

What makes for sustainable Healthy Cities initiatives?—a review of the evidence from Noarlunga, Australia after 18 years

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SUMMARY

This paper examines the factors that have enabled the Healthy Cities Noarlunga (HCN) initiative to be sustainable over 18 years (1987–2005). Sustainability related to the ability of the initiative to continue to operate continuously in a manner that indicated its existence was accorded value by the community and local service providers. The analysis is based on a narrative review of 29 documents related to HCN, including a number of evaluations. Nine factors emerged as important to ensuring sustainability: strong social health 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 perspectives; 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.

Key words: healthy cities; health promotion programs; sustainability; evaluation

INTRODUCTION

This paper examines the factors that have contributed to the sustainability of Healthy Cities Noarlunga (HCN) by using data from a series of evaluations of the project and the initiatives it has given rise to. The lessons concerning sustainability of community-based health promotion initiatives are presented.

The World Health Organization (WHO) developed the Healthy Cities project as a means of operationalizing the Ottawa Charter for Health Promotion (WHO, 1986; Ashton and Seymour, 1988). HCN was directly modeled on the WHO's European Healthy Cities Program (Hancock and Duhl, 1988) but adapted to an Australian suburban setting (Baum *et al.*, 1990).

It commenced in April 1987 when the Australian Community Health Association received funding from the Australian Government to pilot the WHO Healthy Cities concept in three cities—Canberra, Illawarra and Noarlunga. Noarlunga, the subject of this paper, is an outer suburban area of Adelaide, the capital city of the State of South Australia. In 1988 its population was 77 000.

The Australian pilot phase ran for 3 years (1987–89) and was followed by a funded network project (1990–92). These national initiatives were evaluated (Worsley, 1990; Whelan *et al.*, 1992), and it was concluded that they had some successes but also room for improvement.

HCN was based in the State Government funded Noarlunga Health Services (NHS). NHS was then a new primary health care service that, in 1991, was integrated with a new community hospital. Project funds were used to employ a full-time project manager and a half-time administrative assistant. A two-tier committee structure was established with a Reference Committee that met quarterly with senior agency staff and community representatives, and a Management Committee that met monthly. HCN also attracted significant in-kind contribution from NHS and other agencies. During this period numerous initiatives were undertaken, and a clear vision was established for a 'Healthy Noarlunga'. This vision evolved from a community process and built on a needs assessment that had been conducted before HCN was established (Baum *et al.*, 1986). The project followed the WHO Twenty Steps (WHO, 1995) that are conceived as three stages of project development: getting started, getting organized, taking action.

Dedicated funding was withdrawn following the pilot period, and HCN then relied on in-kind contributions, primarily from the local health service. The community activists in HCN initiated a review of the management of the project in 1991, and this resulted in a decision to incorporate HCN as a non-government organization. The constitution of HCN stipulates that there must be a majority of community members on the Management Committee.

Through the 1990s, HCN continued to initiate and be involved in many projects. Three of particular significance were the *Noarlunga Towards a Safe Community* (NTSC) and *Noarlunga Community Action on Drugs* and the *Onkaparinga Collaborative Approach for the Prevention of Domestic Violence*. Each of these health promotion initiatives had their origins in HCN and then developed and established their own identity. NTSC became an accredited WHO Safe Communities Project in 1996 and was redesignated in 2003. HCN's relationship with the Department of Public Health at the local university continued to develop. From 1991, the two organizations have cooperated in running training programs and developing a post-graduate course on Healthy Cities.

Evaluation has been a central concern of Healthy Cities since its inception. Healthy Cities initiatives are complex in design and execution. The more complex a health promotion initiative is the more difficult it is to evaluate (McQueen

and Anderson, 2001). Most significantly, the assignment of causality to a Healthy Cities project is difficult. There are so many other factors that have a direct or indirect impact on city health that isolating one intervention as the cause of change is problematic (Costongs and Springett, 1997; Baum, 2002). Essentially, Healthy Cities is about mobilizing communities and local agencies, and so local politics play a very central role in the project, and evaluations have to incorporate this dimension (de Leeuw and Skovgaard, 2005). These complexities mean that it is not easy to demonstrate a direct causal link between a Healthy Cities project and a health outcome. However, evidence can be marshaled that a Healthy Cities initiative has given rise to activities that can be reasonably linked to expected health outcomes based on articulated program logic. Such approaches to evaluation formed the basis of the evaluation of the Health Action Zones in the UK (Judge and Bauld, 2001). In addition, one of the criteria for success of a health promotion program is that it is sustainable (Shediak-Rizkallah and Bone 1998; Pluye *et al.*, 2004) even though this has proved difficult to define (St Leger, 2005). We consider the HCN project to be sustainable because it has been in continual operation from 1987 until the present and has strong support from community members, local politicians and service providers (shown by willingness to sit on committees, attendance at AGMs and feedback in periodic reports and evaluations). This support reflects HCN perceived success in changing organizational cultures towards a focus on health promotion, in involving community members in health promotion and in building local capacity. These criteria have been identified as important elements of sustainability (Swerissen and Crisp, 2004).

METHOD

This study is based on a narrative review of 29 documents related to HCN that have been published since 1987. Documents include evaluations, annual reports and material describing activities within the initiative (document list is available at http://som.flinders.edu.au/FUSA/PublicHealth/AcademicHome/FB_home.htm). The documents were reviewed by two of the authors (FB/GJ) and analyzed to identify themes relating to the sustainability of the Healthy Cities initiative. The development of these themes drew

on the extensive knowledge of the reviewers of the international Healthy Cities literature. There is not sufficient space to include a review of this literature here but much of the reviewers' knowledge of Healthy Cities is available in Baum (Baum, 2002, Chapters 22 and 24). The themes were then discussed with the other authors and refined in light of this discussion.

FINDINGS

Between 1987 and 2005, HCN has been involved in 25 significant projects (see for details http://som.flinders.edu.au/FUSA/PublicHealth/AcademicHome/FB_home.htm). These include environmental, safety, school-based, drug use and service access projects.

Our analysis of the documents and drawing on our knowledge of the broader Healthy Cities literature indicated that nine factors had been central to the sustainability of the Healthy Cities initiative in Noarlunga. These are:

- (i) Social health vision
- (ii) Leadership
- (iii) Model adapted to local conditions
- (iv) Juggling competing demands
- (v) Strongly supported community involvement
- (vi) Recognized as 'neutral gameboard'
- (vii) University links and research focus
- (viii) International links and WHO leadership
- (ix) Transition from project to approach

Each of these factors is discussed in more detail below.

Social health vision

From the start of the WHO Healthy Cities project, the value of a social health vision has been stressed (Ashton and Seymour, 1988; Hancock and Duhl, 1988). The visions developed as part of Healthy Cities initiatives were based on a sophisticated understanding that the roots of ill health lie in social and economic factors. Documentation from the first 3 years (1987–1990) shows the extent to which a social health vision was the base for the HCN project. It was seen as important to spend time at the beginning of the project in discussing the WHO Health for All Strategy and deriving locally appropriate goals. These first HCN goals stressed the need to promote awareness and participation by organizations and community groups in social health issues (HCN, 1987).

The pilot project established a community vision based on a series of workshops attended by government agency representatives and community members. The workshop participants produced their vision for a healthy Noarlunga in 20 year's time. This led to a community arts project that produced 'The Dream Machine', a three-dimensional display of the community visions for Healthy Noarlunga. The vision project provided a strong basis for HCN.

An understanding of health as a social issue was supported by State Government policies at the time, including a Social Health Strategy (SA Health Commission, 1988) and a Primary Health Care Policy (SA Health Commission 1989) that aimed to address inequities in health status and increase access to living conditions promoting health and wellbeing. While the political commitment to these policies was strongest at the start of the Healthy Cities initiative, the commitment has been strongly maintained at Noarlunga by the local health service and local government. As one key informant noted in an early evaluation:

We have a head start in Noarlunga because we have so many agencies committed to a social concept of health care. (HCN, 1987)

Throughout the history of HCN, an emphasis on the role of social, economic and environmental factors on health has continued. Many of the earlier activities focused on environmental issues (e.g. pollution of waterways, green area planning). More recently, attention has turned to issues such as the impact of illicit drugs in the community, supporting opportunities for young people and indigenous health and wellbeing.

Leadership

Legge *et al.* (1996) identify inspirational leadership as an important pre-condition for good practice in primary health care. HCN has had consistent leadership over its 18 year history. The project was initiated by one of the authors (RH), who holds a senior management position in the regional health service, and he has chaired the Management Committee over the entire period. A consistent theme in evaluations has been that this leadership is a crucial success factor. For example:

The energy, administrative skills, networking capability, tenacity and positivity of key players was seen as

a key feature in the Noarlunga Towards a Safe Community process. (Rosenfeld and Cooke, 1997 p. 21)

The City of Noarlunga and its successor (following local government re-organization), the City of Onkaparinga, have had the same Mayor for the entire period. He has given consistent support to the notion of Healthy Cities, and although this has not translated into direct financial support, this endorsement has added legitimacy to the initiative and provided a strong link between the Healthy Cities project and the local government.

Following the cessation of Australian Government funding, the Management Committee, and in particular the Chair, took on the project management role with the support of NHS. While the loss of a paid project officer was of concern, there was also the view that HCN was able to continue owing to the 'enthusiasm and driving force' of the Chair (Barkway, 1992).

Model adapted for local conditions

The Healthy Cities movement started in Europe (Ashton *et al.*, 1986) and was based in local government. In Australia, health and social services reside with the State Governments; thus, placing Healthy Cities in local government is a less obvious approach. The Noarlunga project has, from the outset, been based in the local community health service, a State Government agency, and this has worked well in most respects. Following the pilot project, HCN was legally incorporated. HCN has a community-directed governance model, which could appear loose but in fact has proved to be a robust mechanism for encouraging action across local government and the many State Government agencies that have responsibilities in the Noarlunga region (including housing, education, health, welfare). The documents reviewed, especially those in the later years, stressed repeatedly that initiatives were often only felt to have happened because of the previous collaborations that Healthy Cities has encouraged. In effect these had laid the seed bed on which future projects grew.

Juggling competing demands

Throughout the history of Healthy Cities there has been a series of competing demands, and the project has had to decide between priorities across a wide range of possibilities. The tensions in these decisions have remained constant from

the outset. The project has to ensure that it is seen to achieve short-term goals while also working on longer-term ones.

HCN has also had to reconcile priorities coming from social planners (in local and State Government) with those coming from community members directly. Local government was reported as reluctant to fund Healthy Cities directly as the social action component might be critical of council actions (Baum *et al.*, 1992). Indeed HCN has been seen as a mediator between residents, and local and state governments:

...when a community member has a good idea, how do they get support for it? Local government reluctance to become involved. (Baum *et al.*, 1990, p. 39)

This juggling of demands is not always easy but the synergies between the two approaches have led to two very significant initiatives: *Noarlunga Towards a Safe Community* (a community injury project) and the *Noarlunga Community Action on Drugs Forum*. These initiatives came originally from ideas within the HCN Management Committee and were then developed as separate initiatives. Both were founded on the strong methods of working that HCN had developed in community participation and working across sectors. Thus an evaluation of a youth peer project auspiced under the Forum concluded that the project was able to make significant advances in a relatively short period of time because:

... the Forum drew on the networks and tradition of collaborative networking and action established by the Noarlunga Healthy Cities initiative. (Baum *et al.*, 2003, p. 20)

Strongly supported community involvement

An assessment of community participation in HCN found both instrumental and developmental participation occurring simultaneously (Cooke, 1995). Community members hold 8 of the 15 positions on the Management Committee and the extent of community involvement evident in HCN is noted consistently as a strength in the analysis of the documents reviewed.

The Onkaparinga River pollution initiative provides an example of a resident-driven project that was facilitated by HCN provision of:

access to the system and to the key people that can get attention paid to community issues. (Cooke, 1995 p. 99).

Some community members reported this experience was personally empowering and went on to join the HCN Management Committee or become involved in other community issues. Community members have been supported to attend and present at conferences and sponsored to attend the Healthy Cities training course.

HCN recognized as a 'neutral game board' (Hancock, 1992)

Over the 18 years of its operation HCN has engaged with a range of government and non-government organizations. Consistent players over that period have been the South Australian Government departments responsible for health, welfare and housing; local government and community representatives. Other State Government departments have been involved intermittently. For instance, the education sector was involved when the Healthy Schools initiative was being established. As this became a mainstream state program the Education Department withdrew from the HCN committee and later rejoined to become involved in the injury prevention program. The local police have also been active supporters, have been represented on the Management Committee and attend the AGM. A government review of HCN concluded that its existence made it easier for State Government departments to work in Noarlunga, because the cross-sector networks and community involvement were already in place and sustainable. In many ways the success of HCN creates the 'complex, hardly recognizable web of social structures' that Grossmann and Scala (Grossmann and Scala, 1993, p. 25) talk of as crucial for effective health promotion intervention.

There has also been support from Federal, State and local politicians. Recent AGMs have been well attended by the local members or their staffers. HCN has been skilful in avoiding association with any one political party and so has attracted bi-partisan political support. The local Mayor has been a consistent supporter of HCN and has willingly hosted visiting delegations, provided representatives for the Management Committee and talked favorably about achievements on many occasions.

de Leeuw and Skovgaard (2005) and Kingdon (1995) talk of the importance of 'windows of opportunity' and spaces that enable innovations in public health agenda and actions. The skill of HCN has been to use these windows on a

number of occasions to promote local community and public health issues. Kingdon (1995) also notes that the policy process environment is forever changing and those wishing to influence it have to be opportunistic. The leadership of HCN has been very effective in doing just this. For example, HCN used the very favorable climate towards environmental issues in 1990 Federal politics to advance the cause of the clean up of the Onkaparinga River; used the political focus on drugs to establish the *Noarlunga Community Action on Drugs Forum*; and locally demonstrated the need to establish *Tackling Injury Prevention in Small Business*.

University links and research focus

Since its inception HCN has been linked with the State Government funded South Australian Community Health Research Unit. This Unit was responsible for the original evaluation of the pilot project (Baum *et al.*, 1990; Baum and Cooke, 1992). It has also been represented on the HCN Management Committee continually over its history ensuring more emphasis was put on evaluation than is often the case in community-based health promotion.

The Unit was linked with Flinders University from 1989 and from this connection evolved the series of short courses and training undertaken by the University in conjunction with HCN. A training course on 'Healthy Cities and Communities' has run since 1991 and in the last 5 years has attracted, on average, 40 participants. In addition, training has been conducted for WHO and AusAID for people from Thailand, China, Vietnam, Malaysia and South Africa. Staff from NHS and community members of the HCN Management Committee have regularly undertaken the training. This increases the network of people with a detailed understanding of Healthy Cities, the theories behind it and the ways it is implemented in Noarlunga.

Value of international links

From the beginning HCN has focused both inwardly and outward. The original pilot project was designed to test the European idea of Healthy Cities in an Australian context. In the first years of the project there were visits by key figures from the European movement including Dr Ilona Kickbusch from the WHO European office, Dr Trevor Hancock (Toronto Healthy

Cities) and Dr John Ashton from the Liverpool Healthy Cities project. These visits have been important in legitimizing the Healthy Cities approach to local actors and in providing encouragement to those implementing the project. Visits have continued with the most recent being from Dr Ilona Kickbusch in April 2005. That international visits have been maintained across the span of the project is in part owing to the training courses. Each year the course has brought a variety of people with whom the HCN team have been able to learn and share ideas. This has been invaluable in providing positive feedback to the project and bringing new ideas and inspiration. The buzz around HCN following a lively visit from overseas colleagues is palpable and certainly an important input to the sustainability of Healthy Cities. HCN's association with WHO programs and membership of the WHO Safe Communities network have been significant in increasing the profile of the initiative locally. HCN acceptance as foundation member of the Western Pacific Healthy Cities Alliance also had this effect and so contributes to the sustainability of the project.

Another innovation that has maintained an international focus has been the relationship between the Sherpur Safe Community and *Noarlunga Towards A Safe Community* programs. During the period 2000–2005 these programs have worked together in developing and implementing an innovative eye injury prevention program at the grass-roots level for metal workers in small businesses located in Sherpur, Bangladesh. Both Noarlunga and Sherpur share a strong belief in the effectiveness of practical community-based, health and injury prevention programs to safeguard workers employed in small business. Staff from NHS and a local community member have made a number of training visits to Sherpur and in total over 950 workers and child laborers have attended the eye-injury prevention workshops and over 1400 pairs of new safety glasses have been distributed to metal trade workers. HCN and local Noarlunga businesses raised the funding to allow for the training of Sherpur Safe Community health coordinators in workplace eye safety risk assessment. This commitment to supporting an injury prevention project in a poor country has increased community involvement in, and understanding of, Healthy Cities among small business people in the city and led to their sustained involvement and support for HCN.

Transition from project to approach

It was through the determination of local community people that the HCN was formally incorporated with its own constitution. In the 1990s HCN moved from being a time-limited project to being an approach to addressing community health issues. The framework of the Ottawa Charter applied though the Healthy Cities model has encouraged NHS to see that 'health is everyone's business'—and in the case of HCN has included meaningful involvement and sustained commitment from local government, public housing, mental health, police, education and welfare sectors.

DISCUSSION AND CONCLUSION

Our analysis of the documentation on HCN indicates that sustainability of complex, community-based projects depend on a myriad of factors. We have deliberately used the term 'sustainability' in this article rather than 'success' because we consider a sustainable initiative provides a base for achieving health promotion outcomes over time. The documents reviewed suggest that HCN has been successful at engaging some community members who report that this has had a lasting positive impact on their lives. Key informants from agencies report that the mode of operation of HCN means that working across sectors in Noarlunga has become a taken-for-granted mode of operation, which makes it easier for central agencies to engage with the region. HCN has also achieved outcomes that have a direct impact on health, such as removing injury hazards from the community, cleaning up the local river estuary so it is safer for swimmers and engaging in community development, which provides social support and networks that have a positive impact on health. However, as with most community-based initiatives, it is very difficult to attribute any action of HCN directly with a defined and discrete health outcome. This has made it hard to gain external resources for evaluation as large grant funding agencies are most likely to fund research where the causal pathways are relatively straightforward (Kavanagh *et al.*, 2002). Our approach to evaluation is based on being able to show that HCN has brought about change in aspects of community life that other evidence suggests is likely to lead in the longer term to health improvement (see Baum *et al.*, 2001 for more details). The data used for this paper certainly

suggest ways in which HCN is likely to have laid the basis for improved health in many cases and led more directly to improved health in other cases.

The comprehensiveness of the data we have analysed for this study provides a sufficient basis to argue that complex, multi-sectoral community-based health promotion initiatives can be sustained longer term and do bring significant benefits to their communities, at little cost.

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