WHO Healthy Cities Project
Phase III: 1998–2002

The requirements and the designation process for WHO project cities

World Health Organization
Regional Office for Europe
CENTRE FOR URBAN HEALTH
22 December 1997

Contents

Summary

The World Health Organization (WHO) Healthy Cities project is a long-term international development project which aims to place health high on the agenda of decision-makers in Europe. Two phases of implementation of the project have now been completed. Phase III, which will run from 1998 to 2002, is about to commence.

This new Phase III WHO network of project cities will play a leading role in progressing action to promote urban, and thereby global, health in ways that are both innovative and sustainable. The work of the new network will reflect international policy developments (most notably, health for all for the twenty-first century and Local Agenda 21) and will build on the experiences and successes of the first two phases. It will be one of a number of interactive Healthy Cities networks to develop action for urban health across Europe.

This document describes the process for recruiting project cities to Phase III. The process involves two main stages. The first stage comprises an assessment of whether cities are eligible to be part of the network. This assessment will focus on evidence of past achievements and ongoing commitment to the Healthy Cities way of working.

The second stage requires greater evidence of political commitment and involves an appraisal of more detailed proposals from eligible cities, setting out how they plan to meet the various requirements for Phase III. This appraisal will inform the final WHO decisions about designation of cities to the network.

The emphasis in Phase III is on the implementation of a city health development plan within each network city. Particular emphasis is placed on the principles of equity in health and sustainable development. Cities are also required to be systematic in their approaches to monitoring and evaluation.

There will be three rounds of designation over the first two years of the third Phase. For the first round, the deadline for applications for eligibility is 27 February 1998. Eligible cities will then be required to submit Phase III applications by 8 May 1998. Cities should be notified of the outcome within 6–8 weeks.

Background

At the turn of the century, half of the world's population will live in cities. Currently more than two thirds of the people in Europe live in towns and cities. The importance of action for health at city level can therefore not be overstated. On a global scale the future of humankind will be shaped largely by urban conditions.

The World Health Organization (WHO) Healthy Cities project is a long-term international development project which aims to place health high on the agenda of decision-makers in European cities and to establish structures and processes to enhance urban health. Two phases of implementation of the Healthy Cities project have now been completed. Each phase involved a number of elements, including a highly committed network of cities, designated by WHO to be WHO project cities. Phase I (1987–1992) involved 35 cities in the network of WHO project cities. The accent was on creating new structures to act as change agents and introducing new ways of working for health in cities[1]. The second phase (1993–1997) is now reaching its end. Thirty-nine cities were involved in the network of WHO project cities, including thirteen that had not participated in such a network in Phase I. This phase was more action-oriented with a strong emphasis on healthy public policy and comprehensive city health planning[2].

During these past ten years, the Healthy Cities way of working has been implemented widely – far beyond the cities formally designated by WHO as part of its project network. National networks, of cities committed to improving the health of their populations in line with the values and principles of health for all, now exist in 25 European countries. Many groups of cities across Europe have also worked together to progress multi-city action planning on particular health issues of common concern. This level of spread is an indication of the success and flexibility of the Healthy Cities approach.

On commencing Phase III of the WHO Healthy Cities project, the network will be strengthened further by bringing in new cities that have to date been developing their work outside that network. Phase III will thus build upon and incorporate city-based developments across Europe.

Phase III will also reflect and support some key international developments. With the approach of the new century, the policies and targets for health for all by the year 2000 are currently being reviewed. Urban health is an area of increasing priority and the Healthy Cities mechanism will be an important implementation route for health for all for the twenty-first century. Long-standing health issues such as the damage caused by tobacco remain, and some newer concerns such as the widening inequalities in health, growth of migrant populations and violence are apparent.

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[1] *WHO Healthy Cities Project: Review of the first five years (1987-1992) A working tool and a reference framework for evaluating the project.*

[2] *Setting Standards for WHO project cities. The Requirements and the Designation Process for WHO project cities. WHO 1993*

The 1997 Jakarta Declaration on health promotion identified five priorities for the twenty-first century:

- promote social responsibility for health
- increase investment for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

Agenda 21 (the United Nations programme of action on sustainable development) brings economic, environmental, sociodemographic and health factors together in its framework. Action at local level is particularly important in the context of the above, and cities need to develop and implement long-term action plans towards sustainability. 'Think globally, act locally' is the guiding slogan that needs to go beyond capturing people's imaginations.

The new European network of WHO project cities will play a leading role in progressing action to promote urban (and thereby global) health, in ways which are both innovative and sustainable. Cities participating in this new network will be designated on the basis of a set of clear criteria, and will be required to deliver an action programme in line with the requirements of this phase. The remainder of this document describes the requirements of the new phase and the process for the designation of cities to this network of WHO Healthy Cities project cities.

Overview of the designation process

Introduction

An overview of the process leading to the designation of cities to the Phase III network is shown in Fig. 1. There will be three rounds for designation over the first two years of Phase III, during which cities will be recruited to the network. The dates for the rounds are shown in Fig. 2. Each round will follow a process which involves two main stages: the first stage, the *eligibility process* assesses whether cities are eligible to be part of the network; the second stage, the *designation process,* appraises the content and quality of the Phase III proposals from eligible cities, leading to designation. Detail on the eligibility process is to be found in the third section of this document; detail on the designation process and requirements for Phase III are to be found in the fourth, fifth and sixth sections.

Eligibility

Eligibility will be assessed by a number of people, appointed by WHO, who are experienced in the Healthy Cities ways of working. WHO will oversee the process but administration will be carried out, on behalf of WHO, by the WHO Collaborating Centre for Research on Healthy Cities at the University of Maastricht. The assessment will be made on the basis of written submissions (in English). There is no limit set on the number of cities that will be considered eligible to apply for Phase III.

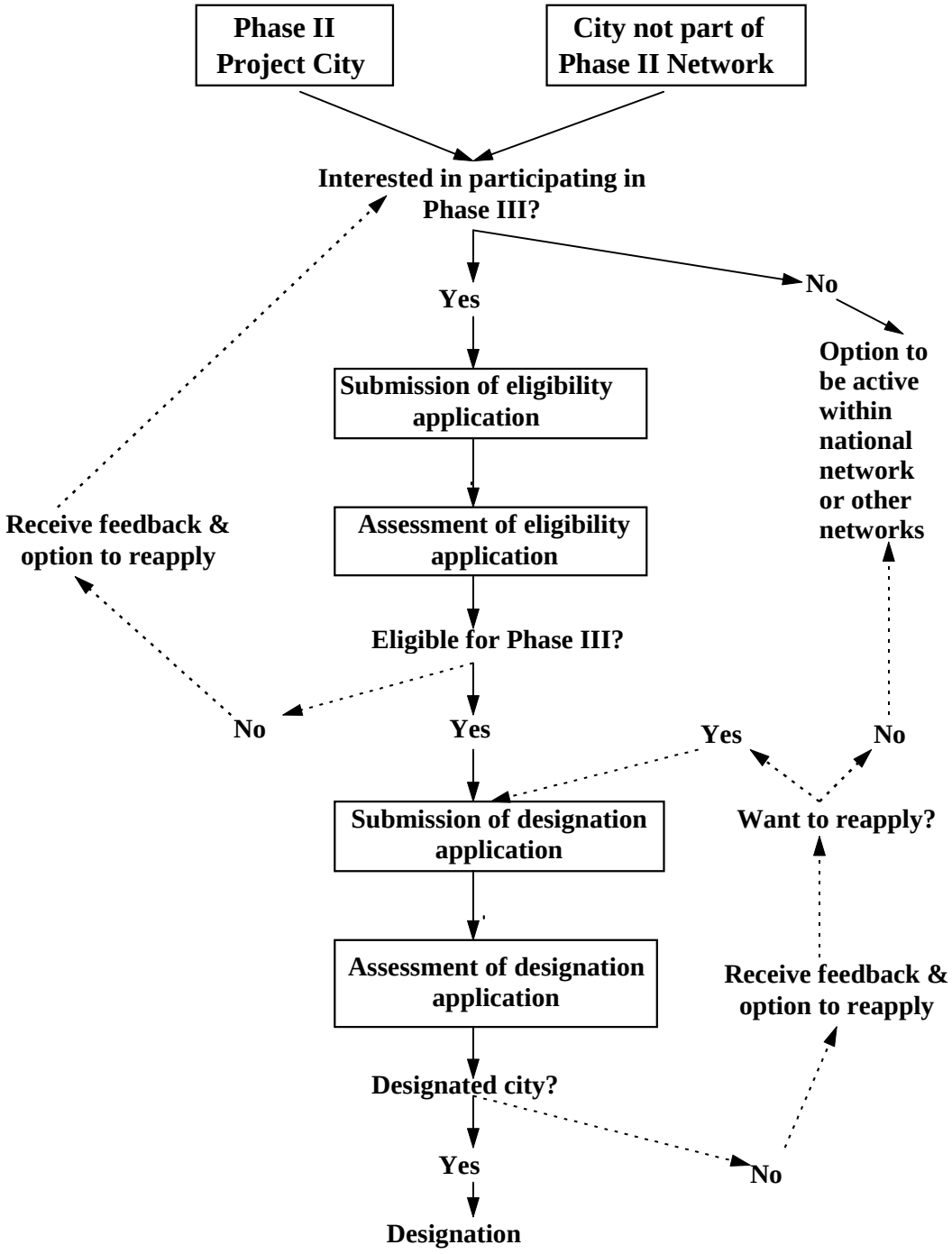
Designation

All eligible cities are then invited to submit an application detailing the city's proposals in relation to the requirements for Phase III, as set out later in this document. This application must contain all necessary documentary evidence. These applications will also be appraised by experienced assessors who will advise WHO but the final decisions about designation lie with WHO.

Numbers and quotas

A maximum of 40 cities will be designated project cities in the new Phase III network and the aim is to have, where possible, a geographical balance to the network. Ten of the forty places will be reserved for "new blood" cities, that is, those who were not part of the Phase II network of project cities. The quota for the number of cities designated per country will be based on population size although, where there were exceptions in Phase II for historical reasons, these exceptions will be retained (Appendix 3).

Fig. 1. Overview of the designation process



Financial contributions

All designated cities will be required to pay a financial contribution to WHO for the phase, equivalent to US $5000 or US $3000 for each of the five years. Cities from countries with economies in transition[3] qualify for the reduced contribution level. The contribution would be due on designation and, thereafter, on the 1 January each year. Cities designated during the second round (late 1998) will only be required to pay 50% of the 1998 contribution. This financial contribution will be used for the provision of specified products and services throughout the phase, some of which are currently provided free of charge by WHO. Further detail on this issue is available in Appendix 1.

[3] List includes Czech Republic, Croatia, Hungary, Lithuania, Poland, Russian Federation, Slovakia, Slovenia, Ukraine.

Time scale

The time-table for the first two rounds of recruitment to Phase III are given in Table 1 below, both for the dates and week numbers of 1998. The timetable and arrangements for the third round will be announced in the second half of 1998.

Table 1. Entry to Phase III: time scale for first and second rounds

Closing Dates	**Round 1**	**Round 2**
Opening date for each round	Monday 5 January 1998	Monday 6 July 1998
	(Start of week 2)	(Start of week 28)
Closing date for applications for eligibility assessment	Friday 27 February 1998 (End of week 9)	Friday 28 August 1998 (End of week 35)
Closing date for applications for Phase III designation	Friday 8 May 1998 (End of week 19)	Friday 6 November 1998 (End of week 45)
End of each round	Friday 19 June 1998 (End of week 25)	Friday 18 December 1998 (End of week 51)

Cities should receive the results of their application for eligibility within 4 weeks of it being received by the administration centre. Assessment of applications for Phase III designation will take longer and notification of results should be within 6–8 weeks of their receipt.

Cities are encouraged to apply for assessment as early as possible. As at least one quarter of places will be reserved for new blood cities, and Phase II quotas per country will be used, there will be an element of competition for places. These will be allocated on a "first come, first served" basis to eligible cities who meet the Phase III designation requirements. Cities that are eligible for designation but for which the country quota has already been met, will be held in a queue until the end of round 2. At the end of round 2, if any of the 40 places are remaining, these will be awarded on a regional basis to ensure a geographical balance to the network.

Withdrawal from Phase III network

Cities may withdraw from the network during the phase, either because they do not wish to continue or because they are not meeting the various requirements of the phase: a mechanism for this is to be developed.

Eligibility for Phase III

All European cities that are interested in participating in the network are invited to submit an application to assess their eligibility.

Preconditions

Cities must meet four preconditions to be able to live up to the challenges and expectations of Phase III. Eligibility applications must address the following issues.

1. Cities must demonstrate that they have sustainable municipal political support, and support from other key decision-makers, to implementation of the principles and goals of the Healthy Cities project within the city and pledge a commitment to the values, principles and objectives of the health for all strategy[4].

Cities must produce a signed statement from their Mayor[5] (or equivalent responsible politician) which demonstrates the above conditions. It should show political commitment to the Healthy City project within the city, and recognize the implications of implementing the health for all strategy at local level. Ideally, the statement will also show: secured financial commitment to the operation of the project; endorsement and support statements from the other key decision-makers from different sectors within the city.

2. Cities must demonstrate that they have produced a city health plan (or equivalent) which is based on an assessment of local health needs and concerns (health profile), and the Healthy Cities policy framework. The plan or its equivalent may be one or several documents. Whichever form it takes, it should provide evidence of health for all based coordinated planning (policy, strategic, operational) for health in a city. If a health plan (or equivalent) is not yet produced, an indication should be given of its expected date of completion. Designation will be withheld from a city unless the final product is received before the closing date of that round.

A copy of the city's health plan (or equivalent) and health profile should be enclosed with the application. If these have not been published in English, there should be a detailed summary (no less than 1000 words) translated into English. If the health plan is not yet produced, cities should provide details of the planning processes that have been undertaken, evidence of the documentation pulled together to date, and a timetable for final production of the plan. The plan (or its equivalent) and profiles should be submitted together with the following information, in English: date of completion; indication of depth of exercise (content of plan, extent & type of partnerships, technical/scientific work undertaken); a statement or explanatory note on the overall political and administrative context within which they were produced.

[4] The health for all strategy for Europe is currently being updated. The second draft of the European policy document *health for all for the Twenty-First Century* is available on request from the Healthy Cities Project Office. The final document should be ready in autumn 1998.

[5] Throughout the document, the term Mayor is used to denote "lead politician" within the city.

3. Cities must demonstrate that they have the basic structures in place to deliver the programme of activity required for Phase III. These structures include having an identified full-time project coordinator or equivalent, who is fluent in English, adequate administrative and technical support for the project, and an intersectoral steering group involving executive-level decision-makers.

A structural diagram (organigram) should be provided which sets out the project structures and decision-making mechanisms. This diagram should be explicit about the staffing of the project office and about the composition and role of the steering group.

4. Cities must be committed to collaboration and networking with other Healthy Cities. This ensures information sharing, joint problem solving, and the provision of support both to cities at similar levels of development and to cities at earlier stages.

Cities must provide a statement of their current networking activities together with an outline of how they would like to contribute to national and European networks related to Healthy Cities. They should indicate both the quantity and quality of their past and present networking partnerships.

Assessment of applications

Eligibility will be assessed by people, appointed by WHO, who are experienced in the Healthy Cities approach. They will then provide WHO with a written statement of the extent to which a city does or does not meet the eligibility criteria. WHO will oversee the process but coordination and administration will be carried out, on behalf of WHO, by the WHO Collaborating Centre for Research on Healthy Cities at the University of Maastricht. There is no limit set on the number of cities that will be considered eligible to apply for Phase III. Cities are encouraged to make their applications as thorough as possible. The administrator may check that a city's application is complete but the actual assessment will be based on the face value of the documents provided by a city.

Each city that applies for eligibility should be informed whether their application has been successful within 4 weeks of its receipt by the administrator. Cities that have been unsuccessful should receive feedback on their applications. Eligible cities are then invited to submit a proposal for Phase III (see requirements and application guidance in following sections). Cities that are not eligible at this stage will be able to reapply at a later stage once they are able to meet all of the eligibility criteria as outlined above, so long as the maximum number of 40 cities in the network has not been reached. It is envisaged that there will be two to three designation rounds in the period January 1998 to June 1999.

In summary, a complete request for assessment of eligibility must include:

- an application letter and statement of commitment from the Mayor (or equivalent);
- a city health plan and city health profile and explanatory note
- organigram and explanatory note of project structures, staffing and steering mechanism;
- a statement of current networking activities.

Phase III requirements for cities

Introduction

Phase III requirements describe the approaches and activities that cities are required to implement during the five years of Phase III. They relate to the four elements of Healthy Cities work (Fig. 2).

Fig. 2. Healthy Cities: four elements for action

A. Endorsement of principles and strategies	C. Commitment to specific goals, products, changes, outcomes
B. Establishment of project infrastructures	D. Investment in formal and informal networking and cooperation

All cities participating in the 1998–2002 network will be obliged to have met the eligibility criteria (as set out above) by the start of the phase, and to fulfil all of the core requirements during the phase. A number of requirements include options. This does not imply that by not selecting an option, a city deems it unimportant. Rather, where there are options, cities should select those areas where they want to take a lead and which address local needs and priorities. An explanation of each requirement is provided in the next section, followed by a statement of the issues that should be addressed by city applications.

Requirements

A. Endorsement of principles and strategies

A.1 Cities must have sustained local government support and support from key decision-makers in other sectors to the principles and goals of the project.

A.2 Cities must have in place mechanisms which ensure an integrative approach to health planning, with links being made between their health policies and other key city-wide strategies, and their health strategies and city-based work on Agenda 21.

A.3 Cities should develop policies and strategies based on health for all for the twenty-first century. Particular emphasis should be placed on the three issues of 1) reducing

inequalities in health, 2) working to achieve social development, and 3) commitment to sustainable development.

A.4 Cities should select **at least one** additional target of health for all for the twenty-first century, which has particular local importance. Progress towards this target should be carefully monitored.

Establishment of project infrastructures

B.1 Cities must have an intersectoral steering group involving political/executive-level decision-makers.

B.2 Cities must have a full-time identified project coordinator or equivalent and administrative/technical support for the project. The project coordinator must have proven fluency in English.

B.3 Cities must identify and give commitment to the package of resources required to implement the strategies and action plans for Phase III.

B.4 Cities should review project management processes and implement a programme of action to address identified weaknesses.

B.5 Cities should demonstrate increased public participation in the decision-making processes that affect health in the city, thereby contributing to the empowerment of local people.

B.6 Cities should establish mechanisms for the engagement of the business sector in local action for health, at both policy and operational levels.

B.7a Cities should implement a communications strategy, involving a range of communications mechanisms, to stimulate visibility for health issues and public health debate within the city; this strategy should be evaluated to assess its impact; **and/or**

B.7b cities should implement an ongoing programme of training/capacity-building activities for health and healthy public policy making; this programme should have two strands: involving key decision-makers across the different sectors in the city, and involving local communities and opinion leaders; the impact of this programme should be evaluated.

C. Commitment to specific goals, products and outcomes

C.1 Cities must produce and implement a city health development plan during the third phase, which builds on previous integrative city health planning and reflects the values, principles and objectives of health for all for the twenty-first century and Local Agenda 21; relevant national health strategies; and local city-specific priorities. This plan must have clear long term and short term aims and objectives and a system on how the city will monitor whether these objectives have been met (indicators and evaluation framework).

C.2 Cities should implement a programme of systematic health monitoring and evaluation, integrated with the city health development plan, to assess the health, environmental and social impact of policies within the city. In addition, cities should strengthen health accountability mechanisms and measures.

C.3 Cities should implement a programme of action targeted at reducing health inequalities within the city

C.4 Cities should carry out a programme of action to promote healthy and sustainable urban planning policies and practice within the city.

C.5 Cities should develop and implement a tobacco control strategy, in line with WHO's identification of tobacco as a strategic priority.

C.6 Cities should implement and evaluate a comprehensive programme of activity to address **at least one** of the following priority topics: social exclusion, healthy settings, healthy transport, children, older people, addictions, civil and domestic violence, accidents.

D. Investment in formal and informal networking and cooperation

D.1 Cities must give executive and political commitment for the attendance of the project coordinator and nominated politician at WHO business meetings and symposia. At each, the city should be represented, as a minimum, by the coordinator and politician responsible.

D.2 Cities should ensure that their Mayor (or lead politician) attends the Mayors' Meetings at start of the phase (1998) and midway through it (in the year 2000).

D.3 Cities should be connected to the Internet and electronic mail, and ideally should have access to video-conferencing facilities.

D.4 Cities should participate actively in different networking activities (thematic, sub-regional, strategic, twinning, etc.) during the phase, including the development of close links with national networks. Cities should demonstrate practical contributions to these networks throughout the phase.

Explanation of Phase III requirements

This section provides further detail about the requirements to be fulfilled by cities designated to Phase III. For each requirement, a short rationale is provided, followed by an outline of the evidence to be included as part of the designation application and then an indication of key factors to be addressed during the five years of Phase III. In some cases where two or more requirements are linked or concern a common theme they are grouped together.

The purpose is to provide cities with a common understanding of the WHO requirements from cities both with regard to the designation application and in relation to action during the phase. These explanations should be read in conjunction with the book *Twenty steps for developing a Healthy Cities Project*.

A.1 Cities must have sustained local government support and support from key decision-makers in other sectors to the principles and goals of the project.

Explanation

Successful projects require high-level commitment from local politicians and other key decision-makers within the city.

Evidence for designation application

Cities must provide:

1. an official letter of support from the mayor or equivalent (regional head/council leader etc);
2. a copy of a council resolution supporting the project, and thereby providing broad political commitment to it; and
3. a partnership agreement, or letter of commitment, signed by executive decision-makers in other bodies or sectors involved in the city's health partnership.

Action required during Phase III

Projects must work to secure continuing contributions and support from politicians and executive decision-makers throughout the phase. Their ongoing commitment will be necessary for the achievement of the various other Phase III requirements.

A.2 Cities must have in place mechanisms which ensure an integrative approach to health planning, with links being made between their health policies and other key city-wide strategies, and their health strategies and city-based work on Agenda 21.

Explanation

Action specifically to improve health within cities cannot be seen in isolation from the wide range of other city strategies which also (either directly or indirectly) impact on quality of life. Mechanisms which ensure that linkages are made between these different strategies will contribute to greater consistency of decision-making, mutual reinforcement and less duplication of effort. They will also ensure that the health consequences of other policy decisions are recognized and considered. This is what we mean by integrative health planning.

Human health and sustainable development are inextricably linked. Agenda 21 – the United Nations programme of action on sustainable development – comprises a framework for sustainable development that focuses on economic, environmental, sociodemographic and health factors. The European strategy health for all provides detailed guidance on taking action on health and shares the fundamental principles of Agenda 21. Healthy Cities applies the principles and strategies of health for all and sustainable development at the local level. However, healthy city projects should not be expected to deliver Agenda 21 plans. Their role is to develop integrative health development policies and plans in the city with strong links to other policies and Agenda 21 plans, and to advocate and facilitate the taking up of Agenda 21 by local governments.

Evidence for designation application

Cities must describe in their Phase III proposal the ways in which they intend to go about integrating the planning for health in the city, and how they intend to develop decision-making and operational links with other key city-wide strategies and plans including Agenda 21.

Action required during Phase III

The development of the city health development plan should include an explicit process leading to the creation of integrative organizational links between all health related policies and strategies and with other city-wide plans (including Agenda 21). This process should also include developing closer cooperation links with national and regional health policy-making processes.

A.3 Cities should develop policies and strategies based on health for all for the twenty-first century. Particular emphasis should be placed on the three issues of 1) reducing inequalities in health, 2) working to promote social development, and 3) commitment to sustainable development.

A.4 Cities should select at least one additional target for health for all for the twenty-first century, which has particular local importance. Progress towards this target should be carefully monitored.

Explanation

Cities need to show their commitment to the values, principles and objectives of health for all through implementation of city health policies that correspond with these principles. As we move into the twenty-first century, three features of the new health for all strategy seem to be particularly pertinent for Healthy Cities projects.

1. Action to address inequalities in health is an overarching priority for Phase III of the network (and is thus reflected in several of the requirements for this phase). Cities need to show their commitment to increasing equity in health.
2. The social aspects of regeneration are often the most challenging to implement, as they require mobilization of a wide range of constituents (including communities themselves) and sustained action over an extended period of time. Physical and economic development without attention to social dimensions will not secure healthy societies. Healthy City projects have a key role to play in working to achieve social development within priority communities and in cities as a whole. Commitment to addressing urban social issues through community development, care and investment strategies is essential.
3. A commitment to sustainable development is integral to the creation of healthy cities (see point A.2 above).

These three strands of health for all for the twenty-first century reflect priorities for the Healthy Cities network as a whole. Although cities should consider the overall adaptation of health for all targets to their local level, they will recognize some of the health for all targets as a particular priority for their own unique situations. Requirement A.4. involves cities in analysing their local situation and health needs and selecting at least one other strand of activity (in addition to the three identified in requirement A.3) which is a priority for the city.

Evidence for designation application

Within their designation applications cities should set out their current analysis of health inequalities within the city, and identify the approaches that the city will plan to put in place during the phase to address these inequalities. They should also describe their plans to enhance social development and sustainability within the city. Cities should make it clear in their applications which other health for all target(s) they are identifying as a priority for action in the city, and give an outline of the rationale for this selection. Cities are expected to chose a target which has integrative or developmental aspects.

Action required during Phase III

Ideally, a wide spectrum of policy within the city should be tested for concordance with the health for all principles, and action taken where new or existing policies do not correspond with health for all. The programmes of action on health for all described in the city's Phase III proposal should be implemented. These are likely to include a number of components including advocacy, policy development, and specific programmes of action. Whilst all of this activity should be monitored (see requirement C.2), there is a specific requirement to produce a 'case study' report of the Healthy City project's contribution to the locally identified priority target. This 'case study' should include a range of components (for example, the views of local citizens, media coverage, sample materials, etc) and must be clear about the impact that this package of activity has made on the selected health for all target.

B.1 Cities must have an intersectoral steering group involving political / executive-level decision-makers.

B.2 Cities must have a full-time identified coordinator or equivalent and administrative / technical support for the project. The project coordinator must have proven fluency in English.

Explanation

These two requirements form part of the eligibility criteria for Phase III. They are essential prerequisites for effective local implementation of the project. It is necessary for the coordinator to be fluent in English, as the project working language is English.

Evidence for designation application

Eligibility applications need to include an organigram of project structures, which is also explicit about the staffing of the project office and the composition of the steering group. The designation application should confirm that this information is still valid. The steering group should have a mixed composition, involving politicians and technical officers. The term 'decision-makers' is used to describe people of chief executive level or equivalent.

Action required during Phase III

Cities must maintain the infrastructures as set out in these requirements.

B.3 Cities must identify and give commitment to the package of resources required to implement the strategies and action plans for Phase III.

Explanation

At the outset of the phase, cities should be clear about the resource requirements to achieve the project's objectives. These include financial resources, staff costs, and overheads. It is not enough for cities to be committed in principle. The necessary resources must also be available in order that the project can achieve its aims. Healthy

Cities projects are in practice not very resource-intensive, and are viewed in most cities as representing extremely good 'value for money'.

Evidence for designation application

Whilst it is not expected that Phase III proposals will be fully costed, it is crucial that they are written realistically in the context of anticipated available resources. If possible, an indication of costs should be attached. In giving their commitment to the principles and goals of the project, city politicians and executives should recognize the resource commitment that underpins it.

Action required during Phase III

As plans are developed into more detailed annual action plans, these should be costed as fully as possible, in order that the necessary resources can be identified. Cities are, of course, expected to deliver their plans within allocated budgets.

B.4 Cities should review project management processes and implement a programme of action to address identified weaknesses.

Explanation

The success of Healthy City projects depends on effective project management. Many cities have in place management processes which have never been systematically reviewed. During Phase III all cities are required to review their project management processes. An overview of the management processes of cities within the Phase II network has been commissioned by WHO and the summary results from this study will be available to cities as they enter Phase III.

Evidence for designation application

Cities must provide a description of current management processes. If these have been reviewed by the city within the last two years, an outline of the review process and subsequent actions should be given. Where the project's management processes have not been reviewed locally, a commitment to doing so should be built into the Phase III proposal.

Action required during Phase III

It is at the discretion of cities to decide how and when to carry out this review, but a recommended approach will be provided early in the phase by the WHO Healthy Cities office. Following their project management review, cities should be clear about existing strengths and should take action to address any identified weaknesses. The WHO Healthy Cities office will require a statement of the conclusions reached following the review process and a copy of the action plan that has resulted.

B.5 Cities should demonstrate increased public participation in the decision-making processes that affect health in the city, thereby contributing to the empowerment of local people.

Explanation

Central to the Healthy Cities way of working is the recognition that health promotion is carried out by and with (not 'on') local people. For effective health promotion it is essential to improve the ability of individuals to take action, and of communities/groups to influence the determinants of health. Efforts to increase community capacity will include education and training as well as access to resources. Individuals need to be given consistent and reliable access to decision-making processes and the skills and knowledge needed to effect change. Innovative approaches need to be developed to harness the social and cultural resources of communities.

Evidence for designation application

Cities are required to provide a statement on the levels of public participation and the mechanisms in place for public participation at the outset of Phase III. Particular emphasis should be given to describing existing mechanisms to ensure public participation in the direct work (planning and implementation) of the Healthy Cities project. Plans to involve local people during Phase III should be made explicit in the Phase III proposal.

Action required during Phase III

Cities will be required to report on how increased public participation has been achieved during the phase. By the end of Phase III there should be demonstrable strengthening of cities' mechanisms for public participation and clear examples of public involvement in health-related decision-making within cities. It is important that cities should ensure that they involve 'marginalized' as well as 'mainstream' communities.

B.6 Cities should establish mechanisms for the engagement of the business sector in local action for health, at both policy and operational levels.

Explanation

In general, Project cities have been more successful to date in mobilizing the resources and commitment of public sector agencies than in engaging the business sector in health for all. Securing private sector involvement remains a challenge, but is essential for comprehensive local action to promote health. The business sector has a key role to play in a number of regards.

- As employers, businesses should be taking action to promote and protect the health of their employees.
- In relation to economic development, the creation of new jobs and the maintenance of existing job complements are essential for the development of healthy cities.

- Concerning town planning and environmental conditions, the impacts of these on health must be recognized. A crucial link here is with the sustainable use of resources and the protection of natural assets.
- Through their marketing and production practices, businesses can act in ways that are positively health promoting (or, if they are not engaged with the health agenda, in ways that are potentially health damaging).

Evidence for designation application

In their organigrams (submitted as part of the eligibility application), cities should be quite explicit about current levels of involvement of the business sector in the work of the project. Phase III proposals should, as necessary according to local circumstances, outline the ways in which the city plans to increase business sector involvement in the project. This should include an indication of which aspects of the business sector are viewed as a priority for the city.

Action required during Phase III

In should be clear from cities' annual reports the extent and ways in which the business community is contributing the Healthy Cities effort locally. Possible routes will be as a member of the project steering group, through specific task forces, through taking the health agenda to other policy-making forums, through contributions to training and capacity-building, through contribution of resources, and through changes to existing business and employment practices in the city.

B.7a Cities should implement a communications strategy, involving a range of communications mechanisms, to stimulate visibility for health issues and public health debate within the city. This strategy should be evaluated to assess its impact.

Explanation

Since its outset, the Healthy Cities Project has always sought to increase the visibility of health and health for all within cities. Successful intersectoral working and community participation require high levels of public understanding about health, its determinants, and effective health promotion strategies for the city.

Evidence for designation application

The city's Phase III proposal should provide the city's rationale for selecting this optional requirement. This rationale should include a description of any previous strategy for communicating about health within the city, together with an assessment of its strengths and weaknesses. The Phase III proposal should also provide an outline of the main components of the communications strategy that is proposed for Phase III and could include: the types of media and mechanisms to be used; the priority issues for communication and the key audiences to be addressed.

Action required during Phase III

Cities must implement their communication strategy and monitor its impact. Updates on communication processes should be provided to the WHO Healthy Cities Office as part of the city's annual report.

B.7b Cities should implement an ongoing programme of training/capacity-building activities for health and healthy public policy making. This programme should have two strands: 1) involving key decision-makers across the different sectors in the city, and 2) involving local communities and opinion leaders. The impact of this programme should be evaluated.

Explanation

The success of a Healthy City project depends on securing the effective involvement of many people beyond the project office and steering group. Investment needs to take place to ensure the quality of this involvement. Capacity building means investing in the infrastructure of a project, in terms of its knowledge, skills, attitudes and awareness, to the benefit of the project.

Evidence for designation application

The city's Phase III proposal should provide the city's rationale for selecting this optional requirement. This rationale should include a description of any previous strategy for capacity building within the city, together with an assessment of its strengths and weaknesses. The Phase III proposal should also provide an outline of the main components of the capacity-building strategy that is proposed for Phase III. This could include: the approaches to be used; the priority issues; the skills to be addressed; identification of the key individuals and groups to be involved. Examples of approaches that could be incorporated within a capacity-building strategy include information dissemination, a range of training programmes and organizational development approaches.

Action required during Phase III

Cities must implement their capacity-building strategy and monitor its impact. Updates on capacity-building processes should be provided to the WHO Healthy Cities office as part of the city's annual report.

Cities must produce and implement a city health development plan during the third phase, which builds on previous integrative city health planning and reflects the values, principles and objectives of health for all for the twenty-first century and Local Agenda 21; relevant national health strategies; and local city-specific priorities. This plan must have clear long term and short term aims and objectives and a system on how the city will monitor whether these objectives have been met (indicators and evaluation framework).

Explanation

A city health development plan builds on the existing city health plan and takes it a stage further. All sectors should be brought together from the beginning to mobilize resources for health development. It should take a broad perspective so that actions taken in different sectors, at different levels and by various players hang together to provide an integrated approach to health and development. Its added value is integration and the mobilization of the total resources of society for health development. It should be people-focused and tackle the determinants of health. The city health development plan should be a single document which describes the city's policy, strategic and operational goals for Phase III. It should be developed from the Phase III proposal submitted as part of the application for Phase III. Requirements C.2–C.5 identify core components of these Plans for all cities.

Evidence for designation application

The Phase III proposal, which is one of the four components required in applications for designation, should in practice be an outline city health development plan. It is important that the Proposal covers the breadth of issues set out in the requirements for Phase III. The detailed action plans describing the proposals in more depth should then be worked up after designation for the five years of the phase. Cities should explain how they intend to build upon their existing planning work in order to fulfil this requirement.

Action required during Phase III

From the Phase III proposal submitted for designation, cities need to draw up a full city health development plan. This process should be completed within one and a half years of designation. Throughout the phase cities are required to implement their city health development plans, in line with the timetables set out in the plans. As part of projects' local accountability mechanisms it is expected that annual reviews of progress against the plan will be presented to the project steering group. These annual reviews should also be submitted to the WHO Healthy Cities office. Where there is significant slippage of progress against a plan, this may be the subject of discussion between WHO and the city. Clearly, plans will need to incorporate scope to respond to new issues and opportunities that develop during the five years, and this flexibility will be taken into account during the review process.

C.2. Cities should implement a programme of systematic health monitoring and evaluation, integrated with the city health development plan, to assess the health, environmental and social impact of policies within the city.

Explanation

The overall aim of the Healthy Cities movement is to improve the health of the citizens of cities. City council and decision-makers are responsible for the impact of their policies and programmes on health. For this principle to have meaning, it is essential that there are mechanisms to evaluate impact and to report the results to decision-makers and ultimately to the public. The monitoring and evaluation process should be linked to the city health development plan and highlight local priority issues (as highlighted through local health needs assessment processes). Programmes of action should be clearly related to health and quality of life outcomes, although it is recommended that cities develop a series of intermediate indicators to act as monitoring steps between actions and ultimate outcomes. In addition to the baseline healthy cities indicators[6], a core set of indicators will be identified by the WHO Healthy Cities Technical Indicators Group during 1998, and cities will be required to accommodate these indicators within their plans.

Evidence for designation application

The city's monitoring and evaluation plan may be produced either as a component of the Phase III proposal, or as a stand-alone document. It should explicitly cover all of the Phase III requirements where monitoring is expressly obligatory. Baseline information of direct relevance to this monitoring and evaluation plan should be included with the proposal. A second round[7] of baseline healthy cities indicators should be submitted with the application. Cities should also commit themselves to reporting on Phase III core indicators.

Action required during Phase III

Information on the impact of activities on health and quality of life should be incorporated into the annual reviews of progress (described in point C.1 above). It is expected that the balance of information will shift over the five years of the phase: in early years, the majority of data will relate to intermediate indicators, but by the end of the phase the focus should be on outcome indicators. Information on the WHO core set of indicators should be provided as required by WHO during the phase. Cities are also required to take part in any network-based evaluations initiated through the WHO Healthy Cities Project Office. The Office is currently developing a framework for healthy cities evaluation, which will guide the Phase III evaluation processes. It is expected that local evaluation activities will also draw on this framework (which will be provided to cities at the start of the Phase).

[6] Submission of these indicators was a requirement for designation to the second phase. Their analysis was reported in the document *Healthy Cities Indicators: Analysis of data from across Europe (WHO 1996).*

[7] The first round of baseline healthy cities indicators was completed in Phase II. The revised baseline indicators list will be available from WHO in March 1998.

C.3 Cities should implement a programme of action targeted at reducing health inequalities within the city.

Explanation

The two themes of equity in health and sustainable development represent the major strategic thrusts of the Phase III network (see requirement A.3). In line with this strategic emphasis, this requirement involves the implementation and evaluation of clearly specified action plans to tackle the issue of equity. Examples of the types of action that might be taken are included in the explanatory text provided for requirement A.3.

Evidence for designation application

Each Project city needs to be clear about the inequalities in health that exist between different subgroups of its population and areas of the city. Information on these, to the extent that it is available, should be included with the Phase III proposal, and priorities for action thereby identified.

Action required during Phase III

Cities are required to implement and monitor their programmes of action to reduce health inequalities, as described in their Development Plans.

C.4 Cities should carry out a programme of action to promote healthy and sustainable urban planning policies and practice within the city.

Explanation

Urban problems are complex because of the interrelated nature of the components of the cities. Urban planning is by definition designed to regulate the use of land in the public interest, and is an important means of cities and towns addressing sustainability issues. Planning practices and processes need to be adapted to reflect a new awareness and to integrate health, environmental, economic and social concerns in the twenty-first century.

Evidence for designation application

For healthy and sustainable urban planning policies and practices, cities need to give a commitment to work in partnership with urban planners, and to outline the ways in which they intend to develop the partnership in this area.

Action required during Phase III

Cities are required to review current practice and develop action for healthy and sustainable urban planning policies and practices.

C.5 Cities should develop and implement a tobacco control strategy, in line with WHO's identification of tobacco as a strategic priority.

Explanation

Tobacco remains the largest single cause of preventable morbidity and mortality in the developed world, and is thus a particular strategic priority for WHO and many cities. The potential for health gain through the effective control of tobacco is well documented.

Evidence for designation application

Where cities have existing tobacco control strategies or policies, these should be included with the designation application, together with an indication of any areas where the city plans to strengthen the existing strategy over the next five years. Where cities do not have a tobacco control strategy, a statement of the current position should be provided.

Action required during Phase III

During Phase III all Project cities are required to implement a strategy to control the use of tobacco within their city. These strategies should take account of tobacco marketing and promotion, the availability and sale of tobacco and tobacco products, the establishment of clean air policies in the full range of settings, smoking prevention programmes, and smoking cessation support programmes. Model policies are available from the WHO Healthy Cities Project Office.

C.6 Cities should implement and evaluate a comprehensive programme of activity to address <u>at least one</u> of the following topics: social exclusion, healthy settings, healthy transport, children, older people, addictions, civil and domestic violence, accidents.

Explanation

Individual cities have different health profiles and their own specific priorities. Within the framework of the European Healthy Cities network, there is a recognition of the need for a degree of flexibility to reflect local circumstances and patterns of need. This requirement asks cities to identify at least one priority from the above list (which has been based upon priorities which emerged from cities within the Phase II network), and to establish an action programme tailored to their local circumstances.

Evidence for designation application

The application should clearly state which issue (or issues) the city has identified as its local priority, and should provide an outline plan of action. It should also state the rationale behind the choice (which might be based on measured need, the issue's current significance for the city, the prevention of an anticipated future health problem, or some other explanation). If the city has a substantial priority which is not included in the above list, or in any of the other requirements set out in this document, then WHO may accept this as a substitute. This is in line with the spirit of this requirement, which is to provide local flexibility in prioritizing.

Action required during Phase III

Cities are required to develop and implement an action plan to tackle the identified priority issue. Mechanisms need to be put in place to evaluate the impact of the action plan, and a case study report summarizing the programme of activity and its impact should be provided to WHO at the end of the phase.

D.1 Cities must give executive and political commitment for the attendance of the project coordinator and nominated politician at WHO business meetings and symposia. At each, the city should be represented, as a minimum, by the coordinator & politician responsible.

D.2 Cities should ensure that their Mayor (or lead politician) attends the Mayors' meetings at the start of the phase (1998) and midway through it (in the year 2000).

Explanation

Business meetings form the core of the network, and represent the only occasions when all cities collect to discuss issues of common importance. It is therefore imperative that all cities are represented, and that their representation involves those individuals responsible for the project at operational and political levels within each city. There will be one or two business meetings each year, and it is possible that one of these may be carried out via electronic communication mechanisms. The Mayors' Meetings at the start of the phase and midway through are particularly significant for securing political commitment to, and understanding of, Healthy Cities and its underpinning strategies and value framework. It may be that Mayors are interested in attending other business meetings also, and this is to be welcomed.

Evidence for designation application

It is recommended that within the official letter from the Mayor (see item A.1 above), commitment be given to these networking requirements. In addition, it would be helpful if the letter could also include a personal guarantee from the Mayor that he/she will attend the Mayors' Meetings as outlined.

Action required during Phase III

Cities are required to attend these meetings as set out. Attendance will be reviewed by WHO. Business meetings will be planned and arranged with the active involvement of an Advisory Committee to WHO. Cities will be invited to volunteer to participate in this committee, membership of which will reflect the geographical spread of the network.

D.3 Cities should be connected to the Internet and electronic mail, and ideally should have access to video-conferencing facilities.

Explanation

Effective networking depends on effective communication on an ongoing basis. The geographical distance between cities across the European network places considerable limitations on the feasibility of ongoing face-to-face communication. Increasingly, we depend on electronic communication mechanisms, and may move to this format for some of our business meetings.

Evidence for designation application

A statement is required from the city confirming that it has, at least, the Internet and electronic mail connections such that it is able to communicate with the WHO Healthy Cities project office and other members of the network. There should also be an indication of the ease of access to video-conferencing facilities.

Action required during Phase III

These communication mechanisms should be maintained throughout the phase.

D.4 Cities should participate actively in different networking activities (thematic, sub-regional, strategic, twinning, etc.) during the phase, including the development of close links with national networks. Cities should demonstrate practical contributions to these networks throughout the phase.

Explanation

All Project cities should take active steps to cooperate nationally and internationally with other networks, cities and institutions. Cities may network on areas of common interest which may include: issue, theme, geographical area, language, mentorship or twinning arrangements. A number of networks currently exist, including national networks, sub-regional networks and MCAPs (multi-city action plan groupings). Phase III cities are expected to provide advice and support to other cities that are developing strategies for health for all. This process could include sharing experience on how to set up a project, critical ‘success factors’ and ‘pitfalls’, sharing of resource materials, training, the provision of data and other forms of assistance. ‘Twinning’ provides the opportunity for cities to pair up with one or more other cities within the WHO or other healthy cities network that have a particular concern or interest in common. ‘Mentoring’ involves cities in providing an ongoing programme of advice and support to a city which is at earlier stages of developing city-based health for all programmes and which is not part of the Phase III WHO Project City network.

Evidence for designation application

As part of the eligibility criteria, cities are required to provide a statement of their current networking activities together with an outline of how they would like to see these

developing. For designation, cities should simply resubmit this application, together with any update to reflect changes in practice or intention since the eligibility application.

Action required during Phase III

Cities are required to contribute to their national networks and to participate in other networking and support activity, as outlined in the explanation. Information about a city's various networking activities should be included within its annual reports. It is expected that cities will develop a varied and flexible approach to networking throughout the phase.

Summary overview of requirements

The requirements for Phase III of the WHO network of project cities have been listed and described separately in sections 4 and 5 above. As stated at the outset of section 4, the requirements relate to the four elements of Healthy Cities work:

1. political commitment to the principles and goals of the WHO health for all strategy and the Healthy Cities project;
2. securing project infrastructures for the management and implementation of the project;
3. explicit commitment to implementing specific health goals, developing policies, strategies and concrete plans, making institutional changes and reaching targeted outcomes; and
4. developing formal and informal networking and cooperation at local, national and international level.

The health for all and Agenda 21 principles and strategies form the overarching framework that guides all of the work of the Healthy Cities network. During Phase III, particular emphasis will be placed on the three strategic priority issues: equity, social development, and sustainability (as described in requirement A.3). Priority action areas will include urban planning practices that are conducive to health and high quality of life, lifestyles and poverty, the needs of the elderly and teenagers, living conditions and social support, ecological management, traffic, pollution, empowerment, investing for health and accountability for health.

In order to develop and deliver effective operational and strategic programmes cities require to have in place strong project infrastructures. These are as set out in requirements B.1–B.7. Experience in the first two healthy cities phases has provided considerable insight into the preconditions for change and the characteristics of effective project management. These include the presence of a full-time coordinator (or equivalent), adequate support staff and financial resourcing, and an intersectoral steering group involving political/executive decision-makers. Increased participation from the business sector and increased public participation are essential.

Cities are required to produce and implement a city health development plan, which builds on previous integrative city health planning and reflects the values, principles and objectives of health for all for the twenty-first century and Local Agenda 21; relevant national health strategies; and local city-specific priorities. This plan must have clear long term and short term aims and objectives and a system on how the city will monitor whether these objectives have been met.

A city health development plan builds on the existing city health plan and takes it a stage further. All sectors should be brought together from the beginning to mobilize resources for health development. It should take a broad perspective so that actions taken in different sectors, at different levels and by various players hang together to provide an integrated approach to health and development. Its added value is integration and the mobilization of the total resources of society for health development. It should be people-focused and tackle the factors that influence health. Plans will need to incorporate scope to respond to new issues and opportunities that develop during the five years, and this flexibility will be taken into account during the review process.

An additional feature of the city health development plan, and indeed of Phase III as a whole, is its emphasis on monitoring and evaluation. It will be a requirement on all cities to ensure ongoing evaluation of the impact of their activities, and to participate in the WHO-led processes to evaluate the work of the network as a whole

The emphasis on networking is a means for cities to learn, share and work together. Networking can strengthen political commitment and provide solidarity, a legitimacy for change, and a public health advocacy at national and international levels.

Content of application for designation to Phase III

Applications for designation to Phase III will have four components. For the first round, applications should be submitted by 8 May 1998.

First, all cities are required to supply the WHO Healthy Cities Project Office with clear evidence of political commitment to the project within the city. This evidence should have three components:

1. an official letter from the Mayor of the city (or equivalent lead politician) which gives his/her explicit commitment to the principles and goals of the project and the values, principles and objectives of the health for all strategy, and gives political support from the city for the range of requirements for Phase III;
2. a copy of a resolution of the city council or parliament in support of sustaining the work of the project within the city throughout Phase III; and
3. a partnership commitment signed by executive decision-makers from the range of sectors that are relevant to the project stating their ongoing commitment to the principles and goals of the project.

Second, when applying for designation to Phase III of the network, all eligible cities are asked to submit a Phase III proposal which covers the five years of the phase. This implementation proposal should demonstrate how the city plans to meet the various requirements for Phase III. It should, thus, incorporate the core requirements set out under each of the four elements: principles and strategies; project infrastructures; specific goals, products and outcomes; and networking and cooperation. The Phase III proposal should show which of the options will be addressed by the city. It should also include a time scale for action and an integrated monitoring and evaluation proposal.

Third, cities need to agree to participate in an ongoing process of monitoring and evaluation by WHO. As a minimum, this should involve agreement to submit an annual report on progress to the WHO Healthy Cities Project Office, agreement to contribute a set of core indicators (to be developed), and agreement to being monitored on progress by WHO. In submitting their designation proposals, cities need to provide a written statement agreeing to these processes. With their application cities should submit a second round of baseline indicators.

Fourth, cities are required to agree to pay an annual financial contribution to WHO, to cover some of the costs of administering the network and to pay for the provision of products and services during the phase. This annual financial contribution will be equivalent to US $5000 or US $3000 (for cities from countries with economies in transition), payable for each of the five years of the phase. Written confirmation of the city's agreement to pay is required with the application.

Assessment of cities' application for designation to Phase III will be coordinated and organized by WHO. In assessing Phase III proposals, special emphasis will be given to the following factors:

- focus on equity and sustainability;
- attention to translating the health for all strategy and principles into city-based action;
- evidence of analysis of local priorities and identification of action programmes to address these;
- innovation and creativity;
- evidence of linkage between Healthy City mechanisms and relevant other decision-making structures in cities.

The final decision about designation lies with WHO and cities will receive notification of the outcome within 6–8 weeks of their application being received. Eligible cities that do not achieve designation status at this stage will be able to reapply at future times, as long as the maximum number of 40 cities in the network has not been reached.

In summary, a complete request for designation must include:

- an application letter from the Mayor accompanied by a resolution of the city council or parliament, and a partnership commitment signed by executive decision-makers of other sectors;
- a documented proposal describing preparations and plans for meeting the requirements of phase III;
- an agreement to participate in ongoing process of monitoring and evaluation by WHO;
- the set of baseline Healthy Cities indicators; and
- agreement to pay the financial contribution.

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Appendix 1. Use of city financial contributions

The monies from the financial contributions will be used for the benefit of the Phase III network of WHO project cities. Some of these products and services will be identified from amongst those things which are already provided free of charge by WHO to the Health City Project. In addition to these, funds could be used for products such as guidelines, training, evaluation. WHO will take full account of the wishes of the members of the Network as to how the monies gained from the city financial contributions shall be used.

Each year, there should be included on the agenda of at least one business meeting of the Network, an item to allow for discussion of the way in which the monies shall be used. WHO reserves the right to take part in those discussions as a partner and to veto any proposals for use of the monies which it may consider: not be feasible; to be incompatible with the spirit of the aims of HCP; to be incompatible with the objects and aims or the rules and regulations of WHO.

At the end of each biennium forming the programme of work for WHO, WHO will account to the members of the Network for the funds received and those spent in connection with the Network.

In early 1998, a supplementary document will be produced which will outline items and mechanisms for the use of monies for products and services in more detail.

Appendix 2. Definitions and abbreviations

Accreditation

Accreditation is the process of granting recognition to those that fulfil certain criteria or attain a certain standard. The purpose of accreditation is to set minimum requirements or a reward for achievements or both. Such a mechanism was developed jointly by WHO and Euronet but has not yet become effective.

Business meetings

Business meetings are an opportunity for all project cities to meet together in order to discuss and make policy and management decisions. These have taken place twice a year during Phase II and the venue has moved between project cities.

City health plan

The city health plan was a designation requirement of Phase II. Cities were committed to producing a city health plan (or equivalent) which is based on an assessment of local health needs and concerns (health profile), and the Healthy Cities policy framework. The plan or its equivalent may be one or several documents. Whichever form it takes, it should provide evidence of health for all based coordinated planning (policy, strategic, operational) for health in a city. The plan should be multisectoral in scope and involve citizen participation in its formulation.

City health development plan

A city health development plan builds on the existing city health plan and takes it a stage further. It should take a broad perspective so that actions taken in different sectors, at different levels and by various players hang together to provide an integrated approach to health and development. Its added value is integration and the mobilization of the total resources of society for health development. It should be people-focused and tackle the determinants of health.

Designation

The process of an eligible city being recruited to Phase III of the WHO network of project cities and being assigned the title of WHO Project City.

Eligibility

The purpose of eligibility is to identify those cities which are able to participate in and meet the demands of Phase III.

Health for all

The European strategy for health for all[8] provides detailed guidance on taking action on health. The revised strategy health for all for the twenty-first century is in drafting process and will be completed by the end of 1998.

Local Agenda 21

Agenda 21 – the United Nations programme of action on sustainable development – comprises a framework for action for sustainable development that focuses on economic, environmental, sociodemographic and health factors[9]. Following the United Nations Conference on Environment and Development held in Rio de Janeiro in 1992, all nations are committed to implementing Agenda 21 at local levels. The WHO healthy cities project integrated Agenda 21 in its policy and planning frameworks and is a core partner of the European Sustainable Cities and Towns Campaign, which promotes Agenda 21 planning at the local level.

National networks

These are the networks of healthy cities (including the WHO project designated cities) within a country.

Phase III WHO Network

A network of WHO project cities forming part of EURO Urban Health Policies/Healthy Cities Programme which is committed to implementing the comprehensive phase III project requirements.

MCAPs

MCAPs are multi-city action plans. Cities from across Europe. work together on common themes such as tobacco, women's health, alcohol, drugs, AIDS, Agenda 21 and accidents. There are currently around 9 MCAPs. Members may be project cities or members of national networks.

Phases I, II, III

Each phase of the WHO Healthy Cities Project has been over five years: Phase I 1987–1992; Phase II 1993–1997. Phase III will be from 1998–2002.

Project coordinators

Project coordinators coordinate the activities of WHO project cities.

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[8] *Health for all targets - the health policy for Europe*. Copenhagen, WHO Regional Office for Europe, 1991 (European Health for All Series, No. 4).

[9] *Earth Summit - Agenda 21*. New York, United Nations, 1993.

Sustainability/sustainable development

Sustainable development encompasses environmental and economic sustenance and sociodemographic and health dimensions. It means development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

WHO

World Health Organization

WHO project cities

WHO project cities are those cities which were designated to Phase II of the WHO Healthy Cities Project. As such they had to fulfil the requirements for designation for Phase II. For Phase III, a new network of WHO project cities will be recruited.

WHO Healthy Cities project (HCP)

The WHO Healthy Cities Project is a long term international 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.

WHO Healthy Cities Project Office (HCPO)

The WHO Healthy Cities Project Office (HCPO) is the based at the WHO Regional Office for Europe in Copenhagen, Denmark. The Office is an integral part of the WHO Centre for Urban Health. The Centre consists of three main components: the urban health policies programme; the healthy cities networks; and the urban planning/development programme.

Appendix 3. Country quotas

A maximum number of cities per country has been assigned based on the size of population, with the exception of four countries (Denmark, Poland, Sweden and the UK) where the Phase II level has been retained for historical reasons. The countries listed below are those where there are Phase II project cities or National Networks already in existence. It is expected that for the Phase III network, cities are likely to come from countries where there has already been significant progress in Healthy Cities ways of working. Cities from countries not mentioned below are welcome to apply to the Healthy Cities Project Office for more details on their country quota.

Country quotas

	COUNTRY	PHASE II cities	Maximum
1	Austria	1	1
2	Belgium	2	2
3	Croatia	0	1
4	Czech Republic	2	2
5	Denmark	2	2
6	Finland	1	1
7	France	2	3
8	Germany	2	3
9	Greece	2	2
10	Hungary	2	2
11	Ireland	1	1
12	Israel	1	1
13	Italy	3	3
14	Lithuania	1	1
15	Netherlands	2	2
16	Norway	1	1
17	Poland	4	4
18	Portugal	1	1
19	Russian Fed.	0	3
20	Slovenia	1	1
21	Slovakia	1	1
22	Spain	0	3
23	Sweden	2	2
24	Switzerland	1	1
25	Ukraine	0	3
26	United Kingdom	4	4
27	Turkey	0	3

Appendix 4. Addresses and contact points

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