Healthy cities as catalysts for caring and supportive environments

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Summary

‘Caring and Supportive Environments’ are fundamental to a social model of health and were a core theme of Phase V (2009–13) of the WHO European Healthy Cities Network. Deploying the methodology of realist evaluation, this article synthesizes qualitative evidence from 112 highly structured case studies from 68 Network cities and 71 responses to a General Evaluation Questionnaire, which asked cities to analyze city attributes and trends. A schematic model was developed to describe the interaction between action targeted toward children, migrants, older people and action on social and health services, health literacy and active citizenship—the six subtopics clustered within the theme Caring and Supportive Environments. Four hypotheses were tested: (i) there are prerequisites and processes of local governance that increase city capacity for creating supportive environments; (ii) investing in health and social services, active citizenship and health literacy enhance the social inclusion of vulnerable population groups; (iii) there are synergies between social investment and healthy urban planning; and (iv) these investments promote greater equity in health. The evaluation revealed many innovative practices. Providers of health and social services have developed partnerships with agencies influencing wider determinants of health. Health literacy campaigns address the wider context of people’s lives. In a period of economic austerity, cities have utilized the social assets of their citizens. Realist evaluation can help illuminate the pathways from case study interventions to health outcomes, and the prerequisites and processes required to initiate and sustain such investments.

Key words: evaluation of healthy cities network, social inclusion, Europe

INTRODUCTION

This article evaluates 112 case studies (CS) submitted by members of the WHO European Healthy Cities Network (WHO-EHCN). Prerequisites recommended by WHO as essential for city health development have evolved over five phases of the Network spanning 25 years (Tsouros, 2013). These include political leadership by municipalities, vision and strategy, intersectoral collaboration and networking. The CS focus on interventions for ‘Caring and Supportive Environments.’ This was the first core theme of the WHO-EHCN in Phase V (2009–13), but can be traced back to the inception of the Healthy Cities movement: ‘A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually
support each other in performing all the functions of life and in developing to their maximum potential’ (Hancock and Duhl, 1986). Supportive environments are one of the five core actions areas of the Ottawa Charter (WHO, 1986) which embraces a social model of health promotion. More recently, the 53 member states of the WHO European Region committed to creating ‘resilient and supportive environments’ as one of four priority actions in Health 2020, the European policy framework (WHO Regional Committee for Europe, 2012).

Supportive environments have physical and social dimensions that interact with each other. A focus on the role of the physical environment in promoting health development can be traced back to the Rio Declaration on Sustainability (United Nations Conference on Environment and Development, 1992) and evolved in the WHO-EHCN by embedding ‘healthy urban planning’ into Phases III and IV (Barton and Tsourou, 2000; Barton et al., 2009). ‘Healthy Urban Environment and Design’ was a second core theme of Phase V. The social environment (associated with ‘caring’) was prominent in the WHO Sundsvall statement (WHO, 1991) and in the deliberations of the WHO Commission on Social Determinants of Health (CSDH) (CSDH, 2008). Following the Zagreb Declaration (WHO Regional Office for Europe, 2009), the Goals and requirements (WHO, 2009) for cities joining Phase V of the WHO-EHCN specified that ‘a healthy city should be above all a city for all its citizens, inclusive, supportive, sensitive and responsive to their diverse needs and expectations’ (WHO Regional Office for Europe, 2009). According to the program logic of Phase V (de Leeuw et al., 2015), interventions in both the first and second core themes are assumed to contribute to the third core theme of ‘Healthy Living’.

Within our theme, WHO-EHCN cities were encouraged to collaborate around a cluster of six specific topics: children, older people and migrants as three potentially vulnerable groups in the population and three categories of investments—in health literacy (Kickbusch et al., 2013), active citizenship (Heritage and Dooris, 2009; Dooris and Heritage, 2013) and health and social services. The three target groups were highlighted for interventions to promote a ‘city inclusive of all citizens’. This article reviews the thematic projects, programs and strategies adopted by members of the WHO-EHCN during Phase V. We aim to guide those joining Phase VI (2013–18) and inform a wider policy community in Europe and beyond who regard cities and their institutions as key agents for developing caring and supportive environments.

**METHODOLOGY**

The underlying framework of our analysis is the social model of health development adopted by WHO and expressed in the widely acclaimed work of the CSDH (CSDH, 2008). We adopted and adapted ‘realist evaluation’ (Pawson and Tilley, 1997) and ‘realist synthesis’ methodology (Pawson et al., 2004) summarized by an earlier article in this special supplement (de Leeuw et al., 2015). This approach synthesizes evidence from different sources—scientific and experiential, primary and secondary—and involves the policy community in the formulation of concepts and propositions which shape the activity of healthy cities. The six topics reviewed are obviously not exhaustive of all those that could be included in caring and supportive city environments, but were highlighted by WHO as requiring special attention in Phase V. Although the coherence this cluster could be debated and challenged, we used an inductive ‘grounded theory’ approach (Glaser and Strauss, 1967; Stoto et al., 2013) with a random sample of 40 CS to analyze the conceptual connections between the six topics and constructed a schematic model of pathways.

**Sources and verification of data**

At the heart of our evaluation are 112 CS structured around a template which followed a political and program logic. City respondents were asked to provide political context, identify the issue or challenge to be addressed, baseline evidence, which actors were involved in initiating and sustaining the project, program or strategy, and the actual or predicted outcome and impact. All 159 (CS) submitted by 73 cities (of the 99 in the network) for the Phase V evaluation were coded with the help of Nvivo, resulting in a subset of 107 CS where the research team had identified action on Caring and Supportive Environments or one of the six focus topics. We also included an additional 5 CS separately identified by respondents as relevant to the theme of Caring and Supportive Environments, arriving at a final subset of 112 CS from 61 cities. A complementary General Evaluation Questionnaire (GEQ) was submitted by 71 cities, providing a quantitative self-assessment of how far the city’s actions had made a difference to city status over Phase V (2009–13) and predicted by the end of Phase VI (2014–18). Fifty questions elicited how—interalia—respondents rated the level of active citizenship, health services and health literacy in their city, and the quality of the lives of their older citizens, children and migrants. They were asked for evidence to justify their rating and to secure political assent to their assessment.
Preliminary categorization and model development

We first interrogated a random sample of 40 CS, using an inductive method to construct our schematic model (Figure 1). We ascertained how cities reported certain prerequisites prior to developing interventions in the three topic areas directed toward one or more of the three target populations. Patterns of intersection and overlap were identified. On this basis, a model was constructed and four hypotheses formulated that describe the relationships. These structure and guide our further analysis and reporting. We then scaled up from the sample by interrogating all 112 CS; of these, 33 related to the topic of age-friendly cities, 52 to children, 9 to migrants, 42 to active citizenship, 36 to health and social services and 51 to health literacy. We then quantified the links between the three categories of intervention and the target populations. These overlapping and interacting topics are modeled in Figure 1.

Our model links the six topics and their potential impact on social inclusion and health equity. The CSDH commissioned an analysis of social exclusion (SEKN, 2007) which maintained that health equity is enhanced by ‘promoting full and equal inclusion for all social groups’ in ‘all social systems’. Potential relationships between the components of the model translate into four dynamic hypotheses to be tested via a review of evidence. These are:

(i) several prerequisites of local governance enhance city capacity for creating supportive environments;
(ii) interventions to improve health and social services, active citizenship and health literacy interact and will enhance the social inclusion of the three population groups;
(iii) there are synergies between Caring and Supportive Environments, Healthy Urban Environment and Design and interventions to improve Healthy Living;
(iv) investment in health literacy, active citizenship and health and social services will lead to greater equity in health.

In-depth qualitative analysis

We examined all 112 CS in detail, testing the first hypothesis that initiating action programs depended on certain institutional prerequisites and critical process factors. Addressing the second hypothesis, we identified the underlying relationships behind the headline intersections and connections between topics revealed by our preliminary analysis. The third hypothesis was addressed first by identifying the number of CS intersecting our Caring and Supportive Environment theme and the two other core themes of Phase V, Healthy Urban Environment and Design and Healthy Living; second by investigating policy frameworks and sequencing of program development. Finally, despite the limitations of this approach, we
gathered clues for an eventual impact evaluation by identifying the number of CS referring (implicitly or explicitly) to health outcomes and non-communicable disease. Ordinal data elicited by the General Evaluation Questionnaire were utilized to triangulate city ‘outcome’ status with CS interventions and target populations. Data from supplementary sources helped illustrate the European context of cities in the WHO-European Healthy Cities Network.

RESULTS

Results are structured around the four hypotheses, assessing the links between intervention categories and the three target populations. Table 1 summarizes the main relationships, although some CS cover more than one category and address more than one target population. In the spirit of the Zagreb Declaration, these links encapsulate a dynamic process or system, characterized by constant change, activity and progress.

First Dynamic: governance prerequisites and processes

The first hypothesis is that various prerequisites of municipal governance enhance capacity for creating supportive environments. An examination of the 112 CS revealed over 90% referred to five prerequisites identified by Tsouros (Tsouros, 2013): (i) intersectoral working, (ii) supportive institutional structures and processes, (iii) political leadership, (iv) community participation and (v) networking. There was little difference between long established ‘Pioneer’ cities which joined the WHO-EHCN in the first three phases (1987–2002) and ‘New Blood Cities’ joining the Network during Phase IV (2003–09) or V. New cities quickly adopted these prerequisites.

Four similar attributes were also rated by the GEQ: cities assessed performance on a scale of 1–10 at both the beginning and end of Phase V, and predictively in 2019 (following the conclusion of Phase VI, 2014–18) for political commitment, partnership, leadership, and participation. The median values and range of responses are shown in Table 2.

With the exception of ‘Local political commitment to the healthy cities project’, the median values for prerequisites increased between 2009 and 2013. Projecting forward to beyond the end of Phase VI in 2018, the median values for leadership and partnership also increased. Cities provided evidence to justify these changes, and these averages hide significant differences in trajectory. However, as anticipated, there is a degree of ‘gaming’ involved with the majority of cities claiming both an improvement between the beginning and end of Phase V (2009–13) and predicted for the next phase. This biases the results in favor of success.

Although GEQ responses give a temporal dynamic, our evaluation gives priority to the interactions between prerequisites and processes signaled by Kickbusch and Gleicher (Kickbusch and Gleicher, 2012). Seven critical process factors identified by the Healthy Ageing Task Force (a subnet-work of the WHO Healthy Cities Network) provide a structure for deeper analysis of the CS: (i) political commitment, (ii) community participation, (iii) strategy, (iv) health profile, (v) action program, (vi) resources and (vii) evaluation. These factors are understood by cities as multiple entry points, rather than a predetermined sequence of political leadership → participation → profile and so on. The City of Brno’s Healthy Ageing strategy and action program exemplifies a complex process originating in WHO guidance to the Task Force. Here, a population profile persuaded politicians to seek resources from the European Commission to develop a strategic plan, first enhancing the profile, consulting communities as part of ‘colourful’ intersectoral cooperation, and then finally evaluating the outcome and impact as a contribution to the Czech Republic’s national strategy for positive aging.

Second dynamic: complex interaction between interventions and target groups

Our main hypothesis is ‘that health literacy, active citizenship and health and social services, enhance the social inclusion of the three population groups’. This is a second and most important dynamic, with complex intersections and interactions sometimes making the sequence of cause and effect difficult to discern. Although children and older people are clearly differentiated, migrants can be both of these. Of the 26 CS study interventions around health literacy, 50 were specifically oriented to children, 3 to migrants and 9 to older people. Of the 43 CS interventions promoting active citizenship, 12 were oriented to children,
Table 2: Cities’ self-rated assessment of how four prerequisites “were part of your healthy city vision and activities”

<table>
<thead>
<tr>
<th>Metric</th>
<th>2009</th>
<th>2013</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local political commitment</td>
<td>8 (range: 6–9)</td>
<td>8 (range: 6–10)</td>
<td>/</td>
</tr>
<tr>
<td>Health leadership from different political actors</td>
<td>6 (range: 2–10)</td>
<td>7 (range: 4–9)</td>
<td>8 (range: 5–10)</td>
</tr>
<tr>
<td>Participation</td>
<td>6 (range: 2–9)</td>
<td>8 (range: 6–9)</td>
<td>8 (range: 7–10)</td>
</tr>
<tr>
<td>Partnership</td>
<td>7 (range: 2–10)</td>
<td>8 (range: 5–10)</td>
<td>9 (range: 7–10)</td>
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13 to older people and 2 to migrants. Of the 32 interventions by health and social services, 14 were oriented specifically to children, 8 to older people and 2 to migrants. The most important links were between health literacy/children and social services/health literacy, illustrating the complex dynamic between different interventions and between interventions and target populations.

The template asked respondents to classify their CS study as a project, a program, a policy or other. More than half refer to projects, 40% to programs and circa 30% involve policy activity. However, we have not used this typography in our report for two reasons. First, the boundaries between these types are blurred. Many submissions referred to several alternatives (e.g., project and policy or program). Second, past accounts of Network cities suggest they undertake projects nested within an overarching policy framework. Yet only 30% of our CS ‘tick’ the policy option. This suggests under-reporting because these same cities refer to policy activity more frequently.

Health literacy is the first of the three types of intervention we reviewed. According to Kickbusch et al., it ‘entails people’s knowledge, motivation and competences, to access understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course’ [(Kickbusch et al., 2013), p. 4]. However, few CS used the term ‘health literacy’, many referring to raising ‘knowledge and awareness’; health education, health promotion or dissemination of preventive information. The emphasis on children compared with older people is probably because health literacy is closely allied with literacy as an integral part of the school curriculum. The CS generally assume that health literacy promotes healthy behavior and a healthy lifestyle. A quarter focused on making populations aware of nutrition and the imbalance of diet and physical activity as a cause of obesity. Health literacy also includes understanding services provided, for example, pregnancy services in Arezzo, flu vaccination in Rijeka and cancer screening in Carlisle. Health messages may have more salience when associated with salutogenic environments. For example, community control over certain streets in Preston made residents more aware of the health benefits of walking and socializing.

In Vitoria, visiting the municipal food market made shoppers more receptive to health messages. In Denizli, the value of exercise was easier to promote in the cycle training park.

In the second category of interventions, the CS eschewed formal clinical provision and focused instead on two innovative aspects of health and social services. First, reciprocal relationships; by promoting health literacy and active citizenship, citizens are encouraged to influence the priorities and delivery of health and social services. Five exemplars of active citizenship—Barcelona, Turku, Horsens, Newcastle and Rotterdam—all demonstrate this sequence: the municipality initiates active citizenship, and then active citizens influence delivery of municipal services. Second is a multi-sectoral approach to the provision of services. All CS reflect the new and more complex nexus of provision, funding and accountability that have characterized the late 20th and early 21st century. In Cardiff, the Cumbria Partnership Trust brings together the health, social and voluntary sectors, seeking to ‘improve the independence of frail elderly, reduce unplanned hospital admissions and help them remain in their own homes’. Stavropol’s program preventing non-communicable diseases draws on expertise from the State Medical University and involves the municipal departments of healthcare, education and social protection. Despite economic austerity across Europe, most cities envisage future improvements in the well-being of older people and children.

Three assumptions underpin all 42 CS on active citizenship, the third category of intervention. First, participation will promote social inclusion and equity in health. Second, barriers to participation, health and well-being can be overcome by listening to the experiences of citizens and involving them in planning solutions. Third, community participation facilitates implementation of new ideas and solutions for tackling living conditions, as target groups feel more ownership and interventions can be better adapted to needs. While active citizenship interventions for older people often combine information and consultation with more empowering levels of participation, for active citizenship interventions targeted at children and migrants, it was a challenge to go beyond information and consultation. Not so in Belfast, where children are
genuinely engaged in sharing their views and participatory processes in the child-friendly city project.

In Phase V which spanned a period of diminishing resources for municipalities and their intersectoral partners, an innovative feature is a community asset-based development approach (WHO, 2012). In Turku, ‘Representative democracy needs new approaches to enhance (the capacity of) people to participate. People are more interested in small-scale easily accessible possibilities than long-term commitment requiring political roles. Therefore, new models for participation are crucial to find. The city officials need tools, encouragement and motivation to (utilize) people as part of the planning and decision-making, which will be supported by a training programme’. Operating as a ‘health broker’, Rotterdam’s community asset-based approach ‘aimed to radically change the municipality from a service deliverer towards a bottom-up approach that motivates citizens to take initiatives themselves’.

Third dynamic: interaction between other core themes of Phase V

The third hypothesis arising from our model is that ‘There are synergies between Caring and Supportive Environments, Healthy Urban Environment and Design, and interventions to improve Healthy Living’. This reflects the program logic of interaction between the three core themes. The overriding assumption of cities is that these ‘upstream’ interventions shape ‘downstream’ lifestyles within the core theme of healthy living. These links were captured initially by the Nvivo coding referred to in the methodology section. Thirty of the 46 Healthy Urban Environment and Design CS and 72 of the 87 Healthy Living CS overlap with those categorized within the Caring and Supportive Environments core theme. Twenty-four CS are at the nexus of all three core themes. These relationships are elaborated in sister articles in this Special Supplement.

CS reveal a range of professions operating at this nexus. Urban planners led Amaroussion’s ‘Bioclimatic regeneration of the historic city centre’ and Modena’s ‘Ecological Sundays’. After initially focusing on shifting transport modalities from cars to walking and cycling they identified an impact on physical activity and healthy lifestyles, and on increasing social interactions which are at the heart of caring and supportive environments. In Dresden ‘mobility and health in urban space’ targeted at older people, is part of the ‘social city’ program. For Golcuk, the main issue was the design and maintenance of children’s playgrounds. In Preston, the local community was actively involved in designing healthy streets to encourage active living and ‘connect with others in the area’. Belfast’s program to create a ‘Child-friendly City’ was initiated by the Healthy Cities team in schools then developed with the support of the Department for Social Development by the Belfast City Centre Regeneration Office.

Fourth dynamic: outcomes and impact on health equity

The hypothesized outcome of the three categories of intervention is to enhance the social inclusion of the three population groups leading to greater equity in health. Yet, as indicated in the methodological article of this Special Supplement, it is difficult to prove health consequences, both as a specified outcome or wider impact. Almost all the CS do not attempt robust measures of outcome (Udine and Barcelona are exceptions), although many highlight either physical or mental health as an objective. Most CS develop a ‘health’ rationale for their intervention by implicitly (and sometimes explicitly) drawing upon global scientific evidence, grey literature and experiential knowledge. Of the 45% of CS highlighting physical activity, 26 refer explicitly to a hypothesized reduction in non-communicable disease and 33 to an improvement in mental health.

Many cities predict health as an outcome of a specific project for a target population. In other cases, cities predict their strategies will have a more generic impact on their city populations. Exemplars are Belfast’s ‘Health Equity in All Policies’ and ‘The Local Health Contract for the City of Rennes’. About 30% of CS refer to the objective of health equity, often achieved by targeting vulnerable groups or deprived neighborhoods. Mental health is most often referred to as a generalized objective for community services, to be achieved alongside physical health. Social inclusion, a step toward health equity in our overarching conceptual framework, is also an important stage in many of the 33 CS aspiring to improve the mental health of their citizens. Dresden’s ‘Walking Tours for Elderly People’ is designed to enhance the triangular relationship between ‘social integration’ and improvements in mental and physical health. Just a few CS focus on ‘mental activity’ to achieve a specific outcome of improving the mental health of their target populations. The long-term program ‘Move your minds: Minds on the Move’ is Udine’s proudest achievement. ‘Brain training’ is a central feature of the program, based on ‘scientific proof that intellectual stimulation helps maintain mental fitness’. An outcome evaluation based on the self-assessment of participants revealed an improvement in cognitive function.

DISCUSSION

Although ‘caring and supportive environments’ are core to the healthy cities movement, they include many more topics than the six clustered under this thematic heading in
Phase V. For the specific purpose of evaluating this phase, our model focuses primarily on links between the three categories of intervention and three population groups in a dynamic which reflects the overarching program logic. An underlying assumption is of a set of causal pathways leading from the prerequisites of local governance via multiple interventions to healthy living outcomes and maybe a generic city impact (I) on population health—reflecting the classic formulation of realist evaluation, Context (C) → Mechanism of change (M) → Outcome (O) plus Impact (I).

Causality cannot be proved, and indeed inferential statistics are not deployed to gage degrees of association between variables. However, by segmenting the pathways and assessing the dynamics at each stage of the journey, causality can be deduced from the 112 CS. Add these stages together and there is a compelling argument that a Healthy Cities approach helps make a difference to the generic health and well-being of city populations. The CSDH makes a compelling case for the comparative efficacy of ‘upstream’ interventions in a social model of health development; the Goals and Requirements for Phase V (WHO, 2009) accepts there are multiple intervention points along the causal pathway to health. ‘Healthy Living’ may therefore be both an outcome of Caring and Supportive Environments and an entry point for specific interventions such as drug rehabilitation.

The first dynamic links the prerequisites of health promoting local governance to a series of strategic or thematic interventions. Although the CS and GEQ templates encouraged explicit reference to these prerequisites, responses indicated more than just a nominal commitment and a rejection of the counterfactual that interventions in similar quantity and quality would have occurred without these prerequisites in place. The strategic and programmatic interventions are applied explicitly to the three population groups (the second dynamic) and should encourage ‘downstream’ lifestyle changes of behavior and attitudes. Although it may appear unremarkable, the CS do provide evidence that programs designed to encourage healthy lifestyles do in reality engage a target population in active living. At its simplest Dresden’s organization of walking tours for older people (M) did lead to the desired outcome (O) of older people walking. The issues for further consideration are the counterfactual—are more older people walking without the benefit of walking tours—and scale. Only a few cities—for example, Udine and Barcelona—have piloted successful neighborhood initiatives. The broader impact on whole city populations is not been modeled or empirically demonstrated.

A great advantage of our focus on a cluster of topics was the degree to which it revealed intersection and interaction between the three intervention types and the three target population groups. In contrast to some orthodox public health research paradigms, which isolate a dose–response connection for pills or housing conditions, here is evident multiple identities and reciprocal relationships, or feedback loops. For example, both active citizenship and health literacy programs are often initiated by health and social services, in the expectation that health literate, active citizens will respond better to preventive health messages. There is some evidence in the scientific literature that this is indeed the case. Cities do not have to prove it again.

How may we address the impact on health equity (the fourth dynamic)? Here, it is necessary to distinguish (i) the trajectories of an intervention group from (ii) city populations as a whole. Importing evidence from global scientific and grey literature allows us to predict the health impact of living conditions or lifestyle changes induced by (i) a specific policy, program or project. A person embarking on a series of walking tours in Dresden will, all other lifestyle factors held constant, take more exercise, reducing then the risk factors for disease and increasing the probability of a healthy life. Key issues are both the counterfactual and possible displacement of other life-enhancing, and possibly more cost-effective, activity.

However, these focused impacts should be distinguished from (ii) the trajectories of whole city populations. Very mixed city responses to the GEQ suggested that while targeted interventions enhanced health, countervailing forces were contributing to health inequalities. The economic crisis, which spanned the whole of Phase V, and pressure on public finances, was cited by many cities as a cause of sustained or greater health inequalities. The very first city response to the GEQ put it succinctly: ‘it (health inequalities) has increased and we believe it will increase more in these times of crisis and social inequalities’. This city and many others perceive these inequalities as unfair and preventable—constituting health inequity as defined by Whitehead (Whitehead, 1990) for WHO. Although these critical wider determinants are shaped by national governments and global markets, Healthy Cities remain optimistic that they have legitimacy from WHO and some capability to mitigate and in the longer term, modify these powerful forces.

**CONCLUSION**

We conclude with policy, process and methodological recommendations for both cities and the wider European policy community. First, the innovation of asset-based active citizenship, which gained traction during the period of economic austerity spanning Phase V, should be carried forward into creating resilient communities in Phase VI as
recommended by Health 2020. Second, evidence of local action to promote health literacy should be further synthesized to complement current WHO guidance (Kickbusch et al., 2013) with local factors ensuring successful implementation. Third, the CS not only address enduring national challenges to integrating the operation of health and social services, but also add hard evidence on the value of broader intersectoral partnerships in primary prevention.

Processes are as important as the prerequisites at the core of healthy city governance (Tsouros, 2013). Encouraged by the reporting template, the CS reveal a dynamic process weaving together the prerequisites of local leadership, vision, intersectoral alliances and networking. Participation, profiles, strategies, action programs, securing resources and evaluation merge in different pathways critical to the success of project interventions. Their precise mix and sequence is determined by local circumstance. For example, a health profile may precede or follow political commitment, and a neighborhood pilot project may both help implement a strategy and contribute to its modification. Both prerequisites and processes are essential to updating the guidance on how to initiate and sustain a healthy city (WHO, 1997).

We have a final recommendation arising from the methodology of evaluation applied to Phase V. Some of the pitfalls and conundrums are rehearsed in the discussion section and in the article on methodology at the beginning of this special supplement (de Leeuw et al., 2015). However, realist evaluation and its derivation, realist synthesis, have systematically analyzed the complex dynamics of caring and supportive environments and should be applied in subsequent evaluations of the Network and by member cities. We attempted to enhance this analysis with ordinal data derived from a General Evaluation questionnaire which rated cities’ attributes and trends. Although some city respondents found difficulty with this method of self-assessment, the methodological framework should endure into Phase VI. More broadly, in Europe and beyond, the raison d’etre of progressive politicians everywhere is to improve the lives and well-being of citizens. Their goals should be converted into targets and milestones. Evaluation should inform them whether they are on the right track.

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