# Healthy Cities - What makes the difference at a local level?

**An analysis on factors for success in creating healthy public policy**

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## ABSTRACT

The World Health Organization (WHO) states that working intersectorally and internationally with health issues is crucial in creating a change towards healthy public policy at a local level. Healthy Cities is one of the programmes where WHO uses a health governance approach (governing through networks) to try to reach this objective. The aim of this bachelor thesis is to identify the factors that make member cities of the WHO European Healthy Cities Network successful in reorienting local public policy towards healthy public policy. An analysis of nine documents corresponding to the selection criteria set up by the authors was conducted. These documents consisted of reports published by WHO on the Healthy Cities programme, but also of independent research articles and one thesis published on other networks similar to Healthy Cities. Also, further data was collected through telephone interviews with contact persons in four member cities. The interviews were transcribed word by word. Both data (documents and interviews) were analysed using a qualitative content analysis.

The results show that the four key "elements for action" (political commitment, leadership, readiness for institutional change and intersectoral collaboration) crystallized by WHO for creating healthy public policy were mainly confirmed in this research study. Therefore, the authors draw the conclusion that WHO has succeeded in making the member cities commit to the Healthy Cities philosophy and in spreading the idea of health governance in Europe. However, additional factors were found both in the document analysis and in the interviews. When looking at the top four frequently occurring factors in the documents, community participation and status were highlighted. The two additional factors found in the interview data was holistic thinking and systematic, goal-oriented work. Also, the importance of political commitment was questioned by a minority of the respondents. This might indicate that the four key "elements for action" crystallized by WHO might not have as big of an effect in creating change at a local level as has been made out by WHO. Furthermore, respondents stated that difficulties existed in translating theory into practice at a local level. This might indicate that potential changes made in the member cities after joining the Healthy Cities programme are mainly ideological. Despite this, the attitudes among the respondents towards membership in the WHO European Healthy Cities Network were overall positive, and even though difficulties still exist, the respondents maintained that Healthy Cities enables them in taking the next step towards healthy public policy at a local level.



**Key words:** public health, Healthy Cities, success factors, health policy, healthy public policy, health governance, Europe

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## SAMMANFATTNING

Världshälsoorganisationen (WHO) fastslår att intersektoriellt och internationellt samarbete för hälsa är avgörande för att skapa förändring mot en hälsosam samhällspolitik på lokal nivå. Healthy Cities är ett av de program där WHO använder sig av ”health governance” (nätverksstyrning) för att uppnå detta mål. Syftet med denna kandidatuppsats är att identifiera de faktorer som gör medlemsstäder i WHO:s europeiska Healthy Cities-nätverk framgångsrika i att omfokusera lokal samhällspolitik mot en hälsosam samhällspolitik. En analys av nio dokument som uppfyller urvalskriterier uppsatta av författarna genomfördes. Dokumenten bestod av rapporter som publicerats av WHO på ämnet Healthy Cities, oberoende forskningsartiklar och en uppsats om andra nätverk liknande Healthy Cities. Ytterligare data samlades in via telefonintervjuer med kontaktpersoner från fyra medlemsstäder i nätverket. Intervjuerna transkriberades ord för ord. Det kompletta datamaterialet (dokument- och intervjudata) analyserades med kvalitativ innehållsanalys.

Resultatet visar att de fyra faktorer (politiskt engagemang, ledarskap, beredskap för institutionell förändring och intersektoriellt samarbete) som utkristalliserats av WHO som nyckelfaktorer för att skapa hälsosam samhällsplanering till största delen bekräftades av denna studie. Därför drar författarna slutsatsen att WHO har lyckats få medlemsstäderna att förbinda sig till Healthy Cities-filosofin och sprida idén om nätverksstyrning i Europa. Dock återfanns ytterligare faktorer både i dokumentanalysen och i intervjuerna. Genom att titta på de fyra faktorer som återfanns flest gånger i dokumenten framhävdes också samhälleligt deltagande och status. De två extra faktorerna som återfanns i intervjuerna var holistiskt tänkande och systematiskt, målorienterat arbete. Dessutom ifrågasattes betydelsen av politiskt engagemang av en minoritet av respondenterna. Detta kan tyda på att de fyra ”nyckelfaktorerna för handling” som utkristalliserats av WHO inte har lika stor betydelse för att skapa förändring på lokal nivå som påståtts av WHO. Vidare uppger respondenterna att svårigheter med att översätta teori till praktik förekom på lokal nivå. Detta kan tyda på att eventuella förändringar som gjorts i medlemsstäderna efter att de gått med i Healthy Cities är till största del ideologiska. Trots detta var inställningen till medlemskapet i WHO:s europeiska Healthy Cities-nätverk generellt sett positiv bland respondenterna, och även om svårigheter fortfarande existerar, står respondenterna fast vid att Healthy Cities möjliggör för dem att ta nästa steg mot en hälsosam samhällspolitik på lokal nivå.

**Nyckelord:** folkhälsoarbete, Healthy Cities, framgångsfaktorer, hälsopolitik, hälsosam samhällspolitik, nätverksstyrning, Europa

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# 1. INTRODUCTION

The rapid changes in patterns of lifestyle, work and leisure, and the new patterns of social interaction, have a big impact on people's health today. New health problems followed by the globalization stretch over national borders, and draw the attention of committed people across the globe (WHO 1986, Commission on Social Determinants of Health 2008, Tillgren 2009). The insight that people's health and wellbeing are dependent on social, environmental and economic structures as well as public health efforts and the health service, calls for intersectoral collaboration between various actors in society to take action on these issues. To facilitate this process, the Ottawa Charter for Health Promotion (WHO 1986) suggests a reorientation of local public policy towards healthy public policy. Healthy public policy means that all government sectors include and take into account health when formulating policy. Also, the sectors should be held accountable for health consequences following their policy decisions. Consequently, the health status of the citizens will be raised. WHO states that healthy public policy will lead to economic benefits and that it will make social and physical environments health-enhancing, and thus enabling people to make the healthier choice (WHO 2009d). This policy reorientation is to be achieved by using health governance, a less hierachical type of governance that focuses on cooperation in networks and other types of partnerships between various actors in society (Tillgren 2009). One such partnership is the WHO European Healthy Cities Network, through which WHO encourages intersectoral and international collaboration and promotes the idea of health governance in Europe. In doing so, WHO and Healthy Cities want to put public health on the political agenda (WHO 2009a).

The WHO European Healthy Cities Network functions as a knowledge base for its member cities. Together, the member cities strive to "build political support and improve policy and practice through information sharing" (WHO 1997, p. 5). For a city to be successful in this commitment, WHO has crystallized four key "elements for action" that need to exist in a member city: explicit political commitment, strong leadership, readiness for institutional change and intersectoral collaboration (WHO 2006). According to WHO, the presence of these specific elements in a city will help raise public health and make it visible on the political agenda, and consequently promote a reorientation of local public policy towards healthy public policy (WHO 1997).

As most documents, descriptions and evaluations published on Healthy Cities are a product of WHO, there is a need for an external view that might give another insight, more neutral on the issue relating to the success of the Healthy Cities programme. The question is whether the key success factors, or "elements for action", crystallized by WHO (mentioned above) really make all the difference. Or are there other factors that explain the success? By investigating success factors of the Healthy Cities programme in regards to its affect on the reorientation of local public policy towards healthy public policy, we hope to advance the knowledge about how to best facilitate ideological and institutional changes in regards to public health within traditional municipal structures.

## 1.1 Research aim

The Healthy Cities programme claims that membership in the WHO European Healthy Cities Network makes a difference. Member cities have shown to be more successful in working towards a healthy public policy after joining the programme than they were before (WHO c. 1998). With this thesis we want to identify the factors that make member cities successful in reorienting local public policy towards healthy public policy.

- What are the factors needed for a successful reorientation of local public policy towards healthy public policy in member cities of the WHO European Healthy Cities Network?
- Might there be other factors besides the key "elements for action" previously crystallized by WHO?

# 2. THEORETICAL FRAMEWORK

In this chapter we will introduce Healthy Cities as a concept, the history behind the programme and its main objectives and aspirations. We will also present the connection between public health and politics, and point out the importance of decentralization and governance for achieving policy changes at a local level. Also, we have included previous research that has identified success factors in other Healthy Cities programmes around the globe, and to conclude, a summary of the theoretical framework is presented.

## 2.1 Healthy Cities

Firstly, the authors would like to clarify the difference between the various terms used in this text. When the term "the Healthy Cities programme" is used, it refers to the entire concept of Healthy Cities and its philosophy. When referring to the European network, which is the focus of this thesis, we will consistently use the term "the WHO European Healthy Cities Network". There is also a difference between the European network and the national networks that exist in most European countries. A city can be a member of both their national network and the European network, but can also choose to exclusively be a member of one or the other. One of the objectives of the European network is to support the national networks by passing on knowledge from an international to a local level[1].

During the 1970s and 1980s, several international public health policy initiatives were launched that were given a lot of attention by both governments and press. These policies, together with new global priorities and socio-political changes in Europe, changed how people thought about and understood health. As a response to this, the WHO Regional Office for Europe initiated the Healthy Cities project in 1988 (Janss Lafond et al. 2003). Healthy Cities was firstly started as a pilot project with the objective to prove that the strategies documented in the "Targets for Health for All" (WHO 1985) could work in practice. Initially, the pilot project had 11 member cities (WHO 1997), but it quickly expanded and developed into a movement (Janss Lafond et al. 2003). Today, The WHO European Healthy Cities Network has 79 member cities[2]. The diverse socioeconomic and organizational profiles of the members "provide a vast and unique seeding ground to test new ideas and harvest precious knowledge" (Green & Tsouros 2008, p. 2).

The Healthy Cities programme is inspired by the ideas of WHO, documented in several international charters and declarations (Green & Tsouros 2008). Among these is the Ottawa Charter for Health Promotion (WHO 1986), which together with the "Health for All"-strategy (WHO 1985) and Agenda 21 (UN 1992) provide the framework for the Healthy Cities programme (WHO 1997). The Healthy Cities programme focuses particularly on equity,

[1] Christina Halling, project assistant at Lund University, Sweden, e-mail 2008-04-14.
[2] Elisabeth Bengtsson, Chair of the Advisory Committee for the WHO European Healthy Cities Network, Helsingborg, Sweden, e-mail 2009-05-24.

participatory governance, solidarity, intersectoral collaboration and actions to address the determinants of health (WHO 2006).

The Healthy Cities programme seeks to make health issues a priority in its member cities by putting health high on the political agenda. It recognizes local decision makers' role in public health issues. As local structures are needed for creating this change (WHO 1997), member cities are required to put together an intersectoral committee for health, and establish the programme at the top political level (Green & Tsouros 2008). Furthermore, for a city to be accepted into a Healthy Cities network, it has to present a written approval (confirmed with signatures) from both the city mayor and the responsible civil servant, commiting to uphold the values of Healthy Cities and to implement the Healthy Cities approach within their own city (WHO 1997).

The WHO European Healthy Cities Network has evolved over four five-year phases, each giving special attention to a number of priority themes (WHO 2009a). During the current phase V (2009-2013), member cities have agreed on three main themes. These are caring and supportive environments, healthy living and healthy urban design, and these themes will influence the work done in the member cities for the next five years. The themes for the next upcoming phase are decided on in an international Healthy Cities conference, that the member cities participate in a few months before the launch of the next phase. The latest conference was held in Zagreb, Croatia, in October 2008, and produced a document, the "Zagreb Declaration for Healthy Cities", in which the main objectives for the next phase are concluded (WHO 2009b).

### 2.2 Health policy, public health policy and healthy public policy

To facilitate this sometimes complex discussion, we will start by trying to explain important terms and how they are interlinked. Traditionally, health policy (Sw. hälso- och sjukvårdspolitik) has had a focus on individuals and patients. However, public health policy (Sw. folkhälsopolitik) has increasingly been seen as a complementary perspective on how to tackle health issues (Tillgren 2009). The focus of public health is not disease and medical care, but a holistic view based on the determinants of health that matters for health and public welfare (Marmot & Wilkinson 2006). Today, health policy and public health policy exist side by side, and this follows a global development of health issues that has been chanelled first and foremost by WHO, with the support of the governments of its member countries (Tillgren 2009).

According to Tillgren (2009), politics, economics and other social forces are all strong explanatory factors for health in a society. Politics is a multidimensional term, aiming to steer or affect the development in a society based on a specific ideology. The term "policy" is also connected to politics and political decisionmaking. In the Swedish language, the terms "politics" and "policy" are closely related, and it is hard to differentiate the two. Politics in this context is related to the processes through which power is exerted and political decisions are made, and policy is more about the principles of the current political ideology and its actual contents (Tillgren 2009).

Tillgren (2009) speculates why health is considered a subject for national and international politics, and says that there are many reasons. For instance, health in itself has a value and together with other factors, it constitutes a base for a nation's welfare. It is also considered valuable in a socioeconomic sense, as it is regarded favourable for the nation state to have a healthy population and workforce. A healthy population is of vital importance to economic

growth and the social order of society. According to Tillgren (2009), the objective of public health policy is to improve public health through politics. The goal is to create supportive environments that enable people to live healthy lives. This definition corresponds partly with the contents of WHO's term "healthy public policy" (Sw. hälsoinriktad samhällspolitik), which was firstly introduced in the document "The Ottawa Charter for Health Promotion" in 1986. With this document, healthy public policy was made one of five prioritized actions areas:

> *[Health promotion] puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilites for health… Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well. – WHO, 1986.*

The healthy public policy idea was further developed during the Adelaide Conference for Health Promotion in 1988. The Adelaide Conference states that healthy public policy is concerned with health and equity in all areas of policy making, and that all government sectors should take into account health as an essential factor when formulating policy. Also, these sectors should be held accountable for health consequences following their policy decisions (WHO 2009d). In pursuing the goal to achieve healthy public policy, WHO promotes intersectoral collaboration and political commitment to public health issues. To facilitate this desired change, WHO offers membership in the Healthy Cities programme to countries and cities all over the world where members together can strive to build political support and improve local public policy through information sharing (WHO 1997, Walt 1994).

## 2.3 Governance in policy making

### *Policy approaches*

According to Walt (1994), in a top-down approach, it is assumed that policy formulation occurs within national government. When the policy has been formulated, implementation of it is a largely technical process. Implementation is most often carried out by administrative agencies at the national or sub-national levels. In the case of health policy, decisions by politicians and bureaucrats within the ministry of health are communicated to planners in the health planning unit (they may or may not have been involved in policy formulation), who operationalize policies by designing appropriate programmes, with guidelines, rules and monitoring systems. These are then transferred to local authorities or to health care institutions (e.g. hospitals or health centres) to be put into practice (Walt 1994).

In contrast, a bottom-up approach means that implementers often also play an important part in policy formulation, as active participants in an extremely complex process that informs policy upwards as well as downwards. Hence, implementers may change the way a policy is implemented, or even re-define the objectives of the policy because they are closer to the problem and the local situation. In this approach, policy making is interactive, with formulation and implementation as two elements in a continuous loop (Walt 1994).

### *Governance and decentralization*

The term "governance" is in broad terms synonymous with coordination and steering, and generally, it is more a question of process than institutions. The traditional hierarchy is a type

of governance, and so are various types of network constellations and other informal types of collaborations and partnerships. Governance includes both public and private actors (Pierre 2001).

Pierre (2001) states that decentralization of power from an international or national level to a local level contributes to making the municipality administration a more interesting business partner for the local industry and local organizations. When the municipality gets more room for self-determination, these local actors have more to gain from trying to affect the local politics. In a more centralized system, this would have been pointless as the important decisions are made by institutions on a higher level. Decentralizing power also affects the municipality administration itself, as they improve their possibilities to form partnerships or other types of permanent cooperation organs with local businesses, sports associations, culture associations and other local organizations. Another consequence of decentralization is the strenghtened position of the citizens. This has lead to that the work of the public sector, and the political support for it, has increasingly become a question of trust and legitimacy (Pierre 2001).

***The position of WHO***

When talking about WHO and the Healthy Cities programme in terms of what they can contribute with to the member cities when it comes to reorienting local public policy (Sw. lokal samhällspolitik) towards healthy public policy (Sw. hälsosam samhällspolitik), one has to consider their position in the global public health community. WHO is a United Nations' organ, with the authority to direct and coordinate. It is responsible for providing leadership on global health matters and shaping the health research agenda, setting norms and standards and monitoring and assessing health trends, among other things (WHO 2009c). This responsibility indicates a top-down approach to adressing health issues, but WHO itself recognizes the need for, and advocates, a bottom-up approach by supporting networks like Healthy Cities. Basically, WHO tries to affect issues concerning global public health by decentralizing power to the local level. This coordinating action is a type of governance (Pierre 2001).

### 2.4 Health governance

Health governance is a less hierarchical model than the traditional types of governance used in the public sector. It is based on cooperation in networks and partnerships between the state, the business sector and organizations within the society. It has been promoted due to the limitations of the more hierachical types of governance when it comes to dealing with intersectoral issues. Also, people and products increasingly move over national borders in our globalized world. This development has a major impact on the public health of a population as the risks for ill health and disease can quickly change and spread (Tillgren 2009). In addition, health is not only an outcome of other social and economic developments today, but also a significant defining factor of these developments. The most obvious example is the increased health and longer life expectancy that occur in modern societies today, which affect and redefine nearly every area of public policy (Kickbusch 2007). To be able to handle this development, this new form of health governance has been promoted and started to be implemented.

As health governance becomes a more and more acknowledged model of governance, it helps expand the reach of public health policy into other sectors of society. This has an affect on local public policy, sometimes by shaping laws and regulations, and in other cases promoting shifts in cultural understanding and perception (Kickbusch 2007). Despite this expansion of public health policy, and the effect it has on local public policy, the national and international

policy arenas are slow in creating the necessary change. This is by Leppo (1998, in Kickbusch 2007) called "the modern health policy paradox". Leppo says that "one of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has occurred about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different" (Kickbusch 2007, p. 157). This implies that there is still work to be done in promoting healthy public policy.

### 2.5 Previous research

Springett (1998) examined a Healthy Cities initiative in Liverpool, UK. She found that the implementation of the Healthy Cities programme had a major influence on the development of a settings approach towards health policies and programmes. Springett talks about "terms of effectiveness", and she found that intersectoral collaboration was crucial for an ideological change to occur:

> *…joint working is effective if it facilitates the desired change (outcome) with the best possible use of working together (process), and that it brings about "more" change for health… than single organizations would have achieved on their own or in other ways (p. 167).*

Springett also mentions that the key to sustainable change within an organization is participatory decision-making, and that all participants in the process are encouraged to participate in a dialogue about what is appropriate and possible. Hence, opening channels for communication within the organization is important for a programme like Healthy Cities to be successful. In Liverpool, the people working with Healthy Cities tried to develop their own framework for evaluation of health measures, and by systematically addressing key concerns, people eventually changed their perceptions on the concept on health and therefore their priorities. Consequently, the need for health evaluation rose up on the political agenda (Springett 1998). The Liverpool experience is a live example of how the Healthy Cities programme has made a difference for a member city.

A research study performed in Brisbane, Australia, claims that creating healthier and more sustainable cities requires new approaches in planning at the local level (Davey 2005). The report presents the findings from the evaluation of a local project, MPHP (Municipal Public Health Planning), which is based on the philosophy of Healthy Cities, and the success factors that was found. MPHP success factors for sustainability included the importance of a 'platform approach' when implementing a model like MPHP in a city. The platform had three dimensions; governance (including a long term vision, layers of planning and industry support), a platform (mechanisms for networking, a stakeholder forum, an advisory committee and project management) and implementation (local strategies and priority action arenas, desired outcomes, communication process and evaluation) (Davey 2005).

Baum et al. (2006) examined the factors that have enabled the Healthy Cities programme in Noarlunga, Australia, to be sustainable over 18 years, and a number of factors emerged as important. They were; a strong healthy vision, inspirational leadership, a model that can adapt to local conditions, ability to juggle competing demands, strongly supported community involvement that represents genuine engagement, recognition by a broad range of players that Healthy Cities is a relatively neutral space in which to achieve goals, effective and sustainable links with a local university, an outward focus open to international links and outside perspective and, most crucial, the initiative makes the transition from a project to an approach

and a way of working. These sustainability factors are likely to be relevant to a range of complex, community-based initiatives (Baum et al. 2006).

Donchin et al. (2006) explored the level of implementation of the Healthy Cities programme's strategies in eighteen member cities in Israel. A number of significant enabling factors were recognized by the authors: the network coordinator's participation and commitment in activities and ability to capacity building was shown to be important. Also, political commitment and support from the decision makers were found to lead to better implementation of the Healthy Cities strategies in Israel (Donchin et al. 2006).

### 2.6 Summary of the theoretical framework

The globalized setting in which we exist today affects health risks and therefore also the ways in which we need to work with reducing these risks (WHO 1986, Commission on Social Determinants of Health 2008, Tillgren 2009). As a response to this development, a new type of governance has emerged when trying to reorient local public policy towards healthy public policy - health governance. Health governance is less hierachical than its traditional predecessors and focuses on collaboration in networks or other partnerships in all sectors and at all levels (Kickbusch 2007). By supporting networks like Healthy Cities, WHO promotes a bottom-up approach (Walt 1994) to policy making by decentralizing power to a local level. The idea to try to achieve healthy public policy to improve public health was firstly expressed in the Ottawa Charter (WHO 1986), and WHO continues to work towards this objective today. The Healthy Cities programme has itself identified several success factors for creating change in local public policy, and four key "elements for action" have been especially highlighted; explicit political commitment, strong leadership, readiness for institutional change and intersectoral collaboration (WHO 2006). Other factors for creating this desired change has been identified in other research reports presented above, where neutral persons have evaluated several Healthy Cities initiatives in countries across the globe (Springett 1998, Davey 2005, Baum et al. 2006, Donchin et al. 2006). In this bachelor thesis, the aim is to identify the factors that make member cities of the WHO European Healthy Cities Network successful in reorienting local public policy towards healthy public policy.

## 3. METHODS

### 3.1 Choice of approach

In this bachelor thesis, we have chosen to use a qualitative research approach. This is because we believe it fits adequately with our research aim. According to Repstad (2007) qualitative methods are used when looking for insights on the basic or distinctive processes in a certain setting. Patel and Davidson (2003) claim that the purpose of a qualitative approach is to accumulate a deeper knowledge of the chosen phenomenon.

Quantitative research approaches on the other hand seek to form a general, broad picture of the conditions of a large group. According to Eliasson (2006), quantitative research methods are first and foremost suitable for investigating how widely spread different conditions are within a certain group.

Taking this into consideration, we consider a qualitative approach as the most suitable. This is because we are striving to get a deeper knowledge about the factors that facilitate the process of improving public policy at a local level, both from an official WHO perspective and from a local level perspective.

### 3.2 Research design

To get a comprenhesive insight on what the factors are that make a difference for reorienting local public policy towards healthy public policy, two research methods were used; a document analysis and interviews. By doing this, we got both a large amount of written information that we could immerse ourselves in and analyze, and the spoken word, which reflected the thoughts and opinions of our respondents.

***Document analysis***

Based on our theoretical framework and the research aim of this bachelor thesis, we chose to conduct an analysis of relevant documents in order to identify factors that are determinants of success at a local level when trying to reorient local public policy towards healthy public policy as a member of the Healthy Cities programme. To get a comprehensive view, an analysis of documents produced on this topic was considered the best way to apprehend a sufficient quantity of data. The Healthy Cities programme has existed for more than 20 years, and during this time WHO has continually evaluated the progress made in the member cities (Green & Tsorous 2008). These evaluations have resulted in a large amount of documents, which give a complete picture of the factors needed for a city to be successful in creating the desired change. We have also included research articles and a bachelor thesis on other networks similar to Healthy Cities (Health Promoting Schools and Health Promoting Hospitals) in the document analysis. The purpose of the document analysis was firstly to identify the success factors present in the chosen documents, but also to assist in preparing the interview guide for the further data collection.

***Interviews***

As a complementary method, qualitative interviews with contact persons from four member cities (Leganés in Spain, Turku in Finland, Milan in Italy and Belfast in the United Kingdom) of the WHO European Healthy Cities Network were conducted. This was due to the fact that documents in general might be insufficient or give only partial information, depending on the motive of the production of the document, e.g. propaganda purposes (Bryder 1985, Patel & Davidson 2003). Also, we wanted to get the respondents' own thoughts and opinions on what success factors might have made a difference in their particular circumstances (Repstad 2007). Repstad (2007) also talks about the importance of critically examining the sources of data, and the importance of trying to find impartial documents that describe your chosen subject. Since documents on the topic of Healthy Cities most often are products of WHO, we wanted to get an impartial view on what really makes a difference for the member cities by interviewing people with a more neutral position.

In the qualitative interview, knowledge is constructed via interplay and an exchanging of opinions between two people with a common interest. The purpose is to capture the diversity and the sometimes contradictory in the respondent's answers (Kvale 1997). To facilitate this interplay and promote an open and honest discussion, we chose to use a semi-structured form of interview. According to Kvale (1997), a semi-structured interview is neither an open conversation nor completely restricted to a questionnaire. This makes the interview open to new perspectives and insights additional to the themes constructed in advance (Kvale 1997). As a base for the interviews, an interview guide was constructed in advance (see Appendix B). But as we did not want to control the respondents' answers, we emphasized that the interview guide should be seen as a support for memory, not as a set structure to be strictly followed.

***Telephone versus in-person interviewing***

To conduct interviews by telephone is one method of reducing fieldwork-time in social science research, which often is the most time consuming part of the research process. When deciding whether to use telephone-based or in-person interviews, there are some criteria that have to be considered. For example, what kind of interview (e.g research, polling, journalistic) is to be conducted? What type of information is desirable (e.g demographic, sensitive)? And, what are the economic, time and location constraints of the research? Advantages of telephone interviewing are for example that they reduce the effect of the interviewer, there can be greater standardization of questions and greater cost-efficiency and fast results can also be received. Disadvantages of telephone interviewing might be that you get less accurate responses due to contextual naturalness (the respondents may not feel safe and calm, and small talk, politeness, joking and non-verbal communication can not be as present). Other disadvantages could be less effectiveness with complex issues, less thoughtful responses and the interview may be experienced as more exhausting and difficulty in discussing sensitive questions (Shuy 2002).

Taking all this into consideration, performing telephone interviews suited our situation the best. We had no external resources for visiting the respondents in person, and they are all very much tied up by their work, which made it difficult to be able to fit an in-person interview in the schedule. Also, since the questions asked were not considered sensitive or personal, and our aspiration was to conduct relatively short interviews (in respect of the respondents' busy schedule), telephone-based interviews were again considered more suitable for our research.

### 3.3 Operationalization

In order to create an instrument for the collection of data, we tried to operationalize the main terms in our research questions. This is because we wanted to have a clear image of what we were looking for when starting the data collection (Patel & Davidson 2003). No set definition of "success" has been made by the Healthy Cities programme, but by going through WHO websites and documents on Healthy Cities we understand that a successful outcome in this context means that a city has succeeded to conduct an institutional and ideological change towards healthy public policy (WHO 1986, 2006, 2009d).

Healthy public policy means that health is considered in all sectors and at all levels when formulating public policy in a city. Also, the sectors should be held accountable for health consequences following their policy decisions. Consequently, the health status of the citizens will be raised. WHO states that healthy public policy will lead to economic benefits and that it will make social and physical environments health-enhancing, and thus enabling people to make the healthier choice (WHO 2009d).

We will thus assume that healthy public policy is synonymous with success in this context. What we want to identify are the factors facilitating this success, i.e. factors that has brought about change in

- Making all government sectors and all levels taking health into consideration when formulating policy
- Making all sectors and all levels responsible for health consequences following their decisions
- The health status of the citizens
- Economic benefits for the municipality/city
- Making social and physical environments health-enhancing

- Enabling people to make the healthier choice

### 3.4 Implementation

***Document analysis***
In choosing the documents that were to form the base of our data collection, we searched for documents relevant to our research aim. As the aim of this thesis is to identify the factors that make member cities of the WHO European Healthy Cities Network successful in regards to reorienting local public policy towards healthy public policy, we chose the documents that fulfilled the following criteria:

- Documents had to discuss success in some form when it comes to creating change in structures and ideologies
- Documents had to discuss the issue from a local level perspective and/or have a settings based perspective
- Documents had to focus on Healthy Cities or other programmes similar to Healthy Cities started by WHO

We started by conducting a wide search for documents on the accredited internet database PubMed, and also in the online journal Health Promotion International. Also, we searched the local library database for books and previously published bachelor theses that corresponded with our criteria. In addition, we included documents published by WHO found on their website. Search terms used to find these documents were; Healthy Cities, success factors, local public health, network WHO, implementation, public health policy, internationella nätverk, nätverk hälsa, internationell hälsa.

The documents were divided equally between the authors, and we then studied them separately, one by one. The documents were sorted into two piles; documents relevant to our research aim and irrelevant documents. We arrived at a number of nine documents in total that we considered useful. For a general view of the included documents, see *Table 1* below.

*Table 1. Description of the included documents*

| **Name of document** | **Type of document** | **Number of pages** | **Summary of document** |
|---|---|---|---|
| Twenty steps for developing a Healthy Cities project (WHO 1997). | Control document (providing guidelines). | 69 | The document presents the basic facts and history of the Healthy Cities philosophy. The Regional Office for Europe (WHO/Europe) introduced the Healthy Cities project in 1988 to prove that the strategies in "Health for all" could work in practice. During the following years, cities and towns in Europe became members of the WHO European Healthy Cities Network, and national Healthy Cities networks started to operate in countries all over Europe (WHO 1997). |
| Healthy Cities makes a difference (WHO c. 1998). | Brochure promoting a membership within the network. | 4 | The document defines the Healthy Cities project "a powerful movement for health and sustainable development at the local level". It also emphasises the fact that the health of people living in towns and cities is strongly determined by their working and living conditions and the quality of the physical and socioeconomic environment. Accordning to the document, Healthy Cities gives comprehensive policy and planning solutions to urban health problems (WHO c. 1998). |
| National Healthy Cities Networks - a powerful force for health and sustainable development in Europe (Janss Lafond et al. 2003). | A descriptive report on the national networks' importance and an evaluation of each of the 29 national Healthy Cities networks within Europe. | 92 | This publication has a focus set on highlighting the national networks in Europe. It consists of two parts: an analysis of the multidimentional work and achievements of national networks across Europe, and a profile of each network focusing on its special features, successes and aspirations. National Healthy Cities Networks provide political, strategic and technical support to their members, represent a national resource of experience and expertise in health development isues and offer a dynamic platform for public health advocacy at the national and international level. Each national network is unique and develops in response to the needs of its member cities, according to the resources available and within its own cultural and legal framework (Janss Lafond et el. 2003). |

| | | | |
|---|---|---|---|
| City leadership for health (Green & Tsouros 2008). | Evaluation of Phase IV of the WHO European Healthy Cities Network. | 31 | This report is a summary evaluation of the previous Phase IV of the WHO European Healthy Cities Network, and focuses on the organization of Healthy Cities, their values and the core themes worked upon during Phase IV. A number of key messages for city decision-makers and the international public health community are presented. The report states that health is the responsibility of every sector in a city, and that mayors have a key role in orchestraiting the contribution of many important actors. Healthy cities, acording to the authors, provide a "compass" which promote health as an enduring core value in city policies and development plans striving for participatory governance (Green & Tsouros 2008). |
| Zagreb Declaration for Healthy Cities (WHO 2009b). | Consensus document originated from the Zagreb Conference 2009. | 8 | This declaration was composed by the mayors and senior political representives of European cities gathered at the 2008 International Healthy Cities Conference in Zagreb. This was a preparation for the launching of a fifth phase of Healthy Cities action that will inspire and guide their work in the next five years. It reviews plans and priorities for phase V (2009-2013) of the WHO European Healthy Cities Network and national Healthy Cities networks in Europe and identifies how regional and national governments and the WHO can support and benefit from these approaches. The declaration expresses a clear and strong commitment of political leaders of cities in Europe to work towards health equity, sustainable development and social justice (WHO 2009b). |
| Health Promoting Hospitals: a typology of different organizational approaches to health promotion (Johnson & Baum 2001). | Research article published in Health Promotion International, Vol. 16, No. 3, 281-287, September 2001. | 7 | This article discusses the network Health Promoting Hospitals, which was initiated by WHO after the first conference on Health Promotion in Ottawa in 1986. Five major action areas were at the time singled out by WHO as settings-based health promotion arenas; hospitals, the workplace, the community, schools, and the home and family. (Johnson & Baum 2001). |
| Evaluation of the participation of Aretaieion Hospital, Greece, in the WHO pilot project of Health Promotiong Hospitals (Tountas et al. 2004). | Research article published in Health Promotion International Vol. 19, No. 4, 453-462, November 2004. | 10 | When the Hellenic Network for Health Promoting Hospitals was established in Greece, the Aretaieion University Hospital took part in the WHO:s Pilot Health Promoting Hospitals Project from 1993 until 1997. This article presents a study which is an overall evaluation of the participation of Aretaieion Hospital in the HPH Pilot Project. The evaluation comprised two questionnaire surveys, one among all the professionals, and the other among the patients involved in the subprojects. The results of the surveys indicate on both problems of the project but also successes (Tountas et al. 2004). |
| Managerial attitudes on the development of Health Promoting Hospitals in Beijing (Guo et al. 2007). | Research article published in Health Promotion International Vol. 22, No. 3, 182-190, May 2007. | 9 | In 2002, the Beijing Committee for Disease Prevention launched guidelines based on Health Promotion Hospitals, promoted by the Ottawa Charter for Health Promotion. HPH pilot projects were then initiated, on a voluntary basis, in 44 Beijing hospitals. This article outlines this HPH project and its development, and reports on the attitudes and contribution of hospital management as determined by questionnaires and interviews from 281 managerial employees from 106 Beijing hospitals. The results of the evaluation reveals main percieved barriers, but also on what can be done for further development of HPH:s in China (Guo et al. 2007). |
| Ideal och realiteter om miljö- och hälsofrämjande skola i Värmland (Björklund & Guldbrandsson 2006). | Bachelor thesis published at Karlstad University | 29 | This article analyzes the methods used by member schools of the European Network for Health Promoting Schools (ENHPS) to make the arena a healthy arena for both students and staff. ENHPS uses a settings approach and targets the school as their primary arena for change. The aim for the network is to support all people in the arena to adopt a healthy lifestyle by creating supportive environments and by working with a health promotive approach. The network also strives to promote positive relations between the schools and the society in which they exist (Björklund & Guldbrandsson 2006). |

### *Interviews*

For finding our respondents, we consulted with the Chair of the Advisory Committee for the WHO European Healthy Cities Network. Initially, we selected 20 cities throughout Europe, considering their size, geographic location and how long they had been members in the WHO European Healthy Cities Network. We consulted with the Advisory Committee Chairperson and she then narrowed the selection down to eleven, considering the contact persons' ability to perform an interview in English and thus being able to give sufficient information. We then contacted the cities via e-mail. After a week's wait and a reminder e-mail sent out seven days after the initial invitation, we received five responses in total, four that said that they were happy to help and one that declined due to lack of time. As our aspiration was to get as many respondents as possible, we turned back again to the complete list of member cities and chose another six cities. Our second selection was again supported by the Chairperson of the Advisory Committee. We contacted these additional cities via e-mail, and after another

reminder e-mail sent out five days after the initial invitation, we got two responses back. This gave us in total six respondents that were willing to be interviewed. Unfortunately, we had to decline one of the interviews due to an inability to find a date for an interview that suited both parties, and another respondent expressed the wish to provide answers via e-mail. This e-mail was never received, which gave us a final number of four interviews. Through intense e-mail contact, dates and times were decided for the telephone interviews with all four cities (Léganes, Turku, Milan and Belfast).

The respondents were all women, and they were all representatives for their city in the WHO European Healthy Cities Network. When consulting with the Advisory Committee Chairperson, she was confident that these contact persons would be able to give solid information on our research topic. Approximately one week before conducting the interviews, the interview guide was sent out to the respondents via e-mail. The interview guide was constructed by looking at the factors found in the result of the document analysis, i.e. we included the success factors that we considered the most important in that analysis. As we had considered the possibility that the interview guide might have an affect on the respondents' answers, we pointed out to them that the idea was to conduct open interviews with a relaxed atmosphere in which the respondents could speak freely. Respondents could see the interview guide as a starting point but were encouraged to talk about the factors that had determined success in their particular city. All of the interviews were performed via telephone, and varied from 30 to 55 minutes in length. The interviews were conducted by both authors collaboratively via speaker phone. We taped the interviews using an mp3-player with a recording function. This worked adequately for us to be able to transcribe the data. The interviews were trancribed word by word, and after the transcribing of interviews was finished, the content analysis of the data was conducted.

### 3.5 Analysis methods

According to Krippendorff (2004), content analysis is one of the most important research techniques in the social sciences. It seeks to understand data as symbolic phenomena, not as a collection of physical events. A content analysis should be used when trying to draw valid and reproducible conclusions from a text to its context and it gives the researcher the possibility to find recurring categories that are useful for the analysis of the data both before and during the process (Krippendorff 2004). As we used both a deductive and an inductive approach in our analysis, a content analysis suited our work very well. Some of the categories of success factors were already identified from the document analysis (deduction), but we were also openminded when it came to adding new categories (induction) (Patel & Davidson 2003). A content analysis was used both for analyzing the data collected from the documents and the data collected from the interviews.

After deciding on documents relevant to our research aim, we sat down together to analyse the texts. We went through the selected documents systematically as recommended by Krippendorff (2004). When we found sentences or words that we interpreted as success factors, these were highlighted and we wrote the code in the margin (e.g community participation, leadership). After going through all the documents, we summarized the factors and thus created a code map (see Appendix A). From this code map, we then chose to present the success factors that occurred most frequently in the texts in the result chapter. This is because we interpreted the most reoccuring factors as being the most important for creating change in local public policy.

When analyzing the interview data, we used the transcribed text as our base. In total, the transcribed text from all four interviews amounted to 30 pages. Again, we sat down together to analyze the collected data. We systematically read the transcriptions and identified categories in the same way as in the document study, by writing the code in the margin when finding a sentence or words that implied a success factor. We summarized these factors and created a complete list (see Appendix C). From the total amount of success factors found in the interview data, we chose, in the same way as in the analysis of the document study, the most frequently occurring success factors to present in our result chapter.

# 4. RESULTS

## 4.1 Results of the document analysis

Throughout the document analysis, 22 factors for determining success in regards to reorienting local public policy towards healthy public policy were identified (see Appendix A). In this chapter, we have chosen to present ten of these factors, as we interpreted the most frequently occuring factors as being the most important. These were: community participation, intersectoral collaboration, political commitment, status, meeting places, funding and financing, innovative projects ("thinking outside the box"), mass media, holistic thinking and systematic, goal-oriented work. We will present the categories in order of recurrence, i.e. the most frequently occurring success factor will be presented first.

The most common success factor found in the documents was community participation. The significance of community participation for the success in improving local public policy was strongly emphasized in all documents, and this was made clear in phrases like:

> *Community members were invited to a meeting where they were asked to participate more formally in a community health group. The meetings also provided the community to discuss local issues with mayors.*
>
> *…ensuring the individual and collective right of people to participate in decision-making that affects their health, health care and well-being. Providing access to opportunities and skills development together with positive thinking to empower citizens to become self-sufficient.*

The next success factor identified throughout the document analysis was intersectoral collaboration. Intersectoral collaboration is seen as crucial for the success of the Healthy Cities programme's ability to affect local public policy, and it was written about in ways like:

> *Mayors, local government heads, the Ministries of Health, nongovernmental organizations and institutes of public health were partners of the project.*
>
> *… the process through which organizations working outside the health sector change their activities so that they contribute more to health. Urban planning which supports physical fitness by providing ample green space for recreation in the city is an example of intersectoral action.*

Political commitment emerged in the documents as the third most frequently mentioned success factor. As the previous two factors, it was emphasised in a most urgent way when

talking about what makes a difference in affecting local public policy. This was made clear in phrases like:

> *Politicians generally agreed that membership of the Network had helped to increase local awareness of the importance of health promotion and disease prevention.*
>
> *The political commitment of city mayors is essential to ensure the cooperation of municipal departments.*

The next success factor to be identified in the analyzed texts was status. In the documents, status referred to the status of local public health actions and projects, and that giving such activities status was important for being able to raise the status of public health within the city administration, and consequently affect local public policy in a later stage. The importance of giving the public health actions and projects status in the city/country was mentioned like:

> *The following main principles of the healthy city project have been adopted within the national programme: an increased role for local authorities in public health; policy support for health for all at a city level…*
>
> *... the WHO label of quality, which has helped to mobilize local support for initiatives that had been at the periphery of our policy focus, such as dealing with inequalities.*

Meeting places was another success factor identified in the document analysis. By meeting places, we have considered not only the possibility for different political parties to meet and discuss things, but also places where the community can meet politicians and local/national authorities, and also the opportunity for specialists within a certain area to come together. All of these aspects were mentioned in the texts, and the emphasis lay on the importance of the city to create such forums to encourage participation and communication between groups in society and the private/public sector in creating change towards healthy public policy. It was expressed in phrases like the following:

> *X University broadcasts the course to municipalities by videoconference. Small municipalities in northern [parts of the country], which are distant from universities, have especially benefited from this interactive technique.*
>
> *Each county team was composed of atleast nine people, including political, technical and community representatives.*
>
> *Concurrently, training courses were held for health personnel, including nurses, midwives, primary health care physicians and gynaecologists.*

Another important success factor to emerge from the texts was funding and financing. Almost all documents mentioned this as an important factor to reach success in reorienting local public policy towards healthy public policy, mostly because of the reality of having to have resources for financing projects for them to be able to make an impression and have an affect on peoples' lives. Funding and financing was presented in ways like:

*The Ministry of Health and the Ministry of Labour and Social Welfare expressed support and paid the trainers, making the course free of charge for the participants.*

*Successful Days for Health activities included: …; and planned financial resources in the annual budget.*

Another success factor to be identified throughout the document analysis was the ability to organize innovative projects, and the possibility and the will to "think outside the box" when organizing projects. Doing this was said to help raise the status of public health in the cities/countries mentioned, and consequently made health an important issue to consider in shaping local public policy. Phrases like the following were recurrent:

*Building on the success of this first step, the idea of creating an annual mass media award for coverage of the healthy cities movement in X was born.*

*Community facilitators presented the project to local people by going door-to-door and explaining the project...*

*A full programme of activities was organized on the boat to raise awareness of health issues through theatre, film, exhibitions, video and shows.*

Furthermore, utilization of mass media was seen as crucial for success. This was, not unlike the previous success factor "innovative projects" stated as being a help towards raising the status of the public health in general and Healthy Cities and its principles in particular. An elevated status would then lead to a greater awareness of the possibility for achieving healthy public policy. The contribution of mass media was written about in terms of:

*The event had been promoted in the local and national press to give visibility to issues surrounding physical exercise and to invite all population groups to participate.*

*The basic idea of the award is to give higher visibility to health and environmental issues through coverage of Healthy City activities in various forms of national and local media.*

*The event and the publication helped to strengthen political support for the Network as well as the focus on health in cities and counties.*

Holistic thinking was also found to be one of the important factors in regards to making clear connections between political decision making and health, and also between for example environment and health. Phrases like the following ones where used to describe the matter:

*... the Profile explicitly linked health and environmental data provided cities with a stronger basis to discuss comprehensive solutions to local problems.*

*The participants generally agreed that the key to the public's health lay outside the health care system.*

The final success factor to be frequently mentioned throughout the document analysis was systematic, goal-oriented work. This was described in terms of working systematically and having set goals to achieve change in local public policy. Some of the phrases used to describe this were:

> *...there had to be strong organizational commitment to change, supported at multiple levels of the organization, and reflected in policy and practice change.*

> *The study also concludes that we have to work systematically, and that more evaluative research is needed if the rethoric of healthy settings is to become a reality.*

### 4.2 Results of the interviews

Throughout the analysis of the data collected from the interviews, 18 success factors for the reorientation of local public policy towards healthy public policy occurred frequently (see Appendix C). From these 18 factors, we chose to present the six most frequently occuring factors. These were: intersectoral collaboration, holistic thinking, systematic and goal-oriented work, political commitment, status and funding and financing. We will present the success factors in order of recurrence, i.e. the most frequently occurring success factor will be presented first. In addition to these factors, we will also present the opinions expressed on community participation and readiness for institutional change, as they present a mixed picture on whether they are determinants of success for reorienting public policy at a local level.

The success factor that the respondents expressed as most important for improving local public policy was intersectoral collaboration. The need to work together to create change was strongly emphasized by all respondents, even though a few also pointed out the difficulty in achieving this. This was expressed in sentences like:

> *… I think a lot of the key decisionmakers in the city, both from environmental health… and the health service… decided that… this was a very new approach to health so looking at it from that broader intersectoral perspective… could actually deliver better health outcomes for the city…*

> *… there now we have been successful in… in the city council actually establishing a strategic healthy ageing partnership, and it will look at implementing for issues ehm… that engage a whole range of the sectors across the city.*

> *…health will have a strategy for older people, housing will have a separate strategy, city council will have a separate strategy… so, it's a huge challenge, because you're dealing with very different administrative systems, and, chief executives all have their own responsibility.*

The success factor to get mentioned second to most frequently in the interviews was holistic thinking. The respondents expressed that Healthy Cities has brought a new way of looking at health, the holistic way, and that this new approach has lead to a more successful approach in working towards creating healthy public policy.

*This would be incorporating what the WHO understands by health, that would be a bio-psychological aspect that would be incorporated into the public agenda in the area of health… so we're talking about town planning, the creation of new green spaces… cycle lanes… reduction of pollution, and… in general making the city as healthy as possible and the city as friendly as possible…*

*So yes, I would say Healthy Cities produced the initial holistic thinking…it's testing the whole concept of integrated planning… that, we, you bring sectors together… So, for us, the whole concept of holistic thinking is taking it to that stage of… joint integratus planning from the very early stages of policy development.*

Another success factor to get mentioned as important in the interviews was working systematically to achieve locally set goals. This means that Healthy Cities has contributed with a systematic approach to working with public health issues, and implementing this way of working has, according to the respondents, made public health more visible and has helped create a positive change for local public policy.

*At the same time, we developed in X the proper active work on that issue and we provide the municipality with guidelines in order to approach the urban planning with the consciousness of the factors that… ehm… determine health.*

*Before this plan was drawn up, there was a diagnosis of health in the city. And then they coordinated ehm… a number of factors in order to be able to meet the objectives. Objectives, actions and evaluations.*

Political commitment to the programme was also frequently mentioned as important for success. Political commitment to the strategies of Healthy Cities was said to facilitate creating the desired change towards healthy public policy by giving the issue a sense of immediacy. Also, political support for interventions and projects were considered crucial for the interventions to happen, and for ensuring a positive reception of them. Despite this, a minority of the respondents surprisingly downplayed the importance of political commitment, and instead implied that the real work done to create the needed change and design healthy public policy was performed by the civil servants.

*We go, yeah, we get support for the initial application on the themes at the very highest both political and administrative level. And then, when we do, when we plan… our implementation we go back to that level and say: -Can you identify a senior person with which we can work?*

*…when we receive for example the Phase V paper that has just came out, if we look at the core themes in [that], we go to regional government department here, ehm, that would have responsibility for that particular issue, and we gain their support… So that then we can come back and say: -Well you've signed up to this, we now need to be able to deliver…*

*It is important, yes… to have political support…You have to have this contact also on a policy level, but if the civil servants don't want to promote Healthy Cities to the politicians… then it won't even be on their agenda.*

Furthermore, status was mentioned as one of the important factors for success: in this category we include both the importance of the level of status that public health has in the city and the status that membership in Healthy Cities bring to public health. Both of these aspects of status are identified as success factors for improving local public policy.

> *So, it works very well, and we now… we now identify the senior officers that we would want to work with, and not choose the acceptable. And that's about… that's about maturity of the organization and… about the credibility, the high profile credibility that we have now.*

> *I think the WHO label is very important, to… arrange a very senior people and political administrative within the city. So it's important that it's seen as… a project or a piece of work that is connected internationally to experts in health…*

Another essential factor for success we identified in the interview data was funding and financing. As can be seen below, it was mentioned as a factor for success in creating change for local public policy due to its immediate effect on the ability to work towards bettering health and reducing its inequalities.

> *And I think… honestly now don't believe that… if we weren't succeeding we wouldn't be funded.*

> *Yes, it may… may change from one year to the next, it depends on the programmes that are presented… Yes, X always hope for it to increase from one year to the next. Due to the credit crunch X are going to be cutting back 20% this year. …what X gonna try and do is ehm… cut back on projects that were… that still haven't been implemented but they were hoping to implement… So that people… don't get the impression that X is cutting back on their… ehm… health conditions.*

In addition to these factors that occurred frequently in the interview data, we would also like to present the opinions expressed on community participation and readiness for institutional change. This is because these factors are strongly emphasized in documents presented on the success of Healthy Cities published by WHO, but when asking the respondents, we got vaguely negative responses about the affect of these factors. All respondents agreed on that community participation and readiness for institutional change were important, but the difficulty lay in the implementation of these factors in practice. This compromised the affect the factors had on the success in reorienting local public policy towards healthy public policy.

> *Yes… of course it [community participation] is important…because it is the people that know best… what happens in the townships. So of course it is important to listen to them, but… it's still, I would say, a sort of fear that you are asking enough from the people, cause the civil servants know everything… we don't have to ask the people that much. Which isn't true of course, but… too little is happening.*

> *I think the readiness for institutional change is quite a challenge. You know, as in any department.*

*…it's, it's very positive on one hand, but on the other hand they actually know that if we're asking… if we're going to the housing for example or the municipality, or some sector in the city, they know that what we will be asking them to do is quite challenging. So, sometimes we're not very welcome, haha!*

# 5. DISCUSSION

In this chapter, we will discuss the results of our document analysis and the results from the conducted interviews. We will also make connections between these results and governance in public health and the promotion of healthy public policy made by WHO through the Healthy Cities programme. In addition, we will discuss the methods used and the validity and reliability of our research. Finally, important and interesting thoughts on health governance that has appeared during this research process will be presented and last but not least, suggestions for further research on this topic will be made.

## 5.1 Discussion of results

The results of the document analysis show that the success factors identified in the selected documents are numerous (see Appendix A). WHO (2006) has stated that the four key "elements for action" that must exist in every city for the Healthy Cities programme to be successful are political commitment, intersectoral collaboration, strong leadership and institutional change (WHO 2006). Since WHO has highlighted these four factors explicitly, we understand these factors as being the most important for success according to WHO. These four factors were also confirmed as significant for determining success through our own analysis. However, another two factors occurred frequently in our document analysis. These two additional factors were community participation and status, and status was referred to as both the status given to local actions for health and the status of public health within the city administration. As the included documents all discussed factors that determines success in WHO programmes, we also consider these two additional factors as being important from a WHO perspective. Furthermore, in the interviews, we found another two deviant factors from the ones mentioned above, namely; holistic thinking and systematic and goal-oriented work. These findings might indicate that the factors that make a difference at a local level and actually facilitate the needed change for achieving healthy public policy differ slightly from the key factors previously crystallized by WHO.

In the interview data, we also found additional thoughts on political commitment and community participation that differed from the positive image WHO promotes on these particular factors. For example, a minority of the respondents downplayed the importance of political commitment for the success of the Healthy Cities programme, and instead implied that the real work done to create the needed change in creating healthy public policy was performed by the civil servants. Also, the overall opinion on the importance of community participation in health governance was uncertain. As can be seen on the code map (see Appedix C) from the interviews, community participation was not even mentioned among the top four factors for success. This was found surprising by the authors, as community participation emerged as the number one success factor in the document analysis. In other words, even though the respondents recognized that including the community in decisions was very important, they also said that this was not always practically feasible. Even though community participation has been one of the main focuses of the Healthy Cities programme

from the start, respondents said that enabling community members to take part in decision making was recognized as the biggest challenge for the member cities.

As the code maps resulting from the analysis of the documents and the analysis of the interviews in great part overlap and identify similar factors for success (see Appendix A and Appendix C), we can come to the conclusion that WHO has been successful in implementing the Healthy Cities philosophy, and thus been able to spread the idea of health governance in Europe. Despite this, the majority of the respondents expressed that even though a holistic view on health has been adopted and some form of health governance is in practice in the cities, creating an institutional change for health is difficult. For instance, intersectoral collaboration and a readiness for institutional change were mentioned as challenges in the interviews. The difference in success factors found in the interviews and the document analysis might thus indicate that the change that has taken place in the member cities so far is mainly ideological. This discrepancy corresponds with Leppo's (1998, in Kickbusch 2007) discussion. Leppo says: "one of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has occurred about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different"(p. 157).

However, when drawing the conclusion that WHO has succeeded in spreading the idea of health governance and implementing the Healthy Cities philosophy in its member cities, one also has to have in mind that member cities commit to uphold the values of the Healthy Cities programme upon entrance into the network (WHO 1997). They are thereby obligated to adopt the strategies that WHO provide them with, and this might create a bias in information given by the respondents. By providing the member cities with set guidelines, WHO employs a top-down approach (Walt 1994) to policy making at a local level. The member cities also agree to be governed when entering the network, even though they still have a large amount of self-determination when it comes to shaping policies in their own cities (Pierre 2001). As WHO at the same time advocates a bottom-up approach (Walt 1994) and strives for community participation, the complex relationship between WHO at an international level, and the member cities at a local level, constitute a predicament and a paradox.

As mentioned in previous research, there is a need for a model that can adapt to local conditions for the Healthy Cities programme to be successful (Baum et al. 2006). Since we have come to the conclusion that implementing strategies promoted by WHO at a local level can be difficult for the member cities, adapting Healthy Cities to one's own context might help in reducing the difficulties of translating theory into practice. In other previous research, intersectoral collboration was mentioned as crucial for succeeding in reorienting local public policy towards healthy public policy (Springett 1998), and it has also been identified as a key success factor by WHO (WHO 2006). Throughout the interviews, the respondents agreed with this but expressed that this too might be difficult to realize in practice. Again, translating the strategies promoted by WHO into plans for every city's specific circumstances might help reduce these difficulties. Despite this, the attitudes among the respondents towards membership in the WHO European Healthy Cities Network were overall positive, and even though difficulties still exist, the respondents maintained that Healthy Cities enables them in taking the next step towards healthy public policy at a local level.

Also, during this research process, interesting thoughts on the justification of the governance performed by WHO has emerged. Historically, health policy has had a focus on individuals and patients, but public health policy has increasingly been seen as a complementary

perspective, which focuses on the social determinants of health (Marmot & Wilkinson 2006). As the social determinants of health has been emphasized more and more, the health concept has been connected to moral and social order (Tillgren 2009). This has had a considerable affect on the work of WHO. Tillgren (2009) says that health has a value in itself, but also that it is considered favourable for the nation state to have a healthy population and workforce. This indicates an agenda that considers and prioritizes the society before the individual's freedom of choice. Naturally, WHO has the individual's best interest in mind when directing and coordinating in global health matters (WHO 2009c), but by exercising this influence, the individual's room for self-determination shrinks. By providing strategies that are to be implemented in the member cities of the WHO European Healthy Cities Network in all sectors and at all levels, WHO can affect laws and regulations regarding health at a local level (Kickbusch 2007). This might force individuals to adjust to these new regulations and thus limit their control over their own health. This insight also contradicts the alleged strenghtened position of citizens that Pierre (2001) talks about as a consequence of decentralization of power, and the emphasis on community participation made by WHO and the Healthy Cities programme (WHO 1997, WHO c. 1998, WHO 2006, WHO 2009a, Green & Tsorous 2008).

### 5.2 Discussion of methods

In all research, the question whether the results found can be trusted and reliable is always raised. The term "reliability" refers to the trustworthiness of the research, and if another research study using the same prerequisites would end up with the same results as in the first one, the reliability is considered good. We believe that our research, if performed in the exact same way by people with the same knowledge as us, would lead to the same results as has been presented in this study. The only thing that might differ is the interpretations of data and the conclusions drawn from this data. Overall, we consider the reliability of this study as sufficient as we have a good understanding of the factors that may have had an affect on our data.

The term "validity" refers to the researcher's ability to actually investigate what the research is meant to investigate. The validity can never be better than the reliability (Patel & Davidsson 2003). One of the consistent criticisms of research originating from the human science tradition is that it lacks validity. This means that it is without a foundation from which one can assess the differences between objective facts and subjective interpretations of the researcher. Human sciences relies heavily on the interpersonal involvement of the researcher and his/her judgement, and a discussion whether this reliance is too heavy is always present within this context. For example, statements like "human science research is not valid because it is not objective" are discussed. However, human science researchers reject the claim that any form of research can lead to absolute certainty and says that the goal of pure observation, free from theoretical, social, historical or cultural bias has proven unrealistic (Kvale 1989).

As we can never know why our respondents chose to participate in this study, we can not question their motives, but in some cases the agenda of the respondents can play a major role. This can in turn affect the data as respondents can use the study as a forum for publicity, and only give comments and answers that reflect positively on them and their city. In other cases, the respondents might feel a responsibility towards WHO and/or their decision makers to give certain answers (Repstad 2007). Despite this, we have to believe that the respondents participated with a good intent and wanted to help us in our research, and that they therefore provided us with truthful answers. Another factor that might have had an affect on our validity is the small number of respondents that participated in interviews. Four interviews

might be too few to give a complete picture of the member cities' opinions on success factors, but taking into consideration the lack of economic resources, the authors did not have the opportunity to include any more interviews. Despite this, we believe that the validity of this study is good, as we feel we have adequately answered our research questions. Also, considering the fact that our results correspond with previous research conducted on the success factors in creating change in local public policy by using Healthy Cities, and that the factors found on the whole match the ones identified by WHO, we feel that the result is valid.

To get a broad, general view of our research topic, and an explicit knowledge regarding the factors needed for achieving success in changing local public policy, we chose to use a document analysis as an initial method. One important thing to remember while searching for relevant literature is to be critical when assessing the document. One has to take into consideration the purpose of the article or book, who the author is, and if the document has been produced as an assignment for a particular organisation or authority (Patel & Davidson 2003, Bryder 1985). In our document analysis, the majority of documents are produced by WHO and by people with great insight into the Healthy Cities programme and other similar networks, and this might create a bias in the empirical data. However, since we were aware of this potential bias and analyzed the documents as objectively as we could, this bias was not considered a problem.

As a complementary method, interviews were conducted to get the respondents' own thoughts and opinions on what success factors might have made a difference in their particular circumstances. For getting in touch with our respondents, e-mails were sent out inviting them to participate in our research. This might have affected the number of replies we got, as contact persons in this field most often are very busy and get a large number of e-mails every day. Our e-mail might have been overlooked or the respondents might have prioritized their everyday work instead. Also, since we mentioned that the research topic would be about success factors in reorienting local public policy towards healthy public policy, some of the contact persons might have felt that they did not have anything to contribute with, as their work might not have been successful. Before conducting the interviews, the interview guide was sent out to the respondents to give them an idea of what we might discuss during the interviews. This was also due to requests from the respondents. However, we pointed out that the factors brought forward were just suggestions and that the respondents were free to discuss any factors that they considered important. Nevertheless, this might have directed the respondents into talking about certain factors and to give specific answers to our questions. And finally, we considered the use of the term "success factor" when planning the interviews, and if this term would be the best one to use as it is subjective. What is considered a success for one city might not be success for another. Still, we finally decided to use this term when contacting the respondents, as we wanted to identify the factors determining success and not look at the success in itself.

As the authors had limited economic resources, the interviews had to be conducted via telephone. Shuy (2002) mentions a few disadvantages of telephone interviewing that might also have applied to our situation. These were; less accurate responses due to contextual naturalness, less effectiveness with complex issues, less thoughtful responses and a difficulty in discussing sensitive matters. As we did not consider our interview questions as sensitive, this disadvantage did not affect the results. However, the other disadvantages mentioned by Shuy (2002) might have had an effect on the data collected from our interviews. Despite this, we consider the information collected as sufficient.

When choosing the success factors that were to be included in our result chapter, we looked at the factors that were mentioned most frequently in both the documents and in the interviews. We realize that just because a factor is mentioned many times it might not be the most important factor, but when looking at the documents and listening to our respondents, we consider this the most logical conclusion. Also, we are aware of that our selection of documents might have had an affect on what success factors were identified by the document analysis. Nevertheless, after analyzing a majority of documents, most factors reoccurred several times and finally, no more factors could be added as they had all been mentioned before. The documents were also very different in length, style and purpose, and because of this variation, we consider the results of the document analysis as reliable.

Finally, the fact that neither the authors nor the majority of the respondents had English as their first language might have had an effect on the interview data. Questions might have been wrongly understood, and the answers to the questions might have been inadequately apprehended by the authors. Furthermore, the use of a speakerphone and an mp3-player for recording the interviews partly obstructed the collection of data, as the sound quality was sometimes affected.

### 5.3 Conclusions

In conclusion, the results of this research have shown that health governance practised by WHO through the Healthy Cities programme is considered successful, and that being a part of the WHO European Healthy Cities Network has made a difference for its member cities. The main difference for the member cities is to be found in ideology and attitudes in regards to public health issues, but translating these ideological changes into practice is a challenge. Therefore, the authors promote further research in this matter for reducing the difficulties in translating theory into practice. Also, during this research process, interesting thoughts on the justification of the governance of WHO has emerged. As the social determinants of health has been increasingly emphasized in recent decades, the work done by WHO has been affected. Health has been connected to moral and social order (Tillgren 2009), and the individual's right to decide over his/her own health is less emphasized. This indicates a perspecive that puts the society and its structures before the individual, and as WHO increasingly affect laws and regulations concerning health issues at a local level through programmes like Healthy Cities, this might lead to individuals having to adjust to these new regulations. Consequently, the best interest of the individual has to give way for the control of society, and this ultimately limits the individual's control over his/her own health. The fact that WHO is essentially omnipotent in the field of public health today, and that its member countries support its authority, create a kind of super-institution that operates without being questioned. And does the existence of this global institution not contradict two of the core strategies of health promotion, namely participatory governance and community participation?

### 5.4 Future research

During this research process, reflections on the purpose of the published materials on Healthy Cities have been made by the authors. WHO presumes in all the published material on the Healthy Cities programme that the changes made in the member cities after joining the Network in regards to reorienting local public policy has been an affect of the membership (WHO c. 1998, Janss Lafond et al. 2003). But is that the sole fact? Considering the global changes in knowledge about and attitudes towards health issues we see today (Kickbusch 2007), changes in local public policy might have happened in the member cities even if they had not joined the WHO European Healthy Cities Network. To be sure of the origins of these

policy changes, there is a need for conducting comparative research between changes made in member cities to changes in non-member cities.

During this research process, we have sensed a lack of research regarding the actual effect that a healthy public policy has on the health status of the citizens. As the long term goal is to improve the health of the citizens, some research on this topic would greatly clarify the purpose of the fierce struggle for achieving healthy public policy on a local level.

Also, as it has been shown in previous research (Baum et al. 2006), the factors determining the success of the member cities might be contextual, and this insight raises important and interesting questions about the general applicability of Healthy Cities – for instance, is the Healthy Cities programme feasible in regions less developed than Europe? Can intersectoral collaboration and political support exist in countries with corruption? These questions would make interesting future research topics.

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Appendix A.

# CODE MAP – DOCUMENT ANALYSIS

Community participation/involvement/commitment

Intersectoral collaboration

Political involvement/commitment

Status of the programme

Meeting places

Funding and financing

“Thinking outside the box”

Mass media

Holistic thinking

Systematic, goal-oriented work

The ability to work over country borders

Administrative and technical resources

Exchanging knowledge through the network

Leadership

Evaluation

Readiness for institutional change

The network should be allowed to achieve influences on several levels

Ability to juggle competing demands

Genuine engagement

Visibility

Capacity building

Attitudes

Appendix B.

# INTERVIEW GUIDE

LEADERSHIP
- Strong and enthusiastic leader/coordinator

READINESS FOR INSTITUTIONAL CHANGE

SYSTEMATIC, GOAL-ORIENTED WORK WITHIN YOUR CITY
- Settings approach
- evaluation, long-term vision → sustainability

POLITICAL COMMITMENT/INVOLVEMENT

INTERSECTORAL COOPERATION
- joint action

STATUS AND VISIBILITY
- to establish the project in "important" authorities
- to use global "happenings" (like world health day) → common goals, common action
- involve established high-status organizations within the community
- Massmedia attention

FUNDING AND FINANCING
- from external authorities, local or national

MEETING PLACES
- discussion forums for politicians from different political parties
- forums where people from different levels can meet (like politicians, national/local authorities, different sectors and the community)
- networking between cities in Europe

COMMUNITY PARTICIPATION/INVOLVEMENT/COMMITMENT
- meeting people in their own environment
- listen to the communities own opinion, communication
- participatory decisionmaking, community based initiatives
- empowerment

HOLISTIC THINKING
- clarifying connections between political decision making and health/environment and health
- focusing on solutions rather than problems

"THINKING OUTSIDE THE BOX"
- a lot of imagination when organizing the interventions
- innovative projects

Appendix C.

# CODE MAP – INTERVIEWS

Intersectoral collaboration

Holistic thinking

Systematic, goal-oriented work

Political commitment/support

Status

Funding and financing

Leadership

Community participation

Meeting places

Innovative projects

Exchange of information

Genuine engagement

Mass media

Visibility

Attitude

International collaboration

Having external organizations engaged in the program

Technical support