to values-based urban health development.
2. Health equity is the fundamental value guiding healthy cities' policies and programmes, even during a period of economic and social crises.

Healthy cities: from creative disruption to continuous innovation

From its very inception, the healthy cities idea sought to be different. It could be different in many ways: putting health in the hands of communities; in seeking local political leadership for its creation, support and sustainability; in aiming to create new partnerships; in striving for equity and social justice; in recognizing the quintessence of environments for health; and in valuing unique, historically grounded, diversity in urban development. At the very start of the global healthy cities evolution, these values were introduced as the 11 qualities (Fig. 3.1).

Fig. 3.1. Eleven qualities a healthy city should strive to provide



Source: Hancock & Duhl (1).

European Member States embedded the right to health and the identification of health equity as a societal goal. They were integrated for the first time with other social agendas in the fields of education, housing and employment – the social determinants of health approach (2). The Ottawa Charter for Health Promotion (3) formally recognized the pivotal roles of participation and empowerment.

Sustainability became a mainstream concern and strongly associated with health in *Our common future* (4).

These values resonated with the aspirations of thousands of communities and local governments around the world (5). WHO has legitimated cities as natural laboratories for change and as catalysts

for many types of networks, including national networks of healthy cities, language networks (spanning, for example, the francophone globe), and settings for health (such as health-promoting schools). The success of healthy cities lies in assessing health and equity effects across many domains of city life.

Enduring values

These 11 ideals were formulated in 1986 based on a historical and contemporary review of urban development and health in cities (1). They were aligned with the value system of the United Nations and WHO. WHO strategies supported by

Innovation

These values have been the foundation of WHO European Healthy Cities Network since it was launched. Cities and WHO in the European Region continued to adapt and innovate on these strong bases. Geopolitical, financial, social, epidemiological and ecological transitions have strengthened rather than threatened the dynamic of healthy cities. Chapter 5 shows that many cities in the WHO European Healthy Cities Network have successfully adopted an anthropocentric model of sustainability to encourage healthy urban environments and design. Chapter 6 reveals cutting-edge participation processes to support active citizenship. These build on assets and the resilience of communities.

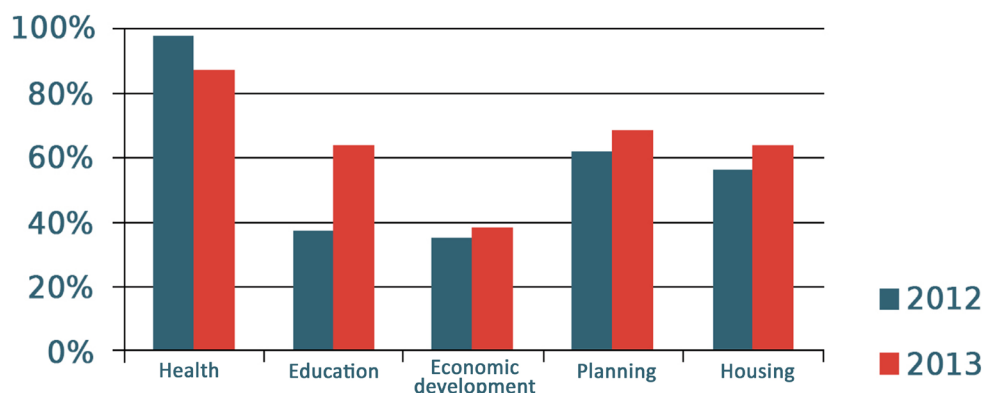
In the period of European austerity that spanned Phase V, health equity was more difficult to achieve. Many cities reported how increases in unemployment and poverty and income inequality were directly linked to poorer health. Nevertheless, cities in the WHO European Healthy Cities Network have demonstrated remarkable resilience. They had to reinvent their role and focus their scope and action where it would bring most benefit from more limited resources. They developed and implemented health equity in all policies, an overarching theme of Phase V.

Fig. 3.2 shows the percentage of policy documents adopting the value of health equity in five sectors. As demonstrated by the next chapter, these provide a framework for action. However, only 14 case studies – mainly from Sweden and the United Kingdom – measured the effects on health inequalities. An example is the controlled intervention study of a school programme by Østfold County in Norway designed to increase physi-

cal activity and reduce dropout rates, especially among socially disadvantaged students.

Cities are the go-to places for inspiration, and the WHO Healthy Cities programme profoundly influenced the development of Health 2020. Cities now contribute significantly to its implementation. Their practical experience of intersectoral partnerships, the *realpolitik* of building consensus

Fig. 3.2. Local policy documents: percentage embedding health equity, 2012 and 2013



for action around core values and their skill in securing local political leadership close to the action make a real difference.

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4. Policy and governance

Evelyne de Leeuw, Geoff Green, Ilona Kickbusch,
Nicola Palmer & Lucy Spanswick

Summary

1. The WHO European Healthy Cities programme pioneered and sustained good local governance, with health on the agenda of intersectoral partnerships.
2. Health in all policies has provided a strategic framework for strategies and action programmes.

Pioneers of city governance

The WHO Healthy Cities programme pioneered the paradigm shift from city government to city governance, now the new norm in WHO European Member States (1). The third prerequisite in Ron Draper's 10-year perspective concluding Phase I in 1992 (2) signalled new "structures and processes" required to promote health (Fig. 4.1). Phase V provides evidence of cities securing and embedding these reforms.

Although health authorities have formal responsibility for health services, municipalities are responsible for many of the wider determinants of health. WHO therefore charged municipal governments, especially executive mayors, with responsibility for promoting healthy cities. They have evolved as key drivers of city health development, marshalling persuasive evidence and using their convening power to form coalitions of intersectoral partners.

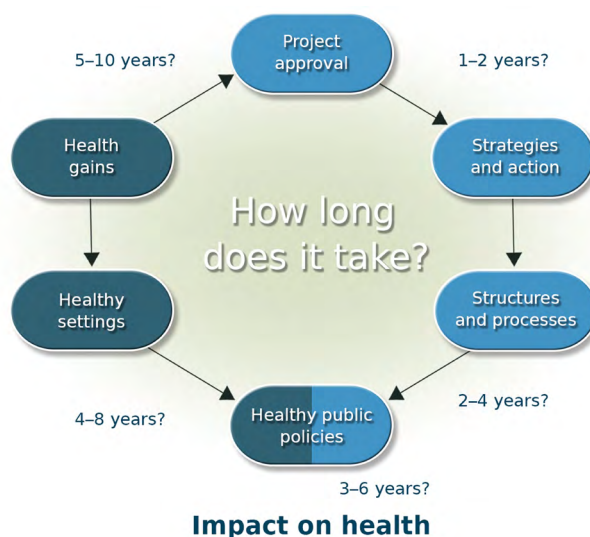
WHO's Health 2020 strategy adopted this pioneering form of local governance from *Governance for health in the 21st century* (3): "the joint action of health and non-health sectors, of the public and private sectors and of citizens for a common interest" or "... the attempts of governments or other

actors to steer communities, countries or groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches".

Half the cities in the WHO European Healthy Cities Network in Phase V submitted case studies that use this new form of local governance. Health authorities, municipalities and civic society each featured in a third of case studies. Ourense,

for example developed a municipal service to support families by involving the regional government, the city hospital complex and the information centre for women. Master planning in Bursa involved three universities, the transport sector, the business community and nongovernmental organizations.

Fig. 4.1. Ron Draper's 10-year perspective on developing health in cities



Health in all policies

Building healthy public policies is the fourth prerequisite in Ron Draper's 10-year perspective (2). It challenged the pioneering cities to move from demonstration projects to longer-term policy. The requirement to produce city health plans in Phase II and city health development plans in Phase III uncovered the complexities of broad health policy development.

Healthy city projects often found it difficult to share a health dimension across other sectors' strategies and plans (4). The period of austerity spanning Phase V tended to focus sectors on delivering their core business – for example, efficient and economical transport was given priority over a health-promoting transport system.

Phase V revitalized health and health equity in all policies as the overarching theme. Cities responded to this call: of the 159 case studies submitted by cities in the WHO European Healthy Cities Network, 53 described policy initiatives, supported by sophisticated local governance structures and processes. Good policies should drive targeted action within a coherent longer-term strategy (5). In Barcelona, a policy framework of health in neighbourhoods used environmental regeneration and community action in 14 vulnerable districts to redress inequalities in health.

Most case studies refer to policies initiated within municipal departments, the mayor's office, the healthy city project or in combination. Very few originate within the local community. More often the catalyst is external, at the regional, national or European levels. Barcelona responded to regional

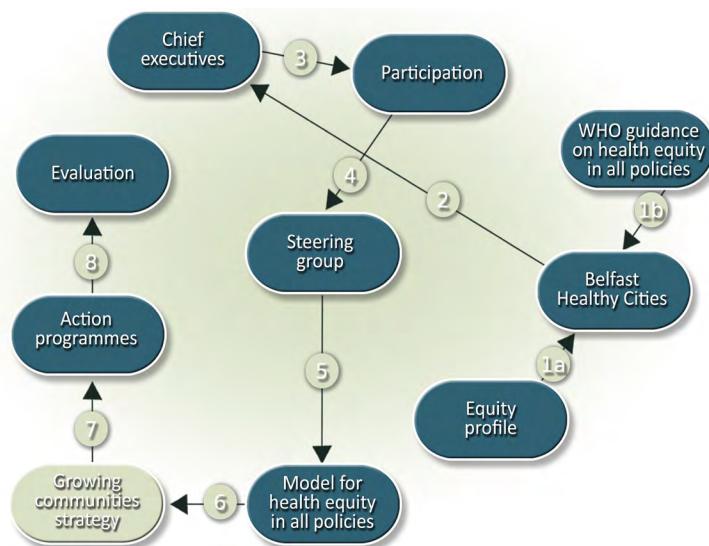
government policy and used regional funds. New national laws were a catalyst for Newcastle's policy on health and social care. The European Union guided and funded both Amarousson's policy on sustainable development and Brno's policy on active ageing. WHO policy guidance has often catalysed local policy development, most notably

Belfast's overarching framework of health equity in all policies (Fig. 4.2).

The case study from Belfast illustrates the policy process. The eight steps begin with Belfast Healthy Cities initiating the development of policy; then securing political commitment from the chief executives of key partner agencies; and developing a

health equity in all policies model for Belfast as a framework for a growing communities strategy. Although in many other cases, healthy cities offices initiate (and may fund) such processes, whole-of-government policy commitments underline this as a collective endeavour.

Fig. 4.2. Belfast's eight-stage policy process for health equity in all policies



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5. Healthy urban environment and design

Marcus Grant, Helen Lease, Gabriel Scally, Erica Ison, Jean Simos,
Lucy Spanswick & Nicola Palmer

Summary

1. Health impact assessment gives a sharper focus to the inputs and multiple benefits of healthy urban planning and design.
2. Innovative neighbourhood planning should grow organically, adopting then adapting citywide frameworks for social and physical regeneration.

Context and concept

The United Nations Conference on Environment and Development in 1992 profoundly influenced the agenda of the WHO European Healthy Cities Network. Agenda 21, emanating from the Conference, highlighted opportunities for local governments to address climate change and promote a sustainable natural environment. Phase II of the WHO European Healthy Cities Network was characterized by fusion between these two agendas.

Phases III and IV of the WHO European Healthy Cities Network introduced urban planners, with their focus on the built environment and transport systems of member cities. The WHO Collaborating Centre for Healthy Urban Environments at the University of West England developed an anthropocentric

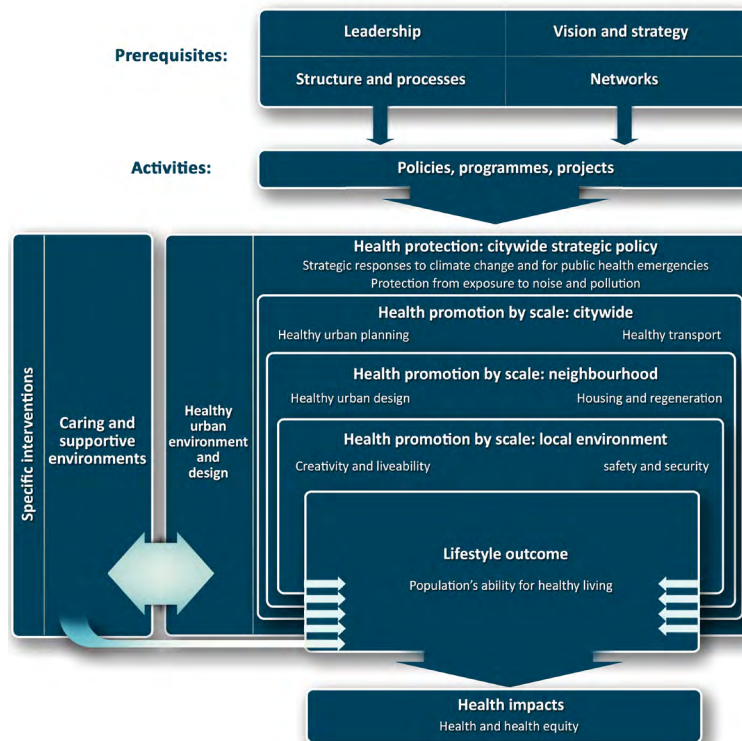
model that puts people at the heart of sustainable development while recognizing ecological

limits to growth. A graphic human settlement map (1) encapsulated in spatial form the concentric influences on health popularly illustrated by Whitehead (2).

For the evaluation of Phase V, this map was fused with programme logic to develop a new outcomes model (Fig. 5.1) of a healthy city – offering “a physical and built environment that supports health, recreation and well-being, safety, social interaction, easy mobility, a sense of pride and cultural

identity, and that is accessible to the needs of all its citizens” (3).

Fig. 5.1. Model for the outcomes of a healthy city



Inputs and outcomes

The case studies were analysed for evidence of activity in one or more of eight topic areas: climate change and public health emergencies; exposure to noise and pollution; healthy urban planning; healthy transport; healthy urban environment and design; housing and regeneration; safety and security; and creativity and liveability. A total of 46 case studies from 31 cities were assigned to healthy urban environment and design. Most referred to project or planning interventions. The general evaluation questionnaire detected an overall increase in the number of cities linking these interventions to better health outcomes.

Spatial environment

The evaluation distinguishes urban environments from caring and supportive environments by their primary focus on buildings, the public realm, green spaces and transport systems. A further distinction is the spatial focus of case studies. Fourteen are city-wide, exemplified by the health paths that join districts of Izhevsk. Kirikkale's Bulvar Park (Fig. 5.2) is one of five city-centre regeneration projects. Fifteen neighbourhood projects either address equity issues by targeting deprived areas (walking tours in Dresden) or are pilots (Preston's Healthy Streets) for scaling up to parts of the city.

Co-benefits

A targeted investment can produce multiple benefits. Preston invests in healthy streets, which inspire residents to walk in safety, cycle and play outside, making stronger social connections with neighbours. Amaroussion's regeneration of the historical city centre includes more green

spaces and pedestrian streets to improve its microclimate. City officials predict that illness and death from the urban heat island will decline, there will be more walking, relaxation and social interaction and the commercial life of the area and local employment will be boosted. Six wins.

Fig. 5.2. Bulvar Park in Kirikkale, Turkey



Health impact assessment

Health impact assessment was introduced to WHO European Healthy Cities Network cities in Phase III and applied in Phase IV (1). Most case studies in Phase V reveal at least a preliminary assessment of health effects before initiating projects, programmes and

policies. However only 10 applied formal health impact assessment methods based on the Gothenburg consensus (4). Three of these were specific projects – upgrading a suburban rail station in Rennes, enlarging a waste disposal site in Arezzo and a major infrastructure project in Vitoria-Gasteiz. Others, such as Pécs and Cardiff, introduced generic health impact assessment policy and planning processes, with Belfast highlighting applying this to health equity in all policies.

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1. Green G, Tsouros A. City leadership for health: summary evaluation of Phase IV of the WHO European Healthy Cities Network. Copenhagen: WHO Regional Office for Europe; 2008.
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3. Phase V (2009–2013) of the WHO European Healthy Cities Network: goals and requirements. Copenhagen: WHO Regional Office for Europe; 2009.
4. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper. Brussels: European Centre for Health Policy, WHO Regional Office for Europe; 1999 (<http://www.euro.who.int/document/PAE/Gothenburgpaper.pdf>, accessed 2 September 2014).

6. Caring and supportive environments

Geoff Green, Josephine Jackisch, Gianna Zamaro,
Nicola Palmer & Lucy Spanswick

Summary

1. Many elements of caring and supportive city environments interact dynamically to increase social inclusion and promote greater equity in health.
2. Innovative interventions to improve the health and well-being of vulnerable populations are nested within a whole-of-city approach.

Context

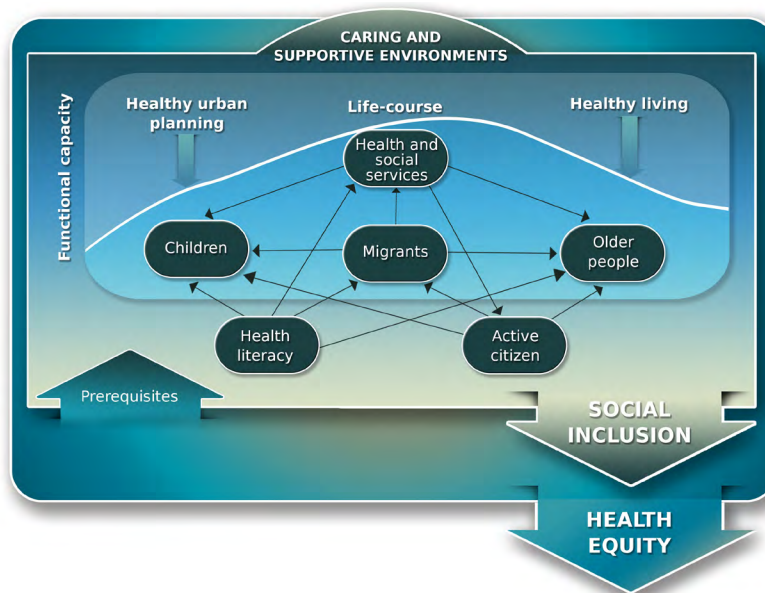
The core theme of caring and supportive environments developed out of the Zagreb Declaration for Healthy Cities (1) by city mayors that concluded Phase IV of the WHO European Healthy Cities Network in 2008 and initiated Phase V. It highlights new challenges, including “narrowing inequality in health, social exclusion, preventing and addressing specific health threats, especially to vulnerable groups, including our children, older people and migrant populations”. These “inspired and guided” the requirements for membership of the WHO European Healthy Cities Network, specifically the goal of “a city for all its citizens, inclusive, supportive, sensitive and responsive for their diverse needs and expectations”.

Dynamic model

Six topics are clustered in this theme. Three interventions – health literacy, active citizenship and health and social services – target the three vulnerable populations identified in the Zagreb

Declaration: children, older people and migrants. WHO provides expertise and guidance on each topic (2–4). A dynamic model (Fig. 6.1) indicates interactions between the six topics over the life-course and (together with healthy urban environment and planning and healthy living) how they potentially affect social inclusion and health equity.

Fig. 6.1. Interactions of factors related to caring and supportive environments over the life-course and how they potentially affect social inclusion and health equity



Proposition

The main proposition explored by the evaluation is that improving health and social services, active citizenship and health literacy will enhance the social inclusion of children, older people and migrants, leading to greater equity in health.

Process

Almost all the 112 case studies related to caring and supportive environments adopt a whole-of-city approach to address the complexity of their cities and achieve social change. Health literacy, active citizenship and health and social services have an interactive dynamic. Vulnerable people often have multiple and intersecting identities. Such is the case of poor migrant mothers supported by Arezzo to become more health literate in childcare.

A holistic approach adopts the prerequisites of political commitment, vision and strategy with intersectoral partnerships to secure health in all policies. Equally important are seven critical process factors identified by the Healthy Ageing Task Force of the WHO European Healthy Cities Network as being necessary to initiate and sustain successful programmes. Applying the wisdom derived from Task Force membership, Fig. 6.2 illustrates the eleven-stage process of developing Brno's Active Ageing Plan.

Fig. 6.2. Process of developing Brno's Active Ageing Plan



assume that personal knowledge and awareness promotes healthy lifestyles. Łódź invests in health-promoting schools to make children aware of how the imbalance of diet and physical activity causes obesity. Health literacy among

older people is often within an active ageing framework of physical and mental activity, exemplified by Udine's Move Your Mind programme. A healthy city approach identifies the causes of the causes. Stoke-on-Trent found that health literacy is higher among people with more social connections and higher education levels.

Active citizenship

Case studies assume that citizen participation in setting policies and programmes leads to more relevant interventions, increasing satisfaction with services provided by municipalities and partners. Citizen involvement was particularly relevant in times of economic recession; allocating resources more efficiently by preventing duplication of initiatives and facilities, co-producing services by municipalities and citizens. Truly innovative responses to austerity are the motor group in Barcelona, a co-creative process and self-help in Horsens, small-scale and accessible possibilities in Turku, Health Brokers in Rotterdam and a community asset-based approach in Newcastle.

Health and social services

Health and social services are fundamental to European welfare systems. Nevertheless, only a fraction of case studies focus exclusively on either health or social care services. In a period of austerity, many cities have adopted a multisectoral approach, reflecting a new and more complex nexus of provision, funding and accountability. Sarajevo's project to enhance physical activity in the third age refers to cooperation between the health sector and welfare sector. The development of home care services for seniors in Ljubljana involved the City Administration, Home Care Institute and Community Health Centre.

Health literacy

Many cities hesitated to use the concept of health literacy. Nevertheless, most case studies

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1. Zagreb Declaration for Healthy Cities. Copenhagen: WHO Regional Office for Europe; 2008.
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7. Healthy and active living

Jill Farrington, Johan Faskunger, Karolina Mackiewicz,
Mariana Dyakova, Nicola Palmer & Lucy Spanswick

Summary

1. Healthy cities have an innovative role in creating social and economic environments for healthy living – pushing boundaries, developing ideas, being early adopters, creating new partnerships and tackling social determinants of health.
2. The focus of interventions to promote active living has generally moved from specific events and projects to integrated policies and programmes based on intersectoral collaboration.

Healthy living – an overview

The core theme of healthy living in Phase V of the WHO European Healthy Cities Network refers to chronic disease, risk factors, systems, approaches and overall well-being (1). This chapter presents the main findings on factors influencing health, such as active living; alcohol and drugs; healthy food and diet; and healthy settings.

Most of the cities working on healthy living are from the Organisation for Economic Co-operation and Development (OECD) and Mediterranean sub-regions; they are predominantly new to Phase V. Active living is the most popular subtheme, with most of its interventions presented by western European and pioneering cities (2).

include schools and smoke-free environments. There is a marked relationship between healthy living and other Phase V core themes: for example, the health literacy of children is assumed to influence a healthy diet.

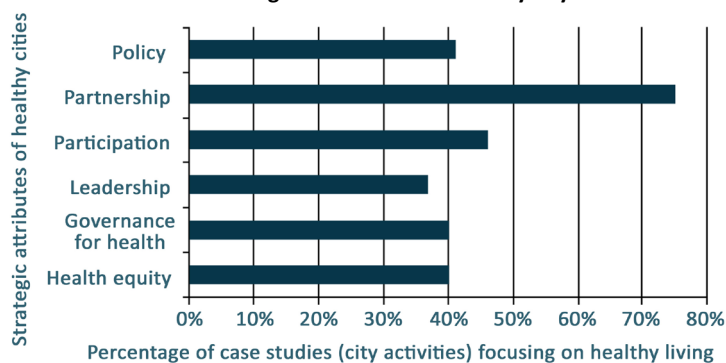
Active living activities are often integrated into other policy areas and in related interventions, such as regenerating city centres, community investment and urban planning and design.

Most case studies relate in some way to sustainable development; 55% include participatory action and 38% action on health inequalities.

The strategic priorities (Fig. 7.1) of equity and partnership are important, especially

in case studies on local health services. Partner agencies are engaged in driving work forward to achieve specific outcomes. Intersectoral cooperation appears to be strong, especially between local authorities and education and public health agencies. There are good examples of engagement with communities, also involved in co-designing and shaping projects. Equity also features strongly in the many case studies addressing social determinants of health, especially those designed to reduce the consumption of tobacco and alcohol (Fig. 7.2).

Fig. 7.1. Proportion of healthy living case studies demonstrating the strategic attributes of a healthy city



Interrelations and connections

Within the healthy living theme, consumption of tobacco, alcohol and certain foods is linked to non-communicable diseases. Cities have undertaken a range of preventive activities. Specific settings in-

Cities free from tobacco, alcohol and drugs

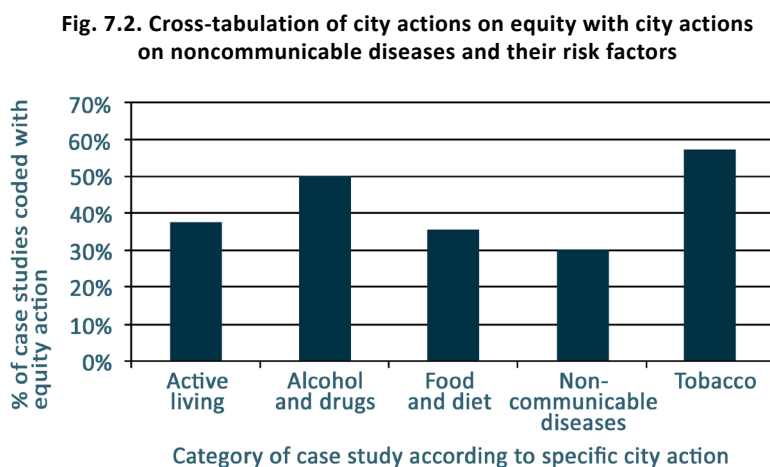
The interdependence of the local and national levels of governance is especially important for tobacco and alcohol control, where cities have a critical role in implementing and enforcing regulatory frameworks, often leading the way, piloting approaches, challenging the status quo and developing innovations.

Most cities have taken broad, fairly comprehensive strategic approaches to prevent the use, misuse or harmful use of addictive substances: a life-course approach to preventing addictions through school, family and community in Ourense; and the systematic partnership approaches of Galway and Swansea. The vision for a smoke-free city in Copenhagen was created by linking health professionals and politicians with academe.

especially to schoolchildren and their parents. Action on food and nutrition within the health sector has been minimal.

Active living

Active living interventions serve many goals: improving social cohesion and transport in cities; preventing noncommunicable diseases; and improving equity and healthy urban environment and design. Some cities experiment and go beyond business as usual: for example, promoting links between physical activity, culture and the mental health of older people. Planning and implementation have been predominantly informed by evidence. Most case study interventions are assessed as fully transferable to other settings, ready to be shared among healthy cities. A major challenge has been to select appropriate interventions to reach some target populations, especially disadvantaged groups.



Healthy food and diet

Interventions are realized through diverse partnerships and focus predominantly on children in educational or care settings. A few cities, such as Udine, have taken a comprehensive approach to tackling obesity. The main areas of activity are: ensuring healthy and sustainable food supply (such as Preston's community food growing project and Cork's consideration of social, environmental and economic aspects of the food system) and providing comprehensive information and education to consumers,

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8. National healthy cities networks in Europe

Mariana Dyakova, Leah Janss Lafond,
Maria Palianopoulou, Lucy Spanswick & Nicola Palmer

Summary

1. National healthy cities networks in 31 countries of the WHO European Region promote the strategic healthy cities priorities of health equity, partnership and health in all policies.
2. National healthy cities networks are an effective intermediary between local and national governments, communities, academe, industry, the WHO Regional Office for Europe and the European Union.

Consolidation

European national healthy cities networks have worked with and supported their member cities in adopting and implementing the values, strategic priorities and approaches of the healthy cities movement. Phase V has witnessed national networks consolidate their organization, membership and position at the local and national levels. They have intensified the communication and collaboration among themselves and with the WHO Regional Office for Europe, making the Network of European National Healthy Cities Networks more effective and visible. At present, national healthy cities networks have been established in 31 European countries, involving around 1500 cities. The 20 networks accredited by WHO represent 1137 local governments with a combined population of 156 million people.

Strategic priorities as prerequisites for positive change

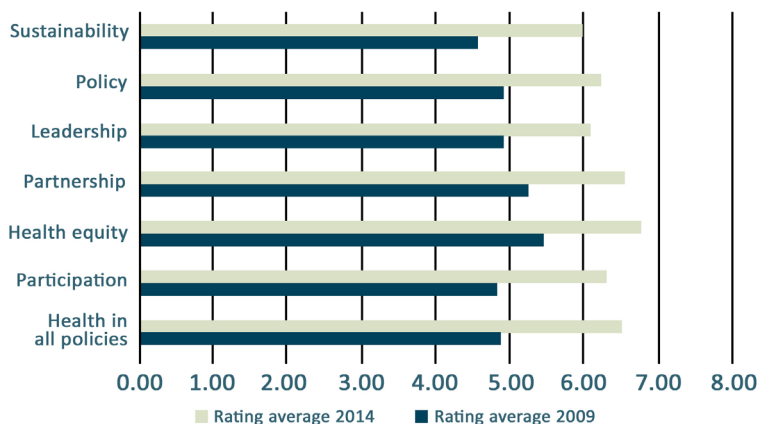
National networks have enhanced their sustainability through better governance, improved resource management and communication strategies. They have dual leadership and policy roles

– ensuring strategic alignment and inspiring their members, gaining political commitment from local governments and engaging with external stakeholders (1–3). The strongest attributes of the national networks' vision and Phase V work have been tackling health inequalities, developing part-

nerships and placing health high in all policies locally and nationally (Fig. 8.1).

National networks place high value on bringing added value to their city members by identifying gaps in knowledge and implementation experience, sharing best practices, providing training, producing guidance materials and managing change. The expertise and capacity gained

Fig. 8.1. Rating of strategic priorities (scale 0 to 9, with 9 fully integrated) as part of the national networks' vision and specific activities



through this process makes them attractive to a range of partners, including health ministries and other sectors; government agencies and national institutes; nongovernmental bodies, such as professional and local authority associations; and academe (1–3).

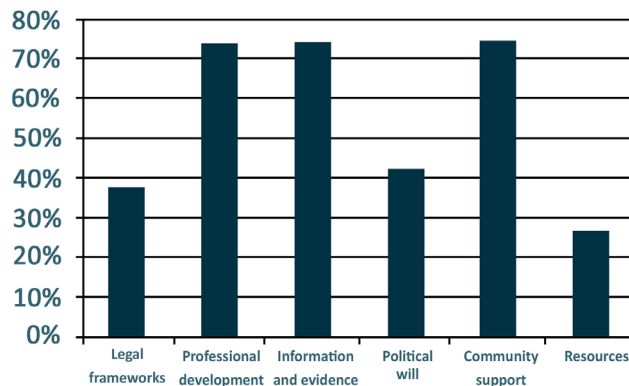
Healthier environments, healthier lifestyles and healthier people

Working along the four core Phase V priority areas, national networks faced common challenges, overcame various barriers and used their assets to influence positively determinants of health and health status. Their approach towards improving urban settings matured from tackling unhealthy environments through supporting healthier lifestyles to achieving an integrated approach to and impact on health outcomes. The most important factors supporting health equity in cities are professional development, available relevant information and community support (Fig. 8.2). The national network or its member cities initiated most of the specific strategic actions for health in the respective country.

Stronger networks for health

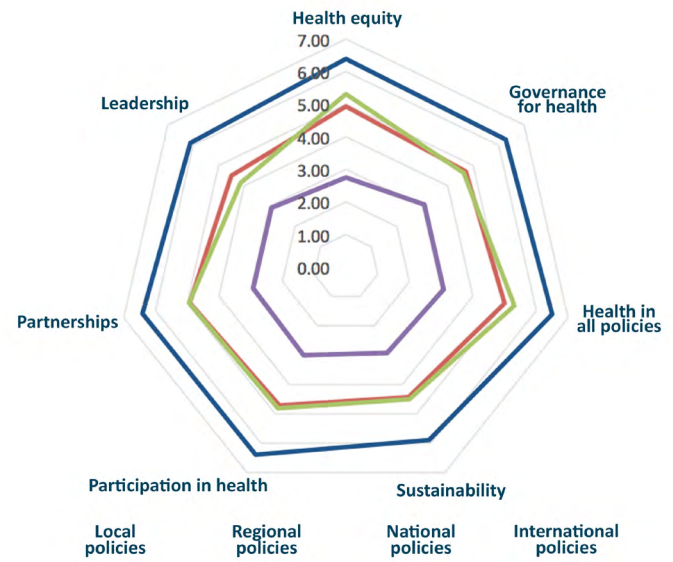
Most national networks (75–90%) agreed that European networking has added value and contributed to attracting new partners; improved strategic direction; and, above all, strengthening legitimacy at the national level. National networks have reached a higher position influencing

Fig. 8.2. Percentage of respondent cities saying that various factors support achieving health equity in cities



national but also regional and European health policies and practices (Fig. 8.3). Supported formally and informally by the WHO Regional Office for Europe and trusted by their members, national networks have naturally become a strong instrument for disseminating and implementing the WHO European Health 2020 policy framework and strategy (4) in the future.

Fig. 8.3. Effects of national networks on policies (scale 0 to 9, with 9 being the greatest effects)



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9. Health and equity

Geoff Green, Evelyne de Leeuw, Anna Ritsatakis, Premila Webster, Mariana Dyakova, Nicola Palmer & Lucy Spanswick

Summary

1. Members of the WHO European Healthy Cities Network remain committed to more equitable urban health but have difficulty in measuring progress.
2. Cities have developed policy and programme frameworks to guide action on health and equity, gained better understanding of concepts and positively changed local and national agendas.

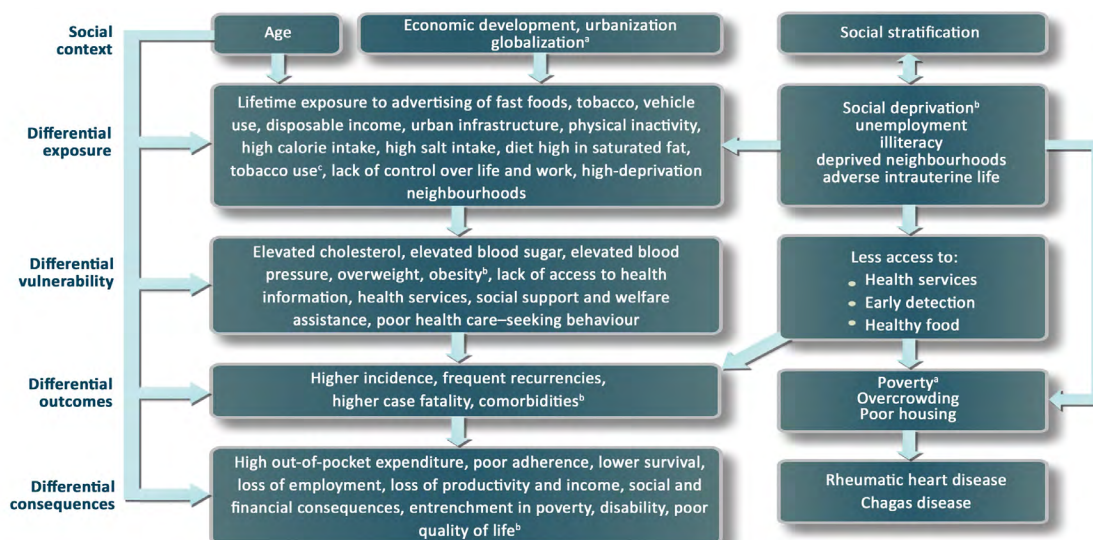
Concept and context

The ultimate goal of the WHO European Healthy Cities movement is to make a difference in health and well-being and to improve equity through action on underlying urban factors – social, environmental and economic. In complex systems, action on social determinants of health is both an end in itself and a starting point for healthy cities.

The realist programme logic recognizes the many levels of influence and multifactorial nature

of health and well-being (Fig. 9.1). However, moving beyond germ theory (controlling disease through relatively simple cause–effect interventions) into action on the causes of the causes highlights the challenge of providing evidence of effectiveness and attributing specific health outcomes. The variety of cultural norms and behaviour in Europe and the differences in available data, information systems and length of membership between cities contribute to the complexity of the evaluation process.

Fig. 9.1. Conceptual framework for understanding health inequities, pathways and entry points in preventing and controlling cardiovascular disease



Determinants

a. Government policies influencing social capital, infrastructure, transport, agriculture, food.

b. Health policies at macro, health system and micro levels.

c. Individual, household and community factors: use of health services, dietary practices, lifestyle.

Source: Blas & Kurup (1).

Evidence for improving health and equity

The healthy living theme analysis highlights healthy city action on preventing noncommunicable diseases and innovation in local health systems. Evidence indicates a broad spectrum of local engagement in the prevention, control, management and care of disease and their design. Cities focus on individual and population dimensions of healthy living and report a wide spectrum of accomplishments.

Besides the primary focus on the value of physical activity, many cities identify mental health interventions as a priority, both at an individual and community level. Few cities (Rennes and Cardiff) have taken a comprehensive approach to preventing and controlling noncommunicable diseases across multiple risk factors or combining population and individual-level approaches. Others act on multiple pathways and entry points to address inequity (1), specifically social determinants in the care of people with chronic conditions (Milan, Carlisle, Aydin and Amaroussion).

Cities invest in caring and supportive environments, gauging that their activities will change the determinants of health and thereby affect health outcomes. Nearly one third of the thematic case studies address health equity, often focusing on vulnerable groups or deprived neighbourhoods. Cities have undertaken various initiatives and approaches to enhance the social inclusion of vulnerable population groups, to promote greater equity in health. Some (Dresden and Izhevsk) have been successful in bringing together interventions to improve physical and mental health and social inclusion to achieve equity.

Within the theme of healthy urban environment and design, health inequity is addressed through action on housing and regeneration; safety and security; healthy urban planning and healthy transport. Active travel is one of the main reported achievements, featuring enhanced walking,

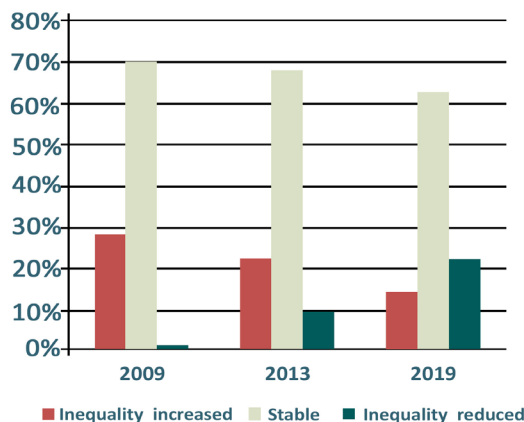
cycling and healthy public transport. Cities have also identified creativity and liveability, designed by WHO to promote community development by improving social cohesion and building human and social capital, as an instrument towards improving equity, health and well-being.

Phase V has led to better understanding of the effects of social determinants of health, the concept of equity (2) and the importance of identifying and quantifying inequalities. The issue of health inequalities is now higher on local agendas, ensuring visible delivery of action at the local level. Health and equity are prominent not only in health and well-being plans (Bologna) but also in overall development plans (Klaipeda) and structural or governance changes (Manchester).

Cities have made progress both in measuring inequalities and planning measures to reduce them. They were also asked by the evaluation team to provide an assessment of the overall trend in health inequalities in their cities. Fig. 9.2 summarizes responses to the penultimate question in the general evaluation questionnaire – “Have overall health inequalities between population groups increased or decreased?” There is a positive trend from the beginning of Phase V in 2009 through the end in 2013 and projected to the end of Phase

VI in 2019. These self-assessments should be treated with great caution. Respondents often use statistical evidence, but naturally there is political pressure to report progress. They are not objective. Consequently, they are only a very initial assessment of city health status and a prelude to more forensic analysis in Phase VI.

Fig. 9.2. Self-assessment of trends in overall health inequalities in healthy cities



Note: general evaluation questionnaire (n = 71).

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10. Towards Phase VI

Evelyne de Leeuw, Geoff Green & Mariana Dyakova

Summary

1. Cities assume a critical role in the governance arrangements underpinning health development in Europe.
2. Confounding factors pose difficulty in attributing effects to certain healthy city interventions.

The European context

This initial report on the evaluation of Phase V of the WHO European Healthy Cities Network identifies twin challenges – contextual and methodological. In his foreword, Agis D. Tsouros refers to the changing socioeconomic landscape of Europe and the strategic response of the WHO Regional Office for Europe. In her introduction to Health 2020, WHO Director-General Margaret Chan refers to the considerable challenges in the WHO European Region (1): “Health inequities within and between countries reflect economic and social divisions across society. As economic pressures bite and health care costs rise, the risk of exclusion increases, too often leaving behind those with the greatest health needs.”

A companion report to Health 2020 – *Governance for health in the 21st century* (2) – recounts the many layers and domains of government in the countries in the European Region. Local government has a key role, reflected in the goals and requirements for Phase VI (3): “The WHO European Healthy Cities Network is now being positioned as a strategic vehicle for implementing Health 2020 at the local level. Local action and the decisions of local governments can strongly influence all the public health challenges noted above as well as many of the determinants of health. Healthy city leadership is more relevant than ever.”

Methodological challenges

The very complexity of cities and their layers and domains of governance require a corresponding method to understand the context and impact of a healthy city approach. According to Whitfield et al. (4), “Orthodox public health evaluation paradigms seeking to isolate single causes of ill-health

from a noisy city context, are inappropriate for evaluating typically interrelated interventions by city authorities and their partners, operating in more or less salutogenic environments, and with multiple, coexisting outcomes.” A framework of realist synthesis was adopted for this Phase V evaluation to better address this dynamic, and we recommend that it be debated, modified and comprehensively resourced for Phase VI.

Context is important. The divergence of sociopolitical conditions is challenging. Each local government area has a unique combination of characteristics, is located in a specific place and has profound roots in social, cultural and political history. Although the WHO Regional Office for Europe provides a common set of objectives, values and ideals for further development, the starting-point and direction of travel varies between cities and sometimes between communities and neighbourhoods within cities. The expansion of the European Union, for instance, has influenced opportunities for developing local government infrastructure. Austerity measures have had differential effects on cities across the European Union.

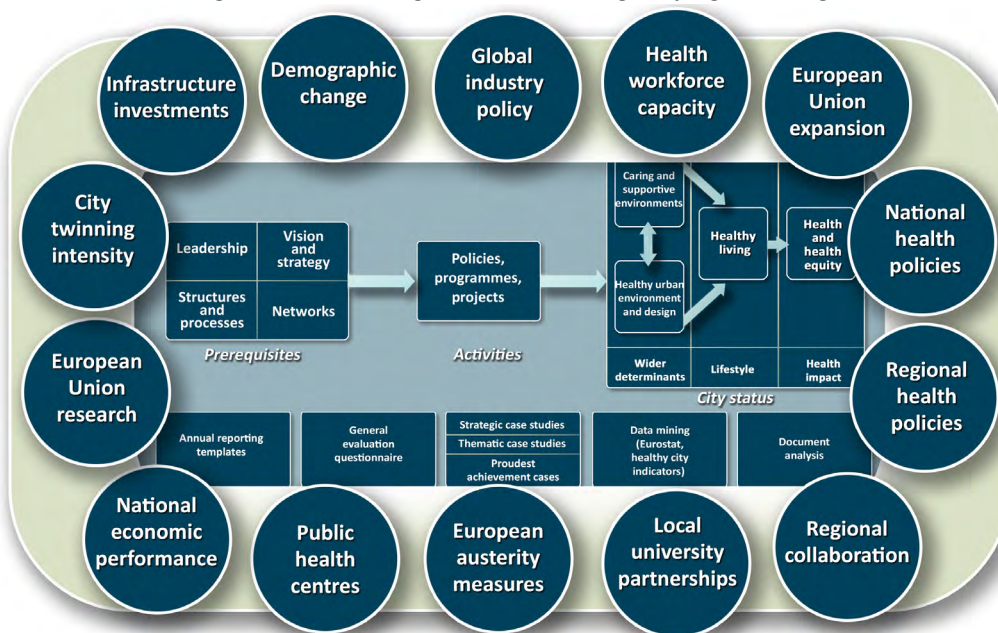
Accounting for extraneous confounders

Good research attempts to identify confounding factors: issues or events that disturb or complicate the dependent and independent variables that are the focus of the research. An example is the complicating factor of pollution from vehicular traffic, which diminishes the effects on health (dependent variable) of outdoor physical activity (independent variable). Another is the complicating factor of austerity, which may diminish the effects of signing up for the prerequisites of a healthy city. This in itself

has been shown to be essential to embedding health across social and political sectors (5). Documenting evidence of the effectiveness (6) of being a healthy city, especially in the dynamic European context, is much harder. We recommend that any evaluation of Phase VI identify key confounding variables surrounding the programme logic as one of the first steps (Fig. 10.1).

For Phase VI, it is also necessary to identify who influences or controls the causes of the causes: for example, which agencies control or influence traffic pollution or the creation of safe cycling paths. The Phase V evaluation had limited capacity to identify and account for such factors. WHO is clearly not the only actor that drives health – as recognized in its own Health 2020 strategy and global efforts toward health in all policies (7). National governments are influential, limiting cities' control over their funding, future and resilience. Within cities, governance arrangements allocate responsibilities and budgets between partner agencies.

Fig. 10.1. Confounding factors surrounding the programme logic



key theories (of change) to be explored cannot meaningfully occur in the absence of input from practitioners and policy-makers.”

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Dialogue

The evaluation team will respond to opportunities to debate these issues at the International Healthy Cities Conference and afterwards. The evaluation team concurs with Pawson et al. (8), who developed the realist synthesis approach and recommend a healthy two-way dialogue with the policy community throughout the process, from the initial expert framing of the problem to the final judgement on what works: “The tasks of identifying the review question and articulating

Annex 1. Members of the WHO European Healthy Cities Network in Phase V

The 99 members of the Network

Amaroussion	Izmir	Ptolemaidas
Arezzo	Jerusalem	Rennes
Aydin	Jurmala	Rijeka
Barcelona	Kadiköy	Rotterdam
Belfast	Karsiyaka-Izmir	Samara
Bologna	Kirikkale	San Fernando
Brighton	Klaipeda	San Sebastian
Brno	Kocaeli	Sandnes
Brussels	Kuopio	Sant Andreu de la Barca
Bursa	Leganes	Sarajevo
Çankaya	Liège	Seixal
Cardiff	Liverpool	Sheffield
Carlisle	Ljubljana	St Petersburg
Celje	Lódz	Stavropol
Cheboksary	Manchester	Stockholm
Cherepovets	Milan	Stoke-on-Trent
Copenhagen	Modena	Sunderland
Cork	Montijo	Swansea
Denizli	Nancy	Torino
Derry (Londonderry)	Nantes	Trabzon City
Dimitrovgrad	Newcastle	Turku
Dresden	Nilüfer	Udine
Dunkerque	Novi Sad	Ulyanovsk
Eskisehir Tepebasi	Novocheboksarsk	Velikiy Ustyug
Galway	Novosibirsk	Venice
Glasgow	Oeiras	Viana do Castelo
Golcuk	Østfold County	Vienna
Grasse	Ourense	Villanueva de la Canada
Győr	Padova	Vitoria-Gasteiz
Helsingborg	Pärnu	Warsaw
Horsens	Pécs	Waterford
Istanbul	Poznan	Yalova
Izhevsk	Preston	Zagreb

The 20 accredited WHO European national healthy cities networks

Belgium	Hungary	Russian Federation
Croatia	Greece	Slovenia
Czech Republic	Israel	Spain
Denmark	Italy	Sweden
Finland	Norway	Turkey
France	Poland	United Kingdom
Germany	Portugal	

National network applied for accreditation

Austria

The 10 European national networks that are not accredited

Bosnia and Herzegovina

Cyprus

Estonia

Ireland

Latvia

Lithuania

Netherlands

Slovakia

Switzerland

Ukraine

The WHO Regional Office for Europe

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

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Albania
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Israel
Italy
Kazakhstan
Kyrgyzstan
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Luxembourg
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Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
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