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Lifelong learning for health in cities: A guide

Enacting the Yeonsu Declaration for Learning Cities

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Enacting the Yeonsu Declaration for Learning Cities

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Education and learning are at the very core of what makes 'health for all' possible. The crisis, therefore, has been an eye-opener regarding the importance and need for lifelong health education. Instituting such a place-based lifelong learning culture could play a key role in building resilience for individuals, communities and cities.

In Yeonsu, Republic of Korea, the fifth International Conference on Learning Cities was convened from 27 to 30 October 2021. Attending in person or online were: mayors, deputy mayors, officials, representatives from 229 learning cities in 64 countries worldwide, education executives, education experts, representatives of United Nations agencies, the private sector, and regional, international and civil society organizations. At the end of the conference, a declaration was issued.[1] It includes a set of commitments to build healthy and resilient cities.

This guide aims to assist municipal teams in the concrete development of a policy that promotes lifelong learning for health within the framework of the Yeonsu Declaration. It is intended not only for cities already identified as learning cities or healthy cities – which may use the guide to integrate a lifelong learning for health dimension into existing city policies and projects – but also for all cities that wish to implement a policy promoting lifelong learning for health.

[1] **www.uil.unesco.org/sites/default/files/medias/fichiers/2022/02/iclc5_yeonsudeclaration.pdf**

This guide proposes a three-step process for enacting such a policy: 1. raising awareness of the role of cities in lifelong learning for health; 2. developing a policy that promotes a healthy and resilient city; and 3. implementing the policy.

The lifelong learning for health policy can be formalized through the creation of a learning for health pathway. The pathway makes explicit – and simultaneously formalizes – the content, the learning approaches and learning outcomes of the learning opportunities offered throughout people's lives. It focuses on building individual capacities for awareness and understanding of complex health issues, critical judgment and action. The pathway also has a communication purpose by making what is being done to promote health in the city explicit to citizens, partners and professionals. It is based on four key action principles: 'valuing, sharing, aligning and improving'. This approach seeks, first, to demonstrate the value of the educational work carried out in formal, non-formal and informal settings of the urban environment; then to make this known among stakeholders and to make the pathway coherent; and, finally, to identify the gaps and take the necessary initiatives to fill them.

The guide can be used in different ways depending on the context, means and objectives of the individual cities. It is not always necessary to read the whole guide. And we expect that a large proportion of readers and users will simply pick and choose from the various sections of the guide elements that are of particular interest to them. Nonetheless, we hope that everyone will find something to contribute to their city's efforts and actions for implementing an inclusive policy for promoting lifelong learning for health.

Introduction

With more than half of the global population residing in cities in almost all countries affected by the COVID-19 pandemic, cities have been the epicentres of infection and on the frontline for dealing with the vast implications of this public health emergency (OECD, 2020; UNESCO, 2020). This health crisis has led the world's cities to put public health issues at the top of their agendas (WHO, 2020b).

The pandemic has highlighted that one cannot implement public health measures without, or indeed against, the goodwill of the population. The population is not the 'problem', it is part of the solution to a health crisis. Even if the primary role of cities has not historically been to implement health policies, it is now widely recognized that cities could play a more central role, because factors that influence people's health and well-being go far beyond the health care system (WHO and UN Habitat, 2016). Urban planning, transport, housing, social services and water supply are all major determinants. Regarding the relationship between health and place, neighbourhoods – and, by extension, cities – have been said to 'essentially involve the availability of, and access to, health-relevant resources in a geographically defined area' (Bernard et al., 2007).

The pandemic revealed that, beyond these environmental dimensions of health, cities also play a major role in developing populations' capacities to promote individual and collective health. Education and learning are at the very core of what makes 'health for all' possible (WHO, 2020a). The crisis prompted by COVID-19, therefore, has been an eye-opener regarding the importance of instituting lifelong health education. A place-based lifelong learning culture could play a key role in building resilience for individuals, communities and cities.

Individuals build their capacity to take care of their health throughout their lives, and much of this process is place-based and local to where they live. They learn through their family, but also through their community, school, workplace, cultural, sport and health care settings,

and through all kinds of media. However, the implementation of lifelong learning in the field of health and well-being faces operational difficulties. Cities' capacities to lead and collaborate in formulating or instigating policies and interventions to promote 'learning for health and well-being' vary significantly, depending on the political, economic and social context. Accordingly, there is no such thing as one size fits all. Evidence shows that for a policy to be sustainable, several elements need to be combined, for example: genuine participation of the population in policy process and implementation; having the means to reach all the people and communities concerned, especially the most vulnerable; taking into account how health issues may interact with diverse social and cultural factors; appreciating the norms and perceptions of subpopulations; and having a well-trained municipal health workforce. These challenges are common to all cities but are more acute in the countries most afflicted by poverty and conflict (Brown, Blanc and Press, 2020).

> ***If there is one lesson to draw from this crisis, it is that education and health are global public goods that are to be prioritized.***
>
> — *Stefania Giannini, UNESCO Assistant Director-General for Education*

In order to address these global urban challenges, the fifth International Conference on Learning Cities (ICLC 5) was convened online and in person in Yeonsu, Republic of Korea, from 27 to 30 October 2021. In attendance were mayors, deputy mayors, officials, representatives from 229 learning cities in 64 countries worldwide, education executives, education experts, representatives of United Nations agencies, the private sector, and regional, international and civil society organizations. At the end of the conference, a declaration was issued. It includes a set of commitments to build healthy and resilient cities. This guide aims to assist municipal teams in the implementation of this declaration.

Knowing that lifelong learning policies and practices can contribute to the development of healthy and resilient learning cities, this guide addresses how cities can promote more opportunities for their citizens to benefit from such policies and programmes. It is intended not only for places already designated as learning cities or healthy cities, but also for all cities that want to implement a policy to promote lifelong learning for health. The guide has been developed with a wide range of people involved in city management, education and public health from the five continents. It is not intended to be a magic wand, but simply to provide support to those involved in lifelong learning for health and to help them to carry out their projects, whatever their political or socio-economic circumstances may be.

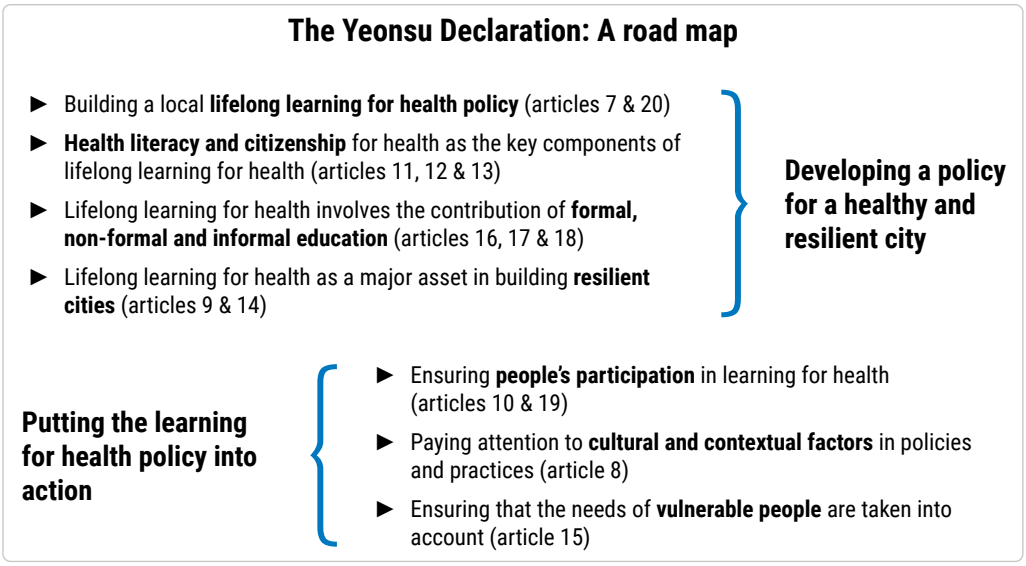
This document, subtitled 'Enacting the Yeonsu Declaration for Learning Cities', is not intended as a guide to implementing the declaration. Indeed, due to the diversity of political, legal, economic, cultural and social contexts of cities around the world, it is not possible to propose a single policy programme that is adaptable and implementable in every situation. Instead, each city will need to create its own dedicated policy that builds on the declaration but also incorporates all the appropriate contextual elements.[2]

This guide offers a step-by-step approach. It consists of three sections:

- *A backdrop for enacting the Yeonsu Declaration (Section A).* This first section sets the scene. It takes stock of the key elements, such as the content of the Yeonsu Declaration, definitions, and recommendations for implementation.
- *Suggestions for formulating a policy for lifelong learning for health (Section B).* This second section makes the articles of the declaration more concrete and explains all the concepts. It describes the various pathways to lifelong learning for health.
- *Implementing a policy to promote lifelong learning for health (Section C).* This third part is about policy definition and implementation.

[2] Enactment is the act of putting something into action (Cambridge Dictionary).

Figure 1: The structure of the Yeonsu Declaration



Source: Author's own elaboration.

This declaration thus constitutes a road map for the implementation of a lifelong learning for health policy, and the present guide is intended to help cities adapt their policies as appropriate to suit the various local contexts.

Using the guide

On the basis of exchanges with the cities involved in the preparation of the guide, we have identified three main situations. The first concerns cities that do not have a fully structured policy framework for health and lifelong learning. These cities can use the guide in its entirety (sections A, B and C) both to develop their team capacities and to create a common lifelong learning for health culture among those involved.

The next two situations concern cities already involved in lifelong learning for health policies, such as members of the UNESCO Global Network of Learning Cities (GNLC) and those with experience in health policies, such as the World Health Organization's (WHO) healthy cities. In these cases, the lifelong learning for health policy will be one of the components of an existing policy. The cities of the UNESCO GNLC could go directly to the implementation section (Section C) of this guide, while the WHO healthy cities might find sections A and B useful.

The guide can be used in different ways depending on the context, means and objectives of each city. it is not always necessary to read the whole guide. A large proportion of readers will simply pick and choose elements from the various paragraphs of the guide that they find particularly pertinent. We hope that everyone will find something of use that will contribute to their city's efforts and actions for the implementation of a policy that promotes lifelong learning for health.

Section A

A backdrop for the development and enactment of a lifelong learning for health policy

Guiding questions

1. What is the Yeonsu Declaration and in what way does it constitute a road map for local policies promoting lifelong learning for health?
2. How can existing city policies have a positive impact on lifelong learning for health?
3. What is known about the success factors in implementing policy on lifelong learning?

THE YEONSU DECLARATION: A ROAD MAP

The Yeonsu Declaration comprises 28 articles.[3] The first six articles constitute a preamble, while articles 7 to 20 constitute the heart of the declaration and describe the commitments taken by the participants in the conference. The last eight articles propose ways to implement the declaration.

The 14 articles that describe the commitments to building healthy and resilient cities through lifelong learning (7 to 20) can be organized into two parts. Ten of them describe the policy to be developed and four describe how to put the learning for health policy into action at the city level.

Table 1 summarizes the articles of the Yeonsu Declaration, specifically articles 7–20. Though the declaration has 28 articles in total (beginning with a preamble and concluding with ways forward), the 14 presented in *Table 1* constitute the core.

[3] **www.uil.unesco.org/sites/default/files/medias/fichiers/2022/02/iclc5_yeonsudeclaration.pdf**

Table 1: Summary of Yeonsu Declaration articles related to health

7. Demonstrating the necessary political will	8. Paying attention to contextual factors	9. Crisis implementation of plans for essential services	10. Empowering local people to build capacity to protect their health
11. A new paradigm of learning for health in cities	12. Promoting health literacy in the city	13. Strengthening and promoting citizenship for health	14. Strengthening community resilience through multisectoral planning
15. Providing learning opportunities for vulnerable populations, including children	16. Recognizing the contribution of the formal education sector	17. Building the capacity of non-formal learning providers	18. Making use of informal spaces in cities
19. Broadening the scope of stakeholder involvement at city level	20. Strengthening our efforts to achieve the 17 SDGs		

Source: Yeonsu Declaration of Learning Cities, 2021.

DEVELOPING A POLICY FOR A HEALTHY AND RESILIENT CITY

Building a local policy for lifelong learning for health that contributes to achieving all SDGs

Demonstrating the political will necessary to place lifelong learning for health and the development of resilience at the centre of our cities' agendas is essential, as is recognizing the influence this has on developments within the city, as well as the resonance of such leadership at national and international levels.

Building an effective local policy for lifelong learning for health also means strengthening efforts to achieve the 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable

Development, and recognizing the contributions made by learning cities to these 17 SDGs, particularly **SDG 3** (good health and well-being); **SDG 4** (inclusive and equitable quality education and lifelong learning opportunities for all); **SDG 5** (gender equality); **SDG 8** (employment and decent work); **SDG 11** (inclusive, safe, resilient and sustainable cities) and **SDG 13** (combat climate change). (See articles 7 and 20 of the declaration.)

Health literacy and citizenship for health as the key components of lifelong learning for health

A new paradigm to promote learning for health in cities needs to be established, which means supporting a concept that includes mental health and well-being, as well as personal and societal aspects for health literacy and citizenship for health. As a dimension of learning for health, it is important to promote health literacy in the city – meaning the ability to locate, understand and critically evaluate health information, including through technology, and to apply that information to address health issues. This also means supporting local people to identify false information and reduce its impact on health-related decision-making.

Citizenship for health also needs to be strengthened in recognition of the wider societal impact of health issues and the common good of global health, giving learners more agency to act with ethical and social responsibility when it comes to their own health and the health of their communities. (See articles 11–13.)

Lifelong learning for health involves the collective contributions of formal, non-formal and informal education

It is important to recognize the contributions of the formal education sector, including schools, universities and technical and vocational education and training (TVET) institutions, to learning for health and resilience in cities throughout and beyond the COVID-19 pandemic, especially their adaptability in ensuring the continuation of learning during this time. It is also important to build the capacities of local non-formal learning providers, and to recognize the positive impact of

early childhood care and education on health, as well as the long-term roles that youth and adult learning centres and organizations can play in creating learning opportunities for health awareness and promoting the use of technology for health literacy.

Moreover, we should make use of informal spaces within our cities, such as homes, local neighbourhoods, workplaces, green spaces, public transport, municipal buildings and the digital sphere, in order to promote learning for health and develop resilience. (See articles 16–18.)

Lifelong learning for health as a major asset in building resilient cities

In response to crises, coordinated local plans for the preservation and provision of essential services need to be implemented, including emergency medical services, sexual and reproductive health services, education, public transport, housing and sanitation services.

Strengthening resilient cities in terms of community resilience calls for multi-sectoral planning involving local people, and bottom-up and top-down policies and practices to foster long-term resilience in communities, as well as the resilience of local learning systems, particularly with regard to the continuation of learning in cities during crises, and the protection of learning systems in the face of future disruption through innovation and technology. (See articles 9 and 14.)

PUTTING THE LEARNING FOR HEALTH POLICY INTO ACTION

Ensuring people's participation in learning for health

For the successful implementation of a learning for health policy, it is vital to work with and empower local people to develop capacities to protect their own health by providing them with an array of educational tools for the acquisition of knowledge about the COVID-19 virus, for example, transmission prevention, self-protection and effective use of the health care system.

Also, the scope of stakeholder involvement in lifelong learning at the city level should be broadened so that the health sector is well represented; this should include health professionals, practitioners and experts, as well as stakeholders in the field of urban design, since city planning decisions impact health and learning. (See articles 10 and 19.)

Paying attention to cultural and contextual factors in policies and practices

In order to implement policies and initiatives for learning for health in a way that involves everyone in the city, attention has to be given to the specific contextual factors of each of our cities while also considering local communities' social and cultural perceptions of health-related issues, including Indigenous knowledge. (See Article 8.)

Ensuring that the needs of vulnerable people are taken into account

Learning opportunities should involve and respond to the needs of vulnerable populations, including children, with the understanding that vulnerabilities are often intersectional – meaning individual learners may experience multiple forms of disadvantage at the same time – and that people with lower levels of education often have lower levels of health literacy. (See Article 15.)

> ***Learning cities promote education for sustainable development as a way to raise awareness of climate change, pollution, threats to mental and physical health, and the need to protect the environment.***
>
> — *Seok jin Mun, Mayor of Seodaemun, Seoul*

CITIES AS KEY SETTINGS FOR HEALTH AND WELL-BEING

During the pandemic, cities were the epicentres of infection and on the frontline for confronting the vast implications of this public health emergency. The health crisis has led all the world's cities to put public health issues at the top of their agendas. What is true for the COVID-19 pandemic is also relevant for health crises in general.

To be effective during a public health crisis, cities need to employ two kinds of measures:

- **Measures targeting the living conditions that influence health.** There should be coordinated local plans to ensure continued provision of essential services, such as emergency medical and surgical care, as well as services dealing with sexual and reproductive health issues, drug and alcohol abuse, vaccination, public transport, energy supplies and repairs, housing, communication, water and sanitation. In addition, the implementation of protection and prevention measures that serve the whole population needs to be ensured.
- **Measures linked to developing the population's capacity to face health crises using multi-faceted tools.** The objective is to give everybody the means to take care of their own health in an autonomous and responsible way through appropriate information and education. More specifically, this includes, for example, having access to scientifically validated knowledge about the health crisis, protection, capacity to implement the protection measures for oneself and for all, and making good use of the health care system.

One consequence of the COVID-19 crisis is that local governments and populations had to quickly learn new skills and acquire knowledge in response to the rapid spread of the virus. To reach all citizens, cities had to find complementary channels and ways to inform and educate people in a timely and effective manner. In many contexts, this has meant harnessing the power of information and communications technology (ICT) and distance learning. In some cases, the concept

of the city as a brand name and a shared identity has been used to underline the mutual dependency and responsibility of citizens for each other, and thus to enhance compliance. This underscores the potential for creating social capital at the city level.

Data show that the COVID-19 crisis has enabled a large proportion of the population to acquire health skills. However, there are significant disparities in COVID-19-related knowledge, attitudes and behaviours, which vary according to people's knowledge about health in general. Major inequalities exist within and between countries.

> ***The local experiences reported … highlight the benefits not only of finding ways to live with a pandemic, but of appreciating the nuance of change while remaining optimistic about the future. Moreover, this pandemic, like other challenges before it, is but another opportunity – an invaluable learning experience that will leave an indelible mark on people's lives.***
>
> — *UIL, 2021c*

Beyond the context of the COVID-19 crisis, the health benefits to cities in learning for health are strongly influenced by the knowledge we now have of what determines the health of populations. This goes far beyond health crisis management.

The main reason municipal policies appear to have such an impact on health generally is the recognition of how much personal, social and environmental factors determine health, affecting both individuals and populations. Access to quality health care is only one element. These individual health determinants interact with each other and influence the overall living conditions that help define our health. Good urban policies and practices have the potential to bring about positive changes. Some of the most relevant factors include:

- Factors related to representations of health, personal behaviours and lifestyles that are influenced by education and the patterns of social relations in communities and in society at large. These relationships can be favourable or unfavourable to health. Disadvantaged people tend to show a higher prevalence of behavioural factors such as smoking or poor diet and will also face greater financial constraints in choosing a healthier lifestyle.
- Relational and community networks, including social and group influences, are also important factors. Examples include embeddedness in a community or culture, and the presence or absence of mutual support in adverse situations.
- Factors related to living and working conditions, access to essential services and facilities, such as water, housing, health services, food, and education, as well as the relationship to the local environment, need to be taken into account. Inadequate housing conditions, exposure to dangerous and stressful working conditions and poor access to services create differential risks for the socially disadvantaged, as well as anyone else experiencing these conditions, if only temporarily.
- Factors related to commercial determinants, including policies for the regulation and enforcement of product advertising and the placement of products in schools and other municipal and community locations, also play a role. Unhealthy products have been found to be disproportionately advertised in places close to deprived populations and a significant proportion of advertisements aimed at children are harmful to health.
- Socio-economic, cultural, labour market and environmental conditions encompass factors that influence society as a whole by affecting all the other determinants.

The way in which health determinants affect the health of city dwellers is complex. However, the control of health determinants often lies outside the responsibility and capacity of the health sector. Therefore, in order to take effective actions to solve urban health problems, it is necessary to integrate the efforts of other sectors. These include not only the health, social and education departments of governments, but also non-governmental organizations, private companies, as well as the communities themselves. Developing this

integrated, intersectoral approach with community participation is a key objective.

The COVID-19 crisis makes visible the importance of the non-medical determinants of health and the need for a paradigm shift in the role played by cities in controlling the epidemic. Due to the proximity of citizens and local resources, cities can take action immediately and in a contextualized way, thus responding to emergencies and addressing citizens' needs more efficiently, especially the needs of vulnerable groups. At the same time, cities require greater health protections as a result of their concentration of people. Many cities have actively developed and implemented innovative measures that take these factors into account. Beyond the measures targeting the living conditions that influence health, cities must also focus on skills development.

Evidence shows that there is a strong link between health status and the ability of citizens to find, understand, evaluate and use information to manage their health. People with inadequate health knowledge and skills (health literacy) had poorer understandings of COVID-19 symptoms, were less able to identify behaviours to prevent infection, and experienced more difficulty finding information and understanding government messaging about the virus than people with adequate health knowledge and skills. These deficits are associated with less participation in activities that promote health and help to detect disease, riskier health choices (such as higher smoking rates and lower vaccination rates), more work accidents, poorer management of chronic diseases (such as diabetes, HIV infection and asthma), faulty use of medication resulting in increased antimicrobial resistance, more frequent hospitalization and rehospitalization, increased morbidity and premature death.

When people think of acquiring health knowledge and skills, they think of children and young people in school, but in fact it is a lifelong process, and the health literacy of older people, for example, remains a significant challenge. Inadequate health knowledge and skills among older people is consistently associated with increased hospitalization, greater emergency care use, lower mammography and

vaccination rates, poorer ability to take medicines or interpret labels and health messages correctly, and poorer overall health status and higher mortality.

Research further shows that people with good health knowledge and skills participate more actively in economic prosperity, have higher earnings and rates of employment, are more educated and informed, contribute more to community activities, and enjoy better health and well-being.

The proximity of municipal governments to the local population, the social interventions they implement and their capacity to generate and support non-formal educational processes make cities key players in advancing equitable learning for health. They have the power to reduce barriers. All regions, and low-, middle- and high-income countries, would benefit from promoting health knowledge and skills, especially where people lack immediate service provision. Supported by good governance, promoting health literacy could mitigate some of the negative effects that intensive urban development is creating for the planet.

Limited health knowledge and skills follow a social gradient and can further reinforce existing inequalities. Data show that higher levels of health knowledge and skills can help people better deal with misinformation and fake news. People with limited health knowledge and skills usually have lower levels of education, are more likely to be older adults or migrants, and depend more on various forms of public welfare support. In today's world, health care systems, like systems in other sectors, are placing information burdens on populations. People with higher levels of health literacy and skills are more likely to adopt healthier behaviours, to make better health-promoting decisions, and to access and make greater use of such resources as information services and universal health coverage.

Health is not just a matter of individual behaviour. People need to be able to understand their rights and responsibilities, to be aware that their thoughts and actions affect others, and they should support social decisions promoting improved health for everyone

(Paakkari and Paakkari, 2012). The determinants of health transcend national barriers; global health is in fact a common good of humanity that can only be ensured for all through a common commitment (Jourdan, 2012).

Lifelong learning for health is then a key determinant of health and well-being. This is why lifelong learning policies at local as well as national levels must include a health dimension.

> ***Lifelong learning is rooted in the integration of learning and living, covering learning activities for people of all ages, in all life-wide contexts and through a variety of modalities that, together, meet a range of learning needs and demands. This is the holistic understanding of lifelong learning that frames the guidance contained within the present guide.***
>
> — *Source:* **https://www.uil.unesco.org/en/unesco-institute/mandate/lifelong-learning**

The challenge of inequalities in health

It is likely that the world will face more health crises. Building resilient communities is not independent from other major social and environmental challenges such as climate change, conflicts, and the fight for equity and inclusion in all our societies. Reinforcing the linkages between SDG 3 (health), SDG 4 (education and lifelong learning), SDG 5 (gender equality) and SDG 11 (sustainable cities) in municipal policies is a way to gain coherence and sustainability (UNESCO, 2016).

Health issues, and especially COVID-19, disproportionately affect migrants, Indigenous people and all marginalized communities (Büyüm et al., 2020; Gosselin et al., 2021). Since the ability to promote one's health and that of one's family is embedded in, and influenced by,

culture, socio-economic situation and community, learning for health has to take place in multiple ways, and different skills are needed for different situations and contexts. Cities are well placed for facilitating this because of their proximity to local populations, access to resources and expertise in social interventions.

So, learning for health should start early in life and continue throughout. Education and lifelong learning are at the heart of the Sustainable Development Goals (SDGs) and indispensable to their achievement. Lifelong learning (the philosophy, conceptual framework and organizing principle of all forms of education, based on inclusive, emancipatory, humanistic and democratic values) is central to equipping us to deal with rapid changes and to build resilience in our societies (Nikolitsa-Winter, Mauch and Maalouf, 2019). Local policies and interventions are not magic wands, but they have a role to play in learning for health throughout life within the framework of the SDGs. This contribution could be shaped into a health learning pathway that integrates health literacy and citizenship for health.

> ***It is clear to everyone that the pandemic has exacerbated the difficulties of the most vulnerable categories: the physically and mentally disabled, migrants, elderly, unemployed, and so on.***
>
> — *Carlo Nofri, Fermo, Italy*

LESSONS LEARNED FROM GLOBAL EXPERIENCE

A review, including case studies of cities on different continents (UIL, 2021a), was conducted in preparation for the fifth International Conference on Learning Cities by the UNESCO Chair for Global Health & Education. Based on the contributions of the members of the UNESCO GNLC and the community of the UNESCO Chair, the World Health Organization's guidelines on health literacy and healthy cities, as well as the International Union for Health Promotion document on

Urban Health Promotion (IUHPE, 2016), we summarized what is known at this time about the key components that influence the success of municipal policies to promote lifelong learning for health.

Such a policy at the city level has to be part of a comprehensive intersectoral approach the aim of which is to address the determinants of health (WHO, 1986). A whole-society approach to learning for health at the city level is best achieved through:

- **Municipal policy.** Integrating learning for health into all municipal policies, including implementing international and national programmes, action plans and digital strategies. Checking that other municipal practices do not conflict with good health policies, e.g. acceptance of funding from manufacturers of unhealthy commodities.
- **Education.** Using learning for health as a framework for improving formal health education in schools, with policies aiming to support non-formal initiatives and informal programmes of adult education throughout the lifespan.
- **Whole setting approach.** Developing strategies in various in-person and virtual settings, such as primary care, hospitals, schools, communities, workplaces, media, social networks, and innovative apps.
- **Communication, health information and language.** Adopting policies based on plain-language communication tools, but also other means of communication, such as images, photographs, graphic illustrations, apps, audio and videos, as well as providing signage and communication documents in minority languages, and creating transparent, consumer-friendly environments and easy-to-understand social media strategies. Using the city brand name to underline collective action.
- **Capacity-building.** Supporting professionals, vocational and higher education institutions, networks, and all parties interested in learning for health, developing easy access to online resources and databases, as well as setting up and supporting contact points and working groups.

- **Participation.** Facilitating and maximizing genuine participation of the whole population (young and old, well and infirm, affluent and deprived, digitally connected and others) in defining and implementing learning for health policies.
- **Collaboration.** Developing cross-sector collaboration to improve learning for health. Using municipal policies and city cohesiveness as platforms to develop stronger links among institutions, associations and private sector organizations and with a wide range of stakeholders.
- **Empowerment and inclusion.** Positioning learning for health as an empowerment tool for a health agenda which can be promoted through a multi-strategic approach at individual, community and society level. Promoting a sustainable approach that maximizes participation and leaves no one behind. Inclusion of all on an individual and population level, regardless of their culture.
- **Health equity agenda and social justice.** Exploring associations at the intersections of health equity, health inequalities, and learning for health to improve health equity and health for all. Moreover, using proportionate universalism – whereby resourcing and delivery of universal services are undertaken at a scale and intensity proportionate to the degree of need – in order to address hard-to-reach groups.
- **Intervention research.** Developing links with research bodies in order to promote intervention research that aims to produce knowledge and to support change toward health literacy and citizenship for health (modified from IUHPE, 2016).

KEY POINTS

Section A included a discussion of:

1. The Yeonsu Declaration: A road map;
2. Cities as key settings for health and well-being;
3. Lessons learned from global experiences: What is known about the key components that condition the success of a municipal policy to promote lifelong learning for health.

ESSENTIAL READING

UIL (UNESCO Institute for Lifelong Learning), 2021. *Yeonsu Declaration for learning Cities: Building healthy and resilient cities through lifelong learning.* Available at: <**https://uil.unesco.org/sites/default/files/doc/lifelong-learning/cities/5th-conference/iclc5_yeonsudeclaration.pdf**> [Accessed 3 March 2023].

UIL, 2022. *Making lifelong learning a reality: A handbook.* [online] Hamburg: UNESCO Institute for Lifelong Learning. Available at: <**https://unesdoc.unesco.org/ark:/48223/pf0000381857/PDF/381857eng.pdf.multi**> [Accessed 3 March 2023].

Section B

The content of a policy promoting lifelong learning for health

Guiding questions

1. What is lifelong learning for health?
2. What is a health learning pathway?
3. What are the knowledge and skills that citizens should acquire to improve their own health and that of the community?
4. Which city organizations and people could contribute to the lifelong learning for health policy?
5. How can municipalities contribute to learning for health?

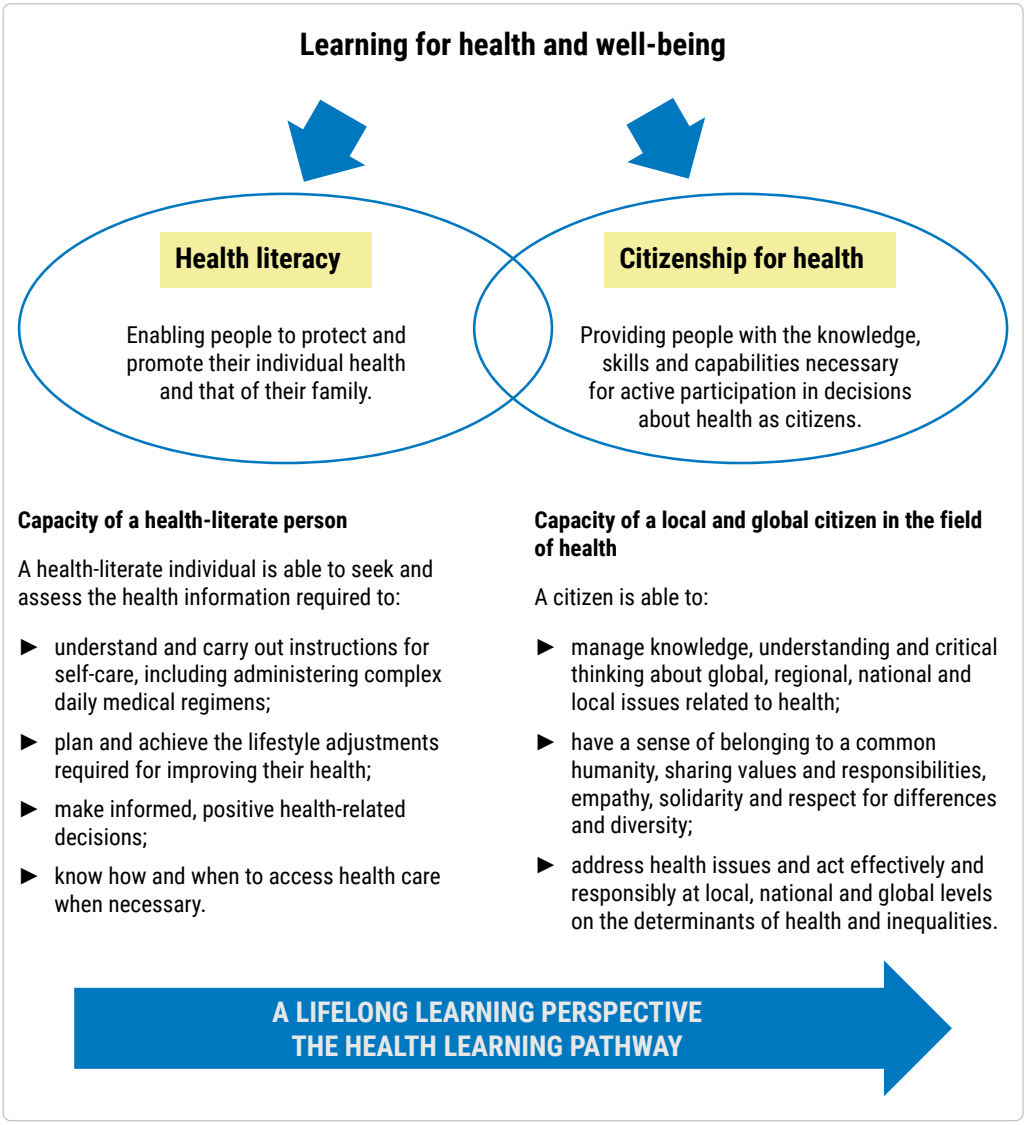
The following parts of this section are based on policies and practices implemented by cities. Each part will include examples.

LIFELONG LEARNING FOR HEALTH

Although good health is a central dimension of everyone's daily life, it is not the very object of living nor an ultimate aim. It is a resource that permits people to lead an individually, socially, culturally and economically fulfilling life (Nutbeam, 1998). The circumstances in which everyday life takes place shape people's capacity to lead healthy lives. People's knowledge and skills are among multiple factors that influence the health of individuals and populations. From the perspective of local policies, learning for health and well-being is a means to fulfil people's lives (Jourdan, 2012).

Learning for health and well-being has two embedded dimensions. Learning for health aims, on the one hand, to enable people to protect and promote their individual health – and that of their family – and, on the other, to provide them with the knowledge, skills and capabilities necessary for actively participating in decisions about health as citizens (Jourdan et al., 2021). What is expected from all citizens is for them to be able to take care of themselves and to contribute to building and maintaining healthy urban environments. Hence, learning for health is both a personal asset for health and a societal health resource (IUHPE, 2018) (see *Figure 2*).

Figure 2: Core dimensions of lifelong learning for health



Source: Author's own elaboration.

> ***Without the participation of citizens, the efforts made by the health sector, or the government sector, would not have seen results.***
>
> — *Alejandro Gómez López, District Secretary of Health, Bogotá, Colombia*

The first core dimension of learning for health is a way to contribute to building people's capacity to manage their own health. It means that people should be able to access, understand, appraise and apply health information in order to make judgments and take everyday decisions concerning health care, disease prevention and health promotion to maintain or improve quality of life across the life course (Kickbusch et al., 2013). The necessary combined knowledge, motivation and competences are often called '**health literacy**' (Saboga-Nunes et al., 2021).

Within health literacy, an increasingly important element is e-health literacy, defined as the ability to seek, find, understand and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem (Norman and Skinner, 2006). Many of the educational responses of cities during the COVID-19 pandemic aimed to equip the population with such knowledge and competences (UIL, 2020a). For example, leveraging e-health literacy skills and, more specifically, media literacy, was shown to be of great value in mitigating the detrimental effects of erroneous information on vaccination decision-making (Dib et al., 2022).

Table 2: The dimensions of health literacy

(47 items)	**Access/ find/obtain information relevant to health** (13 items)	**Understand information relevant to health** (11 items)	**Appraise/ judge/evaluate information relevant to health** (12 items)	**Apply/use information relevant to health** (11 items)
Health care (16 items)	Ability to access information on medical and clinical issues (4 items)	Ability to understand medical information and derive meaning (4 items)	Ability to interpret and evaluate medical information (4 items)	Ability to make informed decisions on medical issues (4 items)
Disease prevention (15 items)	Ability to acces information on risk factors for health (4 items)	Ability to understand information on risk factors and derive meaning (3 items)	Ability to interpret and evaluate information on risk factors for health (5 items)	Ability to make informed decisions on risk factors for health (3 items)
Health promotion (16 items)	Ability to update oneself on determinants of health in the social and physical environment (5 items)	Ability to understand information on determinants of health in the social and physical environment and derive meaning (4 items)	Ability to interpret and evaluate information on health determinants in the social and physical environment (3 items)	Ability to make informed decisions on health determinants in the social and physical environment (4 items)

Note: Number of items in the HLS-EU-Q47 for each cell was added into the original table of Sørensen et al (2012) for this publication. The European Health Literacy Survey Questionnaire (HLS-EU-Q) is a tool for assessing health literacy.

Source: Sorenson et al, 2012, cited in Kickbusch et al., 2013.

Planning for a healthy city – Belfast (UK)

The city of Belfast has implemented a comprehensive health promotion policy. The document '**Planning for a Healthy City**' summarizes the approach taken by partners involved in the city health development planning process. It outlines actions to be taken by a number of sectors and government departments to tackle the social, economic and environmental determinants of health. The areas for action were identified through a public consultation process and the results have been brought about through an intense period of collaborative work. The framework for cooperation is summarized in a Charter of Commitment. The main themes of the policy are mental well-being for young people, transport, environment, planning and housing, and lifelong learning.

Health literacy is among the city's priorities, together with health equity in all policies, creating resilient communities and supportive environments, adapting to climate change and expanding public health capacity. Belfast Healthy Cities provided leadership in bringing to Northern Ireland a Health Literacy Training Programme for health care and other professionals, and held customized training sessions. It also hosted the 2018 UK Health Literacy Conference.

The second core dimension is that learning for health is a key component of citizenship education. Health is not just a matter of individual behaviour. People need to be able to understand their rights and responsibilities, to be aware of the effects of their thoughts and actions on other people and the world at large, and to be committed to social decisions related to health (Paakkari and Paakkari, 2012). The determinants of health transcend national barriers; global health is in fact a common good of humanity that can only be ensured for all through a common commitment (Jourdan, 2012)

The COVID-19 pandemic revealed the interdependence of countries globally (Greer et al., 2021). It also showed that while the manifestation of inequity in individual countries or regions is bound up in the local-

to-global interface of historical, economic, social and political forces, the pandemic disproportionately affected marginalized communities (Büyüm et al., 2020). There are links between health and global economic and social structures – especially mechanisms of exploitation and oppression. It is necessary to understand these relationships in order to be able to act on the determinants of health. Health is thus one dimension among others of global citizenship within the framework of the Sustainable Development Goals (Nikolitsa-Winter, Mauch and Maalouf, 2019). Learning for health aims to develop people's citizenship agency by enhancing their ability to act in an ethically responsible way, and to take social responsibility. The objective is to give learners the means to take informed decisions and actions at the individual, community and global levels (UNESCO, 2021). It is part of a process of empowerment (WHO, 1986). This education process includes cognitive (knowledge, critical thinking), socio-emotional (values and responsibilities, empathy, solidarity, respect) and behavioural (act effectively and responsibly at local, national and global levels) dimensions (Nikolitsa-Winter, Mauch and Maalouf, 2019).

Many cities are leading or participating in programmes to strengthen community confidence to combat the pandemic through global citizenship education (Nikolitsa-Winter et al., 2019). 'Health citizenship requires a combination of personal and social responsibility from individuals, but even more so it requires the institutions of society to promote choice, empowerment, self-management, responsiveness and participation in health and well-being' (Cayton & Blomfield, quoted in Kickbusch et al., 2013). Healthy and resilient cities require citizens who are able to take care of their own health and well-being, contribute to collective health actions and commit to building healthy environments, locally as well as globally.

> ***The experience of Bandar Khamir shows that if the focus is on increasing participation and social cohesion and giving people global motivation, it can make the city safer and more resilient for the challenges ahead.***
>
> — *Javad Mahmoodi, Mayor of Bandar Khamir, Iran*

Population Health Education Project – Cotia (Brazil)

The Education Department of Cotia is implementing the '**Population Health Education Project** – Cotia 2021'. This initiative, which is part of a partnership with the Israelita Albert Einstein Hospital, aims to disseminate children's health education by providing a methodology for population health education to professionals in the municipal network.

This municipal project offers managers and teachers an online training course focusing on health in all its aspects, such as physical health, mental health, nutrition and hygiene, as well as different material supports for developing the theme with the pupils. The materials provided to educators allow them to work on health issues by combining the different disciplines, making children an actor in health issues, both their own and those of their entourage.

HEALTH LITERACY AND CITIZENSHIP FOR HEALTH ARE INTIMATELY LINKED

Most health issues have both an individual and a collective dimension, thus the two dimensions (health literacy and citizenship for health) are intimately linked. For example, understanding vaccination, its indications, contraindications and adverse effects, and knowing how and when to be vaccinated, are all part of health literacy. Identifying the collective challenges of protecting the most vulnerable and participating in the public debate on access to vaccination for all are citizenship skills (Jourdan, 2021b; 2021c). On a similar theme, in the case of the front-of-the-pack label (Nutriscore), it is a question of knowing how to use the nutritional information available on packaging to make healthy food choices, but also to support, in the various countries, the general implementation of labelling systems that are understandable to all (Van Den Akker et al., 2022). Physical activity as a third example is linked to mobility, road and public safety policies and to people's ability to engage in physical activity appropriate to their personal circumstances (McCormack and Shiell, 2011).

Building health skills and abilities is a lifelong process. No one is ever fully health literate and competent. Everyone at some point needs help in understanding or acting on important health information or navigating a complex system (Kickbusch et al., 2013). The COVID-19 pandemic itself has produced new personal and collective dilemmas where health literacy skills need to be applied to rapidly emerging challenges. Learning for health could be shaped into a dynamic and responsive health learning pathway that integrates these two intertwined dimensions (Jourdan, 2017).

Building healthy and resilient cities through learning – Beijing (China)

In 2018, in order to enable young citizens to protect and promote their own health, a large cross-sectoral programme to address puberty, obesity and cardiovascular risk in children aged 6–8 years was conducted in collaboration with the Shunyi District Education Commission and the Shunyi District Centre for Disease Control and Prevention. The programme was conducted in partnership with local hospitals to conduct health check-ups and ensure medical follow-up for children. A total of 1,914 children and their parents were recruited for longitudinal follow-up in a selection of six representative schools.

The programme included a series of extracurricular programmes, organized in collaboration with sports experts, aimed at modifying the course of physical exercise during schooling, as well as specific physical activity programmes for overweight and obese pupils. A series of interactive parent-child sports videos was proposed to encourage physical activity at home in a fun way and reduce sedentary behaviour.

Conferences and information dissemination activities were organized, sharing key findings on children's health status through posters and official websites, and several national and international academic conferences and advocacy meetings to raise community awareness took place.

Workshops were also held for physical education teachers on how to increase interest in physical education, as well as advocacy workshops for local stakeholders on key child health challenges in the community.

In addition, a mobile application was developed, with an integrated survey system, health education subscriptions and a fitness intervention programme.

Cross-sectoral communication strategies targeting children were also developed.

In order to encourage the involvement of parents, their child's health check-up report and intervention recommendations were shared with them, and they were also provided with a sports/ physical activity education programme.

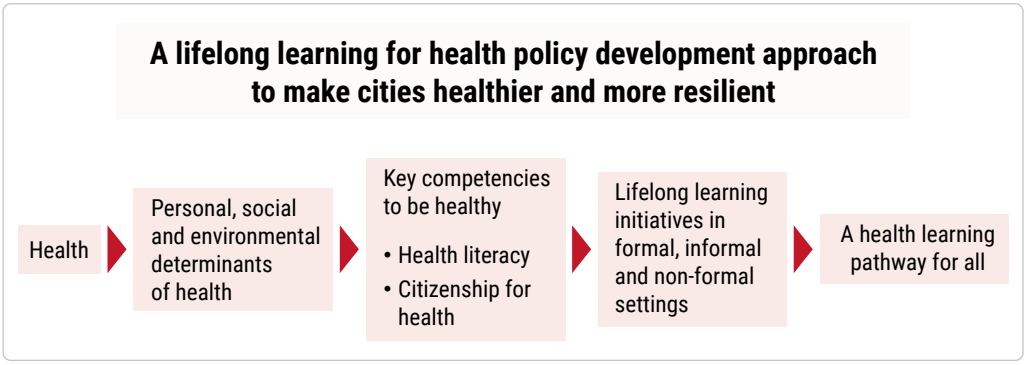
THE KNOWLEDGE AND SKILLS THAT CITIZENS SHOULD ACQUIRE

To build a lifelong learning for health policy, we must start from the knowledge and skills that citizens should acquire to help them gain control over their health and that of the community. In order to define what these knowledge and skills are, we need to rely on what we know about the factors that condition health, the determinants of health.

If this has not already been done, and in order to identify the determinants of health specific to the city, it is possible to conduct a 'city health profile' prior to identifying the key competences. Cities can find resources to establish such a profile on the WHO website.[4]

[4] **www.euro.who.int/en/health-topics/environment-and-health/urban-health/who-european-healthy-cities-network/membership/become-a-member/how-new-cities-can-get-started/city-health-profiles**

Figure 3: Developing a lifelong learning for health policy to make cities healthier and more resilient



Source: Author's own elaboration

HEALTH DETERMINANTS AND KEY COMPETENCIES

Health determinants are the personal, social or environmental factors that have an impact on the health of individuals or populations. These health determinants interact with each other and define the living conditions that influence health. Health determinants can be organized into three main groups: 1) factors related to views on health, personal behaviours and lifestyles (personal health); 2) relational and community networks including social and group influences (social health); and 3) socio-economic, cultural and environmental conditions (environmental health).

Nine key competencies, linked to these three families of health determinants, have been identified. The knowledge and skills related to each of the determinants of health are learned at different ages of life and are of differential importance (Jourdan, 2021d). For example, while developing self-knowledge skills is crucial during infancy and childhood, learning to use the health care system is more important during adulthood and old age.

In a health learning pathway, these nine key competencies can be organized in the following way:

Personal health

- Self-knowledge: Ability to know oneself, self-awareness, self-evaluation skills.
- Autonomy: Ability to stand back, self-management skills, risk, stress and time management.
- Lifestyle: Basic knowledge of health behaviours, ability to identify the link between behaviour and health, evaluating the future consequences of present actions.
- Decision-making: Ability to make free and responsible choices in relation to health, negotiation/refusal skills and assertiveness skills.

Social health

- Communication: Ability to build respectful relationships, to take part in a group, to understand other points of view, to identify the emotions of others, problem-solving skills.
- Critical thinking: Ability to distance oneself from social pressures, from the media, social networks, advertising, peers, and to understand health-related issues.
- Resources: Ability to identify and make appropriate use of social and health support (individuals and services), information-gathering skills.

Environmental health

- Belonging: Ability to know, understand and find a place within one's social and cultural environment.
- Rootedness: Ability to know the physical environment (air, water, housing, transport, land use) and its interaction with health, and identify the role of each individual in creating healthy environments (at local to global levels).

TOWARDS A HEALTH LEARNING PATHWAY FOR ALL

A lifelong learning for health policy can be formalized in many different ways. We propose here to make it explicit through the creation of a health learning pathway.

Lifelong learning in the field of health is shared among primary, secondary and tertiary education institutions, health settings, home care and help, leisure settings, social networks, mass media, peers and families, and in the work environment. It is a major challenge to bring coherence to all these different contributors to learning for health – one that involves thinking in terms of a 'pathway' capable of linking together the different educational inputs (Jourdan, 2017). This challenge of coherence is directly linked to those of inclusiveness and equity because marginalized communities and vulnerable people do not have the same access to health learning opportunities as the rest of the population. The aim of such a pathway is to support all people, throughout their lives, to develop healthy and self-determined lifestyles and to enable them to contribute to the collective effort to bring about changes that will benefit the health of all. It is a means to empower people.

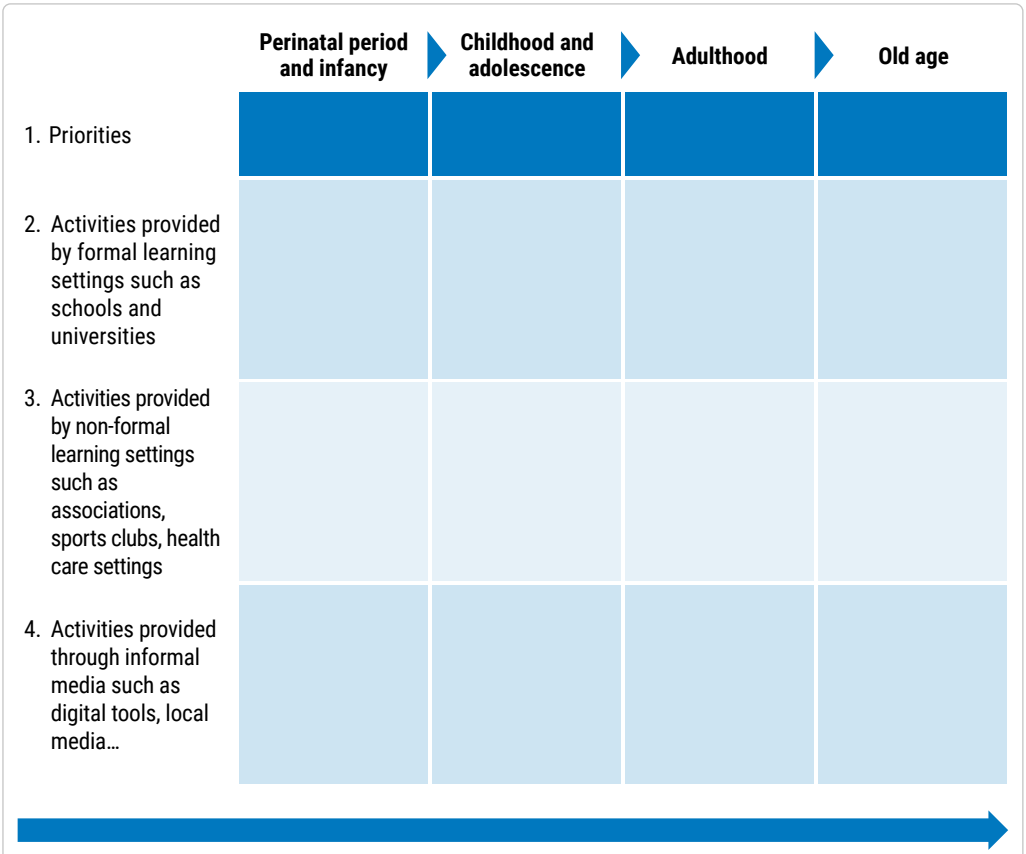
The terms 'learning pathway' or 'educational pathway' do not refer to a universally accepted definition. Rather, they are expressions that come from common language and cover a wide variety of meanings.

When referring to municipal policies, a **learning pathway** can be defined as an organized and coherent lifelong succession of learning experiences of a varied nature. The pathway mobilizes all the actors in a person's life setting beyond school and health care services, integrating formal, non-formal and informal contributions. The pathway makes explicit – and simultaneously formalizes – the content, the contributors and the pedagogical methods of what is being offered to the people. It is focused on the development of capacities for awareness and understanding of complex issues, critical judgment and action skills. It is the enactment, in a given context, of an educational ambition that finds concrete expression in a local setting. The pathway also has a communication purpose by making what is done in the city explicit to families, partners and professionals.

This pathway has to be anchored in lifelong learning for sustainable development (UNESCO, 2018), together with environmental, media, and digital learning. The health learning pathway has to be linked to all policies and interventions aiming to promote health and well-being and – more broadly – sustainable development.

There are many ways of creating a health learning pathway. But, in general, the pathway is best organized based on the ages of life (perinatal and infancy, childhood, adolescence, youth, adulthood, old age).

Figure 4: Structuring a health learning pathway



For each of the ages of life (perinatal and infancy, childhood and adolescence, adulthood, old age), the pathway is made of four sections. The first one describes its objectives and priorities, the three other sections describe the initiatives enacted in the formal, informal and non-formal educational settings, respectively. These three sections are systematically organized according to health determinants.

Source: Author's own elaboration

Building a health learning pathway – Clermont-Ferrand (France)

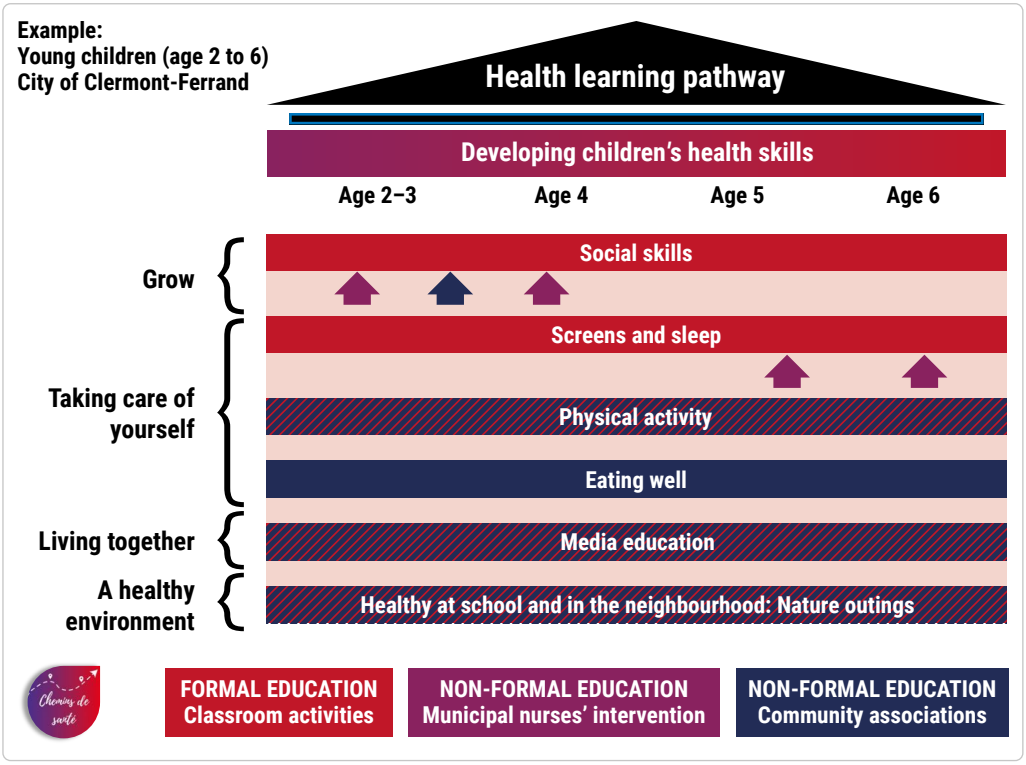
Developing a health learning pathway in Clermont-Ferrand was the result of a political choice, a decision by the mayor and the municipal team as part of its educational policy to create a learning city.

The process is being led by the municipality in partnership with the University of Clermont Auvergne. It began in a priority neighbourhood and focuses on children and young people aged 0 to 25, and will subsequently cover the entire population, from young adults to senior citizens. Everything began with talking to local residents, associations, social centres, schools, day care centres, sports clubs and health professionals. An exhaustive inventory of formal, non-formal and informal educational initiatives related to health competencies was drawn up with the people involved. A summary was produced and shared with the stakeholders.

A process for building the health learning pathway was launched by a working group involving the key partners. They have gradually built a pathway based on the city's public health and education priorities. For example, work on sleep and screen time at school is coordinated with the work of municipal nurses and local parenting support schemes. Specific support was offered to schools, sports clubs, after-school programmes and teams of social workers to help them organize activities in a coherent way and enrich them with relevant educational materials, such as children's books, a resource shared by families, health services, leisure centres and schools alike.

The work in Clermont-Ferrand involved all the stakeholders, and has led to the creation of a comprehensive pathway – a greenway that winds through priority neighbourhoods. Using appropriate communication tools, such as flyers and posters in schools or associations, this pathway has now been translated into language and media suitable for families, particularly those most vulnerable, and will soon be accompanied by a digital application.

Figure 5: Example of a health learning pathway for children aged 2 to 6 in Clermont-Ferrand



Source: City of Clermont-Ferrand

THE DIFFERENT WAYS OF LEARNING ABOUT HEALTH

The rapid evolution of ways people access information has changed the balance between formal, non-formal and informal education. Health information is directly accessible via smartphones, tablets and computers, which represents considerable progress in terms of information democracy, but also exposes people to fake news and creates new challenges with regard to data privacy and security.

It is evident now that a person's education in the field of health is not limited to formal education in the school context. This is one component of a much broader educational dynamic that develops throughout life.

Non-formal education is organized according to identifiable pedagogical objectives for a normally voluntary audience. It may include programmes for adult literacy, education of out-of-school children, social skills, health or environmental education, development of vocational skills and general culture. This educational process is experience and action based, starting from the needs of the participants. Non-formal education or training is mostly provided by municipalities (libraries, museums, after-school programmes), associations, non-governmental organizations or faith-based groups.

Informal education is a diffuse form of education in which each individual acquires attitudes, values, skills and knowledge from everyday experience and at random from the educational influences and resources of his or her environment. Informal education takes place in the family, but it also refers to the systematic and cumulative aspects of learning related to everyday experience (work, leisure, travel, media, social networks, medical interactions with the health care system). This learning is not subject to strict programming and takes place outside organized institutions and structures (Jourdan, 2021a).

This paradigm shift towards lifelong learning led to the emergence of the concept of the '**learning society**' which considers learning as a continuum that takes place well beyond the early stages of school, secondary, and postsecondary education, and in formal and informal settings outside institutions. A learning society exists within the overall context of political systems (formal educational institutions, informal and community training infrastructure); health care systems (social determinants of health); governance systems (gender equality, ethnic equality, Indigenous knowledge); digital systems (online and blended learning, social media, job placement platforms, digital media making digital learning more democratic with inclusive opportunities); and environmental sustainability (education for sustainable development and climate change, food security and well-being) (Ra, Jagannathan and Maclean, 2021).

Developing youth-friendly health services – Chisinau (Republic of Moldova)

Since 2002, the Chisinau municipality has had a successful partnership with the Health for Youth Association in establishing and supporting sustainable development of youth-friendly services and different programmes promoting adolescents' health and development. This cooperation is reflected in a set of memoranda of understanding (MoUs) and common action plans between the Health for Youth Association and the Chisinau municipality.

Its innovative approach lies in having integrated, all in one place, age-appropriate consultative multidisciplinary health services, psychological and social services that include informational activities and educational programmes for adolescents and youth, their parents and caregivers, and specialists involved in promoting adolescent health and care (family doctors, school nurses, schoolteachers, youth specialists, police).

Following Chisinau's pioneering example, many youth-friendly health centres (YFHCs) have been established throughout the country since 2005, with the support of the Ministry of Health, local authorities and international partners. Since 2008, the basic activities of these centres have been financed by the state through the National Health Insurance Company. Many innovative health promotion activities implemented by these centres continue to be developed, including:

- Capacity-building programmes for specialists, for example developing capacities of YFHCs/YK staff for promoting adolescent health, and the creation of a guide to promote adolescent health for community resource persons (school nurses, schoolteachers, youth specialists, police).
- Training sessions for school staff, periodical multi-disciplinary conferences on promoting adolescent health at the local and national level.

- Implementation of different parental programmes (e.g. 'Clubs for parents of adolescents', the Parenting for Lifelong Health programme adapted to the local context and, in 2020, an online pass for educational and group counselling sessions.
- Non-formal educational programmes and activities for adolescents and youth.
- Advocacy and community mobilization groups.

THE CITY'S KEY PLAYERS IN LEARNING FOR HEALTH

During the COVID-19 pandemic, the three forms of education were mobilized. Although, in many countries, municipal governments have little or no jurisdiction over the formal schooling system, they are usually responsible for a number of non-formal learning spaces, such as community learning centres, libraries and museums, and often support various community learning initiatives, such as learning neighbourhoods, study circles or family learning. Furthermore, cities can cooperate with partners from a variety of sectors to design, develop and implement non-formal and informal learning programmes. In many cases, cities also support their schools through intersectoral programmes and capacity-building initiatives. Cities can thus support and potentialize the activity of the formal education sector (UIL, 2020b).

It is necessary to take a broad view of the type of initiatives that should be included, as they concern formal, informal and non-formal education. The key players whose efforts may need to be coordinated in a lifelong learning for health policy can be divided into four groups:

- Community players who are closest to the people, such as community members, community service providers, including nurses and other community health professionals, community-based organizations (associations, sports clubs), and faith-based groups.
- Professionals of the formal education sector working in primary and secondary schools, vocational schools, universities, adult education, and special education institutions.

- City and government service providers from a variety of sectors (e.g. health, welfare, transport, police, arts and culture, public housing authority), local media, regional or national non-governmental organizations.
- Decision-makers, including local government authorities provincial/state government authorities, and relevant national government authorities.

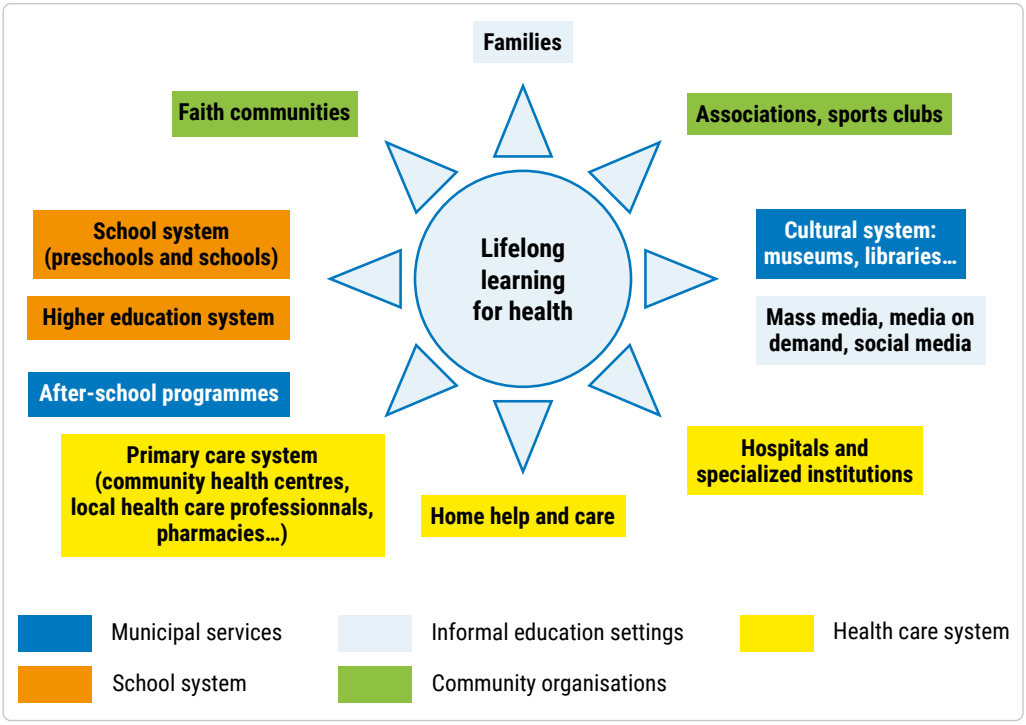
The learning initiatives could be focused on a variety of themes related to the physical, mental and social dimensions of health. These might include promotion of physical activity and healthy eating, mental health, vaccination, or road safety education. The COVID-19 crisis has shed light on mental health issues, such as loneliness, stress, fear and anxiety, associated with the pandemic. Social confinements and social-distancing measures have also had a severe impact on people's well-being (WHO, 2020c).

Once the contributions of the different actors have been identified, it is possible to know whether it will be necessary for the municipality to support these initiatives. If so, the appropriate support needs to be defined.

Learning programmes for health – Mexico City (Mexico)

Mexico City is a member of the UNESCO Global Network of Learning Cities. It is committed to expanding learning opportunities for all its citizens. In partnership with non-governmental organizations and the private sector, it is developing various innovative non-formal and informal education initiatives to address the complex challenges facing this megacity, which range from obesity, illiteracy and social inequality to natural disasters. A large number of partnerships with governmental or non-governmental organizations and corporations have been formed to implement initiatives, such as basic literacy programmes and SaludArte, which aim to improve the health, nutrition, personal hygiene, well-being and civic awareness of public primary school children in some of the most disadvantaged areas of Mexico City.

Figure 6: Key players in lifelong learning for health



Source: Author's own elaboration

> ***All organizations and citizens are stakeholders in a learning city. A structure that involves all stakeholders in building the learning city through dialogue and consensus should therefore be created.***
>
> — *Guidelines for Building Learning Cities, UIL*

THE CONTRIBUTION OF MUNICIPALITIES TO LIFELONG LEARNING FOR HEALTH

Highlighting the diversity of spaces in which people learn for their health shows how cities themselves could be key players. They are already well placed to help tackle the inequalities linked to poverty, gender, origin or

migration by influencing many of the social, educational and economic determinants of health. That's why identifying – and then filling – the gaps in existing education resources and planning initiatives could lead cities to play a crucial role in lifelong learning for health. The health learning pathway can help build coherence among all the different initiatives and make visible the resources that people can access.

Figure 7 provides examples of possible city interventions to support lifelong learning for health and strengthen the health learning pathway.

Figure 7: The contribution of cities to lifelong learning for health

Settings	Potential role of the municipality
Formal Primary, secondary and tertiary education settings	• Supporting health education initiatives
Non-Formal After-school programmes, cultural system (museums, libraries), primary care system, home help and care, hospitals and medical specialized institution (ETP), associations, faith communities, sports clubs, companies, public services, unions…	• Mobilization of stakeholders, creating platforms for collaborations • Strengthening after-school learning programmes • Organizing libraries, museums and other cultural initiatives to support learning • Contribution to education capacity building of community health services • Supporting lifelong learning initiatives • …
Informal Print media (municipal media, posters, flyers…), broadcasting (radio and television), exhibitions, websites, social media, informal learning within education, health and social interventions (families, health services, associations, faith communities, sports clubs, museums, libraries, homeless shelters, companies, public services, unions…)	• Mobilization of stakeholders, creating platforms for collaborations • Supporting family learning • Supporting digital learning for health, posting in streets and waiting rooms… • Supporting lifelong learning initiatives • …

Source: Author's own elaboration

A comprehensive policy for health – Montpellier (France)

The city of Montpellier has committed to promoting better health and access to care for all, particularly for the most vulnerable populations. Priorities include fighting against inequalities in access to health care and bringing preventive health care to schools during extracurricular hours and activities.

Montpellier is thus implementing a series of initiatives to promote health and health education for all its citizens. These include interventions in schools. For example, 'J'agis pour ma santé!' ('I'm taking action for my health') uses games and various activities to promote physical activity, nutrition and oral hygiene. This is an initiative of the City and Metropolis of Greater Montpellier that brings together many partners, including the Caisse primaire d'assurance maladie (CPAM) of the Hérault region, the Epidaure-cancer prevention centre, the Faculty of Ontology, Pierre Fabre Oral Care and the French Union for Oral Health of Hérault.

Another initiative is 'My new canteen'. As part of its Sustainable Food Awareness Programme and its food policy, Montpellier, in conjunction with the Association Terres Nourricières, has created workshops to raise awareness of sustainable food production and has distributed educational materials among students in the city's schools. This came about following a study that brought together professionals and civil society through a Monitoring Committee for School Catering. By 2025, more places will participate and additional activities will be created, along with a solidarity grocery store and an educational space focusing on the kitchen, as well as an itinerant educational bus, allowing decentralized training in agroecology and food. All this is in line with the municipality's efforts to create a 'food city'.

Montpellier's comprehensive policy for health also includes helping its citizens to deal with cardiac arrest. In partnership with the TOM Association, the city has mounted a mass programme to train the general public, free of charge, in cardiac massage. And when COVID-19 erupted, it became clear that the city had to respond

quickly to the emergency by developing effective initiatives to accelerate vaccination and protect the public. For example, a mobile 'vaccibus' was launched in order to reach the most vulnerable.

With its Capital Santé approach, Montpellier is striving to unite local actors to design the health care of the future.

The fact that cities play a pivotal role in lifelong learning for health does not mean that they can do everything. While it is true that what shapes learning for people's health includes some important policies and interventions driven by cities, there are others where they are only partners or collaborators, essentially supporting or hosting the initiatives. Depending on their mandate, policy direction and capacity (human resources, funding), cities can play several different roles.

Cities can be leaders in lifelong learning for health when they organize libraries, museums and other cultural initiatives to support learning for health, create after-school educational programmes, act as a platform for collaboration between public and private stakeholders, and integrate learning for health in their communication strategies, especially when they take innovative initiatives using information and communication technologies (applications, microlearning strategies).

Cities can also be partners in learning for health when they support social and health services, education institutions, associations and sports clubs in shared learning for health initiatives. And they can be collaborators in learning for health when they support – financially or in kind – learning for health initiatives offered by civil society or health and education institutions.

Moreover, cities can act as hosts for learning for health initiatives when they welcome programmes and interventions implemented by the national government or NGOs on their territory without being involved in the management of the programme. Nevertheless, cities facilitate the implementation of such initiatives through logistical and administrative support, such as providing office space or other premises, and authorizing the initiatives.

Health-promoting schools as a municipal initiative – Gualeguaychu (Argentina)

In Gualeguaychu (Province of Entre Rios, Argentina), the municipality has taken the initiative to develop a health-promoting schools dynamic and strategy together with the educational community. The agenda integrates the work of schools, health centres and the community for a shared objective.

In order to avoid competition with school planning, the health promotion activities are an integral part of it, thus improving the quality of the teaching-learning process and helping to improve direct and indirect educational variables, such as class attendance, family participation, the performance and motivation of boys and girls, or the commitment of the teaching team, as well as activities open to the community.

Education institutions that join this municipal initiative and aim to be a health-promoting school are encouraged to participate in the following proposals and activities:

- Healthy squares and schools.
- My active school: a call for active recreation experiences and projects.
- Healthy kiosks: sensitization, support for the installation of healthy snack kiosks in schools.
- Comprehensive sexuality education (CSE): accompaniment, workshops and proposals for the implementation of the CSE programme.
- Oral hygiene and healthy eating: interacting and coordinating with municipal health centres and their professional teams.
- Vaccination and vaccination cards.
- Smoke-free schools: contests, calls, workshops, and certification of tobacco-free schools.
- Health check: the municipality facilitates and carries out the school health programme.
- School and community: creating community participation tools.

- Annual meetings: meetings and social events to promote projects in schools and in the classroom.
- Training: organization of training open to everyone on different topics related to lifelong learning for health that are important and covered in the classroom.

KEY POINTS

Section B included a discussion of:

1. Things to know about lifelong learning for health.
2. The knowledge and skills that citizens need to acquire in order to be able to gain better control over their own health and that of the community.
3. A way to make a lifelong learning for health policy concrete through the creation of a health learning pathway for all.
4. Some ways that Chair of Global Health & Education organizations and local people can contribute to lifelong learning for health.
5. Ways that municipalities can help promote learning for health.

ESSENTIAL READING

UIL (UNESCO Institute for Lifelong Learning), 2022. *Making lifelong learning a reality: A handbook*. [online] Hamburg: UNESCO Institute for Lifelong Learning. Available at: <**https://unesdoc.unesco.org/ark:/48223/pf0000381857/PDF/381857eng.pdf.multi**> [Accessed 3 March 2023].

UNESCO, 2020. *How cities are utilizing the power of non-formal and informal learning to respond to the COVID-19 crisis*. Available at: <**https://unesdoc.unesco.org/ark:/48223/pf0000374148**> [Accessed 20 July 2021].

Section C

Implementing a lifelong learning
for health policy

Guiding questions

1. The key action principles needed to implement a policy to promote lifelong learning for health.
2. Raising awareness of lifelong learning for health.
3. Formulating a policy for developing a healthy and resilient city.
4. Putting a learning for health policy into action.
5. Evaluating the learning for health policy.

IMPLEMENTING A LIFELONG LEARNING FOR HEALTH POLICY: KEY ACTION PRINCIPLES AND APPROACHES

The UNESCO Institute for Lifelong Learning (UIL) has produced several procedural guidelines for developing a learning city, by using examples drawn from different parts of the world (UIL, 2015). Creating and implementing a lifelong learning for health policy is part of the same overall approach. Of course, there is no single model applicable to all cases. The resources available to cities are extremely diverse. Being in a conflict zone (war or civil war) also influences the capacity of cities to act. Health issues also differ considerably. For example, intestinal worms are a major cause of school absenteeism in some countries and addressing this problem in order to maintain learning is a public health priority, while in other countries the issue is a minor problem. Cities also differ considerably in terms of their autonomy in matters of education and health, depending on the political context and degree of decentralization at the national level. Many cities must depend on national or regional initiatives, United Nations programmes or NGOs, and have very few resources for carrying out such projects on their own. While it is possible to implement health promotion programmes in specific contexts with limited resources – such as preventive action in refugee camps – instituting policies for lifelong learning requires a different approach and cannot be built on the same basic model.

There are public and/or private initiatives in education everywhere, whether formal, non-formal or informal. The challenge in developing a policy to promote lifelong learning for health is to make the most of existing institutions and programmes by identifying them, enhancing

them, making them visible, aligning them within a coherent policy and enriching them through training and targeted funding. This process might be summarized by the following action verbs: **valuing**, **sharing**, **aligning**, **improving**.

These action principles could be applicable to various contexts and usable as a common framework. However, when developing lifelong learning for health policies, this common framework should be applied flexibly and in light of local political, economic and social considerations. Projects need to take into account local circumstances, and so the nature and sequencing of activities will differ from setting to setting.

THE IMPORTANCE OF PARTICIPATION

This approach can only work if everyone genuinely participates. In fact, when cities set up learning for health schemes, there is a risk that these will only be aimed at the most easily accessible populations. The most vulnerable and least socially integrated people are more difficult to reach. Ethnicity, migration, gender, cultural differences, religion, language, age and disability are sources of exclusion. For example, migrants generally score lower on literacy and health literacy measures, and also have poorer access to – and use less – information about health, disease prevention and care services (Kickbusch et al., 2013). Their social situation, the cultural differences and linguistic barriers make the implementation of learning for health strategies more difficult to achieve. Similarly, illiterate, low-literate and low-skilled youth and adults, who constitute significant portions of the population in many developing economies, are especially in need of accessible, relevant and targeted information about learning for health schemes.

Participation of citizens is a key condition for the success of any lifelong learning for health policy. If participation processes are inclusive – meaning that the whole population has or can acquire the skills to participate – social participation can be understood as a key driver of health equity. To ensure such participation, spaces and opportunities need to be provided for reflection and discussion on the nature of

problems, as well as for decision-making with organized interaction among citizens, civil society groups, governments and other actors to establish action plans that involve all stakeholders and encourage them to take part in evaluation.

Citizenship for health – Valencia (Spain)

'MIH Salud: Women, children and men working for better health' is a programme developed in different areas of Valencia since 2007. It seeks to reach all neighbourhoods, but especially the most disadvantaged ones. MIH Salud trains lay people as peer supporters and works collaboratively with local community non-profit organizations and primary health care centres. The objective is to promote health, intercultural relations and coexistence by mobilizing community assets in health throughout the city.

Special attention is given to sexual and reproductive health and the health of women and children, prioritizing the most vulnerable populations in Valencia. MIH Salud is run by the city's Public Health Centre.

IMPLEMENTING A LIFELONG LEARNING FOR HEALTH POLICY: A THREE-STEP PROCESS

The following section describes the main steps in the development of a lifelong learning for health policy, whether it is a component of a learning city or healthy city policy or an independent project. The process is divided into three phases:

Phase 1: Raising awareness of lifelong learning for health and preparing the project. This starts with awareness-raising and establishment of an intersectoral initial task force for a lifelong learning for health policy and ends with gaining strong commitment and support of the local government.

Phase 2: Developing a policy for a healthy and resilient city. This aims to develop an organizational structure, working mechanisms, an action plan, and capacity for carrying out the project.

Phase 3: Putting the learning for health policy into action. This concerns the implementation of the established action plan, and aims to continue to ensure the visibility of the policy and to develop sustainable mechanisms to support learning for health in the city.

This section partly follows the approach developed by WHO's Regional Office for the Western Pacific (WHO ROWP, 2000).

Figure 8: Three-step process for developing a policy for lifelong learning for health

Source: Author's own elaboration

PHASE 1: RAISING AWARENESS AND PREPARING THE PROJECT FOR LIFELONG LEARNING FOR HEALTH

- Raising awareness of the of the role of cities in lifelong learning for health.
- Establishing an intersectoral task force to oversee the lifelong learning for health strategy.
- Building support mechanisms.
- Gaining strong commitment of the local government and key stakeholders.

Raising awareness of the role of cities in lifelong learning for health

Not all cities will want to commit to promoting a policy for lifelong learning for health. Indeed, there is no consensus on the role of cities in supporting health and many cities often have no legal competence in the field. But raising awareness of the concept of lifelong learning for health is an important first step in developing intersectoral collaboration and integrated planning, regardless of whether it is a component of a learning city or healthy city policy or an independent project.

What are the arguments that can help to raise awareness of the potential role of cities in promoting lifelong learning for health?

- An ambition to empower people and populations.

As stated in Article 13 of the Yeonsu Declaration, the aim is to strengthen citizenship for health in recognition of the wider societal impact of health issues and the common good of global health, giving learners more agency to act with ethical and social responsibility when it comes to their own health and the health of their communities. The ultimate aim of lifelong learning for health is to enable people to increase control over their health and its determinants, and thereby improve their health (WHO, 1986).

- Differences in the autonomy of cities regarding health and education policies.

Local authorities' ability to act depends on political circumstances – for example, the level of decentralization coupled with the extent to which the national government supports the activities of local governments (Clark, Coll-Seck and Banerjee, 2020). When cities have a wide field of responsibilities (environment, education, health, social interventions) they lead initiatives related to learning for health. When the power is in the hands of the state, as in centralized countries, it is more difficult for cities to take initiatives in learning for health. In fact, depending on the social and political context, cities can contribute to the health of their residents in different ways. In interaction with public (especially the governments/states) and private actors, cities play a pivotal role

in learning for health. This is not to say that they do everything, but much of what shapes learning about health includes policies and interventions being driven by cities, or in which they are partners or collaborators, and others in which they host the initiatives.

- City resources and priorities.

The range of human and non-human resources available to cities is a major issue. In many cities, the needs and problems of neighbourhoods are enormous. Problems include meeting basic needs – such as lack of access to drinking water and sanitation, poor-quality housing with overcrowding, scarcity of formal job offers, lack of adequate public transport and poor access to social protection. These are often combined with low access to diagnostic tests, hospital services and technologies, as well as fragile health systems and epidemiological surveillance networks, low resilience and a lack of studies about health systems preparedness to face crises like the COVID-19 pandemic. This analysis is common to many cities in the Global South, even where there is a political framework already in place to create the right conditions for lifelong learning for health and for developing health policies at the city level. The learning for health policy must be adapted to the city's means. There is no kit to be implemented, but rather an approach that mobilizes the different sectors. For example, health knowledge and skills are necessary for the educational success of pupils, so it is possible to orient the organization of schools and pedagogy to improve these skills. The same applies to sports clubs, where the issue of health can play a significant role. Concerning home help and care, it is the daily activity of professionals with the elderly or disabled that is the main driver of lifelong learning for health. Cities may prefer, however, to engage in a 'host' situation for initiatives led by the state or national or international NGOs.

- From state of emergency to ordinary regime.

The COVID-19 crisis has led many cities around the world to adopt initiatives that educate the population more broadly about health. While the question of the long-term sustainability of this commitment

by cities to learning for health is still unanswered, it is clear that two distinct modes of action have emerged from the public health responses to the COVID-19 crisis. In the event of a health crisis, the first response tends to be activating a state of emergency, usually resulting in disruption in social organization and limiting the freedom of individuals. The second 'ordinary' response is based on interventions on the multiple environmental, social and individual factors that influence health. The aim here is to create the conditions for health for all, with reference to a wide variety of cultures, contexts and individual and collective relationships to health. Since most of these health determinants fall within fields other than the health care system, promoting health and reducing inequalities requires the implementation of coherent intersectoral approaches at the local level.

We can see that cities are key actors in times of crisis as well as in ordinary times. The specificity of educational time (a long-term perspective), which is measured in years and thus differs greatly from political time and even more so from media time (more often focused on short-term dynamics), is to impose a strategic vision. It is the commitment of all the actors in the life of the city in the long term that allows cities to be resilient. It is therefore necessary to think about learning for health as an integral part of ordinary times as well as integral to crisis regimes. In the aftermath of the pandemic, some cities have put measures in place that will be sustained for the long term.

Use of communication tools like local media, social networks, websites, meetings, educational workshops, and webinars led by UIL (**https://uil.unesco.org/**) can provide people in cities with a chance to explore the lifelong learning for health concept, and then consider its applicability to their context (formal, informal, and non-formal education settings).

Establishing an intersectoral task force to oversee the lifelong learning for health strategy

Once awareness of the lifelong learning for health concept has been raised and a degree of local political support gained, the next step is to find a group of people sufficiently interested in, and willing to spend time on, developing a local lifelong learning for health policy. A local intersectoral task force should be set up with people from this group (citizens, policymakers, social workers, educators, health professionals, urban planners). This task force could be made up of people already involved in the learning city or healthy city policy where one exists, or it could be an independent entity.

Its tasks are to gather information about the city, make a preliminary analysis of the local situation, establish contact with key individuals working on health and urban development, convince potential supporters to come on board, and prepare a plan for the full development of the lifelong learning for health policy.

Capacity-building is important for developing and implementing effective policy actions for lifelong learning for health. This can be achieved through the use of local, national, and international expertise. Technical support could be provided by UIL, UNESCO chairs and universities actively involved in urban health and/or education issues.

> ***Genuine partnerships between academics, policymakers and practitioners are a key feature of healthy and sustainable learning cities.***
>
> — *Billie Giles-Corti, Vice Chancellor, Professorial Fellow and Director, Healthy Liveable Cities Lab, Centre for Urban Research, RMIT University, Melbourne, Australia*

Cross-sectoral collaboration – Cork (Ireland)

The learning city of Cork has developed a range of cross-sectoral initiatives that bring together public agencies that deliver learning and health services with community and voluntary organizations as partners to tackle issues that are identified as social determinants of health.

For example, the Cork Learning City Steering Group includes the Health Service Executive Cork Kerry, as it was set up as a multi-sectoral, inter-agency partnership, with four lead partners and two strategic partners and a stakeholder group. All have signed a memorandum of understanding committing their organizations to work together, taking an integrated 'EccoWell' approach to learning city development, and to jointly host conferences and webinars, including the third UNESCO ICLC 2017 and the GNLC webinar 'Learning for Well-Being, supporting resilience in Learning Cities 2020' (**https://www.corklearningcity.ie/unesco-learning-for-health-and-well-being/**).

Another initiative is 'Learning Neighbourhoods', which promotes well-being at community level through courses and other learning activities that engage hard-to. An example is the 'Lantern Community Development Project', which was shared during the UNESCO Global Network of Learning Cities Cluster Webinar 2020.

The Health Action Zones initiative should also be mentioned. Located in the most disadvantaged communities of Cork, it aims to engage residents in health-promoting actions through a range of lifelong learning approaches.

Moreover, there is the Cork City Community Response Forum, which is an inter-agency city-wide support structure that brings together the health service with the learning city of Cork and a wide range of other partners. It coordinates responses to the needs of the most vulnerable people, linked through 16 grassroots teams in defined areas of the city, and mapped for visibility and accessibility by the public.

The 'Cork Age-Friendly City' designation, awarded by WHO in 2019, resulted from collaboration among inter-agency partners and community organizations, with older people as elected representatives on decision-making bodies, and including lifelong learning, health and well-being as part of its strategy.

Building support mechanisms

Gaining access to, and establishing good communication with, the executive decision-making body of a city is crucial, as these decision-makers can provide resources and legitimacy to the lifelong learning for health project. Their support is important for achieving integrated planning and action in various settings. Decision-makers in local government play the most crucial role in developing and implementing a lifelong learning for health policy. National and/or provincial/state support in terms of technical expertise available at those levels is also important. UIL, UNESCO chairs and universities could also provide required technical support.

Gaining strong commitment from the local government and key stakeholders

Political support for developing a lifelong learning for health policy is vital. Mayors and other local councillors and politicians need to be convinced of the value of a such a policy for their city. Gaining a strong commitment from the local government to the project is an important step towards incorporating the health agenda into citywide strategies. It facilitates the integration of all concerned departments, attracts various agencies, and involves many supporters.

PHASE 2: DEVELOPING A POLICY FOR A HEALTHY AND RESILIENT CITY

- Carrying out an inventory of existing contributions to lifelong learning for health in the city.
- Developing an action plan for a comprehensive health learning pathway for all.
- Integrating action plan activities at formal, non-formal and informal settings to gain wider impact.

First, understand the situation

Various concerned groups from different sectors, including the community, should be involved in this step as it will ensure their views on health and related matters will be heard. Their involvement will also help to identify gaps and available resources.

Different activities are carried out in this step. Examples include compiling existing information, establishing a vision of the city, doing a field survey of specific health and environmental issues, analysing health determinants, assessing needs, developing actions and activities, identifying and allocating available resources, monitoring, evaluating, reporting, and preparing an initial health learning pathway with the existing initiatives.

Identifying pre-existing conditions – Leeds (UK)

Community builders employed by the city of Leeds work with neighbourhoods to uncover and develop pre-existing assets, strengths and connections between people. Their aim is to help neighbourhoods to thrive by bringing people together and improving their health and well-being. They use Asset Based Community Development (ABCD), a community-building approach that Leeds City Council has developed into

a pioneering programme in the city.[5] ABCD is a strategy for sustainable community-driven development. Beyond the mobilization of a particular community, ABCD is concerned with how to link micro-assets to the macro-environment. The appeal of ABCD lies in the premise that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognized assets, thereby responding to and creating local economic opportunity.

One way of better understanding the health situation of a city is to produce a city profile. If the city's health profile has not been created elsewhere, it could be organized through the framework developed by WHO's Western Pacific Regional Office (WPRO) (see *Table 3*).

A city health profile gives a comprehensive view and some background information on the health and environmental situations of the city. In addition to the current status, trends from the past as well as future projections can be included. The process of developing a city health profile requires the involvement of multiple sectors, in order to facilitate further intersectoral collaboration in the planning and implementation of the project activities.

The following framework has been developed by WHO/WPRO for healthy cities, and can be useful in taking stock of a city's health situation and identifying priorities for the health learning pathway (WHO ROWP, 2000).

[5] The evaluation of Leeds ABCD is available at: **https://eprints.leedsbeckett.ac.uk/id/eprint/7640/1/AssetBasedCommunityDevelopmentEvaluationOfLeedsABCDPV-SOUTH.pdf**

Table 3: Contents of a city health profile

Topic	Items
Demography and epidemiology	Total population Age and sex breakdown Ethnic distribution Birth rate Fertility rate Death rate Morbidity rate Communicable diseases Non-communicable diseases Injuries/accidents Crime Disabilities Suicide rates/occupational injury Perceptions of health and well-being Individual risk factors Immunization rate Nutrition Alcohol and drugs Smoking Exercise Screening rates (cancer and other diseases) Domestic violence
City background	History Culture Climate Topography

Topic	Items
Physical environment	Environmental quality Air Water Noise Soil Scenery Percentage green space/parks
Living environment	Access to safe drinking water Adequacy of housing Amount of living space Rates of homelessness Food hygiene Insect and rodent control Sewage treatment Waste treatment Coverage of solid waste collection Recycling
Urban infrastructure	Description of urban planning/zoning system Main mode of transport Availability of public transport Availability of communication and information technology Use of public media
Legislation and regulations	Disease prevention and control Hospitals, schools, workplaces, markets Food hygiene, building, housing Drinking water, waste management Air, water, noise, soil

Topic	Items
Organizations and services	Description of administrative structure of departments, districts and communities, and local government Description and assessment of the effectiveness of existing intersectoral coordinating mechanisms. Description of availability of: • hospitals • community health facilities (maternal/child, disability, aged care) • schools • community centres • sporting facilities Environmental health services: • food inspection • standard of monitoring/enforcement
Economy	Assessment of impacts of economy on health: • main industries/business • health of economy • level of development
Social environment	Sources of social stress Description of social support mechanisms/networks: • family/household • community • cultural • gender relations
Education	Formal, non-formal and informal education: • inclusiveness • equity

Source: Author's own elaboration

The development of a policy promoting lifelong learning for health – Indore (India)

Indore, in the state of Madhya Pradesh, India, is a city that has undergone a process of transformation into a 'healthy city'. It has a population of about three million. This process was funded by USAID's Building Healthy Cities project and implemented by Indore Smart City Development Ltd and by the John Snow India Research and Training Institute.

First, a 'needs assessment' was conducted which provided a multisectoral overview of the critical issues and applied a design thinking approach. It identified key leverage points for improving health and refocused city policies and services using a health equity lens. It has conducted initiatives to plan, fund and improve health services, air quality, health education in schools, transportation, city sanitation, road safety and food safety.

The Healthy City project started in 2017 and a project report was published in 2022. Indore is recognized as the cleanest city in India.

Carrying out an inventory of existing contributions to lifelong learning for health in the city

Identifying existing activities is the starting point for developing a policy promoting lifelong learning for health. Efforts to improve urban health and education will be more effective if such integration is achieved, because it will involve the people in charge of the various initiatives, avoid duplication and increase cooperation and coordination at the city level. Integration will lead to cost-effective solutions, synergy between activities, and substantial benefits in terms of resource sharing. It is necessary to take a broad view of the type of initiatives that have to be included, as they include formal, informal and non-formal education.

Management of the population's health determinants is more effective if the various efforts are integrated, developmental work is carried out in the most efficient order, and diverse strategies are coordinated (formal, informal and non-formal interventions). Intensive efforts should be made to incorporate existing community activities/projects which fit into the lifelong learning for health policy. The planning process provides a good opportunity to develop and share the vision of the city and to involve people in the local community in a co-design activity as well as to disseminate the lifelong learning for health vision.

This stage consists of taking stock of the various public or private, institutional or non-formal contributions to lifelong learning for health. It is then possible to draw up the initial version of the health learning pathway that gives a comprehensive view and some background information on the actors, the contexts and the nature of the education initiatives carried out in the city. In addition to the current status, past trends as well as future projections can be included.

The process of developing an initial version of the health learning pathway requires the involvement of multiple sectors in order to facilitate further intersectoral collaboration in the planning and implementation of the project activities. Direct community participation enhances the quality of the initial version of the health learning pathway. Information gathered by and with people in the community reveals different aspects of the city and everyday life of the population. It also indicates how people in the field understand these initiatives. There are many activities that can help to involve the population beyond surveys and neighbourhood meetings, such as taking a tour of the city or co-designing a poster with young people.

The initial version of the health learning pathway should present reliable information in a user-friendly and publicly understandable manner. This is a tool to facilitate information-sharing among concerned people, including executive-level decision-makers and lay people.

The initial version of the health learning pathway should also supply baseline data of the city. Periodic revision of the pathway then enables

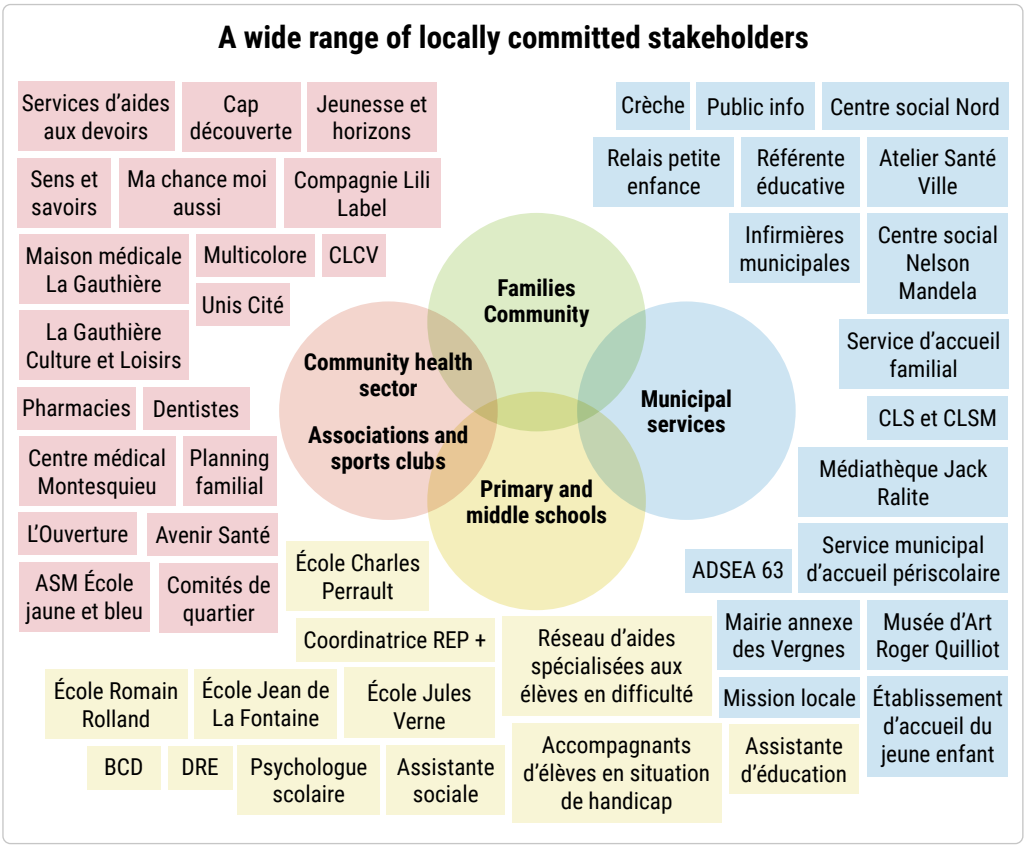
evidence-based evaluation of the lifelong learning for health project. Finally, the successive versions of the health learning pathway serve as an essential tool to support the planning cycle: plan, do, see.

Communication, negotiation and discussion during this process will raise awareness of the need to have a lifelong learning for health policy. Various types of information technology can be used to share information among the concerned groups, in particular in the local community. The local media are a useful resource in this regard.

An inventory of existing contributions to lifelong learning for health – Clermont-Ferrand (France)

In order to draw up the initial version of its health learning pathway, the city of Clermont-Ferrand made an inventory of the various public or private, institutional or non-formal contributions to lifelong learning for health in two disadvantaged neighbourhoods (La Gauthière and Les Vergnes) in 2022. These two neighbourhoods fall into the 'very precarious' category, characterized by indicators of precariousness (low income, unemployment, dependence on benefits) that are higher than in the city as a whole. However, there are many local associations, in particular the ASM sports club, which is the driving force behind many activities. The collaborative inventory led to the identification of nearly 50 organizations ranging from secondary schools to small local associations, including social centres, sports clubs and health clinics.

Figure 9: An inventory of existing contributions to lifelong learning in Clermont-Ferrand



Source: City of Clermont-Ferrand

Developing an action plan for a comprehensive health learning pathway for all

The process of building the options within the pathway takes time and planning. Only well-designed, feasible plans can lead to effective and sustainable development of the project, as well as to specific outcomes. An action plan is needed to describe strategies for the development and implementation of a lifelong learning for health policy, which then can lead to the definition of a health learning pathway. The aim is to bring together partnerships among the public, private and voluntary sectors, with a focus on the capacity-building of the population.

Planning is a cyclical process and requires feedback with regard to implementation of the action plan. The initial step is to understand the situation. This step includes information gathering, analysis and evaluation. The second step is to set a plan for the development and implementation of a lifelong learning for health policy in collaboration with various stakeholders. Then, the plan should be implemented to achieve its goals. After the implementation of the planned activities, there should be information gathering, analysis and evaluation. If need be, the project should be revised, and the revised action plan should be implemented in the next cycle.

Setting a plan

An action plan helps to identify priority health problems in the city and suggests lifelong learning actions/activities to resolve them. It is the responsibility of the local coordinating body to identify these problems and actions.

An action plan thus incorporates and coordinates a series of activities but does not develop disparate single-issue 'projects'. It also coordinates elemental lifelong learning for health activities within the city (schools, workplaces, markets, hospitals, communities, home help and care, media, social networks).

An action plan serves as a tool to stimulate partnerships between various groups, agencies and settings in the city by identifying joint activities. Roles of concerned groups should be identified in individual activities. This identification facilitates good collaboration among the groups in achieving the goals. Cross-sector collaboration can be further improved using municipal policies and city cohesiveness as platforms. The aim as always is to develop stronger links between institutions, associations and private-sector organizations and with a wide range of other stakeholders.

Action plans should include activities that facilitate community participation. Activities carried out in the community on the basis of a common perception of the priority health issues can make a lifelong learning for health policy sustainable.

An action plan is also used to better mobilize and allocate resources. Efforts to use existing resources efficiently and to expand available resources are effective if the action plan can demonstrate achievable, useful outcomes. Learning for health has to be integrated into all municipal policies, including implementing international and national programmes, action plans, commercial activities and digital strategies.

A well-conceived action plan should then make it possible to draft a coherent health learning pathway. This involves three main steps: 1. organizing the existing initiatives; 2. planning the implementation of additional learning interventions to fill the gaps (including the needed resources and capacity-building); and 3. developing a strategy for implementing the health learning pathway.

Another very important dimension of the action plan is capacity-building. This means supporting professionals, institutions, associations, and all parties interested in learning for health, developing easy access online resources and databases, and implementing and supporting contact points and working groups.

Participation is equally critical. The action plan has to make clear how the whole population (young and old, well and infirm, affluent and deprived, digitally connected and others) will be incited to genuinely participate in the definition and implementation of learning for health policies.

Without an understanding of the local situation, the organizers of a lifelong learning for health policy can attain only limited success. Because cities have diverse characteristics which often change rapidly, it is essential that diverse partners work together on the same platform. An action plan for developing a health learning pathway can thus serve as a common platform for all partners.

It is important to ensure that the introduction of the health learning pathway action plan complements and does not conflict with existing plans. By integrating or at least establishing linkages between the lifelong learning for health policy and other plans for the city (learning city, healthy city) greater consistency in decision-making is assured, along with mutual reinforcement and avoidance of duplication of efforts.

Similarly, consistency between the action plan and the citywide development plan should also be achieved. This consistency will strengthen the effective implementation of the lifelong learning for health policy. If the citywide development plan does not clearly address priority health learning issues, one of the important tasks of the lifelong learning for health policy will be to advocate and facilitate raising such health issues in the city-wide development plan.

A local development plan tends to focus on activities in the city and the community, rather than on regional and global concerns. There are some government policy-making functions and services controlled by national ministries. These functions and services remain beyond the responsibility of the city government but should nonetheless be taken into consideration in preparing the local development plan.

Strategic Plan and Vision for city activities up to 2030 – Cork (Ireland)

The Cork Learning City Steering Group has developed a long-term Strategic Plan and Vision for its activities up to 2030. In 2017, a plan was drawn up that incorporated two purposes: 1) to present a short- to medium-term action plan, and 2) to provide a discussion document as a basis for consultation for a long-term strategic plan.

The document, entitled '**Cork Learning City Past, Present and Exploring Our Future Strategic Plan Discussion Document 2017**', sets out the Cork Learning City Steering Group's views on the key elements of the development strategy and invites all stakeholders and interested parties to respond to these views. They are asked to identify issues they feel need to be addressed in the long-term plan and to identify how the city of Cork should be developed as a learning city. The elements identified in this document are drawn from two main sources: directly from the UIL publication, 'Guidelines for Building Learning Cities', and the City Local Economic and Community Plan 2016–2021, 'Pure Cork: An Action Plan for The City'.

Figure 10: Lifelong learning for health is part of the learning city plan of Cork

Source: City of Cork

In the process of delineating activities suitable for a policy devoted to lifelong learning for health, Cork looked to the experiences of other cities – both within the country and abroad, though the UNESCO GNLC – to provide practical examples of how to make the plan persuasive and feasible. At the same time, it developed the links with research bodies that would be needed later to implement interventions aiming to produce knowledge and support change towards health literacy and citizenship for health.

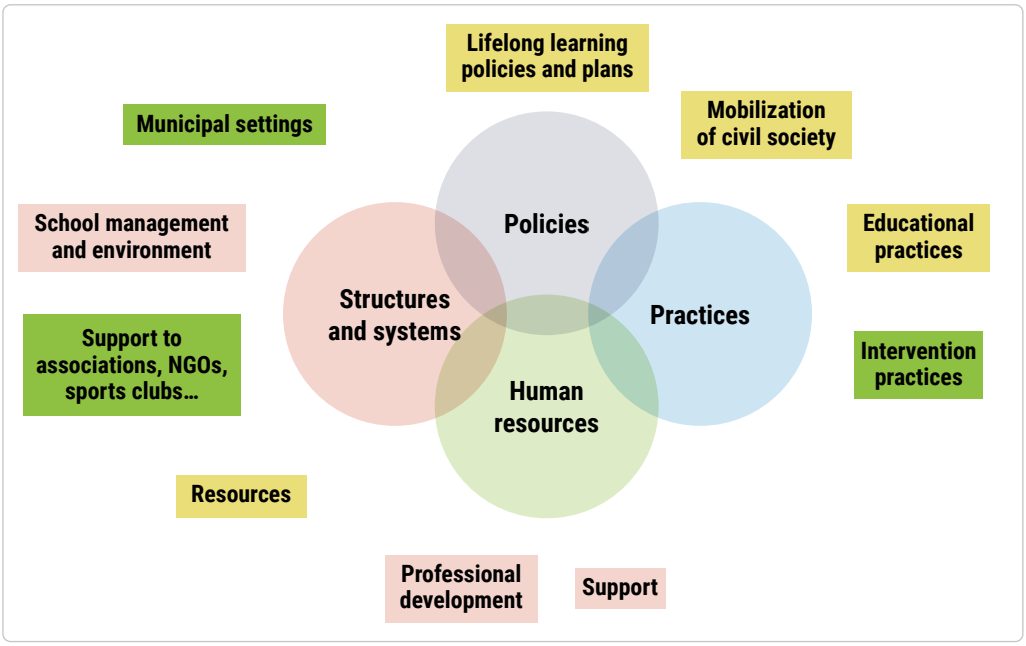
The multilevel dimension of health promotion – Porto Alegre (Brazil)

The Inter-institutional Research Group LEIA (Reading, Information and Accessibility) is made up of professors and researchers from the Federal University of Rio Grande do Sul (UFRGS) in Porto Alegre. This is a partnership with the ProLiSa network, characterized as an interdisciplinary and transdisciplinary research group. In the 12-year trajectory of Grupo LEIA's activities, themes such as information accessibility, communication, knowledge translation, reading, literacy, management, inclusion, biblio-diversity and health have been major targets. Among these, the CAPAGIIC Extension Project stands out as a training action aimed at workers of the Ministry of Health in Brazil and professionals linked to libraries that make up the BiblioSUS Network focusing on health literacy. The Network of Cooperating Health Information Units and Libraries (Rede BiblioSUS) aims to expand and democratize the access and use of health literacy in community service at the municipal, federal and state levels of the Unified Health System (SUS) in Brazil.

There are many ways to organize an action plan. A 'wish list' is not enough; to be effective, the enactment process has to be based on a change management strategy. We have to understand the modus operandi of the education system (Bryk, 2015) to be able to influence it. Four levers have to be activated: policies, structures and systems, human resources, and practices (UNESCO, 2017; SHE, 2018). Based on

the literature and our experience, we therefore propose to organize the action plan following these four components and 10 domains of action (see *Figure 11* and accompanying text).

Figure 11: Components of an action plan



Source: Author's own elaboration

More specifically, the following four main components and 10 domains of action make up an action plan.

Local lifelong learning policies

In this component, two elements must be integrated: the lifelong learning policies existing in the different sectors, as well as those dedicated to lifelong learning for health; and advocacy initiatives aimed at inducing citizens' participation and raising awareness of learning for health issues. To scale up health-promoting practices in schools, communication documents and resources targeting civil society are indispensable to influence people's views of education.

Structure and systems

The existence of supportive organizational structures is an essential condition for successful change (UNESCO, 2017). It is also vital to take into account the issues of steering, management and financing when formulating an action plan. Four elements must be integrated: management of municipal settings (libraries, museums, communication services, social institutions); support to schools' management and organization; support to associations, NGOs and sports clubs' management and organization; and resources.

However, since we are not starting from scratch, and because culture and contexts differ from one place to another, the key question is more about how to improve the quality and outcomes of the lifelong learning service provided to the population than how to implement a programme that is supposed to follow step by step the order dictated by these structures (Dadaczynski and Paulus, 2015).

Practices

Having political and institutional frameworks is necessary, but without capacity-building for professionals, progress will stall (WHO and UN Habitat, 2016). To ensure genuine sustainable buy-in of lifelong learning for health practices – i.e. having a significant influence on motivation and agency of professionals – it is critical to understand the views and practices of the professionals (Jourdan et al., 2013). Professional development (pre-service and in-service training, access to support services) can help those involved in lifelong learning initiatives acquire skills to incorporate health-promoting, equitable and inclusive practices. Professional development has to be part of a coherent strategy, as staff training is not just a matter of stacking modules. Concerning practices, two elements must be integrated: the educational practices of professionals supporting the population on a daily basis (teachers, librarians, nurses, general practitioners, social workers, police officers); and the practices of those who intervene on an ad hoc basis within the framework of initiatives dedicated to lifelong learning for health.

Human resources

Concerning human resources, two elements must be integrated: professional development training, which can also concern non-professionals, such as volunteers from associations; and support for professionals in their work.

To summarize, in addition to these four components, the action plan for lifelong learning for health should also comprise the following 10 domains:

- Characteristics of the city (topography and climate; history, culture, and heritage; administrative structure; demographics).
- Vision of the city.
- Health and education profile of the city (population health; lifestyles and preventive activities; health care services; welfare services; lifelong learning policy; environmental health services; living environment; environmental quality; urban infrastructure; natural environment; land use and urban planning; local economy; education; income and family living expenses; community activities; legislation and regulations).
- Priority health problems.
- Planning goals and targets of the lifelong learning for health policy.
- Strategies for action on policies, structures and systems, human resources, and practices (see *Figure 11*).
- Actions and activities to develop learning for resolving priority health problems (formal, non-formal and informal education).
- Roles of individual groups in implementing the above actions/activities.
- Resources required and available for implementing the actions/activities.
- Implementation and monitoring/evaluation mechanisms (coordination and communication mechanisms for implementation, indicators for monitoring and evaluation of progress, mechanisms for evaluation, and reporting systems).

Building children's capacity to manage their health – Braga (Portugal)

The Planning Health in School programme (PHS-pro) in Braga was created to help schoolchildren build their capacity to manage their own health. The municipality partnership is crucial in promoting PHS-pro in all city schools. The PHS-pro design is based on the transtheoretical model of change and on integrated learning modules to guide children towards healthy eating and active living. The specific research goals at the core of the PHS-pro include improving children's nutritional status, eating and physical activity habits and knowledge; promoting better eating behaviours in all learning modules; process evaluation from the participants' views; and assessing the economic costs of the programme's implementation.

Integrating action plan activities in formal, non-formal and informal settings to gain wider impact

Local government staff in relevant sections are encouraged by the lifelong learning for health taskforce to reorient their activities in accordance with the action plan. Partners outside local government are expected to collaborate with local government in implementing activities identified by the plan. And all potentially relevant groups are encouraged to participate in the process of developing and implementing the action plan.

The community should be closely involved in the implementation process. The experience of participating in local activities is a step towards participating in decision-making and also raises awareness.

The progress in implementing individual activities can be monitored by groups responsible for the activities. Are they fulfilling their responsibility, are they making progress, and are they encountering any unexpected difficulties, such as how to ensure a no-blame, open learning culture, if things are going wrong? Will people hide such problems so that their funding continues? In addition to

periodic meetings of the concerned groups, occasional meetings and information exchange, as and when necessary, are useful to facilitate collaboration.

The progress of the overall action plan needs to be monitored. Periodic reporting of individual activities is also useful to comprehend the overall progress and to identify areas requiring further coordination of activities.

Development of a lifelong learning for health policy – Rome (Italy)

In 2016, the metropolitan area of Rome (cf. Nicolucci et al., 2019) was the first Italian city to join the international project Cities Changing Diabetes (CCD), which aims to prevent diabetes in urban areas. This global initiative, launched in 2014 by the Steno Centre in Copenhagen and University College London (UCL), is coordinated in Italy by the Health City Institute.

The CCD team conducted a three-year mapping project to analyse various social and environmental aspects related to the different prevalence rates of diabetes in the different health districts of the Rome metropolitan area (Rome City Changing Diabetes Report, 2021).

One of the most interesting results stresses the correlation between the prevalence of diabetes and the level of formal education: districts with a higher prevalence of diabetes showed a lower school education ratio. Moreover, the use of inactive transport and the lack of physical activity in general also play an important role, likely connected to the increased risk of obesity: the use of motor vehicles is more frequent in those districts where the prevalence of diabetes is higher, while the proportion of citizens walking or cycling is lower.

The findings suggested the need to implement effective strategies to reach socially disadvantaged citizens by increasing their access to preventive activities. Together with the municipality,

the Health City Institute has therefore implemented a project for Rome, devoted particularly to the more disadvantaged areas of the city, aiming at strengthening social networks, promoting low-cost, high-impact public policies stimulating physical activity and increasing healthy lifestyles awareness, which both the Organisation for Economic Co-operation and Development (OECD) and the United Nations have marked as a priority.

The project is called 'Passport for Rome – A city for walking and running' and aims to make the city more walkable, runnable, cyclable and, in general, provide for more physical exercise and sports in green areas and public parks. Existing green areas and pathways have thus been expanded to 320 km in total, which has made Rome the largest walkable city in Europe. Thanks to participatory processes that were planned in collaboration with diabetes patients, associations, medical and care structures, the 'Passport for Rome' project is also raising awareness of the importance of addressing nutrition and health issues, promoting urban health at all institutional levels, and especially in schools and workplaces. The new paths created are explorable via an app and a platform.

PHASE 3: PUTTING THE LEARNING FOR HEALTH POLICY INTO ACTION

- Implementing the planned activities, taking into account the diversity of cultural and socio-economic contexts.
- Monitoring and evaluating implementation.
- Making the policy visible and ensuring its sustainability.

Implementing the planned activities, taking into account the diversity of cultural and socio-economic contexts

A range of educational activities at the city and local levels are implemented, some already existing, others new. Successful implementation depends on there being a coherent pathway that

leaves no one behind. Other factors of success include genuine respect for the social and cultural values of communities, and broad-based participation of various sectors and the community, including those at the intersections of health equity, health inequalities and learning for health. These all contribute to improving health equity and health for all.

An approach based on proportionate universalism can also be useful, especially for addressing hard-to-reach groups. It means that actions have to be of sufficient scale and intensity to be universal but also proportionately targeted to reduce the steepness of the inequality gradient (Marmot, 2010). This combines an intervention openly available to all people with specific targeting strategies for those most in need. During the COVID-19 crisis, as emergency education measures were devised for all citizens including the most vulnerable, governments found complementary channels and modalities to reach and 'educate' in a timely and effective manner (UNESCO, 2020).

Universal approaches that apply to the entire population and targeted approaches that apply to a priority sub-group may also be implemented, but should always be accompanied by constant monitoring of their impact on inequalities.

Inclusion of all individuals and populations, regardless of their culture and socio-economic conditions, is a major challenge. There are many levers that can be activated to improve the inclusiveness of policies. The use of appropriate language is one of them. Cities should adopt policies based on plain-language communication and education tools, but also other means of communication, such as images, photographs, graphic illustrations, apps, audio and video, providing signage and communication documents in minority languages, and creating transparent, consumer-friendly environments, and easy-to-understand social media strategies. This is particularly important for illiterate, low-literate and low-skilled youth and adults.

While implementing the planned activities, observations and data on changes in the city's lifelong learning offer should be recorded. These indicators will be processed and analysed; monitoring and evaluation will be the next step.

> ***Cities need to localize their agenda on supporting education and lifelong learning.***
>
> — *Roberto Piazza, City of Lucca, Italy*

Monitoring and evaluating implementation

The monitoring and evaluation of results of the implementation of the planned activities are crucial for the management of the lifelong learning for health policy. The outcomes of the monitoring should lead to periodic revisions of the health learning pathway, and the revised pathway should be disseminated to the people involved in the project as well as to the community. An analysis of changes to the lifelong learning offer will provide information about the impacts of the policy and will suggest necessary revisions to the action plan.

Evaluation of the lifelong learning for health policy is important because it:

- monitors the progress of the project;
- demonstrates the effectiveness of a lifelong learning for health policy, including cost effectiveness;
- provides individuals involved in the project with feedback;
- ensures a commitment to relevant, inclusive and equitable educational practices;
- provides a basis for planning by identifying local contexts;
- accounts for disbursement of resources to funding bodies, policymakers, associations and communities;
- indicates how the project operates;
- improves practice, serves as a reference for the future;
- determines outcomes achieved by the project.

As with the evaluation of all education policies, the difficulty lies in the fact that these are long-term projects. It is therefore important both to evaluate long-term developments (health indicators, regular surveys) and to identify short-term effects (quick wins). A lifelong learning for health policy is a long-term developmental activity which seeks to change the ways in which organizations work and attempts to put health and lifelong learning at the top of their agendas. Such a policy is complex by nature, consisting of multiple actions at different levels. Consequently, the evaluation has to be similarly complex.

Evaluation of a lifelong learning for health policy often uses both quantitative and qualitative measures. It is usually evaluated in terms of changes in people's representations of health and the ways people deal with health problems, as well as changes in the health/quality of life outcomes. The action plan for a lifelong learning for health policy should be revised and amended in light of information from project evaluation and the changing situation within the city. The planning process should be dynamic. Any feedback from the evaluation should enable lifelong learning for health projects to be responsive to the changing needs and situation of the community. Consequently, information about the city and the health learning pathway should be periodically revised and the action plan reviewed in light of new information.

A lifelong learning for health policy needs to determine why an evaluation is required, as this will indicate whether the evaluation should be internal or external. For instance, if the purpose is to report to a funding body, then the input from an external assessor is likely to have more credibility. If the evaluation is designed to improve implementation, then the project staff may be able to do this. The most effective evaluation is likely to be one which combines internal and external perspectives on the project. The people undertaking the evaluation need to have a good understanding of the variety of processes used in the project (especially community participation and collaboration across sectors), as well as an expertise in lifelong learning and its implications for positive health. They have to be skilled at synthesizing complex information and integrating and developing conflicting perspectives from multiple sources. They should be able

to write in an engaging and lively style so that the evaluation data can be presented to the project participants in a way that maximizes the chances of this information being understood and used.

Certain actors in a successful lifelong learning for health policy should be engaged in a process of critical reflection about the progress of their project. This exercise should make it possible to adjust and change the project in response to experiences. It is important that project managers keep the project open to review and assessment. Time and resources need to be put aside for this activity.

There is currently no established procedure or framework to evaluate lifelong learning for health policies. Evaluation needs to consider process evaluation in the short-term as well as long-term impact and, eventually, outcome evaluation. Short-term process evaluation is important because it allows the assessment of the project and early identification of problems and helps keep the morale of participants high by demonstrating and monitoring progress (for WHO's detailed *Checklist for process evaluation* see *Annex 4*).

The focus of the evaluation depends, at least in part, on the maturity of the project of a lifelong learning for health policy and the level of funding. Process indicators are particularly important to collect in the setting-up stage of a project, while outcome indicators are more appropriate for a more mature project. Of course, both are important in a project, but outcome indicators will only be possible over a reasonably long term.

Indicators should be developed with specific relevance to local communities. The development of indicators is not a technical issue, but an issue of values and beliefs about processes necessary for developing health. Consequently, the type and interpretation of indicators will vary from community to community. Relevant, sensitive and easy-to-collect indicators may be used for the monitoring of, and comparison between, a number of lifelong learning for health policies at the country or intercountry levels, and indeed advances are currently being made in this area. These indicators should demonstrate changes, and the participating projects should find

them easy to use. The exact choice of indicators will depend on local circumstances and the priorities of the lifelong learning for health policy.

Evaluation of a lifelong learning for health policy – Logan (Australia)

Implementing a healthy city agenda and addressing the different social, political and environmental determinants of health is a complex undertaking that requires the use of a comprehensive monitoring and evaluation system. The use of broad and appropriate indicators helps in understanding the key drivers and barriers and in better addressing the needs of different stakeholders.

This is the case in the city of Logan, whose evaluation of the city's health plan included an analysis of health service gaps, urban renewal initiatives, and community capacity (such as local event support, networks for social justice, and implementation of various projects). Logan's evaluation framework adopts a mixed method with interviews and focus groups, documentary analysis, and analysis of action status. It also takes into account capacity-building, as well as Logan's growing reputation as a leader in public health both nationally and internationally. Logan is ideally positioned to prepare a 'Community Plan' integrating strategic planning across different administrative departments, a mandatory requirement under the Queensland Local Government Act. Logan's healthy city plan has supported the city's efforts to improve city governance and management.

Evaluation: A three-stage process

We suggest dividing the evaluation of a lifelong learning for health policy into three distinct stages: short-term (or primary) impacts and implementation; medium-term (or intermediate) health and well-being outcomes; and long-term health and development outcomes.

- *Stage One:* Short-term impacts and implementation. This stage is concerned with describing the implementation of the health learning pathway project and, in particular, with ensuring that the project has been implemented according to established guidelines and criteria. For example, a project that had brought about intersectoral action but had not sought to increase opportunities for community participation would not be judged to have been implemented properly.
- *Stage Two:* Medium-term learning outcomes. This stage concerns the intermediate outcomes that might be linked to long-term health and environmental outcomes. Increases in people's knowledge of health crises and non-communicable diseases, and the development of the psychosocial skills of young children are examples of these outcomes.
- *Stage Three:* Education, health and development outcomes. This stage underscores the specific individual, communal or environmental health outcomes. Levels of health literacy, a decline in mortality or morbidity from particular diseases linked to an intermediate outcome, an improvement in living environments or a higher than before level of perceived health status in a community are distinct examples of such outcomes.

In the early stages of the project, the evaluation focus should be on Stage One. As the project develops to Stage Two, the intermediate outcomes could be monitored. The individual, communal or environmental health outcomes of Stage Three are likely to take years or even decades to achieve.

A mechanism must be established for regular review and evaluation of action plan implementation. An annual progress review meeting should be helpful. A system of periodic reporting, assessment and evaluation will facilitate timely and appropriate revision of the lifelong learning for health action plan.

Making the policy visible and ensuring its sustainability

To implement activities, resources need to be mobilized. These include participation from the community, the local government, and other groups and agencies; introduction of technologies and academic expertise; and training of the participants – all of which are necessary for building project capacity.

Next, mechanisms to secure political commitment, intersectoral collaboration, community participation, visibility, funding, human resources, information sharing, awareness building, and national and international networking are all required to ensure the project's sustainability. Continuing training programmes and opportunities to develop both the personal and professional skills of project staff are also essential.

The action plan ought to be shared by as many people in the city as possible. Publicizing and promoting the health learning pathway not only contributes to raising awareness about the health and education situation of the city, it also raises awareness across sectors. Moreover, the media and local associations have a crucial role to play in promoting the action plan and stressing the importance that lifelong learning can have for the health of the population. Other important strategies include workshops aimed at the transfer of technical skills, web pages, video channels, posts on social networks, and organizing community meetings.

Raising awareness of the lifelong learning for health policy involves both community participation and the commitment of the city's executive level. For example, a foreword for the action plan written by the mayor can indicate strong commitment to the action plan by the highest level of local government. Sustainability depends on keeping the values, vision and concept of healthy cities alive. Special events, international visits and celebrations can also be very useful means of support in this effort.

A tobacco-free city – Setif (Algeria)

The city of Setif is implementing actions for tobacco control. These are based on information, education and communication initiatives targeting the general population, particularly young people. The project is overseen by the epidemiology service of the university hospital centre of Setif in collaboration with the district (wilaya) Directorate of Health and Population and the WHO office in Algeria.

Many lifelong learning goals may take decades to achieve. Consequently, it is important for projects to start with at least some initiatives that can demonstrate achievements in a short time. These early accomplishments are essential for maintaining political and community commitment to a project. Projects, therefore, need a mix of initiatives. Some should achieve short-term successes, while others should be more developmental, achieving desired health outcomes over a longer period. Short-term outputs may not clearly demonstrate a health or environmental outcome but could show a link to the longer-term achievements.

Health education initiatives – Nairobi (Kenya)

Community health education programmes that target diabetes, cancer, sickle cell disease, and mental health are available in Kenya and generally mediated by NGOs in collaboration with the Ministry of Health. Community health workers are also involved in community education, especially for fighting infectious diseases, but are now increasingly trained in basic information on noncommunicable diseases (NCDs), palliative care, and COVID-19. In Nairobi, print and broadcast media are also intimately involved in efforts to provide community health education. Most work with NGOs and discipline-based experts from the Ministry of Health, education institutions (universities/colleges), practising health care providers and health journalists. Radio and television shows are often used for community education.

Further innovative tools are utilized to spread awareness of these initiatives.

Youth-led online health forums include:

- NCD 365 App by Stowelink Inc, available for download from Google Play Store.
- TransplantEd Kenya provides information and raises awareness and supports organ, eye and tissue donation.
- YouTube and other social/digital media.
- #TuongeeNCDs by NCD Alliance Kenya – NCD information service.
- Fafanuka *215# – USSD NCD information platform – provides information on NCDs and healthy living via SMS. Collaboration between NCD Alliance Kenya, Safaricom PLC (largest mobile service provider in Kenya) and Ministry of Health.

WhatsApp and SMS are often used for health education of organized community groups, e.g. women's groups (chamas), and family/religious groups.

SMS is popular as internet data bundles can be expensive and the majority of older community members do not have smart phones. Young adults are more likely to have access to smart phones and use social media.

Infographics, cartoons and videos are also used for health education – often translated into Kiswahili and other vernacular languages to make them more accessible to the community. Posters and other information, education and communication materials are also used.

Community radio, especially in vernacular languages, is a major mechanism for community health education. Youth radio shows are also common and use youth-friendly language and strategies.

Webinars, especially in the COVID-19 era, were useful. However, these were often restricted just to community members with access to internet and smart phones, as data bundles to access the internet can be expensive. Webinars were organized by

NGOs, social clubs, or the Ministry of Health. Most educational forums are open to the public but generally not widely publicized so many community members may not know about them.

Social and digital media health-related campaigns target youth and digitally 'savvy' community members.

KEY POINTS

Section C included a discussion of:

1. The key action principles that might be summarized by the following verbs: 'Valuing, Sharing, Aligning, Improving'.
2. The description of a three-phase approach to implementing a lifelong learning for health policy.

ESSENTIAL READING

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CONCLUSION: LEARNING FOR GLOBAL HEALTH IN CITIES

The COVID-19 crisis has made clear how close interactions between the sectors of education and health could point the way to sustainable lifelong learning about health rooted in urban settings. Better synergy between these sectors can contribute positively to the lives of individuals, communities and societies. It can help reduce inequalities and support human development, not only improving health and well-being, but also enhancing learning and personal growth, as well as fostering healthy and resilient communities (WHO, 2015).

It is now possible to draw on the experiences of cities during the pandemic to make progress with the implementation of sustainable learning for health policies. To move forward, there is a crucial need for building and sharing knowledge. UNESCO learning cities will play a key role in advancing learning for health in cities as they are ecosystems of innovation accustomed to intersectoral collaboration (city board, services, civil society, associations, schools and universities). As the world continues to respond to and recover from the COVID-19 pandemic, it is expected that the work of learning cities and communities will continue to contribute to the development of lifelong learning policies and strategies in connection with learning for global health and future resilience (UIL, 2021a).

GLOSSARY

Co-design
Co-design is the act of creating with stakeholders, specifically within the design development process, in order to ensure that the results meet their needs and are usable.

Diversity
People's differences which may relate to their ethnicity, gender, sexual orientation, language, culture, religion, mental and physical ability, class, or immigration status (UNESCO, 2017).

Equity in education and lifelong learning
Ensuring that there is a concern with fairness, such that the education and lifelong learning of all people is seen as being of equal importance. (UNESCO, 2017)

Global citizenship
Global citizenship refers to a sense of belonging to the global community and a common sense of humanity, with its presumed members experiencing solidarity and collective identity among themselves and collective responsibility at the global level. Global citizenship can be seen as an ethos or a metaphor rather than a formal membership. Being a framework for collective action, global citizenship can, and is expected to, generate actions and engagement among, and for, its members through civic actions to promote a better world and future (UNESCO, 2021).

Health citizenship
Health is not just a matter of individual behaviour. It is a matter of public decisions and collective commitment. People need to be able to understand their rights and responsibilities, to be aware of the effects of their thoughts and actions on other people and the world at large, to be committed to social decisions related to health and to contribute to building healthy living environments (Paakkari and Paakkari, 2012). The determinants of health transcend national barriers; health is in fact a common good of humanity that can only be ensured for all through a common commitment (Jourdan, 2012).

Health determinants
Health determinants are the personal, social or environmental factors that have an impact on the health of individuals or populations. These health determinants interact with each other and define the living conditions that influence health. The determinants can be organized into five categories: 1. irreducible individual characteristics that influence health; 2. factors related to representations of health, personal behaviours and lifestyles that are influenced by the patterns of social relations in communities and in society at large; 3. relational and community networks, including social and group influences; 4. factors related to living and working conditions and access to essential services and facilities; and 5. socio-economic, cultural and environmental conditions encompassing factors that influence society as a whole.

Health inequalities
Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (WHO, 2018).

Health learning pathway
A health learning pathway is an organized and coherent lifelong succession of learning experiences of a varied nature. The pathway mobilizes all the actors of the city beyond school and healthcare services, integrating formal, non-formal and informal contributions. The pathway makes explicit – and simultaneously formalizes – the content, the contributions and the pedagogical methods of what is offered to the people. It is focused on the development of capacities for awareness and understanding of complex issues, critical judgment and action skills. The pathway also has a communication purpose by making what is done in the city explicit to families, partners and professionals.

Health literacy
Health literacy is linked to literacy in general and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgments 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). Health literacy is a shared responsibility and providers have to be mindful of the skills needed by the public to navigate health systems successfully and to remove the barriers that might keep people from doing so.

Healthy city
A healthy city is one that is continually creating and improving the physical and social environments and expanding community resources that enable people to mutually support each other in performing all the functions of life and in developing their maximum potential (WHO).

Inclusion in education and lifelong learning
A process that helps to overcome barriers limiting the presence, participation and educational achievement of people (UNESCO, 2017).

Indicators
An indicator is an estimate (a qualitative or quantitative measurement with some degree of imprecision) of a given dimension of the lifelong learning for health policy.

Intercultural translation
A term coined by Boaventura Santos (2014) as an alternative to both universalism and strict relativism. Intercultural translation is a process that seeks to identify differences and similarities in order to develop new forms of cultural knowledge.

Intervention
An intervention is a programme, service, policy, product or action that is intended to ultimately influence or change people's social, environmental, and organizational conditions as well as their choices, attitudes, beliefs and behaviour (Bowen et al., 2009).

Learning city
A learning city promotes lifelong learning for all. UNESCO defines a learning city as a city that effectively mobilizes its resources in every sector to promote inclusive learning from basic to higher education; revitalizes learning in families and communities; facilitates

learning for and in the workplace; extends the use of modern learning technologies; enhances quality and excellence in learning; and fosters a culture of learning throughout life. In doing so, the learning city enhances individual empowerment and social inclusion, economic development and cultural prosperity, as well as sustainable development (UIL, 2021d).

Lifelong learning

Lifelong learning is rooted in the integration of learning and living, covering learning activities for people of all ages (children, young people, adults and the elderly, girls and boys, women and men), in all life-wide contexts (family, school, the community, the workplace, and so on) and through a variety of modalities (formal, non-formal and informal), which, together, meet a wide range of learning needs and demands. Realizing the potential of lifelong learning requires political commitment and the development of cross-sectoral and multilevel policies. It also requires the recognition, validation and accreditation of skills acquired in non-formal or informal environments (UIL, 2021b).

Lifelong learning for health

Lifelong learning for health is a process that aims to enable people to protect and promote their individual health – and that of their family – on the one hand, and to provide them with the knowledge, skills and capabilities necessary for actively participating in decisions about health as citizens, on the other (Jourdan et al., 2021).

Participation

The participation of stakeholders in the project for a lifelong learning for health policy implies that everyone involved has a voice and an active role in the development and/or implementation process, with more or less influence on decision-making. It is assumed that people have the needed skills to act in this process. Based on participation ladders, the level of participation can be described as ranging from representative to consensus levels (Mygind, Hällman and Bentsen, 2015).

Proportionate universalism
This refers to actions of sufficient scale and intensity to be universal but also proportionately targeted to reduce the steepness of the inequality gradient (Marmot, 2010).

Targeted approach
This applies to a priority subgroup within the broader, defined population. Eligibility and access to services are determined by selection criteria, such as income, education status, health status, employment status or neighbourhood (NCCDH, 2013).

Universal approach
This approach is applied to an entire population. Eligibility and access are based simply on being part of a defined population without any further qualifiers such as income, education, class, ethnicity, place of origin, or employment status (NCCDH, 2013).

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ANNEX 1

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ANNEX 2

How the World Health Organization defines a health-literate city
A health-literate city:

- recognizes at the highest political level the importance of becoming and remaining health literate and gives this priority through policies and interventions;
- strives systematically to improve the health literacy of its people, its communities, various social groups and its institutions and services;
- has leaders who understand the high relevance of health for the well-being of the city overall and the need to continually invest in and enhance the social assets of the city, by considering health literacy, community resilience, community empowerment and participation and social networking;
- is committed to intersectoral work across government because decision-makers in many sectors understand the high relevance of health and seek health co-benefits and synergy in their policies in cooperation with the health sector;
- provides individuals and communities with skills and knowledge because healthy people and communities are one of the key assets of cities;
- aids citizens in navigating through the health, education and social service systems, making healthy choices the easier choice in settings under city jurisdiction;
- uses a range of media to deliver consistent and understandable messages using plain language.
- regularly reviews programmes, encourages innovation and adapts services to the health literacy requirements of the most vulnerable people;
- works with the private sector and the many voluntary organizations in the city as well as adult learning institutions to improve the overall level of health literacy in the city;
- regularly measures the levels of health literacy in the city; and
- is committed to accountability and transparency.

Source: Kickbusch et al., 2013.

ANNEX 3

The WHO document *Participation as a key driver of health equity* describes the main components of a participatory process (WHO, 2019) as follows:

Spaces for discussion
The configuration of participatory institutional and non-institutional spaces for discussion offers opportunities for promoting health equity.

Communication-related opportunities for health equity
The configuration of a participatory space requires that all affected stakeholders, including those in disadvantaged situations due to social conditions (groups with lower socioeconomic capacity, invisible and oppressed groups, minorities and illiterate, low-literate and low-skilled youth and adults, for instance), be contacted and their participation facilitated. The creation of a participatory space (through specific communication and mobilization strategies for groups that are disadvantaged in terms of health) promotes awareness raising and recognition of the rights of these group.

Opportunities to reflect on health equity
Opening a space for participation provides an opportunity for interaction, communication, socio-economic information exchange, training, discussion and definition of problems and priorities based on the needs of those who participate in the process, and not only on technocratic or administrative criteria. This requires, therefore, a change in the collective framing of the problem and priority-setting to take account of the most disadvantaged groups, who go from being considered mere beneficiaries of interventions to agents and protagonists of the policies and programmes that affect them.

Pedagogical opportunities for health equity
Opening a space for communication and discussion on health issues generates a space for learning that encourages health literacy, through which individuals gain control over individual behaviours that promote health. Health literacy can be understood as a bidirectional process, as health professionals, scientists, civil servants and others can gain

knowledge about the wider determinants of health inequities through participants' narratives.

Opportunities for decision-making
Establishing a more or less formalized system for interaction with citizens, civil society groups, governments and other stakeholders allows for an approach to address problems that generate inequality in health.

Coherence
Participatory processes can serve to align the objectives of different actors in the struggle against health inequity to achieve a more consensus-based strategic vision.

Responsiveness
As a result of negotiation, deliberation and opening spaces for consensus (or conflict), responsiveness is developed on behalf of all intervening stakeholders in general, and governments in particular, enabling institutions to better serve all stakeholders, including those most in need.

Transparency
Interaction requires the development of a transparent system of exchange. It should guarantee that information is available, accessible and comprehensible. Participants' narratives and the available information create new knowledge about the social determinants of health.

Rule of law
There is a tendency to formalize the decision-making process to favour the rule of law (because of a restriction in the informal exercise of power) to reduce possible mechanisms of abuse of power and discrimination.

Implementation
The participation of everyone with a stake in decisions in applying strategies, programmes and activities permits the following to occur.

Opportunities for coordinated action
When stakeholders are involved in the participatory process they work in synergy, improving effectiveness and the efficiency of interventions.

Identification of the population with policies

It is possible to achieve greater acceptance of policies in which the population feels ownership due to having participated in their development and implementation. When policy implementation follows a technocratic model in which elites make decisions based on technical and professional criteria, there is a tendency to generate greater symbolic violence, whereby humiliations are internalized in groups that do not share the cultural codes of the socially dominant groups.

Determining the impact of learning for health policies

Impact evaluation links decisions made with possible effects on the population, which provides essential information about how decisions increase or reduce health inequalities. This serves to reorient action towards health equity.

Return of results

The return of results is a two-way process. On the one hand, it permits the population to make use of the knowledge and information provided (which, in reality, is their own), and, on the other, it is helpful in validating the information obtained in the participatory process (results validation).

ANNEX 4

CHECKLIST FOR PROCESS EVALUATION

1. How were the priorities for action arrived at?
2. What information was collected to inform this process? Was it appropriate?
3. Who was involved? Did all groups feel satisfied with the say they had? If not, why not? What would have enabled them to have more say?
4. What process is there for reviewing and revising priorities?

Project management

1. What sectors are represented on the management bodies? Which are not represented? Why aren't they represented?
2. What form does the community representation take? Do the community representatives make a genuine contribution? What are the constraints to them doing this?
3. Who holds most power in decision-making? Is this appropriate?
4. What connection does the management group have to the key decision-makers in the city (usually the mayor and town clerk)?
5. What is the strength of political support for the project?
6. How have policies, structures, practices and human resources been influenced?

Participation

1. Who participates (inclusivity)?
2. How do they participate (intensity)?
3. How are discussions and decisions linked with policy or public action (influence)?

Characteristics of the project activities

1. Description of all initiatives which have been part of the lifelong learning for health project.
2. Details of the contribution of each component of the health learning pathway.

3. Documentation of the process of how change was achieved.
4. Detailed accounts of problems encountered in implementing the project.
5. Details of alternative ways to implement the project.
6. Determining whether the initiative was worth the money.
7. Status of innovation after the initial impetus.

How successful was the cross-sector activity and collaboration in the project?

1. Which sectors appear most supportive of the healthy cities initiative and why?
2. Which sectors are not supportive of the initiative and why not?
3. What are the most successful cross-sector initiatives? What factors appear to account for their success?
4. Are there any cross-sector activities that have not been successful? Why does this appear to be the case?

The future of the project

1. How is innovation being maintained after the initial impetus is over?
2. Is political support for the project continuing? If not, how can it be revived?
3. Are the project successes sustainable?
4. Is the project continuing to generate new ideas?

The fifth International Conference on Learning Cities, convened in Yeonsu, Republic of Korea, in October 2021, resulted in the Yeonsu Declaration, a commitment from global stakeholders to create resilient and healthy cities. This guide, built on the foundations of the declaration, is a practical resource for municipal teams, tailored to support the development and implementation of policies that promote lifelong learning for health.

The guide outlines a three-step process, from raising awareness to policy development and implementation. It advances the concept of a 'learning for health pathway' – an approach focused on valuing, sharing, aligning and improving health education opportunities within urban environments, ultimately aiming to create inclusive policies at the local level.

The approach seeks, first, to demonstrate the value of the educational work carried out in formal, non-formal and informal settings of the urban environment; then to make this known among stakeholders and to make the pathway coherent; and, finally, to identify the gaps and take the necessary initiatives to fill them.

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