IMPLEMENTATION FRAMEWORK FOR PHASE VII (2019–2024) OF THE WHO EUROPEAN HEALTHY CITIES NETWORK:

GOALS, REQUIREMENTS AND STRATEGIC APPROACHES

FINAL

Implementation framework for
Phase VII (2019–2024)
of the WHO European Healthy Cities Network:
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ABSTRACT

This document outlines the overall goals and development themes of Phase VII (2019–2024) of the WHO European Healthy Cities Network and explains the application process for cities and national networks interested in joining this Network.

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Background

The launch of Phase VII of the WHO European Healthy Cities Network presents a unique opportunity for our 30-year-old movement. There is a growing global consensus on the need to tackle urgent common and interlinked challenges affecting our countries, cities and communities. We face increasing calls for more sustainable economic and social development models; the increasing impact of climate change and environmental challenges; a growing noncommunicable disease burden; challenges and opportunities created by ageing populations and increasing movements of people; the impact of new technologies on many aspects of public and community life; increasing inequities in health; and other health and security challenges. These trends and shifts are driving major regional, national and local debates on ways to ensure that values-driven decision-making is central to economic and social development planning, and to redesigning and reconfiguring approaches to health and well-being.

To address this changing health landscape, in September 2012 countries of the WHO European Region agreed on Health 2020,[1] a new common European policy framework for health and well-being now being implementing across the Region. The Network was a strategic vehicle for implementing Health 2020 at the local level in Phase VI.

Two further developments provide renewed opportunities. First, the adoption of the United Nations 2030 Agenda for Sustainable Development[2] by all countries of the United Nations in September 2015 was a call for transformative action, more partnerships and a values-based approach to sustainable development in a globalized world. Second, the adoption of WHO's Thirteenth General Programme of Work (GPW13) *Promote health, keep the world safe, serve the vulnerable*[3] in May 2018 created a framework for renewed partnership between the cities of the Network and WHO.

Local action and the decisions of local governments can strongly influence all of the public health challenges noted above, as well as many of the determinants of health. Healthy city leadership is more relevant than ever.

Changing cities to improve health and well-being

Two thirds of the Region's population live in urban environments, which can provide opportunities for individuals and families to prosper and promote health through enhanced access to services, culture and recreation. Yet, while cities are the engines of economic prosperity and often the locations of the greatest wealth in the country, they

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[1] Health 2020. A European policy framework for health and well-being. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf, accessed 9 February 2019).

[2] Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations; 2015 (https://sustainabledevelopment.un.org/post2015/transformingourworld, accessed 9 February 2019).

[3] Draft Thirteenth General Programme of Work, 2019–2023. Geneva: World Health Organization; 2018 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1, accessed 9 February 2019).

can concentrate poverty and ill health. High levels of pollution and social isolation can also characterize cities as unhealthy places to live. Below are several examples of health risks that can be exacerbated by urban environments.

- **NCDs:** A total of 63% of global mortality can be attributed to noncommunicable diseases (NCDs). Risks include physical inactivity and obesity as well as transport-generated urban air pollution, which can lead to cardiovascular and pulmonary disease. Indoor air pollution increases the risk of ischaemic heart disease, cancer and asthma. A total of 1.4 million Europeans die prematurely each year because of polluted environments, corresponding to 15% of Europe's total annual deaths. Physical inactivity is responsible for 1 million deaths in the Region every year.

- **Child poverty:** In high-income countries, one child in five still lives in poverty, and one in eight lives in food insecurity. Many countries have used social transfers in the form of welfare benefits to alleviate this, and these are often determined and delivered at the local level by municipalities. In high-income countries, social transfers can reduce child poverty by 40%. The most impressive results have been seen in Finland, Iceland and Norway, where rates of child poverty have fallen by up to two thirds since 2008.

- **Childhood obesity:** Defined as a form of malnutrition, obesity is increasing in the children of almost all countries of the Region: among children aged 11 years, one in three is overweight or obese. Schools, which are often governed by local authorities, play a crucial role in influencing children's diets through school meals and nutrition education, and by limiting or banning the advertising and marketing of energy-dense, nutrient-poor foods and drinks at school.

- **Road traffic injuries:** A total of 92 492 people die every year from road traffic injuries in the Region, and half of these are pedestrians, cyclists or motorcyclists. Good city planning can improve road safety with measures such as better pedestrian crossings, separate cycle lanes and locally determined speed limits.

City living can affect health through the physical and built environment, the social environment, and access to services and support. Quality of housing, neighbourhood design, density of development, mix of land uses, access to green space and facilities, recreational areas, cycling lanes, air quality, noise, and exposure to toxic substances have been shown to affect health and well-being in many different ways. Some circumstances of urban life – especially segregation and poverty – contribute to and reinforce discrepancies by imposing disproportionate exposure to unhealthy and socially undesirable patterns of response to economic and social deprivation.

In recent years, cities have faced the consequences of a changing social landscape, including population ageing, migration, poverty and growing inequalities, as well as

climate change and the need for physical and social resilience. Urbanization is set to continue, and planning this expansion with health and well-being in mind will save lives.

Most local governments in the Region have a general duty to promote the well-being of their citizens and to provide equal access to municipal resources and opportunities. Cities can achieve this through their influence in several domains, such as health, social services, the environment, education, economy, housing, security, transport and sport. Intersectoral partnerships and community empowerment initiatives can be more easily implemented at the local level with the active support of local governments. Cooperation through national Healthy Cities networks allows cities to partner with national-level ministries and actors to facilitate, support and enable local action by building vertical coherence across levels of government.

Cities significantly influence people's health and well-being through various policies and interventions, including those addressing social exclusion and support; healthy and active living (through, for example, the creation of cycling lanes and smoke-free public areas); safety and environmental issues for children and older people; working conditions; climate change preparedness; exposure to hazards and nuisances; healthy urban planning and design (through, for example, neighbourhood planning, removal of architectural barriers, and improvement of accessibility and proximity of services); and participatory and inclusive processes for citizens.

Phase VII builds on the Network's 30 years of experience, which provides an excellent foundation to meet challenges and opportunities in the current global context.

Copenhagen Consensus of Mayors: Healthier and Happier Cities for All

The Copenhagen Consensus of Mayors[4] was adopted at the WHO European Healthy Cities Network Summit of Mayors at UN City in Copenhagen, Denmark, in February 2018. It sets out a transformative approach for creating safe, inclusive, sustainable and resilient societies. Its vision aligns fully with the 2030 Agenda and the GPW13, and serves to guide the work of Healthy Cities up to the year 2030. This document marks Part 1 of this vision (2019–2024). A review is planned for the end of this period to evaluate and assess actions and priorities for Part 2 (2025–2030).

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[4] Copenhagen Consensus of Mayors: Healthier and Happier Cities for All. Copenhagen: WHO Regional Office for Europe; 2018 (http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/who-european-healthy-cities-network/policy/copenhagen-consensus-of-mayors.-healthier-and-happier-cities-for-all-2018, accessed 9 February 2019).

The Copenhagen Consensus of Mayors commits cities to the following statements.

- Healthy Cities foster health and well-being through governance, empowerment and participation, creating urban places for equity and community prosperity, and investing in people for a peaceful planet.
- Healthy Cities lead by example, tackling inequalities and promoting governance and leadership for health and well-being through innovation, knowledge sharing and city health diplomacy.
- Healthy Cities act as leaders and partners in tackling our global public health challenges, including NCDs, communicable diseases, environmental challenges, health inequalities, antimicrobial resistance, health emergencies and the pursuit of universal health coverage.

Box 1. The Copenhagen Consensus of Mayors

Phase VII core themes are based on the six themes of the Copenhagen Consensus of Mayors:

- investing in the **people** who make up our cities;
- designing urban **places** that improve health and well-being;
- promoting greater **participation** and partnerships for health and well-being;
- improving community **prosperity** and access to common goods and services;
- promoting **peace** and security through inclusive societies; and
- protecting the **planet** from degradation, including through sustainable consumption and production.

These six themes are not discrete areas of action, but rather interdependent, indivisible and mutually supportive processes. In order to achieve each one, they must be tackled together.

WHO Thirteenth General Programme of Work, 2019–2023

All WHO Member States adopted the GPW13 at the World Health Assembly in Geneva, Switzerland, in May 2018. The GPW13 affirms that governance for health and multisectoral action are both crucial for achieving universal health coverage in Member States; achieving Sustainable Development Goal 3 on health and well-being, as well as other health-related Goals; designing, implementing, monitoring and evaluating national health policies, strategies and plans; setting strategic priorities; and achieving strategic organizational shifts. It explicitly recognizes the key role of municipal governments in the promotion of health in all policies.

In order to meet the objectives set out in the GPW13 and to achieve impact on a triple-billion scale (see Box 2), countries must have systems that facilitate the improvement of the health and well-being of the people living in, visiting and passing through them. The Network is experienced and well positioned to act as a partner, vehicle and platform to strengthen WHO's impact at the local level: as a partner in the implementation of the

GPW13; as a vehicle to drive it forward at the local level; and, through national Healthy Cities networks, as a platform to build capacity and impact at local and national levels. The three key areas of the GPW13 – promote health, keep the world safe and protect the vulnerable – fully align with the work of the Network and the themes of Phase VII.

Box 2. The triple-billion goals of the GPW13
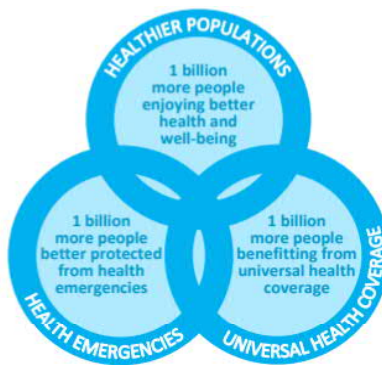
United Nations 2030 Agenda for Sustainable Development

All 193 Member States of the United Nations adopted the 2030 Agenda at the United Nations Sustainable Development Summit in New York, United States of America, in September 2015. The 2030 Agenda calls for bold, transformative action to ensure no one is left behind. It consists of 17 ambitious Sustainable Development Goals (SDGs) that are mutually reinforcing and indivisible (see Box 3), and provides the first unified global plan for sustainable development applicable to developing and developed countries alike. While Goal 11 explicitly recognizes the urban dimension of sustainable development, all are relevant to life in cities and fully align with the work of the Network.

The 2030 Agenda also aligns with Health 2020, which builds on the legacy and experience of the Region and the values and principles enshrined in the Health for All policy framework,[5] the Ottawa Charter for Health Promotion,[6] the Tallinn Charter: Health Systems for Health and Wealth,[7] Health 21[8] and declarations adopted at ministerial conferences on environment and health. Health 2020 recognizes the importance of action

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[5] The Health for All policy framework for the WHO European Region. 2005 update. Copenhagen: WHO Regional Office for Europe; 2005 (http://www.euro.who.int/__data/assets/pdf_file/0008/98387/E87861.pdf, accessed 9 February 2019).

[6] Ottawa Charter for Health Promotion. Ottawa: World Health Organization; 1986 (https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion/charter.pdf, accessed 9 February 2019).

[7] Tallinn Charter: Health Systems for Health and Wealth. Tallinn, WHO Regional Office for Europe; 2008 (http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf?ua=1, accessed 9 February 2019).

[8] Health 21. Health for all in the 21st century. Copenhagen: WHO Regional Office for Europe; 1998 (http://www.euro.who.int/__data/assets/pdf_file/0003/88590/EHFA5-E.pdf, accessed 9 February 2019).

at the local level and the central of role local governments in promoting health and well-being.

Box 3. The 17 Sustainable Development Goals

The SDGs are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. They build on the successes of the Millennium Development Goals while including new areas such as climate change, economic inequality, innovation, sustainable consumption, and peace and justice, among others. The SDGs are interconnected and require multisectoral and intersectoral action – the key for achieving any single SDG will involve tackling issues commonly associated with others.

Goal 1: No poverty
Goal 2: Zero hunger
Goal 3: Good health and well-being
Goal 4: Quality education
Goal 5: Gender equality
Goal 6: Clean water and sanitation
Goal 7: Affordable and clean energy
Goal 8: Decent work and economic growth
Goal 9: Industry, innovation and infrastructure

Goal 10: Reduced inequalities
Goal 11: Sustainable cities and communities
Goal 12: Responsible production and consumption
Goal 13: Climate action
Goal 14: Life below water
Goal 15: Life on land
Goal 16: Peace, justice and strong institutions
Goal 17: Partnerships for the Goals

Cities are uniquely placed to provide leadership for health and well-being. In the complex world of multiple tiers of government, numerous sectors, and both public and private stakeholders, local governments have the capacity to influence the determinants of health and inequities (see Box 4).

Box 4. The influence of cities on health, well-being and equity

- **Regulation:** Cities are well positioned to influence land use, building standards, and water and sanitation systems and to enact and enforce restrictions on tobacco use and occupational health and safety regulations.
- **Integration:** Local governments are capable of developing and implementing integrated strategies for health promotion.
- **Intersectoral partnerships:** Cities' democratic mandate conveys authority and sanctions their ability to convene partnerships and encourage contributions from many sectors.
- **Citizen engagement:** Local governments have everyday contact with citizens and are closest to their concerns and priorities. They have unique opportunities to partner with the private and not-for-profit sectors, civil society and citizens' groups.
- **Equity focus:** Local governments can mobilize local resources and deploy them to create more opportunities for poor and vulnerable population groups, and to protect and promote the rights of all urban residents.

The Network is a key partner, platform and vehicle for delivering on regional and global agendas. It provides opportunities for increased collaborative leadership across levels of government to gain improved equitable and sustainable development, with equitable health and well-being outcomes at all levels.

Overall goals of the WHO European Healthy Cities Network

Since its founding in 1988 and throughout its 30 years of activity, the Network has been an active and vibrant process and a platform for inspiration and learning for European cities working to contribute to equitable health and well-being. Six strategic goals underpin its work, and they remain as central today as when they were established (see Box 5).

Box 5. Strategic goals of the WHO European Healthy Cities Network

- To promote action to put health high on the social and political agenda of cities
- To promote policies and action for health and sustainable development at the local level that emphasize addressing the determinants of health, equity in health and the principles of the European policies Health for All and Health 2020
- To promote intersectoral and participatory governance for health, well-being and equity in all local policies and integrated planning for health
- To generate policy and practice expertise, good evidence, knowledge and methods to promote health in all cities in the WHO European Region
- To promote solidarity, cooperation and working links between European cities and networks of local authorities, and partnerships with agencies concerned with urban issues
- To increase the accessibility of the Network to all European Member States

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Phase VII framework

The Phase VII framework is shaped around the themes presented in the Copenhagen Consensus of Mayors, which was developed under the leadership of the Political Vision Group. The WHO Regional Director for Europe appointed the Political Vision Group, made up of mayors and politicians from across the WHO European Region, in 2016 to oversee the development of the Network's vision for its next phase of work. This process involved 18 months of regional consultation, including through meetings and written correspondence.

The Copenhagen Consensus of Mayors is inspired by and aligned with Health 2020, the 2030 Agenda and the GPW13. The adoption of the *Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy, for health and well-being*[9] by all 53 European Member States in 2018 provides a supportive and encouraging environment for implementing Phase VII locally. All of these documents recognize the important role of local governments in developing health, and all focus on whole-of-government and whole-of-society approaches.

Phase VII is an adaptable and practical framework for implementing the Copenhagen Consensus of Mayors at the local level. It provides a unique platform for joint learning and the sharing of expertise and experience between cities, at the subnational level and within countries. It recognizes that every city is unique and will pursue the overarching goals and core themes of Phase VII according to its situation. In delivering on the 2030 Agenda, the GPW13 and Health 2020, Phase VII will support and encourage cities to strengthen their efforts to bring key stakeholders together to work for health and well-being, harnessing their potential for innovation and change and resolving local public health challenges.

Phase VII asserts that the equitable and sustainable development of cities and the community prosperity of urban populations depends on our willingness and ability to seize new opportunities to enhance the health and well-being of present and future generations.

Transition from Phase VI to Phase VII

The seamless transition from Phase VI to Phase VII offers practical pathways to address current and emerging challenges in cities. Phase VII offers a broad scope as well as specific priorities, and promotes flexibility in decision-making related to these priorities.

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[9] Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy, for health and well-being. Copenhagen: WHO Regional Office for Europe; 2017 (http://www.euro.who.int/__data/assets/pdf_file/0008/345599/67wd09e_SDGroadmap_170638.pdf?ua=1, accessed 9 February 2019).

The WHO Regional Office for Europe will support Phase VII as a key vehicle for implementing global objectives and regional public health priorities at the local level.

Key action principles

Political commitment remains fundamental to implementation, and the Network encourages cities to strengthen leadership and participatory governance for health. Phase VII will continue to explore and promote innovative action for whole-of-government and whole-of-society approaches, and to value the concept of the city health development plan (or equivalent). In Phase VII, cities will demonstrate how health and well-being are central to their municipal development strategies. Multi- and intersectoral work will remain key, including whole-of-city and health-in-all-policies approaches. A new major focus will be on creating systems approaches both within cities and through national Healthy Cities networks, including by strengthening community resilience and health literacy. City health profiles, integrated planning for health and sustainable development will remain at the heart of urban health work.

Phase VII will take into account the diversity, distinctiveness and unique circumstances of cities within the Network. Within its framework, cities will apply the Phase VII lens to their local situation to identify areas for priority action that could yield maximum health benefits for their populations. The scope for strategic work and operational delivery of each of the core themes is broad, and through the designation process the Regional Office will support cities to identify areas for specific attention during Phase VII. All cities in the Network, working individually and collectively, will address the overarching goals and core themes.

Overarching goals for Phase VII

The strategic direction of Phase VII is defined by the pursuit of the following three goals based on the Copenhagen Consensus of Mayors.

- **Goal 1:** Fostering health and well-being for all and reducing health inequities
- **Goal 2:** Leading by example nationally, regionally and globally
- **Goal 3:** Supporting implementation of WHO strategic priorities

Goal 1. Fostering health and well-being for all and reducing health inequities

Health and health inequities are socially determined. Shortfalls in health result from a society's social, economic, environmental and cultural situation, especially the conditions of daily life and the decisions that influence the distribution of power, money and resources. Health inequalities are widening in the face of economic crises, and concerted action is imperative because of this. Available, evidence-informed knowledge of the magnitude of health gaps, their causes and the actions that could close them is greater than ever. Phase VII will promote systematic action to address health inequalities through whole-of-local-government approaches, strong political support and an emphasis on building capacity for change.

Policies and interventions within a life-course approach will include action on children's well-being and early childhood development; employment and working conditions; lifelong learning; the conditions of life for older people; social protection and poverty; community resilience; social inclusion and cohesion; and gender equality.

Goal 2. Leading by example nationally, regionally and globally

From its inception, the WHO European Healthy Cities Network has emphasized multi- and intersectoral action and community participation. With increased attention on the social determinants of health and whole-of-government, whole-of-society and health-in-all-policies approaches, the need to reach out and engage a wide range of stakeholders has become a challenging priority for city leaders.

A key feature of Phase VII is therefore governance for health and well-being, which serves to reinforce the vision of health and well-being at the heart of equitable and sustainable local development. Phase VII also includes new approaches to strengthen coherence within and between national, regional and international levels, and to strengthen accountability for health and well-being.

Phase VII offers cities opportunities to explore new and innovative applications of shared and participatory governance. Many of the public health challenges facing the WHO

European Region today – such as the NCD epidemic and the unacceptable inequities within and between countries, societies and communities – require strengthened local leadership for health, well-being and sustainable development with capacity to support and implement a broad range of policies and interventions that draw on the contribution of many sectors and the active involvement of civil society.

Local leadership for health and well-being means:

- having a vision and an understanding of the importance of health in social and economic development;
- having the commitment and conviction to forge new partnerships and alliances;
- promoting accountability for health and well-being by statutory and non-statutory local actors;
- aligning local action with national, regional and international policies and agendas;
- anticipating and planning for change and shocks; and
- ultimately acting as a guardian, facilitator, catalyst, advocate and defender of the right to the highest level of health and well-being for all residents and visitors.[10]

Effective leadership for health and well-being requires political commitment, a vision, a strategic approach, supportive institutional arrangements and networking, and connections with others who are working towards similar goals. Strengthening governance and local leadership for health and well-being is vital to improving health and well-being in the context of the economic, social and political instability that plagues much of the Region today.

City diplomacy for health and well-being will continue to grow in Phase VII, reflecting new opportunities for working internationally and linking with national and global public health agendas.

Goal 3. Supporting implementation of WHO strategic priorities

WHO has long recognized the importance of the work undertaken by cities and other initiatives at the local level to implement the WHO Healthy Cities approach. The unique contributions of the Healthy Cities movement include a strong, values-based commitment to using innovation and collaboration to address some of our most pressing challenges.

Today, thousands of cities worldwide are part of the Healthy Cities movement in all WHO regions. It has become an important platform for achieving improved health, well-being and sustainable development in many parts of the world as mayors and municipalities

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[10] Tsouros AD. City leadership for health and sustainable development. Critical issues for successful Healthy Cities projects. Second edition. Copenhagen: WHO Regional Office for Europe; 2019.

spearhead efforts to improve the daily conditions of urban life. The adoption of the 2030 Agenda and the GPW13 presents greater need and opportunity to strengthen the Healthy Cities movement to support WHO's strategic priorities at the local level.

WHO is a United Nations agency of Member States who set the Organization's strategic priorities through its governing bodies, namely the World Health Assembly (globally) and regional committees (regionally). In this context, the Healthy Cities movement can strengthen local action to achieve strategic priorities, build public health capacity to address climate change, and promote population-based activities for disease prevention and health promotion at the local level. This approach is illustrated in Fig. 1.

Fig. 1. WHO European Healthy Cities Network development approach*
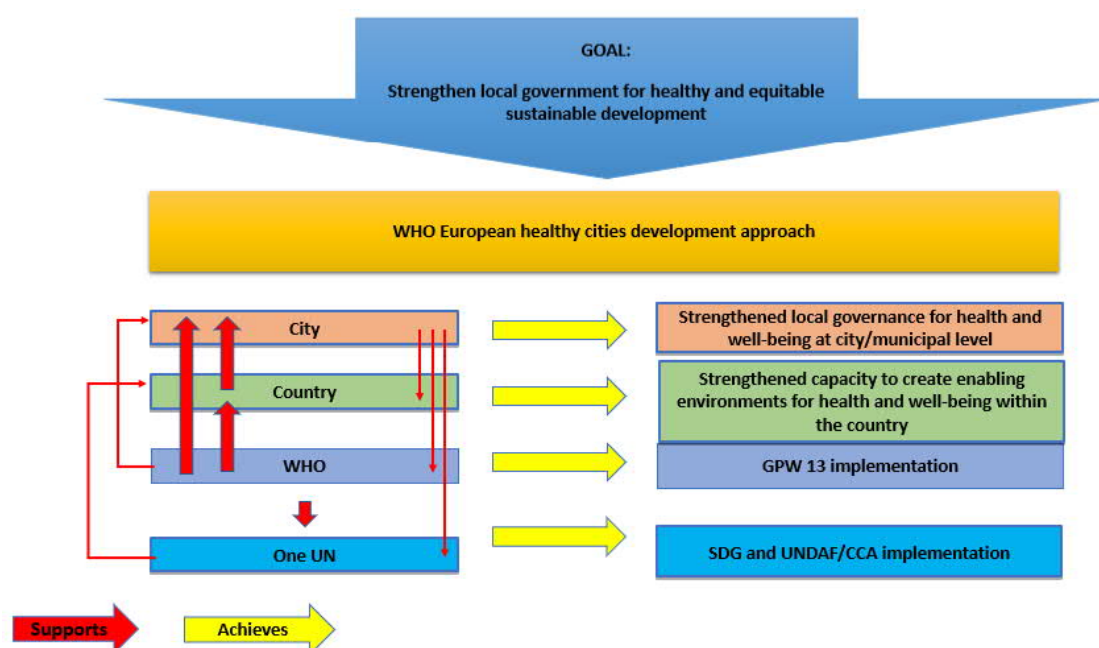
* CCA: Common Country Assessment; UN: United Nations; UNDAF: United Nations Development Assistance Framework.

National Healthy Cities networks can function as implementation vehicles for national health and development priorities, strategies, plans and agendas, as well as for global and regional agendas such as the 2030 Agenda. They can foster vertical coherence and cooperation among different levels of governance, and the alignment of policy and action from the international through to the local level.

These national networks provide platforms for increasing the visibility of issues related to local health and well-being; for sharing and learning; and for supporting cities to create the political, technical and administrative environments in which innovative projects can be developed and delivered. National networks represent a rich resource of implementation-based public health knowledge and expertise. They maximize limited local resources by providing local governments with direct support through training, opportunities to share best practices, and access to national and international expertise.

Their functions and achievements have made national networks fundamental to the success of the WHO European Healthy Cities Network.

Phase VII strategic approaches

These goals will be operationalized in Phase VII through the following strategic approaches.

- **Goal 1:** Fostering health and well-being for all and reducing health inequities
  Strategic approaches: Cities and national networks in Phase VII will foster health and well-being and reduce inequalities through:

  a. improving governance, empowerment and participation;

  b. designing urban places that deliver for equity and community prosperity; and

  c. prioritizing investment in people in local policies and strategies for a peaceful planet.

- **Goal 2:** Leading by example nationally, regionally and globally
  Strategic approaches: Cities and national networks in Phase VII will lead by example locally, nationally and globally, starting with the functioning of municipal administrations, by:

  a. innovating in policy and practice;

  b. sharing knowledge and learning;

  c. engaging in city diplomacy for health and well-being;

  d. ensuring policy coherence at the local level; and

  e. promoting health and well-being through municipal administrations.

- **Goal 3:** Supporting implementation of WHO strategic priorities
  Strategic approaches: Cities and national networks in Phase VII will support the implementation of WHO strategic priorities by:

  a. acting as partners and vehicles for local- and national-level implementation;

  b. pursuing universal health coverage;

  c. tackling global public health challenges;

  d. transforming local service delivery;

  e. fostering peaceful and inclusive societies;

  f. building public health capacity at the local level; and

  g. building coherence between all levels of governance.

Phase VII core themes

The core themes in Phase VII are based on the six themes in the Copenhagen Consensus of Mayors:

1. investing in the **people** who make up our cities;
2. designing urban **places** that improve health and well-being;
3. fostering greater **participation** and partnerships for health and well-being;
4. improving community **prosperity** and access to common goods and services;
5. promoting **peace** and security through inclusive societies; and
6. protecting the **planet** from degradation, including through sustainable consumption and production.

These six themes are interdependent and mutually supportive. Cities will achieve more in these areas by linking up policies, investments and services, and by focusing on leaving no one behind. Combining governance approaches to make health and well-being possible for everyone will foster innovation and orient investments towards promoting health and preventing disease.

Introduction to Phase VII themes

People's opportunities for healthy, happy and sustainable lives are closely linked to the conditions in which they are born, grow, live, love, work, play and age. Resilient and empowered communities respond proactively to new or adverse situations; prepare for economic, social, cultural, political and environmental change; and cope better with crisis and hardship.

Communities that remain disadvantaged and disempowered have disproportionately poor outcomes in terms of health, well-being and other social determinants. Health challenges that span the life course impact vulnerable groups, in particular children, migrants and refugees; pregnant women; older people; malnourished people; and people who are ill or immunocompromised. Poverty and its common consequences, such as malnutrition, homelessness, poor housing and destitution, is a major contributor to vulnerability, and cities can work to address this directly.

The changing demographics of cities require an effective life-course strategy that prioritizes new approaches. Supporting good health and its social determinants throughout the life course leads to increased healthy life expectancy as well as enhanced well-being and enjoyment of life, all of which can yield important economic, social and individual benefits. Interventions to tackle health inequities and their social determinants can focus on key stages of the life course to support mothers and babies, children and adolescents, and adults and older people.

In Phase VII, cities will act as champions for developing and including effective life-course approaches in city strategies, policies and plans. They will apply new approaches to promoting health and well-being and preventing disease from early childhood through to later life, especially for people who live in vulnerable circumstances.

Effective, comprehensive and integrated strategies and interventions are essential to addressing the major challenges of infectious diseases and NCDs alike. Both areas have been shown to benefit from coordinated public health action and health system interventions. These interventions (along both the course of disease and the life course) are most effective when paired with actions on equity, the social determinants of health, empowerment and supportive environments to address the unequal distribution of diseases within cities. Governments, the public sector, civil society and the private sector all have a role to play in this work. In Phase VII, cities will make explicit efforts to strengthen actions related to combatting NCDs as defined in global mandates (see Box 6).

Box 6. Healthy Cities action areas for tackling NCDs

- **Supporting people living with NCDs:** This includes access to joined-up services, including mental health services, social services, disability services and community integrated care; support for families and carers of people living with NCDs; and investments in social inclusion for people living with NCDs, mental disorders and related physical or mental disabilities.

- **Local-level health promotion and disease prevention:** This includes integrated strategies for health promotion, such as investments in health literacy and community empowerment; local-level, community-led, needs-driven health promotion and disease prevention interventions; programmes for violence and injury prevention; and health promotion in settings such as schools and workplaces.

- **Built environment:** This includes urban planning policies to create health-promoting environments that tackle risk factors and support health; more green spaces and active transport; bans on smoking and marketing of tobacco products; bylaws regulating sales or marketing of foods high in fat, salt and sugar; and planning laws that support air quality, road safety, housing quality, urban ecosystems and urban food systems.

- **Socioeconomic environment:** This involves taking targeted action using a whole-of-society approach to the social determinants of health throughout the course of NCDs as well as the life course to address the unequal distribution of these diseases within cities; investing in the early years; supporting parenting; using joined-up approaches that engage the health, education and social sectors; supporting the transition from education to work; addressing the spatial dimensions of poverty, including housing and transport; and implementing targeted interventions for people at risk of vulnerability, including migrants and older people.

Box 6 continued. Healthy Cities action areas for tackling NCDs

- **Coherence across municipal policies:** This includes reviewing and addressing the internal policies and processes of local administrations, such as municipal procurement policies for food, transport and other public tenders; divesting from health- and environment-harming industries; greening municipal buildings/vehicles/services through retrofitting; and supporting health promotion in the municipal workplace.

- **Multilevel governance:** This includes working in partnership with other levels of government on action to tackle and prevent NCDs through strengthened approaches to improving road safety and healthy food systems; tackling the commercial determinants of health; improving governance, public management and planning; and supporting an integrated health information system.

Cities can make a difference at the local level by initiating action through strong political leadership and whole-of-government, whole-of-society approaches. They can also adopt an integrated policy approach comprising an overarching policy framework and mechanisms with shared goals and targets, common information systems, joint project implementation, target-specific mass-media messages, and joint planning and priority-setting activities (see Box 7).

Box 7. Three-tier policy and planning for health and well-being at the local level

- **Tier 1:** Integrated policy frameworks for health, well-being and sustainable development to facilitate setting common goals and joined-up planning that draws on the contribution of different sectors

- **Tier 2:** Promoting active and healthy living in different city settings and places where people live, love, work and play

- **Tier 3:** Disease prevention approaches and interventions that are population-based and account for equity

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A main priority in this area will be taking an integrated, common risk-factor approach to disease prevention in order to implement effective interventions more equitably and on an appropriate scale. Cities can also focus on interventions to encourage active mobility and promote health in places and settings, such as through urban design and health initiatives in the workplace. Additionally, health impact assessment of the environmental determinants of health and of policies across sectors is essential for developing and implementing environmental standards and reducing or eliminating environmental risks.

Cities will work to adapt to changing social and demographic patterns and patterns of disease in the Region, especially for mental ill health, chronic diseases and conditions related to ageing. This includes reorienting health systems to give priority to disease prevention, and ensuring that city-sector services addressing the social determinants of health are people centred, high quality, affordable and universally accessible. Partnerships that create new working cultures and foster new forms of cooperation between professionals in public health, health care, social services and other sectors will support this people-centred approach.

Theme 1. Investing in the people who make up our cities

A healthy city leads by example by emphasizing a human focus in societal development and by prioritizing investment in people to improve equity and inclusion through enhanced empowerment.

Priority issues

Under this theme, the following issues are highly relevant to most cities and represent areas of promise for improving health and well-being.

Healthy early years, including positive early-childhood experiences. A good start is the foundation for a healthy life, and physical, cognitive, social and emotional development from birth are crucial for all children. Those born into disadvantaged home and family circumstances have a higher risk of poor growth and development, but investing in high-quality early-years child care and parenting support services can compensate for these negative effects.

Adverse childhood experiences are some of the most intensive and frequently occurring sources of stress that children can suffer. They include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence. Considerable and prolonged stress in childhood has been shown to have lifelong consequences for health and well-being. It can disrupt early brain development and compromise functioning of the nervous and immune systems. In addition, because some people who have faced adverse childhood experiences adopt risky behaviours, it can lead to serious problems such as alcoholism, depression, eating disorders, HIV/AIDS, heart disease, cancer and other chronic diseases.

To optimize health and well-being in later life, cities must invest in strategic, integrated plans that provide positive early-childhood experiences and development. A strategic focus on healthy living for younger people is particularly valuable; this requires a broad, multiagency strategy that includes the contribution of citizens.

Healthy older people. The life-course approach focuses on ensuring a good start in life and empowering people to adopt healthy lifestyles while adapting to age-associated changes. Age discrimination in access to high-quality services is widespread, and

inequities in the living conditions and well-being of older people are greater. Addressing these issues through social and economic policies at the local level is key to improving the health of older people.

Reduced vulnerability. Vulnerability refers both to social adversity and ill health. This results from exclusionary processes that operate differentially across society and give rise to the social gradient of health. Measures that combat these processes are likely to have the most fundamental effect on the health of individuals and groups. While there is substantial variation between groups, the burden of ill health among excluded migrant groups is often unacceptably large. Improving health system data and designing integrated policies in cities to tackle the multiple causes of social exclusion are the most successful in addressing the social gradient of health.

Mental health and well-being. A rights-based approach to health care requires that mental health services are safe and supportive and that every patient is treated with dignity and respect. People receiving mental health care should be involved in decision-making concerning their care, and in designing, delivering, monitoring and evaluating services. Coordination to ensure effectiveness and efficiency is essential and best achieved at the local level for sectors that do not traditionally work together, such as benefit offices, debt counsellors and community mental health services.

Revitalized public health capacity. Achieving better health outcomes in the Region's cities requires strengthening public health functions and capacity. While public health capacity and resources vary across cities, investing in public health institutional arrangements and capacity-building, as well as strengthening health protection, health promotion and disease prevention, are priorities. Reviewing and adapting public health legislation to modernize and strengthen public health functions is one way forward. Public health preparedness to deal with climate change consequences and other emergencies is an essential investment at the city level.

Healthy diet and weight. Tackling unhealthy diets, overweight and obesity requires systems thinking and analysis, collaboration among stakeholders within and beyond government, and governance mechanisms that facilitate working across sectors and levels. Cities can work towards local-level adoption of the recommendations in WHO's *Global strategy on diet, physical activity and health*,[11] which promotes a mix of actions in the areas of education, communication and public awareness; adult literacy and education programmes; marketing, advertising, sponsorship and promotion; labelling; and health claims and health-related messages. Integrated strategies, plans and actions in cities on physical activity and nutrition will require strong political leadership, good governance, and the commitment of all sectors to significantly reduce the burden of poor

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[11] Global strategy on diet, physical activity and health. Geneva: World Health Organization; 2004 (https://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf, accessed 9 February 2019).

nutrition and obesity – and thereby prevent NCDs – in city populations, especially among children.

Reduced harmful use of alcohol. Sustained political commitment, effective coordination, sustainable funding and appropriate engagement of various sectors at the local level as well as from civil society and economic operators are essential for reducing the harmful use of alcohol. Leading and coordinating city departments and other partners to develop strategic goals, coherent approaches and effective implementation actions are key. Cities can work to adapt the 10 mutually supportive and complementary target areas in WHO's *Global strategy to reduce the harmful use of alcohol*[12] to local contexts: leadership, awareness and commitment; health service responses; community action; drink–driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance.

Tobacco control. Smoke-free cities can become a reality with strong political leadership and the adoption of the WHO Framework Convention on Tobacco Control[13] and the six WHO MPOWER strategies.[14] These provide evidence-informed interventions that can be implemented at the local level, including monitoring tobacco consumption and the effectiveness of preventive measures; protecting people from exposure to tobacco smoke; aiding smoking cessation; warning about the dangers of tobacco; enforcing restrictions on tobacco advertising, promotion and sponsorship; and raising taxes on tobacco. Tobacco control interventions are the second-most effective way to use funds to improve health, after childhood immunization. Increasing the price of tobacco through higher taxes is the most effective way to reduce tobacco consumption and to encourage tobacco users to quit.

Human capital. Human development is essential to sustainable development: it contributes to job creation, improved working conditions and long-term social and economic benefits. Investing in people also fosters social cohesion by improving trust and civic participation in society. Human capital encompasses education and training, health and social care, well-being, and the accumulation of work and habits that contribute to knowledge and health of the population. Investing in human capital in the form of the health, social and education workforce improves health, reduces unemployment and stimulates sustainable economic growth, particularly as the health and social work sectors have been the largest contributors to employment in many countries in recent years.

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[12] Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010 (https://apps.who.int/iris/bitstream/handle/10665/44395/9789241599931_eng.pdf;jsessionid=CCE86E096715AFD458484D35DA716916?sequence=1, accessed 9 February 2019).

[13] WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2005 (https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf?sequence=1, accessed 9 February 2019).

[14] MPOWER [website]. Geneva: World Health Organization; 2019 (https://www.who.int/tobacco/mpower/en/, accessed 9 February 2019).

Social trust and social capital. There is growing evidence that social trust and social capital play an important role in health and well-being. The more extensive and regular an individual's social interaction (for example, via frequent contact with friends and relatives, participation in social events and meetings, and membership in formal and informal organizations), the easier and more affordable it is for them to access information on disease prevention and treatment, the best hospitals, the most qualified physicians, etc.

Improved access to information is particularly important in health-care settings, where asymmetric information between health suppliers and consumers represents a pervasive market failure. Even in countries where formal health care is developed and ubiquitous, a substantial demand for informal care and assistance, housing services and child care in case of temporary illness still exists. Social capital may also serve to coordinate people's efforts to lobby public authorities to obtain potentially health-promoting public goods such as health infrastructure, traffic regulations, sports facilities and green space areas.

Theme 2. Designing urban places that improve health and well-being

A healthy city leads by example by aligning its social, physical and cultural environments to create a place that is actively inclusive and that facilitates the pursuit of health and well-being for all.

Priority issues

Under this theme, the following issues are highly relevant to most cities and represent areas of promise for improving health and well-being.

Healthy places and settings. Continually striving to improve living and working conditions is key to supporting health. At the city level, action in the settings where people live, love, work and play – such as homes, schools, workplaces, leisure environments, care services and older people's homes – can be very effective. Social and economic policies must create environments that ensure people of all ages are better able to reach their full health potential.

Healthy urban planning and design. City living affects health through the physical and built environment, the social environment, and access to services and support. Efforts to improve urban planning to, for example, increase physical activity and enhance the mobility of ageing populations and people with disabilities are vital. Intersectoral partnerships and community empowerment initiatives can be implemented more easily at the local level with the active support of local stakeholders.

Healthy transport. Good public transport in combination with cycling and walking can reduce air pollution, noise, greenhouse gas emissions, energy consumption and traffic congestion; improve road safety; protect landscapes and urban cohesion; provide more opportunities to be physically active and socially connected; and improve access to

educational, recreational and job opportunities. Regular physical activity provides significant benefits for health, reducing the risk of most NCDs and contributing to mental health and overall well-being. Inactive groups empowered to engage in some activity will experience the greatest health gains. Social and physical environments can be designed to integrate physical activity safely and easily into people's daily lives. Urban planning and integrated transport systems to promote walking and cycling are essential elements of integrated strategies to increase physical activity.

Green spaces. Green spaces in urban areas positively affect health, and local measures to increase access to green spaces can produce major health benefits. People enjoy them by walking, playing and cycling, turning physical activity into an integral part of their daily lives. These spaces also reduce the risk of injuries, the urban heat-island effect, stress levels and noise pollution while simultaneously increasing social life. Public green space can also contribute to flood management.

Energy and health. Energy is essential to health, development and livelihoods whether used inside the home for cooking and heating or in our cities and towns for transport and productive activities. Yet energy use can also be harmful to health: methods of heating, cooking and transport may degrade home and community environments and have severe impacts on health both directly and indirectly (for example, through inequalities such as fuel poverty, through contributions to climate change and through poor air quality). Deriving energy from clean sources is paramount.

Theme 3. Fostering greater participation and partnerships for health and well-being

A healthy city leads by example by ensuring the participation of all individuals and communities in the decisions that affect them and the places they live, work, love and play.

Priority issues
Under this theme, the following issues are highly relevant to most cities and represent areas of promise for improving health and well-being.

Healthy older people. Social support, especially social relationships with family and friends, is one of the most important factors influencing quality of life among older people. One of the most powerful strategies for promoting health and well-being in older age is therefore preventing loneliness and isolation. Adopting intersectoral policies for making cities age-friendly is one of the most effective ways to respond to demographic ageing. This requires supportive transport, appropriate neighbourhood and urban planning, fiscal policies, housing, and public health awareness of risk factors.

Reduced vulnerability. Training health workers, involving vulnerable populations in designing, delivering and evaluating services, and addressing gender inequities and

discrimination supports and promotes improved life opportunities and independence in older age.

Increased physical activity. Taking part in physical activity increases opportunities for social interaction and a sense of belonging in the community. Inactive groups empowered to engage in some activity will experience the greatest health gains. Local partnerships with communities, nongovernmental organizations and the private sector can maximize participation in physical activities for significantly improved health outcomes.

Transformed services delivery. Partnerships that create new working cultures and strengthen the capacity of institutions and city departments to support people-centred services are at the heart of cities fit for the 21st century. Health and social services, and especially primary care services, that reach out to families in their homes, to employees at their workplaces and to local community groups are important entry points for systematically supporting individuals and communities over the life course and especially during critical periods. Close collaboration and coordination between primary health care and public health services is also essential.

Increased health literacy. Empowerment is a multidimensional social process through which individuals and populations gain better understanding of and control over their lives. For people to see themselves as the coproducers of their own health, increased health literacy and access to good health-related information are necessary. Inadequate or problematic health literacy in populations across Europe results in less-healthy choices, riskier behaviour, poorer health, less self-management and more hospitalization.

Strengthening health literacy requires a life-course approach that is sensitive to cultural and contextual factors. It necessitates the consideration of both individuals and the settings within which they obtain and use health information. Cities are a key setting for addressing health literacy. Through innovative partnerships with civil society, including with key populations at higher risk, cities can advocate for and support health literacy programmes and services.

Culture and health. Culture is at the heart of cities in the form of cultural sites and customs, and promoting it can stimulate a city's tourism sector, contribute to its attractiveness, and act as a bridge to inclusion and cohesion among diverse groups. Cities can harness culture as a vehicle for improving health and well-being through celebration and inclusion, and for building health literacy through cultural understandings of health. This allows the public sector to strengthen services and adaptive responses to population needs.

In addition, understanding of the importance of the cultural determinants of health and of the increased cultural diversity of cities is growing. This diversity adds to the rich social fabric of urban spaces, but also calls for services that are sensitive to the special needs and cultural contexts of communities.

Theme 4. Improving community prosperity and access to common goods and services

A healthy city leads by example by striving for enhanced community prosperity and strengthened assets through values-based governance of common goods and services.

Priority issues

Under this theme, the following issues are highly relevant to most cities and represent areas of promise for improving health and well-being.

Community resilience. Building and unleashing resilience are key factors in protecting and promoting health at individual and community levels. Communities play a vital role in health promotion and disease prevention activities, and in the social inclusion of people with chronic diseases and/or disabilities. This role is influenced and shaped by the complex interrelationships between the natural, built and social environments. Cities coordinating policy and action at the local level can create healthier environments and communities and empower the people living within them to make choices that help to sustain their own health.

Strong leadership and public investments in communities that build on local strengths and assets will raise levels of aspiration, build resilience, release potential and enable communities to take responsibility for their health and their lives. Asset-based approaches should form an integral part of city strategies to improve health and reduce health inequities.

Healthy older people. Lifelong financial hardship is associated with worse health outcomes later in life, and older people who have not been married throughout their adult lives are outlived by those who have. Effective measures to promote healthy ageing for all include legislation and social and economic policies that provide for adequate protection.

Mental health and well-being. Mental ill health is a major contributor to health inequity in Europe. It has serious consequences for individuals and their families, but also for the economy and the well-being of society. Poor mental health is both a consequence and a cause of inequity, poverty and exclusion. Challenges for mental health include sustaining population well-being during times of slow economic growth and reduced public expenditure.

Creating employment, either in the public sector or through incentives for expanding the private sector, is the most cost-effective intervention for mental well-being at the population level. Promoting early diagnosis, initiating community-based interventions, extending and maintaining counselling and mental health services, increasing employment opportunities, and expanding debt advice services also play crucial roles in promoting good mental health.

Healthy housing and regeneration. Great health benefits can be achieved in the housing and construction sector through a mix of measures, including more effective use of active and passive natural ventilation for cooling; reductions in mould and damp; energy-efficient home heating, appliances and cooking; provision of safe drinking-water; provision of outdoor space; improved sanitation; and stronger buildings. Regeneration programmes that provide improved social, economic and environmental opportunities can address some of the design disadvantage in cities.

Healthy urban planning and design. The way neighbourhoods and streets are built and designed, the way cities are planned and expanded, how effectively transport provides opportunities for easy and active mobility – these are all aspects of healthy urban planning and design that can make a significant difference to the health of individuals and communities. Cities are responsible for promoting the well-being of their citizens and for providing equal access to municipal resources and opportunities.

Health and well-being as an indicator of success. In addition to the traditional economic metrics of successful urban development, healthy cities will explore the use of health and well-being measures as indicators of development and progress.

Transformative economic models for equitable, sustainable development. Meeting complex challenges for modern cities means exploring new and more equitable models for development, such as achieving health and well-being through the circular economy, the silver economy and the green economy. The circular economy is an alternative to the traditional linear economy in which a good is made, used and disposed of. It keeps resources in use for as long as possible, and recovers and reuses materials at the end of the resource's lifespan. New economic models also create favourable conditions in cities for investment in sectors that foster the development of human and social capital.

Ethical investment for health-promoting, equitable and sustainable development. Cities are significant investors of public funds in many countries, whether generated through direct income, pension funds or other modalities. Municipal financial and investment strategies that support health and well-being and align with the values of equality, fairness and adherence to human rights are key to achieving a systemic approach to health and well-being for all.

Universal social protection floors at the local level. Cities and local governments are at the frontline of service delivery and have a critical role to play in tackling the local drivers of health inequalities. Essential baskets of local services, transformative care models and integrated or joined-up services are examples of universal social protection floors at the local level that can improve health and well-being.

Commercial determinants of health. In addition to leveraging cobenefits with sectors and partners, addressing the commercial determinants of health is critical, particularly

where economic benefits may come at a cost to health and well-being. These impacts may be direct or indirect, such as negative effects on social or environmental determinants. In Phase VII, the Network will use the following working definition of commercial determinants.

> A commercial determinant of health refers to a good or a service where there is an inherent tension between the commercial and the public health objective: where the public health objective is to rationalize the use of the good or service, and the commercial objective is to increase the use or consumption of the good or service; or conversely, where the public health objective is to increase the accessibility or affordability of a good or service, and the commercial objective is to reduce the accessibility and affordability of the good or service. [15]

Theme 5. Promoting peace and security through inclusive societies

A healthy city leads by example by promoting peace through inclusive societies that focus on places, participation, prosperity and the planet, while putting people at the centre of all policies and actions.

Priority issues

This is a new theme for Phase VII whose priority areas were presented and adopted at the International Healthy Cities Conference in Belfast, Northern Ireland, United Kingdom, in October 2018. This theme recognizes that peace is not only the absence of war, and emphasizes that the core dimensions of peace and peaceful societies – social justice, fairness, tolerance, dialogue, alliance building, consensus and city diplomacy – have been at the heart of the Network's activities throughout its 30-year history.

Health as a Bridge for Peace. Health as a Bridge for Peace is a multidimensional policy and planning framework that supports health workers in delivering health programmes in conflict and post-conflict situations and also contributes to peace building. It uses health services to prevent the emergence of conflict and radicalization, build peace, and promote security – including health security and social cohesion.

Peace through healthy places. Urban planning, spatial planning and urban design are tools available to local governments for enhancing social cohesion, societal trust, community resilience, peaceful communities and population well-being. This includes strengthening community cohesion through place-based inclusion and universal health coverage and access.

Violence and injury prevention. Violence and unintentional injuries cause significant human death, suffering and disability in cities. Injury and violence remain the leading causes of death in young people in the Region. Work in this area includes preventing

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[15] Kosinska M, Östlin P. Building systematic approaches to intersectoral action in the WHO European Region. Public Health Panorama. 2016;2(2):117–247.

intentional and unintentional violence against children, intimate-partner violence, gender-based violence, hate speech, bullying and ostracization, and hostility towards migrants and refugees, as well as promoting road safety, water safety, fire safety and safety in other areas.

Human security. Human security is a multidimensional concept that refers to a state of integrated well-being. It embraces elements ranging from physical safety and employment to food security and access to basic services, such as health care and clean water. The human security approach to development takes account of the close interrelationships among the elements people need in order to live without fear, without deprivation and with dignity. It seeks solutions to build emergency preparedness and response; water, food and energy security; and individual and collective resilience against natural disasters and acts of terrorism.

Health security. Global health security is defined as the activities required to minimize the danger and impact of acute public health events that threaten the collective health of populations living across geographical regions and international boundaries. All countries have a responsibility to keep their people safe, and cities have a key role to play in this area. Collective, international public health action can build a safer future for humanity.

Mental health and well-being. Urban planning and design and the delivery of public services and targeted actions at the city level have significant impacts on mental health and well-being among urban populations. Action in this area ranges from addressing the psychosocial elements of post-conflict reconciliation in cities to strengthening inclusion, participation and social cohesion among those experiencing mental disorders or disabilities.

Theme 6. Protecting the planet from degradation, including through sustainable consumption and production

A healthy city leads by example by ensuring that the protection of the planet is at the heart of all city policies, both internal and external.

Priority issues
Under this theme, the following issues are of relevance to most cities and represent areas of promise for improving health and well-being.

Climate change mitigation and adaptation. Demonstrating the relationship between sustainable development and health is a powerful argument to support climate change mitigation and adaptation, as measurable health outcomes can generate public and political interest. Important opportunities to improve the environment are also emerging in the greening of health services. The health sector is one of the most intensive users of energy and a significant producer of waste, including biological and radioactive waste. It therefore has an essential part to play in mitigating the effects of climate change and in

reducing pollution by taking steps to limit its significant climate footprint and negative impact on the environment.

Protected biodiversity and transformed urban places. Cities and local governments have a key role to play in transforming urban places to prevent biodiversity loss and environmental degradation. This includes transforming brownfield sites and retrofitting existing buildings; greening cities and promoting new models of management of green spaces to support local ecosystems; strengthening local food systems; reducing chemical and pollutant exposure; reducing soil degradation; and requiring new developments to protect biodiversity.

Health-promoting and sustainable municipal policies. Action to improve health and well-being starts with leading by example. This means reviewing and addressing the internal policies and processes of local administrations seeking to become healthy cities. This includes reviewing municipal procurement policies for food, transport and other public tenders, divesting from health- and environment-harming industries, and greening municipal buildings/vehicles/services through retrofitting. The use of health impact assessments and health-in-all-policies approaches should be mainstreamed for both internal and external action.

Waste, water and sanitation. Safe waste disposal, clean water and good sanitation are critical for the health and well-being of urban populations. The vast majority of all wastewater from homes, cities, industry and agriculture flows back to nature without being treated or reused, polluting the environment and losing valuable nutrients and other recoverable materials along the way. Recycled water can satisfy most water demands when adequately treated to ensure appropriate quality. In homes, for example, greywater – the relatively clean wastewater from baths, sinks, washing machines and other appliances – can be reused on gardens and lawns. In cities, wastewater can be treated and reused for green spaces. In industry and agriculture, discharged water can be treated and recycled for cooling systems or irrigation. The costs of wastewater management are greatly outweighed by their benefits to human health, economic development and environmental sustainability.

Implementing Phase VII

Phase VII, like Phase VI, provides cities with a flexible framework to work on overarching goals and to address selected issues under the core themes that are most relevant to their local situation. Conducting a situation analysis that applies the Phase VII lens at the city level is an important first step in the transition to Phase VII, which amplifies, reinforces and connects to the concepts in Phase VI in a more integrated way. It provides new strategic and political impetus as well as new evidence to support cities to strengthen governance for health and well-being. Phase VII will put added emphasis on leadership and innovation as well as on building local capacity for change. Tables 1 and 2 summarize the overarching goals, approaches and core themes of Phase VII.

The concepts of the health profile and the (intersectoral) city health development plan remain valid, and will be adapted to reflect the wider scope of the goals of Phase VII. The new commitment to that ensuring health and well-being are central to local development strategies brings the Network in line with the 2030 Agenda and contributes to the implementation of the *Roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy, for health and well-being.*

Table 1. Phase VII overarching goals and approaches

Overarching goals and approaches		
Reducing health inequalities	**Leading by example**	**Implementing WHO priorities**
Improving governance, empowerment and participation	Innovating in policy and practice	Acting as a partner and vehicle for local- and national-level implementation
Designing urban places for equity and community prosperity	Sharing knowledge and learning	Pursuing universal health coverage
Prioritizing investment in people	Engaging in city diplomacy for health and well-being	Tackling global public health challenges
	Ensuring policy coherence at the city level	Transforming local service delivery
	Promoting health and well-being through municipal administrations	Building public health capacity at the local level
		Building coherence between all levels of governance

Table 2. Phase VII core themes and their priority issues

Core themes					
People	**Place**	**Participation**	**Prosperity**	**Peace**	**Planet**
Highly relevant priority issues					
Healthy early years	Healthy places and settings	Healthy older people	Community resilience	Healthy urban planning and design	Climate change mitigation and adaptation
Healthy older people	Integrated planning for health	Reduced vulnerability	Healthy older people	Health as a Bridge for Peace	Protected biodiversity
Reduced vulnerability	Healthy transport	Increased physical activity	Mental health and well-being	Violence and injury prevention	Waste, water and sanitation
Mental health and well-being	Green spaces	Transformed service delivery	Healthy housing and regeneration	Human security	Health-promoting and sustainable municipal policies
Revitalized public health capacity	Energy and healthy	Health literacy	Integrated planning for health	Health security	
Healthy diet and weight		Culture and health	Indicators of health and well-being	Mental health and well-being	
Reduced harmful use of alcohol			Transformed economic models		
Tobacco control			Ethical investment		
Human capital			Universal social protection		
Social trust and capital			Commercial determinants of health		

Requirements in Phase VII

Cities and national networks must implement certain approaches and activities during the five years of Phase VII. As a precondition to making commitments to work in the areas described previously, cities and national networks must secure political support and adequate resources, and to put in place the necessary structures and mechanisms to facilitate the implementation of the goals related to a healthy city. To be members of the WHO European Healthy Cities Network, they also need to be prepared to work and network with other cities and national networks both domestically and internationally.

Organizational structure of the WHO European Healthy Cities Network

The Network will have the following components in Phase VII.

1. The Network will include cities and national networks in all WHO European Member States, and is expected to count 100 cities and 35 national networks as members. Its highest governing body will be the full meeting of the Network, normally at its Annual Business Meeting and Technical Conference, but also virtually if necessary.

2. The Network will be supported by the following committees representing its diversity.

    a. Political Committee: This advisory committee is comprised of city and national-network political representatives appointed by the WHO Regional Director for Europe to advise the Regional Office on the political direction and bring to its attention emerging issues of political significance in the WHO European Region. It will operate within the framework of WHO values, policies and priorities.

    b. Scientific and Advisory Board: This advisory committee of scientific and technical experts from both within and outside WHO oversees the applications for designation and accreditation; guides the technical programme of conferences and meetings; advises on technical publications; and leads the monitoring and evaluation of Phase VII. It will comprise two separate committees that will meet together to constitute the Scientific and Advisory Board, and meet separately in the following respective committee functions.

        i. Scientific Committee: This committee is comprised of independent scientific and technical experts and senior WHO staff appointed by the WHO Regional Director for Europe in an expert capacity for the duration of Phase VII.
        ii. Advisory Committee: This elected committee of city and national-network coordinators guides the work of the Network.

3. The Network will also include subnetworks, taskforces, and working groups of cities and national networks. During Phase VII, a range of mechanisms for themed interest groups will be established or strengthened to support designated cities and national network cities in implementing the requirements of Phase VII. Their role will be to support the development of technical guidance and training materials, to organize and run training courses, and to offer a platform for cities with a strong commitment to certain themes and issues.

Methods of working

Phase VII will prioritize capacity-building across the Network, both by strengthening the capacity of individual member cities and by investing in the potential of the Network as a whole. WHO collaborating centres, thematic subnetworks, experts in various fields and WHO advisory committees will support this work. Several WHO units and programmes are also expected to provide direct technical input to the Network during Phase VII. Subnetworks in Phase VII will be reviewed and strengthened to provide support to cities. External institutions with appropriate experience and expertise will carry out the secretariat functions of the Network during Phase VII.

Networking

Networking represents a key aspect of the added value that the Network brings to its member cities. It offers a wide range of possibilities for learning, sharing experience and working together, as well as opportunities for mutual support, mentoring, advocacy and resource development. During Phase VII, the Network will also focus on strengthening and expanding the creative use of electronic interaction and communication, and the use of social media.

Capacity-building and tool development

As part of its strategic and technical leadership for Phase VII, WHO is developing an implementation package to support cities to deliver the Phase VII framework at the local level. The package will comprise guidance, tools and services aimed at advancing the capacity of cities to understand and implement Health 2020 locally. It will conduct training and learning activities relevant to implementing and evaluating Healthy Cities approaches.

Monitoring, evaluation and knowledge

Recognizing that impact must be monitored with appropriate indicators and a focus on outcomes, and that evidence and knowledge of good practices should be documented, shared and built upon, the Network will encourage empirical, comparative studies on selected topics involving groups of interested cities.

Partnerships

The WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks will formalize links and work closely and creatively with relevant strategic global and European partners, including networks of cities, institutions, nongovernmental organizations and platforms, in mutually beneficial partnership.

Support structures and mechanisms

These include the WHO Regional Office for Europe; the Secretariat of the Network (consisting of one or more external institutions with complementary roles); WHO collaborating centres; the Network Advisory Committee; and other partners internal and external to WHO.

Part 1. Designation of cities in Phase VII

City requirements in Phase VII

The following list outlines the 13 specific requirements for cities to be members of the WHO European Healthy Cities Network in Phase VII.

1. **Sustained local support.** Cities must have sustained local governmental support as well as support from key decision-makers (stakeholders) across sectors for the Healthy Cities principles and goals. Cities must submit with their applications a letter of commitment from their mayor or lead politician, together with a council resolution supporting the city's participation in Phase VII and a commitment to partnership with different stakeholders.

2. **Coordinator and steering group.** Cities must have a full-time coordinator (or equivalent) who is fluent in English, and administrative and technical support for their initiative. Cities must also have a steering group involving political and executive-level decision-makers from the key sectors necessary to ensure delivery of the requirements for Phase VII.

3. **City health profile.** City health profiles provide invaluable insight into the factors that influence the health of citizens and the degree of health inequality within a city. All cities must prepare a city health profile. For new members, this may be prepared as a new report for the city in accordance with the WHO guidance for city health profiling. Cities that have prepared a profile in the past must produce an updated version for this phase. Profiles should actively inform city-based planning processes and indicate changes in health within the city. In Phase VII, cities should ensure that their health profiles focus as much attention as possible on inequalities in health and the health of vulnerable groups.

4. **Phase VII analysis.** Cities must apply the Phase VII lens to make an initial assessment of their local situation in relation to the goals and core themes of Phase VII. The situation analysis should be 2–3 pages long. This will identify major health and well-being challenges and opportunities at the city level, and provide the basis for identifying and assigning priority issues for Phase VII.

5. **City statement.** Cities must make a statement on how they will benefit from being a member of the Network.

6. **Integrated planning for health and well-being.** To implement the goals and core themes of Phase VII, cities must work systematically through processes that support the creation of a comprehensive vision for health, and that use integrated ways of planning that involve different sectors. Cities must demonstrate progress on integrated strategic planning related to the Phase VII core themes. This may comprise a city health development plan, a city policy and strategy for health and well-being, or equivalent document(s). These plans are strategy documents that present a comprehensive picture of a city's specific and systematic efforts to develop health, its vision and values, and a strategy to achieve this vision. They

draw on the contribution of the numerous statutory and non-statutory sectors and agencies whose policies and activities influence health. As such, they provide a process and framework for Phase VII at the local level.

7. **Health-promoting, equitable and sustainable local development.** To implement the goals and core themes of Phase VII, cities must work systematically through processes that support the creation of a comprehensive local system for health and well-being using a whole-of-city approach. Cities must demonstrate a commitment to health and well-being in their overall strategic development. This may involve the inclusion of health and well-being in a city development plan, a city economic development strategy or equivalent document(s). These plans are strategy documents that present a comprehensive picture of a city's development that includes the dimension of health and well-being, its vision and values, and a strategy to achieve this vision. They draw on the contribution of the numerous statutory and non-statutory sectors and agencies whose policies and activities influence urban development.

8. **Partnership.** Cities must work in and strengthen partnerships as the testing ground for developing knowledge, tools and expertise on the Phase VII goals and core themes. This will require developing and implementing programmes of action in relation to the core themes. Cities must also participate in the wider work of the Network and its thematic subnetworks, and contribute to disseminating knowledge and products.

9. **Capacity-building.** Cities must create and invest in learning environments for individuals, politicians and organizations to achieve the Phase VII goals and core themes. This should focus on developing city leadership and diplomacy for health and well-being; facilitating intersectoral work through whole-of-city and whole-of-society approaches; and measuring and monitoring health and its determinants.

10. **Attendance at Network meetings and other relevant WHO meetings.** Cities must make an executive and political commitment that the project coordinator and nominated politician will attend meetings and conferences of the Network. At each meeting, the city should be represented by at least the coordinator and politician responsible.

11. **Attendance at meetings of mayors.** Cities should ensure that their mayor (or leading politician) attends any meetings of mayors or politicians held during Phase VII.

12. **Participation in networking activities.** Cities should participate in various networking activities, actively support the national network and participate in at least one thematic subnetwork. Cities must be connected to the internet and have access to teleconferencing and WebEx videoconferencing.

13. **Monitoring and evaluation mechanisms.** Cities must have monitoring and evaluation mechanisms that enable the ongoing assessment of progress and annual

reporting to WHO. Cities must also have an annual plan for activities based on achieving progress on all Phase VII core themes; complete the annual reporting template; and participate in any external evaluation processes WHO initiates.

Process of city designation in Phase VII

Table 3 presents an overview of the process leading to the designation of cities to the Network in Phase VII. Cities will be designated on an ongoing basis throughout Phase VII based on the applications received. Cities applying for membership are expected to be members of their country's national network.

Table 3. Summary of steps in the process of designating cities for membership in Phase VII*

Step	Cities that were members of the WHO European Healthy Cities Network in Phase VI	Other cities
1	City sends expression of interest to WHO, including commitments to the implementation framework for Phase VII and financial contribution	City sends expression of interest to WHO, including commitments to the implementation framework for Phase VII
2	City sends financial contribution to WHO	WHO accepts or declines the expression of interest
3	City submits full application to WHO (see Annex 3)	City sends financial contribution to WHO
4	Assessors carry out designation assessments on behalf of WHO	City submits full application to WHO (see Annex 3)
5	WHO accepts designation, formally communicates this to the city and informs the country's health ministry	WHO requests relevant background information and information to be provided by national networks
6	WHO issues Phase VII designation certificate	Assessors carry out designation assessments on behalf of WHO
7		WHO accepts designation, formally communicates this to the city and informs the country's health ministry
8		WHO issues Phase VII designation certificate

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*At any stage in this process, WHO may seek further clarification or information from the city, undertake a city visit or carry on an interview with the Healthy City coordinator and lead politician.

Expression of interest letters

Any city that meets the designation requirements can apply to be a member of Phase VII. Cities should send a letter of expression of interest from the mayor of the city, indicating that they wish to apply to be a member of the Network in Phase VII and that the city will dedicate resources to deliver the Phase VII implementation framework, make the annual financial commitment to WHO, and participate actively in the Network and subnetworks. The letter should also identify the city's focal point for the Phase VII application, including their email address.

Application for designation

The Phase VII application form will be available online on the Network website in English and Russian.

Country quotas

The cities designated to the Network will be geographically balanced from across countries in the WHO European Region. Membership will total approximately 100 cities, and the maximum quota per country will be 15 cities. Deviation from these numbers during Phase VII will be considered to ensure good geographical balance among all parts of the Region.

New cities are encouraged to apply even if the country reached its quota in Phase VI. A special effort will be made to encourage greater participation from underrepresented countries and regions in Europe. Annex 1 provides details on country quotas.

Financial commitment

All designated cities must make an annual financial contribution for each of the six years of Phase VII (2019–2024), paid directly to WHO. Cities that were not members in Phase VI will be sent an invoice when the expression of interest is received. When cities are successfully designated to the Network, they will receive the official WHO Phase VII designation certificate. WHO will designate the financial contributions to the costs of staffing, technical work, and secretarial and managerial functions of Phase VII according to need and in accordance with WHO procedures and capacity to provide support. Designated cities that have not paid their annual financial contribution will not be invited to attend the Annual Business Meeting and Technical Conference.

All cities from European Union countries, Andorra, Iceland, Israel, Monaco, Norway, San Marino and Switzerland will pay a full contribution of US$ 6000 each year (see Annex 2). Cities from other countries will pay US$ 3500 per year. In exceptional circumstances, a city that has difficulty in meeting this financial commitment can discuss with WHO alternative ways of making this contribution.

The WHO Regional Office for Europe retains the right to amend the above document in the context of organizational prioritization and the WHO transformation agenda.

Part 2. Accreditation of national networks in Phase VII

National network requirements in Phase VII

As a minimum, each national Healthy Cities network should:

- make a political commitment to the Copenhagen Consensus of Mayors and the WHO European Healthy Cities Network Phase VII implementation framework;

- identify a national network coordinator with technical and administrative resources who is able to operate professionally in English;

- be formally organized under a clear set of bylaws or a constitution accepted by its members and have an established structure and accountability mechanisms;

- be non-profit in nature and in its activities and advocacy;

- have a steering committee with a national or city political representatives and stakeholders representing the overarching goals and core themes;

- outline a plan of activities with defined products for each year of Phase VII, including national network meetings, and have the capacity and resources to support national network cities to implement the Copenhagen Consensus of Mayors and the Phase VII implementation framework;

- attend the Network's Annual Business Meeting and Technical Conference;

- attend the annual national network meeting and other relevant Network meetings where resources permit;

- agree to make an annual financial contribution to WHO, which will be paid starting the year the application for accreditation to WHO is made;

- complete and submit the annual reporting template questionnaire to WHO within the specified time period; and

- demonstrate the active participation of designated cities in the national network.

Table 4. Summary of steps in the process of accrediting national networks in Phase VII*

Healthy City element	Minimum requirements
1. Political commitment: endorsement of principles and strategies	• A political commitment or declaration to Health 2020 and the Phase VII goals, core themes and requirements
2. Infrastructure	• A coordinator or focal point with technical and administrative resources and annual programme budget • A steering committee with city and national political representation and partners representing Phase VII goals and core themes • Formal organization of the national network under bylaws or a constitution • Clear membership requirements for cities that follow the four elements of Healthy Cities action
3. Products and outcomes	• Regular business meetings with member cities • An action plan with visible evidence that the national network actively supports its member cities • A completed annual reporting template that reports on national network activities and contributions to Network publications and newsletters • Systematic monitoring and evaluation of the national network's annual programme of work or action plan • Dissemination of information and services to members
4. Networking	• Attendance at the Annual Business Meeting and Technical Conference • A website, an email address and access to WebEx videoconferencing • Two national network member cities to attend the Annual Business Meeting and Technical Conference on a self-funded or national network-funded basis, where resources permit • Proactive networking with other national networks as well as mutually beneficial networking with other networks or partners
5. Annual financial contribution	• Annual payment to WHO

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* At any stage in this process, WHO may seek further clarification or information from the national network, undertake a visit or carry on an interview with the national network coordinator and lead politician.

Minimum requirements for a city's application to a national network

As a minimum, each national network city will:

- make a mayoral commitment to the Copenhagen Consensus of Mayors and the Phase VII implementation framework;
- provide a political resolution from the city demonstrating commitment to the accreditation requirements;
- identify a coordinator or focal point with resources;
- have a steering committee with a political representative;
- show evidence of Healthy Cities activities through an annual action plan and the required reporting mechanisms (for example, in the annual reporting template for the national networks); and
- attend meetings of the national network.

Table 5. Membership requirements for cities applying to be a member of a national network

Healthy City element	Minimum requirements	Ideal requirements (in addition to minimum requirements)
1. Political commitment: endorsement of principles and strategies	• A political commitment to the Copenhagen Consensus of Mayors and the Phase VII implementation framework • Political commitment by the city mayor to participate in the national network through a council resolution	• Local partnership agreements with sectors, departments, institutions and nongovernmental organizations • Full commitment to work on Phase VII goals and core themes
2. Infrastructure	• A coordinator or focal point with administrative and office support and resources • An intersectoral steering committee with a city political representative	• Full-time coordinator and additional support staff to work in the healthy city office

Table 5 continued. Membership requirements for cities applying to be a member of a national network

Healthy City element	Minimum requirements	Ideal requirements (in addition to minimum requirements)
3. Products and outcomes	• A range of Healthy Cities activities, such as actions to address inequality in health, promote healthy living, support vulnerable groups, advance healthy urban planning, etc. • Annual report and annual reporting template submitted to the national network, and exchange of information	• A plan or programme for delivering on the Phase VII framework • A city health profile, a city health development plan or the equivalent • The reflection of health and well-being in the overarching city development strategy or equivalent • A formal annual reporting mechanism and monitoring of progress
4. Networking	• Attendance at national network meetings	• Attendance at national network meetings and, where resources permit, the Annual Business Meeting and Technical Conference • Active participation in national network training and learning events • A website and access to WebEx videoconferencing

Process of national network accreditation in Phase VII

Accrediting national networks is a means of promoting consistency and high standards. Accreditation has four elements:

- political commitment at the level of the steering committee of the national network;
- capacity to manage, coordinate and implement activities to support cities in delivering Phase VII and other Healthy Cities programmes;
- strategic planning with defined products and expected outcomes; and
- networking at the local, national and international levels.

The accreditation of a national network focuses on both the network's function at the national level and the commitments and standards of its member cities. All national

networks in the WHO European Region are eligible to become members of the WHO European Healthy Cities Network. National networks will strengthen their efforts throughout Phase VII to actively support their members in improving health and to increase the proportion of cities meeting the minimum accreditation requirements to become members of a national network.

In submitting an application to WHO, national networks will indicate that:

- at least 70% of their members have endorsed the minimum national network accreditation requirements;
- that they are committed to working with and contributing to the Network; and
- that they fulfil the minimum accreditation requirements of the Network.

The accreditation process comprises three components:

- Declaration for national networks (Annex 4);
- Supporting documentation for the national network accreditation process (Annex 5);
- Application form for national networks in Phase VII (Annex 6);

Accredited national networks will receive a WHO certificate at the end of Phase VII.

Annex 1.

Country quotas for cities participating in the WHO European Healthy Cities Network in Phase VII

The quotas are based on a maximum of 15 designated cities per country, with 5 cities for each country of up to 5 million people. Several exceptions have been made for historical reasons (participation in earlier phases of the Network). Quotas may be exceeded in certain countries if the Healthy Cities movement is underrepresented in neighbouring countries and provided there is geographical balance between the different parts of the WHO European Region.

Country	Population (million)	Maximum quota
Albania	2.9	2
Andorra	0.7	1
Armenia	2.9	2
Austria	8.7	6
Azerbaijan	10	7
Belarus	9.4	6
Belgium	11.5	7
Bosnia and Herzegovina	3.5	3
Bulgaria	6.9	6
Croatia	4.1	4
Cyprus	1.1	1
Czechia	10.6	7
Denmark	5.7	5
Estonia	1.3	2
Finland	5.6	5
France	65.4	12
Georgia	3.9	3
Germany	82.4	15
Greece	11.1	7
Hungary	9.6	6
Iceland	0.3	1
Ireland	4.8	4
Israel	8.5	6
Italy	59.2	12
Kazakhstan	18.5	8
Kyrgyzstan	6.2	6
Latvia	1.9	1
Lithuania	2.8	2
Luxembourg	0.5	1
Malta	0.4	1
Monaco	0.03	1

Country	Population (million)	Maximum quota
Montenegro	0.6	1
Netherlands	17.1	7
North Macedonia	2.0	2
Norway	5.4	5
Poland	38	10
Portugal	10.2	7
Republic of Moldova	4.0	4
Romania	19.4	8
Russian Federation	143.8	15
San Marino	0.03	1
Serbia	8.7	6
Slovakia	5.4	5
Slovenia	2.0	2
Spain	46.4	10
Sweden	10	6
Switzerland	8.6	6
Tajikistan	9.2	6
Turkey	82.9	15
Turkmenistan	5.9	5
Ukraine	43.7	10
United Kingdom	66	12

Annex 2.

Countries in which cities in the WHO European Healthy Cities Network must pay the full financial contribution to WHO

Andorra

Austria

Belgium

Bulgaria

Croatia

Cyprus

Czechia

Denmark

Estonia

Finland

France

Germany

Greece

Hungary

Iceland

Ireland

Israel

Italy

Latvia

Lithuania

Luxembourg

Malta

Monaco

Netherlands

Norway

Poland

Portugal

Romania

San Marino

Slovakia

Slovenia

Spain

Sweden

Switzerland

United Kingdom

Annex 3.

Application form for cities in Phase VII

Guidance for application for designation as a member city of the WHO European Healthy Cities Network in Phase VII (2019–2024)

Assessment will not begin until WHO has received a complete electronic application. The application must be submitted in English. The supporting documents must be submitted electronically in their original language with a correct English translation (or a summary in certain cases).

Before you complete the form, please carefully read the document outlining the implementation framework of the Network in Phase VII and the Copenhagen Consensus of Mayors (referenced in Annex 7).

If you need assistance or have questions while completing this application, please contact the WHO Regional Office for Europe at: eurohealthycities@who.int.

Application for designation as a member city of the WHO European Healthy Cities Network in Phase VII

Applicant city	
City:	Country:
City population:	
Social media details:	

Coordinator		
Name:	Title:	
Address 1:	Address 2:	City:
Country:	Postal code:	
Telephone:	Email:	Website:

1. Political and partnership commitment

Mayor

Name: Title: Date elected:

Address 1:   Address 2:   City:

Country: Postal code:

Telephone: Email: Website:

Politician responsible for the healthy city project in your city

Name: Title: Date elected:

Address 1:   Address 2:   City:

Country: Postal code:

Telephone: Email: Website:

Council resolution supporting the participation of the city in Phase VII

Date of council resolution:
Please email a signed, scanned copy of the council resolution.

A 2–3-page Phase VII situation analysis document

This should identify the opportunities and challenges in the goals and themes at the city level and the priority issues for Phase VII.
Please email a scanned copy of the document.

Letter of commitment from the mayor

The letter should indicate the mayor's agreement to the city participating in Phase VII and include explicit commitment to the following:
- the dedication of resources to deliver the implementation framework for Phase VII;
- active participation in meetings of the Network and subnetworks;
- participation of the mayor in meetings of mayors;
- external monitoring and evaluation of the city by WHO; and
- payment of an annual financial contribution throughout Phase VII (2019–2024).

Please email a signed, scanned copy of the letter of commitment.

2. Human resources

Coordinator

Name of coordinator (or equivalent) for the healthy city project in your city:
Title:
Date appointed:
Full time? Yes ☐   No ☐
(Full-time employees who only work part-time for the healthy city project are classified as part-time)

Curriculum vitae of coordinator
Please email a one-page summary.

Job description for coordinator
Please email a summary in English.

Coordinator's competence in English: basic ☐ intermediate ☐ advanced ☐
If the coordinator is not fluent in English, what support is available?

Healthy city project office or team

How many staff members currently work for the healthy city project office or team?
(Full-time employees who only work part-time for the healthy city project are classified as part-time.)
Number of full-time staff:
Number of part-time staff:
Number of regular volunteers:

3. Intersectoral steering group or partnership group

Which people and agencies are represented on the main intersectoral steering group or partnership group that supports the healthy city project in your city?

What are the names of main agencies or representatives?
Please email a scanned copy of the letter of commitment to this application signed by the chair of the steering or partnership group.

4. City health profile

If your city has a city health profile, please answer these questions.

What is the title of the profile?
What is its date of issue?
What is its status (for example: draft, in consultation, endorsed, implemented)?
What time does it cover?
Please email a copy of the city health profile or its website link.

If your city does <u>not</u> have a city health profile, please answer these questions.

Do you have anything similar? If so, please describe it.
What are your intentions and time scale for producing a city health profile?

5. Integrated planning for health

If your city has a city health development plan or equivalent, please answer these questions.

Can your city show evidence of integrated planning for health, such as a city health development plan or equivalent?
What is the title of the plan?
What is its date of completion?
What is its status (for example: draft, in consultation, endorsed, implemented)?
What time period does it cover?
Please send a copy of the plan by email or the website link to the report.

If the plan is being implemented, are there progress or evaluation reports?
Yes ☐   No ☐
If yes, list the titles and dates produced.
Please email the reports or the website links to the reports.

If your city does <u>not</u> have a city health development plan or equivalent, please answer these questions.

Do you have anything similar? If so, please describe it.
Is there evidence of strategic partnerships for health in your city?
Please outline the remit and/or achievements of the partnerships (in fewer than 200 words).

6. Health-promoting, equitable and sustainable local development

Can your city show evidence of health and well-being dimensions in the overall city development strategy or equivalent?
What is the title of the plan?
What is the date of its completion?
What is its status (for example: draft, in consultation, endorsed, implemented)?
What time period does it cover?
Please send a copy of the plan by email or the website link to the report.

If the strategy is being implemented, are there progress or evaluation reports?
Yes ☐   No ☐
If yes, list the titles and dates produced.
Please email the reports or the website links to the reports.

7. a) Goal 1: Fostering health and well-being for all and reducing health inequities

How will your city take forward Goal 1?

Please outline no more than three actions in fewer than 250 words. These actions should be measurable and represent key priorities as identified by the city health profile. These actions will provide the basis for the evaluation of the city throughout Phase VII.

7. b) Goal 2: Leading by example nationally, regionally and globally

How will your city take forward Goal 2?

Please outline no more than three actions in fewer than 250 words.

7. c) Goal 3: Supporting implementation of WHO strategic priorities

How will your city take forward Goal 3?

Please outline no more than three actions in fewer than 250 words.

8. Core themes of Phase VII

Theme 1: Investing in the people who make up our cities
Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.

Theme 2: Designing urban places that improve health and well-being
Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.

Theme 3: Greater participation and partnerships for health and well-being
Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.

Theme 4: Improved community prosperity and access to common goods and services
Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.

Theme 5: Promoting peace and security through inclusive societies
Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.

> **Theme 6: Protect the planet from degradation, leading by example, including through sustainable consumption and production**
> *Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your city's Phase VII situation analysis report.*

9. Three areas of good practice for Phase VII

Phase VII will include the identification of **three examples of good practice** that will be shared with cities across the Network for mutual learning and inspiration. These should address priority health outcomes or populations according to need, and should be demonstrated through the appropriate indicators.

Once your application to Phase VII is deemed successful, you will be asked to provide a full case study of the examples that will be shared with other cities, included in Phase VII publications and featured on the WHO website. These examples will also be used for your city-specific evaluation of Phase VII.

> For each of the **three examples of good practice**, please provide the following.
>
> - a short description of the example, including the need it addresses, its main achievements and the lessons learned *(please provide a narrative text of fewer than 350 words)*;
>
> - which Phase VII goal or theme this example addresses;
>
> - which Sustainable Development Goals (SDGs) and specific SDG targets this example addresses *(please provide a simple list)*; and
>
> - the relevant SDG indicators for the last available year for the SDG targets that this example addresses – this will act as a baseline for the evaluation of Phase VII for your city *(please provide a simple list)*.

10. Three priority areas of action for Phase VII

Phase VII will include the identification of **three priority areas of action** that you will address in Phase VII as a member of the Network. These should emerge from the findings from your city health profile, and address priority health outcomes or populations according to need. Progress will need to be determined through the appropriate indicators.

These priority areas of action should be consistent with your answers to Section 8 of this application form. They will be used as the basis of your joint commitment with WHO under Phase VII and for your city-specific evaluation of Phase VII.

> For each of the **three priority areas of actions**, please provide:
>
> - a short description of the priority action, including the need it addresses, the main activities planned (including the evidence base for the planned interventions) and the expected outcome(s) *(please provide a narrative text of fewer than 350 words)*;

- which Phase VII goal or theme it addresses;

- which SDGs and which of their specific SDG targets it addresses *(please provide a simple list)*; and

- the relevant SDG indicators for the last available year for the SDG targets that it addresses – this will act as a baseline for the evaluation of Phase VII for your city *(please provide a simple list).*

11. Strengthening partnership and coherence

Please provide a short description how your healthy city activity links to SDG implementation within your city; with other cities; with national initiatives led by your national government; and with international partnerships.
Please provide a simple list.

12. Capacity-building

How will your city address training and capacity-building for increasing leadership, strengthening participatory governance, improving health for all and reducing health inequalities throughout Phase VII?
Please identify no more than three actions in fewer than 250 words.

13. Networking

What are the strengths or experiences your city could contribute to the overall work of the Network?
Please identify no more than three areas in fewer than 250 words.

How does your city expect to gain from membership in the Network during Phase VII?
Please respond in fewer than 250 words.

National network of Healthy Cities

Does your country have a national network?   Yes ☐   No ☐
Is your city a member of this national network?   Yes ☐   No ☐

Other networks of healthy cities

Are you a member of a regional or metropolitan (subnational) network of healthy cities?
Yes ☐   No ☐
If yes, which?

Other international city networks

Are you a member of any other international city networks working for health or sustainable development?
Yes ☐   No ☐
If yes, which?

14. City Phase VII overview

Once your application is successful and your designation complete, your city will be featured on the WHO website. Please provide a narrative text providing an overview of your city's Phase VII implementation, and provide a high-resolution photograph to be included on the WHO website. The narrative should focus on the reasons for applying to the Network, the city's vision in terms of Phase VII outcomes, the city's main health needs, examples of what the city intends to address during Phase VII and an example of good practice.

The narrative should be fewer than 400 words. It does not need to include key facts and figures as these will be presented elsewhere on the relevant webpage.

15. Monitoring and evaluation

Does your city confirm that it agrees to be externally evaluated by WHO?
Yes ☐   No ☐
This should appear in the letter of commitment from the mayor (see Section 1).

Is your healthy city project systematically monitored or evaluated?
Yes ☐   No ☐
If yes, describe:
Please email a signed, scanned copy of any substantial report or a website link to the original.

Thank you for your interest in becoming a member of the WHO European Healthy Cities Network in Phase VII.

Please print a copy of this page for your records.

Below is a checklist of signed, scanned or original documents to be submitted by email with the application.

- Council resolution supporting city participation in Phase VII
- Letter of commitment from the city mayor supporting city participation in Phase VII
- Phase VII city situation analysis document
- City development strategy analysis document
- City statement indicating how the city will benefit membership in Phase VII
- Curriculum vitae of coordinator
- Job description for coordinator
- Letter of commitment to this application signed by the chair of the steering or partnership group
- City health development plan
- City health profile
- Optional evaluation report
- Completed and signed Declaration of Interests form for the city coordinator
- A completed and signed non-exclusive licence to use photographic images

In the heading of your application package, please reference "Phase VII application documentation".

Healthy Cities Programme
Division of Policy and Governance for
Health and Well-being
WHO Regional Office for Europe
UN City
Marmorvej 51
DK-2100 Copenhagen Ø
Denmark

Telephone: +45 45 33 70 00
Facsimile: +45 45 33 70 01
Email: eurohealthycities@who.int

Annex 4.

Declaration for national networks

The [*name of national network*] hereby applies to join the WHO European Healthy Cities Network. This declaration confirms that the [*name of national network*] has met the minimum requirements for membership as laid out in the implementation framework.

We hereby confirm that the [*name of national network*] endorses the goals, aims, objectives and actions of the WHO European Healthy Cities Network.

The [*name of national network*]:

1. makes a political commitment to the Copenhagen Consensus of Mayors and to the WHO European Healthy Cities Network Phase VII implementation framework;
2. has at least 70% of its members fulfilling the membership criteria that follow the four action elements of healthy cities;
3. has a coordinator with technical and administrative resources;
4. is formally organized under a constitution or equivalent;
5. has a steering committee with political representatives and stakeholders that represent Phase VII goals and core themes;
6. will support cities in delivering the Copenhagen Consensus of Mayors and the Phase VII implementation framework;
7. can demonstrate that its actions actively support member cities in achieving Phase VII goals and other activities;
8. is committed to attending the Network's Annual Business Meeting and Technical Conference; and
9. will actively strive to increase the number of cities that meet the minimum requirements of the Network.

The [*name of national network*] promises to fulfil the responsibilities of the WHO European Healthy Cities Network by:

1. providing relevant information to WHO and the WHO European Healthy Cities Network as required and regularly updating that information, including completing the annual reporting template;
2. paying an annual contribution to WHO of US$ 1000 per year;
3. disseminating resources (information and other products) from the Network and WHO to its member cities;
4. taking the initiative to promote healthy cities at the national level; and
5. acting as a link between the Network and member cities.

Name: Signature:

Political chairperson: …………………………………………………………………..

National network coordinator: ………………………………………………………….

Date: ……………………………………………………………………………………

Annex 5.

Supporting documentation for the national network accreditation process

Please provide the following information electronically to the WHO Regional Office for Europe at: eurohealthycities@who.int.

1. A list of the members of the national network that describes how they meet the minimum requirements for membership in the national network, including the political commitment
2. An action plan of activities for the year ahead for the national network
3. A 2–3-page Phase VII situation analysis report identifying the opportunities and challenges related to the goals and themes at the level of the national network and the priority issues for Phase VII
4. The completed form found in Annex 6
5. The contact details, curriculum vitae and job description of the national network coordinator, specifying the technical and administrative resources available to the national network
6. A list of members of the national network's steering committee (with title or function and whether they have decision-making authority), including political representatives
7. A translated copy (or summary) of the national network's constitution, accepted by the steering committee and members
8. A completed and signed Declaration of Interests form for the national network coordinator
9. A completed and signed non-exclusive licence to use photographic images

Annex 6.

Application form for national networks in Phase VII

1. National network implementation of Phase VII goals

Goal 1: Fostering health and well-being for all and reducing health inequities

How will your national network foster health and well-being for all and reduce health inequities?

Please outline no more than three actions in fewer than 250 words. These actions should be measurable. These actions will provide the basis for the evaluation of the national network throughout Phase VII.

Goal 2: Leading by example nationally, regionally and globally

How will your national network lead by example nationally, regionally and globally to achieve the strategic goals of Phase VII?

Please outline no more than three actions in fewer than 250 words.

Goal 3: Supporting implementation of WHO strategic priorities

How will your national network support the implementation of WHO strategic priorities?

Please outline no more than three actions in fewer than 250 words.

2. National network implementation of core themes

Theme 1: Investing in the people who make up our cities

Please describe (in fewer than 250 words) how you intend to address the core theme overall and which issues you intend to emphasize. These should be relevant to the results of your network's Phase VII situation analysis report.

Theme 2: Designing urban places that improve health and well-being

Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your national network's Phase VII situation analysis report.

Theme 3: Greater participation and partnerships for health and well-being

Please describe (in fewer than 250 words) how you intend to address the core theme overall and which issues you intend to emphasize. These should be relevant to the results of your national network's Phase VII situation analysis report.

Theme 4: Improved community prosperity and access to common goods and services

Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your national network's Phase VII situation analysis report.

Theme 5: Promoting peace and security through inclusive societies

Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your national network's Phase VII situation analysis report.

Theme 6: Protect the planet from degradation, leading by example, including through sustainable consumption and production

Please describe (in fewer than 250 words) how you intend to address this core theme overall and which issues you intend to emphasize. These should be relevant to the results of your national network's Phase VII situation analysis report.

3. Three areas of good practice for Phase VII – for existing national networks only

Phase VII will include the identification of **three examples** of good practice that can be shared with other national networks for mutual learning and inspiration. These should address priority health outcomes or populations according to need, and should be demonstrated through the appropriate indicators.

Once your application to Phase VII is deemed successful, you will be asked to provide a full case study of the examples to be shared with other national networks, included in Phase VII Healthy Cities publication and featured on the WHO website. These examples will also be used for your national network specific evaluation of Phase VII.

For each of the three examples, please provide:

- a short description of the example, including the need it is addressing, main achievements and lessons learned *(please provide a narrative text of fewer than 350 words)*;
- which SDGs and which of their specific targets this example addresses *(please provide a simple list)*; and
- the relevant SDG indicators for the last available year for the targets that this example addresses – this will act as a baseline for the evaluation of Phase VII for your network *(please provide a simple list).*

4. Three priority areas of action for Phase VII

Phase VII will include the identification of **three priority areas for action** that you will address in Phase VII as a member of the WHO European Healthy Cities Network. These should reflect the needs of your member cities and address priority health outcomes or populations according to need. Progress will need to be determined through the appropriate indicators. These three priority areas should be coherent with your answers to Part 1 and Part 2 of this form. They will be used as the basis of your joint commitment with WHO under Phase VII and for your network-specific evaluation of Phase VII.

For each of the **three priority actions,** please provide:

- a short description of the priority action including the need it is addressing and the main activities planned (including the evidence base for the planned interventions) and the expected outcome(s) *(please provide a narrative text of fewer than 350 words)*;

- which SDGs and which of their specific targets this priority area addresses *(please provide a simple list)*; and

- the relevant SDG indicators for the last available year for the targets this example addresses – this will act as a baseline for the evaluation of Phase VII for your network *(please provide a simple list)*.

5. Strengthening partnership and coherence

Please provide a short description how your national network links to SDG implementation; other partnerships or networks at the national level; national initiatives led by your national government; and international partnerships.
Please provide a simple list.

6. Capacity-building

How will your national network address training and capacity-building of cities within the network for improving leadership, strengthening participatory governance, improving health for all and reducing health inequalities throughout Phase VII?
Please identify no more than three actions in fewer than 250 words.

7. Mayors campaign

The WHO Regional Director for Europe announced her intention to have 20 000 mayors sign the Copenhagen Consensus of Mayors. How will your national network support this campaign in Phase VII?
Please include proposed partnerships and advocacy with existing networks of cities in and beyond your country, for example, your national municipal association.

8. National network Phase VII overview

Once your application is successful and your accreditation complete, your national network will be featured on the WHO website. Please provide a narrative text providing an overview of your national network Phase VII implementation, and provide a high-resolution photograph to be included on the WHO website. The narrative should focus on the reasons for applying to the Network, the vision for the national network in terms of Phase VII outcomes, the main health needs of the national network, examples of what the national network intends to address during Phase VII and an example of good practice.
The narrative should be fewer than 400 words. It does not need to include key facts and figures as these will be presented elsewhere on the relevant webpage.

9. Outreach and communication

Social media details (as relevant):

Annex 7.

Phase VII key documents

WHO European Healthy Cities Network Copenhagen Consensus of Mayors: Healthier and Happier Cities for All. A transformative approach for safe, inclusive, sustainable and resilience societies (2018)
(Available in English, Russian, French and German at: http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/who-european-healthy-cities-network/policy/copenhagen-consensus-of-mayors.-healthier-and-happier-cities-for-all-2018)

Belfast Charter for Healthy Cities. Operationalizing the Copenhagen Consensus of Mayors: Healthier and Happier Cities for All (2018)
(Available in English, Russian, French and German at: http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/publications/2018/belfast-charter-for-healthy-cities-2018)

Transforming our World: the 2030 Agenda for Sustainable Development (2015)
(Available in Arabic, Chinese, English, French, Russian, Spanish at: https://sustainabledevelopment.un.org/post2015/transformingourworld)

City health profiles: how to report on health in your city (1995)
(Available in English at:
http://www.euro.who.int/__data/assets/pdf_file/0009/101061/wa38094ci.pdf)

City health profiles: a review of progress (1998)
(Available in English at:
http://www.euro.who.int/__data/assets/pdf_file/0010/101062/E59736.pdf?ua=1)

Twenty steps for developing a Healthy Cities project (1997)
(Available in English, Russian, French and German at:
http://www.euro.who.int/__data/assets/pdf_file/0011/101009/E56270.pdf?ua=1)

The WHO Regional Office for Europe

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

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