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The Hidden Cities: Addressing Equity in Health and Inclusiveness in Cities

17–19 June 2010
Sandnes, Norway

Report on a WHO Business and Technical Conference

Healthy Cities 21st Century

Abstract

This is the report of the Second Annual Business Meeting and Technical Conference of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks in Phase V (2009–2013): The Hidden Cities: Addressing Equity in Health and Inclusiveness in Cities, held on 17–19 June 2010 in Sandnes, Norway. This event set out the context of equity in health for local authorities, connecting the international and urban public health agendas. Strong focus was placed on narrowing inequity in health by addressing the whole of the social gradient through evidence-based interventions focusing on community assets, capacity and skills. An action framework to guide local action on equity in health was presented and put under consultation. Several conclusions and recommendations were made regarding the future strategic focus of Healthy Cities on equity in health as well as the areas for future technical guidance.

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1. Introduction

The City of Sandnes, Norway hosted the Second Annual Business Meeting and Technical Conference of the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks in Phase V (2009–2013) on 17–19 June 2010.

Norunn Østråt Koksvik, Mayor of Sandnes, opened the meeting and welcomed participants. Further speeches were given by Guri Ingebrigtsen, Political Leader of the Norwegian Healthy Cities Network; Bjørg Tysdal Moe, Deputy Mayor of Stavanger and Vice Chairperson of the Norwegian Association of Local and Regional Authorities, and Agis D. Tsouros, Unit Head, Noncommunicable Diseases and Environment and Head, Centre for Urban Health, WHO Regional Office for Europe. Per-Harald Nilsson, Chief Executive of Urban Development, Municipality of Sandnes chaired the opening session.

Equity has long been a central theme of the healthy cities movement, and the issue has reached prominence in the wider international policy agenda. This international dimension was reflected in the Conference through presentations and recognition of overarching processes, including World Health Day 2010, which was dedicated to urbanization and health, the International Meeting on Health in All Policies in Adelaide (13–15 April 2010), the EU's Lisbon Treaty and the development of a new WHO health policy for the European Region. The Conference also addressed the need for local preparedness to respond to global events such as the H1N1 influenza virus and the global economic crisis.

Concretely, the purpose of the Conference was to put the topic of equity in health into an urban context to enable and support local action via four thematic strands:

- tackling inequity in health in cities
- technical guidance on Phase V themes
- urban governance, citizen participation and public health
- connecting the international and urban public health agendas.

These themes were addressed in 5 plenary presentations, 24 parallel sessions and 19 teach-ins.

The meeting was attended by 324 participants, including 80 political representatives and representatives of 57 cities in the WHO European Healthy Cities Network and 16 national healthy cities networks.

In addition, there were two business sessions and two subnetwork meetings.

The City of Sandnes demonstrated outstanding hospitality throughout the event. This included a series of cultural performances alongside the technical programme, which demonstrated the cultural diversity and rich resources of the local population. Participants also took part in city site visits and social events.

2. The context of equity in health

The context of the Conference was set out by a round-table comprising a series of presentations and discussions. The panellists were experts and professionals who had a key role in developing documents and other processes that steered the development of the Conference agenda. An additional presentation with contextual information and concrete examples on the topic of urban ecology was also provided. The round-table was facilitated by David Vlahov, Senior Vice President for Research and Director, Centre for Urban Epidemiologic Studies, New York Academy of Medicine, New York, USA and Agis D. Tsouros.

2.1 The European context

Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

The focus on inequity in health in Phase V of the WHO European Healthy Cities Network was described as an issue relevant not only to cities but to regions and countries. Inequity in health is widening in Europe across all health indicators. Whereas in the 1970s, the European Region had a homogeneous life expectancy, in 2010 there are gaps. This cannot be afforded politically, economically or ethically. This widening health gap is also demonstrable between neighbourhoods of cities and towns.

Inequity is inherited and developed during the life cycle. For example, children born in an unhealthy environment are more likely to have cognitive problems, to leave school without qualifications, to struggle in the labour market and very likely not to live to the retirement age. Governments could respond to the problem of widening inequity in health, especially in the context of an economic crisis, by putting equity at the centre of policy and the delivery of core services and infrastructure. Past crises demonstrated that cities with good institutional capacity to address the social determinants of health and reduce inequality in health had more options to cope and perform better. Taking action against inequity in health would require a shift in approach away from projects and individual sector-led interventions to a whole-of-government priority.

2.2 Addressing the social determinants of health: the urban dimension and the role of local government

Michael Grady, Senior Lecturer, University College of London, United Kingdom

The key messages of *Addressing the social determinants of health: the urban dimension and the role of local government. A working document for consultation (1)* were presented to the Conference. This document was based on evidence and recommendations of a report of the WHO Commission on Social Determinants of Health *(2)* and a strategic review of health inequalities in England after 2010 *(3)*. The latter review took stock of global evidence and translated it into policy measures that would enable governments to move beyond standard infant mortality and life expectancy targets.

A key message of these reports and for setting the context of Conference discussions is that social injustice kills on a large scale and that coordinated action is needed at all levels of government on structural conditions as well as the conditions of daily life. Although the gaps in health have been

known for at least 25 years, it has nevertheless been a struggle to bridge them. There is a need to respond to the social gradient of inequality in health with proportionate universalism. The policy community has significant achievements, such as increasing life expectancy, that have produced valuable lessons and insight. However, an exclusive focus on disadvantage will not narrow inequality. A focus on the whole social gradient will bring wider benefits to society as a whole and be more effective in narrowing gaps in health.

A challenge of the review in England was to establish the economic place for addressing inequality in health. This was achieved by estimating what would be the difference if everyone enjoyed the same life opportunities and health expectancy of the most affluent people in society. Inequality is costly to society in terms of lost productivity, lost taxes and increased health costs. In financial terms, these factors amount to a cost of about £50 billion per year in the United Kingdom *(4)*.

Policy-makers need models and practical initiatives to be able to drive the agenda forward.

2.3 Tackling the social determinants of inequality in health

Anna Ritsatakis, Senior WHO Expert Adviser

The WHO Constitution established health as a human right, and for 30 years the first target of the WHO Health for All policy was equity in health. Many countries took health for all on board, and among these were countries with equitable social policies and rigorous research and data collection traditions, yet inequality in health persisted or was increasing in these countries.

Inequity in health refers to differences that are unnecessary and avoidable and considered to be unjust. There has been a huge increase in research on the extent and causes of inequality in health but less research on effective action. Over the years, experience had led to greater understanding of the need for an increasingly strong focus on the social determinants of health. This affected a shift from the Health for All approach on environment, health care and lifestyles and behaviour to one that focuses on root causes. This understanding has been facilitated by a report from the WHO Commission on Social Determinants of Health *(2)*.

At the national level, there have been five levels of progress:

- the development of awareness of the problem via high-profile reports;
- sustained research, monitoring and evaluation of inequality in health;
- political commitment to tackle the gaps;
- acceptance by non-health sectors that they have responsibility and accountability for equity in health; and
- coordinated action across sectors to close the gaps, not fully achieved by most countries.

At the local level, equity needs to be considered as a foundation of well-being and development. Cities need to perceived changes in inequality in health as important indicators of progress in local economic and social development. Evidence is available to demonstrate that health and social problems are worse in countries with more inequality across all indices, including life expectancy, numeracy and literacy, infant mortality, homicide, imprisonment, teenage births, obesity, mental illness and social mobility *(5)*. Similarly, equal societies performed better across positive indices.

A shift is needed towards assets-based working in which the potential of a community is valued in terms of capacity and skills. Local partners need to better understand each other's objectives to facilitate win-win scenarios. Cities need to be alert to windows of opportunity in the form of committed politicians, shifts in political alliances, administrative changes, a new programme or an unexpected external event. This preparedness needs to be facilitated by a strengthened knowledge base (such as small-area data) and training (such as health impact assessment and working with other sectors).

Healthy cities are in a strong position to take the equity agenda forward. Cities have experience with targeted work on equity through city health profiles and plans and benefit from existing tools, guidelines, training packages and case studies.

2.4 The 2010 World Health Day report

Geoff Green, Professor Emeritus of Urban Policy, Faculty of Development and Society, Sheffield Hallam University, United Kingdom

WHO dedicated 2010 as a landmark year for urbanization and health to be celebrated by 1000 cities. A joint WHO/United Nations Human Settlements Programme global report on urban inequality in health, *Hidden cities: unmasking and overcoming health inequities in urban settings (6)*, was being published in 2010. The WHO European Region substantially contributed to that report.

Six themes were expected to emerge from this global report.

- **Urbanization**. In 2007, the population of cities and towns surpassed that of rural areas. Population growth in low- and middle-income countries was explosive. Europe had led the world in urbanization, and although some cities in Europe had declined for a period, they were expanding again as a result of migration and immigration. With an ageing population trend in Europe, immigration has the potential to rejuvenate cities.
- **Prosperous cities**. Around the world, cities are at the centre of economic activity. However, persistent inequality limits increases in health and well-being as gross domestic product (GDP) per person increases as well as the product of economic growth. To illustrate that unequal societies underperform, an example was that the United States has lower life expectancy than Cuba. There is a reciprocal relationship between health and the economy, and good health does not simply trickle down from a good economy.
- **Hidden cities**. Cities concentrate risks and hazards for health as well as opportunities, jobs and services. Poverty is heavily concentrated in cities. In some parts of the world, the inequality and its causes are visible (such as poor housing), but the hidden inequality needs to be unmasked. New guidance on healthy cities indicators will help pave the way.
- **Leadership**. Cities have been seen as settings for health interventions. International agencies and national governments often set policies, but the effects are felt at the local level. The role of cities extends beyond formal competencies and power to values and commitment and convening power.
- **Prerequisites**. *Hidden cities* will highlight four prerequisites for action: political leadership, vision and strategy, institutional structures and networking.
- **Action**. Cities will be encouraged to take action through a process of: defining problems; identifying the determinants of the problems a city can influence; giving them political priority; producing a strategy and creating strategic and project-level interventions; and monitoring and evaluation.

2.5 Health in all policies: a report from Adelaide 2010

Jean Simos, Director, Research Group on Environment in Health, University of Geneva and Vice President of S2D (Association Internationale pour la Promotion de la Santé et le Développement Durable) – WHO Collaborating Centre for French-speaking Healthy Cities

Health in all policies emerged as a priority of the 2006 Finnish Presidency of the European Union. WHO and the South Australian Government jointly hosted the International Meeting on Health in All Policies in Adelaide on 13–15 April 2010.

The main outcome of the Meeting was the Adelaide Statement on Health in All Policies, which called for shared governance for health through more effective government. It strongly promoted health equity in local policies via such tools as health impact assessment. WHO plans to use this statement in the two years following the Meeting to development consensus on health in all policies and to identify how to implement models of practice appropriately in the various institutional frameworks of its Member States.

Details of the Meeting are available at http://www.dh.sa.gov.au/pehs/HiAP/adelaide-2010.htm (accessed 6 November 2010). The Adelaide Statement on Health in All Policies is available at http://whqlibdoc.who.int/publications/2010/9789241599726_eng.pdf (accessed 6 November 2010).

2.6 Applying a health equity lens to Phase V goals

The Health Equity Lens round-table facilitated by David Vlahov and Agis D. Tsouros featured speakers and experts in health literacy, noncommunicable diseases and gender mainstreaming. The speakers were:

- Franklin Apfel, Managing Director, World Health Communication Associates;
- Kristine Sørensen, Researcher/Project Coordinator, European Health Literacy Survey, Department of International Health, Maastricht University, the Netherlands;
- Jill Farrington, Honorary Senior Lecturer, Nuffield Centre for International Health & Development in Health Systems Strengthening, University of Leeds, United Kingdom; and
- Piroska Östlin, Special Adviser, Office of the Regional Director, WHO Regional Office for Europe.

The round-table highlighted how the health equity lens focusing on fairness, health for all, social determinants, differential exposure, unequal participation and upstream intersectoral engagement can provide a barometer for evaluating all of health development.

Within the health literacy frame, focus was placed on differential capacity and assets and the health literacy interventions that could improve individual knowledge and skills, systems and settings through navigation and policy and planning through advocacy. The health literacy domains of health systems, education and information and marketplaces, politics and citizenship can put health literacy at the heart of achieving the Phase V goal of health equity in all local policies. Communication is a determinant of health, because it influences individuals' capacity to access health information and use it.

Several approaches were highlighted that could make a difference to gender equity. This included action that tackles social biases that generate differences in health risks and outcomes, collecting

data disaggregated by sex and gender analysis of such data. Women's organizations, which are critical to ensuring that women have a voice and that give priority to demands for accountability from everyone, could also provide support.

Several requirements were outlined for building equity- and gender-based health policies and programmes, including: joint commitment and action supported by resources; strengthening the knowledge base to inform policy; action at various policy levels to encourage policy change; documenting and disseminating knowledge on effective and gender-sensitive interventions; and developing incentives and structures to eliminate gender bias and equity bias in programmes and services.

In relation to noncommunicable diseases, the speaker identified key concepts in tackling noncommunicable diseases and the key role disease prevention has along the disease course with the results from early intervention compared with years lost with late or no intervention. Within noncommunicable diseases, applying the health equity lens can, through city health profiles, identify differences and assess the implications and the need for action. Several entry points, interventions and measurements were suggested to incorporate action for equity, including the role for equity leadership during this stringent economic period.

2.7 Urban ecology and health

David Vlahov, Senior Vice President for Research and Director of the Centre for Urban Epidemiologic Studies, New York Academy of Medicine, USA

Urban ecology is defined as the complete environment of a city, such as the physical and social environment, health services and the political and cultural forces. Several global trends in the development of cities were discussed.

The expansion of cities
Cities around the world are expanding, with dramatic increases in low- and middle-income countries. By 2015, the urban population is expected to surpass the rural population in low- and middle-income countries. Fifty per cent of the urban population lives in cities with less than 500 000 inhabitants. These cities are the primary targets for policy interventions to mitigate against negative effects as they expand in terms of population and urban sprawl. Solutions need to be found to create high population density so that cities do not eliminate rural agricultural resources while promoting economic efficiency.

Cities as sources of climate change
Cities generate 80% of all carbon dioxide and significant amounts of other greenhouse gases, contributing to climate change mainly through energy generation, vehicles, industry and biomass use. A 1–3°C increase in average annual temperatures is forecast in 2020 compared with 200 and 5–7°C by 2080. Each 1°C increase in temperature will reduce work ability by 20%. Work ability is a reference level of physical exertion measured in watts. This would have dramatic effects in low- and middle-income countries, as the temperatures are typically 4–5°C higher in urban areas than in the countryside. Climate change will lead to regional weather changes such as heat-waves and precipitation, with health effects such as temperature-related illness and death, air pollution–related health effects, water- and foodborne disease, vector- and rodent-borne diseases, food and water shortages and population displacement.

Cities as the centre of globalization
Globalization should be understood as more than banking and finance. Cities are centres of globalization in terms of growth, climate change, vulnerability and susceptibility. An example of the severe acute respiratory syndrome (SARS) epidemic was given to demonstrate a chain of disease transmission from several guests in a hotel in Hong Kong Special Administrative Region to cities around the world. Examples were also given of network-based crime rings that had developed as a consequence of the lack of legal resources to jobs and services for migrants.

Health issues in cities
Although there are no unique urban diseases in cities, interrelated risk factors are exacerbated in cities:

- chronic disease (diet, exercise and primary care)
- road safety (car culture and infrastructure)
- violence (social exclusion and culture clash)
- infectious diseases (overcrowding, natural population growth).

For example, in areas with considerable violence, people would be less likely to walk and cycle and to use cars, which increases chronic disease through lack of exercise, promoting car culture and worsening air quality. The stress of social exclusion also affects chronic disease.

Cities continue to promote inequality
Examples were given to illustrate how low levels of income, unemployment and educational attainment and high rates of teenage births and homicide are concentrated into specific districts of cities. However, these districts also have positive health outcomes that should be learned from and transferred to other communities. This would involve changing focus to look at the assets in a community rather than exclusively focusing on problems.

Reducing inequality requires new approaches to population health to address the whole social gradient instead of using narrower interventions targeted only at population groups at higher risk. Through whole-gradient approaches, the risk curve for an entire population could be shifted to benefit everyone. Some groups would benefit more from this approach – those with better access to services and information – and interventions to limit this inequality are needed.

3. Political round-table: city leadership for health equity and inclusiveness

This round-table discussion sought to explore how city politicians perceive and promote the need to address inequality in health. The six panellists were chosen to provide a representative focus group reflecting the diversity of the WHO European Region as well as city size and dynamics. The round-table was chaired by Norunn Østråt Koksvik, Mayor of Sandnes and moderated by Franklin Apfel, World Health Communication Associates. The participating panellists included:

- Bülent Tanik, Mayor of Çankaya, Turkey;
- John Dixon, Councillor for Health, Social Care and Well Being, Cardiff, United Kingdom;
- Marianna Klicka, Deputy Speaker, Vienna Provincial Parliament;
- Valerie Levy-Jurin, Political Chair of the French Healthy Cities Network and Deputy Mayor of Nancy;
- Lubomír Gajdusek, Political Chair of the Czech National Healthy Cities Network; and

- Denis Zaytsev, Deputy Mayor of Cherepovets, Russian Federation.

Despite the differences between the represented cities (and countries) in population size and configuration, economic performance and institutional organization, representatives shared common challenges and views.

Most cities have to deal with the needs of a transient daytime population as well as a permanent residential population. Several representatives referred to geographically defined areas of deprivation and dispersed vulnerable groups. Most panellists referred to negative effects of the economic recession in terms of increased unemployment and poverty, weakened social services and the loss of industry.

The political representatives referred to human rights, fairness, social cohesion, good governance and creating attractive cities as drivers of action for equity in health. If equity principles were a routine part of policy-making and planning, they would not have to be protected in a time of crisis. Further, John Dixon pointed out that, in the budget cuts that stemmed from the economic crisis, equity principles could be used to mitigate against the potential unfair effects of the cuts.

Many panellists spoke of the benefits equity brought to the city. The politicians think that equity policies promote social cohesion and make cities more accessible and better places to live. Generally, equity policies and action were considered to improve the attractiveness of cities to their inhabitants and to outsiders.

Healthy Cities provides a starting-point and a set of tools for taking action for equity in health. Several examples of targeted initiatives related to poverty and unemployment were shared. However, the panellists felt that more needs to be done at the national and international levels to enable action for equity locally.

4. Tackling inequality: strategic thinking and practical results

4.1 Addressing the social determinants of inequity in health: lessons from implementation

Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

Health in Europe has become more and more unequal, with a difference in 20 years of life expectancy between countries across the WHO European Region. This disparity is also a growing problem within cities. Significant evidence is available at the global level to support the need for work on inequality *(2)*.

Europe could do well to learn from the countries of central and eastern Europe, which faced a great political, economic and social crisis in the 1990s. These countries were forced to make choices related to economic development that would affect equality within their societies. The European Region could benefit by studying those choices, the principles that underpinned them and the outcomes.

A definition of inequities in health was provided *(7)*:

> Social inequities in health are systematic differences in health status between different socioeconomic groups. These inequities are socially produced (and therefore modifiable) and unfair.

Although this definition has worked well in academe and among international professionals and experts, it has not always been the right language for local politicians and citizens. What matters is how the evidence gets put into action. Typical obstacles to action at the national level include:

- securing political commitment;
- rigid systems – technology, human resources and sharing resources – that make intersectoral work difficult;
- unskilled human resources;
- lack of incentives for intersectoral action;
- isolated programmes;
- insufficient or fragile financing mechanisms; and
- organizational or institutional weakness.

Key lessons from the work of WHO's investment for health programme were shared. These examples were based on in-depth analysis of implementation work on inequity in health with both national and subnational partners.

Monitoring inequality in health
Monitoring inequality in health should include data across the social gradient, reflecting the social groups within the population. Data must be collected routinely.

Reacting to data
Two possible reactions to data were described: denial or indifference or concern leading to action. If policy-makers decided to take action, they often had difficulty knowing what to do. Action tended to begin with isolated initiatives, which built experience for more structured development, and finally a comprehensive coordinated strategy.

Strategies that unite
Strategies should bring together civil society with political and professional constituencies and city assets. Appropriate institutional arrangements need to be established to create the context that would move sectors beyond mere cooperation to a scenario of genuine integrated policies.

Whole-of-government approach
Addressing the social determinants of health and the related inequity in health requires a shift to a whole-of-government approach. A coherent set of policies and interventions must be developed on a scale appropriate to the trends and magnitude of the problem in the country or city.

Think in terms of assets
Cities should focus on maximizing their assets for public health rather than solely focusing on reducing risks.

National versus local
Many national governments have national action plans, but these often remain on the shelf and are only partly implemented or translated into isolated demonstration projects. These are seldom scaled up or adapted systematically within a whole country. Plans should ensure that the local social situation and health situation are integrated and should not prescribe generic interventions.

4.2 Reflections on the results of annual reports

Premila Webster, Director of Education and Training, Head, School of Public Health, Oxford University, United Kingdom

Premila Webster provided an overview of the results of city responses to the annual reporting template in 2009–2010 *(8)*. The key sections of the annual reporting template included political commitment, political and organizational changes, the frequency of intersectoral steering group meetings and the focus of the main partnerships in the cities. Key reflections on the outcomes and process of the annual reporting template are summarized below.

Most healthy cities cited political commitment as a key facilitating factor. Political and national changes in the past year at the national and local levels were likewise mainly positive. About one third of cities regard the current economic downturn as an obstacle. WHO endorsement of cities via the city accreditation mechanism and the expertise from the WHO European Healthy Cities Network were also important facilitating factors.

Regarding equity, it has been difficult to ascertain whether the cities understand well the concept and policy implications of equity in health based solely on annual reporting template results.

Information was collected on the three Phase V core themes: caring and supportive environments, healthy living and healthy urban environment and design. Because of inconsistencies in the responses, analysing the quality of the activities undertaken by cities has been difficult. Cities had a good range of activities for the first two themes but had carried out limited activities on the third theme.

Regarding the annual reporting template instrument, the format and scope of the questionnaire did not lend itself to structured and detailed information on activities, making assessment of the quality of activities very difficult. The presenter suggested that more thought should be given to how useful the information collected is, and this should be used to modify the type of information collected. If data on activities were to be collected in a more structured way, they could be better analysed and used appropriately. It was also suggested that clear guidance on how to complete the questionnaire should be produced. The view of the city coordinators on the process and challenges of working with the annual reporting template would be beneficial.

In previous years, subnetworks were perceived as useful, and it was suggested as a good means to share experience between old and new cities. A buddy system was also proposed, in which a new city would be paired with an experienced city.

Cities are carrying out a variety of projects in a range of areas but need to start grappling with addressing equity at a strategic level. If cities were to deliver on the core themes at a strategic level with a focus on equity, they would require help and guidance to enable them to understand and implement the overarching concept of equity in all activities.

5. Coordinators' debate panel

Panellists representing cities as well as national networks were invited to respond to questions related to the overarching theme of equity and their plans to address it. Panellists included the following city coordinators:

- Karen Amlaev, Stavropol, Russian Federation
- Colin Cox, Manchester, United Kingdom
- Francisco Gomez, Vitoria-Gasteiz, Spain
- Iwona Iwanicka, Lódz, Poland and the Polish Healthy Cities Association
- Inge Kristiansen, Horsens, Denmark
- Ankica Perhat, Rijeka, Croatia.

The key issues highlighted centred on four broad themes, which are addressed below.

Terms and communication
Although healthy cities have worked with equity for many years, communicating the issue to other sectors and to the public remains a challenge. The term equity presents linguistic and communicative barriers. In many languages, no single term encapsulates the technical definition of equity. Although the panellists were well aware of the distinction between equity and equality, the latter term provides a better point of departure for discussing the issue with partners and the public.

Panellists said that partners in cities agree on the principle of equity in health, but the message for action has been unclear. Concrete, sector-specific examples and messages should be presented to municipal partners. Different messages are needed for politicians, practitioners, the general public and the mass media. It is likewise considered important to understand the various reactions these groups have to these messages.

Data collection and evidence
Panellists remarked that general data are available that demonstrate that inequality exists but that more data are needed at the national and local levels. Cities need help to demonstrate local-level inequality in a cost-effective way. More needs to be done to bridge academic researchers with the practitioners who lead implementation. Developing stronger messages to illustrate the magnitude of the impact of inequality, likening it to a global pandemic with statistical information on deaths compared with recent threats such as H1N1 influenza, was proposed.

Bridging evidence and action
International evidence shows where inequality exists and why, but national governments need to take a direct role or cities will continue to struggle. The WHO European Healthy Cities Network has led in bridging experts and policy actors to produce effective, relevant tools for cities. It is considered important that politicians know that tools (such as health impact assessment) exist to help them put health among the top priorities in cities.

Institutional capacity and Healthy Cities
The WHO European Healthy Cities Network has developed sustainable capacity to harness political commitment, engage other sectors in strategic-level approaches to health and manage institutional changes. Participation in the WHO European Healthy Cities Network has provided cities with a process for transforming the vision of equity in health into a reality by providing a starting-point, tools, an incremental process for building institutional capacity and a network for tapping into European knowledge.

The international policy agenda at the time of the Conference provided added legitimacy for Healthy Cities to take the equity agenda forward.

6. Coordinators' meeting

A session was held for coordinators of the cities in the WHO European Healthy Cities Network to discuss strategic and management issues for delivering Phase V goals.

An overview of the subnetworks in Phase IV was provided. There were subnetworks on the topics of health impact assessment, healthy urban planning and healthy ageing. It was suggested that additional networks be established on health literacy and biodiversity.

It was decided that there should be common terms of reference for all subnetworks that also set out the deliverables for the phase. The Advisory Committee of the WHO European Healthy Cities Network was given the task of producing these terms of reference. The thematic work of the subnetworks should be grounded on equity in health and the overall principles of Healthy Cities. It was proposed that subnetworks could have both traditional and virtual meetings. The role of collaborating centres in supporting the subnetworks was explored. Finally, it was agreed that participation in the subnetworks should be open to cities in the WHO European Healthy Cities Network and to cities in national healthy cities networks. Generally, it was noted that there must be mutual support between the WHO European Healthy Cities Network and the Network of European National Healthy Cities Networks, and the influence of national healthy cities networks at the national level should be enhanced.

The meeting discussed different organizational strategies that would allow the Healthy Cities movement to survive political changes. There was agreement that healthy city teams in planning, health or sustainable development departments enable Healthy Cities goals and incorporating methods to be mainstreamed.

Coordinators discussed methods to enable Healthy Cities to have a greater impact locally, nationally and internationally. Suggested actions focused on communication and partnerships.

Participants thought that Healthy Cities should be easier to find and to navigate to on the WHO web site. The WHO European Healthy Cities Network should have a communication plan. This includes producing tangible facts and practical examples related to achievements and goals for external partners as well as tools for better communication within the WHO European Network and national networks.

It was further suggested that the WHO European Network build partnerships with other networks and with the European Union.

7. Politicians' meeting

City action for health equity and inclusiveness – sharing practical experience
The politicians' meeting was chaired by Norunn Østråt Koksvik, Mayor of Sandnes and facilitated by Agis D. Tsouros and Franklin Apfel. Bent Høie, Chair of the Standing Committee on Health and Care Services of the Norwegian Parliament, provided a presentation on Norway's health policy and legislation, with emphasis on health promotion at the local level and the role of the municipalities within this. Norunn Østråt Koksvik also gave a presentation on gender equity in Norway. Politicians shared their experience in the challenges in and success of promoting action on equity at the local level. The discussion also centred on the role of national governments in promoting policy to support delivery at the local level.

8. Strengthening national healthy cities networks

Six national healthy cities networks gave presentations covering the development and organization of the networks, the nature and breadth of their activities, current projects and achievements. These networks were:

- Czech Republic
- Israel
- Norway
- Slovenia
- Sweden
- Turkey.

The presentations demonstrated that the Healthy Cities model can be effectively transferred across cultures and a range of institutional setting and provide flexibility to respond to various health challenges according to local institutional capacity. Following this overview, the discussion focused on aspects that might help to strengthen national networks in the European Region.

It was pointed out that national networks would be stronger as a group, validating and encouraging further work at the national level as the Network of European National Healthy Cities Networks, to which national networks could apply for WHO accreditation. It was suggested that there be applied research that would allow comparison between countries.

Another point of discussion was the connection national networks have to make between the national and local levels. Systems need to be in place locally and nationally with regular evaluation to produce sustainable effects at both levels. For example, each national network needs to develop activities, tools and services to enable pioneering work at the local level to legitimize the network as a whole as an expert body that should be involved nationally in government bodies and national strategy development.

Whereas the local political level is well aware of their need for national-level support, the converse is not always true. National network coordinators spend much time demonstrating to the national level how the local level, via national healthy cities networks, can empower and enable the national level to articulate and achieve goals.

It was recognized that national network partnerships had to move on from ministries of health and engage other government ministries.

It is also acknowledged that national networks have a key role in enabling the knowledge gained by cities within the WHO European Healthy Cities Network to be effectively transferred to cities within national networks.

9. Parallel sessions

The major themes of the Conference, corresponding to the goals of Healthy Cities in Phase V, were addressed in detail in 24 parallel sessions based on case study presentations and 19 teach-ins.

Each major theme is summarized below based on the reports provided by session rapporteurs, providing the outcomes of discussions and recommendations to WHO based on available reports.

Case studies and PowerPoint presentations from the parallel session presentations are available to the cities in the WHO European Healthy Cities Network and to national healthy cities networks on the WHO password-protected web site (https://euro.sharefile.com/?cmd=f&id=fo21c22e-6a3d-4178-9210-3db9f1a03e3e).

9.1 Equity

The issue of equity was the basis of several parallel sessions. Three of these sessions were consultations on *Healthy cities tackle the social determinants of inequalities in health: a framework for action. A working document for consultation (4)*, the results of which are covered in detail in section 10.8. Of the remaining sessions, five reports were submitted. Key issues stemming from the discussion of the city presentations are reflected below.

Community participation was identified as being essential to the development of almost every intervention presented in the sessions. Presentations reflected how processes such as developing a long-term vision for the city or producing and analysing profiles were substantially more valuable as a result of the input of local residents.

Overall, the discussion on the various aspects of addressing inequality in health indicated the effectiveness of the basic tenets of the Healthy Cities approach and the need to strengthen and enhance city capacity on aspects of this approach. Tools such as health impact assessment and health in all policies were considered useful, but session participants thought more training was needed on both approaches and how they complemented one another.

Beyond community participation, there was a consistent conclusion that there is a need for solid local data, systematic monitoring and evaluation and effective partnerships. Regarding partnerships, including the use of tools such as health impact assessment and health in all policies, participants identified the need for non-health sectors to recognize what they can do to deliver health gains rather than exclusively assess whether their proposed interventions affect health.

Recommendations to WHO included the following.

- Develop examples of how to engage the variety of groups in communities in a flexible way.
- Provide examples of how to move successful pilot projects into mainstream policy-making and interventions.
- Provide examples of innovation for overcoming barriers to work on inequality in health, including using timely issues, such as the economic recession, to put inequality in health on the agenda.
- Provide further training on health impact assessment and on health in all policies.

9.2 Caring and supportive environments

Five parallel sessions were held on caring and supporting environments, covering a range of action as well as action at the national level. Topics included the ageing population, empowering local people and healthy settings at the national and local levels.

Work on the ground illustrates the difficulty of ensuring that local initiatives genuinely promote equity between and among social groups, bringing into question appropriate settings for action and the barriers to access to services these might overcome or inadvertently create. For example, older people cannot be treated as one group that might be accessed through one setting. Likewise, in relation to ageing and in relation to other population groups, action should focus on the assets and opportunities that various groups bring to society rather than solely on the problems they create or confront. The effective allocation or reallocation of resources was a key topic of discussion for one group. It was noted that equal distribution of resources does not necessarily bring about equitable outcomes.

Many issues have to be addressed to create caring and supportive environments, including social inclusion, addressing key public health challenges, community involvement in local decision-making and the delivery of mainstream services, general awareness-raising of health and well-being and social networking.

Effective monitoring and evaluation also need to be in place. Many of the projects had a strategic view of rolling out pilots and initiatives more widely within one city or within regions and countries.

National healthy cities networks presented several initiatives. Network coordinators pointed out that it often takes 5–10 years to embed healthy public policy. This requires systematic approaches to ensure national-level involvement and leadership, including involving the political level, adequate funding from a range of sectors and a complementary strategic and operational focus to take a vision for health settings forward. National networks act as clearinghouses for information for cities and other partners, lobby governments on behalf of their cities and provide training and support to their members.

9.3 City health profiles

The topic of city health profiles was addressed via one parallel session and three teach-ins. Presentations on city health profiles revealed that cities had successfully managed to collect data and to analyse it to identify inequality in health at the local level. Likewise, cities have gone on to use this information as evidence to create appropriate interventions targeted at the right people. When used within the WHO European Healthy Cities Network or national healthy cities networks, city health profiles enable inequality in cities to be compared.

Although city health profiles are deemed valuable, there is a persistent problem of funding and overall sustainability because the profiles are generally carried out by volunteers and as inexpensively as possible. Gaining national support for city health profiles would make this a more powerful instrument.

Recommendations to WHO included:

- setting up a buddy system between experienced and new healthy cities;
- using the HEPRO[1] survey as a model for exchanging ideas and comparing results of city health

[1] HEPRO (Health and Social Well-being in the Baltic Sea Region) was a public health project that was partly financed by EU in the Baltic Sea Region INTERREG IIIB programme and managed by Østfold County Council

profiles within the WHO European Healthy Cities Network; and
- supporting cities in establishing a cycle of monitoring and review to identify interventions that are appropriate and improve the health of citizens.

9.4 Healthy living

Five parallel sessions were held on the topic of healthy living. The themes of the sessions covered alcohol and drug abuse, community participation, intersectoral cooperation, obesity among children and active travel.

Cross-cutting themes in these reports are the need for small-area data, regular monitoring and effective project design. Discussions underlined the importance of the basic tenets of the Healthy Cities approach across the topical areas, with emphasis on political and multisectoral support. The role of the mass media in new activities (such as in supporting anti-tobacco legislation) is deemed very important.

Regarding project design, participants felt that it is essential that projects identify success criteria and that they be set up to measure and demonstrate how interventions affect equity. Projects must be designed to better appeal to their target audiences.

Participants said that small-area data are lacking: these would enable cities to better identify target groups and to understand deprivation. Similarly, participants said that cities should understand how best to make use of this data in implementing interventions.

Recommendations to WHO included:

- supporting cities in collecting small-area data;
- supporting cities in monitoring the impact on equity in health;
- providing an equity lens focus on project design to assist in designing, implementing and evaluating projects; and
- providing examples of how cities can lobby for national policy change, such as on tobacco legislation.

9.5 Healthy urban environment and design

Four parallel sessions and three teach-ins were held on healthy urban environment and design. The topics covered included sustainable mobility and safer neighbourhoods, creating healthy urban places, tools to promote urban planning and equity and citywide planning.

It was underlined that equity in health is a politically loaded term and that the term has to be used in a way that draws political interests into the debate (such as fairness and equal opportunities). Identifying and defining inequality in health is easier than designing effective interventions to

(Norway). Further information is available at http://www.heproforum.net (accessed 6 November 2010).

reduce it. Clarity is needed on effective plans, mechanisms for community influence on land-use, effective management and consensus-building.

Case study examples demonstrated the importance of the following:

- setting clear achievable goals (such as a tax on air pollution);
- ensuring good public awareness on issues that require behavioural change;
- high-profile actions (such as banning cars from city centres);
- community engagement as a means to gaining support for interventions;
- the option of using aspects of health impact assessment to inform interventions and plans rather than carrying out a full assessment; and
- the importance of indicators as a tool for understanding how people live.

It was noted that disadvantaged areas are disproportionately affected by poor physical environments, poor air quality and poor urban design and maintenance.

One group identified a series of planning issues that affected equity in health. These included parks in deprived areas, affordable housing, the disruption caused by regeneration, road crashes affecting children, housing areas with high proportions of immigrants, kindergarten provision, retail decentralization, park-and-rides and poor access to health services.

Recommendations to WHO:

- develop training and tools for consensus-building;
- help cities to develop skills for using the language of equity;
- develop more resources highlighting interventions that have not worked (such as social housing in the 1960s and 1970s in Europe); and
- update *Healthy urban planning: a WHO guide to planning for people (9)* to include new case studies and to systematically address equity.

9.6 Teach-ins

Teach-ins were provided and had high-level participation on a wide range of topics: planning, local governance, gender mainstreaming, city health profiles, health equity in all policies, health literacy, physical activity, health impact assessment and noncommunicable diseases. Specific teach-ins were held for beginners, and a special session was also held for newcomers to Healthy Cities. A consultation was also held on the research consortium European Healthy Cities Research Centre described in section 10.6.

10. Business sessions I and II

The purpose of the business sessions was to outline and report back on the practical management of the WHO European Healthy Cities Network and to provide news and information relevant to the future direction of the healthy cities programme. Within these sessions, participants formally adopted the programme and appointed the general rapporteur.

10.1 Report of the WHO Centre for Urban Health

Agis D. Tsouros, Unit Head, Noncommunicable Diseases and Environment and Head, Centre for Urban Health, WHO Regional Office for Europe

Zsuzanna Jakob took office as the new WHO Regional Director for Europe on 1 February 2010. The WHO Regional Office for Europe is producing a new health policy for the WHO European Region leading to national strategies in which local health policies are expected to be integral. The WHO European Healthy Cities Network and the national healthy cities networks will be actively consulted and involved in developing the new European policy.

The range of activities undertaken by the WHO Centre for Urban Health on behalf of the WHO European Healthy Cities Network were outlined and included:

- organizing *The Hidden Cities: Addressing Equity in Health and Inclusiveness in Cities*;
- analysing annual reports;
- preparing for, monitoring and eventually evaluating Phase V of the WHO European Healthy Cities Network;
- assessing city applications for membership in the WHO European Healthy Cities Network;
- accrediting national healthy city networks;
- providing input for World Health Day 2010; and
- producing and promoting documents.

As of June 2010, the WHO European Healthy Cities Network has 61 member cities; 50 had previously been designated and 11 were new. Further, 40 cities had submitted applications, and 16 of these were being assessed. Sixteen national networks were accredited at the time of the Conference.

A summary of income and expenses for the WHO European Healthy Cities Network was presented.

There was a suggestion to re-establish thematic subnetworks during Phase V.

The need was identified to strengthen communication, partnerships and training within the WHO European Healthy Cities Network.

10.2 Report of the Advisory Committee of the WHO European Healthy Cities Network, 2010–2011

Elisabeth Bengtsson, Chair, Advisory Committee, WHO European Healthy Cities Network and Healthy City Coordinator, Helsingborg, Sweden

Elections were held electronically in November and December 2009 for the Advisory Committee of the WHO European Healthy Cities Network. Representatives of the new Advisory Committee included the following coordinators of cities in the WHO European Healthy Cities Network:

- Karen Amlaev, Stavropol, Russian Federation
- Elisabeth Bengtsson, Helsingborg, Sweden
- Colin Cox, Manchester, United Kingdom
- Iwona Iwanicka, Lódz, Poland
- Sule Onur, Kadikoy, Turkey
- Gianna Zamaro, Udine, Italy.

The first meeting of the Advisory Committee was held in Sandnes on 16 June 2010, during which Iwona Iwanicka was elected as the new chair of the committee.

10.3 Report of the Advisory Committee for the Network of European National Healthy Cities Networks, 2009–2010

Milka Donchin, Chair, Advisory Committee, Network of European National Healthy Cities Networks and Coordinator, Israel Healthy Cities Network

The Advisory Committee has been operating since 2006, at which time it was decided that training, a newsletter and a US$ 1000 annual membership fee for national networks would be introduced.

In June 2009, the first training session was held in Viana do Castelo. The outcome was successful, and it has been decided to hold an event annually. The second event was held in Herzliya, Israel on 17–20 March 2010. The main theme of this event was health literacy. Coordinators who were present also discussed Phase V themes as well as the need to strengthen cooperation between national networks.

The Baltic Region Healthy Cities Office prepared the first newsletter of the national networks as a pilot.

10.4 Report of the WHO Healthy Cities Secretariat, Belfast

Joan Devlin, Head, WHO Healthy Cities Secretariat and Director, Belfast Healthy Cities

The role of the WHO Healthy Cities Secretariat in Belfast is to support both the WHO Regional Office for Europe and the city members of the WHO European Healthy Cities Network. The specific functions of the Secretariat during the past year were:

- to support the process of designating member cities to the WHO European Healthy Cities Network in Phase V;
- to support the annual reporting process, including developing a new annual reporting template;
- to carry out preparations for business and technical conferences;
- to provide strategic input into documents;
- to manage the election of the advisory committee of the WHO European Healthy Cities Network; and
- to provide administrative support.

10.5 Election of the Advisory Committee of the Network of European National Healthy Cities Networks

Leah Janss Lafond, WHO Temporary Adviser

The Advisory Committee of the Network of European National Healthy Cities Networks was elected at the Conference. Coordinators and political representatives from accredited national networks were eligible to stand for the election and vote. The following coordinators of national networks were elected to the Network Advisory Committee:

- Selma Sogoric, Croatia
- Camilla Meyer, Denmark
- Zöe Heritage, France
- Milka Donchin, Israel.

10.6 Launch of the European Healthy Cities Research Centre

Geoff Green, Professor Emeritus of Urban Policy, Faculty of Development and Society, Sheffield Hallam University, United Kingdom

The European Healthy Cities Research Centre was formally launched at the Conference. The Centre will be based at Lund University at a campus in Helsingborg, Sweden. The rationale behind the Centre is to encourage the development of research and robust evidence that will be accessible and useful to the policy community and to encourage the use of this research.

Partners of the Centre include four universities and three cities offering three pillars of research, teaching and training. The Centre will contribute to the Phase V objective of generating policy and practice expertise and of promoting solidarity, cooperation and working links between European cities. The work is to be based on:

- the Zagreb Declaration for Healthy Cities: Health and Health Equity in All Local Policies;
- an action-research model;
- policy;
- providing accessible and robust evidence to local policy communities; and
- synthesizing evidence for European policy initiatives.

The aim is to get evidence into local debates and policy formulation within the WHO European Healthy Cities Network and national healthy cities networks instead of having research confined within academe.

The Centre will draw equally on the capabilities of both academics and city professionals, especially coordinators. The work will be context-driven, problem-focused and interdisciplinary. The Centre will seek feedback from healthy cities and national healthy cities networks on its draft programme for training and its research agenda.

10.8 Results of consultation on the action framework

Anna Ritsatakis, Senior WHO Expert Adviser

Healthy cities tackle the social determinants of inequalities in health: a framework for action. A working document for consultation (4) was produced for the Conference to propose a framework for tackling the social determinants of inequalities in health for local authorities. A consultation on this action framework was carried out in three parallel sessions involving 46 participants.

As a whole, participants felt that a long document is needed with city examples aimed at coordinators and other target groups. The objective of the document should be to stimulate ideas and provide a format that city coordinators could dip in and out of, selecting entry points suitable to their particular situation. The consultation document will be revised based on the discussions in the parallel sessions. There was also general agreement that a short document is needed that

concisely outlines main points. The target group for this short document will be decision-makers and stakeholders.

Participants also asked for a ready-made PowerPoint presentation that cities could adapt. Coordinators also requested pamphlets that would present general and specific issues related to equity. A "calculator" instrument was proposed. This tool would demonstrate the effects of influencing a social determinant of health. More city examples should be shared online.

The main emphasis of consultation discussions was the need for raising awareness. There were discussions regarding whether there should be indicators of progress on changes in inequality in health. It was agreed that there should be some kind of annual reporting on local inequality in health and that changes in equity in health should be considered an indicator of city development.

There was agreement that cities need to look further at the assets-based methods, and a healthy cities subgroup was proposed for this area that could examine this area more deeply.

Coordinators were uneasy about equity action plans as set out in the draft paper because this would require them to take action in areas over which they have no formal responsibility. The revised framework should indicate how other sectors might more effectively be reached.

There was interest in training, peer review and buddy systems.

More guidance is needed on health impact assessment. It is felt that health impact assessment could be overwhelming and costly and that simple tools for screening and scoping are needed.

10.9 Healthy Cities communication and video download facility

Steve Turner, WHO Temporary Adviser

Cities submitted video material before the Conference that was used to produce the global World Health Day video. A video presentation disk, including 29 videos and a link to a download facility, was provided to participants in their Conference packs. The facility allows users to download video clips and images and to make versions and productions in other languages. The facility will additionally be promoted to broadcasters throughout the European Region, making a contribution to the Healthy Cities communication programme.

The video download facility can be accessed via the following web site: http://www.turner-associates.org/HCDownload/Default.html (accessed 6 November 2010).

11. Conclusions and recommendations

This Conference set out the international evidence and policy processes related to inequality in health and its relevance to the urban setting. It was clearly demonstrated that addressing inequality in health benefits societies as a whole and that focusing on the whole of the social gradient is needed to narrow health gaps. Although there is a huge body of research on the extent and causes of inequality in health, less research has been carried out on effective action. To drive the agenda forward, policy-makers need access to models and practical initiatives; however, this needs to be enabled by increasing the availability of equity-related data and evaluating interventions at both the local and national levels.

A rich programme of expert plenary presentations and practical examples of local action in parallel sessions demonstrated that healthy cities are in a strong position to take the equity agenda forward. Healthy cities have mature experience with targeted work on equity through city health profiles and plans, the use of tools such as health impact assessment and a general focus on good governance principles. However, changes are still needed in how cities manage institutions, deliver core services, carry out research and collect data, communicate with and engage partners and stakeholders and give communities a voice. Future action on equity requires a shift in approach away from projects and sector-led interventions to a whole-of-government priority. The difficulty of communicating the issue of inequality in health to partners is frequently raised as an issue.

Work on the ground illustrates the difficulty of ensuring that local initiatives genuinely promote equity between and among social groups, bringing into question appropriate settings for action and the barriers to access to services these might overcome or inadvertently create. Cross-cutting conclusions during the Conference included the need for effective project design, small-area data and regular monitoring and evaluation.

Community involvement is regarded as being essential to equity-related interventions. The Conference called for a shift towards assets-based working in which a community is valued in terms of its assets and skills. Communication directed at the population level also poses a risk of increasing inequality in health, as some groups in society are better equipped to access, understand and act on health information than others.

Cities with good institutional capacity to address the social determinants of health perform better than their peers during times of adversity: notably, the current economic crisis. Preparedness to mitigate against economic shocks can be facilitated by strengthening the local knowledge base and capacity to work with tools such as health impact assessment. Networking among healthy cities offers an effective means of transferring knowledge and gaining support and knowledge for new initiatives and interventions.

Throughout the Conference, expert presenters, panellists and local representatives made informal recommendations in plenary and parallel sessions. These recommendations are summarized below and also take into account the recommendations made in Section 9. Overall, the recommendations of the Conference could be related to increasing the visibility and leadership of Healthy Cities at the international and national levels, better communicating Healthy Cities and inequality in health at all levels, monitoring and evaluation and further developing support via networking, training, tools and information resources.

International and national influence

- The WHO European Healthy Cities Network and national healthy cities networks should build partnerships with other international networks and with the European Union.
- The capability of national healthy city networks to influence the national level should be enhanced.
- WHO should provide examples of how cities can lobby for national policy change, using successful examples such as tobacco legislation.

Communication

- Stronger messages need to be developed to illustrate the magnitude of the effects of inequality in health.
- The WHO European Healthy Cities Network should have a communication plan. This includes producing tangible facts and practical examples related to achievements and goals for external partners as well as tools for better communication within the WHO European Healthy Cities Network and national healthy cities networks.
- Participants thought that Healthy Cities should be easier to find and to navigate to on the WHO web site.

Monitoring and evaluation

Cities need further support from WHO:

- to collect and analyse data, especially small-area data, reflecting the full social gradient;
- to identify local-level inequality in a cost-effective way;
- to improve local monitoring and evaluation on equity in health, improving the ability of cities to identify appropriate interventions and demonstrate how they affect the health of citizens; and
- to bridge academic research with local implementation.

Further training and support

- There was agreement that cities need to further examine assets-based methods. It was proposed that a healthy cities subgroup in this area could examine this more deeply.
- A buddy system should be established to bridge gaps between long-established and new healthy cities.
- Tools such as health impact assessment and health in all policies are considered useful, but session participants thought that more training is needed on both approaches and how they complement one another.
- Evaluation should be strengthened.
- National networks should have a key role in enabling the knowledge gained by city members of the WHO European Healthy Cities Networks to be effectively transferred to cities within national networks.

Development of tools and resources

- It was proposed that an equity checklist be developed to assist in project design, implementation and evaluation.
- The network should harvest tools and experiences from previous phases, such as the evidence gained from the health impact assessment subnetwork.
- Participants suggested that resources should be developed on:
    - how to engage the variety of groups in communities in a flexible way;

  - how to move successful pilot projects into mainstream policy-making and interventions;
  - overcoming barriers to working on inequality in health: for example, by using timely issues, such as the economic recession, to put inequality in health on the agenda;
  - highlighting interventions that have not worked (such as social housing in the 1960s and 1970s in Europe); and
  - local consensus-building.
- It was suggested that *Healthy urban planning: a WHO guide to planning for people (9)* be updated to include new case studies and to systematically address equity.

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