Thematic tool 12

Developing a lifelong for health policy: building the action plan

Phase 2 Developing a policy toward a healthy and resilient city

The questions this sheet answers

- What are the levers to activate to induce change in education at the city level?
- How to build the action plan?

Articles of the Yeonsu declaration

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Summary

The enactment process of the Yeonsu declaration has to be based on a change management strategy. Four levers have to be activated (1) policies; (2) structures & systems; (3) human resources; (4) practices. Since we’re not starting from scratch, and because culture and
contexts are different from each other, the key question is more to improve the quality and outcomes of the lifelong learning service provided to the population than to implement a program to be followed step by step by these structures.

Building the action plan

There are many ways to organize the action plan. To be effective, a “wish list” is not enough, the enactment process has to be based on a change management strategy. We have to understand the Modus Operandi of the education systems (Bryk, 2015) to be able to influence it. Four levers have to be activated (1) policies; (2) structures & systems; (3) human resources; (4) practices (SHE, 2018; UNESCO, 2017). Based on the literature and our experience, we propose to organize the action plan following these four components and ten domains of action.

Local lifelong learning policies

In this component, two elements must be integrated.

- The first is policies, both the lifelong learning policies existing in the different sectors and the policy component dedicated to lifelong learning for health.

- Secondly, it is about advocacy 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 the civil society are indispensable to influence the views of education.

Structure and systems

The existence of supportive organizational structures is a condition for successful change (UNESCO, 2017).

The issues of steering, management and financing must be taken into account in the 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
Since we’re not starting from scratch, and because culture and contexts are different from each other, the key question is more to improve the quality and outcomes of the lifelong learning service provided to the population than to implement a program to be followed step by step by these structures (Dadaczynski & Paulus, 2015).

**Practices and human resources**

Having political and institutional frameworks is necessary, but without capacity building for professionals, progress will stall (WHO, 2016a). 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 service) could 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 stacking of modules.

Concerning the practices, two elements must be integrated:

- the educational practices of professionals supporting the population on a daily basis (teachers, librarians, nurses, GPs, social workers, police officers etc.)
- the practices of those who intervene on an ad hoc basis in the framework of initiatives dedicated to lifelong learning for health

Concerning the human resources, two elements must be integrated:

- The professional development (we point out here that the training can also concern non-professionals such as volunteers from associations)
- The support for professionals in their work
This table could be integrated in a document that could include the following ten items.

| 1. Characteristics of the city (topography and climate; history, culture, and heritage; administrative structure; demographics; etc.) |
| 2. Vision of the city |
| 3. Health and education situation 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; etc.) |
| 4. Priority health problems |
| 5. Planning goals and targets of the lifelong for health policy |
| 6. Strategies for action on (1) policies; (2) structures & systems; (3) human resources; (4) practices (cf. table) |
| 7. Actions and activities to developpe learning to resolve priority health problems (formal, non-formal and unformal education) |
| 8. Roles of individual groups in implementing the above actions/activities |
| 9. Resources required and available for implementing the actions/activities |
10. Implementation and monitoring/evaluation mechanisms (coordination and communication mechanisms for implementation; indicators for monitoring and evaluation of progress; mechanisms for evaluation; reporting systems; etc.)

Activity: Conducting a SWOT on the levers and obstacles to the implementation of a lifelong learning for health policy

Examples:
Thematic tool 13

Identifying health priorities: the health city profile

Phase 2 Developing a policy toward a healthy and resilient city

The questions this sheet answers

• If the city's health profile has not been done elsewhere, how can it be done?
• How to identify the health priorities to build the health learning pathway?

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Summary

Making a city health profile could be useful in taking stock of the health situation of the city and identifying priorities for the health learning pathway. If the city's health profile has not been done elsewhere, it could be organized through the framework developed by WHO WPRO.
Working path for practical enactment

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 could 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 the health situation of the city and identifying priorities for the health learning pathway (WHO, 2000).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Items</th>
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<tbody>
<tr>
<td>Demography and Epidemiology</td>
<td>Total population</td>
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<tr>
<td></td>
<td>Age and sex breakdown</td>
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<td>Ethnic distribution</td>
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<td></td>
<td>Birth rate</td>
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<td>Fertility rate</td>
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<td>Death rate</td>
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<td>Morbidity rate</td>
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<td></td>
<td>Communicable diseases</td>
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<td></td>
<td>Non-communicable disease</td>
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<td></td>
<td>Injuries/accidents</td>
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<td></td>
<td>Crime</td>
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<td></td>
<td>Disabilities</td>
</tr>
<tr>
<td></td>
<td>Suicide rates/occupational injury</td>
</tr>
<tr>
<td></td>
<td>Perceptions of health and well-being</td>
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<tr>
<td></td>
<td>Individual risk factors</td>
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<tr>
<td></td>
<td>Immunization rate</td>
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<tr>
<td></td>
<td>Nutrition</td>
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<td></td>
<td>Alcohol and drugs</td>
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<td>Smoking</td>
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<td></td>
<td>Exercise</td>
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<tr>
<td></td>
<td>Screening rates (cancer)</td>
</tr>
<tr>
<td></td>
<td>Domestic violence</td>
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<tr>
<td>City background</td>
<td>History</td>
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<td></td>
<td>Culture</td>
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<td>Climate</td>
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<tr>
<td></td>
<td>Topography</td>
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<tr>
<td>Physical Environment</td>
<td>Environmental quality</td>
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<tr>
<td></td>
<td>Air</td>
</tr>
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<td></td>
<td>Water</td>
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<td></td>
<td>Noise</td>
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<tr>
<td></td>
<td>Soil</td>
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<tr>
<td></td>
<td>Scenery</td>
</tr>
<tr>
<td></td>
<td>Percentage green space/parks</td>
</tr>
<tr>
<td>Living Environment</td>
<td>Access to safe drinking water</td>
</tr>
<tr>
<td></td>
<td>Adequacy of housing facility</td>
</tr>
<tr>
<td></td>
<td>Amount of living space</td>
</tr>
<tr>
<td></td>
<td>Rates of homelessness</td>
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### Food hygiene
- Insects 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

### 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 inspector
    - standard of monitoring/enforcement

### Economic
- Assessment of impact of economy on health
  - main industries/business
  - health of economy
  - level of development

### Social
- 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

### Legislation and regulations
- Disease prevention and control
- Hospitals, schools, workplaces, markets, etc.
- Food hygiene, building, housing
- Drinking water, waste management
- Air, water, noise, soil, etc.

**Activity** — Take the big list and look at the hotspots and hot topics for each issue, and who in the population is affected most by each issue.

**Examples:**
Thematic tool 14

The collection of the existing contributions from the various stakeholders

Phase 2 of the enactment process: Developing a policy toward a healthy and resilient city

The questions this sheet answers

- Who are the actors in learning for health?
- How do they contribute to lifelong learning for health?

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Summary

It is necessary to take a broad view of the type of initiatives that have to be included, as they are related to formal, informal and non-formal education. The initiatives could be focused on a variety of themes in relation to the physical, mental and social dimensions of health. Once the contribution of the different actors is identified, it is possible to define whether it is necessary for the municipality to support these initiatives. If so, define the appropriate support.

A working path for practical enactment

It is necessary to take a broad view of the type of initiatives that have to be included, as they are related to formal, informal and non-formal education. A list of key players whose efforts may need to be coordinated in a Lifelong Learning for Health policy is given in the box below.

List of key players in a Lifelong Learning for Health policy

• community members
• local, provincial/state and national politicians
• government service providers from a variety of sectors (e.g. health, welfare, transport, police, public housing authority)
• health and educational institutions
• community service providers
• nongovernmental organizations
• community-based organizations
• private enterprise interests
• consumer groups
• local government authorities
• provincial/state government authorities
• relevant national government authorities
• Faith communities
• ethnic groups
• community media
The learning initiatives could be focused on a variety of themes in relation to the physical, mental and social dimensions of health. They include promotion of physical activity and healthy eating, mental health, vaccination, road safety education etc. The COVID-19 crisis has shed light on mental health issues: 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, 2020).

Once the contribution of the different actors is identified, it is possible to define whether it is necessary for the municipality to support these initiatives. If so, define the appropriate support.

Cities’ policies and practices are at the core of people and communities’ health learning modified from Ra et al., 2021.

Activity – create a table of the interests of the actors named above – what will mobilise them?

Look at the ‘sun’ figure – list of learning opportunities

How well developed are they?

Do we have the capacity to deliver?
Are we able to extend opportunities to other populations?

Examples:
Thematic tool 15

Valuing, Sharing, Aligning, Improving: Ensuring people’s participation in learning for health (YD articles 7,8,10,15,19,20)

Phase 3 of the enactment process: Putting the learning for health policy into action

The questions this sheet answers

- How can we promote participation in the lifelong learning for health policy?

Articles of the Yeonsu declaration

| Articles |
|---|---|---|---|
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Summary

Participation of citizens is a key condition of the success of the lifelong learning for health policy. To ensure participation, there is need for spaces for discussion with citizens in which to reflect on the nature of problems; spaces for decision-making with organized interaction with
Working path for practical enactment

When cities set up learning for health schemes, there is a considerable risk that these will only be aimed at the more accessible parts of the population. 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 they have poorer access to - and use less - information and health promotion, disease prevention and care services (Kickbusch et al., 2013). Their social situation, the cultural difference and linguistic barriers make the implementing of learning for health strategies more difficult to achieve.

Participation of citizens is a key condition of the success of the lifelong learning for health policy. If participation processes are inclusive – meaning that all of the population are entitled and have the skills to participate – social participation can be understood as a key driver of health equity. To ensure participation, there is need for spaces for discussion with citizens in which to reflect on the nature of problems; spaces for decision-making with organized interaction with citizens, civil society groups, governments and other actors to establish plans of action; organization of such actions involving all stakeholders; and their involvement in evaluation.

The WHO document “Participation as a key driver of health equity” describes the key component of the governance of a participatory process (WHO, 2019) as follow:

**Spaces for discussion**

The configuration of participatory institutional and noninstitutional 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, and minorities, for instance), are 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
raising awareness and recognition of the rights of groups with the highest level of health disadvantage.

**Reflexive opportunities for health equity**

Opening a space for participation provides a reflexive (or deliberative) opportunity through interaction, communication, information production, training, reflection, deliberation and appropriation, defining problems and the agenda of 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.

**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.

**Coordinated action**

This involves stakeholders involved in the participatory process working 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 participation in their development and implementation. When policy implementation takes place from a technocratic model in which elites make decisions based on technical and professional criteria, there is a tendency to generate greater symbolic violence with groups that do not share the cultural codes of the socially dominant groups because of their positions in the social structure.

**Evaluation**

Evaluation favours the following issues.

**Determining the impact of learning for health policies**

Impact evaluation links decisions made with possible effects on the population, which increases 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).
Activity: For different groups how are they involved in participation work?
How could we engage them more meaningfully?

Examples:
Building coherence and visibility: Monitoring the enactment of the Yeonsu declaration

Phase 3 of the enactment process: Putting the learning for health policy into action

The questions this sheet answers
- How to evaluate the enactment of the Yeonsu declaration?

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Summary

Evaluation of the enactment of the Yeonsu declaration 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. The participation of the population in the lifelong for health policy is a major issue and should be evaluated on a regular basis.

**Working path for practical enactment**

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.

The focus of the evaluation depends, at least in part, on the maturity of the project of 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 inter-country levels. These indicators should demonstrate changes and the participating projects should find them easy to collect.

**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 could be shown to be linked to long-term health and environmental outcomes.
Increase in the knowledge of people on health crises, non-communicable diseases, and 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. Level 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 1. As the project develops to Stage 2, the intermediate outcomes could be monitored. The individual, communal or environmental health outcomes of Stage 3 are likely to take years or even decades to achieve.