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Healthy Cities Evaluation: the co-ordinators perspective

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SUMMARY

The Healthy Cities Project is based on the development of healthy public policies by local governments. The study aim of some project teams in different countries has been to find out what processes are involved in the development of these policies, how decisions are made, and who and what they are influenced by. The Valencian Community Healthy Cities Network conducted an evaluation process, part of which is presented in this paper. The aim was to find out the concepts and opinions of the project co-ordinators concerning the opportunities and problems for healthy municipal policies, and to analyse the municipal organization with a view to detecting structural opportunities for interdepartmental work. Interviews were conducted with the people responsible for the project in 13 cities and the relevant documents analysed. When discussing their health concept and actions for health, few of the co-ordinators mentioned the ideas contained in the Ottawa Charter. The established health programmes were rather based on personal/individual changes and topic approach than setting-based strategies. The structural and strategic opportunities for interdepartmental work, as well as the active participation of the community in the healthy policies decision-making process need to be strengthened, as they are perceived to be insufficient. Personal relationships and political differences between the different actors appear to play an important role in the opportunities for the implementation of intersectoral policies.

Key words: health policies; health promotion; healthy cities; evaluation

INTRODUCTION

The Healthy Cities Project in the Valencian Community has been developed, as in many other places, based on the philosophy of the New Public Health and Health Promotion (WHO, 1986; Kickbush, 1989; Ashton, 1992). According to these principles, governments at any level have the responsibility to provide, through the public policies they establish, the basic conditions for citizens to live a healthy life (Reports on Sub-plenary sessions, 1987). The Project, now a movement, has undergone rapid growth, developing many practical experiences in the new way of working on health (Tsouros, 1995). Due to the complexity of the processes involved, and the amount and variety of key actors participating, its evaluation has been one of the most difficult aspects (Baum and Cooke, 1992; Ouellet *et al.*, 1994; Nuñez *et al.*, 1994; Curtice *et al.*, 1995). Considering that a healthy city is not only defined in terms of health outcomes but also in terms of health awareness and the establishment of health promotion strategies (Duhl, 1992), the evaluation should also encompass these processes.

Health policies are established to a great extent by politicians, but the environment in which they are created and the knowledge on which they are based are influenced by other actors. Local policies are, by far, those most open to influence by individuals and groups outside the strictly political circle. Knowing how they are made, who

influences them and how, is of essential importance for taking effective action to promote changes (Walt, 1994). In the specific case of Healthy Cities, there are people who we consider to be crucial with regard to the possibilities of influencing local health policies: the project co-ordinators in each city. These people, normally health professionals, are the people politicians rely on where health issues are concerned. By finding out more about them, we are able to understand the process the project has undergone and identify needs for its future development.

The Valencian Community Healthy Cities Network (VCHCN) was established in 1987 with two cities, and by 1995 its membership had expanded to 98. This rapid growth, which has always dwarfed the shortage of material and human resources needed for its co-ordination and technical support, has made it difficult to plan a suitable evaluation. From the first time an evaluative intervention was carried out (Nuñez *et al.*, 1994), the need was identified for a more continuous, dynamic and participative evaluation, oriented towards sharing the progress made with those in charge of the project and helping to solve the problems encountered. This new evaluation process included a range of different and complementary actions. This paper presents the results of the interviews with project co-ordinators in the most active cities of the Network. The objective of this part of the evaluation was to learn more about the concept of health held as a working framework by the people responsible for the development of the project: their opinions about the role of the municipality in establishing healthy public policies; the difficulties they perceived in putting them into practice; and the strategic and structural opportunities they saw for interdepartmental work.

METHODS

The selection of the cities included in the study in each case was based on the voluntary decision of the people politically responsible for the project. After offering the possibility of participating to all 98 cities involved in the regional network, the 13 cities who applied within the application period were included. All are especially active in the project, both on a local level (completion of a study on health needs, availability of project staff, establishment of commissions and development of health programmes), and on network activities (organization of meetings or congresses, and participation in working groups).

Semi-structured interviews were carried out with the technical co-ordinators of each of the cities.

Interviewees were asked to provide up-to-date information about local government structure (different areas or departments and the formal relationships between them).

Interviews

The interviews were conducted by a researcher assisted by a colleague who observed and took notes.

The issues included in the interviews and the criteria used to analyse them were as follows.

(1) The health concept. To analyse the respondents' concept of health, we used the WHO definition (physical, mental and social well-being, and not just the absence of disease) and the Ottawa Charter (which includes aspects of empowerment and autonomy of people and social aspects). Two response categories were defined:
   (i) only the WHO definition was mentioned;
   (ii) the ideas of autonomy and empowerment were included with or without the WHO definition.

(2) The perception of the role of the local government to promote the citizens' health and possible ways of doing so. Interviewees' responses were analysed from two different angles:
   (i) according to the principles of the Ottawa Charter (1986):
      • building healthy public policies;
      • strengthening community action;
      • developing personal skills;
      • creating supportive environments; and
      • reorienting health services.
   (ii) from the point of view of their specific objectives:
      • to educate;
      • to allow the community to participate;
      • to empower the community;
      • to develop policy; and/or
      • to solve specific problems.

(3) The role of the community in municipal policies related to health. I.e. does the community contribute by proposing ideas for possible healthy municipal policies?, what channels are available for transmitting these

ideas (if any special procedure exists?), what is the response of the local government to these ideas?, and does the community have any say in municipal policy decision making, and/or collaborate in their elaboration?

(4) Strategic opportunities and difficulties for interdepartmental collaboration between the different local government departments. The following aspects were considered in order to analyse these points.

   (i) The existence of a strategic framework to develop healthy public policies (a health plan or development plan which includes health issues, health policies and/or projects).

   (ii) The kind of strategy used to address health problems. Interviewees were asked about what actions the local government takes to solve health problems. First they answered freely about any health-related problem in their municipality, and secondly they were asked about three specific issues (refuse, unemployment and immigration). The intention was to use them as tracers in order to compare different approaches in the different cities. They were selected for their importance and prevalence as existing or emerging problems in the Valencian Community.

   (iii) The existence of formal collaboration between departments for taking part in the development of plans, projects or policies, and if this was considered as sufficient collaboration to prepare and implement them.

Difficulties and constraints

The question of how interdepartmental collaboration is influenced by the nature of relationships between council departments, reasons for collaborating or lack of, and what could be done to encourage/consolidate collaboration was asked.

Analysis

Analysis of the interviews was carried out by the two researchers who interviewed the co-ordinators. They read the notes they had taken first individually and then jointly to extract the relevant information with regard to the study aims mentioned above. First, the issues were identified, and subsequently, tables were devised to obtain an overview of the replies of all the interviewees.

Document analysis

In order to study the structural opportunities for interdepartmental collaboration, the organizational structure of the local governments was analysed by looking at the different existing sectors, their organization and the existence of formal relations (commissions, areas, plans).

RESULTS

In 11 cases the interviewee's profile was the co-ordinator of the healthy cities project in the city, in one case the health councillor, and in one case the co-ordinator and the councillor were interviewed together. All respondents worked in the local health sector and were experienced in working on the Healthy Cities Project.

Most reproduced the WHO health definition when asked about their concept of health, and some referred to autonomy and empowerment in their responses.

The actions they think the Town Hall can undertake in order to improve the health of the citizens are mainly related to the development of personal skills in the population for promoting their own healthy lifestyles. Some also included creating or maintaining a supportive environment and encouraging community participation in municipal decision making. No reference was made to reorienting health services.

In relation to the specific objectives, most of the answers included population information, and educational or problem-solving actions regarding the environment or pollution. Several interviewees mentioned actions to facilitate community participation, empowerment and policy development.

It was observed that those interviewees who included aspects, e.g. autonomy and empowerment in their definition of health, also included aspects, e.g. empowerment and community participation in their opinion about the actions the Town Hall should take to improve the health of citizens in both categories.

The Town Hall has the means to protect and improve the health of the population … One action could be to improve the personal skills of the citizens in order for them to demand what they are entitled to. Furthermore, the Town Hall can develop policies for the

different sectors, following the strategies recommended in the Ottawa Charter.

With regard to community participation, the majority of cases report that formal and/or informal channels exist, and that the community uses them for contributing ideas. Their contributions are taken into account and discussed in the Town Hall, but generally the community does not intervene in policy making.

Strategic opportunities

According to the interviewees, the majority of the municipal governments conduct interdepartmental plans or programmes among the different council departments. Most consider this collaboration to be sufficient for addressing the problems. Some cities stated that health aspects are included in other types of plans, although the health department does not always formally participate in the development commissions. As a result, it is difficult for them to be heard and to monitor their impact on the health of the population.

The more important health problems mentioned by the interviewees, which are reflected in the health diagnoses of their municipalities, are those concerning young people's lifestyles, and in particular risk behaviours (alcohol and drug abuse, accidents, sexually transmitted diseases). Likewise, problems were mentioned related to the environment, with noise and water pollution or the environment and housing standing out. All of them mentioned unemployment as a key problem concerning health.

With regard to the policies established to deal with these problems, several examples were given, including: the organization of training programmes for the 'consumer', the building of water treatment plants, and pressure put on contaminating industries to look for solutions to avoid polluting the environment. With regard to problems, e.g. noise caused by the airport, they are of the opinion that these are difficult to resolve from the local perspective. As for housing, one case described a plan of phasing out poor housing or financial aid for rent.

Among the 'tracer problems', unemployment was identified as the common denominator with actions against it in practically all the cities. This issue has been addressed in the following ways:

(i)   training for the unemployed;
(ii) aid through social services;

(iii) business development (actions between the local government and business people).

With regard to refuse, they consider that much is being done or has already been done at a municipal level and that in general the infrastructure is good. One of the respondents said that 'now we need to change the public's behaviour' in the sense of being more aware of environment protection.

Immigration did not seem to be a problem in any town. However, gypsies, as an ethnic minority, at times find it difficult to integrate, e.g. in terms of schooling.

Considering key problems which impact on the health of the city's population, in relation to questions about to what extent policies take them into account and what projects are being carried out to address these problems, an idea can be formed of the importance of the health of the population on current policies. Those in charge of health collaborate in some of these policies or actions, but in the majority of cases, collaboration is lacking between the different council departments where solution seeking and addressing the problems is concerned. In short, the respondents indicated that half the Town Halls have the population's health on their agenda when it comes to municipal policy making, the other half does not, or the position is not clear.

Difficulties and constraints

The largest obstacles detected with regard to interdepartmental collaboration in the establishment of policies which address the problems mentioned take the form of personal and political differences, which, even when formal working relations exist, cause problems for joint collaboration. Among the solutions mentioned are the improvement in communication and training for those involved, as well as better management and teamwork skills in politicians and professionals.

Structural opportunities

An overall organization chart of 11 of the municipalities involved in the study was obtained. Table 1 shows that the number of councillors and departments, structures and organization of the local governments differ greatly. Health responsibilities are always combined with other sectors within the structure of the Town Hall, usually with social welfare, consumer affairs, social

Table 1: Structural opportunities for interdepartmental work: organizational structure of municipal governments

City	Council departments	Councillors	Health shares department with:
A	5	Mayor + 4	Consumer affairs, social welfare, education, youth, sport
B	10	Mayor + 9	Elderly
C	16	25	Social welfare
D		4 area managers, 1 delegate councillor and the mayor	Education, culture, sports, social services information/communication, local development (Area of Personal Services)
E			Social services, consumer affairs and food markets, employment and development (Social and Economic Promotion Area)
F	3 commissions	11	(i) Consumer affairs and food markets (in the council department) (ii) Social services, culture, youth, education, consumer affairs, food markets, women, sports (Social Welfare Commission)
G		Mayor + 10	Consumer affairs (Area of Public Health)
H		7 deputy mayors	Social services and food markets
I			
J		12	Environment
K		9	Social services, consumer affairs
L			
M	14	10	Women (Council Dept) Social services (Informative Commission)

services, etc. (the elderly, women, …). On one occasion it is linked to the environment or employment, but in none of the cases is it linked to sectors, e.g. town planning or agriculture. Logically, the small size of the city influences the structural possibilities of collaboration, by having to share the same manager with other departments or areas.

DISCUSSION

Healthy Cities Project and its co-ordinators

Probably the most important result of our study was the confirmation of the heterogeneric nature of the Healthy Cities Project, whereby each city conducts the project's development according to its characteristics. The conditions in which the projects are developed are unique and heterogeneous with no two alike, and this is not only because the needs and health problems in each city are different or the economic resources available vary from one city to another. Despite this being true, in the establishment of health policies these factors are of equal importance as the above existing opportunities to influence them: i.e. the persons who can inform the process and the structures and organization of the sectors

(Walt, 1994). In our study, we have observed that these aspects are the most heterogeneous of all.

The project co-ordinators interviewed identify themselves with a health concept broader than the biomedical concept which includes at least the social aspects of the health–illness process. However, only in a few cases do they refer to the need to promote the autonomy of people to control their health. When referring to the possible actions that the municipality could perform to promote the citizens' health, its capacity to consider aspects beyond the health sector and the traditional concept of health actions is appreciated. Since all the interviewees were health professionals, these replies would be surprising if we did not take two aspects into consideration. Firstly, as those responsible for the project, they have undergone continuous training in health promotion. Secondly, in Spain, the local government are not responsible for health care services (hospitals and primary health care), but are in charge of public health, thereby facilitating the orientation of these professionals and accounting for the fact that they do not include health services reorientation actions in their responses.

For the future of the project, it is interesting to consider the need for more training of and discussion with the key actors (professionals and politicians) to further develop those health

promotion aspects related to change in the context and community participation, instead of those related to the development of individual skills, apparently still considered the principal focus for action in the municipalities. Instead, it is important to develop personal skills for the population to be autonomous and have control of their own health and life. It is clear that to solve problems, e.g. unemployment or pollution, to name just two examples, structural actions are needed, thinking more in terms of the setting's opportunities rather than a topic approach (Álvarez-Dardet, 1993).

Local government structure

The health departments of local governments are usually included in areas that also involve other aspects of welfare policies. Although this has its logic and offers a series of interesting opportunities to work jointly in these issues, it also complicates work with other areas, e.g. agriculture, tourism, employment and town planning. There is no tradition of collaboration with these areas for health gains, although it is considered that common health objectives can and should be established (Colomer *et al.*, 1996). The same applies to the immediate structural opportunities for interdepartmental collaboration, i.e. possibilities for sharing resources, which include the classical resources (social services, programmes for specific need population groups). Therefore, special effort is necessary to establish forums of collaboration with other more technical sectors with greater power.

According to the protocol of the Healthy Cities Project in our Network, every city wishing to become part of the Network must perform a situation and health needs analysis that serves as a base for the development of a Health Plan (Nuñez *et al.*, 1994). This plan, which must be intersectoral, creates the strategic opportunities for the participation of the different departments or areas of the local government that have to jointly negotiate and decide the actions to implement. This forum must serve to reinforce the strategies for collaboration through the leadership of the mayor, economic and/or political incentives, or share the same point of view and interest in the citizens' well-being (Milio, 1986; Delaney, 1994).

Unfortunately, the elaboration of a City Health Plan is no easy task, and not all the cities achieve their aims. Obviously this is one of the weak points which needs to be worked on by reinforcing the role, knowledge and abilities of the project co-ordinators to enable them to facilitate, negotiate and market the process (Baum and Cooke, 1992). On one hand, the support of the person politically responsible for the project (preferably the mayor whose role spans the various departments) is necessary and important to establish the framework and strategies for collaboration. On the other hand, the project co-ordinators can play a key role as internal change agents and agenda setters based on their more stable position (they are less affected by political changes) and their technical knowledge, allowing them to influence the decision-making process. It must also be taken into account that, often, collaboration evolves or is inhibited by personal and/or political similarities or differences, and that these factors can be reduced through communication and negotiation.

Community participation

It seems that the most deficient aspect in the development of the project is that of community participation in the municipal health policies. According to the interviewees, channels have been established for the community to transmit their ideas to the government, which is a first important step that did not exist some years ago (Nuñez *et al.*, 1994), but there is still no participation in decision making, which means that the professionals and the politicians are still in control (Rifkin *et al.*, 1988). This has a negative influence on the development of health policies in the short term because citizens find it harder to feel involved, and consequently their success is harder to achieve. But it also has long-term consequences, as we have noticed in our Network, because the policies have no roots in the community, and the mechanisms of their control and defence by the population are lacking, which makes them too vulnerable to political changes. Healthy public policies, when effective, imply a threat to some established interests and existing powerful groups (Ashton, 1992), and the balance between consensus and conflict in which the project moves (Delaney, 1994) should not only be based on political goodwill and commitment of the 'governors' of the moment, but also on the community's involvement. Community participation has been identified as one of the priority needs for a solution to improve the project in our setting, and therefore it will first of all be

necessary to modify the negative attitudes and the reticence to sharing information and responsibilities which occurs only too often in our society.

About the methods

Our study has the typical limitations of a study of this kind, in that it is a description of the opinions and perceptions of some of the project co-ordinators of our Network. It was not our intention to draw conclusions about the Network as a whole, or to generalize our results to other cities, but to become more familiar with the inner workings of some of our cases. That is why the fact that the cities studied are those most active in the Network did not influence the validity of the study; on the contrary, it has enriched both the results and the cities, which is the ultimate goal of the evaluation: to work on this improvement. To achieve this, the results of the study were discussed with those involved and the intention was to continue offering the evaluation process in subsequent phases to other cities of the Network so they too may benefit. The difficulties suffered by the continuity of the project over the past months have impeded this from happening.

The fact that we only collected information from the project co-ordinator has the limitation that we only have access to part of the story, which is, moreover, the perspective of one of the people involved. Despite being aware of this, we decided to go ahead, considering that, from all those involved in the process (politicians, health professionals and the community), they are the ones who have more information about the project as a whole and greater possibilities for introducing changes. On the other hand, as already mentioned, they have the capacity to influence the politicians and to work with community groups, acting as facilitators of the process and bridging the gaps between the key actors. Furthermore, although they are involved in the development of the project, they have a critical capacity and much more freedom to express themselves than politicians.

Semi-structured interviews are a suitable method for gathering knowledge about the functioning of processes (Patton, 1990). This had already been used in other Healthy Cities evaluation experiences (Baum and Cooke, 1992; Nuñez *et al.*, 1994; Ouellet *et al.*, 1994) and was therefore considered the best way to gain more in-depth knowledge of the issues that made up

our study aims. If community participation had been greater, we would have been able to use the methodology proposed by Rifkin (Bjäras *et al.*, 1991). However, in the given situation with little community involvement, the study had to be limited to general aspects.

Despite the limitations mentioned above, we consider this study a valuable contribution to a better understanding of local policy decision-making processes, especially where health issues are concerned. It describes one part of the evaluation process which, with other activities already put into practice, completes the municipal government's point of view. What still needs to be developed is the evaluation by the community, which given its current level of development would be aimed more at setting future strategies than describing the existing ones.

We consider it necessary to develop and publish research in these fields where little empirical knowledge is available. We have found it very useful to be able to share our concerns with other researchers in the joint development of concepts and methods (Curtice *et al.*, 1995). We are confident that these networks will continue to function and allow us all to progress in this field.

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