Report on the Integrated Meetings of the WHO European Healthy Cities Network and the Network of the European National Healthy Cities Networks

Report on a WHO Business and Technical Meeting, Bursa, Turkey, 21–23rd September 2005

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Business Meeting of the WHO European Healthy Cities Network

Plenary WN1: opening session

The second Business Meeting of the WHO European Healthy Cities Network in Phase IV (2003–2007) took place on 21–23 September 2005 in Bursa, Turkey. The meeting of the WHO European Healthy Cities Network was held in association with the annual Business Meeting of the Network of the European National Healthy Cities Networks and the First Annual Conference of the Turkish Association of Healthy Cities. The three meetings were integrated, with delegates able to attend parallel meetings as observers.

A total of 275 delegates attended the meetings of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks. More than 350 delegates attended the three integrated meetings. Forty-one of 45 cities in the WHO European Network were represented as well as 10 of 12 cities applying for membership. Twelve cities attended as observers, and 26 of the 30 European national networks participated. Forty-five urban planners and 51 politicians from cities and national networks participated in the integrated meetings.

The opening session set the scope and purpose of the Business Meeting. The main focus of the Business Meeting was the role of urban planning in designing safer and healthier cities.

Nalan Fidan, Healthy City Coordinator in Bursa, introduced participants and guests to the City of Bursa. A video was shown illustrating the City of Bursa as a thriving modern city with a rich history and culture, set within an impressive natural environment between the mountains and the sea.

Hikmet Sahin, Lord Mayor of the Metropolitan Municipality of Bursa

Hikmet Sahin warmly welcomed the delegates to the City of Bursa. He described how Bursa is taking a lead role in the healthy city movement in Europe. The City of Bursa is committed to sharing innovative practice and solutions to create healthier cities within Turkey. He supported the exchange of views to develop cities culturally and economically to achieve healthy urban transformation. The Business Meeting presented an opportunity for Bursa and Turkey to promote their commitment to the healthy city movement worldwide. Hikmet Sahin urged the country and city delegates to take advantage of their time in the city to gain insight into the rich history and culture of the city.

Nihat Canpolat, Governor of Bursa

Nihat Canpolat praised Hikmet Sahin and the City of Bursa for taking on great responsibility as an advocate for the healthy city movement within Turkey and Europe. Through coordinated planning, cities like Bursa will improve the quality of living conditions within the urban environment and shape a diverse range of city services that promote the health and well-being of its citizens. The integrated meetings presented an opportunity for sharing information and imparting knowledge. Everyone has a role to play.

Faruk Çelik, Member of the Grand National Assembly of Turkey from Bursa

Faruk Çelik welcomed the delegates to the City of Bursa and congratulated everyone for working towards a healthier world. Our generation is obligated to leave a healthy and livable world to the future generations. The quality of the soil, water and air is directly linked with the health of humans, plants and animals. Developments that came with industrialization have triggered migration from rural areas to the cities and increased urban problems in cities with inadequate infrastructure. These developments have put the challenge of healthy cities on the global agenda. Faruk Çelik thanked the delegates of the meeting for their contributions for creating a healthier world for future generations.

Agis Tsouros, Head, WHO Centre for Urban Health and Regional Adviser, WHO Healthy Cities and Urban Governance, WHO Regional Office for Europe

Agis Tsouros noted that cities can be both strong and vulnerable and need to be prepared for major emergencies and disasters. Poor and vulnerable people are disproportionately affected when emergencies or disasters, such as floods, earthquakes and fires, occur. The recent hurricane affecting New Orleans demonstrates that poor people pay the heaviest price. Local governments have an essential role in planning for safer, healthier and sustainable cities. This is reflected in the draft politicians' statement to be discussed and endorsed by all politicians present.

Preparation for a potential global flu pandemic requires mobilizing personnel, medicines and targeted vaccination programmes coordinated at the international, national, regional and local level. Help should be provided for everyone and not just the most privileged members of society.

Acting on the principles of equity, solidarity and democratic governance are key to improving global health. Success in creating a healthier society and individuals requires action beyond the health sector and health professionals. The promotion and protection of health requires action on the physical and social environment of cities. Increasing rates of obesity across the world comprise another cause for concern. Here too, local governments and urban planners have a key role to play in designing cities that promote health, increasing opportunities for more physically active lifestyles and access to healthy and affordable food.

Agis Tsouros referred delegates to the Bangkok Charter for Health Promotion in a Globalized World, which identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion. Progress towards a healthier world requires strong political action, broad participation and sustained advocacy. A key commitment is making the promotion of health a core responsibility for all governments, including at the local level.

Cities deal with all factors that influence people's lives. Action at the local level can make the greatest contribution to improving the health and well-being of citizens.

Social determinants contribute to most of the global burden of disease and death and most of the existing health inequality between and within countries. Throughout the world, vulnerable and socially disadvantaged people have less access to health resources and get sicker and die earlier than people in more privileged social positions. These unfair gaps are growing despite unprecedented global wealth and increasing knowledge and health awareness.

On 18 March 2005, the WHO launched a Global Commission on the Social Determinants of Health. This builds upon the previous work conducted by WHO on the social determinants of health (The solid facts: social determinants of health). Operating for three years, the Commission will recommend interventions and policies to narrow health inequality through an innovative multisectoral approach that ensures access to health care, healthy living conditions, safe working environments and access to food and education for people who are poor and marginalized.

Agis Tsouros informed delegates that a politician's statement would be discussed at the politician's sessions. The Statement by the Mayors and Political Leaders (Designing Healthier and Safer Cities: the Challenge of Healthy Urban Planning) seeks:

- to reaffirm values and commitment to address new challenges such as preparedness for emergencies and disasters and protection of the most vulnerable people in our societies;
- to acknowledge the links between the built environment and its important influence on the health of our communities;
- to support the delivery of the commitments in Phase IV of the WHO European Healthy Cities Network.

Agis Tsouros noted that 18 more cities have joined the WHO European Healthy Cities Network since the last Business Meeting in Udine in October 2004. He welcomed Albania and Serbia and Montenegro to the Network of the European National Healthy Cities Networks. Agis Tsouros also welcomed members of the Turkish Association of Healthy Cities who were also attending and encouraged them to reap the benefits of shared learning from the Business Meeting.

Agis Tsouros thanked Hikmet Sahin and his colleagues for their excellent organization, investment and goodwill in preparation for the integrated Business Meetings. The whole City of Bursa has been mobilized with commitment at all levels.

Abdulkadir Aksu, Minister for the Interior

Abdulkadir Aksu described Bursa as a beautiful city where history and culture meet. He noted that citizens have the right to live in a healthy and balanced environment and that national, regional and city authorities have an obligation to protect human health by taking coordinated action to prevent the spread of communicable diseases, prevent environmental pollution and reduce threats from terrorism. National and local governments have an obligation to take action to ensure that today's generation leaves a healthy environment for future generations. Enabling individuals to live healthy lives and removing the barriers to health in cities requires local, national and international cooperation. Unhealthy cities are a problem for the whole world. The integrated meetings of the WHO European Healthy Cities Network, the Network of the European National Healthy Cities Networks and the Turkish Association of Healthy Cities provided an excellent working context to facilitate international cooperation on improving urban health.

Healthy cities is a modern management concept demonstrating how the democratic culture of participation is realized in local governance. The action of international organizations and associations working across borders creates a positive policy context that can make a real difference to the lives of citizens at a local level. Through cooperation within international bodies like the WHO European Healthy Cities Network, joint solutions can be found for city problems. A good relationship with neighbours in a global world facilitates international peace.

The Government of Turkey has introduced local government reforms that are intended to enable good democratic management and governance. Local governments have been delegated powers to facilitate cooperation at a local level between local government and nongovernmental organizations. Power is devolved to the point closest to the individual.

Cities need to plan for today's generation and future ones. This meeting offers a special opportunity to contribute to achieving this goal. The new healthy urban planning concepts and associated themes of healthy ageing, health impact assessment and physical activity and active living are being placed on the agenda. Citizens have the right to live in healthy and safe environments.

Parallel Session WN2: WHO European Healthy Cities Network business session 1

Hikmet Sahin, Lord Mayor, Metropolitan Municipality of Bursa

Hikmet Sahin chaired the first business session. He explained that the purpose of this session was to provide an annual report on the progress of the WHO European Healthy Cities Network during 2004/2005 (since the Business Meeting in Udine in October 2004). The session presented clear expected outcomes for the Business Meeting; a draft budget plan, a draft 2005/2006 action plan and draft proposal to include the year 2008 in Phase IV of the WHO European Healthy Cities Network.

Goals of the Business Meeting and presentation of the 2005/2006 action plan and budget report (Agis Tsouros)

Agis Tsouros explained that the Business Meeting was the second official meeting of the WHO European Healthy Cities Network in Phase IV. The business meetings represent the main forum for collective decision-making and strategic development of the WHO European Healthy Cities Network.

The Bursa Meeting especially emphasized two topics: healthy urban planning and physical activity and active living. The Meeting agenda and programme were developed around three strategic headings:

- implementing work on all Phase IV priority themes with special emphasis on healthy urban planning;
- the role of municipal governments in promoting physical activity and active living; and
- keeping abreast of international developments and new opportunities.

The Bursa meeting devoted significant time to healthy urban planning, with briefing and technical sessions tailored for urban planners, coordinators and politicians.

Agis Tsouros confirmed that WHO continues to give commitment to the WHO European Healthy Cities Network and developing a sustainable future for the Healthy Cities programme. This is in a challenging context in which WHO and United Nations budgets are constrained. Voluntary donations comprise 50% of WHO's budget. The fee system of the WHO European Healthy Cities Network is part of this voluntary contribution.

Three new subnetworks focusing on the themes of healthy urban planning, healthy ageing and health impact assessment have been established in the past year. These subnetworks provide

guidance to all cities participating in the WHO European Healthy Cities Network on taking forward action to comply with the respective objectives for each theme. Member cities of these subnetworks are also expected to demonstrate development at a faster pace of acceleration.

A draft action plan for 2005/2006 was presented for consideration and debate. The action plan was endorsed in the final business session of the meeting (see WN18). The action plan outlines minimum levels of previously agreed and proposed actions on three levels:

- local minimum action to be taken on each core theme by all member cities;
- joint action by member cities of the WHO European Healthy Cities Network, the Advisory Committee, subnetworks and other associated groups and networks; and
- action to be taken by the WHO Regional Office for Europe in the form of guidance and technical support and capacity-building events.

The plan, as part of the minimum 2005/2006 actions, also requires cities in the WHO European Network to specify, initially provisionally and subsequently in detail, the deliverables they plan to achieve by the end of Phase IV as well as the main action they will undertake for that purpose. Agis Tsouros requested that cities outline their provisional commitments for deliverables for the end of Phase IV and submit these during the Business Meeting using a local action template.

Cities are expected to consult their key strategic bodies on the provisional commitments and give further definition to these. WHO will provide guidance on completing full city accounts. WHO will collect the accounts and create a table or list of all Phase IV city deliverables. This will enable WHO to capture and organize in one composite document the full range of deliverables expected by all the WHO European Network cities and WHO. This will also reflect the volume, range and impact of collective action.

Agis Tsouros noted how the annual Business Meeting has changed to a conference format to facilitate improved learning opportunities among a large transnational delegation. Agis Tsouros informed participants that Joan Devlin and Iwona Iwanicka from the Advisory Committee would act as focal points for the conference.

Agis Tsouros presented the network budget report. The budget assumptions are that all the cities that apply are designated; that all Phase III cities continue to pay Phase IV fees from 2003 onwards; and that designated cities pay beginning in the year they applied (as a minimum). A total of 80% of income from fees covers staff and management costs. Additional expenditure covers Network and subnetwork meetings, expert advice and products. There is a current funding gap of US$ 71 000 from delayed receipt of fees. Annual membership fees may have to increase to cover the costs associated with the effective management of the Network.

Report of the Advisory Committee of the WHO European Network (Joan Devlin)

Joan Devlin informed participants that the Advisory Committee had met twice in the reporting period: Barcelona (January 2005) and London (May 2005). The key action areas for the Advisory Committee have been:

- preparing the Bursa meeting, including consideration of and planning related to case studies, the annual review templates and the Business Meeting programme;
- establishing the three subnetworks for healthy ageing, health impact assessment and healthy urban planning; and
- communicating with coordinators and reviewing the role of the Advisory Committee.

The Advisory Committee is now providing more direct support to and communication with coordinators. The Committee consulted members on the establishment of a subnetwork for physical activity and active living. However, no interest was expressed in this. All work developed by the Advisory Committee is available on the WHO Healthy Cities web site.

Joan Devlin explained the proposed changes to the terms of reference for the Advisory Committee, which includes the additional roles of:

- facilitating and representing the views of coordinators in the activities of the WHO European Healthy Cities Network; and
- each member of the Advisory Committee acting as a focal point for contact in identified countries.

Joan Devlin also outlined proposed changes to the nomination and election of the Advisory Committee. The changes proposed to provide stability and continuity by electing three members for two years only and electing an additional three members for three years only. Further, it was proposed that the Committee elect a chairperson every two years.

Joan Devlin explained that, if members endorsed the proposed amendments, there would be no election to the Advisory Committee in 2005 and three new members would be elected at the Business Meeting of the WHO European Healthy Cities Network in 2006. Members had previously been consulted by e-mail, and no written objections were received. The members of the WHO European Network present endorsed the proposed revisions.

The Chair, Hikmet Sahin, informed participants that the budget, the proposal for extending Phase IV by one year to 2008, the draft action plan for 2005/2006 and the Statement by the Mayors and Political Leaders were to be presented for adoption in Business Session 2.

Analysis of health profiles by Premila Webster and Alistair Lipp

Premila Webster presented a review of city health profiles. She explained that city health profiles identify, in writing and in graphs, health problems and their potential solutions in a specific city. The aims of the review were to determine whether city health profiles produced by cities are comprehensive and to identify areas in which problems are encountered. The content was reviewed using a framework developed by the WHO Technical Group on City Health Profiles in 1995 for the first review of city health profiles. The review included: demography; health status; lifestyle; socioeconomic conditions; environment; inequality in health; infrastructure; and public

health policies and services. A total of 49 profiles were submitted, and the review included 33.

As in the previous 1995 analysis, all city health profiles included comprehensive information on demography. The data and evidence presented were accompanied by the expected scientific rigour. The 1995 review found areas of inadequate coverage in city health profiles; this has improved, with most profiles now comprehensively covering: health status; socioeconomic conditions; lifestyles; infrastructure; and public health policies and services.

There are also areas for improvement from the 2004/2005 review of city health profiles. These include: identifying and analysing inequality in health; providing a good summary that can synthesize the data and making it meaningful to the citizens; and identifying areas for improvement and making recommendations.

Premila Webster acknowledged that there are challenges in producing meaningful city health profiles. She quoted an excerpt from the Udine city health profile:

> The question always looms over the compiling of a health profile: how can the complex reality of a city, the interactions of its sub-systems and the multiplicity of the aspects that influence the health of its population be described with a limited set of figures and indicators.

Premila Webster concluded that city health profiles have come a long way since the early days and that much has improved since the last review. However, there is still some work to be done.

Alistair Lipp presented an overview of a review of indicators of inequality within the city health profiles, focusing on health status, well-being, services, economic conditions and the environment within cities. He described the rationale for this focus as “awareness of the problem brings you closer to the solution”. Cities should be able to influence inequality within their boundaries. A clear understanding of inequality in health within a city can help to redress inequity, injustice and unfairness.

The review identified 500 indicators of inequality from 35 cities in the WHO European Healthy Cities Network across 16 countries. The number of indicators contained in city health profiles varied widely: from less than 5 to more than 40. Of the indicators, 33% focused on health status, services 14%, economic conditions 13%, lifestyles 12%, demographics 9% and environment 6%. Education, crime, traffic and housing accounted for 3% or less respectively. No city health profile contained indicators of inequality in health associated with religion.

A total of 51% of the indicators focused on the whole city, 38% focused on a targeted geographical level, 7% on deprivation clusters and 4% on key streets and locations. Alistair Lipp identified a series of weaknesses for the indicators of inequality in health presented in the city health profiles.

- There are problems with indicators used at the whole-city level, as this hides underlying inequality and problems within the city.
- The city health profiles relied excessively on very basic subgroup data, such as sex and age. However, biological differences complicate understanding of the inequality.

As a result, injustice was poorly described. Alistair Lipp highlighted several examples demonstrating a more sophisticated approach to identifying inequality in health within cities,

such as disability rates by district in Bursa, infant mortality associated with nationality in Brussels and deprivation by district in Brighton & Hove.

Quantifying inequality is important, as this helps to track changes in equality over time. Seven cities quantified inequality; 25 indicators quantified inequality, only 5% of all indicators, and 14 of these were from the City of Sunderland.

Alistair Lipp closed this presentation by advocating the need for developing skills for cities in: describing inequity, unfairness and injustice within cities and quantifying inequality.

Analysis of the annual reporting templates by Zoe Heritage

Zoe Heritage presented an overview of the analysis of the 2004/2005 annual reports. The analysis was undertaken on the 42 reports received from the 45 member cities. Overall, the annual reports were full of good content. The reports reflect experience and progress in the first full year of Phase IV. Some cities were designated later in the reporting period, so their reports reflect a shorter period of performance.

The reports reveal that the most important feature of optimizing success as a healthy city is political commitment. Surprisingly, some of the cities designated in Phase III showed lower levels of enthusiasm than cities designated for the first time in Phase IV. Further, less political support was demonstrated in the Mediterranean countries than in other parts of Europe. Most cities held between one and four steering group meetings and nine had none.

Only two cities have no city health profile. Seixal updated its city health development plan in 2004, and another 26 cities have current plans to update their city health development plans. Nine do not have city health development plans, of which four were designated before Phase IV.

All cities are working with the community, and community participation is very much alive. Cities are increasingly finding opportunities to link their healthy city programmes with Local Agenda 21. Fewer cities, however, are demonstrating active partnerships with the private sector. There are a few exceptions to this: for example, Vienna is working with bakeries to promote healthy eating. Some cities are working with pharmaceutical companies. Some challenging ethical issues need to be explored regarding relationships between the private sector, in particular pharmaceutical companies and healthy city programmes.

Nearly half the cities have been active in healthy urban development, either altering policy and plans or actually starting to implement physical projects. Another 16 are building the necessary capacity. About three quarters of cities are making good progress in health impact assessment. Cities are setting up local infrastructures and partnerships to implement health impact assessment. There is wide variation in progress on healthy ageing. Many of the proposals aimed at improving the well-being of older people concentrated on providing care services rather than promoting health. Most cities, however, had adopted a strong multisectoral approach, involving older people. Cities demonstrated little progress in tackling age discrimination.

Forty-one of 42 cities report progress on promoting active living. Zoe Heritage noted this as a big success. Most cities have strategies on active living in place. Some cities are linking this agenda with work to improve the built environment. The “Day of Dance” continues to be a success in many cities.

Thirty-eight of 42 cities are evaluating their healthy city programmes in some way. However, the annual report responses do not allow the quality of this evaluation to be assessed.

Zoe Heritage concluded that the volume and range of activities of the cities in the WHO European Healthy Cities Network is very satisfactory overall. Most cities have solid foundations to continue to implement the objectives of the WHO European Network during the coming years of Phase IV. Cities have demonstrated many actions on core theme deliverables and a strategic approach to developing and implementing their healthy city programmes. Promoting active living and community participation has become the norm among cities.

Zoe Heritage noted than one in five cities may have some weakness. Several cities designated in Phase III are experiencing challenges that may require monitoring and assistance from WHO. It is also possible that many other examples of good progress have not been recorded in the reports.

A delegate asked about the level of nongovernmental organization involvement in healthy city programmes. Zoe Heritage said that two thirds of cities are working with nongovernmental organizations.

General Rapporteur

Terry Blair-Stevens, Healthy City Coordinator, Brighton & Hove was appointed General Rapporteur.

Healthy city communication (Franklin Apfel)

Franklin Apfel invited delegates to complete a healthy city communication questionnaire. This will help the WHO Regional Office for Europe in developing a communication plan for cities in the WHO European Healthy Cities Network. Franklin Apfel introduced the Working with media handbook, which was included in all delegates' packs and is also available in Russian, French and German in PDF format.

Parallel Session WN3: first meeting of city urban planners

Chair: Hakan Koyunlular, Head, Research, Planning & Coordination Department, Metropolitan Municipality of Bursa

The purpose of this session was to provide an opportunity to introduce urban planners to the concept and applications of healthy urban planning and to facilitate discussion among urban planners on this subject.

Healthy urban planning by Hugh Barton

Hugh Barton explored how urban planning can affect health. He identified characteristics of modern planning, including the creation of attractive homes but unattractive neighbourhoods; local facilities that are inaccessible by foot and access that is centred on cars; and office and retail parks that are often lavish but land-hungry, car-dependent and impermeable.

He noted that physical factors in the built environment affect people's living experience within that environment with associated health outcomes. Hugh Barton highlighted the 12 key health

objectives for good urban planning. These objectives should be reflected in policies and practice that promote and encourage personal lifestyles, social cohesion, housing quality, access to work, accessibility, local, low-input food production, safety, equity, air quality and aesthetics, water and sanitation quality, quality of land and mineral resources and climate stability.

High Barton introduced the concept of collaborative communities in neighbourhood planning and the local planning process for healthy urban planning. He outlined the conceptual model of the neighbourhood:

- building on the health and well-being of people living, working and playing in the locality;
- supported by collaborative communities that build social capital and plan for balanced populations;
- providing for local human needs such as housing, work opportunities, local facilities, recreation and movement;
- developing spaces and routes that define the city's spatial framework, neighbourhood character, design of the home-patch and renewal strategies; and
- encouraging local resource management, including energy, water, food, waste and biodiversity.

Hugh Barton identified the emerging strengths of cities in the WHO European Network in taking forward healthy urban planning objectives. Cities are: mainstreaming and widening policy commitments; creating innovative projects; developing effective programmes to combat current weaknesses; integrating health into city land use plans; and making links to health impact assessment and healthy ageing. Hugh Barton also identified weaknesses in some cities, including: the low level of involvement of planning, regeneration or transport officers; no recognition of key health themes, such as personal lifestyles, work, food and climate stability; no links made to health impact assessment and healthy ageing; and failure to see planning as an integrated activity.

Hugh Barton presented examples of good healthy urban planning practice from Belfast, Bursa, Dresden and Seixal. Emilio Cazzani and Marco Zanussi presented the work of the WHO City Action Group on Healthy Urban Planning.

The healthy urban planning approach in Sandnes, Norway (Marco Zanussi)

Marco Zanussi outlined how the Sandnes Municipal Plan and City Health Development Plan reflect healthy urban planning. The goals of Sandnes Healthy City are to build healthier urban environments and improve the inhabitants' quality of life. Marco Zanussi summarized the regional policy context supporting healthy urban planning and outlined policy objectives at the municipal and neighbourhood levels. Realizing these healthy urban planning policy objectives has resulted in: better accessibility for all to green spaces; less car use, less car pollution and fewer car accidents; less public investment in private car infrastructure; more rational land use; safer and healthier local environments; increased physical activity; and more cycling and walking and better health.

Progress of planning in Bursa (Hakan Koyunlular)

Bursa is a city of history, nature, water, industry and tourism. Bursa is located on the Silk Road connecting Asian and Aegean seaports, which has triggered the development of industry and

commerce over the centuries. The city has an industry capable of producing various highly valued products (textiles and automotive) and holds a very important position in both the region and Turkey.

Until 1950, the industry of Bursa was dominated by the textile sector, which used traditional textile technology. During the 1950s and 1960s, the food, chemistry, machinery and automotive sectors have emerged using an advanced level of technology. Planned and unplanned industrial zones have developed. Unplanned residential areas have developed especially around unplanned industrial zones. Unplanned zones produce visual, acoustic and environmental pollution. Infrastructure problems emerge in the unplanned zones. Environmental pollution arises since installing purification plants in unplanned industrial zones is very difficult. The high prices of land in organized industrial zones push industrialists to establish their companies in agricultural zones and areas that are close to the city centre, which harms the agricultural areas and the goal of sustainability. This situation makes enforcing plans even harder.

The 2020 Bursa Strategy Plan is a 1:100 000 scaled plan that envisages "a sustainable, livable environment; where agricultural, tourism and historical values are protected and where healthy growth and development goals are ensured via sectoral development plans in the scope of the development policy of Turkey". The 2020 Bursa Strategy Plan includes intervention strategies for problems, suggestions for development and planning principles and goals in the scope of the plan. The boundaries of the plan have been drawn by the Bursa city plan.

The 2020 Bursa Strategy Plan has become necessary because of the rapid increase in population in Bursa and its surroundings; the rise in the number of municipalities within the city boundaries; and the change in the status of the central district municipality which has been designated as the Metropolitan Municipality of Bursa. The changes resulting from these management bodies have resulted in different authorities taking different decisions. As a result of all this, the plans in Bursa and its surroundings had to be re-evaluated and new strategy plans had to be developed.

Decisions concerning planning are taken through the principles of policy, plan, programme, project and payment. The goal is to execute the policies, strategies, technical and tactical decisions that are developed to solve the existing problems.

Sectoral and intersectoral cooperation has been taken as the basis of the working method. The current situations of the sectors, problems and abilities have been identified. Data have been gathered on: natural resources; commerce and services; population; industry; transport; and technical infrastructure. All sectors are taken into consideration with their surroundings and the whole city. As a result of this, policies, strategies, tactical and technical decisions are taken into account and carried out in comparison with the city and the individual sectors.

Transparency is the main principle during the preparation of planning decisions. In this context, decisions are taken during the meetings and discussions with central institutions and local institutions, organizations and establishments and business chambers. The decisions are taken by institutions. For this reason, these institutions must be committed to fulfilling their decisions and developing their application plans in this context.

The building of illegal residential development in the Bursa area results from the rapid increase in population and the migration into large cities. This affects the physical, social, cultural and economic structure and reduces the quality of life. In order to solve the problems caused by shared land development, improvement development plans (and transformation plans within

these) have been prepared. But none of these plans has solved the existing problems and they even enhanced the problems.

The most important part of the project is the planning phase, which is carried out together with the residents of the concerned planning area. The main goal is to raise the quality of life. Additional goals include: raising the awareness of citizenship; ensuring that the residents of planning areas are participating in the decision-making process; and ensuring that the citizens take responsibility for the city and area in which they live.

Plenary Session WN4: core theme: healthy urban planning

Chair: Jostein Rovik

Healthy urban planning: core theme (Hugh Barton)

Hugh Barton introduced the concept of healthy urban planning. He explained that healthy urban planning means planning for people. Healthy urban planning focuses on the positive impact that urban planning can have on human health, well-being and quality of life and reflects WHO's broad definition of health. It aims to refocus urban planners on the implication of their work for human health and well-being and, in particular, to make health objectives central to the decision-making process.

The plenary session aimed:

- to develop a common understanding of healthy urban planning and present a progress update on the action of the healthy urban planning subnetwork and five agreed priorities for in-depth work and progress from the work of cities based on the analysis of annual reports;
- to develop an understanding of the scientific evidence related to the relationship between urban planning and health; and
- to learn how healthy urban planning and health impact assessment processes are being mainstreamed in London.

Hugh Barton explained that modern planning was invented as a reaction to poor health in industrialized societies, addressing such issues as poor sewerage, overcrowded housing and poor sanitation in poorly built environments. The challenge for healthy urban planning in the 21st century is to combat the modern equivalent of sewage and filth, such as stress, poor mental health and transport. Planning has the potential for global impact in health, environmental and economic terms. Health can be used as a proxy for sustainable development.

Hugh Barton briefly summarized the strategic development of the WHO approach to healthy urban planning and the technical guidance WHO offers to cities.

Urban planning and health: the evidence (Hugh Barton and Mark McCarthy)

Hugh Barton and Mark McCarthy made complementary presentations summarizing the current English-language academic literature on health and planning.

Planning urban health – science and practice (Mark McCarthy)

Mark McCarthy briefly reviewed the published scientific health literature related to urban planning. This drew on the biomedical literature, especially review articles that assess several studies together. The literature is not as definite as might be hoped and reminds us to be cautious in proposing policy based on, for example, a single research study or case study alone. The strengths of a scientific approach include demonstrating a causal link and understanding the degree of effect. But scientific studies are easier to do at the micro level (on cells, as in biochemistry, or with people, as in psychology) than at the meso (community) and macro (city-wide) levels. The reason is that science needs comparisons: repeating a laboratory experiment to confirm its result is much easier than assessing the effect of community-level interventions over time.

Mark McCarthy highlighted seven themes emerging from the biomedical literature relating to planning and urban health.

- Environmental health: the understanding of environmental health is changing from narrower concepts of chemicals and pollutants towards the broader "system" determinants of urban health – how people live within their physical environments.
- Sprawl: dense cities are changing globally towards dispersed suburbs due to motor transport. The good aspects – space, green and better housing – are balanced by the harm from cars, of energy use (air pollution and climate change) and less exercise.
- Housing: as a result of high building standards in western European countries, showing negative health effects of "poor" housing is now difficult. But there remain design issues of preventing accidents, cleaner air, reducing damp and promoting hygiene.
- Residential environments: poorer people live in poorer areas – markets and income "select" people. So there are also local geographical differences in health. It is not clear, however, whether the quality of a residential environment itself directly affects health.
- Nature: similarly, some people welcome and are willing to pay for access to nature. Many people value green space, but some people also successfully achieve health in dense urban areas.
- Obesity: the challenge is to create ways of integrating exercise into ordinary daily tasks. Transport options (walking, cycling, bus and car) are important supports for adequate physical activity.
- Income: more affluent people are generally healthier, but it is still impossible to show directly that improving an individual's wealth will also improve their health; education and resulting behaviour are important intermediate factors.

Mark McCarthy noted that Europe has many models for promoting health through the built environment. Planners and health activists need each other. Existing research does not yet provide direct evidence of how urban design affects health. Planning schemes for large development projects present an opportunity to make health predictions and then measure the impact on health of new design. The focus on healthy urban planning through the WHO European Healthy Cities Network also presents an opportunity to test the impact of urban planning on health.

Research and action on healthy urban planning (Hugh Barton)

Hugh Barton presented an overview of the urban planning research literature related to health. He noted that global warming has passed the point of no return, with polar ice-caps melting at an accelerated rate. The bad news is that road traffic emissions have grown, are growing and will continue to grow. Although more people are walking, traffic on the roads has not declined. The good news is that spatial planning can open up non-car options. Achieving real change in terms of reduced car use depends on changing societal values.

People are living longer. The challenge is to enable people to live healthier and independent lives into their older years. The good news is that the healthy ageing approach enables creating opportunities to plan for a healthier and active society for people of all ages. Older people want to live locally, with good local accessibility and high-quality facilities.

Urban design creates opportunities to encourage active living. Current estimates indicate that 50% of young people will become obese. The research is not conclusive on the links between urban design and desired health outcomes. For example, poor non-car owners are more overweight than affluent car owners. However, good design may encourage walking and cycling. Evidence indicates that people will walk more within cities when facilities are close. However, in many cities facilities are closing down or moving to the outskirts of city boundaries. Good urban planning requires provision for local human needs such as housing, work opportunities, local facilities, recreation and movement.

Good neighbourhood planning builds on the health and well-being of people living, working and playing in the locality. Collaborative communities involving community groups, the local planning authority, investors and providers and local people are essential for building social capital and for planning for balanced populations.

The spatial layout and routes of people’s local built environment shape the density, form and character of neighbourhoods. People like to live next to people “like” them. People want live in an environment with safe streets and access to green space. Access to affordable healthy food and management of local resources such as energy, waste and biodiversity are also required for healthy neighbourhoods within the built environment.

Long-term strategic planning is essential for building healthy built environments. Land-use planning needs to incorporate transport, housing and economic planning. What will not work is disconnected policy and action. The public and private sector must have shared strategic approaches for built development, and the community and local people must be partners in planning development. What will work is integrated strategy, including top-down and bottom-up processes with all sectors participating.

Healthy urban planning: priority areas and overview of city progress (Emilio Cazzani)

Emilio Cazzani explained that Milan was the city that led the WHO City Action Group on Healthy Urban Planning from 2000 to 2003, and it still maintains this role in the new 2004–2007 healthy urban planning subnetwork. In order to give concrete form to its international commitment, the Municipal Administration of Milan promoted a programme of research and action on this subject conducted jointly with the Healthy City Office of the Social and Health Services Department, the Urban Planning Department and the Department of Architecture and Planning of the Politecnico di Milano Technical University.

This programme used the key principles of the healthy city and healthy urban planning approach (fairness, environmental sustainability, cooperation between sectors and community involvement) to identify public and private sector planning already existing in the city that is consistent with these principles. It then attempted, in a few particularly critical neighbourhoods, to implement, in a more conscious fashion, an intersectoral and community involvement approach to urban planning in specially constructed pilot projects that set the policies and actions of the different sectors of administrative intervention involved in relation to the actions of local actors who operate in these neighbourhoods. This experimentation with pilot projects had interesting side-effects, not just in terms of integrated intervention that explicitly sets health and the quality of life as priority objectives but also in terms of institutional learning with the growth of the culture and methods within the municipal administration. A series of guidelines for the promotion of health in urban planning policies was formulated to strengthen and diffuse both.

The new healthy urban planning programme adopted recently intends to further consolidate and make use of this experience by extending the knowledge, skills and the results acquired to a broader field of action. More specifically, it intends to transform the guidelines into a strategic document on urban health calling on all the many different parts of Milan to participate in this important project to promote the quality of life, well-being and urban livability, endowing it with strong political commitment and social support.

In this framework, two key issues of the current configuration of urban degradation will be investigated specifically: housing and the conditions of elderly people. The question of housing, with particular reference to social housing, requires strong cultural and operational investment to redefine traditional housing policies, which are inadequate to deal with new and multiple forms of housing hardship. This will find a useful filter to define a rich and detailed body of guidelines, policies and specific indications on the subject of housing that may act as a reference framework for the action of everyone involved in these policies.

The question of the conditions of elderly people is one of the most significant and clamorous issues for a healthy city. With its special characteristics, this issue must be approached from a multidimensional viewpoint encompassing the relationship between social, housing and community problems and by adopting new approaches to social and economic programming and urban planning. More specifically, the intention is to address the innovative housing demand of the elderly population both in terms of the performance characteristics and the type of accommodation (such as integration with health and social services, measures for “remote support”, housing solutions specifically for single elderly people, design for all versus mainstream use and support for maintenance) and with regard to the community context (availability, accessibility and safety of intermediate, proximity spaces, courtyards and collective spaces, such as public places).

Planning for health in London: approaches to health impact assessment and healthy urban planning (Gail Findlay and Paul Plant)

Gail Findlay explained how the Greater London Authority is responsible for promoting economic and social development in greater London and the improvement of the environment, with a cross-cutting focus on improving health, promoting equality and promoting sustainable development. The London Health Commission is responsible for planning for the health of Londoners. The Commission builds upon the London Health Strategy, consists of seven cross-sector partner agencies with 30 members and seven forums linking with wider networks. It aims to reduce inequality in health in the capital and to improve the health and well-being of all

Londoners by: raising awareness of inequality in health; promoting coordinated action to improve the determinants of health; influencing key policy-makers and practitioners; supporting local action; and driving specific priority issues through joint programmes.

Under the auspices of the London Health Commission, an Urban Planning and Regeneration Forum was established with responsibility for undertaking health impact assessment on all new mayoral strategies. Health impact assessment has already been completed on spatial development, transport, economic development, air quality, waste management, ambient noise, biodiversity, culture, the strategy for children and young people, a review of the economic development strategy and extension of congestion charging.

The London approach to health impact assessment involves: a steering group; emphasizing prospective intervention at the screening and scoping phase of policy development; a policy appraisal workshop with all key stakeholders; rapid appraisal completed within six weeks; a report and recommendations to the Mayor; converting recommendations into final strategies; and monitoring and evaluation.

Independent evaluation demonstrates that the health impact assessment has made a difference in final strategies. For example, the Economic Development Strategy gives priority to health, and the Transport Strategy gives higher priority to cycling and walking. There has been increased stakeholder awareness of the impact of wider policies on health and involvement in health impact assessment. Health is considered earlier in strategy development and in strategy review.

Paul Plant emphasized the importance of streamlining and integrating, where possible, assessment processes, such as strategic environmental assessment, environmental impact assessment and health impact assessment. This pragmatic approach will improve efficiency and is tactically and politically prudent.

A successful healthy urban planning approach requires that the health sector play a prominent role in designing and delivering sustainable communities. However, the health sector in Greater London has little expertise in planning and working with developers. There is a lack of liaison with local planning authorities and little understanding of why the urban development of London is important. The Healthy Urban Development Unit within the Greater London Authority provides support mechanisms to facilitate better engagement with health and other sectors. It is staffed by three town and country planners who are specifically tasked to build capacity within the National Health Service. The Unit provides resources and expertise advice and negotiating skills on urban planning.

Parallel Session WN5: case studies on healthy urban planning

Scope and purpose

In this session case studies were presented on practical experience of cities with the healthy urban planning concept. Presentations took place in two rooms.

Social housing in Milan: towards a healthy perspective

Milan, the capital town of Lombardy Region, has 1.3 million inhabitants. The city plays a central role in the larger metropolitan area, where 3.5 million people live and work. Public institutions own about 20% of the residential housing properties in Milan. This represents an important

resource for facing the housing problem, but the central role of Milan as a metropolitan city for business, trade and services determines the growing need for residential housing. According to recent surveys, about 31 000 dwellings are needed in the city territory.

The main targets the Milan City Council intends to achieve to solve the housing problem are:

- to promote new public programmes to satisfy the demand of specific population groups (new families, people with low income, elderly people, single people and students);
- to promote the requalification of council houses in districts in a state of degradation;
- to promote new private programmes, forecasting a minimum percentage of dwellings with controlled prices or reserved for the rental market;
- to balance the market, selling public areas at low cost with the aim of reducing prices and rents and giving operators contributions to reduce construction costs; and
- to give economic support to people in need that contributes to payment of rent.

The realization of new residential districts and, in particular, the promotion of social housing is one of the most important policies the Milan City Council is pursuing. The aim is to contrast the phenomenon of residents leaving the city, which is typical of most large European cities that are changing their previous industrial identity due to the process of the reorganization of the industrial economic system of production.

To make this strategy more effective, the City Council's policy aims at creating new synergy between public and private operators, stimulating the quality of the projects in compliance with the healthy city approach.

The case study regards the area of the Barona Village, which is owned by a private foundation. It is a successful example of private and public collaboration to solve the housing problem at a local level. The Barona project concerns an area of about 40 000 m2 in the southern suburbs of the city. In the past, the foundation organized a centre for people with special needs, such as elderly people, terminally ill people and young people with family problems. The present project aims at realizing a new village in the area, conserving the existing centre and providing new dwellings and services for new and old residents.

The village will be a pleasant and welcoming place within the Barona area. In particular, the project foresees:

- 80 new dwellings at a moderate rent, with spaces available for shops and private services at the ground level;
- 120 new mini-apartments with rooms for students and young workers;
- a fitness centre, a library and a meeting place for the locals, which will include people from the outer district;
- spaces for people who are elderly, terminally ill or disabled;
- a centre for families in difficulty;
- a social and cultural centre;
- a public park of about 22 000 m2 situated in the middle of the village with street furniture and play areas for children.

The new village is being realized by a specific agreement with the City Council, which allowed the initiative after having evaluated the content of the programme and the quality and functionality of the project. The project has been developed with the involvement of the local people, who contributed substantially to its implementation. At the moment, the village is being constructed.

Starting urban regeneration in Seixal: a new policy for a derelict area

Seixal is one of the 18 municipalities of the Lisbon Metropolitan Area. Lisbon is the capital and the largest city in Portugal. Seixal has experienced strong urban development due to its location close to Lisbon. Seixal has had one of the highest registered population growth rates in the country for the past 30 years.

Seixal joined the WHO European Healthy Cities Network in 1998 and participated in the discussions on the theory and practice of healthy urban planning in the WHO City Action Group on Healthy Urban Planning from 2001 to 2003. This experience has been a good incentive for a new approach to Seixal’s urban planning process. Interdepartmental thematic groups were set up and new procedures are being gradually implemented in local plans and projects. A master plan has been designed for the regeneration of a derelict area of about 370 hectares, where the national steelworks was located until the end of the 20th century.

The municipal authorities have established a partnership with the owner of this site for the design and implementation of the plan. This plan keeps the industrial activity on site to increase the number of jobs and foresees the development of a residential area, new facilities and wide green spaces for recreation and leisure. The site, on the waterfront, faces Lisbon across the Tagus River.

The concept of healthy urban planning stresses the concept of sustainable urban development. The framework of healthy urban planning is contributing to gradually changing working processes and attitudes. Some change has been noticed concerning municipal projects, which are adopting a multidimensional perspective and becoming more appropriate to the community needs.

Working together in a group is very demanding and time consuming. Nevertheless, it has been a good experience and a good way to improve final results.

Healthy urban planning in Glasgow: an overview and case study

Glasgow has taken a creative approach to healthy urban planning by creating a full-time post of Public Health Programme Manager with a remit for healthy urban planning within the Glasgow Centre for Population Health. The Glasgow Centre for Population Health is a research and development centre that works across the boundaries of research, policy, implementation and community life to shape a healthier future for Scotland. The Centre is part of the Scottish Executive’s strategy to reduce health inequality; and as a partnership between the Greater Glasgow National Health Service, the University of Glasgow and Glasgow City Council, combines competence in high-quality research and learning with practical action and the scope to influence local and national policy. The Public Health Programme Manager for healthy urban planning has a background in public health research and strategic planning and works closely with urban planners in Glasgow to raise awareness of how planning can create an enabling

environment to optimize health, to mainstream health in policy and land-use plans and to provide and generate evidence when needed.

One area of work involves the development of strategic plans for the local area. The Glasgow and Clyde Valley Structure Plan is a long-term overarching planning strategy approved by the Scottish Parliament to which local authorities adhere in their own planning documents. This document includes a section that makes the links between planning, health and quality of life and draws attention to particular areas of need. The Glasgow City Plan is another strategic plan in which links are being made to health. Each of these plans must have an accompanying strategic environmental assessment, and the Public Health Programme Manager has provided evidence and examples of how to increase the presence of health in these assessments.

The Glasgow Centre for Population Health is currently producing a new health map of the Glasgow area that will serve to provide further evidence for policy and planning. This map will bring together existing data, both quantitative and qualitative, on a wide range of determinants of health. The Centre is also involved in partnership with NHS Greater Glasgow in the third wave of the Greater Glasgow Health and Well-being Study, a face-to-face household questionnaire that draws on a representative sample to provide a snapshot of health and well-being and tracks population-based changes over time. These efforts, along with reviewing and sourcing evidence on request, provide planners with much-needed information on health. When evidence is not readily available, studies are undertaken to help fill the gaps. Two examples of such studies currently underway include a qualitative study on the facilitators and barriers to the use of green space, leisure centres and community halls for recreational activity and a series of analyses on the health and well-being of the minority ethnic communities in Glasgow.

Another important aspect of this work is the development and implementation of a healthy urban planning network, which will bring together academics, policy-makers, practitioners and the community in a open forum for debate and discussion. Part of the purpose of the network is to raise awareness and allow people who would not normally come into contact with each other an opportunity to share ideas. This network will link with existing networks, such as the Scottish Health Impact Assessment Network and the European Healthy Urban Planning Network. Members of the network have been invited to the BLOCK architecture festival and the Urban Summit entitled New Urbanism and the Health of Cities that the Glasgow Centre for Population Health is co-sponsoring with the Lighthouse (the Scottish Centre for Architecture and Design). In order to further raise awareness, the Centre has produced a history of public health walk that can either be a guided tour (as during the festival) or self-guided. Booklets are currently being distributed.

Joint work with the Glasgow Centre for Population Health has identified some of the communities where there is the greatest need and potential for creating a healthier environment by identifying action to improve the housing and physical conditions of these areas. Additional work examined links between health and planning using the Scottish Index of Multiple Deprivation, which ranks small areas in Scotland from most to least deprived based on a wide variety of indicators in several categories, such as income, employment, education and health. As a result, the Glasgow and Clyde Valley Structure Plan Team has obtained agreement from its Board to include the areas of Springburn and Larkhall as two areas of priority need that had been previously overlooked by various policies.

Sandnes: the Children's Trails Project

Building on previous development plans, the Municipality of Sandnes has made a systematic effort to identify and strengthen the interests of children and young people in local authority planning work. Giving children and young people the opportunity to influence and participate in this work has been an important part of the planning process.

At the end of 1998, the Municipality received an invitation from the Ministry of Children and Family Affairs to take part as one of 10 local authorities in a development programme aimed at improving the environment in which children and young people grow up. Within this programme, Sandnes developed what has been called the Children's Trails Project.

Children's Trails is a method involving registering children and young people's use of urban areas based on their own knowledge. These are informal green spaces and play areas and tracks or paths that are important for children and young people's games, motion and physical activities, regardless of whether they are on private land, public areas or land with other forms of ownership (such as space left over after planning (SLOAP)).

The goal of the Project was:

- to strengthen and make visible children and young people's interests in municipal planning;
- to give children and young people the possibility of participation and influence about using and shaping their own environment;
- to give planners and politicians a better decision platform for future land use; and
- to follow national directives for taking care of children and young people's interests in planning.

Taking care of children's informal playing and moving areas gives children a better quality of life and a feeling of possession of and identification in the local neighbourhood and as a result, a feeling of well-being and security.

Children aged 8–13 years old, schoolteachers and nursery school nurses were involved in the project. Children in all schools were asked to record on maps their own use of all kinds of areas. As a supplement to map registration, children provided qualitative information about areas and paths (what was positive about the areas? Why was it good being there? Was there something that could be done better?). All mapped information was transformed into digital form and was made available through the municipal mapping programme and intranet system. The project started in October 1999 and was completed in January 2001. The registration process in the nurseries was carried out from January to March 2000. Registration in the test schools took place at the same time and in the remaining schools from August to October 2000. Sixteen of 18 primary schools, one lower secondary school and 34 of 39 nursery schools took part in the registration.

The Municipal Council endorsed the Project's final report and decided that all spatial planning should take account of the report's findings. Consideration and evaluation of Children's Trails registration has been introduced as a permanent routine in all spatial planning processes. The registration is a regular part of the "start package" handed out to estate developers at the start of their planning work. Municipal and private planners proposing local development plans are strongly demanded to use the mapped information of the Project in their planning, to take into account and possibly include informal children's paths and play areas in their plans. The

representative of children and young people ensures that the recorded children's trails and playing areas are taken into account.

On several occasions, plan proposals have been modified or even rejected because the representative of children and young people had pointed out substantial conflicts between the plans and the Children's Trails registrations. Moreover, the Municipal Development Plan contains separate targets and initiatives aimed at ensuring that areas defined as important for the physical activities and development of children in the Children's Trails project are taken into account, possibly preserved or replaced through spatial planning and development.

Healthy urban planning in Zagreb – approaches, results and future activities

The City of Zagreb has a long history of planning for urban environment and development. Promoting healthy urban planning, as an implicit part of this process, is viewed as shaping the quality of life in all components of urban space. This approach is particularly highlighted in Zagreb's recently developed long-term strategic planning documents and is sustained by an interdisciplinary approach and public participation.

The Zagreb Master Plan plays a crucial role in creating spatial and environmental preconditions for healthy life, quality of socioeconomic, cultural and environmental conditions and richness of social activities. The Master Plan is a part of the continuous improvement of the city's development vision using different instruments and tools. Attitudes are further developed at a lower planning level: in detailed plans, designs and other documents. Four examples were presented.

To bridge different transitional processes and gaps between plans and practice, the City Bureau for Urban Planning will work with the Healthy City project team and other actors:

- to better promote and educate the public on the Zagreb Healthy City Project and healthy urban planning;
- to establish a healthy urban planning intersectoral group;
- to effectively control the plans' implementation (through inspection and supervision);
- to ensure the proactive participation of public-sector stakeholders and the general public in addressing public issues;
- to ensure the collaboration of professionals and decision-makers involved in the housing sector;
- to ensure networking projects based on the best available and environmentally sound solutions;
- to provide promotion and awards to the best healthy urban planning practices in the City; and
- to recognize the contribution health impact assessment and environment impact assessment can make to healthy urban planning in the City.

The City of Bursa and the development of healthy urban planning

The City of Bursa has grown rapidly since the 1960s. The unexpected and rapid immigration to Bursa from within Turkey and from other countries has posed challenges related to green spaces, health, education and other city services and problems concerning transport, housing and environmental protection. Illegal residential development has also presented a significant challenge for urban planning. In order to reduce the rapidly developing urban problems, planning efforts began in 1960. In 1994 the Planning Department of the Metropolitan Municipality of Bursa was established and started operations related to planning and applications.

The assessment of planning applications and integration of planning and health approaches began after Bursa became a member of the WHO European Healthy Cities Network. Projects have been developed targeting housing, accessibility, lifestyles, social cohesion, open and green spaces, air quality, water and sewerage, employment, security and equality while taking health to the centre of planning efforts.

The guiding principles of urban planning in Bursa are intersectoral collaboration, community participation, equity, health promotion, sustainable environment and socioeconomic development. Important decisions and plans are debated in the city council with the involvement of all city actors, including mayors, university representatives, nongovernmental organizations, political parties and chambers of professionals. These institutions provide good understanding of the local context, create a common vision and promote strong community involvement and participation and satisfaction of social, economic and aesthetic human needs before preparing plans.

In general, planning projects are based on the long and medium terms. The 2020 Bursa Strategy Plan is the reference for all the smaller-scale plans and projects in Bursa. All targets in the Strategy Plan will be met by 2020.

The City of Bursa takes many planning initiatives in the framework of healthy urban planning. The current topics include:

- regional strategy plans;
  - the Bursa 2020 Strategy Plan;
  - subregional planning studies;
- transformation and renewal projects;
- historical and cultural heritage utilization projects;
- green space expansion projects;
- pedestrian walkways and cycle paths projects;
- rehabilitation projects for industrial zones;
- Bursa Light Rail System (BursaRail) project;
- a public transport integration project; and
- a project for facilitating transport for disabled, elderly and poor people.

Healthy urban planning in Brighton & Hove: the newcomers’ approach

This case study outlined how urban planners, transport planners and public health specialists are working in partnership to achieve health integration in urban planning. Robust partnership structures within Brighton & Hove have enabled healthy urban planning processes to be introduced into mainstream planning.

Brighton & Hove is a small city of 250,000 people. It is situated just under 100 km south of London. Many residents commute to work in London every day. The city is set between the sea and the rolling hills of the South Downs, an area of 8267 hectares, of which half is built-up urban area. There is considerable pressure for development in Brighton & Hove. It is one of the most economically successful cities in south-eastern England. About 11 000 new homes are needed by 2026 to meet a projected population of 283 700. Most of this demand is created by people moving to Brighton & Hove. The resident population of the city would decline if it were not for migration into the city.

Many of the nine principles of healthy urban planning (human health as a key facet of sustainable development, cooperation between planning and health agencies, cooperation between the public, private and voluntary sectors, community consultation and empowerment, political commitment at the highest level, health-integrated plans and policies, health integration at all scales from macro to micro and a comprehensive approach to the determinants of health and evidence-based planning for health) are based on coordinating policy and establishing good links between various organizations in the city. For Brighton & Hove, this task was made easier by a requirement in England to have community strategies produced by a local strategic partnership comprising representatives of all sectors in the city. The Brighton & Hove Local Strategic Partnership identified the healthy city approach as a strategic priority for the city. A healthy city partnership is responsible for steering the development of a healthy city approach within a city. This is chaired by the Chair of the Primary Care Trust (the lead public health and health commissioning organization in the city) and the Deputy Leader of the City Council. The head urban planner also sits on this Partnership. The Partnership ensures that the healthy city priorities have political and organizational support to achieve the city's Phase IV objectives.

Integrating healthy city objectives into the city's urban planning policy was straightforward. A newly adopted urban planning system requires that new strategic local plans conform to regional and national planning advice. New urban planning policy for the built environment must demonstrate how new local plans meet the strategic aims of the community strategy. New guidance also supports the use of health impact assessment. The whole system of urban planning in Britain therefore supports integration of the healthy city objectives into the new urban plans.

A healthy urban planning steering group supports the implementation of the WHO European Network Phase IV objectives within the city. Two new policy reviews present an opportunity to integrate healthy urban planning principles and approaches. A new local development framework outlines a 20-year plan for land use, sustainable development and design. A new five-year local transport plan is also in development. Work has begun on introducing a health focus to the new policy documents within the local development framework and local transport plan, and health impact assessment will be undertaken on both. In addition, health impact assessment will be undertaken on two other major urban planning developments in 2005/2006.

Training is being provided for all Council staff involved in urban planning through a series of master class sessions on health and urban design, policy and planning. These are open to urban planners, transport planners, sustainability and environmental teams as well as public health and health promotion practitioners, demonstrating that healthy urban planning is not just within the remit of urban planners.

Healthy urban planning in Helsingborg, Sweden

The healthy urban planning approach in Helsingborg aims to achieve sustainable development by increasing the participation of its citizens. A comprehensive plan promotes spatial development but includes health strategies and has a focus on human beings. The plan has been developed within a process of great participatory involvement from both individuals and organizations.

The South in Transition is a process (started in 2001) by which spatial features and citizens' involvement aim to raise the standard and the status of a geographical area. Thirty-one objectives of improvement have been jointly described and are now being implemented with ongoing participation of citizens. This work has resulted in an organizational change. The whole municipality now focuses on neighbourhood development and intersectoral thinking.

Five civic committees have created local plans for development. These plans are based on a dialogue between the committees and those who live and work in the geographical areas. The local plans are to be presented to the various municipal boards and will be used as background documents to inform decision-making.

An intersectoral reference group was created in spring 2005, and subsequently two working groups were established to pursue one project each: a housing development with broad participatory process among the local inhabitants and a walking trail through the urban parts of the city.

There is broad understanding of the link between health, welfare and participation in Sweden. The municipal work is supported both by legislation (the Planning and Building Act, the Social Service Act and others) and by national policies (such as those on public health and the environment). The definition of healthy urban planning in Helsingborg is timely thinking together.

Welfare housing policies for senior citizens (WEL_HOPS), Gyor, Hungary (Maria Miklosy Bertalanfy)

The number of elderly people is growing all over Europe. There is a growing need to establish suitable high-quality accommodation for elderly people. In the framework of the European Union INTERREG IIIC Programme there is an initiative about welfare housing policies for senior citizens. Partners in six countries are participating: Hungary (Gyor), Italy, Lithuania, Spain, Sweden and the United Kingdom.

The overall aims of the project are to promote independent living and well-being and to improve housing conditions for older people across Europe by:

- analysing good practice from across Europe;
- publishing a housing design guide based on good practices, which would establish a common European Union standard for high-quality housing;
- developing a web site to disseminate good practice and other information;
- piloting housing schemes according to the housing design guide guidelines;
- improving the quality of life of elderly people by enabling them to remain in their own homes for as long as possible by realizing dwellings especially designed to meet their needs;
- establishing and guaranteeing a common European standard for high-quality housing for elderly people; and
- speeding up the process related to housing in new European Union countries by sharing solutions that have already been tried and validated in other countries.

The project has established management bodies, created a system for permanent relations, analysed the experiences of the project partners and compared them with those of other European countries. The project's survey areas include: analysis of the models of planning and building of housing infrastructures; domotics (informatics in the home) and installation technology aspects; and services for elderly people in connection with the surroundings.

In the partner cities there are different stakeholders. In Gyor the main stakeholder is the Municipality of Gyor. Within the Municipality, the Town Architectural Department and Health and Social-political Department with additional partners cooperate in this project. The City of Gyor joined the project in May 2005. The first surveys were prepared in July and August 2005. Interviews will take place in autumn 2005. Gyor will host a meeting for the partners in May 2006. The WEL_HOPS project will end in December 2007.

The guidelines for the design of homes for elderly people will help in the practical construction of economically sustainable homes that will provide elderly people greater independence and a better quality of life. The necessary development should be based on identification of needs and requirements of the beneficiaries and on the involvement of local actors, both public and private.

Parallel Session WN6: working groups on healthy urban planning

Scope and purpose

The purpose of these sessions was to discuss how cities will be taking forward healthy urban planning work. Participants were invited to describe the strengths and challenges involved in taking forward the implementation of healthy urban planning objectives and priority themes within their cities. Participants were encouraged to consider the five priority themes identified by the healthy urban planning subnetwork in their responses:

- long-term strategic urban planning;
- transport and mobility;
- enabling urban design for healthy ageing;

- physical activity;
- healthy neighbourhoods; and
- cross-cutting approaches with health impact assessment.

Participants were invited to agree and propose three key recommended action commitments for healthy urban planning that all cities will deliver, to be included in the 2005/2006 action plan. Common themes arising from the healthy urban planning workshops were:

- All stakeholders need to be made aware of healthy urban planning objectives through education, training and consultation.
- Health professionals need to understand the urban planning agenda and urban planners need to understand the health agenda.
- An enhanced health focus is required where this is implicit in existing urban planning processes.
- The sustainability agenda can be used to link health and urban planning.
- Cities should plan for choice – alternatives to car use such as cycle paths, safe pedestrian walkways and improved public transport infrastructure.
- Cities should make options more attractive to increase participation in physical activity and active living.

Challenges

- Political interest is not always strong.
- Long-term outcomes of healthy urban planning objectives are not always an attractive political priority.
- Use demographic modelling to design a city for people of all ages.
- Planning legislation differs across Europe.
- Accessibility and facilitating active living need to be balanced.
- Understanding of the evidence base for healthy urban planning and physical activity and active living should be used carefully.

What can WHO do?

- Provide training guidance for urban planners and architects.
- Provide more examples of good practice linking healthy urban planning with healthy ageing and physical activity and active living.
- Provide practical support to individual cities.
- Continue to provide up-to-date review of scientific evidence.
- Provide examples of good practice in urban design for healthy ageing.

Parallel Session WN7: first politicians' session

Chair, Hikmet Sahin, Lord Mayor, Metropolitan Municipality of Bursa

Scope and rationale

Healthy urban planning is a core theme of Phase IV of the WHO European Network. This session provides an opportunity to present and discuss the political and strategic implications of healthy urban planning and also to consider a draft political statement with emphasis on healthy urban planning.

The healthy urban planning approach (Hugh Barton)

Hugh Barton explained that modern planning was invented as a reaction to poor health in industrialized societies, addressing such issues as poor sewerage, overcrowded housing and poor sanitation in poorly built environments. The challenge for healthy urban planning in the 21st century is to combat the modern equivalent of sewage and filth, such as stress, poor mental health and transport. Hugh Barton briefly summarized the strategic development of the WHO approach to healthy urban planning and the technical guidance WHO offers to cities.

Hugh Barton described how healthy urban planning can be progressed through policies and proposals that promote 12 health objectives: personal lifestyles, social cohesion, housing quality, access to work, accessibility, local, low-input food production, safety, equity, air quality and aesthetics, water and sanitation quality, quality of land and mineral resources and climate stability. Mr Barton also outlined the five healthy urban planning priorities: transport and mobility; healthy ageing and accessibility; urban design and physical activity; neighbourhood planning; and long-term strategic plans. An example was given of a model well-planned city characterized by: mixed housing; a pleasant living environment; accessible by foot, pedal and bus; safe feeling; car parking well overseen; low car ownership; shops on the street; local employment; strong social interaction; and community focus.

Draft political statement

A draft political statement – Designing Healthier and Safer Cities: the Challenge of Healthy Urban Planning – was presented to politicians for consideration. The statement commits politicians to reaffirm on behalf of their cities to the healthy city values in the context of new challenges such as emergencies and disasters. It commits cities to proactive planning for a healthier built environment and to acknowledge the impact of urban design on the health of communities. Finally, the statement recommits cities to delivering Phase IV objectives. It was agreed that the statement would be discussed and refreshed to incorporate expressed views at the second politicians' meeting.

Plenary Session WN8: local governments and physical activity

Chair: Mustafa Yurtkuran, Rector, Uludag University, Bursa

Scope and purpose

Agis Tsouros described how child and adult obesity is a pan-European challenge. Promoting work that can support individuals to take more physical activity is particularly relevant to the

roles and responsibilities of local governments. Urban planning can design for healthier neighbourhoods and communities by creating healthier options that encourage more active lifestyles.

This session set the scene, presented scientific evidence, explored the United States context and gave examples of two cities in Denmark that have invested a great deal in this field.

The context and the links (Francesca Racciopi)

Francesca Racciopi outlined how physical inactivity is a leading risk factor for ill-health and has great costs to society: costs of treatment and care, lost quality of life and days lost at work. Physical inactivity and the associated poor health outcomes are unequally distributed across Europe. Countries in eastern Europe are more severely affected. This presents a challenge for policy-makers and presents a role and opportunities for local authorities and cities to address this.

The health benefits of physical activity are clear. Undertaking 30 minutes of physical activity each day can reduce the risk of developing coronary heart disease, type 2 diabetes, hypertension, colon cancer, overweight and obesity. It can protect against osteoporosis; improve balance, coordination, mobility, strength and endurance; and increase self-esteem and overall psychological well-being.

The prevalence of obesity ranges from 10% to 27% among men and up to 38% among women across European countries. One in five children in Europe is overweight, and their number is increasing by about 400 000 per year. The effects of overweight and obesity in children are significant. Overweight children are more likely to become overweight adults, with an associated risk of greater cardiovascular disease, diabetes and other disorders. Type 2 diabetes is now being reported among children in several European countries. Excess weight in childhood may lead to: hypertension; increase in “bad” and decrease in “good” cholesterol; interruption of breathing during sleep; bone and joint problems; and poor mental health (such as eating disorders, poor social relationships and educational disadvantages).

In many countries, fewer children are walking to school and more are being driven by car. However, walking and cycling to school and for leisure can help in achieving the recommended daily amount of physical activity (60 minutes of moderate physical activity every day for children).

The health sector cannot meet this challenge on its own. The scale of the problem is too great. The environmental approaches that are needed are outside the control of the health sector. New partnerships must therefore be developed across different sectors.

Getting millions of people more physically active poses complex challenges. This includes incorporating physical activity into daily routines; avoiding dependence on facilities for sports; ensuring equitable and easily accessible options; and targeting and supporting the most sedentary part of the population in a cost-effective and engaging way that makes physical activity fun.

Methods for successfully supporting the most sedentary people in becoming active need to be understood. It is also important to understand which groups of the population are most likely to engage in more cycling and walking, the most supportive conditions for choosing walking and cycling, the overall balance between benefits and possible increased risks (such as injury or

exposure to air pollution) and how to evaluate the effects of interventions promoting more cycling and walking.

Designing for environments that encourage increased physical activity benefits cities. Transport and urban planners gain by reducing: emissions of air pollutants and greenhouse gases; congestion; road traffic injuries; and the need to invest in costly infrastructure to cater for more cars. The approach can also improve the accessibility and quality of urban life; provide tools to support investment in infrastructure for cycling and walking; and lower health expenditure by reducing noncommunicable diseases and injuries.

Cities and local authorities have an important role to play. Political commitment and leadership at the local level are essential. Urban planning and transport policies at the local level can be part of the answer. This requires developing appropriate tools to understand the effects of urban planning and transport policies in changing patterns of physical activity. Tools are required to assess the proportion of health effects attributable to changes in physical activity and to present strong arguments to the transport and urban planning sectors to invest in cycling and walking. Francesca Racciopi described several international health policy tools that support the promotion of physical activity in urban settings and introduced the European Network for the Promotion of Health-enhancing Physical Activity (HEPA Europe).

Rebuilding the environment to promote physical activity (Susan Handy)

Susan Handy described how the obesity epidemic is growing: public health officials are searching for both explanations and answers. She presented insight into the United States experience of how the design of the built environment provides obstacles to and opportunities for participation in physical activity. The United States suburban environment is characterized by low-density development and high dependence on car use. In the United States, walking accounts for only 6% of urban trips and cycling 1%. Traditional transport concerns have focused on economy, the environment, equity and safety. However, with increasing obesity and sedentary lifestyles, there is a stronger focus on how the design of the built environment can facilitate increased participation in physical activity.

Susan Handy posed two key questions.

- Can physical activity be increased by changing the built environment, and if so, in what ways?
- How can policy and investment decisions be used to make these changes happen?

A growing body of research provides evidence on the association between the characteristics of the built environment and higher levels of physical activity. Most clearly, closer proximity to destinations is linked to more walking and biking as a mode of transport, and better accessibility to recreational facilities along with nicer aesthetic qualities are linked to more walking and biking for exercise. Susan Handy presented evidence demonstrating a positive association between walking and cycling and: population and employment density; accessibility to destinations; and walkable, transit-oriented, traditional measures. Most people will not walk more than 400 metres to the nearest store. Factors positively associated with levels of physical activity include: access to facilities; the presence of sidewalks; and the perceived aesthetics of the neighbourhood environment. People who walk their dogs walk significantly more than those who do not have a pet to walk.

Susan Handy emphasized the importance of designing environments for specific groups, such as women, children, elderly people and low-income people. Research on low-income households suggests that people from low-income households in the United States walk for travel and use public transport more than moderate- and high-income households. Low-income people perceive less favourable walking conditions, and pedestrian accidents are relatively frequent in low-income areas. Healthy food choices are more limited, and unhealthy food choices are more abundant in low-income and ethnic-minority neighbourhoods. Higher levels of walking among low-income households have not translated into lower levels of obesity.

The evidence does not affirm that changing the built environment will necessarily lead to increases in physical activity. The evidence does support the premise that changing the built environment will increase opportunities for physical activity.

Susan Handy gave an overview of the United States policy context, in which physical activity can be supported through urban planning. She described how street connectivity ordinances can improve accessibility by creating shorter distances to travel and more choices of routes. Main street programmes can plan for stores and other community facilities within walking distance. Trails programmes provide separate facilities for pedestrians and cyclists. Traffic-calming programmes increase safety and comfort for pedestrians. Safer routes to schools programmes offer parents, children and other local stakeholders (including road traffic engineers) an opportunity to work together to make streets safer for pedestrians and cyclists along heavily travelled routes to schools. Community and neighbourhood severance (the barrier effect) can be reduced by building pedestrian and cycle bridges and tunnels and by sinking or removing freeways.

Susan Handy described how across North America and around the world, a movement called new urbanism is changing the way cities and towns are built. New urbanist developments create walkable neighbourhoods rather than large, single-use developments connected by roads hostile to pedestrians.

Susan Handy concluded by noting positive steps in linking the design of the built environment and the creation of opportunities to increase physical activity. Collaboration between researchers and practitioners to improve the evidence base is increasing. Planners and public health officials are increasingly combining their efforts to advocate for change in community design.

Copenhagen on the Move (Inger Marie Bruun-Vierø, Mayor for Health, Copenhagen)

Inger Marie Bruun-Vierø presented a video of the Copenhagen on the Move programme in action. She described the urban health challenges for the City of Copenhagen. The life expectancy for inhabitants of Copenhagen is lower than that of residents of Helsinki and Stockholm. Obesity rates (body mass index >30) within the city increased by 3% between 1991 and 2004. Light, moderate and strenuous exercise did not increase significantly among inhabitants during the same time period.

Copenhagen on the Move was developed to increase citizens’ participation in physical activity. It combines action to improve nutrition and diet with interventions to increase physical activity. The programme involves long-term strategic planning and builds on the experience of previous projects. Key to the programme is the promotion of positive role models, including the Mayor for Health.

The programme has invested in more signage to encourage commuters to walk, use stairs etc. "Green Pulse" areas within the city offer grades of exercise for citizens including a strength training pavilion, which is protected from rain and located next to a children's playground in a low-income area.

The programme supports schools in improving the standard of physical education and food in schools. It also supports exercise policies for workplaces. Exercise consultants provide face-to-face guidance. Consultants provide personal and group instruction and introduce citizens to exercise facilities. The programme also trains trainers in motivational dialogue.

In conclusion, Inger Marie Bruun-Vierø described Copenhagen on the Move as a multifaceted long-term programme. Demonstrating successful experience is crucial for motivating partners to support the programme and for motivating citizens to participate in its activities.

The (bicycle) road to a longer life in Odense (Henrik Lumholdt)

Henrik Lumholdt described approaches aimed at increasing physical activity in Odense, Denmark. The Safer Routes to Schools programme asked 4359 children about their experience of transport to school. The results from the consultation were mapped using interactive media onto a database. The data gathered included: mode of transport such as walking, cycling, car, bus etc.; distance travelled; and injuries experienced travelling to school. The results reveal that the mode of transport for the first trip of the day determines the mode of transport for the rest of the day; 85% of children walk or bike to school in Odense.

Henrik Lumholdt outlined a comprehensive campaign approach to increase cycling in Odense. The campaigns targeted specific audiences and were based on the principle that children have a right to their own mobility and that blaming should be avoided. The campaigns encouraged all children to travel by bicycle; attempted to reach parents through their children; and encouraged the children and adults to try cycling.

A cycle trailer campaign offered parents the opportunity to borrow a cycle trailer for up to one week. Ten trailers were made available to 3000 parents; 45% of the trailer users previously drove a car. A picture book resource was produced to encourage safe cycling around the city. It was designed for the whole family and distributed to 5400 children in grades 2 and 3. Associated with this, children were encouraged to enter a competition, writing about and sending photos of their cycling experience. The Freewheeling campaign targeted 960 12- to 13-year-old schoolchildren, challenging them as to who could cycle furthest in one week. Computers were fixed to bikes to measure distances travelled. On average, children cycled 100 km during the competition week and the winners cycled 244 km. Of the 960 children, 60% cycled before the campaign, 81% cycled during the campaign and 74% of children continued to cycle afterwards.

Campaigns also targeted companies to encourage their employees to cycle to and from work and reduce their dependence on private and company cars and taxis. Campaigns included providing folding bikes for car users who had long commutes and encouraging them to park on the outskirts of the city and to cycle for the remainder of the commute. In another campaign, 29 companies ordered bicycles. People who cycled more than 500 km per year were able to buy the bikes at half price. The average distance travelled by 67 cyclists was 5 km per day; 37% of workers also used their bikes in their spare time, and everyone cycled more.

A Home-Helpers on Bicycles campaign encouraged companies to provide personal company bicycles for home-help staff rather than paying them a cycling allowance. The companies bought 77 company bicycles, and 56% of participating workers cycled more in their spare time and lost weight.

Henrik Lumholdt concluded that campaigns make a difference. Those who wish to initiate campaigns to increase cycling must attend to the safety issues involved. Participation should be kept simple and voluntary. In Odense, cycle traffic has increased by 20%; every fourth trip is cycled; and there have been 35 million new cycle trips in four years. This represents 25 000 extra cycle trips every year, and more than half the new cyclists used to be car drivers.

Parallel Sessions WN9: case studies on physical activity and active living

Scope and purpose

This session presented case studies on the practical experience of cities in physical activity. Presentations took place in two rooms.

Copenhagen on the Move, Copenhagen, Denmark

The number of physically active Copenhagen residents has stagnated since 1991. A third of all Copenhagen residents are overweight (body mass index (BMI) exceeding 25). Almost one tenth of Copenhagen residents are obese (BMI exceeding 30).

Copenhagen on the Move aims:

- to make more Copenhagen residents physically active to combine efforts for better nutrition with physical activity interventions in order to prevent obesity;
- to ensure long-term and intersectoral cooperation and planning in the City of Copenhagen in order to achieve better results and more synergy in urban planning, education and the development of policies that promote physical activity; and
- to ensure that new interventions are based on the lessons learned and experience from former projects.

Three main strategies were used: knowledge, opportunities and action. The impact on the behaviour of a certain target group depends on the intervention’s ability to give the individual knowledge about why they should adopt the new behaviour. The individual must also be given some opportunities to act in the local environment and with the physical settings available there. This could be done with facilities or policies that support physical activity. Finally, the intervention needs to motivate the individuals to take action themselves.

An intersectoral steering committee has been established with representatives from each of the seven departments in the city. The steering committee will decide what specific intervention to implement, when and where, targeting predefined groups and activities.

Healthy urban planning to enhance opportunities for physical activity: the Admiral Park Project, Liverpool, England

The Admiral Park Project aims to use wasteland in Liverpool to create outdoor sport and activity facilities. The Project has created a new sports ground in the heart of the Toxteth area of Liverpool, which is one of the most deprived wards in the country. The case study gave an overview of the results of four years of work involving a unique partnership between three local regeneration agencies. The Project demonstrates how the Liverpool: Active City programme is creating ways in which people can be more active as a means of tackling obesity, preventing the onset and rehabilitating those with heart disease.

A partnership of local schools, Merseyside Police and Liverpool City Council has turned a local run-down area into a much-needed sports facility for the community, with phase 1 providing grass mini-pitches, athletic facilities and a multi-use hard court area for tennis, netball and basketball. This cost £290 000, with funding from Include, Liverpool City Council and the Neighbourhood Renewal Fund.

The success of the project led to an additional grant award of £180 500 from the National Football Foundation for a changing pavilion. The programme aims to expand: it has been recognized as an example of good practice and may be introduced to other areas.

The project clearly demonstrates the benefits of partnership working between organizations and increased access to physical opportunities in one of the most deprived areas of the city.

Active Stirling, Scotland

Scotland's Physical Activity agenda is guided by the national strategy Let's make Scotland more active adopted in 2003. In Stirling, the Stirling Community Planning Partnership Physical Activity Action Team takes forward the recommendations of this document at the local level. This group consists of staff from transport, public health, health promotion, sports and leisure, countryside, voluntary sector organizations and children's services. All partners have individual strategies and plans that have a relationship with physical activity. The Physical Activity Action Team brings these plans together and has developed several joint actions.

This has resulted in more efficient use of resources and effective outcomes and has explicitly recognized the positive impact these actions have on population health. This joint approach is described in documents such as the Stirling Council physical activity strategy (adopted in 2004) and deals with a wide range of major developments such as the new sports village, active schools and active commuting to school.

In practice, several joint actions have been developed. These include active urban design, walking and active citizenship in later years, midnight football, workplace lunchtime walking groups and play-at-home support services.

Dedicated physical activity and health resources are moderate and limited to particular services. However, raising partnership awareness of the impact all services can have on increased physical activity can transform combined resources into a significant pool of expertise, support, funding and commitment to design living communities, workplaces and facilities for active living.

Walking campaigns in Stockholm, Sweden

The Stockholm Diabetes Prevention Program for 1995–2004 has implemented models for community-based intervention. One objective was to increase physical activity in the target population, consisting of people aged 35–54 years not exercising regularly. Walking campaigns were implemented in a suburban area.

The strategy (intervention within the community) made it possible to address smaller subgroups of the population in certain settings such as residential areas. A project leader and the local health promotion authority had the responsibility for the campaigns in cooperation with a sports organization. Advertising in local mass media was used to recruit volunteer leaders. Twenty-seven volunteers were trained in a brief education programme. They then organized walking groups in several residential areas. Questionnaires designed to get information from both leaders and participants were used in three campaigns. Thanks to good urban design, the walking campaigns were easy to carry through.

About 5% of the inhabitants in the target population followed one or several groups. Those who participated 1–3 times a week were predominantly married women with good health and regular physical activity. One third of the participants had never been exercising regularly before. Several participants expressed that they found walking with leaders safe and stimulating. The voluntary leaders were remarkably easy to find and recruit.

It was expected that this model would attract people with less possibility to attend expensive exercise facilities as well as parents who prefer to remain near their homes. However, from a public health perspective, even this small change in habits can have a considerable population impact.

Innovative and enthusiastic people, fire-souls, can make the change: Turku, Finland

The case study focused on the importance of partnership, communication and research as well as practical examples of developing and implementing a successful active living strategy. Experience in Turku has identified several steps towards success. This includes:

- determining the important and various facts of physical activity;
- formulating a core message;
- analysing the local situation;
- developing a strategy and policy;
- implementing it; and
- monitoring and evaluating.

A strategic approach has been taken in Bergen, Glasgow, Liverpool and Turku. The proportion of people who engage in physical activity sufficient for their health has increased from 32% to 42% during the last 10 years in Turku. Implementation of an active living strategy requires services for diverse groups of sedentary people. These hard-to-reach groups differ: middle-aged men, girls, immigrants, frail elderly people etc. Horsens has developed theatre courses for overweight children, and Turku and Rotterdam have mobile containers in the neighbourhoods where people can borrow equipment etc.

Implementing a successful active living strategy also requires effective communication. Turku distributes a newsletter three times a year to each household. In Belfast the four active living weeks of walking, cycling, swimming and dancing get very good visibility.

City planning also plays a key role in active living. Turku and Bergen work with planners in making the schoolyards more attractive and conducive to physical activity. Counselling is also an important part of an active living strategy. In practice, exercise referrals or general practitioner prescriptions of physical activity are used in Stockholm, Glasgow and Turku.

Partnership is another key to success. Physical activity promotion requires a multidisciplinary approach in which sport, health, social welfare, youth, education and city planning departments, clubs and nongovernmental organizations work together.

Promoting healthy eating and active lifestyle choices in Udine, Italy

Nutrition and physical activity are fundamental to a sense of well-being and to meet the growth, development and activity needs of children and youth. School health programmes can help children and adolescents to attain full educational potential and good health by providing them with the skills and environmental reinforcement they need to adopt long-term, healthy eating behaviour. The City of Udine is trying to create supportive environments and establish patterns for healthy living through food and mobility policies.

Food policy includes two main projects: Melanch'io (for nursery school children) carried out both in Udine and in 15 municipalities of the regional network and Crescere Sani (for primary school children). The first aims at sensitizing children to simple and natural tastes, such as apples, through lovely and cheerful approaches (a booklet written in five languages and practical activities in class). The second encourages children to eat healthy and nutritious snacks, avoiding junk food. Both initiatives include evaluation phases and involve several stakeholders, including parents, teachers and public health professionals. The Going to School on Foot, by Bike, by Bus with Topo Topazio project focuses on increasing physical activity and sustainable mobility in schools.

An important aspect of these projects is the multisectoral and integrated approach adopted, involving strong collaboration between local authorities, health care services, schools, university and families. They have proven to be effective and meet citizen's needs. However, efforts will have to become more focused, including more formalized nutrition education and mass-media campaigns.

Becoming an active city, Stoke-on-Trent, England

In England, 32% of adults currently meet the Chief Medical Officer's minimum recommendations, undertaking 30 minutes of physical activity on at least five days a week. In Stoke-on-Trent, this is likely to be even less because of the levels of deprivation.

Locally, several strategies and projects have been developed in partnership to systematically tackle this problem and target and involve diverse social groups. Closing the Gap is a project that aims to give people 0–25 years old the same opportunity to enjoy the benefits of sport and recreation, focusing on those already experiencing or at risk of social exclusion. It will raise levels of participation and be a tool for working with this group to achieve a number of

objectives. It is a community-oriented, innovative pilot project with funding from Active England.

The GO5 Project aims to help people become more physically active by enabling health care professionals to refer clients to a 10-week programme offering up to five activities per week: gym visits, swimming and led walks for a maximum cost of £10. The project is based on a medical model and is evidence based.

The key lessons from the Stoke-on-Trent experience are that: partnership working is the key to success of these programmes; to achieve sustainable changes, organizational change is required to deliver programmes to those in greatest need; and a range of approaches is needed to increase physical activity.

Parallel Sessions WN10: working groups on physical activity and active living

Scope and purpose

The purpose of these sessions was to explore the role and commitment of cities in addressing physical activity and to make recommendations.

Participants were invited to describe the strengths and challenges involved in taking forward the implementation of physical activity objectives and priority themes within their cities. Working groups were asked to agree and propose three key recommended physical activity action commitments that all cities will deliver, to be included in the 2005/2006 action plan.

Common themes arising from the physical activity and active living workshops included the following.

- Some cities have little information or statistics on physical activity.
- Some cities are at an early stage in developing a strategy for physical activity.
- Even those with well-developed strategies reported lack of awareness among politicians and low levels of participation.
- Planning for choice – provide alternatives to car use and sedentary lifestyles.
- Radical plans can work if there is political commitment, such as London congestion charging.

Challenges

- Partnerships need to be developed across organizations and departments.
- Health professionals and urban planners need to be involved.
- Joint understanding of opportunities linking healthy urban planning and physical activity and active living need to be developed.
- Opportunities that already exist need to be promoted.

What can WHO do?

- Promote the WHO brand of healthy city tied to physical activity initiatives at the local level.
- Develop core indicators that cities can use for population profile and mapping of physical activity.
- Disseminate the evidence base and good practice.
- Provide evidence of the cost-effectiveness of interventions and developments that urban planners can use.
- Provide examples of good practice related to urban design for active living.
- Early guidance from WHO will help cities to achieve the milestone for their physical activity and active living report – July 2006.

Parallel Session WN11: meeting of coordinators of cities in the WHO European Healthy Cities Network

Chair: Joan Devlin

Purpose and scope

The role of healthy city coordinators is fundamental to how cities implement the requirements for Phase IV of the WHO European Healthy Cities Network. Healthy city coordinators are expected to interact with many sectors within the city, with senior politicians, with key decision-makers and with the community to support the healthy city work. This interaction requires multifaceted skills, and yet coordinators often operate within cities and countries with little peer or other support.

Some healthy city coordinators have been in their posts for a number of years and have a range of experiences of operating within cities that could be shared with existing and new coordinators. Action on common issues within the WHO European Network could strengthen support for coordinators.

The session focused on identifying the key challenges experienced by healthy city coordinators and recommendations for action by the Advisory Committee and WHO that will support coordinators in delivering Phase IV objectives.

Key discussion points

Coordinators are located in different sectors and departments. There are problems contacting and maintaining communication with different departments in some cities. Some cities have succeeded in establishing and maintaining strong links with sustainability teams and leading officers. Others succeed in communicating directly with the public.

A healthy city is not a political priority in some cities. City authorities change over time in terms of democratically elected leadership and senior officer roles. Coordinators need to survive these changes.

Awareness of healthy city work varies between cities. Some cities have achieved a good level of awareness and commitment across all their stakeholder groups. The city council resolution that commits cities to the objectives of the WHO European Network in Phase IV should help this.

Some coordinators find that they are not senior enough to have influence within city departments. Coordinators require sophisticated personal skills in developing relationships with key people.

Coordinators often have other responsibilities in addition to healthy city responsibilities, which places pressure on the time they can commit to healthy city activity. Coordinators are often challenged to manage excessive expectations, resulting in an unrealistic workload. Coordinators require time for reflection and listening to other people.

Several suggestions were made for support from WHO to aid coordinators in their role. This included producing an induction pack for new healthy city coordinators and updating Twenty steps for developing a healthy city. There was a request for an ongoing review on evidence demonstrating the links between healthy urban planning and physical activity and health outcomes, such as whether cycling adds years to life. There was also a request for an annual schedule of WHO guidance and support activities for coordinators and cities. A request was made that old literature currently available on the WHO Healthy Cities web site be transferred to the new web site.

The Advisory Committee should consider how it can facilitate support for new cities provided by the experienced older cities. The Advisory Committee could make available a list of cities and coordinators from which new coordinators can choose a coach or mentor coordinator.

WHO can help by informing all coordinators of new cities in the WHO European Network as they are designated. Every coordinator should receive a list of all subnetwork cities.

WHO and the Advisory Committee should consider opportunities to raise the profile of the healthy city movement in Europe linked to the 20th anniversary of the WHO Healthy Cities project in 2007. Activities could be organized to celebrate the successful impact of the movement and demonstrate its valid role in meeting future urban health challenges.

Budget for 2004/2005

Coordinators generally endorsed the budget report.

Coordinators were asked how much detail was necessary to keep their finance departments sufficiently informed as to how WHO is spending their fee contribution. Only one city's finance department had requested accountability regarding where money goes. In this context, a request was made that the budget report be simplified in a shorter format. In addition, the budget report should be accompanied by a WHO programme report highlighting what activity WHO has undertaken to support cities in the budgetary year.

On the issue of the delay of payment of city fees: some cities could not pay their fees until they become formally designated.

Draft action plan for 2005/2006

There was general consensus that the draft action plan was useful to encourage thinking about what will be achieved by the end of Phase IV. It was agreed that the template was a good tool, but some cities may require more time to agree on provisional commitments with their politicians and key stakeholders or partnerships.

Extension of Phase IV

There was general support for the idea of extending Phase IV by one year to the end of 2008. However, for some cities this may prove problematic in securing funds to pay the WHO European Network fee for an additional year, as this will require a new council resolution. Most cities will need a formal agreement. A letter from WHO to political leaders explaining the rationale for extending Phase IV would be helpful in facilitating these discussions and formal commitments at the local level.

A question was raised regarding the possibility of extending the deadline for designation application linked to the extension of Phase IV. Joan Devlin would raise this question in business session 2.

Parallel Session WN12: second politicians' session

Chair: Agis Tsouros

Presentations from mayors and politicians from Bursa, Sandnes, Sunderland, Sterling and Bologna addressed the questions of key challenges and benefits of healthy city engagement for politicians and identified ways to use their positions to strengthen support for and give more visibility to healthy city efforts. Challenges included: finding ways to engage all actors and stimulate action for health; making the case for health and establishing health outcomes as a barometer for development; and addressing inequality in all systems.

The benefits of the healthy city approach include: a common platform to bring actors together; bringing science and politics together; and health is everyone's business. Mayors and politicians in their leadership role can: proactively get things done; articulate a vision; provide incentives for action; give recognition to good work; engage the mass media; publicize issues; and create partnerships with nongovernmental organizations, business, associations, faith groups, etc.

The session also addressed the Statement of the Mayors and Political Leaders of the WHO European Healthy Cities Network and the Network of the European National Healthy Cities Networks. Amendments were proposed, discussed and agreed. The final draft was presented to the full plenary on the final day of the Business Meeting for formal endorsement by politicians.

This discussion was followed by an introductory film about Bursa visions and plans and a reception for politicians at the City Hall. Politicians were then taken on a tour of key urban developments that demonstrate the healthy city approach in action in Bursa.

Parallel Session WN13: second meeting of city urban planners

Chair: Hugh Barton

The purpose of this session was to exchange experience and knowledge about healthy urban planning, with a particular emphasis on the two priority areas of neighbourhoods and transport. Key health themes discussed included physical activity, mental well-being, social norms and values. Key spatial planning themes were:

- the degree to which populations in an area should be mixed;
- the nature of mixed use;
- the necessary level of density – or whether urban sprawl could work;
- safe, interconnected street networks; and
- the ownership and control of public space.

Urban planners are at very different stages in implementing the healthy urban planning approach and working within very different institutional contexts. Therefore, at this stage of Phase IV, there are no common healthy urban planning deliverables across cities. Nevertheless, two priorities were agreed for action that will support delivery of health and sustainability goals: the need for long-term planning (such as 25 years); and the need to increase the choices open to people in a range of fields (transport, housing, work, facilities and green space) and to ensure that in doing so, healthy choices are as easy as possible for all the people.

Parallel Session WN14: healthy ageing

Chair: Geoff Green

Scope and purpose

Healthy ageing is a core theme. The purpose of this session was to present an overview of the Healthy Cities approach to healthy ageing and strategy based on the Stockholm subnetwork meeting recommendations and an overview of city progress based on analysis of annual reports. An overview of the city health profiles for elderly people was considered and case studies were presented.

Health profile of older people: overview of submitted profiles (Geoff Green and Gianna Zamaro)

At the first meeting of the subnetwork in Stockholm in June 2005, cities made a commitment to produce a profile of their older citizens for the Bursa Business Meeting. The WHO European Healthy Cities Project Office circulated a template to assist the process. Only two cities submitted full profiles before the Bursa Business Meeting. These were used to illustrate the rationale behind the three sections of the template:

- demographics – population and health;
- access to health and support services; and
- the social picture – vulnerabilities and strengths.

In contrast to the “time bomb” perspective, subnetwork cities regard ageing as of a civilized society and older people as a resource for their cities.

One of the four objectives of the subnetwork cities is to “promote accessible health and social care services that support independence while providing, where needed, formal care for older people and support for their families and carers”. The healthy ageing template provides an opportunity for cities to provide a comprehensive summary of health, social and other indices for older people.

Data collected in the social picture of vulnerabilities and strengths illustrates the dynamic of ageing in subnetwork cities, identifying levers for positive change. The example of employment of older people was presented.

Some problems were noted in collecting data. Quantitative data were lacking:

- individual health-related data, such as the exact number of people living with a disability in the city;
- individual socioeconomic data: such as education, employment and job career, household composition, social support network and income; and
- lack of some process economic data (for internal and external comparison).

There were also problems in processing qualitative data:

- defining correct indicators;
- sharing meaning among different social actors; and
- comparing indicators among different cultural contexts.

Data must be collected, but commentary on the indictors is also important. A long list of indicators is useful at the local level, but comparison between cities requires choosing synthetic and effective indicators.

Healthy ageing in Sweden (Lars Andersson)

Lars Andersson introduced Sweden’s public health policy and the actions of the Stockholm County Council to promote good health among older people.

Sweden’s new public health policy aims to “create social conditions that will ensure good health for the entire population”. Under the policy, equity in health has a high priority and many sectors and players are responsible. The overall aim will be achieved by implementing initiatives in 31 policy areas related to 11 domains:

- participation and influence in society;
- economic and social security;
- secure and favourable conditions during childhood and adolescence;
- healthier working life;
- healthy and safe environments and products;
- health and medical care that more appropriately promotes good health;
- effective prevention against communicable diseases;
- safe sexuality and good reproductive health;
- increased physical activity;
- good eating habits and safe food; and

- reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

The Stockholm County Council seeks:

- to improve cooperation between actors in issues related to older people;
- to contribute to increased opportunities for older people to live an independent life with a good quality of life;
- to facilitate and stimulate the opportunities for older people to live an active life (physically, socially and intellectually);
- to support disease prevention and health promotion efforts focused on common health problems among older people such as falls, dementia and stroke; and
- to promote the best conditions for physical activity and food intake for older people who cannot manage this themselves any more.

Lars Andersson presented insight into the demography of the health profile for Stockholm County.

Interaction – towards an action plan, Belfast, Northern Ireland

Within Northern Ireland, several strategies developed recently focus on older people. There is limited evidence, however, that these policies deliver consistent action at the local level or of intersectoral working between government departments in addressing the wider health needs of older people. As an integral element of the Eastern Health Board's strategy for older people, Belfast Healthy Cities is leading the development of an intersectoral action plan to meet the specific needs of older people.

This is being developed within the framework of Investing for Health, the regional interdepartmental public health strategy for Northern Ireland, and under the umbrella of the Eastern Area Investing for Health Partnership. Investing for Health has three elements: developing the interaction plan; and developing a profile and a mapping exercise presenting a current picture of action from all sectors on the broad determinants of the health of older people. The action plan will centre around seven themes older people have identified as priority areas: transport, community safety, home safety, housing, income, health and well-being and community support networks. A draft action plan was launched at an event on 20 May 2005 to validate the content of the document and develop proposals and mechanisms for action. A mapping exercise providing a current picture of organizations' contribution to and action on older peoples' health and well-being was also presented at this event. This identifies the gaps on specific areas. Working groups are currently being established, including one that will carry out a profile of older people on the broad determinants of health. The final action plan is planned for early 2006.

Through this work, Belfast Healthy Cities aims:

- to raise the profile and make visible the health and well-being needs of older people within the public policy agenda;
- to encourage all sectors to engage in action that promotes independent living for the older population;
- to identify gaps in action and models of good practice and to encourage sectors to build on these; and
- to ensure that older people validate and assure the quality of the gaps and agreed action.

Healthy ageing in Ljubljana, Slovenia

The City of Ljubljana is working to achieve a better quality of life for its elderly population. Obligatory activities include a financial contribution towards living expenses in retirement homes for those who do not have enough income to pay the full price of institutional care. Ljubljana has six retirement homes with 1900 beds.

Service assistance at home is mandated by law. It includes social care of the individual in the case of disability, old age and some other cases when such care (domestic help, help with eating and help with hygiene) can replace institutional care before it is truly necessary. The Home Care Centre provides service assistance at home.

Many additional programmes for elderly people are led by nongovernmental organizations and public institutions chosen by the City of Ljubljana and paid through the city budget. The City Retirement Association is a network of 1500 volunteers, all of whom are retired and lead the programmes. They visit their members at home, providing counselling about legal questions, guardianship, placement into institutional care and other matters. They also advise about new legislation concerning older people. They organize leisure activities such as lectures, workshops, trips and competitions.

The Society for Education of the Third Age is more than 20 years old and includes 4000 members. The Society delivers its work at 50 different locations in the city. Activities include education of elderly people through study sessions, expert trips, research work, development of new programmes, education of new mentors to lead study sessions, publishing and other initiatives. The Anton Trstenjak Institution provides a specialist service of programmes to support quality ageing and good relationships across generations. The Institute provides training for companions to support older people; provides training for mentors for intergenerational groups to support quality ageing; initiates self-help groups; introduces voluntary work among lonely elderly people; and provides a social network of intergenerational programmes.

The Intergenerational Association for Quality Old Age in Ljubljana very successfully develops a network of social companionship for old and lonely individuals. Their activities include: organizing companionship for elderly people; organizing intergenerational groups; educating volunteers; and educating for counselling. The Local Association of Red Cross of Ljubljana and Diocesan and its Parish Caritas also support older people. Activities include: visiting elderly people in their homes and retirement homes; working with groups that provide assistance at home; and providing domestic help, help with hygiene and help with gardening. The Day Care Centre of the Papilot Institution provides care and security for elderly people, companionship, supervision and help.

In addition to all this, the City of Ljubljana provides financial aid for meals and distribution of meals to people older than 65 years who have limited incomes. The distribution is provided by the Retirement Homes.

Healthy ageing case study, Rijeka, Croatia (Romana Jerkovic)

The population of Rijeka is influenced by a progressive ageing trend. Numerous programmes, projects and initiatives in Rijeka meet the specific needs of older people and deal with particular problems that senior citizens might have. They are designed in cooperation with various institutions, such as social welfare, health, charity, cultural and educational institutions, municipal utility companies and citizen's associations.

The programmes involved are non-institutionally based. They include:

- various forms of aid and home care;
- a hello-help programme;
- counselling for elderly people (health and psychological and legal advice);
- a programme of nine clubs for elderly people;
- programmes of health care for infirm elderly people (osteoporosis, kidney diseases, cancer, diabetes, alcoholism, smoking and mental disorders);
- a project for preventing diseases of the circulatory system;
- promoting health by giving lectures to the citizens and publishing a free health gazette; and
- informing citizens about the pollen count by type of pollen and appropriate measures of precaution.

Apart from these programmes directed towards care for physical and mental health, numerous other programmes indirectly deal with health care for this population group. For example, public transport is free for people older than 65 years; free transport is organized in a specially adapted van for people in wheelchairs; psychological and social aid is provided for elderly people with different forms of disability; a programme of continuous computer literacy is organized; and entertainment nights and trips are organized.

An interest group for promoting the quality of life of senior citizens was formed during Phase III (1998–2003) of the WHO European Healthy Cities Network. It has been continuously launching and putting into effect various programmes of intergenerational projects.

Rijeka's social welfare programme provides additional protection for the most socially disabled population within the city. This programme entitles citizens to have more rights and more financial support than is provided by the government. Citizens learn about the range of help and funding criteria through a brochure (City of Rijeka – for Healthy Ageing) and a leaflet (City of Rijeka – the Social Welfare Programme). These are regularly updated and promoted by the local newspaper and local radio and TV stations and by the web site of the City of Rijeka (www.rijeka.hr).

Most of the programmes, projects and initiatives reflect the key principles of the healthy ageing approach. For example, the Association of Retired Persons in Rijeka aims to improve the living

conditions of retired people. They seek to improve the financial, social and cultural aspects of everyday life for older people. In 2005 the Association has 9385 members and has one full-time and eight part-time employees.

The members take an equal and active part in local government projects, with two representatives in the City Council and County Assembly and nine representatives in various committees of the City Council and County Assembly. Further, the members participate in the Rijeka Healthy City Project: in the auditing committee of the Project and in all the subgroups of interest. In addition, the members themselves set the guidelines for the Association, represent the Association in the community and design and promote its ideas and initiatives.

The City of Rijeka is developing a strategy based on a quality of life survey among elderly people and will create a profile of elderly people with indicators based on the shared experience of other European cities.

Conditions in Rijeka are very favourable for mainstreaming implementation of the principles that form a basis for healthy ageing. First, this implies firm political support, a good network of organizations that promote the activities and, above all, a general understanding of the approach, its objectives and its importance. Previous experience has shown that senior citizens are the ones who are aware of their own needs and possess the capacity to fulfil them. It is up to the rest of us to support them as much as we can, as their present is about to become our reality.

The condition of elderly people in Milan: interaction between social, housing and community problems

Studying healthy ageing in Milan means looking at society as a whole, by means of one of the most unusual and revolutionary processes for which the city is equipping itself. This means designing for healthy ageing through a healthy urban planning approach. It means planning for the 23% of the Milanese citizens who are older than 65 years old and their younger relatives: their children, who care for them every day and their grandchildren, who discover a privileged sphere of caring, growth, support and knowledge in their relationship with their elderly relatives.

It means looking at the subject of how citizens can live together without fear, trying to design spaces that are safe primarily because they are inhabited. It means reformulating how illness and the experience of frailty and limits exist in our cities, aware that these affect all citizens in different ways and to different degrees. Above all, it means ensuring, in design and planning, that the physical and social environment contributes to this weakness as little as possible and that, in contrast, it facilitates everyone's capacity for readaptation and freedom of choice.

Producing planning that is attentive to a society with a large number of elderly people means working on a dual front: that of social cohesion (the relationships between generations, between parts of cities and populations, etc.) and that of forms of housing (which include forms of accommodation with care but just as one possible configuration), seeking to keep these two sides of the question together.

The case study focused on:

- a reflection on the elderly population and its relations with other generations;
- a spatial structure and the areas on which the Milan Healthy City Project will focus over the next three years; and
- some possible research-action studies.

Parallel Session WN15: health impact assessment surgery

The surgeries complemented the health impact assessment teach-ins. Guidance was given that could apply to more than one healthy city and provided advice to individual cities about specific problems they have experienced when working on health impact assessment. The surgeries ran as open forums.

Parallel Session WN16: healthy urban planning surgery

This session focused on challenges faced by cities regarding the integration of health considerations into urban planning processes.

Parallel Session: media surgery

Facilitator: Franklin Apfel

The workshop comprised participants from several countries (France, Hungary, Japan, Latvia, the Russian Federation, Sweden and the United Kingdom) with various experience of media advocacy work. The workshop was interactive, with participants free to discuss examples from their own experience. The following points came out of the sessions.

- The point of media advocacy is to use the mass media to change policies that shape the choices, behaviour and perceptions of large numbers in the population – changing individual behaviour (the aim of social marketing) requires different approaches. Enhancing organizational image is seen as a secondary gain.
- Communication is a core public health capacity, and good communication is critical to the success or failure of any campaign.
- Media advocacy is a means to an end and should form part of an overall strategy, combined with other forms of campaigning (festivals, etc.).
- One of the benefits of proactive media work is that the organization gets to be seen as a good source for journalists and consequentially gets invited to put forth their messages around breaking news issues and other features on which journalists may be working. It particularly helps if the healthy city perspective is seen as a “different” viewpoint. If journalists can be persuaded that the healthy city approach or viewpoint is different, then they will come to you.
- Healthy cities have the advantage of having credibility as a source, with the extra advantage of having a good evidence base to back them up. Additionally, talking with the backing of WHO gives healthy cities both evidence-based credibility and the credibility that comes from having no vested interests.

- All participants felt this was an area in which healthy cities can have a comparative advantage, and further investment in it would yield good returns.

As to enhancing media advocacy skills, the questionnaire, distribution of books and sponsorship of the workshops put forth a strong message that this is a priority area. WHO can build on this by featuring this topic next year and supporting the development of subnetwork communication capacity.

Premila Webster and Alistair Lipp Health Profiles teach-ins

A teach-in on city health profiles

This session illustrated how to use indicators to look at inequality within a city and gave the participants information and ideas about how to identify and measure this inequality. Then participants discussed how various cities developed profiles and how they included citizen's views on health in the profiles as described within the HEPRO project.

Erica Ison Health Impact Assessment teach-ins

Community-led health impact assessment

During 2003–2004, Belfast Healthy Cities undertook two community-led health impact assessments. The key difference between health impact assessment and community-led health impact assessment is that the communities select the proposal to be assessed. The community-led health impact assessment process had several steps.

- Communities were identified that were willing to work on community-led health impact assessment. Organizations working at the local level helped gain community contacts.
- Community steering groups were established to support the work.
- Community profiles were produced – the steering groups were involved in finding and analysing data.
- Training was provided on health impact assessment and facilitation skills to all stakeholders, which built community cohesiveness.
- Stakeholders selected proposals using a screening tool.
- Meetings were held with decision-makers to inform them of the proposal selected and to ensure that they understood the purpose and benefits of health impact assessment.
- Stakeholder workshops were held to identify health effects (appraisal).
- Meetings were held to negotiate and report back to decision-makers.

Erica Ison, a leading expert in the United Kingdom on health impact assessment, advised on the work and developed the screening and appraisal tools used during workshops.

Having a wide stakeholder involvement throughout the process provided many benefits. Belfast Healthy Cities was able to gain a community perspective on the health effects of the proposals and to gain local views on the information collected for the community health profiles. There was an opportunity for networking, training and capacity-building for all stakeholders; community representatives were subsequently invited to participate in other health impact assessment processes carried out by government departments.

Challenges to engaging stakeholders in health impact assessment included:

- limited knowledge of health impact assessment;
- lack of experience and capacity by all sectors in conducting and implementing health impact assessment;
- health impact assessment appears complex;
- misunderstanding of the purpose of health impact assessment;
- the perceived relevance or profile of a proposal will affect participation;
- community apathy – poor experience of working with statutory organizations in the past; and
- health impact assessment not being a legislative requirement, unlike environmental impact assessment or equality impact assessment.

During 2005, Belfast Healthy Cities carried out a further three health impact assessment processes: two on urban regeneration plans and one on an air quality action plan for the city.

Health impact assessment of extending smoke-free environments: sharing the Brighton & Hove experience (Tom Scanlon, Lydie Lawrence and Terry Blair Stevens)

Following the report of the Chief Medical Officer for England and Wales on action to reduce harm to public health from second-hand smoking, the impact of the health, social and economic impact of extending smoke-free environments was assessed in Brighton & Hove, overseen by the Healthy City Partnership.

The integrated impact assessment of smoke-free environments had three parts:

- collating an up-to-date evidence base from the literature of the positive and negative impact (health, social and economic) of banning smoking in public places;
- a population survey (postal and web-based) of local views; and
- a formal consultation with the local business sector.
- The results have given impetus to local policy change. A Smoke-Free Charter demonstrating the city's commitment to becoming smoke-free was recently launched with cross-party political commitment.

Through the WHO European Healthy Cities Network, Brighton & Hove was invited to share the experience of health impact assessment. The lessons learned were presented at the annual meeting of the Réseau Francophone des Villes-Santé de l'OMS. This meeting led to further communication and exchange with colleagues in Geneva and Rennes. Communication with colleagues within the WHO European Healthy Cities Network has resulted in the continuing exchange of ideas and approaches to common issues, including health impact assessment. In particular, it has provided an opportunity to reflect and share experience on how best to tackle common public health issues in different political, cultural and social settings.

Experience of implementing health impact assessment in Helsingborg (Elisabeth Bengtsson)

This case study focused on how political awareness was raised and support secured for the use of health impact assessment in Helsingborg. As a member of the WHO European Healthy Cities Network and thus focusing on the priority themes, the City of Helsingborg started a process in 2004 of implementing health impact assessment into its municipal organization. A workgroup of technical staff from various departments set out the first steps. Very soon two political representatives from the Healthy City steering group were invited to join in.

The political influence created a change of direction, and common understanding of the decision-making process and the health impact assessment process was achieved. The political representatives have expressed personal fulfilment and engagement due to a sense of involvement from the beginning of the process. This support leads to further political discussions within various political organizations and boards and creates a wider political commitment towards the method.

Political representatives with executive rights and a mandate through the Healthy City steering group have found no problems in giving priority to health impact assessment. They realize that this method will clearly provide them with a basis for improving the political decision-making process.

Gaining political commitment requires inviting political representatives to participate in the implementation process at an early stage. Commitment is best achieved by early involvement in working groups, as ready-made plans and tools are not enough support for understanding the complexity of health impact assessment.

Health and environment impact assessment in Sandnes (Hans Ivar Sømme)

In 1990, the Sandnes City Council adopted Sandnes' first Environmental Plan, which emphasized the connection between health and the environment as well as a sustainable approach to conservation of nature. In 1995, the first Municipal Development Plan and the Environmental Plan were revised.

As a tool to ensure good follow-up, a checklist was then drawn up with control questions for assessing the health and environmental impact. The tool was expanded so it could be used in land-use cases, new public buildings and major private development projects. The method is based on experience gained by other municipalities with checklists for the evaluation of environmental effects. In Sandnes, this tool has been developed in cooperation with regional authorities and discussed in meetings with representatives from commerce and industry and voluntary organizations.

From 1995 to 2002, the checklist was used in connection with major issues and as a planning tool in the work with new land-use plans. During this period, checklists were not mandatory in all new land-use plans. In 2002, the Municipal Development Plan and the Environmental Plan were revised again. Health for all was incorporated as a separate in-depth area in the new Municipal Development Plan, and along with the Environmental Plan and other plans, this constitutes the Sandnes city health development plan. It was decided that the impact on health and the environment was to be consistently assessed and highlighted in certain issues such as land-use plans, major development projects, schools and playgrounds.

The Municipality of Sandnes has implemented a special management and control system (balanced scorecard) for continuous monitoring of development work and the provision of

services. The use of the checklist to assess health and environmental effects is one of the selected indicators in the balanced scorecard for Sandnes. In all cases concerning land use, the effects on health and the environment are to be assessed, and a checklist depicting the assessment with "+" and "–" plus brief comments to be attached to the case when it is submitted for political consideration. The impact on health and the environment is also to be explicitly discussed in the actual processing of the case.

The most difficult part is implementing the tool. The opportunities for successful implementation depend on the system's user-friendliness. Success requires a simple checklist with clear and easily available references to adopted objectives and rules. In Sandnes, environmental topics are well defined with clear objectives and easily available background data. For the health aspect, the Municipality needs to do more work in defining relevant indicators. According to the topics given priority in the healthy city work, these indicators will be related to young people's formative environment, housing conditions, security, old people, immigrants and disabled people.

Three pilot cases – introducing health impact assessment in Turku (Heini Parkkunen)

Nothing happens if you do not make the first move. Start from small, concrete pilot cases and find partners to collaborate with and help from experts. Be patient. Developing health impact assessment is one focus of Finland's Health 2015 public health programme, although health impact assessment is voluntary in Finland. STAKES (the National Research and Development Centre for Welfare and Health) collaborates with the Finnish National Healthy Cities Network, and they have introduced tools and support for the municipalities to develop health impact assessment.

The aim regarding health impact assessment in Turku is to introduce assessment and, later, integrate it into decision-making processes. The work has been supported by STAKES and the Finnish National Healthy Cities Network and is set as an obligation by WHO. This combination of incentives and directives is helpful. Turku has carried out three pilot cases in health impact assessment during 2003–2005. In each there has also been help from the sustainable development students and district partnership of the local Turku Polytechnic. The latter is community involvement carried out in the neighbourhoods, where the citizens are encouraged to participate and express their ideas.

The pilot cases were selected through the contacts of the Healthy City Coordinator. The first case was reviewing the alternatives for locating a cabin for youth in the suburban area and its effects on people of different ages and officials. As a result, the cabin was built in a location preferred by young people. The second case was assessing the administrative model of the district partnership. The results will be used in deciding how to continue with the future of community involvement. The third case assessed a revised city plan in one neighbourhood. As a result, the assessment process diminished people's concerns and fears towards the plan.

Plenary Session WN17: feedback from working group discussions and general debate

Chair: Joan Devlin

Health profile for the cities in the Baltic Sea region: the Baltic Profile (Heini Parkkunen and Mari Siimar)

Heini Parkkunen and Mari Siimar introduced the Baltic Profile (www.marebalticum.org). The WHO Collaborating Centre for Healthy Cities and Urban Health in the Baltic Sea Region, based in Turku, has produced a shared web-based health profile of healthy cities in the Baltic region. The idea of the Baltic Profile is to gather and make available information about the local health and well-being situation of healthy cities in the Baltic Sea region in a web site. The information will support decision-making on health promotion and well-being.

Coordinators wished to include qualitative and descriptive information about the healthy city work as well as statistical and survey-based indicators. The Baltic Profile is a story of city health, offering a wide range of information: statistics and surveys; experiences from healthy city activities; descriptions of the decision-making and operational environment; and citizens' viewpoints. The Baltic Profile includes the perspectives of individuals and communities and subjective and objective viewpoints that can inform city health development planning. It helps interested people in understanding the division of health and welfare information.

The division of information in the web site structure follows the scientific theories of human needs and resources. The Baltic Profile is an opportunity to learn from the experience and activities of other cities.

The Baltic Region Healthy Cities Association coordinates and administrates the profile and facilitates and helps the cities. The coordinators are experts on health promotion and in information on their cities. International and external experts will help in the future development.

Heini Parkkunen and Mari Siimar concluded by stating that the Baltic Profile enables information to be compared between cities. They proposed that the Baltic Profile model could be used for the whole WHO European Healthy Cities Network.

A delegate from Zagreb requested that such a model give priority to the use of the local first language on this type of web-based product.

Agis Tsouros commended the healthy cities in the Baltic states for their excellent work in developing the Baltic Profile. He noted that this tool offers cities an accessible means of learning from one another's experience and practice. He agreed with the proposal to extend the use of this kind of tool across all the cities of the WHO European Healthy Cities Network.

Synthesis of healthy urban planning and physical activity and active living (Terry Blair-Stevens)

Sessions WN6 and WN10 synthesize the discussions of the healthy urban planning and physical activity and active living workshops.

Agis Tsouros noted that many cities had developed well-thought-out strategies for physical activity and active living. All cities have a wide range of activities promoting active living. In response to calls for radical public health action to increase active living, Agis Tsouros noted that what is perceived to be radical change politically can often be accepted by everyone when it is being implemented. Agis Tsouros cited a number of examples to illustrate this, such as smoking bans in Ireland and Italy.

Agis Tsouros thanked the delegates for participating in the workshops and informed them that the workshops would directly contribute to the consultation process informing the first European ministerial conference on counteracting obesity to be held in Istanbul in November 2006.

WHO European Healthy Cities web site (Connie Petersen)

Connie Petersen introduced the new WHO European Healthy Cities web site and informed delegates that this has been under development for the past year. The new site contains new menu items. Its structure is simplified and allows more consistent navigation. Health topics have been expanded to include a wider range of related urban health topics, which are linked to relevant WHO programmes and to other relevant resources, agencies and institutions.

The new site enables users to directly link to individual city web sites. Cities should ensure that information on their web sites is up to date. Coordinators should also inform the WHO European Healthy Cities Project Office of changes to their city's web site or e-mail addresses.

The new web site will permit increased use of the password-protected area, as this is a rapid and cost-effective way to disseminate information. This facility greatly reduces the need to attach group information e-mails and will help to achieve a paperless WHO Healthy Cities office from 2006. The password-protected web site has enabled online registration and was a breakthrough for the administration of this meeting.

As the site is developed, it will include a publications catalogue with a picture of the front cover of each publication and a list of available language translations. The WHO Healthy Cities project has a rich catalogue of publications. No other programme in the WHO Regional Office for Europe has so many core documents translated into languages other than French, German and Russian. For the documents translated into languages other than French, German and Russian, users will be directed to web site links to download the documents.

Connie Petersen advised delegates that those who wish to translate WHO documents should seek permission from the WHO Healthy Cities Project Office before doing so. Cities translating the WHO health impact assessment toolkit into their national languages must sign a consent form. Cities should provide the web link for the health impact assessment toolkit on their local or national web site.

HEPRO: focus on health and social well-being in the Baltic Sea region (Richard Brattli)

- Richard Brattli explained how the national healthy cities networks in the Baltic Sea region have taken the initiative to carry out the INTERREG IIIB project HEPRO. The project will have a budget of about €2 million, and the project period is June 2005 until December 2007. The main objectives are:
- to integrate health considerations into spatial planning and development;
- to show how health profiles and environmental factors related to health can be used as a basis for a sustainable public health policy at the local and regional levels;
- to carry out a survey of the population's state of health in which data can be used across the national boundaries;
- to develop and implement training programmes in public health work aimed at various target groups in order to build understanding of spatial health planning and the use of local health profiles; and
- to raise awareness of European cohesion strategies and enhance understanding in rural districts and smaller towns about opportunities and challenges within the European Union.

The partnership comprises 32 partners from the European Union and Norway, including regions, municipalities and scientific institutions.

The anticipated effects of the project are improving the decision-making basis for setting priorities and the utilization of resources and strengthening the quality of and accelerating the progress of the public health work by providing and exchanging knowledge and common strategies across national boundaries. The project is innovative in relation to a traditional epidemiological model, as both health-promoting and positive health indicators are included, and health, environment and culture are viewed in context. The planned toolkit will be made available to countries in the Baltic Sea region and to the rest of Europe as well.

Feedback from the communication survey (Franklin Apfel)

Franklin Apfel explained the methods used in the communication survey and summarized key findings. Communications questionnaires were handed to most participants at the first session on 21 September 2005, and participants were requested to complete the questionnaire and return them to the Secretariat during the conference.

Participants returned 56 questionnaires: 25 from the 45 cities that are members of the WHO European Healthy Cities Network, 6 from the 12 cities that have applied for membership and 25 from observer cities (more than one received from some cities). Preliminary results were prepared and reported back to the conference on 23 September 2005. These results did not distinguish between the three categories of city. The results therefore reflect the position among all cities present at the conference.

Key findings were the following.

- Only half the cities have a communication plan.
- Most work with the municipal communication department.

- Less than half publish a newsletter.
- Most undertook three to six campaigns in the past year (the top topic was lifestyles, including tobacco, diet and nutrition, diet and exercise and alcohol).
- The top partner was other municipal departments, closely followed by nongovernmental organizations.
- Most cities issued six or fewer press releases in the past year.
- Seventy-five per cent held less than four press conferences (21% held none) in the past year.
- Most received fewer than 10 press enquiries from journalists in the past year.
- One person had the phone numbers of 34 journalists on a mobile phone.
- Most cities monitor public perceptions (78%).
- Half the cities have a crisis plan.
- Half the cities provide communication training to staff.
- Very few cities offer training to journalists.
- The three top measurable indicators of healthy cities were: smoke-free, fewer health inequalities and more green spaces.
- The three top visible indicators of improvement were: more no-smoking areas, walking and cycling and participation in sport.
- The top ambassadors for cities are mayors.

Franklin Apfel concluded that, although some cities are very engaged with the mass media and demonstrate strong communication capacity (such as Bursa), there appears to be substantial scope for strengthening media connectivity, especially in being considered a good source for health-related information.

Accessing European Union funding to support the delivery of the core themes of the WHO European Healthy Cities Network (Lydie Lawrence)

Lydia Lawrence explained that funding programmes and budget lines managed by the European Commission provide opportunities to obtain funding for the development of projects and activities initiated from European Union countries. With its established partnerships and subnetworks of European cities working together to achieve common goals and objectives, the WHO European Healthy Cities Network is ideally placed to explore these opportunities.

Several current and forthcoming programmes funded by the European Union could enhance and support the delivery of the core themes of Phase IV of the WHO European Healthy Cities Network: healthy urban planning, healthy ageing, health impact assessment and active living and future healthy city developments. In addition, existing projects funded by the European Union are being implemented within the WHO European Healthy Cities Network that can add value to the development of the objectives and core themes of Phase IV.

Lydia Lawrence suggested that it would be useful to create a list or map of current and proposed projects funded by the European Union related to Phase IV objectives undertaken by cities. She

concluded by encouraging cities in the WHO European Network to consider and express their interest in joint action on accessing European Union funding.

Agis Tsouros strongly supported this and suggested that the Advisory Committee address this. He advised that funding should be pursued systematically and that people should think laterally in interpreting the funding criteria. New European Union funding programmes require participation of a minimum of seven national partners. The WHO European Healthy Cities Network provides a ready-made transnational partnership.

Feedback from politicians' sessions (Agis Tsouros and Franklin Apfel)

Agis Tsouros reflected that the politicians' sessions provided an opportunity for mayors and leading politicians to share their experiences of taking forward healthy city development in their cities. Politicians would have benefited from having more time to discuss the important issues raised in the two sessions. The presence of Agis Tsouros and Hikmet Sahin (the Lord Mayor of the Metropolitan Municipality of Bursa) was welcomed and helpful. Agis Tsouros and Hikmet Sahin developed a strong professional relationship during the preparation for the integrated meetings, and this resulted in a very well-organized Business Meeting.

Agis Tsouros introduced the final draft of the politicians' statement. Several further revisions were requested to fully reflect discussions on this matter, which took place in the second politicians' session, WN12. This included emphasizing participation and empowerment of citizens in city governance; and including Healthy Cities national networks in the title of the statement.

Plenary Session WN18: WHO European Healthy Cities Network business session 2

Chair: Joan Devlin

Action plan 2005/2006

Six local action templates with provisional commitments were submitted during the Business Meeting proceedings. Examples of commitments from those received were added to the action plan as illustrations of deliverables at the local level. The action plan was adopted unanimously.

Budget

The budget was endorsed unanimously. Joan Devlin gave brief feedback from the coordinators' session, where a request was made for the budget report to be shorter.

Extension of Phase IV

Agis Tsouros explained that there had been requests to extend Phase IV by an additional year. He explained the rationale for this. Phase IV started later than planned, and extending Phase IV would give member cities until the end of 2007 to work on core themes and Phase IV deliverables followed by evaluation and a conference at the end of 2008. He stressed however that there was a need of formal approval by WHO top management before such an extension was official. Joan Devlin gave feedback from the coordinators' meeting, where it was highlighted that many cities would require a formal city council resolution to agree to participating in an

extended year of Phase IV. For some cities this would also mean negotiating an additional year's funding for fees and a local programme of action.

Agis Tsouros agreed to write to all politicians requesting that they discuss the extension of Phase IV with their local stakeholders and seek formal council resolutions in support of this. This proposal was adopted unanimously.

Clarification was also sought on whether or not the deadline for submission of applications would be extended. Agis Tsouros explained that the existing deadline would remain.

Signing of the Statement by the Mayors and Political Leaders

The revised version of the Statement by the Mayors and Political Leaders was presented to participants and endorsed unanimously. Politicians were invited in alphabetical order of city to sign the statement (Appendix 1).

General Rapporteur's report (Terry Blair-Stevens)

Summary of proceedings

Introduction to the City of Bursa

The City of Bursa has become a champion city for the healthy city movement. Hikmet Sahin, the Lord Mayor, has succeeded in mobilizing the whole city on applying healthy city principles and approaches throughout all city strategy and planning processes.

In attendance

The annual Business Meeting of the WHO European Healthy Cities Network has changed to a conference format to facilitate improved learning opportunities. More than 350 delegates attended, including national network representatives. This included representation from 41 of 45 cities in the WHO European Healthy Cities Network. Eighteen new cities have been designated since the last Business Meeting in Udine in 2004. Eleven applicant cities were present with 33 representatives. Forty-five leading city planners were present from the Member States of the WHO European Region.

Preparedness for emergencies and disasters

The participants heard how cities can be both strong and vulnerable and that cities must prepare for major emergencies and disasters. Poor and vulnerable people are disproportionately affected when emergencies or disasters occur. Local governments have a significant role to play in planning for safer, healthier and sustainable cities. This was reflected in the Statement by the Mayors and Political Leaders signed by all political leaders present.

Subnetworks

WHO continues to give commitment for the WHO European Healthy Cities Network. Three new subnetworks focusing on the themes of healthy urban planning, healthy ageing and health impact assessment have been established in the past year. These subnetworks provide guidance to all member cities on taking forward action to achieve the respective objectives for each theme.

Member cities of these subnetworks are also expected to demonstrate development at a faster pace of acceleration.

2005/2006 action plan

A draft action plan for 2005/2006 was presented for consideration and debate. The action plan was endorsed in the final business session of the meeting. The action plan outlines minimum levels of previously agreed and proposed actions on three levels.

Local minimum actions by member cities	Local minimum action to be taken on each core theme by all member cities of the WHO European Healthy Cities Network. These minimum actions will be reviewed and, where appropriate, expanded on a yearly basis.
European joint actions	Joint action by member cities of the WHO European Healthy Cities Network, the Advisory Committee, subnetworks and other associated groups or networks.
WHO	Action to be taken by the WHO Healthy Cities office in the form of guidance and technical support and capacity-building events.

The further action required at the joint European and local levels to maximize achievement of Phase IV objectives should be identified. This will enable WHO to capture and organize in one composite document the full range of deliverables expected by all the member cities and WHO.

Cities were encouraged to outline their provisional commitments for deliverables by the end of Phase IV using the local action template. Cities are encouraged to consult their key strategic bodies on the provisional commitments and to further define these.

Annual reporting template analysis

Feedback from the annual review of member cities' progress on core objectives was positive. The most important factor supporting cities in fulfilling their potential using the healthy city approach is high-level and cross-party political commitment. Cities are making good progress on all core themes.

Healthy urban planning

Healthy urban planning is about planning for people. Urban design has a social, environmental, economic and global impact. Health is a proxy for sustainable development. The scientific literature on urban sprawl, housing, residential environments, nature, obesity and income does not present clear evidence of whether and how urban design affects health. However, physical activity directly improves health, and good urban planning can create opportunities for citizens to participate in physical activity and active living. Urban planning can therefore potentially have a very positive impact on improved health outcomes.

Transport continues to directly contribute to global warming. Spatial planning can provide alternative options to car use. Design may encourage walking and cycling. Long-term strategic plans are needed. Health impact assessment is a useful tool in strengthening the healthy urban planning approach. Involving communities and the voluntary sector in urban planning processes is essential. Benefits can be achieved by streamlining planning and assessment processes, such as

strategic environmental assessment, environmental impact assessment, sustainability appraisal and health impact assessment. This will increase efficiency and is tactically and politically prudent.

The health sector needs to understand more about urban planning processes, and urban planners need to understand the health agenda. Several case study presentations reveal innovative healthy urban planning approaches in European cities.

Physical activity and active living

Physical inactivity is a leading risk factor for ill-health, with great societal costs. Obesity is a growing global problem. Physical activity and related health morbidity and mortality are unequally distributed within populations. Poorer people are less active and suffer greater health-related inequality.

The benefits of physical activity and active living are clear. The health sector cannot respond effectively to this challenge on its own. The Copenhagen on the Move campaign seeks to increase the proportion of people who regularly cycle to work from the already-impressive 34% to 40%. Urban planners are actively involved in designing cycling and pedestrian thoroughfares to support this modal shift. Copenhagen has a Mayor for Health who is responsible for coordinating city-wide strategic action for improving health and is promoted as a personal ambassador for healthy lifestyles.

Odense, Denmark has planned and targeted approaches to increase active living for people of all ages. Experience has demonstrated that sophisticated strategies and designing alternatives to car use are not sufficient on their own to motivate citizens to choose a more active lifestyle. Positive and sustained communication and campaigns are essential requirements of approaches to increase participation in physical activity.

The United States experience illustrates the pervasiveness of urban sprawl, characterized by low-density housing and high car use. Communities are often divided through poor urban design. Urban planners have a role in reconnecting neighbourhoods and communities. Specific groups within the community may have specific needs that urban planners need to address, such as young people, older people, women and ethnic minorities.

Active living should be part of people's daily lives and supported through good urban design. Collaboration between researchers and urban planners will help to strengthen the strategic and technical knowledge for developing urban planning approaches that present options for active and healthy lifestyles. This needs to be supported by rigorous evaluation and advocacy for policy change.

Healthy ageing

There was also a focus on healthy ageing through a plenary, case study presentations and workshops. Fourteen cities are participating in the healthy ageing subnetwork. All these cities are making good progress on fulfilling healthy ageing objectives. Urban planners need to consult with older people and involve them in city design to maximize access and facilitate active living.

Returning to Bursa

Terry Blair-Stevens concluded by commenting on how Hikmet Sahin and his colleagues had given participants an insight to the rich culture and history of Bursa. They had demonstrated generous hospitality. This successful Business Meeting hosted by the City of Bursa has facilitated new friendships and the development of a bigger healthy city family.

2006 Business Meeting

Agis Tsouros was pleased to announce that the City of Turku, Finland will host the next annual Business Meeting of the WHO European Healthy Cities Network. Agis Tsouros invited the Vice Mayor of Turku, Kaija Hartiala, to welcome delegates to Turku in 2006. Kaija Hartiala introduced a short film that gave delegates insight into their experience in Turku next year.

Closing the meeting of the WHO European Healthy Cities Network

The closing ceremony included the announcement of the results of Healthy Cities photography and painting competitions. The City of Bursa organized two local competitions, one with children's paintings and the other photography. A local committee chose the winners. Hikmet Sahin presented certificates to the winners. In parallel, WHO launched an international photography competition. Nine cities submitted 20 photographs, from which the City of Brno was selected as the winner.

In his closing remarks to the Business Meeting, Agis Tsouros noted that this Meeting presented new ways to share experiences and practice and made decisions quickly. Delegates had been given insight into the evidence base that informs strategy and practice towards achievement of shared goals. He encouraged delegates to consider the science with a sense of reality: that this should account for culture and personal circumstances.

Agis Tsouros affirmed that the Healthy Cities movement was a strong and cutting-edge approach. The implementation of the 2005/2006 action plan and provisional and full city commitments will capture the rich diversity of actions and experience of cities in the WHO European Network.

WHO continues to be committed to the WHO European Healthy Cities Network and will increase support by providing more tools, guidance and support.

Agis Tsouros expressed his thanks to Hikmet Sahin and everyone who had been involved in preparing and organizing the Business Meeting of the WHO European Healthy Cities Network.

Hikmet Sahin thanked delegates for their participation and thanked his colleagues for their hard work in preparation the successful Business Meeting. Hikmet Sahin declared the meeting to be closed.

Sessions of the Network of the European National Healthy Cities Networks

Plenary Session NN1: Network of the European National Healthy Cities Networks Business Session 1

The agenda for the Business Meeting of the Network of the European National Healthy Cities Networks comprised five main items:

- the Network's strategy and action plan for 2005–2007;
- working with ministries of health and contributing to the planning and implementation of national health policies and programmes;
- working on common themes in Phase IV;
- developing the evidence base for healthy city work; and
- expanding Healthy Cities in the WHO European Region and developing links with international agencies and the global Healthy Cities movement.

In preparation for the Business Meeting, national network coordinators had been asked to answer a set of web-board questions; 25 national coordinators answered these questions. These covered the issues of cooperation with national governments, communication and contact with the mass media, core themes, health planning, evaluation and partners. Zoe Heritage presented the feedback. The future priorities reported were health profiles, communication, ageing, planning, implementation of national goals and health impact assessment.

Richard Brattli, chair of the Advisory Committee of the Network of the European National Healthy Cities Networks, reported on the activities of the Committee during 2005 and introduced the revised paper on accreditation of national networks and an amendment to the current procedures of electing members to the Advisory Committee. Members of the Advisory Committee for one year have been Richard Brattli (Norway, Chair) and Mirieme Ferreira (Portugal); members for two years have been Algimantas Kazemekaitis (Lithuania) and Igor Krampac (Slovenia). It was decided not to change the members but to change the election periods from one year to two years and from two years to three years and also to allow members to be re-elected if they wished to stand for election again.

Agis Tsouros introduced the draft strategy and action plan developed by WHO and the Advisory Committee defining strategic and operational priorities from 2005 to the end of 2007 (which coincides with the scheduled completion of Phase IV of the WHO European Healthy Cities Network).

- The following were the stated strategic goals for 2005–2007:
- to strengthen the strategic capacity of national networks to promote full commitment to the goals of the Healthy Cities project and to provide leadership and guidance for this purpose;
- to strengthen the links between national networks of healthy cities and health ministries and to influence national health policies;
- to promote and support work on healthy ageing, physical activity, health impact assessment and healthy urban planning;

- to promote and support evaluation and evidence-based development of the work of national networks of healthy cities;
- to introduce Healthy Cities in new countries in south-eastern and eastern Europe;
- to strengthen cooperation links with international bodies and agencies: the European Commission, Council of Europe, Organisation for Economic Co-operation and Development and the European networks of local authorities; and
- to strengthen links with the global Healthy Cities movement.

Plenary Sessions NN2 and NN4: the national-local perspective – working with health ministries and contributing to the planning and implementation of national health policies and programmes

Sefik Kutlu (Turkey), Kristiina Poikajärvi (Finland), Bengt Sundbaum (Sweden) and Begona Merino (Spain) gave presentations on the national-local perspective in the work of national networks. The web-board answers (Zoe Heritage's presentation) showed that only five national networks had national government representatives in their network. Some of them are from health ministries.

The strategy and action plan emphasizes increasing collaboration with health ministries. This is a key strategic issue for the future development of national networks. Representatives from health ministries had been invited to attend the Meeting, and a special session was devoted to this issue. Representatives of the health ministries of Cyprus, Spain, Turkey and Ukraine and representatives of the national health agencies of Finland and Sweden were present. The question of how to get ministries involved in the meetings and working with the national networks was addressed in small groups. Some national coordinators said that they do not have any kind of permanent contact people in the ministries, which seems to be a critical issue in collaboration. Turkey's Ministry of Health instead of WHO had sent the invitations to ministries. Participants felt that it is also important to have an official invitation from WHO. In addition, the ministry representatives should have a clear role and a more specific meeting agenda, which they might find more attractive. There were also suggestions that WHO should restart visits to health ministries, and national networks should participate in these visits. Julia Taylor suggested that national network representatives should participate at the annual session of the WHO Regional Committee for Europe.

Plenary Session NN5: developing the evidence base of healthy city work

Agis Tsouros emphasized that Healthy Cities cannot have a sustainable future without developing a robust evidence base, demonstrating the difference it can make and the added value it brings to health development efforts in countries and cities. Evelyne de Leeuw gave a video presentation on the concept of healthy city evaluation approaches, which was followed by three case studies by the national networks of Israel, Slovenia and Japan on evaluating aspects of healthy city work. Selma Sogoric gave an overview of evaluation activities in national networks. Evaluation is one of the least systematically developed aspects of Healthy Cities. Zoe Heritage's presentation about web-board answers showed that only 10 networks had conducted evaluation. Geoff Green, Alistair Lipp, Premila Webster and Zoe Heritage presented insights from the evaluation of Phase III of the WHO European Healthy Cities Network. The objective in the future is to start developing a common plan for documenting and evaluating the work of national

networks of healthy cities and their member cities in Europe. Annual reporting to the Network of the European Healthy Cities Networks is an important aspect of this process.

Plenary Session NN7: Network of the European Healthy Cities Networks Business Session 2

The proposed strategy and action plan was accepted as well as the revised accreditation papers. WHO and the Advisory Committee will take into account the comments they received from national coordinators about the strategy and make amendments accordingly.

Three new subnetworks have been established under the WHO European Healthy Cities Network on healthy ageing, healthy urban planning and health impact assessment. It was agreed that selected representatives from national networks are also allowed to join subnetwork meetings and especially training events and courses. National network representatives requested information about planned subnetwork meetings for budgeting purposes.

It was decided to continue to use the web-board; it was considered useful and good but might include too many questions. It was felt that it was a particularly effective means for discussion rather than for collecting information. Questions need to be short and preferably open-ended. Richard Brattli's presentation of the electronic newsletter of the Norwegian Healthy Cities Network was appreciated. It was regarded as a good tool for the whole Norwegian Network but needs a permanent editor, and the texts need to be edited (summaries and key points). Richard Brattli will prepare a proposal about the use of a common electronic platform for the newsletter. The issues of fees for national networks and the reactivation of the EURONET Association were not discussed because of lack of time.

The WHO accreditation certificate to the Turkish Association of Healthy Cities was presented to Hikmet Sahin, the President of the Association and Lord Mayor of Bursa.

The Meeting was concluded with thanks and appreciation by Agis Tsouros and Hikmet Sahin, the Lord Mayor of Bursa.

Appendix 1: Statement

STATEMENT

Designing Healthier and Safer Cities: the Challenge of Healthy Urban Planning

Statement by the Mayors and Political Leaders of the WHO European Healthy Cities Network
and
the Network of the European National Healthy Cities Networks

23 September 2005, Bursa, Turkey

Dedicated to promoting health and sustainable development through improving the living conditions and quality of life of all our citizens, we, the Mayors and Political Leaders of the WHO European Healthy Cities Network, declare that:

We are becoming increasingly aware that the policy decisions we take can have a positive or a negative impact on the physical and mental health and well-being of our citizens and on the social capital and vibrancy of our communities.

We are ready to put health considerations at the heart of all urban planning and to generate political commitment and resources to achieve this goal.

We acknowledge scientific evidence that good urban spatial planning can shape people's health by designing environments that address key determinants of health by providing:

- **opportunities for healthy active lifestyles (especially regular exercise);**
- **access to affordable, high-quality housing;**
- **opportunities for social cohesion and supportive social networks;**
- **access to diverse employment opportunities;**
- **access to high-quality facilities and public goods (educational, cultural, leisure, retail, health and open space);**
- **opportunities for local food production and healthy food outlets;**
- **accessible, environmentally sound and safe transport systems;**
- **an attractive environment with acceptable noise levels and good air quality;**
- **good water quality, sanitation and waste disposal;**
- **reduction in emissions that threaten climate stability;**
- **emergency planning and community safety; and**
- **equity and reduction in poverty.**

We also understand that success will require close cooperation between health and planning agencies; robust partnerships with public, private and voluntary sectors; active and democratic citizen participation processes; and strong political support from the top tier of the city government.

Recognizing our key advocacy and leadership role in addressing these determinants that influence the health of our citizens, we therefore commit ourselves to the following objectives and priority actions:

1. **raising local awareness and creating a common understanding of the concept of healthy urban planning and all that it implies as key to changing practice;**
2. **gaining local practical experience from the application of healthy urban planning principles and approaches in the following five priority areas:**
   - **transport and mobility**
   - **healthy ageing and accessibility**
   - **urban design and physical activity**
   - **neighbourhood planning**
   - **long-term strategic and master plans; and**
3. **mainstreaming healthy urban planning through appropriate and feasible institutional and technical solutions.**

We call upon our fellow Mayors in the wider healthy cities networks across Europe and beyond to follow our example and take up the challenge of healthy urban planning, to promote solidarity and cooperation and to share knowledge and experience.

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