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

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

Abstract

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

Key words

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

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Introduction

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

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

Background

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

FIGURE 1 ABOUT HERE

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

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

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

The German Healthy Cities Network (HCN)

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

- development and strengthening of interagency health promoting municipal politics
- development and strengthening of practices for the assessment of the health impacts of urban development and
- development and strengthening of conditions for mobilisation of citizens, civic participation and self-help.

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

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

BOX 1 ABOUT HERE

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

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

Methods

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

Recruitment

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

The questionnaire, developed in January 2002, was distributed over a three month period (March - May 2002). The survey was *retrospective*, relating to the period 1999 – 2002, based on assessing standards listed in the aforementioned Nine-point Programme of Action. Questions were developed by the principle researcher (Author 1: KP) in consultation with health promotion specialists, academics and the HCN Coordinator for Germany at that time. Items were developed in accordance with survey objectives, key stakeholder information needs and existing indicators identified from a systematic review of the relevant health promotion literature (e.g. Webster et al., 1996; WHO 1997a, 1998a & 1998b).

The original questionnaire contained 78 standardised and 23 open questions; a further 27 questions, using 10-point-rating-scales, were added following consultation, to allow local coordinators to rate perceptions relating to performance of local HCP, the Nine-Point Programme of Action, the Cologne Resolution and the Osnabruck Recommendations (see: www.gesunde-staedte-netzwerk.de). The questionnaire was divided into six broad areas (Box2). BOX 2 ABOUT HERE

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Respondents were asked to operationalise key concepts, such as 'intersectoral collaboration', through open-ended questions. Internal validity was enhanced through respondent checking including presentations to professionals via HCN annual general meetings (AGM) (Hamburg, June, 2002; Münster; June, 2003).

A sub-set of 30 questions from the questionnaire were subsequently adapted to construct a monitoring tool for local projects, or the aforementioned "Healthy Cities Barometer" (Plümer & Trojan 2004). Six dimensions were organised into three themes:: (i) *Structure* (staff and equipment, commitment), (ii) *Process* (concept quality, network integration) and (iii) *Outcome* (self- reported success, city integration (Box 3). This was developed to inform HCN about the range and variety of local HCP via a simple to use profile of 'quality indicators' through an ongoing benchmarking process within the German HCN.

BOX 3 ABOUT HERE Construction of Quality Indices for the "Healthy Cities-Barometer"; for the modelling of an easy to handle quality monitoring instrument (Plümer & Trojan, 2004), we have constructed six weighted and aggregated variables which are based on 30 questions of the questionnaire. We called the instrument "Healthy Cities Quality Index" or "HC Barometer". The indicators represent the quality dimensions structure, process and outcome according to Donabidian (1966, 1991) in order to illustrate standards of quality achieved by single cities and the HC-network. For '*structural quality*', we used the indicators (S1) equipment and (S2) self-commitment (to what extent are the minimum standards fulfilled); for the *process quality* the indicators (P1) concept quality and (P2) integration in the local policy structures; and for the *outcome quality* the indicators (O1) self assessed success and (O2) integration within the council or rather the local Political-Administrative-System (PAS) of a city.

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

BOX 4 ABOUT HERE

Data Analysis

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

Findings

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

Characteristics of the Healthy Cities Network Germany

Membership is not restricted to Cities, with towns, administrative rural districts and

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boroughs accepted into the German HCN. More than half (53.2%) of the cities questioned in 2002 had been long-standing (i.e. 10 years or more) members of the network; a further 17% members for 5-10 years; with approximately a third (29.8%) involved four years or less. Growth of the network slowed considerably in the second five-year-period (1994-1998) whilst growth in the third period (1999-2002) is marked by the entry of six Berlin city districts; three out of these six Berlin City districts came from the former Eastern part of Berlin (East-Berlin). The city state Berlin joined HCN later in 2003..

Staffing, Coordination & Resources

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

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

Resources and facilities available to Healthy Cities Offices

In all cases the Healthy Cities Office and Coordinator (HCC) act as the local interface between the Healthy Cities Project (HCP) and the wider community. An important consideration therefore is whether the resources and facilities available locally are adequate to support this function. Approximately one third of coordinators reported having adequate access to 'basic office facilities' (Tab. 1), including own office, desk, telephone , fax, internet access and personal e-mail-address; almost half (46.7%) however relied upon access to facilities through their host organisation.

Only 10 (22%) HCC reported having access to specific budgets to support activities; a third (31%) had no budgetary support and the remaining 47% accessed minor expenses only (e.g. basic office supplies, printing services) through their associated department. The annual budget available to HCC was minimal; typically ranging from below 2.500 Euro to 5.000 Euro per year (Tab. 2).

TABLE 2 ABOUT HERE .

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

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

TABLE 3 ABOUT HERE

Respondents were asked about the nature and quality of their activities, as prescribed by the

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Healthy Cities Nine-Point Programme of Action. Clearly, intersectoral collaboration, public relation work, documentation and evaluation are all essential components of their work. Coordinators were then invited to rank their involvement in the range of core HCP activities identified. Core activities cited most often (Box 4), were: child and youth health activities (34), thematic (health) action days (33) and self-help (31). This was followed by moderate level of action in more strategic aspects, like 'local health conferences' (28), action to promote interdisciplinary working and collaboration, public participation (26) and networking (25). 'Core activities' undertaken less often included 'settings for health' (18), poverty and health (15), environments, sustainability and health (13), and mobilising partners (agencies). It was possible to gauge from respondents' accounts whether individual HCP adopted traditional, such as lifestyle (smoking) or risk group (migrant health) oriented approaches or more innovative approaches to health promotion. Descriptive statistics revealed that traditional approaches on the one hand and innovative ones on the other were equally applied in the cities.

Almost half HCC said they had a high degree of autonomy in terms of planning and prioritising workload. The other half however was directed by the aims and objectives of the employing organisation.

Network Integration: Self-reported success and City Integration

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

TABLE 4 ABOUT HERE

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

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

TABLES 5 AND 6 ABOUT HERE

At the time of the Survey several efforts had already been initiated to redress these problems, for example, the creation of so-called 'centre's of competence'or excellence, in certain fields of action like child and youth health or migrants and health; in 2002 a modified service fee or

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budget was introduced for public relations work, based on the size of the community, which replaced the voluntary fee previously introduced in 1994; and the introduction of the quarterly circular 'Healthy Cites News'. Nonetheless, in 2002 the 'centres of competence' and the new 'service fee for public relation' had not yet fully developed and were therefore unable to have as great an impact on improving the internal network communication as intended; this may explain why the relevant structural elements of the network (Tab. 7) have been somewhat critically appraised by HCC's, with only modest mean scores, on the 10-point-rating-scales, ranging between 5.6 (importance for the local work) to 6.6 (exchange of information); whilst the benefit of the HCN Website, launched 1996, was poorly rated by most HCC (mean 4.6). A majority of 33 respondents out of 38 marked a need for change of the HCN.

TABLE 7 ABOUT HERE

Levels of evaluation and monitoring activity

Nearly all coordinators described being actively involved in public relations, with 68% using reports, presentations and/or brochures to promote their work. A further 60% claimed they evaluate activities, mostly internal, with only 10 of 47 projects engaging external evaluators (Tab. 8). The whole Healthy Cities Project was externally evaluated only in two cases (Plümer, 2002), one of them in conjunction with the WHO European Healthy Cities Network (WHO 1997b) and the second by internal and external (Tab. 9).

TABLES 8 AND 9 ABOUT HERE

Self-Assessment of achieved Success

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

TABLE 10 ABOUT HERE

When asked to rate their performance at the local and national level, most felt that the work they were doing was both effective and worthwhile. This is underpinned by applying the benchmark scores of the "Healthy Cities Barometer" as shown in Tab 11. Almost 75 percent of HCN member municipalities (35 out of 47) demonstrate results in the survey that indicate strong level performance (good to excellent), with approximately one third (12) of Healthy Cities projects described as somewhat weak. With one exception these are medium towns and small cities which joined the HCN after 1993, in some cases after 1998, and were therefore assessed over a much shorter development period. Closer inspection of the results in Table 11 and the details of member cities suggests however that the duration of membership in HCN does not necessarily explain quality or performance; the ten founding member cities from 1989 can be found in all three performance levels but mostly in the satisfactory (B-Category); whilst two show ratings as excellent whereas another project's

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performance was particularly weak. It would seem that the size of a city (population) in combination with the length of membership and the continuity of the local project coordinator are critical factors in determining performance. Of the nine rated excellent, five were in the highest population category , most had been members of the HCN since before 1992.

TABLE 11 ABOUT HERE

Discussion

This paper offers insight into the diverse and complex nature of a Healthy Cities Network (HCN) in northern Europe and important snapshot of current progress by the Healthy Cities Programme in Germany. Besides a few exceptions (e. g. Boonekamp et al., 1999; Donchin et. Al., 2006; Goepel, 2007), two thirds of all Healthy Cities in Europe have yet to undertake some form of evaluation. As the findings suggest valuable insight can be gained from surveying HC coordinators working in the field; illuminating details of day to day implementation and issues, but particularly the tensions between policy and practice. This was strengthened by the adoption of a total population sample, involving all HCC and the successfully high response rate in the first ever survey of German Healthy Cities. In doing so the German HCN continues its efforts to achieve progress towards the original goals (WHO, 2003b) *"to establish an alliance to increase the impact of health promotion … by working more closely within institutions active in this field, such as the Federal Centre for Health Education, the Federal Association for Health, medical associations, public health organisations and environmental groups"* (WHO, 2003b).

All research has its limitations. Surveys are inherently limited by the use of predefined concepts and structured questions but as was the case here can partly be overcome by including open-ended questions. The subjectivity of individual perception and judgment is a particularly contentious issue in health promotion research. Some claim that subjective perception acts as a filter regarding reality (Berger & Luckmann, 1966; Rohrer, 2007). Others argue that there is no single truth but multiple versions of reality co-exist in people's narratives or stories (Brown at al., 2005) providing a rich and more complex understanding of social phenomena. Hence, in interpreting these findings it is worth acknowledging that several factors could influence respondent's perspectives. First, individual expectations of quality and performance inevitably differ between coordinators; second, variations exist between HCC in terms of creativity and personal engagement in a project; thirdly, structural factors, like degree of autonomy, independence from external agencies or political alliances. . Shortcomings apply to most research situations and the authors are confident that steps to improve validity such as member checking, triangulation (e.g. multiple and alternate forms of questionnaire items) for internal consistency and validity and respondent verification, strengthen the generalisability of the findings.

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

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

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

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

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

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

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

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

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significantly shift the political situation in Germany towards a broad health agenda.

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

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

Conclusion

National networks of healthy cities are a powerful resource for health and sustainable development in Europe. They provide an infrastructure for achieving the goals and principles of Health for All and moreover, for implementing Health in All Policies locally. The findings here add to and extend the findings produced from previous surveys of national networks. They support the common structural and organisational features and activities identified for successful Healthy Cities across Europe. Several cross-cutting criteria have been identified for successful Healthy Cities operations: endorsing principles and strategies, establishing infrastructure, making a commitment to products and outcomes, and networking. But the most important aspect is in helping extend the Healthy Cities Concept as an integrated template for local policies as a guiding strategy for effective healthy and sustainable development of cities.

Current international debates about "Domains of Core Competency for Building Global Capacity in Health Promotion: The Galway Consensus Conference" (Barry et al., 2009) and increasing body of programmes and activities focusing on setting-oriented health promotion for socially disadvantaged populations in Germany, should be viewed as a welcome opportunity for German HCN to professionalize and improve its performance particularly in

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current financial climates. Generating evidence – and appropriate tools – to demonstrate whether Health Promotion works remains a key challenge for Healthy Cities.

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For Peer Review

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

For Peer Review

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

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

Source: WHO/EURO 1986

For Peer Review

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

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

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

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

For Peer Review

Box 2: Example of type of qualitative indicator developed fro the Healthy Cities Barometer: (S1) equipment quality (6 items)

Box 2: Example of type of qualitative indicator developed fro the Healthy Cities Barometer: (S1) equipment quality (6 items)

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

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

In terms of content the three quality levels express:
***A**-level:* the project coordination is a fulltime job. The office is equipped with working hours representing at least one fulltime job and has sufficient office equipment. There is an own budget and an own telephone number.
***B**-level:* the project coordination has a fulltime worker or is a part time job, which is exercised as one particular task of the job. The office has no fulltime job and less than three part time jobs. There is no budget but material and financial means can be taken from other sources. The office has no own telephone number.
***C**-level:* the project coordination is only sporadically available, an office is not announced and financial means are not available.

An overall score per member municipality was formed by given points per indicator: 3 to ***A**-level*, 2 to ***B**-level* and 1 to ***C**-level*; these points were added up to set a benchmark within the German HCN.

For Peer Review

Box 3: Survey Instrument – Question areas (Questions relating to…)	Corresponding items
(1) Equipment, stationary and human resources (staff)	4
(2) Accommodation & facilities available to the local Healthy Cities Projects	12
(3) Priorities, concepts and strategies employed by local Healthy Cities projects	25
(4) Questions relating to the Nine-Point Programme of Action adopted by the HC-Network in Germany (1993)	72
(5) Questions related to the Cologne Resolution »Equality of opportunity for a healthy life« and the Osnabruck »Recommendations of Quality Criteria« (2000)	5
(6) Healthy Cities Network and its development.	9

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

For Peer Review

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

(citations, numbers of respondents)

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

multiple response

For Peer Review

Table 1

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

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

The differences to the total sample of 47 are missing.

Tab. 2: Budget & total Amount per Year

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

The differences to the total sample of 47 are missing

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

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

The differences to the total sample of 47 are missing.

For Peer Review

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

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

The differences to the total sample of 47 are missing.

Tab. 5: Linkage between HCN & Member Cities

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

The differences to the total sample of 47 are missing.

Tab. 6: Exchange of Information between the Member Cities

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

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

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

The differences to the total sample of 47 are missing.

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

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

*2 did it partly

Tab. 9: Mode of Evaluation

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

The differences to the total sample of 47 are missing.

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

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

The differences to the total sample of 47 are missing.

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

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

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

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