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Evaluating the implementation of the WHO Healthy Cities Programme across Germany (1999-2002)

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**Evaluating the implementation of the WHO Healthy Cities
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view

Evaluating the implementation of the WHO Healthy Cities Programme across Germany (1999 – 2002).

Abstract

The WHO Healthy Cities Project (1988) is a well-known example of the setting-based approach to health promotion. Developed as a framework for translating the key principles of the Ottawa Charter for Health Promotion (1986) into practice, it is best characterised as a process for successfully encouraging healthy public policy. In 2001 the German Healthy Cities Network (HCN) commissioned a survey of the 52 local Healthy Cities programme Coordinators (HCC), to monitor progress and identify strengths and weaknesses associated with its implementation. Most (90%; 47/52) HCC participated in the survey. Several positive aspects of the HCP in Germany were identified: during the first five years it expanded rapidly; project coordinators felt highly engaged, despite limited resources; a combination of traditional and innovative approaches were adopted and applauded; and almost 75% of HCC felt their efforts had been beneficial. Nonetheless, the following shortcomings were identified: increased resources required; greater clarification of concepts and strategies at the local level; stronger commitment to the Nine-Point-Programme of Action; greater integration within the national Healthy Cities Network (HCN) and the local political administrative system (PAS); better programme documentation and evaluation. In conclusion the Healthy Cities Network in Germany has expanded and developed since its inception twenty years ago. German HCP will only improve if professionalism and quality of local work are improved, particularly in terms of strengthening their influence on the local political-administrative system and on public policies.

Key words

Healthy Cities, healthy public policy, evaluation of healthy cities network, quality criteria, implementation strategies

Introduction

The WHO "Healthy Cities" project (WHO, 1986b) is probably the most widely recognised example of a settings-based approach to health promotion with programmes in over 1200 cities globally. From its origins as a Europe-wide action plan to facilitate implementation of the principles identified in the WHO Ottawa Charter (WHO, 1986a), the *Healthy Cities movement* has spread across the six WHO regions (e.g. WHO, 2003; de Leeuw, 2009). More than 29 *National Healthy Cities Networks* have developed in 29 European member states (WHO, 2003b). A primary goal is to support cities in implementing policies and plans based on Health for All (WHO/EURO, 1985 & 1991) and Agenda 21 (UN, 1993). Despite its increased popularity, research or evaluation on implementing the approach adopted by Health Cities Programmes (HCP), remains limited (Tannahill, 1997; Eklund, 1999; Strobl & Bruce, 2000; Green & Tsouros, 2007); partly due to the lack of suitable indicators but also because health promotion relies heavily on qualitative evidence, which compared to evidence from scientific paradigm, tends to be disregarded in policy decision making process. In response, the WHO has developed its own evaluation of the four phases of the European HC Network (Green & Tsouros, 2007), but evaluation at national level, including Germany, remains inadequate.

The survey described here represents one of the most comprehensive to date on the implementation and development process of Healthy Cities in Germany. It therefore makes a timely and useful contribution to discussions on the monitoring and evaluation of HCP, including the role of National HCP Networks (HCN) and of Healthy Cities Project Coordinators (HCC),

Background

The WHO Healthy Cities Programme (HCP) is best characterised as a process rather than any specific output (health or otherwise); indeed, Healthy City status is achieved not on the basis of a set of health indicators but through demonstration of a certain level of political support and commitment, in the form of '*health enabling structures and processes*' (Figure 1). Hence progress has mainly been measured in terms of indicators mirroring achievements in terms of structures and processes for better health.

FIGURE 1 ABOUT HERE

A key objective for HCP is '*to improve community infrastructures to enable communities and people to increase control over and to improve their health*' as set out in the original Ottawa Charter (WHO, 1986a). Not surprisingly therefore the kinds of strategies developed under HCP are required to be innovative, in order to tackle individual and societal factors but also the increasing emphasis on Salutogenic environments. Twenty years earlier Hancock & Duhl (1988) proposed the following framework for HCP practitioners to adopt: explicit political commitment; leadership; institutional change and intersectoral partnerships. Again, in the absence of appropriate tools to capture such complex and qualitative indicators, monitoring progress in such areas remains difficult.

1 A basic principle of any Healthy Cities programme is to embrace the subjectivity of health.
2 At the same time the interrelationship between the individual citizen, the local environment
3 and the decision making process of local communities has to be recognised (Goodman et al.,
4 1998; Doyle et al., 1999; Raphael et al., 1999; Jackson et al., 2003; Hoeijmakers et al., 2007).
5 Each city is responsible for developing activities relevant to local population and situational
6 needs and it is critical that HCP is closely linked to the local political administrative system
7 (PAS). This forces HCP to focus on creating supportive policy structures.
8
9

10 Although HCP are well suited therefore for healthy public policy analysis, the paucity of
11 suitable research tools makes evaluation of HCP problematic (Curtis et al., 2001; O'Neill &
12 Simard, 2006). As previous researchers argue innovative techniques are required (Rootman
13 et al., 2001; Dooris, 2005; de Leeuw & Skovgaard, 2005 & de Leeuw 2009; Green & Tsouros
14 2007).
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17 **The German Healthy Cities Network (HCN)**

18 The German HCN was established in 1989 at a meeting of representatives from 10 cities, in
19 Frankfurt, to agree upon Healthy Cities Action Programme: '*Strategies for Local Health*
20 *Promotion*'. Therein, the German HCN defined itself as a voluntary association of
21 participating communities and its principle aim was to serve '*as an instrument for activities,*
22 *mutual learning, and information exchange which supports the local work in terms of the Healthy*
23 *Cities Conception*' (Gesunde Städte-Sekretariat 2008). Translated, Germany HCN has three
24 objectives (HCN Germany 2008):
25
26

- 27 • development and strengthening of interagency health promoting municipal politics
- 28 • development and strengthening of practices for the assessment of the health impacts of
- 29 urban development and
- 30 • development and strengthening of conditions for mobilisation of citizens, civic
- 31 participation and self-help.
32

33 The network was further strengthened at the annual general meeting (AGM) in
34 Greifswald (1993), with the introduction of the '*Nine Point Programme of Action*' as the
35 declaration of commitment for all member cities (Box 1). For a detailed account of the "Nine-
36 Point Programme of Action" refer to "*Healthy Cities Network Germany – 20 years of partnership*
37 *for health*", (Healthy Cities-Secretary's Office, 2009a), which marks the 20th anniversary of
38 the European Healthy Cities Network in Germany.
39

40 These were updated (Osnabruck Recommendations of Quality Criteria, 2000) (Box 1) and
41 in 2001 a review of progress made by HCN Germany was requested. The review focused on:
42 the extent to which this Nine-Point-Programme had been achieved; identifying the lessons
43 learned, including the range of topics and actions carried out locally; assessing the degree of
44 internal and external cooperation of the HCP work; and assessing the degree of integration
45 of HCP in local policy areas and their relationship to political administrative system(PAS).
46

47 **BOX 1 ABOUT HERE**

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50 The Academy for Public Health in Dusseldorf, in association with the HCN Office and the
51 Department of Medical Sociology at the University Medical Center of Hamburg, was
52 commissioned to develop the study. The results of this research were subsequently used to
53

1 inform the development of an innovative monitoring tool for use by other national HCN, to
2 provide a simple means of assessing the quality of individual cities and HCN, resulting in
3 the so-called: "Healthy Cities Quality Index" or "HC Barometer". (Pluemer and Trojan, 2004):
4 Details of which are outlined in Methods below. The remainder of this paper focuses on the
5 survey findings, relating to the implementation of HCN in Germany, and identification of
6 lessons for health promotion policy and practice.
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9 **Methods**

10 The research aim was to design an appropriate research tool to survey Healthy Cities
11 Network Coordinators (HCC) across Germany to explore their individual and collective
12 experiences relating to the implementation of the Healthy Cities Programme (HCP) locally.
13 In 2002 the German Healthy City Network (HCN) consisted of 52 municipalities. Given the
14 information sought, number and location of projects, and resources available, a cross-
15 sectional survey was considered the most appropriate study design. A self-administered
16 postal questionnaire was chosen as the primary means of data collection, because it is a
17 relatively quick and inexpensive means of obtaining data on known dimensions from a large
18 number of respondents within a short space of time. Moreover, as topics and dimensions had
19 already been established, through the Healthy Cities Nine-Point Programme of Action
20 (WHO-EURO, 2003b), methods associated with constructionist methodology were
21 disregarded.
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25 **Recruitment**

26 A total population sample involving all 52 HCN-Coordinators, active at the time of study
27 (March 2002), was adopted. Letters were sent to all 52 HCP offices registered across Ger-
28 many, including study details, pre-paid envelope and consent forms; reminders were sent 2-
29 weeks later, after 6 weeks non-responders were contacted by telephone. Standard
30 confidentiality and anonymity procedures were adopted. Respondents were allocated
31 unique identifiers (UI) and all data was treated according to established ethical procedures.
32
33

34 The questionnaire, developed in January 2002, was distributed over a three month
35 period (March - May 2002). The survey was *retrospective*, relating to the period 1999 – 2002,
36 based on assessing standards listed in the aforementioned Nine-point Programme of Action.
37 Questions were developed by the principle researcher (Author 1: KP) in consultation with
38 health promotion specialists, academics and the HCN Coordinator for Germany at that time.
39 Items were developed in accordance with survey objectives, key stakeholder information
40 needs and existing indicators identified from a systematic review of the relevant health
41 promotion literature (e.g. Webster et al., 1996; WHO 1997a, 1998a & 1998b).
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45 The original questionnaire contained 78 standardised and 23 open questions; a further
46 27 questions, using 10-point-rating-scales, were added following consultation, to allow local
47 coordinators to rate perceptions relating to performance of local HCP, the Nine-Point
48 Programme of Action, the Cologne Resolution and the Osnabruck Recommendations (see:
49 www.gesunde-staedte-netzwerk.de). The questionnaire was divided into six broad areas
50 (Box2). BOX 2 ABOUT HERE
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1 Respondents were asked to operationalise key concepts, such as 'intersectoral collaboration',
2 through open-ended questions. Internal validity was enhanced through respondent checking
3 including presentations to professionals via HCN annual general meetings (AGM)
4 (Hamburg, June, 2002; Münster; June, 2003).
5
6

7 A sub-set of 30 questions from the questionnaire were subsequently adapted to construct
8 a monitoring tool for local projects, or the aforementioned "Healthy Cities Barometer"
9 (Plümer & Trojan 2004). Six dimensions were organised into three themes: (i) *Structure* (staff
10 and equipment, commitment), (ii) *Process* (concept quality, network integration) and (iii)
11 *Outcome* (self-reported success, city integration (Box 3). This was developed to inform HCN
12 about the range and variety of local HCP via a simple to use profile of 'quality indicators'
13 through an ongoing benchmarking process within the German HCN.
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16 BOX 3 ABOUT HERE Construction of Quality Indices for the "Healthy Cities-Barometer"; for
17 the modelling of an easy to handle quality monitoring instrument (Plümer & Trojan, 2004),
18 we have constructed six weighted and aggregated variables which are based on 30 questions
19 of the questionnaire. We called the instrument "Healthy Cities Quality Index" or "HC
20 Barometer". The indicators represent the quality dimensions structure, process and outcome
21 according to Donabedian (1966, 1991) in order to illustrate standards of quality achieved by
22 single cities and the HC-network. For '*structural quality*', we used the indicators (S1)
23 equipment and (S2) self-commitment (to what extent are the minimum standards fulfilled);
24 for the *process quality* the indicators (P1) concept quality and (P2) integration in the local
25 policy structures; and for the *outcome quality* the indicators (O1) self assessed success and
26 (O2) integration within the council or rather the local Political-Administrative-System (PAS)
27 of a city.
28

29 For the comparative illustration of these quality dimensions in a Healthy Cities
30 benchmarking we have defined three levels: *A-level* (»excellent«), *B-level* (»satisfying«) and *C-*
31 *level* (»worthy of improvement«). In the following we will give an example how the Healthy
32 Cities Quality Index was developed. As an example we will take the first indicator (S1) to
33 illustrate 'structural quality' (Box 4)
34

35 BOX 4 ABOUT HERE
36

37 Data Analysis

38 Survey data was collated, verified and entered into SPSS and Epi-Info by the primary author
39 (KP). This was analysed using descriptive statistics and significance tests. Qualitative data
40 was analysed using constant comparative analysis; data was clustered into common themes,
41 in accordance with thematic analysis; divergence and consensus in themes were explored.
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44 Findings

45 A response rate of 90% (47/52) was achieved; ranging from 67% in Schleswig-Holstein to 100
46 percent in eleven of the 15 German federal states; one, Bremen (City State), due to internal
47 reasons decided to cease membership in the early nineties.
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50 *Characteristics of the Healthy Cities Network Germany*

51 Membership is not restricted to Cities, with towns, administrative rural districts and
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2 boroughs accepted into the German HCN. More than half (53.2%) of the cities questioned in
3 2002 had been long-standing (i.e. 10 years or more) members of the network; a further 17%
4 members for 5-10 years; with approximately a third (29.8%) involved four years or less.
5 Growth of the network slowed considerably in the second five-year-period (1994-1998)
6 whilst growth in the third period (1999-2002) is marked by the entry of six Berlin city
7 districts; three out of these six Berlin City districts came from the former Eastern part of
8 Berlin (East-Berlin). The city state Berlin joined HCN later in 2003..
9

10 *Staffing, Coordination & Resources*

11 Most (78%) HCP across Germany are located within organisations run by local public health
12 departments, local government or municipalities; in just 9 cases the HCC has a designated
13 office, under the local Director of public health (medical officer), in three such cases a
14 dedicated sign: 'Healthy Cities office' is visible to the public.
15
16

17 The academic profile of project coordinators was skewed towards the social sciences
18 (47%), particularly in western Germany, with only 17% from medical backgrounds. The
19 remaining 36% represented a range of professions for example: lawyers, journalists,
20 administration experts. A similar proportion of men and women were employed as
21 Coordinators with most (65%) aged 45 years or above.
22

23 *Resources and facilities available to Healthy Cities Offices*

24 In all cases the Healthy Cities Office and Coordinator (HCC) act as the local interface
25 between the Healthy Cities Project (HCP) and the wider community. An important
26 consideration therefore is whether the resources and facilities available locally are adequate
27 to support this function. Approximately one third of coordinators reported having adequate
28 access to 'basic office facilities' (Tab. 1), including own office, desk, telephone, fax, internet
29 access and personal e-mail-address; almost half (46.7%) however relied upon access to
30 facilities through their host organisation.
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34 Only 10 (22%) HCC reported having access to specific budgets to support activities; a
35 third (31%) had no budgetary support and the remaining 47% accessed minor expenses only
36 (e.g. basic office supplies, printing services) through their associated department. The annual
37 budget available to HCC was minimal; typically ranging from below 2.500 Euro to 5.000
38 Euro per year (Tab. 2).
39

40 **TABLE 2 ABOUT HERE .**

41 *Conceptual Quality: Core areas of work and approaches adopted by Healthy Cities* 42 *Programmes in Germany*

43 We asked all the HCC about strategic priorities and working methods adopted in their
44 particular locality. This was used to characterise key working practices and identify priorities
45 undertaken locally and nationally (for e.g. is there a plan, a local concept, common agreed
46 aims, etc.) (Tab. 3).
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49 **TABLE 3 ABOUT HERE**

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51 Respondents were asked about the nature and quality of their activities, as prescribed by the
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2 Healthy Cities Nine-Point Programme of Action. Clearly, intersectoral collaboration, public
3 relation work, documentation and evaluation are all essential components of their work.
4 Coordinators were then invited to rank their involvement in the range of core HCP activities
5 identified. Core activities cited most often (Box 4), were: child and youth health activities
6 (34), thematic (health) action days (33) and self-help (31). This was followed by moderate
7 level of action in more strategic aspects, like 'local health conferences' (28), action to promote
8 interdisciplinary working and collaboration, public participation (26) and networking (25).
9 'Core activities' undertaken less often included 'settings for health' (18), poverty and health
10 (15), environments, sustainability and health (13), and mobilising partners (agencies). It was
11 possible to gauge from respondents' accounts whether individual HCP adopted traditional,
12 such as lifestyle (smoking) or risk group (migrant health) oriented approaches or more
13 innovative approaches to health promotion. Descriptive statistics revealed that traditional
14 approaches on the one hand and innovative ones on the other were equally applied in the
15 cities.
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18
19 Almost half HCC said they had a high degree of autonomy in terms of planning and
20 prioritising workload. The other half however was directed by the aims and objectives of the
21 employing organisation.
22

23 *Network Integration: Self-reported success and City Integration*

24 Respondent's individual and collective interpretations of the term intersectoral collaboration
25 were operationalised through open-ended questions asking how they saw intersectoral
26 collaboration occurring in practice. When asked to rate the intensity of integration in the
27 local PAS, most items were considered to be successfully implemented (Tab. 4).
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29

30 **TABLE 4 ABOUT HERE**

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33 We asked HCC to characterise their approach to 'intersectoral collaboration' in terms of a
34 continuum from being passive to being active. Clarification of active or passive collaboration
35 was obtained qualitatively through open-ended questions; evidence of HCC using their
36 initiative and contacts to initiate collaboration compared with others who relied solely upon
37 traditional channels and/or waiting for requests (passive) was requested. More than 70% of
38 the coordinators described themselves as actively initiating intersectoral collaboration, as
39 well as active citizen participation, e. g. through local health conferences or involving self-
40 help groups.
41

42 When asked about the relationship between HCC and the national network, most
43 acknowledged that above adequate opportunities existed to attend meetings or symposia;
44 communication and exchange of information with other national HCC was however
45 evaluated less favorably HCN (Tab. 5), with networking between cities also weak (Tab. 6).
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48 **TABLES 5 AND 6 ABOUT HERE**

49
50 At the time of the Survey several efforts had already been initiated to redress these problems,
51 for example, the creation of so-called 'centre's of competence' or excellence, in certain fields
52 of action like child and youth health or migrants and health; in 2002 a modified service fee or
53
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1 budget was introduced for public relations work, based on the size of the community, which
2 replaced the voluntary fee previously introduced in 1994; and the introduction of the
3 quarterly circular 'Healthy Cities News'. Nonetheless, in 2002 the 'centres of competence' and
4 the new 'service fee for public relation' had not yet fully developed and were therefore
5 unable to have as great an impact on improving the internal network communication as
6 intended; this may explain why the relevant structural elements of the network (Tab. 7) have
7 been somewhat critically appraised by HCC's, with only modest mean scores, on the 10-
8 point-rating-scales, ranging between 5.6 (importance for the local work) to 6.6 (exchange of
9 information); whilst the benefit of the HCN Website, launched 1996, was poorly rated by
10 most HCC (mean 4.6). A majority of 33 respondents out of 38 marked a need for change of
11 the HCN.
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13 TABLE 7 ABOUT HERE
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15 *Levels of evaluation and monitoring activity*

16 Nearly all coordinators described being actively involved in public relations, with 68% using
17 reports, presentations and/or brochures to promote their work. A further 60% claimed they
18 evaluate activities, mostly internal, with only 10 of 47 projects engaging external evaluators
19 (Tab. 8). The whole Healthy Cities Project was externally evaluated only in two cases
20 (Plümer, 2002), one of them in conjunction with the WHO European Healthy Cities Network
21 (WHO 1997b) and the second by internal and external (Tab. 9).
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25 TABLES 8 AND 9 ABOUT HERE
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27 *Self-Assessment of achieved Success*

28 When asked to self-assess achievements at the local level, improvements over time, and
29 recognition of activities by local government HCC were able to provide concrete examples of
30 success, such as the introduction of cooperative structures (health conferences). Most HCC
31 felt their work had improved, with 25% of HCC describing progress as excellent (Tab. 10),
32 only two responded negatively. At national level progress of Healthy Cities was described as
33 moderate to fair by almost three-quarters.
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37 TABLE 10 ABOUT HERE
38

39 When asked to rate their performance at the local and national level, most felt that the work
40 they were doing was both effective and worthwhile. This is underpinned by applying the
41 benchmark scores of the "Healthy Cities Barometer" as shown in Tab 11. Almost 75 percent
42 of HCN member municipalities (35 out of 47) demonstrate results in the survey that indicate
43 strong level performance (good to excellent), with approximately one third (12) of Healthy
44 Cities projects described as somewhat weak. With one exception these are medium towns
45 and small cities which joined the HCN after 1993, in some cases after 1998, and were
46 therefore assessed over a much shorter development period. Closer inspection of the results
47 in Table 11 and the details of member cities suggests however that the duration of
48 membership in HCN does not necessarily explain quality or performance; the ten founding
49 member cities from 1989 can be found in all three performance levels but mostly in the
50 satisfactory (B-Category); whilst two show ratings as excellent whereas another project's
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1 performance was particularly weak. It would seem that the size of a city (population) in
2 combination with the length of membership and the continuity of the local project
3 coordinator are critical factors in determining performance. Of the nine rated excellent, five
4 were in the highest population category, most had been members of the HCN since before
5 1992.
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8
9 TABLE 11 ABOUT HERE

10 11 Discussion

12 This paper offers insight into the diverse and complex nature of a Healthy Cities Network
13 (HCN) in northern Europe and important snapshot of current progress by the Healthy Cities
14 Programme in Germany. Besides a few exceptions (e. g. Boonekamp et al., 1999; Donchin et.
15 Al., 2006; Goepel, 2007), two thirds of all Healthy Cities in Europe have yet to undertake
16 some form of evaluation. As the findings suggest valuable insight can be gained from
17 surveying HC coordinators working in the field; illuminating details of day to day
18 implementation and issues, but particularly the tensions between policy and practice. This
19 was strengthened by the adoption of a total population sample, involving all HCC and the
20 successfully high response rate in the first ever survey of German Healthy Cities. In doing so
21 the German HCN continues its efforts to achieve progress towards the original goals (WHO,
22 2003b) *“to establish an alliance to increase the impact of health promotion ... by working more closely
23 within institutions active in this field, such as the Federal Centre for Health Education, the Federal
24 Association for Health, medical associations, public health organisations and environmental groups”*
25 (WHO, 2003b).
26
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29 All research has its limitations. Surveys are inherently limited by the use of predefined
30 concepts and structured questions but as was the case here can partly be overcome by
31 including open-ended questions. The subjectivity of individual perception and judgment is a
32 particularly contentious issue in health promotion research. Some claim that subjective
33 perception acts as a filter regarding reality (Berger & Luckmann, 1966; Rohrer, 2007). Others
34 argue that there is no single truth but multiple versions of reality co-exist in people's
35 narratives or stories (Brown et al., 2005) providing a rich and more complex understanding
36 of social phenomena. Hence, in interpreting these findings it is worth acknowledging that
37 several factors could influence respondent's perspectives. First, individual expectations of
38 quality and performance inevitably differ between coordinators; second, variations exist
39 between HCC in terms of creativity and personal engagement in a project; thirdly, structural
40 factors, like degree of autonomy, independence from external agencies or political alliances. .
41 Shortcomings apply to most research situations and the authors are confident that steps to
42 improve validity such as member checking, triangulation (e.g. multiple and alternate forms
43 of questionnaire items) for internal consistency and validity and respondent verification,
44 strengthen the generalisability of the findings.
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47

48 Since its foundation in 1989 and the survey in 2002, the German HCN steadily expanded
49 to include 52 member Cities. In June 2009, all 67 members in the network participated in the
50 20th anniversary celebrations of the German Healthy Cities Network. Whilst the basic
51 principles and approach of the Health Cities programme are clearly popular and well
52 implemented in Germany there is limited evidence of its effectiveness as a means of
53

1 promoting health. Nonetheless, the goals of health promotion are notoriously difficult to
2 evaluate and demonstrate. As Healthy Cities is more about a *process* and structures to
3 facilitate achievement of Health For All (Green & Tsouros, 2007) than about progress relating
4 to attainment of key process indicators, such as health. The study here attempts to do just
5 that by focusing on issues such as the association with the local political administration
6 situation (PAS) or policy leaders.
7
8

9 Most respondents were confident that work they undertook on behalf of Healthy Cities
10 was successful or worthwhile. They were fully aware of the concepts and principles of the
11 HCP and were cognisant of the various strategies available to them in adopting a settings
12 approach. Nonetheless, despite these strengths, the quality of experience of the HCN in
13 Germany varies; only three pairs of member cities shared exactly the same performance
14 profile, but cities differed in size, duration of membership, and their location (pre-
15 unification).
16

17 As the results indicated, the majority of participating HCP and coordinators identified
18 areas for improvement; more than 90 percent identified major structural and organisational
19 factors that undermined their performance, grouped across the following five areas:
20

- 21 1. inadequate programme resources;
- 22 2. inadequate understanding of the HC concept;
- 23 3. lack of commitment to the Nine-Point Programme of Action as a guide for
24 implementation and performance;
- 25 4. inadequate integration into the national Healthy Cities Network (HCN) and into the
26 local Political-Administrative System (PAS); and
- 27 5. Poor documentation and evaluation procedures.
28

29 Evidently, the profile, visibility and identity of local HCP offices is not always clear to
30 colleagues in local government or the public (citizens). Poor programme visibility and
31 market positioning is unlikely to engage communities or organisations locally or foster
32 public confidence in services offered. This problem is symptomatic of under-resourcing of
33 programmes.
34

35 This was also true of the 'range of activities' on offer by HCP. When local HCC were
36 unclear about the strategic goals and objectives of the HCP, or their association with the
37 broader concepts of the WHO Healthy Cities Programme, they were less likely to provide a
38 meaningful service to the local population. Moreover, although most HCP were good at
39 monitoring 'public relations' (numbers of events/numbers of people attending), they rarely
40 monitor effectiveness of strategies such as partnership working or collaboration. This confers
41 with the literature (Boonekamp et al., 1999, Winkler & Brandenburg, 2001, and Donchin et
42 al., 2006).
43

44 A major concern for HCN Germany is the extent to which local programmes are
45 integrated into local political-administrative system (PAS). At the time of the survey this was
46 described by most HCC as inadequate. As Green and Tsouros (2007) pointed out "*Cities are
47 engines of health development and not merely settings for health promotion*". Politics in relation to
48 Healthy Cities differ from the political mainstream; it represents an area of political
49 responsibility around health and attempts to tackle the dominance of conflicting political
50 interests. Twenty years of the Healthy Cities movement are clearly insufficient to
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1 significantly shift the political situation in Germany towards a broad health agenda.

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3 The impact of Healthy Cities could be much stronger on the local level if they succeed to
4 merge with other programmes such as "Local Agenda 21" and the Federal-State Programme
5 "Socially Integrative City", because these programmes are more widely disseminated and
6 better integrated into local policies. This might help broaden the traditional, biomedical
7 focus of health preventive activities towards environmental and quality of life issues, but as
8 Dooris (1999) previously argued key challenges around *how* we integrate such frameworks
9 and how to move them from the margins and into mainstream local policy making largely
10 remains unanswered.
11

12
13 On June 25, 2009 the German HCN celebrated its 20th anniversary in Frankfurt am Main,
14 where it was founded twenty years before. An expert panel expressed the wish to increase
15 the impact and political visibility of the network in future years. A vision supported by its
16 members. As announced in the welcome address, the German HCN needs to increase
17 intersectoral collaboration if it is to be integrated into the heart of local political
18 administrative systems (PAS) (2009b, *Gesunde Städte Nachrichten* 2/2009, p. 2). The
19 resounding message was clear: creating 'new alliances for more health and life' is the
20 strategic orientation for the German HCN in coming years. We are cautiously optimistic that
21 strategies exist to achieve improvement. For example, in 2007 the German HCN joined the
22 'Federal Union of Prevention and Health Promotion' and the national programme 'Health
23 promotion with socially disadvantaged groups' (*Gesundheitsförderung bei sozial*
24 *Benachteiligten*); in 2008 a cooperation with the TK health insurance company (Techniker
25 Krankenkasse) was launched focussing on community-oriented health promotion projects;
26 and in 2010 Berlin hosts a 2-day high-ranking workshop, entitled 'Prevention and Health
27 Promotion in Municipalities – where are the cities today?' to develop stronger collaboration
28 between the nationwide programme 'Socially Integrative City' and the German HCN. It is
29 important that HCN Germany initiates processes to monitor progress towards these
30 aspirations; replication of the current study could help monitor progress.
31

32 33 **Conclusion**

34 National networks of healthy cities are a powerful resource for health and sustainable
35 development in Europe. They provide an infrastructure for achieving the goals and
36 principles of Health for All and moreover, for implementing Health in All Policies locally.
37 The findings here add to and extend the findings produced from previous surveys of
38 national networks. They support the common structural and organisational features and
39 activities identified for successful Healthy Cities across Europe. Several cross-cutting criteria
40 have been identified for successful Healthy Cities operations: endorsing principles and
41 strategies, establishing infrastructure, making a commitment to products and outcomes, and
42 networking. But the most important aspect is in helping extend the Healthy Cities Concept
43 as an integrated template for local policies as a guiding strategy for effective healthy and
44 sustainable development of cities.
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48 Current international debates about "Domains of Core Competency for Building Global
49 Capacity in Health Promotion: The Galway Consensus Conference" (Barry et al., 2009) and
50 increasing body of programmes and activities focusing on setting-oriented health promotion
51 for socially disadvantaged populations in Germany, should be viewed as a welcome
52 opportunity for German HCN to professionalize and improve its performance particularly in
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1
2 current financial climates. Generating evidence – and appropriate tools – to demonstrate
3 whether Health Promotion works remains a key challenge for Healthy Cities.
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Evaluating the implementation of the WHO Healthy Cities Programme across Germany (1999 – 2002).

For Peer Review

Figure 1: The Healthy Cities Concept has four elements for action

A Explicit political commitment at the highest level to the principles and strategies of the Healthy Cities project	C Commitment to developing a shared vision for the city, with a health development plan and work on specific themes
B Establishment of new organisational structures to manage change	D Investment in formal and informal networking and cooperation

Source: WHO/EURO 1986

For Peer Review

Box 1: The “Nine-Point-Programme of Action” and concluded Minimum Standards (MS)*

- 1. Agree to join the Network by a council resolution**
(MS) In case of resignation from HCN the local HC coordinators (both local community and self help groups & citizens initiatives) have to be heard before decision making.
- 2. Found a healthy cities office locally**
(MS) The responsible local contact person fulfilled the tasks of the local coordinator.
- 3. Develop intersectoral health promotion policies**
(MS) Intersectoral structures are used, developed and strengthened.
- 4. Carry out health impact assessment**
(MS) The responsible local contact person will be informed early and complete about urban planning's, which affect health.
- 5. Involve communities**
(MS) The available opportunities of cooperation and participation on the part of community will be made transparent to the citizens and put in practice.
- 6. Report on health**
(MS) Health and social reporting have to be understood as local joint task from analysis over the opportunities of advice to concrete act.
- 7. Participate in network activities**
(MS) The local representative of and self help groups & citizen's initiatives (including self organised projects) have to be selected in transparent ballot. The expenses of participation at the annual general meeting have to be covered by the municipality.
- 8. Exchange information**
(MS) The members inform the HC secretary's office regular and extensive about their activities in order to guarantee a lively information flow within the network.
- 9. Report experiences and success to the Network every 4 years**
(MS) A report of experiences who reflects the insights of the local healthy cities work of the last four years is based on the “Nine-Point-Programme of Action” and its minimum standards and portrayed the results of the membership within the network.

Source: www.gesunde-staedte-netzwerk.hosting-kunde.de/dieidee/9-punkte-programm (own translation, KP)

*The entry criteria have been concluded on the general meeting in Greifswald, May 24./25,m 1993; point nine have been changed in Osnabruck at June 7, 2000, the minimum criteria have been concluded on the general meeting in Frankfurt at June 11, 1999. The minimum criteria additional to the “Nine-Point-Programme of Action” have been published as Osnabruck Recommendations of Quality Criteria in 2000.

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3 **Box 2: Example of type of qualitative indicator developed fro the Healthy Cities Barometer: (S1)**
4 **equipment quality (6 items)**
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9 **Box 2: Example of type of qualitative indicator developed fro the Healthy Cities Barometer: (S1)**
10 **equipment quality (6 items)**
11

12 The index to describe and show the equipment quality of the local Healthy Cities project is
13 constructed from six items of the questionnaire. The main indicators are the personnel, financial and
14 technical situation of local Healthy Cities offices (appointment of a coordinator, budget, own
15 telephone as minimum standard).
16

17
18 The total score varied between 0.5 and 2. The quality levels were assigned to *A-level* = >1.5, *B-level* >1.1
19 to ≤1.5 and *C-level* all scores <1.1.
20

21 In terms of content the three quality levels express:

22 *A-level*: the project coordination is a fulltime job. The office is equipped with working hours
23 representing at least one fulltime job and has sufficient office equipment. There is an own budget and
24 an own telephone number.
25

26 *B-level*: the project coordination has a fulltime worker or is a part time job, which is exercised as one
27 particular task of the job. The office has no fulltime job and less than three part time jobs. There is no
28 budget but material and financial means can be taken from other sources. The office has no own
29 telephone number.
30

31 *C-level*: the project coordination is only sporadically available, an office is not announced and financial
32 means are not available.
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34 An overall score per member municipality was formed by given points per indicator: 3 to *A-level*, 2 to
35 *B-level* and 1 to *C-level*; these points were added up to set a benchmark within the German HCN.
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Box 3: Survey Instrument – Question areas (Questions relating to...)	Corresponding items
(1) Equipment, stationary and human resources (staff)	4
(2) Accommodation & facilities available to the local Healthy Cities Projects	12
(3) Priorities, concepts and strategies employed by local Healthy Cities projects	25
(4) Questions relating to the Nine-Point Programme of Action adopted by the HC-Network in Germany (1993)	72
(5) Questions related to the Cologne Resolution »Equality of opportunity for a healthy life« and the Osnabruck »Recommendations of Quality Criteria« (2000)	5
(6) Healthy Cities Network and its development.	9

Box 4: Indicators / Criteria for Quality	Corresponding items	Quality Dimensions
S1 Equipment quality	6	Structure
S2 Self-commitment	2	
P1 Concept quality	8	Process
P2 Integration in the German HCN	4	
O1 Self assessed success	5	Outcome
O2 Integration within the local Political-Administrative-System (PAS)	5	

Box 5: Core areas of work undertaken by Healthy Cities Programmes within the German Healthy Cities Network (HCN) identified by HC Coordinators

(citations, numbers of respondents)

1. Child and Youth Health (34)	15. Healthy Ageing (19)
2. Thematic (Health) Action Days (33)	16. Settings (School, Company, etc.) (18)
3. Self help (31)	17. Neighbourhoods (18)
4. Health Conferences (28)	18. Smoking (18)
5. Citizen Participation (26)	19. Mobilisation/ Organisation non-health Departments (17)
6. Networking (25)	20. Poverty and Health (15)
7. Nutrition (25)	21. Women's Health (13)
8. Health Reporting (24)	22. Environment, Sustainability & Health (13)
9. Physical Activity (22)	23. Mobilisation/ Organisation - Institutions, Trade, Economy and Associations (12)
10. Social Disadvantage (22)	24. Traffic (11)
11. Alcohol /Drugs (22)	25. Housing and Health (5)
12. Citizen (community) Mobilisation/ Organisation (21)	26. Men's Health(3)
13. Urban Development / Social City (20)	27. Others (9)
14. Migrant Health (19)	

multiple response

Table 1

Tab. 1: Equipment, Visibility and Reachability of the Local Healthy Cities Offices

	Stationary	Postal Address	Office Rooms	Phone	Fax	e-mail	Homepage	Internet-Access
YES	17	12	15	23	19	14	7	14
NO	28	33	30	20	23	29	35	18

The differences to the total sample of 47 are missing.

Tab. 2: Budget & total Amount per Year

HC Office Budget

Total annual budget	Yes	Shared Budget	Cities
<2.500 €	5	11	16
2.500-5.000 €		4	4
>5.000 €	5	7	12

The differences to the total sample of 47 are missing

Tab. 3: Work plan, local concept, quality standards and common goals for the Healthy Cities work on the local level

	Work plan for the HC Office	Local concept or guidelines	Extended Quality Standards	Commonly agreed goals
YES	24	30	10	30
NO	21	15	34	17

The differences to the total sample of 47 are missing.

Tab. 4: Integration in the local PAS & Citizen Participation

	Informing other policy departments	Health Impact Assessment	Involvement of HC Project Coordinators	Invited to local policy meetings	Active Citizen Participation is realised
YES	42	13	6	25	43
NO	2	4	15	18	2
partly	–	29	24	–	–

The differences to the total sample of 47 are missing.

Tab. 5: Linkage between HCN & Member Cities

	regularly & comprehensive information flow to HCN	can attend all HCN events and meetings	take the opportunity whenever possible
YES	19	32	29
NO	24	3	13
partly	–	9	24

The differences to the total sample of 47 are missing.

Tab. 6: Exchange of Information between the Member Cities

	regularly	occasionally	if necessary	seldom	only on HCN meetings
Frequency of information about other network cities	14	14	20	1	2

Tab. 7: Advantages of German Healthy Cities Network for the work on the local level (ten-point-rating-scale)

	excellent (> 7)	fair (4 – 7)	weak (< 4)
Healthy Cities-Network	10	24	10
HCN Secretariat	11	21	12
HCN Symposium	18	17	9

The differences to the total sample of 47 are missing.

Tab. 8: Documentation & Evaluation of HC Work, Projects and Activities

	Documentation* (Progress reports)	Evaluation of local programme	Evaluation of local activities
YES	32	9	29
NO	11	36	15

*2 did it partly

Tab. 9: Mode of Evaluation

	Self Evaluation	only external	both
Evaluation of local programme in general	7	1	1
Evaluation of temporary local activities	19	5	5

The differences to the total sample of 47 are missing.

Tab. 10: Self-Assessment of achieved Success of HCP

self-assessed success	excellent (> 7)	fair (4 – 7)	weak (< 4)
on the local level	12	29	2
on the national level	4	34	1

The differences to the total sample of 47 are missing.

Tab. 11: Performance of Healthy Cities according to Quality Indicators (Scores of the 'Health Cities Barometer') and Number of Inhabitants

	XXL	XL	X	Σ
A	5	6	2	13
B	3	18	1	22
C	1	7	4	12
Σ	9	31	7	47

Number of Inhabitants: **XXL** = >500.000; **XL** = 100.000-500.000; **X** = <100.000.
Benchmarking scores: **A** = excellent; **B** = satisfactory; **C** = worthy of improvement