The Secretary
Environment and Planning References Committee
Legislative Council
Parliament House
Spring Street
Melbourne VIC 3002

Drumcondra, 6 June 2011

Dear members of the Environment and Planning References Committee,

I am delighted that an opportunity has arisen for you to review the evidence and experience that the international Healthy Cities initiative may provide to further improve the contribution of environmental design to prevention and public health in our State. I feel I am in a unique position to (re)present such evidence and experience[*].

For your information I am attaching two of my contributions to the literature around Healthy Cities. One (2001, in *Global Change and Human Health*) outlines history, scope and development of the remits of the programme, and would demonstrate my conviction that it is unconditionally applicable to any (urban) planning environment. I should observe here that, although its catch phrase alludes to Healthy *Cities* the approach has been demonstrated to be viable and effective in virtually any community that is engaged with social and environmental determinants of health: the smallest 'Healthy City' in the world is the thriving l'Isle Aux Grues (island of geese) in the mouth of the St. Lawrence River (Quebec, Canada) with a population of 250. The largest, by the way, is Shanghai.

The Evidence:

- *Environments impact on health significantly*
- *'Healthy Cities' present approaches to dealing with that evidence*

So what?

- *Concerted action is required by all stakeholders*
- *Victoria would be in an excellent position to make this happen*

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[*] I have been involved with initiatives of the World Health Organization at the nexus of urban planning and health promotion since 1986. Some of this experience culminated in me setting up, and being the foundation director, of a World Health Organization Collaborating Centre for Research on Healthy Cities which existed between 1992 and 2002, hosted first by Maastricht University (The Netherlands) and then by the University of Southern Denmark. With my transfer from Europe to Australia (and thus a move between the European – EURO – and Western Pacific Region –WPRO – of WHO) the Centre became dormant. I have continued to be a senior evaluation advisor to WHO/EURO Healthy Cities; I am a founding member of the Australian Chapter of the Asia-Pacific Alliance for Healthy Cities; I work with WHO/WPRO in its efforts to upscale Healthy Cities in the region, and in particular in China; and was one of three delegates from Australia selected to attend the joint HABITAT/WHO Global Forum on Urbanization and Health. I teach 'Healthy Cities' to postgraduate students and executive professionals in a range of formats, and publish regularly on the topic.

The other piece (2005, in *Social Science and Medicine*) contemplates an issue that the members of your Committee will be struggling with: despite the overwhelming evidence that the holistic, comprehensive, community-driven, fair and equitable Healthy Cities programmes work effectively, their operations are continuously challenged by competing agendas of communities, politicians, bureaucrats, academics, developers, and many others. We found that most evidence is rarely generated with direct utility in mind, and therefore will not readily be taken up by politicians and practitioners. Perhaps your inquiry does present an opportunity to weigh the evidence more wisely and move forward on such an important agenda.

Because one thing is abundantly clear: the shape and quality of our environments does impact directly on human and ecosystem health and well-being. It is tempting to be encyclopedic, but I would like to refer you to two sources that would clarify this position more than anything I have written myself. First, Howard Frumkin (most notably in *Urban Sprawl and Public Health*, Public Health Reports 2002) shows consistently how the uncontrolled sprawl of suburbia, without appropriate services, infrastructure, resources and social and economic opportunities, impacts severely on quality of life of suburban dwellers. Car dependency, food insecurity and detrimental levels of social capital are just a few of the 'scourges' of sprawl that impact heavily on population health. The resulting unacceptable and avoidable inequities in health have been documented across the world, including in OECD countries and Australia, in the 2010 *Hidden Cities* report. There is no reason why a state such as Victoria, with its sound economy, wealth of intellectual ability, and reasonably transparent governance systems, would not be able to create (urban) environments that would in fact be *promoting* health.

How this in fact could be achieved has been documented, second, by Hugh Barton and colleagues (for instance in their books *Shaping Neighborhoods*, 2010, and *Healthy Urban Planning*, 2003) and Jason Corburn in *Toward the healthy city: people, places, and the politics of urban planning*, 2009. The message is consistently that people and stakeholders (communities but also financiers; activists but also developers; politicians but also engineers) need to be involved from the very start not just in 'ivory tower' planning exercises but in real, tangible processes that could be guided by principles of social networking, health and social impact assessment, and community development.

Above I have already stated that it is tempting to be encyclopedic. However, elaborate written submissions may in fact cloud the urgency of these issues. I would therefore more than pleased to give further evidence in a public hearing before your Committee.

Yours sincerely,

Global and local *(glocal)* health: the WHO healthy cities programme

Urban health is likely to be one of the momentous challenges of the twenty-first century. Ever increasing numbers of people move to urban environments; the failure to adequately link urban planning to public health is described in this paper, and the WHO Healthy Cities Programme initiated in 1986 is presented as a vehicle to redress that problem. This article describes the foundations, scope and purpose of the Healthy Cities Programme with currently more than four thousand participating towns, communities and cities. Healthy Cities are put in a context of other global agency's agendas. Evaluation efforts in Healthy Cities are described for which a proper inquiry perspective is provided. The Healthy City notion is defined and operationalised and an overview is given of various evaluation enterprises. The paper is concluded with a description of the MARI Framework (Monitoring, Accountability, Reporting and Impact Assessment) currently operational in the European Region of WHO.

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Urbanization and health

Never before the people of our planet have moved to live in cities at the rate we are witnessing in the early years of the third millennium. Half the world's population is already urbanized, and estimates are that at least 60% of the world population will live in large conurbations by 2030. More people are going to live in cities, even more will live in *mega-cities*. Taking the size of a mega-city to be at least ten million population, nearly three hundred million people will be living in twenty such cities by the year 2015 (APEC, 2000; table 1).

Though the relationship between urbanisation and health seems apparent, no unequivocal empirically validated theories are explaining causal or final correlates between 'urbanisation' and 'health'. In 'focussed' fields (e.g. environmental health, infectious disease public health, and increasingly lifestyle-related behavioural health) there is a considerable body of knowledge, but theories covering the complex relationship between the concepts that both at best can be defined as 'fuzzy' are yet only in the early stages of development. In a related field, Clark (1999) concluded a review of the literature with the statement that '*The challenge for analysts is to develop a comprehensive understanding of urban development and change so as to enable governments to act to secure a sustainable urban future.*' Naturally, health and sustainability have long been regarded as two sides of the same coin, and we are thus to create fuller understanding of the relationship between urban development, (social) change, and health as well, and its consequences for policy and intervention development.

Two works that should be considered attempts to do exactly that are noted here. Aicher (1998) has pulled together what he calls the 'stressors' and 'supporters' of health in designing health-enhancing (or 'healthy') cities. He thus compiled an impressive list of hundreds of determinants of urban health which urban developers have to take into account (categorised into physical, biochemical, socio-economic, and psychological stressors and supporters, combined with economic considerations in urban health planning). He is also one of very

Table 1 The World's biggest cities, 1999 and 2015 estimates in millions. City sizes on basis of urban agglomeration, not administrative boundaries (APEC, 2000)

City; country	Population 1999	% increase expected	City; country	Predicted population 2015
Tokyo, Japan	26.3	2.6	Tokyo, Japan	26.4
Mexico City, Mexico	17.9	15.8	Mumbai, India	26.1
Mumbai, India	17.5	72.7	Lagos, Nigeria	23.2
Sao Paolo, Brazil	17.5	23.4	Dhaka, Bangla Desh	21.2
New York, USA	16.5	6.7	Sao olo, Brazil	20.4
Los Angeles, USA	13	13.5	Mexico City, Mexico	19.2
Shanghai, China	12.9	11.2	Karachi, Pakistan	19.2
Lagos, Nigeria	12.8	125.3	New York, USA	17.4
Calcutta, India	12.7	12.7	Jakarta, Indonesia	17.3
Buenos Aires, Argentina	12.4	18.6	Calcutta, India	17.3
Dhaka, Bangla Desh	11.7	124.3	Delhi, India	16.8
Karachi, Pakistan	11.4	97.4	Metro Manila, Philippines	14.8
Delhi, India	11.3	69	Shanghai, China	14.6
Osaka, Japan	11	- 0.3	Los Angeles, USA	14.1
Beijing, China	10.8	35.2	Buenos Aires, Argentina	14.1
Jakarta, Indonesia	10.6	88.4	Cairo, Egypt	13.8
Metro Manila, Philippines	10.6	59.4	Istanbul, Turkey	12.5
Rio de Janeiro, Brazil	10.5	16.9	Beijing, China	12.3
Cairo, Egypt	10.3	44.3	Rio de Janeiro, Brazil	11.9
Seoul, South Korea	9.9	3.2	Osaka, Japan	11

few authors that stresses the aesthetic component of urban life. An overarching notion for 'healthy urban planning', however, does not emerge from his work. Schell & Ulijaszek (1999) have compiled a body of knowledge on urban health that stretches over seven thousand years and from infectious disease, poverty, chronic disease to nutrition issues in city contexts. The contributors to their book largely single out *disease* patterns in the urban context and as a consequence seem to favour singular interventions rather than packages of integrated approaches. The *poverty and urban health* section in this book (Dowler, 1999, Johnston & Gordon-Larsen, 1999, Czerwinski, 1999) deals mainly with pattern description rather than with a review of successful intervention studies (if any) to combat the enormous burden of urban poverty on public health. Barton and Tsourou (2000) attempt to apply an urban planner's perspective to the complex interrelations between health, its determinants, and urban living. The synonyms for urban planning as compiled by the European Commission (1994) they agree upon using for their book, however already describe the schism between the urban planning profession and the public health community: *spatial planning,*

land-use planning, town and country planning, physical planning, territorial planning and *space management systems.* None of those terms would be familiar to public health professionals, nor would probably the notion of *'determinants of health'* have a profound meaning in the urban planning commons.

Connecting public health to urban studies and urban planning seems therefore an urgent task. Two approaches to that task are presented here. Based on the extended metabolism model of human settlements by Newman and Kenworthy (1999) used by APEC in its *'Healthy Futures for APEC Megacities'* project a conceptual framework as presented in figure 1 has been developed. The figure describes the various components necessary for urban health; arrows between components would indicate the areas of possible intervention.

These elements of the framework are concordant with the recent policies proposed by the United Nations Centre for Human Settlements UNCHS (Habitat) in its good urban governance framework (UNCHS, 2000). In its *'Inclusive City'* Declaration UNCHS sets forth the norms for governance:

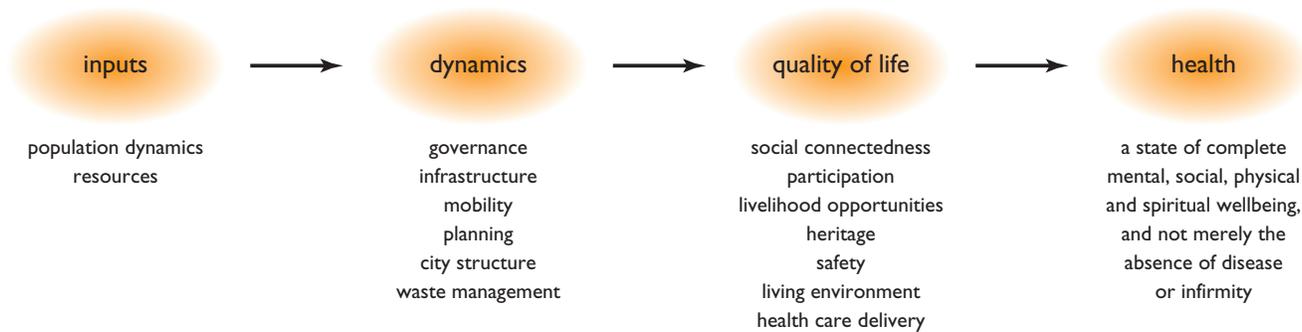| inputs	→	dynamics	→	quality of life	→	health
population dynamics resources		governance infrastructure mobility planning city structure waste management		social connectedness participation livelihood opportunities heritage safety living environment health care delivery		a state of complete mental, social, physical and spiritual wellbeing, and not merely the absence of disease or infirmity

Figure 1

"Urban governance is the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action can be taken. It includes formal institutions as well as informal arrangements and the social capital of citizens;

Urban governance is inextricably linked to the welfare of the citizenry. Good urban governance must enable women and men to access the benefits of urban citizenship. Good urban governance, based on the principle of urban citizenship, affirms that no man, woman or child can be denied access to the necessities of urban life, including adequate shelter, security of tenure, safe water, sanitation, a clean environment, health, education and nutrition, employment and public safety and mobility. Through good urban governance, citizens are provided with the platform which will allow them to use their talents to the full to improve their social and economic conditions."

(UNCHS, 200, p. 5)

It is remarkable to confront the objective of the *'Inclusive City'* as '*citizens allowed to use their talents to the full to improve their social and economic conditions'* with the central tenet of the policy programme of the World Health Organisation originally launched as *Health for All by the Year 2000*, and recently re-endorsed as *Health 21*: '*The main social target of governments and World Health Organisation should be the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life'* (World Health Assembly, 1977). Possibly such a phrasing of objectives is clouded by *'UN-speak'*, i.e. a type of jargon prevalent in circles of the United Nations and its technical agencies, but one thing is clear: urban governance as well as global public health aim at the improvement of the human condition. Yet, whereas health is considered by UNCHS as only one of the contributing factors to that objective, WHO regards health as the prime condition, determined by a range of other factors, for an economically and socially productive humanity. The current WHO policies for Healthy Cities join those positions.

WHO policy
The acceptance by European member states of the World Health Organization in 1981 of 38 targets for *Health for All* marked a shift in European health policy development. One of the action programmes that subsequently developed aimed at the establishment of an innovative health promotion perspective, stepping away from only behaviour change for health towards more structural and policy-oriented approaches for the promotion of health. The innovation first culminated in *The Ottawa Charter for Health Promotion* (WHO & Health Canada, 1986, De Leeuw, 1989a) and eventually led to the *Jakarta Declaration on Health Promotion* (WHO, 1997).

The WHO perspective on health promotion has its foundation in the recognition of the fact that the creation of health is a multi-causal phenomenon for which, among other things, intersectoral collaboration, community action and political support are required (WHO Healthy Cities Project, 1988a).

Both the *Charter* and the *Declaration* consist of visionary statements regarding the development of health promotion. To the World Health Organization, and the participants in its *International Health Promotion Conferences*, the promotion of health goes beyond mere behaviour modification. Following the logo of the first conference (where the *Ottawa Charter* was accepted) in figure 2 health promotion should start with enabling, mediating and advocating strategies towards an overall, integrative and intersectoral health perspective. Action areas would include the reorientation of health services to include health promotion, the creation of supportive physical and social environments for health, and finds

healthy public policy

community action
personal skils

enable
mediate
advocate

create supportive
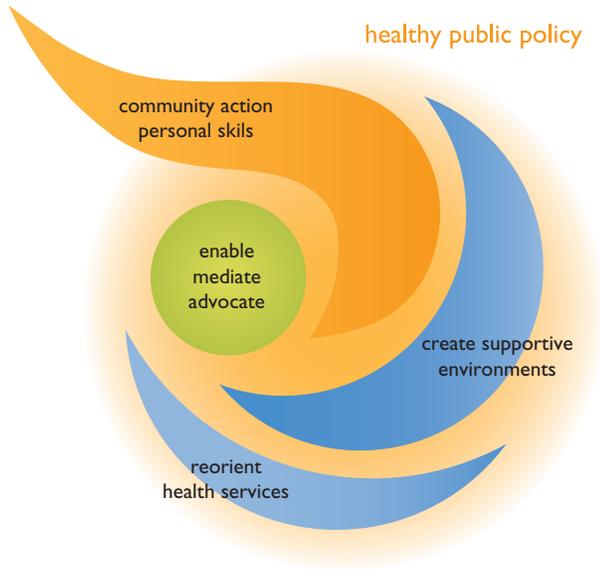environments

reorient
health services

Figure 2

its foundation in community action and personal skills for health. The development of healthy public policy (policies taking into account health consequences of programmes in each public sector, De Leeuw, 1989b) is an inextricable part of health promotion endeavours.

In order to demonstrate that such visionary statements could be implemented in real-life situations, the WHO Regional Office for Europe decided to initiate an urban health promotion programme in 1986 (Hancock & Duhl, 1988, Kaasjager, Van der Maesen & Nijhuis, 1989, WHO Healthy Cities Project, 1988a, 1988b). The Toronto Healthy City programme already operational since the early 1980s inspired the WHO choice for urban contexts. This was based on a seminal work edited by Duhl (1963). Duhl and his colleagues compared the urban environment to a living organism which could be healthy in itself, and therefore healthful for its citizens.

WHO had hoped that a handful of European cities would want to volunteer in its pilot urban health promotion programme, embarking on an adventure of innovation in health development. No-one could really predict or guarantee the outcomes of that process. Much to WHO's surprise, more than a handful of cities at the first European conference (Lisbon, 1986) did volunteer. Some thirty cities wished to commit themselves to the ambitious goals set. This was more than the WHO infrastructure could initially cope with, and a process of designation for European Healthy Cities was set up, as well as a series of more concrete guidelines such Healthy Cities would have to strive for. The main theme of the Healthy Cities Project within WHO became '... to put health high

on social and political agendas' (Tsouros, 1994), not just in officially designated cities, but through a commitment by these cities to the establishment of national networks also in other European cities.

By World Health Day 1996 (8 April), some 3000 cities worldwide had in some way or another joined the international Healthy Cities Network. By the year 2000, we have counted a little more than 4000 cities (figure 3). Kenzer (1999) gives a rather superficial overview of the existing literature on those cities, providing the reader, though, with a very inspiring range of examples of urban health activities in a global perspective.

Only the European Region of the World Health Organization maintained rigorous entry requirements into its Healthy City Network. For the first (1996-1992), second (1993-1998) and third phase (1998-2002) of the Healthy City programme cities had to demonstrate political commitment to Health for All and the Healthy City vision, appropriate resource allocations to secure a full-time project coordinator and support staff in a Healthy City Office, and commitment to specific objectives leading to the establishment of local health policies. In the first phase, among the most important of such objectives was the establishment of an urban health profile. In the second phase, designated cities were supposed to be working on the creation of City Health Plans, and the third phase committed Healthy Cities to the production of a City Health Development Plan and a process of more rigorous internal and external monitoring and evaluation.

For designated European Healthy Cities, the policy development evolution would take them from the production of Health Profiles into the development of City Health Plans, and ultimately City Health Development Plans. A City Health Plan is a policy document including the Health Profile identifying health challenges, their deter-

Figure 3

minants, and roles various actors should play in targeting those challenges. A City Health Development Plan takes the process a step further; it identifies strategic development issues, incorporating also urban planning, sustainable development and equity concerns on a long-term basis.

'The' Healthy City does not exist. First of all, each city is unique in its historical and social development. But more importantly, the context in which cities move towards Healthy City status is markedly different in each of those 3000 cities worldwide. The group of designated European Healthy Cities is the core of 25 European networks (including some 1500 cities) that each

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The qualities of a healthy city
a city should strive to provide

1   a clean, safe physical environment of high quality
    (including housing quality)

2   an ecosystem that is stable now and sustainable
    in the long term

3   a strong, mutually supportive and non-exploitive community

4   a high degree of participation and control by the public
    over decisions affecting their lives

5   the meeting of basic needs
    (food, water, shelter, income, safety and work) to all people

6   access to a wide variety of experiences and resources,
    for a wide variety of interaction

7   a diverse, vital and innovative city economy

8   the encouragement of connectedness with the past,
    and heritage of citydwellers & others

9   a form that is compatible with the past,
    and enhances the preceding, charecteristics

10 an optimum level of appropriate public health
    and sick care services accessible to all

11 high health status
    (high levels of positive health and low levels of disease)

Figure 4

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may work under their own organizational and ideological prerequisites (Tsouros & Krampac, 1997). In other WHO regions and countries there may be Healthy City networks as well, providing mutual support and information, but under less rigorous conditions. And then there are isolated but enthusiastic endeavours by individual city administrations that lack a formal superstructure guiding their work (Krenzer, 1999, Werna et al., 1998). It should be noted that some of these cities, like Curitiba in Brazil which regards itself an *'Ecological City,'* could be counted among almost proverbial 'Healthy Cities' in which all the core values and strategies of the WHO project are operational, without even having joined the WHO endeavour. Some have noted this as a weakness of the WHO approach, others have used such examples as illustrations of the 'arrogance' international organisations have over unique local action. To us, this phenomenon only signifies the universal applicability of innovative approaches to urban health, with or without the support of global actors.

What unites thousands of Healthy Cities?

In her seminal research piece '*Innovations in a Fuzzy Domain*' Marleen Goumans (1998) asked politicians and civil servants in ten British and Dutch cities what their perception of their town being a Healthy City was (cf. also Goumans & Springett, 1997). No two perceptions were alike. Had she included community leaders and NGO representatives, like De Leeuw, Abbema & Commers (1998) did, the picture would have been even fuzzier. Responses range from *good local governance* to *ecological urban planning*, and from *community consultation* to *healthy public transport*.

Looking at writings that are used to underpin Healthy City projects globally, there appears to be somewhat more consistency, but even here the sets of core values range from a number of merely four (WHO/EURO, 1998) to seven (Ashton, 1991), three (Werna et al., 1998, p. 18), six (WHO, 1995, similar to the core principles of the Health for All strategy) or eleven (Tsouros, 1992), figure 4.

In a way, it is peculiar that the thing which has become known as 'The Healthy Cities Movement' (e.g. Tsouros, 1992) seems to have such a limited sense of history; or maybe this is exactly what constitutes a movement: a perceived lack of (theoretical) foundation which is compensated by enormous enthusiasm. A quick guesstimate among colleagues involved in Healthy City implementation both in academia and in practice

would indicate that there is very little sense of the sheer innumerable quantity of booklets, brochures, books published by quite reputable companies, by WHO and by passionate believers, newsletters and articles, which over the years have produced a reasonably solid foundation of the movement.

Most if not all about the foundation of the Healthy City concept has been laid down in a series of WHO publications, most notably the 'yellow booklets' that were published in the late 1980s (Hancock & Duhl, 1988, Kaasjager et al., 1989, Kickbusch, 1989, WHO/ EURO 1988a, WHO, 1988b)). Reviewing the material over a decade later, it is striking how much of these writings should still be considered inspirational and validated observations on the creation and maintenance of health promotion in the urban context. Hancock & Duhl (1988, p. 23) point out that a healthy city can only be identified by encountering it: *"It must be experienced, and we must develop and incorporate into our assessment of the health of a city a variety of unconventional, intuitive and holistic measures to supplement the hard data. Indeed, unless data are turned into stories that can be understood by all, they are not effective in any process of change, either political or administrative."*

Since the beginning of the Healthy Cities Project in Europe there have been less or more successful efforts at evaluation of the achievements of the network cities and the Project as a whole (for review, see Curtice, 1995, and Tsouros, 1994). Research in, with for and on healthy cities over time has become an important issue in the movement (De Leeuw, 2000a). There is no conference, seminar or meeting where the research issue has not been debated (De Leeuw et al., 1992). Currently, there still is very little empirical work on Healthy City evaluation, work by Werna & Harpham (1995, 1996) being the exception rather than the rule. Some process evaluation (Goumans, 1998, National Institute of Public Health, 2000, and WHO, 2000) and a few policy studies (Goumans, 1998, Springett, 1998, Goumans & Springett, 1997, De Leeuw et al, 1998, De Leeuw, 1999) indicate that Healthy Cities principles facilitate the development of comprehensive health policies at the local level. However, equivocal notions of what Healthy Cities are all about have obscured the development of a reasonable and validated research paradigm.

Judging all this contextualism and diversity, it might be tempting even to the rational investigator to adopt the words by Italian author Italo Calvino in his '*The Invisible Cities*':

(...) è inutile stabilire se Zenobia sia da classificare tra le città felici o tra quelle infelici. Non è in queste due specie che ha senso dividere le città, ma in altre due: quelle che continuano attraverso gli anni e le mutazioni a dare la loro forma ai desideri e quelle in cui i desideri o riescono a cancellare la città o ne sono cancellati.
(Italo Calvino, Le città invisibili, Le città sottili. 2. 1972)
or in my own limited English translation:
(...) it is useless to establish whether Zenobia should be classified as one of the happy cities, or as one that is unhappy. It does not make sense to divide cities into these two types, but it does into two others: cities that through the years and changing times still shape longing, and cities in which longing manages to wipe away the city, or is being wiped away itself.

Yet, the quote itself is useful in determining the values that unite Healthy Cities globally: they are the values that cities shape themselves for their healthful futures, and developmental perspectives they are trying to maintain or avoid in order to secure a healthy existence in the future. Such values find their foundation in community action, empowerment, sustainable development, equity, and generally in a locality-based strategic and systemic approach of all determinants of health and disease. Hancock and Duhl (1988) have proposed the following working definition for a Healthy City:
A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

This so-called 'working definition' might -even though all-encompassing and inspirational- be regarded as a trifle normative rather than scientifically operative (i.e., a definition which would enable us to formulate theoretical presuppositions and their subsequent research questions). In order to develop a more operational definition, we would want to develop a more generic Healthy City logic. Breaking down the logic of Healthy Cities world-wide (i.e. beyond the strict WHO European Regional normative perspective), then, would lead us to the following:

- the geographical set-up in which most people live is the town or city;
- towns and cities have certain degrees of authority and governance to create, *r*ecreate and maintain their social and physical infrastructures;
- towns and cities are more often than not the lowest level of formal (democratically elected, and therefore accountable to communities) authority and level of governance in a country;

- thus, actions and policies of city authorities impact on the options people have for living.
- The above options are also known as 'determinants' (cf. Marmot & Wilkinson, 1998) of health.
- Local authorities are thus in an ideal position to formulate and implement policies impacting on determinants of health, thereby potentially improving health; however, 'top-down' approaches in policy-making and intervention development are doomed to fail in their sustainability (Boutillier, Cleverly & Labonte, 2000, De Leeuw, 2000b).
- Full involvement of local communities in formulation, implementation and evaluation of health programmes is therefore imperative
- in order to achieve equity in local health.

In spite of the enormous number of (normative) definitions and recipes for *Healthy Cities* (or whatever they are called, such as for instance '*Comunidades Saludables*' in the Americas) we thus propose here as a unifying *'constituent'* definition:

a locality-based strategic and systemic approach of social, physical and individual determinants of health and disease incorporating the full involvement of communities in the formulation, implementation and evaluation of policies and interventions aiming at equity in health and sustainable development.

Apart from defining the *concept* of Healthy Cities, however, it is also important to identify its primary objective(s). As we have stated in an earlier major Healthy City evaluation (De Leeuw, Abbema & Commers, 1998) one can only evaluate what one has set out to do in the first place. Thus: if a health education intervention sets out to reduce the number of eighth-grade pupils from taking up smoking, this is what should be evaluated, and not whether these pupils happen to eat more potato chips in the course of not smoking.

As we have observed above, there are thousands of municipalities and urban governance levels that are now sharing the Healthy City vision. Whether they have committed themselves to achieving specific objectives is an issue that cannot be answered; we are unaware of any exploratory global surveys mapping the existence of specifically formulated individual Healthy City objectives.

A global publication (WHO, 1995, p. 11) states that the core objective of Healthy Cities is *to improve the health of urban dwellers, and especially low income urban dwellers, through improved living conditions and better health services.* However much commendable this objective might be, we do not find that it conveys a vision or innovative networking perspective, which is so direly needed in urban health.

The only group of Healthy Cities that has agreed upon a clearly stated objective is the network of European WHO designated Healthy Cities. In their commitment to a rigorously applied set of designation requirements (WHO/EURO, 1997, see Appendix I for an overview) they share these overarching objectives:

'The WHO Healthy Cities project is a long-term international development project that seeks to put health on the agenda of decision-makers in the cities of Europe and to build a strong lobby for public health at the local level. Ultimately, the project seeks to enhance the physical, social and environmental well-being of the people who live and work in the cities of Europe. The project is one of WHO's main vehicles for giving effect to the strategy for Health for All (HFA).' (Tsouros, 1994, p. 1)

'The strategic objectives for the second phase include the speeding up of the adoption and implementation of policy at city level based on the European HFA policy and its targets; strengthening national and subnational support systems; and building strategic links with other sectors and organizations that have an important influence on urban development.' (Tsouros, 1994, pp. 11-12)

While investigating European Healthy Cities at a comparative level, therefore, only these policy oriented (i.e. '*health on the agenda*') issues can be the research objective (cf. also Springett, 1998). Many of these issues have been addressed in an investigation funded by the European Union (e.g. De Leeuw, 1999, Capello, 1999, 2000). An important finding of that study was produced by a research team from Milano, demonstrating that the mere involvement of a city in Healthy City networks impacted positively on its capacity to address health and its determinants. One might wonder why this finding in itself would not be convincing enough evidence for anyone to start participation in the Healthy City movement.

Creating evidence for Healthy Cities

Or wouldn't there? Some authors have argued that the diversity of perspectives of the Healthy Cities movement is its strength, and that precisely this strength should be mapped and understood. This mapping has been going on since the very beginning of the programme, in 1986. Enormous collections of 'best practices' have been amassed, which lead a rather successful life in themselves as sources of inspiration of Healthy City officers and community leaders (e.g. Price & Tsouros, 1996).

Still, inspiration by a good story is only one piece of evidence. Epidemiologists would be tempted to refute a story as proof of the efficacy of an intervention; they would go for the randomized control trials, hard numbers, small α's and even smaller p-values. This seems to be a conflict never to be resolved.

Yet, 'focussed' theories on specific elements of the Healthy City vision yield effectiveness insights in, e.g. community participation for health (such as works by Minkler, 1997, Bracht, 1999, Boutilier, Cleverly & Labonté, 2000) and intersectoral action (Gillies, 1998, Taket & White, 2000). But it seems it is the synergistic element of Healthy Cities that requires further evidence development.

It is worth pointing out here that the uniqueness of Healthy Cities does not lay in their application of models of community action, or of determinants-based health education campaigns, or of a policy-driven urban perspective. Goumans (1998) has demonstrated that in their operational functions, Healthy Cities can be divided as falling into three models: the *Health* model, the *City* model, and the *Vision* model. In the *Health* model, Healthy Cities use the WHO vision in order to develop and implement innovative health promotion interventions. In the *City* model, Healthy Cities feel enabled to use the concept to develop and improve intersectoral urban *policies for health*. And finally, in the *Vision* model, the Healthy City becomes a vehicle to enhance the health of the city (economically, ecologically, psychologically, etc.) rather than only that of its population. This means that the question whether the Healthy City (as a generic concept) *'works'* could never be answered: evidence in its synergy would have to demonstrate how each city reaches the specificity of its own objectives.

Monitoring, Accountability, Reporting, and Impact assessment: MARI

An example of a programme in monitoring and evaluation in Healthy Cities that aims precisely at those synergistic effects is provided by the European WHO Healthy Cities Project in its third phase.

Healthy Cities need to show their communities, their politicians and their partners that their work yields real results. Showing results, that is, being accountable, can be done in different ways. It is a true, and shared, responsibility for Healthy City operators and researchers. We feel that the research community should nurture the Healthy City movement more than it has done so far. Until now, academia has looked upon Healthy Cities with justifiable criticism. Good research, however, would

intend to support Healthy City endeavours, and identify their weak points with constructive critique.

In Phases I and II of the Project cities were required to produce Health Profiles and City Health Plans. For the first (1996-1992), second (1993-1998) and third phase (1998-2002) of the Healthy City programme cities had to demonstrate political commitment to Health for All and the Healthy City vision, appropriate resource allocations to secure a full-time project coordinator and support staff in a Healthy City Office, and commitment to specific objectives leading to the establishment of local health policies. In the first phase, among the most important of such objectives was the establishment of an urban health profile (Doyle et al, 1996, Garcia & McCarthy, 1994, WHO/EURO, 1998). In the second phase, designated cities were supposed to be working on the creation of City Health Plans (e.g. De Leeuw, 1999), and the third phase committed Healthy Cities to the production of a City Health Development Plan and a process of more rigorous internal and external monitoring and evaluation. The mere production of such reports was a major step towards accountability in itself. Profiles and Health Plans showed the need for action in health, social and sustainable development. However, a city would need to go beyond such needs assessments in order to show that its activities have an impact.

Impact can be determined in different ways. Traditionally, the impact of health interventions was measured in terms of morbidity and mortality outcomes: the presence or absence of death and disease are considered relatively simple proxies for health status in a specified area. However, description of morbidity and mortality measures is in no way an indicator for the degree to which health, well-being and quality of life are currently enjoyed or pursued by communities and cities. Health determinants analyses, and sound and responsible approaches towards influencing determinants of health, would provide relevant and important information on the impact of Healthy City interventions.

Such sound and responsible approaches have now been identified as core principles of the Healthy Cities Project. Cities designated for participation in the Third Phase of the Project have subscribed and committed themselves to such principles.

Research in, with, for and on Healthy Cities has always been a crucial component of the European Project. In the First Phase, cities were invited to contribute to our overall knowledge by filling out a *Healthy Cities Questionnaire*. The responses to that questionnaire have led to the production of a number of pub-

lications, most notably the *Twenty Steps* and *A Project Becomes a Movement* books; these publications still play a very inspirational role in setting up and maintaining Healthy City projects.

In the Second Phase, research and evaluation have been even more prominent. In this five-year period, various studies were undertaken to assess Healthy City processes. Analyses of Health Profiles and Health Plans were supplemented by studies of, among others, policies and networks in Healthy Cities, research needs and research capacities of cities themselves, inventories of project management and national networks, and reviews of tobacco initiatives and city progress reports. The collection of case studies and models of good practice is growing every day. Currently, a project is underway to pull together the findings of these thousands of pages of research.

The Healthy Cities Project Office of the European Region has since long enjoyed the expert advice from an *Indicators Group* that meets regularly in order to collect, analyse and assess a coherent set of health indicators developed for use in the European environment. The set of indicators includes four health, seven health service, fourteen environmental, and eight socio-economic indicators; some of these (e.g. mortality, and cause of death) are broken down into sub-indicators. The indicator *'mortality: all causes'* also includes data on seventeen age-specific rates. Similarly, *'cause of death'* is compiled of twelve cause-specific death rates. A first analysis was published in 1996 by Doyle et al. The 2000 report is currently being prepared by the Danish National Institute of Public Health in Copenhagen. As yet, the merit of such reports may not be the attribution of 'the Healthy City intervention' to changes in health outcomes or determinants of health. These reports are valued by participating cities for their comparative strength and give local politicians arguments and legitimacy for the continuation of their commitment to the Project.

The Third Phase of the Project has committed itself to a systematic and continuous approach to monitoring and evaluation. The foundation of that programme is the MARI Framework (Monitoring, Accountability, Reporting, and Impact assessment; WHO/EURO, 1999). MARI strives to empower cities in their own research and evaluation efforts. It is a set of nearly four hundred questions structured like the designation requirements (Appendix 1) and three types of questions that they may apply to the monitoring and evaluation of those requirements:

- Questions into presence of policies, adherence to principles, and involvement of actors;
- Questions involving processes of change;
- Questions aimed at the identification of results, impact, outcomes and outputs.

It is expressly *not* the purpose of the framework that cities themselves will spend a disproportionate amount of time on answering the questions. At best, they might want to do that once during the running period of the Third Phase (five years). The full MARI framework is intended to inspire cities to ask themselves proper evaluative questions, involve local academia, and set up bodies to advise local authorities in commissioning relevant research projects (EACs: Evaluation Advisory Committees).

Healthy City 'Outcomes'

As a function of the full MARI framework, WHO developed an Annual Reporting Template, ART. Rather than indulging into a grand exercise with four hundred questions, cities committed themselves to produce annual reports. The MARI framework served as a basis for the template for those annual reports. It covers the four basic elements of action in Healthy Cities (cf. the headings of the designation criteria in Appendix 1) and the same three types of questions identified above. A fictitious city was invented (Mîzopør) for which an example of a good Annual Report was developed. This example was sent to the group of 40 cities officially designated by September, 1999. Due to late and incomplete responses from cities (for which a non-response survey was carried out, indicating that non-response cities did not have adequate (human) resources to produce a report) the analysis of the reports was produced in November, 2000 (De Leeuw, 2000c).

Twenty-five out of forty cities responded, implementing over 1000 activities in the Healthy City realm. The response on the operations of the Project Offices yielded between seven activities (Pécs, Hungary) and around 150 (Rotterdam, The Netherlands and Gothenburg, Sweden). Very few of those activities showed a strategic perspective, thus underscoring the earlier observed degree of 'projectism' in cities (Goumans, 1998, Goumans & Springett, 1998) that would hinder the development of urban health policies, or, in terms of Phase III of the European Healthy City Project, 'City Health Development Plans'. It is too early to see whether the five-year strategic perspective offered by WHO throughout this phase contributes to this development. Analysis of future Annual Reports will provide a time-series analy-

sis. However, findings from an evaluation of ten cities in Phase II (De Leeuw, Abbema & Commers, 1998) showed that particularly the *requirement* by WHO to develop Health Profiles and City Health Plans contributed to the implementation of steps towards those goals. This would indicate that the projectism identified in the analysis of the 1999 Annual Reports would wither, and eventually that activities would contribute to a City Health Development Plan which does address urban health issues in an effective manner.

Slowly, other studies on the effects and outcomes begin to emerge. Capello (1999, 2000) demonstrated by means of econometric analysis that active participation in WHO Healthy City networking resulted in longer-term and more sustainable health policy development among designated Healthy Cities. De Leeuw (1999) showed that those cities that connected the urban planning and social change paradigms to a broad understanding of health were able to initiate and maintain intensive community-based health promotion programmes.

Conclusion

The international Healthy Cities movement has blossomed and expanded since its inception by WHO in 1986. Urban issues seem to have acquired increasing prominence in global circles (apart from the Asia-Pacific Economic Cooperation *Healthy Megacities* programme, the United Nations Centre for Human Settlements UNCHS (Habitat) *Inclusive City*, WHO's *Healthy Cities* and a European *Sustainable Cities and Towns Campaign* recently a *Child-Friendly City* initiative was started by UNICEF). A scientific and empirical paradigm for the definition and study of such urban initiatives and a comprehensive approach to the complex relations between public health and urban planning are yet still in the making.

It seems that the WHO Healthy City movement is advancing towards such a paradigm. After a decade of predominantly undertaking case-study research and process evaluations the MARI framework appears to be developing an impact-driven evaluation perspective co-created with its member cities and networks.

Appendix 1 Designation requirements Healthy Cities WHO European Regional Office

A Endorsement of principles and strategies
  1 Cities must have sustained local government support and support from key decision-makers in other sectors to the principles and goals of the project.
  2 Cities must have in place mechanisms which ensure an integrative approach to health planning, with links being made between their health policies and other key city-wide strategies, and their health strategies and city-based work on Agenda 21.
  3 Cities should develop policies and strategies based on health for all for the twenty-first century. Particular emphasis should be placed on the three issues of 1) reducing inequalities in health, 2) working to achieve social development, and 3) commitment to sustainable deveopment.
  4 Cities should select at least one additional target of health for all for the twenty-first century, which has particular local impor-tance. Progress towards this target should be carefully monitored.

B Establishment of project infrastructures
  1 Cities must have an intersectoral steering group involving political / executive-level decision-makers.
  2 Cities must have a full-time identified project coordinator or equivalent and administrative/ technical support for the project. The project coordinator must have proven fluency in English.
  3 Cities must identify and give commitment to the package of resources required to implement the strategies and action plans for Phase III.
  4 Cities should review project management proesses and implement a programme of action to address identified weaknesses.
  5 Cities should demonstrate increased public participation in the decision-making processes that affect health in the city, thereby contributing to the empowerment of local people.
  6 Cities should establish mechanisms for the engagement of the business sector in local action for health, at both policy and operational levels.

see next page

7a Cities should implement a communications strategy, involving a range of communications mechanisms, to stimulate visibility for health issues and public health debate within the city; this strategy should be evaluated to assess its impact; **and/or**

7b cities should implement an ongoing programme of training/capacity-building activities for health and healthy public policy making; this programme should have two strands: involving key decision-makers across the different sectors in the city, and involving local communities and opinion leaders; the impact of this programme should be evaluated.

C Commitment to specific goals, products, changes and outcomes

  1 Cities must produce and implement a city health development plan during the third phase, which builds on previous integrative city health planning and reflects the values, principles and objectives of health for all for the twenty-first century and Local Agenda 21; relevant national health strategies; and local city-specific priorities. This plan must have clear long term and short term aims and objectives and a system on how the city will monitor whether these objectives have been met (indicators and evaluation framework).

  2 Cities should implement a programme of systematic health monitoring and evaluation, integrated with the city health development plan, to assess the health, environmental and social impact of policies within the city. In addition, cities should strengthen health accountability mechanisms and measures.

  3 Cities should implement a programme of action targeted at reducing health inequalities within the city

  4 Cities should carry out a programme of action to promote healthy and sustainable urban planning policies and practice within the city.

  5 Cities should develop and implement a tobacco control strategy, in line with WHO's identification of tobacco as a strategic priority.

  6 Cities should implement and evaluate a comprehensive programme of activity to address **at least one** of the following priority topics: social exclusion, healthy settings, healthy transport, children, older people, addictions, civil and domestic violence, accidents.

D Investment in formal and informal networking and cooperation

  1 Cities must give executive and political comitment for the attendance of the project coordinator and nominated politician at WHO business meetings and symposia. At each, the city should be represented, as a minimum, by the coordinator and politician responsible.

  2 Cities should ensure that their Mayor (or lead politician) attends the Mayors' Meetings at start of the phase (1998) and midway through it (in the year 2000).

  3 Cities should be connected to the Internet and electronic mail, and ideally should have access to video-conferencing facilities.

  4 Cities should participate actively in different networking activities (thematic, sub-regional, strategic, twinning, etc.) during the phase, including the development of close links with national networks. Cities should demonstrate practical contributions to these networks throughout the phase.

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Utility-driven evidence for healthy cities: Problems with evidence generation and application

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Abstract

The question whether the WHO Healthy Cities project 'works' has been asked ever since a number of novel ideas and actions related to community health, health promotion and healthy public policy in the mid 1980s came together in the Healthy Cities Movement initiated by the World Health Organization. The question, however, has become more urgent since we have entered an era in which the drive for 'evidence' seems all-pervasive.

The article explores the nature of evidence, review available evidence on Healthy Cities accomplishments, and discusses whether enough evidence has been accumulated on different performances within the realm of Healthy Cities. A main point of reference is the European Healthy Cities Project (E-HCP).

Building on the information gathered through documentary research on the topic, it is concluded that there is fair evidence that Healthy Cities works. However, the future holds great challenges for further development and evidence-oriented evaluations of Healthy Cities. There are problems with (1) the communication of evidence, (2) the tension between the original intention of the Healthy Cities Movement and its current operations, and (3) the complex nature of Healthy Cities and the methodological tools currently available.
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Keywords: Healthy cities; Health policy; Community health; Health promotion; Utility-driven evidence; WHO

Introduction

The relation between human health and settlement is unmistakable. In fact, the origins of modern public health can be traced back to rapid urbanization processes in the industrial revolution (Cohen, 1989).

Public health programs that address the broad range of relations between health and settlement are, however, not abundant. One of the reasons for this phenomenon may be the complexity of such programs, operating at many levels (individual and community behavior, organizational and policy development) taking into account the population diversities inherent to modern life—not least in its urban form.

One such program, the Healthy Cities Project (HCP) initiated by the World Health Organization, since its inception in the mid 1980s has been challenged to deliver the evidence that it, in substantial ways, makes a difference when dealing with urban health.

Remarkably, in the twenty years that HCP has operated, very little evidence has been accumulated and/or published in the public domain, in spite of a continuous involvement of the academic community.

It has been argued that the 'evidence debate', at least within public health science, has come to a grinding halt

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with essentially two positions: those who stick with experimental or quasi-experimental methodological designs for the generation of evidence, and those who take a broader position, arguing that there are many other possible sources and pathways to produce evidence. Either way, Healthy Cities do not yet seem to have lived up to expectations.

In this article, we will explore the nature of evidence; review available evidence on Healthy Cities accomplishments; and discuss the question whether appropriate evidence has been accumulated on different performances within the realm of Healthy Cities.

A particular point of reference will be the European Healthy Cities Project (E-HCP), which from the latter part of the 1980s explicitly has worked—in an increasingly formalized way—to put health high on the local policy agenda and stimulate ways to improve public health by modifying the physical environment and the social and economic determinants of health.

Utility-driven evidence

What should be understood by evidence? McQueen and Anderson (2001) quote Butcher:

> A piece of evidence is a fact or datum that is used, or could be used, in making a decision or judgement or in solving a problem. The evidence, when used with the canons of good reasoning and principles of valuation, answers the question why, when asked of a judgement, decision, or action.

There are some unresolved issues in using such a perspective. Particularly researchers equating science with the use of experimental methodological designs would criticize this position as an invitation to use almost any data or opinion as evidence. We will explore precisely this methodological tension.

In a recent position paper by the European Advisory Committee on Health Research (Banta, 2004) the relations between public health, decision making, research, knowledge generation and evidence are presented. The Committee acknowledges the many facets of evidence for public health and singles out Healthy Cities as a prime challenge in the amalgamation of evidence:

> (…) a legitimate concern is that research in many areas of "the new public health" aims at actions that are difficult to evaluate, such as those in health promotion. For example, what is a "healthy city" and what are the general and specific outcomes sought? Because of these difficulties, decisions that are mainly determined by good evidence of effectiveness would favor interventions with a medical rather than a social focus, those that target individuals rather than communities and populations, and those

that focus on the influence of proximal rather than distal determinants of health. This would clearly be unsatisfactory for population health activities.

Eriksson (2000) has further mapped these problems. He proposes a distinction between four generations of 'prevention projects' (I. clinical; II. bioepidemiological; III. socioepidemiological; and IV. environment & policy-oriented), based on different theoretical propositions, each of which need increasingly complex evaluation approaches as well as outcome parameters. Generally speaking, Eriksson, with his differentiations, cites an important development within public health research, stretched out over decades, resulting in an increased recognition that much can be gained, especially in terms of reaching many people by changing program delivery or policy, by supplementing the efforts to identify individual determinants of health and health behavior with a focus on social and environmental factors. Recognitions such as these have subsequently provoked efforts to measure, for instance, the impact of manipulating broader determinants of health and discussions on how to expand intervention goals beyond the individual to various community levels.

Birckmayer and Weiss (2000) have demonstrated that application of theory-based evaluation (TBE) yields better research information on various elements of success and failure of health promotion programs. TBE expects researchers and program directors to spell out assumptions to a micro-theoretical level, so that outcomes are not only made *evident*, but also can be *explained*. This perspective offers opportunities to integrate intra-generational 'prevention projects' such as Healthy Cities, drawing heavily on the approaches that Eriksson calls socioepidemiological and environment & policy oriented, and thus unravel and analyze its various components.

These perspectives give, however, indications of *how* evidence is to be produced, but not *for what purpose*.

Ultimately the generation of evidence seems to serve two purposes:

- To assist in decision-making, and thus implementation. In this way evidence is used instrumentally in concrete processes of *problem solving*.
- To contribute to the growth of a more general, contextual oriented body of knowledge into a given domain—in this case urban health, public policy and comprehensive health programs. The qualities of this latter perspective should not be viewed in the short time frame of instrumental utility. Its value is rather in a more non-linear sequence through which relevant stakeholders, often in complex ways, are influenced by, and themselves influence the interpretations of, a broad body of research into a certain domain which subsequently contributes to certain policy directions.

This second perspective is frequently referred to as *enlightened* or conceptual use of evidence.

In the following, we will review such utility-driven evidence[1] from both the *problem-solving* as well as the *enlightenment* perspective.

The notion of *utility-driven evidence* is based on the observations that

- the generation of evidence serves a purpose beyond mere intellectual curiosity (McQueen & Anderson, 2001),
- in connection with public health activities, generation of evidence often takes place in complex interaction between stakeholders (De Leeuw, 1993).

Eriksson (2000), mentioned above, has endeavored to typify public health interventions, and identify relevant evaluation strategies for each (increasingly complex) intervention type. In his perspective, the amalgamation of evaluation strategies and their outcomes would lead to compelling evidence for decision-making. Tones (1997) has argued that evidence is multi-dimensional, and that measures of success are an assembly of different *types* of evidence, such as witness accounts, expert testimony, lab tests, etc. In short, Eriksson has established an *academic*, and Tones a *social* evidence paradigm. Neither, however, speaks out on the question as to what *purpose* either type of evidence is generated. We argue for an overarching *utilitarian* evidence paradigm: whether taking a social or purely scientific perspective, the producers of evidence should take into account how their products may be used in broader decision-making.

Healthy cities—social movement or WHO program?

The HCP started in 1986 as a project to seek out feasible ways to apply and implement the Ottawa Charter for Health Promotion (WHO, 1986) in urban settings (De Leeuw, 1989). Its immediate popularity among cities led to an organizational and management format that had to go beyond a small-scale demonstration project. Soon, hundreds of cities around the world became inspired to adopt the principles and 'ideology' of HCP.

'Healthy Cities' can now mean many different things (De Leeuw, 2001):

1. hundreds of European cities, assembled in national or language networks, partly inspired by and linked to the European branch of WHO;

2. thousands more in other parts of the world, sometimes linked to WHO but also organized in autonomous associations. Both types of 'Healthy Cities' can be identified as parts of a social movement; and, finally,

3. some 50 European towns and political entities part of a network rigorously managed by WHO.

In the first part of the article, we will primarily draw on research carried out in and on the two former types and beyond, whereas in the latter part we will use information originating from the European Healthy Cities Project (E-HCP).

Documentary assessment—search strategy

In this article, we will draw on information gathered through documentary research on the topic Healthy Cities. Both gray literature (e.g. government documents, reports produced by political commissions or international organizations such as WHO) and actual research studies are included. Computerized searches have been conducted in the English-language literature. A number of electronic databases have been scrutinized. In addition, searches of the Internet have been carried out using a broad selection of search engines. The latter effort was deemed important because large amounts of the information on Healthy Cities[2] in general and the E-HCP specifically is to be found in non-scientific domains.

The references mentioned in this article do not represent all reports published on Healthy Cities. However, we do believe they make up the publicly available works in this area.[3]

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[1] http://www.publichealth.sdu.dk/SocSciMed-article-EdLTS/Evidence-and-research-utilization.doc.

[2] http://www.publichealth.sdu.dk/SocSciMed-article-EdLTS/healthy-city-websites.doc.

[3] One of the authors (EdL) has been part of WHO Healthy City endeavours since their inception in 1986. From 1992 to 2002, she has been Director of the World Health Organisation Collaborating Centre for Research on Healthy Cities. In that capacity she has participated in all 'Business Meetings' of HCP and has contributed to research efforts in the first three phases of the project, specifically in the consortium (led by the London School of Economics and Political Science) that assessed the second phase, and in designing the MARI framework (Monitoring, Assessment, Reporting and Impact assessment) implemented in the third phase. She was ex officio member of the WHO Healthy Cities Evaluation Advisory Committee. The other author (TS) has been based in the European Healthy Cities office in Copenhagen to undertake a time-series analysis of data delivered annually by cities through the MARI framework.

All data and information collected during the evaluation and assessment exercises in the three phases are property of WHO. For a variety of reasons WHO can and will not relsease these into the public domain.

Enlightenment: evidence generated independent of Healthy Cities taking action

The roots of Healthy Cities are varied. Part vision of the future of health in an ever urbanizing world, part demonstration project of WHO's move towards a 'new public health' (Kickbusch, 2003) but certainly with strong roots in empirical research. This research established valid scientific foundations for the endeavor; such underpinnings provided the logic for a program of action that included an—in 1986—innovative variety of priorities such as community and intersectoral action, striving for equity in health, sustainable development and governance, the move from projectism to policy development, and a general image of health as social capital to be used for the good of (urban) society. In this case, a complex problem led to a package of solutions that is equally complex.

When looking for evidence that Healthy Cities 'works' it is important to reflect on these theoretical and empirical underpinnings, for they indicate that Healthy Cities *should* work. This body of work thus gives pointers on types of interventions and organizational requirements earlier research has identified as critical when introducing and trying to sustain a richly faceted public health initiative such as Healthy Cities. In other words; we are not just dealing with ideology shared only by true Healthy Cities 'believers'—an accusation sometimes advanced. So, if we are not yet in the position to assess unequivocally *that* Healthy Cities works, we should question what causes of such failure can be identified.

The type of programs Healthy Cities are endeavoring to implement meet health promotion effectiveness requirements outlined by two recent authoritative reviews. Smedley and Syme (2000) and IUHPE (2000a, b) explicitly found that comprehensive health promotion interventions yield more effects and more sustainable effects on a variety of indicators of health (increased positive health, proximal and distal determinants more conducive to health, improved parameters of behavioral health such as beliefs, attitudes, social norms, self-image, organizational capacity for health, and increased policy-making for health). Such comprehensive health promotion interventions mirror to no small degree the visions, objectives and requirements of Healthy Cities Projects. It is interesting that these publications provide the evidence of effectiveness of Healthy Cities *postulated* earlier by other authors. Duhl (1963), as one of the fathers of the Healthy Cities concept, has been arguing for such perspectives for half a century, and Kaasjager, van der Maesen, and Nijhuis (1989), Kickbusch (1989), Hancock and Duhl (1988), APEC, Asia-Pacific Economic Cooperation, APEC Industrial Science and Technology Working Group (2000) and Ashton (1991) have later dressed the skeleton of the argument with

indications of evidence from urban health endeavors and social action.

There is a range of publications that support evidence for Healthy Cities from other perspectives. In the area of urban planning and environmental health there is considerable evidence that careful consideration of health issues would create a healthier urban setting (Duhl, 1963; Aicher, 1998; Schell & Ulijaszek, 1999; Barton & Tsourou, 2000). Takano and colleagues (Takano, Nakamura, & Watanabe, 2002; Takano et al., 2002) have for instance demonstrated that access to green areas has a direct impact on senior citizens' health parameters in cities such as Tokyo and Shanghai. Recently Frank, Engelke, and Schmidt (2003) have made a convincing argument for the impact of the built environment on an important determinant of health—physical activity. In general, the connections between the built environment and health seem to be moving deeper into the mainstream of public health research (e.g. American Journal of Public Health 2003, Vol. 93, No. 9). Noarlunga, probably the Australian town where Healthy City efforts have been best documented and assessed, achieved its successes starting from environmental health needs assessments and an infrastructure oriented Safe Community endeavor (Baum & Cooke, 1992; Baum, 1993, 2003a).

Arguing further in the realm of preconditions for urban health, Gray (1985, 1989), Gillies (1998) and Taket and White (2000) among many others have demonstrated that inter-agency work, when implemented properly, leads to better health actions and health outcomes. Capello (1999, 2000) has sustained this argument by reviewing networking activities among Healthy Cities, and finding that networking per se is an important contributor to the initiation and maintenance of health action.

'*Community health*' in itself is a complex field of academic attention and local action. Boutilier, Cleverly, and Labonté (2000) review the different modalities for health activities of communities. They indicate that evaluation and assessment of such activities are not just (or not in the least) the academic's task. Outcomes in community health are, therefore, hard to qualify and quantify. Baum (2003b) reviews different styles of community development and participation in health and favors Labonté's community development empowerment continuum (Labonte, 1992). Neither produces overwhelming evidence of the effectiveness of the community action perspective alone, although there is a pragmatic and opportunistic consideration that community development and participation contribute to more effective program implementation (Mazmanian & Sabatier, 1989). A review produced by the Healthy Cities program itself (WHO Regional Office for Europe (2002)) shows neither evidence. This view is consistent with a recent review by Merzel and D'Afflitti (2003).

They show that the effects from 32 community-based health promotion interventions published in American scientific journals are not as large as the theory would indicate. Their explanation of the 'failure' of these interventions to deliver hinges on three main arguments:

- *Methodological and research issues*: Because the preferred methodology follows the design of the Randomized Controlled Trial (RCT) or the quasi-experiment, sufficient statistical power is required to demonstrate any effect at all. Such power is lacking because of the challenges to the design of RCTs or quasi-experimental research. These require large numbers of similar (matched) communities. Anyone seriously attempting to engage in community action would recognize that this would be a virtually impossible requirement.
- *Intervention-related issues*: Merzel and D'Afflitti's review shows that the so-called 'comprehensiveness' of community interventions is generally flawed. Although the 'ideology' dictates multi-level interventions (combining regulatory, communicative, and facilitative interventions aimed at individuals, groups and institutions in some magical 'optimal' mix) their review uncovers serious flaws in almost all projects reviewed. Particularly policy and organization oriented interventions were missing from the mix. This flaw is founded in the third issue.
- *Theoretical limitations*: Historically, community interventions have their roots in behavioral approaches to empowerment, health education, and sometimes 'liberation' perspectives (Freire, 1968; Wallerstein, 1992; Minkler, 1997). However engaged community organizers are, they may lack the knowledge and capacity to draw upon insights from management science, organization studies, and political and policy research (De Leeuw, 2000). Where Merzel and D'Afflitti identify in their review of projects a complete lack of '*an integrated theory of ecological change that targeted social and policy influences through an intensive process of community mobilization*' they implicitly expose the most immense challenge to public health training and action today: to involve the wealth of theory development and implementation from other disciplines for health (Gebbie, Rosenstock, & Hernandez, 2003; De Leeuw, 2003).

Merzel and D'Afflitti paint a bleak picture of the state of affairs, which is not entirely warranted. Some of the positive developments in domains neighboring public health are outlined above (such as urban planning). The challenge is further involvement and integration. One major 'Healthy City' achievement is that the movement has ceaselessly endeavored to take action in political, organizational and behavioral realms and that it has continuously integrated requirements to that effect in its own policy statements (De Leeuw, 2001).

Nowhere have these requirements been spelt out more clearly than in the formal network making up the E-HCP. In the next sections, we will, therefore, review to what extent the E-HCP has lived up to meeting the stated requirements. Special attention is drawn to political and organizational perspectives.

Problem solving: European Healthy Cities research effort—fifteen years of evaluation

From the very beginning E-HCP sought to stimulate and enhance the long-term development of healthy public policies by local governments. The European Regional Office of WHO has defined itself as a kind of institutional broker working directly and closely with a select group of 'designated' cities (Tsouros, 2000). Nearly 50 designated cities have thus committed themselves, under the aegis of WHO, to pursue a common set of visions and objectives employing an agreed-upon set of tools, instruments and strategies. For reasons such as these, E-HCP is seen as an obvious place to look for demonstrations of the Healthy Cities approach actually having a visible and steady impact on policies or other comprehensive undertakings of relevance for the sustainable development of health at the local, urban level. The E-HCP has been running for over 15 years. Throughout there has been a formal impetus to monitor and assess whether involvement in the E-HCP has indeed materialized in distinct contributions to the ways in which health topics are dealt with locally. Although there is an absence of common methodology and standardized measures, these different assessments can, nevertheless, be placed together and hereby provide a view of the developmental patterns of the E-HCP over a longer period of time.

Research on political and organizational aspects of the E-HCP

In the following, we shall consider selected developmental trends related to two of the basic strategic perspectives of the healthy city approach that persistently have been underlined in the sets of WHO guidelines for the E-HCP network from 1987 and onwards (e.g. WHO Regional Office for Europe, 1997). They are

- Securing political commitment to the principles and direction of the E-HCP

● Promoting institutional alterations with the intention to install new organizational structures to manage change (e.g. via partnerships for health and inter-sectoral collaboration)

The assessment of progress in relation to these core elements will center on the individual city-level and especially focus on local political and organizational performances.

These foci have been identified by the WHO leadership of the E-HCP as essential for securing political support and process-oriented progress toward health of cities (Tsouros & Draper, 1993). Moreover, they are in keeping with most Healthy Cities projects where the emphasis is not so much on impact assessment at the addressee level but more on advocating and building support for policy change that, in the long run, can promote the installment of systematic judgment of how local structural conditions and community relations influence health (Baum, 2003b).

Political perspectives of the E-HCP: building support and generating policy formation

It has been possible for cities to secure stable and continued political support to the principles of the E- HCP. Moreover, in most cases Healthy Cities have moved one step further and provide visible commitment among city leaders to meet one or more of the specific targets and requirements guiding and giving thrust to the strategic perspectives of E-HCP phase's I (1987–1992), II (1993–1997) and III (1998–2002) (WHO, 2004). Persistent targets throughout the existence of E-HCP have been the obligation of cities to produce comprehensive strategic plans on health and urban development; to implement a systematic health monitoring system assessing the health, environmental and social impacts of policies within cities; to establish mechanisms for public participation in debates and decision-making processes relevant to health and thereby contribute to the empowerment of local people. As the E-HCP is a social movement, these targets have evolved, been refined, and adapted to new insights over time and to the (political) needs identified in each of the Phases (Tsouros, 1990; Blue & Harpham, 2000).

In their review of HCP Phase-I Draper, Curtice, Hopper, & Goumans (1993) come to the inference that it has been possible to build momentum and a solid political basis for Healthy Cities action at the local level. Draper et al. support this interpretation by referring to (1) pronouncements put forward by political leaders, (2) formal commitments to the E-HCP principles (e.g. the 1990 *Milan Declaration on Healthy Cities*) adopted by senior politicians and (3) strategic decisions on lines of action taking by city councils or other formally constituted units with bearing on the Healthy Cities approach.

Notwithstanding the sympathetic angle presented by Draper et al. it is equally fair to see the trends on political support and commitment in a more critical light. Goumans and Springett (1997) point out that the seemingly marked political support for Healthy Cities among urban leaders more often than not is of a symbolic nature only and does not include tangible attempts to integrate the core principles of the E-HCP into the general structure of city administration. This assertion finds empirical support in other findings that cities participating in formal Healthy Cities Networks actually develop and make adjustments without reference to WHO's overarching ideals and strategies concerning health (Boonekamp, Colomer, Tomás, & Nunez, 1999).

Taken together, both the sympathetic and critical viewpoint hint at the old dictum: "Things Take Time". In this case, "Things" is a long-term policy project aiming to make it possible for people to live fulfilling lives via manipulating the whole range of determinants of health in particular urban settings. This is, indeed, a very ambitious objective. Consequently, trying to establish the degree to which results attained accord with this general ambition is a huge challenge. To this the effort may be added to investigate whether the actual outputs of particular Healthy Cities might specifically be attributed to the adoption of principles installed in the E-HCP network. Not much is known on matters such as these.

Our research (De Leeuw, Abbema, & Commers, 1998) indicates that cogent political commitment, relevant for ensuring the health status and stated health targets of a given urban population and environment, is something that most cities have before entering the HCP not something they get along the way.

Elsewhere, in a discussion on policy ontologies in Healthy Cities (Milewa & de Leeuw, 1995), we have found that such ontologies (sets of causal and final relations upon which policy decisions are based) may not change due to the participation of a city in the project.

It is not without reason to interpret these findings as indications that political considerations *lead to* participation in the Healthy Cities Project, whereas participation in the Project does *not lead to* shifts in political considerations and subsequent policy-making. If an assumption, such as the one hinted at above, were found to be true, it would not be favorable to a program which is about "changing the ways in which cities think about, understand, and make decisions about health" (Sharp, 2002). Presently there is no evidence to confirm or deny the mentioned conjecture within the context of the E-HCP.

Organizational perspectives of the E-HCP: partnerships and intersectoral collaboration

Many of the organizational features of the E-HCP are based on the establishment of what is often called partnerships for health, which generically speaking means any agreement between two or more parties to take measures promoting health (WHO, 1998).

From the early days of the E-HCP it has been stated as a joint obligation to move from more or less casual partnerships, deemed as highly precarious and, therefore, not very useful in connection with the long-term effort to ''make health everybody's business'', to formal relationships between part or parts of different sectors capable of taking action on issues deemed as important for urban health and development. The most common appellation for these formal relationships has been intersectoral collaboration in which actors belonging to different sectors unite to address health-related issues (O'Neill, Lemieux, Groleau, Fortin, & Lamarche, 1997; WHO, 1998; Strobl & Bruce, 2000). In fact, mobilizing intersectoral action is highlighted as an indispensable element in developing any Healthy Cities Project (WHO Regional Office for Europe, 1997). The most frequent way to promote intersectoral action has been for cities to establish a widely representative intersectoral steering committee with strong links to the political decision-making system, to act as a focus for the project and oversee the work done. The presumed effectiveness of these committees in providing leadership and policy directions within a number of E-HCP cities led to making the establishment of them a requirement for urban areas participating in the E-HCP from the early 1990s and onwards (Kenzer, 2000).

However, putting together a steering group to promote intersectoral action is one thing. Making such a group work and assuring that their key decisions and formulated viewpoints have real impact on health-related topics in the city at large is quite another.

When commenting on the efforts towards intersectoral collaboration a number of cities involved in the E-HCP have over the years stated that the implementation of this ideal claim is very hard indeed because it challenges traditional patterns of (public) organizations and management (Tsouros & Draper, 1993). Various sectors—both within and outside the framework of municipal authorities—watch over their specific interests and fields of responsibility.

To be sure, power- and bargaining games between pressure groups are an inevitable part of everyday life in a political organization (De Leeuw, 1999). On that background the positive result cities do ascribe to the introduction of intersectoral collaboration should be deemed as very important. These positive results concern strengthened capacities in cities to address new health-related areas based on the presence of increased political and community support, increased visibility, competent staff and committee members, the promotion and facilitation of new thoughts and ideas on where and how health is created and wider support for healthy cities approaches in general (Goumans, 1998; Baum, 2003a, b). Benefits like these are frequently mentioned by cities taking part in the E-HCP (cf. city profiles at WHO, 2004). Still, it is notable that even though the promotion of intersectoral policies and organizational infrastructures for health development has been standard procedure in many countries and settings since the early 1980s, 20 years down the road it is acknowledged that implementing these intersectoral policies has proved more difficult than anticipated. Lasting cross-sector partnerships for health are still not generally in place (Ritsatakis et al., 2000; Mackenbach & Bakker, 2002). In many cases multi-sectoral collaborations take the form of joint projects and actions only. Measures to install long-term, formal co-operations with the ultimate aim of developing innovative policies with lasting impact on the ways in which municipal authorities deal with, and prioritize, health-related issues are few in number (Goumans, 1998). Furthermore, as far as the E-HCP is considered, the evidence of an added value of pursuing the intersectoral approach within certain healthy cities projects is rather inconclusive (Springett, 1997; Oduney, 2001). Some scholars have suggested pulling back from the rigid demand embedded in the E-HCP requirements for the establishment of formal institutional frameworks in connection with intersectoral collaboration and instead put energy into actually sorting out processes through which people can work together effectively in ways that they themselves find sensible and rewarding (Costongs & Springett, 1997).

Interestingly the ability to install intersectoral approaches may be more pronounced in regions, which at present do not have formalized networks similar to the E-HCP. Recent findings suggest that various intersectoral methods have been conducive to local Healthy Cities Projects in developing countries. It is, however, important to note that in these cases working intersectoral is understood as any recognized activity between parts of the community in question. Whether this intersectoral collaboration is ad hoc or permanent, formal or informal is not an issue (Harpham, Burton, & Blue, 2001). In contrast the cities taking part in the E-HCP have for over a decade committed themselves to promote formal, continued, broad-based multi-sectoral co-operations involving high-level political decision-makers from city council or the equivalent.

Starting from this last observation, on the degree of formalized means of cooperation in cities taking part in the E-HCP versus other urban communities designated as Healthy Cities, a general remark should be made that we must remember to compare like with like. In this

particular case it means that we should not make the mistake to caricature the E-HCP network as a stiffened entity and in contrast to this depict other independent Healthy Cities as vibrant and innovative as regards new public health initiatives.

Overall the bar is already at a high level in the cities taking part in the E-HCP. That is to say, at least at a formal level these urban dwellings all have demonstrated qualities such as; sustained political support to the principles of new public health; the establishment of organizational structures to manage change; and solid commitment to develop a common and inclusive vision for the city concerning health. The amount of progress that such cities undergo, at least in a short to intermediate period of time, may seem to be marginal—but important all the same.

Discussion

It is our overall claim that there is fair evidence that Healthy Cities works. However, we have to qualify this statement. There are problems with (1) the communication of evidence, (2) the tension between the original intent of the Healthy Cities Project and its current operations, and (3) the complex nature of Healthy Cities and the methodological toolbox currently available.

Firstly: We have suggested the development of 'utility-driven evidence': evidence that serves a purpose. When contrasting the materials presented under the enlightenment model of knowledge utilization with those that are drawn from the problem-solving perspective it is clear that the E-HCP and its international and local operators require not just 'a general body of knowledge that Healthy Cities work', but specific elements of evidence that given actions or phenomena work under certain conditions. This presents Healthy Cities operators with these challenges: (a) communicate the nature of evidence that is to be pursued; (b) ceaselessly put in place mechanisms to generate those expressions of evidence; and (c) legitimize and validate the range of methodologies and sources that can contribute to such utility-driven evidence. In the report of an expert panel for Research on Healthy Cities (De Leeuw, O'Neill, Goumans, & de Bruijn, 1993) these challenges have been united under the banner of 'vulgarization of research'.

Secondly, the specific account concerning the E-HCP substantiates the assumption that there exists a considerable divide between the original intent of the WHO led initiative on Healthy Cities and the current drive towards evidence. The E-HCP was created to experiment with new approaches to health promotion in cities and to demonstrate how they work in practice. However, the immediate success of the E-HCP made it impossible to preserve it as a "social experimentation program" solely aimed at acquiring, over time, definitive knowledge on particular impacts of public interventions in an urban setting. In rapid succession, cities were included in the network and many more were getting ready to join. In hindsight, the paradoxical fact presents itself that the prompt success of the visions supporting the E-HCP was the very thing that more than anything else ruled out the chance of gathering substantial evidence on the exact added value of the different elements included in the Healthy Cities approach when dealing with urban health and development. There was no way of arranging a small-scale trial run of the health promoting strategies embedded in the original E-HCP framework before enacting them across the board. As a figure of speech the core values backing the Healthy Cities concept, as we have described them above, struck the health promoting and disease preventing *Zeitgeist* perfectly. Understandably energy was primarily put into capitalizing on this momentum by further developing and consolidating the E-HCP network and not so much into performing rigid experimental research on specific health targets or determinants acknowledged in the scientific community as being of special relevance in an urban environment. As Awofeso (2003) neatly puts it: "…the Healthy Cities ethos has been characterized more by action than by reflection".

Thirdly, the nature of the 'problem' that Healthy Cities has the ambition to address is not easily framed in theoretical and methodological terms. The production of definitive evidence thus remains to be a challenge at a time when the scientific state of the art is, in a way, catching up with the ambitions of Healthy Cities. Smedley and Syme (2000), Mackenbach and Bakker (2002), Berkman and Kawachi (2000), Marmot and Wilkinson (1999), Wilkinson (1996) and Evans, Barer, and Marmor (1994), to name just a few of the *books* describing this 'problem', see complex, interconnected and often reciprocal relations between such factors as social capital, community coherence, policy-making, social systems, marginalization, the 'Robin Hood index', the immune system, social networks, poverty, education, physical and economic infrastructure, and health. Although Healthy Cities by any indication from these works seems to be on the right track, it must be conceded that the definitive substantiation of these indications is not immediately forthcoming.

The review by Merzel and D'Afflitti (2003) mentioned above is a point in case. The authors cannot find evidence that community health interventions are effective. However, criteria for inclusion of studies in their meta-analysis specify that these studies must adhere to the methodological 'experiment-control study' design. Perhaps such designs *qualitate qua* are incapable of producing evidence of effectiveness, precisely because of the fact that the complexity and uniqueness of the phenomena under study do not lend themselves to an

application of that methodology (Dobrow, Goel, & Upshur, 2004). The challenge, we feel, is in the establishment of coherent theoretical frameworks that would lead to a methodological toolbox suited to deal with the complex, interconnected and reciprocal problems that Healthy Cities present us with.

The establishment of the theoretical or conceptual frameworks should lead to the implementation of TBE, as discussed above (Birckmayer & Weiss, 2000). Proper application of TBE requires validated operationalizations of theory into appropriate methodologies. These in turn, we repeat, explain not only *that* things work, but also *how*. These answers constitute relevant utility-driven evidence for Healthy Cities operators.

Conclusion: moving forward

From our compilation of findings in an *enlightenment* perspective on utility-driven evidence for Healthy Cities it appeared that there is a convincing body of knowledge to indicate that 'Healthy Cities' works. From the *problem-solving* perspective on E-HCP, though, we have not been able to establish unequivocal proof that would contribute to informed decision-making in urban health.

Two challenges lie ahead for comprehensive and complex public health interventions to deliver.

First, those who argue for more, or more decisive, evidence in this domain would have to clarify the utilities for which such an evidence is to be pursued. The bargaining and negotiation game that policy-making is extends, and very much so in the Healthy Cities realm, to a multitude of actors and stakeholders beyond the academic community and decision-making circles. As long as there is no agreement in this arena on the nature of evidence, it would be hard to produce convincing clarity on its deliverables. We would argue that the nature of 'Healthy Cities'—a realm to test innovations in public health—constitutes an appropriate arena to address this challenge. WHO, the self-declared institutional broker in the field, can and should be instrumental in facing this challenge.

Second, utility-driven evidence and theory-based evaluations constitute solid conceptual foundations for the pursuit of further coherence within a diversity of theoretical and methodological approaches to the assessment of complex public health interventions. Consistent logical frameworks that address proximal and distal determinants and interventions for health should be further developed and applied. Given the almost two decades that Healthy Cities have been around, it is astonishing to find that the combined literature on the subject only presents a rough framework from which operational concepts, presumed final and causal relationships and common features are to be extracted. Building on intervention typologies and planned approaches to the development of health interventions it is high time for *academia* to deliver.

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