Promoting active living in Healthy Cities

Evaluation of Active Living actions by member cities during the WHO Euro Healthy Cities Phase V 2009-2013.

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1. Summary

This report analyses and summarizes the work by member cities of the WHO Euro Healthy Cities during the phase V evaluation (2009-2013) to plan and implement actions to promote active living and physical activity. NVivo qualitative software was used to retrieve and analyse the information from the case studies.

A total of 40 case studies (out of 73) were in some way related to active living, of which 17 had active living as a main goal. Most of the case studies (28 cs) were presented by the cities more experienced in Healthy Cities, i.e. cities that have participated in the network for longer than only in Phase V. Rationales for initiating active living actions mainly concerned social problems in the area (38), perceived need for investments in the community (34) and public health issues (18). Health equity was a salient issue in most case studies. Most interventions (36 cs) were based on pre-evidence, of which 22 cited quantitative evidence. Less common were qualitative or systematic evidence. A total of 29 case studies evaluated their intervention, of which 19 used quantitative measures.

The analysis revealed that active living actions were often integrated in other policy areas and in related actions, e.g. to regenerate city centres, general community investments and urban design. Actions concerning active living seemed to be related to issues of promoting safety, accessibility in cities, social relations, to prevent incivilities, graffiti and damage as well as to actions to enhance attractiveness of cities, to promote sustainable transport and social integration, according to the NVivo label of ‘Creativity’. Thus, there was an obvious link to sustainable development. Furthermore, the analysis showed that 78 % of interventions related to active living were based on intersectoral collaboration, e.g., with the public health sector, education sector, the local government or at the national level. Nearly all interventions were perceived by the member cities to be transferable to other settings and cities.

During the analysis, some of the facilitative factors for planning and implementing active living interventions were identified. They include:

+ Knowing the needs and preferences of the target group (“do the homework”);
+ Involving the community and target group early in the planning stage;
+ Basing the intervention on inter-sectoral collaboration;
+ Making the intervention highly accessible to the target group;
+ Making the intervention free of charge or low-cost.

At the same time, cities were open about the factors that hindered or might have hindered in some way their interventions. Some of the hindering factors were:

- Insufficient planning on how to reach the target group and recruit residents;
- Using technology and channels perceived as “boring” for the target group (the young);
- Trying to reach too many in one intervention;
- Lack of funding, funding not sustained and facilities too costly;
- Bad timing.
This report includes the quantitative and descriptive analysis of the results as well as learning the cities derived from the interventions, which might be of interest for the other Healthy Cities from the European Network. In addition, the report presents conclusions and a set of recommendations – both for member cities and the WHO.
2. Introduction

Strong scientific evidence shows that regular physical activity promotes health-related fitness, substantially lower rates of a large variety of chronic diseases and prevent a number of disabling medical conditions. Regular physical activity lowers the rates of all-cause mortality, coronary heart disease, hypertension, stroke, type 2 diabetes, metabolic syndrome, colon cancer, breast cancer, and depression. In addition, more physically active people, compared to more sedentary people, have a higher level of cardiorespiratory and muscular fitness, a healthier body composition, and exhibit a biomarker profile that is more conducive for preventing cardiovascular disease, type-2 diabetes and enhancing bone health (Physical Activity Guidelines Advisory Committee, 2008).

Despite great potential to promote health and well-being, a majority of the adult population in Europe is not adhering to the current physical activity recommendation (European commission, 2014) and prolonged periods of sedentary behaviours seem to be an independent risk factor for mortality and some chronic diseases regardless of physical activity level (Proper et al, 2010; Faskunger, 2012). Sitting is the most prevalent behaviour during waking hours with an average of approximately 9 hours of sitting per day per person in the Western world (Owen et al, 2009). Local governments have a vital role in promoting physical activity among its citizens, e.g., by creating a supportive and safe environment and providing accessible and attractive facilities for physical activity (Edwards & Tsouros, 2006).

The World Health Organization’s European Healthy Cities Network (WHO-EHCN) was established in 1986 to provide support and leadership to local governments in health development processes. The network emphasises the importance of creating and improving the physical and social environments, as well as expanding community resources, to make a long-term and sustainable difference to public health, and in promoting active living. Active living is a way of life integrating physical activity and exercise into daily routines, such as walking and bicycling for transportation, taking the stairs, and using recreational facilities. Promotion of active living and physical activity has been one of the main topics for Healthy Cities since the Phase III (1998 – 2002). In the Phase IV (2003 – 2008), Active Living was one of four core themes (Physical Activity/Active Living), while in the Phase V (2009 – 2013) - when health and health equity was an overarching theme, active living became part of one of the subthemes, Healthy Living. It is strongly interconnected with the other two subthemes: caring and supportive environments and healthy urban planning and design. Table 1 presents the evolution of Healthy Cities themes since its beginning and the place of Active Living and Healthy Living topic in this development.
The evaluation of phase IV in the WHO-EHCN (Faskunger, 2011) showed that most cities viewed “active living” as an important issue for urban planning. Actions were instigated to improve visual appeal, enhance social cohesion, create a more sustainable transport system to promote walkability and cyclability and to reduce inequalities in public health. Almost all member cities reported on existing policies that support the promotion of active living. However, only eight (of 59) member cities mentioned an integrated framework specific for active living. Many efforts to promote active living were nested in programmes to prevent obesity among adults or children.

The purpose of the present report is to analyse and summarize the work done by member cities during phase V to plan and implement actions to promote active living and physical activity.
3. Methodology

For this analysis, information was extracted from responses by 40 case studies from member cities (99 member cities in total; there were 73 case studies submitted in total). NVivo qualitative software was used to retrieve and analyze the information. A wide range of questions guided the retrieval and analysis of information:

- What 'problem types' are associated with Active Living interventions?
- What outcomes are claimed for Active Living interventions?
- Are Active Living interventions initiated on the base of evidence?
- What kind of evidence?
- What kind of Active Living interventions are transferable outside the initiate city?
- Are Active Living interventions connected to the interventions on food & diet?
- Are Active Living interventions connected to the healthy settings interventions?
- How are the Active Living interventions evaluated?
- What kind of partnership is built for Active Living interventions?
- Is Active Living a goal or means for reaching the goal (i.e. health equity, social inclusion, sustainable transport?)
- What physical activity behaviours are being promoted?
- What interventions/actions are used to promote physical activity?

The main goal of the evaluation was to seek answers to the questions how the member cities implement the principles and learning that comes from the Healthy Cities and what is the added value of belonging to the network. Therefore, the focus of the evaluation was on the following issues, which constitute the core values and principles of the WHO – EHCN:

- Health equity;
- Health in all policies;
- Intersectoral cooperation and partnerships;
- Evidence-based policy planning;
- Contribution to sustainable development.

The analysis studied this from two perspectives: how these principles are driving the active living interventions in the member cities and how these principles are present or realized in the interventions. The question if active living is an ultimate goal or means to realize other goals was also raised.

The evaluation included case studies with active living as the main goal, as well as case studies with some actions related to active living.
4. Findings and results

4.1 Introduction to findings and results of the evaluation

Apart from descriptive information and facts, the results are presented according to themes based on the WHO-EHCN core values and principles outlined in the Methodology section.

4.2 Descriptive results

A total of 40 case studies had actions related to active living, of which 17 had the promotion of active living as a main goal (see table below).

The following cities submitted case studies related to active living or case studies with active living as their main goal. In table 2, cities with active living as main goal of action are presented in bold, while the other cities/case studies had actions of active living within them.

Table 2. Overview of case studies related to active living.

<table>
<thead>
<tr>
<th>City – Country:</th>
<th>Member phase:</th>
<th>Case study:</th>
<th>Main goal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amaroussin, GRE</td>
<td>5*</td>
<td>Regeneration of city centre</td>
<td>HUED**</td>
</tr>
<tr>
<td>Barcelona, SPA</td>
<td>1, 4-5</td>
<td>Community action, urban regeneration</td>
<td>Equity</td>
</tr>
<tr>
<td>Brussels, BEL</td>
<td>3-5</td>
<td>PA for women in disadvantaged areas</td>
<td>Active living</td>
</tr>
<tr>
<td>Bursa, TUR</td>
<td>3-5</td>
<td>Building 152 sport facilities in the city</td>
<td>Active living + HUED</td>
</tr>
<tr>
<td>Bursa</td>
<td></td>
<td>Regeneration of city centre</td>
<td>HUED</td>
</tr>
<tr>
<td>Carlisle, ENG</td>
<td>5</td>
<td>Pedestrian friendly streets, elderly</td>
<td>Active living</td>
</tr>
<tr>
<td>Dunkerque, FRA</td>
<td>4-5</td>
<td>Sport schemes for disadvantaged youth</td>
<td>Outcomes children***</td>
</tr>
<tr>
<td>Dresden, GER</td>
<td>1-5</td>
<td>Urban regeneration, deprived areas</td>
<td>Active living + HUED</td>
</tr>
<tr>
<td>Dresden</td>
<td></td>
<td>Walking people – It’s never too late to start</td>
<td>Active living</td>
</tr>
<tr>
<td>Galway, IRL</td>
<td>4-5</td>
<td>Healthy urban environment team</td>
<td>HUED</td>
</tr>
<tr>
<td>Izhevsk, RUS</td>
<td>3-5</td>
<td>Whole city programs and schemes</td>
<td>Active living + HUED</td>
</tr>
<tr>
<td>Jerusalem, ISR</td>
<td>1-3, 5</td>
<td>Walking schemes for religious women</td>
<td>HUED</td>
</tr>
<tr>
<td>Kirikkale, TUR</td>
<td>4-5</td>
<td>Urban regeneration, green space</td>
<td>HUED</td>
</tr>
<tr>
<td>Klaipedia, LTH</td>
<td>5</td>
<td>Healthy city priorities in all politics</td>
<td>HUED</td>
</tr>
<tr>
<td>Klaipedia</td>
<td></td>
<td>Map of PA facilities and opportunities****</td>
<td>Active living</td>
</tr>
<tr>
<td>Kuopio, FIN</td>
<td>4-5</td>
<td>Be Active Throughout your Life</td>
<td>Active living</td>
</tr>
<tr>
<td>Ljubljana, SLO</td>
<td>3-5</td>
<td>PA scheme for elderly, health centres</td>
<td>Age-friendly cities</td>
</tr>
<tr>
<td>Lodz, POL</td>
<td>2-5</td>
<td>HP schools and kindergartens*****</td>
<td>Outcomes children</td>
</tr>
<tr>
<td>Modena, ITA</td>
<td>5</td>
<td>Workplace HP</td>
<td>Active living</td>
</tr>
<tr>
<td>Modena</td>
<td></td>
<td>WHO HEAT tool, cycle paths</td>
<td>Active living + HUED</td>
</tr>
<tr>
<td>Modena</td>
<td></td>
<td>Traffic-free Sundays, PA in city centre</td>
<td>HUED</td>
</tr>
<tr>
<td>Oerias, POR</td>
<td>5</td>
<td>Child HP scheme in the Municipality</td>
<td>Outcomes children, NCD, obesity</td>
</tr>
<tr>
<td>Ostfold, NOR</td>
<td>4-5</td>
<td>HP schools, health education</td>
<td>Outcomes children</td>
</tr>
<tr>
<td>Ourensen, SPA</td>
<td>5</td>
<td>HP schools</td>
<td>NCD, obesity</td>
</tr>
<tr>
<td>Pecs, HUN</td>
<td>1-5</td>
<td>Workplace HP</td>
<td>HP workplace</td>
</tr>
<tr>
<td>Poznan, POL</td>
<td>2, 4-5</td>
<td>Primary school bad prophylaxis prevention</td>
<td>Outcomes children</td>
</tr>
<tr>
<td>Preston, GBR</td>
<td>5</td>
<td>Sports schemes: European city of sport</td>
<td>Active living</td>
</tr>
<tr>
<td>Preston</td>
<td></td>
<td>Healthy streets: PA, liveliness, safety</td>
<td>Active living + HUED</td>
</tr>
</tbody>
</table>
### Preston’s cycling city programme

**Pärnu, EST**
- 3-5
- Sustainable transport, cycling, walking
- Active living + HUED

**Rennes, FRA**
- 1-5
- HIA, regenerate area near train station
- HUED

**Rennes, FRA**
- Local city health contract, policy
- Equity

**Sandnes, NOR**
- 1-5
- Neighbourhood multi-use trails
- HUED

**Sant Andreu de la Barca, SPA**
- 4-5
- Healthy ageing scheme, PA scheme
- Healthy ageing

**Sarajevo, BIH**
- 4-5
- Health program for children, 72 schools
- Active living + diet

**Stockholm, SWE**
- 1, 3-5
- Exercise groups, people 90+
- Active living

**Stockholm**
- PA schemes in disadvantaged areas, walking
- HP disadvantaged areas

**Turku, FIN**
- 1-5
- Tackling inequalities, PA schemes
- Equity

**Turku**
- Health and well-being through PA, culture
- Active living

**Venice, ITA**
- 4-5
- A journey of heart and mind, PA, parks
- Active living

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**5** refers to being a member in phase 5; ‘1-5’ refers to being a member in phases 1-5, and so on

**HUED** stands for healthy urban environment and design

*** ‘Outcomes children’ refers to outcomes related to physical and social health issues among children

**** ‘PA’ is an abbreviation for physical activity

***** ‘HP is an abbreviation for health promotion or health promoting

### 4.2.1 What is the rationale behind the Active Living interventions?

The blue pillars represent all case studies with active living actions, while the green pillars represent case studies with active living as the main goal. Rationales or problem types for initiating active living actions mainly concerned social problems in the area or neighbourhood (38 cs), perceived need for investments in the community (34), public health issues (18) and politics (12) according to the case studies. A similar trend was evident when looking at case studies with active living as the main goal.

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![Problem types cited by cities](image)

**Figure 1.** Problem types cited in case studies related to active living by member cities.
4.2.2 What types of physical activity behaviours are being promoted?

From a public health perspective, it is interesting to document what types of physical activity behaviours are being promoted. This information may also guide member cities or other cities in future actions or programmes. According to the case studies, different forms of walking and cycling were the most promoted physical activity behaviours, as well as sport schemes or events for children and adolescents. Below is a list of different activities promoted:

- General physical activity (no reference to a specific type of physical activity)
- Walking:
  - Walking generally
  - Nordic walking
  - Walking for religious women
  - Walking for citizens in disadvantaged areas
  - Walking tours for elderly
  - "Freedom of movement” and "independence” in city centres
  - "Intergenerational activities” (based on walking)

- Cycling:
  - Cycling for children
  - Cycling for the disabled
  - Cycling for beginners
  - Active transport (e.g., cycling to work)
  - Cycling in traffic-free city centres on Sundays

- Fitness programmes:
  - Spinning
  - Strength training
  - Tai-chi and related activities
  - Boxing

- Sports:
  - Football
  - Sporting events
  - Sports for the disabled
  - Holiday sport schemes (for children)
  - Summer camp sports
  - Sports for all citizens
  - Ice hockey and skating
  - School sports

- Other:
  - Fishing
4.2.3 What interventions and actions are being used to promote active living?

It is also interesting to document what type of interventions or actions are being used to promote physical activity and active living. The actions have been categorized according to the categories: Built environment, Social environment, Traditional settings (or arenas; health care, workplace, schools) and Miscellaneous.

**Built environment:**
- Investment in sports and exercise facilities in the city
- Investment in cycling infrastructure, e.g., cycle paths
- Transform streets for walking only & remove cars
- Invest in general measures for city attractiveness, e.g., increase green space, stores and services
- Improve existing, build new, playgrounds

**Social environment:**
- Summer camps & holiday sports camps for children and youth
- Walking tours & physical activity programmes for elderly
- Traffic-free city centres on Sundays
- Physical activity programmes for the disabled
- Walking schemes in disadvantaged areas
- Cycling schemes for children, elderly, beginners, women

**Traditional settings:**
- Physical activity on prescription, health care sector
- Health promoting schemes in health centres
- Physical activity programmes in workplaces
- Health promoting schools & physical activity schemes in schools and kindergartens

**Miscellaneous:**
- Social marketing towards citizens & social marketing towards politicians
- Producing local maps with exercise facilities and opportunities for physical activity
- Seminars
- Health education

4.2.4 What outcomes are claimed for Active Living interventions?

The most cited outcomes related to active living actions were cultural difference (13), strategic difference (11) and in terms of stakeholder difference (17). Only two case studies cited health outcomes. In terms of case studies with active living as main goal (green pillars), very few (2) claimed a stakeholder difference, while 7 out of 17 cited a health difference and 9 out of 17 claimed a strategic difference.
4.3. What is the added value of Healthy Cities (i.e. what differs Healthy Cities from other cities)?

4.3.1 Work on health equity

Health equity is an overarching theme of the WHO- EHCN and promoting equity is about working towards addressing inequality in health, and paying attention to the needs of those who are vulnerable and socially disadvantaged. The right to health applies to all regardless of sex, race, religious belief, sexual orientation, age, disability or socioeconomic circumstance (WHO, 2008).

Two cities had health equity as a primary goal in their active living actions (Barcelona, Turku). However, most other cities also seemed to instigate actions to promote active living partly based on equity issues. As outlined in figure 1 above, rationales for initiating active living actions mainly concerned social problems in the area or neighbourhood, perceived need for investments in the community and public health issues which naturally relate to issues of equity and social inequalities.

Examples of actions/strategies at least partly related to health equity is:

- Health promotion in disadvantaged neighbourhoods (e.g., Brussels, Stockholm)
- Healthy urban environment and design (e.g., Bursa, Preston)
- Age-friendly cities and healthy ageing (e.g., Dresden, Ljubliana)
- Better outcomes for children (e.g., Dunkerque, Sarajevo)

4.3.2 Health in all policies

Health in all policies is an approach to policies that systematically takes into account the health and health-system implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity. Health in all policies has great potential to improve population health and equity (Ministry of Social Affairs and Health, Finland, 2013).

There seems to be a strong emphasis on active living actions as being part of other policy areas and actions. The fact that 40 case studies had some connection to active living, but only 17 had...
active living as a main goal, suggests a strong presence of physical activity promotion in other policy areas.

A total of 15 out of 40 case studies (38 %) cited active living actions as being part of actions in other settings ("Settings action") based on the NVivo analysis. This was somewhat less common in actions targeting food and diet with 25 % (10 cs) also targeting active living. Most of diet and active living-combined actions concerned children and youth in school settings.

Case studies with some active living actions within them (but not active living as a main goal) were related to the following categories of main goals according to the NVivo content analysis:

<table>
<thead>
<tr>
<th>Goal</th>
<th>No. of case studies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy urban environment and design (HUED):</td>
<td>17 (43 %)</td>
</tr>
<tr>
<td>Better outcomes for children:</td>
<td>5 (13 %)</td>
</tr>
<tr>
<td>Equity</td>
<td>3 (8 %)</td>
</tr>
<tr>
<td>Age-friendly cities &amp; healthy ageing</td>
<td>2 (5 %)</td>
</tr>
<tr>
<td>Preventing noncommunicable diseases</td>
<td>2 (5 %)</td>
</tr>
<tr>
<td>Diet &amp; nutrition</td>
<td>1 (3 %)</td>
</tr>
<tr>
<td>Leadership &amp; partnership</td>
<td>1 (3 %)</td>
</tr>
<tr>
<td>Workplace health promotion</td>
<td>1 (3 %)</td>
</tr>
<tr>
<td>Health promotion in disadvantaged areas</td>
<td>1 (3 %)</td>
</tr>
</tbody>
</table>

Another way of looking at the connection between active living actions and health in all policies is to analyse the link between active living and the label of Creativity in the NVivo analysis. According to the NVivo analysis, active living actions seems to be related to issues of promoting safety, accessibility in cities, to prevent incivilities, graffiti and damage as well as to actions to enhance attractiveness of cities, to promote sustainable transport and social integration or cohesion. A total of 12 case studies with actions related to active living belonged to the label of Creativity, of which 8 had active living as the main goal. This link supports the notion of promotion of active living in many related policy areas.

4.3.3 Cross-sectoral cooperation and partnerships

Intersectoral cooperation means that organizations work together in a context in which collaboration, co-operation or joint action will achieve an improved outcome or facilitate the implementation of an intervention. Intersectoral collaboration is needed to promote health and active living due to the fact that health and physical activity is influenced by factors on many levels of society.

Intersectoral cooperation seems to be a cornerstone of actions related to active living with 31 case studies (78 %) reporting such cooperation and partnerships as outlined in figure 4. Among case studies with active living as a main goal, 88 % (15 out of 17) claimed intersectoral collaboration. The most salient partnerships typically involve the local government, the Department of Education
and the Department of Public health. Less common are partnerships with the Department of Environment or the transport sector (6 and 4 partnerships respectively).

Figure 3. Intersectoral collaboration cited in case studies related to active living.

Examples of partners cited in the case studies are:

- Local commercial health and fitness clubs
- Local sports clubs
- The community itself and citizens
- European network
- Schools
- Day care centers
- Health care
- Twin cities ("sister city") in Europe
- Universities

4.3.4 Evidence-based policy planning

Evidence-based policy planning is one of the core principles of the WHO European Healthy Cities programme. It means that data and information needs to be based on evidence in order for cities to plan relevant and effective interventions, policies and programmes. In other words, cities need to monitor the health situation, trends and the major public health challenges. Evidence-based policy planning is a tool which needs to be used if the health risks from policies and actions are to be prevented and health equity issues addressed. It requires an understanding of the data and evidence amongst policy makers and practitioners, knowledge of effective interventions – processes and actions, capacity building for all workforces and monitoring and evaluation to measure progress (Belfast Healthy Cities, 2009).
Healthy Cities are encouraged to use available evidence for policy planning. They are requested to prepare a Health Profile for the city and are informed about possible tools for health monitoring, which can be used for preparing the interventions in various fields, including Active Living. According to the analysis, 36 case studies (out of 40) based their actions on some kind of pre-evidence. Most of the case studies (22) based their actions on quantitative evidence, while anecdotal evidence was used in 9 cases. The qualitative (3) and systematic evidence (2) was less popular. Out of 40 case studies, 12 were initiated because the available research showed that the intervention was needed.

All of the case studies with Active Living as a main goal based their actions on some kind of pre-evidence, of which 10 were initiated due to quantitative evidence and the rest on anecdotal evidence. Out of 17 case studies, 6 were initiated because the available research showed that “the intervention was needed”. This indicates that member cities value the evidence-based planning approach to prepare the interventions, although the quality of the evidence is far from perfect.

Figure 4. Type of evidence used to drive the actions in case studies related to active living.

Figure 5. Type of pre-evidence used to drive the actions in case studies related to active living.
The evidence – often conducted by collaborating researchers – seems to play a major role in initiating the Active Living interventions in the first place. Interventions are based on assessment of health status as well as habits and needs of a specific target group or the citizens in general.

Evaluation of the interventions is of equal importance. The information collected this way serves not only to assess the effectiveness of the actions and the satisfaction of the target group but also contribute to the knowledge base for better planning and more effective interventions in the future.

Out of 40 cases that included Active Action, 29 collected the evidence after the action was started. Most of them used quantitative measures (19), while anecdotal evidence was evident in 15 cases. In most cases, the evidence refers to the impact of the intervention with the process being second most popular. The influence on the social determinants of health was visible only in one case study.

At the same time, a closer look at the 17 case studies with Active Living as a main goal reflects the above mentioned more general results. Almost all of the case studies (14) collected the evidence after the interventions but most of it was anecdotal-based (11) with qualitative data being second most popular. This shows that the member cities use a mix of methods to get the information about impact, outcomes, processes and satisfaction of the citizens after the action. The quantitative evidence is collected by the comparison of the statistical data before and after the intervention and it can refer e.g. to the increase of the people who are physically active. The evidence collected referred mainly to impact (12) and process (5) with only 1 intervention investigating the influence on social determinants of health.

![Figure 6. Type of post-evidence cited in case studies related to active living.](image)
The collected evidence shows good impact of the Active Action intervention on the physical activity of the citizens in Healthy Cities. For example, in Turku, physical activity and culturally active citizens in the 20-64 age-group, increased from 46 % to 57 % between 2010 and 2013. In Preston, the participation in sports grew from 29,2 % to 38 % in adults during the intervention phase. In Sarajevo, the evaluation showed that 50 % of children who participated in the intervention, benefited from it by strengthening their muscles and improving their posture.

It is important to realize, however, that cities struggle to assess the impact of their interventions on the population’s health. As the results come late and are influenced by many factors, the regular quantitative evaluation according to health indicators is a challenge.

4.2.5 Contribution to the sustainable development

Healthy Cities are about local involvement for creating healthy conditions in cities, but the scope and impact go well beyond health. The evidence of social determinants of health and the learning which comes from settlement map (Barton & Grant, 2006) shows us that people’s lifestyle and activities are influenced by the environment we live in. But people and activities also can influence and modify these conditions. In this way, the pro-health actions, influence the environment, economies and in consequence the development of the city in a sustainable way. Healthy Cities are committed – from their very beginning to the sustainable development and it has been included in 5 values and principles of Healthy Cities written in Zagreb Declaration 2008. It consists of working on e.g. transport issues and social inclusiveness (Zagreb Declaration, 2008).

As presented before, in Phase V, Healthy Cities focused on three interrelated core themes. They were:

- caring and supportive environments
- healthy living
- healthy urban design.
Healthy living needs to be supported by the proper environments and urban planning. At the same time the actions for healthy living, especially active living, can motivate the urban and health planners to do more to create healthy conditions and help people to move about more. Policies that enable and encourage active living can support sustainable development particularly in two ways: by promoting sustainable transport (cycling, walking) and enhancing social cohesion (actions on equity). Such actions, as evident in the Healthy Cities project, are a solid economic investment. Physically active people have lower annual direct medical costs than people with sedentary lifestyles. It also supports people’s activity on the labour market as it reduces absenteeism and contributes to increased productivity (Edwards & Tsouros, 2006).

Medium- and high-density towns are not only associated with a high share of trips by public transport, walking and cycling. Towns with such urban designs and built environments also have the lowest costs associated with transport and mobility infrastructure. The proportion of community income used on transport rises from less than 6 % in densely populated cities where most trips are made by walking, cycling and public transport to 12 % in sprawling cities where the car is the dominant mode of transport (Edwards & Tsouros, 2006). This finding is in line with results established by the Transport, Health and Environment Pan European Programme (THE PEP). The promotion of safe cycling and walking in urban areas presents great opportunities for “win-win-win” approaches to achieve goals of the transport, health and environment sectors (Thommen et al, 2006).

**Transport**

This analysis suggests that cities view the Active Living actions as contributing to sustainable transport. Out of 40 case studies related to active living, 12 were marked as Transport Actions, along with other actions on environmental issues, e.g., climate (3) reducing pollution (3), noise (1) and house regeneration (7). In that sense, more than half of the actions on active living, related in some way to sustainable development.

![Sustainable Development Oriented Actions in Active Living interventions](image)

Figure 8. Healthy urban environment and design action in case studies related to active living.
The same trend is visible when we look closer at the case studies with Active Living as the main goal. Out of 17 case studies, 5 were marked as Transport Actions, along with other actions on environmental issues, like climate (1), and house regeneration (2).

A closer analysis of the cities’ case studies presents a list of motives of the cities to undertake the Active Living and transport related actions. These include: the need to motivate people to move (health concern) and the need to reduce the traffic congestion in the city (environmental concern). The connection between both issues is understood and the environmental arguments support these of health. Actions that cities realize focus mainly on promotion of cycling and include:

- building of bicycle roads (Izhevsk);
- creation of Healthy Streets – free from traffic and open for walking, playing and cycling (Preston);
- bike sharing (Modena);
- supporting improvement of public transport (Bursa);
- promoting cycling as means of commuting (Kuopio).

The analysis shows that, even if some of the cities use the link between health and environmental issues, still more can be done to explore this potential. It must be mentioned, that today the sustainable development concerns are often environmentally focused and health sector needs to do more to put health higher on that agenda. At the same time, linking health with environmental actions might benefit in access to funding, reserved for sustainable development actions.

**Social cohesion**

Increasing levels of participation in appropriate sports and physical activities can contribute to social cohesion, neighbourhood revitalization and an increased sense of community identity (Edwards & Tsouros, 2006). Green spaces, skateboarding parks, trails, paths and sports facilities provide a social focus and enhance people’s perception of their neighborhood. Providing equitable and safe opportunities for active living may also encourage the expansion of social networks. This is especially important for members of ethnic minorities, racial and religious groups and for older residents (Edwards & Tsouros, 2006).

The analysis shows that the Active Living actions are related to social sustainable development. Out of 40 case studies, 22 included the Participatory Action and 15 the Equity Action. The vast majority (31) was realized in cross-sectoral and multi-level partnerships.

The analysis of the 17 case studies with Active Living as a main goal confirms that trend – more than half of the actions included the participatory factor (9 cs) and nearly half included the equity action (8). Almost all (15) were realized in cross-sectoral and multi-level partnerships.
Figure 9. Strategic actions in case studies related to active living.

Figure 10. Strategic actions in 17 case studies with active living as main goal.
5. Discussion

This analysis of case studies revealed that active living actions were often integrated in other policy areas and in related actions, e.g. to regenerate city centres, community investments and urban planning. However, there were also some cases of “traditional” interventions within a single policy area, e.g., schemes in schools. 40 case studies had actions related to Active Living, but only 17 had Active Living as the main goal. The integration with other policy areas is first and foremost a strength. If actions on active living often are integrated with other policy issues in urban development, it means that active living actions will be undertaken regardless of specific funding or specific priorities concerning active living. However, a possible weakness of the integration of topics is that active living may not be viewed by member cities as a topic demanding special attention in planning, implementation and evaluation, which in turn might lead to ineffective interventions. However, based on the information from member cities, this does not seem to be the case as most interventions were based on pre-evidence and post-evidence.

The analysis also showed that intersectoral collaboration was very common among member cities, with 78% of case studies on Active Living based on such collaboration. Thus, it seems like there is a continuous shift away from interventions based on events and single activities towards interventions using integrated policy and programmes based on intersectoral collaboration. This is in line with the findings of the phase IV evaluation (Faskunger, 2011). The use of intersectoral and multilevel collaboration may be regarded as a tool for capacity building and development of “sustainable interventions”.

5.1 Transferability of Active Living interventions

The cities belonging to the WHO European Healthy Cities network are provided with tools to raise the public health issues on the political agenda and to improve their performance, but they are also encouraged to learn from each other and to find inspiration in the actions of other member cities. Cities share these experiences mainly during the Annual Business and Technical conferences but also through the communication in-between the meetings, shared projects and actions.

Therefore, it is of interest to look at how the cities rate the transferability of their actions to other cities and settings. A total of 21 case studies had information on transferability, of which 19 interventions were rated by member cities to be fully transferable to other cities and settings. The remaining two case studies rated their interventions as partly transferable.
In the 17 case studies on active living as main goal, information about transferability was evident in 7 of them. A total of 6 interventions were rated as transferable and 1 partly transferable. The actions proposed as transferable were: guided physical activity tours for employees, wide promotion of Nordic walking in schools and among the general population, active break at school, building of multi-use trails in the cities, maps with the physical activity opportunities, organizing social cycling groups and combining the physical activity and mental exercise for older people.
5. 2 Learning, facilitative factors and negative experiences

Learning

Through planning, implementation and evaluation of the Active Living interventions, Healthy Cities collect immense amount of information and develop unique experiences to improve future work and develop more effective interventions. During the Phase V evaluation the issue of learning was emphasized. All case studies with active living as the main goal described “lessons learned” of different nature. Most of the cases (12) presented “first-order” learning, which means the learning process related directly to the actual activity, including its replication. The other kind of learning process was of secondary order and concerned:

- equity (3)
- governance (9)
- leadership (2)
- participation (2)
- partnership (7)
- policy (4).

The figure below presents the learning types within the Active Living case studies.

![Learning Types within Active Action focused Case Studies](image)

Figure 13. Learning types among case studies with active living as main goal.

The gained expertise and lessons learned are worth sharing so that other cities can utilize the experience and improve future interventions. According to the cities, it is important and crucial to take the following into account when planning Active Living interventions:
the needs of the target group need to be well understood (this can be collected through surveys or interviews) – especially the needs of the groups who perceive themselves to have little time for physical activity;

- the available statistical health data can be used to assess the impact of the intervention on the target group;

- media must be involved to market the intervention and improve the visibility of the actions;

- community groups, private companies and partners should be included from the very beginning – both in planning, implementation as well as in evaluation;

- campaigns combining promotion of physical activity and diet should be implemented;

- cross-sectoral and multi-level partnerships should be prioritized in order for the intervention to work effectively;

- experts should be involved for better quality and appreciation of participants;

- new technologies should be used for more effective actions, but with appropriate adjustments for the elderly or groups with little access to new technologies;

- choosing the right timing for the actions is crucial and will affect the success of the intervention (winter-summer, weekend-weekdays, one specific day where the other events take place or do not take place in the city);

- choosing an appropriate and attractive role model is very important for the success of the intervention. The role model should especially be appropriate to the target group. It is also important that the role model is not controversial and associated with issues that might damage the intervention.

Working populations, middle-aged women and teenagers seem to be the most challenging groups to reach by the physical activity interventions due to lack of time, conflicting priorities and lack of interest. “Recruiting methods” need to be adjusted in order to impact the target groups. Still, there is little evidence on what works and what does not. However, the Healthy Cities are able to share – within the network - the best practices for the learning and inspiration of other members. The issue of learning from each other for better interventions was raised in detail by one city (Kuopio, Finland). It mentioned that interchange of good models of practice added the significant value to their actions. However the process was still challenging because of the need to use foreign language by the municipal workers.

These lessons mirror the values and principles that Healthy Cities have promoted and stood for during the Phase V and which are written in the Zagreb Declaration (2008), i.e.:

- **Equity**: addressing inequality in health, and paying attention to the needs of those who are vulnerable and socially disadvantaged;

- **Participation and empowerment**: ensuring the individual and collective right of people to participate in decision-making that affects their health, health care and well-being;

- **Working in partnership**: building effective multisectoral strategic partnerships to implement integrated approaches and achieve sustainable improvement in health;

- **Solidarity and friendship**: working in the spirit of peace, friendship and solidarity through networking and respect and appreciation of the social and cultural diversity of the cities of the Healthy Cities movement;
• Sustainable development: the necessity of working to ensure that economic development – and all its supportive infrastructural needs including transport systems;

Most of the cities (14) collected the evidence after the interventions had started. The evidence was usually anecdotal (11) but also quantitative (8) and it refers mainly to the impact of the intervention (12), process (5) and outcomes (3).

Learning about equity focused on how to reach and involve the disadvantaged populations and how to create the multi-sectoral actions that combine promoting physical activity, developing urban spaces and involving different target groups.

Learning about governance focused on the interventions that combine different dimensions of Healthy Cities (health equity, urban planning, physical activity), on how to pool resources to enable a consistent message to be disseminated across the city and how to involve the partners to deliver the joint objectives. The involvement of the experts is necessary to suggest and initiate improvements of interventions and to understand that the physical activity is not an expense but a gain, an investment. The role of the exchange between the WHO Healthy Cities was highlighted as well as a need for coordinated and targeted approach.

Learning about leadership focused on involving employers into the health enhancing physical activity actions, as well as cities as such, who should be responsible for educating people how to commute healthier and with benefit for the environment.

Learning about participation referred strongly to the need of understanding the needs of the target population and cooperation with target groups during planning and implementation.

Learning about partnership referred both to the need to build a good network for implementation of interventions as well to the fact that during the planning and implementation of the physical activity actions, the new and promising cross-sectoral partnerships were created. Partners should be chosen strategically and approached as soon as possible.

Learning about policy highlighted that a coordinated and targeted approach of all partners is the best way to ensure strategic outcomes. The interventions on physical activity and healthy diet should be combined and the actions should be highly accessible in environments close to the target group (where people live, where they work, where they shop etc.).

Facilitative factors

According to the case studies, the following factors facilitate the creation and implementation of the Active Living interventions:

- knowing the needs of the target population – this helps creating time-effective interventions that suits the needs and preferences of the target group;
- involving the communities – this helps avoiding the professional-sport-only orientation and enhance the reach of reluctant groups (often by personal recommendations or bringing-a-friend effect);
- involving private companies (if relevant) and media from the very beginning – this supports the finances and visibility of the actions;
- working in a broad cross-sectoral and multi-level partnership – this helps reaching the disadvantaged population, minimalize the costs and maximize the effect and achieving the comprehensive health action;
- bringing the intervention to the environment of the people: where they live and where they work – this helps maximizing the impact;
- choosing the right timing, right name of intervention and appropriate role models.

Member cities also faced some serious challenges to reach and recruit target groups or other citizens. Often they planned and tried new approaches to involve the groups in the activities. Even if they seemed to be promising and innovative, the evaluations showed that the recruitment procedures often brought poor results. Cities mentioned the following challenges:

- involving the “reluctant groups” – campaigns, reminders and easily available information can draw the participants away from the intervention if the information is perceived as too aggressive and the intervention itself does not feel relevant for the target group. There might also be other barriers, such as perceived limited access to facilities, that had not been fully recognized prior to the start of the intervention;
- using the new technologies – can be a barrier for the older population, hard copies of the materials (leaflets, maps, brochures) should be published in order to reach the specific target groups;
- using traditional materials is not enough to involve younger generations. Other ways of attracting the attention of the young people need to be explored (preferably with their cooperation);
- the intergenerational approach is also very difficult to implement – it is easier and more effective to create partnership within a similar-age group;
- learning from other member cities, i.e. using the information provided in English, is a challenge for the municipal workers.

One of the crucial challenges in this area seems to be universal – how to encourage people with a very sedentary lifestyle. Therefore, cities need to constantly monitor the health situation, learn from each other on what works in order to develop the well-informed, most relevant and effective interventions that will bring good health gains and improve the wellbeing of the citizens.

**Negative experiences**

Even though, the Healthy Cities do their best to create and implement the best possible interventions, the process is not always easy and the experience is not always positive. Bad experiences were cited in 11 out of 17 Active Action focused case studies.

The following are the most common problems shared by the cities:
the target population was not reached and motivated - because the intervention was not found relevant to the target population, the traditional recruiting methods did not work or/and people were not motivated enough to try something new;  
private companies were not involved or got involved too late - because of miscalculation of the time needed for negotiations;  
people from disadvantaged populations were not reached - because of lack of resources (financial, human);  
intervention cannot be continued after the project ends – because of the lack of funding and too high costs of the facilities;  
the partnerships were endangered – because specific demands of different partners working together were not met (e.g. lack of scientific evidence for the academic partner);  
the event did not attract enough participants – because the timing was chosen badly (many events happening in the same time).

5.3 Active Living interventions in WHO Healthy Cities: Goal or means for achieving other goals?

The goal of active living and physical activity, as promoted by Healthy Cities is not primarily to involve residents in competitive sports, but to make active living part of everyday life and to encourage cities to create appropriate supportive environments. Thus, active living is health enhancing for individuals per se, but it also brings other benefits such as improving social networks, social inclusion as well as reducing absenteeism at work and marginalization in the labour market (WHO, 2013). That means that active living interventions have a potential to improve equity by tackling the health and social challenges, but only if they are supported by investments in the environment (environmental modifications), if they involve right target groups and implement tailor-made, evidence-based interventions according to the needs to the population in question.

The overarching theme of Phase V of Healthy Cities was health and health equity in all local policies. That calls for intersectoral action and broad partnerships as well as for the interventions that are located in different settings, involving different target groups and handling various topics and problems. The experience from the knowledge base of social determinants of health is that many social, health and environmental issues are interconnected, modifiable and therefore can be, and should be, tackled jointly.

According to this report, it is argued that the member cities understand these interconnections and the potential active living interventions have in solving other social problems. As presented in the report, the interventions were initiated mainly because of social problems and will to invest in the community. “Traditional public health concerns” were only the third most salient motive. The interventions were different in nature and included not only the promotion of walking of participating in sports, but also the investments in biking routes, regeneration of city areas, closing city centres for motorized traffic and promoting use of public transport. Furthermore, the claimed outcomes were not only health-related. Broad partnerships, reaching well beyond the health sector were established and active living actions were connected with the sustainable development activities of the cities.
However, arguably, this trend may also be heavily influenced by the emphasis of the WHO-EHCN in phase V on placing active living within the broader healthy living theme, which strongly interconnects with the other themes. The clear focus of WHO – in communication and learning materials - on equity issues, might have had an impact as well. This may suggest that active living actions were more a mean for realizing other goals than an independent goal in phase V: Active living contributed to the realization of other policies and the actions in other fields spurred the promotion of active living. Having said that, since 17 case studies claimed active living to be the main goal of their actions, one cannot exclusively rule out that active living also was seen as an important topic on its own.
6. Conclusions and recommendations

The recommendations presented in this chapter serve both member cities and WHO in planning and promoting effective actions related to active living in the future. These recommendations are derived from the experiences and learning shared by the member cities in this evaluation.

Conclusions

- Member cities based their actions related to active living on intersectoral collaboration and partnerships, and the collaboration was viewed as a strength.
- The actions related to active living are often integrated in other policy areas and in related actions, e.g., to regenerate city centres, community investments and urban planning and design.
- Most of the case studies on Active Living interventions were presented by member cities from Western Europe and cities that have taken part in several phases of the WHO-EHCN.
- Healthy Cities base their work on evidence when planning and executing Active Living interventions. In most cases, they use a mix of methods (quantitative, qualitative, anecdotal).
- Evidence helps assessing the actions in the Healthy Cities and plan better for the future. The use of pre-evidence seems to support decision making.
- Cities struggle in collecting and interpreting the evidence. In Active Living interventions, many factors may influence the final effects, and the information and data is time-demanding to collect.
- Healthy Cities have a broad understanding of the purposes the Active Living can serve and they explore this potential. Active Living interventions serve a wide array of other goals: improving social cohesion, improving the transport situation in the city, preventing non-communicable diseases, equity, healthy urban environment and design.
- Some cities experiment and go beyond the business as usual, promoting e.g. links between physical activity and culture or physical activity and mental health of older people.
- However, when looking at all the 73 case studies, or considering that the European network consists of 100 cities, still little is done in exploring the links between health, Active Living and sustainable development. Only 5 out of 100 cities presented case studies on sustainable transport.
- Healthy Cities benefit from planning and executing Active Living interventions as they learn predominantly about governance, partnership, policy and equity.
- Healthy Cities experience challenges in planning and executing the interventions. A major challenge is to reach the target populations (especially from disadvantaged groups or young people). Therefore, it is difficult to assess the real needs of the target group.
- Interventions are viewed as transferable to other settings and cities.
Recommendations

To cities:
- Interventions to promote physical activity seem to have a lot to win by being based on intersectoral collaboration, linking with other important policy areas and using evidence as a foundation for planning, implementation and evaluation.
- Cities could learn more from each other. There should be a better exchange of information, not only of experiences, but also of interventions and support: an “open market of solutions”;
- Cities should explore and use the link between health, Active Living and sustainable transport, which will create better synergies within the cities and allow cities to benefit from the funds reserved for environmental issues;
- Cities should pay more attention to the development of appropriate interventions in cooperation with the target groups during the planning stage.

To WHO:
- Cities need support in effective use of health monitoring tools for collecting the evidence
- Cities should be trained better in the links between health, Active Living and sustainable transport and how to initiate and conduct effective interventions (e.g. using HEAT tool);
- The exchange of information and “lessons learned” between the cities should be boosted (attractive and user-friendly learning platform should be established).
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